


STANDARD OPERATING PROCEDURE FOR KALA-AZAR AND POST KALA-AZAR DERMAL LEISHMANIASIS CASE SEARCH



Directorate of National Vector Borne Disease Control Programme

Government of India, Ministry of Health & Family Welfare
Directorate General of Health Services, 22-Sham Nath Marg, Delhi 110054



**STANDARD OPERATING PROCEDURE FOR
KALA-AZAR AND
POST KALA-AZAR DERMAL LEISHMANIASIS
CASE SEARCH**



Acknowledgement:

Directorate of the National Vector Borne Disease Control Programme (NVBDCP), Ministry of Health & Family Welfare, Government of India, acknowledge the continuous support of RMRI Patna (ICMR), NCDC, WHO, BMGF, CARE, PATH, DNDi, MSF and other stakeholders involved in kala-azar elimination programme in India.

Directorate of NVBDCP extends its sincere gratitude to State Programme Officers (NVBDCP), RMRI Patna (ICMR), NCDC, WHO, CARE, PATH, DNDi, MSF and other officers of NVBDCP who were actively involved in development of this technical document. We are sure this document would be proved user-friendly for programme implementers at all level.

Disclaimer:

This is a consensus document developed by the group of experts under the aegis of the National Vector Borne Disease Control Programme. The document is based on local disease epidemiology, risk factors and health systems contexts and at the same time due cognizance is taken of global best practices and evidences. All precautions have been taken to acknowledge contributions and references. However, contributors or Directorate of NVBDCP will not be responsible for any inadvertent omissions.



CONTENTS

Abbreviations	i
1. Background	1
2. Case definitions	2
2.1 Kala-azar	
2.2 Post-kala-azar dermal leishmaniasis (PKDL)	
3. Methods for case detection and implementation	3
3.1 Active case detection	
3.1.1 House-to-house search	4
3.1.2 Camp-based search	6
3.1.3 Index case-based approach	6
3.2 Passive case detection	7
4. IEC and social mobilization	8
5. Monitoring and supervision	9
Annexures	10
Annexure 1 Clinical presentations of kala-azar	11
Annexure 2: Microplan for active cases search campaign (Form 1A)	12
Annexure 3: Microplanning compilation at block level (Form 1B)	13
Annexure 4: Kala-azar house-to-house case search register (Form 1C)	14
Annexure 5: Kala-azar and PKDL referral slip (Form 1D)	15
Annexure 6 House marking process	16
Annexure 7: Block-level KA case search reporting format (Form 2A)	17
Annexure 8: District-level KA case search reporting format (Form 2B)	18
Annexure 9: State-level KA case search reporting format (Form 2C)	19
Annexure 10: Monitoring format for KA house-to-house case search (Form 3)	20



ABBREVIATIONS

ACD	active case detection
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
BCC	behaviour change communication
BHW	block health worker
CHC	community health centre
CMHO	Chief medical and health officer
CMO	Chief medical officer
CS	Civil surgeon
DVBDCO	District vector borne disease control programme officer
FLW	field-level worker
HSC	health subcentre
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
IPC	interpersonal communication
IRS	indoor residual spraying
KA	Kala-azar
KTS	Kala-azar Technical Supervisor
LAmB	Liposomal Amphotericin B
LD bodies	Leishmania donovan bodies
MI	Malaria Inspector
MTS	Malaria technical supervisor
MPW	Multipurpose Worker
PCR	polymerase chain reaction
PHC	primary health centre
PKDL	Post Kala-azar Dermal Leishmaniasis
RDT	rapid diagnostic test
SI	Surveillance Inspector
SoP	standard operating procedure
SPO	State programme officer
VBD	Vector-borne diseases
VHSND	village health, sanitation and nutrition day
VL	Visceral Leishmaniasis
WHO	World Health Organization

01



BACKGROUND

Visceral Leishmaniasis (VL) or Kala-azar (KA) is the severest form of Leishmaniasis. It is a chronic infectious disease, symptoms of which are nonspecific and it is mostly insidious in onset. The risk factors associated with kala-azar are poor socioeconomic conditions, malnutrition and high population migration. Post Kala-Azar Dermal Leishmaniasis (PKDL) is sequelae of Kala-azar. About 5-10% of kala-azar cases go on to develop PKDL after its cure, although some PKDL cases develop without prior history of kala-azar. All variants of PKDL cases are considered infectious to sand flies.

The mainstay of Kala-azar and PKDL surveillance has been passive case detection. Several factors related to patient and health care system affect early detection of cases. Few important factors are lack of awareness about the disease in general population, poor health seeking behaviour, access to health care services, limited human resources for health, poor kala-azar and PKDL knowledge among health care providers mainly among private sector and unqualified practitioners. The delay in diagnosis results in increased severity of disease, high morbidity and mortality and continued transmission of disease.

Currently about 80% of all kala-azar cases reported each year appear to have come from villages known historically to have reported any case.² During the period of 2013-2019, only 19% of the cases were reported from new villages.³ Certain features in the case detection trend directly reflect the intense ongoing transmission in the area, e.g. villages reporting cases persistently from the last seven years (2013–2019) and villages reporting more than three times cases in the current year (2019) compared to the average of last five years. These are an indication of intense ongoing transmission in these areas.

Above observations suffice that a focused approach of active case detection is needed to identify kala-azar/PKDL cases at the earliest. These would be in line with the kala-azar elimination strategy of “early diagnosis and complete treatment.” Primary objectives of active case search are:

1. To interrupt transmission by early case detection and in turn reduce morbidity and mortality; and
2. To find cases in the community which are missed being detected and reported.

This document outlines various methods of active detection of cases and standard operating procedures (SoP) as well as criteria and situations where each or the combined active detection methods will be implemented.

²Analysis from KAMIS line-list data.

³Operational definition of a new case is considered as ‘a new case of KA reported from a village which has never reported a case before 2013’. This criterion is not epidemiological due to absence of systematic line-list of village-wise cases before this period.

02



CASE DEFINITION

2.1 Kala-azar

- **Suspect kala-azar case:** A person living in or having travel history to a kala-azar endemic area/s showing and having fever of > 2 weeks.
- **Probable kala-azar case:** A person living in or having travel history to kala-azar endemic areas showing and having clinical signs and symptoms of kala-azar (mainly irregular fever lasting more than two weeks and splenomegaly and/or weight loss), after ruling out malaria in co-endemic areas.
- **Confirmed kala-azar case:** A confirmed case of kala-azar is when a person from an endemic area with fever of more than two weeks duration and with splenomegaly, is confirmed by a Rapid diagnostic test (RDT) or a biopsy or polymerase chain reaction (PCR). In cases with past history of kala-azar or with high suspicion and with negative RDT results, confirmation can be done by examination of bone marrow/spleen aspirate for *Leishmania donovani* (LD) bodies at an appropriate level equipped with such skills and facilities.

The detailed clinical features of kala-azar are given in **Annexure 1**.

2.2 Post Kala-azar Dermal Leishmaniasis (PKDL)

PKDL is characterized by a macular, maculopapular, or nodular rash in a patient who is cured of kala-azar and who is otherwise well. The lesion can start from six months to up to five years (Indian subcontinent) after treatment of kala-azar in most cases. However, some cases have been reported beyond five years after successful treatment of kala-azar and without history of kala-azar. The lesions usually start around the face from where it spreads to other parts of the body depending on the severity. The operational definitions to be used in the programme are as follows

Suspected PKDL: A patient from a Kala-azar endemic area with hypopigmented macules, papules, plaques or nodules with previous history of kala-azar.

Probable PKDL: A patient from a kala-azar endemic area presenting with a typically symmetrical multiple hypopigmented macules, papules, plaques or nodules with or without previous history of visceral leishmaniasis, with no loss of sensation and who is RDT positive.

Confirmed PKDL: A probable PKDL case confirmed parasitologically by skin-slit smear or biopsy or PCR.

03



METHODS FOR CASE DETECTION AND IMPLEMENTATION

Broadly, there are two approaches for case detection, namely passive and active.

3.1 Active case search (ACS)

In active case detection, health staff reaches out to the community and systematically screens the population to find cases of kala-azar/PKDL. Active case search is an essential component of visceral leishmaniasis elimination strategy in the Indian subcontinent. It helps reduce disease transmission by shortening the infectious period of patients and an early diagnosis and treatment tends to improve their outcome. Following methods of ACD may be used in different situations depending upon the epidemiological situation of the implementation unit.

- House-to-house
- Camp-based
- Index case-based

Table 1: Features of active case detection methods⁴

Sr No.	ACD Method	Settings	Frequency
I	House-to-house	<ul style="list-style-type: none">• All IRS villages	Four rounds per year including ACD during IRS
		<ul style="list-style-type: none">• Villages reported > three KA cases in the last reporting year• Villages reported cases persistently for three years• Villages observed the outbreak⁵	Six rounds per year including ACD by spray team during IRS
II	Camp approach	<ul style="list-style-type: none">• As a supplementary measure for house-to-house method for early examination of suspects• In hard-to-reach and difficult terrain	In line with house-to-house method 4–6 times per year
III	Index case-based	Following diagnosis of KA case in a community	Round the year

⁴Customized from 'Process of validation of elimination of kala-azar as a public health problem in South-East Asia, WHO/SEARO.'

⁵Refer to SoP for kala-azar outbreak investigation and management guidelines for criteria.

3.1.1 House-to-house search

House-to-house search is considered a gold standard approach. It is resource intensive and requires strong supervision and monitoring for better outcomes. House-to-house is recommended for intense transmission (high burden) areas and areas observing an outbreak as given in Table 1.

It is possible that there are many villages that share more than one out of three criteria. In such a case, a list of villages will be prepared by the respective district officers for planning house-to-house case search activity.

3.1.1.1 Preparations and standard operating procedures

a. National level

- Review action plan for KAE prepared by the states
- Issue of advisory, dissemination of SoP and guidelines to the states
- Finalize central monitoring plan (including partners).

b. State level

- Develop state action plan
- Issue advisory from state to district with SoP and proforma
- Sensitization of DVBDSCO, VBDC and other health personnel in KA meetings
- Explore possibilities for integrated search approach with other national campaigns
- Finalize state monitoring plan (including partners).

c. District level

- Develop district action plan
- Review of block action plans
- Issue directives by Civil surgeon/Chief medical health officer/Chief medical officer/DVBDCO
- Allocate budget to blocks or equivalent administrative level
- Explore possibilities for integrated search approach with other national campaigns
- Sensitize all Medical officer, kala-azar technical supervisor, Malaria technical supervisor (MTS), LTs, Malaria inspector (MI), BHW, KBC and others
- Ensure availability of various formats, referral slips, kits and drugs
- Disseminate guideline and proformas to community health centres Blocks/CHCs/PHCs
- Monitor activities i.e. identifying nodal person for daily/weekly reporting, field visits

d. CHC/PHC/Block level

- Prepare micro plan and undertake team formation
- Conduct batch-wise training of ANM, Multipurpose worker (MW), Accredited Social Health Activist (ASHA), volunteer, MPW supervisors etc
- Select and orient supervisors
- Distribute logistics to team members
- Organizing social campaign well in advance of search during routine immunization (RI) or Village health, nutrition and sanitation (VHNSD) activities

- Monitor activities by identifying nodal person for daily/weekly reporting, field visits
- Monitor the plan by block team and partners.

3.1.1.2 Selection of the team and supervisors

The decision of identifying search teams and supervisors may be done by State/District/Block, which will inevitably depend on the available manpower. The ASHA and MPW will be entrusted with the responsibility of undertaking house-to-house case search activities. While other block level staff i.e. ASHA facilitator/ANM/MPW/BHW/KBC/KTS/MTS/ MI/SI may work as supervisors. In case ASHA has more than one area, the Block medical officer will identify any other health worker for case search in that area. Each team will be given a team number from the block PHC/CHC. Additionally, one supervisor will be deputed to supervise and coordinate the activity of five search teams i.e. 5 ASHA areas.

3.1.1.3 Microplanning and implementation

A realistic micro plan can be made with the help of field workers such as ASHAs, MPWs etc. at the block-level. Any existing micro plan of other programmes i.e. Polio or family register of Maternal and child health (MCH)/Reproductive and child health (RCH) programme may also be used after updating. The purpose of these micro plans is to ensure complete coverage of areas within the identified period. Each of the concerned block PHC/CHC will finalize the micro plan in Form- 1A & 1B (Annexures 2 & 3) by MTS/ KTS/ SI/SW/ANM and ASHA in consultation with the Medical Officer In-charge (MoIC).

For better monitoring, it is important to mention day-wise number of houses to be covered by the search team in the micro plan. To ensure quality, number of houses to be covered in a day shall not exceed 50. Every measure shall be taken to ensure 100% coverage of targeted houses and if required, the duration of active case search activity may be extended.

- While conducting house-to-house search, it is critical that all persons present in the house, including guests are enquired about fever and skin lesions.
- The team will enter details in house-to-house format-Form 1C (**Annexure-4**) after interviewing and meeting all the family members. Following suspicion of kala-azar or PKDL in any person, complete details will be filled by the team in the format and referral slip-Form 1D (Annexure-5). The filled-in referral slip will be given to the suspect for visiting the nearest health facility for further diagnosis and confirmation.
- House marking shall be done as per **Annexure-6**.
- The team will also make sure that the identified suspect goes to the health facility for diagnosis and confirmation. If a suspect does not visit the nearest health facility within 3 days of the referral, the supervisors officer will make provisions for mobilization of such suspect. Concerned supervisors also have an important role to play in assisting the referral of suspects to the respective health centre.
- Cases with less than two weeks of fever will be examined to rule out other causes of disease. The health worker will keep high suspicion of kala-azar for these cases if the fever persist for two weeks.
- After examination, in case the Medical officer suspects the person as a case of kala-azar or PKDL, further management would be done as per protocol. The supervisor will track the result of the diagnosis and finally mention the result as positive (+) or negative (-) in the result column of the suspect KA/PKDL line-list. The consolidated line-list of the suspected kala-azar/PKDL is useful in ensuring that all the suspects who are identified are duly followed-up.

3.1.2 Camp based search

The criteria and frequency of camp-based search is given in Table 1. If camps are organized as a supplementary measure to house-to-house, then it shall be conducted within 1-3 days of the house-to-house search and the team will focus mainly on logistics and social mobilization.

However, in difficult terrain, the camp should be organized during the peak detection period and with extensive planning. For successful organization of the camp in difficult terrain, the following activities must be done.

Pre-camp activities

- Prepare a micro-action plan at least 2-4 weeks before initiation of the camps;
- Plan for number of camps to be organized, name of villages, locations within the village (school, panchayat building etc), duration of camp etc;
- Prepare logistics plan with estimate for fund requirements, requirement of RDT test kits, lancets, gloves, IEC material, etc;
- Inform all the block health staff about the places of camps during monthly meeting at the PHC;
- Constitute a team for the camp which includes Medical officer, lab technician, nurse, MPW, ASHA etc and identify village volunteers and contact them about their roles;
- Arrange mobility for the team and orient the team members about roles and responsibilities of each team members two weeks in advance;
- Encourage the PHC staff and/or ASHA to inform the village head or other village stakeholders about the camp 1-2 weeks in advance; and
- Organize social mobilization activities, at least one day before the camp.

Camp-day activities

- ASHA mobilizes fever patients and other suspect cases of kala-azar and PKDL;
- All fever patients are noted down in the registration register (patients age, sex, etc);
- Medical officer takes past h/o kala-azar, examines for splenomegaly, looks for PKDL like skin lesions, performs RDTs and gives referral slip to all positive patients so they can visit the nearest treatment health facility;
- Take down the details of KA and PKDL patients in the register; and
- Manage all other fever and types of patients as advised by the Medical officer of the camp.

Post-camp activities

- Inform treatment health facilities about number of patients (KA and PKDL) detected and adequate arrangements for their treatment;
- Evaluate yield of the camp and various aspects of how camp activities may be improved;
- Inform ASHA about detected cases for standard period of follow-up; and
- Report camp activities in a prescribed format.

3.1.3 Index case-based approach

Whenever, a new Kala-azar/index case is identified, case search activity shall be done in the entire village

Preparatory activities

- Enlist villages where index case-based approach is to be implemented;
- Team member is identified who will be doing the house-to-house search around index case(s);
- Team is well oriented about the work to be done in the community;
- Suspect registers and referral slips are made available.

Implementation

- Identify details of index case(s) (e.g. name, age, sex etc) in the village and location of their house(s);
- Enlisted all suspects in the suspect register and provide referral slips;
- ASHA workers or volunteers are requested to ensure that suspects reach health facilities for diagnosis and confirmation;
- Make sure this approach continues in all the areas in addition to the house-to-house search campaigns and camps, keeping in mind the need to reduce the duration between onset of symptoms and treatment.

Post index case-based search activities

- Ascertain diagnosis and confirmation of all suspect ;
- Record and report yield of index case-based activities;
- Establish contact with local informers e.g. medical practitioners in the informal sector and teachers, anganwadi or influencer in the community who can provide information about sick people.

3.2 Passive case detection (PCD)

Passive-case detection relates to detection of Kala-azar cases among patients who, on their own initiative, visit health services for diagnosis and treatment of their illness. Cases picked up by the routine and general health system are therefore a direct representation of the efficiency of the health system

04



IEC AND SOCIAL MOBILIZATION

It is essential that adequate awareness and social mobilization measures are undertaken prior to the search activity. This will help the community to be fully informed about the activity and for the search teams to receive full support and cooperation for maximum impact.

Intersectoral coordination with Panchayati Raj Institutions, Education department, Information and Broadcasting department, Integrated Child Development Services (ICDS), key religious institutions and others will help expand the reach and impact of the programme. Depending on the scale of the activity, Information, education and communication (IEC) may be planned at different levels i.e. state, districts and/or blocks. The tool for IEC used shall be in a local language and customized as per need and the state/district IEC plan.

05



MONITORING AND SUPERVISION

Monitoring and supervision are core components of any programme or activity. They help improve the quality of service delivery and better implementation of the programme. Along with the supervisor assigned for the team, monitoring & supervision shall also be done by Block Medical Officer, District & State Level Officials.

Stakeholders play vital role in supervision and monitoring by providing feedback and correction of gaps on real-time basis. The format for monitoring the house-to-house activity is provided in Annexures 7-10. Activities shall be reviewed on a weekly basis at the block level. The district and state level review shall be done within two weeks of completion.

Outcome indicators to be assessed at the end of the activity are as follows

1. Population targeted (population of area for which ACD activity done)
2. Population screened (population of area covered under ACD)
3. Number of kala-azar suspects identified
4. Number of PKDL suspects identified
5. Percentage of kala-azar suspects examined at the health facility
6. Percentage of PKDL suspects examined at the health facility
7. Number of RDTs performed for diagnosis of kala-azar
8. Number of positive RDTs for confirmation of kala-azar
9. Number of RDTs done for diagnosis of probable PKDL
10. Number of positive RDTs for probable PKDL
11. Number of confirmed kala-azar case
12. Number of confirmed PKDL case.



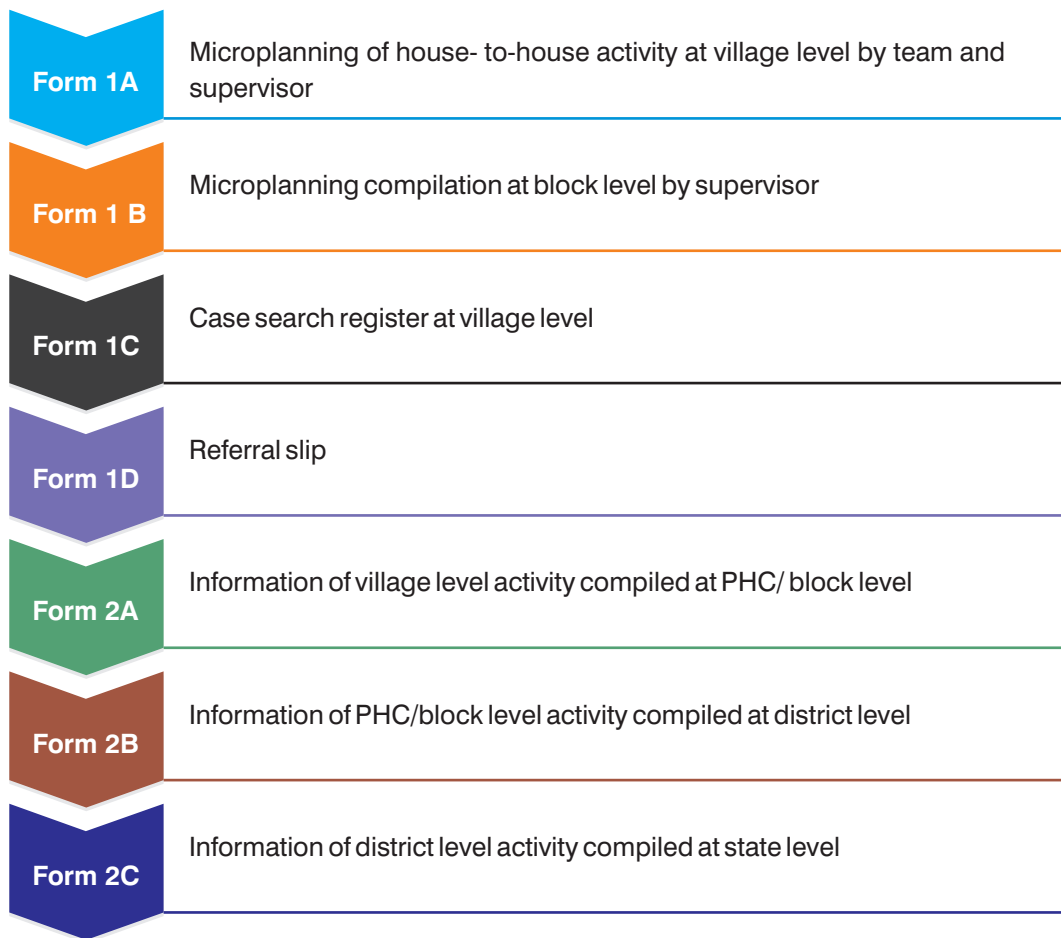
ANNEXURES

ANNEXURE-1 CLINICAL PRESENTATIONS OF KALA-AZAR

Clinical presentation of kala-azar lacks specificity. Below are some of the common presentations (symptoms) which can help peripheral health workers and health personnel at all levels in early detection of cases:

Clinical presentations	Examination findings	Laboratory findings
<ul style="list-style-type: none"> Fever of prolonged duration (2 weeks or more) Distension of abdomen Weight loss Loss of appetite Anaemia Dark colouration of skin-face, feet, abdomen Cough Diarrhoea Nose bleed <p>Other presentations</p> <ul style="list-style-type: none"> Oedema Jaundice Vomitting Lymphadenopathy 	<ul style="list-style-type: none"> Fever- most common manifestation, characteristic of fever is its irregularity. There are irregular bouts of fever, the pattern of which is intermittent. The duration of the bouts is variable but is usually 2 to 4 weeks. Splenomegaly- the most specific sign, non-tender with smooth surface. Regression after cure is a rule and is gradual. Moderate to severe pallor Tachycardia Signs of heart failure in severe anaemia cases Emaciation in the form of wasting with low body mass index (BMI) Hepatomegaly- less common Lymphadenopathy Icterus- usually in severe cases Signs of secondary infections like respiratory and gastrointestinal 	<ul style="list-style-type: none"> Low haemoglobin Low white blood cell count Low platelet count Hypoalbuminaemia Hypergammaglobulinaemia Elevated transaminases Elevated bilirubin Elevated creatinine

FIGURE 1: RECORDING AND REPORTING FLOW DIAGRAM FOR HOUSE-TO-HOUSE SEARCH ACTIVITY



ANNEXURE2: MICROPLAN FOR ACTIVE CASES SEARCH CAMPAIGN FOR KALA-AZAR (FORM 1A)

कालाजार खोज अभियान हेतु मइक्रोप्लान						
जिला:	प्रखंड / शहरी क्षेत्र:	गाँव / मोहल्ला:				
घर घर खोज हेतु आवंटित कुल घरों की संख्या : पर्यवेक्षक का नाम: दल संख्या: दलकर्मियों के नाम: 1..... 2..... फोन नंबर: 1..... 2..... जांच / डायग्नोसिस केंद्र: उपचार केंद्र:						
कार्यदिवस	दिन - 1	दिन - 2	दिन - 3	दिन - 4	दिन - 5	दिन - 6
क्षेत्र का नाम एवं विवरण						
प्रथम घर के मुखिया का नाम और प्रथम घर का पहचान चिह्न						
अंतिम घर के मुखिया का नाम और अंतिम घर का पहचान चिह्न						
क्षेत्र में कुल घरों की संख्या						
क्षेत्र के प्रधान / जनप्रतिनिधि का नाम एवं फोन नंबर						
दलकर्मियों के हस्ताक्षर: 1..... 2..... पर्यवेक्षक का हस्ताक्षर:						
चिकित्सा पदाधिकारी का हस्ताक्षर: विशेष कार्ययोजना- पृष्ठ के पीछे लिखें						

ANNEXURE 4: KALA-AZAR HOUSE TO HOUSE CASE SEARCH REGISTER (FORM 1C)

कालाजार घर घर खोज रजिस्टर

जिला: गांव एवं वार्ड का नाम: खोज की तिथि:

टीम के सदस्य का नाम: पर्यवेक्षक का नाम: दल संख्या:

क्रम संख्या	घर संख्या	परिवार के मुखिया का नाम	परिवार के सदस्यों की संख्या	जांच किये गए सदस्यों की संख्या	दो सप्ताह या उससे ज्यादा दिनों से बुखार से पीड़ित सदस्यों की संख्या (kala & azar suspect)	जिन सदस्यों के चमड़े में दाग हैं उनकी संख्या (PKDL suspect)	संदिग्ध कालाजार या भी के डी एल मरीज का नाम	व्यक्ति को जांच के लिए कहीं भेजा गया है ?	जांच का परिणाम (+ve/&ve)	अभ्युक्ति
1										
2										
3										
4										
5										
6										
7										
Total										

दलकर्मियों के हस्ताक्षर: 1 _____ 2 _____ पर्यवेक्षक का हस्ताक्षर _____

ANNEXURE 5: KALA-AZAR AND PKDL REFERRAL SLIP (FORM 1D)

कालाजाश्पी0के0डी0एल0 रेफरल प्रपत्र (इसे भर कर रेफर किये गए व्यक्ति को दें)

जिला का नाम : _____ प्रखण्ड का नाम _____
गांव / मोहल्ला / क्षेत्र का नाम: _____ उपकेंद्र का नाम _____

व्यक्ति (जिनमें लक्षण हैं) का नाम: _____ मोबाइल _____

नं0: _____ उम्र : _____ लिंग : महिला / पुरुष

पता (घर के पहचान चिह्न सहित) _____
मोबाइल नं0: _____

क्षेत्र की आशा कार्यकर्ता अथवा सहिया का नाम : _____ मोबाइल नं0: _____

व्यक्ति में मौजूद लक्षण

कालाजार	पी0के0डी0एल0 (चमड़ी का कालाजार)
<ul style="list-style-type: none">• दो सप्ताह से अधिक बुखार• भूख नहीं लगती है• पिछले कई दिनों में बहुत अधिक वजन घटा है	<ul style="list-style-type: none">• पूर्व में कालाजार हुआ है• शरीर में हल्के रंग के दाग हैं जो सुन्न नहीं हैं• शरीर पर छोटी गांठें हैं

स्वास्थ्य केंद्र का नाम जहां रेफर किया गया : _____

आशा कार्यकर्ता अथवा सहिया का हस्ताक्षर : _____ दिनांक : _____

ANNEXURE-6 HOUSE MARKING PROCESS (FORM 1E)

House marking is to be done by search team, using chalk or geru. A sample wall marking is illustrated as below:



Fig A.



Fig B.

- i) T-32 stands for Team number 32 of the block
- ii) K-24 stands for house number 24 under KA search, visited by the team
- iii) Denominator 4 indicates that total four members reside in the house
- iv) Numerator 4 indicates that all four members of the house who were present at home were screened for fever and examined (for PKDL) by the search team
- v) The date 01/06/2019 means that the team visited this house on 01 June 2019
- vi) An arrow (→) denotes the direction of team moving in the area
- vii) T-32 stands for Team number 32 of the block
- viii) K-25 stands for house number 25 under KA search, visited by the team
- ix) Denominator 6 indicates that 6 members reside in the house
- x) Numerator 4 indicates that four members of the house were present at home and were examined by the search team
- xi) An arrow (→) denotes the direction of the team moving in the area
- xii) Date of visit is to be written under the arrow
- X) 25 denotes that in-house number 25 all or some members were not enquired by the team due to various reasons (out of house). Team can have another attempt to revisit these houses to complete the interview with all house members.

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

- All X houses marked by the ACD team should be planned for revisit on another date/time. All attempts should be made by the ACD team and supervisors to cover all X-marked houses or any house/area left out during the ACD activity period.

ANNEXURE 8: DISTRICT LEVEL KA CASE SEARCH REPORTING FORMAT (Form 2B)

Reporting of Kala-azar case search activity															
Date: From _____ to _____												District: _____			
To be filled by VBDC/MTS/KTS/DPM at district level in coordination with block supervisor															
Sl. No.	Name of the Block	No. of Team	No. of village covered	No. of houses planned	No. of houses covered	Population targeted	Population covered	No. of suspected kala-azar patients referred	No. of suspected kala-azar tested with rk39	No. of patients confirmed as kala-azar	No. of kala-azar patients treated	No. of suspected PKDL patients referred	No. of PKDL patients brought for examination at any health facility	No. of probable PKDL after examination	No. of PKDL Patients started on treatment
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
Total															

Signature of DVBD: _____ Signature of Civil Surgeon/CMHO _____

ANNEXURE 9: STATE LEVEL KA CASE SEARCH REPORTING FORMAT (FORM 2C)

Reporting of Kala-azar case search activity															
State: _____															
Date: Fromto.....															
Sl. No.	Name of the District	No. of Team	No. of village covered	No. of houses planned	No. of houses covered	Population targeted	Population covered	No. of suspected kala-azar patients referred	No. of suspected kala-azar tested with rk39	No. of patients confirmed as kala-azar	No. of kala-azar patients treated	No. of suspected referred to health facility	No. of suspected brought for examination at health facility	No. of probable PKDL after examination	No. of PKDL Patients started on treatment
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
Total															

Signature of State Programme Officer: _____

ANNEXURE 10: MONITORING FORMAT FOR KA HOUSE TO HOUSE CASE SEARCH

Kala-azar house to house case search monitoring format			
Date: _____ State: _____ District: _____ PHC/CHC: _____ HSC: _____			
Village/ward: _____			
Name of team members (designation in bracket): _____ Mobile number: _____			
Name of monitor (Block letters only): _____ Monitor's Designation: _____ Mobile number: _____			
Note: Monitors should meet the team working in the area and observe their activities concurrently for at least 3-5 houses. Another 3 households supposed to have been covered by the team before the visit of the monitor should be checked for their awareness of the active case search activity.			
S.No.	Questions/ items	Response	Remarks
1	Is the micro plan available with the search team/ is the team aware of the area to be monitored?	Y / N	
2	Is the search team visiting the area as per plan?	Y / N	
3	Are all the search team members present as per plan?	Y / N	
4	Has any supervisor been assigned for the search team?	Y / N	
5	Houses targeted to be covered today as per the micro plan.		
6	Houses covered by the time of visit (cross check from the house to house search format)		
7	Has training been done for the search team before the search activity?	Y / N	
8	Has training being done for the supervisor before the search activity?	Y / N	
9	Is search team aware of whom to identify as kala-azar suspect?		
10	(any case with fever of 2 weeks or more) Is search team aware of whom to identify as PKDL suspect? (skin lesions with characteristic distribution)	Y / N Y / N	
11	Number of fever cases for more than two weeks identified by the time of visit		
12	Number of persons with suspected skin lesions (suspected PKDL) identified by the time of visit		
13	Is the search team aware of where to refer the suspects?	Y / N	
14	Where will the identified kala-azar suspects be referred for confirmation?	In village (camp)/ subcentre/ PHC / CHC/ district hospital/ medical college/ private or non-government health facility / any other (mention)_____	
15	Where will the identified PKDL suspects be referred for confirmation?	In village (camp)/ subcentre/ PHC / CHC/ district hospital/ medical college/ private or non-government health facility/ any other (mention)_____	
16	Is the search team aware of financial incentives for kala-azar and PKDL patients	Y / N	
17	Is the search team aware of incentive for ASHA for detecting and following up a kala-azar case?	Y / N	
18	Is the team using materials such as flash card/ pamphlets/ flipchart with pictures of kala-azar or PKDL patients?	Y/ N/ Not available	
19	Is there any IEC display or activity found in the village?	Y / N	
20	If yes, which IEC method is/was being used (multiple entry allowed): Hoarding/ Banner/ Poster/ Pamphlet distribution/ Miking/ Audio-visual show/ Community meeting/ Nukkad natak/ Rally, prabhat pheri or road show/ Door to door interpersonal communication done by ASHA or others prior to the active case search activity/ Any other method(mention)_____		
21	Are the village residents aware of the case search activity? (verify from an adult respondent each from 3 households which were supposed to have been covered by the search team before the visit of the monitor).	Yes (all 3 households aware) / Partially (1 or 2 households aware) / No	



Directorate of National Vector Borne Disease Control Programme

Government of India, Ministry of Health & Family Welfare
Directorate General of Health Services, 22-Sham Nath Marg, Delhi 110054