AN OVERVIEW

SAPEL IN MADHYA PRADESH, CHHATTISGARH, ORISSA AND TAMIL NADU

AIMS OF SAPEL

- To take leprosy detection and treatment to remote, inaccessible areas and make the service available to hitherto unreached populations.
- To make people in the project areas aware of the causes, signs / symptoms and treatment of leprosy. Above all to make them aware that it is fully curable through MDT and to teach them methods of preventing and minimising disabilities arising from leprosy.
- To remove misconceptions and inaccurate beliefs about leprosy and so remove the stigma attached to it.
- To promote community participation in all areas of leprosy elimination by encouraging voluntary detection and IEC/ awareness campaigns by local groups.
- To promote knowledge and awareness about leprosy among service providers in the general health system and so ensure their participation in leprosy detection and treatment.

SELECTION OF SAPEL AREAS

SAPEL is a high-cost, need-based intervention to be carried out within a limited time period. While flexibility on the ground is seen as essential, very specific criteria have been laid down for selection of areas in which SAPEL is to be implemented.

CRITERIA

Factors contributing to poor access and inadequate health services, are the criteria to select an area for SAPEL. These include:

- Difficult terrain as in hilly, forested regions.
- Distance from service providing agencies, where villages/ hamlets are remote and isolated.

- Poor communication facilities including bad or non-existent roads made worse during the monsoon, with flooded rivers and streams further cutting off settlements.
- Inadequate or no health services, both general and leprosy related.
- Leprosy endemic areas with high PR not yet subjected to any concentrated elimination campaign because of any or all of the above factors.
- Areas with low PR which, however, may not reflect the true picture due to lack of or poor detection campaigns. Such areas are consequently expected to have many hidden cases.
- Nomadic populations not subject to detection/treatment procedures for long periods.
- Urban slums with poor health services.

PROPOSALS

Once the decision was made to implement SAPELs with DANLEP participation in the states of Madhya Pradesh, Orissa and Tamil Nadu, health personnel at the district level (more specifically those in charge of leprosy programmes) were briefed on the concept and asked to present proposals for specific project areas. The proposals were to include:

- Geographical description of the proposed project area.
- Demographic details including literacy levels, livelihood and living patterns, existing beliefs, practices relating to leprosy.
- Description of existing health services, their accessibility and effectiveness.
- Communication facilities or their lack in the project area.
- Reasons for considering the area eligible for SAPEL.
- Plan of implementation of SAPEL.
- Budget estimate.

APPROVAL

A State Screening Committee was set up in each of the three states to study the project proposals. The committee consisted of representatives from the state health system (generally the

Joint Director in charge of leprosy) and representatives of DANLEP in the state.

Following scrutiny by the committee, some proposals were returned to the concerned district officers with requests for more information.

AT A GLANCE

The first round of DANLEP-supported SAPELs in the states under study took place between 1997 and 2000. The number of SAPELs carried out, population covered and cases registered in this round are as follows (figures for Madhya Pradesh include Chhattisgarh):

State	Number of SAPELs	Number of districts	Population covered, in lakhs	Cases detected
Madhya Pradesh	47	21	13.6	822
Orissa	6	6	3.6	838
Tamil Nadu	5	5	0.7	353

MADHYA PRADESH

Not surprisingly Madhya Pradesh (including Chhattisgarh), a large, high endemic state with hilly terrain and extensive forest cover, produced the highest number of proposals for areas which met the criteria of inaccessibility and poor health services. In the first round of SAPELs, 47 proposals were approved and implemented in the state. The 47 SAPELs were spread over 21 districts and covered a population of 13.6 lakhs. A total of 822 cases were detected in this first round of SAPEL in Madhya Pradesh.

Most of the project areas are inhabited by tribals who constitute 23% of the state's population and are among the most poorly served groups when it comes to health needs. These hilly and forested project areas, with poor roads, are difficult to access at all times; they are totally isolated in the monsoon when rivers and streams are in spate and cut off villages and hamlets from each other as well as from the nearest PHC or HSC. Some of the more isolated hamlets are not visited by health workers for long periods — sometimes two or three years.

In many of the thickly forested areas, stories are told of wild animals, including sighting of tigers. In some, especially near the borders of Maharashtra and Andhra Pradesh, Naxalites are said to be in control of some areas. But one is assured, in the same breath, that the Naxalites never interfere with health providers. Some examples of such difficult to access areas in which SAPEL was undertaken lie in the districts of Bilaspur and Bastar in what is now Chhattisgarh, in Balaghat south of Jabalpur and in Khandwa and Khargoan south of Indore. Among the exceptions is Gurur in Durg district of Chhattisgarh where the problem is not one of accessibility. It was selected because it had no government leprosy service structure but was in the care of a leprosy mission which provided excellent treatment but poor coverage for detection.

ORISSA

Also a high endemic state having many hilly, forested stretches with isolated tribal populations, Orissa came up with only six SAPELs, one in each of six districts. Covering a population of 3.6 lakhs, these six projects resulted in detection of 838 cases, a total higher than that of Madhya Pradesh with its 47 SAPELs! This is indicative of a high rate of incidence combined with a low rate of detection in the state. An intensive programme like SAPEL demonstrates its utility is such a case.

The six SAPEL areas were Palahara in Angul district, Kotagad in Phulbani district, Naktideul in Sambalpur district, Bonai in Sundergarh district, Mahakalpara & Rajnagar in Kendrapara district, and Krushnaprasad in Puri district. Four of these are in hilly, forested terrain, inhabited mainly by tribals in scattered villages and hamlets, which are remote and difficult of access. Of the two project areas located in coastal districts the one in Kendrapara, in the Mahanadi delta, has more river ways than roads, making many parts inaccessible except by boat. Krushnaprasad project area in Puri district is also a largely tribal area. It covers 22 islands spread across the southern part of Chilika lake, a huge lagoon separated from the Bay of Bengal by a long sandbar.

According to the Orissa state screening committee, only six proposals were received in the first round, though more would have been welcome. Apparently the SAPEL concept, when first mooted, was unknown territory and many DLOs were hesitant to commit themselves to such an intensive project given the poor infrastructure at their disposal and the existing workload of the more conventional leprosy elimination campaigns. As far as the former factor (poor infrastructure) is concerned, it would seem that what should have been the reason for SAPEL was actually a cause for hesitation in the beginning.

TAMIL NADU

A low endemic state with fewer isolated areas, Tamil Nadu planned for five projects, one in each of five districts, in the first round. These covered a total population of just around 70,000. The number of cases detected was 353.

Four of the areas selected, though relatively small in extent, are isolated, hilly areas, inhabited by tribals living in scattered and inaccessible hamlets, with poor communication facilities and not well served by the health system. These areas are seen as hardship postings by medical personnel and health workers; few have any thought of staying in these hills for long. The fifth SAPEL was conducted in the plains, over an area which had not hitherto been covered by a leprosy detection survey and elimination programme.

PLANNING AND IMPLEMENTATION

Planning of the project was again the responsibility of the district health/leprosy officers who had the knowledge of local conditions to take advantage of the flexibility that was part of the SAPEL concept. Major components in all project areas were deployment of health personnel at various levels, transport and other communication facilities, selection and training of field staff, IEC methods and materials, tools for case detection, extent of coverage, arrangements for confirmation of suspected cases, treatment and follow-up and, of course, cost estimates and budget planning for all these components.

MANAGEMENT TEAM

The management team in each project area consisted of the DLO/DDL, BMO and NMS, advised and supported by DANLEP coordinators at zonal or state level. The BMO as facilitator and the DLO as project manager were to conduct training of the field staff and supervise the work of the NMS and NMA. The BMO was responsible for the provision and utilisation of funds and material for the project. The DLO was expected to be involved in the project on a day-to-day basis, guiding the field staff and ensuring continuous appraisal of the project's progress. In project areas where non-government organisations (NGOs), such as a leprosy mission, were involved in SAPEL, they provided some of the management team members. In Gurur in Chhattisgarh, both the NMS and NMA were mission staff. In Badwaha in Indore zone of Madhya Pradesh, the mission managed and implemented the project completely.

The NMS and NMA formed a link between the field staff and the management team. The former was to plan and coordinate training activities, IEC and survey work, maintain the smooth flow of IEC material and drugs, organise skin camps, maintain daily accounts and deal with news media. The NMA was in charge of assigning the detection work to the survey teams, examining suspected cases for confirmation, registering new cases and initiating treatment, counselling patients and their families and ensuring continuous supply of drugs to patients.

FIELD STAFF SELECTION

Field staff for SAPEL were:

i. Health workers variously designated as MPWs, Health Inspectors (HIs), Auxiliary Nurse Midwives (ANMs), Village Health Nurses (VHNs) in the different states.

ii. Volunteers from the community could include:

- *Anganwadi* workers
- Teachers

- Panchayat members
- NGO members
- *Mahila mandal* members
- Educated youth
- Persons who had worked in other health projects.

Field health workers were necessary as they would subsequently be in charge of ensuring continuing medication for patients in their area.

Since community participation was seen as an essential part of SAPEL, volunteers from the local community were to be recruited and trained, to be used particularly in the detection survey and also, perhaps, in other activities like IEC and raising awareness.

Criteria for volunteer selection included local residency status, literacy (education up to 8th class level), and ability to devote time and energy to the project. It was also recognised that an equal number of male and female volunteers would enable them to work in pairs since, during the detection survey, a subject would be more amenable to questioning and physical examination by a person of his/her own sex.

Certain categories of government and quasi-government employees were seen as logical choices in almost all project areas. These included teachers, Village Administrative Officers (VAOs), elected panchayat members, *anganwadi* workers of the ICDS, and noon meal (midday meal) workers. Members of women's groups, traditional midwives and members of NGO groups were also among the volunteers selected in many areas. Educated youth who had not yet obtained employment and were interested in serving their community provided some volunteers.

Methods of volunteer selection varied. In some areas, the project management team worked through the local panchayat members who provided the names of likely volunteers who were then interviewed by the BMO and/or DLO. Where community participation was high, it often began with the panchayat calling a meeting of the people at which the project was explained to them and they were invited to participate. In other project areas, specific groups (*anganwadi* workers, teachers, the local NGO, *mahila mandal*) were identified as volunteer sources. In some cases,

the choice of volunteers was based entirely on the recommendation of the local health worker. This was the case in the Krushnaprasad project in Orissa, where the female MPW in each PHC/HSC identified possible volunteers. Her choice was based on her personal knowledge of people in her area. Many of those selected in this manner had previously volunteered for other health-related projects and campaigns. In many project areas there was little or no differentiation made between MPWs and other volunteers. In some, only MPWs were selected for the volunteers' work, so that the two terms were used interchangeably.

In one project area in Madhya Pradesh, when the DLO visited the villages with a list of possible volunteers, he found that none of them was willing to undertake the work. The rapport of the leprosy and general health staff with the people was so poor that no volunteers were forthcoming. However, when SAPEL was handed over to a leprosy mission long established in the area, they were able to recruit volunteers from the same villages and complete the project with their cooperation.

TRAINING

Training of selected health workers and volunteers was conducted by the BMO, DLO and the DANLEP state or zonal coordinator. Much of the organisation for training was carried out by the NMS. There were some projects where the NMS also undertook the actual training because the BMO and/or DLO had little interest in the project or had too heavy a workload.

Training was generally for two days, imparting facts about the causes and symptoms of leprosy and its treatment. The trainees were taught to conduct the detection survey, the questions to be asked, conduct of the physical examination and recording of suspected cases. They were trained to provide information to potential patients and families and talk to them in ways to win their trust and persuade them to be examined for leprosy symptoms. They also learnt to discuss beliefs and attitudes about leprosy and ways of helping to remove the stigma attached to it. In project areas where the body chart was used, they were trained in its use. The extent of training in IEC varied. (In some projects volunteers have taken part in IEC activity. There have also been several projects in which IEC activity was carried on not only

before, but also during and after the survey.)

In most project areas, training was conducted for one or, at the most, two batches of trainees and took place at the PHC in block headquarters. In some areas this was a problem as transport from remote villages was irregular and trainees needed two to three hours to travel to the PHC in the morning and could not stay late into the evening. This cut down the time available for training. The quality of training and the extent of understanding and retention among trainees varied. Understanding and retention was highest among MPWs and *anganwadi* workers. It was generally low among teachers, panchayat and *mahila mandal* members, apparently due to lack of interest and non-participation in other aspects of the project. Lanji in Balaghat district of Madhya Pradesh was the exception, with almost the entire community participating in the project and showing a high level of understanding and commitment.

SPREADING THE MESSAGE

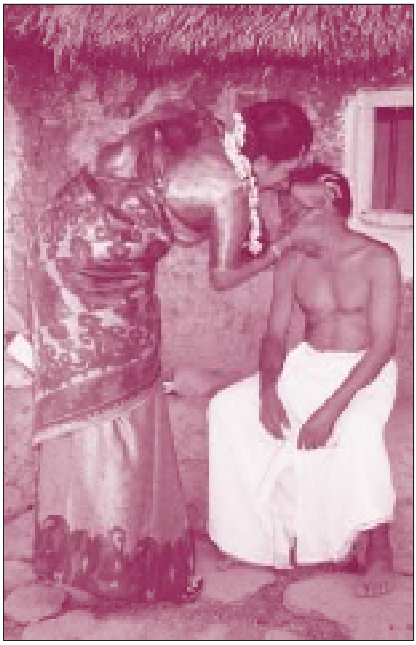
Leprosy elimination in general, and the SAPEL concept in particular, places heavy emphasis on community awareness and participation leading, hopefully, to benefits like voluntary detection and destigmatisation. IEC is, therefore, a significant component of the project. In many project areas, a well-publicised inaugural meeting and rally, with the district collector and other important persons participating, was the first step. The most intense IEC activity took place before the detection survey. These included putting up of posters, writing of wall slogans, verbal broadcasting of messages from vehicles using loudspeakers, large and small group meetings, rallies, street and folk theatre and music.

The pre-survey use of IEC was seen as a means of making people aware of the coming survey — to inform them that house-to-house visits would be made on certain dates for search and detection — so that they would expect it and cooperate with the survey team. In this, it was

largely successful everywhere. Subsequent IEC was mainly through personal contact, with health workers and volunteers talking to patients, their families and neighbours, individually or in small groups. In this, the emphasis was on promoting voluntary detection and making people aware that the disease was curable. The question of stigma was quite often underplayed or bypassed. Where POD camps were part of the follow-up activities, there was further IEC activity aimed at community awareness and participation.

Lanji in Madhya Pradesh was again the exception. Volunteers here took up a variety of IEC activities on a continuing basis and have sustained them even after completion of the project. They have used all possible methods: wall slogans and posters, rallies, group meetings, personal contact and folk music. The last has been very popular and effective because a group of volunteers have formed their own band of performers, composing the songs themselves.

DETECTION SURVEY : COVERAGE AND METHODS



The house-to-house survey to detect suspected cases of leprosy was conducted intensively over a limited period of time, usually five days. Volunteers were to work in pairs of one male and one female covering a specific population (ranging from 500 to 1000). In all project areas the survey had to be conducted early in the morning when most of the people would be available before they left for work. Some mop-up work was done later in the day or in the evening.

In almost all project areas, it was not found practical to conduct a physical examination of every person surveyed though in a few, like Lanji, volunteers tried to do so. In most, volunteers described the symptoms and asked if anyone in a family had them; they then examined those who came forward. They also examined those in whom they themselves noticed possible signs, as well

as family members of previously diagnosed and suspected patients.

The extra inputs provided for SAPEL were most evident during the survey period when more manpower was mobilised and more transport made available for the task. Motivation of the search teams was generally high and coverage, on the whole, was commensurate with the extra inputs and the enthusiasm generated by the project. In most areas, substantially more than 90% of the population was covered by the survey. Only those who had left home for several days, or went to work far too early for even the most persistent searcher, remained uncovered.

Where coverage was low the reasons given were:

- The time period for survey was too short, given the distances between hamlets in difficult terrain.
- The numbers to be covered by each volunteer was too high.
- The survey was initiated at the wrong time of the year when rivers and streams were in spate or when migratory workers had left for seasonal jobs in other places.
- Not enough volunteers were available either because some of the original trainees had dropped out or because training had not been conducted for all batches of trainees. In some areas of Madhya Pradesh, there was difficulty in getting enough female volunteers.

The scheduling of the detection survey was a major factor in its success or failure. Where the survey followed immediately upon training and IEC activity, it was comprehensive and highly effective — provided, of course, that the quality of training was good. Examples of this are the SAPELs in Lanji in Madhya Pradesh and Kolli Hills in Tamil Nadu. In both areas, the search teams faced difficulties of terrain and distances between hamlets. But in both, the searchers (volunteers in Lanji and MPWs in Kolli Hills) were fresh from training and highly motivated. They saw the job as an exciting challenge. In such circumstances, the short period over which the intense search was conducted was an advantage as enthusiasm was sustained and concentrated.

On the other hand, in Alirajpur of Jhabua district in Madhya Pradesh, there was a gap of several weeks between training and survey. When the survey was initiated, in October 1999, it

was found that large numbers of the population had migrated out of the area for seasonal work elsewhere. In the first round only nine of 24 selected villages were surveyed. The percentage of the population covered was very low and the body charts, forming the records of the survey, were found to be unsatisfactory. The survey in the villages covered had been inadequate because:

- Volunteers (mostly MPWs and *anganwadi* workers) misunderstood their instructions about how body charts should be marked.
- They also thought that children below the age of 15 need not be surveyed.
- Volunteers complained of poor support from the National Leprosy Eradication Programme (NLEP) and general health staff.
- They felt that it was too much to expect one volunteer to survey 1000 persons in five days.
- They were resentful that enough body charts had not been distributed when they were briefed and they had to travel to the PHC again, at their own expense, to collect them.

Because the survey results as they stood were unsatisfactory, volunteers were trained again and a re-survey of the initial nine villages was undertaken along with the survey of those not previously covered. But by December 1999, only 16 of the 24 villages had been covered.

Similarly, in project Sondhwa in Madhya Pradesh, inadequate training resulted in the survey being repeated after re-training of volunteers. Among the misconceptions that rendered the first survey unacceptable was the volunteers' belief that the body charts had to be used only for suspected cases. In this project area, a check by the DLO, following the survey, turned up 13 actual cases in a group of villages which had been recorded by volunteers as having zero suspected cases.

Also in Madhya Pradesh, in project Gulaimal in Khandwa district, there was early recognition of the difficulty in covering the whole project area at the same time. So the project, including training of volunteers, was carried out in two phases, the first covering six villages and the second, the remaining 11. This was

a practical solution to a problem recognised in time. But even here, the first phase was implemented in September, soon after the monsoon, and rivers and streams still in spate made the survey very difficult.

Other problems related to the detection survey that arose in some of the project areas were:

- Volunteers were not given a list of cases already under treatment or released from treatment (RFT) and this led to their being listed among the suspected cases.
- In many areas, the search yielded large numbers of suspected cases which proved to be not leprosy at all. Training appears to have been inadequate with reference to discriminating between signs of leprosy and of other skin ailments like leukoderma. In some areas, the DLOs felt that the high numbers yielded by the search were due to excess of zeal and a belief among the volunteers that they were proving themselves by producing more suspected cases.
- On the whole, fewer cases of children than expected have been registered in SAPEL. This raises a question about the extent to which children were examined.
- The volunteers were paid Rs.25/- each for each day of the survey. This was an honorarium meant to help with their expenses, not a salary. In some project areas volunteers were dissatisfied with the amount. In one area, there were complaints that payment was subject to their performance as judged by the NMA.

All those trained were not used in the detection survey. This was particularly true of the Tamil Nadu projects. In Kolli Hills, for example, 411 persons were trained of whom only 40 were health staff (NMS, MMA, VHN, HI, etc). The others consisted of ICDS (anganwadi) workers, noon meal organisers, teachers, VAOs, panchayat members, traditional midwives and *madhar sangham* members. For the survey, however, only the health staff were used and the others remained an untapped pool of trained volunteers. It has been pointed out that in all the Tamil Nadu SAPEL programmes, health staff tended to ignore local groups, adopting the attitude that only they had the expertise to detect leprosy cases. The *anganwadi* workers, whose knowledge and retention

level was high, said that they had not been called upon to participate in the programme after training.

THE BODY CHART: INNOVATION FOR BETTER DETECTION

SAPEL in Madhya Pradesh provides an example of the practical application of innovative thinking — the body chart. Designed by DANLEP, Madhya Pradesh, it shows the front and back outlines of the human form, divided into sections numbered from one to seven. Space is provided below for the name, address, age, etc, of the person examined. Instructions on filling the chart are also printed alongside. The volunteer has to tick those numbered sections of the body which have been physically examined and mark with small circles areas where signs of leprosy have been detected. All those who are marked as having any signs, are re-examined by the confirming authority who notes his/her findings and signs the chart. Like all innovations, the use and efficacy of the body chart has been variable. A majority of the volunteers who were given these charts found them useful in recording the findings of their search.

The chart was used in all project areas of Madhya Pradesh (except Chhattisgarh) with varying levels of thoroughness and efficacy. Lanji provides an example of an area where it was put to optimum use, thoroughly and accurately. The chart had been revised by the DLO, Balaghat, to incorporate further subdivisions in the human form and with more headings under which written information could be incorporated. The survey in the project area covered most of the population and the body chart was used in almost every case. The volunteers understood the use of the chart and marked it with care and honesty.

On the other hand, there were areas where volunteers apparently saw the body chart as a chore, to be got through as fast as possible, with scant regard for reflecting the true picture. There were, of course, many project areas which took the middle way: here volunteers used the body chart only for those persons who, after questioning, warranted a physical examination in their judgement.

An examination of a set of body charts used by one pair of volunteers (male and female) in a village in one of the MP project areas raises some pertinent questions. A total population of 818

in 282 households was surveyed over two time periods of five days each in April 1999. It was recorded that 615 persons were examined. There were 15 suspected cases, of which four were found to be old cases. Of the rest, five (all males) were subsequently confirmed. (It should be noted that confirmation was carried out only in January of the following year.)

525 body charts were made available to the documenter in December 2000. The others were missing and these included one confirmed case and two of the old cases. Of the 525 charts, 279 were of males and 246 of females. 76 of the males and 32 of the females were children of 15 and below. Of the 279 males, 70 were recorded as having been examined fully. None of the females was so recorded. For a majority of the others, both front and back of the groin area numbered 6, had not been examined; for a few males (14) only the front had not been examined.

Two points give rise to the suspicion that the marking was automatic and did not follow actual attempts at physical examination: firstly, number 6 was unmarked even for children as young as three and four years old; secondly, the chest area (number 3, front) was marked as examined for all, including females.

One other question raised by these body charts is their use in the confirmation procedure. While the charts for the four confirmed cases and two RFT cases that were available were so certified and signed by the NMS/NMA (though several months after the survey), others which were apparently suspected cases had patches marked on them but bore no remarks or initials of the confirming authority.

Body charts were not used in Chhattisgarh, or in the states of Orissa and Tamil Nadu. All concerned in the management of projects in Chhattisgarh had exercised the option not to use the charts as they questioned its usefulness. In all these areas volunteers were provided with illustrated booklets and other printed material indicating what to look for, and with forms in which to record signs of suspected cases. Both in Chhattisgarh and in Orissa it was felt that the charts took up too much time, were undependable because the extra work, largely unsupervised, would result in volunteers fudging the records.

CASE CONFIRMATION

Once volunteers had completed the detection survey and listed the suspected cases with their signs / symptoms, these cases were checked for confirmation by the NMS/NMA, sometimes by the DLO or MO. The logistics of the confirmation process varied. In most areas, the additional transport facilities made available for the survey period was used to complete the confirmation within the same period. In Bastanar, an NMS or NMA accompanied each of the 15 search teams and the confirmation procedure took place as soon as a suspected case was turned up. In Krushnaprasad, the NMS/NMA came after the search team, on the same day or the next, to carry out the confirmation procedure. In some project areas, the search team instructed suspected cases to be present either at the PHC/HSC or some other designated place on a specified day and they were examined there. There were a few areas where confirmation took place several weeks or even months after the survey.

TREATMENT AND FOLLOW-UP

In every SAPEL area, MDT was initiated immediately upon confirmation. The single skin lesion (SSL) cases were given their single dose at once. The pauci-bacillary (PB) and multi-bacillary (MB) cases were given the first dose on the spot and the month's blister pack to take home, having had the medication course explained to them. Administration of subsequent doses depended on the circumstances in each project area. In most, the MPWs had the responsibility of seeing that the course of medication was completed. Some were able to meet the patients every month, either at the PHC/HSC or at the patients' homes, supervise the first monthly dose and give the rest to the patients. Many found that monthly delivery was not possible during the monsoon and, for this period only, gave the patients three or four months' supply at one time. In some areas volunteers residing in the same village followed-up on the patients, checking that they had taken their medicine regularly. In others, MPWs and NMAs/ NMSs talked to the patients' family members about ensuring that the medicine was taken.

In all the project areas, patients have been noted as released from treatment six months after treatment was initiated for PB cases and twelve months after for MB cases. What was the process of confirming that each patient had actually consumed the full course of medication? In some areas the DLO/BMO or NMS/NMA said they made regular monthly visits to check on the patients. In others, MPWs said that, as general health workers, they were so constantly in touch with the people they served that they were able to follow up on the leprosy patients and could confidently confirm that the medicine had been taken. Some admitted that they had only the word of the patient, backed up by his/her family, that the medicine had been consumed. In one case, while a patient was assuring the MPW that he had taken the medicine, his little girl ran out of the house with a tin full of unused blister packs.

In a village in Khandwa district of MP an old woman told visitors, more than a year after the detection-confirmation-initiation of treatment process, that she had taken the medicine for three months and then stopped because she felt better. In Kolli Hills, a schoolboy had suffered a bad reaction to the drugs and his parents had stopped giving him the medicine. It was several months later that this was discovered and steps were taken to advise his family about visiting the PHC and renewing the course with other medicine to control the reaction. In the same project area, on the other hand, an old woman who had taken the full course, been checked and pronounced cured, insisted that she needed more medicine because her 'claw' fingers had not straightened out fully. She did not believe that the processes of care that she had been taught at a POD camp would work as well as more tablets.

In an exceptional project area like Lanji, the volunteers have the interest and persistence to help MPWs check that each patient has consumed the full course of medication. Besides which, the DLO, BMO, NMS, NMA and the DANLEP Zonal Coordinator (ZC) have kept in touch with the community, visiting regularly and checking on needs and problems.

Other follow-up activities have included skin and POD camps and counselling. The extent and effectiveness of such activity varies from project to project. A report on SAPEL in Tamil Nadu has commented that the enthusiasm shown in case detection has not been sustained for treatment and follow-up.

FAMILIARITY AND ACCEPTANCE EQUALS PERFORMANCE

Acceptance by the local community, whether of health staff, NGOs or volunteers, proved a crucial factor in the conduct of SAPEL. In Lanji, for example, something close to the ideal situation was achieved, with the DLO, BMO, DANLEP ZC and field health staff gaining as much acceptance in the community as their own volunteers drawn from local youth groups and other village institutions. Other programmes too demonstrate the importance of familiarity with and acceptance by the community.

In Bilaspur district, four SAPELs were conducted in areas which were isolated by fast flowing rivers and nullahs for seven months in the year. Most health staff were non-resident, lacking the familiarity that comes from living in their duty stations. The volunteers who were picked from among the residents of each village became crucial to the conduct of the project. After the survey, detection of cases and start of treatment, the volunteer in each village was assigned specific days in each month for checking on the patients and giving them the month's medication. Despite difficulties of terrain and weather, health officers like NMS, MO and DLO conducted periodic checks in the SAPEL area. The volunteer, being a local person, usually gained the patients' trust and so played a central role in suspecting leprosy and ensuring full treatment.

Badwaha block in Khargoan district is not so heavily forested. The more open bush is interspersed with chequered fields laid out among undulating, rounded hills, making the landscape look deceptively orderly and organised. But the hamlets are small, few and far between. The roads are poor (which is not unusual in Madhya Pradesh) and travel from hamlet to hamlet takes almost as long as it does in the forested hills elsewhere. For these reasons, the block was proposed and approved for SAPEL. However, when the district health officers visited the area, they discovered the extent to which they were out of touch with the local people. They could not get any volunteers to work on the project. SAPEL was therefore entrusted to the missionaries of the St Joseph's Leprosy Centre in Sanawad. Because they were known and accepted by the local population, they were able to recruit volunteers who covered 11 villages in the detection survey, produced six suspected cases, of whom one was confirmed. This also illustrates that the effectiveness of SAPEL is not to be judged only by the number of detected cases but as well by the fact that a population hitherto not surveyed for leprosy incidence has now been fully covered.