

Zero Leprosy Best Practices

Best Practice: *Intensive Mobile Clinic Treatment Programme (IMCTP) for Active Case Finding in Sri Lanka*

Subthemes

- Early detection and prompt treatment

Target Audience(s)

- Program managers
- Health staff
- Other partners such as NTD NGOs

Contributors

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Key Messages

Mobile clinics are an effective and efficient intervention for promoting early and active leprosy case finding and improving leprosy treatment outcomes (treatment compliance) in resource-poor and difficult-to-reach settings.

Key Informant / Date Submitted

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Description of the Best Practice

Introduction

Currently, around 2000 new cases of leprosy are reported annually in Sri Lanka. The majority of them are diagnosed through self-referral. The real number of cases is expected to be higher. This is based on a study conducted by [Dabrera et al in 2012](#), in which a household survey revealed an endemic pocket of leprosy in Thambapanni village in Puttalam. The majority of the villagers are Muslims displaced from the north as a result of war. Among 939 people examined, 35 leprosy patients were identified. All of these patients were referred to the skin clinic at the Base Hospital, Puttalam. Only 8 patients were taking the recommended course of multidrug therapy (MDT) at the end of one year; 10 of the defaulters had taken only the first pack of MDT, 14 patients had not come to collect even the first pack, and 8 patients had defaulted at other various levels of treatment. This demonstrated a serious low treatment compliance of 20% after one year.

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Zero Leprosy Best Practices

Based on these findings, it was determined that a different approach was required to enhance new case detection and compliance of treatment. Outreach through mobile clinics was identified a possible effective solution. Therefore, the IMCTP was designed.

Objectives and Methodology

The main objective of the IMCTP was to increase leprosy detection and treatment outcomes of MDT among patients in hard-to-reach communities through use of mobile clinics.

Mobile clinics are temporary or seasonal units with healthcare professionals who aim to attend to patients in the patients' own communities, particularly communities that are remote, difficult-to-reach, and have poor health services. Globally, mobile health clinics have become an alternative model of healthcare to traditional permanent clinics or hospitals, providing both primary and specialty care to rural and marginalized communities.

Mobile health clinics are increasingly becoming a popular means of providing care to low-resource areas in middle- and low-income countries. As leprosy occurs largely in rural, hard-to-reach communities, the use of mobile clinics provides an innovative way to increase case detection and treatment outcomes. Both leprosy case detection and treatment compliance in these hard-to-reach populations are very often problematic.

Implementation of Practice

The IMCTP included the following activities:

Activity 1: A **retrospective analysis of leprosy data** was done in Thambapanni village in Puttalam, Sri Lanka.

Activity 2: A **house-to-house visit** was carried out for the leprosy patients identified in Activity 1 above.

Activity 3: **Community members** in the designated village were **educated** by a medical team regarding leprosy, including its possible complications, the endemic nature of the disease in their village, and the importance of treatment compliance. The medical team comprised a consultant dermatologist, a medical officer attached to the dermatology clinic, a nursing officer, a public health inspector, and a clinic laborer. A regional epidemiologist also participated at times. People were addressed in accordance with their religious beliefs and culture.

Activity 4: **Monthly mobile clinics** were established in Thambapanni village. People were informed about the mobile clinic schedule in advance, during the home visits. The following services were provided by the mobile clinic: health education, contact screening, routine laboratory investigations, and treatment for leprosy and its complications. The clinic vehicles were sourced from the regional epidemiology unit.

Best Practice: Intensive Mobile Clinic Treatment Programme (IMCTP) for Active Case Finding in Sri Lanka

Zero Leprosy Best Practices

Mobile clinics were held in a hall belonging to the village mosque. **Regular follow up** of diagnosed cases and **detection of new cases** from people who presented to the clinic due to public awareness were continually performed at these mobile clinics, similar to regular skin clinics at the hospital.

When patients did not come to the mobile clinics, they were visited by the medical team and given treatment at their homes. Patients were encouraged to visit the nearest base clinic if they had any related problems between the mobile clinic dates.

Results—Outputs and Outcomes

In the first year of the IMCTP intervention, a total of 35 leprosy patients were detected. Of the 35 cases 17 were new, previously untreated leprosy cases, while 18 were previously defaulted cases. The 35 cases included 6 paucibacillary (PB) child cases, 23 PB adult cases, and 6 multibacillary (MB) adult cases. The detection of cases in 6 children under 14 years of age is indicative of ongoing transmission among the villagers. The majority of the leprosy patients were females (26 cases), with 9 males. During the ITP, all 35 cases completed the recommended course of MDT, resulting in a treatment completion rate of 100%, compared to 20% prior to introduction of mobile units approach.

Case detection was high, with 17 new cases detected among the approximately 1000 (939) population in the village. This figure is very high (1700-fold) in comparison to Sri Lanka's new case detection rate of leprosy (9.6 per 100,000), which is mainly based on self-referral.

Lessons Learned

- Offering leprosy services (diagnosing, treatment and health education) closer to the community through mobile clinics reduces barriers. This results in improved case detection and treatment compliance.
- By integrating the IMCTP in the general health system of Sri Lanka and using staff of the Government Health Services, the IMCTP is a sustainable approach.

Replicability and Scalability

No significant organizational, operational, technical, or financial issues are involved in IMCTP, since it uses regular government skin clinic staff and transport facilities of the regional epidemiology unit. Hence, no major investment is required.

Conclusions

Even in resource-poor settings, IMCTPs are highly effective and feasible to increase leprosy case detection and improve treatment outcomes in endemic pockets.

This programme is replicable in Sri Lanka's high-risk population areas and is sustainable when conducted by the health staff. If partnerships are needed, the CBOs in the area can provide support to coordinate the programmes.

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Further Reading

Hanson, L. Mobile health units in resource-poor settings: review of the literature. Boston University School of Public Health, 2012.