NLEP TECHNICAL SUPERVISION OF MAHASAMUND DISTRICT.

Mahasamund district population 1088879(august 2012). District has 5 CHCs, 15 PHCs & 149 SHC. RLTRI officer visited following 4 CHCs, 3 PHCs & 5 HSCs depending on feasibility & approachability.

Sr NO.	CHC	PHC	HSC
1	Basna	Chanat	Ajgarkhar
2	Saraipali	Baloda	Chiprikona
3	Pithora	Bhitidih	Kisdi
4	Mahasamund		Sirboda
5			Kishanpur

EPIDEMIOLOGICAL PROFILE

PREVALENCE RATE (PR) - 3.58. New Case Detection Rate (NCDR)- 85.50. MB RATE - 53.34. Total no. of new cases of leprosy detected in present year is 931, out of which 433 were detected between April2012 to September 2012. As of September 2012 total of 521 cases are under treatment. Total RFT cases as of September 2012 are 294. Total no. of new child cases detection in current year are 65.Total new female cases detected in current year is 356. Total no of new cases with visible deformity is 43 in current year. The TREATMENT COMPLETION RATE (TCR) IN 2011-2012 was 96.26% for MB cases & 92.81% for PB cases. Total no of cases with Gr I deformity are 19 & of Gr II are 43. Total no of cases screened for RCS is 49 & Reconstructive surgery (RCS) done was 32.

SKIN SMEAR FACILITY- Not available.

HUMAN RESOURCES- There is a scarcity of human resources at all levels.

Sr. No	Designation	In position	Sr. No	Designation	In position
1	Medical officer	45	6	Health supervisor(female)	19
2	Specialist	06	7	MPW(male)	215
3	Nurse	33	8	MPW(female)	237
4	ANM	237	9	Lab technician	20
5	Health supervisor(male)	13	10	Physiotherapist(technician)	1

DISTRICT NUCLEUS TEAM (DNT) t.

DLO (in charge, appointed afresh in May 2012) along with NMS usually is involved in case validation. Details of these validations, confirmation and discrepancies were not available for evaluation at the time of visit .No details or records regarding cases sent by ASHA (Mitanin) were available for evaluation. Advance tour programme of DNT is available. Facilities for treatment of cases, reaction, and neuritis are available in all the health facilities of district.

DISTRICT HOSPITAL DURG

(A.) VALIDATION:-All cases are seen primarily by NMA. Majority of the cases are diagnosed by NMA with or without the supervision of MOs/RMAs. All staff concerned with management of leprosy has received training. NMA has sufficient skill for diagnosis, but lacks the sufficient knowledge for managing reaction & neuritis. MOs & other doctors seem less interested in leprosy management as evident by the fact that leprosy cases are managed at separate counters (room), exclusively by NMAs who examine, evaluate, validate cases, provide MDT & maintain formats & registers.

(B.) RECORDS & REGISTERS: - Only LF1, LF2, LF3 & P2 are available, other formats are not available .Records are not updated regularly & are not supervised by MOs. Many columns are left blank & many are filled incorrectly. WHO grading is not recorded in the formats.EHF Score is not mentioned.

(C.) REACTION MANAGEMENT: - Prednisolone is scarcely available. Prednisolone is locally purchased and distributed evenly in CHCs & not according to no. of under treatment cases of reaction & neuritis. Amount of Prednisolone available is disproportionate to the the no. of reaction patients. MOs, RMAs are not well versed in diagnosis & management of reaction & neuritis. Cases are referred directly to RLTRI for management.

(D.) HEALTH EDUCATION: - No facility is available.

(E.) ULCER CARE: - Ulcer care kits are not available for patients.

(F.) ASHA (MITANIN): -According to NMAs a few cases are sent by ASHA, details of which are not documented separately at district level. Standard incentives given to ASHA for confirmed cases are still pending.

(G.) PHYSIOTHERAPY:-Recently physiotherapist has been posted at district hospital Mahasamund. She has an advance tour programme. She visits one day per block, to evaluate cases.

(H.) PHARMACIST: - Pharmacist is not aware of MDT guide lines.This is managed by NMA.

(B.) LOGISTICS : - 1.) MDT:-As of September 2012 stock position is as under :-

MDT STOCK	PATIENTS	MDT BCP	BCP/MONTH
MBA	335	1140	3.40
MBC	12	38	3.16
PBA	171	608	3.55
PBC	19	74	3.89

2.) MCR FOOTWARE: - List of beneficiaries/patients requiring MCR is not prepared. Recently in September 18 pairs were ordered randomly.

3.) GOGGLES: - Not available in Mahasamund District.

4.) PHYSIOTHERAPY:- Physiotechnician is posted recently in Dist hospital Mahasamund. Separate physiotherapy room has been allotted. On interview told that instruments needed (splints, casts, physiotherapy apparatus) are yet to be purchased.

(C.) REFFERAL & DPMR SERVICES: - No systematic referral system is in place. Almost all the cases needing referral are sent to RLTRI, Raipur for evaluation, reevaluation, reaction & neuritis & Prednisolone therapy. Patients are referred to RLTRI for RCS either on elective basis or camp basis. Reconstructive surgery (RCS) done in 2012 is 32, all done on camp basis at district hospital Mahasamund from 12th March to 15th March.

(D.) DISTRICT ACTION PLAN:-No action plan is available. All the reports are conveyed to DLO office directly. No training calendar is prepared for running year. Just casual talks are delivered in PHC & sector meetings.

(E.) IEC ACTIVITIES: - District Mahasamund conducted a massive IEC/active search campaign by the name KUSHT MUKTI MAHAABHIYAN in April 2011 which included miking, banners, posters, wall paintings, pamphlets, kala jathha, Manav shrinkhala(human chains) for spreading the message that any person having patch should visit nearest health centre for examination on particular mentioned date. This was done on 7th April 2011.Total of 1064426 population of District Mahasamund 906791 people were screened, 6033 suspects were identified, out of this 322 new cases validated 120 were MB cases & 202 were PB cases.

(F.) MAHASAMUND URBAN:-The distribution of health care staff (ANM) is disproportionate. For a population of 60036 only 4 ANMs are posted. This hampers the regular follow up of cases. ANMs visiting in field are not aware of the counseling points for patients.

NLEP OBSERVATION CHC

FOUR CHCs of Mahasamund district namely BASNA, SARAIPALI, PITHORA & MAHASAMUND were visited. Salient observations are as under:-

(A.) DIAGNOSIS: - At all the surveyed blocks **majority of the cases are diagnosed by NMA** with or without the supervision of MOs/BMO/RMAs. All staff has received training. NMA has sufficient skill for diagnosis, but lacks the sufficient knowledge for managing reaction & neuritis. MOs seem less interested in leprosy management as evident by the fact that leprosy cases are managed at separate room, exclusively by NMAs who examine, evaluate, validate cases, provide MDT & maintain all formats & registers.

(B.) VALIDATION:-Is done by NMA most of the time, occasionally looked over by MOs.

(C.) RECORDS & REGISTERS: - Only LF1, LF2, LF3 & P2 are available, other formats are not available .Records are not updated regularly & are not supervised by MOs. None of the MOs/RMAs are thoroughly aware of DPMR formats, Deformity Grading, EHF Score.

(D.) MDT MANAGEMENT: - MDT indent is prepared by NMA. Stock registers (LF3) are available in all survey CHCs, but are not properly maintained at .MDT procurement is not in accordance with the standard guideline.

(E.) REACTION MANAGEMENT: - Number of reaction cases is disproportionately low relative to the no. of under treatment cases. Prednisolone is scarcely available in all the surveyed CHCs. **MOs, RMAs are not well versed in management of reaction & neuritis.** Cases are referred directly to RLTRI for management. None of the MOs/RMAs are thorough enough to diagnose & manage neuritis.

(F.) REFERRAL & DPMR: - No facilities are available in all the surveyed blocks. No trained MOs, physiotherapists & other health care staff available. No MCR Footwear, Goggles, is available. DPMR formats are not properly maintained. WHO grading of GrI & GrII are not evaluated strictly and documented on successive visits. Health care staff is unaware of EHF SCORING and the same is not documented. Cases are referred directly to RLTRI for RCS & management.

(G.) DISABILITY & SELF CARE: - Records are not up to date .Disability management is only restricted to providing antibiotics and betadine to ulcer patients, referring others to higher centers.

(H.) HEALTH EDUCATION: - No facility is available.

(I.) ASHA (MITANIN): -According to NMAs cases are sent by ASHA, details of which are not documented separately. A plain paper slip is attached with individual patient card, with the name of ASHA written on it. Separate list of cases sent by ASHA was available in CHC SARAIPALI.

(J.) IEC ACTIVITIES: - limited to wall paintings as slogans .No banner, posters, and pamphlets audio-visual media is available.

(K.) FOLLOW UP:- Not regularly & efficiently practiced. Patients are only provided with MDT, no regular counseling, monitoring, supervision is done resulting in neglected neuritis, reaction with sinister sequelae as evident in field visit in a neglected adolescent female MBA patient who developed deformity.

(L.) No involvement of pharmacist is noted in leprosy programme.

NLEP OBSERVATION PHC

3 PHCs namely CHANAT, BALODA & BHITIDIH were visited. Salient observations are as under:-

(1.) DIAGNOSIS: - Post of NMA is vacant in PHC Bhitidih & PHC Baloda. All the cases in these two PHCs are referred to respective CHC for diagnosis & treatment. Majority of the cases are **diagnosed by NMA with or without the supervision of MOs/RMAs**. All staff has received training. NMA has sufficient skill for diagnosis, but lacks the sufficient knowledge for managing reaction & neuritis. MOs/RMAs seem less interested in leprosy

management as evident by the fact that leprosy cases are managed at separate counters (room), exclusively by NMAs who examine, evaluate, validate cases, provide MDT & maintain all formats & registers. MOs/RMAs have insufficient knowledge for proper guideline bases management of cases.

(2.) VALIDATION:-Is done by NMA most of the time, occasionally looked over by MOs.

(3.) RECORDS & REGISTERS: - Only LF1, LF2, LF3 & P2 are available, other formats are not available .Records are not updated regularly & are not supervised by MOs/RMAs.

(4.) MDT MANAGEMENT: - MDT indent is not available. Details of stock registers (LF3) are available in all survey PHCs, but are not properly maintained.MDT procurement is not in accordance with the standard guideline.

(5.) REACTION MANAGEMENT: - Prednisolone is not available in all the surveyed PHCs. MOs, RMAs are not well versed in management of reaction & neuritis. Cases are referred directly to RLTRI for management or to other higher centers.

(6.) REFERRAL & DPMR: - No facilities are available in all the surveyed PHCs. No trained MOs, physiotherapists & other health care staff available. No MCR Footwear, Goggles, is available. DPMR formats are not properly maintained. WHO grading of Gr I & Gr II are not evaluated strictly and documented on successive visits. Health care staff is unaware of EHF SCORING and the same is not documented. Cases are referred directly to RLTRI for RCS & management.

(7.) DISABILITY & SELF CARE: - Records are not up to date .Disability management is only restricted to providing antibiotics and betadine to ulcer patients, referring others to higher centers.

(8.) HEALTH EDUCATION: - No facility is available.

(9) ASHA (MITANIN): -According to NMAs a few cases are sent by ASHA, details of which are not documented. **Standard incentives given to ASHA for case sending are pending since about a year.**

(9.) IEC ACTIVITIES: - These are only limited to wall paintings as slogans .No banner, posters, and pamphlets audio-visual media is available.

(10.) 2 Medical officers & 8 Rural medical assistants (RMAs) were interviewed during visit in PHCs. Following is the report.

Sr. no	Particulars	1	2	3	4	5	6	7	8	9	10
1	Find difficulty in diagnosis	no	no	no	No	No	No	No	No	No	No
2	Knowledge of lepra reactions	yes	yes	yes	Yes/ incomplete	Yes	yes	Yes	No	No	No

3	Are managing neuritis/re—actions	no	no	no	No	No	No	No	No	No	No
4	Aware of disability grading	yes	yes	yes	Yes	Yes	No	No	No	no	no
5	Leprosy training done	yes	yes	yes	Yes	Yes	yes	Yes	Yes	Yes	Yes
6	Heard of SIS	yes	yes	yes	Yes	yes	yes	Yes	Yes	No	No
7	Knows NLEP guidelines correctly	no	no	no	No	No	No	No	No	Yes	Yes
8	Activities discussed in meetings	yes	yes	yes	Yes	Yes	yes	Yes	Yes	Yes	Yes
9	Aware of RCS facilities	yes	yes	yes	Yes	yes	yes	Yes	Yes	Yes	Yes
10	Aware of RCS incentives	yes	yes	yes	Yes	no	No	No	Yes	No	No
11	Aware of patient counseling points completely	no	no	no	No	no	No	No	No	no	no

NLEP OBSERVATION HSCs

(A.) 5 HSCs were visited namely AJGARKHAR, CHIPRIKONA, KISDI, SIRBODA & KISHANPUR. Salient features are as under:-

(1.) RECORDS & REGISTERS: - Patient cards are available. Disability grading is often missed. No separate registers for referral, disabled persons are there.

(2) SELF CARE: - Self care management is only restricted to providing antibiotics and betadine to ulcer patients, referring others to higher centers.

(3)HEALTH EDUCATION: - Patients are not being counseled regarding the disease, its course, prognosis, therapy, hand foot & self care.

(4)ASHA (MITANIN): -According to ANMs/MPWs a few cases are sent by ASHA, details of which are not documented.

(5)IEC ACTIVITIES: - These are only limited to wall paintings as slogans, mostly washed off by rain .No banner, posters, and pamphlets audio-visual media is available.

(B.)INTERVIEW OF COMMUNITY MEMBERS: - The team interacted with common people & interviewed about their view, knowledge about leprosy & attitude towards persons affected with leprosy. Approximately 40 people from community in visited HSCs were interviewed. They have heard of leprosy, but are not fully aware of sign/symptoms of disease. Many approach local practioners & quacks. Only a few are aware of MDT, but not of the prognosis of disease. Stigma of disease is high.

(c.)INTERVIEW WITH ASHAs: - The team interacted with many ASHAs in the villages during HSCs visit. Approximately 20 ASHAs were interviewed. Salient features are as under:-

1.) ASHAs have undergone regular episodes of training in leprosy.

2.) ASHAs cannot tell with clarity the cardinal signs & symptoms of leprosy.

3.) ASHAs are not aware of the prognosis of leprosy.

4.) ASHAs are not able to suspect cases of neuritis & reaction for referral to higher centre for treatment as per NLEP guideline.

5.) ASHAs don't have general referee book. Hence she is unaware of cases referred.

6.) ASHAs are not able to give proper counseling & health education to persons affected with leprosy.

7.) ASHAs are not getting incentives timely for sending cases of leprosy, which may be one of the source of disinterest.

(D.)INTERVIEW WITH MPW/ ANMs: - In all the surveyed HSCs ANMs/MPWs were interviewed. 4 ANMs & 4 MPWs were interviewed. Salient features are as under:-

1.) They have undergone regular episodes of training in leprosy.

2.) They cannot tell with clarity the cardinal signs & symptoms of leprosy.

3.) They are not aware of the prognosis of leprosy.

4.) They are not able to suspect cases of neuritis & reaction for referral to higher centre for treatment as per NLEP guideline.

5.) They are not completely aware of the counseling points for patients regarding MDT, prognosis of patch, numbness, its sequel & its prevention.

(E.)INTERVEIW WITH PATIENTS:- - In all the places visited team interacted with patients & interviewed about their view, knowledge about leprosy & attitude towards persons affected with leprosy. Approximately 25 patients from community in visited HSCs were interviewed.

1.) Most of them heard of leprosy only when they enrolled for treatment.

2.) They cannot tell with clarity the cardinal signs & symptoms of leprosy.

3.) They are not aware of the prognosis of leprosy. None of them were counseled at the starting of treatment.

CONCLUSION

1.) At all the visited & surveyed health facilities only **NMA is predominantly involved in examining, validating, providing MDT, maintaining records, with unsatisfactory involvement of other health care** staff including medical officers/RMA.
2.) NLEP staff is attached in other health care, office activities. This hampers the regular activities of leprosy programme.
3.) There is a **lack of interest of general health care staff including doctors in management of leprosy patient's** .Leprosy patients are examined, evaluated, provided MDT from isolated counters/room, and managed almost exclusively by NMA, with little or no supervision of doctors. **The pharmacist is not involved in MDT management**.
4.) At all the surveyed health care facilities record keeping was unsatisfactory .
5.) Prednisolone is not available. Of patients seen in field visit some were with grade I deformity, which was not mentioned in their cards, this indicates incomplete patient evaluation. None of the health care staff interviewed were aware of EHF SCORE.
6.) MOs/RMAs are unaware of DPMR formats & guidelines.
7.) IEC activities are unsatisfactory for mass community awareness. Patient counseling is very poor due to lack of knowledge of proper counseling points of the health care staff.
8.) ASHA involvement in case finding, referral, patient counseling is poor. Incentives for case finding are not provided promptly.
9.) DPMR activities are grossly unsatisfactory, due to lack of trained staff & poor involvement of the existing staff.MCR foot ware; goggles are not available.
10.) There is no advanced training calendar & schedule for health care staff.
11.) Community awareness about leprosy, Its course, prognosis of patch, numbness its sequelae & its prevention is very poor & the resulting stigma remains high.