

TECHNICAL REPORT

FINAL EVALUATION OF THE DGD–DAMIEN FOUNDATION PROGRAMME “SUPPORT TO THE NATIONAL TUBERCULOSIS AND LEPROSY CONTROL PROGRAMMES IN BANGLADESH 2022–2026”

PART B: LEPROSY

Prepared by

Prof. Giovanni Battista Migliori
Dr. Ananthu James

With the support of

Prof. Moijbur Rahman
Dr. David Pahan

And the invaluable support of the health staff of:

Upazila Health Complex, Kendua under Netrokona district
DF Hospital Compound at Madhupur, Tangail
DF Hospital, Mymensingh
SK Hospital, Mymensingh City

And of the whole staff of Damien Foundation–Bangladesh and the health units visited

List of abbreviations

ACF	Active Case Finding
BCG	Bacillus Calmette–Guérin (vaccine)
BI	Bacteriological Index
BT	Borderline Tuberculoid
DAC	Development Assistance Committee
DBLM	Danish Bangladesh Leprosy Mission
DDP	Drug Delivery Point (Leprosy, weekly)
DF	Damien Foundation
DFB	Damien Foundation Belgium
DFBD	Damien Foundation Bangladesh
DFCO	Damien Foundation Coordinating Office
DG	Disability Grade
DGD	Directorate General for Development Cooperation and Humanitarian Aid
ECS	Extended Contact Survey
ENL	Erythema Nodosum Leprosum
F%	Female proportion
G0D	Grade Zero Disability
G1D	Grade 1 Disability
G2D	Grade 2 Disability
GF / GFATM	Global Fund to Fight AIDS, Tuberculosis & Malaria
GIS	Geographic Information System
GoB	Government of Bangladesh
HCE	Household Contact Examination
HHC	Household Contact
IEC	Information, Education and Communication
ITM	Institute of Tropical Medicine, Antwerp
LCA	Leprosy Control Assistant
LEPRA	Leprosy Relief Association
LL	Lepromatous Leprosy
MB	Multibacillary

MDT	Multidrug Therapy
MO	Medical Officer
MoH&FW	Ministry of Health & Family Welfare
NFA	Nerve Function Assessment
NFI	Nerve Function Impairment
NGO	Non-Governmental Organization
NLP	National Leprosy Programme
NTD	Neglected Tropical Disease
NTLEP	National Tuberculosis & Leprosy Elimination Programme
OBS	Observation case (leprosy suspect who needs review)
OECD	Organisation for Economic Co-operation and Development
PAL	People Affected by Leprosy
PB	Paucibacillary
PEP	Post-Exposure Prophylaxis
POD	Prevention of Disabilities
PR	Principal Recipient
PT	Physio-Technician
QMT	Quick Muscle Test
RCS	Reconstructive Surgery
RFT	Released From Treatment (after MDT course)
SDR-PEP	Single-Dose Rifampicin Post-Exposure Prophylaxis
SSS	Slit Skin Smear
ST	Sensory Test
SWOT	Strengths, Weaknesses, Opportunities and Threats
TLCA	TB & Leprosy Control Assistant
TLM	The Leprosy Mission
ToR	Terms of Reference
TT	Tuberculoid (Tuberculoid)
UHC	Upazila Health Complex
UZ	Upazila / Sub-district
VD	Village Doctor
WHO	World Health Organization

ZLI	Zero Leprosy Initiative
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Executive summary

This final evaluation of the leprosy component (Result 1) of the 2022–2026 DGD–Damien Foundation programme was conducted in Bangladesh during the field mission of 14–20 May 2026 (Dr. Ananthu James contributing partly from distance, with national co-evaluator Dr. David Pahan), and organised as per the Terms of Reference (ToR).

The field visits confirmed the excellent quality of leprosy prevention, diagnosis and treatment services. National and WHO guidelines, known and available, were followed; recording and reporting forms were adequately kept and correctly filled; outcomes were correctly reported (confirming the consistency of data received at DF headquarter level); and health education and counselling were performed regularly with standardised materials. Particular strengths were observed in the prevention of disabilities (POD) services, the provision of protective footwear and self-care education, and the surgical and rehabilitation capacity available in the DF hospitals.

In terms of the leprosy programme indicators, the proportion of females affected and the proportion of patients developing additional disabilities during multidrug therapy (MDT) are both performing well relative to their targets, suggesting successful programme impact in these areas. The Grade-2 disability (G2D) proportion among newly diagnosed cases fluctuated above and below the Year-3 target of 12% during the programme period, indicating a need for sustained efforts in early detection; however, the most recent annual data are encouraging, with G2D at 8.43% in 2024 and 6.99% in 2025. Nevertheless, latest data as of the first quarter of 2026 shows that G2D is 10%, exactly at the target of 10% for 2026. During 2022–25, the child proportion has remained slightly above the target of 8% for 2024. Given this and that the 2026-target is 6%, it is of importance to continue strategies to reduce transmission in the community, as the child case rate is an indicator of ongoing transmission.

The participatory end-mission workshop and debriefing was conducted involving all partners (including the National Leprosy Programme and the NGOs active on leprosy), producing a proactive and useful discussion, after which the preliminary recommendations were accepted.

Five recommendations were proposed for the leprosy component (also see [Annex 6](#)).

The DF project in Bangladesh is not only an example of technically sound implementation of leprosy prevention, diagnosis and treatment activities, but also an excellent model of NLP/NGO

collaboration and an ideal setting for training and operational research. A key cross-cutting message agreed among partners is that having approached the leprosy elimination threshold (as defined by WHO, i.e. a registered prevalence below 1 case per 10,000 population) does not mean the problem is resolved: over 3,500 new leprosy cases are still diagnosed nationally in Bangladesh each year, and continued case detection, particularly timely diagnosis and disability prevention as well as transmission interruption remain essential. Partners agreed on the importance of maintaining the size and structure of the present intervention, while strengthening selected aspects like leprosy awareness and involvement of cured leprosy patients in prevention activities.

Part B: Leprosy (Dr. A. James, Dr. D. Pahan)

1. Introduction

This final evaluation of the 2022–2026 support to the National Leprosy Programme (NLP) in Bangladesh is aimed to allow the Damien Foundation (DF) and the Directorate General for Development Cooperation and Humanitarian Aid (DGD) to successfully complete the planned activities and to plan the future (2027–2031) support programme in the best possible way.

This final review is designed to identify strengths and weaknesses so as to allow implementers to focus on best practices and implement strategic and/or operational corrections if/when and where eventually needed, with emphasis on the programme’s sustainability and on the prevention of leprosy-related disabilities.

Furthermore, it is designed to provide added value in terms of inclusiveness, human resource development and participation of staff, partners and local stakeholders at all levels. In particular, the leprosy component draws on evidence from community-based detection activities, disability prevention strategies, and the increasing rarity of the disease, which presents particular challenges to programme visibility and case detection in the later years of the programme cycle.

The DF five-year programme has 5 expected results that have been defined in the ToR. The leprosy component of this report focuses on Result 1:

Expected Result 1: Management of leprosy will be improved through earlier diagnosis and more effective prevention of disabilities despite the increasing rarity of the disease.

Result 5 (operational research aligned with programme objectives) also has a leprosy dimension and is addressed in the indicator analysis below. (Because the other three expected results are regarding TB, they are not addressed in this leprosy-specific component of the report.)

The principle of continuing training guided the different steps of the consultancy. The evaluation was designed to help the programme partners improve the implementation strategy of continuing training and ensure its sustainability — a point of particular importance in leprosy, where clinical diagnostic skills are difficult to acquire and maintain as the disease becomes rarer.

2. Scope

The goal of the final evaluation is to assess the implementation progress and achievement of the final results of the leprosy component, identify strengths, weaknesses and probable bottlenecks, and propose corrective measures for the remaining programme period and the next cycle (2027–2031).

The final evaluation was organised, as per ToR, starting from the identification of Strengths, Weaknesses, Opportunities and Threats (SWOT analysis) so as to: (a) formulate concrete recommendations to improve or adapt the interventions in order to reach the programme’s objectives and plan the 2027–2031 activities; and (b) identify the workforce and operational capacities needed to make this possible.

The evaluation covered the leprosy caseload, G2D rates, contact examination and post-exposure prophylaxis activities, and the integration of leprosy services within the broader primary health care system, taking into account the impact that the Global Fund (GF) Principal Recipient (PR)’s decision to stop DF activities in the Rajshahi and Faridpur regions had on the project and related indicators. Following these adjustments, from April 2024 DF supports leprosy activities in nine districts (five districts for both TB and leprosy and four districts for leprosy only), as described in the ToR. The evaluation, as per ToR, targets the staff implementing the programme (from DF, government and private sector) and the direct beneficiaries (people affected by leprosy), at all levels including the community.

3. Methodology

The final review was preceded by pre-mission calls with core stakeholders (14 April, 8 and 12 May 2026, see timeline below). The review used a combination of methodologies: epidemiological and document review; questionnaire and in-person interviews; field visits; and a participatory and didactical workshop. The methodology included the following steps:

1. *Desk analysis and document review* of the core reports and publications, including epidemiological data, national leprosy guidelines and DF policy documents (see section 4.1).
2. *Questionnaire-based interview* of key stakeholders including leprosy programme managers, DF and government health staff, community-affected populations, patients, village doctors and cured-patient networks, and private practitioners. The questionnaire

was proposed to stakeholders three weeks before the mission as per ToR, approved and finalised two weeks prior to the mission to allow local consultants to collect responses, and preliminarily analysed during the mission.

3. *Visit to Upazila health facilities* at district level and DF hospitals for leprosy (and TB/MDR-TB), guided by a pre-defined check-list (adapted for the leprosy component); staff and patients were additionally interviewed on site. Primary data available at clinic/Upazila and hospital level were examined (treatment cards, leprosy registers, contact-examination records and POD/self-care documentation), together with direct observation of team members at work.
4. *Analysis of the data collected* through questionnaires and check-lists (qualitative and quantitative, by result and by people category).
5. *Analysis of the existing programme indicators* based on monitoring and evaluation documents, conducted at the Dhaka DF office during the mission, using consolidated records produced by DF for internal monitoring, reports to national authorities, and reports to donors.
6. *Participatory end-mission workshop*, which also served as a debriefing on the main results and had a didactical value. This event was planned with DF staff and conducted in Dhaka on the last day of the mission.

The final sections of the report include the SWOT & Gap analysis and the Recommendations. To simplify the reading, the analysis of the interview results and of the collected data have been combined in a single section. The report and annexes were prepared as per ToR according to the timeline below.

Description	Start	End
Data assessment and document reading done remotely; assessment tools developed; stakeholder comments captured (2 working days)	05/05/2026	06/05/2026
Preparatory calls pre-mission (1 working day in total)	12/04/2026	12/05/2026

Description	Start	End
National consultant(s) collect questionnaires and necessary data	10/05/2026	20/05/2026
Field mission in Bangladesh (I worked remotely)	14/05/2026	20/05/2026
Debriefing / restitution session to stakeholders	Within 3 working days after mission end	
First draft report submitted (remote)	22/05/2026	25/05/2026
Feedback received from DFCO and DFHQ	30/05/2026	30/05/2026
Final evaluation report submitted (remote)	04/06/2026	04/06/2026

All acronyms have been defined when they first appeared in the text. The plan above mostly follows the ToR.

4. Main findings

The findings are described in the following sub-sections, complemented by Annexes as needed: 4.1 Desk analysis and document review; 4.2 Results deriving from the interviews; 4.3 Visit to Upazila health facilities and DF hospitals; 4.4 Analysis of the programme indicators; 4.5 Participatory end-mission workshop.

4.1 Desk analysis and document review

The following documents were reviewed and commented ([Annex 1](#) – Desk Review files):

- 1) DF Bangladesh Annual Reports 2022 and 2023
- 2) Mid-term evaluation report 2022-26 by Prof. G. B. Migliori and Dr. T. Hambridge
- 3) Global leprosy (Hansen disease) updates, 2023 and 2024: Elimination of leprosy disease is possible – Time to act!
- 4) Leprosy, Grijsen et al., 2024, Nature Reviews Disease Primers
- 5) Factors that Influenced and Delayed Self-reporting and Registration of Leprosy Affected People in Different Prevalence Areas of Bangladesh, Hossain et al., 2024, Indian J Lepr

(Note: A few selected publications from the below websites were briefly reviewed to understand the Bangladesh context:

1. <https://www.damienfoundation-bd.com/page/research-publication>
2. <https://tlmbangladesh.org/our-research-publication/>)

The specific comments are summarised below.

Annual DF Reports. The DF Annual Reports document the leprosy achievements. The comprehensive information provided in these reports was of primary importance in understanding the focus areas and shortcomings in the context of leprosy control in Bangladesh. These played a crucial role in framing the interview questions and conducting the analysis of the programme indicators (section 4.4).

Mid-term evaluation report 2024. The 2024 mid-term evaluation confirmed the strong technical quality of the leprosy component and the effective collaboration between DF and the NLP. At mid-term, the female proportion and the additional-disability indicator were performing well; the G2D proportion among new cases was fluctuating around the Year-3 target; and the child proportion remained slightly above the target. The mid-term report drew attention to district-level variation in case detection, a tendency for diagnostic delay to lengthen as the disease becomes rarer, the largely manual/paper-based leprosy data systems, and the risk of erosion of leprosy diagnostic skills among general health staff in low-prevalence areas. These themes are revisited in the present evaluation and in the recommendations.

WHO Global Leprosy update and national epidemiology. Bangladesh is among the countries that continue to report a significant leprosy burden. Nationally, around 3,000–4,000 new cases are reported each year (3,519 nationally in 2024). Of these, DF detected 249 cases in 2024 and 429 in 2025. The persistence of several thousand new cases per year, despite the country having passed the WHO elimination threshold (registered prevalence < 1/10,000) decades ago, underlines that elimination as a public health problem is not equivalent to interruption of transmission.

4.2 Results deriving from the interviews

The interviews were conducted using the agreed-upon stakeholder questionnaire and field checklists (*Annex 7*), which set out the structured prompts used for the four respondent groups: people affected by leprosy, community members trained to assist the programme (village doctors,

cured-patient volunteers, religious leaders, pharmacy shopkeepers), DF staff, and government staff. Overall, the survey results strongly underline the important role played by the DF-supported leprosy project in Bangladesh as perceived by staff, stakeholders and patients. The full set of field-work interview notes – people met, site-by-site findings and patient narratives – is provided in [Annex 13](#), and the supporting photographs in [Annex 14](#).

Themes from people affected by leprosy. Several interviewed patients had been diagnosed only after the onset of visible signs, illustrating the late-presentation problem that the programme is working to reduce. There was also reported social stigma in the community, which could prevent infected individuals from getting diagnosed ([Annex 13](#)). These accounts are consistent with the already reported longer diagnosis delays from Bangladesh in another study (*Hossain et al., Indian J Lepr, 2024*) and with the field photographs documenting delayed presentation ([Annex 14](#)).

Themes from staff and community volunteers. DF and government staff described a strong, well-functioning collaboration, but also flagged a shrinking pool of leprosy-experienced personnel, reductions in both government and DF staff numbers, limited leprosy-specific training among newer general-health and TB staff, and finally health staff losing leprosy-specific skills because of the rare leprosy cases at the hospitals. Formal refresher training could be helpful in this regard. Awareness among susceptible individuals and patients also needs to be improved, for which cured patients of leprosy or TB can play a role ([Annex 13](#)).

4.3 Visit to Upazila health facilities at district level and DF hospitals

For the field visits and the interviews (see [Annex 13](#), field-work notes, for the day-by-day record and the people met), the agreed-upon checklist ([Annex 7](#)), adapted for the leprosy component, was used. While MDT was available there, modern diagnostic facilities like X-ray machines were lacking. Digitalisation of the patient registry is another area of improvement. Given these, the limited funding remains a challenge.

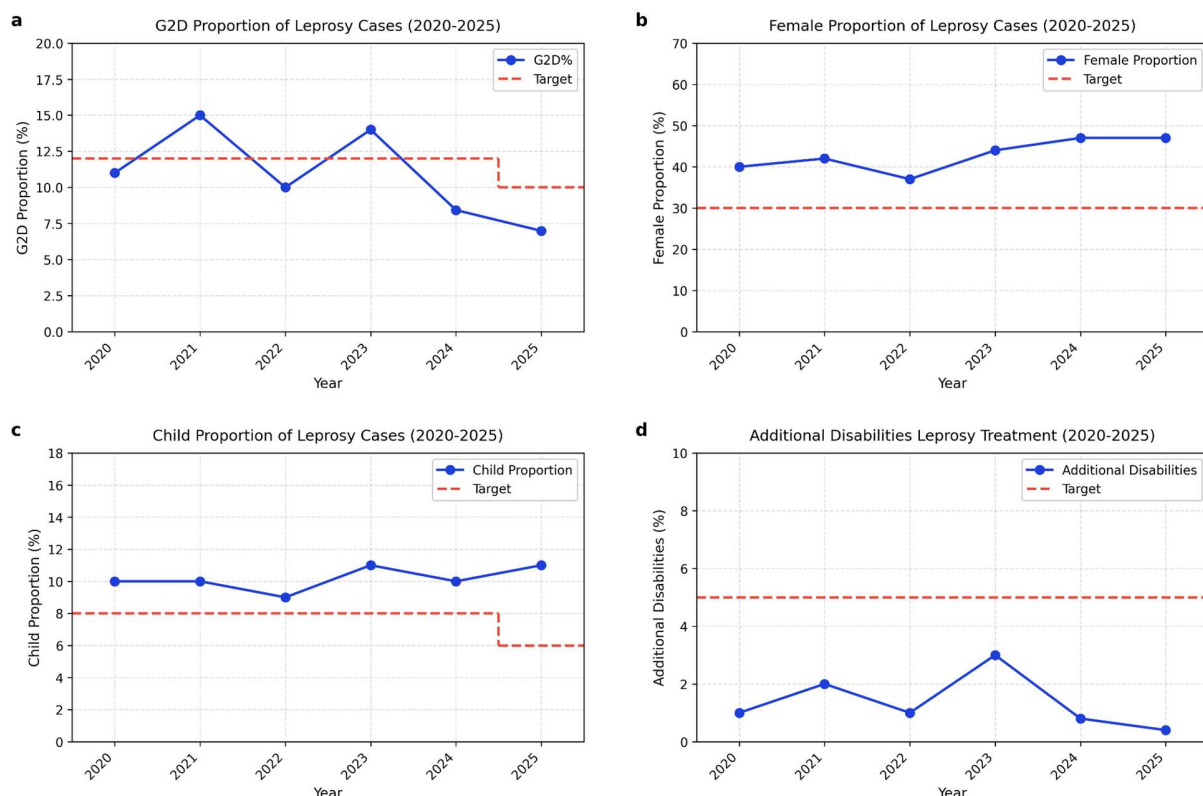
The mission noted, consistent with the mid-term report, that leprosy diagnosis is increasingly concentrated in fewer experienced hands as the disease becomes rarer, and that some senior staff who continue to serve DF after retirement play a crucial role in mentoring younger professionals — a strength that is also a sustainability risk if not actively managed through refresher training. The detailed field-visit notes, the people met and the patient narratives are given in [Annex 13](#), with supporting photographs in [Annex 14](#).

4.4 Analysis of the programme indicators

The indicators are reported below as per the DF proposal (Result 1), with specific comments for each. All strengths, weaknesses, opportunities and threats are reported in the SWOT analysis (section 4.6), from which gaps are derived and recommendations based. The summary leprosy indicator values were taken from the DF debriefing deck ([Annex 6](#)), cross-checked against the field observations.

Result 1: Management of leprosy will be improved through earlier diagnosis and more effective prevention of disabilities despite the increasing rarity of the disease.

A summary of the four leprosy indicators (baselines, Year-3 and Year-5 targets, and observed annual values) is presented in the figure below (also see [Annex 6](#)). Except the proportion of leprosy cases among children (panel c), all the indicators are performing well against their targets, which has been explained in detail.



Indicator 1: Grade-2 disability (G2D) proportion among newly diagnosed leprosy cases

Indicator description: the proportion of new leprosy cases presenting with visible (Grade-2) disability at the time of diagnosis is the key proxy for delay in detection and for the effectiveness of early case finding. A declining G2D proportion indicates earlier diagnosis.

Target Year 3 – 2024: G2D proportion among new cases to be reduced to 12% -> Target met.

Target Year 5 – 2026: G2D proportion among new cases to be reduced to 10% -> The most recent point (2026 Q1) sits at 10% (n = 8), i.e. exactly at the 2026 target. The fluctuation reflects the small absolute numbers of new cases in DF areas (so that a few late-presenting cases shift the percentage substantially) and the challenge of early detection as the disease becomes rarer. The previous reports on case-detection-delay from Bangladesh ([Hossain et al., Indian J Lepr, 2024](#)), indicated delays above 24 months in 68% of the population. In our study, the duration of symptoms before diagnosis, i.e., the case-detection-delays for new patients, was captured using an instrument included as [Annex 8](#).

For further action: The recent improvement is encouraging and should be consolidated through sustained active case finding, contact examination and community awareness, supported by electronic data capture and GIS mapping to identify clusters where late-presenting cases concentrate.

Indicator 2: Female proportion among newly diagnosed leprosy cases

Indicator description: women face particular barriers to accessing leprosy services. A female proportion approaching the expected sex distribution indicates equitable access; a persistently low proportion may indicate under-detection among women.

Target Years 3 and 5: female proportion to be maintained >30% -> The indicator is met.

For further action: Maintain gender-sensitive case finding and continue to monitor the female proportion as case numbers fall, ensuring that women (including female group leaders and cured-patient volunteers) remain actively involved in community detection.

Indicator 3: Proportion of children among newly diagnosed leprosy cases

Indicator description: leprosy in children is a direct marker of recent and ongoing transmission in the community, because of the long incubation period of the disease. A persistently high or rising

child proportion signals continued transmission and is therefore a priority for transmission-interruption strategies.

Target Year 3 – 2024: child proportion to be reduced to 8% -> Target not met.

Target Year 5 – 2026: to be reduced to 6% -> The proportion has not yet reached the Year-3 target of 8% (or the Year-5 target of 6%), which — given that the child case rate is a transmission marker — indicates that transmission is still occurring in the community. This points to undetected cases in the community.

For further action: This is the indicator requiring the most attention. Strengthen systematic household and neighbourhood contact examination of new cases, consider SDR-PEP for eligible contacts where epidemiologically and operationally justified, and use GIS mapping to target high-transmission clusters. Any child case should be treated as a transmission alert and trigger contact screening.

Indicator 4: Additional disabilities developing during leprosy treatment (MDT)

Indicator description: people affected by leprosy have an increased risk of developing new disabilities despite treatment with MDT and disability-prevention services. The disability-prevention services — through correct management of leprosy reactions and neuritis and proper counselling of people with insensitised extremities — are considered effective if no more than 5% of people develop new disabilities during MDT.

Target Years 3 and 5: average additional disabilities during MDT to be kept <5% -> Additional disabilities during treatment remained well below the 5% threshold throughout – 1% (2022), 0.4% (2023), 0.8% (2024), 0.4% (2025). The indicator is comfortably met, reflecting high-quality management of reactions and neuritis, nerve-function assessment, and self-care counselling — capacities that were observed during the field visits ([Annex 13](#)).

For further action: Sustain the quality of reaction and neuritis management and POD/self-care services; ensure refresher training so that this clinical capacity is retained as the disease becomes rarer.

Result 5 (leprosy dimension): Operational research aligned with programme objectives contributes to improving leprosy control strategies.

Operational research – leprosy. In the area of leprosy, one manuscript has been published in Tropical Medicine and Infectious Diseases in 2025 (Ref: <https://www.mdpi.com/2414-6366/10/10/274>). Continued leprosy operational research — on diagnostics, transmission interruption and post-exposure prophylaxis regimens — is recommended (see recommendations).

4.5 Participatory end-mission workshop

The end-mission workshop and debriefing was conducted in Dhaka on the last day of the mission (20 May 2026), involving DF staff, while core stakeholders (NLP, WHO) were met individually. The main findings of the mission were presented and discussed using the debriefing deck ([Annex 6](#)), and agreement was reached on the preliminary recommendations. The debriefing reviewed the leprosy situation in Bangladesh, the four programme indicators and the 2026 Q1 update, the main field-work findings, and the status of the 2023–24 recommendations (electronic data capture and GIS mapping – started in some districts and being expanded; intensified case finding – ongoing; assessment with the WHO Leprosy Elimination Framework – being followed up; *M. leprae* resistance testing – not yet established for want of a specialised set-up and funds; expansion of leprosy research – pursued as opportunities and funding allow).

4.6 SWOT & Gap analysis

The results of the agreed-upon SWOT analysis for the leprosy component are summarised below.

Strengths	Weaknesses
• Trained and motivated staff, with senior leprosy experts mentoring younger professionals • High-quality diagnosis, MDT management, and management of reactions and neuritis • Excellent prevention-of-disabilities (POD) and self-care services; provision of protective footwear	• Largely manual / paper-based leprosy data systems; limited electronic capture and GIS mapping • Erosion risk of leprosy diagnostic skills among general health and TB staff in low-prevalence areas • Child proportion not yet meeting target — a signal of continued transmission • Several diagnoses still occur only after G2D has developed (late presentation)

• Reconstructive surgery and rehabilitation capacity in DF hospitals (e.g. Jalchatra, Mymensingh) • Free-of-cost treatment and rehabilitation; patients report friendly, respectful, stigma-free service • Systematic contact examination; community involvement (village doctors, cured-patient networks, female group leaders) • Strong, longstanding NLP collaboration; DF staff actively support government leprosy activities • Female-proportion & additional-disability indicators consistently meeting targets	• Heavy dependence on DGD funding for leprosy activities (Global Fund focused on TB) • G2D proportion volatile due to small case numbers; sensitive to a few late presenters • Stigma experienced by patients (patient-reported estimate around 5%)
Opportunities • New DGD funding cycle (2027–2031) as the basis of the DF leprosy budget • WHO Leprosy/NTD road map 2021–2030 and Zero Leprosy Initiative framing • Availability of SDR-PEP as a transmission-interruption tool for contacts • Electronic data capture and GIS for real-time cluster mapping (already started in some districts) • Using TB and other trainings as entry points to maintain leprosy skills	Threats • Global Fund PR decision to stop DF activities in the Rajshahi and Faridpur regions • Senior staff turnover / retirement, with loss of scarce leprosy diagnostic expertise • Reductions in both government and DF staff numbers • Reduced programme visibility and complacency as the disease becomes rarer • External factors such as political instability affecting leprosy control • Potential future governance changes at MoH&FW / NLP level

- Cured patients (leprosy or TB) as volunteers for awareness and case detection
- New international collaborations for leprosy research (diagnostics, PEP regimens)

Gap analysis

As a result of the SWOT analysis, the following gaps were identified for the leprosy component:

- The largely paper-based leprosy data systems limit real-time analysis, contact tracking and cluster identification. Digitisation of contact-tracing and case records, with GIS mapping, would substantially strengthen transmission-interruption efforts. This gap was already noted at mid-term, and electronic data capture has now begun in some districts.
- The child proportion remains above target, indicating continued transmission. Systematic contact examination and consideration of SDR-PEP for eligible contacts are needed, supported by mapping of high-transmission clusters.
- As leprosy becomes rarer, diagnostic skills among general health and TB staff risk eroding. Periodic refresher training and the mentoring role of senior staff need to be formalised and sustained to avoid late diagnosis (and rising G2D) in the longer term.

5. Recommendations for the leprosy component

Building on the gaps identified above, on the recommendations of the 2024 mid-term evaluation, the new five recommendations are the following (*Annex 6*):

1. Improving the awareness among susceptible individuals and patients
2. Increasing the capacity of DF staff so that they could transfer their knowledge to new staff
3. Exploring additional funding opportunities to expand digitalisation
4. Involving cured patients in leprosy awareness, detection, and control activities
5. Publishing the info collected during the field work in potential academic journals

6. Conclusions on the leprosy component

With reference to the OECD/DAC criteria used in the ToR as a guide for the report, some concluding remarks are summarised below.

Effectiveness. The analysis of indicators (section 4.4) shows that the female-proportion and additional-disability indicators have been met throughout the period, that the G2D indicator was met in the final two years (8.43% in 2024 and 6.99% in 2025 against the 10–12% targets, and 10% in 2026 Q1, at the 2026 target), and that the child-proportion indicator has not yet been met — reflecting continued community transmission. Overall the leprosy component performed strongly against three of its four indicators.

Alignment and ownership. DF leprosy activities are aligned with WHO and national guidelines and with the NLP’s priorities and the Zero Leprosy Initiative. Staff expressed high motivation and ownership, and the NLP confirmed the importance of the collaboration with DF.

Relevance, efficiency, sustainability and impact. Leprosy remains a relevant public-health priority in Bangladesh: 3,519 new cases were reported nationally in 2024 (around 3,000–4,000 each year), and passing the WHO elimination threshold has not interrupted transmission. The DF leprosy activities are efficiently delivered, as visible from the DF reports, the indicator analysis and the field observations, and they add clear value beyond what the NLP could deliver alone (early detection, disability prevention, reconstructive surgery and rehabilitation). The principal sustainability risk is the heavy dependence of leprosy activities on DGD funding (the Global Fund being focused on TB) combined with the risk of skill erosion as the disease becomes rarer; both argue for continued, well-structured support in the 2027–2031 cycle.

Transversal objectives (gender, environment, human rights). In terms of gender, the female proportion among new leprosy cases is consistently high (47% in 2024 and 2025), indicating good access for women. DF demonstrates strong attention to human rights: the mission saw practical examples of support beyond contractual obligations — for instance, a cured leprosy patient hosted free of charge for more than 30 years in a small house within Jalchatra Hospital, and recently supported for a surgical operation. On the environment, DF maintains clean, well-managed sites, manages waste per regulations, limits plastic and unnecessary printing, rationalises vehicle use, and has invested in solar power across the hospitals it manages.

Overall, the mission findings on the leprosy component met or exceeded expectations. The leprosy services are delivered to a high standard, the disability-prevention results are excellent, and the

recent improvement in the G2D indicator, especially in the past 2 years, is encouraging. The principal areas for continued attention are the interruption of transmission (child proportion), the digitisation of leprosy data, and the retention of leprosy diagnostic skills.

7. Main lessons learned on the leprosy component

The overall finding is that the DF leprosy project is managed very well at both the Dhaka office and the peripheral level, despite the sudden cut in Global Fund funding and the operational challenges posed by the increasing rarity of the disease. Staff are motivated, competent and efficient, and some senior staff continue to serve DF after reaching retirement age under different contractual arrangements in order to share their clinical experience with younger generations — a point of particular importance in leprosy, where diagnosis is difficult and experience is decisive.

This is reflected in the outcomes and indicators (section 4.4) and in the field-work notes ([Annex 13](#)). The patients interviewed were grateful for the services provided, and the survey results confirm the high regard in which the project is held by staff, stakeholders and patients. The NLP and WHO confirmed the importance and quality of DF's support.

Considering the impact of the DF-supported leprosy project, every effort should be made by donors and stakeholders to support it and further strengthen it over time, because:

- it provides a clear 'plus' in terms of early case finding, disability prevention and rehabilitation, with direct impact on the leprosy burden and on the quality of life of people affected;
- it represents a technical model of how to deliver leprosy diagnosis, treatment, disability prevention and reconstructive surgery in a low-prevalence setting, usable as a permanent training / refresher resource for the country;
- it is an excellent example of NGO–NLP collaboration, as testified by the survey results;
- it allows operational research that Bangladesh needs (early detection, transmission interruption, PEP, diagnostics, and the changing role of the leprosy workforce);
- the DF hospitals provide POD, reconstructive surgery and rehabilitation capacity that is scarce nationally and can anchor future training and scale-up.

A central advocacy message is that approaching the leprosy elimination threshold (registered prevalence < 1/10,000) does not mean the problem is solved: with around 3,000–4,000 new cases

per year nationally (3,519 in 2024) and a child proportion still around 10–11%, transmission continues, and reducing funding to the project in the years to come would cause reduced impact and, ultimately, both a missed opportunity (or damage) for Bangladesh and a loss of visibility for the donor(s).

Annexes

The annexes listed below accompany this report.

- [*Annex 1*](#) – Desk-review files (documents consulted).
- [*Annex 6*](#) – Debriefing deck, leprosy component (Dhaka, 20 May 2026): leprosy situation, indicator achievements and 2026 Q1 update, field-work findings, and recommendations.
- [*Annex 7*](#) – Leprosy interview and field-visit questionnaire / checklists (beneficiaries, community volunteers, DF staff, government staff).
- [*Annex 8*](#) – Disease-duration data-collection tool (new-patient symptom duration, 2022–2026).
- [*Annex 13*](#) – Field-work notes (17–18 May 2026): people met, site visits and patient interviews.
- [*Annex 14*](#) – Field-visit photographs (taken by Dr. David Pahan, 17–18 May 2026).