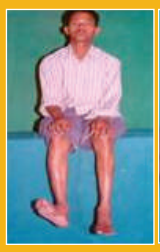
National Leprosy Eradication Programme

ACTIVE CASE DETECTION AND REGULAR SURVEILLANCE FOR LEPROSY

Operational Guidelines - July, 2020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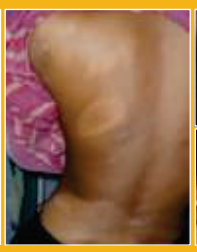
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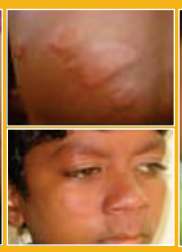
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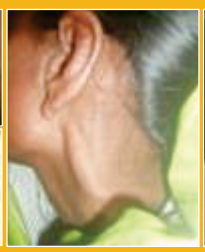
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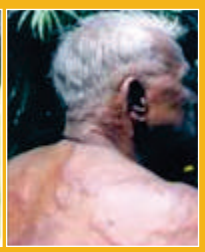
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National Leprosy
Eradication Programme

ACTIVE CASE DETECTION AND REGULAR SURVEILLANCE FOR LEPROSY

Operational Guidelines - July, 2020

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Abbreviations

F/M - FLW	Female/Male Frontline worker (ASHA/NMS (Non-Medical Supervisor)/NMA (Non-Medical Assistant) / trained female or male Health Worker/trained Community Volunteer/ trained Person affected by leprosy/ trained member of Mahila Aarogya Samiti (MAS)
ANCDR	Annual New Case Detection rate
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BLO	Block Leprosy Officer
BMO	Block Medical Officer
CHC	Community Health Centre
CHO	Chief Health Officer
CHO	Community Health Officer
CLD	Central Leprosy Division
DH	District Hospital
DLO	District Leprosy Officer
FY	Financial year
F/M	Female/Male
G II D/G2D	Grade II disability, visible deformity
HH	Household
HTRA	Hard-to-reach area
HWC	Health & Wellness Centre
MAS	Mahila Arogya Samiti (MAS)
MO	Medical Officer
NHM	National Health Mission
NMA	Non-Medical Assistant
NMS	Non-Medical Supervisor
NLEP	National Leprosy Eradication Programme
PHC	Primary Health Centre
PR	Prevalence rate
SC	Sub Centre
SLO	State Leprosy Officer
UCHC	Urban Community Health Centre
UPHC	Urban Primary Health Centre
UT	Union Territory

A. Background

National Leprosy Eradication Programme (NLEP), India is a Centrally Sponsored Scheme under the umbrella of National Health Mission (NHM). The primary goal of the Programme is to detect the cases of leprosy at an early stage and to provide complete treatment free of cost, in order to prevent the occurrence of disabilities in the persons affected and stop the transmission of disease at the community level. The Programme also aims to spread awareness about the disease and reduce stigma attached with the disease.

Leprosy, however, still shows high prevalence in many pockets of certain States/ UTs of India. Besides, urban growth has led to additional challenges of service delivery to the urban population, especially the urban poor, those living in urban slums and the migratory population.

With a view to widen the coverage of population screening for early case detection and to strengthen the active surveillance under NLEP, it is imperative to carry out active case search on a regular basis round the year and not occasionally in a campaign mode. The guidelines explicated in the paragraphs hereafter shall help the States/UTs plan their active case detection activities in such a manner that no one from the vulnerable population is left out of screening and active surveillance for leprosy.

B. Methodology of screening

1. Who will screen

Regular active case detection through screening of each member of the community (in both rural and urban areas) shall be carried out by ASHA/Non-Medical Supervisor/Non-Medical Assistant/Trained Female or Male Health Worker/Trained Community Volunteer/Trained Person affected by leprosy/Trained member of Mahila Aarogya Samiti (MAS) [hereafter referred as Female/Male Frontline Worker (F/M FLW)]. Female members of the community should be screened only by a female FLW and the male members should be screened by a suitable Male FLW. The DLO concerned shall be responsible for the identification of the most suitable F/M FLWs available in the area and for their deployment for the purpose of screening for leprosy.

2. Who will be screened

All persons above 2 years of age shall be screened in order to detect any signs or symptoms of leprosy.

3. How to screen

Inter Personal Communication (IPC) and adequate Information, Education and Communication (IEC) strategies should be deployed to make the community aware about the nature of the disease and the importance of screening for early detection of the signs and symptoms of the disease. Prior consent of the individual concerned must be obtained for screening. In case, if any person shows any reluctance for screening by F/M FLW, some close family member should be involved to carry out the screening.

4. Duration of screening round

Screening of the entire population of any given village/urban pocket needs to be completed within a span of 6 months or 12 months depending upon the number of screening rounds to be conducted there in a year. The number of screening rounds (1 or 2) shall be decided by the State/UT authorities in accordance with the criteria applicable to the given area. The criteria has been explained under the head **"frequency and criteria for screening"** hereafter. The time flexibility allowed for screening ranging from 6 months to one year duly acknowledges the fact that all the members of a given Household (HH) may not be available for screening on a single

day. It also acknowledges the fact that the female and the male FLW may not be visiting a household together, or at the same time, or on the same day for the screening of the HH members. Hence these guidelines provide complete flexibility of time schedules for screening in accordance with the availability of HH members, and/or the convenience of the F/M – FLW involved for screening. This time frame shall also ensure that the quality of screening is of a very high order. In such extended time frame, the F/M FLW should do the screening in a thorough manner as per the standard guidelines laid down by NLEP. This screening model allows multiple visits to a single HH by the F/M - FLW concerned till the time all the members of the HH are screened. It has to be ensured by F/M-FLW that no family member of any HH is left out of the screening coverage within the given time frame of the screening round. The time flexibility allowed to screen the entire population of the village concerned shall not only provide the F/M – FLW concerned with sufficient band width to ensure quality in the screening but shall also provide ample time to maintain complete records in the prescribed formats. This shall also provide sufficient time to the ASHA Facilitator /CHO/ANM of Sub-Centre/Health & Wellness Centre/UPHC, MO-PHC/UPHC and other senior health functionaries for qualitative Monitoring and Supervision of the screening activities.

C. Frequency and criteria for screening rounds

Frequency of screening (rounds)

i. The entire population of the given village/urban pocket in a low endemic block should be screened within 12 months so as to cover the entire population in a year. For areas in high endemic Blocks, there would be two rounds of screening in such a manner that the entire population is screened twice a year. The gap between the two rounds of screening of an individual would be six months in the areas where two rounds of screening are to be conducted. In other words, every person residing in a low endemic area would be screened once a year, and in high endemic areas twice a year.

ii. The screening rounds shall be completed within the given financial year. For example, for F.Y. 2020-21, the screening rounds (1 or 2, as per the criteria) would be carried out between 1 April, 2020 to 31 March, 2021.

Criteria for deciding the number of screening rounds (Table: 1)

S.No	Endemicity Status	Criteria	Frequency of screening
1.	**Low endemic Block**	PR<1/10000 Population AND/OR Annual new cases detected (ANCD) upto 20 cases AND/OR Grade 2 disability < 2 case/million population AND/OR Grade 2 disability percentage < 2% among new cases detected	Once a year
		Any village/urban pocket with in the low endemic blocks, If reporting	Twice a year, only in that particular village/urban pocket

		Even a single child case among new cases AND/OR Child G2D case among new cases AND/OR Any Adult G2D case among new cases	
2.	**High endemic Block**	PR>1/10000 Population AND/OR Annual new cases detected (ANCD) more than 20 cases AND/OR Grade 2 disability 2 or > 2 case/million population AND/OR Grade 2 disability percentage 2% or > 2% among new cases detected	Twice a year Note: Villages which have not reported any case of leprosy in last three years may be kept out of screening rounds. Instead the surveillance should be maintained in such areas by F/M FLW and incentives for confirmation of diagnosis and completion of treatment shall be paid as per the already existing guidelines, in case F/M FLW identifies a case which is confirmed as a case of leprosy and ensures his/her complete treatment.
3.	**Urban Areas**	Districts reporting leprosy cases from urban areas need to focus on the screening of population living in the endemic pockets of given Urban areas. These pockets include urban slums and other key focus areas such as construction sites, colonies inhabited by migrants, mining areas, brick kilns etc. All districts must map such locations for the purpose of active case detection and surveillance. .	Minimum one round of screening must be conducted in such areas even if a single case of leprosy or G2D is reported. Second round of screening would be conducted if the criteria for two rounds of screening given above for high endemic blocks is fulfilled. Besides, State/UTs can decide second round of screening on the basis of the findings of the 1st round.

4.	**Areas with Special needs**	Special strategies may be devised by the states/UTs at their own level for ensuring the screening of 100% population in areas with special needs, e.g. Hard to Reach (HTRA) areas/ geographically far flung areas where the F/M FLW do not reside on a permanent basis. The states may consider training some local female and male community volunteers including persons affected by leprosy residing in such areas for active Leprosy case detection on regular basis. In the scenario where this option is also not available, the states/UTs may decide the time duration themselves for conducting and completing screening rounds for case detection, making optimum use of the resources available.	The screening rounds in area with special needs may be conducted and completed in a focussed manner in shorter durations as per prevailing ground situation. However, the screening rounds should not be closed till the time 100% resident eligible population of the given area is screened for leprosy. It must be ensured that not a single member of the community remains out of the screening coverage.

Note:

The cut-off date for the criteria/indicators for deciding the number of screening rounds would be 31 Dec of the immediately preceding year. The statistical reports finalised by the State/UT upto 31 Dec should be used to decide the number of screening rounds for blocks/urban areas/villages. For example, the statistics upto 31.12.2019 shall be the criteria for deciding the number of screening rounds for F.Y. 2020-21.

D. Flexibilities allowed to decide the number of screening rounds

I. Though the Block level indicators have been mentioned in the criteria in Table -1, States/UTs shall be free to decide whether or not screening should be carried out in all the villages/urban pockets located in the given Block. This means that the States/UTs would be free to select at their own level, on the basis of the village/urban pocket level data available with them, if certain villages/urban pockets need to be left out of screening rounds. Similarly, the States/UTs shall be free to decide the number of rounds (1 or 2) in the villages/urban pockets on the basis of the data available. In other words, in order to ensure the efficient deployment of resources, the decision to select any villages/urban pockets for screening rounds, and/or the decision to decide the number of rounds in a village shall be taken by the State/UTs on the basis of the villages/urban pockets level data, and not the Block level data.

ii. A Village/villages/urban pocket which has not reported any case of leprosy in the last three years may be kept out of active case detection through screening. Instead F/M-FLW should maintain surveillance and refer the Suspect, if any noticed, to the PHC/UPHC concerned. In such areas, the F/M FLW shall be eligible for the incentives as per the extant policy guidelines, i.e. Rs. 250 for confirmation of leprosy case without disability, and Rs. 200 for leprosy case confirmation with disability. Besides, an incentive of Rs. 400 for ensuring completion of treatment of each Paucibacillary (PB) patient, and Rs. 600 for ensuring completion of treatment of each Multibacillary (MB) patient shall be payable to the F/M FLW. However, no incentive for regular screening of the population shall be paid to the F/M FLW in any such village/urban pocket.

E. Definition of suspect/symptoms guide for suspect case identification*

Any person with any of the following symptoms, either singly or in combination:-

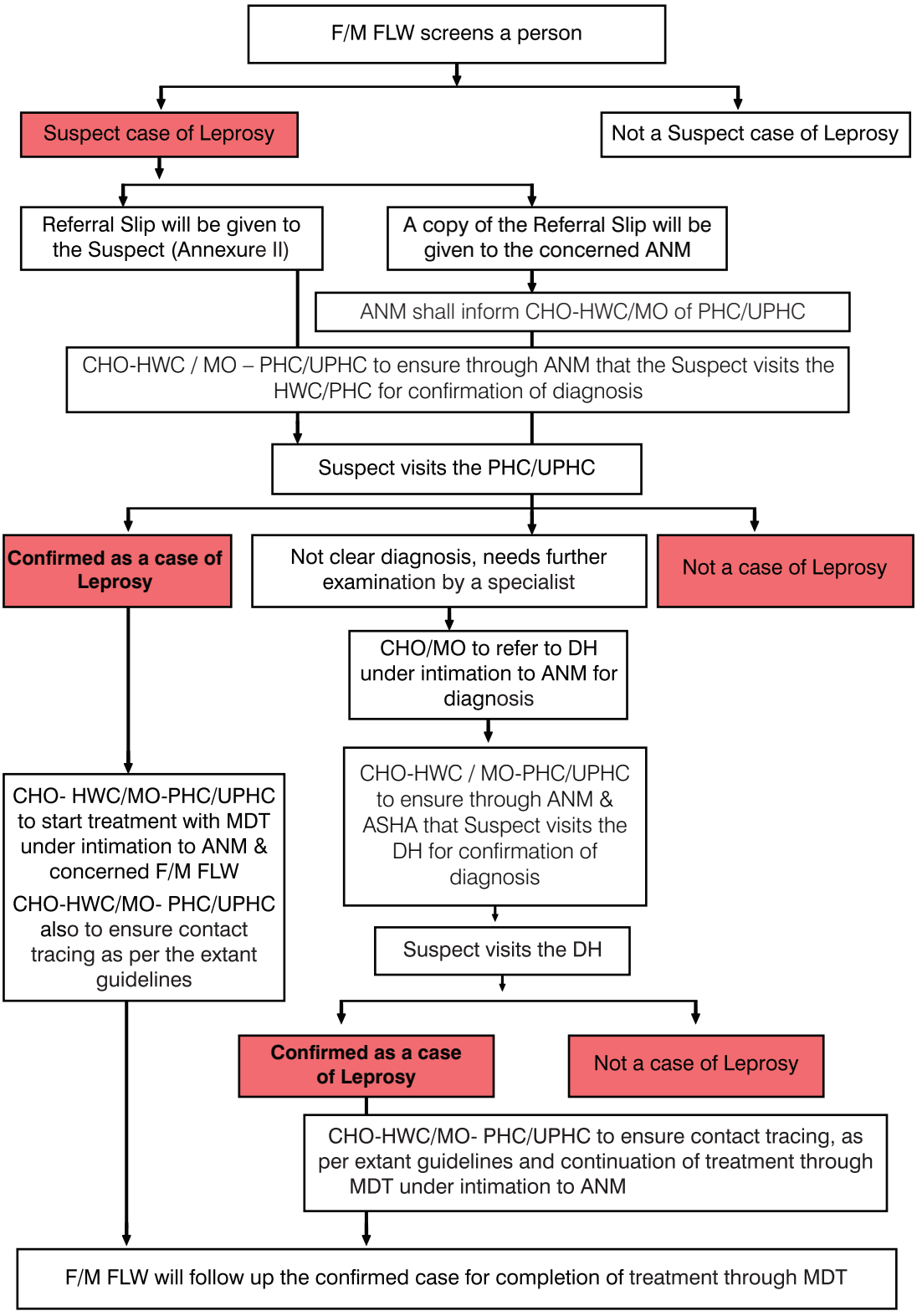
S. No.	Signs and symptoms for identification of Suspect case of Leprosy
1.	Any change in the skin color (pale or reddish patches on skin) with partial or complete loss of sensation
2.	Thickened skin on the patches
3.	Shiny or oily face skin
4.	Nodules on skin
5.	Thickening of ear lobe(s)/nodules on earlobe(s)/nodules on face
6.	Inability to close eye(s)/watering of eye(s)
7.	Eyebrow loss
8.	Nasal infiltration (saddle nose deformity)
9.	Thickened peripheral nerve (s)
10.	Pain and /or tingling in the vicinity of the elbow, knee or ankle
11.	Inability to feel cold or hot objects
12.	Loss of sensation in palm (s)
13.	Numbness in hand(s) / foot/feet
14.	Ulceration in hand(s) / painless wounds or burns on palm(s)
15.	Weakness in hand(s) when grasping or holding objects; inability to grasp or hold objects
16.	Difficulty in buttoning up shirt/jacket etc.
17.	Tingling in finger(s) / toe(s)
18.	Tingling in hand(s) / foot/feet
19.	Ulceration in foot /feet; painless wounds or burns on foot/feet
20.	Clawing / bending of finger(s) / toe(s)
21.	Loss of sensation in sole of foot/feet
22.	Weakness in foot/feet/ footwear comes off while walking
23.	Foot drop / dragging the foot while walking

(*This list is NOT exhaustive)

F. Referral mechanism to refer any suspect for final diagnosis

If F/M FLW suspects that a person screened is a “Suspect case”, she/he will issue a Referral Slip **(Annexure II)** to the Suspect with the advice to immediately visit the nearest PHC for final diagnosis by the MO concerned. A copy of the said Referral Slip shall also be handed over by the F/M FLW to the CHO/ANM of the Sub-Centre/HWC/UPHC concerned within a day of screening of such Suspect.

Flow chart for referral mechanism



G. Contact screening and tracing

After confirmation of a new case of leprosy, the PHC/UPHC Medical Officer will inform the concerned CHO/ANM and F/M FLW and shall ensure screening of all the close contacts of such index case following Guidelines for Post Exposure Chemoprophylaxis shared earlier with all States/UTs. The close contacts of every 'Index Case' of leprosy shall be screened for signs or symptoms of leprosy by a regular trained health worker, under the overall supervision of the CHO- HWC/MO- PHC/UPHC. If a confirmed case of leprosy is found in the contacts, the treatment needs to be immediately initiated with MDT. For the remaining contacts, Single Dose Rifampicin (SDR) is required to be administered as Post Exposure Chemoprophylaxis (PEP). The extant guidelines in respect of MDT/PEP must be followed. In case any close contact of an Index Case is found to be away from home, and is not available for screening, the SoP given for the missing household member(s) in the subsequent paragraph "H" shall be followed. The CHO- HWC/Medical Officer of the PHC/UPHC shall be responsible for ensuring screening of the close contacts of every confirmed new leprosy case (index case), and for administration of PEP to them as per the protocol.

H. SoP for missing member(s) of any household

If any member of a HH is away from home continuously for the entire duration of screening rounds (6 months/year), the F/M FLW shall obtain complete details about the current place of residence of such a person along with the phone number and share such address and phone details with the CHO (HWC)/ANM concerned. The CHO/ANM shall fill the said information in the Information Slip **(Annexure III)** and shall share the information with the MO-PHC/UPHC concerned. The MO-PHC/UPHC, in turn, shall share the said details with the Block Medical Officer, and the Block Medical Officer shall share the same information with the DLO concerned. The DLO shall share the given information further with his SLO as well as with the DLO of other state/district where such a person reportedly resides. Finally, SLO shall share this information with the SLO of the other state where this family member is reportedly residing. The SLO/DLO shall also ensure the screening of that family member in coordination with the SLO/DLO of the other State/District. SLO/DLO of the other State/District shall send the screening report to the SLO & DLO of the referring State/District. Finally, both the SLOs shall share the screening report with the Central Leprosy Division.

Table 2: Flow chart for sharing information regarding missing member of a household

Flow of Information	F/M FLW screens members of a household for leprosy	Flow of Information
↑	If any family member is away from home continuously for the entire duration of the screening round	↓
	F/M FLW to obtain complete address and phone no. of such a family member and share with the CHO/ANM concerned	
	CHO/ANM to share the information with the MO-PHC/UPHC concerned	
	MO – PHC/UPHC to share the information with the Block Medical Officer (BMO)	
	BMO to share the information with DLO	
	DLO to share the information with his SLO as well as with the DLO of other state/district where such a person reportedly resides	
	SLO to share this information with the SLO of the other state where this family member is reportedly residing	
	SLO/DLO will ensure the screening of that family member in coordination with the SLO/DLO of the other State/District	
	SLO/DLO of the other state shall send the screening report to the SLO & DLO of the referring state	
	Both the SLOs shall share the screening report with the Central Leprosy Division	

I. Incentive structure

Table 3: Role & Responsibilities of a F/M FLW

Female FLW	Male FLW
I. To complete the screening of all the female members of each household and maintain the record in the HH Screening Register **(Annexure I)**	I. To complete the screening of all the male members of each household and maintain the record in the HH Screening Register **(Annexure I)**.
II. If any Suspect found is in any household, he/she must be referred to the MO-PHC for examination and final diagnosis.	II. If any Suspect found is in any household, he/she must be referred to the MO-PHC for examination and final diagnosis.

NOTE: Both female as well as male FLW involved in screening shall maintain separately the Household Screening Register with complete details of each Household.

Incentives Details

1. F/M FLW involved in the screening for leprosy shall be paid an incentive of Rs. 1000/- each individually per round of screening and complete reporting after each round. The incentive shall be paid for one screening round in low endemic areas, and for two screening rounds in high endemic areas in a F.Y. The payment shall be made after due verification by the ASHA Supervisor/ANM as per the procedure laid down by the state/ UT concerned in this regard. No incentive for screening shall be paid to F/M FLW in a village where no case of leprosy has been reported in the last 3 years.
2. ASHA Supervisor/Facilitator shall be entitled for incentive @ 10% per ASHA incentive at the end of each completed screening round. The said incentive shall be paid to ASHA Supervisor/Facilitator only after she ensures that all the Hhs in the village, where screening rounds were conducted by the ASHA(s) under her jurisdiction, have been fully screened for leprosy, suspects have been duly referred by ASHA(s) and final diagnosis has been made by the concerned MO PHC/CHC/DH. A certificate **(Annexure IX- A)** dully filled in shall be required to be submitted by the ASHA Supervisor/Facilitator to the MO-PHC concerned in this regard. Thereafter, the due incentive @ 10% of the incentive paid for the screening round to each ASHA under her jurisdiction/supervision shall be paid to the ASHA Supervisor/Facilitator. For example, if a screening round is carried out by 20 ASHAs under the jurisdiction/ supervision of an ASHA facilitator, ASHA Supervisor/Facilitator shall be entitled to the incentive of Rs. 2000/- for one completed round of screening. If a screening round is carried out only by 10 ASHAs in 10 villages under the jurisdiction of the ASHA Supervisor/Facilitator, she shall be entitled to the incentive of Rs. 1000/- only.

3. Additional incentive will be paid to the F/M FLW who refers any Suspect to the health facility and in whose case the diagnosis for Leprosy is confirmed. Incentive will be paid at the rate of Rs. 250 for confirmed leprosy case without disability, and Rs. 200 for confirmed leprosy case with disability.
4. Incentive shall be paid to F/M FLW for ensuring the completion of treatment of a leprosy patient at the rate of Rs. 400 for each Paucibacillary (PB) case and Rs. 600 for each Multibacillary (MB) case.

Essential conditions for Payments of Incentives:

1. A Female FLW shall get the incentive only after she completes the screening of all the female members of a HH and gets the female Suspect, if any, examined by the MO-PHC/UPHC concerned. Similarly, a male FLW shall get the incentive only after he completes the screening of all the male members of a given HH, and gets the male Suspect if any, examined by the MO-PHC/UPHC concerned. The screening work of F–FLW and M-FLW shall be evaluated separately, independent of each other's work or performance.
2. Incentive payment shall be released only after all the relevant entries are made in the HH Screening Register by the F/M FLW concerned and duly certified by ASHA Facilitator/ANM **(Annexure –IX- A)**.
3. In case any member of a household is missing during the entire duration of screening round, the F/M FLW shall pass on the address and phone details of such a member to the CHO/ANM concerned in the Information Slip **(Annexure III)**. After submission of the Information Slip, he/she will become eligible for the payment of the incentive if the screening of the rest of the available male/female members of that household has been completed.
4. If above mentioned conditions are fulfilled, F/M FLW will submit the claim for incentive payments to ASHA Facilitator/ANM as per the procedure laid down by the state/UTs.
5. The payment shall be made after due verification by the ASHA facilitator/ Supervisor/ANM/NMS/Medical Officer PHC/UPHC as per the procedure laid down by the state/UT concerned.
6. Household Screening Register maintained by the F/M FLW must be checked by the CHO/ANM/ASHA Facilitator/Supervisor along with the Referral Slips and the PHC/UPHC-OPD/referral register for verification of screening claims made by ASHAs/F/M FLW.

J. Supervision and monitoring

(I) Whenever any ASHA submits the claim for payment of incentive for completed screening round to ASHA Facilitator/ Supervisor, she will cross verify the claims after checking the HH Screening Register maintained by ASHA(s) and referrals slips. She will also certify each ASHA's work for screening round completion (Annexure IX- A).

(ii) Whenever any F/M FLW submits the claim for payment of incentives for screening for leprosy, the CHO (HWC)/ANM concerned shall independently verify at least 10% of the persons claimed to have been screened by her/him. The MO- PHC/UPHC shall randomly and independently cross-check and certify at least 10% of the persons claimed to have been screened for leprosy in the area under the given PHC/UPHC jurisdiction.

(iii) Before closing any screening round in a village/urban pocket, the CHO/ANM (SC/HWC/UPHC) concerned shall certify under her signatures that 100% population of the village/Urban pocket concerned has been screened for leprosy, 10% of population has been cross-checked by her, and complete information in respect of the missing person(s), if any, has been submitted to the MO-PHC/UPHC concerned **(Annexure IX - AA)**.

(iv) The MO-PHC / MO - UPHC concerned shall certify under his/her signatures that 100% population of the area under PHC/UPHC jurisdiction has been screened for Leprosy, 10% of population has been cross-checked by her/him, and complete information in respect of the missing person(s), if any, has been submitted to the MO-CHC/UCHC concerned **(Annexure IX–B and Annexure IX -BU)**.

(v) The MO CHC/UCHC concerned shall certify that 100% population of the area under CHC/UCHC jurisdiction has been screened for Leprosy, and complete information in respect of the missing person(s), if any, has been submitted to the District Leprosy Officer concerned **(Annexure IX-C)**.

(vi) The DLO concerned shall certify that 100% population of the area under his/her jurisdiction has been screened for Leprosy, and complete information in respect of the missing person(s), if any, has been submitted to the State Leprosy Officer concerned **(Annexure IX - D)**.

(vii) The SLO shall certify that 100% resident eligible population of his/her state has been screened for leprosy, and complete information in respect of the missing person(s), if any, has been submitted and shared with the respective State/District Leprosy Officer concerned **(Annexure IX-E)**. SLO shall submit the final State level round completion certificate to the Central Leprosy Division.

(viii) The SLO and DLO concerned would also independently and randomly cross verify the population screened in his/her jurisdiction and satisfy himself/herself about the veracity of the claims regarding screening.

K. Maintenance of records

Household screening register for leprosy

Each F/M FLW involved in the work of screening for leprosy shall be required to maintain a Household (HH) Screening Register for leprosy as per the format given in **Annexure I**.

The register should be maintained in the form of a permanent record, and therefore, should be used for multiple years. Both male as well as female Frontline Worker (F/M FLW) involved in the screening would maintain separate HH Screening Register and would complete all columns of the register as per the prescribed format **(Annexure I)**. The details captured in the Register are as follows in Table 4 below:

Table 4: The details captured in the HH screening register

Cover Page and summery details	Household details
1. Name of the State: 2. Name of the District: 3. Name of the Block/Ward: 4. Name of the Village/Urban Pocket: 5. Population of the Village / Urban Pocket: 6. Name of Sub- Centre/HWC/UPHC: 7. Name of CHO/ANM 8. Name of PHC/UPHC In -charge for this village/urban pocket: 9. Name of the ASHA/Trained volunteer/ female Health Worker/MAS member (Trained for screening for Leprosy): 10. Name of the Male Health Worker /NMS/Trained male volunteer: (Trained for screening for Leprosy) 11. Name of the ASHA Facilitator/ ASHA Supervisor: 12. Name of the ANM (SC):	1. Total no. of family members: _____ 2. Address: _____ 3. Telephone No: (three preferably) _____ 4. Names, Age, Gender of all the family members. 5. Date of screening: 6. If any family member living elsewhere, complete address and contact no: 7. Whether under treatment for leprosy OR an old/known case of Leprosy: 8. Suspect for Leprosy (Y/N): 9. Confirmed as case (Y/N): 10. Date of start of MDT treatment: 11. Date of completion of MDT treatment:

Other documents

1. Referral Slip, for the Suspect identified during household screening **(Annexure II)**
2. Information Slip for the Missing household members/contacts **(Annexure III)**
3. Village/Urban pocket level Monthly Report form for details of Active Case Search Activity for submission to MO – PHC/UPHC by CHO/ANM – Sub Centre/HWC/UPHC **(Annexure IV)**
4. PHC/UPHC level Monthly Report form for details of Active Case Search Activity for submission to Block Medical Officer by MO – PHC/UPHC **(Annexure V)**
5. Block level Monthly Report form for details of Active Case Search Activity for submission to District Leprosy Officer by Block Medical Officer **(Annexure VI)**
6. District level Monthly Report form for details of Active Case Search Activity for submission to State Leprosy Officer by District Leprosy Officer **(Annexure VII)**
7. Compiled district wise Monthly Report form for details of Active Case Search Activity in the State for submission to Central Leprosy Division by State Leprosy Officer (Annexure VIII)
8. Certificates for closure of Screening rounds **(Annexure IX)**

a) Screening completion certificate to be signed by ASHA Supervisor/Facilitator for each ASHA, and to be submitted to CHO-HWC/MO-PHC/CHC **(Annexure IX-A)**

b) Village/Urban pocket level certificate to be signed by CHO (HWC) /ANM on round completion and to be submitted to the PHC/UPHC concerned **(Annexure IX-AA)**

c) PHC level certificate to be signed by MO – PHC on round completion and to be submitted to the CHC concerned **(Annexure IX-B)**

d) UPHC level certificate to be signed by MO – PHC/UPHC on round completion and to be submitted to the UCHC concerned **(Annexure IX – BU)**

e) Block CHC/UCHC level certificate to be signed by MO – CHC/UCHC on round completion and to be submitted to the District Leprosy Officer concerned **(Annexure IX-C)**

f) District level certificate to be signed by DLO on round completion and to be submitted to the State Leprosy Officer concerned **(Annexure IX-D)**

g) State level certificate to be signed by SLO on round completion and to be submitted to the Central Leprosy Division **(Annexure IX-E)**

Table: 5 steps to be followed for monthly reporting of active case detection and regular surveillance

Female as well as male FLW will maintain the HH Screening Register and show to the CHO/ANM/ ASHA Facilitator of assigned Sub-Centre/Urban pocket on monthly basis along with the incentives claim **(Annexure I & II)** The CHO/ANM SC/HWC/Urban pocket shall submit the village/urban pocket level monthly report to the MO-PHC/UPHC concerned in the prescribed format **(Annexure IV)**
MO – PHC/UPHC shall submit the compiled monthly report of the PHC/UPHC to the concerned Block health office in the prescribed format **(Annexure V)**
Block Health Officer shall submit the compiled monthly report of the block to the DLO concerned in the prescribed format **(Annexure VI)**
DLO shall submit the compiled block wise (both rural and urban) monthly report to the concerned SLO in the prescribed form **(Annexure VII)**
SLO shall submit the district wise monthly report to the CLD in the prescribed format **(Annexure VIII)**
SLO will submit the district wise monthly report to the CLD in the prescribed form **(Annexure VIII)**

ANNEXURE I

Household Screening Register for Leprosy (Cover Page of the Household Screening Register)

(To be maintained and filled by (ASHA/NMS (Non-Medical Supervisor)/NMA (Non-Medical Assistant) / trained female or male Health Worker/trained Community Volunteer/ trained Person affected by leprosy/ trained member of Mahila Aarogya Samiti (MAS)

1. Name of the State: _____
2. Name of the District: _____
3. Name of the Block/Ward: _____
4. Name of the Village/Urban Pocket: _____
5. Population of the Village/Urban Pocket: _____
6. Name of Sub- Centre/HWC/UPHC: _____
7. Name of CHO/ANM _____
8. Name of PHC/UPHC In -charge for this village/urban pocket: _____
9. Name of the ASHA/Trained volunteer/trained female Health Worker/MAS member: (Trained for screening for Leprosy) _____
10. Name of the Trained Male Health Worker/NMS/NMA Trained male volunteer: (Trained for screening for Leprosy) _____
11. Name of the ASHA Facilitator/ASHA Supervisor: _____
12. Name of the ANM (SC): _____

Summary of screening activity
(To be filled at the end of each completed round) (BACKSIDE OF COVERPAGE)

	YEAR	2020		2021		2022	
	ROUND	I	II	I	II	I	II
1.	Name of Frontline worker (FLW)						
2.	Gender of FLW (Male/Female)						
3.	Date of completing screening for leprosy						
4.	No. of members of family enumerated of particular gender Male / Female						
5.	No. of persons screened						
6.	No. of missing members reported						
7.	No. of suspects referred						
8.	No. of suspects examined						
9.	No. of cases of leprosy confirmed						
10.	Signature of FLW						

Household Screening Register for Leprosy Format (Household wise format)

Address of the Household: _____

Telephone No: (i). _____ (ii) _____ (iii) _____

S. No	Name of the family Members	Age	(F/M)	Year	Rounds	Date of Screening	If family member living elsewhere: address & contact no.	Whether under treatment for leprosy OR an old/known case of Leprosy	Suspect for Leprosy (Y/N)	Confirmed for leprosy Y/N	Date of start of MDT treatment	Date of completion of treatment	Signature (F/M FLW)
1.				2020	I								
					II								
				2021	I								
					II								
				2022	I								
					II								
2.				2020	I								
					II								
				2021	I								
					II								
				2022	I								
					II								
3.				2020	I								
					II								
				2021	I								
					II								
				2022	I								
					II								

ANNEXURE II

Referral Slip for Suspect

Referral Slip for Suspect	Copy of Referral Slip for CHO/ ANM record
Name of the State	Name of the State
Name of the District	Name of the District
Name of the block	Name of the Block
Name of the village/urban pocket	Name of the village/urban pocket
Name of the Suspect	Name of the Suspect
Address and telephone no.	Address and telephone no.
Date of screening	Date of screening
Referred to CHO-HWC/PHC/UPHC name:	Referred to CHO-HWC/PHC/UPHC name:
Name and Signature of the Female/Male FLW	Name of the Female/Male FLW

ANNEXURE III

Information Slip for Missing Household Members

Information sharing mechanism: If any household member is not available throughout the duration of the screening round			
Complete address of the household			
Phone no.			
Details of the missing household member			
Name:	Age:	Gender:	Female/Male
Current address of the missing household member			
Phone no.			
Name and signature of the CHO(HWC)/ANM			

ANNEXURE IV

Village/Urban pocket level Monthly Reporting format for details of Active Case Search Activity for submission to the MO-PHC/UPHC by CHO/ ANM-Sub centre/HWC/UPHC Concerned

Name of reporting Month: Year:

Name of the State /UT		
Name of District		
Name of the Block		
Name of the PHC/UPHC		
Name of the Sub–Centre/Health & Wellness Centre/UPHC		
Enumerated Population of Sub–Centre/Health & Wellness centre/ UPHC		
Population eligible for screening under Sub-Centre/Health & Wellness Centre/UPHC		
Screened Population		
Suspects referred		
Suspect examined		
Cases confirmed		
Cases started MDT		

.....

Name and signature of CHO/ANM – Sub centre/HWC/UPHC:

Date: .....

ANNEXURE V

PHC/UPHC level Monthly Reporting format for details of Active Case Search Activity for submission to Block Medical officer by MO-PHC/UPHC

Name of reporting Month: Year:

Name of the State /UT		
Name of District		
Name of the Block		
Name of the PHC/UPHC		
Enumerated Population of PHC/ UPHC		
Population eligible for screening under PHC /UPHC jurisdiction		
Screened Population		
Suspects referred		
Suspect examined		
Cases confirmed		
Cases started MDT		

.....

Name and signature of MO-PHC/UPHC:

Date: .....

ANNEXURE VI

Block level Monthly Reporting format for details of Active Case Search Activity for submission to DLO by BLO/ Block Health Officer

Name of reporting Month: Year:

Name of the State /UT		
Name of District		
Name of the Block		
Enumerated Population of Block		
Population eligible for screening at Block		
Screened Population		
Suspects referred		
Suspect examined		
Cases confirmed		
Cases started MDT		

.....

Name and signature of Block Health Officer:

Date: .....

ANNEXURE VII

District level Monthly Reporting format for details of Active Case Search Activity for submission to SLO by DLO

Name of reporting Month: Year:

Name of the State /UT		
Name of District		
Enumerated Population of District		
Population eligible for screening at District		
Screened Population		
Suspects referred		
Suspect examined		
Cases confirmed		
Cases started MDT		

.....

Name and signature of District Leprosy Officer:

Date: .....

ANNEXURE VIII

State level (Compiled District- wise) Monthly Reporting format for details of Active Case Search Activity for submission to Central Leprosy Division by State Leprosy Officer

Name of the State /UT	Name of Districts	Enumerated Population of District	Population eligible for screening at District	Screened Population	Suspects referred	Suspect examined	Cases confirmed	Cases started MDT
Total								

.....

Name and signature of State Leprosy Officer:

Date: .....

National Leprosy Eradication Programme

ANNEXURE IX-A

Screening Round Completion Certificate by ASHA facilitator

This is to certify that _____ ASHA of _____ village/urban pocket of _____ Block, _____ District, _____ State has completed the ____ (First / Second) round of screening for leprosy for the Financial Year _____. 100% resident eligible population has been screened during this round; suspects have been referred and final diagnosis has been made by concerned Medical officer – PHC/UPHC/ CHC/DH. The HH screening register for leprosy has been duly checked in respect of all the entries.

.....

Name and Signature of
ASHA Supervisor/Facilitator

Date: ……

National Leprosy Eradication Programme

ANNEXURE IX-AA

Screening Round Completion Certificate by CHO/ANM

This is to certify that _____ village/urban pocket of _____ Block, _____ District, _____ State has completed the ____ (First / Second) round of screening for leprosy for the Financial Year _____. 100% resident eligible population has been screened during this round, and complete information in respect of missing persons has been submitted to the concerned Medical officer – PHC/UPHC.

I do hereby declare that above information and facts stated are true, correct and complete to the best of my knowledge and after random checking of 10% of the screened population.

.....

Name and Signature of CHO/ANM, Sub-Centre/Health & Wellness Centre/UPHC: Date: ……

National Leprosy Eradication Programme

ANNEXURE-BU

Screening Round Completion Certificate by MO UPHC

This is to certify that _____ urban slum / key focus area falling under the jurisdiction of _____Urban - PHC, _____ Ward /Block, _____ District, _____ State has completed the _____ (First / Second) round of screening for leprosy for the Financial Year _____. 100% resident eligible population has been screened during this round, and complete information in respect of missing persons has been submitted to the Medical officer – Urban Community Health Centre.

I do hereby declare that above information and facts stated are true, correct and complete to the best of my knowledge and after random checking of 10% of the screened population.

.....

Name and Signature of
MO – UPHC:

Date: ……

National Leprosy Eradication Programme

ANNEXURE IX-B

Screening Round Completion Certificate by MO-PHC

This is to certify that all the villages falling under the jurisdiction of _____PHC, _____ Block, _____ District, _____ State has completed the ____ (First / Second) round of screening for leprosy for the Financial Year _____. 100% resident eligible population has been screened during this round, and complete information in respect of missing persons has been submitted to the Medical officer – Community Health Centre.

I do hereby declare that above information and facts stated are true, correct and complete to the best of my knowledge and after random checking of 10% of the screened population.

.....

Name and Signature of MO – PHC:

Date: ……

National Leprosy Eradication Programme

ANNEXURE IX-C

Screening Round Completion Certificate by MO- CHC/UCHC

This is to certify that all the population covered under the jurisdiction of _____CHC/UCHC of _____ Block, _____ District, _____ State has completed the _____ (First / Second) round of screening for leprosy for the Financial Year _____. 100% resident eligible population has been screened during this round, and complete information in respect of missing persons has been submitted to the District Leprosy Officer.

.....

Name and Signature of
MO – CHC/UCHC:

Date: ……

National Leprosy Eradication Programme

ANNEXURE IX-D

Screening Round Completion Certificate by DLO

This is to certify that all the population covered under the jurisdiction of _____ District, _____ State has completed the _____ (First / Second) round of screening for leprosy for the Financial Year _____. 100% resident eligible population has been screened during this round, and complete information in respect of missing persons has been submitted to the District /State Leprosy Officer.

.....

Name and Signature of
District Leprosy Officer:

Date: .....

National Leprosy Eradication Programme

ANNEXURE IX-E

Screening Round Completion Certificate by SLO

This is to certify that all the population covered under the jurisdiction of _____State has completed the _____ (First / Second) round of screening for leprosy for the Financial Year _____. 100% resident eligible population has been screened during this round, and complete information in respect of missing persons has been submitted to the State Leprosy Officer of the State concerned.

.....

Name and Signature of
State Leprosy Officer:

Date: ……

Operational Guidelines are issued by Central Leprosy Division, Directorate General of Health Services, as per the approval of Ministry of Health and Family Welfare, Government of India accorded on 22nd July, 2020.

Guidelines printed in the month of August, 2020

Central Leprosy Division
Directorate General of Health Services,
Ministry of Health and Family Welfare,
Nirman Bhawan, New Delhi 110011