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Dr. Claire Vellut, Founder-DFIT receiving the International Gandhi Award 2011,
from His Excellency Dr. Hamid Ansari, Vice president of India.

Activity Report 2012

DAMIEN FOUNDATION INDIA TRUST

Farewell to our beloved leader of DFIT

Dr. Padabettu Krishnamurthy started his illustrious career in the year 1977 as Medical Officer in Central Government Health Scheme. He embarked on his career in leprosy as Assistant Director and later became Deputy Director (epidemiology) at Central Leprosy Training and Research Institute, Chengalpet over a period of twelve years and has published many research studies on leprosy during his tenure. He joined Damien foundation India Trust as an Epidemiologist in 1994. He became the secretary of DFIT in 1996. He was instrumental in transforming the project oriented organization into a Government support organisation and made it a valued partner of the government. He developed a compassionate workforce and made it an important asset for the organization. He worked tirelessly to bring changes in the lives of people affected by leprosy and TB. He pioneered the idea of placing technical support teams at district level to support leprosy and TB control program in Bihar and other places in South India. He developed new strategies for involvement of local NGOs to improve community participation. He encouraged the establishment of referral centers for managing leprosy. He was keen in developing the younger generation of staff in DFIT and encouraged innovative ideas. He is a voracious reader and well known for his writing skills. Apart from his professional excellence, he is an excellent person, a mentor and a person with good sense of humor.

He also served as ILEP coordinator between 2008 and 2010. He was the member of ILEP technical commission from 2004 to 2007. He is a member of WHO Technical Advisory Group for leprosy and a member of Technical Resource Group for leprosy, Govt. of India. After his retirement as Secretary, he continues to guide DFIT as President of the trust.

Dr. Krishnamurthy is married to Mrs. Padmini Krishnamurthy and blessed with two daughters Smitha and Shruthi.

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DFIT Activity Report – 2012

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Foreword

I am pleased to present the DFIT Activity Report 2012. This Activity report provides a summary of our activities with significant highlights and a general overview of its projects and their achievements. DFIT achieved significant progress in implementing new strategies in the projects. The quality changes in the program are a testimony to the dedication of our team. I am very proud and grateful for their efforts.

Dr. P. Krishnamurthy, after his superannuation has kindly accepted the responsibility to head DFIT as President of the Trust.

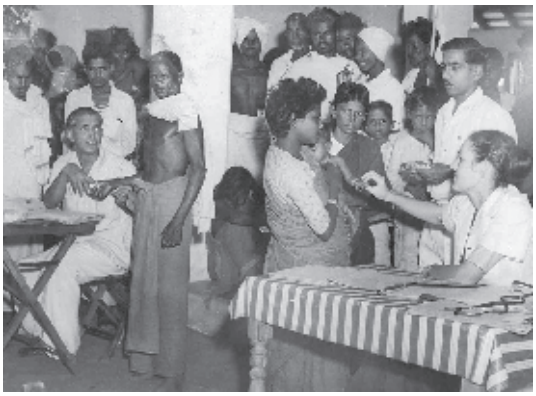
The strategy of engaging and involving Civil societies in Krishnagiri District of Tamil Nadu for supporting Disability Prevention and Medical Rehabilitation gave us an insight into the potential partnership of involving them for sustaining the Leprosy services to the leprosy affected persons with disabilities. DFIT expanded this strategy to other supported districts in 2012.

DFIT as part of its plan to upgrade to referral centres made infrastructure developments in Delhi project, Madhavaram in Tamil Nadu, Dehri on sone in Bihar, Amda in Jharkand and Pirappencode in Kerala. The centres will play a vital role in providing referral services in 2013.

Finally, let me acknowledge the contributions of the Govt of India, State Governments, programme staff, general health staff, DFIT staff, Damien Foundation Belgium, Trust members, DGD, Chantier Damien, Triangle groups from Belgium, community volunteers and all persons affected who have given us the opportunity to serve them.

Dr. M. Shivakumar
Secretary

Introduction:



DFIT is a charitable Non-Governmental Organisation involved in leprosy & tuberculosis control activities in India supported by Damien Foundation Belgium. DFIT began its work in Polambakkam, a small village situated in Kanchipuram district of Tamil Nadu State in the year 1955.

The Mission of DFIT is to reach the people especially the underserved and underprivileged who are afflicted with Leprosy or Tuberculosis. Sustainable services are delivered either through self governing projects or in close partnership with the NGO projects and indirectly through capacity building of the government, civil society, private institutions and the community.

Projects and Infrastructure:

DFIT implements its activities through 16 projects (three own projects, two in collaboration with State Govt. and eleven NGO partners) by providing direct care for persons affected by leprosy & TB in the hospital & field covering the population ranging from 100000 to 1000000 in eight States. In addition, 35 District Consultancy Teams comprising of experienced medical and non-medical field staff provide support to government's TB control activities. DFIT with its new strategy involves civil society organisations (CSO) to enhance the sustainability of Disability Prevention and Medical Rehabilitation (DPMR) services.

DFIT - Self Governing Projects:

S.No	Projects	Location
1	Anandapuram Leprosy Home	Polambakkam, Tamil Nadu
2	Damien Foundation Urban Leprosy & TB Centre	Nellore, Andhra Pradesh
3	Margaret Leprosy & TB Centre - DFIT	South West Delhi

DFIT – Projects in Collaboration with State

S.No	Projects	Location
1	Damien Tuberculosis Research Centre	Darbhanga, Bihar
2	Damien RCS Referral Centre	Rudhrapura, Dehri-on-sone, Rohtas, Bihar

DFIT Supported - NGO Projects:

S.No	Projects	Location
1	Arogya Agam	Aundipatty, Tamil Nadu
2	Holy Family Hansenorium	Fathimanagar, Tiruchirappalli, Tamil Nadu
3	Nilgiris Wynaad Tribal welfare Society	Ambalamoola, Nilgiris, Tamil Nadu
4	St. Mary's Leprosy Centre	Arisipalayam, Salem, Tamil Nadu
5	Asaniketan Rural Health Centre	Kavali, Andhra Pradesh
6	Gandhi Memorial Leprosy Foundation	Chilakalapalli, Vizianagaram, Andhra Pradesh
7	Swami Vivekananda Integrated Rural Health Centre	Pavagada, Tumkur, Karnataka
8	St. John's Hospital & Leprosy Services	Pirappencode, Thiruvananthapuram, Kerala
9	Assisi Sevasadan Hospital	Nagepalli, Maharashtra
10	Claver Social Welfare Centre	Amda, Seraikela, Jharkhand
11.	Don Bosco Beatitudes Social Welfare Centre	Pope John Garden, Madhavaram, Chennai, Tamil Nadu

Support to Government through District Consultancy Teams (DCTs):

1. Bihar : 28 districts
2. Andhra Pradesh : 6 districts
3. Kerala : 1 district

The objective of placing consultancy teams is to sustain quality services to both leprosy and TB affected persons in its supported districts, through:

- Building the capacity of General Health Staff and other stakeholders in the Community.
- Supplementing infrastructure support for implementation of TB control programme.
- Identifying and filling the gaps to provide uninterupted quality services by construction / renovation of laboratories, supplying the Laboratory reagents and appointing Senior Treatment Supervisor (STS), Senior Treatment Laboratory Supervisor (STLS) and Lab Technicians (LT) as a stop gap arrangement.

- Dr. P. Krishnamurthy retired as Secretary, DFIT and selected as President of the Trust.
- Dr. M. Shivakumar has taken over as Secretary of DFIT.
- Damien TB Research Centre, Nellore was accredited by GOI for Line Probe Assay (LPA), a molecular technique to diagnose drug resistant tuberculosis
- Establishment of referral laboratory at Darbhanga, Bihar for catering services to manage drug resistant TB and will be functional from April 2013.
- Establishment of referral services including Re-Constructive Surgery (RCS) for leprosy affected persons at Margaret Leprosy & TB Centre, Delhi .
- Establishment of referral centre for managing complications related to leprosy in Amda (Jharkhand), Dehri-on-sone (Bihar), Pirappencode (Kerala) and Pope John Garden (Tamil Nadu).
- Expansion of Civil Society partnership programme to improve the access and sustainability of DPMR services in Karur, Pudukottai and Aundipatty (Tamil Nadu); Nalanda and Gaya (Bihar); Viziayanagaram (Andhra Pradesh).

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Leprosy care:

After the integration of leprosy care into general health services, DFIT supported projects are involved in referral services for managing complications related to leprosy. Among the projects supported by DFIT, ten projects provide primary and secondary levels of care for persons affected by leprosy, while three projects are providing tertiary care, 5 more projects are proposed to be established for tertiary level care.

- 301 (MB 185) persons were diagnosed with leprosy and referred to nearby Primary Health Centers for follow up treatment
- 231 patients were managed for lepra reactions.
- In the projects where in-patient facility is available for leprosy care, 1344 patients were admitted (Bed days: 35915) for managing complications like lepra reactions, chronic ulcers and correction of leprosy related deformities and other complications.

DPMR activities in the 22 districts through NGO projects:

- Number of patients living with disability: 11744
- Number of patients visited by the team: 7445 (63%)
- Number of patients practicing self care: 4964 (66%)
- Number of patients referred for surgery: 206
- Number of patients provided with protective foot wear (MCR): 3744

Tuberculosis care:

- Nine out of 16 projects supported by DFIT provide TB services.
- 4252 TB cases were registered (NSP: 1590) and initiated treatment.
- 86% Sputum Conversion Rate (Ranges from 70 % to 95%)
- 81% Cure Rate (Ranges from 65% to 90%)

It was observed that 315 TB patients admitted (3272 bed days) for the management of complications due to TB and its treatment side effects.

Anandapuram Leprosy Home

Project Holder : Mr. Ilango Yesu
Staff : 7 (Field: 2)
Facilities : 19 beds.
Main activities :
- Care after cure is provided to the patients in the home.
- Support to DPMR activities in Kanchipuram district.
- Livelihood Enhancement Programme (LEP)

Budget : Rs. 1450936

Anandapuram Leprosy Home is situated in Kanchipuram district. DFIT initiated its activities here in India six decades ago. It is a self governed project of DFIT. At present the home caters to 10 leprosy affected persons. The home has good facilities for taking care of inmates. The project holder is also responsible for implementation of DPMR activities in this district.

Performance	2010	2011	2012
Persons affected by leprosy with disability practicing self care visited by the team	410	487	562
Persons affected by leprosy with disability seen practicing self care	365 (89%)	413 (85%)	355 (63%)
Surgery done	6	9	6
Persons provided with MCR footwear	301	234	90
LEP supported	11	10	5
Training in DPMR 2012: Medical Officers : 59 and Health staff including field staff: 427			

Leprosy control in tribal population: How to overcome the hidden challenges?

Anjetty is a tribal area with 15000 population spread over nine mountains in Krishnagiri district Tamil Nadu. Initially seven new leprosy cases self reported to the nearest Primary Health Centre in 2011. The Medical Officer and the health supervisor of the health centre reported to the district leprosy programme officer. The district team conducted a week long campaign with a team of doctors, health staff and local volunteers financially supported by a local corporate company. The team identified 21 new leprosy cases during the campaign. The major challenge was monthly follow up. The district team took support of St Mary's Leprosy Centre (SMLC), Salem involved in leprosy control programme for monthly follow up and supply of MDT for patients under treatment. The team identified eleven new leprosy cases during follow up visits and most of these new cases were self reported to the team during IEC. The programme officer and SMLC staff were very keen to organize one more campaign with the help of health staff, women self help groups, local volunteers and students from a social science college. They were divided into five groups to cover five mountains over one week. The team identified eighteen new leprosy cases in

second campaign. It was not the end for reporting new cases, a few more new leprosy cases were identified during the follow up visits. A total of 72 new leprosy cases were identified, among them 28 were Multi-bacillary leprosy cases and three of them had deformity at the time of diagnosis.

The case study illustrates how different stakeholders can work together to reach the underserved population and overcome the hidden challenges in leprosy.

Polambakkam Village & Post, Kanchipuram District Tamil Nadu -603309 Phone: 044-27544258 E.mail: dfitpolambakkam@gmail.com

Damien Foundation Urban Leprosy & TB Centre

Project Holder : Mr. Nabi Thiagarajan

Staff : 23 (Hospital: 14; DTRC: 7; Field: 2)

Facilities :
- Hospital with 14 beds for Leprosy & TB
- Damien TB Research Centre (DTRC)
- Designated Microscopy Centre
- Surgery (RCS) Unit

Budget : Rs. 16743285

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	18	27	37
Among them MB	7	21	23
Reaction cases managed	46	38	46
Surgery done	22	47	43
In-patients managed	168	124	129
Bed days	2821	2051	2223
LEP beneficiaries	12	30	48
Protective foot wear (MCR) provided	110	300	53

TUBERCULOSIS CARE	2010	2011	2012
Total New TB cases registered	213	190	190
Among them New Sputum Positive cases	92	63	63
Sputum Conversion rate for NSP	90%	89%	84%
Cure Rate for NSP	82%	83%	84%
In-patients managed	36	42	52
Bed days	1104	987	884
MDR cases under treatment	23	29	26
TB cases given Nutritional supplement	11	12	16

This project self governed by DFIT is located in Nellore, Andhra Pradesh. It was started with leprosy control activities in the year 1993 and for TB control activities in 1998. It is now one of the important referral centres for Leprosy & TB including MDR TB in the State. It has outpatient and inpatient facilities with 14 beds for providing tertiary care services for leprosy and 24 beds for TB. The Centre extends its support for DPMR activities and RCS support to the two adjoining districts (Prakasam & Kadapa) apart from Nellore District.

Damien TB Research Centre (DTRC) was established in 2009 as a new initiative to support the MDR diagnosis and follow-up in 6 adjoining districts

of Nellore (Anantapur, Chittoor, Kadapa, Kurnool, Nellore and Prakasam) covering 19 million population in Andhra Pradesh. The lab has been accreditated for both LJ medium and molecular techniques by GOI. A special inpatient ward with all infection control measures has been established to manage MDR TB patients.

Activities carried out:
During the year, about 969 MDR suspects were screened, of which 830 (86%) were found to be Smear Positive for AFB. LPA was done for 761suspects and 227 (30%) cases were found to be MDR-TB. 1330 follow up samples are processed and 403(30%) were smear positive and 146 (11%) samples were found as culture positive.

Adhoc Consultant for DFIT referral labs:
Dr. N. Selvakumar, Senior Scientist, appointed as adhoc consultant for DFIT laboratories at Nellore and Darbhanga. His role is to support supervision and monitoring of the laboratories at least thrice a year. He is also guiding and supporting the teams for conducting operational research in drug resistant TB.

Appreciation to Dr. B.S.V. Prasad
On 24th September 2012 in the mid process of reconstructive surgery a patient went into seizures, an intervention of an anaesthetist was an emergent need. In search of identifying an anaesthetist immediately, we approached nearby multi specialty hospital eventually came in contact with Dr. B.S.V. Prasad a retired Civil Surgeon from Government service, residing at Nellore. He unhesitatingly provided his services.

Impressed by the vision and mission of Damien Foundation, Dr. Prasad magnanimously volunteered offering free service for subsequent RCS camps. DFIT acknowledges his self less service.

Active Participation of a private Dermatologist in National Leprosy Eradication Programme:

In India Private Practitioners are the first contact points for any type of ailments both in the urban and rural areas. Nevertheless, the large private health care sector has hitherto been virtually alienated from activities of public health importance including priority disease control programme. In India Leprology as a speciality is integrated with Dermatology and Venereology. All the dermatology teaching Programme in India lay adequate stress on teaching of Leprosy. A considerable proportion of new leprosy patients seek treatment from private Dermatologists. Here is an example of a private Dermatologist whose active participation in the Leprosy Programme has made a huge difference in the lives of many Leprosy affected people.

Dr. Penchala Reddy is one of the popular private Dermatologists practicing in Nellore town of Andhra Pradesh. Few years back during one of the IMA meetings, he came to know about Damien Foundation's work in the area of Leprosy and TB. After learning about the specialized leprosy hospital in Nellore, he started referring new leprosy cases for the treatment and management of complications. He has been referring around 15 to 20 new leprosy cases every year.

He says “one reason is that the patients belonging to low socio-economic conditions get deferred from the private doctors during the course of treatment due to the long duration of MDT (6 months to 1 year), the other reason being non affordability of expensive drugs and hence the drop out of patients”. These patients can be brought under the National Leprosy Eradication Programme (NLEP) and can be treated effectively at the early stage.

General Practitioners (GP's) are the frontline health-service providers of our population. Majority of patients visit them for acute and short illnesses and their access to tertiary hospitals and more specialized services is limited. Following this example, the private Dermatologists can play an important role in leprosy eradication by supporting the programme through referrals, counselling and managing of complications.

Bakthavatchala Nagar, AK Nagar Post, Nellore, Potti Sriramulu Nellore district, Andhra Pradesh-524004
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Margaret Leprosy & TB Centre

Project Holder : Dr. Ramesh Kumar

Staff : 27 (Hospital: 6 Admin: 5 Field: 15 Others: 1)

Facilities :
- 10 Designated Microscopy Centres
- 2 ICTCs

Budget : Rs. 10223179

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	8	12	17
Among them MB	5	5	7
Reaction cases managed	2	1	3
Surgery done	0	0	0
In-patients managed	0	0	0
LEP beneficiaries	1	2	2
Protective foot wear (MCR) provided	1	1	163

TUBERCULOSIS CARE	2010	2011	2012
Total New TB cases registered	2479	2595	2579
Among them New Sputum Positive cases	806	767	825
Sputum Conversion rate for NSP	90%	92%	95%
Cure Rate for NSP	92%	92%	90%
In-patients managed	0	0	0
MDR cases under treatment	19	30	89
TB cases given Nutritional supplement	29	21	38

This project is self governed by DFIT. It was started with leprosy control activities in South West part of Delhi in the year 1999. After the integration of leprosy control into general health services, the project took up TB control activities in 2002. Initially the project covered a population of 500000 through one TB Unit and it was extended by adding one more TB unit in 2004.

The Govt. of Delhi supported in establishing two Integrated Counseling and Testing Centres for managing TB with HIV co-infection in two of its DMCs.

DFIT has established a referral services for managing complications related to leprosy including RCS.

Contact tracing vital to curb the transmission of MDR TB

Ms. Archana (Name changed), 13 year old girl studying in eighth standard is on MDR TB treatment from one of our TB clinics in Delhi. Initially she was treated for category I regimen for sputum positive pulmonary tuberculosis. The first follow up sputum was positive at the end of two months i.e., after completion of intensive phase. The sputum samples were sent to a referral lab in Delhi for drug susceptibility test and results revealed that TB bacilli were resistant to INH and Rifampicin.

TB Supervisor was very keen to know why she developed MDR TB. First he reconfirmed that she never took treatment for TB and also confirmed that there was no family history of TB or MDR TB before the initiation of category I regimen. Supervisor did not stop the investigation and he enquired about her history of cough among her friends, classmates and teachers; he finally got the answer for his question, she revealed that her very close friend Ms. Sushma (Name changed) was taking treatment for TB and she was living in the same locality. Together they spent lot of time every day like going to school, sitting on same bench and attending tuitions. The supervisor came to know that Ms. Sushma had completed MDR TB treatment from his centre in 2011.

Many a time we consider that history of contact is restricted to the family members but we should also remember that history of TB among intermediate and casual contacts is vital to identify MDR TB at early stage. This could have prevented further lung damage, unnecessary chemotherapy with first line drugs and spread of drug resistant TB.

Lesson learnt:
We should carefully collect history of contact with MDR TB among family members, close friends and co-workers while initiating treatment for new sputum positive cases.

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Nilgiris Wynaad Tribal Welfare Society

Project Holder : Mr. Peter Ronald
Staff : 3 (Hospital: 1; Admin: 1; Field: 1)
Facilities : • In-patient care with 12 beds for leprosy & TB
• Designated Microscopy Centre
• ICTC and Mobile Outreach Medical Services
Budget : Rs. 572550

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	5	6	4
Among them MB	2	3	2
Reaction cases managed	0	2	1
Surgery done	0	0	0
In-patients managed	3	3	1
Bed days	18	5	16
LEP beneficiaries	4	2	10
Protective foot wear (MCR) provided	18	18	18

TUBERCULOSIS CARE	2010	2011	2012
Total New TB cases registered	15	11	18
Among them New Sputum Positive cases	8	5	8
Sputum Conversion rate for NSP	86%	87%	88%
Cure Rate for NSP	88%	80%	80%
In-patients managed	13	5	17
Bed days	87	93	127
TB cases given Nutritional supplement	10	10	12

This Project is located in a tribal area of Nilgiris district, Tamil Nadu. It renders its services for Leprosy & TB control to a tribal population of about 100000 with a Designated Microscopy Centre. It has a 12 bedded hospital for in-patients. It has an Integrated Counseling and Testing Center and also provides outreach Medical services for the tribal population through its mobile clinic.

Timely intervention-Regular DOTs – Sure Cure for TB

Mrs. Pushpa a tribal woman of 25 years of age hailing from Katunayaka community had developed fever, cough and general weakness that continued for a long period for which she had visited many hospitals, including Govt. Health centres and got treated. But her condition worsened. By then she was pregnant and later got admitted for delivery at a Private hospital. The mobile outreach team from Nilgiris Wyanad Tribal Welfare Society- Ambalamoola during their monitory visit saw her when she was brought by her husband for check up and she was taken to their centre and was subjected to sputum examination. Her sputum was diagnosed to be Positive and she was put on DOTs. She was provided with nutritional support too. After completing full course of treatment she is now completely cured and gained weight and she is feeding her baby well and leads a happy life.

Ambalamoola Post, Via-Bitherkad, Gudalur Taluk, Nilgiris,Tamil Nadu-643240
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Claver Social Welfare Centre

Project Holder : Fr. Antony Panneerselvam

Staff : 12 (Hospital: 3 Admin: 6; Field: 3)

Facilities : • Hospital with 16 beds for leprosy patients

• Support to DPMR activities in 8 districts of Jharkhand.

Budget : Rs. 2419812

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	36	34	38
Among them MB	18	16	21
Reaction cases managed	20	17	44
Surgery done	27	15	13
In-patients managed	21	25	33
Bed days	848	905	629
LEP beneficiaries	12	10	0
Protective foot wear (MCR) provided	53	44	49

This Project is situated in Amda, Sareikela district of Jharkhand, a Tribal State of India and it mainly supports Leprosy control activities. At the request of the State Government the Project supports DPMR activities in eight districts (Deoghar, E. Singhbhum, Godda, Gumla, Lohardagga, Sareikela, Simdega and W. Singhbhum). Tertiary care services are provided for the Leprosy patients through its 16 bedded hospital. DFIT is establishing a referral centre including RCS services in this project which is expected to be functional in the middle of 2013.

Small help, Great delight

Mr. Amar Mahato (name changed), aged 44, is living at Bara Lupung village of Seraikela-Kharswan District. When he was studying in school, he found that he was suffering from leprosy following which the fingers of his right hand became clawed. When the villagers came to know of his disease they began to despise him. He was detected by C.S.W.C, AMDA staff and with their help he completed the full course of treatment and was cured, still his fingers remain clawed. Since Amar's parents were too old to support him, they got him married. Having three children, it had become difficult for Amar to support his family. The death of his parents brought him more despair.

On his own initiative he started a small shop for cycle repair and tyre puncture in his village, he was able to meet only the minimum needs of his family. He was identified for support under LEP (Livelihood Enhancement Program) by C.S.W.C Amda and recommended to DFIT. DFIT provided him with Rs.10000/- for expanding his cycle repairing shop. It was a great help for Amar. Things began to change gradually. His income started increasing and also the attitudes of the villagers towards him also changed. He learned to repair the motorcycles.

Now Amar's monthly income is around Rs. 2000/- to 3000/- and his children are going to school. Amar and his family members are very happy now. A small help can bring delight in someone's life

Claver Bhavan, Amda Post, Sareikela, Kharswan, Jharkhand-833101 Phone:06583-252714 e-mail:apanneersj@gmail.com

Project Holder : Dr. Sabu M. Simon

Staff : 3 (Hospital: 2; Field: 1)

Facilities : • In-patient care with 35 beds.
• Designated Microscopy Centre

Budget : Rs. 467880

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	29	14	9
Among them MB	18	8	3
Reaction cases managed	4	2	0
Surgery done	0	0	1
In-patients managed	98	88	92
Bed days	668	610	591
LEP beneficiaries	3	5	22
Protective foot wear (MCR) provided	135	120	104

TUBERCULOSIS CARE	2010	2011	2012
Total New TB cases registered	38	31	39
Among them New Sputum Positive cases	23	21	26
Sputum Conversion rate for NSP	82%	80%	93%
Cure Rate for NSP	80%	78%	79%
In-patients managed	156	144	128
Bed days	1248	1100	927
MDR cases under treatment	0	0	0
TB cases given Nutritional supplement	7	6	8

This Project is situated in Aundipatty, Theni district of Tamilnadu, is involved in Leprosy & TB control activities since 1982. The Project extended its DPMR services throughout the district in 2011 with the involvement of local NGOs and Civil Society partnership. It supports TB activities through its Designated Microscopic Centre and through its 5 bedded in-patient facility for TB and Leprosy patients.

Community solidarity gives new lease of life

Mr. Velusamy was born and brought up in Koilaparai, Theni district, Tamil Nadu. At a very young age he was affected by leprosy and gradually he lost his fingers and toes. He was deserted by the village members and was living in the nearby forest under the trees. Around 8 to 10 years back he returned to his village and somehow he has been accepted by the community. During the day time he takes care of the village like a watchman when all the people are engaged in their agricultural work in the fields. He gets food from the villagers; he takes food only two times a day and spends rest of his time under the tree. He keeps his small bundle of old clothes and bedspread in his aunt's house, who lives in the same village, but he is not allowed to sleep or live in her house.

The local NGO involved in DPMR activity as part of the civil society partnership had discussion with his aunt for the renovation of her house with the agreement that she would allow him to live and sleep in the same house. Initially she agreed but after the sanction of funds, she bluntly refused to the agreement.

The funds allotted were only Rs. 5000 for renovation. NGO staff was very upset that they could not help Mr. Velusamy. One of the senior member of the Self Help Group, Mrs. Pachiammal came forward to help him. She consulted a few people in the village and requested them to give a small land for Mr. Velusamy.

Mr Rajendran, a young man came forward to provide 36 sq ft of land near his house. The challenge was that the allotted budget was not enough to construct the house of 36 sq ft. The construction work will be completed soon.

Actual cost of the house was estimated around Rs. 7500 and there was a shortage of Rs. 2500. Mr. Velusamy gave the remaining amount from his savings from disability pension. It was decided to construct the house by using broken bricks and mud instead of cement.

Apart from helping in constructing a house for him she also assisted and supported him to practice self care regularly by which the ulcers completely healed.

Aundipatty, Theni district, Tamil Nadu-625512 Phone: 04546-242306, 244311 E.mail: arogyaagam@gmail.com

St. Mary's Leprosy Centre

Project Holder : Sr. Francisca

Staff : 14 (Hospital: 4; Admin: 3; Field: 7)

Facilities : • In-patient care with 22 beds for Leprosy & TB
• Designated Microscopy Centre

Budget : Rs. 3449323

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	46	34	66
Among them MB	27	30	52
Reaction cases managed	25	25	28
Surgery done	8	6	11
In-patients managed	206	120	94
Bed days	3547	3456	2840
LEP beneficiaries:	4	7	28
Protective foot wear (MCR) provided	947	750	499

TUBERCULOSIS CARE	2010	2011	2012
Total New TB cases registered	583	577	590
Among them New Sputum Positive cases	227	220	234
Sputum Conversion rate for NSP	91%	90%	90%
Cure Rate for NSP	81%	85%	85%
In-patients managed	8	18	4
Bed days	259	604	186
MDR cases under treatment	0	1	3
TB cases given Nutritional supplement	898	941	687

This Project is located in Salem town, of Tamil Nadu. It began its Leprosy control activities in 1960. The project initially implemented DPMR services in Salem town and the positive response on the impact was recognised by the Govt. of Tamilnadu and the similar services were extended to the remaining part of the district and also the adjoining districts (Erode, Dharmapuri and Krishnagiri). With collaboration of DFIT the project has implemented its new strategy of involving local NGOs to partner with Civil Society Organisations (CSO) for DPMR activities in Krishnagiri district. This pilot study is aimed at sustainable DPMR services in the district (The details of this pilot study is recorded under DPMR activities).

The project has implemented TB control activities covering a population of around 500000 in Salem urban since 2001.

Lack of awareness among medical fraternity leads to……

This is a case of physical & psychological suffering and huge financial drain because of lack of awareness about leprosy and squandering of resources by running from pillar to post before reaching a proper diagnostic & treatment facility.

Raja, aged 28 from a village in Salem district, was leading a normal family life with his wife & two children. A year ago he developed numbness in both the hands. He first consulted a private neurologist at Erode and was given general treatment for about 3 weeks. Raja did not notice any improvement and so discontinued the treatment. The condition deteriorated after six months with loss of sensation and movement in his left hand and developed foot drop in both his feet. He went to a private hospital at Bhavani where he was admitted and treated.

As there was no improvement in his condition, he went to another private hospital at Coimbatore & consulted a neurologist who advised expensive investigations. Results were normal. The neurologist then conducted a careful clinical examination and found a big patch on his right shoulder. The doctor suspected leprosy and referred him to a Dermatologist who also did not give proper treatment.

When an ICMR team visited this village for sample survey, they found him to be in lepra reaction with neuritis of multiple trunk nerves. The team referred the case to St. Mary's Leprosy Centre through DLO for the management of reaction.

The ignorance among the medical fraternity has forced Raja to go through long period of hardship due to under diagnosis and improper treatment. Now Raja requires surgical correction for his deformities which could have been prevented.

Arisipalayam, Salem, Tamil Nadu-636009 Phone: 0427-2352645 e-mail: smlcslm@gmail.com

New Hope Rural Leprosy Trust (Gandhi Memorial Leprosy Foundation)

Project Holder : Mr. V. Prabhakar Rao

Staff : 12 (Hospital: 4 Admin: 4 Field: 4)

Facilities :
- Hospital with 21 beds for leprosy patients
- Support to DPMR activities in Viziayanagaram district

Budget : Rs. 1379150

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	58	7	9
Among them MB	20	5	6
Reaction cases managed	4	2	8
Surgery done	23	21	19
In-patients managed	147	143	162
Bed days	3230	3246	3627
LEP beneficiaries	16	38	16
Protective foot wear (MCR) provided	679	648	580

Gandhi Memorial Leprosy Foundation (GMLF) located in Chilakalapalli, Vizianagaram district of Andhra Pradesh is one of the oldest projects in India working for eradication of leprosy. This project has been supported by DFIT since 1978. This project was handed over by GMLF to "New Hope Rural Leprosy Trust" but DFIT continued its support. Vizianagaram district was considered to be high endemic for leprosy in the country having the highest number of persons (about 3000) affected by leprosy living with disabilities. The project was initially involved in supporting DPMR activities in 4 PHCs and later on extended to 16 PHCs. Realising the needs, the project now covers the entire district through CSO partnership.

If every teacher in a school could do this!

This is an interesting incident in GMLF Chilakalapalli project.

P. Raghuram Rao, (M.Sc. M.Ed.) is a Science Teacher in High School in Balijipeta. He has a good reputation as a teacher because he realizes that teaching means managing the learning process and yearns to make his students understand the subject well.

In the text book of 'Biological Science' for VIII Standard, under the topic 'Diseases caused in Man by Bacteria', leprosy as a disease is briefly covered. While teaching this topic, Mr. Raghuram Rao explained to the students about patches on skin with loss of sensation as most important early signs of leprosy. He also explained to the students that they have an important role to share this information among their friends and relatives to suspect leprosy if such patches are noticed and report to the health workers.

Ampavalli Dhananjaya Rao aged 12 years, a student of the same class, immediately reported to the teacher that he had some patches on his hands. The teacher examined the boy, and also tested for loss of sensation on the patches. He advised the student to immediately go to GMLF Hospital at Chilakalapalli.

The case was reported at Chilakalapalli. It was examined and found to be a BT case. It was referred to the PHC, Balijipeta by the project. The case was registered on 4th October 12 and was put under PB treatment.

The boy takes regular treatment and his teacher also ascertains the regularity of his treatment.

If every teacher is so diligent to teach leprosy in schools, what a big contribution it would make for early detection and treatment of child cases?

Chilakalapalli Post, Balijipeta, Vizianagaram District, Andhra Pradesh-535557
Phone: 08944-256265 e-mail: prabhaa.vrudhula@gmail.com

Holy Family Hansenorium

Project Holder : Dr. Sr. Rita Adaikalam

Staff : 13 (Hospital: 6 Admin: 1: Field: 6)

Facilities :
- Hospital with 75 beds for Leprosy & TB
- Designated Microscopy Centre
- Surgery (RCS) Unit
- TB-HIV Care Centre

Budget : Rs. 4600448

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	47	30	36
Among them MB	35	12	29
Reaction cases managed	70	67	72
Surgery done	35	39	67
In-patients managed	487	477	521
Bed days	16264	17074	17705
LEP beneficiaries	0	13	0
Protective foot wear (MCR) provided	673	439	503

TUBERCULOSIS CARE	2010	2011	2012
All type of TB cases registered	37	16	21
Among them New Sputum Positive cases	12	5	8
Sputum Conversion rate for NSP	92	90	90
Cure Rate for NSP (%)	92	100	88
In-patients managed	14	12	10
Bed days	154	242	340
MDR cases under treatment	0	0	0
TB cases given Nutritional supplement	16	15	9

Holy Family Hansonorium is one among the oldest projects supported by DFIT, which is located at Fathimanagar in Thiruchirapalli, Tamil Nadu. It has been rendering leprosy control activities for more than three decades. It provides tertiary level care to leprosy and TB cases in its 75 bedded hospital. The project has implemented DPMR activities in five districts (Ariyalur, Karur, Perambalur, Trichy and Pudukottai) by involving the general health staff.

The project has adequate expertise and facilities for providing trainings. This Project has been awarded for its noble services of excellence in the field of Leprosy by Govt. of Tamil Nadu. The project supports TB control activities through its Designated Microscopy Centre covering a population of 100000 by diagnosis and treatment through DOT supervision.

The story of Velmurugan

Velmurugan, aged 32 years is from Keeliyur village of Nagapattinam district, Tamil Nadu. One day Velumurugan was surprised to notice a swelling over the right side of his ear. He was scared and approached a skin specialist at Mayiladuthurai town and the treatment given by him did not yield any response. So he took the advice of his neighbours and visited a native medical practitioner at Kumbakonam assuming the swelling was due to insect bite and there also the treatment did not provide any relief. Then he visited one more native medical practitioner at Sirkazhi, who treated him with some oil for his swelling for two weeks, but no improvement was seen.

He heard about a person who was treating skin diseases at Thirukkadaiyur town and visited him as a last option. The treatment provider is a retired leprosy trained worker and not a medical practitioner, who diagnosed Velmurugan with leprosy. He treated him with medicines for about 10 months and still Velmurugan's condition did not improve. The situation further worsened and became unmanageable, as it was leprosy Type II reaction which was not diagnosed. So far Velmurugan, a daily wage labourer has spent about Rs. 50,000/-. Seeing his plight the treatment provider referred Velmurugan to the Government Hospital at Myladuthurai. The Government hospital referred Velmurugan to Holy Family Hansenorium for Type II leprosy reaction management.

Velmurugan was shocked to know that he was suffering from leprosy and felt that his wife and children may also get the disease. The stress worsened his condition. HFH supported him through counselling and appropriate treatment. Now Velmurugan is aware of the facts of leprosy and responding to the treatment.

Fatimanagar post, Thiruchirapalli, Thiruchirapalli District, Tamil Nadu- 620012
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Asaniketan Rural Health Centre

Project Holder : Sr. Christu Rani

Staff : 6 (Hospital: 3 Admin: 2 Field: 1)

Facilities : • DPMR activities in the project area

Budget : Rs. 539300

This centre is situated in Kavali, Nellore district of Andhra Pradesh and supported by DFIT for its leprosy activities since 1975. This project is being supported for DPMR activities in 4 blocks of Nellore District.

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	7	7	2
Among them MB	4	5	0
Reaction cases managed	0	0	2
Surgery done	1	0	1
In-patients managed	0	0	0
LEP beneficiaries	3	0	3
Protective foot wear (MCR) provided	0	0	3

Trickle down theory: Does it work?

Bujjamma, a tribal girl is living in a village near Sriharikota in Nellore District has an interesting episode.

Sriharikota is the nerve centre of Indian Space Research Origination and had reached the milestone of launching the 100th space craft in to space in the presence of Indian Prime Minister. The ground realities tell a different story. The fruit's of development in economy should be reflected in the improvement of standard of living and health status of its subject. Does the economic development trickle down to the people? The story of Ms Bujjamma aptly reflects the malady.

Bujjamma, lives with her parents and her younger brother. Around six years back her parents noticed changes in the skin and took her to a private doctor, she was provided with some medicines but there was no improvement. Her parents not knowing the gravity of the situation kept her indoor with no treatment. The community also neglected her. She became weak and patches on her body started to disfigure her. DFIT Medical team consisting of Medical Advisor and Physiotherapist visited the village as 10 new leprosy cases were identified by the district team earlier. Bujjamma's parents brought her to the team for an opinion. The team found her with severe leprosy infiltration and Type II reaction. The team provided some money for transport along with the address of the DFIT hospital at Nellore. She was admitted in the hospital for two weeks. Multidrug therapy and steroid treatment was initiated. She was severely malnourished, so nutritional supplementation was provided. After 10 months of treatment and support, her condition has drastically improved. Now the family members and neighbours have accepted her. The pictures show the return of her smile and integration with family. It is a wake up call for us as there could be many like Bujjamma waiting for the trickle.

Vengal Rao Nagar, Kavali, Andhra Pradesh-524202 Phone: 08626-241403 e-mail: asaniketan@yahoo.com

Assisi Sevasadan Hospital

Project Holder : Sr. Marina Francis

Staff : 14 (Hospital: 3 Field: 10 Admin: 1)

Facilities : • Hospital with 10 beds for Leprosy & TB
• Designated Microscopy Centre

Budget : Rs. 1684305

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	20	25	43
Among them MB	8	13	20
Reaction cases managed	3	2	8
Surgery done	0	0	0
In-patients managed	22	30	19
Bed days	110	183	166
LEP beneficiaries	6	0	0
Protective foot wear (MCR) provided	92	72	97

TUBERCULOSIS CARE	2010	2011	2012
Total New TB cases registered	141	204	221
Among them New Sputum Positive cases	75	119	119
Sputum Conversion rate for NSP	89%	87 %	86%
Cure Rate for NSP	92%	81%	79%
In-patients managed	60	83	83
Bed days	193	182	192
MDR cases under treatment	0	0	0
TB cases given Nutritional supplement	39 39	62 62	98 98

This Project, supported by DFIT since 1972, is situated in Allapalli, Gadchirolli district of Maharashtra State. The project is located in a difficult tribal area infested with insurgents. It provides services to Leprosy and TB affected persons in these remote areas. The project has been recognised as a Designated Microscopy centre. It provides tertiary care to both leprosy and TB through its 10 bedded hospital. The project extends DPMR services in the project area.

Hedri's relief to a new lease in life.

Hedri is from a village on the way to Gatta PHC, near Ettapalli PHC. He hails from a very poor family. Owing to poverty he discontinued his studies and started working as a truck cleaner in Madhya Pradesh for a livelihood. While working he took treatment for TB, but he could not complete his treatment due to his busy occupation. His family members arranged his marriage. He restarted his treatment for TB in a private clinic. During this period of sickness he had to face many a struggle and difficulty. He sold all his property for his treatment .He once again discontinued his treatment as his wife deserted him but she returned later. Their happiness did not continue for long as he got repeatedly fell sick. For this he approached Assisi Seva Sadan Hospital in Nagepalli, he shared his story with the medical officer, who counseled and encouraged him to take treatment again. This time he continued treatment under the guidance of Medical Officer. Now he is happy and got a new lease of life.

Nagepalli, Allapalli Post, Gadchirolli District, Maharashtra-422703 Phone: 07133-2266461 e-mail: assisinagepalli@gmail.com

Swami Vivekananda Integrated Rural Health Centre

Project Holder : Swami Japananda

Staff : 12 (Hospital 7 Admin: 2 Field: 3)

Facilities : • Hospital with 30 beds for Leprosy & TB
• Surgery (RCS) Unit

Budget : Rs. 2726045

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	11	21	30
Among them MB	5	13	16
Reaction cases managed	0	0	8
Surgery done	30	48	45
In-patients managed	92	144	152
Bed days	1799	3021	2511
LEP beneficiaries	13	0	9
Protective foot wear (MCR) provided	52	50	30

TUBERCULOSIS CARE	2010	2011	2012
Total New TB cases registered	557	518	572
Among them New Sputum Positive cases	284	265	292
Sputum Conversion rate for NSP	84%	80%	82%
Cure Rate for NSP	80%	84%	80%
In-patients managed	17	12	4
Bed days	84	97	29
MDR cases under treatment	0	1	2
TB cases given Nutritional supplement	35	0	35

Swami Vivekananda Integrated Rural Health Centre (SHIRHC) is located in Pavagada, Tumkur district. The area of its operation is one of the most backward regions in Karnataka. The project is involved in Leprosy control activities since 1993. The project has referral services for leprosy including RCS with 15 bedded inpatient facilities in the hospital, which is supporting the adjoining districts.

The project is involved in TB control programme since 1996 and recognised as a TB unit covering a population of 500000 under RNTCP since 2003. The project was selected as one of the eighteen sites for piloting the Gene Xpert programme for diagnosis of TB including rifampicin resistance under rural setup.

RCS gave her a new life


Before

Kuruba Shanthamma (Name changed) had never thought that the patches appearing on her body would play havoc in her life. She initially neglected these patches but ultimately went to a hospital where she was diagnosed as having leprosy. It was a shocking revelation for her, but she took treatment regularly and during the course of treatment she became pregnant. She developed pain in her left hand and soon developed deformity of her hand. Her husband and family members became hostile and abandoned her. She was forced to stay with her parents. She had lost all her hopes until she visited SVIRHC Pavagada project with her parents. The Medical Officer advised her for correction of her deformity of her hand. The surgery was carried out and she responded well. The appearance and function of her hand improved tremendously. Soon she regained all her hopes. There was a resounding change in her life and was accepted by her family, constantly thanking the doctors for giving her a new life which she thought had been hopelessly lost.


After

K R Extension, Pavagada, Tumkur District, Karnataka-561202 Phone: 08136-244548 e-mail: swajapa@yahoo.com

St. John's Hospital & Leprosy Services

Project Holder : Fr. Jose Kizhakedeth

Staff : 10 (Hospital: 6 Admin: 1 Field: 3)

Facilities :
- Hospital with 40 beds for Leprosy & TB
- Designated Microscopy Centre
- TB-HIV Care Centre

Budget : Rs. 1930700

LEPROSY CARE	2010	2011	2012
New leprosy cases diagnosed and referred to PHCs	9	6	10
Among them MB	9	4	6
Reaction cases managed	7	7	11
Surgery done	0	5	0
In-patients managed	111	164	141
Bed days	8229	6956	5607
LEP beneficiaries	20	50	15
Protective foot wear (MCR) provided	262	156	224

TUBERCULOSIS CARE	2010	2011	2012
Total New TB cases registered	48	20	22
Among them New Sputum Positive cases	22	11	15
Sputum Conversion rate for NSP	70%	72%	70%
Cure Rate for NSP	43%	43%	65%
In-patients managed	25	13	17
Bed days	2176	472	577
MDR cases under treatment	0	0	0
TB cases given Nutritional supplement	25	18	16

This hospital located in Pirappancode, Thiruvananthapuram district of Kerala state is involved in Leprosy control activities since 1955, it supports TB control activities through its District Consultancy Team (DCT) since 1996 in Thiruvananthapuram. The project is recognised for its Designated Microscopic Centre facility. The hospital provides tertiary care for both leprosy and TB patients with complications, through its 40 bedded hospital. The project caters DPMR services throughout the district of Thiruvananthapuram and Kollam district.

Robert says I am confident now

I was suffering from ulcer for a long time and I did not know what to do. Both my feet were numb and there was no pain. For some time I took treatment for my ulcer from Leprosy Sanatorium in Nuranadu, Kerala. My family members avoided me and I felt alone. I was not able to walk and I could see my stump bone ebbing out of my right toe. I lost the toes of my right leg. The toes of my left leg were already absorbed.

I visited St. John's Health Services, where I was told that I had multiple sinuses in my right foot. My ulcer was cleaned up, dressed and given antibiotics. In spite of the treatment, the condition of my ulcer deteriorated and I was advised to consult a surgeon. I was depressed when I was informed by the surgeon, that my leg may have to be amputated. I asked the surgeon to cut my throat rather than cutting my leg. I was put under local anesthesia and the surgeon removed the bone parts and dressed with antibiotics.

I stayed in the hospital for almost six months and by the grace of God my ulcer healed and was discharged. I thanked the doctor and the team of workers at St. Johns Health Services for saving my foot.

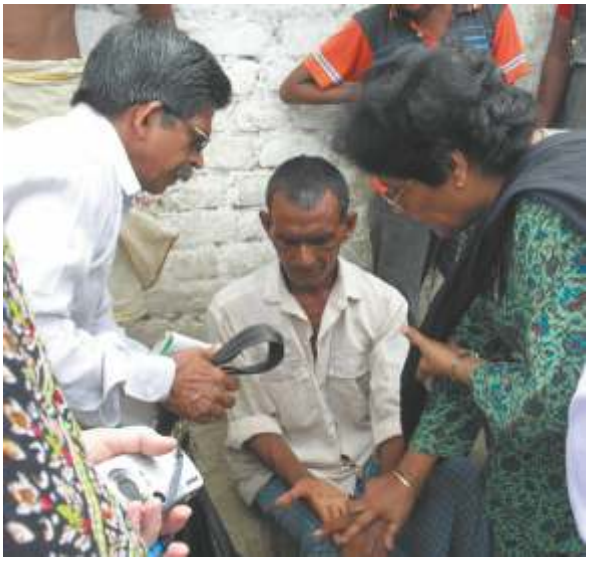
Pirappancode Post, Thiruvananthapuram District, Kerala-695607
Phone: 0472-2872047 e-mail: stjohnshealthservices@gmail.com

District Consultancy Teams (DCT): Bihar and Andhra Pradesh

DFIT adopted a new strategy of providing a District Technical Support Team (DTST) consisting of one Medical Officer and one or two Supervisors for each district for building the capacity of general health staff and community was implemented in 28 districts in Bihar, one district in Delhi and initially 3 districts and later on expanded to 3 more districts in Andhra Pradesh. Success of this strategy in leprosy control leads to its extension in TB control. While technical support for leprosy control ended in March 2007, support to TB control programme was continued in 28 districts in Bihar and 6 districts in Andhra Pradesh (Population covered 102 million).

The Teams from DFIT for supporting TB control in Bihar and other States were called District Consultancy Teams (DCT). Each team composed of one supervisor who had been trained in Revised National TB Control Programme (RNTCP). Initially a medical person designated as TB Medical Advisor / Medical Consultant supervises the DCT in five to six district with the support of 6 Zonal supervisors for mid level supervision cover 3-4 districts each and they assist the teams in supervision and monitoring but there was found to be no added value of mid level supervisors and it was dropped in 2012 in Bihar but continued in Nellore zone for the monitoring purpose. All the members of DCT were provided with vehicles. TB Coordinator guides and supervises the teams. Major role of the teams is capacity building of the community, key staff of RNTCP and laboratory staff. System support includes strengthening of infrastructure by providing key staff wherever essential, providing Lab materials including Microscopes, helping in the transportation of drugs from State depots to districts and from districts to TB units.

The total number of staff working for Damien Foundation in Bihar and Nellore zone for support to TB control is 94, which include 4 Medical doctors, 25 TB Supervisors, 2 Laboratory Coordinator, 2 microbiologists, 14 Para Medical Workers, 35 Drivers, and 13 Administrative Staff. The teams visit Primary Health Centres (PHC) and Designated

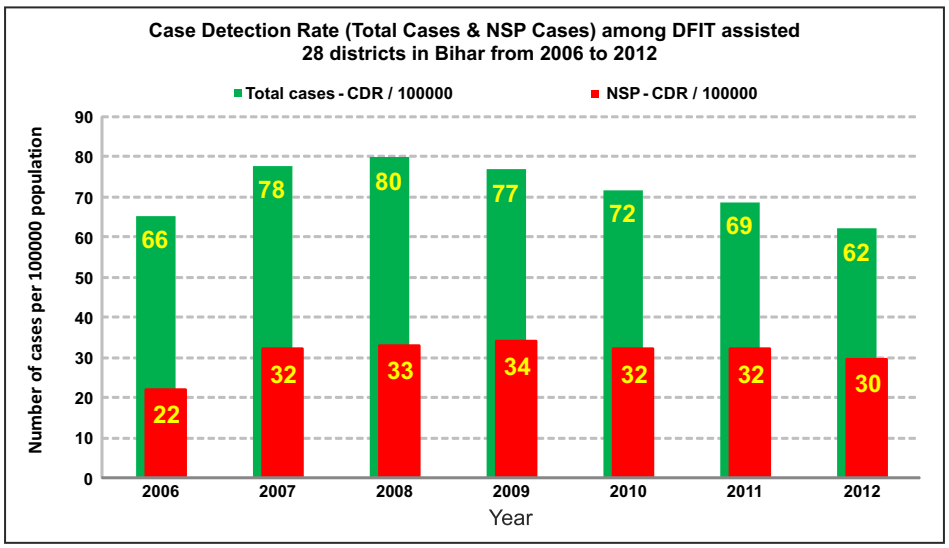


Microscopy Centres (DMC) based on the problems identified during previous visits along with STS and STLS. All health facilities are covered at least once in six months some times more frequently depending on the need. They assist in retrieval of absentees and defaulters, facilitate the trainings and review meetings at district and PHC level. Teams visit sample of cases under treatment to ensure the DOT and treatment regularity. On–the-job guidance to all categories of personnel is done during these visits. Feed back is given to Medical Officer in PHC and District TB Officer (DTO). Teams also ensure that TB control activities were reviewed during monthly meetings at different levels.

Two Laboratory Coordinators are mainly involved in training the Lab staff in supervision and monitoring of the Sputum Microscopy services. The trainings are usually organised once in two years by the Govt and the role of lab coordinator is to facilitate the trainings.

Progress in case notification:

The estimated New Sputum Positive TB case load was 75 per 100000 population. The target for case detection in the national guideline was 70% of estimated cases i.e. 52 per 100000 population. The target was revised from 70% to 90% by the TB programme in 2012.

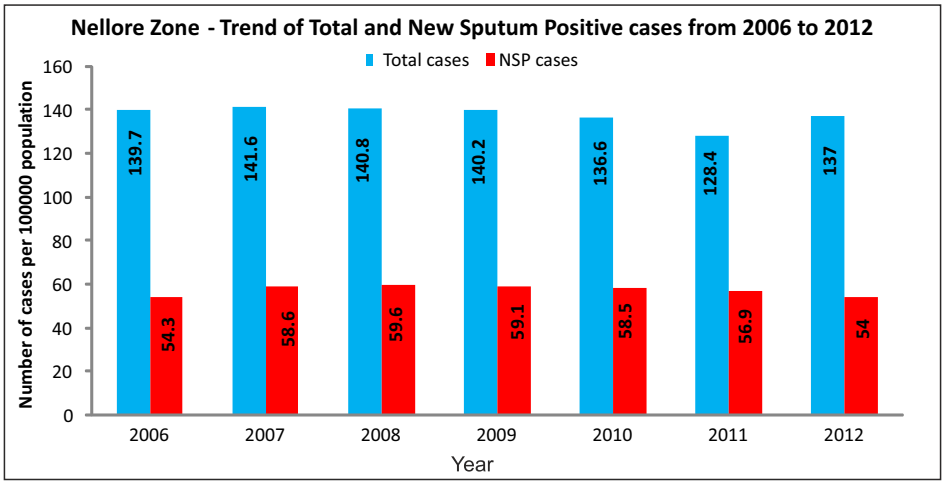


Bihar:

Improvement in NSP case notification was observed in 13 districts which could achieve more than 32 NSP cases per 100000 population but there was no improvement observed in 15 districts. The average NSP case detection rate was around 31 per 100000 population in Bihar compared to 32 per 100000 population in 2010, one of the main reasons for no improvement in case detection could be non-functioning of 19% of the DMCs due to vacancy of lab technicians, second main reason could be due to irregularity of LTs at DMCs, due to delay in payment of salaries. These Administrative issues were discussed frequently with the district level officers and also at State level officers, but there was no impact. It was also observed that medical officers were overburdened with large number of outpatients, each medical has to provide medical care for 100 to 120 patients per day which sometimes leads to missing of chest symptomatic for screening TB. DFIT teams made an intervention through training the LTs and Pharmacists to screen chest symptomatic at patients waiting place. It was observed that only 81% of the DMCs were functioning and remaining were not functioning due to vacancy of lab technicians. Additional DMCs sanctioned during 2012 as per the revised population, efforts were made to involve Rural Medical Practitioners (RMPs) and General practitioners (GPs) in TB control. The DFIT team trained 1293 GPs including RMPs in 2012 and were involved in various IEC activities during routine field visits. Teams provided information on TB through public announcement system; team covered 4976 villages for awareness on TB and also 100329 school children including teachers. With introduction of ASHA the situation has improved and most of the villages benefitted through them as they constituted a channel for accessing health services in Bihar. During the reporting year 30652 (82%) of ASHA workers were given re orientation training on TB. DFIT has established sputum collection centres in 61 places, they altogether collected 2583 samples of which 265 were found to be positive.

Nellore zone:

There has been an improvement in total TB and NSP case notification in Nellore zone. It was observed that 74% of the estimated cases were diagnosed in 2012 but there was slight reduction compared to 2010 (76%), this reduction was mainly due to vacancy of lab technicians in 14 DMCs. An alternative arrangement was made to make these DMCs functioning for three days a week through the deputation of lab technicians from non DMCs. Teams disseminated information on TB in 2688 villages through public announce system and sensitised 14979 school children including teachers. During the reporting year 5054 (31%) of ASHA workers got



trained in RNTCP. Team trained 263 GPs including RMPs in TB control through one to one meetings and continuous medical education.

Progress in patient management:

Bihar: Health facilities with quality diagnosis was observed in 81% of the DMCs compared to 85% in 2010, this reduction was due to increase in the number of additional DMCs. Treatment card update at health facility was improved from 72% in 2010 to 75% in 2012. Wrong categorisation declined from 4% in 2010 to less than 3% in 24 districts in 2012, it could not be achieved in remaining districts due to newly recruited medical officers who were not trained in TB and another problem was shortage of Cat II medicines in third and fourth quarters, this shortage resulted in prescription of Cat I medicines for retreatment patients.

Timely follow-up of sputum microscopy was 88% which is maintained since 2010. Improvement in microscopy services and better functioning of health workers, ASHA workers and monthly reviews could be the reasons for good follow up examination. The teams conducted re orientation training of 9467 (92%) health staff, 30652 (93%) ASHA workers and 798 (80%) medical officers in 2012.

DFIT had provided infrastructure support to improve functioning of health system:

1. Placement of Laboratory Technicians: As a stop gap arrangement DFIT provided 20 lab technicians on request from State TB Officer to facilitate smooth functioning of DMCs. Team facilitated reorientation training for 73 lab technicians in 2012.

2. STS/STLS in Vaishali district: Vaishali district had problem in recruiting supervisory staff (STS and STLS) in RNTCP. On request of STO Bihar and DTO Vaishali DFIT facilitated placement of 5 supervisory staff who took up duel responsibilities (STLS cum STS) from 2008 and this support has been continued.

3. TB Units under DFIT: DFIT was requested to provide support to TB units in underserved areas. Accordingly two TB Units were supported (by providing a STS and STLS at Bagha-1 TU and Bahadurganj TB Unit). TB units supported by DFIT had been performing well in both case notification and treatment outcome in 2012.











Damien Foundation India Trust
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DAMIEN FOUNDATION URBAN LEPROSY, TB CENTRE


Charitable Organisation for Leprosy & TB Control

Case notification and end results from 2007 in Bagha I TB Unit in West Champaran – Bihar

Year	Population	Case detection		Case notification (per lakh)		Conversion Rate	Cure Rate
		NSP	Total	NSP	Total		
2007	349000	59	169	17	48	45/56 (80%)	15/36 (42%)
2008	359000	109	266	30	74	78/87 (90%)	30/59 (51%)
2009	450000	234	435	52	97	209/219 (95%)	96/110 (94%)
2010	582000	279	385	48	66	240/245 (98%)	226/236 98%)
2011	582000	256	371	44	64	270/281 (96%)	256/279 92%)
2012	595000	305	427	51	64	270/281 (95%)	236/256 92%)

Case notification and end results from 2007 in Bahadurganj TB Unit in Kishanganj district – Bihar

Year	Population	Case detection		Case notification (per lakh)		Conversion Rate	Cure Rate
		NSP	Total	NSP	Total		
2007	480000	135	209	28	43	86/96 (90%)	28/47 (60%)
2008	492000	253	386	51	78	221/251 (88%)	85/135 (63%)
2009	500000	180	381	36	76	173/190 (91%)	221/253 (87%)
2010	541000	176	344	33	64	172/183 (94%)	141/172 (82%)
2011	541000	216	313	40	58	211/226 (93%)	171/191 (90%)
2012	620000	212	309	34	50	186/204 (90%)	191/216 (88%)

4. **Reagents:** DFIT supplied lab chemicals and materials to DMCs on request from districts for uninterrupted and smooth functioning of labs in 2012.

Material	Quantity
1. Sputum cups	5500
2. Slides	16000
3. Basic Fuchsine	10 Bottles (25 Gm.)
4. M. Blue	4 Bottles (25 Gm.)
5. H2 So4	21 litres
6. Distilled Water	190 litres
7. Spirit	61.5 litres
8. Phenol	311 Bottles (500 Gm.)
9. Immersion oil	47 (Bottles (30 ml)
10. Tissue Roll	20 Rolls
11. Lens Paper	20 Books
12. Filter Paper	20 Packs
13. Diamond Marker	20 Nos.
14. Cotton Rolls	93 Rolls
15. Sprit Lamps	26 Piece
16. Dropper Bottles (125 ml)	130 Nos.

I Minor repairs: Lab coordinators visited the DMCs with problems identified by the team and minor repairs were done in 25 DMCs and 10 microscopes were given as stop gap arrangement.

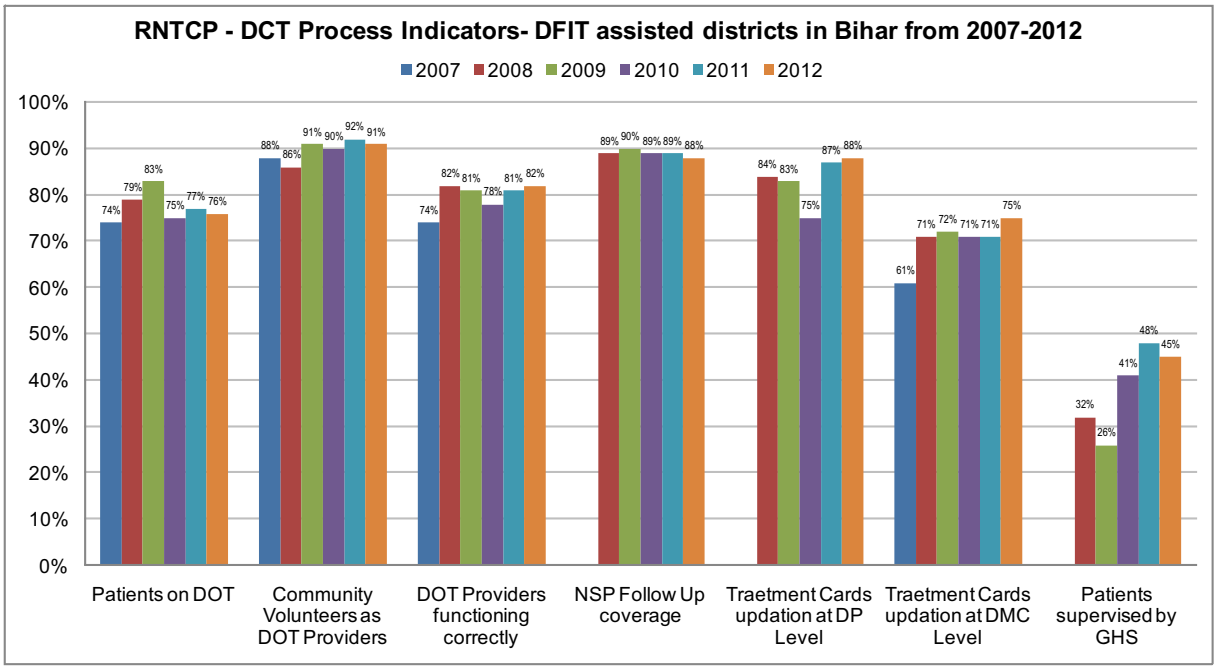
ii. Sputum collection centres: TB suspects and TB patients under treatment could not reach DMCs (underserved population) for various reasons such as poor transportation mechanism from village to health facilities, non-functioning of nearby health facility or DMC, villages near riverbeds depend only on water transportation. These places were identified and sputum collection centres were made available through community volunteers. About 61 sputum collection centres have been established in different districts (one to two centres in 28 districts). Some of them were functioning from 2008 and 16 centres were closed due to non-functioning (no samples collected from these centres consecutively for one

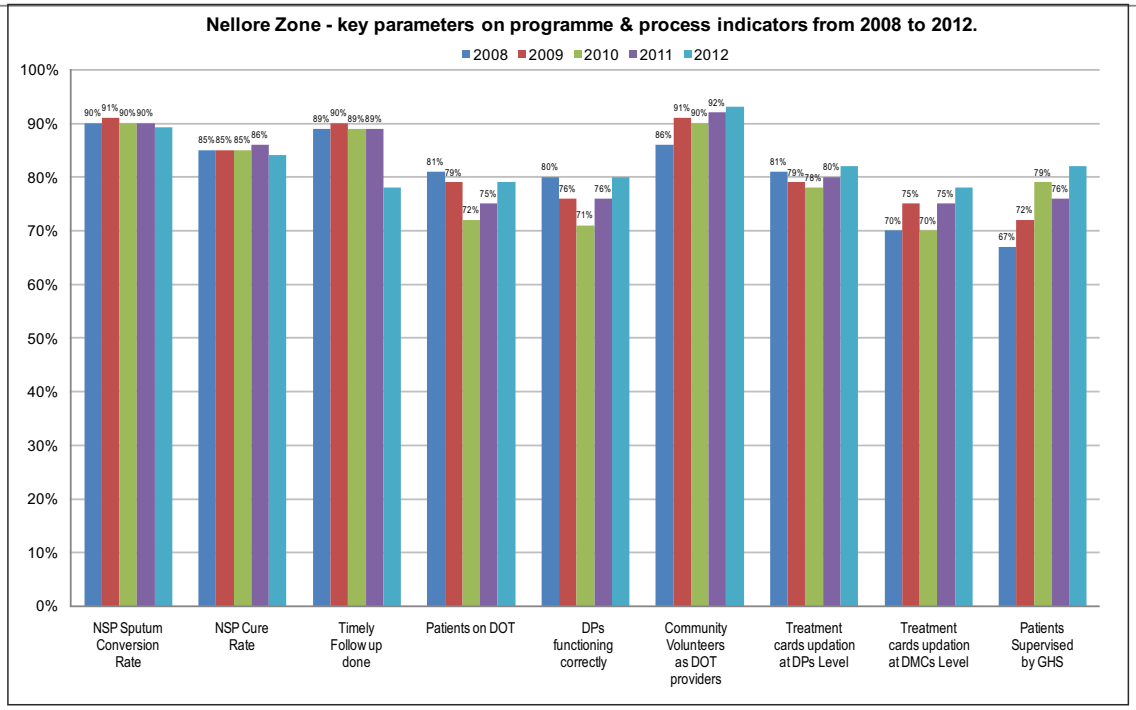
year) even after frequent monitoring visits in 2012. About 2583 samples collected through these centres and 265 samples found to be positive.

DOT supervision was improved from the time of involvement of ASHA workers in TB control programme (2008). Over all a slight improvement was observed in DOT supervision, it was 76% compared to 75% in 2010. It was observed that 12 districts could achieve more than 80%. This was mainly due to improvement in functioning of DOT providers which was improved from 78% in 2010 to 82% in 2012. It was more than 85% in 10 districts.

One of the key activities of the teams was to retrieve absentees and defaulters from the treatment, the DFIT teams could retrieve 382/483absentees and 83/155 treatment defaulters (probably from 2011 and 2012) in 2012 during patients visit. TB patients tend to default without adequate means for earning livelihood, for this reason, DFIT provided nutritional supplement to 416 patients. Even though defaulter level was considerably reduced in all the districts, it still remains too high, this was mainly due to more attention being given to NSP cure rate by the TB control programme. Good progress was observed in cure rate, over all it was 79% compare to 76% in 2010. It could achieve more than 82% cure rate in 12 districts and overall success rate was 88%. There was improvement in the management of TB patients with HIV co infection, even though it was planned to establish HIV testing centres at PHC level, the state had failed to establish HIV testing centres at all PHCs. TB patients were asked to visit district hospital for HIV testing, majority of patients were not willing to reach district hospital due to the long distance and travelling cost. This was the main reason for not achieving the target. It was noticed that 20% of the TB patients were screened for HIV compared to 8% in 2010. It was expected from the Govt expanding HIV testing centres at PHC level in 2012 as per National AIDS Control Programme plan. It was not happened due to lack of political commitment. DFIT discussed this issue with STO and WHO consultants, it was assured that a special cell with technical team for AIDS control will be established in Bihar in 2013. Teams motivated TB patients for HIV test and provided them referral slips during field visits. But only a few who can afford were reached district head quarter for HIV testing.

Nellore: It was observed that quality diagnosis has improved from 86% in 2010 to 94% in 2012. Re orientation training was given to all the STLSs in six districts. Card updation at health facility has improved from 62% in 2010 to 78% in 2012 but it was 85% in three districts. Wrong categorisation declined from 3% in 2010 to less than 1% in 2012. Over all timely follow-up was around 78%, it was observed around 85% in three districts. It was improved when compared to 2010. Sputum conversion rate was around 90% in all the 6 districts. The teams carried out re orientation training of 4232 health staff and 5054 ASHA workers in 2012. The teams facilitated the training on MDR TB for 23 PHC medical officers and 263 RMPs. It was observed that involvement of the community was very interesting in all six districts, it was one of the important features of successful TB control programme in terms of good case notification and cure rate in all the 6 districts. DOT supervision has improved from 64% in 2010 to 79% in 2012 and three districts had achieved around 85%. There was improvement in functioning of DOT providers from 65% in 2010 to 80% in 2012. It was around 85% in two districts. One of the key activities of the team was to retrieve absentees and treatment defaulters. It was maintained below 5 % in all the six districts. Teams could retrieve 570 absentees and 68 treatment defaulters in 2012. TB patients tend to default for treatment without adequate means for earning livelihood. DFIT provided nutritional supplement to 76 patients. The defaulter level declined marginally in all the districts; this was mainly because of high priority given towards TB control programme by the Govt. Management of TB-HIV co infection was improved in all six districts, Screening of TB patients for HIV has improved from 70% in 2010 to 91% in 2012. Two districts could achieve more than 85% cure rate and around 83% in 4 districts, overall success rate was around 90%.


RNTCP - DCT Process Indicators- DFIT assisted districts in Bihar from 2007-2012
2007 2008 2009 2010 2011 2012
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
74% 79% 83% 75% 77% 76%
88% 86% 91% 90% 92% 91%
74% 82% 81% 78% 81% 82%
89% 90% 89% 89% 88%
84% 83% 75% 87% 88%
61% 71% 72% 71% 71% 75%
32% 26% 41% 48% 45%
Patients on DOT
Community Volunteers as DOT Providers
DOT Providers functioning correctly
NSP Follow Up coverage
Traetment Cards updation at DP Level
Traetment Cards updation at DMC Level
Patients supervised by GHS


Nellore Zone - key parameters on programme & process indicators from 2008 to 2012.
2008 2009 2010 2011 2012
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
90% 91% 90% 90%
85% 85% 85% 86%
89% 90% 89% 89%
81% 79% 72% 75%
80% 76% 71% 76%
86% 91% 90% 92%
81% 79% 78% 80%
70% 75% 70% 75%
67% 72% 79% 76%
NSP Sputum Conversion Rate
NSP Cure Rate
Timely Follow up done
Patients on DOT
DPs functioning correctly
Community Volunteers as DOT providers
Treatment cards updation at DPs Level
Treatment cards updation at DMCs Level
Patients Supervised by GHS

Progress in programme management:

Bihar: Maintaining buffer drug stock at all the health facility levels is an important aspect in TB control to initiate the treatment at the earliest to prevent the delay. Early initiation of treatment will prevent the initial defaulters. At least one month drug stock had been maintained in all the health facilities during 2012. There was shortage of Cat II drugs including streptomycin for one month in the districts and even in the State during third and fourth quarter. Teams provided the assistance in transportation of drugs from districts to TB units and to PHCs. There was improvement in programme review levels. Monthly review meetings were conducted in all the districts and 93% of the PHCs during 2012 when compared to less than 50% in 2010. Teams participated and shared their field observations in the meetings at all district level review meetings and at 320 PHCs and at the district level in all the districts once a month.

Nellore zone: There were no serious problems in supply of drugs except that there was shortage of Cat II drugs and Streptomycin for 2 months at district level. At least one month buffer stock was maintained at all the levels. Monthly review on TB control had been conducted at district and PHC level in all the districts. Teams participated in 259 PHCs and monthly meetings at district level, shared their field observations and suggestions in the meetings.

Progress in MDR TB control programme

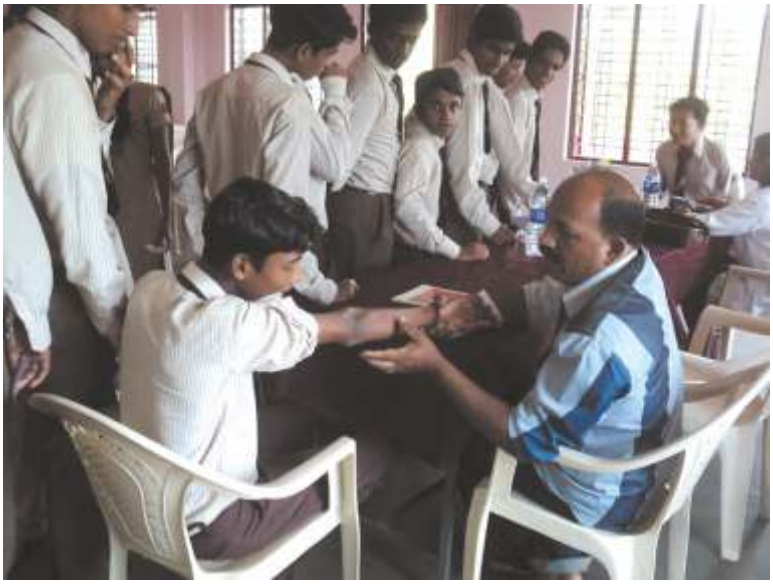
Bihar: The proportion of defaulters among retreatment cases was reduced in 12 districts and there was no increase in remaining districts. TB patients tend to default to treatment, as they are unable to tolerate the side-effects of TB drugs. DFIT provided nutrition supplement to 416 TB patients during the treatment and referred those with severe side effects to nearby PHCs. Teams could retrieve 382 absentees and 83 defaulters in 2012.

MDR TB control programme has been implemented in 5 districts in the first quarter of 2012. DOTs plus site started functioning in Patna from March 2012. The Govt referral laboratory is still not functional. All the samples for diagnosis and follow up were sent to another state for the culture and sensitivity.

Nellore: There was considerable reduction in defaulters among retreatment cases in 3 districts. Reasons were more or less same when compared to the year 2011. DFIT provided nutrition supplement to 55 TB patients during the treatment and referred those with severe side effects to nearby PHCs. Teams could retrieve 229 absentees and 54 defaulters in 2012. MDR TB control programme was supposed to be implemented in entire Nellore zone by the end of first quarter 2011 but there was delay in the whole implementation process. Training of key staff, health staff of various cadres and appraisal of districts was completed only in August 2011 and again there were changes in the protocol for the diagnosis of MDR TB. One major change that occurred in the diagnosis of MDR TB was that the use of molecular techniques helped to prevent unnecessary delay. Another change was in the inclusion criteria for suspects screening.

The programme decided to include all re treatment sputum positive cases, follow up sputum positives and sputum positive contacts of MDR TB cases. The number of suspects expected had raised to ten times when compared to previous criteria (only Failures of NSP, Re treatment cases and sputum positive contacts of MDR TB cases). The lab at Nellore was accreditated for Line Probe Assay (LPA) in Feb 2012. As per the MoU, project in Nellore started delivering services in 6 districts from March 2012. It was observed that only 44% of the MDR TB suspects were screened for drug resistance. It was less due to lack of required logistics, for example lack of sputum containers, boxes for the transportation etc. Team visited 80% MDR TB patients once a month during the intensive phase. It was observed that there was delay in starting treatment due to delay in supply of second line drugs. Around 30 MDR TB patients had to wait for the drugs for nearly one month.

District Consultancy Team (DCT) in Kerala



DFIT has been supporting TB control Programme in Thiruvananthapuram district by placing a District Consultancy team since 2004. In 2012 the district registered 1246 New Sputum Positive cases among 2646 cases of TB of all types. Cases notification ranges from 31-35 per 100000 population for NSP and 70-75 per 100000 population for total TB cases since the beginning of the programme. Among 1280 patients visited by the team 79 % was found to be on DOT. Out of 870 DOT providers visited, 80% of them are monitoring patients on DOT. The sputum conversion rate ranges from 85% to 90% for the last three years and Cure rate ranges from 80% to 86%.

DPMR activities:

DFIT started supporting DPMR activities from 2008. All the 86 PHCs are covered by the team. The disability cases on record as on 2012 are 346. Out of them 334 (89%) patients were visited and 297 found practicing self care regularly. Out of 57 patients with ulcers monitored, the team found that ulcers healed for 22 patients. The team followed 58 General Health (GH) staff and found that 28 (50%) of the staff are monitoring patients practicing Self care. The team provided 224 pairs of protective footwear to the needy patients with disabilities.

Support to Leprosy Control: ILEP Coordination in Bihar State

DFIT has been providing support in thematic areas in leprosy control at state level since 2007 after the integration of leprosy services into the general health system. DFIT as the Co-ordinating ILEP member has placed a State Co-ordinator at Patna assisting State Leprosy Officer in planning, monitoring and implementation of leprosy control programme.

During the year the State detected 18639 cases of leprosy (MB: 8975-48%); Disability rate was 2.03%.; Child rate was 16.2%.; ANCDR: 10.03 per 100000 population & PR: 1.23 per 10000 population; reaction cases managed at PHC level: 463 and at District level 81. The PHCs referred 12 cases of suspected relapse and among them 5 were confirmed as relapse by the district.

DPMR activities:

Two Physio-technicians were placed by DFIT to assist DPMR activities in 28 districts. In 17 POD camps conducted by the team, 1354 ASHA workers, 521 GH field staff and 86 patients were trained in self care and 145 new cases of leprosy were diagnosed during the camps. 105 patients affected by leprosy disabilities were provided socio economic rehabilitation support till 2012, involving Rs. 6,95,000/-.

Establishment of referral centre brings ray of hope

Thikau Kumar Sahani is 25 years old living in Pansala Chowk village in Darbanga District of Bihar. Thikau has severe physical impairments due to Leprosy. His mother died soon after his birth and his father remarried. Thikau's uncle, who was childless, adopted him on seeing his pathetic condition. Thikau had a small pale patch over his right thigh 6 years back, for which he went to a nearby Primary Health Centre where he was misdiagnosed and was treated for some other skin disease. After about one year he noticed partial clawing of fingers in his right hand, for which he again approached the same PHC but due to lack of awareness and training of health staff in leprosy, his condition was ignored again and was prescribed symptomatic treatment.

In the mean time the neighbours advised him to take some alternative medicines for his condition for which he travelled to India-Nepal border where he took some herbal medicines. His condition kept on worsening over a period of time. By 2011 he had developed clawing of all fingers of his right hand. He had lost sensation in his left hand, soles of both the legs and developed ulcers on both his feet. Along with this physical deterioration, Thikau was discriminated by his family. Despite this physical condition, he was forced to work for his livelihood as a tricycle puller.

During routine visit of a leprosy health worker he was noticed and was brought to the Singhwara PHC where he was put on MDT. During the winter he was warming himself in front of a bonfire. Due to lack of sensation he did not even notice that both his hand and feet were burnt. DFIT team noticed his condition and took him to its newly established referral hospital at Dehri-on-Sone. He was managed for complications and counselled for regular self care

Thikau Kumar's story is a good example for the need of referral centre for leprosy in a state like Bihar.

Disability Prevention & Medical Rehabilitation (DPMR)

DFIT has been involved in DPMR activities after the integration of leprosy control services into the general health system. The strategy which was experimented in Salem district through its NGO project (SMLC) was successful and replicated in 22 districts in 4 States (10 districts in Tamilnadu, 3 in Andhra Pradesh, 1 in Kerala and 8 in Jharkhand) through its NGO Projects. The strategy followed was very simple. The NGOs collaborated with one or more districts and assisted the District Nucleus team in planning, implementing, supervision & monitoring the DPMR activities. Key staff within the district were identified, trained and guided frequently by the NGO project staff in implementing the DPMR programme. GH staffs were trained in such a way that they update the existing list of persons affected by leprosy related disabilities and arrange DPMR camps at the block/PHC level to train the staff and the patients with practical demonstration on self care practices.

The projects are also providing the services for the management of complications including RCS and livelihood enhancement, which facilitates the persons to lead a respectable life.

Involvement of Civil Society Organisation (CSO) to enhance DPMR services: A Pilot study done in Krishnagiri district, Tamil Nadu

Background:

Damien Foundation in India conducted an observational study to examine the feasibility of involving civil society organisations to implement sustainable leprosy services in Krishnagiri district, Tamil Nadu in the year 2012. DFIT supported project in Salem being a nodal NGO (experience in leprosy control and having referral centre for managing complications) took the initiative to implement the newer strategy, it identified four local development NGOs having good network at gross root level to cover the whole district for POD services. These NGOs are mainly involved in women empowerment through facilitating self help groups in villages to deliver microfinance services, rural development, education of children and health education. Nodal NGO was made responsible to train local NGOs in self care, identification of suspects, establish coordination with the government health system, monitoring and supervision of entire process. The local NGOs were requested to submit the monthly reports to nodal NGO. The intervention package for the involvement of local NGOs includes updating the list of disability cases; visit persons affected by leprosy with disability to support and motivate them to practice self care; refer patients with complications; identify, provide and monitor the livelihood support

for needy persons and facilitate to receive government entitlements and dissemination of message on leprosy and refer suspects to Primary Health Centres.

Results:

The NGO staff and volunteers updated the list of persons affected by leprosy with disability. Initial list of 505 persons affected by leprosy with disabilities received from District Leprosy Office was updated by the local NGOs and the numbers became 410 after additions and deletions from the list. An assessment after one year of implementation showed a remarkable improvement in the proportion of disability cases practicing self care from 16% to 89% and all of them were frequently monitored by local NGO members. Around 70% of plantar ulcers were healed. There were 35 new leprosy cases confirmed from 323 suspects referred by the local NGOs. Fifty one persons were identified and supported with socio economic assistance. The most promising result was change in the mind-set of the community towards persons affected by leprosy. The local NGOs members were able to provide counselling, assist them to receive government entitlements and ensure regular practice of self care.

Conclusion:

Involvement of Civil Society Organisations to improve the access and sustainability of the leprosy services is feasible. It will be useful to evaluate after 3 to 4 years to assess the situation in Krishnagiri district in order to get an idea about the long-term impact and the degree of sustainability of this approach. The short-term impact is undeniably positive but we cannot say anything yet about the long-term effects.

Results: implementation period from January to December 2012. (population covered: 18, 83,731)

Information	NGOs				
	REEDS	KINGSLEY	RDC	ARCOD	Total
Number of Persons affected by leprosy with disabilities at the beginning of the project (as/ Govt. data)	47	188	60	73	368 + 137 Leprosy home = 505
Number of Persons affected by leprosy with disabilities deleted from the list during one year period (2012)	36	125	41	11	213 + 19 deleted from Govt. homes = 232
Number of Persons affected by leprosy with disabilities added to the list during one year period (2012)	37	73	27	-	137
Number of Persons affected by leprosy with disabilities at the end of 2012	48	136	46	62	505-232+137 =410 (118 are living in leprosy home)
Number of Persons affected by leprosy with disabilities visited during the year (cumulative by nodal NGO)	48	136+118 (leprosy home)	46	35	383
Number practising self care	48	130+118 (leprosy home)	45	29	370
Number of persons with plantar ulcers among 410 persons affected by leprosy	25	48	17	13	103
Number of persons free from plantar ulcers at the end of 2012	18	35	13	6	72
Number of them required foot wear were identified in 2012	36	80	32	23	171
Number of them provided foot wear in 2012	30	73	29	23	155
Number referred to hospital/PHC for any problems (cumulative)	7	19	14	1	41
Number of persons received LEP support	20	14	11	6	51
Number of suspects referred to PHC for diagnosis	109	81	102	31	323
Number of leprosy cases confirmed	13	5	17	-	35

Prevalence of cough symptomatic in Punganur and Puttur Tuberculosis Unit (TU), Chittoor District, Andhra Pradesh

Satheesh[1] & Santhosh Kumar[2]

Background:
Chittoor is one of the districts in Andhra Pradesh implemented RNTCP in the initial phase in 2001. In Punganur TU the case detection has been found to be consistently low since the implementation of RNTCP. It has not shown any improvement even after repeated sensitization. The aim of the study is to find out whether any difference in the prevalence of cough symptomatic (cough more than two weeks) in both the TB units.

Methodology:
Puttur and Punganur TU have the highest and lowest case detection in Chittoor district respectively. Cross sectional survey was carried out in seven mandals covering 42 villages in Puttur and Punganur. The sample size was estimated to be around 4200. All adults above 15 years of age were included in the study. The survey was carried out by TB supervisor with the support of local health staff in 2012.

Results:
The prevalence of cough symptomatic was found to be 1.35% (38/2799) and 0.92% (19/2061) in Puttur and Punganur TU respectively. (p 0.16) Out of them one was diagnosed as sputum positive TB in Punganur and three as sputum positive and one sputum negative TB in Puttur. Suspect referral for sputum examination was found to be higher in Punganur. Sputum positivity rate is low in Punganur TB Unit.

Conclusion:
Prevalence of chest symptomatic was found to higher in Puttur TB Unit when compared to Punganur TU but not statistically significant. Plausible explanation for the low case detection in Punganur could be due to low TB transmission because of the predominantly rural, scattered population compared to Puttur.

1-Zonal TB Supervisor, Chittoor, Andhra Pradesh
2-Chief Medical Advisor, DFIT Chennai.

Evaluation of Livelihood Enhancement Programme (LEP) to assess the long term impact

Introduction: Persons affected by leprosy with disability face socio economic barriers mainly due to stigma and discrimination within their families, community and work place. Socio economic assistance could help them to improve their livelihood options and raise their status in the community. Damien Foundation has initiated its socio economic rehabilitation programme in India in the year 2007. The support was provided in the form of livestock like cow or goats and self employment assistance. The aim of this study is to assess the long term impact of the socio economic assistance in improving the livelihood of the affected people.

Methods: Damien Foundation India has conducted a cross sectional survey using a semi structured interview schedule to study the socio-demographic profile of the beneficiaries, impact of the socio economic support and access to government entitlements. Beneficiaries supported in the year 2008, 2009 and 2010 were interviewed by the field staff. In case of absence of beneficiary, family members were interviewed. The support provided is considered to have long term added value if it is utilized by the beneficiary or family members currently for generating income or the support provided is sold and invested in to another activity. The support provided is considered to have no long term added value if the support provided is completely sold or all the livestock has died. The data was entered and analyzed using the statistical software Epi InfoTM 7.

Results: We have contacted 315 beneficiaries supported in 2008-10. Among them 266 (84.4%) persons are available for the interview, 37 (11.7%) died and remaining migrated or not traceable. The mean age of the beneficiaries is 52 years and 81% of them are above 40 years. Support was provided to 121 (38%) women. Around 55% of beneficiaries are from socially deprived groups. Majority of them are Illiterate (71%), have own house (89.5%) and do not own land (69%). Around 10% of beneficiaries are

living in leprosy colonies. Around 50% of the beneficiaries receive disability or old age or widow pension from government. Beneficiaries were supported with live stock like cow/buffalo (20.5%), goat/sheep (48%) and other self employment (31%). Among those received livestock 10% have died. The programme has long term added value among 71% of the beneficiaries in improving their livelihood option. The support provided in the form of goats and beneficiaries from leprosy colony was found to be significantly associated with poor outcome.

Conclusion: The programme has long term added value to improve the livelihood options of persons affected by leprosy.

Operational Research - UMDT Trial in Bihar

Field trial on Uniform Multi Drug Therapy (UMDT) for all types of leprosy is a multi centric trial by the World Health Organisation (WHO). This trial design is prospective, non-randomised, controlled and open trial.

Damien foundation India Trust as one of the participating centres has recruited 1070 newly detected leprosy patients in the Study area (Gaya & Rohtas districts) from 2005 to 2007. The treatment regimen employed in this group is MB treatment for all cases (MB & PB) for six months.

In the Control area (Nalanda district) 918 newly detected leprosy patients have been included in the Study. The treatment regimen employed in this group is the standard regimen employed under NLEP.

The objective of the study is to determine the efficacy of short duration of MDT with three drugs among both Multi-bacillary (MB) and Pauci-bacillary (PB) leprosy in comparison to presently employed standard regimens.

Among 1070 patients in Study group 926 (86.5%) patients completed treatment and out of 918 patients in Control group 786 (85.6%) patients completed treatment. Drop out including temporary migration during treatment was 13.5% in Study group and 14.4% in Control group. Lepra reactions were observed during treatment period in 3.2% in Study group and 2.5% in Control group.

Annual follow-up assessment:
Follow up of these patients was initially planned for eight years. But recently NIE, after meeting experts in the Leprosy field have decided to end the Study at the end the fifth year.

The patients have shown no signs of deterioration or relapse in either of the groups during 2323 person years of follow up in Study and 2088 person years in Control group. Leprosy Reactions were observed in 7.5% of patients during first year of follow up in Study group and it was 4.1% in Control group. Majority of lepra reactions were observed during first year of follow up (63.2% in Study group and 61.5% in Control group).

Follow up examination will be completed in Gaya district at the end of year 2012 and three months grace period is allowed up to March 2013 to complete the data analysis and in Rohtas follow up examination will be completed in December 2013 and a three months grace time is allowed to complete the data analysis up to March 2014. Follow up examination in Nalanda district-Control area will come to end in June 2013.

Intake:

Group	Period	District	MB patients	%	PB patients	Total
Study	Jun. 2005 - Jun. 2007	Gaya	181	28.7	450	631
	Jun. 2007 - Jun. 2008	Rohtas	176	40.1	263	439
		Total	357	33.4	713	1070
Control	Jun. 2005 - Jun. 2007	Nalanda	330	35.9	588	918

Treatment

Results	Study Group		Control group	
Completed treatment (RFT)	926	86.5%	786	85.6%
Drug side effects	11	1.0%	1	0.1%
Refusal	16	1.5%	7	0.8%
Migrated	51	4.8%	100	10.9%
Died	1	0.1%	4	0.4%
Others	65	6.1%	20	2.2%
Total	**1070**	**100**	**918**	**100**

Yearly follow-up

Details	Study Group					Control Group				
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 1	Year 2	Year 3	Year 4	Year 5
Assessed	861	833	814	802	411	674	672	646	618	447
Addition (Assessed)	23	18	27	18	4	49	33	26	32	27
Migrated	28	13	5	4	2	5	9	1	8	4
Not available	43	15	27	16	6	38	36	52	37	16
Died	1	3	0	1	0	4	4	5	2	2
Refusal	15	16	5	4	1	0	2	1	5	2
Not assessed yet	0	0	0	14	405	0	0	0	2	179
Total	**971**	**898**	**878**	**859**	**829**	**770**	**756**	**731**	**704**	**677**

Sputum Microscopy in DFIT Supported Projects

In 2012, DFIT supported NGO projects screened 16066 sputum samples of which 2047 (12.74 %) were found to be positive for AFB. The positivity ranges from 2.90 % in Trivandrum project to 20.13% in Nellore project.

Additional 14 (4.36 %) sputum positives were reported from 321 repeated sputum examinations.

Among (6708) follow up sputum examinations 655 (9.76 %) were reported to be positive for AFB. The range is 5.78 % in Aundipatti to12.57 % in Arisipalayam.

Trend of Sputum Positivity

A comparison between 2011 and 2012

Year	Sputum Exam	Suspects		Follow up		Total
		No	%	No	%	
2011	Low positive (Scanty &1+)	769	37	570	70	1339
	High Positive (2+ & 3+)	1310	63	243	30	1553
	Total	**2079**	**100**	**813**	**100**	**2892**
2012	Low positive (Scanty &1+)	755	37	509	78	1264
	High Positive (2+ & 3+)	1292	63	146	22	1438
	Total	**2047**	**100**	**655**	**100**	**2702**

Livelihood Enhancement Programme (LEP)

Socio-economic rehabilitation is offered under the name of Livelihood Enhancement Programme (LEP). The programme since its inception in 2007 has built the confidence of DFIT and its Projects in handling the socio economic interventions. There are many success stories and few failures, but the success has thrown open opportunities and challenges in our efforts to reach the needy patients. The positive factors of the programmes are profound increase in the confidence levels of the patients, sense of belonging to the community and a bit of pride in owning something. The selection of beneficiaries is done by committees comprising of staff and patients. The committee identifies the needs of beneficiaries after assessing their capabilities. The applications are prioritised by DFIT and forwarded to DFB for their approval. Since the beginning about 1920 persons were benefited under this programme. The programme is monitored by the field workers from the project periodically and the review report on the progress is sent every six months to DFB.

Year	Live stock support	Self employment support	Construction/ repair of houses	Educational support	Nutritional support to TB patients	Total beneficiaries
2007	91	36	17	23	140	307
2008	79	52	36	13	10	190
2009	40	19	2	300	50	411
2010	49	44	22	3	110	228
2011	134	87	14	15	34	284
2012	165	90	29	6	210	500







Chantier Damien is a group of volunteers which is a wing of DFB – Belgium supporting construction and renovation of buildings like hospitals, laboratories, houses for the leprosy and TB affected. The group is formed by individuals from different walks of life with the main aim of supporting the Leprosy and TB activities in the countries supported by DFB. The group generates funds from its volunteers through campaigns. Their representatives in batches of 8 to 12 members visit India to scout and review the construction work and also participate in the construction activities. This has become a regular feature and has now been going on for seventeen years.

Chantier Damien activities in 2012:

- Referral Laboratory constructed in Darbhanga TB Demonstration Centre. (Rs. 32,20,000/-)
- Construction of Drug store and OPD in Nardiganj in Nawada district, Bihar. (Rs. 6,77,557/-)
- Renovation of 10 houses in a Leprosy colony at Motipur, E.Champran district of Bihar. (Rs. 5,00,000)
- Construction of Physiotherapy care block in Chilakalapalli Centre, Vizianagaram district of Andhra Pradesh. (Rs. 8,00,000)
- Construction of Kitchen and renovation of toilets in Holy Family Hansonorium hospital, Fathima Nagar, Tamil Nadu. (Rs. 6,00,000)

This year 6 volunteer groups participated with a zeal and energy in the construction and renovation works. Despite the difficult situations and local problems like lack of quality accommodation and food, they have contributed their best. The activities drew accolade from local community members and local newspapers.

Endowment Prize Examination

Leprosy burden is gradually declining but India is still contributing every year around 50% of total new cases detected globally. With the decrease in the trend of the disease, health workers get less opportunity to see new leprosy cases regularly. The medical doctors need skills for diagnosis and management of leprosy. DFIT is making efforts to sustain leprosy expertise through training of medical doctors, Continuing Medical Education (CME), publishing educational materials and conducting endowment prize examination.

DFIT conducts CME in collaboration with "The Tamil Nadu Dr MGR Medical University" since two decades. In 2012, about 207 students from 12 medical colleges participated in the theory examination. Out of them 21 were selected for practical examination which was conducted at Holy Family Hansenorium, Fathimangar. Students had an opportunity to examine different types of leprosy cases, followed by an interactive session. For the year 2012, a student from Thirunelveli Medical College was selected for the endowment award.

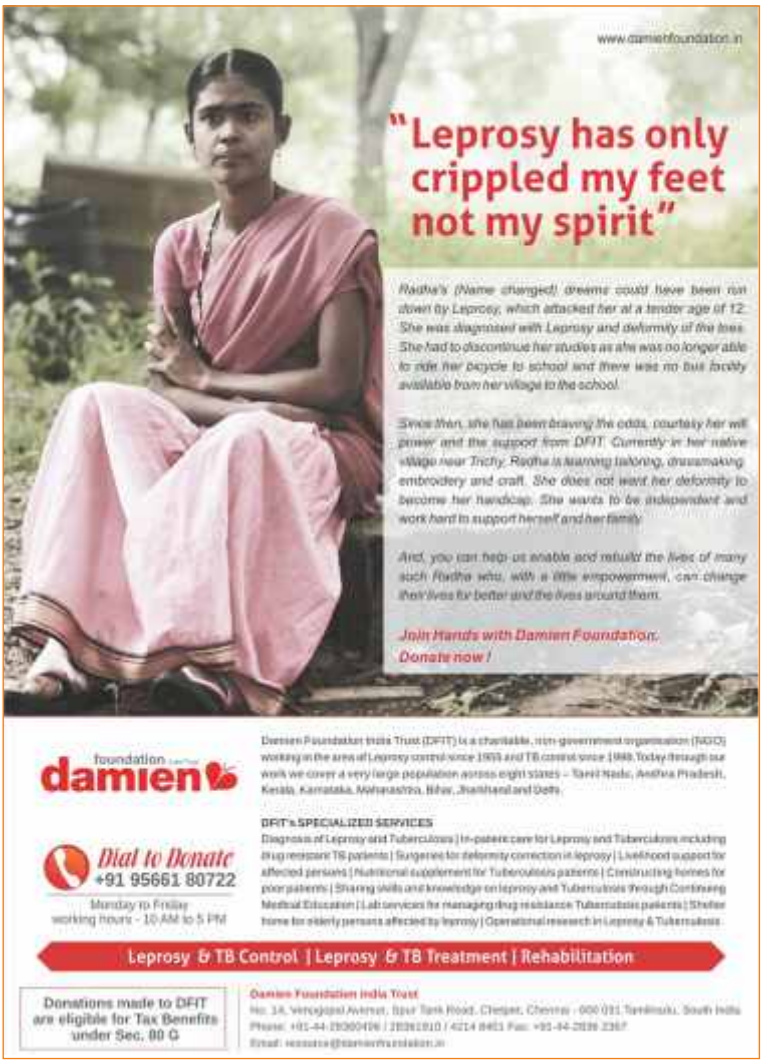
Renowned entrepreneur GT. Smith shared that, "Donors don't give to institutions. They invest in ideas and people in whom they believe". Going by the same lines, DFIT initiated its local fund raising efforts in the year 2011 to involve the larger community in its efforts. Initially the institutional fund raising was the focus by engaging individuals, especially the next generation that is the youth and children.

DFIT with its initial experience set up a separate unit of fund raising with a team of two members at its Chennai office. The team's initial focus was to involve corporate companies, institutions and individuals in DFIT efforts.

Activities of 2012

- Developed new communication materials like DFIT brochure, development and link of social network site, documentary film about the DFIT founder, and annual activity report.
- In house Pay roll giving was initiated and rolled out as a pilot programme.
- Approached and submitted proposals to 30 corporate companies and Embassy for assisting the ongoing and new projects.
- Individual fund raising was initiated by the team. As part of it, donation coupons were developed and distributed.

The future focus will be to harness the support from individuals by approaching the clubs and associations to involve them in our projects. This will aim at developing new individual partnerships, which aim at a sustainable and cost effective branding as well as harnessing the potential philanthropist for our mission.



Financial activities during the year saw many new initiatives being taken up for Leprosy and TB control. The initiative under TB was meant to establish a referral laboratory for managing drug resistant TB at Darbhanga by an agreement with Government of Bihar. Funds were allotted for establishment of four new referral centres including reconstructive surgery units. Funds were provided for the involvement of Civil Society Organisations (CSO) in the leprosy control programme for DPMR. Belgian volunteer group Chantier Damien financed and participated in the infrastructure development (construction) for leprosy and TB activities and contributed 5.8 Million rupees. Socio economic assistance under LEP (Livelihood Enhancement Programme) was provided to 299 patients.

This year DFIT continued to fund ten existing NGOs associated with DFIT programmes. DFIT extended its partnership with one new NGO "Pope John Garden" for establishment of a leprosy referral centre including reconstructive surgery.

In collaboration with Govt. of Bihar, DFIT has established referral centre at Dehri-on-sone. It has also upgraded its health facilities in its supported projects for leprosy referral services in Delhi and Amda.

DFITs own project activities through hospitals in Delhi and Nellore, Anandapuram leprosy home at Polambakkam continued during the year. Government Support activities continued in 28 districts for TB control, 22 Districts for Leprosy control in Bihar, 6 districts in Andhra Pradesh and, 1 district in Tamil Nadu. The total funds allocated for the year was around 91 Million rupees. DGD (Directorate General for Development, Government of Belgium) co-financed the activities of Nellore, Delhi and Bihar to the tune of 58 Million rupees.

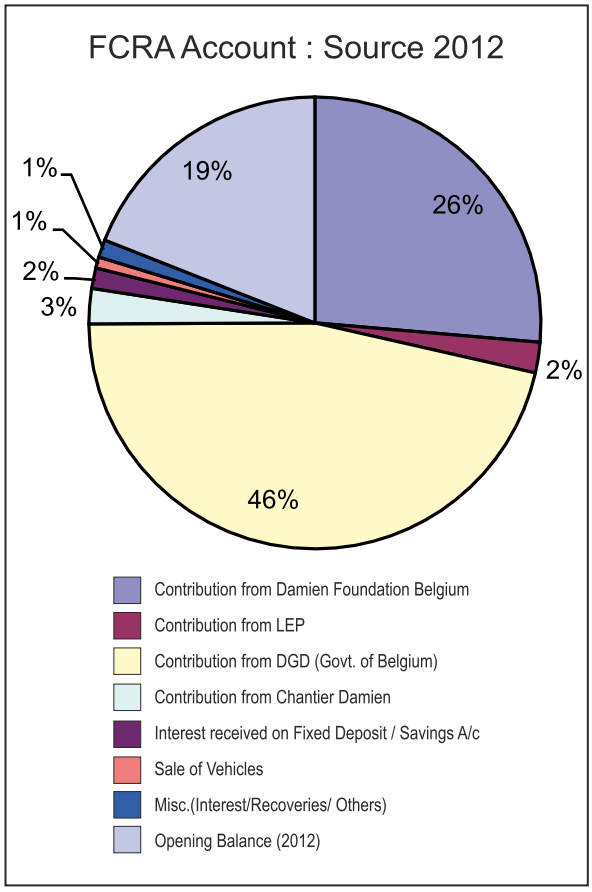
DFIT established a local fund raising unit at Chennai office and sponsored projects were also involved in fund raising efforts.

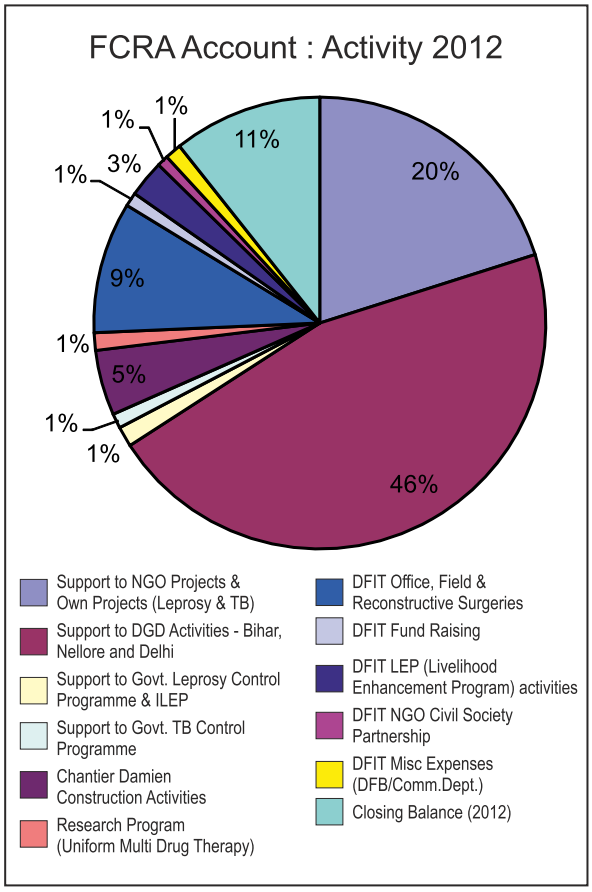
Finance Report : 2012 (Foreign Contribution a/c)

Source	Income (IRS)	%
Contribution from Damien Foundation Belgium	3,56,05,153.35	26
Contribution for LEP	29,44,269.00	2
Contribution from DGD (Govt of Belgium)	6,26,41,611.92	46
Contribution from Chantier Damien	34,00,500.00	3
Interest received on Fixed Deposit / Savings A/c	19,85,064.70	1
Sale of vehicles	10,66,000.00	1
Misc.(Interest/Recoveries/ Others)	17,17,790.33	1
Opening Balance (2012)	2,56,77,983.82	19
Total	**13,50,38,373.12**	**100**
Activity	**Expenditure (IRS)**	**%**
Support to NGO Projects & Own Projects (Leprosy & TB)	2,71,37,611.00	20
Support to DGD activities - Bihar, Nellore, and Delhi	6,18,29,480.00	46
Support to Govt Leprosy Control Programme & ILEP	19,62,858.00	1
Support to Govt. TB Control Programme	14,17,475.00	1
Chantier Damien Construction activities	63,19,093.00	5
Research program (Uniform Multi Drug Therapy)	16,86,218.00	1
DFIT Office, Field, and Reconstructive Surgeries	1,27,08,136.59	9
DFIT Fund Raising	13,37,761.00	1
DFIT LEP(Livelihood Enhancement Program) activities	35,62,542.00	3
DFIT NGO Civil Society Partnership	10,91,999.00	1
DFIT Misc Expenses (DFB/Comm.Dept.)	15,77,918.00	1
Closing Balance (2012)	1,44,07,281.53	11
Total	**13,50,38,373.12**	**100**

Indian Account 2012

Source	Income (IRS)	%
Donations Received	12,82,262.00	24
Sale of Sputum cups	4,18,365.00	8
Rent advance	70,000.00	1
Interest received on FD / Savings A/c	1,52,532.00	3
Gratuity from LIC	4,38,450.00	8
Miscellaneous Receipts	5,61,836.00	11
Opening Balance (2012)	23,66,567.00	45
Total	**52,90,012.00**	**100**
Activity	**Expenditure (IRS)**	**%**
Building Maintenance	2,800.00	0
Public Relations	1,791.00	0
Bank Charges	156.00	0
Delhi Construction	5,50,000.00	10
Gratuity settlement to Staff	4,38,450.00	8
Closing Balance (2012)	42,96,815.00	81
Total	**52,90,012.00**	**100**





Schedule of Meetings

Month	Date	Particulars	Organised by	Participant(s)
January	17th	Launching of DOTS Plus Site for Phase IV districts at Nellore project	TB Division, A.P. and DFIT	CMA / Secretary/ Mr. Luc Comhaire
	18th	Project Holders meeting at Chennai	DFIT	All Project Holders
	18th	Leprosy Hospital Coordination Committee Meeting at Gurgaon	Swiss Emmaus India	CFO as DFIT representative
	28th	28th Biennial Conference of IAL at Mumbai (LEPCON 2012)	IAL	Secretary CMA
February	7th	ILEP meeting at Goa	ILEP	CMA
	8th & 9th	SLOs Conference at Goa	GOI	Secretary / CMA / Dr. Anne Mattam
	15th	DCT Review meeting at Nellore	DFIT	CMA and DCT staff
	27th & 28th	DPMR Action Plan Meeting for Bihar	DFIT	CMA (North) Dr. Satish Kumar Dr. S.K. Singh Mr.C.P.Dwivedi Mr. R.B. Das Mr. Murari
March	27TH	3RD Meeting of Technical Resource Group at Delhi	Central Leprosy Division, Delhi	Secretary
	27th	FCRA & DTC Seminar at Chennai	Christian Institute of Management	CAO CFO
April	10th	Meeting with SLO, Andhra Pradesh, at Hyderabad	LEPRA Society	CMA
	19th & 20th	Strategic Planning Workshop at DFIT, Chennai	DFIT	Mr. Ronald, Sr. Francisca, Mr. Prabhakara Rao Dr. Ramesh Mr. Thiagarajan Sr. Dessy Mr. Satheesh Mr. Somasekhara Reddy Dr. A.K. Pandey Mr. K.V.R.Murthy
May	24th	Subcommittee meeting for categorization of high endemic districts at Delhi	CLD, New Delhi	Secretary as Chairman
	26th	RNTCP NGO Partners meeting at Hyderabad	STO, Andhra Pradesh	Mr. Thiagarajan
	28th	Presentation of International Gandhi Award to Dr.Claire Vellut by Hon'ble Vice President of India at Delhi	GMLF, Wardha	Secretary CMA Dr. Brijpal Singh Deo
	30 & 31st	ILEP State Coordinators meeting at Delhi	Central Leprosy Division	Dr. Anne Mattam
	31st	Seminar on Integration of tobacco control in tuberculosis control programme at Nellore	DFIT, Nellore	AP DCT staff
June	2nd	Trust Meeting	DFIT	Mr. Rigo Peeters and Trust members
	5th	Project Holders Meeting at Chennai	DFIT	All Project Holders Mr. Luc Comhaire and Mr. Koen Van – as Special invitees
	7th & 8th	SLOs review meeting at Cochin	Central Leprosy Division	D. Anne Mattam
August	6th – 8th	ILEP Meeting at Delhi	ILEP	Secretary
September	18th	National Conference on Leprosy at Delhi	National Human Rights Commission, GOI	Dr. Santhosh
	20th & 21st	National consultation meeting on Leprosy services in urban localities at Delhi	Govt. of India	Secretary
October	4th	NGOs Meeting at Patna	DFIT	Secretary
	19th & 20th	DCT review meeting at Nellore	DFIT	President, Secretary, MA and DCT members
	30th	Civil Society Partnership review meeting at Chennai	DFIT	PT from Trichy, Salem, Gaya, Bihar, Chilakalapalli, Aundipatty
November	7th	NGOs Grant-in-aid scheme meeting at Chennai	GLRA	Secretary
	9th	Meeting of ILEP members with Joint Secretary at Delhi	GOI	Secretary
	16th	International Workshop on Peripheral Nerve Ultrasound at Nellore	Narayana Medical College	Dr. Rahamthunissa Begum, MO, Nellore
	23rd	NLEP – AP – 3rd quarter review meeting followed by meeting with SLO at Hyderabad	ILEP, AP	Dr. Santhosh Kumar
	26th – 28th	1st CBR World Congress at Agra	CBR India	Secretary Dr. Santhosh Kumar Dr. Ashish Wagh Mr. Rajkumar
December	21st & 22nd	NGO Review Meeting at Hyderabad	ADG (L)	Dr. Santhosh Kumar

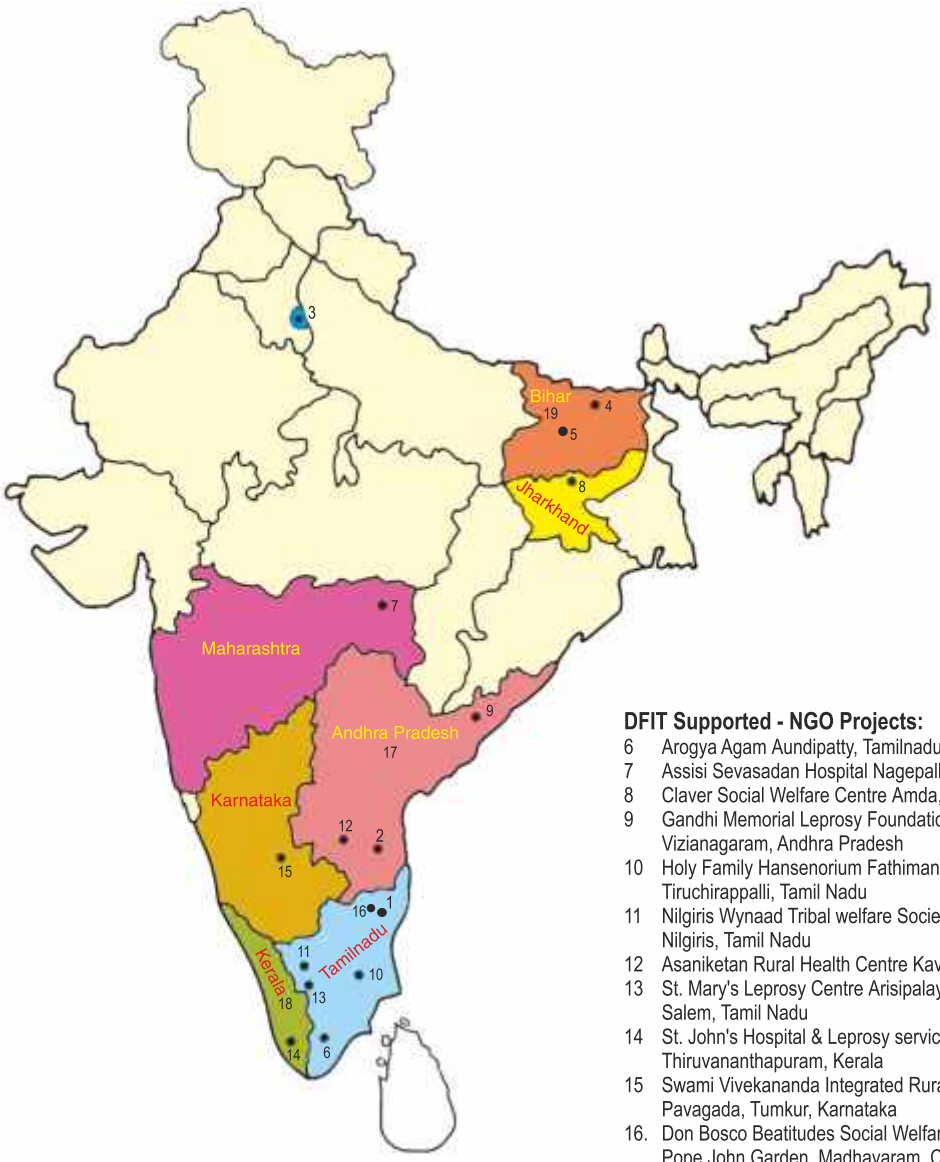
Schedule of Trainings

Month	Date	Particulars	Organised by	Facilitator(s)/ Participants
January	17th to 21st	National Training on Programmatic Management of Drug Resistant TB (PMDT) at Hyderabad	Central TB Division	Dr. Santhosh Kumar Dr. Shoe Kumar Singh Dr. Satish Kumar
February	20th to March 2nd	Rehabilitation and Prevention of Disability (RPOD) Training at Nepal	Bikash Training Centre	Mr. Arun Prasad, PT, Salem
April	15th to 20th	Leprosy Training for Medical Officers	BIKASH, Nepal	Dr. Santhosh Kumar Dr. Brijpal Singh Deo
	25th to 27th	Short-term Training on Qualitative Research Methods in Health & Medical Research at Gandhi Nagar, Ahmadabad	Indian Institute of Public Health	Dr. Shivakumar, Dr. Ramesh Kumar
June	18th to 22nd	PMDT Training at Hyderabad	STDC, Hyderabad	Dr. A.K. Pandey Dr. Asish Wagh
July	23rd to 27th	PMDT Training at Trivandrum	STDC, Trivandrum	Dr. Dileep Kumar
August	21st to 31st	Training programme on Culture and DST at Chennai	TRC, Chennai	Mr. Moses Anandraj Mrs.Esther Mary Mr. Aman Kumar Mr. Chandan Kumar
September	15th to 26th	Exposure visit on Fund Raising	DFB-Communication Department	Mr. Camillus Rajkumar Mr. Victor Chandran Ms. Mariatta Judelyne Vaz
November	5th to 9th	Clinical Management of MDR – TB at Delhi	CTD, Delhi	Dr.Rahamthunissa Begum
December	15th	STLS Orientation Training – Kadapa District	DTO, Kadapa	10 STLS participated / Mr. Jaishankar as facilitator
	17th & 18th	STLS orientation Training – Kurnool District	DTO, Kurnool	9 STLS participated / Mr. Jaishankar as facilitator

Visitors

NAME	PERIOD	PLACE OF VISIT
Mr. Luc Comhaire	16th to 20th January	16th – DFIT 17th – Nellore – DOT Plus Site launching function 18th – P.H. Meeting 19th & 20th – Delhi – Meeting with DDGL, Belgium Embassy, WHO Office and Delhi Project
Mr. Chen Yongun & Mr. Yang Jianing, Doctors from China	29th February to 14th May 2012	Nellore & Fathima Nagar – Physio training to RCS patients
H.E. Pierre Vaesen, Ambassador of Belgium and Mrs. Vaesen	4th July 2012	Delhi Project and Vijay Enclave, DMC
Chantier Volunteers	1st to 30th July 30th July to 25th August	Group I: Dharbanga & Group II: Nardiganj Group I: Motipur & Group II: Dharbanga
	14th July to 6th August	Fathimanagar
	2nd October to 20th October	Chilakalapalli
Dr. Tiine Demeulenaere	28th August to 5th September	Review visit to Nellore project, Prakasam district, Salem, Krishnagiri, Bihar and Delhi
Triangle group visit	30th September to 6th October	Fathimanagar & Arisipalayam
	25th to 29th November	Delhi

Projects supported by DFIT



DFIT – Self Governing Projects:

1 Anandapuram Leprosy Home
Polambakkam, Tamil Nadu
2 Damien Foundation Urban Leprosy & TB Centre
Nellore, Andhra Pradesh
3 Margaret Leprosy & TB Centre
South West Delhi

DFIT – Projects in Collaboration with State Government:

4 Damien Tuberculosis Research Centre
Darbhanga, Bihar
5 Damien RCS Referral Centre
Rudhrapura, Dehri-on-sone, Rohtas, Bihar

DFIT Supported - NGO Projects:

6 Arogya Agam Aundipatty, Tamilnadu
7 Assisi Sevasadan Hospital Nagepalli, Maharashtra
8 Claver Social Welfare Centre Amda, Seraikela, Jharkhand
9 Gandhi Memorial Leprosy Foundation Chilakalapalli,
Vizianagaram, Andhra Pradesh
10 Holy Family Hansenorium Fathimanagar,
Tiruchirappalli, Tamil Nadu
11 Nilgiris Wynaad Tribal welfare Society Ambalamoola,
Nilgiris, Tamil Nadu
12 Asaniketan Rural Health Centre Kavali, Andhra Pradesh
13 St. Mary's Leprosy Centre Arisipalayam,
Salem, Tamil Nadu
14 St. John's Hospital & Leprosy services Pirappancode,
Thiruvananthapuram, Kerala
15 Swami Vivekananda Integrated Rural Health Centre
Pavagada, Tumkur, Karnataka
16. Don Bosco Beatitudes Social Welfare Centre
Pope John Garden, Madhavaram, Chennai, Tamil Nadu

Support to Government through District Consultancy Teams (DCTs):

South

17. Andhra Pradesh - 6 districts
18. Kerala - 1 district

North

19. Bihar - 28 districts

State support to Leprosy

Bihar and Jharkhand State
(In collaboration with other ILEP organisations)

Glossary

ADG(L)	Assistant Director General (Leprosy)
AFB	Acid Fast Bacilli
AIDS	Acquired Immuno Deficiency Syndrome
ASHA	Accredited Social Health Activist A lady volunteer from the community selected and involved in public health programmes as a link between the community and General health system under National Rural Health Mission
C & DST	Culture & Drug Susceptibility Testing
CBR	Community Based Rehabilitation
CFO	Chief Financial Officer
CLD	Central Leprosy Division-Delhi
CMA	Chief Medical Advisor
CME	Continuing Medical Education
CSO	Civil Society Organisation
CSWC	Claver Social Welfare Centre
CTD	Central TB Division-Delhi
DDG(L)	Deputy Director General (Leprosy)
DCT	District Consultancy Team
DFB	Damien Foundation Belgium
DFIT	Damien Foundation India Trust. (One of the ILEP members in India supporting leprosy and TB control)
DFUL &TC	Damien Foundation Urban Leprosy & TB Centre, Nellore: NGO Project directly run by DFIT, Chennai.
DGD	Directorate General for Development
DGDC	Directorate General for Development Cooperation. (Belgian Government Agency for providing support to NGOs)
DLO	District Leprosy Officer. Programme Officer at the district level (2 to 3 million population) responsible for the leprosy control programme in the district
DOTS Plus	The strategy for management of Multi Drug Resistant TB is called DOTS Plus.
DMC	Designated Microscopy Centre one for every 100000 population for diagnosis of TB cases through sputum microscopy
DOT	Directly Observed Treatment. Treatment of a TB case under direct supervision by a person other than a family member
DOTS	Directly Observed Treatment Shortcourse. A package with five elements constituting the fundamental strategy of TB control adopted by all the countries including India
DPMR	Disability Prevention and Medical Rehabilitation. New name given to POD
DST	Drug Sensitivity Test
DTC	District Tuberculosis Centre (the government agency in District responsible for implementing TB Control District TB Officer. Programme Officer at the district level (2 to 3 million population) responsible for the TB control programme in the district
DTO	District Tuberculosis Officer
DTRC	Damien TB Research Centre (a facility in Nellore project for diagnosis, management and research in MDR TB)
DTST	District Technical Support Team. Strategy adopted by ILEP to support leprosy control through the placement of a mobile resident team in a district
ENT	Ear, Nose & Throat
FCRA	Foreign Contribution Regulation Act
FD	Fixed Deposit
GH	General Health
GLRA	German Leprosy Relief Association
GMLF	Gandhi Memorial Leprosy Foundation: NGO Project at -Chilakalapalli supported by DFIT, Chennai.
GOI	Government Of India
GP	General Practitioner. (Medical practitioner)
HFH	Holy Family Hansonorium. NGO Project at -Tiruchirapalli supported by DFIT, Chennai
HIV	Human Immunodeficiency Virus
IAL	Indian Association of Leprologists
ICMR	Indian Council for Medical Research
ICTC	Integrated Counselling and Testing Centre

IEC	Information, Education and Communication
ILEP	International Federation of Anti-leprosy associations. Has ten members
IMA	Indian Medical Association
INR	Indian Rupees
IRL	Intermediate Reference Laboratory. A laboratory where culture and sensitivity test for suspected MDR cases is done and is generally located in the capital of a State
LAP	Leprosy Affected Person
LEP	Livelihood Enhancement Programme (a socio economic rehabilitation programme implemented by DFIT assisted projects)
LJ	Lowenstein-Jensen
LIC	Life Insurance Corporation
LPA	Line Probe Assay
LT	Laboratory Technician
MB	Multi Bacillary leprosy
MCR	Micro Cellular Rubber. Rubber sheet used for insole in the footwear of leprosy affected person with anesthesia or deformity in the foot
MDR	Multi Drug Resistance
MDR TB	Multi Drug Resistant Tuberculosis
MDT	Multi Drug Therapy
MO	Medical Officer
NGO	Non Governmental Organisation
NLEP	National Leprosy Eradication Programme
NIE	National Institute of Epidemiology
NSP	New Sputum Positive case (Pulmonary TB never treated or minimally treated less than a month and found to be sputum positive)
OPD	Out Patient Department
PAL	Persons Affected by Leprosy
PB	Pauci Bacillary leprosy
PHC	Primary Health Centre. The main health facility in rural area covering a population of 25000 to 200000 and responsible for implementing curative and preventive services in the designated population
PMDT	Programmatic Management of Drug Resistant TB
POD	Prevention Of Disability. Important component of leprosy control aimed at preventing the occurrence and management of disability
PT	Physio-Therapist
RMP	Registered Medical Practitioner
RNTCP	Revised National TB Control Programme
RCS	Re-Constructive Surgery
RPOD	Rehabilitation and Prevention Of Disability
SLO	State Leprosy Officer
SMLC	St. Mary's Leprosy Centre
STDC	State TB Training and Demonstration Centre. One in every state meant for training all the staff in RNTCP
STLS	Senior TB Laboratory Supervisor- Laboratory supervisor in TB unit for guiding laboratory work in the 5 Designated microscopy centres
STO	State TB Officer. Programme officer in a state in charge of TB control
STS	Senior TB Supervisor. One in every TB unit at sub district level for 500 000 population and responsible for field supervision in TB control
TB	Tuberculosis
TBS	Tuberculosis Supervisor
TU	Tuberculosis Unit
TB-HV	Tuberculosis Health Visitor (a person employed on contract by RNTCP for treatment of TB cases in urban areas)
TRC	Tuberculosis Research Centre, Chennai
UMDT	Uniform Multi Drug Treatment
WHO	World Health Organisation

Mr. Palpani (Name Changed) never thought his bout with leprosy disease would bring his life to despair. His life took a downward spiral when he was affected by the disease. Though he had taken complete treatment for the disease, the nerve damage and lack of awareness of self care left him with no fingers on his right hand. His wife left him; he was left alone to fend for his four children, two boys and two girls. He could not take up regular job as his deformity had a profound effect on his earnings and employment. Left with little options he started collecting and selling scraps of iron and plastics. The meager income he made was sufficient to provide his children with only bare necessities of life. He was shattered when his elder daughter was affected by cerebral palsy and started to suffer from frequent convulsions, the expenditure for her drugs drained his meager resources. Aundipatty project identified him and recommended his name for support under Livelihood Enhancement Program (LEP) to DFIT. DFIT provided financial support for his rehabilitation. DFIT took initiatives to refer his daughter to a specialist and medical care and support was given. She is now free from convulsions. He started concentrating on his business, the financial support provided to him proved to be timely and it helped him to improve his earnings. The living standards of his family slowly improved. The motivation given for self care also paid rich dividends and he is free of ulcers on his hand. Mr.Palpandi never thought that he would come out of his misery, but now he is a happy man living with his family. The whole family is very pleased with the help provided to them.

The Ambassador of Belgium to India, His Excellency Mr Pierre Vaesen inaugurating a block at Margaret Leprosy & TB Hospital, Delhi

Dr. Agrawal, Deputy Director General (Leprosy)-GOI inaugurating Operation Theatre at Margaret Leprosy & TB Hospital, Delhi

Damien Foundation India Trust

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