

ATTACHMENT B

INVESTMENT CONCEPT (FOR PUBLICATION PURPOSES)

The Australia-Indonesia Health Security Partnership	
Proposed start date: Jan 2019 End Date: Dec 2023	
Total DFAT funding allocation: \$20 million - \$35 million over five years	
Risk and Value Profile:	Low Risk / Low Value
Proposed Design Pathway: DFAT-facilitated design	
Delegate approving concept at post: Fleur Davies, Minister Counsellor Governance and Human Development	
Delegate approving concept at desk/in Canberra: Andrew Schloeffel, Acting Assistant Secretary, Indonesia Branch Robin Davies, Head Centre for Health Security	

B: Problem/Issue definition and rationale for investment (Why)

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

Infectious diseases continue to contribute to morbidity and premature mortality in Indonesia. Indonesia has the second highest (after India) tuberculosis (TB) burden in the world (an estimated 1.6 million cases in 2016) and has one of the highest burdens of multidrug resistant (MDR) TB. MDR-TB is one example of antimicrobial resistance (AMR) – a growing threat to Indonesia and beyond. AMR develops when micro-organisms – bacteria, parasites or viruses – no longer respond to the drug or drugs designed to treat them.

Indonesia is among few countries in the world that have reported a recent increase of HIV incidence among key affected population groups (KAP). Although the epidemic is concentrated in KAPs, there is a generalized HIV epidemic in Papua and West Papua. Despite good levels of immunisation coverage, vaccine preventable infections and outbreaks continue to be reported, most recently (in 2017) for measles and diphtheria. Mosquito borne infections are also a key challenge, with an increase in reported cases of dengue (to 130,000 in 2015) and around 152 million people living in malaria transmission areas.

Indonesia is a 'hot spot' for emerging infectious diseases (EIDs) due to the close proximity between humans and animals through poultry and livestock management practices, increased cross-border travel and trade, and weaknesses in human and animal health systems. The majority (75 per cent) of EIDs are zoonoses— animal diseases that can infect humans. The main zoonoses continuing to occur in Indonesia are avian influenza, rabies, leptospirosis and anthrax¹. Highly pathogenic avian influenza is endemic in poultry in Indonesia. Backyard poultry practice and contaminated Live Bird Markets are risk factors for transmission of

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



avian influenza from poultry to humans. To date, 200 human cases with an 84% fatality rate have been reported from 15 provinces in Indonesia. DKI Jakarta, West Java, Banten and Bali are considered high risk provinces. Indonesia is also at risk of Middle East Respiratory Syndrome transmission (also zoonotic) due to a high number of hajj and umrah pilgrimages from Indonesia to the Middle East.

Progress has been made in building Indonesia's emerging infectious disease preparedness, detection and response capacities, but many challenges remain. These include limited human resources, unclear policies, governance constraints, as well as infrastructure and operational resource limitations. Disease response efforts are hampered by a myriad of policies and coordinating mechanisms. Moreover, since the majority of EIDs are of animal origin, an increased attention to the animal-human interface and strengthening of the cross-cutting capacities of line and coordinating ministries to deal with zoonotic diseases is needed. This aligns with the globally supported "One Health" approach that encourages multi-sectoral approaches to address zoonotic diseases.

Indonesia's decentralised system of government has devolved responsibility for the management 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 the basic legal and policy framework which provides the basis for effective programs, the division of responsibilities between central and local levels, the sheer number of institutions involved, and the varying capacity between levels of government, presents major challenges. There is a need to improve decision making structures, 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 made a pre-election commitment under *The Coalition's Policy for a Safe and Prosperous Australia* to invest in regional health security. Foreign Minister Julie Bishop subsequently launched the Australian Government's \$300 million Indo-Pacific Health Security Initiative on 8 October 2017 to help combat the challenges of existing and emerging infectious diseases for our region. The initiative recognises that Australia's health security is closely linked to the health security of countries in our 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 by Minister Bishop on 23 November 2017.

Health security is a key priority area for Australia's ongoing health program and policy engagement in Indonesia². 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. The AIPEID supports the World Health Organization (WHO) to work with the Indonesian Ministry of Health (MoH) to improve public health emergency preparedness and risk management. In addition, the Australian Department of Agriculture and Water Resources (DAWR) works with the Indonesian Ministry of Agriculture (MoA) to strengthen emergency management systems and veterinary leadership, as well as enhance Indonesia's animal health information systems. The second phase of AIPEID (\$9.9 million) which commenced in 2015, aimed to work synergistically in both animal health and human health sectors. Australian support has been well received by the Government of Indonesia. It has supported Indonesia to increasingly comply with its international obligations under WHO's International Health Regulations (IHR) as well as building national human and animal disease surveillance systems and emergency response mechanisms. This program is expected to end in December 2018.

The *Australia-Indonesia Health Security Partnership* (AIHSP) will continue to help strengthen Indonesia's ability to mitigate, detect and respond to health emergencies and reduce the threat posed by emerging infectious diseases. The new program will help curb potential threats to Australia and beyond. It will facilitate

² Since DFAT's major health programs in Indonesia closed in 2016, DFAT's health spend in Indonesia is primarily focussed on health security and nutrition (approx. \$4 million per year).

better access to senior levels within Indonesian government agencies, particularly in the event of an emerging infectious disease 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 the program review finalised in June 2017. The primary purpose of the review was to make recommendations on options for Australia's future bilateral programmatic support in the area of health security beyond 2018. Extensive consultation was undertaken by the review team – including across whole-of-government partners (DFAT, DAWR and the Department of Health), the Indonesian Ministries of Health and Agriculture and other key stakeholders in Indonesia. The review strongly recommended the Australian Government continue to provide Indonesia with assistance in the area of detection and response to emerging infectious diseases. It urged DFAT to maintain certain 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 the Regional Health Security Initiative Design Concept, there are challenges to regional collaboration on health security. The AIHSP will help address some of those challenges when it comes to Indonesia's engagement. It will help ensure oversight and buy-in, at senior levels of Government, for initiatives and activities funded regionally. 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. Without this investment, it will be difficult for regional initiatives to get traction in Indonesia.

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

Indonesia's commitment to Health Security

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

Indonesia is closely engaged on the Global Health Security Agenda (GHSA)– having served as Steering Committee Chair in 2016 (followed by Korea in 2017 and Italy in 2018), and is leading on the GHSA Action Package 2, Zoonotic Disease. Domestically, it has also established working groups to address each GHSA action package. Indonesia is set to host the next High-Level GHSA Ministerial Meeting in November 2018 in Bali. Indonesia 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 co-hosted alongside WHO 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.

SEARO (including Indonesia) and WPRO countries developed the Asia Pacific Strategy for Emerging Diseases (APSED) in 2005. The strategy addresses eight focus areas: surveillance, risk assessment and response; laboratories; zoonoses; infection prevention and control; risk communication; public health emergency preparedness; regional preparedness; and monitoring and evaluation. Indonesia and countries across our region are using APSED III as the framework of action for working towards the IHR core capacities, building national capacity to prevent, detect, respond to and mitigate health security threats through an all-hazards approach.

Indonesia undertook the WHO-supported Joint External Evaluation (JEE) on 20-24 November 2017 to assess its health security capacity including gaps when it comes to preparedness, detection and response systems. There were a number of areas where Indonesia was identified to have limited capacity by the multi-sectoral external review team, including on "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 at all levels, and strengthening event-based

surveillance and risk assessment. The team also recommended capacity building through training including for surveillance, laboratory, case management, infection control, and risk communication.

The JEE's overarching recommendations, however, largely related to issues of governance and coordination. These were; (1) Develop and implement a fully integrated, multi-sectoral National Action Plan for IHR implementation, 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.

Some of these issues were highlighted during the National Pandemic Influenza Simulation conducted by the Indonesian government in September 2017. It was led by the Health Ministry in coordination with the Ministry of Agriculture, the National Disaster Management Agency (BNPB), the Indonesian Army (TNI), PMK, local government (South Tangerang, Banten) and health service providers. It is the third exercise of its kind, with previous simulations taking place in South Sulawesi in 2009 and Bali in 2008.

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

Since November 2016, the Coordinating Ministry for Human Development and Cultural Affairs (PMK) took over the national coordination function in relation to zoonoses (previously managed by Komnas zoonosis). PMK's role includes devising a health security action plan (which includes a non-natural disaster risk map), continuing the development of SIZE which draws information from both animal and human health information systems (iSIKHNAS and EWARS respectively), as well as the 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 when it comes to responding to an outbreak if declared a disaster (infectious diseases outbreaks are termed "non-natural" disasters).

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 the 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 (JKN). 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 help elevate issues pertaining to health security.

Development Partners

A select number of development partners are supporting health security related activities in Indonesia. The WHO Indonesia country program is supporting Indonesia's Ministry of Health to achieve its International Health Regulation (IHR) requirements. The WHO's current work-plan is financed through core funding as well as contributions from DFAT's APEID program, USAID and CDC (DFAT funds approximately 50% of WHO's workplan).

Indonesia is a focal country under the World Bank MDTF's health security window, supported by DFAT. A health security finance assessment for Indonesia will be completed by October 2018, which will help identify the scale of dedicated resources for health security at both central and subnational levels. The MDTF is also financing advisory services to support Indonesia's efforts to accelerate and sustain progress towards Universal Health Coverage (UHC) by strengthening reforms related to governance, financing, and service delivery.

USAID's Emerging Pandemic Threats Phase 2 (EPT-2) program, which is closely linked to the GHSA, is a close partner of the AIPEID program in strengthening the GOI's ability to prevent, detect and respond to zoonotic and emerging infectious diseases. The program is administered globally and consist of five elements: strengthening capacity to prevent and control EID (through WHO and FAO work in Indonesia), strengthening EID through One Health Approach (joint WHO and FAO trainings in pilot districts), PREDICT 2 (surveillance for pathogens that can spillover from animal hosts to people), One Health workforce (incorporating 'one health' subject in University curriculum), and Preparedness and Response (supporting Kemenko PMK to take on role from the Commission for Zoonotic Diseases). EPT-2 components strongly link with AIPEID components as both programs fund the WHO to help strengthen MoH capacity in detecting and responding to EIDs, and both programs work with the MoA to strengthen their capacity in dealing with Zoonosis and EIDs but in different areas (FAO mostly in Lab assessments and poultry market chain surveillance, while AIPEID mostly support the MoA 'internal systems' by helping establish the main disease detection information system as well as build capacity in disease control management).

FAO's health security activities in Indonesia are largely focused on the provision of technical support for the EPT2 program. Like the AIPEID team, FAO staff are embedded in the Ministry of Agriculture.

US Centre for Disease Control's (CDC) support is focused on the GHSA framework, with an emphasis on workforce development. It is working with the Indonesian Association of Epidemiologists (PAEI) to develop a career pathway. CDC is also providing support to the PHEOC at the MoH, through technical advice, training workshops, and hosting one MOH staff for a 4-month fellowship with CDC Atlanta. There are also efforts to establish a form of FETP for veterinarians (FETPV) in Indonesia, with FAO as a partner.

The Global Fund to Fight AIDS, TB and Malaria (GFATM) is a long term supporter of Indonesia in combatting the three diseases, with current grants to the value of US\$250 million. Indonesia is due to graduate from GFATM support in 2020. DFAT through a World Bank MDTF is providing Indonesia with support to help effectively manage this transition. Post also provides technical assistance to the GFATM Country Coordinating Mechanism through UNDP to boost the effective implementation of these grants.

The EPT-2 program coordinating committee meetings are chaired by PMK and include MOH and MOA representation. Development partner coordination currently occurs through a monthly meeting under auspices of EPT-2.

C: Proposed outcomes and investment options (What)

Stronger health security within health systems depends on a number of foundational components such as; infection prevention and control; community engagement; quality service delivery; health workforce development; information systems; and supply chain management. An integrated, multi-sectorial approach is key to strengthening health security and national capacity by engaging key stakeholders to help prepare for prevention, detection and response to public health emergencies. Leadership and governance are key to resilient and sustainable health systems.

The goal of the new Australia Indonesia Health Security Partnership is **“to strengthen Indonesia's capacity to prevent, detect and respond to infectious disease outbreaks to increase national, regional and global health security”**.

The new partnership will likely focus on achieving some or all of the following objectives in support of this goal:

- Strengthened multi-stakeholder coordination and leadership at national and sub-national levels for health emergency preparedness and risk management³
- The Indonesian government has stronger systems for preparing for and responding to public health and animal health emergencies

³ For subnational engagement, CHS suggests considering a focus on eastern Indonesia for example by working with NTB and NTT and through this potentially inviting Maluku and Papuan provinces to provincial-based activities here. This would help address Australia's interests in terms of cross border disease risks.

- The Indonesian government can innovate through operational research and piloting technologies and approaches to combat infectious diseases and strengthen health systems
- The Indonesian government's health surveillance and information systems (including animal and human health) are robust, responsive and used effectively at the local and national level
- Partnerships between Australian and Indonesian institutions on health security issues are fostered and promoted.

The AIHSP will take the shape of a facility⁴, under which a range of activities will be supported to strengthen Indonesia's ability to better manage its health security risks. All activities funded under the Australia Indonesia Health Security Partnership will contribute to one or more of these objectives. These objectives have been selected because they are; essential to achieving the overarching goal; represent areas of mutual interest for Indonesia and Australia; and reflect the priority areas recommended through recent reviews/studies, including the AIPEID Review (Jun 2017), the ODE evaluation of Australia's pandemic and EID support (Aug 2017), the OIE PVS, and the JEE (Nov 2017).

Specific activities under the new program will likely be identified on a yearly/biannual basis by the facility's Program Coordinating Committee (PCC) consisting of senior Government of Indonesia representatives and senior representation from DFAT and other Australian Government agencies (DAWR and the Department of Health). Stakeholders (both GOI and GOA) have already identified a number of focus areas deemed a priority for investment during AIPEID Review consultations:

1	further develop Indonesia's early detection and response information systems (EWARS and iSIKHNAS) and improve the linkages of these human and animal health information systems (through SIZE)
2	increase awareness of EWARS and iSIKHNAS systems at the subnational level and the importance of reporting, including strategies to institutionalise community engagement approaches
3	strengthen the use of data from surveillance systems to better improve planning and response
4	strengthen Indonesia's veterinary lab information system
5	support collaborative research and studies into interventions to reduce the risk of occurrence, spread or harm from infectious diseases; including research into diagnostics or treatment options
6	Capacity building activities, including through short term training, at the central and subnational level such as economics training to help Government make more informed policy decisions ⁵ .
7	Testing and piloting new technologies and approaches for disease control at the national and subnational level

There will be scope under the new program to address priority health security areas beyond emerging infectious diseases, such as multi-drug-resistant tuberculosis, antimicrobial resistance, vector borne diseases (malaria, dengue), vaccine preventable diseases, HIV, and foot and mouth disease.

Gender is a key factor in EID exposure and vulnerability, given the role of women in small-scale poultry farming, the health workforce, protecting the health of their families, and food preparation. Gender will be a taken into consideration in developing activities under the facility; gender outcomes and monitoring indicators will form part of the facility's M&E framework.

⁴ A facility is one modality of delivering aid that incorporates a flexible approach. It is an imprecise term which can refer to different types of aid investments with varying purposes. It can focus on a single sector or multiple sectors to deliver development outcomes or perform administrative or enabling functions. A facility is usually delivered by a managing contractor or a multilateral partner (DFAT Guidance Note: Facility Investments February 2018).

⁵ AIPEID team leader notes that there is certainly a huge gap in the MoA in the need for enhanced regulatory practices including through assessing impacts (economic and non-economic). Whilst MoA have in the past been adverse to foreign involvement in the regulatory drafting process, they have certainly taken on the economics training and projects we have assisted with and are really keen to expand on this work. With moving into the regulatory sphere, they may be accommodating if approached with a clear objective/strategy for engaging in this work and which gives them some room to operate independently.

Links to the Indo Pacific Health Security Initiative

Given the complementary nature of DFAT's bilateral and the Centre for Health Security investments and the common set of stakeholders in-country, Post and CHS have agreed to undertake a synchronised consultation and design process. The CHS' scoping missions will identify priorities at the regional and bilateral levels. CHS anticipates that Australia will support regional activities with benefits to Indonesia. These will likely be delivered through regional and multilateral partners, and include activities such as laboratory strengthening, community based surveillance and AMR surveillance systems. CHS will also support some bilateral activities whose benefits could potentially be amplified regionally, such as improvements to animal diseases surveillance and information systems. DFAT already has a strong foundation to build on in Indonesia, with its long-standing bilateral health security program, the forward-looking EID review finalised in June 2017 and the recent JEE.

The AIHSP program will ideally have two main sources of funding: an indicative budget of around \$17.5 million over five years (2019-2023) from Post's bilateral program; and some country-level funding (amount to be determined) from the Indo-Pacific Health Security Centre (CHS). Bilateral activities could be funded through the AIHSP to potentially cover activities prioritised by the PCC. For instance, in Indonesia CHS is particularly interested in support to developing a National Action Plan based on the JEE and the potential extension and sustainability of ISIKHNAS. It is hoped that if country-level investment from the CHS falls under the new AIHSP, the activities under the CHS will receive better traction from the GOI as they will be negotiated with the GOI from the outset and fall under the umbrella MOU of the AIPHSP. This will ensure coherence of health security investments in Indonesia and help secure government buy-in and oversight of DFAT-supported activities. The AIHSP will be managed by the Health Unit (Jakarta Post) reporting to Minister Counsellor Governance and Human Development. The Centre for Health Security (CHS) will provide the link to regional programs, helping to identify and emphasise their benefits to Indonesia, and contribute to program development and oversight, in its role on the PCC. The design of the facility's M&E framework will also accommodate the reporting needs of the CHS.

D: Implementation/delivery approach (How and with whom?)

DFAT will negotiate a subsidiary arrangement with the Government of Indonesia) under the bilateral development cooperation treaty to cover all activities under the Australia Indonesia Health Security Partnership. A managing contractor will be engaged to administer the facility.

Governance arrangements

A decision making body, the AIHSP Program Coordinating Committee (PCC), comprising senior representatives of GOI (MoH, MoA, PMK) and GOA (including DFAT, DAWR and the Department of Health⁶), will oversee the program, convening on an annual or biannual basis to review progress and agree activities/workplans to be supported under the facility. Ministries such as Bappenas and BNPB⁷ can also be engaged in the PCC.

An implementing contractor will be selected to manage the facility, through a competitive tender process⁸. The contractor will take a responsibility for the day-to-day management of the whole program to achieve the stated objectives. Coordination and communication will be a key part of the managing contractor's role, as well as secretariat services for senior-level and technical advisory meetings, leading on contracting arrangements to support PCC-approved activities, establishing a monitoring and evaluation system, and delivering performance assessments and corporate reports. We would expect that the managing contractor would engage the appropriate animal and human health expertise (veterinary and public health experts) required to effectively manage the program.

⁶ DFAT representation will include Post and the Centre for Health Security. Department of Health have indicated an interest in engaging but limitations in resources – if so, they can be represented through the CHS (which includes WoG representation including from Health).

⁷ Note, Post is also undertaking a design for a new five year "Australia-Indonesia Disaster Risk Management program" (2018-2023) in partnership with BNPB

⁸ CHS will be invited to nominate an official to take part in the tender selection process.

DFAT will have a key role in leading policy dialogue and engagement with GOI and ensuring strategic oversight of the running of the facility. Post's Health Unit will oversee the AIHSP and provision of strategic advice to DFAT management, facility contract management, management of working-level relationships with GOI, M&E in accordance with DFAT's PAF and aid quality processes, and program reporting and communications. The Health Unit will also maintain close engagement with CHS and DAWR throughout program implementation.

Further, while many activities will be contracted directly by the managing contractor, others may be more appropriately contracted directly by DFAT. The managing contractor would provide advice on and support for the reporting, monitoring and evaluation for specified activities directly contracted by DFAT.

The program could also benefit from ensuring Indonesian technical experts are embedded with the managing contractor and seeking regular technical advice from the CHS' Technical Reference Group.

An outline of governance arrangements can be found at attachment B.

Subsidiary arrangement

The subsidiary arrangement for AIPEID under the bilateral development cooperation treaty expires in December 2018, and currently is an agreement between DFAT and the Ministry of Finance (with MOA as executing agency) and is limited to animal health. The new SA will serve as an umbrella agreement for all DFAT-funded health-security activities and arrangements. An option we will explore during consultations will include Subsidiary arrangement with Ministry of Finance (as is currently in the place) covering both human and animal health with MoA and MOH, and potentially PMK as executing/implementing agencies.

The approach outlined above addresses key shortfalls of the existing AIPEID program – including the need for more strategic, senior-level engagement with the Indonesian Ministries of Health and Agriculture and counterpart Australian agencies. It will also encourage a more integrated and coordinated “**One Health**” approach – an area that faltered under AIPEID, partly due to separate grant arrangements with DAWR and WHO. The facility model will help ensure greater oversight and coordination across human and animal health activities. It will bring senior GOI officials – from various ministries – to the table to agree priority activities together and oversee their implementation.

In addition, the facility model provides **flexibility** by allowing Post to be more responsive to the Indonesian Government's needs, including those identified through the recent JEE, and to capitalise on opportunities as they arise.

E: Risk assessment approach (What might go wrong?)

One of the key risks of the program is that activities and investments taken forward under the Facility are adhoc and incoherent, compromising strategic focus and sustainability. There are also multi-sectoral challenges working with a 'one health' outlook, and risks of poor government buy-in. Such risks can be mitigated with extensive stakeholder consultations throughout design and program implementation, clearly defined outcomes and investment criteria, inclusive governance mechanisms that engage senior-level government officials across ministries, and strong DFAT-led policy engagement.

There are program transition risks; the Ministry of Agriculture preference engaging DAWR over DFAT due to their longstanding relationship under AIPEID and their in-built 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. We also expect the managing contractor to engage appropriate animal health expertise to ensure credibility and effective engagement with MOA.

Should there be delays in finalising the contractual, governance or mobilisation arrangements for the new program, DFAT can arrange to separately contract partners to continue priority activities, for example, WHO or AusVET (under an extension of the existing SA).

No 'work with children' or 'child-focused' organisations are involved in this initiative, and there are no infrastructure projects planned. As such, the investment is low-risk in relation to child protection, displacement and resettlement and environmental protections issues.

Risks will be fully assessed in the design process and through ongoing program implementation as workplans and activities are decided. The contract manager 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: Proposed design and quality assurance process (What are the next steps?)

The design approach for the new Australia Indonesia Health Security Partnership was reviewed and noted by the Aid Management Meeting (AMM) held on 7 December 2017, chaired by Post's Deputy Ambassador and FAS SED. Delegates approved the commencement of the design on 26 March 2018. The AIHSP will be a DFAT-led facilitated design, using this concept note as a basis and drawing on analysis and consultations from the 2017 EID review, the OIE PVS and the JEE.

As the new program will take the shape of a facility, the design will be focussed on clearly setting out the partnership's goal and objectives, investment criteria, governance arrangements, an outline of the M&E approach for the facility, as well as the division of responsibilities between the managing contractor, DFAT and whole of government partners. The design will also detail contract deliverables, a policy dialogue and partner engagement strategy and a mobilisation plan for the new program. It may also identify initial activities to be supported during the first year of the program, and current activities delivered under separate arrangements which will be monitored and coordinated through the facility.

An indicative timeframe for the design, tender and mobilisation process is as follows:

Mar-Apr 2018: *Consultations with DFAT and WOG partners.*

Apr 2018: *Consultations with GoI (including MoH, MoA, PMK, Bappenas, and Ministry of Finance) and development partners (e.g. WHO, FAO, USAID) jointly with the Indo-Pacific Centre for Health Security.*

Apr-Dec 2018: *Subsidiary arrangement: negotiations with GoI.*

May 2018: *Design consultant to produce first draft of design. Consultations with DFAT and GoI on the design.*

May 2018: *CHS Scoping team to debrief CHS and post on findings from Indonesian visit*

Jun 2018: *Revise design and complete quality assurance processes (including independent appraisal) and ensure the investment is fit-for-purpose.*

Jun 2018: *Finalise design document and seek approval to approach the market.*

Jul-Nov 2018: *Finalise of scope of services, tender process, contract negotiations⁹*

Jan 2019: *Mobilisation*

⁹ The procurement process can commence before a Subsidiary Arrangement is in place, provided there is a letter of endorsement (or similar form of agreement) from the partner government (DFAT Aid Programming Guide)

ATTACHMENT A:

POSSIBLE GOVERNANCE ARRANGEMENTS – AUSTRALIA INDONESIA HEALTH SECURITY PARTNERSHIP

