



Heroin Use & Medication Assisted Treatment in Indonesia

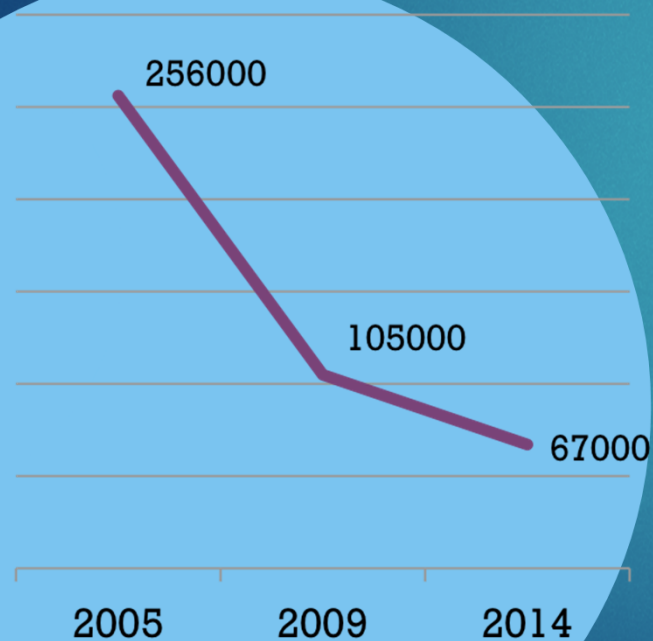
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Heroin Use in Indonesia

- ▶ After independence day in 1945, first wave of heroin use was documented in early 70s, then “disappeared” for a decade
- ▶ Second wave of heroin use was in early 90s
- ▶ Initially most user used it by smoking (chasing the dragon), then rapidly changed to injection
- ▶ Injecting heroin use became most popular in 1995 but then decreased significantly in 2010
- ▶ First case HIV among people who inject drug (PWID) in 1991

Heroin Use in Indonesia (cont'd)

Estimated of PWID



■ Household survey (National Narcotics Board, 2016):

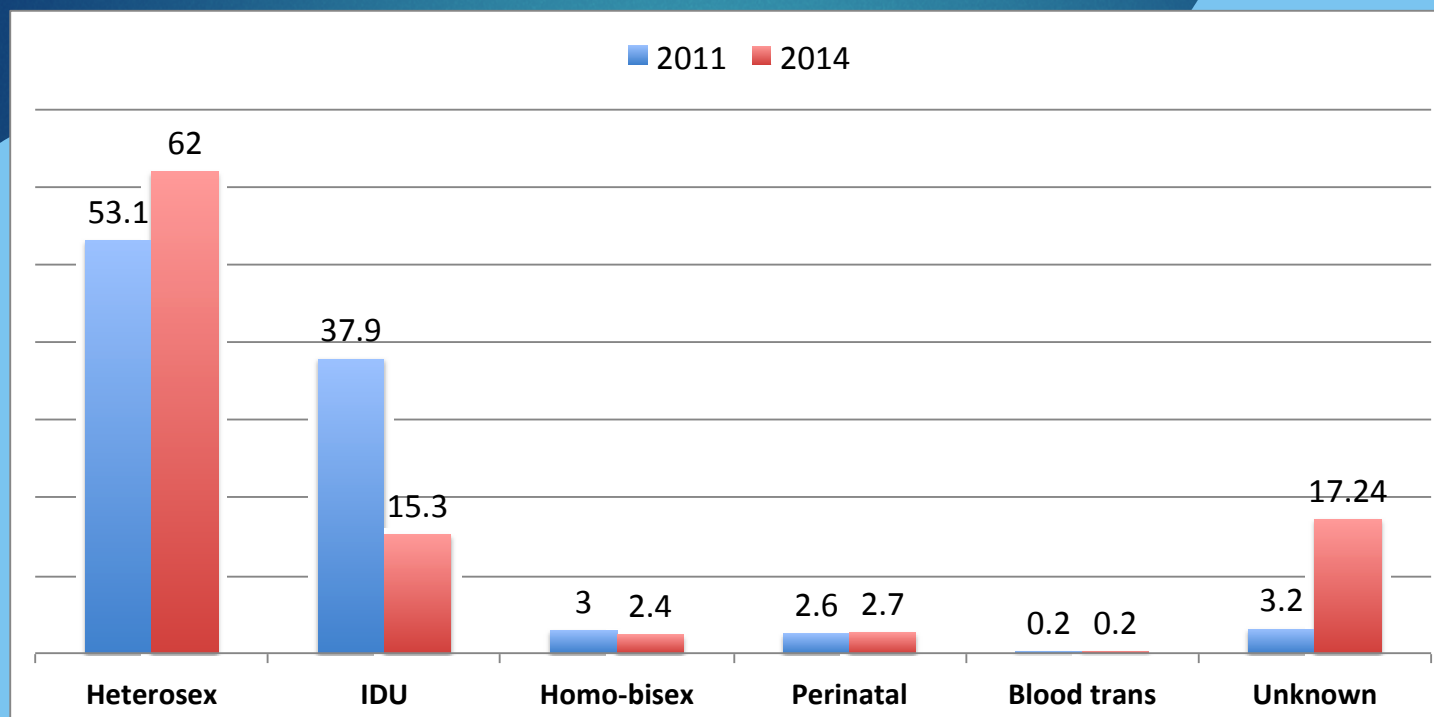
- Prevalence of PWID decreased from 12% (2005) to 5% (2015)
- Substances to inject currently:
 - Heroin
 - Buprenorphine + Naloxone
 - Benzodiazepine
 - Methamphetamine
 - MDMA

HIV Situation in Indonesia

- Before 2000, HIV infection due to injecting drugs shared < 1% of total cases
- 2008: HIV infection among PWID > 50%
- 2014: PWID were the third major group (after heterosexual and unknown) w/ HIV infection
- PWID may also contributed heavily to heterosexual and perinatal transmission

Cumulative Percentage on AIDS Cases in Indonesia by Mode of Transmission

5



Response to HIV among PWID

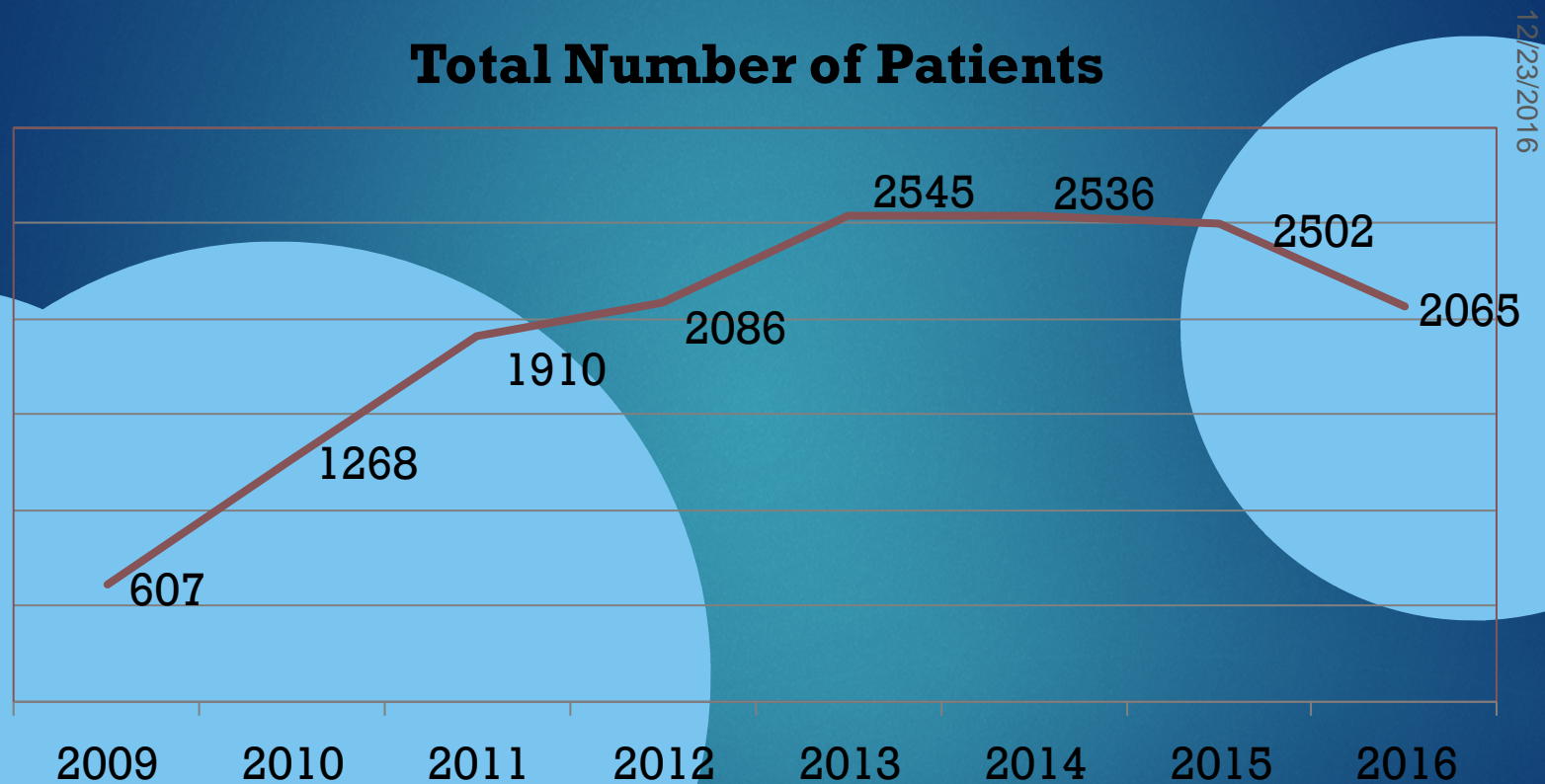
6

- MAT (methadone & buprenorphine) and NSP were initiated in 2000s:
 - NSP started in 1998:
 - Initially run by NGOs
 - Since 2009 run by Primary-Health Centers with help of NGO
 - Buprenorphine maintenance therapy program started in 2002 through private sector
 - Methadone maintenance therapy program started in 2003 through government sector

MMT Performance

7

Total Number of Patients



Estimated Prevalence of Heroin Users accessed
MMT: 20%

Current MMT situation

8

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- ▶ Most of the clinics only focus on methadone dispensing, lack of psychosocial intervention
- ▶ Average prescribed doses: 60 – 100 mg
- ▶ >60% of methadone patients are HIV-positive, approx. 45% of them access ARV
- ▶ 88% have routine activities (full-time job, part-time job and studying)
- ▶ 43% patients have right to take the dose home (RSKO, 2012):
 - ▶ Around 43% access methadone clinic between 1-2 hours from their work-place

Current MMT situation (cont'd)

9

- By June 2016, MMT still available only in government health facilities:
 - 29 general hospital
 - 8 mental health
 - 1 drug dependence hospital
 - 44 primary health care (PHC)
 - 6 prisons
 - 4 detention centers
- Primary health care (PHC) generally perform better compared to hospitals
- Large numbers of patients and families have benefited enormously from OST
- Domestic methadone production from 2008

Current MMT Situation (cont'd)

10

- There was strong political commitment to harm reduction in Indonesia in 2000 to 2013, but then slightly weakened in the last 3-4 years due to change in major drugs of choice and political policies
- Performance of MMT service providers relatively stagnant, some decreased significantly:
 - Clinical staff level (turn-over; burn-out)
 - Program level (lack of management support; diminished additional support from international donor agencies)
 - Patient level (not-adherence)

Buprenorphine Maintenance (BM) Performance

11

- ▶ Available in combination preparation (buprenorphine and naloxone)
- ▶ Average prescribed doses are suboptimal (2 – 4 mg) due to high price
- ▶ Idea to produce domestic buprenorphine (single) in 2011 – 2013 as a respond to MAT external review (Ministry of Health – WHO) but not cost efficient & cost effective
- ▶ Evidence of diversion through injection for about 80%
- ▶ Significant decrease of patients due to recent change in regulation on distribution

General Challenges

12

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- Coverage generally too low to impact HIV
- MoH is inadequately resourced to support MAT
- Lack of national operational guideline for buprenorphine assisted treatment
- Dose of methadone and buprenorphine is oftenly inadequate
- Cost of buprenorphine is unaffordable for some patients, bigger probability to diversion
- Quality of service is widely various between clinics
- Shared misunderstandings about MAT among patients and stakeholders

Challenges at Prison & Detention Center

13

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- ▶ Coverage of MMT is very low
 - ▶ Prisons and detention centers that have MMT Clinic are only available in 2 cities
- ▶ Many prisoners sentenced for minor drug offences, mostly due to methamphetamine and cannabis possession
- ▶ Very limited access to MMT & NSP at prison
- ▶ Injectable drugs readily available in many prisons

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Thank You