ANNUAL REPORT - 2006

NLR Projects in India

An Overview

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INDIA

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LIST OF ABBREVIATIONS

ANCDR	Annual Case Detection Rate
ANM	Auxiliary Nurse Midwife
AWW	Angan-Wadi Worker
CMO	Chief Medical Officer (CMO & CS are same designation for the chief of
CLD	Central Leprosy Division
DANIDA	Danish International Development Agency
DDG (L)	Deputy Director General (Leprosy)
DLS	District Leprosy Societies
DLO	District Leprosy Officer
DLA	District Leprosy Advisor
DN	District Nucleus
DPMR	Disability Prevention & Medical Rehabilitation
DTST	District Technical Support Team
GHC	General Health Care
GHS	General Health Services
GOI	Government of India
ILEP	International Federation of Anti-Leprosy Associations
IEC	Information, Education, Communication
INR	Indian Rupee
LEC	Leprosy Elimination Campaign
LA	Leprosy Assistants
LFA	Logical Framework Approach
M&E	Monitoring and Evaluation
M.O.	Medical Officer
MB	Multi Bacillary
MDT	Multi Drug Therapy
MOU	Memorandum of Understanding
MPWs	Multi Purpose Workers
MSW	Multipurpose Social Workers
MLEC	Modified Leprosy Elimination Campaign
NCDR	New Case Detection Rate
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
UP	Uttar Pradesh
UT	Under Treatment
TOR	Terms of Reference
WHO	World Health Organization

EXECUTIVE SUMMARY

Netherlands Leprosy Relief (NLR) is supporting National Leprosy Eradication Programme (NLEP) of India, which started from Bihar in the year 1993. This support was extended to Uttar Pradesh and Uttaranchal (now termed as Uttarakhand) 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. Besides national level support, NLR support is at present mainly in the form of State and District Technical Support Teams (STST & DTSTs). NLR is supporting 63 districts in 6 problem states of India, through 35 DTSTs, and 1 STST (Table 1). The main function of these teams is to strengthen General Health Care (GHC) system for provision of sustainable quality leprosy services.

NLEP of India has already achieved its goal of elimination of leprosy in December 2005. While analyzing epidemiological trends under NLEP, the Prevalence Rate has been declining steadily while the new case detection has been either constant or fluctuating till 2002. From 2002 onwards the PR and NCDR are constantly declining. (refer figure 1 chapter 2.1) Reason could be: WHO and GOI discouraged active case detection. Integration started and case detection was mainly passive: through voluntary reporting. GOI is focusing more on controlling operational factors like wrong diagnosis, re-registrations and deletion of extra registered and cured leprosy patients from the registers. With these efforts National average of PR has gone down to 0.83 by December 2006. ILEP raised voice against the 'extra efforts' made to reduce prevalence and achieve elimination at sub national level. This led to reduction in emphasis on PR. In the year 2006, a total of 110157 cases were detected between April and December 2006 with MB proportion of around 44%, female 34% and disability Grade II around 2.06%.

From the chapter 3, it can be seen that most of the activities, which were planned and budgeted, were implemented. Major activities, which need mention, are completion of training of District Nucleus of all the districts of Bihar, Delhi, Uttar Pradesh Uttarakhand & West Bengal. Though budgeted, Jharkhand state could not even start the training of District Nucleus, as the District Nuclei are still not formed. All the states could complete training of newly recruited doctors. Symposium for dermatologists and physician of district hospitals could take place only for UP state. A workshop on Disability Prevention and Medical Rehabilitation (DPMR) was held at the national level and DPMR operational guidelines are under preparation. A workshop on Nerve Function Impairment Assessment was held under the leadership of Dr. Wim van Brakel at Delhi. Reconstructive surgery facilities were established in Ranchi Medical College of Jharkhand. ILEP India together prepared learning material for District Nucleus/Medical Officers and for Para Medical Workers. Extra copies of WHO Operational guidelines were printed by ILEP India and distributed to all the districts of the country. Independent evaluations of DTST projects of problem states were conducted during the year. All the evaluations confirmed the contributions made by DTST in strengthening integrated leprosy services. They highlighted the need for strengthening of services for management of complications, POD & drug supply management.

With the above achievements made in the project, there were some problems encountered during the year. Different states have different combinations of ILEP agencies and there is no mechanism whereby joint discussions are held within ILEP partners and with the state authorities, to come to a consensus and develop a common action plan. Some of the ILEP agencies have expanded their functioning to support TB and other national programmes through the same workforce or minimal extra resources. This will lead to diversion of focus away from leprosy. There is a tendency of dependence on DTSTs and high expectations from ILEP. There are adhoc requests from GOI and State Govts. & Some times ad-hoc activities are organized as per the circulars of GOI, which leads to disruption in our planned activities.

NLR, in general, has maintained its quality in India in the year 2006. NLR DTSTs have played a major role in strengthening integrated leprosy services, which is acknowledged by the States & GOI. NLR is concerned over the need to strengthen POD services, drug supply management, supervision and referral services including absentee follow-up and other problems of urban areas. This will be taken up under the next project. The following report is prepared by taking into account annual reports prepared and submitted by individual NLR teams and annual report submitted by State Coordinators. The report highlights the functioning of NLR in India during the year 2006 and is submitted for reading by the NLR Head Quarter at Amsterdam only.

1. INTRODUCTION

1.1 Background information about India

"Those who wear cotton clothes, use the decimal system, enjoy the taste of (curried) chicken, play chess, or roll dice, and seek peace of mind or tranquility through meditation are indebted to India" writes historian Stanley Wolpert (cited in Country-data, 2004). India is one of the countries in South Eastern region of Asian sub-continent. Spread over 3.3 million sq km. Comprised of 28 states, 1 National Capital territory of Delhi and 6 union territories covering 522 districts. These districts are subdivided into tehsils or taluks, townships that contain from 200 to 600 villages.

Economy transformed from primarily agriculture, forestry, fishing, and textile manufacturing in 1947 to major heavy industry, transportation, and telecommunications industries by late 1970s. Central Government is giving way to economic reforms and more private sector initiatives since 1980s and 1990s. Gross Domestic Product (GDP) of nearly US$ 1.2 trillion in 1994 rose to 7.8 trillion by 2005 (country data, 2005) and Gross National Income per capita rose from 450 dollars in 2000 to 720 dollars in the year 2005 but 28.6 percent of the population is still living below poverty line.

As per data of 2004, 61 percent of adult population is literate.

Accommodating 16 per cent of the world's population, India is the most populous country in the world after China, inhabiting around 1.1 billion persons by the year 2005. 28 percent of this population is urbanized having high population density with national average of 284 persons per square km., it has more than 700 persons per sq. km in major states.

1.2 About the Health infrastructure & NLEP of India

The Health infrastructure at the peripheral level starts with a sub-center covering a population of 5,000 – 10,000 and is manned by Multi Purpose Worker (MPW) Male or Female. Above this center there are Additional Primary Health Centers (APHC) covering a population of 25,000 – 30,000. This center is manned by a Medical Officer (MO) and other staff. Above this APHC there are (Block) Primary Health Centers (PHC), which are catering to a population of around 100,000. These centers are manned by a Medical Officer & other staff with facilities for hospitalization and emergency services. In some of the states, few PHCs are upgraded as Community Health Centers (CHC), where the facilities for specialized services are also available. Above these Health Centers, there is at least one district hospital in all the districts of the country. All this structure is under the control of Chief Medical Officer (CMO) and Directorate of Health Services (DHS) of the State.

For control of leprosy, National Leprosy Control Program (NLCP) was launched in the year 1955, which was changed to National Leprosy Eradication Program (NLEP) in the year 1983 with the introduction of Multi Drug Therapy (MDT). World Bank (WB) supported NLEP from 1993 to 2004. DANIDA supported the program in few states from 1986 – 2003. ILEP has been supporting the program since the beginning of the control program. Other partners like WHO, NIPPON Foundation and other local NGOs are also supporting the program.

1.3 About NLR India

Netherlands Leprosy Relief (NLR) 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 State & District Technical Support Team (STST and 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 13 years ago i.e. in 1993. This support was extended to Uttar Pradesh and Uttaranchal (now termed as Uttarakhand) 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. (Maps depicting

NLR supported districts of six states are placed at annexes) NLR established its branch office, in India, at Delhi, in the year 2000.

At present NLR is supporting 63 districts in 6 states of India through 35 DTSTs and 1 STST as given in the table below.

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)

1.4 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. 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	-	-	-	-	7*	8	-	-	**18**	**22**	**NLR**
4.	**Uttarakhand**	-	-	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

* Against the commitment under MOU, 1 team less was provided by DFIT
**There is one State level Technical Support Team (STST) provided by NLR at Dehradun, Uttarakhand state

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. This report gives an overview of functioning of NLR in India.

1.5 Problems and Delays

During the year 2006 also, all efforts were made by GOI & State Govts. 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 & confirm them before registration, update the registers and follow Accompanied MDT. All measures to achieve elimination at sub national level. Our DTSTs were also pressurized to be involved in confirmation / validation of cases, deletion of wrongly diagnosed cases, defaulters, over treated or cured cases but not removed from the registers. ILEP raised the voice against these practices, which slowed this momentum. Other problems which affected DTST's functioning are :

1. There is lack of uniformity in NLEP activities in districts of different state except in UP, Uttarakhand and to some extent in Bihar, because different ILEP partners are working with their own mandates and priorities. There is no mechanism whereby joint discussions are held with state authorities, consensus is reached and a common action plan is prepared. Efforts were made in UP, Bihar and Uttarakhand but the process is still not well established. It is expected that from the next project, more uniformity will be seen.

2. Some of the ILEP agencies have expanded their functioning to support TB and other national programmes through the same workforce or minimal extra resources, which led to decrease in focus on leprosy and also discontentment at the level of GOI and all ILEP members were criticized for using DTSTs for other programmes. The matter was resolved by preparing list of staff engaged for TB & Leprosy, which was submitted to GOI but the deviation of focus is observed in the teams.

3. Since the activities are dependent on the government machinery, there were some problems and delays in organizing them. These are due to either non-availability of officials, non-finalization of dates, lack of motivation for lack of incentives as provided in other programs, and other priorities of the state like pulse polio, transfers, ensuing elections, strikes of GHC staff etc.

4. There are funds allocated by Central Government for the activities as per Govt. of India "Project Implementation Plan" (PIP) for 2005-07. GOI puts special emphasis on utilizing this budget but the activities are sometimes not conducted because of delays or non-approval of funds by District Leprosy Societies. ILEP agencies are expected to support those activities because of the ease at which ILEP agencies can approve funds. Through discussion with State Govts., district authorities and pressure from GOI, some funds from District Leprosy Societies were utilized

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. They were minimum this year due to the explanation given in point 4 above.

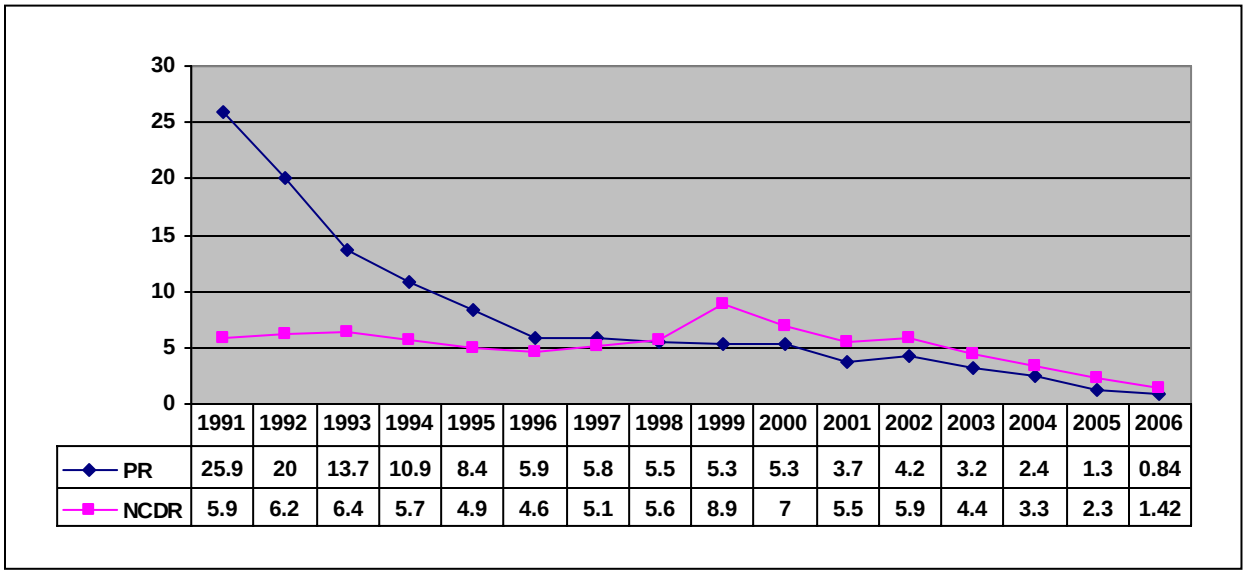
6. Because of technical expertise and uninterrupted mobility of the teams, there is dependence on DTSTs for almost every activity. On the other hand enthusiastic DTSTs have tendency to implement rather than facilitate the activities, sometimes also due to lack of GHC staff. Discussions are held repeatedly with district, State authorities and DTSTs, so that dependency on the DTSTs is reduced. With WHO & GOI insistence on sustainability, GHC staff is realizing the need and gradually taking over the responsibilities

2. EPIDEMIOLOGICAL DEVELOPMENTS

2.1 India

After achieving elimination at the National level by December 2005, efforts were continued by Govt. of India & the State to control the so called 'operational factors' and the PR has reached to 0.84 per ten thousand population, at national level, by the end of March 2006.

Figure 1 Trend 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	2006
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	0.84
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	1.42

(Source: NLEP, GOI 2006)

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. Extra efforts were made not to register old cases and delete long 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 but was ignored. 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 NCDR & PR, well before the natural decline.

2.2 NLR Supported States

NLR is supporting six of the problem states of India namely UP, Bihar, West Bengal, Jharkhand, Delhi and Uttarakhand by provision of State & District Technical Support Teams. A brief account of epidemiological status, of leprosy in these states, is given in the table below:

Table 3 Essential Indicators used in NLEP for the NLR supported States

S. N.	State/UT	Cases on Record as on Dec. 2006	Prev. Rate/ 10000	New Cases Detected from Apr. - Dec. 2006			Proportion among new cases			
				PB	MB	Total	MB	Female	Child	Gr.2
1	Jharkhand	4564	1.51	3077	2932	6009	48.79	38.24	12.40	2.70
2	Bihar	12649	1.33	11137	6043	17180	35.17	36.16	15.49	2.16
3	Delhi	2877	1.73	999	1385	2384	58.09	17.86	4.73	4.61
4	Uttarakhand	716	0.77	332	278	610	45.57	29.18	5.57	1.14
5	U.P.	21715	1.15	16073	10058	26131	38.49	30.69	6.08	1.01
6	West Bengal	10425	1.19	5555	5420	10975	49.38	35.26	10.25	2.97
Total (6 states)		**52946**	**1.28**	**37173**	**26116**	**63289**	**45.91**	**31.23**	**9.08**	**2.43**
India (all states)		**94459**	**0.83**	**61606**	**48551**	**110157**	**44.07**	**34.28**	**10.37**	**2.06**

(Source: Central Leprosy Division, GOI Dec 2006)

Data from six states have been taken to give an idea of epidemiological status of NLR supported projects. These data are generated from the monthly progress reports from CLD. It is to be notified here that the reporting year in India is taken from 1st April to 31st March of the coming year. As can be seen from the above table, National average of PR has gone down to 0.83 by December 2006. Since the data for case detection from January to March 06 are not available separately, it is reported that a total of 110157 cases were detected between April to December 2006 with MB proportion of 44%, female 34% and disability Grade II around 2.06%. We have compared the national average with the data provided by the state supported by NLR. It can be seen from the table above that around 57% of the total new cases detected in India, (during nine months period) are contributed by the states supported by NLR. It can also be seen from the table that UP & Bihar, being larger and most populous states are still contributing the highest number of cases followed by West Bengal and other states. Disability Grade II is still high in Delhi and West Bengal. Delhi's high proportion could be attributed to the reporting of late, neglected cases originating from all problem states of India, which have migrated to Delhi (whether temporary or permanent is unknown). High proportion of MB cases with high proportion of Disability Grade II in West Bengal indicates that the cases are not detected early and that there may be more hidden cases.

As a practice and follow up of new WHO operational guidelines, NLR, through its DTSTs, has initiated assessment of completion rates while visiting the PHCs/dispensaries/hospitals. The completion rates are ranging from 40% in Delhi to 92% in Jharkhand. 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.

3. ANALYSIS OF ACTIVITIES

The main focus of activities was to consolidate 'integration' of services at PHC & district level. Last year i.e. 2005, the focus by GOI and State Governments, was towards achieving 'Elimination target' hence DTSTs were also expected to focus on validation of cases and controlling the so called operational factors. During 2006, when the focus was less on elimination, DTSTs focused on quality services through GHC staff and priority was given to nerve function impairment assessment & disability prevention.

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

- Our teams supported state and district authorities in planning of activities at state & district level.
- Our teams supported GHC system in implementing leprosy control activities effectively, 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
- Our teams provided trainings by participating in formal courses as facilitator and also on the job by visiting health centers. 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 interactions with GHC staff and case validation, NLR teams were able to assess training needs and imparted trainings accordingly, which led to improvement in quality of services. On an average, wrong diagnosis is at the level of 3 – 7 percent, wrong classification between 1 – 4 percent.
- Our teams supported GHC staff, in implementation of Simple Information System (SIS) introduced by Government of India. Our teams also participated in GOI directed 'Intensive supervision' in the month of September 2006, 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 general support provided by the teams, some activities were planned and budgeted from NLR source for the year 2006, as follows:

3.1 Analysis of approved activities, Branch Office – 2006

Table 4 Analysis of activities, Branch Office – 2006

ILEP No.	Description of activities	Result	Analysis/comments
1.3	**Gen. Equipments**		
1.3.1	Replacement of Photocopier	New photocopier Purchased	This photocopier has facilities for printing and copying and is connected to all the computer terminals. It has many other useful features.
2.2	**Salary and staff Benefits**		
	Salary Share of Dr. S. B Taranekar	Share of Dr. Taranekar's salary contributed	Dr. Taranekar's salary was shared for 3 Months only. He resigned subsequently
2.5	**Training**		
2.5.1	Meetings & Conferences (sharing with ILEP agencies)		
	Training in Nerve Function impairment Assessment (NFA) for Senior dermatologists	Organized at Delhi in Oct 2006	Dr Wim Brakel was the resource person in designing & conducting the workshop. About 22 senior & Junior dermatologists participated. It was well appreciated. Dermatologists trained in this workshop will train other trainees
	Training of District Nuclei of Delhi	Done	Organized by TLM being coordinating agency. NLR Delhi teams participated as resource persons & shared the cost
	Training of District Nuclei of North East States & Mizoram	Done	Organized by TLM being the coordinating agency & expenditure of these trainings were shared by NLR
	DPMR Workshop/ Meeting at Delhi	Done	Organized by GOI, Expenditure done by ILEP, shared by NLR
2.5.2	Joint review meetings of NLR DTSTs.	2 Meetings of DTSTs were conducted, one at Dehradun and other at Bodhgaya.	Besides review of activities of DTSTs, Topics on Supervision & Counseling (by role play) were discussed at Dehradun. Introduction to Logical Framework Approach was given, WHO operational guidelines were discussed in detail at Gaya. Presentation skills were also strengthened.
4.3	**Special budget**		
	Support to Operational Research (Issue of Leprosy in Women)	Could not be done	Proposal could not be developed due to disappearance of Dr. Anjali of Jamia university
4.5	**Teaching materials**		
4.5.1	Sharing with ILEP for Learning Material (Booklets for District Nucleus, WHO Operational Guidelines)	Printing done through ILEP coordinator	NLR India contributed in developing the booklets technically and shared the cost of printing
4.5.2	Printing of Booklets for Capacity Building of DN Staff,	Done	Additional booklets for DN printed through branch office. These were provided to all the PHC MOs of NLR supported districts
4.5.3	Training & learning Material for Jharkhand state	Done	Folders on Lepra Reaction, Patient Counseling, POD and general IEC were developed by branch office
4.5.4	Folder for Para Medical Workers (GHC)	Done	Printing done by ILEP coordinator, NLR shared the cost. Technical contribution was provided by NLR in its development.

3.2 Analysis of approved activities, Trust Office – 2006

Table 5 Analysis of activities, Trust Office – 2006

ILEP No.	Description of activities	Result	Analysis/comments
1.3	**Gen. Equipments**		
1.3.1	Laptop (One IBM Think Pad for Uttarakhand Coordinator)	Not purchased this year	As per approval from Mr. J. W. Dogger, the laptop was purchased in November 2005
2.5	**Training**		
2.5.1	Review Meeting of Uttarakhand Teams	Done	The STST & DTSTs visited Delhi NLR office for review
2.5.2	Board & Trust Meeting	Done	Trustees met to discuss the course of action for making major expenditures from the trust office account
4.5	**Teaching materials**		
4.5.1	Training Slides (5 Sets x Rs. 2000)	Not done	It was discussed that after preparation of the slides, they will not be used for lack of slide projectors in districts and states
4.5.2	ILEP Learning Material (Rs. 50 x 130 Sets)	Not done	Share for the learning material was paid through Branch office account
4.5.3	POD Booklets (Rs. 21 x 130)	Not purchased	POD booklets and other IEC material to Uttarakhand was provided by TLM

In addition to the above activities, share of Bihar & West Bengal evaluation was sent to DFIT & GLRA respectively from the Trust Account and share of sponsoring Dr. H. Srinivasan was also paid to DFIT through Trust account.

Besides activities, which were carried out directly by the Branch and Trust office, some of the important activities, which were budgeted and supported in the states, are as under. Details could be seen in Separate state reports.

3.3 Activities in Delhi – 2006

- NLR DTSTs supported and shared the expenditure of training of District Nucleus and Leprosy Assistants (LAs) recruited by Delhi Government.
- Capacity building, of nurses, pharmacists, PG students, Medical officers and Para medical staff of various dispensaries & medical colleges, was done by our DTSTs
- NLR DTSTs also conducted awareness and sensitization trainings of civil defense volunteers, Non leprosy NGOs and independent volunteers
- NLR supported in printing & distribution of flash cards. DTSTs participated and supported in performance of street plays, essay competition, celebration of Anti Leprosy Day and Half Marathon on 2nd October, the Mahatama Gandhi's birthday.
- In addition to the above activities, technical support by the DTSTs was provided during POD workshops.
- Joint Quarterly Review Meetings of DLOs & DTSTs facilitated the monitoring of the program in Delhi

3.4 Activities in Bihar – 2006

- DTSTs of Bihar participated in training of trainers of training institutes, newly recruited medical officers, refresher training for District Nucleus, supervisory staff, health educators, trainee nurses & nurses of the medical colleges.
- Training of erstwhile NLEP staff, to refresh their knowledge and emphasis on POD component, was done.

- DTSTs also organized trainings of Angan Wari Workers, Auxiliary Nurse Midwives, and Health Educators.
- DTSTs conducted sensitization meetings with Non Leprosy NGOs and village leaders.
- DTSTs conducted sensitization meetings with school head masters, panchayati raj system, female group NGOs and leaders of marginalized communities.
- DTSTs also supported and participated in POD camps to promote self-care practices.

3.5 Activities in Jharkhand – 2006

- Major achievement in NLR supported project of Jharkhand was establishment and strengthening of Reconstructive surgery in medical college of Ranchi.
- Besides this activity, our teams participated in classroom and on the job training of newly recruited Medical officers, AWWs and ANMs throughout the state.
- Advocacy meetings were conducted with NGOs and private practioners.
- Training of telecommunication staff, mahila mandals, & village leaders was carried out in selected districts.
- In some of the districts, re-orientation of health supervisors was done
- Meetings with AWWs, Mahila Mandal, and marginalized communities were conducted, to sensitize them.
- Exhibition sets were used for display and discussion with the community in markets & crowded places

3.6 Activities in Uttarakhand – 2006

- Training, of remaining two batches of District Nuclei and re-orientation of newly inducted staff of District Nucleus, was conducted.
- STST & DTSTs participated in training of newly recruited medical officers of all the districts.
- A special training of health supervisor was organized at Nainital and Haridwar districts, where after briefing them on the concepts of supervision and how to supervise, they were taken to the field with checklist and the field visits were discussed. This was very successful training and was highly appreciated by the supervisors.
- Patient's education folders, folder on reaction, booklets on self-care and WHO operational guidelines were provided by the Branch Office and were distributed to all the PHCs of the state.

3.7 Activities in Uttar Pradesh – 2006

- Major achievement in the project was completion of training of District Nuclei of all the 70 districts of UP
- Another achievement was organization of Symposium for dermatologists and physicians of district hospitals to establish referral centers in the district hospitals. Besides state authorities, Dr. Myo Thet Htoon from WHO Global Leprosy Program along with C.R. - NLR, also participated.
- DTSTs participated in training of newly recruited doctors and GHC staff of all the districts.
- UP being a very large state, regional review meetings were conducted jointly with DLOS and DTSTs. SLO and WHO coordinators participated. This experiment led to better review and good interaction among participants.

3.8 Activities in West Bengal – 2006

- DTST participated in training of newly recruited Medical Officers and Multipurpose Social Workers
- DTSTs participated in training of GHC staff in providing self-care and POD through camp approach.
- Training of teachers and private practioners was undertaken
- Advocacy meetings in urban health areas were conducted with the help of DTST State coordinator & SLO.

4. OTHER DEVELOPMENTS

4.1 Introduction

With no change in Program Manager of NLEP and good relations with NLR there were no major hiccups in NLR functioning during the year 2006. Attention was paid & priority was given to quality of services, disability prevention & medical rehabilitation. ILEP representatives in India met & discussed on various occasions the future support to NLEP beyond March 2007. Other than this some of the important developments, which took place in our projects are as under:

4.2 Overall Developments

- NLR in India contributed technically in developing learning material for District Nucleus /Medical officers, for MPWs & Para Medical Workers. Its cost on printing and distribution was also shared.
- In agreement with GOI, Evaluation of DTST projects were carried out in the states of – Bihar (Feb 2006), Chattisgarh (Feb 2006), Delhi (Jan 2006), Uttar Pradesh (Mar. 2006), West Bengal (Mar.06), Orrisa (Feb. 06) and Andhra Pradesh (Mar.06). All evaluations endorsed the contribution made by the DTSTs in strengthening integrated leprosy services. Recommendations were in favor of continuation of support with focus on management of complications, POD and drug supply management.
- Medical Advisor NLR, Participated as evaluator in evaluation of DTST project Chhattisgarh from 26th Feb – 3rd March
- GOI organized a workshop to develop DPMR plan with the help of ILEP India. Medical Advisor, NLR participated as resource person in the workshop.
- In continuation to above, another workshop was organized to develop 'operational guidelines for DPMR' by ILEP India. Medical Advisor NLR participated as core group member to develop these guidelines.
- Medical Advisor NLR was invited to participate as resource person and coordinate POD training of trainers, in Punjab State.
- Country Representative participated in an independent evaluation of National TB & Leprosy Control Program of Nigeria.
- Country Representative and District Leprosy Advisor of DTST Delhi participated in 'Logical Frame Work Approach for Planning Workshop' at Hanoi.
- Country Representative participated as core group member to design strategy and plan for the future support to NLEP beyond March 2007.
- Country Representative participated as Expert Committee Member, to evaluate proposals, developed by independent agencies, for evaluation of NLEP of India.
- NLR Branch office contributed in the development of protocol for evaluation of DTSTs of Delhi.
- NLR Branch office explored the possibility of providing rehabilitation services in the States of Uttarakhand and Delhi. Visit to leprosy colonies of Haridwar and Delhi was found to be very positive in the sense that the inhabitants are happy to undergo training in self-care and there is scope of considering provision of other rehabilitative services.
- Dr. H. Srinivasan, the eminent Orthopedic & Leprosy Surgeon was awarded "Pioneer of Hand Surgery" by International Federation of Societies of Surgery for the Hand. To receive this award, ILEP India sponsored the participation of Dr. Srinivasan in 10th International Congress of hand surgery at Sydney, Australia, which will be held in second week of March 2007. NLR shared the cost.

- NLR India organized visits of foreign delegates-
  - Field Visit of Mr. Doug Soutar, General Secretary, ILEP, to observe the activities of DTSTs under urban set up of Delhi
  - A delegation of Govt Officials of Indonesia visited Delhi to study urban leprosy
  - A delegation of Govt Officials of Brazil also visited Delhi to study urban leprosy
  - Mr. J.W. Dogger, Project Coordinator, NLR visited India in the month of June & October 2006
  - Mr. Jan Joseph Stok, Fundraising Department, NLR visited Delhi for photography and interaction with the communities
  - Mr. Henny Heyer, NLR Rehabilitation Advisor from Indonesia visited the Branch office on a short visit to Delhi.
- Participation in review meetings
  - SLO's review meeting in the month of June & August 2006
  - State DTST & WHO Coordinators' meetings organized by GOI in February & Sept 2006
  - ILEP member representatives meetings in January, March, July, September, November 06.
- Dr. Pannikar, from WHO Global Program and Mr. Douglas Soutar, General Secretary, ILEP participated in ILEP India Meeting in September 2006. With the idea from Mr. J. W.Dogger, Country Representative NLR suggested in this meeting that a tripartite agreement should be made between WHO, ILEP & GOI, which was well taken by all present. To take it up further informal discussions were held with Dr. Pannikar on different occasions and a meeting was planned with WHO Regional Director, Dr. Samlee Plianbangchang.

4.3 Developments in Delhi

- Evaluation of DTST project was carried out under the leadership of Dr. Wim van Brakel
- An initiation has been made to refer cases from hospitals to dispensary for follow up treatment so that overload on hospitals can be reduced and it becomes more convenient to patients. Since it is a beginning, the outcome is not enough to be notified
- DTST facilitate the visit of Ms. Wilma van der Maten (Journalist of Dutch National Television and Radio) in Delhi.
- IEC consultant of GOI visited West District for coverage of IEC events, for the making of a documentary film. DTST facilitated the visit.

4.4 Developments in Bihar

- An independent evaluation of DTST project was carried out. NLR shared its expenses.
- Local Panchayat elections were held in the whole state, which affected mobility of DTSTs and its functioning
- More IEC & POD activities were carried out from the society budget, which led to savings in NLR Bihar budget
- A new doctor was recruited in Aurangabad district.

4.5 Developments in Jharkhand

- Dr. A. K. Singh was replaced by a new SLO Dr. S. C. Nayak, who was further replaced by Dr. B. B. Singh on 18.12.06
- Support activities, which were derailed, were resumed in February 2006 and rapidly regained its momentum. New State DTST Coordinator was posted by NLR

- Since the project in Jharkhand started again, New Medical Officers were appointed in District Technical Support Teams of Garhwa, Giridih, Bokaro, Chatra and Pakur district.
- Despite the commitment under MOU, DFIT did not provide 8 teams. Being the coordinating agency of the state, NLR posted a team at Pakur district to fulfill ILEP commitment.
- Two Joint review meetings of DLOs & DTSTs were held. DDG(L), WHO National Program Officer, WHO National Consultant participated in the meetings. These meetings were funded by NLR

4.6 Developments in Uttarakhand

- New Principal Secretary, Medical & Health Mr. S. Raju joined in the year 2006
- New State Leprosy Officer (SLO), Dr. Mrs. Sushma Dutta jointed in August 2006.
- Dr. Mishra, DLA Nainital team was transferred to join Delhi DTST team
- Many of ex-NLEP workers were transferred to UP. In spite of new recruitment, there is shortage of GHC staff in most of the districts.
- 70 – 80% of the trained staff of District Nucleus either transferred or retired. This has affected the NLEP – functioning badly.
- Dr. H. C. Pandey, DLA of Haridwar DTST participated as resource person in POD training of DLOs of Punjab State at Chandigarh.

4.7 Developments in Uttar Pradesh

- An independent evaluation of DTST UP Project was carried out in March 06, NLR shared its expenditure.
- New SLO took over the charge in March 06.
- About 10 MOs of DTSTs left the project to join WHO Polio project or State Govt. permanent jobs. New doctors were recruited but they were of least experience in leprosy.

4.8 Developments in West Bengal

- An independent evaluation of DTST was carried out in March 06, NLR shared its expenditure.
- Post of DLA in Burdwan district remained vacant after the resignation of Medical Officer, DTST. DLA of East Midnapur district is looking after Burdwan district also.
- More attention was paid to urban areas of Burdwan and West Midnapur districts.
- More emphasis was given to POD activities.

5. FINANCE

In following tables, an overall view of expenditures in India followed by detail expenditures made through Branch & the Trust office is provided. Detail of expenditure in the states and their explanation could be seen in individual annual reports.

5.1 Expenditure Statement of NLR India - 2006

Table 6 NLR India Budget Allocation & Expenditure – 2006

S.No.	State	Allocated Amount INR	Expenditure INR	Exp In %
1.	Branch Office	6,965,783.00	6,425,583.31	92%
2.	Trust office	874,408.00	605,276.00	69%
3.	Bihar	3,291,434.00	2,583,122.00	78%
4.	Delhi	2,023,722.00	1,438,753.00	71%
5.	Jharkhand	8,314,267.00	5,701,002.00	69%
6.	Uttar Pradesh	11,471,200.00	10,691,928.00	93%
7.	Uttarakhand	2,795,470.00	2,568,999	92%
8.	West Bengal	2,433,346.00	2,088,192.35	86%
TOTAL (INDIA) in INR **In Euro**		**38,169,630.00** **€ 655,900**	**32,102,855.66** **€ 551,649**	**84%**

Conversion in Euro as on 31.12.2006, www.oanda.com

5.2 Expenditure Statement of Branch Office - 2006

Table 7 Expenditure statement, of Branch office, for the year 2006

		Total Expenditure in the Year (INR)	Total Budget for the Year (INR)	Savings / (Over) Expenditure (INR)	Expen-diture in %
I. INVESTMENTS					
1.1	Buildings / Land	-	-	-	
1.2	Medical Equipment	-	-	-	
1.3	General Equipment	120,000.00	120,000.00	-	
1.4	Vehicles	-	-	-	
1.5	Rehabilitation of equipment	-	-	-	
1.6	Miscellaneous	-	-	-	
	TOTAL INVESTMENTS	120,000.00	120,000	-	100%
II. SALARY, STAFF AND TRAINING					
2.1	Medical Doctors	756,756.00	756,756.00	-	
2.2	Other Medical Staff	373,200.00	385,200.00	12,000.00	
2.3	Administrative Staff	653,549.00	658,264.00	4,715.00	
2.4	Staff Benefits	2,084,594.00	2,342,127.00	257,533.00	
2.5	Training	128,582.00	97,000.00	(31,582.00)	
2.6	Miscellaneous staff exp.	-	-	-	
	TOTAL SALARIES & TRAINING:	3,996,681.00	4,239,347.00	242,666.00	94%
III. MAINTENANCE					
3.1	Repairs and Utilities	487,062.00	512,086.00	25,024.00	
3.2	Anti-Leprosy drugs	-	-	-	
3.3	Other Drugs	-	-	-	
3.4	Vehicle Maintenance/ travel & Transport	984,285.00	1,253,000.00	268,715.00	
3.5	General supplies	-	-	-	
3.6	Miscellaneous	-	-	-	
	TOTAL MAINTENANCE	1,471,347.00	1,765,086.00	293,739.00	83%
IV. ADMINISTRATION					
4.1	Office Expenses	281,959.68	266,600.00	(15,359.68)	
4.2	Public relations	76,203.63	72,000.00	(4,203.63)	
4.3	Special budget	64,328.00	50,000.00	(14,328.00)	
4.4	Health education activities	-	-	-	
4.5	Teaching materials	291,285.00	427,750.00	136,465.00	
4.6	Miscellaneous	123,779.00	25,000.00	(98,779.00)	
	TOTAL ADMINISTRATION:	837,555.31	841,350.00	3,794.69	100%
	TOTAL EXPENDITURE	**6,425,583.31**	**6,965,783.00**	**540,199.69**	**92%**
	In Euro	**€ 110,416**	**€ 119,699**	**€ 9,282.69**	

(Conversion in Euro as on 31.12.06, www.oanda.com)

Brief explanation on the utilization of Branch office budget is given as under:

2.5, Training: Over expenditure is seen due to sharing of expenditure for training of District Nucleus in North Eastern States of India & Delhi. Also Nerve Function Impairment Assessment workshop was organized under the leadership of Dr. Wim Van Brakel, for which an approval was granted from Amsterdam.

4.3, Special Budget: Over Expenditure is due to expenditure made by NLR for evaluation of DTSTs of Delhi. As per the initiative from NLR, the evaluation of Delhi was conducted under the leadership of Dr. Wim Van Brakel in which the entire expenditure was borne by NLR. Share from TLM and GLRA was received but DFIT refused to share.

4.5, Teaching Material: Additional budget was requested & allocated from Amsterdam for sharing the cost of booklets for PMWs & District Nucleus but the share paid to TLM was less than budgeted.

4.6, Miscellaneous: Over expenditure is seen due to the expenditure made for travel of Dr. M. A. Arif and Dr. Vipin Kr. Mishra to Vietnam (LFA workshop), which was booked under this head as per the guidelines issued by Mr. Ted Willemse vide his e-mail dated 13th September 2006.

5.3 Expenditure Statement of Trust Office - 2006

Table 8 Expenditure statement, of Trust Office, for the year 2006

		Total Expenditure in the Year (INR)	Total Budget for the Year (INR)	Savings / (Over) Expenditure (INR)	Expen-diture in %
I. INVESTMENTS					
1.1	Buildings / Land	-	-	-	
1.2	Medical Equipment	-	-	-	
1.3	General Equipment	-	90,000.00	-	
1.4	Vehicles	-	-	-	
1.5	Rehabilitation of equipment	-	-	-	
1.6	Miscellaneous	-	-	-	
	TOTAL INVESTMENTS	-	90,000	90,000	0%
II. SALARY, STAFF AND TRAINING					
2.1	Medical Doctors	-	-	-	
2.2	Other Medical Staff	-	-	-	
2.3	Administrative Staff	199,928.00	199,728.00	(200.00)	
2.4	Staff Benefits	38,765	37,350.00	(1,415.00)	
2.5	Training	32,729.00	7,000.00	(25,729.00)	
2.6	Miscellaneous staff exp.	-	-	-	
	TOTAL SALARIES & TRAINING:	271,422.00	244,078.00	(27,344.00)	111%
III. MAINTENANCE					
3.1	Repairs and Utilities	219,264.00	241,400.00	22,136.00	
3.2	Anti-Leprosy drugs	-	-	-	
3.3	Other Drugs	-	-	-	
3.4	Vehicle Maintenance/ travel & Transport	67,437.00	200,000.00	132,563.00	
3.5	General supplies	-	-	-	
3.6	Miscellaneous	-	-	-	
	TOTAL MAINTENANCE	286,701.00	441,400.00	154,699.00	65%
IV. ADMINISTRATION					
4.1	Office Expenses	38,917.00	43,700.00	4,783.00	
4.2	Public relations	8,236.00	19,000.00	10,764.00	
4.3	Special budget	-	15,000.00	15,000.00	
4.4	Health education activities	-	-	-	
4.5	Teaching materials	-	19,230.00	19,230.00	
4.6	Miscellaneous	-	2,000.00	2,000.00	
	TOTAL ADMINISTRATION:	47,153.00	98,930.00	51,777.00	48%
	TOTAL EXPENDITURE	**605,276.00**	**874,408.00**	**269,132.00**	**69%**
	In Euro	**€ 10,400.9**	**€ 15,025.7**	**€ 4,624.71**	

Conversion in Euro as on December 31, 2006, www.oanda.com

Brief explanation on the utilization of Trust Office budget is given as under:

1.3, General Equipments: As per approval, the laptop for STST Coordinator (Uttarakhand) was purchased in the year 2005.

2.5, Training: Training of district nucleus of Bihar and DTST evaluation was to be shared. Payments made by the Branch office through a draft, were not accepted by DFIT Bank at Chennai because the draft did not originate from FCRA account hence, the payment of the share was made through the trust account and this over expenditure is seen.

3.4, Vehicle Maint./Travel: Because of previous SLO, no major activity was conducted and less travel was made to Uttaranchal state.

4.3, Special Budget: Operational research, which was planned to study the outcome of the POD camps, could not be conducted as we could not find the information regarding the number of patients who attended the camp and their addresses.

4.5, Teaching Material: Savings are seen because all the payments for teaching and learning material were paid to TLM through Branch Office. Also POD booklets and IEC material for Uttarakhand, was provided by TLM.

6. CONCLUSIONS & RECOMMENDATIONS

1. The national goal of elimination of leprosy has been reached by December 2005. In the year 2006, NCDR and PR continued to decline but very slowly. 'Special efforts' were made to control so called operational factors. ILEP India raised the voice, which minimized the emphasis on these 'special efforts'. There is a need to shift focus from Prevalence Rate to Case detection as described under WHO Operational guideline.

2. Out of the 6 states supported by NLR, UP detected more than 26,000 cases in nine months (April – Dec 06) followed by Bihar (17180) and West Bengal (10975).

3. The treatment completion rates are poor in an urban setup of Delhi. There is a need that patient follow up and retrieval is established/strengthened in an urban setup. The completion rates were calculated by NLR teams. GHC staff is not in habit of assessing completion rates by cohort. There is a need that cohort reporting by GHC staff is practiced. NLR teams have made some efforts in this direction.

4. Project activities continued satisfactorily in 6 NLR supported states. There was some problem with the State Govt. of Jharkhand initially, which was resolved through additional inputs by NLR and the teams regained its functioning with full momentum. Most of the planned activities were completed in NLR supported states. Some of the planned activities could not be carried out due to change in the priority & funds provided by NLEP/GOI.

5. Most of the Govt. funded activities in the states and districts are adhoc depending on the circulars issued by GOI from time to time. There is a need to strengthen and bring in practice the concept of proper planning of activities so that the activities can be monitored and supervised adequately. Management training courses will be required at the district and the state level.

6. Integration of leprosy into General Health Care Services progressed satisfactorily. NLR DTSTs played a major role in strengthening and improving the quality of services. NLR DTSTs in general have achieved a very good reputation in the districts and the states supported including Jharkhand. Diagnosis, treatment, maintenance of record, generation of reports, drug supply management and other components of the program are taken care by GHC staff independently with varying shades of quality. However, nerve function impairment assessment & management of complications need to be strengthened.

7. With the implementation of DPMR project by GOI for the coming five years, there will be a need to support the GHC staff in training in self-care and other POD services. Referral system under GHC is still under developed. This needs to be strengthened and also to provide services to disabled and complicated cases. Assessment of all disabled cases, and strengthening of POD services, to be provided, is a major challenge.

8. Surgeons & PTs of selected Medical Colleges are to be trained further on the job with practice to operate independently so that Reconstructive Surgeries could be done by them regularly with proper post operative care.

9. Seminars to train Physicians/dermatologists of district hospitals are only organized in the State of UP. To strengthen secondary referral hospitals, there is a need that these seminars are held in other states also. Medical colleges & State Health and Family Welfare institutes need to be sensitized to teach leprosy in their routine trainings and also help in management of referred complicated cases.

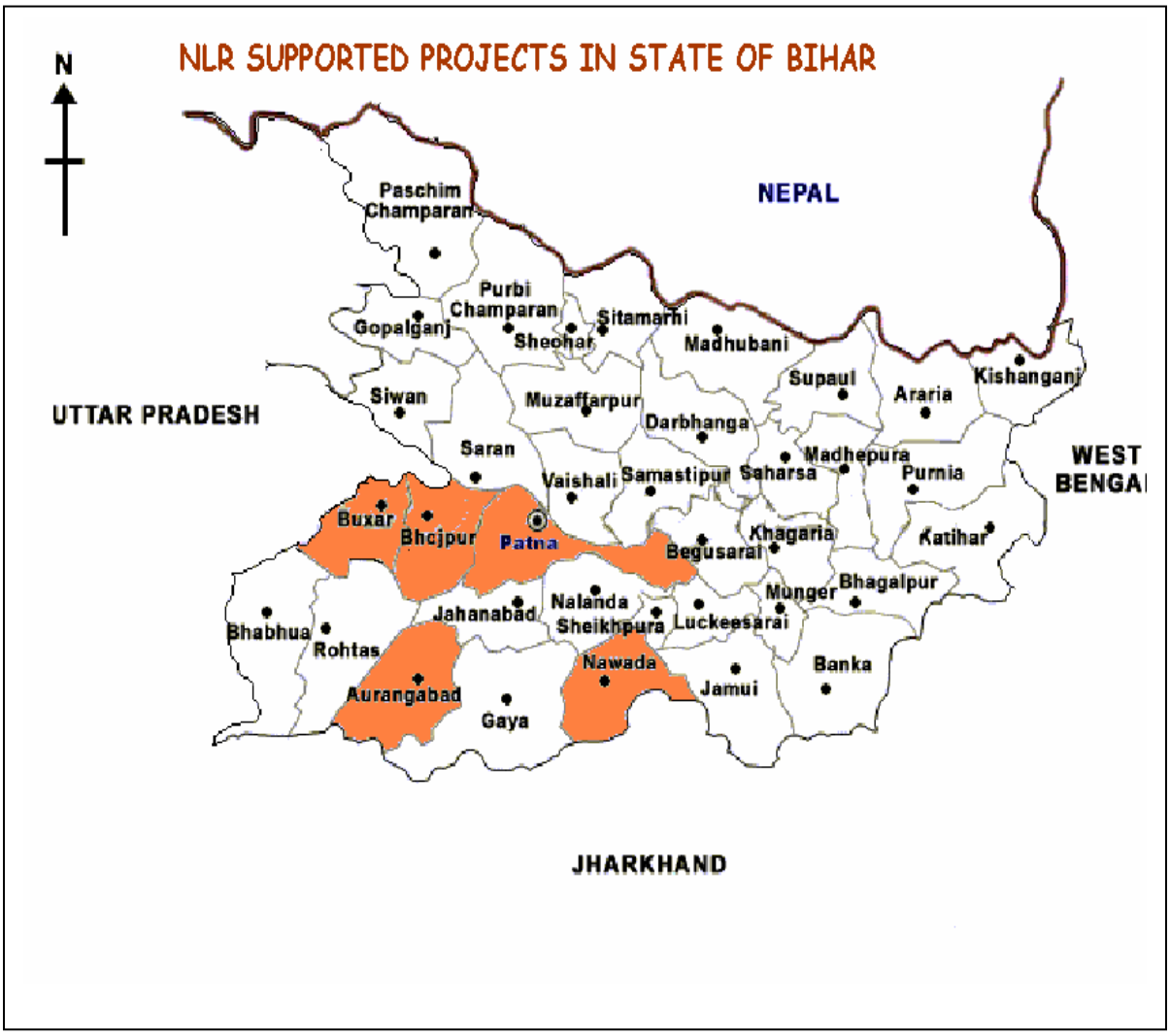
10. State Govts. of NLR supported states have shown their appreciation and emphasized the need for continuation of DTSTs. We feel that the support teams are required but with a focus on transfer of skills for self-care practices and other POD activities. This is also highlighted in the recommendations of all the independent evaluations.

11. Different ILEP agencies are formulating their plans independently. There is a need to plan the activities jointly by all ILEP partners in respective states.

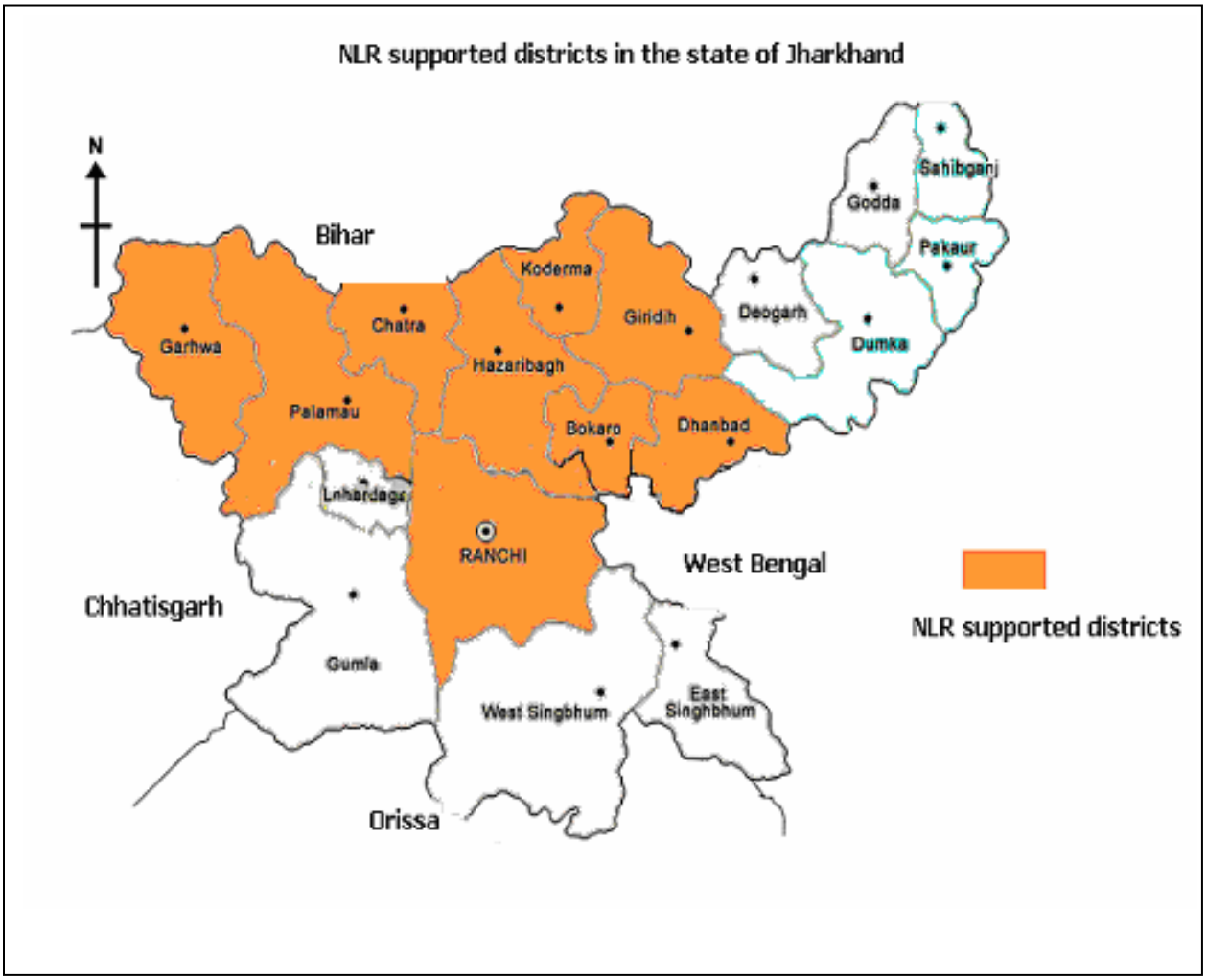
12. MOU signed between ILEP and GOI is coming to an end on 31st March 07. There is a need to have frequent discussions and workshops with the State Govt. to discuss and formulate future plan of action. NLR, being the coordinating agency for two states, has planned a LFA workshop in Jharkhand State and also drafted a strategy paper, and initiated discussions with the State authorities of Uttarakhand.

Annex I Map of NLR supported districts in Delhi state

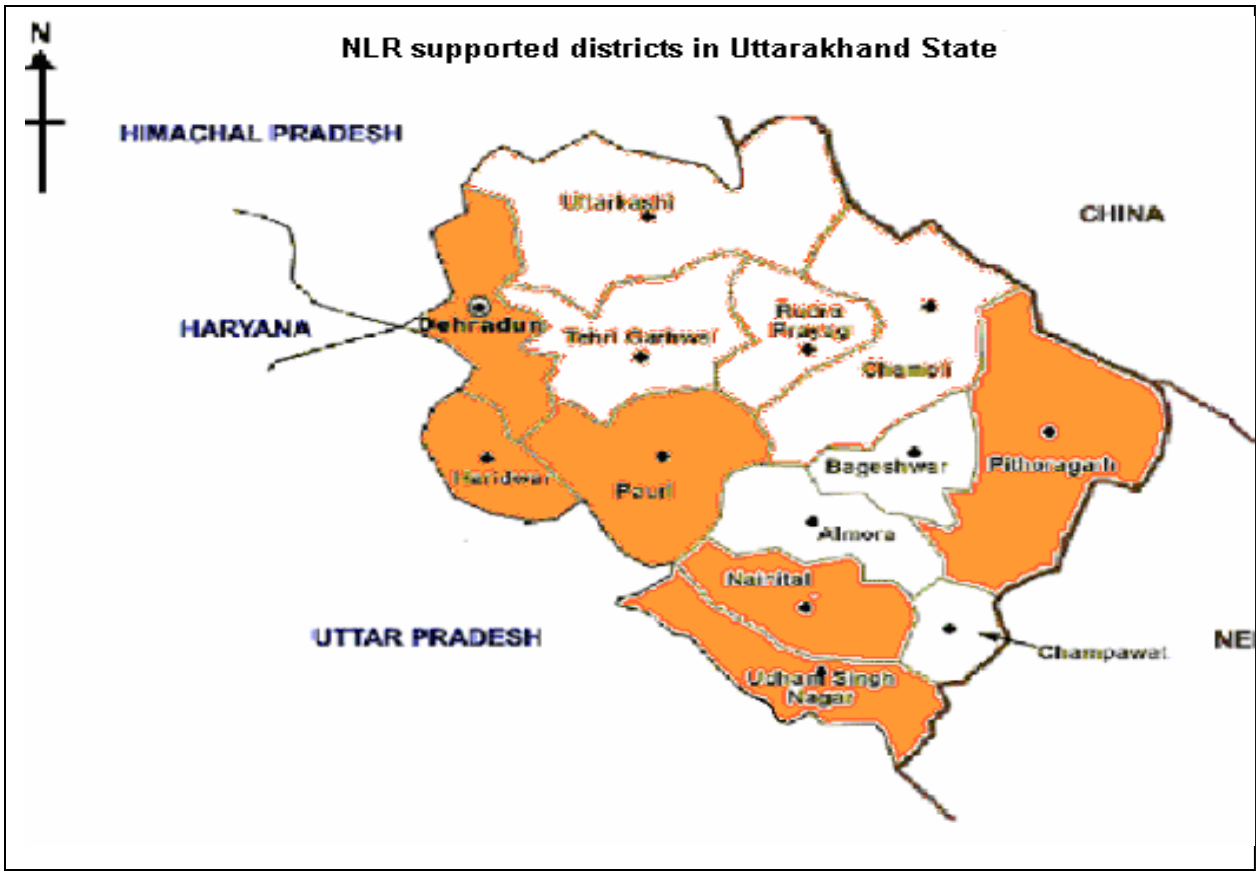
Annex II Map of NLR supported districts in Bihar state



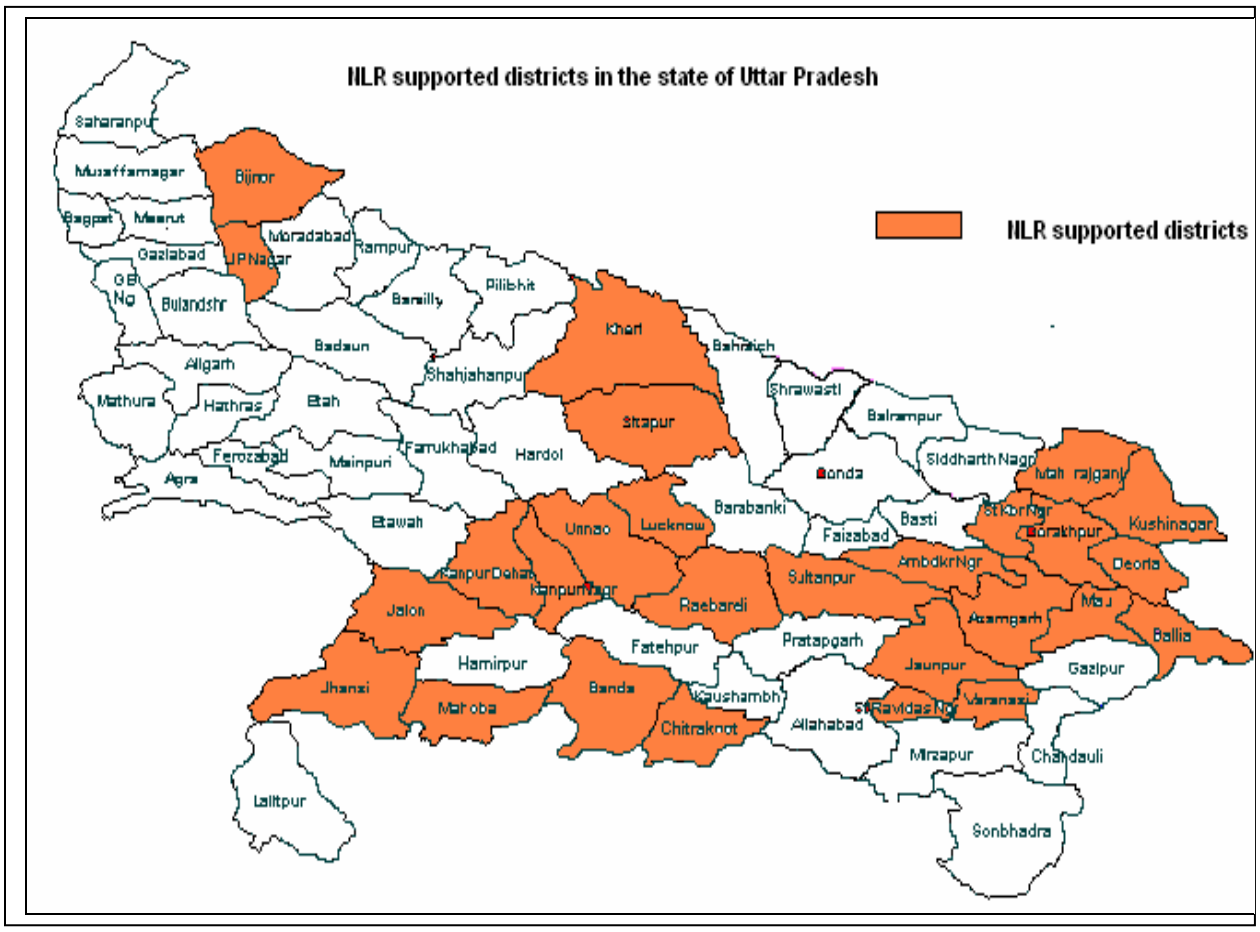
Annex III Map of NLR supported districts in Jharkhand state



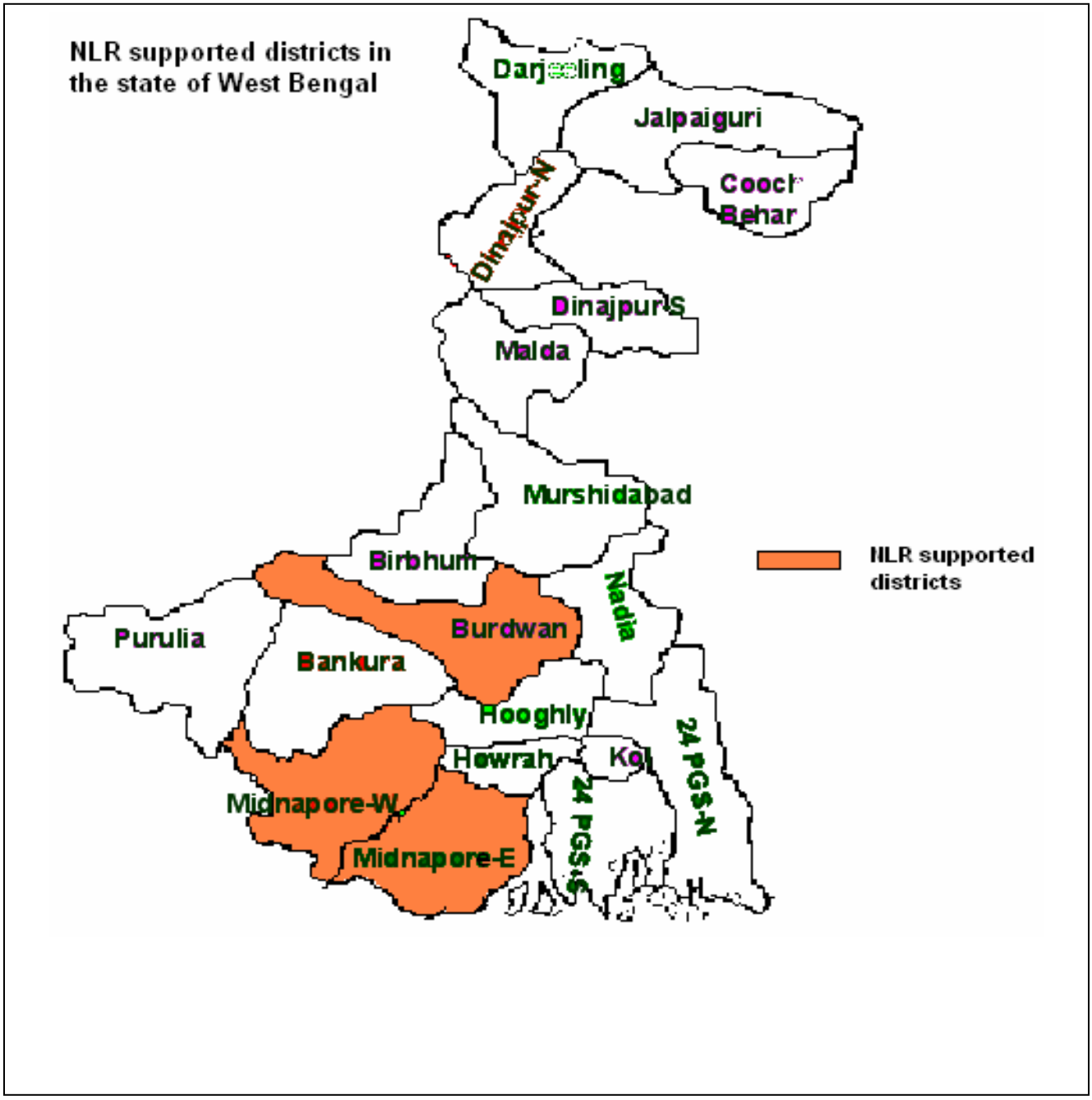
Annex IV Map of NLR supported districts in Uttarakhand state



Annex V Map of NLR supported districts in Uttar Pradesh state



Annex VI Map of NLR supported districts in West Bengal state



Annex VII Details of NLR 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