National Strategic Plan 2021-2025

Towards zero leprosy, zero disability, zero discrimination

Sri Lanka

Anti-Leprosy Campaign, Welisara
Ministry of Health, Nutrition and Indigenous Medicine

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Contents

Development and Contributors

National Strategic Plan (NSP) for control of leprosy, in Sri Lanka, for the year 2021-2025 was developed using the management cycle and participatory approach. Consultations were held with variety of stakeholders including the Director, Consultant Community physicians (CCPs) and officers from the Anti Leprosy Campaign (ALC), Dermatologists, from hospitals and Medical Colleges and those Dermatologists attending satellite clinics, Provincial and Regional Epidemiologists, Medical Officers of Health (MOH), Leprosy control Public Health Inspectors (PHI-LCs), PHIs, National Professionals from WHO Country Office, NGOs, persons affected by leprosy etc. Desk review was done of 10 years of leprosy data, external review of the Leprosy Control Programme of Sri Lanka (2019), Annual Reports of 2019, and WHO Global Strategy 2021-2030. Attempts have been made to align the plan with the WHO Global Strategy 2021-2030, Sustainable Development Goals (SDGs), Universal Health Coverage (UHC) and Neglected Tropical Diseases (NTD) Roadmap 2021-2030. Issues and challenges were identified during consultation and the way forward were suggested by the participants which led to setting of objectives by ALC under consultation with technical experts as under:

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Abbreviations/Acronyms

ALC Anti-Leprosy Campaign

AIDS Acquired Immuno-Deficiency Syndrome

BH Base Hospital

CBO Community-based Organization

CDR Crude Death Rate

CLC Central Leprosy Clinic

CCP Consultant Community Physician

DDG Deputy Director General

DOT Directly Observed Treatment

EHF Eye Hand Foot

E&UH Estate and Urban Health

GH General Hospital

GIS Geographic information system

G2D Grade 2 Disability

GP General Practitioner

GPS Global Positioning System

HDI Human Development Index

HIMS Health Information Management System

HIV Human Immuno-deficiency Virus

ICNO Infection Control Nursing Officer

IEC Information, Education and Communication

ILEP International Federation of Anti-Leprosy Associations

IPF Individual Patient Form

IT Information Technology

LPEP Leprosy Post Exposure Prophylaxis

MLT Medical Laboratory Technician

MB Multibacillary

MO Medical Officers

MOH Medical Officers of Health

MSD Medical Supplies Division

NCDR New Case Detection Rate

NGO Non-Governmental Organization

NHSL National Hospital of Sri Lanka

NTDs Neglected Tropical Diseases

OPD Out Patient Department

PALs Persons affected with Leprosy

PB Paucibacillary

PCR Polymerase Chain Reaction

PG Postgraduate

PHI Public Health Inspector

LC Leprosy Control

PHLT Public Health Laboratory Technician

PoD Prevention of Disability

RDHS Regional Director of Health Services

RE Regional Epidemiologist

RMSD Regional Medical Supplies Division

SDR Single dose Rifampicin

SMI School Medical Inspection

SMS Short Message Service

SLCD Sri Lanka College of Dermatologists

SSO Social Service Officer

TOT Training of Trainers

UHC Universal Health Coverage

YEDD Directorate of Young, Elderly and Disabled persons

WHO World Health Organization

Foreword

Elimination of Leprosy as a public health problem in Sri Lanka was achieved in 1995 as a result of the successful implementation of a social marketing campaign along with Multi Drug Therapy (MDT). However, Leprosy continues to be a burden to the health sector with around 2000 new cases detected annually. A National Leprosy Strategy created in 2016 sought to address the requirements of Leprosy eradication and lasted until 2020, taking into consideration WHO global strategies and National Health Policies.

With the end of the national leprosy strategy in 2020, the Anti Leprosy Campaign had an opportunity to evaluate it's successes and failures, along with formulating a vision for the future. Through the achievements of the previous national strategy, it was possible to conclude that eradication of Leprosy should be the next viable goal for the country.

Notable achievements of the National Leprosy Strategy 2016 – 2020 are the successes seen in patient contact tracing and systematic mapping with the establishment of a practical online system, the improvements to disability management of patients with issuing of sufficient prosthetic devices and rehabilitative therapy, achievements in reducing stigma and discrimination with emphasis on disease awareness and reintegration of former patients as well as several innovative approaches focusing on children, women and other vulnerable populations.

The new strategy to be implemented was developed over several months through an interactive consultation process including Leprosy stakeholders from across the board including national and foreign public health consultants, communication specialists, curative sector specialists, field sector staff, rehabilitative managers, diverse NGOs, patient representatives and community leaders. This approach gives the new National Leprosy Strategy 2020-2025 the most diverse perspective in terms

of Leprosy stakeholders, despite the difficulties of arranging such consultations in the midst of the Covid pandemic.

Key focus points of the new strategy will be the integration of resources with other specialized campaigns from Neglected Tropical Diseases, research in leprosy notably in the areas of drug resistance and adverse reactions, improvements to the online system of patient data logging and every endeavour to the ultimate goal of zero leprosy in Sri Lanka.

The title 'Final sprint towards Zero Leprosy in Sri Lanka' reflects the current requirements of the country in mustering a concerted effort in the last stages of achieving leprosy eradication.

Dr. Champa Aluthweera
Director – ALC

Executive Summary

The Anti-Leprosy Campaign (ALC) was established as a vertical programme under the Department of Health Services in 1954. Multi-Drug Treatment (MDT) was started in 1983. In 1989, ALC was decentralised and maintained a supervisory role. Sri Lanka achieved the status of elimination of leprosy as a public health problem (prevalence < 1 per 10000 population) at the national level in 1995. In 2001, leprosy control activities were integrated into the General Public Health Services; day-to-day management, recording, and reporting of leprosy patients became the responsibility of general public health staff as for any other health conditions. With the National Health Strategic Master plan 2016 -2025, the main areas of the strategic plan of Anti-Leprosy Campaign were incorporated under preventive health services. The Government has embarked on organizational, structural and logistical reforms to re-organise the primary health care system aiming "to provide citizen-centric integrated health care that is affordable, sustainable, and ensures a continuum of care for every patient."

The National Strategic Plan (NSP) for leprosy for 2021-2025 was developed by consultants who performed desk review of relevant documents, analysed data of ten years, and had consultations with a variety of stakeholders including persons affected by leprosy. Three main targets have been set, in-line with WHO Global Strategy 2021-2030, as under:

- Reduction - in number of new cases detected annually from 1660 in 2019 to 1,494 by 2023 and 1,328 by 2025 at the national level. Reduction by 10% of the present by the year 2023 and 20% by the year 2025, in all districts
- Reduction - in the rate of new cases detected with grade 2 disability per million population from 4.29 in 2019 to 3.22 by 2023 and 2.14 by 2025 at the national level. Reduction by 25% of the present by 2023 and by 50% by 2025, in all districts
- Reduction - in the rate of new child cases detected per million children from 34.64 in 2019 to 25.98 in 2023 and 17.32 by 2025 at the national level. Reduction by 25% of the present by 2023 and by 50% by 2025, in all districts

To achieve the above targets and address various issues and challenges, the following objectives have been identified:

Objective 1: To strengthen the implementation of integrated leprosy services. To achieve this objective, efforts will be made to increase political commitment, districts will be prioritized, the

program will be strengthened accordingly, national partnerships will be strengthened, the capacity of PHC staff will be built, there will be effective surveillance and a data management system, and systems for monitoring of antimicrobial resistance and adverse drug reactions will be established.

Objective 2: To scale up leprosy prevention alongside integrated active case detection. To achieve this objective, contact tracing of newly detected cases will be streamlined, active case-finding activities will be strengthened in targeted populations and the possibility of research for potential vaccines will be explored

Objective 3: To manage leprosy and its complications and prevent new disability. To achieve this objective: efforts will be made to detect cases early; quality of diagnosis and treatment will be improved; the referral system will be strengthened; diagnosis and management of leprosy reactions, neuritis and disabilities will be improved; training, monitoring and supervision in self-care will be promoted; and therapeutic counselling for mental issues will be undertaken.

Objective 4: To combat stigma and ensure human rights. To achieve this objective: principles and guidelines for the elimination of discrimination against persons affected by leprosy and their family members will be followed; organisations and networks of persons affected by leprosy will be encouraged to participate in the program; efforts will be made to repeal discriminatory laws; a system to reduce, assess and monitor stigma will be established and efforts will be made that the access of affected persons is increased to social support and rehabilitation.

This strategy will be implemented principally with the strengthening of the general public health care infrastructure, revision of guidelines, production of learning material, improved recording and reporting formats with capacity building of staff. Implementation of the communication strategy, developed to address the issues in communication with patients, community, health care providers and policymakers, will be synchronized appropriately with that of the NSP to ensure achievement of the targets of the ALC. Supervision and monitoring will be carried out at different levels; a mid-term evaluation will be carried out in the year 2023 and end evaluation will be carried out at the end of 2025.

Chapter 1: Background

1.1 Country Profile

Sri Lanka is a tropical country located southeast of India having a land area of approximately 65,610 square kilometres, and a population of approximately 21 million (Dept. of Census & Statistics, 2012) (Figure 1). It has a central mountainous region surrounded by plains stretching to coastal areas. The mean temperature varies between 26ºC–-28ºC in the low country, and between 14ºC-24ºC in the central hill country. For administrative purposes, the country is divided into 9 provinces, 26 districts and 332 Divisional Secretariat areas . The Ministry of Health (MoH) recognizes Medical Officer of Health (MOH) area as a health unit; preventive health care in a health unit is provided by the Medical Officer of Health (MOH) of the area and the Primary Health Care team.

Figure 1. Map showing the location of Sri Lanka

Approximately 23% of the country's population inhabits urban areas. The country has a high population density of 298 persons per km^2. Life expectancy is around 75 years and the literacy rate is 96.9%. Sri Lanka had a meagre economic growth rate of about 3.9% per year during the period 1981–1991 during which time a separatist war in the North and East raged in the country; the separatist war ended in May 2009.

Sri Lanka is a lower-middle-income country with a per capita Gross Domestic Product (GDP) of USD 4,011.78 in 2019. GDP after growing by 2.3 percent in 2019, the economy contracted by 1.6 percent in the first quarter of 2020. The economy of the country is mainly agricultural with industries rapidly becoming a major contributor to the country's economy. Sri Lanka's traditional exports of tea and rubber as well as other exports such as garments, tourism and inward remittances of Sri Lankans working overseas have significantly contributed to the economy in the last 30-35 years.

The road network in the country is reasonably well developed and organized with all areas being largely accessible including the previously inaccessible conflict areas of the North and East of the country.

1.2 Healthcare system

Healthcare is delivered through the government and private providers. The government health system has been partially decentralized to Provincial Councils since 1989. The Ministry of Health is the leading agency providing stewardship to health service development and delivery. The organogram of the Ministry of Health is presented in Figure 2. Its main function is formulating public health policy and regulating services for both the public and private sectors. It is also responsible for directly managing several large specialized services (National Hospital of Sri Lanka, Teaching hospitals, specialized hospitals, Provincial General Hospitals and selected District General Hospitals) whilst the rest of the government services in the allopathic system is managed by the decentralized system, i.e. nine provincial health authorities. The Ministry of Health is also responsible for the recruitment and training of majority of human resources for health.

1.3 Health Facilities

An extensive network of curative care institutions comprising Teaching Hospitals with specialized consultative services to small Primary Healthcare Units which provide only outpatient services is in place. In 2018 (latest available data), there were 641 government sector medical institutions including 17 Teaching Hospitals, 2 Provincial General Hospitals, 19 District General Hospitals, 76 Base Hospitals categorized as type A and B, 482 Divisional Hospitals categorized as type A, B and C, and 9 Primary Medical Care Units with Maternity Homes. The total bed strength in the government sector was 84,728 giving a bed strength of 3.9 beds per 1000 population. There is a specialized hospital for infectious disease and there are a few

specialized teaching hospitals for the treatment of chronic diseases, such as Tuberculosis, Leprosy, Cancer, Mental Illnesses, etc.

Dermatologists are stationed in Base Hospitals and above, and in District Hospitals having facilities of Base Hospitals. In the past, when the number, of Dermatologists, was few in the country, and no Dermatologists were attached to the Base Hospital, the satellite clinics were conducted in the Base Hospitals by Dermatologists monthly or every 2 months, by a Dermatologist in the same District. With the appointment of permanent Dermatologists in stations that had satellite clinics, the number of satellite clinics conducted has decreased over time.

1.4 History of Leprosy control in Sri Lanka

During the Dutch reign in Sri Lanka, the disease was identified as an infectious disease and since there was no treatment available, the only possible preventive method was that the patients were segregated from the community. In 1708, the first leprosy hospital was established in Hendala which is situated just outside the northern border of the Colombo Municipality. The second leprosy hospital was established later by the British in Manthivu, which is an island in Batticaloa District. The Hendala hospital is still functioning and had 32 in-ward patients affected by leprosy at the end of the year 2019. The Manthivu hospital has three patients who were diagnosed as leprosy, and are on treatment.

During the British rule, compulsory segregation of leprosy patients was carried out as enacted in Lepers Ordinance No. 4 of 1901. This ordinance gave powers to detain and isolate patients diagnosed with Leprosy. In the early 1940s, use of Dapsone was started which was found to be effective against *Mycobacterium leprae*, the causative acid-fast bacilli.

1.5 Anti-Leprosy Campaign (ALC), Sri Lanka:

The Anti-Leprosy Campaign (ALC) was established as a vertical programme under the Department of Health Services in 1954. The ALC was and is responsible for all leprosy related activities in Sri Lanka including diagnosis, management, rehabilitation, control activities etc. Multi-Drug Treatment (MDT) was started in Sri Lanka in 1983. In 1989, ALC was decentralised and maintained a supervisory role (Figures 2 and 3).

Figure 2. Organogram of the Anti Leprosy Campaign, Sri Lanka

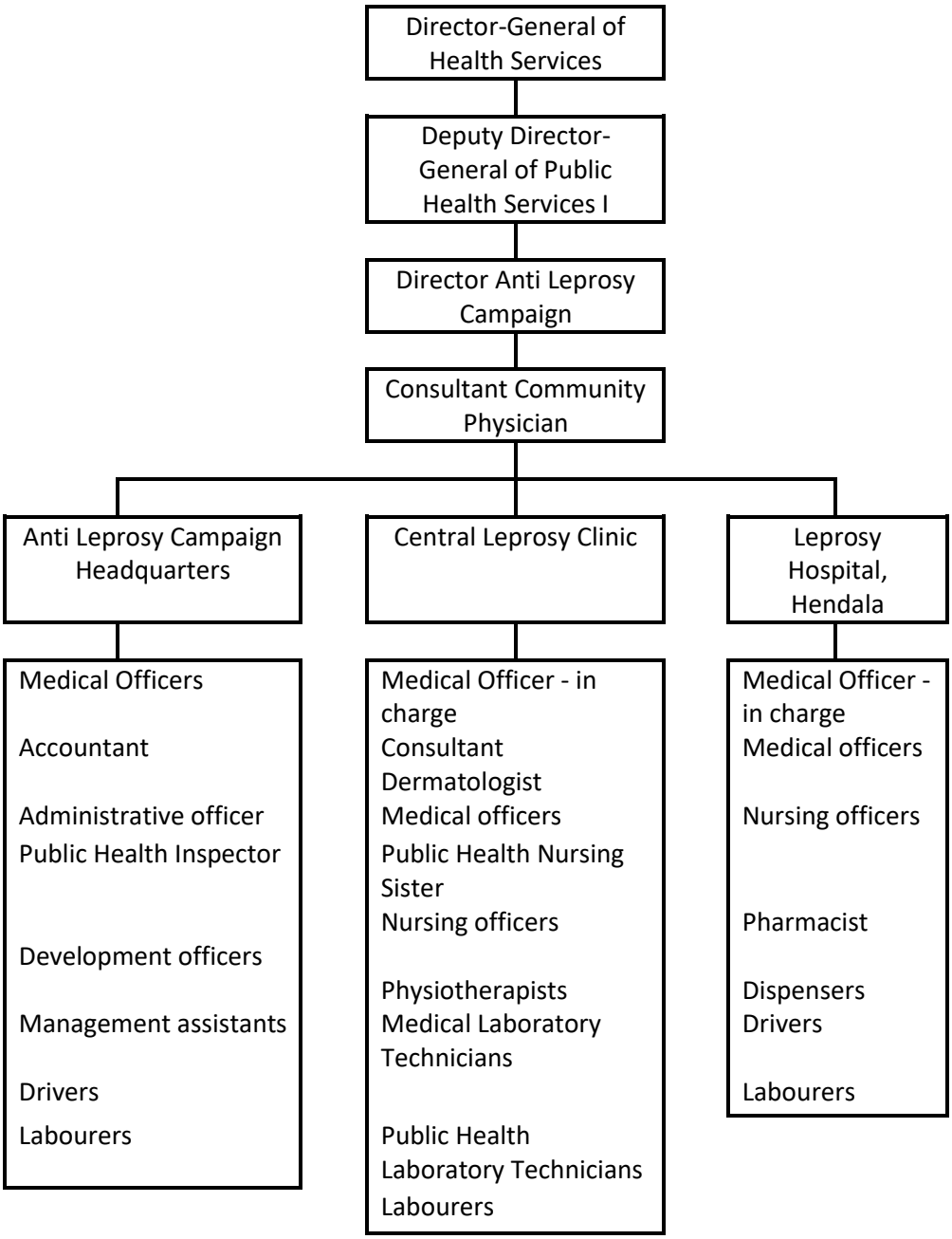
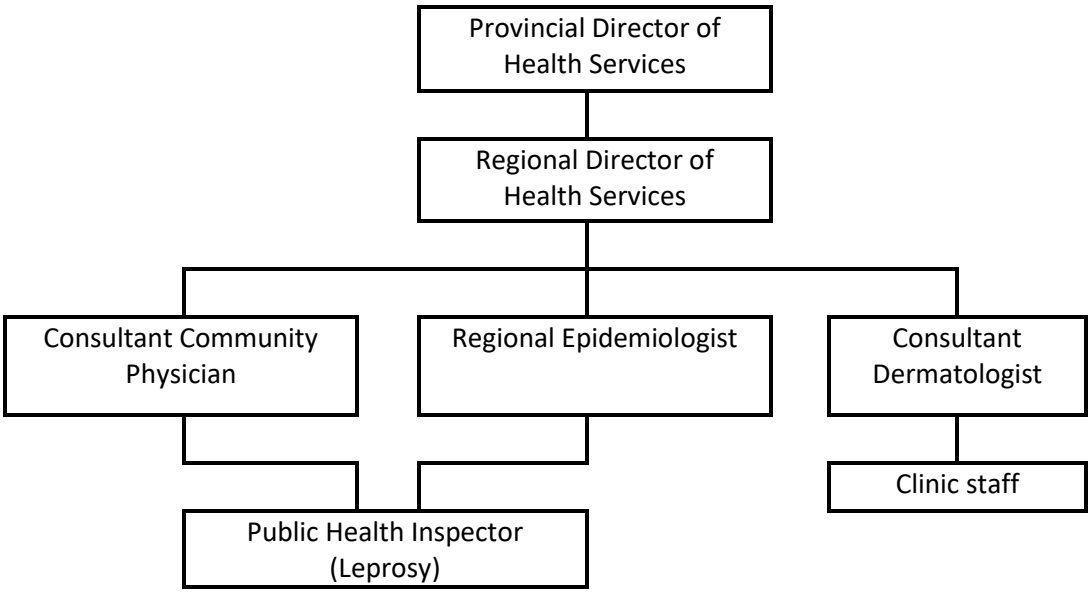


Figure 3. District Leprosy control team



An important landmark in the leprosy control programme in Sri Lanka was the successful social marketing campaign launched in 1989. As a result, significant improvements were observed in awareness, decrease in stigma and discrimination in the society towards leprosy-affected persons. This led to many patients voluntarily reporting to healthcare facilities for diagnosis and treatment. Sri Lanka achieved the status of elimination of leprosy as a public health problem (prevalence < 1 per 10000 population) at the national level in 1995.

In 2001, leprosy control activities were integrated into the General Health Services; for surveillance and control, Regional Epidemiologists (RE) were trained in leprosy at district and provincial level. With the integration, day-to-day management, recording, and reporting of leprosy patients became the responsibility of general health staff as for any other health conditions. Leprosy was made a notifiable disease in 2013 to improve follow-up at the field level, to trace defaulters more efficiently and for contact screening.

Following integration, the role of the ALC at the central level changed to policy making, planning, monitoring and evaluation, supervising, capacity building, setting technical standards and conducting research. At the district level, preventive part is conducted through RE, PHI-LC and range PHI. While RE is the coordinator, PHI-LC, Medical Officers of Health (MOHs), range PHIs, play a supportive role. The curative aspect is under Consultant Dermatologist with support from nursing officers, pharmacist and physiotherapists. This team is responsible to carry out appropriate interventions and ensure the sustainability of leprosy control in the respective

districts. The Regional Director of Health Services (RDHS) is responsible for all leprosy control activities in their respective districts.

Medical officers either in OPD or clinic settings are provided adequate training on diagnosis and treatment of leprosy and MDT was made available in selected health care institutions. Later, due to the logistical problem of maintaining MDT stocks in all institutions, it was decided that stocks of MDT be confined to hospitals with dermatology clinics. At present, the majority of all leprosy cases are diagnosed and treated in such clinics.

Leprosy services in Sri Lanka are generally provided through skin clinics conducted at higher-level hospitals by the Consultant Dermatologists. However, accessibility to these skin clinics is an issue, especially in areas located far away from major hospitals. Satellite clinics were established at peripheral health facilities facilitating improved access to leprosy services. Dermatologists from nearby major hospitals provide services at these satellite clinics twice or thrice a week. With the appointment of Consultant Dermatologists on a permanent basis to hospitals in which satellite clinics were held, the actual number, of satellite clinics conducted by the ALC, has decreased over time.

ALC conducts a daily leprosy clinic (Central leprosy clinic) at the National Hospital of Sri Lanka (NHSL) in Colombo. The consultant dermatologist from the Anti Leprosy Campaign provides clinical care services for leprosy patients at this clinic (OPD Clinic No. 12, NHSL, Colombo).

Leprosy Post-Exposure Prophylaxis (LPEP) pilot study was initiated in November 2015 in Puttalam and Kalutara Districts with Gampaha district was taken as the control district. Final conclusion was that LPEP has limited value to initiate in Sri Lanka. Online data collection was started with the launching of an online database for disease surveillance activities in 2016. The Anti-Leprosy Campaign website was launched in 2016 to keep leprosy on top of the health agenda. The National Inter-Faith Conference was held in 2017 to increase the awareness of all religious leaders about leprosy.

Leprosy has been included in the list of neglected tropical diseases. Many other diseases including leishmaniasis and Typhus, which are also prevalent in Sri Lanka are diagnosed and treated in dermatology units. Management of disabilities caused by Filariasis & leprosy share a common approach at the district level.

1.6 National Health Policy Sri Lanka: 2016-2025:

A national health policy plan (National Health Policy Sri Lanka: 2016-2025, Ministry of Health Nutrition & Indigenous Medicine Sri Lanka) has been designed in a systemic process over 3 years (2014-2016) addressing newly emerged and emerging health issues. This was developed by carrying out a situational analysis in each sub-sector with an extensive collaboration with all stakeholders. The policy issues identified and documented under the title 'National Health Strategic Framework for Health Development 2016-2025'. Policy issues were analysed and the master plan with specific objectives and major activities identified and the expected outputs with verifiable indicators to monitor and evaluate the progress were documented as "National Health Strategic Master plan 2016 -2025 Preventive Services, Ministry of Health Sri Lanka". Leprosy is coming under the preventive health services and highlighted as "Leprosy, Tuberculosis, HIV/AIDS, and Dengue, need utmost attention with new strategies in the health care delivery system, to reduce the present threat imposed by said diseases on population". The main areas of the strategic plan of Anti-Leprosy Campaign were incorporated into Preventive Services Volume 1 page 95. The Government of Sri Lanka has decided to adopt these strategies as the guide for the leprosy control programme for Sri Lanka till 2020.

1.7 Reorganizing Primary Health Care in Sri Lanka: Preserving our progress, preparing our future

Sri Lanka has achieved good health outcomes, such as rising life expectancy due to low levels of mortality among mothers, infants, and children, and the recent elimination of malaria from the island, among other indicators. These gains in health, achieved at a relatively low cost, have resulted primarily from the public health system's intense focus on the prevention, treatment, control and elimination of infectious diseases and the promotion of maternal and child health. Sustaining these interventions is vital to protecting the gains that the country hasachieved. The government has embarked on organizational, structural and logistical reforms to re-organise the primary health care system aiming "to provide citizen-centric integrated health care that is affordable, sustainable, and ensures a continuum of care for every patient."

Within this rubric, some of the proposals that are directly relevant to Leprosy control include

- Offer quality primary medical care services to a defined catchment population through establishment of Primary Medical Care Units (PMCUs) and Division Hospitals (DHs) as Primary Medical Care Institutions (PMCIs),

- Link each PMCU/DH with defined MOH areas to integrate and better coordinate primary prevention and health promotion, primary medical services, referrals, and community-based follow-up services,
- Establish a package of primary medical services, including services for prevalent NCDs, and communicable diseases based on the emerging needs of the population that will be made available through the PMCU/DH and MOH,
- Streamline referrals among primary health services and from primary to secondary and tertiary health care institutions, and
- Expand the capacity of human resources for health, ensuring all providers have the skills, time and supplies necessary to provide quality, people-centred primary health care to Sri Lankans throughout their lives.

1.8 Leprosy situation and trends

Disease trend of the last ten years (2010 – 2019) is shown in the tabe 1 . It can be seen that the new case detection over the years has shown a decreasing trend but fluctuations are seen and the decline is very slow. The proportion of MB and Child cases are showing an increasing trend from 2010 to 2019. WHO recommends to assess new child case detection rate per million of general population and per million of child population. In the absence of yearly base data of these indicators, an effort has been made to calculate them for the year 2019 and they are 8.36 new child cases/million general population and 31.53 new child cases/million of child population. This will help in setting the tragets for coming years.

Table 1 Situation of Leprosy in Sri Lanka in the past 10 yrs.:

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total cases	2091	2229	2211	2131	2281	2098	1973	1993	1825	1749
New cases	2091	2229	2229	1990	2157	1977	1832	1877	1703	1660
NCDR	9.5	10.6	10.6	9.6	10.4	9.43	8.6	8.68	7.86	7.61
Child cases	202	238	163	182	213	223	158	195	174	181
% of Child Cases	9.7	10.72	7.64	9.17	9.87	11.28	8.6	10.39	10.22	10.9
Child Rate/- Million Population	9.77	11,4	7.98	8.84	10.25	10.6	7.45	9.09	8.02	**8.36**
Child rate/- Million Children	38.49	45.16	31.73	35.29	41.12	42.93	30.30	37.25	33.17	**34.64**
Deformity cases	147	147	148	133	147	198	138	137	110	93
Deformity %	7.09	6.66	7.37	6.73	7.1	10.01	7.5	7.3	6.46	5.6
Deformity Rate/- Milion population	7.11	7.04	7.24	6.46	7.07	9.44	6.5	6.38	5.07	**4.29**
MB cases	967	1069	1089	947	1014	1064	980	1085	1030	961
MB %	46.19	48.18	49.34	48.82	47.01	53.81	53.5	57.81	60.48	57.89
Late presentation(> 6 m)	55%	55%	55%	46%	55%	45%	55%	30%	28%	27%

As far as grade 2 disability cases are concerned, they are showing a fluctuating trend and a decline in last four years but still high (93 cases detected in 2019 with disability grade 2 disability showing proportion of 5.6% and rate of 4.29/Million population), indicating delayed detection of new cases.

District base Data of 2019

Sl. No.	District	New Case Detection Rate (NCDR) (/100,000)	Child cases among new cases (%)	Grade 2 disability among new cases (%)	MB cases (%)	Late presentation of cases (%)
1	Batticaloa	21.91	15.08	3.17	57.14	23.02
2	Ampara	18.51	6.00	2.00	54.00	12.00
3	Kalmunai	14.85	13.24	2.94	52.94	27.94
4	Colombo	13.19	11.61	6.25	49.55	33.48
5	Polonnaruwa	11.60	3.92	0	66.67	19.61
6	Kalutara	10.59	5.88	5.15	58.82	25.74
7	Ratnapura	9.05	5.66	7.55	57.55	29.25
8	Gampaha	8.81	16.90	5.63	58.69	25.35
9	Hambantota	8.62	8.77	3.51	64.91	33.33
10	Matara	8.11	11.43	5.71	65.71	32.86
11	CMC area	8.00	18.33	6.67	53.33	25.00
12	Anuradhapura	7.68	6.94	4.17	61.11	41.67
13	Galle	6.46	5.48	8.22	67.12	24.66
14	Kurunegala	6.10	13.33	6.67	63.81	27.62
15	Trincomalee	5.86	20.00	4.00	28.00	24.00
16	Puttalam	5.16	9.30	4.65	55.81	25.58
17	Mannar	4.50	40.00	0	60.00	80.00
18	Moneragala	4.23	19.05	19.05	61.90	19.05
19	Vavuniya	4.23	12.50	12.50	62.50	0
20	Mullaithivu	4.12	0	25.00	75.00	50.00
21	Jaffna	4.05	12.00	0	76.00	28.00
22	Matale	4.02	14.29	4.76	57.14	23.81
23	Kegalle	3.38	0	6.67	60.00	23.33
24	Badulla	2.72	8.33	4.17	50.00	20.83
25	Kandy	1.83	0	18.52	55.56	22.22
26	Nuwara Eliya	1.82	7.14	7.14	50.00	28.57
27	Kilinochchi	1.55	0	0	100.0	50.00

Chapter 2: Issues and challenges for ALC of Sri Lanka

Issues and challenges have been identified after analyzing ten-years data (table 1), desk review including the review of ALC in 2019 and consultation with a variety of stakeholders. They will be the background to define objectives, strategies, indicators, monitoring and evaluation framework. Major issues and challenges affecting the program are as follows:

Transmission of leprosy is on:

From the table above, it can be seen that the New case detection number has declined from 2091 cases in the year 2010 to 1660 cases in the year 2019 but the decline is very slow, could also be due to inadequate active case finding activities and late presentation of cases. In contrast, the child proportion is static and high (around 10-11%). There is an increase in the proportion of MB i.e. infectious cases from around 46% to 58%. All these data show that the transmission of leprosy is on, and extra efforts and measures arerequired to break the chain of transmission.

Late Case Detection:

Higher MB percentage (58%) and higher grade 2 disability (5.6%) indicate that active case transmission is prevalent and late presentation is the reason for identifying the patients with disability. One of the reasons for late presentation is that the patients who have been suspected for leprosy are not reporting to hospitals on time. Other reason for late case detection would be non availability of resources for the diagnosis of leprosy at peripheral level and almost all cases are diagnosed at the tertiary level hospital where consultant dermatologist is available.

Misdiagnosis of Leprosy:

It is the view of stakeholders that inadequate capacity to diagnose leprosy at field level is one of the reasons for misdiagnosis. More centres or satellite clinics need to be identified and strengthened at the periphery to increase the access of patients for confirmation of diagnosis, initiation of treatment and follow up

Follow up of cases during treatment:

Treatment of cases is initiated at hospital setting under the supervision of Consultant Dermatologists. This leads to inadequate follow up of cases under the direct supervision of dermatologists because the link between hospital and public health staff at the field level is inadequate.

Laboratory services:

Skin smear or lab services for diagnosis are not used adequately despite training of laboratory staff. It can be imagined that skin smear taking skills must also be dwindling and hardly anyone is trained in the field to take the smears. More and more relapse cases are reported indicating the need for quality lab services. There is hardly any centre identified to collect samples for drug resistance surveillance. Few labs could be identified to be part of WHO drug resistance surveillance. At field level there are no facilities to do skin smears.

Prevention of disability:

5.6% of disabilities among new cases indicate that the cases are not detected early and are somehow neglected. If the cases are not picked up early, or the awareness in the community is poor, the patients neglect themselves and land up with a disability. More MB cases (57%) indicatemore possibility of reaction and neuritis leading to development of disability, if not treated in time. It means early identification of reactions/neuritis by sensory test (ST) and voluntary muscle testing (VMT) should be in place before the start, during and after the treatment is complete.

Management of disability during and after treatment:

From the literature and discussion with the stakeholders, it is clear that limited facilities are available for managing disabilities. Management of disabilities during and after treatment need extra attention. Provision of MCR footwear, self-care training, provision of aids, appliances and provision of RCS services need to be strengthen and streamlined.

Recording and reporting need improvement:

The data recording is initiated at dermatology clinic in the hospital and the data areentered into the system by PHI-LCs in relevant districts. There is no infrastructure facilities to enter the data on-line and the existing data management system need to be revised.

Supervision, Monitoringand Evaluation:

The mechanism that the supervision, monitoring and evaluation are carried out by the regional epidemiologists (REs) in the field under the supervision of ALC need to be strengthened. The main issues encountered by PHI-LCs are: inadequate internet facilities, limited fuel allowance, transport facilities and restricted extra payments.

Awareness and stigma:

Stigma exists in the community indicated by the fact that the patients prefer to take treatment from a far-away hospital rather than visiting a nearby health centre. Invisible stigma is also noticed even among health care providers. Late presentation of cases (27%) can be attributed to either lack of awareness in the community or prevailing stigma or both. It is clear from the discussion with stakeholders that communication is lacking at all levels i.e. with policymakers, with service providers, with patients and with the community. Communication strategy need to be developed to target the above-mentioned groups.

Less priority is given to leprosy control program:

After achievement and declaration of elimination of leprosy as a public health problem, attention given to leprosy control seems to be reduced. It is indicated by the fact that less time is given to leprosy in different meetings. Arranging resources for the ALC seems a major problem. Infrastructure at the peripheral level is not uniformly distributed for suspecting, referring and follow up of cases. Leprosy services are not fully integrated into primary health care system despite the policy change in 2001 of integration of leprosy into general health care system.

In-adequate rehabilitation provided to persons affected by leprosy:

In the case of persons affected by leprosy, rehabilitation could be physical, socio-economic and mental. For physical rehabilitation, there is no established centre for reconstructive surgery in the country. Rehabilitation centres are available, but there is no link for providing care to persons disabled due to leprosy. Self-care training to persons disabled due to leprosy is not given due attention. Staff is either not available or cannot impart training in self-care to people having disabilities due to leprosy. There is limited supply of aids and appliances to the affected people. Socio-economic rehabilitation of persons affected by leprosy is inadequately addressed. It is well established now that patients with leprosy have mental health issues and if not treated properly may go into depression and even commit suicide. Psychological support in the form of counselling at the time of diagnosis and afterwards is a priority.

In-adequate partnerships:

- **Poor involvement of persons affected by leprosy in leprosy control**

It is clear from reviews, reports and consultations that persons affected by leprosy are less inclined and not involved in leprosy control activities. This could be due to lack of self-confidence, self-stigma, lack of motivation, lack of capacity or lack of awareness about their role in the program.

Persons affected are still not well organized, and they will need counselling, capacity building and motivation to participate.

- **Inadequate involvement of NGOs and faith-based organizations**

A good partnership exists between ALC and WHO. Few national, international NGOs and faith-based organizations are operating in Sri Lanka in allocated areas with more of a verticality, they are in-adequately involved in planning, monitoring and supervision of activities. Their involvement in leprosy control needs to be enhanced.

- **Inadequate involvement of private practitioners**

A large number of non-allopathic and allopathic practitioners are practising in Sri Lanka but are not involved in the leprosy control program. There is a need to define their role, build the capacity, motivate them and engage them in leprosy control activities. There is no involvement of Health Promotion Bureau and School Health Program. The involvement of Health Promotion Bureau need to be strengthened in leprosy awareness programme and in case detection.

Under-served population:

There are pockets of hilly and inaccessible areas, and few urban areas where case detection, treatment and follow up of cases is inadequate. There is a need to re-design special programmes to cover these areas

Training:

Its cross-cutting issues, deficiency in the capacity is indicated in reviews, reports and consultations. Capacity building of all cadres/ levels of general health care staff is needed in leprosy control, self-care, monitoring, supervision and recently introduced contact tracing and post-exposure prophylaxis. It will be useful to identify staff at all levels, define their job responsibilities, prepare curriculum and train them accordingly. Training & learning material is also not available for different categories of health staff. There are no identified centres for training in leprosy and staff need to travelabroad to get trained. There is a need to identify and develop training centres at the provincial level. There is a need to identify and train the trainers as well.

Research:

Few research are carried out in Sri Lanka, more by NGOs and dermatologists but more operational research needs to be carried out. Topics identified by WHO in its global strategy 2021-2030 may give the lead to opt for research

Chapter 3: Vision, Goal,Mission and Objectives

3.1 Vision

Leprosy free Sri Lanka

3.2 Goal

Reduce the magnitude of leprosy, disabilities and stigma due to leprosy

3.3. Mission

To stop transmission of the disease, reduce stigma,plan and implement cost-effective quality leprosy services to all persons affected by leprosy, and to sustain such services to ensure a reasonable quality of life to those affected

3.4 Main Targets:

For setting the targets, COVID -19 pandemic is taken into account and data of the year 2019 are taken as baseline. In the year 2020, due to COVID-19 pandemic, fewer cases may have come seeking care and no active case detection resulting in poor case detection than expected. Hence, MB cases and disabilities are expected to rise in 2021 and 2022. On the other hand, with the use of masks by almost everyone and maintaining of social distance in COVID-19 pandemic, the transmission of bacteria from one to another may have reduced. Impact of wearing masks & maintaining distance will be seen in 2022 due to thelong incubation period of leprosy. Keeping the above scenario in mind, it is difficult to project the true targets. Anyway, attempts have been made to set the targets, which could be reviewed in 2023 or 2025 and re-set. **Targets are given in percentages so that each district can set their targets based on their data of 2019. Three main targets, in-line with WHO Global Strategy, are as under:**

- Reduction - in number of new cases detected annually from 1660 in 2019 to 1,494 by 2023 and 1,328 by 2025 at the national level. Reduction by 10% of the present by the year 2023 and 20% by the year 2025, in all the districts
- Reduction - in rate of new cases detected with grade 2 disability per million population from 4.29 in 2019 to 3.22 by 2023 and 2.14 by 2025 at the national level. Reduction by 25% of the present by 2023 and 50% by 2025, in all the districts
- Reduction - in rate of new child cases detected per million children from 34.64 in 2019 to 25.98 in 2023 and 17.32 by 2025 at the national level. Reduction by 25% of the present by 2023 and by 50% by 2025, in all the districts

Other targets

- Reduction in New Case Detection Rate (NCDR) per 100 000 population by 10% by the year 2023 and 20% by the year 2025, in all the districts
- Reduction in the proportion of new cases with gr 2 disability by 25% by the year 2023 and 50% by the year 2025, in all the districts
- Reduction in the proportion of child cases among newly detected cases by 25% by the year 2023 and 50% by the year 2025, in all the districts
- Reduction in the late presentation of cases from the present % by 25% by 2023 and to 50% by the year 2025, in all the districts
- Treatment completion rate to be more than 90% by 2023 and 95% by 2025, in all the districts

3.5 Objectives under the program

On the basis of isssues and challenges as suggested by a varity of stakeholders, general and specific objectives have been set following WHO global strategy 2021-2030:

General Objective 1: to strengthen the Implementation of integrated leprosy services

Under this objective, specific objectives will be as under:

1.1 To Ascertain Increased Political commitment

1.2 To stengthen the program per the prioritization of districts

1.3 To strengthen and develop national partnerships

1.4 To build the capacity of general health care and other staff of the healthcare system

1.5 To enhancecoverage of surveillance to all districts and strengthen data management systems

1.6. To develop and implement monitoring of antimicrobial resistance and adverse drug reactions in central and district level hospitals

General Objective 2: To scale up leprosy prevention alongside integrated active case detection

Under this objective, specific objectives will be as under:

2.1 To improve coverage of contact tracing for all the new cases

2.2 To scale up preventive chemotherapy

2.3 To strengthen integrated active case-finding in targeted populations

2.4 To promote research on existing and potential new vaccines

General Objective 3: To manage leprosy and its complications and prevent new disability

Under this objective, specific objectives will be as under:

3.1 To improve early case detection, accurate diagnosis and prompt treatment

3.2 To improve access to comprehensive, well-organised referral facilities

3.3 To imrove diagnosis and management of leprosy reactions, neuritis and disabilities

3.4 To promote self care by traning, monitoring and supervision

3.5 To ascertain mental wellbeing of affected persons through psychological first aid and therapeutic counselling

General Objective 4: To combat stigma and ensure human rights are respected

Under this objective, specific objectives will be as under:

4.1 To adopt pinciples and guidelines for elimination of discrimination against persons affected by leprosy and their family members

4.2 To include organisations and networks of persons affected by leprosy in different committees, planning and implementation of leprosy services e.g. disability care, counselling, referrals etc.

4.3 To ascertain amendment of discriminatory laws

4.4 To establish a system to document and address the issues related to stigma and promote reduction in communities

4.5 To increase access of affected persons to social support and rehabilitation

Chapter 4: National Strategic Plan (NSP) of Sri Lanka 2021-2025

The strategic plan of Sri Lanka was developed in consultation with a variety of stakeholders, including program manager and staff from ALC, dermatologists from hospitals, medical colleges, dermatologists attending satellite clinics, provincial and regional epidemiologists, medical officers of health, PHIs, WHO, local NGOs, , persons affected by leprosy etc. Attempts have been made to align the plan with WHO global strategy 2021-2030, sustainable development goals (SDGs), universal health coverage (UHC) and NTD roadmap 2021-2030. This plan is made for 5 years, in which mid-term review will be undertaken internally, involving local experts, at the end of 2023 and external evaluation will be undertaken at the end of 2025. The plan is developed under 4 general objectives/pillars following the WHO global strategy 2021-2030.

General Objective 1: To strengthen the Implementation of integrated leprosy services

For this general objective, specific objectives and strategies to be followed, are described as under:

Specific objective 1.1 To Ascertain Increased Political commitment

Strategic actions will be undertaken as follows:

- Efforts will be made to advovate with officials of Ministry of Health for adopting the goal of 'interruption of transmission of leprosy infection by 2030'
- Regular face to face meetings will be conducted with, Minister, Secretary, DGHS and other policymakers to communicate initially the ALC plan 2021-2025 for agreement, later with progress and hurdles in implementation.
- Advocacy will be carried out from time to time through improved communication with policymakers and influencers with relevant data to show persisting leprosy and disability problem in the country leading to loss of productivity and economy.
- Request an increase of funds be allocated for leprosy control at central and provincial levels.
- Partners will be encouraged to participate in advocacy meetings.
- Persons affected by leprosy will be supported , their capacity will be built, and will be motivated and encouraged to advocate for ALC
- Efforts will be made to establish a Technical Support Group including a civil society member and a person affected by leprosy at the national level

Specific objective 1.2: To stengthen the program per the prioritization of districts:

Strategic actions will be undertaken as under:

Districts of Sri Lanka will be prioritized on the basis of Number of new cases, Number of child cases and grade 2 deformities.

High Priority Districts

Sl. No.	District	New Cases	Child cases among new cases	Grade 2 disability among new cases
1	**Colombo**	**224**	**26**	**14**
2	**Gampaha**	**213**	**36**	**12**
3	**Kaluthara**	**136**	**8**	**7**
4	**Batticaloa**	**126**	**19**	**4**
5	**Kurunegala**	**105**	**14**	**7**
6	**Rathnapura**	**106**	**6**	**8**

Medium Priority Districts

Sl. No.	District	New Cases	Child cases	Grade 2 disability cases
1	**Kalmunai**	**68**	**9**	**2**
2	**Mathara**	**70**	**8**	**4**
3	**Anuradhapura**	**72**	**5**	**3**
4	**Galle**	**73**	**4**	**6**
5	**Hambanthota**	**57**	**5**	**2**
6	**Polonnaruwa**	51	2	0
7	**Ampara**	50	3	1
8	**Puttalam**	43	4	2
9	**Trincomalee**	25	5	1

Low Priority Districts

Sl. No.	Districts	New Cases	Child cases	Grade 2 deformity case
1	**Kegalle**	30	0	2
2	**Kandy**	27	0	5
3	**Jaffna**	**25**	**3**	**0**
4	**Badulla**	24	2	1
5	**Moneragala**	**21**	**4**	**4**
6	**Matale**	**21**	**3**	**1**
7	**Nuwara Eliya**	14	1	1
8	**Vavuniya**	**8**	**1**	**1**
9	**Mannar**	**5**	**2**	**0**
10	**Mullaithivu**	**4**	**0**	**1**
11	**Kilinochchi**	2	0	0

Special interventions will be initiated to strengthen the system:

At the National level:

- Plans will be made to appoint at least one Consultant Dermatologist at each base hospital.

For High priority districts

- Existing PMCUs DHs as primary care institutions, will be utilized for leprosy control activities.
- A Medical Officers (NTD) will be appointed for each district by 2023

For High and Medium priority districts

- A dedicated PHI will be identified/posted for Leprosy for each district
- Testing facilities will be made available in hospitals, base hospital level and above
- Dermatologists will be expected to conduct satellite clinics in Divisional Hospital level and above.

- MDT will be made available at all satellite clinics.
- All primary healthcare workers, including Medical Officers of Health will be trained in diagnosis of Leprosy.
- Public Health Midwives and Public Health Inspectors will be trained for suspecting leprosy and referral
- Awareness of Ayurveda Physicians and Pharmacists will be raised and their cooperation will be sought to refer suspected cases to Dermatologists
- Arrangements will be made for direct referrals to specialist Dermatology clinics
- Monthly reviews through meetings and field visits will be undertaken in each district
- Rehabilitation (PT and OT) services will be provided at Base hospital and above.
- Locally relevant and effective communication strategy will be developed
- Data management system to be digitalized

Low Priority Districts

- Existing infrastructure and services will continue
- All primary healthcare workers, including Medical Officers of Health will be trained in diagnosis of Leprosy.
- Public Health Midwives and Public Health Inspectors will be trained for suspecting leprosy and referral
- Awareness of Ayurveda Physicians and Pharmacists will be raised and their cooperation will be sought to refer suspected cases to Dermatologists
- Arrangements will be made for direct referrals to specialist Dermatology clinics
- Monthly reviews through meetings and field visits will be undertaken in each district
- Rehabilitation (PT and OT) services will be provided at Base hospital and above.
- Locally relevant and effective communication strategy will be developedContinuous advocacy programme will continue.
- Data management system to be digitalized

Specific objective 1.3: To increase and strengthen National partnerships:

Strategic actions will be undertaken as follows:

- In line with SDGs, NTD and WHO strategies, partnerships for zero leprosy will be developed with WHO, persons affected by leprosy, NGOs, GPs, faith-based organization, medical colleges, associations etc., in the form of coalitions, task force or

coordination committees to advocate for leprosy and assist ALC in improving leprosy services

- Partners will be encouraged to assist and participate in planning, implementation, monitoring and supervision of the leprosy control program at the national level and the field
- MOUs may be signed with different partners enlisting roles and responsibilities of each partner with the commitment of each party to support activities under ALC with manpower, financial and material resources.
- Partnerships would be developed with medical colleges and college of dermatologists to carry out operational and implementation research in the topics identified in WHO global strategy 2021-2030. This will help in evidence generation for advocacy and if applied in the field, in the improvement of leprosy service

Specific Objective 1.4: To Build the Capacity of General Health Care and Other Staff of the healthcare system

Strategic actions will be undertaken as follows:

- Training centres in departments of medicine, paediatrics, family medicine and community medicine in medical faculties will be identified and strengthened for training in leprosy.
- For sustainability, one trainer in each province will be identified and trained to impart further training to public health care staff
- Training and learning materials will be revised/developed for different categories of health staff with additions of new interventions e.g. contact tracing, cohort reporting, management of drug supply etc.
- A system will be developed so that any new staff who is assigned the task of provision of leprosy services will be trained immediately after joining, maybe in the centres stated above.
- Training in managing programs i.e. analysis and interpretation of data, indicators, cohort analysis, planning, monitoring supervision etc. will be imparted to regional and provincial epidemiologists and medical officers (NTD) to better plan and manage the program in their area
- Capacity in online training and e-learning will be developed and practised

Specific objective 1.5: To Improve effective Surveillance and Data management:

Strategic actions will be undertaken asfollows:

- A surveillance system will be developed/strengthened to detect the un-diagnosed cases in hard to reach areas, cases of reactions, neuritis, physical impairments or psychological problems during and after the treatment
- All formats will be revised/updated and digitalized with the inclusion of new data e.g. children with disability, reactions, details of contacts etc.
- Fields will be created in the existing digital management tool to report these additional data, accordingly geographical information system (GIS) will also be modified.
- More primary care staff, PHII in the field and health staff in dermatology clinics will be identified and their capacity will be strengthened to enable them to use digital recording and reporting
- Endemicity and priority areas will be identified using GIS

Specific Objective 1.6: To Improve Monitoring of Anti-microbial Resistance (AMR) and Adverse Drug Reactions (ADR):

Strategic actions will be undertaken as under:

- At least one lab/centre will be identified/strengthened in Sri Lanka to be equipped with tools like PCR and DNA sequencing with building capacity of the staff to be part of WHO Anti-microbial Resistance (AMR) Surveillance
- Strengthen health facilities (district level) in collecting specimens for AMR surveillance
- A referral system will be established for the cases with adverse drug reaction (ADR) to be referred to the identified hospitals for better management
- A system will be established and formats developed to record and report adverse drug reactions at all levels
- Monitoring of AMR and ADR will be part of all meetings and field visits

General Objective 2 : To Scale-up leprosy Prevention alongside integrated active case detection

For this general objective, specific objectives and strategies to be followed, are described as follows:

Specific objective 2.1: To improve contact tracing for all the new cases

Strategic actions will be undertaken as follows:

- Contact tracing will be ensured for screening of all contacts within 30 days of detecting a new case involving public health care staff and partners

- Counselling of index cases and their contacts per the WHO guidelines will be undertaken as a routine
- Contact tracing of index cases detected earlier in the last 5 years will be undertaken and expanded to 25-50 neighbours and social contacts
- Proper records of index cases and their contacts will be maintained so that they could be followed up for 5 years

Specific objective 2.2: To scale up Preventive chemotherapy:

Strategic actions will be undertaken as follows:

- Considering the prevailing circumstances related to consensus among experts, staff required, and procurement of Rifampicin, Sri Lanka ALC is not yet ready to implement post-exposure prophylaxis (PEP) using a single dose of rifampicin (SDR)
- A review of the situation will be undertaken in 2021 when a decision may be taken to implement SDR PEP per WHO guidelines

Specific objective 2.3: To strengthen integrated Active case-finding in targeted populations

Strategic actions will be undertaken as follows:

- Culturally and locally acceptable activities for increasing awareness in the area will be undertaken in targeted populations, with special attention to women and girls
- Active case finding activities will be undertaken in identified pockets, hard to reach and high-risk areas using innovative methods
- Efforts will be made to combine leprosy case detection with other campaigns

Specific objective 2.4: To promote research on existing and potential new vaccine

Strategic actions will be undertaken as follows:

- Research need to be carried out to find new vaccine

General Objective 3: To Improve Management of leprosy and its complications and prevent new disability

For this general objective, specific objectives and strategies to be followed, are described as follows:

Specific objective 3.1: To improve early case detection, accurate diagnosis and prompt treatment

Strategic actions will be undertaken as under:

- Infrastructure will be further expanded to include leprosy control in primary health care , to increase access to leprosy patients
- Leprosy detection activities will be undertaken with the help of Ayurvedic practitioners, pharmacists and practitioners of other systems of medicine
- Leprosy detection activities will be undertaken with the help of school health services, general practitioners, faith-based organizations, persons affected by leprosy and combining the activities with other campaigns e.g. NTD, TB or others
- Job descriptions will be defined for a variety of general health care staff and training will be imparted accordingly
- The existing referral system will be expanded and strengthened so that cases could be suspected at the periphery by primary health care staff, referred and followed up at hospital setting forinitiation of treatment
- In line with SDG and UHC, web-based and mapping tools will be used to identify sporadic cases and cases with reactions in low endemic and hard to reach areas

Specific objective 3.2: To improve Access to comprehensive, well-organised referral facilities

Strategic actions will be undertaken as follows:

- The referral system will be strengthened from the periphery to the consultant dermatologists for identifying a case, confirmation and treatment of leprosy
- Linkages will be strengthened between dermatologists and rehabilitation centres for the provision of care after completying the treatment for reconstructive surgery (RCS)
- Linkages will be established for persons with disabilities due to leprosy to be referred to the social welfare centres for availing schemes, aids, appliances and socio-economic rehabilitation

Specific objective 3.3: To imrove Diagnosis and management of leprosy reactions, neuritis and disabilities

Strategic actions will be undertaken as under:

- Capacity building of PHC staff will be undertaken to identify reaction and neuritis using WHO document: Management of Reactions and Prevention of disabilities 2020

- Voluntary Muscle Testing (VMT) and sensory testing (ST) with EHF scoring will be ensured at the time of diagnosis, during and at the end of the treatment of all cases
- Recording and reporting of reaction/neuritis cases will be ensured at all levels
- Referral system as indicated above will be strengthened

Specific objective 3.4: To promote self care by training, monitoring and supervision

Strategic actions will be undertaken as follows:

- All the activities will be backed up by good monitoring and supervision at all levels
- Training in self-care will be provided to identified staff in hospitals, rehabilitation centres and general health care staff
- Trained staff will carry out self-care training of persons disabled due to leprosy by forming self-care groups at identified hospitals, rehabilitation centres or at field level.
- Records of cases trained in self-care will be maintained to monitor the practising and progress of self-care
- Progress of self-care and its outcome will be reported routinely from all centres
- An operational research will be carried out to assess the feasibility of practice of self-care by affected persons at home after training at health centres

Specific objective 3.5: To ascertain mental wellbeing of affected persons through psychological first aid and therapeutic counselling

Strategic actions will be undertaken as follows:

- Training in counselling will be providedto more identified health care staff at all levels
- It will be ensured that the counselling is done immediately after the diagnosis is made to allay the patient's fears, anxiety, to make him/her aware of facts of leprosy, the importance of regular treatment, contact examination etc.
- A mechanism will be established to refer the cases to the higher centre for psychological support if the need is felt by the health staff

General Objective 4: To ensure stigma reduction and respect of human rights of persons affected by leprosy

For this general objective, specific objectives and strategies to be followed, are described as follows:

Specific objective 4.1: To adopt principles and Guidelines for elimination of discrimination against persons affected by leprosy and their family members

Strategic actions will be undertaken as follows:

- Principles and Guidelines for the elimination of discrimination against persons affected by leprosy and their family members, adopted by the United Nations General Assembly, will be advocated with the Government for implementation
- Advocacy will be carried out at all the levels for repealing of leper ordinance
- Persons affected by leprosy will be facilitated to get themselves organization into an association
- Training will be imparted to persons affected by leprosy for their personality development, knowing their rights and entitlements
- Series of training and counselling sessions will be organized to improve knowledge, awareness and attitude of service providers, persons affected by leprosy and the community
- Faith-based organizations, religious leaders and other influencers will be involved to convey the right kind of messages to the community and help in the removal of stigma

Specific objective 4.2: To promote inclusion of organisations and networks of persons affected by leprosy

Strategic actions will be undertaken as follows:

- Persons affected by leprosy will be included in technical committees/groups and will be involved in policy change and decision making
- Persons affected by leprosy will be involved in stigma reduction, case detection and other activities
- Attempts will be made to involve persons affected by leprosy under the program as 'social change agents'

Specific objective 4.3: To ascertain amendment of discriminatory laws

Strategic actions will be undertaken as under:

- Efforts will be made to repeal Leprosy ordinance and other laws related to discrimination against people affected by leprosy

A mechanism will be established to report any discrimination experienced by the persons affected so that appropriate action may be initiated against the abusers

Specific objective 4.4: To establish systems to monitor stigma reduction in communities

Strategic actions will be undertaken as follows:

- Stigma assessment tools developed by ILEP agencies will be used to assess stigma
- Research projects will be undertaken to assess stigma in the community including the perception of service providers, patients and the community

Specific objective 4.5: To increase access of affected persons to social support and rehabilitation

Strategic actions will be undertaken as follows:

- Coordination mechanisms will be established with social welfare and labour department therefore the rights and entitlements of persons with disabilities could be availed by persons with disabilities due to leprosy
- Efforts will be made to form self-help groups (SHGs) of persons with disabilities due to leprosy in which persons with other disabilities may be included.
- Linkages will be established for community-based rehabilitation (CBR) of persons affected by leprosy
- Advocacy, involving groups of persons affected, will be carried out and thereby that persons affected may get their rights and entitlements through various government schemes

Chapter 5: Monitoring & Evaluation Framework – Sri Lanka National Strategic Plan 2021 – 2025

Monitoring of the program will be a continuous process. It will consist of collection of data from districts to province, from province to ALC, compilation, interpretation and providing feedback to the provinces and districts. Monitoring will also be carried out by review meetings and field visits. An internal mid-term evaluation will be carried out in 2023 and external end evaluation will be carried out near the end of 2025. Following process and result indicators will be used to assess the progress and evaluate the program:

Strategies	Strategic actions/activities	Indicators	Means of Verification	Risk/Assumptions
Goal: Reduce the magnitude of leprosy, disabilities and stigma due to leprosy				
General Objective/Pillar 1 Strengthening integrated leprosy services for zero leprosy roadmap				
Specific objective 1.1: Increased political commitment	• Advocacy meetings with Health Secretaries, DG & other functionaries • Improved communication with policy makers • Efforts to secure more funds • Participation of partners including persons affected by leprosy in advocacy meetings • Establishment of a Technical Support Group	• Increased participation of decision makers in leprosy meetings • Easy approvals of proposals/budgets • Fund release and utilization improved in prioritized districts • Participation of partners including persons affected in advocacy meetings • Technical Support Group established on adverse drug reaction, Anti microbial resistance, Introduction of new MDT drug regime	• Minutes of the meeting • Percent of funds released	• Appointment/transfers of policy makers
Specific objective 1.2: Prioritization of districts:	• Appointment of one Consultant Dermatologist at each base hospital • Existing PMCUs and DHs as primary care institutions will be utilized for leprosy control activities • Appointment of a Medical Officers (NTD) for each of 6 high priority districts • A LeprosyPHI will be identified/posted for Leprosy for all districts • Provision of testing facilities in hospitals, base hospital level and above in high and medium priority districts • Dermatologists involved in satellite clinics in divisional hospital level and above in high and medium priority districts. • MDT available in all satellite clinics. • Training of primary healthcare workers, including MOH in diagnosis of Leprosy, in high and medium priority districts • Training of public health midwives and public health inspectors for suspecting leprosy and referral in high and medium priority districts • Involvement of Ayurveda Physicians and Pharmacists in refering suspected cases in high and medium priority districts • Direct referrals to specialist Dermatology clinics	• Mapping of districts endemicity wise • Availability of district wise plans • Number of dermatologists available at each base hospital • No. of PMCIs upgraded to identify leprosy • Number of NTD MOs available in 6 high priority districts • Number of PHI-LC identified for leprosy in alldistricts • Number of hospitals providing lab facilities • Number of dermatologists attending satellite clinics • No of satellite clinics with available MDT treatment • No. of trained primary health care staffavailable • No. of trained public health midwives and PHIs available • No. & % of cases referred by Ayurvedic physicians and other therapeutic physicians	• DGHS/ALC records • Records and reports • Drug stock register • Records and reports • Reports of training held	• Agreement by national and provincial policy makers • Motivation of staff • Un-interrupted WHO supply

	• Monthly reviews through meetings and field visits will be undertaken in each district • Rehabilitation (PT and OT) services provided at Base hospital and above. • Locally relevant and effective communication strategy will be developed • Continuous advocacy for the programme	• No. & % of cases referred directly • No. of reviews and field visits undertaken • No. of patients availed physiotherapy and OT services • Availability of IEC material • No. of advocacy meetings held	• Monthly reports • Visible IEC material and events • Minutes of the meeting	
Specific objective 1.3 National partnerships	• Closer partnerships including WHO, NGOs, faith-based organizations, Persons affected etc. • MoUs will be encouraged to be signed • Joint monitoring missions will be undertaken	• No. coalitions, committees available • No. of partners involved in planning and policy decisions • No. MoUs signed between partners • No. of joint monitoring missions (JMM) carried out	• Minutes of meetings • Available MoUs • JMM reports	• Motivation of different organizations
Specific objective 1.4 Capacity building	• Identification and strengthening of training centers • Training of trainers • Revision/printing of learning material • Training in management of leprosy program • Promotion of e-learning	• No. of training centers identified and strengthened • No. of trained trainers available at center and in the provinces • Availability of training/learning material for all the categories of health staff • No. trained in management of Leprosy program • e-learning material/resource available • No. trained through e-learning	• Centers providing training • Trainers list with ALC and provinces • Available learning material • Names/List trained in management • Names/list trained through e-learning	• Release of staff for training in leprosy
Specific objective 1.5 Surveillance and data management	• Strengthening of surveillance system • All formats will be revised/updated • Fields created in the existing digital management tool to report additional data, (GIS) modified • Capacity building of staff in using digital recording and reporting • Endemic/priority areas identified using GIS	• No. of new cases, reactions, neuritis reported from in-accessible areas • Revised/updated forms/formats available with children with disability, reactions, details of contacts etc. • Fields to fill above data created in digital reporting • GIS modified and updated • No. trained in digital recording and reporting • No. endemic/priority areas identified using GIS	• Reports • Revised forms/records • GIS system	• Availability of technical expertise

Specific objective 1.6 Monitoring AMR and ADR	• Lab/centre identified/strengthened for PCR and DNA sequencing • Capacity building of staff to be part of WHO Anti-microbial Resistance (AMR) Surveillance • A referral system will be established for the cases with adverse drug reaction (ADR) to be referred to the identified hospitals for better management • A system will be established and formats developed to record and report adverse drug reactions at all levels • Monitoring of AMR and ADR will be part of all meetings and field visits	• Centre for AMR identified and linked with WHO • No. staff trained in PCR, DNA sequencing • No. of ADR cases referred and treated at referred hospital • Records available for recording and reporting of relapses, AMR and ADR cases • Monitoring visits recorded and monitored reporting for AMR and ADR cases	• Reports of no. of cases tested and referred • Records • Monitoring visit report	• Importance given to AMR and ADR
General Objetive/Pillar 2: Scale-up leprosy prevention alongside integrated active case detection				
Specific objective 2.1 Contact tracing	• Counselling of index cases and their contacts • Contact tracing of index cases detected in the last 5 years • Records of index cases and their contacts maintained	• No. and proportion of index cases counselled • No. and proportion of contacts counselled • No. and proportion of contacts examined/screened • Records of index cases and their contacts maintained • No. and proportion of contacts re-examined every year • No. detected from contacts each year	• Records and reports	• Consent by index case
Specific objective 2.2 Active case-finding in targeted populations	• Increasing awareness with special attention to women and girls • Active case finding activities undertaken in identified pockets, hard to reach and high-risk areas • Efforts will be made to combine leprosy case detection with other campaigns	• No. of target population areas identified • No. of IEC activities undertaken in targeted population in a year • No. of IEC material prepared for girls and women • No. of active detection campaigns undertaken in the targeted area • No. of campaigns combined with other programs • No. of cases detected from identified pockets	• List/map of identified areas • IEC material • Records and reports	• Knowledge about hard to reach and in-accessible areas

General Objective/Pillar 3: Manage leprosy and its complications and prevent new disability				
Specific objective 3.1 Early case detection, accurate diagnosis and prompt treatment	• Infrastructure expanded to include primary health care in leprosy control program • Job descriptions defined and training imparted • Leprosy detection through Ayurvedic practitioners, paramedics and other systems of medicine • Leprosy detection undertaken with school health services, faith-based organizations, private practitioners, persons affected by leprosy and combining the activities with other campaigns e.g. NTD, TB or others • Referral system expanded for suspecting and referring cases from periphery and followed up • Web-based and mapping tools used to identify sporadic cases and cases with reactions in low endemic and hard to reach areas	• No. and proportion of peripheral heath care centers involved in leprosy control • No. and % of GHC staff category wise trained • No. and % staff initiating treatment at the periphery • No. and % of cases detected through school health services • No. and % of cases detected through Ayurvedic practitioners and pharmacists • No. and % of cases detected through private practitioners • No. and % of cases detected through faith-based organizations • No. and % of cases detected through persons affected by leprosy • No. and % of cases detected through combined campaigns • No. &Proportion of new child cases • No. &Proportion of new female cases • No. &Proportion of new cases with grade-2 disability • Number of new child cases with grade-2 disability • Number of relapses • Proportion of MB cases among new cases • Proportion of cases detected late (>6 moths) • MDT completion rate • No. and % of cases referred from periphery to Dermatologists • No. and % of cases with reactions identified at periphery and referred to Dermatologists • No. of cases reported thru web-based tool from low endemic and hard to reach areas • Treatment completion rate for MB (cohort analysis)	• List of health centers providing leprosy services • Records and reports	• Political commitment • Quality of training • Coordination among state players • Motivation of support organizations • Motivation of affected persons

		• Treatment completion rate for PB (cohort analysis)		
Specific objective 3.2 Access to comprehensive, well-organised referral facilities	• Referral system strengthened • Linkages strengthened between dermatologists and rehabilitation centres • Linkages established with the social welfare centres	• No. and % of cases referred from periphery to Dermatologists • No. and % of cases followed up by peripheral staff • No. and % of cases referred from Dermatologists to rehabilitation center • No. of cases provided with reconstructive surgery • No. and % of cases referred to social welfare department • No. given MCR footwear • No. given aids and appliances • No. and % availed social schemes	• Records and reports	• Coordination between different centers/staff
Specific objective 3.3 Diagnosis and management of leprosy reactions, neuritis and disabilities	• Capacity building of PHC staff undertaken to identify reaction and neuritis • Voluntary Muscle Testing (VMT) and sensory testing (ST) with EHF scoring ensured • Recording and reporting of reaction/neuritis cases ensured at all levels • Referral system as indicated above will be strengthened	• No. and % of PHC staff trained in performing VMT, ST, EHF scoring, reaction and neuritis • No. and % performing VMT/ST at start, during and after treatment • No. and % of cases of reaction/neuritis recorded • No. and % of cases of reaction/neuritis reported • No. and % of reaction/neuritis cases referred	• Records and reports	• Motivation of staff
Specific objective 3.4 Monitoring, support and training in self-care	• Monitoring and supervision undertaken at all levels • Training in self-care provided to identified staff • Trained staff imparted self-care training to persons disabled due to leprosy • Records of cases trained in self-care maintained to monitor progress of self-care • Progress of self-care and its outcome reported routinely • Operational research project carried out to assess the feasibility of self-care	• No. of monitoring and supervision visits paid • No. and % of staff trained in self-care • No. and % of persons affected trained in self-care • No. of self-care groups formed in leprosy colonies and in Hendala hospital • Records of persons practicing self-care maintained • Progress of persons practicing self-care reported • Operational research on persons practicing self-care initiated and results reported • Number of review meetings conducted • Compilation of annual report	• Monitoring and Supervisory visit reports • Records and reports	• Logistic support for visits

Specific objective 3.5 Mental wellbeing through psychological first aid and therapeutic counselling	• Training in counselling provided to health care staff at all levels • Counselling done immediately after the diagnosis is made • Cases referred to the higher centre for psychological support	• No. and % of staff trained in counselling techniques • No. and % of patients counselled at the time of diagnosis • No. and % of cases referred for mental ailments to higher centers • Number of persons received counselling	• List of staff trained in counselling • Records and reports	• Co-operation by the patients
General Objective/Pillar 4: Stigma reduction and respect of human rights of persons affected by leprosy				
Specific objective 4.1 Adoption of Principles and Guidelines for elimination of discrimination against persons affected by leprosy and their family members	• Advocacy for repealing of leper act • Organization/s of persons affected by leprosy formed • Training imparted to persons affected by leprosy • Training and counselling sessions organized for service providers, persons affected by leprosy and the community • Faith-based organizations, religious leaders and other influencers involved in increasing awareness and removal of stigma	• No. of advocacy meetings • No. of associations/organizations (including women and girls) of people affected, formed • No. of persons affected trained in personality development • No. of advocacy meetings held between different organizations and service providers • No. of meetings held between community and faith-based organizations and persons affected by leprosy • No. of affected persons participated in social functions	• Minutes of advocacy meetings	• Availability of govt. policy/ies promoting participation of people affected by leprosy
Specific objective 4.2 Inclusion of organisations and networks of persons affected by leprosy	• Persons affected by leprosy involved in decision making • Persons affected by leprosy involved in stigma reduction and other activities • Persons affected by leprosy involved in case detection and other program activities	• No. of affected persons involved in decision making and participating in review meetings • No. of affected persons involved in stigma reduction activities • No. of affected persons involved in case detection and other activities	• Reports/minutes of the meeting	• Motivation of affected persons
Specific objective 4.3 Amendment of discriminatory laws	• Efforts for repeal of Leprosy ordinance and other laws • Report of any discrimination experienced by the persons affected	• Lepers ordinance of 1904 repealed on discriminatory and stigmatization areas. • No. of cases of discrimination reported in a month/year	• Government notification	• Political commitment
Specific objective 4.4 Systems to monitor stigma reduction in communities	• Stigma assessment tools developed • Research projects undertaken to assess stigma	• Stigma assessed using ILEP developed tools • Research project for stigma assessment initiated • Level of stigma known	• Survey report • Research findings	• Co-operation by the interviewees

Specific objective 4.5 Access to social support and rehabilitation	• Establishment of coordinationwith social welfare and labour department • Formation of Self-help groups (SHGs) • Linkages established for community-based rehabilitation (CBR) • Advocacy, involving groups of persons affected, carried out for their rights and entitlements	• A coordination committee including health, labor and social welfare department established • No. of self-help groups including affected persons formed • No. of CBR projects involving affected persons in place • No. of advocacy meetings held between affected persons and social welfare department • No. of affected persons benefitted by social schemes	• Minutes of meetings of co-ordination committee • Self-help groups • Records and reports of benefitted persons	• Motivation of different departments for leprosy

Chapter 6: Communication Staregy

Data and trend analysis of case detection shows that the transmission of leprosy is present in the community. Experiences indicate that the stigma associated with the disease has a negative impact in case detection and treatment. Control of leprosy largely depends on perception, attitude and behavior of a society, it was planned to have an extensive communication programme, to address all the related aspects. Thereby, to overcome the negative perceptions, attitudes and behaviors related to the disease.

The key stakeholders involved in control of leprosy are public, patient, family members and health care providers. This chapter describes in brief the different communication strategic approaches, with the objective of change of the behavior of key stakeholders in a supportive manner, to have an effective impact on control of leprosy. Detail of the communication strategy and related activities are described in "Communication Strategic Plan for Anti-Leprosy Campaign'' of Ministry of Health.

6.1 Gaps and issues to be addressed to meet the expected behavior change

Key informant interviews as well as health and non-health stakeholder interviews and discussions were carried out to identify the gaps that are to be addressed through a behavior change communication programme.

In addition, desk reviews were carried out specially the ALC National Strategic Plan 2016-2020 and the national level research carried out for the ALC in 2018.

Gaps and issues identified:

6.1.1 Public:

- Unawareness and misconceptions on causative agent, transmission, curability and persistence of deformity. Special communities which have limited socializing with main stream of public have more misconceptions.
- Unawareness on symptoms, about becoming non-infectious after one month of proper treatment, period of treatment, availability of free treatment', effect of untreated leprosy also noticed among the public
- 'Fear' is the commonest perception about the disease
    - about possibility of getting disfiguration, loss of body parts eg., fingers
    - social discrimination – from family members, friends, society
    - getting the disease from the patient
- Deformity: misconception as leprosy causes disfigurement, loss of fingers and toes

6.1.2. Patients and family members:

- lack of awareness on persistency of deformity, fear of disease transmission to family members, loss of self-confidence

6.1.3 Health care providers

- fear of transmission of the disease from the patient
- lack of proper knowledge on behavior ('natural history') of the disease
- delay in diagnosis due to misinterpretation of the symptoms
- lack of special training on communication with patients and family members on a disease with stigma
- lack/absence of training on counselling a patient on a disease with a social stigma

6.1.4 Policy makers/Media:

- low priority among policy makers and higher health authorities in control of leprosy,
- misconception of health authorities as leprosy is no longer considered a public health problem,
- less budgetary allocations for leprosy control activities including behavior changing communication activities
- Absence of media based programmes, lack of usage of media for creating awareness, absence of commitment from the media

6.2 Communication Strategic Plan

The expected outcome of the communication strategy for control of leprosy is to create necessary behavioral changes among the target groups to enhance effectiveness of the measures lined up in the national strategic plan of the ALC.

6.2.1 Strategic Directives for Communication Strategic Plan

The communication strategic plan itself has its own vision, goal, mission and targets and they are directed towards the achievement of the targets of the National programme.

Vision

Leprosy free Sri Lanka

Goal

Motivate people for leprosy free in Sri Lanka

Mission

To create awareness on leprosy among the public and health care providers to overcome discrimination against the disease and promote early case detection and complete cure

Targets to be achieved at the national level:

1) Decrease in late presentation to 20% by 2023 and 13% by 2025
2) Reduction in late presentation with Gr2 disability among the new cases by 25% by 2023 and 50% by 2025

Expected Outcomes

1. Leprosy related misconceptions and social stigma among general public and health care providers minimized.
2. Individuals with symptoms of leprosy are motivated for early case detection.
3. Health care seeking behavior for suspected childhood leprosy increased.
4. Compliance for contact tracing is enhanced.
5. Compliance for completion of treatment is increased.
6. Communication skills of the health care providers are strengthened
7. 'Befriend' behaviour of the health care providers for leprosy patients and family members is enhanced
8. Counselling skills of health care providers for leprosy patients and their family members are improved
9. Creative audio-visual & print materials are available to support training programmes for capacity development of health care providers on control of leprosy
10. Commitment of stakeholders, for the development of supportive environment, to develop leprosy free Sri Lanka is built up.

Implementation of activities of the CSP is synchronized with the objectives and implementation of that of the NSP.

6.2.2 Key Priority Areas

The directions of the communication strategic plan address three key priority areas:

- Creating correct awareness on the disease,
- Re-enforcing communication and counselling skills of the health care providers
- Developing a supportive environment to achieve leprosy free Sri Lanka

Strategic objectives and the activities are lined up to address these key priority areas which are directed to achieve the ALC objectives and the targets through supporting the NSP for 2021 – 2025.

6.2.3 Communication Approach

The gaps and issues to be addressed through behavior change for control of leprosy, is multifaceted. An adaptation of the collective ACSM approach introduced by WHO will be used.

This approach would enhance case detection, minimize stigma and discrimination, and empower individuals affected by leprosy. It will enhance commitment of policy makers through advocacy and mobilization of the community.

6.2.4 Communication Strategic Objectives and Activities

The activities of CSP are given under 4 strategic objectives

6.2.4.1 Communication Strategic Objective -1 (CSO-1):

To create awareness and appropriate behavioral changes among the public, leprosy patients & their family members and health care providers on leprosy and leprosy management

The activities to be implemented will lay the foundation to develop interventions necessary to overcome the behaviors based on misconceptions and lack of awareness. Thereby facilitate early case detection, enhance treatment compliance and engagement in rehabilitation.

Strategic Activities (SA) of CSO-1:

SA-1.1: Motivation of individuals with leprosy symptoms for early case detection.

SA-1.2: Engagement of patients for treatment compliance.

SA-1.3: Motivation of leprosy patients for engagement in rehabilitation services

SA-1.4: Motivate health care providers to deliver patient centered care without negative perceptions on leprosy

6.2.4.2 Communication Strategic Objective -2 (CSO-2):

To re-enforce communication and counselling skills in healthcare providers

This will enhance the quality of care provided at the service delivery points, thereby improving leprosy case detection, treatment completion and care provided for rehabilitation.

Strategic Activities (SA) of CSO-2

SA-2.1: Development of comunication skills of the health care providers to deliver patient centered care in 'Befriend' manner.

SA2.2: Development of couselling skills of specially selected health care providers to address needs of the patients and family members to provide optimum services in appropriate manner

6.2.4.3 Communication Strategic Objective – 3 (CSO-3):

To minimize stigma and discrimination associated with leprosy

This will be used to reverse leprosy related mental and psycho-social trauma caused to patients and family members.

Strategic Activities (SA) of CSO-3

SA 3.1: Mobilization of individuals to perform social responsibilities by motivating patients and their family members to undergo standard management without the fear of social stigma.

SA 3.2: Establishment of support groups to overcome effects of social stigma

6.2.4.4 Communication Strategic Objective -4 (CSO-4):

To conduct advocacy programmes to create a conducive environment to reach leprosy free Sri Lanka

This will create a responsive and receptive context for development of policies, mobilizing society and implementation of leprosy control activities.

Strategic Activities (SA) of CSO-4

SA 4.1: Policy advocacy

SA 4.2: Programme advocacy

SA 4.3: Media advocacy

6.2.5 Development of messages

Health message development incorporating the expected content, to change a behavior related to a disease like leprosy which is founded on social stigma and discrimination is a challenge. The production has to be sensitive for the sociocultural setting and creativity plays an important role in overcoming this difficulty. Also pretesting and piloting the messages are important to ensure effectiveness. Impact of an inappropriate creation would have a calamitous effect on programme targets and objectives.

6.2.6 Implementation plan

Implementation of a communication plan of a programme always should be harmonized with the NSP. Readiness of a programme to accommodate the results of communication activities e.g., availability of health care providers to address increase clinic attendance of individuals suspected to have leprosy, and availability of investigation facilities and treatment, are fundamental requisites to be met.

Prior to implementation, preparedness for media buying is important for cost effectiveness. Media usage pattern of the target groups and availability of funds play an important part in determining the extent of engagement of the mass media campaign.

6.2.7 Monitoring and evaluation

Process indicators are to be used to ensure timeliness of implementation of the activities. Appropriate parameters are to be included in the routine information system to monitor the output and the outcome of the communication programme. Based on the output, the implementation plan is to be adjusted and redirected. Depending on the outcomes of the communication campaign, the implementation plan will be revisited and adjusted.

Chapter 7: Management arrangements:

The National Strategic Plan 2021-2025 will be implemented in close collaboration and co-operation with partners including persons affected by leprosy, hence the roles and respossibilities are indicated as follows.

7.1 Roles and responsibilities of ALC

The directorate of ALC functions under the purview of Deputy Director General of Public Health services I (DDG-PHS I) of the Ministry of Health. The ALC will plan, implement and coordinate all leprosy control activities in the country, including diagnostic, therapeutic and rehabilitative services and also development of policies and regulation. Furthermore, the ALC will provide technical guidance to all activities at central, provincial and district level activities. ALC manages Central Leprosy Clinic at the central level which provides diagnostic and curative services and also responsible for establishment of quality assurance systems for diagnosis, treatment and rehabilitation.

The goal of ALC is to achieve a Leprosy free Sri Lanka which encompasses zero leprosy, zero disability and zero discrimination. In this endeavour, ALC will promote establishing partnerships that will facilitate achieving this milestone.

In order to highlight the importance of leprosy control in the country, ALC will mediate between policy makers, administrators, health care workers and the general public by using appropriate communication strategies.

ALC is totally responsibe for provide MDT medication incollaberation with WHO. In addition, providing prosthesis, MCR shoes and rehabilitation appliancesto leprosy affected patients also done by ALC.

ALC will develop a system to monitor and evaluate all leprosy control activities in the country and will inform and advice the Ministry of Health on necessary steps that should be taken based on available evidence.

ALC responsible for conducting research in relaton to public health aspect of leprosy and with collaboration of dermatologists, development of guidelines for treatment.

7.2 Roles and responsibilities of WHO

WHO is a key partner of the Ministry of Health and the ALC. WHO has and will be expected to provide the following:

- Technical assistance;
- Ensure MDT supply for the treatment of Leprosy;
- Funding when necessary;
- Assist in monitoring and evaluation of the leprosy control programme;
- Facilitating international and local collaboration in leprosy control activities; and
- Assist in coordinating different sectors and institutions within and outside the health sector.

Roles and Responsibilities of Private Sector Health Providers (Allopathic & Non-Allopathic)

Identifing patients and proper referral to the dermatology clinic at government sector and the patients who are on treatment, early identification of adverse reeactions are expeted fromprivate sector.

Roles and responsibilities of Non-Health Government Sector Ministries and Departments

Leprosy is a disease well known to have collaborations with other non-health governmental organiations such as Social service department, Public Administration etc. Providing disability care services and providing inancial support are expected from other governmental ministries and departments.

Roles and responsibilities of Media

ALC expects support from all the media in taking correct messages and news to the audience to create a positive behavior within the society. It should avoid in developing fear psychosis on leprosy, through its news and other programmes which will have a negative impact in creating benefits for the citizen. Also it is expected all the mass media programmes which have a content on leprosy to get the concensus from the ALC of MInistry of Health.

7.3 Roles and responsibilities of NGOs

ALC encourages cooperation and partnership with NGOs for leprosy control activities. However, the following conditions need to be met so that all leprosy control activities conducted in the country target the overall goal of ALC:

- All NGOs working in leprosy control should sign an MOU with the ALC outlining their activities;

- All NGOs are expected to provide details of their functioning, area of support and related activities. They are expected to obtain prior permission from ALC, provincial and district health authorities, which will be facilitated by ALC;
- NGOs are expected to play a supportive role and assist ALC in providing services;
- NGOs should assist patients not only in their treatment but also in their social needs;
- NGOs should support ALC, provinces and districts to mobilise communities;
- All activities of NGOs which are related to leprosy shall be supervised and monitored by ALC; and
- NGOs shall be involved in developing plans and their implementation which are related to leprosy.

7.4 Roles and responsibilities of persons affected by leprosy

ALC promotes the active engagement of persons affected by leprosy to be partners of the leprosy control programme. Persons affected by leprosy are expected to volunteer in supporting and facilitating the following activities:

- To inform ALC of their needs and be active partners in the development of plans and their implementation;
- To assist the ALC in mobilising similar persons and to organise community groups to serve their needs including social needs; and
- To be an active voice to advocate for leprosy control and needs of persons affected by leprosy.

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