Support for Demonstration Sites of Partner Notification Implementation in Indonesia

Background:

HIV epidemic in Indonesia is concentrated among key populations (KP); Female sex Workers (FSW), Man having Sex with Man (MSM), transgender (waria), People who Inject Drugs (PWID), and clients of sex workers. These populations make up 30% of estimated PLHIV in 2017 in Indonesia, and the remaining 70% are from non-KP, previously KP and partners of KP/PLHIV.

Indonesia has over the years scaled up HIV testing services at health facilities which has resulted in doubling the number of test from 1 million in 2013 to 2.5 million tests in 2017. Despite this scale up, Indonesia still has to increase HIV case finding efforts. This increase is needed to reach the first 90, as currently not more than 40% of PLHIV know their HIV status.

Studies globally have shown high positivity rates among partners of PLHIV. National AIDS Program (NAP) acknowledged this population as targeted population for HIV testing intensification. Therefore, national testing guideline are being updated to include guidance on partner notification (PN), including assisted PN by health workers. WHO is supporting NAP in the guideline updating process to ensure that the national guidelines are in line with WHO HIV Testing Services (HTS) guideline, 2016.

Furthermore, with WHO’s support NAP developed workshop module for PN, and the workshop to disseminate the PN procedure has been conducted with 18 provinces consisted of provincial HIV officer and health staffs at facilities. NAP has selected 5 districts for demonstration sites of PN service implementation in Surabaya, Semarang, Makassar, Denpasar, DKI Jakarta.

Objectives:

To strengthen PN implementation in 5 districts, including:

1. Conducting qualitative assessment on partner notification
2. Develop best model to implement PN based on qualitative assessment
3. Routine monitoring through data collection at facilities in selected districts
4. Evaluation of the result on partner notification implementation at district

Methods:

1. The project will be held in three phases;
   1.1 Phase 1, qualitative assessment
   1.2 Phase 2, develop and implement best model of PN delivery, and data collection
   1.3 Phase 3, data analysis, result and lesson learn
2. Institution/individual with team, with research capacity and able to organize workshop will be recruited to conduct the two phases.
3. The two phases will include these activities:
1. Phase 1, qualitative assessment;
   Qualitative assessment should address the following objectives:
   1. Assess existing partner notification practices as part of a baseline assessment to
determine the impact of the strengthening workshop and mentoring;
   2. Determine how best to deliver PNS overall and for different populations of index
clients and partners in Indonesia in order to inform protocols and training
materials and address barriers raised by providers and clients; and
   3. Explore how to motivate health workers to provide PNS beyond offering client
referral for spouses and children and how to sensitize the community of PLHIV
and their partners regarding PNS.

   Qualitative assessment will need to include health workers, health officers, peer
support and outreach workers, and other key stakeholders engaged in the delivery
and support of PNS as well as potential clients and their partners, including members
of key populations and PLHIV from the general population and their partners. A mix
of in-depth interviews (IDIs) and focus group discussions (FGDs) may be needed to
obtain the relevant information from each group. Decisions regarding the mode of
data collection should take into consideration both the project’s scientific objectives
(i.e. whether group dynamics and norms or individual context and decision-making
will be more useful for the project’s objectives) as well as the feasibility of conducting
FGDs vs. IDIs. For example, the sensitivity of the topics and populations of interest
may prevent potential participants from being willing to join or openly discuss their
experiences in FGDs or it may not be possible to bring together sufficient numbers of
health workers for a FGD.

2. Phase 2, develop and implement best model of PN delivery, and data collection;
   a. Development of the tools and protocol for implementation and evaluation
   b. Workshop for strengthening implementation at facilities in Semarang City.
The same workshops are to be held in Denpasar, Makassar, Surabaya, DKI
Jakarta utilizing other source of fund at MOH. For effectiveness, workshops
will be done in each city, for facilities who will be implementing.
   c. Two time monitoring visit by APW holder, subdit, Dinkes, WHO. to districts
and selected facilities.
   d. Quantitative assessment will include number of test, number of positives,
number of index testing, number of index testing tested, number of positive,
numbers on ART.
   e. Routine data collection at districts
   f. Monthly data collection at districts. Data of 5 months implementation will be
collected.
   g. Data analysis and result report
   h. End line qualitative assessment will assess experience of health workers and
clients (patients and testing index), assess if there are challenges, lessons
learned, harms and benefit of the partner notification services.

1.4 Phase 3, data analysis, result and lesson learn
   i. Evaluation and lesson learned workshop (will be done through DFC)
j. Report development

Outputs:

1. Phase 1:
   - Qualitative assessment report
   - Consultant report

2. Phase 2:
   - Tools and demonstration site protocol (implementation and recording reporting)
   - Five districts partner notification implementation data.
   - Report on implementation process, result and recommendation.
   - Consultancy report on phase 1 and 2.

Timeline:

Phase 1; Mei-June 2019
Phase 2; July-December 2019