HUMAN RIGHTS AND SOCIAL INCLUSION OF PERSONS AFFECTED BY LEPROSY-RELATED: A GLOBAL LEPROSY STRATEGY 2021–2030

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Abstract

This study examines the human rights and social inclusion of persons affected by leprosy-related disabilities within the framework of the Global Leprosy Strategy 2021–2030. Despite significant medical advances, individuals affected by leprosy continue to experience stigma, discrimination, and social exclusion, which undermine their fundamental human rights. The study adopts a doctrinal and analytical approach to evaluate human rights standards, policy frameworks, and the strategic objectives of the Global Leprosy Strategy. The study finds that effective implementation of the strategy requires stronger legal protections, increased awareness, and inclusive policies that address both medical and socio-economic dimensions of leprosy. It concludes that promoting dignity, equality, and full participation of affected persons is essential to achieving sustainable development and the eradication of leprosy-related discrimination by 2030.

Keywords: Leprosy, Human Rights, Inclusion and Strategy

1.0. INTRODUCTION

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Leprosy is a chronic infectious disease which has lived with mankind for thousands of years while leprosy patients developed severe skin conditions leading to disabilities that terrified people and the society. It was believed that disease is caused by a curse or caused by sin against God or gods as believed by most cultures around the continents.[1] This belief has been widespread until the present day as shown in the studies of Alubo in Nigeria, Burathoki in Nepal and Idawani in Indonesia.[2] They showed that communities perceived leprosy as a disease from God, the will of God or as a punishment by God.[3]The mycobacterium leprae was discovered by Gerhard Henrik Armauer Hansen (GHAH) a scientist from Norway in 1873. He took many years to understand that the disease of leprosy is not hereditary or a curse from God or cursed from sin committed.[4] Until the late 1940s, leprosy doctors all over the world treated patients by injecting them with oil from the chaulmoogra nut. This course of treatment was painful, and although some patients appeared to benefit its long-term effectiveness was questionable. The use of multidrug therapy (MDT) which comprises rifampicin, clofazimine and dapsone is the best treatment for preventing nerve damage, deformity, disability and further transmission course by leprosy. However, researchers are working

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[1] Alubo O, Patrobas P, Varkevisser C, Lever P, *Gender, leprosy and leprosy control: A case study in Plateau State, Nigeria*(KIT, Amsterdam, 2003), Burathoki K, Varkevisser C, Lever P, *Gender, leprosy and leprosy control: A case study in the far west and eastern development region Nepal.* (KIT, Amsterdam, 2004), Brown W, 'Can social marketing approaches change community attitudes towards leprosy?' (2006) 77(2) L. R. J. 89; Try L,'Gendered experiences: Marriage and the stigma of leprosy' (2006) 17 A.P.D.R.J 55.

[2] ibid.

[3] Alubo O, Patrobas P, Varkevisser C, Lever P, *Gender,leprosy and leprosy control: A case study in Plateau State, Nigeria* (KIT, Amsterdam, 2003), Burathoki K., Varkevisser C., Lever P., *Gender,leprosy and leprosy control: A case study in the far west and eastern development region* (Nepal. KIT, Amsterdam, 2004) Idawani C, Yulizar M, Lever P, Varkevisser C, *Gender, leprosy and leprosy control: A case study in Aceh, Indonesia* (KIT, Amsterdam, 2002).

[4]The history of leprosy <https://www.webmd.com/skin-problems-and-treatments/guide/leprosy-symptoms-treatments-history> accessed on 10 April, 2026.

on developing a vaccine and ways to detect leprosy sooner in order to start treatment earlier.[5] The stigma and discrimination attached to leprosy still persists in most countries especially in Nigeria.[6] Stigma is a serious obstacle, to case finding and to the effectiveness of treatment, which are the major concerns of disease control programmes.[7] Many attempts have been made to reduce the stigma attached to leprosy. For instance, leprosy services have been integrated into the general health care system to reduce the differences between victim of the disease and those suffering from other health conditions. Alternative terms have been used instead of leprosy, such as numbing skin disease or Hansen's disease.[8] A lot of programmes were put in place in the effort to reduce stigma through information dissemination which may help to address fear and

[5]Hussain T, 'leprosy and tuberculosis: an insight-review' (2007) 33 C.R.M.J 15–66; World Health Organization 'Global leprosy situation 2009' (World Health Organization; 2009 Report No 33).

[6]Idawani C, Yulizar M, Lever P, Varkevisser C, *leprosy and leprosy control: A case study in Aceh, Indonesia* (KIT, Amsterdam, 2002); Heijnders M.L, 'The dynamics of stigma in leprosy' (2004) 72 (4) I.J.L other Mycobacterium Disability 43–44; Weiss M.G., Ramakrishna J., Somma D., 'Health-related stigma: rethinking concepts and interventions' (2006) 11 P.H.M.J 277–287; Predaswat P. KhiThut, 'The disease of social loathing, An anthropology of the stigma in rural Northeast Thailand' (PhD thesis, University of California; 1992).

[7]Alubo O, Patrobas P, Varkevisser C, Lever P, *Gender,leprosy and leprosy control: A case study in Plateau State, Nigeria* (KIT, Amsterdam, 2003), Burathoki K., Varkevisser C., Lever P., *Gender,leprosy and leprosy control: A case study in the far west and eastern development region, Nepal* (KIT, Amsterdam, 2004); Idawani C, Yulizar M, Lever P, Varkevisser C, *Gender, leprosy and leprosy control: A case study in Aceh, Indonesia* (KIT, Amsterdam, 2002); Weiss M.G, Ramakrishna J, Somma D, 'Health-related stigma: rethinking concepts and interventions' (2006) 11 P.H.M.J 277–287; Van Brakel W.H, 'Measuring health-related stigma - a literature review' (2006) 11 P.H.M.J 307–334; Arole S, Premkumar R, Arole R, Maury M, Saunderson P, 'Social stigma:a comparative qualitative study of integrated and vertical care approaches to leprosy' (2002) 73 L.R.J 186–196; Rafferty J, 'Curing the stigma of leprosy' (2005) 76 (2) L.R.J 119–126; Moreira T, Varkevisser C., *Gender, leprosy and leprosy control: A case study in Rio de Janeiro State, Brazil* (KIT, Amsterdam, 2002).

[8] Hosoda M., 'Hansen's disease recoveries as agents of change: a case study in Japan' (2010) 81 L.R.J 5–16; Raj PrachaSamasai Institute 'Proceeding of the meeting on guideline for delay in diagnosis, Chiangmai, Thailand' (Raj PrachaSamasai Institute, Nonthaburi, Thailand, 22nd DECEmber, 2003).

consequence of discrimination related to the biological realities of leprosy.[9] The aim of this study is to examine the human rights and social inclusion of persons affected by leprosy-related disabilities within the framework of the Global Leprosy Strategy 2021–2030, with a view to identifying challenges and proposing measures for promoting dignity, equality, and full participation.

2.0. LITERATURE REVIEW

The work of Tesema and Beriso[10] are relevant to this literature. They find out that societal attitude on the victims is unpleasant. Individuals of the society have bad reaction towards leprosy patients, they do not sit with leprosy patients in public transportation, they keep away from leprosy patients in different activities, do not share food from the same plate with them, they will not marry from the family with history of leprosy.[11] The authors stated that community do not agree to work in the same place with leprosy patients and they do not allow their children to play with children of leprosy patients, feel ashamed if they have leprosy patient in their family. The reason for avoiding leprosy patients is the fear of their deformities and fear that the patients will transmit the disease to them.

[9]Cross H., Choudhary R., 'STEP: an intervention to address the issue of stigma related to leprosy in Southern Nepal' (2005)76 L.R.J 316–324; Silatham S, Van Brakel, W.H., 'Stigma in leprosy: concepts, causes and determinants' (2014) 85(1) L.R.J 36–47.

[10] Tesema A, Beriso M, 'Assessment of Knowledge and Attitude of Community on Leprosy Patients in Kuyera Town' <https://www.walshmedicalmedia.com/open-access/assessment-of-knowledge-and-attitude-of-community-on-leprosy-patientsin-kuyera-town-west-arsi-zone-oromia-region-southeast-ethiopia-2161-1041- 000156.pdf> accessed on 10 April, 2026.

[11] ibid.

Steve[12] revealed the advantage of community-based rehabilitation programme. This is usually to support all people with disabilities across a community horizontally, rather than focusing vertically on a specific group or those with a particular disabling condition. This distinction highlights an important value issue that informs choice of model. For instance, in a situation of working with people with leprosy, practitioners who hold a community-oriented values framework, argue for the integration of leprosy treatments and control programmes into community base rehabilitation and similar horizontal approaches. Steve expresses the position that a key to combating social stigma is social and service integration.[13] Seddon emphasise the values of specialized services prefer a traditional vertical service model for the same reason, to address the social stigma people may experience.[14] This highlights suggestion that at the level of model, values need to be incorporated along with research into the evidence debate and decision making.[15] The author did not consider the existing laws in justifying the rights of the leprosy patients which the research work will attempt to consider. Srinivasan,[16] research reveals that about one third of leprosy in effected people and their families face social, economic or combined social and economic problems and destitution.[17] For people with chronic impairments due to leprosy, a common problem

[12]Steve P.H, 'Considerations in the quest for evidence in community based rehabilitation' (2008) 19 (2) Asia Pacific Disability Rehabilitation Journal; Deepak S, 'Answering rehabilitation needs of leprosy affected persons in integrated setting through Primary Health Care (PHC) and community-based rehabilitation (CBR)' (2003) 75(2) Indian Journal Leprosy.
[13] ibid.
[14] Seddon D, Seeley J, 'Leprosy and stigma' (2006) 17 Asia Pacific Disability Rehabilitation J. 3-5; Arole S, Premkumar R, Arole R, Maury M, Saunderson P, 'Social stigma: a comparative qualitative study of integrated and vertical care approaches to leprosy' (2002) 73 Leprosy Review Journal 96.
[15] ibid.
[16]Srinivasan H, 'The problem and challenge of disability and rehabilitation in leprosy' (2000) 72 (3) Asia Pacific Disability Rehabilitation Journal 37.
[17] ibid.

is experiencing severe difficulties with the normal activities of daily life.[18] The author suggests that the role of assistive devices also known as technical aids and assistive products can contribute to solutions of the challenges confronting the victim of the leprosy disease patients undergone but the author ought to have examine relevant laws in relation to people with leprosy disease which will consider in the research work. Another significant work is Alubo in Nigeria, Burathoki in Nepal and Idawani in Indonesia. Their works showed that communities perceived leprosy as a disease from God, the will of God or as a punishment by God. In their study only attempts to address the social consequences of disabled people, the research work will attempt to address the social consequences affecting people living with disease of leprosy through existing legal instruments.[19] James N, Nick E, Gbenga A, Bola O,[20] the authors in their findings showed that connotations of leprosy in Yoruba culture included the following: perception of leprosy as the most shameful and detested condition and symbolic association with dirty and immoral behaviour that is dishonouring to Yoruba identity.[21] They went further to states that contrary to the portrayal of Yoruba attitudes to leprosy as entirely negative, the authors identified that people affected by leprosy were creating new life courses to counter existing cultural accounts of marginalization. Emerging narratives of inclusion outlined five facilitators

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[18] Van Brakel W.H, Anderson A.M, 'A survey of problems in activities of daily living among persons affected by leprosy' (1998) Asia Pac Disability Rehabilitation Journal.

[19] Alubo O, Patrobas P, Varkevisser C, Lever P, *Gender,leprosy and leprosy control: A case study in Plateau State, Nigeria* (KIT, Amsterdam, 2003), Burathoki K, Varkevisser C, Lever P, *Gender,leprosy and leprosy control: A case study in the far west and eastern development region* (Nepal. KIT, Amsterdam, 2004); Idawani C,Yulizar M, Lever P, Varkevisser C, *Gender, leprosy and leprosy control: A case study in Aceh, Indonesia* (KIT, Amsterdam, 2002).

[20] James N, Nick E, Gbenga A, Bola O, 'Changing stigmatisation of leprosy: an exploratory, qualitative life course study in Western Nigeria' (2019) 4 BMJ Global Health Journal.

[21] ibid.

of acceptance namely, anti-leprosy treatment, good moral character, supportive family networks, livelihoods, and contribution to community survival. [22]They concluded that Gaps highlighted by the study suggest that the global target of zero stigma and discrimination of leprosy will remain unattainable without better understanding of cultural significance of leprosy and the local sources and underlying drivers of stigma that are crucial for developing context-specific stigma reduction interventions.[23]

3.0. NATURE OF LEPROSY RELATED DISABILITIES

World Health Organisation (WHO) estimated that about 15% of the world's total population has various rage of disability due to leprosy.[24] Disability is a restriction in the utility of the part or entire body of a person. Disability can also lead to constraint in social participation of the victim of disease of leprosy.[25] Disability can also be divided into three broad areas that is Neurological Disability these are classic disabilities resulting from sensory impairment e.g. blindness, deafness, mental retardation, speech defects, epilepsy, and cerebral palsy.[26] Neuromuscular Disability these are disabilities resulting from damage to the muscles e.g. monoplegic, paraplegic, quadriplegic, hemiplegic, polio, leprosy, cerebral palsy, etc. and finally Orthopaedic Disability these are disabilities, which has to do with deformities of the body, e.g. amputation, arthritis, cosmetic

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[22] ibid.
[23] ibid.
[24] WHO 'world report on disability Geneva: World Health Organization'<http://www.who.int/disabilities/world_report/2011/report.pdf> accessed on 10 April 2026.
[25] Leonardi M, Bickenbach J, Ustun T.B., Kostanjsek N, Chatterji S, 'The definition of disability: what is in a name?' (2006) 368 Lancet Journal 21; Van Brakel W.H, Benyamin S, Hernani D, Kerstin B, Laksmi K, Rita Y, Indra K, Muhammad K, Kadek I. K and Annelies W.S, 'Disability in people affected by leprosy: the role of impairment, activity, social participation, stigma and discrimination'(2012) 5 G.H.A.J
[26] ibid.

surgery, old age etc.[27] Quite a lot of scope of disability is acknowledged in the International Classification of Functioning, Disability and Health (ICF) these include body structure and function, activity restrictions and participation restrictions.[28] In the arrangement it identify the role of physical and social environmental factors in affecting disability outcomes.[29] It also move to center on the cause of disability, therefore, emphasis on the environmental factors such as cultural, social and political rather than focusing on disability as a medical dysfunction.[30] Physical impairment associated with leprosy is usually secondary to nerve damage resulting from the chronic granulomatous inflammation due to *Mycobacterium leprae*.[31] Impairments lead to disabilities, this include restrictions of activities of the part of the body in social activities.[32] The WHO classifies leprosy-related impairment into three grades: Grade 0-no impairment, Grade 1-loss of sensation in the hand or foot, and Grade 2-visible impairment.[33] MDT can cure leprosy, and, if instituted early, can prevent disability. [34] However, the disease of leprosy is still frequently diagnosed too late, when permanent injury has already taken placed. Despite undergone medical treatment the degree of damage in the body will still took place.[35] Future projections of the global leprosy burden

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[27] ibid.
[28] WHO 'International classification of functioning, disability and health' <http://www.who.int/classifications/icf/en/> accessed on 10 April 2026.
[29] ibid.
[30] ibid.
[31] Wilder S, Van Brakel W.H, 'Nerve damage in leprosy and its management' (2008) 4 NCPNJ 656.
[32] ibid.
[33] World Health Organisation 'Global Strategy for Further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities Operational Guidelines' <http://www.who.int/lep/resources/SEAGLP20062.pdf> accessed on 10 April 2026.
[34] ibid.
[35] Wilder S, & Van Brakel W.H, 'Nerve damage in leprosy and its management' (2008) 4 NCPNJ 656.

show that more than 5 million new cases would arise between 2000 and 2020, and that in 2020 there would be an estimated more than 1 million people with grade 2 disability due to leprosy.[36] There is very little data on the types of problems faced by victim of the leprosy disease.[37] The global trait on how to address the pandemic of the disease is based on prevention of disabilities and rehabilitation of victim of the disease.[38] Though much improvement has been achieved in reducing the number of affected individual registered for MDT across the world and relatively little is known about disability after release from treatment. Therefore, there is an urgent need for data on leprosy-related disability to assess the need for prevention of disabilities (POD) and rehabilitation services. Such data are also needed for programmed monitoring, research, evaluation and for advocacy.[39] In addition, to physical impairments and activity restrictions, victim of leprosy disease suffer from social stigma and unfair treatment leading to economic, social and political failure which may constitutes psychosocial challenges in their life.[40] According to the ICF, social stigma and discrimination are considered an important environmental factor that contributes to disability.[41] Stigma is not a single fact, but consists of many components. For instance, it could be conceptualized as self-stigma which

[36] Richardus J.H., Habbema J.D, 'the impact of leprosy control on the transmission of M. leprae: is elimination being attained?'(2007) 78 L.R.J 330.
[37] Wilder S, Van Brakel W.H, 'Nerve damage in leprosy and its management' (2008) 4 NCPNJ 656.
[38] ibid.
[39] Van Brakel W.H, Officer A, 'Approaches and tools for measuring disability in low and middle-income countries' (2008) 79 L.R.J 50.
[40] Jopling W.H, 'Leprosy stigma' (1991) 62(1) L.R.J 1.
[41] WHO 'International classification of functioning, disability and health' <http://www.who.int/classifications/icf/en /.> accessed on 11 April 2026; Van Brakel W.H, 'Measuring health-related stigma – a literature review' (2006) 11 Psychology Health Medical Journal, 307; Stevelink S.A, Van Brakel, W.H, Augustine V, 'Stigma and social participation in Southern India: differences and commonalities among persons affected by leprosy and persons living with HIV/AIDS' (2011) 16 Psychology Health Medical Journal, 695.

includes shame and lowered self-esteem or public stigma which leads to public prejudice and intolerance.[42] There is also challenges face by individual affected by this disease such as health-related stigma which is measured using questionnaires, qualitative methods, indicators and scales.[43]The ICF instruments now exist to consider different characteristic of disability and the factors contributing to them.[44]

4.0. NATURE OF LEPROSY RELATED STIGMA

The word *stigma* originated from a Greek word which means a kind of tattoo mark that was cut or burned into the skin of criminals, slaves or traitors, to visibly identify them as blemished or morally polluted people.[45]These individuals were to be avoided, particularly in public places. The word was later applied to other personal attributes that are considered shameful or discrediting.[46]There are various words that are commonly used as alternative terms for stigma. These include negative attitude, prejudice, stereotype, discrimination and exclusion. Each words has its own definition; sometimes linking to each other depending on the circumstance of the applicability. It is important we understand each of these words so that the research work will be appreciated. For instance,

[42]Reeder G.D, Pryor J.B, 'Dual psychological processes underlying public stigma and the implications for reducing stigma' (2008) 6 Mens Sana Monographs Journal 17; Weiss M.G., 'Stigma and the social burden of neglected tropical diseases' (2008) 2 PLoS Negligent Tropical Disease Journal 237.

[43] Van Brakel W.H, Officer A, 'Approaches and tools for measuring disability in low and middle-income countries' (2008) 79 L.R.J 50.

[44] Wilder S, & Van Brakel W.H, 'Nerve damage in leprosy and its management' (2008) 4 NCPNJ 656; Van Brakel, W.H, Benyamin S, Hernani D, Kerstin B, Laksmi K, Rita Y, Indra K, Muhammad K, Kadek I. K, and Annelies W.S, 'Disability in people affected by leprosy: the role of impairment, activity, social participation, stigma and discrimination' (2012) G.H.A 5.

[45] Rebecca J.F, 'Stigma health article: Definition' <http://www.healthline.com/galecontent/stigma ?utm_term¼stig maandutm_medium¼mwandutm_campaign¼article> accessed on 5 July, 2021.

[46] ibid.

attitude is defined as feeling or opinion about something or someone.[47] In other words it is a complex system of interaction among three components that is belief evaluation, feelings and behaviour tendency.[48] Prejudice is typically conceptualised as an attitude that, like other attitudes, has a cognitive component for example, belief about a target group or an affective component such as dislike, and or behavioural component for example, a behavioural predisposition to behave negatively towards a particular group.[49] In psychology, prejudice is not merely a statement of opinion or belief, but an attitude that includes feelings such as contempt, dislike or hate.[50] Stubbier, Meyer and Link,[51] based on the definitions of stigma given by Goffman[52] states that 'prejudice' which include exposure to negative attitudes, structural and interpersonal experiences of discrimination or unfair treatment, and violence perpetrated against persons who belong to disadvantaged social groups. Goff man defined stigma as an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one.[53] Prejudice was define as aggressive feelings in the direction of a person who belongs to a particular group, simply

[47] Cambridge University Press, 'International dictionary of English, Bath: Bath press'<https://www.amazon.com/Cambridge-International-Dictionary-English-Flexicover/dp/0521484693>accessed on 11 April, 2026.
[48]Dalal A.K, 'Social interventions to moderate discriminatory attitudes: the case of the physically challenged in India' (2006) 11 (3) P.H.M Journal 374.
[49]Dovidio J.F, Hewstone M, Glick P, Esses V.M, 'Prejudice, Stereotyping and Discrimination: Theoretical and Empirical Overview. Handbook of Prejudice, Stereotyping and Discrimination' (2010) SAGE Publications Ltd 3-28.
[50] Social Psychology Network, 'the Psychology of Prejudice: An Overview' < http://www.understandingprejudice.rg/apa/english/index.htm.> 11 April, 2026.
[51] Stubbier J, Meyer I and Link B, 'Stigma, prejudice, discrimination and health' (2008) 67 (3) S.S M Journal 251
[52] Goffman E, 'Stigma: Notes on the management of spoiled identity' (1963) Prentice-Hall, Englewood Cliffs; Link B.G, Phelan J.C, 'Conceptualizing stigma' (2001) 27 A.R.S.J 363.
[53] ibid.

because he belongs to that group, and is therefore alleged to have the unpleasant qualities attributed to the group.[54] Stubbier, Meyer and Link further comment that stigma research has traditionally emphasised studying people with unusual conditions, such as facial disfigurement, while prejudice research tend to focus on the far more ordinary, but clearly powerful implications of gender, age, race and class division. They conclude that dishonour and intolerance are interrelated that are used in different conditions or circumstances.[55] Stereotypes are often the basis of prejudice.[56] They argue that the fact that most people have familiarity of a set of stereotypes does not imply that they agree with them.[57] They give an example that many persons can recall stereotypes about different racial groups but do not agree that the stereotypes are valid. People who are prejudiced are those endorse the negative stereotypes.[58] While discrimination implies exclusion from all component of life and that has the effect of denying the respect or enjoyment by all persons, on an equal basis of all rights.[59] From the definition the word exclusion is a major ground of discrimination. [60]Sigma was view, as personal experience which is characterized by exclusion, rejection, blame, or depression that results from experience of an undesirable social conclusion about the

[54] Gordon All port's 'The Nature of Prejudice' (1991) 12 Archival Journal & Primary Source Collection 125.
[55] Stuber J., Meyer I., Link B., 'Stigma, prejudice, discrimination and health' (2008) 67(3) S.S.M Journal 351.
[56] Corrigan, P.W., Watson, A.C., 'Understanding the impact of stigma on people with a mental illness' (2002) 1 World Psychiatry Journal 6.
[57] ibid.
[58] ibid.
[59] Dalal A.K, 'Social interventions to moderate discriminatory attitudes: the case of the physically challenged in India' (2006) 11(3) P.H.M Journal 374; UN Human Rights Committee (HRC). CCPR General Comment No. 18: Non-discrimination. <http://www.refworld.org/docid/453883fa8.html.>accessed on 11 April, 2026.
[60] Oxford Dictionaries<http://www.oxforddictionaries.com/definition/english/attitude> accessed on 11 April, 2026.

person or individual group identified with a particular problem.[61] The definition by the author encapsulates the entire fundamental ingredient stigma which is change consistently base on the nature that triggers an undesirable social judgment and its results. Stigma or discrimination could be related to many factors such as attribute that signifies that an individual is different from normal people and that the person is of a less desirable kind in the intense or abnormality, a person who is bad, or dangerous or weak person.[62]

5.0. GLOBAL LEPROSY STRATEGY 2021–2030

The WHO Global Leprosy Strategy 2021–2030, which was developed through a consultative process with all major stakeholders, reflects these epidemiological changes. Whereas previous strategies focused on the elimination of leprosy as a public health problem, defined as less than one case on treatment per 10 000 populations, the new strategy focuses on interrupting transmission and achieving zero autochthonous cases. In doing so, the strategy aims to motivate high-burden countries to accelerate activities while compelling low-burden countries to complete the unfinished task of making leprosy history. Notably, the strategy is aligned with broader global health trends, including the move towards multi-disease service integration, digitalization and accountability, and addresses key challenges, such as human resource capacity, surveillance and antimicrobial resistance.[63]The strategy promotes innovative approaches such as the use of targeted active case detection and the

[61] Weiss M.G, Ramakrishna J, Somma D, ‘Health-related stigma: rethinking concepts and interventions’ (2006) 11(3) P.H.M Journal, 277.

[62] Goffman E, ‘Stigma: Notes on the management of spoiled identity’ (1963) Prentice-Hall, Englewood Cliffs J; Link B.G., Phelan J.C, ‘Conceptualizing stigma’ (2001) 27 A.R.S.J 363.

[63]Towards Zero Leprosy Global Leprosy (Hansen’s disease) Strategy 2021–2030 <file:///C:/Users/user/AppData/Local/Temp/9789290228509-eng.pdf> accessed on 11 April, 2026.

potential introduction of a safe and effective vaccine, and calls on countries to develop "zero-leprosy roadmaps" and provide chemoprophylaxis to all contacts of confirmed cases.[64] Crucially, the Strategy redefines the burden of leprosy to not only includes persons in need of physical treatment and socioeconomic rehabilitation, but also persons suffering from the mental health impact of leprosy.[65] The implementation of the Global Leprosy Strategy 2021–2030 will drive rapid and sustained progress in all leprosy-endemic countries, advancing progress on the WHO Roadmap for Neglected Tropical Diseases 2021–2030 and the Sustainable Development Goal targets.[66] A world with zero leprosy infection and disease, zero disability, and zero leprosy-related stigma and discrimination, is possible. The Global Leprosy Strategy 2021–2030 is one of the disease-specific strategies underpinning the WHO Road map for Neglected Tropical Disease (NTDs) 2021–2030. The road map, its companion documents and the related strategies are a significant contribution to the Sustainable Development Goals (SDGs), especially SDG 3 which is healthy lives and wellbeing, including the goal of universal health coverage, SDG 10 that is reduced inequalities and SDG 17 that is partnerships. The commitments of the SDGs are to leave no one behind and to endeavour to reach the utmost behind first.[67] Through the combination of disability and stigma, persons affected by leprosy are consistently among the most left behind. This strategy sets out to challenge and change that. The role of partners, at global and country

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[64] ibid.
[65] ibid.
[66] ibid.
[67] Transforming our world: the 2030 agenda for sustainable development' <https://sustainabledevelopment.un.org/post2015/>transforming our world/publication > accessed on 11 of April, 2026.

level, is significant. The 2021-2030 strategic plans highlighted key area which needs to be focus and how to achieve the eradication of leprosy.

i. Implement Integrated, Country-Owned Zero Leprosy Roadmaps In All Endemic Countries

The implementation includes; political commitment with adequate resources for leprosy in integrated context, National partnerships for zero leprosy and zero leprosy roadmaps engaging all stakeholders, Capacity building in the healthcare system for quality services, Effective surveillance and improved data management systems and Monitoring of Antimicrobial Resistance (AMR) and adverse drug reactions. Government ownership, national policies and strategies are the essential foundation for progress towards zero leprosy.

Health, education, social development and law ministries may all share responsibility for leprosy activities, so continuous advocacy and communication within and across ministries are essential to the wellbeing of persons affected by leprosy during and after treatment. Cross-border collaboration may also be needed to ensure continuity of care and the interruption of transmission. Attaining all SDGs and NTD goals is founded on strong partnerships initiated by governments with WHO, academic institutions, the private sector, local and international NGOs, community leaders and civil society organizations including organisations of persons affected by leprosy.[68] Mechanisms such as national partnerships for zero leprosy should be established to ensure effective coordination between partners. Such structures will also enable ongoing focus on leprosy when it is mainstreamed into national health systems and integrated with other health conditions, such as skin NTDs and NTDs

[68] ibid.

associated with ongoing disease management, disability and social exclusion.[69] Partners and academia should collaborate on basic and operational research, in participation with persons affected by leprosy, to build the evidence base for better policies, strategies and programmes. Zero leprosy roadmaps, integrated into national healthcare strategies, operate as a focus for the action of all stakeholders, in higher- and lower-endemic countries.[70] They should be developed within a thorough, well-structured, government-led process supported by WHO and GPZL. The process involves an independent, in-depth situation analysis to identify gaps and priorities, development of a roadmap containing the steps and appropriate strategies and tools to reach zero leprosy in integrated contexts, and a monitoring and evaluation framework to enable progress to be measured. The national partnerships for zero leprosy should be involved in all stages of roadmap formulation, implementation and monitoring and evaluation.

ii. Scale Up Leprosy Prevention Alongside Integrated Active Case Detection

This includes Contact tracing for all new cases, preventive chemotherapy scaled up, Integrated active case-finding in targeted populations and existing and potential new vaccines, passive case detection and treatment with MDT alone have proven insufficient to interrupt transmission. To boost the prevention of leprosy, with the consent of the index case, WHO recommends tracing household contacts along with 25-50 neighbours and social contacts of each patient, accompanied by the offer of a single dose of rifampicin as pr

[69] ibid.
[70] ibid.

eventive chemothera[71] ongoing research may produce a more effective regimen during the period of the strategy.[72] Up to five years' retrospective contact tracing will boost opportunities for case finding and prevention. Defined populations such as islands, institutions, urban slums, villages or even districts with known high transmission may benefit from blanket preventive chemotherapy. Introduction of chemoprophylaxis has proven to strengthen several routine programme components such as counselling, training, supervision, contact tracing etc. Alongside its role in the prevention of leprosy, contact tracing is the most productive tool for finding new cases, and may be the key to leprosy control in the next ten years.[73]

In addition, active case-finding campaigns should be implemented in targeted populations such as areas of higher endemicity, 'silent' areas that are difficult to reach, or among at-risk groups. Where possible, contact tracing and case-finding should be undertaken in combination with other skin NTDs or other relevant diseases and accompanied by training for peripheral health workers.[74] Effective case-finding may result in an initial rise in new case numbers. Case-finding campaigns should be accompanied by innovative and well-targeted community information and awareness activities that combat myths and encourage early self-referral and positive attitudes towards persons affected by leprosy.

iii. Manage Leprosy and Its Complications and Prevent New Disability

[71] Leprosy/Hansen disease: 'Contact tracing and post exposure prophylaxis'< https://www.who.int/publications/i/ite m/9789290228073> accessed on 11 April, 2026.
[72] ibid.
[73] ibid.
[74] ibid.

The management of leprosy include; early case detection, accurate diagnosis and prompt treatment with MDT, access to comprehensive, well-organised referral facilities, diagnosis and management of leprosy reactions, neuritis and disabilities, Monitoring, support and training in self-care and mental wellbeing through basic psychological care and therapeutic counselling. Early case detection and prompt treatment with 6-12 months' MDT (dapsone, clofazimine and rifampicin) continue to be the mainstay of effective leprosy control. Countries have varying approaches to the integration of leprosy into healthcare systems.

WHO recommends integrated skin NTD strategies where feasible,[75] with active coordination in all relevant aspects of planning, management, programme implementation and monitoring and evaluation, In line with goals related to universal health coverage, mapping tools should be used, and surveillance systems developed, at sub-national as well as national level, to ensure detection of sporadic and hidden cases and monitor progress.[76] Leprosy programme managers should engage with dermatologists, private practitioners and tra ditional healers and capture also their contribution when collating data. Close attention is needed to the supply chain, especially last-mile delivery, for MDT, prophylactic drugs, second-line drugs and drugs to treat leprosy reactions. During MDT treatment, a significant proportion of patients experience complications such as leprosy reactions and nerve damage leading to new grade-1 (loss of sensation) and/or grade-2 disability visible impairments. Health staff needs training in nerve

[75] Recognizing neglected tropical diseases through changes on the skin: a training guide for front-line health workers <https://apps.who.int/iris/handle/10665/272723> accessed on the 11 April, 2026.
[76] ibid.

function assessment to recognise and treat or promptly refer signs and symptoms of leprosy reactions and neuritis. Well-organised referral systems should provide access to suitably resourced facilities that can manage reactions, offer wound care, deal with other complications such as damage to the eye, supply assistive devices such as tailor-made footwear along with training and advice on self-care, and offer reconstructive surgery with associated physiotherapy services. Careful attention should be given to ensuring equitable access to services by women and girls and, where necessary, supporting the costs of travel to the referral centre. A good understanding of referral pathways is essential, along with efficient communication between primary health units and referral services. Major events that may occur after completion of treatment include leprosy reaction, neuropathic pain, recurrence of disease (relapse) and worsening of disabilities or occurrence of new disabilities.

Although relapse is relatively rare, laboratory facilities are needed to confirm it and track relapse trends. Reactions, worsening of disabilities and new disabilities particularly grade-1 progressing to grade-2 are relatively common, and negatively affect the quality of life and social participation of persons affected by leprosy. Thorough examinations including nerve function assessments and eye-hand-foot scores should be undertaken at the beginning and end of MDT treatment, followed by post-treatment surveillance, to identify, record, monitor and provide customised support for persons who at higher risk of developing reactions or worsening disability and need ongoing care and

access to referral facilities.[77] Access to clean water is important for routine self-care including daily soaking of hands and feet to prevent secondary disabilities.[78]

iv. Combat Stigma and Ensure Human Rights Are Respected

In combating sigma this includes: Adoption of Principles and Guidelines for elimination of discrimination against persons affected by leprosy and their family members, Inclusion of organisations and networks of persons affected by leprosy, Repeal or amendment of discriminatory laws, Interventions and processes to reduce and monitor leprosy-related stigma in communities and access to social support and rehabilitation. Stigma and discrimination against persons affected by leprosy and their families are almost as old as recorded history. Effects may include social exclusion, loss of income, reduced access to healthcare and education, and reduced mental well-being. Changing beliefs and prejudices is not easy, though school children may be more receptive than adults to messages about changing behaviour and attitudes. Reduction in community prejudice promotes early detection of leprosy and improves acceptance of diagnosis and adherence to treatment and self-care practices. The document Principles and Guidelines for elimination of discrimination against persons affected by leprosy and their family members[79] was adopted by the United Nations General Assembly in 2011 and it provides

[77] Leprosy/Hansen Disease: 'Management of reactions and prevention of disabilities. New Delhi: World Health Organization, Regional Office for South East Asia, 2020'.<https://www.who.int/publications/i/item/9789290227595 accessed on 11 April, 2026.

[78] ibid.

[79] Elimination of discrimination against persons affected by leprosy and their family members; Principles and guidelines for the elimination of discrimination against persons affected by leprosy and their family members A/HRC/15/30 New York: United Nation<https://ilepfederation.org/wp-content/uploads/2020/02/ILEP-Principles-Guidelines.pdf> accessed 11 April, 2026.

a road map for states to meet and clarify their obligations under international human rights law through policy frameworks[80] that protect the rights of persons affected by leprosy. These policy frameworks should stimulate actions to combat prejudice and discrimination, including initiatives to improve the knowledge and attitudes of community and religious leaders and people employed in healthcare, education and social services. Facilitating contact between advocates among persons affected by leprosy and community members can be effective in reducing negative attitudes. There should be zero cases of persons affected by leprosy or their family members being excluded from health facilities, schools or other public services on account of leprosy. Persons affected by leprosy should be encouraged and supported to form self-help groups, ideally including other persons with disabilities or facing social exclusion, for mutual support and resilience, advocacy, and the development of livelihoods and socioeconomic advancement. Initiatives should also be taken to nurture, support and strengthen the capacity of regional and national community-based organisations and networks of persons affected by leprosy, so that they can provide meaningful engagement on issues relevant to them at all decision-making levels.[81]

[80] A recommended policy framework for rights-based action plans aims at the enforcement of de facto equality for persons affected by leprosy and their family members, with specific recommendations in four main areas: adequate standard of living; non-discrimination and community inclusion; elimination of stereotypes; and empowerment. UN Human Rights Council <https://undocs.org/A/HRC/44/46> accessed on 11 April, 2026.

[81]Guidelines for strengthening participation of persons affected by leprosy in leprosy services New Delhi:
World Health Organization, Regional Office for South East Asia, <https://apps.who.int/iris/bitstream/handle/10665/205169/B4726.pdf?sequence=1&isAllowed=y> accessed on 11 April, 2026; Report of the informal consultation on stopping discrimination and promoting inclusion of persons affected by leprosy: 'World Health Organization, Regional Office for South-East Asia, <https://apps.who.int/iris/handle/10665/272637> accessed on 11 April, 2026.

6.0. CONCLUSION

This study examined the human rights and social inclusion of persons affected by leprosy-related disabilities within the framework of the Global Leprosy Strategy 2021–2030. The study reveals through the existence of it literature review that, despite significant medical progress in the treatment and control of leprosy, affected persons continue to face persistent stigma, discrimination, and social exclusion. These challenges undermine their fundamental human rights, including access to healthcare, education, employment, and participation in social and economic life.

7.0. RECOMMENDATIONS

i. There is a need for effective implementation of policies that relevant authorities should ensure the full implementation of the global leprosy strategy 2021–2030 through adequate funding, monitoring, and evaluation mechanisms.
ii. A need to engage in public awareness and sensitisation to sustained public education campaigns to combat stigma, misinformation, and negative cultural perceptions associated with leprosy.
iii. There is a need for aggressive improvement of access to healthcare services for people affected by leprosy-related disabilities victims that will help to strengthened ways to provide accessible, affordable, and inclusive services, including early detection, treatment, and rehabilitation.
iv. Encourage socio-economic empowerment that is programmes aimed at improving education, vocational training, and employment opportunities for affected persons should be prioritised to enhance their independence and social inclusion. And finally,

v. Community participation and inclusion that is allow persons affected by leprosy to be actively involved in decision-making processes, policy formulation, and programme implementation that affect their lives.