

## Knowledge & Practices Of ASHA Functionaries In Active Case Detection Of Leprosy, Lucknow, Uttar Pradesh

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**Abstract:** Background: : Leprosy Case Detection Campaign (LCDC) is first of it's kind initiative taken by Govt. of India for early detection and treatment of Leprosy cases in the community. ASHA functionaries are involved in this campaign to make it successful. LCDC campaign is primarily a door to door search with physical examination & identification of suspects followed by confirmation of diagnosis by Medical officer and free of cost treatment for positive cases. Material & Methods: This was the community based observational study. In this study total 19 ASHA functionaries were involved from two randomly selected Sub-centers Ataria & Kunwarpur out of six Sub-centers attached with Rural Health Training Center Ataria, Lucknow, Uttar Pradesh under department of community medicine of Hind Institute of Medical Sciences Sitapur. All ASHA functionaries were interviewed using semi-structured questionnaire & observed by faculty of department of community medicine during LCDC activity. Results: None of ASHA functionary correctly knew exact cause of leprosy. Only 10% knew mode of transmission, 26% knew complications and 19% knew method of complications prevention. However, most of them knew sign & symptoms (90%) and free of cost availability of treatment in Govt. health centers. During LCDC activity 53% ASHAs were correctly marking the house. 90% ASHA knew their responsibility regarding leprosy case search & treatment. Only 37% knew exact amount of incentives they would get for leprosy case search & treatment. Only 58% ASHA attended the orientation training. Out of them only 27% completed the practical exercises and none of them got IEC material. None of ASHA informed the community before or after starting LCDC activity and same was true for distribution of IEC (Information Education & Communication) material. Only 16% ASHA were working in field from the onset of LCDC activity. Only 53% ASHA correctly filled the tally sheets. 74% ASHA could achieve given target for house to house search. Conclusion –Training quality, organization of IEC activities & supportive supervision are the areas where improvement is needed. [Saxena P Natl J Integr Res Med, 2020; 11(6):38-42]

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**Introduction:** India has eliminated leprosy in year 2005<sup>1</sup>. but leprosy is still endemic in Odisha, Bihar, Jharkhand, Chhattisgarh states and Lakshadweep, Dadra & Nagar Haveli union territories. A total of 133 districts (18.8%), out of total 705 districts showed PR>1/10,000 population Through situational analysis of health indicators of National Leprosy Eradication Programme (NLEP), it was observed that trend of two important indicators of Program i.e. Annual New Case Detection Rate (ANCDR) and Prevalence Rate (PR) remained almost static since 2005 – 2006 and Grade II disability (G2D) rate increased from 3015 (1.87%) in 2005-06 to 5852 (4.60%) in 2015-16, which indicated that a large number of undetected cases were still there in the community, and that the transmission of the disease agent continued<sup>2</sup>.

Early case detection & treatment was the key to achieve elimination as detection of leprosy cases early in the community will lead to depletion of source of infection & so interrupt transmission of

disease in the community<sup>3</sup>. Leprosy Case Detection Campaign (LCDC) is first of it's kind initiative taken by Govt. of India to detect cases of leprosy early in the community in endemic districts<sup>3,4</sup>.

ASHA functionaries are involved in this campaign to make it successful. LCDC campaign is primarily a door to door search activity with physical examination & identification of suspects followed by confirmation of diagnosis by medical officer at Govt. health centre and providing free of cost treatment for positive cases from Govt. health centres.

So knowledge of ASHA functionaries regarding leprosy disease is paramount important for successful LCDC, further it is crucial that she thoroughly understands the process and activities of campaign and implement them as instructed. This research was planned to assess her knowledge and performance in at field level.

**Material and Methods:** This is a community based observational study; data collection was done during 6 - 19 November 2017 when LCDC activities were undertaken. Study was carried out in field practice area of Rural Health Training Centre (RHTC). In this study total 19 ASHA functionaries were involved from two randomly selected Sub-centers Ataria & Kuwarpur out of six Sub-centers attached with RHTC Ataria under department of Community Medicine of Hind Institute of Medical Sciences Sitapur.

All ASHA functionaries were interviewed using predesigned and pretested semi-structured questionnaire & observed by faculty of department of Community Medicine during LCDC activity. Data was analyzed using Microsoft Excel XP.

Study tools included predesigned and pretested questionnaire and an observation checklist.

Questionnaire included basic information on knowledge about disease, its mode of transmission, common complications, availability of treatment etc. Observation Checklist included variable like -how case detection was done, whether ASHAs were having tally sheets and chalks in sufficient quantity, whether correct marking on household was done or not?

**Leprosy Case Detection Campaign (LCDC):** Leprosy Case Detection Campaign (LCDC) is implemented by Central Leprosy Division (CLD). This activity has following objectives – To identify the hidden leprosy cases in the community so as to curtail the spread of disease at community level.

Improving Case Detection with the help of Accredited Social Health Activist (ASHA): This campaign is based on house to house search of leprosy disease suspects conducted by search team. This search team comprises of two members; one of which is ASHA functionary and other one is male volunteer. This search team conducts the physical examination of house- hold members at their houses and finds the suspect.

Then suspects are referred to Govt. Hospital where Medical Officer investigate them and based on investigations Medical Officer confirmed the leprosy and those confirmed gets full treatment free of cost. For its implementation workshops, meetings & trainings are conducted at National, State, district & block level. At block level

In-charge Medical Officers conduct orientation training for ASHAs along with Primary Health Centre staff to ensure optimum participation in the activity. During this training, micro-planning of activity should also be done so to ensure that at least 20 houses covered by the team in one day. Demonstration of tally sheet and house markings followed by exercises for ensuring all operational skills like Role Plays on Interpersonal communication (IPC) and Frequently asked Questions (FAQs) should form an essential component of all ASHAs training sessions.

Team of one ASHA and one field level worker preferably male is made to ensure maximum participation of community during house to house search activity and ensuring physical examination of all household members. During Micro-planning ASHA functionaries are advised to utilize Intensive Pulse Polio Immunization (IPPI) Micro plan. This micro plan will be carried by them during field activity for better coverage of house to house search activity.

During house to house search activity, team member usually ask about signs and symptoms related with leprosy and conduct physical examination of family members, followed by recording in tally sheet and house marking. If all members are available for examination that house will be marked as L/Date and if some family member are not available or house was locked, this house will be marked as X/Date.

The team members will revisit 'X' house and do examination of remaining family members, convert that house to 'L' house. The Health workers from Primary Health Center are first level supervisors. The district levels officers are the part of second level monitoring. The suspected cases during campaign are listed and confirmed by trained Medical Officers .

**Result:** Total population coverage of Sub-centre Ataria & Kuwarpur was around 22,000 & 19 ASHA functionaries were under these two Sub-centers as shown in Table -1.

**Table 1: Sub-Center Wise Population Coverage & No. Of ASHA**

SR. No.	Sub-Centre	No Of Asha	Population Coverage
1	Ataria	10	11,276
2	Kuwarpur	9	10,326

Study findings show that during none of ASHA functionaries correctly knew the exact cause of leprosy. Only 10% knew mode of transmission, however 90% knew sign & symptoms of the disease, 26% knew complications, 19% knew prevention of complications. Although study result report that only 10% knew exact meaning of Multi Drug therapy (MDT), even then all ASHA functionaries knew free of cost availability of treatment & investigation facility at Govt. health

centres. 90 % ASHA were aware regarding their responsibility about leprosy case search & treatment in community. Almost all were aware that they would be getting performance-based incentive but Only 37 % ASHA functionaries knew that for detection, treatment completion of Paucibacillary (PB) & Multibacillary (MB) case they would get Rs 250, Rs 400 & Rs 600 respectively as per GOI guidelines (Table-2).

**Table 2: ASHA’S Knowledge Regarding Leprosy Disease & its Management( N=19)**

Knowledge Component	No. Of Ashas Given Correct Response	No. Of Ashas Given Incorrect Response
Cause	00 (0%)	19 (100%)
Mode of Transmission	02 (10%)	17 (90%)
Signs & Symptoms	17 (90%)	02 (10%)
Complications	05(26%)	14(74%)
Prevention of complications	03(19%)	16(81%)
Multi Drug therapy (MDT)	02 (10%)	17 (90%)
Free Treatment & Investigation Facility in Govt. Health Centers	19 (100%)	00 (0%)
ASHA role regarding Leprosy case search & Treatment	17 (90%)	02 (10%)
Incentives regarding leprosy case detection & Treatment	07(37%)	12(63%)

When ASHA functionaries were asked regarding orientation training for LCDC campaign only 58% ASHAs had prior information about orientation training. Out of these only 27% completed the practical exercises but none of ASHA

functionaries got IEC material. Surprisingly 42 % of ASHA functionaries even did not have prior information of date, time and venue of orientation training before LCDC activity(Table-3).

**Table 3: Orientation Training Of ASHA Functionaries Fo LCDC Activity( N=19)**

Training Components	Response Given By ASHA	
	Yes	No
Prior Information Of Day, Time, Venue Regarding Training	11(58%)	8(42%)
Training Attended	11(58%)	8(42%)
Practical Exercises Conducted At The End Of Training	03(27%)	Not Applicable
IEC Material Received For Distribution In Field	00(0%)	Not Applicable

As observation made by observers local community was remained uninformed about LCDC activity as IEC activities were very poor in both these centers. ASHA functionaries did not distribute IEC materials before or during the LCDC Campaign. Only 50 % ASHA functionaries were correctly marking the houses and 75% ASHA functionaries were completing their daily target of House to House search although almost all ASHA functionaries were correctly asking the symptoms of leprosy disease and correctly conducting the physical examination and referring the suspects to Govt. Health Centre for further investigation & treatment.

**Discussion:** Leprosy Case Detection Campaign (LCDC) is a major initiative taken by Govt. of India to detect hidden cases of leprosy disease in community. Very limited reporting has been done on quality of its conduction. If LCDC activity is implemented properly, early cases of leprosy will be diagnosed and by their adequate treatment, transmission rate certainly will be declined. In our country ASHA workers are the main Health functionaries for LCDC activity. Study findings show that most of ASHAs did not know cause of leprosy or mode of transmission, however most of them knew sign & symptoms of the disease and availability of free of cost treatment at Government health centres.

**Table 4: Activity wise distribution of ASHAs undertaking LCDC in villages (N=19)**

Field Activities During LCDC	No. Of ASHA (Yes) No. (%)	No. Of ASHA(Not Don /Partial/ Incomplete) No. (%)
No. Of ASHA Functionaries Carrying Micro Plan	00 (0%)	19(100%)
ASHA Informed The Community Before Starting This Activity	00 (0%)	19(100%)
ASHA Distributed The IEC Material In Community Before Starting This Activity	00(0%)	19(100%)
ASHA Working In Field From The Onset Of LCDC I.E. 06/11/2017	03(16%)	16(84%)
ASHA Started Working In Field After Supportive Supervision	19(100%)	00(00%)
Asha Having A Map And Itinerary For The Area	00(0%)	19(100%)
ASHA Having Tally Sheets And Chalks In Sufficient Quantity	9(47%)	10(53%)
ASHA Correctly Filled Tally Sheets	10(53%)	09(47%)
ASHA Correctly Marked The Houses "L" & "X"	10(53%)	09(47%)
ASHA Completed The Target For House To House Search	14(74%)	05(26%)
ASHA Correctly Asked The Symptoms Of Leprosy To Family Members	19(100%)	00(0%)
ASHA And Other Team Members Correctly Examined The Villagers	19(100%)	00(0%)
ASHA Referred The Suspects To Govt. Health Facility Correctly	19(100%)	00(0%)

Study has reported that most of ASHAs did not undertake practical exercise of case detection or microplanning during their training, which was vital for case detection. Similar findings were reported by Bhagat VM et al.<sup>5</sup> in their study in four districts of Jharkhand that during LCDC campaign approximately one fourth ASHAs were untrained in Ranchi and Singhbhum districts, however adequate training was received by ASHAs in Godda and Dumka districts Govasi SV et al also reported inadequacy in training of ASHA functionaries from rural areas of Wardha<sup>6</sup>.

Current study also reported that because of inadequate training micro-plan for conducting LCDC were not properly prepared. Contrary to our findings Bhagat VM et al. reported adequate microplanning in their study by ASHAs but High risk areas were not properly identified .Further they reported that Suspect identification was inadequate and there was confusion in exact method of house marking in Godda/dumka districts indicating need for further training and supportive supervision. Almost similar finding were reported in the current study where only fifty percent ASHAs were marking households correctly. Bhagat VM et al. reported that In Godda and dumka First level supervision by ANM

was satisfactory but Supervision by health supervisors (Medical officer/NMA/ BPM) inadequate. In our study all ASHAs were supported by their supervisors but even then tally sheets could not be filled by them properly.

Similarly Kumar et al reported that regular monitoring and supervision at various levels was important for successful conduction of case detection activities<sup>7</sup>. Our study reveals that skill training is required at all levels from supervisory level to field functionary level.

**Conclusion:** Study concluded that quality of training was not adequate compared to GOI guidelines. So all efforts should be made to improve quality of such trainings by ensuring prior information to all ASHAs functionaries, mandatory conduction of practical, exercises and proper microplanning etc. IEC activities need to be improved before & during LCDC activity. Supportive supervision of ASHA functionaries is essential for successful conduction of LCDC.

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