2011

Leprosy: A Continuing Challenge

LEPRA Society: Health in Action

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“Eliminated” . . . but still causing suffering

The Elimination Programme

Leprosy is one of the oldest diseases known to humankind, with references in the Indian and Egyptian scriptures as far back as the sixth century B.C. Until 1980 it was considered a perennial problem, but the introduction of multi-drug therapy (MDT) has resulted in enormous progress towards conquering the disease. In 1991, the World Health Assembly passed a resolution to ‘Eliminate leprosy as a Public Health Problem’, defined as reaching a prevalence of less than 1 per 10,000 population. Since then, the global prevalence has fallen from 5.2 million cases in 1985 to 805,000 in 1995, to 753,000 at the end of 1999, to 213,036 at the end of 2008.

In India, the leprosy programme was started as a control programme in 1954 with a single drug treatment regime using Dapsone. MDT was introduced in a phased manner across the country from 1983 as a centrally sponsored vertical programme entitled the National Leprosy Eradication Programme (NLEP). All districts in the country were covered by 1997. The country achieved the goal of leprosy elimination as a public health problem at the national level in December 2005, when 26 States or Union Territories had attained leprosy elimination. As of March 31st 2010 a total of 510 districts (80.57%) out of the total of 633 had reached a prevalence rate (PR) of less than 1 in 10,000. In 1981, when the disease was considered to be at its peak in India, the PR was 57 per 10,000 population. In March 2009 it had fallen to 0.72.

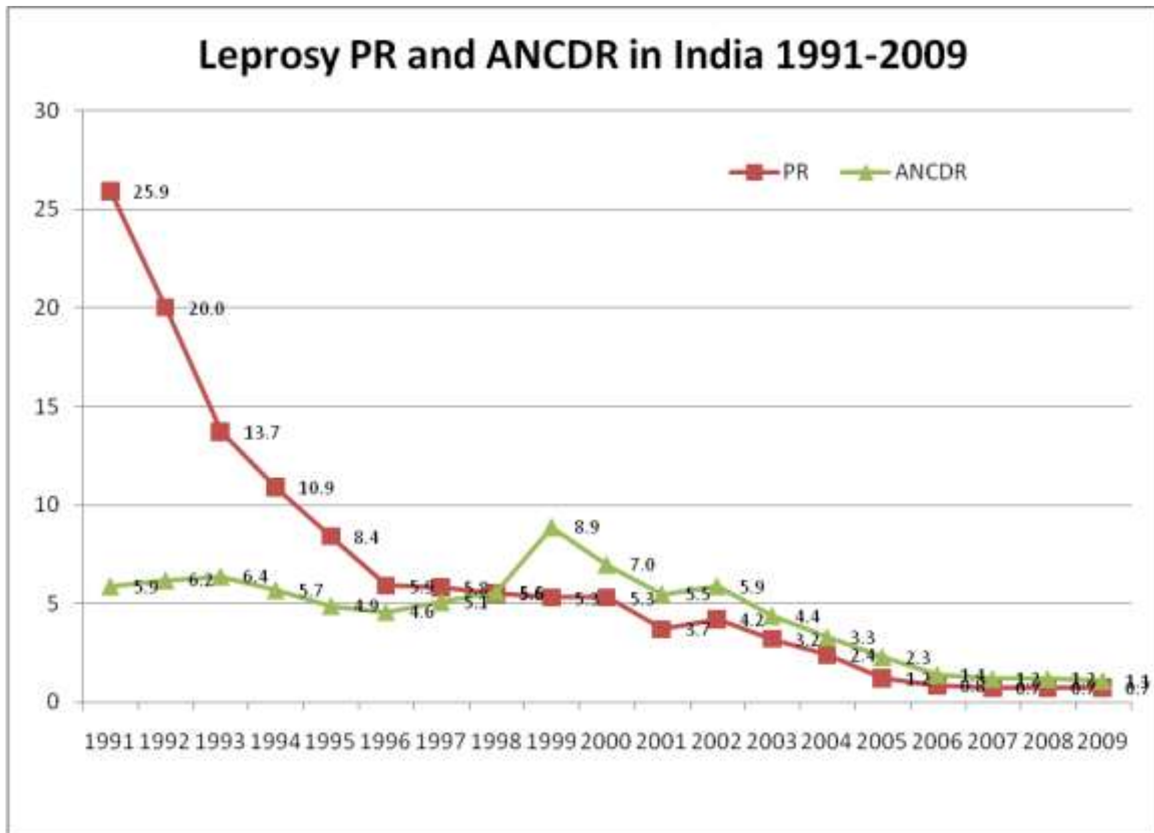
Many now argue that this successful “elimination” means that it is no longer necessary to devote resources to leprosy. The impressive statistics, however, conceal a much more complex picture, of continuing incidence of new cases and a continuing need to rehabilitate those affected.

Between Elimination and Eradication

In 2000, the World Health Organization (WHO) announced that leprosy had been eliminated globally. Conventionally, *control* of disease is defined as the reduction of the disease burden to a locally acceptable level. *Elimination* of disease is defined as the reduction to zero of the incidence in a defined geographical area, and *eradication* is defined as the permanent reduction to zero of the worldwide incidence of infection caused by a specific agent. In leprosy, however, WHO limited elimination to mean only control ("elimination as a public health problem"), by using prevalence instead of incidence of disease (that is, the rate of detection of new cases).

The annual new case detection rate (ANCDR: the total number of new cases detected in the course of each year) has not declined to anywhere near the same degree as the PR (measured as the number of patients registered for treatment on 31 March each year). See **figure 1** for a comparison between PR and ANCDR in India since 1991. Experts have suggested that the decline in prevalence is more the result of the shortened duration of MDT compared to previous forms of drug therapy. MDT is given for twelve months for multi-bacillary leprosy, and six months for pauci-bacillary leprosy, so that many patients complete their treatment within a year and do not appear on registers at all.[1]

Figure 1.



Only since 2002 has ANCDR started to decline in India, and this decline itself has been questioned. No other leprosy-affected country has seen such a sharp and

[1] Fine PE, Warndorff DK. Leprosy by the year 2000-what is being eliminated? Lepr Rev, 1997; 68:201-202

sudden decline in incidence, and regional studies have not corroborated the same scale of decline as has been claimed at the national level. Many involved in the programme view the decline as more due to change of strategy rather than real decline in transmission. Governments have taken a number of actions which reduce the number of new cases being reported, and it has been suggested that, in their eagerness to meet targets, health workers have under-reported ANCDRs. Moreover, between 2007-8 and 2009-10 ANCDR has actually increased in two of the four states where LEPRA operates, Bihar and Orissa (see **table 1**). This in spite of the fact that Orissa has achieved elimination.[2]

Table 1

State	2007-2008			2008-2009			2009-2010		
	New cases	PR	ANCDR	New cases	PR	ANCDR	New cases	PR	ANCDR
Bihar	19,041	1.04	19.33	20,086	1.07	19.8	21,431	1.08	20.71
Orissa	5,685	0.81	13.97	6,381	0.87	15.4	6,481	0.88	15.47

The fact that decline in ANCDR is not matching that of prevalence is a constant worry for scientists and field managers alike. This is reflected in post-elimination strategic plans which seek to meet the still-continuing problem, such as 'Final push', 'Extend strategies' and 'Incidence based surveillance'. In general, experts point out that the scale of leprosy infection is inherently hard to measure. The disease has a very long incubation period – often 3 to 5 years but sometimes as long as 30 years – so that many cases lie dormant within the population. There have even been questions raised about whether MDT is actually effective over the 6- and 12-month courses currently prescribed, with clinicians reporting cases of the disease recurring in patients after they have completed treatment. Moreover, even among those successfully treated, a substantial percentage suffer disabilities which can severely limit their ability to live their lives. In many ways, it is the total number of people disabled by leprosy which represents the true burden of the disease.[3]

Given these concerns, many argue that the focus on elimination – on pushing down the statistical prevalence of leprosy – has now served its purpose. Whether or not leprosy has been eliminated, it has certainly not been eradicated. Leprosy programmes need to address the continuing, although reduced, problem. Moreover, the focus should now not just be on case detection and treatment but on the rehabilitation of patients. This includes not only their medical rehabilitation, but also social, psychological and economic.[4]

While the campaign to eliminate leprosy has brought enormous advances, the WHO's questionable declaration that leprosy has been eliminated has done

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[2] Gupte M.D., Pannikar V., Manickam P. Leprosy case detection trends in India, Health Administrator, Vol. XVIII Number 2 28-36; National Leprosy Eradication Programme in India. Fourth Independent Evaluation.1991, Director General of Health Services. Ministry of Health and Family welfare, New Delhi 1994

[3] WHO. Enhanced Global Strategy for further reducing the disease burden due to leprosy - Plan Period: 2011-2015. Regional Office for South East Asia, New Delhi; Smith WC. We need to know what is happening to the incidence of leprosy. Lepre Rev1997; 68: 195-200

[4] Gupte, Pannikar, Manickam *Ibid*; Yamaguchi K. Demanding dignity they deserve: Seeing Salauddin in perspective, Health Action Vol. 22 No.2 19, 21

enormous harm, particularly to public perceptions of the disease. The public naturally does not appreciate the distinction between elimination and eradication, and the much-trumpeted announcement has led to widespread indifference toward a condition which still causes enormous suffering in many countries around the world.

The WHO's 'Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy (2011-2015)' tries to address these continuing challenges, and contains a number of points which LEPRA India considers to be important milestones towards better programme management. It has adopted disability rate as an important indicator, so that timely case detection and good quality service to patients become imperative. At the field level, re-introduction of contact surveys will have an important impact by reducing the number of delayed case detections. The strategy has also recognised the rights of leprosy patients, the need to ensure their participation in all aspects of the programme, and the importance of reducing stigma and discrimination through community-based rehabilitation. If understood and implemented properly, the new strategy could offer the desired revamp to the leprosy programme.

Responding to the Challenges Post-Elimination

LEPRA and Leprosy

LEPRA India can trace its genesis to the British Empire Leprosy Relief Association (BELRA, now LEPRA (UK)). BELRA started leprosy work in India as early as 1924, under the royal patronage of the Viceroy of India. It was to address both the medical and social needs of leprosy-affected persons. After independence the Indian Council of BELRA continued leprosy work as Hindu Kusht Nivaran Sangh (HKNS) in India. In 1989 LEPRA returned to India and formed LEPRA India, and was registered in Andhra Pradesh with its office in Secunderabad.

At the outset, LEPRA India focused specifically on supporting NLEP in Hyderabad. Leprosy control activities were carried out according to the Survey, Education and Treatment (SET) strategy, in which the prime objective was identifying all patients living in an area, using methods such as mass contact and school surveys, and treating them with MDT.

In the eight-year period from 1988 to 1996, LEPRA made remarkable growth in its leprosy activities, starting with the expansion of MDT reach services and introduction of prevention of disabilities (POD) services in projects. This was followed by the establishment of reconstructive surgery (RCS) services, along with the development of a model for community-supported socio-economic rehabilitation (SER). During this period, 175,000 persons affected by leprosy were treated with MDT, 300 persons with deformities underwent RCS and 500 persons with deformities benefited from SER. In addition, LEPRA India gained experience of working with government services and learned to develop successful partnership models with state governments.

LEPRA India is currently working in the states of Andhra Pradesh (AP), Orissa, Bihar, Madhya Pradesh (MP) and Jharkhand. It works in 65 districts in these five states, covering a population of 12 million people. The AP operations began in 1989 with the launching of the first direct project of LEPRA, in Hyderabad, and gradually moved to other districts of the state. The Orissa operations started in 1990, and are providing services in remote, inaccessible tribal areas. Operations in Bihar and MP have started more recently, in 2001 and 2008 respectively.

Integration, and Loss of Expertise

In India, the role of NGOs in tackling leprosy is particularly important because of a serious reduction in government capacity post-elimination. During the later stages of NLEP, in order to achieve greater synergy of resources and reduce the expenditure incurred in maintaining the vertical NLEP structure, India envisaged integrating it into the different tiers of the General Health System (GHS), with the process to be completed by 2004. It was intended that this would utilize the wider web of GHS for the supposedly sparsely populated leprosy cases. GHS staff, however, had never owned the NLEP programme, and did not share a common understanding with the erstwhile NLEP staff about how to take the leprosy programme forward. Moreover, while integration was appropriate for states such as Jammu & Kashmir and Himachal Pradesh, where cases were indeed sparse, it

was quite inappropriate to states such as Bihar and Orissa, where incidence remained high. This again reflected the problem that elimination at the national level did not mean elimination in all states.

The WHO strategy for 2011-15 envisages a chain of referral services at secondary and tertiary centres. In India, the GHS should refer all complications and difficult cases to expert referral centres, one of which is supposed to be present in every district. However, these are not yet fully operational. Specialized care is thus often available only in theory, and in any case many GHS staff do not have the expertise to diagnose leprosy reliably. The role of NGOs in providing clinical expertise and specialist services, and rebuilding government capacity, is therefore particularly important.

Providing Expert Services

To provide the clinical expertise lacking in GHS services, LEPRA India established 21 referral centres in AP, Orissa, MP and Bihar. These function in collaboration with District Nucleus Teams, District Hospital staff and International Federation of Anti-Leprosy Associations (ILEP) partners. Patients are referred from primary health centres (PHCs), and community and private health providers. Centres provide initial diagnosis, slit skin-smear testing, and diagnosis of difficult cases. Once patients are diagnosed, referral centres provide POD services, including treatment of ulcers, provision of micro-cellular rubber (MCR) footwear, self-care counseling for patients and family members, management of reactions and neuritis (using steroids and physiotherapy), and post-operative follow-ups. Also, importantly, referral centres work to build the capacity of health care staff, particularly in the GHS.

LEPRA also maintains Technical Resource Units (TRUs) to support NLEP in AP, MP and Orissa. In the latter state, it also operates a Strengthening Referral System (SRS) as a partnership project between ILEP member organisations and the Government of Orissa for a period of 5 years (2007-2012). This provides capacity building, support for disability prevention and medical rehabilitation (DPMR), operational research, monitoring & supervision, support to local NGOs, socio-economic rehabilitation (SER) and community participation. It provides DPMR clinics, RCS and physiotherapy. These are managed by 10 referral centres at NGO and government hospitals, including 5 LEPRA-supported centres. LEPRA Society, along with other ILEP agencies, has pioneered the designing and implementing of referral mechanisms in the states where it is coordinating. The leprosy programmes in the centre and states mostly pin their hopes on LEPRA Society for strengthening the referral system and promoting its replication on a wider scale.

Prevention of Disabilities

In many ways, the real burden of leprosy is a burden of disability, not disease. Though MDT cures leprosy, late or incomplete treatment leads to nerve damage. In Bihar, the disability rate among leprosy patients is as high as 8%. Thus, activities for POD, including promotion of self care by persons with disabilities,

remain important components of LEPRA's projects. Physiotherapy services are an area of particular limitation for the GHS. As described above, referral centres provide treatment of ulcers and management of reactions and neuritis.

POD camps are organized at PHCs to demonstrate self-care and complication management to patients and their family members. Self-care kits are also provided during the camps. In AP in 2009, 27 DPMR camps were organized, treatment and self-care counselling was provided to 7,276 cases, and family members were educated about self-care and given self-care kits.

Almost all projects include well-equipped shoe manufacturing units producing protective MCR footwear. By the end of 2009, 84,915 pairs of footwear, including 22,049 pairs for Grade I disability and 32,623 pairs for Grade II had been provided to 37,346 males and 17,326 females. The referral centre at Munger is the only one in Bihar providing MCR footwear and exclusive podiatric appliances.

Case Study: Reluctant Bridegroom

I was diagnosed with leprosy during my final year in college. I continued my studies and my medication and by the time I was ready to work I had been 'cured'. My job in the government school in Hyderabad was very demanding and I had to walk quite a distance and work for long hours. I developed ulcers on my feet and my husband started asking me to stay away as he said they smelled bad. I am not an unhygienic person but I could do nothing about the smell. Besides I was in so much pain. Then one day my husband asked me to go to my parent's house and not come back.

I had old anxious parents who did not want me at home and on the other hand a husband who didn't want me either. I actually comtemplated killing myself but the

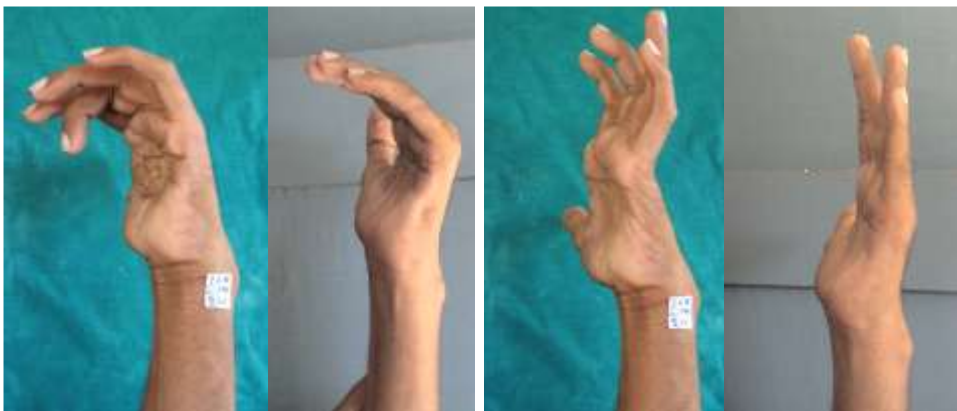
team at HYLEP[5] was very supportive and gave me a lot of emotional support. There I also learned self care for my wounds but best of all was the special footwear they provided me with that made walking bearable. No sandals or chappals I had ever worn had given me this relief.

Reconstructive Surgery

For many of those cases that develop deformities, the lost forms and functions can be restored only through RCS. The procedure is highly demanding in terms of cost, surgical skill, physio-care and cooperation needed from the patients. The service is almost non-existent in the GHS, with 71% of RCS operations in 2007 being conducted at specialized leprosy hospitals managed by NGOs. LEPRA India pioneered this service, and conducted or facilitated 4,869 RCS surgeries by the end of 2009.

As ILEP Coordinator for Orissa, LEPRA piloted RCS in medical colleges, government leprosy institutions and NGO hospitals. Support was extended in the form of surgical and physiotherapy expertise, physiotherapy equipment, surgical instruments and operating theatre consumables.

In 2009 the Madhya Pradesh team carried out 163 operations: 128 for hands, 23 for feet and 12 for eyes. An impact assessment study conducted by TRU MP showed 90% improvement in the functional capacities of persons who underwent surgery of the hand, and 80% for foot, thumb and eye. RCS is helping people to get back to work.



Rebuilding Capacity

LEPRA is also working to re-build capacity and expertise in leprosy in both governmental and non-governmental health services. A large element in this is the provision of training for healthcare workers. In AP in 2009, 153 medical officers, 1,842 PHC staff, 126 registered/rural medical practitioners, 120 medical

[5] LEPRA's project in Hyderabad.

students, 562 Aagan Wadi workers (AWWs), 496 self help group members, 1,144 acredited social health activists (ASHAs), 322 nursing students and 4 health management students received training. In MP, training was provided to medical students and trainee physiotherapists, and a question on leprosy was added to their final examinations.

LEPRA also works to build the capacity of facilities. St. Joseph's Leprosy Centre in MP, an NGO, has been supported by LEPRA financially and technically since 1993, while the TRU/SRS project in Orissa in 2008 included the up-gradation of operating theatres at two government institutions (Leprosy Home & Hospital, Cuttack and MKCG Medical College, Berhampur). LEPRA also coordinates and supports government. monitoring and supervision at field levels.

Social Rehabilitation: Working with Communities

Working with communities is one of LEPRA's particular strengths, and this is important as a part of combating leprosy. Education enables people to recognize the symptoms of leprosy, encouraging early case detection and referrals, and provide long-term care to those with disabilities. Mobilising families and communities may ultimately allow them to provide care for leprosy patients with only minimum support from the health institutions.

In 2009, 31,404 different information, education and communication (IEC) programmes were organized, reaching 17,973,996 people, of which 342,254 belonged to tribal communities and 12,721,381 were women. Through IEC programmes, 879 suspected leprosy cases were reported, of which 561 were confirmed.

Community work is one of the main agendas of LEPRA in Bihar. Village Health Forums of 10-12 members, including AWWs, auxiliary nurses and midwives and PRI members, have been formed in four districts of Bihar (Munger, Samastipur, Bhagalpur and Begusarai), particularly targeting hard-to-reach areas. This has enhanced early case detection and timely referrals, and could be a sustainable approach towards community empowerment for villagers.

A particularly important aspect of leprosy work is countering stigma. Still today, for example, many states have legislation barring those affected by leprosy from holding public office. A list of discriminatory laws against leprosy-affected persons is given in the **Annex**. In MP, LEPRA's TRU, in collaboration with IDEAIndia, has been working for social justice and empowering those living in leprosy colonies to

address their sufferings. Twenty houses were constructed by the local developmental authority, among the general community, for homeless leprosy-affected families. The leaders of the colonies were empowered to speak and fight for their rights. The Society of Leprosy Affected-Persons, AP (SLAP) was supported to raise issues with the state health department, including disability pensions, getting disability certificates, and welfare schemes like getting Antyodaya cards. Support was mobilised from NGOs, and a report submitted to 70 parliamentarians.

Case study: Pride and Prejudice

"I will come and stay with my people when the community leaders and others come to me and ask." - This was Lachu bai's hurtful lament when a LEPRA team met her, ostracised and alone, abandoned near the fringes of the woods away from her village, Belsarampur in Adilabad district. Afflicted with leprosy, she was incapacitated and, as no treatment was provided, her condition worsened, visibly. Her husband, Lakku, solemnly gave in to the village panchayat's decision to isolate her and lodge her outside the village. LEPRA took Lachu bai under their care and support and started her treatment. In parallel, they started advocacy programmes in the village about stigma and the implications of leprosy. The community responded by calling for a village meeting to reintegrate Lachu bai into their village community! On 1st April 2005 a party including LEPRA workers went to bring her back into the village. This was the final cure that every leprosy patient looks for— acceptance. Lachu bai was not only accepted back in the community but found a place as a village elder, to give advice and guide the people with her wisdom that stemmed from pain, age and a mixed sense of belonging and isolation.

The late Lachu bai (wearing dark glasses), with self-help group members and LEPRA staff.

Economic Rehabilitation

A poor person affected by leprosy is doubly disadvantaged and often stigmatised. Disability due to nerve damage further compounds the problem. LEPRA offers training and monetary support from its own funds to initiate some community based vocational activities. It also helps in getting bank loans and benefits from government welfare schemes. In 2009, under SER, approximately Rs.5,775,750 was mobilised to support 313 individuals, through government schemes, LEPRA's Revolving Fund, support from philanthropists, and old age, disability and widow pensions.

Case Study: Rehabilitating Gundala

When my second daughter was born they told me that the white patches on my body indicated 'leprosy.' They put me on treatment. My husband asked me for divorce, and told me that under the Hindu Marriage Act divorce was granted to partners of leprosy-affected persons. I was alone and desolate with two small children. I started working in a beedi making factory but soon my hands and feet started distorting and there was a foul smell from the ulcers that became a part of my everyday pain. At ADILEP[6] they taught me how to look after my ulcers and gave me special footwear to protect my feet. They also gave me 12,000 rupees to buy buffaloes, so that I had a constant source of livelihood. I have repaid the loan since I make good money from selling milk. The factory also agreed to employ my daughter after I told them about how leprosy was curable and my children are not infected. My older daughter too goes for work at the daily wages 'adda' and I hope I can get them married soon.

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[6] LEPRA's programme in Adilabad district. Now ARTH.

The Way Forward

Looking to the future, LEPRA's priorities are:

- **Prevention of disabilities**. This includes not just medical rehabilitation (especially physiotherapy and reconstructive surgery, which are particular areas of limitation for the GHS), but also the psychological and socio-economic rehabilitation of those affected by leprosy.
- **Referral services.** Taking a lead in creating the chain of referral centres envisaged by the WHO strategy 2011-2015.
- **Strengthening government health services.** This includes both capacity building, provision of lab testing facilities, supporting monitoring and supervision work.
- **Community mobilisation** to provide long-term care to sufferers, assisting in the prevention of disabilities and taking pressure off government health services.
- **Advocacy** to empower those affected by leprosy, reverse stigma, and work for the repeal of discriminatory laws.
- **Research** to expand knowledge of how leprosy is transmitted, and to develop improved treatment methods.
- **Sustainability of achievement**, in the face of a resurgence of leprosy in many parts of India, and concerns about relapse and drug resistance.

To achieve these, LEPRA will continue to work not only with the government health system but with other NGOs, community-based organisations, Panchayat Raj institutions and members of local communities.

Annex: Discriminatory Laws against Leprosy-Affected Persons

The **Dissolution of Muslim Marriage Act 1939**, Section 2 (vi), grants divorce if the spouse has been insane for a period of two years or is suffering from leprosy or a virulent venereal disease'.

The **Industrial Disputes Act 1947**, Section11, provides for termination of service of workmen on the grounds of continued ill-health. This needs to include safeguards protecting leprosy-affected persons.

The **Orissa Municipal Act 1950**, Section 16 (A) (5), disqualifies any person from being elected if they are of unsound mind or are a leprosy or tuberculosis patient. Section 17 (1) (b) states that a councillor shall cease to hold his office if he becomes of unsound mind or a leprosy or a tuberculosis patient. The **Orissa Gram Panchayat Act 1964**, Section 25 (1) (e), disqualifies any person from being elected or nominated as a sarpanch or any other member of the gram panchayat if they are a deaf-mute or suffering from tuberculosis or an infectious type of leprosy. The Supreme Court ruling in the case of Dhirendra Pandua vs State of Orissa & others (2008) has upheld judgments of an Election Tribunal and the Orissa High Court that leprosy patients cannot contest civic election or hold a municipal office in the State of Orissa. However, the Supreme Court has observed that the legislature may seriously consider whether it is still necessary to retain such provisions in the statutes.

The **Special Marriage Act 1954**, Section 27 (1)(g), states that divorce can be granted if a partner has been suffering from leprosy for at least three years, the disease not having been contracted from the petitioner.

The **Hindu Marriage Act 1955**, Section 13 (iv), gives grounds for divorce if a partner has been suffering for at least three years from avirulent and incurable form of leprosy. Section 10 (1) states that judicial separation can be granted if a partner has been suffering from a virulent form of leprosy for at least one year. A committee has been appointed for repealing these clauses.

The **Hindu Adoption and Maintenance Act 1956**, Section 18 (c), states that a Hindu wife is entitled to live separately from her husband without forfeiting her claim to maintenance if he is suffering from a virulent form of leprosy.

The **Life Insurance Corporation Act 1956**, Section 12, provides for charging of very high premium rates to leprosy-affected persons.

The **Rajasthan Municipality Act 1959**, Section 26 (9), and the **Rajasthan Panchayati Raj Act 1994**, Section 19 (F), declare leprosy patients ineligible to contest elections.

The **Indian Divorce Act 1869**, Section 10(1), states that a marriage can be dissolved on the grounds that a partner has been suffering from a virulent and incurable form of leprosy for at least the previous two years.

The **Indian Railways Act 1989**, Section 56, gives power to railway authorities to refuse to carry persons suffering from infectious or contagious diseases. This does not specifically exclude leprosy.

The **Rehabilitation Council of India Act 1992**, Section 2 (C), does not cover all the disabilities associated with leprosy under its definition of 'handicapped'.

The **Chattisgarh and Madhya Pradesh Panchayat Raj Act 1993**, Section 36 (1) (H), bars any leprosy patient who spreads infection from becoming a member of a panchayat.

The **Andhra Pradesh Panchayati Raj Act 1994**, Section 19 (2) (B), disqualifies leprosy-affected persons and deaf-mutes from becoming members of panchayats.

The **Persons with Disabilities Act (Equal Opportunities, Protection of Rights and Full Participation) 1995**, Section 2, includes 'leprosy cured' under the term 'disability', but not leprosy-affected persons who have not yet been cured. 'Disability' also refers only to medical disability, and does not recognise the social and economic hardship caused by stigma.

The **Juvenile Justice (Care and Protection of Children) Act 2000**, Section 48(2), classifies leprosy as a disease that is communicable and inherently risky. It provides for children affected by leprosy to be dealt with separately through specialised referral services.

Abbreviations

ANCDR	Annual New Case Detection Rate
AP	Andhra Pradesh
ASHA	Accredited Social Health Activists
AWW	Aagan Wadi Workers
BELRA	British Empire Leprosy Relief Association
DPMR	Disability Prevention and Medical Rehabilitation
GHS	General Health System
IEC	Information, Education and Communication
ILEP	International Federation of Anti-Leprosy Associations
MCR	Micro-Cellular Rubber
MDT	Multi-Drug Therapy
MP	Madhya Pradesh
NLEP	National Leprosy Eradication Programme
PHC	Primary Health Centre
POD	Prevention of Disabilities
PR	Prevalence Rate
RCS	Reconstructive Surgery
SER	Socio-Economic Rehabilitation
SET	Survey, Education and Treatment strategy
SRS	Strengthening Referral System
TRU	Technical Resource Unit