Sustaining leprosy control and improving quality of services under NRHM

30th Foundation Day
Commemorative National Workshop
23rd October 2008

Inaugural Session

Inaugural Session: (R to L) Dr. Ashok Ladda, JDHS (Leprosy & TB) GOM; **Dr. Indranath Banerjee,** NPO, WHO; **Mr. Kishore Gajbhiye,** AMC (WS), MCGM (Chief Guest); **Dr. P. R. Mangalani,** DPMR Consultant, GOI; **Ms. Olatz Landa,** Asia unit, Anesvad Foundation; **Mr. A. Antony Samy,** Chief Executive, ALERT-INDIA

◄ **Mr. Kishore Gajbhiye,** AMC, Chief Guest releasing the book 'Task Today' Series 5 - a LEAP publication along with **Dr. Ashok Ladda,** JDHS, GOM

Dr. Indranath Banerjee, WHO ► releasing a guide on Prevention of Deformities in *Hindi* along with **Ms. Olatz Landa,** Anesvad Foundation

A section of audience at the National Workshop

Sustaining leprosy control and improving quality of services under NRHM

(National Rural Health Mission)

National Workshop

23rd October 2008

Organised under the auspices of

LEPROSY
ELIMINATION
ACTION
PROGRAMME

Association for **L**eprosy **E**ducation, **R**ehabilitation and **T**reatment - **India**
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NRHM: need for greater investment for NLEP

The declaration of achieving the goal of leprosy 'elimination' at the national level by the Government at the end of 2005 had reduced the much needed resources, both financial and manpower for NLEP. The announcement of reducing the leprosy burden as a public health problem (less than 1 per 10,000 population) is understood by the public as an end of all leprosy problem in the country.

Further, this public declaration has resulted in giving low priority for leprosy by health planners and donors. The donor's response has affected the quantum of resource mobilized for leprosy relief work by national and international organizations. Consequently, less and less numbers of trained workers are deployed to tackle the remaining issues related to leprosy in the field. Sustaining effective leprosy control measures require a specific long-term commitment and appropriate investments in terms of manpower and materials within the public health system.

The **'National Rural Health Mission (NRHM)',** launched in April 2005, is aimed to improve the access for essential health care by the people, particularly those living in rural areas. The main strength of NRHM is the decentralization of health care financing and establishment of organizational linkages with the formal health financing and service provider network. The NRHM also aims to strengthen and improve community participation in delivering health care through an army of ASHA (Accredited Social Health Activists) workers.

The positive aspect of bringing all national disease control programmes including the NLEP under NRHM umbrella should be taken full advantage for the benefit of leprosy affected persons at the district level.

This National Workshop on *"Sustaining leprosy control and improving quality of services under NRHM"* organized by ALERT – INDIA is to bring to the fore the major challenges facing the leprosy control programme in providing quality care to the leprosy affected persons as a matter of right.

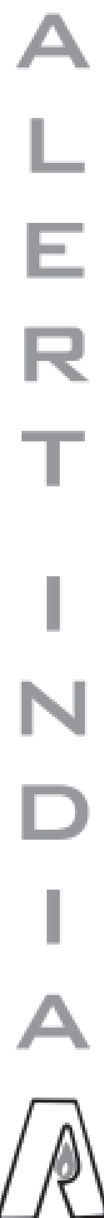
Hence, the aim of this National Workshop was two fold:

(i) to sensitize the leprosy programme managers on the immense opportunity that NRHM provides to sustain leprosy control measures and

(ii) to identify the core service areas needed at different levels of public health system to ensure provision of sustained quality care to the leprosy affected persons.

The presentations at the workshop had highlighted the immediate concerns from across the country. The deliberations by the programme managers and experts had helped to formulate recommendations on behalf of the leprosy affected persons to NRHM through Central Leprosy Division (CLD) of NLEP.

We hope NRHM take NLEP concerns into its umbrella along with all its priorities.



25th March 2009
Mumbai

A. Antony Samy
Chief Executive, ALERT-INDIA

Sustaining leprosy control: Concerns and rights issues

A. Antony Samy
Chief Executive,
ALERT-INDIA,
Mumbai

Distinguished dignitaries on the dias, delegates and friends, on behalf of ALERT-INDIA, I would like to express my appreciation for your participation at this workshop, as it is an expression of your concern for a cause. We look forward to a valuable participation from each of you, so that at the end of the workshop, our recommendations can provide a valuable feedback to the planners and programme managers.

Today, this Workshop will discuss certain specific aspects related to the needs of leprosy affected persons. The policy thrust, in the post elimination period, calls for a paradigm shift from the era of target based approach to a scientific and programmatic approach.

We need to explore programme components that can enhance / alter the system for delivering quality services to the leprosy affected persons in our country. An appropriate alteration within general health care system can pave way to improve / ensure quality of services. The importance of this aspect to sustain leprosy control efforts are to be commonly understood and accepted by all the key players for a collective effort. This is the crux of the matter – the most important and difficult part of deciding the future course.

The present effort of those who are concerned about quality care is to identify an effective referral system at the secondary level, sustaining capacity building at all levels, decentralising monitoring and community mobilization. These will remain a distant dream until the time, adequate policy formulations and strategic decisions are made.

Mainstreaming all the leprosy related services within the health care system need technical support by trained manpower for decades to come. If we fail to provide quality care for the leprosy affected persons today, we cannot erase the stigmatizing socioeconomic consequences of leprosy. Only a quality care assurance can meet the rights of every leprosy affected person. The question is, how to ensure these rights of the leprosy affected persons?

The National Rural Health Mission (NRHM) seeks to provide universal access to equitable, affordable and quality health care, and at the same time responsive to the needs of the people. It also aims to effectively integrate health concerns through decentralized planning and management at the district level. Can these determinants (a thing that decides whether or how the desired result to be achieved) address the social concerns and the rights issues of leprosy affected persons. We need to find answers !

This workshop is an effort to call on all the players, engaged in exploring the prospects of sustaining leprosy control and ensuring quality care, to look at NRHM as one of the means to ensure quality care and to meet the rights of the leprosy affected persons.

What are the structures available or can be created a new within the health care system under NRHM that can be adopted, deployed and sensitised to serve the interest of the leprosy affected persons?

This National Workshop is to gather insights about how the health reforms carried out under NRHM can be utilized to sustain leprosy control and provide quality services to leprosy affected persons. We believe that by making specific recommendations on the ways and means to fulfil the objective of this Workshop, we will take a step forward towards ensuring the rights of leprosy affected persons. ■

Sustaining leprosy control and improving quality of services : need for commitment and determination

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For centuries, often with the best possible intentions for their welfare as well as that of the wider community, persons affected by leprosy were turned out of their homes and isolated in "leprosaria". Children were often forcibly separated from their parents for long periods of time. Today, throughout the world, all persons diagnosed with leprosy can be treated and cured while leading a completely normal life. Now the challenge is one of logistics and infrastructure, of determination and dedication, of joining hands and not letting go until the goal of ensuring that no further lives are devastated by this disease is achieved.

Together we have made tremendous progress in reducing the disease burden in all endemic countries and in improving access of communities to leprosy diagnosis and treatment, particularly in the underserved areas and marginalized population groups. In addition, significant progress has been made towards changing the negative image of leprosy. But much more needs to be done to make sure that no individual suffers from discrimination due to present or past leprosy.

Today, a different set of operational issues are emerging which need to be discussed and debated - such as ensuring timely and correct diagnosis and treatment completion, improving access and coverage, setting up an effective referral network and improving quality of services provided to persons affected by leprosy. And all these need to be tackled in the context of integration of leprosy control activities within the primary health care system that is providing essential services at the most peripheral level. We therefore need to be increasingly effective in the way we deliver our services and be also cost-effective with our resources in order to sustain control activities in the future.

It is well known that leprosy leads to greater poverty, as it is a leading cause of permanent disability in the world. The chronic symptoms often afflict individuals in their most productive stage of life, and impose a significant economic and social burden on their families and society at large. We need to do something to bring about more equity and reduce discrimination. In addition, some countries facing civil conflicts and economic turmoil have experienced severe damage to their health infrastructure, affecting all developmental projects. Leprosy control, by joining hands with the primary health care system, in re-establishing services in these areas can provide benefit to thousands of people.

Even though WHO is pursuing a public health policy to control leprosy, I strongly believe that there should be no compromise in ensuring that all persons affected by leprosy receive the best possible treatment and care. *Quality care must be an integral part of the public health approach.*

Paper read by Dr. Indranath Banerjee

The main principles of leprosy control based on timely detection of new cases and their treatment with effective chemotherapy, in the form of Multi-Drug Therapy (MDT) will not change over the coming years. The emphasis will remain on providing quality care that is equitably distributed, affordable and easily accessible. At the moment there are no new disease prevention tools or information available that may warrant any drastic changes in the current strategy for leprosy control. However, there is an urgent need to make decisive changes in the organization of leprosy control, in the attitude of health care providers and beneficiaries, and in the working arrangements between all partners.

In almost all of the endemic countries, control activities have been integrated within the general health care system, although details of the integration process vary depending on the health infrastructure and availability of resources. It is important that the coverage of leprosy control activities and the quality of services are maintained and improved to ensure that the disease burden declines in all endemic countries, not only in terms of statistical numbers but also in terms of the reduction of disabilities, cases occurring among children and reducing leprosy-related stigma and discrimination.

One of the important challenges is in the area of capacity building: maintaining expertise among health-care workers, particularly in countries/areas where endemicity is relatively low.

Strengthening referral networks is crucial in order to support integrated leprosy control services, otherwise integration is likely to fail. Referral facilities, where possible, must be integrated into the general health-care system, so that these services are easily accessible to persons affected by leprosy who need them. It is important to ensure that the services offered in these referral facilities are effective and affordable.

I believe that leprosy control programmes in many countries will need continued political and professional commitment and support from their governments and partners to ensure that leprosy remains on the health agenda as long as necessary and that success does not lead to complacency.

The WHO's Global Strategy 2006-2010 focuses on sustaining the gains made so far and on reducing the disease burden further in all endemic communities. At the same time, particular attention is given to ensure that the quality of services is not compromised.

Every person affected by leprosy should have easy access to diagnosis and free-of-cost treatment with multi-drug therapy. All of us need to make certain that sustainable activities and quality services are carried out within an integrated set up that includes an effective referral network, so that leprosy related complications, including prevention of disabilities and rehabilitation requirements can be managed effectively.

The implementation of an appropriate leprosy control strategy will require renewed commitment from all partners working towards the common dream of ***A World without Leprosy***.

The decisive factor in this endeavour, however, will be the human element. We need people who show initiative and who are not afraid to come forward with new ideas; individuals who wish to be active partners in this global effort and who want safer and happier lives for themselves and their families.

Together we can further reduce the leprosy burden and ensure that the physical and social consequences of the disease continue to decline throughout the world.

Sustaining leprosy control and improving quality of services under National Rural Health Mission

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Introduction

The Alma-Ata declaration in 1978 had proposed health for all through the Primary Health Care approach. The introduction of multipurpose workers in early eighty's, set the motion for integrated service delivery in India.

Leprosy was considered to be a very complex disease for diagnosis and management at the Primary Health Care System. It was decided that the disease can be tackled only with the specially trained and skilled workers working in a vertical system of command. The Govt. machinery to control leprosy was working through specially formed Leprosy Control Units, Survey Education and Treatment centres, Urban Leprosy Centres and the Temporary Hospitalization Wards run by specially trained persons.

These centres were also supported by Non-Governmental Organizations. All such services were provided through specially built "leprosy clinics", away from the General Health Care facilities. The vertical service delivery system continued till March 2001-02. Dedicated service system provided by the Govt. and NGO workers served the Persons Affected by Leprosy (PAL) remarkably well but a stage had reached when integration of service provision was felt necessary at least to reduce the stigma and discrimination associated with the disease and better accessibility of the services to the patients from all health facilities.

Leprosy has been widely prevalent in India for centuries. India has always been the country with the largest number of leprosy cases in the world. In the 1980s there were over three million registered cases.

National Leprosy Control Programme was launched by Govt. of India in 1955 based on Dapsone monotherapy. With the introduction of Multi Drug Therapy (MDT) and following the recommendations by the WHO study group, the National Leprosy Eradication Programme was launched in 1983. After introduction of MDT, spectacular success has been achieved in reducing the disease burden. The prevalence rate has come down from 57.6 cases per 10,000 population in 1981 to 0.74 in March 2008.

The National Health Policy, 2002 had set the goal of leprosy elimination in India by the year 2005. India achieved the goal of elimination of leprosy as a public health problem, defined as less than 1 case per 10,000 population, at the National Level in December 2005.

The National Leprosy Eradication Programme is a 100% centrally sponsored scheme being implemented in all the states.

Programme objectives

- Further reduce leprosy burden in the country
- Provide quality leprosy services through GHC system
- Enhance Disability Prevention & Medical Rehabilitation services
- Enhance advocacy to reduce stigma and discrimination

Paper read by Dr. P. R. Manglani.

- Capacity building of GHC staff
- Strengthening monitoring & supervision

The aims and objective under the 11th Plan (2007-2012) calls for further reducing the leprosy burden in the country, provide quality leprosy services, enhance Disability Prevention and Medical Rehabilitation, increase advocacy towards reduction of stigma and stop discrimination and strengthen monitoring and supervision. These objectives are also in conformity with the global strategy issued by WHO (2006-2010).

Quality services will need to be sustained because new cases will keep emerging, there is long term requirement of POD services and to develop community based rehabilitation of persons affected with leprosy.

Institutional developments required to sustain the program activities are developing trainers for capacity building of service providers, equipping supervisors for regular cyclic supervision, developing disease surveillance system and working under NRHM umbrella.

The long term process of sustaining integrated high quality leprosy services, which in addition to case detection and treatment with Multi Drug Therapy, also include prevention of disability and rehabilitation. There is an opportunity for this process to build on the gains made by the elimination campaigns, such as increased awareness of leprosy, political commitment and involvement of general health services.

Quality of services can further be improved by quality training of GHC staff and regular technical supervision. In addition, the availability of strong back up from an effective referral system will improve the quality of care provided by the integrated leprosy services. PHC-staff needs to refer the difficult cases because they have not been trained to deal with it, or because they do not have the necessary resources (drugs, equipment, other staff, etc.) to manage the condition.

The referral network must be part of the integrated system, providing referral services for other diseases and conditions in the area e.g. district hospitals or medical colleges. Community health centre with adequate infrastructure including trained manpower and equipment may serve as first referral unit in the referral network. Staff at the peripheral level should develop good links with the referral units they are most likely to use regularly. Staff at peripheral centres should know the specialist clinics and other professional to whom they may refer patients.

Leprosy may lead to physical, functional, social and/or economical problems. Physical rehabilitation includes physiotherapy and occupational therapy, orthotics and prosthetics services, assistive and protective devices and sometimes corrective surgery. Social & economic rehabilitation aims at social integration, equal opportunities and economic advancement.

A comprehensive approach to rehabilitation is needed to maximize the benefit for the individual, family and society at large. Community Based Rehabilitation (CBR) approach emphasizes community participation and empowerment of the individual involved. Govt. of India / State Governments have schemes for providing financial support to disabled persons. We have to ensure that persons affected with leprosy are also included in these schemes.

The Ministry of Health & Family Welfare and Ministry of social justice & empowerment, GOI are expanding rehabilitation services to the persons with – disabilities. For example Ministry of Health & Family Welfare GOI is under the process of establishing Physical Medicine & Rehabilitation (PMR) department in medical colleges & regional hospitals.

IEC is an integral component of the program. The major theme of community awareness is to provide accurate information about the disease, its curability and availability of services at the nearest health facility. The objective of such IEC efforts is to encourage self – reporting of new cases and to reduce stigma and discrimination.

The spectrum of spreading awareness has to be widened with involvement of all sectors.

Integration of disease control programmes

Integration means day to day management, recording and reporting of the disease by general health care staff. However, it does not mean that the specialist staff or expertise should disappear from the general health system. Expertise is required within general health system at central & intermediate levels for planning & evaluation of the programme, provision of training, giving technical advice, rendering referral services and conducting research.

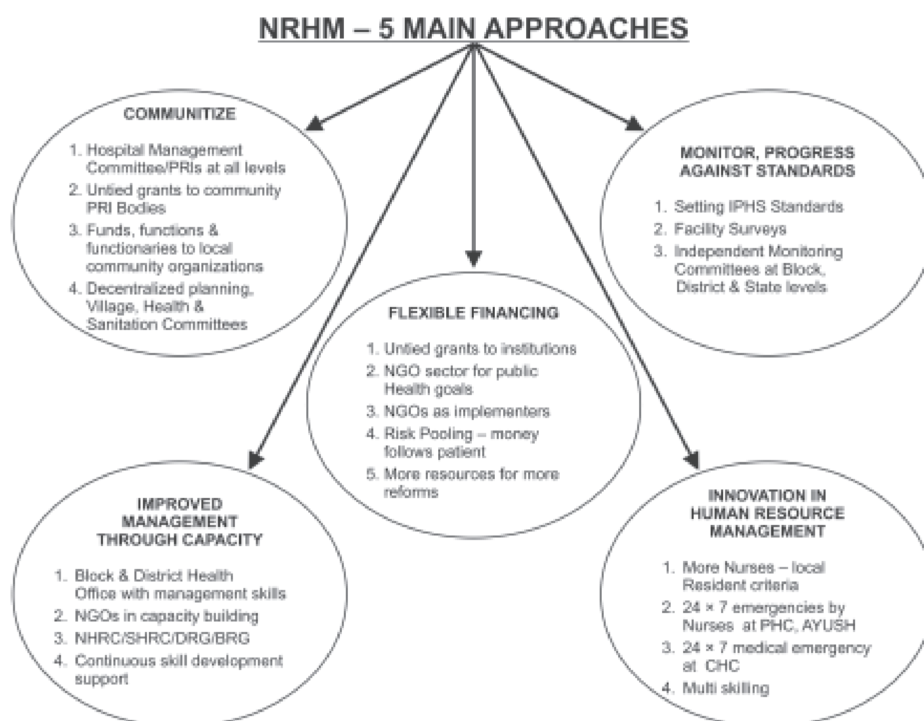
Successful integration of leprosy services with general health system means

Every health facility provides leprosy diagnosis and treatment services on all working days.

- At least one leprosy trained staff is available in every health facility.
- Adequate amount of MDT drugs with 2 months' buffer stock is available at each health facility.
- IEC materials are available for the patient and their family members.
- A simple treatment register is maintained.
- Referral services are available and accessible to all and general health staff knows where and how to refer patients.

Lessons learnt from Leprosy

- The staff working in the National Leprosy Eradication Programme had vertical mindset which led to possessiveness about the programme.
- There was resistance from over burdened GHC staff to take over responsibility of delivering leprosy services.
- Apprehension was felt among programme managers about loosing focus & priority to leprosy programme.
- Due to inadequate publicity there was lack of awareness in community about availability of leprosy services through primary health care system.
- Capacity building in leprosy of general health care staff was inadequate.
- Addition of new national health programme in general health care led to inadequate staff at various level.



- Monitoring & supervision of the programme in integrated setup was found to be poor.

Integration with NRHM

Under the NRHM, institutional mechanisms have been created at each level to support various National Health Programmes. The National Leprosy Eradication Programme is an integral part of NRHM. The State and District Leprosy Societies have been merged with the State and District Health Societies under NRHM.

The programme may seek support of NRHM as below-

- Village Health & Sanitation Committee (VHSC) formed at village level analyses the health problems, decide health priorities and take appropriate action to overcome the problems. These committees can be utilized for discussion on leprosy problem like stigma and discrimination against persons affected by leprosy and their family members and seeking collaboration from the health services.
- Accredited Social Health Activist (ASHA) can identify suspect cases of leprosy and refer such cases to nearest health centre for diagnosis and treatment. ASHA can also ensure timely completion of treatment by the diagnosed leprosy cases by conducting regular follow up of these cases. During visits, ASHA can also identify persons with leprosy related disability and refer them for further management.
- Rogi Kalyan Samities (RKS) at PHC and CHC can be utilized for procurement of prednisolone & other supportive drugs for treatment of leprosy reactions which is an emergency condition.
- Panchayati Raj Institutions (PRIs) can help in planning & implementing IEC activities like arranging health melas, IPC workshops/meetings and orientation camps.
- A single budget head for activities with separate subheads for various programme has been formed under NRHM which provide State the flexibility to direct funds to those areas where they are needed the most. The funds flow through integrated health society at the state & district level.
- The funds allocation is on the basis of integrated State/District health action plans. The district health action plans are first drawn up. Based on district plans, the state health action plan is prepared and submitted for sanction of GOI. A detailed NLEP district action plan should be drawn up with consultation and approval of district NRHM authority which would form the basis of NLEP state action plan.
- Finance Management Group (FMG) is formed under NRHM at States & Districts, should be utilized for release of funds from states to districts and from districts to blocks and monitoring progress of expenditure.

Dynamics of Integration

Our challenge is to sustain the quality of leprosy services and to ensure that all persons affected by leprosy, wherever they live, have an equal opportunity to be diagnosed and treated by competent health workers, without unnecessary delays and at an affordable cost.

The future challenges remaining to be dealt

- Performance of GHC staff in Clinical & Managerial aspects of services
- Establishing Referral System
- Establishing Supervisory System
- Developing Linkages, Collaboration & Co-ordination
- Disease Surveillance- Changing distribution & determinants
- Dealing with stigma and discriminations
- Nurturing Partnerships

■

NLEP : Leprosy control under National Rural Health Mission & National Urban Health Mission in Maharashtra

Dr. Ashok Ladda
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Govt. of Maharashtra,
Pune

Maharashtra State is second largest State with 9.42% contribution to National Population. State Population estimated by end of March 2008 is 111.44 millions.

Since 1955 National Leprosy Control Programme was being implemented on SET pattern (Survey, Education and Treatment) through vertical Infrastructure.

In 1981-82 MDT was introduced in the State in phase wise manner, covering all the districts by 1995-96. MDT has yielded wonderful results in the form of reduction of P.R. from 62.4/10000 in 1981-82 to 0.83 by end of September 2008.

Goals to be achieved under NLEP

- To sustain the elimination status at State Level
- Elimination of Leprosy in every village by 2012

The Strategies of NLEP are as follows

The number of new cases indicates how much leprosy there is in an area. Case finding is mainly focused on promoting Self Reporting, with appropriate clinical examination and history taking to avoid wrong diagnosis and re-registration.

The most important components of the leprosy control programme are timely detection of new cases and ensuring that all new patients who start multi-drug therapy complete the full course of treatment within a reasonable period of time.

The proportion of new patients who complete their treatment on time is an indication of how well the leprosy patients are being served by the health services. A satisfactory completion rate is indicative of efficient case holding, counseling and patient satisfaction.

To reduce deformity under the Disability Prevention and Medical Rehabilitation Plan. Gr.I anaesthetic patients should be diagnosed to avoid conversion to visible i.e. Gr.II deformity. The Functional Integration of NLEP into general health care service is done. Integration means active involvement of general health services in leprosy control activities.

The general health care services should take full responsibility for leprosy control in their areas as part of their routine day to day activities.

The current scenario of the programme is as under.

Sr. No.	Particulars	Area / Type		2005-06	2006-07	2007-08
1	NCDR per lakh	Rural		14.86	11.41	12.26
		Urban		8.88	7.88	8.88
		Total		**12.93**	**10.24**	**11.12**
2	Treatment Completion Rate (in %)	Rural	PB	Not Monitored	96	96
			MB		92	92
			Total		**93**	**94**
		Urban	PB		95	96
			MB		93	88
			Total		**94**	**92**
		Total (R+U)	PB		96	96
			MB		92	91
			Total		**94**	**94**
3	% of Child Cases among NCD	Rural		11.00	11.37	9.98
		Urban		14.80	13.90	14.25
		Total		**11.84**	**12.01**	**11.12**
4	% of Gr. II Deformity Cases among NCD	Rural		0.25	0.24	0.42
		Urban		1.90	1.69	2.08
		Total		**0.61**	**0.61**	**0.86**
5	% of MB Cases among NCD	Rural		40.28	44.47	49.48
		Urban		49.48	49.12	50.85
		Total		**42.31**	**45.65**	**49.84**
6	% of Female Cases among NCD	Rural		41.90	42.64	44.41
		Urban		39.22	39.36	38.50
		Total		**41.31**	**41.81**	**42.83**

Following are the issues in Rural Areas for NLEP implementation

To detect / suspect leprosy patient & refer to MO, PHC for confirmation, completion of full course of treatment within specified time, capacity building of General Health Care Staff through training activities is absolutely essential. In case of defaulters, action should be taken to retrieve them for continuation of treatment. The nature & number of new case detected in a given area are mainly influenced by the following four factors:-

(i) Effectiveness of IEC activities in promoting awareness & self reporting.

(ii) Health worker's competence to make an accurate and timely diagnosis.

(iii) Quality of supervision by programme managers.

(iv) Completeness of programme coverage, ensuring that all inhabitants are reached.

Solutions to issues in Rural area

Considering the linkages & co-ordination between NLEP & NRHM

The Health infrastructure & Manpower in Rural Area is as follows.

Sr.	Type of Institutions	Number
1	Rural/Cottage Hospitals (CHCs)	365
2	Primary Health Centres	1818
3	Primary Health Units	167
4	Mobile Health Units	61
5	Sub - Centres	10800

Manpower

Sr.	Category	Sanctioned
1	MMHS Class II	4600
2	Health Assistant (Male)	4707
3	Health Assistant (Female)	3651
4	Multipurpose Health Workers (Male)	12651
5	Multipurpose Health Workers (Female)	11915
6	Village Health Guides	39603
7	T.B.A	45681

To increase Voluntary Reporting, following are the important contributors.

1) ASHA workers should be involved

2) School Health Activity will help to detect child case of leprosy and hidden female cases through Healthy contacts' survey of leprosy affected children

3) Citizen Charter will also help to detect voluntary reporting of leprosy cases.

4) Involvement of RKS (Rugna Kalyan Samiti) at various institutions.

5) Participation of Village Health Nutrition & Sanitation Samiti.

6) Activity carried out on Health & Nutrition day and "Health Melas", will also help to detect voluntary reporting of leprosy cases.

To develop Capacity of GHC staff in NLEP, training activities at various level is important factor. Block level training, District level training & Nursing schools' training will help to built capacity of GHCs staff.

New case detection & treatment activities, ASHAs are involved by giving incentives of Rs.50/- for newly detected case, Rs.120/- for completion of MB patient's MDT treatment & Rs.60/- for completion of PB patient's MDT treatment.

Drug (Prednisolone) & other materials' availability (viz. MCR chappals, Goggles, splints etc. under DPMR) should be made available for needy leprosy patients. Also funds made available under RKS, IPHS etc. should be utilized for welfare activities of needy leprosy patients.

Issues in Urban area

There is no well established infrastructure at par with the Rural Area. Authorized and unauthorized Slum population is posing big problem in implementing the programme.

Solutions to issues in Urban area

If we consider the linkages & co-ordination between NLEP & NUHM, Urban Scenario of Maharashtra is as follows.

Maharashtra is Second Largest State contributing 9.42% of National Population as per 2001 census. The estimated population for Maharashtra & India by end of March 2008 is 111.44 Millions & 1176.34 Million respectively. There are 22 Municipal Corporations, 222 Municipal Councils & 7 Cantonments. There is 42.3% Urban Population (2001 Census). 47.14 Millions population (estimated for March 2008) is living in urban area of the state. About 30% i.e. 14.14 Millions population is living in urban slums. 47.14 Millions population of urban area of the state is contributed 34.55 Millions (73.3%) in 22 Municipal Corporations, 12.21 Millions (25.9%) in 222 Municipal Councils & 0.38 (0.8%) millions in 7 Cantonments. Few Municipal Corporations out of 22 have financial & administrative capacity for providing Urban Health.

Following are the Health Institutions that received funds from Govt. of India.

(A) Urban Family Welfare Centres (UFWCs)

There are total 81 (61*) UFWCs in the State sanctioned in 13 Corporations & 42 Muni. Councils. Out of 81 (61*) UFWCs, 21 (11*) are of Type I, 10 (10*) are of Type II (one run by NGO), 50 (40*) are of Type III (22 run by NGOs).

(B) Urban Health Posts (UHP)

There are total 285 (260*) UHPs in the State sanctioned in 20 Corporations & 9 Muni. Councils. Out of 285 (260*) UHPS 13 (13*) are of Type A, 13 (13*) are of Type B, 43 (41*) are of Type C (4 run by NGOs) & 216 (193*) are of Type D (30 run by NGOs) [* figures indicates functional centres out of sanctioned].

Urban Scenario in relation to NLEP for sensitive indicators like Child, Gr. II deformity, Female & MB are as follows.

Year	Area	Child %	% Urban rise compared to Rural	Gr. II Def. %	% Urban rise compared to Rural	Female %	% Urban decrease compared to Rural	MB %	% Urban rise compared to Rural
2005-06	Rural	11.00	+3.81	0.25	+1.65	41.90	-2.68	40.28	+9.2
	Urban	14.81		1.90		39.22		49.48	
	Total	**11.84**		**0.61**		**41.31**		**42.31**	
2006-07	Rural	11.37	+2.53	0.24	+1.45	42.64	-3.28	44.47	+4.65
	Urban	13.90		1.69		39.36		49.12	
	Total	**12.01**		**0.61**		**41.81**		**45.65**	
2007-08	Rural	9.98	+4.27	0.42	+1.66	44.41	-5.91	49.48	+1.37
	Urban	14.25		2.08		38.50		50.85	
	Total	**11.12**		**0.86**		**42.83**		**49.84**	

Urban Health infrastructure in Maharashtra

No.	Type of Institutions	Number
1	Medical Colleges (Govt. + Private)	40
2	General Hospitals	26
3	Women Hospitals	9
4	T.B. Hospitals	6
5	Regional Mental Institutes	4
6	Leprosy Hospitals (Government)	4
7	Health Posts	285
8	UFWCs	61
9	Supervisory Urban Leprosy Units	23
10	Urban Leprosy Centres	237
11	Temporary Hospitalization Ward	3
12	Govt. Lep. Dispensaries / *Kushtdham*	4
13	Reconstructive Surgery Units	29
14	Leprosy Training Centres Govt.	2

Following are the Proposed linkages between NLEP & NUHM

1) Asst.. Director of Health Services (Leprosy) is given Additional Responsibility to Monitor Urban Health Programme under National Urban Health Mission (NUHM).
2) State level NUHM Cell established at Pune to monitor this programme in the State.
3) There is no Strong Health Infrastructure in Urban as compared to Rural. Therefore, Primary Health Care Structure is proposed for Urban Areas.
4) Public Private Mix partnership is expected in Urban Areas.
5) In NUHM, Focus is mainly in Slum Areas, both authorized & unauthorized.
6) 85 Health Posts are proposed in PIP.
7) Networking with Community Based Organisation like "Bachat Gat", "Youth Groups" etc. Private Medical Practitioners, USHAs worker in urban on the basis of ASHAs in rural.
8) Strengthening of Selected Urban Hospitals for Management of Complicated Cases of Leprosy Patients. ■

'We need to make a difference . . . .'

Ms. Olatz Landa
Coordinator, ASIA Unit,
Project Department, Anesvad Foundation,
Bilbao, Spain

I am pleased to bring this message on behalf of ANESVAD Foundation to this national workshop on "sustaining leprosy control and improving quality services under the National Rural Health Mission".

Only very recently the World Health Organization Director-General, Dr. Margaret Chan, stated that "*A world that is greatly out of balance in matters of health is neither stable nor secure*".

This was stated at the launch of the World Health Organization World Report 2008 that calls for return to PRIMARY HEALTH CARE SUPPORT, articulated already 30 years ago in Alma Ata, Kazajtán.

The values and principles of this paradigm presented three decades ago are fundamental to the values of equity, solidarity, people-centeredness, community participation and social justice. The Alma Ata Declaration promoted a shift in the paradigm in thinking about health. Strengthening primary health care is essential to health care based on practical, scientifically sound and socially acceptable methods and technology.

Through primary health care, health care can be made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development.

All this help to promote the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is central to its function and also to the overall social and economic development of the community, which is the main focus.

The primary health care values to achieve 'health for all' requires a health system that "PUT PEOPLE AT THE CENTER OF HEALTH CARE", giving balanced consideration to integral health and well-being as well as the values and capacities of the population and the health workers.

This is precisely ANESVAD Foundation's driving force for many years and we can sustain the effectiveness and success of this very valuable shift through our experiences in many countries.

Following the dismantling of the vertical leprosy programme, people have to rely on the General Health Care system to be diagnosed correctly and receive quality treatment. The continued transmission of leprosy infection, occurrence of new cases and the burden of patients with disabilities and deformities pose a challenge.

Sustaining early new case detection and providing quality care during this transition phase is a matter of concern for all of us. We need to make a difference for the population and strive to develop new strategies to strengthen the integration and sustain leprosy control activities. The Leprosy Elimination Action Programme (LEAP) implemented by ALERT-INDIA is result of such an endeavour.

ALERT-INDIA's LEAP project in India, with all its intervention components and their objectives are endorsed by ANESVAD Foundation since 2004. We also think that LEAP is an answer to a special situation related to leprosy work in India after integration.

Developing a practical and feasible framework that emphasizes more on strategies to meet the needs of the leprosy affected persons during the integration phase has been critical.

Integration and control of leprosy is a process that can only be realized by sustained interventions. However, this process can only be achieved through effective community partnership strategies during the integration phase, in alliance with all stakeholders, to make leprosy control a reality for people.

The forms of practical actualization, the steps and inputs may differ and depend on the demographic situation. The components of the programme may be modified, strengthened and enriched based on the situation analysis.

In view of the long term needs for care and services to leprosy affected persons, it is mandatory to explore what components or aspects of the vertical programme need to be retained or incorporated into the present scheme of the public health programme.

This requires a policy change, innovation and perspective planning. We must take full advantage of the new situation arising. We must accept the positive role that the integration can play.

However, this integration needs essential ingredients within the system in place to make it happen. It requires a shift towards the need for more comprehensive thinking about the performance of the health system as a whole.

The world context is changing and therefore the response to such change must be innovative too. The same applies in this case. People expect their health systems to be equitable.

The workshop today brings a very important opportunity to explore and discuss on the components or aspects of an effective and sustainable leprosy control programme in the integrated general health system.

On behalf of ANESVAD Foundation, I would like to extent to all the participants in this workshop a very fruitful and successful discussion.

Thank you!

Leprosy control activities in Mumbai

Shri. Kishore Gajbhiye
Additional Municipal Commissioner (WS),
Municipal Corporation of Greater Mumbai,
Mumbai

It is my pleasure to be here this morning at this National Workshop on 'Sustaining leprosy control and improving quality of services under NRHM' organised to commemorate the 30th Foundation Day of ALERT-INDIA. I wish a very happy Foundation day to ALERT-INDIA.

As we all know, earlier the National Leprosy Control Programme (NLCP) was redesigned as National Leprosy Eradication Programme (NLEP) by Govt. of India (GoI).

Now, the present strategy is focusing on 'elimination' rather than 'eradication'. As of now, it is impossible to eradicate the disease, hence it is better to aim to 'control', rather than 'eradicate' the disease and maybe this would be possible much later.

This National Workshop organized by ALERT-INDIA definitely will give insights into the best practices in leprosy control.

MCGM's role in leprosy rehabilitation

The Municipal Corporation of Greater Mumbai (MCGM), where I am in charge of health care services, give due importance to disease control programmes. MCGM is implementing the leprosy control programme through Acworth Municipal Hospital for Leprosy (AMHL) in Mumbai. Perhaps, MCGM is the only Municipal Corporation in the country to have an independent leprosy hospital, which was established in 1890, exactly 118 years ago, located in the heart of Mumbai city. Currently there are 108 leprosy affected persons staying in this hospital to whom the treatment for curative as well as rehabilitative services are provided free.

Rehabilitation of the leprosy affected persons

AMHL is more than a hospital and termed as a rehabilitation centre or asylum. This hospital gives protection and shelter for the leprosy affected persons who stay permanently, even if they are treated and cured, as they find it comfortable and more homely.

You will be surprised to learn that one of our leprosy patients has been residing in AMHL for the last 55 years. This patient came to this hospital at his age of 9 and he has been treated and cured. Similarly there are many leprosy affected persons staying in this hospital for more than 30 years to 50 years.

I would like to emphasize that though it is important to treat the leprosy affected persons but more than that we need to rehabilitate and provide care and support specially those displaced from the society.

Leprosy control programme is no more a domain of medical doctors or leprosy specialists only and it should involve all the segment of society. Of course, the integration of leprosy services into the general health care system is crucial; hence it should be the core idea for now. Mainstreaming the care of leprosy affected persons should be the main focus and we need to work hard towards this goal.

Strengthening the programme at ground level

To sustain the leprosy control, the programme has to be taken up to a different level. In one of the presentations, it was mentioned that there is a need for policy changes and the experts need to make sure what kind of policy changes are required. In my view, policies are already there in place, which are well documented and expressly prepared. By and large the policy can be easily formulated and it is just a vision statement and the programme attribute to mission. Ironically, to put the policy into practice, we must strengthen the programme and implement action at the ground level.

Every segment of the society must participate

I am aware of the practical problems at various levels in the health sector. A literacy programme known as 'Sarvashiksha Abhiyan' was implemented through a mission approach at the country level targeting a large number of illiterate people and almost everybody like volunteers, teachers, officers, executives, doctors and professors were involved in the programme.

During my tenure as a District Administrative Officer, literacy campaigns were organized in such a manner that every segment of the society participated at different level and it proved to be very successful. Media was fully involved and many artistes performed street plays and so much creativity and involvement of all the stakeholders were put into the programme.

Subsequently, the AIDS control programme had a similar approach with multi dimensional programmes by involving cultural groups and agencies working together for targeted interventions and it delivered fruitful results. In my opinion, similar approach should be adopted for leprosy control, which will go beyond the diagnosis and treatment and that requires a serious consideration. Incidentally, this should be an integral part of the general health care system.

Leprosy control in Mumbai

In Mumbai city, there are 4 teaching medical colleges and 21 specialty hospitals where a large number of medical doctors and para medical workers are delivering health services to the citizens. Interestingly, what happens when a leprosy patient goes to any of the doctors in these hospitals. The patients are conveniently referred to Acworth Municipal Hospital for Leprosy and not referred to the higher level.

I admit such lacunae exist in the general health care system and efforts are being made to improve the situation gradually. I earnestly wish that all leprosy affected persons are diagnosed and treated at all the 167 primary level health units (Health Post) and 61 dispensaries of MCGM. Plans to add 70 more Health Post units are underway, which will have a wider coverage of basic health services in Mumbai.

At present, the leprosy prevalence in Mumbai is 0.6 per 10,000 population, which is much lower than the state prevalence. I have learnt that there is a slight increase of prevalence rates in the country and in the state since 2006 as compared to Mumbai. Perhaps this is due to more focused and intensified effort on identification of new leprosy cases; however we need to consolidate further.

Enabling the leprosy cured to lead a normal life

Recently, a Joint Parliament Committee visited Mumbai to study the needs of the leprosy affected persons living in leprosy hospitals and colonies and to know their demands. Surprisingly, these affected persons wanted education for their children, job for themselves, civic amenities and facilities, besides they did not want any thing else. These demands were the same as any other poor man.

However the leprosy affected persons are neglected and deprived of all basic needs in addition to social problems. The problem is more acute as they live

together in self-settled colonies and most of them are unemployed and it is necessary to address this situation on priority basis.

MCGM is taking initiatives to give proper education to their children, safe drinking water and provide health care facilities at these colonies. In Nashik city, the leprosy affected persons gather in one locality and brew liquor for their livelihood as they have no other alternative for employment.

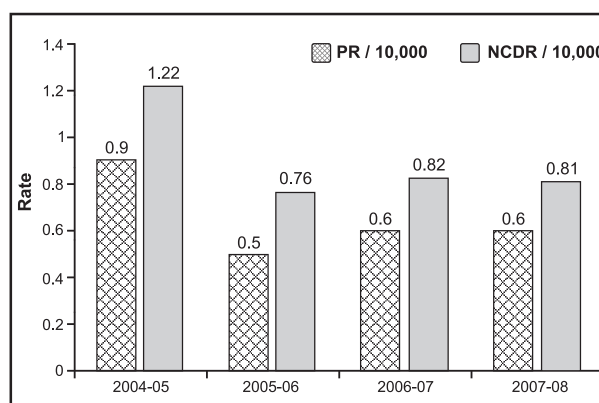
I find that the people who consume liquor have no problem in taking from the hands of leprosy affected persons, but for any other thing like vegetables they will not accept if it is sold by leprosy affected persons. As an civic administrator, my concern is how to provide employment opportunities to these leprosy affected persons, which is their basic demand along with education facilities for their children.

I wish to stress more on the need for social rehabilitation of the leprosy affected persons, which will enable them to live as a normal human beings. How to do this effectively is a great challenge that lies before all of us. I thank ALERT-INDIA for inviting me to this Workshop. ■

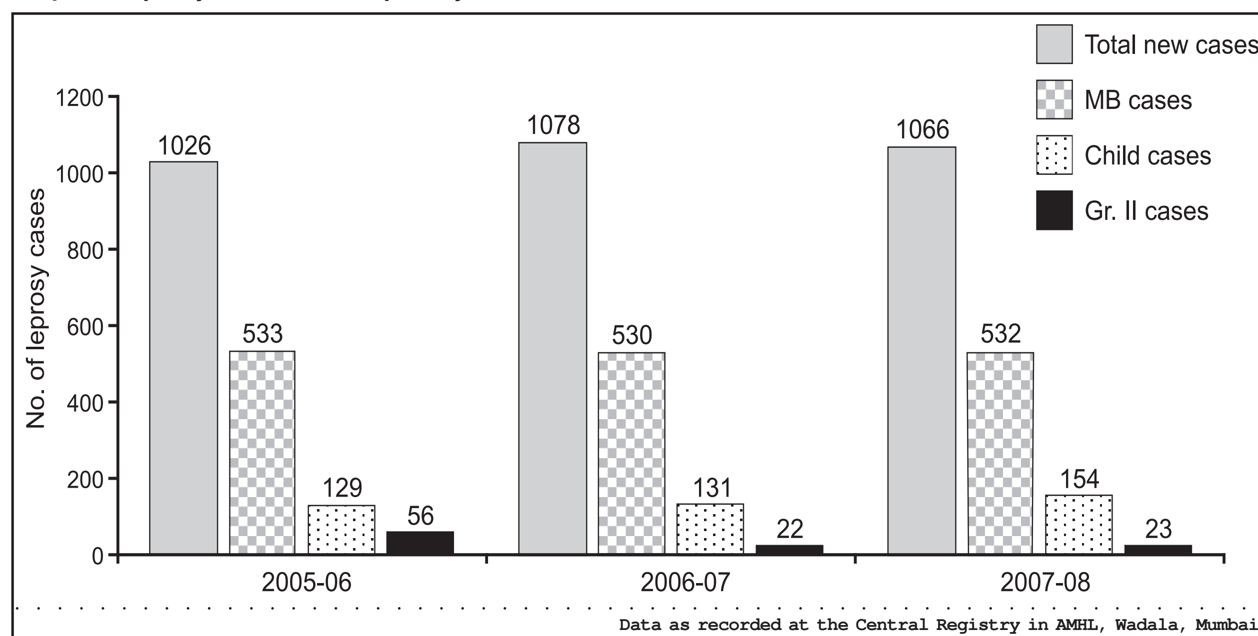
Leprosy situation in the Health Post areas of MCGM

Prevalence of leprosy (per 10,000 pop.)	Health Posts in Mumbai (as on March 2008)
0	8 (5%)
< 1	139 (82%)
1 – 2	18 (10%)
2 - 2.9	3 (2%)
> 3	1 (1%)
	169 (100%)

Graph 1: **Trend - PR and NCDR in Mumbai**



Graph 2: **Leprosy in Mumbai - as per key indicators**



Defining quality of leprosy services and indicators for the desired outcomes : the benchmarks across India

Dr. Indranath Banerjee
National Professional Officer
(Leprosy & Neglected Tropical Diseases),
WHO Country Office for India,
New Delhi

This presentation tries to examine the dimensions of quality of leprosy services and what the indicators of such quality need to be. Then it quotes examples from different states and organizations which could be considered bench marks for that particular type of service or activity.

Quality leprosy services could be said are those which have the following attributes

Are accessible to all who need them

- Are patient centric and observe patients' rights: are timely and appropriate and ensure privacy and confidentiality
- Diagnosis is timely, accurate and is available with counseling
- Treatment is timely, free and user friendly
- Appropriate prevention of disability is available
- Management of complications is available
- Referral and rehabilitation services are available
- Recording, review and evaluation are available

The indicators of the quality of leprosy services could be either process indicators or outcome indicators

- Some examples of process indicators are.
  - Services are actually available to all who need them
  - That the services are actually patient centric
  - That treatment is free, timely and accurate
  - Management of complications and prevention of disability is available
  - Referral and rehab services are actually available
- Some examples of outcome indicators are
  - Whether cases remain untreated in remote areas and societies
  - Whether patients rights and conveniences were actually respected when treated
  - Whether diagnosis was timely and accurate
  - Whether treatment was free and counseling given
  - Whether facilities for complication and deformity management exist and are used

'The best benchmarks are those that we set ourselves'

Examples from different areas and programs are quoted

Accessibility of treatment

Since the ASHA has access to all the households in the community, she can easily find out about any suspect cases. An example of using her services are becoming more frequent in Orissa and UP.

Treatment compliance

Using the ASHA's access to the household and her credibility with the patient's family, she becomes an agent to positively influence treatment compliance. Examples are from Orissa and UP.

Treatment availability everyday

Availability of treatment for leprosy at all health centers everyday is an important attribute of the integration of services besides being an indicator of the service quality. In the state of Jharkhand the program management has ensured this by putting up posters in every health unit that leprosy services are available on all working days. This serves as a reminder to the staff and the patients.

Availability of treatment at the patient's convenience

Treatment is available at the patient's workplace. The health worker takes the MDT to the patient so that he does not lose his day's earning when he comes to collect his monthly doses. This example is from Chhattisgarh.

Ensuring quality of diagnosis

All cases that are diagnosed are validated within two weeks. This ensures that the quality of diagnosis is good. This example is from Orissa.

Evaluation of awareness

Though a lot of IEC activities take place, there is less effort to find out the actual awareness level. The NLEP State Coordinator of Orissa actually finds out by asking groups of people.

Management of deformities and complications

Salem district in Tamil Nadu has a community based program for management of deformities and complications. A health worker explains how to take care of ulcers and other complications to group of patients.

Reconstructive surgery

Reconstructive surgery is an important part of rehabilitation. In Orissa (Cuttack) a disused leprosy hospital has been re-equipped to perform RCS.

Record keeping

In Moradabad District, UP the District Leprosy Officer maintains a register of patients of each block. Any health worker who visits the district headquarters for any work updates the register. As a result the DLO is always updated about the program.

Equity of services

The Central Leprosy Division tries to ensure that the program is given importance in the non endemic areas as in the endemic areas. A Review Meeting of the North Eastern States, a non endemic area was held in Sikkim, Gangtok.

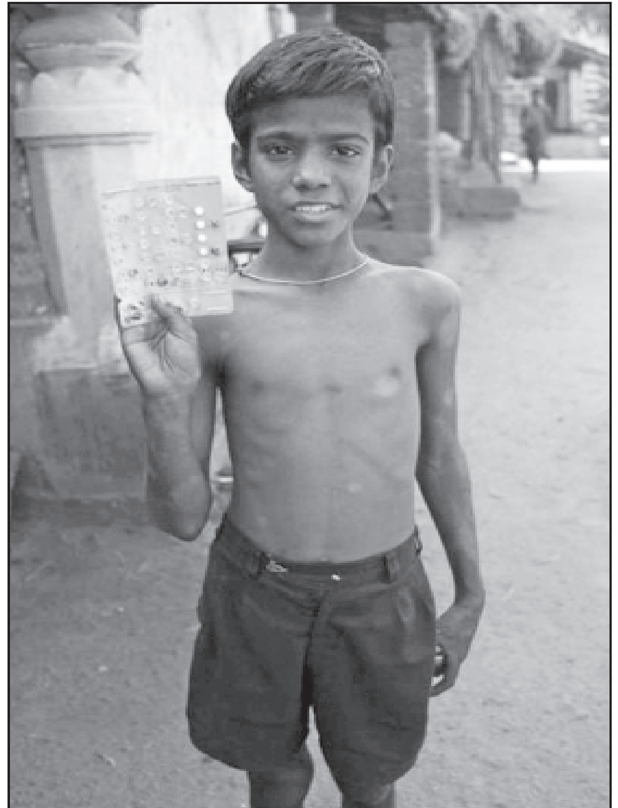
Rehabilitation

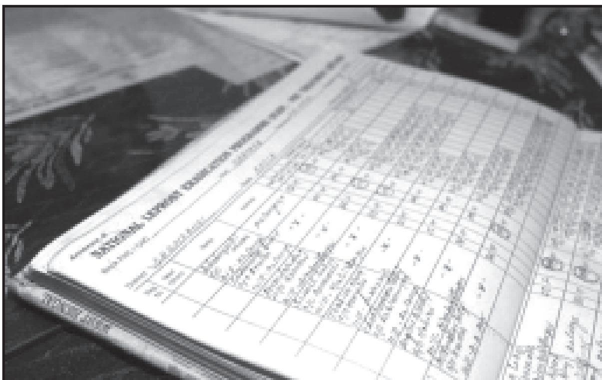
Socio Economic Rehabilitation is important for helping restoring the leprosy affected person to his former position in society before the disease and the attendant stigma affected his social position and livelihood. The Missionaries of Charity's leprosy center in Titagarh, West Bengal and Sarthak Manav Kusthashram, Jaipur, Rajasthan have services which could be considered bench marks for this activity. ■

Involving the ASHA in suspecting cases in Orissa and UP

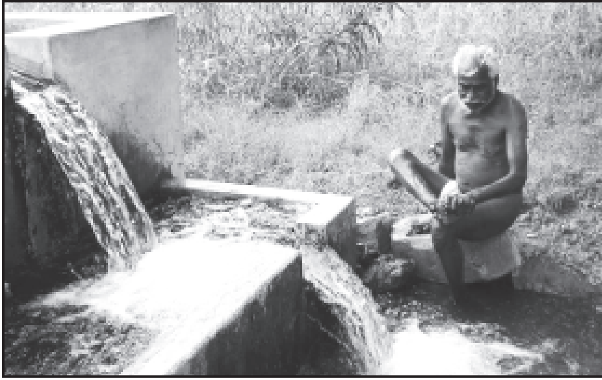
Use of ASHA and family members

Information about availability of MDT at PHC



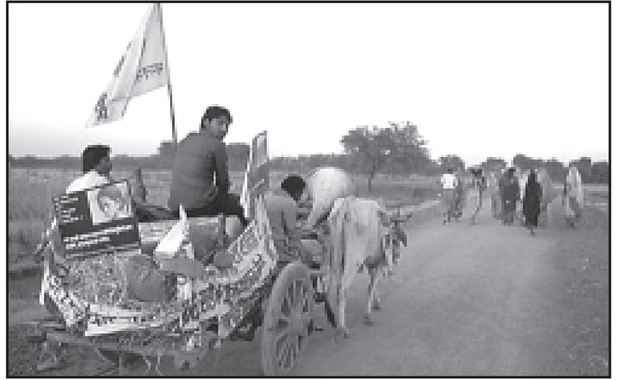


Record keeping and case validation by PHC workers



Self care by a leprosy patient

NLEP Review meeting of North-Eastern States



Leprosy awareness among public in rural areas

Awareness about leprosy and deformity care

Rehabilitation of leprosy cured persons

Capacity of GHC staff to deliver quality services : Tamil Nadu & Bihar experiences

Dr. P. Krishnamurthy
Secretary,
Damien Foundation India Trust,
Chennai

Introduction

The revised strategy for leprosy control formulated by WHO and ILEP and accepted by all the member countries where leprosy is a public health problem envisages delivery of comprehensive services in an integrated set up with an essential accent on quality, equity and sustainability.

One should not be presumptuous in wondering whether these quad elements were not integral part of the programme in the pre-integration period and what was the reason for this renewed accentuation?

While under the vertical set up all the components of the leprosy service were delivered by the same vertical structure, in the integrated set up we cannot afford this luxury and leprosy service would necessarily have to be delivered at different levels by different staff of the same general health service. This scheme would permit the realisation of the conditional elements in the new strategy.

Yes, quality is an important component of any public service enterprise. While defining it, the perceptions and priorities of the clients should be given as much importance as the capacity of the system and the cultural context in which the referred service is delivered. It is important, therefore, to assert that when referring to quality of a service, a minimum set of criteria and standard is required that allows comparison across space and time. Proving quality may not be easy because it involves measuring client perception which is not easy and programmes may not accept it as an essential requisite.

Quality as a prerequisite

In a complex system of health care provision, quality may have current value but it may not be valued unless all the personnel providing the service are mandated to a certain optimum requirement through clear enunciation of procedures and processes. There is also a need for a control mechanism (effective supervision and monitoring) to ensure that there is little deviation in the guidelines and also measures for responsive intervention. It becomes all the more important in the critical field of public health. When sick persons are treated as "patients" in a transition not as clients with special needs, quality could become a sure casualty.

Quality as a tool

Why do people prefer to avail services from non-qualified practitioners rather than from a qualified, sanctified expert? The difference is not in the technology that is used but in the way the technology is applied. Two persons with the same disease taking same treatment on different settings may have totally different perception and understanding about the disease. The only way of ensuring success in a public health programme is ensuring that every intervention, every transaction between the service provider and client ends in total satisfaction to the client.

Quality health service

Health service is a systematic process of prevention, treatment and management of illness and the

Paper read by Dr. Ravi D'Souza.

preservation of mental and physical well-being and restoration of the capacity to work through the services offered by the medical and allied health professions. When one refers to quality in health service one has to understand that it is not fixed but continually evolving, it reflects changing scientific and technological nature of medical practice and it also reflects culture and values of society.

A reflection on quality of health service should focus on the five elements- health service itself, management, organisation structure, financing and resources. Each of these elements can be influenced by several factors. I am going to discuss these factors in relation to the principal elements with respect to Leprosy control particularly from the experience of the programme in two States- Bihar and Tamil Nadu. Before starting the discussion let me assert that basically for me quality implies to do things better, rather than do better things; not to do more of the same, but better of the same.

Quality in management

To ensure quality in management one needs to have a clear policy, a well defined strategy, an integrated plan, expert committee, guidelines, standards, criteria of care (site-specific).

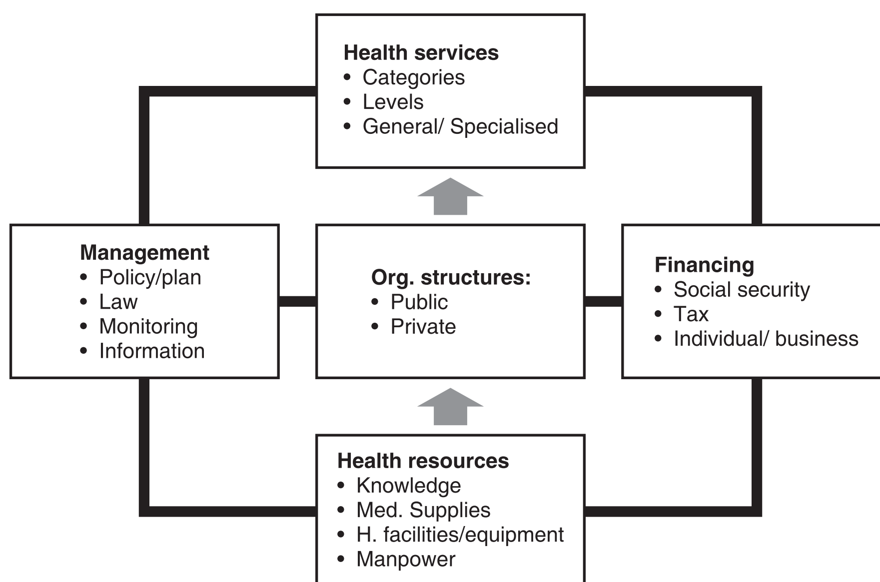
While there is a clear policy and strategy dictated by the federal Government which gives little room for flexibility, the plan is still not integrated. Plan for leprosy control is still independent of plans for other programmes. The plans are consolidated at the highest level not integrated. Programmes are often ignorant of the resource input at various levels so that finally one ends up with more than what is required or nothing at all.

Even though under NRHM things are changing but the change is not enough. There is a constant state of premium on the utilization of scarce resources. An expert committee if constituted and given the responsibility for assisting the programme managers in monitoring and planning would help in improving the quality.

Even though standards and criteria of care are available for managing simple cases of leprosy, there is still a lot of ambiguity in the guidelines on managing patients with complications. Another important aspect is the monitoring mechanism.

To what extent leprosy control can do independent monitoring outside of the general health system, it is difficult to say. But one thing is clear, in an integrated set up less time is available for more elaborate monitoring of a single programme.

A strategy needs to be worked out to find ways of making leprosy monitoring an effective, integral part of overall monitoring mechanism.



There is also the most important element in management- quality assurance particularly of the information system. Unless a control mechanism is instituted for cross-checking the validity of data generated, again, as part of the overall health service, information that is captured loses its value.

Quality in service delivery

Levels of integration are more important to be studied. It depends on the infrastructure, availability of manpower and other resource and the seriousness and magnitude of the problem. In leprosy control, integration as it is mistakenly referred to occurred a bit too late. In Tamil Nadu it was done without any preparation and plan. It succeeded a lot of inertia at least in the initial post integration period.

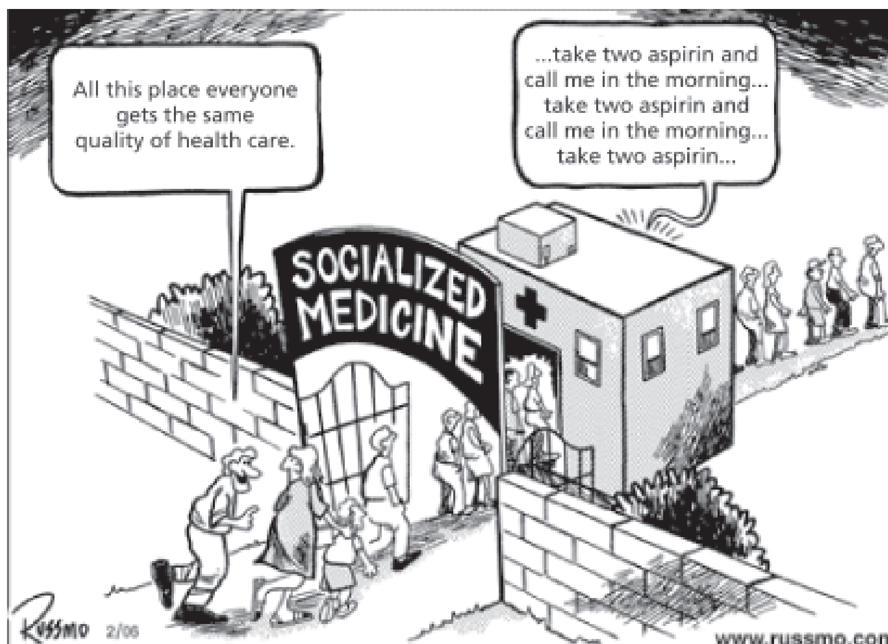
Integration in Bihar at least was a more elaborately prepared and planned exercise with phased operationalisation. But overall, throughout the country, integration has occurred in the most peripheral levels only in tasks but there is no integration at managerial and administrative levels and at organizational levels. For example, training for leprosy is separate from training for TB.

This causes a lot of strain to the peripheral workers. Before integration strengths and weaknesses of the general health service should be studied and the support of the strong elements in leprosy control could be retained without much distortion, if they help in strengthening the general health service.

We never consider patient preferences, providers and settings. Decisions to integrate are made arbitrarily without careful, critical look at the needs and demands. Another area which is rarely given a serious thought is organisation and delivery of primary, secondary and tertiary care.

Integration would not succeed if there is no attendant establishment of appropriate system to take care of persons needing specialized treatment. Existence of referral centres does mean little, if there is no mechanism for smooth transfer of patients between health facilities depending on the needs and capacities. A medical Officer in a PHC when confronted with a patient with complications may not know where to refer him and finally end up not treating him at all or mismanaging him.

Even in Tamil Nadu, the state with the longest period of integration is not able to establish an effective referral system. It is rudimentary or completely nonexistent in Bihar. Organisation and delivery of care, needs the back up support of quality assurance and research. In these two areas nothing much seems to be happening. Quality control is confined to looking



at the validity of diagnosis without any back up intervention measures (training, capacity building).

Quality in organizational structure

Several factors are important in considering organizational structure. The most important is partnerships. The programme should have tangible, viable partnerships based on recognition of mutual strengths with the community, civil society groups, other sectors, other service providers, NGOs, academic institutions and business enterprises.

The reality is that there is no significant partnerships or even if it is there it is based on dominant-recessive relationship which rarely promotes lasting, reciprocally beneficial association and is not beneficial to the programme.

Partnerships without effective coordination will not promote confluence of resources and convergence of ideas. It is also important to realize that availability and accessibility of service is one of the most important factors to be taken into consideration.

The situation in Bihar is grim- one PHC for every 150000 to 200000 population compared one for every 25000 in Tamil Nadu says it all. Basically, there is urban-rural divide in availability and accessibility of service.

In spite of the multiplicity of health posts in urban areas the situation is not better there because of the difficulties in coordination, lack of involvement of private practitioners and medical institutions and also absence of outreach staff.

Quality in resource input and utilization

There is a need to collect intelligence, not merely data, from the different sites not only for monitoring the programme but also for disseminating the information to all the important stakeholders to ensure their participation in all important facets of the programme including decision making. Following declaration of elimination there is a misconception among the bureaucrats and community leaders that leprosy is not 'there' or it has been 'eradicated'.

This is mainly due to nonuse of communication channels for dissemination of correct information (dispatch of reports is not the same as diffusion of knowledge).

There is also very few forums for exchange of intelligence on best practices. The only forum is the DLOs' review meeting which is more often than not used for collecting reports rather than discussing and exchanging information on best field practices.

Lack of mobility support is a constant source of frustration for programme officers and it places a premium on effective supervision.

Even though district hospitals are considered as the first referral point in the district, lack of specialists with adequate training does not help in establishing an effective referral system. Lack of expertise among specialists in academic institutions and difficulties in building their capacity adds to the woes.

Physicians/other specialists in district hospitals in Tamil Nadu have been trained. But their participation in providing referral service is negligible or nil. Less said about the situation in Bihar the better. They are either not available or even if available are not trained.

Conclusion

Quality is a relative concept. Quality in leprosy service in an integrated set up though essential may not be a reality unless the jagged edges in various influencing components of the health service system- like management, organizational structure, service delivery, resource input and finances are critically viewed and measures are taken to remove the constraints and all available means are employed to involve all the stakeholders in a coordinated manner so that there is confluence of resources and convergence of ideas. One should not lose sight of the pivotal figure in the programme- the leprosy-affected person. His needs, priorities and perceptions should become the central focus of all our actions.

■

Referral centres in integration of leprosy control in India

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Leprosy programme in India

Leprosy control activities in India since 1954 moved on adopting new strategies and evolved into a vertical National Leprosy Eradication Programme (NLEP). In 1984 Multi Drug Therapy (MDT) was included in NLEP, which reduced the disease burden significantly. The leprosy services were integrated into general health care (GHC) gradually across the country. The integration of leprosy services was planned to improve access of leprosy services closer to the patient's homes. All through these steps, the NLEP focused on detecting more cases and treating them with MDT. Though being integral components of comprehensive leprosy treatment disability prevention and care of deformities did not receive sufficient attention in integrating leprosy services in GHC. .

Data from leprosy programme

In India, 137,685 new cases were registered in different PHCs[1] during the year 2007. Among these new cases 3477 cases had Grade II disabilities. The existing disability case load is estimated at 150,000 cases with Bihar and Orissa contributing to more than one third of disability cases (Bihar 38350 + Orissa 29750)[2]

Need of additional care and services

MDT is provided at all health facilities both in rural and urban health facilities. In addition to this, expertise in certain areas of management of leprosy care like management of Lepra Reaction/Neuritis, treatment of ulcers/wounds and reconstructive surgery and teaching self care to patients with Grade II disabilities was identified as a need for a comprehensive health care[1].

Referral centres

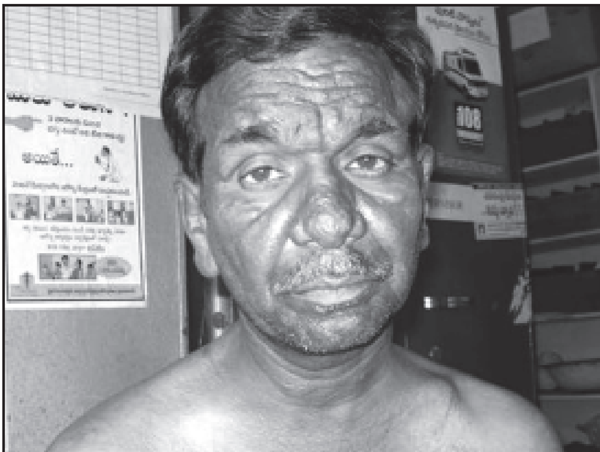
Certain institutions were identified as referral centres to provide the support to the PHCs and urban health facilities as referral centres. The centres are designed to meet the needs of patients referred from, PHC, health workers and community volunteers and private health providers. It is also expected to have some patients themselves walking in for additional treatment. Besides providing additional care in leprosy, the referral centres also are expected to function as a clinical training resource for the district or a given geographical area. Referral centres are planned to function from a suitable location either at district headquarters hospital or a suitable health facility in the district. In certain districts, where such facilities are not available in public sector, hospitals and dispensaries run by Leprosy NGOs were also included.

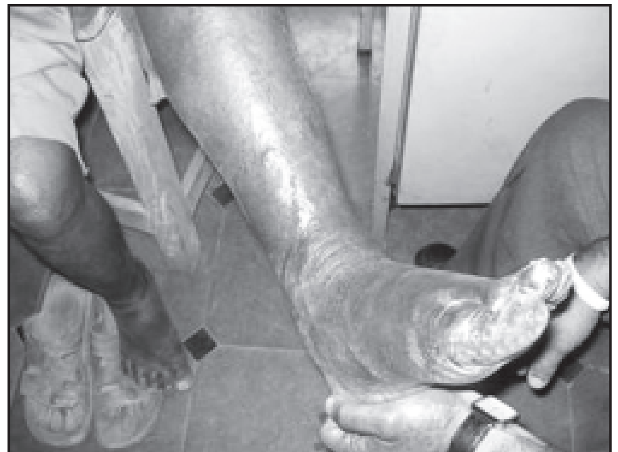
Additional leprosy services

The referral centres are equipped to treat complications due to leprosy. The facilities included, a laboratory with capacity to provide skin smear examination services for cases which are not clinically obvious. The centre would also be equipped to provide foot wear and other appliances to the needy patients, both for Grade I disability and for those with ulcers. Pre-operative physiotherapy and post operative physiotherapy would be available in select referral centres.

Case Studies

Admitted in medical college hospital for fever with neurological complication. Intern diagnoses leprosy and directs to referral centre. Diagnosis confirmed and feed back given to intern. Registration with MDT at concerned UHP. Deformity improved with Prednisolone and Physiotherapy after 5 months.

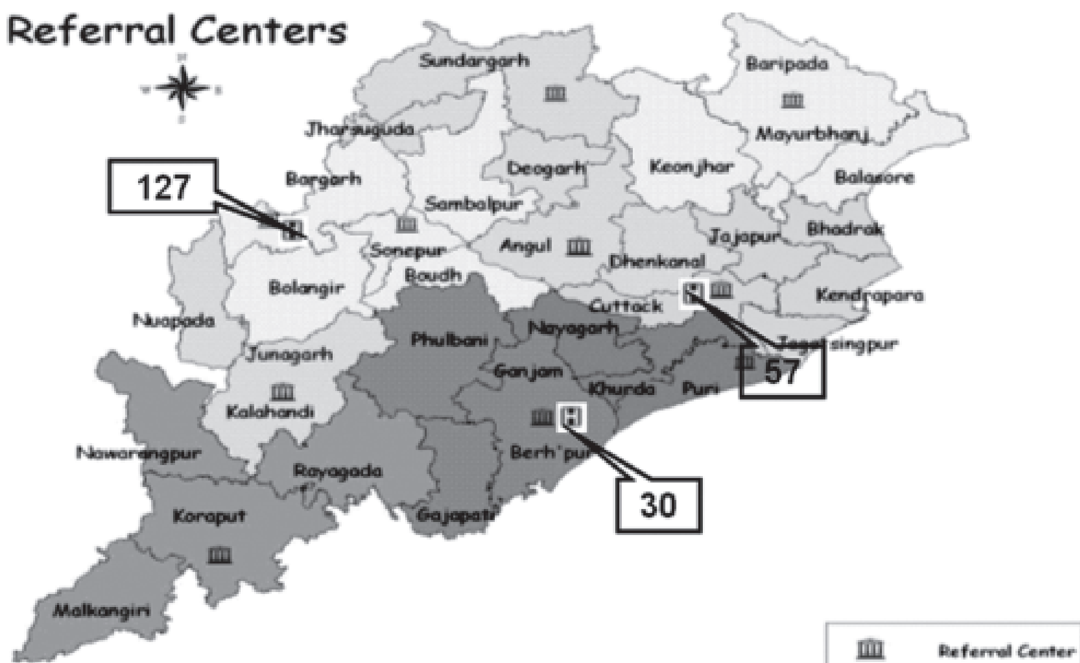




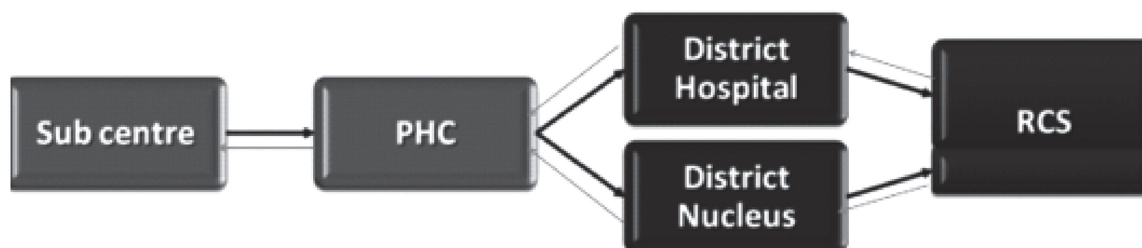
Referred by family doctor with swollen legs and oozing from broken skin. Smear from the fluid shown BI 3+ and 6% solid bacilli. Diagnosed at Referral Centre and registered for MDT from concerned UHP.

11 years old, primary school student taken to family doctor for 'bent fingers'. Referred to NIMS, a super specialty hospital. Gone through lot of suffering and uncertainty of diagnosis, appropriate service. Diagnosed at a referral centre and treated with MDT at concerned UHP. Improved with splints, physiotherapy and steroids, five months later. Now back to school.

Referral Centres and Reconstructive Surgery Hospitals in Orissa State



Referral System Flow Chart



Referral System - Activities / Referrals

Institution	Implementation	Referrals
1 Sub centre	• Advice on self care • Advice to RCS cases	• Reactions • Disabilities
2 PHC	• Manage reactions • Identify cases needing RCS • Identify cases needing footwear • Advice to RCS cases • Advice on self care	• Reactions difficult to manage • Complicated ulcers • RCS cases • Patients needing footwear • Follow-up of RCS cases
3 District Hospital	• Management of complicated ulcers • Management of reactions	• Difficult ulcer cases to RCS centre
4 District Nucleus	• Management of reactions • Supply of footwear	• RCS cases • Follow-up of RCS cases
5 Reconstructive Surgery Centre	• Reconstructive surgery • Follow-up after RCS • Supply of footwear to District Nucleus	

Location of Referral Centres in Andhra Pradesh State

Experience of referral centres

In the current year 2008, 11 referral centres were operational in Orissa and AP. The experience from the centres showed that 6141 patients walked in for consultation and 2551 patients were diagnosed as leprosy. In Hyderabad urban referral centre 31 out of 80 new cases presented with symptoms and signs of reaction.

In the year 2007, a 5806 patients were treated for Lepra reactions. National data on Reconstructive surgery showed that 3439 surgeries were conducted and 26,155 foot wears were provided to patients with Grade II disability. The Referral centres treated 500 persons on an average including, 75 persons requiring physiotherapy and 100 persons with ulcers. Three sets of training programmes were feasible last year.

Cost estimates for each Referral Centre[4]

The cost of equipments required for initial establishment of a referral centre are at Rs.500,000. The recurring costs are estimated at Rs.300,000. The personnel costs are estimated at Rs. 400,000. Costs of personnel included - salaries for part-time Medical Officer, laboratory technician, nurses and a full-time physiotherapist and an attendant.

The total cost of a referral centre will be around Rs.1,200,000 to establish and run in the first year and Rs.700,000 from the 2nd year. Replacement of some of the capital equipment is planned at the end of five years.

References

[1] World Health Organisation, Weekly epidemiological record, 15th August 2008, No.33, 2008, 83.

[2] NLEP, GoI, Guidelines for Disability Prevention and Medical Rehabilitation, DPMR 2007.

[3] Evaluation of District Technical Support teams in India 2006

[4] Costs calculated as per the experience of referral centres in LEPRA projects in Orissa and Andhra Pradesh since 2006.

■

Supervision & monitoring for quality control in leprosy in the decentralized health care system

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Decentralization of powers, control and financial management exists in health care system of India for a long time. More emphasis is given to decentralized management under National Rural Health Mission (NRHM). It is envisaged that all the National Health Programmes will be managed & monitored under the umbrella of NRHM.

After declaration of Elimination, to prevent sliding interest in National Leprosy Eradication Programme (NLEP), it becomes more valid & relevant that leprosy is kept on high agenda in NRHM meetings and discussions. It is also very essential that Monitoring and Supervision in the programme is not neglected and the quality, of leprosy services, is not compromised. WHO, in its Operational guidelines 2006-2010 defines quality of leprosy services as under:

- which are accessible to all with no geographical, economic or gender barriers, irrespective of caste, creed, religion, without discrimination and are provided with equity
- where MDT treatment is provided through all the health facilities
- which are patient-centered and observe patients' rights, including the rights to timely and appropriate treatment and to privacy and confidentiality
- which address each aspect of case management, based on solid scientific evidence i.e.
  - Diagnosis is timely and accurate, with supportive counselling
  - Treatment with MDT is timely, free-of-charge and user-friendly
  - Prevention of disability interventions are carried out appropriately
  - Referral for complications and rehabilitation is done as needed
  - Maintain simple records and encourage review and evaluation

An important component of maintaining and improving quality of leprosy services is regular supervision and monitoring, at all levels.

Levels of Supervision and Monitoring:

Mission Director and SLO at State level.

Dist. Magistrate, CMO and DLO at District level.

MO In-charge of PHC at Block level.

Health Supervisor Male & Female at PHC level.

ANM, ASHA, MPW etc. at village level.

Paper read by Dr. S. C. Pandey.

What is Supervision & What is Monitoring?

As per WHO,

'Supervision is a way of ensuring Staff Competence Effectiveness and Efficiency through Observation, Discussion, Support & Guidance".

On the other hand,

monitoring is to ensure that the activities are carried out as planned and that the objective and expected results are achieved in desired time and with available resources. Both the components of the programme are very important to maintain quality of Leprosy services. To begin with, the Supervision is not inspection or fault finding mission but a way to improve staff performance. This is not only done by collecting data, analyzing reports, indicators, or by conducting meetings but is done by observation, guidance, discussion and support.

The main component of supervision is *human touch,* in which the 'Supervisor' (one who supervises) and 'Supervisee' (one who is being supervised) have a relationship. Monitoring on the other hand is a continuous process to keep track of the planned activities so that if there is any deviation or deficiency, corrective action can be taken. Monitoring is, also, to ensure that planned activities are leading to achievement of desired results and objectives.

How to Supervise and How to Monitor?

Supervision is not an ad-hoc visit to a PHC but a systematic process, which involves preparation, implementation, reporting and follow-up.

Supervision is done through observation of staff performance on the spot and if any deficiency is observed in staff knowledge, skill or attitude, on the job training, discussion and guidance is provided with psychological and moral support.

Monitoring on the other hand may be done by analyzing regular reports, through review meetings, through field visits and by analyzing definite indicators. Indicators which are used in NLEP are as under:

- New case detection rate,
- Prevalence rate
- Proportion of Gr II disability among new cases
- Treatment completion rate
- Proportion of MB among new cases
- Proportion of Children among new cases
- Proportion of Female among new cases

Some additional indicators could be used to assess the quality of leprosy services e.g. proportion of new cases correctly diagnosed, proportion of reaction cases who received complete course of prednisolone, proportion of new cases developing new or additional disabilities during MDT, etc.

How to conduct a field visit for Monitoring and Supervision?

There is a bit of overlap in the processes of monitoring and supervision and that is why these terms are used together and both are important for maintaining and improving the quality of leprosy services, supervision by improving staff performance and monitoring by assessing maintenance of records, report, drug supply management and analysis of indicators. While going on a field visit both can be conducted simultaneously in a systematic way.

Preparation – As part of preparation, one should familiarize himself/herself with the health center being visited and staff to be supervised. One should have as much information as possible of the activities and performance of staff at the center.

This could be done by having discussions with the colleagues, collecting relevant information and by seeing previous visit reports. One of the most important instrument for supervision and monitoring is a 'Checklist'.

Checklist is a series of questions / observations, which has to be made on the visiting health center so that the supervisor doesn't forget the expected steps in the functioning of the health center or performance of the staff.

Preparation of checklist will be guided by clear understanding of job description of a person, who is being supervised, expected activities to be performed at the health center. The visit should be pre planned and intimation should be given to the staff and health center being visited.

Implementation of a visit to a Health Centre – One should not jump into seeing the records and reports but should first develop rapport with the staff, explain the purpose of the visit. One should silently OBSERVE the performance of the workers with eyes and ears open, without much of discussion, direction or questioning.

By sharp and sensitive observation, one can find the gaps in performance and the skills of a particular staff. After observation of the performance, the supervisor can examine the patient cards, registers, reports, whether the records are maintained, and correctly and that reports are prepared and sent in time and that there is no discrepancy between records and reports. One can also examine drug stocks and registers and indents sent.

On the basis of these observations, one has to analyze and prioritize the deficiency and inputs required. Some deficiencies will have to be corrected on the spot with discussion and demonstration. Some skills, knowledge may need to be improved in class room sessions or in the forthcoming visit.

Reporting and follow up – During the visit, one can record the deficiencies and observations made using checklist. After a visit to the center is over, the checklist which was prepared, can guide him/her to prepare his/her report.

The report should contain observations, which were made including inputs provided on the spot and future course of action. One of the essential components of supervision and monitoring is that one should give feed back to the staff, on the spot, positive feedback first and areas needing improvement. Feedback should also be given to the senior officers so that appropriate actions can be taken at their end.

These reports could be used as baseline information for the future visits to the center and the process continues.

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Flahault, D., Poit, M., Franklin, A.(1988) The supervision of health personnel at district level, WHO, Geneva, Chapter 1 and 2

WHO, Global Strategy for Reducing the Leprosy Burden and Sustaining Leprosy Control Activities (2006-2010), Operational Guidelines, SEARO, New Delhi, 2006 ■

NLEP
Sustainability, Quality, Needs

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NLEP: New Paradigms

10th Plan – MDT coverage, elimination target

11th Plan - Quality services, Institutional development, DPMR services, Dealing with new challenges e.g. Drug resistance.

Challenges

- Performance of GHC staff in Clinical & Managerial aspects of services
- Establishing Referral System
- Establishing Supervisory System
- Developing Linkages & Co-ordination
- Disease Surveillance- Changing distribution & determinants
- Dealing with stigma and discriminations
- Nurturing Partnerships

Why Sustainability

- New cases will keep emerging
- Long term requirement of POD services
- Community Based Rehabilitation
- Reducing herd immunity

Requirements for sustainable services

Institutional developments:

- Capacity building of service providers
  - Formal training-short courses
  - On the job training
  - CME, Review meetings

Requirements for sustainable services

Institutional developments:

- Capacity building of service providers
- Regular cyclic supervision
- Disease surveillance
- Working under NRHM umbrella
- Long term partnership
- Better communication, regular & horizontal
- Medical education
- Resources-drugs,….

Quality Services

- **Indian Public Health Standard -** criteria
- **Medical**- diagnosis, classification, MDT regimen, complication management
- **Surgical**-RCS, nerve decompression, abscess, cataract extraction etc.
- **DPMR** services –self care, protective aids
- **CBR**, SER –referral without delay
- **Hi-tech** services-SMART card, CO-MIS, Web site, Elec. case stories
- **Patient** satisfaction / client perspective

Gaps

1. Hidden pool of untreated cases-?
2. Epidemiological monitoring-changing endemic pockets
3. Burden of disabled cases
4. Performance of service providers-?
5. Coordinated services for comprehensive care
6. Non responders to MDT
7. Tools against stigma & discrimination
8. Backlog requiring DPMR services

Needs

1. Sample survey, skin camps, OPD- screening
2. GIS mapping, Cluster approach
3. Clinical accuracy for disability assessment
4. Quality training & Supervision / on job training
5. Linkages with dermatological services
6. Operational research
7. Amendments of discriminatory acts
8. Upgrading PMR departments ■

National Rural Health Mission : Prospects for leprosy eradication

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Leprosy Eradication

From Elimination (Dec. 2005, < 1 per 10,000 population) to Eradication through NRHM

Core Strategies in NLEP

1. Decentralisation
2. Integration with GH Services
3. Capacity Building - GHS Functionaries
4. Surveillance for Early Diagnosis
5. Intensified BCC
6. Prevention of disability and Care

Key NRHM Goals

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition
- Prevention and control of communicable and non-communicable diseases, including local endemic diseases
- Access to integrated comprehensive primary health care
- Population stabilization, gender and demographic balance

NRHM - Key Core strategies

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved health care at household level through ASHA.
- Health Plan for each village through Village Health Committee.
- Enabling local planning and action through an untied fund
- Strengthening existing SCs, PHCs and CHCs
- Preparation and Implementation of an inter-sectoral District Health Plan
- Integrating vertical Health and FW programmes at National, State, Block, and District levels.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.

Key perspectives

- Policy Perspective
- Programme Perspective

Policy Perspective

Leprosy Eradication through a Comprehensive, Integrated, Campaign Approach

Justification for Policy Perspective

- Health Rights Perspective
- Economic Perspective
- Political Perspective

MDT – 1982, NLEP – 1983, Elimination -Dec. 2005,

NRHM 2006, has potential for Eradicating Leprosy through a Time Bound Programme

Programmatic Perspective

- **Core NRHM Approach**
- Integrating the key determinants of Health such as Poverty and Nutrition with Health Care Systems

- **Implication**
- Eligibility under NREGA
- Use of Untied funds at SC PHC, CHC levels for leprosy
- Eligibility for Nutritional Security under PDS and ICDS

- **Core NRHM Approach**
- Integrating Vertical Organisational Structures

- **Implication**
- Start Integration at Community Level
  - Surveillance and Case detection
  - BCC and stigma Reduction - Social Norms
  - Counselling – ICTC
  - Eye care for Leprosy with Blindness Control
  - Nutritional Security through ICDS

- **Core NRHM Approach**
- Train and Enhance capacity of PRIs to Control and Manage Services

- **Implication**
- Involve – PRIs, VHSCs, ASHA, AWW in :
  - Information dissemination
  - Demand Generation
  - Include NLEP in village, SC, PHC plans
  - Monitor Case Detection through Surveillance
  - Monitor service provision

- **Core NRHM Approach**
- Decentralisation

- **Implication**
- Active Case Detection - Surveillance through ASHA
- Include MDT a concrete Service Guarantee at SC, PHC levels in addition to CHC
- Ensure Compliance, Adherence through a DOTS strategy
- Include Restorative services as a Service Guarantee at CHC level

- **Core NRHM Approach**
- BCC and Promotion

- **Implication**
- Undertake BCC through Social Norms approach for NLEP
- Address Stigma against Leprosy
- Involve village level CBOs in BCC – PRIs, VHSCs, ASHA, AWW, SHGs

- **Core NRHM Approach**
- Untied Funds at Village, PHC, CHC level

- **Implication**
- Make NLEP eligible for use of Untied funds

- **Core NRHM Approach**
- Community Monitoring System

- **Implication**
- Make NLEP part of Community Monitoring System
- Community to Monitor:
  - Surveillance and case detection
  - BCC through social norms approach
  - Service provision
  - Compliance and adherence ■

Linkages and coordination between NLEP and NRHM : Uttar Pradesh

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The National Rural Health Mission (2005-12) seeks to provide effective health care to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh. NRHM is in different stages of implementation in different States.

NRHM is basically a strategy, a mission, an umbrella under which all public health activities are to be managed. It envisages improvement in Sanitation and Safe drinking water, Reproductive and Child Health, National Disease Control Programmes (NDCP) including National Leprosy Eradication Programme (NLEP) and Integrated Disease Surveillance Project (IDSP). NRHM will also enable the mainstreaming of Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health (AYUSH).

Institutional Framework of NRHM in Uttar Pradesh

State level : State Health Mission
Chaired by the Chief Minister of Uttar Pradesh

Co-chaired by the Health Minister with the State Principal Secretary(Medical & Health), Mission Director and representation from related Departments, NGOs, private professionals etc.

District level : District Health Mission
Chaired by the Chairman, Zilla Parishad / District Magistrate

Managed by the District Head of the Health Department i.e. Chief Medical Officer with representation from all relevant Departments, NGOs and private professionals.

Under NRHM, local governments have been empowered to manage, control and be accountable for public health services at various levels.

At District level : The District Health Mission (DHM) is led by the Zila Parishad and will control, guide and manage all public health activities, including activities under NLEP of the district.

At Block level : The Block hospitals and Rogi Kalyan Samitis

At Village level : Committees are formed at the grass root level i.e. The Village Health & Sanitation Committee (VHC), the standing committee of the Gram Panchayat (GP), which will provide oversight of all NRHM activities, including activities related to NLEP, at the village level and be responsible for developing the Village Health Plan including leprosy, with the support of the ANM, ASHA, AWW and Self Help Groups.

Block level Panchayat Samitis will co-ordinate the work of the Gram Panchayat in their jurisdiction and will serve as link to the District Health Mission.

Paper read by Dr. Rashmi Shukla.

Core strategies under NRHM

- **Decentralized Village and District level Health planning and management**
- **Improved management capacity:** For this purpose, skilled professionals like CAs, MBAs, MIS specialists and Social Mobilizers have been appointed on contract basis at State and District level to organize health systems and services in public health, emphasizing evidence based planning and implementation through improved capacity and infrastructure. They are being sensitized to leprosy as a public health problem in the training programmes.
- **Accredited Social Health Activist (ASHA)** 1 lakh 34 thousand ASHAs have been selected and 70% have been given orientation in leprosy work and shall receive incentive for each case detection and follow-up.
- **Mainstreaming Ayurvedic, Yoga, Unani, Siddha and Homeopathy (AYUSH):** There is provision of two rooms in each CHC for bringing AYUSH practitioners under the same roof.
- **Promoting the non profit sector to increase social participation and community empowerment**
- **Promoting healthy behaviours, and improving inter-sectoral convergence.**

How NLEP can be linked and co-ordinated with NRHM ?

- **Infrastructure & Manpower-** Leprosy services can be improved as infrastructure and manpower is strengthened under NRHM. In capacity building programmes leprosy should be essentially included.
- **Monitoring & Supervision -** *Review meetings* will be conducted under State & District Health Mission and State Leprosy Officer and District Leprosy Officers can take this opportunity to keep leprosy on the agenda and ensure good discussion on problems and solutions. *State Quality Monitors* (9 Officers in the state) can be involved in monitoring NLEP work in districts. *Divisional, District and Block level Programme Management Units* are being sensitized in leprosy and can play a crucial role in monitoring and supervising all aspects of leprosy programme implementation.
- **IEC -** Expertise available for IEC activities under NRHM can be utilized in planning, and propagating correct messages on leprosy and carrying out activities to reduce stigma and discrimination. *Health melas* include all health programmes. *PRIs* can take up IEC activities for leprosy particularly IPC meetings , IPC workshops, orientation camps for NGO & mahila mandals. *The BCC strategy* being prepared for the state must include the leprosy component. The *School Health Programme* in U.P. is including screening for leprosy in children. *Health Education Officers* (545 in the state) newly appointed can be sensitized to include leprosy in their health education plan at block level.
- **Case Detection, timely treatment completion and stigma reduction** -*ASHAs* can be involved in case detection, referral, follow up and spreading correct messages.
- **Supportive Medicines, Aids & Appliances and Patient Welfare** - Prednisolone & other supportive material eg. aids and appliances can be procured *through Rogi Kalyan Samiti.* The flexible fund available under NRHM could be used in adhoc needs, supply of aids & appliances etc.
- **Stigma Reduction**- Panchayati Raj Institutions & Village Health & Sanitation Committee can be involved, in keeping leprosy on high agenda, in advocacy for reduction of stigma and discrimination, in IEC activities.
- **Reporting & Recording -** Logistics like computers, internet and other facilities provided under NRHM are to be utilized for leprosy control programme.
- **Fund Flow**- Facility of *e-banking* are being utilized for electronic transfer of funds at state and district level.

Leprosy Programme managers have to work in close co-ordination with the State & District Health Mission functionaries and explore all avenues for linkage with NRHM for improving leprosy services. ■

Linkages and coordination between NLEP and NRHM : Karnataka

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NRHM

At the National level one of the outcomes of NRHM is to reduce the Leprosy Prevalence rate from 1.8/10,000 population in 2005 to less than 1/10,000 population.

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens , the Govt. of India has resolved to launch the National Rural Health Mission (NRHM) to carry out necessary architectural correction in the basic health care delivery system.

The Goal of the Mission is to improve the availability of and access to quality health care by Rural areas, the poor, women and children.

NLEP in Karnataka

Karnataka has already achieved the goal of elimination of Leprosy in 2005. Prevalence Rate (PR) in 2004-2005 was 0.87/10,000 population. PR in 2008 is 0.51/10,000 population. There are 29 Districts, 176 Blocks & 27066 villages in the state. The PR in 95-96 was 4.2/10,000 population, because of the effective MDT services the PR has come down. The annual New case detection rate in Karnataka as on 31-3-2008 is 7.67/100000 population . ANCDR was 48.86/100000 population during the year 95-96 gradually decreased to 7.67 during 2007-2008. Out of 176 Blocks in 4 Blocks PR is 1 to 2 & in only 3 Blocks the PR is more than 2.

Urban Leprosy control Program

As the country has achieved leprosy elimination at National level and also in the state, leprosy cases in the rural areas has gradually gone down. More number of leprosy cases are now prevalent in the urban localities where the people migrate for their livelihood. The NLEP urban control plan has been strengthened in the cities. Govt. of India has allocated budget.

Situation Activity Plan

In one of the Blocks in Bellary district NCDR was more than 20/100000 population & PR was more than 2/10000 population. To control Leprosy efficiently Special Situation Activity campaign was conducted during the year 2007. The name of the Block was Hadagali. The population of Hadagali was 178380, villages 111 & no. of houses 34806. For each sub centre 1 team was formed consisting of 4 members, 1 supervisor, 1 ANM, 1 Male health worker & 1 Volunteer. The team visited all the houses in the villages. Interpersonal communication (IPC), group meetings & orientation camps were done. All the teams covered 111 villages & conducted Special Situation Activity campaign. 25 new leprosy cases were reported from this campaign & MDT was given to all patients.

During 2008-2009 in October - November Special Situation Activity plan is prepared for 3 districts where PR is more than 1/10000 population. The teams are formed for each sub centre. The Activity is planned for 15 days. NRHM is providing funds for the mobility, training, traveling allowances to staff & for IEC activities.

For all the districts to create awareness regarding leprosy, budget is released to do the following activities:-

a) One day orientation training on leprosy to the opinion leaders, Mahila Mandals, NGOs and elected representatives in the selected PHCs.

Awareness about leprosy , the incentive scheme in leprosy and MDT services in leprosy are highlighted.

b) One day orientation training course for the general health staff will be organized in all the districts.

c) Health Mela will be organized in Jathra places. Exhibition, folk songs, dramas, distribution of pamphlets and group meetings will be conducted.

d) Wall paintings are done in some prominent places to create awareness of leprosy.

e) Anti-leprosy month will be organized once in a year, preferably in the month of January.

f) The District leprosy Officer (DLO) organizes all the activities.

Disability Prevention and Medical Rehabilitation activities (DPMR)

a) Providing Micro cellular Rubber (MCR) chappals - Leprosy patients with loss of sensation of the sole will be provided with 1 pair of MCR chappals free of cost.

b) Providing self care kit to all the Leprosy Patients – Bandage, ointments and Medicines will be supplied free of cost.

c) Leprosy Patients with disability will be identified and referred to Reconstructive Surgery (RCS) –

   i) Hubli Hospital for handicapped-Dharwad Dist.

   ii) Sri Rama Krishna Seva Ashrama-Pavagada, Tumkur Dist.

   iii) Belgaum Leprosy Hospital, Hindalga, Belgaum District.

d) Provision of additional incentive to the BPL, Reconstructive Surgery under gone Leprosy patients:

   i) After completion at the time of discharge from the hospitals - Rs.3000

   ii) Follow-up visit after one month (4-6 weeks) of operation - Rs.1000

   iii) Follow-up visit after 3rd month of operation - Rs.1000

   Total - Rs. 5000

e) Providing funds for the hospitals other than the recognized - Rs. 5000 to the Hospital conducting RCS – for the drugs and dressings of the patients.

f) Providing Splints and crutches

g) Providing free Blankets to all the patients.

Integration of NLEP and NRHM

Earlier NLEP was a vertical program . Since the case load has decreased Govt. has integrated NLEP with the general health. The state leprosy society along with state TB society and blindness control society merged to form the state Health and Family Welfare society. Like wise in the District also District Society is formed. There is a State Health Mission under the Chairmanship of Hon'ble Chief Minister. District Incharge Minister is the Chairman for District Health Mission. State Leprosy Officer is one of the members of State Health Mission and Society. District Leprosy officer is one of the members of District Health Mission and Society. In the Mission and Society meetings, NLEP is reviewed and suggestions are given for the better implementation of the program.

Program Implementation Plan (PIP)

Every year PIP is prepared for the effective implementation of NLEP. In co-ordination with the village health and sanitation committee, sub-centre and PHCs District action plan is prepared and sent to the state. All the district PIPs are compiled, if needed modified and state PIP is sent to Govt. of India for approval. According to approved PIP, NLEP is implemented and budget is utilized.

Linkages of NRHM and NLEP

a) ASHA (Accredited Social Health Assistant)

Govt. of Karnataka has already selected 11,200 ASHAs to 6 C Category districts (Bidar, Gulbarga, Bijapur, Raichur, Bagalkot and Koppal) and 3 Tribal districts (Chamarajanagara, Mysore and Coorg). The training for the ASHAs has started. ASHAs will also be given training regarding the awareness of leprosy .Govt. of India has already sanctioned Rs.300 for the complete treatment of paucibacillary leprosy case and Rs.500 for multibacillary cases to ASHAs.

b) Village Health and Sanitation Committee

Untied fund of Rs.10,000 released to the committee can be utilized for creating awareness regarding leprosy along with other programs.

c) Sub-centre

All the ANMs are trained in Leprosy. In high endemic areas sub-centre wise Leprosy reports are compiled and analysed. ANM sends the suspected cases to PHC for confirmation.

ANM regularly visits the Leprosy patients and MDT is given. Leprosy awareness is created in the villages. Every third Saturday of the month in one of the Anganawadi centres, she conducts village health day, PHC medical officer also attends IEC materials are displayed & Leprosy awareness is created. Senior health worker (Male), Senior health worker (Female) will supervise the leprosy work.

Untied fund from NRHM of Rs.10.000 is given to all the sub-centres. This fund can also be utilized for NLEP.

d) PHC

All the Medical officers and paramedical workers are trained about Leprosy. Earlier NLEP programme was vertical, now the programme is integrated. The entire team is participating.

MDT drugs are stored sufficiently. DPMR activities and Situational Activities are done under the supervision of the PHC medical officer.

Reports are sent regularly to NLEP district.

e) DLO

District Leprosy Officer along with other staff, works as District Nucleus Team they visit the houses of Leprosy patients and do validation.

f) Suvarna Health Mela

In all District head quarters Health Melas are conducted once a year. All specialists including Dermatologists examine the patients. Mela is held for three days. Leprosy awareness is created. Detected leprosy cases are treated with MDT.

g) Suvarna School Health Program

All school children from 1st to 10th std. of all Govt. & private schools will be examined by the doctors. Leprosy awareness is created. Detected leprosy cases are treated.

h) Community health day

In one of the PHCs, once in three months it is celebrated. Leprosy awareness is created. Detected leprosy cases are treated.

i) Specialists clinic

In all Taluk hospitals once in 15 days, specialists conduct the clinics.

Difficulties

a) The vertical staff working for many years are well trained and experienced.

b) For each PHC one such male worker may be posted to look after the Leprosy work.

c) There are vacancies of male workers. All the vacant post may be filled up early.

d) There are no trained , skilled surgeons to do the reconstructive surgeries in Govt. hospitals.

e) All the medical colleges to co-operate for the implementation of NLEP.

Recommendations

a) Cash incentive of Rs.1,000 /month/PB case for 6 months and Rs.1,000 / month / MB case for 12 months.

b) Advised 5% job reservations in Govt. departments for Leprosy cured, grade 2 disability patients.

c) Free land distribution for the homeless Leprosy cured grade 2 disability patients.

d) Self employment training in small scale industries for Leprosy cured grade-2 disability patients.

e) Awareness to be created in schools for teachers and students.

f) More programs are needed for the removal of social stigma.

NRHM has given importance for the disease control programs like NLEP. Even though Leprosy is not a public health problem, the linkage and co-ordination between NLEP and NRHM is to be strengthened for the sustainability and to reduce further burden of the disease for the attainment of Leprosy free status in the country. ■

Role of National Rural Health Mission in facilitating elimination of leprosy from Andhra Pradesh, India

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Health is a state subject with a large number of vertical centrally sponsored disease control programmes to be delivered through the PHC. These Vertical programmes with little horizontal integration at District, State and National levels need urgent restructuring if we are to achieve our goals. The challenges in Andhra Pradesh in implementing the National Leprosy Eradication Programme are many. The Public health system suffers from poor governance, manpower shortages, ineffective service delivery etc.

The Involvement of community / PRIs / local government / user groups in NLEP is weak. The convergence at district level is weak. Since, a large number of disease control programmes are to be delivered through the PHC system, the quality and coverage of services suffers. There is a general lack of ownership of the programme by the key functionaries like The D M & H O, Regional Director etc. There are many instances of choked fund flows resulting in disruption of planned activities.

Leprosy is a disease of public health concern in India. Current prevalence in Andhra Pradesh is 0.76/10,000. One of the key objectives in NRHM is to eliminate leprosy. The five key components include: decentralization and Institutional development, strengthening and Integration of service delivery, disability care and prevention, Information, education, and communication, and training.

Services need to be provided at PHC, CHC, upgraded PHC, and Hospitals with support from the district nucleus. The sub centres have to be involved in delivery of second and subsequent doses of MDT. The village and district health plans will enable identification and ensure referral of cases requiring disability treatment to the appropriate facility. CMOs, medical officers and all paramedical staff need to be trained on leprosy, consequent to the integration of NLEP into the General Health Services.

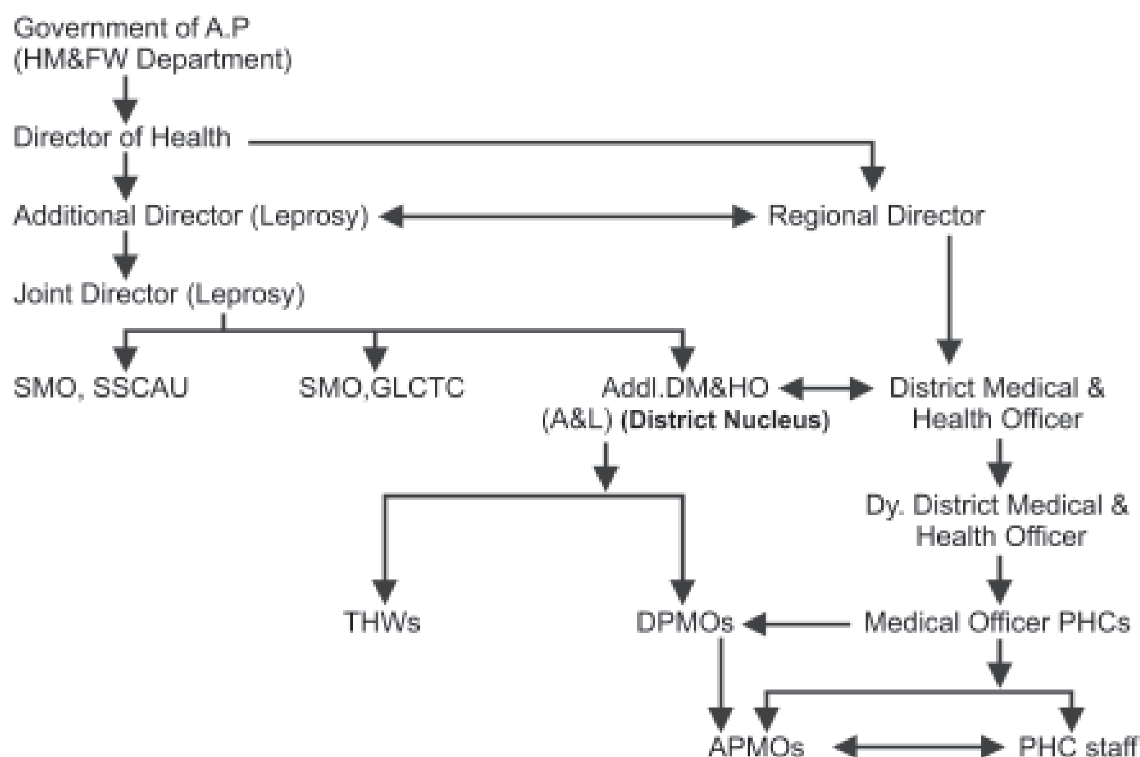
How is NRHM helping and facilitating the elimination of Leprosy from Andhra Pradesh? NRHM has made, providing better health for poor people, a national priority. Improved service delivery through improved governance / community action is one priority areas. The involvement of CSOs/PRIs and restructuring at National, State, and District levels would have a profound effect on NLEP. Under NRHM there is a thrust on building capacities at National. State, District and Sub District level which would go a long way, in ensuring the sustainability of the various components of the programme.

Intersectoral co-ordination is a crucial component of the National Rural Health Mission (NRHM) and promotion of intersectoral linkages is imperative for its effective implementation. These linkages can be within the public health system such as RCH, National disease control programme or with other departments like the Department of Women and Child Development, the Department of Education etc. These linkages could also be with the NGOs, the private health sector and the corporate sector with the overall objective of improving service delivery.

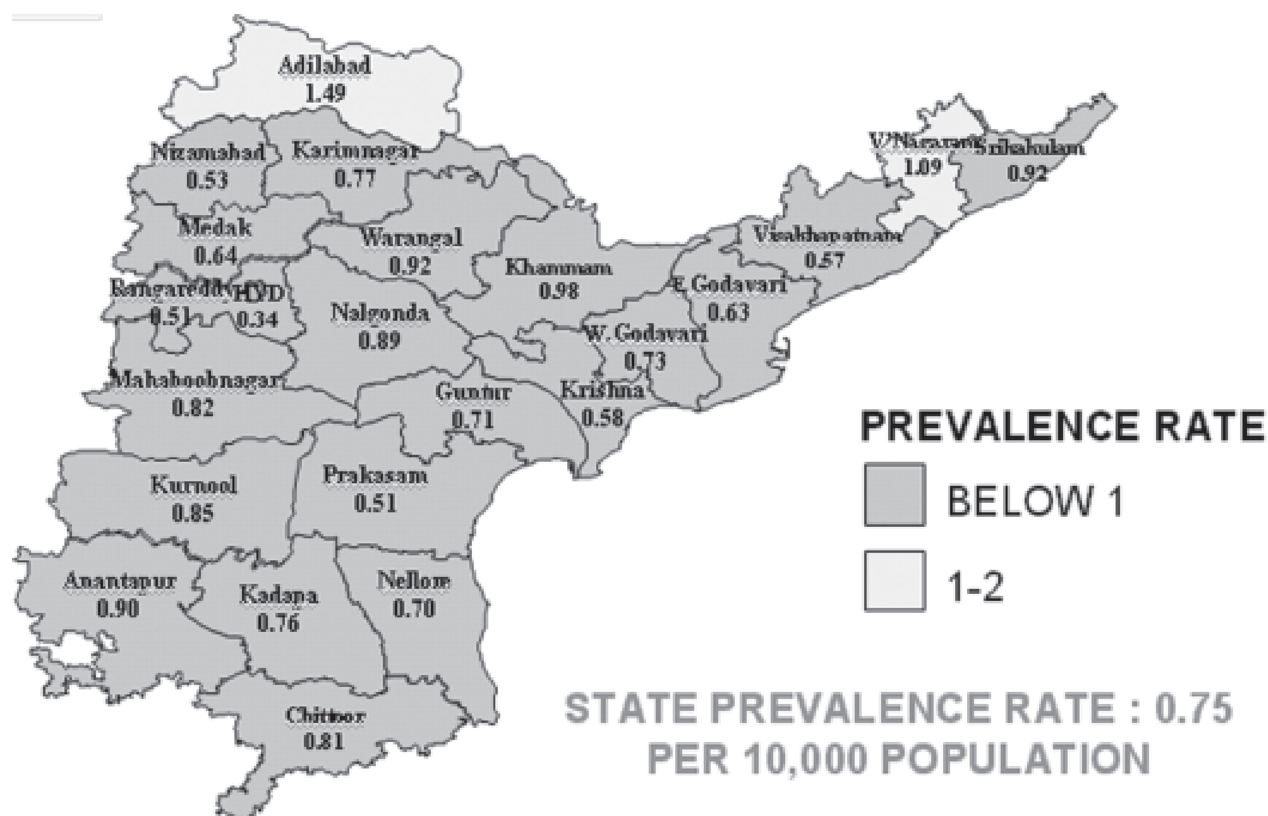
NLEP – Andhra Pradesh
Epidemiological Indicators from 2003-04 to September - 2008

Sl. No.	Indicators	Year					
		2003-04	2004-05	2005-06	2006-07	2007-08	2008-09 upto Sept 08
1	New cases detected	31,816	18,751	8,171	9,443	10,047	5332
	NCDR/1,00,000	40.4	23.5	10.1	11.39	12.12	12.34
2	Registered cases	15,628	6,323	4,567	5,338	5,817	6198
	PR/10,000	1.99	0.79	0.57	0.65	0.70	0.75
3	MB Proportion	7,339 (23.1%)	5,289 (28.2%)	3,381 (41.40%)	3,728 (39.5%)	4,193 (41.78%)	2402 (45.04%)
4	Female %	12,676 (39.8%)	7752 (41.3%)	3159 (38.70%)	3856 (40.8%)	4091 (40.70%)	2222 (41.67%)
5	Child %	7047 (22.1%)	3716 (19.8%)	999 (12.20%)	1332 (14.1%)	1257 (12.5%)	603 (11.3%)
6	Grade - I %	Gr. I from April 07 onwards only				122 (1.2%)	184 (3.45%)
7	Deformity Gr-II %	351 (1.1%)	249 (1.3%)	192 (2.30%)	266 (2.8%)	354 (3.4%)	239 (4.48%)

NLEP - Andhra Pradesh
ORGANOGRAM after Integration



NLEP - ANDHRA PRADESH STATE
ENDEMICITY AS ON SEPTEMBER-2008



The integration of Leprosy control into the general Health services means the ability of peripheral general health workers to suspect leprosy & refer the patient to a referral unit. It also means good linkages of peripheral level staff with referral units. The referral units including district hospital should be able to diagnose and treat leprosy. There should be good linkages of referral level staff with specialist clinics. The continuation of treatment can be delegated to peripheral health facility. There are many benefits of Linkage of NLEP with NRHM. It brought to centre stage, the disease of Leprosy from an obscure position. The myth of Leprosy and its deformities is being dispelled. There is more openness and transparency. The platform of NRHM is available at State Headquarters for resolving programme related issues and problems. The monitoring and evaluation including receipts and expenditure of funds has been made easy as NLEP is part of NRHM which has inbuilt systems for M & E.

The flow of funds under NRHM has been simplified. The GoI funds flow into the Mission Flexipool which has different slots for various activities. NLEP has been allotted 'F' category. The finances are managed by a Finance Management Group (FMG) and a single main account is maintained for The State Health Society with sub accounts for the various programmes including Leprosy. Each programme Officer issues his own sanctions after file approval and the cheques are signed by two signatories out of three notified signatories. The cheques are to be honoured by the FMG within two working days. Regarding Audit there is a single common auditor for all the programmes. The selection of auditor is a one time process. There are separate detailed part-reports for each of the programmes and each part-report is sent separately as and when they are completed. The fund releases are not withheld or delayed due to non-receipt of complete audit report. ■

Integration of leprosy services with institutional set up and initiatives of NRHM in Orissa

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Introduction

The National Rural Health Mission was launched on 12th April 2005 throughout the country with special focus on 18 states. Orissa is also one of the states taken up for implementation of NRHM. NRHM intends to provide accessible, affordable and quality health care to rural and vulnerable population. The key features of NRHM include making health delivery system fully functional & accountable to the community, convergence of health programmes at all levels, improved management through capacity building, involvement of community, monitoring progress against standards and flexible financing for optimum fund utilization.

Institutional set up established under NRHM

For ensuring better community participation; committees / organizations have been formed at various level viz. **Village Health & Sanitation Committee** at village level, **Panchayati Raj Institutions** at village/block level, **Rogi Kalyan Samitis** at PHC, CHC and District level hospitals. **Zilla Swasthya Samitee** at district level under chairmanship of President, Zilla Parishad and **State Health & FW society** under chairmanship of Chief Secretary, Govt. of Orissa have been constituted for better transparency and inter- sectoral co-ordination.

Initiatives undertaken under NRHM

For better delivery of health care services to people at door step following initiatives have been under taken under NRHM

Engagement of ASHA at every village of State

Accredited Social Health Activist (ASHA) is a female volunteer belonging to the same village, selected by the community to work as a link health functionary between community and Health workers and PHC. The main job of ASHA is persuing a pregnant lady to under go regular pre-natal checkup, bringing the lady to nearest PHC for institutional delivery, post natal follow-up of both mother and new born baby and ensuring complete immunization of child. All these jobs were undertaken under Janani Surakshya Yojana.

Untied Fund

Starting from sub-centre to District HQ Hospitals untied funds were released under NRHM to meet day to day emergency expenditures required to run the health facility without seeking Govt. sanction or approval. Clear cut guidelines were issued for expenditure of untied funds with involvement of local PRI member.

Health Mela

To provide health services to rural and outreached population, Health Melas have been organized at different places with massive turnover of people.

Flexible Financing

Financing through the NRHM budget head provide the much needed funds to the districts to facilitate better functioning of health programmes. Based on need of the district, funds are allocated to states.

Paper read by Dr. V. V. Dongre.

Improved management

Programme management units at State, District and Block level constituted with man power with management back ground to plan, implement, and monitor the programme.

Convergence

All national health programmes and state sponsored health programmes, disease control programmes were converged under one umbrella of NRHM.

Monitor progress against standards

Progress is being monitored according to the IPHS standard. Health facility surveys are also being conducted at regular intervals to monitor facilities available at sub-centres, PHCs and CHCs. Independent monitoring committees are also being formed to monitor progress.

Innovation in human resource management

To increase the pool of human resource, additional manpower like nurses, HW (F), MO of Ayurved and Homeopaths are being provided at PHC and CHC. Multiskilling of health functionaries is being done so that a person could carry out multiple tasks.

Finance Management Group

FMG are formed under NRHM at States, Districts and Block level for release of funds, monitoring programme expenditure and maintaining programme accounts.

How NLEP was integrated with above institutional mechanism in Orissa

1. **Planning**: Village Health and Sanitation Committee was involved in identification of priority as per situation. Accordingly village NLEP plan were developed and submitted to Block. At block level integrated plan was developed involving Programme management unit of Block PHC sitting in general body meeting of RKS. The integrated Block plan was consolidated at District level by District Programme Management Unit and discussed in Zilla Swasthya Committee under chairmanship of President Zilla Parishad and Collector cum DM and other members and NGOs. The District PIPs were discussed and consolidated and approved in the NRHM Directorate under chairmanship of Chief Secretary and other members.
2. Important activities like **training and IEC** were carried out under guidance and supervision of Training and IEC committee constituted under NRHM to avoid any duplication and bring convergence so that quality of training and attendance can be improved. Leprosy IEC activities were planned and designed, sitting with other disease control programme people. The monitoring of leprosy training and IEC activities are being carried out by these committees.
3. **DPMR** activities like procurement of prednisolone, dressing materials, MCR foot wears, splints, goggles etc. are being done at PHC level by RKS. For referral of cases to secondary level institutions or tertiary level institutions for complication management and RCS etc. RKS funds are being utilized.
4. **ASHA** workers were entrusted to do IPC at community level, identify suspects, identify early signs of leprosy reactions and refer them to nearest health center. ASHAs have also been entrusted to monitor the treatment regularity and self care practices carried out by PAL with disability.
5. **PMU and FMU** do carry out monitoring of financial performance of NLEP, timely collection of SOEs , compilation and submission of SOE and UCs etc.

The Orissa model of integration of Leprosy Services with institutional set up and initiation of NRHM has resulted in overall improvement in case detection, treatment regularity, prevention of disability and removal of stigma from community in Orissa. ■

Situating NLEP within NRHM : possibilities and challenges

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Introduction

Programmes for control of Leprosy in the Indian subcontinent though have started since 1955 the recent developments in the programme calls for some critical analysis. The recent initiative to integrate Leprosy control activities with the general health services gained momentum with the popularisation of the National Rural Health Mission (NRHM). This is despite the fact that integration of leprosy activities has been initiated since the shift in the programme from eradication to elimination. By the introduction of Multi-Drug Therapy (MDT) in 1983, the programme for the control of Leprosy was renamed as an initiative to eradicate the disease completely whose target was to eliminate the disease by 2000 (Pandey et. al. 2006). Elimination is defined as the stage when the prevalence reaches less than 1 per 10,000 populations. Subsequently significant decline in the number of cases has been reported by the year 2000. Thus in the year 2001 the second phase of National Leprosy Eradication Programme (NLEP) programme started with the objective of decentralising the responsibilities which ultimately initiated the process of integration of leprosy activities with the general health services (ibid.). To integrate various disease control programmes with the general health services has been echoing from various centres for more than three decades. Thus it is important to learn from the experience of Leprosy control in the current context when one of the major objectives of NRHM is to integrate National Health Programmes to the General Health Services. The current paper is an attempt to examine the issues and challenges of integration of Leprosy control activities in the context of NRHM.

Evolution of Leprosy Control Programme

Leprosy control programme was a centrally aided programme whose pace was slow until the introduction of MDT in 1983. The strategy then was based on the endemicity of the cases with vertical structures like Survey Education and Treatment centres, Leprosy control units and Urban Leprosy centres. In each, paramedical workers were given the primary responsibility of surveillance (active) carried out based on house-to-house visits. The strategy for case identification was Survey, Education and Treatment (SET) that involved identification of the cases from the field, provide awareness to those affected and make sure that they take treatment without fail (Banerji 1985, p.118).

In addition to this there were NGOs who have been playing a vital role all through the history of Leprosy control in the country. Currently it has been estimated that around 290 voluntary organisations are actively engaged in Leprosy relief services with 127 of them involved in SET activities of which 50 are covered by

(Footnotes) [1]See *http://mohfw.nic.in/National_Leprosy_Eradication_Programme/LEP_SET_SCH.htm* accessed on 10th Oct 08

SET grant from the govt of India.[1] During earlier periods NGOs were involved in almost all aspects of control, viz. case detection, treatment, public awareness creation, training, disability prevention and so on. Once the programme reached new heights those areas where the government was not able to provide services were only covered by NGOs thus keeping the role of NGOs to a minimum. Despite these, the contribution of NGOs in the field of Leprosy has to be acknowledged for their strong component of training rooted in experience and an efficient system for disability prevention (Lockwood and Suneetha 2005). This calls for the need to redefine and situate the role of NGOs after integration.

Integration: Some Concerns

The concept of integration implies that leprosy control activities became the responsibility of the general health services as part of the routine day-to-day activities. Integration was influenced by the international acceptance of primary health care approach, the WHO campaign for elimination and more importantly the introduction of multi-drug therapy (Feenstra and Visschedijk 2002). Thus equity and sustainability, the major components of primary health care approach also became the major justification for Integration. Equity implies comprehensive care as well as leprosy care to Leprosy patients which is regular and decentralised. This is in contrast to the vertical services that are provided otherwise on specific days and separate for Leprosy patients. Here the challenge is to ensure quality and specialised services to those affected with Leprosy but as a responsibility of the general health services. Second, the question of sustainability gain prominence as the reliability and support towards general health services is higher than those services provided by a vertical setting. Moreover, Integration expects to improve access to leprosy control services through which it reduces stigma and gender bias attached to Leprosy control.

The experiences with integration of Leprosy control services in various countries reveal a mixed trend and are a learning experience. The positive element identified by some countries were the decentralised health services system that could address the uneven distribution of Leprosy cases whereas inadequacy in planning the integration process was identified as a major shortcoming particularly the processes of training and monitoring (ibid.).

Features of the Leprosy Problem

India has always been the country with largest number of leprosy cases in the world. One of the notable features is its uneven distribution in India. Prior to the introduction of multi-drug therapy, Leprosy was found more among the southern states whereas according to the recent report the burden is more among the states such as Bihar, Jharkhand, Chattisgarh, Uttar Pradesh and West Bengal (Joshi et. al. 2007). This could possibly be due to the improved surveillance mechanism prevalent now in these states than earlier times.

As per 2006 estimate, around 50 per cent of new cases detected worldwide were from India, and of this 2/3rd of them were confined to the above five states (ibid.). Few states and union territories like Bihar, Chandigarh, Chhattisgarh, Delhi and Jharkhand have a prevalence rate between 1 and 2 per 10,000 populations with Dadara Nagar Haveli with a rate of 2.11 per 10,000 populations. These together contribute to 25 per cent of the country's recorded case load (ibid.). As per reports there has been drastic decline in *Prevalence Rate* by the introduction of MDT for Leprosy.

Scholars have been sceptical in using *Prevalence Rate* as an indicator for the magnitude of the problem that resulted in a controversy whether elimination is a virtual phenomenon or a reality (Lockwood 2002). This is because the reasons for reduction were more of operational than the real reduction in the number of

cases. The decline is attributed to the reduction in the treatment period with the new regime, when prevalence are taken on the basis of those who take treatment which is only *reported prevalence* (iceberg) thus submerging the real prevalence. The two major indicators that reveal the burden of Leprosy, viz. case detection rate and reported prevalence are predominantly dependent on the surveillance mechanism prevalent and treatment regimen followed as well as access to treatment. This being the case the burden of Leprosy cases can appear to decline once there is a failure in the mechanism for diagnosis and treatment. This was a situation in India when the case detection rates being stagnant with high rates among children (about 17 %), which is an indication of the fact that Leprosy is transmitted in the community (Lockwood and Suneetha 2005). Moreover when disability due to Leprosy is on an increase, it indicates that Leprosy is getting transmitted in the society.

Thus any approach to control Leprosy should ensure a system in place that can ensure prevention of the disease at the primary, secondary and tertiary levels of prevention. These in the context of Leprosy can be active surveillance for new cases, effective provisioning for treatment to the patient as nearby as possible with equally vigorous mechanism to follow-up cases to ensure patient adherence and last but not the least prevention of disability and rehabilitation. It is in this context the call of NRHM to integrate all National Health Programmes becomes relevant both as an opportunity as well as a challenge as any programme once integrated will 'sink' or 'sail' with the General Health Services (Banerji 2005).

Possibilities within NRHM

NRHM acknowledges the need to integrate health programmes as it has recognized limited synergism of disease control activities at the operational level. It further calls for decentralised services that give ample scope to address the regional inequalities which is relevant for the problem of Leprosy. Besides, the overall strengthening and effectiveness of general health institutions, the major focus of NRHM, have positive consequences for Leprosy control programme as it is already integrated. Common Review Mission of NRHM assures to build in the preventive, promotive and curative care for communicable diseases into the definition of *fully functional* health facilities thereby making provision for promotive and preventive services within the general health services (GOI, 2007).

This can be accomplished by developing the standard treatment guidelines, their essential drug lists, their referral systems, their support systems for capacity building, logistics, and monitoring, and their Behaviour Change Communication (BCC) interventions. This along with bringing together of district health societies of TB, Malaria and Leprosy under state health societies is already in the process (Pandey et.al. 2006). In order to ensure horizontal integration it has been recommended to focus on sharing of laboratory infrastructure, equipment and the technician amongst various control programmes. Developing multiple skills is recommended by NRHM for pharmacists, laboratory technician and other support staff. The mission also guarantees full coverage of curative and restorative services related to Leprosy. In addition to these the mission also offers space for NGOs/ civil society organizations especially in the field of training, monitoring and evaluation.

NLEP within NRHM: Possibilities and Challenges

Thus in the current scenario integration provide new outlook when seen through the lens of NRHM. The approach of NRHM on integration of leprosy control activities appear to be to provide Accredited Social Health Activists (ASHAs), the central component of

NRHM, the major responsibility of case detection of Leprosy. The central role of case detection/ surveillance both in terms of administrative and technical competence, in-effective implementation of Leprosy control programme has been identified by many scholars earlier (Lockwood and Suneetha 2005). Here the context in which ASHAs work become cardinal as incentivisation (cash) of the work of ASHAs and its set-backs in Reproductive and Child Health programme cannot be forgotten. However, incentivisation and 'social activism' are contradictory not only conceptually but also in practice. This again is not victimizing ASHAs but the contradictions that has been happening cautions the need to revisit the work constraints by which ASHAs work keeping in mind the unwarranted experience of ANMs with the health service system.

The task of surveillance of Leprosy, if given as a responsibility for ASHAs especially in highly prevalent regions like Bihar, Jharkhand, Uttar Pradesh and Orissa can probably fail due to inadequate time ASHAs have to spare for Leprosy work. This is because these are the regions where health problems are numerous, especially those related to Reproductive and Child Health (RCH) for which ASHAs have to deliver those tasks more importantly than surveillance of Leprosy cases. Moreover in the context where ASHAs are expected to work for a meager amount given as honorarium it is highly possible that those programmes with incentives will get more priority.

Secondly, even for the people affected with Leprosy, the response during initial stages of the disease were found to be very less (Lockwood and Suneetha 2005). This further gets worsened in a situation where the felt need of the people for RCH related services are much higher as compared to Leprosy, a possibility in those states that are highly endemic to Leprosy. Above all it has to be noted that ASHA training does not cover topics on Leprosy and even if it is included, will that be sufficient enough for effective diagnosis is a question that needs to be seriously looked at. This is based on the concern that it is fundamental to distinguish between those cases with skin lesions and nerve involvement for which hands-on-experience with diagnosing Leprosy patients was found to be crucial (Lockwood and Suneetha 2005).

The second aspect of Leprosy control that finds place in NRHM is to provide IEC through Village health and sanitation committee (VHSC) and thus can be effective as it is already responsible for delivering IEC on various other aspects. Here the challenge will be to feed ways by which IEC activities can address the issue of stigma towards leprosy as it is a necessary condition for effective integration into the general health services system.

The third aspect is the strengthening of primary health centres and Pharmacies within the general health services as part of NRHM which can be a welcome move as it can improve provisioning of drugs thereby improving treatment. This calls for overall improvement of service delivery of general health services that should also address the issue of access to health care. If that is ensured then the challenge will be to ensure follow-up and supervision of relapse cases. This is because patients with high bacterial load who are probably responsible for maintaining infection were found to have greater relapse rates despite 24 months of MDT (Lockwood and Suneetha 2005).

The final aspect is the Rehabilitative measures to support disabled patients. The approach could possibly be that of a public-private partnership with the support from the civil society, which can be a technical and advisory body to the general health services until the latter stands on its own. The details need to be worked out meticulously with both the partners functioning together for a common goal. This can also retain the civil society/ NGOs that have been

doing a commendable job in the filed of Leprosy as experts have identified that maintaining these groups as a support system can gain from their invaluable experience (Lockwood, 2002). Again it is important to note that the role of civil society / NGOs should always be *supplementary* and can not be a *substitution* to the general health services.

Conclusion

An attempt has been made to examine the possibilities and challenges within Leprosy control programme in India in the context of NRHM. The experience with Leprosy is an opportunity to learn from one of the disease control programmes which was integrated a few years before the introduction of NRHM. On the other hand with the mission of NRHM that it will strengthen the general health services will generate hope that it will rectify the problems of health service delivery, thereby help in better implementation of Leprosy control activities.

The concept of Integration in Leprosy control has evolved in the backdrop of Primary health care approach thereby carrying forward the notions of equity, sustainability and community participation. NRHM also considers these values as the core through which health services need to be strengthened. Here it becomes imperative to ensure the degree of specialization required and not to compromise the quality of services together with sustainability and communitisation.

This becomes relevant as the two-year review of NRHM identifies that a basic minimum in terms of manpower, resources and services need to be ensured before additional resources are poured in. In other words a system for monitoring, governance and service delivery need to be ensured at every level, so that more resources can be expected to get effectively utilized.

The major task of Leprosy control, like any other disease control is morbidity control for which active surveillance is crucial. Relying on ASHAs for this is not an encouraging option given the constraints with which ASHAs are working. It is high time that we develop a reliable and systematic case identification mechanism both in terms of technical and administrative efficiency that can rule out the dilemmas on the number of Leprosy cases.

Though NRHM conceptually offer ample scope to built Leprosy control into its activities, the task here is to ensure that the programme 'sail' with the general health services. This can only be accomplished by efforts that can strengthen the health services system thereby ensuring that the components of Leprosy control is knit into the general health services system as a responsibility on a regular basis.

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Institutional needs at the rural health units under NRHM and its relevance to leprosy control - a review

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Introduction

India has now developed a mission to improve health of people in land with increased emphasis for rural people. This mission is called 'National Rural Health Mission (NRHM)'. The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care, especially to poor and vulnerable sections of the population. It also aims at bridging the gap in 'Rural Health Care' through creation of a cadre of Accredited Social Health Activists (ASHA) and improve hospital care, decentralization of programme to district level to improve intra and inter-sectoral convergence and effective utilization of resources. The NRHM further aims to provide overarching umbrella to the existing programmes of Health and Family Welfare including RCH-II, Malaria, Blindness, Iodine Deficiency, Filaria, Kala Azar, T.B., Leprosy and Integrated Disease Surveillance. Further, it addresses the issue of health in the context of sector-wise approach addressing sanitation and hygiene, nutrition and safe drinking water as basic determinants of good health in order to have greater convergence among the related social sector Departments i.e. AYUSH, Women & Child Development, Sanitation, Elementary Education, Panchayati Raj and Rural Development.

The NRHM further seeks to build greater ownership of the programme among the community through involvement of Panchayati Raj Institutions (PRI), NGOs and other stakeholders at National, State, District and Sub District levels to achieve the goals of National Health Policy and National Population Policy 2000.

Under the strategy of NRHM, in order to fill the gaps in the existing rural health care infrastructure available in the country, the key components, inter-alia, of the Mission are as given below:

(i) Creation of a cadre of Accredited Social Health Activists (ASHA) in 2.5 lakh villages in four years – 8 EAG States (Empowered Action Group), J&K and Assam.

(ii) Creation of village health scheme and preparation of village health plan – 18+ states.

Anticipations under NRHM

With the provision of village level health provider (ASHA) in all under served villages would strengthen the utilization of health services available at all Sub-centers /PHCs and CHC. In turn, management of health issues at all districts would also enhance activities for Prevention, control of communicable and non-communicable diseases including locally endemic diseases. Similarly, increase utilization of First Referral Units (FRU) should take effect from less than 20% (2002) to more than 75 % by 2010 and therefore bring in faster reduction in the occurrence of communicable diseases including leprosy and would thus also help preventing leprosy related disabilities.

Institutional needs under NRHM

As per the norms set, each Sub Centre (SC) will have 2 workers (one MPW (Female) / ANM & one MPW (Male)) and would act at Most peripheral contact point between Primary Health Care System & Community. A Primary Health Centre (PHC) will have strength of 15 workers, A referral unit for 6 Sub Centres, 4-6

bedded and manned with a Medical Officer Incharge and 14 subordinate paramedical staff. Similarly, a Community Health Centre (CHC) is a 30 beded hospital/Referral Unit for 4 PHCs with Specialized services and should have 4 Medical Officer, 7 Nurse Midwife (staff Nurse), 1 Dresser, 1 Pharmacist/ Compounder, 1 Lab Technician, 1 Radiographer, 2 Ward Boys and 8 other workers, thus totaling to 25 workers.

Institutions in Positions

The data suggest (Table 1) that country needs 158792 Sub-Centres (SC), 26022 primary health centers (PHC) and 6491 community health centers (CHC) as per the decided norms. As on March 2007, there is shortfall recorded by 13.1% for SC, 18.6% for PHC and 38.9% for CHC respectively. In leprosy endemic states (LES) (with PR >1/10,000), this shortfall amounts to 21.2% of SC, 26.7% in PHC and 52.4% in CHC respectively. Apart from the magnitude of shortfall, 42.9% (15/35) states have shortfall of functional SC, 48.6% states for functional PHC and 57.1% states for functional CHC respectively. In comparison, the LES have much higher level of shortfall i.e. 71.4% for SC & PHC each and all for CHC. It is therefore clear that shortage in number of health institutions are significantly ($p<0.0001$) higher in states endemic for leprosy (LES).

Table 1 : Physical Health Infrastructure in Rural areas as on Mar 2007

Health Units	India (35)	LES (7)	Shortfall in States (%)	
Pop '01 (crore)	74.25	33.89 (45.67%)	India (35)	LES (7)
Sub-Centre				
Required*	158792	71202	42.9%	71.4%
Positioned	145272	56128	(15)	(5)
Shortfall (%)	20855 (13.1)$	15074 (21.2)$		
PHC				
Required*	26022	11722	48.6%	71.4%
Positioned	22370	8589	(17)	(5)
Shortfall (%)	4833 (18.6)$	3133 (26.7)$		
CHC				
Required*	6491	2927	57.1%	100%
Positioned	4045	1394	(20)	(7)
Shortfall (%)	2525 (38.9)$	1533 (52.4)$		
$ Significantly different, p<.0001				

Manpower positions at the rural health institutions

Data presented in Table 2, reveals that about 11-12% shortfall exists in availability of Health workers (Females) at Sub-centres, only all around India. Whereas shortfall of Health workers (Females) at Sub-centres+ PHCs are significantly more (18.2%) in LES states than 11% in India as a whole ($p<0.0001$) and health worker (male) were in shortage to the tune of 57-58% in India as a whole. However, Health Assistant (male) at the PHC were short by 39% in LES states in comparison to 22.1% in India , this difference is again significant ($p<0.0001$).

Table 2 : Manpower shortfall at Sub Centre (SC), PHC and CHC

	At Sub Centres		Shortfall in States	
	India (35)	LES (7)	India (35)	LES (7)
HW (F)				
Required*	118601	56128	68.6%	71.4%
Positioned	104630	49480	(24)	(5)
Shortfall (%)	13971(11.8)	6148 (11.1)		
	At SC + PHC			
HW (F)				
Required*	165645	64717	65.7%	85.7%
Positioned	147439	52924	(23)	(6)
Shortfall (%)	18206 (11.0)$	11793 (18.2)$		
HW (M)				
Required*	145272	56128	n/a	
Positioned	62881	23301		
Shortfall (%)	82391 (56.7)	32827 (58.5)		
	At PHC			
HA (F)				
Required*	22370	8589	n/a	
Positioned	15546	5718		
Shortfall (%)	7142 (31.9)	2871 (33.4)		
HA (M)				
Required*	25981	14568	n/a	
Positioned	20234	8880		
Shortfall (%)	5747 (22.1)$	5680 (39.0)$		
Leprosy Endemic State: Bihar, Chhatisgarh, Jharkhand, Orissa, Uttarakhand, U.P., W.B. $ Significantly different (p <0.0001)				

A total of 4.8% subcentres were without ANM / HW (F) in India as on Mar 2007, but HW (male) are short by 36.2%. Although LES states had higher shortfall but due to incomplete data, comparisons are not made (Table 3).

Table 3 : Manpower shortage (%) at Sub-centres in Rural areas as on Mar 2007

Sub Centre Without	India (145272)	LES(56128)	India	LES
ANM/HW (F)	6937 (4.8%)	2585 (1.8%)*	n/a	
HW (M)	52634 (36.2%)	23329 (41.6%) Based on 6 States	n/a	
ANM/HW (F) & HW (M)	4711 (3.2%)	3118 (2.2%) Based on 5 States	n/a	

The manpower availability at PHC and CHC really needs urgent attention of the programme managers, if the health goals of NRHM are to be achieved in time. For example; there is a shortage of doctors by 17.1% in India vs. 24% in LES states (this will be much higher when data from U.P. is added). A total of 3.6% PHCs were without a doctor in the India in comparison to 6% in LES states. Similarly technical manpower like technicians and Pharmacists are also in significant shortages in LES states. The availability

of specialist cadre medical officers at the CHC are even worse with 3/4th requirements are not in positions (Table 4).

Table 4 : Manpower shortage at PHC and CHC

At PHC	India (22370)	LES (4599@+3690)	India	LES
Doctor				
Required*	27274	10094 + 3660 (UP)	n/a	
Positioned	22608	7673 + NA		
Shortfall (%)	4666 (17.1)	2421 (24.0)		
PHC Without				
Doctor	807 (3.6%)	276 (6.0%)	n/a	
Lady Doctor	3109 (13.9%)	251 (5.5%)@		
PHC Without				
LT	7558 (33.8%)	2429 (52.8%)$	n/a	
Pharmacist	3073 (13.7%)	809 (17.6%)$		
Specialists at CHC				
Physician				
Specialist	4045	1451	n/a	
Positioned	1083	177		
Shortfall (%)	2952 (73.0)$	1274 (87.8)$		
Paediatrician				
Specialist	4045	1394	n/a	
Positioned	898	355		
Shortfall (%)	3147 (77.8)	1039 (74.5%)		
All Specialist	16180	1394	n/a	
Positioned	5117	355		
Shortfall (%)	11063 (68.4)	1039 (74.5)		

How the available resources being used?

Although no official data is available on 'How the resources are being used? Frequent news paper reports indicate that 'A Good proportion of resources are not being used for the purpose provided'. Unless official data are available for public opinion in this regards, this issue can not be examined in details.

The print media covers very widely issues related to health and education sectors and publishes report on frequent administrative checks on the functioning and availability of health units including staff posted on these units through-out the country. Some of the observations include that 'Good amount of Health units' are not serving the community properly, they exist for, many do not open even half of the working days, and when open- Non-Availability of staff, facilities, drugs and supplies, staff behaviours are some of the main reasons of poor utilization (Table 5). Problem is many folds in poor states – and among these are Endemic states for Leprosy (LES) and also the pressure to cover higher population size per unit than the norm (Table 6).

Table 5 : % PHC adequately equipped (critical inputs ≥60%) : Health facility survey, 2003

LES State	# PHC	% PHC having at least 60%				
		Infrast.	Staff	Supply	Equip	Training
Bihar	845	8.9	19.6	11.4	6.2	15.5
Chattisgarh	320	2.8	26.3	14.1	8.8	3.8
Jharkhand	285	9.8	38.2	50.5	21.4	42.5
Orissa	595	3.2	0.2	3.5	15.1	13.4
Uttarakhand	144	27.8	68.1	23.6	27.1	7.6
U.P.	2081	17.2	52.8	19.5	28.6	12.4
W.B	209	12.0	5.7	23.0	8.6	9.1
INDIA	**9688**	**31.8**	**48.2**	**39.9**	**41.3**	**19.9**

Table 6 : Average Population being covered as per Mar '07

State	Average Pop'n covered by				
	Sub Centre	PHC	CHC	HW (F) / ANM	HW (M)
Pop'n **to be covered** in					
Plain areas	5000	30,000	120,00		
Tribal areas	3000	20,000	80,000		
Bihar	8342	45095	10,61,667	8346	59933
Chattisgarh	3548	32139	141,085	4539	5837
Jharkhand	5294	63491	108,000	4792	4883
Orissa	5279	24462	135,443	4622	5224
Uttarakhand	3575	27199	128,781	3535	9519
U.P.	6416	35972	341,084	6011	22969
W.B.	5576	62634	166,904	5833	11153
INDIA	5432	41570	297,566	5035	11808

However, some data is available (Table 7) on availability of sufficient medicines in hospitals and dispensaries in India under ISM & H (reported by Health Facility survey, 2003) reveal that only 26.8% of the hospitals and 18.5% dispensaries had sufficient medicines available for common ailments. Whereas specialized medicines were available only in 7.0% of the hospitals and 7.6% dispensaries. The adequate beds were available in 47.4% of the hospitals.

Table 7 : Availability of sufficient medicines in ISM&H Hospitals & Dispensaries

State	No. of Hospital	No. of Dispensary	For Common Ailments		Specialized Medicines		Adequate Beds
	(H)	(D)	H	D	H	D	H
Bihar	20	109	10.0	1.8	10.0	0.9	30.0
Chattisgar	04	370	25.0	23.5	25.0	7.0	75.0
Jharkhand	11	60	27.3	3.3	0	0	9.1
Orrisa	06	546	50.0	15.8	33.3	7.7	66.7
Uttarkhand	212	58	65.6	36.2	5.2	6.9	53.8
UP	1579	1488	13.9	28.2	1.9	11.0	48.0
WB	na	190	na	5.8	na	3.2	na
India	**2151**	**7064**	**26.8**	**18.5**	**7.0**	**7.6**	**47.4**

(Source: Health Facility Survey, 2003)

The situation was worse in some of the leprosy endemic states (LES). For example; sufficient medicines for common ailments were available only in 10% hospitals and 1.8% dispensaries in Bihar, in U.P. (13.9% hospital and 28.2% dispensaries) and in Jharkhand, 27.3% of hospitals and 3.3% dispensaries had medicines for common ailments. The situation further deteriorates on account of the availability of specialized medicines and adequate beds as needed.

Utilization of health services in rural areas

A survey conducted in 10,000 households in Firozabad district of U.P. suggest that 51.9% household have used the health services at least once and 48.1% had never used. The reasons of not using are simply do not go assuming bad services (28.7%), Health Centre located far from their households (7.6%), Medicines not available (5.7%), Services extremely poor (3.2%) and others (2.9%).

The role of link worker 'ASHA' in leprosy control

As per NRHM an ASHA is being located in each village. This worker is an important link between community and service providers at Government health centres and supposed to be a committed person for the local needs as she would be being paid for each and every service. She helps in to be advocating for to the local population. The Government has already set standard compensation for each job under NRHM, she will receive for the any services through health centres.

A survey conducted in Firozabad district of U.P. during September-October 2008 that investigated their availability, educational status, knowledge to suspect leprosy, if they received any training to suspect leprosy, how many cases ASHA helped in detecting leprosy in their areas of work and what honoraria they received for each case suspected?

The ASHA's were available in 74.4% of the villages but most of the small villages still do not have ASHA workers (Table 8). The educational level of most ASHA was below 10th standard (mostly 8th pass) in 41.7% cases, 10-12th in 29.9%, 12th – undergraduate in 19.7% and graduate in only 8.7% cases. Of the total, 71.4% have in place since 12-24 months, 16% even for more than 24 months. Although, 78.1% got a capsule training only, 52% of the ASHA workers knew to suspect leprosy. However none of them ever suspected any case of leprosy and thus had no knowledge on compensation. Interesting to note is that **35% Trained ASHA has no knowledge on leprosy sign and symptoms.**

Table 8 : Availability of ASHA in villages

POP SIZE	Villages	% having ASHA Worker
<500	17	17.6 (3)
500-1000	58	56.9 (33)
$\geq$1000	89	96.6 (86)
Total	**164**	**74.4 (122)**

Of the 164 villages surveyed, 102 villages (62.2%) had ASHA residing in the village, 12.2% ASHA'a stay outside the allotted village or area –mainly closely located bigger village. The survey team detected leprosy cases in 62.7% (64/102) of the villages where ASHA are posted and reside within the village and 109 active leprosy cases were detected in these villages. This is in comparison to 30%(6/20) villages had been found with leprosy cases where ASHA do not stay and 11.6% (5/42) of those villages where No ASHA exists. The cases detected in these villages were 13 and 6 respectively (Table 9).

Table 9 : Villages where JALMA detected Cases

Villages with	No. of Villages	Villages where JALMA got cases	No. of new cases detected by JALMA
ASHA Worker residing in village	102	62.7% (64)	109
ASHA Worker NOT residing in village	20	30.0% (6)	13
NO ASHA worker	42	11.6% (5)	6
Total	**164**	**45.5% (75)**	**128**

Discussion and Conclusion

The available data from Government sources reveal clearly that health institutions under National Rural Health Mission (NRHM) are having severe shortages of resources in terms of Number of health units for the population to be covered, manpower availability in these institutions, medicine availability and other services. Although no government data is available on utilization, but whatever available data is that suggests that the levels of utilization were low and has lots of scope to improve.

Even the first referral units (FRU) are not utilized to the optimum level and still low. However hard data on functional aspects at these health institution and functional availability of respective staff like doctors are not available, media reports give very dismal image. The situation is worse in all the leprosy endemic states because these are already bigger and

An officially functional PHC

demographically poor states. So the issues related to the accessibility, affordability, accountability and reliability of the health system remain the issues until further.

Under these circumstances, a new link worker, namely, ASHA and to realize its role in improving health of the people seems to be a big dream. The supplementary role by ASHA in helping to detect leprosy patients may thus be a bigger dream and unlikely to be achieved unless all the ASHA workers are trained and utilized for this purpose for a specific time and their confidence is built into the programme where they feel they that are wanted and would have important contributions for they would be compensated in honesty.

Teaching ASHA to diagnose leprosy in a village setting

As data suggest, none of the ASHA is found to have done anything related to leprosy and their main job currently is related to RCH programme. It is therefore concluded that although NRHM has very comprehensive agenda and provision of resources were made but ground level data suggests severe shortages of resources in position and functional lacunae would further affect the outcome indicators.

Programme like leprosy are given hardly any attention and would thus severely affect the interest of leprosy control activities as paying very little or no attention would further increase the scope of under reporting.

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ASHA worker suspecting a new case of leprosy

Leprosy services in post-integration phase : the Jan Swasthya Sahyog experience

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Jan Swasthya Sahyog was set up in 1999 by a group of eight doctors in Bilaspur in Chhattisgarh state. It runs a health centre and a community health programme covering 53 villages in rural Chhattisgarh district, with a population of approximately 26000. However, the health centre is accessed by people from nearly 1500 villages. It caters to mainly the rural poor, tribals, scheduled castes and other disadvantaged sections of the population.

The services provided by the Ganiyari health centre are of a primary and secondary level of health care. The health centre is fully equipped with an outpatient clinic, inpatient services, laboratory, radiology and ultrasound and operation theatres. It is used by about 35000 outpatients and 950 inpatients every year.

Cases of leprosy have been reporting to the health centre from the very beginning of its functioning (in the year 2000). Most of these cases are new ones who have not taken treatment elsewhere, but there are also an increasing number of patients who have taken partial or complete treatment from the public health system or private centres.

Leprosy situation in Chhattisgarh

Chhattisgarh is one of the states endemic for leprosy, with a prevalence of about 2.5 cases per 10000 population. The distribution of cases of leprosy is not uniform all over the state. The districts with a higher prevalence are Mahasamund, Raigarh, Raipur, Janjgir and Bilaspur. The districts with a lower prevalence of the disease are Koriya, Surguja and Rajnandgaon.

The mean age of patients is found to be greater than 35 years, and the proportion of cases who are children is about 5%. The deformities and complications are found in about 3% of cases.

Under the NRHM, the ASHA workers (called "mitanins" in Chhattisgarh) are given incentives for detecting and following up cases of leprosy. They get Rs. 300 for detecting a paucibacillary case of leprosy, and Rs. 500 for detecting a multibacillary case of leprosy. Rs. 100 out of these amounts are paid immediately and the balance is paid on completion of treatment.

Trends in leprosy situation at JSS

The number of new leprosy patients reporting to the JSS health centre has shown an upward trend for the last three years, from 76 in 2006 to 110 in the first nine months of 2008. Of these cases, there is a high proportion (about 30%) of multibacillary (MB) leprosy mostly untreated. Among the new cases, there is a high incidence of neuritis. However, there is a low incidence of complications, especially ocular complications.

A large proportion of patients have already received partial or complete treatment from the public health system. They visit the JSS health centre for completion of their treatment or for management of complications like lepra reactions, neuritis and their sequelae.

Lessons learned

The experience of Jan Swasthya Sahyog in treating leprosy patients is that there is a definite need for the continuation of leprosy services alongside general health services. This appears to be a better approach to integration than expecting the general health

services to manage leprosy cases and their complications on their own.

The incidence of leprosy will remain steady for some more time, till socio-economic conditions in the area improve.

The large proportion of cases with nerve function impairment indicates the need for continuing active case finding for detecting new cases.

In the treatment of patients, it has been found that compliance is encouraged and improved by providing all treatment free of cost, the use of postcards and other methods to remind patients, and special leprosy clinic days.

Observations

As a NGO functioning in the state of Chhattisgarh and interacting with both the private and public health systems in the state, there are aspects of the leprosy situation which need further attention. Some of these are:

1. **Knowledge of leprosy :**

   The knowledge and expertise of leprosy among private practitioners and public health personnel (particularly PHC doctors), is quite low. This results in much unnecessary suffering and inconvenience to patients in the form of delayed diagnosis, incorrect treatment and management of reactions and other complications. There is an urgent need for continuing medical education (CME) on all aspects of leprosy care.

2. **Referral mechanisms :**

   These are weak and need strengthening at all levels. For instance, PHCs are provided with only one course of steroids to manage Type 1 lepra reactions. A patient with Type 2 reaction would require a referral to the district hospital. A visit to the district hospital by the patient is difficult owing to large distances and expensive bus transport.

3. **Utilization of NLEP staff :**

   Their experience needs to be utilized even in the post-elimination phase, as they can contribute largely towards ensuring the quality of care of leprosy patients, and also of leprosy control activities (eg. mass surveys, school surveys).

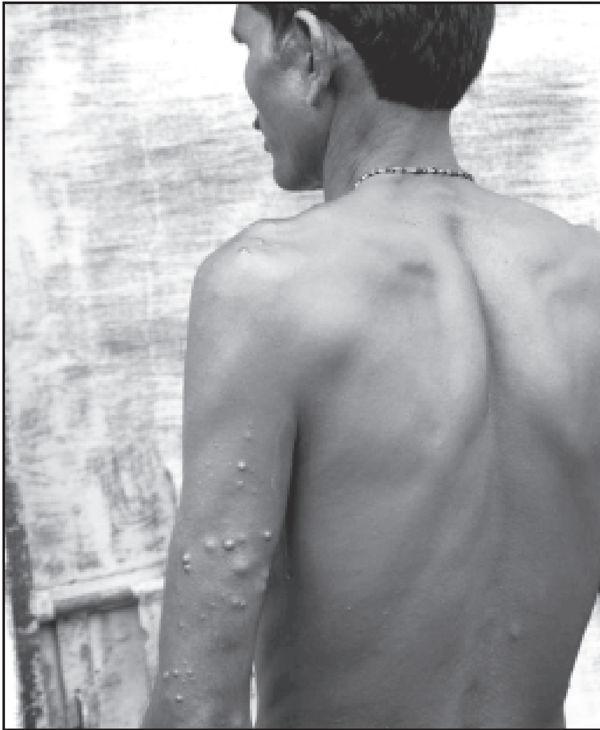
4. **Active v/s passive case finding :**

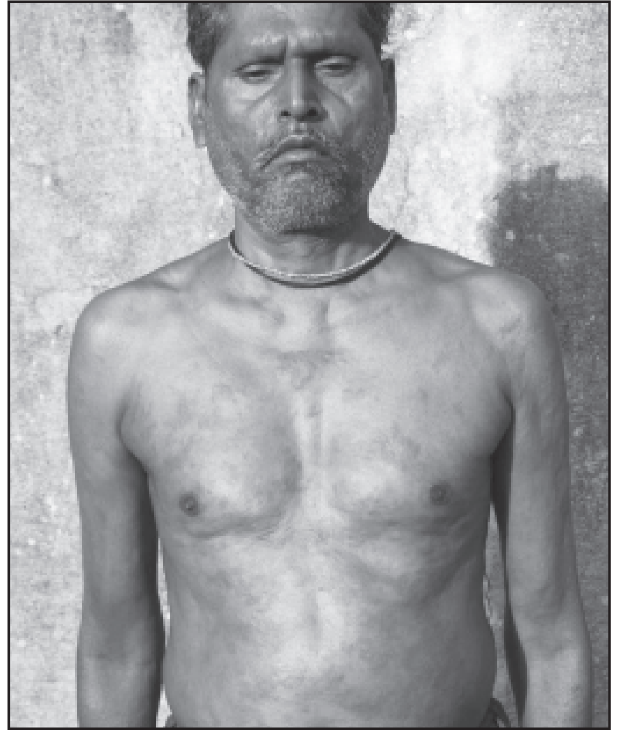
   The emphasis on the latter in the post-elimination phase leaves many undiagnosed leprosy cases. Some active case finding is necessary, especially in more inaccessible and remote areas. Our experience with a large number of cases reporting with neurodeficit indicates the need for active case finding.

5. **Role of NGOs :**

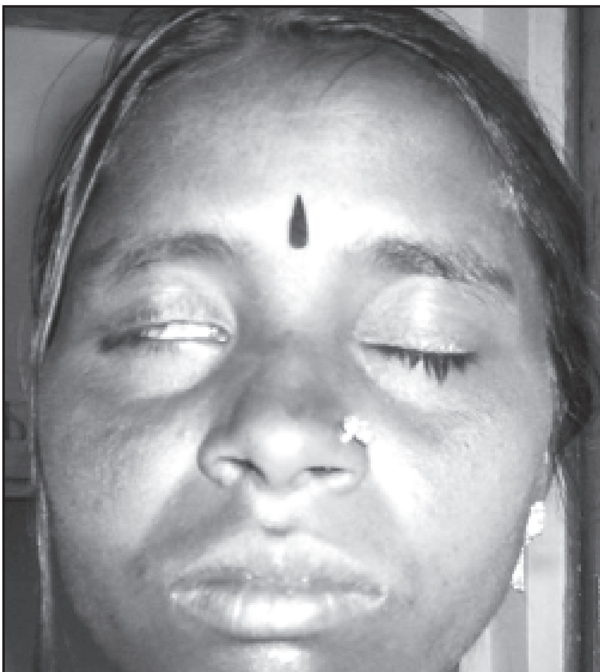
   In the post-elimination phase this needs to be more clearly defined. Unfortunately, there is often suspicion and mistrust on the part of the public health personnel about NGOs and their work in leprosy. There is a unfounded perception that NGOs are perpetuating the leprosy problem for their own self-interest. ■

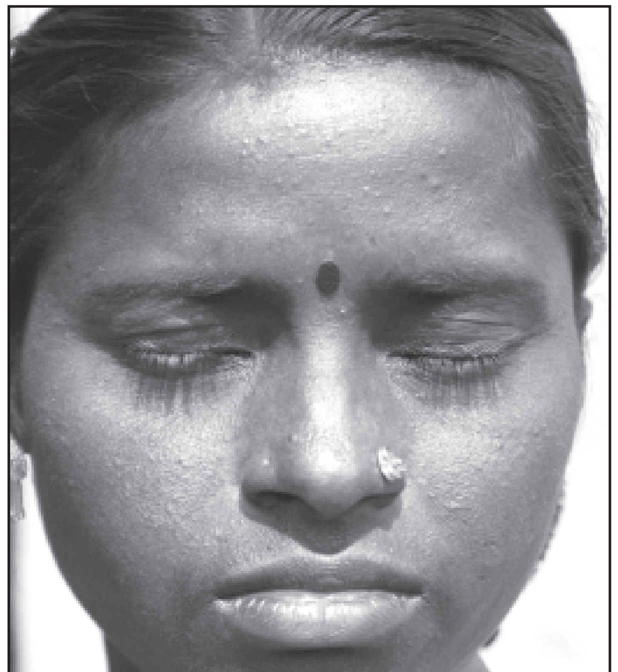
A new untreated case of lepromatous leprosy (Histoid type)





A patient with lagophthalmos – before and after treatment





A critical review of the role of ASHA workers in the context of leprosy control in Uttar Pradesh

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Under the National Rural Health Mission, at village level :

Committees are formed at the grass root level i.e. The Village Health & Sanitation Committee (VHC), the standing committee of the Gram Panchayat (GP), which will provide oversight of all NRHM activities, including activities related to NLEP, at the village level and be responsible for developing the Village Health Plan including leprosy, with the support of the ANM (Auxiliary Nurse Midwife) , ASHA (Accredited Social Health Activist), AWW (Anganwadi Worker) and Self Help Groups.

- **Accredited Social Health Activist (ASHA)** is primarily a woman resident of the village, with formal education up to 8th standard, one for every 1000 population. She is identified to act as a link person between community and the health system, to strengthen the public health service delivery infrastructure, and to facilitate access to health services particularly at village, primary and secondary levels.

- **Role of ASHAs envisaged in leprosy programme**

  Create awareness in the community about the signs and symptoms of leprosy to promote early case detection.

  Refer all suspects to the nearest primary health centre for confirmation of leprosy and initiation of treatment.

  Follow up cases under treatment in her village and promote timely completion of treatment.

  Referral of lepra reaction, ulcer & disability cases to the nearest primary health centre for management.

  Assist in incorporating aspects relating to leprosy during preparation of the Village Action Plan.

- Incentive to ASHAs have been approved by Central Leprosy Division, GOI, for 5 endemic states of India i.e. UP, Bihar, Jharkhand, Chhattisgarh and West Bengal. If she suspects a case of leprosy and if it is confirmed at PHC, she will receive Rs. 100 immediately. She will follow the case up to completion of treatment and on successful and timely completion of treatment, she will receive an additional amount of Rs. 200 for PB and Rs. 400 for MB case.

At present there are 1,34,000 ASHAs in Uttar Pradesh and 70% have been trained in leprosy. Referral of suspects by ASHAs has begun and a good proportion of the suspects are being confirmed as leprosy cases. The female proportion among the newly detected cases in the districts varies between 10 percent to 40 percent in the state. With the active involvement of ASHAs it is expected that cases shall be detected in early stages and there shall be a remarkable rise in female case detection. After integration of the vertical staff - healthy contact examination, follow up of cases under treatment and those released from treatment has been discontinued. These important activities can be resumed with the support of ASHAs. Under the DPMR (Disability Prevention and Medical Rehabilitation) programme launched in 2008 all old treated cases and those under treatment have to be assessed for their present disability status.

1,34,000 ASHAs in Uttar Pradesh

ASHA worker suspecting a new case of leprosy

Training of ASHA workers

Dr. P. L. Joshi examining a case identified by ASHA worker

Mobilization of the leprosy affected persons to the PHC for this assessment can be done very easily with the support of ASHAs. The ASHAs shall have the advantage of being familiar with the psycho-social and economic background of the leprosy affected and hence play a critical role in providing them leprosy services at the health facilities. With sustained orientation of ASHAs in leprosy as a disease and her experience with the leprosy affected, she shall be instrumental in reduction of stigma in her community. She can promote self care practices. Also early referral of lepra reaction, neuritis and ulcers cases by her, shall go a long way in preventing disabilities. ■

Panel Discussion and Recommendations

Despite a progressive policy and increase in the sense of community ownership and responsibility for health care under NRHM, critical problems in delivering quality health care and implementing disease control programmes effectively at the community level still exists. Since NRHM is functioning in many parts of India, it was necessary to review the credence given to the National Leprosy Eradication Programme (NLEP) in sustaining the leprosy control activities in the country.

With a view to achieve an effective convergence of NLEP and NRHM, a group of experts and representatives of World Health Organization (WHO), Govt. of India (GOI), International Federation of Anti-leprosy Associations (ILEP), Indian Council of Medical Research (ICMR), leprosy NGOs and Civil Society Organizations. discussed the issues relating to 1) sustain leprosy control and 2) to improve the quality of services and made the following recommendations.

Recommendations

A. The convergence of NLEP services into NRHM to **sustain leprosy control** (Group 1)

1. All concerned (officials and members) should be sensitized to include leprosy in the community monitoring and supervision system of Village Health Sanitation Committee (VHSC) and Rogi Kalyan Samithi (RKS), a patient welfare society

   - *to take up leprosy into the agenda of monthly / quarterly review meetings.*

2. People affected by leprosy should be involved in planning and formulating appropriate interventions at the village / district level, especially at the level of VHSC

   - *to ascertain the needs of the people affected by leprosy*.

3. Leprosy cured persons should be involved in awareness campaigns and socio-cultural activities to dispel social fear at the village and district level as a matter of policy

   - *to demonstrate the need for social assimilation of the leprosy cured and the real possibility of normal life after leprosy.*

4. 'Accredited Social Health Activist' (ASHA) workers should be given refresher training on leprosy annually under NRHM and incorporate leprosy control measures as a theme (wherever such an inclusion is not made) with more appropriate pictorial content in the ASHA training module

   - *to enhance community participation in leprosy control.*

5. The elected representatives of Panchayat Raj (local self government body) should be oriented on leprosy as a specific activity of NLEP under NRHM

   - to promote integration and decentralization of leprosy services.

6. Positive messages should be propagated through Information, Education and Communication (IEC) activities and campaigns on leprosy in school health programme as one of the public health concern

   - to enlist and enable the participation of school children and nurture a fearless future generation.

B. The convergence of NLEP services into NRHM to **improve quality of services** (Group 2)

7. The lapses in logistic and issues of coordination in MDT distribution at all GHC centres should be addressed as a priority as well as streamline the bottom-up process of MDT indenting mechanisms at the PHC, block and district levels

   - to ensure adequate and timely provision of MDT to new leprosy patients and to achieve increased treatment compliance.

8. The private medical practitioners should be motivated and involved to diagnose and treat or refer new leprosy patients for MDT to the PHCs

   - to strengthen the public-private coordination in the given health seeking behaviour of the majority population.

9. Specialized services such as physiotherapy and skin smear examination including follow-up should be provided by the existing leprosy trained personnel – train new personnel wherever needed – through leprosy referral centres (LRCs) at the secondary level

   - to ensure sustained access to quality care as a matter of right of leprosy affected persons.

10. ASHA workers should be trained and involved to offer effective counselling to leprosy affected persons along with PHC workers at the village level

    - to widen the reach of leprosy service network.

11. The merits and demerits on the involvement of ASHA workers under NLEP in different settings should be studied and provide feedback to the health planners and programme managers

    - to ascertain the effective utilization of ASHA workers in NLEP.

12. The health planners and review panel members of NRHM should be sensitized and involved through constant advocacy measures by the leprosy programme managers at different levels

    - to accord due importance to NLEP deserves under NRHM.

■

NRHM
Second Common Review Mission : Recommendations
(November & December 2008)

National Rural Health Mission
Ministry of Health & Family Welfare,
Government of India,
Nirman Bhawan, New Delhi.

Executive Summary

The Second Common Review Mission of the National Rural Health Mission was held in November-December of 2008, 43 months after the formal launch of the programme and 27 months after the Framework for Implementation was approved by the government. Eighteen officials of the central and state government, 20 public health professionals from academic and technical institutions and 17 public health activists from civil society and 20 representatives of development partners, a total of 67 persons, participated in the mission.

The Mission divided into 13 teams which visited over ten facilities in a minimum of two districts in 13 states. And at each of these sites, the Mission interacted extensively with community representatives, service providers, and officials and then after discussion with state officials submitted their state reports. These state reports have been summarized in this national report along with an analysis of general trends across states.

The Mission studied changes across 19 parameters. In this report we sum these findings up into four main headings. The most important of these is improvement in service delivery and facility functionality leading to a notion of fully functional facilities that deliver on the NRHM promise of service guarantees. The other headings are human resource development, improvements in management and strengthening of community processes.

Key Findings of the Mission:

1. The most important finding is a general increase in utilization of public health services, reflected in increased outpatients, increased in-patients and a sharp increase in institutional deliveries and greater utilization of ancillary services like diagnostics, referral transport etc. This increase is seen across states. Though Janani Suraksha Yojana is a major driver of this increase, other factors like more nurses and doctors put in place, better availability of drugs and improved cleanliness and above all the increasing will to revive public health systems are becoming the dominant contributing factors.

2. The increased utilization is not uniform across all facilities in all states. In six states, all of them high focus, despite an overall increase, the increase at the 1 per 30,000 PHC level is modest or absent. And in a few of these six states increases in service even at the sub-center level have been compromised by the focus on developing the 1 per 1 lakh CHC (or block PHC). This has occurred because of a conscious policy to optimally utilize scarce human resources by pooling them to viable levels at few centers, rather than spreading them thinly. Or this has occurred because of core sub center services being transferred to higher levels, with little plans for those who are still unable to access the higher health facility. In most of these states with secondary centers now overcrowded and reeling under the pressure of institutional deliveries, attention to revitalizing the primary health center is drawing more attention.

3. All states have seen substantial increase in numbers of service providers deployed. There is now an increased awareness of sub-critical densities of human resource in the public health system, a legacy inherited from the nineties, as one of the critical reasons for the poor performance of public health systems. Along with this some states have substantially revised and improved on key dimensions of their workforce management policies whereas other states, though seized of the issues, have yet to push through the minimum necessary changes for ensuring a motivated workforce from whom performance can be demanded. One important development is a range of incentives across states to improve availability of the workforce in hitherto underserved areas. There is concern that the major part of the increases are contractual and sustainability beyond the sanctioned NRHM period would be a problem especially where states have not fully owned the essential nature of such expansion and planned for it in state budgets.

4. Expansion of paramedical, nursing and medical education is occurring in all states and there are plans for a major acceleration of this. Lack of faculty, lack of institutions and lack of resources seriously hamper this expansion. In many states almost all recruitable staff available on the open market have been taken in and unless the pool of new recruits is sharply increased further improvements even in service delivery would become critical. This is most important in the poorest performing states where existing human resource density is extremely low, and all these NRHM driven increases have not been enough to even catch up with the pre- NRHM levels of human resource availability in the high performing states.

5. Quality of care and preparedness of facilities have improved. However states with better baselines like Kerala, Tamil Nadu and Maharashtra have been in a position to make quicker use of untied funds and the state and district planning process for addressing these issues. Though there have been significant improvements in infrastructure, drugs, diagnostics, sanitation and hygiene, dietary arrangements etc in the high focus states the rapid increase in utilization, especially the rise of institutional deliveries tends to outpace the relatively much slower rate of expansion of infrastructure, human resource and supplies. Addressing this would require even more flexibility in funding along with better management arrangements at the state and district level.

6. Induction of management skills, IT skills and accounting skills in a major way into every state and district level has improved the management of programme significantly. Fund flows have increased with computerization of accounting and bank transfers of funds at most levels. However states have shown very varied progress in setting up institutions that are needed to improve management and drive the process of architectural correction. This is particularly a problem in the area of procurement and logistics (where TNMSC is a national benchmark), in infrastructure development (where the Gujarat PIU is a benchmark) and in the area of technical assistance (the planned SHSRCs) and in the area of training institutions (the SIHFW equivalents and the pyramid of institutions below them).

7. ASHA programme has expanded on the ground to cover all the high focus states except Himachal Pradesh and Jammu and Kashmir, and is now being expanded to cover the entire nation. The ASHA has emerged as an enthusiastic community health worker whose effectiveness and live contact with the public health system is sustained through the JSY and her role in the village health and nutrition day/immunization session. Most states are working on improving their support systems, improving the quality and frequency of training, regularizing payments, refilling drug kits, providing special referral support and expanding the incentive package. As these steps come into place the programme can be expected to pick up and provide a much higher level of outcomes. Most other dimensions of community participation - the village health and sanitation committee, the community monitoring programme, the public participation in *rogi kalyan samiti* and district health

societies are showing good potential but in many states it is too early to comment as they are only in the take-off stage. There is scope to increase NGO participation in the ASHA programme and in strengthening other community processes.

8. Systemic inadequacies are affecting all vertical programmes, the most important of these being the poor densities of functional health facilities and consequent low human resource densities in the low performing states. In addition immunization continues to be affected by poor logistics. The efforts at integration, especially by using the district plan process to address systems – programme linkages could be strengthened.

9. Most planning for fully functional facilities or achieving IPHS norms focus on the RCH components. Other health care needs like management of acute illness, so critical to disease control programmes, of trauma, and of non communicable disease are not as yet getting the importance due to them in planning, in resource allocation, in human resource planning or in monitoring. There is a need for high performing states to show the way forward in these areas. There is a need for these states to develop models of integration of these concerns that could represent up to 80% of morbidities, into the district plan.

10. Hospital Development Societies are in place in all district, divisional and block hospitals and in most PHCs. These societies are functional and are an effective vehicle for untied funds and to some extent of improved facility level management and this has substantially contributed to improving quality of services. Much needs to be done however to make them more conscious of their role in safeguarding equity, along with quality of services, and to reduce their image as merely being a vehicle for user fees. The problems of user fees are poorly appreciated by both facility level service providers and these societies. However problems like lack of exemptions for the poor, non utilization of certain services, exclusions are present and were evident to the visiting mission teams.

11. Decentralisation in terms of devolution of governance powers to *panachyats* continues to be a challenge. However progress has been made on involving *panchayats* in the structures of the mission - VHSCs, hospital development committees and in district health societies. Capacities for district planning have improved substantially but the process is hampered by lack of information about the resource envelope available against which the district plan is made and a failure of states to release moneys to districts according to the approved district plan and to use the district plan as the instrument of programme review.

12. A wide variety of non governmental partners have been involved in provision of services or strengthening of the programmes. For the large part they are not-for-profit agencies who are reaching out to underserved areas through different contracting arrangements. In a few states like Bihar there is outsourcing of ancillary hospital services to local agencies and individuals against a standardized agreement. Though these are all useful supplements to the public health system there is no generally replicable model that has been seen in the states visited. In all cases of partnership, even where it is a reputable not-for-profit group involved, there is a need to have an independent monitoring mechanism in place, and careful assessment and construction of financing arrangements so that services are appropriately budgeted and sustainable and for all of this there needs to be sufficient district and state capacity.

Recommendations:

1. Work with states to finalise a clear nomenclature for the different facility levels and their hierarchical relationships to each other. This is a major constraint in planning, financing and monitoring.

2. Work with states to contextualize IPHS guidelines so as to be able to plan and set meaningful annual targets for improvement in a phased approach to reach the goal at every facility level. Also to contextualize so that service priorities under IPHS reflect the epidemiological profile in each state.

3. Renew attention on strengthening the PHC. In most states this would be based on achieving the IPHS norms in human resources for PHCs, but in states with a human resource crunch, alternative human resource management strategies based on multi-skilled paramedics would be needed.

4. Improving the quality of care and comfort of stay for the in-patients in the public hospitals especially at the secondary level, through clean toilets, fresh linen, and a friendly environment. Over time move to a system of ensuring quality improvement in all public health facilities.

5. Mainstreaming AYUSH not merely mainstreaming the AYUSH provider: Provide users with a greater choice of services by having the AYUSH service provider, and not use them as additional allopathic curative care providers.

6. Where an AYUSH doctor is being used as a substitute to a MBBS medical officer, there is a need to specify through standard protocols the level of care that can be provided by them and provide them with the training and legal framework to provide such care.

7. There is a need to urgently strengthen the ASHA support system. This includes a state level resource team capable of developing further state specific material needed and well trained and supported district and block level teams of facilitators and a system of monitoring. Streamlining of payments also needs to be strengthened and its base widened by allowing a larger number of activities to be incentive based.

8. Enhance community participation, especially representatives of user groups in the hospital development committees (*rogi kalyan samitis*), and transform their image from being a vehicle of user fee collection into an organization charged with addressing equity and quality issues.

9. Activise the formation of village health and sanitation committees and strengthen facilitation systems for this. In particular NGOs could play a major role in this.

10. Simplify the current process of community monitoring and broad base the programme participants and expand on it.

11. Improve coordination between the health mission and the directorates in the states and increase training and support inputs to directorate staff so that they are able to participate and eventually lead in the process of change and revitalization of public health systems.

12. Work with state governments to start up 3 management organizations/ arrangements of minimum design specifications immediately – one of these being for procurement and logistics, another for infrastructure and the third for technical assistance (the SHSRCs).

13. Improve the quality of public health management through the development of a public health sector management cadre, expansion of public health education including in-service skill training and improved human resource development policies for health administrators.

14. Make improvement of workforce management policies one of the cornerstones of good governance in the states and support states to move to evolve and implement commonly agreed to policies in this regard.

15. Assist and support states to draw up and implement plans to revitalize their SIHFWs or equivalent organization and other training institutions in the states so as to ensure that in-service skill upgradation meets the quality and pace required to improve service delivery.

16. Assist and support states to draw up and implement state specific human resource development plans to expand with quality medical, nursing and paramedical education, such that the needs of the public health system are prioritized and met within the shortest time possible.

17. Build a national plan linked to the above to take on the responsibility of developing faculty and quality assurance systems for this rapid

expansion in medical, nursing and paramedical education.

18. State spending on human resource component should expand, so as to slowly take in the new positions being created under NRHM. This is essential for sustainability, for better work force performance and as part of states commitment to increased public health expenditure. A wider and innovative set of incentives must be tried out and then institutionalized for attracting and retaining skilled personnel in difficult areas.

19. Link district plans to resource envelopes available for districts and also develop the practice of revising the plan document after sanction and based fund allocation and review on this.

20. Develop the district plans further so that this is used to rationalize, infrastructure and human resource and financial resource deployment to match utilization patterns of different facilities and areas.

21. There is a need to ensure, that there is a proportionate allocation and expenditure of funds for accelerating non JSY dimensions of RCH that would prepare the facilities to deliver quality services as well as address all issues of women's health. In parallel the facilities need to be prepared for addressing neonatal care and meeting felt needs of contraception.

22. The NRHM's emphasis on human resource development should take the needs of the disease control programmes into account. Even in key district level management positions there are shortages of staff. Integration of disease control programmes and IDSP in the district plan in a technically meaningful manner is essential for improved outcomes in many programme, but especially in vector control.

23. While immunisation programmes have been given attention in states with regards to outreach and fixed day immunization services, gaps in availability of vaccines and issues in cold chain management seem to have adversely affected progress in the current year.

24. Progress beyond planning for RCH service delivery in primary and secondary facilities to plan for addressing emergencies, acute illness and even chronic illness into primary and secondary health care and through the development of appropriate referral linkages and human resource development and deployment strategies such that all the facilities within a district become like parts of a single functional unit. High performing states on RCH parameters should take the lead on this.

25. Improve the flexibility of fund allocation to facilities within a district and to districts within a state so that funds flow to facilities and districts which use them best. This is essential to expedite useful absorption of funds. However funds needed to reach a minimum level of functioning and equity considerations within regions are kept in mind so that places already suffering for lack of human resources and sanctioned facilities are not deprived even further.

26. Engage with the private sector to provide services in thematic and geographic areas where the public system is deficient working out packages that are cost effective and transparent and subject to good monitoring practices.

27. Develop HMIS systems and capacities so that action can be taken on information derived from data analysis at the facility and at the sector, block and district level. The main challenge is the development of district level systems and capacities for use of information. The other major challenge is to be able to collect information from the private sector as well.

The full report is available for download at – *http://mohfw.nic.in/NRHM/Documents/2nd_CRM_Report.pdf*

Session 1: Prospects of sustaining leprosy control and ensuring quality care

Dr. Indranath Banerjee
New Delhi

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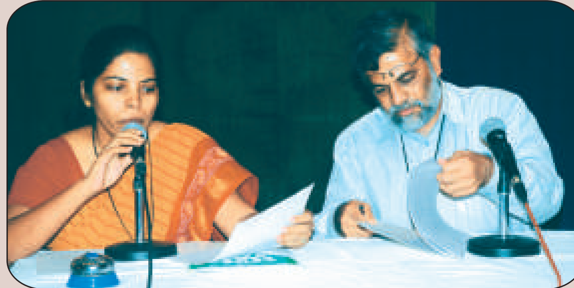
Session 2: Linkages and coordination between NLEP and NRHM



Dr. Sharmila Patil (Co-Chairman) **& Dr. P. V. Ranganadha Rao** (Chairman)

Dr. P. R. Mangalani
New Delhi

Mr. Mathew George
Mumbai

Dr. Shivaram
Karnataka

Session 3: Health policy reforms and social mobilization for leprosy control under NRHM

Dr. Shrikala Acharya (Co-Chairman) **& Dr. Ashok Dyalchand** (Chairman)

Dr. Anil Kumar
Uttar Pradesh

Dr. P. S. Rajkumar
Andhra Pradesh

Dr. Ravi D'souza
Chhattisgarh

Dr. Rashmi Shukla
Uttar Pradesh

Dr. S. C. Pandey
New Delhi

Panel discussion: Sustaining leprosy control and improving quality of services under NRHM

(R-L) Dr. Samuel Sugumaran, Dr. R. Ganapati, Dr. P. V. Ranganadha Rao, Dr. Indranath Banerjee, Dr. Ashok Ladda, Dr. P. R. Mangalani and Mr. A. Antony Samy

Accredited Social Health Activists (ASHA),

an educated female community level volunteer,

will be responsible for awareness building about village health rights,

the implementation of various national health and family welfare programmes

at the village level and for providing first contact minimum health care,

together with appropriate referrals.

Source: National Rural Health Mission : Reaching the needy, Government of India, 2005