National Leprosy Eradication Programme

Salient features of the programme are:

1. ‘Leprosy Eradication programme’ is a centrally sponsored National Health Program.
2. NLEP is decentralized, funds are sent through state health societies.
3. NLEP functions under umbrella of National Rural Health Mission (NRHM).
4. Quality of services and sustainability is the main focus.
5. Disability Prevention & Medical Rehabilitation (DPMR) is a priority.
6. Removal of stigma & discrimination is a part of strategy…..

The National Leprosy control programme (NLCP) was launched in 1954. The strategy of NLEP was based on controlling the disease through reduction in the quantum of infection in the population, and reduction in infective source, thus breaking the chain of disease transmission. The program, therefore, had been planned on the following basic activities

1. Survey and case detection.
2. Registration of cases for treatment.
3. Provision of continuous treatment with Dapsone to all cases, as close to their homes as possible.
4. Education of patients, their families and community at large about leprosy.
5. Correction of deformities through deformity care programme.

Treatment with MDT was introduced under NLEP in phased manner in the year 1983 and programme was renamed as National Leprosy Eradication Programme.

At the 44th World Health Assembly held in 1991, WHO and its Member States committed themselves to eliminate leprosy as a public health problem by the year 2000, elimination being defined as prevalence below one case per 10,000 population. The Government of India was also a signatory to this commitment. To enhance the process of elimination, the first World Bank supported project on NLEP was started in the year 1993-94 and MDT made available to all the registered cases.

The Second World Bank supported National Leprosy Elimination Project was started for a period of 3 years from 2001-02 This phase was implemented with the following objectives:

- Decentralization of NLEP responsibilities to States/ UTs through State/ District Leprosy Societies.
- Accomplish integration of leprosy services with General Health Care System (GHS) and
- Achieve elimination of leprosy at National level by the end of the Project
A large number of voluntary organizations has been playing a pioneering role in anti-leprosy work in India. While some of them were engaged in training, education and research, others were also engaged, in case detection, treatment, rehabilitation and control work. A large number were voluntary, while some received grants from governmental organizations and others from international agencies.

In the Post elimination period, NLEP needs to expand the scope of leprosy services provided to the patients, their families and community at large. The aims and objective under the 11th Plan (2007-2012) calls for

- Further reducing the leprosy burden in the country,
- Provide good quality leprosy services,
- Enhance Disability Prevention and Medical Rehabilitation,
- Increase advocacy towards reduction of stigma and stop discrimination and Strengthen monitoring and supervision.

These objectives are also in conformity with the global strategy issued by WHO (2006-2010).

**New Paradigm** - In view of the need to sustain leprosy services for many years to come, there has to be a shift from a campaign like elimination approach, towards the long term process of sustaining integrated high quality leprosy services, which in addition to case detection and treatment with Multi Drug Therapy, also include prevention of disability and rehabilitation.

To get the programme move in the desired direction, the New Paradigms in NLEP have been detailed as below:

**I. Burden of leprosy:**

The burden of leprosy can be looked at in three ways:

(a) Firstly, the most relevant epidemiological measure of the burden of leprosy is the incidence of disease, which is the number of people developing leprosy during a defined period usually one year. Because leprosy is an insidious disease, number of cases detected/ registered for treatment is generally lower than the actual number of incident cases for that time. Hence, incidence is difficult to measure directly and New Case Detection Rate (NCDR) is used as a proxy for incidence rate.

(b) Secondly, the burden may be related to the registered prevalence of disease, which is the number of people on treatment at a certain point of time. Although registered prevalence was a useful indicator to achieve the leprosy elimination milestone, it is not adequate indicator to reflect changes in the epidemiological trend of leprosy.

(c) Thirdly, the burden of leprosy can be viewed as disability and deformity produced by leprosy.
II. Improving the quality of services:

The quality of care depends on the quality of technical supervision provided by the program and availability of strong back up from an effective referral system. Quality leprosy services means treatment by MDT is available at all the health units without any geographical, economic or gender barriers. Services provided are patient–centred; observe patient’s rights, including the rights to timely and appropriate treatment, privacy and confidentiality. The quality leprosy services addressing each aspect of case management, based on firm scientific evidence like diagnosis is carried out timely and accurate with supportive counselling, timely treatment with MDT, free of charge in a user friendly environment; appropriate disability prevention interventions; referral for complications and appropriate rehabilitation and maintaining simple records and encourage review and evaluation.

The services must be based on principles of equity & social justice. Equity means that leprosy patients should have the same opportunity to attend health services that are of sufficient quality to deal with their problems. Social justice means an absence of discrimination for any reason, including type of disease, level of disability, race, gender, social class or religion.

III. Integration of leprosy services with primary health care system for sustainability:

Integration means active involvement of general health services in leprosy control activities. The general health care services take full responsibility for leprosy control in their areas, as part of their routine day to day activities.

When we refer to case detection, it is important to recognize that in order to achieve leprosy eradication, nearly every case of leprosy in the community should be identified. In practice this does not happen in many situations. The major focus is on creating community awareness about the disease, its curability and the availability of MDT services.

Over the years the technology for diagnosis and treatment has been simplified to a great extent making it possible or general health care staff to deal with leprosy effectively.

IV. Referral services and long term care

Effective leprosy control requires an integrated approach, which implies that leprosy control activities are implemented by the general health services, including integrated referral facilities. The referral network must be part of the integrated system, providing referral services for other diseases and conditions in the area e.g. district hospitals or medical colleges. Community health centre with adequate infrastructure, trained manpower and appropriate equipment may serve as first referral unit in the referral network. Referral services needed are ophthalmology for significant eye pathology; Dermatology for diagnosis of difficult skin conditions; laboratory for skin smears and histopathology, Physiotherapy for assessment and management of disability, Podiatry for the feet and footwear, occupational therapy for rehabilitation and adaptations, Reconstructive and plastic surgery, social workers for assessment
V. Prevention and management of impairments and disabilities

The current situation with regard to the number of persons living with leprosy – related disabilities and impairments may need reassessment, particularly at national level. In addition, programme should ensure that persons affected by leprosy have access to services by other programmes dealing with other disabling diseases or conditions.

Interventions aimed at preventing disabilities / impairments from occurring and/or worsening include early detection and effective management of leprosy – related reactions and nerve damage, proper counselling on self care, participation of household members in home based care, development and use of locally produced and culturally and aesthetically acceptable footwear and other appliances.

VI. Improving community awareness and involvement

The major theme of community awareness is to provide accurate information about the disease, its curability and availability of services at the nearest health facility. The objective of such IEC efforts should be to encourage self – reporting of new cases and to reduce stigma and discrimination. There are four key messages for the general public include early signs of leprosy, its Curability, encourage people to support leprosy affected people to live a normal a life and no need to fear as disease can be managed just like any of other diseases; can be expressed in many different ways.

VII. Support of National Rural Health Mission

Under the National Rural Health Mission (NRHM), institutional mechanisms have been created at each level to support National Health programmes & improve delivery of health care services. At village level there is multi stake holders – village health & sanitation committee to decide the health priorities in the village and their appropriate solution. There is also Accredited Social Health Activist (ASHA) for every village. She is a female volunteer belonging to the same village, selected by the community. ASHA could be utilized for early detection of suspected cases of leprosy, referral of such cases to nearest health centre for confirmation & completion of treatment. Rogi Kalyan Samities at PHC, CHC and district hospitals are autonomous registered bodies constituted at each level to facilitate in management of hospitals and delivery of quality care to patients. The NLEP will be benefited by working in coordination with other programs under the NRHM. District Health Mission which is chaired by the president of Zila Parishad may be helpful for advocacy of the program.

VIII. Rehabilitation

Leprosy is feared because of the occurrence of disabilities it causes, very little has been done in this area. There are several reasons for this, inadequate efforts to develop effective tools and failure to address the issue through integrated services for all disabled in the community. The problem, in social, economic and human terms is enormous and will need many partners to solve it, including the affected communities.
A comprehensive approach to rehabilitation is needed to maximize the benefit for the individual, family and society at large. Community Based Rehabilitation (CBR) approach emphasizes community participation and empowerment of the individual involved. Govt. of India / State Govts has schemes for providing financial support to disabled persons. We have to ensure that persons affected with leprosy are also included in these schemes.

The Ministry of Health & Family Welfare and Ministry of social justice & empowerment, GOI are expanding rehabilitation services to the persons with – disabilities.

Persons affected by leprosy, who are in need of rehabilitation, should have access to any existing (general) rehabilitation services. Similarly, where leprosy specific rehabilitation services are available, people with other disabilities should be given access. This facilitates integration, helps to break stigma and promotes sustainability of rehabilitation services. Harmonization of rehabilitation services provided by public and private sectors would be crucial in making such services realty.

NLEP – Operational aspects: Many operational factors affect the outcome of the programme. Some of the common operation factors affecting the programme are:

1. Availability of various Guidelines issued from Central Leprosy Division, GOI.
2. Supervision to improve the quality of services by check on wrong diagnosis, wrong classification, wrong registration, drop out cases, record keeping and delay in providing services.
3. Regular review meetings to see the implementation, progress and outcome of planned activities.
4. Vertical & horizontal communication (organizational) with its feedback.
5. Check on delay in self reporting of new cases and defaulters retrieval.
6. Improved accessibility to services by ‘user- friendly- approach’
7. Mobility for field workers and officers