

Zero Leprosy Best Practices

Best Practice: *Leprosy/NTD Clinics in an Integrated Health Set-up—Nepal*

Subthemes

- Early detection and prompt treatment
- Disability prevention and treatment
- Operational capacity

Subcategory

- Health services

Target Audience(s)

- Policy leaders
- Health staff
- Persons affected by leprosy
- Donors
- Other partners such as NTD NGOs

Contributors

S. Anand, American Leprosy Missions
K. Subedi, Lalgadh Leprosy Hospital & Services Centre

Key Messages

Hospitals in leprosy-endemic countries have proportionately much higher loads of non-leprosy than leprosy patients, and doctors do not manage enough cases to build significant leprosy clinical experience. This is leading to a loss of leprosy expertise and to less attention given to leprosy as a disease. Having leprosy/NTD clinics within integrated health set-ups gives healthcare staff rotating in the clinics the opportunity to see a number of leprosy patients with different clinical presentations and to learn from managing and following the cases, thereby effectively ensuring leprosy clinical expertise is built, retained, and transferred.

Key Informant / Date Submitted

Shyamala Anand, American Leprosy Missions
May 2019

Country / Location

Nepal / Lalgadh Leprosy Hospital & Services Centre

Best Practice: Leprosy/NTD Clinics in an Integrated Health Set-up—Nepal

Zero Leprosy Best Practices

Description of the Best Practice

Introduction

Lalgadh Leprosy Hospital & Services Centre (LLHSC) is the only government-recognized tertiary leprosy care hospital in the high endemic Province 2 of Nepal, accounting for more than one-third of the country's new leprosy cases. The outpatient department sees 450–500 patients per day, of whom on average, 40 are leprosy patients (most consultations are for dermatological and other diseases). Leprosy numbers at LLHSC average daily around 3 new cases for confirmation of diagnosis and 37 cases for management of morbidity/disability.

In the spirit of integration and to avoid stigmatizing people affected by leprosy, leprosy patients were being assigned to any consultation room rather than a dedicated leprosy consultation room. However, an evaluation conducted in September 2018 found that this well-intentioned practice was actually resulting in loss of leprosy expertise and poorer standards of care for multiple reasons:

1. The huge general patient load and pressure on doctors to clear the outpatients on a daily basis made it difficult for them to gain any meaningful expertise in leprosy. A single doctor in LLHSC sees between 60-90 patients/day, of whom 0-3 may be leprosy patients.
2. Junior doctors were not confident about leprosy as they saw so few cases, and they indicated that they sometimes missed diagnosing leprosy until subsequent visits.
3. Because of long waiting times to see the doctor and collect their medicines, many patients would leave without completing other leprosy examinations.
4. Follow-up, being entirely patient dependent, was poor, and there was no way of knowing if patients revisited as advised.

As a result, one of the evaluation recommendations was to establish a dedicated consultation room for daily leprosy clinics where patients could be examined properly by a doctor and strict adherence to protocols for quality leprosy clinical care could be maintained.

Objectives and Methodology

The main **goal** of having a dedicated consultation room for leprosy was to build leprosy expertise among doctors, ensure adherence to protocols and standards for leprosy care, and improve follow up—especially of patients on steroids—for reactions and neuritis.

Methodology

- LLHSC established a dedicated leprosy consultation room for daily leprosy clinics with protocols in place for quality clinical care
- All leprosy (new and revisit) cases were directed to this clinic rather than randomly assigned to other rooms
- The consultation room did not have a board saying 'leprosy'; it was numbered just like other consultation rooms. This was guided by ethical considerations of perceived stigma associated with leprosy.

Best Practice: Leprosy/NTD Clinics in an Integrated Health Set-up—Nepal

Zero Leprosy Best Practices

- Medical officers are posted to this clinic on rotation every week. They are certain of seeing at least 40 leprosy patients a day, 6 days a week
- One or two leprosy supervisors, a counsellor, and a physio technician/therapist are also assigned to this clinic for a team approach to morbidity and disability management, with good follow up

This design was based on feedback from staff involved in leprosy outpatient care and their concerns about lack of leprosy expertise among new doctors and about patients' diagnoses and follow up being missed.

In 2017–18, around 56% of new leprosy cases diagnosed in LLHSC were multibacillary; 27% of them were smear positive, with 40% of the smear-positive cases having high BI (>4+). Around 29% of the new cases had disability (grade 1 or grade 2 disability) at time of diagnosis. Around 10% of new cases were children. These are significant percentages indicative of delayed detection and treatment with ongoing active transmission of leprosy in Province 2.

In this situation, there is continued need for leprosy clinical expertise to be built and retained among doctors working in LLHSC, which will also enable transfer of expertise to their new places of work when they move on.

Implementation of Practice

A complete medical history and examination of patients was carried out in this consultation room dedicated for leprosy. Leprosy patients no longer had to visit different rooms for body charting, nerve assessment, etc.

There were no resource implications for LLHSC, as activities that had been previously distributed among many consultation rooms were now effectively focused in one room.

Results—Outputs and Outcomes

Six months into implementing a dedicated consultation room for daily leprosy clinics, LLHSC has done its own rapid assessment and reports the following:

- Doctors posted in the leprosy consultation room
 - now have enough time and an appropriate environment to examine leprosy patients without the distraction of general patients
 - are now familiar with and able to follow clinical leprosy protocols for steroid therapy, etc.
 - feel their confidence level in managing leprosy complications has increased
- Leprosy patients' feedback indicates they
 - are happy not to wait for hours along with general patients for their turn to be seen by a doctor and can return home sooner
 - find it easy and are very comfortable being seen in the dedicated leprosy consultation room rather than being randomly assigned to any consultation room

Best Practice: Leprosy/NTD Clinics in an Integrated Health Set-up—Nepal

Zero Leprosy Best Practices

- do not feel stigmatized by a separate consultation room; they are more concerned about waiting times
- Follow-up for patients on steroid therapy has improved
 - Patients on steroids who have mobile phones now receive a mandatory reminder call 2-3 days before their next visit is due. (Some patients from across the border in India and patients without mobile phones continue to default.)

Lessons Learned

The practice appears to be working well because it is solving a problem that existed and was recognized but for which no solution had been earlier explored.

The idea of having a dedicated consultation room for leprosy was instantly welcomed by the senior management and staff as a good and workable solution that would build leprosy expertise among doctors and benefit leprosy patients

Replicability and Scalability

Has the practice be implemented in more than one setting? No

What long term effects can be achieved if the practice is sustained over time?

- Leprosy expertise can be built, retained, and transferred among staff who rotate in the clinic
- A team approach to leprosy care can be adopted in an outpatient setting
- Leprosy patients can be assured of a complete examination and quality management
- Leprosy complications can be detected earlier, and disability avoided or minimized
- There will be fewer defaulters
- More time can be given to listen to and educate leprosy patients on their condition

What are the requirements to sustain the practice over time, considering contextual factors, institutional support, human resources?

The main requirement is a change of mindset that is willing to admit that the well-intentioned integration concept of expecting everybody to be seen by anybody is actually leading to loss of leprosy expertise with less attention given to leprosy as a disease. In busy general hospitals, NTDs still get neglected.

Other requirements are having a dedicated consultation room with dedicated personnel who may rotate and having protocols in place for examination, treatment, and management. The clinic can be run daily, weekly, fortnightly, or monthly as feasible.

Best Practice: *Leprosy/NTD Clinics in an Integrated Health Set-up—Nepal*

Zero Leprosy Best Practices

Conclusions

How have the results benefited the population?

The target population included leprosy patients and their healthcare givers. It is evident that doctors are improving their expertise and that patients feel better looked after. The management feels the leprosy clinic will keep leprosy patients at the forefront and a doctor will be always accountable for their care.

Why may that intervention be considered a “best practice”?

Hospitals in leprosy-endemic countries have proportionately much higher loads of non-leprosy than leprosy patients. Doctors do not manage enough leprosy cases to generate interest or build significant clinical experience and therefore place less emphasis on a complete leprosy examination.

Running Leprosy/NTD clinics within integrated health set-ups gives healthcare staff rotating in the clinics the opportunity to see a number of leprosy patients with different clinical presentations and to learn from managing and following up cases, thereby effectively ensuring leprosy clinical expertise is built, retained, and transferred.

This best practice is a **replicable, effective** way of **efficiently** optimizing existing resources to **sustain** leprosy expertise while respecting **ethical considerations** for patient privacy.

What recommendations can be made for those intending to adopt the documented “best practice,” or how can it help people working on the same issue(s)?

- The clinic can be run as an NTD clinic on a daily, weekly, fortnightly, or monthly basis as required, in a dedicated consultation room where patients with leprosy and related chronic, stigmatizing, and disabling NTDs like lymphatic filariasis, Buruli ulcer, etc., can also be seen
- Bearing in mind ethical considerations of stigma attached to some NTDs, it is not obligatory to hang a sign outside the consultation room that says ‘Leprosy or NTDs’ as long as patients are directed to this particular room. Leprosy can be accorded its status as a specialty like any other, even without a signboard.
- Protocols for the care of patients with leprosy and other NTDs should be available so staff manning the clinic are aware of them
- A team approach should be in place for managing morbidity/disability and its related physical and mental problems
- Healthcare staff must be sensitized not to perpetuate stigma or even connotations of stigma by their own actions/outdated views