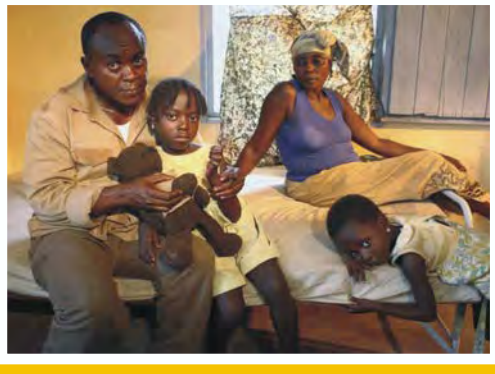
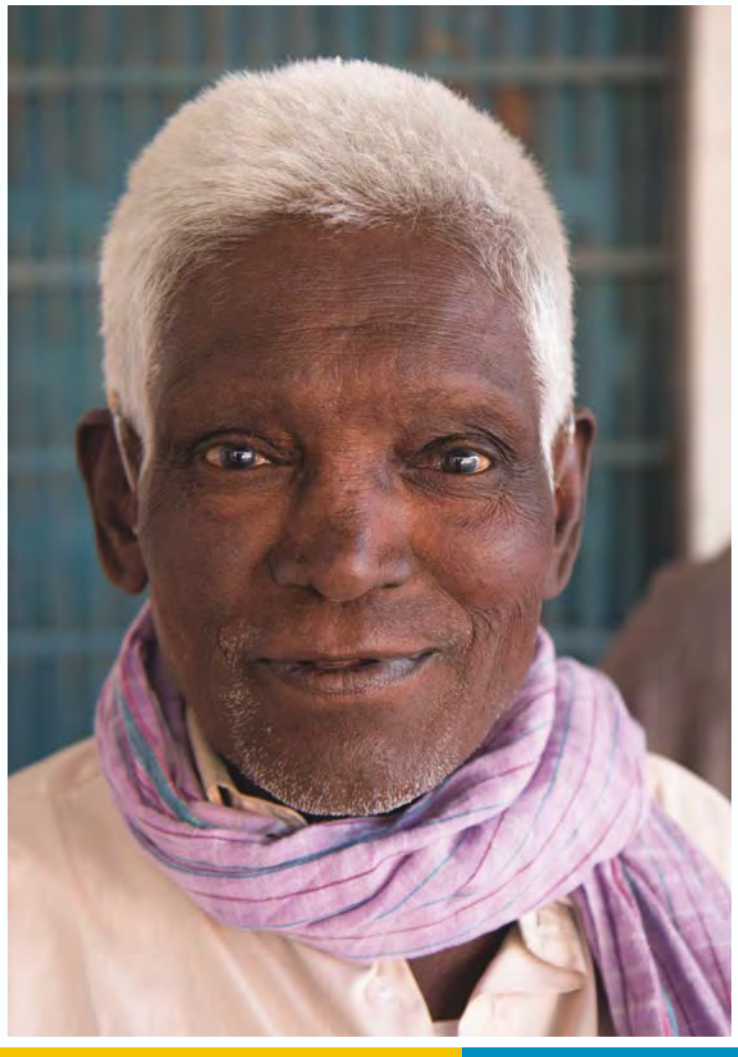
Global Leprosy Strategy 2016–2020





Accelerating towards a leprosy-free world

World Health Organization

Global Leprosy Strategy 2016–2020

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Abbreviations

CBO	community-based organization
GLP	Global Leprosy Programme
G2D	grade-2 disability
ILEP	International Federation of Anti-leprosy Associations
MB	multibacillary
MDT	multidrug therapy
NGO	nongovernmental organization
NTD	neglected tropical disease
PB	paucibacillary
TAG	Technical Advisory Group
UHC	universal health coverage
WHO	World Health Organization

Foreword

Since the introduction of multidrug therapy (MDT) about three decades ago, the leprosy burden in the world was significantly reduced. Leprosaria were closed and leprosy was regarded as a disease that could be treated in hospitals and primary health care levels. Elimination of leprosy as a public health problem was achieved globally in 2000 and in most countries by 2005. Reaching subnational elimination in jurisdictions with a sizeable population continues to be an important milestone.

Having declared leprosy control as one of seven flagship areas for the South-East Asia Region and hosting the Global Leprosy Programme in the WHO Regional Office for South-East Asia provide key opportunities for prioritizing leprosy control work where it is most needed to obtain global impact.

The current global leprosy strategy builds on previous five-year strategies. The Final push strategy for the elimination of leprosy, 2000-2005 focused on MDT and passive case detection. The Global strategy for further reducing the leprosy burden and sustaining leprosy control activities, 2006-2010 consolidated the principles of timely detection and effective chemotherapy in the context of integrated leprosy services. The Enhanced global strategy for further reducing the disease burden due to leprosy, 2011-2015 refined joint actions and enhanced global efforts to address challenges faced in leprosy control with a focus on early detection to reduce disabilities due to leprosy.

Yet the current strategy is innovative as it gives, in addition to a solid medical component, increased visibility and weight to the human and social aspects affecting leprosy control. Reducing stigma and promoting inclusiveness will reinforce better and earlier diagnosis. Innovative approaches include focus on children, women and other vulnerable populations, strengthened referral systems, systematic tracing of household contacts, monitoring drug resistance, working towards a simplified treatment approach and assessing the role of post-exposure prophylaxis. It provides linkages with broader health and development agendas including universal health coverage and the sustainable development goals.

This strategy was developed over a period of one and a half year through an iterative consultation process involving all stakeholders: national leprosy programmes, technical agencies, nongovernmental organizations, development partners, representatives of patients and communities affected by leprosy. As such, the strategy is conceived as an umbrella under which the different partners can develop their strategies and action plans, based on their comparative advantage.

The title "Accelerating towards a leprosy-free world" embodies the need to build on the momentum created in leprosy control at global and local level so that future generations can reach the ultimate goal of a world without leprosy.

Dr Poonam Khetrapal Singh
Regional Director

Executive summary

The past three decades have witnessed some impressive advances in leprosy control. Elimination as a public health problem (i.e. registered prevalence below 1 per 10 000 population) was achieved in all countries[1]. The agenda of eliminating leprosy at the subnational level is still unfinished in many countries and will therefore continue to be pursued in the coming years. Other challenges remain: continued delay in detecting new patients, persisting discrimination against people affected by leprosy and limited impact on transmission of leprosy.

The Global Leprosy Strategy 2016–2020 aims at accelerating action towards a leprosy-free world. It is based on the principles of initiating action, ensuring accountability and promoting inclusivity.

Initiating **action** involves developing country-specific plans of action.

Ensuring **accountability** will be achieved by strengthening monitoring and evaluation in all endemic countries in order to objectively measure progress towards achieving targets.

Promoting **inclusion** can be supported through establishing and strengthening partnerships with all stakeholders, including persons or communities affected by the disease.

The global strategy fits within the WHO aim to provide universal health coverage with its focus on children, women and vulnerable populations. It will also contribute to reaching Sustainable Development Goal 3—reaching health and wellbeing for all by 2030.

Its goal is to further reduce the burden of leprosy at the global and the local level. The strategy is structured around three pillars:

(1) Strengthen government ownership, coordination and partnership

(2) Stop leprosy and its complications

(3) Stop discrimination and promote inclusion.

Under each pillar broad core areas of interventions are included, among which five are the key strategic operational changes:

(1) Focus on early case detection before visible disabilities occur. A special focus will be on children as a way to reduce disabilities and reduce transmission. The target is zero disabilities among new paediatric patients[2] by 2020.

(2) Target detection among higher risk groups through conducting campaigns in highly endemic areas or communities; and improving coverage and access for marginalized populations. This will result in earlier detection and reduction of patients with grade-2 disabilities (G2D) at the time of diagnosis. The target of G2D rate is less than one per million population.

(3) Develop national plans to ensure screening of all close contacts, especially household contacts. The target is to have all household contacts screened.

(4) Promote steps to move towards the use of a shorter, uniform treatment regimen for all types of leprosy based on a thorough review of available evidence on uniform MDT and designing a global plan of action for its roll-out.

(5) Incorporate specific interventions against stigma and discrimination due to leprosy by establishing effective collaboration and networks to address relevant technical, operational and social issues which will benefit persons affected by leprosy. A significant (measurable) reduction of stigma and discrimination against persons

1 In view of fluctuating rates in small populations, this target was not applicable to countries or jurisdictions with a population of less than one million people

2 Paediatric cases include children below the age of 15

affected by leprosy by 2020 is aimed for through actions to reduce stigma and discrimination and promote social inclusion).

National leprosy programmes in endemic countries are encouraged to adapt the concepts and principles as proposed in the Global Leprosy Strategy 2016–2020 for developing country-specific plans of actions. Countries that report few or no cases will still need to adapt the strategy to their context, focusing especially on surveillance and on sustaining of a referral system either at the national level or through linking up to regional centres.

The Global Leprosy Strategy 2016–2020 is aligned with the Roadmap for Neglected Tropical Diseases whose target for leprosy is consistent with the G2D target of this strategy. It aims to promote further integration at the country level between leprosy services and other services at the primary and referral levels aimed at tackling other infectious diseases and also disabilities.

2016-2020
GLOBAL LEPROSY STRATEGY

- Zero disease
- Zero transmission of leprosy infection
- Zero disability due to leprosy
- Zero stigma and discrimination

Further reduce the global and local leprosy burden

INDICATORS	2020 target
Number of children diagnosed with leprosy and visible deformities	0
Rate of newly diagnosed leprosy patients with visible deformities	<1 per million
Number of countries with legislation allowing discrimination on basis of leprosy	0

PILLARS AND COMPONENTS

1. Strengthen government ownership, coordination and partnership

- Ensuring political commitment and adequate resources for leprosy programmes.
- Contributing to universal health coverage with a special focus on children, women and underserved populations including migrants and displaced people.
- Promoting partnerships with state and non-state actors and promote intersectoral collaboration and partnerships at the international level and within countries.
- Facilitating and conducting basic and operational research in all aspects of leprosy and maximize the evidence base to inform policies, strategies and activities.
- Strengthening surveillance and health information systems for programme monitoring and evaluation (including geographical information systems)

2. Stop leprosy and its complications

- Strengthening patient and community awareness on leprosy.
- Promoting early case detection through active case-finding (e.g. campaigns) in areas of higher endemicity and contact management.
- Ensuring prompt start and adherence to treatment, including working towards improved treatment regimens.
- Improving prevention and management of disabilities.
- Strengthening surveillance for antimicrobial resistance including laboratory network.
- Promoting innovative approaches for training, referrals and sustaining expertise in leprosy such eHealth.
- Promoting interventions for the prevention of infection and disease.

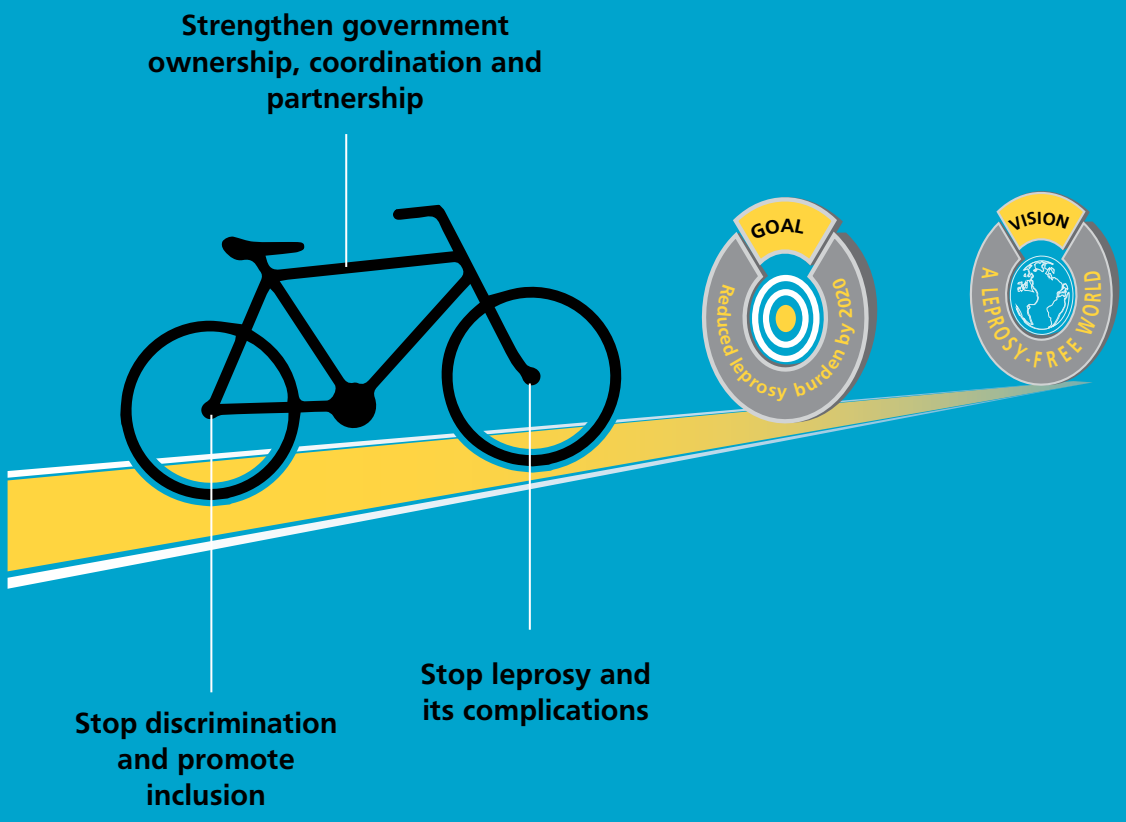
3. Stop discrimination and promote inclusion

- Promoting societal inclusion through addressing all forms of discrimination and stigma.
- Empowering persons affected by leprosy and strengthen their capacity to participate actively in leprosy services.
- Involving communities in actions for improvement of leprosy services.
- Promoting coalition-building among persons affected by leprosy and encourage the integration of these coalitions and or their members with other community-based organizations.
- Promoting access to social and financial support services, e.g. to facilitate income generation, for persons affected by leprosy and their families.
- Supporting community-based rehabilitation for people with leprosy-related disabilities.
- Working towards abolishing discriminatory laws and promote policies facilitating inclusion of persons affected by leprosy.

2016-2020

GLOBAL LEPROSY STRATEGY

Accelerating towards a leprosy-free world



1 Introduction

The Global Leprosy Strategy 2016–2020 aims at early detection of leprosy disease and prompt treatment to prevent disability and reduce transmission of infection in the community. The proportion of G2D cases among newly diagnosed patients and the G2D rate in a population indicate the efficiency of early detection of leprosy. They also indicate indirectly the awareness levels of early signs of leprosy, access to leprosy services and skills of health-care staff in diagnosing leprosy. The strategy is designed to achieve a long-term goal of a 'leprosy-free world", which refers to a situation wherein the community is free of morbidity, disabilities and social consequences due to leprosy.

Considering this rationale of improving early detection of leprosy to reduce transmission of the infection and curb the number of new G2D cases, the Global Leprosy Strategy 2016–2020 aims at the following outcome by 2020: zero disabilities among newly diagnosed children. This will be achieved by working towards the introduction of one type of treatment for all categories of leprosy for a shortened duration, targeting case detection activities in high-endemic pockets, and focusing on screening of contacts.

The target of zero disability in new cases among children has been introduced because it combines a target based on children with that of early detection and reduction in disability. The target emphasizes the unacceptability of disability due to leprosy in children and will stimulate community support for the programme. Each new paediatric patient with G2D should trigger an investigation into the reasons for the delay in detection and diagnosis, and the development of new approaches to avoid recurrence. Baseline data on G2D among paediatric patients is from the year 2015.

The International Leprosy Summit in 2013 in Bangkok, Thailand, reaffirmed political commitment towards leprosy. The honourable ministers of health or their representatives from the high leprosy endemic countries signed the "Bangkok Declaration". This called for reaffirming political commitment, enhancing financial allocations and including persons affected by leprosy. The Nippon Foundation has committed to the allocation of increased funding for leprosy activities to support countries to honour that commitment.

Leprosy affected persons are often experiencing stigma and discrimination. This negatively impacts access to diagnosis, treatment outcomes or care, as well as affects their societal functioning. Stigma is an important cause of delayed diagnosis, facilitating transmission of the infection within families and communities. An indicator was, therefore, introduced to monitor discrimination of persons affected by the disease. Additional indicators related to the social aspects of leprosy were also included for programme evaluation.

The Global Leprosy Strategy 2016–2020 will be discussed at appropriate fora around the world to ensure increased commitment towards a further reduction of the burden of the disease and to prevent children affected by leprosy from living with lifelong disability.

1

1.1 Achievements

The past three decades have seen impressive achievements and progress in leprosy control due to the widespread and free availability of robust chemotherapy in the form of multidrug therapy (MDT), good strategies, strong collaboration with major partners, and political commitment from countries where leprosy is endemic.

Elimination of leprosy as a public health problem at the global level was achieved in the year 2000. It was pragmatically defined as a registered prevalence of less than one case of leprosy per 10 000 population.

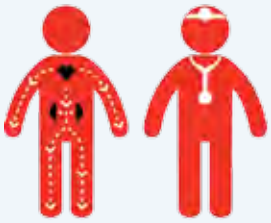
Over 16 million patients have been diagnosed and treated since the introduction of MDT over the past three decades.

The strategy "Final push to eliminate leprosy as a public health problem (2000–2005)" aimed at eliminating leprosy as a public health problem at the country level. It succeeded in engaging policy-makers and the general public through advocacy, communication and campaigns. All countries with a population of one million or more have achieved the elimination of leprosy as a public health problem at the national level.

Two consecutive strategies – the "Global strategy for further reducing the leprosy burden and sustaining leprosy control activities" (Plan period: 2006–2010) and the "Enhanced global strategy for further reducing the disease burden due to leprosy" (Plan period: 2011–2015) – retained emphasis on reducing the disease burden with a focus on sustainability through integration. They have been moving from targets on "elimination" in terms of prevalence of the disease to targets that emphasize a decrease in the number of new cases with G2D to promote early detection and reduction of transmission.

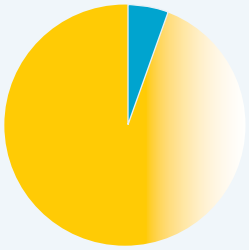
1.2 Current leprosy situation

The "Global leprosy update, 2014: need for early case detection", published in September 2015, was based on annual leprosy statistics received from 121 countries from five[3] WHO regions. The data compilation and analysis showed the following:



213 899

newly diagnosed patients were reported in 2014, corresponding to a detection rate of 3.0/100 000 population.

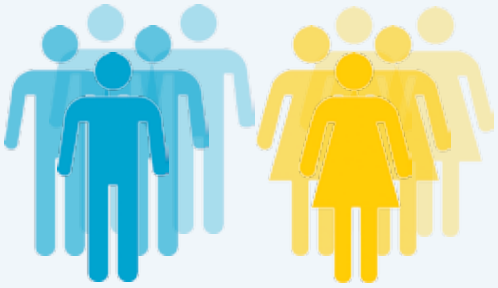


94%

of leprosy patients reported in 2014 were notified in 13 countries: Bangladesh, Brazil, Democratic Republic of Congo, Ethiopia, India, Indonesia, Madagascar, Myanmar, Nepal, Nigeria, the Philippines, Sri Lanka and the United Republic of Tanzania.

175 554

patients were on treatment at the end of 2014 corresponding to a point prevalence of 0.25 per 10 000 population.



14 110

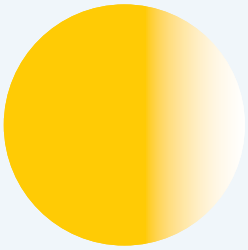
new cases were detected with G2D, corresponding to 6.6% of the total number of newly diagnosed patients and to a rate of 2.0 cases per million.

3 Reports were compiled from countries in the WHO African, Americas, Eastern Mediterranean, South-East Asia and Western Pacific Regions

1

18 869

new patients detected and reported in 2014 were children, corresponding to 8.8% of the total number of reported patients.

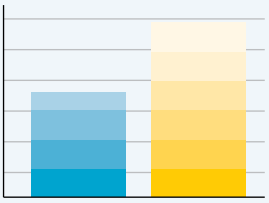


61%

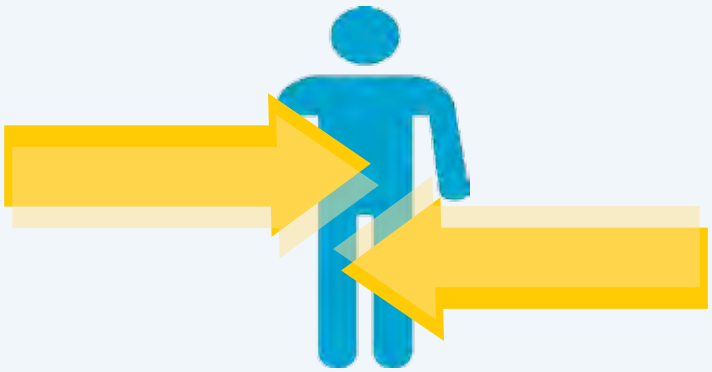
of the patients were multibacillary (MB) cases of leprosy

36%

of the patients were female



Treatment completion rates from 75 countries varied between 55% and 100% for the MB patients reported in 2012 and for paucibacillary patients (PB) reported in 2013.



1312

relapses were reported from 46 countries.

Table 1 shows the registered prevalence at the end of 2014 and the number of new cases detected in 145 countries and territories. Data were not received from WHO European Region countries as well as from some countries in other regions.

There are three countries with large populations – India, Brazil and Indonesia – that report more than 10 000 new patients annually. Together, these three countries account for 81% of the newly diagnosed and reported patients globally.

Detection of new cases has shown only a modest decline in the last five years while the G2D rate among new cases has remained almost static. In some regions, i.e. the South-East Asia Region, it even showed an increase: 0.43 per 100 000 population in 2013 and 0.45 in 2014.

Leprosy interventions should unmistakably focus on addressing the question of how to enhance efforts in the high-burden countries so that cases are detected without any delay. The strategy will also need to guide countries with smaller numbers of new cases but relatively high rates or countries with high-endemic pockets on how to reduce transmission. Other countries with few cases should sustain surveillance and referral services, including countries in the European Region, especially in the light of migration from countries where leprosy is endemic.

WHO will be collecting information on the number of newly detected patients with G2D that are below 15 years of age and are hence defined as "paediatric patients".

1.3 Challenges

The following are the critical challenges leprosy control services are faced with:

- Detection of paediatric patients indicates the continued presence of undetected patients and continued transmission in the community.
- The current detection of patients already with disabilities and the high proportion of multibacillary cases (MB) indicate delay in detection in the community.
- Stigma surrounding leprosy and discrimination against persons affected by the disease continues to challenge early detection and successful completion of treatment. Many patients continue to experience social exclusion, depression and loss of income. Their families often also suffer due to stigma.
- The low proportion of females in new cases in a number of countries may

Table 1: *Registered prevalence at end of 2014 and number of new cases detected during 2014, by WHO Region*

WHO Region	Registered prevalence		Number of new cases	
	Number	Rate per 10 000 pop.	Number	Rate per 100 000 pop.
African	19 968	0.26	18 597	2.44
Americas	29 967	0.33	33 789	3.75
Eastern Mediterranean	2 212	0.04	2 342	0.38
European	–	–	–	–
South-East Asia	119 478	0.63	154 834	8.12
Western Pacific	3 929	0.02	4 337	0.24
Total	**174 554**	**0.25**	**213 899**	**3.0**

indicate differential access to diagnosis and treatment, which negatively affects women. This, therefore, needs a more careful consideration and more systematic collection of information disaggregated by sex for proper assessment.

- Meaningful engagement of all stakeholders, including involvement of persons affected by leprosy, and private providers is still limited.
- Identification, education and examination of contacts has been slow and largely unreported in all countries.
- Prevention and care for disabilities is a challenge in most countries, especially in the context of care after treatment to prevent and manage residual post-treatment disabilities.
- There is tangible public apathy over leprosy which struggles to stay high on the political agenda of countries. There is also an overall lack of a comprehensive approach towards battling the disease which requires collaboration between different ministries and sometimes between countries.
- The lack of new diagnostic tools and new drugs, the limited knowledge on key areas regarding transmission, and inadequate tools to manage complications hamper leprosy control. More coordinated efforts for research are, hence, needed.
- Integration without sustained and enhanced supervision and monitoring together with reduced funding has impeded some of the achievements. This has also posed questions regarding the quality and comparability of data and information collected on leprosy cases.

Vision, goal and targets 2

2.1 Vision

The vision of the strategy is a leprosy-free world.

2.2 Goal

The goal of the strategy is to further reduce the global and local leprosy burden.

2.3 Main targets

The following are the targets envisaged by the Strategy by 2020:

- Zero G2D among paediatric leprosy patients.
- Reduction of new leprosy cases with G2D to less than one case per million population.
- Zero countries with legislation allowing discrimination on basis of leprosy.

In 2018 the WHO Global Leprosy Programme (GLP) will conduct a mid-term strategy evaluation to assess progress towards targets and review evidence in relation to chemotherapy and diagnostics.

For countries that have not yet achieved elimination as a public health problem at the first subnational level, the implementation of the actions recommended in the operational guidelines of the Global Strategy for 2016–2020 will also help achieve that objective. Where relevant, countries with sizeable populations at the first subnational level may include a target for elimination at this level in their country plans.

2.4 Other programme performance indicators

The following indicators and/or targets have also been identified for routine programme monitoring:

- annual new case detection and new case-detection rate (per 100 000 population), disaggregated by sex and age group;
- point prevalence of leprosy (per 10 000 population);
- proportion of newly diagnosed leprosy patients with G2D, disaggregated by sex;
- number of G2D among paediatric cases;
- number and/or proportion of relapses among all leprosy notified cases;
- proportion of MB cases among new cases;
- completion rate of MDT in all cases, disaggregated by sex;
- Availability of web-based, case-based reporting system allowing disaggregation by age, sex, place of residence and other relevant criteria (e.g. foreign born);
- proportion of contacts screened among registered contacts;
- proportion of patients evaluated for disabilities at the end of treatment, disaggregated by sex;
- proportion of patients having reactions among new cases, disaggregated by bacillary load (PB or MB);

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- proportion of reactions occurring after treatment among the total number of reactions;
- number of cured patients presenting with new disabilities not present at the end of treatment;
- proportion of persons affected by leprosy in self-care support programmes among patients with grade-1 disabilities and G2D;
- discriminatory legislation against those affected by leprosy;
- norms and/or regulations facilitating the inclusion of persons affected by leprosy and their communities;
- affected persons or associations of affected persons with a role in care (i.e. for advocacy, health education, detection or treatment);
- use of the participation scale score to assess the social participation of persons affected by leprosy;
- availability of data to assess the level of stigma in the community and among patients and health-care workers;
- presence of a partnership with the private sector: nongovernmental organizations (NGOs), community-based organizations (CBOs), traditional and allopathic private provider, and the like, for case detection/referral, care and/or social support;
- having a coalition against leprosy consisting of multiple stakeholders (either per se or as part of a national coalition against NTDs, tuberculosis or disabilities);
- having access to testing for resistance to leprosy drugs; and
- number and proportion of drug-resistant cases.

For countries or jurisdictions with a population of less than one million the target for G2D rate is not applicable.

For countries that do not detect paediatric patients with G2D, the target shall be zero paediatric cases.

Key tenets of the Global Leprosy Strategy for the next five years (2016–2020) will include early detection of all patients before they develop disabilities, prompt treatment with a uniform MDT regimen with shortened duration (in the case of MB), inclusion of persons affected by leprosy, enhancing of research especially in the area of prevention, new diagnostics and stigma reduction, and promotion of wider partnerships.

These areas will encompass interventions and step-up efforts towards reducing the disease burden from different perspectives, such as disabilities among new patients (particularly children), and magnitude of the disease burden for treatment and discrimination due to the prevailing stigma in the community. A global research agenda will also be developed to ensure the creation of new tools for interrupting transmission and reducing disability. The scientific and public health community involved with leprosy will have to focus on collaboration and greater information sharing to facilitate the implementation of the global strategy.

The following guiding principles, strategic pillars and key areas of interventions support the Global Leprosy Strategy context outlined above.

Guiding principles 3

3.1 Responsibility of national governments and strengthening partnerships

The primary responsibility for leprosy control rests with governments. There is a need for different approaches and increased collaboration at the national and subnational levels within the same country. A range of government departments and agencies will be responsible for leprosy activities, and their actions shall be coordinated and harmonized. The government will act through partnerships with international organizations including WHO, the private sector, local and international NGOs, CBOs, as well as people affected by leprosy. When needed, cross-border collaboration will have to be established to ensure continuity of care and the interruption of transmission.

The collaboration should result in supporting sustainability of expertise, resource mobilization and institutional development, stigma reduction, research, and community-based rehabilitation.

Furthermore, specific efforts should be made to learn from disability prevention strategies used for other neglected tropical diseases and chronic noncommunicable disease programmes.

3.2 Sustaining expertise in leprosy

In order to sustain expertise, there will be a focus on strengthening regional leprosy training centres as well as centres run by partners. New tools utilizing e-learning and tele-medicine, wherever relevant and available, will also be exploited. Nursing and medical schools curriculums as well as education curriculums shall include leprosy to generate a minimum awareness among health-care workers including those in low-endemic countries. Former patients and their family members could be a resource to sustain knowledge about the disease. Social workers and social support departments shall be contacted to facilitate actions towards societal inclusion of those affected.

3.3 Quality leprosy services with children and women as the focus

Quality of services means “consistent provision of efficacious, effective and efficient services according to the latest clinical guidelines and standards which meet the patients’ needs and satisfies providers”. It refers to offering effective and safe care that contributes to the achievement of UHC and patient well-being and satisfaction. Special attention should be given to children and women, promoting early detection through periodical screening, and facilitating diagnosis and access to care.

3.4 Participation of persons affected by leprosy in leprosy services

Persons affected by leprosy are an important resource for leprosy programmes and have a pivotal role to play in leprosy control. Strategies should focus on building the capacity of persons affected by leprosy in the area of advocacy and on setting up networks for psycho-social support for reducing emotional and economic distress that often results in depression and poverty. Persons affected by the disease could be involved to support early identification and improve treatment adherence. International, national and local organizations representing persons affected by leprosy will be integral to this process.

3.5 Protection of human rights

Promoting equity and social justice in all aspects of service provision to patients, their families and communities will be encouraged. Nongovernmental and civil society organizations may complement government actions to reduce stigma and advocate against discrimination. These aspects will be given equal focus in the leprosy agenda. Reference is made in this context to Resolution 29/5 adopted by the Human Rights Council of the United Nations on 2 July 2015 titled: "Elimination of discrimination against persons affected by leprosy and their family members".

3.6 Focus on research to support leprosy control

Basic research designed to study leprosy transmission and to develop new diagnostic tools, regimens for prophylaxis, and new therapeutics and operational research involving all partners to identify innovative implementation strategies and interventions should be supported strongly. The effect of the integration in NTDs shall be assessed. It is also essential to establish linkages and synergies among national and international research bodies, funding agencies, programmes and universities, public laboratories, patient groups and regulators to pave the way for more funding, and for identifying research initiatives, operationalization and integrating results into the leprosy programmes.

Strategic pillars 4

4.1 Strengthen government ownership, coordination and partnership

The first pillar focuses on governance issues, partnerships, policies and strategies and encompasses the following key areas of intervention:

- Ensuring political commitment and adequate resources for leprosy programmes.
- Contributing to UHC with a special focus on children, women and underserved populations including migrants and displaced people.
- Promoting partnerships with state and non-state actors and promote intersectoral collaboration and partnerships at the international level and within countries.
- Facilitating and conducting basic and operational research in all aspects of leprosy and maximize the evidence base to inform policies, strategies and activities.
- Strengthening surveillance and health information systems for programme monitoring and evaluation (including geographical information systems)

4.2 Stop leprosy and its complications

The second pillar includes core activities in the medical and epidemiological area:

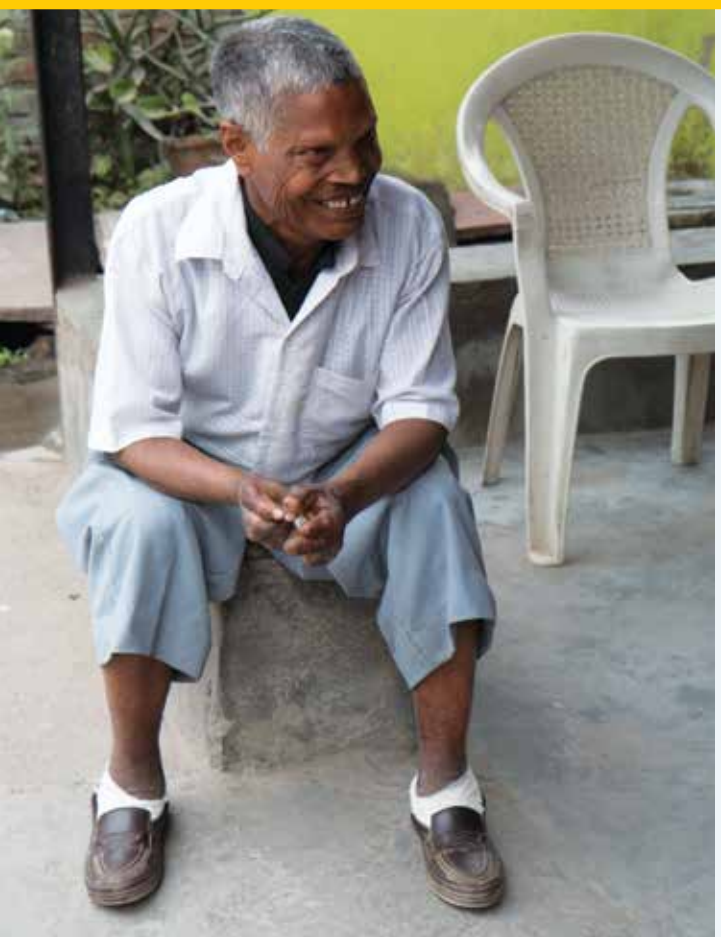
- Strengthening patient and community awareness on leprosy.
- Promoting early case detection through active case-finding (e.g. campaigns) in areas of higher endemicity and contact management.
- Ensuring prompt start and adherence to treatment, including working towards improved treatment regimens.

- Improving prevention and management of disabilities.
- Strengthening surveillance for antimicrobial resistance including laboratory network.
- Promoting innovative approaches for training, referrals and sustaining expertise in leprosy such eHealth.
- Promoting interventions for the prevention of infection and disease.

4.3 Stop discrimination and promote inclusion

Socio-economic and integration aspects compose the third pillar:

- Promoting societal inclusion through addressing all forms of discrimination and stigma.
- Empowering persons affected by leprosy and strengthen their capacity to participate actively in leprosy services.
- Involving communities in actions for improvement of leprosy services.
- Promoting coalition-building among persons affected by leprosy and encourage the integration of these coalitions and or their members with other CBOs.
- Promoting access to social and financial support services, e.g. to facilitate income generation, for persons affected by leprosy and their families.
- Supporting community-based rehabilitation for people with leprosy-related disabilities.
- Working towards abolishing discriminatory laws and promote policies facilitating inclusion of persons affected by leprosy.



Implementation plans 5

5.1 Regional and country implementation

The strategic issues elaborated in this document present the basic concepts, challenges, guiding principles as well as the principal strategic domains for focused action. Regional and country implementation plans that describe practical recommendations for core leprosy services will be developed, discussed and disseminated.

5.2 Monitoring of targets and indicators globally and at country level

It is vital to ensure adequate, reliable data on paediatric disability and the tools to measure it. The indicator "number and proportion of new child cases with G2D" is intended to monitor the programme and measure progress towards achieving zero G2D cases among new child cases by 2020.

Better monitoring of treatment completion and of clinical outcomes shall be ensured.

Monitoring of the elimination of leprosy as a public health problem at subnational levels shall be done in subnational tiers with sizeable populations.

Drug resistance surveillance should be continued and expanded to all endemic countries by setting up a surveillance network.

Recording and reporting of leprosy shall be revised and made more comprehensive, thereby moving towards electronic, case-based databases. In-depth assessments (including secular time-trend analyses and spatial analyses based on geographic information systems) shall be undertaken.

Training and support shall be provided to ensure the introduction or the new system and to validate health information. A pool of monitors shall be trained. Current ongoing research on modelling in order to try to compare expected and observed trends of the disease shall be encouraged and enhanced.

Tools to monitor stigma and the impact of activities to reduce it and to promote inclusion shall be developed and their use promoted through training and supervision.

5.3 Advocacy of Global Leprosy Strategy

The targets and components of the Global Leprosy Strategy will be disseminated for improved acceptance (buy-in) by national programmes and other stakeholders. Innovative approaches of marketing the strategy will be taken up for influencing policy-makers and programme managers. Modern communication strategies need to be developed to increase awareness about leprosy in the community. The possibility to create global and regional forums to advocate jointly for leprosy shall be explored and encouraged.

5.4 Technical advisory bodies to the WHO Global Leprosy Programme

GLP will seek for an enhanced TAG composition to count on a wider support for the implementation of the new strategy with representation of national programmes and from persons affected by the disease. Its link with the Executive Committee will have to be redefined. It is also planned to set up temporary study groups to support with specific issues such as chemotherapy/prophylaxis, research agenda and monitoring tools.

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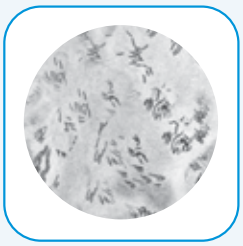
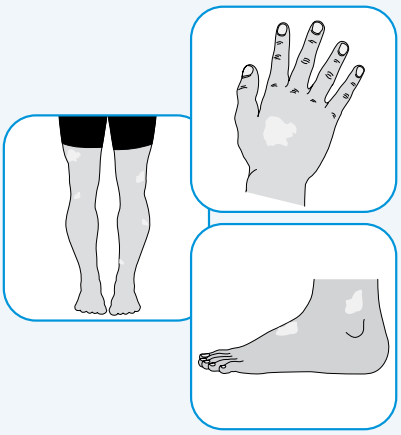
Leprosy is curable

Free treatment is available at health centres



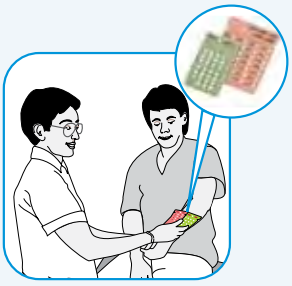
Leprosy is caused by a germ.
It is not a curse.
It is not hereditary.

Casual touch, like shaking hands or playing together or working in the same office, will not transmit or spread leprosy.



Leprosy usually starts as a patch without sensation
- no feeling of touch and pain
- can be anywhere on the body.

It is important to see a health worker or a doctor as soon as you notice any of these skin changes.



Leprosy can be cured with medicines within 6–12 months.
Multidrug therapy (MDT) taken regularly:
- ensures complete cure
- prevents deformities
- stops transmission to other individuals.

People affected by leprosy can lead a normal and dignified life like any other person.

Notes

The Global Leprosy Strategy 2016–2020 "Accelerating towards a leprosy-free world" was developed through a series of consultations with various stakeholders during 2014 and 2015. Inputs were provided by national leprosy programmes, technical agencies, independent leprosy experts, public health experts, funding agencies and representatives of affected patients and communities.

The strategy is built around three major pillars: (i) strengthen government ownership and partnerships; (ii) stop leprosy and its complications; and (iii) stop discrimination and promote inclusion. Its goal is to further reduce the global and local leprosy burden, thereby aiming for zero children with leprosy-affected disabilities, a reduction of new patients diagnosed with leprosy-related deformities to less than one per million population and a repeal of all laws that allow discrimination of leprosy patients.

The strategy was endorsed by the WHO Technical Advisory Group on leprosy.

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