NATIONAL LEPROSY ERADICATION PROGRAMME

National Consultative Meeting
on
Leprosy services in urban localities

Auditorium, PGIMER, RML Hospital, New Delhi

20th and 21st September 2012

PROCEEDINGS AND RECOMMENDATIONS

Organised by

Central Leprosy Division

Directorate General of Health Services, Government of India, New Delhi

in collaboration with

PGIMER, RML Medical College & Hospital, ILEP Agencies
& Government of NCT, New Delhi

Supported by

ALERT-INDIA, Mumbai

Sponsored by

Anesvad Foundation, Spain

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National Consultative meeting on Leprosy services in Urban Localities

i. Background

At the meeting held on 18th April 2012 in Central Leprosy Division (CLD), New Delhi to discuss the NLEP services in urban areas, it was decided to undertake a rapid assessment of the present situation and needs of National Leprosy Eradication Program (NLEP) as a preliminary step and to deliberate in detail about the leprosy services in urban areas through a national consultation meeting.

In response to this crucial initiative, ALERT-INDIA, Mumbai had proposed to host this national consultation meeting at New Delhi. A standard descriptive data collection tool was developed by Rapid Assessment Team (RAT). Subsequently, a rapid assessment was carried out in 30 selected urban areas with the help of ILEP State Coordinators and the data was analyzed by LEPRA India.

ii. Proceedings of the meeting

A national consultative meeting to discuss leprosy services in urban localities was held at Auditorium, PGIMER, RML Hospital in New Delhi on 20th and 21st September 2012. 51 representatives from all partners of NLEP working in urban areas participated. (List of participants and agenda of the meeting is attached as Annexure 5 & 6)

Meeting was represented and participated by State Leprosy Officers (SLOs), District Leprosy Officers (DLOs), Central Leprosy Division (CLD), Regional Leprosy Training & Research Institutes (RLTRI), World Health Organization (WHO), Medical colleges, Municipal corporations, Private Practitioners, ALERT-INDIA, ILEP agencies, beneficiaries and NGOs working in urban areas.

The inaugural session was started with a welcome address by **Dr. K. S. Bhagotia**.

Mr. Antony Samy presented the key note address on the concerns and issues with reference to leprosy services in urban locations. He focused on the need to initiate programmatic interventions for providing leprosy services in urban localities through the urban health establishments of local self-government.

Dr. H. K. Kar said that currently the health officials of the Government at all levels are very much concerned about the successful implementation of NLEP in the country. The urban localities are grossly neglected. The final recommendation arising out of this consultation meeting will result in developing a specific action plan for urban localities.

Dr M. A. Arif said that the Leprosy control program is effectively implemented in rural areas as compared to urban areas. The probable grounds for poor implementation of leprosy control program in urban localities are due to lack of trained manpower and lack of coordination among multiple health bodies of government and private sector including a weak surveillance system.

Dr. S. Barua said that collaboration of all NLEP partners - WHO, ILEP and NGOs – is necessary to provide technical inputs for implementation of leprosy control activities in urban areas.

Dr. C. M. Agrawal mentioned that the public health services are well structured in rural areas; however there is no follow-up and accountability in urban localities. This national consultation is the first step to improve the leprosy services in urban localities and look forward to useful discussion that can produce results in the problem areas identified by NLEP.

Dr. N. K. Mohanty in his address emphasized that it is a paradox in urban areas despite having adequate public health services, the leprosy services are scarce. Migration of population specifically from lower strata of the society, overcrowding coupled with poor sanitation and unhygienic conditions and lack of awareness pose a challenge in urban areas. Social awareness need to be enhanced to reduce stigma and to bring all the people affected by leprosy into mainstream of society.

Dr. Jagdish Prasad emphasized that "Health service delivery in urban is poor than rural areas. Tertiary health care facilities are present in urban areas but the primary health care is lacking which is very important. The NRHM is re-designated as National health Mission consists of two components National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) with same systems. Municipal Corporation has to play a primary role.

Mr. Antony Samy gave the vote of thanks and the meeting continued as scheduled.

Task boarding exercise was carried out with the active involvement of all the participants. Report of the rapid assessment and literature review was presented. Participants were divided into 5 groups. Result areas were assigned and moderators were nominated for each group. Each group discussed the topic given and prepared the recommendations. Presentations by each group rapporteur were discussed.

A core group was formed to examine the group recommendations and draft a report on the outcome of the consultative meeting.

iii. Rapid assessment of urban leprosy program

The consultative meeting was preceded by a rapid assessment of urban leprosy situation in the country. 77 urban health facilities in 30 urban locations were visited and 365 persons affected by leprosy were interviewed for understanding current leprosy situation in the country, assess capacity of urban health facilities to provide MDT services and to have a clear view on satisfaction of clients seeking health services.

In these 30 urban locations, 39% of urban population lives in slums. Migrants are a big challenge in providing quality health services. The epidemiological data shows higher deformity rate at 4.6% (> national average). Treatment completion rate is < 90%. Access to health services is difficult to slum dwellers as health service delivery time coincides with working hours of slum population. Proper coordination among multiple stakeholders and service providers is lacking. Inadequate trained staff particularly in documenting leprosy cases and reporting leprosy data is another important issue that influenced discussions.

iv. Literature review

Scientific publications and unpublished reports from leprosy programs globally and information from other control diseases with specific reference to urban health were reviewed and the following approaches were identified for further reference. Contact screening, counseling, capacity building of health staff, Coordination between health capacities and need of an effective referral system were identified. Specifically the review suggests the need of target specific IEC for different communities, community based approaches for disability care and public private partnership to facilitate holistic care for persons affected by leprosy.

v. Role of Medical colleges

Medical colleges in public and private sector are currently providing Multi Drug Therapy (MDT), DPMR service and research. The main challenges are lack of outreach activities to motivate patients and follow up untraced and defaulted patients and linkage with national leprosy eradication program. Effective coordination from NLEP will help improving access to tertiary care facilities for persons affected by leprosy.

vi. Group work

Participants were grouped into 5 groups to bring out recommendations after discussing the leprosy problem in urban settings based on Terms of Reference (ToR) [Annexure 1]. The suggestions from groups have been compiled and used in the light of findings and discussions to make recommendations for strengthening leprosy services in urban localities.

vii. Outcome of the meeting

The core principles of leprosy control in urban situations should include focusing on timely diagnosis and; appropriate case management with Multi Drug Therapy (MDT) and Disability Prevention and Medical Rehabilitation (DPMR); educating key stake holders and sensitizing and ensuring a coordinated involvement of all partners. This will ensure sustainability, high quality of care, easier accessibility and increased coverage through improving outreach, particularly in the underserved slums and sub-urban areas.

Services need to be accommodated according to special features of urban areas such as migratory population, rapid industrialization, multiple health authorities, establishment and demolition of slums, social, cultural and economic inequalities, increasing density & overcrowding.

There are 524 urban areas which can be divided into 4 categories:

1. Town & cities with population 1 - 5 lakh: 432
2. Medium cities with population 5 lakh to 1 million: 53
3. Mega cities with population 1 - 4.5 millions: 34
4. Metro cities with population > 4.5 millions: 5 (state wise list of urban localities is attached as Annexure 3)

viii. Recommendations

Rapid urbanization bring with it its own challenges like migration, marginalized underserved population especially in slum and per-urban areas, difficulties in accessibility to health services in spite of high density of service providers and lack of coordination. All these challenges should be taken into consideration while planning leprosy control services in the urban areas in coordination with urban health program managers. Even though the size of urban population varies from a little over 1,00,000 to around 10 million, the program response would use “cafeteria approach” with different interventions of varying intensity.

Identification of human resources at the periphery in slums and peri-urban villages and designation of an existing health centre as primary level referral centre with adequate trained staff (a trained medical officer and a health worker) for providing MDT and disability prevention services are the basic tenets of leprosy control in urban locations. Inclusion of person affected and their district and state level forums are recognized as partners and considered as civil society organizations for partnership. There also opportunities like high density media and high density population, which makes it reachable. The following recommendations are made with the presumption that routine NLEP facilities are available in urban localities.

1. New case detection

1.1. **Objective:** To detect all new leprosy cases timely before they develop disability.

1.2. **Strategy:**

a) To focus on 'at risk' individuals (contacts) and population groups (slums, peri-urban areas, work sites / transit camps and Industrial colonies) in an urban setting.

b) To establish mechanisms of referrals from slums and underserved population.

c) Identify at least one health centre (primary level) for diagnosis and management of leprosy.

d) To enhance capacity of health services to diagnose in identified health center.

1.3. **Activities:**

a) Identify and list out human resources available in the community that could be involved in specific leprosy control activities including suspect and referral.

b) Human resource could be from government (E.g. Health Visitors in TB control, USHA / ASHA, AWW) or private (NGOs, PMPs) or Civil Society (Individuals, Volunteers or organized groups (CBOs) including persons affected by leprosy).

c) Allocate at risk population groups to the human resource identified. The size of the population allotted depends on the density of population and magnitude of problem of leprosy.

d) Examination of all house hold contacts of all new cases identified at least once before the index case completed treatment.

e) Counseling should be done for all leprosy cases at the time of Release from Treatment (RFT) to motivate family members to report to the health centre if they notice any lesion – patch or nodule or any complication develop after RFT.

f) Identify and designate at least one health centre in each urban location as referral centre to diagnose and manage leprosy with or without complications. The health centre could be either district hospital or Medical College hospital or Urban Health Centre. All other health facilities (Public and Private) staff in that area should be trained to suspect persons and refer to the identified health centre.

g) Build the capacity of identified human resource. It should be developed through sensitization at the time of induction and periodically.

h) Organize special IEC campaigns at periodic intervals to sensitize the community and program staff and to detect backlog cases. IEC activities in schools could be organized as part of integrated school health program.

i) Utilize locally available technology like mobiles, SMSs, Emails and web based portals for dissemination of information, referrals and follow up of patients.

2. Case management with MDT and DPMR

2.1. **Objective:** To detect and treat with MDT all new cases and adequately followed to ensure that they do not develop new disability, left with residual deformity or worsening of existing deformities.

2.2. **Strategy:**

a) Identify at least one health centre as referral centre for diagnosis and management of leprosy.

b) Ensure treatment completion rate (TCR) at more than 90% among all registered cases in a year.

c) Identify one health worker in the referral centre identified in each urban area for follow up of field activities (suspect / referral, follow up treatment and monitoring self-care).

d) Develop community based DPMR services at the primary level (Urban Health Centres) using all available service providers.

e) Identify at least one tertiary referral centre in every state / group of states (depending on the need) for providing tertiary level care services including Reconstructive Surgery (RCS).

2.3. Activities:

a) At least one health centre in each urban location should be identified to diagnose and manage leprosy with or without complications. The health centre could be district hospital, Medical College Hospital, Urban Health Centre.

b) Medical and Health personnel from all health facilities (Public and Private) in that area should be trained to suspect and refer to the identified health centre and give follow up treatment wherever needed.

c) Train and deploy manpower at least in one referral centre in the cities / towns or municipal wards as secondary level care to manage difficult cases with complications, reactions and disabilities.

d) Human resource to manage this referral centre consists of at least one trained medical professional to diagnose and treat leprosy cases and train health workers to manage and coordinate field (50% of the time) and hospital related activities.

e) The field activities include: *i) follow up of referrals; ii) collection of reports from Private Medical Practitioners (PMPs); iii) monitoring and supervision of field personnel & iv) training and monitoring of persons affected in self-care*.

f) Hospital related activities include: *i) documentation of cases; ii) maintenance of drug stock; iii) maintain disability register; iv) support Inter-departmental referrals and follow ups and v) generation of reports.*

g) Utilize locally available technology like mobiles, SMSs, Emails and web based portals for dissemination of information, referrals and follow up of patients.
h) Ensure linkages with district referral centre for appliances and MCR footwear.
i) Wherever possible services of person affected individually or in groups should be utilized in the key areas like counseling, training and monitoring self-care.
j) State leprosy officer should identify at least one designated tertiary referral Centre in the state. The team of surgeon and physiotherapist could be trained in RCS by visiting team of expert surgeon and physiotherapist. Information on this should be known to all the health centres (Public and Private) in the state.

3. Information, Education and Communication (IEC) and Advocacy:

3.1. **Objective:** To educate all the four important stakeholders – persons affected, public, program staff and policy makers to remove stigma and encourage participation.

3.2. Strategy:

a) Inter-personal communication (IPC) e.g. counseling to improve treatment completion rate (TCR) and self care practices.
b) Integrate with other information campaigns.
c) Emphasis should be on gender specific initiatives like involvement of women group.
d) IEC campaign for public and advocacy meetings for the target audience specific e.g. formal and informal leaders, religious groups.
e) Raising awareness about leprosy and the program among all stakeholders using available media and existing resources in public and private sectors.

3.3. Activities:

a) IPC methodology and material to be developed for use by referral Centre to improve compliance for treatment and self-care (e.g. counselling).
b) IEC activities on leprosy should be integrated with information campaigns of other health, development and welfare programs.
c) Program Manager of the district in which urban area is located should get the advance information on all information campaigns in the areas by other health programs and try to include leprosy also in the campaign.
d) Prepare a plan, taking into consideration complexities of the language and culture of the target groups. Involve major stakeholders including persons affected and media groups in the preparation of the plan. This should be done by District leprosy officer (DLO) in consultation with State Leprosy Officer (SLO) preferably the task can be entrusted or carried out in coordination with the health department of municipal corporation / council of the cities and towns.

e) Identify media, message, method and persons responsible for target audience specific IEC activities – e.g. mass media for general public. Simple education materials could be developed for use by Private Practitioners, other medical professionals and the decision makers of the local community.
f) Utilize locally available technology like mobiles, SMSs, Emails and web based portals for dissemination of information, referrals and follow up of patients.

4. Human resource & capacity building for developing services in urban localities

4.1 **Objective:** To identify the human resources available for leprosy services from different organizations and suggest ways for their capacity building

4.2 Strategy:

a) Training of Corporation / Municipality health staff (Urban health post / Clinic).
b) Training of Registered Medical Practitioners of other systems of Medicine.
c) Refresher Training of the Old staff (NMS & PT) of NLEP.
d) Involvement of medical colleges, medical practitioners and civil societies.
e) Provide accreditation of Private Medical Practitioners mostly serving around the slum areas – under NLEP (Like AFP Surveillance)
f) Promote Public-Private Partnership (PPP) scheme for diagnosis, treatment and reporting (NGO / Individual practitioners).
g) Scheme for Civil Societies: Capacity Building of certain key grass root level staff for IEC, advocacy, referral, contact tracing & follow up.

4.3 Activities:

a) Include leprosy in general health training for all health personnel in urban areas.
b) Plan induction training for all Medical officers at Institutes such as:
    i. Central / Regional Leprosy Training & Research Institutes;
    ii. ILEP supported institutions & NGOs;
    iii. National / Regional Health & Family Welfare Training institutes.
c) Identify eminent Skin Specialists as 'Brand Ambassador' to advocate the cause of leprosy and acknowledge them as a key stakeholder.
d) Hold consultative meetings with National / State chapter of Indian Association of Dermatology, Venereology and Leprology (IADVL) and have a Panel discussion in the Annual Conference of Skin Specialists.
e) Encourage accreditation of Skin Specialist including Private Practitioners.
f) Details of human resources required for different urban localities based on the population are given in Annexure 2.

5. Program Management

5.1. Objective: To manage leprosy services as per the NLEP guidelines and to effectively coordinate in an integrated setting involving all the stakeholders.

5.2. Strategy:

a) A coordination committee should be formed at each urban location consisting of important stakeholders (both from government and private) for overseeing the program implementation and various activities including IEC.
b) The three important elements of program management – implementation, coordination and facilitation should be undertaken by government or private institutions depending on the availability and capacity.
c) Quality care to be ensured through effective monitoring and supervision
d) Adequate quantity of drugs (MDT and Steroids) and appropriate footwear are to be made available at point of care.
e) Ensure simple information system for NLEP is established.
f) A coordination mechanism for smooth implementation of all activities is established.
g) Opportunity is created for the state leprosy program to collect and use data to answer operational questions especially in urban areas linking up with medical colleges and specialized institutions in leprosy and/or research.

5.3. Activities:

a) Establish / maintain a centralized patient registry for cities / towns as a part of health MIS for effective epidemiological monitoring and to avoud multiple registrations.
b) District Leprosy officer and designated Medical Professional at the referral centre are responsible for supervision and monitoring, whereas the non-medical person at the referral centre are responsible for the field supervision. The non-medical person at the referral centre may or may not be exclusively for the leprosy depending upon the problem of leprosy in that area.
c) All government and non-government health institutions in the urban areas should be part of the urban leprosy service network.
d) A coordination committee to be formed consisting of representatives from Municipal health, other departments both health & social welfare, Medical College, NGO, Civil Society, Indian Medical Association (IMA) to ensure coordination of leprosy services in urban areas. The committee will meet periodically under the chairmanship of District Health Officer (DHO) / Medical Officer of Health (MOH) of the Municipal Corporation / Council.

e) Volunteers from ‘at risk population’ can be identified to liaise and facilitate referral and follow up of suspects and persons with disabilities due to leprosy. This is essentially to enhance reaching the migrants who constitute an important part of ‘at risk population’.
f) Mobile health clinics of General health services include leprosy services on their visit to slums, peri-urban villages, work sites / transit camps and migrant agglomerations at industrial zones / corridors.
g) The health worker at the referral centre is responsible for:
    i. Ensuring the adequacy in drug stock and footwear management;
    ii. Maintenance of all the records of leprosy patients under treatment at the referral centre;
    iii. Collect information on all the cases under treatment in the field (volunteer, NGO, PMP, and Hospital) once a month;
    iv. Monitoring progress and generating report.
h) Develop partnerships with NGO and Civil Society Organizations.
i) State leprosy program review should include a separate agenda and appropriate time to review progress of leprosy program management in urban locations under each district report.
j) National leprosy program management review also should include separate agenda and appropriate time for reviewing leprosy program in urban locations.
k) One Medical College Hospital identified as sentinel centre for drug resistance surveillance in the state could be designated as coordinator with the responsibility for coordinating proper implementation of NLEP guidelines in the Medical colleges through annual meetings which could be sponsored by government or its partners.
l) Medical Professional in the referral Centre along with District Leprosy Officer (DLO) / Medical Officer of Health (MOH) of the Municipal Corporation / Council will organize a sensitization meeting of PMPs under IMA at least once a year which could be sponsored by government or its partners.
m) The District Leprosy Officer (DLO) / Medical Officer of Health (MOH) of the Municipal Corporation / Council should link up with Medical Colleges and NGOs to initiate short research in operational aspects of leprosy control that is specific to issues related to urban areas.

Annexure 1

National Consultation meeting on Leprosy Services in Urban localities

Terms of Reference (TOR) for Group Work

Group 1: Case detection and Management in urban localities

(i) Early detection of cases
(ii) Case follow-up for completion of treatment on time.
(iii) Proper management of referred cases.
(iv) Adequacy of supportive drugs & materials for treatment.
(v) Utilization of services of local NGOs.

Group 2: DPMR Service delivery in urban localities

(i) Referral services at District Hospitals and Medical Colleges/Leprosy Institutions.
(ii) Providing services in the leprosy colonies.
(iii) Procurement and supply of MCR Footwear and appliances to PAL.

Group 3: IEC & BCC in urban localities

(i) IEC with focus on communication for behavioural changes.
(ii) Efforts to reduce stigma and discrimination.
(iii) Involvement of Persons Affected in Stigma reduction process.

Group 4: Human Resource & capacity building for developing services in urban localities

(i) Identification of Human Resource available for leprosy services from different Organizations.
(ii) Capacity building of concerned Human Resources.

Group 5: Program management

(i) Mechanism for monitoring leprosy services being provided by various Organizations.
(ii) Maintenance of regular data from all Institutions in the District Leprosy Office.
(iii) Regular review of the urban leprosy services.

Annexure 2

Human resources suggested for different urban locations

A. Metropolitan city

Activity	Human Resource requirement	Specific role in leprosy control program
Program Management	• Senior Medical officer of SLO cadre / seniority.	• Coordination and management • Implementation of IEC in partnership with media agencies and experts
Patient services	• Surgeon trained DPMR • Physiotherapist	• Tertiary referral services
Primary Referral centre one for each urban location (up to 100 cases a year).	• Trained medical officer • Trained health worker	• Case detection • Case management. • Documentation of cases and report generation. • Drug & footwear stock management
Community out reach Slums and migrant colonies	• Community volunteers • ASHA / USHA • Anganwadi Worker • ANM • Health visitor (TB) • NGO staff / Women group	• Case detection • Ensure adherence to MDT • Self care practices • IEC campaigns • Counselling

B. Mega city

Activity	Human Resource requirement	Specific role in leprosy control program
Program Management	• Senior Medical officer or DLO of the district.	• Coordination and management. • Implementation of IEC in partnership with media agencies and experts.
Patient services	• Trained medical officer in DPMR • Physiotherapist	• Secondary referral services.

Primary Referral centre one for each urban location (up to 100 cases a year).	• Trained medical officer • Trained health worker	• Case diagnosis • Case management • Documentation of cases and report generation • Drug and footwear stock management
Community outreach slums and migrant colonies	• Community volunteers • ASHA / USHA • Anganwadi Worker • ANM • Health visitor (TB) • NGO staff / Women group	• Case detection • Ensure adherence to MDT • Self care practices • IEC campaigns • Counselling

C. Cities and Townships

Activity	Human Resource requirement	Specific role in leprosy control program
Program Management	• Senior Medical officer and/or DLO	• Coordination and management • Implementation of IEC in partnership with media agencies and experts
Primary Referral centre one for each urban location (up to 100 cases a year)	• Trained medical officer • Trained health worker	• Case detection • Case management • Documentation of cases and report generation • Drug & footwear stock management
Community outreach slums and migrant colonies	• Community volunteers • ASHA/USHA • Anganwadi Worker • ANM • Health visitor (TB) • NGO staff • Women' group	• Case detection • Ensure adherence to MDT • Self care practices • IEC campaigns • Counselling

Annexure 3

LIST OF URBAN AREAS - STATE WISE

Sr. No	State & UTs	Number of Urban Areas
1	Andhra Pradesh	200
2	Andaman Nicobar	1
3	Arunachal Pradesh	26
4	Assam	97
5	Bihar	143
6	Chandigarh	2
7	Chhattisgarh	188
8	Dadra & Nagar Haveli	1
9	Daman & Diu	2
10	Goa	15
11	Gujarat	234
12	Haryana	91
13	Himachal Pradesh	58
14	Jammu & Kashmir	93
15	Jharkhand	41
16	Karnataka	241
17	Kerala	69
18	Lakshadweep	0 (No data available)
19	Madhya Pradesh	394
20	Maharashtra	259
21	Manipur	39
22	Meghalaya	10
23	Mizoram	23
24	Nagaland	19
25	NCT of Delhi	6
26	Odisha	122
27	Puducherry	7
28	Punjab	160
29	Rajasthan	205
30	Sikkim	8
31	Tamilnadu	730
32	Tripura	16
33	Uttar Pradesh	670
34	Uttarakhand	80
35	West Bengal	138
	TOTAL	**4388**

Annexure 4

RAPID ASSESSMENT OF NLEP IN URBAN LOCATIONS

Course of action:

Rapid Assessment Team (RAT) consisting of the following members defined tools, location and persons responsible for collection of information on urban leprosy situation from different states with support of ILEP members and WHO:

I. Dr. K. S. Baghotia, State Leprosy Officer, NCT of Delhi
II. Dr. P. R. Manglani, Country Representative, NLR India
III. Mr. Antony Samy, Chief Executive, ALERT India
IV. Dr. P. V. Ranganadha Rao, Chief Executive, LEPRA India

DDG (Leprosy) communicated to State leprosy officers and ILEP representatives to support RAT to collect information from respective states. The following urban locations are identified for rapid assessment of leprosy urban control activities:

Sl. No	Urban location	State	State Leprosy Officer	NLEP Consultant
1	West Delhi	NCT Delhi	Dr. K. S. Baghotia	Dr. J. B. Singh
2	New Delhi	NCT Delhi		
3	Mumbai	Maharashtra	Dr. Pradeep Gaikwad	Dr. Pramila Barkataki
4	Nagpur	Maharashtra		
5	Bardwan	West Bengal	Dr. P. K. Mandal	Dr. P. K. Mitra
6	24 Paraganas South	West Bengal		
7	Assansol	West Bengal		
8	Kamrup	Assam	Dr. D. Hazarika	Dr. N. Manimozhi
9	Vijayawada	Andhra Pradesh	Dr. T. Tarachand	Dr. Michael Sukumar
10	Hyderabad	Andhra Pradesh		
11	Chennai	Tamil Nadu	Dr. K. Ramalingam	Dr. P. Vijayakumaran
12	Coimbatore	Tamil Nadu		
13	Muzaffarpur	Bihar	Dr. U. Jha	Dr. Anne Mattam

14	Patna	Bihar		
15	Jabalpur	Madhya Pradesh	Dr. K. K. Thassu	Dr. Bhandarkar
16	Indore	Madhya Pradesh		
17	Bengaluru	Karnataka	Dr.	
18	Kanpur	Uttar Pradesh	Dr. R. B. Singh	Dr. Rashmi Shukla
19	Lucknow	Uttar Pradesh		
20	Dehradun	Uttarakhand	Dr. Shusma Datta	Dr. J. B. Singh
21	Raipur	Chhattisgarh	Dr. Bhatpahari	Dr. Manotosh
22	Ranchi	Jharkhand	Dr. Barwar	Dr. S. P. Sood
23	Dhanbad	Jharkhand		
24	Surat	Gujarat	Dr. Girish Talsania	Dr. Hiren Tanki
25	Ahmedabad	Gujarat		Dr. Rajbir Singh
26	Rourkela	Odisha	Dr. P. K. B. Patnaik	Dr. S. N. Pati
27	Cuttack	Odisha		
28	Tiruvanthapuram	Kerala	Dr. B. Srilatha	Dr. P. Vijayakumaran
29	Jaipur	Rajasthan	Dr. P. C. Dandoria	Dr. Rajbir Singh
30	Chandigarh	Chandigarh	Dr. S. D. Mehta	

Objectives:

1. Understand the epidemiological situation of leprosy in different urban locations
2. Assess the capacity of urban health facilities to provide leprosy services
3. Assess the satisfaction levels of persons affected by leprosy

Sample:

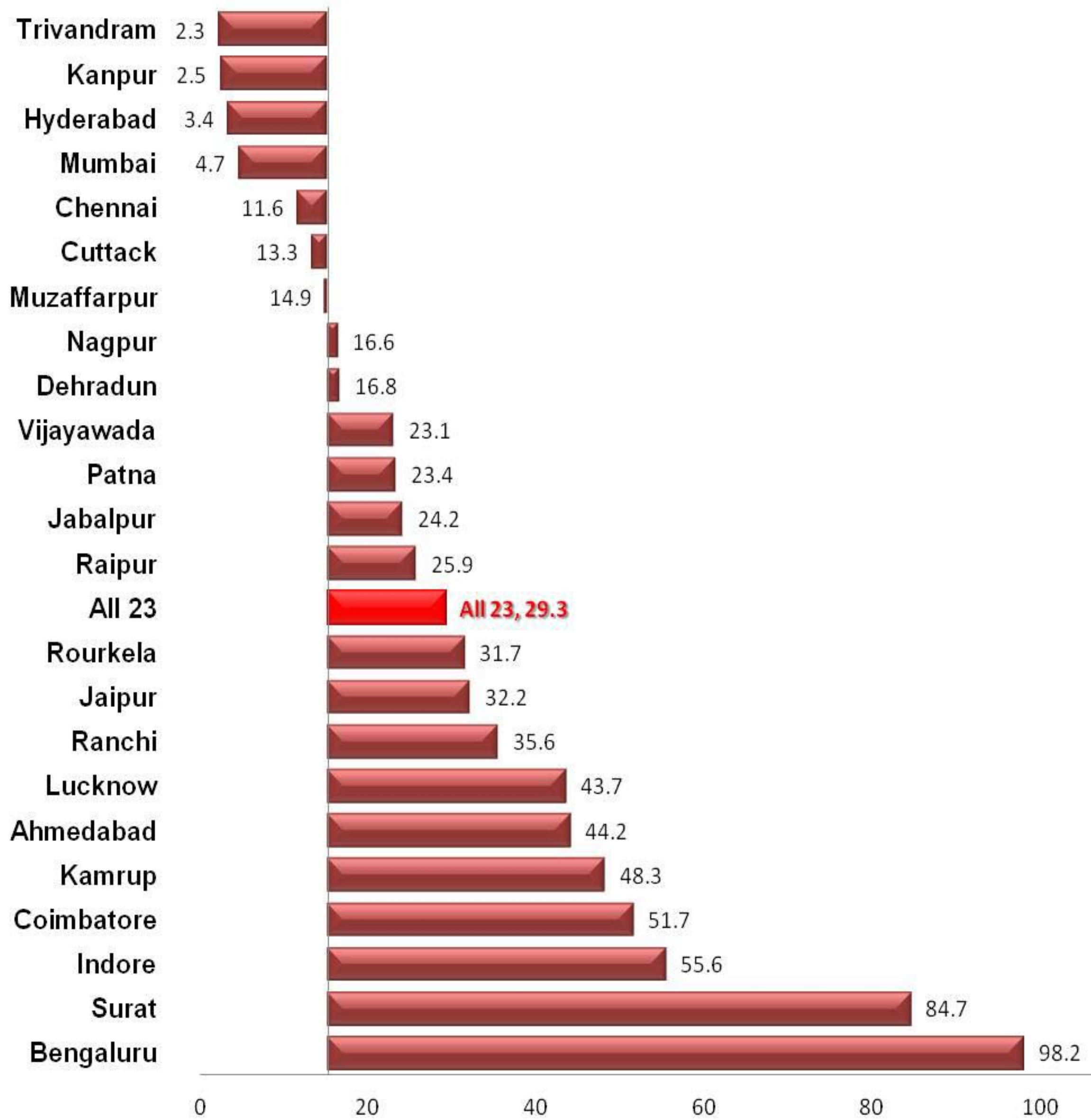
30 Locations (Epidemiological data of 23 locations used)

- 30 Urban city locations (RAT-1 DLO)
- 77 Health Facilities (RAT-1 HF)
- 365 Leprosy patients (RAT-2)

a) DISCUSSIONS ON FINDINGS

Population in Urban Locations

Chart 1: Decennial population growth rates (2001-11)



- Average increase in urban locations is 29.3%
- 10 Urban locations showed increase
- 13 urban locations showed decrease
- Benguluru showed a phenomenal increase 98.2%

Table 1: Slum population in urban locations

#	Description	Value
1	Number of urban locations for which data is available	15
2	Registered slums	2,749
3	Population of the urban locations 2011	4,50,27,831
4	Population of the slums	1,76,31,754
5	% of slum population to city population (Locations range)	39.16 (1.2 to 66.6)
6	Existing of cases of leprosy	1,210
7	Average population per slum	6,414

Prevalence rate in slum populations: 0.68 per 10,000

Table 2: Peri-urban village population in urban locations

#	Description	Value
1	Number of urban locations for which data is available	7
2	Number of peri-urban villages	374
3	Population of the urban locations 2011	1,95,93,866
4	Population of the Peri-urban villages	71,90,597
5	% of Peri-urban population to city population (Locations range)	36.7 (2.6 to 60.9)
6	Existing of cases of leprosy	214

Prevalence in peri-urban village populations: 0.29 per 10,000

Table 3: Leprosy indicators in 23 urban locations

Indicator	Value	Range	National Value
Population	6,68,85,858		1,189,172,906
New cases	4772	28 - 709	1,27,000
Deformity cases	218	0 - 48	3,865
Child cases	392	1 - 109	12,305
Female cases	1404	2 - 207	
ANCDR / 100,000	7.13	2.3 - 22.3	10.35
Child %	8.21	1.3 - 24.6	9.7
Female %	29.42	6.2 - 56.5	37.0
Deformity %	4.57	0 - 20.7	3.0
Deformity Rate/ lakh population	0.33	0 - 1.3	0.314

Table 4: Leprosy colonies in urban locations

#	Description	Value
1	Number of urban locations for which data is available	8
2	Number of leprosy colonies	34
3	Population of the urban locations 2011	3,89,27,822

4	Population of the leprosy colonies	6679
5	% of colony population to city population	0.02%
6	Existing of cases of leprosy	1538*
	**All cases old and new, completed treatment*	

Chart 2: Leprosy trained staff in urban locations

Table 5: Health facilities in urban locations

Health facility level	# of facilities	Facility rate per million population
Primary	1122	15.4
Secondary	208	2.9
Tertiary	67	0.92

Table 6: Budget utilization for leprosy services

Budget	Percentage utilization	# of Locations
Under utilization	< 50%	4
Normal utilization	50 - 80%	6
Good utilization	> 80%	14
No data	0	6
Total		**30**

Table 7: Involvement of stakeholders in NLEP

Stakeholders involved	
Municipal Corporation	17
CSOs, PRGs, Networks	16
Railways	9
Police	8
ESI	15
Central Govt.	10
Medical Colleges	24

- < 50% involvement of stakeholders.
- Efforts should be made to involve stakeholders
- There is scope to enlarge (*Private practitioners)*

Table 8: Client satisfaction on leprosy services

Reason for not satisfied	#
No improvement	9
Developed deformity	3
Doubt in Diagnosis	1
Lack of awareness	1
Loss of sensations	1
Lost phalanges after MDT	1
No Prednisolone & supportive medicine from hospital	1
Persistence of Neuritis	1
Worry about complications	1
After RCS for foot drop	1
Change in Skin colour	1
Total	**21**

b) SUMMARY OF THE FINDINGS

1. Case detection

- Growth rate for 30 urban locations 28.46%
- Challenges of migrant population, slums, hygiene, follow-up
- Slum population to city population - 39.16% (1.2 to 66.6)
- Facility rate per million population - 15.4
- 26/30 urban locations identified migrants as an issue
- High Deformity 4.57% (National average 3%)

2. **Case holding / Quality of Services**
    - Existing of cases of leprosy – 4772
    - Service delivery time same as working hours
    - Defaulters - Migrants/Construction workers
    - Sub-optimal TCR (<90%) in 36% Urban Location
    - No DPMR services
    - Drugs (Process of procurement of Prednisolone – difficulties in 15/30 locations)
    - Counseling is an emerging need
        - Defaulters
        - Sub-optimal TCR
        - Client satisfaction survey findings

3. **Program Management**
    - Involvement of Municipalities, ESI, Police, etc <50%
    - Inadequacy of trained staff
    - Facility rate per million population - 15.4 Coverage
    - Service delivery time same as working hours
    - RCS is not uniformly practiced and there is need for strengthening RCS
    - Inclusion of people affected in MDT and DPMR services
    - No Urban Leprosy Committee in 29 locations
    - Budget
        - Inadequate
        - Delay in release of funds
        - Funds provided to district not to urban location
        - Need more budget for MCR footwear

4. **Information system**
    - Inadequacy of trained staff
    - RCS is not uniformly practiced – data from other NGOs and Institutions not available
    - Needs manpower to improve recording
    - Need for training to use SIS formats
    - Others: Need to identify Interface agency to address leprosy in urban settings

Annexure 5

NATIONAL CONSULTATION ON LEPROSY SERVICES IN URBAN LOCALITIES

20-21 September 2012, PGIMER, Dr. RML Hospital, New Delhi

LIST OF PARTICIPANTS

S.NO	NAME & DESIGNATION	CONTACT DETAILS (ADDRESS, PHONE NUMBER & EMAIL)
	STATE LEPROSY OFFICERS	
1.	**Dr. K. S. Baghotia*** State Leprosy Officer	Directorate of Health Services, Govt. of Delhi, Swasthya Seva Bhawan, F-17 Karkardooma, **DELHI** – 110 032 **Mobile:** **Email:** slodelhi@hotmail.com / baghotia@yahoo.com
2.	**Dr. P. K. B. Patnaik*** Joint Director of Health Services (Leprosy &TB)	Directorate of Health Services, Heads of Department Building, Unit – 5, **BHUBANESWAR** – 751001, Orissa **Mobile:** 09861144888 **Email:** patnaikpranav@yahoo.com / asloorissa@sify.com
	DISTRICT LEPROSY OFFICERS	
3.	**Dr. Naveen Kothari** District Leprosy Officer	O/O The chief Medical & Health Officer, Main Hospital Campus, **JABALPUR**, Madhya Pradesh **Mobile:** 09425356849 **Email:** kotharidrnaveen@gmail.com / cmhojab@nic.in
4.	**Dr. Shivchandra Jha** District Leprosy Officer	O/O District Leprosy Office, Sadar Hospital Campus, **MUZAFFARPUR**, Uttar Pradesh **Mobile:** **Email:**
5.	**Dr. S. A. Sharif** Surveillance Medical Officer	O/O State Surveillance Medical Officer, Directorate of Health Services, **RAIPUR**, Chhattisgarh **Mobile:** **Email:** drsharif@gmail.com
6.	**Dr. R. Ramesh** District Leprosy Officer	O/O District Leprosy Office, **VISAKAPATNAM**, Andhra Pradesh **Mobile:** 09849902295 / 0949116451 **Email:** ronanki.ramesh@gmail.com
7.	**Dr. G. Shivaram** Surveillance Medical Officer	O/O State Leprosy Officer, Directorate of Health Services, **BANGALORE**, Karnataka **Mobile:** 09844186122 **Email:** drsharif@gmail.com
8.	**Dr. S. D. Khosla** District Leprosy Officer	O/O Directorate of Health Services, Govt. of Delhi, Swasthya Seva Bhawan, F-17 Karkardooma, **DELHI** – 110 032 **Mobile:** **Email:**

MEDICAL COLLEGES & HOSPITALS		
9.	**Dr. H. K. KAR*** Consultant Dermatologist	Head, Department of Dermatology, Dr.RML Hospital, **NEW DELHI** **Mobile:** 09212409060 / 09868506372 **Email:** hkkar_2000@yahoo.com
10.	**Dr. V. Anandan** Dermatologist	Head, Department of Dermatology, Govt. Stanley Medical College, OSH Road, Royapuram, **CHENNAI** – 600001 **Mobile:** 09841043213 **Email:** dermanandan@gmail.com
11.	**Dr. A. K. Singh** Plastic Surgeon	Head of Department, Plastic Surgery, King George's Medical College (KGMC), **LUCKNOW**, Uttar Pradesh **Mobile:** 09415006600 **Email:** singhkarun@hotmail.com
12.	**Dr. Ajit Kumar Verma** Orthopaedic Surgeon	Head, Department of Physical Medicine & Rehabilitation, Patna Medical College, **PATNA** – 800 004, Bihar **Mobile:** **Email:** ajitvarma592@yahoo.com
13.	**Dr. Naresh Chandra** Orthopaedic Surgeon	Head, Department of Orthopaedic, Gurugovind Singh Hospital, **DELHI** **Mobile:** 09718387322 **Email:** drnc67@yahoo.co.in
MUNICIPAL CORPORATIONS AND COUNCILS		
14.	**Dr. A. Prabahar*** Medical Officer	O/O Office of the City Health Officer, Corporation office, Town Hall, **COIMBATORE** – 641 001, Tamil Nadu **Mobile:** **Email:** majorprabahar@gmail.com
15.	**Dr. Ramesh Nikam*** Chief Health Officer	O/O Chief Health Officer, Navi Mumbai Municipal Corporation, CIDCO Bhavan, CBD Belapur, Navi Mumbai, Maharashtra **Mobile:** 09322033871 **Email:** healthnmmc@gmail.com
NON-GOVERNMENTAL ORGANIZATIONS		
16.	**Dr. Atul Shah*** Plastic Surgeon & Director	Department of Plastic Surgery, Grant Medical College, JJ Hospital, **MUMBAI** & Novartis Comprehensive Leprosy Care Association, Andheri (W), **MUMBAI** – 400058 **Mobile:** **Email:** clcp@vsnl.com
17.	**Dr. Mohanadas** Medical Superintendent	St. John's Health Services, Pirappancode, **TRIVANDRUM** – 695607, Kerala **Mobile:** **Email:** stjohnshealthservices@gmail.com
18.	**Mr. A. Antony Samy*** Chief executive	ALERT - INDIA, B-9, Mira Mansion, Sion (West), **MUMBAI** – 400022 **Phone:** 022-24033081 **Email:** alert@bom5.vsnl.net.in

19.	**Mr. S. Kingsley*** Coordinator, Epidemiological Monitoring & Evaluation Unit	ALERT-INDIA, Mira Mansion, Sion (West), **MUMBAI**–400022 **Mobile:** 09867256609 **Email:** alertemu@rediffmail.com
20.	**Mr. A. B. Prabhavalkar*** Director, LEAP Partnership	ALERT–INDIA, Mira Mansion, Sion (West), Mumbai -400022 **Mobile:** **Email:** alert@bom5.vsnl.net.in
	ILEP AGENCIES IN INDIA	
21.	**Dr Manimozhi*** Medical Director	Amici Di Raoul Follereau Trust (AIFO), Dharmaram College Post, **BANGALORE** – 560029, Karnataka **Mobile:** 09448466264 **Email:** manimozhi@aifoindia.org / aifo@aifoindia.org
22.	**Dr. Shivakumar*** Secretary	Damien Foundation India Trust (DFIT), Chetput, **CHENNAI** - 600031, Tamil Nadu **Phone:** 044-28360496 / 2836 1910 **Email:** admin@damienfoundation.in
23.	**Dr. P. Vijayakumaran*** Regional Director (South)	German Leprosy and TB Relief Association - India Trust (GLTRA), 4 Gajapathy Street, Shenoy Nagar, **CHENNAI** – 600030, Tamil Nadu **Phone:** 044-26643724/3184/6115/42183747 **Email:** vijay@glraindia.org
24.	**Dr. P. V. Ranganadha Rao*** Chief Executive	LEPRA – Society, PB No-1518, Krishnapuri Colony, West Marredpally, **SECUNDERABAD** – 500 026, Andhra Pradesh **Mobile:** 09000111272 **Email:** ranganadh@leprahealthinaction.in
25.	**Dr. M. A. Arif*** Country Representative and ILEP India Coordinator	Netherlands Leprosy Relief - India, B-38, 1st Floor, Panchsheel Enclave, **NEW DELHI** **Phone:** 011 26498546 **Email:** nlrindia@airtelmail.in
26.	**Dr. Pramila Barkataki*** Coordinator – Public Health	The Leprosy Mission Trust India, TLM Hospital, Naini, **ALLAHABAD**, Uttar Pradesh **Phone:** 011 237169201 **Email:** pramila.barkataki@tlmindia.org
27.	**Mr. John Kurian George** Representative	Swiss Emmaus Leprosy Relief -India, J-17, First floor, South City-1, **GURGAON** - 122001, Haryana **Mobile:** 08826899568 **Email:** john@swissemmausindia.org
28.	**Dr. P. R. Manglani*** Medical Consultant	Netherlands Leprosy Relief - India, B-38, 1st Floor, Panchsheel Enclave, **NEW DELHI** **Mobile:** 09313880476 **Email:** nlrindia@airtelmail.in
29.	**Dr. P. K. Mitra*** Regional Director (East)	German Leprosy and TB Relief Association - India Trust (GLTRA), 274, Rajdanga, Shanti Pally, **KOLKATA** – 700107, West Bengal **Mobile:** **Email:** mitra@glraindia.org

30.	**Dr. Manotosh Elkana** Regional Coordinator	The Leprosy Mission Trust India, I – 15 Phase 1, Shreeram Nagar, Near Doordarshan TV tower, **RAIPUR** -492007, Chhattisgarh **Mobile:** **Email:** manotosh.elkana@tlmindia.org
31.	**Dr. A. K. Mishra*** Medical Consultant	Swiss Emmaus Leprosy Relief -India, J-17, First floor, South City-1, **GURGAON** - 122001, Haryana **Mobile:** **Email:**
32.	**Dr. Sonia Sethi** Coordinator - Delhi	LEPRA – Society, **NEW DELHI** **Mobile:** 09000111272 **Email:** ranganadh@leprahealthinaction.in
	NATIONAL FORUM FOR PEOPLE AFFECTED BY LEPROSY	
33.	**Dr. P. K. Gopal*** President, International Relations	IDEA India, 58, Selvam Nagar, Collectorate P.O. **ERODE** – 638011, Tamil Nadu **Mobile:** 09944467395 **Email:** ideaind@sancharnet.in
		SPECIAL INVITEES
34.	**Dr. Gurmohan Singh*** Consultant Dermatologist	B-34, Brij Enclave Sunderpur, **VARANASI**, Uttar Pradesh Tel: 0542-2316956 **Mobile:** 09651108108 / 09336823000 **Email:** drgurmohan@gmail.com
35.	**Dr (Ms.) Marivic F. Balagon*** Executive Director	Leonard Wood Memorial, Center for TB and Leprosy Research Cebu, **PHILIPPINES** – 6000 Tele/fax: (63) (32) 2311-601 **Mobile:** 09054266489 **Email:** csc_epi@yahoo.com
36.	**Dr. V. Pannikar** Team Leader (Retiree), GLP	Global Leprosy Programme, WHO-SEARO, World Health House, IP Estate, MG Marg, **NEW DELHI** – 110 002 **Mobile:** **Email:** pannikarv@gmail.com
37.	**Dr. P. Krishnamurthy*** Consultant Leprologist	**Mobile:** **Email:**
38.	**Dr. G. Rajan Babu*** Consultant Leprologist	C/O The Schieffelin Institute of Health Research & Training Centre, Karigiri - 632106, (via Katpadi), **VELLORE**, Tamil Nadu **Mobile:** 08903201179 **Email:** rajan.babu@tlmindia.org
39.	**Mr. Awezu Chicako**	The Nippon Foundation, 5th Floor, 1-2-2 Akasaka, Minato-ku, Tokyo, **JAPAN** **Mobile:** **Email:**

	MINISTRY OF HEALTH & FAMILY WELFARE	
40.	**Dr. R. N. Sabat*** Director	Regional Leprosy Training & Research Institute (RLTRI), Lalpur, Post Bag No. 112, **RAIPUR** - 492001, Chhattisgarh **Phone:** 0771-2412792 / 2411427 **Email:** rltri@sify.com
41.	**Dr. C. M. Agrawal*** Deputy Director General (Leprosy)	Directorate General of Health Services, Central Leprosy Division, Room No. 550 'A' Wing, Nirman Bhawan, **NEW DELHI** **Mobile:** **Email:** ddgl@nb.nic.in
42.	**Dr. A. K. Puri*** Assistant Deputy Director General (Leprosy)	Directorate General of Health Services, Central Leprosy Division, Room No. 550 'A' Wing, Nirman Bhawan, **NEW DELHI** **Mobile:** **Email:** ddgl@nb.nic.in
43.	**Dr. B. N. Barkakaty*** National Consultant, NLEP (HQ)	Directorate General of Health Services, Central Leprosy Division, Room No. 740 'A' Wing, Nirman Bhawan, **New Delhi** **Mobile:** **Email:** barkakaty2000@yahoo.com
44.	**Dr. P. K. Pattanayak*** National Consultant (DPMR)	Directorate General of Health Services, Central Leprosy Division, Room No. 740 'A' Wing, Nirman Bhawan, **NEW DELHI** **Mobile:** **Email:** pkp_ph@rediffmail.com
45.	**Dr. T. B. Singh*** National Consultant (Training)	Directorate General of Health Services, Central Leprosy Division, Room No. 740 'A' Wing, Nirman Bhawan, **NEW DELHI** **Mobile:** **Email:** drbhubonth@gmail.com
	WORLD HEALTH ORGANIZATION	
46.	**Dr. Sumana Barua** Team Leader - GLP	Global Leprosy Programme, WHO-SEARO, World Health House, Indraprastha Estate, MG Marg, **NEW DELHI** – 110 002 **Mobile:** 09910699076 **Email:** Baruas@searo.who.int
47.	**Dr. Rui Paulo*** Regional Adviser – WHO SEARO	WHO-SEARO, World Health House, Indraprastha Estate, MG Marg, **NEW DELHI** – 110 002 **Mobile:** 09910699076 **Email:** jesusr@searo.who.int
48.	**Mr. Kamaraj A. Devapitcai*** Consultant - Rehabilitation	WHO Country Office for India, 536, "A" Wing, Nirman Bhawan, Maulana Azad Road, **NEW DELHI** - 110 011 **Mobile:** **Email:** devapitchaik@searo.who.int

49.	**Ms. Edlin Jash***	WHO Country Office for India, 536, "A" Wing, Nirman Bhawan, Maulana Azad Road, **NEW DELHI** - 110 011 **Mobile:** **Email:**
50.	**Dr. Saurabh Jain*** NPO (NLEP)	WHO Country Office for India, 536, "A" Wing, Nirman Bhawan, Maulana Azad Road, **NEW DELHI** - 110 011 **Mobile:** **Email:**
	NLEP STATE CONSULTANT	
51.	**Dr (Mrs) Rashmi Shukla*** NLEP Consultant – UP State	Office of NPSP (Polio), Red Cross Building, Kaiserbagh, **LUCKNOW**, Uttar Pradesh **Mobile:** **Email:** tiwarirashmi14@gmail.com

	SECRETRAIT TEAM (ALERT-INDIA & NLR India)	
52.	**Mr. Rajeev Dudhalkar*** Programme Officer	LEAP (Nashik & Nandurbar), ALERT – INDIA B-9, Mira Mansion, Sion (West), **MUMBAI** - 400022 Mobile: Email: alert@bom5.vsnl.net.in
53.	**Mr. Vincent*** Programme Officer	LEAP (NST), ALERT – INDIA B-9, Mira Mansion, Sion (West), **MUMBAI** - 400022 Mobile: Email: alert@bom5.vsnl.net.in
54.	**Mr. Kamlesh Chavan*** Programme Officer	LEAP (Navi Mumbai), ALERT – INDIA B-9, Mira Mansion, Sion (West), **MUMBAI** - 400022 Mobile: Email: alert@bom5.vsnl.net.in
55.	**Ms. Suneeta Vittal*** Liaison & Information Officer	LEAP – Programme Unit, ALERT – INDIA B-9, Mira Mansion, Sion (West), **MUMBAI** - 400022 Mobile: Email: aiprogrammeunit@gmail.com
56.	**Ms. Janet James*** Management Volunteer	Netherlands Leprosy Relief - India, B-38, 1st Floor, Panchsheel Enclave, **NEW DELHI** Mobile: 09968418230 Email: janet.james1608@gmail.com

** Participated on 21 & 22 September 2012*

Annexure 6

National Consultation meeting on Leprosy Services in Urban Localities

PROGRAMME SCHEDULE

Day 1: 20 September 2012 (Thursday) **Venue**: PGIMER, Auditorium, Dr. RML Hospital, New Delhi

9.30 am	***Registration***		
10.00 am	**Inaugural Session**		
10.00 am	Welcome	:	***Dr. K. S. Baghotia***, State Leprosy Officer, Govt. of NCT Delhi
10.05 am	Address	:	***Mr. A. Antony Samy,*** Chief Executive, ALERT-INDIA Urban leprosy services : concerns and issues -
10.15 am	Address	:	***Dr. Sumana Barua,*** Team Leader, Global Leprosy Program, SEARO-WHO, Defining WHO strategies for elimination of leprosy in urban areas. -
10:25 am	Address	:	***Dr. M. A. Arif,*** ILEP India Coordinator Improving leprosy services in urban localities – ILEP perspective and support
10.30 am	Address	:	***Dr. T. S. Sidhu,*** Director, Post Graduate Institute of Medical Education & Research (PGIMER), Dr. RML Hospital, New Delhi
10:35 am	Address	:	***Dr. N. K. Mohanty,*** Additional Director General of Health Services, Ministry of Health & FW, Govt. of India
10.40 am	Address	:	***Dr. C. M. Agrawal,*** Dy. Director General of Health Services (Leprosy), Ministry of Health & FW, Govt. of India
10.50 am	Inaugural Address	:	***Dr. Jagdish Prasad,*** Director General Health Services, Ministry of Health & FW, Govt. of India
10.55 am	Vote of Thanks	:	***Dr. A. K. Puri,*** Deputy Director General of Health Services (Leprosy), Central Leprosy Division, Ministry of Health & FW, Govt. of India
11.00 am	***Tea break***		
11.30 am	**Session 1**		**Strengthening delivery of leprosy services in urban locations**

Chairman: ***Dr. V. Pannikar*** **Co-Chairman:** ***Dr. A. K. Puri***

11:35 am	**Hoisting issues**	:	TASK BOARDING – Each participant to write four points (2 issues & 2 recommendations) on each of the sticker - Chairman.
11.50am	Dissemination	:	***Dr. P. V. Ranganadha Rao,*** Chief Executive, LEPRA - Rapid Assessment of urban localities
12.05 pm	Presentation 1	:	***Dr. D. R. Rai***, Hon. Secretary General, Indian Medical Association - Involvement of private practitioners in delivering services in urban locations in conformity to the National Leprosy Eradication Programme.

12.20 pm	Dissemination	:	***Dr. K. S. Baghotia,*** State Leprosy Officer, Govt. of NCT, Delhi - Actions initiated by GNCT Delhi on recommendations of Urban leprosy workshop for Delhi held in May 2012
12.35 pm	Presentation 2	:	***Dr. (Prof) H K Kar,*** Head and Consultant, Department of Dermatology, Dr. RML Hospital, Delhi - Role of public and private medical colleges and institutions in delivering leprosy services in urban localities.
12.50 pm	Presentation 3	:	***Dr. Rajan Babu,*** Consultant Leprologist, TLM - Leprosy control in urban settings – review of literature.
1.30 pm			***Lunch Break***
2.30 pm		:	**Group discussion**
	Group I	:	Case Detection & Management in urban localities
	Group II	:	DPMR service delivery in urban localities
	Group III	:	IEC & BCC in urban localities
	Group IV	:	Human resource & Capacity building for delivering services in urban localities
	Group V	:	Program management
5.00 pm-6.00 pm			Finalization of report by each group

Day 2: 21 September 2012 (Friday)

10.00 am	**Leprosy services in urban localities: reports from Groups**		
Chairman:	***Dr. P. Krishnamurthy***	***Co-Chairman:***	***Dr. P. R. Manglani***
10.10 am	Presentation of Group work		
10.45 am	**Tea break**		
11.00 am	Presentation of Group Work continues		
01.30 pm	**Lunch Break**		
02.00 pm	Discussion on group presentation		
03.15 pm	Presentation of recommendations		
04.30 pm	**Concluding session**		
Chairman:	***Dr. C. M. Agrawal***	***Co- Chairman :***	***Dr. M. A. Arif***
Vote of thanks:	***Mr. Antony Samy***		