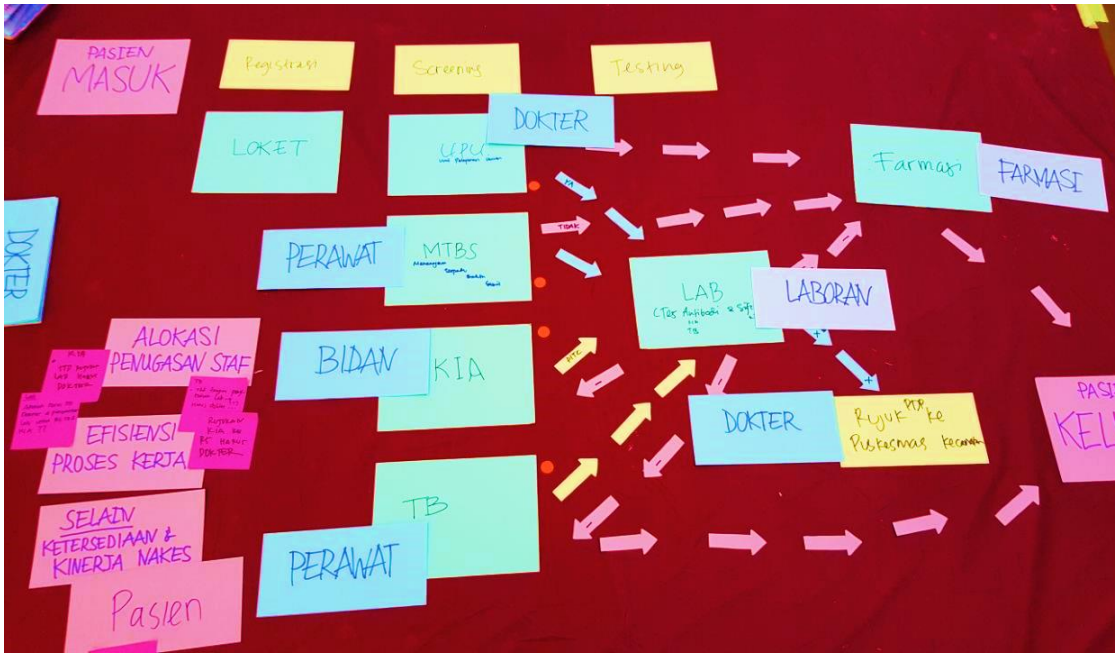
Indonesia HIV and Human Resources for Health (HRH) Policy & Site-level Assessment: SITE-LEVEL ANNEXES

HRH2030: Human Resources for Health in 2030



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HRH2030: Human Resources for Health in 2030

Cooperative Agreement No. AID-OAA-A-15-00046

Cover photo: Health worker focus group discussion mapping undertaken at a puskesmas in July 2018. (Credit: Anton Purnama/Solidaritas)

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Annex J. Rapid Site-Level Health Workforce Assessment Tool: Unit Manager Questionnaire (English)

INSTRUMENT 1. QUESTIONNAIRE FOR HEAD OF PUSKESMAS/HEAD OF ADMINISTRATION UNIT

(adapted from Rapid Assessment Tool on Health Workforce at the Site Level, developed by PEPFAR)

I. INTRODUCTION / START OF ASSESSMENT

Opening statement explaining about this tool to be read out by the data collector

Good morning/afternoon Ibu/Bapak, thank you for agreeing to participate in this data collection process. I am..... from SOLIDARITAS, an Indonesian consulting company supporting USAID/Indonesia, HRH2030 and LINKAGES to conduct site-level data collection.

This process is part of a rapid assessment at health facilities implemented by USAID in collaboration with HRH2030 and LINKAGES. One aspect of the assessment is availability of health workers at the health facility.

As a background information, we see the importance to understand how the health workers are assigned and supported in performing HIV/AIDS prevention, care and treatment. This is to ensure delivery of quality diagnosis which will then be linked to effective treatment, care and adherence process. Therefore, information gathered from the assessment will eventually be used to:

- Ensure staff adequacy in reaching the site-level targets and the 90-90-90 goals;
- Optimize health worker utilization across health care continuum for HIV;
- Identify HRH barriers to quality HIV service provision; and
- Collect site-specific data to inform program planning and transition.

Additionally, we would also like to clarify that the gathered information will be about the health facility as a whole and will not be linked to a particular health worker. The informasi will be reviewed together with the Government of Indonesia to understand the impacts of various obstacles faced by health workers working at the health facilities. The data collected with this tool covers:

- Types, number and availability of health workers at facility;
- Contributing reasons for absenteeism, retention and productivity;
- Current health worker allocation per facility;
- Health worker capacity and preparation in providing quality HIV service; and HRH barriers related

to service provision.

Time needed to complete this tool is approximately 30-45 minutes. Many questions are in multiple choice, while some will need numerical data on health workers in this facility. If you have any question or need further explanation on each question, please ask me.

Do you understand what I have explained about this tool?

- If so, can we begin the filling out process?
- If not, for which specific part do you need further explanation? **Shall we…?!**

II. INFORMATION OF SITE

Site name : _____

Estimated daily patient volume per day :
_____

Estimated Number of HIV patients per day : _____

Estimated Number of ART patients per day : _____

III. HEALTH WORKERS' AVAILABILITY

This section asks about availability of health workers for HIV services. First, I will ask some questions about the context of health workers' availability in this facility.

QUESTION #1

Q1-1. What are the days of service at this facility? (Tick all relevant answers)

a. Monday b. Tuesday c. Wednesday d. Thursday e. Friday f. Saturday g. Sunday

Q1-2. What are the operational hours at this facility each day?

(Example: Monday – Friday, 7-4 and Saturday, 8-12)

Q1-3. Are there dedicated days for HIV or ARV services? If so, what days and time?

a. Yes

b. No

Q1-4. (Data collector) write down your notes related to Q1-3!

If "Yes", write down the days and time of the HIV/ART service OR If "No", write down the reasons!

Q1-5. How many hours a week is considered a full-time work? _____

(Example: 40 hours a week)

Q1.6. (Data collector) write down your notes related to Q1-5!

Example: working hours for civil servants are 40 hours/week, but on Saturday the facility is open (outside the 40 hours/week) and staff on duty will be the non-civil servant ones who receive incentives.

QUESTION #2

The following question uses a table in the next page.

Q2. Referring to the table's first column, please inform the types of staff working in this facility. (Data collector should fill these in.) Including paid and volunteer workers. Also, workers working in the community but linked to this facility. Examples based on the categories below include:

- **Clinical** – Clinical professions including doctors, nurses, midwives, medical assistants and nurses, auxiliary nurses, auxiliary midwives, test and counselling service providers. Notes: They have completed a diploma or certification program based on standardized or accredited curriculum, who function as support for or substitute of university-trained professionals.
- **Clinical support** – Pharmacists, pharmacy technicians, medical technicians, laboratorians, laboratory technicians.
- **Managerial** – Facility administrators, HR managers, M&E advisors, epidemiologists and other professional staff critical to health service delivery and program support.
- **Social service** – Social workers, child & adolescent development workers, social welfare assistants.
- **Lay or Community** – Adherence support, mother mentors, cough monitors, expert patients, lay counsellors, peer educators, community health workers and other community-based cadres. Note: Lay workers are those with non-clinical training and providing direct services to patients/clients. They are health workers providing important services for the care continuum in the facility and/or community. Lay workers who may work in the community but are formally managed / report to the facility need to be recorded. Community-based lay workers managed by / report to a CSO/NGO and are only affiliated to the facility for certain tasks (such as referrals) are recorded only in terms of total numbers.
- **Others** – Workers who are not included in the above categories. Note: if other staff like cleaning/maintenance workers or guards interact with patients or provide support to HIV service (for example: preventing drug theft), please record under this category.

	Q2b. For each staff category, what is its total number in this facility?	Q2c. In this facility, how many full-time staff working for HIV service delivery? (Regardless the time/workload allocated for non -HIV service)	Q2d. For full-time staff working for HIV service delivery, how many hours a week in average they provide HIV service? (Covering time on-site)	Q2e. For these full-time staff working for HIV service delivery, how many hours a week in average they provide HIV service in the community?	Q2f. For these full-time staff working for HIV service delivery, how many hours a week in average they provide for ART service?	Q2g. For these full-time staff working for HIV service delivery, how many hours a day in average they spend on other clinical/ administrative tasks?
Example: Nurse	*12*	*7*	*20*	*0*		
Example: Expert patient	*4*	*0*	*0*	*0*		
Clinical						
a. PNS doctor						
b. Non-PNS doctor						
c. KPLDH doctor						
Clinical Support						
a. PNS nurse						
b. Non-PNS nurse						
c. KPLDH nurse						
d. PNS midwife						
e. Non-PNS midwife						
f. KPLDH midwife						
MANAGERIAL						
a.						
b.						
SOCIAL SERVICE						
a.						
b.						
LAY						
a. CSC/CBS						
b.Peer support group						
OTHERS						
a.						
b						

QUESTION #3 - #4

The following set of questions continues asking about health workers availability.

Q3-1. Is there any health worker not working today?

- □ Yes
- □ No

If "Yes", to question Q3-2 and Q3-3, If "No" to question Q4-1.

Q3-2. For the health workers not working today, what are their reasons? Select all relevant answers.

(Tick all relevant answers)

- □ Off duty
- □ National holiday
- □ Workshop/meeting
- □ Training
- □ Sick leave
- □ Maternity leave
- □ Annual leave
- □ Other personal leave (such as family leave)
- □ Others

Q3-2a. Others, please specify: _____

Q3-3. Take notes (as data collector) related to question Q3-1 dan Q3-2!

Ex: There are 2 staff not working for today. 1 on sick leave and 1 on maternity leave since 2 months ago.

Q4-1. When was the last time a health worker resigned/quit or transferred from their job at this facility?

- □ Less than a month ago
- □ Less than six months ago
- □ More than six months ago
- □ No one resigned/quit or transferred
- □ I don't know

Other than "no one resigned…" or "I don't know" continue to Q4-2, Q4-3, Q4-4

Q4-2. What was her/his role/function?

Q4-3. Has there been a substitute to fill this role/function?

□ Yes

□ No

Q4-4. Take notes (as data collector) related to question Q4-1!

Ex: The staff resigned since s/he was transferred to another facility since Oct 2017

QUESTION #5 - #6

Q5-1. In your opinion, what are the top 3 reasons for health workers to quit from their job or ask to be transferred from this facility? Which from the three reasons is the most common? *(Tick the top 3. Then circle the most common of the three)*

□ Remoteness of assigned area

□ Burnout

□ Reassigned/transferred by government

□ Relocate to another country

□ Better opportunity in the private sector

□ Relocating with/following spouse

□ Not performing the task trained for

□ Less opportunity for professional advancement

□ Lack of supervision

□ Poor occupational safety and health

□ Insufficient salary and benefits

□ Insufficient facility – housing, equipment or wifi/phone services

□ Others (specify): _____

Q5-2. (Data collector) write down your notes related to Q5-1

Example: health worker transfer is only related to government-assigned transfer (option #3); however, there 2 possible reasons for this assigned transfer: (1) keeping a balanced distribution of the KPLDH contract staff, and (2) routine transfer every 5 years.

Q6-1. When a health worker takes a leave more than a week, how do you ensure support for the vacant function?

□ Nothing

□ Assigning the tasks to existing staff

□ Assigning a new staff

□ Others

Q6a. Others, specify: _____

Q6-2. Take notes (as data collector) related to question Q6-1!

Ex: In some periods we can get new staff, as the Provincial Health Office has a recruitment for contract staff. But this year we can't do anything as such program has ended. So, if there is a willing staff, the task can be transferred to her/him.

IV. HEALTH WORKERS' PERFORMANCE MANAGEMENT

The following section asks about performance management of health workers.

QUESTION #7 - #8

Q7-1. Is there any document or visual aid which clarifies roles and expectations towards the staff involved in HIV service delivery at this facility? Note: the document or visual aid can cover job description, staff work schedule or work flow which distributes and explains tasks for all relevant team members.

□ Yes, and displayed for the health workers to see (data collector should confirm)

□ Yes, but not displayed

□ No

Q7-2. (Data collector) write down your notes related to Q7-1

Example: Document is not available but the role of each health worker is discussed in monthly team meeting so that health workers are always updated about their role in providing HIV services.

Q8-1. What are the ways for health workers to get feedback about their performance from supervisors, co-workers or patients? (Tick all that relevant:)

□ Performance review according to national plan/guideline

□ Routine supervisory support

□ Participation in Quality Improvement team (QI)

□ Clients' feedback collection (such as survey, suggestion box)

□ No formal mechanism so far

□ Others

Q8a. Others, specify: _____

Q8-2. Take notes (as data collector) related to question Q8-1!

Ex: There is no a formal mechanism from supervisor or colleagues/team, only available in the form of a 'smiley box' from patients.

QUESTION #9 - #10

Q9-1. Does this facility have the following guideline, policy and practice to protect patients who live with HIV from stigma and discrimination?

- □ Guideline on people living with HIV's right to equal care
- □ Guideline on key populations' right to equal care
- □ Guideline on voluntary testing and informed consent
- □ Guideline on patients' confidentiality and privacy
- □ In-service training to increase awareness and change stigmatizing attitudes
- □ Supervisory support to staff in providing non-discriminative services
- □ Practical standards for health workers' safety, including guideline on HIV transmission and post-exposure prophylaxis (PEP) use
- □ Use of care models involving key populations (MSM, drug/injection users, female sex workers or transgenders), such as through job provision or linkages with CSO/CBO supporting key populations
- □ Others (specify):_____

Q9-2. (Data collector) write down your notes related to Q9-1

Example: What is the name of the reference/referred document? What is the form of supervisory support? (option #5)

Q10. Is this way of infection control and universal prevention available to protect the health workers?

- □ Sufficient availability of gloves, disposal of used syringes and PEP
- □ Staff having confidential access to HIV testing and treatment
- □ Others (specify):_____

V. HEALTH WORKERS ALLOCATION

The following question looks at health workers assigned specifically for HIV tasks and the reasons for their assignments. For example, a community nurse may conduct mobile services as this is within his/her work scope, while expert client/patient also conducts mobile services in her/his community due to high patient

volume.

QUESTION #11

VI. VII. VIII. IX. X. **Task Categories:**	XI. Q11a. List the type(s) of health workers that perform each of the tasks below. Examples include: • Clerk • Nurse • Clinical officer/doctor • Lab • Pharmacy	XII. **Q11b.** Select all reasons staff do these tasks					
		XIII. It is in their job scope	XIV. They have received training for this task	XV. High patient volume (staff assists/ provides back-up support)	XVI. Health worker shortage (task is shifted to this worker)	XVII. Govt. directive	XVIII. Other (Specify)
XIX. EXAMPLE:	XXI. *MEDICAL DOCTOR*	XXII. x					
XX. *MOBILE TESTING*	XXIII. *NURSE*			XXIV. x			
1. EXAMINATION OF HIV, STIs AND HEPATITIS							
2. ART ENROLLMENT & INITIATION							
3. COUNSELING							
4. CLINCAL EXAMINATION & CONSULTATION							
5. RECORDING & REPORTING							
6. HEALTH EDUCATION (PROMOTIVE, PREVENTIVE)							
7. INTEGRATED TB-HIV SERVICES							
8. MOBILE TESTING							
9. PMTCT							
10. HARM REDUCTION							

QUESTION #12 - #13

Q12-1. Is there any day or time in a week where there are more health workers scheduled to work?

□ Yes

□ No

If yes, continue to Q12-2. If not, directyly go to Q13-1.

Q12-2. How is the schedule and assignment of the staff decided?

- □ Based on number/volume of patients
- □ Based on patients' needs during night time/weekend
- □ Based on clinic days (for example, HIV clinic/testing day)
- □ Based on waiting time
- □ Based on existing staff norms
- □ Others

Q12-2a. Others, please specify: _____

Q12-3. Take notes (as data collector) related question to Q12-1 and Q12-2!

Ex: There is no day where there are more staff assigned than usual, it tends to be the same number each day. But in special cases, like outbreak, where there are more staff

Q13-1. How do the staff access their schedule and assignments?

- □ Displayed on the wall
- □ Discussed in team/staff meeting
- □ Provided by the supervisor
- □ Others
- □ Not relevant (for example: not provided because it's according to a regular/routine schedule)

Q13-1a. Others, specify: _____

Q13-2. Take notes (as data collector) related to question Q13-1!

Ex: *Due to its regularity, there is no need for special announcement, but it's still displayed on the wall.*

QUESTION #14 - #15

All the following set of questions is related to in-service HIV training conducting at this facility.

Q14-1. Do you have a system to know which health workers have received in-service training?

□ No

□ Yes: *(circle)*: electronic OR written

Q14-1a. If "Yes", select one:

a. Electronic

b. Written

Q14-2. Take notes (as data collector) related to question Q14-1!

Q15-1. What are the priorities of HIV training at this facility?

_____

Q15-2. How are staff selected to receive these priority HIV trainings?

_____

Q15-3. What are the types or categories of health workers receiving these priority HIV trainings?

_____

Q15-4. Are there additional staff needing these priority HIV trainings?

□ Yes

□ No

If "Yes", continue to Q15-4a dan Q15-4b

Q15-4a If "Yes", about how many people? _____

Q15-4b If "Yes", why?

_____

XXVI. SUMMARY

Thank you for your patience. We are almost at the end of the assessment.

QUESTION #16 - #17

Q16-1. In this question, I will ask you to rank 3 biggest HRH challenge related to HIV service delivery at this facility. I will read all the possible existing challenges, then will ask you to tell me the first or most significant challenge, followed by the second and the third one. *(Use number 1 to 3 to rank based on their significance, where "1" is the most challenging/significant:)*

□ High non-availability rate of health workers (specify with numbers if available:_____)

- □ Recruitment, contracting and/or payroll processes
- □ Inadequate infrastructure
- □ Shortage of supplies
- □ Absence
- □ Lack of HRH management's capacity/support
- □ Inadequate clinical competence
- □ Lack of operational policies and guidelines for service provision
- □ Not doing job relevant to training received
- □ Shortage of health workers
- □ Unclear position descriptions
- □ Inadequate staff compensation
- □ Staff turn-over
- □ Low staff motivation
- □ Inadequate transport
- □ payroll
- □ Others (specify): _____

Q16-2. (Data collector) write down your notes related to Q16-1

Example: Related to option about inadequate infrastructure, what is meant is the number/adequacy of rooms available, not linked to equipment.

Q17. This is the last question of the assessment. Is there any other issue related to staffing I haven't asked, which you think is important to know?

XXVII. THE END OF ASSESSMENT

Data collector, please give comments based on your visit. For example: Did you see long queue? How organized was the registration and/or triage process you saw?

Data collector needs to complete this part when conducting the assessment:

Name of Data Collector :
_____

Informant / Respondent : _____

Date of Data Collection : _____

Time for Data Collection : Start Time: _____ **End Time:**
_____

Annex K. Rapid Site-Level Health Workforce Assessment Tool: Unit Manager Questionnaire (Bahasa)

INSTRUMEN 1. KUESIONER KEPALA PUSKESMAS/TATA USAHA

(diadaptasi dari Instrumen Kajian Cepat tentang Ketersediaan Tenaga Kesehatan di Fasilitas Kesehatan, yang dikembangkan oleh PEPFAR)

PENGANTAR

Pengantar instrumen dan proses pengisian instrumen. Harap dibacakan oleh pengumpul data.

Selamat pagi/siang/sore, terima kasih atas kesedian Bapak/Ibu untuk berpartispasi dalam proses pengumpulan data ini. Perkenalkan, Saya..... dari SOLIDARITAS, sebuah perusahaan konsultan Indonesia yang bekerjasama dengan USAID/Indonesia, HRH2030, dan LINKAGES, untuk melakukan pengumpulan data tingkat Fasilitas Kesehatan.

Pengumpulan data ini adalah bagian dari kajian cepat tingkat Fasilitas Kesehatan, yang diselenggarakan oleh USAID, bekerjasama dengan HRH2030 dan LINKAGES. Salah satu unsur yang menjadi fokus kajian adalah Ketersediaan Tenaga Kesehatan di Fasilitas Kesehatan.

Sebagai latar belakang dan informasi, kami memandang pentingnya memahami bagaimana para nakes difungsikan dan didukung dalam penyediaan layanan pencegahan, perawatan dan pengobatan HIV/AIDS. Hal ini ditujukan guna memastikan tegaknya diagnosa bermutu tinggi, yang terhubung dengan proses pengobatan, perawatan serta kepatuhan dalam perawatan.

Oleh karenanya, informasi yang dikumpulkan dari instrumen ini, bertujuan untuk:

Memastikan kecukupan nakes, dalam rangka pencapaian target tingkat faskes dan pencapaian target yang lebih luas, yaitu tecapainya akselerasi 90-90-90;

Mengoptimalkan pemanfaatan nakes dalam kontinum layanan HIV;

Mengidentifikasi kendala-kendala SDMK (Sumber Daya Manusia Kesehatan) dalam penyediaan layanan HIV yang bermutu; dan

Mengumpulkan data spesifik tingkat faskes sebagai masukan dalam proses perencanaan program dan transisi.

Selain itu, perlu juga kami sampaikan bahwa informasi yang dikumpulkan dalam kajian ini adalah informasi terkait faskes secara keseluruhan, bukan informasi terkait masing-masing individu nakes. Informasi yang terkumpul nantinya akan ditinjau bersama-sama Pemerintah Indonesia, guna memahami dampak dari berbagai kendala yang dihadapi nakes ditingkat faskes. Berikut beberapa data yang akan dikumpulkan dalam instrumen ini:

Jenis, jumlah dan ketersediaan nakes dalam faskes;

Hal-hal yang berkontribusi pada ketidakhadiran, retensi dan produktivitas tenaga kesehatan;

Alokasi tenaga kesehatan per faskes saat ini;

Kapasitas tenaga kesehatan dan persiapan untuk menyediakan layanan HIV bermutu; serta kendala SDMK terkait penyediaan layanan.

Waktu yang dibutuhkan untuk proses pengisian kuesioner ini sekitar 30-45 menit. Umumnya pertanyaan

berupa pilihan ganda dan beberapa isian. Jika Bapak/Ibu ada pertanyaan atau memerlukan penjelasan lebih lanjut di masing-masing pertanyaan, silahkan ajukan kepada Saya.
Apakah Bapak/Ibu memahami penjelasan saya seputar instrumen ini?
Jika Ya, Apakah kita bisa mulai melakukan proses pengisian instrumen?
Jika Tidak, bagian mana yang yang Bapak/Ibu perlu mendapatkan penjelasan lebih lanjut?

Mari kita mulai!

INFORMASI FASILITAS KESEHATAN

Nama Faskes : _____
Perkiraan jumlah puskesmas pasien per hari : _____
Perkiraan jumlah pasien layanan HIV per hari : _____
Perkiraan jumlah pasien terapi ARV (ART) per hari : _____

KETERSEDIAAN TENAGA KESEHATAN (NAKES)

Bagian ini mengenai ketersediaan Nakes untuk layanan HIV. Pertama-tama saya akan bertanya beberapa pertanyaan umum terkait ketersediaan nakes di faskes ini.

PERTANYAAN #1

Q1-1. Sebutkan hari layanan di Faskes ini? (pilih yang sesuai)
Senin Selasa Rabu Kamis Jumat Sabtu Minggu

Q1-2. Tuliskan jam operasional layanan di Faskes setiap harinya?

(misal: Senin – Jumat, pukul 07:00 s.d pukul 16:00 dan Sabtu, pukul 08:00 s.d 12:00)

Q1-3. Apakah ada hari khusus untuk layanan HIV atau terapi ARV?
Ya ada
Tidak ada

Q1-4. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q1-3!

Jika memilih "Ya ada", tuliskan hari dan jam layanan HIV/ARV tersebut! ATAU Jika memilih "tidak ada", tuliskan alasannya!

Q1-5. Berapa total jam kerja Nakes dalam seminggu? _____
(*misal: 40 jam seminggu*)

Q1.6. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q1-5!

Misalnya: jam kerja untuk PNS 40 jam/minggu, namun hari sabtu puskesmas tetap buka (diluar jam kerja 40 jam/minggu), dan staf yang bertugas khusus untuk staf Non PNS, dan diberikan insentif.

PERTANYAAN #2

Pertanyaan berikut menggunakan tabel di halaman berikutnya.

Q2. Merujuk pada kolom pertama tabel, tolong Ibu/Bapak informasikan jenis-jenis staf yang bekerja di faskes ini. *(Pengumpul data yang perlu mengisi jawaban ini.)* Termasuk pekerja yang dibayar maupun yang sukarela. Juga petugas yang bekerja di komunitas/masyarakat namun terkait dengan faskes ini. Contoh berdasarkan kategori tertentu meliputi:
Klinis – Profesi klinis termasuk dokter, perawat, bidan, petugas klinis, asisten medis dan perawat, perawat bantu, bidan bantu, penyedia layanan tes dan konseling. Catatan: Mereka telah merampungkan program diploma atau sertifikasi berdasarkan kurikulum yang sesuai standar atau akreditas, yang berperan sebagai

pelengkap ataupun pengganti para profesional lulusan universitas.
Dukungan klinis – Farmasi, teknisi farmasi, teknisi medis, laboran, teknisi laboratorium.
Manajerial – Administrator faskes, manajer SDM, penyelia/penasihat monev, ahli epidemiologi serta staf profesional lainnya yang esensial bagi penyediaan layanan kesehatan dan pendukung program.
Layanan sosial – Petugas sosial, petugas pengembangan anak dan remaja, asisten kesejahteraan sosial.
Komunitas – Pendukung kepatuhan, mentor ibu, pengawas batuk, pasien ahli, konselor awam, pendidik sejawat, petugas kesehatan komunitas dan kader-kader berbasis komunitas lainnya. Catatan: Pekerja awam adalah mereka yang memiliki pelatihan non-klinis dan menyediakan layanan langsung kepada pasien/klien. Mereka adalah pekerja kesehatan yang menyediakan berbagai layanan penting bagi keberlanjutan perawatan di dalam faskes maupun/atau di komunitas. Pekerja awam yang mungkin bertugas di komunitas namun secara formal dikelola/melapor ke faskes perlu didata. Pekerja awam yang berbasis di komunitas dan dikelola/melapor ke CSO/LSM dan hanya memiliki afiliasi dengan faskes untuk tugas tertentu (misalnya rujukan) masuk sebagai catatan jumlah saja dalam pendataan.
Lainnya – Petugas yang tidak termasuk dalam kategori-kategori yang disebutkan di atas. Catatan: Jika staf lain seperti petugas kebersihan/pemeliharaan atau petugas keamanan berinteraksi dengan pasien atau menyediakan dukungan bagi layanan HIV (misalnya mencegah pencurian obat), harap di data dalam kategori ini.

Q2a. Di bawah ini daftar kategori petugas/tenaga kesehatan terkait: .	**Q2b.** Untuk setiap jenis Nakes, berapa jumlah keseluruhan Nakes yang dimiliki faskes ini?	**Q2c.** Berapa jumlah Nakes yang bekerja untuk layanan HIV? *(terlepas dari waktu/beban kerja yang dialokasikan untuk layanan non-HIV)*	**Q2d.** Untuk Nakes yang bekerja untuk layanan HIV, rata-rata berapa jam dalam seminggu yang mereka gunakan untuk menyediakan layanan HIV? *(untuk layanan di faskes atau dalam gedung)*	**Q2e.** Untuk Nakes yang bekerja untuk layanan HIV, rata-rata berapa jam dalam seminggu yang digunakan untuk layanan HIV di komunitas (luar gedung)?	**Q2f**. Untuk Nakes yang bekerja untuk layanan HIV, rata-rata berapa jam seminggu yang digunakan untuk layanan ART?	**Q2g.** Untuk Nakes yang bekerja untuk layanan HIV, rata-rata berapa jam sehari yang digunakan untuk tugas klinis lain atau administratif lainnya?
Contoh:Perawat	*12*	*7*	*20*	*0*		
Contoh:Pasien ahli	*4*	*0*	*0*	*0*		
KLINIS						
Dokter PNS						
Dokter non-PNS						
Dokter KPLDH						
DUKUNGAN						
Perawat PNS						
Perawat non-PNS						
Perawat KPLDH						
Bidan PNS						
Bidan non-PNS						
Bidan KPLDH						
MANAJERIAL						
a.						
b.						
LAYANAN						
a.						
b.						
AWAM						
a. Konselor						
b.Kelompok dukungan sebaya						
LAINNYA						
a.						
b						

PERTANYAAN #3 - #4

Set pertanyaan selanjutnya melanjutkan pertanyaan mengenai ketersediaan nakes.

Q3-1. Apakah ada Nakes yang tidak masuk hari ini?
Ya, ada
Tidak ada

Jika "Ya", Lanjut ke Q3-2 dan Q3-3, Jika tidak lanjut ke Q4-1.

Q3-2. Apa saja alasan mereka? (*pilih yang sesuai*)
Libur/bebas tugas
Libur nasional
Lokakarya/rapat
Pelatihan
Cuti sakit
Cuti melahirkan
Cuti tahunan
Cuti personal lainnya (misal, cuti keluarga)
Lainnya

Q3-2a. Lainnya, sebutkan: _____

Q3-3. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q3-1 dan Q3-2!

Misalnya: ada 2 petugas yang tidak masuk, 1 karena cuti sakit dan 1 cuti melahirkan sejak 2 bulan lalu.

Q4-1. Kapan terakhir kali seorang nakes mengundurkan diri/berhenti/mutasi dari pekerjaan mereka di faskes ini? *(Pilih salah satu)*
Kurang dari sebulan lalu
Kurang dari enam bulan lalu
Lebih dari enam bulan lalu
Belum pernah ada nakes berhenti/mengundurkan diri/mutasi
Saya tidak mengetahuinya.

Jika selain "belum pernah" dan "tidak mengetahui", lanjut ke Q4-2, Q4-3, Q4-4

Q4-2. Jenis/fungsi nakes apakah yang dijabatnya?_____

Q4-3. Apakah sudah ada petugas pengganti untuk posisi/pekerjaan ini?
Ya
Tidak

Q4-4. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q4-1!

Misalnya: petugas yang mengudurkan diri karena dia dimutasi ke unit lain sejak Okt 2017

PERTANYAAN #5 - #6

Q5-1. Menurut Ibu/Bapak, apa yang menjadi 3 alasan tertinggi bagi Nakes berhenti atau meminta dipindahkan dari faskes ini? *(pilih 3 alasan tertinggi, kemudian tentukan alasan yang paling umum dari ketiga pilihan tersebut*)
Terpencilnya daerah penugasan
Kelelahan (*Burnout*)
Dialihtugaskan/mutasi oleh pemerintah
Pindah ke negara lain
Peluang lebih baik di swasta
Kepindahan/mengikuti pasangan
Tidak melakukan tugas yang sesuai dengan pelatihan
Kurang peluang bagi kemajuan profesional
Kurang supervisi

Buruknya keselamatan dan kesehatan dalam pekerjaan
Gaji dan tunjangan tidak mencukupi
Fasilitas – rumah, peralatan atau wifi/telepon tidak mencukupi
Belum pernah ada nakes yang berhenti/mutasi
Saya tidak tahu apa alasan nakes berhenti/mutasi
Lainnya (sebutkan) :_____

Q5-2. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q5-1

Misalnya: alasan nakes mutasi hanya terkait dimutasi oleh pemerintah (pilihan 3), namun dalam konteksnya ada 2 alasan kenapa mutasi tersebut terjadi, yaitu (1) karena pemerataan petugas KPLDH, dan (2)mutasi rutin setiao 5 tahun.

Q6-1. Ketika seorang nakes mengambil cuti lebih dari seminggu, strategi apa yang Ibu/Bapak lakukan untuk mengisi kekosongan tersebut?
Tidak melakukan apapun
Melimpahkan pekerjaan pada staf yang hadir
Menugaskan staf baru
Lainnya

Q6a. Lainnya, sebutkan: _____

Q6-2. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q6-1

Misalnya: pada periode tertentu, kami bisa menugaskan staf baru, karena ada program tenaga honorer dari dinkes provinsi. Namun tahun ini kami tidak bisa berbuat banyak karena program itu sudah selesai. Jika ada petugas yang bersedia, maka tugas akan dialihkan kepada staf lain yang bersedia tersebut.

MANAJEMEN KINERJA TENAGA KESEHATAN (NAKES)

Bagian berikut ini menanyakan tentang manajemen kinerja tenaga kesehatan (nakes).

PERTANYAAN #7 - #8

Q7-1. Apakah tersedia dokumen atau alat bantu visual yang menjelaskan peran masing-masing Nakes yang terlibat dalam penyediaan layanan HIV di faskes ini?
Misal: dokumen atau alat bantu visual yang meliputi deskripsi pekerjaan, jadwal kerja staf atau alur kerja yang mendistribusikan dan menerangkan tugas-tugas bagi seluruh anggota tim terkait.
Ya ada dan dipampang agar para Nakes dapat melihat (pengumpul data perlu mengonfirmasi)
Ya ada, tapi tidak terpampang
Tidak tersedia

Q7-2. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q7-1

Misalnya: Dokumen tidak tersedia, namun peran masing-masing Nakes dibahas dalam rapat rutin bulanan, sehingga Nakes selalu terpapar informasi terkini mengenai peran mereka di layanan HIV.

Q8-1. Bagaimana cara Nakes mendapat umpan balik mengenai kinerja mereka, baik dari atasan, teman sejawat atupun dari pasien? *(pilih yang sesuai)*
Review kinerja yang merujuk pada rencana/panduan nasional
Dukungan rutin atasas
Partisipasi dalam tim peningkatan kualitas (QI)/Rekan sejawat
Pengumpulan umpan balik klien (misalnya survei, kotak saran)
Sejauh ini belum ada mekanisme formal
Lainnya

Q8a. Sebutkan! _____

Q8-2. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q8-1!

Misalnya: kalau mekanisme formal dari atasan dan teman belum ada, dan baru ada dari pasien berupa "kotak smile".

PERTANYAAN #9 - #10

Q9-1. Untuk melindungi pasien yang hidup dengan HIV (ODHA) dari stigma dan diskriminasi; Panduan, kebijakan dan praktik apa saja yang dimiliki Faskes? *(pilih yang dimiliki Faskes)*

Panduan hak ODHA atas perawatan yang setara
Panduan hak populasi kunci atas perawatan yang setara
Panduan tes sukarela dan persetujuan/informed consent
Panduan kerahasiaan dan privasi pasien
Pelatihan in-service untuk meningkatkan kesadaran dan mengubah sikap-sikap yang memperkuat stigma
Dukungan atasan kepada staf dalam menyediakan layanan yang tidak diskriminatif
Standar-standar praktik untuk keselamatan kerja para nakes, termasuk panduan mengenai transmisi HIV dan penggunaan profilaksis pasca-pajanan (PEP)
Penggunaan model-model perawatan yang melibatkan populasi kunci (LSL - lelaki seks dengan lelaki, penasun - pengguna NAPZA suntik, WPS – wanita pekerja seks, atau transgender), misalnya melalui pemberian kerja atau hubungan dengan CSO/CBO yang mendukung populasi kunci
Lainnya

Q9a. sebutkan: _____

Q9-2. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q9-1

Misalnya: Apa nama panduan/dokumen yang menjadi rujukan? Bagaimana bentuk dukungan atasan? (pilihan 5)

Q10. Untuk melindungi para nakes, cara pengendalian infeksi dan pencegahan universal seperti apa yang tersedia? *(Centang yang relevan)*

Tersedianya sarung tangan, tempat pembuangan jarum suntik dan APD yang memadai.
Tersedianya mekanisme tes dan pengobatan HIV bagi Nakes secara rahasia.
Lainnya

Q10a. Sebutkan:_____

ALOKASI TENAGA KESEHATAN (NAKES)

Pertanyaan berikut ini melihat nakes yang ditugaskan secara spesifik untuk tugas-tugas HIV dan alasan mereka ditugaskan untuk tugas-tugas ini. Sebagai contoh, perawat komunitas mungkin melakukan layanan keliling karena hal ini masuk dalam ruang lingkup pekerjaannya, sementara klien/pasien ahli juga melakukan layanan keliling di komunitasnya dikarenakan volume pasien yang tinggi.

PERTANYAAN #11

Kategori Tugas:	**Q11a.** Tuliskan jenis-jenis nakes yang melakukan setiap tugas di bawah ini. Termasuk sebagai contoh: Petugas admin Perawat Petugas klinis/dokter Laboran Farmasi Konselor Komunitas (CSC)	**Q11b.** Pilih semua alasan yang relevan untuk penugasan nakes					
		Termasuk dalam lingkup pekerjaan	Telah mendapat pelatihan untuk tugas ini	Volume pasien tinggi (staf membantu/ menyediakan dukungan)	Kekurangan nakes (tugas dialihkan kepada nakes ini)	Arahan pemerintah	Lainnya (*Sebutkan)*
CONTOH: LAYANAN KELILING KE KOMUNITAS	*DOKTER*	x					
	PERAWAT			x			
PEMERIKSAAN HIV, IMS DAN HEPATITIS							
ENROLLMENT & INISIASI ART							
KONSELING							
PEMERIKSAAN KLINIS & KONSULTASI							
PENCATATAN DAN PELAPORAN							
EDUKASI KESEHATAN (Promotif, preventif)							
LAYANAN INTEGRASI TB-HIV							
LAYANAN TES KELILING (Mobile testing)							
PMTCT/PPIA							
HARM REDUCTION							

PERTANYAAN #12 - #13

Q12-1. Apakah ada hari atau waktu dalam seminggu dimana ada lebih banyak nakes yang dijadwalkan untuk bertugas?

Ya
Tidak

Jika ya, lanjutkan ke Q12-2. Jika tidak, langsung ke Q13-1.

Q12-2. Bagaimana jadwal dan penugasan Nakes tersebut ditentukan? *(pilih yang sesuai)*

Berdasarkan jumlah/volume pasien
Berdasarkan kebutuhan pasien di malam hari/akhir pekan
Berdasarkan hari-hari klinik (misalnya, hari klinik/pemeriksaan HIV)
Berdasarkan lamanya waktu tunggu
Berdasarkan norma/peraturan kepegawaian yg ada
Lainnya

Q12-2a. Sebutkan: _____

Q12-3. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q12-1 dan Q12-2

Misalnya: tidak ada hari dimana petugas lebih banyak hadir, dan cenderung sama setiap harinya. Namun ada hari-hari dimana lebih ramai ketika ada kasus-kasus khusus (misalnya KLB)

Q13-1. Bagaimana Nakes mengakses jadwal dan penugasan mereka? *(pilih yang sesuai)*

Dipampang di dinding
Dibahas di dalam rapat tim/staf
Diberikan oleh atasan
Lainnya (Q13-1a)
Tidak relevan (misalnya karena jadwal bersifat regular/rutin, sehingga tidak diberikan)

Q13-1a. Lainnya, sebutkan: _____

Q13-2. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q13-1

Misalnya: karena sudah reguler tidak perlu ada pengumuman khusus, namun tetap ditempel juga di dinding.

PERTANYAAN #14 - #15

Seluruh set pertanyaan berikut ini terkait dengan pelatihan HIV in-service yang diadakan di faskes ini.

Q14-1. Apakah Anda memiliki sistem untuk mengetahui siapa saja nakes yang menerima pelatihan di masa kerja/penugasan (*in-service*)?

Ya ada
Tidak ada

Q14-1a. Jika "Ya", Hal tersebut dilakukan secara:

Elektronik
Tertulis di kertas

Q14-2. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q14-1

Q15-1. Pelatihan-pelatihan HIV apa saja yang menjadi prioritas di faskes ini?

Q15-2. Bagaimana cara Anda memilih nakes yang akan diikutkan dalam pelatihan prioritas tersebut?

Q15-3. Fungsi Nakes apa saja yang menerima pelatihan prioritas tersebut?
(Misalnya: Dokter, Perawat, Bidan, dll)

Q15-4. Apakah ada staf tambahan yang membutuhkan pelatihan prioritas tersebut?
Ya
Tidak
Jika "Ya" maka lanjut ke Q15-4a dan Q15-4b
Q15-4a. Ada berapa orang Nakes tambahan yang membutuhkan pelatihan prioritas tersebut?
Q15-4b. Dan apa alasannya ?

RANGKUMAN

Terimakasih atas kesabaran Anda, kita hampir selesai

PERTANYAAN #16 - #17

Q16-1. Pada pertanyaan ini Anda diminta untuk memilih 3 tantangan SDMK terbesar terkait penyediaan layanan HIV di faskes ini. (*Selanjutnya, berdasarkan 3 pilihan Anda tersebut, berikan peringkat 1 - 3 untuk masing-masing tantangan. Dimana peringkat "1" adalah tantangan yang paling menantang*)
Tingginya tingkat ketidaktersediaan nakes (sebutkan seberapa tinggi jika angka tersedia:_____)
Proses rekrutmen, kontraktual dan/atau penggajian
Infrastruktur tidak mencukupi
Kurangnya persediaan (bahan-bahan)
Absensi
Kapasitas/dukungan manajemen SDMK tidak mencukupi
Kompetensi klinis tidak mencukupi
Kebijakan dan panduan operasional bagi penyediaan layanan tidak mencukupi
Tidak melakukan pekerjaan yang sesuai dengan pelatihan yang didapat
Kekurangan nakes
Deskripsi posisi/fungsi kerja tidak jelas
Kompensasi staf tidak mencukupi
Pergantian staf (keluar-masuk)
Motivasi staf rendah

Transportasi tidak mencukupi
Pembayaran gaji
Lainnya (sebutkan):_____

Q16-2. Tuliskan catatan Anda (sebagai petugas pengumpul data) terkait pertanyaan Q16-1

Misalnya: terkait pilihan infrastruktur yang tidak mencukupi, yang dimaksud adalah kecukupan ruangan, bukan alat.

Q17. Ini adalah pertanyaan terakhir dari kajian. Adakah hal lain terkait kepegawaian yang belum saya tanyakan, yang menurut Ibu/Bapak penting untuk diketahui?

PENUTUP

Pengumpul data, tolong berikan komentar dari kunjungan Anda. Misalnya: Apakah Anda melihat antrian panjang? Seberapa teraturkah proses registrasi dan/atau triase yang Anda lihat?

Pengumpul data perlu merampungkan bagian ini pada saat melakukan kajian:

Nama Pengumpul Data :
_____

Informan/Responden :
_____

Tanggal Pengumpulan Data:
_____

Waktu Pengumpulan Data : Jam Mulai: _____ **Jam Selesai:** _____

Annex L. Rapid HIV Task Analysis (English)

I. GENERAL INFORMATION

1. Name of the site: select one
2. What is your function in the HIV core team: select one
3. How long have you been working as a professional: _____ year
4. How many years have you been working in this facility: _____ year

Questions for Cadres/Communicty Counselors only

5. How long have you been working as a cadre/community counsellor: _____ year
6. How long have you been supporting this facility _____ year
7. How many hours in a week you work for HIV services: ___hour per week

II. TASK OF DOCTOR AND NURSE

Notes: Doctor / nurse will only respond list of tasks based on their selection below

Question for Doctors and Nurses only

2A. For the tasks listed below, which ones are yours in providing HIV services? (tick the relevant ones)

☐ Conduct medical checkup and provide diagnosis for all HIV patients/and PLHIV	☐ Conduct adherence Counselling
☐ Conduct palliative Counseling	☐ Deliver counseling of ART initiation
☐ Provide comprehensive TB-HIV services	☐ Conduct counseling on addiction (LASS, PTRM)
☐ Managing ARV Therapy in pregnant women	☐ Conduct mobile testing
☐ Perform advanced clinical examination on possible Opportunistic Infections, Sexually Transmitted Infections, Medicine Side Effects, TB, Hepatitis)	☐ Menyediakan informasi terkait positive prevention / Provide related information on positive prevention

2B. If there is any other HIV-related task that not listed yet, please write it down: _____

Below list of tasks for Doctor and Nurse:

2.1 Conduct medical checkup and provide diagnosis for all HIV patients/and PLHIV, including: informed consent, pre and post-test HIV counseling, STI and hepatitis screening)
2.2 Conduct adherence counselling, including counseling for key populations: gay, lesbian, transsexual, sex workers, drug users, HIV+ couples, families, correctional and assisted residents, HIV + clients/couples with mental health problems, also counselling on nutrition, and disclosure status (especially children)
2.3 Conduct palliative counseling
2.4 Deliver counseling of ART initiation
2.5 Perform advanced clinical examination for ART patient on possible Opportunistic Infections, Sexually Transmitted Infections, Medicine Side Effects, TB, Hepatitis
2.6 Conduct counseling on addiction (Sterile Syringe Service, Methadone Maintenance Therapy Program)
2.7 Provide comprehensive TB-HIV services, including coordinating services; screening all HIV+ patients for TB; and conduct promotional activities, behavior change communication and build community support for collaborative TB-HIV in each unit, e.g. DOTS units

2.8 Conduct mobile testing, including pre and post-test counseling: evaluating and enforcing the diagnosis; providing HIV test reference checks; completing CT HIV
2.9 Managing ARV therapy for pregnant women, including supporting in the care of pregnant women, mothers in labor and their baby
2.10 Provide related information through IEC about HIV-AIDS, STIs and reproductive health including positive prevention

Question for Each Task (English)

Task 2.1: Conduct medical checkup and provide diagnosis for all HIV patients/and PLHIV

211 In your opinion, to what extend is your knowledge about this task?

a. I have not acquired the basic knowledge
b. I only have the basic knonwledge
c. I have the necessary knowledge to perform the task
d. I already have the advance knowledge

212 In your opinion, how confident are you in performing the task?

a. I need more opportunity to apply my knowledge
b. I can apply my knowledge but still need help to perform task
c. I am confident in performing the task, but not yet when teaching other people
d. I am confident in performing the task and teaching it to other people

213 Have you been trained for this task? ☐ Yes ☐ No

213a If "Yes", what was the form of the training:

☐ **Informal** or **on-the-job training**, for instance, peer support at work

☐ **Clinical mentoring**, for instance, mentoring from external party, including facilitating organization or governmentby doing visitation or task facilitation

☐ **Formal in-service**, for instance, certifiied training from the Ministry of Health

☐ **Pre-service training**, for instance, before you work professionally or still at school

213b If "Yes", when did you last have training for this task?

☐ 0 – 3 months ago ☐ 7 – 12 months ago

☐ 4 – 6 months ago ☐ More than a year ago

214 How often do you perform this task?

☐ Never ☐ Seldom ☐ A few times in a month ☐ A few times in a week ☐ Almost every day

215 Are you assigned for this task? ☐ Yes ☐ No
(either formally written or verbally from supervisor)

III. TASK OF MIDWIFE

Notes: Midwifes will only respond list of tasks based on their selection below

Questions for Midwifes only

3A. For the tasks listed below, which ones are yours in providing HIV services? (tick the relevant ones)

☐ Refer a pregnant mother to full medical examination in case of symptoms or signs of HIV, syphilis and/or hepatitis when providing antenatal service

☐ Providing education on ART for pregnant women enrolled in ART

☐ Conduct counseling in ART initiation for pregnant women

☐ Carrying out PMTCT activities integrated within MCH, family planning and adolescent counseling
☐ Provide related information through IEC about HIV-AIDS, STIs and reproductive health including positive prevention
3B. If there is any other HIV-related task that not listed yet, please write it down: _____

Below list of tasks for Midwives:

3.1 Refer a pregnant mother to full medical examination (HIV) in case of symptoms or signs of HIV, syphilis and/or hepatitis when providing antenatal service
3.2 Providing education on ART for pregnant women on ART enrollement
3.3 Conduct counseling in ART initiation for pregnant women
3.4 Carrying out PMTCT activities integrated within MCH, family planning and adolescent counseling
3.5 Provide related information through IEC about HIV-AIDS, STIs and reproductive health including positive prevention

Question for Each Task

Task 3.1: Refer a pregnant mother to full medical examination

311 In your opinion, to what extend is your knowledge about this task?
a. I have not acquired the basic knowledge
b. I only have the basic knonwledge
c. I have the necessary knowledge to perform the task
d. I already have the advance knowledge

312 In your opinion, how confident are you in performing the task?
a. I need more opportunity to apply my knowledge
b. I can apply my knowledge but still need help to perform task
c. I am confident in performing the task, but not yet when teaching other people
d. I am confident in performing the task and teaching it to other people

313 Have you been trained for this task? ☐ Yes ☐ No
313a If "Yes", what was the form of the training:
☐ **Informal** or **on-the-job training**, for instance, peer support at work
☐ **Clinical mentoring**, for instance, mentoring from external party, including facilitating organization or governmentby doing visitation or task facilitation
☐ **Formal in-service**, for instance, certifiied training from the Ministry of Health
☐ **Pre-service training**, for instance, before you work professionally or still at school
313b If "Yes", when did you last have training for this task?
☐ 0 – 3 months ago ☐ 7 – 12 months ago
☐ 4 – 6 months ago ☐ More than a year ago

314 How often do you perform this task?
☐ Never ☐ Seldom ☐ A few times in a month ☐ A few times in a week ☐ Almost every day

315 Are you assigned for this task? ☐ Yes ☐ No
(either formally written or verbally from supervisor)

IV. TASK OF LABORATORIUM TECHNICIAN

Notes: Lab Technician will only respond list of tasks based on their selection below

Questions for Lab Technician only

4A. For the tasks listed below, which ones are yours in providing HIV services? (tick the relevant ones)

☐ Conduct a complete HIV test
☐ Conduct pre-initiation supporting test
☐ Keep activity logs of HIV lab test
☐ Conduct monitoring to ensure the availability of tools
☐ Input data of lab check results to SIHA
☐ Conduct lab testing for HIV and syphilis while mobile testing

4B. If there is any other HIV-related task that not listed yet, please write it down: _____

Below list of tasks for Laboratorian:

4.1 Conduct a complete HIV test, including antibodies; culture; EID; PCR + HIV RNA (Viral Load); P24 Antigen; CD4 lymphocytes count, also monitoring therapy and syphilis test
4.2 Conduct pre-initiation supporting test
4.3 Keep activity logs of HIV lab test
4.4 Conduct monitoring to ensure the availability of tools
4.5 Input data of lab check results to SIHA
4.6 Conduct lab testing for HIV and syphilis while mobile testing

Question for Each Task

Task 1: Conduct a complete HIV examination

411 In your opinion, to what extend is your knowledge about this task?
a. I have not acquired the basic knowledge
b. I only have the basic knonwledge
c. I have the necessary knowledge to perform the task
d. I already have the advance knowledge

412 In your opinion, how confident are you in performing the task?
a. I need more opportunity to apply my knowledge
b. I can apply my knowledge but still need help to perform task
c. I am confident in performing the task, but not yet when teaching other people
d. I am confident in performing the task and teaching it to other people

413 Have you been trained for this task? ☐ Yes ☐ No

413a If "Yes", what was the form of the training :

☐ **Informal** or **on-the-job training**, for instance, peer support at work
☐ **Clinical mentoring**, for instance, mentoring from external party, including facilitating organization or governmentby doing visitation or task facilitation
☐ **Formal in-service**, for instance, certifiied training from the Ministry of Health
☐ **Pre-service training**, for instance, before you work professionally or still at school

413b If "Yes", when did you last have training for this task?

☐ 0 – 3 months ago ☐ 7 – 12 months ago
☐ 4 – 6 months ago ☐ More than a year ago

414 How often do you perform this task?

☐ Never ☐ Seldom ☐ A few times in a month ☐ A few times in a week ☐ Almost every day

415 Are you assigned for this task? ☐ Yes ☐ No
(either formally written or verbally from supervisor)

VI. TASK OF RECORDING AND REPORTING OFFICER

Notes: Record and Reporting Officer will only respond list of tasks based on their selection below

Questions for Record & Reporting Officer only

5A. For the tasks listed below, which ones are yours in providing HIV services? (tick the relevant ones)

☐ Set up/fill out a referral form
☐ Record keeping and reporting on HIV services, including pre-ART / ART registration
☐ Input data to SIHA and KOHORT
☐ Write LBPHA report (monthly report on HIV-AIDS Care, sheet 1)
☐ Keep logs of LASS and PTRM (harm prevention for HIV+ drug users) and providing condoms
☐ Keep client's registration (patient's card)

5B. If there is any other HIV-related task that not listed yet, please write it down: _____

Below list of tasks for Recording and Reporting Officer:

5.1 Set up/fill out a referral form
5.2 Record keeping and reporting on HIV services, including pre-ART / ART registration
5.3 Input data to SIHA and KOHORT
5.4 Write LBPHA report (monthly report on HIV-AIDS Care, sheet 1)
5.5 Keep logs of LASS and PTRM (harm prevention for HIV+ drug users) and providing condoms
5.6 Keep client's registration (patient's card)

Question for Each Task

Task 1: Set up/fill out a referral form

511 In your opinion, to what extend is your knowledge about this task?
a. I have not acquired the basic knowledge
b. I only have the basic knonwledge
c. I have the necessary knowledge to perform the task
d. I already have the advance knowledge

512 In your opinion, how confident are you in performing the task?
a. I need more opportunity to apply my knowledge
b. I can apply my knowledge but still need help to perform task
c. I am confident in performing the task, but not yet when teaching other people
d. I am confident in performing the task and teaching it to other people

513 Have you been trained for this task? ☐ Yes ☐ No

513a If "Yes", what was the form of the training :

☐ **Informal** or **on-the-job training**, for instance, peer support at work
☐ **Clinical mentoring**, for instance, mentoring from external party, including facilitating organization or governmentby doing visitation or task facilitation
☐ **Formal in-service**, for instance, certifiied training from the Ministry of Health
☐ **Pre-service training**, for instance, before you work professionally or still at school

513b If "Yes", when did you last have training for this task?

☐ 0 – 3 months ago ☐ 7 – 12 months ago
☐ 4 – 6 months ago ☐ More than a year ago

514 How often do you perform this task?

☐ Never ☐ Seldom ☐ A few times in a month ☐ A few times in a week ☐ Almost every day

515 Are you assigned for this task? ☐ Yes ☐ No

(either formally written or verbally from supervisor)

VII. TASK OF PHARMACIST

Notes: Pharmacist will only respond list of tasks based on their selection below

Questions for Pharmacist only

6A. For the tasks listed below, which ones are yours in providing HIV services? (tick the relevant ones)

☐ Provide medicinal services for all HIV patients
☐ Keep register of medicine dispensing for all HIV-related drugs
☐ Provide adherence counseling/education
☐ Write LBPHA report (monthly report on HIV-AIDS Care, sheet 2)
☐ Write usage reports of reagent and disposable materials
☐ Administer methadone

6B. If there is any other HIV-related task that not listed yet, please write it down: _____

Below list of tasks for Pharmacy officer:

6.1 Provide medicinal services for all HIV patients
6.2 Keep register of medicine dispensing for all HIV-related drugs
6.3 Provide adherence counseling/education
6.4 Write LBPHA report (monthly report on HIV-AIDS Care, sheet 2)
6.5 Write usage reports of reagent and disposable materials
6.6 Administer methadone

Question for Each Task

Task 1: Provide medicinal services for all HIV patients

516 In your opinion, to what extend is your knowledge about this task?
a. I have not acquired the basic knowledge
b. I only have the basic knonwledge
c. I have the necessary knowledge to perform the task
d. I already have the advance knowledge

517 In your opinion, how confident are you in performing the task?
a. I need more opportunity to apply my knowledge
b. I can apply my knowledge but still need help to perform task
c. I am confident in performing the task, but not yet when teaching other people
d. I am confident in performing the task and teaching it to other people

518 Have you been trained for this task? ☐ Yes ☐ No

213a If "Yes", what was the form of the training :

☐ **Informal** or **on-the-job training**, for instance, peer support at work
☐ **Clinical mentoring**, for instance, mentoring from external party, including facilitating organization or governmentby doing visitation or task facilitation
☐ **Formal in-service**, for instance, certifiied training from the Ministry of Health
☐ **Pre-service training**, for instance, before you work professionally or still at school

213b If "Yes", when did you last have training for this task?

☐ 0 – 3 months ago ☐ 7 – 12 months ago
☐ 4 – 6 months ago ☐ More than a year ago

519 How often do you perform this task?

☐ Never ☐ Seldom ☐ A few times in a month ☐ A few times in a week ☐ Almost every day

520 Are you assigned for this task? ☐ Yes ☐ No

(either formally written or verbally from supervisor)

VIII. TASK OF COMMUNITY SUPPORT COUNSELOR

Notes: Community Support Counselor (CSC) will only respond list of tasks based on their selection below

Questions for CSC only

7A. For the tasks listed below, which ones are yours in providing HIV services? (tick the relevant ones)

☐ Develop partnerships with patients and communities

☐ Connecting patients with resources and peer support

☐ Conduct adherence counseling, including counseling for key populations

☐ Identify and get key populations to do HIV test

☐ Conduct pre and post HIV tests' counseling

☐ Provide related information through IEC about HIV-AIDS, STIs and reproductive health including positive prevention

7B. If there is any other HIV-related task that not listed yet, please write it down: _____

Below list of tasks for Cadre/Community Support Counselor:

7.1 Develop partnerships with patients and communities

7.2 Connecting patients with resources and peer support, including paying attention to the priorities and concerns of patients

7.3 Conduct adherence counselling, including counseling for key populations: gay, lesbian, transsexual, sex workers, drug users, HIV+ couples, families, correctional and assisted residents, HIV + clients/couples with mental health problems, also counselling on nutrition, and disclosure status (especially children)

7.4 Identify and get key populations to do HIV test

7.5 Conduct pre and post HIV tests' counseling (trained cadres only)

7.6 Provide related information through IEC about HIV-AIDS, STIs and reproductive health including positive prevention

Question for Each Task

Task 1: Develop partnerships with patients and communities

711 In your opinion, to what extend is your knowledge about this task?

a. I have not acquired the basic knowledge
b. I only have the basic knonwledge
c. I have the necessary knowledge to perform the task
d. I already have the advance knowledge

712 In your opinion, how confident are you in performing the task?

a. I need more opportunity to apply my knowledge
b. I can apply my knowledge but still need help to perform task
c. I am confident in performing the task, but not yet when teaching other people
d. I am confident in performing the task and teaching it to other people

713 Have you been trained for this task? ☐ Yes ☐ No

713a If "Yes", what was the form of the training :

☐ **Informal** or **on-the-job training**, for instance, peer support at work

☐ **Clinical mentoring**, for instance, mentoring from external party, including facilitating organization or governmentby doing visitation or task facilitation

☐ **Formal in-service**, for instance, certifiied training from the Ministry of Health

☐ **Pre-service training**, for instance, before you work professionally or still at school

713b If "Yes", when did you last have training for this task?

☐ 0 – 3 months ago ☐ 7 – 12 months ago

☐ 4 – 6 months ago ☐ More than a year ago

714 How often do you perform this task?

☐ Never ☐ Seldom ☐ A few times in a month ☐ A few times in a week ☐ Almost every day

715 Are you assigned for this task? ☐ Yes ☐ No
(either formally written or verbally from supervisor)

Annex M. Rapid HIV Task Analysis (Bahasa)

Kuesioner Kajian Cepat: Analisis Tugas Tim Inti HIV

I. INFORMASI UMUM

Nama Fasilitas Kesehatan: pilih salah satu.
Apa fungsi Anda dalam tim inti HIV: pilih salah satu
Berapa lama Anda telah bekerja sebagai profesional: _____ tahun
Berapa tahun Anda telah bekerja di faskes ini: _____ tahun

Pertanyaan khusus Kader/Konselor Komunitas

Berapa lama Anda telah bekerja sebagai Kader/Konselor Komunitas: _____ tahun
Berapa tahun Anda telah memberikan dukungan di Faskes ini _____ tahun
Berapa jam dalam seminggu Anda bekerja untuk layanan HIV: _____ jam per minggu

II. TUGAS DOKTER DAN PERAWAT

Catatan: Dokter / Perawat hanya menjawab daftar tugas sesuai dengan pilihan tugas dibawah

Pertanyaan khusus Dokter dan Perawat

2A. Untuk daftar tugas dibawah ini, tugas mana saja yang menjadi pekerjaan Anda dalam layanan HIV? (pilih yang sesuai)

☐ Melakukan pemeriksaan medis dan menegakkan diagnosis untuk semua pasien HIV/ODHA

☐ Melakukan konseling kepatuhan

☐ Melakukan konseling paliatif

☐ Memberikan konseling inisiasi ART

☐ Menyediakan layanan TB-HIV yang komprehensif

☐ Melakukan konseling adiksi (LASS, PTRM))

☐ Mengelola terapi ARV untuk ibu hamil

☐ Melakukan layanan tes keliling

☐ Melakukan pemeriksaan klinis lanjutan terkait Infeksi Oportunistik, Infeksi Menular Seksual, Efek Samping Obat, TB, Hepatitis)

☐ Menyediakan informasi terkait *positive prevention*

2B. Jika menurut Anda ada tugas lain yang terkait layanan HIV namun belum ada didaftar, silahkan tuliskan:

Berikut adalah daftar tugas untuk Dokter dan Perawat:

2.1 **Melakukan pemeriksaan medis dan menegakkan diagnosis untuk semua pasien HIV/ODHA**, termasuk *informed consent*, konseling pra dan pasca tes HIV, sert *screening* hepatitis)

2.2 **Melakukan konseling kepatuhan** termasuk konseling pada populasi kunci: gay, lesbian, waria, pekerja seks, pengguna NAPZA, pasangan HIV +, keluarga HIV+, warga binaan pemasyarakatan HIV+ dan klien/pasangan HIV+ dengan gangguan jiwa; serta konseling nutrisi dan pengungkapan status (terutama pada anak)

2.3 **Melakukan konseling paliatif**

2.4 **Memberikan konseling inisiasi ART**

2.5 **Melakukan pemeriksaan klinis lanjutan bagi pasien ART** terkait Infeksi Oportunistik, Infeksi Menular Seksual, Efek Samping Obat, TB, Hepatitis

2.6 **Melakukan konseling adiksi** (Layanan Alat Suntik Steril (LASS), Program Terapi Rumatan Metadon (PTRM))

2.7 **Menyediakan layanan TB-HIV yang komprehensif**, termasuk mengkoordinasi layanan, melakukan screening TB pada semua pasien HIV+, serta melakukan kegiatan promosi, komunikasi perubahan perilaku dan membangun dukungan masyarakat bagi kolaborasi TB-HIV di masing-masing unit terutama di unit DOTS

2.8 **Melakukan layanan tes keliling (*mobile testing*)**, termasuk konseling pra dan pasca tes: mengevaluasi dan menguatkan diagnosis; memberikan rujukan pemeriksaan untuk tes HIV; dan melengkapi KT HIV

2.9 **Mengelola terapi ARV bagi ibu hamil**, termasuk memberikan dukungan perawatan bagi ibu hamil, bersalin dan bayinya

2.10 **Menyediakan informasi melalui KIE tentang HIV-AIDS dan IMS serta kesehatan reproduksi termasuk positive prevention**

Pertanyaan Untuk Masing-Masing Tugas

Tugas 2.1: Melakukan pemeriksaan medis dan menegakkan diagnosis untuk semua pasien HIV/ODHA

211 Menurut Anda, sejauh mana pemahaman Anda seputar tugas ini?

a. Saya belum memiliki pengetahuan dasar
b. Saya hanya memiliki pengetahuan dasar
c. Saya memiliki pengetahuan yang dibutuhkan untuk melakukan tugas ini
d. Saya telah memiliki pengetahuan yang tinggi (*advance knowledge*)

212 Menurut Anda, sejauh mana Anda merasa percaya diri dalam melaksanakan tugas ini?

a. Saya butuh lebih banyak peluang untuk mempraktekkan
b. Saya dapat mempraktekkan pengetahuan saya namun butuh bantuan dalam pelaksanaannya
c. Saya menguasai tugas ini, namun belum percaya diri untuk mengajarkannya kepada orang lain
d. Saya menguasai tugas ini dan mampu mengajarkannya kepada orang lain

213 Apakah Anda pernah mendapat pelatihan untuk tugas ini? ☐ Ya ☐ Tidak

213a Jika "Ya", Bagaimana bentuk pelatihan yang Anda dapatkan:

☐ Pelatihan informal atau *on-the-job,* misalnya dukungan dari sejawat di tempat bekerja

☐ Mentoring klinis, misalnya mentoring dari pihak eksternal baik lembaga pendamping ataupun pemerintah dalam bentuk visitasi atau pendampingan lapangan

☐ Pelatihan Formal Dalam Bertugas (*Formal in-service*), misalnya pelatihan tersertifikasi dari Kemenkes / Dinkes

☐ Pelatihan Pra-penugasan, misalnya sebelum Anda bekerja secara profesional seperti sekolah dsbnya

213b Jika "Ya", kapan Anda mendapat pelatihan terkait tugas ini terakhir kali?

☐ 0 – 3 bulan lalu ☐ 7 – 12 bulan lalu

☐ 4 – 6 bulan lalu ☐ Lebih dari setahun lalu

214 Seberapa sering Anda melakukan tugas ini?

☐ Tidak pernah ☐ Jarang ☐ Beberapa kali dalam sebulan ☐ Beberapa kali dalam seminggu ☐ Hampir setiap hari

215 Apakah Anda mendapat penugasan untuk melakukan tugas ini? ☐ Ya ☐ Tidak
(*baik berupa penugasan tertulis ataupun verbal dari atasan)*

III. TUGAS BIDAN

Catatan: Bidan hanya menjawab daftar tugas sesuai dengan pilihan tugas dibawah

Pertanyaan khusus Bidan

3A. Untuk daftar tugas dibawah ini, tugas mana saja yang menjadi pekerjaan Anda dalam layanan HIV?
(pilih yang sesuai)

☐ Merujuk ibu hamil untuk dilakukan pemeriksaan medis lengkap apabila ditemukan gejala atau tanda-tanda HIV, sifilis dan/atau hepatitis ketika memberikan layanan antenatal
☐ Memberikan edukasi ART untk ibu hamil dalam ART enrollment
☐ Melakukan konseling inisiasi ART
☐ Melakukan aktivitas PPIA yang diintergrasikan dalam layanan KIA
☐ Menyediakan informasi melalui KIE tentang HIV-AIDS dan IMS serta kesehatan reproduksi termasuk *positive prevention*

3B. Jika menurut Anda ada tugas lain yang terkait layanan HIV namun belum ada didaftar, silahkan tuliskan:

Berikut adalah daftar tugas untuk Bidan:

3.1 **Merujuk ibu hamil untuk dilakukan pemeriksaan medis (HIV) lengkap, apabila ditemukan gejala atau tanda-tanda HIV, sifilis dan/atau hepatitis ketika memberikan layanan antenatal**
3.2 **Memberikan edukasi ART untuk ibu hamil dalam ART *enrollment***
3.3 **Melakukan konseling inisiasi ART** untuk ibu hamil
3.4 **Melakukan aktivitas PPIA yang diintergrasikan dalam layanan KIA**, Keluarga Berencana (KB) dan Konseling Remaja
3.5 **Menyediakan informasi melalui KIE tentang HIV-AIDS dan IMS serta kesehatan reproduksi termasuk *positive prevention***

Pertanyaan Untuk Masing-Masing Tugas

Tugas 3.1: Merujuk ibu hamil untuk dilakukan pemeriksaan medis (HIV) lengkap

311 Menurut Anda, sejauh mana pemahaman Anda seputar tugas ini?
a. Saya belum memiliki pengetahuan dasar
b. Saya hanya memiliki pengetahuan dasar
c. Saya memiliki pengetahuan yang dibutuhkan untuk melakukan tugas ini
d. Saya telah memiliki pengetahuan yang tinggi (*advance knowledge*)

312 Menurut Anda, sejauh mana Anda merasa percaya diri dalam melaksanakan tugas ini?
a. Saya butuh lebih banyak peluang untuk mempraktekkan
b. Saya dapat mempraktekkan pengetahuan saya namun butuh bantuan dalam pelaksanaannya
c. Saya menguasai tugas ini, namun belum percaya diri untuk mengajarkannya kepada orang lain
d. Saya menguasai tugas ini dan mampu mengajarkannya kepada orang lain

313 Apakah Anda pernah mendapat pelatihan untuk tugas ini? ☐ Ya ☐ Tidak

313a Jika "Ya", Bagaimana bentuk pelatihan yang Anda dapatkan:

☐ Pelatihan informal atau *on-the-job,* misalnya dukungan dari sejawat di tempat bekerja

☐ Mentoring klinis, misalnya mentoring dari pihak eksternal baik lembaga pendamping ataupun pemerintah dalam bentuk visitasi atau pendampingan lapangan

☐ Pelatihan Formal Dalam Bertugas (*Formal in-service*), misalnya pelatihan tersertifikasi dari Kemenkes / Dinkes

☐ Pelatihan Pra-penugasan, misalnya sebelum Anda bekerja secara profesional seperti sekolah dsbnya

313b Jika "Ya", kapan Anda mendapat pelatihan terkait tugas ini terakhir kali?

☐ 0 – 3 bulan lalu ☐ 7 – 12 bulan lalu

☐ 4 – 6 bulan lalu ☐ Lebih dari setahun lalu

314 Seberapa sering Anda melakukan tugas ini?
☐ Tidak pernah ☐ Jarang ☐ Beberapa kali dalam sebulan ☐ Beberapa kali dalam seminggu ☐ Hampir setiap hari

315 Apakah Anda mendapat penugasan untuk melakukan tugas ini? ☐ Ya ☐ Tidak
(baik berupa penugasan tertulis ataupun verbal dari atasan)

IV. TUGAS LABORAN

Catatan: Petugas Laboran hanya menjawab daftar tugas sesuai dengan pilihan tugas dibawah

Pertanyaan khusus Laboran

4A. Untuk daftar tugas dibawah ini, tugas mana saja yang menjadi pekerjaan Anda dalam layanan HIV? (pilih yang sesuai)

☐ Melakukan pemeriksaan HIV lengkap
☐ Melakukan pemeriksaan penunjang pra inisiasi
☐ Melakukan pencatatan kegiatan pemeriksaan labortorium
☐ Melakukan pemantauan untuk memastikan ketersediaan alat

☐ Menginput hasil pemeriksaan lab ke SIHA
☐ Melakukan pemeriksaan lab sebagai bagian dari layanan keliling (*mobile testing*)

4B. Jika menurut Anda ada tugas lain yang terkait layanan HIV namun belum ada didaftar, silahkan tuliskan:

Berikut adalah daftar tugas untuk Laboran:

4.1 **Melakukan pemeriksaan HIV lengkap**, termasuk antibodi, kultur/biakan, EID, PCR+HIV RNA (Viral Load), antigen P24, jumlah limfosit CD4 dan pemantauan terapi, serta pemeriksaan sifilis
4.2 Melakukan pemeriksaan penunjang pra inisiasi
4.3 **Melakukan pencatatan kegiatan pemeriksaan labortorium**
4.4 Melakukan pemantauan untuk memastikan ketersediaan alat
4.5 Menginput hasil pemeriksaan lab ke SIHA
4.6 Melakukan pemeriksaan lab sebagai bagian dari layanan keliling (*mobile testing*)

Pertanyaan Untuk Masing-Masing Tugas

Tugas 1: Melakukan pemeriksaan HIV lengkap

411 Menurut Anda, sejauh mana pemahaman Anda seputar tugas ini?
e. Saya belum memiliki pengetahuan dasar
f. Saya hanya memiliki pengetahuan dasar
g. Saya memiliki pengetahuan yang dibutuhkan untuk melakukan tugas ini
h. Saya telah memiliki pengetahuan yang tinggi (*advance knowledge*)

412 Menurut Anda, sejauh mana Anda merasa percaya diri dalam melaksanakan tugas ini?
e. Saya butuh lebih banyak peluang untuk mempraktekkan
f. Saya dapat mempraktekkan pengetahuan saya namun butuh bantuan dalam pelaksanaannya
g. Saya menguasai tugas ini, namun belum percaya diri untuk mengajarkannya kepada orang lain
h. Saya menguasai tugas ini dan mampu mengajarkannya kepada orang lain

413 Apakah Anda pernah mendapat pelatihan untuk tugas ini? ☐ Ya ☐ Tidak

413a Jika "Ya", Bagaimana bentuk pelatihan yang Anda dapatkan:

☐ Pelatihan informal atau *on-the-job,* misalnya dukungan dari sejawat di tempat bekerja

☐ Mentoring klinis, misalnya mentoring dari pihak eksternal baik lembaga pendamping ataupun pemerintah dalam bentuk visitasi atau pendampingan lapangan

☐ Pelatihan Formal Dalam Bertugas (*Formal in-service*), misalnya pelatihan tersertifikasi dari Kemenkes / Dinkes

☐ Pelatihan Pra-penugasan, misalnya sebelum Anda bekerja secara profesional seperti sekolah dsbnya

413b Jika "Ya", kapan Anda mendapat pelatihan terkait tugas ini terakhir kali?

☐ 0 – 3 bulan lalu ☐ 7 – 12 bulan lalu
☐ 4 – 6 bulan lalu ☐ Lebih dari setahun lalu

414 Seberapa sering Anda melakukan tugas ini?
☐ Tidak pernah ☐ Jarang ☐ Beberapa kali dalam sebulan ☐ Beberapa kali dalam seminggu ☐ Hampir setiap hari

415 Apakah Anda mendapat penugasan untuk melakukan tugas ini? ☐ Ya ☐ Tidak
(*baik berupa penugasan tertulis ataupun verbal dari atasan)*

V. TUGAS PETUGAS PENCATATAN DAN PELAPORAN

Catatan : Petugas Pencatatan dan Pelaporan hanya menjawab daftar tugas sesuai dengan pilihan tugas dibawah

Pertanyaan khusus Petugas Pencatatan & Pelaporan

5A. Untuk daftar tugas dibawah ini, tugas mana saja yang menjadi pekerjaan Anda dalam layanan HIV?
(pilih yang sesuai) / *For the tasks listed below, which ones are yours in providing HIV services? (tick the relevant ones)*

☐ Menyiapkan/mencatat formulir rujukan
☐ Melakukan pencatatan dan pelaporan terkait layanan HIV, termasuk registrasi pra-ART/ART
☐ Menginput data ke dalam SIHA dan KOHORT

☐ Membuat laporan LBPHA (laporan Bulan Perawatan HIV-AIDS, lembar 1)
☐ Melakukan pencatatan LASS and PTRM serta pemberian kondom
☐ Melakukan registrasi klien (kartu pasien)
5B. Jika menurut Anda ada tugas lain yang terkait layanan HIV namun belum ada didaftar, silahkan tuliskan:

Berikut adalah daftar tugas untuk Petugas Pencatatan dan Pelaporan:

5.1 **Menyiapkan/mencatat formulir rujukan**
5.2 **Melakukan pencatatan dan pelaporan terkait layanan HIV, termasuk registrasi pra-ART / ART**
5.3 **Menginput data ke dalam SIHA dan KOHORT**
5.4 **Membuat laporan LBPHA** (laporan Bulan Perawatan HIV-AIDS, lembar 1)
5.5 **Melakukan pencatatan LASS and PTRM serta pemberian kondom**
5.6 **Melakukan registrasi klien (kartu pasien)**

Pertanyaan Untuk Masing-Masing Tugas

Tugas 1: Menyiapkan/mencatat formulir rujukan

511 Menurut Anda, sejauh mana pemahaman Anda seputar tugas ini?
a. Saya belum memiliki pengetahuan dasar
b. Saya hanya memiliki pengetahuan dasar
c. Saya memiliki pengetahuan yang dibutuhkan untuk melakukan tugas ini
d. Saya telah memiliki pengetahuan yang tinggi (*advance knowledge*)

512 Menurut Anda, sejauh mana Anda merasa percaya diri dalam melaksanakan tugas ini?
a. Saya butuh lebih banyak peluang untuk mempraktekkan
b. Saya dapat mempraktekkan pengetahuan saya namun butuh bantuan dalam pelaksanaannya
c. Saya menguasai tugas ini, namun belum percaya diri untuk mengajarkannya kepada orang lain
d. Saya menguasai tugas ini dan mampu mengajarkannya kepada orang lain

513 Apakah Anda pernah mendapat pelatihan untuk tugas ini? ☐ Ya ☐ Tidak

513a Jika "Ya", Bagaimana bentuk pelatihan yang Anda dapatkan:

☐ Pelatihan informal atau *on-the-job,* misalnya dukungan dari sejawat di tempat bekerja

☐ Mentoring klinis, misalnya mentoring dari pihak eksternal baik lembaga pendamping ataupun pemerintah dalam bentuk visitasi atau pendampingan lapangan

☐ Pelatihan Formal Dalam Bertugas (*Formal in-service*), misalnya pelatihan tersertifikasi dari Kemenkes / Dinkes

☐ Pelatihan Pra-penugasan, misalnya sebelum Anda bekerja secara profesional seperti sekolah dsbnya

513b Jika "Ya", kapan Anda mendapat pelatihan terkait tugas ini terakhir kali?

☐ 0 – 3 bulan lalu ☐ 7 – 12 bulan lalu

☐ 4 – 6 bulan lalu ☐ Lebih dari setahun lalu

514 Seberapa sering Anda melakukan tugas ini?
☐ Tidak pernah ☐ Jarang ☐ Beberapa kali dalam sebulan ☐ Beberapa kali dalam seminggu ☐ Hampir setiap hari

515 Apakah Anda mendapat penugasan untuk melakukan tugas ini? ☐ Ya ☐ Tidak
(*baik berupa penugasan tertulis ataupun verbal dari atasan)*

VI. PETUGAS FARMASI/PHARMACIST

Catatan: Petugas Farmasi hanya menjawab daftar tugas sesuai dengan pilihan tugas dibawah

Pertanyaan khusus Petugas Farmasi

6A. Untuk daftar tugas dibawah ini, tugas mana saja yang menjadi pekerjaan Anda dalam layanan HIV? (pilih yang sesuai)

☐ Memberikan pelayanan obat bagi pasien HIV
☐ Pencatatan pemberian obat terkait HIV
☐ Memberikan konseling/edukasi kepatuhan
☐ Membuat laporan LBPHA (laporan Bulan Perawatan HIV-AIDS, lembar 2)
☐ Membuat laporan penggunaan reagen dan bahan habis pakai (BHP)
☐ Memberikan metadon

6B. Jika menurut Anda ada tugas lain yang terkait layanan HIV namun belum ada didaftar, silahkan tuliskan:

Berikut adalah daftar tugas untuk Petugas Farmasi / Apotik:

6.1 **Memberikan pelayanan obat bagi pasien HIV**
6.2 **Pencatatan pemberian obat terkait HIV**
6.3 **Memberikan konseling/edukasi kepatuhan**
6.4 **Membuat laporan LBPHA** (laporan Bulan Perawatan HIV-AIDS, lembar 2)
6.5 **Membuat laporan penggunaan reagen dan bahan habis pakai (BHP)**
6.6 **Memberikan metadon**

Pertanyaan Untuk Masing-Masing Tugas

Tugas 1: Memberikan pelayanan obat bagi pasien

611 Menurut Anda, sejauh mana pemahaman Anda seputar tugas ini?
a. Saya belum memiliki pengetahuan dasar
b. Saya hanya memiliki pengetahuan dasar
c. Saya memiliki pengetahuan yang dibutuhkan untuk melakukan tugas ini
d. Saya telah memiliki pengetahuan yang tinggi (*advance knowledge*)

612 Menurut Anda, sejauh mana Anda merasa percaya diri dalam melaksanakan tugas ini?
a. Saya butuh lebih banyak peluang untuk mempraktekkan
b. Saya dapat mempraktekkan pengetahuan saya namun butuh bantuan dalam pelaksanaannya
c. Saya menguasai tugas ini, namun belum percaya diri untuk mengajarkannya kepada orang lain
d. Saya menguasai tugas ini dan mampu mengajarkannya kepada orang lain

613 Apakah Anda pernah mendapat pelatihan untuk tugas ini? ☐ Ya ☐ Tidak

613a Jika "Ya", Bagaimana bentuk pelatihan yang Anda dapatkan:

☐ Pelatihan informal atau *on-the-job,* misalnya dukungan dari sejawat di tempat bekerja

☐ Mentoring klinis, misalnya mentoring dari pihak eksternal baik lembaga pendamping ataupun pemerintah dalam bentuk visitasi atau pendampingan lapangan

☐ Pelatihan Formal Dalam Bertugas (*Formal in-service*), misalnya pelatihan tersertifikasi dari Kemenkes / Dinkes

☐ Pelatihan Pra-penugasan, misalnya sebelum Anda bekerja secara profesional seperti sekolah dsbnya

613b Jika "Ya", kapan Anda mendapat pelatihan terkait tugas ini terakhir kali?

☐ 0 – 3 bulan lalu ☐ 7 – 12 bulan lalu

☐ 4 – 6 bulan lalu ☐ Lebih dari setahun lalu

614 Seberapa sering Anda melakukan tugas ini?
☐ Tidak pernah ☐ Jarang ☐ Beberapa kali dalam sebulan ☐ Beberapa kali dalam seminggu ☐ Hampir setiap hari

615 Apakah Anda mendapat penugasan untuk melakukan tugas ini? ☐ Ya ☐ Tidak
(baik berupa penugasan tertulis ataupun verbal dari atasan)

VII. TUGAS KADER/KONSELOR KOMUNITAS/PENDAMPING

Catatan: Kader/Konselor/Pendamping hanya menjawab daftar tugas sesuai dengan pilihan tugas dibawah

Pertanyaan khusus Kade/Konselor Komunitas/Pendamping

7A. Untuk daftar tugas dibawah ini, tugas mana saja yang menjadi pekerjaan Anda dalam layanan HIV? (pilih yang sesuai)

☐ Menjalin kemitraan dengan pasien dan komunitas
☐ Menghubungkan pasien dengan sumber daya dan dukungan sebaya *support*
☐ Melakukan konseling kepatuhan termasuk konseling pada populasi kunci
☐ Menjaring populasi kunci dan mengajak untuk melakukan tes HIV
☐ Melakukan konseling pra dan pasca tes HIV
☐ Menyediakan informasi melalui KIE tentang HIV-AIDS dan IMS serta kesehatan reproduksi termasuk *positive prevention*

7B. Jika menurut Anda ada tugas lain yang terkait layanan HIV namun belum ada didaftar, silahkan tuliskan:

Berikut adalah daftar tugas untuk Kader/Konselor/Pendamping Komunitas:

7.1 **Menjalin kemitraan dengan pasien dan komunitas**
7.2 **Menghubungkan pasien dengan sumber daya dan dukungan sebaya**, termasuk memperhatikan prioritas dan kekhawatiran pasien
7.3 **Melakukan konseling kepatuhan termasuk konseling pada populasi kunci**: gay, lesbian, waria, pekerja seks, pengguna NAPZA, pasangan HIV +, keluarga HIV+, warga binaan pemasyarakatan HIV+ dan klien/pasangan HIV+ dengan gangguan jiwa; serta konseling nutrisi dan pengungkapan status (terutama pada anak)
7.4 **Menjaring populasi kunci dan mengajak untuk melakukan tes**
7.5 **Melakukan konseling pra dan pasca tes HIV** (hanya untuk kader terlatih)
7.6 Menyediakan informasi melalui KIE tentang HIV-AIDS dan IMS serta kesehatan reproduksi termasuk positive prevention

Pertanyaan Untuk Masing-Masing Tugas

Tugas 1: Menjalin kemitraan dengan pasien dan komunitas

711 Menurut Anda, sejauh mana pemahaman Anda seputar tugas ini?
a. Saya belum memiliki pengetahuan dasar
b. Saya hanya memiliki pengetahuan dasar
c. Saya memiliki pengetahuan yang dibutuhkan untuk melakukan tugas ini
d. Saya telah memiliki pengetahuan yang tinggi (*advance knowledge*)

712 Menurut Anda, sejauh mana Anda merasa percaya diri dalam melaksanakan tugas ini?
a. Saya butuh lebih banyak peluang untuk mempraktekkan
b. Saya dapat mempraktekkan pengetahuan saya namun butuh bantuan dalam pelaksanaannya
c. Saya menguasai tugas ini, namun belum percaya diri untuk mengajarkannya kepada orang lain
d. Saya menguasai tugas ini dan mampu mengajarkannya kepada orang lain

713 Apakah Anda pernah mendapat pelatihan untuk tugas ini? ☐ Ya ☐ Tidak

713a Jika "Ya", Bagaimana bentuk pelatihan yang Anda dapatkan:

☐ Pelatihan informal atau *on-the-job,* misalnya dukungan dari sejawat di tempat bekerja

☐ Mentoring klinis, misalnya mentoring dari pihak eksternal baik lembaga pendamping ataupun pemerintah dalam bentuk visitasi atau pendampingan lapangan

☐ Pelatihan Formal Dalam Bertugas (*Formal in-service*), misalnya pelatihan tersertifikasi dari Kemenkes / Dinkes

☐ Pelatihan Pra-penugasan, misalnya sebelum Anda bekerja secara profesional seperti sekolah dsbnya

713b Jika "Ya", kapan Anda mendapat pelatihan terkait tugas ini terakhir kali?

☐ 0 – 3 bulan lalu ☐ 7 – 12 bulan lalu

Tugas 1: Menjalin kemitraan dengan pasien dan komunitas
☐ 4 – 6 bulan lalu ☐ Lebih dari setahun lalu **714** Seberapa sering Anda melakukan tugas ini? ☐ Tidak pernah ☐ Jarang ☐ Beberapa kali dalam sebulan ☐ Beberapa kali dalam seminggu ☐ Hampir setiap hari **715** Apakah Anda mendapat penugasan untuk melakukan tugas ini? ☐ Ya ☐ Tidak (*baik berupa penugasan tertulis ataupun verbal dari atasan)*

Annex N. Client Flow Mapping Tool (English)

CLIENT FLOW MAPPING TOOL

Instructions: *The data collector will unobtrusively and from a distance observe and follow clients who come for HIV services and record the time each spends at each respective point in the HIV service delivery process. Each data collector will observe one client at a time for a total of 3-5 clients per puskesmas.*

Time	*Service delivery area*	*Health Worker[1]*	*Describe what client is doing*	*General comments (if any)*
08:00	*in front of service unit*			
08:02	*Waiting room for registration*		Waiting to be called	Waiting room is used together for TB and Geriatrics, there are 10 people waiting
08:30	*Registration counter*	Nurse/Registration officer	Patient hands in ID/Health card	
08:32	*Patient waiting room*		Patient waits to be called for check up	Not clear if this waiting room is only for STD service or for general policlinic
08:50	*STD/HIV check-up room*	Doctor	*Dokter memeriksa pasien dan melakukan konseling Adherence* Doctor checks patient and conduct adherence counselling	Doors open, voices can be heard from outside
08:50	*General check-up room*	Doctor	Doctor checks patient and conduct adherence counselling	Clinical check is done at general poli, as there is no specific poli
09:10	*Laboratory waiting room*		Queueing for lab check	The queue for lab check is quite long
09:30	*Laboratory check*	Laboratorium Technician	Sample check	
09:35	*Laboratory waiting room*		Waiting for lab result	
09:50	*Counselling room*	Nurse/doctor	Health counselling	Nurse counsels in a hurry
10:00	*Pharmacy waiting room*		Waiting for medicines	

Time	*Service delivery area*	*Health Worker[1]*	*Describe what client is doing*	*General comments (if any)*
10:10	*Pharmacy*	Pharmacy assistant	Patient receives medicines from the assistant	
10:12	*In front of service unit*			
	Others……			

If possible, specify the type of health worker serving the client; if not, leave it blank

Additional question related to client

1. *As you know as counselor / during your support as counselor, how long client already did ART follow-up?* _____ *years*
2. *As you know as counselor / during your support as counselor, did the client doing viral-load testing?*
    a. *Yes, client has been tested*
    b. *Not yet, client has never been tested*
    c. *I don't know*

2.a. *If question #2 "Yes, client has been tested", do you know the viral load test result?*
    a. *Yes, I know*
    b. *No, I don't*

2.a-1. *If question #2.a "Yes, I know", write the viral load test result:* _____

2.a-2. *When the client tested:* _____

Puskesmas: _____ ***Date*** _____

Annex O. Client Flow Mapping Tool (Bahasa)

INSTRUMEN PEMETAAN ALUR LAYANAN HIV (*FOLLOW UP ART CLIENT*)

Instruksi:

- Instrumen ini digunakan untuk melihat alur layanan HIV di Puskesmas. Dan mendokumentasikan waktu yang dibutuhkan pada setiap bagian layanan. Mulai dari pasien tiba di unit layanan, sampai dengan pasien selesai mengakses layanan tersebut.
- Pengumpulan data ini akan dilakukan dengan observasi secara partisipatif. Observer akan mengikuti pasien yang datang dan mengakses layanan HIV, mulai dari pasien tiba sampai dengan selesai mengakses layanan.
- Observer akan mencatat waktu yang dibutuhkan di setiap titik layanan yang diakses oleh pasien.
- Observer akan hanya akan melakukan observasi untuk satu pasien per sekali pelayanan, sampai dengan maksimal 3-5 pasien per unit layanan.

Waktu	Area penyediaan layanan	Nakes yang Melayani[1]	Jelaskan apa yang dilakukan pasien	Komentar umum (jika ada)
08:00	*Pilihan drop-down (checkin):* • *Halaman Depan*			
08:02	• *Ruang tunggu pendaftaran*		*Menunggu dipanggil*	*Ruang tunggu bersaatu dengan pasien TB dan Geriatrik, ada 10 orang yang menunggu*
08:30	• *Loket Pendaftaran*	*Perawat/petugas pendaftaran*	*Pasien menyerahkan KTP/Kartu BPJS*	
08:32	• *Ruang tunggu pasien*		*Pasien menunggu dipanggil untuk pelayanan dokter*	*Tidak jelas apakah ini ruang tunggu untuk klinik IMS atau untuk semua pasien di semua poli.*
08:50	• *Ruang pemeriksaan IMS/HIV*	*Dokter*	*Dokter memeriksa pasien dan melakukan konseling Adherence*	*Pintu terbuka, suara terdengan dari luar*
08:50	• *Ruang pemeriksaan umum*	*Dokter*	*Dokter memeriksa pasien dan melakukan konseling Adherence*	*Pemeriksaan dilakukan di poli umum, tidak dilakukan di poli khusus karena memang tidak ada.*
09:10	• *Ruang tunggu laboratorium*		*Menunggu antrian lab*	*Antrian untuk pemeriksaan lab cukup ramai*
09:30	• *Laboratorium*	*Laboran*	*Proses pengambilan sampel*	
09:35	• *Ruang tunggu laboratorium*		*Menunggu hasil Lab*	

Waktu	Area penyediaan layanan	Nakes yang Melayani[1]	Jelaskan apa yang dilakukan pasien	Komentar umum (jika ada)
09:50	• *Ruang Konseling*	*Perawat/dokter*	*Konseling kesehatan*	*Perawat melayani konseling dengan terburu-buru*
10:00	• *Ruang tunggu apotik*		*Menunggu obat*	
10:10	• *Apotik*	*Asisten Farmasi*	*Pasien menerima obat dari asisten farmasi.*	
10:12	• *Halaman Depan*			
	• *Lainnya:.....*			

[1]Jika memungkinkan, jelaskan nakes yang melayani klien; jika tidak diketahui, kosongkan

Pertanyaan Tambahan Seputar Klien

1. Sejauh Anda ketahui / selama pendampingan, sudah berapa lama klien sudah menjalani follow-up ART (refill ART)? _____ tahun

2. Sejauh Anda ketahui / selama pendampingan, apakah klien sudah melakukan tes viral-load?
   a. Ya, klien sudah pernah melakukan tes viral-load
   b. Belum, klien belum pernah melakukan tes viral load (VL)
   c. Saya tidak mengetahui

2.a. Jika pertanyaan #2 "Ya saya mengetahui", apakah Anda mengetahui hasil tes viral-load klien?
   a. Ya, saya mengetahui
   b. Tidak, saya tidak mengetahui

2.a-1. Jika pertanyan #2.a "Ya saya mengetahui" – tuliskan hasil tes viral-load klien: _____

2.a-2. Kapan klien melakukan tes tersebut:_____

Puskesmas: _____ **Tanggal: _____**

Annex P. Health Worker Focus Group Discussion Guide (English)

A. *Introduction & Objective*

Good afternoon / evening, thank you for your willingness to participate in this data collection process. Introduce, I / us ..... from SOLIDARITAS, an Indonesian consulting company in collaboration with USAID / Indonesia, Chemonics / HRH2030, and LINKAGES, to conduct HRH data collection in sites level.

One method of data collection in this study is to conduct focus group discussions (FGD) with all of you, as the core team of HIV services in this Health Facility. This afternoon / afternoon discussion will focus on related matters:

• HIV service flow and maps of actors involved in each service point.

• Identify constraints and causes in each service points

The discussion process will end with the rapid assessment questionnaire relating to the analysis of the tasks of the HIV service core team, that we have developed in a digital questionnaire (based on ODK), which we will guide.

Furthermore, all data and information collected will be processed and analyzed by the HRH2030 team, and discussed together with the Government of Indonesia (in this case the Ministry of Health), to jointly understand the forms of service flow in Health Facilities and the obstacles that in the field.

Estimated time needed for the discussion process is about 2 x 60 minutes (2 hours). Please be willing to be actively involved during the discussion process. If you have questions or need further explanation about this process, please submit to me.

Do you have questions regarding this discussion process?

Can we begin this focus group discussion process (FGD)?

B. *FGD Process Plan*

1. *Preparation*

a) *arrangement*

- *Sit in a circle*
- *notes:*
    - *FGD should be conducted when the health workers are not performing their tasks in delivering HIV services. Probably in mid-afternoon.*
    - *FDG duration 1-2 hours*

b) *Equipment/Materials*

- *Magic wall*
- *Flipchart paper*
- *Sticky notes (squares, dots and stars)*
- *Markers (as many as the participants & facilitators –black, red, green, blue)*
- *Cue cards (with colors and, if possible, shapes, following the ones used in the National Guideline)*
- *Tapes*

2. *Main Activities/Process*

a) *Introduction*

1) *Self-introduction of those involved; quick explanation of reasons & purposes of HRH2030 review*
2) *Explanation of the discussion's focus: not on the individual health worker nor service point, but to learn about the current process happening daily to be able to map i> issues, ii> potential improvements.*
3) *Agreement on "rules" during the discussion*
   - *(e.g. no mobile phones, no "right/wrong" answer, each participant should speak/give opinions)*
4) *Introduction to the mapping activity:*
   - *Explanation of mapping objective: to gather understanding on how health workers and the clients 'move' in a service point during HIV service delivery.*
   - *Explanation of what is meant by "magic wall" and its use*

b) Alur Diskusi (*Discussion Flow*)

1) *Mapping the service flow to clients. Consider using the service flow draft on the national guideline to save time, but this guideline will not be shown in advance. Focus the exploration first on probing the participants' perspectives about what currently happens at their service point.*

   Use cue cards with colors (and, if possible, shapes) following those of the national guideline:
   - *Pink – for starting and ending points*
   - *Green – for the processes & activities involved*
   - *Blue Arrow – to identify flow followed by registered patients (not yet stable)*
   - *Yellow Arrow – to identify flow followed by stable patients*

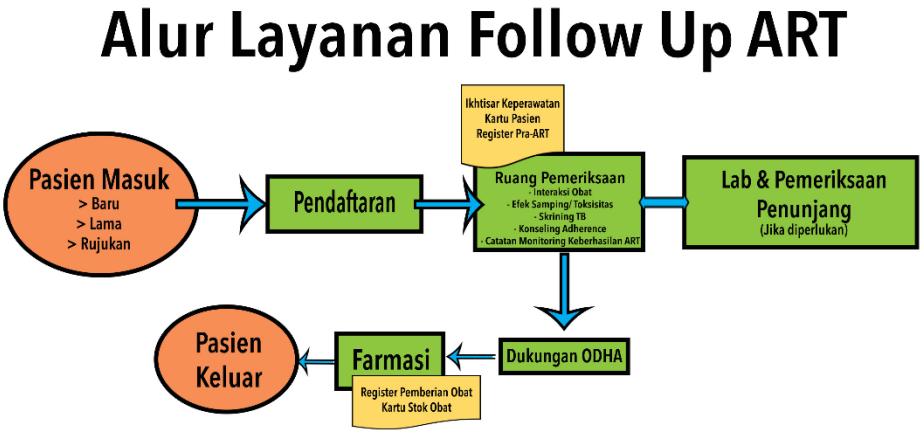
   Cards with health worker functions (doctor, nurse, midwife etc.) will be provided in advance to identify functions involved in each point of activities. – Ask if there is CSC/cadre involved

   Additions:
   - *Red dots – to identify problems (1-2 top priority) in relevant points in the process*
   - *Red post-it – to elaborate the top priority problems*
2) *Take a picture of these post-it papers first while still attached to the flow, then move them as needed to proceed with problem categorisation*
3) *Starting problem categorization participatorily – supported by the facilitator whenever necessary.*
4) *Identifying root causes after completing with problem categorization*
   - *Blue post-it – to identify root causes in each problem category.*

3. *Discussion Content*

Below is the service flow according to the national guideline which the facilitator will use as a reference to probe in the discussion, not to be shown to the participants.

Follow-up ART Service Flow Reference – for Registered and Stable Clients



- *Record which health worker present at each point in the service flow.*
- *Differentiate types/colors of arrows used when a flow is considered good and when it is considered as problematic (patients are 'lost'/confused, patients spending too much time)*
- *When a flow is considered good, ask why?*
  - *This will promote positive deviance, but there may not be enough time for the flow to happen as expected*
- *When a flow is considered problematic/poor, ask why? (This can be elaborated by "Problem Tree" visual)*
  - *Categorize respon ("problem") with:*
    - *Inadequate competence/skills of health workers*
    - *Adequate number of health workers*
    - *Low motivation of health workers*
    - *Poor task allocation to staff*
    - *Inefficiency of work process*
    - *Issues outside the health workers' availability and performance (e.g. infrastructure, drug availability, low client volume)*
  - *After categorizing those responses, as the participants why they think such problem happens.*
  - *Probe the reason "Why?" for several times to get to the root of issues.*

C. EXPECTED RESULT

Problem tree will then be presented as a table in the FGD key notes:

Problem Categories	*Problems Identified*	*Perceived Root Causes*
1.	1.a.	1.a.i
		1.a.ii
	1.b.	1.b.i
		1.b.ii
2.	2.a.	2.a.i
		2.a.ii
	2.b.	2.b.i
		2.b.ii

For further process in HRH2030 Data Collection, key notes will then be translated into English to be further analysed.

Annex Q. Health Worker Focus Group Discussion Guide (Bahasa)

PANDUAN FGD TENAGA KESEHATAN DI FASILITAS KESEHATAN

A. PENGANTAR & TUJUAN (*INTRODUCTION & OBJECTIVE*)

Selamat siang/sore, terima kasih atas kesedian Bapak/Ibu untuk berpartisipasi dalam proses pengumpulan data ini. Perkenalkan, Saya/kami ..... dari SOLIDARITAS, sebuah perusahaan konsultan Indonesia yang bekerjasama dengan USAID/Indonesia, Chemonics/HRH2030, dan LINKAGES, untuk melakukan pengumpulan data tingkat Fasilitas Kesehatan.

Salah satu metode pengumpulan data dalam kajian ini adalah dengan melakukan diskusi kelompok terarah (FGD) dengan Bapak/Ibu sekalian, selaku tim inti layanan HIV di Fasilitas Kesehatan. Diskusi siang/sore ini akan membahas beberapa hal terkait:

- Alur layanan HIV dan peta aktor yang terlibat di masing-masing titik layanan dalam alur pelayanan tersebut.
- Mengidentifikasi titik-titik layanan yang dinilai memiliki kendala serta mengidentifikasi faktor penyebabnya.

Proses diskusi ini akan diakhiri dengan pengisian kuesioner kajian cepat terkait analisis tugas tim inti layanan HIV. Yang telah kami kembangkan dalam bentuk kuesioner digital (berbasis Android), yang akan kami pandu.

Selanjutnya seluruh data dan informasi yang terkumpul akan diolah dan dianalisis oleh tim HRH2030, dan didiskusikan bersama dengan Pemerintah Indonesia (dalam Hal ini Kementerian Kesehatan dan Dinas Kesehatan), untuk sama-sama memahami bentuk-bentuk alur layanan di Fasilitas Kesehatan dan hambatan-hambatan yang ada di lapangan.

Perkiraan waktu yang dibutuhkan untuk proses diskusi sekitar 2 x 60 menit (2 jam). Mohon kesediaan Bapak/Ibu untuk terlibat aktif selama proses diskusi ini berlangsung. Jika Bapak/Ibu ada pertanyaan atau memerlukan penjelasan lebih lanjut seputar proses ini, silahkan ajukan kepada Saya.

Apakah Bapak/Ibu ada pertanyaan terkait proses diskusi ini?

Apakah kita bisa mulai melakukan proses diskusi kelompok terarah (FGD) ini?

B. RENCANA PROSES FGD (*FGD PROCESS PLAN*)

1. PERSIAPAN (*PREPARATION*)

a) PENGATURAN (*ARRANGEMENT*)

- Duduk dalam lingkaran
- Catatan *(notes):*
    - FGD akan dilakukan ketika para nakes tidak sedang melaksanakan tugas pelayanan. Kemungkinan di siang menjelang sore hari.
    - Durasi FGD 1-2 Jam

b) Perlengkapan (*Equipment/Materials*)

- *Magic wall*
- Kertas flipchart
- Sticky notes (kotak, bulat kecil dan bintang)
- Spidol (sejumlah peserta & fasilitator – hitam, merah, hijau, biru)
- Metaplan (warna, dan jika memungkinkan bentuk, disesuaikan dengan yang dipakai pada alur layanan di Pedoman Nasional)
- Lakban kertas

2. Aktivitas/Proses Utama

a) Pembukaan

1) Perkenalan dengan nakes; penjelasan singkat mengenai alasan & tujuan review HRH2030
2) Penjelasan mengenai fokus diskusi: tidak pada individu nakes maupun individu faskes, melainkan belajar mengenai proses yang terjadi dalam keseharian, untuk dapat memetakan i> masalah, ii> potensi perbaikan.
3) Persetujuan mengenai "aturan" selama berlangsungnya diskusi
   - (misalnya tidak menggunakan ponsel, tidak ada jawaban yang "benar/salah", setiap partisipan perlu berbicara/memberikan opininya)
4) Perkenalan kepada aktivitas pemetaan:
   - Penjelasan tujuan pemetaan: untuk memahami bagaimana naker dan para klien 'bergerak' dalam sebuah faskes selama penyediaan layanan HIV.
   - Penjelasan apa yang dimaksud dengan "magic wall" dan penggunaannya

b) Alur Diskusi

1) Pemetaan alur layanan klien. Pertimbangkan untuk menggunakan draft alur layanan sesuai panduan nasional untuk mempersingkat waktu, namun panduan ini tidak diperlihatkan di awal. Fokus eksplorasi adalah menggali perspektif para partisipan diskusi dulu atas apa yang terjadi di faskes mereka.

   Gunakan *metaplan* dengan warna (dan, jika memungkinkan, bentuk) yang sesuai dengan panduan nasional:
   - Merah jambu – untuk titil awal dan akhir
   - Hijau – untuk proses & aktivitas
   - Panah Biru – untuk mengidentifikasi alur yang dilalui pasien yang sudah ter-register (tapi belum stabil)
   - Panah Kuning – untuk mengidentifikasi alur yang dilalui pasien stabil

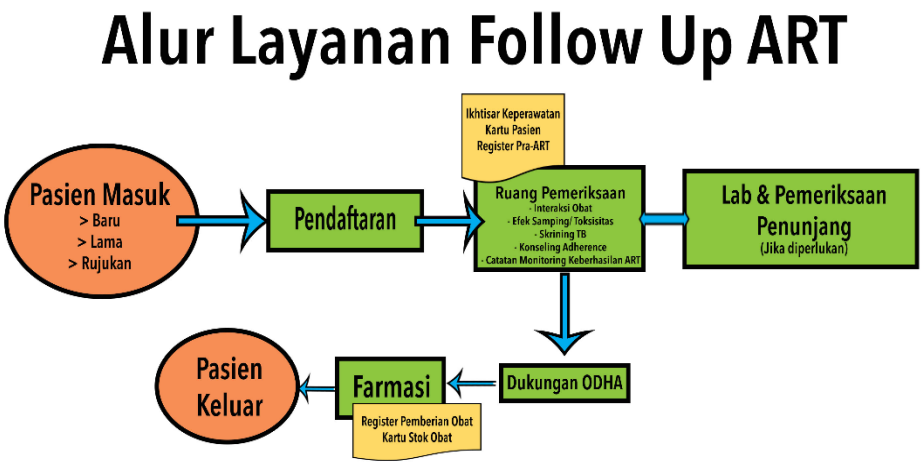
   Kartu-kartu fungsi nakes (dokter, perawat, bidan etc.) akan disediakan untuk dapat dipilih ketika mengidentifikasi fungsi nakes yang terlibat di setiap titik aktivitas. – Tanyakan jika ada kader/CSC yang terlibat.

   Tambahan:
   - Dots Merah – untuk mengidentifikasi adanya masalah (1-2 prioritas utama) di titik-titik tertentu dalam proses
   - Post-it merah – untuk mengelaborasi masalah prioritas tersebut
2) Foto dulu seluruh post-it merah ini ketika masih menjadi bagian dari identifikasi alur, lalu dapat dipindah sesuai kebutuhan ketika lanjut dengan kategorisasi masalah.
3) Memulai kategorisasi masalah secara partisipatif – dipandu oleh fasilitator sebagaimana dibutuhkan.
4) Pencarian akar permasalahan setelah pengkategorian masalah selesai.
   - *Post-it biru* – untuk mengidentifikasi akar permasalahan pada tiap-tiap kategori masalah.

3. MATERI DISKUSI

Di bawah ini alur layanan sesuai panduan nasional yang akan digunakan fasilitator hanya untuk memantik diskusi, tidak untuk ditunjukkan kepada partisipan.

Acuan Alur Layanan Follow-up ART – untuk Klien Terdaftar & Stabil



- Catat nakes yang mana yang berada di tiap titik dari alur layanan.
- Bedakan jenis/warna panah yang digunakan ketika alur dianggap baik dengan ketika dianggap ada masalah (pasien 'tersesat'/bingung, pasien menghabiskan terlalu banyak waktu)
- Ketika alur dianggap baik, tanyakan mengapa?
  - *Ini akan mempromosikan deviansi positif, namun mungkin tidak tersedia cukup waktu agar alur ini terjadi sesuai harapan*
- Ketika alur dianggap bermasalah/buruk, tanyakan mengapa? (Hal ini bisa dielaborasi dengan visualisasi "Problem Tree")
  - Kategorikan respon ("masalah") dengan:
    - Ketidakcukupan kompetensi/keahlian nakes
    - Kecukupan jumlah nakes
    - Rendahnya motivasi nakes
    - Buruknya alokasi penugasan kepada para staf
    - Tidak efisiennya proses kerja
    - Masalah diluar ketersediaan & kinerja nakes (misalnya infrastruktur, ketersediaan obat, volume klien yang rendah)
  - Setelah mengelompokkan respon-respon tersebut, tanyakan pada nakes mengapa mereka berpikir masalah ini terjadi.
  - Probing alasan "Mengapa?" beberapa kali untuk mendapatkan akar permasalahan.

C. HASIL YANG DIHARAPKAN

Problem Tree kemudian akan disajikan dalam bentuk tabel dalam key notes diskusi:

Kategori Permasalahan *Problem*	Masalah yang diidentifikasi	Yang dianggap akar permasalahan
1.	1.a.	1.a.i
		1.a.ii
	1.b.	1.b.i
		1.b.ii
2.	2.a.	2.a.i
		2.a.ii
	2.b.	2.b.i
		2.b.ii

Selanjutnya, untuk kepentingan HRH2030 Data Collection, key notes akan diterjemahkan ke dalam Bahasa Inggris agar dapat diproses lebih lanjut oleh Chemonics International.

Annex R. SITE-LEVEL DATA REPORTS (*Anonymized)*

Introduction and explanations
The site-level data report combines: key HIV service delivery statistics; the rapid site-level health workforce assessment (unit manager questionnaire); the client flow mapping results; and key results from the health worker focus group discussions. In addition, the full focus group discussion notes are provided.

The following notes may be helpful to navigate the site-level data reports:

- People receiving testing and counseling services and Testing and ART - These two line graphs are verified data sourced from https://data.PEPFAR.net. Adding facility targets to these graphs could help to better capture potential service delivery issues.
- Client Flow for ART Refills - This stacked bar chart contains the information collected from two different clients from the Client Flow Mapping instrument. The total of the bar reflects their total time spent at the clinic in minutes. The bar is then broken up into the different service points the client went to within the facility and how much time they spent at each one. Values where a client spends a lot of time in one spot could potentially indicate areas for further reflection to see if that is an impediment that could be improved.
- Flow of ART Refill Service per Staff Focus Group Discussion Mapping - The diagram replicates that created through the focus group discussion when health workers were prompted to map the various paths clients might take through the facility.
- Results from Questionnaire for the Head of Puskesmas/Head of Administration Unit – This table summarizes results from question 2 and question 11 of the unit manager survey. See the legend for a description of the color coding. It identifies: if there are cadres performing a task that is not in their job description, where there aren't any FTE staff from a certain cadre, and/or if there are any tasks that are not being performed by anyone.
- Focus Group Discussion Findings – This box pulls the high-level impediments identified in the focus group discussions.
- Other key findings – This box includes additional information from the unit manager survey outside of questions 2 and 11.
- Rapid Task Analysis – this table holds the responses from each health worker who was included in the RTA survey regarding whether they're assigned to a task, whether they've been trained in that task, and rating their confidence, knowledge, and frequency of performing the task. Each cell is color coded per the legend. The dark red and orange colors suggest potential priority areas.

Annex R-01. Puskesmas Kecamatan A

FOCUS GROUP DISCUSSION NOTES

PUSKESMAS KECAMATAN A

Date & Time	Monday, 2 July 2018
Participants	HIV Core Team: doctor, nurse, lab technician, pharmacist, RR, peer-cadre ('young cadre')

A. SUMMARY OF DISCUSSION

- HIV+ clients access the ART refill service in one of these two ways, i.e. 1) going straight to the STIs policlinic (the blue arrow #1 in Figure 1 below), or 2) going to the registration desk to settle administration first (the blue arrow #2 in the Figure).
    - Option 1) is preferred by many clients, especially those who are already 'long-timers' and have a good relationship with the STI services staff, about 90% of the refill clients. When option 1) is selected, the administration process is handled directly by the STI services staff who will liaise with the registration desk after completing the ART refill service for the clients (the back arrow pointing from the STI services point in Figure 1).
- At the STI services policlinic, when clients are indicated/detected of either having opportunistic infections (OI) or experiencing ARV side-effects, they will be sent to the laboratory (the orange arrow in Figure 1).
    - To access some lab test services, clients would be asked if they have insurance, most would rely on BPJS – the national health coverage scheme – to cover. If so, they would need to undergo administrative process for the BPJS coverage first to access. However, according to the lab technician, further lab tests needed by the refill clients (on a case-by-case basis) are not usually covered by BPJS.
    - A similar administrative process is done when clients need referral to the hospital for further testing or if they don't have BPJS and can't afford test services. Then they go back to the STI services policlinic to update the completed process at the lab and/or referral administration.
- Those who have completed services at the STI services policlinic, including ones who are back from the lab and/or referral, will go to the pharmacy to get the ART refill to complete the service flow.

The client flow discussed is visualized in Figure 1 below:

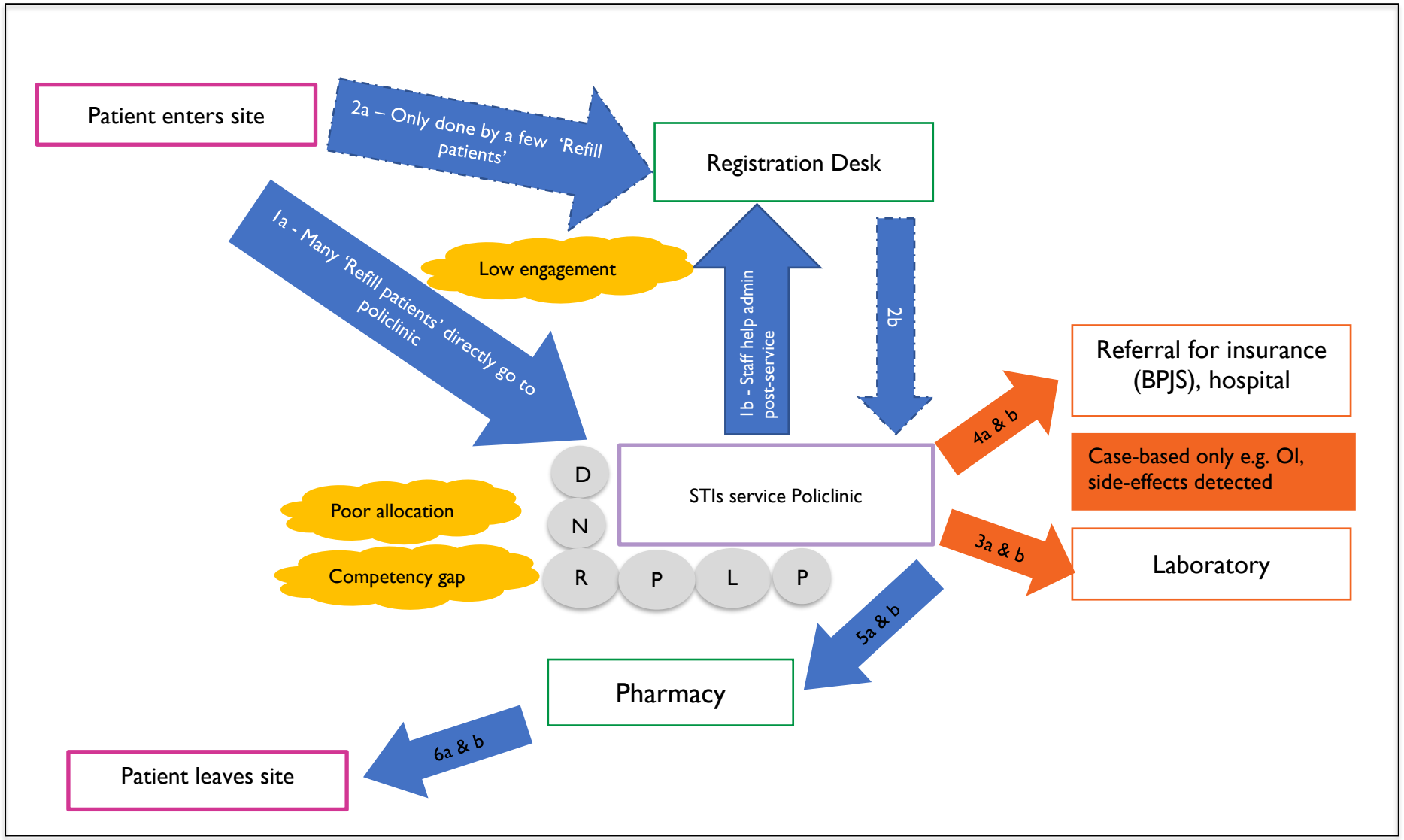


Figure 1. Flow of ART Refill Service in Puskemas Kecamatan A

B. Actors Involved at Each Point & Impediments Experienced

Having identified the client flow, the discussion identified actors involved at each service points and the impediments they experience. The discussion mainly covered daily work experience of the STI services team and their relationship with staff outside STI services policlinic whose tasks linked to the process of acquiring ART refill. Hence, the impediments raised are mainly about the team's experience and how work relationship with staff outside the STI services policlinic brings consequence which can add to their workload.

The team does not use the term 'stable' patients/clients, and there is no differentiation of categories for patients recorded in ART refill. When they are already in the refill program for more than 12 months, regardless of whether they have taken a VL test, they are considered as 'refill patients'.

This section covers actors involved and cause of consequential impediments at each service point, while categorization of impediments is covered in the next section.

- **Registration Desk – Admin staff (non-core HIV team)**
    - There remain some staff who are reluctant to handle HIV+ clients directly, and this stigmatization is felt by the clients. Therefore, many clients preferred going straight to the STI services team with whom they have mostly had a good relationship with.
- **STI, HIV, and narcotics management policlinic**
    - Core HIV team:
        - Doctor (D) = 1
        - Nurse (N) = 1
        - Lab Technician (LT) = 1, this staff sees that having only 1 lab for all types of testing and no dedicated lab for STIs/HIV-AIDS testing contributes to the longer queue of patients. Challenges associated with this is elaborated more in the 'Laboratory' pointers.
        - RR = 1, being the only RR in the team, this staff deals with a dilemma when required to attend an outside meeting during the reporting period.
        - Pharmacist (P) = 1, this staff is usually on standby at the STI services policlinic since recording and reporting of HIV drugs stock, as well as the adherence counseling of the drugs prescribed are done there. But occasionally s/he must go back & forth to the pharmacy when pharmacist on duty there is not available to serve the HIV/STI patients. S/he does not have access to CST training due to being a high school graduate, which is below the required minimum education (of a diploma degree) to access the training.
        - Peer-cadre (PC) = 1, is assigned and remunerated as staff from Puskesmas budget
        - Midwife (M) = 0, as midwives are positioned in MCH policlinic, and do not seem to have accessed to PMTCT training yet (information from the STI services team only, as the FGD facilitators did not meet directly with midwives to confirm).
    - The workload of the team can be high for a few reasons:
        - Despite the existing load/queue of patients, all cases related to STIs and deemed slightly related to HIV are referred to the STI services policlinic, when in some cases General Policlinic should be able to help ease the load. Like experienced in the registration desk, the team perceives that there are some health workers in General Policlinic who are reluctant to deal with a potentially HIV+ or STI-infected client.
        - This is felt the most during 'seasonal' peak, like when the Hajj pilgrimage month is near. The STI services team has been for years assigned to handle the test/care for the Hajj purpose, e.g. providing meningitis shots etc. as general/non-HIV specific responsibility.
        - Another peak is when there is a high number of mobile testing to be conducted within the month – up to 12 visits – which are all outside/after official work hours and based on schedules informed mainly by the CSCs and sometimes by collaboration with

private companies. The team has no 'back-up' staff like it used to have, so even after completing official work hours during the day and continuing to mobile services until late evening, the team must be back the next day at the start of official work hours (8 a.m.).

- The STI services team tends to stick together as a full team with LT and P are more likely to be on standby at the STI services unit, and only go to their relevant unit(s) whenever they must do the technical service, e.g. lab testing for or drug dispense to HIV clients. Two reasons seem to contribute to this:
  - They have always been assigned as one whole team for non-HIV tasks (the Hajj task force mentioned above)
  - They face stigmatization from internal puskesmas/fellow staff, some of whom are not only reluctant to serve HIV clients, but also would prefer everything related to HIV service provision is done only by STI services team.
- Following up on patients to sustain their ART refill is sometimes challenging when their contact details changed, and they don't update the STI services team.
- The size of the STI services working space/room and its setting (no separation between counselling and admin tasks) are seen to need upgrading. The team needs a bigger working space with appropriate allocation/separation to accommodate both the different tasks, technical vs. administrative, and different functions.
- With the cut in mobile testing budget, the team no longer has budget for team building events, especially seen helpful after a high workload doing mobile services. Team building is more about entertainment and refreshing activity to recover team bond/spirit after an intensive work period. This was not formally budgeted from the 'in-house' operational budget, while the budget for mobile services used to be sufficient in allowing for such activity.

- **Laboratory – Lab technician/analyst (LT)**
  - Since there is only one lab for all types of patients, HIV clients are usually reluctant to queue together with the others (non-HIV) for risk of being stigmatized. So, they would want to go directly and wait inside the lab, with the help of the STI service policlinic's LT. This often creates suspicion over special treatment from the other patients. In such cases, the STI service policlinic's lab technician would need to go into the lab and support the HIV clients.
  - RDT reagent supply is deemed insufficient, with some close to expiry date. The FGD didn't explore further of why there can be insufficiency and close to expiration cases – as they are not directly related to HRH themes.
- **Referral Point – Admin staff (non-core HIV team)**
  - The STI services team's concern is more on the patients if they don't have BPJS coverage or having one but still can't access lab tests. Such patients must be referred to other facilities (hospitals/others providing free services) and can't access services on the site.
- **Pharmacy – Pharmacist (P)**
  - Not all responsible in the pharmacy are willing to deal with HIV patients, due to the remaining stigmatization towards the HIV clients (and fellow staff providing HIV services at the STI services policlinic).

C. Categorization of Impediments

Having identified impediments at each service point, the discussion carried on with categorizing them and, whenever possible, endeavored to dig deeper on the root cause. Root cause identification by the operating team is not always possible to do, as they would perceive some impediments as a consequence of a given standard or regulation 'from above' (the Puskesmas management or the higher-level government). For such cases, the discussion would focus more on elaborating working context or impeding working environment. The summary of problem mapping/categorization is below:

1. **Health worker competency gaps**

- The need to upgrade knowledge and competence.
  i. Regardless of the required minimum education background, there is a pressing need to access formal training once a health worker is formally assigned to a specific task. This is specifically true to the pharmacist on CST training.

2. Low engagement

- The perceived on-going stigmatization towards HIV clients from the internal, non-STI service Puskesmas staff.

  i. As mentioned in section B, there remain several service points at the Puskesmas, like registration, pharmacy and general policlinic, having staff showing reluctance to serve HIV-related clients, whether they have been tested, indicated/screened or just showing similar symptoms with HIV/STIs. These kinds of patients are directly 'forwarded' to the STI services policlinic.

3. Poor allocation of staff or tasks

- High workload of the HIV core team.
  i. Providing mobile services outside the official working hours can happen 12 (twelve) times a month, about 4 hours at the minimum which means they will complete the service in late evening. Without having back-up personnel, the same people will need to be present for routine service provision at the facility the next morning during the official working hours.
  ii. The seasonal high workload on preparing for Hajj pilgrimage period, on top of the STIs/HIV-related services. The same full team is formally assigned by Puskesmas management for some consecutive years now, instead of forming a periodic 'task force' comprising multi-unit representatives.
- Limited number of personnel in STI services policlinic.
  i. Related to workload in the above point, the team once experienced having back-up personnel to take turns, making 2 sub-teams available, in handling the mobile services. This is no longer the case as they have been transferred, mostly to support Puskesmas at the *kelurahan* level.

4. Inefficient work processes

Mostly related to poor allocation of staff or tasks and low engagement perceived from the other units.

5. Other health system issue

- **Inadequate supplies / equipment**

  i. RDT reagent supply is deemed insufficient, with some close to expiry date

- **Poor infrastructure**

  i. The size of the STI service working space is not big enough to accommodate different team members who often must use the room at the same time for administrative and counseling purposes.
  ii. There are no separation/room division for doing technical/counseling work vis-á-vis administrative, or if different functions in the team needing to do their task separately at the same time.

- **Low client demand**

Not mentioned

Annex R-02. Puskesmas Kecamatan B

FOCUS GROUP DISCUSSION NOTES

PUSKESMAS KECAMATAN B

Date & Time	Friday, 13 July 2018
Participants	VCT/STI Clinic's team: doctor, nurse, midwife, lab analyst, pharmacist, RR, peer-cadre ('young cadre')

A. SUMMARY OF DISCUSSION

- Midwife involvement happens when there is a patient at the MCH is sent for a PITC lab test, whose result – if found positive/reactive must be forwarded to the VCT/STI services clinic. Midwife's responsibility for this task was not deeply explored in the discussion, as PITC at MCH is not the flow experienced by ART refill clients. However, when discussing about actors involved at each service point (in the next section), midwife's experience and perspective were explored.
- The VCT/STI services clinic specifically puts a 'VCT and STIs services' sign on its door. They didn't cover much mobile testing in the discussion, but from the interview session with the Puskesmas manager which was joined by the VCT/STI services doctor, it was explained that mobile services are mostly done together with the other non-HIV service units/policlinics and do not necessarily involve the VCT/STI services core team.
- The VCT/STI team differentiates clients based on 6 months' cut-off period, where: i) clients in refill category under 6 months will be monitored with further lab tests (indicated by the blue arrow in Figure 1 and ii) refill clients above 6 months (with the yellow arrow in the same Figure).
    - Clients in i) will go back to the VCT/STI services clinic from the lab, for result reading – whenever readily possible – before they continue on to the pharmacy.
    - Clients in ii) will usually go straight to the pharmacy upon completing service at the VCT/STI services clinic.
- The pharmacy is the last service point accessed to obtain the ART refill.

The client flow discussed is visualized in Figure 1 below, where blue arrows exhibit the flow for ART refill clients under 6 months in the program and yellow arrows exhibit the flow for ART refill clients above 6 months in the program. Orange arrows exhibit patients' flow from screening points:

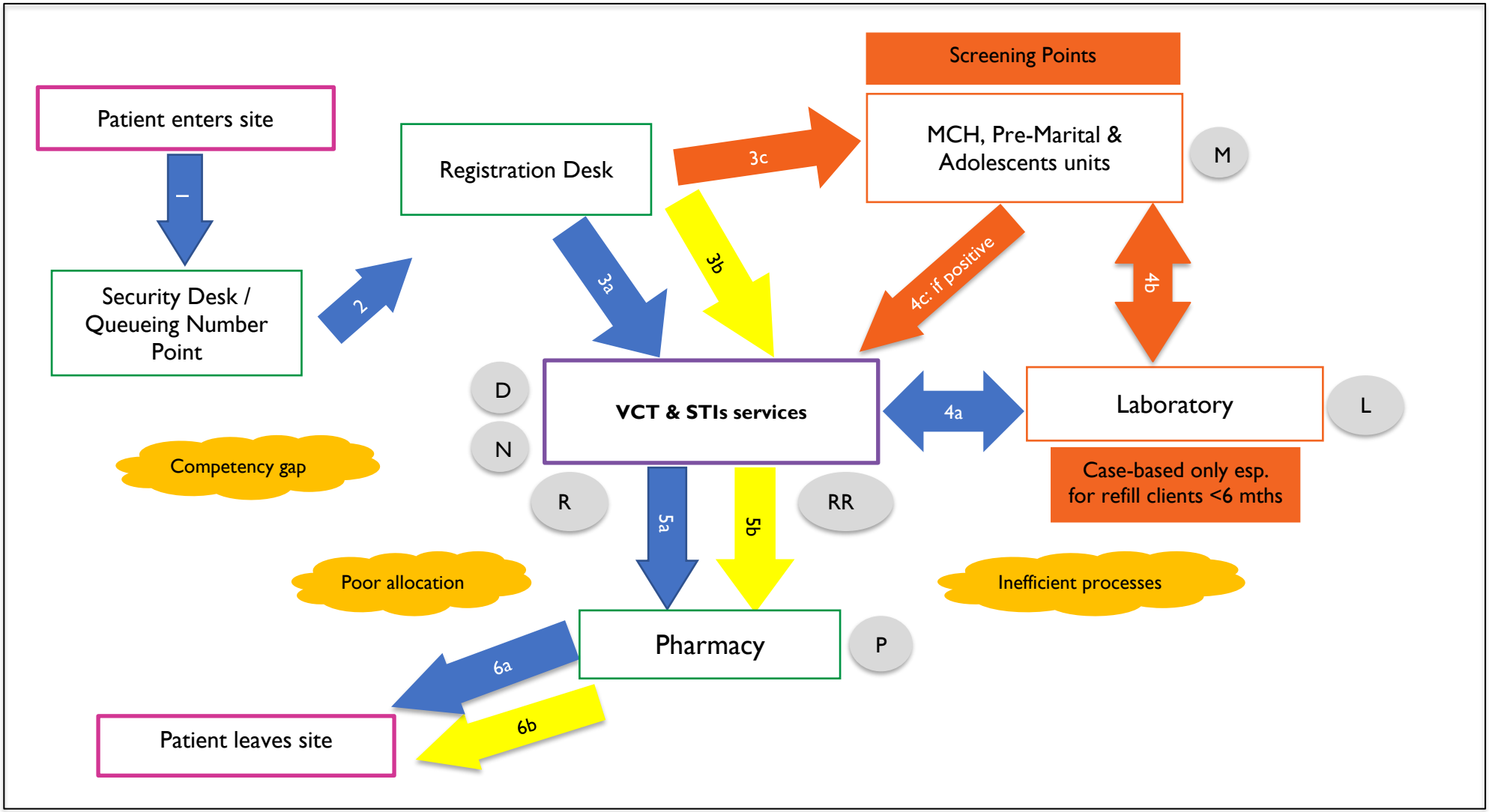


Figure 2. Flow of ART Refill Service in Puskesmas Kecamatan B

B. Actors Involved at Each Point & Impediments Experienced

Having identified the client flow, the discussion identified actors involved at each service point and the impediments they experience. The discussion mainly covered daily work experience of the VCT/STI services team and their relationship with staff outside the VCT/STI services clinic whose tasks linked to the process of acquiring ART refill or the general HIV services which may impact the refill service provided.

The team does not use the term 'stable' patients/clients, and there is no differentiation of categories for patients recorded in ART refill. As mentioned in the previous section, they differentiate clients based on 6 months' cut-off period, where clients in refill category under 6 months will be monitored with further lab tests and refill clients above 6 months will usually go to the pharmacy upon completing service at the VCT/STI services clinic.

This section covers actors involved and cause of consequential impediments at each service point, while categorization of impediments is covered in the next section.

- **Security Desk** – Security Officer (non-core HIV team)
    - This is the point where patients get their queueing number coded according to the unit they want to access.
- **Registration Desk** – Admin staff (non-core HIV team)
    - Dealing with approximately 200 patients/day for the 8 a.m. – 2 p.m. service provision period, there is usually a long queue.
    - Patients wanting to access the different units in the puskesmas will be 'channeled' accordingly from here. So, ART refill patients will have to wait to be channeled with other patients queuing for other services, even though there may not be a long queue in the VCT/STI services clinic which provides the ART refill itself.
    - 'Mis-register' occasionally happens particularly for STIs/HIV clients who are not candid in informing what sort of service they actually need. They would just say they'd like to go to the general policlinic, and only when in anamnesis at the policlinic they would say, for instance, "It hurts when I urinate, and it excretes pus", that it gives a real indication of the actual problem. And the general policlinic needs to refer the patient to the VCT/STI services clinic, for which the patient needs to re-register, with right coding in the queueing number.
- **VCT/STI services clinic**
    - Core HIV team stationed at the VCT/STI services clinic:
        - Doctor (D) = 1
        - Nurse (N) = 1
        - Peer-cadre/RR = 1, this staff is appointed and remunerated mainly to perform RR function, but informally filling in for when the doctor or nurse is out
        - RR assistant (RRA) = 1.
    - The clinic supports 4 programs run by the puskesmas, some of which link to work of other units: STIs, HIV, services for brides and grooms to-be, and service for adolescents.
    - Working in interlinked programs like this means the medic/doctor and paramedic/nurse need to support activities in the other units, e.g. General Policlinic too.
    - Such support and required meetings held outside often make the VCT/STI services clinic without a doctor or a nurse on standby, which leave peer-cadre having to be ready to fill in as much as s/he can and is allowed to do.
    - With these circumstance, there is a need for the peer-cadre/RR to be properly trained for counseling in the case when there is no doctor nor nurse available to do it.
    - The high mobility of the doctor sometimes can cause lack of attention/focus of patients' status, which can manifest in the form making mistakes in writing drug regimen for a patient. When this happens, two consequences appear:
        - It takes time to revise the regimen document

        - The revision needs to immediately be communicated to the pharmacy for an updated drug dispense (linked to a relevant impediment at the pharmacy below)
    - The doctor also faces a challenge in the required reporting load, particularly on the following:
        - Measuring the effectiveness of adherence follow up
        - Writing '*ikhtisar pasien*' (a patient's individual HIV/ART record, apart from the general medical record usually kept at the registration desk) requires a sufficient amount of time, since it needs to be inputted into three separate reports: individual *ikhtisar*, SIKDA and Kohort.
    - RR is responsible for inputting around 400 patients' data monthly into the SIHA which comprises several reporting types, i.e. *ikhtisar*, VCT, PITC, and STIs. And this can overwhelm RR.
    - Whenever there is mobile service/visit which, as mentioned in the beginning, does not necessarily involve VCT/STI services personnel since it is conducted by an inter-unit task force, it takes a while before mobile testing data can be received by the VCT/STI services team.
    - VCT/STI personnel lack of training on STIs.
    - There is no dedicated space/room for conducting counseling.
- **Laboratory**
    - Lab analyst (LA) = 1, this staff is amongst the three analysts available in the puskesmas. There are two analysts who have been formally trained on HIV, the other one is peer-trained internally.
    - The analyst dedicated to handle patients from the VCT/STI services clinic handles around 70 clients daily.
    - Comparing number of personnel and workload, they see that there is a need for more personnel.
- **MCH**
    - Midwife (M) = 1, while this staff is positioned in MCH policlinic, she is considered part of the VCT/STI services clinic when linked to HIV screening and testing services. She is one of two midwives assigned at MCH and both have never had HIV training. There used to be one more midwife whom was trained but is no longer working there.
    - Handling about 50 patients daily, for several programs – pregnancy, bride & groom to-be services, and immunization, they see a need for more personnel.
    - No dedicated space/room for counseling at MCH.
- **Pharmacy**
    - Pharmacist (P) = 1, while this staff is stationed at the pharmacy, s/he is considered part of the VCT/STI services clinic, particularly since s/he is the only one out of three pharmacists who has been trained on HIV. There is a need for the other colleagues to have access to such training.
    - In the case of doctor writing a wrong drug regimen for a patient, an immediate update from the VCT/STI services clinic is lacking to be able to dispense the right dose/type of drugs.
    - Pharmacy handles around 200 patients daily, which means a long queue for patients. And particularly for the ART refill patients, they need to queue with the other patients, having to wait longer than they should (refill ARV being a regular need should be a more straightforward dispensing than other patients' regimen).
    - Being the only pharmacist trained on HIV, s/he conducts ARV adherence counseling and consequent required reporting on top of the non-HIV related tasks, leading to a higher workload than the other colleagues.
    - No dedicated space/room for conducted the ARV adherence counseling.

C. Categorization of Impediments

Having identified impediments at each service point, the discussion carried on with categorizing them and, whenever possible, endeavored to dig deeper on the root cause. Root cause identification by the operating

team is not always possible to do, as they would perceive some impediments as a consequence of a given standard or regulation 'from above' (the Puskesmas management or the higher-level government). For such cases, the discussion would focus more on elaborating working context or impeding working environment. The summary of problem mapping/categorization is below:

1. **Health worker competency gaps**
   a. Lack of trained personnel
      i. This is especially true for pharmacists, lab analysts and midwives.
      ii. Counseling for RR/peer-cadre due to the specific circumstance when doctor and nurse are on assignment outside.
2. **Low engagement**
   Not mentioned.
3. **Poor allocation of staff or tasks**
   a. Higher workload for some personnel.
      i. Doctor often has outside assignments, on top of the technical and administrative work inside.
      ii. Formally trained personnel are likely to have more responsibility than non-trained/peer-trained ones. This is especially true for pharmacist and lab analyst.
4. **Inefficient work processes**
   a. Process of data collection, recording and updating is not efficient
      i. Data from mobile testing is not timely obtained from the other unit.
      ii. Several types of reporting need to be inputted to SIHA.
5. **Other health system issues**
   a. **Poor infrastructure**
      i. Lack of dedicated space/room for counseling, true to the VCT/STI services clinic, MCH and Pharmacy
   b. **Inadequate supplies / equipment**
      Not mentioned.
   c. **Low client demand**
      Not mentioned.

Annex R-03. Puskesmas Kecamatan C

FOCUS GROUP DISCUSSION NOTES

PUSKESMAS KECAMATAN C

Date & Time	Tuesday, July 17th, 2018; 14:00 – 15.45
Participants	HIV Core team of Puskesmas • Doctor (Coordinator of HIV service unit) • Midwife • Nurse • Lab technician • Coordinator of registration desk

A. SUMMARY OF DISCUSSION

- Patients began to make use of services at the **registration desk**. Patient, then, did an examination and counselling in **HIV policlinic**. From policlinic, patient would be given a prescription to be handed over to **the pharmacy**
    - If there was an emergency –where the patients' condition dropped, patient would be directly taken to the doctor in the HIV Policlinic. While, cadre and patient's family would administer the registration.
    - For patients who were pregnant, after registration, patient would be referred to Mother and Children's Health (MCH) Policlinic for routine examination. Then, patients would have consultation with doctors in the HIV Policlinic. Afterwards, patients would obtain services according to the doctor
    - If there was an indication of TB, patient would be referred to the TB policlinic. Afterwards, they were back to HIV Policlinic, doctor would give a prescription and clients went off to the pharmacy
- The team does not use the term 'stable' patients/clients, and there is no differentiation of categories for patients recorded in ART refill. As mentioned in the previous section, they differentiate clients based on 6 months' cut-off period, where clients in refill category under 6 months will be monitored with further lab tests and refill clients above 6 months will usually go to the pharmacy upon completing service at the HIV policlinic

- According to the coordinator of the HIV policlinic, Puskesmas C complied the flow of the national standard as the Puskesmas was accredited.

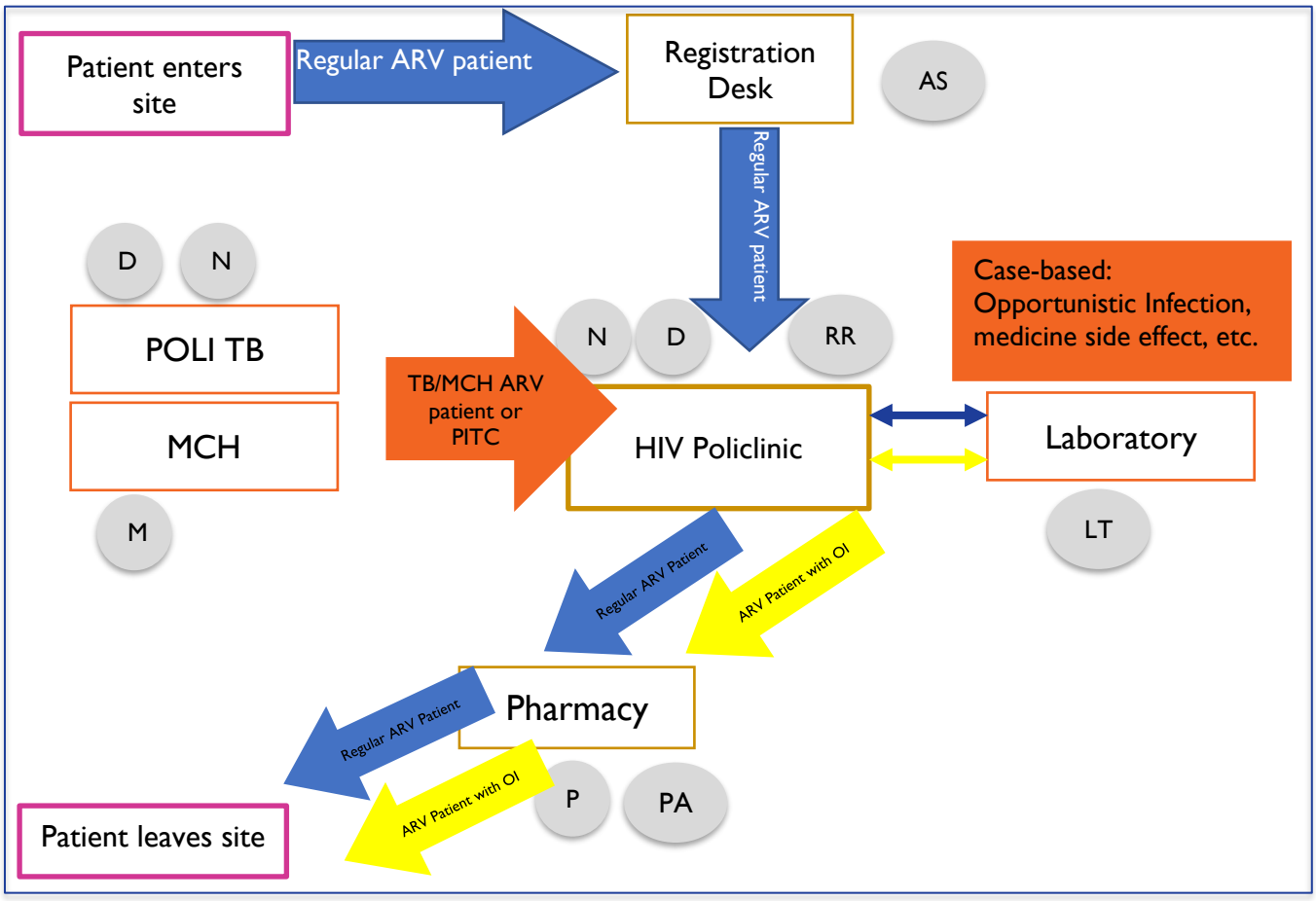


Figure 3. Flow of ART Refill Service in Puskesmas Kecamatan C

B. Actor Involved at Each Point & Impediments Experienced

Health Staff Involved At Each Point & Impediments Experienced

Having identified the client flow, the discussion identified actors involved at each service point and the impediments they experience. The discussion mainly covered daily work experience of the HIV team and their relationship with staff outside HIV policlinic whose tasks linked to the process of acquiring ART refill or the general HIV services which may impact the refill service provided.

This section covers actors involved and impediments experienced by them at each service point, while categorization of impediments is covered in the next section.

- **Registration desk - Admin Staff (Non-HIV Core team)**
- **HIV Policlinic**
  - Doctor (D)
    - HIV service doctors are coordinators of the HIV service unit, and are the only doctors in the unit. Therefore, doctors often carry out external services such as meetings representing the heads of Puskesmas, especially those related to HIV, PTRM and STI issues. There is no substitute doctor when an HIV service doctor does an outside assignment, and the tasks such as counseling and prescribing are delegated to the nurse.
  - Nurse (N)

        - Puskesmas C has one nurse for HIV program. So that the nurse must be mobile in ensuring service to the patient, for example delivering the patient to the lab, or to the pharmacy. Sometimes this mobile task is assisted by RR officials.
    - RR (RR) - PTRM admin (PA)
        - Recording and reporting officer are come from Young Cadre (at beginning). But now, the cadre act as an honor staff and budgeted from by BLUD. He also managed the Methadone services.
- **Laboratory - Lab analyst/technician (LT)**
    - HIV team felt that the number of Lab technician in Puskesmas C was less than other Puskesmas. According Lab technician, ideally there was 5 – 6 Lab technicians for each Puskesmas, but Puskesmas C only has 3 Lab Technicians.
- **Pharmacy - Pharmacist (P)/ Pharmacist assistant (PA)**
    - Pharmacy officers have received HIV training. However, according to the HIV team, pharmacists rarely counsel patients, even when there is a color change in HIV drugs the patient is not notified so the patient must return to the HIV policlinic to ask..
- **TB Policlinic (Poli TB) - Doctor (D) and Nurse (N) (Non-HIV Core team)**
    - Officers at the TB Policlinic consist of 2 officers. But according to the Nurse, they have problems in the division of tasks. When Nurse A is absent, Nurse B is not willing to do HIV screening for TB patients. So, so far screening is only delivered by one Nurse.
- **Mother and Children Health (MCH) - Midwife (M)**
    - There is one midwife involved in HIV services (PMTCT). The midwife is not an HIV core team but is trained to do PMTCT

C. Categorization of Impediments

Having identified impediments at each service point, the discussion carried on with categorizing them and, whenever possible, endeavored to dig deeper on the root cause. Root cause identification by the operating team is not always possible to do, as they would perceive some impediments as a consequence of a given standard or regulation 'from above' (the Puskesmas management or the higher-level government). For such cases, the discussion would focus more on elaborating working context or impeding working environment. The summary of problem mapping/categorization is below:

1. **Inefficient work processes**

- Status of patient was at the HIV Policlinic
    - According to the HIV coordinator, patient status should have been kept at the registration desk. Based on the information from the registration admin staff, patient status was kept in HIV Policlinic due to lack of storage room to keep the document of patient status
- No clear segregation of the patient code of PTRM, IMS, and HIV at the registration desk
    - HIV policlinic was merged with PTRM Policlinic under the HIV Policlinic. According HIV team, there should have been 3 policlinics which were IMS Policlinic, HIV Policlinic, and PTRM Policlinic. All this time, the coding of the patients was coalesced under the code of PTRM Policlinic. Hence, it perplexed the staff in HIV policlinic –whether the patient was supposed to be HIV/PTRM/IMS patient, and there was no segregation of queue number
- Number of HIV patient status was different with the general patient number
    - HIV patient followed the registration number of SIHA, but not yet following the standard of medical record in the Puskesmas. According to the regulation, the numbering of this status should have been from one point. However, according to the HIV coordinator, the segregation of this status eased the HIV team while searching for the status of HIV patients

        - But when asked whether it is an obstacle or even facilitates the process of finding status when the patient arrives, according to the HIV coordinator it actually makes it easier for the HIV team to look for patient status so that the patient does not wait too long
- IMS Policlinic did not have clear technical and system
    - In IMS Policlinic, there was no clear technical and system. It was not clear who the staffs were, how reporting would be like, the one who was responsible for, the room, and there was no letter of assignment to manage IMS.

2. Poor allocation of staff or tasks

- No clear division of roles and services among PTRM, IMS, and HIV
    - There were plenty of new staff but many of them who were not confident of receiving responsibility to manage IMS because they were not trained
    - According to HIV coordinator, it was not supposed to be an issue if PTRM, IMS, and HIV was unified, as long as the staff support was also sufficient. What happened was all work was imposed on HIV team. As a result, sometimes, IMS service was undergone by one nurse. On the other hand, this work often added with other tasks, e.g. meeting, assisting other policlinics, etc.
- Specifically, there was no staff who was responsible for the IMS policlinic
    - In the old Puskesmas building, the HIV and IMS rooms were separated with its own counselling room. But, it was not clear who was responsible for managing the IMS policlinic and there was no letter of assignment from the management. According to HIV coordinator, the Management of Puskesmas C (Head of Puskesmas) only recognized the PTRM Policlinic and not yet aware of the existence of HIV and IMS Policlinic, while those three policlinics should have been differentiated. This issued had been raised to the management but they did not seem to followed up
- Limited number of counsellors in HIV Policlinic
    - There was 1 counsellor (doctor). So, when the doctor was absence, there was no counselling session conducted. According to the HIV coordinator, ideally there were 2 counsellors
- No back-up staff during the absence of HIV Policlinic staff
    - The number of staffs in HIV Policlinic was limited, including the doctor who was responsible for the policlinic. So, when the staff was absence, it was difficult for the team to search for replacement
- Lack of lab technician at the laboratory
        - Lab analyst felt overwhelmed with the load of work in the lab due to the lack of staff. There were only 3 laboratory analysts but on the other hand, there were many of patients who tested every day. For HIV test, there were about 150 up to 200 patients per month. For general chemical test, analyst worked on 150 tests per day, not including urine test, blood test, etc. The number of patients who took the test would significantly increase if the Puskesmas conducted *Mobile Testing*
- HIV team had been repeatedly discussed their constraints to the management. HIV team had been spoken out their policlinic's need. However, there was never been a positive response from the leader of the Puskesmas. The leader once argued that other policlinics needed more support than HIV policlinic
    - HIV team also discussed with other health staff at the Puskesmas, e.g. about counselling, medication, or registration to overcome issue. But, according to the HIV team, these issues would be overcome only if the management system at the Puskesmas was improved
    - According to HIV team, the **root of problem** was on the leader or the management of Puskesmas who were not responsive to the suggestion of the HIV team

- HIV team requested SOLIDARITAS to discuss these findings with the leader with an expectation that if other people who conveyed these findings –which were their aspiration, the leader would listen to them and took actions

3. Low engagement

- Sometimes, staff who had been trained TB-HIV did not examine TB-HIV patient
  - According to the nurse from TB Policlinic, in TB Policlinic there were 2 nurses, including himself (Staff 1). The other TB nurse (Staff 2) seemed to be sluggish to do an HIV screening to the TB patient if staff 1 was absence. Staff 1 was hesitant to remind the staff 2 regarding this issue or even to communicate via WA.
- Medication consultation was not conducted at the pharmacy, but at the HIV policlinic
  - At the pharmacy, there was a staff/pharmacist who had been trained to provide the medication consultation. But, she was reluctant to do so. It seemed to be related to her motivation. But it was not clear why.
    - HIV team exemplified where a patient did not appear to know the brand/type of ARV which had been replaced. Patient had just been aware that his ARV was not the same with the previous one. Patient came back to the Puskesmas and consulted to the doctor at the HIV policlinic. HIV team was eventually aware of the 'fact' that the pharmacist did not inform the change of the new brand/type of ARV to the patient

4. Health worker competency gaps

D. Not mentioned

5. Other health system issue categories

- Reagent stock was expired on August 2018. There were lots of reagent and most of them would be expired on August 2018.
  - There was no information related to the schedule of reagent delivery and the total number of stocks from SUDIN. Puskesmas solely waited for the delivery from the Kemenkes through PHO and SUDIN
  - According to the government regulation, procurement of reagent stock could not be done by Puskesmas (In Jakarta context, the PHO managed the procurement of reagent based on the proposal of Puskesmas which was coordinated by SUDIN)
- Legal basis for providing HIV and IMS lab test result for the patients
  - Lab technician found that the practice of handing over the lab test results was varied in every Puskesmas in DKI Jakarta. Where the regulation forbade the patient from directly receiving their lab test result, one or two Puskesmas did this practice. But other Puskesmas technician directly handed over the lab result to the doctor so the doctor could explain and handed over the result to the patient. These differences confused Puskesmas C's Lab technician and scared her of making mistakes in the procedure of giving the paper
    - This condition was not a constraint for Puskesmas, but it was assumed to be precarious if the regulation forbade the Puskesmas to hand over the lab test result.
- Related to the Governor Regulation about pre-marital health test,
  - Mdwife suggested that HIV test for bride and groom should be free of charge. Some cases were found by Puskesmas C where bride/groom was willing to take HIV test but they cancelled it because they had to pay for the test. Puskesmas C regretted if bride/groom must pay for HIV test whereas the HIV test itself was free and reagent was plenty. On the other hand, Puskesmas also found some cases where the bride/groom was HIV positive both before and even after marriage. According to the HIV team, if HIV test could be free of charge, it might espouse prevention of the HIV transmission

Annex R-04. Puskesmas Kecamatan D

FOCUS GROUP DISCUSSION NOTES

PUSKESMAS KECAMATAN D

Date & Time	Wednesday, 18 July 2018
Participants	HIV/STI Policlinic's team: 2 doctors, nurse, RR, 2 lab analysts, pharmacist

A. SUMMARY OF DISCUSSION

- HIV+ clients access the ART refill service starting from the registration desk to get a queueing number and get called based on the number coded for a specific unit/policlinic.
- After being called, clients carry on to the HIV/STI policlinic on the 3rd floor, where 2 doctors, 1 nurse and 1 RR are stationed.
- Since April 2018, the HIV/STI policlinic recruits a new doctor to be trained as the HIV/STI policlinic coordinator by the current doctor who will soon leave the puskesmas. While the coordinator-in-training has a good understanding about the job's technical aspects, the broader perspective about the HIV/STI services including its historical context is gathered more from the soon-to-leave doctor.
- Upon accessing service at the HIV/STI policlinic, refill patients will either:
    - Go straight to the pharmacy for ART refill dispense, or
    - Access the laboratory on a case-by-case basis for a lab test. Examples of cases involving laboratory for refill patients are as follow:
        - Refill patients under 6 months in ART will be monitored with CD4 test once a month and other lab tests, such as hemoglobin or STI test, if there is an indication of need (shown with the blue arrow in Figure 1).
        - The HIV/STI services team recognizes the term 'stable clients' and refers it to the ones who have taken a VL test (indicated by the yellow arrow in Figure 1). VL test is run once a year for each stable patient.
- Both CD4 and VL tests are done at the hospital level with a referral from puskesmas, as the puskesmas cannot yet conduct them in-house.
    - CD4 actual cost is around IDR 265,000 (USD 18), while VL actual cost is approximately IDR 450,000 (USD 31)[1]. These costs are currently borne by the puskesmas fund, so it is free for the patients.
    - The only difference between patients covered by BPJS (the national insurance scheme) and the ones not having BPJS is a registration fee of IDR 5,000 (USD 0.35) to be paid by the latter. This fee is settled at the registration desk before accessing any service in the puskesmas.
- Midwife involvement happens when there is a patient at the MCH is sent for a PITC lab test. Midwife was not part of the FGD, so when discussing about actors involved at each service point (in the next section), midwife's experience was explored from the HIV/STI services team viewpoint.
- The pharmacy is the last service point accessed to obtain the ART refill.

The client flow discussed is visualized in Figure 1 below, where blue arrows exhibit the flow for ART refill clients under 6 months in the program and yellow arrows exhibit the flow for ART refill clients above 6 months in the program. Orange arrows exhibit patients' flow from screening points:

[1] With exchange rate IDR 14,500 per USD.

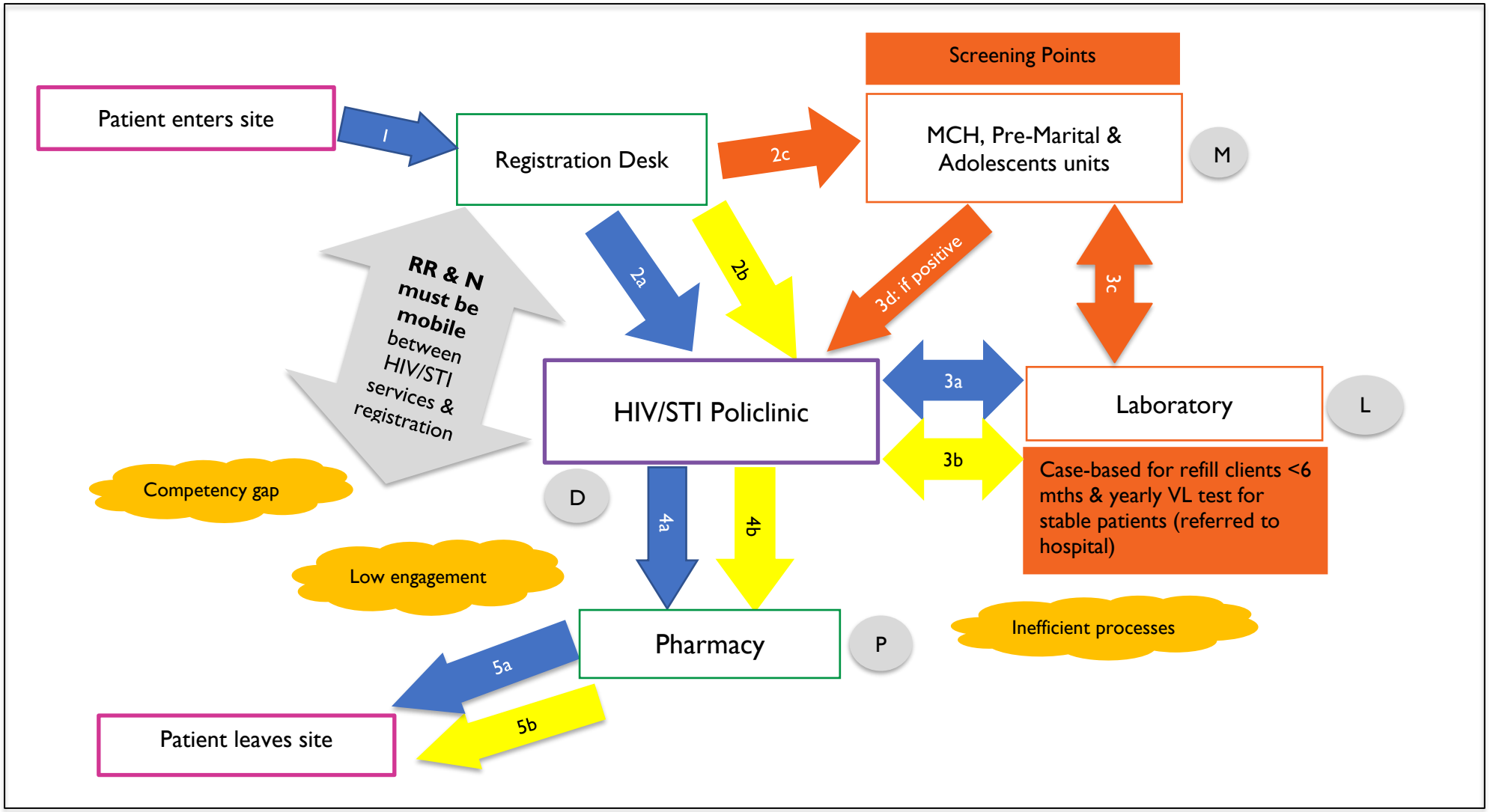


Figure 4. Flow of ART Refill Service in Puskesmas Kecamatan D

B. Actors Involved at Each Point & Impediments Experienced

Having identified the client flow, the discussion identified actors involved at each service point and the impediments they experience. The discussion mainly covered daily work experience of the HIV/STI services team and their relationship with staff outside the HIV/STI policlinic and the puskesmas whose responsibilities linked to the process of acquiring ART refill or the general HIV services which may impact the refill service provided.

As mentioned in the previous section, the team recognizes 'stable patients' as ones who have taken a VL test which is supposed to be a yearly test. Currently it is still done as a referral test in a hospital, like the CD4 test.

This section covers actors involved and cause of consequential impediments at each service point, while categorization of impediments is covered in the next section.

- **Registration Desk** – Admin staff (non-core HIV team)
    - Admin staff at registration desk is responsible for distribution of patients' MR (medical record) to the relevant unit they need to access. But, it often takes a long time before MRs get to the HIV/STI policlinic
    - The delay in getting patients' MR requires both the HIV/STI policlinic RR and nurse to be 'mobile', going back and forth to the registration desk to get the MRs themselves.
- **HIV/STI policlinic**
    - Core HIV team stationed at the HIV/STI policlinic:
        - Doctor (D) = 2, the soon-to-leave doctor is in the process of handing over responsibility as the HIV/STI policlinic coordinator to the newly recruited doctor. The actual resignation time is not clear as s/he is unwilling to share even after a few times probing by the facilitators.
        - Counseling is considered a doctor's task in the HIV/STI policlinic. There have been two other doctors and a midwife trained as counsellors, but they are assigned in different units. It is useful to have more trained counselors within the HIV/STI policlinic to anticipate future needs.
        - Nurse (N) = 1, this staff particularly focuses on dealing with examination and recording of patients with STIs. S/he must go back and forth to the registration desk to get STI-patients' MR.
        - RR = 1, this staff focuses on dealing with HIV patients' recording and reporting. S/he also go back and forth to the registration desk to get HIV-patients' MR.
    - The HIV/STI services team is in a unique situation where their long-time request (since 2016) for a nurse/paramedic to support their work has just been granted in last January. This makes everyone in the team feels there are less problems, particularly since task differentiation is now able to do, with:
        - The nurse can back doctors in doing pre-anamnesis examination for STI patients and completing their status recording post-service.
        - The RR backs doctor in planning, recording and reporting of HIV data.
    - ARV adherence counseling is done more intensively at the HIV/STI policlinic first, so that once at the pharmacy counseling will function more as a quick reminder/reinforcement (read Pharmacy section for its impediment relating to this.)
    - It is for the new clients that counseling takes longer, about ½ - 1 hour per client. VCT clients will usually need more counseling at pre-testing, while PITC ones will only be counseled post-testing when found reactive/positive.
    - No dedicated space/room for conducting counseling remains a feature to improve. But the HIV/STI policlinic's circumstance is better than the pharmacy's, since the HIV/STI policlinic only focuses on STIs and HIV patients while pharmacy convenes patients coming from all the different service units.

- Currently, there are around 110 refill patients (including stable ones) and approximately 200 STI patients.
- The monthly target set for testing is 1,000 tests and this is rarely achieved, even though mobile testing for STIs is scheduled once a month and for HIV three times a month.
- The HIV/STI policlinic's relationship with CSOs and, seemingly more significant, the businesses where the key populations work is a perceived cause of this underachieved target.
    - The HIV/STI policlinic's key populations are female sex workers (FSW) and men having sex with men (MSM), each having distinct natures. It is easier to track FSWs once they are in ART-initiation since most of them rent rooms near their workplace, but they tend not to do VCT, so outreach and PITC is key. While, it is easier to expect VCT from MSMs, but since they tend to be 'nomadic' they are difficult to track. The HIV/STi policlinic's experience shows that the percentage of HIV+ found in tested MSMs is higher than in tested FSWs.
    - There are approximately 62 entertainment places and/or massage parlors in the surrounding to target the above key populations, but only about 10% (6-8 places) can be accessed by the HIV/STI policlinic's mobile testing because "the CSOs we partner with still cannot bring us in".
    - There were relationships built with non-targeted workplaces/businesses, like a gas company, the kecamatan and kelurahan offices for mobile testing but were marginal in helping to achieve target.
    - What is seen effective so far is when there is an esteemed individual linked to or directly from the targeted business/workplace who can approach the owner to open up and engage with the HIV/STI policlinic. An independent HIV expert is mentioned to bring this kind of effectiveness. As well as some medics working in the establishments to care for the key populations.
    - On average, the medics working at entertainment places, having their own way and freedom to practice, are the toughest to collaborate. The HIV/STI policlinic has tried to maneuver this by negotiating if these medics can share data of key populations under their care to the HIV/STI policlinic, even if the HIV/STI policlinic can't do testing to them. But there seems to be a high level of privacy the medics prefer to uphold.
    - This challenge is not unknown by the District Health Office.
    - The HIV/STI services doctor wonders if there is a regulation which can bind the inter-sectoral relationship between puskesmas and the private businesses to help secure key population testing coverage.
- Based on the above challenges in meeting the testing target, if they are improved, there is an anticipation that the HIV/STI policlinic will lack of trained personnel to handle a sufficient increase in patient's volume.

- **Laboratory**
    - Lab analyst (LA) = 2, these staff are the only two trained pharmacists amongst six working in Puskesmas D.
    - Mobile testing always involves either of them and the high workload is felt after, since:
        - Mobile testing is conducted outside the formal working hours, which can include weekends.
        - After such time/day, they will need to perform their formal working hours' duty without having 'time in lieu' to replace their time spent for mobile testing.
- **MCH**
    - Midwife (M) was not part of the FGD, hence, personnel data and dynamics at MCH was not explored. However, from HIV/STI services team it was shared that MCH does not share PMTCT data (both on mothers and babies) to the HIV/STI services team.
- **Pharmacy**

- Pharmacist (P) = 1, while this staff is stationed at the pharmacy, s/he is considered part of the HIV/STI policlinic as the only who has been trained on HIV. The other 3 pharmacists have not been trained.
- No dedicated space/room for conducting the ARV adherence counseling, while such counseling needs some privacy. Patients, coming from the other units, queue for their medicines too, so can easily listen to the counseling. Therefore, the HIV/STI policlinic handles most of the counseling first before patients go to the pharmacy.
- No dedicated room/space for ARV storage.

C. Categorization of Impediments

Having identified impediments at each service point, the discussion carried on with categorizing them and, whenever possible, endeavored to dig deeper on the root cause. Root cause identification by the operating team is not always possible to do, as they would perceive some impediments as a consequence of a given standard or regulation 'from above' (the Puskesmas management or the higher-level government). For such cases, the discussion would focus more on elaborating working context or impeding working environment. The summary of problem mapping/categorization is below:

6. **Health worker competency gaps**
   a. Lack of trained personnel, in anticipation of a higher client volume, as experienced by counsellors, lab analysts and pharmacists.
7. **Low engagement**
   a. Difficult to reach the HIV/STI policlinic's testing target due to:
      i. Relationship with CSOs and relevant decision makers in the private sector where key populations can be found.
      ii. Workplaces with non-targeted key populations which are open to testing contribute marginally to target achievement.
      iii. Health professionals in the private sector working to care for key populations have different priorities and incentives to uphold privacy (of their work and clients e.g. owners of entertainment clubs, massage parlors).
      iv. No binding inter-sectoral regulation to overcome the above testing challenges.
8. **Poor allocation of staff or tasks**
   Not mentioned.
9. **Inefficient work processes**
   a. Patients' data (MRs) from other units are not timely communicated to the HIV/STI policlinic, as happened with data from the registration desk and at MCH.
10. **Other health system issues**
    a. **Poor infrastructure**
       i. No dedicated space/room for counseling to respect privacy of HIV clients, as experienced by the HIV/STI policlinic and pharmacy.
    b. **Inadequate supplies / equipment**
       Not mentioned.
    c. **Low client demand**
       Not mentioned.

Annex R-05. Puskesmas Kecamatan E

FOCUS GROUP DISCUSSION NOTES

PUSKESMAS KECAMATAN E

Date & Time	Friday, 20 July 2018
Participants	VCT/STI services team: doctor, nurse, lab analyst, pharmacist, RR

A. SUMMARY OF DISCUSSION

- HIV+ clients access the ART refill service starting from the Registration Desk on the first floor to take a queueing number. The numbering is coded according to three units/service points: General Service, MCH Service, Dental Service. The VCT/STI policlinic is classified under the General Service.
- Based on the queueing number patients carry on to the VCT/STI policlinic on the 4th floor, the only service point on the top floor of the puskesmas, separate from the other units.
- Puskesmas does not recognize the term 'stable' patients/clients as there is no differentiation in categories for patients recorded in ART refill.
- On a case-by-case basis, refill patients would need to access lab tests, particularly for self-report cases like STIs or medicinal side-effects, as well as VL test (for 6th month and consecutive every 12th month refill period) and CD4 test. The previous two tests are done in the laboratory on the 2nd floor, the latter two are done as a referral to the hospital. So far patients bear no costs for these tests, whether they have BPJS (national insurance coverage) or not. The non-BPJS holders are covered with the puskesmas' HIV program budget.
- Screening points for HIV testing were identified in the discussion, comprising MCH, Labor & Delivery, TB, General Service and ER. Although these services are not directly related with the ART refill service, their role as screening points is identified as carrying an immediate impediment potential in the supply of reagents and, thus, the budgeting for the VCT/STI policlinic overall which includes ART refill budget. More on this will be elaborated in section B when discussing the VCT/STI policlinic's actors and impediments.
- The pharmacy is the last service point accessed to obtain the ART refill and located on the 2nd floor.

The client flow discussed is visualized in Figure 1 below where blue arrows exhibit the main flow for ART refill client and orange arrows exhibit the case-by-case flow to the lab and from screening points:

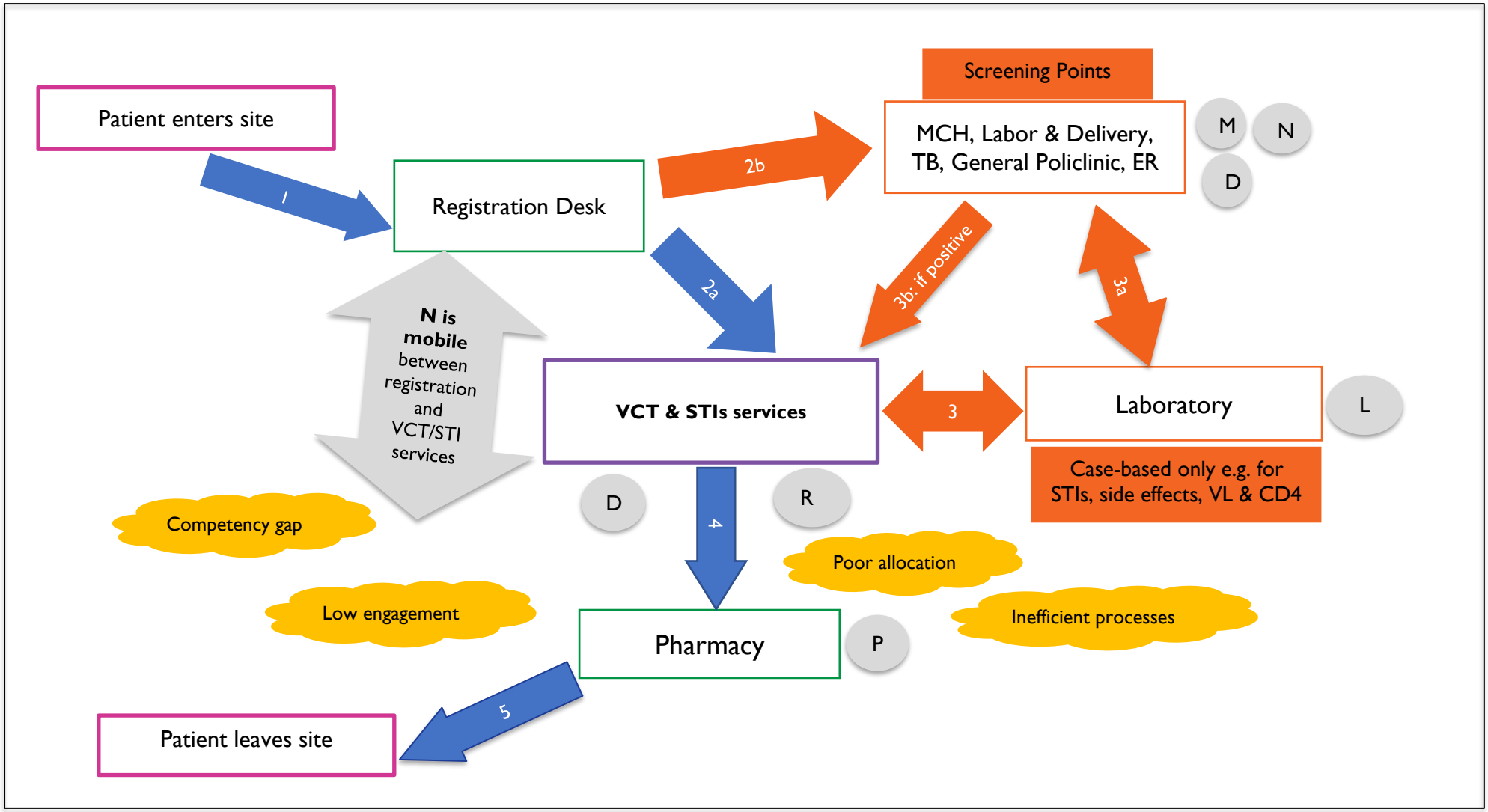


Figure 5. Flow of ART Refill Service in Puskesmas Kecamatan E

B. Actors Involved at Each Point & Impediments Experienced

Having identified the client flow, the discussion identified actors involved at each service point and the impediments they experience. The discussion mainly covered daily work experience of the VCT/STI services team and their relationship with staff outside the VCT/STI policlinic whose tasks linked to the process of acquiring ART refill or the general HIV services which may impact the refill service provided.

As previously mentioned, the VCT/STI policlinic does not recognize the term 'stable' patients/clients as there is no differentiation in categories for patients recorded in ART refill. Clients reaching 6 months' period in refill program will be asked to do VL test, with consecutive VL test every 12th month. Clients in refill category under 6 months will have a monthly CD4 test. Both tests are done with a referral from the VCT/STI policlinic to the hospital.

This section covers actors involved and cause of consequential impediments at each service point, while categorization of impediments is covered in the next section.

- **Registration Desk** – Admin staff (non-core HIV team)
- With patient volume reaching its highest 8a.m.–2p.m. period, there is usually a long queue at the registration. For the General Policlinic alone, there are approximately 300-400 patients daily to handle, the number highly increases when including Geriatry, MCH etc.
- Patients wanting to access the different units in the puskesmas will be 'channeled' accordingly from here. So, ART refill patients will have to wait to be channeled with other patients queuing for other services, even though there may not be a long queue in the VCT/STI policlinic which provides the ART refill itself.
    - The same coding used for the VCT/STI policlinic and General Service/Policlinic makes the queue worse for the refill patients. Doctor at the VCT/STI policlinic says, "I am already here (at the VCT/STI policlinic) since 7:30 a.m. every day, but sometimes it is not until 10 a.m. that my first patient can reach me, as they are stuck downstairs waiting with patients of the General Poli. Both of us have wasted time."
- Due to the high patient volume here, it takes a long time for a patient's medical record (MR) to be delivered to the relevant unit. This situation requires the VCT/STI policlinic's nurse to go fetch the MRs to bring to the VCT/STI policlinic for a timely process.
- **VCT/STI Policlinic:**
- Core HIV team stationed at the VCT/STI policlinic:
    - Doctor (D) = 1
    - Nurse (N) = 1
    - RR = 1
- There are 177 refill patients considered 'active' (trackable and routinely coming to refill) from a cumulative total of 260 which includes 'loss to follow-up' and deceased ones.
    - Number of HIV clients daily = 15-20, where 10-15 are refill ones.
- All the three functions stationed at the VCT/STI policlinic feel that there is a lack of personnel in their team, particularly to backstop whenever:
    - There is mobile service/visit which is done twice a week, each starts from 1:30p.m. about 2-3 hours working effectively but can include a total of 4-5 hours with travel time (reach of the kecamatan area is quite far). It always requires a full team in conducting mobile service: doctor, nurse, RR, lab analyst, pharmacist.
    - Inputting patients' data monthly into the SIHA & ENA which is done by 1 RR and can be overwhelming.
    - Doctor and/or nurse are on assignment outside or on leave. This will affect recording of patients' *ikhtisar* (HIV MR) supposedly done by the nurse, and counseling supposedly done by doctor.
    - Also, the nurse has to go back and forth to the registration desk on the 1st floor to get patients' general MR.

- There is a need to input data to the ENA system (the puskesmas information system) with another computer, separate from SIHA. But the dedicated computer for this has long been broken, a request for replacement has been launched to the management and remains to await for effective response.
- The dedicated room for conducting counseling next door to the VCT/STI policlinic lacks the standard facility/equipment as provided in the other units, e.g fan/air conditioner, TV, chairs, so when patients queueing for their counseling turn, they sit on the floor and sometimes feel hot. It sends a message that they are less respected than patients in the other units.
- Linked to the less respect felt, the team also feels the same treatment towards themselves as the operator of the HIV service.
    - The upper management seems to underestimate the team's workload, by comparing it with the General Policlinic's workload which has a different context.
    - Requests for improvement sent to the upper management seem to take a long time to follow up. This situation applies even for as basic a need as universal protection device/PEP. Doctor says, "I have been requesting for at least one goggle to be on standby for the team here, but there is no response until now."
- A 50% adherence rate is seen as something to be improved.
- An additional note for context: the VCT/STI policlinic mostly serves FSW and MSM as key population, but there seems to be a higher HIV+ incidence amongst housewives in the past year. Puskesmas E is very close to a sex localization area before it was closed by the Governor's decree in 2016. The team notices that after the area's closure, the sex service seems to spread more into the residential area, narrowing the boundary between sex customers – more likely husbands – and sex workers.
- **Laboratory**
- Lab analyst (LA) = 1, this staff is amongst four analysts available for the morning to afternoon shift at the Puskesmas E. A total of seven analysts are employed with three assigned only for the 24-hour shift which is separate from the main daytime period. Lead analyst sees that four is already a sufficient number to serve the current laboratory need.
- The stock of reagents is increasingly worrying due to inter-unit programs linked to HIV screening and testing.
    - There is an enormous lack of awareness on the need to have an interlinked/collaborative planning between different program holders within the Puskesmas. These programs will impact the stocking of reagents and other HIV test-related budgeting which cannot be covered only by the VCT/STI policlinic budget. (More on the collaborative programs when elaborating Screening Points)
- As mentioned in Section A, lab tests are free of charge for the patients due to the coverage by BPJS or the puskesmas collaborative HIV programs. However, the budget for VL and CD4 test is still not distributed to/received by the VCT/STI policlinic for months. These two are referral tests which puskesmas needs to pay to the hospital.
    - From HIV pilot project in Jakarta, Puskesmas E has received a VL test machine. But it is not used yet due to not having the material to do VL testing in-house.
- Long queue at the registration desk is experienced once again here by the HIV patients. Sometimes they must come back another day since the lab has reached a maximum quota of the day.
    - However, the quota is based on the number of patients only, without any regard to where they come from. This is not fair, as the overall number will be dominated by patients from General Policlinic.
    - To soften the 'rejection' when a daily quota is reached, HIV patients are asked to "fast for your lab test, then come back tomorrow." When the patient reports back to the VCT/STi policlinic, the team knows that the required lab test does not need prior fasting. This sometimes creates silent tension between the two service points.
- **Screening Points – MCH, Labor & Delivery, TB, General Service, ER**
- There are few programs related to HIV prevention, screening and testing that are done collaboratively or interlinking with the other units. There are among others brides & grooms to-be, First 1,000 Days,

pregnant mothers, and TB where midwives (M) are involved. But no midwives were present in the FGD due to a meeting they were having at the same time.

- These interlinked programs are still performed separately, particularly in terms of budgeting. There are no meetings designed by the management to involve relevant program holders/budget owners to allow shared perspective/understanding in planning and implementing the programs.
- **Pharmacy**
- Pharmacist (P) = 1, this staff is among two of trained pharmacist in the puskesmas. A total of three pharmacists are employed.
- The two will take turn in performing HIV service, but when they both are not available somehow – e.g. one is on leave while the other is conducting mobile service – there is no backstopping for dispensing ARV.
- No dedicated space/room to conduct the ARV adherence counseling.
- ARV stock comes in a tight supply, and sometimes there is a delay for ARV restock to arrive. Hence, lab can experience empty ARV stock at times.

C. Categorization of Impediments

Having identified impediments at each service point, the discussion carried on with categorizing them and, whenever possible, endeavored to dig deeper on the root cause. Root cause identification by the operating team is not always possible to do, as they would perceive some impediments as a consequence of a given standard or regulation 'from above' (the Puskesmas management or the higher-level government). For such cases, the discussion would focus more on elaborating working context or impeding working environment. The summary of problem mapping/categorization is below:

11. Health worker competency gaps

Budgeting and planning competencies for the overall management – including service unit heads – which can affect future ARV supply/HIV testing programs.

12. Low engagement

a. Lack of common perspective, understanding and empathy on what HIV work entails across the puskesmas
   i. Lack of awareness and understanding to plan and budget interlinked/collaborative HIV programs, impacting stocking/supply of reagents and ARV.
   ii. Lack of effective response from the upper management to VCT/STI policlinic needs to safely operate in a high-risk environment without proper protection.
   iii. A general feel shared by the team about less of attention towards the team's personnel and less of respect towards the VCT/STI policlinic's patients. "Just look at where we are located, far up on the highest floor, as the only unit servicing patients (other rooms on the floor are allocated for meetings) with minimal mixing with other people."

13. Poor allocation of staff or tasks

a. Lack of personnel to backstop whenever the core team is not available/away, as experienced by doctor, nurse, RR, pharmacists.

14. Inefficient work processes

a. Long queue at the registration desk and again in the pharmacy is experienced by the HIV patients. Sometimes they must come back another day since the lab has reached a maximum quota of the day.

15. Other health system issues

a. Poor infrastructure
   i. Lack of necessary facilities in the VCT/STI policlinic: computer, chairs, AC/fan, TV in waiting room.
   ii. Dedicated room to ensure privacy in adherence counseling in the pharmacy.

b. Inadequate supplies / equipment
   i. ARV stock comes in a tight supply, and sometimes there is a delay for ARV restock to arrive. Hence, lab can experience empty ARV stock at times.

ii. Goggle set as universal protection device/PEP has long been requested but never procured.
iii. Dedicated computer for data input to ENA has long been broken.

c. Low client demand

Approximately 50% adherence, which the VCT/STI services team would like to improve but not yet able to do (challenges in 'loss to follow up' is beyond control).

Annex R-06. Puskesmas Kecamatan F

FOCUS GROUP DISCUSSION NOTES

PUSKESMAS KECAMATAN F

Date & Time	Tuesday, 24 July 2018
Participants	VCT/STI services team: 2 doctors, nurse, RR, lab analyst, pharmacist assistant, midwife

A. SUMMARY OF DISCUSSION

- Patients wishing to access health services at Puskesmas Kecamatan F will start from Information/Security Point to get a queueing number and, depending on the service unit they'd like to access, continue to Registration Desk either on the first (ground) floor – for HIV/STIs, MCH and Non-Communicable Diseases – or on the second floor – for General Policlinic, Integrated Toddler Service, Adolescent, TB, Dental, Nutrition, Ophthalmology, etc.
- From the Registration Desk on the first floor of the main building, HIV clients access the ART refill service go to the HIV/STIs service unit, in a separate building on the side of the main one.
- Puskesmas does not link the term 'stable' patients/clients specifically to ARV refill clients for differentiating 'long-timers' from new clients. The term is associated with clients under methadone therapy and refers more to mental state.
- On a case-by-case basis, refill clients would need to access lab tests, either for self-reported cases like STIs or medicinal side-effects, as well as provider-suggested tests like Hb, PT, AST/SGOT, ALT/SGPT, Urea, Creatinine, CD4 and VL tests. CD4 is usually done in the 6th month of a client's refill period, while VL is done every 12th month. Both are done in cooperation with a private laboratory, secured by an MoU.
- Screening points for HIV testing were identified in the discussion, comprising internal and external referral routes. The internal route comes from units like providing MCH, TB, Pre-Marital, Toddler, ER, General services. The external route comes from Puskemas at Kelurahan level, midwife private practices. These routes affect workload of the laboratory more than the VCT/STI unit which will be elaborated more in Section B.
- The pharmacy is the last service point accessed to obtain the ART refill and located on the 2nd floor.

The client flow discussed is visualized in Figure 1 below, where blue arrows exhibit the main flow for ART refill client and orange arrows exhibit the case-by-case flow to the lab and from screening points:

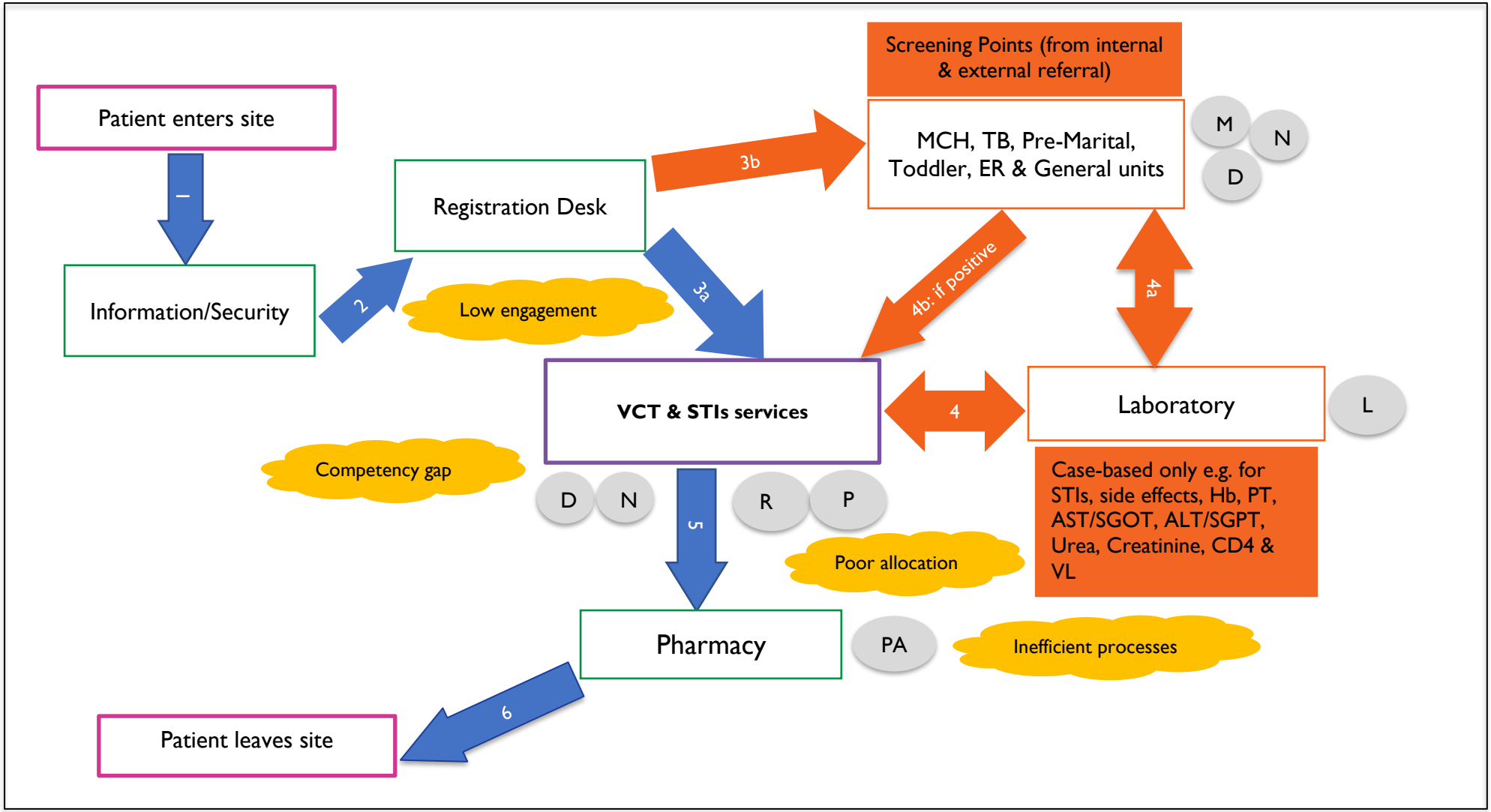


Figure 6. Flow of ART Refill Service in Puskesmas Kecamatan F

B. Actors Involved at Each Point & Impediments Experienced

Having identified the client flow, the discussion identified actors involved at each service point and the impediments they experience. The discussion mainly covered daily work experience of the VCT/STI services team and their relationship with staff outside the VCT/STI policlinic whose tasks linked to the process of acquiring ART refill or the general HIV services which may impact the refill service provided.

This section covers actors involved and cause of consequential impediments at each service point, while categorization of impediments is covered in the next section.

- **Registration Desk** – Admin staff (non-core HIV team)
    - By having two registration desks catering for separate grouping of service units, the queue for HIV refill patients is not seen as an issue.
    - The issue lies in how the VCT/STI policlinic manages clients'/patients' data from the registration desk, which is elaborated in the next sub-section.
- **VCT/STI policlinic**
    - Core HIV team stationed at VCT/STI policlinic:
        - Doctor (D) = 2, one is stationed at VCT/STI unit and deals with daily service provision at the frontline, one provides a more supervisory function from an upper-management level which oversees several frontline service units. The doctor stationed at the VCT/STI unit deals with ARV-related reporting to backstop the RR. This creates administrative load alongside clinical work.
        - Nurse (N) = 1, this staff is responsible for reporting on KOHORT, STIs and methadone treatment alongside the counseling work. S/he hasn't received formal training on CST. S/he also is the one to ensure the Quality Improvement and Patients' Safety reporting is fulfilled for quarterly M&E of puskesmas accreditation.
        - RR = 1, s/he experiences a high reporting load when having to input data by (patients') name into the SIHA. Data validation is done every three months, and this requires data to be manually re-inputted just like the first time.
        - 'Young-cadre'/peer-cadre (PC)= 1, this worker was first recruited to support communication in outreach, mobile service and home visits, particularly amongst the injection drug users. As an ex-Methadone Therapy patient, s/he is seen effective in that function. Recently, s/he has also been assigned to collect and recapitulate patients' individual data coming from the Registration desk. There has been repeated data loss or double recap ever since. S/he received a 4-day basic course on data administration with CAI (Computer-Assisted Instruction) as part of a pilot program grant for puskesmas.
    - With the averagely high load on reporting, alongside clinical in-house and mobile services, the team sees a challenge in staff allocation and wishes for a "second-layer" team to back the current team.
    - All together the 'static'/in-house services reach approximately 700 – 1,000 VCT, PITC and STIs clients monthly. This creates a high workload for all involved at the VCT/STI policlinic and the laboratory.
        - There are approximately 270 refill patients, about 15-20 daily.
        - Screening clients range approximately 40 – 70 daily, with the maximum number experienced was 120 a day.
        - The VCT/STI policlinic also provides STIs service to approximately 500 patients monthly (for both required visits, 1st day to conduct testing and 2nd day to read results).
    - Setting of the VCT/STI working space is not conducive, especially for counseling new clients where there is usually more privacy needed. Two desks are placed side by side in a room fits for four people without partitions/dividers.

- **Laboratory**
  - Lab analyst (LA) = 1, this staff is amongst a total of six analysts working in two shifts (four in daytime, two in the evening).
  - Dealing with approximately 220 – 250 patients daily (in daytime shift), the daily workload is high split between technical and reporting responsibilities. [Read more on testing time for pregnant mothers in the next sub-section]
  - With this high load, lab workers are prone to recording/writing errors as it is done manually. Handwritten results would entail spelling mistakes or are unclear to read, for which readers in the other units would ask for clarification. And it takes more to correct them.
  - The PMKP reporting for quarterly M&E in fulfilling puskesmas accreditation standard is delegated to one dedicated analyst.
  - Puskesmas owns a machine used for VL testing but VL's reagent cartridge has been out of stock since March that VL test needs to be done outside with a private laboratory secured by an MoU.
- **Screening Points –** MCH, TB, Pre-Marital, Toddler, ER & General units
  - The discussion was focused on the sharing of the MCH's midwife and not of the other units. There are 5 midwives, two of whom are assigned for HIV screening.
  - The MCH applies a 'One-Stop Service' which targets a maximum of 25 new clients/pregnant mothers to be tested.
    - This 'One-Stop Service' in practice means that the pregnant mothers do not only access an MCH service but a complete lab test which includes HIV testing (PITC).
    - Results of pregnant mothers' test need to be out in the afternoon at the latest, so they do not spend too long in the puskesmas being exposed to risks of viruses and diseases. This means, the laboratory has to prioritize working for this unit before other units. One sample/specimen takes about 8-10 minutes to analyze, which makes about 4,17 hours of lab work daily to be spent for MCH clients.
  - As a comparison, HIV screening and testing for TB patients are done in-house at the lung health clinic, so TB specimens are not sent to the lab and 'scramble' for daily slots at the lab.
- **Pharmacy**
  - Pharmacist assistant (PA) = 1, this staff amongst four pharmacist assistants in the puskesmas to support one pharmacist. This number is seen sufficient in the daily operation of pharmacy.
  - The occasional impediments experienced are related to drug dispense:
    - Incorrect dispense of drug
    - This usually caused by incomplete or unclear data filled into the SIKDA system by the other units.
  - While drug stocking is done quarterly, anticipating puskesmas future needs/clients' volume, there seems to be a tight supply for ARV's current buffer stock.

C. Categorization of Impediments

Having identified impediments at each service point, the discussion carried on with categorizing them and, whenever possible, endeavored to dig deeper on the root cause. Root cause identification by the operating team is not always possible to do, as they would perceive some impediments as a consequence of a given standard or regulation 'from above' (the Puskesmas management or the higher-level government). For such cases, the discussion would focus more on elaborating working context or impeding working environment. The summary of problem mapping/categorization is below:

1. **Health worker competency gaps**

a. True to the nurse who hasn't been formally trained in CST and the young cadre who is not used to dealing with data input/recording despite receiving a basic training for this.

2. **Low engagement**

a. There may be a mismatch in expecting young-cadre to be good at data input if in the beginning s/he was expected to focus on communicating with a specific key population.

3. **Poor allocation of staff or tasks**
   a. There are the right people on the jobs (except the young-cadre) but not enough in number, particularly at the VCT/STI policlinic and the lab.
   b. The required split of focus between technical/clinical responsibility and reporting/recording does not only increase workload but makes health workers prone to make mistakes in documenting/recording patients' data.
   c. For the VCT/STI services team, this split of focus in-house is further divided into caring for different categories of clients: VCT, newly tested and refill HIV clients as well as STI patients who altogether makes a monthly high volume.
   d. With PITC screening and testing on HIV, lab is especially inundated by specimens from multi-units.
4. **Inefficient work processes**
   a. Computerized system, like SIHA, seems to remain less efficient in the way it requires re-enter data just like the first time for routine validation process. RR says it is like "double inputting data" to the same platform.
   b. Handwritten process is prone to mistakes (in both writing and reading), taking more time to make essential corrections.
5. **Other health system issues**
   a. **Poor infrastructure**
      i. VCT/STI work space is not set up for private counseling, particularly for new clients.
   b. **Inadequate supplies / equipment**
      i. Unavailable VL reagent cartridge for months, while VL machine is ready to use.
   c. **Low client demand**

      N/A

Annex R-07. Puskesmas Kecamatan G

FOCUS GROUP DISCUSSION NOTES

PUSKESMAS KECAMATAN G

Date & Time	Wednesday, 25 July 2018
Participants	VCT/STI services team: nurse, RR, lab analyst, pharmacist, midwife

A. SUMMARY OF DISCUSSION

- HIV clients going for an ART refill start accessing the service from the Registration Desk on the first floor.
- From the Registration Desk, they go to the HIV/STIs service unit on the second floor.
- The VCT/STI unit provides refill service only on Wednesday each week when the doctor and nurse are on standby in the unit. Any other day of the doctor and nurse are stationed at the other units and if there are HIV-related patients coming to the VCT/STI unit on those days, they will have to wait until the doctor or nurse can free their time from the other units.
- On a case-by-case basis, refill clients would need to access lab tests on the 3rd floor, either for self-reported cases like STIs or medicinal side-effects, as well as provider-suggested tests like Hb, CD4 and VL tests. The last two are part of a routine monitoring check with cut-off period of 6th month and 12th month, involving cooperation with external parties (another puskesmas and a private laboratory). More on this will be elaborated in the relevant section below.
- Screening points for HIV testing were identified in the discussion, comprising MCH, TB, Pre-Marital and General services.
- The pharmacy is the last service point accessed to obtain the ART refill and located on the 3rd floor.

The client flow discussed is visualized in Figure 1 below, where blue arrows exhibit the main flow for ART refill client and orange arrows exhibit the case-by-case flow to the lab and from screening points:

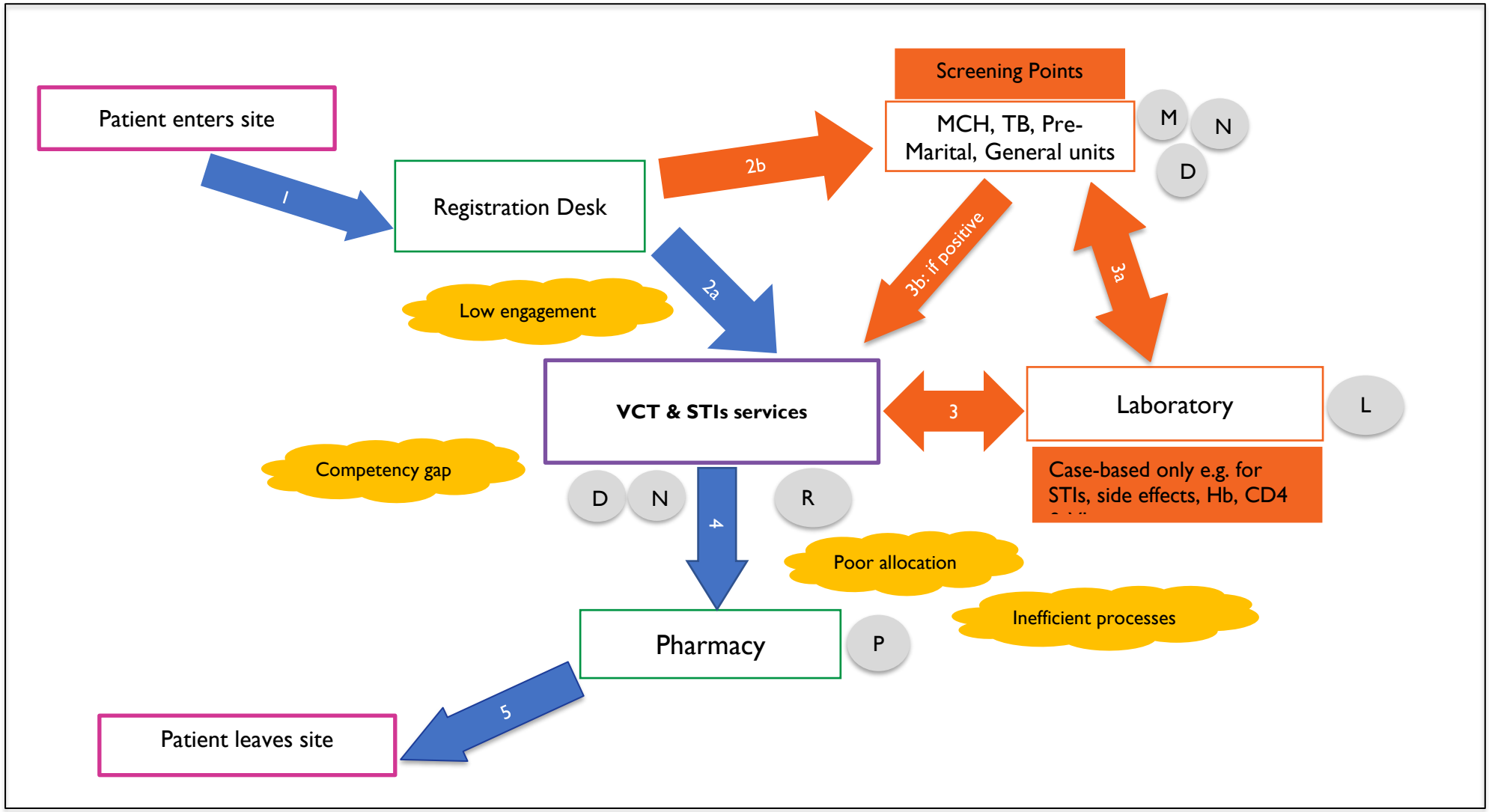


Figure 7. Flow of ART Refill Service in Puskesmas Kecamatan G

B. Actors Involved at Each Point & Impediments Experienced

Having identified the client flow, the discussion identified actors involved at each service point and the impediments they experience. The discussion mainly covered daily work experience of the VCT/STI services team and their relationship with staff outside the VCT/STI unit and/or the puskesmas whose tasks linked to the process of acquiring ART refill or the general HIV services which may impact the refill service provided.

This section covers actors involved and cause of consequential impediments at each service point, while categorization of impediments is covered in the next section.

- **Registration Desk** – Admin staff (non-core HIV team)
    - There is no separate coding for queuing number to different service units. This creates a long queue for ARV refill or HIV patients to go to the VCT/STI unit, even if at the VCT/STI unit itself there is no long queue.
- **VCT/STI unit**
    - Core HIV team stationed at the VCT/STI unit:
        - Nurse (N) = 1, this staff is the newest on board, about a year ago, and does not yet receive CST training. It was Wednesday when we held the FGD, the only day officially scheduled for ART refill service. So, s/he was often out to attend to the refill patients and did not really participate in the FGD.
        - RR = 1, s/he is the longest staff in the HIV service unit, started his/her career as a young cadre first, but still hasn't got the formal CST training.
        - Doctor (D), was not present in the FGD as on a 5-day CST training held by the MoH.
    - There are 81 refill patients on the list and while the RR said only 10% of them has poor adherence, the challenge for those who do is in tracking and keeping in contact with them.
    - The support with partner CSOs is seen as low, with only 1 CSO actively involved in following up with clients from 5 CSOs the puskesmas recognizes as partners in reaching key population.
    - Workload and difficulty to focus are seen as the obvious impediments.
        - RR who is the only one on standby every day deals with delays in completing records and reports whenever having to attend outside assignments.
        - Doctor and nurse are fully present in the VCT/STI unit only on Wednesday and are assigned in the other units on other days. The challenge is that not all patients can be scheduled to come on Wednesday. For PITC patients, for instance, once their test result shows reactive/positive status, the need to counsel will be borne by the VCT/STI services team and this can happen any day.
    - The room the VCT/STI unit uses for counseling is not conducive:
        - It is small and barely fits four people, while there were 6 of us cramped doing the FGD.
        - It is used as multi-function room where printer and other office equipment are kept and accessed by staff from the other units. Even during the FGD other people came in and out of the room, became quite a distraction. The RR said, "during counseling I have to lock the door, even then people still knock on the door trying to get in. The printer is just right there, so…"
    - Mobile service is done twice every three months.
        - In 2012, there used to be more routine mobile service done directly by the puskesmas team without any support from the CSOs.
        - In 2015, the regulation to partner with CSOs for mobile service was enforced and it has not been seen as productive as the one done independently before.
        - Just recently in 2018, the Sudin (the District Health Office) has updated that it is now become a choice for the puskesmas whether to partner with CSOs in conducting their mobile service. There is a sense of relief from the RR and midwife to learn about this new regulation, since as mentioned in the above, they have only experienced an effective partnership with only 1 CSO amongst 5 partner CSOs.

- **Laboratory**
  - Lab analyst (LA) = 1, this staff is amongst a total of seven analysts working with dedicated focus (some taking care of TB and Pre-Marital specimens, the other of HIV, MCH etc.).
  - VL testing is done in collaboration with another Puskesmas – following the Sudin's (the District Health Office's) advice – and a private laboratory by establishing a MoU.
    - For HIV clients with 1-year refill period, VL testing is done at the other Puskesmas.
    - For refill patients within their 2nd year period and above, their specimen will be forwarded to the private laboratory from the VCT/STI unit.
  - The MoU with the private laboratory targets VL test for 15-25 clients/year and CD4 for 100 clients/year.
  - While the LA sees there is sufficient stocking of reagent from the Sudin, the quality is not seen as good. There were cases where it looked not as the "usually good" reagent used and made her/him unsure of what to expect in the results.
  - LA wishes there is some prior notification/labeling used when sending specimens to the lab if they are indicated/potentially related to HIV, so that safety and prevention for both the lab staff and equipment can be taken prior to testing.
    - Not all lab equipment is disposable and used for one time only. And for this kind of non-disposable equipment extra care should be taken, which can be better prepared by the advanced notification/labeling.
- **Screening Points –** MCH, TB, Pre-Marital & General units
  - The discussion was focused on the sharing of the MCH's midwife (M) and not of the other units. She amongst the longest serving staff – 26 years in her career – and has supported the HIV service since its beginning in the puskesmas (around 2010). She has been trained as a HIV counselor.
  - There are 3 midwives in total at MCH.
  - The challenges shared are more about the Pre-Marital service which is comparatively new compared to the other services.
    - There remains some confusion/non-clarity about the nature of PITC for HIV screening in Pre-Marital services. The form still includes language which suggests it is more of a VCT, but the Sudin says it is PITC.
    - There are no dedicated counselors at Pre-Marital unit. The flow in screening and testing regulates that post-testing, PITC patients need to go back to the unit which has sent them for testing to read the test result. It is only when the result shows it is reactive/positive that such patients will be forwarded to the VCT/STI unit. But there are often no counselors on standby at Pre-Marital that patients are asked to go directly to the VCT/STI unit.
    - In cases where some HIV+ clients from Pre-Marital screening experience pressure/rejection from the immediately family while already pregnant, the question lies in who is the right staff to do the home visit in following up: Pre-Marital, KIA or VCT/STI team?
  - Midwife having to conduct MCH home visits will not be able to be on standby for her counseling function at the puskesmas.
  - MCH room for counseling is not suitable to keep clients' privacy.
- **Pharmacy**
  - Pharmacist (P) = 1, this staff amongst two pharmacists supported by four pharmacist assistants in the puskesmas. This number is seen sufficient in the daily operation of pharmacy.
  - There is no dedicated room/space in the pharmacy to conduct drug counseling in private.

C. Categorization of Impediments

Having identified impediments at each service point, the discussion carried on with categorizing them and, whenever possible, endeavored to dig deeper on the root cause. Root cause identification by the operating team is not always possible to do, as they would perceive some impediments as a consequence of a given standard or regulation 'from above' (the Puskesmas management or the higher-level government). For such cases, the discussion would focus more on elaborating working context or impeding working environment. The summary of problem mapping/categorization is below:

6. **Health worker competency gaps**
   a. True to the long-time RR and new nurse who have not been formally trained in CST.
7. **Low engagement**
   a. From 5 CSOs the puskesmas partners with, only 1 that is actively supporting the HIV services on the ground/for the key population.
8. **Poor allocation of staff or tasks**
   a. There is only one day in a week where the VCT/STI unit is in full team with doctor and nurse on standby, i.e. Wednesday. The other days doctor and nurse are assigned in other services, leaving only RR on standby.
   b. Counseling function needs to be clarified and more personnel allocated to perform it at PITC screening points.
9. **Inefficient work processes**
   a. Clarity in providing Pre-Marital service is lacking.
   b. Advanced notification/labeling is needed for lab personnel and equipment's prevention and safety measure.
   c. VL testing involving two separate parties – other puskesmas and private laboratory – for different types of clients needs to be further clarified, as the other PKM and Puskesmas G have different catchment areas. It might not be straightforward for potential clients within Puskesmas G's catchment area to access services from the lab puskesmas, due to distance, transport etc.
10. **Other health system issues**
    a. **Poor infrastructure**
       i. The VCT/STI unit, MCH and the pharmacy need a properly sized room appropriately set to keep privacy when doing counseling.
    b. **Inadequate supplies / equipment**
       i. Quality of reagent supplied by the Sudin is sometimes questioned.
    c. **Low client demand**
       Not mentioned

Annex R-08. Puskesmas Kecamatan H

FOCUS GROUP DISCUSSION NOTES

PUSKESMAS KECAMATAN H

Date & Time	Friday, 26 July 2018
Participants	VCT/STI services team: nurse, RR, lab analyst, pharmacist

A. SUMMARY OF DISCUSSION

- Patients wishing to access health services at Puskesmas H will start from Queueing Number Point to get a queueing number for the Registration Desk.
- From the Registration Desk on the first floor of the main building, HIV clients access the ART refill service in the VCT/STIs unit. The unit is in the same building, but access for patients is made separate that they have to go outside the main building to the right side, further back there are doors to access STIs and TB units, also a pharmacy especially for those units.
- On a case-by-case basis, refill clients would need to access lab tests on the 2nd floor, either for self-reported cases like STIs or medicinal side-effects, as well as provider-suggested tests like Urea, Creatinine. The periodic CD4 and VL tests are conducted in cooperation with a private laboratory, secured by an MoU. CD4 is usually done in the 6th month of a client's refill period, while VL is done every 12th month. For these the private lab staff will meet clients at the VCT/STI unit, take the specimens and bring them to their lab. They will send the results to the VCT/STI unit in a week or two. It takes some time to get the results as the private lab sends a pool of results altogether, not for individual patients.
- Screening points for HIV testing were identified in the discussion, comprising MCH, TB, Integrated Counseling (Pre-Marital & Adolescents) and Labor & Delivery units for patients outside catchment area. These routes affect workload of the laboratory more than the VCT/STI unit which will be elaborated more in Section B.
- The dedicated pharmacy is the last service point accessed to obtain the ART refill and located next to the VCT/STI unit.

The client flow discussed is visualized in Figure 1 below, where blue arrows exhibit the main flow for ART refill client and orange arrows exhibit the case-by-case flow to the lab and from screening points:

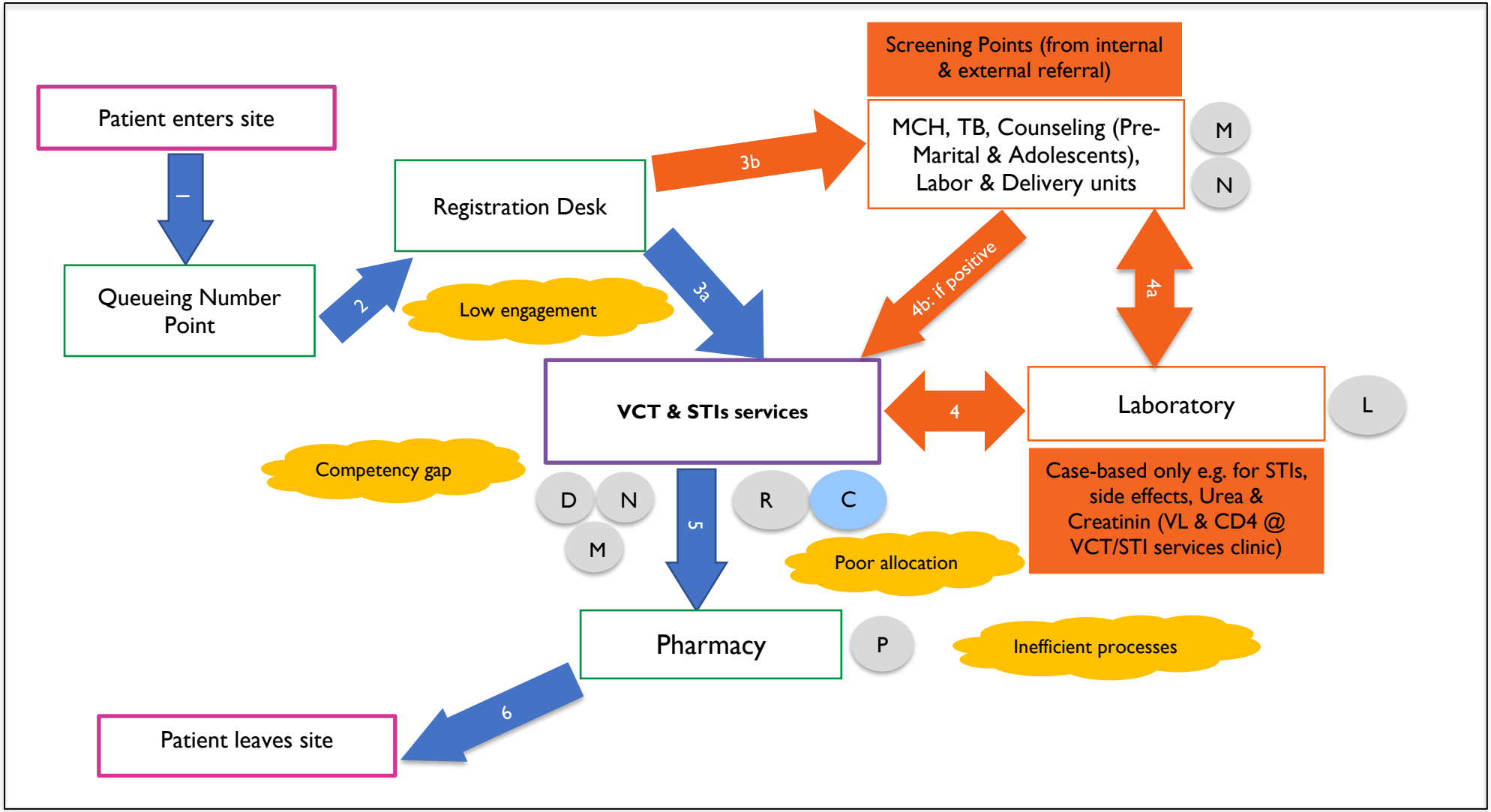


Figure 8. Flow of ART Refill Service in Puskesmas Kecamatan G

B. Actors Involved at Each Point & Impediments Experienced

Having identified the client flow, the discussion identified actors involved at each service point and the impediments they experience. The discussion mainly covered daily work experience of VCT/STI services team and their relationship with staff outside the VCT/STI unit whose tasks linked to the process of acquiring ART refill or the general HIV services which may impact the refill service provided.

This section covers actors involved and cause of consequential impediments at each service point, while categorization of impediments is covered in the next section.

- **Registration Desk** – Admin staff (non-core HIV team)
    - Without different coding to access different service units, patients queue according to the number they get when arriving at the Queueing Number point. This means, ART refill clients can wait long to be called, even if there is no/short queue at the VCT/STI unit.
    - Due to the usual busyness at the registration desk, it takes a while for patients' Medical Records (MR) to be forwarded to the relevant units.
- **VCT/STI unit**
    - Core HIV team stationed at the VCT/STI unit:
        - Nurse (N) = 1, this staff participated in the FGD is among two nurses at the VCT/STI unit, assigned to focus more on STIs than HIV. But the other nurse who specializes in HIV is quite senior and is a recognized ToT trainer on HIV who often goes out to deliver trainings or advisory. On the FGD day, for instance, the senior nurse was delivering the CST training held by the MoH.
        - RR = 1, s/he has just been in the position for three months, prior to this s/he was in the registration desk. RR has been formally trained on CST.
        - Doctor (D) = 1, not present in the FGD. Based on N's explanation D is new in the position, not yet trained on CST and does not handle counseling and mobile service.
        - Midwife (M) = 1, not participating in the FGD, so information is derived from the N. Midwife's assignment is more focused on STIs but three times a week she supports the HIV service by being one of the counselors.
        - Community-cadre (CC) is mentioned as part of daily support from a partner CSO, with separate accountability line from the puskesmas; hence, the different background color in Figure 1 above identifying 'CC' from the other functions at the VCT/STI unit. The CC is on standby at the VCT/STI waiting room, greets and chats with the HIV clients as part of KIE, introducing them to the availability of Peer Support Group (PSG). The VCT/STI unit recognizes its presence but has no involvement in it.
    - There are 247 refill clients recorded at the VCT/STI unit.
    - Patients' data in March 2018 recorded a total of 800 patients, with approximate contribution from:
        - Pre-Marital screening = 60-70 patients daily and

        - Mobile service twice a month, each time = about 30 patients.
    - Reporting is the most felt challenge shared by N and RR. Particularly for the N who must split focus between the technical/counseling and administrative responsibilities.
    - Inefficient data inputting process set on SIHA, in particular, and EPUS (the puskesmas' information system). When inputting patients' data on different sheets actually connected to each other, all details recorded in the previous sheet have to be re-inputted yet again, which take longer time and impractical.
        - The setting of these systems should be improved by comparing them to the SITT (Integrated Information System for Tuberculosis).
    - When all functions at the VCT/STI unit are out, either for assignment or on sick leave (as happened during on the FGD day), the tasks of those absent functions fall on the ones present. N has more tasks to cover than RR.
    - VCT mobile service is held twice a month – on 1st and 3rd Fridays of the month for the last one year – at a big trade center nearby. Usually from 3 p.m. to about 7 p.m. Sometimes there is also requests from private practice midwives, a partner CSO focusing on FSWs and massage parlors (for the hidden FSWs).
        - Staff required in the task are nurse/midwife, RR and lab analyst. Doctor and pharmacist are not usually involved.
        - The target set by the Provincial and District Health Offices of reaching 2,000 tests monthly is not seen achievable, even after including screening from Pre-Marital service which has boosted the number of tests.
        - It is also seen as unrealistic since the catchment area remains the same, "Where will the people come from every month, if not from around here? Impossible to get that many people in a month from this area." This concern has been raised in coordination meeting with both layers of Health Offices.
        - All puskesmas kecamatan in the district seem to experience a similar impediment of underachieved target. There is no sanction for underachievement on this.
    - Difficulty to get more help by recruiting new staff directly from outside, due to stigma attached to the VCT/STI unit and its related responsibilities.
        - Usually staff is transferred from internal puskesmas, like the RR.
- **Laboratory**
    - Lab analyst (LA) = 1, this staff is amongst a total of five analysts performing all lab work without task separation – from sampling, blood/mucus test, delivering results.
    - Three out of the five Las have not yet been trained on CST.
    - Dealing with a maximum of 120 – 150 patients daily, the test is done on a first-come-first-serve basis without quotas set for different service units.
    - 5 staff are not enough to cover the daily load.
        - One patient can have 5 to 8 items to test, so it takes some time to finish testing one specimen.
        - Specimens for PITC HIV testing are sent in high number, especially from the Integrated Counseling (Pre-Marital).

    - Lab is located far from the VCT/STI unit, on the 2nd floor and accessible through the main entrance (different from a separate side-entrance for the VCT/STI unit).
- **Screening Points –** MCH, TB, Integrated Counseling (Pre-Marital & Adolescents), Labor & Delivery units
    - There was no representative from any Screening Point attending the FGD. Quick information derived from the N at the VCT/STI unit.
    - Midwife from the VCT/STI unit sits in twice a week at the MCH to conduct PITC counseling.
    - There are often incomplete forms filled in for HIV screening records from MCH, Counseling or referral from Puskesmas Kelurahan
        - Indicating lack of knowledge in dealing with HIV-related recording.
- **Pharmacy**
    - Pharmacist (P) = 1, this staff is the only one assigned in the pharmacy specifically dedicated for the VCT/STI and TB units.
    - Work schedule is arranged as below:
        - Monday – Thursday serve a maximum of 25 patients for HIV, 25 patients for TB and 10 for STIs.
        - Friday is dedicated for drug counseling
        - Since TB unit opens until 3 p.m., an hour longer than the other units, P has a longer patient-serving hour. But, since s/he works alone, there is a liberty to set flexible time to split between serving and reporting/administrative times.

C. Categorization of Impediments

Having identified impediments at each service point, the discussion carried on with categorizing them and, whenever possible, endeavored to dig deeper on the root cause. Root cause identification by the operating team is not always possible to do, as they would perceive some impediments as a consequence of a given standard or regulation 'from above' (the Puskesmas management or the higher-level government). For such cases, the discussion would focus more on elaborating working context or impeding working environment. The summary of problem mapping/categorization is below:

11.Health worker competency gaps

a. True to doctor at the VCT/STI unit and lab analysts for CST and staff at screening posts for HIV-related form filling/recording.

12.Low engagement

a. Not mentioned by the FGD participants, but from an outsider perspective of the FGD moderator, separate entrance far from the main entrance for a unit that remains in the main building – making patients having to go around and take more time to reach – implies a link to the unspoken stigma raised in the FGD.

13.Poor allocation of staff or tasks

a. True to nurse and RR at VCT/STI unit when covering for absent staff/functions.
b. True to lab analysts compared to specimen volumes and kinds of testing need to done per specimen.

c. With PITC screening and testing on HIV, lab is especially inundated by specimens from multi-units.

14.Inefficient work processes

a. Computerized system, like SIHA and ENUS, seems to remain less efficient as it requires re-enter data just like the first time on different sheets. There is a good example of what efficient looks like from SITT (IS for TB).
b. Lab is on a higher floor accessible from main entrance, separate and far from the entrance of the VCT/STI unit.

15.Other health system issues

a. Poor infrastructure
Not mentioned

b. Inadequate supplies / equipment
Not mentioned

c. Low client demand
Not mentioned.

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