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UPDATE
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SUPERVISION WITH A CAUSE

Supervision has become a buzzword, a recurring theme for discussion, a desperate reference to our inabilities and inactions, a cure-all panacea for all the manifest ills, a priority intervention that is yet to assume the status it deserves.

Public health programmes are managed by Medical professionals and it is not every day that one comes across a Medical Officer who is endowed with the consummate aptitude to deftly manage human resource. In a rigid hierarchical system it is often difficult, if not impossible, to expect openness in communication which could remove potential threats to individual performance. People complainingly attribute lack of objective supervision to many of the performance problems in the field. The primacy of supervision in the management of public health programmes remains at best an aspirational theme. It is like everybody talks about it but nobody seems to be doing anything about it!

To supervise means to observe and direct the execution of a task or an activity (Oxford dictionary). It means, to observe and guide. It demands thorough observation, not probing check; clean listening, not imperious questioning; analytical interpretation, not procedural elucidation; and critical feedback, not disapproving censure. It can elevate or decimate a person's motivation. Being a management tool and if used appropriately it certainly brings about the expected change in task management.

To be an effective supervisor one needs certain tools- right attitude, access to job description, checklist of functions and tasks with measurement criteria and standard and logistic support.

Attitude:

Being supportive is an attitude of mind. It is a settled way of thinking and feeling about others that tends to transgress barriers, real or imagined, helps others see the things as they are and puts them in a more acceptable position in relation to their job function. It is also possible that a supervisor may not be able to convert problems in the discharge of functions and tasks into needs. Misreading of the performance or capacity gaps as mistakes, not as needs, does not often help in developing the right kind of attitude. It breeds belligerence and is anathema to individual betterment.

Job chart:

A good supervisor needs to be invested with the complete knowledge about the job responsibilities of the supervisee. This serves to temper expectations. The job chart should be precise, specific, with a reasonably robust content validity. More often than not many a function that is not part of the original job chart is thrust on the unsuspecting employee either intentionally or instinctively resulting often in mismatch between expectation and outcome. This can be avoided if the job responsibility is clear and is known to both the supervisor and supervisee.

Checklist:

The most important tool that a supervisor needs is a simple, distinctive checklist that looks at job functions and tasks empirically with objective measurable criteria, standard and scale. Proper use of the checklist helps in identifying the needs of the supervisee and formulating appropriate measures to address them.

Logistics:

Finally, a supervisor would be helpless without mobility support.

When supervision becomes a tool to find faults it places people in spotlight and under duress. This attitude which is in direct contrast to guided support generates confrontation and resentment, not enthusiasm and inspiration. We don't see inspirational moments which would uplift the spirit of the workforce against a backdrop of dreary routineness. More often than not supervision is treated as an essential obligation, not as a moral imperative intended to help a person wiggle through imbalances in routine actions. Supervisors often fail to nudge their wards into higher performance orbit because they lack clarity in job function. This leads to widely distorted expectations. The outcome of such a supervisory act is punishment. The misguided action is borne out of ignorance about the essential character and purpose of Supervision. Very rarely one finds a supervisor with a checklist or using one, if available. One needs to move in the field to become familiar with people, their work, their problems that offers an

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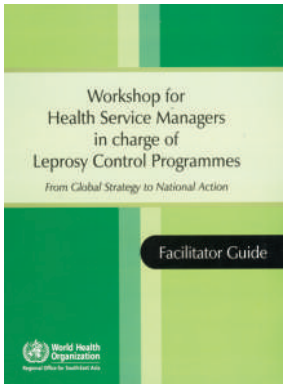
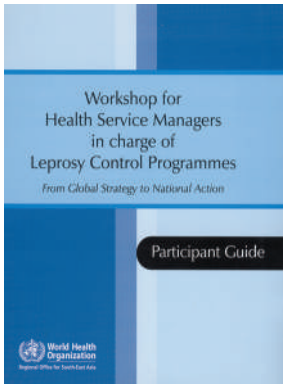
opportunity to refocus their gaze. This does not happen generally and one hears a multitude of reasons for this. Every state has middle level supervisory infrastructure (Regional directors) which are there to monitor all the public health programmes in a zone of 5-8 districts. They are not trained in leprosy and are rarely involved in leprosy control. There is a tendency to depend on external resource, often easily and readily available, for supervisory support which, sadly enough, is detrimental to sustainability.

One, therefore, sees more problems than promises as far as effective supervision is concerned. There is an urgent need for resuscitation. Adequate use of all available supervisory infrastructure (at state, regional, district and subdistrict level), adequate training of supervisors that may lead to more precise understanding and proper use of the fundamental tool, bringing together the supervisory staff on a common platform for discussions and decisions on valences in operational issues, removing any ambiguities in job definition, formulating pragmatic guidelines on vehicle support, mandatory use of checklist, are some of the measures that could be introduced on priority basis to address the most important problems and achieve sustainable, quality leprosy service.

Supervision is one of the most essential management tools to enhance the energy and the enthusiasm and to further productivity in an organisation. It is a deeply affecting experience. It is an event where people should engage themselves in emotionally intelligent ways to support each other and forge a successful path towards achieving the maximum benefit to the central figure of all their action- the person affected with leprosy. It is imperative for all major players to marshal all their thoughts, knowledge and efforts to make 'supervision with a cause' a relevant, recurrent inspirational theme.

Publication and use of management training modules from WHO





Regional Office for South East Asia, World Health Organisation, has developed training modules for health service managers in charge of leprosy control programmes. The modules are meant for training especially the programme managers with little or no exposure to management of leprosy. The unique training methodology employed is aimed at making the learning experience interesting and exciting. WHO has already conducted the workshop in three places. First workshop in India was sponsored by ILEP, WHO and GOI using these modules was conducted in Guwahati from 23rd to 26th June, 2008 for Programme managers from the North Eastern States of India.

Total number of participants and observers in the workshop was 12 (Assam:5; Tripura:1; Megalaya:1; Mizoram:1; Nagaland:1; ILEP:2 & CLD:1) and 3 respectively: Dr. Myo Thet Htoon, Dr. N. Manimozhi and Dr. P. Vijayakumaran were the facilitators.

Dr. N. Manimozhi who had been exposed to training methodology at Leprosy Management Workshop held at Addis Ababa, Ethiopia in the first week of May 2008, was the chief coordinator for the workshop held at Guwahati.

Operational guidelines for Leprosy control activities

(World Health Organisation SEA/GLP/2006.2)

Contd. from October 2007 Issue

Check for muscle weakness

The three key muscles are:

(1) thumb up (tests the median nerve)
- ask the person to put out their hand, palm up
- support their hand in your hand
- ask them to point the thumb towards their own nose
- test the strength of the thumb to stay in that position

(2) little finger out (tests the ulnar nerve)
- ask the person to put out their hand, palm up
- support their hand in your hand
- ask them to move the little finger out
- test the strength of the little finger to stay in that position

(3) foot up (tests the peroneal nerve)
- ask the person to sit down
- support the person's lower leg in your hand
- ask them to point the foot up to the roof
- test the strength of the foot to stay in that position

Muscle strength is recorded as "Strong" (S), "Weak" (W) or "Paralyzed" (P):

"Strong" (S) - means that the muscle being tested is of normal strength;

"Weak" (W) - means that the muscle can move, but it is definitely weak;
and

"Paralyzed" (P) - means that the muscle cannot move at all.

4.7 What are the key messages for someone newly diagnosed with leprosy?

When someone is newly diagnosed with leprosy, he/she should receive help and counselling so that the disease can be treated in the best possible manner. It is important that the person learns:

- that he/she should lead a normal life
- where to get answers to any questions about leprosy
- that leprosy is caused by a germ and is curable:
  - the treatment is for either 6 or 12 months
  - common side-effects include red urine and darkening skin
  - tablets must be taken every day at home
  - a new blister-pack is needed every 28-days
- that consultations and treatment are free-of-charge:
  - discuss how often the person should attend: monthly or less often
- that leprosy is no longer infectious once treatment has started:
  - close contacts may develop leprosy, so should be brought for examination at the next visit
- that the skin patches take time to disappear
- that leprosy reactions can occur, and can be treated:
  - patches can suddenly become red and swollen again
  - there may be pain or numbness in the limbs
  - there may be weakness of hand or feet
  - there may be eye problems: loss of vision, pain or redness
- new disability can occur at any time but it can be treated
- existing disability may or may not improve with treatment
- that when problems occur, treatment may be available locally, or the patient may need to be referred to another clinic for specialist care
- that various skills will need to be learnt to help prevent and manage disability.

5 Treatment

5.1 What is MDT and what steps need to be taken when starting treatment?

Multi-drug therapy (MDT) is a combination of drugs that is very safe and effective in treating leprosy to prevent the emergence of drug resistance; under no circumstance should leprosy be treated by a single drug. MDT is available freeof-charge to all who need it. The drugs are all taken by mouth. MDT is provided in convenient blister packs covering four weeks of treatment (in these guidelines the four-week period is referred to as a "month"). There are different packs with the same drugs, but in smaller doses, for children. MDT is safe for women and their babies during pregnancy and breast-feeding. MDT can be given to HIVpositive patients, those on anti-retroviral treatment and to patients on treatment for tuberculosis (TB). If a leprosy patient is treated for TB, the MDT regimen should omit rifampicin as long as the TB regimen contains rifampicin.

PB patients need two drugs for six months. MB patients need three drugs for 12 months. See section 5.2 for drugs and dosages. Every effort must be made to ensure regularity, so that PB cases complete their treatment in six months and MB cases in 12 months.

There are various groups of people who need MDT, recorded as either New or Other:

- New Cases: people with signs of leprosy who have never received treatment before

- Other Cases include:
  - *Relapse cases* receive exactly the same treatment as new cases (either PB or MB); *(*section 5.5)
  - People who *return from default* receive exactly the same treatment as new cases (either PB or MB; section 5.4)
  - Cases who have been *transferred in*: these people should come with a record of the treatment they have received to date. They require only enough treatment to complete their current course.
  - People with a *change in classification* from PB to MB, need a full course of MB treatment.

NB: None of the "Other Cases" should be recorded as "New Cases".

When it is determined that a patient needs to be treated with MDT, the following steps must be taken:
- Fill in the Patient Record Card and the Leprosy Treatment Register (section 8.4)
- Determine which type of MDT is required: PB or MB (section 4.3)
- Determine which dose level is required: adult or child (section 5.2)
- Counsel the person (and the parents, if it is a child) to indicate:
  - the need for regular treatment
  - the possibility of complications of leprosy which may need other treatment
  - that the clinic is always ready to see them if they have any problems
- Give the first dose of treatment and explain how to take treatment at home.

As long as accessibility is not a problem, the drugs given once a month should be supervised – in other words, the health worker should make sure that the drugs have actually been taken. The other drugs are taken at home. The supervised dose is most conveniently arranged by having the patient attend the clinic each month. This monthly visit is also useful for monitoring the regularity of treatment and to identify complications (such as neuritis, reaction, etc.) at an early stage. Supervision of the monthly dose is important to ensure regularity of treatment, eventual cure and prevention of relapse.

5.2 Which drugs are included in MDT and what are the doses for adults and children?

MDT treatment is provided in blister packs, each containing four weeks' treatment. Specific blister packs are available for multibacillary (MB) and paucibacillary (PB) leprosy as well for adults and children.

The standard adult treatment regimen for MB leprosy is:
Rifampicin: 600 mg once a month
Clofazimine: 300 mg once a month, and 50 mg daily
Dapsone: 100 mg daily
Duration: 12 months (12 blister packs)

The standard adult treatment regimen for PB leprosy is:
Rifampicin: 600 mg once a month
Dapsone: 100 mg daily
Duration: six months (six blister packs)

Standard child (ages 10 – 14) treatment regimen for MB leprosy is:
Rifampicin: 450 mg once a month
Clofazimine: 150 mg once a month, and 50 mg every other day
Dapsone: 50 mg daily
Duration: 12 months (12 blister packs)

The standard child (ages 10 – 14) treatment regimen for PB leprosy is:
Rifampicin: 450 mg once a month
Dapsone: 50 mg daily
Duration: six months (six blister packs)

The appropriate dose for children under 10 years of age can be decided on the basis of body weight. [Rifampicin: 10 mg per kilogram body weight, clofazimine: 1 mg per kilogram per body weight daily and 6 mg per kilogram monthly, dapsone: 2 mg per kilogram body weight daily. The standard child blister pack may be broken up so that the appropriate dose is given to children under 10 years of age. Clofazimine can be spaced out as required.]

Rarely, it may be considered advisable to treat a patient with a high bacillary index (BI) for more than 12 months. This decision may only be taken by specialists at referral units after careful consideration of the clinical and bacteriological evidence.

5.3 What should be done when a person does not attend regularly for treatment?

Every effort should be made to persuade newly diagnosed patients to complete their treatment as prescribed (section 5.1); discuss attendance at the clinic and if there is likely to be any difficulty, work out ways in which it can be made easier for the patient. There are several reasons why someone may not attend regularly for treatment:
- Poor accessibility of the clinic (may be far from home, or a difficult journey, or working hours of the clinic may be inconvenient)
- Difficulty in taking time off work, or nomadic/migrant work
- Lack of understanding about the disease and the importance of regular treatment
- Stigma, often fed by negative attitudes and fear in the community
- A poor relationship with the health worker

To be contd.

The Way Forward...

For many years now in India, caring for leprosy afflicted was in the domain of missionaries and NGO's. As a result many leprosy centers mushroomed in and around the country with a single point agenda of caring for leprosy patients which included treatment and rehabilitation in all its dimensions.

However, with the Government of India stepping in to supply free MDT's as early as 1982, there was a perceptible role change and NGOs started to feel that it was time to rethink and revisit some of the objectives they had enshrined in their constitutions. This need to change was further hammered in when in 2003, the Government decided to integrate leprosy with general health thereby making it clear that leprosy had moved from the private domain to the public.

If government statistics are anything to go by then with the prevalence rate less than one per ten thousand, Hansen's disease has ceased to be a public health threat in this country and if that is so, have all the so called "leprosy hospitals" really been pushed to the abyss?

Understandably in an increasing competitive healthcare scenario, many hospitals and institutions which focused exclusively on leprosy suddenly find it difficult to adjust to this drift. This anxiety is largely because of a myopic view for many hospitals and institutions have managed to break out of this mould and adapt to the changing times.

GREMALTES (Greater Madras Leprosy Treatment and Education Scheme) showcases how such change is possible. Guided by their commitment to work with marginalized they converted this strength to bridge the gap between the city's so called elite corporate and private hospitals and the not-so-rich public by providing composite and affordable healthcare.

Few people in Chennai would be able to identify GREMALTES, but many know the German Hospital at Shennoy Nagar and what's even more surprising is that many will tell you that it is a good 'Eye hospital' with excellent medical facilities and very reasonable charges!

GREMALTES and the German Hospital is the same, but for some strange reason the German name is the one that is more popular and known by word of mouth. The hospital is a 70-bedded hospital and started in 1980 as a leprosy hospital fitted out to tackle satisfactorily all the problems related to leprosy. It partnered with the Government in eradicating leprosy and apart from pioneering programs in leprosy it has more than 1275 reconstructive surgeries to its credit. Even today caring for leprosy patients is high on their agenda and it is common to see leprosy patients walk their corridors.

But this did not prevent it from becoming a multi-specialty hospital. Today the hospital boasts of treatment facilities in dermatology, tuberculosis, ophthalmology, general medicine, ENT, dentistry, orthopedics, diabetes and hypertension, HIV/AIDS and VCTs.

History

Founded by William Gershon with the express mandate to care for leprosy patients, GREMALTES was registered under the Tamil Nadu Societies Registration Act in 1978.

The hospital started with 100 beds and all the facilities, including a shoe-unit, to take care of leprosy-related problems. Mr Gershon was supported by his wife Sybille Gershon and a team of expert and committed personnel. The hospital soon built up a reputation in leprosy care.

Changing with the times

When the Government announced the integration of leprosy with general health, it was obvious that leprosy work would take on different dimensions.

With bed occupancies reducing, the hospital was being under utilized. It was time to take stock and GREMALTES was ready to change to keep pace with times and seize the opportunities as and when they evolved.

A kind of SWOT analysis, helped to give the management a direction even as they decided to open its facilities to include treatment for other ailments.

"Our first priority was to re-orient our staff to this change. I spoke to them and explained the situation. It was not easy and it took time" says Pius Kalathil, Director GREMALTES. "We offered VRS three times to trim the number of staff and slowly weeded out redundant and unwilling workers. We also ensured that our competent doctors and nurses continue with us by increasing their salary substantially. All staff went for capacity building workshops or training"

The hospital then focused on building on its strengths and cashed in on their reputation for eye care and skin care. Even today, they get 80 per cent of their funds from the department of ophthalmology, dermatology and dentistry. About 14,000 patients visited the eye department and 33,000 patients visited the Dermatology department last year. Thanks to their team of good doctors and nurses of this hospital it is known by word-of-mouth and its bed occupancy is almost 60 per cent now.

Change was not just limited to diversifying to include general health but also the hospital spruced up its image to be reasonably competitive with other healthcare facilities. Some wards were converted to single rooms with attached toilets for

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private patients. Latest equipments for eye care and orthopedics were bought, and even the hospital changed from a dull grey colour to bright off- white exterior with lot of potted plants to add to the aesthetics!

Early Struggles

Changing mindsets and getting non-leprosy patients to come to a hospital that was associated with leprosy was not easy. But this did not discourage the management and after identifying eye care and skin care as their USP they conducted eye camps in the community.

"The first year we got only leprosy patients. We were not discouraged or disheartened because leprosy work is always our priority area. But we changed our strategy and instead of going alone into the community for camps we partnered with other NGOs and supported their work with eye camps. This paid off and in the second year we got 147 cataract patients. From there on there was no looking back, numbers picked up and it slowly grew to 500 then 600 and today we have 14000 patients" says a beaming Pius.

As patients began to come in slowly the financial scenario too started changing and though their rates are modest, 60% of their total expenses are met from the hospital's income. In addition to the hospital income, GREMALTES is largely supported by GLRA, CBM as well as the IDF and also gets help from individual donors who sponsor meals or donate money for camps and surgeries.

Breaking barriers

Anxieties about whether the general public accepting this hospital as a "regular" hospital were brushed aside and tackled on an "as-and-when" basis with minimum fuss. Staff at all levels, infused confidence in the patients by not just saying that leprosy is not contagious but by walking- that-talk and by shaking hands with leprosy patients or by patting them without the slightest hesitation.

The hospital's kitchen which catered for the in-patients also provides food and tea for the staff and everyone eats from the same plates. All this had its ripple-effect on the other patients and slowly their fears started to melt.

Today the hospital has a state-of-the-art operating theater and provides care that can be matched for its quality and professional expertise with the best hospitals in the city.

FACILITIES

1981: DERMATOLOGY: Over 120 clients on an average avail benefits from the daily Out Patient Clinic. Over 371195 persons have benefited since inception.

1992: TUBERCULOSIS: 3055 persons were detected and treated since 1992. The Corporation of Chennai has allocated 9 divisions in Zone V with a population of over 300,000 to GREMALTES for RNTCP (DOTS).

2000: OPHTHALMOLOGY: Over 79,515 persons with eye impairments have benefited since started in 2000. 7,194 cataract surgeries with IOL have been performed. 2002: DENTISTRY: It started in a humble way with equipments gifted by a generous dental surgeon, Dr. Albert Shieh, the facility is well patronized. GLRA and IDF have also contributed towards acquiring new equipments for the department. Around 14,245 persons have benefited since inception.

2003: ORTHOMOBILITY & CBR PROGRAMME: Supported by CBM, the programme has helped to improve the quality of life of the physically challenged persons with appropriate medical/surgical interventions and socio- economic orientation with appropriate counseling and monitoring. 260 clients are enlisted in this programme.

2003: JOINT TB / HIV PROGRAMME: Supported by GLRA, the programme was started to find out the HIV prevalence among the TB patients walking into the GREMALTES OPD and help them for appropriate management. 1,154 persons have so far benefited through this programme.

2004: DIABETES & HYPERTENSION: An Out Patient Clinic has begun functioning from June 2004 and over 2,324 persons have benefited.

2004: SEXUALLLY TRANSMITTED INFECTIONS (STI): A Clinic for persons with STI [Sexually Transmitted Infections] has begun to function from July 2004 and over 174 persons have benefited.

Ancillary Facilities:

- Clinical Laboratory
- Counseling
- MCR Footwear Unit
- Derma Procedure Unit
- CBR Group
- Optical Facility
- X-ray & ECG
- Pharmacy
- Specialty Training
- Physiotherapy
- Dental X-ray
- Phototherapy
- Self Care Group

Future

The hospital has managed to find its feet and each year earns 20-25% more than the previous year. The staff and management are optimistic about facing new challenges and look forward to expanding and including new programs each year. According to the Director "We plan to expand and modernize our footwear section and optician facilities. Our future plans include providing community welfare centers for the aged, women and children because whatever else we might do, our priority is to work for the poor and the marginalized. " On a parting note he adds, " for change to happen one needs support, and we at GREMALTES have always had the unstinting support and encouragement from our Board of Trustees and donors."

- Reena Mathai Luke

Meeting of ILEP State Coordinators at Hyderabad
(6th-8th May 2008)

Issues discussed during the meeting:

1. Meeting of ILEP State coordinators from 21 states was held at Hyderabad from 6th to 8th of May 2008 to discuss the ILEP support plans for the states; tasks and job responsibilities of the coordinators including reporting format; and to arrive at a consensus on the modus operandi in low endemic states like those in the North East and North.
2. ILEP State coordinators made presentations focussed on the status of supervisory infrastructure and its functional orientation, progress in the programme and strategic planning including plan of action of ILEP support. Important issues that emerged out of the presentations and discussion that was generated were:

i. Leprosy situation in general is comparable to all the major endemic states. New case has gone up, MB proportion and disability proportion have increased slightly, Child proportion has remained the same or gone down and the treatment completion is very good (more than 90%). Prevention of disability has not taken off in many states and referral system has not yet been established.

ii. It was suggested and accepted that there could be reference in the Strategic plan statement of the Action plan of ILEP state coordinators to two key elements: Strengthening the supervisory structure at all levels and establishment of a sustainable referral system in the state. Action plan could consist of various actions that could be common to all the supporting ILEP members in the State or could be different depending on the perceptions and priorities of the ILEP members. ILEP State coordinator would take into consideration these essential differences while preparing the plan for the State;

iii. As far as possible the ILEP State coordinator could ensure that the ILEP Support plan is incorporated in the State plan. ILEP plan should aim at sustainability and there should be exit strategy built into the plan (whether the plan is providing support through TRU or Consultants).

iv. ILEP could develop a common minimum implementation plan for North eastern states where the prevalent situation is the almost similar in all the 8 states (very low endemicity, full-fledged supervisory infrastructure and good mobility support, lack of training and absence of referral centres).

v. ILEP State Coordinators would also try to explore the possibility of upgrading the skills and capacity of intermediate level supervisors (Regional Directors) so as to improve the supervision capacity of the programme.

vi. ILEP would not support activities which are already planned to be implemented by the state with budgetary support from GOI.

vii. Attempt should be made to train the trainers in all the training institutes, identify good trainers from these Institutes so that they could be involved later in training the GH staff.

viii. ILEP should urge the states to ensure that all the new cases irrespective of the place of their origin are registered and treated.

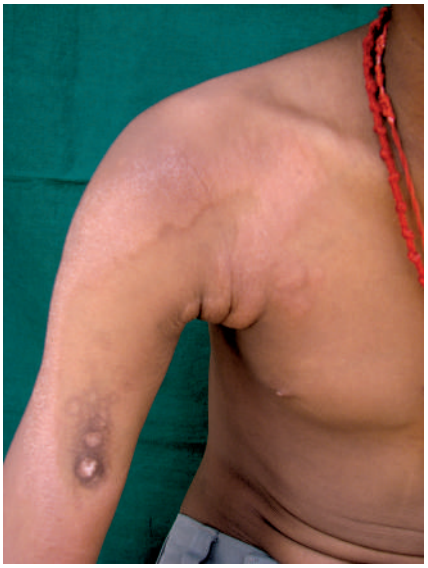
Annual Conference of State Leprosy Officers - India
Bengalooru – 2nd and 3rd April, 2008

Recommendations:

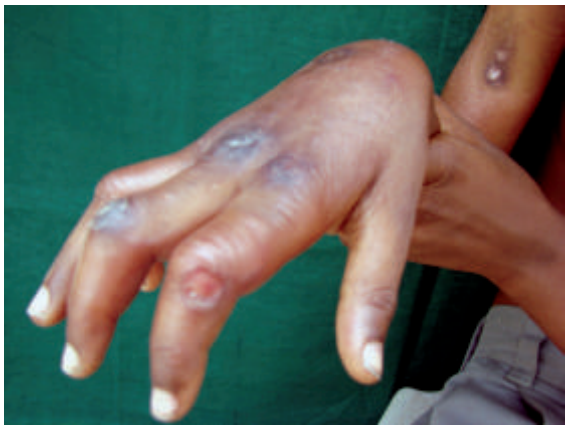
1. Strengthening of the District Nucleus component in all the States should be given top priority.
2. The States will carry out listing of the existing disabled cases due to leprosy block wise. Some States that have already completed the exercise may forward the data to the Central Leprosy Division.
3. The WHO operational guidelines (2006-2010) fully endorsed by ILEP, recommends "Treatment Completion Rate (TCR)" as one of the main indicators for monitoring progress of leprosy services. GOI accepted the recommendation and decided to include TCR as one of the main indicators in the New Paradigms under NLEP. A number of States have not yet competed this exercise for the year 2006-07, which must be done as the baseline data. The WHO Coordinators and ILEP Coordinators / Advisors posted in the States / UTs should help their States in completing this exercise within next 2 months time, and send the report to CLD.
4. The North Eastern States have many problems not similar to other States and they require urgent help. Action taken report on the decisions taken at the last meeting held at Gangtok in December 2007 may be submitted by the SLO's of North Eastern States to the Central Leprosy Division immediately. A follow up meeting may be arranged along with ILEP organizations shortly.
5. It is essential to discuss and finalise the revised communications for behavioral changes in NLEP strategies. As decided in the last meeting of core partners in NLEP held on 28th February 2008, the group of IEC experts at National level be constituted early.
6. A consultative workshop to discuss about the proposed changes in the communication under NLEP may be organized early with support from the partners.
7. Validation of cases need not be done routinely as a part of diagnostic process under NLEP. This should be carried out by the District Nucleus as a part of routine supervision, recorded properly so that the indicator "Proportion of correctly diagnosed cases" can be worked out annually.
8. Participation of State ILEP Coordinators in the State Leprosy Officers Conference to be ensured in the future. The ILEP Coordinator may intimate the names, addresses and contact numbers of the remaining 15 State Coordinators to the Government early.
9. Nearly 50% child proportion among new cases in Chennai, need urgent attention. The State may form a small group of epidemiologists to examine the factors involved at the earliest.
10. Now that ILEP has completed printing of the three operational guidelines, the same should be made available to all Institutions up to PHC level. Training of core trainers for State / District level be completed early with ILEP support.
11. DPMR activities should be started after training of PHC Medical Officers, supply of printed forms for registers/reports and provision of drugs / materials.
12. MDT stock management should receive personal attention of the State Programme Officers. All wastage of such drugs should be stopped. Old expired drugs should be quickly destroyed as per guidelines issued from the CLD.
13. Next State Leprosy Officers Conference is to be held after 6 months in September 2008 with ILEP support.

Ref: Report of the National State Leprosy Officer's Conference-Bengalooru-April, 2008. (No.M.11035/1/2007-Lep. Vol. II, Directorate General of Health Services (Central Leprosy Division) Nirman Bhawan, New Delhi)

"What the mind does not know, the eyes cannot see"



Dinesh (name changed) is 11 years old, the only child of poor labourer. He cannot go to school now and cannot play. He feels cheated. The parents feel wronged. There is no joy and fun in Dinesh's life. When Dinesh developed a patch on his right shoulder the parents became worried. They promptly took him to the doctor at the local ESI hospital. The doctor prescribed an ointment to be applied on the lesion and gave him an injection. This went on for 6 months. Dinesh developed blisters on the lesion and it started growing and become angry red. The parents stopped going to the hospital. After 6 months Dinesh developed swelling in the right hand, he was not able to hold pencil. He had terrible pain. The parents were worried. They did not wish to go to ESI hospital. Their neighbour advised them to take the child to an NGO hospital at Fathimanagar. The child had triple nerve palsy in the right hand- Radial, Ulnar and Median were paralysed. All the three nerves were considerably enlarged and tender. The skin lesion was in reaction. He was put on MDT and steroids.



Incidentally when we saw the father we were surprised to see that he had cervical lymphadenitis. He said that he was taking treatment from a private doctor who had removed pus three times and given him some drugs and injection. He had TB lymphadenitis. He said that he had spent Rs.2000 till then for his treatment.

The case underscores the need to strengthen referral system where persons with leprosy, with or without complications, are correctly diagnosed and promptly treated.

Sensitisation Meeting on Leprosy for Health Programme Managers, 28th June 2008 at Nashik.
(Conducted by Government of Maharastra in-collaboration with TLM (ILEP)

It is very rare that Health Programme Managers from all the 34 districts assemble at one place. Due to the inauguration of a Super Specialty Hospital in Nashik, which was going to be attended by ministers both from the Central and the State governments, this opportunity was utilized to call all the health programme managers a day early to sensitise them on Leprosy and TB control activities in the state.

The Health Programme Managers include Director of Health Services, Joint Director of Health Services (Leprosy & TB), Joint Director for Hospitals, Regional Deputy Directors, District Medical and Health Officers, Civil Surgeons (District Medical Superintends), District Leprosy Officers and District TB officers. About 100 senior doctors from 34 districts of the state participated in the meeting which went on from 9.30AM to 5 PM. Dr. Doke, the Director for Health Services and Dr. Ashok Ladda, Joint Director (Leprosy & TB) participated in the meeting. The major topics covered were Clinical Leprosy, Treatment, DPMR (Disability Prevention & Medical Rehabilitation), Monitoring & Supervision NLEP.

This sensitisation meeting generated lot of interest and enthusiasm among the participants, which will help in implementing ILEP supported activities.

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