

ACTIVITY REPORT

2003



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Damien Foundation India Trust





PREFACE

This report, a compendium of the activities of Damien Foundation India Trust in the year 2003, is a veritable extension of 2002: activities initiated last year were further intensified and consolidated. The report contains aspirations and achievements. It portrays a picture of capacities and intentions. It points to rationale and reason for actions and inactions. An attempt has been made to look critically at issues of common concern through reams of data available and gleaned from the projects. The information, I think, certainly sheds fresh light on certain enigmatic, operational questions. If you also feel so, then it warrants a word of appreciation. Please write even if you don't. We are willing to improve.

This report has been made possible because of the untiring effort of my dedicated colleagues, unstinted support from the trust, unwavering confidence reposed in us by Damien Foundation Belgium and DGDC, Belgium. We are thankful for receiving support and we are extremely happy that we have been able to help a few help themselves and share happiness.

*P. Krishna Murthy
Secretary*

CONTENTS

		Page No
1.	Introduction	3
2.	Projects	3
3.	Personnel	4
4.	Strategy and outcome - Leprosy	4
4.1	Urban projects	4
4.2	Rural Projects	8
4.3	District Technical Support Team	9
4.3.1	Bihar	
	i. Introduction	9
	ii. District Technical Support Teams	10
	iii. Prevalence, NCDR and PD ratio	10
	iv. Duration of disease	10
	v. Status of integration	11
	vi. Modified Leprosy Elimination Campaign	12
	vii. Evaluation of NLEP	13
	viii. Health System Research (HSR) projects:	16
4.3.2	Jharkhand	16
	i. Prevalence, NCDR and PD ratio	16
	ii. Duration of disease	17
	iii. Status of integration	17
	iv. MLEC	17
4.3.3	DTST South	17
	i. DTST Andhra Pradesh	18
	ii. DTST Karnataka (Tumkur)	19
4.4	Chemoprophylaxis to household contacts of leprosy patients	19
4.5	Support to Construction of buildings for PHC:	20
5.	Prevention of Disability (POD)	20
5.1	Reactions	21
5.2	Disability profile	21
5.3	Introduction of prevention of disability in districts	22
5.4	Corrective surgery	23
5.4.1	Surgery in south projects	23
5.4.2	Reconstructive surgery in Bihar	23
5.4.3	Footwear	24
6.	Revised National Tuberculosis Control Programme (RNTCP)	24
6.1	Introduction	24
6.2	Strategy	24
6.3	Outcome	25
6.3.1	In sponsored projects	25
6.3.2	In supported projects	27
	i. RNTCP in Ananthapur	27
	ii. RNTCP in Nellore	28
	iii. RNTCP in Kadapa	29
	iv. RNTCP in Tumkur	29
	v. RNTCP in Bangalore urban	30
	vi. RNTCP in Bihar and Jharkhand	30
6.4	Evaluation of RNTCP in Vaishali	31
6.5	Quality Assurance of sputum microscopy	32
7.	Trainings	35
8.	Finance	36
9.	Annexures	37
10.	Glossary	

1. Introduction:

It has been more than four decades since Damien Foundation started its involvement in reaching the people affected by leprosy. Ever since the first patient was detected and treated in its project in Polambakkam in Tamil Nadu it has been an engaging journey, a fascinating evolution and an unfolding saga of natural adaptation to the changing needs and demands. The character of involvement of Damien Foundation has changed slowly but surely from a phase of direct involvement in isolation through a phase of togetherness, standing side by side with the government in reaching the community, to finally a phase of partnership with the Government, supporting the leprosy and Tuberculosis control programmes in specific areas of need. The emphasis is now in supporting the Government, in building the capacity of the Government functionaries at various levels, so as to enlarge the reach of the programme and make it self-sustainable.

2. Projects:

Damien Foundation is currently involved in supporting National Leprosy Eradication Programme (NLEP) and Revised National Tuberculosis Control Programme (RNTCP) in several states and union territories either directly or through Non Governmental Organisation projects. It has two projects, one in Delhi and the other in Nellore, both urban and directly operated, which are supporting leprosy and tuberculosis control programmes. The project in Delhi is run by Damien Foundation in partnership with LEPRO, a sister agency of International Federation of Antileprosy Association (ILEP). There are twelve NGO (Non Governmental Organisation) projects of leprosy alone or leprosy and tuberculosis supported by Damien Foundation in various states out of which two projects, one each in Bihar and Jharkhand, are part of District Technical Support Teams (DTST) and one project (Maitri) in Bihar confined itself to supporting IEC (Information Education and Communication) and POD (Prevention of Disability) activities in Gaya district. Support to three NGO projects (Amda, Bam India and Maitri) was withdrawn. In addition, Damien Foundation is supporting NLEP through District Technical Support Teams in 22 districts of Bihar and 6 districts of Jharkhand. Each District Technical Support Team is composed of a Senior Medical Officer and a Supervisor experienced in public health programme and is provided vehicles. They are placed in the district to assist the programme staff in planning, organising, supervising and monitoring NLEP and / or RNTCP. The principal task of the support team is to develop the capacity of the programme staff so that they will be able to implement the programme independently without any outside assistance. Support to National Leprosy Eradication Programme (NLEP) and Revised National Tuberculosis Control Programme (RNTCP) is given to three districts (Ananthpur, Kadapa and Nellore) in Andhra Pradesh and one (Tumkur) in Karnataka. Support to only RNTCP through District Technical Support Team is given to one district (Bangalore Urban) in Karnataka.

3. Personnel:

Damien Foundation is a Trust consisting of eight members under the chairmanship of Mr. Marcel De Doncker guiding the organisation through its Secretary, Dr. P. Krishna Murthy, in executing the policies. The organisation has 326 personnel comprising of 3 Chief Medical Advisors, 2 Medical Advisors, 3 Senior Medical Advisors, 13 Medical Officers, 21 District Leprosy/TB Advisors, 1 Field Investigator, 55 Supervisors, 38 Field workers, 8 Physiotechnicians, 15 Laboratory Technicians, 1 Central Laboratory Supervisor, 30 hospital staff and 136 administrative staff including 56 drivers. The projects in the north is co-ordinated by its office at Ranchi in Jharkhand headed by a Chief Medical Advisor (CMA) who also co-ordinates the functioning of the teams in Jharkhand. He is assisted by one other Chief Medical Advisor at Patna in Bihar who co-ordinates the functioning of District Technical Support Teams in the 22 districts of Bihar. The Chief Medical Advisors are assisted by three Senior Medical Advisors (SMA) who supervise the District Support Teams. The projects in the South are co-ordinated by a Chief Medical Advisor who is assisted by a Medical Advisor and a Prevention of Disability (POD) consultant. Administration and financial management is co-ordinated by a Chief Administrative Officer (CAO), Chief Finance Officer (CFO), Administrative officer (AO) and two Accounts Officers (AO).

4. Strategy and outcome - Leprosy:

4.1. Urban projects:

Five projects, either directly operated or supported, are involved in providing technical and operational support to NLEP in urban areas. These projects are located in Delhi, Dindigul, Nellore, Salem and Trivandrum. The strategy that they have adapted includes identifying service points, both private and public, training the personnel, identifying various stakeholders, sensitizing them so that they could participate in the programme in various activities like dissemination of proper information on the disease and the programme, suspecting and referring cases and providing follow-up treatment and ensuring accurate recording and reporting. Considerable success has been achieved in Delhi, Dindigul and Salem.

The project at Delhi is covering a population of 1881261 in South-West Delhi. Support is given to Government dispensaries in validating diagnosis, supervising updating of register and reporting, disseminating information to the community, encouraging general practitioners to participate in the programme by suspecting and referring and /or providing follow-up treatment. There are 36 Government dispensaries, 4 Primary Health Centres, 1 Government hospital and one NGO hospital in the area. The project has identified 26 general practitioners, trained them in recognizing leprosy and involved them in the programme. They suspect and refer cases to Government health facilities and also offer follow-up treatment to patients whenever required. A total of 16289 suspects were referred by General practitioners in 2003 out of whom 25 (6 MB) were confirmed as cases. The Government health facilities detected 540

new cases (283 MB) in 2003. Updating of register in the referral hospital is still a problem.

Case category	MB	PB	Total
Cases under treatment in November	399	348	747
Cases deleted during record verification			
Completed MDT	25	92	117
Defaulted	73	98	171
Total deleted	98	190	288
Cases remaining on record after deletion	301	158	459

About 38% of the cases on record were removed during record verification for reasons of completion of treatment or defaulting from treatment. Since majority of cases reporting to the hospital were from outside the area follow up of these cases would be difficult. Even if the cases were from Delhi no attempt was made by the hospital to contact the cases in case of irregularity in collection of drugs. Since major teaching hospitals did not subscribe to the guidelines, would it be better if they were permitted to treat leprosy cases? But statistics from these facilities were not taken into consideration.

Hidden cases of leprosy

One of the reasons for the persistent level of new case detection is ineffective coverage of the population resulting in a significant proportion of new cases remaining undetected by the health system. Effective coverage means reaching with MDT service to every individual in need without any constraints in terms of affordability, acceptability, resource availability, provider quality, adherence and physical access. These constraints render it difficult for the health system to detect all the cases that occur in the community and treat them promptly so that they are cured and have no residual impairment. For example, in Bihar, geographic coverage with MDT service began effectively with the first Leprosy Elimination Campaign (LEC) in 1998. There is one health facility on an average for every 100000 to 200000 population as against one for every 30000 population in some of the states in the South. There is one Female health worker for every 10000 to 15000 population as against one for every 5000 in the Southern States. For 50-60% of the population health facilities are not easily accessible because of difficult terrain, frequent flooding of the villages and bad roads. Till about two years back MDT service was available with vertical staff at a few drug delivery points known to only a few. It is no wonder that the system is not picking up all the cases. Leprosy programme has been integrated into general health. MDT service is available at almost all Primary health centres. Yet, experts believe the problem of hidden cases is far from over.

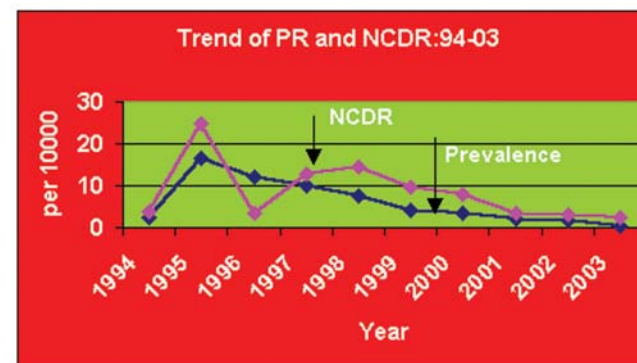
Evaluation of Modified Leprosy Elimination Campaign carried out in Bihar in March 2003 reported interesting information. Of the 1608 MB cases detected by the programme 1206 were examined and all except 153 were found to be MB cases. About 5258 suspects not screened by the programme were examined by the evaluators from whom 108 MB cases were detected. During the evaluation the evaluator teams also detected 188 MB cases. Therefore the total number of MB cases detected during evaluation was 296 or 18% of the MB cases detected by the programme. It is clear that about 20% of the MB cases are missed. However, these cases will sometime or the other be captured by the programme. Another study conducted in November 2003 indicated that 75% of the people were aware of the disease and the programme and 84% of them said that treatment was available at Government health facilities. The same study also found that in 45% of MB cases the duration of disease was more than one year and disability among the MB cases was 7.1%.

What do these results tell us? At any point in time a significant proportion of new cases that occur may remain undetected. These cases, however, do not remain hidden forever. They are eventually captured by the health system, after a delay. The delay is neither good for the patient because of the possibility of adverse consequence nor for the community because of the risk of prolonged transmission of infection. What should we, then, do about it? The programme managers should be made aware of this fact. On the one hand the programme is detecting cases a significant proportion of whom may not be cases and on the other it is missing cases of consequence. Some experts may argue that the information on hidden cases might be used to confirm elimination. This may be true but there are no simple, realistic, scientifically valid and useful methods to estimate the magnitude of the undetected cases. Also there should not be any attempt to resort to surveys to reach the hidden cases. Instead, activities directed at the community to sustain a high level of awareness should become a routine. The role of health workers in this activity is crucial. They can disseminate appropriate information during their routine family visits and also identify and refer suspects to health facilities. Quality delivery of MDT service at health facilities should be ensured. Good service is the best publicity. The aim should be to provide quality MDT service at all health facilities.

The project in Salem is supporting NLEP in Salem town with a population of 527635. There are 15 Government dispensaries and two hospitals one each of Government and NGO. A total of 80 new cases were detected in the area in 2003. The project has identified important



stakeholders and trained them. The stakeholders participate in educating the public in suspecting and referring cases. Involvement of general practitioners is not as much as expected. There has been a considerable reduction in the new case detection especially in the last three years. The reasons could be cessation of surveys including school surveys. There has been a reduction in the number of positive cases also. From 36 in 1999 it



has come down to 6 in 2003. This could be real or apparent. Only doubtful cases are sent to the project hospital for smear examination.

The project at Dindigul is supporting NLEP activities in Dindigul and neighbouring Palani, Karur and Kulithalai municipalities covering a total population of 428288. The NLEP in Dindigul is managed by the staff in the 5 Municipal health dispensaries. There are 29 Government field workers who are involved in IEC, suspecting and referring cases, providing follow-up treatment and defaulter retrieval.

In Nellore town with a population of 488341 there are 7 dispensaries and a hospital. These dispensaries and hospital are diagnosing leprosy and providing treatment. They keep antileprosy drugs. They do maintain a simple register but do not prepare any report. Involvement of general practitioners is almost negligible. There are consider-

able number of anganawadi workers (106) who are involved in spreading message about leprosy and suspecting and referring cases. The new case detection after an initial decline has remained almost constant (around 3) in the past three years whereas prevalence has come down to less than 1 per 10000 (0.41). High proportion of PB, child cases and disability indicates the possibility of overdiagnosis

In Trivandrum the project has trained all the staff in the dispensaries. Cases are diagnosed and managed by the dispensary staff. Only doubtful cases are referred to the project. The number of cases detected in the city was very small. There is no involvement of general practitioners, necessarily so because of low endemicity.

Total number of new cases detected in the areas covered by projects was 697 (319 MB). Cases detected in the area covered by Nellore, Kavali and Pavagada are included under DTST of respective districts.

ISOLATION OF LEPROSY-AFFECTED CHILDREN

- A NEW DEFINITION OF PROGRESS!



Isolation of persons affected by leprosy to prevent the spread of infection which was in vogue in the bygone era appears to be back! In one of the districts in Andhra Pradesh a new scheme called Sparsha has been launched with

much fanfare. The public health staffs are asked to search for cases in Government schools and isolate them for the period of treatment in a residential school opened specially for the purpose. The newspapers published the event with the caption "Leper school started". At the end of treatment the children are sent back to their original school. Parents who are unwilling to send their "affected" children are asked to give reason!

Let us look at the facts.

- A significant proportion of lesions among the school going population may be either innocuous with a high probability of self-resolution or may not be leprosy at all.
- Even if the lesions are of leprosy they are mostly Paucibacillary, which are generally not responsible for spread of infection. From the evidence that is available with us they are not infective.
- Isolating them will not have any consequence to the society but will have a traumatising effect on the children themselves.
- It will also increase social stigma which the programme is trying hard to mitigate.

- Even if the child has MB leprosy, isolation has no impact. By the time the disease is detected the person has already spread the infection and furthermore, within two months of treatment with MDT the person is rendered non-infective.

School survey which was in practice till recently has now been replaced with school awareness programme which serves several purposes including creating awareness among this important segment of the society.

4.2. Rural projects:

There are nine projects, all rural, supported by Damien Foundation. Three out of these are in Bihar and Jharkhand. The project CSWC at Amda in Singhbhum district of Jharkhand and Bam India at Gaya district of Bihar have become part of the District Technical Support Teams in the respective districts. In addition they also take care of patients with complications. The other NGO project at Gaya (Maitri) evolved a programme to support IEC and POD activities in the district. It has been decided to stop support to this project at the end of December 2003.

Out of the remaining six projects three are in Tamil Nadu and one each in Andhra Pradesh, Karnataka and Maharashtra. Damien Foundation provides support to only inpatient care in the project at Ambalamoola located in tribal area of Nilgiris district in Tamil Nadu. Arogya Agam in Aundipatty in Theni district of Tamil Nadu supports POD programme in the area in addition to assisting the Government in setting up the programme in nearby urban areas. It has also been decided to restrict DF support to only the hospital part of the project from January 2003. Holy Family Hansenorium at Fathimanagar in Trichy district is providing referral service for managing complications and reconstructive surgeries. The project also assists the Government in training all categories of staff in the adjacent districts. One of the achievements of the project is the capacity building of the staff of 10 PHCs in Pudukottai and Trichy districts in managing leprosy and simple complications including ulcer care. It has also introduced a good system of managing cases reporting to the centre. A simple case of leprosy is referred back without registration to the PHC to which the patient belongs after diagnosis and first dose. A patient with complication is managed till the acute phase is over and then transferred to the respective PHC for subsequent management. Patients coming to the centre for reconstructive surgery are operated upon only after ensuring that facility for proper post-operative follow-up is available.

The project at Fathimanagar is functioning as a tertiary referral centre for managing complications due to leprosy including disabilities. The project gets cases with complications referred by health facilities from Trichy and other neighbouring districts. Fifty cases with reactions (including 9 type II) were managed in the project in 2003. The project has trained Medical Officers and other staff from 10 PHCs in the district so that they are able to manage leprosy cases and also those with simple complications. The project has plans to extend support to building the capacity to equal number of centres next year.

The projects in Kavali (Andhra Pradesh), Pavagada (backward area in Tumkur) and Nagepalli (tribal area in Maharashtra) provide technical support to the Primary Health Centres in managing the programme. In none of the three projects involvement of the Primary health centres in NLEP is complete. The projects are encouraged to improve the capacity of the general health staff so that their participation in the programme can reach the expected level of satisfaction.

Total number of cases detected in the areas covered by the projects was 116 (56 MB). Cases detected in areas covered by Kavali and Pavagada are included under respective districts.

4.3 District Technical Support Team:

4.3.1. Bihar:

i. Introduction:

Bihar with a population of 88222796 (2003) and a prevalence of 5.19 per 10000 (October 2003) is one of the high endemic states in India contributing 22% to the nation's caseload. Even though NLEP under MDT was initiated in late 80s in the rest of the country it was introduced practically in 1998 in Bihar. Lack of infrastructure and resources, exceedingly poor communication and prevailing work culture led to the delay in introducing the programme.

ii. District Technical Support Teams:

District Technical Support Teams were thought of as an intermediary solution to augment the capacity of the personnel and hasten the process of integration. All the districts in Bihar have been provided District Support Teams by different ILEP (International Federation of Antileprosy Associations) agencies, each comprising of a Senior Medical Officer and/or a Senior Supervisor with extensive experience in implementing NLEP in other states. Damien Foundation India Trust is supporting 22 districts through District Technical Support Teams. Active involvement of the support teams, quality leadership at the state level and motivated participation of the staff in the districts has resulted in a sea change in leprosy situation in Bihar. Prevalence has fallen to a considerable level (from 52.7 to 5.19 per 10000), New case detection has also shown a corresponding decline, Treatment completion has improved and integration is in the right course. The teams have provided one-day orientation to the Medical Officers, disseminated the key messages about leprosy through the meetings with village leaders which was conducted in all the districts and assisted in establishing the baseline level of awareness among the community. The teams also provided valuable assistance in validating new cases and developing the capacity of the various cadres of staff through on-the job training. The teams evaluated the MLEC and also the programme with assistance from personnel from outside the state. Two Health System Research projects were implanted one each in Madhepura and Saran. Still problems remain: drug distribution system, supervision and monitoring by the programme officers at the district and PHC levels, which need considerable improvement.

iii. Prevalence, NCDR and PD ratio:

The overall Prevalence in 22 districts was 4.17 per 10000. There were two districts (Vaishali and East Champaran) with a prevalence of less than 3 per 10000. There were 4 districts with prevalence between 5 and 6. There was no district with prevalence 6 and above. The overall NCDR was 9.72 per 10000. There were 10 districts with NCDR of 10 and above. There was only one district with NCDR less than 6 per 10000. The PD ratio overall was 0.43. In 9 districts it was less than 0.42. Very high NCDR and low PD ratio indicates perhaps high rate of case detection, the new cases being mainly PB. A total of 53500 new cases (15521 MB) were detected in the 22 districts. The MB proportion was 29%, which is very low. This could be due to MLEC, which was conducted in the first quarter of the year.

iv. Duration of disease:

The teams collected information on duration of disease from cases screened during 3 months, from March of last year. A total of 6971 MB cases were interviewed. In about 56.3% of them, duration of disease was less than one year and in 43.8% it was one year and above. Similarly among 12685 PB cases interviewed 71.11% had the duration of disease for less than one year before detection and 28.89% had it for one year and more.

v. Status of integration:

There were 257 PHCs in the 22 districts. MDT services were available in all. But in 99.22% (255) PHCs service was available all the days. The treatment register was available in all the PHCs and it was up to date in 98.05% (252). The capacity of the General health staff to manage leprosy was found to be good. During their routine visits the District support teams assessed 14776 cases from January to December. About 5.3% (780) of them were found to be wrongly diagnosed as leprosy and 6.8% (999) were reregistered. There are 5334 subcentres in 22 districts and 5025 (94%) are involved in the programme. Treatment completion for MB was 89.39% and for PB it was 88.94%. There was only one district with less than 80% treatment completion for MB and two for PB. The overall Prevalence was 4.17 per 10000 and NCDR was 9.72 with a PD ratio of 0.43. Twelve out of the 22 districts (54.5%) had the problem of inadequate drug stock three times or more during the year.



Integration Status in General Health System - ANM.



Integration Status in General Health System - Medical Officer

**CAN MULTIPURPOSE HEALTH
WORKER DETECT LEPROMATOUS
LEPROSY**

Mrs. Rajodevi, 35 years of age and wife of Mr. Karisahani, of Khauna Panchayat in Basopatti PHC area in Madhubani district of Bihar, noticed tingling sensation in the Limbs. She did not take it seriously. But when she developed swelling of hands and feet including fingers and toes she decided to seek medical attention. She contacted Mrs. Lal Pari Devi, the Auxiliary nurse midwife from the nearby PHC, during one of her routine visits to the village.

The ANM listened to Rajodevi. She also observed that the skin on her face was red and shiny. She did not have any patches on the skin. She suspected leprosy and asked the patient to see the doctor at the PHC. When the patient promptly presented herself to the



doctor, he examined her and said that it was not leprosy. Even though she was reassured she was not comfortable. She contacted the ANM and told her about it. The ANM asked her to see the other doctor in the PHC. He also concluded that it was not leprosy.

When I visited the PHC on 25th of June 2003 the ANM brought the patient and asked me to see her and give my opinion. The patient had diffuse infiltration. There was no patch. Peripheral nerves were not thickened. She had oedema of the hands and feet including digits. Smear was taken and examined at nearby NGO hospital. It was 3+

vi. Modified Leprosy Elimination Campaign (MLEC):

Modified Leprosy Elimination Campaign (MLEC) was conducted in Bihar in February-March 2003. A total of 20773 cases (5153 MB) were detected in the 22 districts supported by DFIT. An evaluation of the MLEC was conducted in March-April 2003 in 32 blocks of 17 districts.

MLEC/Routine	MB	PB	Total
MLEC	5153 (25%)	15620	20773 (39%)
Routine	10368 (32%)	22359	32727(61%)
Total	15521(29%)	37979	53500 (100)

MLEC contributed 39% to the total new cases detected in 2003. MB proportion among MLEC cases was less than among routinely detected cases.

Total number of suspects identified during the campaign was 12595 of which 7295 (58%) including 738 MB had been screened by the programme. Total number of cases

detected from among the 7295 screened suspects was 2510 (34.4%). Of these cases 1791 (71.35%) including 506 MB were examined by evaluators. It was found that 5.9% (30) of the MB cases and 8.1% (104) of the PB were not cases. This means 7.5% (134) of the cases screened by evaluators were found to be wrongly diagnosed as leprosy. Wrong typing among MB was 1.79% (23) and among PB 5.93%(30). Similarly 10.83% (194) of the total screened cases were found to be old cases.

Among the 3997 of suspects reported as not cases 3022 (75.6%) were examined by the evaluators and 58 (1.92%) were found to be cases.

Of the 5300 suspects not screened by the programme 3279 (62%) were assessed by the evaluators and 327 (9.97%) were found to be cases.

During the evaluation process the teams came across some suspects not identified during MLEC and from among them 376 new cases were detected.

The campaign detected 738 MB and 1772 PB (total of 2510). New cases detected by the evaluators was 327 (56 MB) from unscreened, 58 (11MB) from among cases which were reported as not cases by the programme and 376 (89 MB) from the community. Additional MB cases detected were about 21% of the MB cases detected during MLEC. These cases were missed by the programme. It is clear that on the one hand one is over detecting cases to the extent of about 20% the programme is also likely to miss equal proportion of cases (30% overall and 20% MB) especially the cases of consequence. .



MLEC Evaluation - Bihar



NLEP Evaluation – Bihar 2003

vii. Evaluation of NLEP:

Damien Foundation carried out evaluation of NLEP in 19 districts on the lines of LEM in November 2003 with the objectives of analysing the trend of the disease, validating prevalence and new case detection, validating the diagnosis of recently detected cases, assessing the status of integration, assessing the quality of MDT services in general health system, assessing the level of community awareness and assessing the level of awareness among recently detected leprosy patients. Medical Officers and supervisors from the District Support Teams in Bihar and from other projects outside Bihar and from other ILEP agencies were involved in the exercise. Data from one randomly selected block

in each of the districts was used for assessing all parameters except validating the diagnosis of recently detected cases). For validation all cases in the district were assessed. (MB detected two months before and PB one month before). The following are the salient findings and recommendations:

- i. The DLOs were able to identify several implementation problems including drug supply management, functioning of health facilities, IEC, training of the staff, monitoring of the programme. Out of the 19 DLOs 8 said that elimination could be achieved by 2005. Only 5 of them said that they were using indicators to monitor the programme. It is clear that the capacity building of the DLOs in monitoring leprosy programme including drug supply need to be given the highest priority.
- ii. Looking at the trend of the disease it is obvious that mass case detection campaigns, which have become almost routine seem to be affecting the trend of the disease. Very small proportion of disability and less than 30% MB proportion perhaps indicates the persistence in active case detection. Six of the 19 districts had a prevalence of more than 10 per 10000. In Siwan, Kathihar, Khagaria and Kishanganj the prevalence has not shown any decline and it is more than 10 per 10000 indicating problems in discharge or in new case detection. It is imperative that instruction be given to all the districts to stop active case detection in any form.
- iii. There was no stock of PBA in one district, PBC in 3 and MBC in 5. Similarly in health facilities in 6 districts there was no stock of MBC, in 2 the PBC was nil, and in one district MBA was nil. Drug position overall appears adequate but distribution among and within the districts seems to be a serious problem. It would be useful to train the DLO and one person at headquarters at the district level and MO and the pharmacist at the health facility level in drug supply management. The flow of the system should be from health facility up, not from state down. Estimation should be done by the health facilities and order for the drugs should be placed at the DLO's office for supply every quarter. Similar system should be followed from the district to the state.
- iv. Quality of blister packs was good at district level and health facility level.
- v. There was no discrepancy in prevalence and new cases between the report and register in 9 out of 49 health facilities. Overall discrepancy was one unit for prevalence. There were minor discrepancies in all other parameters except disability and child proportion. MPR was not available for comparison in 5 health facilities. This shows the need to introduce monitoring of the parameters with a review of the register every month at health facilities. This should be done by the staff at these facilities. All health facilities should be asked to submit monthly progress report in the prescribed format. This will certainly help the MO at the facilities to monitor progress.
- vi. Involvement of PHCs in NLEP was very good. It was satisfactory in Sadar hospital. It was very poor in APHCs. Majority of the APHCs were functioning as subcentres. In some diagnosis and treatment services are available but recording and reporting was not. Medical officers posted at majority of the APHCs rarely visit the centres. The situa-

tion may not change.

- vii. The functioning of subcentres was very good. Majority (98%) were involved in the programme.
- viii. Treatment completion for MB was 90% and for PB it was 94%. In 40 (89%) out of 45 facilities cohort treatment completion for PB was more than 80% and in 37 health facilities (84%) the treatment completion for MB was more than 80%. There was problem in completion (<70%) for MB in 2 districts and for PB in one district. Generally it appears that treatment completion is good. It is important to note that 2.6% of MB cases had taken more than the stipulated number of doses. This should be avoided. This can happen only if there is a review of the situation at least once every quarter at every level.
- ix. Awareness about the disease among the community was 67%, which is good. The main source of information for the community was found to be radio. Even attitude towards the disease was found to be favourable.
- x. Blister pack collection was found to be correct in 82% of the cases. Since all the cases were registered one or two months before one cannot impute too much meaning into this. About 24% of the patients said that they collected drugs only on Tuesdays. This is in contrast to information obtained from the health facilities, which indicated that cases were managed every day in 37 (98%) of PHCs and only Tuesdays in 4 (2%). This indicates that still a substantial number of cases are getting the drugs only on Tuesdays or any other fixed day. This may be because on Tuesdays or fixed day the NLEP staff attend the OPD and they may ask the patients to come on Tuesday to collect the drugs. This should change. All the health facilities adapted flexibility in drug delivery.
- xi. Only 55% of MB cases had the duration of disease less than one year whereas it was 82% for PB. Average duration of disease was 15.1 months. This indicates a delay in detection of cases especially MB. The average duration of disease was 12 months or more in 12 districts.
- xii. The predominant mode of case detection appears to be by referral (55%). About 3% of the cases were detected by survey, which should be given up.
- xiii. For a majority of patients (46%) Government staff were responsible for their going to the health facility. About 25% were prompted to visit the health facility by their relatives, friends or other patients. This is an extremely positive finding, which should be encouraged.
- xiv. Knowledge about the disease and treatment among the patients was good in 73%.
- xv. Wrong diagnosis among MB was 5% and among PB it was 8.8%. Reregistration among MB was 11.56% and among PB it was 7.72%. Inactive not requiring treatment was 1.32% for MB and 1.66% for PB. It was observed that 18 MB cases (2.5%) were wrongly grouped as PB whereas 69 PB cases (11.4%) were wrongly grouped as MB. About 12% of MB and 10% of PB were non-existent. About 18% of MB and PB were not

cases. The situation can improve if criteria for diagnosis and grouping are strictly followed. A mechanism for routine validation of new cases should be built into the system.

- xvi. There was considerable underreporting of disability. The workers should be taught how to identify and record visible disabilities. Otherwise the data may not indicate the actual situation and one may misinterpret it and come to wrong conclusion.
- xvii. Situation of NLEP in Bihar is satisfactory in almost all aspects except in management of drug supply distribution, availability of MDT services at APHCs and diagnosis of leprosy. The situation will improve in these aspects also if programme is reviewed at health facility and district level every month and at state level at least every quarter.

viii. Health System Research (HSR) projects:

Two HSR projects were implemented in two districts of Bihar. One was "Non reporting of leprosy suspects and its impact on case detection in Saran district" and the other was, "Does flexibility in MDT delivery improve treatment compliance". The first study is not yet completed and the results for PB cases for the second study are available. A comparison between regular MDT (meaning patients collect the monthly blister pack from PHC, Subcentre or volunteer every month) with accompanied MDT (patients are given all the packs at the start of treatment). The health facilities were randomly divided into two groups and all the patients detected during the MLEC 4 were allotted to either R MDT or A MDT group based on the PHCs. Both the groups were given counselling and advised to keep the empty blister packs. At the end of treatment period the patients were contacted at their residence by field workers, interviewed and the blister packs were examined to find out monthly dose and daily dose compliance. Monthly dose compliance was consumption of all the monthly pulses. Daily dose compliance was defined as consumption of two-third daily doses (empty blisters in the pack). About 54% of the patients under RMDT and 80% of patients under AMDT did not miss even a single pulse dose. There was no difference in the regularity of consumption of daily dose between the groups. The study is in progress.

4.3.2. Jharkhand:

Jharkhand is also one of the leprosy-endemic states with a prevalence of 5 per 10000 (November 2003). It contributes 5% to the caseload of the country. Six districts in the state (East and West Singhbhum, Deoghar, Godda, Lohardugga and Gumla) are supported by Damien Foundation through the District Technical Support Teams. The teams have provided valuable assistance in validating new cases and developing the capacity of the various cadres of staff through on-the-job training. Prevalence has fallen to a considerable level. New case detection has



Driver giving Health Education to Patients

also shown a corresponding decline, Treatment completion has improved and integration is in the right course. Still problems remain: drug distribution system, supervision and monitoring by the programme officers at the district and PHC levels, which need considerable improvement.

i. Prevalence, NCDR and PD ratio:

The overall Prevalence was 5.43 per 10000. There were two districts (Gumla and Lohardugga) with a prevalence of less than 3 per 10000. There were 2 districts with prevalence between 5 and 6 and two with prevalence of more than 6. The overall NCDR was 7.56 per 10000. There was only one district with NCDR of 10 and above. There were three districts with NCDR less than 6 per 10000. The PD ratio overall was 0.72. There was one district (Deoghar) with a PD ratio of more than one. A total of 6311 new cases (2434 MB) were detected in the 22 districts. The MB proportion was 38.56%.

ii. Duration of disease:

The teams collected information on duration of disease from cases screened during 3 months from March of last year. A total of 1442 MB cases were interviewed. In about 46% of them duration of disease was less than one year, in 54% it was one year and above. Similarly among 1609 PB cases interviewed 53% had the disease for less than one year before detection. It is clear that there is a delay in detection of both MB and PB cases.

iii. Status of integration:

There were 71 PHCs in the 6 districts. MDT services were available all days in all. Treatment register was available in all the PHCs and it was up to date in 90% (64). The capacity of the General health staff to manage leprosy was found to be good. During their routine visits the District support teams assessed 2520 cases from January to December. About 2.5% (63) of them were found to be wrongly diagnosed as leprosy and 3.7% (94) were reregistered There are 1548 subcentres in 6 districts and 1477 (95.4%) are involved in the programme. Treatment completion for MB was 81.9% and for PB it was 85.5%. There were three districts with less than 80% treatment completion for MB and two for PB. There was one district with completion of less than 50% (Deoghar). The overall Prevalence was 5.43 per 10000 and NCDR was 7.56 with a PD ratio of 0.72. One district (East Singhbhum) did not have any problem with drug stock at any time of the year, two districts had inadequate stock twice in the year, and three districts had inadequacy three times during the year. Drug supply management in Jharkhand districts appears to be better than in Bihar districts.

iv. MLEC:

There was no MLEC in Jharkhand in 2003.

4.3.3.DTST South:

Damien Foundation has placed District Technical Support Team in three districts (Anantapur, Kadapa, Nellore) in Andhra Pradesh and two (Tumkur and Bangalore Urban)

in Karnataka. The teams in Andhra Pradesh are operated directly by Damien Foundation and the teams in Karnataka are run through the NGO project at Pavagada in Tumkur. The support in Andhra Pradesh and Tumkur district in Karnataka is for both NLEP and RNTCP whereas support to Bangalore urban in Karnataka is only for Tuberculosis.

i. DTST Andhra Pradesh:

In the absence of directive from the Government on integration it is difficult to expect total integration of tasks. In spite of this the teams have been able to achieve substantial progress in making the general health staff participate in NLEP. Support to NLEP in all the three districts have been there for the last two years. In 2003 the three districts reported 4777 new cases (1069 MB).

MDT services are available all days in more than 90% of PHCs in the three districts. Out of 206 PHCs in the three districts in 201 (97.5%) leprosy services are available. Drugs are available in all the PHCs in the



Education to Community – DTST Anantapur

all the districts. Registers are kept up to date in 90% of the PHCs. There are 1519 subcentres and only 46.5% (707) are involved in the programme. The capacity of the Medical Officers of PHCs to diagnose and manage leprosy is good. Case validation done by the teams reveals that wrong diagnosis on an average is 2.3% and reregistration is 3.6%. Treatment completion for two districts is available and it is 93% for MB and 96.8% for PB. Prevalence in the three districts ranged from 1.91 (Nellore) to 3.87 (Kadapa). Similarly NCDR ranged from 3.76 (Nellore) to 8 (Kadapa). PD ratio was around 0.5. High NCDR and low PD ratio may indicate active case detection with a high proportion of PB cases. The proportion of MB cases detected in the three districts confirms this. It was 22%, 14% and 32% in Nellore, Kadapa and Ananthpur respectively. In the absence of involvement of peripheral health staff and in the absence of IEC the NLEP vertical staff may resort to active case detection. At this rate it would be difficult for the districts to reduce the burden of leprosy. About 61% of the MB cases and 78% of PB cases are detected within one year of occurrence which is good.

HSR Project:

An operational research project to know if Female Multipurpose health workers (MPHW) can be trained to diagnose and treat leprosy independently has been started in Nellore

district. The district was divided into two zones each comprising of a certain number of PHCs. The female MPHWS were trained to diagnose and treat leprosy in the study area. In the control area the Medical Officers diagnosed and managed the cases. A core team at the district level was formed with the responsibility of screening all the cases detected in both the area and look for correctness of diagnosis and grouping. Till now 205 cases in the study area and 334 cases in the control area have been registered. Out of the 205 cases registered in the study area 119 were verified and 116 were correctly diagnosed (1 reregistered and 2 wrongly typed). Similarly, out of the 334 cases registered in the control area 58 were validated and 53 were correctly diagnosed (3 not case, 2 reregistered). The study is in progress.

ii. DTST Karnataka (Tumkur):

Tumkur district in Karnataka is a unique example of a district, which has been able to eliminate leprosy mainly because of involvement of the general health staff for the last two years. The team was placed in 2002. Integration is complete, there has been both functional and structural integration. But involvement of the peripheral staff in not as per expectation. Wrong diagnosis is less than 1% (0.7%) and there is no reregistration. Treatment completion for MB is 100% and for PB 92.26%. It has already reached elimination with a current prevalence of 0.45 per 10000 and NCDR of 0.58 per 10000. A total of 153 new cases were detected in 2003 of which 73 (48%) were MB. There is no active case detection in the district. Leprosy is confined to only two out of 10 taluks in the district and one of them is adjacent to Ananthpur in Andhra Pradesh where integration has not yet taken place and where active case detection still goes on.

Parameter	Tumkur	Anantapur
PR (December 2003)	0.45	2.39
NCDR(Jan-Dec 2003)	0.58	4.53
New cases detected	153	1648
MB%	48	32
Child%	9.15	18
Integration	Yes	No
Survey	No	Yes

The difference in picture between two adjacent districts in two adjacent states due mainly to operational factors becomes clear from the table given above.

4.4 Chemoprophylaxis to household contacts of leprosy patients

Randomized double blind controlled trial had been in progress since the year 2000. The NCDR was 153.8 per 10000 during the initial screening.

Baseline information		
1	Total household contacts	8060
2	New cases of leprosy	124
3	* Gross Prevalence Rate of leprosy (at intake)	495
4	Contacts Examined	7756
5	Coverage	96.2%
6	* Gross prevalence Rate of leprosy at intake	495
7	* NCDR (initial screening)	153.8

* Rates per 10000 person years

Results of follow up			
* Incidence Rates			
	Annual	Cumulative	Coverage
Year I	5.5	5.5	94.6%
Year II	5.9	5.7	96.7%
Year III	14.7	7.1	91.9%

* Rates per 10000 person years

Third follow up examination was done for 50% of the contacts, which were due for follow up this year. Overall incidence for all contacts was 7.1 per 10000 person years. The incidence of leprosy was 88% less in study group when compared to that of control group.

Plan: The manpower in participating centres had been reduced remarkably as a result of integration of leprosy services into general health care system. Hence follow up of household contacts had become increasingly difficult. It was originally proposed to follow up these contacts for a minimum period of 5 years.

4.5. Support to construction of buildings for PHC:

Damien Foundation supported the construction of 5 PHCs in three districts of Jharkhand and two districts of Bihar. The PHCs constructed in Jharkhand are Karon PHC in Deoghar, Bano in Simdega and Bharno in Gumla. In Bihar they are Ramgarhwa in East Champaran and Majholiya in West Champaran.

5. Prevention of disability (POD):

All the projects supported by Damien Foundation are assisting the Government in developing the capacity of the Primary health centre staff in managing simple complications including reactions and simple disabilities (e.g. plantar ulcers). There are three projects that are functioning as tertiary referral centre. Two projects are making MCR foot wear for patients with plantar anaesthesia and/ or ulcer. Attempt is made to develop the capacity of Medical College at Patna in Bihar for taking up reconstructive surgery for leprosy patients with deformities.



POD Training to General Health Staff



POD – Self Care Training by Volunteer

5.1. Reactions:

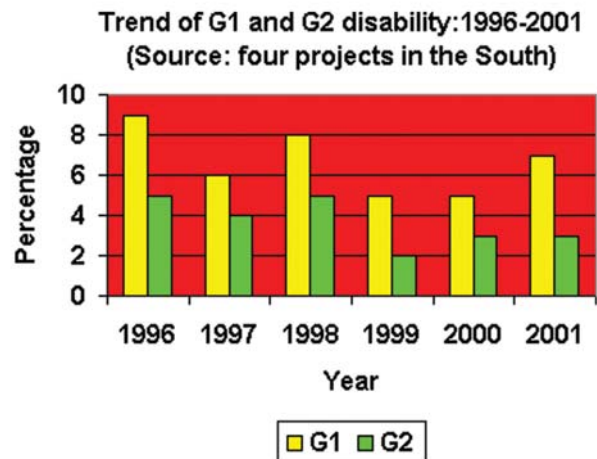
Projects reported 72 cases of reaction from MB cases and 9 from PB cases, all type 1 reactions. Out of the 72 cases of reaction among MB one was from 95 cohort, 2 from 97 cohort, 4 from 99 cohort, 7 from 2000, 7 from 2001, 17 from 2002 and 34 from 2003 cohort. The reaction rate was 2.1% for MB cases (denominator is the cases registered in a year: from 1993 to 2003). Similarly for PB cases 9 cases reported with reaction (Type 1): one each from 98 and 2002 cohort and 7 from 2003 cohort. The reaction rate was 0.6%.

In Bihar 934 cases of reaction (419 neuritis, 442 type 1 reaction and 73 type 2 reaction) were reported. Overall there were 17 cases of reaction for every 1000 new cases detected. The type 2 reaction was 4.7 for every 1000 MB detected. Highest number of reactions occurred in Nalanda (324) followed by Purnea (198). The least (0) was in Araria. The average number of reactions reported in a district was 20. In Jharkhand there were 165 cases of reaction (43 neuritis, 114 type 1 reaction and 8 type 2 reaction), 26 for every 1000 new cases detected. The type 2 reaction was 3.2 for every 1000 new MB case detected. The average number of reactions reported in a district in Jharkhand was 40.

5.2. Disability profile:

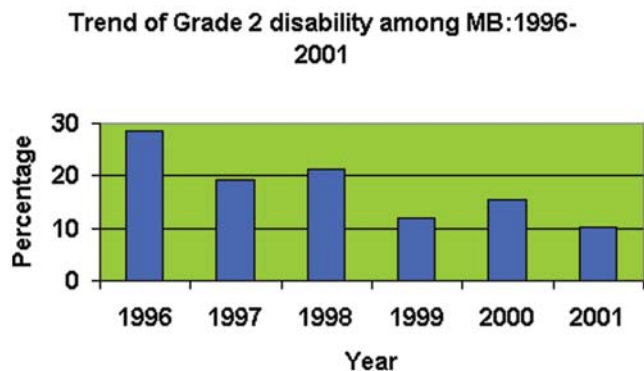
We have been able to glean the data collected from four projects in the south on disability from 1996 to 2001.

Year	New case			Disability		
	MB	PB	Total	G1	G2	Total
1996	151	1067	1218	103 (8.5)	64(5.2)	167(13.7)
1997	186	880	1066	63 (5.9)	40 (3.7)	103 (9.7)
1998	211	1018	1229	98 (8)	61 (5)	159 (13)
1999	208	1178	1386	67 (5)	30 (2.2)	107 (7.7)
2000	163	933	1096	58 (5.3)	32 (3)	90.9 (8.2)
2001	117	411	528	37 (7)	15 (2.8)	52 (9.8)



The drastic reduction in the number of cases seen in 2001 coincides with the decision by DFIT to change the strategy from active case detection to passive one and from direct involvement to active support to the programme at the PHC and other health facilities. This is also the reason why the MB proportion has gone up from 12% to 22% in 2001.

The trend of disability both Grade 1 and 2 was analysed. The ratio of Grade 2 to grade 1 was around 1: 1.8 throughout the 6-year period. It was 1:1.8 in 1996 and 1:2.3 in 2001.



This indicates impact of Leprosy elimination programme.

Overall disability, which was 5% in 1996, has come down to 3% in 2001. Grade 2 disability among MB cases as such has shown a declining trend: from 28% in 1996 to 10% in 2001.

An analysis of grade 2 disabilities of hand, eye and foot was done. Of the 186 grade 2 disabilities detected from 1996 to 2001 about 5%(10) were of eye, 53% (98) were of hand and 42% (78) were of foot.

Bilateral blindness was seen in one, bilateral ulnar claw in 39, bilateral total claw in 17, bilateral foot drop in 1 and bilateral absorption of foot in 2. There were 101 cases with grade 2 disabilities of foot (average of 17 per year or 1 per 100000 population per year). This information is useful for planning support activities like foot wear supply.

5.3. Introduction of Prevention Of Disability in districts:

Since the staff of all the projects supported by DFIT is adequately trained in POD, they were involved in training the general health staff of PHCs in districts where they are functioning.

In Nellore district, the DFIT District Technical Support Team (DTST) assisted the district authorities in training all the Government health functionaries in POD. A core group of key functionaries were initially given training on POD by the staff of the Nellore project and the District support technical team. The core group was assisted in preparing a plan of action including training of the peripheral staff and monitoring. A simple reporting format was developed for use by the Multipurpose health workers which gave the details of the name of the patient, the date visiting the patient and observation whether self care activities are followed or not (Yes/No). The forms were printed and distributed to all the workers. The core group as per the guidelines of GOI did training of peripheral staff. The technical team along with the worker would contact patients with disability if any, and assess the self-care compliance. The training has been completed by the end of December 2003. Sixteen patients were assessed out of whom 8 were doing their self-care activities regularly and having all the implements for self-care. The rest were either irregular or did not have some of the self-care implements. Six of the patients were wearing the appropriate type of footwear. This is really a good beginning in a state where integration of leprosy has not yet taken place.

In Salem District, the project in Arisipalayam has been involved in imparting training on POD in 20 blocks in the district. Out of the 780 health workers from these blocks 200 have been trained. Six blocks have been evaluated. It was found that 200 patients out of 305 (66%) were doing self-care practices at home. This is due to the committed involvement of the health workers and good technical support provided by the Physiotherapist from the

DFIT-supported project at Arisipalayam (Salem).

Regarding the project in Dindigul, the training of health workers was confined to the 5 Municipal Health Centres with 29 workers.

Holy Family Hansenorium, the project at Fathimanagar in Trichy district trained the staff from 10 PHCs in the district on prevention of disability. The workers identified 92 patients with foot ulcers of which 14 healed within 8 months. This was due to the excellent effort by the field workers of the PHCs.

5.4. Corrective Surgery:

5.4.1. Surgery in South projects:

The project at Fathimanagar, Trichy, gets cases referred from all over Tamil Nadu and even from outside the state for chronic ulcer management and reconstructive surgery. Corrective surgery was also done in Nellore in Andhra Pradesh, Pavagada in Karnataka and Trivandrum in Kerala. Totally 49 cases underwent reconstructive surgery (2 for eyes, 36 for hands and 11 for foot). Twenty-eight cases underwent other surgical procedures like decompression (4), skin grafting (4), amputation (8) and septic surgery (12). Out of the 49 corrective operations done this year there has been no failures. Watering of the eyes of the patients corrected for lagophthalmos has stopped. Out of the 36 operated hands, 19 patients having had 29 operations amongst them have resumed daily activities. Five patients having 7 operations still have not adopted themselves with the surgically corrected hands. They were operated only in the last quarter of the year. All patients with foot drop corrections have started walking normally. Long-term follow up of earlier operated patients is being routinely done with parameters such as appearance, function, social and economic impact before and after surgery.

5.4.2. Reconstructive surgery in Bihar:

Efforts are underway to initiate reconstructive surgery in Medical College Hospital at Patna in Bihar. A proposal for Reconstructive Surgery in Bihar was submitted to the Government and the Hospital authorities. It has been approved. Surgery would be taken up from January next year. Cases requiring surgery would be mobilised by the District support team in districts around Patna, surgeons would be trained in a workshop where they would actually operate under the guidance of the consultant from DFIT. A physiotherapist would be identified and trained by the consultant and physiotherapist from DFIT. Immediate postoperative follow-up will be done by the surgeon and physiotherapist at the hospital, mobilisation of patients for long term follow-up would be done by the district support team. There is no baseline data on disability in Bihar. It was also proposed to collect baseline from four districts around Patna. From the data that is available, it is believed that there would be on an average of 70 to 80 patients with grade 2 disabilities. About 30% may be eligible for surgery and about half of them may be willing to undergo the operation. In

other words there could be about 10 cases eligible and willing to undergo surgery in a district. Taking the whole of Bihar there could be about 400 such cases in the State.

5.4.3. Footwear:

In 2003 DFIT supported projects supplied 1095 pairs of footwear to patients free of cost.

6. Revised National Tuberculosis Control Programme (RNTCP):

6.1. Introduction:

Damien Foundation India Trust (DFIT) is supporting Revised National Tuberculosis Control Programme (RNTCP) through eleven area-specific NGO projects (Microscopy centres or TB units) or through District Technical Support Teams (DTST) to entire districts (five in number). Of the 11 projects 7 are Microscopy centres and four are TB units. The projects in Ambalamoola, Aundipatty, Dindigul, Fathimanagar, Nellore, Nagepalli and Trivandrum run microscopy centres and the projects in Arisipalayam, Delhi, Kavali and Pavagada run TB units as per the guidelines of Government of India. While TB units at Arisipalayam, Kavali and Pavagada provide supervisory and monitoring support through Senior TB Supervisor (STS), Senior TB Laboratory Supervisor (STLS) and MO and inpatient care, the project at Delhi provides total support through 5 microscopy centres and Supervisory staff (STS, STLS and MO).

6.2. Strategy:

The project Out Patient Department (OPD), running Microscopy centres do sputum microscopy of respiratory symptomatics suggestive of TB, diagnose and manage them either directly or through DOTs volunteers selected from the community. Damien Foundation subjects their sputum microscopy to a two-level quality control.

In Dindigul town there are 5 municipal dispensaries that suspect and refer respiratory symptomatics to microscopy centre at the project for diagnosis, categorisation and initiation of treatment while follow-up treatment under DOTs is managed by the dispensaries and their peripheral staff.

Fathimanagar project is covering a small number of villages around it for managing TB cases. The number of cases that the project manages, therefore, is very small. The main focus of the project is on providing specialised service to leprosy patients referred by PHCs from and outside the district in addition to building the capacity of the staff of ten PHCs in managing leprosy cases with simple complications.

Even though there are Government health facilities nearby, the projects at Ambalamoola and Aundipatty serve as additional microscopy centres. DFIT has decided to provide support only to inpatient service at these two projects.

The project at Nellore, which is managed directly by DFIT runs a microscopy centre covering a population of about 100000 in Nellore town.

The three TB units located at Kavali, Pavagada (both rural) and Arisipalayam (urban) function by providing supervisory and monitoring support to 500000 population in addition to providing primary diagnostic and treatment service to 100000 population in the immediate neighbourhood. Each project has supervisors (STS and STLS) and Medical Officer for guidance. The project at Delhi is unique in the sense it operates all the microscopy centres directly. Each MC has a field worker trained in sputum microscopy. There are supervisors (STS and STLS) and Medical Officer. The project detects cases from among those reporting to Microscopy centres directly or referred by General practitioners or Medical Officers of Corporation dispensaries. After diagnosis and initiation of treatment, follow-up treatment under DOTs is provided directly by the field workers at MCs or organised through General practitioners, Medical officers of dispensaries and community volunteers. It is noteworthy to mention that over 60 general practitioners are participating in the programme.

Damien foundation is supporting RNTCP in five districts- three in Andhra Pradesh (Anantapur, Nellore and Kadapa) and two in Karnataka (Bangalore urban and Tumkur). Each district team has a Medical Officer and two to three supervisors with vehicles. The team members move around in the district building the capacity of the general health staff, assisting the District TB officer in identifying problems in specific areas and instituting prompt remedial action. The team in Anantapur was placed in 2001 and in other districts in 2003.

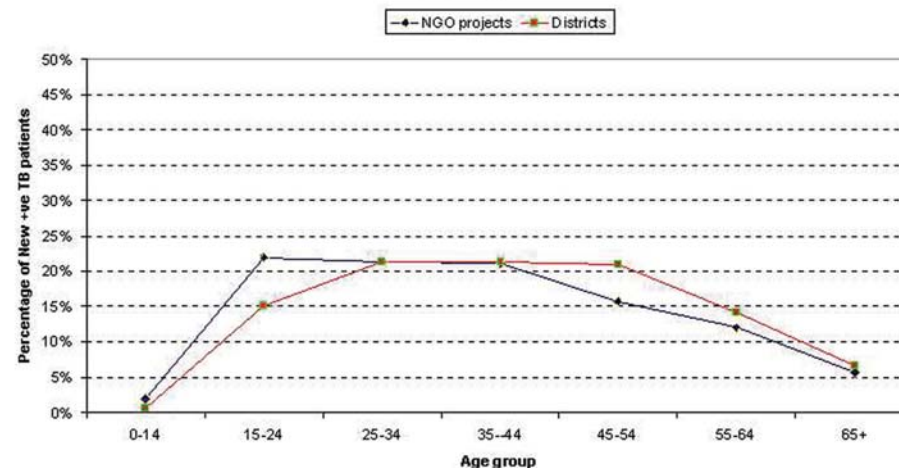
6.3. Outcome:

6.3.1. In sponsored projects:

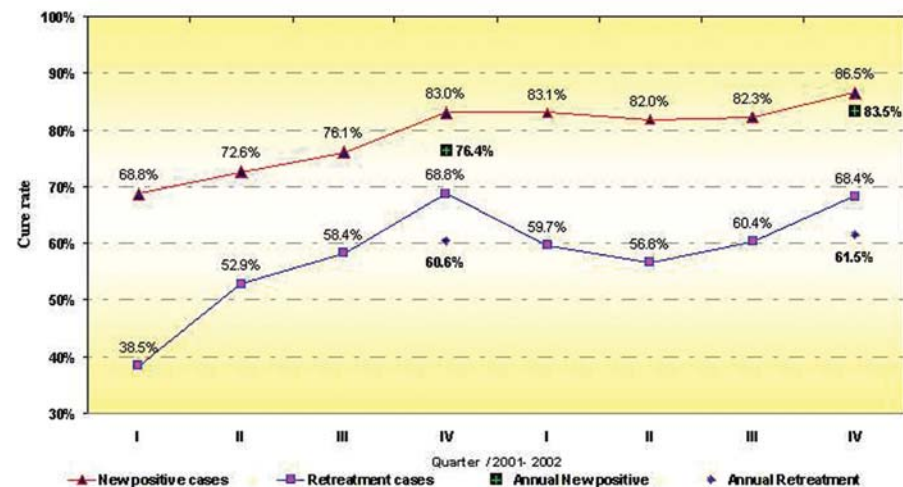
There were 1715 TB patients registered for treatment during 2003 in the NGO projects among whom 87.7% were new cases and 12.3% were retreatment cases. About 30% of all cases were new sputum positive pulmonary cases. Majority (80.1%) of cases was in the age group of 25-54 years.

Sputum conversion rate reported during 2003 for new sputum positive cases was 84.2% and cure rate for the 2002 cohort was 82%. It was more than 90% in one project (Arisipalayam) and less than 50% in one (Aundipatty). Since the number of cases in Fathimanagar was very small the conversion in the project does not have meaning. Cure rate in Aundipatty was again low (77.8%). Similar was the case with Trivandrum, an urban project. It is 85% or more in four projects (Ambalamoola, Delhi, Dindigul and Nagepalli).

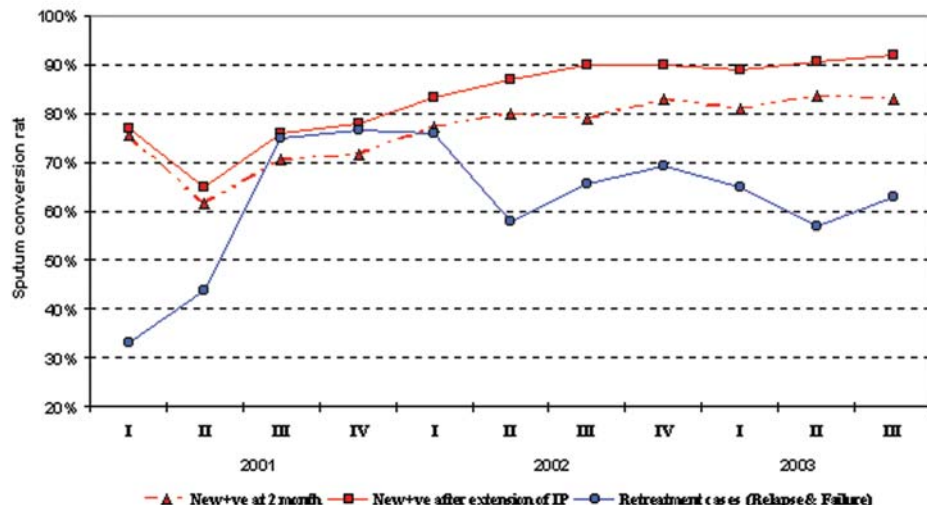
Age distribution of New Sputum positive TB patients in NGO projects and districts



Treatment outcome of RNTCP - 2001 & 2002 cohort of Ananthapur district



Sputum conversion in Ananthapur district (RNTCP) 2001-03



6.3.2. In supported districts:

Reorientation training of all Medical Officers and Pharmacists was done in Ananthapur district. Reorientation was also done in Kadapa for Medical Officers, Laboratory technicians and pharmacists. The teams in Nellore and Tumkur were involved in training of all the staff during the preparatory phase. Reorientation training for peripheral health workers, supervisors and pharmacists for one half of Bangalore urban has been completed.

There were **18580** TB patients registered for treatment during 2003 in the 5 districts. About 86% of these cases were new and 14% were retreatment cases. About 43% of all cases were new sputum positive pulmonary TB cases. Majority (78.5%) of cases was in the age group of 25 to 54 years. Sputum conversion rate was 87.2% for cases reported in 2003. Cure rate for 2002 cohort was 83.8%. It was 83.5% in Anantapur and 85% in Bangalore urban. Sputum conversion rate was more than 80% in all the districts except Tumkur. Direct observation of treatment was practised for 49% in Kadapa and 83% in Bangalore urban. It was more than 90% in other districts.

i. RNTCP in Anantapur district:

One of the notable features of the programme has been the committed and motivated participation of all the general health staff in the programme. About 80% of the DOTs providers in the district are volunteers from the community. They are not paid any incentives. Still their motivation is certainly laudable. A two-level quality assurance mechanism has been introduced in the district.

RNTCP in Anantapur district has shown tremendous improvement in the last two

years. Case detection improved by 72% (compared to 2001). New sputum positive detection is 77 per 100000 population, slightly less than the expected 85 per 100000 (it was 42 per 100000 in 2001 and 64 in 2002). About 95% of the total cases were pulmonary, about 60% of the pulmonary cases were sputum positive and 26% of the pulmonary sputum positive cases were retreatment ones. Sputum conversion improved from 77% in the first quarter to 90% in the third quarter of 2002 and it continued at that level in the third quarter of 2003. Cure rate improved from 68.8% in the first quarter of 2001 to 86.5% in the last quarter of 2002. The improvements seen in 2003 were due to better identification of suspects, better categorisation, better treatment compliance because of improved DOTs supervision and better follow-up of patients.



DOTS provider – Shop Keeper.

SERVICE WITH A SMILE



Mr.Chinna Adeppa is a physically challenged person living in a village in Anantapur district. His neighbour had a long standing cough and loss of weight. He contacted the health worker and got sputum examination done. He was found to be suffering from TB. Mr.Adeppa was preferred by the patient for administration of DOT. He has already volunteered for 4 TB patients so far. He is willing to be a DOT provider to anybody in the village. He is very enthusiastic and proved himself by his service. He has found a real meaning to life by helping others in need in spite of his handicap.

ii. RNTCP in Nellore district:

RNTCP in Nellore was started about a year back exactly one year after the staff were trained. All the staff were retrained to build their competence in managing cases. The district did not have enough number of supervisors (STS) for covering all TB units. This was one of the reasons for the delay in introduction of RNTCP in the district. Damien Foundation at the request of district administration provided 3 STS in the beginning of 2003 so that the programme could be started without further delay. They have since been replaced by Government staff (in December).

New sputum positive case was 36 per 100000. Since the programme was started only in January 2003 the case detection was less than expected. About 95% of the total cases were pulmonary, about 54% of the pulmonary cases were sputum positive and 36% of the

pulmonary sputum positive cases were retreatment ones. Sputum conversion rate was 83.4%. Since the programme was started only in January 2003 cure rate results are not available.

iii. RNTCP in Kadapa district:

In Kadapa the team from Damien Foundation was given the responsibility to support the district only in May 2003. The programme was reporting more than 90% cure rate. Several problems were observed: majority of cases were not categorised correctly; they did not have DOTs supervisors (drugs were handed over to patients); there was no supervision of treatment compliance; follow-up sputum examination was incomplete; and records were not updated. The TST with the help of three additional staff from neighbouring districts screened 635 cases. The knowledge of RNTCP among the staff was inadequate. Categorisation was correct in 493 (77.6%) of cases, only 133 (21%) of cases were on DOTs supervision, only 4% of patients were taking the drugs in single dose. While 77% of patients had adequate knowledge about disease only 35% had adequate knowledge on treatment. Follow-up sputum examination had been done in only 19% of the cases. About 42% of the cases were irregular in treatment. About 15% of the patient cards had complete information. About 12% of patients were not traceable. Laboratory registers were not maintained properly in all the MCs visited. Blister packs available with patients who had completed treatment had many tablets and capsules. The team arranged DOTs providers for all the cases, gave on-the job training to the supervisors and the peripheral staff, updated patient cards and registers. They were retrained. DFIT has strengthened its team by placing an additional supervisor with a vehicle.


New sputum positive case was 78 per 100000. About 96% of the total cases were pulmonary, about 47% of the pulmonary cases were sputum positive and only 15% of the pulmonary sputum positive cases were retreatment ones. Sputum conversion rate was 88.3%.

iv. RNTCP in Tumkur district:

In Tumkur in Karnataka the team started support with the initiation of RNTCP in the district in January 2003. The team has one Medical Officer and three supervisors with vehicles. The team participated in the training of all the staff. The team carried out periodic sensitisation of Medical Officers at Taluk level.

New sputum positive case was 44 per 100000. Since the programme was started only in January 2003 the case detection was less than expected. About 86% of the total cases were pulmonary, about 68% of the pulmonary cases were sputum positive and 23% of the pulmonary sputum positive cases were retreatment ones. Sputum conversion rate was 78.5%. The district seemed to have problem in categorisation.

HELPING EACH OTHER



Mr. Damodar is a tailor. He studied up to school. He developed cough and lost weight. He went to nearby PHC where he was diagnosed to have TB after sputum examination. In the same village two more people, an old lady who is a distant relative of Damodar and the other a neighbour of his, were diagnosed with TB. All the three were counselled. Damodar became the DOT provider for his neighbour and the old lady who agreed to be the DOT provider for Damodar. All of them are taking the treatment regularly.

v. RNTCP in Bangalore urban:

RNTCP in Bangalore urban was started in the district about 5 years back. The team was placed in January 2003. Several problems were noticed. DOTs coverage was poor. There are two TB sanatoria that were not providing treatment with RNTCP drugs. The patients reporting from within the district were given different regimens. The two institutions did not have field staff for following patients. DTO, therefore, refused to provide RNTCP drugs to the sanatoria. The lab technician in one of the sanatoria had not been trained in RNTCP. There was only one STS instead of the required five. There was lack of technical guidance to general health staff. Their knowledge about the disease and the programme was very poor. Majority of patients were asked to come to the PHCs for treatment. There was no follow-up of absentees. Very few patients were under real DOT. The team conducted a survey of cases reporting at the sanatoria and getting referred to PHCs. Of the 269 cases (67 OPD cases and 202 inpatients) reporting to Old Madras Road Sanatorium from within the district only 101 were referred to PHCs for RNTCP treatment and 168 received NTCP treatment with no follow-up. Damien Foundation placed a field worker to assist the sanatoria for organising DOT for TB patients diagnosed at the centres. The situation in one of the sanatoria (SDS) has improved. All cases from the district are given RNTCP drugs. Situation in the other sanatorium has not changed. The health workers and supervisors from one half of the district have been retrained. The DTO has appointed and placed 4 STS. Every new patient is under DOTs supervision.

New sputum positive case was 13.67 per 100000. About 83% of the total cases were pulmonary, about 65.5% of the pulmonary cases were sputum positive and 24% of the pulmonary sputum positive cases were retreatment ones. Sputum conversion rate was 90.2%.

vi. RNTCP in Bihar and Jharkhand:

Three districts in Bihar and two in Jharkhand are implementing RNTCP. Five districts in Bihar have been under preparation for more than two years. Considering the slow pace of implementation DFIT was requested to coordinate the activities including hastening the

process of preparation of districts for taking up RNTCP. Damien Foundation is supporting NLEP in 22 districts of Bihar and 6 of Jharkhand. The teams have been trained in RNTCP also. DFIT will involve itself directly in the 28 districts whereas in other districts which are supported by other ILEP agencies it will coordinate the activities. All the TST were trained in RNTCP. DFIT intends to place a core team at the disposal of both the states. The core team will consist of ten members drawn from the teams in the two states and also from the South which will assist the districts in training the staff, in identifying workers for the position of Microscopists and in completion of upgrading of the laboratory facility. Following the introduction of RNTCP the core team along with the district teams will assist the State TB officer in monitoring and evaluating the programme. The teams have been asked to collect baseline data from all the districts.

To get an idea about the implementation problems in RNTCP in Bihar Damien Foundation carried out evaluation of the programme in Vaishali district, which has been under RNTCP for more than four years. Evaluation brought out several problems. The team consisting of a Medical Officer and two supervisors has already started assisting the District TB officer in all the major activities since October 2003. All the personnel (the DTO, 5 MOTC, 1 MODTC, 77 Medical Officers, 5 STS, 5 STLS, 18 Lab Technicians, 41 MPHS and 478 MPHWS) in the district were retrained in RNTCP

6.4 Evaluation of RNTCP in Vaishali:

Vaishali, one of the three districts implementing Revised National Tuberculosis Control Programme (RNTCP) in Bihar, was evaluated by a team from Damien Foundation India Trust in the first week of July 2003. Data was collected from district tuberculosis centre, TB units, Microscopy centres, DOTs (Directly Observed Treatment Short course) providers and patients either from records, registers, reports or directly by interview. Variables like infrastructure, case detection, sputum microscopy, categorisation, follow up of patients, outcome, records and reports, supervision, drug supply management were studied.

The programme was introduced in a phased manner in the district and it took almost 5 years to cover the whole district. The district has adequate number of TB units but has only 15 Microscopy centres (MC) which are not adequate to cover the district with a population of 2.7 million. Staff are adequate and either they are not trained or the training that they have undergone is totally inadequate. On an average the district has been detecting about 2500 new cases every year. Even though sputum positive cases are predominant (58%) it is still less than expected. From the data in second quarter of 2003 it was found that around 50% of the out patient attendees were adults, 23% of them were found to be respiratory symptomatics and about 20% of the respiratory symptomatics were positive. Only 59% of the respiratory symptomatics had three sputa examination. Quality control of sputum microscopy revealed serious problems like false positives and false negatives to the extent of 18%.

There is serious problem in categorisation. About 42% of Cat 1 cases had previous

history of treatment of more than 4 weeks, about 30% of Cat 2 should not have been in Cat 2 and 30% of Cat 3 were doubtful cases.

All the cases were under DOTs. All the DOTs providers were Auxiliary Nurse Midwives (ANMs). Whereas their knowledge about disease was good, knowledge about follow up treatment was not. Only 74% of 70 DOTs providers interviewed had the correct number of blister packs. About 17 out of 360 Cat 1 cases, 4 out of 69 Cat 2 cases were irregular. Sputum conversion as per the laboratory register was 90%. Cure rate was different in different records. As per the report 93% of the cases were reported as cured. It was 16% as per the treatment card (in 269 cases there was no entry of sputum smear examination), 35% as per the TB register and only 29% as per lab register. It is clear from these variations in results in different sources that there are serious problems in updating of information, supervision and monitoring at all levels. Supervision at all levels was inadequate. There is no monthly review of the programme. Drug supply management is not a serious problem. Maintenance of records is very poor. Cards, registers are not up dated regularly.

It is recommended that training of the different cadres of staff should be carried out immediately. All Medical Officers (MO) newly posted should undergo the mandatory training. Quality control of sputum microscopy should be introduced. Community volunteers should be identified for DOTs supervision. DOTs providers should be educated properly and patients should be counselled adequately. Proper history should be taken from all new cases so as to facilitate correct categorisation. There should not be any target pressure for case detection. All Cat 3 cases should be reviewed by the supervisor (Senior TB Supervisor or STS) and Medical Officer (MO) at TB unit. There should be monthly review meeting at the district level. All the supervisory staff at the TB unit (STS, STLS – Senior TB Laboratory Supervisor - and MO) should be asked to submit report every month. Evaluation of the programme should be done at least once a year.



RNTCP – Evaluation - Vaishali

6.5. Quality assurance of Sputum microscopy:

6.5.1 Sputum microscopy - Projects

There were 5750 respiratory symptomatics screened by sputum microscopy during 2003 in NGO projects and sputum positivity rate was 20.88%. It was more than 20% in 5 projects and less than 10% in Trivandrum project.

Sputum positivity rate among follow up patients was 14.2%. It was more than 15% in 3 projects.

6.5.2 Quality Assurance - Projects

A total of 15804 sputum smears were done in 11 projects during the year 2003. Among them 81.9% was negative, 14.8% was positive and 3.3% was scanty positive.

A total of 2299 (14.54%) slides were examined for Quality Assurance. Total variation was 2.6%. FP was 3.6% and FN was 1.9%. Majority of HFP+HFN was observed in Delhi. HFP+HFN was more than 1% in Trivandrum and Nellore.

6.5.3 Quality Assurance – Anantapur district

A two-level quality assurance of sputum microscopy has been in place for all the NGO projects for more than three years. It was introduced in Ananthpur district also in October 2002. The new system was implemented along with the routine (as per the guideline of Government of India).

Results of routine quality assurance (Anantapur district) in 2003

Result by LT	Result by STLS		Total
	Positive	Negative	
Positive	13766	156	13922
Negative	135	12572	12707
Total	13901	12728	16629

False positive = 1.12%; False negative = 1.

Result of two-level quality assurance (Anantapur district) in 2003

Result by LT	Result by second level quality control LT			Total
	Positive	Scanty positive	Negative	
Positive	705	34	19	758
Scanty positive	33	31	12	76
Negative	18	11	1888	1917
Total	756	76	1919	2751

HFP	SFP	HFN	SFN	QE
19	12	18	11	61

The routine quality assurance reported a false positivity of 1.12% and false negativity of 1.06% in 2003. It was 0.79% and 0.87% respectively in 2002. Two-level quality assurance reported 3.7% false positivity and 1.5% false negativity. False positivity in the last quarter of 2002 was 6.5%. False positivity came down by 50% in 2003. Overall, it is clear that there are limitations in the routine quality assurance mechanism. Two-level quality assurance seems to be better.

6.5.4 Additional yield of positivity in two sputum samples for follow up examination in RNTCP – experience in Anantapur district

As per the RNTCP guideline two sputum specimens (early morning & spot) are collected for follow up. The main purpose is to ensure that positive results are not missed. There is

considerable effort and time spent by patients and health system to achieve successful examination of two sputum samples.

A study was conducted in Anantapur district to determine the additional yield of second specimen examinations in follow up sputum microscopy. All New sputum positive Pulmonary TB patients registered during 2002 were included in the study.

Result of spot sputum sample (second sample)	Result of early morning sputum sample (1 st sample)			Total
	Positive	Scanty	Negative	
Positive	98 (62.5%)	4 (4.5%)	Nil	102
Scanty	33 (21%)	39 (44.5%)	Nil	72
Negative	26 (16.5%)	45 (51%)	1612	1683
Total	157 (100%)	88 (100%)	1612	1857

Among 1612 samples with negative results for early morning sample, none of the corresponding spot samples revealed positive for AFB. The average time required for processing (including microscopy) is 8 minutes per sample. A total of 14128 specimens were examined in the district for follow up during 2003. This would have consumed 1883.7 hours (14128x8/60). Considering that a lab technician works for 5 hours a day, it required 376.7 man-days (1883.7/5) in a year.

It is clear that examination of second sample of sputum for follow up is not productive. Considerable man-days of skilled personnel are saved by avoiding examination of second sample. The reduction in workload may also improve quality of sputum microscopy.

7. Trainings

Training programmes 2003

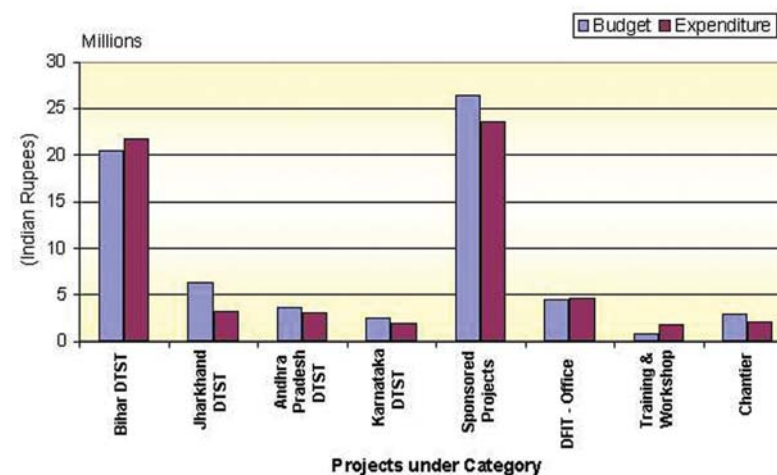
	Particulars	Venue	Participants
1	Management workshop on NLEP for DLOs - Bihar	Patna	14
2	Orientation course at IMA Chapter	Bangalore	150 GPs
3	HSR workshop for Tamilnadu & Karnataka	DFIT, Chennai	Koppal (4), Gulbarga (3) Madurai (3) Vellore (3) Kancheepuram (4)
4	Meeting of the Core Group for Facilitating Effective Participation of General Practitioners in RNTCP Programme	Bangalore	14
5	PCM Training – organised by DFB	Chennai	DF-Bangladesh (3) DF-China (4) DF-LAOS(4) DFIT-Ranchi(5) DFIT- Chennai (5)
6	Action plan meeting for TSTs of Bihar and Jharkhand and North Projects	Ranchi	66.
7	Action Plan meeting for South Projects	DFIT, Chennai	14
8	Action Plan meeting for TST south	DFIT, Chennai	18
9	LT Training at Nellore	DFULC, Nellore	9 LTs from South projects
10	LT workshop Nellore district	DFULC, Nellore	27
11	POD training to MOs & DLOs from Government	Patna	88
12	RNTCP – DTST Training for Bihar & Jharkhand	DFIT, Anantapur	39
13	Training of trainers for TST Bihar	Hotel Pataliputra, Patna	28 (including TLM & LEpra)
14	Training of trainers for Bihar Zone (Purnea, Gaya, Vaishali and Madhubani- Zonal Review Meeting)	Hotel Pataliputra, Patna	MO – 8 NMS – 10
15	Training on Lab aspects of RNTCP for TST-South	DFULC, Nellore	12
16	Validation diagnosis (Standardization workshop) for GOI	NIHFW, Delhi	
17	Endowment Prize Examination	Theory	83 from Dr.MGR university and 5 from Ramachandra Medical College
18	Endowment Prize examination	Practical exam (conducted at MMC)	21 from Dr.MGR university & 2 from Ramachandra Medical College.
19	PG seminar at Kempagowda Institute of Medical Science	Bangalore	83 Students

8. Finance Report:

The overall receipt and payment for the year is as follows:

Income:	(INR)
Contribution from Damien Foundation Belgium	31,425,096.48
Contribution from DFB - DGDC	22,487,256.58
Contribution from Chantier Damien	2,369,665.60
Contribution from Lepira India for Delhi Project	519,150.00
Interest received from Fixed Deposit / Savings a/c	507,223.88
Donation / Fund raising	20,491.50
Staff Benefits	1,147,527.00
Miscellaneous Income	761,218.47
Opening Balance of RBF Fixed Deposit	2,551,962.00
Opening Balance for the year 2003	7,026,793.82
	68,816,385.33
Expenditure	
Fund transferred to Projects	24,146,768.00
Bihar Activities - Technical Teams	21,467,263.32
Jharkhand Activities - Technical Teams	4,885,307.53
Andhra Pradesh - Technical Teams	3,097,314.00
Karnataka - Technical Teams	1,997,270.00
DFIT Office, Field, POD	4,776,246.47
Training & Workshops	1,726,157.00
Chantier Damien activities	995,150.65
Closing balance for the year 2003	5,724,908.36
	68,816,385.33

Damien Foundation India Trust - Budget & Expenditure 2003



STATISTICS

S.N	Project Name	Population	New Cases			G2 Deformity	
			MB	PB	TOT	No.	%
I PROJECTS							
1	Ambalamoola	68000	3	2	5	1	20.00
2	Arisipalayam	527635	18	62	80	0	0.00
3	Aundipatty	253657	8	20	28	3	10.71
4	Dindigul	428288	7	36	43	5	11.63
5	Delhi	1881261	6	19	25	1	4.00
6	Fathimanagar **	0	40	26	66	14	21.21
7	Nagepalli	100563	5	32	37	0	0.00
8	Trivandrum	907000	5	4	9	0	0.00
TOTAL :		4166404	92	201	293	24	8.19
II TST - SOUTH							
1	Ananathapur	3639304	534	1114	1648	21	1.27
2	Kadapa	2628428	302	1807	2109	20	0.95
3	Nellore	2715370	233	787	1020	11	1.08
4	Tumkur	2620870	73	80	153	1	0.65
TOTAL :		11603972	1142	3788	4930	53	1.08
III TST - BIHAR							
Muzaffarpur Zone							
1	Darbhanga	3489172	1132	2305	3437	30	0.87
2	Madhubani	3756325	1059	2135	3194	76	2.38
3	Siwan	2844282	756	2528	3284	22	0.67
4	Gopalganj	2261109	693	1413	2106	28	1.33
5	Saran	3420551	1025	1738	2763	43	1.56
6	Sitamarhi	2846100	868	2779	3647	55	1.51
7	Sheohar	551317	156	362	518	3	0.58
8	Vaishali	2853433	558	973	1531	19	1.24
9	W.Champaran	3225627	875	1744	2619	6	0.23
10	E.Champaran	4161787	794	1916	2710	33	1.22
TOTAL :		29409703	7916	17893	25809	315	1.22
Purnea Zone							
11	Purnea	2718643	644	2183	2827	10	0.35
12	Kishanganj	1374295	578	1257	1835	6	0.33
13	Araria	2260820	931	3051	3982	36	0.90
14	Katihar	2537684	650	2178	2828	13	0.46
15	Madhepura	1613023	433	1499	1932	28	1.45
16	Kagharia	1350724	379	857	1236	7	0.57
17	Saharsa	1605842	343	943	1286	30	2.33
18	Supaul	1849773	630	1696	2326	28	1.20
TOTAL :		15310804	4588	13664	18252	158	0.87
Gaya Zone							
19	Gaya	3672882	1083	2034	3117	41	1.32
20	Jehanabad	1599068	475	942	1417	32	2.26
21	Nalanda	2458323	776	1391	2167	32	1.48
22	Rohas	2585893	683	2055	2738	19	0.69
TOTAL :		10316166	3017	6422	9439	124	1.31
BIHAR - TOTAL :		55036673	15521	37979	53500	597	1.12
IV TST -JHARKHAND							
1	Lohardagga	385742	66	112	178	2	1.12
2	W.Singhbhum	1265528	479	718	1197	32	2.67
3	Gumla&Simdega	1391268	109	174	283	1	0.35
4	E.Singhbhum	2081414	607	1198	1805	39	2.16
5	Godda	1085140	197	446	643	0	0.00
6	Saraikela	905149	469	705	1174	19	1.62
7	Deogarh	1225128	507	524	1031	9	0.87
TOTAL :		8339369	2434	3877	6311	102	1.61
GRAND TOTAL		79146418	19189	45845	65034	776	1.19

** Referral Hospital

AT A GLANCE : 2003

Child Cases No.	%	MB %	Cases On Record TOT	PR /10000	NCDR /10000	PD Ratio	Rel. No	Cohort (%)	
								PB %	MB %
2	40.00	60.00	4	0.59	0.74	0.80	0	100.00	100.00
16	20.00	22.50	46	0.87	1.52	0.57	0	96.70	94.40
2	7.14	28.57	22	0.87	1.10	0.78	1	96.20	78.57
8	18.60	16.28	19	0.44	1.00	0.44	0	100.00	100.00
2	8.00	24.00	17	0.09	0.13	0.68	0	99.00	97.18
1	1.52	60.61	0			0.00	0	0.00	88.10
10	27.03	13.51	20	1.99	3.68	0.54	0	100.00	100.00
0	0.00	55.56	0	0.00	0.10	0.00	0	99.10	100.00
41	13.99	31.40	128	0.31	0.70	0.43	1	85.57	87.16
300	18.20	32.40	869	2.39	4.53	0.52	0		
496	23.52	14.32	1018	3.87	8.02	0.48	0	93.60	89.50
194	19.02	22.84	519	1.91	3.76	0.50	0	100.00	89.00
14	9.15	47.71	119	0.45	0.58	0.77	0	92.26	100.00
1004	20.37	23.16	2525	2.18	4.25	0.51	0	95.80	90.70
563	16.38	32.94	1861	5.33	9.85	0.54	0	97.90	89.32
388	12.15	33.16	1497	3.99	8.50	0.46	0	81.80	78.01
675	20.55	23.02	1269	4.46	11.55	0.38	0	95.30	81.33
432	20.51	32.91	878	3.88	9.31	0.41	0	79.02	81.01
506	18.31	37.10	1251	3.66	8.08	0.45	0	76.64	87.78
628	17.22	23.80	1536	5.40	12.81	0.42	0	92.98	90.06
88	16.99	30.12	238	4.32	9.40	0.45	0	95.10	93.10
160	10.45	36.45	817	2.86	5.37	0.53	0	93.59	84.90
150	5.73	33.41	1289	4.00	8.12	0.49	0	89.95	90.70
507	18.71	29.30	1241	2.98	6.51	0.45	0	92.66	92.83
4097	15.87	30.67	11877	4.04	8.78	0.46	0	89.49	86.90
665	23.52	22.78	930	3.42	10.40	0.32	0	91.19	86.54
312	17.00	31.50	789	5.74	13.35	0.42	0	91.30	96.10
581	14.59	23.38	1342	5.94	17.61	0.33	0	95.93	90.71
482	17.04	22.98	976	3.85	11.14	0.34	0	87.98	84.98
271	14.03	22.41	714	4.43	11.98	0.36	0	94.04	93.32
176	14.24	30.66	482	3.57	9.15	0.38	0	97.81	98.25
209	16.25	26.67	503	3.13	8.01	0.39	0	93.92	91.30
235	10.10	27.09	846	4.57	12.57	0.36	0	95.48	91.04
2931	16.06	25.14	6582	4.30	11.92	0.36	0	93.46	91.53
438	14.05	34.74	1567	4.27	8.49	0.50	0	94.39	88.45
228	16.09	33.52	679	4.25	8.86	0.47	0	93.54	93.18
378	17.44	35.81	1090	4.43	8.81	0.50	0	97.39	92.41
503	18.37	24.95	1177	4.55	10.59	0.42	0	98.87	96.23
1547	16.39	31.96	4513	4.37	9.15	0.48	0	96.05	92.57
8575	16.03	29.01	22972	4.17	9.72	0.43	0	88.94	89.39
7	3.93	37.08	109	2.83	4.61	0.60	0	72.50	92.00
236	19.72	40.02	720	5.69	9.46	0.60	0	95.10	92.90
25	8.83	38.52	203	1.46	2.03	0.71	0	96.70	93.80
313	17.34	33.63	1121	5.39	8.67	0.62	0	88.90	85.90
81	12.60	30.64	476	4.39	5.93	0.70	0	87.10	78.90
235	20.02	39.95	781	8.63	12.97	0.66	0	85.00	79.90
103	9.99	49.18	1120	9.14	8.42	1.00	0	73.20	49.80
1000	15.84	38.56	4530	5.43	7.57	0.72	0	85.5	81.88
10620	16.33	29.51	30155	3.81	8.22	0.46	1		

STATUS OF LEPROSY INTEGRATION

District	Total number of PHC	Leprosy managed on all days	%	Drug availability (adequate)	%	Register/Maintenance - upto date	%	Total Number of HSc	Hsc involvement	%
Projects										
Arisipalayam	27	22	81.48	17	62.96	15	55.56	22	20	90.9
Ambalamoola	5	5	100.00	4	80.00	5	100.00	27	20	74.1
Aundipatty	6	6	100.00	6	100.00	6	100.00	42	41	97.6
Dindigul	7	7	100.00	7	100.00	7	100.00	0	0	0.0
Delhi	37	37	100.00	37	100.00	37	100.00	10	10	100.0
Fathimanagar	21	7	33.33	21	100.00	7	33.33	58	42	72.4
Nagepalli	5	3	60.00	5	100.00	5	100.00	55	21	38.2
Trivandrum	5	5	100.00	5	100.00	5	100.00	0	0	0.0
TOTAL	113	92	81.41	102	90.26	87	76.99	214	154	72.0
South TSTs										
Ananthapur TST	86	86	100	78	90.6	80	93	605	260	42.9
Kadapa TST	61	61	100	61	100	52	85.2	437	101	23.1
Nellore TST	59	54	91.5	59	100	54	91.5	477	346	72.5
Tumkur TST	96	96	100	96	100	87	90.6	645	3	0.4
TOTAL	302	297	98.3	294	97.4	273	90.4	2164	710	32.8
BIHAR TSTs										
Dharbanga	14	14	100	14	100	14	100	249	211	84.7
Madhubani	18	16	88.9	18	100	18	100	418	418	100.0
Sitamarhi	13	13	100	13	100	13	100	212	212	100.0
Sheohar	2	2	100	2	100	2	100	33	33	100.0
Siwan	15	15	100	15	100	15	100	302	299	99.0
Gopalganj	11	11	100	11	100	11	100	186	186	100.0
Saran	15	15	100	15	100	15	100	434	417	96.1
Vaishali	12	12	100	12	100	12	100	332	249	75.0
W.Champaran	17	17	100	10	58.8	12	70.6	371	357.0	96.2
E.Champaran	20	20	100	20	100	20	100	313	293	93.6
Purnea	11	11	100	11	100	11	100	278	278	100.0
Kishanganj	8	8	100	6	75	8	100	53	36	67.9
Araria	9	9	100	9	100	9	100	200	160	80.0
Katihar	11	11	100	11	100	11	100	257	234	91.1
Madhepura	7	7	100	7	100	7	100	191	168	88.0
Khagaria	6	6	100	6	100	6	100	150	150	100.0
Saharsa	7	7	100	7	100	7	100	150	150	100.0
Supaul	9	9	100	9	100	9	100	175	146	83.4
Gaya	20	20	100	20	100	20	100	439	439	100.0
Jehanabad	7	7	100	7	100	7	100	121	121	100.0
Nalanda	12	12	100	12	100	12	100	296	296	100.0
Rohtas	13	13	100	13	100	13	100	174	172	98.9
TOTAL	257	255	99.22	248	96.50	252	98.05	5334	5025	94.2
JHARKHAND TSTs										
E. Singhbhum	9	9	100	9	100	8	88.9	250	241	96.4
W. Singhbhum	15	15	100	15	100	13	86.7	312	258	82.7
Saraikela	8	8	100	8	100	8	100.0	164	164	100.0
Gumla & Simdega	19	19	100	19	100	17	89.5	397	394	99.2
Deoghar	8	8	100	7	87.5	6	75.0	181	176	97.2
Godda	7	7	100	7	100	7	100.0	171	171	100.0
Lohardagga	5	5	100	5	100	5	100.0	73	73	100.0
TOTAL	71	71	100	70	98.6	64	90.1	1548	1477	95.4

(Projects, TSTs South-Bihar & Jharkhand) 2003

Wrong Diagnosis (%)	Reregistration (%)	Treatment completion %		Prevalence / 10000	NCDR / 10000	PD Ratio	Duration of disease					
		MB	PB				MB	< 1 yr	> 1 yr	PB	< 1 yr	> 1 yr
		Total	%				%	Total	%	%		
0	0	94.4	96.7	0.87	1.52	0.57	18	72	28	62	92	8
0	0	100	100	0.59	0.74	0.80	3	100	0	2	100	0
6	0	78.5	96.2	0.87	1.1	0.78	9	100	0	20	90	10
0	0	100	100	0.44	1	0.44	7	100	0	36	10	90
0	0	97.18	99	0.09	0.13	0.68	289	75	25	276	65	35
5	0	88.1	0	0	0	0	67	29.8	70.21	219	58.9	41.1
0	0	100	100	1.99	3.68	0.54	4	0	100	28	0	100
0	0	100	99.1	0	0.1	0.00						
1.1	0.1	87.16	85.57	0.31	0.7	0.43		65.6	34.2		59.4	40.6
2	0			2.39	4.53	0.52	162	59.8	40.2	144	84	16
3.2	8.1	89.5	93.6	3.87	8.02	0.48	23	73	27	174	66	34
1.7	2.9	89	100	1.91	3.76	0.50	233			787		
0.7	0	100	92.26	0.45	0.58	0.77	73	60	40	80	95	5
2	2.7	90.7	95.8	2.18	4.25	0.51		61.2	38.8		78.4	21.6
1.8	1.6	89.32	97.9	5.33	9.85	0.54	566	53.2	46.8	697	68.9	31.1
8.4	10.1	78.01	81.8	3.99	8.5	0.46	253	33.7	66.3	696	61.8	38.2
3.2	6.8	90.06	92.95	5.4	12.81	0.42	91	32.4	67.6	283	76.1	23.9
2	7	93.1	95.1	4.32	9.4	0.45	90	44	56	257	85	15
14.1	5.5	81.33	95.3	4.46	11.54	0.38	153	43.3	56.7	513	92	8
3.6	5.9	81.01	79.02	3.38	9.31	0.41	514	18	82	1005	17.8	82.2
13.7	9.8	87.78	76.6	3.66	8.08	0.45	1025	57	43	1738	79	21
5	9.3	84.9	93.59	2.86	5.37	0.53	276	24.2	67.5	160	17	66.3
1.1	1.6	90.7	90.0	4.0	8.1	0.50	321	85.4	14.6	425	95.9	4.1
5	6.3	92.83	92.66	2.98	6.51	0.45	630	91.3	8.8	1178	91.9	8.1
1.1	10.3	86.54	91.19	3.42	10.39	0.32	629	66	34	353	76	24
2.8	1.2	96.1	91.3	5.74	13.35	0.42	66	17.2	82.8	79	1.3	98.7
14	10	90.71	95.93	5.94	17.61	0.33	52	39	61	60	87	13
11.8	12.7	84.98	87.98	3.85	11.14	0.34	529	43.9	56.1	1416	72.3	27.7
4.6	4.5	93.32	94.04	4.43	11.97	0.36	145	69.1	30.9	264	72	28
4	11.9	98.25	97.81	3.57	9.15	0.38	109	34.2	65.8	285	72	28
3.9	4.9	91.3	93.92	3.13	8	0.39	266	64.1	35.9	672	79.1	20.9
5	8.3	91.04	95.48	4.57	12.57	0.36	27	41.4	58.6	107	58.6	41.4
3.4	3	88.45	94.39	4.27	8.49	0.50	376	51.6	48.4	779	71.1	28.9
2.2	2.4	93.18	93.54	4.25	8.86	0.47	272	91.3	8.7	452	97.9	2.1
2.4	7.4	92.41	97.39	4.43	8.81	0.50	323	73.4	26.6	713	60	40.0
2.9	8.1	96.23	98.87	4.55	10.58	0.42	258	49.6	50.4	553	68.2	31.8
5.3	6.8	89.39	88.94	4.17	9.72	0.43	6971	56.3	43.8	12685	71.11	28.9
2.0	1	85.9	88.9	5.4	8.7	0.62	139	68.3	31.6	351	79.8	20.2
4.0	3.0	92.9	95.1	5.7	9.5	0.60	413	27.3	72.7	588.0	75.3	24.7
2.0	3.0	79.9	85.0	8.6	13.0	0.66	439	33.3	66.6	90.0	70.2	29.8
3.0	4.5	93.8	96.7	1.5	2.0	0.71	78	73.0	27.0	149.0	86.5	13.5
2.2	11.6	49.8	73.2	9.1	8.4	1.10	124	67.6	32.4	147.0	70.6	29.4
2.5	1.3	78.9	87.1	4.4	5.9	0.70	183	76.5	23.5	172.0	83.0	17.0
2.0	2.0	92.0	72.5	2.8	4.6	0.60	66	40.0	60.0	112.0	80.0	20.0
2.5	3.7	81.9	85.5	5.4	7.6	0.72	1442	45.9	54.1	1609	53.1	46.9

Annexure 3

Newly registered TB patients in NGO projects and districts – 2003							
Name of the Projects	Total cases	New cases	%	New +ve cases	%	Re-treatment cases	%
NGO projects							
Ambalamoola	33	32	97.0%	14	42.4%	1	3.0%
Aundipatty	73	57	78.1%	48	65.8%	16	21.9%
Dindigul	32	29	90.6%	16	50.0%	3	9.4%
Fathimanagar	16	14	87.5%	6	37.5%	2	12.5%
Nagepalli	22	22	100.0%	10	45.5%	0	0.0%
Trivandrum	17	14	82.4%	12	70.6%	3	17.6%
Arisipalayam	1207	1114	92.3%	298	24.7%	93	7.7%
Delhi	315	222	70.5%	111	35.2%	93	29.5%
Total	1715	1504	87.7%	515	30.0%	211	12.3%
Districts							
Anantapur	5911	4908	83.0%	2811	47.6%	1003	17.0%
Bangalore	2165	1880	86.8%	896	41.4%	285	13.2%
Kadapa	5259	4882	92.8%	2131	40.5%	377	7.2%
Nellore	3030	2461	81.2%	995	32.8%	569	18.8%
Tumkur	2215	1864	84.2%	1156	52.2%	351	15.8%
Total	18580	15995	86.1%	7989	43.0%	2585	13.9%

Annexure 4

Results of Treatment - New sputum positive TB patients on RNTCP (2003)						
Name of the Project	Total New +ve	Sputum converted	Sputum conversion rate	Total cases	Cured	Cure rate
Ambalamoola	25	22	88.0%	25	22	88.0%
Aundipatty	54	24	44.4%	54	42	77.8%
Dindigul	17	14	82.4%	17	17	100.0%
Fathimanagar	4	2	50.0%	4	3	75.0%
Nagepalli	32	27	84.4%	32	30	93.8%
Trivandrum	39	32	82.1%	22	16	72.7%
Arisipalayam	270	246	91.1%	268	215	80.2%
Delhi	85	76	89.4%	34	29	85.3%
Total	526	443	84.2%	456	374	82.0%
Districts						
Anantapur	2726	2464	90.4%	2399	2002	83.5%
Bangalore	859	775	90.2%	711	604	85.0%
Kadapa	2057	1817	88.3%	-	-	-
Nellore	686	572	83.4%	-	-	-
Tumkur	1095	860	78.5%	-	-	-
Total	7423	6488	87.4%	3110	2606	83.8%

Annexure 5

Sputum slides done in projects during 2003							
Projects	Neg.	Scanty	Pos.	T	Neg	Scanty	Pos
Ambalamoola	459	13	32	504	91.1%	2.6%	6.3%
Arisipalayam	2000	97	352	2449	81.7%	4.0%	14.4%
Aundipatty	1243	62	243	1548	80.3%	4.0%	15.7%
Dindigul	719	9	65	793	90.7%	1.1%	8.2%
Delhi	3238	98	591	3927	82.5%	2.5%	15.0%
Fathimanagar	297	24	45	366	81.1%	6.6%	12.3%
Kavali	1693	69	461	2223	76.2%	3.1%	20.7%
Nellore	1383	79	288	1750	79.0%	4.5%	16.5%
Nagepalli	643	35	162	840	76.5%	4.2%	19.3%
Trivandrum	839	10	28	877	95.7%	1.1%	3.2%
Pavagada	408	11	58	477	85.5%	2.3%	12.2%
Vandavasi	33	7	10	50	66.0%	14.0%	20.0%
Total	12955	514	2335	15804	82.0%	3.3%	14.8%

Annexure 6

Variation in sputum microscopy in NGO projects - 2003								
Projects	Total slides	HFP	SFP	% FP	HFN	SFN	% FN	QE
Ambalamoola	82	0	0	0	0	5	6.9	0
Arisipalayam	342	1	4	5.5	0	1	0.4	3
Aundipatty	218	0	0	0	0	1	0.68	0
Dindigul	100	0	0	0	0	0	0	1
Delhi	543	3	2	3.47	3	0	0.36	9
Fathimanagar	103	0	0	0	0	0	0	0
Kavali	302	0	3	2.56	1	5	3.24	4
Nellore	246	1	6	8.3	1	2	2.46	1
Nagepalli	137	0	0	0	0	1	1.13	1
Trivandrum	131	0	0	0	2	7	7.3	0
Vandavasi	38	0	1	9.0	0	1	3.7	1
Total	2242	5	16	3.3	7	25	1.98	20

DAMIEN FOUNDATION INDIA TRUST - DISTRICT TECHNICAL SUPPORT TEAMS

TST	ADDRESS	TST	ADDRESS	TST	ADDRESS
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Andhrapradesh - Support to NLEP & RNTCP-Training, Supervision & Monitoring

Anantapur	D. No. 3-250-3 Maitri Nilayam Topova Nagar, NH-7, Bypass Road, Anantapur - 515 004 Ph : 08554-243591 E-mail - dfittstatp@yahoo.com	Kadapa	7-201-A, NGO Colony, Kadapa - 516 002 Ph : 08562-253285	Nellore	Urban Leprosy Centre Bakthavachala Nagar A.K. Nagar Post Nellore - 524 004. Ph : 0861-2325163 E-mail : dfulcnlr@sanchamet.in
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Karnataka - Support to NLEP & RNTCP-Training, Supervision & Monitoring

Tumkur	District Laboratory Building District Hospital Compound, Tumkur Ph : 080-34445303 (R) E-mail - swajapa@yahoo.com	Bangalore Urban-	No. 69, 4th Main, 5th Cross, 1st Stage, Rajaji Nagar Industrial Town Bangalore - 560 044 Ph : 080-3209903		
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Bihar - Support to NLEP - Training, Supervision & Monitoring

Araria	C/o. New Vaishali Medical Agency, Hospital Road, Araria Ph : 06453-222247	Dharbanga	C/o. Pallavi STD Booth, Khaja Sarai, Laharia Sarai, Dharbanga - 846004 Ph : 06272-242008 06272-245017	Madhubani	C/o. District Leprosy Officer, Sadar Hospital Madhubani, Ph : 06276-222156 - C/o. Hotel Sumanta, Room No. 107
Siwan	C/o. Sri. Chandeshwar Prasad Singh (Rtd. CID Inspector) Fatehpur, Durga Mandir, Siwan 841 226 Ph : 06154-223951	Katihar	C/o. Jawaharlal Yadav, Parabagan, Bari Durga Asthan, Katihar 854 105 Ph : 06452-234704 223848, 228748	Gopalganj	C/o. Narendra Kumar Bikram Sadan Thane Road, Gopalganj - 841 428 Ph : 06156-226322
Saran	C/o. Ashok Kumar Dubey, Ratanpura, Jaiprakash Nagar, Chapra, Saran 841 301. Ph : 06152-226081	Nalanda	C/o. Mr. Ramachandra Prasad, Rajgir Block Morh, Saidpur Rajgir - 803 116 Ph : 06112-255898	Gaya	C/o. Mr. B.M. Mishra, MIG 43, Near Temple, Chanakyapuri Colony, Gaya - 823 001. Ph : 0631-2432761
Sitamarhi & Sheohar	C/o. Shri. Laxman Singh, Bank Colony, Anand Nagar, Dumra Road, Sitamarhi 843 302. Ph : 06226-253359	Jehanabad	C/o. Sanjay Medical Professors Colony, Malha Chowk, Jehanabad, 804408 Ph : 06114-222205 Cell : 9431289676	Purnea	C/o. Mr. Arjun Prasad Sinha, Sepahi Tola, Chunapur, Street No. 1, Purnea-Bihar-854301 Ph : 06156-226322

TST	ADDRESS	TST	ADDRESS	TST	ADDRESS
Rohtas	C/o. Sanjay Kumar Singh, Next to Prakash Pump, G.T. Road, Sasaram- 821 115 Ph : 06184-224159	Madhepura	C/o. Mr. Chandan Kumar Yadav, Teacher, Nia Toli, Near Block Office, Madhepura - Ph : 06476-224233	West Champaran	C/o. Jagdish Narayan Shukla, New Colony, Dack Bunglow Road, Bettiah, W. Champaran, - 845 438 Ph : 06254-23362
East Champaran	C/o. Dr. Harikishore Verma, Agarawa, Motihari East Champaran Ph : 06252-223710 (P.P.)	Supaul	C/o. Rasbihari Choudari, Ward No. 2, Kachari Road, Supaul - Ph : 06473-223055	Saharsa	C/o. Dr. C.M. Chaoudary, Ganjala, Panchavadi chowk Saharsa Ph : 06478-224173 06478-228536
Khagaria	C/o. Shri. Lalbabu, Advocate Near Town Hall, Chitragupta Nagar, Khagaria Ph : 06244-229047	Kishanganj	C/o. Azad Razak, Milanpalli Village, Kajala Mani, Kishanganj - 855107 Ph : 06456-223816		

Bihar - Support to NLEP & RNTCP - Training, Supervision & Monitoring

Vaishali	C/o. Sri. A.K. Sinha, S.D.O. Road, Near to Veterinary Hospital, Hajipur, Vaishali - 844 101 Ph : 06224-273864				
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Jharkhand - Support to NLEP - Training, Supervision & Monitoring

Gumla	C/o. Sri. Bendheshwar Prasad Teacher, Lohardagga Road, Dunderiah, P.O. & District Gumla- 835207 Ph : 06524-221839	Deoghar	C/o. Sri. Dilip Jha's, New Building, Shivapuri, Bilasy-Deoghar- - 814117 Ph : 06432-225627 06432-220973 (DLO) (O) Cell : 09431157880	Lohardagga	New Road, Lohardagga, Near Little Flower School Lohardagga- Ph : 06526-223461
Singhbhum West	C/o. Dr. Durga Saran Near Janatha Soap Factory NIMDIH, CHAIBASA West Singhbhum- 833201 Ph : 06582-256184 Cell : 94311-96316	Singhbhum East	C/o. Abhijeeth Chandra Chanda, Qr. No. 18, Gandhi Marg, Dev Nagar Near Bharadwari Jamshedpur - 1 Ph : 0657-2440571 Cell : 98351-31583	Godda	C/o. Shanthi Niketan,, West Side of DC Office Godda - 814113 Ph : 06422-220656 223376 PP 222753

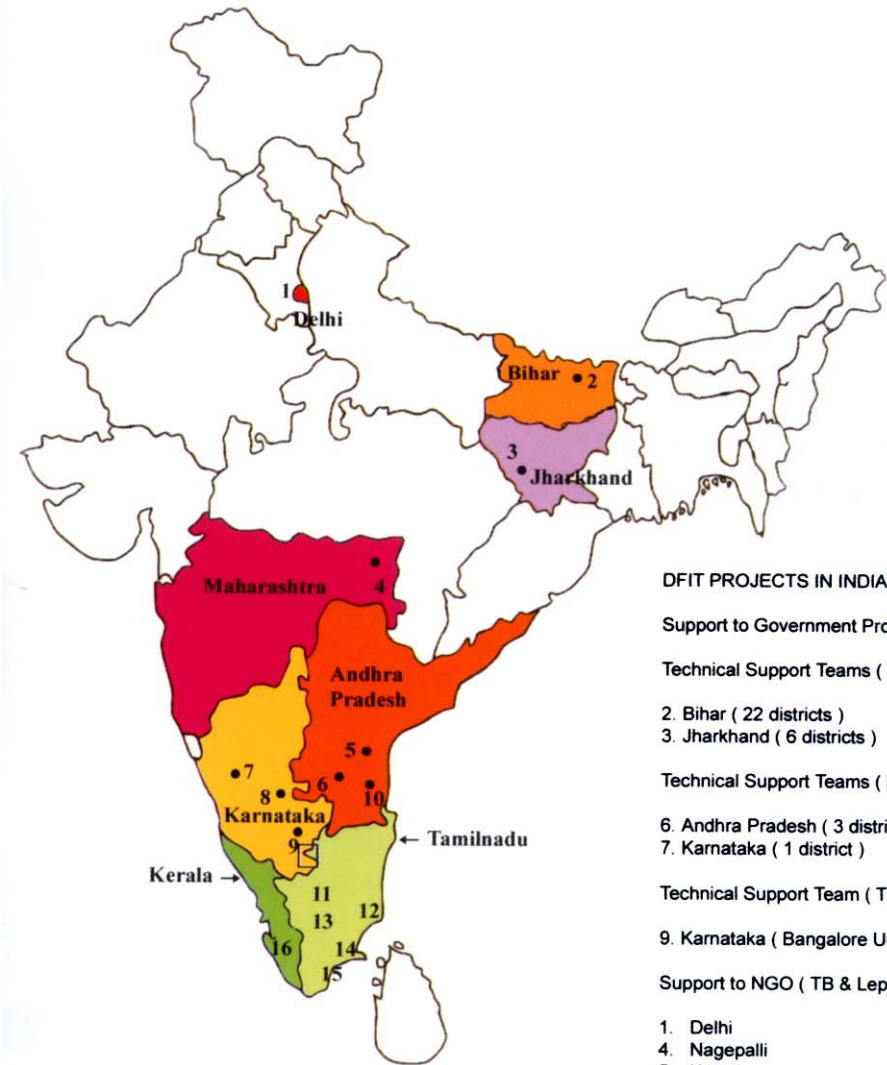
PROJECT	ADDRESS	AREA OF OPERATION	ACTIVITIES		Specialities	Personnel
			LEPROSY	TUBERCULOSIS		
DAMIEN FOUNDATION INDIA TRUST- HEAD OFFICE: CHENNAI	New No: 14 (Old No:27) Venugopal Avenue, Spur Tank Road, Chetput - 600 031 Ph: 044- 28360496 044- 28361910 Fax: 044- 28362367 E. Mail : damienin@vsnl.com	12 Projects District Technical Support Teams: South : Andhra Pradesh : 3 Karnataka : 2 North : Bihar : 22 Jharkhand : 6	Support to NLEP in Planning, Training and POD programme Supervision and Monitoring, Evaluation and Research	Support to RNTCP in Planning, Training Supervision, Monitoring, Evaluation and Research		Office : 16
DAMIEN FOUNDATION INDIA TRUST - NORTH OFFICE RANCHI, JHARKHAND	Indian Medical Association Campus, Near Karamtoli Chowk Morabadi, Ranchi-834008 Ph : 0651-2360714 Fax : 0651-2360315 E-mail : rch_dffiran@sancharnet.in rch_dffihar@sancharnet.in	District Technical Support Teams : Bihar - 22 Jharkhand - 6	Support to NLEP in Planning, Training and POD programme Supervision Monitoring, and Evaluation.	Support to RNTCP in Planning, Training Supervision, Monitoring, Evaluation in Vaishali District		Office : 12 Technical Team Staff 87
DAMIEN FOUNDATION INDIA TRUST - PATNA BIHAR	House No. J-13, P.C. Colony Kankar Bagh, Patna Bihar - 800 020 Ph : 0612-2343841 0612-2367183 (R) E-mail : dfitpat@Sancharnet.in					Office : 2
AROGYA AGAM AUNDIPATTY TAMILNADU	Theni District, Tamil nadu - 625512 Ph : 04546-242306 Fax : 04546-244311 E-mail : info@arogyaaagam.org	6, Municipalities (Theni, Cumbum, Bodi, Periakulam and Kodaikanal)	Support to NLEP in Urban and Rural Training and POD Programme Supervision and Monitoring.	RNTCP Microscopy Centre for TB Resource Organisation for 4 NGO run Microscopic Centres Supervision and Monitoring.	In-patient care facilities for leprosy and Tuberculosis No. of beds 35	7
ST. MARY'S LEPROSY CENTRE ARISIPALAYAM TAMILNADU	Salem - 636009 Ph : 0427-2352645 E-mail smicsm@eth.net	Salem Corporation Namakkal Urban & Rasipuram Urban	Support to NLEP Training and POD activities, Supervision and Monitoring.	Microscopy Centre, Tuberculosis Unit Covering 5,00,000 Population Support to RNTCP in Training, Supervision & Monitoring.	In-patient care facilities for leprosy and Tuberculosis No. of beds 22	11
POORNASUKHA LEPROSY PROJECT St. JOSEPH HOSPITAL DINDIGUL TAMIL NADU	P.B.No. 75,Trichy Road Dindigul, Tamilnadu-624001 Ph : 0451-2430399 0451-2430998	Dindigul Urban, Palani Urban, Karur Urban & Kulithalai Urban	Support to NLEP Training and POD activities, Supervision and Monitoring.	Microscopy Centre, Support to RNTCP in Training, Supervision & Monitoring the Programme.	In-patient care facilities for leprosy and Tuberculosis No. of beds 10	8
HOLY FAMILY HANSENIUM FATHIMA NAGAR TRICHY TAMILNADU	Fathima Nagar, Thiruchirappalli Tamilnadu-620012 Ph : 0431-2680222 0431-2680033 E-mail: ritasr@sify.com	Thiruchirappalli & Pudukottai	Out Patient and in patient care Training in leprosy and POD, Technical Support to Urban Health Post Reconstructive Surgery and Rehabilitation.	Tuberculosis treatment Programme for 35,000 Population around the Project area.	In-patient care facilities for leprosy and Tuberculosis Reconstructive Surgery for leprosy patients No. of beds 70	11

PROJECT	ADDRESS	AREA OF OPERATION	ACTIVITIES		Specialities	Personnel
			LEPROSY	TUBERCULOSIS		
ASSISI SEVA SADAN HOSPITAL NAGEPALLI MAHARASTRA	Allapalli Post, Gadchiroli District Maharashtra-442703 Ph : 07133-266461	Rural Nagepalli	Support to NLEP Training and POD activities.	Microscopy Centre, Support to RNTCP in Training, Supervision & Monitoring the Programme.	In-patient care facilities for leprosy and Tuberculosis No. of beds 4	14
St. JOHN'S HOSPITAL & LEPROSY SERVICES PIRAPENCODE KERALA	Pirapencode Post Trivandrum Dist. Kerala - 695 607 Ph : 0472-2872047 Fax : 0472-2872378 E-mail : stjpp@vsnl.net	Trivandrum Urban	Technical Support to NLEP in Trivandrum Dt. Training, Supervision, Monitoring & POD activities.	Microscopy Centre, guiding & providing Technical Support to RNTCP Programme Supervision & Monitoring the programme. in Trivandrum District.	In-patient care facilities for leprosy and Tuberculosis Reconstructive surgery facility for leprosy patients No. of beds 38	5
DAMIEN FOUNDATION URBAN LEPROSY & TUBERCULOSIS NELLORE ANDRAPRADESH	Bakthavatchalam Nagar, A.K. Nagar Post Nellore - 524004 Ph : 0861-2325163 E-mail dfulcnlr@sancharnet.in	Nellore Urban	Support to NLEP Training & POD activities	Microscopy Centre Support to RNTCP in Training Supervision & Monitoring the Programme	Inpatient care facility for leprosy and Tuberculosis, Reconstructive surgery No. of beds 10	11
RURAL HEALTH CENTRE ASANIKETAN KAVALI ANDRAPRADESH	Vengal Rao Nagar Kavali, Andhrapradesh-524202 Ph : 08626-241403 E-mail : asanikethan2netlinx.com	Rural Kavali	Support to NLEP Training & POD activities supervision & Monitoring	Tuberculosis Unit, Support to RNTCP in Training Supervision & Monitoring the Programme	Inpatient care facility for leprosy and Tuberculosis, No. of beds 6	7
SWAMI VIVEKANANDA INTEGRATED RURAL HEALTH CENTRE PAVAGADA KARNATAKA	Sri Ramakrishna Sevashram, K.R. Extension Tumkur - Pavagada Karnataka 561202 Ph : 08136-244548 08136-244030 E-mail : swajapa@yahoo.com	Pavagada Taluk Tumkur Dist.	Support to NLEP Training & POD activities supervision & Monitoring	Tuberculosis Unit, Support to RNTCP in Training Supervision & Monitoring the Programme	Inpatient care facility for leprosy and Tuberculosis, Reconstructive surgery facilities for leprosy patients No. of beds 25	12
NILGIRIS WYNAAD TRIBAL WELFARE SOCIETY AMBALAMOOLA TAMILNADU	Ambalamoola post Via Bitherkad, Gudalur Taluk Nilgiris - 643 240 Ph : 04262-224558 E-mail : nwtws@hclinfinet.com	Ambalamoola Rural	Support to NLEP Training & POD activities Supervision & Monitoring	Tuberculosis programme treatment programme	Inpatient care facility for leprosy and Tuberculosis, No. of beds 12	3
MARGARET LEPROSY & TB CENTRE DAMIEN FOUNDATION INDIA TRUST- LEPRO-INDIA NEW DELHI	Qutub Vihar Phase I, Goyela Diary Main Rd. Near Police Checkpost Najafgarh-110 071 Ph : 011-25319112 011-25319123 011-55492609 E-mail : dfitlepdelhi@vsnl.net	South & South west Districts New Delhi	Support to NLEP Training Supervision & Monitoring	Tuberculosis Unit for 5,00,000 Population. Microscopy Centre, DOTS Centre, Support to RNTCP in Training, Supervision and Monitoring the programme	Inpatient care facility for leprosy and Tuberculosis, No. of beds 10	10

GLOSSARY

AO : Administrative Officer; Accounts Officer	MPR : Monthly Progress Report
AMDT : Accompanied MDT	NCDR : New Case Detection Rate
APHC : Additional Primary Health Centre	NGO : Non Government Organisation
CAO : Chief Administrative Officer	NLEP : National Leprosy Eradication Programme
CFO : Chief Financial Officer	NMA : Non Medical Assistant
CLS : Central Laboratory Supervisor	NMS : Non Medical Supervisor
CMA : Chief Medical Advisor	NLR : Netherlands Leprosy Relief
DFIT : Damien Foundation India Trust	PB : Paucibacillary
DGDC : Directorate General for Development Co-operation	PBA : PB Adult
DLA : District Leprosy Advisor	PBC : PB Child
DLO : District Leprosy Officer	PD Ratio : Prevalence Detection Ratio
DLT / A : District Leprosy / Tuberculosis Advisor	PHC : Primary Health Centre
DTO : District Tuberculosis Officer	PMW : Para Medical Worker
DTST : District Technical Support Team	PO : Project Officer
FI : Field Investigator	POD : Prevention of Disability
IEC : Information, Education, Communication	PR : Prevalence Rate
ILEP : The International Federation of Anti Leprosy Association	PT : Physiotechnician
IUATLD : International Union Against Tuberculosis and Lung Diseases	QA : Quality Assurance
LCU : Leprosy control Unit	QC : Quality Control
LEC : Leprosy Elimination Campaign	RFT : Released From Treatment
LEM : Leprosy Elimination Monitoring	RMDT : Regular Multi Drug Therapy
LEPRA : Lepa India	RNTCP : Revised National Tuberculosis Control Programme
LT : Laboratory Technicain	SC : Subcentre
MA : Medical Advisor	SD : Standard Deviation
MB : Multibacillary	SLO : State Leprosy Officer
MBA : MB Adult	SMA : Senior Medical Advisor
MBC : MB Child	SSL : Single Skin Lesion
MC : Microscopy Centre	STS : Senior Tuberculosis Supervisor
MDT : Multi Drug Therapy	STLS : Senior Tuberculosis Laboratory Supervisor
MLEC : Modified Leprosy Elimination Campaign	TST : Technical Support Team
MO : Medical Officer	TT : Technical Team
	TU : Tuberculosis Unit
	ULC : Urban Leprosy Centre
	WHO : World Health Organisation

Projects Supported by Damien Foundation India Trust



DFIT PROJECTS IN INDIA

Support to Government Projects

Technical Support Teams (Leprosy)

2. Bihar (22 districts)

3. Jharkhand (6 districts)

Technical Support Teams (Leprosy & TB)

6. Andhra Pradesh (3 districts)

7. Karnataka (1 district)

Technical Support Team (TB)

9. Karnataka (Bangalore Urban)

Support to NGO (TB & Leprosy)

1. Delhi

4. Nagepalli

5. Kavali

10. Nellore

8. Pavagada

11. Ambalamoola

13. Arisipalayam

12. Fathimanagar

14. Dindigul

15. Aundipatty

16. Trivandrum

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