Managerial Response to the DGD End Term Evaluation Recommendations:

We would like to thank Dr. Diefenhardt for his thorough, meaningful, and deeply human critical view and subsequent advice.

Here we provide a point by point answer to all his recommendations in the final evaluation report. Such recommendations will certainly contribute to the continuous learning that is needed for the continuous improvement of the service we contribute to the people affected by leprosy and TB, as well as their communities.

Some recommendations align with activities that were already started in the current funding cycle, whereas others will contribute to the next funding cycle, adapted to the context, priorities and operational arrangements of the forthcoming programme.

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Main Recommendations:

1. *Strengthen co-operation with SLO expressed in a new MoU with new priorities and continuation of monitoring and training at all levels of the health system.*

Managerial Response:

A new Memorandum of Understanding (MoU) between DFIT and the State Leprosy Office (SLO) for the period 2026–2031 will be formalised in 2026, incorporating the recommended priorities and strategic directions. Under this MoU, DFIT will expand its operations to four additional districts, which will be included as part of the agreement.

The MoU will emphasise continued capacity building through structured training programs for health staff across all levels of the health system, including community, primary, secondary, and tertiary levels.

Out of the existing 28 districts, DFIT will directly implement disability prevention and medical rehabilitation activities in the selected districts as per the assessment. These efforts will include targeted interventions to further strengthen the referral system and improve service delivery.

The remaining intervention districts will not be part of the core implementation plan; however, sustainability will be ensured through annual training of district-level Nodal Persons (NPs), including Physiotherapists (PTs), Paramedical Workers (PMWs), and General Health Staff (GHS). Additionally, these districts will continue to receive technical and programmatic support for National Leprosy Eradication Programme (NLEP) activities, as and when requested by the State Leprosy Office.

2. *Expand into all districts in Bihar State with the "3 pillar concept" of DF for leprosy management to establish a common standard.*

Managerial Response:

DFIT is committed to progressively expanding its operations across Bihar in alignment with the “three-pillar concept” for leprosy management, with the aim of establishing an efficient functioning referral system and standardised practices across districts. Currently, DFIT is implementing activities in 28 out of 38 districts. From 2027 onwards, DFIT plans to expand its coverage to four additional districts, which will be incorporated under the forthcoming MoU. Expansion to all remaining districts is not feasible at this stage due to budgetary constraints. Furthermore, several districts are already supported by other ILEP partners with limited interventions; therefore, to ensure optimal utilisation of resources, a strategic decision has been made to prioritise expansion into four new districts where gaps in services are identified.
This phased approach will allow DFIT to maintain quality implementation while gradually moving toward broader state-wide coverage.

3. *Pursue a twin-track approach by reducing gradually and consolidating the support in 28 districts where a good referral system has been established.*

Managerial Response:
DFIT will adopt a phased twin-track strategy aimed at gradually consolidating its efforts in the 28 existing districts where functional referral systems have already been established. Under this approach, more focused implementation for disability prevention and medical rehabilitation will be continued in some selected intervention priority districts based on assessment, with a focus on further strengthening referral linkages and enhancing the quality of service delivery.
In the remaining intervention districts, DFIT will transition from direct implementation to a sustainability-focused support model. This will include periodic capacity-building initiatives, such as annual training for district-level Nodal Persons (NPs), including Physiotherapists (PTs), Paramedical Workers (PMWs), and General Health Staff (GHS). In addition, these districts will receive ongoing technical guidance and programmatic assistance for National Leprosy Eradication Programme (NLEP) activities, based on requirements communicated by the State Leprosy Office.

4. *Continue pilots (NSP) in ACF, considering identifying hotspots via vulnerability GIS-led mapping as well as areas in high-burden communities (with “officially” low ANCDR). Consider – more innovative pilots – to promote and establish an incentive-based system for each confirmed patient or patients with complications referred from the informal health sector to a PLRC/SLRC (in accordance with the authorities and linkage with ASHA and PLRC)*

Managerial Response:
Pilot initiatives on Active Case Finding (ACF) will continue to be recognised as an important strategic area. DFIT will explore the implementation of such pilots in selected high-burden and vulnerable communities through alternative funding sources, including Corporate Social Responsibility (CSR) support. Particular emphasis will be placed on identifying hotspots through vulnerability-based approaches and field evidence. Learnings from the ongoing ACF interventions in Musahar communities will be systematically documented and presented to health authorities, as well as shared with potential donors to facilitate replication and

scale-up.
Concerning promoting an incentive-based referral mechanism from the informal and private health sector to PLRCs/SLRCs, in the current phase of the operational research conducted in Saran district, DFIT has focused on engaging private practitioners through regular sensitisation and one-to-one interactions to improve referral of suspected cases into the formal health system. The findings will be presented to government authorities to support advocacy for structured integration of private providers within the National Leprosy Eradication Programme (NLEP).
While recognising the potential value of incentive-based systems, it is noted that there are currently no formal provisions for financial incentives to private practitioners under existing NLEP guidelines. DFIT will therefore continue to advocate for strengthening the referral linkages in alignment with government frameworks.

5. *Define future strategies and/or handover of Darbhanga Referral Laboratory and TLRC in Rohtas in the next 5 years to come.*

Managerial Response:
DFIT will adopt a phased and strategic approach over the next five years to define the future direction and potential handover of the Darbhanga Referral Laboratory and the TLRC in Rohtas, with a strong focus on long-term sustainability within the government health system despite a context of reducing external funding. This approach will explicitly address the challenges of sustaining quality services, including infrastructure maintenance, operational continuity, and resource mobilization, while reinforcing the shared responsibility of both DFIT and government health authorities to ensure services are delivered through adequately maintained and properly functioning facilities.

Tertiary Care Services:

The management of leprosy complications including reconstructive surgery (RCS) for deformities, recurrent lepra reactions, and chronic ulcers remains a critical gap in Bihar, a large and densely populated state where geographical distance and limited accessibility significantly restrict timely access to specialized care. Currently, only two centres in the state provide these essential services, including one established by DFIT in 2013, which is far from sufficient to meet the needs of the widely dispersed affected population. Moving forward, DFIT will prioritise strengthening tertiary care services through strategic collaboration with government medical colleges and district hospitals to expand both geographic coverage and service capacity. Previous efforts to establish such services at Vardhman Institute of Medical Sciences (Nalanda) and Little Flower Hospital (East Champaran), as well as initiatives to train district-level surgeons, have not yet achieved the desired outcomes. Nevertheless, DFIT will continue to actively pursue opportunities to strengthen public health system capacity for complication management and RCS, with the aim of improving equitable access and ensuring long-term sustainability.

Laboratory Services:

Laboratory capacity for DRTB diagnosis in Bihar remains limited, with only four

reference laboratories serving a large population, including the DF-supported BSL-3 laboratory established in 2014. Challenges such as frequent service disruptions in National TB Elimination Programme (NTEP) laboratories due to maintenance and infrastructure issues further highlight the critical role of DFIT-supported laboratory services. Over the next five years, DFIT will work towards strengthening government ownership and operational capacity of these facilities. DFIT will continue to engage closely with government stakeholders to gradually transition both tertiary care and laboratory services into the public health system.

6. *Include and confirm the contribution of other ILEP members in a 5–10-year strategy in Bihar State.*

Managerial Response:

All ILEP partners operating in Bihar have clearly defined roles, responsibilities, and strategic priorities that guide the implementation of their respective programme activities as per the MoU signed. DFIT plays an active and important role within this coordinated ILEP network, contributing both technical expertise and operational experience while supporting strategic planning, service delivery, and system strengthening efforts. There is strong coordination and collaboration between the State National Leprosy Eradication Programme (NLEP) and ILEP organisations, with DFIT serving as a key partner in facilitating alignment of interventions, optimal resource utilisation, knowledge sharing, and avoidance of duplication. This collaborative framework enhances effective programme delivery and significantly contributes to strengthening leprosy control and rehabilitation initiatives across Bihar.

7. *Add another 2 (or more) districts in the catchment area of Darbhanga Referral Laboratory for DR-TB control.*

Managerial Response:

At present, the Darbhanga Referral Laboratory supports nine districts in Bihar, utilizing its existing infrastructure and human resources. Any further expansion of its catchment area could be done based on requests and guidance from the State National TB Elimination Programme (NTEP). DFIT remains open to extending support to additional districts, subject to feasibility and alignment with state program priorities.

Leprosy:

8. ***DF-SLO co-operation approach in future***

Design a new MoU with SLO:

8.1. Get authorization from the SLO office about implementing the 3-pillar model of DF in 10 remaining Districts (rationale: avoid double standards and implement best practice)

Managerial Response:

Kindly refer to response number 2. (Above)

8.2. Lobby for getting a Nodal person at the PLRC level and a PT (or similar) at the SLRC level.

Managerial Response:
At the time of implementation in 2022, the State Health Society recruited 34 physiotherapists at the district level under NLEP. DFIT strategically identified and trained one nodal person (NMA/PMW/GHS) along with one physiotherapist at each secondary-level referral centre (SLRC/district level), which proved effective in establishing a functional referral system for complication management and rehabilitation services.
In subsequent years, turnover among physiotherapists due to transfers or vacant positions, as well as the retirement of NMAs, created operational challenges for SLRCs. DFIT responded proactively, in close coordination with district authorities, by identifying and training replacement nodal persons to maintain continuity of services.
At the Primary-Level Referral Centre (PLRC) level, the feasibility of sustaining dedicated nodal persons in each facility remains an important consideration. In response, the new DGD project places specific emphasis on targeted training to strengthen human resource capacity at this level and improve long-term functionality of the referral network.
Simultaneously, DFIT undertook sustained advocacy at multiple levels, including with the State Health Society and the Central Leprosy Division, which successfully facilitated the reposting of physiotherapists who had been transferred to other departments back under NLEP. While DFIT continues to advocate for strengthened staffing, the recruitment and rehiring of vacant government positions remain under the authority of the State Health Society, where recruitment processes have not yet been reopened.

8.3. Use the concept of GIS mapping and get approval of vulnerability mapping and consecutive intensified ACF in ….
- *either hotspot areas with a high number of cases (with possible underdetection) or*
- *Mahadalit areas where there is under detection and underreporting (only low figures) or*
- *other criteria why to investigate further in each „hotspot "– always children reported or Child G2D, etc.*

Managerial Response:
Initiatives on Active Case Finding (ACF) using GIS mapping will continue to be recognised as an important strategic area. DFIT will explore the implementation of such pilots in selected high-burden and vulnerable communities through alternative funding sources, including Corporate Social Responsibility (CSR) support. Particular emphasis will be placed on identifying hotspots through vulnerability-based approaches and field evidence. Learnings from the ongoing ACF interventions in Mahadalit (Musahar communities) or where children reported with G2D will be systematically documented and presented to health authorities, as well as shared with potential donors to facilitate replication and scale-up.

8.4. Lobby for being able to do SSS in (all or some selected) District Labs (workload appr. 350 in one year – 8-12 slides per district per year).

Managerial Response:
Advocacy will be undertaken at the state level to enable selected district laboratories to conduct SSS under NLEP. Efforts will focus on training NTEP

laboratory technicians to perform SSS at the district level. DFIT will actively support this initiative by providing qualified resource persons for capacity-building and training activities.

8.5. Get reassurance in the MoU by mentioning your relevant contribution to training (at different levels).

Managerial Response:
In the new MoU, DFIT's relevant contributions to training across different cadres and levels will be clearly defined and documented.

8.6. Try to convince SLO to replace NMA 's (non-medical assistants) with other cadres that could support in future (among others) registration, monitoring and management of leprosy cases.

Managerial Response:
DFIT has consistently identified and designated paramedical workers or suitable nodal persons from the general health staff in situations where NMAs have retired or are nearing retirement. This process has been carried out in close coordination with district and state authorities to ensure continuity in registration, monitoring, and management of leprosy cases. Regular advocacy will continue with the State Leprosy Office to promote the replacement of NMAs with appropriate cadres for sustained program support.

8.7. Current gaps in case management of leprosy (esp. Reactions, RCS) to discuss openly with SLO on the ground of existing data (in intervention and non-intervention districts)

Managerial Response:
In Bihar, we regularly conduct NLEP state coordination meetings under the chairmanship of the State Leprosy Officer (SLO), with participation from ILEP partners and WHO. During these meetings, we review program progress and discuss key challenges, including gaps in leprosy case management—particularly leprosy reactions and RCS. These issues are already part of ongoing discussions, and moving forward, greater emphasis will be placed on district-wise analysis and targeted deliberations to strengthen case management and improve outcomes.

9. DF Conceptual approach in future:

9.1. Reduce gradually the frequency of monitoring/training inputs in 28 existing districts and increase gradually within 5 years the DF leprosy concept to all remaining districts. Still maintain a minimum (monitoring/training, etc.) support for the remaining "old "districts.

Managerial Response:
Kindly refer to the responses 2 & 3 (Above).

9.2. Consider finding an alternative site to do RCS during or after the next project. Period (backlog for RCS cases is in 5 yrs almost over) – this issue should also be discussed with TLMI in Muzaffarpur.

Managerial Response:
Kindly refer to response 5 (Above).

9.3. *Identify a rational way to set priorities in intensified case detection – examples:*
   - *Focus on 9/28 districts where the Musahar community is above 15% (health camps with ASHA and referral to PLRC) and where blocks/villages are suspected to have low reporting and low detection*
   - *Focus on 14/28 districts where ANCDR is above 10 and where you might suspect still more undetected cases*
   - *continue as a pilot training private practitioners (formal/informal) in a hotspot area or among vulnerable communities (as they play a relevant role in the system) – like in the blocks in Supaul and Saran (up to 10% more patients)*
   - *think about implementing a mixture of survey and health camp approach in 2-3 districts, etc. (get information about methods and costs from LEPRA, on how they did it) – involvement of ASHA is mandatory*

Managerial Response:

Active Case Finding (ACF) will continue to be prioritised as a key strategic intervention. These interventions are more labour intensive also requires huge resources including HR. DFIT will explore the implementation of targeted pilot approaches in selected high-burden districts and vulnerable communities, leveraging alternative funding sources such as Corporate Social Responsibility (CSR) support. Particular emphasis will be placed on districts with a high proportion of Musahar populations, elevated ANCDR, and areas with suspected under-reporting and low detection.

Efforts will also include engaging private practitioners (both formal and informal) within the limited resources that DFIT will have in the future, given their important role in the healthcare system, especially in identified hotspot areas. Additionally, a mixed approach combining survey and health camp models—currently being implemented by DFIT in districts like Supaul and Araria—will be further refined and scaled in future interventions. Active involvement of ASHAs will remain integral to all such initiatives to ensure effective community outreach and referral.

9.4. *Improve the cost-effectiveness of LCDC if acceptable to the government (include anaemia, malaria, TB, leprosy, filariasis MDA, maternal health), if possible; if not possible, propose 2x/yr LCDC with approval from SLO in hotspot areas and a better cost-benefit ratio.*

Managerial Response:

Decisions on integrating LCDC with other health programs or modifying the duration and frequency of LCDC cycles are taken at the government level. These suggestions have already been shared with both the State and Central Leprosy Divisions, and we will continue to provide evidence-based inputs and advocacy to strengthen the effectiveness and efficiency of LCDC implementation.

9.5. *More emphasis on working with dermatologists, orthopaedic surgeons, etc., especially in urban hotspots (negative examples seen in Begusarai and Samastipur)*

Managerial Response:
Engaging private specialists, such as dermatologists and orthopaedic surgeons, within the NLEP framework remains a persistent challenge, reflecting broader systemic difficulties in strengthening public–private healthcare collaboration in India that extend beyond DFIT's direct scope and capacities. While establishing large-scale structural incentives may be difficult, DFIT continues to explore practical and feasible approaches to improve specialist engagement, particularly in urban settings. These include supporting districts to engage professional platforms such as the Indian Medical Association (IMA) and other relevant medical associations in Bihar, using professional gatherings as opportunities for sensitisation, technical training, and dissemination of programme objectives, referral pathways, and case management protocols.
DFIT also facilitates referrals to private practitioners for cases that cannot be adequately managed within government facilities, helping to ensure continuity of patient care. However, significant gaps remain in developing clear, systematic, and sustainable referral linkages with private super-specialists. As an important and achievable next step, DFIT will also explore operational research opportunities to better understand and quantify the role of private healthcare providers in key programme indicators, such as case notification rates, diagnostic delays, and patient versus system-related barriers. Such evidence could inform more targeted strategies for future public–private collaboration in leprosy care.

Recently, Leprosy has been made a notifiable disease by the Ministry of Health, which means all states are required to ensure mandatory reporting of cases. This will help in understanding the actual number of cases reported from the private sector and strengthen disease monitoring and control efforts.
However, Bihar has not yet declared Leprosy as a notifiable disease. DFIT will carry out advocacy at the state level to support and encourage the Government of Bihar to implement this notification.

10. Share key issues (data, projects, forms) with ILEP, SLO and National Health Mission Director:

10.1. Disseminate data on the usefulness and impact of LCDC with disease patterns that are relevant to curb transmission, reduce disease burden, reduce disability, and promote equity, etc.

Managerial Response:
It has been shared regularly during the State review meetings.

10.2. Disseminate data on gaps in case management of leprosy to discuss openly within ILEP (esp. Reactions, RCS), SLO and the National Health Mission Director proposing to introduce the 3-pillar approach everywhere.

Managerial Response:
In Bihar, NLEP state coordination meetings are regularly conducted under the chairmanship of the State Leprosy Officer (SLO), with participation from ILEP partners and WHO. These forums are actively used to review program progress and openly discuss key gaps in leprosy case management, particularly related to leprosy reactions and RCS. Moving forward, greater emphasis will be placed on systematic dissemination of such data, along with district-wise analysis and

targeted discussions involving the SLO and State Health Society.
While the DFIT 3-pillar approach has shown value, its uniform implementation across all 38 districts in Bihar may not be feasible, as all districts are supported by various ILEP partners with their own established operational models. To avoid duplication and ensure complementarity, any scale-up will require careful strategic alignment and coordination.
DFIT has already expanded its activities into five additional districts during the 2020–26 phase (in LEPRA-supported areas) and plans further expansion into four new districts during the 2026–31 phase. Wherever feasible, the 3-pillar approach will be implemented in close coordination with the State Health Society and ILEP partners to ensure synergy, optimal resource utilisation, and strengthened program impact.

10.3. Continue with standard IEC/training material, established for different cadres, proposing frequency, including key records/register/reporting – (avoid double standards)

Managerial Response:
It will be continued in our next phase from 2026 to 31.

10.4. Cooperate in districts with LEPRA on patient care

Managerial Response:
Collaboration with LEPRA on patient care is already being actively implemented. DFIT has expanded its activities into five additional districts during the 2020–26 phase in LEPRA-supported areas, ensuring coordinated efforts and avoiding duplication. Further expansion into four new districts is planned for the 2026–31 phase. This partnership approach will continue to be strengthened to improve patient care outcomes through effective coordination and resource sharing.

10.5. SLO has agreed to print Patient Tx Cards, Master Registers and Stock Registers.

Managerial Response:
Advocacy and regular follow-up will be done to ensure that Patient Tx Cards, Master Registers and Stock Registers are printed at the state level and distributed to all the districts.

10.6. Lobby with GVT to include Clofazimine in PB Tx blisters (expected fewer reactions)

Managerial Response:
Advocacy will be done at the State and the Central Leprosy Division level.

11. DF- internal project indicators and procedures:

11.1. Always use project indicators where you do not strongly depend on the input of government or any other stakeholder (2 indicators in the current project, e.g. 1.4 Nikusth and 1.5, which depend strongly on the partner or are beyond control, and you may loose credibility in front of the donor if you do not meet results).

Managerial Response:
DFIT acknowledges the importance of designing project indicators that more

accurately reflect areas directly influenced by our interventions, thereby reducing excessive dependence on government systems or external stakeholders for the achievement of results. In the next phase (2026–31), DFIT will carefully review and incorporate recommended indicators that better capture programme-driven outputs, particularly those linked to DFIT's direct contributions such as training, capacity building, service quality improvement, referral system strengthening, proportion of patients receiving complete screening for disabilities or health worker capacity improvements. This approach will strengthen accountability, improve result measurement and ensure that programme performance is more realistically aligned with DFIT's sphere of influence.

11.2. Consider an indicator that portrays well the functioning referral system, e.g. No. of referrals by PLRC's to SLRC versus No. of feedback forms filled from SLRC to PLRC's (then express a valid % indicator).

Managerial Response:
It will be implemented in the next phase.

11.3. In case the SLRC are not sending a feedback form back to PLRC, they could still fill a feedback form in their SLRC unit and put a remark on that form with a telephone number that the PLRC unit has been informed (in case, for example, a suspect was sent and then the diagnosis was something else, not leprosy.

Managerial Response:
This practice is already being implemented at all levels—primary, secondary, and tertiary care facilities. Feedback and referral forms are routinely used, and in cases where direct return of forms from SLRC to PLRC is not feasible, the SLRC unit records the feedback at its level with necessary remarks, including contact details confirming that the PLRC has been informed.

11.4. Improve filing of referral and feedback forms (No. to be entered on referral form, and that number should also appear on Feedback Form)

Managerial Response:
It will be taken into consideration.

11.5. Stock reports for MDT and loose drugs to be improved in some units (drug stock, e.g. in TLRC Dehri on Sone, Mahua PLRC/Vaishali)

Managerial Response:
DFIT recognises that timely stock reporting for MDT and loose drugs is a critical component of programme quality, particularly in centres under the project coverage such as TLRC Dehri-on-Sone and supported PLRCs including Mahua in Vaishali. In the next phase, DFIT will place stronger emphasis on improving drug inventory management systems through enhanced supervision, regular stock audits, standardised reporting mechanisms, and strengthened accountability at facility level.
Specific corrective measures will include refresher training for relevant staff on

stock management protocols, closer monitoring of stock registers and reporting accuracy, periodic verification during supervisory visits, and improved forecasting to prevent stock discrepancies or interruptions.

11.6. Register: improve on HH and contact screening registers as well as follow up of HH screening for 3 or 5 yrs of index case (PB/MB) by ASHA

11.7. Household registers with the SDR/PEP register and follow-up data

Managerial Response:

Regular advocacy will be done with the health staff at the primary health centre, focusing on ASHAs and CHOs. For SDR/PEP see the response to recommendation 11.9. This is also interdependent with recommendation 11.5.

11.8. Follow-up of RCS for 2 years by TLRC and 3 years by SLRC.

Managerial Response:

The recommendation has been implemented across all 28 DFIT-supported districts. Regular follow-up of Reconstructive Surgery (RCS) beneficiaries is being undertaken by DFIT field teams in coordination with designated nodal persons at the TLRC and SLRC levels. In addition to tracking follow-up visits, DFIT is strengthening monitoring by documenting key outcome indicators such as the number of eligible persons identified, the number receiving RCS, post-surgical functional improvement, and adherence to the recommended follow-up schedule. These indicators will help assess the effectiveness of the intervention and guide program improvements. The new DGD proposal also includes tracking the proportion of identified eligible persons who successfully receive RCS services.

11.9. Application of SDR PEP prophylaxis – more systematic.

Managerial Response:

DFIT recognises the importance of ensuring a more systematic application of SDR-PEP prophylaxis as a key preventive strategy within leprosy control efforts. While regular advocacy has been undertaken at the State level to promote wider and more consistent implementation, a major operational limitation remains the procurement and availability of rifampicin for SDR administration.

In the next phase, DFIT will therefore strengthen its strategic approach by advocacy, improved forecasting of rifampicin requirements, DFIT will also continue to support training, operational planning (integrated with HH activities), and monitoring systems to improve the systematic identification of eligible contacts and effective delivery of prophylaxis.

11.10. Screening for co-morbidities (diabetes, hypertension, anemia, worm infestation, TB)

Managerial Response:

Regularly done at the SLRC level for the leprosy patients as per the requirements.

11.11. Transport allowance paid to PAL: Transport to RCS for patients (there is an element of positive discrimination if everything is given free for PAL. They receive partly higher

pensions than other disabled persons – decision to be taken/confirmed within DF).

Managerial Response:

Transport assistance for RCS patients is being provided to support the patients, as this has been particularly important for financially vulnerable patients and those with severe disability who may otherwise face difficulties in accessing care. It is also noted that disability pensions are not always received immediately, as the process involves multiple administrative steps before initiation. The transportation allowance will be continued in the next phase also.

11.12. Implement key elements of NSP as indicated (see page 29).

Managerial Response:

DFIT acknowledges that the full implementation of the National Strategic Plan (NSP) 2023–2027 is primarily the responsibility of the National Leprosy Eradication Programme (NLEP) and government health systems. Within the context of limited project resources, DFIT's role is to strategically prioritise and strengthen those NSP components that remain insufficiently covered (essential gaps) and where its technical and operational support can add the greatest value. While certain highly resource-intensive components, such as antimicrobial resistance (AMR) surveillance for leprosy, are currently beyond the feasible scope of DFIT-supported interventions, many other NSP priorities can be strengthened through targeted programme support. Accordingly, DFIT will continue to focus on improving implementation of key NSP elements that are not always consistently operationalised at PLRC/SLRC levels or sufficiently facilitated by programme staff. Priority areas include strengthening household and contact screening with appropriate follow-up schedules, supporting five-year post-treatment follow-up of index cases, improving systematic application of SDR-PEP prophylaxis, enhancing screening for relevant comorbidities (such as diabetes, hypertension, anaemia, worm infestation, and TB), supporting vulnerability mapping linked with active case finding initiatives, improving maintenance of suspect and household registers including SDR/PEP documentation, and strengthening stock management systems for MDT and loose drugs. Through regular training, supportive supervision, monitoring, and sustained advocacy with State and Central authorities, DFIT will continue to build health system capacity to improve practical implementation of these prioritised NSP components.

Tuberculosis:

12. *DF reached good Tx adherence rate of almost 75% in MDR/XDR multi- and extensively drug-resistant TB) cases (gov figures reflect Tx success rate of 40-45% for MDR and 38-40% for XDR TB in Bihar). Adherence rate and success rate should be similar or comparable over time but do not refer exactly to the same cohort. Decision to be taken if process indicator or Tx success indicator to be chosen.*
13. *In a new project, it may be better to distinguish between cohorts of MDR TB and XDR TB in terms of outcomes (make **2 indicators in future**) – for adherence and/or Tx success. For comparative reasons, you might consider Tsing the same indicator as government (Tx success rate)*

14. *The added value of DF and relevance for patients is so evident through the indicators (and patients' stories) that it would be deplorable not to continue and even expand this support.*

Managerial Response:

From the 2026–31 phase, DFIT is planning to gradually withdraw field-level support for DR-TB treatment initiation and adherence activities due to severe resource constraints. It is also observed that, with the existing resources and strengthened capacity within the National TB Elimination Programme (NTEP), these indicators can be effectively improved by government staff. However, DFIT acknowledges the importance of clearly distinguishing outcomes for MDR-TB and XDR-TB cohorts in future programming, including separate indicators for adherence and/or treatment success where feasible. The relevance and value of DFIT support for patients have been clearly demonstrated through improved adherence. Therefore, the transition strategy will be carefully discussed with stakeholders to ensure continuity of care and avoid any disruption in patient support systems.

15. *SSS smears should be done in SLRC hospitals (with good experience or as you have organized zones in Bihar, maybe 3 or 4 zonal Labs could be doing the SSS at District Level).*

Managerial Response:

SSS is already planned at the SLRC levels, and advocacy will be undertaken at the state level to enable selected district laboratories to conduct SSS under NLEP (see also recommendation 8.4). Efforts will focus on training NTEP laboratory technicians to perform SSS at the district level, and ensuring the supplies needed. DFIT will actively support this initiative by providing qualified resource persons for capacity-building and training activities.

16. *As Darbhanga Referral Lab has a catchment area of 9 districts, it would be plausible to expand the DRTB project part gradually from the current 5 districts towards these 9 districts in future project periods to come. Especially if there are districts where DF works already. (e.g. Samastipur, Sheohar, Sitamarhi, Muzaffarpur). This is also given the fact that the benefit for the patients, according to indicators, is relevant and significant.*

Managerial Response:

From the 2026–31 phase, DFIT is planning to gradually withdraw field-level support for DR-TB treatment initiation and adherence activities due to severe resource constraints. It is also observed that, with the existing resources and strengthened capacity within the National TB Elimination Programme (NTEP), these indicators can be effectively improved by government staff.

LEP Program:

17. *Consider providing LEP projects with women, as 50% of beneficiaries (if not, give a good reason in the report why more men are chosen).*

Managerial Response:

DFIT has consistently prioritised gender equity across its interventions, including RCS and LEP programmes, and has made efforts to ensure women beneficiaries are included under LEP support wherever feasible. However, in certain field-level contexts, particularly in Bihar, achieving an exact 50% gender distribution has not always been possible due to prevailing socio-economic and contextual barriers. These include men often being the primary household earners, variable family support for women's participation, differences in educational attainment, social mobility constraints, and the practical willingness or feasibility of women beneficiaries to engage in livelihood activities.

Recognising these challenges, DFIT remains committed to strengthening gender-responsive programming during the new DGD implementation period (2027–2031). Special efforts will be made to increase the identification, enrolment, and support of eligible women beneficiaries under LEP interventions. In addition, sex-disaggregated indicators will be incorporated into programme monitoring systems to systematically track participation, livelihood outcomes, and sustainability of supported enterprises for both women and men. Analysis of these outcomes will enable DFIT to assess whether there are gender-related differences in the success and sustainability of livelihood interventions and to use this evidence to further strengthen programme design and beneficiary selection strategies.

18. *LEP is a chance desired to facilitate commitment: to increase commitment and perception of the value of this chance, you might consider signing an MoU with the beneficiary with 2 or 3 key expectations/milestones (even if such an MoU does not have a legal value).*

Managerial Response:
It will be implemented in the next phase

19. *Link successful LEP projects with a new peer PAL who is considered to become a beneficiary or who has challenges during his new business.*

Managerial Response:
This practice is already being implemented at the field level. DFIT coordinators and community social workers actively facilitate linkages between successful LEP beneficiaries and new or prospective PALs, particularly those who may be facing challenges in establishing or sustaining their livelihood activities.

20. *Consider a second indicator – not only availing a new LEP shows the quality of this intervention, but the % of successful LEP's after 6 or 12 months (if you get above 70%, this would be a very good achievement) – for the many groceries "the value of the inventory and cash/bank" could be easy indicators to obtain after 6, 12, 18 and 24 months for example.*

Managerial Response:
DFIT already undertakes regular follow-up of LEP beneficiaries at 6- and 12-month intervals, along with longer-term monitoring as part of ongoing program activities. These follow-ups help assess the sustainability and effectiveness of the livelihood support provided. Annual reports are generated based on these reviews

to capture the success and failure rates of LEP interventions.
DFIT will explore strengthening the monitoring framework in future phases to better reflect the long-term success and sustainability of LEP support.

21. Pay the LEP support given in 2 instalments to avoid total failure.
Managerial Response:
It has already been implemented in the current phase.

Tertiary CENTRES IN ROHTAS AND DARBHANGA

22. Darbhanga Referral Laboratory:

22.1. SSS smears should not be done in a Referral Laboratory (ZN – Ziehl Neelsen stain is available at the District level)
Managerial Response:
Advocacy will be undertaken at the state level to enable selected district laboratories to conduct SSS under NLEP (recommendations 8.4 and 15). Efforts will focus on training NTEP laboratory technicians to perform SSS at the district level. DFIT will actively support this initiative by providing qualified resource persons for capacity-building and training activities.

22.2. Very poor infrastructure.
Managerial Response:
Maintenance and improvement of infrastructure primarily lie with the Government and the respective State/District authorities. DFIT operates its laboratory within government-provided facilities and therefore has limited direct control over infrastructure renovation or upgrades.
However, DFIT regularly undertakes advocacy at both the State and District levels to highlight infrastructure gaps and to request necessary improvements for better service delivery. These efforts will continue to ensure that infrastructure-related issues are appropriately addressed through the relevant government mechanisms.

22.3. DF implements Ref Lab on behalf of government, support from Gov on cartridges is good but lack of sundries and consumables, acquisition and maintenance of highly specialized equipment remain an administrative and financial burden for DF
22.4. Considering the funding situation of DF, the next project period could be used to define a 5-10 yr (handover) strategy together with government for Darbhanga (exit?). The Referral Lab is a government responsibility. The current building is in a deplorable state and requires huge renovation costs or should be built completely new. DF as implementor has of course capacity and competence to support the government but ideally should not shoulder government tasks.
22.5. The relevance of DF is more to be seen as a facilitator in (future) projects where it can successfully fill gaps left by government, improving patient management. DF‘s core competence is expertise, not running non-self-reliable expensive institutions bearing the costly administrative responsibility for buildings, premises, equipment, key consumables of a Referral Laboratory

etc. Years ago, this step has begun by handing over the ownership of the premises of Dehri and Darbhanga officially to government.

Managerial Response:

See recommendation 5: Laboratory capacity for DRTB diagnosis in Bihar remains limited, with only four reference laboratories serving a large population, including the DF-supported BSL-3 laboratory established in 2014. Challenges such as frequent service disruptions in National TB Elimination Programme (NTEP) laboratories due to maintenance and infrastructure issues further highlight the critical role of DFIT-supported laboratory services. Over the next five years, DFIT will work towards strengthening government ownership and operational capacity of these facilities.

DFIT will continue to engage closely with government stakeholders to gradually transition laboratory services into the public health system.

23. <u>TLRC Rohtas/Dehri on Sone:</u>

23.1. Currently, the TLRC in Rohtas is underutilized[52] with a BoR (bed occupancy rate) of 45- 50%, not cost-effective (1 RCS costs around 500 € - 2x more than in TLMI hospitals) and premises and buildings are in a deplorable shape. For the time of operating the backlog of RCS for disabled patients for the next 5 years, it might make sense to keep this premise for surgery, but eventually, cases are going down (less than expected 50 RCS/yr after 5 years). Currently, 80 RCS can be done in a year.

In summary:

23.2. SSS smears and other services reaction care, ulcer care etc. should be done in SLRC hospitals (with good experience).

23.3. RCS is needed in Bihar State in 5 years under 100 NC per year. TLMI hospital, Muzaffarpur, offers free RCS and is otherwise self-sufficient

23.4. Looking at reported funding situation an exit strategy should be considered in the next 5 years

Managerial Response:

DFIT will adopt a phased and strategic approach over the next five years to define the future direction of the TLRC in Rohtas. Indeed, the government commitment to the maintenance of the infrastructures is a key element for the sustainability of the project and will be taken into account when considering the potential options suggested by the reviewer:

1. Continue as it is (sustainability problem)
2. Potential handover, with a strong focus on sustainability within the government health system.
3. Phase out and decide to continue working with other partners or
4. complete transfer of the RCS capacities.

The management of severe leprosy complications—such as reconstructive surgery (RCS) for deformities, recurrent lepra reactions, and chronic ulcers—continues to be a significant gap in Bihar. Currently, only two centres in the state provide such specialised services, including one established by DFIT in 2013, which is insufficient to meet the existing demand. Moving forward, DFIT will

prioritise strengthening tertiary care services through collaboration with government medical colleges and district hospitals. Previous efforts to establish such services at Vardhman Institute of Medical Sciences (Nalanda) and Little Flower Hospital (East Champaran), as well as initiatives to train district-level surgeons, have not yet yielded the desired outcomes. However, DFIT will continue to explore and pursue opportunities to build capacity for complication management and RCS within the public health system to ensure long-term sustainability.

DFIT will continue to engage closely with government stakeholders to gradually transition tertiary care into the public health system.