NLEP Technical Supervision of Kawardha District of Chhattisgarh state

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Purpose and objectives of the Visit: **RLTRI** officer visited Kawardha District for monitoring of NLEP activities during 10th to 14th September 2012. Kawardha is one of the leprosy endemic district having Prevalence Rate >1 PER 10.000 Population with ANCDR (Annual New case detection rate) more than 10. The purpose of the visit was to assess the NLEP situation in the district to identify the existing gaps, put suitable suggestions to improve the programme performance to achieve sub national elimination and also assess the DPMR activities.

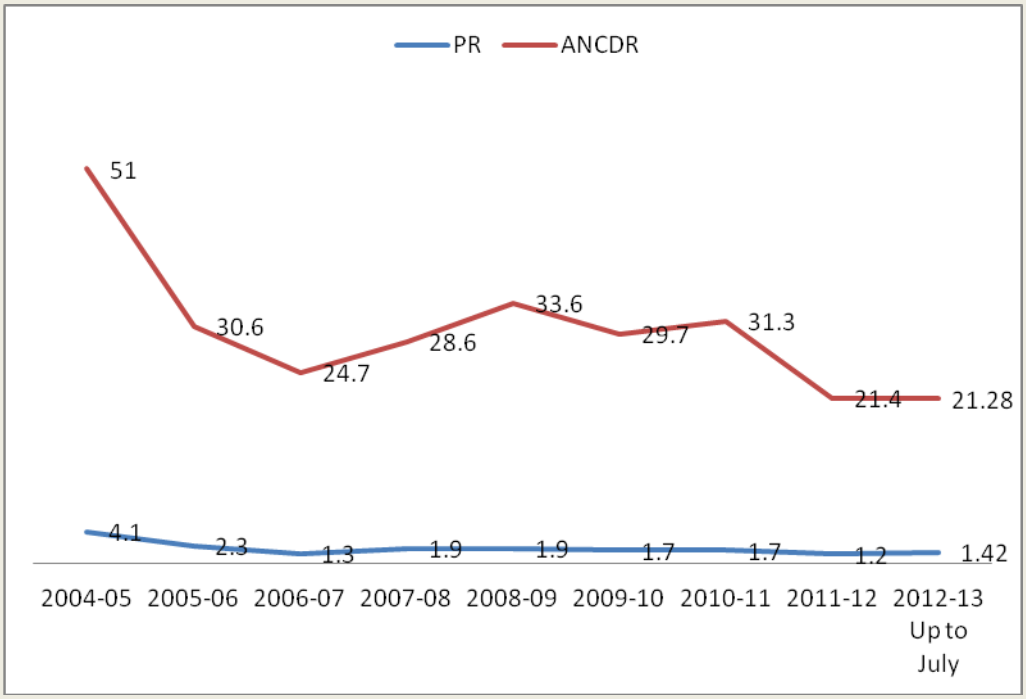
About district: According to the 2011 census Kawardha district has a population of 822,239. This gives it a ranking of 479th in India (out of a total of 640). The district has a population density of 195 inhabitants per square kilometre (510 /sq mi). Its population growth rate over the decade 2001-2011 was 40.66 %. Kawardha has a sex ratio of 997 females for every 1000 males, and a literacy rate of 61.95 %. A total of 981 villages and 389 gram panchyat were in the seven blocks of the district.

Sampling: Three blocks (Out of 4) were randomly selected, one Primary Health Center and Health subcenter from each selected blocks was included based on the approachability and operational feasibility. All the officials and paramedical health staff was interacted and verified by available record and reporting. ASHA and community voluntaries at village level were interacted regarding NLEP activities. The information regarding NLEP was collected in the predesigned checklist developed facility wise based on it's functioning.

Sr No	Block Community Health Centers	Primary Health Centers	Health Subcenter
1	Pandhariya	Kunda	Ruse
2	Bodla	Podi	Khairbane
3	S.Lohara	Oriyakala	Maharatola

The DPM at District and BPM at Blocks were also interacted for their involvement in the NLEP programme.

Epidemiological Aspects of the NLEP of the Kawardha District:



Above chart showing the PR (Prevalence rate) remains above 1 per 10,000 since year 2006-07. There was not much fluctuation in the Prevalence and annual case detection rate since long. MB proportion ranges from 34 to 46% of the total and child proportion from 6 to 16%. Female proportion cases are constantly below 40%. The grade II disability cases among newly detected cases ranged from 4 to 7% from year 2004 to till date.

S.No.	Name of Blocks (CHC)	Total villages	Cases detected No of Villages	Villages have no cases	Position of Under Treat. Up to Aug.12	
					Villages. Having one case	Villages have >1 cases
1	Kawardha	184	70	114	26	10
2	Bodla	314	39	275	8	2
3	S.Lohara	198	50	148	16	3
4	Pandariya	285	60	225	20	3
Total		**981**	**219**	**762**	**70**	**18**

Out of 981, 78% of the villages had no case of leprosy since last 3 years, only 22% of the villages having one or more than one cases. Out of total 24 sectors in the

districts only 5 sectors are free of leprosy cases remaining 19 sectors having leprosy cases.

THE SALIENT NLEP OBSERVATIONS OF THE HEALTH FACILITIES ARE AS FOLLOWS-

A) District Nucleus team (DNT):

Presently there is **NO District programme officer i.e. DLO**. The chief medical and health officer is looking NLEP programme after retirement of DLO. Actually the Physiotherapy technician and NMS are looking the whole functionaries of the Programme.

Less involvement of DPM was noted in the review of NLEP programme. Case validations of the neighboring blocks were done by the NMA and Physiotherapist. Skin smear facility was not available at district hospital and whole district.

1. There is no mobility support for Monitoring and Supervision of whole district
2. No Vehicle and Fuel for DNT mobility in field.
3. Currently Pandariya Block having more disability cases
4. Kawardha Block had Child disability cases
5. Leprosy cases having more 96 villages out of 1009 villages
6. Out of 24 sectors only 3 sectors having disability cases > 10 case
7. 5 sectors had no Leprosy cases since last 3 year

MDT management: The MDT is kept by DNT and available as per guidelines. Based on the indent received from pheripherial health institute prepared by NMA, the DNT staff provides the MDT to the PHI. The loose Clofazimine tablets are available but utilization was not available.

Self Care Kits: **No self care kits** purchased and provided since last 2 years. Only 135 numbers self care kit Received on 01.06.09. The district nucleus team as well as District programme manager (DPM) not aware of the budgetary provision of self care kits in PIP.

MCR:-90 Pairs MCR pairs were received on 10.07.09 and 30 Pairs received on 07.07.10. As per demand received from block the MCR are distributed.

Leprosy cases confirmed by DNT: **There is no Medical officer in DNT. The NMA and physiotherapist are confirming leprosy. The details of the cases confirmed are as follows:**

1) In year 2010-11 ,94 case out of 210 cases confirmed by team - **44%**
2) In year 2011-12, 76 cases out of 148 cases -**51%**
3) In year 2012-13, 55 cases out of 103 cases -**53%**

The CMO should appoint the Medical officer of DNT for proper functioning of the NLEP activities at district level.

Training: The NLEP training calendar for different general health care staff of current year was not available or prepared by the District. Since year 2010, NLEP training has not been imparted to the General health care staff. The RMA and medical officer's needs to be trained for proper management of the leprosy cases at the peripheral health facility.

TCR (Treatment Completion rate): The treatment completion rate of the district was more than 95% since many years. The officer interacted with the DNT Staff regarding calculation of the rate and selection of correct Cohort group. The officer observed that they are using wrong cohort period for calculation of TCR for PB and MB groups since many years. The officer shows the correct procedure to select and calculate correct TCR.

RCS: The eligible RCS cases were referred to tertiary leprosy institute (RLTRI) for RCS. The list of no of patients screened for RCS during current year was not available at district nucleus team.

Fund Utilization: Fund utilization details under NLEP were not available with available staff of the DLO office.

Involvement of ASHA IN THE NLEP PROGRAMME:

Year	New case detected	Confirmed by DNT	%	Detected by Mitanin	%	Confirmed at CHC & others	%
2008-09	225	137	60.9	0	**0.0**	88	39.1
2009-10	202	102	50.5	8	**4.0**	92	45.5
2010-11	210	94	44.8	5	**2.4**	111	52.9
2011-12	148	76	51.4	0	**0.0**	72	48.6
2012-Aug.	103	55	53.4	2	**1.9**	46	44.7

Above table depict that 40 to 60% of the leprosy cases were confirmed by DNT team while nearly about 50% were confirmed by Block level NMA/ MO during 2008 to till date.

ASHA involvement in the NLEP is poor in the district since 2008. Efforts should be taken so that each new case comes /refer by ASHA by imparting reorientation training and develop necessary skill for appropriate suspect and refer to nearest health centers. All the mitanins are receiving the monetary benefits from corresponding blocks under the programme after the leprosy cases referred by the Mitanin are diagnosed as confirmed leprosy cases.

B) COMMUNITY HEALTH CENTER (BLOCKS)

The officer visited three blocks and has interacted with the block medical officer, BPM, NMA/NMS, RMA etc at community health centers. The logestics related to the programme were assessed.

1. All the suspected leprosy **patients have to travel to block for confirmation** and after confirmation they are referred to concerned health facilities for further treatment. The NMA/NMS of the blocks are confirming the leprosy cases instead of medical officer except Pandaria. The dosage of the steroids were also decided by the NMA and referred back to concerned health facilities for further treatment. **The RMA posted at community health centers are unaware of the correct diagnosis of leprosy in the visited surveyed health** facilities. They are also not aware of the diagnosis of reactions and management of reaction with dosage of steroid. The knowledge regarding the disability grading is not upto the mark among interacted RMAs in the surveyed Community health centers.
2. DPMR Records are not filled by the medical officer. P II forms are not also prepared except Pandaria. P II forms of the newly diagnosed patients were filled by NMA.
3. **The Pharmacist is not keeping the MDT drugs**. **MDT drugs are kept by NMA** & indent is prepared by the NMA himself.
4. **MO is also not aware of the DPMR activities.**
5. **Grade I and II disability register not** maintained at Block level except Pandaria.
6. MCR Chappal record was not available in the stock except Pandaria.
7. Monitoring and supervision at block and sector is poor. The record keeping was poorly maintained at Pandaria and Bodla blocks. The NMA was involved in the sundry responsibilities at blocks.
8. IEC materials are not displayed in the CHC. But slogans are written on the wall.
9. Prednisolone available at CHC and regulated by NMA. PIII registers are not filled at Bodla and Pandaria CHC while filled properly at S lohara CHC.

10. Newly suspected Leprosy patient are referred by ASHA (Mitanin) but confirmation record was not available at CHC.

11. The record of incentives received and distributed was not available.

12. The Epidemiological indicators were unavailable at BLOCK.

13. The record of self care kits distributed and received not available. The lists of RCS eligible patients are not prepared.

14. The programme was running in vertical setup at block level in the surveyed health facility. The quality of care was hampered due to non-availability of diagnosis at PHC level, patient has to travel to the block for confirmation. The patient has to bear the cost of conveyance from his place of residence to the block.

15. Block program manager are totally unaware of the leprosy activities and epidemiological picture in the block.

C) PHC OBSERVATIONS:

The state is adopting the strategy of deploying RMAs in PHCs and relocating MOs to CHCs. There is need for capacity building of RMAs in program management and clinical care.

Six RMAs in 3 Surveyed PHCs were interacted regarding the NLEP programme. **They are unable to diagnosis and classify the cases of the Leprosy.** They refer the suspected cases to the block NMA for diagnosis and treatment. There is no record and reporting at Primary health centers. The daily OPD attendance of the surveyed PHC running by RMA is less than 25.

1. DPMR records are not filled by Rural Medical Assistant (RMA).
2. RMAs are unaware of WHO Disability Grading & DPMR activities.
3. Knowledge regarding self care practices among the RMA and supervisor is lacking and they are not aware of the list of the disabled cases under their area.
4. No proper indents are prepared for procurement of MDT by PHCs. The pharmacists are not aware of the MDT management.

5. Prednisolone is not available in any of the surveyed PHCs. Monitoring, treatment; knowledge about lepra reaction is poor.
6. IEC materials not displayed at surveyed Primary health centers.
7. Monitoring & supervision of HSCs (villages) are not done by Rural Medical Assistant.

D) HSC OBSERVATION

Three HSCs were surveyed by the team, namely. Salient observations are as under:-

1. Health care workers at grass root level (**ANMs, MPW) were having knowledge regarding the sign and symptoms**, type and duration of leprosy. They are also well aware of the referral system under integrated system of the General Health care but they are list aware of the lepra reaction and self care practices.
2. Proper display of IEC materials is lacking.
3. Awareness in all the concerned villagers (Total interview no 15) about the disease, its symptoms, treatment & its prognosis, disability prevention & rehabilitation is totally lacking. More IEC needed among the PRI and community members
4. Team has interacted with 9 mitanins (ASHA) at selected subcenter villages .They have undergone NLEP training and aware of the sign and symptoms of leprosy and referral points in the health system. The skills are lacking which needs improvement by supportive supervision and reorientation training.

Conclusions:

1) **Vacancies for DLO and DNT staff should be filled for proper functioning of NLEP in the district and Capacity building of existing District Nucleus staff** including skin smear examination facility at district hospital .Laboratory smears can be carried out by RNTCP personnel in an integrated approach through education and coordination between the two national programmes.
2) Inadequacy of trained staff at block and PHC level in the NLEP and also need for training to use DPMR formats. Knowledge and skills of RMA is inadequate for diagnosis and treatment of leprosy case and treat Lepra Reactions.
3) DPM at district level and BPM unit at Block level should involved the programme review and their involvement helps in the improvement in the programme administrative compondent and review at each level.
4) MDT and tablets Prednisolone should be kept by pharmacist as per guideline by giving proper training.
5) Give Priority and Focus on the quality of leprosy services under integrated setup.
6) All leprosy cases should be diagnosed independently by BMO/MO instead of referring to NMA by giving training to them. The Lepra reaction should be managed at PHC all patients have to travel to Block for treatment.
7) There should be programme review at district as well as block level for improvement in the prevention of disability and reduction of existing disability load. The disability register should be completed and updated time to time which was not happened in surveyed blocks.
8) Involvement of mitainin (ASHA) in the identifying and proper referral o next level for diagnosis should be improved by supportive supervision and reorientation training.
9) All leprosy cases should be validated by the DNS medical officer. Urgently appoint officer for validation.
10) BMO should take proactive role in the management of NLEP programme at Block level.

11) Recording and reporting related NLEP should be improved at all pheripherial health institutes.

12) Health education and counseling: Community still needs more aggressive health education strategy by involving village health and sanitation nutrition committee at village level. Panch prayas was implemented in the some district should be replicated in all endemic districts. Focus on the counseling to the patients on the right time in right way.

Brief Information of NLEP at district Kawardha

District	**Kawardha**		
Population	822239		
Skin smear facility	No		
New case detection rate(Last five Year)	**ANCDR**	**PR**	
April 2009- March 10	39.7 (202)	1.79	
April 2010-March 2011	31.31 (210)	1.71	
April 2011-March 2012	21.47 (148)	1.2	
Treatment Completion rate at District level			
	Rural Area	**Urban Area**	
MB	94.7 (2009-10)		
PB	98.3 (2010-11)		
Coordination with NRHM Authority	No Coordination		
DPMR			
MCR footwear procurement and distribution status			
2010-11			
PB	3 (2011-12)		
MB	17 (2011-12)		
No of patient screened for RCS RCS conducted during the year	2 (1PB & 1 MB) 2012-13 and 2MB 2011-12		
Distribution of dressing material and supportive Medicine for ulcer care	135 (Received on 01.06.2009) Distributed		
IEC activities for reduction of stigma and discrimination	Stickers, Posters and pamphlets.		
MDT stock	No of UT patient as on date	No of available MDT BCP	Per month BCP
MBA	73	169	2.3
MBC	5	14	2.8
PBA	49	76	1.55
PBC	9	27	3
Steroids	5417(10 mg) 2145 (5 mg) and Cap. Clofazimine 1066 (100 mg)		
Leprosy reaction at CHC Type I Type II	1) 2010-11 LR-I 11case neuritis 7 cases & LR-II 2 cases. 2) 2011-12 LR-I 10 cases Neuritis 2 cases & LR-II 1 case 3) 2012-13 only 2 cases LR-I		

DLO office

2. (i) Is there any district leprosy nucleus (as per PIP)? No

Category	In position	Functions
DLO / Dy CMO	0	
MO	0	
NMS	0	
PMW	1	1
Physiotherapist	1	1

5. DPM and NLEP:

District action plan		Comments
Attended meeting with DLO	NA	
Training calendar	NA	

6. Status of health facilities in the district:

Health facilities	No.	No. Providing MDT services	
District Hospital(s)[1]	1		
Block PHC/CHC[2]	4	Yes	
PHC	23	Yes	
HSC	144	Yes	

6. GHS staff trained in leprosy work:

Category (Designation)	**No. in position**	**Trained**	**Category (Designation)**	**No. in position**	**Trained**
Medical Officer[1]	NA	NA	Health Supervisor (Female)[6]	NA	NA
Specialist[2] 1.Physican 2.Surgeon 3.Ophthalmologist 4. Orthopedic. 5.OBGY	NA	NA	Multipurpose Worker (Male)[7]	NA	NA
Nurse[3]	NA	NA	Multipurpose Worker (Female[8]	NA	NA
ANM[4]	NA	NA	Pharmacist[9]	NA	NA
Supervisor (Male)[5]	NA	NA	Other specify[10] (Lab tech/ Radiographer)	NA	NA

8. DPMR (2011-2012) since 2012

	No	Managed at Primary level	Managed at Secondary level	Cases refer to primary level after diagnosed from secondary level	Cases refer to Tertiary center
Lepra reaction Type I	32 19				
Lepra reaction Type II					
Complicated ulcer	No record				
Relapse	No				
Disability Type I					
Disability Type II					
Patient provided MCR					
Neuritis					

09. No of the cases screening for RCS: 19-10, 11- 2

10. Whether BLAC /ULSAC conducted in last 2 year: Yes (2009-10 Kwardha block district

Area:

Activity:

No of cases

SAP- KAWARDHA BLOCK