ACTIVITY REPORT 2005

DAMIEN FOUNDATION INDIA TRUST

Farewell to President, DFB by DFIT Trustees

PREFACE

Yesterday is history. But the good deed done continues to reverberate, inspiring at least some to greater deeds and giving contentment to others. We learn more from the past than we tend to admit. That is why we spend time chronicling our past actions. The reflections are rewarding for some, lessons for others.

It is time to tell you what we did in 2005.

Predictably, leprosy has become like any other manageable public health problem. Integration has been a success. There is now a different perception to leprosy. The expansion and coverage of TB control has been far beyond anyone's imagination. These programmes stand as good examples of successful collaboration between public and private enterprises. The reciprocally rewarding enterprise has brought out the best in the programmes, has revealed that quality service need not be a dream and that excellence becomes tangible only when all the needs of the service recipients are realised. The projects supported by Damien Foundation have strived with unwavering focus and great success in skill transfer and transformation among the general health staff who are the pivotal elements in providing service to those in need. We appreciate their continued effort to provide quality secondary and tertiary care services to those affected with the consequences of leprosy. We appreciate the unending endeavour of the Damien Foundation fraternity in providing joy and happiness to thousands through their timely intervention and guidance. We are grateful to Damien Foundation Belgium, the people of Belgium, the Government of Belgium, European Union and Government of India for their unstinted support to the common cause. We thank the trust members for their time, trust and guidance.

P. Krishnamurthy
Secretary, DFIT

CONTENTS

1. INTRODUCTION:

Considering the fact that there was a substantial reduction of leprosy disease burden in the country and taking into account the inherent strengths, the role of Damien Foundation India Trust (DFIT), a Non Governmental Organisation (NGO) and a subsidiary of Damien Foundation Belgium (DFB), which is a member of International Federation of anti-leprosy associations (ILEP), had to become less broad-based and more need-based. DFIT operates through its projects, which it supports both financially and technically. Even though there is no limit to the array of activities that an NGO can engage in, DFIT has restricted its commitment to leprosy and TB for various reasons including its long experience and extensive expertise in these two diseases. Mandate for the projects involved in leprosy control was to establish a sustainable mechanism of delivering primary and secondary leprosy care services in the general health system in the area identified for the project, district or part of the district, while themselves providing specialised referral service to persons suffering from leprosy-related complications. For the projects involved in TB control the responsibility ranged from providing service directly to population ranging from 100000 to 1000000 to providing support to the leprosy and TB control programmes at various levels. DFIT is involved in the two important national programmes through its projects- 12 NGO centres (including two own-operated) and 36 District Technical Support Teams (DTSTs).

2. PROJECTS AND PERSONNEL:

Damien Foundation India Trust has two distinct types of projects - centres that are directly operated or run by NGO and doing leprosy or leprosy and TB work, and District Technical Support Teams (DTST). There are 10 NGO centres in south India and 2 in the north. Leprosy services provided by the NGO centres range from training general health care staff, managing patients with complications referred from Government health centres, surgical correction of deformities to providing support to the general health system in establishing Prevention of Disability (POD) services. TB services offered by the NGO centres include managing patients through Microscopy centres and offering supervisory support as TB Units (TU). Some of the NGO centres have taken up additional activities like HIV/AIDS. The DTST first

Action Plan Meeting (South)

established in Bihar in 1996 provide support to leprosy and /or TB control programme in all its major activities. Totally 22 districts in Bihar, 8 in Jharkhand, 3 in Andhra Pradesh, 2 in Karnataka and 1 in Kerala are covered by DTSTs. Additional manpower with mobility support has been placed in Andhra Pradesh, Bihar and Jharkhand to support TB control activities. The teams in Jharkhand were withdrawn in October 2005 for reasons that were not programme-related. Total numbers of personnel working for DFIT is 283 consisting of 39 Medical Officers (MO), 66 Supervisors, 10 paramedical workers (PMW), 23 lab technicians (LT), 7 Physiotechnicians (PT), 61 drivers, 11 hospital staff and 66 administrative staff. All the personnel are well trained and experienced. The main office located in Chennai monitors and supervises all the projects. It has a Chief Medical Advisor (CMA) supported by Chief Medical Consultant (CMC) and Medical Advisor (MA) for POD, Field Investigator and Central Lab Supervisor for monitoring and supervising the projects in the South and planning various research projects. There is also an office at Ranchi, which is headed by Chief Medical Advisor for north and its responsibility is to monitor and supervise the projects in Bihar and Jharkhand. The Chief Medical Advisor in the north is assisted by Senior Medical Advisors (one for each of the 4 zones) who are responsible for supervising the District Technical Support Teams in their zones. Each DTST has one District Medical Advisor and one or more Non Medical Supervisors (NMS) for covering one or two districts. Mobility is provided to both Medical officers and supervisors. A senior Lab Supervisor is placed at Patna. The Secretary manages the trust with guidance from members of the board. The financial monitoring is done by Chief Financial Officer located in Chennai and is supported by Accounts officers, one each for North and South. Supervisors from headquarters regularly visit the projects for assessing the progress. Medical advisor from Damien Foundation Belgium also makes an annual visit to review the progress.

3. ACTIVITIES:

Competence development of programme personnel and medical students through on-the-job training, information dissemination through quarterly bulletin- UPDATE and seminars; provision of service to leprosy and TB patients with or without complications; reconstructive surgery for patients with deformities; operational

Seminar on Leprosy by Post Graduate Medical Students

research in critical areas of common concern are some of the important activities carried out by the projects in 2005. Support to BAM India project at Wasirganj in Gaya was withdrawn. Support to Aundipatty was restricted to hospital based activities. It was also decided to provide support to POD activities in the southern districts and Bihar through the DTST. DFIT has succeeded in establishing reconstructive surgery service in two Medical College hospitals (Patna and Dharbanga) in Bihar.

Table.1 DFIT-supported projects by type of activities

Projects	Hospital care for leprosy	Referral service	Hospital care for TB	Field programme TB	Support to TB (District)	Support to Leprosy (District)	Support to POD	Support to urban leprosy
Amda	✓							
Ambalamoola, Aundipatty,	✓		✓					
Chilakalapalli	✓		✓					
Dindigul	✓			✓				✓
Fathimanagar	✓	✓	✓	✓			✓	✓
Arisipalayam	✓	✓	✓	✓	✓		✓	✓
Nellore	✓	✓	✓	✓			✓	✓
Kavali	✓			✓			✓	
Pavagada	✓	✓	✓	✓			✓	
Nagepalli	✓	✓	✓	✓				
Delhi				✓		✓		
DTST Bihar (22 Districts)						✓		
DTST Bihar (22 Districts)					✓			
DTST Jharkhand (8 districts)						✓		
DTST Jharkhand (8 districts)					✓			
DTST Andhra Pradesh (3 districts)					✓	✓	✓	
DTST Bangalore Urban					✓			
DTST Tumkur					✓		✓	
DTST Trivandrum					✓			

4. PROGRESS IN 2005 - NGO CENTRES:

4.1. Ambalamoola

(Nilgiris Wayanad Tribal Welfare Society, Ambalamoola post, via Bitherkad, Gudalur Taluk, Nilgiris-643240,

E-Mail : oty_nwtwse@sancharnet.in
Project Holder : Dr. N.C.Wilson) Budget: Rs. 357552

The project at Ambalamoola is located in the Nilgiris district of Tamil Nadu in the hilly and densely forested area bordering the Wayanad district in Kerala. The Project manages tuberculosis control in a predominantly tribal population of about 100,000 through its Microscopy and treatment centre in the 12-bedded base hospital, two sub-centres, and a network of community DOT providers. Leprosy control has been integrated with primary health care in Tamil Nadu and the project continues to support the local PHCs (in Tamil Nadu and Kerala) to diagnose and treat leprosy. The Nilgiris district in which the project is situated has been low endemic right from the start of the MDT programme, but pockets of leprosy were found in the tribal community with an incidence as high as 40/1000 in 1987. The project immediately implemented a leprosy control with technical and financial assistance from Damien Foundation India Trust and the NCDR has progressively decreased over the last 15 years and stands at 0.14 (1 case in 70,000 in the SET area) in 2005. The project was also recognised as a SET centre for the NLEP by the Tamil Nadu government in 1993 and continues to serve as a resource centre for leprosy control in the district. The neighbouring Wayanad district still throws up leprosy cases among tribals due to a combination of reasons, one of them being not enough commitment to leprosy control in that district. The project, therefore, continues to register a small number of leprosy cases annually, almost all of them tribal and from Kerala and a majority of whom are multi-bacillary (bacteriologically positive). The project notified 2 cases (1 MB and 1 PB) in 2005. Three MB cases, all tribals, all smear positive and reported from outside the project area were treated at the centre. The hospital provides quality health care services accessible to the tribal community. DFIT supports the project with an annual grant-in-aid to manage leprosy and TB inpatients. The project provided MCR footwear to 15 patients.

Case validation by DTST

The project registered 42 TB cases (23 cases from Tamil Nadu and 19 cases from Kerala) in 2005 of whom 33 (79%) were new sputum positive. 39/42 (93%) were from the tribal community. TB case finding by the project compares to 8.8% (23/262) of all TB cases notified by the corresponding TB unit in 2005. The sputum positivity rate in the laboratory was 11% and the cure rate for patients diagnosed in 2004 was 89% (16/18). A total of 474 patients were treated as in-patients in the hospital in 2005 out of which 7 were for leprosy related complications and 37 for TB. Out of the 2018 bed days for inpatients 211 was for TB and 57 was for leprosy, together accounting for 13.33% of the total bed days.

4.2. Amda

(Claver Social Welfare Centre, Claver Bhavan, P.O. Amda, Saraikela, Kharswan, Jharkhand – 833 101. Director : Fr. Ranjeet Kindo) Budget: Rs. 1352341

This is one of the oldest projects supported by DFIT. It is located in Saraikela in Jharkhand and functions as part of the District Technical Support Team for the district supporting both leprosy and tuberculosis control in addition to managing leprosy patients with complications referred from the Primary Health Centres (PHC). The centre has a ward with 12 beds. Before integration the project used to detect on an average 1000 new cases every year in a population of 238000 covered by it. There is a large number of multiple case families in the area. There is also a high incidence of reaction among the cases. The project manages on an average 50 to 100 patients with reaction every year. It covered one block for assessing the magnitude of leprosy-related disabilities in the population by doing a survey of known cases living in the area. The block has 2724 cases on record from the beginning of the project. As per the record 98 of these cases had grade 2 disability and 91 grade 1 disability. If one extrapolates to the district one would expect about 1000 cases with disability in a district with a population of 1500000 (7.5 living cases with disability per 10000 population). Out of the 2724 cases 898 were screened by the project in three months from January 2005. Among them were 28 cases (3.1%) with grade 1 disability and 70 (7.8%) with grade 2.

POD camp

4.3. Arisipalayam

(St. Mary's Leprosy Centre, Arisipalayam, Salem – 625 512.
E.Mail : smlcslm@eth.net
Administrator : Sr. Francisca)
Budget: Rs. 2055429

The main activities of the project in leprosy control are management of leprosy cases with complications, managing TB cases through its TB Unit with six microscopic centres, competence development of the general health staff in Salem town in implementing leprosy control, capacity building of the staff in the district in managing patients with disabilities, supervisory support to TB unit in the town, and dissemination of information regarding leprosy and TB control to the general population through voluntary youth groups.

The project has realised the objective of establishing leprosy services in the 21 corporation dispensaries and the district hospital through continuous on-the-job training and guidance. It manages complicated cases including those in reaction referred by the Government health centres. It has trained several youth groups and women self-help groups in spreading correct messages about leprosy and TB, referring suspects and supervising treatment. The groups voluntarily arrange group talk to women, railway employees, and truck drivers, etc. They held street corner voluntary reporting camps and street plays resulting in the voluntary reporting of 750 leprosy suspects out of whom 6 MB and 33 PB cases were diagnosed. What is noteworthy is the active participation of corporation councillors in these activities. The most significant achievement of the project is the successful transfer of skills to the general health staff in managing patients with disability. This has been possible due to the excellent collaboration between the Government and the project. Initially 21 PHCs in 5 blocks (70 PHCs in the district) have been covered. There were 675 patients with disability (601 grade 2 and 74 grade 1). All the 114 Village Health Nurses (VHN) in the 21 PHCs were involved in POD activities. Out of the 675 patients 530 (78.5%) were found to be practicing self-care regularly. Out of the 571 pairs of footwear provided in the district 446 were contributed by volunteers which is highly appreciable and the rest by the project. This is in addition to 60 pairs of footwear supplied by District Leprosy Society. The programme will be extended to the entire district by the end of 2006.

The good data generated by the programme staff enables one to estimate the size of disability problem. One would expect 12 living cases with disability problem per 10000 population in a highly endemic district like Salem.

This project assists two more urban areas (Namakkal and Rasipuram) in establishing MDT service as per request from Government of Tamilnadu. The project also manages Tuberculosis cases from 100000 population (Microscopy Centre) allotted to it in addition to providing TB Unit support to the whole town (population of 550000) as per guidelines of Revised National TB Control Programme (RNTCP). It has one Medical Officer (MO), one Senior TB Supervisor (STS) and one Senior TB Lab Supervisor (STLS) who report directly to the District TB Officer (DTO). Involvement of the Medical practitioners and community in the programme is very good in the city.

Table.2 Community involvement in RNTCP in Salem town

Category of community involved (1)	Number involved (2)	Suspects referred by them (3)	TB cases diagnosed from (3) (4)	Function as DOT providers (5)
General practitioners	55	285	22	14
Registered Medical Practitioners	5	20	2	5
Hospitals	8	142	18	0
Volunteers	42	600	120	42
NGOs	6	50	20	1

In 2005 general practitioners (55) referred 285 suspects out of which 22 cases were registered. 5 registered medical practitioners referred 20 suspects and 2 found to be TB cases. 8 hospitals, 42 volunteers and 4 NGOs referred 142, 600 and 50 suspects from whom 18, 120 and 20 TB cases respectively were registered.

The project was involved in training 45 Medical college students, 200 nursing students, 385 college students, 30 Medical Officers. Sensitisation training was given to 750 members of women's self help group. A total of 102 physiotherapists - BPT and 20 Non Medical Supervisors (Tamil Nadu state) and 209 VHNs (Salem district) were given training in POD.

Health Education to volunteers

4.4. Aundipatty

(Arogya Agam, Theni District,
Aundipatty – 625 512
E.Mail : info@arogyaagam.org
Secretary – Mr. John Dalton)
Budget: Rs. 1205778

Arogya Agam in Aundipatty in Theni district of Tamil Nadu introduced MDT in the project area (238992 population) in 1983. Following integration, leprosy work was handed over to the Government. The project has multifarious social developmental activities and leprosy, TB and HIV/AIDS are some of them. It has networked with other similar, well-meaning NGO in the district to address several important social issues plaguing the area. There were 29 leprosy cases (14 smear positive), which were diagnosed and referred to the PHCs for treatment. In the area, which was covered by the project before integration, there were 428 cases with disabilities who were not being taken care of. The project could focus on 95 cases and ensure that they were following self-care regularly. Involvement of the General health staff in POD programme is negligible. It has 35 beds for inpatient management. The hospital admitted 214 leprosy cases and 7 TB cases. MCR footwear was provided to 216 leprosy patients.

The centre functions as a microscopy centre under RNTCP covering a population of 120000. There were 30 cases registered in 2005 of which 12 were new sputum positive. Conversion was 92.3% and Cure rate was 79.3%.

The project has taken a lead to extend leprosy and TB work into the field of HIV/AIDS prevention and care and has relocated its staff for this.

"The aim of leprosy control should be the reduction not only of disease burden but of disability burden too."

Group Talk

4.5. Chilakalapalli

(Gandhi Memorial Leprosy Foundation, Chilakalapalli P.O. Balijipeta, Vizianagaram Dist – 535 557.
E.Mail : gmlfclp@inbox.com

Project Holder - Mr. Appala Naidu) Budget: Rs. 360762

Located in Vijayanagaram district of Andhra Pradesh the project is operated by GMLF in Wardha. The project was covering a population of 148385 before integration was announced. The area covered by the project was highly endemic for leprosy with a large number of cases with disability. There are 196 living cases with grade 1 disability and 396 with grade 2 disabilities. The project has 1 MO, 1 NMS and 4 field staff who are involved in field-based POD programme under modified SET scheme of GOI. The POD activities of the project need technical support and guidance. DFIT assists the project through grant-in-aid only for hospital activities. In 2005 the hospital admitted 118 leprosy cases with complications.

4.6. Delhi

(Margaret Leprosy and TB centre, Qutub Vihar Phase-I, Goyela Diary Main Road, Near Police Check Post, Najafgarh, New Delhi – 110 007.
E.Mail : dfitlepdelhi@vsnl.net
Medical Officer : Dr. S.C. Sharma) Budget: Rs. 4179792

The Damien Foundation project in Delhi covering a population of one million in Southwest part of the union territory has been implementing Leprosy control since 1999 and tuberculosis control since 2002. Following integration, leprosy control activities are restricted to supporting the Government in establishing sustainable programme in the district (population of 2031714) and managing patients with complications. The district has 88 urban villages, 83 urban slums, several resettlement colonies and 36 Primary health centres/ urban health centres (UHC) with 381 ANMs. In 2005 the project detected 16 leprosy cases (5 MB). The project had 3 cases with lepra reaction. There were 16 patients with disability who were monitored for self care. Sixteen of them were provided footwear.

The main responsibility of the project in NLEP is to provide support and guidance to the 36 Government health facilities in the area in implementing National Leprosy Eradication Programme. All the centres are visited by the supervisors every month to ensure that the registers are up to date and leprosy cases are reviewed on a sample basis for validity of diagnosis and regularity of treatment. The 36 facilities registered 360 new cases (164 MB) of which 53 (19 MB) were validated by the team and all of them were found to be new cases. Register maintenance in all the centres was good. All were managing leprosy cases.

Since there were no Government health facilities in an area of 1 million population, the Government allotted two TB unit areas to Damien Foundation India Trust each covering a population of around 500000. Recently the Government opened 8 dispensaries which did not have any field staff.

Of the two TB units one was getting financial support from GOI till March 2005. Damien Foundation India Trust declined to accept any financial assistance from April onwards. Except for anti-TB drugs no other assistance is taken from the Government. The project has ten Microscopy centres including the central hospital each staffed by a microscopist-cum-field worker with a motorbike for mobility. Five of the ten workers are basically field workers trained in sputum microscopy whereas the other five are laboratory technicians trained in field work. Surprisingly, none of the field workers with laboratory technician's diploma had been exposed to sputum microscopy during the study course. Therefore all the ten workers were given two sessions of training, each of fifteen days duration, on sputum microscopy. In addition they also underwent regular RNTCP training given by the Government. The project has two senior TB supervisors, one Senior TB Laboratory supervisor and a Medical Officer. The supervisors are provided with motorbikes and the Medical Officer a vehicle for mobility.

Each worker does IEC activity twice a week in one of the pre-identified areas from 6 to 8.30 in the morning. The message conveyed to the community is about the symptoms of tuberculosis and where to go for help in case anyone had the suggested

symptoms. In each microscopy centre there is one worker who manages the OPD from 9 am till 2 pm 6 days a week. Three days a week are designated as DOTs days when the worker treats the patients under treatment under his supervision. For six centres, Monday, Wednesday and Friday are the DOTs days and for the other four it is Tuesday, Thursday and Saturday. If a patient is absent he/she is contacted the same day in the afternoon. On other days patients reporting to the centre with minor complaints are treated and if there is any respiratory symptomatic, spot sputum is collected from the patient and is asked to come the next day with early morning sputum. The worker collects the sputum samples and examines them the same day. He is also expected to counsel newly diagnosed cases and submit reports every month to the project.

The Senior TB Supervisor (STS) attends the centres on DOT days and assists the worker in preparing the cards and ensuring that all the activities are carried out by the worker as per the guidelines. He visits the field to verify the address of newly diagnosed patients and to counsel them, identify DOT providers for patients near their residence, meet the community volunteers once a week and participate in IEC activities.

The Senior TB Laboratory Supervisor (STLS) visits the centres on non-dots days to supervise the laboratory work. External Quality Assurance (EQA) was introduced in 2003 itself. A predetermined number of sputum smears are collected from each centre by the STS and sent to DFIT in Chennai for EQA. The Medical Officer also visits the centres on DOT days to diagnose cases and supervise the work of microscopist. All the staff come to the central hospital every Saturday afternoon for a meeting to discuss various problems and issues.

The project gets TB cases through voluntary reporting, referral by General practitioners and volunteers and referral hospital. Sputum negative suspects are referred to hospital for confirmation of diagnosis. So far the project has been able to mobilize 50 General practitioners, 147 Registered Medical practitioners, 180 community volunteers and 25 others for referral and DOT. The adult OPD was 55246 out of which 4067 suspects were identified and 723 (17.8%) were positive. In 2005 the project registered 463 new sputum positives, 74 relapses, 16 failures, 140 TAD, 323 sputum negatives, 369 extra-pulmonary cases and 144 others (total 1529). The project has achieved 61% of the case detection target, 51% of the target for new sputum positives and a cure rate of 89%.

Every patient is a mirror cracked and dense.

We don't see in it what we don't wish to see.

- Krishnamurthy

Table.3 Community involvement in RNTCP (Delhi project)

Category of community involved (1)	Number involved (2)	Suspects referred by them (3)	TB cases diagnosed from (3) (4)	Function as DOT providers (5)
General practitioners	44	40	12	2
Registered Medical Practitioners	153	173	68	46
Hospitals	2	1626	833	Nil
Volunteers	201	180	38	68
NGOs	5	205	40	Nil

4.7. Dindigul

(Poorna Sukha Leprosy Project, St. Joseph Hospital, Dindigul – 624 001. Director – Mr.Anto Rodriguez) Budget: Rs. 1089293

The project which has a Medical Officer, two health workers, a lab technician and a vehicle with a driver has the mandate to assist the Government in establishing leprosy service in 4 urban areas- Dindigul, Palani, Karur and Kulithalai. Total population of these four urban areas is 428288. One more urban area (Kodaikanal with a population of 32950) was allotted to the project in April 2005. The project trained all the staff in the municipal hospitals where leprosy services are now being offered. Very few cases are detected in these towns. An intense IEC campaign was organised in Kodaikanal following the training of the staff. No case was detected. It will, therefore, be difficult to say whether services are available in these places when there are no cases reporting to the municipal health facilities. In Dindigul town 11 cases (6 MB) were detected and managed by the municipal dispensaries in 2005. In Karur one MB and in Kulithalai one PB was detected. Not a single case was detected in Kodaikanal and Palani Towns. Trainings were organised for the staff in Kodaikanal, Palani, and Dindigul. A total of 34 Medical officers, 23 Supervisors, 71 multipurpose health workers and 400 volunteers were trained in leprosy. Similarly 4 Medical Officers, 5 supervisors and 19 multipurpose health workers were trained in TB control. There were 75 patients with disability in Dindigul urban which were followed by the Municipal health staff with guidance from the project. There are also 216 patients in the rural area covered before by the project. The project decided to train and involve the general health staff in the rural area to manage the patients with disabilities. This will be taken up in 2006.

The system, warts & all, works after all ... ⓘ

Mr.Krishnamurthy – 57 years old is a weaver in Dindigul town. He belongs to an orthodox Hindu family. He had nodules in his body for two years but he did not bother much about as it did not give him trouble. Slowly the lesions spread all over the body. He consulted a private doctor, a paediatrician, who prescribed treatment for "allergy". The nodules did not subside. He thought that the disease might be due to the curse of God. He consulted some traditional faith healers. He visited many temples and churches – the condition deteriorated and the nodules ulcerated. He again visited the paediatrician whom he had consulted earlier. He referred him to a dermatologist. Dr. Kaleeswaran, who suspected leprosy, referred the case to PSLP, Dindigul for confirmation. Slit skin smear examination showed that he was positive and the BI was 6+. The hospital confirmed the diagnosis, started treatment (MB MDT) and referred him to Municipal health centre, Dindigul for further treatment. Now patient is on MB MDT from 4-3-2005.

(Dr. N. Raman)

Case detection at Maternity centre

What is really gratifying to note is that 69 of the 75 patients in Dindigul town were found to practice self care regularly. The project provided MCR footwear to 119 patients. The unit has 8 beds for managing patients with complications. A total of 23 leprosy cases and 2 TB cases were admitted in the hospital.

The unit has a microscopy centre for managing TB cases. Newly diagnosied TB cases are referred to the municipal dispensaries for treatment which is done either at the dispensaries themselves or in the field through field staff or volunteers. Supervisors from the project visit periodically to guide them.

4.8. Fathimanagar

(Holy Family Hansenorium, Fathimanagar P.O. Trichy – 620 012.
E.Mail : holyfamilyhansenorium@yahoo.co.in
Project Holder – Dr. Rita Adaikalam) Budget: Rs. 1963067

Holy Family Hansenorium (HFH) project which is located in Fathimanagar, a village about 18 Kms. from Trichy town in Tamil Nadu, has been providing service to leprosy-affected for the past five decades. The activities of the project related to leprosy and TB control are supported by Damien Foundation India Trust (DFIT). From Survey Education Treatment (SET) activities implemented in a field area allotted by the Government with hospital back-up support through a large workforce of unipurpose workers to a programme, with limited staff, of supporting and strengthening the Government programme following integration the journey for the project has been exciting and gratifying. It has helped the Government in Trichy district to establish Prevention of Disability (POD) care services. The project had dialogue with District programme Officer and the Staff at PHCs in Trichy and Pudukottai district. All the staff were trained, first at the PHCs and subsequently at the subcentres. The project in collaboration with the District Leprosy Officer (DLO) has initiated holistic service to leprosy affected in 14 PHCs of Pudukottai district and 17 PHCs of Trichy district. The total population covered is 659168 and 473839 in Trichy and Pudukottai respectively. In the year 2005 a total of 68 cases (29 MB) were detected in these PHCs out of which 26 were referred by VHNs,

To serve is Human, to reach out is Divine

Thalaivasal block in Salem district has 25 Health Sub centers and covers a population of 11,200. It is heartening to note that the Village Health Nurses in these sub centers are actively involved in National Leprosy Eradication Programme. They disseminate the messages about Leprosy to the community and try to help persons with Leprosy related disabilities.

Mrs. Tamizharasi, a Village Health Nurse of this block is fully committed to the cause of Leprosy. After getting the orientation training from a local NGO she traced 52 disabled patients including 20 patients with plantar ulcers. One may be interested to know that she closely monitors these patients on self-care. What is really interesting is that she has mobilised community resources for providing MCR footwear to 25 patients!.

Mrs. Thamizharasi like her colleagues in the block is a sterling example for dedication, commitment and service to people affected with Leprosy.

Ulcer care by PHC staff

4 by General practitioners and 27 reported voluntarily. On verification of cases wrong diagnosis was found to be 4%. There was no re-registration. The PHCs diagnosed and treated 7 cases of reaction (2 ENL) and 3 cases were referred to the NGO project because of complications. The PHCs referred 10 cases with deformity for reconstructive surgery. Total number of VHNs in the 31 PHCs is 174 of whom 159 are actively involved in leprosy control including prevention of disability. The total number of patients with disability in the 176 subcentres covered by these VHNs is 427 (33 patients with plantar anaesthesia, 236 with disabilities including plantar ulcers, 158 with disabilities without plantar ulcers). Of these 427 patients 303 were identified by the VHNs. Of the 427 patients 363 are found to practice self care.

The project is a referral centre and managed 32 lepra reactions (11 Type-2). The centre has 70 beds and it managed 358 patients with plantar ulcers and 10 with TB. A total of 31 patients underwent reconstructive surgery. The project supplied MCR footwear to 213 patients.

The project also manages TB cases in a population of 120192. It acts as a microscopy centre under RNTCP detecting and treating TB cases in the area allotted for the purpose. Of the 2268 adult OPD attendees 123 symptomatics were identified, 94 were subjected to sputum examination and 14 (14.9%) were found to be positive. There were 18 cases registered in 2005 (5 NSP, 1 TAD, 3 smear negative and 9 extrapulmonary).

The project is involved in numerous socio-developmental activities. It has rehabilitated a number of leprosy-affected families, and arranged for the education of countless number of children born to leprosy-disabled parents. Since December the project has started working against HIV/ AIDS.

A CASE OF RELAPSE

KUPPAMMA, a girl 12 years age, came with her father in 1963 to clinic at Kanchipuram. There was infiltration all over the body and small nodules on ear lobes. Both ulnar and lateral popliteal nerves were enlarged. She also had a generalized type of scabies. Skin smears were positive for AFB.

As per therapy in vogue in the sixties, she received low doses of dapsone (20-200mg/week). Patient was very irregular in spite of many reminders through personal visits by para medical worker. The bacteriological index decreased and became negative in 1974. From 1973, patient received dapsone 100 mg/day but was still irregular for treatment. She developed loss of eyebrows. Bilateral ulnar median nerve palsy with resorption of tips of the fingers and ulcer in left foot.

In November 1976 (at the age of 25) patient presented with generalized infiltration. Skin smears showed 4+ on infiltrated lesions, 1+ on face and ears.

In March 1977 and later INH plus Ethionomide 300 mg/day were added to dapsone. Mutilations of hands and feet increased. She took treatment regularly. Skin smears became negative in 1980. She continued treatment with dapsone 100mg/day.

In Novemebr 1982, patient was admitted in the MDT Field trial (THELEP/WHO). She was put on Regimen A

DDS 100 mg / day; RMP 600 mg/day for 2 days;

CLF 600 mg/day for 2 days DADDS 225 mg on alternate month

At the time of entry in the trial, patient presented a residual infiltration all over and the same deformities as above. Patient maintained clinical inactivity and bacteriological negativity during treatment (2 years) and follow up (10 years) till April'95.

Kuppamma was not seen for 10 years. She came for admission at Hemerijckx Government Leprosy Centre, Polambakkam on 20-06-04 for oedema of both hands, inability to pass urine and chronic ulcer on left foot. She was treated for these conditions. On close examination, small nodules and infiltrated skin were found on both ear lobes and on the face. There was watering and weakness of the oculi of left eye (20 years after RFT)

She was started on MDT MB plus Prednisolone 20 mg

CONCLUSION: Inform the patients about the possibility of relapse. Be on your guard. The case history shows the importance of maintaining a good record.

- Dr. CLAIRE VELLUT

Leprosy Campaign

4.9. Kavali

(Rural Health Centre, Asaniketan, Vengalrao Nagar, Kavali – 524 202
E.Mail : asaniketan@rediffmail.com
Superintendent – Sr. Madeleine)
Budget: Rs. 1154679

The centre located in Nellore district has been involved in leprosy work for more than two decades and in TB work since 1996. The staff consisting of a Medical Officer, one supervisor, one paramedical worker and a lab technician provide support to the Government staff in 11 PHCs, 1 Community health centre (CHC), 2 Urban health centres (UHC) and 1 area hospital in implementing leprosy and TB control. The centre detected 12 leprosy cases (6 MB). The project area has 11 cases with disability that are followed regularly. The project supplied footwear to 35 persons.

The project provides supervisory support to one TB unit covering a population of about 500000. The Medical officer, STS and STLS of the project cover the 14 health facilities (including 5 designated microscopy centres) for supervising and monitoring RNTCP. In the population covered by the TB unit 1605 suspects were identified from among 184239 adult OPD attendees and 283 were found to be positive (17.6%). A total of 541 cases were registered (Cat1-298, Cat 2-117 and Cat 3-126). Sputum conversion was 94% (149/158) and cure rate 84.4% (189/224). There is a good involvement of general practitioners, rural medical practitioners and hospitals. These health care providers referred 84 suspects out of whom 9 leprosy cases were confirmed. They also referred 162 respiratory symptomatics out of whom 56 were confirmed as TB cases.

"It is unfortunate that the leprosy-disabled are neglected by themselves, ignored by their families and forgotten by the programme."

POD assessment in Tribal area

4.10. Nagepalli

(Assissi Seva Sadan Hospital, Nagepalli, Allapalli P.O. Gadchirolli District, Maharashtra – 4422 703

Project Holder : Sr. Marina Francis) Budget: Rs. 1018680

The project covers a population of 100563 in 289 villages in two blocks of Gadchiroli district of Maharastra. There are 5 PHCs and 56 subcentres in the area. The population is sparsely distributed and villages which are in thick forest are small with scarcely any road to reach them. During rainy season at least for three to four months it becomes impossible to reach majority of villages. Primary health centres (PHC) are scarcely utilised because of difficulty in accessibility and frequent turnover of staff at these centres. Initially Sisters were covering the area in cycles of 7-10 days. Now the project has tribal staff for the field activities. They visit the field for providing support to the PHC staff and also for monitoring patients treated by their own project. The project has a hospital which is one of the very few well-run centres in the area. A total of 32 leprosy patients with complications were admitted in the hospital. The project detected 18 leprosy cases (6 MB) in 2005. There were 65 patients with disabilities living in the project area and 59 were practicing self care regularly. Out of the 99 female workers in the Government 25 were found to be involved in POD programme. The project also supplied MCR footwear to 36 leprosy patients. Of the 4715 patients attending the OPD 230 were respiratory symptomatics out of which 57 were found to be positive. The project registered 85 TB cases (39 new sputum positive, 1 relapse, 3 return after default, 4 others, 16 pulmonary negatives and 22 extrapulmonary cases). The centre was involved in training 35 Doctors, 25 multipurpose health workers, 30 other health staff, 75 volunteers, 55 poojaris in both leprosy and TB. The project was recognised as a DMC in 2002 and TB cases from outside the project area are referred back to the concerned PHCs after diagnosis for treatment.

Training of health staff

4.11. Nellore

(Damien Foundation Urban Leprosy and TB Centre, Bakthavachala Nagar, A.K. Nagar Post, Nellore : 524 004.
E.Mail: dfulcnlr@sancharnet.in

Medical Officer : Dr. G. Sarojini) Budget: Rs. 1693945

The project, which was started in December 1994, is located about 150Kms. from Chennai in Nellore district of Andhra Pradesh. It covers Nellore town for establishing leprosy work including POD services and covers a population of 100000 for TB control activities. The project also assists 10 PHCs outside the project area for managing complications. A total of 36 patients (4 reactions, 16 complicated ulcers and 16 for reconstructive surgery) were admitted in the hospital which has 14 beds. In the urban area there are 21 ANMS out of whom 14 were involved in monitoring self care activities of patients with disabilities. The centre registered 23 leprosy cases (14 MB). The project provided MCR footwear to 71 patients. As part of the Nellore TB unit the unit identified 301 respiratory suspects from 1584 new OPD attendees and registered 175 TB cases (89 Cat 1, 40 Cat 2, and 46 Cat 3). There were 67 new sputum positive cases. Cure rate was 92%.

The project trained 10 Medical officers, 30 urban health staff, 96 doctors of Indian Medical association, 126 community volunteers, 90 medical students from Narayana Medical College and 22 leprosy Supervisors.

Table.4.Community involvement in RNTCP (Nellore urban)

Category of community involved (1)	Number involved (2)	Suspects referred by them (3)	TB cases diagnosed from (3) (4)	Function as DOT providers (5)
General practitioners	8	23	9	3
Registered Medical Practitioners	12	13	7	12
Hospitals	9	34	12	9
Volunteers	24	93	28	16
NGOs	5	1	1	5

The system, warts & all, works after all ...⑪

Mr. Sepang (Name changed) from Nepal came to Nellore and is working as watchman. He noticed a skin patch on the back of right hand three years back. He did not seek treatment for this because as he admitted “there was no problem”. He developed pain in the elbow region ten months back. He was not able to pick food and button his shirt. Still he did not seek any treatment. He had similar pain in Oct 04.He consulted a neurologist. He was diagnosed as leprosy with neuritis and MDT PB regimen was given.He completed treatment for five months but weakness remained. He consulted a dermatologist who referred him to DFIT center in Nellore Town.

On examination, he had a large vague hypopigmented anaesthetic patch with illdefined margin over dorsum of right hand extending to forearm. Right ulnar nerve was markedly thickened throughout its palpable course. There was a localised swelling of the nerve near the elbow. The nerve was not tender. There was ulnar weakness in the right hand. Prednisolone was started 40 mg per day in single dose. Posterior slab was provided for restricting movement at elbow. Active exercise (fingers) was advised.

Comments: The practitioner rightly diagnosed as Leprosy with neuritis. MDT-PB regimen was started. Steroid therapy was not initiated. Prednisolone at early stage would have been much more helpful.

DOT Supervision

4.12. Pavagada

(Swami Vivekananda Integrated Rural Health Centre, K.R. Extension, Tumkur, Pavagada – 561202.
E.mail : swajapa@yahoo.com

Project Holder : Swami Japananda) Budget: Rs. 1669724

The project situated about 150 Kms. from Bangalore in Tumkur district of Karnataka functions mainly as a support centre for leprosy and TB for the district. Following integration in 2003 the project acts as a referral centre managing leprosy cases with complications. It also has facilities for reconstructive surgery. The surgeon from DFIT conducts reconstructive surgery there once a quarter. In 2005 reconstructive surgery was done for 11 patients. The project detected and treated 35 new cases of leprosy (18 MB). There were 99 patients with disabilities in the area and 36 were found to be practicing self care. Twenty patients were provided MCR footwear. POD programme involving the General health staff is yet to be established.

The project apart from functioning as referral centre for leprosy and TB also provides supervisory support to Pavagada TB unit covering a population of about 500000 in two taluks (Pavagada and Madugiri). The Medical Officer along with Senior TB supervisor and Senior TB lab supervisor provide guidance and monitor RNTCP in the area covered by the unit. The project staff provided on-the-job training to the field staff of the Government. About 175 volunteers from Shree Shakthi and Swashakthi women group were also sensitised about TB control. The project also organised orientation to 20 General practitioners under the auspices of Indian Medical Association.

The hospital admitted 42 leprosy cases and 87 TB cases with complications in 2005. The project detected 315 sputum positive TB patients among 9877 suspects screened at the OPD.

In the TB unit covered by the centre out of 159628 adult OPD attendees 3339 suspects (2%) were identified , 2536 were subjected to sputum examination and 497 (19.6%) were found to be positive. Out of the 715 total cases registered new sputum positives were 338. Sputum conversion was 85% and cure rate 82.5%.

Health talk in a village

5. PROGRESS IN 2005 - DTSTs SOUTH :

District Technical Support teams, each consisting of a Medical Officer with one or more supervisors and jeeps/motorbikes for mobility, have been placed in 6 districts in South, 3 in Andhra Pradesh (Nellore, Anantapur and Kadapa), 2 in Karnataka (Bangalore Urban and Tumkur) and 1 in Kerala (Trivandrum). While the teams in Andhra Pradesh support both leprosy and Tuberculosis programmes, the teams in Karnataka and Kerala support only TB control programme. The teams assist the Government staff in planning, organizing Leprosy control programme and in organising DOT, absentee/defaulter retrieval, Information Education and Communication (IEC), establishing quality microscopy and capacity building of staff in TB control programme.

5.1. Anantapur

(Damien Foundation India Trust, D.No.6-3-17, Ramnagar Extension, Anantapur – 515001 - E.Mail : dfittstatp@yahoo.co.in
District Medical Advisor – Dr. M.Shivakumar) Budget: Rs. 1644360

The district covering a population of 3833278 (2005) in 1896 villages under 73 PHCs, 13 Community health centres (CHCs), 4 area hospitals and 13 Urban health centres (UHCs) is one of the largest districts in South India. There were 174 Medical Officers, 90 multipurpose health education officers, 139 multipurpose health supervisors and 998 multipurpose health assistants.

The District Technical Support team (DTST) with 3 supervisors and a Medical Officer with extensive experience and expertise was placed in 2001 to support leprosy and TB control programmes in the district. The team has helped in integration of leprosy and in effective implementation of TB control. Mainly the former vertical staff, the paramedical workers and supervisors, implement leprosy control activities. Each health facility has a paramedical worker who is in charge of leprosy control programme. The paramedical worker examines any patient coming to the PHC with suspected leprosy. Treatment is started after confirmation of diagnosis by the supervisor. The paramedical worker does record maintenance and reporting. There

Where there is suffering, there is succour

Pakiranima from Korrapadu in Anantapur is a patient suffering from pulmonary tuberculosis (new, sputum positive). She was identified by Aswathu, a community worker. After diagnosis he has been providing the drugs under his supervision.

The patient is profusely thankful of Aswathu's service. It is gratifying to note that he has been the DOT supervisor for 8 patients, so far and out of 15 suspects referred by him 8 have been found to be cases of Tuberculosis.

Achari Pothulaiah from Shivapuram village in Anantpur district suffers from pulmonary tuberculosis (new, sputum positive). His treatment is supervised by Mr.Veeriah, an ironsmith.

Ram Vilas Paswan from Fitkychak village in Gaya district in Bihar is a patient of pulmonary tuberculosis. His treatment is supervised by the Panchayat leader Ashok Paswan. His understanding of the problem of tuberculosis and the need for supervision of treatment is very good. When asked to give reason for his involvement, pat came the reply "Service to fellow human being is worship".

It is the committed involvement of people like Aswathu, Veeriah and Ashok Paswan that contributes to the success of RNTCP.

was no problem regarding drug supply management. Referral system is yet to be established. The DTST validated 160 new cases of which 4 (2.5%) were wrongly diagnosed. The team interviewed about 6337 community members about awareness about leprosy and 3104 (49%) were found to be aware about leprosy. Six general practitioners who were trained by the team were found to be involved in referring suspects. The team trained the staff (4 Medical Officers, 18 MPHS, 29 MPHAs (male) and 51 MPHAs (female) and 76 patients with disability in 5 PHCs in POD. The district has data on POD from 39 out of 74 PHCs. As per the record there were 539 cases with disability.

The team has supported RNTCP ever since its placement in 2001, about 6 months after initiation of RNTCP in the district. The team in consultation with the District TB officer identified several problems in diagnosis, treatment, supervision and monitoring and rectified them. The staff that had been trained about a year before the start of RNTCP were retrained by the team. The team accompanied the programme supervisors during their field visit. One of the most laudable effect of the team's functioning in the district has been the involvement of volunteers from the community in DOTS. About 80% of the DOT providers were from the community. So far more than 3000 members from the community have participated as DOT providers. The team with help from the central lab supervisor from DFIT, Chennai, could establish a two-level quality assurance mechanism in 2002 itself. It resulted in considerable improvement in sputum microscopy. The staff did not find it difficult to implement EQA once it was introduced in the district in 2005 because of their prior exposure and practice. Sputum conversion rate improved from 73% in 2001 to 90% in the third quarter of 2002 and it has been maintained at that level ever since. Cure rate was 84.8%. The new sputum positive which was 42 per 100000 in 2001 improved to 61.2 per 100000 in 2005. The team along with the district programme conducted operational research the results of which were presented in international conference. The team participated in facilitating the training of 1438 Anganawadi workers, 10 VCTC counsellors, 27 Railway doctors, 41 Medical officers, 459 MPHAs, 59 Lab technicians, 48 staff from NGO project, 86 pharmacists, 86 Staff nurses and 189 Medical students.

The team monitored 4816 patients of whom 4690 (97.3%) were found to be under DOT supervision. Categorisation was correct in 99.8% of cases. The team also monitored 1002 DOT providers and arranged 16 new DOT providers in 2005.

In public health, service is the name the providers give; Not the one desired by those who receive.

- Krishnamurthy

5.2. Kadapa

(Damien Foundation India Trust, 7-201-A, NGO Colony, Kadapa-516002 - Zonal Coordinator – Dr. S. Pera Reddy)

Budget: Rs. 1461041

The team consisting of three supervisors and a Medical Officer with extensive experience and expertise has been functioning in the district since 2001. While support to leprosy control has been given by the team since 2001 support to TB control was started in May 2003. The district has 61 PHCs and leprosy services are available in all like in Anantapur district. The district detected 403 new cases (166 MB) in 2005 compared to 1031 cases in 2004. Almost 50% reduction in 2005 could be due to various reasons including cessation of all active case detection activities. The team validated 142 new cases out of which 2 (1.4%) were wrongly diagnosed and 3 (2.1%) were reregistered. The programme was managed mainly by the former vertical staff. The district will take up POD activities from January 2006. Preparations were made to initiate POD in 16 PHCs.

The team has been supporting TB control since May 2003. After a gap of 3 years the PHC staff especially the Medical Officers were trained last year. Totally 45 Medical Officers were trained in 3 batches in December. The team also trained 485 NGO DOT providers, 438 community health workers and 45 staff nurses. The team visited 2895 patients and 1772 DOT providers, and helped in identifying 153 DOT providers. About 84% of the DOT providers (1489/1772) were found to be functioning correctly. The team was able to retrieve 174 absentees and brought them back to treatment. A total of 17 GPs were involved in the programme. Awareness level among the community about tuberculosis was 53% (2089/3927). Case notification was 155 per 100000 (it was 137 in 2004). NSP was 52.6 per 100000 population. About 85% of the patients were under DOT and cure rate was 84% (2004).

5.3. Nellore

**(Damien Foundation India Trust,
Bakthavachala Nagar,
A.K. Nagar Post,
Nellore-524 004
E.Mail :** dfulcnlr@sancharnet.in

District Medical Advisor – Dr. B.Prabhakar Reddy) Budget: Rs. 937358

The team consisting of two supervisors and a Medical Officer with extensive experience and expertise has been functioning in the district since 2001 for support to Leprosy and January 2003 for support to TB control.

The district which has a population of 2818888(2005) covered by 61 PHCs implements NLEP like Anantapur. The programme is managed by former vertical staff with minimal involvement of the general health staff. The district detected 318 new cases (124 MB) in 2005 as compared to 1019 in 2004 and 1020 in 2003 (a reduction of 68% like in Kadapa where the reduction was 50%) MB proportion which was only 18% in 2004 went up slightly to 25% in 2005. The team validated 33 cases of which 2 were not cases. The team picked up 2460 community members and interviewed them about awareness about leprosy and 1549 (63%) were found to be aware. The district has implemented POD service in 14 PHCs. The field workers were trained along with patients in self care practice and assessment by the core team consisting of DTST and district level physiotherapists and supervisors. List of disability cases was given to Multipurpose Health workers for verification and a final list prepared after screening by the core team.

The team monitored 1436 TB cases (1429 were under DOT) and 1179 DOT providers out of which 1025 (87%) were found to be functioning correctly. The team also arranged 53 DOT providers. Awareness of the community about Tuberculosis was found to be 63%. The district registered 1461 new sputum positive cases (52 per 100000). Cure rate was 86.5%.The main problem in the district is that the staff have not been trained (refresher training) even once in the past 3 years.

Group Talk on TB DOTS

5.4. Bangalore Urban

**(32/35, I Floor,
II Cross, K.R. Road,
7th Block,
Jayanagara (W),
Bangalore – 560 070**

E.Mail : vivekanandadfit@yahoo.com, **RNTCP Consultant – Dr. K.R. Govinda)**
Budget: Rs. 1893560

The district with a population of 2415000 has 5 TB units, 16 Microscopy centres, 5 STS and 5 STLS, 33 lab technicians and 1128 Anganawadi workers. The team consisting of three supervisors and a Medical Officer has been supporting RNTCP in the district since 2003. RNTCP was started in the district in 1999 itself. At the time of placement of the team there were several problems in implementation. There were only one STS and STLS. Only 8 out of 11 DMCs were functional because of the absence of laboratory technician or working microscope. DFIT provided one microscope. The Government added 820000 population from Bangalore city to Bangalore urban. This necessitated the increase in DMCs from 11 to 16. This was made possible due to the constant efforts of the team. Drug supply management was inadequate resulting in shortage of drugs. There was very little supervision and monitoring. The two sanatoria were not involved in the programme - the staff were not trained in RNTCP (!), they were still giving non-RNTCP treatment and there was no follow-up of cases diagnosed and referred to PHCs resulting in loss to follow-up of more than 70% of the cases. Referral of suspects was very low (less than 1%) in health facilities. There was very little involvement of the community including general practitioners. Very few patients were under DOT. Almost all the patients were taking treatment at PHCs and those who were absent were not followed. The staff had not been trained since the start of the programme. There was very little involvement of the general health staff.

The team along with the District TB officer organised training to all the staff including the laboratory technicians. The DTST with assistance from Medical Officers of TB Units trained health workers and Anganawadi workers. A microscope was supplied to one of the DMCs. Five STS and STLS were taken on contract and trained. One supervisor from DFIT was placed in the sanatorium to help the staff there to trace

the patients registered there. The team assisted the STS in identifying community volunteers for DOT. At the moment 189 community members are helping the patients in their treatment. The volunteers have so far referred 15 new sputum positive cases. About 95 General practitioners are involved in the programme: they have so far referred 2500 suspects from whom 210 cases have been detected. It is also noteworthy to observe that 8 NGO are now involved: they have referred 721 suspects from whom 150 cases have been detected. All the 8 NGOs are also involved as DOT centres for patients under treatment. There has been a significant improvement in the involvement of general health staff. The team facilitated the training of staff in the two sanatoria. Initially one of the team members was assisting in address verification and tracing the patients referred to PHCs by the sanatorium. Now the sanatoria have identified their own staff for this activity. In the SDS Sanatorium in 2002 out of the 387 cases diagnosed at the sanatorium and referred to the PHCs only 185 (47.8%) could be traced. In 2005 out of the 571 cases referred 474(83%) could be traced. In the OMS Sanatorium 81% (357/439) of the cases referred could be traced in 2005. Drug supply management has shown a great improvement over the past three years. In 2005 the team along with the programme supervisors trained 358 NGO staff and Anganawadi workers, 35 Medical officers and staff of Sri Sathya Sai hospital, and 10 general practitioners.

The referral rate improved from 1.9% to 2.5%, positivity rate from 9 to 10.5%, cure rate from 81% to 84%.

When the team started functioning in the district the defaulter rate was high (8.5%) and it came down to 4.3% in 2004. This was mainly because of on-the-job training given to the field staff, discussion with the PHC staff during their meetings, direct intervention by the team, training of the pharmacists and the LTs to collect correct address from patients and finally through interaction with the STS in the weekly review meetings. In 2005 211 irregular patients and 37 defaulters were retrieved because of the efforts of the team. In a community awareness survey conducted among 6251 populations 3366 (54%) were found to be aware about tuberculosis and the availability of free drugs in health facilities.

5.5. Tumkur

(District Leprosy Building, District Hospital Compound, Tumkur - RNTCP Consultant – Dr. K.R.Govinda) Budget: Rs. 734424

The district with a population of 2580172 (2005) living in 19596 Sq Kms. has 5 TB units (one is with an NGO), 27 microscopy centres, 116 PHCs, 586 subcentres, 5 STS, 5 STLS, 217 Medical Officers, 76 general health supervisors, 572 ANMs and 4264 Anganawadi workers. RNTCP was started in the district in January 2003. The team consisting of two supervisors and a Medical Officer with extensive experience and expertise has been functioning in the district since 2004.

The district has very good complement of general health staff. Supervision and monitoring by the programme officer is very good. One of the significant features of

the programme in the district is the frequent trainings given to the staff which has rendered their involvement more intense. Community involvement is not as much because of the mistaken belief among the Government staff that only Government health workers would be ideal DOT providers. In a community survey conducted among 1855 population 931 (50%) were found to be aware about the disease and the programme. Involvement of General practitioners in the programme is very good. A total of 36 General practitioners, 19 registered medical practitioners, 20 hospitals, and 215 volunteers are involved in the programme. Cure rate for the year 2004 was 83%. One of the problems in the district is the high defaulter rate which was 12.5% in 2004 and it was brought down to 6.6% in 2005. This was due to effective counselling of patients, sensitisation of field workers, training of DOT providers, organising community members as DOT providers close to the residence of patients, involving General practitioners as DOT providers, arranging awareness campaigns in the community and through interaction with STS during the DTC meetings. The team retrieved a total of 178 irregular patients and 34 defaulters.

5.6. Trivandrum

(St. John's Hospital & Leprosy Services, Pirappancode P.O.
Trivandrum Dist – 695 607 - E.Mail : stjpp@vsnl.net
Director – Rev. Fr. Joseph Thadathil) Budget: Rs. 895456

The district with a population of 3353246 (2005) is predominantly urban. It has 6 TB units, 54 designated microscopy centres, 19 primary health centres, 66 Additional primary health centres, 14 hospitals, one TB sanatorium and one NGO centre. The team consisting of two supervisors and a Medical Officer with extensive experience and expertise has been functioning in the district since 2004.

One of the characteristics of the TB programme in the district has been low suspect referral, very low positivity rate among symptomatics (5%), very low case notification (76 per 100000 population), low NSP case notification (30% in 2004 and 48% in 2005), low bacillary load among new cases (very few NSP being 2+ and above) and age distribution

Action Plan Meeting (South)

of new cases (high proportion among older age groups). Cure rate was found to be 83.4%. DOT supervision in terms of quality improved from 57% in 2004 to 80% in 2005.

The team was involved in training the staff, identifying and supervising DOT providers, IEC among the community and defaulter retrieval. The team participated as facilitator in training of 47 Medical Officers and 562 field staff. About 48 default patients were traced and were retrieved for treatment. The team arranged about 49 DOT providers. The team conducted a survey among the community to study their awareness level and it was found that 1235 (50%) of the 2468 members interviewed were aware about TB and the programme. This was really surprising because the population being literate was expected to have access to information about TB control. As a result of this awareness campaigns were intensified. The team also visited 1130 patients to find out about their regularity of treatment. Initially quite a good number of DOT providers were not found to be functioning correctly. The team assisted the staff in the proper selection of DOT providers. A total of 628 DOT providers were contacted and 569 (91%) were found to be functioning correctly. Initially sputum cups were not provided with drug boxes and therefore there was considerable delay in follow-up sputum examination. The district has now introduced the system of providing sputum cups along with drug boxes. There was no follow-up and absentee retrieval which was taken up by the team along with the supervisors. Sensitisation programme for 138 Anganawadi workers, 120 paramedical staff, 165 community members, 7 medical college students was organised by the team. A study to look at the referral status in three hospitals was carried out. One of the team members waited at the reception and took brief history from all OPD attendees and referred respiratory symptomatics directly to the lab. Even though the referral rate increased from 1.7% to 3-6% positivity rate still remained below 4%. A sensitisation programme for General practitioners (GP) in three batches was conducted. A total of 110 GPs were involved in the programme of which 85 were involved in DOT supervision of patients under treatment.

The team has been asked to establish a referral system in the district to manage leprosy cases with complications. This will be started in the first quarter of 2006.

Leprosy Campaign

6. PROGRESS IN 2005 - DTST BIHAR

(Damien Foundation India Trust, House No. J-13, P.C.Colony, Kankarbagh, Patna – 800 020 E.Mail : dfitpat@sancharnet.in **Chief Medical Advisor (North) – Dr. Biswanath Prasad)** Budget: Rs. 25519684

Since 1996 Damien Foundation India Trust has been supporting leprosy control programme in Bihar through its District Technical Support Teams (DTST) placed in Districts, different number at different times. In 1996 only 13 districts were supported and as on December 2005 a total of 22 districts were covered by DFIT teams. LEPRA India, Netherlands Leprosy Relief (NLR) and The Leprosy Mission (TLM) covered the remaining districts. The mandate for the teams was to build the competence of the General health system to manage the programme on their own. Each team consists of a Medical Officer with one or more Supervisors with Jeep/ motorbike for mobility and covers one or two districts. The DTST as a concept was

conceived and operationalised in Bihar by DFIT and realising its utility and usefulness to the programme, other ILEP members followed suit by placing similar teams in other states. Inadequate number of staff, untrained and unguided, leading to very low case detection and high prevalence, was the feature that was characteristic of Leprosy control programme in 1996. DFIT mobilised experienced staff from Southern states and placed them in Bihar with the express purpose of building the capacity of the programme staff and turning the programme around. The teams have succeeded, to a large extent, in their mandate and the situation now is that the programme is being managed by the general health staff.

Bihar state with a population of 92626217 (2005) is one of the most populous and economically backward states with weak infrastructure and contributes about 20% to the total leprosy case load of the country. Majority of the villages are not easily accessible especially during the rainy season. In spite of various problems, the state has done exceedingly well in leprosy control mainly because of the excellent leadership provided by the leprosy programme officers, significant contribution by ILEP agencies and noteworthy coordination between the major partners. From a situation in 1996 when not even a single PHC was providing leprosy service and treatment completion of cases was less than 30% to the present situation of almost 90% of health facilities providing leprosy service on all working days and a treatment completion rate of 85%, the progress has been significant and tangible. Using criteria like diagnostic and treatment service at PHCs, record maintenance, report generation, MDT stock availability, suspect referral and treatment follow-up an integration index was developed. It was 0.78 (1 ideal) in 2002 and 0.97 in 2005.

"Where there is skill, there is a way"

Dr.Rajeswari, a school health medical officer, was one among the Medical Officers who was trained in NLEP by the NGO project (Poorna Sukha Leprosy Project) in Dindigul. In one of her routine health camps in a school, she came across a boy with loss of eyebrows and shiny skin (infiltration) all over the body. He did not have any anaesthetic patch. She found that both the Radial cutaneous nerves were thickened.

Diagnosis of lepromatous leprosy is not easy even by experienced medical staff. But in this case the Medical Officer of General Health could diagnose the disease correctly and institute proper treatment promptly.

Table.5 Trend of new case detection in DFIT supported districts in Bihar (1996 to 2005)

Year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
New cases	27369	53079	102031	36939	87499	86346	44756	53500	36891	14926
NCDR	10.9	16.4	30.3	9.2	21.5	16.6	8.4	9.7	6.5	2.6
WD	-	-	-	-	-	-	6.5%	5.9%	7.8%	3.5%
RR	-	-	-	-	-	-	4.9%	6.2%	5.7%	4.7%

If one looks at the new case detection in the past 5 years one sees a dramatic reduction in 2004 and 2005 compared to previous years: the reduction was 30% in 2004 compared to 2003 and 55% in 2005 compared to 2004. While mass case detection (MLEC) and surveys were routinely done every year from 1998, the last MLEC was done in 2004 and all surveys were also stopped in 2004. Wrong Diagnosis (WD) and Re-Registration (RR) among routinely detected cases was 7%. It was almost 20-25% among cases detected through active case detection (MLEC). Wrong diagnosis and re-registration which was 12% in 2003 and 2004 came down to 8% in 2005. Therefore, deletion of cases due to wrong diagnosis or the newly introduced system of confirmation of cases before registration contributed to only 5% of the total decline in new cases. One of the major reasons for the significant (50%) reduction in new cases could be cessation of active case detection. It is to be noted here that initial overzealous adherence to validation protocol has been replaced gradually by a cautious approach wherein validation is done for only cases which are considered 'doubtful' by the PHC staff. Each PHC is visited by the team on a designated day when doubtful cases are mobilised to the PHCs and thoroughly discussed before confirmation. This would have a positive bearing on the competence of the PHC staff in managing leprosy cases

Decline in new cases started in 2004 itself in majority of the districts. This corresponded to cessation of active case detection from that year onwards. The reduction was 70% or more in 6 districts (Sitamarhi, Sheohar, Supaul, Katihar, Kishanganj and Purnea). All these districts except Sitamarhi and Sheohar had high new case detection partly because of the surveys that were routinely conducted by the vertical contractual staff. These personnel were retrenched in a phased manner from 2002 and by the end of March 2004 all the contractual staff had been removed. About 13 districts (Araria, Khagaria, Madhepura, Siwan, Gopalganj, Saran, Dharbanga, Madhubani, West Champaran, Rohtas, Jehanabad, Gaya and Nalanda) had a reduction of around 50%. In 2 two districts (East Champaran and Vaishali) the reduction has been less than 40%.

Table 6 - NCDR per 10000 and New cases of leprosy detected in DFIT supported districts in Bihar (1998-2005)

District	1998	1999	2000	2001	2002	2003	2004	2005
W. Champaran	16.5 5031	13.3 4038	6.7 2049	11.1 3383	8.1 2619	6.4 2039	2.4 793	2.2 733
East Champaran	22.8 8268	9.1 3385	5.9 2255	11.9 4667	7.7 3093	5.2 2160	3.6 1573	2.7 1179
Dharbanga	30.5 8825	9.3 2759	18.7 5682	16 5265	6.9 2342	9.9 3437	6.9 2494	2.5 917
Madhubani	32.6 10568	5.9 1964	17.5 5996	10.3 3590	5.4 1941	8.3 3194	5.1 2035	2.4 978
Sitamari	33.4 7450	12.5 2852	24.3 5646	18.9 5045	10.2 2800	12.8 3647	8 2354	3.1 921
Sheohar	12.3 561	28.8 1316	9.2 421	27.3 1405	8 450	9.2 518	6.7 385	1.9 110
Saran	20.6 6305	9.6 2999	13.1 4186	9.8 3172	8.8 2985	6.5 2221	3.7 1333	3 1064
Siwan	21.6 5410	8.8 2251	18.4 4817	15.4 4170	11.2 3159	11.5 3284	7.5 2196	2.7 821
Gopalganj	33.3 6540	5.4 1095	18.8 3876	10.2 2195	8.5 1877	9.3 2106	6.4 1484	3.2 761
Madhepura		12.3 1709	30.7 4369	28.5 4341	10 1570	12 1932	6.1 1004	2.8 473
Khagaria	34.1 3903	6.2 729	17.8 2118	17 2164	6.7 875	9.1 1236	3.7 517	1.8 257
Saharsa	30 4078	10.3 1443	23.1 3372	19.8 2977	8.1 1264	8 1286	5.6 926	1.7 289
Supaul			12.5 2102	18.7 3277	9.6 1691	12.6 2326	8.3 1579	1.3 252
Purnea	24.8 4979	49.7 10143	34.6 7741	22.8 6186	25.2 6828	11.4 3086	8.2 2289	1.8 534
Araria	39.8 7649	32 6373	21.5 4429	26.1 5537	12.2 2685	10 2270	4.6 1068	2.9 685
Kishanganj	11.4 1302	10.8 1263	29 3444	20.7 2684	12.6 1675	13.5 1835	10 1400	3.8 549
Katihar	24 6230	20.5 5284	17 4499	21 5431	13.5 3487	7.7 2073	2.4 652	1.3 362
Vaishali	13 3233	2.6 661	8.3 2151	8.1 2198	4.4 1212	5.4 1531	3.8 1141	2 709
Jehanabad			23.3 3297	17.1 2578	9.5 1486	8.8 1417	5.6 922	2.9 488
Nalanda	25.6 5788	7.4 1705	16.2 3766	14 3311	6.7 1621	8.8 2145	7 1728	3.2 837
Gaya	30.7 9673	15.9 5099	14.1 4900	14.3 4977	8.7 3093	8.2 3117	6.4 2544	3.3 1296
Rohtas		19 4129	20.8 4590	16.2 3959	8.7 2179	10.6 2738	6.7 1798	2.6 711

The teams managed and/or assisted the general health staff in managing 254 Type 1 reaction cases, 43 Type 2 reaction cases and 145 neuritis patients in 2005. Five cases ended with deformity. All the cases were provided Prednisolone by the teams.

The teams validated 9514 new cases (PB cases within one month and MB cases within two months of registration) in 2005. Out of this the teams found 335 (3.5%) as wrong diagnosis and 447 (4.7%) as reregistered. The teams during validation of cases also verified the disability status of these cases. There were 56 new cases reported with disability whereas the teams found disability in 92 patients giving an underreporting of disability to the extent of 60%.

INTEGRATION CAN DO IT

Ms. Devi (name changed) aged 24 years from Siwan District in Bihar had a patch on her right upper arm since one and a half years and she went to a local General Practitioner (GP) who treated her with Rifampicin (450mg daily), Dapsone (100 mg daily) and Clofazimine (50 mg daily) with chalmoogra oil for local application for 2 months with no response. The patient spent Rs.500 for her treatment.

The traditional dai from the village asked the lady to consult the doctor at the PHC where the Medical Officer, Dr. Sushil Kumar Singh observed that the patch was erythematous with definite sensory deficit. The right ulnar was thickened but not tender. She was correctly diagnosed as PB leprosy and treatment was initiated. About two weeks after the start of treatment the patch became raised, red and there was severe pain in her right elbow. The patient went to the PHC where a diagnosis of Type 1 reaction with ulnar neuritis was made. Prednisolone was started.

The PHC did not have prednisolone. Technical Support Team provided the drug to the patient.

POD assessment by DTST

7. PROGRESS IN 2005

DTST Jharkhand
(Damien Foundation India Trust, Indian Medical Association Campus, Karamtoli Chowk, Morabadi, Ranchi – 834 008

E.Mail – dfitran@dataone.in
Chief Medical Advisor (North) – Dr. Biswanath Prasad) Budget: Rs. 6693988

Jharkhand is one of the newly formed states in India. It was part of Bihar till November 2001. At the time of formation of the state there were 18 districts with a population of 26909428 living in an area of 79714 Sq km. Four more districts were formed later and the state now has 22 districts with a population (2005) of 29288490. Unlike Bihar that has a number of rivers Jharkhand is predominantly a plateau with hillocks, forests and rapid streams. The terrain is difficult and it is not easy to reach some of the villages which are small and scattered. The state is rich in minerals.

The state has a high tribal population (28.7%). For every 1000 males there are 944 females. Literacy rate is 54.1% (67.94% among males and 39.4% among females). The annual growth rate of the population is 2.32%.

DFIT which was placed in Jharkhand in 1996 and supported leprosy control ever since and TB control since 2003. DFIT covered 8 districts with a total population of 8410370 living in an area of 28413 Sq km. There were 70 blocks, 10518 villages (1183 not easily accessible and 2971 not accessible during rainy season) in these 8 districts. Support to the state was withdrawn in October for reasons other than operational.

General health infrastructure in the state is better than its neighbours. Even though there is adequate number of peripheral health workers the number of health facilities (Primary Health Centres) is less than adequate. In the early part of last year a recruitment drive resulted in the filing up of majority of vacant positions in the general health system. But the deployment was not uniform and not according to the needs of the district and the programme. New doctors recruited were posted to the same Primary health centres where there were already doctors. A PHC covering

150000 population which got about 30 patients at the OPD every day and which had 3-4 doctors now had 6 to 7 doctors. Recruitment of doctors without infrastructure development would not be useful. The norm of one PHC for every 25000 to 35000 population has not yet been realised.

In 2005 there were 69 PHCs, 80 Additional PHCs and 1526 subcentres in the 8 districts. There are 712 Medical Officers, 223 Multipurpose health supervisors, 279 Multipurpose health workers (male), 1499 Multipurpose health workers (female) and 60 pharmacists. In addition there were also 5436 Anganawadi workers.

Integration of leprosy into general health was almost complete- except a few APHCs all the health facilities provided MDT services on all days.

In all the districts there was considerable reduction in new case detection over the last 5 years ranging from 91% in Lohardugga to 52% in Godda It was 88% in East Singhbhum, 83% in West Singhbhum, 58% in Saraikala and 53% in Gumla. But if one looks at the case detection in the last three years the reduction has not been as appreciable as in Bihar. In Gumla it was 5.2 in 2002 and it has been around 3 ever since. In Godda it was 12, 6.6 and 9 in the last three years. East Singhbhum had 8.67, 11.64 and 3.2 in the past three years. West Singhbhum also had an NCDR around 9 in 2003 and 2004 and it went down to 4.6 in 2005. The trend seen in different district was different. The fall in new case detection in 2005 compared to 2004 was 75% in Saraikala, 69% in East Singhbhum, 50% in Lohardugga, 49% in West Singhbhum and 14.5% in Deoghar. In all the districts except Godda, Gumla and Simdega MB proportion went up. Disability proportion remained at the same high level (5.2%) in Lohardugga, it went up in Saraikala, West Singhbhum and East Singhbhum. The team validated 1259 cases the Wrong diagnosis varied between 0 in Simdega to 3.3% in Deoghar and 1.6% (21) for all the districts together and re-registration varied between 0 in Simdega and Gumla to 6% in Godda and 1.3% (16) for all the districts.

Each of the 8 districts had a District TB Officer. Totally there were 19 TB units, 93 Microscopy centres, 19 STS, 18 STLS and 102 LT. The District technical support team in the eight districts, well trained in operational aspects of programme management and also in training and coaching, had the mandate to build the capacity of the general health system in providing quality TB control services to the community in need. Their main focus was on the patients, DOT providers and the community. They moved around in the district contacting TB patients and the DOT providers to identify and solve any problems in treatment compliance, ensure that the patients had follow up sputum examination at the right times, disseminated correct information to the community and invited their participation in the programme and provided on-the-job training to the peripheral health workers

The RNTCP was initiated in the state in the last quarter of 2003. The State was able to achieve complete coverage of the population with RNTCP in July 2005. While Deoghar started the programme in 2003, it was initiated in 6 districts in

November 2004. Godda started RNTCP in July 2005. The six districts became eight now because of bifurcation of Gumla and West Singhbhum districts. Simdega was part of Gumla district and Saraikala was part of West Singhbhum district till about 15 months back. All the districts had District TB officer. All the districts had adequate complement of staff for implementing TB control. The programme implementation was as per the expected lines.

Suspect referral is an average 4% (it varies from 3% in Godda to 6.8% in Lohardugga). Out of 9318 patients examined 153 (17%) were found to be sputum positive for AFB. In some districts it was very high (more than 20%). This is something of a paradox. Generally the community does not have much confidence in the services offered at the Government health facilities because of several reasons like lack of general drugs, absence of doctors. Leprosy and TB control are the only programmes where good quality drugs in attractive package are available free of cost at all the health facilities. There is already self selection in the small number of people who go to health facilities: those with respiratory symptoms or skin problems may be the predominant service seekers. The situation will improve only with an improvement in the infrastructure and facilities at health units. The teams did use public address system to spread the right messages about the disease and the programme whenever they visited a village. They also gave group talk.

Follow up sputum examination was a problem. For cat 1 cases about 50% of the eligible patients were examined in Simdega and 67% in Gumla. Data from East Singhbhum was incomplete. This is because of the inadequate follow up of cases and monitoring of DOT providers.

TO SERVE WITH LOVE ....

Mrs. Anandaselvi is an unemployed graduate, and an active member of the self-help women's group in Dindigul town. Her child was treated for leprosy and cured. She volunteered herself to be a DOT provider for a TB patient in her locality. She was trained in RNTCP and successfully administered the drugs with commitment and care to the patient. She also took active interest in the RNTCP activities. She referred four TB suspects for sputum examination and personally brought a TB suspect to the hospital for consultation. On sputum examination three among five suspects referred by her were found to be positive. She volunteered to be DOTS provider for them also. She ensures regularity in drug consumption by the patients. Mrs. Anandaselvi deserves appreciation for her determination to serve the society and help in the fight against TB.

Categorisation of cases was good in all the districts. It was wrong only to the extent of 2% (only in Lohardugga it was more than 5%). This is because proper history was not taken from patients when they presented themselves with symptoms at the health facilities. Wrong categorisation was recognised when the teams interviewed the patients and got proper history from them.

In the districts only the general health staff (mostly ANMs and Anganawadi workers) functioned as DOT supervisors. Our experience is that volunteers from the community will be better DOT providers than Government workers. Involving volunteers from the community also promotes better awareness among the people.

Totally 2101 patients were seen during field visits by the teams and among them 1777 (85%) were found to be under DOT supervision. A total of 875 DOT providers were seen by the teams and out of them 671 (77%) were functioning correctly as DOT providers. This is a problem. In spite of the fact that more than 90% of the DOT providers were Government staff, their functioning needed considerable improvement. This is for two reasons: majority of the districts were put on RNTCP only recently; and the health workers because of their myriad activities may not give as much attention as the programme deserves. This is the reason why it is better to have community members as DOT providers who can then be supervised by the health workers. The Government staff need to be convinced about the benefits of involving the community as DOT providers. The teams trained Anganawadi workers as DOT providers. The teams started identifying community volunteers with assistance from the General health staff and training them. At the health facilities the pharmacists were trained by the teams to provide treatment to patients.

Updating of the patient cards was also a problem. Out of the 5487 cards verified by the teams 3980 (71%) were found to be updated. The teams provided on the job training to the ANMs to bring the duplicate cards when they visited the PHC and update the entries in the original cards maintained at the PHCs. From the observation of smear preparation, staining, record maintenance it was clear that at least 50% of the laboratory technicians were found to be good. Others required training on practical aspects of smear preparation.

About 40% of the TB supervisors (STS) were contractual appointees with little public health exposure. They sometimes found it difficult to supervise peripheral health workers who might have better and more experience in implementing public health programmes. Sometimes lack of logistics support added to the problem. The teams had a two-pronged strategy. They visited patients and DOT providers along with the supervisory staff. This would help in promoting better supervisory practices. The teams also attended monthly meetings at the PHCs and the District where they could provoke discussions on Tuberculosis control. The teams visited all the health facilities at least once a month, attended monthly meetings of 4 PHCs and district (once) in a month. The teams were involved in the training of 74 Medical Officers, 267 General health staff and 267 Anganawadi workers.

8. PREVENTION OF DISABILITY:

Very little attention has been given to one of the principal facets of leprosy control, prevention of disability. Every year about 1000 to 5000 new cases with disability are detected in India. The number can at best be conservative since there may be considerable underreporting of disability in some areas. The country is estimated to have one million persons with leprosy-related disabilities. Even if it is an overestimation, as suggested by some, the number would not by any means be small. The aim of leprosy control should be the reduction not only of disease burden but of disability burden too. The role of NGOs in this cannot but be overemphasized. NGOs who have worked/are working in leprosy control are in a very good position to act as an interface between the persons affected with leprosy related disabilities and the Government health service. This is what DFIT is trying to achieve through its myriad projects.

8.1. The problem of disability:

A. New cases with disability:

According to reports brought out by the Government, every year the country is detecting on an average 1000 to 5000 new cases with disability. It works out to around 1% of new cases detected annually. There is a genuine feeling among dispassionate observers that the reported disability among new cases is less than that which occurs. A study was conducted in Bihar by the DTSTs. The teams reviewed the diagnosis among 9514 leprosy cases (total cases detected in the 22 DFIT supported districts was 14926) in 2005. As per the records there were 56 cases with disability whereas the teams found Grade 2 disability among 92 cases. This represents an underreporting of disability to the extent of 60%. Since the case population examined was almost 50% of the total detected this represents a good sample and it can be extrapolated to the state. A similar situation could be prevailing in other states with similar leprosy endemicity.

B. Prevalence of disability:

An attempt was also made to assess the magnitude of disability from data collected systematically from 3 projects, one in Jharkhand and two each in Andhra Pradesh and Tamilnadu. While the disability burden was 7 per 10000 population in Amda in East Singhbhum in Jharkhand, it was 12 per 10000 population, 5 per 10000, 27 per 10000 and 14 per 1000 in Salem district, Fathimanagar in Trichy, Chilakalapalli in Vijayanagaram district and Nellore in Andhra Pradesh respectively. It varied between 5 and 27. This means in a district with an average population of 1.5 million there would be between 750 and 4000 cases. What is interesting is that all these districts were equally endemic. Such wide variation in the magnitude of disability burden could be due to various factors including intensity of POD activities, of follow up of disabled cases and of maintenance of records.

8.2. Reactions:

In Bihar the districts with the assistance of teams managed 254 patients with Type 1 reactions, 43 with Type 2 reaction and 145 with neuritis. The number of Type 1 reactions would be equal to 2.5% of new cases detected in a year, of Type 2 would be 0.45% and of Neuritis would be 1.55% of new cases detected in a year. This information would be useful to estimate the requirement for Prednisolone. Though quite a good number of cases with reaction were treated, prednisolone for managing reactions was generally not available in majority of health facilities in Bihar. These patients were given prednipacks (prednisolone in blister packs) supplied by ILEP.

NGO projects in the South reported 59 cases of reaction from MB cases and 14 from PB cases during 2005. Out of these 59 cases 1 is from 2001 registration cohort, 4 from 2002, 5 from 2003, 15 from 2004 and 34 from 2005. The reaction rate for MB was 1.4%. (Denominator is the MB cases registered from 1993-2005). Similarly, from PB cases 14 were reported with reaction, 2 from 2002 registration cohort, 3 from 2003, 4 from 2004 and 5 from 2005. The reaction rate for PB cases was 0.1%.

8.3. Prevention of disability activities:

8.3.1. NGO Centres:

A. Fathimanagar:

The project adapted the two adjacent districts-Trichy and Pudukottai. The project first had a discussion with the District Leprosy Officer (DLO) and sought permission to facilitate POD in the district. The intentions of the project were not clear to the Government staff- they thought that the project was interested in taking over leprosy control activities in the district. The field staff from HFH had to overcome initially the suspicion in the minds of the vertical staff who were still possessive about the programme and reluctance on the part of the General health staff to take up 'additional responsibility'. Persistence paid off. The project was asked to train the staff for implementing POD as per GOI guideline. The Medical officers and former leprosy staff were trained. In spite of that POD was not implemented in the districts. Then the project with permission from the District health officer identified one block in each district to facilitate the introduction of POD. The key field staff of the HFH then met the staff of each Primary Health Centre (PHC) and discussed with them the possibility of introducing the POD component in their field area. List of cases treated before integration was not available. Initial list of cases who had been managed by the HFH before integration was handed over to the PHCs. Patients with disability were identified from the list by the Village health nurses (VHN) accompanied by the project field worker. Training (2003) was arranged first at the PHC and then at each Subcentre. All the Medical Officers were trained to manage leprosy and its complications. All the health workers were trained to recognise and refer reactions and manage patients with disability. The field staff from HFH demonstrated the benefits of self

Self Care supervision by VHN

care to the patients and workers. Monthly combined field visits by the VHN and project worker was arranged. Gradually the VHNs were convinced about the immense benefits in the intervention. After 3 to 5 months of combined field visits, on-the-job training and guidance the VHNs were happy enough to carry out the activity on their own. When the VHNs and the former vertical staff realized the intentions of HFH and saw the benefit to patients, their initial reluctance was replaced by total committed involvement.

Patients were contacted once a month by the VHNs to monitor the status. If there was any complication the patient was immediately referred to the PHC or HFH depending on the severity. The VHNs were helped in their work by former leprosy staff (paramedical workers). Patients with disability were not issued any gauze or cotton or antiseptic cream to avoid dependency. Self care with available materials (pot, stone, washed cotton ribbon cloth -for bandage, oil) was the key intervention. The whole process took almost 6 months.

The enthusiasm of the VHNs is unbelievable. When asked what made them accept the responsibility and involve themselves in the programme their stock response is, “We never knew that we could bring so much difference to the lives of these people. They also did not know that such simple procedures could reduce their suffering and give meaning to their lives. The benefits from our efforts are immediately visible”.

The project in collaboration with the DLO has initiated holistic service to leprosy affected in 14 PHCs of Pudukottai district and 17 PHCs of Trichy district. The total population covered is 659168 and 473839 in Trichy and Pudukottai respectively. In the year 2005 a total of 68 cases (29 MB) were detected in these PHCs out of which 26 were referred by VHNs, 4 by General practitioners and 27 reported voluntarily. On verification of cases wrong diagnosis was found to be 4%. There was no re-registration. The PHCs diagnosed and treated 7 cases of reaction (2 ENL) and 3 cases were referred to the NGO project because of complications. The PHCs referred 10 cases with deformity for reconstructive surgery.

Self Care demonstration by VHN

Total number of VHNs in the 31 PHCs is 174 of whom 159 are actively involved in leprosy control including prevention of disability. The total number of patients with disability in the 176 subcentres covered by these VHNs is 427 (33 patients with plantar anaesthesia, 236 with disabilities including plantar ulcers, 158 with disabilities without plantar ulcers). Of these 427 patients 303 were identified by the VHNs. Of the 427 patients 363 are found to practice self care.

B. Arisipalayam:

The project has achieved tremendous success in implementing POD through the Government staff. This has been possible due to the excellent collaboration between the Government and the project. The Physiotechnician of the project participated as facilitator in the POD camps conducted as per the guideline of Government of India. These camps did not help in establishing the programme but it helped in establishing a good, working relationship between the Physiotechnician of the project and the Government staff. Out of 970 staff only 200 were trained. An assessment of the training revealed that very few staff were actually involved and a negligible number of patients were practicing self care. The plan had to be changed. Later at the initiative of the District Leprosy Officer and the project five blocks (21 PHCs and 114 Subcentres were chosen for intensive training and monitoring. All the Medical Officers were retrained and all the staff were given on the job training at the PHC. The PT along with Government Supervisor started guiding the staff at the subcentre level. The changes were tangible. The staff started showing interest and when they saw the benefits in the patients they became really motivated. There were 675 patients with disability (601 grade 2 and 74 grade 1) and all the 114 Village Health Nurses (VHN) in the 21 PHCs were involved in POD activities. Out of the 675 patients 530 (78.5%) were found to be practicing self-care regularly. There were 330 patients with plantar ulcer and in 240 the ulcer healed following self care. These 21 PHCs also manage reactions. Only those cases with severe reactions are referred to the project. Out of the 571 pairs of footwear provided in the district 446 were contributed by volunteers, which is highly appreciable, and the rest by the project. The programme will be extended to the entire district by the end of 2006.

Self Care demonstration by VHN

8.3.2. Nellore DTST:
POD programme was initiated in Nellore district also because of the fact that it has a few Physiotechnicians with the Government and the NGO centre supported by DFIT in Nellore town has an experienced Physiotechnician to provide the necessary support. While the POD activities in the town has been implemented ever since the start of the project in 1994, in the district it was initiated systematically only 6 months back. The district has taken 14 PHCs initially for introducing POD. All the staff including 10 Medical Officers, 25 General health supervisors, 158 of the 190 MPHAs (in 134 subcentres) were trained with the help of 103 patients with disability at the respective PHCs. Of the 134 subcentres 104 had patients with disability. Out of 139 MPHAs who had cases with disability 78 were involved in monitoring the cases. There were 501 patients with disability (118 grade 1 and 383 grade 2) in these 104 centres. There were 137 patients with plantar ulcers. The district supplied footwear to 71 patients and 41 were referred for reconstructive surgery.

8.3.3. Other projects and DTSTs:
It has been decided to start POD activities earnestly in all the districts supported by DFIT from January 2006. Initially two blocks will be selected and all the staff in these blocks will be trained. Data on persons with leprosy-related disability will be collected and all the cases would be screened by a group of supervisors from the Government and NGO centre staff. The peripheral staff would be guided through field visits and demonstration of patient monitoring. Other blocks will be taken up in a phased manner so that by the end of 2007 all the blocks would be implementing POD service.

8.4. Reconstructive surgery:

A. Government hospitals:
Capacity building of the Government health system is the principal objective of DFIT. Accordingly it has tried and succeeded in establishing reconstructive surgery facilities in two medical college hospitals, one at Patna and the other at Dharbanga, in Bihar. While surgical service at Patna Medical college hospital started in 2004 it was launched in Dharbanga Medical College hospital in 2005. Both the hospitals

Surgical case of deformity

were given a set of surgical instruments by DFIT. Funds for covering the expenditure for surgery and postoperative treatment were also provided (Rs 1500 per patient is provided for this). While the progress in Patna Medical College is significant it is not as much as expected in Dharbanga Medical College hospital because there is only one surgeon there and it is difficult to expect him to devote more time for leprosy surgery. Even in Patna there has been very few referral of cases requiring surgery from Districts. The Operation theatre is allotted to Physical medicine and rehabilitation department, which actually provides reconstructive surgery service, only one day a week which is felt to be inadequate. Efforts are being made to improve the situation in both the fronts. The ILEP coordinator in consultation with the State Leprosy Officer is trying to establish direct communication between the DLO of districts and Patna Medical College Hospital to facilitate easy referral and follow-up of cases. The DTSTs were also given orientation training to identify cases suitable for surgery and refer them to the hospitals and also do the follow-up of cases following surgery. The district nucleus in consultation with the district technical team would cover two blocks for identifying cases with disability that need special assistance and try to establish POD service in the two blocks and then gradually extend it to the whole district in a span of two years. Similarly Patna medical college hospital would provide every week to the State Leprosy Officer the list of patients, who have undergone surgery, with address. The SLO will inform the District nucleus of respective districts to facilitate easy follow up of patients for post operative care.

In 2005 at Patna Medical College hospital 19 patients underwent surgery for deformity of hands and at Dharbanga Medical College hospital 9 underwent correction for deformity of hands (7) and feet (2).

B. NGO Centres:

Three NGO centres supported by DFIT provide tertiary care (reconstructive surgery). These centres are located in Pavagada (Tumkur district in Karnataka), Nellore in Andhra Pradesh and Fathimanagar in Trichy district of Tamil Nadu. All the three have experienced Medical Officer, staff nurse and Physiotechnician. The Medical Advisor (POD) based in Chennai Office of DFIT visits these centres once in a

quarter for reconstructive surgery. All the cases who are operated upon are followed regularly either voluntary visits from patients or through visits to the patients at their residence by the PT. Altogether 60 surgeries (hands 29, feet 9, eyes 5, amputations 11, septic surgery 6) were performed in these three centres in 2005.

C. Follow up of operated persons:
All the persons who are operated for leprosy-related disabilities are followed regularly for impact assessment, both clinical and socioeconomic. The assessment is done 3 months after removal of plaster, 6 and 12 months after the last assessment and every year thereafter for 5 years. An assessment form was used for the purpose. The follow-up mechanism involved the NGO centre PT contacting the patients through field visits or the DLO office. Follow up data collected from patients operated between 1996 and 2004 was analysed. Patients operated between 1996 and 2000 were 116 (for 130 deformities) followed for 5 years and twenty were lost to follow up (6 migrated, 5 died, 9 not available). Among the 96 patients who had undergone 108 surgeries there was improvement in 95% (103/108).

Number of persons who had been accepted socially went up by 37% (from 54 before surgery to 89 after surgery). Similarly number of persons with improvement in earning capacity went up from 29 to 76 (49%).

From 1996 to 2004, a total of 233 persons had undergone 260 surgeries out of which 22 were lost to follow up. The 211 persons were followed for 2 years. There was improvement in 94% (198/211). Social acceptance went up from 155 to 196 (increase of 20%) and earning capacity improved by 35% (72 before surgery and 146 after surgery).

8.5. MCR Footwear:
The projects supported by DFIT provided MCR footwear to 1080 persons in 2005.There is only one unit (Fathimanagar) manufacturing MCR Footwear.

8.6. Training:
All the staff in the general health service in the selected project areas were given training in POD. In each area certain number of blocks were initially selected for implementation of POD. Effort was focused in these selected blocks. The DTSTs in the South and in Bihar and Jharkhand were also trained in self-care and identification of persons with disability requiring surgical intervention. Each DTST in Bihar and Jharkhand would take up two blocks and train all the staff on POD.

8.7. Monitoring:
Damien Foundation India Trust has formed a POD cell consisting of four members from headquarters at Chennai for planning, supervising and monitoring POD activities in the projects. Members of the cell keep track of various POD related activities in the projects on a regular basis to identify problems and institute remedial measures. A simple reporting system has been designed to help the cell in getting the right information at the right time.

9. MONITORING AND EVALUATION:

9.1. NGO Centres:

Review of projects is done through periodic visits by Officers from DFIT at Chennai, through monthly reports and also through two meetings (one in the first quarter and the second in the last quarter of the year). All the projects were visited by technical supervisors at least once a year.

9.2. DTST South:

DTSTs are assessed and their performance reviewed through field visits, reports and meetings. All the DTSTs were visited by the Supervising Officers at least twice last year. Review meetings were conducted in Tumkur in January, Trivandrum in March, Nellore in June and Salem in October. The meeting was for two days. The first day the teams from other districts would visit different health facilities and patients to assess the situation and prepare a report which is presented to the local team in the presence of the DLO/DTO and Government staff for discussion and suggestions.

9.3. DTST Bihar/ Jharkhand:

DTSTs are constantly reviewed by the Senior Medical Advisors (one for every zone of 5 to 8 districts) and the Chief Medical Advisor through monthly field visits. Assessment through field visits is also done by supervising officers from DFIT, Chennai. Monitoring is also done through monthly zonal meetings. The monthly review meetings of DTST usually take place in one of the 8 districts. It is for a period of two days. The first day the teams from other districts visit the various health facilities along with the Government supervisors and interact with the staff and patients and collect information. The teams' observations and recommendations are presented in the presence of the /District Leprosy Officer/ District TB officer and his staff. Thereafter each team from the district presents its performance report which is discussed by all the teams with suggestions for improvement. This has contributed to a large extent in improving the performance of the teams and also the district programme staff. There are also quarterly review meetings that are attended by Supervisors from DFIT office at Chennai.

The DTSTs in Bihar were also reviewed through field visit by members of the core team identified specially for this purpose. Six members of the core team from the South visited 12 districts (Saran, Siwan, Gopalganj, Vaishali, Dharbanga, Madhubani, Jehanabad, Rohtas, Supaul, Saharsa, Araria and Kishanganj) for monitoring and guidance. Central Lab Supervisor from DFIT, Chennai visited in July and laboratory technician from Dindigul visited Patna in December for imparting training to LTs from the Government.

10. RESEARCH:

10.1. Uniform MDT:

Uniform MDT study was been started in August 2005 in two districts of Bihar- Gaya and Nalanda with partial support from WHO. Some changes were made in the WHO protocol to adapt to our requirement. Gaya would be the trial district and Nalanda, control district. All the new cases detected in both the districts would be screened by a core group of supervisors. All the cases in Gaya screened and verified and willing to be under trial would be given MB regimen for 6 months and followed every year for 8 years. All the confirmed cases would be photographed, smear from standard sites taken, information from them would be entered in a standard recording form. Treatment would be started only after taking informed consent. Smears and photographs would be taken again at RFT for all cases, once a year for 8 years for initially positive cases and all cases presenting with events. In the control district all the cases are confirmed before starting conventional MDT (6 pulses of PB for PB cases and 12 pulses of MB for MB cases), smears taken initially and photographed. The initially positive cases are smeared again at RFT and once in a year. Similarly photographs are taken from all cases at start of treatment, RFT and during any event.

So far Gaya has registered 145 (36 MB) Cases under trial and Nalanda 186 (63 MB) cases. There were 9 smear positive cases (6.2%) in Gaya and 6 (3.2%) in Nalanda. There were four cases with dapsone hypersensitivity (3 in Gaya and 1 in Nalanda), two cases of lepra reaction (one each in Gaya and Nalanda). Two cases from Gaya had migrated.

10.2. Chemoprophylaxis:

The study on chemoprophylaxis which has been going on for 5 years involves follow up of contacts of index cases after treating them with a single dose of Rifampicin (two months after starting treatment with MDT for index cases) and looking for efficacy of prophylaxis with Rifampicin in terms of relapse.

Progress:

Coverage for the first two years of follow up was good (90% or more). And then leprosy was integrated and projects handed over their areas to the Government and reduced their staff or closed their units (two). These factors affected the follow-up subsequently. In 2005 fifth year follow-up for 2000 cohort and fourth year follow-up for 2001 cohort was done.

Results:

Annual incidence of leprosy was 5.2 per 10000 for 4th year and 4.4 per 10000 for 5th year. Preliminary analysis indicates that cumulative incidence among control group was 3 times higher than in study group.

10.3. Study on relapse:

A multicentric study on relapse would be initiated in several ILEP supported projects/ districts. Cohort of cases registered in 2000 and 2001 would be screened for evidence of active disease. Smear would be taken from these cases. This would give some insight into the problem of relapse and possibly indicate measures to be taken to address the issue.

10.4. Yield of positivity for AFB in three sputum examinations in the diagnosis of pulmonary Tuberculosis

RNTCP recommends examination of 3 sputum samples for all respiratory symptomatics suspected of Tuberculosis. The first sample is collected from a patient when he reports to the health facility. When the patient reports to microscopy centre with 2nd sample, which is usually early morning specimen, another spot collection (3rd sample) is done.

Several studies indicate that the additional yield of positivity in the third sample is minimal to negligible. DFIT has taken up a study to investigate this important element in Sputum microscopy under RNTCP.

Data from lab registers of 5 microscopy centres for the year 2000-2002, 15 microscopy centres for 2003 and 20 microscopy centres for 2004 & 2005 supported by DFIT was collected.

Examination of first sputum samples (n=1559) yielded 1457 (93.4%) positive results in 2005. Second sample examination yielded additional 98 positives (6.3%). Additional positive results were observed in 4 (0.3%) smears in third sample.

Similar findings had been observed in previous years. The additional yield of positives was (7.84%) in second sample (2000-2005). It was minimal in 3rd sample (0.3%). The quality of microscopy was good in all these microscopy centres. Probably the first examination itself could identity maximum number of positives.

Only 13 (0.3 %) positives were detected on examination of 3rd sample of 22481 respiratory symptomatics examined during 2003-2005. Total number of symptomatic with positive results in one of the first two samples was 362 among whom 300 (83%) were found to be positive in 3rd sputum sample. This group represents 1.6% of total respiratory symptomatics. Third sample examination may be required in this group for confirmation of diagnosis.

Childhood leprosy is clinically challenging, epidemiologically significant and socially consequential. It is also the barometer of effective MDT intervention.

"Even though the image of the programme has changed with the change in the image of leprosy, a lot more needs to be done to make the change sustainable and long lasting."

11. EXTERNAL QUALITY ASSURANCE (EQA):

Damien Foundation India Trust has implemented EQA in the projects supported by it since 1998. The two-level EQA system has ensured good quality sputum microscopy in all the supported projects. The system was also introduced in Anantapur district in 2002. There is a Central Lab Supervisor based in Chennai who is responsible for implementing EQA in the projects. He is assisted by Lab Supervisor in Patna.

External Quality Assurance was implemented in 20 labs (11 projects). A total of 2032 (5.5%) slides were examined.

Variation in Sputum Microscopy in NGO Projects – 2005

Projects	Slide Selected for QC				HFP	%	SFP	%	HFN	%	SFN	%	QE	%
	Neg	Scan	Pos	Total										
Ambalamoola	83	3	9	95	1	11.1	1	33.3	0	0	0	0	0	0
Arisipalayam	81	7	8	96	0	0	1	14.3	0	0	7	8.6	0	0
Aundipatty	93	2	12	107	0	0	0	0	0	0	2	2.2	1	7.1
Dindigul	146	0	10	156	0	0	0	0	2	1.4	0	0	0	0
Delhi	893	19	106	1018	2	1.9	1	5.3	4	0.4	8	0.9	4	3.2
Fathimanagar	51	0	9	60	0	0	0	0	0	0	1	2	0	0
Kavali	49	2	18	69	0	0	0	0	0	0	1	2	0	0
Nellore	46	0	13	59	0	0	0	0	0	0	0	0	0	0
Nagepalli	49	2	7	58	0	0	0	0	0	0	0	0	0	0
Pavagada	124	2	32	158	1	3.1	0	0	0	0	2	1.6	0	0
Trivandrum	144	1	11	156	0	0	0	0	0	0	13	9	0	0
Total	**1759**	**38**	**235**	**2032**	**4**	**1.7**	**3**	**7.9**	**6**	**0.3**	**34**	**1.9**	**5**	**1.8**

Altogether about 2.6% false positives (both HFP and SFP) and 2.3% false negatives (both HFN and SFN) were reported. However, High False Positive (HFP) and High False Negative (HFN) were low, 1.7% and 0.3% respectively. HFP+HFN were more than 1% in Ambalamoola, Dindigul, Delhi & Pavagada. Ambalamoola and Dindigul reported very small number of positive slides(around 100) and Pavagada did not participate in the EQA system for two years. Scanty False Positive (SFP) was 7.9%, Scanty False Negative (SFN) was 1.9%. Two labs recorded high number of SFN at one point of time (Arisipalayam-8.6% & Trivandrum-9.6%). This could probably be due to contamination of smears with atypical mycobacteria from tap water.

Endowment Prize Exam

12. CONTINUING MEDICAL EDUCATION (CME):

A. UPDATE:

As part of continuing medical education DFIT brought out four issues of UPDATE, a technical bulletin intended to disseminate information on best practices in leprosy and TB control among health personnel. A copy of each issue of the bulletin was circulated to Medical officers at the PHCs and programme officers of all the districts where DFIT projects are located. The main topics presented in the bulletin were Prevention of disability, case detection, community involvement, maintenance of microscope, checklists for supervision, clinical examination, besides interesting case histories. Even though impact analysis was not made, it was found that quite a good number of Medical Officers who were given the bulletin were keenly following the topics discussed therein. Interactive sessions for general practitioners were held in all the projects and districts in the South and in some districts of Bihar and Jharkhand to make them aware about the two diseases, the programmes and promote their participation in it.

B. Sensitisation workshop:

DFIT organised a CME programme on Tuberculosis at Nellore in February. Fifty general practitioners attended the programme. Similar programme was organised for the faculty of Patna Medical College. There was good interaction between the audience and the discussants on important issues related to Tuberculosis control especially rationale of chemotherapy of Tuberculosis.

C. Seminar and Endowment examination:

Damien Foundation India Trust also organised a Seminar for Postgraduate medical students at Stanley Medical College, Chennai, on 6th September. The intention of this exercise which is done regularly in one or two selected Medical colleges every year is to promote better understanding of the various aspects of Leprosy control and best clinical practice in the field. An endowment examination on leprosy for undergraduate medical students of 16 medical colleges under MGR University, Tamil Nadu, was held on 14th July. A total of 147 final year undergraduate medical students

Chantier Team

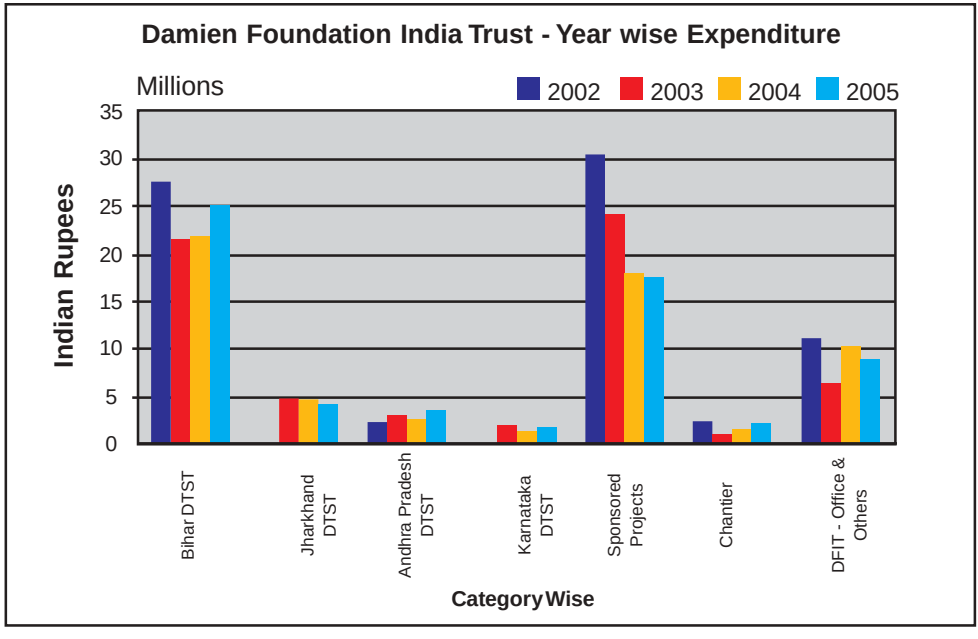
participated in the theory examination out of which 18 were selected for practical examination which was held at Kilpauk Medical College, Chennai, on 9th of September. The best student would be awarded gold medal by the MGR University.

13. CHANTIERS:

Damien Foundation India Trust through Chantiers Damien has been supporting infrastructure development in Bihar and Jharkhand for the past four years. Old PHC buildings are either renovated or new buildings constructed at sites chosen by the district administration. In 2005 construction in 5 sites in different districts was undertaken. Volunteers from Belgium visited the sites and participated in the construction process for two weeks. Support for the construction of APHC building was provided at Pokharia and Semapur in Katihar district of Bihar and Manpur in East Singhbum district of Jharkhand; and PHC building at Vaishali in Vaishali district of Bihar and at Bolba in Simdega district of Jharkhand. Volunteers from Belgium numbering 22 participated in the construction process at different sites.

14. FINANCE:

Receipts :	
DFB Fund Transfer	27254856.96
Contribution from DGDC	19397634.46
Contribution from EU	3485766.62
Contribution from Chantier	1731134.79
Contribution from Lepra India	850000.00
Interest received from Fixed Deposit / Savings A/c	249506.98
Staff Benefits	187342.00
Opening Balance for the year 2005	13762004.11
	66918245.92
Payments :	
Fund transferred to Projects	17547777.53
Bihar Activities - Technical Teams	25031919.38
Jharkhand Activities - Technical Teams	4255133.48
Andhra Pradesh - Technical Teams	3616213.50
Karnataka - Technical Teams	1829340.75
DFIT Office, Field, POD	6507701.20
Training & Workshop	277526.00
Chantier Expenses	2368153.25
Miscellaneous Expenses	2229593.72
Closing Balance for the year 2005	3254887.11
	66918245.92



15. TRAININGS:

	Particulars	Date	
1	In-service training at Anantapur and Nellore	January & February in three batches	Staff of Bihar/Jharkhand and South TSTs
2	CME Programme at Nellore	12th to 16th February 2005	50 private practitioners and 49 MPHS
3	Training Of Trainers of District Nucleus at Hyderabad	6th & 7th April 2005	Facilitators: Dr. P. Krishnamurthy Dr. P. Vijayakumaran Dr. T. Prabhakar Rao
4	Training on laboratory aspects at Nellore Project	18th to 20th April 2005	MO and NMS of DTST - south
5	POD training at Patna Medical College	23rd May to 3rd June 2005	Physiotherapists Facilitator – Dr. Jacob Mathew & Mr. Piet Paul
6	Training on RNTCP at Anantapur	20th to 24th June 2005	Staff of Nagepalli project
7	Study visit (TB control) to Bangladesh	28th to 31st August 2005	Dr.M.V.Bhat, Dr.K.R.Govinda, Mr.P.Rajendran, Mr.S.Manoharan, Mr.R.Giri
8	Seminar on Leprosy at Stanley Medical College	6th September 2005	Postgraduate medical students of Stanley Medical College
9	Endowment Prize Exam (Theory)	14th July 2005	147 Final year MBBS students from MGR University
10	Endowment Prize Exam (Practical)	9th September 2005 at Kilpauk Medical College	18 Final year MBBS students
11	In-service training on TB in Nellore, Anantapur and Kadapa for Bihar DTSTs	14th to 19th November 2005	21 NMS from DTST Bihar
12	RNTCP training TRC, Chennai	21st November to 1st December 2005	19 NMS from DTST Bihar and southern TSTs
13	RNTCP training at NTI, Bangalore	12th to 23rd December 2005	6 Medical Officers from DFIT South & Bihar
14	EQA Training for STLS at TRC * State level	Chennai (26 to 28th July) 8th to 12th August	3 participant from DFIT Mr. R. Jaishankar Mr. A. Moses Anandaraj

16. CONFERENCES/MEETINGS

	Particulars	Venue & Date	Participants
1	Inter-country Meeting of National Programme Managers for Leprosy elimination orgnised by WHO	6th to 8th January 2005 at Kathmandu	Dr. P. Krishnamurthy
2	Annual conference of SLOs	21st & 22nd January 2005 at Hyderabad	Dr. P. Krishnamurthy
3	59th National Conference of Tuberculosis and Chest Diseases Delhi	3rd to 6th February 2005	DLAs of Anantapur, Nellore, Kadapa & Tumkur, DTO of Anantapur, Kadapa
4	International Course in Management & Logistic for TB control at Jaipur	6th to 21st February 2005	Dr. Biswanath Prasad Dr. Anne Mattam
5	Review meeting of southern TSTs and Action Plan meeting of south projects at Trivandrum	15th to 18th March 2005	Mr. Luc Comhaire Dr. Tine Demeulenaere DFIT - Chennai Officers DMAs/NMS/DTST/South MO-NMS - Projects (South)
6	ILEP meeting at Pondicherry	4th April 2005	Dr. P. Krishnamurthy Dr. P. Vijayakumaran
7	Action Plan meeting of North projects & DTST at Ranchi	19th & 20th April 2005	Dr. P. Krishnamurthy Dr. P. Vijayakumaran Dr. T. Prabhakar Rao Dr. Biswanath Prasad All DTST and Amda project
8	11th review meeting with State/Zonal Coordinators (NLEP) and State DTST Coordinators	26th May 2005 at New Delhi	Dr. P. Krishnamurthy
9	ILEP Technical Commission at London	8th to 10th June 2005	Dr. P. Krishnamurthy
10	Review meeting of DTST - south at Nellore	27th & 28th June 2005	All officers from DFIT and all team members
11	IUATLD Conference at Paris	18th to 22nd October 2005	Dr. Prabhakar Reddy Dr. Anne Mattam

16. CONFERENCES/MEETINGS - CONTD.

	Particulars	Venue & Date	Participants
12	DFB Project Forum Meeting at Brussels	24th to 29th October 2005	Dr. P. Krishnamurthy Dr. P. Vijayakumaran Dr. Biswanath Prasad Dr. Anne Mattam Mr. Premkumar Velu
13	24th Biennial Conference of Indian Association of Leprologists	12th November 2005 at Agra	Dr. Biswanath Prasad, Dr. Satish Kumar and 2 DLOs from Bihar
14	Meeting of Partners on Tropical Diseases organised by WHO	17th & 18th November 2005 at Banglaore	Dr. P. Vijayakumaran
15	ILEP Technical Commission	6th & 7th December at London	Dr. P. Krishnamurthy

17. VISITORS

	Particulars	Venue & Date	Participants
1	Communication department - DFB	26th February to 10th March 2005 at Bihar/Jharkhand & Fathimanagar	Mr. Willem Gees, Mr. Jean Platteau & Ms. Hilde Eynikel from Communication Dept., DFB
2	Review meeting of TST and Action Plan meeting of south projects	15th to 18th March 2005 at Trivandrum	Dr. Tine Demeulenaere & Mr. Luc Comhaire
3	Chantier Damien	7th to 18th March 2005 at Bihar/Jharkhand	Mr. Marcel Lootens & Mr. Guy Reniers
4	Project review by DFB	19th to 24th March 2005 at Bihar/Jharkhand	Dr. Tine Demeulenaere & Mr. Luc Comhaire
5	Communication department – DFB	20th April to 14th May 2005 at Bihar/ Jharkhand 15th to 29th May 2005 at Fathimanagar	Ms. Carla Reynders, Mr. Jean Platteau & Mr. Willem Gees
6	Evaluation of DTST in RNTCP & NLEP Bihar/ Jharkhand	4th to 11th June 2005	Dr. Armand Van Deun
7	Communication department - DFB (Triangle Group)	8th October to 4th November 2005 (2 groups) and 4th to 11th November 2005 at Fathimanagar & Aundipatty	Cameraman, teachers, media person & students from Brussels under the leadership of Mr. Willem Gees

DAMIEN FOUNDATION INDIA TRUST

HEAD OFFICE : CHENNAI

Dr. P. Krishnamurthy	Secretary
Dr. P. Vijayakumaran	Chief Medical Advisor (South)
Dr. T. Prabhakar Rao	Chief Medical Consultant
Dr. Jacob Mathew	Medical Advisor (POD)
Mr. A. Marianathan	Chief Financial Officer
Mr. D.V. Premkumar Velu	Accounts Officer (South)
Mr. G. Kothandapani	Field Investigator
Mr. R. Jaishankar	Central Lab.Supervisor
Ms. R. Parameswari	Assistant
Mr. C.R. Ramabadran	Assistant (Admn)
Mr. R. Giri	Accountant
Ms. S. Susheela	Junior Assistant
Mr. K. Joseph Das	Library cum Lab.Attendant
Mr. A. Govindaraj	Driver
Mr. P.K. Ram Mohan	Attender

NORTH OFFICE : RANCHI

Dr. Biswanath Prasad	Chief Medical Advisor (North)
Mr. S. Manoharan	Administrative Officer
Mr. A.I. Suresh Babu	Accounts Officer (North)
Mr. T.S. Sugathan	Office Superintendent
Ms. R. Sreelatha	Accountant
Ms. P. Sreelatha	Junior Assistant
Mr. S. Ramesh	Junior Assistant
Mr. E. Ravi	Mechanic
Mr. Ram Pravesh Sharma	Driver
Mr. Ambika Prasad	Driver
Mr. Rupan Ram	Care Taker

PATNA OFFICE

Mr. M.Srinivasulu	Field Investigator
Mr. Moses Anandraj	Lab.Supervisor
Mr. R.K.Prajapati	Junior Assistant
Mr. Akilesh Prasad	Driver

DELHI PROJECT

Dr. S.C. Sharma	Medical Officer
Mr. P.Rajendran	Non Medical Supervisor
Mr. D.Franklin	Non Medical Supervisor
Mr. Ravikant	Microscopist
Mr. R. Thangavelu	Microscopist
Mr. P.C. Bhatt	Microscopist
Mr. Joginder Singh	Microscopist
Ms. Saneh Lath	Microscopist
Mr. Varun Kumar	Microscopist
Mr. Chander Bhan	Microscopist
Ms. Sunitha Chacko	Microscopist
Mr. Mohanasundaram	Microscopist
Mr. Navin Kumar	Microscopist
Mr. Sarat Babu	Microscopist
Mr. Suresh Kumar	Microscopist
Mr. Sanjeev Kumar	Accountant
Mr. Mohan Singh	Driver
Mr. Harish Singh	Attender

NELLORE PROJECT

Dr. G. Sarojini	Medical Officer
Mr. R. Perumal	Non Medical Supervisor
Mr. Piet Paul Hemerjickx	Senior Physio Technician
Mr. Francis Vijayakumar	Lab. Technician
Mr. Tatiparthi Murali	Para Medical Worker
Ms. Thresia Varghese	Staff Nurse
Ms. Vijaya Bharathi Bai	Staff Nurse
Ms. R.Parameswari	Junior Assistant
Mr. Mohammed Rafi	Driver
Mr. G.Mahesh	Ward Boy

TECHNICAL SUPPORT TEAMS - SOUTH

District	Dist.Medical Advisor	Non Medical Supervisor	Driver
Anantapur	Dr. M.Shivakumar	Mr. Y. Somasekhar Reddy Mr. S. Satheesh Mr. K.S. Sudhakara	Mr.Anjaneyulu Mr.B.Suryanarayana Mr.Lakshmi Narasaiah
Kadapa	Dr. S. Pera Reddy	Mr. R.Vinayagam Mr. K. Naresh Kumar Mr. P.M. Premkumar	Mr.D.Venkata Subbiah
Nellore	Dr. B.Prabhakar Reddy	Mr. R. Keskar Mr. U.Charles	Mr.Mohammed Safi
Bangalore	Dr. K.R. Govinda	Mr. Rama Anjineyulu Mr. Madhava Reddy Mr. Venugopal	Mr.Mallikarjun Mr.Govindaraju
Tumkur	Dr. K.R. Govinda	Mr. Anil Kumar Mr. Ravi Kumar	Mr.Ramu
Trivandrum	Dr. Raveendranathan Nair	Mr. A.Vijayan Mr. Tharmaraj	Mr.John

TECHNICAL SUPPORT TEAMS – BIHAR

District	Dist.Medical Advisor	Non Medical Supervisor	Driver
Dharbanga	Dr. H.S.Mishra	Mr.V.K.Ravikumar	Mr.Baidyanath Yadav Mr.Mohan Paswan
Madhubani		Mr. Maria Dominic Mr. Saryoo Prasad	Mr.Shatrughan Paswan
East Champaran	Dr. S.Tiwari	Mr. O.Abraham Mr. Kripa Sindhu Singh	Mr.Jagmohan Prasad Mr.Mishrilal Sah
Nalanda	Dr. M.V.Bhat (SMA)	Mr. T.Mohanraj Mr. Ramdeo Gope	Mr.Akshyabar Prasad Mr.Lalbahadur Singh
Gaya	Dr. R.K.Mishra	Mr. Peter Paul Mr. Raghuwir Gope	Mr.Atma Pandey Mr.Binod Prasad
Jehanabad		Mr. Braj Kishore Prasad Mr. R.Jayaraman	Mr.Jaishankar Prasad
Rohtas	Dr.Ajay Kumar Pandey	Mr. K.Dhekshinamoorthy	Mr.Ramjee Sharma

TECHNICAL SUPPORT TEAMS – BIHAR *(Contd.)*

District	Dist.Medical Advisor	Non Medical Supervisor	Driver
Purnea	Dr.S.C. Choudhury	Mr. S.William	
		Mr.Sesuraj	Mr.Prakash Chandra Jha
Katihar	Dr.Harinarayan Pandey	Mr. P.Jayapal	Mr.Ajit Kumar
		Mr. Suresh Kumar	Mr.Pramod Kumar Jha
Kishanganj	Dr.Arjun Prasad	Mr.K.Karunanidhi	Mr.Ram Pravesh Singh
Araria		Mr.M.Francis	Mr.Rakesh Kumar Sah
Vaishali	Dr.M.K.Haque	Mr.R.Ramanujan	Mr.Rakesh Kumar
		Mr.Loknath Mahato	Mr.Uday Prasad
West Champaran	Dr.Ramjeet Mishra	Mr.G.Elangovan	Mr.Dhananjay Kumar
Siwan	Dr.N.Appa Rao (SMA)	Mr.Rajendra Prasad	Mr.Subodh Paswan
Saran	Dr.P.Thakur	Mr.Ash Narayan Singh	Mr.Bogendra Paswan
Gopalganj		Mr.M.S.Antony Samy	Mr.Johinder Prasad
Sitamarhi		Mr.S.K.Dwivedi	Mr.Bhola Kumar Mandal
Sheohar	Dr. S.P. Sinha	Mr.M.Rajan	Mr.Mahesh Pandit
Madhepura	Dr.Adisesha Reddy(SMA)	Mr.U.A.Kharkar	Mr.Pamod Kumar Singh
			Mr.Prem Shankar Ram
Supaul	Dr.Om Prakash Pathak	Mr.James Nag	Mr.Rakesh Kumar Verma
Saharsa	Dr.Sheo Kumar Singh	Mr.Joy Daniel	
Khagaria		Mr. D.Manavalan	Mr.Anand Kumar

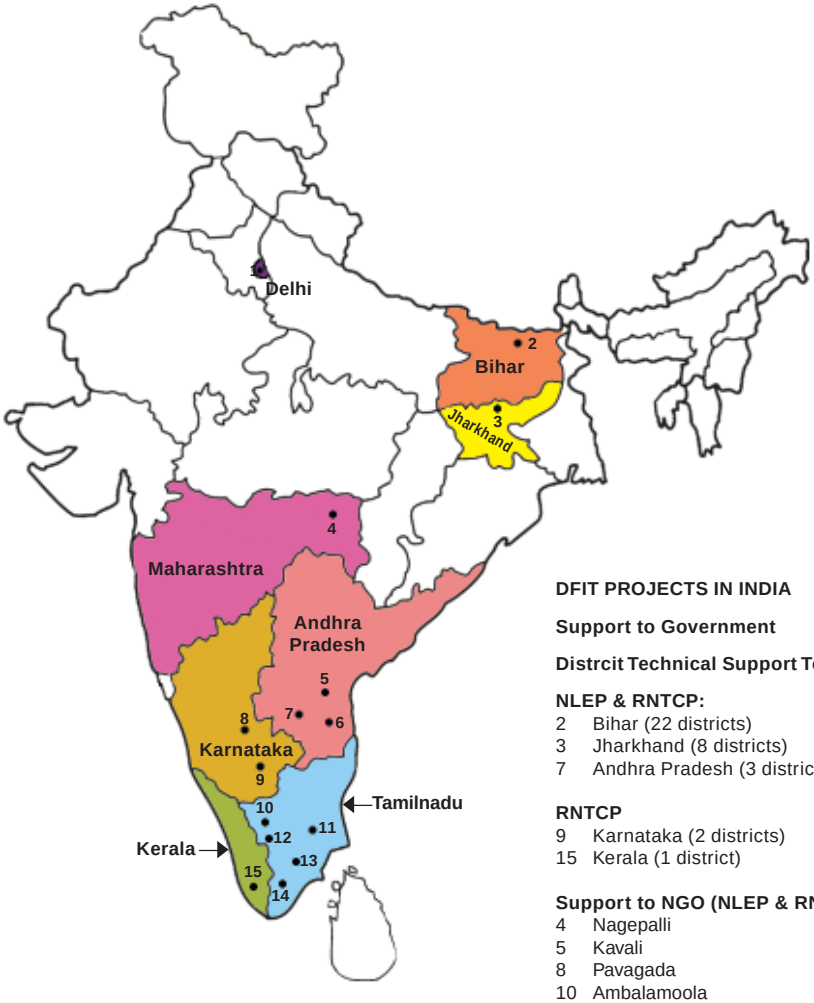
TECHNICAL SUPPORT TEAMS – JHARKHAND

District	Dist.Medical Advisor	Non Medical Supervisor	Driver
Godda	Dr.Anne Mattam (SMA)	Mr.Yesupatham	Mr.Sukra Khalko
Deoghar	Dr.K.P.Sinha	Mr.D.V.Kharkar	Mr.Jitendra Paswan
Lohardagga		Mr.Shiopujan Pandey	Mr.Rajesh Kumar Lui
Simdega		Mr.R.Sekar	Mr.Mukesh Kumar Sharma
Gumla	Dr.Satish Kumar	Mr.K.Srinivasan	Mr.Lakshman Kumar Singh
West Singhbhum	Dr.Mohan Sunkad	Mr.Charles	Mr.Pradeep Kumar Rai
Saraikela		Mr.Balram Mahato	Mr.Dursu Purty
East Singhbhum		Mr.K.V.R.Murthy	
			Mr.Sajan Kumar
			Mr.Ajit Kumar

GLOSSARY

AFB	Acid Fast Bacilli
ANM	Auxiliary Nurse Midwife
APHC	Additional Primary Health Centre
CHC	Community Health Centre
CME	Continuing Medical Education
DFIT	Damien Foundation India Trust
DLO	District Leprosy Officer
DMC	Designated Microscopy Centre
DOTS	Directly Observed Treatment Shortcourse
DTO	District TB Officer
DTST	District Technical Support Teams
ENL	Erythema Nodosum Leprosum
EQA	External Quality Assurance
GMLF	Gandhi Memorial Leprosy Foundation
GOI	Government of India
GP	General Practitioner
HFN	High False Negative
HFP	High False Positive
IEC	Information Education Communication
ILEP	International federation of anti-leprosy associations
Kms	Kilo meters
LT	Lab Technician
MB	Multi Bacillary
MCR	Micro Cellular Rubber
MDT	Multi Drug Therapy
MLEC	Modified Leprosy Elimination Campaign
MO	Medical Officer
MPHA	Multi Purpose Health Assistants
MPHS	Multi Purpose Health Supervisor
NCDR	New Case Detection Rate
NGO	Non Governmental Organisation
NLEP	National Leprosy Eradication Programme
NLR	Netherlands Leprosy Relief
NMS	Non Medical Supervisor
NSP	New Sputum Positive
OPD	Out Patient Department
PB	Pauci Bacillary
PHC	Primary Health Centre
POD	Prevention Of Disability
PT	Physiotechnician
QE	Quantification Error
RNTCP	Revised National TB Control Programme
RR	Re Registration
RFT	Released From Treatment
SET	Survey Education Treatment
SFN	Scanty False Negative
SFP	Scanty False Positive
STLS	Senior TB Lab Supervisor
STS	Senior TB Supervisor
TAD	Treatment After Default
TLM	The Leprosy Mission
TU	TB Unit
UHC	Urban Health Centre
VCTC	Voluntary Counselling and Testing Centre
VHN	Village Health Nurse
WD	Wrong Diagnosis
WHO	World Health Organisation

Projects Supported by Damien Foundation India Trust



DFIT PROJECTS IN INDIA

Support to Government

Distrcit Technical Support Teams :

NLEP & RNTCP:

2 Bihar (22 districts)
3 Jharkhand (8 districts)
7 Andhra Pradesh (3 districts)

RNTCP

9 Karnataka (2 districts)
15 Kerala (1 district)

Support to NGO (NLEP & RNTCP)

4 Nagepalli
5 Kavali
8 Pavagada
10 Ambalamoola
11 Fathimanagar
12 Arisipalayam
13 Dindigul
14 Aundipatty

DFIT Own projects (NLEP & RNTCP)

1 Delhi
6 Nellore

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