



Damien Foundation India Trust

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2007
Activity Report

Damien Foundation India Trust



PREFACE

The year 2007 was like any other, neither pedantic nor prodigious. It, however, defined the character of involvement of major Non Governmental Organisations including Damien Foundation and designated a shift in the programme's posture. District Technical Support Teams from ILEP which formed the fundamental bedrock that infused essential vigor into the programme and catapulted it from the sidewalk into the freeway glory finally reached a state of irrelevance. The uniquely emphasizing support concept which attained for ILEP an exalted position in its relationship with the partners, broadened the gauge of the programme and distributed largesse of skills to the Government staff, finally had to reach the finish line. The neoattitude that has helped programme managers move away from prevalence-obsession to patient-orientation gained momentum and registered detailed strategy prescriptions for leprosy affected persons with or without residual consequences. There is, strangely and suddenly, a new found resolve to tackle imbalances decisively to make progress sustainable. Damien Foundation is extremely happy that it has played an important role in all these happenings. It is pleased that there is contemporiness in its actions. Damien Foundation thanks all its staff for bringing the change and being the change. Our thanks are equally due to its Belgian counterparts for providing the most essential backing, the ILEP colleagues for standing together, the Government of India for bringing mutuality in the partnership, the DGDC for anchoring their faith, and the trust members for their moral support.

What lies in front of you in between the colourful covers reflects aspirations and achievements, inclinations and intentions, renditions and redundancies, exclamations and excuses, all rolled into a bundle called "report". Please spare some time. Say your piece! We are willing to listen!

Yours,



P. Krishnamurthy
Secretary

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1. INTRODUCTION:

The happenings in the year portrayed a deep sense of satisfaction for the achievements and accomplishments. The projects supported by Damien Foundation did remarkably well to titre their actions to the needs of people and patients. Change was the defining principle on which the collective exertion was directed. Change has become the alter ego of Damien Foundation. Change in the status of people affected by leprosy or Tuberculosis. Change in the way affected people are perceived. Change in the way things are done by the programme staff. Change in affirmative actions. Naturally it expects from its projects and gets the change that is desirable.

Damien Foundation is happy that there is confluence of resources and convergence of ideas. For the first time, in spite of choice, there is one voice. People affected with leprosy first! People and patients are more important than the programme and programme is more important than statistics! The three mantras: integration, quality and sustainability have become the guiding anthem of the programme. The guiding strategy is that all activities should necessarily promote integration, improve quality and contribute to sustainability. This is what Damien Foundation strives for.

An NGO has a specific role to play: make a difference to the lives of people through its direct actions and indirect forays that render public health service people-friendly. One is likely to fall by the wayside if one tries to deify its role through emotional engagement. Passion and compassion are necessary accessories but they will not succeed if they are not attached to the lapels of professionalism.

2. DAMIEN FOUNDATION PROJECTS AND ACTIVITIES:



Damien Foundation has three kinds of projects: projects which are directly operated by the organisation called “own projects”; projects operated by other NGOs and supported by the organisation called “NGO projects”; and projects which provide support to the Government called “support projects”. There are two own projects (Delhi and Nellore), 11 NGO

projects (Ambalamoola, Aundipatty, Amda, Chilakalapalli, Dindigul, Fathimanagar, Kavali, Nagepalli, Pavagada, Arisipalayam and Trivandrum) and 34 support projects (28 in Bihar, 3 in Andhra Pradesh, 2 in Karnataka and 1 in Kerala). Some of them do only leprosy or TB work, some both and some others carry out many developmental

programmes including leprosy, TB and HIV/AIDS. Those projects which are involved in leprosy control manage persons living with leprosy-related disabilities in small geographic areas, or support POD programme in a district or provide secondary care services to those with complications like reactions or disabilities. Some projects get full support and some others partial to the activities jointly identified. TB activities consist of running a Designated microscopy centre for a population of about 100000 (Ambalamoola, Aundipatty, Fathimanagar, Nagepalli, Nellore, Trivandrum) or a TB unit with full-fledged basic and supervisory staff in a population of about 500000 (Delhi and Kavali) or providing supervisory staff support to Government TB unit (Pavagada and Salem) or providing technical support through consultancy teams in 34 support projects.

Other activities carried out by Damien Foundation include capacity building of the Government staff in leprosy and TB control; supporting the establishment of POD activities in clusters of pre-identified districts; continuing medical education through prize examination for undergraduate medical students in Tamil Nadu, Seminars and Symposia for post graduate medical students and also through the medical bulletin "UPDATE" published on behalf of ILEP; construction of PHC and laboratory building for supporting General health and TB control in Bihar; supporting reconstructive surgery activities in two medical college hospitals in Bihar; publication of learning materials as a joint action of ILEP; and socioeconomic rehabilitation of leprosy affected individuals and families.

The total personnel working in Damien Foundation India Trust and its supporting projects is 26 Medical Officers, 151 field staff, 62 hospital staff and 52 administrative staff.

Centrepiece of our action should be commitment to break our collective action out of dangerous paradigms.

3. PROGRESS IN 2007:

3.1. NGO PROJECTS:

The eleven NGO projects supported by Damien Foundation for long have not lost focus on the primacy of purpose - providing service to leprosy-affected. Other activities are often taken up to make leprosy service more cost-effective. From direct management of leprosy-affected they have moved away to offering secondary and tertiary care services to those with complications (those with simple leprosy are referred back to PHCs). Their involvement in leprosy control is mainly in providing referral service and in helping the Government establish leprosy control services in urban areas and in introducing DPMP component of leprosy control through the general health system. Majority of the projects have taken up support to TB control, either in small areas (Designated Microscopy centres) or in population of 500000 (TB unit). At least four projects are actively involved in promoting socioeconomic rehabilitation.

3.1.1. AMBALAMOOLA:

(Nilgiris Wynaad Tribal Welfare Society, Ambalamoola post, via Bitherkad, Gudalur Taluk, Nilgiris-643240) E.mail: ambalamoolatribalsociety@gmail.com
Total Staff : 2

A project in predominantly tribal area covering a population of about 100000 it has earned the goodwill of the local people through its quality preventive and curative services. Even though it caters to the general health needs of the population, only it's TB and leprosy control components are supported by Damien Foundation India Trust. Through its 12-bedded hospital constructed by DFIT it manages patients with complications due to leprosy, TB or thalasaemia. It continues to support 5 PHCs in Tamil Nadu and 3 PHCs and 1 government hospital in Kerala. The area in which the project is located has been low endemic for leprosy right from the beginning. It detected and managed one MB and one PB case in 2007. There were 3 cases with reactions. All the 12 persons with leprosy-related disability were monitored for self care and 11 of them were provided MCR footwear.

The project manages TB through its DMC. In 2007 it screened 268 chest symptomatics and registered 20 cases (NSP 12). The sputum conversion rate was 80% and cure rate for NSP was 80%.

The project also carried out IEC activities in the form of group meetings (5), outreach camps (114) to educate the tribals on leprosy and TB.



The patient on left noticed a vague patch on his right elbow about four years back. Even though he was a regular visitor to the local PHC he did not consult the doctor for the patch because he did not think that it was serious. Once when he went to the PHC with his son to consult the doctor for his son's ailment he noticed the message written on the outside wall of the PHC. It said, "Any skin patch without sensation could be leprosy. MDT completely cures leprosy". He showed the patch to the doctor. When the doctor examined him he found two more patches on his back. He was put on MDT. He says that the patches have become smaller.

Sometimes the most inscrutable actions of ours lead to the most unexpected results.

3.1.2. AMDA:

(Claver Social Welfare Centre, Claver Bhavan, P.O. Amda, Saraikala, Kharswan, Jharkhand – 833 101)

Total Staff : 11



The picture on the left shows the left hand of a lady with leprosy lesion. First she noticed a vague patch which did not 'bother her'. While cooking she accidentally poured hot water on her forearm. There was scald which she got treated by a local doctor. A few years later similar incident happened. This time she noticed that there was no pain. She consulted the same local doctor who treated her and then referred her to the PHC where a diagnosis of leprosy was made and MDT was started.

The project in Saraikala district of Jharkhand state is one of the oldest projects supported by Damien Foundation India Trust. It provides support to Prevention of disability activities in the district through on the job guidance to the General health staff. One of the characteristic features of the project is the large number of reactions it manages. Three elements stand out in the district: a high incidence of leprosy ever since the start of Leprosy control activities, high incidence of type 1 reactions and neuritis and a large disability burden. The area in which the project is located is difficult in geographical terrain. Even in the absence of a regular Medical Officer the project was able to manage leprosy affected persons and also the capacity building of the general health staff with professional efficiency.

The principal aim of the project is to build the capacity of the district staff to manage leprosy and its complications. In 2007 the district detected 351 new cases. All the cases were validated by the project and found that only one was not a case and one had already taken treatment before.

The hospital admitted 29 cases for ulcer, 6 for severe lepra reaction and 1 for preoperative training for reconstructive surgery. The project managed a total of 30 reactions during 2007. A total of 351 patients were interviewed to know their knowledge about the disease and treatment. Strangely enough 39% of them were found to have adequate knowledge about the disease and 61% had correct knowledge about treatment.

3.1.3. ARISIPALAYAM:

(St. Mary's Leprosy Centre, Arisipalayam, Salem – 625 512)

E.Mail : smlcslm@eth.net

Total Staff : 15



One of the oldest NGO projects involved in Leprosy control in Tamil Nadu the project has contributed immensely to the establishment of integrated leprosy control including POD in the district. It has supported the introduction of leprosy control through the 21 corporation dispensaries in the town. The district which has the largest number of persons with leprosy related disabilities (2500) needed support in introducing POD programme in the district. The project trained the key Government staff and with their active collaboration has been able to introduce POD in the district which can be considered as a model intervention. The programme is now monitored by the District team consisting of the DLO, the NMS from the DLO office and the PT from the project. The DLO who is responsible for two other districts- Krishnagiri and Dharmapuri- has taken up the task of extending integrated POD service in these districts also with the help of the POD team.

Of the 270 health workers in Salem District who had been trained in POD 253 were found to be involved in self-care promotion activities (regular supervision of disabled patients in self care). Out of 1062 patients 751 (71%) were found to be practicing self care regularly. The project also provided 666 patients with MCR footwear. The hospital attached to the project with 22 beds managed 156 patients with ulcer and 2 with lepra reaction. It also referred 4 patients for RCS. DFIT provided a computer to the DLO.

The project has been involved in TB control activities since 1996. It was allotted a TB unit in 2004. The MO, STS and STLS of the project plan and supervise the RNTCP activities in Salem TB unit covering a population of 578161 under the guidance of DTO. In 2007, DFIT provided a microscope to the DMC attached to the DTCO. Total cases registered in 2007 was 845 (NSP 269). Sputum conversion rate was 87% and cure rate 79.7%. One of the key features of the programme in the TB unit is the extensive involvement of the community in referral and DOT supervision.

Category of persons involved	Suspects referred	Positive cases
General practitioners	696	57
Registered Medical practitioners	202	17
NGOs	25	3
Private lab	36	2
Self help women's group	240	54
Cured patients	56	4
Through IEC	640	60

Among the DOT providers involved 24 were private practitioners, 26 Chemists, 19 Corporation centres and 160 community members.

The project is also involved in socioeconomic rehabilitation (SER) of leprosy affected individuals and families. Activities in SER include construction and repair of houses (64), distribution of goats (80), self-employment assistance (7), distribution of food grain (550) and educational support (115).

Who decides who needs what? Why do I get the niggling feeling that we often use rehabilitation platitudinously to humour ourselves into celebrity status?

3.1.4. AUNDIPATTY:

(Arogya Agam, Theni District, Aundipatty – 625 512)

E.Mail : arogyaagam@gmail.com

Total Staff : 5

The project located in Theni district in Tamil Nadu is one of the oldest NGO projects in the area which has been providing medical and social support to the people around. Known for its multifarious activities including leprosy, TB, HIV/AIDS, it has earned the goodwill of the local people through its efforts in addressing the most basic public health and social issues related to the three important diseases. After integration its focus has been on TB and HIV/AIDS. The project could not activate the Government staff in taking up prevention of disability programme for the more than 500 persons

with disability living in the area for various reasons including resistance from the staff. The project manages TB cases through the Designated Microscopy Centre. In the 100000 population that the DMC covers there is also a Government DMC which sometimes raises questions about duplication of service. A total of 35 TB cases (26 NSP) were registered in 2007. It managed in its hospital 132 leprosy cases with complications, 9 TB cases and 81 HIV/TB co-infected cases.

3.1.5. CHILAKALAPALLI:

(Gandhi Memorial Leprosy Foundation, Chilakalapalli P.O. Balijipeta,

Vizianagaram Dist – 535 557) E-Mail : prabhaa_wda@sancharnet.in

Total Staff : 8

This project is located in the most backward area of Vijayanagaram district. It has the distinction of being one of the oldest in the country and also being associated with the genesis of SET programme in India. It is managed by Gandhi Memorial Leprosy Foundation (GMLF) in Wardha. Following integration of leprosy the project decided to support leprosy activities including POD in four PHC areas and also take up support to TB control. DFIT is supporting only the leprosy component especially the inpatient management. The General health staff were trained in POD programme. The staff were able to cover all the cases with disability in the area (65 Grade 1 and 437 Grade 2) through regular visits and 352 (70%) of them were found to be practicing self care regularly. A total of 130 cases with complicated plantar ulcer were managed in its 21 bedded hospital. The project also referred 9 cases for reconstructive surgery and provided footwear to 260 patients.

3.1.6. DINDIGUL:

(Poorna Sukha Leprosy Project, St. Joseph Hospital, Dindigul – 624 001)

Total Staff : 4



The project has been involved in leprosy control activities for more than two decades. Following integration the project, at the request of Government, took up the task of establishing leprosy care service in four urban areas- Palani, Karur, Kulithalai and Kodaikanal- in addition to Dindigul town. It has succeeded in introducing sustainable service in these areas. The project did not succeed in assisting the Government in establishing POD programme in the district for various reasons including resistance from the Government vertical staff. It however tried to take care of persons with

leprosy-related disability in the area covered by it before integration. Ninety one out of 97 cases that had been trained in self care were found to be regularly practicing self management. The hospital diagnosed 4 MB and 5 PB cases and referred them to Urban health centres for management and also managed 20 cases with plantar ulcer in its 8 bedded leprosy ward.

The project is allotted one DMC in Dindigul to manage TB cases in a population of about 100000. It registered 32 TB cases (19 NSP) in 2007 and achieved sputum conversion of 80% and a cure rate for NSP of 93%.

One of the problems observed in the project is that the main hospital (not supported by DFIT) which treats quite a good number of TB cases does not follow DOT which is unfortunate.

3.1.7. FATHIMANAGAR:

(Holy Family Hansensorium, Fathimanagar P.O. Trichy – 620 012)

E. Mail: holyfamilyhansensorium@yahoo.co.in

Total Staff : 26

The project is located in Trichy district and has achieved several milestones in leprosy control. It has trained the staff at the PHCs in both Trichy and Pudukottai districts to manage simple cases of leprosy and those with simple complications. Cases with severe complications are referred to the project for management. Cases reporting to the project are diagnosed and referred back to the concerned health facilities. A total of 16 MB and 16 PB cases were diagnosed and referred to PHCs for management. The project also managed 25 cases with reaction (12 from Trichy and 13 from Pudukottai).

The project has been supporting integrated POD in the two districts for the past two to three years. Patients with disability are identified by the General health staff after getting the training by the project, mobilized to the PHCs or Subcentres for training through demonstration of self care procedure. The GH staff follow the patients subsequently during their routine village visits. They consult the project if there is any problem with patients which they cannot manage. In Trichy 82 of the 91 Health workers monitored by the project were found to be regularly supervising the patients and similarly in Pudukottai 84 of the 97 workers were found to be involved in POD activities. In Trichy 166 cases with disability were visited and 138 were found to be practicing self care. In Pudukottai 300 cases were visited and 253 were found to be regularly practicing self care. The project also provided MCR footwear to 267 patients in Trichy and 367 in Pudukottai.

A total of 13 patients from Trichy, 16 from Pudukottai and 19 from other districts underwent reconstructive surgery in 2007. The hospital which has 70 beds for leprosy, TB and HIV/AIDS managed 294 leprosy cases with ulcer, 25 cases with lepra reaction, 10 TB cases and 524 with HIV/TB coinfection.



Look at the boy in the photograph above. He is just ten years! As persons working in public health we are expected to be unemotional! When one sees him it is difficult to restrain our feeling. Is it because of 'past sin' he has developed deformity in his hands and eye? Or is it the unresponsive public health service that has rendered him the misery of the family? How can we make the system respond to the needs of the people? When you enjoy all the good in the world spare a nanosecond for the unfortunate few like the boy and think of how to prevent it from happening.

The project also manages TB through its DMC covering a population of about 120000. In 2007 it registered 91 TB cases (33 NSP) and achieved a cure rate of 74%.

The project is involved in Socio-economic Rehabilitation of Leprosy/TB /TB-HIV affected persons. Totally 292 children and 188 adults were benefited in 2007.

3.1.8. KAVALI:

(Rural Health Centre, Asaniketan, Vengalrao Nagar, Kavali – 524 202)

E. Mail : asanikethan@yahoo.com

Total Staff : 11

The project which started with developmental activities more than two decades back took up with support from DFIT first leprosy and then TB as its most important interventions. After integration its leprosy activities are confined to supporting the Government staff in two Urban health centres (UHC) in implementing leprosy control

including POD. In 2007 the project referred after diagnosis 6 MB and 4 PB to the health facilities. The 12 patients with disabilities are regularly supervised for self care activities.

The project is implementing RNTCP in one TB unit covering a population of 500000. There are 5 microscopy centres and the LTs in these centres are provided by the project. The TB control in this TB unit population is supervised by the Medical Officer, Senior TB Supervisor and Senior TB Lab Supervisor from the project. Totally 633 cases (NSP 273) were registered in the unit. Conversion was 80.5% (203/252) and cure rate was 88.5% (186/210).

3.1.9. NAGEPALLI:

(Assisi Seva Sadan Hospital, Nagepalli, Allapalli P.O. Gadchirolli Dist. Maharashtra – 4422 703) E-Mail : assisinagepalli@gmail.com
Total Staff : 15



The project is located in an area which is inhabited predominantly by tribal population in a difficult geographical terrain. It is run by Sisters and provides curative and preventive services for major tropical diseases including leprosy, TB, malaria. For leprosy it supports four Government health facilities in diagnosis and treatment of simple leprosy cases and also in POD. A total of 4 MB and 12 PB cases were diagnosed and referred to PHC for treatment. The project has placed one field worker in each PHC for supporting leprosy and TB control activities. There were 61 patients with disability and 55 (90%) were found to be practicing self care. All the eight health workers from the Government were found to be involved in POD activities. The project supplied footwear to all the 61 patients.

A Designated Microscopy Centre has been allotted to the project which manages TB cases in a population of 100000. There were 132 cases registered (45NSP) in 2007. Conversion rate was 100% and cure rate was 96% (23/24).

The hospital with a bed strength of four managed 23 leprosy cases and 101 TB cases in 2007.

3.1.10. PAVAGADA:

(Swami Vivekananda Integrated Rural Health Centre, K.R. Extension, Tumkur, Pavagada – 561202)
E.mail : swajapa@yahoo.com
Total Staff : 12

The project is situated in the most backward region of Karnataka where frequent droughts, inadequate infrastructure form the backdrop against which the project is striving to establish quality leprosy and TB services. Established in 1993 the project has carried out leprosy control activities in a population of about 250000. Following integration it has striven to support the establishment of integrated leprosy control in the area. Its main activities in leprosy control now are training of the general health staff, diagnosing and referring back to PHCs cases reporting to its centre and managing patients with disability in its old field operation area. In 2007 the project diagnosed and referred 25 MB and 9 PB cases and managed 3 cases with lepra reaction. There are 112 cases with disability in the area. All these cases were regularly monitored by the Physiotechnician who found 86 of them regularly practicing self care. The project has been allotted 5 districts (Tumkur, Davanagere, Chitradurga, Chickamagalur and Kolar) for reconstructive surgery. The PT visited the districts on request to screen the disability cases mobilized to the District hospitals for assessing their fitness for Reconstructive surgery and for advice in the management of other cases. A total of 14 surgeries were done in 2007. The project also provided MCR footwear for 44 patients.



The project has been allotted a Designated Microscopy centre (DMC) for implementing RNTCP in a population of about 100000 population in addition to making it responsible for supervising TB control in one TB unit covering two Taluks (Pavagada and Madugiri with a total population of 405105). The MO, STS and STLS from the project supervised the RNTCP activities in 4 DMCs and 12 PHCs. Total cases registered in 2007 was 579 (304 NSP), with a conversion rate of 85.3% and cure rate of 96.2%.

The hospital with 15 beds managed 146 leprosy cases for reaction, ulcer and reconstructive surgery.

3.1.11. TRIVANDRUM:

(St. John's Hospital & Leprosy Services, Pirappancode P.O.
Trivandrum Dist – 695 607)
E. Mail – stjohshealthservices@gmail.com
Total Staff : 11

One of the oldest leprosy projects in Kerala State, St John's hospital and leprosy centre in Pirappengode in Trivandrum district now manages leprosy cases with complications in its 38-bedded hospital and also in the field operation area previously covered by it. The project diagnosed and referred 14 new leprosy cases. The project is facilitating integrated POD programme in the district. It organized 45 training camps in which 486 general health staff were trained and conducted 18 POD camps where 186 patients were trained in self care.

It has been assigned to carry out TB control through its DMC covering a population of about 100000. In 2007 it registered 19 cases (NSP 11) and reported a sputum conversion of 70% and cure rate of 80%.

It managed 232 disability patients and 26 TB cases in its 38-bedded hospital. It also provided MCR footwear to 162 leprosy affected persons with disability. The project has also started community care centre for managing HIV/TB co-infection.

3.2. OWN PROJECTS:

The two projects, at Nellore and Delhi, are managed directly by Damien Foundation. The primary focus of the project in Nellore is leprosy and that of the project in Delhi is Tuberculosis control. The two projects have contributed immensely to the capacity building of the general health staff in leprosy and TB control. Till April last year the project in Delhi was providing technical support to Government institutions in the South West district. Following the decision by ILEP to suspend DTST support, the project stopped the activities and now restricts itself to diagnosing and referring cases reporting to its centre back to the Government facilities. The two projects like all other projects of Damien Foundation have won accolades for their commitment, quality service and active support to the programmes.

3.2.1. DELHI:

DELHI: (Margaret Leprosy and TB centre, Qutub Vihar Phase-I, Goyela Diary Main Road, Near Police Check Post, Najafgarh, New Delhi – 110 071)
E. Mail : dfitlepdelhi@vsnl.net
Total Staff : 21

The project is located in the South West part of Delhi and covers a population of about 1 million for TB control activities. Till April Last it also played an important role in building the capacity of the Government staff in implementing leprosy control. Following the decision of ILEP to withdraw the Technical teams from Districts, support activities were suspended. It still manages cases which report to its centres and



diagnosed and referred to the Government facilities for treatment. The district registered 205 MB and 180 PB.

The project has one Medical Officer, two STS, two STLS and 12 field staff. There are 10 Microscopy centres in the two TB units allotted by the Government. Each Microscopy centre is managed by a field worker with the combined responsibility of doing sputum microscopy, DOT supervision and arranging DOT providers and their monitoring. The STS visits all the centres on DOT days and STLS visits the centres at least twice a month. One of the unique features of the project is that both sputum microscopy and field activities are done by one field worker who is given a bike to move in the field. The workers were asked to manage treatment through community DOT providers whose number after much persuasion is increasing. The mandate is that by the end of 2009 treatment for at least 60% of the patients will be managed by community DOT providers.

Year	TB cases registered	
	NSP	Total
2002	34	96
2003	111	315
2004	369	1211 (second unit established)
2005	463	1529
2006	612	1919
2007	661	2026

Totally 2026 TB cases (661-NSP) were registered in 2007. There was one TB unit till 2004 when the second one was added. Case notification has improved gradually and it is now as per expectation. Sputum conversion was 88% (560/636) and cure rate was 85.6% (524/612). Two ICTC centres were started in 2007 covering a population of 200000. These centres are totally supported by the Government.

One of the unique features of the project has been the community involvement in the programme.

Category	Number involved	No of suspects referred	No of TB cases diagnosed	Number involved in DOT supervision
Qualified General Practitioners	56	127	76	3
Registered Medical Practitioners	163	378	127	53
Government Hospital and Dispensaries	16	2620	1125	0
Community Volunteers	405	2755	698	65
Non Government Organisations	5	0	0	0
Total	665	58	2026	121

Whereas the number of community members involved in suspect referral is quite large, number involved in DOT supervision is not (less than 20%). "People working in public health should be ready and willing to face disappointments and frustrations". This applies very well to some projects. Despite being praised by all for the excellent work being done by the project the project's existence and its contribution have not been acknowledged in the annual report of the Government for the flimsiest reason that the microscopy centre has only one field worker which does not correspond to the requirement under GOI guidelines.

3.2.2. NELLORE:

(Damien Foundation Urban Leprosy Centre, Bakthavachala Nagar, A.K. Nagar Post, Nellore : 524 004) E.Mail: dfulcnlr@sancharnet.in
Total Staff : 5

The project which started in 1993 has been doing leprosy work since then and TB work since 1996. It is one of the projects of DFIT which introduced TB service under DOTS in 1996 and has continued to provide quality service to the people in Nellore town.

Its leprosy control activities include facilitating the 7 Urban health centres in Nellore town in managing leprosy cases, diagnosing and referring cases to UHCs, managing cases with complications either in the field or in its ten-bedded hospital. It also does reconstructive surgery for patients with disability referred from Nellore, Prakasam and Kadapa districts, assisting the UHC staff in following patients with disability in

Nellore town and training the general health staff. The project diagnosed and referred 9 MB and 6 PB leprosy cases to UHCs.

The project is supporting POD activities in the district. In 2007 it covered 14 PHCs. All the staff were trained in POD activities. Patient list was prepared and given to the Paramedical worker and ANM for monitoring them in self care activities. Out of the 241 cases with disability who were monitored 162 (67%) were found to be practicing self care. Out of the 62 health workers 48 were found to be actively monitoring the patients in self care. The project also did reconstructive surgery for 25 patients and provided MCR to 226 patients. The hospital managed 26 patients with complicated plantar ulcer and 27 patients with lepra reaction.

The project is allotted a DMC for managing TB cases in about 100000 population in Nellore town. It has a Medical Officer, a Supervisor, a paramedical worker and a Laboratory technician for this purpose. In 2007 it registered 219 cases (73 NSP) and achieved a conversion rate of 92% and cure rate of 93%. NSP went up from 48 in 2003 to 73 in 2007, total cases from 143 to 219, extra pulmonary cases increased from 8 to 28 and cure rate from 67% to 93%. A separate wing for managing TB cases with drug resistance is under construction.

3.3. SUPPORT PROJECTS IN THE SOUTH:

This patient with ulnar abscess who presented to the PHC was treated with Prednisolone 10mg once a day for 10 days. The doctor at the PHC then told



him that he did not require any more treatment and he would be all right. When the tingling and numbness sensation in the hand became worse he went to a General practitioner who referred him to the NGO hospital in Pavagada. Integration of leprosy is certainly beneficial from the point of view of accessibility of service but it will not succeed unless it is supported by an effective referral system.

Damien Foundation has been supporting TB Control in 6 districts in three States for periods ranging from three to seven years. The three districts supported in Andhra Pradesh are Anantapur, Kadapa and Nellore; in Karnataka, they are Bangalore Urban

and Tumkur; in Kerala, it is Trivandrum. The main focus of DF intervention is in strengthening the DOT supervision through proper identification of DOT providers from the community, their training and supervision so as to achieve good cure rates especially for New Sputum Positive cases; assisting the staff in ensuring that follow-up sputum examination is done for all cases; dissemination of correct messages among the community; interacting with the ANMs at the PHCs to ensure that the cards are updated; and assisting the DTO in the trainings of all key staff. Each of the six districts has a team of Senior Medical Consultant with two to three supervisors with mobility support.

3.3.1. ANDHRA PRADESH:

A. Anantapur:

(Damien Foundation India Trust, D.No.6-13-17, Vijaya Nivas, Ramnagar Extension, Anantapur – 515 001)
E-Mail : dfittstap@yahoo.co.in
Total Staff : 8

The support team consisting of a Senior Medical Advisor and three Supervisors has been functioning in the district since 2001. They were placed in the district at the request of the Government of Andhra Pradesh. The team in its 7 years of involvement in leprosy and TB control activities has contributed immensely in the improvement of both the programmes. Before the withdrawal of support to leprosy control from April 2007, the team succeeded in bringing about qualitative changes in the integrated management of leprosy control through periodic trainings, accompanied supervision and review meetings at various levels. The team interviewed 997 community members and found 64% with correct knowledge about leprosy.



It trained 225 general health staff including 35 Medical Officers in Prevention of disability. Follow up of patients and workers could not be carried out because of the collective decision of ILEP to suspend DTST support.

The photograph on the left shows the right foot of a lady with deformity. She had been trained in self care by the team about a year back. At that time she had a deep ulcer in the right heel with foul-smelling discharge. A poor lady with no financial support she was happy to understand that her ulcer could be cured with simple self-help measure (soaking in water

in a broken pot, scraping with stone, applying neem oil and covering the ulcer with a clean cloth – she used strips from her husband’s sarong – lungi). Recently the team contacted her when they visited the village. They were surprised to find that she was practicing self care regularly and there was no ulcer. Rather, the skin in the sole was soft and supple.

The main focus of the team now is in strengthening the TB control in the district. The team trained all the key staff and general health staff once, had regular meetings with the staff at PHCs and key staff at the District headquarters to assist them in identifying and solving problems especially in DOT supervision, follow up sputum examination and in sputum microscopy. They visited all the PHCs and TB units including DMCs at least once every month, all the new positive cases at least once in the intensive phase and all other cases at least once to ensure correct DOT supervision.



Mr. Chand Basha, a Registered Medical Practitioner in Anantapur town agreed to participate in RNTCP by suspecting and referring cases and also providing DOT to patients. He has so far treated 32 cases most of them referred by him. Currently he has 6 patients who take treatment under his supervision. Of the 26 cases one died and the remaining were cured or completed treatment. He is one of the 34 RMPs in Anantapur town who are actively involved in RNTCP.



They visited 2471 DOT providers and found that 94.5% of them were functioning correctly. They also visited 3714 cases to verify treatment regularity and found that 94% of them were on DOT. The team retrieved 301 of the 359 absentees. A total of 4863 community members were interviewed and found 57% with adequate knowledge about the disease and the programme. The team also supported the transportation of drugs from the DTO to TUs and PHCs whenever required. The team was also involved in the pilot testing of Cotrimoxazole prophylaxis in the district and several operational research projects. It will extend its support activities to the neighbouring district of Chittoor from January 2008.

The district detected 6100 cases (NSP 2684) from 30507 suspects. Sputum conversion was 91.8% and cure rate was 86.3%. External Quality Assurance has been well established in the district. The district has achieved both case notification and cure targets.

B. Kadapa:

(Damien Foundation India Trust, 7-201-A, NGO Colony, Kadapa – 516 002)
E-Mail : dfitkdp@yahoo.co.in
Total Staff : 4

The support team consisting of a Senior Medical Advisor and two Supervisors started functioning for supporting leprosy control in 2001 and for TB in addition in 2003. Since April 2007 the team does not have a MO but has been functioning under the guidance from the Senior Medical Advisor located in Anantapur. From January 2008 the team will be under supervision by the Senior Medical Advisor located in Nellore. Before the withdrawal of support to leprosy control from April 2007, the team succeeded in bringing about qualitative changes in the integrated management of leprosy control through periodic trainings, accompanied supervision and review

meetings at various levels. The team trained 176 staff from the Government in Prevention of Disability.

The team members visited all the PHCs at least once in two months, attended the PHC level meetings once in 6 months and District level meetings every month. The team also supported the transportation of drugs from the DTO to TUs and PHCs whenever required. It found that 28% of the health facilities were identifying and referring adequate number of TB suspects, positivity rate was within normal limits in 69% of the DMCs, drug stock was adequate in all the facilities, about 93% of the 1903 patients visited were found to be on DOT and 91% of 935 DOT providers visited were functioning correctly. The team retrieved 101 out of 136 absentees and 29 out of 63 defaulters. Of the 5690 community members interviewed 63.3% (3602) were found to have adequate knowledge about TB.

The district detected 4393 cases (1558 NSP). Sputum conversion was 89.9% and cure rate was 84.2%. The district has achieved case detection target and almost reached the cure target.

C. Nellore:

Damien Foundation India Trust, Bakthavachala Nagar, A.K. Nagar Post, Nellore – 524 004) E-Mail : dfulcnlr@sancharnet.in
Total Staff : 4



The team consisting of two Supervisors and a Senior Medical Advisor has been involved in supporting leprosy control since 2001 and TB control since 2003. Support to leprosy control was suspended from April 2007 as per the decision of ILEP. The team trained all the staff in leprosy including POD, assisted the paramedical workers in updating the list of cases in the disability register, carried out an operational research study to determine the diagnostic efficiency of ANMs in comparison to the Medical Officers (ANMs were found to be equally good in diagnosis), helped the Government in establishing POD in 14 PHCs and monitored self care activities along with the project staff from Nellore in Nellore town.

The team played a crucial role in the training of all the staff in RNTCP at the beginning of the programme. The team visited all the PHCs at least once a month, attended meetings at PHCs once in a quarter and participated in district level meetings every month, helped in transporting drugs from DTO to the TB units and the PHCs whenever required, trained the staff along with the RNTCP consultants and provided support for the establishment of EQA. The team visited 2772 patients of whom 72% were found to be on DOT. The team also visited 2007 DOT providers and found 76% of them functioning correctly. In addition, the team was able to retrieve 118 out of 182 absentees and 29 out of 51 defaulters. Out of 3381 community members interviewed 67% were found to have adequate knowledge about TB.

3.3.2. KARNATAKA:

A. Bangalore Urban:

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

E-Mail : vivekanandadfit@yahoo.com

Total Staff : 6



The team in Bangalore Urban consisting of a Senior Medical Advisor and three supervisors was placed in 2003. The team was meant to support only TB control which was really in a bad shape. The team established good rapport with the Government staff and brought about several significant changes. The two sanatoria which had refused to be involved in RNTCP fell in line and acceded to implement TB control as per RNTCP guidelines. A large number of TB cases after diagnosis at the sanatoria used to be lost because of lack of follow up. The team established a mechanism of proper referral and follow up. As on December 2007 about 88% of the TB cases diagnosed and referred back to the PHCs could be traced and brought under treatment. About 90% of the cases used to take treatment at the PHCs and in

the absence of adequate number of field workers it was difficult to ensure regularity of treatment. Now at least 60% of the patients take treatment close to their home either from Anganawadi workers or from their neighbours or from RMPs. There was only one STS and STLS. The situation has changed now - there are 5 STS and STLS, one for each of the 5 TB units. The team trained several NGOs in RNTCP.

The team visited all the health facilities (26 DMCs, 16 PHCs, 33 APHCs, two sanatoria and two hospitals) at least once in two months. It found that 75% of the health facilities were referring adequate number of suspects; positivity rate was within normal limits in 80% of health facilities; 93% of 3430 patients visited were on DOT; and 71% of the 4566 community members interviewed had correct knowledge about TB. It retrieved 156 out of 214 absentees and 21 out of 42 defaulters and arranged 36 new DOT providers.

The district registered 3384 cases (NSP 1186). Conversion was 81.7% and cure rate was 72.9%.

Damien Foundation has provided 6 Laboratory technicians and 4 TB health Visitors to strengthen the programme. The team has been requested to support two more districts- Bangalore rural and Bangalore City.

B. Tumkur:

(Swami Vivekananda Integrated Rural Health Centre, K.R. Extension, Tumkur, Pavagada – 561202)

E.mail : swajapa@yahoo.com

Support to the district was in the form of 3 health visitors provided to the district, one each for Pavagada, Madhugiri and Tipatur. Each has been given a bike for covering a population of about 200000 for helping the programme in DOT supervision and defaulter retrieval.

3.3.3. KERALA:

A. Trivandrum:

The team in the district consisting of a Medical Advisor and two supervisors was placed in 2004 and has been helping the District TB Officer in all the TB control activities like training, DOT and Sputum microscopy. It visited all the health facilities (52 DMCs, 34 PHCs, 26 UHCs) at least once in three months. The team found that 93% of the health facilities were referring adequate number of suspects; in no DMC the positivity rate was within normal limits; 80% of 1808 patients visited were on DOT; 89% of 904 DOT providers were functioning correctly; and 65% of the 2604 community members interviewed had correct knowledge about TB. It retrieved 84 out of 162 absentees and 12 out of 26 defaulters and arranged 83 new DOT providers. In the district 78 GPs were involved and they referred 26 Suspects.

The district registered 2672 cases (NSP 1133). Conversion was 83.5% and cure rate was 80%.



Different manifestations of leprosy



3.4. BIHAR:

(Damien Foundation India Trust, C 16-A, Sree Krishnapuri, Patna – 800 001)

E-Mail : dfitpat@sancharnet.in

Total Staff : 103

3.4.1. LEPROSY CONTROL:

A. Introduction:

Damien Foundation has been supporting Leprosy control since 1996. It started with introduction of SET centre in two places - Wasirganz in Gaya and Amda in Saraikala in 1985. It culminated in the placement of District Technical Support Teams in ten districts and by 2000 it was supporting 22 districts. Other districts were supported by other ILEP members - LEPRO Society, Netherlands Leprosy (NLR) and The Leprosy Mission (TLM).

The situation has improved to a large extent but there are still residual problems which need to be addressed. The state needs support in meeting the challenges through appropriate interventions. Though ILEP has decided to withdraw the DTSTs from April this year based on the evaluation report which indicated that a reasonably functioning mechanism had been established to manage simple cases of leprosy, support from ILEP would continue. Under the new arrangement ILEP members would support leprosy control in thematic areas in all the 38 districts in Bihar through a mechanism other than DTST.

B. Methodology:

The programme in the district is managed by the District Leprosy Officer (DLO). At the subdistrict level there are Primary Health Centres (PHC) and Additional primary health Centres (APHC). Each PHC covers a population of 150000 to 200000. Under every PHC there may be 2 to 4 APHCs. Each PHC has at least 4 Medical Officers and other staff including staff nurse, pharmacist and Laboratory technician. Each PHC also has field workers, one female worker (ANM) and one male worker (Multipurpose health worker, male) for every 5000 to 10000 population. For every four to five ANMs/MPHW (M) there is a Supervisor (Lady Health Visitor/ Multipurpose health supervisor). APHCs are practically nonfunctional. Patients reporting to PHCs either on their own or on being referred by the ANMs are diagnosed and treatment is initiated. Follow up treatment is managed by the ANMs or by the PHC. Treatment cards are maintained by the person who manages the patient and a master register is maintained at the PHC. Reports are prepared by the PHC every month and sent to the DLO who collates the reports, prepares the District report and sends it to SLO. The programme is reviewed by the DLO every month. Drugs are transported from the State headquarters to the zonal depots and from there to districts. The PHC staff collect the drugs from the DLO every month. The programme administration is decentralized so that the District Health Society of which the District Magistrate is the head is given the responsibility for planning and implementing the programme.

The principal theme of ILEP support is strengthening of Government infrastructure. Facilitating the District Nucleus in discharging their responsibility, facilitating the establishment of referral system for managing patients with complications and ensuring that all peripheral health institutions provide quality leprosy service to those in need are the three main areas which are given primary focus by ILEP. Maintaining the same high level of quality in managing simple cases of leprosy through periodic training, strengthening the supervisory support mechanism through appropriate training of district supervisors and helping their mobility in the district, identification and training of specialists in every district to improve their capacity in managing patients with complications, providing support to the state level functionaries in monitoring the programme through periodic review meetings of DLOs are some of the activities that will be given attention. For this ILEP has identified a State Level Coordinator from DFIT who would act as a liaison between ILEP and the Government and would ensure the implementation and monitoring of jointly agreed activities. The coordinator would mobilize resource persons from the common ILEP pool whenever required for facilitating the support activities. An independent monitoring will be carried out every year to review the progress.

C. Problem analysis:

The DTST in every district has played an important role in facilitating the integration process and strengthening the leprosy service with focus on quality of care. The DTSTs visited all the PHCs on designated days to examine doubtful cases and assist the Staff in confirming diagnosis and managing reactions. The staff of the District nuclei in all the districts were trained to improve their skills in supervision and monitoring. Formal training was followed by continuous on the job guidance. The DTSTs attended the monthly meetings at PHCs to discuss various field problems and help in instituting remedial actions. A sample of cases under treatment was visited to assess the treatment regularity and a sample of persons from community was interviewed to assess their awareness about leprosy disease and the programme. The DTSTs assisted in training the staff, both NLEP and GH, in Prevention of disability including management of reactions and helped the staff at PHCs in treating cases with reactions. In subcentres without staff the teams identified volunteers from the community with the help of staff from adjacent centres and these volunteers participated by referring suspects and providing follow-up treatment to cases. The teams were involved in dissemination of appropriate messages on the disease whenever they visited villages for any activity through group talk. Strengthening the technical and operational competence of the staff was the main responsibility of the teams and they did this through verification of a sample of cases and demonstration of these cases at the PHCs and through accompaniment with the Medical Officers/ District nucleus staff. An independent evaluation of DTSTs in NLEP which was done in the early part of the year indicated that the programme was reasonably good and there was little need for continuation of DTSTs.

D. Residual problems:

Case detection:

Trend of leprosy in a sample of 23 districts: 2003-2007

Year	New cases	MB%	Disability%	Child%	WD%	RR%
2003	53500	29.01	1.12	16.03	5.3	6.8
2004	36891	26.4	0.9	19.2	8.8	6.9
2005	16227	35.4	1.5	16.2	3.5	4.7
2006	13789	34.3	2.1	15.0	1.1	2.0
2007	11241	38.1	2.5	14.8	NA	NA

a. Awareness among the community is good (average 60%). But it needs to be sustained through a well-coordinated and directed plan of activities.

b. The turning point as one can see from the table above was 2005 when case detection fell by over 50% which was mainly due to the cessation of all active case detection efforts. The rise in MB proportion and disability proportion and significant fall in discrepancies in diagnosis indicate an obvious improvement in quality of diagnosis. Three districts reported more than 1000 new cases. All the three (Dharbanga, Madhubani, West Champaran) are big with large population and bordering Nepal. Quality of diagnosis was good in all the three. Two-thirds of several districts become inaccessible for at least four months in a year because of inundation. Case detection during this period is a serious problem.

c. Cases are detected mainly through self-reporting either at the PHCs or at IEC camps. As per the norms (1 PHC for about 30000 population and one subcentre for every 5000 population) there should be 1500 PHCs and 11661 subcentres but actually there are 258 PHCs and 5325 subcentres in 23 districts. Sometimes one ANM looks after two or three subcentres. It is therefore not surprising if there is less number of suspect referral from subcentres. Volunteers from the community were identified in some districts to help the programme in suspect referral and follow-up treatment. The number involved is too few to make an impact.

d. Nonavailability of general drugs at the PHCs discourages people from self-reporting. If a person with suspect patches reports to a PHC he gets the treatment. If the skin disease is anything other than leprosy he does not get treated. This may not encourage people with suspect patches to report to PHCs unless they are sure that it is leprosy.

Treatment:

e. All the subcentres of all the PHCs were involved in providing follow-up treatment. Wherever there was shortage of SC staff community members were identified to

carry out two important tasks - suspect referral and follow-up treatment. Treatment was initiated at the PHCs and continued at subcentres. Treatment completion was 80% for MB (2004 cohort) and 93% for PB (2005 cohort). Follow-up treatment of cases during the monsoon season is a serious problem which is overcome to a large extent by giving the drugs for the period of inaccessibility to the patients or handing over the drugs to volunteers in the community. Occasional disruption in drug transporting poses problems in prompt initiation of treatment.

f. A total of 643 cases with reaction were managed by the PHCs with the help of the teams. For majority of these cases steroids were provided by the teams. Steroids were not available in majority of the districts because of various reasons including difficulties in obtaining through the District Leprosy Society (DLS). The district hospitals are not trained to deal with complicated cases. Referral mechanism is still not established.

Prevention of disability:

g. Prevention of disability activities were taken in right earnest. Training was given to patients and General health staff block-wise in self-care. Training on POD was completed in 40% of districts. A total of 2948 patients with disability were identified of whom 1729 were trained on self-care in POD camps. In addition to patients 1057 family members of patients were also trained in self care. A total of 5486 general health staff (471 MOs, 2940 ANMs and 2075 other staff were trained in the POD camps). Involvement of the general health staff in POD activities is poor for various reasons including lack of general guidelines from the Government, nonavailability of appropriate footwear and other appliances to patients, lack of supervision and monitoring.

h. From among the patients who underwent self care training 124 were identified to be eligible for reconstructive surgery and referred to the two medical colleges. A total of 69 of them underwent surgery. Generally patients with long standing disability don't like to undergo surgery for various reasons including loss of livelihood (for 3 months) and also the fact that they learn to live with it. Of the two RCS centres (Patna and Dharbanga) practically only one (unit at Patna Medical College) is active. The other one has serious problems like lack of facilities for hospitalization of patients. DFIT has agreed to construct a ten bedded ward. Concurrence from the Government is awaited. Totally 64 patients in Patna and 5 in Dharbanga were operated upon.

i. Management of patients with complications like reaction is still a problem. Referral system is not yet established. So cases with complications will have to go to Medical college hospitals which are few and far in between. Even simple septic surgery for patients with complicated ulcers is not done at district hospitals. The specialists in the district hospitals are not trained.

Programme management, Monitoring and Supervision:

j. Monitoring and supervision at all levels are inadequate. There are eight districts where district nucleus is not there because of nonavailability of staff. In these eight districts monitoring and supervision is almost nonexistent. In other districts even though skeletal staff in the nucleus are available their movement is restricted because of absence of transport support. The District nucleus staff were moving with the teams all these years. After assessment of the leprosy situation in various states including Bihar where District Technical Support Teams had been placed by various international NGOs collaborating under the banner of International federation of anti-leprosy associations (ILEP), it was decided to withdraw the teams for leprosy from April 1st 2007 and provide support in thematic areas identified jointly by ILEP and the states. With the withdrawal of teams mobility will be a serious problem. The staff also needs training in management including supervision.

k. DFIT and other ILEP members supported the quarterly zonal review of the programme through meetings of DLOs. Six zonal level meetings were conducted in 2007 with help from ILEP.

l. There are several individuals, groups, organisations in the state and the districts who if involved in the programme could make a significant difference to the outcome. Even though DLO has to act under the guidance of District Health society in which District Leprosy Society is integrated he is handicapped by the necessity to consult the chairman of the DHS, the district magistrate, for every activity that he is expected to implement. This poses restrictions on his managerial capacities.

m. The state's plan is directed by Government of India. It is mainly activity-based plan not result-based. As such there is little interest or effort in microanalysis of problem. Problems often are not solved because solution is mentioned in the guidelines.

3.4.2. TB CONTROL:

A. Introduction:



India is one of the countries with a huge Tuberculosis disease burden. Every year in the country 1.8 million are detected and 400000 die from it. It is estimated that for every 100000 population there could be about 75 new sputum positive pulmonary Tuberculosis cases. Revised

National Tuberculosis Control Programme (RNTCP) launched a decade back by the Government in response to the dangerously spiraling epidemic has succeeded in covering the entire country with TB services under Directly observed treatment short

course (DOTs) strategy. Bihar state situated in the North of the country has been one of the last states to achieve total coverage under DOTs recently. It is one of the most populous states (96864593 [2007]) in India. The state which has more than 70% of the population below the poverty line has been beset with several constraints and obstacles which have prevented it from achieving the predetermined, universally adopted objectives of 70% case detection and 85% cure rate. Considering the seriousness of the problems faced by the state, the government of Bihar sought the help from Damien Foundation India trust, a subsidiary of Damien Foundation Belgium (DFB), International Non Governmental organisation, to bolster up the programme. DFIT which has supported National Leprosy Eradication Programme (NLEP) in the state since 1996 through District Technical support Teams (DTST - each team consisting of a doctor and a non medical supervisor with a vehicle) in 22 districts used its experience to extend support to TB control from 2003.

DFIT extended support to the programme through consultancy teams placed in 28* districts. In each district one or two experienced supervisors with mobility support were placed to assist the programme mainly in DOT provider identification, DOT supervision, dissemination of correct messages about the disease and the programme in the community and ensuring regular updating of patient cards. A Medical consultant was posted for 4 to 5 districts to provide supervisory guidance to the Supervisors, facilitate trainings of DOT providers, identify problems at the DMCs (Designated Microscopy Centres) and assist the DTOs (District TB Officers) in taking immediate remedial action and providing necessary support in drug supply management. Both visited the field for about 20 days a month. Whereas the supervisor would confine himself to the district in which he was placed the consultant covered 3 to 4 districts in a month. The supervisor visited the patients, DOT providers, community groups to ensure proper treatment and involvement of the community.

He also visited the sub-centres and PHC (Primary health centres) during the meeting days to interact with the ANMs (Auxiliary nurse midwife) and other staff. The Medical consultant visited the PHCs in the districts under him to observe sputum microscopy and quality of service at the PHCs and interacted with the Medical Officers to facilitate solving problems. He also attended the monthly meetings at the district level to facilitate solving problems encountered by the PHC staff. The supervisor and the consultant visited the field accompanied by the MO/STS/ANM/DTO so that the intervention resulted in augmentation in the capacity of the staff. The Medical consultants were supervised by either Chief Medical Consultant (CMC) or Chief Medical Advisor (CMA) located at Patna. Every month 3-6 districts were visited along with the DFIT teams by CMC/CMA. There was also monthly meeting of the supervisors of the Districts done by the Medical consultants, monthly meeting of consultants by the CMC/CMA and quarterly meeting of all teams. These meetings would help in identifying key issues and problems, exchange experiences.

* Vaishali, Saran, Siwan, Gopalganj, Sitamarhi, Sheohar, Dharbanga, Madhubani, East Champaran, West Champaran, Purnea, Katihar, Kishanganj, Araria, Rohtas, Nalanda, Jehanabad, Arwal, Saharsa, Supaul, Madhepura, Khagaria, Muzaffarpur, Patna, Bhojpur, Buxur, Aurangabad, Nawadah,

Each team also submitted a report every month which helped in reviewing the progress. A Senior Lab Coordinator was placed at Patna to assist the programme in implementing External Quality Assurance (EQA) and also in training and monitoring. He visited the districts 15 days a month to help the districts in identifying and solving problems related to Sputum microscopy or in assisting training of the lab staff. The Senior Lab Coordinator was assisted by the Central Lab Supervisor from Chennai and Senior TB Lab Supervisor from Delhi project whenever required.

B. Situation analysis:

Tuberculosis is one of the serious public health problems in India with 1.8 million new cases (0.8 million infectious) getting notified and around 400000 dying from it every year. Estimated new sputum positive is 75 per 100000 population per year. The problem is more severe in states like Bihar because of various constraints and obstacles in making available TB services to people in need. Bihar state situated in the eastern part of the country is one of the most economically backward and lags behind in the implementation of all the Public Health programmes for various operational, geographic, socio-economic and administrative reasons. High population density, poor economic development, extremely poor infrastructure, inaccessibility of villages because of lack of roads and frequent seasonal flooding, a lethargic bureaucracy are some of the factors that are responsible for the situation.

C. Problem analysis and DFIT intervention:

The past:

Till 2003 only two districts were under RNTCP. Even in these districts case detection was pathetically low and cure rate was a measly 40%. Less said about the situation in other districts the better it is. Laboratory services were nonexistent and drugs were not available. Diagnosis was mainly by X ray and treatment most often was monotherapy which was available sometimes only at the District headquarters hospitals. Peripheral health staff were not involved.

Several problems encountered during the preparation of districts for RNTCP which prevented the state from rapid expansion of the programme have now been largely resolved. Staff were recruited or identified from among the former TB control staff for important vacant positions. Lack of training facilities and manpower for training key personnel also hampered the preparations. DFIT assisted in training majority of doctors, field supervisors and laboratory technicians in 10 districts which took up RNTCP in 2006 through trainers from the South at State TB Training and Demonstration Centre (STDC), Patna. In addition, the staff from 11 districts which had started RNTCP before were given reorientation training. Establishment of Laboratories was a serious problem. Laboratories could be established mainly in Primary Health Centres (PHCs) not in Additional Primary Health Centres (APHCs) (even though there are 896 APHCs) as a large proportion of them lacked basic infrastructure and manpower.

DFIT has been supporting TB control in Bihar since 2003. It assisted the State in preparing and introducing RNTCP in all the 22 districts. DFIT provided facilitators for the training of key personnel in State TB Training and Demonstration Centre (STDC) at Patna and other staff in the districts. Facilitators from DFIT with vast experience in implementation of TB control and in training were involved in the orientation activities. Each district was provided with a Supervisor with mobility support for assisting the general health staff in implementing TB control. A Senior Laboratory Supervisor, extensively trained and experienced, was placed at Patna to assist the state in training the Laboratory technicians and Laboratory supervisors called Senior Tuberculosis Laboratory Supervisors (STLS). DFIT assisted the State in replacing defective objectives and eyepieces in the microscopes in Vaishali, Katihar and Purnea. Immersion oil of high quality was supplied to all the DMCs in the 22 districts. Sputum cups of WHO (World Health Organisation) specification were supplied to two districts.

Present situation:

Tuberculosis control activities like all other public health programmes in the state are coordinated by State Health society headed by an administrator under whose guidance each programme has a technical head. For Tuberculosis control it is the State Tuberculosis Officer (STO) who implements all activities in each of the 38 districts through a District Tuberculosis Officer (DTO). All the public health programmes in the district are controlled by Civil Surgeon who is assisted by the DTO in planning and monitoring Tuberculosis control. In each district there are Primary Health Centres one for every 200000 population which is headed by a Medical Officer and under each PHC there are Subcentres each covering a population of 5000 to 15000 and manned by a Male (multipurpose health worker-MPHW) and female health worker (called auxiliary nurse and midwife-ANM). All the public health programme activities are carried out by multipurpose health workers from subcentres and controlled by Medical Officer in charge at PHC. Health staff at the PHC manage the patients attending the Outpatient at the PHC and all field activities are managed by the MPHWs. Since TB control has been integrated into general health all activities under RNTCP are also implemented by the staff at the PHC and Subcentres. The programme has certain specialized staff for either basic activities or for supervision and monitoring. For every 500000 population in the district there is a Tuberculosis Unit which has a Medical Officer, Senior TB Supervisor and Senior TB Laboratory supervisor for overall supervision and control, for field supervision and for laboratory supervision respectively. Under each TB unit there are at least 5 designated microscopy centres which are basically primary health centres which are provided with a laboratory, a laboratory technician and a microscope for diagnosis of Tuberculosis disease. Suspects reporting to the PHC or designated microscopy centre are suspected to be respiratory symptomatic and referred by Medical officer to the Microscopist. Three sputum samples are collected from suspects for diagnosis. After diagnosis treatment is initiated under one of the three categories depending on the severity and previous treatment. Treatment is given under direct supervision. Field supervision is done by Senior TB Supervisor who also maintains TB register and Senior TB laboratory supervisor does the supervision of designated microscopy centres (DMC) to ensure quality sputum microscopy.

There are 135 TB units and 488 Microscopy centres (functioning) in the 28 districts (which are being covered by DFIT now) covering a population of 77632458 (2007). There should have been at least 770 microscopy centres for this population. Number planned is 676. The six new districts (Patna, Bhojpur, Buxaur, Aurangabad and Nawadah) were allotted to DFIT in November 2007.

Case detection

Coverage of the districts under TB control could be extended to all the districts only by the second quarter of 2006 (two in 2004, twenty-two in 2005 and the rest in 2006). Before 2004 only three districts had been covered- Patna, Muzaffarpur and Vaishali). This means in many of the districts TB control has been a recent introduction. As such one cannot expect tremendous change in case detection in such a short period of time.

a. The teams from DFIT interviewed 48653 community members and found 26017 (53 %) aware about TB disease and RNTCP. In the six new districts 1985 were interviewed out of whom 1110 (60%) had adequate knowledge about the disease and the programme. It was highest (75%) in Saran and lowest (33%) in Sheohar. There were 6 districts (Arwal, Jehanabad, Gaya, Katihar, Vaishali and Gopalganj) with levels above 60% and 5 districts (Khagaria, West Champaran, Sheohar, Siwan, Kishanganj) below 40%. The low level of awareness has a negative impact on suspect identification. Awareness levels are influenced by several factors like extent of contact with peripheral health workers, intensity and coverage of areas with effective IEC (Information Education Communication) activities, extent of involvement of cooperation partners in awareness generation and other activities of RNTCP. Generally IEC is confined to sticking posters on walls of public buildings, distribution of leaflets, and display of rather dull messages through hoardings.

b. There are 326 PHCs, 896 Additional PHCs, and 7276 Subcentres in the 28 districts. Only a few APHCs are functional because of lack of key staff (Medical Officer). The Government in its recent order shifted Medical Officers from Additional PHCs to PHCs apparently to strengthen the PHCs which are the mainstay in providing curative and preventive services. This means majority of the APHCs are nonfunctional. For every PHC there are two to three APHCs. There are 133 MO Tuberculosis Centre, (MO TC), 130 STS, 132 STLS and 603 LTs in position. This number changes constantly. There are 488 functioning DMCs. The number required would be almost twice this. Several DMCs though sanctioned are not functioning for various reasons like lack of proper space, absence of trained laboratory technician, frequent turnover of laboratory technicians because of the method of their recruitment (recruited and appointed on contract basis for one year). DFIT provided 15 Laboratory technicians for 15 DMCs and posted its own staff (LTs, STS and STLS) in two TB units, one each in West Champaran and Kishanganj. It also rectified microscopes in Katihar and provided three new microscopes for Vaishali district.

c. Majority of the functioning centres are also not easily accessible because of difficult geographical location and bad roads. Average OPD attendance in a PHC covering a population of about 200000 was about 30 per day till recently. Things have begun to change. There has been quite some improvement in the number of people (gone up to about 150 per day) availing service at PHCs because of the improvement in drug supply. Total number of OPD attendance in the 23 districts was 5495391. It works out to about 800 per day in a district. With an average of 10 PHCs per district it works out to 80 per day which is not enough. A large percentage of sick people go to general practitioners. Their participation in TB control is minimal because of lack of overtone from the programme. Still case notification is a measly 73 per 100000 population which is considerably below the expected 230. A total of 174318 suspects (3.02%) were identified and 170565 (97.8%) were subjected to sputum microscopy which yielded 24099 sputum positive cases (14.1%). About 4.6% of the suspects were subjected to single sputum examination.

d. At least one half of villages in almost all the districts situated above the Ganges (20) become totally inaccessible 3 to 4 months in a year during the monsoons because of inundation. The Government staff cannot reach these places and activities come to a stand still. Case notification shows a dip always in the third and fourth quarter. National guidelines which are used like Bible by programme managers are always quoted for not considering locally suitable alternatives to overcoming the perennial problem.

e. There were 488 DMCs in the 28 districts. Out of the 652 microscopes 615 (94.3%) are in working condition. The situation does not become better. For example out of 15 microscopes in Vaishali ten had become nonfunctional about 5 years back and nothing was done. Repair and replacement was done by DFIT at the end of last year. Lack of awareness about the maintenance of microscope, lack of training, lack of proper place for keeping the microscope (cupboards were there without doors, without ventilation or without bulbs for keeping it warm), lack of electricity, high humidity make the maintenance of microscope a difficult proposition. DFIT provided all the DMCs facility for maintaining microscope (cupboard with electric bulb, silica gel, etc.,). A total of 25791 slides were reviewed and 19425 (75.3%) were good in smear spreading and 18764 (76.9%) were good in staining among 24412 reviewed.

f. Suspect referral was adequate in all the districts. Sputum positivity rate was over 10% in all the districts. Coverage of suspects with sputum examination was good (above 90% in all). Total cases notified were 42981 of which NSP was 17675 (30 per 100000). There were 9369 retreatment cases representing 22% of all cases. This is expected in the initial years of implementation of TB control. Case notification in 2006 was 73 per 100000 population which was well below that expected by the programme. Case notification for NSP was 30 per 100000 population which was far below that expected.

g. Poor notification can improve only if services improve and if there is good involvement of the peripheral health staff and participation of the community and other cooperation partners. Involvement of General practitioners in the programme is negligible or nil. About 80% of the people in Bihar approach Registered Medical Practitioners (nonqualified but popular among the commoners). Effort could be made to involve them in the programme for suspect referral and DOT. Involvement of the community or NGOs in the programme is negligible. There are other cooperation partners like department of publicity, industries, municipal authorities, panchayat raj institution which are rarely involved in the programme. The situation improved last year with the involvement of ASHA volunteers for suspect referral and DOT supervision.

h. Detection of Extrapulmonary (5%) or sputum negative cases (32%) is still a problem because of lack of facilities and expertise.

Treatment:

i. Out of the 24099 NSP cases 17675 (73.3%) were registered for treatment. A total of 13653 cases were seen by the team and among them there were 1775 cases (13%) with a delay of more than two weeks in starting treatment. Follow-up sputum examination was done in 14974 (74.2%) cases out of 20170 due. This has to improve. Positivity among those who were followed was 4.3%. There are several problems in follow up sputum examination. All the problems associated with the proper functioning of laboratory and other factors like difficulty in accessibility, lack of proper counseling of patients, lack of awareness about the importance and timeliness among the DOT supervisors of follow up examination, inadequate supervision of the laboratories and the staff by Supervisors, inadequate monitoring of patients are some of the reasons for the situation.

j. TB cards of 44883 patients were verified and 27660 (61.6%) were found to be complete and up-to-date. TB cards are maintained at PHCs and duplicate cards are given to the DOT supervisors. Patients may be regular and cards may not be updated by the DOT supervisor for reasons like lack of awareness, or patients may be regular, the card with the DOT supervisor may be updated but the cards at the PHC may not be updated by the Multipurpose health workers (the most common reason).

k. There was no problem in drug supply management. Sputum conversion for patients registered in the first three quarters of 2007 was 84.3%. Of the 10972 NSP cases from 2006 assessed for outcome, the cure rate was 71.3%, death 5.6%, failure 2.6%, default 9.75%. Cure rate was highest (87.7%) in Purnea and lowest in Vaishali (51.4%). The problem in Vaishali was administrative (non renewal of contract for STS and STLS). Lack of awareness among patients or DOT providers about the need for end-of-treatment sputum examination, absence of DOT, irregular treatment, default, inaccessibility of Microscopy centres, problems in sputum



microscopy, problems in supervision – any one or all may be responsible for low cure rates. The teams contacted 28587 patients to assess the regularity of treatment.

About 75.2% (21492) of them were getting the treatment under direct supervision (DOT). The teams also looked at the functioning of DOT providers. Of the 12704 DOT providers reviewed 9966 (78.4%) were functioning correctly. A total of 1532 (12%) were from the community. The teams also arranged 1631 DOT providers. When community volunteers are made DOT providers there are two advantages: in difficult to access areas there is no other choice and secondly the volunteers promote free publicity for the programme. The health workers could then monitor the volunteers through weekly supervisory visits. The experience in other DFIT-supported districts like Anantapur in Andhra Pradesh suggests that this is the best viable option especially in difficult areas.

The situation is changing for better. Lady community volunteers chosen by the Government to act as a liaison between the community and the Health Service, titled ASHA (Accredited Social Health Activist), are increasingly being involved in the programme for suspect referral and DOT supervision. Wherever they are involved the impact has been found to be great. There is a willingness on the part of the Government to involve them increasingly in TB control. This is bound to have a great effect on case notification and treatment outcome.



The gentleman standing on the left in the photograph above is Mr. Vijayakumar Jha, a press reporter by profession and a Social activist by compulsion. Not a day goes by without his doing something good to somebody in the village Jaganigram under Garol PHC in Vaishali district in Bihar. What he has accomplished is nothing short of a wondrous marvel. What started as an interest turned soon into a passion. When he agreed to supervise the treatment of a leprosy patient in 1999 at the request of DFIT team in the district he did not realize that he would immerse himself so deep in the public health programme. After leprosy he turned his interest to Tuberculosis. He has so far supervised the treatment of 97 TB cases since 1999. So far, 89 have been cured, 2 have died and 6 are still under treatment. He spends one hour every morning for this noble task. He gives the drugs to patients who visit him. If a patient fails to come he visits his house and gives the drugs. He is ready to give Rs. 10 to a patient if needed to enable him to go PHC for follow up sputum examination. When asked why, he says that it is his social responsibility. We wish we had more like him!

l. The teams found 1161 (4%) patients with wrong categorization. This is not bad. Often the staff at PHCs do not seek proper history from patients thereby missing some critical information which prevents them from giving appropriate regimen.

m. Because of lack of proper supervision some patients become irregular or even default. The system is not geared to identify potential defaulters and institute measures

for prevention. Now the teams are doing major part of this work. Problems of mobility brought about by lack of motorbikes or their improper maintenance or reduced use because of administrative factors make it difficult for the STS and MO of the TB unit to supervise patients and DOT providers regularly. Another factor is involvement of ANMs as DOT providers. Because of the plethora of responsibilities they may not be able to do effective supervision of treatment of patients. Instead if community members are involved in DOT supervision, ANMs can also help the STS in patient supervision. The teams succeeded in retrieving 1266 irregular patients out of 1939 visited and 444 defaulters out of 897 visited. Teams could arrange 420 Registered Medical Practitioners to involve in RNTCP.

D. Strategy used by DFIT:

i. The first intervention from DFIT was through the teams.

The teams from DFIT would focus mainly on facilitating the involvement of community members in the programme - suspecting and referral, dissemination of key messages and DOT supervision. They visited the field 15 to 20 days a month identifying new DOT providers, training them and supervising their participation. All the DMCs were covered at least once every month, all the new cases detected in the previous month were covered, and all the DOT providers were covered at least three times.

They helped in advocacy effort through meetings with Panchayat leaders.

They visited the DMC to ensure that the cards are updated, meet the ANMs to ensure that they supervise the DOT providers regularly, and discuss other problems. This was done by the MO with inputs from the teams.

They also visited the lab to find out problems so that Senior Lab coordinator of DFIT based in Patna would visit the district concerned to rectify the problems in sputum microscopy. The lab coordinator and other senior lab supervisors from DFIT facilitated the training of 320 LTs and 78 STLS from 18 districts. The facilitators from DFIT were also involved in training 455 MOs, 44 STS, 148 programme managers, 68 GPs, 92 Mukhyas, 2049 GPs, 1249 AWWs, 8308 ASHA and 108 volunteers.

Their visits to the field were always accompanied by somebody from the health service so that it became an opportunity for capacity building.

The Medical consultant of the team would attend the meetings at various levels, interact with the Officers and ensure that problems that were identified were resolved immediately.

ii. The second intervention was aimed at infrastructural development like improving the functioning of the lab (minor repairs of building, providing power-line, placement of LTs, increasing the accessibility of service to villagers (sputum collection centres, health visitors in urban areas, involvement of GPs), training of various personnel,

regular meetings, etc. Renovation of the STDC centre at Patna, supply of quality immersion oil to DMCs, provision of cupboard with facility for correct maintenance of microscope were some of the interventions by DFIT carried out in 2007 with the purpose of strengthening the infrastructure. DFIT also provided 15 LTs in some of the vacant DMCs and posted its own staff (LTs, STS, STLS) in two TB units allotted to it one each in West Champaran and Kishanganj. It also provided three STLS and three microscopes for Vaishali district.

4. PREVENTION OF DISABILITY:

The picture below depicts lacunae in the system! All these had disability and had come to the NGO project at Pavagada in Tumkur district for reconstructive surgery. Detailed history elicited from these persons brought forth important reasons for the disastrous outcome. Out of the ten with disability eight were due to leprosy. Out of these eight, six developed disability after release from treatment and two during treatment. All the six had sought medical help (four went to MO at PHC and two to General Practitioners) as soon as they noticed symptoms of tingling sensation in the limbs. Unfortunately in all, the Doctors failed to recognize neuritis. Out of the two patients who developed disability during treatment, one was given 10mg Prednisolone by the MO at PHC for two weeks and the other was not given any drugs. These patients were from Tumkur, Chitradurga and Davangere districts in Karnataka and from Anantapur in Andhra Pradesh.



4.1. Introduction:

Dispassionate observers are extremely pleased to see that Prevention of Disability (POD) has become the dominant passion of leprosy control in India. It is revived with a renewed vigor and enthusiasm with a new name (DPMR) and a new mandate.

Damien Foundation as a member of ILEP contributed to the development of operational guidelines for Disability prevention and Medical Rehabilitation (DPMR). Its experience in field experiments in several settings at different administrative levels to identify the best field practices that would promote integrated implementation of POD became useful for the development of strategy.

4.2. Progress:

All the projects except Aundipatty implemented Prevention of disability as part of overall leprosy control support activities at different levels (small populations of around



100000 to the whole district). Projects like Ambalamoola, Chilakalapalli, Nagepalli, Kavali, Pavagada, Trivandrum, focused on providing POD service to persons affected with disability in the area where they were implementing leprosy control before integration. Three projects, Fathimanagar, Salem and Nellore, which had taken up POD support to the whole district, continued the support activities. Reconstructive surgery service was offered by three projects- Fathimanagar, Nellore and Pavagada.

4.3. Support to POD:

St. Mary's Leprosy Centre in Arisipalayam assisted the district in training all the health workers in all the 20 Blocks. Visiting 1062 leprosy-disabled persons trained in self care revealed that 751 (70.7%) of them were practicing self care and 253 (93.7%) government health personnel out of 270 were monitoring the leprosy-disabled persons in the areas allotted to them.

The team from Holy Family Hansenorium in Trichy visited 466 leprosy affected persons in their homes and found 391 (83.9%) of them practicing self care. Out of the 188 government workers, 166 (88.3%) were found to be monitoring the leprosy affected persons within their area.

Damien Foundation Urban Leprosy and TB Centre in Nellore is a government recognised centre in Andhra Pradesh for management of complications in leprosy. It had taken up 14 PHCs along with Nellore Urban, for assisting the district in disability prevention activities. Out of 190 leprosy-disabled persons, 157 (82.6%) were practicing self care and out of 73 government health staff, 55 (75.3%) were monitoring these persons.

Swami Vivekananda Integrated Rural Health Centre in Pavagada is a recognised referral centre in Karnataka for management of complications in leprosy. It is assisting the district in implementing self care for patients mainly in Madhugiri and Pavagada taluks. Eighty-six (76.8%) leprosy affected persons out of 112 visited are practicing self care in these taluks.

4.4. Reconstructive surgery:

Surgical correction of deformities in leprosy is being done in Fathimanagar, Nellore and Pavagada. The districts of Ariyalur, Perambalur, Pudukottai and Trichy have been allotted to Fathimanagar for referral of patients for RCS. Similarly, the districts of Kadapa, Pragasam and Nellore are allotted to the project in Nellore and 5 districts (Tumkur, Chitradurga, Davangere, Chikkamagalur and Kolar) to the project in Pavagada. Though a proper referral system is not in place, these 3 projects have started receiving from the allotted districts persons with leprosy-induced deformities for surgical correction. Totally, 65 surgical corrections were carried out in addition to 5 amputations and 6 other corrective procedures.

With financial and technical support from Damien Foundation the Medical College hospitals at Patna and Dharbanga continues to provide reconstructive surgery services for the leprosy affected in Bihar. Total reconstructive surgeries done was 64 in Patna and 5 in Dharbanga. The service provided by the teams at these hospitals is excellent and has won the appreciation from all. We only wish that other medical colleges in the country emulate the efforts. A surgical team consisting of a surgeon and a Physiotherapist from Damien Foundation, Congo were trained in RCS, including pre and post operative physiotherapy.

4.5. Footwear:

A new foot wear unit has started functioning in the Nellore project which is now catering to the districts in Andhra Pradesh. The foot wear unit in Fathimanagar continues to meet the demands from adjacent districts. A total of 2121 pairs of footwear were provided to needy patients.

5. UNIFORM MDT STUDY IN BIHAR:

Uniform MDT study under sponsorship from WHO was started in Gaya and Nalanda in 2005. It involves treating all leprosy cases never treated before with three drugs (MB MDT) for 6 months irrespective of the group, MB or PB, in the study population in Gaya district and comparing this with conventional regimen (PB and MB 6 months and 12 months) in the adjacent District of Nalanda (Control). One more district (Rohtas) was added to the study group in June 2007. All the cases taken into the study are clinically examined, smears and photographs taken, and entries are made in designated data collection instruments.

So far in Gaya (study), out of 1808 cases detected 631 were registered under the study. Out of this, 488 had been released from treatment and other deletion 41. In Nalanda (Control) out of 1448 cases detected 918 were taken for the study out of which 608 had been released from treatment (other deletions was 53). In Rohtas (Study), out of 421 cases detected 235 were taken for the study out of which 7 were released and 3 were deleted for other reasons. In Gaya there were 19 Type 1 reactions, 3 type 2, neuritis 7, drug allergy 8, migration 24 and refusal was 9. In Nalanda, there were 9 type 1 reaction, 4 type 2 reaction, 6 neuritis, 1 drug allergy, 1 death and 29 migrations. In Rohtas there were 2 cases of drug allergy and 3 type 1 reaction.

6. CONTINUING MEDICAL EDUCATION :

One of the pivotal activities of DFIT is promoting dissemination of best clinical and field practices among health workers and medical students so that they would be able to manage leprosy affected persons adequately. In this direction DFIT has a two-pronged strategy: providing updated information through its medical bulletin "UPDATE" and reaching the medical students through endowment exam and seminars.

The quarterly medical publication -'UPDATE' was started with the aim of imparting Continuing Medical Education to Health & Field Workers on Leprosy/TB diagnosis, treatment and current advancements. It has been a tremendous success among the targeted group both by its reach and quality of articles. It started with the inaugural issue in June 1993 and has had an un-interrupted publication till now. On request from ILEP members for a centralized publication incorporating the contributions from all the members the magazine has been renamed 'ILEP INDIA UPDATE'. The editorial committee has been drawn from DFIT and three ILEP members.

DFIT organised theory examination on leprosy for Under Graduate Medical students on 7th August 2007. A total of 227 students appeared for the examination. Dr. K. Manoharan from Chengalpattu Medical College, Dr. B. Sekar from CLTRI and Dr. P. Vijayakumaran from DFIT evaluated the answer sheets. On 4th October 2007 practical examination & continuing medical education session was organised at Chengalpattu

Medical College. Twenty eight candidates participated in the practical examination and 28 in CME session.

Seminar on Leprosy for Post Graduate Medical students was held at Sri Ramachandra Medical College, Chennai on 26th October 2007.

7. LIVELIHOOD ENHANCEMENT PROGRAMME (LEP) :

Damien Foundation initiated a new strategy to support disabled and debilitated leprosy affected persons to lead a self dependent and respectable life in the community called Basic Project, the scheme adds a new social dimension to their plan of action. A committee was formed to scrutinize the proposals received from the projects and monitor their effective implementation of the programme. The proposals received from Fathimanagar, Kavali, Nagepalli and Salem projects during the year 2007 requesting financial support for leprosy affected persons in the form of livestock, children education and safe shelter were approved and necessary funds released to the concerned projects.

8. CHANTIERS 2007:

During the year 2007, Chantier Damien a subordinate organization of Damien Foundation, constructed eight houses each for the leprosy affected persons in Fathimanagar and Salem. In addition it also financed a part amount for the construction of MDR TB Block in Nellore.

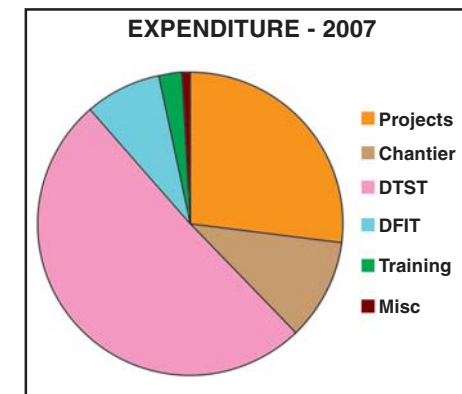
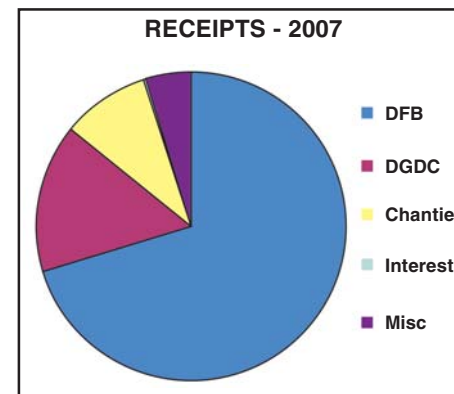
Thirty nine volunteers from Belgium visited the construction sites in two groups in July – August 2007 and participated in the construction activities.



9. FINANCE:

	(Indian Rupees)
INCOME	
Contribution from Damien Foundation Belgium	62520596.63
Contribution from DGDC, Belgium	13616826.72
Contribution from Chantier Damien	8289814.62
Interest received on Fixed Deposit/Savings A/c	185516.47
Staff Benefits	902377.35
Miscellaneous Income	3266796.00
Opening Balance for the Year 2006	51747.21
	88833675.00
PAYMENTS	
Funds Transferred to Projects	22710360.50
Bihar Activities - Technical Teams	37963723.53
Andhra Pradesh - Technical Teams	3220272.69
Karnataka - Technical Teams	1597963.00
Chantier Damien Activities	9082260.00
DFIT Office, Field, POD	6819353.29
Training / Workshop / Conference	2077509.97
Staff Benefits	225847.35
Misc Expenses	446401.00
Closing Balance for the year 2007	4689983.67
	88833675.00

DAMIEN FOUNDATION INDIA TRUST - 2007(Receipt and Expenditure distribution)



10. TRAININGS:

SN	Particulars	Venue & Date	Participants
1	MDR TB Study visit to DF, Bangladesh	9 th to 13 th March 2007	Dr. Krishnamurthy
2	Training on RNTCP	5 th to 16 th March 2007 at TRC, Chennai	Dr. Mohan Sunkad Dr. K.P. Sinha Dr. J.C. Sinha Dr. Prabhakara Reddy
3	Training course for PPM-TB Consultants organized by WHO at Sondalo, Italy	12 th to 17 th April 2007	Dr. Shivakumar
4	WHO Global DOTS Course on TB and TB/HIV Management organized by WHO at Sondalo, Italy	16 th to 29 th May 2007	Dr. Rita Adaikalam
5	UMDT training to Govt. staff of Rohtas district & research teams at Gaya	1 st & 2 nd June 2007 and 11 th to 14 th June 2007	Facilitator : Dr. Vijayakumaran
6	Training on lab. aspects to all Bihar team members	31 st May to 15 th June 2007	Facilitators : Mr. Jaishankar Mr. Moses Anandraj
7	Training for preparation of action plan using logical framework at Chennai	25 th & 26 th June 2007	MOs & NMS of South Projects and TSTs
8	Endowment Prize Exam (Theory)	7 th August 2007	227 final year MBBS students from MGR Medical University
9	Reorientation training to the LTs of Kavali district	13 th to 17 th September 2007	Facilitator : Mr. Jaishankar
10	International Course on budget planning and Project Management for TB control organized by IUATLD at Bangkok	3 rd to 15 th September 2007	Mr. Marianathan Mr. Premkumar
11	HIV/AIDS Counseling Course at Fathimanagar	13 th to 15 th September 2007	Mr. Jaishankar, 7 LTs/NMS from Ambalamoola, Arisipalayam, Delhi, Nellore & Pavagada
12	Reorientation training to the LTs of Kadapa district	22 nd to 26 th October 2007	Facilitator : Mr. Jaishankar
13	25 th Biennial Conference organized by IAL at Kanpur	19 th to 21 st November 2007	Mr. Rajendran
14	Sensitization Programme on DPMR organized by GLRA at Vadathorasalur	11 th December 2007	Resource Person: Dr. Jacob Mathew
15	District Nucleus training on POD at Jharkhand state	5 th to 24 th December 2007 in four batches	Facilitators: Dr. Jacob Mathew Dr. Prabhakar Rao Dr. H.S.Mishra Mr. Murari Mohan
16	Laboratory Training in RNTCP for LTs and STLS of Bihar	2007 - Bihar - 31 batches LT : 320; STLS : 78	Facilitators: Mr. Jaishankar Mr. Moses Anandraj Mr. Johinder Singh

11. CONFERENCES AND MEETINGS:

SN	Particulars	Venue & Date	Participants
1	Meeting with Director, STDC, Hyderabad	9 th January 2007 at Hyderabad	Dr. Krishnamurthy Dr. Vijayakumaran Dr. Shivakumar
2	Meeting organised by Govt. of India & Govt. of Andhra Pradesh for finalisation of training curriculum for DPMR service under NLEP	10 th & 16 th January 2007 at Delhi & Hyderabad	Dr. Jacob Mathew
3	Scientific Committee meeting of 17 th ILC	15 th & 16 th January 2007 at Chennai	Dr. Krishnamurthy
4	Technical Expert Group Meeting at London	18 th January 2007	Dr. Krishnamurthy
5	ILEP Managers meeting	22 nd January 2007 at Delhi	Mr. Marianathan
6	External evaluation of NLEP & RNTCP activities in Bihar	29 th January to 10 th February 2007	Evaluator : Dr. Lalitha, M.S.Ramaiah Medical College, Bangalore
7	CME Programme on TB organised by DFIT & CLTRI in association with IMA	31 st January 2007 at Chengalpattu	Dr. Krishnamurthy
8	ILEP meeting	22 nd March 2007 at Bhubaneswar	All ILEP members
9	Annual Conference of SLOs	23 rd & 24 th March 2007 at Bhubaneswar	Dr. Krishnamurthy Dr. Biswanath Prasad
10	ILEP – ITC Meeting	28 th to 30 th March 2007 at London	Dr. Krishnamurthy
11	Review meeting of DTST South	4 th to 6 th April 2007 at Bangalore	All team members Dr. Krishnamurthy Dr. Vijayakumaran
12	DFIT Trust Meeting	7 th April 2007 at Chennai	All trust members
13	TB Consortium meeting on support to RNTCP organised by World Vision India	9 th April 2007 at Hyderabad	Dr. Vijayakumaran
14	Meeting of SLOs organised by Govt. of India	26 th April 2007 at Delhi	Dr. Krishnamurthy
15	Mid Year Review meeting of south projects	8 th & 9 th May 2007 at Salem	Dr. Krishnamurthy Dr. Vijayakumaran Dr. Jacob Mathew All Project Holders, MOs, NMS

11. CONFERENCES AND MEETINGS - CONTD.

SN	Particulars	Venue & Date	Participants
16	ILEP meeting for preparation of document for National Forum-NLEP	15 th May 2007 at Bangalore	Dr. Krishnamurthy Dr. Vijayakumaran
17	Symposium on TB organised by DFIT in collaboration with MS Ramaiah Medical College	16 th May 2007 at Bangalore	Dr. Krishnamurthy Dr. Vijayakumaran
18	ILEP meeting	17 th May 2007 at Bangalore	All ILEP members
19	Action plan meeting of Bihar support teams	29 th to 31 st May 2007 at Patna	All team members
20	Technical Expert Group meeting organised by ILEP	20 th June 2007 at London	Dr. Krishnamurthy
21	Budget meeting for south projects & consultancy teams	7 th to 10 th August 2007 at Chennai	All Project Holders and MOs
22	DPMR State Implementation Committee meeting organised by GLRA	16 th August 2007 at Chennai	Dr. Vijayakumaran Dr. Jacob Mathew
23	ITC Meeting organised by ILEP	19 th September 2007 at London	Dr. Krishnamurthy
24	DPMR State Implementation Committee meeting at GLRA	19 th September 2007 at Chennai	Dr. Vijayakumaran
25	Review meeting south consultancy teams	24 th to 28 th September 2007 at Kadapa	All team members
26	Launch of Saswkawa India Leprosy Foundation	10 th October 2007 at Delhi	Dr. Krishnamurthy
27	National Workshop on Strategies for new case detection during integration phase organised by ALERT	11 th October 2007 at Bombay	Dr. Krishnamurthy Dr. Vijayakumaran
28	ILEP meeting	16 th October 2007 at TLM Office, Delhi	All ILEP members
29	Quarterly review meeting for DLOs of Bihar organised by State Health Society	17 th October 2007 at Patna	Dr. Krishnamurthy Dr. Biswanath Prasad Dr. Prabhakar Rao
30	TB Consortium meeting organised by World Vision India	24 th October 2007 at Delhi	Dr. Vijayakumaran
31	DFIT Trust Meeting	27 th October 2007 at Chennai	All trust members
32	Workshop on Monitoring and evaluation of leprosy control in the post-elimination era organised by GOI-WHO-ICMR	5 th & 6 th November 2007 at Mamallapuram	Dr. Krishnamurthy

11. CONFERENCES AND MEETINGS - CONTD.

SN	Particulars	Venue & Date	Participants
33	38 th Union World Conference	8 th to 12 th November at Cape Town	Dr. Krishnamurthy Dr. Vijayakumaran
34	National Conference on networking of NGOs in Health & Development organised by ILU	20 th & 21 st November 2007 at Pune	Dr. Krishnamurthy
35	TB Consortium meeting organised by World Vision India	27 th November 2007 at Delhi	Dr. Vijayakumaran
36	PPM training meeting organised by GLRA	30 th November 2007 at Chennai	Dr. Krishnamurthy
37	Core Team meeting at DF Brussels	10 th to 12 th December 2007	Dr. Krishnamurthy
38	Meeting on ILEP support to NLEP – AP & Orissa organised by Lepra	21 st December 2007 at Hyderabad	Dr. Krishnamurthy

12. VISITORS:

SN	Particulars	Venue & Date	Participants
1	Mr. Luc Comhaire & Dr. Tine Demeulenaere, DFB	27 th February to 8 th March 2007	Visited Siwan, Gopalganj, East Champaran in Bihar and the projects at Delhi, Nagepalli & Fathimanagar
2	Mr. Paul Jolie, President, DFB	6 th to 8 th April 2008	Visited Bangalore and attended Trust meeting
3	Dr. V. Pannikar, Team Leader, WHO Global Leprosy Programme	15 th June 2007	Collaboration between DFIT and WHO in supporting NLEP in India and research avenues
4	Mr. Marcel Lootens	1 st to 12 th July 2007	Scouting visit to the chantier construction sites
5	Mr. Tshibangu Kamanyi Jeanplacide, Surgeon Mr. Nzua Nsilu Alphonse, Physiotherapist from DF, Congo	2 nd April to 29 th June 2007	On the job training on POD and RCS conducted by Dr. Jacob Mathew in Fathimanagar and Nellore. RCS done for a junior from Congo in Fathimanagar
6	Mr. Jean Platteau & Ms. Carla Reynders	27 th April to 2 nd May 2007	Filming the surgery of a patient in Fathimanagar
7	Dr. D. Guido Groenen from Belgium	15 th to 25 th July 2007	External evaluation of DFIT support to Leprosy & TB Programme in Bihar

12. VISITORS - CONTD.

SN	Particulars	Venue & Date	Participants
8	Chantier Damien Volunteers in two batches	9 th to 29 th July 2007 & 8 to 25 th August 2007	Participated in the construction of buildings in Fathimanagar, Salem & Nellore
9	Mr. Willem Gees & Mr. Jean Platteau along with representatives from the community	16 th September to 3 rd October 2007 in 3 batches	Filming of field activities and surgery in Fathimanagar, Aundipatty & Arisipalayam
10	Mr. Rigo Peeters, General Secretary, DFB	23 rd to 28 th October 2007	Discussion with DDG (L), Delhi Project visit, participated in the PG seminar and attended Trust Meeting

13. PAPERS PUBLISHED AND PRESENTED IN CONFERENCE:

- 1) Sustainable Disability related disability care within integrated general health services: findings from Salem District, India.
K Madhavan, P.Vijayakumar, L. Ramachandran, C. Manickam, R. Rajmohan, Jacob Mathew, P. Krishnamurthy, *Lepr Rev* (2007) 78, 353-361
- 2) Temporalis Muscle Transfer for the Treatment of Lagophthalmos.
Kanaradi Ravi Krishna, Jacob Mathew, *Asian J Ophthalmol.* 2007 Vol 9 No.6
- 3) "Downtrend in new case detection in India – What does it mean"
Krishnamurthy. P in the National workshop on "Strategies for new case detection during integration phase" organized by ALERT, Mumbai on 11th October 2007 .

GLOSSARY

- ANM: Auxiliary Nurse and Midwife: Basic female health worker, one for every subcentre covering a population varying between 5000 to 10000. They are the most important staff in the General Health system and are responsible for implementing several important public health programmes especially immunization, maternal and child health and family welfare.
- APHC: Additional Primary Health Centre. There are two to three such centres for every Primary Health Centre in Bihar. Generally majority of these APHCs are nonfunctional.
- ASHA: Accredited Social Health Activist. A lady volunteer from the community selected and involved in public health programmes as a link between the community and General health system under National Rural Health Mission.
- CS: Civil Surgeon. Chief of all public health programmes in a District in Bihar.
- DF: Damien Foundation
- DFIT: Damien Foundation India Trust. One of the ILEP members in India supporting leprosy and TB control.
- DGDC: Directorate General for Development Cooperation. (Belgian Government Agency for providing support to NGOs)
- DHS: District Health Society. The administrative body responsible for monitoring all public health programmes. District magistrate or Collector is the chairman and the Civil Surgeon is the member secretary. All the programme officers are members. Expected to meet at least every quarter.
- DLO: District Leprosy Officer. Programme Officer at the district level (2 to 3 million population) responsible for the leprosy control programme in the district.
- DLS: District Leprosy Society. Now merged with District Health Society.
- DMC: Designated Microscopy Centre: one for every 100000 population for diagnosis of TB cases through sputum microscopy.
- DOT: Directly Observed Treatment. Treatment of a TB case under direct supervision by a person other than a family member.
- DOTs: A package with five elements constituting the fundamental strategy of TB control adopted by all the countries including India.
- DPMR: Disability prevention and Medical Rehabilitation. New name given to POD.
- DTO: District TB Officer. Programme Officer at the district level (2 to 3 million population) responsible for the TB control programme in the district.
- DTST: District Technical Support Team. Strategy adopted by ILEP to support leprosy control through the placement of a mobile resident team in a district. Suspended since April last.
- EQA: External Quality Assurance. A mechanism introduced in RNTCP designed to ensure quality of sputum microscopy in the programme. The principal person involved in this is the STLS.
- GH: General Health
- GMLF: Gandhi Memorial Leprosy Foundation. One of the oldest NGO organisations in the country credited with the introduction of SET strategy in leprosy control.
- GP: General practitioner. A medical practitioner.
- HIV/AIDS: Human immunodeficiency virus / Acquired immunodeficiency syndrome.
- IEC: Information education and communication. Strategy used to disseminate correct information about disease and bring about positive changes in community attitudes and action.

IIEP: International Federation of Anti-leprosy associations. Has ten members. They are involved in supporting leprosy control activities in India through a coordinated mechanism designed to promote convergence of ideas and confluence of resources. The ten member organisations are Association Francaise Raoul Follereau (AFRF India), Associazione Italiane Amici di Raoul Follereau (AIFO India), Aide aux lepreux Emmaus – Suisse (ALES India), American Leprosy Missions (ALM), Damien Foundation India Trust (DFIT), Fontilles-India, German Leprosy and TB relief Association (GLRA-India), LEPRO Society (LEPRO), Netherlands Leprosy Relief Association (NLR) and The Leprosy Mission International (TLM Trust India).

MB: Multibacillary leprosy. A person with more than 5 skin lesions with anaesthesia; bacteriological positivity; more than one nerve involved.

MCR: Microcellular Rubber. Rubber sheet used for insole in the footwear of leprosy affected person with anaesthesia or deformity in the foot.

MPHW: Multipurpose health worker. Basic health worker (male and female), one for every 5000 to 10000 population and implementing all public health programmes. The area which is covered by them is the subcentre.

MO: Medical Officer. Posted at every health facility or hospital in Government set up.

NGO: Non Governmental Organisation

NLEP: National Leprosy Eradication programme.

NSP: New Sputum Positive case (Pulmonary TB never treated or minimally treated less than a month and found to be sputum positive)

PB: Paucibacillary leprosy. A person with 5 lesions or less with anaesthesia; bacteriologically negative; single peripheral nerve involvement

PHC: Primary Health Centre. The main health facility in rural area covering a population of 25000 to 200000 and responsible for implementing curative and preventive services in the designated population.

POD: Prevention of disability. Important component of leprosy control aimed at preventing the occurrence and management of disability.

RMP: Unqualified Registered medical practitioner.

RNTCP: Revised National TB Control Programme

SER: Socio-economic rehabilitation

SET: Survey Education and Treatment. Strategy for leprosy control introduced initially by the Government after successful experimentation in GMLF project in Chilakalapalli.

STDC: State TB Demonstration Centre. One in every state meant for training all the staff in RNTCP.

STLS: Senior TB Laboratory Supervisor- Laboratory supervisor in TB unit for guiding laboratory work in the 5 Designated microscopy centres.

STO: State TB Officer. Programme officer in a state in charge of TB control.

STS: Senior TB Supervisor. One in every TB unit at subdistrict level for 500000 population and responsible for field supervision in TB control.

UHC: Urban health Centre. Public health facility in urban area often covering a population of 70000 to 100000 and responsible mainly for maternal and child health and family welfare.

WHO: World Health Organisation

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