WORKSHOP REPORT

National Workshop on “Is integration a leap forward? – Implications of integration on quality care in leprosy”, Mumbai

A. ANTONY SAMY
ALERT-INDIA, Mumbai, India

Accepted for publication 15 June 2007

Following integration of leprosy into general health care (GHC) services in India, there was a need to have a national level feedback on its progress and seek appropriate policy guidelines and directives from the programme managers. To this end, ALERT-INDIA (Association for Leprosy Education, Rehabilitation and Treatment – India) organised a National Workshop on ‘Is integration a leap forward? - Implications of integration on quality care in leprosy’ at Mumbai on 11th October 2006. This Workshop was attended by representatives from 10 States - Delhi, Maharashtra, Tamil Nadu, Karnataka, Chattisgarh, Jharkhand, West Bengal, Bihar, Uttar Pradesh, Madhya Pradesh including from three ILEP agencies, Indian Council for Medical Research (ICMR), Foundation for Medical Research (FMR), Medical colleges and other Non-Governmental Leprosy Organisations (NGLOs).

The proceedings of the Workshop focused on the policy and programme implementation from the disease and patient point of view. The presentations from the States were mainly on the epidemiological trends in the State and the operational factors that affect quality care. Issues related to (i) the process of integration, (ii) methods of ensuring case holding and treatment compliance and (iii) capacity building of GHC system and other stakeholders was discussed.

At the end of the Workshop, the following recommendations were summed up from the deliberations and submitted to Central Leprosy Division (CLD) of Govt. of India (GOI) for its consideration.

Recommendations:

1. **On registration of new leprosy cases for MDT**: We call upon CLD-GOI to issue specific directives to all the States on the criteria for diagnosing and registering new cases (WHO criteria for ‘a case of leprosy’) for MDT services at all GHC centres, Leprosy Referral centres, Public and Private Hospitals and Medical colleges. Registering new patients
with a ‘Zero’ number should be forbidden. Recording and reporting all new leprosy cases should be the norm.

2. **On setting targets:** We strongly advocate CLD-GOI to discontinue setting targets to achieve the goal of leprosy elimination at sub-national level (district and block level), even by way of ‘expected outcome’. A clear and specific instruction to all the States to this effect is urgently needed.

3. **On establishing Leprosy Referral Centres:** We advise CLD-GOI to ensure sustainable leprosy control activities that are carried out within the integrated set up, which includes establishing leprosy referral centres at the block and district level mainly to manage leprosy-related complications including the cured leprosy patients with visible deformities.

4. **On providing POID & POD services:** We recommend CLD-GOI to develop a ‘formal’ and ‘recognised’ training course for Medical and Supervisory staff at GHC on the identification of leprosy-related complications and to treat / refer all new and cured leprosy cases with deformities. This should complement the training on diagnosis and treatment for leprosy undertaken for all GHC staff. This will help in identifying early nerve involvement and provide appropriate care / necessary referral. Also help to follow-up patients at the referral centres who are referred for physiotherapy services at the leprosy referral centres.

5. **On sample survey to determine epidemiological situation of leprosy:** We urge CLD-GOI to encourage as a policy for continuous monitoring of new case detection (Sample survey) and other quality-of-care indicators as a part of routine supervision on sampling basis. Epidemiological data collected at the district / regional level need to be validated without any prejudice and provide feedback to the programme.

6. **On integration of leprosy into general PMR & rehabilitation institutions:** We propose CLD-GOI to support the supply of protective aids and footwear to all the needy leprosy patients through specialised leprosy institutions and other PMR departments in general rehabilitation institutions as a part of their routine services with specific linkages with the local leprosy referral centres.

7. **On the need for skin smear in leprosy control:** We request CLD-GOI to issue an explicit guideline to all State Leprosy Officers on the need for undertaking skin smear examination at referral centres and Medical colleges, where a proper microscope and trained technician are available, as it is the simple tool available to detect early lepromatous cases. Skin smears for leprosy can become a part of the RNTCP microscopy centres.

8. **On leprosy curriculum in medical teaching institutions and ensuring uniform MDT regimen:** We advocate CLD-GOI to acknowledge and convince the MCI to develop a training curriculum on leprosy for under-graduate medical students (all pathies) as a part of routine medical education in the country and ensure by directives that medical colleges and other public health institutions adhere to the appropriate (MDT) treatment recommended by WHO for all leprosy patients.

9. **On legal and social problems:** We recommend CLD-GOI to actively promote consultative meetings with legal experts and social scientists to amend all existing derogatory laws pertaining to leprosy-affected persons and ensure dignity and basic human rights. An official endorsement by the CLD-GOI will make a major difference.

10. **On the protocol for surgical intervention for rehabilitation (SIR):** We suggest CLD-GOI to adopt and communicate officially, the guidelines for selection of referral patients suggested by ILEP and procedures for supervised pre- and post-operative therapy as a
part of Disability Prevention and Medical Rehabilitation (DPMR) of GOI. Corrective surgery should be done only on patient’s informed consent and to whom it will make a difference in the activities of daily life and enhance functional ability. This will help to dissuade unnecessary surgical interventions at the camps. Compensation for loss of wages must be provided during the post-operative period including the hospitalisation care as a part of routine programme expenditure.

References