Project for the Prevention of Impairment and Disability in Andhra Pradesh

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1. Abbreviations

Abbreviation	Description
ADMHO	Administrative Medical Health Officer
ANCDR	Annual New Case Detection Rate
ASHA	Accredited Social Health Activist
CHC	Community Health Centre
CHF	Swissfrancs
DFIT	Damien Foundation India Trust
DLO	District Leprosy Officer
DPMR	Disability Prevention & Medical Rehabilitation
HIS	Health Information System
INR	Indian Rupies
ITDA	Integrated Tribal Development Authority
LAKH	1 lakh = 100,000
MB	Multibacillary Leprosy
MDT	Multi Drug Therapy
MIS	Management Information System
NLEP	National Leprosy Eradication Program
NRHM	National Rural Health Mission
PALs	Persons Affected by Leprosy
PB	Paucibacillary Leprosy
PHC	Primary Health Care system
PIP	Project Implementation Plan
POID	Prevention of Impairments and Disabilities
PR	Prevalence Rate
SC	Scheduled Caste
SLO	State Leprosy Officer
ST	Scheduled Tribe
TCR	Treatment Completion Rate
THW's	Temprorary Hospitalisation Wards
TLM	The Leprosy Mission
UT's	Union Territories
WHO	World Health Organization

2. Introduction

2.1 Leprosy and Disabilities in India

Leprosy is basically a disease of the peripheral nerves and affects several parts of the body especially the eyes, hands and feet. As it advances, it affects other systems in the body. The nerve damage in Leprosy is permanent and progressive. The impairments and disabilities in the eyes, hands & feet as a result of leprosy cause activity limitations and participation restrictions in the Persons Affected by Leprosy (PALs).

Leprosy is an endemic disease in 122 countries in the world. India has been highly endemic for Leprosy and is still contributing about 60-70% of the global Leprosy burden. In order to eradicate Leprosy, India implements the National Leprosy Eradication Program (NLEP) with a major objective of reducing the Leprosy burden, prevention of associated disabilities and improving awareness about Leprosy in the community. Based on the 'World Health Organization (WHO) strategy; operational since the mid eighties of the last century; the national program has promoted the NLEP with the aim of reducing the burden of Leprosy (the so called "elimination of Leprosy as a public health problem").

The standardized and robust treatment weapon (i.e. Multi Drug Therapy - MDT) has demonstrated success in cure of the disease for the first time in human history and hence has contributed towards reducing the burden of the number of active cases of Leprosy. Nevertheless, MDT could prevent impairments and disabilities when applied early enough. As such, it appears that MDT had only a limited impact on newly appearing disabilities and provides no improvement for the large group of affected with existing impairments and disabilities.

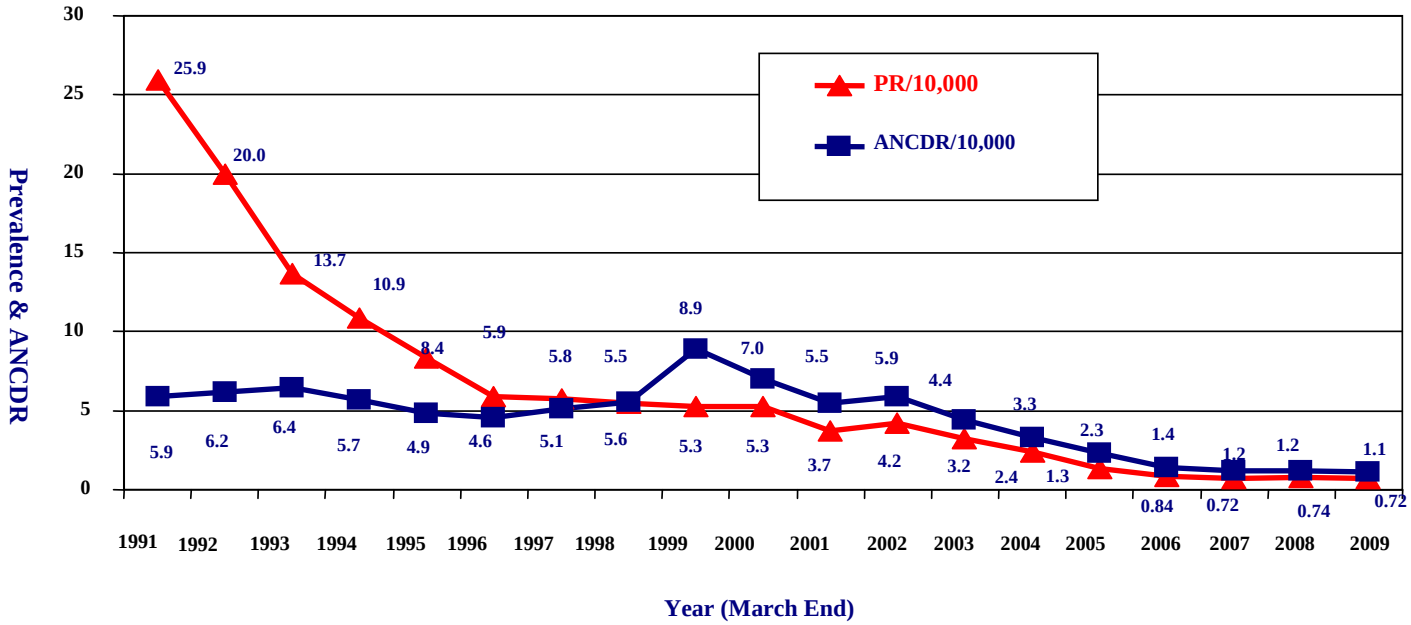
To ensure quality leprosy services and to further reduce the Leprosy burden, National Leprosy Elimination Program (NLEP) has been integrated in the General Health Care system i.e. Primary Health Care system (PHC). In this context, the prevention of impairments and disabilities (POID) has been given high emphasis. Government of India has planned to undertake Disability Prevention and Medical Rehabilitation Programme activity during 11th five year plan i.e. 2007-2012. In the 11th Five year plan (PIP) document, a new indicator is added as "No. of Gr. II disabled cases – 25% reduction by March 2012, taking 2006-07 as the base year". Recently WHO has also proposed to introduce "The new cases with Grade – II disability" as the key indicator to monitor progress in addition to current list of indicators. It is also suggested that Rate of grade – II disability in new cases per 100,000 population should be taken as the new indicator.

Across the country, 0.87 lakh (87,000) leprosy cases are on hand as on 1st April 2008, with PR 0.74/10,000. Till then 29 States/ UTs had attained the level of leprosy elimination. 482 districts (78.5%) out of total 614 districts also achieved elimination by March 2008. Around 90 districts with >500 new cases during the year are selected as high priority areas.
The leprosy situation in the country (2008-09) has been observed as below.

1. A total of 1.34 lakh new cases (134,000) were detected during the year 2008-09, which gives Annual New Case Detection Rate (ANCDR) of 11.19 per 100,000 population. This shows ANCDR reduction of 4.36% from 11.70 during 2007-08.
2. A total of 0.86 lakh cases are on record as on 1st April 2009 giving a Prevalence rate (PR) of 0.72 leprosy cases per 10,000 population.
3. Detailed information on new leprosy cases detected during 2008-09 indicates the proportion of MB (48.4), Female (35.2), Child (10.1), Visible Deformity

(2.8), ST (scheduled tribes) cases (13.3) and SC (scheduled casts) cases (19.4).

4. Trend of leprosy Prevalence (PR) and Annual New Case Detection (ANCDR) are indicated in the graph given below.
5. Total number of cases released as cured during 2008-09, thus comes to 129,798 (90.9%) as against total deletion of 142,772. This brings the total number of persons affected by Leprosy cured of the diseases in the country with MDT from the beginning till date to 12.27 million.
6. Treatment Completion Rate (TCR) for the reporting year 2007-08, based on New case cohorts of PB (2006-07) and MB (2005-06) were reported as PB – 94.60%, MB - 88.00%, Male - 90.98%, Female – 92.00%, Urban – 84.53%, Rural – 93.08% and Total – 91.35%.
7. Number of grade – II disability cases detected increased from 3,477 (2.53%) in 2007-08 to 3,763 (2.80%) in 2008-09. Recording of grade – I cases also started from this year. A total of 5,985 (61.4%) out of total 9,748 cases with disability were recorded in the year (www.nrhm.nic.in).



2.2. Status in the State of Andhra Pradesh

Andhra Pradesh is one among the 32 States/ UTs that has achieved the level of elimination i.e. PR less than 1 case per 10,000 population. Andhra Pradesh is one in the 10 States/UTs where proportion of Child cases is more than 10% of new cases detected (Andhra Pradesh 12.28%). PB Child proportion is also high in the State (9.24%). Andhra Pradesh reported 16 cases as developing new disability during treatment. A total of 35 relapse cases were reported as confirmed out of suspected and referred by the peripheral institutions in the State.

The District Nucleus set for the NLEP consists of Additional District Medical and Health Officer (AIDS and Leprosy), District Nucleus Medical Officer, Para Medical Officer, Physiotherapist, Health Education Officers and 2 Deputy Para Medical Officers and they monitoring the leprosy activities in all districts. During the year 2008-09, Accredited Social Health Activist (ASHA) working under the NRHM at village level were involved for suspecting leprosy cases and after diagnosis follow up the treatment till completion. ASHA are being paid incentive for confirmed leprosy cases out of suspect brought by them (Rs. 100/-) and for completion of treatment in time (PB- Rs. 200/-, MB – Rs. 400/-). The state also has NLEP trained pharmacist and lab technicians in the State.

State Leprosy Program Status(Data From SLO Office)			
1.	State Disability Load		
	Total no. of deformed cases	Grade – I	7,690
		Grade - II	31,204
		Total	38,894
	No. of cases with Grade-II disability		498
2.	Among new cases detected	Total	5,110 (during 2009-10)
		Grade-1	289 (3.2 %)
		Grade-II	40 (4.9%)
3.	Total No. of Leprosy colonies		84
	Total inmates in the colonies		12,695
4.	Services available	Govt. Temporary Hospitalization wards	29 (300 beds)
		ILEP institutions (FAIRMED covers all deformed cases in 6 districts)	19 nos.
		DFIT (covers partially)	2 districts (Cudapah, Nellore)
		Lepra.uk (covers partially)	2 districts (Hyderabad, Adilabad)
5.	RCS centers	8 nos.	
		Sivananda, Kukatpalli, Rangareddy District	
		RISDT, Kathipudi, East Godavari	
		Swiss Emmaus Palmaner, Chittore	
		TLM, Salur, Vizianagaram	
		Bethestha Leprosy Hospital, Narsapuram, West Godavari	
		Gretnaltes, Morampudi, Guntur	
		DLC, Vegavaram, West Godavari	
		DFIT, Nellore, Nellore dt.	
6.	DPMR has been planned under NRHM as a 3 tier system i.e. Primary (PHC), Secondary and Tertiary Specialist Hospitals (ILEP) but not implemented properly.		
7.	Physically handicapped corporation, A.P is providing MCR @200 pairs per district on demand per year.		
8.	All deformed patients are receiving pension of Rs. 200/- pm & Rs. 500/- pm by PALs having 40% deformity. All patients are being given Anthyodaya cards for supply of rice, dal and etc. are subsidized rates.		

3. Situation in the Project Area

3.1 Description of East Godavari and Guntur Districts

3.1.1. East Godavari

One of the coastal districts, West Godavari is located on the eastern side of river Godavari and bordered by Bay of Bengal on East, Khammam & West Godavari districts with Madhya Pradesh on the north & Orissa states on South. Kakinada, a coastal town is the capital of West Godavari. As per 2001 census, it is the most populous district in Andhra Pradesh with population 4,901,420 with a decimal growth rate 7.93 %. It is also most populous district as far as rural population in the state i.e. 3,749,535. It has a distributed area of 10,807 Sq. Km with population density 420/Sq.Km (4^{th} place in the state). The urban area consists of 3 municipal corporations & 6 municipalities with a population of 1,151,885 (23.6%).

East Godavari receives 1,160 mm annual rain fall. The National Highway – 5 divides the district across the dry land and wet land. In 3,23, 244 hectors, there is a forest cover. Rice is the staple food and the district is one of the 'RICE BOWL' districts of the India. Famous temples, such as, Annavaram Satyanarayana, Draksharamam Bhemeswaram temple (Dakshinakasi) Ryali Jaganmohini Chennakesa temple and Dwarapudi Ayyappa temple are located in the district. Sir Arthur Cotton Barrage at Dowleswaram on the River Godavari was constructed by British in the year 1852. At Kakinada, the district capital, there is a Harbor & a Fertilizer factory. At Rajahmundry, there is the Andhra Paper mill, a very famous paper mill. Rajahmundry, also known as Rajahmahendravaram, is the capital of kingdom of King 'Raja Raja Narendra'.

3.1.2. Guntur District

One of the 'nine' coastal districts, Guntur is located on the Southern side of River 'Krishna'. Guntur district, with the capital city as Guntur, is bordered on the East by Bay of Bengal and on West by Krishna, Prakasam and Mahaboobnagar districts. And the Northern side of Prakasam district and the southern by Nalgonda & Krishna districts. As per 2001 census, Guntur is second most populous district with population of 4,465,149 and a decimal growth rate 8.72 % & a sex ratio of 1000: 980 (female: male).

It is a coastal district with 890 mm annual rain fall and 162,005 hectors forest land. National Highway – 5 divides the district across the wet & dry land. The district is spread over 11,381 Sq.Km area space and has a population density of 360/ Sq. Km. Rice is the staple food. It is also known for agricultural crops such as green chilies and tobacco plantation. It has eleven urban towns with population 1,285,760 (36.6%). Famous temples such as Amaravathi, Amaralingeswara, Kalachakram and Mangalagiri (Laxmi Narasimha Swamy) are located in this district. The other world famous water body is Nagarjuna Dam built on River Krishna. The district also has an industrial economy from the production of Cement, Jute, Tobacco and Red Chilly. Historically, the Palnadu kingdom in Kondaveeti kingdoms ruled the district. The district has 12 urban municipalities with a population of 1,285,760 (34%).

3.2 Environmental, Leprosy, Health Situation East Godavari/ Guntur

3.2.1 East Godavari

The forest area, denoted as a tribal area and administratively under the Integrated Tribal Development Authority (ITDA), is known for high incidence of Vector Borne diseases. The wetlands area is affected by frequent gastro intestinal diseases. The district is also know for the presence of traditional sex workers and has a higher proportion of HIV/AIDS. The district is highly endemic for Leprosy. (The State Government data, as of 1987, suggests that the PR in the district is 118/ 10,000 and more than 80,000 PALs have been cured with MDT). At present, the districts has three Medical Colleges, three area hospitals, one district Headquarter hospital, ten Community Health Centers (CHCs) and seventy one PHCs to cater to the medical and health needs of the people living in the district.

3.2.2 Guntur

Vector borne diseases are seen in forest area, while gastro-intestinal diseases are prevalent in the wet land area. There is a highly prevalence of Leprosy in the district (PR at 1988 81/10,000 and cured highest no. of PALs, i.e. around 100,000 with MDT. It is one of the seven districts that have reported highest number of new cases (National Sample Survey, Government of India, June, 2010). The district has three Medical colleges, 12 Government Hospitals and 80 PHC's that cater to the medical and health needs of the people in the district.

3.3. Disability and Impairment in East Godavari and Guntur Districts

As per the data available with the GOAP, the disability burden of Leprosy in the State is as follows: Grade I: 7,690: Grade 2: 31,204 and total deformity: 38,894. These form the PALs that need POID services in the State.

3.3.1.Implementation District Leprosy Program Status

			East Godavari	West Godavari	Guntur
	Deformity load				
		Grade – I	393	351	69
		Grade-II	3,997	3,218	1,860
		Total	**4,390**	**3,569**	1,929
	Deformity status among	Immobile patients: New cases	300 509 in 2009– 10	250 458 in 2009-10	200 698 in 2009 – 10
		Grade – II Grade – I	13 (2.5%) 7 (1.4%)	31 (6.7%) 17 (3.7%)	42 (6.0%) 29 (4.1%)
	Till Dec, 2009 all cases are covered in both the districts by DISPEL				
	Hospitals available	Govt. THWs	1 (10 beds)	1 (10 beds)	1 (10 beds)
		NGO's	3 (RISDT- Kathipudi) TLM-Ramachandrapuram AMG colony, Changiskhapeta St. Joseph-Prathipadu	DLC (vegavaram) St. Mary's (Bhimavaram), Bethestha(Narsapuram)	GRETNALTES, Morampudi.
	DPMR as a 3 tier system suggested yet to be implementing in East Godavari & Guntur districts				
	MCR providing		DISPEL, Kathipudi (3,427 pairs in 2009)	DISPEL, West Godavari (1,543 pairs in 2009)	DISPEL, Gretnaltes (1,253 pairs in the year 2009)

3.4. POID and DISPEL in Andhra Pradesh

To support the Government efforts in Andhra Pradesh, FAIRMED (formerly Leprosy Relief Emmaus Switzerland) had taken up POID service in the form of DISPEL (Disability Prevention and Education in Leprosy) in 6 districts through the support of '2' NGO i.e. Rural India Self Development Trust (RISDT), Kathipudi and Gretnaltes, Tenali.

The main POID service provides by DISPEL at Service Delivery Points @ 80-100 per district mostly at PHCs / CHCs and Leprosy colonies are

- Ulcer Care
- Provision of Self Care Kits
- Provision of MCR
- Provision of Supportive Medicines

Implemented in partnership with the State and district leprosy program, the project supported the NLEP program in reduction/prevention of disabilities and direct provision of care. DISPEL provided medical kits and MCR footwear to supplement governmental supplies and support supply chain streamlining.

The project has been implemented from 2001 in some districts while in the others it was scaled in 2004. The end evaluation has documented the successes of the project. The performance on project is provided below:

3.4.1.Performance of DISPEL Projects RISDT and Tenali (Gretnaltes)

Sl. No.	Particulars	West Godavari 2000-June '09	East Godavari April 2004 - Dec. '09	Vishaka April 2007 - Dec. '09	GUNTUR 2000-June '09	KHAMMAM 2004 - June '09	RANGAREDDY 2004 - June '09
1	Total No. of patients evaluated on self care	52,569	36,930	18,250	29,131	19,021	15,335
2	Total Ulcer patients given dressing	30,005	24,139	11,734	19,188	10,316	9,245
3	Total Ulcer patients provided self care kits	31,813	21,717	10,854	19,188	10,316	9,245
4	Total patients provided MCR footwear	21,878	21,209	7,778	17,242	9,935	9,986
5	Total patients underwent surgical corrections	668	401	157	514	223	129
6	No. of patients admitted in hospitals	2,492	7,003	-	2,622	813	274
7	Total no. of patients underwent physiotherapy	35,598	30,039	-	22,080	13,935	13,427
8	No.of service delivery points visited in Health facilities	3,304	1,213	-	210	78	50
9	Any other work at PHC/CHC/UHC visited	865	396	-			

The service of DISPEL by FAIRMED were found highly satisfying to PALs, NLEP staff and were highly appreciated by the Education Teams. The project demonstrated impressive successes in reducing the burden of the disability in the project areas. It was recommended that, to build on a sustainable and more integrated concept for POID, the project should work towards encouraging more self-care by the PALS and promote the integration of POID into the district health services.

3.4.2. Performance Report DISPEL of RISDT/ Kathipudi 2001 - 2009

		WEST GODAVARI DISTRICT										EAST GODAVARO DISTRICT							DPMR PROGRAM VIZAG			
S.N	**Particulars**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009 June**	**Total**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Total**	**2007**	**2008**	**2009**	**Total**
1	Total No. of patients evaluation on self care	6594	4979	6788	5706	6004	6954	6684	6270	2590	34,208	3850	5471	8165	7356	6582	5506	36930	4126	6961	7163	18250
2	Total Ulcer patients given dressing	4354	3839	3014	3407	3709	3461	3268	3544	1409	18,798	2693	4047	5005	4479	4287	3628	24139	2812	4219	4703	11734
3	Total Ulcer patients provided Self care kits	4232	4060	5248	3555	3214	3207	3607	3350	1340	18,273	2499	3672	4583	3982	3810	3171	21717	2429	4106	4319	10854
4	Total Patients provided MCR Chapels	1834	1838	1898	1805	2235	3775	3615	3335	1543	16,308	1652	2681	4684	4371	4394	3427	21209	1933	2785	3060	7778
5	Total No. of patients underwent surgical corrections	124	100	96	92	97	73	32	35	19	348	87	95	96	55	35	33	401	46	63	48	157
6	Total No. of patients admitted in Hospitals	729	404	307	248	263	224	183	108	26	1,052	440	1187	684	951	1885	1856	7003				
7	Total No of patients underwent physio -therapy	3861	3239	5370	3720	3988	4161	4236	4848	2175	23,128	3083	5099	6973	5942	4821	4121	30039				
8	No. of Service delivery points at PHC's visited	738	737	610	256	208	219	214	241	81	1,219	107	273	242	239	204	148	1213				
9	Any other work at PHC/CHC visited	82	192	177	93	98	90	68	41	24	414	54	55	75	66	71	75	396				

3.4.3. Performance Report DISPEL of TENALI/ Gretnaltes 2001 - 2009

		Guntur										Khammam										Rangareddy			
S.N	**Particulars**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009 June**	**Total**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Total**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009 June**	**Total**
1	Total No. of patients evaluation on self care	2914	3087	3262	3338	3662	3726	3538	3153	2451	29,131	2871	3677	3257	3933	2683	2600	19,021	1964	2434	2891	2448	2882	2716	15,335
2	Total Ulcer patients given dressing	2237	2206	3186	2182	2233	2145	1920	1717	1362	19,188	1570	1860	1671	2081	1519	1615	10,316	1191	1609	1802	1825	1307	1511	9,245
3	Total Ulcer patients provided Self care kits	2237	2206	3186	2182	2233	2145	1920	1717	1362	19,188	1570	1860	1671	2081	1519	1615	10,316	1191	1601	1802	1825	1767	1511	9,697
4	Total Patients provided MCR Chapels	1908	2016	2115	2168	2148	2023	1869	1742	1253	17,242	1179	1683	1925	2233	1345	1570	9,935	1370	1645	1731	1852	1745	1643	9,986
5	Total No. of patients underwent surgical corrections	93	132	71	72	29	9	17	25	66	514	64	95	24	12	9	19	223	27	46	3	6	8	39	129
6	Total No. of patients admitted in hospitals	238	348	325	368	350	268	245	257	223	2,622	110	136	133	204	132	98	813	87	42	27	41	38	39	274
7	Total No of patients underwent physio - therapy	2718	2045	2179	2821	3008	2895	2568	2162	1684	22,080	2207	2566	2708	2741	1856	1857	13,935	1862	2270	2765	2459	2035	2036	13,427

3.4.4. Evaluation of DISPEL / Planning of the Project POID AP

The DISPEL Program was evaluated in July of 2009 by a team of a Leprologist Dr. Krishnan from GLRA & a Social Scientist Dr. Thomas from Karigiri. The Evaluators took a Total of 14 days to complete the evaluation and went in the field conducting Group surveys, interviews, focused Group Discussions of DISPEL beneficiaries as well as PHC staff.

The Evaluation team of DISPEL project, while appreciating the successes of Project, recommended continuation of DISPEL at least for 2 years during which PHC staff can be trained to render DISPEL services.

However during the meanwhile FAIRMED sent their Technical Co-ordinator for India to Nepal to study some best practices Model at Lalgadh Leprosy Hospital & it was thought that a strategy shift from the present service delivery model to a prevention model that is grounded in community and patient empowerment to be initiated. To continue the POID services as a sustainable, comprehensive and holistic option, it was suggested that FAIRMED should initiate on a pilot basis an integrated POID services in the Primary Health Care system in East Godavari through the two partner NGOs of Fairmed, namely, RISDT, Kathipudi and Gretnaltes, Tenali.

The aim of the POID services is *"To assure and maintain improvement in physical and social well being of PALs*"

FAIRMED conducted a professional workshop to deliberate on the plan of action was developed for the project at Hyderabad in January 2010, involving FAIRMED officials from Bern & India, Government officials from Andhra Pradesh (namely SLO & DLO's), the NGO partners RISDT and Gretnaltes and representatives of the PALs played an active part in the deliberation. The project was planned to serve as a model project for possible further enlargements (scale-up) if found feasible during the process. Thus, the project development will be closely monitored and evaluated.

4. Logical Framework of the Project POD AP

4.1. Overall Goal

"The physical and social wellbeing of persons affected by Leprosy (PALs) is improved"

To achieve this overall goal of the project within the project area, the following project purpose has been defined during the planning workshop:

4.2. Project Purpose (Project Goal) and Indicators

"The prevention of disabilities and impairment is assured in 2 districts of Andhra Pradesh"

The following **Indicators** will be used to measure the progress:

- Disability grade 0 cases among the new cases remain on grade 0[1]
- Disability grade 1 cases among the new cases remain on grade 1 level or improve towards grade 0

[1] The disability grading refers to the WHO standard: 0 = no visible deformity and no sensory loss; 1 = no visible deformity but sensory loss in hands and/or feet; 2 = visible deformity

- The number of disability grade 2 cases among the new cases is reduced (proportion)
- The ulcer development among "old cases"[2] is reduced sustainably (proportion)

4.3. Project Objectives (Results)

The Project Purpose shall be achieved by the implementation of the following objectives:

1. The Primary Health Care System in Prevention of Impairment and Disabilities (POID) is assured
2. Self Care to prevent Disabilities and Impairments is reinforced
3. Access is provided to POID Services for immobile and needy Persons
4. The Community Participation in POID is improved
5. The development of the project is assured and is continuously monitored and evaluated

4.4. Project Measures (Activities)

Result 1: The Primary Health Care System in Prevention of Impairment and Disabilities (POID) assured

1.1: Nominate a POID (leprosy) responsible for each PHC (DLO)5
1.2: Train the POID responsible of each PHC (NGOs)
1.3: Motivate the POID responsible (DLO)
1.4: Train the supervisors of the POID responsible (NGOs)
1.5: Supervise all POID responsible NGOs) in case management and monitoring (DLO + NGOs)
1.6: Reinforce the capacities of two NGOs in counseling, self care training, and hand holding (FAIRMED)
1.7: Ensure the provision of materials like MRC, splints, others (NGOs + DLO)
1.8: Provide or adapt existing IEC and IPC materials (NGOs)
1.9 Safeguard monitoring of grade 1 cases on PHC level for HIS purpose (DLO)

Result 2: Self care in POID reinforced

2.1: Provide / adapt guidelines on self care to PHCs, NGOs, PALs (FAIRMED)
2.2: Train teams in counseling self care training (FAIRMED)
2.3: Two teams give self care training at 110 training points (NGOs)
2.4: Assist in the formation of Self Care Groups at 110 training points (NGOs)
2.5: Support the self care groups in assessing economic rehabilitation (NGO + Self Help Groups)
2.6: Create / maintain two referral and training centres (FAIRMED + NGOs)

Result 3: Access provided to POID services for immobile and needy persons

3.1: Assess needs of mobile and needy PALs with cost implication (FAIRMED with consultant)

[2] *old cases" are PALs with already existing disabilities either of grade 1 or grade 2

3.2: Cater case management (FAIRMED with consultant, assisted by NGOs and DLO)

Result 4: Community participation in POID improved

4.1: Involve Handicap Society

4.2: Involve Village Health Committees

4.3: Involve ASHA in case detection and first aid

4.4: Assist the Village Health Committee in identifying supportive actions to PALs (DLO + NGOs)

4.5: Identify a volunteer in the Village Health Committee as multiplier of information (NGOs)

4.6 Use societies of PALs as multiplier of information (NGO)

Result 5: The development of the project is assured and is continuously monitored, supervised and evaluated

5.1 Develop with the ADMHO a system to safeguard monitoring of Grade 1 cases on PHC level for Health Information System purpose (DLO)

5.2 Carry out Situation analysis

5.3 Steering committee meetings (quarterly)

5.4 Perform evaluations (01/2011 and 01/2012 as internal reviews = participatory reviews; 01/2013 as external evaluation)

5.5 Bring HIS in place

5.6 Review the program and the MIS (HIS consultant)

5.7 Monitor the project regularly (Project coordinator by FAIRMED in Hyderabad)

5.7 Implement operational research (find University partner for a “result based funding” project for PALs = feasibility of financial incentives for patients to do better self care and to reduce numbers and severity of foot ulcers)

5. Project Implementation, Development and Monitoring

5.1. Project Strategy and Implementation Approach

The project will continue to provide POID services to the existing 4,500 PALs under the DISPEL program and will additionally extend POID services to the new cases of leprosy which is estimated to be 1,100 per year (as per the new cases identified in 2009). Hypothetically, it is assumed that among these yearly 1,100 new leprosy cases, an estimated 150 cases will develop disability grade 1 (sensory loss of hand and/or feet and/or eyes without visible deformities) and approximately 50 cases will develop disabilities grade 2 (visible deformities and/or neuro-function impairments
The implementation approach will derive its program elements from the four critical aspects of care based on the learning from the innovative approach that has found success at Ladgadh Hospital in Nepal. It will serve as the model on which the current program is envisioned:

- Intensive counseling at a Counseling Department on the premises of the hospital. The PAL will have to reserve and spend a full day here.
- A Community Development Cell offers services beyond the medical care: what is the economic potential and possibilities of the individual PAL
- Integration of every PAL, who is able for that, in a Self Care Group, which will not only provide practical medical training (especially in ulcer prevention) and

assistance, but will also give the positive atmosphere and the feeling of an in-group.

- A Self Care Training Centre is meant for those cases, which need more care and attention as what in a Self Care Group can be achieved.

Strengthen Primary Health Care response to POID among PALs

Taking ahead from the DISPEL project and the learning thereof, the project will continue to work in close collaboration with the Primary Health care system (Result 1) to bring to focus the prevention of impairment and disability and strengthening sustained response at primary health care. In each of these centers, the ADMHO (Leprosy) will identify a focal point person (GOPOID) within the structure of the PHC who will be responsible for POID. The Director of Health, Hyderabad will issue instructions to the District Collector, who in turn will issue orders to the District Medical and Health Officer to take forward the POID activities at the district
The activities leading to result 1 will assure that this person is well qualified, prepared and motivated to provide appropriate services to a person suspected to be affected by leprosy and the supervisory staff to monitor the activities carried out for the prevention of impairment and disability. Only few of such cases are expected per month (60 to 70 cases per month which on a per day basis may work out to be 3 to 5 cases) in each of the roughly 100 PHCs in the two districts.

The centre will provide medical services, counseling and physiotherapy at the referral centers. Appropriate education on self care will be provided during the period of stay. In addition, information will be provided on non-medical aspects especially the importance and possibilities of economic activity and self care groups.
The activities include the training of the GOPOID - especially in counseling and in self care training and to strengthening supervision of his activities. The provision of adequate materials such as MCR (50%), communication material and medical supplies including dressing material through the government system is included. The list of activities shows how the responsibility is shared between the ADMHO (Leprosy), the two NGOs (RISDT and GRETNALTES) and FAIRMED.

Strengthen self care in POID

To achieve Result 2, “Self care in POID”, the heart of the transition, outreach at 110 designated points will be carried out. Whereas in the past the two DISPEL teams rendered services to PALs at these 110 service delivery points, in future two teams each comprising of the identified focal point person within the structure of the PHC /Physiotherapist and NGO outreach counselor (separate driver will be included) will develop self-care competence and self responsibility/empowerment of the affected community. A community volunteer, who will be paid a small honorarium, will facilitate the outreach mobilization and will provide follow up inputs and oversee the PALs on a regular basis at their homes for self care management. The outreach personnel will be supported to develop more and additional competences in counseling and self care training. The outreach teams will emphasize on the formation of Self Care Groups (SCGs). This is not a contradiction to the former approach but its further development.

A group of PALs, whose physical, educational, mental or economic status will not allow them to learn the necessary self care at the 110 self care training points and in SCG will be provided services through the two referral (which are the hospitals maintained by the two mentioned NGOs/Fairmed) and training centers (FAIRMED + NGOs) supported by the Activity 2.6. These centers, will assure that these persons will receive the needed intensive training. These centers will carry out several “sub-activities” that will turn the existing centers into referral and training centres in the spirit of the Lalgadh model.

Increase access to POID among immobile and needy persons

Result 3 “Access provided to POID services for immobile and needy persons” concerns the group of PALs, whose physical, educational, mental or economic status will not allow them to become more independent from the assistance of third parties. As the size of this group and their needs are not known in detail at present, it is planned to undertake a respective survey. On its basis, the NGOs will safeguard that these persons are either transported to the two centres or that they will receive the necessary services by other means.

Enhance community mobilization and empowerment for POID

Result 4 “Community participation in POID improved” is meant to make use of the competences and motivation of the community in order to weave in sustainability of the project. It will to some extent alleviate the burden from the NGOs and their budget. This is also the entry point to a more comprehensive implication of the community in the support and the integration of people affected by disabilities in general (not only leprosy) into the community. As neither of both NGOs have gained much expertise in the field of “Community based rehabilitation” yet, this area will also become an area of training of key staff for the NGOs (training in CBR, e.g. in Nepal). This area still has to be elaborated further among the project partners (FAIRMED, GRETNALTES; RISDT, DLO and SLO).

The existing Government system has an ASHA (Accredited social health activist), a first point of contact at the community and serves as a link between the PHC and the community. The capacity of these workers (around 2000 at each district) will be built to take lead in the establishment of the self care groups along with the community volunteer. They will motivate and oversee the self care management of the PALs in the community on a day to day basis and also support in linking PALs for local economic assistance through local self governance systems. The support of the Village Health and Sanitation Committee, the local village unit for overseeing community health concerns will be ascertained to provide greater visibility and positioning of the concerns of the PALs.

To engage the community more proactively and responsively, the following activities will be carried out:

- Responding to non-health needs of PALs

The Referral Centre will also provide counseling services for POID and also be a point for providing linkages and referrals to socio-development needs of the PALs.

- Assistive aid for POID

All PALs will be provided assistive aids for prevention of POID by the Government and the NGO will support in ensuring that all PALs are covered by the service. Distribution registers will be maintained by the PHC.

- POID through community health services

The ADMHO will organize training programs for all the Asha workers and VHSC and build in a mechanism where POID will be addressed by them. The end evaluation would carry out interviews with these functionaries to learn on the work done by them on POID.

- Capacity building of Primary Health Care functionaries on POID and communities on self care

The Training centre attached to the Referral centre will coordinate and organize training programs for the government functionaries at periodic intervals. Training reports will be documented and collated.

5.2. Project Development and Monitoring

5.2.1. Project Development

To safeguard the monitoring of the project progress, the objective (result) 5 has been attached. The development of the project concerns the management of the project as well as the planning cycles in accordance with the “wheel of Denim” (plan-do-check-act) which describes the continuous monitoring of project data and the response of the “steering committee” and the project coordinator as well as the implementing partners to the registered changes. As the project is defined as “model project”, the lessons learnt will be important beyond the implementation of the project (question of further scale-up later).

This project development and monitoring requires a repeated situation analysis, and a health information system (HIS) that follows the defined indicators on input, output, outcome and later impact level. It requires regular internal reviews of the steering committee as well as internal (participatory) as well as external evaluations.

As the data on the PALs grade 1 is not recorded and maintained by the government system, “Safeguard monitoring of grade 1 cases on PHC level for HIS purpose” (activity 5.1) will be instituted. The two ADMHO (Leprosy) are ready to ensure the necessary. The NGOs will provide the technical support to the PHC to streamline and document the information on Grade 1 cases.

5.2.2. Project Monitoring and Sources of Verification and Responsibilities

Data on Grade 1 available at the Primary Health Centre:

This will be generated and documented at the Primary Health Centre by the ADMHO and GOPOID through their regular clinical service

Knowledge and skills of supervisory health functionaries on POID :

This will be primarily carried out by the NGO and ADMHO. Training sessions will be documented and reports available. At the end of the project, an evaluation will be carried out to assess the knowledge and skills of these functionaries.

Quality of self care among PALs

This will be carried out by the NGOs and the Physiotherapist (Government) at the 110 centres. Registers will be maintained on the self care sessions conducted. At the end evaluation, the self care knowledge and practices will be ascertained. In addition, secondary data available will be reviewed and studied to arrive at the number of POID achieved.

Establishment and activities of the self care committees

This will be an effort of the community that will be supported by both NGO and the PHC. The committees will maintain meeting minutes which will be available with the leader of the self care committee. The functioning and effectiveness of the committee will be reviewed during the yearly evaluation exercises.

Establishment and activities of the referral and learning centre

This will be established by Fairmed and the NGO and would serve as a point for learning. The referral centre will have a 30 bed facility and a training centre for building capacities through trainings.

6. Project Coordination and Partnerships

6.1. Project Coordination

The project will be coordinated through a Project Coordinator, based in Hyderabad. The health information system (HIS) for the indicators of input, output, outcome and impact developed for the project will be accompanied by the same consultant based in Hyderabad in collaboration with experts from the Tata Institute of Social Sciences, Mumbai. The FAIRMED office in Mumbai will provide the overall technical coordination and supervision of the project implementation.

The Project Coordinator will also Co-ordinate activities within the "Project Steering Committee" which comprises of the representatives of the partners and stakeholders and which meets on quarterly bases to review the progress of the project implementation.

6.2. Project Partners, Implementers

Partners and Stakeholders

The major project partners are:

- Fairmed, represented by the coordinator and the Mumbai Office,
- The Andhra Pradesh State and District Leprosy Unit, represented by the State Leprosy Officer/Commissioner Family Welfare
- The NGOs RISDT and TENALI represented by the directors
- The beneficiaries, represented by PAL, Colony Leader

The project will be implemented through these two NGO partners under the DISPEL program of Fairmed, namely, (RISDT and GRETNALTES) in the district of East Godavari and Guntur respectively through active support of the State and district leprosy programs and Consultant and Tata Institute of Social Sciences.

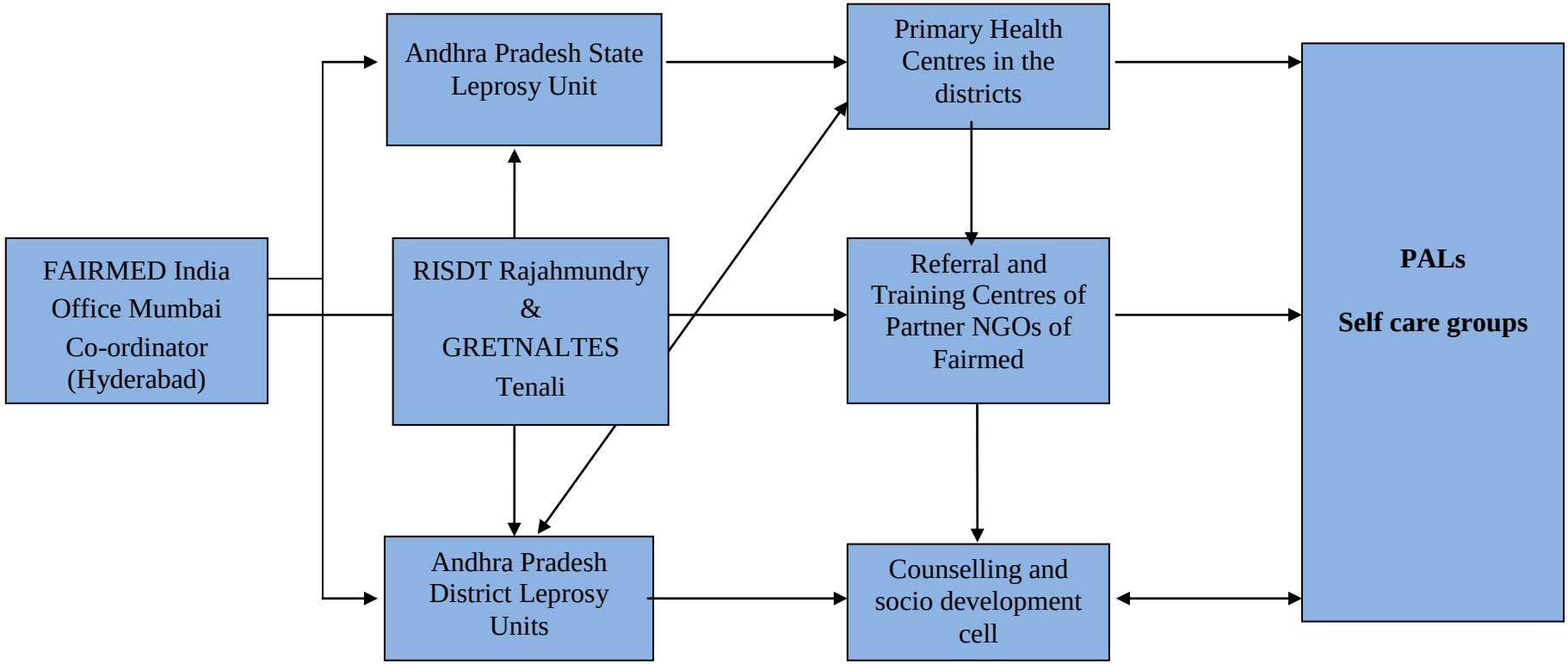
Project Steering Committee

The project will be steered by a committee represented by project officials of Fairmed, Mumbai, State Leprosy official, the Project Coordination for Hyderabad and the two NGOs. Quarterly/two-monthly meeting will be conducted to discuss on the progress made on the project.

The role of the Steering Committee is as follows:

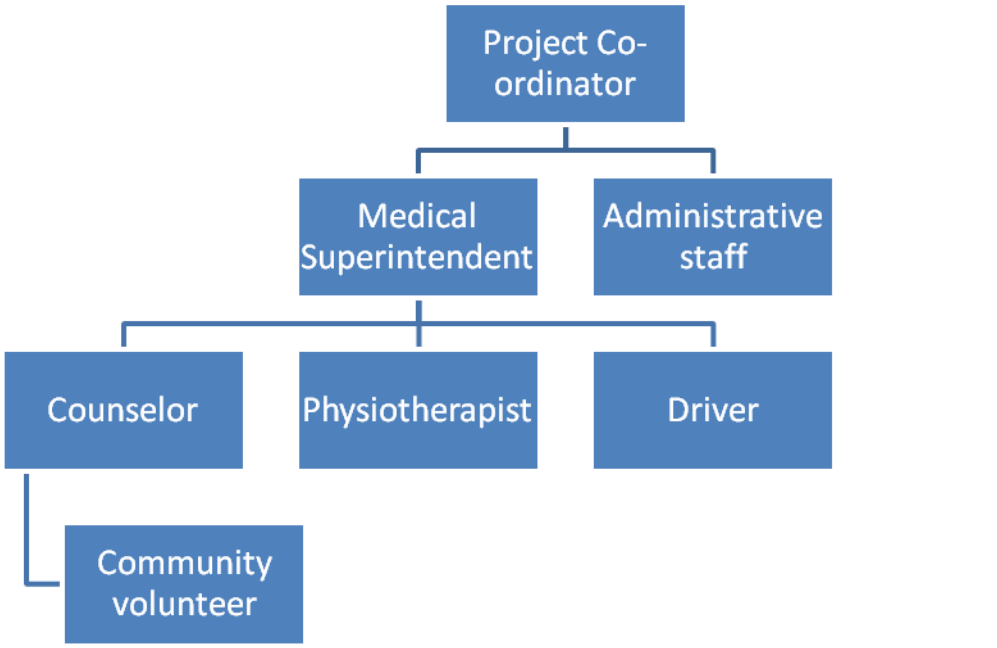
- Ensures project is aligned with organizational strategy.
- Ensures project makes good use of assets.
- Assist with resolving strategic level issues and risks.
- Approve or reject changes to the project with a high impact on timelines and budget.
- Assess project progress and report on project to senior management and higher authorities.
- Provide advice and guidance on business issues facing the Project.
- Use influence and authority to assist the project in achieving its outcomes.
- Review and approve final project deliverables.

6.3. Organigramme of the Project Structure



6.4. Project Staff Organigramme

Staff-Structure of the POD AP project on the level of the NGO partners:

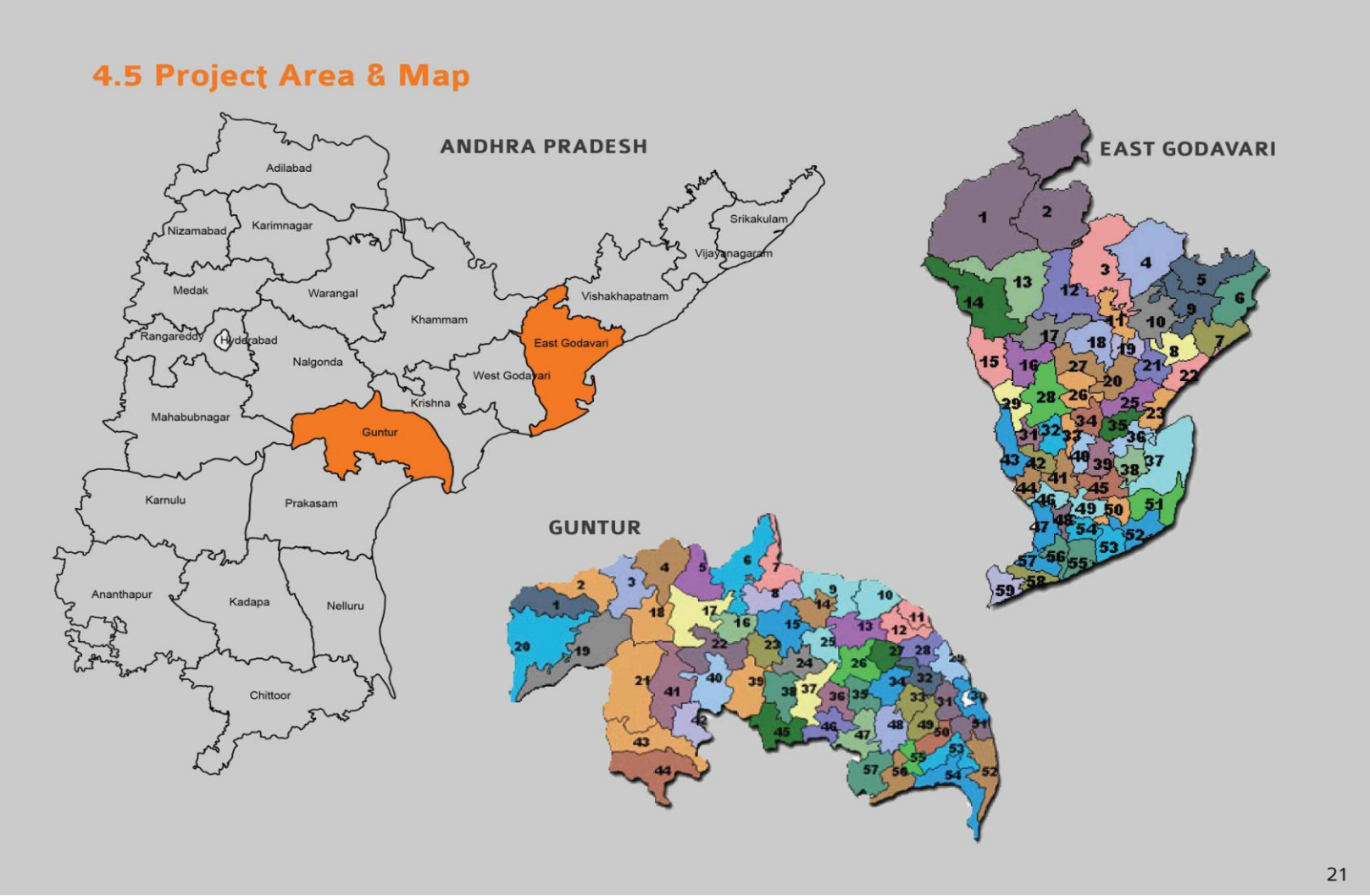


- **Project Co-ordinator:** Responsible for the overall management of the project including administration, financial oversee, reporting and the deliverables of the project (FAIRMED)
- **Medical Superintendent:** Responsible for the clinical and technical aspects of the project especially the referral centre and the outreach planning.
- **Physiotherapist:** The project will have one physiotherapist at the referral centre. Two physiotherapists from the Primary Health Care system will provide outreach services during the outreach camps
- **Counselors:** Three counselors will provide ongoing counseling to the PALs. One of the counselors placed at the referral centre will be responsible for providing counseling on self care management to PALs during the stay at the centre and also support in planning economic options for livelihood. Two other counselors who will serve as outreach counselors will support in building competence on self care among PALs at the outreach camps, building self care groups in coordination with the outreach team and support the community volunteer in community mobilization and empowerment.
- **Community Volunteer:** A person affected by leprosy will be identified at the community level. He will support the outreach team in mobilizing PALs and

overseeing the self care management by the PALs on a day to day basis. He will visit the PALs once a week to motivate and support them in self care. The community volunteer will be provided a token honorarium for the activity.

- **Driver:** To support the outreach team

7. Project Area & Map



8. Logical Framework 2010-2013

Overall Goal: Physical and social well-being of persons affected by leprosy (PALs) improved		
Project Purpose: **Prevention of disabilities and impairment assured in 2 districts**[3]		
Indicators for the project purpose:	1. Grade 0 cases among the new cases remain on grade 0 level. 2. Grade 1 cases among the new cases remain on grade 1 level or improve towards grade 0 3. Number of grade 2 cases among new cases reduced 4. Ulcer development reduced among "old cases" sustainably	
Result 1: The Primary Health Care System in POID is assured		
Activities	**Measures**	**Indicators (Outcome)**
1.1: Nominate a GOPOID (leprosy) responsible for each PHC (ADMHO)[4]	Letter informing the GOPOID to the NGO	GOPOID identified and provided a job description
1.2: Train the GOPOID responsible of each PHC (NGOs)	Pre and post test evaluation of participants	Training conducted and quality of training
1.3: Motivate the POID responsible (ADMHO)	Supervisory visits and review meetings conducted by ADMHO	GOPOID demonstrates service delivery to PALs especially Grade 1
1.4: Train the supervisors of the POID responsible (NGOs)	Pre and post test evaluation of participants	Training conducted and quality of training. Handholding visits conducted by NGO
1.5: Supervise all POID responsible in case management and monitoring (DLO + NGOs)	Supervisory visits and review meetings conducted by ADMHO	Problem solving and technical enhancement sessions conducted on the job
1.6: Reinforce the capacities of two NGOs in counselling, self care training, and hand holding (FAIRMED)	Quality counselling sessions conducted	Counsellors carry out effective counselling and self care sessions

[3] The terms „prevention", „disability" and „impairment" need operational definitions.
[4] Responsibilities marked in brackets

1.7: Ensure the provision of materials like MRC, splints, others (NGOs + DLO)	Distribution of materials	PAL are more effective functionally thus preventing disability
1.8: Provide or adapt existing IEC and IPC materials (NGOs)	Distribution of adapted IEC material	Communities use adapted IEC material
1.9: Safeguard monitoring of grade 1 cases on PHC level for HIS purpose (DLO)	Exit interviews of Grade 1 PALs	No of grade 1 PALs provided education and counselling for POID
Result 2: Self Care in POID is reinforced		
Activities	**Measures**	**Indicators (Outcome)**
2.1: Provide / adapt guidelines on self care to PHCs, NGOs, PALs (FAIRMED)	Manual on self care adapted for Indian contexts	All functionaries of the NGO and health department have access to the manual
2.2: Train teams in counselling and self care training (FAIRMED)	Training programs on self care and counselling provided and applied in clinic and field settings	Functionaries of the NGO and government are informed and knowledgeable on the guidelines for self care and have disseminated it to the community and community groups
2.3: Two teams give self care training at 110 training points (NGOs)	Self care is practiced in the community settings by PALs	Trained community members in place at 110 points
2.4: Assist in the formation of Self Care Groups at 110 training points (NGOs)	Self care groups meet regularly at the community level	Meetings conducted and the content addressed in the meetings
2.5: Support the self care groups in assessing economic rehabilitation (NGO + Self Help Groups)	Community development initiatives carried out by the counsellor address economic and social issues of PALs	Economic problems responded to through the projects
2.6: Create / maintain two referral and training centres (FAIRMED + NGOs)	Referral and training centres established and carry out ongoing capacity building of functionaries	Clinic services and capacity building initiatives carried out by the centre

Result 3: Access provided to POID services for immobile and needy persons		
Activities	**Measures**	**Indicators (Outcome)**
3.1: Asses needs of mobile and needy PALs with cost implication (FAIRMED with consultant)	Baseline and costing study report of the needs of mobile and needy PALs	Completed study on needs of mobile and needy PALs
3.2 Cater case management (FAIRMED with consultant, assisted by NGOs and DLO)	Clinic and outreach services provide case management services both at Government and NGO referral centre	Clinical and community case management services provided
Result 4: Community Participation in POID improved		
Activities	**Measures**	**Indicators (Outcome)**
4.1: Involve Handicap Society	Decisions and actions taken during consultative processes with the organisations working with the disabled	Consultative processes with organisations working with the disabled
4.2: Involve Village Health Committees	Decisions and actions taken at the community level	Consultative processes with VHSC
4.3: Involve ASHA in case detection and first aid	Services provided by ASHA for POID	No of PALs benefiting from the ASHA
4.4: Assist the Village Health Committee in identifying supportive actions to PALs (DLO + NGOs)	Contacts made with VHSC for problem solving	Situations identified and response developed
4.5: Identify a volunteer in the Village Health Committee as multiplier of information (NGOs)	Volunteer advocacy to provide for services to PALs	Services provided by volunteer
4.6 Use societies of PALs as multiplier of information (NGO)	Societies of PALs organised and demonstrate actions for spreading information on POID	Activities conducted by Societies of PALs

Result 5: The Development of the Project is assured and is continuously monitored and evaluated		
Activities	**Measures**	**Indicators (Outcome)**
5.1: Develop a system to monitor Grade 1 cases	Planning process as joint effort with the ADMHO	System available and in use
5.2: Carry out Situation analysis	Employ university/ consultant for the analysis Conduct analysis at the beginning of the project	Analysis available and used for planning
5.3: Conduct Steering Committee meetings	Create a schedule of meetings with protocols to be circulated Conduct meetings quarterly	Steering committee is effectively participating in project development (participatory).
5.4: Perform evaluations	Internal evaluation (reviews) in 01/2011 and 2012; external independent evaluation in 2013	Evaluations conducted, results available, recommendations taken into consideration and project planning changed accordingly
5.5: Bring HIS/MIS in place	Employ university/ consultant to establish the HIS/MIS	HIS/HMS established, introduced at all levels in the project
5.6: Review the programme and the HIS/ MIS	Employ consultant to accompany the HIS/HMS Do continuously supervisions (Fairmed, SLO, NGO cadres)	HIS/ HMS used on regular basis for the steering of the project (data are available for or Steering Committee meetings, for internal and external evaluations) Supervisions conducted (quarterly), reports available for
5.7: Implement operational research	Find university partner for a study on “result based incentives” among PALs Design study, implement study	Study partner available, study implemented, first results circulated before the end of the project

9. Schedule / Timeline

Time frame: The planning horizon for the POID project is from July 2010 to June 2013.

No	Project Activities	2010 (quarters)		2011 (quarters)				2012 (quarters)				2013 (quarters)	
		III	IV	I	II	III	IV	I	II	III	IV	I	II
1	Result 1: Primary Health Care System in POID assured												
2	Result 2: Self care in POID reinforced												
3	Result 3: Access provided to POID services for immobile and needy persons												
4	Result 4: Community participation in POID improved												
5	Result 5: The development of the project assured, continuous monitoring, supervision, evaluation												

10. Budget 2010 - 2013

Result	Objectives	2010	2011	2012	2013	TOTAL 3 years
1	Primary Health Care system in POID assured	690,000	1,385,000	1,165,000	545,000	**3,785,000**
2	Self care in POID reinforced	611,250	1,209,000	1,013,000	509,000	**3,342,250**
3	Access provided to POID services for immobile and needy persons	85,000	170,000	165,000	80,000	**500,000**
4	Community participation in POID improved	275,750	752,000	928,000	491,000	**2,446,750**
5	The development of the project assured, continuous monitoring, supervised	200,000	360,000	210,000	100,000	**870,000**
	Evaluations (01/2011 and 01/2012 participatory reviews, 01/2013 external)		352,000	352,000	1,056,000	**1,760,000**
	Subtotal without Administration FAIRMED	**1,862,000**	**4,228,000**	**3,833,000**	**2,781,000**	**12,704,000**
	Project Administration FAIRMED (10%)	186,200	422,800	383,300	278,100	**1,270,400**
	Total *in INR*	**2,048,200**	**4,650,800**	**4,216,300**	**3,059,100**	**13,974,400**
	TOTAL IN CHF (INR 44 = 1 CHF)	***46,550***	***105,700***	***95,825***	***69,525***	***317,600***