

## 2 Past Initiatives



### 2.1 The leprosy elimination scenario in Burhanpur

At 9.3 per 10,000 population, Khandwa district records the highest prevalence of leprosy in Madhya Pradesh. Burhanpur's PR was 5 per 10,000 population as per the Modified Leprosy Elimination Campaign (MLEC) survey of September 2001. Despite efforts by the NLEP through intensive case-finding activities like the MLEC, leprosy elimination by 2003 appears to be a daunting task. Even with the high PR the awareness of the local population regarding leprosy was very low. This problem was compounded by the fact that the district, in spite of a high PR, did not have a full-time District Leprosy Officer (DLO) until 2001. A general surgeon at the district hospital in Khandwa had been given the additional charge as DLO prior to the appointment of a new DLO.

A specific challenge for the urban leprosy initiative in towns like Burhanpur, which has a large Muslim population, is the practice of *purdah*



The use of *purdah* is common among women in Burhanpur.

**Table 2: Year-wise and caste-wise newly-registered leprosy patients, Burhanpur**

| Year         | Scheduled Castes | Scheduled Tribes | Others    | Total      |
|--------------|------------------|------------------|-----------|------------|
| 1996-97      | 7                | 0                | 12        | 19         |
| 1997-98      | 2                | 0                | 13        | 15         |
| 1998-99      | 13               | 0                | 25        | 38         |
| 1999-00      | 7                | 0                | 29        | 36         |
| 2000-01      | 4                | 1                | 15        | 20         |
| <b>Total</b> | <b>33</b>        | <b>1</b>         | <b>94</b> | <b>128</b> |

Source: NLEP Office, Burhanpur

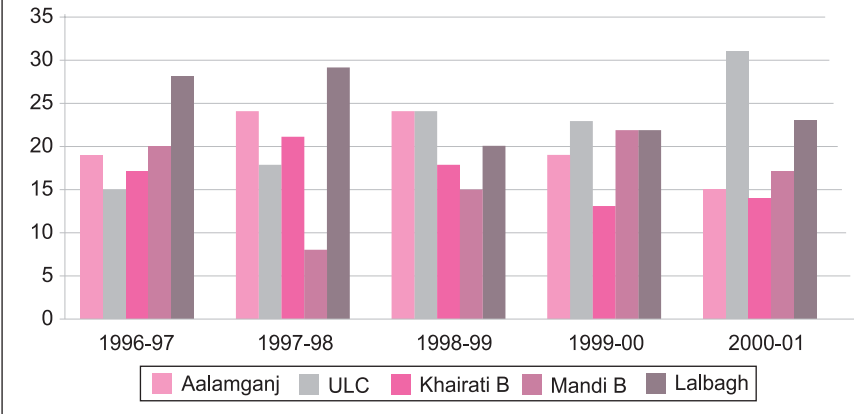
(veil) observed by women. The practice of *pardah* has to be taken into account when access to services and case-detection campaigns are considered, as also the low literacy rate and poverty among the Ansaris. The current initiative was not particularly successful in including this group of the population in the planned activities, as was also illustrated by the fact that during the MLEC, a major part of the information and questions along with the body chart was more or less left unadministered during home visits by functionaries in the localities populated by the Ansaris. Consequently, the actual extent of leprosy prevalence is still unclear, particularly among this community, and also in the rest of the town's population.

From Table 2 it is clear that the proportion of the newly-registered cases was much higher in the 'Others' category, which, however, is a very heterogeneous category comprising Other Backward Castes (OBCs), other Hindu castes and non-Hindus, as compared to the category of the Scheduled Castes. Given the demographic profile of Burhanpur as well as the specific issues raised above, it could be assumed that the Ansaris contributed significantly to the newly-registered leprosy patients (NRLPs) under 'Others', a view which was shared by local NLEP functionaries. However, in the absence of disaggregate data, this at best remained an informed guess.

## 2.2 Trends in leprosy prevalence in Burhanpur

Tabulation of leprosy PR by ward was not routinely done by the NLEP. Therefore, it was difficult to accurately identify pockets of high PR. The

**Fig 1. Year-wise newly-registered leprosy patients, Burhanpur (in percent)**



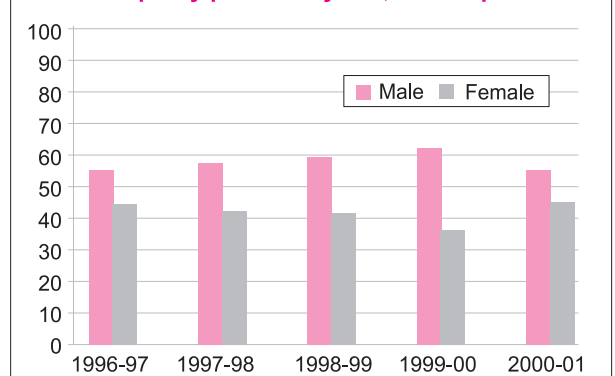
Source: NLEP Office, Burhanpur

target group, therefore, had to be identified based on substitute indicators combined with the perceptions of NLEP functionaries and DANLEP professionals. It was necessary to map the prevalence and relate it to socioeconomic data to devise a more accurate and appropriate strategy for sustainable leprosy elimination.

As can be seen from Figure 1, during the initial couple of years Labagh recorded the highest number of newly-registered cases. However, in the following years the maximum number of cases were consistently recorded by the Urban Leprosy Centre. This could mean that in addition to the cases registered by the NLEP staff during their routine work, voluntary reporting of cases from other sectors at the Centre was possibly also taking place. Patients afraid of being identified by their acquaintances as being afflicted with leprosy might have found the ULC safer to visit rather than report to the service centre in their own ward.

Figure 2 indicates that for all the five years mentioned, the percentage of newly-registered male patients was

**Fig 2. Comparative figures of newly-registered leprosy patients by sex, Burhanpur**



considerably higher than that of the newly-registered female patients. Assuming that the incidence of leprosy was equal among men and women, the figures indicate that the identification of male leprosy-affected persons (LAPs) is easier than the female LAPs. Therefore, there is a need for greater focus on women, especially those belonging to the *purdah*-observing communities, both in terms of leprosy education and development of appropriate strategies to identify potential leprosy patients in this group.

Patients who have already been identified and registered as well as those who have been released from treatment are also a crucial group, which could provide information about the gaps in the current programme being implemented. Interaction with this category of patients could result in course correction. From July 1993 to December 2001, 1107 new cases were registered whereas only 1014 cases were released from treatment. The reasons for the 93 patients discontinuing treatment need to be verified so that appropriate solutions can be incorporated in leprosy elimination strategies.