SERIES NO. 4

LEPROSY
ELIMINATION
ACTION
PROGRAMME

OCT, 09

FOCUS

Partnership for Leprosy Control

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Operational Guidelines, LEAP

Leprosy Referral Centre (LRC) :

Operational Guidelines, LEAP

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Partnership for Leprosy Control

Leprosy Elimination Action Programme (LEAP) is a strategy to sustain leprosy control work during integration phase through a community oriented action programme. The actions proposed are also focussed on enhancing the quality of services to the leprosy affected persons.

The need for sustaining leprosy control work cannot be realised without specific interventions by the specialized leprosy agencies / personnel and the involvement of public health personnel who help to:

i) reach out to the communities for early identification of new leprosy cases among selective population groups where the disease is known to linger and

ii) provide easy access for timely diagnosis and ensure quality care to all leprosy affected persons.

This huge task cannot be comprehensively undertaken by ALERT-INDIA alone, hence the emphasis on partnership with the organizations that have roots in urban and rural areas, where the endemicity of leprosy is known in the recent past.

The LEAP strategy is aimed to meet the needs of the leprosy affected persons by involving various stakeholders such as Government, Municipal Corporations, NGOs (Non-Government Organisations), CBOs (Community Based Organisations) and NGLO (Non-Government Leprosy Organizations) units as partners in action.

Professionals with technical skills and expertise are called to function as LEAP Support Team (LST) of ALERT-INDIA. Building partnership for LEAP is the main task of LST.

Towards this ALERT-INDIA seeks to gather informed involvement and support of the public and private health entities as LEAP partners to augment and strengthen NLEP.

21 October 2009
Mumbai - 400 022

A. Antony Samy
Chief Executive

I

Selective Special Drives

Operational Guidelines

Introduction

Following the reduction in actual number of new leprosy cases and the integration of leprosy services with the general health care system, the active case detection activities through surveys has been abandoned. A general active case detection attempt was considered as not cost effective.

The responsibility to report voluntarily relies on the community who are educated to suspect signs of leprosy and refer / report early thereby minimizes the disease morbidity. This is expected to be the result of all Information Education and Communications (IEC) efforts.

Hence there is a need to educate the community through special campaigns organized in selected areas that is sustainable in detecting new leprosy cases at an early stage. This could be achieved by active participation of the local community in leprosy control through selected partners in a defined area.

Rationale

The Selective Special Drive (SSD) is based on providing information needs that is aimed to achieve behavioral change among local communities using scientific messages about leprosy. Community volunteers and outreach workers are trained and engaged to provide information about the basic scientific facts and education on the signs and symptoms of leprosy to the target communities in selected areas under SSD.

SSD aims to draw the local community resources to conduct various IEC programmes so as to have a significant impact. SSD also promotes involving prospective stakeholders in the targeted areas in order to make it sustainable. This holistic approach has changed the view of the community as ‘owner’ of leprosy control programme that acknowledges their health rights.

Objectives

- To create awareness about the basic scientific facts as well as the signs and symptoms of leprosy.
- To identify, select and train Community Volunteers (CVs) as leprosy spokespersons in the community.
- To promote early voluntary reporting of new leprosy cases.

> The disease control is defined as “reduction of the incidence and prevalence of the disease and of morbidity and mortality from the disease to a locally acceptance level as a result of deliberate efforts. Continued intervention is required to maintain the reduction”. The strategy to achieve disability prevention in leprosy comprises of three major elements : (i) Early case deduction and adequate treatment (MDT), (ii) Prevention of leprosy related disabilities (POD), and (iii) Rehabilitation.
>
> *- Excerpts from GoI, NLEP Guidelines for Disability Prevention and Rehabilitation*

Step 1

Selection and induction of NGOs and NLEP units as Partners in LEAP

The selection and induction of NGOs and NLEP units in the LEAP supported districts is made on basis of following norms:

Norms for NLEP Units

Any organization or a special unit of the Govt. or Municipal Corporation or a registered Non Governmental Organization officially responsible for implementing leprosy control programme in a specific area can become a LEAP Partner.

1. Have a permanent office (owned or rented) with adequate support staff and other basic communication facilities (phone / fax / internet / e-mail), etc. Any Office bearer functioning in the capacity as a member of any advisory committee of the State / National Govt. or international body is preferable.
2. Able to depute or engage the existing personnel with required professional qualification and experience in the field of leprosy control or other community health programmes.
3. Willing to accept the terms and conditions of LEAP Partnership programme for a specific period and agree to implement selected LEAP interventions as per the operational guidelines.

Norms for Health or Development NGOs / CBOs

Any Indian Non Governmental Organization (NGO) / Community Based Organisations (CBO) registered under Society Registration Act / Public Trust Act and fulfilling the following requirements, in addition to the above norms can become a LEAP Partner.

1. Functionally working and have undertaken short or long term projects in health / education / development sector. Experience in undertaking projects related to leprosy control in the past or at present is desirable.
2. Produce on demand the annual financial report certified by a statutory auditor. Registration under Foreign Contribution Regulation Act (FCRA) along with active FCRA bank account is preferable.

Training of NGO and NLEP staff on SSD methodology

The LEAP Support Team (LST) will conduct orientation training on SSD methodology including brief orientation on leprosy to the staff working with the NGOs / NLEP units inducted as ‘Partners’ in LEAP.

Table - 1 : SSD Task Team

NLEP Units (Govt. / Corporation / NGLO)	NGO / CBO
1. District Leprosy Officer (DLO)	1. Project Head
2. Medical Officer (MO)	2. Project In-charge (PI)
3. Non Medical Supervisor (NMS)	3. Project Coordinator (PC)
4. Paramedical Worker (PMW) / Leprosy Technician (LT)	4. Project Health Assistant (PHA)

Step 2

Preparing Action Plan

a) Following the orientation training, the Partner units will prepare an Action Plan for SSD to be implemented in the project areas based on the estimated population - *as per the format given in Annexure 1* - along with the baseline information on the areas selected including budget estimates and the time plan for each SSD - *as per the suggested time period for each SSD (Table - 2)*.

b) Based on the Annual Plan for SSD, the Partner unit prepare a Micro Action Plan on monthly basis – *as per the format in Table 3* - for pre SSD activities, CVs training (date, place and faculty) and the IEC and training materials required for IEC campaigns.

c) The Head of Partner unit must designate one of their senior staff (either PI or NMS) to coordinate with the Project Monitoring Team (PMT) specially created for LEAP. The designated staff will be responsible for submitting the Micro Action Plan and the Activity reports (Monthly / Quarterly) along with supporting documents – *as per format given in Annexure 2, 3, 4, 5, 6 & 7*.

d) The Micro Action Plan for SSD and the estimated budget submitted by the Partner units will be scrutinized by the PMT and recommend for approval and release of funds. All Partner units will be informed about the budget sanctioned along with the schedule for release of funds.

Table - 2 : Suggested time period for each SSD

1	Category of area	Urban	Rural / Tribal
2	Target population (Approx.)	25,000	1,00,000
3	Number of house holds (Approx.)	5,000	20,000
4	Steps for implementing SSD	# of days	# of days
4.1	Pre - SSD activities by NGO / NLEP staff	2 days	6 days
4.2	Preparing Micro Plan for coverage of population		
4.3	Selection of Community Volunteers for SSD		
4.4	Training of Community Volunteers	2 days	8 days
4.5	Planning for coverage of population		
4.6	House to house IPC in the selected areas by CVs	5 days	8 days
4.7	Focussed IEC activities by the NLEP staff		
4.8	Compilation of data and submission of the report	1 day	2 days
	Total duration of SSD* (Approximately)	10 days	24 days

**The duration of SSD may vary in semi urban and tribal areas with hilly and forest terrain.*

Table 3 : Suggested training curriculum for CVs

Day 1 - Self introduction of the participants and faculty members

Session 1: ***Topics (2 hours)***

1. Goals and objectives of leprosy control
2. Cause and spread of leprosy
3. Basic scientific facts about leprosy
4. Signs and symptoms of leprosy and other skin diseases
5. Grouping and treatment of leprosy
6. Methods to identify a suspect for leprosy
   - Group exercise / presentation and discussion

Session 2: Topics (3 hours)

1. Aims and objectives of IEC and SSD
2. Purpose and methods of Intensive H2H IPC campaign
   - Group exercise on IPC activities using communication aids
   - Demonstration by trainees (preferably in the field)

Day 2 - Recap of first day sessions and feedback from trainees

Session 3: Topics (3 hours)

1. Roles and functions of CVs in SSD
2. Personality development and communication skills
3. Records and reports for SSD

Session 4: Topics (2 hours)

1. Division of area and population for IPC by CVs (Micro Action Plan)
2. Planning for IEC campaigns
3. Comments and suggestions from the trainees.

Training methodology:

The training faculty can use any of the following:

- Slide shows / Video shows
- Actual demonstration of leprosy patients
- Mock IEC campaigns using aids
- Group discussion / presentation by trainees
- Photo albums / charts
- Question & answer session

Step 3
Planning and preparation

a) Selection of area and population coverage

In urban areas

Select slum areas / pockets – based on the set criteria *(See box in page 10)* – covering about 25,000 (minimum) to 35,000 (maximum) population under Urban Health Posts of Municipal Corporation wards to undertake SSD. In case, if the target population exceeds more than 35,000, increase the number of CVs or number of SSD days proportionate to the population.

In rural / tribal areas

Select villages including padas – based on the set criteria (See box) - covering about 80,000 (minimum) to 100,000 (maximum) population under Primary Health Care centres in Blocks / Taluks of the district to undertake SSD. In case, if the target population exceeds more than 100,000, increase the number of CVs or number of SSD days proportionate to the population.

b) Pre-SSD activities

Undertake the following activities before implementing SSD (Pre-SSD) in the selected area

(i) Contact and sensitize all the stakeholders from the local area:

In urban areas

- GHC staff (Urban Health Post / Municipal Dispensary)
- School officials (both Private & Municipal Corporation)
- General Medical Practitioners
- Members of mandals / service clubs / municipal council

In rural / tribal areas

- GHC staff (PHC Centre / Sub-Centre / Rural Hospital)
- ASHA / Anganwadi / Pada Workers
- School officials (Govt. & Private including Ashram shalas)
- General Medical Practitioners
- Members of Self Help Groups / mandals / service clubs
- Members of Gram Panchayat / Zila Parishad / Opinion leaders

(ii) Collect and record the following information about majority of the population from the selected area

- Demographic details of the population such as literacy status
- Type and nature of occupation and their availability

- Language commonly spoken and local dialect
- Location of community gathering for festival and marketplace
- Local socio-cultural / religious belief

(iii) Identify and select individuals as 'Community Volunteers' from the area / population selected for SSD from the following:

- Members of Mahila Mandals / Service groups / Self Help Groups / Sports clubs
- ASHA workers / Anganwadi workers / NGO Workers / CBO workers (wherever they can be oriented & effectively deployed).
- Community Health Volunteers / Village Health Visitors / Polio volunteers
- Teachers of Govt. / Municipal and Private school
- Volunteers of NSS / Scouts / Guides.

(iv) Prepare a list of IEC and training materials* required for SSD campaign from the following and procure the same from LEAP

- Flex banner on Leprosy for Poster Exhibition
- Flip chart (Big & small) for group talk
- Colour pamphlets on leprosy for public education
- Colour sticker and posters on leprosy for wall display
- Pictorial diagnostic card for CVs during H2H IPC
- 35 mm slide set / VCD on leprosy for CVs training
- Simple practical guide on leprosy (Hindi / Marathi) for CVs / School teachers

(v) Planning for IEC activities should include the following:

- Proper selection of group
- Exact location and time
- Use of appropriate IEC aids and materials
- Obtain permission / approval from concerned authority / persons
- Availability of electricity and other facilities
- Functional conditions of Audio-Visual equipments
- Ready with an alternate plan, in the event of any unforeseen situation

ALERT-INDIA has designed the above IEC and training materials after a thorough consultation with all stakeholders in urban and rural areas. These materials are produced constantly updated based on the local needs.

In order to decentralize the distribution system of the IEC materials to the NGOs / NLEP units undertaking SSDs, these materials are supplied through LEAP Centres in Mumbai, Nashik and Nagpur.

Step 4

Implementation

I. Training of community volunteers for SSD

Train the required number of CVs selected for SSD. However the number would depend upon the size of population to be covered by SSD. It is suggested to train more number of CVs than actual number of CVs to be engaged for SSD.

In urban areas:

One CV is to be selected for reaching approximately 250 persons from 50 house holds (average 5 persons / house hold) through house to house IPC in one day. Accordingly 20 CVs would be required to reach 25,000 population (i.e. each CV to cover approximately 250 persons from 50 house holds / day) in 5 days.

In case, the population of the area is more than 25,000, the number of CVs required will be proportionately increased (i.e. 1 CV per 1,250 population). However, the total number of CVs selected for training should not exceed 25 and out of which 20 CVs may be engaged for actual SSD.

In semi urban areas:

One CV is to be selected for reaching approximately 200 persons from 35 - 40 house holds (average 5 persons / house hold) through house to house IPC in one day. Accordingly 25 CVs would be required to reach 25,000 population (i.e. each CV to cover approximately 200 persons from 35 - 40 house holds / day) in 5 days.

In case, the population of the area is more than 25,000, the number of CVs required will be proportionately increased (i.e. 1 CV per 1,000 population). However, the total number of CVs selected for training should not exceed 30 and out of which 25 CVs may be engaged for actual SSD.

In rural / tribal areas:

One CV is to be selected in each village (average 1,000 population per village) for reaching approximately 125 persons from 25 house holds (average 5 persons / house hold) through house to house IPC in one day. Accordingly 100 CVs would be required to reach 1,00,000 population (i.e. each CV to cover approximately 200 persons from 25 house holds / day) in 8 days.

In case, the number of villages is more than 100, then either the number of days the CVs to be engaged or the number of CVs to be engaged will proportionately increase (i.e. 1 CV per 1,000 population). In case, the population per village is less than 1,000, then the number of days the CVs to be engaged for house to house IPC will proportionately decrease.

Organize 1 or 2 days training - *based on the curriculum suggested* - for the selected CVs at the convenient place preferably at the nearest GHC centre (Health Posts / Municipal dispensary / Anganwadi centre / Sub-Centre of PHC) or at any community place (Village Panchayat Office / NGO Office / School) from the area selected for SSD campaign.

II Intensive house to house IPC in selected areas by trained CVs

a) Visit every house in the allocated area and give the following information to any one of the elderly member among those available in the family during that point of time.

- Introduce yourself and explain the purpose of visit
- Explain the basic scientific facts about leprosy
- Show the signs and symptoms of leprosy with the help of photo album / diagnostic card
- Inform about the availability of treatment at the local GHC centre
- Motivate to report at the GHC centre for diagnosis, if any suspect signs are noticed in any family member
- If any of the family member report immediately of suspected signs of leprosy, fill the referral slip with all the details.
- Give one colour leaflet for each house hold

b) Maintain a record about the number of persons actually contacted and the number of suspects reported voluntarily during H2H IPC on daily basis in the prescribed format and submit to the respective NGO / NLEP staff on the same day or on the next day of campaign.

c) Refer the suspects reporting voluntarily to the concerned NGO / NLEP staff for examination and confirmation or inform the house holds to report to the nearest HP / PHC / LRC if any of their family members has suspected signs of leprosy.

d) Always carry required number of SSD forms, colour leaflets, diagnostic card, flip chart (small) and a pen during H2H IPC.

III) Focussed IEC campaigns by trained NGO / NLEP unit staff

a) Organize the following Focussed IEC activities as per the Micro Action Plan by trained NGO / NLEP unit staff simultaneously along with H2H campaign.

1. Group talk on leprosy using photo album for a group of 5 to 10 persons, preferably adults.
2. Slide / film shows for a homogenous group of 20 to 30 persons, preferably in schools.
3. Poster exhibition / Street play at the prominent places in the selected areas.
4. Cycle rallies / Awareness march involving the local groups / school students.
5. Display posters / stickers / banners at public places – offices / banks / telephone booth / railway stations / bus stand / chowks & nakas / cinema halls / schools / private clinics.
6. Arrange to telecast TV spots in local cable network (Short celebrity film in CD-ROM is available with ALERT-INDIA).

7. Distribute copies of ‘A Practical Guide for Public Health Doctor and POID Guide (available with ALERT-INDIA) to the local GHC personnel and Private Medical Practitioners in the selected area.

b) Conduct the above activity at important locations where generally people assemble and can be repeated at newer locations in the selected areas.

c) Supervise the work of respective CVs on daily basis and examine all the suspects identified / referred by CVs immediately on the following day.

d) Refer all the suspects to the Medical Officer at the nearest UHP / PHC / LRC for confirming the diagnosis. It is the responsibility of the NGO / NLEP unit staff to arrange confirmation of diagnosis of all the suspects even after the H2H campaign in over.

e) Additionally, the NGO / NLEP unit staff must undertake contact survey of all new leprosy cases under MDT from the selected area and also motivate the cured leprosy cases with disabilities and deformities available in the selected area to avail appropriate POD services at the nearest Leprosy Referral Centres.

LEAP promotes and endorses NGO / NLEP unit staff to develop and organize innovative IEC campaigns with special ideas that is most appealing to the local community.

LEAP also proposes to modify / improve the existing IEC materials or to develop new materials in view of local cultural needs through a Workshop specially organized by LST.

Criteria to select areas or population groups for SSDs

Select minimum one or more slums / villages / schools in areas under Health Posts / PHCs with any of the following criteria:

1. *Areas where no leprosy related campaigns were undertaken in the last 3 years.*
2. *Extended slums / padas or new settlements of temporary migrants / contract workers (Quarries / Brick bhatti / Construction sites).*
3. *High proportion of Child cases / Multibacillary cases / Grade II disabled cases reported in the last 3 years.*
4. *High or low New Case Detection Rate (NCDR) reported consecutively for the last 3 years.*

Basic prerequisite for the Community Volunteers (CVs)

- *Residing in the same area and be familiar with the local community*
- *Able to read, write and speak in the local language*
- *Commit to participate for the entire period of SSD*
- *Age between 18 years (minimum) to 40 years (maximum)*
- *Posses good reputation and influence in the community*
- *Having past experience in community health work (preferable)*

Step 5

Compilation of data and submission of report

a) Collect the reports from individual CVs on cluster* basis and consolidate in terms of total house holds covered, total population actually reached, the number of suspects reported from the area and new leprosy cases confirmed among the suspects - *Annexure 7, 8 & 9* – by the respective NGO / NLEP staff.

b) Compile information of all the IEC activities carried out in the area and the IEC materials used for SSD campaign and prepare a consolidated report after completion of each SSD and submit along with the original bills and vouchers for the expenses incurred for SSD - duly certified by the Medical Officer / Project Coordinator to the LEAP Coordinator / PMT on any mutually agreed date.

** Cluster is a group of villages / slum pockets selected for SSD*

Roles and responsibility of SSD Team

a) Paramedical worker / Leprosy Technician / Project Health Assistant

- Conduct Pre-SSD campaigns to sensitize the local community.
- Select required number of CVs from the local area as per the suggested guidelines.
- Undertake training for the selected CVs based on the suggested training curriculum.
- Plan and allocate the area to individual CVs so as to cover the targeted population / house holds in specified days allocated for H2H IPC campaigns.
- Fecilitate / supervise and provide guidance to CVs during H2H IPC campaign.
- Undertake focused IEC campaigns such as poster exhibition, slide show and group talk etc.
- Collect the daily report from each CV from the area and consolidate clusterwise report - *i) total house holds covered, ii) total population actually contacted, iii) the number of suspects reported and iv) details of new cases confirmed* for submission to Unit Coordinator along with statement of accounts (with original vouchers).
- Collect all the reporting formats and relevant other stationery from ALERT – INDIA’s office with prior intimation.
- Responsible for making the payments to the CVs for training and for the days engaged in intensive H2H IPC campaigns.
- Encourage the CVs engaged in SSD to continue to act as a ‘leprosy spokesperson’ in the local community and to refer any persons with suspected signs of leprosy. Assist the CVs to undertake IEC activities with the help of local resources, whenever there is an opportunity.

b) Non medical Supervisor / Project Coordinator of NGO

- Plan and allocate the area to individual PMWs / LTs / PHAs for focused IEC campaigns.
- Organize 2 days training for the selected CVs based on the suggested training curriculum in coordination with the respective PMW / LT / PHA.
- Collect the daily report from each of the PMWs / LTs / PHAs from the area and consolidate clusterwise report - *i) total house holds covered, ii) total population actually contacted, iii) the number of suspects reported and iv) details of new cases confirmed* - for submission to LEAP Coordinator / PMT along with statement of accounts (with original vouchers)
- Coordinate with the local Health Post / PHC staff – Medical Officer / PHN / MPW – for registering all the confirmed new cases and provide appropriate MDT.

c) Medical Officer of NLEP units / Project incharge

- Responsible for signing the LEAP Partnership agreement – only those NGOs receive LEAP funds directly.
- Maintain liaison with the local Panchayat and GHC health officials and involve them in SSD activities as far as possible so as to seek their cooperation.
- Facilitate the training for CVs in coordination with the NMS / PMWs / LTs / PCs / PHAs.
- Prepare micro action plan for SSDs in consultation with the concerned NMS / PMWs / LTs / PCs / PHAs.
- Examine and confirm all the 'suspects' identified during SSD or reporting voluntarily and refer to nearby Health Post / PHC / LRC for registration and treatment with MDT.
- Authorize all statements / vouchers for expenses incurred by the NGO / NLEP staff with regard to SSD.

The private and NGO sectors and community-based organizations should play a supportive role. This strategy of collaborative endeavours can be decisive in helping individuals to become change agents, self advocates, and partners with anti-leprosy organizations in the quest to change public perceptions.

Partnerships can be formed with individuals, government organizations, community based organizations, NGOs, the private sector, international agencies, professional associations (for example dermatologists) and groups of persons affected by leprosy. A partnership with such organizations helps in raising the profile of the programme and in advocating for an augmented national response in mobilizing resources.

Involvement of the community and community-based organizations through collaborative partnerships will create an opportunity to enable members of the community to actively contribute to and influence the development process.

- Excerpts from WHO, Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy (Plan Period: 2011-2015), SEA-GLP-2009.3

II Leprosy Referral Centre

Operational Guidelines

Background

The Govt. of India (GOI) proposed a plan for Disability Prevention and Medical Rehabilitation (DPMR) as an important component of National Leprosy Eradication Programme (NLEP) to provide quality services to leprosy affected persons under the 11th Five Year Plan from April 2007 to March 2012 *(vide circular No. Z.16025 / 4 / 2006 – Lep. Cordn. dated 29th June 2006)*. Operational Guidelines have been prepared and distributed to facilitate the State Government for proper implementation of the DPMR activities to be carried out in a 3 tier system – the primary level care, the secondary level care and the tertiary level care.

The existing GHC system at the 'primary' level will require substantial inputs in terms of capacity building for human resource development, adequacy of material supplies and an effective referral mechanism. The tasks assigned for 'secondary' level care will increase the accountability of the District Nucleus Team (DNT) in sustaining the quality care and also to involve the GHC system in the leprosy control programme. In order to actualize the objectives of DPMR programme, there is a need to strengthen the services at the 'secondary' level that helps to manage the referrals and re-referrals between 'primary' and 'tertiary' levels of public health care system in the country.

Introduction

ALERT-INDIA proposes establishing Leprosy Referral Centre (LRC) as one of the critical interventions of LEAP strategy that can help promote integration on long-term basis coupled with delivering quality services to leprosy affected persons at easily accessible locations in different regions (at block level). Since 2004, ALERT – INDIA had established LRCs within the premises of general health infrastructure in urban, semi-urban and rural areas in collaboration with local NLEP units of the government.

This Guideline is a tool to help the state and district-level programme managers to plan and establish a LRC at the secondary level health care to meet the needs of leprosy affected persons referred by primary level care to secondary and tertiary levels of care. This Guideline also includes details of services that can be delivered by specially trained health personnel and promote compliance to services offered at LRCs.

Objectives

- To establish LRCs within the existing health infrastructure of GHS as a 'secondary level care' unit at the block / taluk level in a district.
- To provide quality care to leprosy cases during integration phase through capacity building of GHS personnel.
- To create linkages with the specialized or tertiary level centres at the district level and establish a referral system with the care at primary level.

Step 1

Sensitizing health officials on the need to sustain quality leprosy services

Rationale

- Leprosy services are being provided through all Govt. Hospitals, Peripheral Hospitals and Primary Health Care centres after integration; however these health care facilities are governed by multiple health administrative units in the district.
- Even after achieving the goal of leprosy 'elimination', new cases continue to occur and significant number of leprosy cases with disabilities and deformities need to be given comprehensive and quality services.
- Sustaining leprosy services at three levels of health care require good collaboration among all the health care providers in the district thus help to strengthen the integration and improve the quality of leprosy services.
- The policy recommendation of GoI to establish a 'referral system' at the district level is a major step to ensure quality care and services to leprosy affected persons that will increase the accessibility and sustainability.

Tasks

1. The LEAP Support Team (LST) or the District Nucleus Team (DNT) at the district will sensitize the following district health officials of the Government about the objectives and operational methodologies of LRC.

    a) *District Leprosy Officer (DLO)*

    b) District Health Officer (DHO) and

    c) Civil Surgeon (CS)

2. The LST / DNT will form a District LRC Committee (DLC) under DLO, DHO / CS – responsible to operationalize, review and monitor the activities of LRCs in the district.
3. The DLC / LST will obtain official permission from the State Leprosy Officer (SLO) to establish new LRCs in the district or establish network with existing LRCs of the State Government or leprosy NGOs in the district.
4. The local health authority of Rural / Cottage Hospital should provide required space and other infrastructure / facilities for the LRC. Any structure alteration / furniture / electrical points, if required, will be provided by LEAP.
5. The LST / DLC will encourage the local collaborating GHC centre to take complete 'ownership' of LRC and sustain the services at LRC as an integral part of their routine health care delivery / activity.

Table 1: Suggested training schedule for Skill Developmet to LRC Task Team

Time	Day 1	Day 2	Day 3
09.00 – 10.00	Introduction	Recap of Day 1	Recap of Day 2
10.00 – 11.00	*Session I: LRC* • Purpose & Objectives • Operational methodology • Leprosy orientation	*Session V: Complication* • Types of reactions • Management of reaction • Management of relapse	*Session IX: Counselling* • Method of counselling • Referrals and linkages
11.00 – 12.00	*Session II: Basic sciences* • Structures • Functions	*Session VI: Muscles* • Functions & groups • Assessment • Electrical stimulation	*Session X: Monitoring* • Disability grading • EHF Score • Outcome assessment
12.00 – 13.00	*Session III: Nerves* • Functions & effects • Risk factors • Mechanism of damage • Assessment	• Electrical stimulation - Practical	• Criteria and referral for Reconstructive surgery
13.00 – 14.00	Lunch break	Lunch break	Lunch break
14.00 – 15.00	*Session IV: Skin* • Functions & effects • Mechanism of damage • Assessment • Home self care (HOPE)	*Session VII: Joints* • Functions & effects • Assessment • Exercises • Prefabricated splints • Wax therapy	• LRC Records and reports
15.00 – 16.00	• Cause & management of sole wounds • Uses of special footwear	• Splints & Wax therapy - Practical	• Role and responsibility of LRC Task Team
16.00 – 17.00	• Nerve palpationl • Sensory testingl • Ulcer care - Practical	*Session VIII: Eyes* • Functions & effects • Assessment • Basic eye care	• Open discussion • Concluding remarks

Note:
- Each presentation is followed by Question & Answer session for 10 minutes.
- Each session is followed by group discussion and presentation.
- Powerpoint presentation for each lecture is available at ALERT-INDIA.
- Visit to a nearest LRC may be arranged (optional).

Step 2

Establishing Leprosy Referral Centres at 'secondary' level care

Rationale

- Establishment of new LRC under LEAP should be need-based and preferably located in a public health institution that is easily accessible and having patient friendly environment, complemented by quality care at the 'secondary' level health care.
- Existing specialized leprosy treatment centres or clinics managed by the Government and NGLOs during the vertical programme of NLEP can be restructured as LRC with the available trained leprosy manpower.
- Availing the existing infrastructure and facilities with the GHC centre and utilizing the technical personnel through interaction will pave way to sustain quality services to the leprosy affected during Integration phase.

Tasks

The LST / DLC will

1. Identify suitable location for establishment of LRCs within the GHC infrastructure, preferably in the premises of Rural or Cottage Hospital at the block / taluka level of each district.
2. Decide a day in a week, preferably a 'market' day for each LRC in the district as per the availability of trained leprosy personnel.
3. Define specific geographical area - preferably one or more consequtive blocks in a district, where large numbers of leprosy cases with disabilities live at the time of establishing LRC.
4. Train the local GHC personnel and involve in promoting referrals and ensuring compliance for services provided to leprosy affected persons at LRC. Eventually this will minimize the dependence on specialized leprosy personnel, which is already diminishing.
5. Ensure effective utilization of all essential services available at the local GHC centre. This will pave way for accessibility to quality services to the leprosy affected persons and provide sustainability.

> "It was noted that the training issue was integrally linked to that of referral systems and centres. It was agreed that health staff in referral centres needed to have more clinical exposure to patients and leprosy issues and that people in general needed to be more sensitised to the referral process".
>
> *- Excerpts from the Minutes of the 13th Meeting of the ILEP Technical Commission (ITC), 19th April 2009, New Delhi, India*

Table 2: List of materials required for LRC

1. **Physiotherapy equipments:**
   - a) *Electrical Muscle stimulator (Therapeutic)*
   - b) *Wax tub with thermostat control & rexin bags*
   - c) *Paraffin wax and Paraffin oil*
   - d) *Hand grip exerciser / Sponge balls*
   - e) *Plastic tubs for foot soaking.*
2. **Clinical Assessment tools:**
   - a) *Glass slide for skin smear*
   - b) *Scalpel blade with handle*
   - c) *Spirit lamp*
   - d) *Mono Nylon filament (Set of 2 or 5)*
   - e) *Snellen Chart*
3. **Aids and appliances:**
   - a) *Finger loop splint for mobile claw fingers*
   - b) *Finger gutter splint for fixed claw fingers*
   - c) *Opponenns loop splint for 'Ape' thumb*
   - d) *Adductor band splint for 'Abduction' of little finger*
   - e) *MCR sandals / insoles for insensitive foot*
   - f) *Foot drop spring for foot drop*
   - g) *Malleoli cap for 'lateral malleoli' ulcer*
   - h) *Protective goggles for lagophthalmos*
4. **Dressing instruments / materials:**
   - a) *Gauze cloth (Absorbent)*
   - b) *Cotton rolls (Non absorbent)*
   - c) *Sticking plaster / tape*
   - d) *Foot scraper / Pumice stone*
   - e) *Bandage scissors*
   - f) *Artery or thumb forceps*
   - g) *Scalpel blade with handle*
   - h) *Kidney trays / Steel bowls / Square trays*
   - i) *Dressing stand and stool*
   - j) *Plaster of Paris (POP) rolls*
   - k) *Compression / elastic bandage / Hand gloves.*
   - l) *Pair of 'axilla' crutches*
   - m) *Sterilizer (Small)*
5. **Supportive medicines:**
   - a) *Prednisolone tablets (10 or 20 mg)*
   - b) *Clofazimine capsules 100 mg (loose)*
   - c) *Antibiotic tablets and eye drops*
   - d) *Antiseptic solution (EUSOL / SAVLON)*
   - e) *Antibiotic cream (Betadine / Soframycin)*
   - f) *Petroleum jelly / Salicylic Acid (1%) ointment.*

NOTE: ALERT-INDIA will provide these materials to LEAP supported LRCs based on the need.

Step 3

Selection of health personnel for LRC

Rationale

- During the vertical programme, efforts were made to develop trained manpower to deliver quality services to the leprosy affected persons, which is rapidly diminishing following integration.
- Specialized health personnel available at the public health system need to be oriented and involved in providing quality care to leprosy affected persons as an integral part of their health delivery system.
- Training of all the health personnel, both at the 'primary' and 'secondary' level care, to provide quality care and services, is essential to manage the leprosy cases referred by GHC for specialized services.

Tasks

1. Select at least 2 or 3 trained NLEP workers (if available) and 2 or 3 GHC staff (preferably nursing staff) to form a **'LRC Task Team'** for each LRC.
2. Arrange to officially post / depute the following trained health personnel at the designated LRC.
   a) Medical Officer – one
   b) Physiotherapist / Physiotherapy Technician – one
   c) NLEP Workers / Staff nurses – two
   d) Dresser / Helper – one
3. Services of Laboratory Technician at the Sputum Examination Centre under RNTCP should be utilized for taking, reading and reporting skin smear for AFB.
4. Additionally, one Rehabilitation Officer, one Health Educator / Medical Social Worker / Counsellor may be included wherever possible (Optional).

Table 3: Count the number of affected skin areas and trunk nerves for grouping:

Type of leprosy	No. of skin patch[1]	No. of trunk nerve[2]	Total No. (Maximum)
PB	1 - 5	Nil	≤ 5
	1 - 4	1	≤ 5
	Nil	1	1
MB[3]	6 +	Nil	≥ 6
	5	1 +	≥ 6
	Nil	2 +	≥ 2

1. For Skin, count only the leprosy skin patch; 2. For Nerve, count only thickened nerve trunk with definite sensory and / or motor impairment; 3. Classify as 'MB', if the skin smear is positive for AFB.

Risk factors for nerve damage

Any leprosy case without evidence of nerve function impairment (Grade '0' cases) but having any one of the following signs and symptoms (Clinical or immunological events) at the time of diagnosis or during MDT is considered as case of 'risk' for nerve damage.

1. Five or more skin patches on the body surface
2. One or more thickened peripheral nerves
3. Skin lesion on the face or near the eye
4. Skin lesion over / near the course of trunk nerve
5. History of reaction / neuritis episode during MDT
6. Pain or redness of eyes without loss of visual impairment
7. Adolescent age group with active signs of disease
8. Women during pregnancy with active signs of disease

All these 'risk' cases need to be assessed for nerve functions – nerve status, sensory loss and muscle weakness – every 3 / 6 months at LRC. This will help to detect the leprosy cases developing early nerve function impairment either during or after MDT. If any of the 'risk' cases shown appreciable change or deterioration in the nerve function, treat immediately with appropriate services, as it is often possible to prevent the nerve damage.

Method to assess the clinical status of the peripheral nerve

- Locate the site of predilection for damage in course of the nerve
- Palpate the nerve gently with the pulp of fingers
- Feel the nerve along its course in both directions
- Recognize the clinical status and compare with other side (normal)
- Observe the facial expression for pain reflex

Clinical status of the damaged peripheral trunk nerve:

- **Enlarged (E)** - thickening recognized during palpation of the affected peripheral nerve
- **Tender (T)** - pain elicited during the palpation of the affected peripherral nerve
- **Pain (P)** - spontaneous pain in the affected peripheral nerve during the movement of adjacent joint

These findings facilitate in diagnosing the disease and also help in assessing the 'risk' of damage to the peripheral nerves. This assessment is always subjective and requires experience in clinical examination to recognize the accurate status of peripheral nerves.

Step 4

Capacity building of health personnel for managing the tasks of LRC

Rationale

- Following integration, the existing trained leprosy workers are mostly placed at the primary level care centres to enable the GHC workers in providing leprosy services.
- The focus on training is given mainly to the primary level health workers in providing basic MDT services. However the capacity building of health manpower at the 'secondary' care level should not be ignored.
- In order to develop a new cadare of trained leprosy workers, the existing GHC personnel be adequately oriented through elaborate training in providing quality services to leprosy affected persons at LRC.
- The local GHC centre should provide all logistic support and the required supplies / materials to LRC from the State / District Leprosy Society funds under DPMR Plan / Rogi Kalyan Samiti under NRHM, on regular basis.

Tasks

The LST or training faculty of ALERT-INDIA LEAP will

1. Organize 2 / 3 days practical task-oriented training, as per the recommended curriculum, for the LRC Task Teams at the district level *(see Table 1 in page 15)*.
2. Preferably, all the available NLEP staff in the district needs to be reoriented on LRC services as they may be posted at LRC on rotation basis considering the administrative directives issued by the Government from time to time.
3. Provide necessary training manual / guide developed by ALERT-INDIA and practical demonstration of the techniques on the use of physiotherapy equipments by the LST to the LRC Task Teams at LRC.
4. Prepare an indent based on the baseline information for the leprosy cases needing special services at each LRC and procure equipments and materials for providing quality services *(see Table 2 in page 17)*.

What is the policy guideline of NLEP on skin smear examination?

NLEP no longer routinely advises skin smear examination in the leprosy control programme, as majority of the leprosy cases can be diagnosed clinically even without skin smears. However, it recommends skin smear examination, if you suspect leprosy without sensory loss or have any doubts on the clinical signs that can be done at any LRC or general hospital, which is equipped with reliable laboratory facilities and trained technicians, preferably at the sputom examination centre of RNTCP.

Method to assess the sensation of the skin distributed by the nerve trunks

- Use tip of plastic ball point pen / twig of cotton wool
- Touch the skin with the tip of pen at a 90 degree angle
- Test the skin surface randomly, both normal and affected
- Ask the patient to locate the site where he / she feels the touch
- Repeat the same until the patient is familiar with the method
- Continue the test with the leprosy cases' eyes closed or covered
- Note the accuracy and speed of patient's response to the stimulus

Method to monitor the sensory function in hands and feet

- 5 sites are identified each in one hand and foot (Total 20 sites)
- Test for sensation at all the 20 pre-designated sites
- Mark '✓' for normal sensation or 'x' for loss of sensation.
- Count the number of sites with 'x' mark and record the sensory 'score'
- Repeat the same after 6 months interval and compare the 'score'.

Note: Increase in the sensory 'score' indicates increased areas of sensory loss within 6 months (Silent neuritis) and need to be considered for treatment with steroid therapy.

Important consideration for testing sensory loss on palm and sole and eye

- The thickness of the skin on the palm and sole is not same; hence testing sensory loss with same tool may give misleading results.
- Dryness or softness and callous / scar on the skin can either increase or decrease the normal sensory threshold.
- Using a set of two Mono nylon filaments for the hand (2 gms) and feet (10 gms) is ideal to test the loss of sensation.
- Do NOT check for sensation on the cornea in the eyes as it has the potential to damage the corneal epithelium, a complication recognized by the WHO and the GOI, who have recommended that the test be abandoned in the field.

Note: *Loss of corneal sensation is considered to be important it cannot be used as the principal reference factor because it is not as easy to evaluate, as is the sensory loss in the skin. The traditional testing of corneal sensation in the field with a cotton wisp is inaccurate and gives widely variable results.*

Step 5
Collection of baseline information for LRC

Rationale

- Elaborate clinical and bacteriological assessment of leprosy cases has been withdrawn from the records following the integration and a Simple Information System (SIS) is being followed.
- Following the transfer of records maintained by the vertical leprosy personnel to the GHC personnel, the details of the cured leprosy cases needing special services need to be updated.
- Collecting the information on the leprosy cases who require special care and services at the GHC centres (PHC / UHP) situated in the specified geographical area of that particular LRC is crucial.

Tasks

The LRC Task Team will obtain baseline information from the GHC centres and prepare / maintain a PHC / UHP wise list on the follwoing:

1. List of leprosy cases at 'high risk' (especially MB cases) among all new (under MDT) and old (RFT) leprosy cases registered for MDT during the past 5 years.
2. List of all grade I & II disabled cases among all new and old leprosy cases, currently living in the area with details of the disability / deformity status.

   Note: If these details are not available, undertake a 'disability' survey in the LRC area by training and involving the PHC / UHP personnel.

When does one recommend for skin smear examination?

Skin smear examination can be recommended for the following purpose:

i) To diagnose leprosy in a person (suspect) presenting with any one of the following clinical signs (other than the usual cardinal signs).
(a) Hypo-pigmented skin patch having normal sensation.
(b) Smooth, oily and shiny skin.
(c) Nodules on the skin.
The above clinical signs can ONLY be diagnosed by demonstrating the presence of M. Leprae in the skin smears and to differentiate leprosy from other similar skin conditions (Differential Diagnosis).

ii) To confirm bacteriological relapse in any leprosy case with re-occurrence of clinical signs even long after completing full course of standard MDT and also helps to differentiate 'relapse' from possible 'late reversal reaction'.

iii) To declare a leprosy case as 'cured' and to certify a person as 'non-infectious' as per the employment rules of the Government.

Table 4: Reasons for referral of cases from the GHC (PHC / UHP) to LRC

Reason for referral of cases	Action to be taken at LRC
Person with suspect signs of leprosy	Confirm the diagnosis, group as PB / MB and refer back with referral note for treatment with MDT and follow-up.
Case with 'risk' factor for nerve damage	Register and perform periodical nerve function assessment (sensory & motor) once in 3 / 6 months for 3 or 5 years.
Case with lepra reaction / neuritis	Assess and treat if other physiotherapy services are required or else refer back with appropriate advice note.
Case with disabilities and deformities	Assess and treat with relevant services. Provide protective aids and maintain regular follow-up.
Case with psycho-social problems	Assess and provide proper counselling and guidance for rehabilitation assistance. Refer to rehabilitation institution / centre.

Table 5: Indication for quality care and services to be provided at LRC

Problems / Indication	Quality care and services
Suspect with doubtful signs of leprosy	Clinical examination & diagnosis
Suspect with skin patch & no sensory loss	Skin smear examination & diagnosis
Case with active signs of reaction / neuritis	Steroid therapy
Case with 'risk' factor but no disability	Regular nerve function assessment
Case with Gr.I disability in hand / feet / eye	Demonstrate skin care (HOPE)
Case with weak muscles in hand / feet / eye	Steroid therapy + Muscle stimulation
Case with claw finger / thumb / Wrist drop	Exercises + Splints + Wax therapy
Case with foot drop / claw toes	Exercises + MCR sandals
Case with Lagophthalmos / watering of eyes	Exercises + Goggles + Eye drop
Case with wounds / ulcers on hand & foot	Medicine + Dressing + MCR Sandal

Step 6

Offering comprehensive and quality services at LRC

For a successful referral system, the referral service facilities must be accessible, staff must be trained to provide quality care and essential drugs, supplies, and equipment must be available. The most complex aspect of referral care is ensuring good compliance with the referral services. This is often determined by a variety of factors, including the perceived need of a referral (disease severity), quality of the services and the resources. The LRC Task Team will provide the following quality services at LRC.

6.1 : Confirming the diagnosis of 'difficult to diagnose' leprosy suspects

Rationale

- GHC personnel are expected to confirm the diagnosis of all new leprosy cases, however some cases pose difficulty in making an accurate clinical diagnosis even by the well trained leprosy workers.
- Suspects with unusual presentation of cardinal signs such as early lepromatous can only be diagnosed through specific laboratory investigations.
- Providing facility for skin smear examination* at LRC to confirm the diagnosis of difficult cases by trained health personnel is important. The same may also help to diagnose 'relapse' cases after adequate MDT. ** Skin smear examination is not mandatory to start MDT*

Tasks

1. Receive and register all individuals with suspect signs and symptoms of leprosy, referred by the health worker of PHC / UHP / NGO, along with a 'Referral' note reporting to LRC *(see Annexure 8 in page 55)*.
2. Take proper history – duration of disease / deformity and past treatment, if any – and do clinical (Skin patches) / physical (Peripheral nerves) examination for evidence of cardinal signs of leprosy.
3. Perform skin smear examination (refer, if not available at LRC), if the suspect has doubtful signs of leprosy i.e skin patches with intact sensation, smooth, shiny & oily skin (infiltration) or nodules *(see Box in page 20 & 22)*.
4. Make the diagnosis of 'leprosy' only after confirmation of any one of the cardinal signs of leprosy and group as 'Pauci-bacillary' (PB) or 'Multi-bacillary' (MB) *(see Box in page 18)*.
5. Refer all newly diagnosed leprosy case to the respective PHC / UHP along with a 'referral' note for registration and MDT treatment. Counsel the patient for regularity of treatment with MDT.
6. Register and provide appropriate services to all leprosy cases who had 'risk' factor for nerve damage or any signs of reaction or with visible deformity at diagnosis.
7. Examine the household contacts of all new leprosy cases registered at local PHC / UHP, once in a year and motivate them to report voluntarily, if they notice suspected signs of leprosy.

Management of Lepra reactions (recommended by ALERT-INDIA)

A. Any leprosy case having any of the following signs at diagnosis or during / after MDT, irrespective of the Type of reaction (I or II) should be treated with the following standard course of steroid therapy with Prednisolone.

- Pain or tenderness on one or more nerve trunks (Acute neuritis)
- Loss of nerve function within less than 6 months (Silent neuritis)
- Red or swollen skin patch over the face or nerve trunk.

Month :	1		2		3	4	5	6
Week :	1 & 2	3 & 4	5 & 6	7 & 8	9 - 12	13 - 16	17 - 20	21 - 24
Pred dose:	60 mg	50 mg	40 mg	30 mg	20 mg	15 mg	10 mg	5 mg

B. Any leprosy case having Type 1 reaction with red, swollen or raised skin patch at diagnosis or during / after MDT, **without any evidence of nerve involvement** be treated with the following drug schedule.

Month :	1		2		3		4	
Week :	1 & 2	3 & 4	5 & 6	7 & 8	9 - 10	11 - 12	13 - 14	15 - 16
Pred dose:	40 mg	35 mg	30 mg	25 mg	20 mg	15 mg	10 mg	5 mg

Note: Prednisolone 10 or 5 mg may be continued for another 2 months, if the symptoms remain.

C. Any leprosy case having Type 2 reaction with tender and painful or ulcerated nodules (ENL) or with oedema of hands / feet / face, but without any evidence of nerve involvement be treated with the following drug schedule.

Month:	1		2		3		4		5	6
Week:	1 & 2	3 & 4	5 & 6	7 & 8	9 & 10	11 & 12	13 & 14	15 & 16	17 - 20	21 - 24
Pred dose:	40 mg	35 mg	30 mg	25 mg	20 mg	15 mg	10 mg	5 mg	-	-
CLF dose:	300 mg		200 mg				100 mg			

Note: Clofazimine 100 mg may be continued for another 2 months, if the symptoms remain.

Associated signs and symptoms of reaction:

- Joint or muscle pain with fever
- Swelling of small joints of the finger
- Pain or redness of the eye

Note: The above symptoms may occur during 'lepra reactions' and are to be treated symptomatically with conventional treatment.

6.2 : Ensuring uninterrupted MDT servcies at all GHC centres

Rationale

- The purpose of integration is to make the MDT services available on all days at all 'primary' level health facilities that are easily accessible to leprosy cases.
- Non-availability of MDT at GHC centres due to shortage of drugs will lead to delay in 'timely' treatment, hence need to be addressed immediately.
- Since many new leprosy cases might be reporting voluntarily to the existing leprosy clinics upgraded into LRCs, the LRC Task Team should refer back the new cases to the nearest health centre for MDT.

Tasks

1. Liaise with the local PHC / UHP and ensures the availability of MDT so as to achieve 100% cure rate and also confirm the details of new cases registered for MDT among those referred.
2. Promote referrals of leprosy suspects for diagnosis; risk prone cases for nerve function assessment and reaction cases for management and provide necessary technical guidance to the local GHC staff.
3. Encourage and involve the GHC personnel to undertake regular home visits of the leprosy cases in their area to confirm regularity of treatment and advice as well as ensure family support.

6.3 : Identifying and treating early nerve damage among 'risk' prone cases

Rationale

- Risk of developing new nerve function loss and eye problems during and after MDT cannot be ruled out. It is necessary to screen 'risk prone cases' to identify nerve function impairment at an early stage.
- All the risk group cases need to be assessed periodically for nerve function at LRC using a standard assessment tool in order to identify early nerve function impairment.
- Any 'risk' group patient with recent nerve function loss should be provided with appropriate treatment to prevent the onset of new disabilities / deformities. Wherever indicated, the patient may be referred to the specialized surgical or ophthalmological centres at the general hospitals for special services.

Tasks

1. Receive and register all the leprosy cases with Grade '0' disability but having 'risk' factors for nerve damage, referred by the health worker of local PHC / UHP or by an NGO staff (from SSD), along with a 'Referral' note or reporting directly to LRC *(see Table 4 & 5 in page 23)*.
2. Take proper history – duration of signs and symptoms of NFI / disease activity / other precipitating factors – and do regular nerve function assessment (sensory & motor) to identify nerve function loss *(see Table 6 & Box in page 27)*.

Table 6 : Method to assess strength of muscles supplied by the nerve trunks

Nerves	Action by patient	Action by health worker
Facial	**Close eyelids** & hold	Try to separate the eyelids with it tightly thumb & index finger.
Ulnar	**Move little finger** out and hold it tightly	Apply pressure at base of little finger and try to push inside.
Median	**Lift thumb up** (90^0) and hold it tightly	Apply pressure at head of 1 meta carpal and push towards palm.
Radial	**Lift wrist & fingers up** and hold it tightly	Apply pressure at back of hand and try to push downwards.
Lateral Popliteal / Common Peroneal	**Lift foot up** and hold it tightly	Apply pressure on foot in front of leg and try to push downwards.
Posterior Tibial	**Spread toes sidewards** and hold it tightly	Apply pressure at base of great and little toe and push it together.

Method to grade the strength of skeletal muscles:

- **Normal** (S): Able to make full range of movement and against full resistance
- **Weak** (W): Able to make either full / partial range of movement but against no resistance
- **Paralyzed** (P): Not able to make any movement at all.

Note: The above grades are used as objective measurement to test the strength of the muscles, which is reasonably reliable and accurate. This assessment also helps to monitor the response of the weak muscles following treatment.

Method to check the visual acuity

- Stand 6 meters / 20 feet distance away from leprosy case in a well lit room.
- Show the fingers and ask the leprosy case to count the fingers.
- Check for each eye separately by closing the other eye with one hand.
- Refer to 'Ophthalmologist', if there is recent visual loss due to leprosy
- Use 'Snellen' visual acuity chart, if available.

Method to grade the visual acuity

- **Normal vision** – Able to count the fingers at 6 meters / 20 feet distance.
- **Partial loss** - Able to count the fingers only at 3 meters / 10 feet distance
- **Total loss** - Unable to count the fingers at all (Complete blindness).

Note: Cataract is most common among older people and can also lead to 'vision' loss. After identifying the cause, please specify.

3. Palpate all the trunk of the major peripheral nerves and assess for nerve function impairment (NFI) – sensory loss and muscle weakness – periodically (preferably once in 6 months) and record the findings. If the patient does not develop any NFI for the next 5 years, then delete the name from the high 'risk' group register *(see Annexure 10 in page 58)*.

4. Treat all the leprosy cases with early nerve function loss that is less than 6 months duration using a course of 'Prednisolone' depending on the type and severity of NFI. Continue MDT till the completion of full course.

5. Provide appropriate counseling / physiotherapy services, if the patient has any signs of recent NFI (< 6 months duration). Counsel the patient and advise to report on occurrence of any problematic events.

6. Provide relevant physiotherapy services such as electric muscle stimulation / hand splints to all leprosy cases with early NFI, if indicated. Teach self-care measures and demonstrate strengthening exercises to be carried out at home.

7. Delete the leprosy cases from the 'Risk' case register, if developed established NFI (irreversible disability / deformity), even with adequate treatment and enter into the 'Disability / Deformity' register.

6.4 : Managing leprosy related complications - reactions / neuritis

Rationale

- GHC personnel need to provide treatment and manage leprosy cases with complications such as lepra reactions and neuritis, early NFI etc as their routine practice. However the LRC may take this responsibility initially till the GHC personnel acquire skills in managing such complications.
- All reaction cases with acute or silent neuritis need to be assessed periodically for nerve function at LRC using a standard assessment tool in order to monitor the recovery of nerve function.
- Ensuring the progress and response to the treatment given is important. Patient suffering from severe forms of reactions or recurrent reactions may be referred to the specialized centres or hospitals for hospitalization and for special anti-reaction drugs, if required.

Tasks

1. Receive and register all the leprosy cases with signs of reactions referred by the health worker of local PHC / UHP or by an NGO staff (from SSD), along with a 'Referral' note or reporting directly to LRC.

2. Take proper history – Duration of signs and symptoms of reaction / number of episodes / past treatment, if any / other major illness – assess & ascertain the cause (reaction / neuritis or relapse) and its severity.

3. Palpate all the trunks of major peripheral nerves and assess for nerve function impairment (NFI) – sensory loss and muscle weakness - and record the findings.

4. Treat all the leprosy cases with reactions / neuritis depending on the type and severity (pain on palpation of trunk of a nerve) *(see Box in page 25)*. Continue MDT till completing full course as prescribed by the Medical Officer at the respective PHC / UHP.

Table 7: Suggested frequency of follow-up for services at LRC

Services	Frequency of follow-up
1. Skin smear examination	Once (as recommended)
2. Nerve function assessment	Quarterly / Half yearly
3. Steroid therapy (Prednisolone)	Weekly / Fortnightly
4. Electrical Muscle Stimulation	Alternate day / Weekly
5. Skin Care (HOPE)	Fortnightly / Monthly
6. Medicine (Tablets / Ointment / Drops)	Weekly / Monthly
7. Exercises & Splints	Monthly / Quarterly
8. Wax therapy	Weekly / Fortnightly
9. Wound care (Dressing)	Weekly / Fortnightly
10. MCR Sandals / Pair of Goggles	Quarterly / Half yearly

Table 8: Criteria for referral to Tertiary care centre for specialized services

Criteria for referral	Specialized services
1. Difficult to diagnose by clinical / skin smear	Skin / nerve biopsy
2. Suspected relapse – clinical / bacteriological	Drug sensitivity test (MDT)
3. Chronic / recurrent reaction / Steroid dependent	Alternate drugs
4. Neuritis / NFI not responding to steroid therapy	Nerve release surgery
5. 'Dapsone' syndrome / Intolerance to MDT	Alternate drug (Anti-leprosy)
6. Chronic / infected non-healing plantar ulcer	Septic / skin graft surgery
7. Neuropathic joint / Disorganized foot	Foot Orthosis (Mould shoes)
8. Red eye / Impaired vision due to leprosy	Ophthalmic care
9. Deformities of hand / foot / eye / face	Reconstructive surgery
10. Psycho-social / Economic problems	Counselling / Rehabilitation

Indication for providing MCR Footwear

- All leprosy cases with foot disability (Grade 1 or 2) due to leprosy should be provided with MCR Footwear. Priority should be given to those leprosy cases who have marked bony and structural damage of the foot due to repeated ulceration.
- Any leprosy case who have normal foot structure but having only sensory loss and can afford to buy locally available footwear (without any nails), which is technically preferable should be recommended.

5. Initiate the treatment for reaction / neuritis & refer back to PHC / UHP with a note for continuation of treatment, provided the recommended treatment is confirmed to be available at the PHC / UHP from where the patient was referred.
6. Provide appropriate counseling / physiotherapy services, if the patient has any signs of recent NFI (< 6 months duration). Counsel the patient and advise to report on occurrence of any problematic events.
7. Refer the patient to nearest Tertiary level care centre for specialized treatment (e.g nerve release surgery), if the reaction / neuritis is not subsiding even with adequate treatment or getting developed new NFI. Follow-up the patient regularly to ensure treatment compliance.

6.5 : Preventing and treating leprosy cases with disabilities and deformities

Rationale

- The primary objective of disability prevention is essentially to minimize and avert deterioration of the impairment status of leprosy affected persons with established disabilities and deformities.
- The geographic distribution of the leprosy cases needing long-term care for their disabilities is not known. Hence, it is important to collect information about all the leprosy affected persons living in the community and assess their current disability / deformity status.
- Appropriate physiotherapy services such as wax therapy, muscle stimulation and other such physical therapeutic measures should be made available without any interruption at LRC.
- LRC should have sufficient stock of aids and appliances such as pre-fabricated splints, special footwear (MCR), dressing materials for ulcer care and made available to leprosy cases who require them.

Tasks

1. Receive and register all leprosy cases with Grade '1' & '2', referred by local PHC / UHP or by an NGO staff (from SSD) or reporting directly to LRC.
2. List all existing leprosy cases with disabilities and deformities and group them as Grade I & Grade II as per WHO disability grading system (1998).
3. Take proper history – Duration and type of disability / deformity / disease activity / type of occupation – and record the same.
4. Prioritize the leprosy cases according to the frequency of services to be provided at LRC and the follow-up needed *(see Table 7 in page 29)*.
5. Provide relevant physiotherapy services for leprosy cases with deformities and plantar ulcers.
6. Teach self-care and demonstrate exercises to leprosy cases with disability / deformity on every visit to LRC and encourage the patient to repeat the same in front of the LRC Task Team.
7. Provide appropriate aids and appliances – MCR sandals / insoles / Foot drop spring / Pre-fabricated hand splints / pair of goggles – as indicated *(see Box in page 29)*.

Table 9: Guidelines for assessing progress of disability / deformity status

Disability / Deformity	Status of disability / deformity after intervention			
	1. Fully improved	2. Partially improved	3. Static	4. Worsened
Hand				
Anaesthesia	Complete sensory recovery in the area of distribution	Complete sensory recovery in some area of distribution	No change	Developed injuries / wounds on palm
Mobile claw	All fingers became normal (Straight)	1 / 2 fingers became normal (straight)	No change	1 or more fingers developed stiffness
Fixed claw	All fingers became mobile	1 / 2 fingers became mobile	No change	Stiffness increased 1 or more fingers
Ape thumb	Mobile thumb joints with normal web	Thumb joints are mobile, but web contracture	No change	Thumb web space shortened & stiffness of thumb joints
Wrist drop	Wrist joint can be fully extended passively to 90^0	Wrist joint can be straightened (neutral) passively	No change	Passive movement at wrist joint is reduced / restricted
Foot				
Anaesthesia	Complete sensory recovery in the area of distribution	Complete sensory recovery in some area of distribution	No change	Developed injuries / wounds on sole
Foot drop	Ankle joint can be fully extended passively.	Ankle joint can be extended passively up to 90^0	No change	Movement at the ankle joint is reduced
Claw toes	All toes became straight.	Not developed sole wound on forefoot	No change	Developed wounds on fore foot
Plantar ulcer	No visible wound, but scar present.	Size of the wound reduced by 50%	No change	Developed complications or new wounds
Eyes / Face				
Lagopthalmos	Able to close the eyelids tightly	Able to close the eyelids with difficulty	No change	Eye lid gap increased
Facial palsy	Able to drink and eat normally without spilling	Slight difficulty while drinking and eating	No change	Drooling present & restriction in jaws movements.

8. Motivate the patient and family members to practice self care measures regularly at home.
9. Identify leprosy cases who need specialized services at Tertiary level care centres and refer with appropriate 'Referral' note *(see Table 8 in page 29)*.
10. Ensure compliance for specialized services provided to leprosy cases referred through field follow-up.
11. Maintain and regularly update the records / registers as prescribed by ALERT – INDIA under LEAP for assessing the effect of services *(see Table 9 in page 31)*.
12. Prepare and submit LRC report on or before 5th day of every month along with the requirements of materials and supplies for LRC to the LST *(see Annexure 12 in page 62)*.
13. Liaise with GHC staff to undertake follow-up of all disabled leprosy cases received services at LRC periodically and ensure compliance of services.
14. Encourage leprosy cases with disabilities and deformities as well as their family to actively participate in the Prevention of Disability (POD) activities.

6.6 : Counselling of leprosy cases and improving compliance for services

Rationale

- Counselling is a means of enabling the leprosy affected persons to cope with the 'physical or social' problems they face due to leprosy through a purposeful conversation or an open dialogue and help them to break the 'barriers' of their own.
- Counselling is not a 'one' time episode, but a continuous process as the leprosy patients are very unlikely to trust the 'service providers'. It is all the more necessary, when a leprosy affected person is at a 'lifetime' risk due to the irreversible nerve damage caused by leprosy.
- Every leprosy affected person needs to be counselled appropriately in order to boost the self-confidence in solving their own problems and make positive decisions. It will help increase the compliance for services provided at LRC that will improve the physical and social status of the leprosy affected persons.

Precautions for steroid therapy

- Explain to every leprosy patient with reaction / neuritis, the importance of taking steroid treatment regularly without any interruption. Caution the leprosy patient, not to abruptly stop or not to self administer steroid therapy without consulting the doctor / health worker, as it may cause serious problems.
- Generally, the side effects for steroid therapy are minimal and most leprosy patients tolerate well, if taken as prescribed. Provide supportive treatment, if the patient under steroid therapy has developed gastritis or diabetes or osteoporosis, etc in consultation with the medical doctor / physician.
- If the patient had recurrent or chronic reaction / neuritis, rule out other 'precipitating' factors - such as secondary infections, hormonal changes, stress and strain - before starting another course of steroid therapy.

Tasks

1. **Explore** the physical and social problems specific to leprosy by careful listening and having personal discussion with the leprosy patient. Probe into the severity of the problem and discover the opportunity that can make a difference.

2. **Understand** the practical difficulties related to physical activity from the leprosy patients' perspective within the environment and socio-cultural background in which they are placed. Identify their positive health behaviour and attitudes.

3. **Guide** the leprosy affected persons on the effective ways and means that help to overcome the barriers in the given environment. Empower them with appropriate information and better health values.

4. **Interact** with the leprosy patients by suggesting effective approaches that can be easily understood and practised with minimal effort. Give a feedback on the desired benefits that determine the effect on personal relevance.

5. **Involve** the leprosy affected persons in making their own decisions with straightforward actions. Encourage to work together with the service provider by assisting themselves, which is vital to achieve desired outcomes of LRC.

6.7 : Maintaining and updating management information system for LRC

Rationale

- Maintaining and updating proper records and timely submission of activity reports is essential to monitor the progress of activities carried out at LRC. It will also facilitate the LST or LEAP Monitoring Team as a source of verification to identify the operational problems.

- Reports generated periodically from each district will be useful to procure and ensure adequate supply of materials required to treat leprosy cases at LRC. Hence the monthly LRC report should be accurate and must contain baseline information.

Tasks

Registers

1. **LRC Activity Register** – Contains the details of all suspects and leprosy cases referred by the GHC / reported directly at each LRC and the services provided at LRC.

2. **LRC Service Register** – contains baseline details of all leprosy cases - 'risk' cases / cases with Grade 1 or 2 disabilities – along with nerve function assessment including the type of disability / deformity with duration and service provided at LRC.

3. **Reaction Register** – contains details of all leprosy cases with reactions who are referred to LRC and the treatment given for reaction management.

4. **Drug / Material Stock register** – contains details of drugs and materials (medicines / MCR Footwear / Hand Splints / dressing materials and equipments / Physiotherapy equipments / Furniture etc) – supplies, issues and balance stock available at each LRC.
5. **Referral Register –** contains detail of all leprosy cases referred to 'primary' and 'tertiary' level care units and the services provided.

Records

6. **LRC Registration (OPD) Form** – contains details of individual leprosy case, the reason for referral and the treatment advised at LRC *(see Annexure 11 in page 60)*.
7. **Individual Patient card** – contains details of all leprosy cases registered at LRC including the type of disability / deformity with duration and service provided *(see Annexure 10 in page 58)*.
8. **Due date card for steroid therapy** – contains details of reaction cases, type of reaction, the reaction treatment given at LRC and the next due date.
9. **Referral slips** (for primary & tertiary levels) – contains detail of leprosy cases referred, the date, place and the reason for referral *(see Annexure 9 in page 56)*.
10. **Monthly reporting form** – contains baseline information of each LRC, number of suspects, reaction cases, 'risk' cases assessed, Grade 1 and 2 cases treated and referrals for specialized services.

6.8 : Coordinating with local community and GHC centres at 'primary' level

Rationale

- Good coordination with the GHC centres (PHC / UHP) and the support of the health officials will help better usage of human and material resources for the leprosy cases in the local area / region.
- Promoting referrals of appropriate leprosy cases to take advantage of the special services available at LRC is entirely depending on the cooperation and involvement of local GHC personnel.
- Training and involving the staff of local field level NGOs / CBOs in the follow-up of leprosy cases and to provide counseling will enhance the reach and compliance for LRC services in the area / region.

Tasks

At the community level

1. Organize community awareness campaigns (IEC / IPC) such as Poster exhibitions / Slide shows and distribute leaflets on leprosy in the local community by involving the local GHC workers.
2. Train and involve the local Anganwadi / ASHA / NGO workers in giving counseling on self care and follow-up of leprosy affected persons in the local area.
3. Contact the general / private medical practitioners – especially Dermatologists / Diabetologists / Ophthalmologists - in the area and promote referrals of leprosy cases for the services at LRC.

At the primary health care level

1. Visit the local GHC centres (PHC / UHP) at least once in a quarter and update / verify the records (SIS) maintained. Encourage the GHC staff to refer suitable cases for special / quality services at LRC.
2. Conduct 1- day orientation training on leprosy to all the general health care personnel (MO / HS / HA / MPW) of PHC / UHP in batches of 20 to 25 each at the block level.
3. Motivate the staff of PHC / UHP to undertake regular follow up of leprosy cases by home visits to ensure compliance for treatment & advice given at LRC.
4. Organize POD camps at the 'PHC / UHP' level for the Grade 1 and 2 disabled cases who could not avail the physiotherapy services at LRC due to logistic reasons.
5. Participate in the monthly review meeting of the local PHC / UHP and encourage the Medical Officer to review the LRC activities at the PHC / UHP level.
6. Identify the leprosy cases living in the area who need rehabilitation services and refer to Tertiary level care centres or Rehabilitation institutions.

6.9 : Linkages with specialized health centres at 'tertiary' level

Rationale

- Ensuring equal opportunities and full social integration of all leprosy cured persons with disabilities through an integrated rehabilitation programme, preferably along with the persons with disabilities due to other causes is a priority.
- Specialized services such as reconstructive surgery, histopathology examination, vocational training, socio-economic rehabilitation etc should be made available at the Tertiary level care units.
- Need to identify such specialized centres / hospitals / institutions located in the nearby area and establishing linkages for an effective referral service will promote sustaining quality care during integration phase.

Tasks

1. Identify the Tertiary care centres / hospitals / institutions located in the LRC area / in the district and initiate an effective referral system for specialized services *(see Table 8 in page 29)*.
2. Identify and establish linkages with the local hospitals / institutions / Vocational Training and Rehabilitation Centres that offer special services aids and appliances, vocational, surgical and rehabilitation services in the region for leprosy cases.
3. Liaise with the authorities at these specialized centres and refer appropriate cases for providing specialized services. Follow-up the cases referred to confirm the services provided as needed.
4. Collect and maintain updated information of all Govt. welfare schemes and measures offered for the leprosy cured with specific eligibility criteria and the requisites for obtaining benefits.

Step 7

Monitoring and evaluation of LRC

Rationale

- The purpose of monitoring is to measure the outcome and resolve the operational problem with immediate corrective actions. It is recommended to have periodical monitoring of results achieved and their impact to evaluate the quality of patient care.
- The monitoring will be done by LST in collaboration with the DLC based on the relevant indicators suggested by ALERT-INDIA to assess the quality of services provided at each LRC.
- The analysis of the findings and the possible solutions should become the basis for amending approach and altering or improving the interventions. The LST will also provide on-job training to the LRC Task Team and ensure that they have fully acquired the required skills and expertise.

Tasks

1. Plan and visit the LRCs on monthly / quarterly basis and assess the following: location and accessibility; facilities available; updating of records and registers; materials and supplies; patient attendance and compliance to services; quality of services to leprosy cases and referral mechanisms.
2. Provide on-job training to the members of the LRC Task Team and the local GHC workers as well as provide learning materials to increase their efficiency in providing quality services at LRC.
3. Conduct monthly review meetings of all concerned functionaries and suggest local solutions and provide necessary guidance. Prepare an Action Taken Report and submit to the concerned district authorities or to Administrative Team of ALERT - INDIA.
4. Review the disability records of the individual cases and undertake specific analytical studies of special group of cases or specific interventions or results of special schemes promoted through LRC.

Anticipated outcome of LRC

1. Enhanced capacity of the public and private health care personnel to ensure timely treatment and sustain comprehensive quality care to the leprosy affected.
2. Providing quality care at the GHC facilities will result in effective transfer of the existing leprosy expertise to the specialties in public and private health sector.
3. Establishing network with tertiary level care units and promoting referrals for specialized services and socio economic rehabilitation for leprosy cured.
4. Effective disability management and reduction in deformity rate among new cases, leading to reduction in social stigma.

III Decentralised Planning under NLEP

Guidelines, Govt. of India

Introduction

With the introduction of National Rural Health Mission (NRHM), all the activities of a National Program will be planned, implemented and monitored under the umbrella of NRHM. It is envisaged in the NRHM that the district health plan will be formulated through bottom up and result oriented planning process. General steps in planning & management cycle can be seen below:

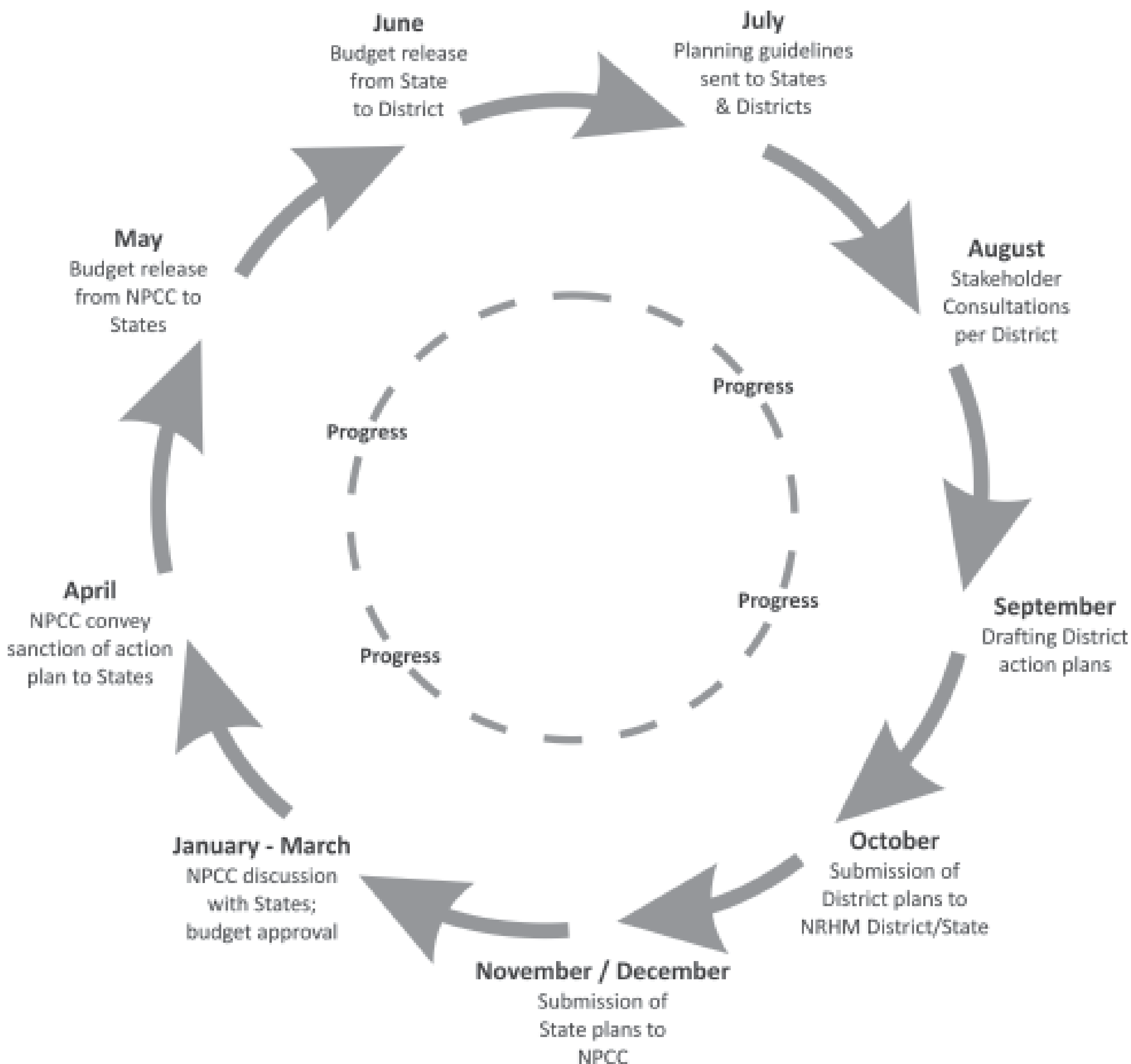
As indicated in the diagram above, planning of health activities is a cyclical process, which should start by analyzing the situation of the district. On the basis of situation analysis, we should set our objectives / results and then the activities should be planned to achieve these objectives / results. During implementation of these activities, we should monitor and supervise the activities and then, at the end of the project or a planning cycle, we should evaluate whether we have achieved what we wanted. This evaluation gives an insight into where we went wrong, and lessons learnt during monitoring and evaluation become part of your situation analysis for next planning process and the cycle continues. Detailed description of planning process is given in the document "Decentralised Planning" (Annexure I).

Outline of steps to be undertaken to prepare a District Health Action Plan (DHAP) in line with NRHM is given below:

Simplified NRHM annual planning process:

Many preparations are required before submitting a plan for approval. For the activities to be undertaken from April next year, a plan should be submitted to NPCC by November / December this year, and the planning process should start in August itself.

Diagram below gives an outline of the steps to be taken month wise:



Month wise desired step - August:

Consultation with Stakeholders at District level:

To make the planning process participatory, meetings and consultations should be organized at village, block and district level, in the month of August. Purpose of these meetings is to involve every stakeholder *(Medical Officers, Traditional healers, Community / religious leaders, Multipurpose workers, AWW, ASHA, Community members, patients etc.)*, in identifying problems of the district in relation to health and health related services *(Refer Annexure 1 - Situation Analysis)*. Stakeholders should also be involved in deciding what results / objectives should be achieved as a solution to the problems.

Month wise desired step - September:

Drafting District Action Plan:

This can be done by discussion among the planning group members. In states where results / objectives have already been identified, at the state level, activities can be planned to achieve these results/objectives. In those states, where objectives / results are not identified, a discussion should be held with stakeholders to identify results/objectives on the basis of the problems identified *(Refer Annexure 1 - Formulation of Objectives).* Indicators should be designed for monitoring the progress in achieving those objectives / results *(Refer Annexure 1 - How to measure whether the results are achieved).*

As examples, a list of identified results and indicators are attached at Annexure II, which could act as a guide to decide for your state and District. Activities at state & district level could be planned for achieving each objective/result identified. Activities should be realistic and doable, taking into account various disturbances, delays, time spent/required etc. Budget should be calculated as per prescribed norms under GOI guidelines.

After the draft document is ready with details of activities and **Month wise desired step - October:** **Submission of planning document to NRHM:** budget, it can be submitted to District NRHM. Discussion may be needed to modify it. After the approval from District NRHM, it can be submitted to state NRHM division for compilation into state plan of action.

Month wise desired step - November:

Submission to National Planning Coordination Committee (NPCC):

Compiled state action plan from the state should be submitted to NPCC by November. Some discussion / modification may be required in state action plan and it can be resubmitted to NPCC by December.

It is presumed that the discussions and approvals will take two or three months at national level hence the bottom line is that the planning process should start in August.

Decentralised Planning

1. What is planning?

It is a step-by-step account of the activities, which are to be undertaken, to achieve desired results / objectives. Planning is to predict the future (where do we want to go?). It is like a road map to reach your destination.

1.1 Desired approach for planning:

As per NRHM the planning should be objective or result based.

Few Examples: Normally we plan as to how many doctors or pharmacist or ANMs are to be trained (activity based) while our approach should be: what will be the outcome (result) of this training or why and what for, are they trained, which of course is for improving their capacity and skills. So, our objective or expected result is that we want to improve their skills and training is one of the activities to achieve that. There are more activities/actions, which will be required to improve staff performance.

Similarly we plan a number of supervisory visits to PHCs but we should think what change these supervisory visits would bring. We should think how to improve quality of services. To achieve this, supervisory visits are one of the activities. There will be more activities required to improve quality of services. Hence in any planning, we should be clear as to what we want to achieve or where do we want to go (Objective based/ result oriented).

2. Planning Cycle:

Planning and management is a cyclical process, which starts with situation analysis setting of objectives, planning of activities, monitoring and supervision and finally evaluation.

2.1 Situation analysis:

Situation analysis of a block / district / state could be conducted by:

- Collecting information on the existing geographical, socio economic and cultural background with prevailing health problems and analyzing relevant indicators.
- Going through the evaluation reports, which will contain observations and recommendations by the evaluators
- SWOT (Strength, Weakness, Opportunities & Threats) analysis. It provides information on positive and negative aspects both within and outside the project. Detail of SWOT is given as follows:

Strengths & Weaknesses:

These are the resources and capabilities (within the organization i.e. internal) that help or hinder the project to carry out leprosy control services. These strengths and weaknesses may be related to quality of staff and management, range of services available, organizational structure, financial management structure etc.

Opportunities:

Opportunities are external factors / situations / circumstances, which are not under the control of the project or the programme and which are likely to affect / help in improving the leprosy control activities. These factors or circumstances could be availability of funding agencies and outside expertise etc.

Threats:

Threats are also outside factors/situations/circumstances, which are not under the control of the project or the programme and these factors may influence the programme in negative way e.g. more importance given to other programmes, stoppage of funding by international NGOs, too many job responsibilities given to officer etc.

This SWOT analysis should be done by involving all levels of stakeholders. We can identify our needs and problems through weaknesses listed in SWOT analysis, evaluation reports and other source of information available described above.

2.2 Formulation of 'Objective' or desired 'Result':

After we know where we are, and have identified the problems and needs, the next step in planning is to set objectives or results, which we want to achieve in the programme. Objective is like a destination or the end result of the activities, which will be undertaken to reach the destination or achieve those objectives / results. Objective should be SMART:

S: Specific

Objective / Goal should be specific e.g. there should not be any ambiguity. It should not be vague. Instead of saying improved awareness about leprosy; it should be "improved awareness about signs & symptoms of leprosy" or "improved awareness about availability of free treatment and curability" etc. Similarly in relation to disability it should be, "disability Grade-I or Grade-II among new cases" or "disability Grade-I or Grade-II among cases under treatment" or "total disabilities".

M: Measurable

It is difficult to understand the quantum of disabilities from the statement "The disabilities are reduced". How one would know whether they're really reduced. It is better to understand if we state that the proportion of Disability Grade-II among new cases (specific) is reduced from 5% to 2% (measurable).

A: Acceptable & achievable

The objective, which the programme or planners want to achieve, should be achievable. Plan/objective should not be over-enthusiastic. Never plan to achieve objective which can not be achieved in relation to deadlines, numbers etc. In addition, the objective should be acceptable to all involved in the planning process.

R: Relevant & Realistic

Objective should be relevant & realistic. While planning for Leprosy Control Programme, we should not think of achieving vaccination coverage of polio drops (relevance) and the objective should also be realistic means we should not plan to achieve the objective, which can not be achieved in desired time e.g. 0 case of leprosy, by 2010.

T: Time bound

The objective should specify the time by which it has to be achieved. For example, if we want to achieve decrease in proportion of disability cases , we should be clear as to within how much time this reduction will be possible; so that at the end of this time, we can measure whether we have achieved that objective.

2.3 How to measure whether Objective or result is achieved?

Example: One of the objective / result, which we want to achieve under NLEP is: *'Improved DPMR services'*. Somewhere down the project or in the program we shall have to measure whether we are moving in the right direction to achieve the desired objectives and whether we have achieved these objectives by the said date. This is monitored / measured by single or a number of Objectively Verifiable Indicators (OVIs).

Indicator is a tool, which measures change. In heath programme indicator will be depicted as rate, ratio or proportion.

A few OVIs for the objective *'DPMR services improved'* may be:

a) "Proportion of cases at risk of developing disability being monitored through nerve function assessment"

   What we want to achieve is that: All i.e. 100% cases (measurable) at risk of developing disability (specific) are monitored by Voluntary Muscle Testing / Sensory Testing (relevant) by the end of 2010 (time bound).

b) "Proportion of disabled cases practicing self care"

   What we want to achieve is that: All i.e. 100% cases (measurable) with Gr. I disability (specific) are practicing self care (relevant) by the end of 2010 (time bound).

3. Planning the activities:

To achieve the objective 'DPMR services improved', a number of activities have to be planned.

Example of some of the activities is as under:

- Procurement of operational guidelines
- Training of trainers (ToT),
- Training of MOs,
- Training of PHCs staff in DPMR & counseling,

- Mobilization of disabled & their disability assessment,
- Procurement of materials e.g. Prednisolone, foot wear,
- Developing self care group, RCS & post operative case etc.

After we have given a thought and listed the activities, we should plan as to when these activities will be conducted, Who will be responsible for this activity?, What resources will be required including budget and then we can also plan from which fiscal source this activity will be funded.

Gantt chart helps us in distributing the activities to be carried out month wise. This also helps us in keeping the track of the activities (monitoring). While preparing the plan, we can also get an idea whether many or few activities are to be planned in one month. If we see that many activities are entered in a particular month, we can re-adjust and space our activities accordingly.

Planning Document:

Whole of the plan can be produced in the form of a document, which could be prepared under following headings:

Executive summary

1. Introduction: This should include brief description of the district (e.g. geography, demography, culture etc.), about leprosy eradication programme of the district, achievements made so far, problems encountered and why this plan is made and the year of planning
2. Situation analysis: A brief description of epidemiology of Leprosy, progress of essential indicators (over the last 5 years), evaluation findings, if any, and SWOT analysis
3. Objectives / results
4. Activities: Schedules with responsible persons & budget and Gantt chart
5. Implementation arrangements: Monitoring, Supervision and & Evaluation and Management
6. Annexes: Map, Detailed budget calculations and References if any

Results and indicators formulation for NLEP for the period 2009-2010

Results	Indicators
1. Sustained case management	1. Wrong diagnosis decreases from ___% to ___% 2. Treatment Completion rate is increased from ___% to ___% for MB & ___% to __% for PB by the end of 2009. 3. Increased percentage of referral by ASHA /SAHIYA / link workers / AWWs from __% to __% and ANMs / Male workers from __% to __% by the end of year 2009-2010. 4. Decreased percentage of cases developing disability during treatment from ___% to ___% by end of 2009-2010.
2. DPMR services established	1. Number of district hospitals equipped to deal with referred complicated cases from __ to __ (all) by the end of March 2009. 2. Number of district hospitals managing complicated cases to increase from __to __ by the end of Dec 2009. 3. Number of district where reaction cases are effectively managed at PHC level to be increased from __ to __ (all) by the end of 2009. 4. Percentage of patients with disability regularly practicing self care will increase from __% to __% by the end of 2009. 5. Percentage of patients getting appropriate footwear will go up from __% to __% by the end of 2009. 6. Number of district arranging RCS to increase from __ to __ by the end of 2009-2010. 7. Number of RCS centers to be increased from ___ (2008-09) to ___ (2009-2010). 8. Proportion of disabled cases (requiring surgery) being referred to surgical center (increased from __% to __% by 2010).
3. Increased community awareness on signs, curability & availability of MDT	1. Reduced disability proportion Gr - II among new cases from __% to __% by the end of 2009-2010. 2. Increased acceptance of LAP in the community 3. Increased percentage of early case detection from __% to …% by the end of 2009-2010. 4. Management of Ulcer cases increased.

4. Drug management system improved	1. Ensured 2 months buffer stock of all categories of MDTs at all PWCs by the end of 2009-2010. 2. Integrated drug supply management within general health care supply chain by end of 2009-2010.
5. Improved referral system	1. Number of referral centers to be increased from ___ to ___ for the management of complicated leprosy cases at district level.
6. System cooperation with other partners/ organizations established	1. Availability of Joint plans made with main cooperation partners. 2. Involved relevant Govt. department / ESI hospitals & identified practitioners by end of 2009-2010.
7. Improved accessibility through public private partnership	1. Increase in proportion of private practitioner (dermatologists) regularly reporting cases detected, registered & completed treatment. 2. Increase in proportion of registered NGOs promoting self care. 3. Increase in proportion of private medical colleges reporting leprosy cases regularly. 4. Increase in number of NGOs/voluntary organization involved in self care, POD & socio economic rehabilitation.
8. Training & supervisory system established	1. Availability of state guidelines and plans for supervision and training by the end of September 2008. 2. Number of district having fully functional DN to be increased from ___ to __ (all) by the end of 2009-2010. 3. Number of district with need based training and supervision to be increased from ___ to __ by the end of 2009.
9. Programme management ensured	1. Ensure that quarterly review meetings are held regularly during 2009-2010. 2. Ensure Program advisory group meetings are held regularly. 3. To increase timely submission of action plan & budget from all districts. 4. To increase timely submission of MPR from __ districts (2008-2009) to __ districts (2009-2010). 5. Each PHC supervised by district nucleus Once In a Month and each district supervised by state in a quarter using checklist and feedback by end of 2009-2010.

Annexure - 1

LEAP : Action Plan for SSD

Plan for the Year: ______ **Submitted on:** ______

A	General information	
1.	Name of Partner unit	
2.	Name of ward / block	
3.	Total population of the area	

B	Details of the Health Post selected	1	2	3
1.	Name of the ward / block selected			
2.	Name of HP / PHC selected			
3.	Criteria for selecting the HP / PHC			
4.	HP / PHC population (Mid-year)			
5.	Target population of the HP / PHC (Estd.)			
6.	Balance active cases in HP / PHC (31 / 3)			
7	New cases registered during last 1 year			
7.1	MB cases among new cases (1 year)			
7.2	Child cases among new cases (1 year)			
7.3	Gr. II cases among new cases (1 year)			
8.	Name of LRC attached to the area selected			

C	Details of areas selected for SSD	1	2	3
1.	Target population selected for SSD (Estd.)			
2.	Number of the areas / pockets selected			
3.	Balance active cases in SSD area (31/03)			
4.	New cases detected during last 1 year			
4.1	MB cases among new cases (1 year)			
4.2	Child cases among new cases (1 year)			
4.3	Gr. II cases among new cases (1 year)			

D	Plan for SSD		1	2	3
1.	Start date of SSD				
2.	End date of SSD				
3.	No. of CVs to be trained				
4.	No. of CHVs to be trained				
5.	No. of CVs to be engaged				
6.	No. of CHVs to be engaged				
7.	Name of staff to be engaged in SSD				
	a. Medical Officer / Project Incharge				
	b. Health Supervisor / Project Coordinator				
	c. Health Worker / Health Assistant	1.			
		2.			
		3.			
		4.			

E.	Details of IEC materials required	1	2	3
1.	Photo album / Flip chart (Small)			
2.	Flex Poster Exhibition			
3.	Colour Leaflets			
4.	Diagnostic cards			
5.	Posters / stickers			
6	Lokshikshanatun Rognirmulan			
7.	Guide for GHC doctor			
8.	POID Guide			
9.	Other specify			

F.	Details of budget estimates (as per norms)	1	2	3
1.	Incentives to CVs for 2 days training			
2.	Lunch expenses for CVs during training			
3.	Incentive to CVs for H2H IPC campaigns			
4.	Training materials / Administrative expenses			
5.	Incentive to MO / PI for SSD			
6.	Incentive to NMS / PC for SSD			
7.	Incentive to PMWs / LTs / PHA for SSD			
8.	Total expenses for SSD			

Name & Designation:____________________________ Signature & Date:_______________

Annexure - 2

SSD: Details of CVs selected for SSD

Name of Unit:		**Date:**	
Name of HP / PHC:		**Ward/Block:**	

	Name of Area	Name of CV	Age / Sex	Contact No.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				

Name & Designation: ______________________________ Signature & Date: ______________

Annexure - 3

SSD: Details of honorarium to CVs trained / engaged for SSD

Name of Unit:		**Date:**	
Name of HP / PHC:		**Ward/Block:**	
Place of training:		**Date(s):**	

	Name of CVs	Village / Slum	No. of days	Amount	Signature
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

Name & Designation: ______________________________ Signature & Date: _____________

Annexure - 4

SSD: Details of population reached through Intensive H2H IPC campaign by CVs

Name of Unit:		**Date:**	
Name of HP / PHC:		**Ward/Block:**	

	Name of CV	No. of Houses	Population Enumerated			Population reached			Suspects referred (No.)	Old Cases (No.)
			Ad.	Ch.	Tot.	Ad.	Ch.	Tot.		
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										
16.										
17.										
18.										
19.										
20.										
		Total								

Name & Designation: ________________________________ Signature & Date: ______________

Annexure - 5

SSD: Details of population reached through Intensive H2H IPC campaign

Name of Unit:		**Date:**	
Name of HP / PHC:		**Ward/Block:**	

	Name of Area	No. of Houses	Population Enumerated			Population reached			Suspects referred (No.)	Old Cases (No.)
			Ad.	Ch.	Tot.	Ad.	Ch.	Tot.		
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										
16.										
17.										
18.										
19.										
20.										
		Total								

Name & Designation: ______________________________ Signature & Date: ______________

Annexure - 6

SSD: Details of new leprosy cases confirmed among the suspects referred / reported

Name of Unit:		**Date:**	
Name of HP / PHC:		**Ward/Block:**	

	Name of Suspect	Age / Sex	Date of Referral	Date of Diagnosis	Status
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

Name & Designation: ________________________ Signature & Date: ____________________

LEAP: Selective Special Drive (SSD) – Report of the activity

A	SSD - coverage		Details
1.	Name of Partner Unit		
2.	Start date of SSD		
3.	End date of SSD		
4.	Name of HP / PHC selected for SSD		
5.	Criteria for selecting are for SSD		
6.	PR (10,000) of area before SSD (as of ....)		
7.	NCDR (100,000) of area before SSD (as of ....)		
8.	No. of slum / villages covered		
9.	Population	Targeted	
		Reached	
10.	No. of schools covered		
11.	School children (Municipal + Private)	Targeted	
		Reached	
B	**SSD - Training**		**Details**
1.	IEC Workshop organised	Number	
		Participants	
2.	No. of CVs / CHVs	Trained	
		Engaged	
3.	No. of students / teachers	Trained	
		Engaged	
4.	No. of NGO / CBO staff	Trained	
		Engaged	
5.	No. of Diagnostic card distributed		
6.	No. of leprosy booklets distributed (Hindi / Marathi)		

C	Focused IEC campaign by staff	Details	
		No. of Prog.	Attendence
1.	Group talk using photo album / mega phone		
2.	Slide / film shows on leprosy		
3.	Street plays / Kalajattha		
4.	Poster Exhibitions		
5.	Cycle rally / Awareness march		
6.	Skin camp / Health mela		

D	IEC materials displayed in SSD area	Number
1.	Posters / Banners	
2.	Stickers	
3.	Slogan writing / painting	

E	Intensive H2H IPC by CVs / CHVs	Number
1.	No. of households contacted	
2.	No. of leaflets distributed	
3.	No. of suspects identified	

F	Results of SSD*	M	F	MC	FC	Tot
1.	No. of suspects confirmed out of identified					
2.	No. of suspects examined by NMS / MO					
3.	No. of suspects confirmed as leprosy					
4.	MB cases among new cases					
5.	Child cases among new cases					
6.	Gr. II cases among new cases					
7.	New cases started on MDT at HP / PHC					
8.	NCDR (100,000) of HP / PHC after SSD					
9.	PR (10,000) of HP / PHC after SSD					

**Please report cases atleast for six months after SSD with the same details. Please attach narrative report contains experiences, observations, any innovative activities done, community participation. Photographs of cases of significance and activity.*

Prepared and Submitted by:______________________________ Date:__________________

Referral Note to LRC

LEAP
LEPROSY ELIMINATION ACTION PROGRAMME

To,
The Medical Officer, Leprosy Referral Centre.................

Dear Sir,

Referring Mr. / Ms. .... .Age / Sex : ....

of village/ area .... Taluka .... District ....

For the following services. *(Please ✓ mark the applicable)*

Diagnosis / Confirmation of Leprosy ☐ Diagnosis & Treatment of Complications (Reaction / Neuritis) ☐

Laboratory Test (Skin smear / Biopsy) ☐ Physio Assessment ☐ Deformity Care ☐ MCR Footwear ☐

Physiotherapy (Wax therapy / muscle stimulation) ☐ Ulcer Care ☐ Splints ☐ Counseling ☐

Surgical Rehabilitation ☐ Economical Rehabilitation ☐ Vocational Rehabilitation ☐

Any other Specify..

Details about case are furnished below for your kind information

Diagnosis : MB-Leprosy ☐ PB-Leprosy ☐ Leprosy Suspect ☐

MDT Treatment : Under Treatment ☐ RFT ☐ Untreated ☐

Duration of Reaction .... No. of Reactional episodes..................................

Duration of Neuritis.. No. of episodes of Neuritis..................................

Previously treated with steroids? (give details separately) Yes ☐ No ☐ Unknown ☐

Duration of Deformity : Less than 6 months ☐ 6-12 months ☐ Over 1 year ☐

Any other relevant information ....

Please guide us to manage the case with your kind advice note.

Signature & Date
Medical Officer PHC / UHP / HP

LEAP
LEPROSY ELIMINATION ACTION PROGRAMME

Leprosy Referral Centre (LRC) Advice Note to PHC / UHP

LRC Ref.
No.: __________
Date: __________

Name of the Patient: ______________________________ Age:____ Sex: M / F

Address: ____

____

Patient Referred by: ______________________________________

(Please ✓ *mark the applicable)*

REASON FOR REFERRAL :

(Complaints)

Diagnosis	☐	Deformity	☐
Smear / Histopath	☐	Aids & Appliances	☐
Lepra Reaction	☐	Counselling	☐
Neuritis (Active / NFI)	☐	Rehabilitation	☐

Others Specify: ______________________________

DIAGNOSTIC SERVICES PROVIDED:

Confirmation of Diagnosis	☐	Others Specify:
Physio Assessment	☐	__________
Smear / Biopsy	☐	__________

DIAGNOSIS:

Leprosy	MB	PB

Reaction	Type I	Type II

Neuritis	Active	Silent (NFI)

Deformity	GR-I	GR-II

Others Specify:

TREATMENT ADVICE:	MDT		Steroid Therapy	CLF Therapy	Others Specify
	MB	PB			
Initiate					
Continue					
Stop					

Patient is adviced to visit LRC			For	
Weekly ☐	Fortnightly ☐	Monthly ☐	Wax Therapy ☐	Ulcer Care ☐
Quarterly ☐	Half Yearly ☐	Once in a year ☐	Muscle Stimulation ☐	Follow-up ☐

DETAILS OF EXAMINATION:

Skin Signs of Leprosy Confirmed: (a) Skin Patches: Less than 5 ☐ More than 5 ☐

(b) Smooth, Oily, Shiny Skin ☐

(c) Skin Nodules ☐

Sites of Patches / Nodules (Specify): ______________________________

____

Skin Smear for AFB: Positive ☐ Negative ☐

Major Trunk Nerves Affected :

Trunk Nerve	Ulnar		Median		Radial		Common Peroneal		Posterior Tibial		Other Specify	
	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt
Enlarged												
Tender												

DEFORMITY DETAILS :

Grade	Hand			Foot			Eye		
		Rt	Lt		Rt	Lt		Rt	Lt
Grade-I	Anaesthesia			Anaesthesia					
Grade-II	**Mobile Claw**			**Mobile Claw Toe**			**Lagoph-thalmos**		
	Ulnar / Median Claw								
	Total Claw (Hand)								
	Fixed Claw			**Fixed Claw Toe**			**Blindness**		
	Ulnar / Median Claw						Partial		
	Total Claw (Hand)			**Plantar Ulcer**			Complete		
	Wound on hand						**Facial Palsy**		
	Wrist Drop			**Foot Drop**					
	Absorption of Fingers			**Absorption of Toes**					
Other Specify									

PHYSIO-SERVICES PROVIDED AT LRC :

Self-care Advice ☐ HOPE (Hydro-Oleo-Physio-Exercise) ☐

Wax Therapy ☐ Muscle Stimulation ☐

Ulcer care ☐ POP Application ☐

Any Other : ____________________

AIDS & APPLIANCES PROVIDED AT LRC :

Micro-celluar Rubber (MCR): Insole ☐ Footwear ☐

Splints: Adductor Band ☐ Finger Loops ☐

Opponnens Loop ☐ Finger Gutter ☐

Goggles ☐ Any Other : ____________________

REFERRED TO : ____________________

For : Surgery ☐ Special Investigations ☐

Rehab. Aid ☐ Expert's Opinion ☐ Other ☐

REMARKS : ____________________

____

____

____

Date: **LRC Medical Officer**

Leprosy: Diagnosis & Treatment

Some Points to remember

(A) Confirm the diagnosis only when you notice one of the following Cardinal Signs.

- A skin patch with definite loss of sensation.
- A thickened or tender Nerve Trunk with definite loss of Nerve Function (Sensory or / & Motor)
- Change in Skin Texture (Smooth-Oily-Shiny skin) with or without nodular skin lesions with presence of Acid Fast Bacilli (AFB) in Skin Smear.

  - The diagnosis of leprosy should be made without any doubts.
  - It should not be made by exclusion or by therapeutic trial with anti-leprosy drugs.
  - In case of doubt/confusion-Wait & Observe the patient for 3 to 6 months.
  - Review the case for established leprosy sign/s.
  - Or take the opinion of Dermatologist / Neurologist / Pathologist.

(B) MDT Treatment

- Only an untreated leprosy patient with a sign of disease activity is eligible for MDT
- A leprosy patient who has completed full course of MDT may not need MDT again. So neither register again nor give MDT.
- If there is definite sign of re-infection or relapse give appropriate MDT
- Follow MDT schedule as per Govt. Guidelines; Fixed Duration Therapy- PB- 6 Months & MB-12 Months.

(C) Complications of Leprosy : Lepra-reactions Signs & Symptoms

Type I Reaction (Reversal)

- **Skin Lesions-** Swollen & oedematous patches,Erythema followed by desquamation & some times by ulceration. Lesions painful and tender
- **New Lesions-** Uncommon in reversal reaction
- **Nerves** -May accompanied by Acute Neuritis- one or more nerves swollen, extremely painful and tender.
- **Systemic Illness** -Uncommon
- **Other Manifestations** -Nil

Type II Reaction (ENL)

- **Other Manifestations** -Nil
- **Skin Lesions-** Superficial or subcutaneous painful red nodules-(ENL), common on face and extensor surface of the limbs. New Lesions- New ENL common.
- **Nerves-** All affected nerves are involved- enlarged and tender. But neuritis in ENL is not as deformity threatening as in Reversal Reaction.
- **Systemic Illness-** Common-fever, headache, insomnia, depression, arthritis
- **Other Manifestations-** Iridocyclitis, Orchitis, Dactylitis, Tender Lymphadenopathy

LEAP Supported LRC

LEPROSY ELIMINATION ACTION PROGRAMME (LEAP)

High risk & Disability Assessment record

High risk	
Disability	
Gr.I	Gr.II

District:	Taluka / Ward:
UHP/ PHC:	LRC Name:
MDT Regd. No:	POD Regd. No:
Date of MDT start:	Date of RFT:

Name of patient:

Year of birth: / / Age: Sex: MA FA MC FC Type: MB PB

Occupation (specify):

Address:

District:: State:

Telephone No: Mobile No:

Category of high risk:

- Case with enlarged trunk nerve ☐
- MB case (> 5 skin lesions) ☐
- History of reaction / neuritis ☐
- Lesion on the course of nerve / face ☐
- Reproductive / Adolescent age group ☐

Date of deletion: / / Reason :

Nerves	Date																								
	Side	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt
Ulnar	Nerve																								
	Sensation																								
	Motor - Little finger out																								
Median	Nerve																								
	Sensation																								
	Motor - Thumb up																								
Radial	Nerve																								
	Sensation																								
	Motor - Wrist up																								
Lat. Popliteal	Nerve																								
	Sensation																								
	Motor - Foot up																								
Post. Tibial	Nerve																								
	Sensation																								
Facial	Motor - Close eyelids																								

Key: For **Nerve** - 'N' - Trunk nerve normal; 'E' - Nerve enlarged / thickened compared to normal nerve; 'T' - Nerve tender on palpation or painful; 'A' - Abscess formation.
For **Sensation** - 'P' - Sensation present - able to feel; 'A' - Sensation absent - Complete loss of sensation (with ball-point pen); *Write the filament number, if nylon filament is used to test the sensation.*
For **Motor** - 'S' - Strong muscle and able to perform movement against full resistance; 'W' - Weak muscle and unable to perform movement against little resistance; 'P' - Paralyzed muscle and no movement

Disability / deformity assessment (once a year) :

Date of assessment:	Initial:	Year 1:	Year 2:	Year 3:	Year 4:
	Right / Left	Right / Left	Right / Left	Right / Left	Right / Left

Key	Disability / Deformity	Duration
✓	Sensation present	
X	Sensation absent	
Λ	Mobile claw finger	
S	Fixed claw finger	
Z	'Z' / Ape thumb	
↓	Wrist / Foot drop	
⊗	Ulcer Wound	
■	Absorption	
>	Lagopthalmos	
⇆	Facial Palsy	

Disability care and services: (Use '9' mark, if services are given atleast once a year)

Assessment / advise						Disability services					
Year						**Year**					
Assessment						Steroid therapy					
Self care						Muscle stimulation					
Oil massage						Wax therapy					
Exercises						Ulcer dressing					
Eye care						POP Cast					
Disability aids						**Referrals**					
MCR sandals						Investigations					
Hand splints						Admission					
Goggles						Surgery					
Ulcer Kit						Rehabilitation					

WHO disability grade: (To assess once a year) '0' No disability; '1' Anaesthesia; '2' All visible deformity

Year												
Side	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt
Eye												
Hand												
Feet												
EHF*												

* **EHF score:** Add disability grades of eyes, hands & feet; Minimum score is '0' & Maximum score is "12"

Specialized services: (To fill only when specialized services are provided)

Type of services	Date	Details	Result
Socio-economic rehabilitation			
Reconstructive surgery			
Treatment of eye complications			
Prosthesis / Orthosis			
Any other - specify			

LEAP
कुष्ठरोग दूरीकरण कृती कार्यक्रम

कुष्ठरोग संदर्भ सेवा केंद्र (एल्.आर.सी.)
रुग्ण उपचार कार्ड

एल्.आर.सी. रुग्ण नं.: | | | |

रोग प्रकार: एम्.बी. / पी.बी. नवीन / जूना

नोंदणीचा दिनांक: ..../......../............

संदर्भ सेवा केंद्राचे नाव : .... तालुका : ....

रुग्णाचे नाव : .... वय : .... लिंग : पु. / स्त्री

रुग्णाचा पत्ता : ....

....

प्रा. आ. केंद्राचे नाव : .... घरापासून ते एल्आरसी पर्यंतचे अंतर : ....

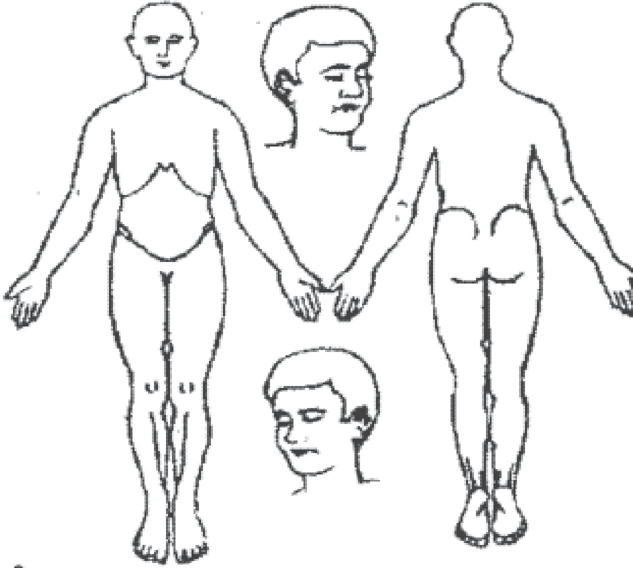
रुग्णास कोणी पाठविले : ....

जूना रुग्ण असल्यास पूर्वी घेतलेल्या उपचाराची माहीती : ....

घरातील एकूण व्यक्ती : .... घरातील कुष्ठबाधित व्यक्तींची माहीती व नाते : ....

उपचारावेळची स्थिती : रोग प्रतिक्रिया : प्रकार-१ / प्रकार-२ / मज्जादाह

जखम: साधी / गुंतागुंतीची विकृती: प्रकार-१ / प्रकार-२



विलेपनाचा दिनांक: ....

बाजू	निष्कर्ष

शारीरिक तपासणी:

त्वचा (अ) डाग संख्या .... आकारमान .... पृष्ठभाग ....

सपाट / उभारलेला / रंग .... कडा .... स्पर्श ....

(ब) त्वचेच्या पोतात बदल / अंगावरील गाठी: ....

चेतातंतू:

चेतातंतू	अल्नार		मिडियन		रेडियल		कॉमन पेरोनियल		पोस्टेरिअर टीबीयल			
N - Normal **E** - Enlarged **T** - Tender	उ.	डा.	उ.	डा.	उ.	डा.	उ.	डा.	उ.	डा.	उ.	डा.

तपासणाऱ्याचे नाव व सही: .... **दिनांक:** ....

रुग्णाचे नाव : .... वय : .... लिंग : पु. / स्त्री

उपचार:

दिनांक	रुग्ण तपासणीचा तपशिल	उपचार	सही

दिनांक	रुग्ण तपासणीचा तपशिल	उपचार	सही

Annexure - 12

Name of Organization: ____________ Date: ____________

Place of LRC: ____________ Month & Year: ____________

Ward / Takula: ____________ District: ____________ State: ____________

I. Leprosy cases with risk factor *

Sr. No	Particulars		Total
1	Balance risk cases in the project area at the end of previous month		
2	Risk cases registered during the month		
3	Total risk cases in the project area at end of the month (1 + 2)		
4	Deletions	a. Patient developed disability / deformity	
		b. Patient did not develop disability in past 5 years	
		c. Left Control Area / Died	
		d. Total deletion during the month (a + b + c)	
5	Balance risk cases living in the project area at end of the month (3 – 4)		
6	Risk cases assessed during the month of reporting (at least once in a year)		

* **Risk factor:** MB with thickened nerves / Patch over face or trunk nerve / Past reaction or neuritis / Women in child bearing age group

II. Leprosy cases with reactions / neuritis *

Sr. No	Particulars		Type I	Type II	Total
1	Balance reaction cases at the end of previous month				
2	Reaction cases added during the month under reporting				
3	Total reaction cases under treatment at the end of reporting month (1 + 2)				
4	Deletions	a. Patient completed full course of steroid (Reaction subsided)			
		b. Patient referred to UHP / PHC for continuation of treatment			
		c. Patient dropped out from reaction treatment & others			
		d. Total deletion during the month (a + b + c)			
5	Balance reaction cases under treatment at end of reporting month (3 – 4)				
6	Reaction cases referred to PHC for steroid therapy during the month				

* **Neuritis:** Includes patients developed early NFI in the past 6 months – silent neuritis

III. Leprosy cases with disabilities / deformities *

Sr. No	Particulars	Grade I	Grade II	Total
1	Disabled cases living in the project area at the end of previous month			
2	Disabled cases registered during the month under reporting			
3	Total disabled cases living in project area at the end of reporting month (1 + 2)			
4	Disabled cases deleted during the month (LCA / Died / Others)			
5	Balance disabled cases living in project area at end of reporting month (3 – 4)			
6	Total disabled cases attended LRC during the month under reporting			
7	Total disabled cases assessed for POD during the month under reporting			

* **Disabled cases:** All registered leprosy cases with disabilities / deformities living in the project area

IV. Referral of cases to LRC during the month

Reason	Diagnosis	Reaction management	Disability management	Others:
Number				

V. Services provided during the month at LRC

New cases attended LRC: ____ **Old cases attended LRC:** ____ **Total cases attended at LRC:** ____

Advise	Initial	Follow-up	Services	Initial	Follow-up	Disability aids	Initial	Follow-up
Diagnosed as HD			Skin smear			Splints		
Assessment			Steroid-therapy			MCR Sandals		
Self care			Muscle stimulation			Ulcer kit		
Exercises			Wax therapy			Goggles		
Eye care			Ulcer dressing			POID folders		
Refer to PHC			POP Cast			Crutches		

VI. Referral of cases to UHP / PHC with referral note for follow-up services during the month

Reason	Number	Reason	Number
For MDT		For follow-up of disabled cases	
For steroid therapy		For providing disability services	

VII. Referral of cases from LRC to specialized centres during the month

Reason	Number	Reason	Number	Reason	Number
Admission		Reconstructive surgery		Ulcer care	
Investigation		Reaction management		Rehabilitation	
Ophthalmic care		Prosthesis & Orthosis		Consultation	

Feedback / Observations:

Prepared by:	Signature & Date:

Note: Prepare separate reporting form for all Out Project Area (OPA) cases.

Suggested reference materials

1. National Leprosy Eradication Programme – Guidelines for drawing up Referral System under NLEP by the States / UTs.

2. National Leprosy Eradication Programme – Referral system for persons affected with leprosy.

3. National Leprosy Eradication Programme – Guidelines for Disability Prevention and Rehabilitation.

4. National Leprosy Eradication Programme – Note on Introduction of New Indicator "Rate of New cases detected with Grade – II disabilities".

5. National leprosy Eradication Programme – Guidelines for use of Treatment completion rate as an Indicator under NLEP

6. National Leprosy Eradication Programme – Guidelines for Facilitating Reconstructive Surgery in Leprosy

7. National Leprosy Eradication Programme – Quality of services Indicators - Significance and Action required NLEP –

8. National Leprosy Eradication Programme – Guidelines for Trainers

9. National Leprosy Eradication Programme – Manual for Training for Medical Officers

10. National Leprosy Eradication Programme – Monitoring and Evaluation tools for implementation of New Paradigms during 11th Plan period

11. National Leprosy Eradication Programme – Disability Prevention and Rehabilitation

12. National Leprosy Eradication Programme – Guidelines for Decentralized Planning under National Leprosy Eradication Programme

13. WHO, Workshop for Health Service Managers in charge of Leprosy Control Programmes : *From Global Strategy to National Action* - Participant Guide

14. WHO, Workshop for Health Service Managers in charge of Leprosy Control Programmes : *From Global Strategy to National Action* - Facilitator Guide

15. WHO, I can do it myself! Tips for people affected by leprosy who wants to prevent disability, 2007

16. WHO, Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy (Plan Period: 2011-2015), SEA-GLP-2009.3

17. WHO, Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy : Operational Guidelines, SEA-GLP-2009.

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WE CAN DETECT TREAT CURE LEPROSY

A Guide for Public Health Doctors

कुष्ठ की पहचान उपचार और उससे मुक्ति हमारे हाथ

जनिक स्वास्थ्य चिकित्सकों के लिए मार्गदर्शिका

विकृति ...?

स्वयं समझो देखभाल करो बचाव करो

स्वास्थ्य कर्मचारी और रुग्ण के लिए मार्गदर्शिका

जनशिक्षा से कुष्ठ उन्मूलन

LEAP 'लीप' कुष्ठरोग दूरीकरण कृति कार्यक्रम

लोकशिक्षणातून रोगनिर्मूलन

LEAP 'लीप' कुष्ठरोग दूरीकरण कृती कार्यक्रम

Guidelines for Action

Leprosy Elimination Action Programme (LEAP) is a strategy to sustain leprosy control work during integration phase through a community oriented action programme.

The Selective Special Drive (SSD), Leprosy Referral Centre (LRC) and Continuing Medical Education (CME), components of LEAP, are in response to the need of the hour.

The Operational guidelines on SSD and LRC given in this issue has emerged from the valuable field experience, practical insights and specific feedback gathered in the past 5 years of implementing LEAP by ALERT-INDIA and partner organizations.

These guidelines provide a standardized operational methodology and a common reporting system with scope for flexibility in planning and implementing SSD and LRC in different settings by the partners.

The tasks specified in this Operational guidelines are focused on the actions that can enhance the quality of services to the leprosy affected persons.

ALERT-INDIA