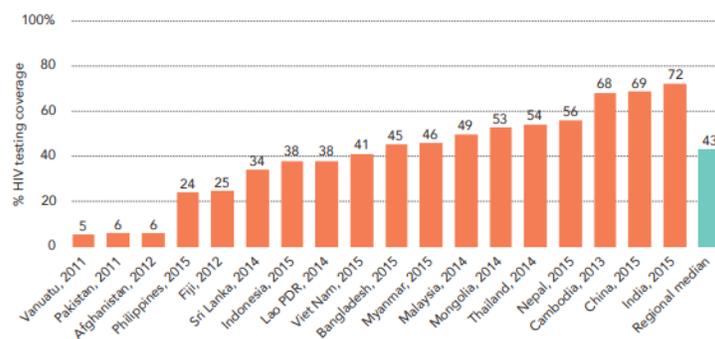


Community Based HIV Screening for Female Sex Workers in 23 Priority Districts

I. Context

Global data showed that three out of four people living with HIV (75%) knew their status, and countries are looking for ways to rapidly increase access to and use of HIV testing services, especially for high risk population as well as have limited access to services. New HIV infection have been reduced by 47% since the peak in 1996. Every week, around 7000 young women aged 15 – 24 years become infected with HIV, and more than one third (35%) of women around the world have experienced physical and/or sexual violence at some time in their lives. As for the key populations, the HIV infection is 47% globally¹.

UNAIDS Asia and the Pacific estimated that there are 5,100,000 people living with HIV in this region with 300,000 new infection and 180,000 AIDS related-deaths². Less than half of the female sex workers in the Asia Pacific region know their HIV status, in which the risk of acquiring HIV for this population are 13 times higher than the general population³, the consistent condom use is low in many countries in this region.



Indonesia has a high burden of people living with HIV, estimated at 630,000⁴. This puts Indonesia in important position – if Indonesia will succeed in ending AIDS as a public health threat, it will also contribute to the regional and global success. However, Indonesia is not on track to reach the 90-90-90 targets by 2020: only 14% of 630,000 people living with HIV are on ARV treatment. It is projected that by 2020, the maximum treatment coverage is 40%⁵. With 49,000 new infections per year, this total number of PLHIV is constantly rising. In terms of the contribution of new infections in the Asia and Pacific region, Indonesia ranks third after India (30%) and China (22%) at 18%. Thus, in order to accelerate achievement

¹ Global HIV & AIDS statistic, Fact Sheet – UNAIDS 2018

² HIV Epidemic in Asia and the Pacific, UNAIDS 2016

³ Miles to Go – Global AIDS Update, UNAIDS 2018

⁴ Estimates and Projection of HIV / AIDS in Indonesia 2015 – 2020, MoH – 2017

⁵ National AIDS Programme Data Q-4, MoH - 2017

of the 90-90-90 in Indonesia, urgent innovative solutions are required to increase testing and treatment in key populations such as sex workers, given the nature of the epidemic and transmission.

In Indonesia, 2017 data shows the HIV prevalence among sex workers at 5.3% out of the estimated sex workers population size of 226,791⁶. From the 2015 IBBS, the HIV prevalence rate among direct sex workers is 7.9% with 6.4% for syphilis. “Direct” FSW (DFSW) refers to women who sell sex as their primary source of livelihood, while “Indirect” FSW (IFSW) have other means of livelihood but sell sex to supplement their incomes. DFSW are usually found at brothels, “localisasi” and some massage parlors, while IFSW are found at bars, Karaoke bars and other entertainment venues.

	Direct sex workers	Indirect sex workers
HIV prevalence (IBBS 2015)	7.9% prevalence rate	2.2% prevalence rate
Syphilis prevalence (IBBS 2015)	6.4% prevalence rate	2.1% prevalence rate

In order to urgently upscale programme coverage and in line with MoH priority “Test and Treat” strategy, the Indonesian national HIV programme supported by UNFPA introduced a new model for HIV prevention outreach to female sex workers (FSW) in late 2016. The new model aims to reorient HIV prevention outreach to focus on ensuring that sex workers with HIV know their HIV status, access life-saving anti-retroviral therapy (ART) and reduce the risk of onward HIV transmission. It promotes the principles and practice of HIV continuum of care and community systems strengthening by introducing the case management approach; and by equipping programme implementers with additional tools, skills and knowledge to upscale and improve the national sex worker HIV programme. The current Ministry of Health target under Global Fund grant 2018 – 2020 aims to achieve 135,700 outreach targets and 55,366 HIV testing targets by the end of December 2020.

Estimation	Period	Target of Outreach	%	Target of HIV Test	%
226,791	Sem 1	73,425	32%	35,244	16%
	Sem 2	97,900	43%	38,181	17%
	Sem 3	110,500	49%	46,446	20%
	Sem 4	123,100	54%	48,341	21%
	Sem 5	129,400	57%	53,194	23%
	Sem 6	135,700	60%	55,366	24%

Indonesia still lags behind other countries in Asia Pacific region on ART coverage. Anti-retroviral treatment for AIDS patients was launched in 2005, initially with support from the Global Fund. Data from the Ministry

⁶ Indonesia Factsheet, UNAIDS - 2016

of Health indicates that in 2017, 91,369 people were receiving anti-retroviral treatment regularly from 890 sites across the country (including satellite services), representing only 14% of the estimated total PLHIV in Indonesia.

HIV Self-Testing (HIVST) among Female Sex Workers

WHO has been prioritizing innovative ways to reach vulnerable and KP groups with HIV testing, prevention and treatment services and the latest WHO guidelines have highlighted HIV self-testing (HIVST) as important tools to identify more people with undiagnosed HIV and at high risk of HIV infection. Community based HIV testing has been recommended as a component of HIV testing Services (HTS) for reaching hard to reach populations⁷. The new recommendations are HIV testing conducted by trained non-health providers and using rapid diagnostic tests (RDTs) and HIV testing in the context of surveillance. HIV testing conducted by trained non-health (lay provider / lay-testers) and using rapid diagnostic tests (RDTs) is recommended to improve the scope of HIV testing target. The trained non-health personnel referred to communities trained and supervised by health workers (laboratories), so they can safely and effectively test HIV with RDT. This recommendation complements MoH policy on improving the scope of HIV testing, namely the expansion of HIV testing of healthcare initiation (PITC) in all health-care facilities including those in the form of mobile HIV testing services.

FSWs community are at risk not only for HIV but also stigma, discrimination and violence. Stigma and discrimination can affect access to HIV testing among FSWs.⁸ For FSWs, stigma can be due to engagement in sex workers itself, or from HIV stigma, particularly in contexts of HIV burden, and can come from family or other community members, partners and healthcare providers.⁹ The current political situation in Indonesia in which the local governments has started to close-down the sex worker establishment (brothel) contributed significantly to the change in focus of the HIV prevention programme. The FSWs community became more hidden and hard to reach, difficult to access HIV prevention commodities as well as health services. This situation may greatly influence uptake of HIV testing, in which interventions that mitigate stigma as barriers to access services including HIV testing is urgently needed. Oral HIVST is an alternative to facility or other healthcare provider testing that may overcome some barriers to access HIV testing for some populations.¹⁰ HIVST has been shown be acceptable in a variety of populations globally including for FSWs community.^{11 12}

A study in Zambia on HIVST among FSW also raised a set of complex barriers at multiple levels that limit access to HIV testing for FSWs, including fear of stigma and abuse, fear of loss of livelihood, and the financial and time costs of using traditional HIV testing services.¹³ HIVST is a promising alternative HIV testing option for FSWs, because it allows for a high degree of privacy, efficiency and flexibility in HIV

⁷ Consolidated Guideline on HIV Testing Services, WHO - 2015

⁸ King EJ, Maman S, Bowling JM, et al. The influence of stigma and discrimination on female sex workers' access to HIV services in St. Petersburg, Russia. *AIDS Behav* 2013;17:2597–603.

⁹ Herek GM. Confronting sexual stigma and prejudice: theory and practice. *J Soc Issues* 2007;63:905–25.

¹⁰ Krause J, Subklew-Sehume F, Kenyon C, et al. Acceptability of HIV self-testing: a systematic literature review. *BMC Public Health* 2013;13:735.

¹¹ Pant Pai N, Sharma J, Shivkumar S, et al. Supervised and unsupervised self-testing for HIV in high- and low-risk populations: a systematic review. *PLoS Med* 2013;10:e1001414.

¹² Figueroa C, Johnson C, Verster A, et al. Attitudes and acceptability on HIV self-testing among key populations: a literature review. *AIDS Behav* 2015;19:1949–65.

¹³ Oldenburg CE, et al. *BMJ Open* 2017;7:e014780. doi:10.1136/bmjopen-2016-014780 9

testing. MoH recommendations indicate that all people at high-risk of HIV infection including FSWs should ideally test for HIV every 3 months.¹⁴ HIVST could reduce the burden of transport to clinics for traditional testing, and also the existing clinics may not offer HIV testing services during hours which are feasible for FSWs.

The Global Fund published a briefing note of Operational Research for HIVST to encourage countries to pilot and explore how HIVST can be used to scale up HIV testing, especially among people not reached by existing HIV testing services.¹⁵

II. Objectives:

1. To develop a model of community based HIV screening using oral fluid test for Female Sex Workers outreach programme in 23 priority districts
2. To explore the linkage to the Puskesmas for confirmation test and access to HIV care following the positive self-test results with the view to maximize treatment uptake and followup

Specific Objectives:

- 1) Establish the effectiveness of different approaches (supervised and un-supervised) and distribution (direct and fixed distribution) for increasing HIV testing coverage among FSWs
- 2) Establish the effectiveness of the two different approaches and distribution on increasing HIV status knowledge among FSWs
- 3) Measure HIVST uptake by distribution approach
- 4) Measure linkage to HIV counselling and care by different approaches

Specific questions to be answered:

1. Does the introduction of community HIV self-testing among FSW increase the rate of HIV testing at health facilities?
2. Does “assisted” or “unassisted” community HIV self-testing among FSW result in a larger increase in the rate of HIV testing at health facilities?
3. Does the introduction of community HIV self-testing among FSW increase the rate of initiation of ART?

III. Methodology:

Study Location and Period

The study will be conducted in 23 priority districts; Kota Medan, Deli Serdang, Kota Palembang, Kota Bandar Lampung, Kota Tangerang Selatan, Tangerang, Kota Jakarta Selatan, Kota Jakarta Timur, Kota Jakarta Pusat, Kota Jakarta Barat, Kota Jakarta Utara, Bogor, Kota Bekasi, Kota Bandung, Kota Depok, Kota

¹⁴ Indonesia HIV Counselling and Testing Guideline, MoH - 2014

¹⁵https://www.theglobalfund.org/media/5723/core_opresearchimplementationhivselftesting_briefingnote_en.pdf

Semarang, Kota Surakarta, Kota Malang, Kota Surabaya, Kota Denpasar, Kota Makassar, Kota Sorong and Kota Jayapura.

Study Design A Randomized Controlled Trial (RCT) will be used for this study to explore in the HIVST evidence for FSWs in Indonesia with tests and treatment results in intervention acceleration districts compared to control districts with no intervention. In the trial, it is recommended the candidates will be tested using two approaches (supervised and un-supervised) through direct distribution system and fixed distribution system. A direct distribution system is where and FSW participant is directly given and HIVST by a peer, and a fixed distribution system is where the FSW participant collects the HIVST from a fixed point such as health clinic. This trial aims to determine the effectiveness and safety of these two HIVST delivery approaches, compared with standard of care, for improving HIV testing coverage and knowledge of HIV status. It is important for the candidates to describe the inclusion and exclusion criteria for this study, as describe in the Table 1.

Table 1. Study Inclusion/Exclusion Criteria

Inclusion	Exclusion
Women, 18 years or older at enrolment	<18 years at enrolment
Reports exchanging sex (vaginal, oral and/or anal) for money or goods at least once in the past month	Has not reports exchanged sex in the past month
Self-reported HIV negative and no recent HIV test (<3 months) OR HIV status unknown	Self-reported living with HIV
Willing to participate in study (assessment, activities, etc)	Self-reported HIV negative but tested within the past 3 months
	Meets inclusion criteria but does not wish to participate
	Concurrently participating in another HIV prevention study

Study dependent variables include HIV test status ie Number and proportion % of FSW who receive HIV tests and test positive at a health facility after assisted self-testing vs. the same statistic for those engaging in unassisted self-testing (intervention districts only), adherence to treatment, behavior change for access to puskesmas and independent variables will include age, district, assisted and unassisted community self test.

Study Sample & Size

The target population of this study is Female Sex Workers in 23 priority districts set by Ministry of Health.

If we assume a testing positivity rate of 10% or less, it is apparent that the expected number of FSWs who would be eligible for treatment will be small and will lack sufficient statistical power to make meaningful comparisons with comparison districts. For this reason, it is recommended that that the impact of community screening among FSW be measured using SIHA data for FSW in both intervention and comparison districts. This estimate of impact derived in this way will be confounded if it were to be the case that interventions other than HIV self-testing were to be better implemented in intervention vs. comparison districts. It might be possible to minimize this potential bias by including measures of

intervention implementation performance in the intervention and comparison districts in multivariable analyses. Thus a large enough sample size is required to ensure sufficient power to determine the difference in the intervention and control districts.

There is need to recruit a sufficient number of FSWs who self-test for HIV in the intervention districts to be able to detect a 5-10 percentage point difference in the rate of HIV testing at health facilities in intervention vs. comparison districts and be 95% certain that a difference of that magnitude would not have occurred by chance and 90% certain of detecting a difference of that magnitude if such a difference actually existed. Note that there is no sample size for comparison districts as all the measurements for such districts will be based upon SIHA data, which are not subject to sampling error (but are subject to non-sampling error, which needs to be controlled in the study as best possible).

Sample size requirements for the third question measurement pertains to the number of FSW who are eligible to initiate treatment. This will depend upon (1) the number of FSW that presented at a health facility for testing and (2) the positivity rate among those tested. Sample sizes should thus be calculated accordingly.

This 23 districts priority is a districts with high HIV prevalence for key population including FSWs, and have comprehensive HIV-TB intervention package both health services and community prevention and support programme. As for the FSWs programme, this 23 priority districts already trained with comprehensive outreach package (reach to test and simplified case management for FSWs living with HIV). Table 2. Below is the Global Fund targets for FSW in 23 priority districts.

Table 2. Global Fund HIV Testing Targets in 23 Districts

No	Provinsi	District	Region	Target of HIV Testing			
				P3	P4	P5	P6
1	Sumut	KOTA MEDAN	1	904	904	1,002	1,002
2	SUMUT	DELI SERDANG	1	406	406	450	450
3	Sumsel	KOTA PALEMBANG	1	1,371	1,371	1,520	1,520
4	Lampung	KOTA BANDAR LAMPUNG	1	393	393	435	435
5	Banten	KOTA TANGERANG SELATAN	1	223	223	247	247
6	Banten	TANGERANG	1	820	820	909	909
7	DKI	KOTA JAKARTA SELATAN	1	536	536	594	594
8	DKI	KOTA JAKARTA TIMUR	1	877	877	973	973
9	DKI	KOTA JAKARTA PUSAT	1	1,341	1,341	1,486	1,486
10	DKI	KOTA JAKARTA BARAT	1	1,318	1,318	1,461	1,461
11	DKI	KOTA JAKARTA UTARA	1	1,431	1,431	1,586	1,586
12	Jabar	BOGOR	2	474	474	525	525
13	Jabar	KOTA BEKASI	2	248	248	275	275
14	Jabar	KOTA BANDUNG	2	582	582	645	645
15	Jabar	KOTA DEPOK	2	374	374	415	415
16	Jateng	KOTA SEMARANG	2	510	510	565	565
17	Jateng	KOTA SURAKARTA	2	172	172	190	190
18	Jatim	KOTA MALANG	3	84	84	93	93
19	Jatim	KOTA SURABAYA	3	1,173	1,173	1,300	1,300
20	Bali	KOTA DENPASAR	3	1,407	1,407	1,559	1,559
21	Sulsel	KOTA MAKASSAR	3	1,444	1,444	1,600	1,601
22	Papua Barat	KOTA SORONG	4	438	438	485	485
23	Papua	KOTA JAYAPURA	4	786	786	871	871

IV. Timeline

The study will be started from August 2019 to November 2020 (16 months). The preparatory phase; proposal review, bidding and selection of the institution will be in June – July 2019. The study preparation may start in August - October 2019, the field implementation from November 2019 to July 2020, and the last 3 months for report writing.

Community Based HIV Screening in 23 Priority Districts	
Activities & Sub Activities	
Field Preparation	
	Consultative meeting (review proposal & design study)
	The Development of Instrument, Guidelines on Implementation and Database Development
	Trial on Instrument & input data base
	Workshop on the Result of the Questioner Trial
	Survey kit - 1
	Souvenir for respondent
Field Activity Stage	
	Coordination Meeting in District Level
	Training and Recruitment District team
	Training and Recruitment for National Field team
	Survey kit - 1
	Community based screening operational research - Souvenir for respondent
	Data Collection Monitoring
Result Dissemination	
	Dissemination Meeting
PROCUREMENT OF ORAL FLUID SCREENING KIT	
PROCUREMENT OF STORAGE EQUIPMENT	
DATABASE DEVELOPMENT	