ARTICLE ON RE-ORGANIZATION OF VERTICAL STAFF UNDER NATIONAL LEPROSY ERADICATION PROGRAMME

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INTRODUCTION:

The national leprosy eradication programme (NLCP) has been in operation since 1955, as a centrally aided programme to achieve control of leprosy through early detection of cases and DDS (dapsone monotheraphy) on an ambulatory basis. The NLCP moved ahead initially at a slow pace, presumably for the want of clearcut polices or operational objectives for nearly two decades. In the 1980, the government of India declared its resolve to "eradicate" leprosy by the year 2000 and constituted a working group to advice accordingly. The working group submitted report in 1982 and recommended a revised strategy based on multi- drug chemotherapy aimed at leprosy "eradication" through reduction in the quantum of infection in the population, reduction in the sources of infection in the breaking the chain of transmission.

Vertical set up of NLEP, Re-Organization of vertical staff and pattern of DLN:

There are about 22,200 regular vertical staff under NLEP. Most of these are non-medical supervisors (NMS), paramedical workers (PMW) and physiotherapists (PT). Of these, 12,500 are working in low/moderately endemic provinces. After integration of these 12,500 staff, about 70–80% staff are supposed to be working in GHS. For this, they are provided training in various national health programmes and general health care delivery. Their training responsibilities lie in provincial health authorities. The remaining 20–30% are retained for leprosy work. Most of them are redeployed in endemic pockets of the district. However, a small nucleus is created at district headquarters.

Pattern of DLN1 is given in Table 1.

Organizational Structure

Health Minister

State Health Minister

Secretary		Secretary
Project Director State AIDS society	Project Director Health Syst Dev Proj-	Director General Health Services

PARTICIPATING UNITS:

Three institutions of union government located in south, east and central India and engaged in leprosy control activities for some time. These are the Central Leprosy Teaching and Research Institute, Chengalpattu and two Regional Leprosy Training and Research Institutes at Aska and Raipur (Nodal agency). All participating units provided three teams each of health officers for field work and data collection.

Table 1

Pattern of district leprosy nuclei

In districts with PR.1,

1 District leprosy officer,

1 Deputy chief medical officer (responsible)

1 Medical (Officer for leprosy and other programmes)

2 Non - medical supervisors

1 Non - medical supervisor

1 Physiotherapist

1 Paramedical worker

1 Driver

1 Worker

URBAN LEPROSY CONTROL PROGRAMME:

The urban leprosy control programme was initiated in 2005 to address the complex problems of larger population size, migration, poor health infrastructure and increases leprosy cases in urban areas. Under this, assistance is provided to 422 urban areas having population size, of more than 1 lakh as Disability prevention and Medical Rehabilitation (DPMR). The main activities carried out during the year 2009-10 were as follows:

1. Implementation of DPMR activities as per guidelines and reporting its out come. Eg. Treatment of leprosy reaction, ulcers, physiotherapy, reconstruction surgery and providing MCR footwear.

2. Integrating DPMR services- there are provision of services to persons with disability by various departments under different ministries.

3. To develop referral system and to provide prevention of disability services to all leprosy disabled persons in an integrated set-up.

4. The primary level care, secondary level and the tertiary level care are the planned activities in DPMR.

a) Central government institutes.

b) ICMR institute JALMA, Agra.

c) ILEP supported leprosy hospitals.

d) All PMR institutes and departments of medical colleges.

Referral system in NLEP:

Sub-center: Implementation– Self care advice,
Advise to RCS cases.
Monitoring.
Referral–reaction, disability

PHC: Implementation - manage reactions or referral
Identify or refer patient needing RCS
Identify patient needing foot wear.
Advise reconstructive surgery cases.
Advise to self care.

Referral: Lepra reactions are difficult to manage.
Complicatated ulcer.
Eye problems.
Reconstructive surgery cases.
Persons needing foot-wear.

District hospital: Implementations
Management of complications ulcers.
Management of lepra reactions.

Referral – refer difficult ulcer cases to reconstructive surgery center.

Reconstructive surgery center: Implementation – Reconstructive surgery
Follow- up after reconstructive surgery.
Supply of foot wear to district nucleus.

Components of disability prevention and rehabilitation:

1. Re assessment of disabilities (grade I and grade II):

All the cases, under treatment and completed treatment are to be mobilized by peripheral health workers and brought to medical officer, PHC for clinical assessment, need assessment and service provisions. AWW & ASHA may also contribute in mobilizing process. Basic data on disability assessment need to be recorded to judge the progress after interventions.

2. Prevention of new disabilities:

Regular monitoring of nerve functions in all cases at risk and treatment of neuritis / reactions is done at primary level. Difficult cases are referred to district hospital. LAP with anesthesia are thought to protect the part from acute & chronic injuries and are given protective footwear. Counseling for self care and supervision of self care practices will be regularized.

3. Control / reducing existing disabilities:

Ulcer care and physiotherapy in deformed cases to prevent worsening is to be strengthened. Developing self-care-groups, self-help-groups in leprosy colonies and home based self care in other cases will be promoted. Provision of dressing material, splints and other assistive devices will assist in self care.

4. Reconstructive Surgery:

Correction of deformities like foot drop, claw hand and lagophthalmos will improve the functions of that

part. All back log cases requiring such surgery will be simultaneously cleared by government and non government hospitals together. CLTRI, JALMA, SLTRI Karigiri, RLTRI, 9 PMR institutes, 5 medical colleges and 33 ILEP hospitals will contribute in surgical treatment. Pre & post operative care is integral part of it.

5. Capacity building of General Health Care (GHC) staff:

a. Infrastructure development: Vacant post will be filled up, especially that of district Nucleus.

b. Formal training courses: A plan of training activities will be implemented at state, district and PHC level and trainers will be supported to supervise the performance &evaluate the trainings done.

c. On the job training – Regular hand on trainings during supervision will be strengthened to improve the clinical skills mainly at primary and secondary level.

6. Reducing stigma and discrimination: Advocacy meetings during village health day and with "Rogi Kalyan Samiti" participatory rural appraisal and demonstration of non discriminatory behavior will reduce the perceived fear of infection and misconceptions related to leprosy.

7. Socio-economic rehabilitation: Increased accessibility to SE rehabilitation services for LAP also will be tried through developing links with social welfare departments. Meeting with MOSJE at national level and with social welfare dept. at district level will facilitate these provisions. Local NGOs and CBOs will be supported for this purpose.

8. Legislative measures: Repeating of some acts that are not relevant now, will further boost the process of rehabilitation and in regaining self-esteem by Leprosy Eradication Programme.

9. Monitoring and Evaluation: Progress of disability prevention and rehabilitation will be monitored by some process indicators and outcome indicators such as early case detection, cure rates by cohort, no of new disabilities. Proportion of cases operated, rehabilitated and treated for neuritis will guide on further interventions required.

ROLES OF THE HEALTH PERSONNEL IN NLEP:

Medical officer:

❖ He is the captain of the health team at the all health care set ups.

❖ He ensures that national health programmes are being implemented in his area properly.

❖ He will organize training of all health personals like ASHAS to involve in NLCP.

❖ He will identify the cases through the signs and symptoms and conduct the investigations.

❖ He is the planner, the promoter, the director, the supervisor, the coordinator as well as the evaluator.

Health worker male (HWM)*:*

Record – keeping:

❖ He will survey all the families in his area and collect general information about each village\locality in his area.

❖ He will prepare maintain and utilize family records and village registers containing columns for recording particulars, educational activities.

In leprosy

❖ Identify the cases of skin patches, especially if accompanied by loss of sensation and refer these cases to M.O.PHC for further investigations.

❖ Check whether all cases of leprosy are taking regular treatment. Motivate defaulter to take regular treatment.

❖ Maintain patient records.

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