



SWISS EMMAUS LEPROSY RELIEF WORK INDIA

Over 50 years of dedicated service to people affected by Leprosy

A close-up photograph of a young child with dark hair and eyes, smiling warmly. The child is wearing a pink and white patterned garment. The background is slightly blurred, showing a blue surface.

Annual Report 2013

www.swissemmausindia.org, www.healthfirstindia.org

Annual Report for the Year 2013

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Message from Directors Desk

Dear Friends and well-wishers,

The year 2013 was specially an exciting year for SEI India on various counts. Firstly, we successfully completed the pilot POID project in 2 districts of Andhra Pradesh, presented 4 scientific papers at the International Leprosy Congress (ILC) in Brussels, and subsequently SEI India reaffirming and further committing ourselves towards eradication of leprosy as a part of our strategic plan 2014-17.

I'm glad to share that besides the 29,224 people SEI India supported hospitals provided services to during 2013, we were able to reach out to an



additional 10,519 new cases of leprosy through our flagship POID project. This project was implemented in 2 high endemic districts of India and aimed at early diagnosis and treatment of people affected by leprosy. This project was implemented in collaboration with the State Government, SEI India supported projects, and SEI India.

The preliminary highlight of this project was accepted as a presentation at the ILC where it won the 'young scientist' award. From a service delivery perspective, this been a huge achievement as deformities were prevented among a large section of the population.

Needless to say this accolade provided the motivation for my projects and me to strive for bigger goals. As a result, SEI India changed its course of leprosy control work by undertaking regular systematic fieldwork so as to reach out to people before deformity sets in. SEI India believes that if we want to reach out to the last case of leprosy then its paramount to

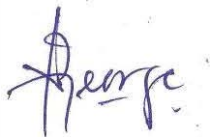
undertake field visits and expand our field based programs to other districts and states currently demarked as SEI India's project area.

This happened to be the core discussion and deliberation during our strategic planning exercise in Sept. '13, where we further pledged ourselves towards leprosy eradication. In this light, I'm pleased to share that we've expanded our field-based projects in 2 remote districts of Maharashtra besides it being implemented in Andhra Pradesh.

This could have only been possible due to the tireless collective work of the SEI India team and its supported projects, the unconditional support provided by my HQ colleagues, and the fervent support of all well-wishers. I take this opportunity to thank you and wish you best in all future endeavors.

Thank you,

Sincerely,

A handwritten signature in blue ink, appearing to read "George".

(John Kurian George)

Programmatic feature

Hospital Services

One of the core services of Swiss Emmaus India (SEI India) is to provide tertiary care facilities to leprosy affected people and SEI has supported many hospitals across the country in the past. Since last few years the number has come down and now there are only 5 hospitals located in Andhra Pradesh, Karnataka and Tamil Nadu. These hospitals have been involved extensively in the roll out of MDT services in the country as well as provision of specialized care for the Leprosy affected. These specialized services include both out-patient as well as in-patient care for management of reaction and neuritis, ulcer care, reconstructive surgeries (RCS) and provision of Microcellular rubber Footwear and self-care kits. Besides, these hospitals also provide diagnostic services to new and complicated cases of leprosy. Patients get referred from different parts of the respective state where SEI India tertiary hospital is located as well as neighboring states. These hospitals also form necessary linkages with government health facilities and other NGOs to provide other required services to the leprosy affected like cataract operations, provision of aids and appliances and various social welfare measures.

- The SEI India supported hospitals are as follows:

Andhra Pradesh:

- Emmaus Swiss Leprosy Integrated Project (ESLP), Palamaner, Chittoor District
- Gretnaltes, Morampudi, Guntur District
- Rural India Self Development Trust (RISDT), East Godavari District

Karnataka:

- Hubli Hospital for Handicapped (HHH), Hubli & Dharwad District

Tamil Nadu:

- Sacred Heart Leprosy Centre (SHLC), Kumbakonam, Thanjavur District

Table-1: Showing the no. of patients provided out-patient services under different categories.



Out-Patient services		
	Ulcer care	10019
	Reaction management	1371
	General ailments	12011

Table-2: Showing the no. of patients provided in-patient services under different categories.

In-Patient services		
	Beds	307
	Ulcer care	3862
	Reaction	301
	Reconstructive surgery	397
	General ailments	1248

The hospital partners were involved in a Quality Circle meeting to discuss about the performance of each hospital, the gaps and the proposed remedial measures. These discussions were based on the analysis of the patient data obtained from the Hospital Information System (HIS). Besides, issues related to fundraising as well as finance and administrative matters were also discussed in these meeting. In 2013, there were 2 quality circle meetings held, one at Palamaner in March and the other at Chennai in August.

Salient points discussed in the QC meetings:

- Update on the country and state specific leprosy scenario (NLEP annual report)
- Share of each hospital in OP and IP services as well as various OP and IP categories.

- Gaps in the “date of Birth” field and “Duplicate data entry” issues in the HIS.
- Steps taken in the HIS for improving the data quality.
- MCR Footwear being provided to patient from categories other than neuritis / ulcer.
- High frequency of certain patients (>50 times in a year) visiting the hospital
- Emerging and increasing trend of new cases especially among children.
- Issue of providing MDT to the new patients getting diagnosed in our hospitals under NLEP
- Issue of providing the financial incentives to the RCS patients coming from the neighbouring districts and states.
- Low attendance by females in all the categories across the hospitals.
- Annual performance of the hospitals against their committed targets.
- Dissemination about the New NGO schemes.
- Discrepancy in the RCS cases reported to NLEP and SEI.
- Update on the new financial guidelines and formats.
- Dissemination the Human resources standardization report by TISS

ILEP State Coordination

Haryana:

The state of Haryana is considered as low endemic states in the country and the Annual New Case Detection Rate (ANCDR) was 2.13/ 1 Lakh population and Prevalence rate (PR) of 0.26/10,000 population (2012-13 Annual report). The ANCDR as well as the PR has been showing a consistently increasing trend since last 3 years. Out of 21 districts, 2 districts are considered high endemic (Panipat as well as Faridabad). As part of providing technical support to the state NLEP program, 9 districts were visited and around 50 cases under treatment were validated. Among them around 50% cases were found to be having visible deformity and with reaction/neuritis. The state had no designated functional RCS centre. With the assistance of Damien Foundation India Trust (DFIT) in Delhi, screening camps were conducted to identify patients eligible for reconstructive surgery in Panipat and Faridabad. The needs assessment for the program in the state was done and based on the Needs Assessment findings the Annual Program Implementation Plan for 2014 was developed. One orientation cum review meeting of the all the Paramedical Workers (PMW) of the state was organized at Panchkula and the PMWs were oriented on the latest NLEP guidelines as well as the Nerve Function assessment. The concept of Linelist was introduced to the PMWs and the Linelist of all the existing patients (new

as well as old) patients is being generated for the entire state. One joint monitoring visit comprising the Assistant Director General (ADG) of the Central Leprosy Division (Dr. A. K. Puri) and the NLEP consultant (ILEP representative) was carried out in Panipat as well as Sonapat districts. The observations from the visit were shared with the Director of Health Services for appropriate action to strengthen the program in the state. A review meeting of the District Leprosy Officers and a comprehensive training of the PMWs has been planned.

Following the success of the Haryana model of providing technical support and based on the request of the Central Leprosy Division, Government of India (GoI), Swiss Emmaus India agreed to extend the similar support to the neighboring states / UT like Chandigarh, Punjab and Himachal Pradesh.

Chandigarh: The introductory visit to the UT of Chandigarh was done in Dec. 2013 and a preliminary assessment of the situation of NLEP was done. As part of the assignment, the NLEP Consultant attended one National review meeting of the NLEP Consultants organized by Central Leprosy Division to review the performance of the consultants and address the concerning issues held at New Delhi.

Output Based Aid (OBA) and its impact:

Swiss Emmaus India was first to bring in the concept of Result based funding in the field of Leprosy in India under the name of "Out Based Aid (OBA)". This process was pilot tested in 2006 involving a team of cost-accountant, key hospital staff, programmatic and financial staff, as well as the North Western University of Applied Science, Switzerland in one of our supported hospital, RISDT. In order to streamline the funding mechanism and scientifically estimate the budget for the hospitals, SEI established the processes to clearly establish core service delivery areas in its supported hospitals, derive the cost per service, and subsequently benchmark the costs.

To start with, real time expenditure for a calendar year was considered while deriving costs per service. Complete treatment expenses including medical supplies, general supplies, number of bed occupancy days, food, staff salaries, and other overhead costs were factored in while finalizing the cost.

Patients were divided into 11 different categories in-patient [IP] and out-patient [OP]) on the basis of which cost for each category was calculated. Most importantly the number of patients being provided service played an

integral part in finalizing the budgets per hospital. Patient uptake of services was reported through SEI's Hospital Information System (HIS).

Review of the costing exercise for all the five hospitals was undertaken after which it was suggested to arrive at a suitable benchmark cost considering the third Quartile (Q3).

Standardizing human resources requirement in SEI India supported hospitals

The SEI's OBA exercise saw some major changes in the year 2013. Based on our previous observations, an initiative was undertaken along with the Tata Institute of Social Sciences (TISS), Mumbai to standardize the human resources engaged in the SEI supported hospital for providing the services. The team from TISS went to all the hospitals with a semi-structured tool to assess the burden of various services, the staff required for the existing burden, compare the staffing pattern with some of the available norms and make recommendations for all the 5 hospitals.

Upon completion of the assignment, the team came up with a recommendation to divide the hospitals into 2 categories (30 bedded and 60 bedded). It was also observed that except one hospital (ESLP, Palamaner), all the hospitals were closely fitting to the recommended staff strength for the existing work-load in their respective hospital. They also recommended having a social worker in all the hospitals to provide the counseling services to the patients, which is one of the key interventions to improve adherence to the MDT treatment as well as practice of self-care.

The Human resources standardization report findings resulted in standardizing the staff structure across the hospitals and also highlighted the realistic benchmarked unit cost for the services.

The outcome of the HR exercise as well as the benchmarked unit cost was shared among the partners and the Headquarter. It was finally decided to freeze the unit cost of this year, with a yearly increment in the subsequent years based on a mutually agreed inflation indicator and to review the unit costs again after 3-5 years.

POID Pilot Project in Andhra Pradesh:

Brief description of the POID project: SEI India has launched a pilot project to prevent disability due to leprosy in the 2 high prevalent districts of Andhra Pradesh in collaboration with Government of Andhra Pradesh and 2

SEI India supported projects namely RISDT in East Godavari and Gretnaltes in Guntur. In both the districts all the 110 PHCs were covered. This was a 3 years project and was launched in Sep. 2010. The POID pilot project, which was initially planned till Sep. 2013, was given an extension till end of Dec. 2013, and it was successfully completed.

SEI considers this project as a pilot model to prevent disability among leprosy patients through strengthening the primary health care system for delivery of the NLEP services in the following manner.

1. One senior staff (PHN / MPHEO / MPHS / MPHA) in each PHC was identified as the point person for the POID project and designated as GOPOID (Govt. official for POID project) and were trained in both the districts. Later they were re-designated as NLEP Nodal officer/ coordinator to expand their scope to all the NLEP activities. All the 200+ such officials from the PHCs of both the districts have been trained on the NLEP program and the POID project deliverables.
2. Considering the importance of the PHC Medical Officers in implementation of the POID project and more so in NLEP program, we trained almost 250 PHC Medical Officers of both the districts (newly appointed and Old) in 2011-12. All the PHC Medical Officers were also trained on Nerve Function Assessment (NFA) and recording.
3. In order to promote early/timely detection of leprosy cases, ASHA (Accredited Social Health Activist) workers in the PHCs were considered as the key staff in the PHC. Through this project we trained 200+ ASHA Coordinators (those who are point person for ASHA workers at the PHC level) from each PHC in both districts in 6 batches in 2011-12 as the Master Trainer to train the ASHA workers in their respective PHCs.
4. Timely issuing of MDT and prednisolone to the patients is one of the important ways to prevent disability among leprosy patients. SEI India with its influence could issue orders from Central Leprosy Division to ensure continuous availability of prednisolone in the PHCs.
5. Development of the line list of all the patients (Old & New), capturing all the services like reaction management, ulcer management, RCS operation, MCR footwear supply, cataract operation, issue of disability certificate, issue of pension, ration, any aid etc.

6. As part of the project, SEI supported placement of 2 mobile teams in each district from the beginning. These 2 teams consisting of a counselor and physiotherapist visited all the PHCs in the district once in every quarter and conducted POID camps in the PHCs. The teams used to train old leprosy patients on home-based self-care practices, training staff nurses on dressing of wounds, updating the linelist, referral of patients for higher level care (RCS, reaction management or Ulcer management), cataract operation etc.
7. SEI had appointed a Backstopper (Dr. S. A. Ramakrishnan) since Sep. 2011 for visiting the projects in both the districts every quarter to give his inputs about the achievements, quality of services and identify areas for further improvement. He could complete 9 backstopping exercises in both the districts, except for the last one which could not be executed in East Godavari due to political unrest in that region.
8. Cohort analysis of all the cases diagnosed since 2010 with regard to the disability.
9. Collaboration with the support department like NRHM, DRDA, National Blindness Control program / District Blindness Control Society and other Voluntary organizations working in the field of Blindness control etc.

Summary of Backstopping exercises:



Pic-1: Showing Dr. Krishnan and Dr. Raja Rao (Medical Superintendent of RISDT) examining a patient in a PHC in East Godavari

A. Progress made through POID project:

1. Number of PALS with disability grade 2 who are improved is increased from 4.28% to 41.33% the highest by practicing self-care, mostly due to wound healing.
2. Number of PALS who live with irreversible disabilities and keep their eyes, hands, and feet in good, functioning condition is raised from 56.6% to 91.4% by home based self-care practice.
3. Number of PALS who got worse is reduced from 14.7% to 2 % which is the least and further reduction will not be realistic/possible in the field condition mostly due to complicated foot and/ or with foot ulcers.
4. Access to eye Care for PALS has increased from 100s to 1000 PALS by doing refraction, cataract operations through net workings health services in the district.
5. There were no recurrent foot ulcers seen only among the cases evaluated during all these visits.
6. All immobile PALS evaluated (50 to 100 PALS) get health care from the PHCs/ mobile teams.
7. All PHCs visited have at least one leprosy trained staff to diagnose, treat, and manage complications of leprosy at the PHC level.
8. All newly diagnosed leprosy cases have valid and reliable base line information in the records at the PHC level and MDT is available to treat all newly diagnosed Leprosy cases.
9. All newly diagnosed cases with neuritis have access to prednisolone treatment at the PHC level.
10. The concept of integration of leprosy is visible by sharing the tasks / responsibilities between medical officers, DPMOs, nurses, pharmacists.
11. Line listings of all old PALS as well as the new cases are up dated.
12. CBR in POID is integrated through DRDA.

B: Lessons Learnt:

1. Total integration of NLEP/POID activities works at the level of PHCs with PHC health workers.
2. Annual case detection rate, MB & Child proportion, 10 % disability rate indicates that the infection remains within the urban, rural communities and cases are yet to be diagnosed early.
3. It indicates that lot more is to be done in all aspects of Leprosy Control to reach the goal of Leprosy elimination stage.

4. By continuous patient education, self-care training and follow up the PALs at home 98% of PALs can lead normal life with their irreversible disabilities and attend themselves their day to day activities.
5. It is possible to link POID activities with other support NGOs/ Government organization to provide services to PALs to improve their quality of life and for them to live with dignity, to live with the family / community, without stigma and discrimination.

Feedback from the State Leprosy Officer, Dr. Tarachand Naidu on POID Project:

The SLO of Andhra Pradesh visited both the project sites and interacted with the patients as well as the PHC staff involved in the NLEP work. Based on the observations, he was quite encouraged to implement this project in other districts as well. In one of the District Leprosy Officers (DLO) review meetings held in Hyderabad, he appraised all the DLOs about the achievements and expressed his willingness to scale up the project in the other high endemic districts like Anantapur, Vizianagram, and Chittoor. He also requested all the DLOs to develop line-listing of all the cases in their respective districts which would form the basis of the annual action plan for the forthcoming years.

POID End Evaluation :

As per the Project proposal, there were 2 internal evaluations by Dr. Krishnan (India) and Ms. Valerie Simonet (Switzerland) at the end of 1st and 2nd year. The final / end evaluation was executed by an independent team of external evaluators in Dec. 2013.



Pic-2, 3: Showing the evaluators interacting with the Medical Officer of the Sample Survey Unit at Guntur and a focus group discussion with some of the patients in a PHC.

Strengths of POID Project:

- The field level practical demonstration of simple actions and procedures to persons affected by leprosy has helped to prevent and reduce the effect of disabilities and deformities as perceived by them and that has improved the compliance.
- Moreover this POID project has helped to sensitize and train the PHC staff including ASHAs to integrate leprosy control activities with other health services at the local level.
- The interactions and advocacy functions have strengthened the collaboration with other stakeholders, particularly from the social sector of the government (DRDA) and created great demand for integrated rehabilitation services for socio-economic mobilization and equal opportunities for people affected by leprosy.
- Additionally, this POID project has also improved the quality of services and ensured the availability of adequate MDT at the PHCs for all new leprosy cases as a matter of 'right to health'.
- One of the major strength of this POID project is the dedicated project team who is technically well versed with the management of leprosy as well as in implementing the project activities and the availability of hospital based leprosy care that provide comprehensive leprosy services and support the referrals from the PHCs.

Limitations of POID project:

- POID activities were more functionally incorporated into the NLEP than the GHC system, which require more technical skills and motivation on part of the health care providers. The presence of a trained GO-POID in a GHC facility made no difference in the involvement of other GHC staff in performing POD activities routinely.
- The POID project has contributed to health policy developments at state level in AP and to a lesser extent to the NLEP. Additionally, supporting the POID activities at PHC level has increased the dependency on the SEI India supported NGO partners.
- Lack of appropriate monitoring system since the initiation of the project in September 2010 and the inadequacy of data in the templates for line-listing defy any scientific analysis and possible correlation of the anticipated outcomes.
- Lack of collaboration agreement with the state government in the form of Memorandum of Understanding (MoU) that could have facilitated a forum

involving both government health officials and NGO representatives for planning and decision-making in allocation of adequate resources for POID activities under NLEP.

- Barring one or two district level NLEP officials, the initial response to this initiative by NRHM in the state and district health department was mainly passive that has given a sense of uncertainty in sustaining the POID activities after completion of this project.

Lessons learnt and recommendations:

- The project needs to strongly advocate increased participation of the health personnel at the General health systems – PHC & CHCs in delivering POID services as well as encourage active involvement of ASHAs in promoting home based care.
- It may be argued that the ASHAs are not paid ‘incentives’ for delivering additional health services and therefore the project should consider drawing support from the available local funds available with Village Health & Sanitation Committee as well as Rogi Kalyan Samithis at village level.
- The trainings conducted for various categories of PHC and NLEP personnel in the districts need to be task specific and adopt participatory methodology.
- The assessment of indicators show that the shortfalls are also a result of the fact that the SEI India does not set valid and measurable targets to monitor the 5 project measures implemented under this POID project in these districts.
- Although specific actions to be undertaken by different stakeholders to implement these project measures are clearly defined in the project matrix, it did not set concrete targets and timelines for action.
- Moreover, the added value of this POID project had a limited effect on the strategy of NLEP at district and state as the process of the project is developed in a pilot mode.
- Since inception, the Government perceived this POID project as a NGO initiative. Therefore, SEI India in coordination with the NGO partners need to play an advocacy role to ensure that the state authorities initiate processes for institutional acceptance and responsiveness for this POID program at all levels as an integral part of the public health system.
- Lack of community level action and enticing active participation of the community and groups including the person affected by leprosy in leprosy control activities, which needs to be addressed effectively with innovative measures in future. This can result in voluntary reporting of new leprosy cases early without any disabilities and deformities.

- In order to achieve this, SEI India can strengthen the core team of the NGO Partners with further leadership and management skills and make them more consistent through improved program monitoring for realizing the set objectives and goals of this project.
- There seems to be a general responsiveness of district health officials in both the districts, but if cooperation is not mandated from the state level officials, then it becomes a low priority and seems to be optional.
- Astonishingly, it was learnt that there is no provision of funds for NLEP activities in both the districts as per the District Health Action Plan (DHAP) under National Rural Health Mission (NRHM) in the year 2013-14.
- Hence the project team should engage in consultation with the district and state level health officials and evoke response and support to replicate this initiative in all other districts through government resources.

POID Project publication:

The findings from the project were published in two issues of the “Health Action” journal. The **first article** covered the justification for the project, the project methodology and the achievements in the end of first year. It highlights the emphasis on the early case detection, the involvement of ASHAs, their capacity building and the innovation the project adopted by means of line-listing of all the cases in the project districts. It also captures the concept of “GOPOID”, the officer from PHC who has been trained for overseeing the project deliverables in the PHC area.

The **second article** emphasizes on the major achievements by end of 2nd year. It highlights the capacity building initiatives undertaken under the project for the Medical Officers (old & new), the ASHA coordinators, DPMOs and APMOs (vertical staff of NLEP). The value addition gained by placing the 2 mobile teams in each of the districts, the synergies drawn with the supporting agencies like District Rural Development Agency (DRDA) for facilitating the issue of disability certificates and issue of pension, District Blindness society for cataract operations and issue of spectacles and with NRHM for streamlining availability of Prednisolone and MCR footwear through PHCs. Finally the Backstopping exercises, which brought the quality issues from the field was considered as one of the important interventions.

1. Akshay Kumar Mishra, John Kurian George. New Approaches to address disability in Leprosy-Part-I. Health Action, Jan. 2012: 36.

2. Akshay Kumar Mishra, John Kurian George. New Approaches to address disability in Leprosy-Part-II. Health Action, Sep. 2013: 36.

POID Presentation in 18th International Leprosy Congress (ILC), Brussels (Belgium) in Sep. 2013.

The findings from the POID Project were presented as e-Poster in the conference and SEI India received the **Young Scientist Diploma Award** for the **Best paper**.



Picture-4: 'Young Scientist Award' to Swiss Emmaus India for the POID

Urban Health Project:

Bainganwadi is home to Mumbai's largest and oldest garbage dumping site. The slum dwellers face many challenges in terms of health, hygiene, water and sanitation. Lack of various public amenities/facilities related to education, health, and poor socio-economic condition of the population complicates the situation even further. Considering the limitations and the challenges, SEI launched the Bainganwadi Slum Project in collaboration with three other local partners LSS, Mumbai, Tata Institute of Social Sciences (TISS) and Health administration of Mumbai city with the overall objectives of improving the health and economic condition of its residents. It was envisaged to achieve the objectives through strengthening the organization and empowerment by formation of Self Help Groups in the community. The project was implemented for three years, i.e. April 2009-Mar 2012. But at the end of 2012, considering the request of the implementing agency one year of extension was given till end of 2013.

Improved access to primary health care: The clinic run by LSS was huge success among the local residents. The government run health posts would operate during the day time and the services are hardly utilized due to lack of availability of staff / medical officer / drugs etc. These challenges were met by the LSS run clinic and it also provided services in the evenings. The evening timing of the clinics helped the population so much that the attendees increased from 70 per month in the beginning to 315 per month at the end of the 3rd year. The general clinic also provided facility for running weekly skin clinic for treatment of skin ailments and screening - cum

- referral of the Leprosy cases. The KAP study conducted during the project period for the general medical practitioners and the private health service providers threw some light about the gaps in their knowledge and prevailing practices. Subsequently through different sensitization workshops it was attempted to bridge the gaps in the existing awareness levels and practice towards the prevailing health problems in the community.

Access to TB diagnostic and treatment services: During these 4 years, 5 DOTS centres, 2 sputum collection centres and 1 Designated Microscopy Centre were made functional in the slum area. The infrastructures related to TB diagnosis and treatment established under the project could achieve 83% success rate in the TB treatment by providing facilities like sputum collection, diagnosis and treatment closest to the doorstep of the inhabitants of the Bainganwadi slum.

Access to Leprosy services: The POID clinic/camps provided facilities for ulcer management and self-care training to the old PALS.

Under 5 children care: The project also collaborated with the local Balwadi centre (An Unit run by Voluntary Organizations supported through GoI to provide care for under 5 year children) for ensuring 100% of coverage of the under 5 children for immunization, growth monitoring and nutritional supplementation.

Self-help group formation: As part of the project, total 12 self-help groups were formed involving 168 members from the community. They were provided trainings on various income generation activities, managing a petty business, review of the achievements of the groups through monthly meetings and the like. The group members were helpful in conducting various activities for their own population by spreading awareness about the prevailing health issues and assisted the functioning of the general clinic and DOTS (Directly Observed Treatment using Short course for TB) centres. Overall the project could demonstrate significant success in terms of improving the health services in the community, health and sanitation condition of the population and enhancing the socio-economic condition of the population.



Population covered: 2.5 lakhs

Health posts covered: 3

Major activities:

- Strengthening Leprosy services
- Providing TB diagnosis, treatment and outreach services
- Primary health care services
- IEC activities
- Community Development initiatives

Leprosy interventions:

- Improved awareness resulted in increased referrals.
- New cases registered: 35
- New cases completed MDT: 30
- No. of old cases provided POID services: 267
- MCR footwear provided: 17 pairs
- Reconstructive surgery in Hand: 1



TB Interventions:

- Increased suspect referral
- Total suspects examined: 234
- Confirmed with TB: 64 (27%)
- Initiated on TB (DOTS) treatment: 59
- Death among TB cases: 8
- Defaulter, failure, MDR: 30

Needs Assessment of LSS and Mumbai Slums:

As by the end of 2013, the Bainganwadi project was completed for holistic development of the slum population especially the 3 health post areas covering 2.5 lakhs of population implemented by LSS. Considering the value addition created through LSS interventions and the potential needs in the slums areas, it was proposed to explore the possibilities of extending the collaboration in a different form. In this regard, it was recommended to undertake a Needs Assessment exercise for the entire population of slums covered by LSS, which approximately covers 25 Lakhs from 3 wards of Mumbai. An external consultant was engaged and the summary of the findings and recommendations is as follows:

- In the absence of sustained new case identification, chances are that many cases are going undetected and amongst those detected 44% are MB cases (average of three wards), with good number of children being detected with leprosy.
- Majority of government staff and frontline workers in the Urban Health Posts are not trained on leprosy and leprosy seems not to be a major responsibility for them.
- Need stronger advocacy with government especially at MoH level for better institutional integration into mainstream health care system.
- LSS has experienced and qualified staff to provide quality health care services to leprosy, but is understaffed.
- LSS key staff seems comfortable in providing services but are not too comfortable in data management, documentation, and facilitating other non-health needs of people affected by leprosy like SHG formation, livelihoods, etc.
- Need support in implementing sustainable and outcome based programming.
- LSS need more hands to increase their coverage in identification and providing care and support services to patients.
- Profiling of adolescent and young adult cases is to be taken up for planning and initiating vocational training options and better livelihood.
- The District Health authorities concerned with Leprosy were proactive and supportive. Therefore, a sincere and professional approach is to be made to the existing issues with appropriate utilization of available resources from government and bridging the gaps
- An attempt to make the MoH of respective wards and the ADHS a responsible stakeholder can be made for better integration and outcomes of the future program budgetary support for training of HP staff, regular official communication through these offices to their respective HP staff on leprosy related activities, etc.
- From the day one of implementation the project should have a clear laid out exit/transition plan. Like earmarking the last year or additional

one year with phase wise exit or transition of the project activities into existing health infrastructure and systems.

Welcome to new Head, Project Management (Mr. Thomas Gass)



Mr. Thomas Gass made his first ever visit to India in Aug. 2013 after taking over this new responsibility at Bern Headquarters. During the same time it was scheduled to have a Quality Circle meeting at Chennai. During this occasion all the OBA partner organizations along with India country office colleagues and board members of SEI joined hands together to welcome Mr. Thomas. All the partners made presentation about their organizations and their activities.

Fundraising Initiatives – Healthfirst India



The year 2013 was eventful and we made some significant strides in local fundraising. Following are the fundraising activities conducted during the year 2013.

Direct mailing

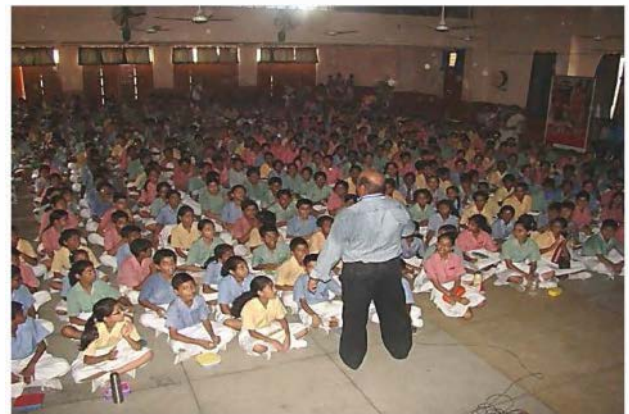
Direct mailing is one of our core strategies. We sent out mailers four times a year. The mailers were aimed at those people who wanted to support a social cause and at the same time avail the tax benefit. Likewise, mailers were also sent on 3 different occasions during the course of 2013. As part of the Direct mailing, warm appeal letters are sent periodically to our donors during the course of 2013. Direct mailing is a very successful activity

Lucky Draw Event

Swiss Emmaus Leprosy relief Work India Planned Lucky Draw as one of its activities to raise funds dedicated to support the medical care and social rehabilitation of people affected by leprosy, tuberculosis and other poverty related diseases through its supported projects in India. The learning from the Lucky draw event held during the year 2012 was incorporated for better performance. The Lucky draw event was conducted on 20th Nov 2013 at our Gretnaltes project.

School Fundraising

During the year 2013 we approached few schools at Chennai to spread the awareness about Leprosy. All the students above the primary class were involved. Apart from raising funds, the students were also involved in educating about our initiative for Leprosy. The principal and staff of the School extended their full support throughout the campaign.



Telemarketing

Telemarketing is the hybrid of telephone and face to face fundraising. It is a modified extension of the major donor process to encompass cold solicitation. Swiss Emmaus Relief Work opened its office in Chennai, where in-house tele-calling activity was conducted. The objective of this activity is to expand the



Inauguration of Chennai FRU Office

warm & cold donor base and simultaneously encourage monthly giving.

Corporate Fundraising

Corporate fundraising is one of the core strategies for raising funds in India. SEI approached various corporate bodies to support the cause of Leprosy. Proposals were submitted; few corporate extended their support for the cause of leprosy. During the year corporate events were organized and funds were raised through these events.



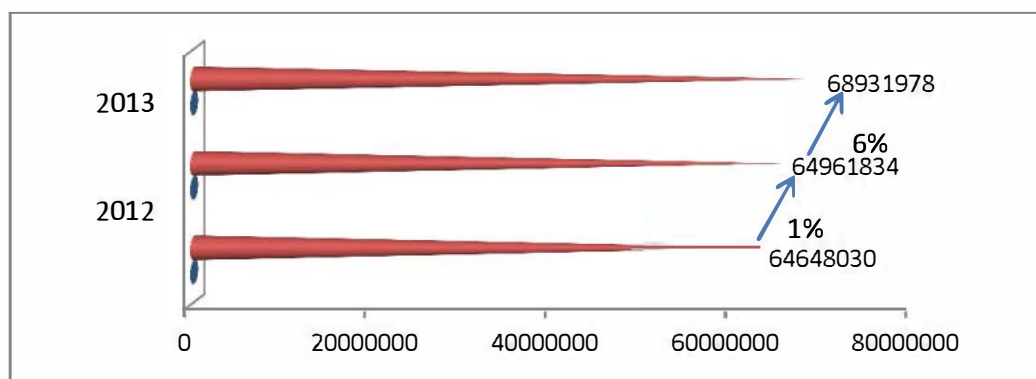
RISDT School Science Lab

Financial Report for the Year 2013

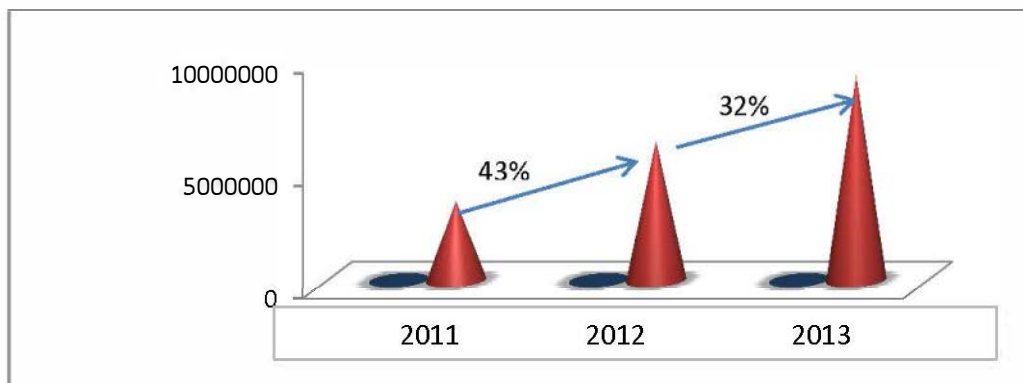
1) Increase in Consolidated Expenditure which leads to Increase in Local funds raised

There was an overall 6% increase in expenditure during the year 2013 (please refer to graph-1 [a]). But the support from Switzerland was continuously reducing. It was decided to raise funds locally in India. The organization recorded an overall increase of 32% during the year 2013 (please refer to graph-1 [b]). Organization continued to raise a balance mix of funding this year. The largest share of funding 53% came in from the corporate followed by revenue from individuals including HNI's which contributed 46% of the total funds raised and 1% from Schools (please refer to graphs- 1[c]).

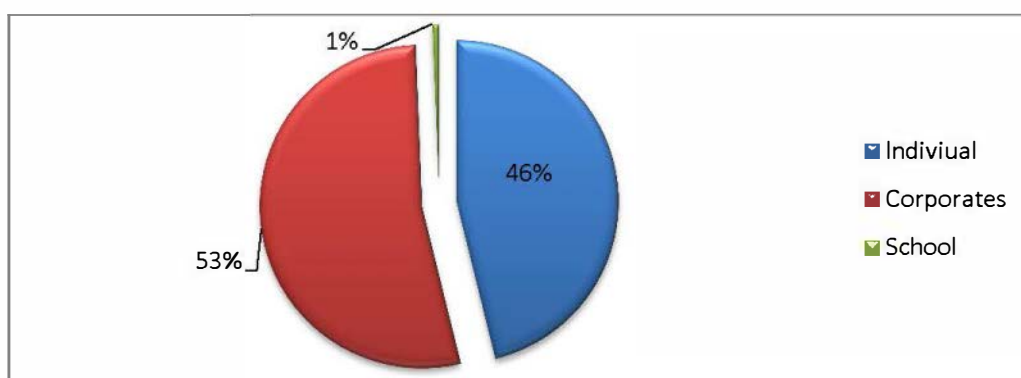
Graph: 1(a) Presenting increase in expenditure during the last 3 years



Graph: 1 (b) Presenting % increase in funds raised during last 3 years



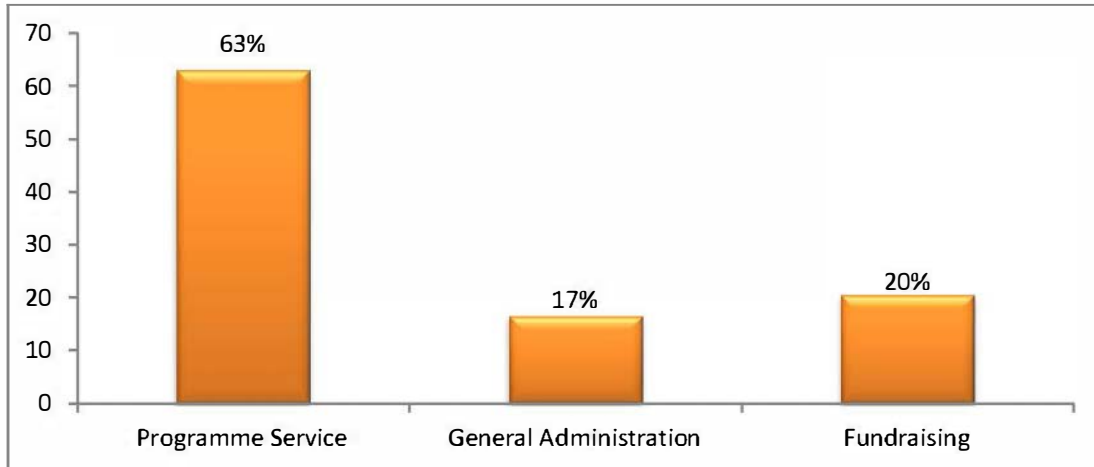
Graph: 1 (c) Presenting % of funds raised from different source



2) Deployment of funds

Efforts in delivering programmes with high quality and cost efficiency helped the organization in keeping general administration cost at a low level. Major portion of the funds raised during the year have been deployed for the purpose of program implementation (please refer to graph-2). The general administration cost includes expenses towards salaries of admin staff, maintenance and other office expenses. Fundraising includes the cost incurred towards raising local funds in India and strengthening the team so that dependency can be reduced on the foreign funds and increase on the local donations raised within India. Program services which consumes the major portion of expenditure includes the cost towards different activity supported by SEI for providing services to people affected by Leprosy, such its supported Hospitals, POID project, Schools.

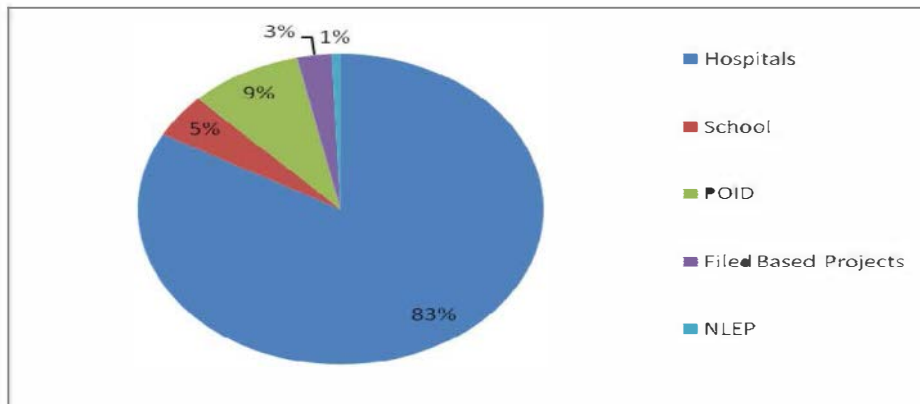
Graph: 2 presenting utilization of funds under different heads



3) Thematic Utilization of Funds

Thematic utilization during the year was more in the area of Hospital i.e. 83%, followed by 9% for POID, 5% towards school, 3% towards field based projects and 1% towards NLEP support to government of India (please refer to graph-3).

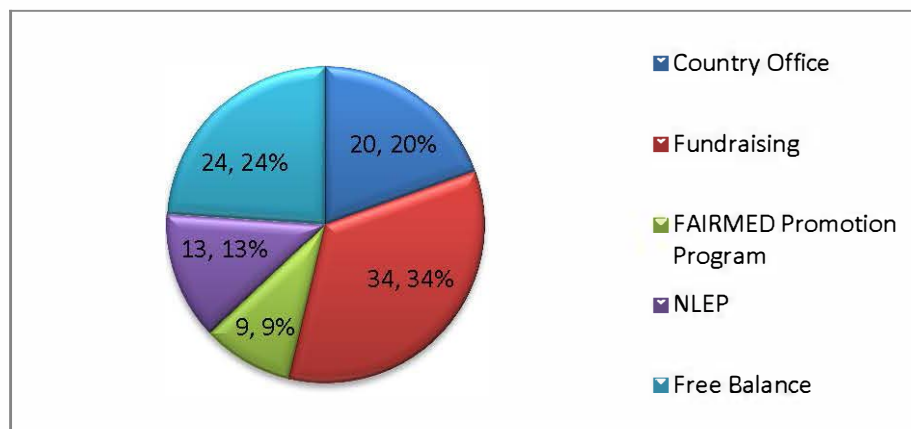
Graph: 3 presenting utilization of funds in different categories



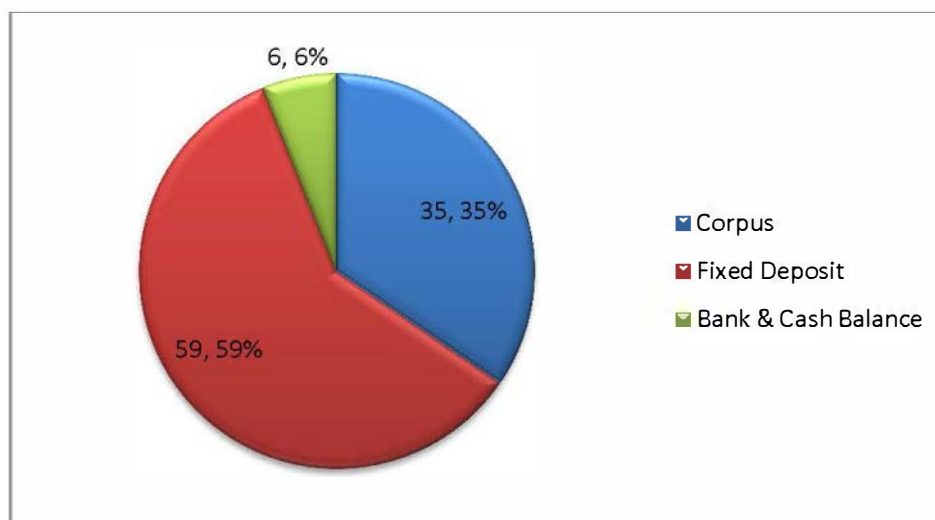
4) Savings under different project heads

During the year SEI tried to make savings by controlling the expenses under different project heads (please refer to graph- 4[a]) . These savings will be used in the coming years, which will help us to reduce our dependency on the foreign funds. These closing balances included the Corpus fund, bank and cash balances, and fixed deposits (please refer to graph- 4[b])

Graph: 4 (a) Presenting savings under different project heads



Graph: 4 (b) Presenting allocations of savings under different forms of deposits



Human Resource

All employees working with Swiss Emmaus India play an important role in the organization and are working towards a common goal i.e. to provide their support to the people affected by leprosy.

Staff Salary Band		
S. No.	Designation	Band
1	Senior Management Staff	50,001 - 300000
2	Middle Management Staff	30,001 - 50,000
3	Supervisory Level	10,001 - 30,000
4	Junior Level	5,000 - 10,000

Table 3- staff salary distribution between different levels of management.

Acknowledgements

Swiss Emmaus India acknowledges with all the donors, friends and well-wishers for recognizing our work and making a meaning contribution in the best possible ways towards our endeavors in eradication of Leprosy, control of TB and other poverty related illnesses.

We are grateful to the dignitaries in FAIRMED, Bern, Switzerland for their timely support and guidance. We are also thankful to the Government at Central, State and District level for extending the necessary support towards our cause. Our heartfelt gratitude is to ILEP, CCM and National TB Consortium (NTC) for giving us the opportunity to strive for a "World free of Leprosy and TB". We take this opportunity to express our deepest appreciation towards our partners who implement the projects and activities with sincerity and professionalism. Finally, sincere thanks to our trustees, colleagues at Central Office who have continuously guided and motivated us to serve better to achieve our goal.

Abbreviations

AP: Andhra Pradesh
CEO: Chief Executive Officer
DOTS: Directly Observed Treatment with Short course Chemotherapy
DRDA: Department of Rural Development Agency
ESLP: Emmaus Swiss Leprosy Project TB: Tuberculosis
HHH: Hubli Handicapped Hospital
IDF: Indian Development Foundation
IEC: Information, education and communication
ILEP: International Federation of Anti-Leprosy Organizations
IP: In patient
MD: Managing Director
OP: Out patient
NTC: National TB Consortium
POID: Prevention of Impairment & Disability
RISDT: Rural India Self Development Trust
RNTCP: Revised National TB Control Program
SEI: Swiss Emmaus Leprosy Relief Work India
SET: Survey, education and treatment
SHG: Self Help Group
SHLC: Sacred Heart Leprosy Centre
WHO: World Health Organization

SEI Project MAP





***Support us
to transform the lives of many!***



✓ ***Tick one of the following***

- Care for a person affected by Leprosy @ RS.....
- Sponsor patient's Ulcer care @ Rs.1,500
- Sponsor a child's Education @ Rs 2,500/- per Year
- Sponsor Corrective eye Surgery @ Rs 10,429
- Hand / foot reconstructive surgery @ Rs.19,185
- Support the Prevention of Impairment and Disability Camp @ Rs.20,000 per camp

Mode of Payment

- ✍ MO /DD/Cbeque in favour of HealthFirst India
- ✍ Payment to HealthFirst India No: 016010100833141, Axis bank
- ✍ Donate Online :
<http://www.healthfirstindia.org/donate.php>

Name:.....

Date of Birth

Address.....

.....

.....

email:

mobile:

Donations to the trust are eligible for tax exemption under section 80G of the IT Act 1961

Swiss Emmaus Leprosy Relief Work India

J-17, First Floor, South Cit 1, Gurgaon- 122 007 |

Telephone: +91- 0124-2384224, | Email: info@healthfirstindia.org

|Website: www.healthfirstindia.org |

Samiya, 8, affected by leprosy

"Help - I don't want to lose my fingers."



**Leprosy is curable
However, drugs alone are not sufficient**

Support us

You can make a difference in the lives of people affected by Leprosy.



HealthFirst India is an initiative of Swiss Emmaus Leprosy Relief Work India

Mode of Payment
MO /DD/Cheque in favour of HealthFirst India
A/C No:
016010100833141,
Axis Bank.



Inertive limbs get infected easily. Treating ulcers prevents the loss of limbs.



With reconstructive surgery crippled hands and feet can be saved and made usable again.



Special footwear protects the insensitive feet and helps avoid infections.



Central Office

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email ID: info@healthfirstindia.org

Donations to Swiss Emmaus Leprosy Relief Work India are eligible for tax exemption under section 80G of the IT Act 1961. Online : www.healthfirstindia.org

www.swissemmausindia.org, www.healthfirstindia.org



**SWISS EMMAUS LEPROSY
RELIEF WORK - INDIA**

***Support us
to transform the lives of
people affected by leprosy!***



**HealthFirst India is a fundraising initiative of
Swiss Emmaus Leprosy Relief Work India**

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Telephone: +91- 0124-2581224**

Mumbai Office

**Swiss Emmaus Leprosy Relief Work
India**

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Telephone: +91- 044-65459500**

**Donations to the trust are eligible for tax exemption under section 80G of
the IT Act 1961**

| Email: info@healthfirstindia.org |

Website: www.healthfirstindia.org | www.swissemmausindia.org

Make online donation : <http://www.healthfirstindia.org/donate.php>