

# THE SPECIAL AMBASSADOR'S JOURNAL

## India Orissa (July 7-9, 2003)



*Residents of a colony in Orissa*

In July, I went to the northeastern state of Orissa. After Bihar, it is the state with the highest prevalence rate in India, with 7.3 leprosy patients per 10,000 inhabitants at the time of my visit.

Of Orissa's 30 districts, nine have a prevalence rate of more than 10 per 10,000. Political leaders such as the governor, chief minister and health minister are keenly committed to eliminating leprosy. Meanwhile, integration is moving ahead and MDT is widely available. Nonetheless, in the past 10 years, not much progress has been made. Why?

There are three major problems, the first relating to urban areas, the second to border regions and the third to tribal areas. The prevalence rate in urban areas is more than double that in rural districts, and particularly bad in the urban slums that account for 13% of Orissa's population. Next, 34 of the state's 314 blocks are situated in border areas where patients frequently move back and forth across the state line. For a long time, healthcare services in these rural border areas were inadequate; furthermore, MDT was only introduced to these areas in 1994, and full state-wide coverage wasn't achieved until 1997. Finally, proper information about leprosy is not getting to the tribal peoples who make up 22% of the state's population. Enhancing interpersonal communication programs is crucial to reaching them.

Faced with these adverse conditions, a four-step milestone plan to eliminate leprosy, district by district, before the end of 2005 has been drawn up under Governor M.M. Rajendran. With the governor leading the way, I sense an enthusiasm for the task not seen in other states. I hope that all involved will step up their efforts to make the plan a success.

Visiting a leprosy hospital-cum-colony of about 200 people, I was struck by the fact that there were

young women and children there who are completely cured. That they are living in unnecessary isolation is proof of the social stigma attached to them. In addition to the drive for leprosy elimination, therefore, we need a separate effort to ensure such people can be welcomed back into society.

## West Bengal (November 11)

In November, I visited Kolkata, Delhi, Wardha and Mumbai. In Kolkata I went to Garden Reach, an urban slum of 300,000 people with a population density of 30,000 per square kilometer. In the slum clinic I found neatly organized records going back 26 years for as many as 8,000 leprosy patients who had been treated there. I have nothing but admiration for the dedicated efforts of the staff over such a long period. The clinic also acts as an NGO office, and provides micro-financing for people affected by leprosy to help them start their own small businesses. So as well as treating patients, it is also helping them to become self-reliant once they are cured, and as such serves as a very good example of how to encourage social participation.

Elimination activities in West Bengal generally seem to be making good progress, although from what I have seen there are still a few problems. First, there are flaws in the management of MDT. The availability of drug supplies at Primary Health Centers varies, and there are insufficient stocks of children's dosages—a point I was asked to convey to the relevant authorities in Delhi. Second is the problem of defaulters—patients failing to complete treatment. With the integration of leprosy services into the general healthcare system in Kolkata, responsibility for case-holding has passed to local government. As a result, many patients have had to change the clinic where they go for treatment, or have found that they have been inadvertently dropped



*Children in Garden Reach, Kolkata*