REVIEWING FEMALE SEX WORKERS' ACCESS TO AND QUALITY OF HIV, SEXUAL AND REPRODUCTIVE & OTHER HEALTH SERVICES IN INDONESIA

RESULTS OF A COMMUNITY-LED STUDY

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ABSTRACT

Female sex workers (FSW) in Indonesia have seen improved access to HIV/STI services in recent decades, but conservative Islamic politicians have started to hamper the delivery of proven HIV/STI/SRH interventions in certain locales. This study explored barriers to health care among FSW in three cities in Indonesia using a mixed-methods approach.

Most participants were satisfied with the health services they received. The number of survey participants reporting stigma or discrimination was remarkably low (<5%). Key informants suggest this could be caused by selection bias of the survey, and state that stigma and discrimination, especially in smaller towns or rural areas, remains an important barrier. Only a third of FSW had health insurance, and condom shortages were reported. FSW have responded to the crackdowns on prostitution by not disclosing their status as sex workers anymore, and sex work appears to be moving from brothels and entertainment venues to homes and online venues, making it harder for public health workers to reach FSW.

The study found that there was a lack of involvement of FSW in the planning and design of interventions aimed at improving their life. Partly as a result of this, interventions are focused mostly on health, whereas other pertinent problems in the life of FSW are not (sufficiently) addressed. FSW were generally satisfied with the quality and attitude of health care workers while accessing health services.

In conclusion, a more holistic and 'structural intervention' approach that a) is fully sex-worker-owned and led, b) diversifies HIV/STI/SRH service delivery and c) incorporates broader priorities of FSW, including reducing exposure to violence and harassment, improving child care services, and provision of opportunities for vocational and educational development will likely improve HIV/STI/SRH health outcomes. In addition, coordination between stakeholders needs to be improved and strategies for reaching adolescent FSW as well as FSW operating via social media need to be urgently designed.

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
APBD	Local Government Budget
ART	Antiretroviral Therapy
BKKBN	National Population and Family Planning Board
BPJS	Indonesian Health Care Insurance
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
KI(I)	Key Informant (Interview)
MoH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Commission
NGO	Non-government Organization
PLHIV	People living with HIV
PMK	Regulation of Ministry of Health
PWID	People who inject drugs
Puskesmas	Primary Health Center (Government-run)
SPM	Minimum Service Standard
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection

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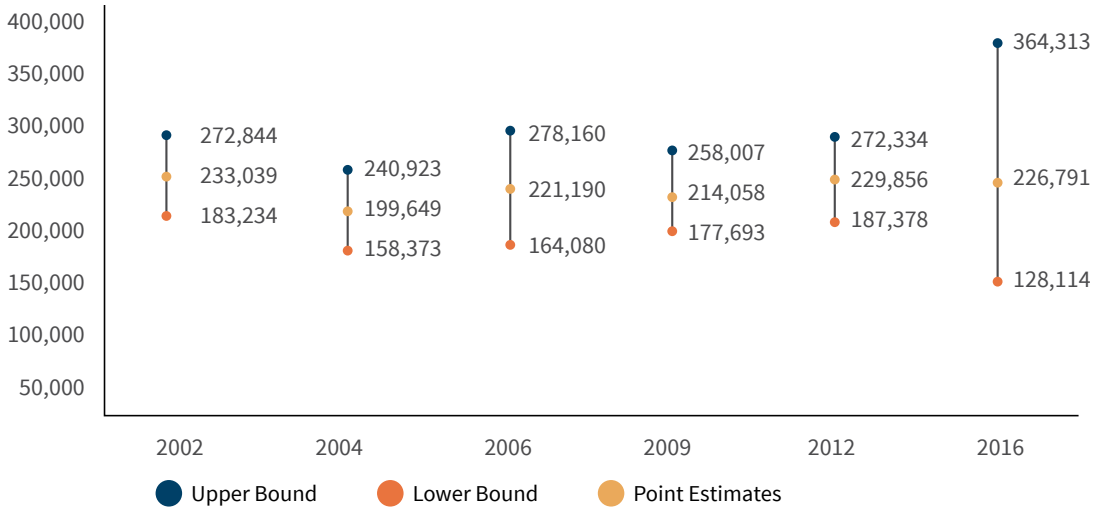
CHAPTER 1

INTRODUCTION

1.1 Background

Indonesia has a concentrated HIV epidemic, with a national prevalence of 0.3-0.4%, except in Papua where there is a generalized epidemic with prevalence of 2.3% among general population (1). An estimated 640,000 people are living with HIV in Indonesia (2). As is the case in all concentrated epidemic countries, key populations are at the center of Indonesia's HIV epidemic. Key populations include prisoners, female sex workers, transgender people, men who have sex with men and people who inject drugs.

It is estimated that there are around 226,791 FSW in Indonesia (3) (see Graph 1).

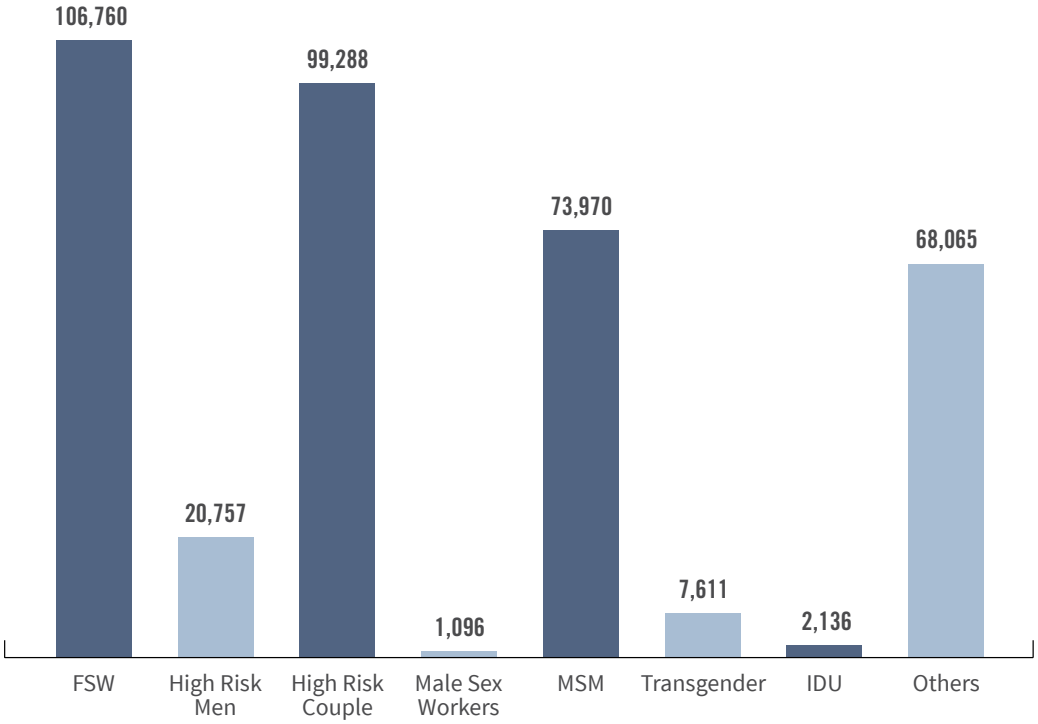


Graph 1. Estimation of the number of FSW in Indonesia (2002-2016)

According to the MOH, 28% of reported STI cases between 2002 and 2016 were among FSW (2016-Sept 2019), making this the key population which is most heavily affected by STI epidemics (4). Of course, this is probably partly caused by successful outreach efforts and probably higher STI testing rates compared to some of the other populations depicted in the graph on the next page.

HIV prevalence in female sex workers has been found to be around 8% out of an estimated total number of 128.000-364.000 FSW (3). As is the case in other countries in the region, people engaged in sex work are disproportionally affected by the human immunodeficiency virus (HIV) epidemic, as well as by sexually transmitted infections (STI) (5, 6). For this reason, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have identified sex workers as a key population for focused HIV service provision. These organizations suggest that the HIV epidemic can only be contained if key populations, including sex workers, are engaged and reached with comprehensive, diversified, high-quality and non-judgmental HIV, STI and sexual and reproductive health services (7-9).

Sexually transmitted infections (STI) cases 2016 - Sept 2019



Graph 2. Number of sexually transmitted infection (STI) cases based on syndromic and laboratory approach (2016 – September 2019)

The national HIV service cascade, which depicts access and utilization of different HIV services, shows that just about 327,282 of the estimated 640,000 people living with HIV (PLHIV) had been diagnosed with HIV through counseling and testing, amounting to 51% of the estimated PLHIV population. Only 108,479 (33% of the diagnosed population) were on treatment by the end of 2018 (2). This data shows that many HIV cases remain undiagnosed and are not yet accessing secondary prevention and life-saving HIV treatment, including antiretroviral therapy (ART). A recent study in Indonesia found that key populations have even poorer access and retention to ART treatment than the general population (10).

Meanwhile, HIV risk among Indonesian FSW remains high. A sample of 115 FSW from Sengigi, Lombok found that only 39% used condoms consistently, but that condom use varied across sex work venues. At the individual level, higher condom use was associated with female sex workers having ever been married, and at the client level, condoms were more likely to be used with foreign rather than domestic/ local Indonesian clients. The authors conclude that low rates of condom use among Indonesian female sex workers during commercial sex suggests the need for increased HIV prevention efforts that acknowledge sex worker characteristics and relationships with clients that place them at risk. Future research into the effects of social context on HIV risk should also be considered (11).

According to the 2007 and 2011 integrated behavioral and biological survey (12, 13), sex workers who had any STI symptoms were usually self-medicating. In the 2015 survey, a large proportion of FSW went to hospitals or health centers for treatment of STI (14). Data from the series of surveys showed that the number of FSW who had had an HIV test and knew their HIV test result increased between 2007 and 2015 (12-15). Despite this trend, the most recent IBBS in 2019 showed that around 58% of FSW had never been tested for HIV, and only 19.8% had tested on their own volition (15).

While access to HIV related services has shown a positive trend, there are still disparities in terms of access and utilization of HIV services among different subgroups of female sex workers. A study conducted by OPSI and NSWP in Bali and Jakarta found that in general, FSW reached by the national HIV program could access testing for HIV (16), but an important barrier to increased access remained for unreached FSW, especially those who are just entering the sex industry. A recent qualitative study revealed that 'newcomer FSW' faced multiple levels of vulnerability that contributed to increased HIV risk. First, a lack of knowledge and self-efficacy about HIV prevention practices was related to their younger age and low exposure to sexual education. Second, on entering sex work, they experienced intensely competitive working environments fuelled by economic competition. This competition reduced opportunities for positive social networks and social learning about HIV prevention. Finally, the lack of social networks and social capital between FSW undermined peer trust and solidarity, both of which are essential to promote consistent condom use. For example, newcomer FSW did not trust that if they refused to have sex without a condom, their peers would also refuse; this increased their likelihood of accepting unprotected sex, thereby increasing HIV risk. The researchers conclude that public health and social welfare interventions and programmes need to build social networks, social support and solidarity within FSW communities, and provide health education and HIV prevention resources much earlier in women's sex work careers (17).

In the past decade, Indonesia adopted several policies denouncing and prohibiting sex work. Various districts issued local anti-prostitution regulations which were followed by brothel closure & elimination around Indonesia. For example, Jambi City Regulation No. 2 of 2014 concerning prostitutions eradication and immoral behaviors. The city which follow anti-prostitution policy immediately close the brothels and give 'a new beginning' for sex workers. The government assisted sex workers went back to their origin and provided some compensation in order to start 'a new life'. A recent study on the impact of brothel closures in Indonesia pointed out that there are more challenges now than before for female sex workers' access to HIV services, and that there was a negative effect of these brothel closures on sex workers' ability to adhere to ART treatment (18). The closure of brothels leads to changes in the way FSW work; rather than face-to-face contacts, their business moves online, making them more difficult to reach with health interventions (18, 19).

Other barriers faced by sex workers when accessing HIV services include conflicting laws between the local and national level, weak enforcement of laws supporting FSW's rights

to HIV services and the rise of Islamic conservatism leading to policies such as forced brothel complex closures throughout Indonesia. Another barrier is widespread societal stigma, discrimination and violence against sex workers.

All these barriers hamper the successful implementation of HIV and other health programs in Indonesia, and need to be addressed if the government of Indonesia is to fulfill its development agenda and other global commitments it has committed to, such as the UNAIDS-mandated goal that 95 of PLHIV are diagnosed, 95% of diagnosed PLHIV have access to ART and 95% of PLHIV on ART have an undetectable viral load by the year 2025. Community-led and driven responses are essential for scaling up prevention and treatment services for meeting these targets.

1.2 Study rationale

From a human rights perspective, sex workers are a vulnerable group because they are at high risk of experiencing sexual abuse, violence, exploitation, discrimination and poor health. Related to the latter, this refers mainly to exposure to HIV, STI and unwanted pregnancy due to limited access to health protection and social and healthcare services. Therefore, programs to address sex workers' needs have to include comprehensive HIV and STI services, sexual and reproductive health services (SRH) and harm reduction interventions. In other countries, studies have found that important barriers to accessing such services exist for sex workers (20-23). These barriers include stigma directed towards sex workers by health care providers, long distances and high transportation costs to reach the services, inconvenient opening hours of the services, long waiting hours, unfriendly attitudes by medical personnel, and high costs (actual or perceived) of the services. It has been proven that projects aimed to help FSW attain better health lack a focus on services that many sex workers deem important, and which they often consider to be of higher priority than HIV/STI/SRH, such as reducing gender-based violence by clients, reducing violence and harassment by police and improving child- and other care and social support services (24-29).

The APNSW KPRA Project aims to strengthen evidence-based advocacy and, related to this, the capacity of sex workers to monitor the quality of HIV/STI/SRH services, so that they can effectively demand for improvements of these services for their community. The project is envisioned to strengthen community capacity to improve access to quality HIV prevention, testing, treatment, care and support services among key populations. One focus of this work includes female sex workers, building evidence and engaging in strategic advocacy for the purposes of improving quality of HIV prevention and care services for sex workers in Bangladesh, Cambodia, Indonesia, Myanmar and Vietnam.

This report presents the results of a mixed-methods assessment study in Indonesia, which will form a baseline for further program implementation.

1.3 Study objectives

The main objectives of the study were:

- To better understand policies, laws, legislation and other barriers that affect access to HIV and health services including HIV prevention and testing, treatment and other services for FSW.
- To better understand the needs of FSW for HIV and health services and the quality of current HIV and health services for FSW.

CHAPTER 2

METHODOLOGY

2.1 Study location and design

A cross-sectional study among 300 FSW was implemented, focusing on availability, accessibility and quality of services including stigma and discrimination faced by sex workers. The data was collected from Manado, Jambi, and Pekanbaru between 14 and 26 October 2019.

Besides this, qualitative data were collected in November 2019 through in-depth interviews based on an interview guideline used for district and national level to apprehend the policy and programs related SRH, including HIV. Thirteen participants were interviewed as key Informant, from Manado (4 persons), Jambi (2 persons), Pekanbaru (3 persons), and also at the national level (4 persons). The key informants at the national level were Ministry of Health, UN agencies & donor agencies. At district level, the District Health Office, District Aids Commission and NGO that backed by the funding to reach sex workers were interviewed. Nine out of 13 interviewed key informants were female.

2.2 Sampling

Purposive sampling technique was used for this study, with study participants identified and recruited through the interviewers, outreach workers and peer educators of OPSI within three cities, Jambi, Manado and Pekanbaru.

City	Estimated size of SW population	Sample size in current study
Jambi	367	75
Manado	489	75
Pekanbaru	1729	150

2.3 Eligibility criteria

The participants had to be over 18 years old, self-identify as a female sex worker, and had to have used at least one of the following services in the past 12 months: HIV services, sexual and reproductive health services, or sexually transmitted infection services. Participants also should have been residing in the study city for more than 12 months.

2.4 Data collection tools and process

Procedure

The selected interviewers included outreach workers and peer educators; they were all individuals who identified a FSW and were well-networked in sex worker communities. As a part of ongoing interventions funded by the Global Fund, outreach workers and peer educators routinely meet with sex workers in order to create awareness about HIV and STI and mobilize and facilitate access to health care services. They are also involved in other advocacy activities carried out by Indonesia SSRs.

Preparation

The data collection process was led by a Project Coordinator with local enumerators in each city. After their selection process, nine enumerators were trained on how to collect data using the community survey tool developed regionally; enumerator training was conducted in Jakarta on 8 - 10 July 2019. The training included research ethics, research techniques for semi-structured interviewing, discussion of questions in the questionnaire, and questionnaire trial. OPSI facilitated testing of the draft questionnaire with FSW before the questionnaire was finalised.

Field work

Data collection occurred between 14 October and 1 November 2019. The first day of visit to each city, the Project Coordinator and National Consultant refreshed the interview techniques with the interviewers. The interviews were conducted at the Drop in Center (DIC) OPSI, at FSW work locations or at the premises of health services, depending on the preference of the participant.

2.5 Data analysis

APNSW provided a data entry program in which to enter the responses from the questionnaires by the national partner organizations. The entries were first checked by the project coordinator. A statistical consultant reviewed the data for consistency, completeness and quality and performed data cleaning and data analysis. Data analyses were shared with each study country's SSR under the KPRA project for validation and to check the validity of interpretation of the codes to ensure that the data is understood and interpreted in the appropriate cultural context. The national consultant & project coordinator conducted the analysis and interpreted the results from each city to obtain a deeper understanding about current health service situation and the health needs of sex workers. The STATA data analysis program was used.

2.6 Ethical considerations

Ethical approval for this study was obtained from Atma Jaya Catholic University of Indonesia (approval number: FR-UAJ-26-13/RO). The database containing the interview data was only accessible to directly involved staff responsible for the study, APNSW, and research consultant. The database was kept in a secure place and was password-protected.

2.7 Limitations of the study

The data was collected using convenience sampling, meaning that the results that may not represent the general FSW population in Indonesia.

Considering the fact that the study recruited participants through the network of outreach workers and peer educators, it may have disproportionally excluded FSWs who are underserved by current HIV programs—i.e. untested and unreached FSW were not included.

Third, for ethical reasons participants had to be at least 18 years of age to take part in this study. The current study therefore does not reflect the voices of very young, and probably most vulnerable FSW—many of whom may operate via social media and the internet.

Due to the purposive character of the recruitment strategy, the participants in the study were from urban areas only, where access to HIV, STI and SRH services is probably relatively better than that in rural areas. Stigma and discrimination of FSW at urban-based facilities may be lower than that experienced in rural areas. A future study should put more emphasis on the situation and health needs of rurally-based sex workers.

CHAPTER 3

OVERVIEW OF THE HIV/STI/ SRH RESPONSE FOR FSW IN INDONESIA

3.1 Legal and policy environment of sex work in Indonesia

In Indonesia, there are no national prohibitions against sex work but the Indonesian Criminal Code prohibits pimping (trading in women) and living on the earnings of female sex workers. A resolution from the Ministry of Social Affairs allow sex workers to be detained in rehabilitation centers for up to six months (30). The recent rise of conservatism and fundamentalism has resulted in multiple incidents of raids and closures of entertainment establishments that include sex workers and men who have sex with men including massage parlors. As a result the Ministry has pushed for closing brothels and eliminating them altogether by 2019, as was reported in several media outlets.[1] Currently, the Indonesian parliament is drafting a penal code that potentially criminalizes all people who sell sex or who take advantage of those selling sex, outreach

[1] *Menteri Khofifah: 2019, Indonesia Bebas Lokalisasi* (Minister Khofifah: 2019, Indonesia Free of Brothel Complexes). *https://nasional.tempo.co/read/750572/menteri-khofifah-2019-indonesia-bebas-lokalisasi* Several articles have been published in international and local papers. See: https://www.reuters.com/article/us-indonesia-lgbt-police/indonesia-police-detain-51-men-in-jakarta-gay-spa-raid-idUSKBN1CC0L7; Qualitative Study on Brothel Complexes (lokalisasi) closure in 6 cities in Indonesia. HIV research Center, Atma Jaya University, 2015; Illegal brothel Alexis closed, Jakarta Governor urges workers to find jobs in Sharia-compliant hotels. http://www.abc.net.au/news/2017-11-08/indonesia-transforms-brothels-into-sharia-compliant-hotels/9130504

workers, same-sex behaviors, and those couples who are cohabitating without being legally married.

Although the Indonesian government has favored taking decisions based on perceptions of public morality and religious attitudes rather than a rights-based framework when it comes to sexuality, it has also at the same time focused on the prevention of HIV, which is a top priority. Five years ago the government began implementing a national strategy inclusive of female sex workers called the *PMTS Paripurna*, Comprehensive HIV Prevention through Sexual Transmission (31). The strategy takes a community-based HIV prevention approach for all key populations focusing on behavioral change and structural interventions.

In 2016, the government set up the "Minimum Service Standard for Health" (32), considered as an important step standardizing services across the provinces since local governments play a greater role in administering their areas. Through the National Health Insurance (JKN) scheme the health system aims to reach all Indonesians down to the village level. But a recent study by OPSI, the national sex workers network, and its partners ARC and Aidsfond found that more than 58% of participants did not have a JKN card. The most recent Integrated Behavioral and Biological Survey (IBBS) among young key affected populations in Bandung City found that only 37.1% of adolescent sex workers had a JKN card and only 12.9% had a national ID card (15). Sex workers including not possessing a valid JKN card face additional barriers because they often live away from home and are registered in a different district or province from where they receive services.

The law of local government states that any national strategic programs are to be implemented as local programming by local government. But local laws are often not compatible with a rights-based approach to HIV, and they have not been repealed or amended to accommodate HIV strategies and action plans. For example, regulations prohibiting discrimination against key populations in accessing health care services and requiring providers to actively engage with these communities are not followed. For example, on voluntary HIV testing the Ministry of Health has stated that testing must be performed with consent from the client. However, in some provinces there is mandatory testing in the context of employment, pre-marital testing of couples, and military. In some provinces, HIV transmission and non-disclosures is criminalized by local regulations, for example Bali Provincial Regulation Number 3/2006 and 27 and Cilacap district regulation 2/2015 article 25, reflecting a lack of understanding on part of local administration of national HIV policy. The situation for key population worsens when provincial and district level governments tend to copy existing regulations from each other.

On the other hand, there are positive example such as the Lombok Barat district regulation No. 47/2014 that enables key population to access HIV services and includes non-discrimination clauses, rights of patients to make informed decisions, prohibit healthcare service providers from stigmatizing and discriminating against key populations, and provides social assistance and legal aid. The government also engaged in an *Evidence-informed Deliberative Processes (EDPs)* that included provincial level local authorities in development of its HIV strategic plan and action 2015-2019.

Although the *National HIV Strategy and Action Plan 2015-2019* includes an enabling environment component, it has yet to be formally released to the public and no information is available on budgeted activities. The National HIV Strategy and Action Plan for the upcoming five years (after the current plan 2015-2019 ends) is under discussion and a series of meetings inclusive of all key populations including sex workers are taking place. The communities of key populations including sex workers are urging that issues concerning rights and protections be included through supportive

regulations and polices, and in turn these should be widely disseminated and understood by healthcare workers and local law enforcement agencies and legislators. An enabling environment means the protection of rights of sex workers and health as a fundamental human right indispensable for the exercise of other human rights.

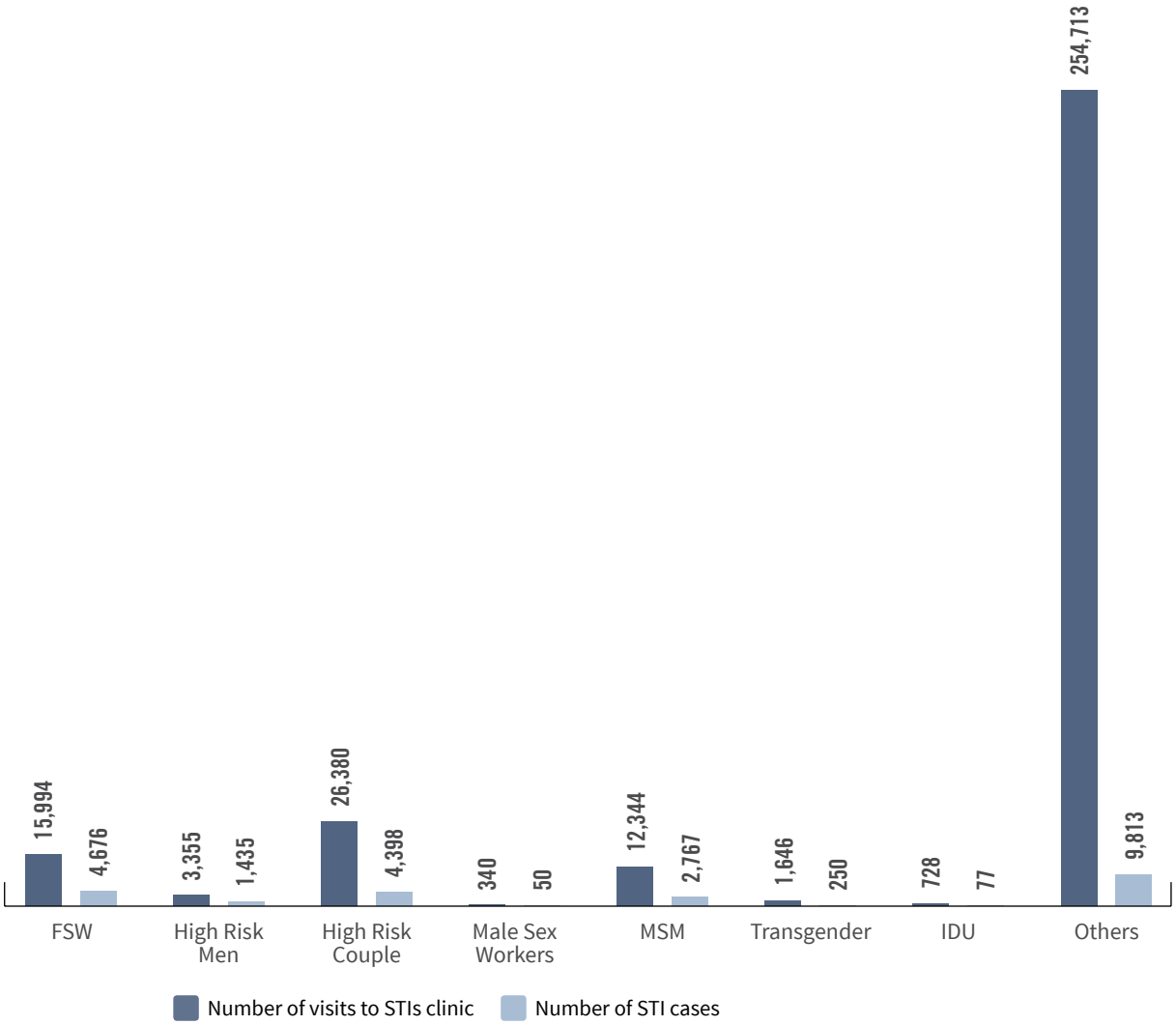
3.2 FSW within the Indonesian HIV/STI/RSH response

At the national level, Ministry of Health through Minimum Service Standards (PMK 4/2019) regulates in providing health services among groups at high risk of HIV, including sex workers. Therefore, the implementation of HIV and STI services for sex workers is compulsory as it has become a district target. Specifically, the NSP 2015-2019 set a target of 182,602 FSWs to be HIV tested in 2019, equal to 80% of the estimated number of FSW in the country. In the current HIV response for FSW, Global Fund provides support for FSW outreach programs in 88 districts (out of 514 districts) of Indonesia.

3.3 Services for FSW by government-led programs

Currently, the SRH services that are available for sex workers are primarily delivered through HIV and STI Clinics at Puskesmas. MOH data for July to September 2019 show that 15,994 FSW visited an STI clinic during this period (4), or about 7% of the estimated total FSW population. The data from the third quarter of 2019 showed that almost one-third of FSW who visited clinics were diagnosed with an STI (see Graph below).

STI Clinic Visit & cases July to Sept 2019



Graph: Number of Visit to STI Clinic and STI Cases in July to September 2019

All the three sites where the current survey took place can carry out rapid HIV testing (i.e. a test result is available within two hours). HIV testing and ART treatment are free of charge. However, clients may need to pay an administration fee if they do not have national health insurance (BPJS). This also applies to STI testing and treatment services. FSW who can afford to pay for health services themselves prefer to go to private clinics; most of them access vaginal douching and Pap smear service, in addition to regular HIV & STI testing.

Puskesmas provide integrated services for HIV and STI, including a Prevention of Mother-to-Child Transmission (PMTCT) program and a non-communicable diseases program through Pap smear testing (for cervical cancer) and STI testing. In theory, it would therefore be sensible for FSW to access health services at the Puskesmas rather than at hospitals or private clinics. Mother & Child Health services also provide access to pregnancy prevention, family planning, abortion and support against violence. FSW do not need to disclose their sex work background as long as they claim to be married.

Adolescent Health Care Services provides SRH services for adolescents to deal with problems related to adolescent growth and development, including counseling for SRH problems, consultation on psychiatric issues, pregnancy testing, detection and prevention of HIV AIDS and STI, etc. However, FSW under 18 years old usually refer to HIV & STI services, because staff there are more accustomed to deal with sex workers' health problems; according MoH regulation number 290/2008 regarding consent for medical interventions consent is given by a competent patient which refers to adult.

Currently, there are no national SRH guidelines specifically for FSW. However, Indonesia has a minimum service standard (SPM) for HIV. This guideline includes sex workers as part of targeted populations for HIV prevention. This document, (SPM PMK 4/2019) is an essential document that prioritizes HIV prevention up to the city/ district level. There are also UNFPA HIV guidelines for outreach workers (how to reach FSW, basic HIV information, outreach flow, referrals, BPJS, violence, etc) and a simple case management module to help newly-diagnosed FSW enroll into ART and stay on treatment.

Previously, the National AIDS Commission (NAC) provided free condom as part of the national HIV prevention program. However, this has been discontinued. In some places, only BKKBN still provides free condoms, but only if the purpose is prevention of pregnancy. Under that guise, sex workers can still come to the Puskesmas (Mother & Child Health Services) and obtain free condoms. Some other cities may still support free condoms using the budget provided by donor agencies.

Mobile clinics helps to overcome the barriers for sex workers in accessing HIV & STI services. Mobile clinic requires collaboration between NGO that reach FSW with Puskesmas or private clinics. Therefore, the arrangement and available services during the mobile clinic could be divergent among cities. HIV testing via mobile clinics usually are rapid tests. If the test result is reactive, a confirmation test needs to be done at the Puskesmas. However, some of the Puskesmas already conduct complete HIV testing services via mobile clinics with same-day results. Mobile clinics also provide consultation and treatment for common ailments, such as fever, headache, diarrhea, allergic, etc. Mobile clinics in collaboration with private clinics sometimes provide vaginal douching, which is a favorite service for FSW, even though they have to pay extra for that service.

3.4 Services for FSW supported or implemented by CBO, NGO and INGO programs

Outreach (conducted by NGOs/CBOs and funded by Global Fund and USAID) is the starting point for access to health services for many if not most sex workers. Through outreach, FSW are encouraged to do regular HIV & STI testing. Outreach activities are delivered to promote behavior change for safe sex and increase awareness of their sexual and reproductive health. For FSW who are living with HIV, outreach workers encourage the enrolment and adherence to ART. No outreach activities are currently funded by the government.

In order to provide comprehensive health services for FSW, collaboration between different health service providers is essential. Collaboration and joint management of local HIV services between the Department of Health, Puskesmas, CBO/NGO who do outreach and other services can varies between cities.

Offline or face-to-face method is a common and probably the easiest way to reach out to FSW. In recent years, however, sex work has started to move online. Outreach efforts have tried to follow; online outreach methods intend to keep up with changes in the pattern of sex transactions, reach sex workers who have not been reached yet, and possibly reach more beneficiaries. Online outreach is executed through social media or web applications.

CHAPTER 4

RESULTS OF THE QUANTITATIVE SURVEY

4.1 Socio-demographic characteristics & history of working in the sex industry

There was a total of 298 participants who were eligible for the study: 74 participants from Jambi (24.8%), 75 participants from Manado (25.2%), and 149 participants from Pekanbaru (50%). This imbalance in the sampling reflects the underlying differences in the estimated number of FSW in each city. It is therefore important not to overlook variations in each city's data as this can support details in locally-targeted advocacy plans.

Overall, 28.2% of the sample had a primary school education, and 11.8% did not complete primary education. 59% completed secondary education and 1% of FSW had a college degree. Comparing the three sites shows significant differences, however, with Pekanbaru more or less following the pattern above, but FSW from Manado much better educated, with 92% having a secondary degree and only 1.3% not completing primary education. In Jambi, 18.8% did not complete their primary education, and 35.1% completed secondary school.

In terms of marital status, 18.1% of the overall sample had never been married; 9.7% were married, 37.9% were widowed and 33.9% were divorced/separated. Again the differences between the three sites are remarkable. In Jambi, 66.2% of participants were widowed, almost double the average percentage, and 17.6% were divorced or separated. In Manado, the biggest groups were either unmarried (36%) or divorced/

separated (36%). In Pekanbaru the biggest group (41%) were divorced/separated. Nearly half the sample (47.3%) were not in a relationship at the time of the interview (in Manado only 24% were not in a relationship).

In terms of their living situation, there were big differences between the sites again. In Jambi and Pekanaru, 25.7% and 44.3% were living at the place where they worked, but in Manado only 1.3% lived at their work site—which is partly caused by selection bias when recruiting participants, but probably also indicative of different local practices regarding allowing or forbidding brothels or other sites where sex work occurs. 66.2% of FSW in Jambi lived in a private home; in Pekanbaru and Manado this was 34.7% and 38.3%, respectively. The rest lived in family- or shared homes, but in Manado 29.3% listed 'other', but it is unclear how and where they lived at the time of the interview. Only 1 FSW (in Jambi) reported that she was living on the streets.

In terms of their mobility, 32.6% of FSW across the three sites said they were away from their residence for more than one month per time at least once per year. There were no significant differences in this variable across the three sites.

Almost two-thirds (62.8%) of FSW said they had no health insurance (ranging from 52% in Manado to 70.3% in Jambi). Overall, 14.8% had national health insurance (ranging from 8.1% in Jambi to 16.1% in Pekanbaru) and 20.9% overall had 'extra health insurance' (ranging from 17.5% in Pekanbaru to 26.7% in Manado). Only 1 FSW per each site had private health insurance (1.3% of the sample).

Based on Chi-square tests, there were significant differences in characteristics (P-value < .05) between the three cities in terms of educational level, marital status, relationship status and living status. However, residential characteristics and availability of insurance were not significantly different between Jambi, Manado, and Pekanbaru.

Contact to majority of the clients (n=298)

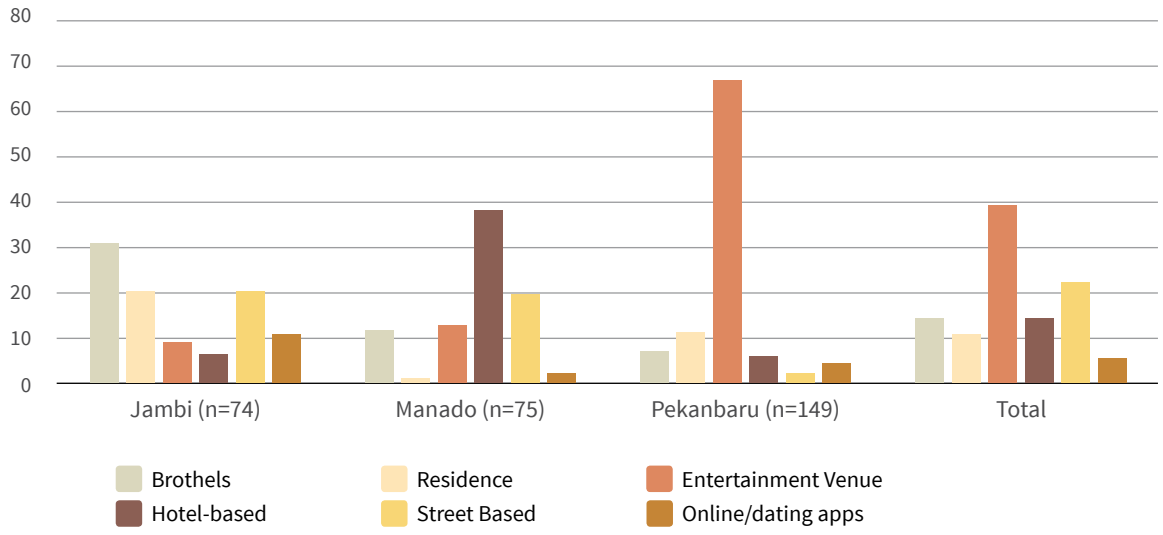


Figure: Approach to Contact the Clients

When looking at how and where FSW find their clients, the majority of participants contact clients through entertainment venues (39%) and on the streets (22%). However, there were major differences between participants in Jambi, Manado, and Pekanbaru. In Jambi brothels were most important (31%), followed by street-based (20%) and residence-based (20%) initiation of contact. Meanwhile, in Manado hotels are preferred (38.7%) followed by street-based initiation of contact (20%). In Pekanbaru,

entertainment venues (67%) were the preferred option, with residence-based sex work a distant second option.

Based on this data, it becomes possible to categorize sex workers based on their modus operandi. The majority of participants can be described as non-direct sex workers (67%), which is defined as sex workers who work in entertainment venues, hotels, or are based in their residence. In Manado, 60% are non-direct sex workers and in Pekanbaru 85%. In contrast, in Jambi 52% are direct sex workers (defined as those who are brothel- and street-based). The sex worker type significantly differs between cities (Chi-square X2 = 56.75, $p < .05$).

Looking at the sexual behavioral history of the FSW, on average they reported to have had average of 49 and a median of 30 male partners for either vaginal, anal or oral intercourse over the past three months, with a range of 0 to 450 partners. In Jambi the numbers were highest, with a median number of 35 sexual partners; in Manado the median was 25. Looking at non-paying partners, the overall average was 8 non-paying male partners in the past three months, which a range from 0 to 120 and a median of just one overall (the median was 0 in Jambi).

In terms of the number of times FSW had sexual intercourse in the past month, the median was 10 and average 27.5 overall; again, the mean was probably skewed upward by one or a few extremely high (and perhaps barely believable) data points. For instance, the range of the number of times FSW had sexual intercourse in the past month came out as 0 to a maximum of 3,020; since this is monthly data, the upper value of the range would mean 100 times of sexual intercourse per day! The median seems a more reliable indicator of sexual activity: median number of times that FSW had had sexual intercourse in the past month was 12 in Jambi, 6 in Manado and 10 in Pekanbaru. In the past 30 days, 15.9 of the average of 27.5 times FSW had sexual intercourse were protected by condoms, suggesting close to 58% condom use. Condom use in Pekanbaru was lowest (<50%) and highest in Jambi, which is an indication of the important role brothels can play in enabling safer sex in the context of sex work.

Based on statistical analysis ANOVA, there are significant differences between Jambi, Manado and Pekanbaru in the context of sexual history, except for number of sexual intercourses in the last month.

Obtaining Condoms (n=295)

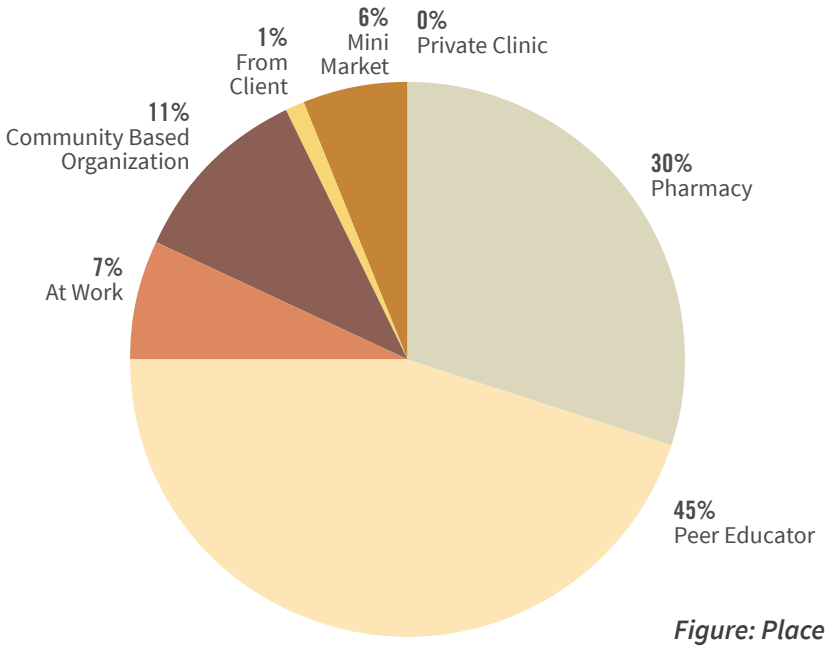


Figure: Place to obtain condoms

Almost all of the participants from Jambi, Manado, and Pekanbaru relied on peer educators (45%) and CBOs (10%) to get condoms. Over a third (30% and 6%) of FSW buy condoms at pharmacies and minimarkets, respectively; most of them were from Pekanbaru. Only a few (6.5%) workplaces provide condoms for FSW, showing the potential for better structural interventions in the three cities.

4.2 Experiences in accessing general healthcare services

In accessing general health services, some participants said they were refused health services, whether because they were known to be sex workers or not (3% and 3.7% respectively, n=298). Reported experienced stigma and discrimination during accessing health services was low at 3.7%, with the highest level at Jambi (6.8%).

More than three-quarters of the participants (77%, n=231) felt comfortable to disclose as sex workers during their last visit to a health facility; in Jambi and Manado this was more than 90% and in Pekanbaru 64.4%. As can be seen in the table below, within that group, 194 out of 231 (84%) participants felt comfortable to disclose as a sex worker at Government Health Centers and 21% at private clinics. For those who did not disclose as sex workers (N=52), mostly they gave as a reason that they felt ashamed or embarrassed (69%), 30.7% said they feared discrimination and the same proportion felt there was not enough privacy to disclose.

Table: Participants' comfort disclosing their status as sex workers while accessing general health services (n=231)

	Jambi		Manado		Pekanbaru		Total	
	n	%	n	%	n	%	n	%
What type of health facilities did you feel comfortable enough in to disclose yourself as being a sex worker? (n=231; note that participants could choose more than 1 answer)								
Government Health Center	52	77.6	58	85.3	84	87.5	194	84
Government Hospital	6	9	7	10.3	10	10.4	23	9.96
Community Health Center/ DIC	5	7.5	1	1.5	8	8.3	14	6.06
Private Clinic	17	25.4	10	14.7	22	22.9	49	21.21
Traditional caregiver	1	1.5	0	0	1	1.04	2	0.87
Nowhere	0	0	0	0	2	2.08	2	0.87

What is rather surprising is the low percentage of FSW who feel comfortable disclosing as a sex worker at a Community Health Center/DIC, as compared to a government health center or private clinic. Probably this is because the number of community clinics is very small; in some cases it is not even clear if a clinic that calls itself as such really is a community clinic. Participants seem to be giving answers based on the clinic/health services that they ever went to, hence, the chance they disclosed at a government clinic is much higher.

4.3 Access to STI services

During the last 12 months, 78% of participants visited STI services, with no significant difference between the three sites. The main reason participants went to STI clinics was to have routine STI screening (43.3%) or for STI counseling (36.8%). As can be seen from the table below, there were remarkable differences between the cities: while most of the Pekanbaru-based participants visited the STI clinic for routine STI screening (67.5%), in Jambi a large majority (74%) went for STI counseling, and only 20.7% went for routine screening. In Manado the main reason to visit an STI care facility was because they suspected an infection (41.5%); in the other two cities these percentages were only 3.5%

in Jambi and 5% in Pekanbaru. These differences are hard to explain.

Table: Main reason to Visit STI clinic (n=231)

Main reason to visit STI Clinic N (%)	Jambi (n=58)	Manado (n=53)	Pekanbaru (n=120)	Total (n=231)
Routine STI screening	12 (20.7)	7 (13.2)	81 (67.5)	100 (43.3)
Suspected an infection	2 (3.5)	22 (41.5)	6 (5)	30 (13)
Follow-up visit after an initial diagnosis and treatment	1 (1.7)	1 (1.9)	4 (3.3)	6 (2.6)
Obtaining condoms	0	4 (7.5)	0	4 (1.7)
STI counseling	43 (74.1)	18 (34)	24 (20)	85 (36.8)
Others	0	1 (1.9)	5 (4.2)	6 (2.6)

The majority of participants preferred to regularly visit the STI clinic at a Government health center (81%) and only 12.5% went to private clinics; here there were no differences between cities.

Meanwhile, around 22% of participants in Jambi, Manado, and Pekanbaru have not visited STI clinic in the past year, mainly because they felt it was not necessary (56.7%) or did not know where to go (32.8%). 15% gave as a reason that they already learned about STI from peers; only 7.5% of those who did not visit STI clinics (a total of 5 persons) said they did not go to an STI clinic because they feared negative attitudes by healthcare personnel.

Experience while obtaining STI services

Half of the participants said they felt it was very easy to visit STI services from their home. A total of 8% of participants fout it somewhat difficult or very difficult. Over two thirds (70%) expressed satisfaction with the services received and with the STI staff attitudes. A large majority (91%) found the waiting times were reasonable. Many participants visit specific STI clinics; they consider the cost (50.2%), location of the STI clinic (48%), and the friendliness of staff of the services (44.2%) important criteria for deciding to which clinic to go. 86% of the FSW felt comfortable to disclose their status as a sex worker at the clinic; Jambi and Manado-based FSW felt most comfortable (>90%) whereas in Pekanbaru nearly 21% of FSW did not feel comfortable to disclose. The most important reasons for non-disclosure were embarrassment (71%), worries about confidentiality/privacy (31%) and worries about being stigmatized (25%). Overall, three quarters of FSW in the survey said they would recommend the STI service they last visited to friends; again, in Jambi and Manado this percentage was much higher (93.1% and 88.7%, respectively) than in Pekanbaru (59.2%). It is interesting that many participants feel satisfied with the services and the staff attitude, but some still would not recommend this STI service to other sex workers. This may be related to internalized stigma and shame about having been to an STI clinic; this is information FSW may not naturally wish to share with other FSW.

4.4 Access to HIV services

HIV testing history and status

A large majority of participants (96.6%, n=298) had been tested for HIV: 72 participants from Jambi (97.3%), 75 participants from Manado (100%) and 141 participants from Pekanbaru (94.6%). Nine participants (3.1%) reported being HIV positive, and eight out of nine HIV positive participants had sought medical care and received treatment. About 99% of participants had been tested for HIV with their consent.

There were two participants from Jambi and eight participants from Pekanbaru who were not willing to be tested for HIV. They gave as reasons that no one advised them to do so, that they did not know where to get tested, that they thought that they were not at risk, or were worried about stigma & discrimination. Only one participant reported she did not want to know her HIV status.

Regarding the result of HIV testing, all of the participants received their result. As can be seen in the figure below, only 38% participants received it within 2 hours. Fifty-seven percent (166) participants received it on the same day, and others 1 to 3 days or even one week after the test (4.2%).

How long did it take to get your HIV test results? (n=288)

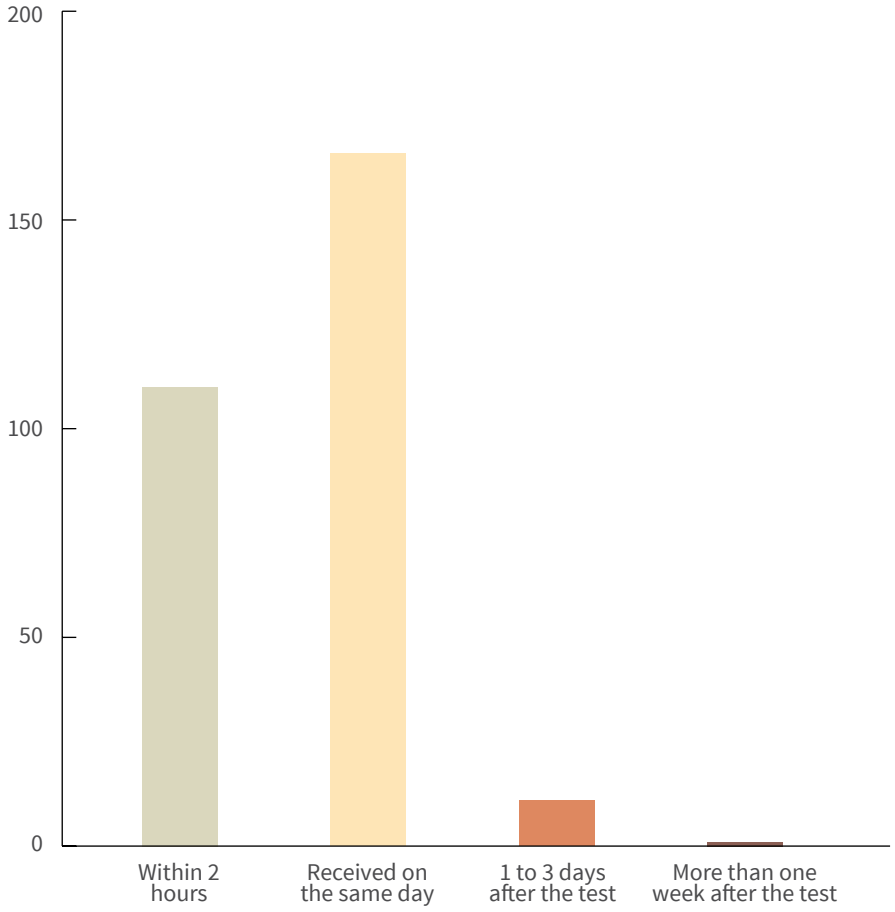


Figure: Duration to get the result of HIV testing

In general, all participants (n=288) had been tested for HIV on average four times. Participants usually get HIV testing from a government health center (58%) or from mobile clinics (36%). Interestingly, considering the difference in the way sex work happens across the three sites, the average number of HIV tests and places where HIV testing was obtained were not significantly different between Jambi, Mando and Pekanbaru.

Experiences when obtaining HIV services

About 42% of participants felt it was easy or very easy to visit HIV service providers from their home. Nearly 28% said it was “not very difficult”. Around 10% (n=71) participants in Jambi and 6% (n=141) participants in Pekanbaru reported it is difficult to reach HIV services from their home. About a quarter (23%) said the question was not applicable because they made use of mobile clinics; this was the case mostly in Jambi (30.6%) and

Manado (50%). Most of participants felt very or somewhat satisfied with the services (91%) and attitude (91%) of the staff at HIV clinics. Only 1.4% participants (2 from Jambi and 2 from Pekanbaru) said they were only a little or not satisfied with HIV services received. Satisfaction with both HIV services and staff attitudes was highest in Manado and lowest in Pekanbaru.

At the HIV clinic, a wide variety of services were received, as can be seen from the table below. Participants were explained about HIV transmission and prevention (96%), received counselling regarding their HIV test and test result (94%), and were offered condoms (76%). Condom provision was most common in Manado (94.5%) and least common in Pekanbaru (66%). Referrals to testing services for other STIs were provided to over three quarters (77%) and half of participants were referred to SRH services (52%).

Table: Services received while visiting HIV services (n=288)

	Jambi		Manado		Pekanbaru		Total	
	n	%	n	%	n	%	n	%
Services Provided								
Explanation of HIV transmission & prevention (n=288)	70	97.2	75	100	132	93.6	277	96.2
Counseling regarding HIV testing and results (n=288)	70	97.2	73	97.3	129	91.5	272	94.4
Suggestion to test for other STI (n=287)	65	90.3	43	58.1	115	81.6	223	77.7
Referral to SRHS (n=287)	56	77.8	29	39.2	66	46.8	151	52.6
Condom provision (n=283)	54	78.3	69	94.5	90	66	216	76.3

Nearly 90% of FSW in the survey across sites felt comfortable disclosing their status as sex workers to staff there. This was highest in Jambi (97.2%) and Manado (98.4%) and lowest in Pekanbaru (80.8%). Similar to the findings in the STI section, the reasons for the 30 participants who did not disclose (27 of whom were from Pekanbaru) were embarrassment (83.3%), fear of stigma and discrimination (26.7%) and a perceived lack of privacy and confidentiality (20%). Over three quarters (77%) would recommend their HIV service to others; again, the figures in Jambi (91.7%) and Manado (93.3%) were much higher than for Pekanbaru (60.3%).

Participants went to specific HIV clinic for particular reasons; their key criteria for selecting a particular service were cost (59.7%), friendly staff (47%), nearby location (42%), and because they were referred there (35%).

Despite their high marks for HIV service quality and staff attitude, it is remarkable that 43 out of 72 participants in Jambi (46%) said that they always felt uncomfortable during their visit there. Though there was a high number of participants in Jambi whom were okay to disclose their sex workers status, in general, almost half of participants in Jambi always had an unpleasant experience when visiting HIV clinic (see Figure below).

During any time of your visit, did the service provider make you feel uncomfortable? (%)

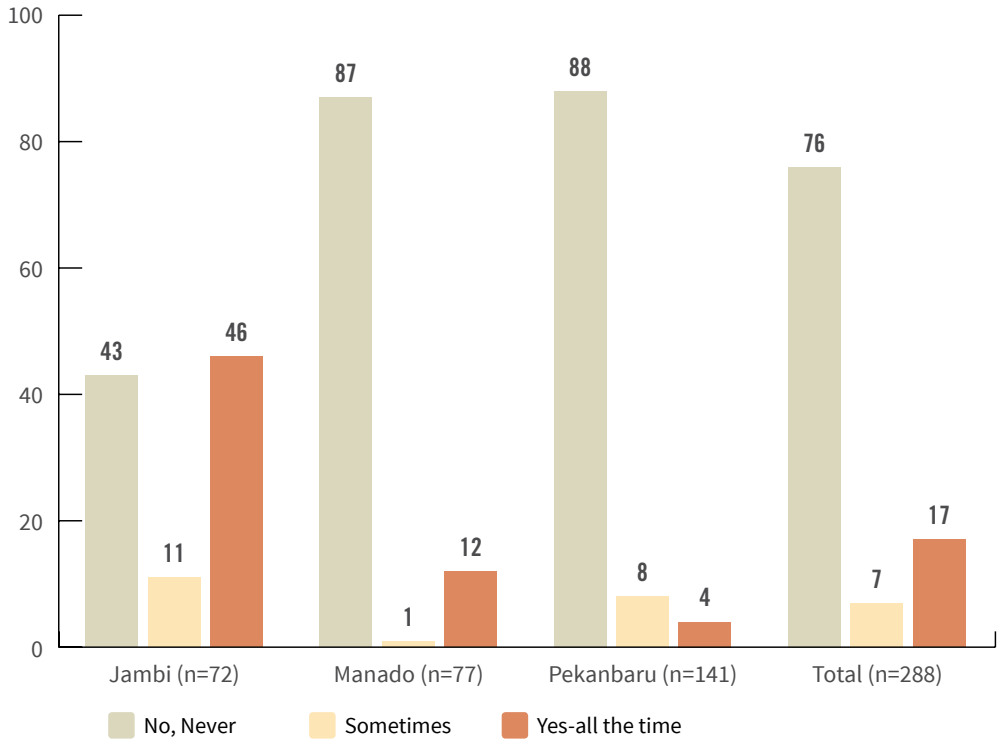


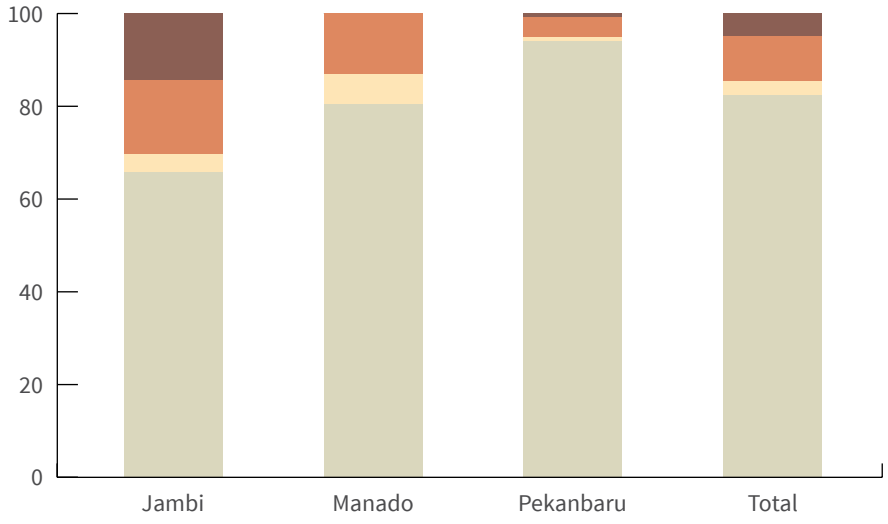
Figure: Uncomfortable experiences during visits to HIV clinics

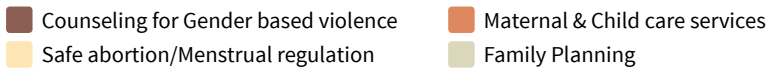
4.6 Access to SRH services

During the last 12 months, 73.8% participants visited sexual and reproductive health (SRH) services (61 participants from Jambi, 47 participants from Manado, and 112 participants from Pekanbaru).

The majority participants (66.4%) from the three cities went for the purpose of accessing family planning programs, and 7.7% accessed maternal & child care services in the last 12 months. In Jambi, 11 out of 74 (14.9%) participants accessed counseling for gender-based violence during the past year; this reason for accessing SRH services was not or hardly not mentioned in the other cities (see graph below).

Type of SRH services accessed in the last 12 months (n=220)





Graph: Type of SRH services accessed in the last 12 months

During their last visit to an SRH clinic, most of the participants (78%) accessed the family planning program; about a quarter (23%) went for prevention of unwanted pregnancy, mostly participants from Pekanbaru, and a few participants received a Pap smear during their last visit, mainly participants from Jambi and Manado.

Table: Reason for the last visit to SRH services

Reason for last visit to SRH services	Jambi (n=67)	Manado (n=47)	Pekanbaru (n=112)	Total (n=220)
Family planning	36 (59)	34 (72.3)	102 (91)	172 (78.2)
Obtain free condoms	0	6 (12.8)	0	6 (2.73)
Maternal & newborn care	3 (4.9)	6 (12.8)	0	9 (4.1)
Prevention of unwanted pregnancy	6 (9.8)	6 (12.8)	39 (34.9)	51 (23.2)
Assistance on gender-based violence	0	0	0	0
Pap smear	16 (26.3)	12 (25.5)	6 (5.4)	34 (15.5)

In contrast with HIV and STI services, which are mostly accessed in Government Health Centers, FSW access SRH services more often at a private clinic (44%) then at a government clinic (38%). In Pekanbaru, a quarter of participants accessed their SRH services at a local midwife, mobile SRH services or pharmacy.

Experience in accessing SRH Services

Less than 9% of participants found accessing SRH services somewhat or very difficult. When asked how satisfied participants were with the SRH services they received, 100% of participants in Manado said they were very satisfied; in Jambi satisfaction was 90.2% and in Pekanbaru, similar to satisfaction levels at STI and HIV facilities, it was lowest at 71.2%. Overall, only 2.8% of participants were only a little or not satisfied with services received. Satisfaction with the staff at these facilities was similarly high: 92.7% overall said they were either very satisfied or satisfied with the attitude of the healthcare provider at their SRH clinic. Only 1.4% was not satisfied.

Just 4.5% found waiting times too long or somewhat long. The average time spent in accessing SRH services was about 1 hour and 20 minutes, ranging from 1-3 hours in Manado and 1 to 5 hours in the other two cities.

The considerations in determining which SRH clinic to go to were generally proximity to the location (45%, n=220), low or reasonable cost (36.4%), and friendly staff (35%). Perceived quality of the service (14%) came in fifth place as a consideration for participants in choosing an SRH clinic.

Most participants said they were given private SRH counseling (81.7%) and 83.1% felt there was a high level of confidentiality. The 5% participants who did not feel there was a high level of confidentiality were all from Pekanbaru. About 12% of participants, mostly from Jambi and Pekanbaru, explained that the SRH clinic does not have a private space for SRH counseling.

44.9% of participants also accessed HIV services and 43.1% also accessed STI services while visiting SRH service providers, except in Pekanbaru where only 13.5% accessed HIV services and 12.6% STI services as part of their SRH service access.

In terms of disclosure, 68.8% of FSW felt comfortable disclosing their status as a sex worker in SRH clinics (ranging from 85.3% in Jambi to only 58% in Pekanbaru), which is quite a lot lower than disclosure levels at STI and HIV services. Reasons why 68 FSW did not disclose their status as sex workers at SRH facilities were embarrassment (44.1%. especially in Jambi and Pekanbaru), not thinking it was relevant (35.3%-especially in Manado), worries about confidentiality (25%, especially in Pekanbaru) and fear of discrimination (23.5%, in Pekanbaru and Jambi).

Around 85-95% participants within the three cities reported they had been pregnant at least once. In the past 12 months, 12.2% had an unexpected/unwanted pregnancy. Participants in Manado had higher levels of unwanted pregnancy (25.5%, n=47) compare to Jambi (6.7%, n=61) and Pekanbaru (9.2%, n=111).

16 out of 25 participants kept the pregnancy, and the rest had an abortion, either at a private clinic or by unsafe abortion (drinking herbal medicine, drinking lots of pineapple juice, or taking abortion pills). Only after a miscarriage would they visit health services for post-abortion care.

4.4 Barriers while seeking healthcare services at different service sites

Policies and regulations

According to key informants, after anti-prostitution policies (including forceful brothel closures) have been introduced, local stakeholders seem to adopt the perspective that there are no more sex workers in their locality. They do not realize that most sex workers will return to work to the same city or in other cities when they run out of money. The economic empowerment program of the Ministry of Social Affairs as a solution for FSW was mostly not successful and collapsed within a few months. According to key informants, the urgent need for money for their family always brings them back to what they can do to make most money: sex work.

The anti-prostitution regulations have a detrimental impact on attitudes among stakeholders/gatekeepers in providing HIV, STI and SRH services for sex workers. Some local stakeholders avoid to discuss the existence of sex workers in their cities, after brothels have closed. This is then reflected into the lower number of sex workers in the district database. On the other hand, there are an increased number of pregnant women and other populations that access HIV, STI and SRH services. Some informants said sex workers change themselves and present at health services as pregnant women or another category, even when they accessed the services at sex work 'hotspots'. In that way, a lower number of reported sex workers using health services is used to demonstrate the 'success' of the brothel closure policy, whereas it is in fact a data artefact. Indeed, the third-quarter of 2019 HIV progress report of the MOH shows a higher number of the 'unknown' category visiting STI clinic as well as in the number of STI cases (4).

These unrealistic assumptions among stakeholders that there are no more sex workers in their cities make it difficult for Puskesmas to conduct mobile clinic services to FSW in hot-sports; Puskesmas are prevented by the hostile policy environment to actively reach out to sex workers. In some sites, the District Health Office does not allow Puskesmas to conduct mobile clinics in certain hotspots.

Lack of coordination between Stakeholders

Communication and coordination are necessary in building good relationships among stakeholders. For example, mobile clinics can only be successful if there has been good prior coordination between NGOs, who provide outreach and can mobilize prospective FSW clients, and Puskesmas/private clinics. In this way, the achievement of district

targets in preventing transmission of HIV & STI for FSW is dependent on the level of communication and coordination between its stakeholders. In some cities, coordination between stakeholders leaves lots to be desired, with only the minimum level of communication and coordination occurring on a case-by-case basis.

At the national level, the National AIDS Commission (NAC) is responsible for coordinating stakeholders in Indonesia's HIV response. Currently the NAC has been merged into Ministry of Health. At the district level, some District AIDS Commissions are not functioning as coordinating and coordinating bodies, and only take responsibility for collecting and managing HIV/AIDS related data within the District Health Office. Others are working with limited and/or delayed grants from local government budgets (APBD) and therefore they may not be effective in coordinating the local HIV programs. Condom availability has also recently become problematic; previously condoms were provided directly by the NAC.

Stigma & Discrimination

Indonesian media coverage always creates negative images about sex workers and about prostitution. This creates long-term negative perceptions, not only about sex workers but also among sex workers themselves (internalized stigma). The media also often misrepresents and exaggerates news related to condoms. When police find condoms at premises suspected of harboring sex workers, the focus is not on the fact that condoms indicate that safe and responsible sex transactions were taking place, but the discussion shifts to 'immoral behavior'. Once, a key informant related, the media accidentally published a photo of sex workers attending a mobile clinic without blurring the photo. As a result, not surprisingly, afterwards many sex workers refused to access mobile clinic services.

The Ministry of Health states that current services are easy to access and sex worker-friendly, and the current survey seems to confirm this. However, some local, national and donor stakeholders have observed that stigma and discrimination still occur. Some informants indicated that some health care workers still manifest a judgmental attitude towards sex workers that can create unpleasant experiences when accessing health services (which could explain the finding that nearly half of Jambi FSW felt 'always uncomfortable' when accessing HIV services there, despite having high praise for the quality of services received). Stakeholders acknowledge that current services have improved and are more accessible than ever before.

Lack of condoms

Key informants note a lack of condom availability for sex workers. This problem has occurred since the National AIDS Commission is now under the Ministry of Health and cannot procure medical supplies anymore. At the same time the National Family Planning Bureau only provides condoms if they are used in the context of family planning, hence FSW can only access them if they present themselves as a family planning client; likely the number of condoms they are provided in this context is much lower than they need as sex workers.

Structural Barriers

The survey results indicate that FSW have few problems accessing HIV, STI and SRH services, but this is likely caused by selection bias when recruiting participants for the survey (i.e. having successfully accessed health services was one of the criteria for eligibility to participate in the study). Key informants paint a different picture. They suggest that accessing primary health services is still an obstacle for FSW, primarily due to service operational time (i.e. during daytime/office hours only), length of waiting time, and costs that must be incurred if there is no BPJS. For that reason, many FSW who can afford to pay prefer to go to private clinics or postpone their obtain medical care until their condition has escalated. The participants in the survey, however, reported

relatively few structural barriers while accessing health services.

Key informants indicate that many FSW are reluctant to access health services alone and prefer to be accompanied when going to the Puskesmas. Most of them rely on outreach workers to go to the Puskesmas, so they do not have to pay for transportation costs and because they appreciate the outreach workers' guidance while in the health facility.

Low health seeking behavior

Health service stakeholders state that sex workers, due to competing priorities in their life, place low priority on their health, and hence have low health seeking behavior. Some health care providers assume that many sex workers are afraid to learn of any adverse health condition they may have. They would rather not know their health condition than to know if they have an illness.

Part of this fear is caused by the lack of condoms and, as a result, their low condom use. Low condom use is also caused by the urgent need to get money to support their family's economy, which makes it more difficult for them to negotiate condom use with clients. As a result, key informants say, sex workers cannot do anything if the client refuses to use protection.

Factors that inhibit FSW from accessing SRH services include the need to ask permission from brothel-keepers each time they leave the brothel. In addition, if a FSW is known to be living with HIV they will often be thrown out of the establishment and will not be able to work, at least not in their previous brothel or locality.

Lack of outreach coordination

Health care providers in some cities appreciate the role of outreach workers. The Puskesmas officials admit the difficulty of reaching sex workers by themselves. Outreach workers have become the key to gaining trust and allowing sex workers to gain access to health services. However, in terms of collaboration, some informants mentioned constraint in scheduling the mobile HCT due to Puskesmas availability. They also mentioned the need to increase the number of trained HCT counsellors.

4.7 Engagement of FSW in CBO/NGO planning

In the past 12 months, 85% of the survey participants from Jambi participated in any group-, organizational or network activity aimed at defending the rights of female sex workers. In sharp contrast, in Manado and Pekanbaru only 27% and 15% had been involved, respectively. In general, organizations that defend the rights of sex workers aim, among other things, to encourage ownership of health insurance as a basic health rights. In that sense it is disappointing that in Jambi, higher participation rates in groups/organizations /networks did not increase health insurance ownership.

Among those who participated in activities, around 80-98% are member of that particular group, organization or network. The reasons to participate are because they have opportunity to meet outreach workers & access services (36.7%), for solidarity & belonging to a community (27.5%), and last for skill building on advocacy, communication and livelihood (18.4%). Chi-square result shows that the difference in participation in organizations between cities is statistically significant.

Table: Participation in groups, organizations, or networks for female sex workers

During the past 12 months, did you participate in any group, organization or network that defends the rights of female sex workers?				Chi-Square
City	**Yes**	**No**	**Total**	
Jambi	63 (85.1)	11 (14.9)	74 (100)	Pr = 0.000 *
Manado	20 (26.7)	55 (73.3)	75 (100)	
Pekanbaru	22 (14.8)	127 (85.2)	149 (100)	
Total	105 (35.2)	193 (64.8)	298 (100)	

The results of this survey indicate that the level of participation among sex workers to engage in organizations or networks related to the rights of women sex workers are very low. Most of the participation of sex workers aims to access services and very little is involved to increase the necessary knowledge, skills development, or building community and empowerment against violence, exploitation et cetera.

CHAPTER 5

DISCUSSION

While FSW in Indonesia have seen improved access to general, HIV, STI and SRH services in recent years, at the same time, the political situation and enabling environment for delivering such services to FSW has worsened in recent years. At the national as well as local level, FSW seem to be crushed by the competing agendas of the Ministry of Health and the Ministry of Social Affairs, the latter backed by conservative Islamic politicians and activists. In line with international guidance by the World Health Organization and UNAIDS, the MOH has made sex workers part of a set of targeted key populations in need of HIV prevention, testing and treatment services; as such, they have decreed minimum service standards (SPM) for FSW, which are used as a guideline to achieve the national target of eliminating HIV. At the same time, the Ministry of Social Affairs has been actively pushing to close and eliminate brothels by 2019, without any consideration of the negative impact of that policy on the MOH's HIV & STI programs.

At the local level a string of conservative, moralistic policies and regulations have been put in place; anti-prostitution legislation and brothel evictions are part of this new hostile climate. These policies have the potential to severely impact FSW access to health services. For example, mobile HIV/STI clinics have seen their work made nearly impossible, and provision of this important service (on which over a quarter of the survey participants depended) is on the decline in many localities. Key informants suggest that so far, some FSW appear to respond to these changes in pragmatic ways, for example by no longer disclosing that they are sex workers when accessing services, even if they access them in well-known sex work hotspots. A recent MOH report shows this clearly, reporting a sharp drop in FSW clients and a large increase of clients in the 'other' category (4).

Due to the above changes in 'self-reporting', cities that have anti-prostitution laws showed a decrease in the number of self-declared sex workers. Ironically, this statistic has become a justification for conservative activists that their policy is working, and that sex work no longer exists in their area. In order to protect themselves and their clients, counselors at HIV/STI/SRH services are reluctant to further explore risk factors with clients, preferring to keep suspicions they may have about whether a client is engaged in sex work under the table.

The problem with the lower and lower numbers of reported FSW is that current outreach activities in Indonesia are still depending mostly on donors' support. If the donors take the numbers at face value, and see a lower number of sex workers at the national/district level, they may decide to cut funding for FSW HIV/STI programs. It is important that donor organizations, perhaps with the help of the UN, are educated about this situation so they understand it, in order to ensure that sex workers continuously have equitable access to HIV prevention, care, and treatment services.

The more hostile political and religious environment is also leading to changes in the way sex work 'works' in Indonesia. In response to harassment and violence, there is a tendency for sex work to remove itself from the public eye. Hence, brothels are becoming more and more rare, and more sex work is taking place from hotels and entertainment venues (although the latter may also soon become a target for conservative anti-prostitution activists). In other words, FSW will gradually become harder and harder to reach for outreach workers and health professionals. Since demand for sex work is not declining as a result of conservative policies, it is likely that sex work will move underground and the HIV and STI epidemics are due to get worse. In the survey, the effect of different local policies on how sex work 'works' is clear: in Jambi, the most common form of sex work seemed to still be brothels; in Pekanbaru it was entertainment venues, and in Manado it was mostly hotel-based. It is very important that local service providers understand how sex work is organized in their city, and that it keeps track of possible changes, so that service delivery strategies can be adapted in response.

One important new form of sex work was not reflected in the survey results: online sex work. It is likely that many FSW are resorting to social media apps and platforms, including Facebook, to find clients. However, due to the recruitment strategy for the current survey, i.e. participants were recruited via existing service providers, and one of the criteria was that they had to have accessed health services at least once in the past 12 months, this important new (and probably young, unexperienced and more vulnerable) group of FSW has been left out of the findings, and hence, the discussion. An 'online ethnography' of sex work should be conducted to help health professionals (from both the MOH and NGOs/CBOs) understand in which new ways sex work is being (informally) organized in Indonesia, so that changes in outreach and service delivery mechanisms and strategies can be made.

Regarding experience accessing the health services, only a few of the survey participants felt not satisfied or only a little satisfied with the services received—possibly indicative of selection bias in the survey, because FSW who would be really upset with the services and might never return also had less chance to be recruited. Key informants indeed suggest that not everything is fine in terms of stigma and discrimination, despite the number of survey participants reporting such instances was remarkably low (<5%). The high satisfaction finding was contradicted by the fact that many 'satisfied' participants would not necessarily recommend the services to other sex workers. In Jambi, FSW gave very high (>90%) marks for service quality and for staff attitude, but at the same time 46% of respondents said that the HIV service health care provider 'always' made them feel uncomfortable during and after their visit there.

Another proxy for health service quality – whether a FSW feels comfortable to disclose as a sex worker – showed mixed results. A surprisingly high number (77%) said they felt comfortable to disclose as FSW in a government health center, but less than 10% felt comfortable disclosing as such in a government hospital. Readiness to disclose was lower when accessing SRH services (often delivered in private clinics) than when accessing STI or HIV services. One reason could be that the focus of the government, donors and hence, NGOs and CBOs has been strongly on HIV programs, encouraging HIV testing, starting treatment and continuing treatment. Under current practice, STI and SRH services are not yet fully integrated with HIV programs; this means that FSW may be 'over-serviced' when it comes to HIV services but do still lack access to quality health care for other pressing health needs. A future qualitative study should take the contradictory disclosure findings in the survey and try to make more sense of them.

Overall, FSW have very limited access to health insurance (only a bit over a third had any kind of insurance).

In terms of HIV services, almost all participants had been tested and had received their test result (partly caused, as said, by selection bias of the participants). Only 38% of FSW in the survey received their test result within 2 hours, showing how many service providers apparently still use outdated test kits. Over half (55%) said they relied mainly on outreach workers and CBOs to obtain condoms; key informants mentioned that there is a lack of condoms available for prevention programs for FSW. Partly as a result, only 6.5% of FSW in the study said that their work place provided condoms to them; this shows how there may be room for more structural interventions, especially in brothels, hotels and entertainment venues, ensuring that condoms (and lubricants) are easily available there, paid for either by the client, by the FSW, by the management of these places or by the MOH/National AIDS Program.

Globally, community empowerment and participation has played a fundamental role in the fight against HIV. It has a clearly positive effect on prevention strategies, uptake and availability of treatment and use of services (33). The Sex Worker Implementation Tool (SWIT) for HIV & STI testing, treatment and prevention strategies clearly emphasizes recommendations for community empowerment and participation at the center of this strategy, because it is clear that without these components, HIV and STI outcomes will be weaker. But Indonesian NGOs working with and for FSW, including DIC, seem to be very limited and are narrowly focused on delivering HIV services, ignoring needs that are, from a FSW perspective, more urgent to fulfill.

The survey conducted in the three sites looks at the extent to which FSW have 'participated in networks or organizations fighting for sex worker rights'. At face value, the results show very high participation in Jambi (85%) and low participation among sex workers in Manado (27%) and Pekanbaru (15%). But it was unclear what this 'participation' actually meant. From key informant interviews, it can be derived that current outreach workers and peer leaders mostly focus on participation of sex workers in HIV services (testing and treatment). This is implied in the higher number of sex workers who access HIV clinics compared to STI and SRH clinics. Meanwhile, the empowerment and community mobilization aspect is still lacking. Sex workers confirmed that the current form of participation in the three cities is mostly only to meet outreach workers & access services. There is little focus on providing in other FSW needs, including provision of safe spaces, support to obtain health insurance or social welfare, opportunities for improving literacy or educational level, or for empowering sex workers to jointly take action to improve aspects of their life, for example organizing action against violence or providing and sharing child care. Data from the survey confirms that the main focus of NGOs is to refer sex workers to health services—although again, this could partly be because of selection bias.

The essence of community empowerment and participation, such as activities related to promoting a human rights framework, strengthening the collective, creating a supportive environment, and many more are therefore far from optimal. An important reason that CBOs and NGOs are not focusing on this may be the unavailability of donor support, but also—very importantly—this may be caused by the fact that many CBOs and NGOs are not led by sex workers themselves.

Lack of coordination and cooperation between different stakeholders in the response was seen as an important barrier leading to impediments to care for FSW. However, even though donor organizations currently only provide incentives for outreach workers and transportation costs for mobile clinics, some cities have shown they are capable of maintaining regular meetings with stakeholders to discuss their work in order to reduce misunderstanding. These meetings also discussed more collaborative action to achieve district targets, challenges and strategies to overcome barriers to FSW health care. Having a jointly agreed collaboration plan is important in this regard. Based on health care providers' experiences, STI & HIV services effectively reach sex workers if they are conducted in appropriate time intervals between information, testing, and treatment. Good communication among local stakeholders leads to better outcomes for outreach and for the mobile clinics.

CHAPTER 6

RECOMMENDATIONS

1. It is essential for the future success of any general, HIV, STI or SRH program for FSW that a strong community mobilization and empowerment component is established first. This should start with designing ways to increase meaningful FSW leadership and participation in the design and implementation of such programs. This should include opportunities for FSW to set their own agenda for priority programs and services that are not necessarily related to HIV, STI or even health, such as social welfare, child support, shelters from violence or provision of opportunities for vocational or literacy education. Collective groups or 'unions' of sex workers could be set up based on the type of sex worker or work location in order to build solidarity and take collective action to improve the life situation of FSW. The basic principle should be 'For Sex Workers, By Sex Workers', in other words, programs should be sex worker-led.

2. The capacity of outreach workers and peer leaders needs to be improved so that do not only have factual knowledge about HIV, condoms and STIs, but that they learn how to listen carefully to FSW needs and provide assistance and encouragement in processes of community mobilization and empowerment. If new outreach workers and peer leaders are to be recruited, it is important that people with current or past involvement in the sex industry are given preference, as they are least likely to harbor negative moral sentiments about sex work, and will be—if properly supported and encouraged by supervisors—most motivated and committed to positive change. As stated above, the basic principle should be 'For Sex Workers, By Sex Workers', in other words, programs should be sex worker-led.

3. In order to ensure availability and appropriateness of health services for sex workers, HIV services need to be strengthened, particularly the provision of condoms and lubricants and rapid HIV/STI testing following different modalities, and in terms of improved access and adherence to ART. As a first step, District Health Offices need to translate and formally adopt the Ministry of Health Regulation 21 and turn them into a locally agreed technical implementation guideline and workplan, in order to counter possible local anti-prostitution guidelines that aim to criminalize sex work in their area. If possible, STI, HIV and SRH services should be integrated into such local implementation guidelines rather than be offered as separate programs.

4. To solve the current lack of condoms in the field, condoms and lubricants should be directly procured and distributed by the Ministry of Health as part of the National AIDS Program to support HIV prevention program for sex workers. This has become urgent, since the National AIDS Commission is now under the Ministry of Health and cannot procure medical supplies anymore. At the same time the National Family Planning Bureau only provides condoms if they are used in the context of family planning.

5. To improve coordination and collaboration, District Health Offices or Provincial Health Offices should reinforce routine coordination meetings and advocacy activities targeting local stakeholders, especially after the District AIDS Commissions merge into the District Health Offices. Representatives of FSW collective groups should be invited to become part of coordination mechanisms and meetings. To that extent, it is important that the different work and life rhythm of FSW is taken into consideration: coordination meetings should not be held in the early morning when most FSW are not yet awake.

6. Since NGOs play an important role in reaching sex workers, it is necessary that Puskesmas consistently develop strong collaboration with local NGOs to provide mobile HIV testing service for sex workers or to ensure that the Puskesmas is friendly and accepting towards sex workers who prefer to obtain services there.

7. Reducing stigma and discrimination among health workers against sex workers should be incorporated as part of improvement of quality of service efforts, in order to increase utilization of HIV/STI services among sex workers.

8. At the local level, cooperation with private clinics and private doctors for the promotion of STI services and reproductive health for FSW should be strengthened, especially in locations where FSW feel unwelcome in Puskesmas or other government health services. This can help reduce the gap sex workers face in access to STI and SRH services.

9. The potential of drop-in centers should be utilized better. DICs can function as sites for cooperation and collaboration between NGOs, but more importantly, the DIC can be a safe space and function as a gathering place for sex workers. In this sense, the DIC can have both the function of improving the provision of health information and services whereas it can also function as a location where FSW can meet and prepare collective actions to improve their situation.

10. NGOs and CBOs should work to improve FSW access to health insurance.

REFERENCES

1. Ministry of Health. National Action Plan for the HIV/AIDS Response in Indonesia 2015-2019. In: Program NA, editor. Jakarta: Ministry of Health; 2015.
2. (UNAIDS) UNJPoHA. Indonesia Country Snapshot 2019. Geneva: United Nations Joint Programme on HIV/AIDS; 2019.
3. Ministry of Health. Estimates and Projection of HIV in Indonesia 2015-2020. In: Control DGoDPa, editor. 2017: Ministry of Health; 2017.
4. Ministry of Health. 3rd Quarterly Progress Report on HIV/AIDS. In: Control DGoDPa, editor. Jakarta: Ministry of Health; 2019.
5. Shannon K, Strathdee SA, Goldenberg SM, Duff P, Mwangi P, Rusakova M, et al. Global epidemiology of HIV among female sex workers: influence of structural determinants. The Lancet. 2015;385:55–71.
6. Baral S, Beyrer C, Muessig K, Poteat T, Wirtz AL, Decker MR, et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. The Lancet infectious diseases. 2012;12(7):538-49.
7. Francis C, Mills S. HIV cascade framework for key populations: FHI 360, Linkages, PEPFAR and USAID; 2015 October 2015.
8. World Health Organization. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update. 2016.
9. World Health Organization. Policy brief: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. World Health Organization; 2017.
10. Januraga PP, Reekie J, Mulyani T, Lestari BW, Iskandar S, Wisaksana R, et al. The cascade of HIV care among key populations in Indonesia: a prospective cohort study. The Lancet HIV. 2018;5(10):e560-e8.
11. Safika I, Levy JA, Johnson TP. Sex work venue and condom use among female sex workers in Senggigi, Indonesia. Culture, Health & Sexuality. 2013;15(5):598-613.
12. Ministry of Health. Integrated bio-behavioral survey on HIV in Indonesia. In: Control DGoDPa, editor. Jakarta: Ministry of Health 2011.
13. Ministry of Health. Integrated bio-behavioral survey on HIV in Indonesia. In: Control DGoDPa, editor. Jakarta: Ministry of Health 2007.
14. Ministry of Health. Integrated bio-behavioral survey on HIV in Indonesia. In: Control DGoDPa, editor. Jakarta: Ministry of Health 2015.
15. Ministry of Health. Integrated bio-behavioral survey on HIV in Indonesia. In: Control DGoDPa, editor. Jakarta: Ministry of Health 2019.
16. OPSI. Case Study on Stock-outs of HIV/STI commodities and treatments in Bali and Jakarta, Indonesia. . Jakarta: NSWP; 2018.
17. Januraga PP, Mooney-Somers J, Ward PR. Newcomers in a hazardous environment: a qualitative inquiry into sex worker vulnerability to HIV in Bali, Indonesia. BMC Public Health. 2014;14(1):832.
18. Organisasi Perubahan Sosial Indonesia. Laporan penelitian penutupan lokalisasi gondang legi kota Malang dan payosigadung Jambi. Jakarta: OPSI; 2016.
19. Praptoraharjo I, Sukmaningum E, Navendorf L, Widihastuti A, Apriana K, Sihaloho BS, et al. Laporam Studi Kwalitatif: Dampak penutupan lokalisasi/Lokasi di Empat Kota. Jakarta: Universitas Katolik Indonesia Atma Jaya & Komisi Penanggulangan AIDS; 2016.
20. Scambler G, Paoli F. Health work, female sex workers and HIV/AIDS: Global and local dimensions of stigma and deviance as barriers to effective interventions. Social science & medicine. 2008;66(8):1848-62.
21. Ghimire L, Van Teijlingen E. Barriers to utilisation of sexual health services by female sex workers in Nepal. Global Journal of Health Science. 2009;1(1):12-22.
22. Beattie TS, Bhattacharjee P, Suresh M, Isac S, Ramesh B, Moses S. Personal,

interpersonal and structural challenges to accessing HIV testing, treatment and care services among female sex workers, men who have sex with men and transgenders in Karnataka state, South India. J Epidemiol Community Health. 2012;66(Suppl 2):ii42-ii8.
23. Chakrapani V, Newman PA, Shunmugam M, Kurian AK, Dubrow R. Barriers to free antiretroviral treatment access for female sex workers in Chennai, India. AIDS patient care and STDs. 2009;23(11):973-80.
24. Dayton R, Alvarez B, Morales GJ, Rojas Almonte J, Faccini M, Gomes B, et al. Assessing an inclusive model to increase access to comprehensive gender-based violence response services and improve HIV outcomes in Puerto Plata, Dominican Republic. Culture, health & sexuality. 2019:1-17.
25. Leddy AM, Weiss E, Yam E, Pulerwitz J. Gender-based violence and engagement in biomedical HIV prevention, care and treatment: a scoping review. BMC public health. 2019;19(1):897.
26. Jana S, Singh S. Beyond medical model of STD intervention–lessons from Sonagachi. Indian journal of public health. 1994;39:125–31.
27. Jana S, Basu I, Rotheram-Borus MJ, Newman PA. The Sonagachi Project: a sustainable community intervention program. AIDS Education and Prevention. 2004;16:405–14.
28. Jana S, Bandyopadhyay N, Saha A, Dutta MK. Creating an enabling environment: lessons learnt from the Sonagachi Project, India. Research for Sex Work Newsletter. 1999;2:22–4.
29. Ghose T, Swendeman D, George S, Chowdhury D. Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India: the boundaries, consciousness, negotiation framework. Social science & medicine. 2008;67:311–20.
30. Kesepakatan penanganan prostitusi dan gelandangan pengemis or resolutions on addressing prostitution and homelessness, national coordination meeting of Ministry of Social Affairs, (2015).
31. Komisi Penanggulangan AIDS Nasional (Indonesia). PMTS paripurna: comprehensive HIV prevention through sexual transmission guidelines: partnership between government, private sector, communities, and media. . Menteng, Jakarta: National AIDS Commission of Indonesia; 2014.
32. Health regulation No. 43, 43 (2016).
33. Mbuagbaw L, Shurik E. Community participation in HIV/AIDS programs. HIV-infection-Impact, Awareness and Social Implications of living with HIV/AIDS: IntechOpen; 2011.