

Investment Design

The Australia Indonesia Health Security Partnership (AIHSP)

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ABBREVIATIONS

AIHSP	Australia Indonesia Health Security Partnership (the “Partnership”)
AIPEID	Australia Indonesia Partnership for Emerging Infectious Diseases
AIPH	Australia Indonesia Partnership for HIV
AIPHSS	Australia Indonesia Partnership for Health Systems Strengthening
AIPMNH	Australia Indonesia Partnership for Maternal and Neonatal Health
AMR	Antimicrobial resistance
APSED	Asia Pacific Strategy for Emerging Diseases
ASEAN	Association of South East Asian Nations
BNPB	National Disaster Agency
CDC	Centers for Disease Control and Prevention (US Government)
DAWR	Department of Agriculture and Water Resources (Government of Australia)
DFAT	Department of Foreign Affairs and Trade (Government of Australia)
DoH	Department of Health (Government of Australia)
EID	Emerging infectious disease
EPT-2	Emerging Pandemic Threats program, Phase 2
EWARS	Early Warning Alert and Response System
FAO	UN Food and Agriculture Organization
FETP(V)	Field Epidemiology Training Program (for Veterinarians)
GHSA	Global Health Security Agenda
GoA	Government of Australia
Gol	Government of Indonesia
HPAI	Highly Pathogenic Avian Influenza
IHR	International Health Regulations
INOVASI	Innovation for Indonesia's School Children
Inpres	Presidential Instruction
IPCHS	Indo-Pacific Centre for Health Security (DFAT)
iSIKHNAS	Integrated National Animal Health Information System
JEE	Joint External Evaluation
Kemenko PMK	Coordinating Ministry for Human Development and Cultural Affairs
KOMNAS Zoonosis	National Commission for Zoonotic Disease Control
KOMPAK	Governance for Growth program
KPI	Key performance indicator
KSI	Knowledge Sector Initiative
LOGICA	Local Governance Innovations for Communities in Aceh
MAHKOTA	Towards a Strong and Prosperous Indonesian Society
M&E	Monitoring and evaluation
MEL	Monitoring, evaluation and learning
MELF	Monitoring, Evaluation and Learning Framework
MoA	Ministry of Agriculture (Government of Indonesia)
MoH	Ministry of Health (Government of Indonesia)
NAPHS	National Action Plan for Health Security
OIE	World Organisation for Animal Health
PCC	Program Coordinating Committee
PHEOC	Public Health Emergency Operations Centre
PNPM	Indonesia's National Program for Community Empowerment
P&R	Preparedness and response
PSC	Program Steering Committee

PVS	Performance of Veterinary Services
RPJMN	Indonesia's National Medium Term Strategic Plan
SEDIA	Support for Education Sector Development in Aceh 2009-2013
SehatSatli	Wildlife health information system
SIZE	Zoonosis and EID information system
TAG	Technical Advisory Group
TASS	Technical Assistance for Education Systems Strengthening
TB	Tuberculosis
UHC	Universal Health Coverage
USAID	United States Assistance for International Development
WHO	World Health Organization

B: EXECUTIVE SUMMARY

Health security threats remain a major concern around the world. Zika, Ebola, Middle Eastern Respiratory Syndrome and highly pathogenic avian influenza are just some examples of diseases that have emerged as health crises over the last decade. These diseases have left health systems and governments of the affected countries and the international health community scrambling to respond and mitigate their social and economic effects.

Many of the drivers of disease emergence and rapid spread are present in Indonesia, which is considered among the world's 'hot spots' for emerging infectious diseases (EIDs). Over seventy five percent of EIDs are zoonoses – animal diseases that can be transmitted to humans. EIDs, as well as re-emerging infectious diseases, antimicrobial resistance (AMR) and vector-borne diseases, have the potential to exact a heavy economic and social toll on communities and countries where they take hold. The massive scale of international travel and trade means infectious diseases in Indonesia pose a real threat to other countries in the Asia-Pacific region, including Australia.

The World Health Organization (WHO) manages the global regime for controlling the international spread of infectious diseases. The International Health Regulations (IHR), administered by WHO, provide the legal instrument for doing so. These regulations are the only internationally-agreed set of rules governing the timely and effective response to outbreaks and other health emergencies that may spread beyond the borders of an affected country. However, less than a third of WHO Member States currently meet the minimum requirements for core capacities needed to implement the IHR.

Similarly, the World Organisation for Animal Health (OIE) manages the global effort to fight animal diseases. OIE has developed the Performance of Veterinary Services (PVS) tool to assist countries to assess their current level of veterinary service performance and to identify gaps and weaknesses in their ability to comply with OIE international standards, establishing priorities for improvement. The last PVS in Indonesia was carried out in 2011.

The factors that govern global health security extend well beyond the mandate and capacity of WHO and OIE; most of the responsibility for response rests with countries themselves. Indonesia undertook the WHO-supported Joint External Evaluation (JEE) of their capacity to implement the IHR in 2017. As a follow up to this, the Indonesian Government is now putting together a National Action Plan for Health Security (NAPHS) to guide interventions to fill gaps which were identified by the review.

Through the AIHSP design process, Australian officials have consulted with Indonesian Government officials from relevant Ministries to develop a program of support to health security and build shared commitment to policy dialogue and effective and sustained program implementation. Both governments recognize the role this program can play, building on the successes of Australia's previous support to the response to EIDs in Indonesia, including through support to address the recommendations of the JEE and PVS. The AIHSP design reflects these key policy documents.

The goal of the program is to increase national health security in Indonesia so that women, men and communities are less at risk from EIDs/zoonoses, thereby contributing to Australian, regional and global health security, as well as supporting sustainable economic development and food security in Indonesia.

The AIHSP will be a flexible program, under which a range of activities will be supported and regularly updated based on emerging issues and experience to support a) the GoI to build stronger systems to prevent, detect and respond to public health and animal emergencies from

EIDs/zoonoses, and b) stronger national coordination of responses to national, regional and global health threats. A managing contractor will work with GoI counterparts to identify and develop a set of activities to be presented as an annual work plan for approval by a Program Coordinating Committee (PCC), made up of Australian and Indonesian government officials. Guiding principles/Investment criteria (parameters) have been developed to guide the choice of activities for support. The AIHSP will continue to adopt a 'One Health' approach by working synergistically in the animal health and human health sectors. The program will build on existing collaborations between the Australian Department of Agriculture and Water Resources (DAWR) and WHO and their Indonesian counterpart agencies. Activities will be coordinated with other key development partners working on health security in Indonesia.

The program will commence in July 2019 and will continue for five years. The AIHSP has a total budget of up to \$17.5 million dollars over the five year period, including \$500,000 for DFAT's internal reviews, monitoring and administration. DFAT expects to enter into a grant arrangement with WHO and potentially other international organisations, and may provide funding to DAWR for specific short-term assignments/activities. This leaves an approximate budget of up to \$14 million available for program implementation and management costs, to go out for tender.

C: ANALYSIS AND STRATEGIC CONTEXT

The threat of current and emerging infectious diseases remains high in Indonesia, posing risks for Australia and the Indo-Pacific region. Many of the drivers for the emergence and rapid spread of infectious diseases are present in Indonesia, making this issue an ongoing focus of Australia's health security efforts. A major disease outbreak in Indonesia, and the region, would have severe health and economic implications – costing lives and disrupting trade, investment and the movement of people.

Indonesia is a 'hot spot' for EIDs due to the close proximity between humans and animals through poultry and livestock management practices, high levels of cross-border travel and trade, and weak human and animal health systems. The majority (75 per cent) of EIDs are zoonoses – diseases that can be transmitted to humans from animals. The main zoonoses continuing to occur in Indonesia are highly pathogenic avian influenza (HPAI), rabies, leptospirosis and anthrax.¹ HPAI is endemic in poultry in Indonesia. Backyard poultry raising and contaminated live bird markets are risk factors for transmission of HPAI from poultry to humans. To date, 200 human cases with an 84% fatality rate have been reported from 15 of 34 provinces in Indonesia. Indonesia is also at risk of Middle East Respiratory Syndrome transmission (a zoonosis transmitted from camels) due to a high number of hajj and umrah pilgrims returning to Indonesia from the Middle East.

Other infectious diseases continue to contribute significantly to morbidity and premature mortality in Indonesia. Vaccine preventable infections and outbreaks continue to be reported in Indonesia and neighbouring countries, including re-emerging infectious diseases such as measles and diphtheria, and the threat of the reintroduction of polio.² There are continuing high levels of tuberculosis (TB). Indonesia has the second highest TB burden in the world (1.6 million cases in 2016) and one of the highest burdens of multidrug-resistant (MDR) TB. MDR-TB is one example of AMR, a growing challenge to global health, which develops when pathogenic micro-organisms – bacteria, parasites,

¹ National priority diseases are stipulated in Presidential Regulation no 30/2011: rabies; anthrax; bird flu; brucellosis; and leptospirosis.

² Indonesia was declared polio-free in 2014 but a case of circulating vaccine-derived polio was identified in Papua in late 2018. A polio outbreak was also reported in Papua New Guinea in mid-2018 – which has not been identified as being related to the case in Papua – and is at risk of crossing the border to the Indonesian Papuan Provinces.

viruses or fungi – continue to grow in the presence of a drug that would normally kill them or limit their growth, making it harder to treat infections as existing drugs become less effective. Vector-borne diseases, particularly mosquito-borne infections, continue to be a key challenge in Indonesia, with an increase in reported cases of dengue (130,000 in 2015) and around 152 million people living in malaria transmission areas.

Progress has been made in building Indonesia's EID and other infectious disease preparedness, detection and response capacities, but many challenges remain. These include limited human and operational resources, insufficient infrastructure, numerous and unclear policies and coordinating mechanisms, and governance constraints. Moreover, since the majority of EIDs are of animal origin, it is necessary to increase attention to the animal-human interface and strengthen the cross-cutting capacities of line and coordinating ministries to deal with zoonotic diseases. This aligns with the globally supported One Health approach that encourages coordinated multi-sectoral approaches to address zoonotic diseases.

Indonesia's decentralised system of government has devolved responsibility for the management of and response to animal and human infectious disease to the subnational level (district and provincial governments), with the central government's role limited to oversight, support and management only in the case of national-level outbreaks. While Indonesia has developed a basic legal and policy framework which provides the basis for effective programs, the division of responsibilities between central and local levels, the large number of institutions involved, and the varying capacity of different levels of government, present major challenges. There is a need to improve decision making structures, and delegation of authority and responsibility to act, not only between the national and sub-national levels, but also at the national level.

HEALTH SECURITY: A PRIORITY FOR THE AUSTRALIAN GOVERNMENT

Building regional preparedness and capacity to respond to emerging health threats is one of the two strategic priorities of DFAT's Health for Development Strategy 2015-2020, along with building country-level health systems that are responsive to people's needs. In June 2016, the Government of Australia (GoA) made a pre-election commitment to invest in regional health security.³ The foreign minister subsequently launched the Australian Government's \$300 million Indo-Pacific Health Security Initiative in October 2017 to help combat the challenges of existing and EIDs in the region. The initiative recognises that Australia's health security is closely linked to the health security of countries in the region, and that strengthening health systems and investing in research and partnerships can help mitigate the social and economic risks of a major disease outbreak. The importance of managing health security risks was also reflected in the Foreign Policy White Paper released in November 2017.

Health security is a key priority area for Australia's ongoing health program and policy engagement in Indonesia. Australia has provided long-standing support to Indonesia on health security, including under the current Australia Indonesia Partnership for Emerging Infectious Diseases (AIPEID), which commenced in 2010 and will end in 2019. AIPEID has supported WHO to work with the Indonesian Ministry of Health (MoH) to improve public health emergency preparedness and risk management. In addition, the Australian DAWR has worked with the Indonesian Ministry of Agriculture (MoA) to strengthen emergency management systems and veterinary leadership, and enhance Indonesia's animal health information systems. The second phase of AIPEID, which commenced in 2015, works synergistically in both animal health and human health sectors. This assistance has been well received by the GoI. It has supported Indonesia to increase its capacity to comply with international obligations under the IHR and to build national human and animal disease surveillance systems and

³ The Coalition's Policy for a Safe and Prosperous Australia, Liberal Party of Australia, June 2016

emergency response mechanisms. A large proportion of this program ended in December 2018, with some small transitional activities continuing in 2019.

In this context, the new AIHSP will continue to help strengthen Indonesia's ability to mitigate, detect and respond to health emergencies and reduce the threat posed by EIDs. The new program will help curb potential threats to Australia and beyond. It will facilitate better access to senior levels within Indonesian government agencies, particularly in the event of an EID threat. It will support Indonesia to better equip itself to detect and control pandemic threats to the region.

The new partnership will build on lessons from the two phases of the AIPEID program, including those identified in the June 2017 program review.⁴ The primary purpose of the review was to recommend options for Australia's future bilateral program support in the area of health security beyond 2018. Extensive consultation was undertaken by the review team – including whole-of-government partners (DFAT, DAWR and the Department of Health [DoH]), Indonesian Ministries of Health and Agriculture and other key stakeholders in Indonesia. The review strongly recommended that DFAT continue to assist Indonesia to detect and respond to EIDs. It urged DFAT to maintain key elements of the existing program (particularly in relation to surveillance systems), to strengthen strategic high-level engagement with the Indonesian Government, and to increase One Health efforts under a new program.

As highlighted in DFAT's Indo Pacific Health Security Initiative Design Concept⁵, there are challenges to regional collaboration on health security. This proposed program will help to address some of these challenges in Indonesia particularly by ensuring senior levels of Government buy-in to, and oversight of, regionally funded initiatives and activities. An effective bilateral program is integral to the success of any regional initiative that seeks to establish partnerships and build health system capacity to respond to health security threats.

The new program will also help to meet the Australian Government's broader interests in protecting Australian livestock from infectious diseases that might enter Australia through Indonesia, and will keep communication channels open for trade dialogue.

INDONESIA'S COMMITMENT TO HEALTH SECURITY

The 2003 avian influenza outbreak experience, along with more recent infectious disease alerts such as the Zika virus outbreak, has kept health security on Indonesia's political agenda. In recent years, Indonesia has demonstrated its preparedness to take an active global role on the issue.

Indonesia is closely engaged in the Global Health Security Agenda (GHS), having served as Steering Committee Chair in 2016, and is leading on the GHS Action Package 2 on Zoonotic Diseases. Domestically, it has also established working groups to address each GHS action package. Indonesia hosted the most recent GHS Ministerial Meeting in November 2018 in Bali. It is also a member of the JEE Alliance for Country Assessment (which Australia currently co-chairs) and leads the JEE Alliance's subgroup for 'Harnessing Regional Capacity'. As Chair of the International Committee of Military Medicine, Indonesia and WHO co-hosted a 'Managing Future Global Health Risks' conference from 24-26 October 2017 in Jakarta. This conference was opened by President Widodo at the state palace.

WHO South-East Asia Region (including Indonesia) and Western Pacific Region countries developed the Asia Pacific Strategy for Emerging Diseases (APSED) in 2005. Indonesia and countries across the Indo-Pacific region are using the 2017 Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED III) as the framework of action for working towards the IHR core capacities:

⁴ DFAT. *Indonesia AIPEID II Strategic Review and Options Development Paper and management response*. 2017. <https://dfat.gov.au/about-us/publications/Pages/indonesia-aipeid-strategic-review-options-development-paper.aspx>

⁵ DFAT. *Health Security Initiative for the Indo-Pacific region*. 2017. <https://dfat.gov.au/aid/topics/investment-priorities/education-health/health/Pages/health-security-initiative-indo-pacific-region.aspx>

building national capacity to prevent, detect, respond to and mitigate health security threats through an all-hazards approach. The latest strategy addresses eight focus areas: public health emergency preparedness; surveillance, risk assessment and response; laboratories; zoonoses; prevention through health care; risk communication; regional preparedness, alert and response; and monitoring and evaluation (M&E).

Indonesia undertook a WHO-supported JEE in November 2017 to assess its health security capacity including gaps in preparedness, detection and response systems. The review team found it to have insufficient capacity in a number of areas, including “established and functional mechanisms for responding to infectious diseases”, and “integration and analysis of surveillance data”. The JEE provided recommendations to enhance information sharing between human and animal health stakeholders at all levels, and to strengthen event-based surveillance and risk assessment. The team also recommended capacity building through training including for surveillance, laboratories, case management, infection control, and risk communication.

The JEE’s overarching recommendations, however, related to issues of governance and coordination. These were to: (1) develop and implement a fully integrated, multi-sectoral National Action Plan, facilitated by a presidential level decree; (2) establish a mechanism to coordinate the IHR and global health security work of all relevant ministries, agencies and institutions; and (3) evaluate and improve decision-making structures and delegation of authority and responsibility to act, not only between the national and sub-national levels, but also at the national level. The Indonesian Government is currently developing a NAPHS to guide interventions in line with these recommendations.

Responsibility for disease control in (human) public health lies with the Directorate-General of Disease Prevention and Control in the MoH, and the provincial and district health offices. The Directorate-General of Disease Prevention and Control has been appointed as the IHR National Focal Point for Indonesia. In 2016, the MoH established an EID sub-directorate and a Public Health Emergency Operations Centre (PHEOC), under the Directorate of Surveillance and Health Quarantine (a part of the Directorate-General of Disease Prevention and Control). Responsibility for animal health lies with the MoA, Directorate-General of Livestock and Animal Health Services.

Since November 2016, the Coordinating Ministry for Human Development and Cultural Affairs (Kemenko PMK) took over the national coordination function in relation to zoonoses (previously managed by the now-disbanded National Commission for Zoonotic Disease Control, KOMNAS Zoonosis). Kemenko PMK’s role includes preparation of a health security action plan (including a non-natural disaster risk map⁶), continued development of an integrated zoonosis and EID information system, SIZE, which draws information from both animal and human health information systems (iSIKHNAS and EWARS respectively), and development of joint protocols with Indonesia’s National Disaster Management Agency (BNPB). Further work is needed for national and district levels of BNPB to fulfil their role in responding to an outbreak if declared a disaster.

Indonesia’s national medium term strategic plan (RPJMN) sets national priorities and targets for all ministries and levels of government. The current RPJMN (2015-2019) identifies “improving the availability and coverage of basic services for poor communities” as a priority. In the health sector, priority continues to be given to maternal and child health, and nutrition, as well as to the implementation and expansion of the national health insurance program. In the livestock/animal health sector, priority is given to food security, increasing production and protecting the livelihoods of farmers. DFAT is supporting the Indonesian government to undertake its 2018 Health Sector Review which will serve as an input to the new RPJMN (2020-2024) and will work to elevate issues pertaining to health security. Indonesia is committed to achieving the Sustainable Development Goals: a universal call to action to end poverty, protect the planet and ensure that all people enjoy

⁶ Infectious disease outbreaks are considered to be ‘non-natural’ disasters.

peace and prosperity. Particularly relevant to the AIHSP are Goal 3 (Good health and well-being) and Goal 17 (Partnerships for the goals).

HEALTH SECURITY AND UNIVERSAL HEALTH COVERAGE

The GoI is committed to achieving universal health coverage (UHC). In addition to the continued roll out of its national insurance program, Jaminan Kesehatan Nasional, health system strengthening is vital to GoI achieving the goal of UHC. Health system strengthening is also necessary for Indonesia to improve its health security capacities and comply with its international obligations under the IHR. Strong health systems are the best way to stop infectious disease outbreaks developing into epidemics⁷; UHC and improved global health security are therefore mutually reinforcing goals⁸, and it is important to avoid a vertical or “siloed” approach to health security.⁹ Australia’s efforts in the health sector will also be supported through the Governance for Growth (KOMPAK) program. This program works at the subnational level to support basic service delivery using a health systems strengthening approach.

While GoI is shifting focus to a more evidence-based approach to policy making there are challenges to operationalising this commitment. The JEE recommended Indonesia conduct a policy analysis to evaluate the need for new policies across line ministries and administrative levels. Previously the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) (2011-2016) and the Australia Indonesia Partnership for Pro-poor Policy: The Knowledge Sector Initiative (KSI) (2012-ongoing) worked together to support the health sector in this approach. While the AIPHSS program completed in 2016, the KSI program has continued. Although KSI has broadened its focus across multiple sectors, it is currently supporting UHC through the Centre for Public Health Management (a health sector think tank) based at Gadjah Mada University. Both programs have provided valuable lessons and potential linkages to allow AIHSP to support evidence-based policy development in the field of health security.

GENDER AND DISABILITY INCLUSION IN HEALTH SECURITY

An analysis of links between gender and EIDs carried out by the Indo-Pacific Centre for Health Security (IPCHS) has shown that gender differences in behaviours, activities, and access to resources and decision-making affect disease transmission and outcomes for many different EIDs.¹⁰

Interactions between gender roles, disease transmission, and socio-economic stability can reach a tipping point in epidemics, threatening setbacks for women’s health and development gains.

Gender norms and roles influence the risks of women and girls in acquiring infectious diseases because:

- Women are at increased risk of exposure to disease when carrying out common activities such as water and firewood collection, or doing laundry when standing in polluted water;
- Women usually take care of poultry in backyard farms and transport animals to wet markets, practices that increase the risk of exposure to avian influenza;
- Women typically care for sick family members at home and are exposed to pathogens that spread from person-to-person;

⁷ Ghebreyesus, TA. All roads lead to universal health coverage. *The Lancet Global Health*. 2017; 5(9): e839-840.

⁸ Kluge H, et al. Strengthening global health security by embedding the International Health Regulations requirements into national health systems. *BMJ Global Health* 2018; 3: e000656.

⁹ DFAT Office of Development Effectiveness. *Evaluating a decade of Australia’s efforts to combat pandemics and emerging infectious diseases in Asia and the Pacific 2006-2015: Are health systems stronger?* 2017.

¹⁰ IPCHS. *Investment Design Health Security Workforce Program* (draft). 15 November 2018.

- Women and girls, usually responsible for childcare, touch and embrace small children who have little immunity from past illnesses and easily pass along infections. Severe acute respiratory syndrome, Ebola, avian influenza, and Nipah viruses have forged deadly routes via caregiving;
- In most countries, the vast majority of healthcare workers, particularly nurses and midwives, are women, working on the frontlines of disease outbreaks.

Further, gender can also differentially affect the impact of and responses to infectious disease outbreaks, and these differences must be taken into account. For example:

- There are gendered differences in how public health messages are communicated and followed;
- More or less research funding and policy attention may be given to diseases depending on their gendered impacts, reflecting gender disparities in the broader health workforce (beyond nurses and midwives) and governance structures.
- Infectious disease outbreaks may impact sexual and reproductive health rights, for example by limiting access to family planning services. Cultural, social and religious norms can affect responses to infectious disease outbreak protection measures, particularly in the context of growing social and political conservatism in some parts of Indonesia.
- Men and women will likely experience the economic impact of disease outbreaks differently. Women, for instance, are likely to see their unpaid care burden increase, which could result in them reducing their connection to the formal economy, or reducing their output through the informal economy. These factors should be taken into account when estimating disease burdens and economic impacts.
- Due to Indonesia's high level of diversity and sub-national health care delivery model, women in different provinces, of different religions and ethnic backgrounds, and of different classes and education levels will have different levels of risk (in terms of disease transmission and economic impact) and also influence (regarding prevention, surveillance and recovery efforts).

Surveillance systems typically collect data on epidemiological variables such as incidence, prevalence, severity, and deaths, as well as clinical data on typical signs and symptoms of disease. While sex disaggregated data is recorded on health facility records, separate tallies for men and women are not often included in reports.¹¹

Pregnant women are particularly vulnerable during an infectious disease outbreak. Maternity services are often disrupted and those that are operating may do so unsafely. Some diseases can cause pregnancy-related complications and miscarriage or other harm to the foetus, and obstetric procedures may further spread pathogens. Influenza has a more severe course during pregnancy.

While higher rates of infectious disease among people with disabilities are not well documented, people with disabilities are particularly vulnerable to deficiencies in health care services and are therefore also likely to be more vulnerable in an infectious disease outbreak. WHO highlights the need to integrate disability education into undergraduate and continuing education for all health-care professionals and train community workers so that they can play a role in preventive health care services.¹² WHO also recommends that people with disabilities should be included in health

¹¹ WHO. *Taking sex and gender into account in emerging infectious disease programmes: an analytical framework*. 2011. http://www.wpro.who.int/topics/gender_issues/Takingsexandgenderintoaccount.pdf

¹² WHO. *Health and Disability: Key facts*. 2018. <http://www.who.int/news-room/fact-sheets/detail/disability-and-health>

care surveillance and that more research should be conducted on needs, barriers and health outcomes for people with disabilities.

DEVELOPMENT PARTNERS

A select number of development partners are supporting health security-related activities in Indonesia. These include:

The World Health Organization (WHO)

The WHO Indonesia country program supports the MoH to meet IHR requirements. It uses the APSED framework and has a central role in facilitating the JEE in Indonesia. The current biennial work-plan for Indonesia is financed from the regular budget and contributions from Australia and the US.

During the 2017 AIPEID review, the WHO country team identified the following priorities for further assistance: laboratory capacity building, developing the PHEOC, introducing an all-hazards approach, and expanding One Health to include wildlife and environment.

USAID

USAID support is provided through the Emerging Pandemic Threats program, Phase 2 (EPT-2), a global program which is closely linked to the GHSA and focuses on zoonoses and EIDs. It is managed by USAID with technical collaboration from the CDC, WHO and FAO. In addition to these partnerships, EPT-2 has projects that provide additional technical support: PREDICT 2, One Health Workforce, and Preparedness and Response (P&R). The P&R component has supported Kemenko PMK to take on the role previously held by the now-disbanded KOMNAS Zoonosis.

There are a number of program outputs in Indonesia: strengthened surveillance systems for zoonoses and EIDs, incorporating laboratory diagnosis; effective, sustainable and One Health-focused prevention and control of targeted zoonoses and EIDs (including a national web-based platform for sharing information for influenza virus genome monitoring); an increased knowledge base and information sharing on poultry productivity; improved identification of disease risks along the poultry market chain to support policy making; collaboration between government and educational institutions on One Health capacity building; and improved P&R systems for zoonotic diseases and EIDs.

The P&R component ended in September 2018 and the overall program is due to end in April 2019. However, USAID is considering continuing some work in the area of health security in Indonesia.

US Centers for Disease Control and Prevention (CDC)

CDC primarily supports activities under the GHSA framework with a focus on workforce development including support to enable the Field Epidemiology Training Program (FETP) to transition to a 2-year degree program, and collaboration with the Indonesian Association of Epidemiologists to develop a career pathway. CDC also supports the PHEOC through technical advice, training workshops and hosting one MoH staff member for a 4-month fellowship at CDC Atlanta. CDC is also working with FAO to establish a FETP for veterinarians (FETPV) (see below).

The Food and Agriculture Organization (FAO)

The FAO Emergency Centre for Transboundary Animal Diseases in Indonesia is the AIPEID's partner in supporting the MoA in the area of animal health. Its activities in Indonesia focus on provision of technical support, funded by EPT-2 (USAID). FAO staff are embedded in the MoA.

FAO is also supporting a Field Epidemiology Training Programme for Veterinarians (FETPV) to strengthen the epidemiological capacity of the government's veterinary services. The programme was launched by the MoA and FAO in May 2017. It aims to produce competent field veterinary epidemiologists in the country who can interact with animal owners, investigate, assess, analyse,

and report the findings of outbreak investigations effectively and rapidly. The programme is also expected to improve veterinarians' capacity for animal disease prevention, detection, and response.

The World Bank

Indonesia is a focal country under the World Bank Multi-Donor Trust Fund's health security window, supported by DFAT. A health security financing assessment for Indonesia is under way to help identify the scale of dedicated resources for health security at both central and subnational levels. The Multi-Donor Trust Fund is also financing advisory services to support Indonesia's efforts to accelerate and sustain progress towards universal health coverage by strengthening reforms related to governance, financing, and service delivery.

The World Animal Health Organization (OIE)

OIE carries out PVS Gap Analyses to review national compliance with international veterinary/animal health standards. The most recent PVS for Indonesia was carried out in 2011. It found that the main animal health (disease control) priorities set by Indonesia are to prevent the international spread of transboundary animal diseases to support export objectives; enhance national strategies and management of all priority endemic diseases; and to facilitate the prevention and early detection of, and rapid response to, imported infectious diseases.

OIE does not have an in-country office in Indonesia.

Partners and the AIHSP

Given that there is already support being provided to Indonesia in various areas relating to health security it will be critical for partners to continue to collaborate and ensure that activities funded as part of the AIHSP will build on successful AIPEID interventions and complement the work being supported by other partners.

Donor and international agency coordination is currently occurring through monthly donor coordination forum meetings under the auspices of USAID/EPT-2 which includes PREDICT 2, FAO and WHO. The Kemenko PMK also holds a national donor coordination meeting annually. The DFAT Health Unit is represented at these meetings, and will work with the key AIHSP decision making body (PCC) and program management body (managing contractor) to ensure that all DFAT support is fully coordinated with other programs.

LESSONS LEARNED

A number of lessons from past and current initiatives in Indonesia have direct bearing on the design of the AIHSP. The most important of these, and how the AIHSP design has responded to them, are summarised in the table below.

Table 1:

Lesson	AIHSP Design Response
<p><u>Understanding the Indonesian context and political framework is paramount.</u>¹³</p> <p>Indonesian government priorities might change following the 2019 presidential election. Political economy dynamics will continue to shape the reform agenda and priorities in the health security context.</p>	<p>AIHSP has sought GoI commitment to the program aims. Throughout the process of developing the design of the program, relevant stakeholders have been kept up-to-date with developments; this will continue as the program progresses.</p> <p>Designing the investment as a flexible program based on annual work plans will ensure that</p>

¹³ This is an important general lesson which is underlined in: DFAT. *Effective Governance: Strategy for Australia's aid investments*. 2015. <https://dfat.gov.au/about-us/publications/Pages/effective-governance-strategy-for-australias-aid-investments.aspx>

	<p>Gol health security priorities are reflected and will enable adjustments post-election if priorities change, and on an ongoing basis throughout the implementation period, based on ongoing and updated analysis of the operating context in Indonesia.</p> <p>DFAT is engaged in the Indonesian Health Sector Review which will provide an evidence base for the new RPJMN and Health Strategy (Renstra Kesehatan) to be delivered by the new Government.</p> <p>The timing of the program's inception period should also enable adaption to any changes resulting from the presidential election.</p>
<p>Aligning with national priorities will ensure better engagement with counterparts.</p>	<p>DFAT is involved in the RPJMN development process which will set out priorities of the new government, and has advocated for health security issues as part of this process.</p> <p>AIHSP has referred to the JEE and PVS gap analyses, which will guide the development of the NAPHS, ensuring that the program aligns with Gol priorities. DFAT and the managing contractor will continue to monitor emerging priorities, particularly through the NAPHS.</p>
<p>There is a need to garner support for activities from the outset from the Gol.</p> <p>It is critical that activities are implemented in line with Gol systems (including the legal/regulatory framework, incentives, accountability mechanisms and resourcing flows) to ensure that the program will achieve systemic impact through the learning, adoption, adaptation and replication of interventions. Interventions need to take account of this reality and have the required backing from the relevant Indonesian government department and stakeholders from the outset.</p> <p>There are frequent examples in Indonesia of exceptional technical proposals falling short during implementation, and back-tracking being required to fulfil regulatory requirements or garner support from the relevant authorities. These activities are generally developed at arms-length from the government and have not garnered adequate and timely support for smooth implementation.</p>	<p>AIHSP is designed to ensure ownership by key stakeholders from the outset: activities will be developed jointly under the program, and work plans will be signed off annually by Indonesian and Australian Government representatives to ensure agreement and commitment to implementation.</p> <p>AIHSP will work with and through existing and emerging local partners (including Gol, universities, and research organisations). Prospective contractors should have the skills and resources to support Gol officials to develop their proposals and advocate for senior Gol stakeholders in preparing new policy/regulations that support the implementation of identified improved practices.</p> <p>Not all activities will need to be proposed by the Gol, but all activities in the public sector or requiring the Gol to be accountable for the funds will require their support and this will be done through a process of negotiation and PCC approval of the annual work plan.</p>
<p>Developing strong partnerships is critical and takes time.</p>	<p>The AIHSP will have a 12 month inception phase (with some activities operational) in order to build operational capacity and</p>

<p>Developing partnerships based on mutual respect and trust, and a clear understanding of shared and individual responsibilities, is particularly important for programs that are running pilots and where success is defined by systemic influence.</p> <p>Establishing such partnerships takes time and requires a good understanding of government systems and processes.</p>	<p>establish strong working relationships with the relevant Ministries as well as in the province/s identified for specific sub-national activities. Preparatory and ongoing (e.g., from AIPEID) activities will be carried out during this inception phase.</p>
<p>There is a need to develop a strategic system which clearly determines parameters for what will and won't be funded.</p> <p>This will help ensure that activities proposed by counterparts are coherent and contribute to long-term aims, and that interaction with counterparts is a valuable use of both parties' time.</p> <p>Examples of programs where such systems have been developed include INOVASI, AIPHSS and MAHKOTA.</p>	<p>AIHSP will develop investment criteria/guiding principles to set parameters around funding (see Table 3) ensuring that activities will be strategic, cohesive and clearly aimed towards outcomes.</p> <p>The program will aim to provide technical assistance which is otherwise difficult for the GoI to procure and/or resource (for example, to pilot innovative ideas that could be replicated). Throughout this process, vigilance will be required to ensure that funding is not displacing GoI funding nor duplicating funding provided by other donors.</p>
<p>Direct government to government engagement is considered valuable to partner governments.</p> <p>A key strength of the AIPEID program noted in the program review is the MoA engagement with DAWR.</p>	<p>DAWR do not wish to take on a management role in the AIHSP, but are open to providing technical input. Similarly, DoH are keen to stay engaged, through the IPCHS or possibly directly with the program. DFAT are currently supporting MoH and DoH to develop a memorandum of understanding which lists "health security" as a key collaboration area.</p>
<p>Supporting coordination and collaboration can improve outcomes.</p> <p>Coordination and cooperation is often weak between different agencies/bodies with a responsibility for or direct interest in working on a One Health approach. Donors can advocate for and support enhanced coordination and collaboration between these stakeholders when they are seen as a trusted partners and the benefits of coordination are evident.</p> <p>Examples of programs demonstrating this lesson include SEDIA, LOGICA, PNPM and AIPMNH.</p>	<p>By sitting outside the bureaucracy's formal structures, AIHSP will be able to provide impartial and objective advice, tailored to the needs of different stakeholder groups.</p> <p>Proposed coordination arrangements will help ensure that AIHSP can facilitate enhanced coordination and collaboration between different agencies/bodies without being seen as representing one group's interest over another.</p>
<p>Weak capacity at district level can be addressed using donor funding and technical assistance to improve health care delivery.</p> <p>This can be done through many channels, for example, planning and budgeting or improving</p>	<p>The program has the scope to have a sub-national component, but this would be determined by the PCC in the development of annual plans over time. This would open up a link between national and sub-national</p>

workforce availability and quality (as demonstrated in the AIPMNH).	government for policy development, testing ideas and capacity building.
<p>GoI is shifting to focus more on the evidence base for policy making.</p> <p>The JEE recommends Indonesia to conduct a policy analysis to identify and evaluate the need for new policies; review existing policies for gaps and potential conflicts; and harmonize and develop strategies for policy implementation across line ministries and administrative levels.</p>	The program will seek to collaborate with the KSI program and learn from the previous AIPHSS program to strengthen the evidence base to inform decision making and policy development in health security.
<p>Avoid vertical programming in health security.</p> <p>Vertical programs focus on a specific health condition or issue, and are not integrated with broader policies or programs. An integrated approach is necessary to build and maintain the strong, comprehensive health systems that are essential for health security.</p>	AIHSP will seek to ensure IHR capacity strengthening is integrated with interventions to provide UHC. Recognising the limitations of funding, the program will seek to collaborate with KOMPAK and KSI programs and learn from the lessons of the previous AIPHSS program.
<p>Government to government partnership programming produces results in Indonesia.</p> <p>Governance is a core component of the WHO's framework for the building blocks of health systems.</p>	The program has sought to build on lessons learned from previous programs, including AIPH, AIPMNH, INOVASI, KOMPAK and TASS, and to set up governance structures which provide a partnership framework for GoI. The partnership approach at both high and technical levels is recognised as necessary for program implementation in Indonesia. Program governance arrangements should also be closely linked to AIHSP's subsidiary arrangements.

D: INVESTMENT DESCRIPTION

GoI stakeholders have indicated that they would welcome support in the form of technical assistance, innovation and piloting of new systems and approaches, and strengthening cross-government coordination to improve their JEE scores and meet IHR commitments (in accordance with their upcoming NAPHS), building on the foundation established by AIPEID.

LOGIC AND EXPECTED OUTCOMES

The program responds to the 2017 JEE of Indonesia's capacity to meet the requirements of the IHR, and will focus on support to address the three main recommendations of the JEE: developing a National Action Plan, establishing a mechanism to coordinate health security work, and improving decision-making structures.

Australia is well positioned to assist Indonesia to address the JEE recommendations, building on a decade of experience in support to the areas of prevention, detection and response to EIDs, particularly in the areas of: policies and procedures for pandemic preparedness and response; cross-agency coordination; and disease surveillance. The program will build on demonstrated success from

the AIPEID in these three areas, while also taking lessons on board as the AIHSP improves and expands on this work. AIHSP will work in close cooperation with other development partners, particularly WHO, USAID, CDC and the FAO.

Program activities will be aligned with the GoI's multi-sectoral NAPHS, currently being developed, which maps out the needed improvements (or maintenance) in the 19 JEE technical areas. The program's M&E process will contribute to measuring progress (in relevant areas) of the implementation of the NAPHS.

Program Goal and End of Program Outcomes

The goal of the AIHSP is to increase national health security in Indonesia so that women, men and communities are less at risk from EIDs/zoonoses, thereby contributing to Australian, regional and global health security, as well as supporting sustainable economic development and food security in Indonesia.

By the end of the program in 2024 it is expected that the AIHSP would have supported a) the GoI to build stronger systems to prevent, detect and respond to public health and animal emergencies from EIDs/zoonoses, and b) stronger national coordination of responses to national, regional and global health threats.

Intermediate Outcomes

To achieve these end of program outcomes, three intermediate outcomes have been identified which align with GoI priorities as outlined in Indonesia's key health security documents, namely the NAPHS, JEE and the PVS. Progress towards these outcomes should be demonstrated by around 2022, to guide activities for the remainder of the program.

The intermediate outcomes focus on: improved policies and procedures, cross ministerial coordination and information sharing, and the efficiency and effectiveness of animal and human health surveillance systems.

These outcomes have been selected because they: are essential to achieving the overarching goal; represent areas of mutual interest for Indonesia and Australia; and reflect priority areas identified in recent reviews and studies, including: the AIPEID Review (Jun 2017); the DFAT Office of Development Effectiveness evaluation of Australia's pandemic and EID support (Aug 2017); the OIE PVS; the JEE (Nov 2017); and a DFAT program scoping mission (Apr 2018) and DFAT/GoI workshop in Jakarta (Aug 2018).

Indicative Areas of Investment

Indicative areas of investment have been identified to achieve these outcomes. These align with the areas that Indonesia needs to further develop as highlighted in the JEE (and as summarised in Figure 1). All activities carried out under the program will link to one or more of these areas of investment, will meet the investment criteria/guiding principles as set out in Table 3 (below), and will be agreed upon by the PCC on an annual basis.

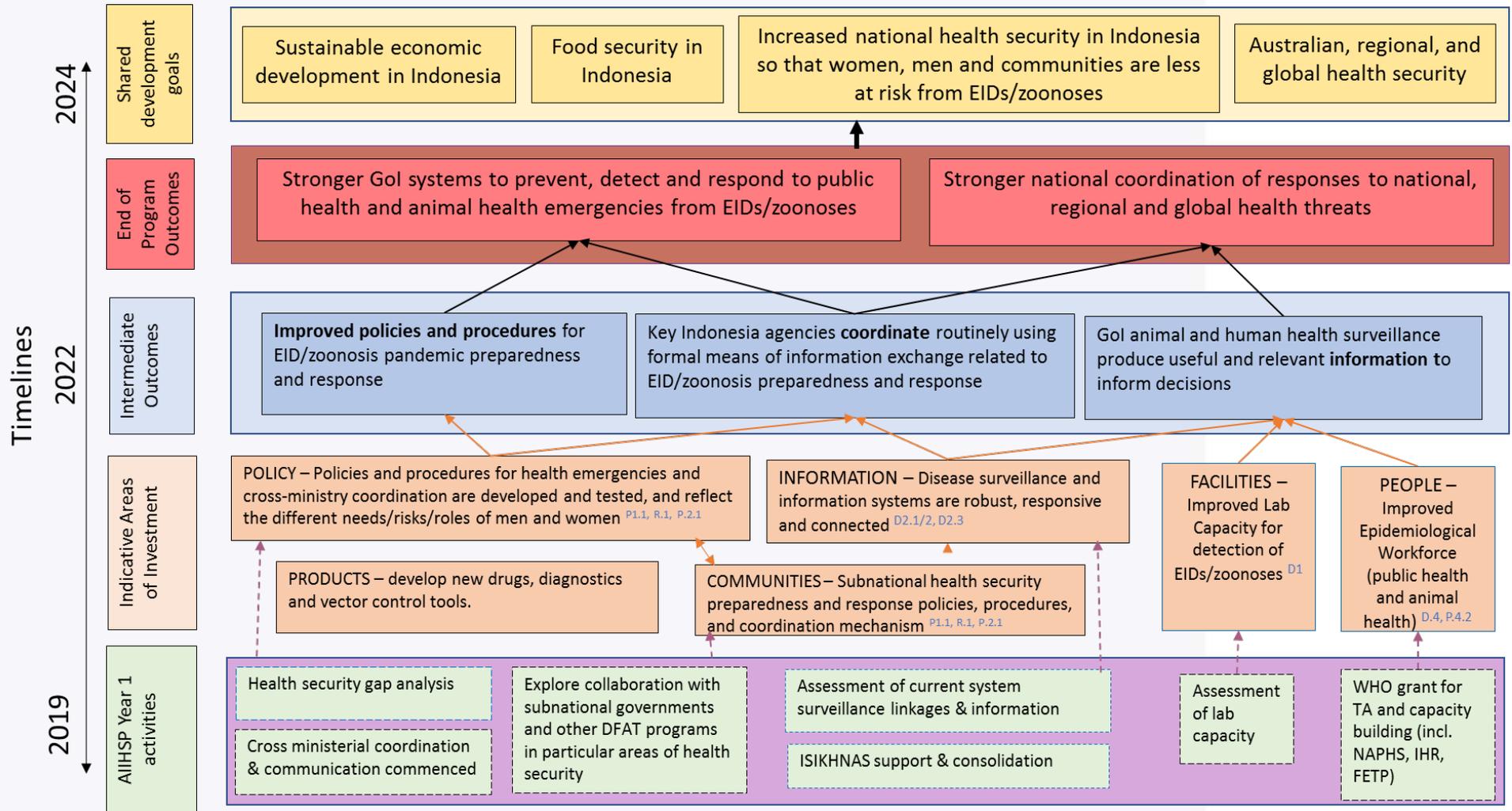
The investment areas are:

1. POLICY - Policies and procedures for health emergencies and cross-ministry coordination;
2. COMMUNITIES - Subnational health security preparedness and response policies, procedures and coordination mechanisms;
3. INFORMATION - Disease surveillance systems and information systems;
4. FACILITIES - Improved laboratory capacity for detection of EIDs/zoonoses;
5. PEOPLE - Improved epidemiological workforce (public health and animal health); and
6. PRODUCTS - Develop new drugs, diagnostics and vector control tools.

Indicative Investment Areas 1 and 2 are interdependent: implementation of activities at a subnational (provincial or district) level will allow new policies, procedures and coordination

mechanisms to be piloted and tested, and the results of piloting fed back to central government to inform policy and regulatory changes and enable the government to replicate/scale up successful pilots. The potential for a subnational presence for the program as it develops will allow it to identify and test coordination mechanisms which work at the subnational level, and how these can best be aligned with reporting systems and coordination at the national level. Indicative Investment Areas 1-3, in particular, must respond to relevant gender and social inclusion analysis and, where appropriate, reflect the different needs/risks/roles of men and women regarding health security.

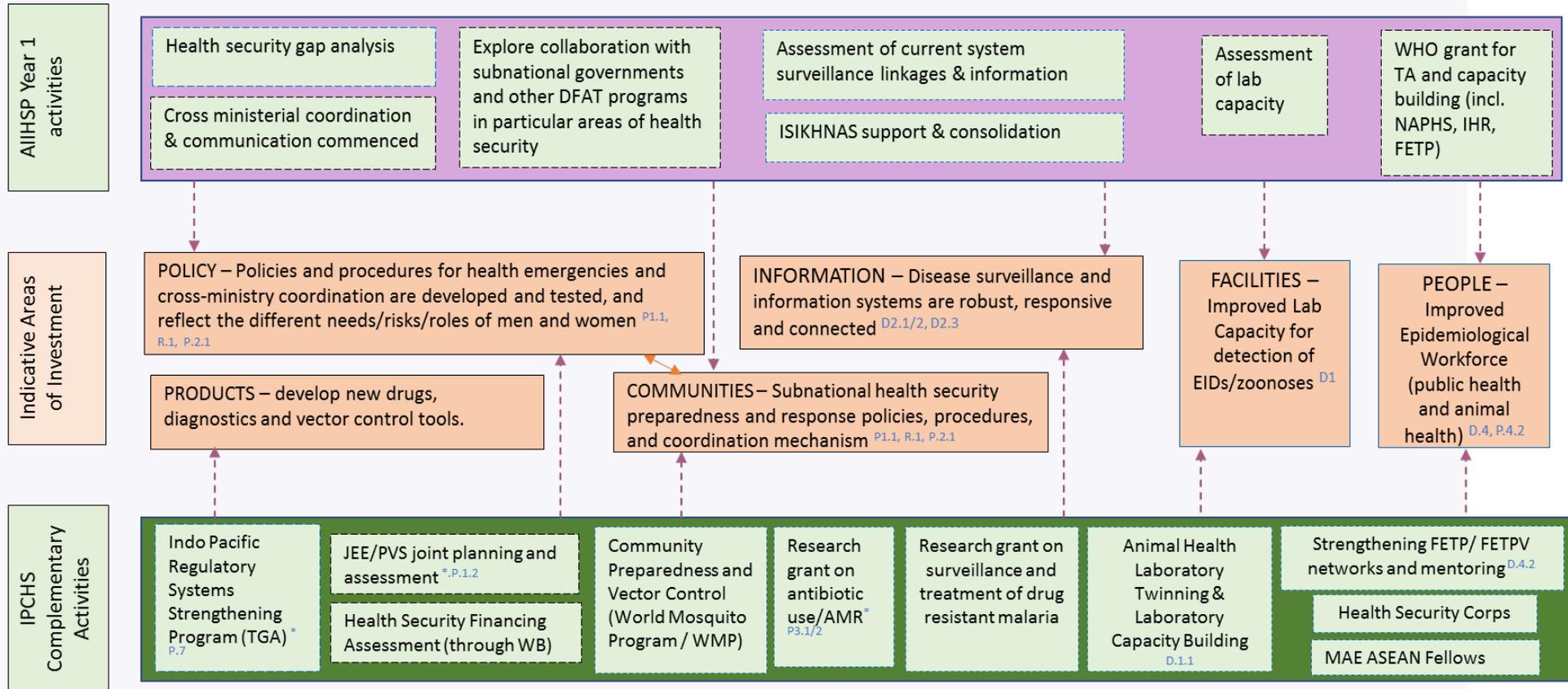
Figure 1. AIHSP Program Logic



The blue captions in the diagram (under Indicative Areas of Investment) refer to JEE technical areas and are aligned with NAPHS.



Figure 2. Links between Indo-Pacific Centre for Health Security Activities and AIHSP Indicative Areas of Investment/Activities



The blue captions in the diagram (under Indicative Areas of Investment) refer to JEE technical areas and are aligned with NAPHS.

AIHSP First Year Activities

The program is expected to commence in July 2019 following the Indonesian presidential election. Health security is a dynamic space and, while a significant amount of research and evaluation has been done in recent years, the policy environment is constantly changing. For example, the JEE was undertaken over one year prior to the program design being finalised, and its recommendations included monitoring progress through annual national or subnational self-assessments using the JEE tool, and repetition of the external evaluation process after five years.¹⁴ The findings of these assessments will inform and update the AIHSP, allowing interventions and activities to be adjusted as implementation proceeds.

Noting this, some indicative activities have been identified for the first 12 months of the program. These will focus on building communication, coordination and a greater understanding of the health security environment in Indonesia:

- the managing contractor will be expected to conduct a number of gap analyses relating to the contextual environment, current surveillance systems, policies and procedures, coordination mechanisms, and lab capacity;
- a component of the program will be the ongoing development of preparedness at the subnational (provincial and district) level. The managing contractor may explore collaboration at the subnational level for particular areas of health security, and may identify opportunities for establishing a subnational presence (e.g. program office/s or representative/s) to support this as the program develops;
- DFAT expects to enter into a grant arrangement with WHO to continue to provide technical advice and capacity building for GoI, particularly in relation to the NAPHS, IHR capacities and FETP¹⁵. The managing contractor would support DFAT in monitoring the WHO activities and coordinating these with other AIHSP activities;
- the program will continue to support the development and enhancement of the animal health surveillance system (iSIKHNAS) and the related assessment of linkages and information sharing between all current animal and human health surveillance systems (SehatSatli, SIZE, EWARS).

Links/Complementary Activities with the IPCHS

In 2017, Australia announced a Health Security Initiative for the Indo-Pacific region, which is being implemented by the new IPCHS with funding of \$300 million over five years. The initiative contributes to the prevention and control of infectious disease threats with the potential to cause social and economic harms on a national, regional or global scale.

IPCHS will release their guiding strategy for Indonesia in early in 2019, together with remaining designs for work under the following six core themes which align with the AIHSP investment areas (see Figure 2 and Table 2). Table 2 also shows planned IPCHS activities for each core theme/investment area that are relevant to the AIHSP and likely to benefit Indonesia directly, as well as having regional impacts.

¹⁴ WHO. *Joint External Evaluation of IHR core capacities of the Republic of Indonesia. Mission Report: 20-24 November 2017*. 2018. <http://www.who.int/ihr/publications/WHO-WHE-CPI-REP-2018.9/en/>

¹⁵ While FETP is already well established and institutionalised in Indonesia, due in part to GoA support, optimal human resource placements and career progression for all graduates have not yet been achieved. DFAT Office of Development Effectiveness. *Evaluating a decade of Australia's efforts to combat pandemics and emerging infectious diseases in Asia and the Pacific 2006-2015: Are health systems stronger?* 2017.

Table 2:

IPCHS core themes/AIHSP investment areas	IPCHS activities relevant to AIHSP
POLICY - Whole-of-government policy coordination.	JEE/PVS joint planning and assessment; and Health Security Financing Assessment through the World Bank.
COMMUNITIES- Community-level action on prevention and preparedness, including vector-control measures.	World Mosquito Program study in Yogyakarta.
INFORMATION - Disease surveillance capacity and networks, along with broader support to improve the quality and availability of health information for decision-makers.	Research grant on surveillance and treatment of drug resistant malaria; and research grant on antibiotic use/AMR.
FACILITIES- Laboratory strengthening, along with infection prevention and control in key health facilities.	Laboratory twinning arrangement between Indonesia's Animal Disease Investigation Centre and the Australian Animal Health Laboratory; and laboratory capacity building.
PEOPLE - Workforce capacity building, including support for FETP.	Strengthening FETP/FETV networks and mentoring; Health Security Corps; and ASEAN-Australia Health Security Fellowship Program through which Fellows from ASEAN countries will undertake the Australian National University Master of Applied Epidemiology.
PRODUCTS - Access to medical products, including development of new drugs and diagnostics, and strengthening the drug regulatory environment.	Partnership with Indonesia's National Regulatory Authority and the Australian Therapeutic Goods Administration to strengthen medicine regulation.

While the IPCHS is a regional initiative, it presents a valuable opportunity for coordination and collaboration with the AIHSP. The AIHSP has therefore been designed to ensure that it will complement activities supported by the IPCHS and will lead to shared achievement of key performance indicators in Indonesia. A DFAT/Gol workshop to finalise the Program Logic agreed the areas where IPCHS will complement the program activities. Although IPCHS activities may be managed separately, given their regional focus, they will contribute to achievement of certain intermediate outcomes in Indonesia specifically. These activities are also discussed in further detail in the IPCHS Indonesia Country Investment Plan which will be released separately.

PROGRAM DESCRIPTION

AIHSP will be a flexible program, under which a range of activities will be identified and supported to strengthen Indonesia's ability to better manage its health security risks. A managing contractor will be required to work with Gol counterparts to identify and develop specific activities which will be presented as an annual work plan for approval by the PCC. The PCC will be made up of senior Gol representatives and will be co-chaired by a senior representative from DFAT, and may include representatives from other GoA agencies (DAWR, IPCHS and possibly DoH) as observers/advisors.

The program will have the scope to address priority health security areas beyond EIDs, including AMR, re-emerging infectious diseases and/or vector-borne diseases, under the proviso that approval is given by the PCC.

All activities proposed for program funding should meet the following investment criteria and guiding principles:

Table 3: Investment Criteria/Guiding Principles	
Relevance	Will the activity contribute to one or more of the end-of-program outcomes?
Effectiveness and Impact	What is the evidence that the activity will be likely to achieve significant progress towards the end-of-program outcomes?
Ownership and commitment	Is there support from the relevant beneficiary (government ministry, local government, affected population)?
Monitoring and evaluation	Are there arrangements in place to track implementation, and to measure the outcomes of the activity?
Learning and innovation	Is there a mechanism in place to ensure that lessons will be learnt from the activity?
Replication, scale and policy influence	What evidence is there that the activity can be/is being replicated, or is influencing national policy at sufficient scale to have impact (if applicable)?
Affordability and sustainability	Is the activity considered to be value for money and has consideration been given to ensure that the benefits of the activity will be sustained once program inputs come to an end?
Gender and social inclusion	Does the activity appropriately consider gender and social inclusion issues?

DELIVERY APPROACHES

The following options for program delivery were considered:

Option 1: DFAT provides support to the Australian DAWR and DoH to engage directly with relevant GoI Agencies.

This is similar to the delivery approach for animal health under AIPEID where DAWR is the implementing agency for all animal health components of the program, contracting the staffing and mobilising the resources needed to implement activities.

Pros: the Indonesian Government values the direct government to government relationship.

Cons: DAWR and DoH do not have the resources to provide the international administrative, logistical and general operational support required to manage this program.¹⁶

Option 2: DFAT Post manages the program directly.

DFAT does not have the required staff and resources at Post to manage the administrative, contractual and logistical elements of a program of such a size and technical nature, and will not be able to undertake the level of stakeholder engagement which will be needed. More appropriate roles for DFAT will be to: provide strategic direction for the program; lead policy dialogue with government; ensure compliance with internal program requirements; and lead coordination with other areas of DFAT, such as the IPCHS.

¹⁶ DAWR has indicated they are happy to provide appropriate levels of technical assistance to the program.

Option 3: DFAT engages a contractor (or consortium) through a competitive tender process to manage the program.

This option will provide an optimal combination of efficiency, effectiveness and value-for-money. DFAT will engage a managing contractor with: understanding of GoA and GoI regulations; capacity to meet the operational requirements needed to work in Indonesia; ability to mobilise high quality technical resources as and when required; and capacity to take responsibility for the day-to-day management of the program.

This will free up time for DFAT to concentrate on providing strategic oversight of the program, and will maximise the flexibility of DFAT staff to respond to Indonesian Government and partner agency needs. It will also enable DFAT to continue close engagement with DAWR and DoH on health security issues, and will provide the option for DAWR and DoH technical personnel to be involved in the program as and when required without having to take on a management role.

E: IMPLEMENTATION ARRANGEMENTS

GOVERNANCE AND IMPLEMENTATION ARRANGEMENTS

Proposed governance arrangements are presented in Figure 3. The roles and responsibilities of key bodies are summarised in Figure 4. These arrangements have been discussed and agreed by key stakeholders including the Indonesian MoA and MoH. They build upon lessons learned from previous programs and have been developed to ensure that the program will be a full partnership, with joint Australian and Indonesian Government ownership.

These arrangements aim to address key issues identified in reviews of AIPEID, including the need for more strategic, senior-level engagement with Indonesian government and counterpart Australian agencies. They will support development of a more integrated and coordinated One Health approach and will ensure that senior GoI officials from different ministries work together to agree priority activities and oversee their implementation.

These arrangements reflect the critical role of governance as outlined in WHO Health Systems Framework building blocks and referenced in DFAT's Health for Development Strategy 2015-2020.

Figure 3: AIHSP Governance Arrangements

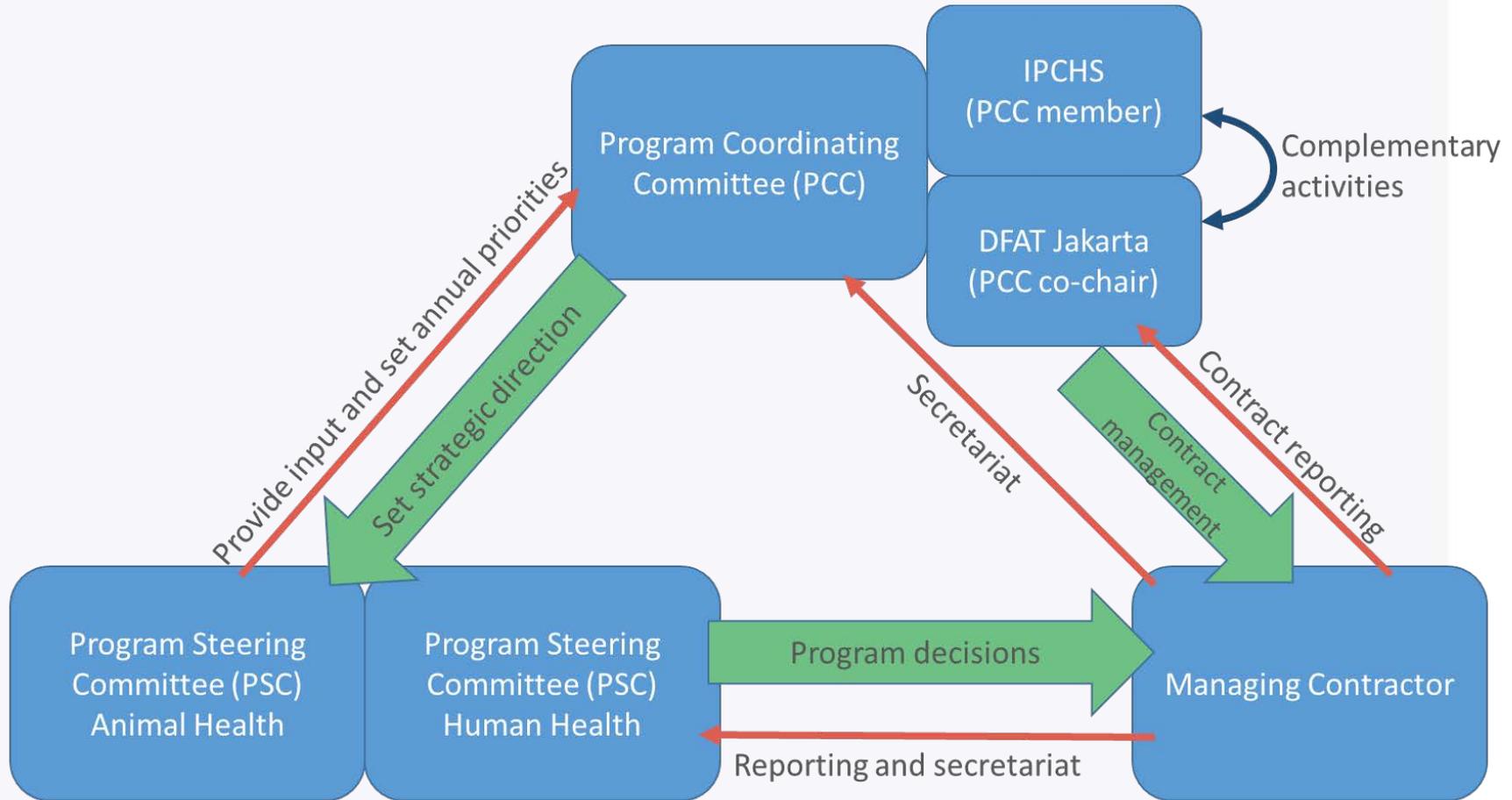
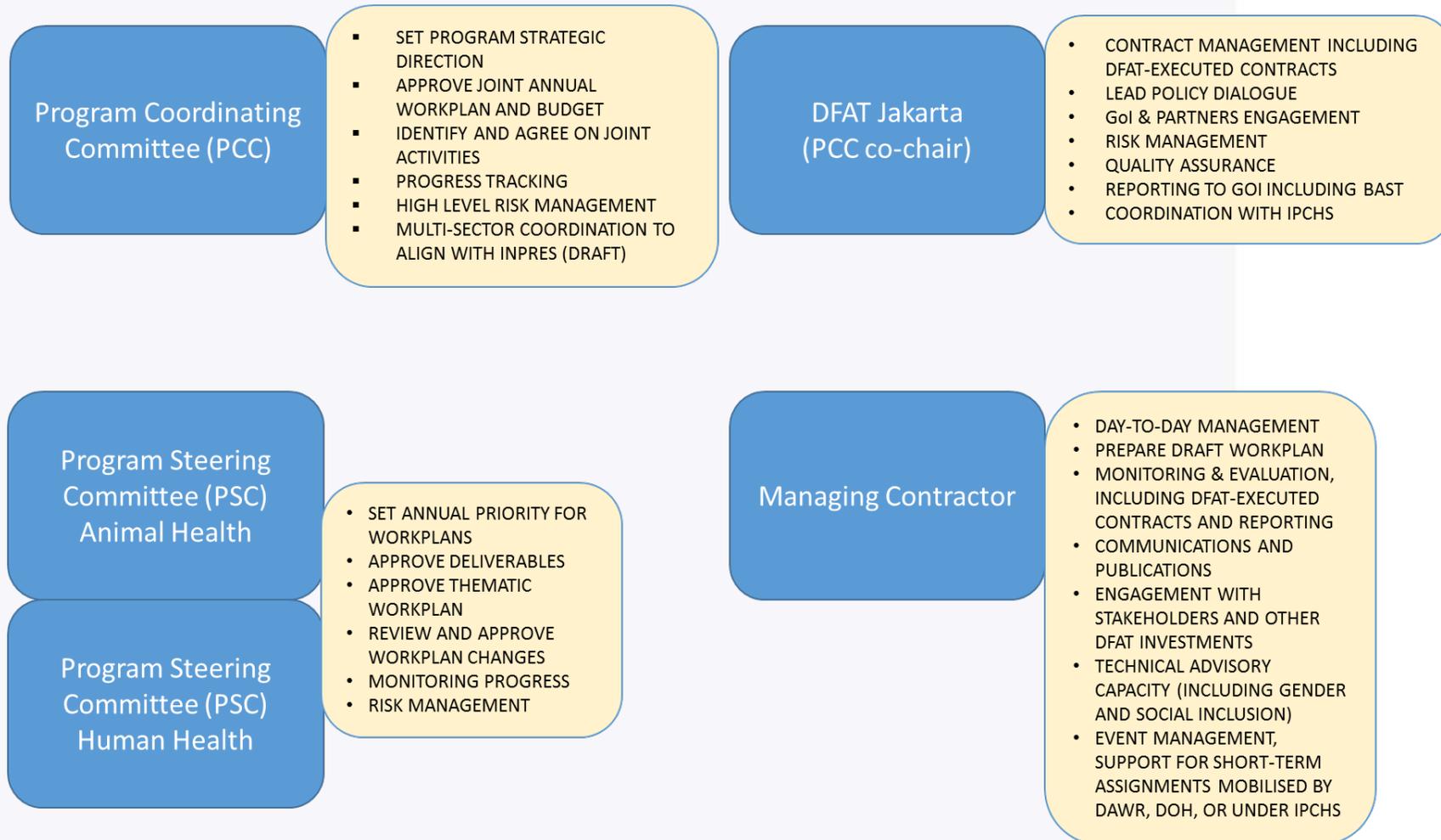


Figure 4: Overview of roles and responsibilities



DFAT will negotiate a subsidiary arrangement with Gol under the bilateral development cooperation treaty to cover all activities under the AIHSP and ensure the program provides the required handover (BAST) reporting to Gol. A managing contractor will be engaged to administer the program and required to further develop the terms of reference for the governance arrangements.

The Managing Contractor

A managing contractor will be engaged through a competitive tender process to coordinate and support national and subnational activities and facilitate communication and coordination across the program. The contractor will deliver/manage the program from a central program office in Jakarta. The program team will be required to liaise with partners from Gol, GoA and international organisations. The managing contractor will engage the staff required to deliver/manage the program, including staff with animal and human public health expertise and relevant experience.

Key elements of the managing contractor's role will include:

1. Providing all day-to-day management, coordination, administration, implementation and support resources necessary to deliver the program effectively and efficiently in accordance with the strategic direction agreed to by the PCC, and as set out in the annual work plan and following the terms of reference for the contract;
2. Establishing and maintaining a program office (in Jakarta) including ICT, the recruitment and commencement of any support personnel staff as well as the establishment of all systems required for effective implementation of the program;
3. Preparing the draft work plan; and delivering the agreed annual work plans and budget;
4. Engaging with stakeholders and other DFAT investments, and supporting coordination and communication across the program, including DFAT's role in policy dialogue with Gol;
5. Technical support (including gender and social inclusion), including conducting strategic and technical analysis and other advice to Gol and international organisation partners as required;
6. Providing secretariat services for senior-level and technical advisory meetings, and assisting with organising PCC and other governance meetings in collaboration with all relevant parties;
7. Managing events and supporting short-term assignments mobilised by DAWR, DoH or IPCHS;
8. Leading program wide planning, contracting arrangements to support PCC-approved activities; communications, publications and reporting;
9. Establishing and maintaining the M&E system, and delivering performance assessments and corporate reports (including for DFAT-executed contracts);
10. Risk management, including in relation to safeguards, fraud, security, workplace health and safety, and program risks.

DFAT

DFAT will lead policy dialogue and engagement with Gol, and ensure strategic oversight of program implementation. The Health Unit at Post will: oversee the program and provide strategic advice to DFAT management; undertake program contract management; be responsible for working-level relationships with Gol; and provide internal program reporting and communications. The Health Unit will also maintain close engagement with IPCHS, DoH and DAWR throughout program implementation.

DFAT expects to enter into a grant arrangement with WHO (and potentially other international organisations). If so, the Health Unit at Post would have a direct contract with WHO for defined health security activities, particularly (but not only) in the areas of Emergency Response and Pandemic Preparedness. This reflects the key role of WHO as the arbiter of the IHR. The scope of

potential activities has not been fully defined at this stage but could include: support to government-led planning processes (multisectoral and sector specific) in response to JEE recommendations; support as and when requested to GoI in the event of an emergency; and expansion and district level piloting of the WHO and FAO model for One Health surveillance and response capacity building. In the event of a grant arrangement with WHO and/or other international organisations, the managing contractor will provide support to DFAT for coordination, technical assistance and M&E.

Program Committees

The PCC will be the decision making body for program implementation. Membership is expected to include senior representatives of GoI (Bappenas [National Development Planning Ministry], Kemenko PMK, MoH, MoA) and GoA (including DFAT, DAWR and IPCHS¹⁷). The PCC will oversee the program and set strategic direction, convening on an annual basis to review progress and approve activities/work plans to be supported under the program. Ministries such as Kemenko Polhukam (Coordinating Ministry for Political Legal and Security Affairs), Kemenko EKUIN (Coordinating Ministry for the Economy, Finance and Industry), Ministry of Finance, Ministry of Home Affairs, Ministry of Environment and Forestry, and BNPB¹⁸ can also be engaged in the PCC.

Two Program Steering Committees (PSC) will sit below the PCC. The PSCs will support program decision making processes, enabling more detail to be considered than at the PCC. The Animal Health PSC will be made up of representatives from the MoA, DFAT and DAWR; the Human Health PSC will be made up of representatives from the MoH, DFAT and WHO.

The managing contractor will play a secretariat role for these committees.

Technical Advisory Group (TAG)

A TAG may be set up by the managing contractor to provide strategic advice to the program as and when requested if deemed necessary. It would need to be set up on advice from the PCC throughout the course of the program. During the inception period, the managing contractor – in consultation with DFAT and GoI – will consider this option, and make recommendations to the PCC.

BUDGET

The AIHSP has a total budget of up to \$17.5 million dollars over a period of five years, including \$500,000 for internal reviews, monitoring and administration. DFAT expects to enter into a grant arrangement with WHO and potentially other international organisations, and may provide funding to DAWR for specific short-term assignments/activities. This leaves an approximate budget of up to \$14 million available for program implementation and management costs, to go out for tender following the timeline below:

Year 1 (Inception)	Year 2	Year 3	Year 4	Year 5
\$1.5 million	\$ 3.5 million	\$3.5 million	\$3.5 million	\$2 million

MANAGEMENT ARRANGEMENTS

The basic responsibilities of the managing contractor are outlined in Figure 4: Overview of roles and responsibilities. More detailed roles and responsibilities of the managing contractor will be set out in the scope of requirements.

¹⁷ DFAT representation will include Post and the IPCHS. DoH have indicated an interest in engaging but limitations in resources – if so, they could be represented through the IPCHS.

¹⁸ Post is also undertaking a design for a new five year “Australia Indonesia Disaster Risk Management program” (2018-2023) in partnership with BNPB.

HUMAN RESOURCES/STAFFING

Bidders will propose the personnel to manage and implement the program in their technical proposals. They will need to propose positions/personnel with the appropriate technical, management and operation skills needed to manage, deliver and maintain the continuity of the program. The core management team will liaise closely with DFAT throughout implementation to ensure the program remains responsive to Indonesian and Australian priorities and meets their information needs.

Employment conditions for internationally-recruited staff contracted as part of the core management team will align with the DFAT Adviser Remuneration Framework. Remuneration rates and employment conditions for nationally-recruited staff will be expected to be commensurate with existing norms, and align with other donor-funded programs in Indonesia and local employment and manpower legislation.

Prospective bidders will be asked to outline how they will resource the program, including the names and CVs of the people who they put forward in the key positions.

COMMUNICATIONS AND REPORTING

The managing contractor will work with DFAT during the inception period to develop a communications and public affairs strategy that supports the dissemination of information and learning from the program stakeholders. The communications and public affairs strategy will need to identify information needs for all key stakeholders, including GoI partners, DFAT, the Australian taxpayer, non-government stakeholders and program beneficiaries. The strategy should link to the Monitoring, Evaluation and Learning Framework (MELF). Qualitative data will be tailored to different audiences and purposes, such as policy briefs, case studies, and stories of change. This will ensure that information generated by the program will support broader analysis of the enabling environment and will be relevant and meaningful to a range of different stakeholders. Quantitative data sourced from the MELF will be collated into reports that provide DFAT and key program partners with evidence of headline results from the program.

The reporting cycle for the program will include six-monthly and annual reports from the managing contractor linked to the annual work plans as approved by the PCC. The content, structure and timing of the reports will be agreed with DFAT during the inception phase, but the annual report will generally include: a general review of the previous twelve months (key outcomes/results against the MELF); progress against targets/work plans; key issues and constraints; and requests for alterations to the planned activity schedule. A summary of expenditure against the budget should be forwarded independently to DFAT.

MONITORING, EVALUATION AND LEARNING (MEL)

A preliminary description of the MELF is attached at Annex A; it describes some of the key principles and components that should be included in the final MELF. The MELF will be further developed and completed by the managing contractor during the inception period in collaboration with DFAT and key development partners. The managing contractor will be expected to ensure that the finalised MELF and progress reports meet DFAT's M&E Standards.¹⁹

Outcome level Key Performance Indicators (KPIs) will include quantitative and qualitative indicators to answer the following questions:

- How effective was AIHSP in helping to improve policies and procedures related to health security?

¹⁹ DFAT. *DFAT Monitoring and Evaluation Standards*. April 2017. <https://dfat.gov.au/about-us/publications/Documents/monitoring-evaluation-standards.pdf>

- Are key Indonesian agencies routinely coordinating and using formal means of information exchange? How has AIHSP contributed to improved coordination and information exchange?
- Do GoI animal and human health surveillance systems produce sufficiently useful and relevant information to inform decisions? How has AIHSP contributed to this?
- How effectively has AIHSP strengthened partnerships between regional, Australian, and Indonesian institutions on health security issues?
- How relevant and strategic are the choice of activities?
- Are activities being replicated, or influencing national policy at sufficient scale to have impact (if applicable)?
- How well managed is the program?
- How well has the project coordinated with other Australian Government initiatives?
- How well are projects achieving their expected outcomes? What was the quality and reach of outputs?
- Does the program respond to the findings of the Gender Gap Analysis (to be carried out by the managing contractor during the inception period), and meet DFAT standards for Gender Equality and Social Inclusion?

The MELF will specify who will assess what and when, to learn from and share information on the program's direct achievements and contributions to development results.

Implementation progress will be tracked against a baseline which will be established collaboratively with stakeholders during the inception period. This will include relevant gender disaggregated data. Annual work plan targets will be identified, agreed with the PCC, and reported against to track progress towards the achievement of the end-of-program outcomes, which will describe the extent of change in health security systems and capacity.

The MEL system will also generate information on program performance through qualitative progress markers, including key deliverables and performance standards that can be used by key stakeholders for management decision making, learning and mutual accountability purposes.

Accountability under the program will be both external (e.g., to Australian taxpayers) and internal (to DFAT Program Management, and the PCC). This will enable progress reports to meet DFAT, GoI and implementing partner needs, report against the MELF, have a credible basis for claims, and recommend actions to improve performance.

The MELF will provide sufficient annual performance information to address DFAT aid quality requirements. DFAT rules and tools, policies and M&E standards will be adhered to throughout implementation.

Progress reports will also present how the MEL system will have informed learning, decision-making and action on the part of DFAT, GoI and/or development partners.

At the national level, MEL information will be generated through existing or enhanced GoI systems wherever possible – as part of the institutional strengthening approach. It should also be noted that the JEE report recommended an annual internal review using the JEE tool and to repeat the external JEE review in 2022. This information will be complemented, as required, by the conduct of additional (mutually agreed) studies/analysis, to be funded by the program.

Thereafter, sufficient resources should be allocated for MEL in the program budget to carry out identified and scheduled MEL activities. This may include regular short-term inputs from an M&E practitioner to refine the MELF during inception and to provide on-going MEL inputs to the program management team and to government partners throughout the entire implementation period.

Contributions to AIHSP outcomes and impact will be assessed during a proposed mid-term review of the program. This review will take stock of progress and help inform decision making regarding future investment. If inadequate progress is being made on developing sound partnerships and securing partner resource commitments, the option of ceasing the program at this time will be seriously considered. Assuming the program does continue for the full term, an end-of-program independent evaluation will also be conducted to verify outcomes and inform DFAT and Gol of future directions.

SUSTAINABILITY

Sustainability has been at the forefront of the design process by ensuring strong collaboration with and ownership of the Gol at every step. This will need to continue throughout implementation. Issues of sustainability will be considered in the selection and implementation of activities, and relevant indicators of sustainability will be incorporated in the MELF.

Evaluation of the current AIPEID program show that many activities are likely to be sustained over time. This has happened largely because the Gol has been very involved in priority-setting and design (to ensure activities are fit for purpose), Indonesian government staff have been integral to the implementation of activities, and budgeting for these activities have been incorporated into Gol plans.

Lessons learned have informed the design and will inform program implementation. The governance mechanisms (see Figure 3) and shared decision-making will ensure relevance and alignment with Gol priorities, and the partnership model of implementation will build capacity and maintain a strong sense of ownership by Gol. Technical assistance will focus on sustainable capacity development, with program staff adopting advisory and mentoring (but not operational) roles. All areas of work proposed in the future program should build on outcomes developed in the current AIPEID program, and the recommendations of the JEE, PVS and NAPHS which are already largely embedded and supported within the Gol framework.

GENDER EQUALITY

Gender equality is recognised as a core principle of Australia's aid program. DFAT launched their Gender Equality and Women's Empowerment Strategy in 2016. The strategy aims to promote equal opportunities and outcomes for all. It places gender equality and women's empowerment centrally in Australia's foreign policy, economic diplomacy and development efforts. The 2017 Foreign Policy White Paper also identified gender as a top foreign policy priority.

AIPEID's gender equality and women's economic empowerment efforts will need to be built on and expanded upon throughout this program, noting that gender considerations were more successfully incorporated in the animal health component, as compared to the human health component. Women play a critical role at all levels in both the human health and animal health systems. Gender is a key factor in EID exposure and vulnerability, given the multiple roles of women in small-scale poultry farming, domestic and commercial food preparation, and the gender make-up of the health workforce. Recognising the different roles that men and women play in preventing/controlling the spread of disease (relevant to public health campaigns) and the gendered economic impacts of disease outbreaks will increase the effectiveness of the partnership.

Gender equality and inclusiveness will be considered in all activities of this program and gender indicators will form part of the program's MELF. The managing contractor will be required to do a gender gap analysis during the inception phase of the program (considering the gender strategy that was previously developed under the animal health component of the AIPEID program) and to develop a plan/strategy as to how they will best integrate gender into the program. The managing contractor will therefore need to have strong technical skills in relation to gender equality and social

inclusion. The gender gap analysis will further inform the indicative areas of investment, noting that gender considerations are already highlighted in indicative areas of investment 1-3, above.

Although participation in program events is largely based on position within the Indonesian Government (and thus subject to gender biases that may exist within partner institutions), program staff will need to be familiar with gender issues, and methodologies to amplify women's voices in decision-making. Differences in the roles that men and women may play in livestock production, for example, will be considered in the design of interventions for which the community is the ultimate beneficiary, to ensure that benefits are equitably distributed. Recruitment and communication methods will need to encourage gender equality and follow an equal employment opportunity policy. All M&E data will be gender disaggregated and the program will need to be able to provide a clear synopsis of how the program has committed to gender equality, and ensured the program has effectively addressed gender issues throughout implementation.

INCLUSION

Guided by the Australian Government's *Development for All 2015-2020: Strategy for strengthening disability-inclusive development in Australia's aid program*, AIHSP will need to ensure that the principles espoused in the Strategy are adhered to. Approximately 15-20% of the population of Indonesia are estimated to have some form of disability. People with disabilities in Indonesia are often largely invisible or face stigma, enduring multiple barriers to accessing opportunities for health, education and economic development in Indonesia. While the partnership is not designed to specifically address the needs of such groups, staff employed under the program may be in a position to strategically advise GoI on how they can factor in the needs of such groups into their policy making and operational planning, and opportunities to do so should be taken.

AIHSP should develop a disability guideline which aims to ensure that interventions are inclusive of people with disability and that impact is captured. For example, program personnel will be trained on disability and other inclusion issues, and the managing contractor will support the appointment of disability focal points. Inclusiveness will need to be captured either qualitatively or quantitatively through the program's MELF.

CHILD PROTECTION

Child protection will be integrated in AIHSP and its partnerships to ensure appropriate safeguards are in place to protect children, prevent child exploitation, and comply with applicable laws. All program personnel will undertake training in child protection and the managing contractor will develop a program-specific child protection policy that complies with DFAT's Child Protection Policy and relevant DFAT guidance notes.

The managing contractor will also develop a robust child protection reporting and management process. Having a process, supported by appropriate systems and governance, for identifying, reporting and managing child protection incidents is crucial to meeting DFAT's child protection requirements.

CLIMATE CHANGE

Climate change has impacts on human and animal environments and living conditions, movements and health. For example, hotter atmospheric and seawater temperatures and changing rainfall patterns may lead to the increased transmission of vector-borne diseases such as malaria and

dengue, which are already major public health concerns in Indonesia. Changing agricultural practices in response to climate change may also contribute to zoonosis outbreaks.^{20,21}

AIHSP should systematically consider the potential impacts of climate change on EIDs/zoonoses in planning its activities and also take opportunities to advocate for the integration of health security considerations in climate change-focused initiatives.

INNOVATION AND PRIVATE SECTOR ENGAGEMENT

DFAT recognises the importance of the private sector in health security in Southeast Asia and the scope for private sector engagement. However, the size and nature of this proposed investment presents challenges to this. Private companies have the resources and expertise to contribute to strengthening health security in a variety of ways, including: development of innovative data collection technologies to enhance disease surveillance; availability of personnel, resources and expertise for emergency response; and supply chain management systems to improve storage and delivery of essential health supplies. Internationally, many companies already support increased health security as a contribution to corporate social responsibility (e.g., to the malaria elimination agenda). Health security threats are stimulating new opportunities for private sector engagement and they should be considered in the broader context of public-private partnerships and cooperation. The program should identify opportunities to build upon private sector insights to address specific health and development risks and vulnerabilities in Indonesia.

Australia's previous EID programs in Indonesia have focused on public sector partnerships with government agencies. This approach will continue under AIHSP and it is not proposed that there will be a large private sector component to the program. This does not preclude the program from working with the private sector: there could be opportunities for the private sector to support the MoA for capacity building in areas such as iSIKHNAS technical programming support, provided that Gol approves this, and that it will help to ensure sustainability at the conclusion of the program.

Innovation will similarly be promoted under the program and the managing contractor should identify opportunities for appropriate innovation. Innovative approaches and pilots that are proven to work can be scaled up or mainstreamed further.

RISK ASSESSMENT

A draft risk matrix (at Annex B) provides a preliminary assessment of high level risks and potential mitigation strategies. The managing contractor will develop a more comprehensive risk management plan during the inception phase. This plan will be reviewed regularly by the senior management team and will guide implementation, ensuring early identification and management of potential risks. Progress reports will review risks to ensure all stakeholders can contribute to risk management throughout implementation.

This section presents key identified risks including:

- reduced priority given to health security and reduced support from government counterparts following the 2019 presidential election: this is unlikely, given the global momentum on health security and the economic impact of an epidemic;
- program activities and investments are ad hoc and incoherent, compromising strategic focus and sustainability: this will be mitigated by ensuring program implementation is aligned with the NAPHS, and responds to JEE and PVS recommendations;

²⁰ Wirawan, MA. Public health responses to climate change health impacts in Indonesia. *Asia Pacific Journal of Public Health* 2010; 22(1): 25-31.

²¹ Haryanto B. Health Adaptation Scenario and Dengue Fever Vulnerability Assessment in Indonesia. In R Akhtar (ed.) *Climate Change and Human Health Scenario in South and Southeast Asia*. Springer. 2016.

- multi-sectoral challenges working with a One Health outlook result in lack of incentives for coordination: coordination was a key result requiring work noted by the JEE and is expected to be a GoI priority, and clear policy outcomes and investment criteria have been developed to ensure cohesion across sectors;

- poor government buy-in results in failure to address implementation challenges: government interests will be fully reflected by ensuring that the extensive stakeholder consultation throughout the design process is continued during program implementation, by ensuring that investment criteria are adhered to, through inclusive governance mechanisms to engage senior-level government officials across ministries, and through a high level of DFAT-led policy engagement.

A key program transition risk is the MoA preference for engagement with DAWR (rather than DFAT) following their longstanding relationship under AIPEID and their in-house veterinary expertise. Early DFAT engagement with MoA has commenced to ensure a smooth transition. MoA will be assured of ongoing DAWR engagement under the new program. It is expected that the contractor will engage appropriate animal health expertise to ensure credibility and effective engagement with MoA.

No 'work with children' or 'child-focused' organisations are currently involved in this initiative and are unlikely to be, but this will need to be monitored throughout the program. There are no infrastructure projects planned. As such, the investment is low-risk in relation to child protection, displacement and resettlement and environmental protection issues.

Risks will continue to be assessed throughout the implementation process as work plans and activities are decided. The contractor will be expected to support partners' efforts to monitor program risks, including through a "live" risk management plan throughout the life of the investment. In addition, the DFAT program team (Health Unit at Post) will retain its own risk register, with any significant risks to be escalated to the Post development cooperation risk matrix.

F: Annexes

Annex A: Monitoring, Evaluation and Learning Framework– Preliminary Description

Annex B: Risk Register

ANNEX A: MONITORING, EVALUATION & LEARNING FRAMEWORK (MELF) – PRELIMINARY DESCRIPTION

Purpose

The purpose of the MELF is to:

- Provide evidence of progress and quality of program delivery so as to be accountable to the PCC and to DFAT.
- Provide rigorous data to fuel learning and program improvement for the managing contractor and the partnerships' key stakeholders.
- To ensure that all funded activities meet investment criteria and are set up for success.

The primary audiences for the MELF and the results that it will produce are the managing contractor, the PCC, DFAT and the key partners.

Accountability under the program will be both external (e.g., to Australian taxpayers) and internal (to DFAT Program Management, and the PCC). This will enable progress reports to meet DFAT, GoI and implementing partner needs, report against the MELF, have a credible basis for claims, and recommend actions to improve performance. The MELF will provide sufficient annual performance information to address DFAT aid quality. DFAT rules and tools, policies and monitoring and evaluation standards will be adhered to throughout implementation.

Scope

The MELF has two key areas of focus. Firstly, it will focus on the performance of the program as a whole, its progress towards end-of-program outcomes and addressing other key evaluation questions at the whole-of program level. Secondly, it will provide a framework for ensuring the upfront quality and selection of investments as well as monitoring their performance.

The scope of the MELF includes any potential activities that may be undertaken by WHO, other international organisations, and/or DAWR under the AIHSP. It does not extend to IPCHS activities; M&E for these activities will be undertaken separately. However, given that complementary IPCHS and AIHSP activities are expected to be coordinated, the MELF should acknowledge and take account of IPCHS planning, activities and M&E outcomes in evaluating the AIHSP (where relevant).

Approach to M&E

AIHSP will be guided by a utilisation-focused approach, whereby the key stakeholders will be involved in the shaping of the evaluation framework to ensure it fully meets their needs. In the inception phase of the program, the MELF will be refined, with input from key government partners to ensure it meets needs.

A balanced score-card approach will be taken to ensure that as well as focusing on results against targets, we also evaluate the quality of the program delivery, as well as whether it is promoting gender equality and inclusion.

Annual progress markers will be set, with input from key partners, to ensure accountability, but at the same time allowing for emergence and program adaption. The approach will be guided by the following principles:

- Fit for purpose approach that meets needs
- Accountable and transparent
- Flexible and able to accommodate emergence
- Learning focused

Main components of the MELF

The MELF components include: a set of balanced key evaluation questions, a program logic with a matching results framework, and description of investments that will be quality assured and monitored. It also outlines the reporting requirements, roles, responsibilities and resources for implementing the M&E plan.

Key evaluation questions

Key evaluation questions		Evidence needed	Score card domain
1.	<i>How effective was AIHSP in helping to improve policies and procedures related to health security sufficiently?</i>	<ul style="list-style-type: none"> • What policies and procedures were improved? • What is the significance of these policy improvements for health security? • To what extent was gender and inclusion considered? • What was the role of AIHSP in this? 	Outcomes EOPO1
2.	<i>Are key Indonesian agencies routinely coordinating and using formal means of information exchange, and what was the role of AIHSP?</i>	<ul style="list-style-type: none"> • Who are the key agencies who should be coordinating formally? • What changes occurred with regard to coordination and formal information exchange? • What was the role of AIHSP? 	Outcomes EOPO2
3.	<i>Are Gol animal and human health surveillance producing sufficiently useful and relevant information to inform decisions, and what was the role of AIHSP?</i>	See intermediate outcomes.	Outcomes EOPO3
4.	<i>How effective was AIHSP in strengthening partnerships between regional, Australian, and Indonesian institutions on health security issues?</i>	<ul style="list-style-type: none"> • What new partnerships were formed? • How sustainable are these partnerships? • What was the role of AIHSP? 	Outcomes EOPO4

5.	<i>How relevant and strategic are the choice of activities?</i>		Quality
6.	<i>How well managed is the program?</i>	<ul style="list-style-type: none"> • Effectiveness of M&E and learning. • Partnership and engagement with Gol. 	Quality
7.	<i>How well has the project coordinated with other Australian Government initiatives?</i>	<ul style="list-style-type: none"> • Has AIHSP coordinated with IPCHS and other Australian Government initiatives/agencies? • Are complementary activities being implemented collaboratively? • Are resources being leveraged and used efficiently across Australian Government? 	
8.	<i>How well are projects achieving their expected outcomes, and what was the quality and reach of outputs?</i>		Effectiveness of projects
9.	<i>Does the program respond to the findings of the Gender Gap Analysis (to be carried out by the managing contractor during the inception period), and meet DFAT standards for Gender Equality and Social Inclusion?</i>		Effectiveness of projects

The results framework and how progress will be assessed

To address key evaluation questions 1-3 (which relate directly to the program's three intermediate outcomes), an accompanying results framework which details progress markers for 18 months and at the end of the program should be developed. Given that the program is flexible, after the first 18 months, annual progress markers will be developed ahead of the 12 month period and will be used to assess adequacy of progress. Progress markers will form part of the annual work plan and will be identified and agreed with the PCC.

Contributions to AIHSP outcomes and impact will be assessed during a proposed mid-term review of the program during year 3. This review will take stock of progress and help inform decision making regarding future investment. If inadequate progress is being made on developing sound partnerships and securing partner resource commitments, the option of ceasing the program at this time should be seriously considered. Assuming the program does continue for the full term, an end-of-program independent evaluation will also be conducted to independently verify outcomes and inform DFAT and GoI of future directions.

Resourcing for MELF

Progress reports will also present how the monitoring and evaluation system will have informed learning, decision-making and action on the part of DFAT, GoI and/or development partners.

At the national level, M&E information will be generated through existing or enhanced GoI systems wherever possible, as part of the institutional strengthening approach. Nevertheless, such information will be complemented, as required, by the conduct of additional (mutually agreed) studies/analysis, to be funded by AIHSP through the flexible program.

Thereafter, sufficient resources should be allocated for MEL in the program budget according to identified and scheduled MEL activities. This may include regular short-term inputs from an M&E practitioner to refine the MELF during inception and to provide on-going M&E inputs to the program management team and to government partners throughout the entire implementation period.

ANNEX B: RISK REGISTER

	Event/Impact	Mitigation/Treatment	Responsibility	Rating after Mitigation		
				Likelihood	Consequence	Rating
Operating Environment	Government health expenditure is well below regional and lower middle-income averages which undermines health service delivery in Indonesia. There are limitations in Indonesia’s overall health system capacity, including challenges associated with decentralisation. There may be a preference or pressure deliver health security activities ‘vertically’ for expedited results.	<ul style="list-style-type: none"> ➤ DFAT and the contractor will work closely with the GoI when negotiating and developing activities to ensure that they are feasible and fit within the investment criteria. ➤ M&E and how each activity will be reported on will be considered from the outset. ➤ DFAT will actively advocate for a health systems strengthening approach as outlined in DFAT’s Health for Development Strategy (2015-2020). 	DFAT/Contractor	Possible	Moderate	Medium
	Indonesia faces a health crisis, such as a major outbreak, distracting attention from longer term capacity building and objectives.	<ul style="list-style-type: none"> ➤ Given the flexible nature of the program, attention and investment can be reoriented if deemed necessary; a crisis could be turned into an opportunity to build capacity in crisis response through Australia and Indonesia working together. ➤ Using the NAPHS, JEE and PVS to guide investments should ensure that program objectives align with GoI’s objectives. 	DFAT/ Contractor	Possible	Minor	Medium

<p>Gol or GoA does not want to support or trial certain activities being proposed by respective governments.</p>	<ul style="list-style-type: none"> ➤ Ensure that Gol/GoA are consulted on new activities from the outset and ensure there are clear communications channels between both so there are no surprises when activity plans are signed off in the PCC. 	<p>DFAT/Contractor</p>	<p>Possible</p>	<p>Minor</p>	<p>Medium</p>
<p>Change in Government in 2019 in Indonesia results in changes in priorities.</p>	<ul style="list-style-type: none"> ➤ The flexible program design, with annual work plans will allows for adjustment to changed priorities if considered necessary. ➤ Indonesia has undertaken a JEE and is developing a NAPHS so it is unlikely that momentum will be lost. ➤ The international momentum around health security and the economic impact of a potential epidemic/pandemic are likely to ensure that health security remains a priority. ➤ DFAT is working with other donors on the Health Sector Review which will inform the RPJMN and health strategy under the new president. 	<p>DFAT</p>	<p>Possible</p>	<p>Moderate</p>	<p>Medium</p>
<p>High turn-over of staff resulting in reduced capacity, understanding of the program objectives and momentum.</p>	<ul style="list-style-type: none"> ➤ DFAT will ensure that its program aligns with the JEE and PVS recommendations. ➤ DFAT and the managing contractor will take note of new strategic documents as they emerge, ensuring that even if staff turn-over, their commitments remain unchanged. 	<p>DFAT/Contractor</p>	<p>Possible</p>	<p>Moderate</p>	<p>Medium</p>
<p>National and subnational policy-making processes do not use evidence from research and health</p>	<ul style="list-style-type: none"> ➤ The managing contractor and DFAT Health Unit will draw from evidence in policy dialogue; advocate for use of evidence; and work to create demand for evidence. 	<p>DFAT/Contractor</p>	<p>Moderate</p>	<p>Moderate</p>	<p>Medium</p>

	systems programs to inform future policies and policy implementation.	<ul style="list-style-type: none"> ➤ Possible linkages with KSI will also support evidence-based policy making. 				
Management	The transition to a new style of programming (from DAWR as a manager for the Animal Health component of the AIPEID) to a contractor responsible for the implementation of the new program will damage relationships with counterparts, processes and momentum.	<ul style="list-style-type: none"> ➤ Changes clearly communicated to Gol throughout the process and consultations will continue when establishing program work procedures and processes. ➤ Development of a clear transition approach and communication processes will ensure effective management and continuity, and will maintain momentum from AIPEID. 	DFAT/Contractor	Possible	Minor	Medium
	Program leadership of different components is uncoordinated.	<ul style="list-style-type: none"> ➤ Figure 3 sets out the governance structure agreed with Gol stakeholders to ensure coordination. ➤ Ensure oversight so all program components are contributing to shared program outcomes. ➤ The managing contractor will be responsible for ensuring coordination within and between PCC and PSCs. 	DFAT/Contractor	Possible	Moderate	Medium
Results	Activities and investments taken forward under the program are ad hoc and lack congruity, compromising strategic	<ul style="list-style-type: none"> ➤ The goal of the program is in direct alignment with the Indo Pacific Initiative for Health Security and in accordance with global, regional and domestic thinking on health security. 	Contractor	Possible	Moderate	Medium

	<p>focus. Working multi-sectorally with a 'One Health' outlook is too cumbersome. Key partners fail to engage in activities and the desired results are not achieved.</p>	<ul style="list-style-type: none"> ➤ Coordination was a key result requiring work noted by the JEE and is expected to be a Gol priority. ➤ Clear policy outcomes and investment criteria have been developed to inform the design of specific activities and the measurement of their success and to ensure cohesion across sectors. ➤ Flexible programming will support alignment with Gol priorities (across multiple ministries) and work being carried out by other development partners. 				
<p>Safeguards</p>	<p>While children are not the target of activities anticipated under this new program, any activities at the local level can involve contact with children, therefore, there is a possibility of harm. With regard to the environment, activities prioritised under this investment would more likely serve to protect than harm. No infrastructure related activities are expected as part of this initiative, therefore resettlement and displacement are highly unlikely.</p>	<ul style="list-style-type: none"> ➤ The contractor will need to be aware of DFAT's requirements on safeguards and fulfil all requirements including for child protection. ➤ Throughout implementation and once activities have been selected for funding under the program, child protection policies will be revisited. ➤ DFAT's child protection policy extends to all contractors, multilateral organisations and CSOs. 	<p>DFAT/Contractor</p>	<p>Unlikely</p>	<p>Major</p>	<p>Medium</p>

<p>Fraud/Fiduciary</p>	<p>Partners engaged in the program or staff act fraudulently leading to the misuse of program funds.</p>	<ul style="list-style-type: none"> ➤ Risk and fraud training provided for all program personnel including fraud awareness training at induction and regular refresher training for personnel throughout implementation. ➤ Regular financial audits of program expenditure conducted throughout implementation. ➤ Measurement of value-for-money measures across portfolio, regular benchmarking using comparative analysis and investigation of outliers. ➤ Adequate resourcing within operational team for conducting partner audits, spot-checks and training for program personnel and key partners in identifying and managing risk and fraud. ➤ Clear and robust fraud reporting systems and processes aligned with DFAT policies on financial management and fraud. 	<p>Contractor</p>	<p>Possible</p>	<p>Moderate</p>	<p>Minor</p>
<p>Reputation</p>	<p>DFAT commits to a health security program and later decides not to proceed with the program or to cut the program budget resulting in distrust and reduced collaboration.</p>	<ul style="list-style-type: none"> ➤ Consideration needs to be given to raising expectations within GoI unless firm commitments have been made. ➤ Health security is a key focus of the Australian government and is an issue that was canvassed in the Foreign Policy White Paper. 	<p>DFAT</p>	<p>Unlikely</p>	<p>Major</p>	<p>Medium</p>