2019 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 the national HIV/AIDS response across 17 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 critical 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 4,284 (2018), and 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 elaborate rollout of a national single-payer universal healthcare scheme. Indonesia is also faced with rising income inequality as 20% of the wealthiest 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 significantly to the national HIV/AIDS response in 2018. However, after DFAT's departure from HIV programming in mid-2016, there was a significant negative impact on the HIV/AIDS response in Papua, which had been previously 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 Principal Recipients (PRs) have historically been unable to spend much of their total annual budget. The majority of internatioal resources focus heavily on strengthening prevention activities and the quality of care across the cascade, particularly for KP and other priority populations.

SID Process:

The PEPFAR/Indonesia Program in partnership with UNAIDS, led an innovative process to complete the 2019 SID, involving (1) an online questionnaire to collect preliminary results of the SID from a

variety of stakeholders from GOI, private sector, donors and civil society, and (2) an "Interface Workshop" to validate and confirm the preliminary results and questionnaire responses.

1. Online questionnaire

1.a. Development of the online tools

The online questionnaire was developed through a web-based system that provided online participants with an introduction to SID, previous SID results, and the 2019 questionnaire. The online questionnaire can be found at www.keberlanjutan.id. The site development included translation to Bahasa Indonesia, input coding into the online system, and validation and testing the online questionnaire. The online system provides the opportunity for participants to track progress and results. Workshop participants acknowledged that the discussion process was more robust when compared to previous years, having had the opportunity to review and understand responses from various respondents.

1.b. Selection of the respondents

120 respondents were selected from various government partners, CSOs/community networks, universities, private providers and development partners. The respondents were selected and assigned based on their expertise and ability to complete critical elements 2-6 of the SID.

1.c. Selection of the Facilitators

The process designated 17 facilitators chiefly from USAID, USAID implementing partners, and UNAIDS to facilitate the "Interface Workshop" discussions for the 17 elements in the questionnaire. Each facilitator was assigned to manage one element. A preparation meeting was conducted among the facilitators to briefly discuss the expected role of each facilitator, as well as the process of completing the questionnaire, and analysing and obtaining the result.

1.d. Completion of the questionnaire

The English questionnaire was translated into Bahasa Indonesia. There were two steps to complete the questionnaire. 1) An online questionnaire link was sent to the selected respondents. The link could be opened via laptop or smartphone. It took an estimated 10-15 minutes to complete elements 2-6 of the questionnaire for each respondent. 2) The completed online questionnaires were then compiled and analyzed before the workshop. The response rate was about 80%.

2. T**he interface workshop**

2.a. World Cafe

78 respondents attended the interface workshop. The meeting used the "world café" method, which is designed to create a safe, welcoming environment to connect multiple ideas and perspectives on a topic by engaging participants in several rounds of small-group discussion. In this case, 17 facilitators were assigned to 17 group discussions. Each respondent was assigned to work on six different elements. Each element took a 15-minute discussion to confirm the result of the online questionnaire. A timekeeper reminded respondents to move to the next group discussion every 15 minutes. The compiled online questionnaires were printed and attached to the flipchart per element. The dedicated facilitator stood next to the flipchart to lead the group discussion and to confirm the answer of an online questionnaire with the attended respondents, including the answer of an essay question after every multiple choice question. After each group discussion finished, the facilitator provided a small reward (t-shirts, cups, et al) as a token of appreciation to some active respondents to thank their participation.

2b. Presentation of the results

The result of the questionnaire was compiled after the interface workshop into the file of the original English questionnaire. A summary of the results was presented at the and of the workshop. Participants were able to give comments and suggestions after the presentation. At the end of the workshop, all participants agreed to the results.

Result of 2019 SID

Planning and Coordination (element 1), Service Delivery (element 6), Human Resources for Health (element 7) and Commodity Security and Supply chain (element 8) experienced a decrease in score. While most of the elements increased to some extent, none of the elements bear red score which unsustainable and require significant investment.

Sustainability Strength

Public Access to information (Score: 9,78 ; dark green)
This element gained a relatively high score compared to the previous SID and achieved the highest score of all elements under the 2019 SID process. During the previous year, Indonesia widely disseminated 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, significant contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publicly. Efforts are made to ensure that the public has access to data through print distribution, websites, radio, and other methods of disseminating information. There is a provision for transparency in surveillance data, which is reflected by Permenkes no. 45 /2014 which provides regulations on health surveillance. However, there were some stakeholders who reported difficulty in accessing this information, specifically data on expenditures and budget for the HIV program. Some have commented that the general public has limited access to the data.

Performance Data (Score: 9,72: dark green)
The Government of Indonesia, through Ministry of Health routinely collects, reports, analyses, and makes HIV/AIDS service delivery data available. Service delivery data are analysed 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, and viral load testing coverage and suppression. The service data are aggregate, cross-sectional data. However, lack of routine cohort data collection limits the ability of the national program to identify and rapidly respond to programmatic gaps and challenges. The MoH takes the lead in collecting this information; however, timeliness and completeness of data recording/reporting is variable across facilities, districts and provinces. In addition, timely utilization of epidemiological data to assess trends, revisit size estimates, and update cumulative cascade data needs to be improved.

Quality management (Score: 8,00: light green)
Indonesia has institutionalized quality management (QM) systems, plans, workforce capacities, and other vital inputs to ensure that modern quality improvement (QI) methodologies are applied to managing and providing HIV/AIDS services. Although a rigorous HIV QM/QI system is not yet in place in Indonesia and QI cannot be reliably tracked within current HIV information systems, there has been some partial implementation of QM and QI. However, QM and QI systems and information needs to be improved and accessible more widely with targeted follow up and a balanced approach to ensure quality. Even though the GOI regularly trains the health workforce, more extensive and varied trainings are necessary to ensure the health workforce is able to translate trainings into

improved results and quality of services at the workplace. Most of QM and QI activities solely rely on staff from the Ministry of Health at the central level and there is a need to involve more subnational health office staff to ensure that quality management is institutionalized at subnational levels. Some participants recommended the creation of a district-based QM/QI team that can be mobilized as needed, where the districts health office will act as QM/QI manager.

Domestic Resource Mobilization (Score: 7,90; light green)
Although Indonesia's budget and domestic resources available for the national HIV/AIDS response is adequate in terms of bottom line numbers, actual expenditures in 2018 were only 80% of total funding. There are also a number of critical components within the HIV/AIDS response that are underfunded by domestic resources including 1) VL test reagents- where only 25% of total PLHIV on treatment are covered and 2) prevention and active case-finding services provided by CSOs. Although there is a high level of resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control, the existing financing schemes are quite fragmented and not comprehensive.

Data for Decision making ecosystem (Score: 7,67; light green)
Indonesia has demonstrated commitment and has sufficient capacity to advance the use of data in informing government decisions and cultivating an informed, engaged civil society. However, the integration of data needs to be prioritized to avoid double counting and dual program efforts. The role of information systems in the MOH (Pusdatin) needs to be strengthened in the area of data integration to ensure that comprehensive decision-making processes take place. While data is reported and shared, the aggregate nature of the reporting does not easily lend itself to rapid site-level responses. It should also be noted that outreach and community case management data is not routinely collected or stored within the national HIV information system.

Financial Expenditure Data (Score: 7,50; light green)
Indonesia routinely collects, tracks, analyses and makes financial data available on HIV/AIDS. The GOI collects and produces reports on HIV/AIDS financing and spending from most sources, costing, economic evaluation, efficiency and market demand analyses for cost-effectiveness. However, contributions from the regional government budgets have not yet been adequately incorporated and there is a need to identify which programs and activities can be funded by regional governments. Although some brand of cost-effectiveness analyses have been done; it may be more appropriate to say that these are costing analyses and costing projections.

Service Delivery (Score: 7,32; Yellow)
There is a great need to improve linkages between facility and community-based HIV services at all levels in Indonesia. Public policy and regulation for continuum services for HIV emerged in 2013; however, its implementation has varied by region. Not all local governments are able to support linkages between health facilities and the KP community. Some regions regularly fund this type of engagement for community groups at large, however most sub national units do not support these activities.

Sustainability vulnerabilities

Technical and Allocative Effectiveness (Score: 6,86; Yellow)
The ability to analyze and use relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions is limited. Current resource allocation for the National HIV/AIDS Program reflects estimated burden and epidemiological estimates. For example, ARV procurement is based on estimates with specific calculations for the next two years. Comparing to the international benchmark prices, ARV prices in Indonesia are still significantly higher than

international prices and there is a great opportunity for savings by purchasing at lower prices and optimizing ARV regimens.

Policies and Governance (Score: 6,48; Yellow)
There is limited opportunity to develop, implement, and oversee 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.

WHO guidelines are used as a reference in making national guidelines for the governance of HIV programs in Indonesia. However, most of the national guidelines still need to be updated.

Indonesia has a protection and equality law based on human rights, but this law has not yet been fully implemented. There are no articles that specifically mention the equality of sexual orientation. The Anti- Discrimination Law does not exist, so there are no clear consequences are given to violators. However, criminalization and persecution are often experienced by key populations. At the national level, there is no criminalization law against sex workers or clients of sex workers. However, at select sub-national locations, some local laws exist.

In general, Indonesia has a law on violence protection. However, it does not explicitly mention protections for PLHIV. Reporting procedures for complaints are unclear to the public. Supervision of this regulation needs improvement. Several commissions have been formed such as the Child Protection Commission, National Human Rights Commission, Women's Commission.

Planning and Coordination (Score: 6,45; Yellow)
The Ministry of Health (MOH) 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. The MOH, along with other technical ministries, annually submits their budget plan to the National Planning Agency (Bappenas) with an annual budget approved by the legislative authorities. With the dissolution of the National AIDS Commission; the Coordinating Ministry of Human Development and Culture (PMK) is responsible for planning and coordination of HIV/AIDS programming among all relevant technical ministries. PMK will need to coordinate between ministries to establish an effective coordinating mechanism. There is limited information on planning and coordination successes and challenges at district, sub-district and facility-community levels in the 2019 SID.

Market Openness (Score: 6,29; Yellow)
Competition is limited for goods and commodities in the HIV/AIDS space. Some policies and regulations exist that limit competition and market openness for key HIV/AIDS commodities.

Commodity Security and Supply Chain (Score: 6,17; Yellow)
Although the majority of HIV/AIDS commodities are financed by the Government of Indonesia, the National HIV/AIDS Program faces a number of challenges in ensuring 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. For example, there are 24 million condoms procured through the Global Fund; however, there are major issues around distribution that have limited access to these commodities.

Epidemiological and Health Data (Score: 6,06; Yellow)
Even though data is routinely collected, analysed, and made available, there is still a need for improved implementation and follow up. Behavior and HIV prevalence data on key populations are collected

and analyzed by the national level for use at the national level and should be more routinely 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 who are identified positive is still low, but there has been a slow and gradual improvement in those figures. However, the number of PLHIV identified positive is still under-reported in the national system.

The MOH has initiated HIV cohort reporting and is scaling up to other public health facilities, which will begin to look at retention issues. Separately, there are substantive issues and a need for greater clarity related to national PLHIV estimates and how these estimates have been assigned to provinces. This would greatly impact cascade performance.

Civil Society engagement (Score: 5,83; 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 as to how GOI funding would be accessible to CSOs. There are no statutory regulations that limit or restrict civil society from playing an oversight role in the HIV/AIDS response and there are no clear regulations that mandate or encourage the government to involve CSOs in conducting oversight. Most participants see the practice of monitoring HIV programs by CSOs as not yet systematic, for several reasons: 1) There are no regulations that encourage or make the CSO supervision component mandatory, 2) Mechanisms to provide oversight on CSO engagement exist but are limited. The involvement of CSOs is still incidental based on the program stages (planning, implementation, monitoring and evaluation), where more robust CSO involvement involving a greater majority of CSOs is needed. There have been opportunities identified for more CSO engagement including: 1) national and sub national planning processes 2) accreditation of facilities and through PAC/DAC.

Laboratory (Score: 5,76; Yellow)

Indonesia does not have adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services needed by PLHIV. There is an organizing body to monitor laboratory services within the Ministry of Health; however, its resources are limited. The majority of monitoring of point of care services is implemented through external funding sources. The capacity of laboratory technicians is also limited. Total numbers of laboratory technicians are high; however, the workforce distribution is uneven.

Human Resource for Health (Score: 5.44; Yellow)

Health workforce staffing decisions for those working on HIV/AIDS are based on the use of workforce data and are aligned with national plans. Indonesia is struggling to close the gap between supply and demand of health workers. Challenges include insufficient numbers, categories and distribution of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care, and treatment services in health facilities and the community. The Government of Indonesia provides almost all of the public health workers salaries, however there is currently no transition plan for health workers that are supported or subsidized using donor funding. Private health facilities play a significant role in providing HIV/AIDS services and funded their workers independently using their budget. The education sector has incorporated HIV/AIDS contents in their curriculum; however, there is a need to improve the in-service training for both public and private sectors. HIV/AIDS services are included in the minimum service standards, meaning that all available health workers must have fulfilled the qualifications and provision for understanding HIV/AIDS; however, there is a need to

review Indonesia's policy regarding placement of health workers, because the competency and number of workers deployed does not always match with the HIV burden of a region.

Private Sector engagement (Score: 4,67; Yellow)

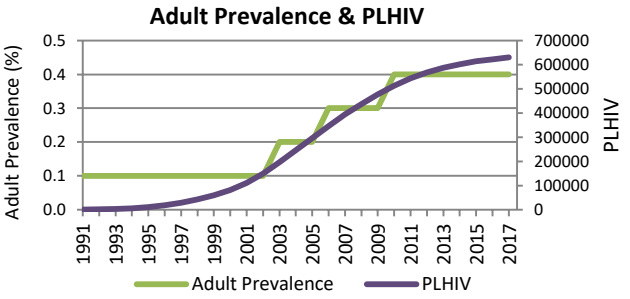
There are limited supportive policies and mechanisms for the private sector to engage, review and provide feedback regarding public programs, services, and fiscal management of the national HIV/AIDS response. Historically, the private sector has not participated in the national HIV/AIDS response in Indonesia in a significant way. However, private providers (KP friendly clinics and private laboratories) have provided quality HIV services for key populations. The private sector has also participated in the Indonesian Business Coalition on AIDS and it is believed that a stronger collaborative effort between the MoH, Ministry of Man Power and business coalition will support the implementation of national strategy, reaching more high risk people in industries, and support the scale-up of HIV services. Leveraging private sector outlets could also help to accelerate key program elements such as self-testing, PrEP, and ART provision.

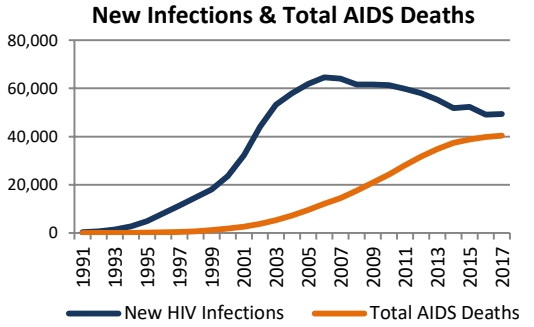
Sustainability Analysis for Epidemic Control: Indonesia

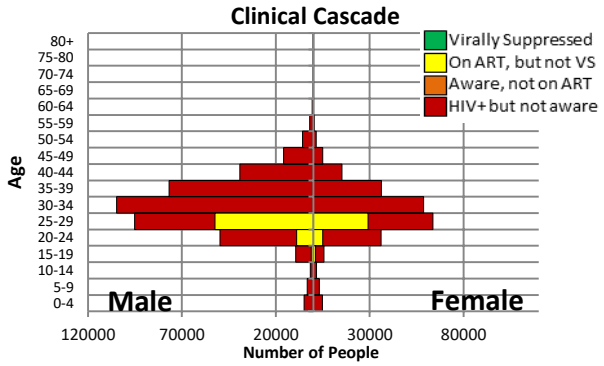
Epidemic Type: Concentrated
Income Level: Lower middle income
PEPFAR Categorization: Asia Region
PEPFAR COP 19 Planning Level: $ 5,622,503

SUSTAINABILITY DOMAINS and ELEMENTS

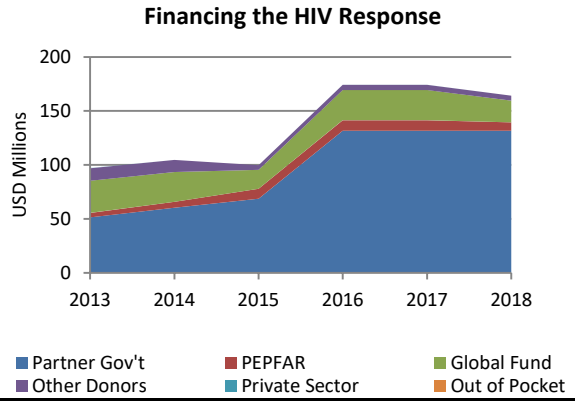
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	10.00	8.57	6.45	
2. Policies and Governance	6.58	7.06	6.48	
3. Civil Society Engagement	7.00	4.67	5.83	
4. Private Sector Engagement	2.75	4.78	4.67	
5. Public Access to Information	8.00	5.00	9.78	
National Health System and Service Delivery				
6. Service Delivery	6.30	7.69	7.32	
7. Human Resources for Health	7.58	6.74	5.44	
8. Commodity Security and Supply Chain	4.11	7.11	6.17	
9. Quality Management	6.48	7.38	8.00	
10. Laboratory	6.30	5.33	5.76	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	7.78	7.93	7.90	
12. Technical and Allocative Efficiencies	6.94	8.00	6.86	
13. Market Openness	N/A	N/A	6.29	
Strategic Information				
14. Epidemiological and Health Data	6.90	5.54	6.06	
15. Financial/Expenditure Data	7.08	8.33	7.50	
16. Performance Data	8.43	7.11	9.72	
17. Data for Decision-Making Ecosystem	N/A	N/A	7.67	

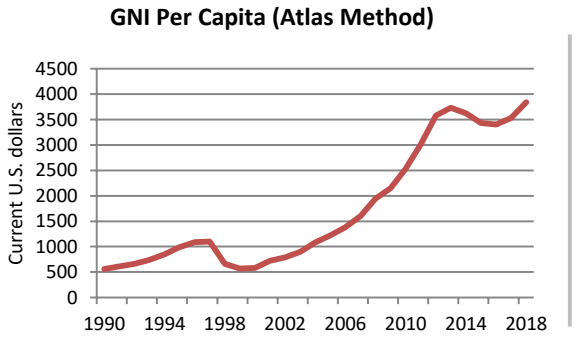


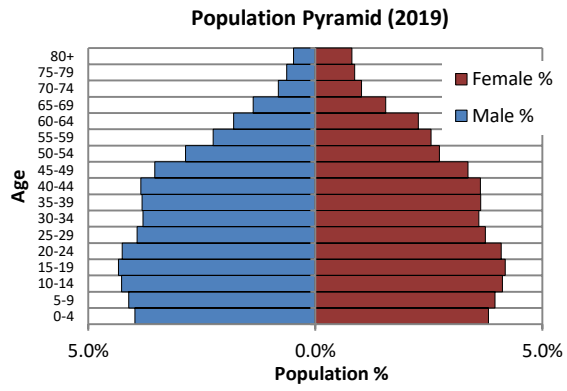




CONTEXTUAL DATA



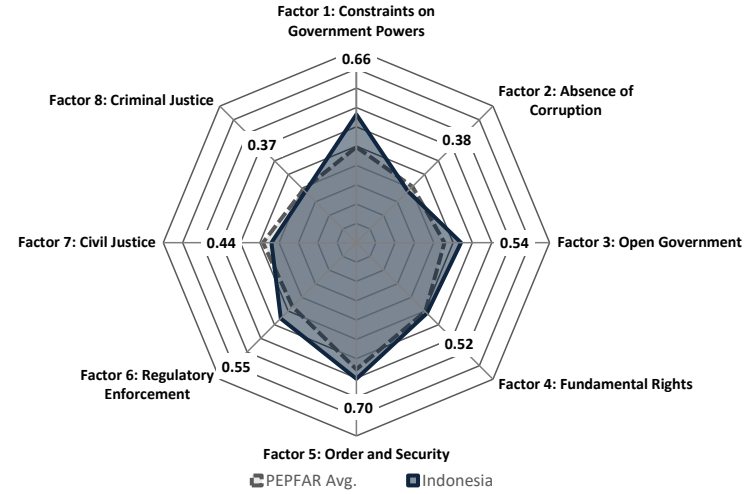


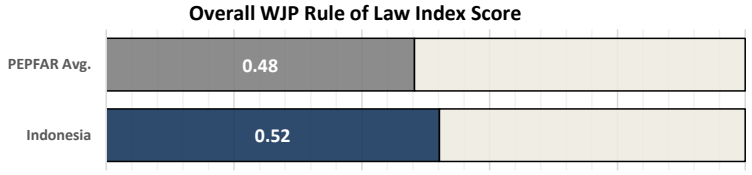


Sustainability Analysis for Epidemic Control: Indonesia

Contextual Governance Indicators

Rule of Law Index (World Justice Project)





WJP's Rule of Law Index measures the general public's experience and perception across eight 'factors':

1. Constraints on Government Powers: Governmental powers are limited by both internal and external checks, including auditing and review. Governmental officials are subject to the law and sanctioned for misconduct.

2. Absence of Corruption: Government officials in all branches of government do not use public office for private gain.

3. Open Government: Citizens have open access to government information and data, complaint mechanisms, and civic participation.

4. Fundamental Rights: There is equal treatment of citizens and absence of discrimination. The rights to freedom of expression, security of the person, and due process are effectively guaranteed.

5. Order and Security: Crime and civil conflict are effectively limited. Personal grievances are not redressed through violence.

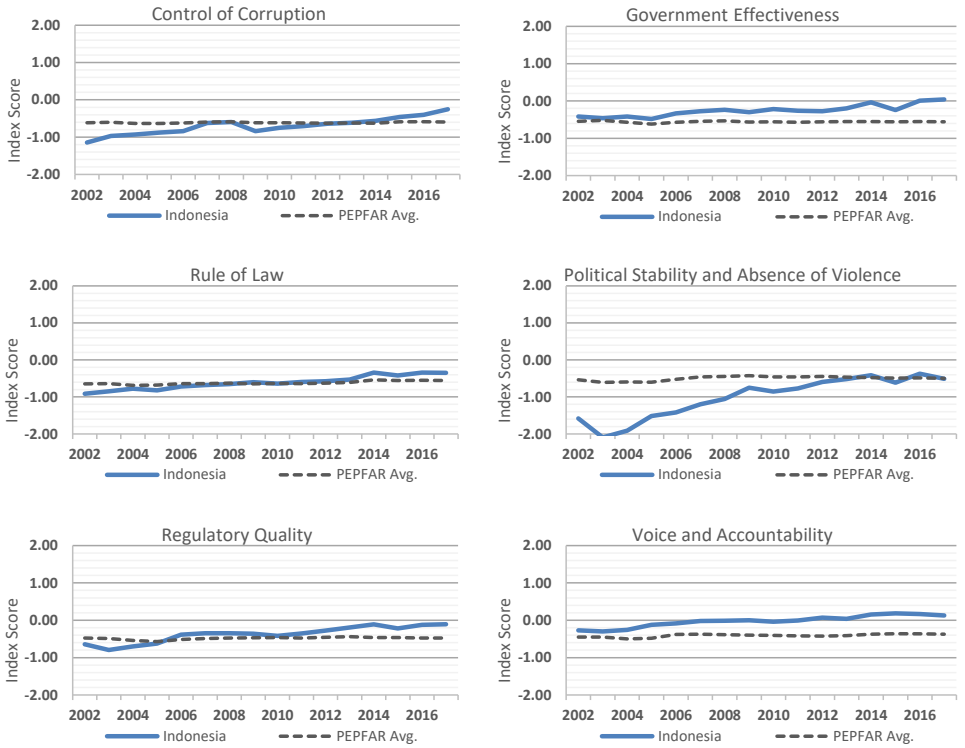
6. Regulatory Enforcement: Government regulations are effectively applied and enforced without improper influence. Due process is respected in administrative proceedings.

7. Civil Justice: Civil justice is accessible and free of discrimination, corruption and improper government influence.

8. Criminal Justice: Criminal justice is impartial, timely and effective, and free from corruption or improper government influence. There is due process of law and rights of the accused.

More information can be found at: https://worldjusticeproject.org/our-work/research-and-data/wjp-rule-law-index-2019

Worldwide Governance Indicators (World Bank)



The World Bank Worldwide Governance Indicators (WGI) score countries based on six dimensions of governance:

1. Control of Corruption: captures perceptions of the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as 'capture' of the state by elites and private interests.

2. Government Effectiveness: measures the quality of public services, the quality of the civil service and its independence from political pressure, the quality of policy formulation and implementation (including the efficiency of revenue mobilization and budget management), and the credibility of the government's commitment to its stated policies.

3. Rule of Law: captures perceptions of the extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence.

4. Political Stability and Absence of Violence: measures perceptions of the likelihood of political instability and/or politically-motivated violence, including terrorism.

5. Regulatory Quality: Measures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development.

6. Voice and Accountability: captures perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media.

More information can be found at: https://info.worldbank.org/governance/wgi/

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.

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.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ◉ B. There is a multiyear national strategy. Check all that apply: ☑ It is costed ☑ It has measurable targets. ☑ It is updated at least every five years ☑ 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) ☑ Strategy includes explicit plans and activities to address the needs of key populations. ☑ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children ☐ Strategy (or separate document) includes considerations and activities related to sustainability	1.1 Score: 2.29	NAC SRAN 2015-2019 NAP - MOH RAN 2015-2019	The 2015-2019 RAN is not final yet Recommendation: Add interventions on preparednes for transition with BAPPENAS, KSP (Presidential office) MoF, MOHA.
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy ☐ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☐ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 1.50	NAC SRAN 2015-2019 NAP - MOH RAN 2015-2019	The National Strategy is drawn up jointly between the Ministries in connection with the community component and other partners coordinated by the Ministry of Health with the support of technical partners, national and international MoH lead in development of national strategy, but need to ensure involvement of all critical stakeholders (education, empowerment, Bappenas, etc) Role of private sector need to be more prominent. Compared to the 2017 SID, participants in the 2019 SID did not believe that private health sector providers/ the private sector in general

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?	Check all that apply: ☐ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☑ The host country government routinely tracks and maps HIV/AIDS activities of: ☐ civil society organizations ☐ private sector (including health care providers and/or other private sector partners) ☑ donors ☐ 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. ☐ Joint operational plans are developed that include key activities of implementing organizations. ☐ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 0.17	SID 2019 consensus Interface meeting/workshop	The central government is responsible for activities in the regions because it cumulatively influences national performance. But the control system cannot be carried out as a whole, especially in activities funded by the region itself. Recommendation: PMK to take lead and to coordinate in establishing effective coordinating mechanism. Similarly as in 1.2 ; the role of private sector needs to be more prominent. Compared to the 2017 SID, participants in the 2019 SID did not believe that the government routinely tracks and maps HIV/AIDS activities in the private sector. This resulted in a decrease in score from 2017.

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)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.) ☑ Sub-national units have performance targets that contribute to aggregate national goals or targets. ☐ The central government is responsible for service delivery at the sub-national level.	1.4 Score:	2.50	Home Affairs Ministerial Regulation No 32 Year 2017 on Minimum Service Standard (SPM) in Health Sector Health Ministerial regulation no 43/2016 on Minimum Service Standard (SPM) in Health Sector	Link this to PKM as coordinator (ex. National level report) Sub national level had their own target, but no reporting mechanism that synchronize
		Planning and Coordination Score:	**6.45**		

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**
2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current WHO guidelines for initiation of ART - i.e., optimal ART regimens for all populations (including TLD as recommended)?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines on optimal ART regimens for each of the following: A. Adults (>19 years) ☑ Yes ☐ No B. Pregnant and Breastfeeding Mothers ☑ Yes ☐ No C. Adolescents (10-19 years) ☑ Yes ☐ No D. Children (<10 years) ☑ Yes ☐ No	2.1 Score: 0.91	Health Ministerial Regulation No 21/2013 on HIV Control Health Ministerial Circulation Letter No 129 / 2013 on Strategic Use of ARV Health Ministerial Regulation No 87/2014 on HIV Treatment	WHO guidelines are used as a reference in making national guidelines for the governance of HIV programs in Indonesia. However, currently the national guidelines are still very out-dated, so many programs cannot run optimally because the Hospital will follow the national guidelines.

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? Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.	Check all that apply: ☑ A national public health services act that includes the control of HIV ☑ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☑ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☐ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) ☐ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☑ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☑ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS ☑ Policies that permit HIV self-testing ☐ Policies that permit pre-exposure prophylaxis (PrEP) ☐ Policies that permit post-exposure prophylaxis (PEP) ☐ Policies that allow HIV testing without parental consent for adolescents, starting at age 15 ☐ Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent	2.2 Score: 0.45	Health Ministerial Decree HK.02.02/Menkes/52/2015 on National Health Strategy 2015-2019 that includes HIV Control Law No 23/2002 on Child Protection that includes protection of children orphaned and or made vulnerable by HIV/AIDS. Law No 36/2014 on Medical Health Force that among others regulates policy on task-shifting	

2.3 User Fees for HIV Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any HIV services in the public sector: clinical, laboratory, testing, prevention and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☐ No, neither formal nor informal user fees exist. ☑ Yes, formal user fees exist. ☐ Yes, informal user fees exist.	2.3 Score: 0.23	Law 36/2009 on Health Law 29/2004 on Medical Practices Health Ministerial Regulation No 36/2012 on Medical Confidentiality	
2.4 User Fees for Other Health Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any non-HIV services in the public sector, such as MCH/SRH, TB, outpatient registration, hospitalizations, and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☐ No, neither formal nor informal user fees exist. ☑ Yes, formal user fees exist. ☐ Yes, informal user fees exist.	2.4 Score: 0.23	SID 2019 consensus Interface meeting/workshop	Official costs are costs that must be incurred for retribution in hospitals and clinics (government). However, if you want to meet with a specialist doctor, there will be additional costs in accordance with applicable fees. For private hospitals, hospital and doctor / service registration fees will be charged to patients. Patients can use BPJS so that there are no costs to incur, but BPJS does not cover the need for tests (some cities have APBD funds to cover this).
2.5 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?	The country has policies in place that (check all that apply): ☑ Govern the collection of patient-level data for public health purposes, including surveillance ☑ Govern the collection and use of unique identifiers such as national ID for health records ☑ Govern the privacy and confidentiality of health outcomes matched with personally identifiable information ☑ Govern the use of patient-level data, including protection against its use in crimincal cases	2.5 Score: 0.91	Law 36 / 2009 on Health Law 29/2004 on Medical Practices Health Ministerial Regulation No 36/2012 on Medical Confidentiality	Law 36 of 2009 concerning Health regulates that Medical Records are classified as medical secrets that must not be accessed or given access to any party.

2.6 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?	Check all that apply: Transgender people (TG): ☑ Constitutional prohibition of discrimination based on gender diversity ☐ Prohibitions of discrimination in employment based on gender diversity ☐ A third gender is legally recognized ☐ Other non-discrimination provisions specifying gender diversity (note in comments) Men who have sex with men (MSM): ☐ Constitutional prohibition of discrimination based on sexual orientation ☐ Hate crimes based on sexual orientation are considered an aggravating circumstance ☐ Incitement to hatred based on sexual orientation prohibited ☐ Prohibition of discrimiation in employment based on sexual orientation ☐ Other non-discrimination provisions specifying sexual orientation Female sex workers (FSW): ☑ Constitutional prohibition of discrimination based on occupation ☐ Sex work is recognized as work ☐ Other non-discrimination protections specifying sex work (note in comments)	2.6 Score: 0.27	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 a protection and equality law based on human rights, but not in full implementation. That is, there are no articles that specifically mention the equality of sexual orientation. The Anti-Discrimination Law does not exist so that no clear consequences are given to violators. Of all the key populations mentioned above, by law, only injecting drug users are criminalized under the Act. However, criminalization and persecution are experienced by all key populations. In general, Indonesia has a law on violence protection. However, it is not specifically intended to protect PLHIV. In addition, many reporting mechanisms, complaints and interventions remain largely unknown to the public. Like the misconduct reporting mechanism and malpractice in the Police there are actually a number of mechanisms that can be used - not necessarily through a litigation process. Supervision of this law is still very minimal. Several Commissions have been formed such as the Child Protection Commission, National Human Rights Commission, Women's Commission, but HIV is still not a priority and does not receive special attention.

	People who inject drugs (PWID): ☑ Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments) ☐ Explicit supportive reference to harm reduction in national policies ☐ Policies that address the specific needs of women who inject drugs			
2.7 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?	The country has the following to protect key populations and people living with HIV (PLHIV) from violence: ☑ General criminal laws prohibiting violence ☐ Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population ☑ Programs to address intimate partner violence ☑ Programs to address workplace violence ☑ Interventions to address police abuse ☑ Interventions to address torture and ill treatment in prisons ☑ A national plan or strategy to address gender-based violence and violence against women that includes HIV ☑ Legislation on domestic violence ☑ Criminal penalties for domestic violence ☑ Criminal penalties for violence against children	2.7 Score: 0.82	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. Law 16 No 2011 on Provision of Legal Aid 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 Police Chief Regulation No 12/2009 governs the probihition of abuse of police Law No 23/2004 on Domestic Violance Law No 23 /2202 on Child Protection Law no 13/ 2003 on Labour that governs	At the moment the Bill on the Elimination of Sexual Violence is being discussed. Although this score decreased from 2017, this decrease is mainly due to a change in weighting of the scores in the template. The same items in 2019 were selected as in 2017.

2.8 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	2.8 Score: 0.63	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. Presidential Regulation 29/2014 on Performance Accountability System of Government Agencies	Regarding the question of drug offenses, the death penalty is NOT APPLIED to USERS, but to those charged with drug trafficking. In national level, there is no criminalization law againts sex workers or client to sex worker. However, in the sub-national level (like in Aceh) some local law exist. Local laws that criminilize sex worked are better captured in the 2019 SID score. This has resulted in a decrease in total score for 2.8 from 2017. 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
- [x] 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?

- [x] 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
- [x] 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
- [x] No

	Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people? ☐ Yes, promotion ("propaganda") laws ☑ Yes, morality laws or religious norms that limit LGBTI freedom of expression and association ☐ No			
2.9 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, adolescents, and those who may access HIV services about these rights?	There are host country government efforts in place as follows (check all that apply): ☐ To educate PLHIV about their legal rights in terms of access to HIV services ☐ To educate key populations about their legal rights in terms of access to HIV services ☑ National law exists regarding health care privacy and confidentiality protections ☐ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	2.9 Score: 0.23	Presidential Regulation 29/2014 on Performance Accountability System of Government Agencies	Legal rights education is carried out but not by the government. Financial support to access legal aid is only provided for the poor. With greater participation and leadership from civil society groups in the 2019 SID process compared to 2017, the perception of the host-country efforts to educate and ensure rights of PLHIV and KPs was lower. This resulted in a total lower score compared with 2017.
2.10 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)?	○ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ◉ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.10 Score: 0.91	Presidential Regulation 29/2014 on Performance Accountability System of Government Agencies	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. Depending on donor interests - GF or based on state financial audits when using APBN funds.
2.11 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?	○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ○ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ◉ 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.	2.11 Score: 0.91	Presidential Regulation 29/2014 on Performance Accountability System of Government Agencies	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.
		Policies and Governance Score: 6.48		

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**
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?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ◉ 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. ○ 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.	3.1 Score: 0.83	No law that restrict CSO from oversight role in HIV AIDS response	Oversight conducted by civil society is still limited to the health sector. Whereas the issue of HIV should be a multi-sector issue. In addition, knowledge of monitoring and reporting mechanisms is still very minimal. Only a handful of organizations understand and can use this mechanism. Besides being very formal, special abilities are needed to use the mechanism. Example: Ombudsman mechanism
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)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ○ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ◉ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☑ In joint annual program reviews ☑ For policy development ☐ As members of technical working groups ☑ Involvement on government HIV/AIDS program evaluation teams ☑ Involvement in surveys/studies ☑ Collecting and reporting on client feedback ☐ Service delivery	3.2 Score: 1.25	MOH Regulations, PERMENKES NO. 21/2013 on community involvement for HIV response MOHA regulations, PerMendagri NO. 20/2007 on community enpowerment for HIV AIDS response	

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply): ☑ In policy design ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☑ In HIV/AIDS basket or national health financing decisions	3.3 Score: 1.67	MOH Regulations, PERMENKES NO. 21/2013 on community involvement for HIV response MOHA regulations, PerMendagri NO. 20/2007 on community enpowerment for HIV AIDS response	
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)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ◉ 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). ○ 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). ○ 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). ○ 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).	3.4 Score: 0.83	SID 2019 consensus Interface meeting/workshop	
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)? Note: This sometimes referred to as "social contracting" or "social procurement."	○ 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). ◉ 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: ☑ Competition is open and transparent (notices of opportunities are made public) ☑ Opportunities for CSO funding are made on an annual basis ☐ Awards are made in a timely manner (within 6-12 months of announcements) ☐ Payments are made to CSOs on time for provision of services	3.5 Score: 1.25	MOHA regulations, PerMendagri NO. 20/2007 on community enpowerment for HIV AIDS response	
		Civil Society Engagement Score:	**5.83**	

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**
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? (If option B is true, check all subsequent boxes that apply.)	○ A. There are no formal channels or opportunities for private sector engagement. ◉ B. There are formal channels or opportunities for private sector engagement. 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): ☑ Corporations ☑ Employers ☐ Private training institutions ☐ Private health service delivery providers ii. Stakeholders contribute in the following ways (check all that apply): ☑ The private sector contributes technical expertise into HIV program planning ☐ Data and strategic input into supply chain management for HIV commodities ☐ Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning ☐ Data on staffing in private health service delivery providers ☐ Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning ☑ For technical advisory on best practices and delivery solutions	4.1 Score: 1.25	MOHA regulations, PerMendagri NO. 20/2007 on community empowerment for HIV AIDS response	There is a (strong) tendency that each ministry rigidly acts only according to the "job description" or tupoksi (the main task of the agency). Rhetorically good, but in reality there are still many problems. For example: a job description "job place" is the authority of the ministry of labor. The problem of HIV and AIDS is the authority of the ministry of health. Then who has to take care of the problem of working age that is potentially infected with HIV? Isn't 75% of people with HIV and AIDS in the working age group? The Ministry of Manpower will take care of this issue if there is a "project". The project is complete then everything is complete. The Ministry of Health is reluctant to take care of HIV prevention efforts among the working age because they feel that this is not their authority. The Ministry of Manpower has a decree to combat HIV and AIDS in the workplace. When there are projects there are activities. After the project is finished the activity stops. There are VCT efforts at work but in reality there is no commitment from the ministry of health to provide support to VCT in the workplace. It supports rhetorically but needs a complicated bureaucratic path and makes us despair. Companies that have policies related to HIV / AIDS will have a need to provide services, but still have obstacles considering HIV-related insurance is still minimal, companies still do not understand much about access to ARV drugs as a Government Drug Program.

	iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply): ☑ The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response. ☑ A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan ☐ 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.			Drug access connections as part of the BPJS and Drug Program still lead to miscommunication about the availability of HIV / AIDS services for employees in the company. Interest from companies is very large when there is information about HIV services that can be accessed, but information is not available except when training for HIV services is provided at the company level.
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?	Check all that apply: ☑ 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). ☐ 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). ☐ The host country government has standards for reporting and sharing data across public and private sectors. ☐ 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). ☐ There are strong linkage and referral networks between on-site workplace programs and public health care facilities.	4.2 Score: 0.50	Ministry of Manpower regulation No. 68/2014	Although formal channels are available, in reality very few non-governmental parties are actually targeted or those who have the potential do not know the mechanisms available. Apart from that there are several mechanisms available but cannot operate because some important elements are still not considered, such as existing regulations that are possible but the instruments to implement these regulations are not available, or vice versa. Often the fundamental issues such as the absence of trust (trust) between the government and the private sector are so deep, but the environment that creates the trust is not improved (eg governance and accountability) As a result of this, the 2019 score was reduced compared to 2017

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? Note: Full score possible without checking all boxes.	○ A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services. ○ B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years. ◉ C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply): ☑ 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. ☑ Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting. ☑ Joint (i.e., public-private) supervision and quality oversight of private facilities. ☐ The government offers tax deductions for private facilities delivering HIV/AIDS services. ☐ The government offers tax deductions for private training institutions. ☐ The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores ☐ The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services. ☐ HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes ☐ There are open competitions for private health care providers to compete for government service contracts ☐ 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 ☐ The government effectively regulates the flow of subsidized commodities into the private sector. ☐ Private Banks or lenders provide access to low interest loans prioritizing private health sector small and medium-sized enterprise (SME) development and expansion.	4.3 Score: 1.67	MoH regulations No: - Permenkes 87/2014 - on ARV guidelines	Ministerial Decree No. 68/2004 concerning HIV / AIDS Prevention and Control in the Workplace (through the K3 program, Occupational Health and Safety) Decree of the Director General of PPK Ministry of Manpower No. Kep. 44 / PPK / VIII / 2012 concerning Guidelines for Awarding HIV / AIDS Prevention and Control Programs in the workplace National OHS Profile 2018 has included HIV / AIDS as a component of OHS, this is the basis for integration of all OHS programs to integrate HIV prevention / AIDS in the world of work There are formal channels that can actually be used by the private sector but the government's attitude is still "half-hearted". Example: the most cases of HIV and AIDS are working age. This means that comprehensive HIV and AIDS prevention efforts must be able to reach the working age for prevention and prevention efforts. YKB has been pioneering consistently in this field (since 1993) but government support (specifically the Ministry of Manpower and the Ministry of Health) is inconsistent. Provides support when there is project funding but is not sustainable when the project is completed. While NGO resources are limited, the scope is limited. In my opinion there is a large missing opportunity by ignoring the approach at work. Another example: VCT @ Work efforts in the workplace require reagent support but only a few can be allocated because reagent priorities are for key populations and pregnant women so the allocation for VCT in the workplace is

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?	○ A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response. ○ B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response. ◉ C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply): ☑ Market opportunities that align with and support the national HIV/AIDS response ☐ 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)	4.4 Score: 1.25	GoI regulation No: UU 44/2009, on hospital MoH regulation Permenkes No. 451/2012, on referral hospitals for HIV/AIDS	There is a (strong) tendency that each ministry rigidly acts only according to the "job description" or tupoksi (the main task of the agency). Rhetorically good, but in reality there are still many problems. For example: a job description "job place" is the authority of the ministry of labor. The problem of HIV and AIDS is the authority of the ministry of health.
	Private Sector Engagement Score:	**4.67**		

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**
5.1 Surveillance Data Transparency: Does the host country government ensure that national HIV/AIDS surveillance data and analyses are made available to stakeholders and general public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS surveillance data available to stakeholders and the general public, or they are made available more than one year after the date of collection. ○ B. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within 6-12 months. ◉ C. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within six months.	5.1 Score: 2.00	MoH regulations : Permenkes 45/2014 - on Health Surveillance (HIV is included)	Not all stakeholders get surveillance data within 6-12 months. The general public usually receives surveillance data for more than one year.
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?	○ A. The host country government does not track HIV/AIDS expenditures. ○ 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. ○ 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. ◉ D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.	5.2 Score: 2.00	NAC: National AIDS Spending Assesment	Not all stakeholders are easy to get information / data on the expenditure budget for HIV / AIDS. The general public also has limited access.

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?	○ 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. ○ 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. ◉ 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 . At what level of detail is this performance data reported? [CHECK ALL THAT APPLY] ☑ National ☑ District ☐ Site-Level	5.3 Score:	1.78	MoH quarterly reports	Performance data is usually presented at coordination meetings with stakeholders and the community (MARP).
5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. The host country government does not make any HIV/AIDS procurements. ○ B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ○ C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ◉ D. The host country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score:	2.00	LKPP : E-catalogue http://e-katalog-lkpp.go.ig	pricing monitoring, anaituc capacity moh

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?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score:	2.00	www.kemenkes.go.id	
		Public Access to Information Score:	**9.78**		

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.

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.			**Data Source**	**Notes/Comments**
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.)	☑ 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) ☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☑ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 0.95	MoH annual report SIHA report	
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.)	The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply): ☑ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☑ National guidelines detailing how to operationalize HIV/AIDS services in communities ☑ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities ☑ Providing financial support for community-based services ☑ Providing supply chain support for community-based services ☑ 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)	6.2 Score: 0.95	Ministry of Health regulation No. 21, National guidelines on continues sustainable services (LKB), Form CBS (EOA) from Linkages project	In certain regions and conditions of high need are already accommodated, for example DKI Jakarta. but in some regions in Indonesia health services have not yet implemented needs-based services.
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)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services ◉ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services	6.3 Score: 1.25	Data from APBN dan APBD, NASA	In the 2015-2019 National Strategy and Action Plan for Combating HIV and AIDS in Indonesia, recording funding needs related to HIV / AIDS in 2019 is US $ 184.71 million. However, the available budget is only US $ 75.59 million, so there is a shortfall of US $ 109.12 million.

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?	○ A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services with some external technical assistance. ◉ D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.	6.4 Score: 0.95	Activity report from Bimtek and Binwasdal	
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)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations, or information is not available. ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations. ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.	6.5 Score: 0.83	NASA, Annual report from Ministries (APBN, APBD, and BLUD)	Consensus from the 2019 SID meeting resulted in a lower score for service delivery to KPs. According to meeting participants, donor resources provide greater financing for service delivery for KPs.
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?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ◉ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.63	Monev and activity report from Provincial Health Office (Dinas kesehatan)	
6.7 Management and Monitoring of HIV Service Delivery: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV service delivery activities including practice standards, quality, health outcomes, and information monitoring across all sectors. Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget. ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	6.7 Score: 0.63	Report on APBN, APBD, accreditation report, report on administration and management (sistem kinerja nakes di layanan)	

6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	National health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engage with civil society in program planning and evaluation of services. ☐ 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	6.8 Score: 0.79	Fastrack Report, MoH decree No. 75/2014	SID 2019 participants reached consenus that there is no adequate staff performance management plan to make sure staff working in high burden sites maintain good clinical and technical skills.
6.9 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?	Sub-national health authorities (check all that apply): ☐ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☐ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☐ Effectively engage with civil society in program planning and evaluation of services. ☐ 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.	6.9 Score: 0.32	Fastrack Report, MoH decree No. 75/2014	SID 2019 participants reached consenus that there are great needs for improvement in this area at subnationa levels. This resulted in a lower SID score in 2019.
		Service Delivery Score **7.32**		

7. Health Workforce: Health workforce staffing decisions for those working on HIV/AIDS are based on use of workforce 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 Health Workforce 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: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers ☐ The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas ☐ 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. BPPSDM and HR inventory WHO Based on the discussion with key stakeholders during SID workshop, overall there was not enough health workforce supply and skill mix of clinical health care providers. These available clinical health workers are not adequately deployed and are concentrated in urban areas. There are no retention schemes available and there are no social services provided, especially to vulnerable children.	All boxes are intentionnaly not checked. When in health workers are proven by an education certificate, so the remuneration and compensation are given based on this recognition. Workers who come from the community, if they have an appropriate educational background will not have obstacles to providing their services, but if based on volunteerism, or even in the provision of authority (task shifting), conditions without an educational background are more difficult to be accommodated in the official health system, even in areas where there is clearly a shortage of health workers.
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: ☐ 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). ☐ Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors. ☐ The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services.	7.2 Score: 0.00	Based on the discussion with key stakeholders during SID workshop, there is no formal recognition for CHW role in delivering HIV/AIDS services and thus, there is no defined role for CHW. Data on staffing and deplyoment of CHWs is currently self-managed by donors and to date, there is no available system / mechanism from the government to document.	All boxes are intentionnaly not checked. HIV services are included in the minimum service standard, meaning that all available health workers must have fulfilled the qualifications / provision for understanding HIV / AIDS
7.3 Health Workforce 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 and timeline for transition.	◉ A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	7.3 Score: 0.00	Based on the discussion with key stakeholders during SID workshop, all government health workers are already paid using government funding and all private health workers are funded independently by private health facilities. The stakeholders did not identify that there are HIV/AIDS health workers that are funded using PEPFAR and/or other donor fundings. Thus, no inventory or plan for transition of donor-supported health workeres is identified from the SID workshop.	

7.4 Domestic Funding for Health Workforce: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ○ D. Host country institutions provide most (approx. 50-89%) health worker salaries ◉ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.4 Score: 3.33	Staff Data GF financial report	The state health workers are 100% funded by the state through the state budget or regional budget. For private workers, it is funded by the private sector Most of all healthcare workers are under government or private health facilities.
7.5 Pre-service Training: 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? Note: List applicable cadres in the comments column.	○ 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) ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☑ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☑ Institutions maintain process for continuously updating content, including HIV/AIDS content ☑ Updated curricula contain training related to stigma & discrimination of PLHIV ☐ Institutions track student employment after graduation to inform planning	7.5 Score: 0.83	MoH decree No.87/ 2014	For relatively large universities, such as Airlangga University, UI, Padjadjaran University, Gadjahmada University, Hasanudin University, and several others, the HIV and AIDS curriculum has reached a complete course. But it is not yet known how many tertiary institutions have implemented the curriculum, for the Faculty of Medicine, the Faculty of Public Health, and Nursing and Midwifery. The training curriculum has been adjusted to national standards, current issues, and even components of stigma and discrimination
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? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☐ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☑ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☐ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☐ 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 ☐ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☐ 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)	7.6 Score: 0.12	LINKAGES assessment data on HRH 2015 DKI Jakarta	Government only provides training for civil servant, private healthcare provider did not receive proper training and support from the government. This resulted in a lower score. A78:R87 Nevertheless, based on the SID workshop, the frequency of capacity building provided is less than 50% for health workers in-service training (only around once or twice basic training per year).

7.7 Health Workforce 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?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☑ The HRIS is primarily financed and managed by host country institutions ☑ There is a national strategy or approach to interoperability for HRIS ☑ The government produces HR data from the system at least annually ☐ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.7 Score:	0.83	HRIS managed by National body for human resources management and empowerment (BPPSDMK).	
7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for health workforce activities in HIV service delivery sites, including training, supervision, deployments, quality assurance, and others across all sectors. Select only ONE answer.	○ A. No, there is no entity. ◉ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	7.8 Score:	0.32	HRIS managed by National body for human resources management and empowerment (BPPSDMK)	Placement of Health Workers or other assignments does not see the HIV burden of a region because Indonesia has variations in the region BPPSDMK also has limitations in terms of staff and budget to ensure adequate support is provided to improve health workforce capacity in HIV service delivery. BPPSDMK requires support from relevant unit in MOH in acquiring programmatic and technical inputs.
		Health Workforce Score:	**5.44**		

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**
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) (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known. ○B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ○D. Some (approx. 10-49%) funded from domestic sources ○E. Most (approx. 50 – 89%) funded from domestic sources ◉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)	100% of 1st line ARVs are purchased with the Ministry of Health's APBN funds. While 96% of all drugs come from the government.
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) (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known ○B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ○D. Some (approx. 10-49%) funded from domestic sources ○E. Most (approx. 50-89%) funded from domestic sources ◉F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.83	Internal Document in MoH	Almost 100% of test kits come from the GOI.
8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known ◉B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ○D. Some (approx. 10-49%) funded from domestic sources ○E. Most (approx. 50-89%) funded from domestic sources ○F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.00	NHA and NASA	24 milions condom procured through Global fund (30% of total demand) Minimum package for key population No condom procurement from MoH budget; condoms are generally only procured by the GOI for family planning purposes. There are no condoms procured for HIV/AIDS with GOI resources. A change in intepretation of this question to apply only for HIV/AIDS,

8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	○ A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ◉ B. There is a plan/SOP that includes the following components (check all that apply): ☐ Human resources ☐ Training ☑ Warehousing ☑ Distribution ☐ Reverse Logistics ☐ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☐ Supply planning and supervision ☐ Site supervision	8.4 Score: 0.76	Documents available for: - 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. There is a programmatic supervision, but not specifically for supply plan.	Scheduled training Supervision and feedback Return mechanism Distribution and order of condom for key population. Waste management, reverse logistics and training are not included.
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)? (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not available. ○ B. No (0%) funding from domestic sources. ○ C. Minimal (approx. 1-9%) funding from domestic sources. ◉ D. Some (approx. 10-49%) funding from domestic sources. ○ E. Most (approx. 50-89%) funding from domestic sources. ○ F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score: 0.42	Possible data source: - Asset registry - Subdit budget - Expert Judgement	Training Budget for supervision and M&E

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Check all that apply: ☐ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☐ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☑ Team that conducts analysis of facility data is at least 50% host government	8.6 Score: 0.56	Deliver project report - Stock status assessment	There is difference in definition of stock out from health provider and community Combination of push and pull policy to reduce stock out need to be implemented Not well socialized
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? (if exact or approximate percentage known, please note in Comments column)	○ A. A comprehensive assessment has not been done within the last three years. ○ 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 ◉ 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	8.7 Score: 1.67	JSI Assessment (2014) HSS assessment (HIV external review) 2017.	Not well socialized
8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities including forecasting, stock monitoring, logistics and warehousing support, and other forms of information monitoring across all sectors? Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	8.8 Score: 1.11	SID 2019 consensus Interface meeting/workshop	Big responsibility, with low budget and huan resources
	Commodity Security and Supply Chain Score:	**6.17**		

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**
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?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ 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 ☑ Has a budget line item for the QM program ☑ 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	9.1 Score: 2.00	Annual report (district profile): describes programs, target and achievements, challenges, analysis, and outlines a follow up/action plan.	
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.)	○ A. There is no HIV/AIDS-related QM/QI strategy ○ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized ◉ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized. ○ D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.	9.2 Score: 1.33	NAC RAN 2015-2019 MoH Fast Tract targets	The implemention is partial WM/QI need to be improved and accesible widely, balance approach toward quality management
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?	○ 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. ◉ 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): ☐ 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 ☑ 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 ☐ 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	9.3 Score: 0.67	MoH System Information for HIV/AIDS (SIHA) MoH Evaluation report (Quarterly, Semesterly - GF, Annually) MoH Annual HIV Data	

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?	○ A. There is no training or recognition offered to build health workforce competency in QI. ◉ B. There is health workforce competency-building in QI, including: ☑ Pre-service institutions incorporate modern quality improvement methods in curricula ☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 2.00	GOI Law No: 36/2014 - on Health workers	Healthcare services need to be trained more for HIV and AIDS
9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☑ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☑ Regularly convenes meetings that include health services consumers ☑ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☑ Regularly convene meetings that includes health services consumers ☑ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 2.00	MoH Annual activity report	Need more identification on stigma for key populations
		Quality Management Score:	**8.00**	

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**
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	○A. There is no national laboratory strategic plan ○B. National laboratory strategic plan is under development ◉C. National laboratory strategic plan has been developed, but not approved ○D. National laboratory strategic plan has been developed and approved ○E. National laboratory plan has been developed, approved, and costed ○F. National laboratory strategic plan has been developed, approved, costed, and implemented	10.1 Score: 0.53	National Lab Strategy	
10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? Select only ONE answer.	○A. No, there is no entity. ○B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○D. Yes, there is an entity with authority and sufficient staff and budget.	10.2 Score: 0.89	Ministry of Health/ Mutu Akreditasi - presentation 7/2017	There is an organizing body whithin MoH with limited resource
10.3 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? (if exact or approximate percentage known, please note in Comments column)	○A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ○C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ◉E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ○F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	10.3 Score: 1.00	SID 2019 consensus Interface meeting/workshop	Implemented with support from outside funding
10.4 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?	○A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ◉B. There are adequate qualified laboratory personnel to perform the following key functions: ☑ HIV diagnosis by rapid testing and point-of-care testing ☑ Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria ☑ Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays ☑ TB diagnosis	10.4 Score: 1.33	SID 2019 consensus Interface meeting/workshop	The number of lab tech enough, however the distribution not even. For example in eastern part of the country.

10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	○A. There is not sufficient infrastructure to test for viral load. ◉B. There is sufficient infrastructure to test for viral load, including: ☑ Sufficient HIV viral load instruments ☐ All HIV viral load laboratories have an instrument maintenance program ☐ Sufficient supply chain system is in place to prevent stock out ☐ Adequate specimen transport system and timely return of results	10.5 Score: 0.33	SID 2019 consensus Interface meeting/workshop ; draft national HIV/AIDS Laboratory strategy.	Refereal is not enough GenXpert available however mostly only used for TB screening. Some VL maintanence programs need to be renewed and are not currently running, this the reduction in score from 2017.
10.6 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○A. No (0%) laboratory services are financed by domestic resources. ○B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ◉C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ○E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	10.6 Score: 1.67	SID 2019 consensus Interface meeting/workshop	Most laboratory services are financed by domestic resources and donors provide less than half to support programming. Perception and consensus from SID participants was that although most lab services nationally are financed by domestic resources, a greater proportion of VL and HIV testing services are financed by donor funding.
		Laboratory Score: **5.76**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Financing and Market Openness

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. Finally, having and effectively implementing policies that ensure leveraging markets (both nonprofit and for profit) where appropriate and enabling their participation and competition will be critical for a sustained HIV response.

Fiscal Context for Health and HIV/AIDS This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.			**Data Source**	**Notes/Comments**
1. What percentage of general government expenditures goes to health?	5%		Ministry of Finance	Range 7-11%
2. What is the per capita health expenditure all sources?	$99		NIHA 2018	
3. What is the total health care expenditure all sources as a percent of GDP?	3.1%		OECD report 2018	
4. What percent of total health expenditures is financed by external resources?	1.1%		WB, 2018	
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, 2018	

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.				**Data Source**	**Notes/Comments**
11.1 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?	Check all that apply: ☑ 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): ☑ ARVs are covered ☑ Non-ARV care and treatment is covered ☑ Prevention services are covered ☑ B. Yes, there is an affordable health insurance scheme available (check one of the following). ☐ It covers 25% or less of the population. ☐ It covers 26 to 50% of the population. ☐ It covers 51 to 75% of the population. ☑ It covers more than 75% of the population. ☑ C. The affordable health insurance scheme in (B.) includes the following (check all that apply): ☑ ARVs are covered. ☑ Non-ARV care and treatment services are covered. ☑ Prevention services are covered (specify in comments). ☑ It includes public subsidies for the affordability of care.	11.1 Score:	0.95	**NAC National Action Plan for HIV AIDS 2015- 2019**	**This coordination is carried out at the Ministry and Bappenas level as a whole** **1. The existing financing schemes are fragmented, other than that they are not comprehensive** **2. Coverage of the insurance scheme should use the term effective coverage, for example 82% of Indonesia's population is registered as a member of the JKN Program, but around 18 million registered members are not compliant in paying monthly premiums (non-active members)** **3. Subjective terminology such as 'affordable'** **4. The 'Don't know' option should be provided**

11.2 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☑ The HIV/AIDS budget is program-based across ministries ☑ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☑ The budget includes specific HIV/AIDS service delivery targets ☑ National budget reflects all sources of funding for HIV, including from external donors	11.2 Score: 0.95	NASA	Program-based financing (money follow programs) can include financing HIV / AIDS in activities that, although not managed by the HIV Sub-Directorate, are used to achieve the objectives of the HIV program. At present with the existing budget nomenclature it is very difficult / almost impossible to get the full picture without special effort (NASA)
11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?	○ A. There are no HIV/AIDS goals/targets articulated in the national budget ◉ B. There are HIV/AIDS goals/targets articulated in the national budget. ☑ The goals/targets are measurable. ☑ Budget items/programs are linked to goals/targets. ☑ The goals/targets are routinely monitored during budget execution. ☑ The goals/targets are routinely monitored during the development of the budget.	11.3 Score: 0.95	National Action Plan for HIV AIDS 2015-2019	
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? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	○ A. There is no HIV/AIDS budget, or information is not available. ○ B. 0-49% of budget executed ○ C. 50-69% of budget executed ◉ D. 70-89% of budget executed ○ E. 90% or greater of budget executed	11.4 Score: 0.63	http://www.anggaran.depkeu.go.id/content/publikasi/2016	There was a decrease in the trend of realization towards 80% to 2018; the main cause is the realization of Deconcentration funds (Central MOH transfers to recipient provinces). These funds are needed by the Province to carry out its functions as a representation of the Central Ministry

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?	○ 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. ○ B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services. ◉ C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.	11.5 Score: 0.95	NASA	
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)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ○ B. Very liitle (approx. 1-9%) is financed with domestic funding. ○ C. Some (approx. 10-49%) is financed with domestic funding. ◉ D. Most (approx. 50-89%) is financed with domestic funding. ○ E. All or almost all (approx. 90%+) is financed with domestic funding.	11.6 Score: 2.50	NASA	
11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?	○ A. There is no budget for health or no money was allocated. ○ B. 0-49% of budget executed. ◉ C. 50-69% of budget executed. ○ D. 70-89% of budget executed. ○ E. 90% or greater of budget executed.	11.7 Score: 0.32	MoH Performance Report (LAKIP): www.depkes.go.id/resources/download/laporan/kinerja/lakip-kemenkes-2015.pdf	It is estimated that only 50-69% of the annual budget has been executed which resulted in the decrease of score in 2019.
11.8 Data-Driven Reprogramming: Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle?	○ A. There is no system for funding cycle reprogramming. ○ B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used. ◉ 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. ○ 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.	11.8 Score: 0.63	National Spending and Budget Plan for change (APBNP)	SID 2019 participants reached consensus that there is a policy/system in place that allows for funding cycle reprogramming and repgogramming is done as per the policy, but these are not typically based on data. This consensus decision resulted in a lower SID 2019 score compared to 2017.
Domestic Resource Mobilization Score:		**7.90**		

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**
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? 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) (note: full score achieved by selecting one checkbox)	○ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ◉ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☑ Optima ☑ Spectrum (including EPP and Goals) ☑ AIDS Epidemic Model (AEM) ☑ Modes of Transmission (MOT) Model ☐ Other recognized process or model (specify in notes column)	12.1 Score: 2.00	UNAIDS Investment case analysis	Planning based on HIv epidemiological estimates. For example in the procurement of ARVs, based on information from the HIV Sub-Directorate at the TWG SHP HIV meeting that the procurement of ARV volumes is based on estimates with certain calculations for the next 2 years Based on the initial HP + analysis related to BPJSK's 1% claim data on the use of services in PLWHA it is known that the majority of services (> 60%) are in Java and Papua as the highest geographic target areas
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)? (if exact or approximate percentage known, please note in Comments column)	○ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ◉ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ○ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.2 Score: 1.00	National Fast Track Strategy	There is a discourse to implement "Differentiated Service Deliveries" and for example "community dispensing" in Jakarta and Papua as part of the service provider workload assessment recommendation (HRH2030 study). ARVS are allocated based on demand. Thus, central resources (largest and most expensive item) follows the demand/burden. However most other resources are allocated based on equal distribution across all districts and provinces. This understanding of allocations resulted in SID 2019 when compared to SID 2017.

12.3 Information on cost of service provision: Does the host country government have a system that routinely produces information on the costs of providing HIV/AIDS services, and is this information used for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country DOES NOT have a system that routinely produces information on the costs of providing HIV/AIDS services. ○ B. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services, but this information is not used for budgeting or planning. ◉ C. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services AND this information is used for bugeting or planning purposes for the following services (check all that apply): ☑ HIV Testing ☑ Laboratory services ☑ ART ☑ PMTCT ☐ VMMC ☐ OVC Service Package ☐ Key population Interventions ☐ PrEP	12.3 Score: 1.80	SID 2019 consensus Interface meeting/workshop	VMMC costs are not collected. This resulted in a reduced 2019 SID score.	0
12.4 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☑ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☑ Reduced overhead costs by streamlining management ☑ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☑ Improved procurement competition ☑ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☑ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☑ 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)	12.4 Score: 1.56	National Public Procurement Agency (LKPP) E-Catalague Permenkes No 28/2014		

	☐ 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) ☐ Developed and implemented other new and more efficient models of HIV service delivery (e.g., multi-month scripting, testing modalities targeted to the population profile, etc. - specify in comments)			
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? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	○ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ◉ 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. ○ 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. ○ 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. ○ 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.	12.5 Score: 0.50	e- catalogue, 2016 Tender GOI	ARV prices are 3.5 times higher than international prices
	Technical and Allocative Efficiencies Score:	**6.86**		

13. Market Openness: Host country and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition.			Data Source	Notes/Comments
13.1 Granting exclusive rights for services or training: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies grant exclusive rights for the government or another local provider to provide HIV services?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) polices: A. Restrict the provision of any one aspect of HIV prevention, testing, counseling, or treatment services to a single entity (i.e., creating a monopoly arrangement for that service)? ☐ Yes ☑ No B. Mandate that only government facilities have the exclusive right to provide any one aspect of HIV prevention, testing, counseling, or treatment services? ☐ Yes ☑ No C. Grant exclusive rights to government institutions for providing health service training? ☐ Yes ☑ No	13.1 Score: 0.36	**SID 2019 consensus Interface meeting/workshop**	**Try to give opportunity to other more competent organization**
13.2 Requiring license or authorization: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies establish a license, permit or authorization process as a requirement of operation?	A. Are health facilities required to obtain a government-mandated license or accreditation in order to provide HIV services? [SELECT ONE] ☐ No ☑ Yes, and the enforcement of the accreditation places equal burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) and government facilities. ☐ Yes, and the enforcement of the accreditation places higher burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) than on government facilities. B. Are health training institutions required to obtain a government-mandated license or accreditation in order to provide health service training? [SELECT ONE] ☐ No ☑ Yes, and the enforcement of the accreditation places equal burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) and government institutions. ☐ Yes, and the enforcement of the accreditation places higher burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) than on government institutions.	13.2 Score: 0.36	**Badan POM regulations**	

13.3 Limiting provision of certain direct clinical services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local providers to provide certain direct clinical services?	National government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local health service providers to offer the following HIV services: ☑ Prevention ☐ Testing and Counseling ☑ Treatment	13.3 Score: 0.12	SID 2019 consensus Interface meeting/workshop	
13.4 Limiting provision of certain clinical support services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed local providers to provide certain clinical support services?	A. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from providing essential HIV laboratory services? ☐ Yes ☑ No B. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly arrangements in lab testing (i.e., arrangements where effectively only one lab service provider is allowed to conduct a certain essential HIV lab service)? ☐ Yes ☑ No C. National government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from procuring or distributing the following HIV commodities and supplies [PLEASE SPECIFY TYPE IN NOTES]: ☑ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other D. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly supply chain arrangements for HIV commodities (i.e., arrangements where effectively only one entity is able to supply a certain essential HIV commodity)? ☐ Yes ☑ No	13.4 Score: 0.33	SID 2019 consensus Interface meeting/w	

13.5 Limits on local manufacturing: Do national government policies limit the ability of the local manufacturing industry to compete with the international market?	A. Do national government policies restrict the production of HIV commodities and supplies by local manufacturers beyond international standards? ◉ Yes ○ No B. [IF YES] For which of the following is local manufacturing restricted? ☑ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other	13.5 Score: 0.24	SID 2019 consensus Interface meeting/w	
13.6 Cost of entry/exit: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of entry or exit by a local provider?	Do local health service facilities face higher start-up or maintenance costs compared to government or donor (e.g., PEPFAR, GFATM, etc.) supported facilities (e.g., lack of access to funds, higher accreditation fees, prohibitive contracting costs, etc.)? ☑ Yes ☐ No	13.6 Score: 0.00	SID 2019 consensus Interface meeting/w	
13.7 Geographical barriers: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create geographical barriers for local providers to supply goods, services or labor, or invest capital?	A. Are certain geographical areas restricted to only government or donor-supported HIV service providers? ○ Yes ◉ No B. [IF YES] Which of the following are geographically restricted? ☐ Supplying HIV supplies and commodities ☐ Supplying HIV services or health workforce labor ☐ Investing capital (e.g., constructing or renovating facilities)	13.7 Score: 0.36	SID 2019 consensus Interface meeting/w	
13.8 Freedom to advertise: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the freedom of local organizations to advertise or market HIV goods or services? [Note: "organizations" in this case can refer broadly to clinical service providers and also organizations providing advocacy and promotion services.]	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the freedom of nongovernment (e.g., FBOs, CBOs, or private sector) organizations to advertise or promote HIV services either online, over TV and radio, or in public spaces? ☐ Yes ☑ No	13.8 Score: 0.63	SID 2019 consensus Interface meeting/w	

13.9 Quality standards for HIV services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality? [CHECK ALL THAT APPLY] ☑ Yes ☐ No, government service providers are held to higher standards than nongovernment service providers ☐ No, FBOs/CSOs are held to higher standards than government service providers ☐ No, private sector providers are held to higher standards than government service providers	13.9 Score: 0.63	SID 2019 consensus Interface meeting/w	
13.10 Quality standards for HIV commodities: Do national government policies set standards for product quality that provide an advantage to some commodity suppliers over others?	Do national government policies set product quality standards on HIV commodities that advantage some suppliers over others? [IF YES, PLEASE EXPLAIN IN NOTES] ☐ Yes ☑ No	13.10 Score: 0.63	SID 2019 consensus Interface meeting/w	
13.11 Cost of service provision: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of service provision for some local providers relative to others (especially by treating incumbents differently from new entrants)?	A. Do government HIV service providers receive greater subsidies or support of overhead expenses (e.g., operational support) as compared to nongovernment (e.g., FBOs, CBOs, or private sector) HIV service providers? ☑ Yes ☐ No B. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local HIV service providers over others? ☑ Yes ☐ No C. Do government health training institutions receive greater subsidies or support of overhead expenses as compared to nongovernment (e.g., FBOs, CBOs, or private sector) health training institutions? ☐ Yes ☑ No D. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local health service training institutions over others? ☑ Yes ☐ No	13.11 Score: 0.16	SID 2019 consensus Interface meeting/w	
13.12 Self-regulation: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow for the creation of a self-regulatory or co-regulatory regime?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow HIV service providers—either groups of individuals or groups of institutions—to create structural barriers (e.g., closed network systems) that may reduce the incentive of other potential providers to provide HIV services? ☑ Yes ☐ No	13.12 Score: 0.00	SID 2019 consensus Interface meeting/w	Sometimes there is a donor who make another regulation that different from the national policy

13.13 Publishing of provider information: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies require or encourage information on local providers' outputs, prices, sales or costs to be published?	A. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require nongovernment (e.g., FBOs, CBOs, or private sector) health service facilities to publish more data than government facilities on the following [CHECK ALL THAT APPLY]: ☑ HIV service caseload ☑ Procurement of HIV supplies/commodities ☑ Expenses B. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require HIV commodity suppliers to publish data on the following [CHECK ALL THAT APPLY]: ☐ Distribution ☐ Sales/Revenue ☐ Production costs	13.13 Score: 0.63	SID 2019 consensus Interface meeting/w	
13.14 Patient choice: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of patients to decide which providers or products to use?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of patients or specific groups of patients to choose: A. Which HIV service providers they use? ☐ Yes ☑ No B. Which HIV supplies/commodities they use (e.g., ARVs, PrEP, condoms, needles, etc.)? ☑ Yes ☐ No	13.14 Score: 0.63	SID 2019 consensus Interface meeting/w	
13.15 Patient mobility: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies reduce mobility of patients between HIV service providers by increasing the explicit or implicit costs of changing providers?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies impose costs or other barriers that restrict a patient's ability to transfer from a government HIV service provider to a nongovernment (e.g., FBO, CBO, or private sector) HIV service provider? ☐ Yes ☑ No	13.15 Score: 1.25	SID 2019 consensus Interface meeting/w	Its difficult for PLWHA who want to access ARV outside their regular services
	Market Openness Score:	**6.29**		

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.

14.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**
14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including: data collection, analysis and interpretation; data storage and retrieval; and quality assurance across all sectors. Select only ONE answer.	○ No, there is no entity. ○ Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○ Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ◉ Yes, there is an entity with authority and sufficient staff and budget.	14.1 Score: 0.83	SID 2019 consensus Interface meeting/workshop	general polls survey only conducted in Papua, and lastly carried out in 2012/2013
14.2 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 surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ◉ 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	14.2 Score: 0.83	2014 IDHS (National Statistic Agency and Family Planning Bureau)	STBP TNI is largely funded by Ministry of Defense funding and only a small portion is supported by international partners (ODC) incident measurement is difficult, There is no surveillance. The government should have done it by involving the community
14.3 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.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ◉ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ 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	14.3 Score: 0.63	MoH regulations : Permenkes 45/2014 - on Health Surveillance (HIV is included)	The government must involve the community The government finances 100% every year, but the costs are very high

14.4 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.)? (if exact or approximate percentage known, please note in Comments column)	◉A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○B. No financing (0%) is provided by the host country government ○C. Minimal financing (approx. 1-9%) is provided by the host country government ○D. Some financing (approx. 10-49%) is provided by the host country government ○E. Most financing (approx. 50-89%) is provided by the host country government ○F. All or almost all financing (90% +) is provided by the host country government	14.4 Score: 0.00	MoH regulations : Permenkes 45/2014 - on Health Surveillance (HIV is included)	During this time HIV surveillance activities in the TNI were carried out by the Ministry of Defense and the Puskesmas TNI and supported by other stakeholders such as the Cycle Foundation and ODC TNI surveillance is carried out by the Ministry of Defense and the TNI Health Center and assisted by stakeholders providing technical assistance such as the Indonesian Cycle and international partners It should be 100% by the government,
14.5 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.)? (if exact or approximate percentage known, please note in Comments column)	○A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○B. No financing (0%) is provided by the host country government ◉C. Minimal financing (approx. 1-9%) is provided by the host country government ○D. Some financing (approx. 10-49%) is provided by the host country government ○E. Most financing (approx. 50-89%) is provided by the host country government ○F. All or almost all financing (approx. 90% +) is provided by the host country government	14.5 Score: 0.42	SID 2019 consensus Interface meeting/w	

14.6 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?	Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age (at coarse disaggregates) ☐ Age (at fine disaggregates) ☑ Sex ☑ Key populations (FSW, PWID, MSM, TG, prisoners) ☑ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☐ Sub-national units ☑ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☑ Age (at coarse disaggregates) ☑ Age (at fine disaggregates) ☑ Sex ☑ Key populations (FSW, PWID, MSM, TG, prisoners) ☑ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☐ Sub-national units	14.6 Score: 0.75	HIV epidemiologic review - 2017	

14.7 Comprehensiveness of Viral Load Coverage Data: To what extent does the host country government collect/report viral load coverage data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage is known, please note in Comments column)	○ A. The host country government does not collect/report viral load coverage data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load coverage data (answer both subsections below): Government collects/report viral load coverage data according to the following disaggregates (check ALL that apply): ☑ Age ☑ Sex ☑ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) For what proportion of PLHIV does the government collect/report viral load coverage data (select one of the following): ☐ Less than 25% ☑ 25-50% ☐ 50-75% ☐ More than 75%	14.7 Score: 0.52	MoH System Information for HIV and AIDS (SIHA)	Collected but not published
14.8 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct integrated behavioral surveillance (either as a standalone IBBS or integrated into other routine surveillance such as HSS+) and size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.) Please note most recent survey dates in comments section.	○ 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.). ◉ B. The host country government conducts (answer both subsections below): IBBS (or other integrated behavioral surveillance) for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☑ Transgender (TG) ☑ People who inject drugs (PWID) ☐ Prisoners ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☑ Transgender (TG) ☑ People who inject drugs (PWID) ☑ Prisoners ☐ Priority populations (AGYW, clients of sex workers, miliitary, mobile populations, non-injecting drug users)	14.8 Score: 0.83	HIV epidemiologic review - 2017	IBBS data on Prisoners and Priority populations is not comprehensive and is not available. There are no size estimations for priority polulations.

14.9 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)?	○ 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 ○ 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 ◉ 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	14.9 Score: 0.83	MoH regulations: Permenkes 45/2014 - on Health Surveillance (HIV is included)	
14.10 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?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☐ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☑ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection ☐ An in-country internal review board (IRB) exists and reviews all protocols.	14.10 Score: 0.42	MoH regulation/Permenkes No: 45/2014A80:Q85B80:Q85A80:Q85	As a result of the SID 2019 consensus process. It was determined that an appropriate IRB does not exist who reviews all protocals and a national approved survey and surveillance strategu is not in place.
	Epidemiological and Health Data Score:	**6.06**		

15. 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.			**Data Source**	**Notes/Comments**
15.1 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?	○ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○ 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 ○ 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 ◉ 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 ○ 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	15.1 Score: 2.50	NASA	Most 50% of external (2017) Now it is encouraged that the role of government increases Efforts to collect web-based or online data
15.2 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?	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉ B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☑ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☐ Sub-nationally ○ A. No HIV/AIDS expenditure data are collected	15.2 Score: 2.50	NASA	DHA in sub national Contributions from the regional budget have not yet been described Identify which programs have not been funded by the central government and need to be funded by the regional government. As a result, consensus from the 2019 SID participants did not agree that robust and sufficient subnational HIV data is collected resulted in a lower SID score in 2019.
15.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ○ C. HIV/AIDS expenditure data were collected at least once in the past 3 years ◉ D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ○ E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	15.3 Score: 2.50	NASA	Once every two years+R100
	Financial/Expenditure Data Score:	**7.50**		

16. Performance data: Government routinely collects, reports, 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, and viral load testing coverage and suppression.			**Data Source**	**Notes/Comments**
16.1 Who Leads Collection and Reporting of Service Delivery Data: To what extent is the routine collection and reporting of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government at the national level?	○A. No system exists for routine collection of HIV/AIDS service delivery data ○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 ○C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ○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 ◉E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	16.1 Score: 1.33	MoH System Information for HIV and AIDS (SIHA)	Under certain circumstances, technical assistance is requested from government partners. Note Cannot give more than one mark Not complete, the data collected is incomplete and does not reflect the overall achievements.
16.2 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.)? (if exact or approximate percentage known, please note in Comments column)	○A. No routine collection of HIV/AIDS service delivery data exists ○B. No financing (0%) is provided by the host country government ○C. Minimal financing (approx. 1-9%) is provided by the host country government ○D. Some financing (approx. 10-49%) is provided by the host country government ○E. Most financing (approx. 50-89%) is provided by the host country government ◉F. All or almost all financing (90% +) is provided by the host country government	16.2 Score: 3.33	GoI Law No: 36/2014 - on Health workers Ministry of Labor regulations	

16.3 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.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☑ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☐ Orphans and Vulnerable Children ☐ Voluntary Medical Male Circumcision ☑ HIV Prevention ☑ AIDS-related mortality ☑ B. Service delivery data are being collected: ☑ By key population (FSW, PWID, MSM, TG, prisoners) ☐ By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ By age & sex ☑ From all facility sites (public, private, faith-based, etc.) ☑ From all community sites (public, private, faith-based, etc.)	16.3 Score: 1.22	MoH System Information for HIV and AIDS (SIHA)	Monthly data collection via SIHA (online and off-line) The majority of HIV is of working age. Specific research needs to be done to find out which sectors are at risk, including to determine the prevalence. So the intervention can be targeted. VMMC and priority data is not collected and included, which resulted in a lower score in 2019 compared to 2017.
16.4 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?	○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data ○ B. The host country government collects & reports service delivery data annually ○ C. The host country government collects & reports service delivery data semi-annually ◉ D. The host country government collects & reports service delivery data at least quarterly	16.4 Score: 1.33	MoH System Information for HIV and AIDS (SIHA)	

16.5 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, viral suppression, AIDS-related mortality rates)?	○ A. The host country government does not routinely analyze service delivery data to measure program performance ◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☐ 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, and viral load ☑ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention, and viral load ☑ Results against targets ☑ Coverage or recent achievements of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☑ Site-specific yield for HIV testing (HTC and PMTCT) ☑ AIDS-related mortality rates ☑ Variations in performance by sub-national unit ☑ Creation of maps to facilitate geographic analysis	16.5 Score: 1.17	MoH System Information for HIV and AIDS (SIHA)	There has been a development of the Fast Track Dashboard to measure the target range of 90-90-90 based on routine data coming into SIHA. Continuum of care cascade will is not developed and reviewed for priority populations, which resulted in a lower score in 2019 compared to 2017.
16.6 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?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☑ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☑ 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 ☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☑ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☑ 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	16.6 Score: 1.33	MoH System Information for HIV and AIDS (SIHA)	
		Performance Data Score: 9.72		

17. Data for Decision-Making Ecosystem: Host country government demonstrates commitment and capacity to advance the use of data in informing government decisions and cultivating an informed, engaged civil society.			**Data Source**	**Notes/Comments**
17.1 Civil Registration and Vital Statistics (CRVS): Is there a CRVS system in place that records births and deaths and is fully operational across the country? Is CRVS data made publically available in a timely manner?	○ A. No, there is not a CRVS system. ◉ B. Yes, there is a CRVS system that... (check all that apply): ☑ records births ☑ records deaths ☑ is fully operational across the country [IF YES] How often is CRVS data updated and made publically available (select only one)? ☐ A. The host country government does not make CRVS data available to the general public, or they are made available more than one year after the date of collection. ☐ B. The host country government makes CRVS data available to the general public within 6-12 months. ☑ C. The host country government makes CRVS data available to the general public within 6 months.	17.1 Score: 2.00	National statistic data from BPS 2018	There is a birth record and a Nation wide death record Birth and death registration by the local Dukcapil.
17.2 Unique Identification: Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? Do national polices protect privacy of Unique ID information?	Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? ○ A. No, there is no national Unique Identification system used to track delivery of services for HIV/AIDS or other health services. ◉ B. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS, but not other health services. ○ C. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS and other health services. [IF YES to B or C] Are there national policies, procedures and systems in place that protect the security and privacy of Unique ID information? ☑ Yes ☐ No	17.2 Score: 1.33	National statistic data from BPS 2018 SIHA	At SIHA there is a NIK <but cannot trace individual patient data. Not integrated with policy

17.3 Interoperability of National Administrative Data: To fully utilize all administrative data, are HIV/AIDS data and other relevant administrative data sources integrated in a data warehouse where they are joined for analysis across diseases and conditions?	○ A. No, there is no central integration of HIV/AIDS data with other relevant administrative data. ◉ B. Yes, national HIV/AIDS administrative data is integrated and joined with administrative data on the following: ☑ a. TB ☑ b. Maternal and Child Health ☑ c. Other Health Data (e.g., other communicable and non-communicable diseases) ☐ d. Education ☑ e. Health Systems Information (e.g., health workforce data) ☐ f. Poverty and Employment ☐ g. Other (specify in notes)	17.3 Score: 1.33	National statistic data from BPS 2018	Inter operability is carried out by PUSDATIN KES for certain specified main indicators Not yet integrated
17.4 Census Data: Does the host country government regularly (at least every 10 years) collect and publically disseminate census data?	○ A. No, the host country government does not collect census data at least every 10 years ○ B. Yes, the host country government regularly collects census data, but does not make it available to the general public. ◉ C. Yes, the host country government regularly collects census data and makes it available to the general public. [IF YES to C only] Data that are made available to the public are disaggregated by: ☑ a. Age ☑ b. Sex ☑ c. District	17.4 Score: 2.00	National statistic data from BPS 2018	
17.5 Subnational Administrative Units: Are the boundaries of subnational administrative units made public (including district and site level)?	○ A. No, the country's subnational administrative boundaries are not made public. ◉ B. Yes, the host country government publicizes district-level boundaries, but not site-level geocodes. ○ C. Yes, the host country government publicizes district-level boundaries and site-level geocodes.	17.5 Score: 1.00	National statistic data from BPS 2018	
	Data for Decision-Making Ecosystem Score:	**7.67**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D