

2017 Sustainability Index and Dashboard Summary: Indonesia

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years by PEPFAR teams and stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 89 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Table 1: Sustainability Element Score Criteria
Dark Green Score (8.50-10.00 pts) (sustainable and requires no additional investment at this time)
Light Green Score (7.00-8.49 pts) (approaching sustainability and requires little or no investment)
Yellow Score (3.50-6.99 pts) (emerging sustainability and needs some investment)
Red Score (<3.50 pts) (unsustainable and requires significant investment)

Indonesia Overview:

Indonesia is a large and complex country with an estimated 255 million people and hundreds of different ethnic groups spread across nearly 17,000 islands. Local governments and municipalities became the key administrative units responsible for the provision and budgeting of public services when the Government of Indonesia (GoI) began decentralization in 2001. Indonesia has a GNI per capita of USD 3,440 (2015), is classified as a lower-middle income country by the World Bank. However, the country continues to struggle with fragile institutions, inadequate infrastructure, endemic corruption, terrorism, rising religious and ethnic intolerance, and the complex rollout of a national single-payer universal healthcare scheme. Indonesia is also faced with rising income inequality as 20% of the richest Indonesians hold 80% of the wealth and two-thirds of the population lives on less than USD 3 per day.

International donors, most significantly the Global Fund (GF), PEPFAR, and Australia's Department of Foreign Affairs and Trade (DFAT), contributed greatly to the national response in 2014. However, DFAT's departure from HIV programming in mid-2016 has had the greatest impact on the HIV response in Papua, which was heavily supported by DFAT. In late 2015 the GF approved an HIV grant of USD 97 million for 2016 and 2017 implementation years. Despite this envelope, Indonesia's Principle Recipients (PRs) have historically been unable to spend much of their total annual budget. The majority of international resources focus heavily on strengthening prevention activities and the quality of care across the cascade, particularly for KP and other priority populations.

SID Process:

On November 2, 2017, OU Indonesia, in collaboration with UNAIDS, conducted a one-day SID workshop to complete FY17 SID. Representatives from Sub-directorate of HIV/AIDS Ministry of Health, Ministry of Defense, Ministry of Work Force, National AIDS Commission, World Bank, ILO, DFAT, Provincial Health Office, District Health Office, civil society, PEPFAR implementing partners, and private sector associations participated in the workshop. At the workshop participants were divided into 6 groups to complete SID questionnaires based on data and information assembled from the group discussion. All groups then presented their results and gained consensus from other groups in the plenary. After the workshop, OU Indonesia shared the result and requested additional feedback from all participants, and then incorporated additional input and shared it with the head of Sub-Directorate HIV/AIDS for clearance.

Sustainability Strengths: (we have to choose which ones to highlight, 2-3 examples)

Indonesia is in the process of strengthening its system for supply chain management to ensure program results can be achieved and patients receive the commodities they need for continued care and treatment. Technical assistance and support from PEPFAR has been provided to share best practices and models of supply chain management from other countries to ensure continuity of resources and strategic thinking around a supply chain management system that supports the national HIV program.

Universal health coverage/Jaminan Kesehatan Nasional (UHC/JKN) is another significant opportunity to reform and refocus the national HIV response and address challenges in maintaining sustainable HIV services. The UHC principles, which call for the delivery of a comprehensive package of health services that respond to the burden of disease, can support the integration and quality of HIV services, improve equity in HIV service access, build coherence across different health areas, help address the social and economic determinants of HIV, strengthen health and community systems, and contribute to human rights.

Working on generating HIV specific financing data by supporting National Health Accounts, HIV Unit Costing and National Resource Estimations, PEPFAR is contributing toward building a robust discussion leveraging both civil society advocacy for domestic resource mobilization and GOI capacity to include HIV into the country's UHC benefit package. Additionally, PEPFAR is also working at the systems level to improve national health financing functions and capacity, which will have a direct impact on influencing provider behavior through strategic purchasing of health services.

Planning and coordination (score 8.40, light green):

The MOH, along with other technical ministries, annually submits their budget plan to the National Planning Agency (Bappenas) with annual budget approved by the legislative authorities. With the dissolution of the National AIDS Commission this CY; the Coordinating Ministry of Human Development and Culture (PMK) is responsible for planning and coordination of HIV/AIDS programming among all relevant technical ministries. It remains to be seen how the PMK will engage civil service organizations in prevention, and to help ensure PLHIV are retained in care and treatment.

At the national level, there are no policy barriers to the implementation of HIV prevention, care and support services. However, gaps remain in local policies and/or regulations that support access of KAP and PLHIV to services, including recognition of their right to services and policies that are gender sensitive and address stigma and discrimination. Moreover, some local governments have passed regulations relating to HIV, drug use, sex work and male-to-male sex that are not consistent with national guidelines or provisions on human rights.

Quality Management (score 8.38, light green):

The country has a QM/QI system in place for the HIV Program although particular elements of the program, such as laboratory systems, do not yet have a robust QM/QI system in place.

At present, the GOI has a sufficient number of VL machines to provide 567,600 tests per year, which meets the needs for the 3rd 90. These machines, however, lack an appropriate supply chain system to ensure they are properly supplied or a specimen transport network to ensure access to testing. The GOI, supported by PEPFAR and GFATM, and building on the USAID TB Program's efforts around specimen transport, is developing a specimen transport network to increase access to high throughput VL testing. In Terms of Workforce Lab Capacity, the responses in the SID reflect Jakarta and other major cities. In locations such as Papua, West Papua and Kalimantan, the capacity of lab workforce is lower and does not meet the diagnostic needs of the national program.

Domestic Resource Mobilization (score 7.93, light green):

The role of the national government is limited to regulatory, supervisory and partial financial support for program activities, while program implementation, budgetary and planning responsibility is devolved to approximately 500 sub national district governments. The local governments have the primary role for ensuring that policies are being implemented, and districts have considerable latitude in making choices about resource allocation.

The GOI funds the majority, around 60%, of the national HIV response. The National Social Health Insurance (JKN), that is about 60% GOI tax-funded, provides Non- ARV care and treatment services for PLHIV. ARV treatment, VL monitoring and rapid diagnostics are largely provided by the national vertical program. Outreach services and community support still rely on external funding, mainly from GFATM, and public funds transfer to civil society organizations is still constrained by existing regulation. In high burden districts and provinces, the local governments allocate budget for promotion and prevention through the public sector health providers.

Financial/Expenditure Data (score 8.33, light green):

The National AIDS Program uses Spectrum and the AIDS Epidemic Model to inform the allocation of resources, although this was not necessarily reflected in the most recent (2015) NASA report. In terms of geographic allocation however, the NAP has developed a National Fast Track strategy which prioritizes high burden HIV districts and provinces. Priority provinces and districts, depending on the total estimated number of people living with HIV, are provided with varying packages of services and

commodities across the cascade to improve case-finding, detection, Test and start, and VL suppression performance.

GOI is also executing several policy and programmatic changes, such as the release of the “test and treat all” policy, new HIV and laboratory strategic plans, updated district prioritization plans, and recent fast-track targets at the provincial and district levels; these, however, have not been accounted for in currently used HIV resource needs estimates.

PEPFAR is partnering with the GOI to develop sustainable financing platforms for the national HIV and AIDS response. This analysis will generate a comprehensive HIV resource requirement estimate to achieve national HIV targets by estimating province-specific unit costs and using recently-set province-specific targets. In addition, options for financing HIV-related services from subnational government resources as well as the feasibility of integrating different HIV service packages into JKN will also be explored.

Sustainability Vulnerabilities: (we have to choose which ones to highlight, 2-3 examples)

Civil Society Engagement (score, 4.67, yellow):

With the revocation of the Presidential Decree for the National AIDS Commission (NAC) in 2018, the current NAC is being absorbed into the Coordinating Ministry for Human Development and Cultural Affairs (PMK). There is no clarity yet how GOI funding would be accessible by CSOs.

Private Sector Engagement (score, 4.78, yellow):

Historically, the private sector has not participated in the National AIDS Response in Indonesia in a major way. However, private providers (KP friendly clinics and private laboratories) have provided quality HIV services for key populations

Epidemiological and Health Data (score, 5.54, yellow):

Behavior and HIV prevalence data on key populations is collected and analyze by the national level for use at the national level and rarely shared with sub national governments. Program data is mostly used for reporting purposes and, when available, is aggregated, but is of limited use for HIV surveillance at the district or national level. Additionally, surveys conducted in districts suspected to have high HIV prevalence among key populations cannot be utilized to determine the prevalence in the rest of the country.

The clinical cascade indicates that those are identified positive is still low but there is slow and steady improvement of the numbers. However, the number of identified positive is under reported in the national system. MOH started the HIV cohort reporting and it is scaling up to other public health facilities to cover data on number of retention at the national level.

Additional observation:

Contact: For questions or further information about PEPFAR’s efforts to support sustainability of the HIV response in Indonesia, please contact trachmawati@usaid.gov.

Sustainability Analysis for Epidemic Control: Indonesia

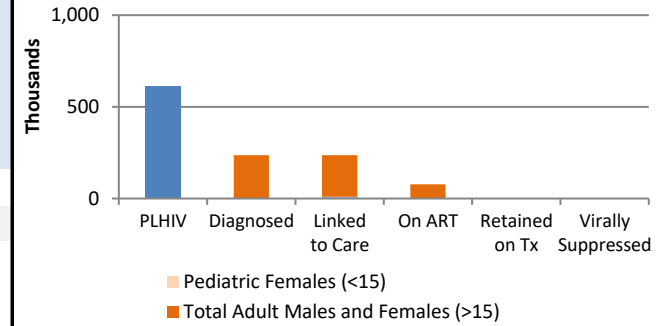
Epidemic Type: Concentrated
 Income Level: Lower middle income
 PEPFAR Categorization: Targeted Assistance
 PEPFAR COP 17 Planning Level: \$10,000,000

SUSTAINABILITY DOMAINS and ELEMENTS

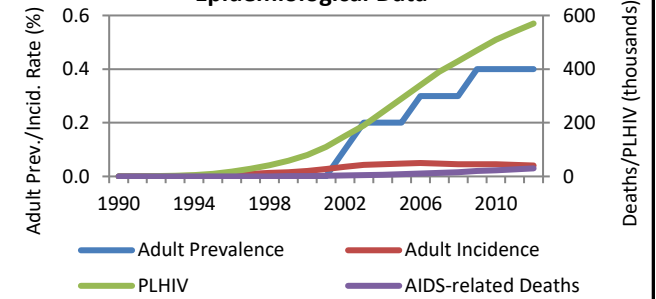
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	10.00	8.57		
2. Policies and Governance	6.58	7.06		
3. Civil Society Engagement	7.00	4.67		
4. Private Sector Engagement	2.75	4.78		
5. Public Access to Information	8.00	5.00		
National Health System and Service Delivery				
6. Service Delivery	6.30	7.69		
7. Human Resources for Health	7.58	6.74		
8. Commodity Security and Supply Chain	4.11	7.11		
9. Quality Management	6.48	7.38		
10. Laboratory	6.30	5.33		
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	7.78	7.93		
12. Technical and Allocative Efficiencies	6.94	8.00		
Strategic Information				
13. Epidemiological and Health Data	6.90	5.54		
14. Financial/Expenditure Data	7.08	8.33		
15. Performance Data	8.43	7.11		

CONTEXTUAL DATA

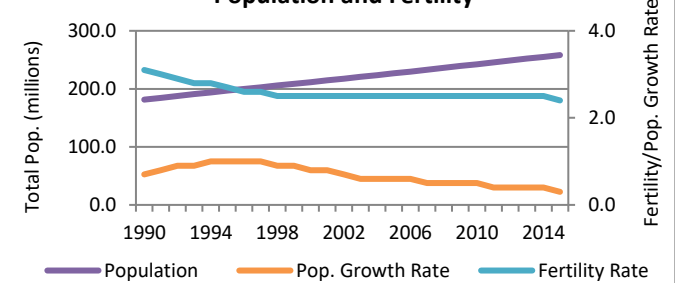
National Clinical Cascade



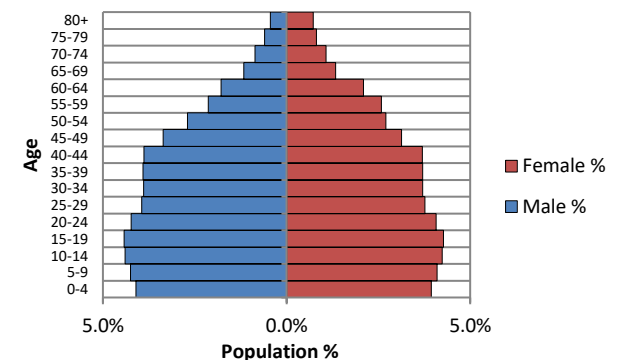
Epidemiological Data



Population and Fertility

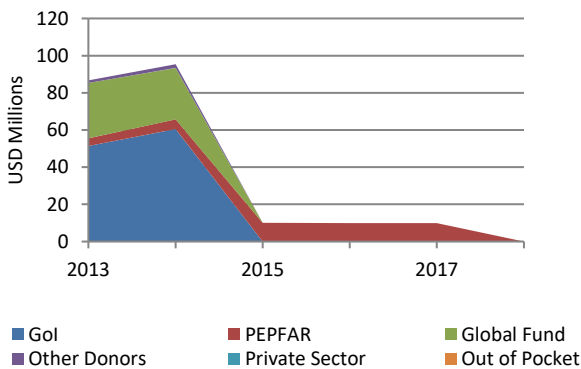


Population Pyramid (2017)

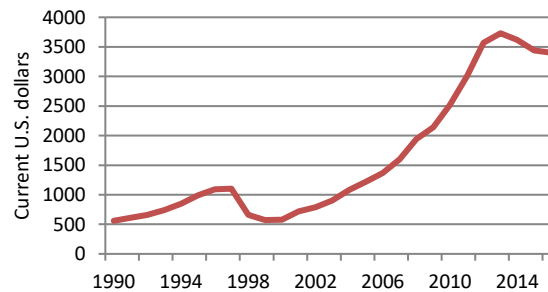


CONTEXTUAL DATA

Financing the HIV Response



GNI Per Capita (Atlas Method)



Domain A. Governance, Leadership, and Accountability

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, create space for and promote participation of the private sector, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

		Data Source	Notes/Comments
<p>1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.</p> <p>1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?</p>	<p><input type="radio"/> A. There is no national strategy for HIV/AIDS</p> <p><input checked="" type="radio"/> B. There is a multiyear national strategy. Check all that apply:</p> <p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> It has measurable targets.</p> <p><input checked="" type="checkbox"/> It is updated at least every five years</p> <p>Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics)</p> <p><input checked="" type="checkbox"/> Strategy includes explicit plans and activities to address the needs of key populations.</p> <p><input type="checkbox"/> Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children</p> <p><input type="checkbox"/> Strategy (or separate document) includes considerations and activities related to sustainability</p>	<p>1.1 Score: 2.07</p>	<p>NAC SRAN 2015 - 2019 NAP - MOH RAN 2015-2019</p> <p>Presidential Regulation No. 124/2016 has stipulated that all functions and roles of NAC to be absorbed by the responsible Ministries; all health-related service delivery functions to be under NAP-MoH and all coordination functions to Coordinating Ministry of Human Development & Culture.</p> <p>Current RAN 2015-2019 is currently under review by the government.</p>
<p>1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?</p>	<p><input type="radio"/> A. There is no national strategy for HIV/AIDS</p> <p><input checked="" type="radio"/> B. The national strategy is developed with participation from the following stakeholders (check all that apply):</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p> <p><input checked="" type="checkbox"/> Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy</p> <p><input type="checkbox"/> Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR)</p> <p><input checked="" type="checkbox"/> External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy</p>	<p>1.2 Score: 2.00</p>	<p>NAC SRAN 2015 - 2019 NAP - MoH RAN 2015-2019</p> <p>During the development of SRAN 2015-2019, NAC has actively involved multi-sector stakeholders including the private sector. SRAN 2015-2019 was developed with active participation from CSOs and international development partners.</p>

<p>1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?</p>	<p>Check all that apply:</p> <p><input type="checkbox"/> There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc.</p> <p><input checked="" type="checkbox"/> The host country government routinely tracks and maps HIV/AIDS activities of:</p> <p><input type="checkbox"/> civil society organizations</p> <p><input type="checkbox"/> private sector (including health care providers and/or other private sector partners)</p> <p><input type="checkbox"/> donors</p> <p>The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes.</p> <p><input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of implementing organizations.</p> <p><input type="checkbox"/> Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.</p>	<p>1.3 Score: 2.00</p>	<p>NAC SRAN 2015 - 2019 NAP - MoH RAN 2015-2019</p>	<p>Up to recently, NAC conducts national coordination of all HIV/AIDS activities implemented in the country, including those implemented by CSOs, private sector, and other implementing partners.</p>
<p>1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for either checkbox under option B)</p>	<p><input type="radio"/> A. There is no formal link between the national plan and sub-national service delivery.</p> <p><input checked="" type="radio"/> B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.)</p> <p><input checked="" type="checkbox"/> Sub-national units have performance targets that contribute to aggregate national goals or targets.</p> <p><input type="checkbox"/> The central government is responsible for service delivery at the sub-national level.</p>	<p>1.4 Score: 2.50</p>	<p>Home Affairs Ministerial Regulation No 32 Year 2017 on Minimum Service Standard (SPM) in Health Sector</p> <p>Health Ministerial regulation no 43/2016 on Minimum Service Standard (SPM) in Health Sector</p>	<p>As of 2016, Ministry of Health has stipulated the implementation of Minimum Service Standard (MSS-SPM) in Health Sector, which includes HIV indicator and target.</p> <p>This was strengthened in 2017 by MOHA. The Ministry of Home Affairs (MOHA) has released a ministerial regulation in 2017 stipulating the implementation of Minimum Service Standard (MSS-SPM) in Health Sector which includes HIV indicator and target. This will apply to all sub-national level cities/districts.</p>
<p>Planning and Coordination Score:</p>		<p>8.57</p>		

2. Policies and Governance: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.		Data Source	Notes/Comments
<p>2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current WHO guidelines for initiation of ART, i.e. Test and START for all populations?</p>	<p>For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines for each of the following:</p> <p>A. Adults (>19 years)</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>B. Pregnant and Breastfeeding Mothers</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>C. Adolescents (10-19 years)</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>D. Children (<10 years)</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p>	<p>2.1 Score: 0.28</p>	<p>Health Ministerial Regulation No 21/2013 on HIV Control</p> <p>Health Ministerial Circulation Letter No 129 / 2013 on Strategic Use of ARV</p> <p>Health Ministerial Regulation No 87/2014 on HIV Treatment</p> <p>The current national HIV/AIDS technical practice for initiation of ART follows 2012 WHO Guidelines.</p> <p>However in 2013 Indonesia has introduced Strategic Use of ARV for key populations and special populations such as TB patients, hepatitis patients, pregnant women, sero-discordant couples and general population in Tanah Papua.</p> <p>Indonesia is in the process of developing guidelines for test and treat in 2018, and in the process of updating the HIV/AIDS treatment guidelines following the most updated & recent WHO Guidelines.</p>

<p>2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?</p> <p>Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.</p>	<p>Check all that apply:</p> <p><input checked="" type="checkbox"/> A national public health services act that includes the control of HIV</p> <p><input type="checkbox"/> A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART</p> <p><input checked="" type="checkbox"/> A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits</p> <p><input type="checkbox"/> Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months)</p> <p><input type="checkbox"/> Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months)</p> <p><input type="checkbox"/> Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready</p> <p><input checked="" type="checkbox"/> Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS</p> <p><input type="checkbox"/> Policies that permit HIV self-testing</p> <p><input type="checkbox"/> Policies that permit pre-exposure prophylaxis (PrEP)</p> <p><input checked="" type="checkbox"/> Policies that permit post-exposure prophylaxis (PEP)</p> <p><input type="checkbox"/> Policies that allow HIV testing without parental consent for adolescents, starting at age 15</p> <p><input type="checkbox"/> Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent</p>	<p>2.2 Score: 0.37</p>	<p>Health Ministerial Decree HK.02.02/Menkes/52/2015 on National Health Strategy 2015-2019 that includes HIV Control</p> <p>Law No 23/2002 on Child Protection that includes protection of children orphaned and or made vulnerable by HIV/AIDS.</p> <p>Law No 36/2014 on Medical Health Force that among others regulates policy on task-shifting</p>	<p>Indonesia has adopted policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of most HIV service delivery.</p>
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<p>2.3 Data Protection: Does the country have policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS?</p>	<p>The country has policies in place that (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Govern the collection of patient-level data for public health purposes, including surveillance <input checked="" type="checkbox"/> Govern the collection and use of unique identifiers such as national ID for health records <input checked="" type="checkbox"/> Govern the privacy and confidentiality of health outcomes matched with personally identifiable information <input checked="" type="checkbox"/> Govern the use of patient-level data, including protection against its use in criminal cases 	<p>2.3 Score: 1.11</p>	<p>Law 36/2009 on Health Law 29/2004 on Medical Practices Health Ministerial Regulation No 36/2012 on Medical Confidentiality</p>	
<p>2.4 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?</p>	<p>Check all that apply:</p> <p>Transgender people (TG):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constitutional prohibition of discrimination based on gender diversity <input type="checkbox"/> Prohibitions of discrimination in employment based on gender diversity <input type="checkbox"/> A third gender is legally recognized <input type="checkbox"/> Other non-discrimination provisions specifying gender diversity (note in comments) <p>Men who have sex with men (MSM):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constitutional prohibition of discrimination based on sexual orientation <input type="checkbox"/> Hate crimes based on sexual orientation are considered an aggravating circumstance <input type="checkbox"/> Incitement to hatred based on sexual orientation prohibited <input type="checkbox"/> Prohibition of discrimination in employment based on sexual orientation <input type="checkbox"/> Other non-discrimination provisions specifying sexual orientation <p>Female sex workers (FSW):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constitutional prohibition of discrimination based on occupation <input type="checkbox"/> Sex work is recognized as work <input type="checkbox"/> Other non-discrimination protections specifying sex work (note in comments) 	<p>2.4 Score: 0.09</p>	<p>Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question.</p>	<p>Indonesia has policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS. The policy is for everybody - not only for KP Input for SID template: The question is about law and policy, but the answer options are only law.</p>

	<p>People who inject drugs (PWID):</p> <p><input type="checkbox"/> Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments)</p> <p><input checked="" type="checkbox"/> Explicit supportive reference to harm reduction in national policies</p> <p><input type="checkbox"/> Policies that address the specific needs of women who inject drugs</p>			
<p>2.5 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?</p>	<p>The country has the following to protect key populations and people living with HIV (PLHIV) from violence:</p> <p><input checked="" type="checkbox"/> General criminal laws prohibiting violence</p> <p><input type="checkbox"/> Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population</p> <p><input checked="" type="checkbox"/> Programs to address intimate partner violence</p> <p><input checked="" type="checkbox"/> Programs to address workplace violence</p> <p><input checked="" type="checkbox"/> Interventions to address police abuse</p> <p><input checked="" type="checkbox"/> Interventions to address torture and ill treatment in prisons</p> <p><input checked="" type="checkbox"/> A national plan or strategy to address gender-based violence and violence against women that includes HIV</p> <p><input checked="" type="checkbox"/> Legislation on domestic violence</p> <p><input checked="" type="checkbox"/> Criminal penalties for domestic violence</p> <p><input checked="" type="checkbox"/> Criminal penalties for violence against children</p>	<p>2.5 Score: 1.00</p>	<p>Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question.</p> <p>Indonesian Criminal Law (KUHP) that governs general criminal law which includes the prohibition of violence and also prohibition of ill torture & ill treatment in prison</p> <p>Police Chief Regulation No 12/2009 governs the prohibition of abuse of police</p> <p>Law No 23/2004 on Domestic Violence</p> <p>Law No 23/2002 on Child Protection</p> <p>Law no 13/2003 on Labour that governs the prohibition of violence at workplace</p>	<p>Indonesia has protections in place for victims of violence including for key populations and PLHIV</p>

2.6 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services?

For each question, select the most appropriate option:

Are transgender people criminalized and/or prosecuted in the country?

- Both criminalized and prosecuted
- Criminalized
- Prosecuted
- Neither criminalized nor prosecuted

Is cross-dressing criminalized in the country?

- Yes
- Yes, only in parts of the country
- Yes, only under certain circumstances
- No

Is sex work criminalized in your country?

- Selling and buying sexual services is criminalized
- Selling sexual services is criminalized
- Buying sexual services is criminalized
- Partial criminalization of sex work
- Other punitive regulation of sex work
- Sex work is not subject to punitive regulations or is not criminalized.
- Issue is determined/differs at subnational level

2.6 Score:

0.88

Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question.

Indonesia has no laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services.

However the following acts are penalized:

- 1) Facilitating prostitution (Criminal Law - KUHP)
- 2) Drugs/Narcotics Offence (Criminal Law - KUHP and Law No 35/2009 on Narcotics)
- 3) Unnatural Sexual Intercourse (Law No 44/2008 on Pornography)
- 4) Restriction of foreign teachers living with HIV to work in Indonesia (National Education Ministerial Regulation No 66/2009)

Does the country have laws criminalizing same-sex sexual acts?

- Yes, death penalty
- Yes, imprisonment (14 years - life)
- Yes, imprisonment (up to 14 years)
- No penalty specified
- No specific legislation
- Laws penalizing same-sex sexual acts have been decriminalized or never existed

Does the country maintain the death penalty in law for people convicted of drug-related offenses?

- Yes, with high application (sentencing of people convicted of drug offenses to death and/or carrying out executions are a routine and mainstreamed part of the criminal justice system)
- Yes, with low application (executions for drug offenses may have been carried out in recent years, but in practice such penalties are relatively rare)
- Yes, with symbolic application (the death penalty for drug offenses is included in legislation, but executions are not carried out)
- No

Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?

- Yes
- No, but prosecutions exist based on general criminal laws
- No

Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?

- Yes
- No

	<p>Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people?</p> <p><input type="checkbox"/> Yes, promotion ("propaganda") laws</p> <p><input checked="" type="checkbox"/> Yes, morality laws or religious norms that limit LGBTI freedom of expression and association</p> <p><input type="checkbox"/> No</p>			
<p>2.7 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</p>	<p>There are host country government efforts in place as follows (check all that apply):</p> <p><input checked="" type="checkbox"/> To educate PLHIV about their legal rights in terms of access to HIV services</p> <p><input checked="" type="checkbox"/> To educate key populations about their legal rights in terms of access to HIV services</p> <p><input checked="" type="checkbox"/> National law exists regarding health care privacy and confidentiality protections</p> <p><input checked="" type="checkbox"/> Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>2.7 Score: 1.11</p>	<p>Law 16 No 2011 on Provision of Legal Aid</p>	
<p>2.8 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?</p>	<p><input type="radio"/> A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry.</p> <p><input type="radio"/> B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more.</p> <p><input checked="" type="radio"/> C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.</p>	<p>2.8 Score: 1.11</p>	<p>Presidential Regulation 29/2014 on Performance Accountability System of Government Agencies</p>	<p>Programme Audit is conducted by the Ministry of National Planning & Development (BAPPENAS) and the outcome is reported to the President as platform to track performance of sectoral ministries.</p>
<p>2.9 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?</p>	<p><input type="radio"/> A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted.</p> <p><input type="radio"/> B. The host country government does respond to audit findings by implementing changes as a result of the audit.</p> <p><input checked="" type="radio"/> C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.</p>	<p>2.9 Score: 1.11</p>	<p>Presidential Regulation 29/2014 on Performance Accountability System of Government Agencies</p>	<p>Programme Audit is conducted by the Ministry of National Planning & Development (BAPPENAS) and the outcome is reported to the President as platform to track performance of sectoral ministries.</p>
Policies and Governance Score:		7.06		

3. Civil Society Engagement: Local civil society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.				
			Data Source	Notes/Comments
<p>3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?</p>	<p><input type="radio"/> A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response.</p> <p><input checked="" type="radio"/> B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen.</p> <p><input type="radio"/> C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.</p>	<p>3.1 Score: 0.83</p>	<p>No law that restrict CSO from oversight role in HIV AIDS response</p>	<p>The Ministry of Man Power has Ministerial Regulation on the implementation of HIV program at the work place. But CSOs don't play any role in that regulation, as at the moment CSO actively has role within the Health facilities</p>
<p>3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?</p>	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p> <p><input type="radio"/> A. There are no formal channels or opportunities.</p> <p><input checked="" type="radio"/> B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback.</p> <p><input type="radio"/> C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply:</p> <p><input type="checkbox"/> During strategic and annual planning</p> <p><input type="checkbox"/> In joint annual program reviews</p> <p><input type="checkbox"/> For policy development</p> <p><input type="checkbox"/> As members of technical working groups</p> <p><input type="checkbox"/> Involvement on government HIV/AIDS program evaluation teams</p> <p><input type="checkbox"/> Involvement in surveys/studies</p> <p><input type="checkbox"/> Collecting and reporting on client feedback</p> <p><input type="checkbox"/> Service delivery</p>	<p>3.2 Score: 0.83</p>	<p>MOH Regulations, PERMENKES NO. 21/2013 on community involvement for HIV response</p> <p>MOHA regulations, PerMendagri NO. 20/2007 on community empowerment for HIV AIDS response</p>	<p>With the revocation of Presidential Decree for NAC in 2018, there is no certainty yet how the structure for Government channels and opportunities for CSOs</p>

<p>3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?</p>	<p>A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS.</p> <p><input type="radio"/></p> <p>B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply):</p> <p><input checked="" type="checkbox"/> In policy design</p> <p><input type="checkbox"/> In programmatic decision making</p> <p><input checked="" type="checkbox"/> In technical decision making</p> <p><input checked="" type="checkbox"/> In service delivery</p> <p><input checked="" type="checkbox"/> In HIV/AIDS basket or national health financing decisions</p>	<p>3.3 Score: 1.33</p>	<p>MOH Regulations, PERMENKES NO. 21/2013 on community involvement for HIV response</p> <p>MOHA regulations, PerMendagri NO. 20/2007 on community empowerment for HIV AIDS response</p>	<p>CSOs actively involve at the international funding, however for domestic funding CSOs feel that their engagement is only limited on the program implementation.</p>
<p>3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)?</p> <p>(if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)</p>	<p>A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources.</p> <p><input type="radio"/></p> <p>B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input checked="" type="radio"/></p> <p>C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input type="radio"/></p> <p>D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input type="radio"/></p> <p>E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input type="radio"/></p>	<p>3.4 Score: 0.83</p>	<p>NAC</p>	<p>With the revocation of Presidential Decree for NAC in 2018, there is no certainty yet how the structure for Government channels and opportunities for CSOs</p>
<p>3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)?</p> <p>Note: This sometimes referred to as "social contracting" or "social procurement."</p>	<p>A. There is no law, policy, or regulation which permits CSOs to be funded from a government budget for HIV Services through open competition (not to include Global Fund or other donor funding to government that goes to CSOs).</p> <p><input type="radio"/></p> <p>B. There is a law, policy or regulation which permits CSOs to be funded from a government budget for HIV services. Check all that apply:</p> <p><input checked="" type="checkbox"/> Competition is open and transparent (notices of opportunities are made public)</p> <p><input type="checkbox"/> Opportunities for CSO funding are made on an annual basis</p> <p><input type="checkbox"/> Awards are made in a timely manner (within 6-12 months of announcements)</p> <p><input type="checkbox"/> Payments are made to CSOs on time for provision of services</p>	<p>3.5 Score: 0.83</p>	<p>MOHA regulations, PerMendagri NO. 20/2007 on community empowerment for HIV AIDS response</p>	<p>Information on funding for CSO is not widely spread. Few CSOs aware of the information due to close relationship with government staff.</p>
<p>Civil Society Engagement Score:</p>		<p>4.67</p>		

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.				Data Source	Notes/Comments
<p>4.1 Government Channels and Opportunities for Private Sector Engagement: Does the host country government have formal channels and opportunities for diverse private sector entities (including service delivery, corporations, and private training institutions) to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p> <p>(If option B is true, check all subsequent boxes that apply.)</p>	<p><input checked="" type="radio"/> A. There are no formal channels or opportunities for private sector engagement.</p> <p><input type="radio"/> B. There are formal channels or opportunities for private sector engagement.</p> <p>i. The following private sector stakeholders formally contribute input into national or sub-national processes for HIV/AIDS planning and strategic development (check all that apply):</p> <p><input type="checkbox"/> Corporations</p> <p><input type="checkbox"/> Employers</p> <p><input type="checkbox"/> Private training institutions</p> <p><input type="checkbox"/> Private health service delivery providers</p> <p>ii. Stakeholders contribute in the following ways (check all that apply):</p> <p><input type="checkbox"/> The private sector contributes technical expertise into HIV program planning</p> <p><input type="checkbox"/> Data and strategic input into supply chain management for HIV commodities</p> <p><input type="checkbox"/> Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning</p> <p><input type="checkbox"/> Data on staffing in private health service delivery providers</p> <p><input type="checkbox"/> Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning</p> <p><input type="checkbox"/> For technical advisory on best practices and delivery solutions</p>	<p>4.1 Score: 0.00</p>	<p>MOHA regulations, PerMendagri NO. 20/2007 on community empowerment for HIV AIDS response</p>	<p>There is no formal channels for private sector to be involved at National HIV AIDS program. However the Ministry of Manpower has HIV programs that involve the private sector. The engagement between government and private sector usually is a top down communication - from government to private sector</p>	

	<p>iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply):</p> <p><input type="checkbox"/> The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response.</p> <p><input type="checkbox"/> A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan</p> <p><input type="checkbox"/> The government and private sector effectively coordinates and executes a total market approach for HIV service delivery, which accounts for whether people are able and/or willing to pay for HIV services.</p>			
<p>4.2 Enabling Environment for Private Corporate Contributions to HIV/AIDS Programming: Does the host country government have systems and policies in place that allow for private corporate contributions to HIV/AIDS programming?</p>	<p>Check all that apply:</p> <p><input type="checkbox"/> Tax policies and incentives are designed to encourage corporate social responsibility efforts from companies who are contributing financial commitments and/or non-financial resources (including, but not limited to, product donations, expertise, and employee staff time).</p> <p><input checked="" type="checkbox"/> The host country government has in-house expertise in contracting services to private sector corporations when appropriate and necessary (e.g., transportation and waste management).</p> <p><input checked="" type="checkbox"/> The host country government has standards for reporting and sharing data across public and private sectors.</p> <p><input checked="" type="checkbox"/> Regulations help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies).</p> <p><input checked="" type="checkbox"/> There are strong linkage and referral networks between on-site workplace programs and public health care facilities.</p>	<p>4.2 Score: 2.00</p>	<p>Ministry of Manpower regulation No. 68/2014</p>	<p>There are some activities that are assigned to the private sector, for example to PRODIA Lab and advertising agency. There are government standard reporting, but not all involved private sector use the standard reporting. Public sharing information still need to improve.</p>

<p>4.3 Enabling Environment for Private Health Service Delivery: Does the host country government have systems and policies in place that allow for private health service delivery?</p> <p>Note: Full score possible without checking all boxes.</p>	<p><input type="radio"/> A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services.</p> <p><input type="radio"/> B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years.</p> <p><input checked="" type="radio"/> C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply):</p> <p><input checked="" type="checkbox"/> Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications.</p> <p><input checked="" type="checkbox"/> Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting.</p> <p><input type="checkbox"/> Joint (i.e., public-private) supervision and quality oversight of private facilities.</p> <p><input type="checkbox"/> The government offers tax deductions for private facilities delivering HIV/AIDS services.</p> <p><input type="checkbox"/> The government offers tax deductions for private training institutions.</p> <p><input type="checkbox"/> The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores</p> <p><input type="checkbox"/> The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services.</p> <p><input type="checkbox"/> HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes</p> <p><input type="checkbox"/> There are open competitions for private health care providers to compete for government service contracts</p> <p><input type="checkbox"/> There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming</p> <p><input type="checkbox"/> The government effectively regulates the flow of subsidized commodities into the private sector.</p>	<p>4.3 Score: 1.53</p>	<p>MoH regulations No: - Permenkes 87/2014 - on ARV guidelines</p>	
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<p>4.4 Private Sector Capability and Interest: Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response?</p>	<p><input type="radio"/> A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response.</p> <p><input type="radio"/> B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response.</p> <p><input checked="" type="radio"/> C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply):</p> <p><input checked="" type="checkbox"/> Market opportunities that align with and support the national HIV/AIDS response</p> <p><input type="checkbox"/> Opportunities to contribute financial and/or non-financial resources to the national response (including business skills, market research, logistics, communication, research and development, product design, brand awareness, and innovation)</p>	<p>4.4 Score: 1.25</p>	<p>-Gol regulation No: UU 44/2009, on hospital - MoH regulation Permenkes No. 451/2012, on referral hospitals for HIV/AIDS</p>	<p>The government supports the private sector in the HIV/AIDS response and there's still opportunity for exploring the private sector's leverage for government needs in HIV/AIDS program</p>
<p>Private Sector Engagement Score:</p>		<p>4.78</p>		

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.				
			Source of Data	Notes/Comments
<p>5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data and analyses are made available to stakeholders and general public in a timely and useful way?</p>	<p>A. The host country government does not make HIV/AIDS surveillance and survey data available to stakeholders and the general public, or they are made available more than one year after the date of collection.</p> <p><input type="radio"/></p> <p>B. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within 6-12 months.</p> <p><input checked="" type="radio"/></p> <p>C. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within six months.</p> <p><input type="radio"/></p>	<p>5.1 Score: 1.00</p>	<p>MoH regulations : Permenkes 45/2014 - on Health Surveillance (HIV is included)</p>	<p>Report of HIV/AIDS surveillance and survey data usually come out 6-12 month after the survey</p>
<p>5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data available to stakeholders and the public in a timely and useful way?</p>	<p>A. The host country government does not track HIV/AIDS expenditures.</p> <p><input type="radio"/></p> <p>B. The host country government does not make HIV/AIDS expenditure data available to stakeholders and the general public, or they are made available more than one year after the date of expenditures.</p> <p><input checked="" type="radio"/></p> <p>C. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within 6-12 months after date of expenditures.</p> <p><input type="radio"/></p> <p>D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.</p> <p><input type="radio"/></p>	<p>5.2 Score: 0.00</p>	<p>NAC: National AIDS Spending Assessment 2015</p>	<p>There is report on expenditure, but publication of the report is not optimal</p> <p>Score between A and B does not change!</p>
<p>5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way?</p>	<p>A. The host country government does not make HIV/AIDS program performance and service delivery data available to stakeholders and the general public or they are made available more than one year after the date of programming.</p> <p><input type="radio"/></p> <p>B. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within 6-12 months after date of programming.</p> <p><input checked="" type="radio"/></p> <p>C. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within six months after date of programming .</p> <p><input type="radio"/></p>	<p>5.3 Score: 1.00</p>	<p>MoH quarterly reports</p>	

<p>5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?</p>	<p><input type="radio"/> A. The host country government does not make any HIV/AIDS procurements.</p> <p><input type="radio"/> B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available.</p> <p><input checked="" type="radio"/> C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available.</p> <p><input type="radio"/> D. The host country government makes HIV/AIDS procurements, and both tender and award details available.</p>	<p>5.4 Score: 1.00</p>	<p>LKPP : E-catalogue http://e-katalog-lkpp.go.id</p>	<p>Tender is openly public but detail information of the award never published</p>
<p>5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for providing scientifically accurate education to the public about HIV/AIDS?</p>	<p><input type="radio"/> A. There is no government institution that is responsible for this function and no other groups provide education.</p> <p><input type="radio"/> B. There is no government institution that is responsible for this function but at least one of the following provides education:</p> <p><input type="checkbox"/> Civil society</p> <p><input type="checkbox"/> Media</p> <p><input type="checkbox"/> Private sector</p> <p><input checked="" type="radio"/> C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.</p>	<p>5.5 Score: 2.00</p>	<p>www.kpan.or.id (NAC website), www.kemenkes.go.id</p>	<p>This is done by the NAC and PAC. Education can be accessed from NAC/PAC website</p>
<p align="right">Public Access to Information Score: 5.00</p>				

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving prevention, treatment, and care services and interventions. There is a high demand for HIV/AIDS services, which are accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and/or are affected by the HIV/AIDS epidemic.

			Data Source	Notes/Comments
<p>6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.</p>				
<p>6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)</p>	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) <input checked="" type="checkbox"/> Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) <input checked="" type="checkbox"/> There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services 	<p>6.1 Score: 1.11</p>	<p>MoH Annual Report, mobile testing apps (Aplikasi DOKLING), SIHA report</p>	<p>Extended hours only available at site that has managed support from external funding and usually only in Jakarta. The government officers does not have overtime system so it is difficult to do it as limited to policy. To eliminate stigma, some services perform rotational tasks in HIV services for all health staff to provide experience working directly with key populations.</p>
<p>6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)</p>	<p>The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services <input checked="" type="checkbox"/> National guidelines detailing how to operationalize HIV/AIDS services in communities <input checked="" type="checkbox"/> Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities <input type="checkbox"/> Providing financial support for community-based services <input type="checkbox"/> Providing supply chain support for community-based services <input type="checkbox"/> Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness) 	<p>6.2 Score: 0.56</p>	<p>Ministry of Health regulation No. 21, National guidelines on continuous sustainable services (LKB), Form CBS (EOA) from Linkages project</p>	<p>- Indonesia only acknowledge counselor that already listed under Indonesian HIV Counselor Association (PKVHI) or received special training to give care. Funding comes from otonomus primary health care (BLUD) but recruitment is through the Provincial Health Office therefore there might be gap in having sufficient number of health staff at the facility level. Linkages project has just started a Community system tracking (EOA).</p>
<p>6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services (i.e. excluding any external financial assistance from donors)?</p>	<ul style="list-style-type: none"> <input type="radio"/> A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services <input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services <input type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services <input checked="" type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services 	<p>6.3 Score: 1.25</p>	<p>Data from APBN dan APBD, NASA</p>	<p>Funding is mostly used for commodities, while prevention and promotion for community services and support group still mostly depends on external funding</p>

(if exact or approximate percentage known,
please note in Comments column)

E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services

<p>6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors?</p>	<p><input type="radio"/> A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions.</p> <p><input type="radio"/> B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance.</p> <p><input type="radio"/> C. Host country institutions deliver HIV/AIDS services with some external technical assistance.</p> <p><input checked="" type="radio"/> D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.</p>	<p>6.4 Score: 1.11</p>	<p>Activity report from Bimtek and Binwasdal</p>	<p>External support only minimal and based on requested topic</p>
<p>6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations (i.e. without external financial assistance from donors)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input checked="" type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.</p>	<p>6.5 Score: 1.25</p>	<p>NASA, Annual report from Ministries (APBN, APBD, and BLUD)</p>	<p>- Still depends on external funding. Domestic funding are for : Viral load, CD4, Secondline ARV, buffer ARV, and mobile testing/DOKLING</p> <p>- Does this include spending for PLHIV? Graph 3.7 NASA 2015 indicated that Non PLHIV Key Population Groups received far less than 50% and assuming that most activities for key populations were preventative promotive then the share of external sources is much higher.</p>
<p>6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations without external technical assistance from donors?</p>	<p><input type="radio"/> A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions.</p> <p><input type="radio"/> B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance.</p> <p><input checked="" type="radio"/> C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance.</p> <p><input type="radio"/> D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.</p>	<p>6.6 Score: 0.74</p>	<p>Monev and activity report from Provincial Health Office (Dinas kesehatan)</p>	<p>Several issues still need TA from external funding especially for field of Health innovation. Some training for Health staff also supported by external funding - if the training wasn't budgeted by domestic.</p>
<p>6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?</p>	<p>National health authorities (check all that apply):</p> <p><input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities.</p> <p><input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations.</p> <p><input type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations.</p> <p><input checked="" type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service delivery locations.</p> <p><input checked="" type="checkbox"/> Effectively engage with civil society in program planning and evaluation of services.</p> <p><input checked="" type="checkbox"/> Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.</p>	<p>6.7 Score: 0.93</p>	<p>Report on APBN, APBD, accreditation report, report on administration and management (sistem kinerja nakes di layanan)</p>	<p>Some of the funding for subnational only available in several provinces, like Jakarta. Community engagement in the planning usually only during accreditation period, where community was asked to give input through a survey.</p> <p>Some Health facilities in Jakarta have implemented Admen system, the system can provide a competency gap for each health staff.</p>

<p>6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?</p>	<p>Sub-national health authorities (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. <input type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. <input type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. <input checked="" type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service delivery locations. <input checked="" type="checkbox"/> Effectively engage with civil society in program planning and evaluation of services. <p>Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.</p>	<p>6.8 Score: 0.74</p>	<p>Fastrack Report, MoH decree No. 75/2014</p>	<p>At the moment planning for health staff is based on population number, not based on epidemic. Especially for HIV services, higher level who work on health staff distribution still not use epidemiology data to distribute staff with several reasons related to stigma/racial intolerance.</p>
<p>Service Delivery Score</p>		<p>7.69</p>		

7. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.					Data Source	Notes/Comments
7.1 HRH Supply: To what extent is the clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level?	Check all that apply: <ul style="list-style-type: none"> <input type="checkbox"/> The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers <input type="checkbox"/> The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden <input type="checkbox"/> The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas <input type="checkbox"/> The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children 	7.1 Score:	0.00	Included in Medical / other pre-service medical curricula. BPSDM and HR inventory WHO	Skill related to HIV is very limited. Distribution of health staff into the facility is also always incompatible with the HIV epidemic	
7.2 Role of Community-based Health Workers (CHWs): To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery?	Check all that apply: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> There is a national community-based health worker (CHW) cadre that has a defined role in HIV/AIDS service delivery (e.g., through a national strategy or task-sharing framework/guidelines). <input checked="" type="checkbox"/> Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors. <input checked="" type="checkbox"/> The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services. 	7.2 Score:	1.11		There is no special nomenclature (budget code) for CHW, but CHWs is part of the service delivery structure. However, only in several provinces the CHWs are trained and well equipped.	
7.3 HRH transition: What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation? Note in comments column which donors have transition plans in place.	<ul style="list-style-type: none"> <input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers <input checked="" type="radio"/> B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support <input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented <input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan <input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated 	7.3 Score:	0.28	HRH donor (USAID)		

<p>7.4 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Host country institutions provide no (0%) health worker salaries</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) health worker salaries</p> <p><input type="radio"/> C. Host country institutions provide some (approx. 10-49%) health worker salaries</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) health worker salaries</p> <p><input checked="" type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries</p>	<p>7.4 Score: 3.33</p>	<p>Staff Data GF financial report</p>	
<p>7.5 Pre-service: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</p> <p>Note: List applicable cadres in the comments column.</p>	<p><input type="radio"/> A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years)</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input type="checkbox"/> Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input checked="" type="checkbox"/> Institutions maintain process for continuously updating content, including HIV/AIDS content</p> <p><input type="checkbox"/> Updated curricula contain training related to stigma & discrimination of PLHIV</p> <p><input type="checkbox"/> Institutions track student employment after graduation to inform planning</p>	<p>7.5 Score: 0.69</p>	<p>MoH decree No.87/ 2014</p>	<p>Latest MoH Decree on 2014, related to HIV Lab, and on 2015 for STI.</p>
<p>7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p>Check all that apply among A, B, C, D:</p> <p><input checked="" type="checkbox"/> A. The host country government provides the following support for in-service training in the country (check ONE):</p> <p><input type="checkbox"/> Host country government implements no (0%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements some (approx. 10-49%) HIV/AIDS in-service training</p> <p><input checked="" type="checkbox"/> Host country government implements most (approx. 50-89%) HIV/AIDS in-service training</p> <p><input type="checkbox"/> Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training</p> <p><input type="checkbox"/> B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS</p> <p><input checked="" type="checkbox"/> C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians</p> <p><input type="checkbox"/> D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)</p>	<p>7.6 Score: 0.49</p>	<p>LINKAGES assessment data on HRH 2015 DKI Jakarta</p>	<p>Need to advocate for a Professional Credit Unit (SKP) for each training conducted to health personnel. The SKP is crucial requirement to renew of letter of registration (STR)</p>

<p>7.7 HR Data Collection and Use: Does the country systematically collect and use health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?</p>	<p><input type="radio"/> A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management</p> <p><input type="radio"/> B. There is no HRIS in country, but some data is collected for planning and management</p> <p><input type="checkbox"/> Registration and re-licensure data for key professionals is collected and used for planning and management</p> <p><input type="checkbox"/> MOH health worker employee data (number, cadre, and location of employment) is collected and used</p> <p><input type="checkbox"/> Routine assessments are conducted regarding health worker staffing at health facility and/or community sites</p> <p><input checked="" type="radio"/> C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country:</p> <p><input checked="" type="checkbox"/> The HRIS is primarily financed and managed by host country institutions</p> <p><input type="checkbox"/> There is a national strategy or approach to interoperability for HRIS</p> <p><input type="checkbox"/> The government produces HR data from the system at least annually</p> <p><input checked="" type="checkbox"/> Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)</p>	<p>7.7 Score: 0.83</p>	<p>HRIS managed by National body for human resources management (BPSDM)</p>	<p>HRH data is available but not yet integrated with system information</p>
<p>Human Resources for Health Score</p>		<p>6.74</p>		

8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.		Data Source	Notes/Comments
<p>8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<input type="radio"/> A. This information is not known. <input type="radio"/> B. No (0%) funding from domestic sources <input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50 – 89%) funded from domestic sources <input checked="" type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.83	Internal Document in MoH (% of APBN and GF funds for ARV) - stated by Subdit representative GOI has showed great commitment to finance ARVs through government budget since 2010 onward. Currently, more than 95% of ARV funding come from government budget and just around 5% come from Global Fund (for ARV line 2, and ARV for pediatrics)
<p>8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<input type="radio"/> A. This information is not known <input type="radio"/> B. No (0%) funding from domestic sources <input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources <input checked="" type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.83	Internal Document in MoH Almost 100% is funded by domestic fund
<p>8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources?</p> <p><i>Note:</i> The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs.</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<input type="radio"/> A. This information is not known <input type="radio"/> B. No (0%) funding from domestic sources <input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.21	NAH and NASA 2012 - Condom for HIV related programs is 100% funded by Global Fund, the domestic funding only funds condom for family planning purposes - BKKBN - National health accounts and NASA 2012 (10-29% condom for HIV related programs is funded by domestic funding) - Few provinces have allocated funds to purchase condom for HIV prevention programs

<p>8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?</p>	<p><input type="radio"/> A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP).</p> <p><input checked="" type="radio"/> B. There is a plan/SOP that includes the following components (check all that apply):</p> <p><input type="checkbox"/> Human resources</p> <p><input checked="" type="checkbox"/> Training</p> <p><input checked="" type="checkbox"/> Warehousing</p> <p><input checked="" type="checkbox"/> Distribution</p> <p><input checked="" type="checkbox"/> Reverse Logistics</p> <p><input checked="" type="checkbox"/> Waste management</p> <p><input checked="" type="checkbox"/> Information system</p> <p><input checked="" type="checkbox"/> Procurement</p> <p><input checked="" type="checkbox"/> Forecasting</p> <p><input checked="" type="checkbox"/> Supply planning and supervision</p> <p><input checked="" type="checkbox"/> Site supervision</p>	<p>8.4 Score: 2.02</p>	<p>Documents available for:</p> <ul style="list-style-type: none"> - Training Module for ARV Decentralisation - Waste management SOP - Site supervision: Monev module/checklist - Pharmaceutical Directorate -- One gate policy management (warehousing, distribution, etc.) - ARV Forecasting module --> GHSC PSM - RDTs Module --> Buku Perencanaan Komoditas ARV dan non ARV (RDTs, STI drugs, OI), but the module needs to be developed more. - Supply planning for ARV --> yes, there is a plan e.g., Provincial level has 6 month buffer, District levels has 3 month buffer stock. But the implementation is not adequate. <p>There is a programmatic supervision, but not specifically for supply plan.</p>	<p>Currently, there is a segmented series of modules and manuals regarding ARV logistic management and other HIV commodities. Some of the information related with the HIV supply chain plan, it has been explicitly inside HIV treatment guidelines. Now, there is a plan to develop a national guideline of supply chain for all HIV commodities in the frame one gate policy management and coordination between pharmacist and program in all level which cover all aspects of supply chain management.</p>
<p>8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not available.</p> <p><input type="radio"/> B. No (0%) funding from domestic sources.</p> <p><input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources.</p> <p><input type="radio"/> D. Some (approx. 10-49%) funding from domestic sources.</p> <p><input checked="" type="radio"/> E. Most (approx. 50-89%) funding from domestic sources.</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funding from domestic sources.</p>	<p>8.5 Score: 0.63</p>	<p>Possible data source:</p> <ul style="list-style-type: none"> - Asset registry - Subdit budget - Expert Judgement 	<p>For infrastructure, maintaining the warehouse, etc.,</p> <p>The components are listed in question 8.4</p>

<p>8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?</p>	<p>Check all that apply:</p> <p><input type="checkbox"/> The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities</p> <p><input checked="" type="checkbox"/> Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time</p> <p><input checked="" type="checkbox"/> MOH or other host government personnel make re-supply decisions with minimal external assistance:</p> <p><input checked="" type="checkbox"/> Decision makers are not seconded or implementing partner staff</p> <p><input checked="" type="checkbox"/> Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects</p> <p><input checked="" type="checkbox"/> Team that conducts analysis of facility data is at least 50% host government</p>	<p>8.6 Score: 1.48</p>	<p>Deliver project report - Stock status assessment (2015)</p>	<p>Definition of stock out: Patient could not get ARV or its substitute at all.</p> <p>- Assumption the ARV stocks are measured by Stock out indicator because we cannot see the ARV stocks in facilities in under 1 month. Stock out % in 2016 is around 1.5%</p> <p>- Reporting rates (in time report) around: 80%, the accuracy is between 60% - 69%</p>
<p>8.7 Assessment: Was an overall score of above 80% achieved on the National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. A comprehensive assessment has not been done within the last three years.</p> <p><input checked="" type="radio"/> B. A comprehensive assessment has been done within the last three years but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments</p> <p><input type="radio"/> C. A comprehensive assessment has been done within the last three years and the score was higher than 80% (for NSCA) or in the top quartile for the assessment</p>	<p>8.7 Score: 1.11</p>	<p>- JSI Assessment (2014)</p> <p>- HSS assessment (HIV external review) 2017.</p>	<p>For national stock, there is external review and external audit for GF</p>
<p>Commodity Security and Supply Chain Score:</p>		<p>7.11</p>		

9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			
		Data Source	Notes/Comments
<p>9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?</p>	<p><input type="radio"/> A. The host country government does not have structures or resources to support site-level continuous quality improvement</p> <p><input checked="" type="radio"/> B. The host country government:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Has a budget line item for the QM program</p> <p style="margin-left: 20px;"><input type="checkbox"/> Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions</p>	<p>9.1 Score: 1.33</p>	<p>Annual report (district profile): describes programs, target and achievements, challenges, analysis, and outlines a follow up/action plan.</p>
<p>9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)</p>	<p><input type="radio"/> A. There is no HIV/AIDS-related QM/QI strategy</p> <p><input type="radio"/> B. There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized</p> <p><input checked="" type="radio"/> C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized.</p> <p><input type="radio"/> D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.</p>	<p>9.2 Score: 1.33</p>	<p>- NAC RAN 2015-2019 - MoH Fast Tract targets</p>
<p>9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?</p>	<p>A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting.</p> <p><input type="radio"/> A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting.</p> <p><input checked="" type="radio"/> B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply):</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> There is documentation of results of QI activities and demonstration of national HIV program improvement through sharing and implementation of best practices across HIV/AIDS sites at all levels</p>	<p>9.3 Score: 2.00</p>	<p>- MoH System Information for HIV/AIDS (SIHA) - MoH Evaluation report (Quarterly, Semesterly - GF, Annually) - MoH Annual HIV Data</p>

<p>9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?</p>	<p><input type="radio"/> A. There is no training or recognition offered to build health workforce competency in QI.</p> <p><input checked="" type="radio"/> B. There is health workforce competency-building in QI, including:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pre-service institutions incorporate modern quality improvement methods in curricula <input type="checkbox"/> National in-service training (IST) curricula integrate quality improvement training <input checked="" type="checkbox"/> For members of the health workforce (including managers) who provide or support HIV/AIDS services 	<p>9.4 Score: 1.00</p>	<p>GOI Law No: 36/2014 - on Health workers</p>	
<p>9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?</p>	<p>The national-level QM structure:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services <input checked="" type="checkbox"/> Regularly convenes meetings that include health services consumers <input checked="" type="checkbox"/> Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement <p>Sub-national QM structures:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services <input type="checkbox"/> Regularly convene meetings that includes health services consumers <input checked="" type="checkbox"/> Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement <p>Site-level QM structures:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement 	<p>9.5 Score: 1.71</p>	<p>MoH Annual activity report</p>	<p>Use Clinical mentoring clinics, etc for Quality improvement</p>
<p>Quality Management Score:</p>		<p>7.38</p>		

10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			Data Source	Notes/Comments
<p>10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?</p>	<p><input type="radio"/> A. There is no national laboratory strategic plan</p> <p><input checked="" type="radio"/> B. National laboratory strategic plan is under development</p> <p><input type="radio"/> C. National laboratory strategic plan has been developed, but not approved</p> <p><input type="radio"/> D. National laboratory strategic plan has been developed and approved</p> <p><input type="radio"/> E. National laboratory plan has been developed, approved, and costed</p> <p><input type="radio"/> F. National laboratory strategic plan has been developed, approved, costed, and implemented</p>	<p>10.1 Score: 0.33</p>	<p>The draft of National Lab Strategy</p>	<p>Draft strategy is being developed by the Subdirectorate HIV with PEPFAR TA and Support. Estimated to be completed late CY 2017/early CY 2018.</p>
<p>10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Regulations do not exist to monitor minimum quality of laboratories in the country.</p> <p><input type="radio"/> B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated).</p> <p><input type="radio"/> C. Regulations exist, but are minimally implemented (approx. 1-9% of laboratories and POCT sites regulated).</p> <p><input checked="" type="radio"/> D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated).</p> <p><input type="radio"/> E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated).</p> <p><input type="radio"/> F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).</p>	<p>10.2 Score: 0.83</p>	<p>Ministry of Health/ Mutu Akreditasi - presentation 7/2017</p>	
<p>10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?</p>	<p><input type="radio"/> A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control</p> <p><input checked="" type="radio"/> B. There are adequate qualified laboratory personnel to perform the following key functions:</p> <p><input checked="" type="checkbox"/> HIV diagnosis by rapid testing and point-of-care testing</p> <p><input checked="" type="checkbox"/> Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria</p> <p><input checked="" type="checkbox"/> Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays</p> <p><input checked="" type="checkbox"/> TB diagnosis</p>	<p>10.3 Score: 1.67</p>	<p>MoH</p>	<p>The scores reflect an average estimation of some of the bigger cities in the country such as Jakarta or Surabaya with higher capacity. Although there are 22 VL testing points in 18 provinces, the Complex laboratory testing (VL and molecular assays) are not adequate yet across the country to meet the needs of the national program. (still on progress). Additionally - the workforce for routine laboratory testing is still not adequate for more remote areas such as Papua, West Papua, and Kalimantan-</p>

<p>10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?</p>	<p><input type="radio"/> A. There is not sufficient infrastructure to test for viral load.</p> <p><input checked="" type="radio"/> B. There is sufficient infrastructure to test for viral load, including:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Sufficient HIV viral load instruments <input checked="" type="checkbox"/> All HIV viral load laboratories have an instrument maintenance program <input type="checkbox"/> Sufficient supply chain system is in place to prevent stock outs <input type="checkbox"/> Adequate specimen transport system and timely return of results 	<p>10.4 Score: 0.83</p>	<p>Draft of HIV National Strategy 2017</p>	<p>- Sufficient in here is just enough number of VL facilities, but not well distributed/placed.</p> <p>- The implementation/maintanance program is just from GF funding</p> <p>-The Subdit is currently developing a specimin transport network which will also be further explained within the National HIV Lab Strategy.</p>
<p>10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No (0%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources.</p> <p><input checked="" type="radio"/> C. Some (approx. 10-49%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> D. Most (approx. 50-89%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.</p>	<p>10.5 Score: 1.67</p>	<p>MoH</p>	<p>The majority of the laboratory services are funded by domestic funding. However Viral Load is largely funded by international/donor funding.</p> <p>Notes: Laboratory services including diagnostic, chemical labs, CD4, VL, etc.,</p>
<p>Laboratory Score:</p>		<p>5.33</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

Fiscal Context for Health and HIV/AIDS			Data Source	Notes/Comments
This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.				
1. What percentage of general government expenditures goes to health?	5%		MoF	range 7-11%
2. What is the per capita health expenditure all sources?	\$99		NHA 2014	
3. What is the total health care expenditure all sources as a percent of GDP?	3.1%		OECD report, 2016	
4. What percent of total health expenditures is financed by external resources?	1.1%		WB, 2014	
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	75.3%		WB, 2014	

<p>11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.</p>	<p>Data Source</p>	<p>Notes/Comments</p>
<p>Check all that apply:</p> <p>A. Yes, there is a universal, comprehensive financing scheme that integrates social health insurance, public subsidies, and national budget provisions for public health aspects (e.g., disease surveillance). It includes the following (check all that apply):</p> <p style="text-align: right;">11.1 Score: 0.44</p> <p><input type="checkbox"/> ARVs are covered</p> <p><input type="checkbox"/> Non-ARV care and treatment is covered</p> <p><input type="checkbox"/> Prevention services are covered</p> <p><input checked="" type="checkbox"/> B. Yes, there is an affordable health insurance scheme available (check one of the following).</p> <p><input type="checkbox"/> It covers 25% or less of the population.</p> <p><input type="checkbox"/> It covers 26 to 50% of the population.</p> <p><input checked="" type="checkbox"/> It covers 51 to 75% of the population.</p> <p><input type="checkbox"/> It covers more than 75% of the population.</p> <p><input checked="" type="checkbox"/> C. The affordable health insurance scheme in (B.) includes the following (check all that apply):</p> <p><input type="checkbox"/> ARVs are covered.</p> <p><input checked="" type="checkbox"/> Non-ARV care and treatment services are covered.</p> <p><input type="checkbox"/> Prevention services are covered.</p> <p><input checked="" type="checkbox"/> It includes public subsidies for the affordability of care.</p> <p>11.1 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?</p>	<p>NAC National Action Plan for HIV AIDS 2015- 2019</p>	<p>BPJS since March 2017 covers up to 70% of eligible population</p> <p>BPJS includes care and treatment</p> <p>The planning and budgeting at the Central and sub national level has not put different sources of financing together; funds label continue up to the government owned points of service, and at this point most actual coordination of fund occurred.</p>

<p>11.2 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?</p>	<p><input type="radio"/> A. There is no explicit funding for HIV/AIDS in the national budget.</p> <p><input checked="" type="radio"/> B. There is explicit HIV/AIDS funding within the national budget.</p> <p><input checked="" type="checkbox"/> The HIV/AIDS budget is program-based across ministries</p> <p><input checked="" type="checkbox"/> The budget includes or references indicators of progress toward national HIV/AIDS strategy goals</p> <p><input checked="" type="checkbox"/> The budget includes specific HIV/AIDS service delivery targets</p> <p><input type="checkbox"/> National budget reflects all sources of funding for HIV, including from external donors</p>	<p>11.2 Score: 0.83</p>	<p>NAC NASA 2015</p>	<p>Donors reported funding allocation and expenses to MOF but they are not necessarily reflected in the national budget (Off budget)</p>
<p>11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?</p>	<p><input type="radio"/> A. There are no HIV/AIDS goals/targets articulated in the national budget</p> <p><input checked="" type="radio"/> B. There are HIV/AIDS goals/targets articulated in the national budget.</p> <p><input checked="" type="checkbox"/> The goals/targets are measurable.</p> <p><input checked="" type="checkbox"/> Budget items/programs are linked to goals/targets.</p> <p><input checked="" type="checkbox"/> The goals/targets are routinely monitored during budget execution.</p> <p><input checked="" type="checkbox"/> The goals/targets are routinely monitored during the development of the budget.</p>	<p>11.3 Score: 0.95</p>	<p>NAC National Action Plan for HIV AIDS 2015- 2019</p>	<p>The National Action Plan reflects the needs from the National Budget.</p>
<p>11.4 HIV/AIDS Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level?</p> <p>(If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)</p>	<p><input type="radio"/> A. There is no HIV/AIDS budget, or information is not available.</p> <p><input type="radio"/> B. 0-49% of budget executed</p> <p><input type="radio"/> C. 50-69% of budget executed</p> <p><input checked="" type="radio"/> D. 70-89% of budget executed</p> <p><input type="radio"/> E. 90% or greater of budget executed</p>	<p>11.4 Score: 0.63</p>	<p>http://www.anggaran.depkeu.go.id/content/publikasi/2016</p>	<p>ARV procurement and GF expenditure The website provides information on budget allocation not on execution. During the meeting the participants reached consensus D as reflection of budget execution for HIV</p>

<p>11.5 Donor Spending: Does the Ministry of Health or Ministry of Finance routinely, and at least on an annual basis, collect all donor spending in the health sector or for HIV/AIDS-specific services?</p>	<p>A. Neither the Ministry of Health nor the Ministry of Finance routinely collects all donor spending in the health sector or for HIV/AIDS-specific services.</p> <p><input checked="" type="radio"/> B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services.</p> <p>C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.</p>	<p>11.5 Score: 0.67</p>	<p>NAC: NASA 2015</p>	<p>The spending from donor is reflected in 2015 NASA</p>
<p>11.6 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. None (0%) is financed with domestic funding.</p> <p><input type="radio"/> B. Very little (approx. 1-9%) is financed with domestic funding.</p> <p><input type="radio"/> C. Some (approx. 10-49%) is financed with domestic funding.</p> <p><input checked="" type="radio"/> D. Most (approx. 50-89%) is financed with domestic funding.</p> <p><input type="radio"/> E. All or almost all (approx. 90%+) is financed with domestic funding.</p>	<p>11.6 Score: 2.50</p>	<p>NAC: NASA 2015</p>	<p>NASA 2015, 60% domestic funding source for HIV The spending from donors is reflected in 2015 NASA</p>
<p>11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?</p>	<p><input type="radio"/> A. There is no budget for health or no money was allocated.</p> <p><input type="radio"/> B. 0-49% of budget executed.</p> <p><input type="radio"/> C. 50-69% of budget executed.</p> <p><input type="radio"/> D. 70-89% of budget executed.</p> <p><input checked="" type="radio"/> E. 90% or greater of budget executed.</p>	<p>11.7 Score: 0.95</p>	<p>MoH Performance Report (LAKIP): www.depkes.go.id/resources/download/laporan/kinerja/lakip-kemenkes-2015.pdf</p>	<p>2015 budget execution was 90.4% (LAKIP Kemenkes 2015). 2016 Data is not available yet</p>
<p>11.8 Data-Driven Reprogramming: Do host country government policies/systems allow for reprogramming domestic investments based on new or updated program data during the government funding cycle?</p>	<p><input type="radio"/> A. There is no system for funding cycle reprogramming.</p> <p><input type="radio"/> B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used.</p> <p><input type="radio"/> C. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, but not based on data.</p> <p><input checked="" type="radio"/> D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, and is based on data.</p>	<p>11.8 Score: 0.95</p>	<p>National Spending and Budget Plan for change (APBNP)</p>	<p>Gol has system to revise budget commitment in the mid year based on budget absorption. National Spending and Budget Plan (APBNP) that need to be discussed with Legislative body</p>
<p>Domestic Resource Mobilization Score:</p>		<p>7.93</p>		

12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			
		Data Source	Notes/Comments
<p>12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources?</p> <p>If yes, please note in the comments section when the model was last used and for what purpose (e.g., for Global Fund concept note development)</p> <p>(note: full score achieved by selecting one checkbox)</p>	<p><input type="radio"/> A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources.</p> <p><input checked="" type="radio"/> B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply):</p> <p><input type="checkbox"/> Optima</p> <p><input checked="" type="checkbox"/> Spectrum (including EPP and Goals)</p> <p><input checked="" type="checkbox"/> AIDS Epidemic Model (AEM)</p> <p><input type="checkbox"/> Modes of Transmission (MOT) Model</p> <p><input type="checkbox"/> Other recognized process or model (specify in notes column)</p>	<p>12.1 Score: 2.00</p>	<p>UNAIDS Investment case analysis 2015</p>
<p>12.2 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Information not available.</p> <p><input type="radio"/> B. No resources (0%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas.</p> <p><input checked="" type="radio"/> E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.</p>	<p>12.2 Score: 1.50</p>	<p>National Fast Track Strategy (2017- still under development)</p>

<p>12.3 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes?</p> <p>(note: full score can be achieved without checking all disaggregate boxes).</p>	<p><input type="radio"/> A. The host country government does not have/use recent expenditure data or cost analysis to estimate unit costs</p> <p><input checked="" type="radio"/> B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply):</p> <p><input checked="" type="checkbox"/> HIV Testing</p> <p><input checked="" type="checkbox"/> Laboratory services</p> <p><input checked="" type="checkbox"/> ART</p> <p><input checked="" type="checkbox"/> PMTCT</p> <p><input checked="" type="checkbox"/> VMMC</p> <p><input type="checkbox"/> OVC Service Package</p> <p><input type="checkbox"/> Key population Interventions</p>	<p>12.3 Score: 2.00</p>	<p>MoH</p>	<p>VMMC in Papua 2018 sub national government's funds</p>
<p>12.4 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?</p>	<p>Check all that apply:</p> <p><input checked="" type="checkbox"/> Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies</p> <p><input checked="" type="checkbox"/> Reduced overhead costs by streamlining management</p> <p><input checked="" type="checkbox"/> Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc.</p> <p><input checked="" type="checkbox"/> Improved procurement competition</p> <p><input checked="" type="checkbox"/> Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years)</p> <p><input checked="" type="checkbox"/> Integrated HIV into primary care services with linkages to specialist care (need not be within last three years)</p> <p><input checked="" type="checkbox"/> Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years)</p> <p><input checked="" type="checkbox"/> Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years)</p> <p><input checked="" type="checkbox"/> Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)</p>	<p>12.4 Score: 2.00</p>	<p>National Public Procurement Agency (LKPP) E-Catalogue Permenkes No 28/2014</p>	<p>- New service delivery models including innovative interventions such as mobile outreach, community-based screening and self testing, and PrEP still in pilot and study phase.</p> <p>- According to the permenkes Health care for JKN member with HIV/AIDS and drug use that need medical rehabilitation and other care can be provided at primary health facility through the capitation payment and for those needing referral care the health service and non ARV drugs can be reimbursed through hospital tariff system (INA- CBGs)</p>

<p>12.5 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year?</p> <p>(Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)</p>	<p><input type="radio"/> A. Partner government did not pay for any ARVs using domestic resources in the previous year.</p> <p><input checked="" type="radio"/> B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen.</p> <p><input type="radio"/> C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen.</p> <p><input type="radio"/> D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen.</p> <p><input type="radio"/> E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.</p>	<p>12.5 Score: 0.50</p>	<p>ARV Price Analysis (2017)</p>	<p>ARV Price Analysis (2017)</p>
<p>Technical and Allocative Efficiencies Score:</p>		<p>8.00</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

What Success Looks Like: Using local and national systems, the host country government collects, analyzes and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

13. Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.

			Data Source	Notes/Comments
<p>13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?</p>	<p><input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions</p> <p><input type="radio"/> C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies</p> <p><input checked="" type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</p> <p><input type="radio"/> E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies</p>	<p>13.1 Score: 0.71</p>	<p>2014 IDHS (National Statistic Agency and Family Planning Bureau)</p>	<p>BPS and BKKPN conducted in 2014 IDHS that showed population behavior on reproductive health, that include some risk for HIV infection. MOH in 2017 is also conducting National Health Survey that covers populations behaviors.</p>
<p>13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?</p>	<p><input type="radio"/> A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions</p> <p><input type="radio"/> C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies</p> <p><input checked="" type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</p> <p><input type="radio"/> E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies</p>	<p>13.2 Score: 0.71</p>	<p>MoH regulations : Permenkes 45/2014 - on Health Surveillance (HIV is included)</p>	
<p>13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input checked="" type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (90%+) is provided by the host country government</p>	<p>13.3 Score: 0.00</p>	<p>MoH regulations : Permenkes 45/2014 - on Health Surveillance (HIV is included)</p>	<p>2006 and 2015, Gen Pop survey in Papua and West Papua (funded by DFAT, USG and national budget).</p>

<p>13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input checked="" type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (approx. 90%+) is provided by the host country government</p>	<p>13.4 Score: 0.42</p>	<p>Concept note "New Funding Model" submitted to GF 2015</p>	
<p>13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units?</p> <p>(Note: Full score possible without selecting all disaggregates.)</p>	<p>Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data:</p> <p><input checked="" type="checkbox"/> A. The host country government collects at least every 5 years HIV prevalence data disaggregated by:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Age (at coarse disaggregates) <input checked="" type="checkbox"/> Age (at fine disaggregates) <input checked="" type="checkbox"/> Sex <input checked="" type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners) <input checked="" type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input checked="" type="checkbox"/> Sub-national units <p><input type="checkbox"/> B. The host country government collects at least every 5 years HIV incidence disaggregated by:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Age (at coarse disaggregates) <input type="checkbox"/> Age (at fine disaggregates) <input type="checkbox"/> Sex <input type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners) <input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input type="checkbox"/> Sub-national units 	<p>13.5 Score: 0.48</p>	<p>HIV epidemiologic review - 2016</p>	<p>Incidence data is collected by MoH but currently just initiating reporting system to integrate HIV&TB monitoring system.</p>

<p>13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. The host country government does not collect/report viral load data or does not conduct viral load monitoring</p> <p><input checked="" type="radio"/> B. The host country government collects/reports viral load data (answer both subsections below):</p> <p>According to the following disaggregates (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Age</p> <p><input checked="" type="checkbox"/> Sex</p> <p><input type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners)</p> <p><input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p> <p>For what proportion of PLHIV (select ONE of the following):</p> <p><input checked="" type="checkbox"/> Less than 25%</p> <p><input type="checkbox"/> 25-50%</p> <p><input type="checkbox"/> 50-75%</p> <p><input type="checkbox"/> More than 75%</p>	<p>13.6 Score: 0.36</p>	<p>MoH System Information for HIV and AIDS (SIHA)</p>	
<p>13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)</p> <p>Please note most recent survey dates in comments section.</p>	<p><input type="radio"/> A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM, TG, prisoners) or priority populations (Military, etc.).</p> <p><input checked="" type="radio"/> B. The host country government conducts (answer both subsections below):</p> <p>IBBS for (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Female sex workers (FSW)</p> <p><input checked="" type="checkbox"/> Men who have sex with men (MSM)</p> <p><input checked="" type="checkbox"/> Transgender (TG)</p> <p><input checked="" type="checkbox"/> People who inject drugs (PWID)</p> <p><input checked="" type="checkbox"/> Prisoners</p> <p><input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p> <p>Size estimation studies for (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Female sex workers (FSW)</p> <p><input checked="" type="checkbox"/> Men who have sex with men (MSM)</p> <p><input checked="" type="checkbox"/> Transgender (TG)</p> <p><input checked="" type="checkbox"/> People who inject drugs (PWID)</p> <p><input checked="" type="checkbox"/> Prisoners</p> <p><input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p>	<p>13.7 Score: 0.95</p>	<p>HIV epidemiologic review - 2016</p>	

<p>13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?</p>	<p><input type="radio"/> A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys</p> <p><input type="radio"/> B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups</p> <p><input checked="" type="radio"/> C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups</p>	<p>13.8 Score: 0.95</p>	<p>MoH regulations: Permenkes 45/2014 - on Health Surveillance (HIV is included)</p>	
<p>13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?</p>	<p><input type="radio"/> A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data <input checked="" type="checkbox"/> A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance <input checked="" type="checkbox"/> Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection <input checked="" type="checkbox"/> An in-country internal review board (IRB) exists and reviews all protocols. 	<p>13.9 Score: 0.95</p>	<p>MoH regulation/Permenkes No: 45/2014</p>	
<p align="center">Epidemiological and Health Data Score:</p>		<p align="center">5.54</p>		

			Data Source	Notes/Comments
14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.				
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	<input type="radio"/> A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years <input type="radio"/> B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions <input type="radio"/> C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance <input checked="" type="radio"/> D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance <input type="radio"/> E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 2.50	NAC NASA 2015	
14.2 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	<input type="radio"/> A. No HIV/AIDS expenditure tracking has occurred within the past 5 years <input checked="" type="radio"/> B. HIV/AIDS expenditure data are collected (check all that apply): <input checked="" type="checkbox"/> By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input checked="" type="checkbox"/> By expenditures per program area, such as prevention, care, treatment, health systems strengthening <input checked="" type="checkbox"/> By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel <input checked="" type="checkbox"/> Sub-nationally	14.2 Score: 3.33	NAC NASA 2015	
14.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	<input type="radio"/> A. No HIV/AIDS expenditure data are collected <input type="radio"/> B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago <input type="radio"/> C. HIV/AIDS expenditure data were collected at least once in the past 3 years <input checked="" type="radio"/> D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures <input type="radio"/> E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.3 Score: 2.50	NAC NASA 2015	
Financial/Expenditure Data Score:			8.33	

15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.			
		Data Source	Notes/Comments
<p>15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?</p>	<p><input type="radio"/> A. No system exists for routine collection of HIV/AIDS service delivery data</p> <p><input type="radio"/> B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions</p> <p><input type="radio"/> C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution</p> <p><input checked="" type="radio"/> D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution</p> <p><input type="radio"/> E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government</p>	<p>15.1 Score: 1.00</p>	<p>MoH System Information for HIV and AIDS (SIHA)</p>
<p>15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No routine collection of HIV/AIDS service delivery data exists</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input checked="" type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (90%+) is provided by the host country government</p>	<p>15.2 Score: 1.67</p>	<p>Gol Law No: 36/2014 - on Health workers Ministry of Labor regulations</p> <p>The government finance the collection of service delivery data</p>

<p>15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)</p>	<p>Check ALL boxes that apply below:</p> <p><input checked="" type="checkbox"/> A. The host country government routinely collects & reports service delivery data for:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> HIV Testing <input checked="" type="checkbox"/> PMTCT <input checked="" type="checkbox"/> Adult Care and Support <input checked="" type="checkbox"/> Adult Treatment <input checked="" type="checkbox"/> Pediatric Care and Support <input type="checkbox"/> Orphans and Vulnerable Children <input checked="" type="checkbox"/> Voluntary Medical Male Circumcision <input checked="" type="checkbox"/> HIV Prevention <input checked="" type="checkbox"/> AIDS-related mortality <p><input checked="" type="checkbox"/> B. Service delivery data are being collected:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> By key population (FSW, PWID, MSM, TG, prisoners) <input checked="" type="checkbox"/> By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input checked="" type="checkbox"/> By age & sex <input checked="" type="checkbox"/> From all facility sites (public, private, faith-based, etc.) <input checked="" type="checkbox"/> From all community sites (public, private, faith-based, etc.) 	<p>15.3 Score: 1.33</p>	<p>MoH System Information for HIV and AIDS (SIHA)</p>	<p>Data on orphans and vulnerable children collected by DepSos but not reported to national HIV monitoring system</p>
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<p>15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?</p>	<p><input type="radio"/> A. The host country government does not routinely collect/report HIV/AIDS service delivery data</p> <p><input checked="" type="radio"/> B. The host country government collects & reports service delivery data annually</p> <p><input type="radio"/> C. The host country government collects & reports service delivery data semi-annually</p> <p><input type="radio"/> D. The host country government collects & reports service delivery data at least quarterly</p>	<p>15.4 Score: 0.44</p>	<p>MoH System Information for HIV and AIDS (SIHA)</p>	
<p>15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?</p>	<p><input type="radio"/> A. The host country government does not routinely analyze service delivery data to measure program performance</p> <p><input checked="" type="radio"/> B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Continuum of care cascade for each identified priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention <input checked="" type="checkbox"/> Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention <input checked="" type="checkbox"/> Results against targets <input checked="" type="checkbox"/> Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) <input checked="" type="checkbox"/> Site-specific yield for HIV testing (HTC and PMTCT) <input checked="" type="checkbox"/> AIDS-related mortality rates <input checked="" type="checkbox"/> Variations in performance by sub-national unit <input checked="" type="checkbox"/> Creation of maps to facilitate geographic analysis 	<p>15.5 Score: 1.33</p>	<p>MoH System Information for HIV and AIDS (SIHA)</p>	<p>Important component to consider in transition plan - integrated M&E system accessible by all sector.</p>
<p>15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?</p>	<p><input type="radio"/> A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance <input checked="" type="checkbox"/> A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government <input checked="" type="checkbox"/> Standard national procedures & protocols exist for routine data quality checks at the point of data entry <input checked="" type="checkbox"/> Data quality reports are published and shared with relevant ministries/government entities & partner organizations <input checked="" type="checkbox"/> The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans 	<p>15.6 Score: 1.33</p>	<p>MoH System Information for HIV and AIDS (SIHA)</p>	

Performance Data Score: 7.11

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D