NLEP TECHNICAL SUPERVISION OF DURG & BEMETARA DISTRICT(undivided durg)OF CHHATTISGARH STATE.

About District: Durg district is one of the densely populated districts of the Chhattisgarh state of India. The Durg district is situated in the southern part of the rich Chhattisgarh plain.

Its population growth rate over the decade 2001-2011 was 18.95 %. Durg has a sex ratio of 988 females for every 1000 males, and a literacy rate of 79.69 %.Situated on the east bank of river Shivnath, District Durg is herald of Chhattisgarh's Industrial Development, Cultural competence, Social harmony and Meaningful use of resources. It is a symbol of status, prestige and glory of Chhattisgarh. History of Durg is like conducive inspiration which is unique mixture of oldness and modernity, culture-rite and entrepreneurship. Bhilai known as "Mini India" for Industrial development, social harmony and cultural diversity is a twin city of Durg. Establishment of Bhilai steel plant in Durg district had created vast opportunities.

Recently (Jan 2012) Dist Durg was divided into three parts, namely Durg, Bemetara & Balod. Durg has three blocks namely Durg, Dhamdha & Patan, while Bemetara has four blocks namely Khandsara, Saja, Nawagarh & Berla. RLTRI officer visited considering Durg undivided for NLEP technical supervision. Five CHC, four PHC & six HSC in Dist. Durg & two CHC, four PHC& four HSC in Dist. Bemetara were visited depending upon feasibility & approachability.

Sampled Selection for NLEP Survey: The officer has visited the following CHC, PHC & HSC during 10- 14 September 2012. A total of 10 community members and Leprosy patients were interviewed. All information was collected in pretested proforma at different health facility level.

Sr NO.	CHC	PHC	HSC
1	Utai	Hanoda	Dhanora
2	Nikum	Ranitarai	Anda
3	Patan	Vaishali nagar	Santoshi nagar
4	Bhilai urban	Khursipar	Asoga
5	Jheet	Katai	Phunda
6	Nawagarh	Nanghat	Housing board
7	Berla	Sarda	Mehna
		Anandgaon	Kheda
			Khudmuda

Raka

EPIDEMIOLOGICAL PROFILE

(A.) DISTRICT DURG

District Durg is one of the high endemic districts of Chhattisgarh state with a population of 17, 83,387.As of August 2012,

PREVALENCE RATE (PR) is 2.62; New Case Detection Rate (NCDR) is 35.15, MB RATE of 56.83. Total no. of new cases of leprosy detected in present year is 339, out of which 193 are PB & 146 are MB cases. As of April 2012 total of 468 cases are under treatment, out of which 202 are PB & 266 are MB cases. Total RFT cases as of March 2012 are 226, out of which 138 are PB & 88 are MB cases. Total no. of child cases in current year are 23(17 PB, 6MB).Total female cases are 147(93 PB, 54 MB). Total no of cases with visible deformity (Gr-II) are 9(1 PB, 8 MB).41 are SC cases & 32 are ST cases.

The TREATMENT COMPLETION RATE (TCR) IN year 2011-2012 was 96% for MB cases & 97.67% for PB cases. In 2010-2011

Reconstructive surgery (RCS) done was 21 in 2011-2012 was 12 & in 2012 recently 2 RCS are done.

SKIN SMEAR FACILITY

Skin smear facility is not available in District hospital and other health facilities of District. Cases are referred to RLTRI, Raipur for the same & also for clinical opinion & diagnosis confirmation.

OVERALL HUMAN RESOURCES

There are 7 CHCS, 21 PHCS & 127 HSCS in DURG District. All the facilities provide services for persons affected with leprosy. There is a scarcity of human resources at all levels. As per interaction with the District Leprosy Officer & CMHO all the concerned staff has received training in leprosy.

Sr. No	Designation	In position	Sr. No	Designation	In position
1	Medical officer	61	6	Health supervisor(female)	23
2	Specialist	16	7	MPW(male)	70
3	Nurse	76	8	MPW(female)	174
4	ANM	174	9	Lab technician	22
5	Health supervisor(male)	7	10	Physiotherapist(technician)	1

DISTRICT NUCLEUS TEAM (DNT)

No DNT is in place in Durg District. DLO along with NMS usually 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. Due to scarcity of staff & lack of vehicle for movement, regular visits for follow up, validation & supervision are not done on regular basis. 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. The cases are predominantly evaluated by NMA alone. 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 in. WHO grading is not recorded in the formats.EHF Score is not mentioned.

(C.) **REACTION MANAGEMENT:** - Number of reaction cases is disproportionately low relative to the no. of under treatment cases. Prednisolone is not available. MOs, RMAs are not well versed in management of reaction & neuritis. Cases are referred directly to RLTRI for management. CMHO & DLO has advised all the health facilities to purchase Prednisolone through JDS (Jeevan deep samiti) fund.

(D.) **HEALTH EDUCATION**: - No facility is available. Patients are not being counseled regarding the disease, its course, prognosis, therapy, hand foot & self care.

(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. Standard incentives given to ASHA for confirmed cases are pending since about a year.

(G.) **LOGISTICS**: - 1.) MDT:-As of August 2012 stock position is as under clearly showing excess stock lying at district level. There is need to channelized stock in the proper way to avoid expiry.

MDT STOCK	PATIENTS	MDT BCP	BCP/MONTH
MBA	258	934	3.62
MBC	10	46	4.6
PBA	182	428	2.35
PBC	20	340	17.0

(H) MCR FOOTWARE: - Not available in last two years.

(I) GOGGLES: - Not available in Durg District.

(J**) PHYSIOTHERAPY:-** Physiotechnician is posted in Dist hospital Durg, but is not involved in care of leprosy cases, is attached to office,& has no records of neuritis, deformity(Gr I, Gr II).On interview told that instruments needed (splints, casts, physiotherapy apparatus) are not available since many years.

(K) 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, as Prednisolone is not available in health facilities & proper physiotherapy. Patients are referred to RLTRI for RCS either on elective basis or camp basis. . In 2010-2011 Reconstructive surgery (RCS) done was 21, in 2011-2012 was 12 & in 2012 currently 2 RCS are done.

(L) DISTRICT ACTION PLAN:-No proper 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.

(M) IEC ACTIVITIES: - District Durg has launched a IEC campaign by the name PEHCHAN KAHAN ABHIYAN, which included miking, a few banners, posters 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 & 1st JULY 2012. As to how many cases were sought by this activity were not separately documented. Other IEC materials included only wall paintings at secluded sights.DLO complained of lack of sufficient funding for intensification of IEC activities.

(N) DURG & BHILAI URBAN:-The distribution of health care staff (NMA) in health facilities is also disproportionate. This causes a decrease in trained resource in areas of need, especially peripheral areas, leading to patient suffering and excess in areas where case load is less. There is need to streaming the human resource as per need in special context to the NMA.

(B.)DISTRICT BEMETARA (NEW DISTRICT)

Epidemiological Aspects : District Bemetara is one of the high endemic districts of Chhattisgarh state with a population of 665538. As of August 2012, PREVALENCE RATE (PR) is 1.99/10,000, New Case Detection Rate (NCDR) is 28.09/10,000, Total no. of new cases of leprosy under treatment is 136, and out of which 72 PB & 64 is are MB cases. Total no. of child cases in current year are 10(06 PB, 04MB).Total female cases are 50(32 PB, 18 MB).No cases with deformity has been noted.

SKIN SMEAR FACILITY:

Skin smear facility is not available in District Bemetara. Cases are referred to RLTRI, Raipur for the same & also for clinical opinion & diagnosis confirmation & further management.

OVERALL HUMAN RESOURCES

There are 4 CHCS, 21 PHCS & 125 HSCS in Bemetara District. All the facilities provide services for persons affected with leprosy. There is a scarcity of human resources at all levels. The DLO incharge was unavailable during the visit. All the concerned staff has received training in leprosy management.

Sr. No	Designation	In position	Sr. No	Designation	In position
1	Medical officer	08	6	Health supervisor(female)	13
2	Specialist	05	7	MPW(male)	34
3	Nurse	NA	8	MPW(female)	79
4	ANM	NA	9	Lab technician	NA
5	Health supervisor(male)	05	10	Physiotherapist(technician)	00

DISTRICT NUCLEUS TEAM (DNT)

No DNT is in place in Durg Bemetara. As per interview with NMA, DLO in charge along with NMA usually is involved in case validation.DLO was not available during visit. 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. Regular visits for follow up, validation & supervision are not done on regular basis, as evident by the discrepancies in records of the peripheral health facilities. Facilities for treatment of cases, reaction, and neuritis are available in all the health facilities of district.

DISTRICT HOSPITAL BEMETARA

(A.) **VALIDATION:-**All cases are seen primarily by NMA. The cases are predominantly evaluated by NMA alone. 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 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.

(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.

(C.) **REACTION MANAGEMENT:** - Number of reaction cases is disproportionately low relative to the no. of under treatment cases. Prednisolone is not available. MOs, RMAs are not well versed in management of reaction & neuritis. Cases are referred directly to RLTRI for management.

(D.) **HEALTH EDUCATION:** - No facility is available. Patients are not being counseled regarding the disease, its course, prognosis, therapy, hand foot & self care.

(E.) **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.

(F)LOGISTICS: - 1.) MDT:-As of August 2012 stock position is as under clearly showing erratic distribution.

MDT STOCK	PATIENTS	MDT BCP	BCP/MONTH
MBA	55	182	3.3
MBC	06	03	1.5
PBA	69	20	0.6
PBC	03	10	0.3

(G) MCR FOOTWARE: - Not available.

(H) GOGGLES: - Not available at Dist hospital Bemetara.

(I) PHYSIOTHERAPY: - No physiotherapist is available in Dist Bemetara.

(J) 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, as Prednisolone is not available in health facilities. Patients are referred to RLTRI for RCS either on elective basis or camp basis.

(K) DISTRICT ACTION PLAN:-No proper action plan is available. All the reports are conveyed to DLO office directly. No training calendar is prepared for running year.

(L) IEC ACTIVITIES: - Restricted to wall paintings. No specific activities under taken.

NLEP OBSERVATION CHC

FIVE CHCs of Dist. Durg namely UTAI, NIKUM, PATAN, BHILAI URBAN, JHEET & TWO CHCs of Dist. Bemetara NAWAGARH, & BERLA were visited. Salient observations are as under:-

(A.) **DIAGNOSIS:** - Uniformly at all the surveyed blocks the cases are predominantly evaluated by NMA alone. 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 counters (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.

(D.) **MDT MANAGEMENT:** - MDT indent is prepared by NMA. Details of stock registers (LF3) are available in all survey CHCs, but are not properly maintained at CHC PATAN & CHC BERLA.MDT procurement is not in accordance with the standard guideline. The pharmacist was not involved in the MDT management and also not aware of it in all surveyed CHCs.

(E.) **REACTION MANAGEMENT:** - Number of reaction cases is disproportionately low relative to the no. of under treatment cases. Prednisolone is not 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.

(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 Grade I & Grade II are not evaluated strictly and documented on successive visits. Health care staff is unaware of EHF SCORING and the same is not documented. No RCS facility is available & cases are referred directly to RLTRI for 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:** - Patients are not being counseled properly regarding the disease, its course, prognosis, therapy, hand foot & self care.

(I.) **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.

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

NLEP OBSERVATION PHC

Eight PHCs namely HANODA, RANITARAI, VAISHALI NAGAR, KHURSIPAR, KATAI, NANGHAT, SARDA, & ANANDGAON were visited. Salient observations are as under:-

A) **DIAGNOSIS:** - Uniformly at all the surveyed PHCs the cases are predominantly evaluated by NMA alone. 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 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.

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/RMAs.

D) **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.

E) **REACTION MANAGEMENT:** - Number of reaction cases is disproportionately low relative to the no. of under treatment cases. 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.

F) **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 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. No RCS facility is available & cases are referred directly to RLTRI for 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. Patients are not being counseled regarding the disease, its course, prognosis, therapy, hand foot & self care.

I) **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.

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

NLEP OBSERVATION HSCs

Cumulatively ten HSCs were visited namely DHANORA,ANDA,SANTOSHI NAGAR,ASOGA PHUNDA,HOUSING BOARD,MEHNA,KHEDA,KHUDMUDA,& RAKA. Salient features are as under:-

A) RECORDS & REGISTERS: - Only patient cards are available. Disability grading is often missed**. Out of 10 reviewed cards only 2 patient cards are not signed by MOs.** No separate registers for referral, disabled persons are there.

B) REACTION MANAGEMENT: - MPW/ANM have insufficient working knowledge of reaction & neuritis. Cases are referred directly to RLTRI for management or to other higher centers.

C) REFERRAL & DPMR: - No facilities are available in all the surveyed HSCs.MPW/ANMs are unaware of WHO grading & so Grade I & Grade 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 to higher centers for management.

D) DISABILITY & SELF CARE: - Disability management is only restricted to providing antibiotics and betadine to ulcer patients, referring others to higher centers.

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

F) **ASHA (MITANIN):** -According to ANMs/MPWs a few cases are sent by ASHA, details of which are not documented. Standard incentives given to ASHA for cases confirmed are pending since about a year.

G) **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.

INTERVIEW OF COMMUNITY MEMBERS: -

In all the places visited team interacted with common people & interviewed about their view, knowledge about leprosy & attitude towards persons affected with leprosy. In community people 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 are not at all aware of the prognosis of disease. Stigma of disease is high.

INTERVIEW WITH ASHAs

The team interacted with10 ASHAs in the villages during HSCs visit. 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. The record keeping of suspected referral cases were not available. 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 becomes a source of disinterest.

INTERVIEW WITH ANMs:- In all the surveyed 10 HSCs ANMs were interviewed.

Sr. no	Questionnaire	1	2	3	4	5	6	7	8	9	10
1	Any patient under treatment	yes	Yes	yes	yes	yes	Yes	yes	yes	Yes	Yes
2	Patient card signed by MO	yes	Yes	yes	yes	yes	yes	yes	yes	No	No
3	Referral slip present	no	No	no	no	no	no	no	no	No	No
4	Aware of cardinal signs	yes	Yes	yes	yes	yes	no	yes	yes	No	No
5	Aware of reaction/neuritis	no	No	no	no	no	no	no	no	No	No
6	Aware of patient counseling points thoroughly	no	No	no	no	no	no	no	no	No	No
7	IEC display at HSC	yes	Yes	yes	yes	yes	yes	yes	yes	Yes	Yes
8	List of deformity patients	no	No	no	no	no	no	no	no	No	No
9	Flash card present	no	No	no	no	no	no	no	No	No	No
10	Aware of MDT side effects properly	no	No	no	no	no	no	no	no	No	No
11	Aware of referral points in case of need	yes	Yes	Yes	yes	yes	yes	yes	yes	Yes	Yes

INTERVEIW WITH PATIENTS:-

All interviewed PAL are satisfied with the MDT services. They are not all aware of the prognosis of patch and numbness etc. None of patients were undergone counseling properly. They are frequently interacting with the nearest subcenter ANM and interaction with ASHA is minimal as observed.

CONCLUSIONS

1.) Filled the vacant post of the DNT staff of both the surveyed district for proper functioning of the NLEP programme and capacity building of the staff in context with DPMR in the district.

2.) 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. NLEP staff is attached in other health care, office activities and sundry jobs. 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 separate counters/room, and managed almost exclusively by NMA, with little or no supervision of doctor which is not in accordance with integrated system of general health care system. The pharmacist is not involved in MDT management.

4.) At all the surveyed health care facilities record keeping was unsatisfactory albeit to variable extents. So there is need to monitor and supervise DPMR and SIS records.

5.) The proportion of patients with Reaction/neuritis was disproportionately low as compared to case load, this shows either lack knowledge about reactions/neuritis or lacks of regular follow up. **The most important drug in the management of Reaction i.e Prednisolone is not available in all surveyed hospital**. The health officials should procure the same as per prescribed guideline at pheripherial health institute. Of patients seen in field visit some was 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.) IEC activities are unsatisfactory for mass community awareness. Patient counseling is very poor.

7.) ASHA involvement in case finding, referral, patient counseling is poor. **Incentives for case finding are not provided timely, which could be a source of disinterest.**

8.) DPMR activities are grossly unsatisfactory, due to lack of trained staff & poor involvement of the existing staff.MCR foot ware; goggles are not available.

9.) There is no advanced training calendar & schedule for health care staff for current year.

10.) Community awareness about leprosy, its course, prognosis of patch, numbness its sequelae & its prevention is very poor & the resulting stigma persists.