NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

सत्यमेव जयते

National Leprosy Eradication Programme

Revised Operational Guidelines for
LEPROSY CASE DETECTION CAMPAIGN

August 2016

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Central Leprosy Division
Directorate General of Health Services
Ministry of Health and Family Welfare
Government of India

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FOREWORD

The National Leprosy Eradication Programme (NLEP) was started in the year 1983 with the objective of achieving eradication of the disease from the country. Though the Elimination of Leprosy at National level has been achieved by India, in the month of December, 2005, it is still home to around 57% of the worlds' leprosy-affected persons. The trend of two important indicators of program i.e. Annual New Case Detection Rate (ANCDR) and Prevalence Rate (PR) and the percentage of grade II disability amongst new cases detected indicate that the cases are being detected Late in the community and there may be several cases which are lying undetected or hidden. The decision of Government of India to launch the Leprosy Case Detection Campaign is a unique initiative under NLEP to detect cases of leprosy early in the community. It is a committed move to strengthen the services & facilities to leprosy affected persons in India.

Early case detection and treatment is the key to achieve elimination as detection of leprosy cases early in the community will lead to depletion of source of infection in the community and so interrupt the transmission of the disease. The house to house visits by the team of one ASHA and male volunteer will help in increasing our capacity to detect most of the leprosy cases at the community level.

I am sure that the Revised Operational Guidelines prepared by various stakeholder of the programme i.e., Central Leprosy Institutes, State Leprosy Officers of high endemic States, WHO, ILEP representatives, will be useful in giving clear direction to programme administrators and implementers in State and make practical use of the same. I wish the programme for Leprosy Elimination a success.

(Dr. Jagdish Prasad)

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MESSAGE

As per the key facts publicized by WHO in April 2016, from 121 countries of 5 WHO regions the global registered prevalence of leprosy is 175554 cases at the end of 2014. During the same year, 213899 new cases were reported. However, in India, although the Elimination of Leprosy at National level has been achieved in December, 2005, it is still home to around 57% of the worlds' leprosy-affected persons. Under the National Leprosy Eradication Programme (NLEP), India is giving emphasis on early detection of cases and treatment completion. However, the percentage of grade II disability amongst new cases detected has been increased from 3.10% (2010-2011) to 4.51% (2014-2015), which indicate that the cases are being detected late in the community and there may be several cases which are lying undetected or hidden. These hidden cases are the obstacles in achieving elimination as untreated Leprosy affected person is an active reservoir in the community which transmit the disease to susceptible.

The introduction of Leprosy Case Detection Campaign, as a paradigm shift to detect hidden cases in high endemic districts ensuring coverage of labourers population at construction sites, mining industries, migratory workers, slum dwellers in the country by NLEP during 2015-2016 is highly commendable.

The Revised Operational Guidelines for Leprosy Case Detection Campign, which is an outcome of Central Level workshop, held in CLTRI, Chengalpattu, 23rd-24th June 2016, which was attended by State Leprosy Officers of high endemic districts, Representatives from Leprosy Institutes, partners like ILEP, WHO etc. will definitely guide all the Field Level Workers and Implementers to implement quality LCDC. I would like to thank all participants of the Central level Workshop for their technical input to the guidelines.

(Dr. N.S. Dharmshaktu)

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PREFACE

Leprosy Case Detection Campaigns (LCDC) is the need of the programme to detect the hidden cases in the community. It is a unique initiative of its kind under NLEP, which will be implemented in high endemic districts of the country, in line with Pulse polio Campaign. The "Revised Operational Guidelines for Leprosy Case Detection Campaign" is the result of constructive feedback received by various stakeholders of the programme, after successful implemention of first LCDC, March 2016, during Central level workshop for LCDC, held in Central Leprosy Training and Research Institute (CLTRI), Chengalpattu on 23rd - 24th June, 2016.

These guidelines will help all the programme officers at all levels, in understanding their role to implement the LCDC. It wil give the directions for systematic implementation of the activities pertaining to LCDC i.e. planning, coordination, implementation, monitoring and review.

I hope this "Revised Operational Guidelines will be helpful in smooth implementation of LCDC. I would like to acknowledge all the experts who helped in bringing out these guidelines.

I would also like to acknowledge the support of Central Leprosy Training and Research Institute (CLTRI), Chengalpattu for organizing the Central level workshop.

Anil Kumar
(Dr. Anil Kumar)

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1. THE EPIDEMIOLOGY OF LEPROSY

Agent: Leprosy is caused by Mycobacterium leprae intracellular, obligatory parasite. It is a slow growing bacillus and one Leprosy bacillus takes 12–14 days to divide in to two. It is an acid-fast bacillus and is stained red by a dye called carbol fuschin.

Source of infection: Untreated Leprosy affected person (Human beings) is the only known source for M leprae.

Portal of exit: The major sites from which bacilli escape from the body of an infectious patient is respiratory tract especially nose. Only small proportion of those suffering from Leprosy can transmit infection.

Transmission of infection: Leprosy is transmitted from untreated Leprosy affected person to a susceptible person through droplets, mainly via the respiratory tract.

Portal of entry: Respiratory route appears to be the most probable route of entry for the bacilli.

Incubation period: Incubation period (Duration from time of entry of the organism in the body to appearance of first clinical sign and symptom) for Leprosy is variable from few weeks to even 20 years. The average incubation period for the disease is said to be 5–7 years.

Host factors

Age: Leprosy can occur at any age but is usually seen in people between 20–30 years of age. Increased proportion of affected children in the population indicates the presence of active transmission of the disease in the community. As the disease burden declines, it is seen more in older age groups.

Gender: Disease occurs in both the genders. However, males are affected more as compared to females

Immunity: Occurrence of the disease depends on susceptibility/immunological status of an individual.

Socio-Economic Factors: Leprosy is a disease generally associated with poverty and related factors like overcrowding. However, it may affect persons of any socioeconomic group.

Factors influencing susceptibility

- **Age:** Children are more susceptible than adults.
- **Individual immunity:** May be determined by certain genetic factors which influence the susceptibility of an individual
- **Climate:** Leprosy is prevalent in tropical and subtropical climates.

Leprosy cases can be classified as under:

S.No.	Characteristic	PB(Pauci bacillary)	MB(Multi bacillary)
1	Skin lesions	1-5 lesions with definite loss of sensation	6 and above with definite loss of sensation
2	Peripheral nerve involvement	No nerve/ only one nerve	More than one nerve
3	Skin smear	Negative at all sites	Positive at any site

Table 1: Classification of Leprosy cases

Duration of treatment for leprosy cases and treatment regimen is as under:

Type of Leprosy	Drugs used	Criteria for RFT
MB Leprosy	Rifampicin	Completion of 12 monthly pulses in 18 consecutive months
	Clofazimine	
	Dapsone	
PB Leprosy	Rifampicin	Completion of 6 monthly pulses in 9 consecutive months
	Dapsone	

Table 2: Duration of treatment for leprosy cases and treatment regimen

2. BACKGROUND

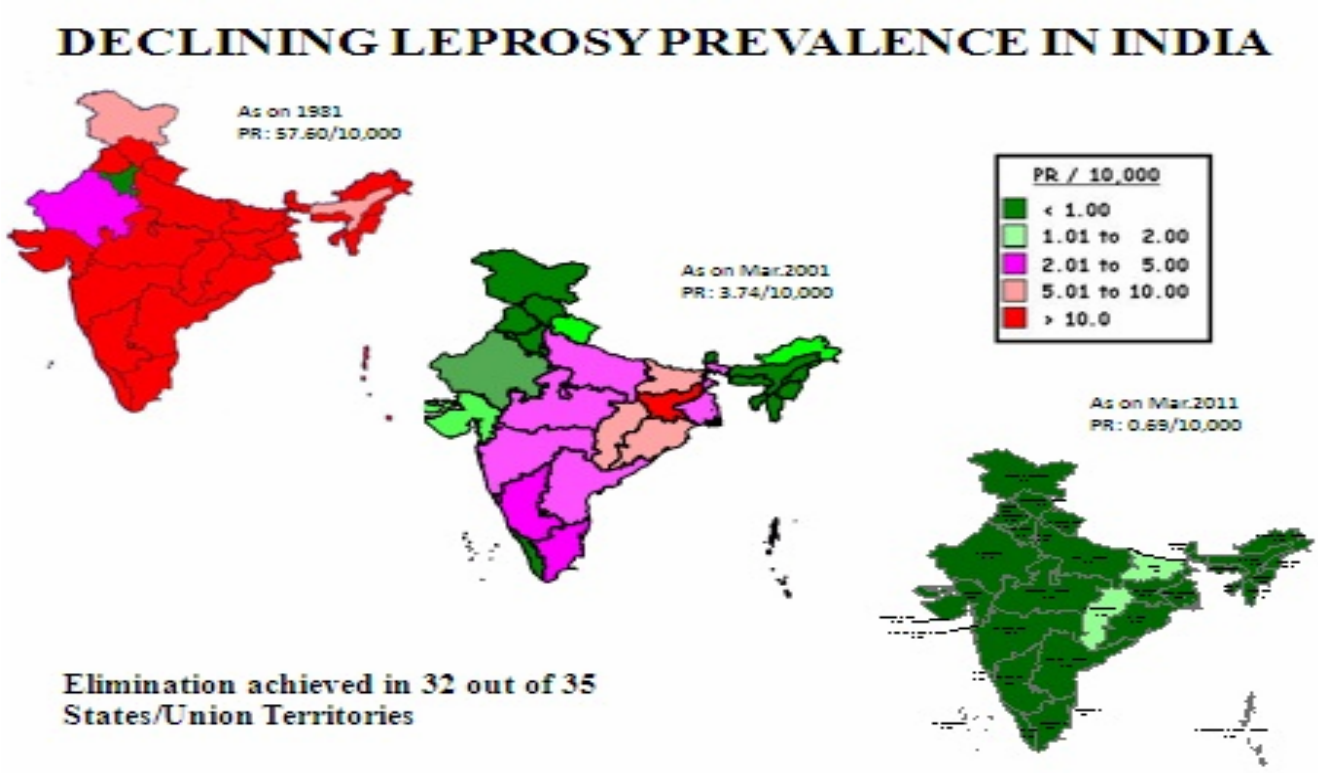
National Leprosy Control Programme was started by Govt. of India in 1955, wherein Dapsone domiciliary treatment was given through vertical units and survey education and treatment activities were implemented. It was only in 1970s that a definite cure was identified in the form of Multi Drug Therapy (MDT). MDT consisting of dapsone, clofazimine and rifampicin was recommended as a standard treatment for leprosy by the World Health Organization (WHO) in 1982. Following the recommendations of WHO Study Group, Geneva (October, 1981) and Dr. M.S. Swaminathan committee (1981) the NLEP was launched in 1983 by GoI with the objective to arrest the disease activity in all the known cases of leprosy. However coverage remained limited due to a range of organizational issues and fear of the disease and the associated stigma. Further, in view of substantial progress achieved with MDT, in 1991 the World Health Assembly resolved to eliminate leprosy at a global level by the year 2000. In order to strengthen the process of elimination in the country, the first World Bank supported project was introduced in 1993.

The 1st Phase of the World Bank supported Project initiated from 1993-94 was completed on 31.3.2000 with further 6 months extension to complete the preparation of proposal for 2nd Phase Project. Wherein, 3.8 million leprosy cases were newly detected against a target of 2 million cases and 4.4 million leprosy cases were cured with MDT. The prevalence rate reduced from 24/10,000 population in 1992 before starting 1st Phase project to 3.7/10,000 by March 2001. The 2nd Phase of World Bank Project on NLEP started for a period of 3 years from 2001-02 till 31st December 2004. This phase was implemented with the objectives which are as under:

1 Decentralization of NLEP responsibilities to States/ UTs through State/ District Leprosy Societies.
2 Accomplish integration of leprosy services with General Health Care System (GHS) and
3 Achieve elimination of leprosy at National level by the end of the Project.

Herein, well planned activities were efficiently implemented in close association of various NLEP partners viz. State & UTs Governments, World Bank, WHO, ILEP, DANLEP, NGOs and Community, Pvt. Medical Practitioners and various concerned Govt. Ministries/Departments such as Information & Broadcasting, Social Justice & Empowerment, Education, Railways, Defence/ paramilitary, Labour and Industries etc. During the last two years of the project a component of validation of case diagnosis was introduced.

In 2005, as the NRHM launched, the programme was subsumed under the aegis of NRHM and being implemented as a centrally sponsored scheme, as per the defined rules. The disease has come down to a level of elimination i.e. less than one case per 10,000 population at the national level by December 2005.



Map 1: Maps of India showing prevalence trend since 1981 to 2011

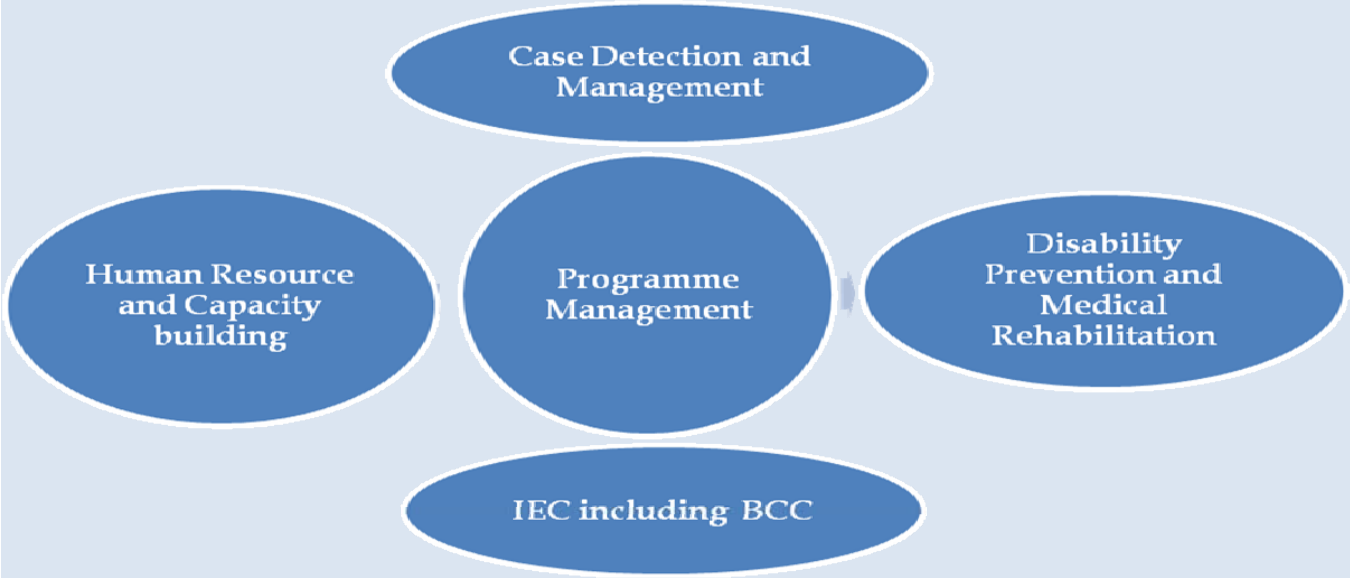
Strategies for XII Five Year Plan (FYP)

Leprosy is a chronic disease with a long incubation period (average 5-7 years). Although the disease has been eliminated at the National Level, there are Districts & Blocks which are still having prevalence rate >1/10,000 population. Besides this the new cases would continue to occur for few more years on account of long incubation period of the disease. Therefore, creating awareness for self reporting, timely diagnosis and complete MDT treatment of leprosy cases is crucial for ultimate eradication of the disease. Another aspect of the programme is gender imbalance as seen in new cases detection. Since the programme aims for eradication i.e. zero case of leprosy as the ultimate goal, sustained control measures need to continue during the 12th plan period.

Results (Objectives) to be achieved during 12th plan period i.e. 2012-2017 are as follow:

- Improved early case detection
- Improved case management
- Stigma reduced
- Development of leprosy expertise sustained
- Research supported evidence based programme practices
- Monitoring supervision and evaluation system improved
- Increased participation of persons affected by leprosy in society
- Programme management ensured

The programme components approved under XII FYP are as follows –

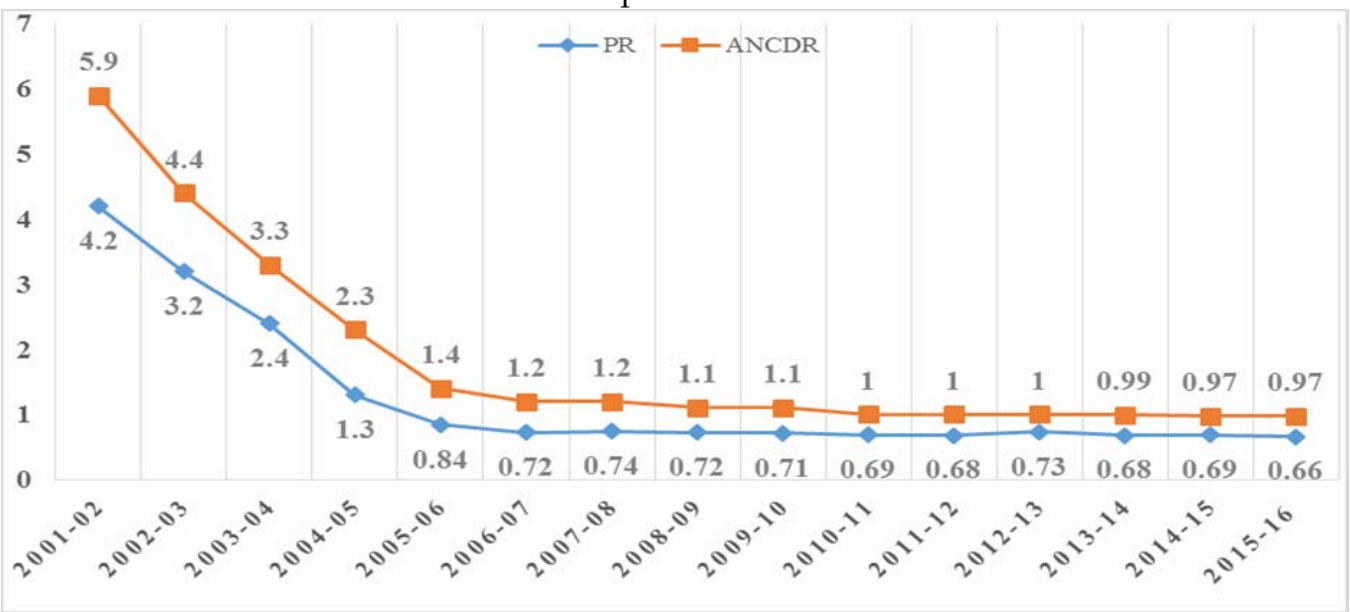


Flow chart 1: Programme components under XII FYP

Epidemiological Situation, as on March, 2016:

- Elimination at State level achieved in 34 States/UTs out of total 36 States/UTs.
- Chhattisgarh State and UT Dadra & Nagar Haveli yet to achieve elimination.
- Four states namely Delhi, Lakshadweep, Chandigarh and Orissa who have achieved elimination earlier, shown PR >1/ 10000 population.
- Approx. 127326 new leprosy cases detected.
- 86028 cases are on record as on 31st March 2016.

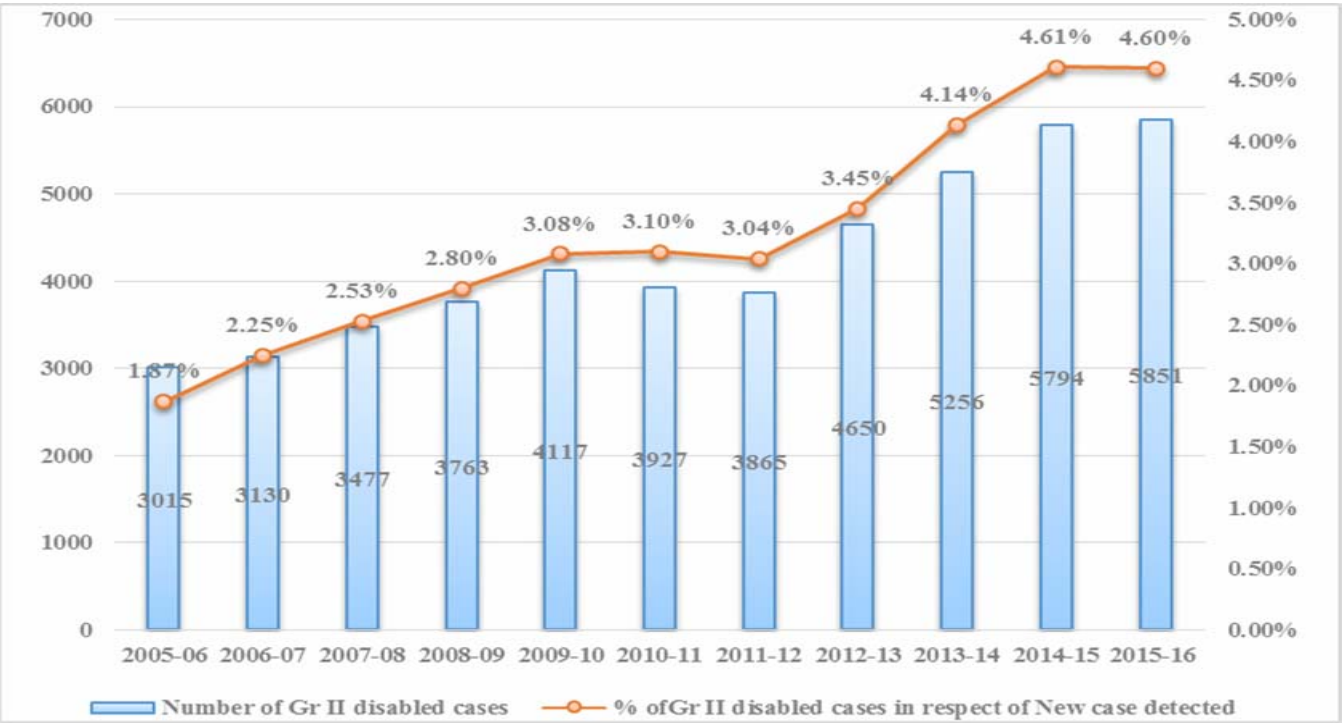
Further, the trend of Prevalence and Annual New Case Detection Rate per 10,000 population since 2001-02 to 2015-16 is shown in the Graph below:



Graph 1: Trend of Prevalence and Annual New Case Detection Rate per 10,000 population, 2001-02 to 2015-16 (provisional)

It has been observed that trend of two important indicators of National Leprosy Eradication Program, India i.e. Annual New Case Detection Rate (ANCDR) and Prevalence Rate (PR) are almost static since 2006 – 2007.

In addition, the percentage of grade II disability amongst new cases detected has been increased from 3.10% (2010 - 2011) to 4.61% (2014 - 2015), which indicates that the cases are being detected late in the community and there may be several cases which are lying undetected or hidden. The trend of Gr II disability cases amongst new leprosy cases from 2005-06 to 2015-16 is depicted in the graph below.



Graph 2: The trend of number of Gr. II disabled cases and % of Gr. II disabled cases i.r.o new leprosy from 2005-06 to 2015-16 (provisional)

Inter-alia, the report of Midterm Evaluation of the National Leprosy Eradication Programme, India 10 – 21 November, DGHS, MoHFW and WHO joint initiative stated that "It is clear that there are cases occurring in the community and detection capacity is not exactly matching the level and intensity of disease occurrence." (Para no.2, page no.41) It was also mentioned that "There is presumptive and scientific evidence that the number of cases detected is less than the number that occur. The exact magnitude of the gap cannot however be known" and recommended that "Periodic active case detection campaigns should be undertaken in priority areas with focus on detection of backlog cases as well as new cases. (Para no.2, page no.70)

As per the epidemiology of Leprosy disease, the major source of infection in the community is an untreated case i.e., a hidden case of leprosy lying undetected in the community, who transmit the disease agent to other people of the community. Early Detection

of same will lead to depletion of source of infection in the community, interrupt the active transmission of disease, reduce the complication of case management and reduce the disability. Hence, in order to detect the hidden leprosy cases, Leprosy Case Detection Campaigns (LCDC), on line with Pulse polio Campaign has been introduced specifically for high endemic districts, by Central Leprosy Division.

The LCDC as a flagship activity of NLEP is unique in its approach as various committees are formed at each level i.e., National, State, District, Block to plan & implement the LCDC. Intensive IEC activities, through various media are conducted during and before the LCDC. Under this Focused training of all health functionaries from District to Village level being given. The teams herein are being trained to suspect the leprosy patients through physical examination of each and every person of house visited. House to house visits by team encompassing one Accredited Social Health Activist (ASHA) and male volunteer i.e. Field Level Worker (FLW), conducted during LCDC days as per micro-plans prepared for local areas. Supervision of house to house search activities are done through identified field supervisors. Central Monitors nominated by Central Leprosy Division are directly monitoring the activities. Continuous, systematic collection and compilation of reports is being done through the formats designed for this purpose which are filled by search teams and supervisors. After the completion of the campaign the post LCDC evaluation also carried out through independent evaluators.

3. LEPROSY CASE DETECTION CAMPAIGN (LCDC) – INSTITUTIONAL FRAMEWOR

For better organization and management it is proposed to formulate special committees at various levels. These committees will ensure inter-sectoral coordination between all partners and other departments and review the progress in planning, implementation and monitoring of LCDC. The constitution of various institutes for each level will be as under:

Central Operation Group

It comprises of officials from Government of India, ILEP, WHO and other partners at the national level chaired by the DGHS, Government of India. The role of the Central Operations Group is to:

- Support pre-planning and to fast track decisions on extent of LCDC.
- Coordinate activities with partner organizations like WHO, ILEP and State level representatives Principle secretary HFW etc.
- Coordinate with other National and International organisations.
- Monitor implementation of LCDC activities at national, state and district level.

State Co-ordination Committee

State Co-ordination Committee under the chairmanship of Principal Secretary Health & Family Welfare of the State with State Leprosy Officer as the Member Secretary, will be formed. Other members of the committee would be Mission Director (MD), NHM, Director Health Services (DHS), State level representatives of the key partners like Social Welfare, Education, PRI, Partners i.e. ILEP, WHO, Association of Persons Affected with Leprosy (APAL), Indian Medical Association (IMA), Senior Regional Director, State Program Manager, NGOs working for Leprosy in the State. In addition two persons may be nominated by Principal Secretary Health & Family Welfare of the State.

The role of the committee is:

- To ensure intersectoral coordination and full utilization of resources from partner government and non government departments.
- Monitor preparedness in each district of the state.

State Leprosy Awareness Media Committee

State Leprosy Awareness Media Committee under the chairmanship of DHS/ MD (NHM)/ Director SIHFW of the State with the State Leprosy officer as the Member Secretary will be formed. Partner organizations like ILEP, WHO, APAL, local NGOs and State Media Cell, local Akashwani and Doordarshan Kendras will be represented in the committee through their state level representatives. The role of the committee is to:

- Develop a media plan with timeline.
- Utilize all available resources and channels for delivering simple and clear messages to the community, which will help to ensure success of LCDC & more acceptability and cooperation to health teams during house to house visits.
- Monitor implementation of IEC/social mobilization activities in the states.

District Coordination Committee

District Coordination Committee under the chairmanship of the District Collector/Magistrate/ Chief Executive Officer, Co-chaired by CMO/ CS/ DMO with the District Leprosy officer as the Member Secretary will be formed. District level representatives from Zila Parishad, APAL, Social Welfare deptt., District Publicity Department and District Health Education Officer, District ASHA Coordinator, District Programme Manager, District Epidemiologist should be a part of the committee. The role of the committee is to:

- Supervise, Support, Monitor and ensure Implementation of the highest quality LCDCs in the district.
- DM and CMO should also use these meetings to clear obstacles for planning and implementation of the LCDC.

Tehsil / Block Coordination Committee

Similar to the District Coordination Committee, Tehsil / Block Coordination Committee must be set up under the chairmanship of Sub Divisional Magistrates (SDM) with Block Medical Officer as co-chairman. Further, member of PRI, ICDS, Education, local NGOs, APAL, Social Welfare deptt., ASHA facilitators/ Sahiya Saathi, Community mobilizers, Block development officers and Block MOICs should be a part of the committee. The role of the committee is to:

- Supervise, Support, Monitor and ensure Implementation of the highest quality LCDCs in the block.
- SDMs, BDOs and MOICs should also use these meetings to clear obstacles for planning and implementation of the LCDC.
- The Committee should meet at least once before the LCDC and at least once during the activity.

LCDC control rooms shall be set up in the office of the State Leprosy Officer and District Leprosy Officers. The role of the control rooms will be to monitor preparedness of LCDC on a day to day basis especially mobilization of human and other resources like transport, ensure intersectoral coordination and full utilization of resources from partner, government and non-government departments. They should also monitor implementation of the programme during the campaign. The control rooms should provide feedback to the committees on progress being made and also on any obstacles being faced.

4. LEPROSY CASE DETECTION CAMPAIGN (LCDC) – PLANNING & IMPLEMENTATION

In order to plan and implement in State, it is expected that meetings of all the committees must be scheduled with clear objectives, agendas, and action points to be undertaken further. The proceedings of meetings include progress, problems encountered, proposed solutions and new action points with clearly defined responsibilities and deadlines. Minutes of the meetings and action points should be shared with all the participants within 72 hours of meeting conducted. It is the responsibility of the committees to ensure that activities are completed, adhering to guidelines and timelines.

Meeting for LCDC planning at State level

- **State Co-ordination Committee Meeting:** Meeting of State Co-ordination Committee must be held before each LCDC with the objective to channelize State resources for successful implementation of LCDC.
- **State Leprosy Awareness Media Committee Meeting:** Meeting of State Leprosy Awareness Media Committee must be held before LCDC to formulate the IEC plan and select best suitable media approach for communication prior and during the campaign.

Meeting for LCDC planning at District level

- **District Coordination Committee Meeting:** Meeting of District Co-ordination Committee must be held before each LCDC with the objective to materialize inter-sectoral coordination for LCDC implementation and after LCDC to review the LCDC implementation.
- **District Micro planning Meeting/Urban Area Planning Meeting:**
  - The Chief Medical Officers (CMO) / District Leprosy Officers (DLO)/ District Leprosy Consultants and the NLEP consultants from ILEP, should facilitate these meetings.
  - The meetings have to be attended by all Block/Municipal Medical Officers, urban health planners, representatives from Social Welfare deptt., and other organizations involved in social mobilization, along with personnel involved in planning at the block level.
  - The objective of these meetings should be to sensitize the block medical officers (BMOs) and the urban area planners on how to prepare micro plans for their areas for the upcoming LCDCs. Special attention should be paid on developing **area-specific IEC strategies for problem pockets.**

Meeting for LCDC planning at Block level

- **Tehsil / Block Coordination Committee Meeting:** Meeting of Block Co-ordination Committee must be held regularly before, during and after LCDC with the objective to materialize inter-sectoral coordination for LCDC implementation in block, resolve issues if any regarding LCDC and plan corrective measures timely. It is the responsibility of this committee to forward the important decision taken during the meeting to higher level committee.

Trainings at Various level

State LCDC training workshop (More than one trainings may be conducted if number of participants is higher. States may take decisions to conduct training workshop at regional level.):

- Two days training workshop for District and Sub – district level officers to be conducted, wherein SLOs, SLCs, Central Nominee and ILEP/WHO Representatives would train **DLOs, DLCs and Block/Municipal Medical Officers.**
- The objective of the workshop is to sensitize the district & block level planners on the strategy to be followed, need for preparing microplans for their areas, and sort out issues of coordination between the implementing partners. Power point presentation (PPT) on the need and guidelines of LCDC may be used to orient all participants in respect of LCDC.
- The attendees may also be sensitized for the need of physical examination of each and every person of the community to suspect the leprosy cases in the community.

Block/ Ward level training workshop:

- One day orientation training at blocks /ward level to be organized wherein, DLOs, DLCs, Block/Municipal Medical Officers and ILEP/WHO Representative (wherever available) would train ASHAs/ Field Level Workers (FLWs)/NGO staff/ Health Worker Male & Female/ Health Supervisors and any other field supervisors.
- The objective of the trainings would be to build the capacity of search team members and supervisors to conduct the house to house case search activity.

The orientation will cover the operational as well as the interpersonal communication aspects of the LCDC. The instruction sheet for search team, tally sheets, info kit on frequently asked questions should be distributed and discussed during this orientation. The training session has to be interactive and participatory with particular focus on newly inducted search team members. Demonstration of filling up of tally sheet house marking followed by exercises for imparting operational skills with help of Role Plays on IPC and FAQs should form an essential component of the training sessions. Additionally, supervisors must be trained on their role with the help of the training instruction given in the annexure and to fill the formats pertaining to them.

State /District/ Block Review Meetings after completion of LCDC:

A review meeting should be organized at Block level after 2 days at District level after 5 days & at State level after a week of completion of LCDC activities to review the performance of LCDC activity based on the feedback from state, district and block level supervisors. Data analysis from the LCDC round should also be presented at this meeting. The meeting should identify actions to be undertaken for rectification of deficiencies in the next campaign. Timeline to complete the confirmation process of suspects identified during LCDC has to be defined herein.

Monitoring by State, District and Block Monitors (nominated by CLD, SLO, DLO respectively):

The monitors for States will be nominated by Central Leprosy Division, from Central Leprosy Institutes (CLTRI, RLTRIs), National JALMA Institute for Leprosy & Other Mycobacterial

Diseases (NJILOMD), Regional Office for Health & Family Welfare (RoHFW), World Health Organisation (WHO) and International Federation of Anti-Leprosy Associations (ILEP) etc. District and Block Monitors must be nominated by State Leprosy Officers and District Leprosy Officers respectively. The human resources working for the NLEP/ Health system of the district where the LCDC is not planned in a particular year and representatives from ILEP, WHO, NGOs may also be identified as district & block monitors.

These monitors should be allotted State/ Districts / Blocks/ Urban areas, which must be meticulously visited before the LCDC for monitoring the preparedness and during the activity to monitor the implementation of the activity. The monitors should identify any constraints that are likely to affect the implementation of the programme and find solutions to remove any bottlenecks. Qualitative and quantitative assessment of the LCDC activity from monitors should be utilized for long term corrective actions like problems faced by ASHAs & FLWs during campaign, review of microplans etc. or immediate corrective actions like repeating the activity in an area where significant number of uncovered houses are found after completion of activity.

The list of monitors along with the districts / blocks/ urban areas allotted must be shared with Central Leprosy Division.

Role of monitors during preparatory phase:

State Monitors:

- Attend State level workshops and meetings.
- Conduct visits to few of the districts selected for LCDC to assess preparedness.
- Report findings to DDG Leprosy.

District Monitors:

- Attend District Coordination Committee meetings.
- Conduct visits to few of the blocks for LCDC to assess preparedness and if microplanning is being followed or not.
- Report findings to SLO.

Block Monitors:

- Attend Block Coordination Committee meetings.
- Review the micro plans to ensure that:
  - All components are present.
  - All geographical areas have been included.
  - Team composition is appropriate – all house-to-house teams have at least one ASHA and at least one male Volunteer.
  - Sensitization trainings to detect the cases have been planned for all ASHAs and Volunteers.
  - Workload of teams in terms of houses to be covered/ day has been rationalized.
  - Areas requiring special attention have been identified and plans developed to cover them.
  - IEC/ Social Mobilization plans have been developed and documented.

Role of monitors during implementation phase:

- All officers should again visit their allotted States/ districts / blocks/ urban areas as applicable during the implementation phase to assess the quality through the completeness of coverage of population/ area during house to house visit.
- Assess the quality through collection of information on missed areas, false (L) covered houses and false X to L conversion conducting field visits. Facilitate immediate corrective action at all levels.

5. LEPROSY CASE DETECTION CAMPAIGN (LCDC) – MICRO PLANNING

Successful implementation of Leprosy Case Detection Campaign (LCDC) requires meticulous microplanning. Important components of microplan are as under:

- Campaign specific IEC
- House-to-house case search activity

Information Education Communication (IEC) and Social Mobilization:
Effective communication is vital to ensure that all cases are detected during LCDC. This requires a planned, intensive approach through interpersonal communication, community mobilization, advocacy, and visibility of the programme through IEC activities. Each state and district should aim to meet two broad objectives:

- Create community and family awareness & acceptance of the LCDC during house-to-house activities so that no cases are missed.
- Coordination with GOI, State governments, district administrations, ILEP/ WHO, NGOs, Panchayati Raj Institutions, Education department, Information and Broadcasting department, ICDS, key religious institutions and others to expand the reach and impact of the programme.

Activities to be undertaken for campaign specific IEC:
It is essential that adequate social mobilization measures and awareness at mass level are undertaken prior to the LCDCs so that community is fully informed about the i) Dates of field visits, to be undertaken by ASHAs and Volunteers in an area, ii) The need & benefits of this campaign for Leprosy patients and community which should be reminded during the campaign also. Considering before-mentioned necessities, following instructions to be pursued:

- There must be publicity of LCDC for 5 days.
- 2 days prior to starting the activity and for 3 days after starting the house to house case search.
- Emphasis on need based planning may be given to address the local need for awareness e.g. leaflets/pamphlets may be suitable for literate targets while folk play, miking, drum beating will be effective for rural areas.
- The day wise IEC activity plan for LCDC is shared at annexure XIX.

Key Strategies:

- Focus on interpersonal communication (IPC) for raising awareness in urban slums and rural areas supplemented by mass media & print material.
- Mobilization of the Panchayati Raj Institutions system to support leprosy elimination, including calling of Gram Sabha to plan and ensure population screening for case detection.
- High-risk area approach for programme planning, monitoring, training and social mobilization in selected areas/ districts.

- Special messages & use of different channels of communication for hard to reach groups and urban areas.
- Consistency in the message should be maintained.

Messages:
The following key messages must be delivered through pamphlets, big hoardings and paintings and through interpersonal communication also in the language understood locally:

- If you have a light color patch, redness, loss of sensation, swelling or nodule over the skin, it may be leprosy.
- Leprosy, like any other disease, can happen to anyone however it is completely curable.
- Disability caused by leprosy can be prevented if reported and treated early.
- Treatment of leprosy i.e. Multi Drug Therapy is available free of cost.

Message can be framed or edited as per the circumstances and availability of resources.

Preparation and Distribution of IEC materials:
State-Level Activities: The State IEC Bureau must coordinate with partners to ensure timely production and distribution of audio cassettes for miking in districts/blocks, Poster and banner, Local Press-Advertisement and announcements/messages in local programs and cable channels. Mobilize local cable-operators and cinema theatres in urban/peri-urban areas to screen leprosy messages in the local cable-TV network and cinema theatres.

IEC/Social Mobilization Microplans: At least 15 days in advance of the LCDCs, a block level microplan will be finalized. The microplan will especially include the following:

- Listing of high-risk pockets and outreach areas requiring special efforts.
- Detailed route-charts/schedules for miking activities, prioritizing high-risk pockets.
- Listing of influencers such as community/religious leaders, gram pradhans, and medical practitioners.
- Miking to be carried out by slow-moving vehicles such as cycle-rickshaws/cycles and not from fast moving vehicles. Miking must be conducted in villages prior to the arrival of a LCDC search team. Miking vehicles/drum-beaters must follow the route-charts. Fixed-post miking in mosques/temples to be mobilized for making live announcements at least thrice a day, on all 5 days. Conduct mobilization meetings with local influencers such as community/ religious leaders, gram pradhans and panchayat members (especially women panchayat members), and local medical practitioners. School children should also be mobilized to encourage families and neighbours for acceptability of LCDCs.

Mobilize local cable-operators and cinema theatres in urban/peri-urban areas to screen leprosy messages in the local cable-TV network and cinema theatres

Essential steps for increasing community participation:
The LCDC, to be successful in detecting maximum number of cases, needs to be supported by:

- Information, Education and Communication (IEC) over the mass media.
- Well planned local miking/drum beating on slow moving vehicles and from fixed sites starting 2 days prior to the campaign and continued during campaign.
- Interpersonal messages from the ASHAs/Health workers prior to the LCDC round.
- Community participation in the selection of the dates to organize the house to house search.
- Increased acceptance by the local level by involving all sectors (Health, ICDS, Education, Panchayati raj institutions, local NGOs).
- Launching of LCDC by local influencers or community leaders.

General Principles to prepare Microplans for house to house case search:

- A micro plan would exist at many places. As far as possible review and make improvements in the existing microplans rather than start to make new plans.
- The existing microplans used in the LCDCs should be reviewed along with the data generated in the recent LCDCs and feedback from monitors, central and state observers, medical officers, district and block level supervisors, to make suitable amendments in the microplans.
- Delegation of planning responsibility to the appropriate administrative level e.g., block or PHC or urban area where the activities will take place. Each block/PHC/urban area should be taken as the basic unit for microplanning. It should be further sub divided into supervisor's areas and these into LCDC team areas.
- Microplans should be developed and reviewed with the volunteers, ASHAs, supervisors, block medical officer, community mobilizers, other field volunteers/ local influencer (if available) and block medical officer (BMO) sitting together.
- Block medical officers and supervisors should be responsible for planning of LCDC activities for their areas.
- All habitations and all houses in block/urban area jurisdictions should be included in the microplans. Microplans must target whole population.
- The national guidelines regarding number of houses/ team/day, logistics and IEC etc as per financial guidelines, should be considered and adapted to local needs. The adapted plans should be communicated to the higher levels.
- Plans should be based on local conditions, accessibility, geography, population movements, working hours (when are people available at home?) culture, etc. in the catchment area.
- Meetings should be held with village pradhans (councilors in urban areas), sarpanches and other local influencers to get their inputs on the local conditions while developing or reviewing the microplans.

- Micro plans should be prepared in local language so that volunteers, ASHAs, supervisors, local influencers and other team members of LCDCs can follow them easily.
- LCDCs activities can only be of high quality if microplans are based on local capabilities and constraints

While planning for rural areas, ensure the following in the micro plan:

- All hamlets (tolas/ purwas) adjoining the village are documented and covered during the activity.
- All residential schools are covered.
- Brick kilns are covered by h-t-h team or special mobile teams.
- Names of prominent local influencers like pradhans, panchayat members, local doctors, teachers, religious leaders, anganwadi workers etc. are incorporated.

For urban areas ensure that:

- All peri-urban areas, slums, pavement dwellers, construction sites and new settlements are covered in the micro plans.
- Households on upper floors are accounted for while estimating no. of houses to be covered by teams.
- The names of local resident welfare organizations, community leaders etc. are included in the microplans.

Use of Data for Planning Actions:

It is essential to use the existing data for identifying actions required to plan and implement LCDC in the area. Existing micro plan of the area can provide data on: -

- Total houses along with population residing in the area.
- Name of villages and their hamlets/ Name of all urban mohallas/ localities. If these lists are not available they should be developed with inputs from census data, revenue records, local municipal bodies, elected representatives etc.
- List of high risk and underserved areas.
- List of areas missed in the previous LCDCs.
- Feedback from monitors and supervisors regarding past LCDC.
- Data derived from analysis of tally sheets and reporting formats.
- List of available volunteers/ ASHAs team members and supervisors with department wise break up.
- Map of the block.

Micro Planning for High Risk Areas and Underserved Population:

It has been observed that the same population groups are often missed by the routine programme activities. All these groups must be identified and such areas must be enlisted in the micro plans. These areas should be considered as high risk and the population as underserved.

Indicators for High-risk areas i.e. area prone to extremely flooding for six months or more per year, naxalite affected areas, hard to reach due to geographical location etc. and underserved population include the following:

- A confirmed leprosy case has occurred in the recent past.
- Problems in terms of non-cooperation from community during case search/ campaign.
- Low routine case detection coverage.
- Urban slums or peri urban areas not recognized by district authorities.
- Remote, sparse and difficult to reach population groups like nomadic tribes, boat people, and isolated families living along riverbanks for farming, river islands etc.
- Mobile population and tribes
- People with working hours that do not coincide with the visit of teams (for example persons going to the fields during harvesting and sowing seasons are simply missed because teams do not reach either before they leave or after they come back from the fields).
- People living at construction sites, brick kilns
- Travelers, who may be on the road or in the train when the campaign takes place.
- People living in houses outside recognized settlements (the "no man's land").
- People that have lost their faith in the health programme, because of low quality of services provided, lack of explanation, and/or rude behavior of health functionaries in the past.
- People of specific socio economic status, which require 'special' efforts to reach. Persons with high socio economic status may disagree with case detection campaign, because they assume that leprosy cannot occur to them. Whereas, People of low socio economic status may distrust anything offered for free and request other services.
- Misinformed groups, who may refuse examination because of wrong beliefs or stigma attached to the Leprosy. They do not oppose examination because of religious reasons, but because of lack of proper information through the proper channels.

Special efforts for high risk areas and underserved populations:

The States and districts will need to take special measures to ensure that all people are examined in these high-risk pockets. The special measures for high-risk areas include the following (these are in addition to what is already being done for other areas):

- Intensive efforts for social mobilization and IEC need to be undertaken in these areas, such as:

  Intensive miking, house-to-house visits by health workers to involve community leaders, panchayat members particularly the women members, religious leaders and other local influencers like medical practitioners, local moneylenders, grocery shop owners, popular teachers, prominent youth etc. to provide proactive support.
- Local community members/influencers must accompany search teams during house-to-house visits in such areas, especially during revisit to X houses.
- Deployment of reliable trained and motivated manpower in such areas – best workers for worst areas.
- Workload of house-to-house search teams should be rationalized to give a feasible workload to each team.

- The search teams should undertake house-to-house visits when all persons are most likely to be available at their homes. This may require changing hours of operational activities to early mornings or late evenings.
- More intense supervision in the area with supervisors being allotted less number of house-to-house search teams.
- Increased supervision in these areas by state and district officials who should make frequent visits both during planning and implementation phase.
- Designate a person in each district to be responsible for these underserved population groups/areas.
- Intensive monitoring of such areas by best supervisors to get accurate feedback.
- In some tribal areas residential schools are run same must be included in microplan.

LCDC in misinformed groups:

- Search teams working in these areas should be specifically selected and specially trained to search for all hidden cases, in each household, convince them and then carry out examination activities.
- Each house-to-house search team in such areas must have at least one male member/volunteer and ASHA from the community where they are working.
- Teams in such areas should be assigned no more than 10-15 houses per day. This would allow the teams to spend more time in each house.
- Local community members/influencers must accompany search teams in such areas to convince reluctant community.
- Teams should also carry appeals from community/religious leaders to convince reluctant people/ community.
- During house-to-house campaign in these areas the male volunteer in the team should take the lead in seeking permission from head of the family before entering the house.
- After introducing themselves and explaining the purpose of their visit members of search team should determine the number of households in each house (as defined by the number of kitchens in the house) and then determine the number of inhabitants in each household by asking all relevant questions.
- Additionally members should also cross verify the number of people living in the house from neighbours, local influencers accompanying the teams, people in the street etc.
- If any family member raises queries regarding leprosy, team member must respond in a respectful and courteous manner to clarify their doubts or misgivings. The portion on FAQs may be referred by the search teams.

LCDC at Brick kilns, construction sites: Brick kilns, construction sites must be covered by house-to-house search teams. Search teams must be specially trained to carry out search in these specific situations.

- Owners of brick kilns/construction sites must be informed well in advance about the date and purpose of visit by search team by the district/ block officials.
- The local clerk/contractor should be contacted in advance and a list of the families working at the kiln/sites should be prepared.
- The search team must carry this list during their visits.

- Search teams must visit the homes of the workers at these sites and also surrounding brick fields (Pather/Pasar) where the families are making bricks. These may be situated at a distance of about 1-2 kilometres from the brick kiln.
- The teams should examine all persons at these sites and should counter check from the list to ensure that all families are covered and all persons are examined.
- Since families frequently migrate to these sites, brick kilns and construction sites should be visited twice during each LCDC to ensure that all new arrivals have also been examined.

Micro planning for urban areas (DLOs may identify areas where chances of existence of leprosy cases are negligible and may exclude those areas for LCDC):

Planning for urban areas is crucial for successful implementation of LCDCs. Some of the commonly observed deficiencies in urban areas are:

- Lack of adequate health infrastructure and manpower
- Large slums (unauthorized)
- Periurban areas with new settlements and some areas/colonies not recognized by municipal health authorities
- Multiple construction sites

For planning and implementation purposes, urban areas should be divided into smaller planning units based on municipal wards or assemblies and if this is not possible then by roads or prominent landmarks. Each such unit should be put under the charge of a medical officer or nodal officer. The officer should be responsible for:

- Development of microplans for house to house LCDCs.
- Male and female volunteers selection from same community. USHAs will replace ASHAs in urban areas.
- Manpower deployment in the area by arranging additional manpower from non health departments like social welfare, education and NGOs or volunteers.
- Developing a plan for IEC activities like:
  - Miking from fixed sites and slow moving vehicles like cycle rickshaws
  - Delivery of messages on the programme through the cable TV, cinema slides and telephone
  - Display of banners, posters, vertical boards, hoardings in the area. A list of prominent sites for display of these should be developed.
  - Meeting with community and religious leaders of the area
  - Training of search team
  - Inter-sectoral coordination with other agencies
- Supervision of LCDC activities
- Daily feedback from supervisors and immediate corrective actions during the LCDC.
- Compilation of daily reports and onward transmission to identified officer/ official.
- Involvement of local municipal bodies and their staff is essential in urban areas. Municipal staff is familiar with the layout of the urban areas and their inputs are vital for planning and supervision of house-to-house activities.
- Coordination with education department, social welfare, civil defence, other local NGOs, resident welfare associations and community leaders is vital for meeting

shortage of community volunteers, social mobilization and also for community acceptance.

- Maps must be used while planning for urban areas. If maps are not available with municipal bodies search teams and supervisors should be sent to the area before LCDC in order to become familiar with the area and develop maps.

Area allocation and workload of teams:

Each search team would be encompassing of one female and one male volunteer i.e. Accredited Social Health Activist (ASHA) and Field Level Worker (FLW) for a population of 1000, on an average 200 households. Each team should be allocated clear-cut, well-demarcated areas clearly mentioning the starting and ending points, identifiable with landmarks; for each day of h-t-h activity. The form P3, placed at Annexure IX may be filled in duplicates during training session only, one copy has to be retained by teams and one to be submitted to supervisor of respective teams.

The optimal number of houses to be covered should be decided in consultation with the concerned teams working in the area taking into account the local geographical conditions and the time taken in travel and to revisit X houses and not be fixed by the district officials. However as a general guideline:

- In rural areas 15-20 houses per team per day may be planned. This number may be changed in view of local situation to allow optimal time for travel and revisits to X houses.
- In urban areas 20-25 houses per team per day may be planned.
- The number of houses per day may be less in sparse/scattered population. This number may vary from day to day depending upon the geographical situation of area planned to be covered by the team on a particular day.

The no. of houses to be covered each day should be mentioned in the microplan. Honorarium will be paid to team members as per norms communicated by CLD.

Activities of teams:

(a) Search and detection/diagnosis of cases affected with Leprosy during house to house visits :

- During h-t-h activity, the form P3 already submitted by teams, should be used to visit all houses systematically. No house should be left unvisited.
- House to house visits and revisits to 'X' marked houses should be undertaken at the time when inhabitants of the area are most likely to be available at their homes.
- During house-to-house visits, teams should knock at the door and then enter each house.
- Team should then greet the respondent politely, introduce themselves, and explain the purpose of their visit.
- Team members should discuss the need & benefits of this campaign for Leprosy patients and community. They should try to address the queries and myths regarding disease and programme.

- The next task is to determine the correct number of inhabitants of the house. To determine correct information, the team members have to go systematically and ask all the following questions in each house:
  - How many families (households) are staying in the house? Number of families is to be determined by the number of *'chullahs'* (kitchens).
  - What is the number of persons residing in each house hold?
  - Are all persons in the house? Determine information household wise.
  - Are any person (who normally live with the family) away from home for reasons like: Gone to fields or market place or school (in case of children), Visiting friends /relatives within the village or in other villages / cities, Gone out to their place of work. Outside the house for any other reason.

The case definition to be followed for suspect identification in the field is "Any person with discoloration of skin and/or thickened and/or shiny and/or oily skin and/or nodules and/or inability to close eyes and/or ulceration in hands and/or feet and/or clawing of fingers and/or foot drop and/or informs tingling and/or numbness in hands and/or feet and/or loss of sensation in palms and/or soles and/or inability to feel cold or hot objects and/or weakness in hands and/or feet for holding/ grasping objects."

All persons above 2 years of age should be should examined. All females should be examined by female volunteer (ASHA or any other) and males should be examined by male volunteers. The physical examination is to be carried out in well lighted room or in compound, maintaining privacy.

The teams must fill the tally sheet for house to house case activity, Form T2, same may be retained till the end of search activity and should be submitted to health system personnel after signature.

Before moving to the next house, team should thank the mukhiya/ head of the family and family members as well for their cooperation and be doubly sure that all inhabitants of house have been examined in the house and if not the details of same has been captured in under X column.

(b) Marking of houses by search teams:

All visited houses should be marked with white/coloured chalks or geru as:

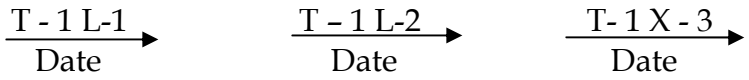
i) L/date:

- All persons staying in the house have been examined in this visit. This includes persons visiting the house when the campaign is on.

ii) X/date:

- All or some eligible inhabitants of the house were not examined for reasons like:
  - Persons not at home for the following reasons away to farms/ fields, place of work, school or market places
  - Visiting friends or relatives
  - Locked house

EXAMPLES OF HOUSE MARKING



In above mentioned examples the T represents the Team No., L and X as per the status of examination of inhabitants residing in house, done during the visit and arrow depict the direction of movement.

However in tally sheets, X houses must be recorded in the table with reasons for the X in the following categories:

i. XR = refusal by family for physical examination
ii. XH = any or all members not at home but will return during search period i.e., away to farms/ fields, place of work, school or market places, visiting friends or relatives
iii. XV = any or all members of the family is not in home and is not expected to return before the end of the search period
iv. XL = the house is locked and is expected to remain locked for the duration of the search period

For revisit - make record of left out houses and revisit on the next day only. If not available revisit on next day, 7th & 14th day of LCDCs. It is instructed to finish all the planned houses by 13th day of LCDC and revisit all the X houses, mark the houses as RV – 1, RV – 2 for revisit to the houses.

The XV and XL houses wherein the inhabitants are not supposed to come back within the stipulated time period of case search activity i.e., 14 days of LCDC or if house remained locked till the end of activity, should not be considered as 'X'.

In areas where people are reluctant to go for physical examination and leprosy case search is an issue, revisits to X houses should be made along with the local influencers/community leaders who would be able to motivate the family for better cooperation.

Flexible timings and flexible days of activity will increase the acceptability and cooperation by the community.

6. OTHER KEY COMPONENTS OF PLANNING AND IMPLEMENTATION

Other key components which require planning and implementation are as under:

- Supervision
- Mapping of areas
- Recording and reporting
- Review of micro plans and data analysis for planning interventions
- Use of data for planning actions

Supervision: There must be three tiers supervision during LCDC. Field level supervisor for ASHAs, Block level supervisors are Public Health Nurses and Block Medical officers and District level supervisors are District Leprosy officers. Engagement of Para medical worker (PMW) and Non-Medical Supervisors (NMS) is essential in supervising this activity.

High quality supervision is vital to the success of the programme. Supervision should not merely be inspection for fault-finding. Supervisors should be supportive and should be able to:

- Identify problems and help to solve them.
- Support, encourage and motivate search teams in carrying out high quality LCDC activities completely.

Supervisors must assist the BMO in reviewing and revising micro plans before the LCDC and carry out the following activities: -

- Note the details of all teams to be supervised by him/her.
- Record the itinerary of all search teams i.e., clearly identified start and end points with landmarks for each day.
- Develop the map for supervisors.
- The names of the local influencers should also be known to supervisors.
- Visit search teams working under him/her during house to house search activities to identify issues like last minute absenteeism of team members.

Ensure that search teams are working as per their microplan and that:

- Ensure that all logistics, needed forms etc. are distributed to teams as per plan.
- All areas and houses are visited, including isolated communities, mountainous areas, and apartment dwellers on top floors.
- Tally sheets are marked immediately after each home visit.
- Correct marking of houses being done.
- Revisit by search teams to X marked houses is being done.
- Randomly visit a sample of the 'L' marked houses to check if all persons are examined.
- Visit 'X' marked houses of reluctant persons to convince them about the need of the LCDC.
- For teams not performing well, conduct on the spot orientation training of ASHAs and FLWs to suspect the cases of leprosy.

- Assist medical officer in Collection, compilation and analysis of data from search teams.
- Attend evening meeting and provide feedback to Medical Officer.
- All cases suspected during the LCDC must be confirmed.

The supervisors should be familiar with the area, prepare a supervisors' maps with assignment of teams on map, and develop a plan for supervising teams in a systematic and planned manner. They should use the supervisors' formats to supervise teams in the field. Each supervisor should visit each team at least twice during the campaign days. Supervisors must be trained on their role with the help of the training instruction given in the annexure.
If a supervisor, during random crosschecking of areas, already visited by search team, detects 3 or more than 3 false 'Ls', then the search team must revisit all houses in that area.

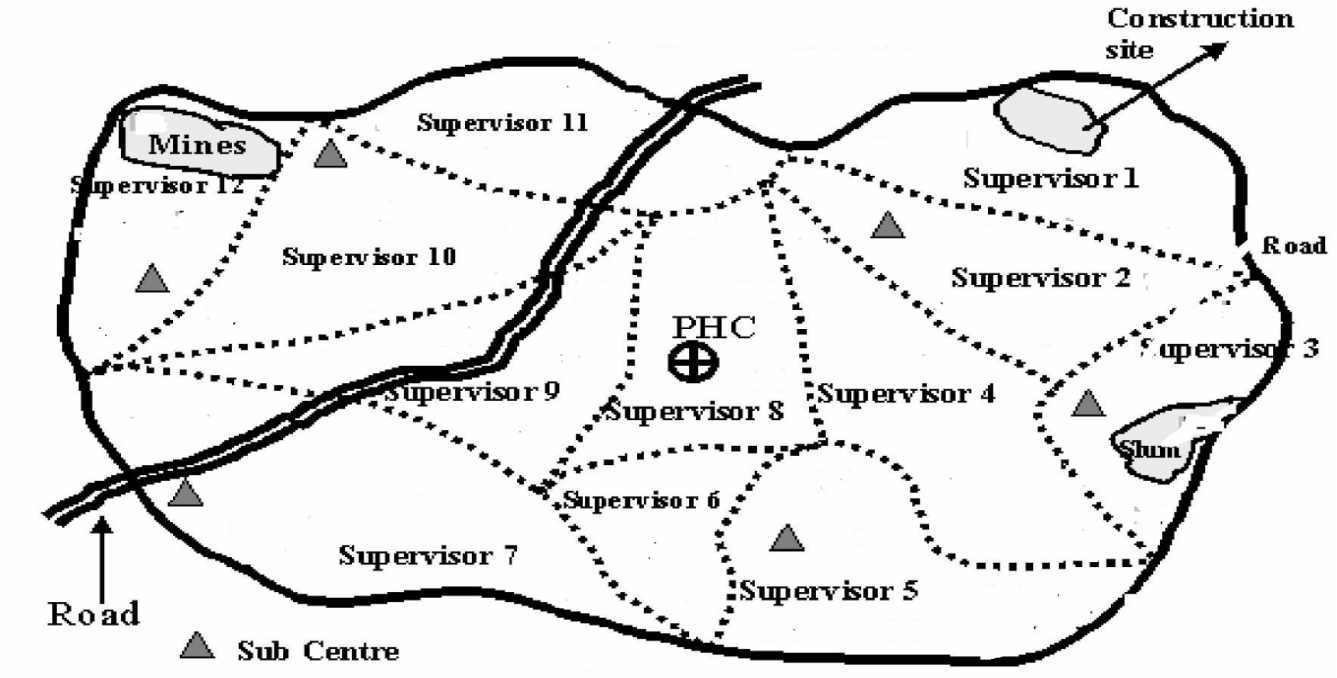
Supervisors must pay attention to high-risk areas and go where teams do not like to go

Mapping: Maps are useful for planning and ensuring completeness of activities.

Planning unit Maps: Maps should be developed at each block/ PHC/ Urban area and should indicate:

- Supervisors' areas with demarcation
- High risk and difficult to reach areas
- Areas from where more cases and grade II disabled cases have been detected
- Population likely to be missed
- Major landmarks and roads

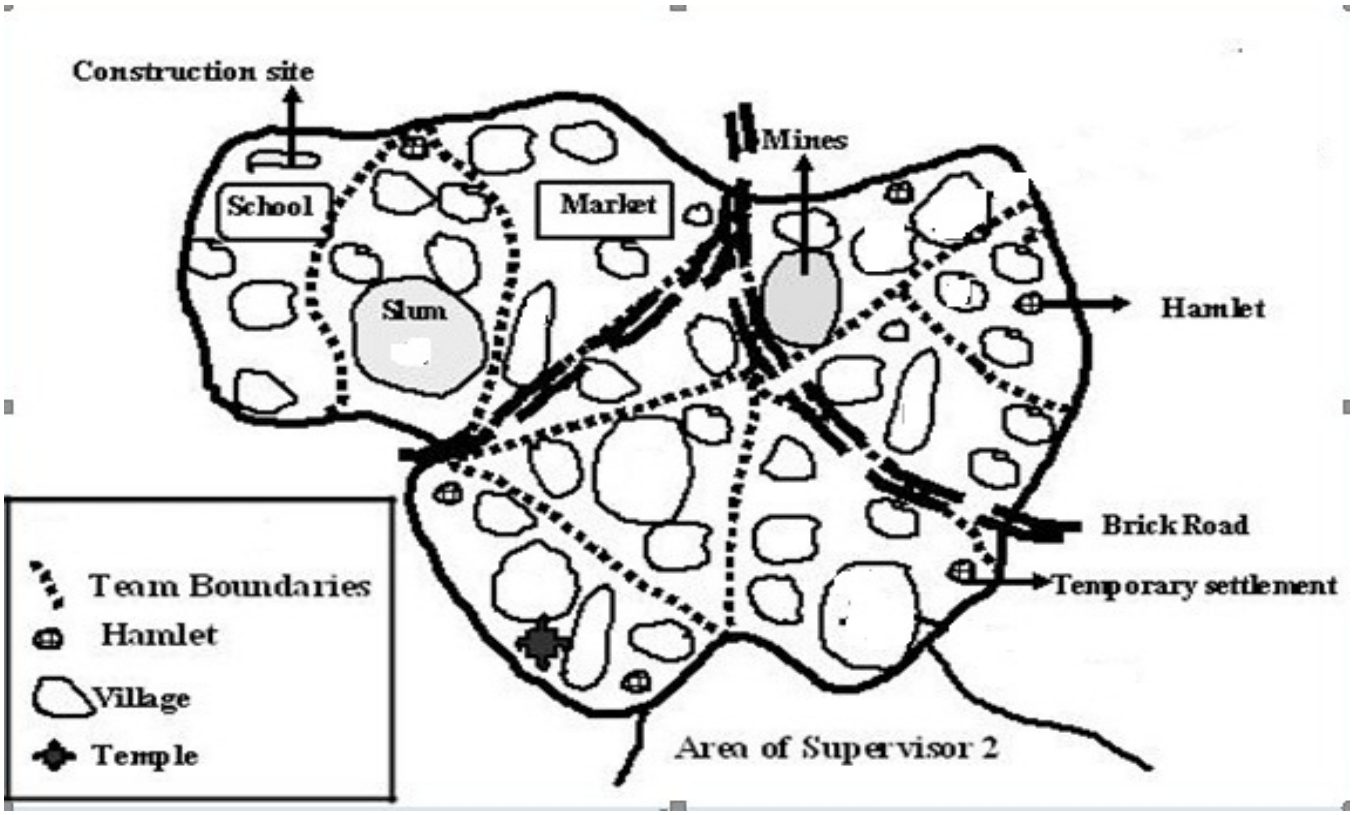
Sample Map of planning unit-PHC/urban area



Map 1: Map of planning unit-PHC/urban area

Supervisor Maps: Every supervisor should also have a map that indicates:

- Team areas with demarcation and day wise work plan
- Villages /urban wards / mohallas/ urban slums / hamlets
- High risk areas
- Areas from where more cases and grade II disabled cases have been detected
- Population likely to be missed
- Major landmarks and roads



Map 2: supervisor map

Recording and Reporting:

- Templates for tally sheets are given as forms T1 to T3. A tally sheet (Form T2) should be used for recording number of persons examined and houses visited during each day. No other system of recording should be used.
- During h-t-h case search days record the number of houses visited and the number of persons examined in each house.
- At the end of each day, each supervisor should go through the tally sheets of all his/her teams, compile the information and submit a consolidated report using the reporting form for supervisors (Form MR1).
- At the end of each day, each block/urban area should send to the District Leprosy Officer (DLO) a report of persons examined and houses visited using form MR2.
- The district should compile the report on form MR3 and send a consolidated district summary report to the state on form MR4.

- The SLO shall consolidate the state report on form MR5 and FAX and mail it to Deputy Director General (Leprosy), Govt. of India within 7 days of completion of activity on email id:- lcdc.cld@gmail.com

Major sources of LCDC data:

(a) Microplans
(b) Search team's Tally sheets
(c) Supervisors and monitors feedback

(a) Microplans: The h-t-h activity microplans provide useful information on: Number of h-t-hteams deployed

- Workload of each h-t-h teams for each day
- Whether all villages/hamlets/urban areas are planned to be covered including theareas found missed in the previous LCDCs
- Teams deployed to cover areas at special risk

(b) Search teams' tally sheets: The various basic data that can be derived from the search team's tally sheets are as follows:

- Number of houses visited by each team during the entire LCDC activity and also during each day of activity.
- Number of persons examined by each search team during the entire LCDC activity andalso during each day of activity.
- Number and percentage of 'X' houses generated by each team
- Number and percentage of 'X' houses revisited by teams to examine persons.
- Number and percentage of 'X' houses left at the end of activity**. It may be noted that any house marked 'X' at the beginning may not be considered 'X' if the inhabitants are not supposed to come back within the search period i.e., 14 days of LCDC.**

All the above information should be collated for each supervisor area and for the block. The information derived should be used to identify areas for interventions as follows:

- Very low generation of 'X' houses in a block or supervisory area or team area denotes that the search activity is probably not been of good quality. If the teams work correctlythere would be some generation of Xs. Very low generation of Xs should, therefore, lead to actions like intensive monitoring in the area and retraining of search teams.
- High X houses left at the end of activity could be due to absence of inhabitants at home or a weak mechanism for revisits to X houses or failure to examine people for various other reasons like refusal to examination. Appropriate actions in the form of strengthening mechanism to revisit X houses or improving social mobilization efforts need to be undertaken.

(c) Supervisors feedback: The information derived from supervisor's feedback is:

- Percent false L houses detected by supervisors
- False L house is a L marked house where search teams have claimed to have screenedall inhabitants (excluding children <2 years of age) of the house, but unscreened

inhabitants are found by supervisors or monitors during their visit to the house. The data on % false L houses detected is one of the most important indicator of performance of search teams. High false L houses in an area could be due to one or all of the following reasons:

- Problems of microplanning such as irrational workload of teams or improper composition of teams.
- Problems of training resulting in lack of understanding of how to enumerate the total number of inhabitants of house, before marking houses as 'L' or lack of motivation to do a complete job of enumerating and examining all persons in the area.
- Lack of proper supervision of search teams.

Actions to be taken following detection of high false "Ls" should be based on the underlying reason. It should call for:

- Analyzing the workload of each team for each day to rationalize the workload by increasing teams or redistributing workload amongst existing teams considering the geographical difficulties.
- Re-look at the composition of teams to have teams suited to the locale; which may mean having at least one male volunteer (preferably from the area) in teams and/ or having a team member of the same religion as the area in which team is working and /or having a member of the local community working as a team member.
- High false Ls due to improper training and lack of motivation should be addressed by retraining of search team by good quality trainers, ensuring attendance during trainings of all search team members who did not perform well during the recent LCDCs and also all volunteers/ search team members who are participating in the programme for the first time.
- Address supervision issues by retraining and motivation of the supervisors to explain the criticality of their role.
- Other actions like reducing the number of teams for supervision and having all teams of a supervisor working in a close geographical area (sector approach) need to be considered for improving supervision.

Areas with operational problems in terms of Missed areas

- % teams with search team members not as indicated in microplans.
- % teams with inappropriate composition of teams i.e. team of only female or male members.
- % teams with inadequately trained members.
- % supervisors not cross checking the work done by the teams.
- % areas with clusters of houses missed by teams.
- % teams not conducting bi-phasic activity.

Percent houses with potentially missed cases (commonly called percent missed houses) : This indicator is derived by adding the % X houses left at the end of the activity (data from tally sheets) and % false L houses detected by monitor (data from monitors formats).

% missed houses = % X houses left at the end of activity + % false L houses detected by supervisors

Data on percentage of missed houses should be looked at for recent LCDCs. High percentage of missed houses indicates the probability of number of cases having been missed. This data, therefore, helps to identify areas where there are problems of microplanning, training and social mobilization. It is more important to look at the data on missed houses at the block and supervisor level to pin point the geographical areas that require specific interventions to reduce the missed cases during LCDCs.

Confirmation of suspects:

The suspects found must be provided with a referral slip printed in duplicates (Annexure XX). One portion of referral slip is to be retained by the teams and one to be given to suspect. Teams are responsible for the confirmation of suspects identified in their area and to claim incentives later on. The MO PHC of the concerned area should confirm the diagnosis of suspect before registration of the same to provide MDT and monitoring. The visits/ camps may be planned for confirmation of suspects by MO of PHC. If any alternative arrangements are made same may be intimated to CLD.

ANNEXURE - I

SCHEDULE FOR LCDCs ACTIVITY AT VARIOUS LEVEL	
Days	**Activities to be planned for LCDC**
40 days before the campaign	State Coordination Committee & State Media Awareness Committee meets
	Communicate the days of LCDCs identified by CLD
	Take all the necessary actions needed to conduct a successful LCDC in State
30 days before the campaign	District Coordination Committee meets to review preparedness and set timeline for completion of planning activities
	Review microplans for house to house case search
	Identify manpower for teams
	Identify requirement of other resources like transport
	Review plan for IEC
	Assign blocks to district officers
15 days before the campaign	Review and refinement of microplans at blocks/PHCs/urban areas
	Place orders for procurement of logistics and printing of supervisory instructions, checklists and tally sheets etc.
	Finalize and release funds to blocks/urban areas
	Start orientation of supervisors and search team members at block level
2 days before the campaign	Start intensive IEC activities and media announcements
	Display IEC materials also for social mobilization
	Continue supervisory visits to areas
Leprosy Case Detection Campaign (LCDC) all days of activity	Implement house to house case search activity
	District Coordination Committee meeting, daily to review activity and take corrective actions
	Daily evening meetings at block/PHC to get feedback from supervisors and plan for corrective actions during the campaign
3 days after completion of campaign	Consolidate reports for the district and report to SLO
5 days after campaign	Organize District Coordination Committee meeting to review implementation of last LCDC and plan corrective actions for subsequent campaigns

ANNEXURE - II

INSTRUCTIONS FOR SEARCH TEAMs' TRAINING

Before conducting the training, make sure:

- The training sessions have been scheduled in consultation with the Block Medical Officer.
- The date and time for the training and the venue has been clearly conveyed to the team members.

Following materials will be required for the training sessions:

- Microplan of the block/urban area to be covered with the names of the search team members, supervisors and local influencers.
- Chalk or geru to demonstrate house marking.
- Tally sheets to demonstrate how they should be filled in.

Following should be covered in Block level training session:

- Registration: Before starting the session registration must be done to ensure all FLWs/ ASHAs are present.
- Introduction: All participants must introduce themselves to trainer who should also give his own introduction.
- Appreciation of the role of each member in attaining achievements under the NLEP.
- Review of the current status of NLEP situation.
- The preactivity preparations including identification and interaction with local influencers.
- Explanation of House to house activities including
    - How to enter the home and initiate a dialogue with the family members ensuring cordiality
    - Key questions to be asked in each house
    - Marking of the house
    - Revisits to X houses
    - IPC including responding to queries from people (with help of frequently asked questions).
    - Procedure for examining a person
    - Tally sheet marking

Microplan and area allocation must be reviewed by the trainer:

- Check the names of search team members attending the programme to ensure that there are no replacements.
- If the absent FLWs/ ASHAs are more than 5 (five), this should be explicitly recorded so that special training sessions may be held for the left out search team members.
- Trainer should assess if the search teams are aware of the area to be covered by them in the forthcoming LCDC.
- If search team members are not aware of the area assigned to them, trainer should note the names of such team members/teams. The area assignment should then be discussed with these search teams after the main training session is over along with the BMO and supervisor.

Trainer should also discuss with the teams whether:

- They are comfortable with workload in the area to be covered by them.
- They have any constraints/problems/concerns in covering their areas.

ANNEXURE - III

INSTRUCTIONS FOR TEAMS

Leprosy Case Detection Campaign (LCDC) aims to detect hidden cases of leprosy in community. Detection of all leprosy cases during LCDCs are essential for elimination of leprosy. No person is safe till leprosy is eradicated. All persons (excluding children up to 2 years of age) must be examined during all LCDCs.

Pre Activity preparations:

- The preparations of the activity should start at least one to two weeks before the scheduled dates of LCDC.
- Local influencers must be identified in advance to provide assistance during house-to-house case search activity.
- Community leaders/local influencers must be identified to inaugurate the campaign in the community/ area.

Before starting the LCDC activities:

- Check all other logistics like chalk/'geru' to mark houses, pen/pencil along with tally sheets
- You should prepare and carry a day wise itinerary with description of the area to be covered before starting LCDC activities.

House to House LCDC activities:

- During h-t-h activity, no house should be left unvisited.
- Do not sit at a convenient place but visit all houses in your designated area and actively search cases by physical examination for signs of leprosy, of all people residing in an area.
- Enter each house. Greet the respondent politely, introduce yourself, and explain the purpose of your visit.
- Enquire about the number of families staying in the house and the members in each family.
- Enquire about any person who may be away from home for reasons like:
  - Gone to farm/fields/workplace/ school/ market/ relative's home etc.
  - Visiting friends, relatives or market places and Accompanying parents to their place of work.
  - If any unexamined person/ persons is not at home during the time of your visit, record this on the 'X' tally sheet and plan to revisit the house in the evening or on the following days when the person would be most likely to be available in the house.
- Before moving to next house ensure that every person in each household has been examined physically during this round.
- Enquire about any person visiting the house. They should also be examined.

- Exercise utmost care in exhibiting polite and courteous behaviour while interacting with family members. Answer all queries correctly and confidently. Do not lose patience or be impolite under any circumstances.
- Before moving to the next house thank the head of the family and family members for their cooperation and ask them if they are sure that all persons have been examined.
- A new tally sheet should be used every day. Record information on the tally sheet for every visited house.
- All visited houses should be marked L/date or X/date.
- All houses marked X/date should be revisited during the LCDC till all persons in the house have been examined.
- House to house activity should stop only when you are sure that all houses have been visited and all persons have been examined.

House marking:

Team No. - L/date: -

- All persons have been examined.
- This also includes persons visiting the house when the LCDC activity is on.

Team No. - X/date*: -

- All or some persons, are not examined for reasons like:
- Persons not at home for the following reasons
  - Away to farm, fields, workplace, school, market places etc.
  - Visiting friends or relatives
  - Refusal
  - Locked house

What to do if…?	
Tally sheets are finished	Use plain paper to record.
Chalks/ Geru not supplied	Procure chalks/ geru locally.
Family members refused for their examination	Find out reasons for their refusal, try to convince them or seek help of local community influencers. If not successful inform supervisor.

* X marked houses should not be considered as 'X', if the inhabitants are not coming within LCDC search period i.e., 14 days.

The case definition to be followed for suspect identification in the field is "Any person with discoloration of skin and/or thickened and/or shiny and/or oily skin and/or nodules and/or inability to close eyes and/or ulceration in hands and/or feet and/or clawing of fingers and/or foot drop and/or informs tingling and/or numbness in hands and/or feet and/or loss of sensation in palms and/or soles and/or inability to feel cold or hot objects and/or weakness in hands and/or feet for holding/ grasping objects."

ANNEXURE - IV

OTHER IMPORTANT TIPS FOR ASHAs AND FLWs

1. Be sure and clear about the programme and its activities to be undertaken.
2. This activity is going to benefit your own people.
3. If there are in doubts and confusion – please get them clarified before start of work.
4. Conduct a group meeting with important people in your village – to explain about the programme and seek their participation.
5. If there are questions difficult to answer – please note them and inform people that it will be answered after consulting your Medical Officer. Document information in your own language.
6. Do not ridicule any opinion, be polite to your villagers and respect their opinion.
7. If possible – rehearse, practice your approaches before starting the programme.
8. Make sure that people trust you and please ensure confidentiality.
9. Make sure that members in the families are examined in privacy.
10. Do not postpone the information to be provided to the Medical Officer/ MPW at the end of the each day's activity.
11. Remember you are a health activist and not a medical professional to make diagnosis of leprosy, you are supposed to suspect the skin disease which includes leprosy.
12. Please keep your higher authorities informed on any difficulty encountered during the programme.
13. Do not give the verdict or any negative comment while screening/ physical examination as this could lead to a lot of unpleasant situations – make sure the Medical Officer confirms the suspects and give their impression.
14. Validity and reliability of your data is important – make sure the data collected is correct – while filling the forms.
15. Be well prepared for the programme and do not hurry-up in haste.

ANNEXURE - V

INSTRUCTIONS FOR SUPERVISORS

Your role is critical to the success of the programme and effective supervision carried out by you will help reaching the goal of leprosy elimination. You have to identify problems and solve them on the spot.

General Instructions:

- You should be familiar with your area of supervision before the day of LCDC.
- You should have a plan for supervising all team areas working in your area.
- You should have maps of the area with team areas assigned on the maps.
- You must meet all teams in the morning before they start work.
- You must meet the medical officer of your area every evening to give a feedback of the work done in your area along with the checklist and map.
- You should be constantly moving in your area on the LCDC days.

Before the LCDC:

Visit the areas to be covered by teams in the areas allotted to you and familiarize yourself with (At least 3 days prior to activity)

- Houses in the areas.
- Search teams.
- Boundaries of your area and boundaries of your teams.

Check:

- Area allocation with day wise activity plan for the teams.
- Team maps and prepare supervisor's maps.
- Areas where problems were encountered in last LCDC.
- Analyse tally sheets and feedback of supervisors from previous LCDCs to determine problems and problem areas.
- Plan for supply of logistics to all your teams.

Meet:

- Community leaders (formal as well as informal) from the area and arrange volunteers to assist teams during house to house visits.
- Team members to discuss the area allocation and special plans to cover problem areas.

Supervision of house-to-house case search activity:

In the morning:

- Check that all h-t-h teams:
  - Have reported to their area
  - Have received logistics. If not, report to Block MO to arrange for same
  - Are clear about the area/houses that they have to visit each day
  - Have begun work on time

- Check at least 5 houses along with each h-t-h team to see whether they are:
  - Making an attempt to enter all houses.
  - Determining the correct number of residents of the house.
  - Examining all persons in each house.
  - Marking the house L/Date or X/date and filling the tally sheet as per the guidelines before moving to next household.
- Check the areas already covered by each team.
  - Also cross check few X to L converted houses for correctness. Border areas between the teams are covered.
  - Border areas with the neighbouring supervisors are covered
  - Fill supervisors' tally sheet and submit to Block MO

I**n the afternoon and evening:**

- Visit X houses/X clusters with the teams to examine the community people.
- Meet all your teams.
- Collect the tally sheets and review them for X houses/X clusters.
- Discuss any problems faced by the teams in the field and suggest solutions.
- Give feedback to teams based on random checks of 'L' houses.
- Plan activity for the next day with all the teams.

Reaching all hidden cases of leprosy in your area is your responsibility

ANNEXURE - VI

FREQUENTLY ASKED QUESTIONS AND ANSWERS

Can everyone get leprosy?
No. Have you ever seen everyone, around you, suffering from all the diseases? Are all sneezing & having running nose? Are all suffering from diarrhea and dehydration? Similar is the case of leprosy that everyone doesn't suffer from leprosy. It indicates that our body responds to different infections differently. This is individuals' capacity to resist a disease or infection, which is also known as immunity or resistance of the body.

What is body resistance/immunity?
Body resistance/immunity is the ability of the body to fight back the germ and prevent causation of disease. There are cells in our blood specially created for the purpose of fighting the infection. These cells have the capacity and power to recognize, engulf, digest and destroy harmful germs. Because of these cells and the capacities they have, our body is resistant to most of the harmful germs and bacteria, including the germs of leprosy.

What leads to development of disease?
When a germ enters our body, it tries to locate itself in a preferred location to nourish, enjoy and multiply itself. If the multiplication and nourishment is not controlled it causes disease. On the other hand, our body resists the spread of germ and aborts the further growth, multiplication and development of disease. If the body is not able to fight the infection the disease develops.

Why all of us don't develop all the diseases?
This is the capacity of individual body and their cells to identify and recognize a particular type of harmful bacteria. Different cells of different human beings have high or low capacity to fight a particular disease. E.g. if a capacity to fight common cold is high in a particular person, he'll not suffer from common cold. On the other hand there are certain individuals, who have low capacity to fight common cold and suffer from common cold easily.

Why everyone is not suffering from leprosy?
This depends on the individual capacity of a person to fight leprosy organisms. Through research it has been found that 95 – 99% of our population is resistant or can fight the leprosy micro-organisms if they enter in their body meaning thereby that 1 – 5% of the whole population is prone to develop the disease.

Facts about leprosy
Leprosy is like any other disease caused by a germ known as Mycobacterium leprae. It affects mainly peripheral nerves, skin and other organs of the body and if not treated adequately, leads to disabilities & deformities.

Can I live with a person infected/suffering with leprosy?
Yes, because the disease is mildly infectious. However, it is mandatory that the person affected should take the MDT regularly.

What, if I marry a person affected by leprosy /patient?
Why not? Your married life will be as normal as of any other couple. If the person is treated with required doses of Multi Drug Therapy, (s)he is taken as cured.

Does the children of persons affected by leprosy have the risk of developing the disease?
Leprosy is not hereditary, susceptibility depends on Body resistance/immunity.

Can a leprosy patient be treated at home?
Yes, it is better to treat him/her at home.

Whether the treatment is life long?
No, only 6 or 12 months, depends upon type of disease.

Can leprosy deformity be corrected?
Yes, the deformities can be corrected, after completion of treatment, by reconstructive surgery.

Should a leprosy patient be accepted by the society?
Why not. The disease is least infectious, curable with effective Multi Drug Therapy (MDT). An infectious patient becomes non-infectious after three regular doses of MDT. If detected early and treated completely, will not lead to development of disability or deformity.

Can persons affected by leprosy be employed?
Yes, a person affected by leprosy is not a threat to the fellow citizens/colleagues if (s)he is taking or has completed the treatment.

Which are the centres for rehabilitation of persons affected by leprosy?
There are many centres in India, where besides vocational trainings, economic rehabilitation is also provided

Can the leprosy treated patient with disabilities get the facilities of disabled persons?
Yes, there are provisions, wherein the facilities are provided through Ministry of Social Justice and Empowerment.

What are the rights of persons affected by leprosy, treated or untreated?
All should be considered as a normal citizen having the same rights.

ANNEXURE - VII

MANPOWER PLANNING FORM

LCDC	Manpower Planning form								Form P1
Name of District/ Block/Urban area: _____									Round:
Name of the Area	Urban/ Rural	House to house case search				Underserved population case search			
		Estimated houses in the area	Teams required	Team members required	Supervisors required	Number of sites with floating population and sparse population to be covered by search team	Teams required	Team members required	Supervisors required
Total									

ANNEXURE - VIII

LOGISTICS AND TRANSPORT PLANNING FORM

LCDC	Logistics and Transport Planning form											Form P2
Name of District/ Block/Urban area: _____												Round:
Name of the Area	Urban/ Rural	Logistics for Supervisors			Other logistics				Transport for supervision			
		Checklists	L sweep tally sheet	Reporting formats	Teams' tally sheets	Chalk/ geru	Pen/ Pencil	Armbands/ Identity cards	No. of Supervisors	No. of Supervisors using own transport	Additional vehicles required for supervisors	Specify type
Total												

ANNEXURE – IX

TEMPLATE FOR HOUSE TO HOUSE CASE SEARCH PLANNING FORM (It must be filled by teams during training session only in duplicates one copy retained by teams and one to be submitted to supervisors)

LCDC	Template for House to House case search Planning form															Form P3
Name of District/ Block/Urban area: _____																Round:
Name of Supervisor: _____																
Team number	Name of team members		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
		Description of area to be covered														
		Name & Address of first house owner with landmark														
		Name & Address of last house owner with landmark														
		No. of houses in the area														
		Name of local influencer/s														
Special area planning																
	Site:1	Timing of visit														
		Type & address of area														

ANNEXURE - X

SUGGESTED CHECKLIST FOR PREPARING / REVIEWING MICROPLANS

Checklist for Preparing / Reviewing Microplans		Form P4
District / Block / Urban Area: _____	Date:___/__/	Round :
MICRO PLANNING CHECKLIST	**YES**	**NO**
Has data and feedback from past rounds been analyzed for corrective actions this round?		
Brick kilns, construction sites, periurban areas, slums, recently developed townships included in microplans		
High risk and hard to reach areas identified and special plans developed to cover these		
Have reliable and motivated volunteers been identified and assigned areas/ search teams?		
Well defined day-wise area allocation to house to house search teams with boundaries		
At least one male volunteer from the local community part of each house to house team		
Are ASHA workers part of search teams in their areas?		
Is the daily workload distribution of house to house teams reasonable (in terms of houses and geography)		
Are young and energetic volunteers deployed as a part of these search teams?		
Supervisors identified and assigned for house to house search teams?		
Is there an orientation plan for volunteers/ search team members and supervisors?		
MAPS		
Map of Planning unit /block/urban area with essential information marked prepared		
Supervisor's map with day-wise demarcation of area to be covered by each team		
TRANSPORT		
Inventory of available and required vehicles		
Firm arrangements made for the procurement/hiring of vehicles		
Independent mobility / transport arranged for each supervisor		
Daily vehicle movement / route chart prepared for each vehicle for supervision		
SOCIAL MOBILIZATION		
IEC plan through mike announcements, inter-personal communication etc.		
Plans for briefing media (District and State level)		
SCHEDULE		
Plan for DTF / TTF / BLTF meetings		
Schedule for District level officials to visit blocks to oversee preparations and monitor implementation		
Work plan with time-line, activities/task, time to be completed and person responsible		

ANNEXURE - XI

SUPERVISOR'S CHECKLIST FOR SUPERVISING SEARCH TEAM'S ACTIVITY

LCDC | Supervisor's Checklist for Supervising search team's Activity		Form T1
Name of Supervisor : _____		
Name of District /Block / Urban Area : _____		Round :
Note: Write Y (Yes) or N (No) in answer each question	Y/N	Corrective action taken(Remark)
Does the area have an IEC material (like banner) displayed prominently?		
Have all team members reported to work? If no, arrange for replacement		
Does the team clear on the work they are supposed to do today?		
Does the team have sufficient tally sheets? If no, arrange to supply		
Is the team examining all the family members (even children more than 2 years) for the cardinal signs of leprosy?		
Is the team marking the tally sheet correctly after each person examined?		
Is the team marking each house correctly after each household's examination?		

ANNEXURE - XII

TALLY SHEET FOR HOUSE TO HOUSE CASE SEARCH ACTIVITY (To be filled by teams every day in order to record the activities done during each day, all forms to be submitted to Supervisors at the end of activity with the signature)

Form T2

Name of the State: …….. Date of visit: …….
Team No……..
Name of the Supervisor: ……
Name of the District: ……. Name of the Block: ……
Name of the Village: ……. Urban Area Ward No. : ……..
Name & Address with Land Mark of First Household:-

House hold No.	Name of the Head of Family & Address	Total no. of persons in Family	No. of persons Examined	House Marking X/L (specify reason of X marking as per codes given below)	Date House Converted from X to L (if house is marked X earlier)	No. of persons examined in X houses	Name of the Person Suspected	Date of Confirmation

A. The X houses must be recorded in the table above with reasons for the X in the following categories:
   i. XR = refusal by family for physical examination
   ii. XH = any or all members not at home but will return during search period i.e., away to farms/ fields, place of work, school or market places, visiting friends or relatives
   iii. XV = any or all members of the family is not in home and is not expected to return before the end of the search period
   iv. XL = the house is locked and is expected to remain locked for the duration of the search period

Name and signature of Team Members: 1. ……

2. ……

TALLY SHEET FOR HOUSE TO HOUSE CASE SEARCH ACTIVITY (To be filled by teams every day in order to record

ANNEXURE - XIII

DAILY SUPERVISOR'S REPORTING FORMAT (TO BE FILLED BY THE SUPERVISOR AT THE END OF EACH DAY)

LCDC	Daily Supervisor's reporting format (to be filled by the Supervisor at the end of each day)																						Form MR1
	Name of Supervisor : _____ _____																		Date: _____/_____/				LCDC:
S. No.	Team no.	Total houses visited by teams		No. of L houses		No. of X houses		no. of persons examined in 'L' houses by teams		no. of 'X' houses converted to 'L' by teams		no. of persons examined in 'X' houses by teams		no. of 'X' houses left at the end of the day		no. of 'L' houses checked by supervisor		no. of unexamined persons examined in 'L' houses by supervisor		Total persons examined (1+2+3)		Suspects identified	
		Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date
								1A	1B			2A	2B					3A	3B	1A+2A+3A	1B+2B+3B		
Total																							

ANNEXURE - XIV

DAILY BLOCK REPORTING FORMAT (TO BE FILLED BY THE BLOCK MEDICAL OFFICER AT THE END OF EACH DAY)

LCDC	Daily Block reporting format (to be filled by the Block Medical Officer at the end of each day)																								Form MR2
	Name of Block: _____																		Date: ____/____/_____						LCDC:
S. No.	Name of supervisor	Total teams supervised and no. of each team	Total houses visited by teams		No. of L houses		No. of X houses		no. of persons examined in 'L' houses by teams		no. of 'X' houses converted to 'L' by teams		no. of persons examined in 'X' houses by teams		no. of 'X' houses left at the end of the day		no. of 'L' houses checked by supervisor		no. of unexamined persons examined in 'L' houses by supervisor		Total persons examined (1+2+3)		Suspects identified	
			Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date
									1A	1B			2A	2B					3A	3B	1A+2A+3A	1B+2B+3B		
Total																								

ANNEXURE – XV

DAILY DISTRICT REPORTING FORMAT (TO BE FILLED BY THE DISTRICT LEPROSY OFFICER AT THE END OF EACH DAY)

LCDC	Daily District reporting format (to be filled by the District Leprosy Officer at the end of each day)																								Form MR3
	Name of District: _____ Date: _____/ _____/ _____																								LCDC:
S. No.	Name of Block	Total no. of search teams	Total houses visited by teams		No. of L houses		No. of X houses		no. of persons examined in 'L' houses by teams		no. of 'X' houses converted to 'L' by teams		no. of persons examined in 'X' houses by teams		no. of 'X' houses left at the end of the day		no. of 'L' houses checked by supervisor		no. of unexamined persons examined in 'L' houses by supervisor		Total persons examined (1+2+3)		Suspects identified	
			Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date
									1A	1B			2A	2B					3A	3B	1A+2A+3A	1B+2B+3B		
Total																								

ANNEXURE - XVI

CONSOLIDATED STATE REPORTING FORMAT (TO BE FILLED BY THE SLO AND TO BE SEND TO CENTRAL LEPROSY DIVISION

LCDC	Daily State reporting format (to be filled by the State Leprosy Officer and sent to Central Leprosy Division at the end of each day and share through fax 011 - 23061801 and email id ddgl@nic.in & cld.dghs@gmail.com)																						Form MR4
	Name of State: _____ Date: ____/ ____/ _____																						LCDC:
S. No.	Name of District	Total no. of search teams	Total houses visited by teams		No. of L houses		No. of X houses		no. of persons examined in 'L' houses by teams		no. of 'X' houses converted to 'L' by teams		no. of persons examined in 'X' houses by teams		no. of 'X' houses left at the end of the day		no. of 'L' houses checked by supervisor		no. of unexamined persons examined in 'L' houses by supervisor		Total persons examined (1+2+3)		Suspects identified	
			Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date	Today	Cumulative till date
									1A	1B			2A	2B					3A	3B	1A+2A+3A	1B+2B+3B		
Total																								

Name of SLO: _____

Signature: _____

ANNEXURE - XVII

TEMPLATE FOR IDENTIFYING SUPERVISORS & TEAMS AREAS WITHIN BLOCKS REQUIRING INTERVENTIONS

LCDC						**Form MR 5**
Template for Identifying Supervisors & Teams areas within blocks requiring interventions						
Name of Block/Urban area: _____						**LCDC:**
Name of Supervisor	**Number of houses visited by teams**	**Number of person examined by teams**	**% X houses generated by teams**	**% Remaining X houses at end of activity**	**% False L houses**	**Any operational problems**

ANNEXURE - XVIII

TEMPLATE FOR IDENTIFYING SUPERVISORS & TEAMS AREAS WITHIN BLOCKS REQUIRING INTERVENTIONS

LCDC						Form MR 6
Template for Identifying Supervisors & Teams areas within blocks requiring interventions						
Name of Block/Urban area: _____						LCDC:
Name of Supervisor	Number of houses visited by teams	Number of person examined by teams	% X houses generated by teams	% Remaining X houses at end of activity	% False L houses	Any operational problems

ANNEXURE - XIX

DAYWISE IEC ACTIVITY PLAN FOR LCDC

S.No.	Mode of Communication	Activities	Days	Remarks
1	Traditional Media	Drum beating	-1st,-2nd, 6th, 9th	Publicity should create noise in the districts through drum beating & loudspeakers before beginning of the LCDC.
		Wall painting	-1st,-2nd	
		Loudspeaker announcement	-1st,-2nd, 3rd ,9th	
		Street Play	6th	
		Magic shows	3rd	
		Puppet shows	6th	
2	Electronic Media	Local Cable TV	-1st, -2nd, 3rd, 6th , 9th	Message will run for all five days.
3	Other Media	IPC/Advocacy meeting with village leaders/Panchayats	-2nd, 9th	Before activity, it is important to know mindset of the locals and at the end of the campaign; an IPC will help us to know how far they are influenced.

In the aforementioned table, (-) indicates days before LCDC. Hence traditional media & electronic media will run two days prior LCDC and on 3rd, 6th and 9th day during the LCDC days. Similarly, other media will run 2 days prior to LCDC and 9th day during the LCDC days.

ANNEXURE - XX

Referral slip format

National Leprosy Eradication Programme **Referral slip** **Leprosy Case Detection Campaign**	**National Leprosy Eradication Programme** **Referral slip** **Leprosy Case Detection Campaign**
S. No._____ Date:_____	S. No._____ Date:_____
Name of suspect:_____	Name of suspect:_____
Age:_____ Sex (F/M)_____	Age:_____ Sex (F/M)_____
Father's/ Husband's name:_____	Father's/ Husband's name:_____
Address:_____	Address:_____
_____	_____
_____	_____
Mobile No.:_____	Mobile No.:_____
Primary Health Centre:_____	Primary Health Centre:_____
Team No.: _____	Team No.: _____
Name and signature of team members:	Name and signature of team members:
1._____	1._____
2._____	2._____

Annexure XXI

Instructions for using different formats during LCDC

Form No.	Name of the format	Who is to prepare	Whom to give	When to give	Remarks
P1	Manpower Planning Form	DLO	SLO	At State level workshop	Block/ Urban wise information to be prepared
P2	Logistic Planning Form	DLO	SLO	Immediately after State level workshop	Block/ Urban wise information to be prepared
P3	Template for house to house case search planning form	Search teams has to prepare	Block MO I/C, Supervisor/ Trainers	During the training session	The formats needs to be filled in duplicates one copy should be retained by teams and other by supervisors.
P4	Suggested check-list for preparing/ reviewing Micro-plan	DLO MO I/C	-	Before and during LCDC	Take corrective actions if required
T1	Supervisor's Checklist for supervising search team's activity	Each Supervisor every day	MO I/C	Every day during LCDC supervision	Take corrective actions if required
T2	Tally sheet for house to house search activity	Each team every day	MO I/C through Supervisor	At the end of each day's activity	This should be compiled everyday by Supervisors
MR1	Daily Supervisor's reporting format	Each supervisor every day	MO I/C	Every day	Compiled at Block-level
MR2	Daily Block reporting format	MO I/C	DLO	Every day	
MR3	Daily District Reporting Format	DLO	SLO	Every day	
MR4	Consolidated District Reporting format	DLO	SLO	On the 5th day after completion of LCDC	
MR5	Consolidated State Reporting format	SLO	DDG (L)	On the 7th day after completion of LCDC	
MR6	Template for identifying supervisors & teams areas within blocks requiring interventions	MO I/C	DLO	At the end of LCDC	

ABBREVIATIONS

ANCDR: Annual New Case Detection Rate
APAL: Association of Persons Affected with Leprosy
ASHA: Accredited Social Health Activist
BCC: Behavior Change Communication
BDO: Block Development Officer
BMO: Block Medical Officer
CBO: Community Based Organization
CMO: Chief Medical Officer
CLD: Central Leprosy Division
DANLEP: DANIDA assisted National Leprosy Eradication Programme
DGHS: Directorate General of Health Services
DHS: Director Health Services
DLC: District Leprosy Consultant
DLO: District Leprosy Officer
DPM: District Programme Manager
DPMR: Disability Prevention and Medical Rehabilitation
DRC: Designated Referral Centre
FLW: Field Level Worker
IEC: Information Education Communication
ILEP: International Federation of Anti-Leprosy Association
LCDC: Leprosy Case Detection Campaign
MD: Mission Director
MDT: Multi Drug Therapy
NGO: Non Government Organization
NLEP: National Leprosy Eradication Program
NRHM: National Rural Health Mission
PHC: Primary Health Centre
PMW: Para Medical Worker
PR: Prevalence Rate
PRI: Panchayat Raj Institution
SDM: Sub Divisional Magistrate
SHS: State Health Society
SIHFW: State Institute of Health & Family Welfare
SHSRC: State Health System Resource Centre
SLO: State Leprosy Officer
SPM: State Programme Manager
SOE: Statement of Expenditure
TOT: Training of Trainers
UT: Union Territory
VHNSC: Village Health, Nutrition and Sanitation Committee
WHO: World Health Organization

Central Leprosy Division
Directorate General of Health Services
Ministry of Health and Family Welfare
Government of India

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