NLEP Technical Supervision of Dhamtari District of Chhattisgarh state (High endemic district)

About District: **Dhamtari** *is* abbreviated from "***Dhamma***"+"***Tarai***" District is situated in the fertile plains of Chhattisgarh Region. Dhamtari district is officially formed on ***6th July 1998*** dividing the Raipur district currently the capital of Chhattisgarh. Kurud, Nagari and Magarlod are included as blocks. The total area of the district is 2029 Sq.Km & total population is 829483.

Sampling:

The RLTRI Officer visited the district during 17th to 22th September 2012 and sampled heath facilities for monitoring of NLEP components for identifying gaps and give suitable appropriate to improve the programme performance. 4 Blocks, 4 PHC and 5 Health subcenter were selected for above purpose based on the operation 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.

S.N.	CHC	PHC	HSC
1	Nagri	Keregaon	Urekel
2	Kurud	Sirri	Darra
3	Magarlod	Kareli Badi	Kareli badi
4	Gujra	Bhatgaon	Rudri
			Bhatgaon

Epidemiology of NLEP of district: Dhamtari is a high endemic district with PR 2.24, Annual new case detection rate of district was reduced from year 2009 to 2012.

Year	ANCDR
April2009-March2010	34.35
April2010-March2011	26.20
April2011-March2012	23.60

Health resources: Overall Health resources under CMHO Dhamtari in general health system (12th June 2012). As discussion with DLO & NMA all were trained in NLEP. There is shortage of clinical and field staff in the district.

Class	sanctioned	available	vacant
First class (Specialist)	28	2	26
Second class (M.O.)	61	29	32
Lab technician	17	13	4
Eye technician	22	20	2
Supervisor (male)	28	7	21
Supervisor (Female)	33	21	12
Staff nurse	28	10	3
MPW	173	88+31(c)	54
ANM	196	184	12
Pharmacist (Grade 2)	22	14	8

District nucleus team: In District nucleus Team Full time **(DNT) DLO, Medical officer & physiotherapist are not in place**. DLO is looking after other programme also.

Officer/staff	In position	Functions
DLO (I/C)	1	Along with all NLEP work (confirmation, validation, training & attend meetings/conference) he is working as Medical officer in district hospital, looking aftert OPD services.He is also I/C DTO, & doing emergency duties in District hospital Dhamtari.
NMA	2	Along with I/C DLO/independently confirmation & validation of leprosy, Preparing monthly & annual reports & given training to general health staff
PMW	1	Doing NLEP work as & when assigned by DLO

Skin Smear examination: Facility not available in district. Needy patients were referred to RLTRI Raipur for slit skin smear examination.

Case validation & confirmation: Case validation & confirmation was done by DNT, Due to I/C DLO having other works like (DTO & medical officer) most of the time the team validate & confirm case with NMA & PMW. Details record regarding how much percentage discrepancies observed by DNT not available in district.

Involvement of ASHA: During current year near about **10% of leprosy cases were confirmed refered by the ASHA** .the Details regarding no. of

suspect leprosy cases referred of ASHA not available in District, in the reporting month of August(2012) 186 cases were new cases under treatment. All ASHA were trained along with other programme at Block level. The 5000 rupees were distributed to each block for ASHA incentives. The block medical officer regulates ASHA incentives.

Block	**Suspected cases referred by ASHA**		**Cases confirmed referred by ASHA**		**Incentive given**
	MB	PB	MB	PB	Rupees
Nagri	NA	NA	3	2	2100
Gujra	NA	NA	2	3	1900
Magarlod	NA	NA	0	0	NA
Kurud	NA	NA	5	5	NA

Logistics:

A) MDT (AUG 2012 Monthly report) & Prednisolone

No of UT patients	Blisters packs	Stock PHC+CHC	District stock	Total stock available in District	Patient month BCP	Expiry date
117	MB (A)	329	96	425	3.6	Mar 14
3	MB (C)	8	2	10	3.3	Apr 14
61	PB (A)	144	20	164	2.7	Apr 14
5	PB (C)	5	1	6	1.2	Apr 14

The MDT is kept by DNT and the stock of MDT BCP was above 2 month except PB child. Based on the indent received from peripheral health institute prepared by NMA, the DNT staff provides the MDT to the PHI.

Prednisolone Tab: are available at DNT and manage the cases at urban and periurban area. As and when required at periphery they were provided tablets Prednisolone. 15 patient taking steroids from DNT.

The present available stock at DNT is as:

Prednisolone tab 5 mg - 88 tab available with expiry date 8/13

Prednisolone tab 10 mg – 1311 tab available with expiry date 11/13

B) MCR: procurement & distribution Status: MCR stock -nil (at present in district)

Year	MCR (Pair)procured	Distributed
2010-2011	24	24
2011-2012	Indent prepared but not received till date	0
2012-2013	Indent prepared & sent to state	0

24 Pairs MCR pairs were received on 2010 then MCR was supplied.

C) Eye goggles: 10 goggles available in stores but not used because lagophthalmos cases not found/registered in district.

DPMR Activities:

1) **No of RCS conducted during the year - 07**
2) No of RCS listed (2012-13) - 09
3) Distribution of dressing material & self care kit – Details not available
4) 4) POD & Self care activities – Details not available
5) MCR distributions were not done since last 2 years, complete list of beneficiaries not available in block.

6) For RCS patients were either referred to RLTRI or in camps conducted in district hospital.
7) Physiotherapist not available in block/District.
8) For DPMR service no separate unit established in block/district, needy patients were referred to RLTRI Raipur.

Referral system

Diagnosis & management of leprosy & reactions were available at PHC/CHC & district hospital but referral system is not well established, many patients taking Prednisolone therapy from RLTRI for reactions & neuritis but details were not available in district. PHCs of Kurud & Magarlod block many patients were referred to RLTRI for diagnosis of leprosy & reactions.

NLEP OBSERVATIONS CHCs (Nagri, Kurud, Magarlod, Gujra)

Diagnosis & management: Patients came to OPD were attended by Medical officer/RMA when they suspect that the case might be leprosy (or lepra reactions/Neuritis) they usually sent patients to NMA/NMS for examination diagnosis & treatment. LF01 & PII Form were filled by NMA/NMS & counter signed by MO but in few forms sign of M.O. not found.

Case validation/confirmation: As per discussion with NMA & district nucleus team, validation /confirmation were done by DNT but

details were not available regarding validation, confirmation & wrong diagnosis etc at the block CHCs.

MDT management: MDT kept by Pharmacist in all surveyed CHCs & in Nagri CHC MDT being kept by Pharmacist & NMA both. LF3 & MDT indene were managed/prepared by NMA in all surveyed CHCs. MDT not available in all surveyed CHCs as per guideline in visit days.

Reaction/Neuritis: Prednisolone not available in Kurud & Gujra CHC & in Nagari & Magarlod CHC Prednisolone available. Details of patients receiving Prednisolone were not properly maintained in all CHCs, Many patients were received Prednisolone therapy from RLTRI & details were not mentioned in concerned block especially in kurud & magarlod block. During patient interview we found that many patient purchases Prednisolone from local market/stores.

Involvement of ASHA: How much number of suspected cases were referred by ASHA & how much Percentage of suspected cases were confirmed not available & referral slips were also not kept by NMA (Block CHC)

DPMR Activity:

- Distribution of dressing material & self care kit - Details not available
- POD & Self care activities - Details not available
- Disability Register not available in Nagari & Kurud CHCs while Disability Register was not properly maintained in Magarlod & Gujra CHCs.
- Complete List of Patients with disability Grade I & II not available in CHCs.
- Complete list of patients with Ulcer (RFT cases) not available in CHCs.
- MCR distributions were not done since last 2 years, complete list of beneficiaries not available in block.
- For RCS patients were either referred to RLTRI or in camps conducted in district hospital.

- Physiotherapist not available in block/District.
- For DPMR service no separate unit established in block/district, needy patients were referred to RLTRI Raipur.
- Counseling guidelines regarding leprosy, POD, self care were not available in all CHCs.

RECORDS & REGISTERS:

- LF 02 (treatment register) not updated properly in Magarlod CHC.
- PI (Disability register) Disability: not available in Nagari & Kurud CHCs & Disability PII forms were filled by NMA in all surveyed CHCs but knowledge of NMA was not up to the mark in all Surveyed CHCs.
- PIII, PV, PVI & PVII forms/registers were not available in all surveyed CHCs.
- PIV (Prednisolone cards) were not available in Magarlod & Kurud CHC. Register were not properly maintained in Magarlod & Gujra CHCs.
- PVIII available in all Surveyed CHCs, monthly reports were sent by NMA to district through PVIII & LF04 forms, Disability mentioned in CHCs reports but in district report zero(0) cases were reported with disability (UT Cases)
- Regular review by BMO to records & registers were physically invisible & knowledge of formats was also not up to the mark during interview on visit days.

Referral system

Diagnosis & management of leprosy & reactions were available In all CHCs hospital but referral system is not well established, many patients taking Prednisolone therapy from RLTRI for reactions & neuritis but details were not available in CHCs. PHCs of Kurud & Magarlod block many patients were referred to RLTRI for diagnosis of leprosy & reactions. Referral registers & records were not available in All CHCs.

IEC activities: IEC activities were limited only to banner/posters & wall paintings, Details regarding IPC, meetings, seminars & other activities were not available in CHCs.

Involvement of General Health system: The only person involved in NLEP work is NMA/NMS they were doing all NLEP work including diagnosis, Management, reporting & counseling to patients. ANM/MPW/Pharmacist was only providing MDT to patients but they were unaware of MDT guidelines, side effects of MDT & lepra reactions in all surveyed CHCs.

NLEP OBSERVATIONS PHCs (Keregaon, sirri, Kareli badi, Bhatgaon)

1) **Diagnosis & management:** In kareli badi PHC Medical officer post was vacant Patients came to OPD were attended by Medical officer/RMA when they suspect that the case might be leprosy (or lepra reactions/Neuritis) they Refer patients to NMA for examination diagnosis

& treatment. LF01 & PII Form were filled by NMA & counter signed by MO but in few forms sign of M.O. not found. In Bhatgaon PHC NMA not posted MPW working as a supervisor he filled LF 01 but PII forms were filled by ANM (in HSC)

2) Case validation/confirmation: As per discussion with NMA, RMA & MO, validation /confirmation were done by DNT but details were not available regarding validation, confirmation & wrong diagnosis etc at the PHCs.

3) MDT management: MDT kept by Pharmacist in all surveyed PHCs except in sirri PHC where MDT being kept by NMA. In Keregaon PHC pharmacist post is vacant & ANM distributed all drugs along with MDT to patients. LF3 & MDT indene were managed/prepared by NMA in all surveyed PHCs. MDT not available in all surveyed PHCs as per guideline in visit days except in Bhatgaon PHC where MDT available as pe guideline.

4)Reaction/Neuritis: Prednisolone not available in all surveyed PHCs. Details of patients receiving Prednisolone were not properly maintained in all PHCs, Many patients were received Prednisolone therapy from RLTRI & details were not mentioned in concerned PHCs especially in PHCs of kurud & magarlod block. During patient interview we found that patient purchase Prednisolone from local market/stores.

5) Involvement of ASHA: How much number of suspected cases was referred by ASHA & how much Percentage of suspected cases was confirmed not available & referral slips were also not kept by NMA.

DPMR Activity:

- Distribution of dressing material & self care kit - Details not available
- POD & Self care activities - Details not available
- Disability Register not available in all PHCs except in Sirri PHC where Disability Register available but not properly maintained (entry was not done after 2010).

- Complete List of Patients with disability Grade I & II not available in PHCs.
- Complete list of patients with Ulcer (RFT cases) not available in PHCs.
- MCR distribution status not available, complete list of beneficiaries not available in all PHCs.
- For RCS patients were either referred to RLTRI or in camps conducted in district hospital.
- For DPMR service needy patients were referred to RLTRI Raipur.
- Counseling guidelines regarding leprosy, POD, self care were not available in all PHCs,

RECORDS & REGISTERS:

- LF 02 (treatment register) not updated properly in Kareli badi & Keregaon PHC.
- P II form were filled by NMA in all surveyed CHCs but knowledge of NMA were not up to the mark in all Surveyed PHCs many entries were filled incorrect. In Bhatgaon PHC NMA not posted MPW working as a supervisor he filled LF 01 but PII forms were filled by ANM (in HSC)
- P V,P VI & P VII forms/registers were not available in all surveyed PHCs.

  PI (Disability register): Disability Register not available in all PHCs except in Sirri PHC where Disability Register available but not properly maintained (entry was not done after 2010).
- P III was not available in all PHCs. Except in Sirri PHC but not properly maintained
- P IV available (Prednisolone cards) only in Bhatgaon PHC (received in current month).
- P VIII available in all Surveyed PHCs, monthly reports were sent by NMA to CHC through PVIII & LF04 forms.

- Regular review by MO to records & registers were physically invisible & knowledge of formats was also not up to the mark during interview on visit days.

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HSC observations

Record keeping: ANM/MPW working in HSCs maintaining only LF01 cards (patient cards) they provide MDT to patients & reporting to ANM/Supervisor in monthly/sector meetings.

Knowledge regarding leprosy, lepra reaction, neuritis & MDT side effects etc was not up to the mark in all interviewed ANMs. The Counseling guidelines not available in all HSCs and none of the ANM refer regularly suspects to PHC. Only 40% of the ANM have referral slips. None of the ANM has complete knowledge regarding Disability care services/POD/Self care /RCS etc.

INTERVEIW WITH PATIENTS: - Total 8 patients were interviewed 2 with lepra reactions,2 with neuritis,2 with PBA & 2 with MBA.

1) 50% patient satisfied with care services during the treatment
2) 75% of interview patient aware that he/she is/was undergoing treatment for leprosy and not aware of the prognosis of patch and numbness etc.
3) None of patients were undergone counseling properly.
4) They are frequently interacting with the nearest subcenter ANM and interaction with ASHA is minimal as observed.
5) If disabled then whether received MCR, physiotherapy other services- nil
6) Single (12.5%) only patient knows about RCS &where it is available & incentives after surgery.

ASHA interview findings: The team interacted with 5 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 and they were not aware of the incentives under NLEP programme.

Interview of community members:

1. 100% of interviewed community members heard of the leprosy disease.
2. No one aware about the sign & symptoms of the disease properly.
3. 20% patients used local private doctor for their health problems.

4. 60% aware of the curability of the disease, but no one knows prognosis properly.

Conclusions:

1) **Vacancies of 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.
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 in some of surveyed health facilities.
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.
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 DNT DLO/ medical officer.
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 peripheral 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. Focus on the counseling to the patients on the right time in right way.