



Country Strategy 2026–2030





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List of Abbreviations

Abbreviation	Expansion
ABSULS	ASHA-Based Surveillance for Leprosy Suspects
ACF	Active Case Finding
AI	Artificial Intelligence
AMR	Anti-Microbial Resistance
ANCDR	Annual New Case Detection Rate
AP	Andhra Pradesh
BCC	Behaviour Change Communication
BPS-N	Basic Psychological Support - Network
CBID	Community-Based Inclusive Development
CBR	Community-Based Rehabilitation
CHW	Community Health Worker
CLD	Central Leprosy Division
CoE	Centre of Excellence
CSR	Corporate Social Responsibility
DRR	Disaster Risk Reduction
DPMR	Disability Prevention and Medical Rehabilitation
EDPAL	Elimination of Discrimination against Persons affected by Leprosy

Abbreviation	Expansion
MH	Mental Health
MYP	Multi-Year Plan
NABH	National Accreditation Board for Hospitals
NCD	Non-Communicable Diseases
NCDR	New Case Detection Rate
NDC	Nationally Determined Contributions
NFI	Nerve Function Impairment
NIHR	National Institute for Health Research
NLEP	National Leprosy Eradication Programme
NNN	Neglected Tropical Disease NGO Network
NSP	National Strategic Plan
NTD	Neglected Tropical Disease
PCR	Polymerase Chain Reaction
PHC	Primary Health Centre
PHQ-9	Patient Health Questionnaire-9
PMS	Performance Management System
PSU	Public Sector Undertaking

Abbreviation	Expansion
ENL	Erythema Nodosum Leprosum
ESG	Environmental, Social, and Governance
FCRA	Foreign Contribution Regulation Act
FLC	Focused Leprosy Campaign
G2D	Grade 2 Disability
GHQ-12	General Health Questionnaire-12
GIS	Geographic Information System
HH	Households
HNWI	High Net Worth Individuals
HR	Human Resource
HRMIS	Human Resource Management Information System
HVCA	Hazard Vulnerability Capacity Assessment
ICMR	Indian Council of Medical Research
IEC	Information Education Communication
ILEP	International Federation of Anti-Leprosy Associations
ILC	International Leprosy Congress
KPI	Key Performance Indicator
LCDC	Leprosy Case Detection Campaign
MDT	Multi-Drug Therapy
PRI	Panchayati Raj Institution

Abbreviation	Expansion
PwD	Persons with Disabilities
PwL	Persons with Leprosy
QoL	Quality of Life
RCS	Reconstructive Surgery
RCT	Randomised Controlled Trial
RPWD	Rights of Persons with Disabilities
SARI	Stigma Assessment and Reduction of Impact
SBL	Stanley Browne Laboratory
SDG	Sustainable Development Goal
SDR-PEP	Single Dose Rifampicin – Post Exposure Prophylaxis
SHG	Self-Help Group
SoV	Share of Voice
TLM	The Leprosy Mission
TLMTI	The Leprosy Mission Trust India
VTC	Vocational Training Centre
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organisation
WHOQOL-BREF	World Health Organisation Quality of Life – Brief
YoY	Year-over-Year

Foreword

Dear Colleagues,

It has been almost two decades since The Leprosy Mission Trust India (TLMTI) spelt out its first Country Strategy and laid out the priorities and outcomes. That was 2007: two years after the WHO declared that leprosy was eliminated as a public health problem in India, and four years after leprosy control programme was integrated into general health services. We were taking definite steps towards strengthening our leprosy services, building leprosy expertise both within and outside TLMTI, and diversifying our service offerings.

As we continued in our journey and learnt from the wins and disruptions, we embraced newer ways of making TLMTI resilient, resourceful and capable of making deeper impact. We included Advocacy as an important programmatic intervention, prioritised environmental sustainability, broadened the scope of partnerships beyond leprosy, and corporate fundraising became a norm rather than an afterthought.

I am happy to share with you the Country Strategy for 2026–30, which comes out at a very critical juncture in the history of leprosy in India. The Government of India has set 2027 as the deadline for elimination of leprosy. Globally, the WHO has set 2030 as the deadline. Government is trying to give new impetus to the national leprosy eradication programme and expects greater involvement of NGOs in intervening in high-priority districts.

For us at TLMTI, it is crucial to live up to the expectations of hundreds and thousands of people living in high-endemic areas and are at

risk of contracting leprosy. More importantly, our own purpose and vision as a leprosy-focussed organisation always push us to do the best for people who need us. Considering our strengths and constraints and the current leprosy landscape in India, this Country Strategy offers before us a window of opportunity to complement government's efforts in achieving zero leprosy.

We may not have made sweeping changes to the priorities from the last country strategy, but we have renewed our commitment to expand access to specialty and preventive healthcare services for people in underserved areas. We have committed to become an enabler for reducing transmission. The strategy also talks about creating a portfolio of accredited training programmes—ranging from degree courses (e.g., physiotherapy, nursing) to diplomas and short-term certifications. Moreover, we have introduced smarter and more practical outcome indicators in this country strategy.

I thank everyone who contributed towards developing this strategy. I appreciate all our partners, be it the government, WHO, ILEP organisations, people affected by leprosy and our key stakeholders, who committed their time and shared their insights with us. I am confident that as an organisation, we will do justice to their efforts and surge ahead with this robust yet agile strategy

Dr. Premal Das

Executive Director

The Leprosy Mission Trust India



Executive Summary

Introduction and Organisational Overview

The Leprosy Mission Trust India (TLMTI) presents its Country Strategy 2026–2030, a pivotal framework developed at a critical juncture in India's fight against leprosy.

This strategy builds on nearly two decades of evolution since TLMTI's first strategic plan in 2007. Following the **integration of leprosy control into general health services (2003)**, and the **WHO declaration of leprosy elimination as a public health problem in India (2005)**, TLMTI continually adapted to strengthen services, diversify offerings, and enhance resilience.

Key advancements include:

- Incorporating advocacy,
- Prioritising environmental sustainability,
- Expanding partnerships beyond leprosy,
- Normalising corporate fundraising.

This strategy emerges amid India's **target to eliminate leprosy by 2027**, three years ahead of the WHO's 2030 global deadline. With government urging greater NGO participation in high-priority districts, TLMTI—India's leading leprosy-focused organisation—commits to complement these efforts while aligning with the TLM Global Fellowship Strategy 2025–2030.

It was developed through participatory consultations with persons affected by leprosy, staff, government partners, WHO, ILEP, and stakeholders. The plan renews focus on **specialty healthcare, prevention, transmission reduction, accredited training programmes, and measurable outcome indicators**.

Context, Challenges, and Needs

India accounts for **58.1% of global new cases — 100,957 detections in 2024–25 (NLEP)**, with persistence in high-endemic states such as **Maharashtra, Chhattisgarh, Uttar Pradesh, Bihar, Odisha, and Jharkhand**. Key indicators include:

India accounts for **58.1% of global new cases — 100,957 detections in 2024–25 (NLEP)**, with persistence in high-endemic states such as **Maharashtra, Chhattisgarh, Uttar Pradesh, Bihar, Odisha, and Jharkhand**. Key indicators include:



4.68% child cases (4,722)



ongoing transmission



63.0% multibacillary forms (63,630)



higher transmission potential



3.1.88% Grade 2 Disability (G2D) [1,893 cases; 1.31/million]



delayed diagnosis



High prevalence in Scheduled Castes (16.7%), Scheduled Tribes (20.8%), and women (40.1%)



reflecting entrenched social and economic inequities



Key Challenges



Stigma & Discrimination

treatment delays, isolation, gendered impacts.



Health system gaps

staff shortages, surveillance, AMR (0–16.4%).



External pressures

rising healthcare costs, donor fatigue, climate disasters.



Social consequences

3M+ living with deformities, 200,000 in colonies.

Needs



Active case finding & contact tracing in 121 high-burden districts.



Comprehensive Disability Prevention & Management (DPMR) including surgery, neuritis care, psychosocial support.



Stigma reduction through empowerment of champions/collectives.



Expertise building via accredited training.



Factoring in social determinants: WASH, nutrition, NCDs, poverty, gender equity.



Sustainable, climate-resilient operations.

NLEP innovations — including **Leprosy Case Detection Campaign (LCDC)**, **Focused Leprosy Campaign (FLC)**, and **Nikusht 2.0 digital reporting system** — have strengthened early detection, digital surveillance, and disability prevention.



The **Annual New Case Detection Rate (ANCDR)** stands at **7.0 per 100,000** population (2024–25).

The **Grade II Disability (G2D)** rate is **1.31 per million**, with **1.88%** of new cases presenting with G2D.



The **national prevalence rate** remains at **0.57 per 10,000**, still above the WHO global average of **0.23**.

India's **2027 Zero-Leprosy commitment** aligns with the **WHO Global Leprosy Strategy 2021–2030**, the **SDGs**, and the **NTD Roadmap**, aiming for **zero transmission, zero disability, and zero discrimination** ahead of the 2030 global target.

Strategic Framework and Aims

Strategic Goal 2030

- Eliminate leprosy in **10 blocks & 9 endemic districts**
- Expand inclusive health/specialty services to **80% of hospitals**
- Build **financial self-sufficiency of 120%**
- Ensure **environmentally responsible operations**



Strategic Priorities

- 1. Together for Zero Leprosy** – Transmission interruption, disability management, stigma reduction, research & training.
- 2. Inclusive Community Health & Development** – Specialty services, mobile clinics, preventive outreach, NTD–WASH linkages.
- 3. Environmental Consciousness & Sustainability** – Green campuses, ESG practices, revenue optimisation, staff wellbeing, branding.

Alignment with global priorities

WHO Strategic Pillar	NLEP / ILEP	TLM Global (2026–2030)	TLMTI (2026–2030)
1. Zero Leprosy Roadmaps	State/national elimination strategies	Zero Transmission: Gov. partnerships	Partnerships, Centres of Excellence
2. Prevention & Case Detection	Early diagnosis, contact tracing,	Active case finding & contact screening	Accelerated case detection, stronger health systems
3. Disability & Complications	Comprehensive care & rehab	Zero Disability: Best practices in care & rehab	Comprehensive rehab, mental health support
4. Stigma & Human Rights	Advocacy, repeal discriminatory laws	Zero Discrimination: awareness, education, livelihoods	Zero Discrimination: repeal discriminatory laws, champions, collectives, education, livelihoods

Monitoring & Evaluation (M&E)

- SMART indicators** disaggregated by demographics.
- Digital tools:** mobile apps, GIS, mixed-method data collection.
- Half-yearly → Annual → Mid (2028) End-term (2030) external evaluations.**
- Alignment with **TLM Global KPIs** (child case reduction, discriminatory law removal, funding growth).



Vision

People affected by leprosy living with dignity in a transformed, inclusive society that has overcome leprosy.

What we are working to achieve is transformation (an inward change that will manifest itself in outward actions) of society, communities, and people affected by leprosy, so that leprosy as a disease and its associated deep-rooted, age-old fear and stigma are overcome and are no longer barriers to the inclusive development of people affected by leprosy.



Mission and Values

We work with individuals and communities disadvantaged by leprosy, irrespective of caste, creed and religion, by addressing their physical, mental, social and spiritual needs to uphold human dignity and eradicate leprosy.

Our values and the way they shape our work

1. To be like Jesus
2. Relevant
3. Professionalism
4. Upholding Justice
5. Integrity
6. Inclusive
7. Humility

To be like Jesus

Being like Jesus means, that our lives will be influenced by His life and teachings, which will reflect in our work as our Christian witness.

As a reflection of this value, we will:

- work with compassion
- treat everyone with dignity and respect
- value men and women
- be servant leaders
- be responsive to the needs of those affected by leprosy and other marginalised sections of society
- take time apart as an organisation to retreat into God's presence to find direction, wisdom and ability to move forward in our service to Him

Relevant

Being relevant means that as an organisation we will constantly scan, strategically develop, and adapt to the current environment. As a reflection of this value, we will:

- be a learning organisation
- be sensitive to the changing environment and the emerging needs of the organisation and primary stakeholders
- be innovative

Professionalism

Being professional in our attitude, actions and management means, as an organisation we are committed to excellence and high ethical standards. As a reflection of this value, we will:

- strive for excellence in all we do
- be good stewards of time and resources
- be participatory and foster team culture and ownership
- be transparent in our dealings

Upholding Justice

Upholding justice means that as an organisation, we will uphold social justice and equity for access to community resources and opportunities. As a reflection of this value, we will:

- defend and promote human rights in a non-confrontational way
- support equity and fair dealings
- prioritise the most vulnerable and marginalised people
- engage with communities in a participatory way to secure justice.

Integrity

Having integrity means that individually as staff and collectively as an organisation, we will conduct ourselves honourably in all our actions. As a reflection of this value, we will:

- be truthful
- be reliable
- adhere to highest standards of service and accountability

Inclusive

Being inclusive means that as an organisation we will ensure that all marginalised and excluded people are stakeholders in their development processes. As a reflection of this value, we will:

- be inclusive in our programmes and policies
- accept diversity and work with people from different backgrounds
- demonstrate mutual respect

Humility

Being humble means, we will appreciate and respect who and what others are and their contribution. As a reflection of this value, we will:

- be open and teachable
- seek and provide honest feedback
- be willing to change for continuous improvement
- learn from mistakes and successes in equal measure

Who We Are

The Leprosy Mission (TLM) is the oldest and largest leprosy-focused organisation in the world today. Established in 1874 in Ambala, Haryana, by Wellesley Cosby Bailey, an Irishman moved by the plight of people affected by leprosy, it was then known as *The Mission to Lepers*. In 1973, TLM in India was registered as a Society under the Societies Registration Act, 1860, and today continues its legacy as *The Leprosy Mission Trust India (TLMTI)*.

TLMTI is a member of the TLM Global Fellowship—an international federation of 27 member countries united through a shared charter and a commitment to serve people

TLMTI's programmes span healthcare, education, sustainable livelihoods, community development, advocacy, research, and training. TLMTI operates across 9 states in India through a network of 15 hospitals, 3 clinics, 7 Vocational Training Centres, 4 residential facilities for elderly care, a state-of-the-art Molecular Biology Research Laboratory, and multiple community development initiatives. TLMTI has a College of Nursing and 2 Physiotherapy Colleges, providing accredited professional training to develop skilled healthcare professionals who help sustain leprosy expertise within inclusive healthcare systems. TLMTI also extends technical support to the National Leprosy Eradication Programme (NLEP) in Chhattisgarh and Maharashtra.

With more than 150 years of dedicated service, TLMTI works in close collaboration with government ministries and departments, the WHO, ILEP, grassroots organisations, local churches, and national and international development partners—continuing its mission of healing, inclusion, and dignity for individuals, families, and communities affected by leprosy.

Christian Identity

TLMTI is Christ-centred in all that we are and do. Guided by Mark 1:41, we seek to reflect the love and compassion of Christ in every word and action – for the glory of God and the good of people. Prayer and reflection from the Word of God are central to our life and work. Being Christ-centred is foundational to our identity. It shapes how we serve persons affected by leprosy, how we relate to one another as colleagues, and how we engage humbly with partners and organisations. We strive to treat every individual with equality, respect, and dignity as bearers of God's image. We are called to be available to individuals, families, and communities in need.





Context

India remains the global epicentre of leprosy, accounting for 58.1% of global new cases, with 100,957 detections in 2024–25 (NLEP). Despite achieving national elimination in 2005 (prevalence <1/10,000), the current prevalence rate stands at 0.57 per 10,000 population (82,297 cases under treatment), with only a slow decline from 125,785 cases in 2014–15. Persistence is evident in high-endemic states such as Maharashtra, Chhattisgarh, Odisha, Uttar Pradesh, Bihar, and Jharkhand, where child cases account for 4.68% (4,722) of new detections, and multibacillary forms 63.0% (63,630), indicating ongoing transmission. The disease disproportionately impacts marginalised groups, with 16.7% of cases among Scheduled Castes, 20.8% among Scheduled Tribes, and 40.1% among women, reflecting entrenched social and economic inequities. India still has 121 high-endemic districts, where TLMTI works in 9 districts through hospital and community-based leprosy services. This aligns with the TLM Global Fellowship Strategy 2025–2030 and its “Triple Zero” goals – zero transmission, zero disability, and zero discrimination. India aims to achieve interruption of leprosy transmission by 2027, ahead of the WHO’s global 2030 target.



Challenges

Leprosy control faces entrenched stigma and discrimination, delaying diagnosis (3.87% present with Grade 2 disabilities) and causing social isolation, marital disruptions, and economic marginalisation, particularly for women and girls. Health system gaps include shortage of health providers diluted focus post-integration, and antimicrobial resistance (AMR) rates of 0–16.4%. External pressures encompass rising healthcare costs, donor fatigue, FCRA regulatory changes, and climate disasters exacerbating vulnerabilities in livelihoods and nutrition. Urbanisation and migration

hinder outreach, while underreporting—estimated 2.5–4 times higher according to ICMR—weakens surveillance. These issues, as noted in TLM Global Strategy and WHO reports, require innovative partnerships with government, ILEP, and NGOs for sustainable progress.



Needs

Leprosy elimination demands integrated interventions to address core needs. Early detection and treatment adherence are vital to interrupt transmission, emphasizing active case finding, contact tracing, and chemoprophylaxis in 121 high-burden districts, where TLMTI operates in nine districts. Comprehensive disability prevention and management (DPMR) require neuritis care, reconstructive surgery, and psychosocial support for over 3 million with visible deformities and 200,000 in 750 leprosy colonies. Stigma reduction calls for rights-based approaches, empowering champions and collectives, and promoting inclusive livelihoods for social integration. Building leprosy expertise through accredited nursing and physiotherapy programmes is essential, alongside tackling social determinants like poverty, gender inequities, WASH, nutrition, and non-communicable diseases (NCDs). Sustainable, climate-resilient operations are needed to support vulnerable populations amid urbanisation and environmental shifts.

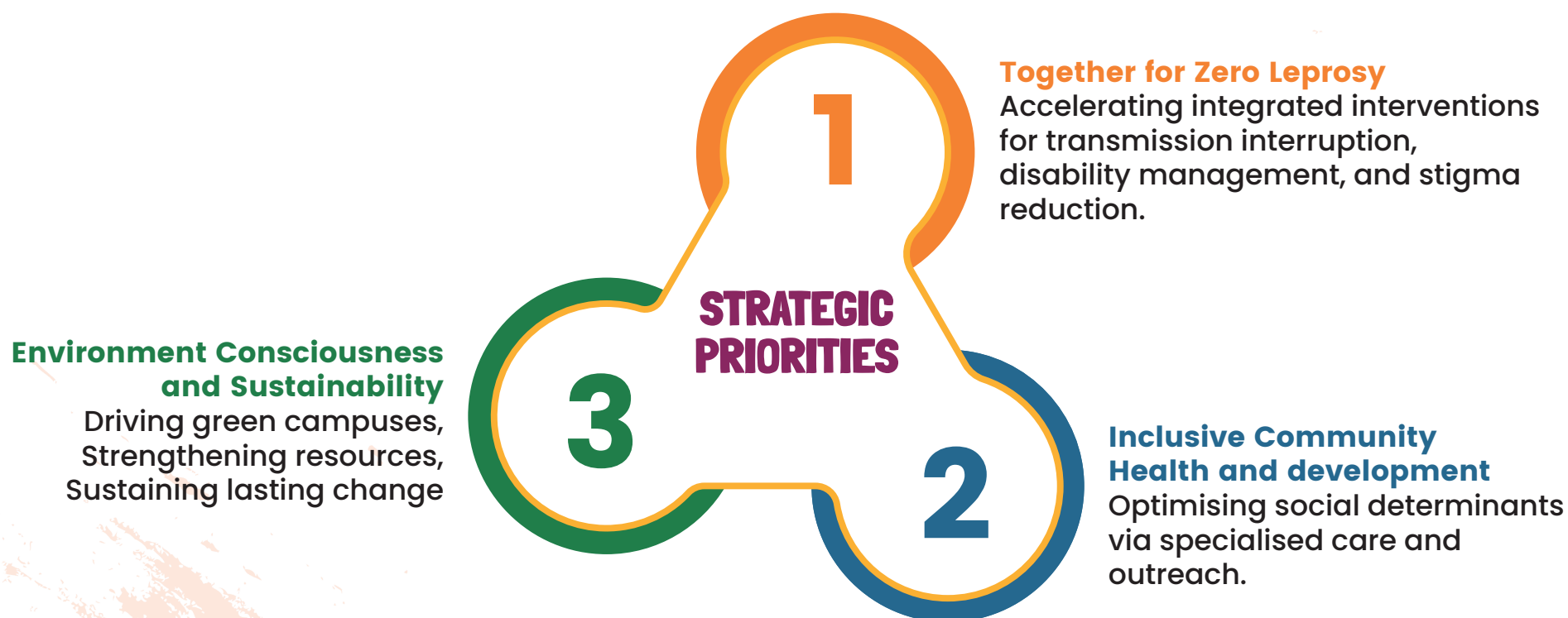
These realities, combined with the need to address social determinants of health, gender inequities, and intergenerational disadvantage, underscore the urgency for a strategic approach that strengthens early detection, clinical care, rehabilitation, stigma reduction, community empowerment, and sustainable, environmentally responsible operations forming the basis for TLMTI’s Country Strategy 2026–30.

Strategic Aims unpacked

Strategic Goal 2030

TLMTI will eliminate leprosy in 10 blocks (TLMTI pre-defined catchment areas) and 9 endemic districts (identified under NLEP), expand inclusive health and specialty services to 80% of its hospitals, establish financial sustainability equal to 120% of annual operational costs, and ensure environmentally responsible operations across all its campuses.

The three Strategic Priorities that will help achieve the Strategic Goal 2030 are



Strategic Priority 1: Together for Zero Leprosy

Introduction

This strategy draws inspiration from Jesus' compassionate healing of a person affected by leprosy: "I am willing... Be clean!" (Mark 1:40–42).

For over a century, The Leprosy Mission Trust India (TLMTI) has led efforts towards Zero Leprosy. Between 2007 and 2025, strategies evolved from disease-focused interventions to person-centred, holistic approaches linking clinical care with socioeconomic rehabilitation.

Although curable with Multi-Drug Therapy (MDT), leprosy continues to present challenges: delayed diagnosis, Grade 2 disabilities (G2D), and persistent stigma that undermines social inclusion and dignity.

The 2026 – 2030 strategy accelerates integrated, community-based interventions to achieve Zero Transmission, Zero Disability, and Zero Discrimination. Using context-specific, person-centred approaches, it addresses both medical needs and social determinants of health (poverty, education, and access to justice). Hospitals provide specialised care, Vocational Training Centres equip people affected by leprosy with market-relevant skills, and community initiatives develop scalable models of inclusion, each reinforcing the others.

The following Strategic Aims will guide action

Strategic Aim 1.1

Zero Transmission – Interrupting Chains of Transmission

Breaking transmission requires proactive case detection, stigma reduction, and integration with public health systems. Aligned with India's National Strategic Plan & Roadmap for Leprosy (2023–27), TLMTI will implement community sensitisation, early diagnosis, prompt, and complete treatment, and contact tracing to achieve zero new cases in endemic districts.

Strategic Aim 1.2

Zero Disability – Sustaining Functional Independence

Beyond cure, TLMTI emphasises disability prevention and medical rehabilitation (DPMR), including early neuritis management, self-care, reconstructive surgery, and psychosocial support. These interventions reduce G2D incidence and secondary impairments, enhancing quality of life through comprehensive rehabilitation.

Strategic Aim 1.3

Zero Discrimination – Advancing Rights-Based Inclusion

Eliminating stigma requires policy advocacy, awareness campaigns, and empowerment of people affected by leprosy. TLMTI will promote Champions and Collectives, rights monitoring, and inclusive livelihoods to end exclusion and foster equitable social participation.

Strategic Aim 1.4

Evidence-Based Interventions & Centres of Excellence in Leprosy

TLMTI will generate robust evidence through operational and translational research to validate, optimise, and innovate interventions for transmission interruption, disability prevention, and stigma reduction. Centres of Excellence will strengthen leprosy expertise within TLMTI and help build leprosy knowledge and skills in the health and development sector in India and globally as well.

TLMTI's 2026–2030 strategy resonates with the following vision:

"Mahatma Gandhi's concern for people affected by leprosy went beyond treatment—he envisioned their full integration into society. The ongoing effort to eliminate leprosy under India's National Leprosy Eradication Programme is a tribute to his vision."

— Prime Minister Narendra Modi.

Aim	Outcomes	Indicators	Core Strategies
1.1: Zero Transmission	1.1.1: Early detection and treatment adherence in pre-defined catchment areas (Blocks) around TLM Hospitals	▪ YoY reduction in G2D at diagnosis ▪ Reduced child cases.	▪ Execute hyper-local BCC campaigns ▪ Implement ACF via screenings, contact tracing ▪ Use AI and digital tools for surveillance and treatment compliance
	1.1.2: Prevention and hotspot management in endemic districts (NLEP-partnered).	▪ Reduced NCDR per 100k ▪ % hotspots under digital monitoring.	▪ Establish and scale Leprosy-free blocks ▪ Integrate screenings in PHC camps ▪ Capacitate district health cadres.
1.2: Zero Disability	1.2.1: Continuum of DPMR from detection to rehabilitation.	▪ Reduced new G2D incidence ▪ % timely reaction/neuritis interventions ▪ % increase in annual surgical volume.	▪ Utilise tech-enabled early impairment detection ▪ Execute standardised protocols for acute episodes ▪ Augment reconstructive surgery and follow-up.
	1.2.2: Community-based rehabilitation for functional autonomy.	▪ Enhanced programmes in operational areas ▪ % of people affected by leprosy participating in mainstream community (analysis of P-scale)	▪ Establish satellite hubs linked to tertiary facilities ▪ Deliver DPMR (assessments, physiotherapy, prosthetics) services ▪ Train frontline workers.
	1.2.3: Psychosocial support integration.	▪ Number of sites offering mental health services; ▪ % improved QoL scores	▪ Embed MH screenings in clinical workflows ▪ Upskill caregivers for referrals.

Aim	Outcomes	Indicators	Core Strategies
1.3: Zero Discrimination	1.3.1: Rights-based inclusive policies and practices	Number of policy engagements	- Form advocacy coalitions - Publish and disseminate rights access reports
	1.3.2: Empowerment of champions and collectives	- Number of federated networks - Number of self-led advocacy initiatives.	- Strengthen/Promote champions - Build/strengthen grassroots & national federations - Support socio-economic collectives (like SHGs, producers' groups) - Curate best-practice repositories.
	1.3.3: Inclusive skilling and livelihoods.	- Increased % in education access - Increased % training completion - Increased % employment gains.	- Ensure enrolment and continuum in educational institutions - Deliver market-aligned skilling - Facilitate dignified income streams.
1.4: Integrated Research, innovation and Centres of Excellence (CoE) in Leprosy	1.4.1: Evidence-based research and innovative solutions	- Number of peer-reviewed publications on zero transmission, disability & discrimination % adoption of findings in TLMTI programmes. - Number of innovative models executed	- Partner for leprosy-related research - Develop field-based research projects and translate recommendations into innovative actions - Publish articles, research work, and case studies and present papers/articles in national and international forums. - Disseminate policy-level recommendations through research
	1.4.2: Sustain leprosy expertise	- Number of TLMTI centres functioning as regional Centres of Excellence in leprosy. - Number of health professionals (health & development) trained annually through CoE. - Percentage of self-sufficiency of CoE	- Define clear parameters for classifying unit as CoE in leprosy - Expand regional Centres of Excellence in leprosy. - Train health and development professionals. - Execute Business Plans for financial sustainability of each CoE.

Strategic Priority 2: Inclusive Community Health and Development

Introduction

This priority echoes the Biblical call to support the vulnerable (Galatians 6:2), uphold justice (Micah 6:8), and promote healing just as Jesus did (Matthew 14:14). Across four strategic cycles (2007–2025), TLMTI shifted from leprosy-centric care to integrated models, merging institutional and community services, health education, and specialties (podiatry, NTDs, Dermatology, Ophthalmology and General medicine). India's health needs are changing, with rising non-communicable diseases (NCDs), persistent leprosy and NTD hotspots, and emerging infections. Marginalised communities still face barriers to affordable, quality care, and rural and semi-urban areas struggle to attract and retain specialists. Government initiatives promote integrated services and partnerships, yet stronger disability-inclusive, community-led health models remain essential. This priority focuses on strengthening specialty care, enhancing community outreach, and creating sustainable, disability-inclusive health models. It aims to integrate hospital-based services with participatory, community-led interventions that address social determinants of health, empower local actors, and ensure equitable access to quality care for marginalised populations. The following Strategic Aims will guide action:

Strategic Aim 2.1

Specialty Services – Bringing the Best in Health Closer to Communities

Maintaining a strong foundation in leprosy-inclusive care, TLMTI will strengthen its role as a provider of quality, inclusive, and affordable healthcare. Expanding into specialty areas will attract and retain skilled medical professionals, deliver integrated care closer to

where people live, and continue TLMTI's legacy of person-centred service within the broader public health system. For the growing elderly population and individuals with disabilities, hospital- and community-based geriatric, and disability models, including residential facilities and support systems will ensure dignity, security, and autonomy. These expanded services will provide vital revenue for TLMTI hospitals, sustain operations, subsidise leprosy care, and contribute to financial reserves.

Strategic Aim 2.2

Community Outreach – Empowering Communities as Health Architects

Through Community-Based Inclusive Development (CBID), TLMTI deploys participatory models addressing WASH, nutrition, NCDs, NTDs, disability inclusion, and maternal/child health. Village health workers, SHGs, champions, and inclusive collectives will be strengthened to build responsive systems and referral pathways. Engagement with local governance will secure entitlements, social protection, and health rights. Innovations such as mobile clinics, health cafés, and telemedicine will be piloted and scaled.

This strategic priority aligns with PM Narendra Modi's National vision

“For a long time, the country has desired such a system of healthcare ... that cares about the health of the poor, protects the poor from diseases, and provides them with the best treatment if they get sick. ... Therefore, holistic healthcare has been placed among the top priorities in our country.”

Aim	Outcomes	Indicators	Core Strategies
2.1: Comprehensive Specialty Services	2.1.1: Access to high-quality, affordable, and person-centred specialty health services	• Increase in speciality services and/or TLMTI units offering these services • Population coverage with satisfaction indices.	• Upgrade and equip TLMTI hospitals to deliver designated specialties • Operationalise mobile clinics, teleconsultation platforms, and outreach camps • Launch local publicity campaigns on services offered by units • Use digital tools for promotion and feedback
	2.1.2: Lifelong care for vulnerable populations.	• Increase in elderly/ persons with disabilities care in integrated models	• Scale geriatric/palliative prototypes • Establish rehab centres with assistive tech.
2.2: Community Outreach	2.2.1: Preventive and referral linkages.	• Increased % of HH access to WASH /NTD /NCD/ MCH/ services	• Undertake joint community health programmes with local govt/ PRI functionaries • Explore funding opportunities with public health donors • Strengthen health system network from grassroots to institutional care
	2.2.2: Entitlement mobilisation.	• Number of participants availed entitlements	• Convene inclusive governance forums • Host awareness camps.

Strategic Priority 3: Environmental Consciousness and Programme Sustainability

Introduction

The Bible calls us to steward God's resources wisely. God has also placed humanity in creation "to work it and take care of it" (Genesis 2:15). Alongside this, 1 Peter 4:10 reminds us to use our gifts as faithful stewards of God's grace. Together, these verses inspire TLMTI to manage natural, financial, and human resources responsibly, building resilient systems that protect the environment, sustain operations, and serve the most vulnerable.

First embedded in the 2019–25 strategy, TLMTI's environmental initiatives promoted responsible energy, water, waste, and transport management across several hospitals and community programmes. These early efforts raised awareness and laid the foundation for greener practices. Today, a system-wide commitment is required, where every campus, hospital, and vocational training centre operates as a model of climate-conscious and resilient practice. Environmental stewardship is especially critical as climate extremes like droughts and floods exacerbate challenges in livelihoods, nutrition, and health for people affected by leprosy.

Similarly, TLMTI has progressively strengthened financial sustainability. From traditional fundraising (2007–2012) to PSU and CSR partnerships (2011–2018), and domestic resource generation with staff-led initiatives (2019–2025), the organisation has diversified its revenue base and reduced dependency on external donors. Moving forward, financial resilience will be reinforced through building reserves, enhancing operational efficiency, and developing income-generating programmes like accredited training courses.

Strategic Aim 3.1

Environment – Institutionalising sustainable practices

TLMTI will advance "green" hospitals and VTCs, building climate-conscious campuses that reduce ecological footprints, cut operational costs, and align with India's SDG 13 (Climate Action). ESG principles will guide decision-making and institutional culture, promoting resilient communities, mitigating NTD surges, and ensuring equitable health outcomes amid environmental changes.

Strategic Aim 3.2

Sustainability– Strengthening systems and financial resilience

This aim focuses on building financial reserves through operational efficiency, and diversified fundraising, while expanding accredited health sector training courses to generate revenue and expertise. Workforce capacity will be strengthened through succession planning and second-line leadership to ensure continuity of leprosy expertise. Branding and visibility efforts will position TLMTI as a trusted leader in leprosy elimination and inclusive health.

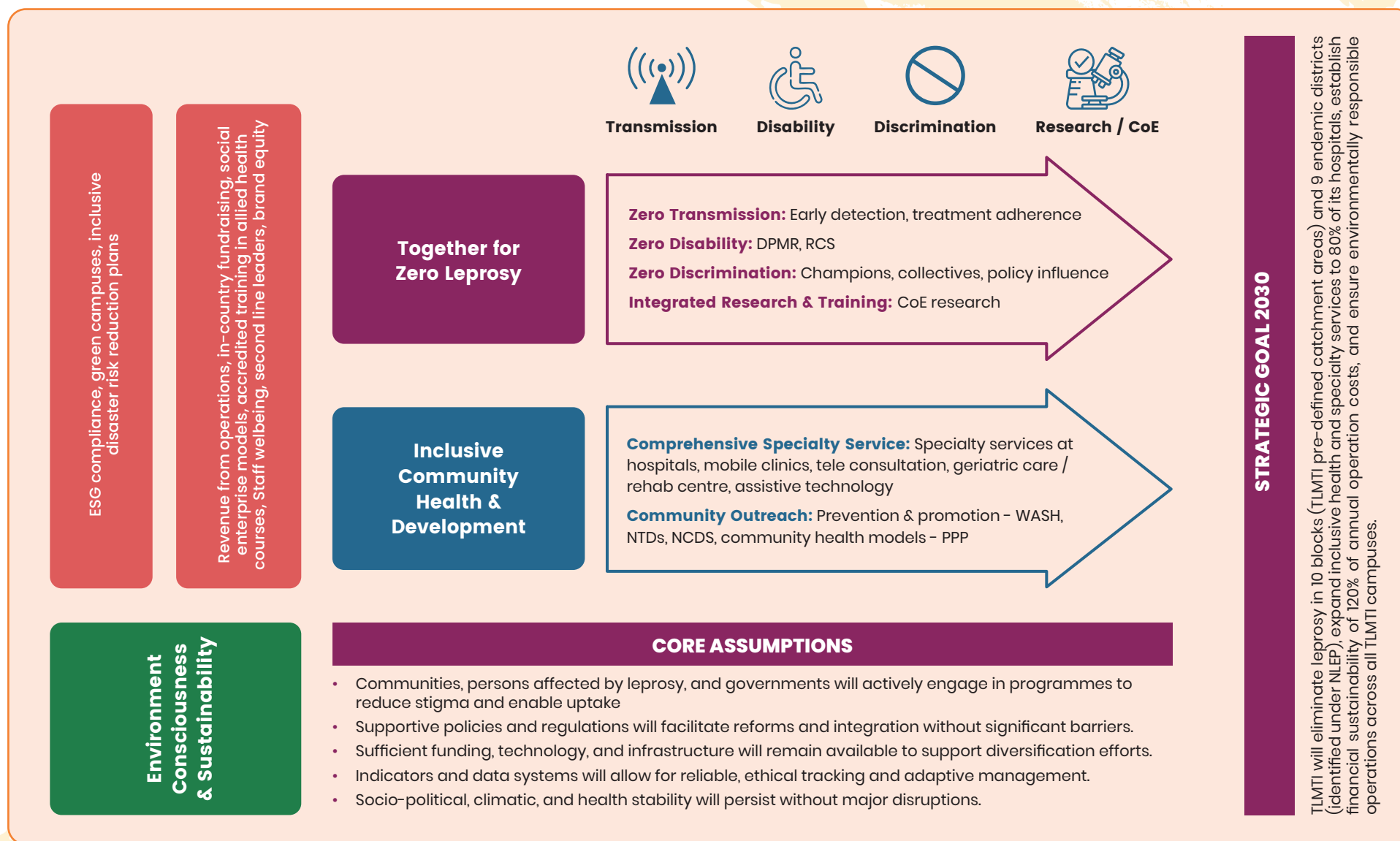
"Economy and ecology can go hand in hand, thrive together," said PM Narendra Modi, highlighting that true progress balances growth with care for creation. This priority aligns directly with the Prime Minister Narendra Modi's vision of "One Earth, One Family, One Future" which reminds us of the interconnectedness of all life on Earth and calls for promoting low-carbon development.

Aim	Outcomes	Indicators	Core Strategies
3.1: Environment	3.1.1: ESG compliance in operations	• % renewable energy adoption; • Reduced carbon footprint metrics; • Number of ESG-audited units. • Number of units that have Universal Design in accessibility	• Develop an ESG framework aligned to TLMTI's mission • Implement solar/waste management in facilities; • Promote Green Hospitals/VTCs and Campuses • Ensure infrastructure is per universal signs in accessibility • Document and disseminate ESG achievements • Execute disaster preparedness plans
	3.1.2: Inclusive disaster risk reduction.	• Number of persons affected by leprosy received inclusive DRR trainings; • Improved access to social protection. • Reduced stigma in emergency responses.	• Include climate risk mapping in all community programmes. • Train workers and leaders in climate-resilient health, disaster readiness, and early warning response

Aim	Outcomes	Indicators	Core Strategies
3.2: Sustainability	3.2.1: Operational revenue optimisation.	• Increase in % of total income from clinical/medical operations.	• Develop and implement hospital business plans
	3.2.2: Funding diversification.	• YoY increase in % in-country grant	• Define and execute in-country FR architecture • Develop the VTCs as self-sustained production and profit centers in social enterprise model (innovative revenue-generating mechanisms (graduate to trainee support, Placement service charges) • Establish a task force to develop and implement plans for optimal monetisation of TLMTI's real estate assets • Engage faith-based networks.

Aim	Outcomes	Indicators	Core Strategies
	3.2.3: Deliver Accredited Training in Allied Health Courses	• Number of TLMTI units running degree, diploma and certificate programmes in allied health courses. • Number of health professionals trained annually. • Percentage of training programme that are financially self-sufficient	• Include leprosy modules in all allied health courses. • Train and certify faculty through ToTs and exposure visits. • Upgrade labs, digital tools, and clinical practice spaces. • Form academic partnerships for recognition and scalability. • Train and certify students
	3.2.4: Talent lifecycle management.	• % of vacancies filled on time. • Number of staff engagement/development initiatives undertaken	• Implement digital HRMIS • Standardise onboarding/PMS • Adopt staff wellbeing strategies • Utilise placement agencies & church-based networks for sourcing staff • Explore innovative retention strategies for doctors (e.g., intellectual capacity development through sabbaticals, skill-aligned conferences, and advanced training opportunities, potentially abroad).
	3.2.5: Second-line leadership and Succession planning.	• % of successors identified and mentored for core roles • Number of staff groomed for second-line leadership	• Develop structured leadership training programmes. • Conduct mentoring and coaching for successors. • Provide exposure
	3.2.6: Brand equity elevation.	• Increased digital engagements to secure higher Share of Voice (SoV) in leprosy and disability domains	• Define and execute TLMTI Brand architecture • Amplify media • Pursue awards

Theory of Change for TLMTI 2026–2030 Country Strategy





Analysis and Background information

Leprosy in India: what is the Current Context and Challenges?

India's Socioeconomic Paradox

India, the world's second most populous and seventh largest country, is renowned for rapid economic growth, a skilled technological workforce, and rising affluence. Yet, this coexists with widespread poverty and deprivation, fostering conditions for neglected diseases like leprosy to persist among the poorest and most vulnerable¹.

Zero Leprosy Transmission

Disease Burden

India remains the global epicentre of leprosy, accounting for 58.1% of global new cases, with 100,957 detections in 2024–25 (NLEP). Despite national elimination in 2005 (prevalence <1/10,000), the prevalence rate today stands at 0.57 per 10,000 population. Persistence is evident in high-endemic states such as Maharashtra, Chhattisgarh, Odisha, Uttar Pradesh, Bihar, and Jharkhand, where child cases constitute 4.68% (4,722 cases) and multibacillary forms 63.0% (63,630 cases) of new detections, highlighting ongoing transmission. The disease disproportionately affects marginalised groups, with Scheduled Castes (16.7%), Scheduled Tribes (20.8%), and women (40.1%) among newly detected cases, reflecting entrenched social and economic inequities. India still has 121 high-endemic districts, with TLMTI working in 9 of them through hospital- and community-based leprosy services. This aligns with the TLM Global Fellowship Strategy 2025–2030 and its “Triple Zero” goals — zero transmission, zero disability, and zero discrimination. India aims to achieve interruption of transmission by

2027, ahead of the WHO's 2030 global target.

Case Detection

The Indian Council of Medical Research (ICMR) estimates that actual cases of leprosy detected in India could be as many as 2.5–4 times higher than the current reported figure. With elimination having been achieved, leprosy went out of the public discourse because it was assumed that the problem was over. Leprosy services were merged with general health services and while this has meant more access for treatment, it has also diluted the sharp focus the disease once received. Instead of active surveillance the system currently depends on voluntary reporting of the disease. But leprosy is still heavily stigmatised in India as detection means stigma, social isolation and loss of educational and employment opportunities, patients tend to not report early symptoms. So, by the time a patient walks in for treatment, he or she has already moved into the later stages of the disease marked by deformities and disability.

Leprosy Expertise

There is also a shortage of healthcare providers for leprosy— nurses, doctors and lab technicians with skills to detect early signs of leprosy. A lot of staff dedicated to leprosy eradication have also been dispersed into other infectious diseases such as TB and HIV infections.

Antimicrobial Resistance (AMR)

AMR is one of the critical areas of intervention in the Global Leprosy Strategy: 2020–2030 under the subheading of “stop leprosy and its complications. The emergence of drug resistance in infectious diseases poses a grave threat, especially when secondary prevention or treatment is the mainstay of therapy. Indian studies from diverse

regions report variable rates of drug resistance ranging from 0 to 16.4%. To meet the challenge of containing the disease and being able to respond to increase in circulation of drug-resistant strains, it is important to assess drug sensitivity patterns and monitor resistance among new and retreatment cases.

Zero Disability

It is estimated that there are over 3 million people with visible deformities due to leprosy in India. There are still around 750 'leprosy colonies' where over 2 lakh people live marginalised lives. What should also cause alarm bells to ring is that 9% of all new leprosy cases in India were reported among children. And that 3.87% of cases reported in the period came in after deformities had set in. Leprosy disproportionally affects the poorest, most vulnerable social groups. As per Census 2011, scheduled castes and tribes constitute 24.4% of the country's population; but 16.2% of new leprosy cases detected are from the SC population and 8.2% from ST, according to the NLEP.

Post Released from Treatment (RFT) Care/ Rehabilitation Services

The lack of focussed training and non-availability of adequate exposure to complicated cases as well as incentives have resulted in a severe shortage of healthcare professionals capable of early diagnosis and treatment of complications. There are also fewer incentives now to specialise in leprosy.

Child Disability

A recent study²⁵ observed a higher proportion of G2D at diagnosis in children (14.2%) and adolescents (21.9%) than similar studies reported from India. These disability rates indicate the possibility of long delays in diagnosis, which may be due to various access barriers to health care. Risk factors that contributed to the development of G2D in this study were MB leprosy, registration delay, nerve thickening, neuritis and the presence of household

contact cases. With these statistics it will be difficult to achieve zero G2D among children diagnosed with leprosy which is one of the key targets of the current Global Leprosy Strategy.

Stigma, Discrimination, and Social Exclusion

Though curable and non-contagious post-treatment, leprosy remains highly stigmatised in India, rooted in cultural taboos, fear, and misinformation, leading to rejection, economic marginalisation, and institutional discrimination⁸. Impacts extend to families, reducing education, livelihood, and marriage opportunities, while delaying care exacerbates disability and transmission.

Knowledge, Misconceptions, and Attitudes

Stigma persists due to misconceptions; in Delhi, <50% correctly identify leprosy's cause, with ~33% unaware and some viewing it as divine punishment⁹. Discriminatory behaviours include >50% unwilling to hire affected individuals as domestic help and ~33% opposing marriages into affected families⁹. Rural Uttar Pradesh, West Bengal, and Chhattisgarh report suspicion and rejection, especially for visible disabilities or low socioeconomic status¹⁰.

Family and Community Exclusion

Consequences are severe; in Bastar, Chhattisgarh, >90% report marital disruption, 94% isolation, and >50% job/home loss¹¹. Exclusions affect children, perpetuating intergenerational disadvantage; urban families conceal diagnoses for daughters' prospects, barring leprosy-affected households from events¹².

Gender and Structural Discrimination

Gender amplifies stigma; women face greater rejection and distress than men¹³. Bihar/Maharashtra research highlights "double jeopardy" for women—physical challenges plus isolation¹⁴; Nagpur studies confirm higher female rejection¹⁵. Vulnerabilities extend to daughters, facing marriage barriers and social exclusion¹⁶. Structural inequities

worsen this; the 1898 Lepers Act's legacy (repealed nationally) lingers in state laws, enabling divorce and harming women dependent on marital security¹⁷.

Poverty, Caste, and Intersectional Inequities

Poverty and caste compound stigma; Scheduled Castes/Tribes (25% population) account for 38% new cases, with Tribes rising from 13.3% (2009) to 18.8% (2017)¹⁸. Women in these groups face triple disadvantage—gendered stigma, poverty, and caste exclusion—isolating them from services¹⁹.

Psychosocial and Intergenerational Impact

Stigma causes profound psychosocial toll: depression, anxiety, withdrawal, reducing adherence and quality of life²⁰. Interventions like BPS-N (peer support/counselling) reduce stigma and improve well-being²¹. For women/girls, impacts are intergenerational: daughters endure education/marriage barriers due to family association²².

Confronting stigma equals halting transmission. Zero leprosy demands dismantling barriers, gender equity, and inclusion; enforce protections against abandonment, prioritise gender-sensitive services, and educate against contagion myths²³. Addressing drivers enables zero disease, disability, and discrimination.

Progress and Achievements

India has advanced leprosy control via the National Leprosy Eradication Programme (NLEP) and innovations like the Leprosy Case Detection Campaign (LCDC) for active searches, Focused Leprosy Campaign (FLC) in high-burden areas, ASHA-Based Surveillance (ABSULS) for early detection, Nikusht 2.0 for real-time data, and antimicrobial resistance guidelines⁴. Results include ANCDR declining from 5.09 to ~4.5 per 100,000 (2022–2024 estimates), G2D rate from 2.47% to 1.2 per million, and prevalence from 0.45 to 0.22 per 10,000⁵.

Commitments to Zero Leprosy

India commits to interruption of leprosy transmission in all districts by 2027, emphasizing transmission halt. It also focusses on disability prevention, and stigma eradication, aligned with WHO's 2030 global vision⁶. Integration with Sustainable Development Goals (SDGs) and 21 Neglected Tropical Diseases (NTDs) enhances visibility and resources, framing leprosy as a health, rights, and justice issue⁷.

Path Ahead

India nears elimination's last mile. While detection/prevalence reductions are significant, transmission, disabilities, and stigma persist. Achieving 2027 goals requires intensified surveillance, health systems, and integrated medical/social/legal efforts, ensuring dignity for affected—especially women, poor, and marginalised²⁴.

What is the rationale for TLM working in India?

India carries the world's highest leprosy burden, with ongoing transmission, childhood cases, and disability at diagnosis highlighting the need for sustained intervention. People affected continue to face stigma, discrimination, and poverty, making leprosy both a medical and a social challenge. With over 150 years of presence in India, TLMTI brings trusted expertise in leprosy treatment, disability management, research, and community-based rehabilitation, while partnering with the Government of India and the National Leprosy Eradication Programme. The Government of India recognises TLMTI hospitals as referral centres for complicated leprosy cases. TLMTI units provide specialised treatment for reactions management, drug resistance, ulcers, reconstructive surgery (RCS), specialised footwear, and other essential services. TLMTI is also recognised for conducting trainings for medical officers, medical students, government officials, and paramedical workers on prevention, management and

rehabilitation as a part of its efforts to strengthen health systems for achieving zero leprosy. Through its integrated approach combining biomedical care with community empowerment, TLMTI addresses the disease and its consequences, advancing national zero-leprosy goals and contributing to the Sustainable Development Goals on health, inclusion, and equality. This enduring need and TLMTI's unique expertise together form the rationale for its continued work in India.

What progress was made during previous country strategy?

2.1 Impact TLMTI Country Strategy 2019–25¹

The Strategic Objectives of Country Strategy 2019–2025 were–

- **Strategic objective 1:** Towards Zero Leprosy: Reduction in new leprosy and leprosy-related disability cases.
- **Strategic objective 2:** Community Empowerment: People affected by leprosy and disability have access to sustainable livelihoods and dignity in living.
- **Strategic objective 3:** Specialty Services in Allied Areas: Underserved communities will have access to quality services in dermatology, disability, ophthalmology and diabetes.
- **Strategic objective 4:** Thought Leader: TLMTI will influence policy in the field of leprosy, disability management and community empowerment.
- **Strategic objective 5:** Organisational Sustainability: TLMTI will build environmental and operational sustainability.

The enablers included – Resource mobilisation, Advocacy and communication, Human resource management, and Strategic partnerships.

Towards Zero Leprosy reflects TLMTI has advanced India's progress towards Zero Leprosy through strong clinical care, community interventions, and technical leadership. Early detection has reduced Grade 2 Disability among children from 72 in 2018 to 23 in 2024, while hospitals diagnose nearly 4,000 new cases and treat over 3,100 complications annually. The rise in reconstructive surgeries (316 in 2020 to 818 in 2024) and 8,000 inpatient admissions highlight its critical role in preventing disability and providing tertiary care. TLMTI also integrated mental health support, built capacity in leprosy by training health and community professionals, provided technical support to NLEP in Maharashtra and Chhattisgarh, and demonstrated replicable models to interrupt transmission in endemic areas of Champa- Janjgir (Chhattisgarh) and Chandrapur (Maharashtra).

The lack of integration across hospitals, VTCs, and community projects limits coordination and shared learning. Strengthening leadership, digital systems, and infrastructure will enable greater synergy and sustain TLMTI's impact towards Zero Leprosy. Naini can be positioned as a Global/National Centre of Excellence for advanced leprosy training, with Regional Centres at Purulia, Vadathorasalur, Faizabad, Champa, and Miraj focusing on leprosy, disability management, mental health, rehabilitation, and inclusion.

Community Empowerment has expanded access to livelihoods and dignity for people affected by leprosy and disability. By 2024, TLMTI exceeded its target by creating 72 livelihood options against 50 planned. Vocational Training Centres admitted nearly 3,600 students (including those affected, dependents, and people with disabilities), with over 90% seat utilisation and 80% placements, while Community-Based Vocational Training created employment opportunities for 3,000 more marginalised individuals. Strengthened self-help groups, OPDs, women's groups (together termed as collectives) and rights-based collectives promoted inclusion, and the "Champion" model enabled 650 leaders to reduce stigma, advocate for rights, and secure entitlements worth nearly ₹7 crore annually.

¹ End-term evaluation of Country Strategy 2019–2025

Adapting courses to changing market demands, supported by infrastructure development, can further strengthen impact. Community-based skills training, the work of Champions, and collectives federated at the national level, can further amplify the voice of people affected by leprosy, enabling greater advocacy and inclusion in policies and programmes. Greater collaboration between VTCs, community projects, and TLMTI hospitals will also help break silos and expand opportunities.

Specialty Services in Allied Areas: TLMTI has broadened its impact by expanding specialty services beyond leprosy to include dermatology, ophthalmology, diabetes, and disability care, addressing wider community health needs while ensuring hospital sustainability. Patient utilisation remained high with a little over 900,000 consultations in 2024, steady growth in diabetes services, and around 3,000 cataract surgeries each year demonstrating relevance and demand. New technologies such as 3D printing, silicone prosthetics, low-vision services, and advanced allied health tools have strengthened disability care. Entry-level NABH accreditation has been secured by 3 hospitals.

Limited availability of specialists has led to underutilisation of some services despite strong community demand. Expanding specialties based on local needs and leveraging digital tools for follow-ups can improve service reach and ensure continuity of care.

Thought Leader: TLMTI has established itself as a global leader in leprosy research, innovation, and training, shaping knowledge, practice, and policy towards Zero Leprosy. From 2019–24, it published 79 peer-reviewed papers with 650+ citations and completed 35 funded projects advancing diagnostics, drug resistance monitoring, disability prevention, stigma reduction, and mental health. The WHO-recognised Stanley Browne Laboratory has led AMR surveillance, PCR-based diagnostics, and researcher mentoring. Partnerships with national and international institutions have enabled sustained funding and multidisciplinary collaborations, influenced national

guidelines and WHO priorities while extending into NTDs, disability, and mental health. Accredited nursing and physiotherapy courses are building skilled health professionals in leprosy and rehabilitation.

Greater use of operational research, stronger systems to track research impact, and field-level documentation are needed to ensure findings inform programmes. Expanding accredited certificate, diploma, and degree programmes with integrated leprosy modules can further scale TLMTI's training initiatives.

Organisational Sustainability: TLMTI has advanced sustainability through renewable energy adoption, infrastructure upgrades, and strengthened disaster preparedness. Solar installations now supply 34% of total energy needs, cutting CO₂ emissions equivalent to preserving nearly 5,000 trees annually, while electric vehicles contribute additional cost savings. One TLMTI campus is progressing towards net-zero carbon status. Infrastructure improvements include new inpatient and OT facilities, ongoing OPD construction, and renovations of staff quarters. Disaster Management Committees are active across all units, conducting regular drills and implementing mitigation plans, with growing collaboration with local authorities to ensure continuity of healthcare during emergencies.

Reinforcing ESG frameworks and investing in staff development through mentoring, coaching, and workforce planning will support TLMTI's growth and effectiveness.

Enablers of the Country Strategy

Resource Mobilisation: TLMTI has diversified funding, aligned with CSR priorities, and achieved 77% financial sustainability through operational and fundraising initiatives by the end of 2024, (securing nearly ₹16 crore through in-country fundraising). Strengthening donor systems, adding skilled staff, and connecting field units with central fundraising can help TLMTI achieve full sustainability and build financial reserves.

Advocacy & Communication: TLMTI's advocacy has shaped policies, reduced stigma, and elevated its profile nationally and globally. Greater inclusion of lived experiences and stronger collaboration between advocacy, communication, and field units will further amplify grassroots voices and reinforce TLMTI's identity.

Human Resources: TLMTI has a strong HR base that can be further enhanced by building a culture of care and learning, strengthening systems, and investing in staff development to improve service quality and sustainability.

Strategic Partnerships: Collaborations with government, ILEP members, NGOs, businesses, and academia have expanded TLMTI's reach and credibility. Sustaining and deepening these alliances can drive systemic change and accelerate progress towards zero leprosy.

Summary of Lessons Learnt from TLMTI Country Strategy (2019–2025)

- **Integration and Coordination Are Critical for Impact:** Siloed operations across hospitals, VTCs, and community projects limit holistic care; better linkages enhance accountability, resource sharing, and outcomes (e.g., technical support to NLEP in Chhattisgarh and Maharashtra showed positive results when integrated with public health systems).
- **Community Ownership and Partnerships Drive Inclusion:** The “Champion” model and local partnerships effectively reduced stigma, improved advocacy, and linked services/social benefits, fostering self-reliance and resilience; however, weak market linkages and policy integration risk sustainability of livelihoods.
- **Diversification Enhances Relevance but Requires Investment:** Expanding allied specialties (e.g., diabetes, ophthalmology) addressed marginalised needs and supported financial sustainability, but shortage of specialists and underutilised services underscore needs for HR, infrastructure, and digital tools like follow-up counselling.
- **Research and Training Strengthen Leadership but Need Field Application:** Advances in AMR monitoring, diagnostics (e.g., PCR at SBL), and training (e.g., Naini as a centre of excellence) aligned with WHO goals, but under-utilised operational research at field level hinders programme improvements and visibility.
- **Data and Monitoring Systems Are Essential for Progress Tracking:** Absence of baselines, unclear targets, and inconsistent data collection (e.g., wellbeing metrics) made impact measurement difficult; outcomes are more feasible to track in short cycles than long-term impacts.
- **Sustainability Demands ESG Frameworks and Data-Driven Approaches:** Disaster preparedness advanced, but limited data on energy/costs/HR impeded efficiency; broadened fundraising (CSR, PSU) increased visibility but needs skilled staff and donor systems for resilience.
- **Advocacy Amplifies Voices but Requires Lived Experience Integration:** Policy changes (e.g., discriminatory law amendments) and campaigns (e.g., “Sapna Hai Kusht Mukh Bharat Ka”) boosted inclusion, but grassroots involvement of people with lived experience of leprosy must be consistent to reinforce narratives.
- **Innovation and Best Practices Offer Scalable Models:** Blending biomedical/community methods (e.g., clinical services to communities through mobile clinics, outreach, and integration with government health systems) improved detection, rehabilitation, and mental health; new initiatives demonstrate adaptability, but sustainability must be prioritised.
- **Workforce Motivation Underpins Mission:** Value-driven HR promotes quality, but strategic capacity-building is needed to attract/retain talent amid rising costs/funding uncertainties.

Recommendations of the End-Evaluation of TLMTI Country Strategy (2019–2025)

1. **Integrated Strategic Framework:** Establish a unified and accountable management system aligning hospitals, VTCs, and community projects with shared KPIs and clear leadership roles.
2. **Short-Term Vision & Strategic Alignment:** Define a five-year strategic position aligned with TLMTI's long-term vision and ensure all unit-level Multi-Year Plans (MYPs) align with it.
3. **Evidence-Based Planning:** Develop SMART indicators, baseline data, and robust systems for outcome tracking and learning.
4. **Zero Leprosy Focus:** Strengthen TLMTI hospitals as referral and training hubs and deepen partnerships with NLEP in high-endemic states.
5. **Community Empowerment:** Scale up the *Champion* model, promote collective enterprises, and modernise VTC courses in line with emerging market and health sector needs.
6. **Thought Leadership:** Expand Centres of Excellence, institutionalise operational research, and offer accredited, blended learning models.
7. **Sustainability & ESG:** Adopt environmental, social, and governance frameworks; strengthen HR systems; and ensure operational and environmental resilience.
8. **Advocacy & Fundraising:** Institutionalise A&C support to field units and expand CSR partnerships to replicate integrated, community-based models.

What are the most important opportunities and threats?

TLMTI's current environment is shaped by both internal capabilities and external forces. A combined SWOT and PESTLE analysis provide a clear picture of TLMTI's strengths, weaknesses, opportunities, and threats in the context of political, economic, social, technological, environmental, and legal factors.

SWOT Analysis

Strengths

- **Strong brand and 150-year legacy:** TLMTI's long history and reputation as a trusted organisation lend credibility and influence, positioning it as a leading voice in leprosy and inclusive health.
- **Expertise in leprosy care and research:** Decades of specialised knowledge and clinical excellence in leprosy management provide TLMTI with a unique niche that few other organisations possess.
- **Strong government and partner networks:** Well-established relationships with government agencies, civil society, and international partners enable effective collaboration, advocacy, and policy influence.
- **Operational assets (land, production units):** The organisation's land holdings, hospitals, vocational training centers, and production units provide tangible assets that support service delivery and future growth.

Weaknesses

- **Shortage of specialists and staff:** Difficulty in attracting and retaining qualified medical and allied professionals limits the organisation's capacity to deliver high-quality services consistently.
- **Weak training and knowledge transfer mechanisms:** Limited structured programmes for internal capacity building result in gaps in institutional memory and succession planning.
- **Low technology adoption and weak data systems:** Insufficient use of digital tools, data analytics, and information management systems restricts efficiency, innovation, and evidence-based decision-making.
- **Risk-averse culture:** The organisation is often hesitant to take risks, leading to delays in seizing opportunities, slow decision-making, and a lack of bold innovation.
- **Weak branding of specialist services:** Despite offering quality specialist care, limited visibility and promotion reduce recognition and potential patient reach.

Opportunities

- **Expand rural healthcare and village adoption models:** Strengthening community-based healthcare delivery can widen TLMTI's reach, especially in underserved rural areas.
- **Growth in CBID, disability, and mental health services:** Expanding beyond leprosy into broader disability-inclusive development and mental health can increase relevance and impact.
- **Increasing CSR and research funding:** Growing corporate and philanthropic interest in health, disability, and inclusion provides new avenues for financial sustainability.

- **Potential for social enterprise development:** Leveraging production units and community enterprises can create sustainable income streams while empowering people affected by leprosy and disability.

Threats

- **Dependence on donors and competition for CSR funding:** Reliance on external funding makes the organisation vulnerable to donor fatigue and competition from other NGOs.
- **Encroachments on unused or underutilised land:** Idle or underdeveloped land holdings face the risk of encroachment, potentially eroding TLMTI's long-term financial assets.
- **Competition from private healthcare providers:** The increasing presence of private clinics in both urban and semi-urban areas may reduce TLMTI's patient base and weaken its community influence.
- **Talent loss and staff attrition:** High staff turnover and migration of skilled professionals to urban areas threaten institutional continuity and service quality.
- **Geo-political and medico-legal risks:** Political instability, regulatory changes, and medico-legal challenges may disrupt operations and create compliance risks.

Strategic Implications

TLMTI can leverage its strong brand, legacy, and expertise in leprosy to expand into emerging areas of community health, disability, and mental health, while positioning itself as a trusted partner for government and CSR initiatives. Its operational assets and partner networks provide a foundation for scaling social enterprise models and rural healthcare interventions. At the same time, TLMTI must address internal weaknesses by strengthening talent pipelines,

investing in technology and data systems, and embedding robust knowledge-transfer mechanisms. To remain competitive and sustainable, the organisation needs to diversify funding sources, proactively manage its land and infrastructure, and differentiate its specialist services to stand out against private sector competition. Building an innovation-oriented culture and reinforcing institutional resilience will ensure that TLMTI is equipped to mitigate risks and continue leading the movement towards Zero Leprosy and inclusive health.

The following PESTLE analysis highlights the key external factors influencing TLMTI's work in leprosy, inclusive health, and community empowerment:

Factors	Key Insights	Strategic Implications for TLMTI
Political	- Strong government commitment to leprosy elimination via NLEP. - Leprosy declared notifiable in May 2025 for mandatory reporting and surveillance. - Positive disability and inclusion policies. - Risk of shifting government priorities and reduced funding for leprosy programmes.	TLMTI will build on government commitment and disability frameworks to strengthen advocacy and partnerships, while expanding funding sources to reduce reliance on fluctuating political priorities.
Economic	- Declining poverty rates but high out-of-pocket health expenses push millions into poverty. - Expanding CSR funding and donor base. - Rising healthcare costs and donor fatigue in leprosy-specific funding.	TLMTI will leverage CSR and broader health financing streams, while adapting its service models to remain affordable and sustainable beyond leprosy-specific donor support.
Social	- Persistent stigma and discrimination against people affected by leprosy. - Growing acceptance and empowerment through community Champions. - Urbanisation, migration, and youth aspirations changing healthcare and livelihood needs.	TLMTI will deepen anti-stigma work through Champions and evolve health and livelihood interventions to remain relevant for urban populations and younger generations.
Technological	- Rapid growth of telemedicine, e-health, and mobile applications. - Innovations in diagnostics (PCR, AMR testing). - Scope for vocational training with digital, green, and healthcare-related courses.	TLMTI will invest in digital health solutions, adopt advanced diagnostic tools, and expand training programmes aligned with emerging employment sectors.
Environmental	- Climate risks and natural disasters affect vulnerable communities. - Rising energy costs. - Opportunity for ESG adoption: renewable energy, waste management, green livelihoods.	TLMTI will embed environmental stewardship across its campuses and programmes, advancing green livelihoods and climate resilience while reducing operational costs.
Legal	- Stronger disability rights and anti-discrimination laws. - RPWD Act 2016 upheld in 2025 rulings for accessibility and judicial eligibility for visually impaired. - FCRA amendments tighten funding, requiring detailed disclosures for NGOs. - Increasing compliance requirements (NABH accreditation, HR laws).	TLMTI will strengthen compliance and governance systems while actively leveraging disability rights legislation to expand inclusion and access for people affected by leprosy.

Ways of Working

TLMTI's ways of working are as follows:

Faith-Based Identity

Grounded Christ-centred values, TLMTI will reflect love, compassion, equality, and dignity in all its relationships, while equipping local churches as partners in transformation.

Integrated Programme Approach

TLMTI will establish a unified framework with cross-unit linkages and accountability mechanisms, ensuring convergence and coordination across domains, hospitals, VTCs, and community projects to maximise collective impact.

Community-Based Approaches

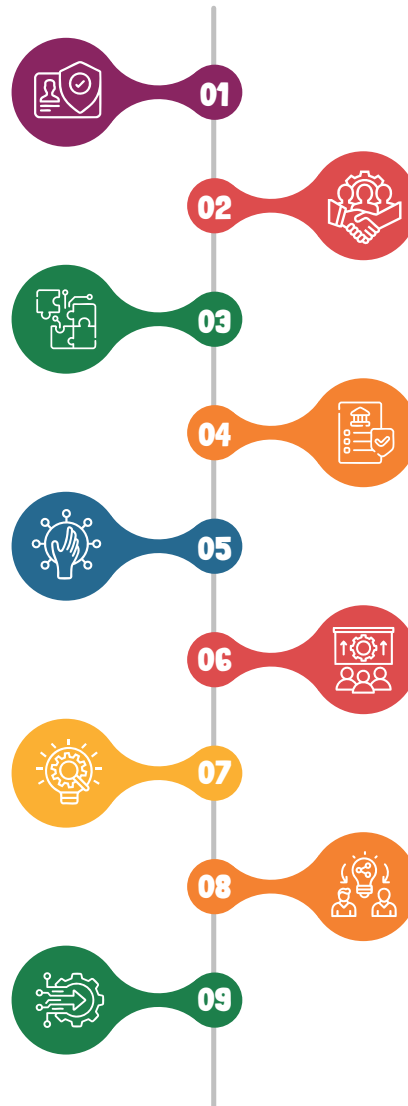
TLMTI will empower communities through collectives, and inclusive local structures, promoting resilience and ownership of development initiatives.

Research, Innovation, and Evidence

TLMTI will generate new evidence and innovative models through research work and partnerships, sharing insights nationally and globally to shape policies and practices.

Technology Integration

TLMTI will position technology as a pivotal component in all programmes and operations, with a systematic review of its role in achieving cost savings and efficiencies



Partnerships and Collaborations

TLMTI will strengthen collaborations with people affected by leprosy, government, WHO, ILEP, research institutions, NGOs, private sector, and local churches to integrate leprosy and disability issues into mainstream development and expand reach.

Advocacy and Policy Influence

TLMTI will influence laws, policies, and programmes to remove discrimination, harmonise legislation, and ensure people affected by leprosy and disabilities are heard in decision-making.

Capacity Building and Training

TLMTI will strengthen institutional and workforce capacity, while also investing in continuous professional development of staff. This will create a skilled workforce equipped for leprosy and disability-responsive care.

Knowledge Sharing and Communication

TLMTI will share research, stories, and best practices to influence policy, challenge stigma, and strengthen TLMTI's positioning as a trusted leader in leprosy and inclusion. It will also publish columns, articles, and case stories in mainstream journals to highlight leprosy-related issues and TLMTI's work.

What TLMTI needs to change about its working

TLMTI must enhance integration, innovation, and sustainability. This includes refining project portfolios, strengthening organisational capacity, and boosting resource mobilisation to advance triple-zero goals.

Project Development

- Refer to the internal Glasscubes link for the current portfolio encompassing 15 hospitals, 7 VTCs, 4 residential facilities, community initiatives in 9 states, Stanley Browne Laboratory research, Research domain and Advocacy Domain.
- **Projects to Retain:** Core leprosy programmes like hospital clinical care (~4,000 annual diagnoses, 818 reconstructive surgeries in 2024), community empowerment (e.g., self-help groups and champions, securing ₹7 crore in entitlements yearly), and VTCs (~3,600 students with 80% placements). These support zero transmission, zero disability, and zero discrimination in high-impact districts such as Champa-Janjgir and Chandrapur.
- **New Projects to Develop:** Integrated models on zero leprosy (such as satellite rehab hubs for CBID, mental health, and climate-resilient livelihoods) with in-built operational research & digital technology; Community health models with PPP²; expand accredited training (e.g., certificate & degree courses), regional CoE in leprosy.

Organisational Development

- **Physical and Human Resources Capacity:** Recruit/retain specialists (e.g., dermatologists), Upgrade infrastructure with solar (34% current usage) toward net-zero, Build leadership through mentoring and succession planning.
- **Systems and Processes:** Deploy digital HR for performance/ wellbeing; embed operational research and field documentation. Cultivate innovation via cross-unit collaboration, ESG integration for resilience.

Resource Development

TLMTI's strategy emphasises diversification and self-sufficiency, building on 2024's 77% sustainability to a 120% by 2030.

- **Key Initiatives:** Expand in-country fundsising, social enterprises, and operational revenue from services/training. explore grants for advocacy/research. and asset monetisation (e.g., land for eco-developments).

² Public–Private Partnership

What risks affect the strategy and how are these being mitigated?

Risk Category	Risk Description	Likelihood	Impact	Risk Level	Mitigation Strategies	Responsible Party
Operational	Siloed operations across hospitals, VTCs, and community projects limiting holistic care and coordination.	Medium	High	High	Establish integrated strategic management framework with cross-unit linkages and accountability mechanisms (per Recommendation 1). Implement regular reviews and domain sub-strategies (Recommendation 6).	Senior Management / Knowledge Management Head
Operational	Shortage of specialists and staff, leading to underutilised services and gaps in allied specialties.	High	High	High	Prioritise specialist recruitment via targeted talent acquisition strategies; develop leadership pipelines and structured training (per HR recommendations). Collaborate with NLEP for capacity-building.	HR Department / Medical Superintendents
Financial	Heavy dependence on donors and CSR competition, risking funding shortfalls amid donor fatigue.	High	High	High	Diversify funding through CSR/PSU ties, social enterprises, and asset leverage (e.g., VTCs as profit centres). Strengthen donor engagement systems and fundraising staff.	Fundraising Team / Finance Department
Human Resources	Talent loss and attrition due to motivational gaps, unclear roles, and rising costs.	Medium	Medium	Medium	Implement digital HR systems for performance tracking; foster a culture of care with wellbeing strategies; clarify roles via succession planning.	HR Department

Risk Category	Risk Description	Likelihood	Impact	Risk Level	Mitigation Strategies	Responsible Party
Environmental	Climate anomalies (e.g., floods, droughts) amplifying leprosy transmission, disabilities, and community vulnerabilities.	High	High	High	Embed ESG principles with renewable energy adoption and DRR training; conduct vulnerability assessments; integrate climate-resilient models in health systems (per sustainability recommendations).	Programme Managers / Environmental Lead
Legal/Political	FCRA amendments and shifting government priorities tightening foreign funding and programme support.	Medium	High	High	Enhance compliance with NABH/HR laws; strengthen NLEP partnerships for technical support; monitor policy changes via advocacy coalitions.	Advocacy & Legal Team
Reputational	Persistent stigma and weak branding of specialist services reducing visibility and partnerships.	Medium	Medium	Medium	Amplify advocacy with PwL-led campaigns; elevate brand through media and awards; curate best-practice repositories.	Advocacy & Communication Team
Strategic	Inconsistent data collection and under-utilised operational research hindering progress tracking and evidence-based decisions.	High	Medium	Medium	Develop Results Framework with SMART indicators and baselines (Recommendation 5); institutionalise field-level research and documentation.	Knowledge Management / Research Team
Geo-political/ Medico-legal	Geo-political risks and medico-legal challenges (e.g., land acquisition, litigation) disrupting operations.	Low	High	Medium	Conduct regular risk assessments; secure land/assets through legal reviews; build disaster preparedness plans.	Senior Management / Legal Team

How will the change be monitored and evaluated?

The Monitoring and Evaluation (M&E) Plan for the TLMTI Country Strategy 2026–2030 integrates key performance indicators from the TLM Global Fellowship, such as reductions in new child cases, the repeal of discriminatory laws, and sustainable funding growth/ROI. It adopts a results-based management approach with a tiered structure: inputs and activities monitored half-yearly, outputs and outcomes assessed annually and at mid-term, and a comprehensive end-term evaluation.

A sample draft Monitoring Framework is provided as Annexure 1. Once the strategy is finalised, this framework will be developed accordingly with baseline data and end-term targets (some are provided in the sample draft as examples), digitalised, and used to guide the development of annual plans with SMART indicators aligned to the framework. Progress will be regularly tracked and reviewed using digital tools to strengthen accountability, learning, and adaptive management throughout the strategy period.

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Annexure–1

Monitoring and Evaluation Matrix for TLMTI Country Strategy Plan 2026–2030

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead	
Strategic Priority 1: Together for Zero Leprosy (Transmission, Disability, Discrimination, Research)	1.1: Zero Transmission	1.1.1: Early detection and treatment adherence in pre-defined catchment areas (blocks) around hospitals.	Execute hyper-local BCC campaigns; Implement ACF via screenings, contact tracing; Use AI and digital tools for surveillance and treatment compliance; Establish and scale Leprosy-free blocks; Integrate screenings in PHC camps; Capacitate district health cadres.	YoY percentage reduction of new leprosy cases with G2D at diagnosis	The annual change in the percentage of newly diagnosed leprosy patients who present with Grade 2 Disability at the time of diagnosis, compared to the previous year, in TLMTI catchment areas.	TBD (To Be Determined)	<1% [over 5 years]	1. Hospital / HMS register – 2. NLEP records	Record the number of newly diagnosed leprosy patients with Grade 2 Disability at diagnosis, verified through standardised disability assessments.	$G2D\% = \frac{\text{New G2D cases}}{\text{Total new leprosy cases}} \times 100$	Biannual	Superintendent –Hospital	Health & SL&E	
				YOY percentage reduction in the newly diagnosed children with leprosy (<15 years) at diagnosis.	The annual change in the percentage of newly diagnosed children with leprosy under 15 years of age, compared to the previous year, in TLMTI catchment areas.	TBD	0 cases [over 5 years]	1. Hospital / HMS register – 2. NLEP records	Identify new leprosy cases under 15 years of age each year, calculate their proportion among total new cases	$\text{Childs} = \frac{\text{New Child cases having age less than 15}}{\text{Total new leprosy cases}} \times 100$	Biannual	Superintendent –Hospital	Health & SL&E	
		1.1.2: Prevention and hotspot management (NLEP partnered Endemic districts).		Reduced NCDR per 100k	Annual new case detection rate (NCDR) per 100,000 population in endemic areas	TBD	<1 per 100k in 9 endemic districts [over 5 years]	District Leprosy Programme reports; GIS hotspot mapping	Record the total number of newly diagnosed leprosy cases in the given geography	$NCDR = \frac{\text{New leprosy cases}}{\text{Total Population}} \times 100000$	Annual	Community Outreach Lead	Health & SL&E	
				% hotspots under digital monitoring.	The proportion of identified leprosy hotspots in the district that are actively tracked through digital tools (e.g., mobile apps, dashboards, GIS, electronic registers).	TBD	100% in operational areas [annual]	AI/digital surveillance tools	Identify leprosy hotspots and verify the number actively monitored using digital tools such as mobile apps, dashboards, GIS, or electronic registers.	$\text{Hotspot tracking \%} = \frac{\text{Hotspots tracked digitally}}{\text{Total identified hotspots}} \times 100$	Biannual	Community Outreach Lead	Health & SL&E	

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
	1.2: Zero Disability	1.2.1: Continuum of DPMR from detection to rehabilitation.	Utilise tech-enabled early impairment detection; Standardise protocols for acute episodes; Augment reconstructive surgery and follow-up.	Proportion of patients completing 12 months of MDT with improved disability status	The proportion of leprosy patients who, after completing a full 12-month course of Multi-Drug Therapy (MDT), show documented improvement in their WHO disability grading.	TBD	<1% [annual]	Physio records	Compare WHO disability grades at treatment initiation and after completing the 12-month MDT course	$\text{Improvement} = \frac{\text{Patients with improved grading}}{\text{Patients completing 12-month MDT}} \times 100$	Annual	Superintendent -Hospital	Health
				% timely reaction/neuritis interventions	Proportion of acute neuritis or reaction cases who received corticosteroid/ appropriate treatment within 1 week of symptom onset.		>95% [annual]	Physio records	Determine the number of acute neuritis or reaction cases that received corticosteroid or appropriate treatment within one week of symptom onset.	$\text{Timely Treatments} = \frac{\text{Cases treated within 1 week}}{\text{Total acute neuritis/reaction cases}} \times 100$	Biannual	Superintendent -Hospital	Health
				Increase in annual surgical volume.	Total number of reconstructive surgery procedures conducted annually in TLMTH facilities compared with baseline year.	818	>5000 [over 5 years]	Physio records	Compare the total number of reconstructive surgery procedures conducted each year with the baseline year	$\text{Changes} = \frac{\text{Current year surgeries} - \text{Baseline year surgeries}}{\text{Baseline year surgeries}} \times 100$	Annual	Superintendent -Hospital	Health
		1.2.2: Community-based rehabilitation for functional autonomy.	Establish satellite hubs linked to tertiary facilities Deliver DPMR (assessments, physiotherapy, prosthetics) Train frontline workers.	Number of programmes in operational areas.	Count of satellite CBR hubs that are operational and linked to tertiary facilities, offering DPMR services (physiotherapy, prosthetics, assessments). A hub is considered functional if it provides at least 2 core services monthly.	Partial coverage in areas around hospitals + 3 blocks in Chidambaram	100% coverage in 10 blocks around hospitals [annual] + 2 new blocks/ year	Community Outreach records	Verify the number of operational satellites CBR hubs linked to tertiary facilities that provide at least two core DPMR services each month.	Count of hubs providing ≥ 2 core services monthly	Biannual	Community Outreach Lead	Health
				% people affected by leprosy achieving ADL independence.	Proportion of people affected by leprosy enrolled in CBR programmes who demonstrate independence (or significant improvement) in Activities of Daily Living (ADL) after intervention.	TBD	>80% of participants [annual]	Community Outreach records	Pre- and post-intervention assessments using standardised ADL evaluation tools (Salsa scores - baseline vs 6- and 12-month report) to measure the proportion of participants showing independence or significant improvement	$\text{ADL Improvement} = \frac{\text{Persons with ADL improvement}}{\text{Total CBR-enrolled persons}} \times 100$	Biannual	Community Outreach Lead	Health

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
		1.2.3: Psychosocial support integration.	Embed MH screenings in clinical workflows: Upskill caregivers for referrals.	Number of sites offering MH services	Count of TLMTI facilities or community hubs where standardised MH screening and referral services are embedded into routine leprosy/DPMR clinical workflows. A site qualifies if it consistently applies MH screening and referral at least once per week.	TBD	>80% of hospitals/ VTCs [over 5 years]	Hospital/VTC/ Community records	Verify the number of TLMTI facilities or community hubs consistently conducting standardised MH screening and referral services at least once per week.	Count of sites conducting weekly MH screening & referral	Biannual	Hospital-Superintendent/ VTC- Principal/ Community Outreach Lead	Health
				% improved QoL scores.	Proportion of patients showing improvement in QoL scores after 6–12 months of integrated MH support.	TBD	>75% patients with improved QoL [annual]	QoL surveys (e.g. WHOQOL-BREF, WHO 5), patient interviews	Baseline and follow-up QoL assessments using standardised questionnaires administered to patients receiving integrated mental health support at 6 monthly intervals	$\text{QoL improvement} = \frac{\text{Patients with improved QoL scores}}{\text{Total supported patients}} \times 100$	Annual	Hospital - Superintendent/ VTC - Principal/ Community Outreach Lead	Health
	1.3: Zero Discrimination	1.3.1: Rights-based inclusive policies and practices.	Form advocacy coalitions; Disseminate reports on access to rights	Number of policy engagement activities conducted	Total number of advocacy events, consultations, meetings, or workshops held with policymakers, legislators, or government departments to influence rights-based policies for people affected by leprosy	TBD	>50 engagement activities [over 5 years]	Advocacy reports	Count all advocacy events, consultations, meetings, or workshops conducted with policymakers, legislators, or government departments.	Total number of events held annually	Biannual	Community Outreach Lead	A & C and SL&E
		1.3.2: Empowerment of champions and collectives	Promote champions from within leprosy affected communities: Build/strengthen grassroots & national federations: Support socio-economic collectives (like SHGs, producers' groups). Curate best-practice repositories.	Number of federated networks	Count of grassroots, district, state, or national-level federations formed or supported to represent the rights and interests of people affected by leprosy. A federation is considered "functional" if it meets at least twice a year and has an active membership base.	4 at District level (Maharashtra, Tamil Nadu, Chhattisgarh & Uttar Pradesh)	>16 at District level, >6 at state level & 1 at National level [over 5 years]	Programme reports, federation meeting records	Verify the number of federations (at the three tiers) formed or supported that meet at least twice a year.	Count of federations meeting >2 times/year with active membership	Biannual	Community Outreach Lead	A & C and SL&E

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
				Number of self-led awareness and advocacy initiatives.	Count of initiatives (e.g. awareness campaigns, advocacy drives, livelihood projects) independently planned and executed by champions or federations/collectives without direct project management.	650 Champions; > 50 initiatives/year	> 1000 initiatives [over 5 years]	Programme reports, Case stories, and self-reported documentation from champions or federations	Verify initiatives independently planned and executed without direct project management support.	Total number of initiatives executed without direct project management	Biannual	Community Outreach Lead	A & C and SL&E
		1.3.3: Inclusive skilling and livelihoods	Ensure enrolment and continuum in educational institutions; Deliver market-aligned skilling; Facilitate dignified income streams.	Number of children and youth from leprosy-affected households who have access to education	The enrolment and retention of children and youth from leprosy-affected households in mainstream schools & professional institutions. Education access is defined as enrolment and continued attendance for at least one academic term.	600 students affected by leprosy	All eligible children and youth from leprosy-affected households in programme geographies [annual]	Community Outreach records	Track the enrolment and continued attendance of children and youth from leprosy-affected households for at least one academic term.	$\text{Education Access} = \frac{\text{Children/youth enrolled \& retained}}{\text{Total eligible children/youth}} \times 100$	Biannual	Community Outreach Lead	SL and E
				Increased % training completion	Proportion of enrolled youth from leprosy-affected households who successfully graduate.	96% VTC utilisation	96-100% VTC utilisation [annual]	VTC reports	Determine the proportion of enrolled youth from leprosy-affected households who successfully graduate.	$\text{Graduation\%} = \frac{\text{Graduated youth}}{\text{Total enrolled youth}} \times 100$	Annual	Principal- VTCs	SL and E
				Increased % employment gains.	Proportion of trained individuals who secure employment, self-employment, or livelihood opportunities within 6 months of training completion.	88%	88-95% [annual]	VTC/ Community Outreach records	Determine the proportion of trained individuals who secure employment, self-employment, or livelihood opportunities within six months of completing training.	$\text{Employments} = \frac{\text{Individuals employed/self-employed within 6 months}}{\text{Total trained individuals}} \times 100$	Biannual	Principal- VTCs	SL and E

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
	I.4: Integrated Research, innovation, and Centres of Excellence (CoE) in Leprosy	I.4.1: Evidence based research and innovative solutions	Partner for leprosy-related research; Develop field-based research projects and translate recommendations into innovative actions; Publish articles, research work, and case studies and present papers/ articles in national and international forums; Disseminate policy level recommendations through research.	Number of peer-reviewed publications on zero transmission, disability & discrimination	Count of research articles, reviews, and case studies authored/co-authored by TLMTI staff/partners published in peer-reviewed journals under the three core themes.	79 (2019-2024)	>125 publications [over 5 years]	Research reports	Count of research articles, reviews, and case studies authored or co-authored by TLMTI personnel under the three core themes.	Total number of articles, reviews, case studies published	Biannual	SBL head, senior researchers, Hospital-Superintendent/ VTC- Principal/ Community Outreach Lead	KM
				% adoption of findings in TLMTI programmes.	Proportion of research recommendations that are incorporated into TLMTI policies, guidelines, or programme interventions.	TBD	>80% adoption [over 5 years]	Research reports, Policy and programme reports	Determine the proportion of research recommendations adopted into TLMTI policies, guidelines, or interventions.	$\text{Adoption\%} = \frac{\text{Recommendations adopted}}{\text{Total recommendations made}} \times 100$	Annual	SBL head, senior researchers, Hospital-Superintendent/ VTC- Principal/ Community Outreach Lead	KM
				Number of innovative models executed	The number of new or improved intervention models, approaches, or practices that have been designed, piloted, or implemented based on findings or recommendations emerging from TLMTI-supported research	TBD	> 15 models [over 5 years]	Programme reports and pilot project documentation	Track the number of new or improved intervention models, approaches, or practices developed from TLMTI-supported research findings or recommendations.	Count of models designed/piloted/ implemented from research	Annual	Hospital-Superintendent/ VTC- Principal/ Community Outreach Lead	KM
		I.4.2: Sustain Leprosy Expertise	Define clear parameters for classifying unit as CoE in leprosy; Expand regional Centres of Excellence in leprosy; Train health and development professionals; Execute Business Plans for financial sustainability of CoE.	Number of TLMTI centres functioning as regional Centres of Excellence in leprosy.	Count of TLMTI facilities formally recognised (internally or by external accrediting agencies) as Centres of Excellence, meeting predefined standards in service delivery.	1- Naini (to be assessed against predefined standards)	6 regional centres [over 5 years]	Reports of the Centre of Excellence	Count TLMTI facilities formally recognised as Centres of Excellence meeting predefined service delivery standards.	Total number of facilities recognised as CoEs	Biannual	Centre of Excellence-Incharge	Health

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
				Number of health professionals (health & development) trained annually through CoE.	The total number of health and development professionals who successfully complete structured training programmes organised by the Centre of Excellence (CoE) within a given year. Trainings may include short-term courses, workshops, certificate programmes, or skill enhancement sessions focused on leprosy, disability inclusion, community health, mental health, rehabilitation, or related development themes.	~2500/year	>20000 [over 5 years]	Reports of the Centre of Excellence	Record the total number of health and development professionals successfully completing structured training programmes each year	Total number completing CoE training annually	Biannual	Centre of Excellence-Incharge	Health
				Percentage of self-sufficiency of CoE	The proportion of the Centre of Excellence's (CoE) total annual operational expenses that are met through its own income-generating activities (such as training fees, consultancy services, research grants, or product sales).	TBD	>70% self-sufficiency [over 5 years]	Reports against Business Plans/ Financial reports	Calculate the proportion of annual operational expenses covered by its own income-generating activities.	Self financing % = $\frac{\text{Income from CoE activities}}{\text{Total CoE operational expenses}} \times 100$	Biannual	Centre of Excellence-Incharge	KM

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
Strategic Priority 2: Community Health and Development	2.1: Comprehensive Specialty Services for Persons affected by Leprosy and Disabilities and marginalised	2.1.1: Access to high-quality, affordable, and person-centred specialty health services	Upgrade and equip TLMTI hospitals to deliver designated specialties (Operationalise mobile clinics, teleconsultation platforms, and outreach camps.)	Increase in consultations in specialty services and/or TLMTI units offering these services	The number of consultations (specialty wise) through TLMTI hospitals	> 900,000 consultations	>1,200,000 consultations [over 5 years]	Hospital reports	Count the number of consultations conducted in each specialty at TLMTI hospitals	Sum of Consultations per specialty for all hospitals)	Biannual	Superintendents-Hospitals	Health, Finance
				Population coverage with satisfaction indices.	The proportion of the target population served by TLMTI programmes who report satisfaction with services received, measured through standardised satisfaction surveys or feedback mechanisms.	TBD	>80% coverage; >85% satisfaction [over 5 years]	Standardised satisfaction surveys, feedback forms, and structured interviews	Analysis of standardised satisfaction surveys, feedback forms, and structured interviews administered to the target population served by TLMTI programmes	$\text{Satisfaction\%} = \frac{\text{Satisfied respondents}}{\text{Total surveyed population}} \times 100$	Annual	Superintendents-Hospitals	Health
		2.1.2: Lifelong care for vulnerable populations.	Scale geriatric/ palliative prototypes; Establish rehabilitation centres with assistive technology.	Increase in elderly/ persons with disabilities care in integrated models	Increase in the number or percentage of elderly persons and persons with disabilities accessing comprehensive, integrated care models (hospital + community-based + social protection services).	4 Residential facilities for elderly affected by leprosy)- 31 elderly availing services	5 additional facilities; >100 elderly availing services (residential/ community based)/year [over 5 years]	Hospital and community programme records	Track the number or percentage of elderly persons and persons with disabilities accessing comprehensive, integrated care models.	$\text{Access Change\%} = \frac{\text{Current year access} - \text{Baseline access}}{\text{Baseline access}} \times 100$	Biannual	Unit heads	Health
	2.2: Community Outreach	2.2.1: Preventive and referral linkages.	Roll out bundled interventions; Strengthen CHW-to-facility networks.	% of households receiving bundled preventive interventions	Proportion of targeted households reached with at least 2 or more bundled preventive services (e.g., nutrition, hygiene, health screening, health education).	0	>80% HHs in geography around hospitals [over 5 years]	Community programme reports	Determine the proportion of targeted households that received two or more bundled preventive services (with details of services received).	$\text{Coverage\%} = \frac{\text{Households reached with } \geq 2 \text{ services}}{\text{Total targeted households}} \times 100$	Biannual	Superintendents-Hospitals	Health & SL&E
		2.2.2: Entitlement mobilisation.	Convene inclusive governance forums; Host awareness camps.	Number of participants availed entitlements	Total number of individuals who have successfully accessed and utilised health-related entitlements or schemes (such as disability certificates, Ayushman Bharat cards, health insurance benefits, assistive devices, or free/subsidised medical services) through facilitation or linkage	0	>90% of the participants [over 5 years]	Community programme reports	Count individuals who have successfully accessed and used health-related entitlements or schemes.	Total number of individuals successfully linked to schemes	Biannual	Superintendents-Hospitals	Health & SL&E

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
Strategic Priority 3: Environmental Consciousness and Sustain-ability	3.1: Environment	3.1.1: ESG compliance in operations.	Convene inclusive governance forums; Host awareness camps. Develop an ESG framework aligned to TLMTI's mission; Implement solar/waste management in facilities; Promote Green Hospitals/VTCs and Campuses; Ensure infrastructure is per universal signs in accessibility; Document and disseminate ESG achievements; Execute disaster preparedness plans.	% renewable energy adoption	The proportion of total energy consumption within a campus that is derived from renewable energy sources compared to total energy consumption from all sources	34%	>70% [over 5 years]	Hospital/VTC Programme reports Audit reports	Calculate the proportion of total energy consumption derived from renewable sources	$\frac{\text{Renewable energy consumption}}{\text{Total energy consumption}} \times 100$	Biannual	Hospitals-Superintendents; VTCs- Principals	Health, SL & E, ARM
				Reduced carbon footprint metrics	The estimated number of trees that have been effectively preserved by reducing carbon emissions through renewable energy use, energy efficiency, and other eco-friendly practices.	Equivalent to 5000 trees preserved	Equivalent to 20,000 trees preserved [over 5 years]	Hospital/VTC Programme reports Audit reports	Calculate the total reduction in carbon dioxide (CO ₂) emissions achieved through interventions such as renewable energy use, energy efficiency measures, or waste reduction. Convert this CO ₂ reduction into an equivalent number of trees preserved using standard conversion factors (e.g. the average CO ₂ absorption per tree per year).	Estimated count based on carbon offset calculations	Biannual	Hospitals-Superintendents; VTCs- Principals	Health, SL & E, ARM
				Number of ESG-audited units.	Number of TLMTI units undergoing ESG audits.	0	100% units audited [over 5 years]	Hospital/VTC Programme reports Audit reports	Records of all units or facilities that have completed a formal ESG audit	Total number of units audited annually	Annual	Hospitals-Superintendents; VTCs- Principals	Health, SL & E, ARM
				Number of units that have Universal design in accessibility	The total count of units that have been designed or modified to ensure barrier-free access for all individuals in line with Universal Design principles.	All units with partial universal design in accessibility	all units with 100% universal design in accessibility [over 5 years]	Hospital/VTC Programme reports Audit reports	Count of units that have universal design in accessibility	Count of units meeting Universal Design standards	Annual	Hospitals-Superintendents; VTCs- Principals	Health, SL & E, ARM

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
		3.1.2: Inclusive disaster risk reduction.	Include climate risk mapping in all community programmes; Train workers and leaders in climate-resilient health, disaster readiness, and early warning response.	Number of persons affected by leprosy participating in inclusive DRR trainings	Count of leprosy-affected persons trained in disaster risk reduction, with inclusive participation ensured.	198	>1000 trained [over 5 years]	Community Outreach reports	Count of leprosy-affected persons who have received disaster risk reduction training with inclusive participation.	Total number of persons trained with inclusive participation	Annual	Community Outreach Lead	SL&E
				Improved access to social protection	Increase in the proportion of people affected by leprosy successfully linked to social protection schemes compared to baseline.	>90% access in community projects	>90% access [over 5 years]	Community Outreach reports	Measure the increase in the proportion of people affected by leprosy successfully linked to such schemes compared to baseline.	$\text{Linkage Change} = \frac{\text{Current year linked persons} - \text{Baseline}}{\text{Baseline}} \times 100$	Biannual	Community Outreach Lead	SL&E
	3.2: Sustainability	3.2.1: Operational revenue optimisation.	Develop and implement unit business plans.	Increase in % of total income from clinical/medical operations.	Year-on-year increase in the proportion of TLMTI income generated from medical services (consultations, diagnostics, hospital operations).	77% self-sufficiency	100% self-sufficiency [over 5 years]	Finance report	Calculate the year-on-year increase in the proportion of income generated from medical services	$\text{Medical Income Change} = \frac{\text{Current year income} - \text{Previous year income}}{\text{Previous year income}} \times 100$	Quarterly	Hospital BoH	Finance
		3.2.2: Funding diversification.	Define and execute in-country FR architecture; Develop the VTCs as self-sustained production and profit centers in social enterprise model; Establish a task force to develop and implement plans for optimal monetisation of TLMTI's real estate assets; Engage faith-based networks.	YoY increase in % in grant and retail donations	Year-on-year growth in the share of TLMTI revenue from external grants and retail donations.	11%	50% [over 5 years]	Fundraising Report	Calculate the year-on-year growth in the share of revenue from external grants and retail donations. Collated by admin manager Finance	$\text{Grant/Donation Growth} = \frac{\text{Current year revenue} - \text{Previous year revenue}}{\text{Previous year revenue}} \times 100$	Quarterly	FR BoH	Finance
					A VTC will be counted as self-sustained if its revenue from production activities covers its operating costs and shows a positive net balance or profit contribution.	0%	3 [over 5 years]	VTC Reports	Count the number of centers whose production revenue covers operating costs and generates a positive net balance.	Count of VTCs with revenue $\geq$ operating costs and positive net balance	Quarterly	VTC BoH	Finance

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
	3.2.3: Deliver Accredited Training in allied Health Courses	Include leprosy modules in all allied health courses; Train and certify faculty through ToTs and exposure visits; Upgrade labs, digital tools, and clinical practice spaces; Form academic partnerships for recognition and scalability; Train and certify students.	Number of TLMTI units running degree, diploma, and certificate programmes in allied health courses.	Total count of TLMTI institutions offering accredited education in allied health sciences.	6 (Purulia, Naini, Vadathorasalur, Dayapuram, Salur, Miraj)	14 [over 5 years]	Allied health courses report -	Count TLMTI institutions offering accredited education in allied health sciences.	Total count of institutions offering accredited programmes	Biannual	Hospital Superintendents	Health	
				Number of health professionals trained annually.	Total number of students or trainees graduating from TLMTI allied health training programmes each year.	24 DMLT graduates	>250 graduates [over 5 years]	Allied health courses report -	Record the total number of students or trainees graduating from TLMTI allied health training programmes each year.	Total number of students/ trainees graduating annually	Biannual	Hospital Superintendents	Health
				Percentage of training programme costs covered through sustainable financing models (e.g., training fees, grants, partnerships).	The proportion of total costs for TLMTI training programmes that are funded through sustainable financing sources, such as participant training fees, external grants, or strategic partnerships.	0	>80% [over 5 years]	Allied health courses report -	Calculate the proportion of training program costs covered by sustainable financing sources.	$\frac{\text{Sustainable financing}^*}{\text{Total training costs}} \times 100$ * Costs covered by sustainable sources, i.e., total training costs	Biannual	Hospital Superintendents	Health
	3.2.4: Talent lifecycle management.	Implement digital HRMIS; Standardise onboarding/PMS; Adopt staff wellbeing strategies; Utilise placement agencies & church-based networks for sourcing staff; Explore innovative retention strategies for doctors.		% of vacancies filled on-time.	Proportion of vacant staff positions filled within the standard recruitment timeline (e.g., 30 days).	TBD	>90% of vacancies [over 5 years]	HR reports	For each recruitment cycle, calculate the time taken to fill a vacant position from the date of vacancy announcement to the date of candidate appointment	$\frac{\text{Positions filled within 30 days}}{\text{Total vacant positions}} \times 100$	Quarterly	HR	HR
				Number of staff engagement/ development initiatives undertaken	Total count of formal activities, programmes, or interventions conducted to enhance employee skills, professional growth, motivation, well-being, or workplace engagement	TBD	>20 across all units/year	Unit reports	Count each formal activity conducted	Total count of formal activities conducted annually	Quarterly	Unit Heads	HR

Strategic Priority	Strategic Aim	Strategic Outcome	Initiative / Activity	Indicator	Indicator Definition	Baseline	Target 2030	Data Sources	Data Collection Methodology	Formula	Frequency of data reporting	Who is Responsible?	Domain Lead
		3.2.5: Second line leadership and Succession planning.	Develop structured leadership training programmes; Conduct mentoring and coaching for successors; Provide exposure.	% of successors identified and mentored for core roles	Proportion of leadership/ critical roles with identified successors undergoing mentoring.	TBD	Successors for all domains, 70% hospitals, 80% Colleges, 70% VTCs, 70% Business Offices [Over 5 years]	HR succession planning records, Unit Reports	Calculate the proportion of leadership or critical roles with identified successors actively undergoing mentoring	$\text{Succession Mentoring} = \frac{\text{Roles with mentored successors}}{\text{Total critical roles}} \times 100$	Annual	Unit Heads	HR
				Number of staff groomed for second-line leadership	Count of staff members trained and prepared for higher leadership positions within TLMTI.			HR Reports	Count of staff who have successfully completed a structured programme or intervention aimed at preparing them for higher leadership positions.	Count of staff trained for higher leadership roles	Annual	HR	HR
		.2.6: Brand equity elevation.	Define TLMTI Brand architecture; Amplify media; Pursue awards.	Increased digital engagements to secure higher Share of Voice (SoV) in leprosy and disability domains	Year-on-year increase in TLMTI's digital presence (reach, impressions, engagement rates) leading to higher Share of Voice compared to peers.			A&C Report	Measure year-on-year changes in TLMTI's reach, impressions, engagement rates, and Share of Voice compared to peers through digital analytics tools such as Google Analytics, social media insights (Facebook, Instagram, LinkedIn, YouTube, etc.), and platform-specific reporting dashboards will be used.	$\text{Digital Growth} = \frac{\text{Current year digital metrics} - \text{Previous year}}{\text{Previous year}} \times 100$	Biannual	Communications Team	A&C

Notes

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