ANNUAL REPORT - 2005

NLR Projects in India

An Overview

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INDIA

TABLE OF CONTENTS

TABLES

FIGURES

ANNEXES

LIST OF ABBREVIATIONS

ANCDR	Annual Case Detection Rate
AWW	Angan-Wadi Worker
BLAC	Block Level Awareness Campaign
BSG	Bharat Scout Guide
CMO	Chief Medical Officer (CMO & CS are same designation for the chief of
CBR	Community Based Rehabilitation
DANIDA	Danish International Development Assistance
DDG (L)	Deputy Director General (Leprosy)
DLS	District Leprosy Societies
DLO	District Leprosy Officer
DMO	District Medical Officer
DLA	District Leprosy Advisor
DTST	District Technical Support Team
FCRA	Foreign Contribution Regulation Act
GHC	General Health Care
GHS	General Health Services
GOI	Government of India
ICHD	International Course for Health Department
ILEP	International Federation of Anti-Leprosy Associations
IEC	Information, Education, Communication
INR	Indian Rupee
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute)
LEC	Leprosy Elimination Campaign
M&E	Monitoring and Evaluation
M.O.	Medical Officer
MB	Multi Bacillary
MDT	Multi Drug Therapy
MOU	Memorandum of Understanding
MPWs	Multi Purpose Workers
MLEC	Modified Leprosy Elimination Campaign
NCEL	National Conference for Elimination of Leprosy
NIHFW	National Institute of Health and Family Welfare
NGO	Non-Governmental Organization
NLEP	National Leprosy Eradication Programme
NMA	Non Medical Assistant (NMA and PMW are same depending upon the State)
PR	Prevalence Rate
PB	Pauci Bacillary
PHC	Primary Health Centre (catering to a population of 25,000 and having at least one medical officer)
POD	Prevention of Disability
PIP	Project Implementation Plan of World Bank
PMW	Para Medical Worker
RNTCP	Revised National Tuberculosis Programme
SAPEL	Special Action Project for Elimination of Leprosy
SC	Sub Centre (catering to a population of 5,000 attended by a ANM or MPW)
SLO	State Leprosy Officer
STST	State Level Support Team
SIS	Simple Information System
TB	Tuberculosis
TLM	The Leprosy Mission
TOR	Terms of Reference
WHO	World Health Organization

1. EXECUTIVE SUMMARY

Netherlands Leprosy Relief (NLR) a member of International Federation of Anti-Leprosy Associations (ILEP) is supporting National Leprosy Eradication Programe (NLEP) of India since the year 1993. The support was provided initially through other ILEP agencies and later NLR established its branch office in New Delhi, India, in March 2000. Besides technical and logistical support, at National and sub-national level, the support is mainly in the form of District Technical Support Teams (DTSTs). These district level teams are placed, to strengthen provision of sustainable and integrated leprosy services, of good quality, through General Health Care (GHC) system. As can be seen in chapter 2.1, through 35 DTSTs, and 1 STST at present, NLR is supporting 63 districts in 6 problem states of India.

While analyzing epidemiological developments under NLEP of India, the prevalence rate has been declining steadily while the new case detection has been either constant or fluctuating till 2002. Increase in case detection before that has been due to special campaigns like MLECs and SAPELs. As can be seen in figure 1 chapter 3.1, from 2002 onwards the PR and NCDR is constantly declining. From 2002 onwards, WHO and GOI discouraged active case detection, integration started and case detection was mainly passive: through voluntary reporting. With WHO and GOI targets of achieving elimination by December 2005 active search of cases has been stopped and GOI is focusing more on controlling operational factors like wrong diagnosis, re-registrations and deletion of extra registered and cured leprosy patients. With these efforts National average of PR has gone down to 0.95 by Dec. 2005 with ANCDR of 1.57 per ten thousand population between January and December 2005. As can be seen in table 3, Disability Gr. II is still high in West Bengal and Delhi amongst NLR supported states.

From the chapter 4, it can be seen that almost all activities, which were planned and budgeted, at branch level, were implemented. District nucleus training in Uttaranchal, Training of MOs and other GHC staff like pharmacists, ANMs, were undertaken in various states supported by NLR. Learning material for district nucleus and protocol for establishing RCS in medical colleges was finalized by ILEP India, in which NLR played a major role right from drafting to finalization. Other learning material developed, printed & distributed includes – exhibition sets, photo cards, stickers and various folders with special mention to a folder for patient counseling, Lepra reaction, and information folder in Urdu language.

NLR in general has made steady progress in its functioning in India in the year 2005 with turbulence in the state of Jharkhand. MOU between ILEP & GOI was formally signed in February 2005. It gave a special status, to ILEP, of being an important and useful partner in eradication of Leprosy from India. NLR played a major role in designing and finalization of this MOU. The MOU signed between ILEP and GOI gives an over view of activities to be supported by ILEP but there is no common working documents or common annual action plan agreed upon by all partners. Within ILEP, different collaborations and co-ordinations exist in different states. This report gives a brief of the functioning of NLR in India.

NLR being the sole ILEP agency supporting the State of Uttaranchal, organized DTST evaluation which was carried out in Aug.2005. This evaluation was of independent character involving all partners like WHO, GOI and ILEP. Main recommendations were reduction in DTSTs, placement of advisor at state level, supervision of all districts, temporary consultants for special trainings etc.

Though the achievements were many but there were some problems and delays in running of NLR projects due to factors beyond our control. Working in Jharkhand state was turbulent throughout the year and implementation of the project remained uncertain till the end of year 2005. While working in states our teams find it difficult sometimes to meet out ad-hoc requests from districts and states. Most of the states depend on support teams for everything and on the other hand enthusiastic team members sometimes implement the activities of their own instead of facilitating it.

2. INTRODUCTION

2.1 About NLR India

Netherlands Leprosy Relief (NLR), a member of International Federation of Anti-Leprosy Associations (ILEP), is supporting National Leprosy Eradication Programme (NLEP) of India since the year 1993. Besides providing technical and logistical support, at National and sub-national levels, presently the support is mainly in the form of District Technical Support Teams (DTSTs). These district level teams are placed, to strengthen provision of sustainable and integrated leprosy services, of good quality, through General Health Care (GHC) system. NLR involvement in India started from Bihar nearly 12 years ago i.e. in 1993. This support was extended to Uttar Pradesh & Uttaranchal state in the year 1998, to Delhi state in the year 1999, to Jharkhand in the year 2000 and to West Bengal in the year 2001. NLR established its branch office, in India, at Delhi, in the year 2000.

Realizing the utility of DTSTs in strengthening the process of integration, GOI agreed to extend placement of DTSTs to cover all the problem districts of the country including districts of low endemic states. Through mutual discussion among ILEP agencies and Central Leprosy Division, ILEP agencies agreed to increase the number of DTSTs and also to place state level support teams in low endemic states. During 2004, GOI developed a protocol on placement of DTSTs in various states indicating States, No. of District level teams with the names of ILEP agency providing them. According to new guidelines and with mutual agreement, in the year 2004, one state level support team was added by NLR in the state of Uttaranchal. Now all the three teams in Uttaranchal are provided by NLR and NLR is the coordinating agency for the state of Uttaranchal. Also in the year 2004, on the request of Delhi state / SLO, one more district – South Delhi was added under NLR DTST support. By the year 2005 NLR is now supporting 63 districts in 6 states of India through 35 DTSTs and 1 STST as given in the table below. This report gives an overview of functioning of NLR in India.

Table 1 State wise number of DTSTs and STST in NLR supported districts

S. No	States	State level Support Team	No. of DTSTs	No. of Supported Districts	Total Districts in the State
1	Bihar	-	5	5	37
2	Jharkhand	-	9	10	22
3	Uttar Pradesh	-	14	34	70
4	Uttaranchal	1	2	6	13
5	West Bengal	-	3	3	18
6	Delhi	-	2	5	9
Total	**6**	**1**	**35**	**63**	**169**

(Source: Adapted from GOI protocol for placement of DTSTs 2004)

2.2 Collaboration with ILEP Partners

In total 9 ILEP members (DFIT, TLM, AIFO, GLRA, Swiss Emmauss, ALM, Fontilles, LEPRA and NLR) are actively supporting NLEP of India. Besides other support ILEP agencies are providing District and State level Technical Support Teams. Table below gives an account of DTSTs provided by different ILEP Agencies in the states supported by NLR.

Table 2 DTSTs by ILEP agencies in NLR supported States

S. N.	Name of State	TLM		NLR		LEPRA		GLRA/ ALES		DFIT		AIFO		Total		Coordinating Agency
		DTSTs	Dt.	DTSTs	Dt.	DTSTs	Dt.	DTSTs	Dt.	DTSTs	Dt.	DTSTs	Dt.	DTSTs	Dt.	
1.	**Bihar**	1	1	5	5	9	9	-	-	22	22	-	-	**37**	**37**	**DFIT**
2.	**Delhi**	1	2	2	5	-	-	1	1	1	1	-	-	**5**	**9**	**TLM**
3.	**Jharkhand**	2	4	9	10	-	-	-	-	8	8	-	-	**19**	**22**	**NLR**
4.	**Uttaranchal**	-	-	2+1*	6	-	-	-	-	-	-	-	-	**3**	**6**	**NLR**
5.	**Uttar Pradesh**	9	25	14	35	-	-	-	-	-	-	4	10	**27**	**70**	**TLM**
6.	**West Bengal**	4	4	3	3	-	-	11	11	-	-	1	1	**19**	**19**	**GLRA**

(Source: Adapted from GOI protocol for placement of DTSTs 2004)

Dt. = Number of Districts supported
DTST = Number of District Technical Support Teams
*There is one more State level Technical Support Team (STST) provided by NLR at Dehradun, Uttaranchal state

In the year 2004, it was agreed by TLM (the erstwhile coordinating agency for Uttaranchal) that NLR will be the coordinating agency for state of Uttaranchal. NLR is also coordinating agency for the state of Jharkhand. As per GOI guidelines, DTST Projects in each state should be supervised and monitored by a State DTST Co-ordinator, which is to be identified and supported by ILEP. Besides monitoring and supervising teams in the state, this coordinator is supposed to represent ILEP and liaise with state authorities and Central Leprosy Division (CLD). Various forms of collaboration and coordination exists in different states. A brief about Coordination in NLR supported states is as follows:

In U.P., it is a joint project, where TLM, AIFO and NLR are the supporting partners and TLM is the coordinating agency. To maintain uniformity in functioning of DTSTs, a common Coordinator has been identified, by above three ILEP agencies. Expenditure, of salary of coordinator, of other staff in his office, expenditure of coordinator's office, is shared by all partners proportionately.

In WB, it is also run as joint project where GLRA is the coordinating agency. There is a common coordinator but his salary, is not shared by all partners. Some expenses of Coordinator's office are shared by NLR.

In Bihar, Delhi & Jharkhand, the Coordinators are appointed by DFIT, TLM & NLR respectively (being the co-ordinating agency of the state). Salary, office and other expenses are born by respective ILEP coordinating agency of the state e.g. salary, staff and other expenses of DTST state coordinator for Jharkhand is born by NLR only.

NLR in India is working in close cooperation, coordination and collaboration with major local and international NGOs (ILEP members), WHO, and Govt. of India.

2.3 Problems and Delays

1. Different agencies are working in India with their own mandates and priorities. Besides other support, provision of DTSTs is common through all partners. There are no working documents or common annual action plan agreed upon by all partners. Within ILEP, different collaborations and co-ordinations exist in different states. ILEP coordinating agency doesn't have any authority or mandate to take a decision or act against the wishes of even one partner.

2. There is lack of uniformity in implementation of activities in all the districts of a state except in UP, Uttaranchal and to some extent in Bihar, because of various ILEP partners working with their own mandates and priorities. There is no mechanism whereby discussions are held with state authorities, consensus is reached and a common action plan is prepared. To solve this problem, to prepare common

action plan for the state, efforts were made and joint meetings, of all partners, with state governments, were held in Uttaranchal and UP in January 2005, and in Bihar in July 2005.

3. NLR believes in working for the governments and with the governments. Since the activities are dependent on the government machinery, there were some problems and delays in organizing activities due to non availability of officials, non finalization of dates for organizing activities, lack of motivation because of lack of incentives as provided in other programs, other priorities like pulse polio, transfers, ensuing elections, strikes of GHC staff.

4. There are funds allocated for various activities as per GOI PIP for 2005-07. GOI puts special emphasis on utilizing this budget but because of lack of knowledge of the PIP document, delays or non-approval of funds for the activities, from district leprosy societies, activities are not implemented or ILEP agencies are expected to support those activities because of the ease at which ILEP agencies can approve funds.

5. In general, district and state level officials are not in the habit of proper planning and budgeting the activities. Often there are ad-hoc requests from district and state officials for the activities not planned in our annual plans & budget.

6. There are over expectations by Govt. staff in the form of demand for vehicle or other logistical support. Denial leads to unnecessary misunderstanding, claims of lack of co-operation, lack of appreciation and delays in implementation of the activities. Most visible example is of Jharkhand. DTSTs were not able to function properly in Districts of Jharkhand, due to non-cooperation from the state government due to denial of their unreasonable demands.

7. Because of technical expertise and uninterrupted mobility of the teams, there is dependence on DTSTs for almost every activity. Sometimes for every problem, solution seems DTSTs. On the other hand enthusiastic DTSTs have tendency to implement rather than facilitate the activities, sometimes also due to lack of GHC staff. Discussions are held repeatedly with district, State authorities and DTSTs so that dependency on the DTSTs is reduced.

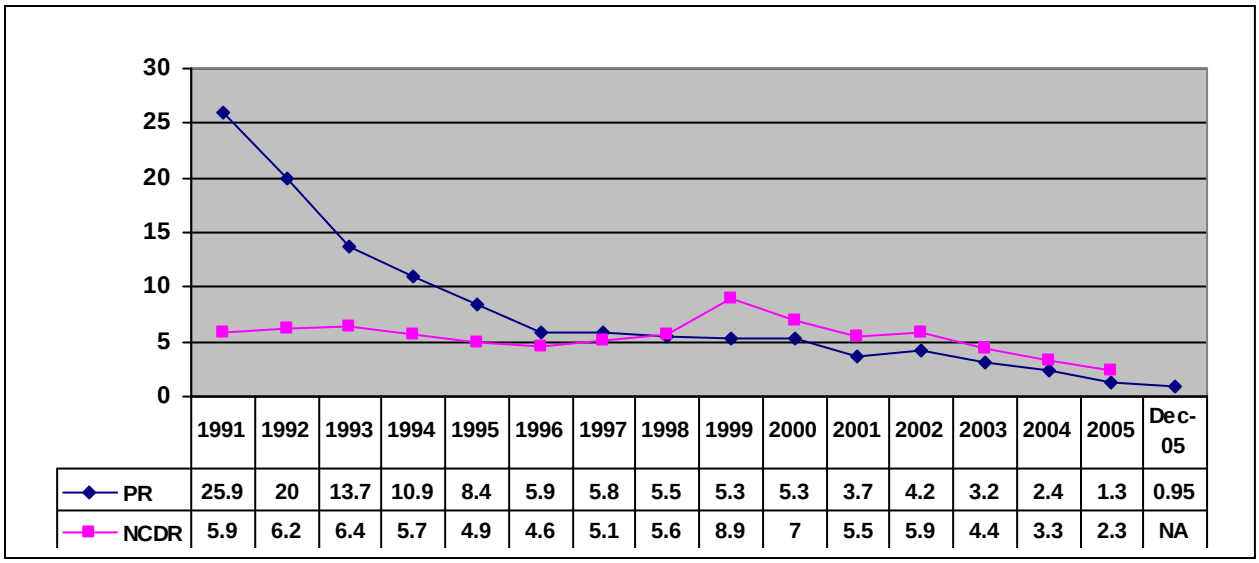
8. For achieving the target of elimination by December 2005, Case validation, Cleaning / updating of registers remained the top priority of GOI, which trickled to the states leading to deviation of focus from other important activities. This led to utilization of DTSTs' major time for participation in these activities.

3. EPIDEMIOLOGICAL DEVELOPMENTS

3.1 India

Reduction in registered Prevalence Rate continued in the yr. 2005 also but extra efforts were made by GOI and states to control so called 'operational factors' and the PR was brought down to .95 per ten thousand population, at national level, by the end of December 2005. Five endemic states i.e. Bihar, Jharkhand, UP, W.B. and Delhi remained endemic this year also.

Figure 1 Trends of Leprosy Prevalence & Annual New Case Detection Rates in India



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Dec-05
PR	25.9	20	13.7	10.9	8.4	5.9	5.8	5.5	5.3	5.3	3.7	4.2	3.2	2.4	1.3	0.95
NCDR	5.9	6.2	6.4	5.7	4.9	4.6	5.1	5.6	8.9	7	5.5	5.9	4.4	3.3	2.3	NA

(Source: NLEP, GOI 2005)

As can be seen in the above graph the prevalence rate has been declining steadily while the new case detection has been either constant or fluctuating till 2002. Increase in case detection before that has been due to special campaigns like MLECs and SAPELs. From 2002 onwards WHO and GOI discouraged active case detection, integration started and case detection was mainly passive: through voluntary reporting only. With the approach of the target date of elimination of Leprosy, operational factors were considered hindering elimination of leprosy. Extra efforts were made not to register old cases and delete absentees and defaulters. New cases were supposed to be only registered after validation by DTST MO, or District Nucleus or special team ……..which cripples integration. Cases who have completed treatment but not deleted from the registers were removed, cases, who were given more than required doses of MDT were also removed from the registers. These efforts led to decrease in PR and NCDR, and Elimination of Leprosy was achieved by December 2005.

Table 3 Essential Indicators used in NLEP (as on December 2005)

S. N.	State/UT	Cases on record as on Dec. 2005	Prev. Rate/ 10000	New Cases Detected from Jan - Dec. 2005			Proportion among new cases			
				PB	MB	Total	MB	Female	Child	Gr.2
1	Jharkhand	4345	1.47	4347	3562	7909	44.73	34.56	12.67	1.57
2	Bihar	12717	1.37	17816	9898	27714	35.79	35.68	16.24	1.29
3	Delhi	3441	2.11	1631	2148	3779	57	18.87	4.84	3
4	Uttaranchal	690	0.75	464	473	937	50.42	29.57	4.14	1.71
5	U.P.	23925	1.3	21430	15897	37327	41.9	29.8	6.3	0.93
6	West Bengal	11478	1.47	11040	11702	22742	51.5	30.81	9.37	2.29
Total (6 states)		**56596**	**1.41**	**56728**	**43680**	**100408**	**46.89**	**29.88**	**8.92**	**1.79**
India		**107000**	**0.95**	**N.A.**	**N.A.**	**N.A.**	**N.A**	**N.A.**	**N.A.**	**N.A.**

NA=Not available

It can be seen from the table above that the cases on record in 6 states supported by NLR are more than 50% of total cases registered in all 35 states of India. Data from these states have been taken to give an idea of epidemiological status of NLR supported projects. These data are generated from the reports our teams received and are not official document. It can be seen from the table that UP is still contributing highest number of cases followed by Bihar and West Bengal. Deformity is still high in Delhi and West Bengal. Delhi's high proportion could be attributed to the reporting of cases originating from all problem states of India, which are resident in Delhi (whether temporary or permanent is unknown). High proportion of MB cases with high proportion of deformity in West Bengal indicates that the cases are not detected early and that there may be hidden cases.

In the last row Indian averages were depicted in the report of 2004 but this year despite our repeated efforts, data could not be received from Leprosy division. Except data on prevalence rates, Central Leprosy Division was reluctant to supply data on new case detection and other essential indicators.

Through DTSTs, NLR has initiated assessment of completion rates while visiting the PHCs/dispensaries/hospitals and validation of new cases. The completion rates are ranging from 43.5% in Delhi to 97.1% in Bihar ….. NLR supported districts of various states are given at Annexure I. GHC staff is yet to learn cohort analysis and interpret the cure rate for PB & MB. Our teams have started discussing cohort reporting with GHC staff. Teams are also verifying the treatment records by examining sample of UT cases during their field visit.

On request of GOI, we (ILEP India) have developed indicators to assess quality of services through GHC staff. In next year's report it may be more visible.

4. ANALYSIS OF ACTIVITIES

In general, following activities were performed by DTSTs, in various states together with and through General Health Care (GHC) staff:

- Our teams supported state and district authorities in planning of various activities at state and district level.
- Our teams supported GHC system in effectively implementing leprosy control activities, including correct diagnosis, treatment, case-holding, POD, disability care, patient counseling and education, drug supply management, planning and monitoring, recording and reporting and implementation of technical supervision by the supervisory staff of the GHC services.
- Our teams provided trainings, both on-the-job and by participation in formal courses. Around 75% of our DTSTs time and budget is utilized in supervision and on the job support.
  Some of the team members were among the core trainers in the state. Through validation and interactions with GHC staff, NLR teams were able to assess training needs and imparted trainings accordingly.
- Our teams supported GHC staff, in implementation of Simple Information System (SIS) introduced by Government of India. Our teams also participated in 'Intensive supervision', and assisted the GHC staff in updating the records and counseling of patients.
- Our teams provided support in Planning & implementation of IEC activities.

Besides above support provided by the teams, some activities were planned and budgeted from NLR source for the year 2005, which can be seen in the table below

Table 4 Analysis of approved activities, Branch Office - 2005

Nr.	Description of activities	Result	Analysis/comments
1.3	**Gen. Equipments**	Completed	Delhi DTST project office shifted to BO premises facilitated better supervision and control Purchased ACs, furnished Delhi DTST office
1.4	**Vehicles and furnishing of office**	Accomplished	Old car of Branch office was replaced
2.2.2	**Salary and staff**	Completed, including share of Dr. Taranekar's salary	Central Leprosy Division requested and ILEP agreed to hire Dr. Taranekar, his salary was shared for 9 months
2.5	**Training**		
2.5.1	Meeting & Conferences	'Oculep conference' at Kolkata was attended by Med. Adv. Dr. Manglani 'IAL' conference was attended by CR & Medical Advisor	Some amount was allocated in this head for sharing of activities requested ad-hoc by state and central government, which is shared by ILEP agencies.

Nr.	Description of activities	Result	Analysis/comments
2.5.2	Refresher course of NLR DTSTs MO at Delhi	Accomplished	To update the knowledge and skills of DTST staff, a re-orientation training was organized at Delhi. During this meeting preparation of presentations in IAL Conference, was also discussed.
2.5.3	Support to Urban Leprosy Control – Advocacy meetings in Delhi	Not organized	TLM being ILEP coordinating agency was reminded repeatedly but meeting could not take place
2.5.4	Participation in Monitoring & Evaluation (LEM)	Not completed	LEM was not carried out this year (because of more emphasis on elimination)
4.4	**Health Education Activities**		
4.4.1	Health Education Material	Completed	Self care POD booklets, purchased & distributed. Cards, stickers and various folders were developed & distributed. Exhibition sets, Photo card developed and distributed
4.5	**Teaching materials**		
4.5.1	District Nucleus training booklet	Dist. Nucleus training material, developed by ILEP India, printed by TLM, received by us & distributed.	Cost of Booklet production was shared by NLR also
	Printing of Urdu leaflets- stickers	Developed & printed	Urdu language stickers developed to cover population knowing Urdu language
	Stickers & diagnostic cards	Developed & printed	Distributed in projects supported by NLR

Table 5 Activities approved as per the Trust office budget, 2005

Nr.	Description of activities	Result	Analysis/comments
1.3	**Gen. Equipments**	Completed	Telephone line, Almirah, Fax Machine, Computer, A.C. purchased Furnished Delhi DTST office
4.3	**Special Budget**		
	End Evaluation, Uttaranchal	Accomplished	An evaluation was organized for Uttaranchal project in the month of August 2005

5. OTHER DEVELOPMENTS

5.1 Introduction

WHO and GOI had set a goal to eliminate leprosy by the year 2000 in line with the resolution at World health assembly. NLEP could not achieve so called elimination by the year 2000. This target was extended to 2002 then to 2003 and finally shifted to December 2005. In the year 2004 DDG (L) changed and with WHO influence, policies of GOI started changing towards achieving the target of elimination of leprosy by December 2005. Special activities like Leprosy Elimination Monitoring (LEM), MLEC, and SAPEL were stopped. Active search was discouraged rather stopped and guidelines were issued to validate all the new cases before registration. Throughout 2005, all efforts were made not to register unnecessary new patients, and delete all the cases, which have over stayed in the registers. GOI issued instructions to State Leprosy Officers (SLO) to validate all the cases, which are newly detected, update the registers, follow Accompanied MDT etc. all measures to eliminate leprosy. Our DTSTs were also pressurized to be involved in 100% validation of cases, deletion of wrongly diagnosed cases, and deletion of cases which are defaulters, deletion of cases, which are over treated or cured but not removed from the registers. This all led to achieving the target of elimination by December 2005 and Hon'ble Health Minister of India declared elimination on 30th January 2006 (the martyrdom day of Mahatma Gandhi).

Other than this some of the important developments, which took place in our projects are as under:

5.2 Overall Developments

1. Govt. of India & ILEP members came out with the Revised Guidelines of the DTST Project for the whole country, which came into effect from March 2005. These guidelines were circulated to all the teams.

2. Some DLAs of support teams took training in leprosy from TLM Shahadra.

3. Team members took active part in IAL Conference at Agra organized in the month of November to share their experiences with other delegates.

4. During IAL conference, 10 oral and 7 posters were presented (list enclosed at Annexure II) by NLR teams and were very much appreciated

5. Shifting of office of DTST staff, Delhi to Branch office promises took place in April 2005, which helped in more interactions with the teams and better supervision.

6. A formal MOU was signed with GOI in February 2005 for a period up to March 2007. NLR played a major role right from initiating the draft to its finalization stage.

7. To facilitate GHC staff, Flow chart for diagnosis and treatment of leprosy was procured and distributed to various DTST districts, feedback was collected about its utilization.

8. Country Representative NLR India along with Mr. Rens Verstappen, Head of Projects Deptt. NLR, Amsterdam, participated in WHO organized Inter country meeting of NLEP program managers at Kathmandu, Nepal from 6-8 Jan 2005.

9. Project officer Mr. J. W. Dogger and Medical Advisor Dr Anrik Engelhard visited Branch office, visited field projects in Delhi, in March 2005, discussed various issues and provided guidance. Mr. Jan Willem Dogger also visited Kanpur & Faizabad in UP, in Nov. 05.

10. Dr. Margaret Hogweg from Amsterdam and Dr. Caleb Mpyet from Nigeria, visited India and participated in first International conference on ocular leprosy held at Calcutta in the month of October 2005. Dr. P.R. Manglani, Medical Advisor, Branch office Delhi, also participated along with them.

11. CR also participated in a Workshop at Amsterdam on NLR Rehabilitation-Policy, on 2-3 Nov. 2005

12. Two SLOs were changed in UP during the year 2005, SLO of West Bengal and Bihar also changed, and one additional post of Secretary state society was created in Bihar to oversee society's functioning.

5.3 Delhi State

1. More interactions with DTST staff and close supervision took place as a result of shifting the office.
2. Five para medicals attended IAL conference held at Agra and presented 3 oral and 3 poster presentations.
3. Two experiments – LEC for Burka (veil) clad women and LEC for Home less People in Delhi were conducted by SLO, which was facilitated by NLR DTSTs.
4. Orientation-training & sensitization of GHC staff regarding POD was carried out in all districts, Medical Officers of NLR DTST played the key role as facilitators.

5.4 Bihar

1. Assembly elections were held in the state of Bihar twice in the year 2005, which led to lot of disturbances and hindrance in activities
2. NLEP &DTST activities were carried out smoothly due to good partnership among state WHO and DTST project.
3. Joint Annual action plan for Bihar was discussed together in the month of July 2005 with State officials, WHO, DFIT, LEPRA, TLM and NLR, which was example of good partnership.
4. District Nucleus Training was completed with support from ILEP.
5. Additional post of Secretary, State Leprosy Society was created and Dr. Bhimsaria joined as the Secretary.
6. Three MOs & 3 NMSs attended IAL conference at Agra presented 3 posters and 3 oral papers

5.5 Jharkhand

1. Discussions with State officials of Jharkhand and among ILEP members, were held repeatedly, formally and informally, to streamline the functioning of DTSTs. Some progress was made but the conflict could not be resolved till the end of December 2005.
2. New Government was elected in Jharkhand.
3. Due to controversial activities, carried out by Dr. Mallick, his past performance and insistence from DFIT, Dr. Mallick was removed from the post of DTST coordinator. New state coordinator, Dr Pandey was posted at Ranchi, in Jan 2005. With the non-cooperation from SLO's office, functioning of State coordinator and DTSTs was affected, which led to suspension of activities for few months.
4. Dr Arun a new MO joined at Giridih,
5. 6 team members participated in IAL conference held at Agra. 4 oral and 2 posters were presented.
6. District Nuclei were not formed so its training could not take place.

Most of the planned activities were delayed due to non cooperation from state officials

5.6 Uttar Pradesh

1. New project was started from January 2005. A new coordinator Dr Vartika joined & worked for about two months. Because of her uncertainty she didn't continue and later Dr. Casabianca was appointed by consensus.
2. Team spirit among partners i.e. DTST, WHO and State NLEP cell was maintained.
3. Frequent change of SLOs has not affected much due to active role of assistant SLO Dr Siddiqui, and WHO coordinator.
4. Training of Dist Nuclei is delayed due to incomplete nuclei formation.
5. Vacant posts of MOs DTST were filled by recruiting new MOs. Because of large number required and frequent resignations all the teams do not have MOs at any given point of time.

5.7 Uttaranchal

1. DTST initiated & facilitated in preparing and updating PHC profiles at every block PHC.
2. New SLO took over in later part of year 2005, because of his involvement in other programs, implementation of NLR planned activities got delayed/shelved
3. End evaluation of NLEP & DTST project was carried out in Aug 2005. To keep it an independent evaluation and maintain quality, the evaluation team was headed by Senior Medical Advisor of KIT Dr. Pieter Feenstra with participants from WHO Dr. Myo Thet Htoon, GOI and ILEP. Its organization, methodology was well appreciated by evaluators as well as by GOI. Main recommendations were reduction in DTSTs, placement of advisor at state level, supervision of all districts, temporary consultants for special trainings, to define job responsibilities, establish referral system etc. Details can be seen in the evaluation report.

An attempt was made to discuss Uttaranchal evaluation and recommendations. GOI requested ILEP coordinator to first compile evaluation report/recommendations of evaluations of all other states. On the basis of these recommendations further discussions will be held with GOI to plan future support. Till that time we have to maintain status quo. Whatever recommendations were to be followed at our DTSTs level they were followed e.g. all the districts of Uttaranchal are being supervised by our teams. Epidemiologists and DLOs of Uttaranchal are moving along with STST and DTSTs respectively. Defaulter retrieval being done through ANMs. A list, of Job descriptions of various categories of health staff, was discussed and handed over to SLO who has promised us to disseminate it to all GHC staff.

5.8 West Bengal

1. Smooth functioning of project continued as good relations with SLO were maintained.
2. New SLO has joined in 2005. His dynamic approach has facilitated output of DTSTs.
3. MO Burdwan resigned in later part of 2005. New doctor has been identified, yet to join..
4. Evaluation of DTST, West Bengal was carried out from 24-31 Jan. 2005. Main recommendations were: MO of DTST should be part of district society, Additional staff in high endemic district, stronger focus on urban areas, sensitization of GHC staff in POD, more emphasis on monitoring of DTSTs, enhancement of capacity of District Nucleus, development of withdrawal indicators of DTSTs. As per the recommendations, attention was paid to improve the quality of services resulting into reduced number of wrong diagnosis and re-registration, paying priority to POD and urban leprosy. An attempt has been made to develop withdrawal indicators, which are yet to be finalized. Feed back on case validation was insisted to improve the capacity of GHC staff. Continued Medical Education for DTST started during monthly review meetings.

6. FINANCE

Table 6 Expenditure statement, of Branch office, for the year 2005

		TOTAL EXPENDITURE IN THE YEAR (INR)	TOTAL BUDGET FOR THE YEAR (INR)	SAVINGS / (OVER) EXPENDITURE (INR)	Expen-diture in %
INVESTMENTS					
1	Buildings / Land	-	-	-	
2	Medical Equipment	-	-	-	
3	General Equipment	186,759.00	144,650.00	(42,109.00)	
4	Vehicles	241,209.00	740,000.00	498,791.00	
5	Rehabilitation of equipment	-	-	-	
6	Miscellaneous	-	-	-	
	TOTAL INVESTMENTS	427,968.00	884,650.00	456,682.00	48%
SALARY, STAFF AND TRAINING					
1	Medical Doctors	720,720.00	720,720.00	-	
2	Other Medical Staff	397,321.00	407,000.00	9,679.00	
3	Administrative Staff	641,995.00	682,000.00	40,005.00	
4	Staff Benefits	226,257.00	235,725.00	9,468.00	
5	Training	113,697.00	140,000.00	26,303.00	
6	Miscellaneous staff exp.	-	-	-	
	TOTAL SALARIES & TRAINING:	2,099,990.00	2,185,445.00	85,455.00	96%
MAINTENANCE					
1	Repairs and Utilities	493,513.00	803,900.00	310,387.00	
2	Anti-Leprosy drugs	-	-	-	
3	Other Drugs	-	-	-	
4	Vehicle Maintenance/ travel & Transport	1,037,102.09	967,000.00	(70,102.09)	
5	General supplies	-	-	-	
6	Miscellaneous	-	-	-	
	TOTAL MAINTENANCE	1,530,615.09	1,770,900.00	240,284.91	86%
ADMINISTRATION					
1	Office Expenses	262,287.625	260,200.00	(2,087.62)	
2	Public relations	55,338.00	72,000.00	16,662.00	
3	Special budget	-	-	-	
4	Health education activities	19,015.00	40,000.00	20,985.00	
5	Teaching materials	87,457.00	100,000.00	12,543.00	
6	Miscellaneous	33,975.00	70,000.00	36,025.00	
	TOTAL ADMINISTRATION:	**458,072.62**	**542,200.00**	**84,127.38**	**84%**
	TOTAL EXPENDITURE	**4,516,645.71 (84,687.10 Euro)**	**5,383,195.00 (100,934.90 Euro)**	**866,549.29 16247.79 Euro**	**84%**

1 Indian Rupee = 0.01875 Euro, as on December 31, 2005

General equipments: Over expenditure is seen due to displaced allocation of budget from Branch Office to Trust office for ACs.

Vehicles: 67% savings are seen because of the inclusion of the funds we received from the sale of old vehicle of Jharkhand, Branch Office and reimbursement of insurance of lost vehicle of Delhi.

Vehicle Maintenance/ travel & Transport: Over expenditure due to two overseas visits of Country Representative and local purchase of tickets for international guests.

Health Education activities: Savings are seen due to release of money from GOI for IEC activities

Miscellaneous: Payment for advertisement for M.O & Project Coordinator was booked in this head.

7. CONCLUSIONS & RECOMMENDATIONS

DTSTs activities continued satisfactorily in all the states except in the state of Jharkhand due to non-cooperation from the state officials. There is a need to improve coordination within ILEP and with the state governments

1. Almost all planned activities were completed in all the states, except in Jharkhand. More discussions are required with DLOs and SLOs before planning for budget and its approval.

2. Progress on integration - process is satisfactory. Diagnosis & treatment of leprosy cases is being carried out by GHC staff but management of reactions and other complications needs to be strengthened further for which services of DTSTs will be required for few more years.

3. Some of the planned activities could not be carried out due to change in the priorities of NLEP Total focus on 'intensive supervision' to achieve Elimination has affected POD & IEC activities. An effort should be made by the teams to focus more on POD activities.\

4. There were special efforts made to reduce prevalence by controlling operational factors. Old cases were not re-registered, cases were deleted, active search was discouraged.

5. MOU was signed with GOI in February 2005 for a period up to March 2007. NLR played a major role right from initiating the draft to its finalization stage. Thoughts should be given and discussion should start for future collaboration.

6. Supervisory system and referral system in GHC is under developed and needs more attention / priority.

7. Working document & annual plan mutually agreed by state & all ILEP agencies needs to be developed. This will facilitate uniform DTST functioning.

8. End Evaluation of Uttaranchal project was conducted from 09^{th} – 17^{th} August 2005. Final report has been distributed to all the evaluators, State authorities and GOI. Recommendations and findings were discussed with SLO and an action plan is prepared. This plan will be followed for upcoming activities.

9. Negotiation Jharkhand issue continued till end of 2005 and the situation was very fluid.

10. Quarterly Review Meeting of partners (ILEP, GOI, WHO) should be organized so that uniform and smooth implementation of planned activities could be facilitated minimizing operational factors and prioritizing the issues.

7.1 Future Challenges

1. Functioning in Jharkhand, coordination within ILEP and with the state government needs to be improved.

2. In Uttaranchal & UP remaining batches of DN are to be trained. State Govt of Jharkhand and Delhi need to be persuaded to complete the formation of District Nucleus so that their trainings are carried out and supervision is strengthened.

3. Seminars to train Physicians/dermatologists of dist hospitals are to be organized, to develop secondary referral hospitals in all the 6 states.

4. There is need to train programme managers like DLOs CMOs in managerial skills

4. Surgeons & PTs of Medical College - RIMS, Ranchi are to be trained in RCS so that RC Surgery could be started there.

5. Patient follow up and retrieval in an urban setting has to be established

6. POD services are yet to be strengthened under GHC

7. Evaluation of DTST projects in various states are to be undertaken to assess the contribution made by DTSTs and to assess the nature of ILEP support to India in future. Future role, of DTSTs, in India is still not clear as GOI has asked ILEP Coordinator for compiled evaluation reports. Future requirement of DTSTs need to be discussed with GOI and State governments. Most of ILEP partners are of the opinion that the number of DTSTs must be reduced in the area of Leprosy but we feel that DTSTs are required but focus of transfer of skills should now be on POD rather on diagnosis and treatment.

Annex I Treatment Completion Rates in NLR supported districts

Cohort period 2003 (MB) and 2004 (PB)

S. No	Particulars	Bihar (5 Distts.)			Delhi (5 Distts.)			Jharkhand (10 distts.)			Uttaranchal (6 distts.)			Uttar Pradesh (34 distts.)			West Bengal (3 distts)		
		PB	**MB**	**Total**	**PB**	**MB**	**Total**	**PB**	**MB**	**Total**	**PB**	**MB**	**Total**	**PB**	**MB**	**Total**	**PB**	**MB**	**Total**
1	Number of cases started treatment	6617	3752	10369	552	814	1366	4606	3192	7798	576	680	1256	14647	16021	30668	3823	3368	7191
2	Number of cases completed treatment	6462	3608	10070	287	308	595	4293	2937	7230	564	626	1190	9431	9282	18713	3413	2777	6190
3	Treatment completion rates	97.6	96.1	97.1	52	37.8	43.5	93.2	92	92.7	97.9	92	94.7	64.3	57.9	61	89.2	82.4	86

Annex II Papers presented in IAL Conference, Agra 2005

Oral Presentation

1.	Involvement of General Practitioners (RMPS, BUMS, BAMS Etc.) of Slums / re-settlement colonies, of central Delhi district, in NLEP	Mr. Anil Kumar
2.	Training Need Assessment of GHC Staff	Mr. Ghanshyam Dixit
3.	Status of Integrated NLEP in Jharkhand State	Dr. H.C. Pandey
4.	Involvement of women's groups to promote voluntary reporting by women	Ms. Premlata Gupta
5.	Integration status at General Health Care dispensaries in North Delhi	Mr. Rajendra Singh
6.	Case Holding in Urban Areas	Mr. P. Mahato
7.	Prevention of Disabilities in Integrated Setup	Dr. S.K Dwivedi
8.	Inter Personal Communication to Promote Voluntary Reporting	Mr. S.N Tiwari
9.	Partnership for Leprosy Control in Urban Area	Dr. S.P Sood
10.	Better Immunity among Female Groups of Reproductive Age	Dr. Sumit Talukdar

	Poster Presentation	**Poster displayed**
11.	Leprosy Elimination Campaign for the homeless of Delhi	Dr. Ajai N. Walters (Could not attend the conference)
12.	Leprosy Elimination Campaign focused on "Burqa" clad women in walled city of Delhi	Mr. Anil Kumar
13.	POD care at PHC	Mr. Fulchand Mahato
14.	Monitoring Patient Compliance in Hazaribagh	Dr. Sumit Talukdar
15.	Case Validation in Bokaro District	Mr. Jagganath K Majhi
16.	Occurrence of reactions and neuritis in new leprosy cases registered in Health Care Facilities (HCFs) of New Delhi district	Mr. Shesh Pal Singh
17.	Drug Supply Management at PHC Level	Dr. S.P. Sood

Annex III Administrative Details of Branch Office Staff

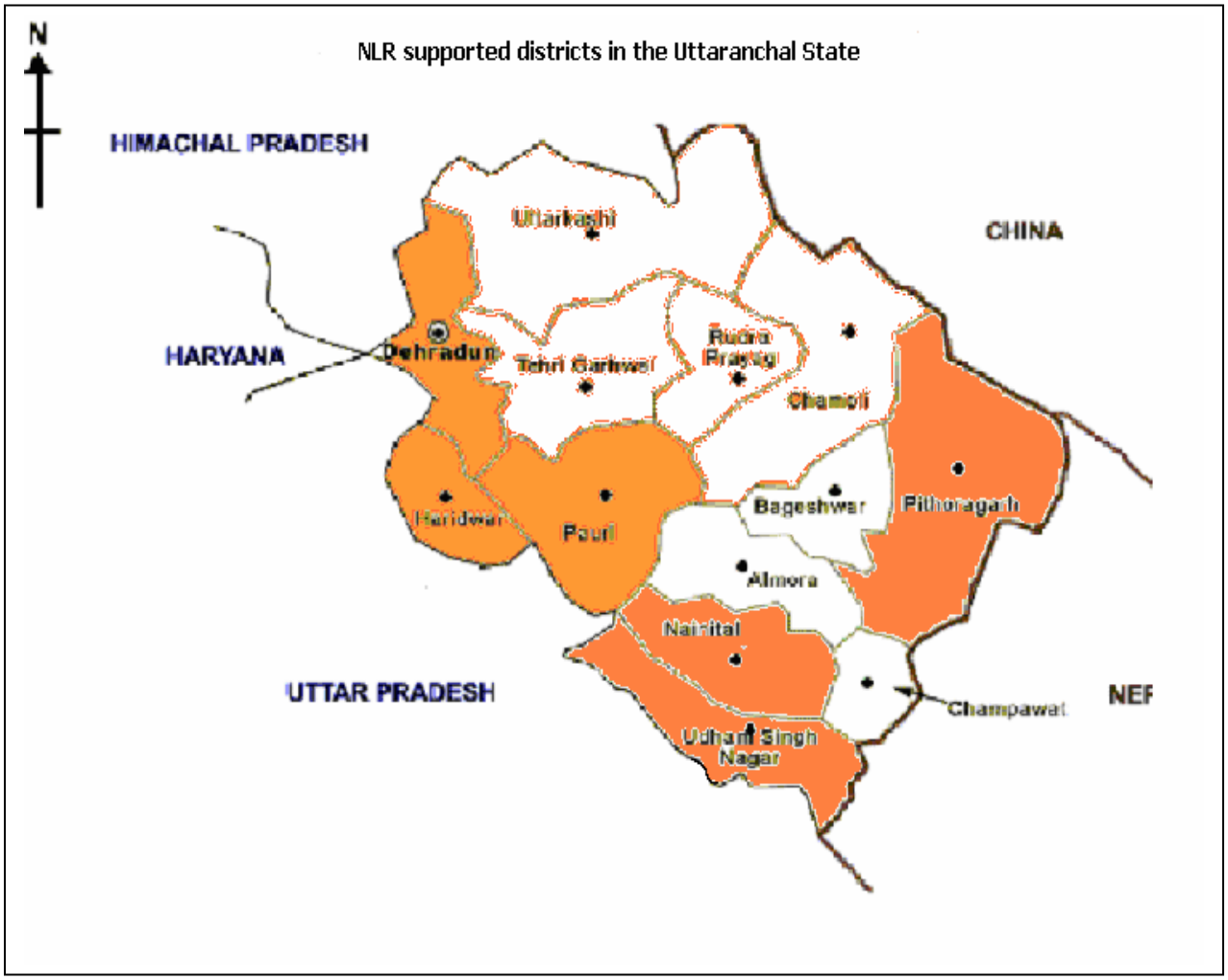
S.No.	Name	Designation	Residential Address
1	Dr. M. A. Arif	Country Representative	A–31-D, DDA Flats, Munirka, New Delhi
2	Dr. P. R. Manglani	Medical Advisor	133, Arjun Nagar, First Floor, Street 29, Safdarjung Enclave, New Delhi – 110 029
3	Mr. Ashok Kumar	Mgr. Accounts & Admn.	C-1/190, Janakpuri, New Delhi
4	Mr. Vishal M. Singh	Accounts Asstt.	196 – A, Hari Nagar, Ashram, New Delhi
5	Ms. Pooja Grover	Personal Sec / Off. Asst.	H.No. 40, Madangir, New Delhi – 110 062
6	Mr. Rustam Mansoor	Driver	A – 182, Shaheen Bagh, Abul Fazal Enclave, Part – II, New Delhi – 110 025
7	Mohd. Ali Ahmed	Driver	F-147/3, Shaheen Bagh, Abul Fazal Enclave - II, Okhla, New Delhi – 110 025
8	Mr. Joginder Prasad	Peon	C – 59, Satya Vihar, Kamal Pur, Burari, Delhi – 110 084

Annex IV Map of NLR supported districts in Delhi state

DELHI

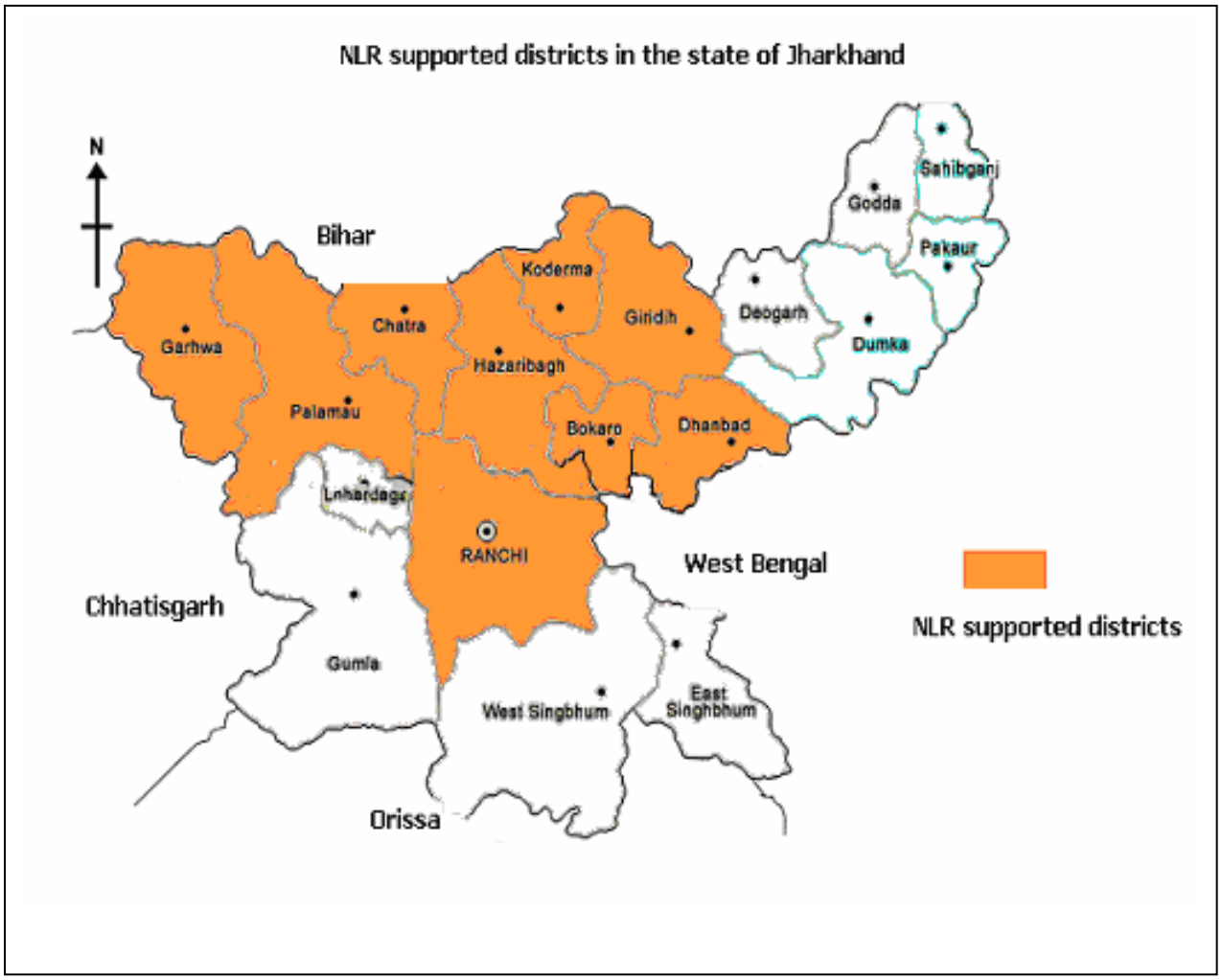
Annex V Map of NLR supported districts in Uttaranchal state

UTTARANCHAL



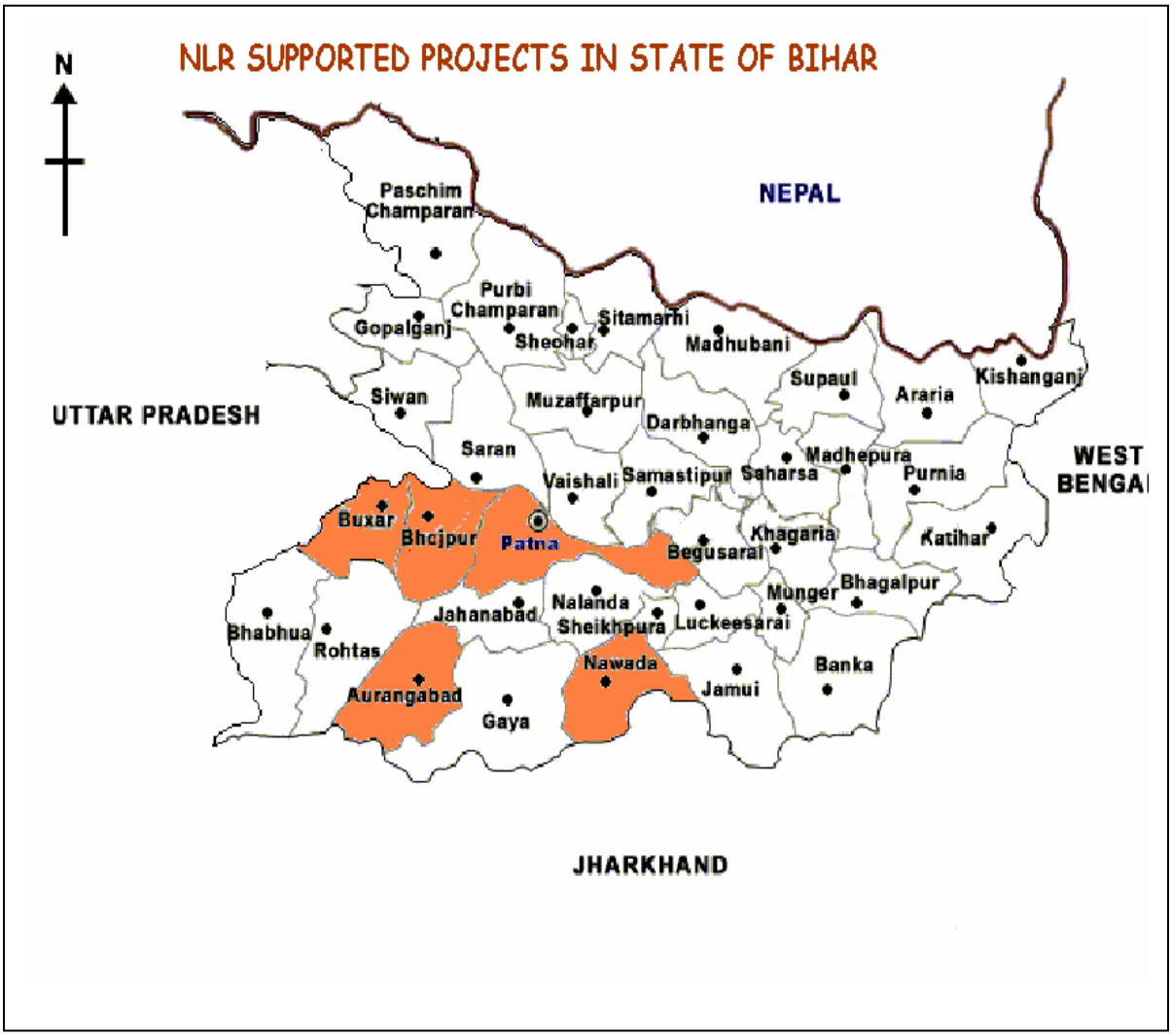
Annex VI Map of NLR supported districts in Jharkhand state

JHARKHAND



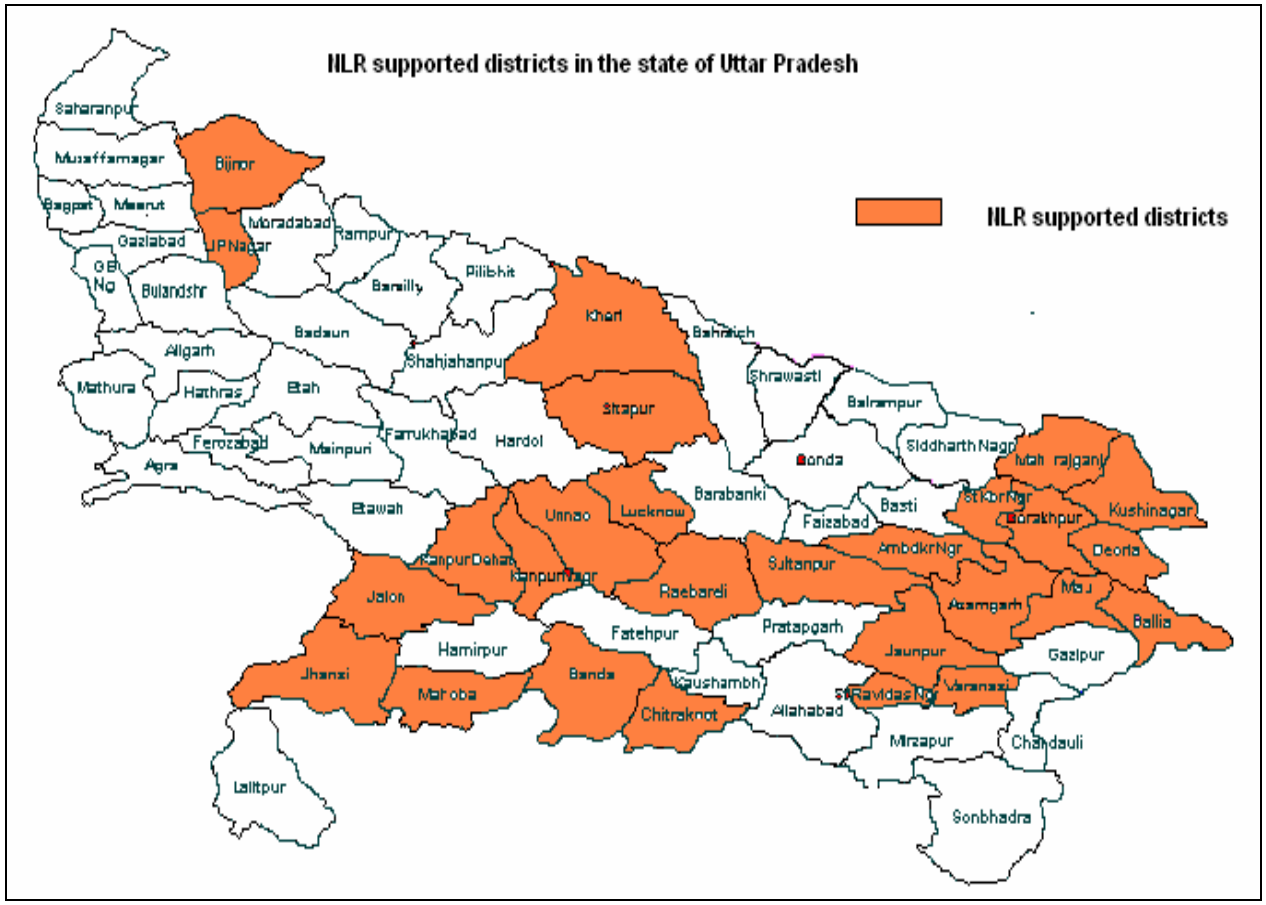
Annex VII Map of NLR supported districts in Bihar state

BIHAR



Annex VIII Map of NLR supported districts in Uttar Pradesh state

UTTAR PRADESH



Annex IX Map of NLR supported districts in West Bengal state

WEST BENGAL