POLICIES, EXPERIENCES & WAY FORWARD FOR POST EXPOSURE PROPHYLAXIS (PEP) IN INDONESIA

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LEPROSY SITUATION

POLICY AND STRATEGY

CHEMOPROPHYLAXIS IN INDONESIA: RESULTS AND LESSONS LEARNT

CONCLUSION and WAY FORWARD
**LEPROSY CONTROL INDONESIA**

### Before 1969
- Leprosy patients are treated at Leprosy Hospital, and stayed at settlement / leprosarium (at ± 15 Provinces)
- DDS monotherapy started in 1951

### 1969
- Leprosy treatment was gradually being integrated in the general health service

### 1982-1997
- WHO MDT started at selected Provinces in 1982
- WHO MDT all over Indonesia in 1988
- WHO MDT shortened period in 1997

### 2000
- Indonesia achieved leprosy elimination at National level
- Pilot on Chemoprophylaxis started in Sampang District

### 2012
- Indonesia and other endemic countries agreed upon Bangkok Declaration aiming to achieve leprosy elimination as a public health problem at Sub national levels

### 2013
- Leprosy elimination in all Provinces by 2019 as one target of National Medium-Term Development Plan

### 2015-2019
- Minister of Health Regulation on Leprosy Control and Minister of Health Decree on National Clinical Guideline on Leprosy launched

### 2019
- Leprosy launched
FACTS:
1. Stable trend in case detection, prevalence - in almost two decades after national leprosy elimination achieved.
2. Intensified promotion and active case findings in the last 5 years, improve the early case finding, **BUT NOT** reduce leprosy transmission.
POLICY AND STRATEGY

LEPROSY ELIMINATION STRATEGY:
1. Strengthening advocacy and intersector/programs coordination
2. Strengthening community role
3. Provision of adequate resource
4. Strengthening surveillance system, monitoring and evaluation of the program

ACTIVITY:
1. Health Education/Health Promotion
2. Surveillance
3. Chemoprophylaxis
4. Case Management

Surveillance and Preventive measure
No. 11, 2019 on on Leprosy Control No. 308, 2019
on The National Clinical Guideline of Leprosy

2019 National Guideline for management of Leprosy
Standardized national case management of Leprosy

EARLY 2000
Health Promotion and Case Management

BEFORE 1990
Institusional Based focus on Case Management
CHEMOPROPHYLAXIS/PEP IN INDONESIA

CONTACT APPROACH
2012: Sampang District East Java
2014: Bima District and City West Nusa Tenggara

BLANKET APPROACH
2014: Mumugu I & II Villages in Asmat, Papua
2015: Tanimbar Maluku

COMMUNITY PARTICIPATION APPROACH
2015: Sumenep District in East Java with Community Participation Approach

Contact: The household, neighbourhod, and social (class mates, office mates) contacts of index case will be screened → single dose rifampicin (SDR) will be administered to eligible contacts.
Blanket: All community members will be screened → eligible community members will get the SDR.
Community participation:
No disclosure of Index case; community is asked to do self screening → community members who already do self screening reported to HC team for confirmation → eligible contacts will get SDR.
**CONTACT APPROACH**

**Sampang, East Java**
Total Population: 958,082
Chemoprophylaxis: (Period 2012-2013)
Index Case: 1,470
Screened Contacts: 26,662
Took SDR: 25,391

**Bima, West Nusa Tenggara**
Total Population: 478,967
Chemoprophylaxis: (Period 2013-2017)
Index Case: 408
Screened Contacts: 9,493
Took SDR: 9,490

**Bima (c), West Nusa Tenggara**
Total Population: 166,407
Chemoprophylaxis: (Period 2014-2017)
Index Case: 117
Screened Contacts: 9,890
Took SDR: 9,815
Sumenep, East Java

Total Population: 1,081,204

Chemoprophylaxis (LPEP Project)
(Period 2015-2017)
Index Case: 1,055
Contacts Screened: 34,664
Took SDR: 33,815

COMMUNITY PARTICIPATION APPROACH

Self screening tool
Lingat Village,
MTB / Tanimbar Islands, 
Maluku
Total Population Est. (registered):
2,065 (1771)
Chemoprophylaxis:
(Period 2014-2015)
Screened Community: 1,639
New Case: 27
Took SDR: 1,468

This is also part of the LPEP Project. It was selected based on the “report” (from the villagers) that there are many leprosy cases there, in this remote island.
A very remote villages (3.5 hours by boat through river) from District Capital

Leprosy program / case management are done by Health Center in collaboration with Catholic Mission.

**Mumugu I & II Village, Asmat, Provinsi Papua**

Total Population: ± 450 (?)

**Chemoprophylaxis**

(Period 2014 - 2015)

Index Case: 117

Took SDR: 284
RESULT OF CHEMOPROPHYLAXIS

**Sampang, Jawa Timur**
Chemoprophylaxis Since 2012

**Kota Bima, Nusa Tenggara Barat**
Chemoprophylaxis since 2014

**Kab Bima, Nusa Tenggara Barat**
Chemoprophylaxis since 2013

**Sumenep, Jawa Timur**
Chemoprophylaxis Since 2015

Number of new case, child case in the areas using contact and community participation approach are not yet reduced significantly.
RESULT OF CHEMOPROPHYLAXIS

Mumugu I & II Village, Asmat, Papua

Chemoprophylaxis since 2014

Number of new case, reduced significantly year by year after PEP intervention.

There were no child case and grade 2 disability at the beginning, and afterward

Lingat Village, Maluku Tenggara Barat, Maluku

Chemoprophylaxis Since 2015
LESSON LEARNT

1. PEP brings new hope to the health workers, and local program managers

2. PEP helps the community to sense that leprosy is preventable (reduce the stigma as incurable disease)

CONTACT

Once the health centers have a good mapping of index case, it is relatively easier to identify the targeted villages, and to prepare for the implementation of PEP

Improved coverage of contact examination (of routine program)

COMMUNITY PARTICIPATION

Health workers are not burdened of disclosing the status of index case

Self screening improves the awareness of leprosy, and the participation of the community in PEP

BLANKET

Feasible to be operationalized in isolated/remote area, with possible high coverage

Can be integrated with routine screening activity of other disease
CHALLENGES

- A good and detailed preparation is needed (resources, logistics, time, etc), including the anticipation of AMR issues that become a concern recently.
- Health workers should be capacitated in three aspects; management, technical skill and program governance.
- Community acceptance and local government commitment and support (head of sub district, head of village, etc) need to be strengthened for all new approaches / program innovation including PEP.
- Sustainability of SDR administration and follow up observation.
- Provision and distribution of drugs and recording reporting mechanism, particularly in remote areas.
- PEP program integration with other approaches at Health Center.
CONCLUSION AND WAY FORWARD

CONCLUSION

PEP as one pillar and choice of approach to accelerate the achievement of leprosy elimination at sub national level in Indonesia.

Lessons learnt from existing PEP areas with different approach methods, can be the foundation of this innovation to be implemented in the field.

WAY FORWARD

1. A nation wide scaling up of PEP implementation need an evidence based support with regard to the effectiveness of PEP implementation.

2. Technically, the health workers at Health Center should be strengthened sufficiently to integrate PEP in the Healthy Indonesia with Family Approach Program (PIS PK), and implementation of Minimum Standard of Service (SPM), for sustainability of PEP.

3. There is a need of village based integration of support, surveillance strengthening and community participation.
THANK YOU