



Australian Government

Department of Foreign Affairs and Trade

PARTNERSHIPS FOR A HEALTHY REGION INITIATIVE

STRATEGIC INVESTMENT FRAMEWORK

Investment Design Title:	Partnerships for a Healthy Region
Start date:	23 February 2023
End date:	30 June 2027
Total proposed DFAT funding:	AUD\$620.47million
Total proposed funding from all donor/s:	AUD\$620.47million
Current program fund annual allocation:	AUD\$124million
Risk:	Medium
Value:	High
Quality Assurance completed:	Independent appraisal, formal peer review, Development Program Subcommittee approval
Delegate in Canberra:	Rod Brazier, Deputy Secretary, Development, Multilateral and Europe Group

TABLE OF CONTENTS

A. EXECUTIVE SUMMARY.....	5
B. ANALYSIS AND RATIONALE FOR AUSTRALIAN ENGAGEMENT	8
B.1 DESIGN CONTEXT.....	8
B.2 DEVELOPMENT CONTEXT.....	9
B.3 ENGAGEMENT CONTEXT.....	16
C. INVESTMENT DESCRIPTION.....	19
C.1 OVERVIEW AND FOCUS	19
C.2 GOVERNANCE AND MANAGEMENT ARRANGEMENTS	22
C.3 IMPLEMENTATION ARRANGEMENTS	29
D. MONITORING, EVALUATION AND LEARNING.....	35
E. CROSS CUTTING priorities	36
E.1 GENDER EQUALITY, DISABILITY AND SOCIAL INCLUSION, AND FIRST NATIONS ENGAGEMENT	36
E.2 ONE HEALTH	39
E.3 CLIMATE CHANGE	40
F. BUDGET AND RESOURCES	41
F.1 BUDGET OVERVIEW.....	41
F.2 VALUE FOR MONEY	42
G. RISK MANAGEMENT AND SAFEGUARDS.....	44
G.1 RISK MANGEMENT	44
G.2 SAFEGUARDS.....	45
H. ANNEXES	47
ANNEX 1: CONSULTATIONS ON FUTURE PRIORITIES FOR REGIONAL HEALTH PROGRAMMING IN THE INDO-PACIFIC REGION	47
ANNEX 2: IMPLEMENTATION PLAN.....	53
ANNEX 3: GEDSI ANALYSIS EXECUTIVE SUMMARY.....	54
ANNEX 4: GEDSI AND FIRST NATIONS ENGAGEMENT STRATEGY.....	59
ANNEX 5: PROGRAM LOGIC	63
ANNEX 6: ONE HEALTH STRATEGY	73
ANNEX 7: CLIMATE AND ENVIRONMENTAL CHANGE STRATEGY	75
ANNEX 8: THEMATIC STRATEGIES AND PRIORITY NEEDS.....	78
ANNEX 9: MANAGEMENT AND GOVERNANCE ARRANGEMENTS	91
ANNEX 10: MONITORING, EVALUATION AND LEARNING.....	95
ANNEX 11: BUDGET.....	100

ACRONYMS AND ABBREVIATIONS

ACPHEED	ASEAN Centre for Public Health Emergencies and Emerging Diseases
AMR	Antimicrobial resistance
AUSMAT	Australian Medical Assistance Teams
CEPI	Coalition for Epidemic Preparedness Innovations
CSO	Civil society organisation
CD	Communicable disease
CHS	Indo-Pacific Centre for Health Security
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DFAT	Department of Foreign Affairs and Trade
DoHAC	Department of Health and Aged Care
DTP3	Diphtheria tetanus toxoid and pertussis
EAG	Expert Advisory Group
EOPO	End of Program Outcome
FAO	Food and Agriculture Organization
FETP	Field Epidemiology Training Programs
FETPV	Field Epidemiology Training Programs for veterinarians
GBV	Gender-based violence
GHD	Global Health Division
GHSI	Global Health Security Index
GEDSI	Gender Equality, Disability and Social Inclusion
GOARN	Global Outbreak Alert and Response Network
HSI	Health Security Initiative
HMG	DFAT Health Management Group
IHR	International Health Regulations
ILO	International Labour Organization
IMR	Investment monitoring reporting
IO	Intermediate Outcome
IPC	Infection Prevention and Control
IPFF	International Planned Parenthood Federation
JEE	Joint External Evaluation
LGBTQIA	Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual
MEL	Monitoring, Evaluation and Learning
NCD	Non-communicable disease
NGO	Non-Governmental Organisation
NRA	National Regulatory Authority
OECD DAC	Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC)
ODA	Overseas Development Assistance
OMRs	Overseas Medical Referrals
OPD	Organisations of people with disabilities
PICs	Pacific Island Countries



PICTs	Pacific Island Countries and Territories
PAF	Performance Assessment Framework
PDPs	Product Development Partnerships
PNG-IMR	Papua New Guinea Institute of Medical Research
PPE	Personal Protective Equipment
PSEAH	Preventing sexual exploitation, abuse, and harassment
PSIDS	Pacific Small Island Developing States
PHR	Partnerships for a Healthy Region
RSP	Regulatory Strengthening Program
SDG	Sustainable Development Goals
SEARO	Southeast Asian Region Office (WHO)
SIF	Strategic Investment Framework
SOGIESC	Sexual orientation, gender identity and sex characteristics
SPC	Secretariat of the Pacific Community
SRH	Sexual reproductive health
SRHR	Sexual and reproductive health and rights
TAC	Technical Assessment Committee
TB	Tuberculosis
TGA	Therapeutic Goods Administration
TRG	Technical Reference Group
UHC	Universal Health Coverage
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAHSI	Vaccine Access and Health Security Initiative
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WPRO	Western Pacific Region Office (WHO)

A. EXECUTIVE SUMMARY

This Strategic Investment Framework (SIF) guides Australia's future investments under the \$620 million Partnerships for a Healthy Region (PHR) over a five-year period, from 2022-23 to 2026-27. PHR aims to support Pacific and Southeast Asian countries to deliver better health outcomes for all, by contributing to more resilient and equitable public health systems with greater capability to respond to health emergencies.

PHR builds and expands on the preceding five-year Indo-Pacific Health Security Initiative (HSI, \$300 million, 2017-2022) and the Vaccine Access and Health Security Initiative (VAHSI, \$523m from 2020-21 to 2022-23).

Through country, regional and multilateral partnerships, HSI (2017-2022) aimed to reduce risks associated with emerging and endemic infectious diseases with the potential to cause social or economic harms on a national, regional or global scale. The COVID-19 pandemic emerged halfway through the lifespan of HSI, having a profound impact globally and in our region. HSI's investments pivoted rapidly to support partner governments' COVID-19 responses. HSI was implemented by the Department of Foreign Affairs and Trade's (DFAT) Indo-Pacific Centre for Health Security (CHS), a specialised body, now part of DFAT's Global Health Division (GHD).

This SIF is informed by learnings of the Health Security Initiative's Mid-Term Progress Report 2017-2019; an internal HSI rapid review conducted in 2022; over 100 consultations with stakeholders and partners in Australia and governments across the region; learnings from other regional investments including the Vaccine Access and Regional Health Security Initiative (VAHSI;) and learnings from bilateral health programming.

Southeast Asian and Pacific partner governments' demand for Australian health support remains strong, even as the region moves beyond the acute phase of COVID-19. The pandemic's impacts on health service delivery – including routine immunisation and sexual and reproductive health services – have been significant. Disease burden for both communicable and non-communicable disease remains high in our region but there is also opportunity to build on the gains made during COVID-19. Partner governments have conveyed a strong desire to collaborate further with Australian institutions that they see as some of the most capable and accessible in the world.

PHR includes an expanded scope, continuing a focus on communicable diseases, while also encompassing non-communicable diseases, sexual and reproductive health and rights (SRHR), and strengthening of health system functions. The Initiative will take a health systems strengthening approach within the broader context of universal health coverage (UHC), one that supports access to essential services without financial harm to individuals and builds resilience to withstand shocks. PHR will complement and reinforce bilateral and global health investments, drawing on Australia's best public health expertise as well as providing targeted support to the regional work of international agencies. It will further expand Australia's health footprint in the region.

Investments under PHR will contribute to five End-of-Program Outcomes (EOPOs):

1. **Communicable diseases prevention and control**: Australian assistance contributes to improved ability of partner countries to anticipate, prevent, detect and control communicable disease threats and to address equity in the delivery of these functions.
2. **Non-communicable disease (NCD) prevention and control**: Australian assistance contributes to improved capacity of partner countries to prevent and control non-communicable disease in an equitable way.
3. **Sexual and reproductive health and rights (SRHR)**: Australian assistance contributes to increased capacity of partner countries to advance equitable and comprehensive SRHR, particularly for women and girls.
4. **Resilient health systems**: Australian assistance contributes to partner countries' improved regulatory mechanisms, data systems, and capabilities to deliver equitable public health action.
5. **Effective partnerships and delivery**: Australia's regional health assistance is flexible, responsive and meets the needs of partner countries.



Cross-cutting issues that will be integrated, measured and reported on across PHR include gender equality, disability and social inclusion (GEDSI), One Health, climate change, and community engagement. PHR will also seek to support the engagement of First Nations peoples of Australia and embed their perspectives, experiences and interests in the design and delivery of activities. PHR will be implemented in Official Development Assistance (ODA)-eligible countries in the Indo-Pacific region with a focus on twenty-two countries across the Pacific and Southeast Asia¹. It will be delivered in partnership with a range of development partners including Australian government agencies, leading Australian health institutions, non-government organisations, multilateral and regional bodies, and health product development partnerships.

DFAT's indicative regional health funding over the next five years totals \$620 million. Communicable diseases remain the focus, building on the preceding five years of investment under HSI and VAHSI, with \$316 indicatively allocated – representing 51% of the total value of the initiative. Indicative funding for other areas include: \$158 million for SRHR (25% of total budget); \$53 million for resilient health systems (9% of total budget); \$50 million for NCDs (8%); \$10 million for projects targeting cross cutting priorities (2%); and the remainder (\$33 million, 5%) allocated for program delivery costs.²

PHR will be delivered through the following programming pathways:

- **Strategic partnerships (indicative \$100 million, 16%)** - will be formed with leading health institutions that will work across countries to support multiple thematic areas and foster cross-regional linkages.
- **Project-based-partners (indicative \$60 million, 10%)** - will be established with organisations that have a smaller thematic or geographic footprint than strategic partnerships. They are intended to support activities in a single and relatively narrow area of defined priority.
- **Public health deployments capability (indicative \$20 million, 3%)** - flexible and responsive technical support will be provided to partner countries through the provision of advice and targeted deployments that respond to partner countries requests for assistance, engaged through a suite of deployment mechanisms. The provision of outbreak response training will also help to bolster the public health deployment capability in the region.
- **Public sector partnerships (indicative \$56 million, 9%)** - partnerships with Australian whole-of-government agencies with deep expertise in human and animal health systems will support engagement with key counterparts in the region which engage in disease prevention and detection and strengthening of health systems.
- **Product Development Partnerships (PDPs) (indicative \$100 million, 16%)** – partnerships with global research and development organisations that bring together public, private, academic and philanthropic actors will support the development of medical products for use in developing country settings, with a focus on our region.
- **Multilateral and regional partnerships (indicative \$251 million, 40%)** - existing partnerships with key international and regional organisations will be continued, and in some instances expanded. Funding will be directed to organisations' disease prevention and control work in the Pacific and Southeast Asia. Strengthening of health system functions will be supported and SRHR related work will continue to be undertaken through leading multilateral agencies with a strong presence in the region and.

Strategic partnerships, projects and PDPs will be subject to competitive calls for proposals issued by DFAT in the first half of 2023. A series of public sector partnerships will be negotiated directly with whole-of-government partners and with multilateral and regional health organisations for work in our region, noting these partnerships will not be subject to a competitive process. A public health deployment training provider will be sourced and contracted to support the development of public health deployment capability in the region. Some partner-led SRHR design work is currently underway, with a design pipeline in place for other SRHR related investments that will require design updates during the life of the Initiative.

¹ Pacific countries include: Kiribati, Federated States of Micronesia, Fiji, Nauru, Niue, Palau, Papua New Guinea, Republic of Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

Southeast Asia countries include: Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Timor-Leste, Vietnam.

² Executive Summary presents a summary of PHR budget. Indicative allocations are provided with figures either rounded up or down. For further detail, refer to [Annex 11](#).



The initiative's five-year timeframe provides welcome certainty to partner governments as well as implementing partners, enhancing our capacity to build lasting relationships and achieve durable outcomes. This will be accompanied by a degree of flexibility within projects and partnerships to ensure they are able to adapt to emerging needs and changing priorities of partner countries in our region.

GHD's management of PHR will provide strong operational, technical and strategic direction, and ensure an integrated approach to policy dialogue in coordination with posts, geographic divisions, and other divisions within DFAT, and with partners. A hybrid management approach will be used with program and partnership management functions performed by DFAT staff, and technical advisory inputs provided in-house, supported by the contracted Specialist Health Service.

DFAT's governance and oversight of PHR will be supported by an internal Health Management Group (HMG) with senior management representation across DFAT divisions. GHD will convene a Technical Reference Group (TRG) comprised of external technical experts to provide technical advice across PHR investments and on emerging health issues. The GHD will also convene a DFAT Health Network to support collaboration and information sharing with health leads from across posts, geographic divisions and GHD.

The initiative is complex and ambitious, operating in multiple countries and through multiple partners. Using the DFAT Risk Factors Screening tool completed during design, PHR has been rated as medium risk. Key risks relate to resourcing being insufficient to support program delivery; effective program management of a regional health program with a relatively small staffing footprint in the region; and, maintaining alignment with and remaining responsive to the needs of the region. It is expected that a medium risk effort will be needed to manage these risks effectively. Controls have been integrated into the design to the greatest extent possible.

Part of PHR's success will hinge on the ability of the GHD to be flexible and strategic, responsive to learnings, requests and emerging opportunities, and to coordinate effectively with multiple partners and stakeholders. PHR management and governance arrangements recognise the critical role of posts as the conduit with partner governments and the need for GHD to maintain strong communication with posts and geographical divisions to support alignment with country priorities and contexts.

B. ANALYSIS AND RATIONALE FOR AUSTRALIAN ENGAGEMENT

B.1 DESIGN CONTEXT

This Strategic Investment Framework (SIF) guides DFAT's future investments under the \$620 million Partnerships for a Healthy Region (PHR) over a five-year period from 2022-23 to 2026-27. It builds and expands on the preceding five-year Indo-Pacific Health Security Initiative (HSI, \$300 million, 2017-2022), presenting a design refresh with communicable disease programming remaining a core focus. This SIF is informed by learnings from the Health Security Initiative Mid-Term Progress Report 2017-2019³, an internal rapid review of HSI conducted in 2022, and over 100 consultations with partners in Australia and across the region. It builds on and draws learnings from other regional initiatives including the Vaccine Access and Health Security Initiative (VAHSI, \$523m from 2020-21 to 2022-23), as well as bilateral health programming and broader development policy reform.

DFAT's HSI, 2017-2022, delivered strong outcomes – including material improvements in laboratory capacity, strengthening of health information systems, support of the development of health products including antimalarials and TB medicines, and contributions to workforce capacity.⁴

The COVID-19 pandemic emerged halfway through the lifespan of the HSI, having a profound impact globally and in our region. It threatened lives and livelihoods, seriously impacted health systems, disrupted economies, exacerbated existing inequalities and vulnerabilities, and challenged social cohesion and political stability. HSI was well positioned to support partner countries capacity to response to COVID-19, complemented by VAHSI which was also managed by DFAT's GHD. Given the current context, the health needs of the region and our proven role as a partner in health, there is a strong impetus to extend the ambition and scope of PHR.

PHR builds on HSI investments and seeks to extend support on broader public health issues. It will reinforce DFAT's bilateral health investments and complement other regional investments, acknowledging the critical nature of these existing investments in responding to the health needs of our region and contributing to positive health outcomes. The initiative includes programming on communicable diseases, NCDs, SRHR and targeted health systems support including on health information systems and regulatory strengthening, and integrates cross-cutting themes of gender equality, disability and social inclusion (GEDSI), First Nations engagement, climate and environmental change, One Health and community engagement.

PHR addresses important and pressing health needs in the Indo-Pacific Region that collectively cause a significant burden of disease, which in turn constrains human and economic development in the Region. PHR uses a public health framework, which provides a cost effective and sustainable approach to improving health outcomes. The WHO defines public health as 'the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.'⁵ Operating within a public health framework will support a focus on population health⁶ and provide an ethical foundation for recognising and addressing health disparities. Public health systems include publicly funded healthcare delivery systems as well as organised efforts of government, civil society and people to prevent, promote and protect health.

³ Health Security Initiative Mid-Term Progress Report 2017-2019.

⁴ A mid-term review of HSI1 in 2019 found that the initiative was on track to deliver strong health security outcomes for the region. A rapid review of HSI (August 2022) reaffirmed the mid-term review findings and found that the initiative successfully contributed to increased health security in the region.

⁵ Nutbeam D. (1998). *Health promotion glossary*. Geneva, World Health Organization.

⁶ Definition of Population Health 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group'. Source: Kindig, D. Stoddart, G. (2003). What is population health?. *American Journal of Public Health*, 93 (3): 380–383.



PHR aligns with global frameworks to which our partner countries are also party. These include the International Health Regulations (2005) (IHR)⁷; the Performance of Veterinary Services (PVS) Pathway which uses a globally consistent methodology based on international standards which enables countries to prioritise improvements to their animal health system⁸; and The Right to Health⁹ and Universal Health Coverage (UHC) which enshrine access to health services and information as a basic human right. PHR implementation is beginning just as multilateral discussions commence to negotiate a new international instrument on pandemic prevention, preparedness and response under the auspices of WHO¹⁰. PHR also aligns with global NCD frameworks including: the [Global action plan for the prevention and control of Non-communicable diseases 2013–2030](#) and associated Implementation roadmap 2023–2030¹¹; and the [Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem](#). On SRHR, the initiative will align with Agenda 2030 and the Sustainable Development Goals (SDGs), particularly on target 3.7¹² and 5.6¹³.

Importantly, PHR aligns with relevant Pacific normative frameworks including the Pacific Legislative Framework for Non-Communicable Diseases (2021)¹⁴; the Pacific NCD Roadmap and MANA dashboard endorsed in 2017 to monitor the roadmap's implementation; and commitments arising from the Fourteenth Pacific Health Ministers Meeting (2022). These commitments are centred on leveraging the COVID-19 pandemic to build sustainable systems and advance universal health coverage, putting health at the centre of the climate change discussion, and accelerating action on non-communicable diseases¹⁵. With regards to Southeast Asia, PHR aligns with the ASEAN Strategic Framework for Public Health Emergencies (2020)¹⁶ which aims to strengthen ASEAN's cooperation in enhancing regional health security, and the NCD Action Plan for Southeast Asia. PHR also seeks to advance regional frameworks including the 2014-2020 [Regional Action Framework for Noncommunicable Disease Prevention and Control in the Western Pacific](#) and the [Regional Framework for the Future of Mental Health in the Western Pacific 2023-2030](#). This section presents a situational analysis, outlining the current status of health in our region (with respect to the aforementioned areas), and associated challenges and opportunities targeted by PHR.

A more detailed summary of thematic issues emerging from consultations is provided in [Annex 1](#). Additional consultations and design work will be undertaken, particularly in the areas of SRHR. A pipeline of future design work is provided in the Implementation Plan set out in [Annex 2](#).

B.2 DEVELOPMENT CONTEXT

The impact of the COVID-19 pandemic on health systems has shown that HSI programming was well focused to support outbreak response, including through laboratory strengthening, investing in health information

⁷ The IHR are an instrument of international law that is legally-binding on 196 countries, including the 194 WHO Member States. The IHR create rights and obligations for countries, including the requirement to report public health events. Source: WHO International Health Regulations.

⁸ The World Organisation for Animal Health (WOAH) has developed international Standards on both the quality of Veterinary Services' provision, as well as technical animal health and veterinary public health management. Source: World Organisation for Animal Health. PVS Pathway. (woah.int)

⁹ The Right to Health is enshrined in international human rights treaties which commit States to protecting this right through international declarations, domestic legislation and policies, reinforced by human rights treaty monitoring bodies including WHO and the Human Rights Council. Source: UN OHCHR. (June 2008). [Fact Sheet No. 31 The Right to Health](#).

¹⁰ On 1 February 2023, WHO released a Zero Draft of the Pandemic Treaty for its member states' consideration at the meetings of the intergovernmental negotiating body in February and April 2023. The treaty is a new international instrument that aims to advance collective action for pandemic prevention, preparedness, and response. Source: WHO News Release, March 2023.

¹¹ WHO. (2023). Implementation roadmap 2023–2030 for the Global action plan for the prevention and control of NCDs 2013–2030.

¹² SDG Target 3.7: Sexual and reproductive health: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information & education, & the integration of reproductive health into national strategies.

¹³ SDG Target 5.6: ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences.

¹⁴ The Pacific Community (SPC). (2021). The Pacific Legislative Framework for Non-Communicable Diseases.

¹⁵ WHO and SPC (22 to 24 March 2022). Outcome of the Fourteenth Pacific Health Ministers Meeting Virtual Meeting hosted by Tuvalu.

¹⁶ ASEAN (November 2020). ASEAN Strategic Framework for Public Health Emergencies.



systems, supporting emergency operation centres, and partnering with the World Health Organization's (WHO) Global Outbreak Alert and Response Network (GOARN). At the same time, the pandemic has placed strain on the capability of healthcare services in our region to respond to longstanding health challenges including routine immunisation and delivery of SRHR services and other essential services. There is, however, great strength and capacity in their health systems. For example, according to the Global Burden of Disease Study 2019, between 2005 and 2015, child mortality declined significantly in the Pacific with the largest declines in child mortality in the three low-middle social development index (SDI) countries of Kiribati, Solomon Islands and Vanuatu.¹⁷

The pandemic has thrust the threat of infectious diseases and pandemic preparedness into the immediate spotlight. There is increased political will, with partner governments eager to build on gains made during the pandemic and to further bolster their health systems to guard against future outbreaks of infectious diseases, particularly diseases of pandemic potential. However, in many of our partner countries in the Indo-Pacific region, the overall burden of disease continues to be weighted towards NCDs. With the disease burden¹⁸ for both communicable and non-communicable diseases remaining high in our region, there is a need to extend the reach of DFAT's regional health initiative and continue to support efforts to build more resilient health systems to maximise health outcomes across the region. It is timely that PHR expands in scope to respond to the broader health needs of the Indo-Pacific region.

The period during which PHR investments will be implemented is likely to be characterised by rolling outbreaks of disease, migration within and between countries, climate and environmental change, climate change-induced disasters, as well as a slow in economic growth in Asia and the Pacific¹⁹. Population fatigue with respect to COVID-19 public health messaging could affect the impact of general health programming. It remains difficult to predict what the full implications of the COVID-19 pandemic will be on public health, or the social and economic conditions in our region in the medium and long-term.

Given this uncertainty, PHR can provide support across core public health (e.g. public health laboratories, NCD prevention) and health system functions (e.g. regulation, workforce) that enable countries to address a wide range of health challenges. Under HSI, this approach has proven effective in supporting partners to address a myriad of disease burdens. As highlighted by government and institutional partners during design consultations, the success of DFAT's programming and COVID-19 response was in part due to the ability to bring together various health system functions (e.g. clinical surveillance, laboratories and information systems). This approach supports the robust continuum of services within a health system which builds resilience to withstand shocks.

The pandemic has underscored how social and gender inequalities influence vulnerability to the social, economic and long-term health consequences of public health emergencies. It has unwound development gains and had a disproportionate impact on groups at increased risk and vulnerability, including women and girls, people with disabilities, Indigenous Peoples and ethnic minorities, undocumented populations and people of diverse sexual orientation and gender identity. With the health of populations also sustained primarily by women who make up 70 per cent of the global health workforce,²⁰ and who fulfil many unpaid caring roles, gender equality, disability and social inclusion (GEDSI) need to be key considerations to support public health programming and achieve inclusive and equitable health outcomes.

Efforts will need to be made to embed GEDSI as core business within DFAT health sector programming. The pandemic has highlighted critical gaps for PHR to target including greater attention to developing and using disaggregated health data, addressing barriers to access and improving inclusion within health sectors, advocating for attention to gender biases in clinical trials, and better integration of GEDSI-sensitive approaches into workforce training, community engagement and health promotion efforts. The PHR design

¹⁷ IHME. (2019). Global Burden of Disease Study 2019, All-cause Mortality and Life Expectancy 1950–2017.

<http://ghdx.healthdata.org/gbd-2017> Accessed 12 April 2019.

¹⁸ Disease burden is the impact of a health problem as measured by financial cost, mortality, morbidity, or other indicators.

¹⁹ IMF. (October 2022). Regional Economic Outlook for Asia and Pacific.

²⁰ World Health Organization. (2019).. Delivered By Women, Led By Men: A Gender And Equity Analysis Of The Global Health And Social Workforce.



is underpinned by a GEDSI analysis (see [Annex 3](#)), and a GEDSI and First Nations engagement strategy (see [Annex 4](#)).

Evidence of the negative effects of a changing climate on health continues to grow.²¹ Climate change alters biodiversity, changes temperatures and increases frequency of extreme weather events, disrupts food and water systems, and alters animal behaviour. These impacts are likely to threaten livelihoods, food security and health systems, as well as influence the emergence and resurgence of disease. In relation to communicable diseases, for example, changing temperatures are expected to alter the transmission dynamics and geographical distribution of vector-borne diseases such as malaria, dengue and Japanese encephalitis – increasing the risk in some locations, and decreasing in others.²² Increased air pollution, high temperatures and threats to food security, among other factors, are also likely to increase the burden of some NCDs.²³ PHR recognises the intersection between climate change and health, embedding climate and environmental change as a cross cutting theme.

COMMUNICABLE DISEASES

THE COVID-19 PANDEMIC

Australia and its neighbours in the Pacific and Southeast Asia continue to face acute communicable disease threats, even as the COVID-19 pandemic winds down across the region. COVID-19 has impacted on the quality, sustainability and the availability of detection, testing and treatment for many infectious diseases. Despite important steps taken by countries to respond to the COVID-19 pandemic, the 2021 edition of the Global Health Security Index (GHSI) concluded that all countries globally remain “dangerously underprepared” to face future pandemics.²⁴ Preventing future outbreaks of vaccine-preventable diseases is urgent and important following the diversion of health resources and workforce to focus on COVID-19. This will require supporting routine immunisation programs, and enhancing local research, surveillance, and data analytics capabilities to identify outbreaks early and enable rapid responses.

The pandemic also shone a light on the strengths and resilience of countries during health emergencies. For example, all countries in Southeast Asia and the Pacific stood up COVID surveillance systems and systematically reported to WHO throughout the pandemic. Countries in the region also developed or enacted health emergency plans for COVID response and closed borders which led to delayed COVID transmission. Many Pacific countries were also able to achieve high vaccination coverage with primary course COVID vaccine before significant disease transmission occurred.

There are opportunities for PHR to sustain gains made under HSI, including in the strengthening of public health laboratories enabling countries to detect COVID-19 cases and outbreaks and guide government responses. For example, through a DFAT-supported activity under HSI, molecular testing facilities in Timor-Leste’s National Health Laboratory increased from one in early 2020 to 11 in 2021, and the number of scientists and technicians working in the molecular diagnostic laboratory increased from five to 28 in less than 12 months. This rapid increase in capacity not only enabled large-scale COVID-19 testing but has also equipped the National Health Laboratory to respond to the laboratory detection of other infectious diseases, preparing Timor-Leste for future outbreaks or pandemics. Ensuring that equipment continues to be maintained and utilised properly by trained staff will be critical in supporting Timor-Leste’s ongoing public health capability.

²¹ WHO. Climate change and health (who.int)

²² Rocklöv, J. and Dubrow, R. (2020). “Climate change: an enduring challenge for vector-borne disease prevention and control”. *Nature Immunology*, 21, 479-483.

²³ Friel, S. et al. (2011). “Climate change, noncommunicable diseases, and development: the relationships and common policy opportunities”. *Annual Review of Public Health*, 32, 133-147.

²⁴ GHSI Report, 2021.

COMMUNITY ENGAGEMENT

Governments across our region have become acutely aware of the role that communities play in prevention and preparedness for disease outbreaks, specifically surveillance. For example, in design consultations, Fiji's Ministry of Health and Medical Services highlighted the need to supplement its existing syndromic surveillance systems with additional sources. They cited an example of community leaders alerting health officials to a change in behaviour among some boys in a village who were not showing up for football training. This led to early detection of a leptospirosis outbreak and enabled early treatment. Past investments in regional health have generated learnings regarding the importance of working beyond formal systems to engage communities through, for example, Non-Governmental Organisations (NGOs) and non-traditional partners. The COVID-19 pandemic has further underscored the importance of community engagement to drive greater health literacy and behavioural change, particularly related to the uptake of vaccines.

DATA FOR DECISION MAKING

The COVID-19 pandemic has also brought the need for analysis and use of data for decision-making to the fore. Despite increasing availability of different data sources during the pandemic, the underlying challenge of collating, interpreting and presenting this data as evidence and in a format to policymakers that supports decision making remains a challenge. New emphasis is being placed on the importance of such capacities. Digitisation of health information systems, for example, is a key pillar of Indonesia's 'National Health Transformation', and Vietnam has expressed interest in the Tupaia health data visualisation platform which DFAT has supported in Laos and several Pacific Island Countries (PICs). Learnings from HSI emphasise the importance of a context specific approach, building in-country data capacity and regional upskilling, and embedding considerations of interoperability.²⁵

ENDEMIC DISEASE THREATS

The impact of COVID-19 on broader health risks has reinforced the importance of continuing to invest in partner countries' capability to tackle endemic communicable disease threats. Concerning trends in areas of disease burden worsening as a result of the pandemic are revealed by the Global Fund's 2021 Results Report which found, for the first time in the Fund's twenty-year history, reversals of progress in key outcomes related to preventing, diagnosing and treating tuberculosis (TB), malaria and HIV/AIDS. The impacts have been profound in some Indo-Pacific countries such as Indonesia, where an estimated 200,000 people infected with TB were not started on treatment in 2020. The rate of malaria mortality in the WHO's Western Pacific Region (WPRO) in 2020 increased back to 2010 levels, attributable in large part to increases in malaria deaths reported in Papua New Guinea during the COVID-19 pandemic.²⁶ There was also an increase in the number of new HIV infections and AIDS-related deaths in the Asia Pacific region between 2020 and 2021.²⁷ Reversals in these areas have significant gendered impacts, with women disproportionately affected by malaria and more susceptible to HIV,²⁸ and men more likely to acquire TB.²⁹

Antimicrobial resistance (AMR) remains a key contributor to disease burden.³⁰ Overuse and misuse of antimicrobials in our region remains pervasive. And in some areas access to, or the lack of a broader range of antimicrobial products is problematic. A systematic analysis of the global burden of bacterial AMR in 2019, published by The Lancet in January 2022, found that AMR is a leading cause of death around the world, with the highest impact in low-resource settings.³¹ Southeast Asia continues to grapple with the challenge of combating drug-resistant malaria parasites even as several countries move closer to elimination of the

²⁵ HSI Rapid Review Report. (2022). p. 7.

²⁶ WHO World Malaria Report. (2021). "Regional data and trends". p. 12-13.

²⁷ UNAIDS. (2022). Global AIDS Update. p.284.

²⁸ Gerberding. (2004). Women and Infectious Diseases. PMC (nih.gov).

²⁹ The Global Fund. (2020). Technical Brief: Tuberculosis, Gender and Human rights.

³⁰ WHO Global TB List 2021-2025.

³¹ Murray, C. (2022). Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis. *The Lancet*, 299 (10325), 629-655.



disease. Multi and extensively drug-resistant TB is an ongoing concern in Papua New Guinea and many countries in Southeast Asia.³² The development of new drug/s (such as pretomanid and bedaquiline) enabling shorter treatment regimens for drug-resistant TB does, however, provide opportunity to reduce the burden of this form of AMR.

Control of vector-borne diseases including malaria and dengue remain a key challenge. While the incidence of dengue is estimated to have declined by more than 58% in Southeast Asia in 2020 as compared to 2019 as a result of changes in population mobility prompted by COVID-19 measures,³³ when outbreaks occur, they may be larger and more severe as a result of delays in the implementation of routine dengue mitigation/vector control activities, and limited clinical care capacity due to COVID-19 disruptions. Timor-Leste, for example, experienced a serious dengue outbreak in early 2022, prompting health authorities to reopen inpatient facilities previously used to isolate COVID-19 patients to treat patients with dengue. The geographic distribution and transmission patterns of vector borne diseases such as dengue, malaria and Japanese encephalitis are impacted by climate and weather patterns, and point to the need to integrate a One Health and climate change lens across investments.³⁴

IMMUNISATION NEEDS

Routine immunisation coverage for vaccine preventable diseases has been significantly affected by the pandemic as the immunisation workforce across our region were largely directed to COVID-19 vaccinations. Annual country monitoring data submitted to UNICEF and WHO demonstrated global declines in coverage. The steepest decline in 2021, compared to 2019, was in East Asia and the Pacific region³⁵ where diphtheria, tetanus and pertussis (DTP3) coverage fell nine percentage points in just two years, down to 83%.³⁶

Routine and catch-up immunisations are one of the region's most pressing priorities. Many countries are either planning or in the early stages of launching catch up programs, however capability constraints and vaccine hesitancy remain a challenge in some countries. There is opportunity to extend COVID-19 gains in immunisation infrastructure and capabilities to broader immunisation programming which is crucial in ensuring our region continues its recovery from the COVID-19 pandemic. PHR's support for immunisation research, use of social and behavioural science to inform vaccine programming and address vaccine hesitancy, and targeting of hard-to-reach populations could support partner countries to head off potential outbreaks of vaccine preventable diseases.

HEALTH PRODUCT DEVELOPMENT AND ACCESS

The research and development of drugs, vaccines and diagnostics for neglected diseases is hindered by large upfront costs and low market returns. Access to new medical products for countries in our region relies not only on a well-funded research and development pipeline to produce the right types of products but also robust health technology assessment processes to demonstrate the cost-benefit or effectiveness of the new product/s compared to existing regimens. Access also requires safe and effective product introduction to developing country contexts. Learnings from DFAT's PDPs and the Regulatory Strengthening Program (RSP), both implemented under HSI, emphasised a need to focus on product access and implementation, including regulatory pathways for new product introduction at the country-level. In some cases, effective malaria and TB drugs and diagnostics already exist, yet these drugs face a range of access barriers. As has been highlighted with the introduction of COVID-19 vaccines, a product can still falter, even at the last hurdle where community acceptance, hesitancy and access barriers are key drivers of uptake. PHR will build on this

³² WHO Global TB List 2021-2025.

³³ Chen et al (2021). "Measuring the effects of COVID-19-related disruption on dengue transmission in southeast Asia and Latin America: a statistical modelling study". *The Lancet Infectious Diseases*.

³⁴ Rocklöv, J. and Dubrow, R. (2020). "Climate change: an enduring challenge for vector-borne disease prevention and control". *Nature Immunology*, 21, 479-483.

³⁵ 29 countries in UNICEF's East Asia and Pacific include: Brunei, Cambodia, China, Cook Islands, DPRK, Fiji, Indonesia, Kiribati, Laos, Malaysia, Marshall Islands, Micronesia, Mongolia, Myanmar, Nauru, Palau, PNG, Philippines, Samoa, Singapore, Solomon Islands, South Korea, Thailand, Timor-Leste, Tonga, Tuvalu, Vanuatu, Vietnam.

³⁶ UNICEF. (14 July 2022). COVID-19 pandemic fuels largest continued backslide in vaccinations in three decades. Geneva/New York.



learning by supporting other partners including local and international NGOs to work on these issues as a complement to investment in PDPs.

NON-COMMUNICABLE DISEASES

NCDs are the leading cause of mortality and morbidity in Southeast Asia and the Pacific,³⁷ and remain a significant health challenge of our region. NCDs have been steadily increasing as a proportion of total disease burden in both regions. In 2019, NCDs were responsible for 75% of deaths in the Pacific, and for 69% of deaths in Southeast Asia.³⁸ – a proportion that is increasing as related risk factors also rise across the region.³⁹

The Pacific region in particular bears a very high burden from NCDs, primarily diabetes, cancer, cardiovascular disease and chronic respiratory diseases.⁴⁰ In 2019, ischemic heart disease, stroke and diabetes were the three leading causes of death, and within the top five causes of morbidity in both Southeast Asia and the Pacific.

The COVID-19 pandemic caused disruption to health services globally, with more than three-quarters of countries reporting significant disruption to NCD services including health promotion, screening and treatment.⁴¹ NCDs pose a major threat to health, sustainable development, and economic growth and the high prevalence of NCDs continues to place increasing pressure on governments' health and general budgets. This is most evident in the Pacific with increasing cost of overseas medical referrals (OMRs) for cancer treatment and dialysis. For example, in 2016 Nauru spent 33% of their current health expenditure to provide for 2.3% of their population; Tuvalu spent 51% of their current health expenditure to provide for 1.6% of their population; and Kiribati spent 8% of their current health expenditure to provide for 0.08% of their population. In 2017, fifteen PICs spent a total of approx. \$59.4 million US dollars on OMRs.⁴²

Recognising the high and increasing NCD disease burden in Southeast Asia and the Pacific, the 73rd Western Pacific WHO Regional Committee Meeting adopted the [Regional Action Framework for Noncommunicable Disease Prevention and Control in the Western Pacific](#) (published June 2023) to counter and reverse the growing burden of NCDs. The seventy-fourth session of the WHO Regional Committee for Southeast Asia agreed to extend the [Regional action plan for the prevention and control of NCDs, 2013–2020](#) through to 2030, accompanied by an [Implementation roadmap for accelerating the prevention and control of noncommunicable diseases in South-East Asia 2022–2030](#) which provides strategic direction while accounting for digital innovations and the context of the COVID-19 pandemic. NCDs also remain a priority focus of partner governments, with PICs endorsing a legislative framework in May 2022 to strengthen national laws that regulate NCD risk factors. The framework builds on a decade of collective approaches to address the regional NCD crisis including through the Pacific NCD Road Map (2014); Tobacco Free Pacific 2025 (2013); Yanuca Island Declaration (2015); Pacific NCD Summit (2016); and Pacific Ending Childhood Obesity (2017).

The 2019 Global Burden of Disease report indicates a steady rise in the public health burden from mental health conditions in the Indo-Pacific region from 1990 to 2019.⁴³ The Regional Framework for the Future of Mental Health in the Western Pacific 2023-2030 outlines how the COVID-19 pandemic has exacerbated

³⁷ World Health Organization. (2023). Regional Framework for Noncommunicable Disease Prevention and Control in the Western Pacific, page 8.

³⁸ World Health Organization. Small Island Developing States NCD Data Portal (sids.ncdportal.org)

³⁹ Global Burden of Disease Collaborative Network, Global Burden of Disease Study 2019 (GBD 2019) Results (2020, Institute for Health Metrics and Evaluation – IHME) ; WHO Regional Framework for Noncommunicable Disease Prevention and Control in the Western Pacific,

⁴⁰ Regional Action Framework for Noncommunicable Disease Prevention and Control in the Western Pacific, page 8.

⁴¹ WHO Noncommunicable diseases and COVID-19 ([who.int](https://www.who.int)).

⁴² The Pacific Community (SPC). (2019). Mapping of Overseas Medical Referral Schemes and Visiting Specialist Medical Teams in the Pacific – a pathway for Regional Cooperation towards UHC.

⁴³ GBD 2019 Risk Factors Collaborators. (2020). Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, 396(10258):1223–49. doi:10.1016/S0140-6736(20)30752-2.



mental health issues and has been a watershed moment that exposed the urgent need to respond collaboratively to enable the fullest expression of health and well-being.⁴⁴ These challenges have amplified the need to improve mental health and suicide prevention systems to address the increased levels of mental health conditions and increased suicidality, with due attention to human rights. Suicide mortality rates have now been included as a mental health indicator in the Sustainable Development Goals (SDGs).

To date, DFAT's regional NCD programming has been delivered principally through the partnership agreement with Secretariat of the Pacific Community (SPC) (\$35.4million, 2013-2023) which supports multisectoral NCD policies and interventions in Pacific Islands countries. Through bilateral health programs, specific NCD investments have been infrequent with the exception of the current phases of Tonga, Nauru and Kiribati health support programs. There are other pockets of NCD-related programming that DFAT is supporting including, for example, through World Bank's Advance UHC multi-donor trust fund. DFAT is funding broader health initiatives, which contain elements of mental health support, and a Mental Health Cooperation program with ASEAN.

Global learning indicates that for the greatest gains, NCD programming requires a focus on equitable access to preventative, early, integrated and people-centred care to help reduce long term complications and avoid the high cost of treatment at a later stage.⁴⁵ The [WHO Mental Health Action Plan 2013-2020](#) reinforces the need for the provision of comprehensive and integrated mental health and social care services in community-based settings and calls for implementation of promotion and prevention strategies. PHR will embed these models, supporting health promotion and policy which enables healthy lifestyle choices, strengthening screening, detection and early treatment of NCDs, and strengthening models of care which promote mental health and psychosocial wellbeing.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

SRHR remain a key element of universal health coverage and essential to health, education, economic productivity, and gender equality. DFAT's global contribution to SRHR has included two significant investments: the \$54.7 million Indo-Pacific SRHR COVID-19 Response (SRHR COVID-19 Surge, 2021-2024) to tackle the accelerated gap in services due to the COVID-19 pandemic, and the \$30 million Transformative Agenda program in the Pacific (2018-2023) which works to strengthen the quality and effectiveness of government SRHR planning and service delivery in six countries. In the Pacific, however, key SRHR indicators lag behind global averages. More than 60% of women in PICTs who would like to delay their pregnancies are unable to do so.⁴⁶ Further, adolescent birth rates are increasing in five PICTs (Nauru, Samoa, Solomon Islands, Tonga and Vanuatu). For example, the adolescent birth rate (births per 1000 women ages 15-19) in Vanuatu increased from 66 (pre 2010) to 81 (2010 to 2021), and in Samoa it has increased from 44 (pre 2010) to 55 (2010 to 2021).

Parts of Southeast Asia, particularly the Republic of the Philippines, Lao People's Democratic Republic and Indonesia, also have high rates of unmet need for services as well as information and education that empowers women and girls to make informed decisions regarding sexual relations, contraceptive use and reproductive health care.⁴⁷ This highlights the need for continued advocacy and support across our region to strengthen both the demand and supply of rights-based comprehensive SRHR. In its first eighteen months of operation, the SRHR COVID-19 Surge investment helped address growing unmet need by providing over 14 million essential SRHR services to over 3.5 marginalised people. While the program has contributed to a critical need, further action is needed if significant reductions in national levels of unmet need is to be achieved.

The COVID-19 pandemic severely disrupted access to lifesaving sexual and reproductive health (SRH) services and has continued to have a severe and disproportionate impact on the health and welfare of women and

⁴⁴ WHO Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030, pg 24.

⁴⁵ WHO (2022). Saving lives, spending less: the case for investing in noncommunicable diseases (who.int)

⁴⁶ Harrington. (2021). Family planning in Pacific Island Countries and Territories (PICTs): A scoping review.

⁴⁷ UNFPA State of the World Report - SWP Report 2022 | United Nations Population Fund (unfpa.org).



girls across our region and accelerated the push back on the rights of women and girls.⁴⁸ The utilisation rate of key sexual, reproductive, maternal, newborn, child and adolescent health services in some countries in the Asia-Pacific region dropped between 20% and 50% in 2020 compared to 2019,⁴⁹ resulting in millions of people not accessing critical services such as antenatal care, facility-based deliveries and family planning services.

Sexual violence against women and girls increases the need for SRH services, but gender-based violence (GBV) also increases access barriers. This is worse for women and girls who experience additional risk of violence and marginalisation including those with disabilities, as well as people with diverse sexual orientation, gender identity, and sex characteristics (SOGIESC). Many people in the region find themselves in a cycle of gender inequality and physical and sexual violence with restricted access to the SRH services they need.⁵⁰ The pandemic has further increased violence against women globally.⁵¹ Risks associated with increased GBV in the Asia-Pacific region include economic strain, alcohol use and school closures, together with reduced access to health and social services.⁵² In some countries in our region, notably Laos, Philippines and Papua New Guinea, the instances of child early and forced marriage are increasing, connected to economic instability, lack of access to SRH services and reduced participation in schools.⁵³

Through PHR, DFAT will continue to build on existing investments delivered through leading SRHR agencies to provide pathways to accelerate access to quality SRH services and information, and support progressive realisation of SRHR across the Indo-Pacific.

B.3 ENGAGEMENT CONTEXT

COVID-19 has highlighted the centrality of strong health systems capable of managing disease threats and supporting our region's shared security and economic prosperity. It also highlighted the importance of effective public health leadership, management and financing. The pandemic had a significant economic impact, disrupting a long trend of poverty reduction in Asia and the Pacific and setting back progress on poverty reduction targets by at least two years.⁵⁴ COVID-19 battered tourism employment in the Indo-Pacific, leaving the sector reeling from job losses, deterioration in work quality and shifts towards increased informality.⁵⁵ While economic production and international trade is rebounding in Southeast Asia, the impact on the Pacific has been deeper and the recovery will take considerably longer.⁵⁶

Demand for partnerships on health in the region is high as countries seek to shore up their health systems to prevent a repeat of COVID-19 and the broader impacts the pandemic wrought on their economies. Partner governments were unanimous in their advice to DFAT through consultations that Australia's investment in health in the region is invaluable, with some seeking increased investments and support in areas such as laboratory strengthening and public health communications campaigns, for example.

Australia is committed to maintaining its role as a trusted partner in the region, working with partner countries over the long haul as they set about recovering from the pandemic and seek to implement the International Health Regulations 2005 (IHR 2005).⁵⁷ By positioning ourselves as a key partner in health

⁴⁸ Cousins, S. (2022). COVID-19 has “devastating” effect on women and girls. *The Lancet*, 396(10247), 301-302.

⁴⁹ UNFPA Asia and the Pacific. (2021). COVID-19 pandemic surge response - Strengthening Sexual and Reproductive Health and Rights to meet the needs of women and girls design document. pg 1.

⁵⁰ UNFPA. (2018). Transformative-agenda-women-adolescents-youth-pacific design document.

⁵¹ UN Women. (2022). COVID-19 Rebuilding for Resilience.

⁵² Nagashima, et al. (2022). Gender-Based Violence in the Asia-Pacific Region during COVID-19: A Hidden Pandemic behind Closed Doors. *Int J Environ Res Public Health*, 19(4), 2239.

⁵³ United Nations Children's Fund and United Nations Population Fund. (2022). Beyond Marriage and Motherhood: Empowering girls by addressing adolescent pregnancies, child marriages and early unions – Patterns and Trends in Southeast Asia and the Pacific. UNICEF East Asia and Pacific Regional Office, Bangkok.

⁵⁴ Asian Development Bank. (2022). Key Indicators for Asia and the Pacific 2022.

⁵⁵ International Labour Organization (ILO). (2021). Brief: COVID-19 and employment in the tourism sector in the Asia Pacific Region.

⁵⁶ DFAT. (2022). New International Development Policy Terms of Reference.

⁵⁷ IHR 2005 are designed to prevent the international spread of infectious diseases, and provides an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies with the potential to cross borders.



through regional health investments and our longstanding bilateral relationships, we were able to respond quickly to urgent priorities during the COVID-19 pandemic, including providing critical equipment, training health workforces, accessing vaccines and bolstering regulatory environments that support vaccine approval processes. DFAT's regional health investments have strong support among partner governments, which have conveyed a strong desire to collaborate further with Australian institutions that they see as some of the most capable and accessible in the world. PHR will draw heavily on Australian expertise in public health, regulatory matters and medical research, strengthening institutional partnerships and expanding Australia's health footprint in the region.

The progress of regional health investments throughout the pandemic, including HSI and VAHSI, has created opportunities for Australia to better position itself as a leader in health. DFAT's responsiveness to requests for support and access to expertise leveraged through core partners, deployment of health experts, and the breadth of health security expertise provided by GHD has been critical to how we support countries in the region. GHD also engages with whole-of-government agencies through partnerships and seconded positions to DFAT and draws on external expertise through GHD's advisory groups.⁵⁸

Health systems, priorities and needs vary across the Pacific and Southeast Asia and require different approaches by PHR. Australia is a primary development partner in the Pacific, building core health capacity and providing critical donor support during health emergencies. PHR will continue to position Australia as a partner of choice in the Pacific in building Pacific resilience to a range of health issues. In Southeast Asia, where we are one of many development partners, PHR provides Southeast Asian countries with greater choice in partners with which to cooperate, reducing the need for over-reliance on any one partner. Developing and strengthening linkages in Southeast Asia enables Australia to be an early responder and display long-term commitment to the region's health. PHR will build Australia's credentials as a reliable partner in Southeast Asia, providing support in line with the region's stronger capability and requests in areas spanning from high end technological solutions to community end engagement and access.

The pandemic also highlighted the need for greater regional cooperation among development partners. PHR will foster collaboration and sharing of information amongst key stakeholders working in the same country, or engaged in similar areas of work, and seek alignment with government health programs and systems. It will seek to complement bilateral programs and support a collaborative, coordinated approach with Australian whole-of-government agencies, global partners and likeminded countries. Investments will be closely aligned with country priorities, seeking to add value to bilateral relationships and/or targeting gaps in partner countries.

Australia is a significant partner for health in the Pacific, with long term partnerships built over many years. DFAT currently has bilateral health programs in eight PICs (PNG, Solomon Islands, Fiji, Vanuatu, Samoa, Tonga, Kiribati and Nauru). We partner directly with Pacific governments to support implementation of their national health strategies, build more resilient health systems and improve health outcomes. We work in a range of areas agreed with governments, such as health policy planning and financing, workforce development, and resilient infrastructure. We also work with other partners in national systems including NGOs and civil society organisations (CSOs) to support provision of quality accessible health services.

Australia also provides multi-country programs and support to key regional organisations such as the Pacific Community (SPC) to respond with collective action to the health challenges and priorities of the Pacific. This includes clinical workforce development (through Royal Australasian College of Surgeons, SPC, and Fiji National University) and quality assurance testing of medicines (through the Australian Therapeutic Goods Administration). Core funding to SPC supports the region to prevent and control non-communicable diseases (NCDs); strengthen clinical services; deliver specialist care; and strengthen regional health governance and

The IHR are legally binding for 196 countries, and requires them to build core capacities in public health prevention, preparedness and response, and report certain disease outbreaks and public health events to the WHO.

⁵⁸ The Technical Reference Group (TRG) was the advisory body for HSI. The Expert Advisory Group (EAG) was established under VAHSI. TRG and EAG members have technical expertise across a range of disciplines with a focus on infectious disease, immunisation policy and planning and health security.



policy. We also work with the World Bank to support Pacific governments in planning and financing health systems so they are sustainable and responsive.

In Southeast Asia, we have fewer bilateral health investments with programs in Indonesia, Cambodia and Timor-Leste. This is in addition to regional investments which include time-bound VAHSI programs in eight countries (Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Vietnam) and ongoing investments in health security, universal health coverage and SRHR. We have an enduring strategic interest in engaging in health and remaining a valued bilateral partner. Our technical expertise and institutional partnerships are valued by partner countries in Southeast Asia with scope to strengthen these linkages, to share technical expertise between governments and institutions, and to support partner countries in addressing priority health needs.

Strategic partnerships will bring a more concentrated approach to the engagement of leading health institutions. International organisations and multilateral bodies, such as WHO and PDPs, also have an important role to play in supporting improved health outcomes of our region. PHR investments will engage with multilateral agencies to advocate for our region's needs and interests. Australia's continued funding of global PDPs enables us to advocate for new drugs and diagnostics to be directed to our region, where diseases disproportionately affect those in low- and middle-income countries. Building on previous programming, DFAT is well positioned to play a role as knowledge broker, bringing together global and local partners to support access to new products in partner countries. DFAT can also facilitate progress along the continuum of product development and trial to regulatory approval and dispersal at a country level.

Further, PHR also enables Australia to continue fulfilling its global and regional commitments. For example, as part of Australia's recent commitment of \$266 million to the Global Fund, 10% (\$26.6 million) will be 'Set Aside' and programmed by DFAT. PHR investments will contribute to this Set Aside by supporting activities that enhance the impact of the Global Fund's work on HIV, TB, malaria and/or health system strengthening in the Asia-Pacific between 2024-2026. PHR will further contribute to strengthening the WHO's authority and capacity to respond to emerging outbreaks, and channel quality support to our region through secondments into GOARN co-ordinator roles in our region. PHR will embed sufficient flexibility to support Australia and partner countries' efforts to contribute to regional and global health architecture and emerging priorities, including efforts of Quad partners and other likeminded countries. Partnerships are expected to support future cooperation with Quad partners in areas such as immunisation support, pathogen genomics, emergency public health deployments and coordinated technical support for the new ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED).

Recognising the importance of supporting localisation, DFAT will continue to build regional connections and partnerships in a way that supports local actors to drive solutions. PHR has been designed in consultation across DFAT and partner governments to support alignment of investments with the priorities of partner countries. In addition to enabling Australian health institutions and partners to share their expertise with countries in the region, future investments in regional health will allow Australia to be a part of and benefit from ideas and lessons generated by our neighbours' experiences in working to address a range of health issues.

The social and economic inequalities exacerbated during the pandemic highlight the need for an inclusive approach to health that accounts for underlying vulnerabilities and ensures no-one is left behind. PHR will advance our efforts to build stronger partnerships in our region founded on shared values of equality, with a focus on progressing GEDSI. While gender equality and disability inclusion were integrated as cross-cutting priorities across the HSI, the HSI Mid-Term Progress Report 2017-2019 found that the incorporation of these cross-cutting priorities was variable but suboptimal, with disability inclusion particularly lagging. Thus, PHR sets a more ambitious approach, embedding GEDSI strongly across the program cycle, and providing technical support, allocating funding, and embedding accountability to drive improved practice.

C. INVESTMENT DESCRIPTION

C.1 OVERVIEW AND FOCUS

PHR builds on and expands the \$300 million, five-year HSI (2017-18 to 2021-22) aimed to reduce risks associated with emerging and endemic infectious diseases. PHR frames Australia's regional health investments to address the intersection of partner needs and Australian strengths. It will continue to include communicable disease control as a core focus and will reframe some key investments under HSI focused on supporting core public health functions, extending their reach beyond infectious diseases. PHR includes an expanded scope encompassing NCDs and SRHR. It will complement and reinforce bilateral and global health investments with a structured program of cross-country support, drawing on Australia's best public health expertise as well as providing targeted support to the regional work of international agencies.

PHR will be implemented in Official Development Assistance (ODA)-eligible countries in the Indo-Pacific region and will focus on twenty-two countries across the Pacific and Southeast Asia⁵⁹ It will be delivered in partnership with a range of development partners including Australian government agencies, leading Australian health institutions, non-government organisations, multilateral and regional bodies, and health product development partnerships.

Australia's indicative regional health funding over the next five years (2022-23 to 2026-27) totals \$620 million. This includes funding to build on the results of HSI by continuing and expanding investments in communicable diseases, with the majority of funded weighted to this area (indicative allocation \$316 million, 51%). It also includes ongoing commitments to SRHR (\$158 million, 25%) and investment in strengthening of core public health functions (\$53 million, 9%). PHR will embed a new focus on NCDs (\$50 million, 8%). Initial NCD investments will be modest at the outset as GHD establishes projects and partnerships, with investments to be scaled up over time based on lessons and results.

This SIF guides the design and management of DFAT's investments under PHR over a five-year period from 2022-23 to 2026-27. It sets out broad parameters, priority areas of work, and establishes intermediate and end-of-program outcomes to which investments must contribute. As a design refresh, PHR will build on the foundation set by HSI, continuing the investment in communicable disease control and seeking projects and partnerships which will support the extension of scope.

C1.1 GOAL, OBJECTIVE AND OUTCOMES

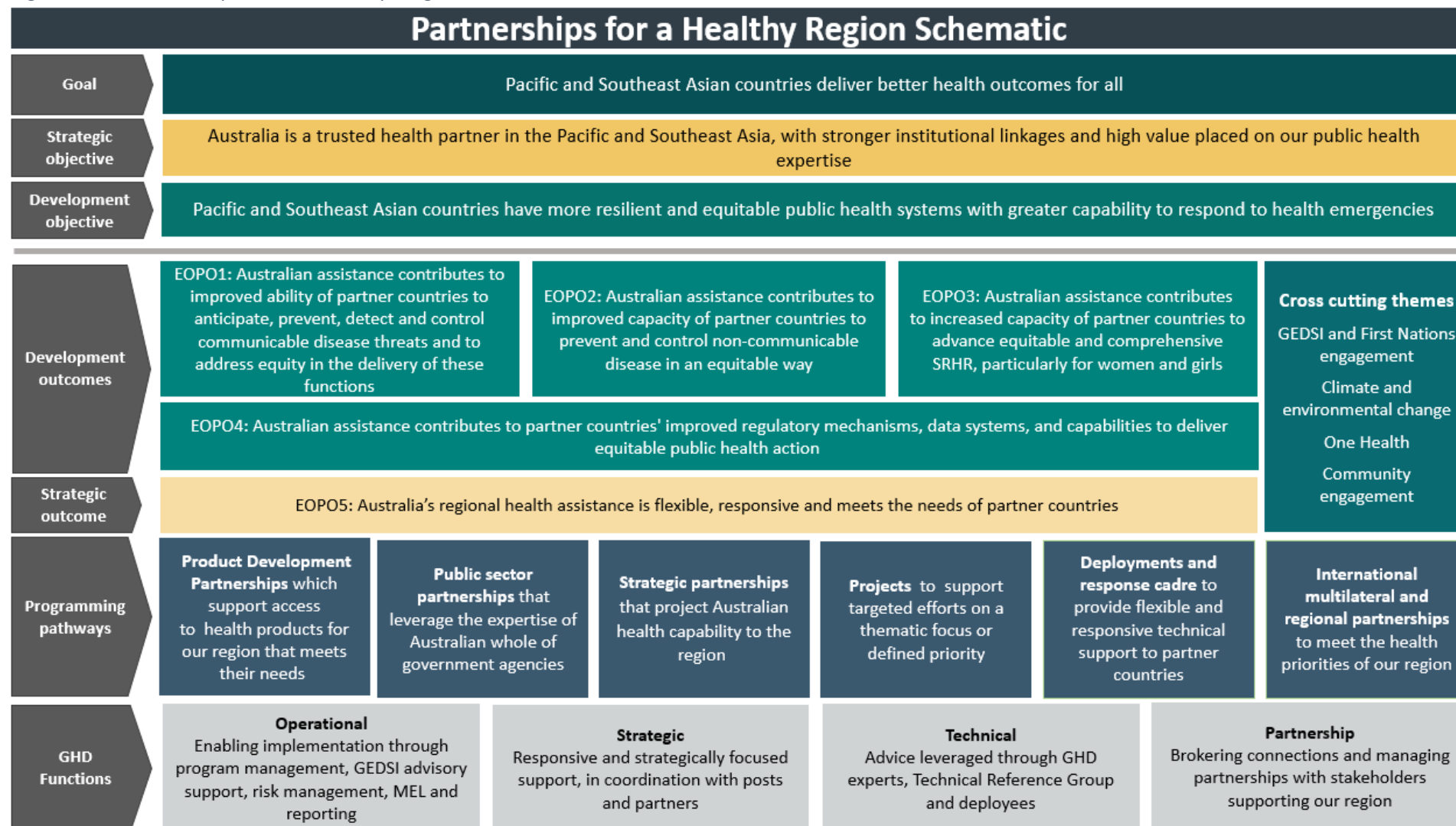
The overall goal of PHR is to support Pacific and Southeast Asian countries to deliver better health outcomes for all, by contributing to more resilient and equitable public health systems with greater capability to respond to health emergencies. The strategic objective of PHR is that Australia is a trusted health partner in the Pacific and Southeast Asia, with high value placed on our public health expertise and stronger institutional linkages between Australia and the region. Core to achieving this strategic objective is ensuring that we listen to the region, provide flexible and high-quality support, and effectively connect Australia's expertise to respond to the needs of the region.

The changes that PHR seeks to facilitate in the Indo-Pacific over the five-year period of the initiative are reflected in five end of program outcomes (EOPOs) and a set of intermediate outcomes (IOs). These EOPOs will be achieved through six core programming pathways and supported by the GHD's core functions, as shown in the PHR Schematic (see Figure 1).

⁵⁹ Pacific countries include: Kiribati, Federated States of Micronesia, Fiji, Nauru, Niue, Palau, Papua New Guinea, Republic of Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu

Southeast Asia countries include: Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Timor-Leste, Vietnam.

Figure 1: Partnerships for a Healthy Region Schematic





EPO 1: Australian assistance contributes to improved ability of partner countries to anticipate, prevent, detect and control communicable disease threats and to address equity in the delivery of these functions

PHR will seek to strengthen the capacity and systems of our partner countries to control epidemic and endemic communicable disease threats including by:

- extending support to laboratory strengthening;
- strengthening effective and locally adaptive vector control systems;
- strengthening surveillance capacity for high priority infectious diseases and AMR, including community-based surveillance;
- strengthening the use of data for decision-making;
- enhancing the policy and institutional environment for Infection Prevention and Control (IPC);
- continuing support to field epidemiology workforce development;
- continuing support for routine and catch-up immunisation programs by building technical and workforce capacity and vaccine demand generation; and,
- continuing to strengthen core capacities for preparedness and outbreak response at the community, regional and national level by supporting multilateral bodies, including the WHO Health Emergencies Programme, WHO GOARN, and public health emergency operation centres.

PHR will also continue investment in PDPs to enable research and development for new diagnostics, vaccines and treatments targeting high burden and neglected infectious diseases in our region. PHR's investment will also include a renewed focus on access to products that are safe and fit for purpose in our region.

EPO 2: Australian assistance contributes to improved capacity of partner countries to prevent and control non-communicable disease in an equitable way

PHR will complement the core support already provided by DFAT to the Secretariat of the Pacific Community (SPC) Public Health Division (2013-2023) that focuses on improving multi-sectoral responses to NCDs, food security and obesity, strengthening political leadership of action to address NCDs, and building capacity of PICs to implement national NCD plans. Targeted opportunities will be identified to leverage the strength of institutions with a strong track record in influencing programming and policy reform in the NCD field. PHR will seek to fund investments that support health promotion measures targeted at reducing major NCD risk factors including tobacco use, harmful use of alcohol, diet and physical exercise, and mental health and suicide prevention. It will also target screening, early detection and management of NCDs for which there are existing treatments, and health infrastructure to support detection and management. Specific priorities in screening, detection and treatment include cardiovascular disease, diabetes and cervical cancer. The focus will be on strengthening the quality of existing systems and treatments, and assisting partner countries to reach and treat more people. PHR will also identify opportunities to develop and support models of care which seek to improve mental health, reduce NCD risk and prevent suicide, including, for example, through strengthened case management systems, integrated services, community-based programming and a focus on preventative and promotive strategies.

EPO 3: Australian assistance contributes to increased capacity of partner countries to advance equitable and comprehensive SRHR, particularly for women and girls

DFAT will build on significant gains made by building trusted, effective partnerships on SRHR, particularly in the Pacific. GHD partnerships with SRHR agencies such as the International Planned Parenthood Federation (IPPF), MSI Reproductive Choices, and the UNFPA, deliver health interventions in our region and strengthen global and national enabling environments. PHR will seek to improve the systems and capabilities of partner countries to deliver comprehensive, rights-based SRH services and support access to evidence-based information and education. Workforce development will be a core area of focus, facilitated through ongoing training and supportive supervision to drive behaviour change in communities to improve services. In collaboration with trusted partners, we will contribute to advocacy to support realisation of SRHR, seeking to contribute to legislative and policy change. PHR will also provide support to improve the quality, range and availability of SRH commodities in our region, particularly for women and girls.



EOPO 4: Australian assistance contributes to partner countries' improved regulatory mechanisms, data systems, and capabilities to deliver equitable public health action

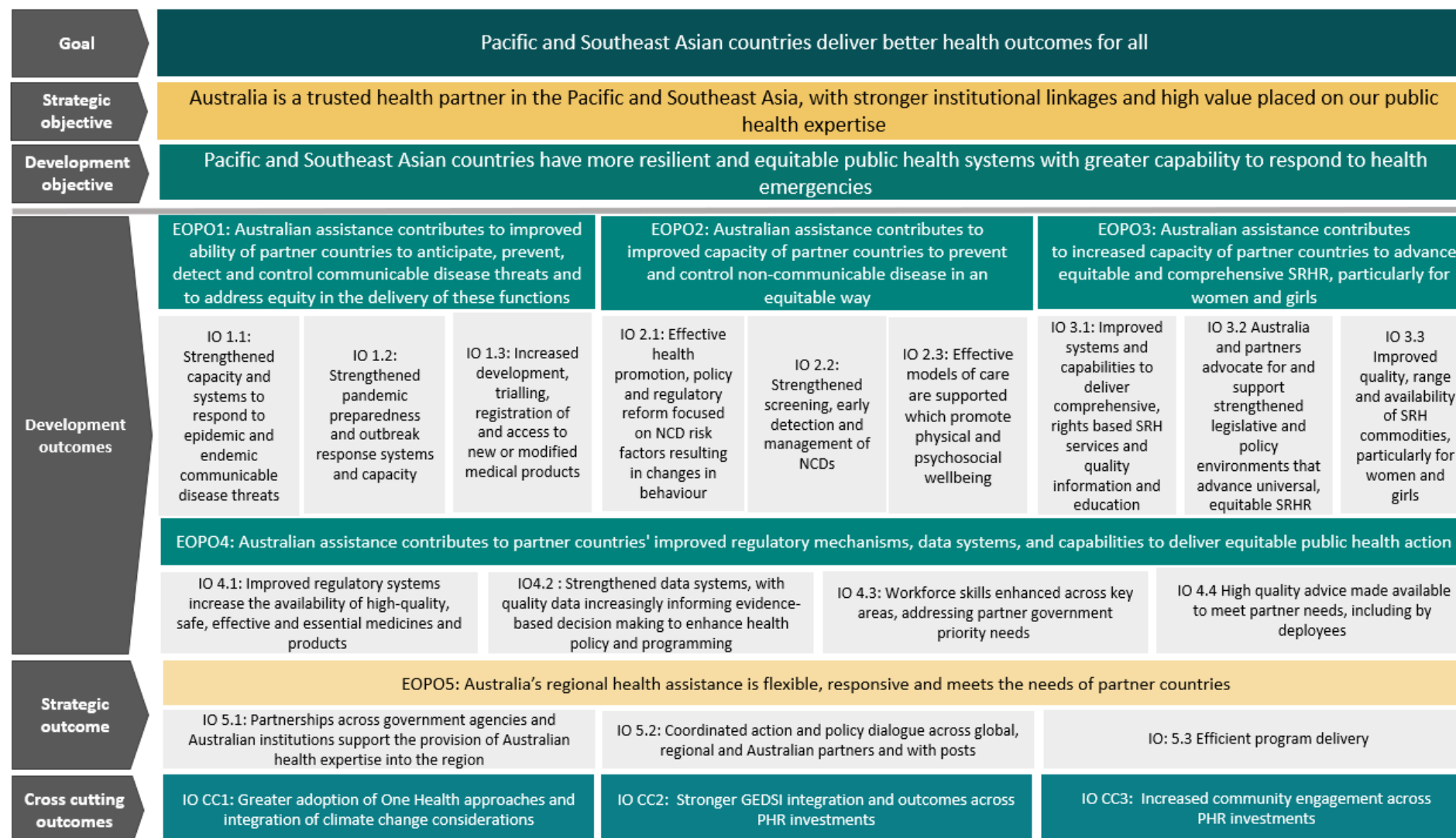
EOPO 4 targets the strengthening of the building blocks of health systems including of regulatory systems, data systems and workforce capabilities, which are in turn expected to build capability to address disease burden, contributing to the achievement of EOPOs 1 to 3. Improved regulatory systems for example, are expected to enhance the access and take up of PDP products, while strengthened data systems are critical in supporting surveillance and policymaking for endemic and infectious diseases, and enhanced workforce capacity and the deployment of public health experts cuts across priority health concerns. This includes drawing on sources of data and expertise outside of the health sector, where appropriate - for example, climate/environmental data - to maximise resilience and sustainability of health systems. Working at this systems level is intended to strengthen the capacity of partner countries to address and respond to a range of disease burdens and build resilience to withstand shocks. Key to progress will be workforce capacity and health leadership and management which are critical to delivering on better health outcomes. PHR will seek opportunities to support public health policy and health leadership across the initiative.

EOPO5: Australia's regional health assistance is flexible, responsive and meets the needs of partner countries

EOPO 5 will assist PHR to deliver on its strategic intent. PHR will support the development of stronger institutional links between Australia and the region. DFAT will invest in partnerships with leading Australian health institutions and support the work of Australian government agencies in our region. For example, PHR will seek to extend the role of Therapeutic Goods Administration (TGA) in supporting regulatory strengthening of national regulatory authorities in our region. In addition to building the capacity of partner countries, PHR will seek to support stronger links between Australian institutions and partner governments, illustrated for example, by health authorities in the region proactively reaching out to the TGA and other regulatory institutions. Australia will continue to be highly responsive to requests for support, through support from our core partners, deployment of health experts, and by the breadth of expertise housed within GHD. It is expected that extensive people-to-people links will be forged through the range of technical engagements taking place between partner governments, DFAT and partners at different levels.

The PHR Program Logic is outlined in Figure 2 (see following page), with a full description of the program logic and summary of programming under each intermediate outcome (IO) presented in [Annex 5](#).

Figure 2: Partnerships for a Healthy Region Program Logic



CROSS CUTTING THEMES

PHR has a set of cross-cutting themes which are reflected as Intermediate Outcomes (IOs) in the Program Logic. These include GEDSI and First Nations engagement, climate and environmental change, One Health, and community engagement, acknowledging these are also cross-cutting priorities for the Australian Aid Program broadly. Under EOPO 5, GHD will integrate cross-cutting issues through the provision of discrete technical advice and requirement for partners to undertake contextual analysis, identify entry points for action, and develop appropriate programming strategies and plans. GHD will also work more broadly to enhance the capacity of partners to understand good practice approaches and models to integrating cross-cutting issues across public health investments through, for example, learning events and briefings.

PHR has developed strategies to support a strategic approach to incorporating these priorities across PHR investments. Cross-cutting strategy documents are provided in [Annex 4](#) (GEDSI and First Nations Engagement Strategy); [Annex 6](#) (One Health Strategy); [Annex 7](#) (Climate and Environmental Change Strategy); with community engagement covered in [Annex 8](#) (Thematic Strategies and Priority Needs).

THEMATIC STRATEGIES

The SIF contains a set of more detailed thematic strategies which provide additional design guidance to GHD to support programming decisions. These thematic strategies cover:

- health product development;
- immunisation;
- vector surveillance and control;
- infection prevention and control;
- outbreak preparedness and response;
- field epidemiology;
- laboratory strengthening;
- antimicrobial resistance;
- regulatory strengthening;
- data for decision making;
- non-communicable diseases and mental health;
- sexual and reproductive health and rights;
- workforce development; and
- community engagement.

The strategies summarise the current context, previous and current DFAT programming in the area, and the needs and priorities of partner countries as derived from consultations and situational analyses. They also include additional detail on the strategic directions of PHR to guide programming practice and decision making. The suite of thematic strategies is provided in [Annex 8](#).

Key to progress on the above thematic areas are public health policies, resourcing and leadership which are critical to facilitating progress on strengthening health systems and delivering on better health outcomes. Thematic strategies and programming will be cognisant of the local context and consider alignment with and support of health policies and resourcing to facilitate systems changes.

C.2 GOVERNANCE AND MANAGEMENT ARRANGEMENTS

C2.1 COORDINATION AND STRATEGIC ALIGNMENT

ENGAGEMENT WITH PARTNER COUNTRIES

PHR has been designed to align with the needs of the region and support regional and partner government health priorities. Noting health needs and in-country priorities are likely to evolve over time, ongoing engagement with partner governments will be critical. This will support PHR to remain responsive to partner country needs, to support alignment with strategic health plans and health services and programs in-country, and to contribute to the health objectives of partner countries in our region.

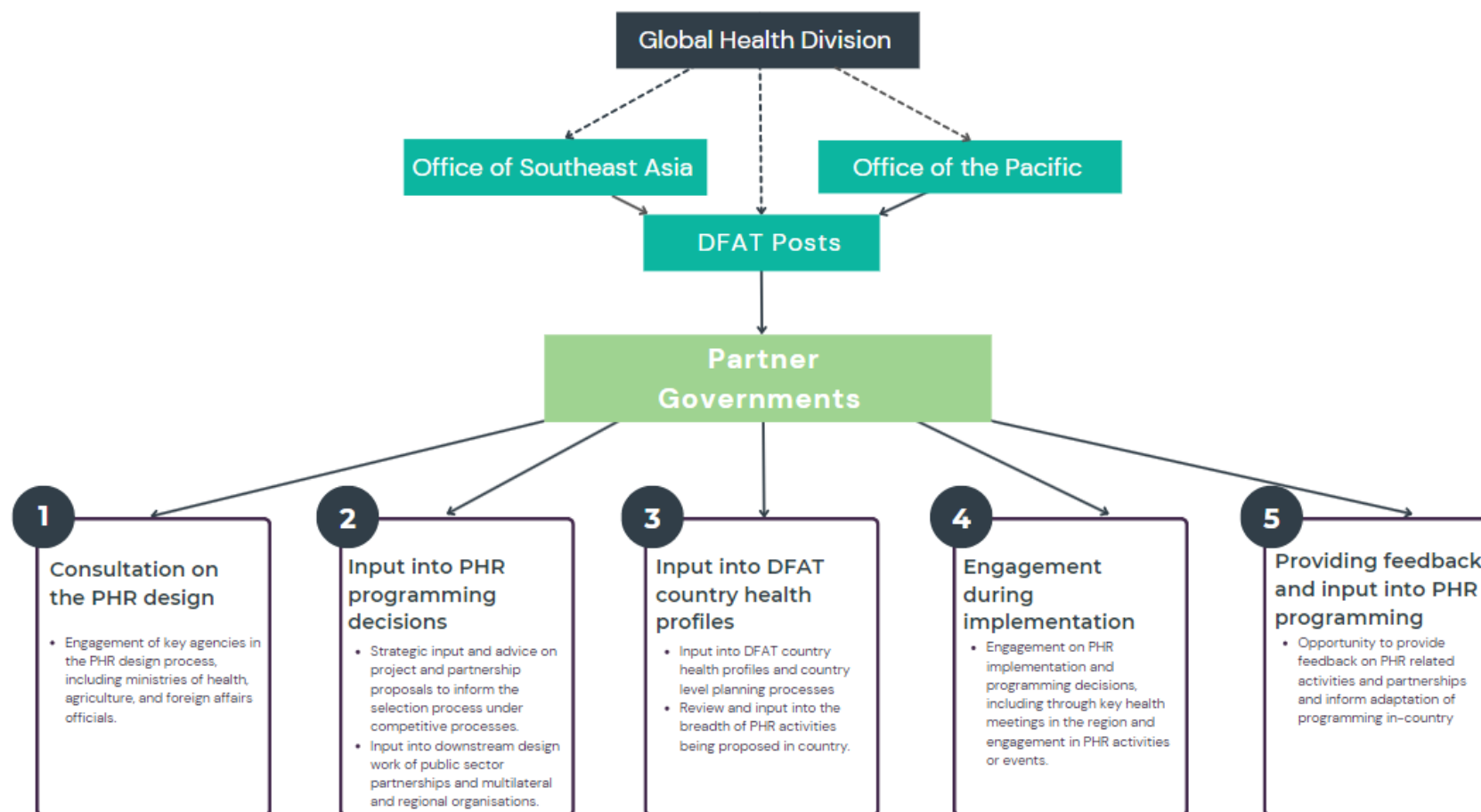
GHD recognises the critical role of posts as the conduit with partner governments, and their key role in managing bilateral relationships. GHD will work closely with and through posts to engage with partner governments and seek input and feedback to inform programmatic decision making. GHD will also work through posts to understand emerging health needs and evolving priorities in-country.

In addition to the consultations with partner governments that informed the design, ongoing engagement with partner countries, working through posts, will include:

- Seeking strategic input and advice from partner governments on project and partnership proposals to inform the selection process under competitive processes.
- Engaging partner governments in downstream programming decisions through seeking their input into design work of public sector partnerships and multilateral and regional organisations.
- Seeking input of partner governments into country health profiles and country level planning processes, including by consulting partner governments on the breadth of PHR activities being proposed in country to ensure alignment with their priorities.
- Facilitating ongoing engagement on PHR implementation and programming decisions, including in PHR partner events and PHR learning forums.
- Providing visibility to PHR activities including through key health meetings in the region and facilitating engagement in PHR partner events. Key health meetings may include, for example, the Pacific Heads of Health, Pacific Heads of Agriculture and Forestry and ASEAN Health Ministers meetings.
- As stakeholders and partners in PHR, key agencies within partner governments will be provided the opportunity to provide feedback on PHR related activities and partnerships.

This engagement with partner government and process of listening to our region will inform programming decisions and support adaptation of PHR programming as indicated. Detail on the partner government engagement is outlined in Figure 3 (see following page).

Figure 3: Engagement with partner governments on Partnerships for a Healthy Region



COORDINATION WITH POSTS, GEOGRAPHIC DIVISIONS AND THEMATICS

Ensuring the complementarity between DFAT's global, regional and bilateral health programs and alignment with the health systems and programs of partner governments will be critically important to reduce duplication and to maximise outcomes. GHD will continue to invest efforts to ensure strategic coherence of DFAT's health programming. Through regular touchpoints with counterparts across DFAT including those at our posts, GHD will seek to support alignment of programming which reinforce and bolster the efforts across the health sector in the region. This will support the operationalisation of the initiative with particular attention to ensuring coordinated action and efficient program delivery.

In addition to the consultation process with desks and posts that informed the design, ongoing cross-departmental engagement to support coherence across programming is expected to include:

- Engagement of the Office of the Pacific (OTP), Office of Southeast Asia (OSA) and posts in the review of downstream designs and the selection process for individual PHR projects and partnerships. This includes inviting OTP and OSA to sit as members of technical advisory committees and for posts to review shortlisted proposals.
- GHD will lead on a first draft of country health profiles which will provide a snapshot of the local country context and DFAT's engagement in the health sector across bilateral, regional and global programs. These will be updated by GHD on a regular basis.
- GHD will work through and support posts in presenting the portfolio of health investments to partner governments and to engage them in PHR downstream design and selection process of projects and partnerships.
- Continued engagement between Posts, OSA, OTP and the Principal Sector Specialist Health and Ambassador for Regional Health Security will support technical oversight of existing health programs (and those under design) as well as to provide outbreak response support.
- Country coordination calls between posts, geographics and GHD country focal points during implementation, with frequency to be determined by the individual post, will support sharing of information on key health developments and any issues arising in-country.
- Continued engagement through DFAT's health network will bring together health leads from across posts, OSA, OTP and GHD on a regular basis. The network supports broad collaboration and information sharing between regional and bilateral health programs.
- Management meetings between senior executive of OTP, OSA and GHD (see section C2.2 Governance and advisory functions for further detail on the Health Management Group).
- Posts, OSA and OTP to be invited to partner briefings and PHR learning forums and to engage in PHR monitoring efforts.
- Regional co-ordinator positions will support regular communication to enhance visibility of programs during implementation. These roles will also support visits of partners to posts and support ongoing monitoring and reporting of program outcomes. These positions will be based either in Canberra or the region depending on need.
- Additional resourcing will also be deployed in the region to support implementation of PHR and the alignment of health programming. Decisions on the resourcing complement and where positions will be located will be determined in close consultation with OSA, OTP and posts. It is expected that these positions will support posts in stakeholder management, monitoring, reporting, communication efforts and supporting visits.

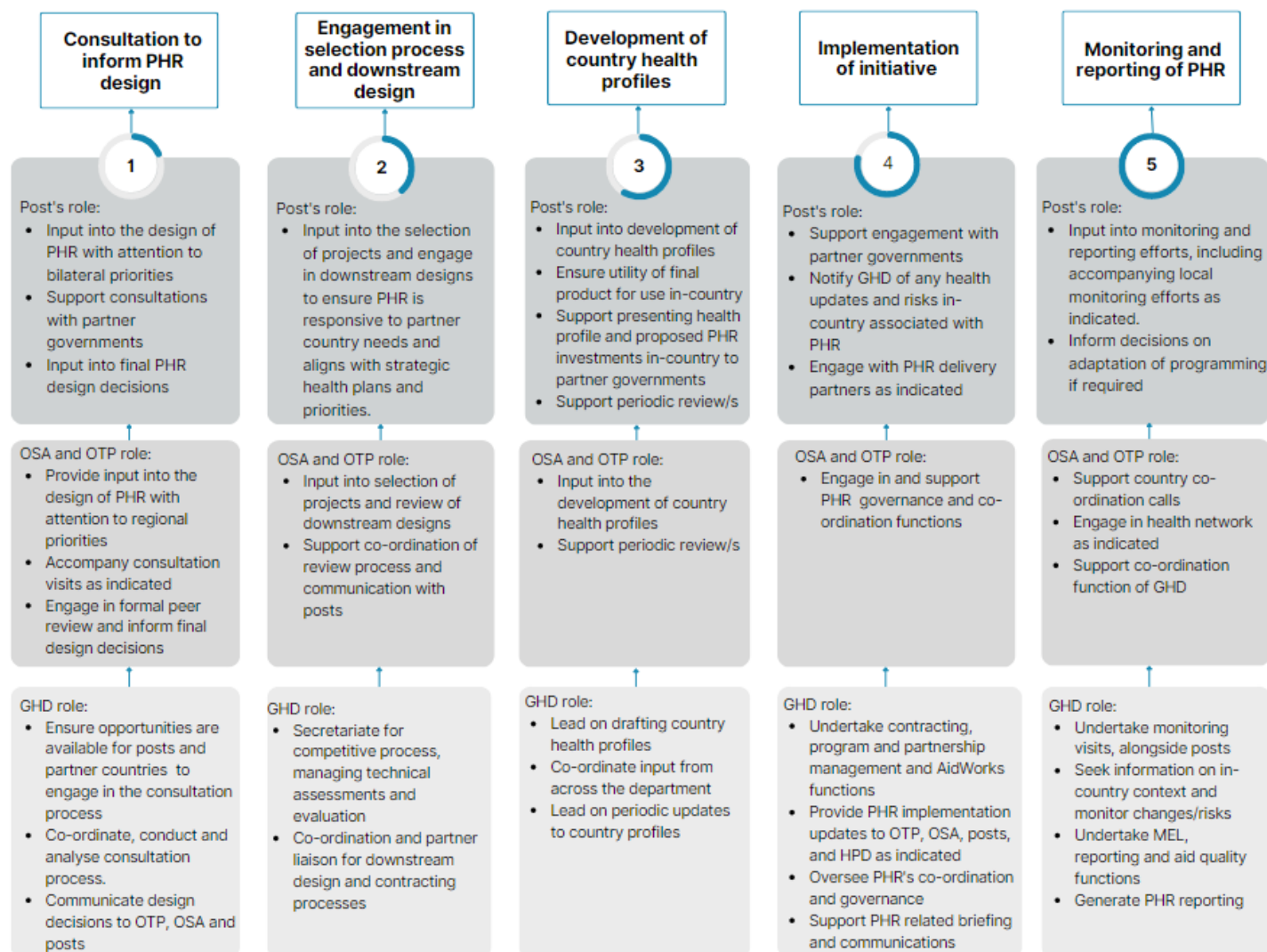
Core to these efforts will be the role of GHD in playing a central co-ordination and support function to OTP, OSA and posts, with country focal points within GHD as the primary conduit with geographic divisions and posts. In addition to taking the lead on PHR program and partnership management, GHD will seek to support posts and OSA and OTP divisions to coordinate, analyse and communicate on PHR investments. Further



detail on the engagement between OSA, OTP, posts and GHD and efforts to pursue alignment across DFAT's health portfolio and the needs of the region is provided in Figure 4 (see following page).

Figure 4: Opportunities for GHD to support co-ordination across bilateral, regional and global programming

Entry points to support co-ordination and alignment across health portfolio



C2.2 GOVERNANCE AND ADVISORY FUNCTIONS

HEALTH MANAGEMENT GROUP (HMG) AND SENIOR RESPONSIBLE OFFICER

DFAT's governance oversight of PHR will be provided by a senior responsible officer, a role assigned to a GHD senior executive staff member, and an internal health management group (HMG).

The senior responsible officer will provide oversight over PHR implementation and hold ultimate responsibility of PHR financial management, risk, fraud, safeguarding, GEDSI and performance reporting. Working closely with other members of the GHD senior executive, they will play an important role in supporting co-ordination and collaboration efforts and will oversee PHR governance arrangements.

The HMG will be chaired by GHD's First Assistant Secretary, with senior management representation across DFAT divisions. The HMG will provide a forum for relevant DFAT areas to:

- Provide strategic input into the implementation of PHR and other key regional and bilateral health investments by representing the priorities, perspectives and expertise from relevant departmental areas.
- Stay abreast of progress, risks, challenges and opportunities and provide input on strategic direction.
- Identify opportunities for leveraging shared learning with other DFAT investments ensuring opportunities for cooperation, coordination and engagement with DFAT's geographic and policy agendas are realised.

Representation from relevant DFAT divisions aims to maximise effective coordination and strategic direction. The core membership of the HMG will likely include nominated representatives at the Senior Executive Service level from the Office of the Pacific, the Office of Southeast Asia, and the Humanitarian Division. Additional engagement will be invited from the Development Policy Division, the Gender Equality, Disability and Social Inclusion Branch, and the Office of First Nations Engagement, once established. Other stakeholders external to DFAT could also be included depending on the agenda of a particular HMG meeting. The HMG will meet on a quarterly basis with scheduling coordinated by the Executive Officer for the GHD First Assistant Secretary.

EXTERNAL TECHNICAL REFERENCE GROUP (TRG)

GHD will convene the TRG to provide strategic and technical advice across PHR. Membership will comprise of public health experts with experience across the span of PHR programming areas. Membership decisions will reflect principles of diversity and gender equality and invite regional representation. A First Nations voice and GEDSI specialist skill set will be considered in the membership of the TRG.

Members will be invited on the basis of their individual skills and expertise. The Specialist Health Advice Section in GHD will be the Secretariat. The TRG will be chaired by GHD's First Assistant Secretary (FAS) and/or thematic health ambassador, with support and engagement from other GHD senior management.

A Terms of Reference for the TRG is provided in [Annex 9](#).

C2.3 PHR MANAGEMENT

Building on HSI which was delivered by a specialised team within DFAT, PHR will be managed in Canberra by Global Health Division (GHD). GHD has a mix of staff with aid programming experience, partnership management skills, and policy and diplomacy expertise. GHD includes public health specialists and contractors in addition to specialists on MEL, GEDSI and One Health to add technical depth to the management of health programs under GHD. From Canberra, GHD is well positioned to hold partnerships with a range of Australian Government agencies and Australian based partners to support common objectives. GHD will also work closely with desks and posts in the delivery of the initiative as indicated in section C2.1 above.



The initiative encompasses a large portfolio of investments at different stages of development or implementation, and of differing duration, outlined further in the implementation plan (see Figure 5). A number of different pathways and delivery partners are proposed to help maximise outcomes across the breadth of the initiative's work. The initiative has been designed to retain some flexibility, with the ability to adapt to changes in the operating environment, but with a strong strategic framework in place to underpin and guide future programming decisions.

The specialised Indo-Pacific Centre for Health Security, a branch within GHD, will develop and implement the communicable disease prevention and control elements of the Initiative. Other key elements of PHR, including the non-communicable disease control and SRHR programming, will be supported by other areas of GHD, particularly the Health Systems Branch.

A hybrid management approach will be used with program and partnership management functions performed by DFAT staff, and technical advisory inputs provided in-house by technical specialists. This may at times be supported by additional technical inputs provided by the contracted Specialist Health Service, with oversight provided by the external technical reference group. The Specialist Health Service will also provide a mechanism to enable the deployment of long term employees into the region. Aid quality functions, including performance, monitoring, risk and GEDSI, will be managed in-house, with GHD to seek surge support as required. Contractor staff will be managed in-house to support a cohesive team and allowing DFAT personnel to focus on strategic, technical and partnership functions.

DFAT's GHD will fulfil four core functions, as outlined below.

Operational function: GHD will be responsible for the overall management and implementation of PHR, ensuring it is flexible, efficient and effective. GHD will also provide operational management of PHR including financial management, integration of GEDSI, risk management, Monitoring, Evaluation and Learning (MEL), reporting, and overall accountability. A senior responsible officer will be assigned to hold overall responsibility for managing risk, including undertaking monitoring against PHR's internal fraud control plan and leading fraud case management. To support internal operations and coordination, a PHR Program Management Team will meet regularly to discuss key program management components, highlight risks, and acknowledge progress and learnings. These meetings will be held monthly at a minimum, with program managers working across all components of PHR engaged in these meetings. These meetings will support program management and alignment with departmental aid quality processes and play an important role in monitoring and escalating risks. GHD will additionally work closely with posts, geographic divisions and DFAT's humanitarian division to coordinate, advise or support responses to partner country requests including for deployment of expertise and, if required, medical products into the region.

Strategic function: GHD will ensure PHR remains strategically focused, considering changing country contexts, regional and global health architecture and frameworks, and emerging opportunities. GHD will coordinate closely with DFAT geographic divisions, policy areas, humanitarian division and posts on a regular basis to ensure continual attention to country situations, and that programming remains responsive to the needs of the countries and the region. PHR strategic engagement will also be informed by internal and external advisory groups, as outlined in Section C2.2.

Opportunities for policy dialogue will be identified with posts, multilateral and regional partners and strategic partners. GHD will be responsive to any requests from DFAT posts in our region for support through their bilateral policy dialogue and promote opportunities for regional policy dialogue alongside geographic divisions. GHD will also work with Australian, regional and multilateral partners and likeminded countries to identify opportunities where Australia's contribution to policy dialogue complements and bolsters the work of others, including through funder groups and board positions, with particular attention to Quad partners and likeminded engagement. This includes the role of Australian government agencies, including the Department of Health and Aged Care (DoHAC), in informing and contributing to policy dialogue.

Technical function: PHR will draw on multi-disciplinary perspectives and the latest scientific developments and health models to inform thematic strategies and priorities, and investment designs and decisions. This will be supported by GHD, staffed by a mix of Australian Public Service staff, contractors with specialist skill



sets, and secondees from other Australian government departments. The team is comprised of a wide range of experts including public health and health policy specialists, epidemiologists, nurses, agricultural and veterinary scientists, as well as public health management, GEDSI and MEL specialists. GHD will continue to provide ad hoc advisory support across DFAT, other Australian government departments, and to partner governments. It will also link partner governments with implementing partners to provide this advice as needed, working through DFAT posts. Additional technical advice will also be sourced through the Specialist Health Service - a DFAT-funded arrangement which provides technical assistance to DFAT's portfolio of health investments. Technical inputs will also be requested of PHR's external technical reference group whose members have experience in public health and technical expertise across a range of disciplines relevant to PHR. Through the public health deployments pathway, GHD will continue to support deployment of experienced health professionals to countries in the region to support regional and country health interventions, in response to partner country requests.

Partnership function: GHD will provide oversight and management of projects and strategic partnerships, including with PDPs, whole-of-government agencies, and multilateral and regional organisations, which will be the direct responsibility of nominated GHD program managers and policy officers. GHD will also continue to engage in global and regional fora and play an important partnership and information brokering role. Working in partnership with partner countries and in co-ordination with posts, GHD will leverage Australia's comparative advantage to advocate, alongside global and regional partners, for the needs of the region and to support local actors. Under PHR, GHD will broker connections between partners, and facilitate alignment with the efforts of other donors and likeminded countries to ensure the initiative is well coordinated and impactful. This may include, for example, creating opportunities for partners to share learnings and establish linkages to work effectively together, such as through learning events and partner forums.

C.3 IMPLEMENTATION ARRANGEMENTS

C3.1 PROGRAMMING PATHWAYS

PHR will be delivered through six core programming pathways, as detailed below.

STRATEGIC PARTNERSHIPS (\$100 MILLION, 16% OF \$620 MILLION)

Strategic partnerships will be competitively awarded to highly capable and well-established organisations with strong track record in delivering public health projects in our region, a commitment to working flexibly and responsively, and a breadth of expertise that spans at least two or three of DFAT's defined priorities areas of work consistent with partner government priorities and demand. Strategic partnerships will largely be formed with leading health institutions. The strategic partnerships tier is new and reflects our familiarity with the strengths of key institutions, as well as a desire to consolidate activities and provide increased flexibility to our strongest partners. Strategic partnerships will be required to work across countries to support cross-regional linkages and replication. It is anticipated that around \$70 million or 70% of the funding would be allocated to communicable disease control activities, with the balance applied to NCD control activities. Some activities may span both categories.

The adoption of strategic partnerships as a key programming pathway responds to the expressed interests of partner governments in collaborating more strongly with Australian institutions. Strategic partnerships will support the engagement of leading health institutions in the Indo-Pacific Region, strengthening institutional linkages and allowing PHR to share Australia's public health expertise into the region more effectively.

PROJECTS (\$60 MILLION, 10% OF \$620 MILLION)

Projects will be competitively awarded to organisations that have a smaller thematic or geographic footprint than strategic partners, or are first-time recipients of DFAT public health funding, who are delivering an activity in a single and relatively narrow area of defined priority. However, there will be some exceptions where larger and multilateral organisations may be eligible for project funding. It is anticipated that around \$30 million or 50% of the funding would be allocated to communicable disease control activities, with the



balance applied to NCD control activities (\$20 million) and cross-cutting priorities (\$10 million). Some activities may span across categories.

Projects are intended to support activities in a single and relatively narrow area of defined priority. This will include eliciting proposals from the sector which have a dedicated focus on either supporting efforts on First Nations engagement, progressing gender equality and/or targeting disability inclusion. All strategic partnership and project proponents will be expected to explain how they would address community engagement and GEDSI, and how they might incorporate perspectives of First Nations peoples of Australia into their work.

The use of project funding as a programming pathway will support targeted programming in response to priority needs of partner governments and enable the engagement of organisations through discrete activity-based funding. This may include non-governmental organisations and representative organisations (including women's rights organisations, organisations of people with disabilities and First Nations organisations).

PUBLIC HEALTH DEPLOYMENTS AND RESPONSE CAPABILITY (\$20 MILLION, 3% OF \$620 MILLION)

PHR will provide flexible and responsive technical support to partner countries through the provision of advice through a technical advisory service, the Specialist Health Service. Additionally, targeted deployments will respond to partner countries requests for assistance. A suite of deployment mechanisms will be used including through strategic partnerships and investments under PHR, the Health Security Corps, and targeted deployments to respond to emerging needs and requests from partner countries. Areas of focus are expected to include laboratory strengthening; field epidemiology; policy development; immunisation policy and planning; public health and risk communications; social and behavioural science; and animal health in assignments across Southeast Asia and the Pacific. These health professionals fill non-clinical roles in partner government agencies, NGOs, international organisations, research bodies and regional institutions, building capacity in-country and forging valuable people-to-people and institutional links in the region.

A public health deployment training provider will be contracted to expand the pool of deployment-ready specialists in public health and allied disciplines through Australia-based training for deployments via a range of mechanisms including, for example, the Global Outbreak Alert and Response Network (GOARN). They will also support the provision of intermediate outbreak response training programs in selected developing countries in Southeast Asia and the Pacific. This will be complimented by a coordinated approach to deployments under PHR, supported by GHD's agreement with the Specialist Health Service which provides a mechanism to enable the strategic deployment of Australian-branded public health experts in response to the needs of partner countries.

Deployments have, and will continue to be, critical to how PHR supports countries in the Indo-Pacific region. A public health deployment training provider will be engaged that is well positioned to strengthen deployment capability and enable greater access to high quality expertise across the region to support more, better coordinated, better supported and long-term public health capacity building. It will be expected that this work will be closely aligned with other deployment mechanisms and deployment capability efforts being supported in the region.

PUBLIC SECTOR PARTNERSHIPS (\$56 MILLION, 9% OF \$620 MILLION)

Existing partnerships with whole-of-government agencies with deep expertise in human and animal health systems will be extended for a further five years. Additional funding will also be made available, recognising that key agencies now recognise a stronger imperative to engage in offshore disease prevention and detection while also strengthening border controls and domestic risk mitigations. The total level of funding allocated to public sector partnerships will be approximately twice as much as what was allocated over the previous five years. Infectious disease prevention, detection and control is the primary interest of most partner agencies, with a particular focus on zoonotic and other diseases that could pose cross-border threats. A substantial proportion of the assistance provided will deliver broader health system benefits for partner government health systems, particularly in the areas of product regulation and data for decision-making.



The use of the public sector partnerships continues to connect Australian whole-of-government agencies directly with the Indo-Pacific Region to tackle shared threats and strengthen institutional links.

PRODUCT DEVELOPMENT PARTNERSHIPS (\$100 MILLION, 16% OF \$620 MILLION)

PDPs are global research and development organisations that bring together public, private, academic and philanthropic actors to drive the development of life-saving medical products for use in developing country settings. PDPs typically maintain broad portfolios of candidate products and work closely with pharmaceutical companies to leverage their capabilities while stipulating that jointly developed products must be affordably priced in developing country markets. While no major PDPs are based in Australia, several PDPs draw on the strengths of Australian health and medical research institutions, particularly for the conduct of pre-clinical and clinical trials and operational research. With this funding, PHR would explicitly encourage PDPs to partner with other organisations well-placed to tackle access barriers such as affordability, regulatory approval, health literacy and demand generation for new products, revision and promulgation of treatment guidelines, training of healthcare personnel and the availability of appropriate storage and transportation infrastructure. This component of PHR also includes a partnership with Coalition for Epidemic Preparedness Innovations (CEPI).

Funding PDPs enables Australia to leverage global resources and to advocate for new drugs and diagnostics to be directed to the Indo-Pacific region where diseases disproportionately affect those in low- and middle-income countries. PHR will continue to progress the existing PDP pipeline to support access and uptake of safe and effective products and support the development of critical new products.

MULTILATERAL AND REGIONAL ORGANISATION PARTNERSHIPS (\$251 MILLION, 40% OF \$620 MILLION)

Existing partnerships with key international and regional organisations will be continued, and in some instances expanded. This funding will be directed specifically to these organisations' disease prevention and control work in the Pacific and Southeast Asia and is distinct from core funding provided to the same organisations through other channels, including assessed contributions. It is expected that GHD's SRHR related work will continue to be directed through leading global agencies with strong presence in the region. Strengthening of health system functions, particularly in the area of health information systems, will additionally be supported through organisations with a strong track record and existing partnerships with partner countries.

International, regional and multilateral organisations engaged under this pathway are generally specialised organisations with a proven track record in delivering assistance and technical assistance to the Indo-Pacific region on a large scale with increased reach to multiple countries. Partnerships with multilateral organisations additionally support the shaping of global health policy and standards and bring coherence to cooperation on global challenges such as sexual and reproductive health and rights. Organisations such as the WHO, WOA and the FAO have longstanding and valued programs in our Region. Our support for multilateral organisations under PHR is targeted to ensure that their work is aligned with the health priorities and needs of the Pacific and Southeast Asia.

C3.2 PROCUREMENT AND SELECTION

Procurement will differ by programming type/pathway.

- **Strategic partnerships, projects and PDPs** will be subject to competitive calls for proposals issued by DFAT in the first half of 2023, focused on supporting communicable and non-communicable disease control, and development of and access to new vaccines, drugs, diagnostics and mosquito-control technologies relevant for the Indo-Pacific region.
- **Partnerships with public sector partners and international and regional organisations** will be sole sourced and directly negotiated with organisations who are able to provide particular services and technical capabilities that are not broadly available. This will be based on knowledge and testing of the market under preceding investments including HSI and SRHR investments.

- **Public health deployment capability** will be supported through contracting of a public health training provider through either a limited tender or grant-based approach⁶⁰. This process will seek to source a provider to enable the expansion of the pool of deployment-ready specialists in public health and allied disciplines through training in Australia and in selected countries in Southeast Asia and the Pacific.

Funding will be allocated for up to five years. The five-year investment timeframe provides welcome certainty to partner governments as well as implementing partners, enhancing our capacity to build lasting relationships and achieve durable outcomes. This will be accompanied by a degree of flexibility within projects and partnerships to ensure they are able to adapt to emerging needs and changing priorities of our region.

COMPETITIVE CALLS

For the programming pathways where there will be competitive calls for proposals (strategic partnerships/projects and PDPs) the evaluation of proposals received will follow a rigorous process of review. For both PDPs and strategic partners/projects calls, the first stage will include a review of the technical merits of conforming proposals by a Technical Assessment Committee (TAC) comprising of subject-matter experts. For the strategic partnerships and projects call, the TAC membership will also include expertise pertaining to the region (with representation invited from OTP and OSA). The TAC will evaluate, score and shortlist proposals. Shortlisted proposals for strategic partnerships and project will then be shared with desks and posts for their review and the input of partner government, as indicated. Where relevant, shortlisted proposals from the PDP calls will also be shared with posts in referenced countries especially in relation to country access components. As the final step in the assessment process, shortlisted proposals will be sent to the Evaluation Committee (EC), chaired by DFAT with at least one independent member (external to DFAT). The EC will moderate scores from the TAC and make funding recommendations to the DFAT Financial Delegate. Following selection, partners and project-leads will progress on to developing partner-led workplans aligned with PHR outcomes and performance framework, embedding the initiative's cross-cutting priorities with particular attention to GEDSI.

Targeted selection criteria will be detailed in the calls for proposals. In selecting activities, PHR will be guided by the relevant applicant guidelines with assessment considering the following:

- Provides a measurable contribution to one or more of PHR's program outcomes.
- Aligns with internationally recognised global health policies, guidelines and frameworks.
- Both calls will be expected to integrate PHR's cross-cutting theme of GEDSI, including through their plans to undertake a robust contextual analysis during design, and development of targeted strategies. The strategic partnerships and projects call will additionally consider how proposals have addressed First Nations engagement, One Health, and climate change, as well as community engagement.
- Provides solutions that are relevant to our region and engages local actors to drive solutions.
- Is responsive to partner country needs aligning with strategic health plans, priorities and absorptive capacity, understands the local context, and garners appropriate buy-in and engagement from partner countries.
- Incorporates a plan for sustainability, particularly to ensure that technical assistance, technology or health products will be adopted, owned and/or maintained by partner countries.

⁶⁰ In exploring procurement and funding options, DFAT will take into consideration procurement rules, market research and value for money principles.

- Proposes activities which benefit ODA eligible countries as defined by the OECD Development Assistance Committee (OECD DAC) Reporting Directives on Overseas Development Assistance (ODA), in one or more of the twenty-two Pacific and Southeast Asian eligible countries.⁶¹
- Proposals that could support contribution to Australia's Global Fund Set Aside will be a consideration under the call for proposals for strategic partnerships and projects.

C3.3 COORDINATION ARRANGEMENTS WITH IMPLEMENTING PARTNERS

COORDINATION WITH AUSTRALIAN GOVERNMENT AGENCIES

A range of Australian government agencies have strong and shared interests in supporting health security and systems in the region, including the Department of Health and Aged Care (DoHAC), Department of Defence, Department of Agriculture, Department of Fisheries and Forestry (DAFF), the Australian Centre for International Agricultural Research (ACIAR), the Commonwealth Scientific and Industrial Research Organisation (CSIRO), the National Health and Medical Research Council (NHMRC) and the Australian Institute of Health and Welfare (AIHW). Funded partnerships with public sector agencies will outline clear governance and coordination arrangements including structured meetings between senior management of GHD and the partner agency. Additionally, GHD senior management will engage on a regular basis with non-funded agencies working in the Indo-Pacific. Meetings will provide an opportunity for DFAT and other government agencies to discuss public health developments and areas for alignment across program implementation. Coordination and engagement with Australian government agencies will be managed by partnership leads within the CHS Branch in GHD.

COORDINATION WITH DELIVERY PARTNERS

In addition to fulfilling DFAT contractual arrangements and compliance standards, investment delivery partners will collaborate and coordinate with DFAT more broadly in partner forums and other engagements. These partners include international, multilateral and regional organisations, strategic partners, and those partners managing projects in a single and narrowly defined area of work.

In addition to the implementation of agreed investment activities, the role of delivery partners will include:

- Working collaboratively with DFAT (including at our overseas posts) and other program partners to identify synergies, accelerate momentum for health outcomes, and creating opportunities to support policy dialogue bilaterally and across the region.
- Participating in and contributing to partner forums by sharing project learnings, experiences, challenges and achievements with DFAT and other PHR partners.
- Providing quality reporting, aligned with PHR requirements and DFAT Design, Monitoring and Evaluation standards.
- Engaging regularly with the nominated DFAT program manager including to escalate risks and issues in a timely manner.
- Attending briefings and seminars on DFAT policies and strategies⁶² and applying concepts to strengthen practice.
- Commit to working in a manner which supports and promotes locally led approaches.

⁶¹ Pacific countries include Kiribati, Federated States of Micronesia, Fiji, Nauru, Niue, Palau, Papua New Guinea, Republic of Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu.

Southeast Asia countries include Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Timor-Leste, Vietnam.

⁶² This includes policies and strategies on, for example: gender equality; disability equity and rights; LGBTIQ+ rights; First Nations engagement; One Health; climate change; child protection; preventing sexual exploitation, abuse and harassment (PSEAH), fraud control; and environment and social safeguarding; and other relevant policies.

- Providing visibility of the role of Australia’s development program and contributing to a culture of accountability and transparency with the use of appropriate branding and acknowledgement of Australia’s aid contributions in communication materials and reporting.

In addition to the above, strategic partners will be expected to:

- Make a commitment to working in a flexible, responsive and collegiate way with other DFAT partner organisations.
- Engage on several of PHR’s defined priorities and ensure areas of work are consistent with partner government priorities and demand.
- Engage in a co-design process with DFAT and collaborate on annual planning processes.

D. MONITORING, EVALUATION AND LEARNING

PHR's approach to MEL is designed to serve three inter-related purposes, as outlined below.

- **Performance management:** MEL processes will generate evidence to measure progress and examine whether PHR is functioning optimally to bring about expected outcomes, supporting GHD to manage projects and partnerships, and make strategic management decisions.
- **Learning and improvement:** GHD will facilitate structured learning processes, facilitating learning across DFAT and partners to enhance and iterate programming approaches, and inform decision-making for continuous improvement.
- **Accountability:** MEL processes will support transparency and accountability to the Australian public, providing evidence on the efficient use of resources and the achievement of program outcomes. These processes will also enable reporting on how DFAT funding is invested and what it has achieved, including against the forthcoming development policy (as indicated), and inform PHR's annual investment monitoring (IMR) reports.

The PHR MEL system will be designed to support targeted and cohesive programming and to guide streamlined reporting. GEDSI and other cross cutting themes will be systematically measured and reported on over the course of the investment. The MEL system will generate sufficient evidence to measure and assess progress towards outcomes, including to answer the key questions posed during mid-term review and final evaluation.

The approach to MEL set out in this SIF is high-level, with much of the detail to be further defined and generated from investment and partner-led designs. Downstream design work will support the confirmation of outcomes, indicators, and methods across all levels. There will be a significant effort within the first six months to build a system that connects across these levels and addresses the PHR's strategic and cross-cutting priorities. GHD will develop a MEL plan within six months of commencement that sets out a fully developed MEL system and outlines steps to operationalise it.

A Monitoring and Evaluation budget line provides funding to support discrete pieces including baseline assessments, mid-term reviews and evaluations. Additionally, four full time staff will be allocated to support monitoring and evaluation of the initiative with surge support on MEL contracted in or engaged through DFAT's Specialist Health Service (SHS) on a needs basis. Monitoring and reporting will be integrated into the role of all partnerships and program managers with partners expected to adequately resource MEL.

Annex 10 provides further details on MEL. It sets out a proposed approach including principles, features, key review questions, and an indicative Performance Assessment Framework (PAF). It will be developed iteratively to finalise the (indicative) indicators, outputs and targets as programming decisions are made, and activities identified. Within the first twelve months DFAT will **assess** available information, and consider commissioning targeted data collection, to provide a baseline to assess PHR's contribution to public health outcomes in the region at the end of the five-year period.

E. CROSS CUTTING PRIORITIES

E.1 GENDER EQUALITY, DISABILITY AND SOCIAL INCLUSION, AND FIRST NATIONS ENGAGEMENT

Gender, sex, sexuality, age, disability, indigeneity, ethnicity and socio-economic inequalities can influence susceptibility to disease and access to health services, affecting who most experiences negative health outcomes^{63 64}. This experience is heightened for those who experience multiple forms of discrimination on account of intersecting factors.⁶⁵ This includes, for example, where gender, disability and ethnicity compound and increase marginalisation.⁶⁶ The link between gender, sex, disability and social inequalities and health outcomes is outlined in detail in the GEDSI Analysis, summarised in [Annex 3](#).

GENDER EQUALITY

Gender and sex are significant factors in relation to disease exposure and susceptibility, access to healthcare services, and health outcomes.^{67 68} Sex is acknowledged as a contributing factor to disease risk, primarily due to physiological differences which may affect susceptibility to serious illness.⁶⁹ Gender is also a key determinant of health on account of social norms, gender roles and structural barriers which influence, for example, autonomy and decision-making power, access to information and health care services, trust in services, as well as experiences of discrimination and violence.⁷⁰ The experience of gender inequality is not homogenous and will vary based on factors including but not limited to pregnancy status, age, disability, ethnicity, occupation and sexuality.⁷¹ The pandemic has had a further disproportionate impact on women and girls and regressive effect on gender equality, reiterating the importance of gender-responsive health programming.

The Health Security Initiative Mid-Term Progress Report 2017-2019 detailed some positive examples of progress on gender equality under HSI, including gender mainstreaming by multilateral partners, consideration of gender in the development and testing of medical products and vector control tools, integration of gender considerations into training curricula for health workers, and investment in qualitative research on gendered barriers to accessing services. A further internal HSI GEDSI Review conducted in 2022 found there was moderate progress on integrating and reporting on gender equality since the HSI Mid-Term Progress Report but noted an ongoing need for stronger and more consistent integration of gender equality across all projects.

DISABILITY INCLUSION

Health outcomes remain poor for people with disabilities, who make up 16% of the world's population – a proportion that is increasing due to demographic trends and chronic health conditions.⁷² Evidence shows people with disabilities have reduced life expectancy and poorer overall health, and experience more

⁶³ Meinhart, M et al. (2021). Gender-based violence and infectious disease in humanitarian settings: lessons learned from Ebola, Zika, and COVID-19 to inform syndemic policy making. *International Affairs*, 15, 84.

⁶⁴ Bamba, C. (2022). Pandemic inequalities: emerging infectious diseases and health equity. *International Journal for Equity in Health*, 6.

⁶⁵ UN Women. (2022). Women, girls, and gender non-conforming people with disabilities: You're your rights! New York.

⁶⁶ United Nations Department of Economic and Social Affairs. (2018). Disability development report. New York..

⁶⁷ Meinhart, M et al. (2021). Gender-based violence and infectious disease in humanitarian settings: lessons learned from Ebola, Zika, and COVID-19 to inform syndemic policy making. *International Affairs*, 15, 84.

⁶⁸ Bamba, C. (2022). Pandemic inequalities: emerging infectious diseases and health equity. *International Journal for Equity in Health*, 6.

⁶⁹ Harman, S. (2021). Threat not solution: gender, global health security and COVID-19. *International Affairs*, 97(3), 601-623.

⁷⁰ Harman, S. (2021). Threat not solution: gender, global health security and COVID-19. *International Affairs*, 97(3), 601-623.

⁷¹ Bamba, C. (2022). Pandemic inequalities: emerging infectious diseases and health equity. *International Journal for Equity in Health*, 6.

⁷² World Health Organization. (2022). Global Report on Health Equity for Persons with Disabilities.



limitations in everyday functioning. These risks are heightened for certain groups, including people with intellectual and psychosocial disabilities, and women and girls with disabilities who experience multiple disadvantages resulting from the interplay between gender and disability.^{73 74}

Where data are available from the COVID-19 pandemic, it indicates that people with disabilities faced significant and disproportionate risk of serious illness and death⁷⁵ with data out of the UK revealing that six out of ten people who died from COVID-19 had a disability.⁷⁶ Persons with disabilities have an increased risk of developing mental health conditions compared to individuals without disabilities⁷⁷ and are among the most marginalised groups when it comes to access to SRH services due to social and gender norms and misconceptions, and negative attitudes around disability.⁷⁸ Despite these heightened risks and poorer health outcomes, the inclusion of people with disabilities is infrequently considered in general health programming. A lack of data on disability often renders people with disabilities less visible in health programming and policy decisions.

Disability inclusion was integrated as a cross-cutting priority across the portfolio of HSI investments. However, the HSI Mid-Term Progress Report found that despite some positive examples, disability inclusion programming was suboptimal and lagging. The internal 2022 HSI GEDSI Review noted this trend had largely endured and called for a stronger integration and resourcing of disability inclusion under the PHR initiative to support improved disability inclusion and tangible change within programs.

FIRST NATIONS ENGAGEMENT

Indigenous Peoples globally experience disproportionately high levels of mortality, malnutrition, cardiovascular illnesses, HIV/AIDS and other infectious diseases including malaria and TB.^{79 80 81} While limited, available data from our region reiterates this global trend, indicating that Indigenous Peoples in the Indo-Pacific experience a disproportionate burden of communicable and non-communicable diseases, lower life expectancies, and face greater barriers to accessing healthcare services compared to non-Indigenous populations.^{82 83}

First Nations peoples in Australia and Indigenous populations in the Pacific and Southeast Asia face a number of shared health challenges. Diabetes, heart disease, mental ill-health, rheumatic heart disease, TB and sexually transmitted diseases all feature as major contributors to morbidity and mortality for these communities. While there are shared health challenges, there are also capacities and synergies that likely offer mutual benefit. Examples include the value placed on the environment and its influence on health, the centrality of culture and community to wellbeing, the importance of community-controlled health services, and the recognition of the critical nature of social determinants.

The Australian Government is committed to embedding perspectives, experiences and interests of First Nations peoples of Australia into foreign policy and international engagement. While not a cross-cutting priority under HSI, the PHR initiative will seek to reflect Australia's emerging First Nations approach to

⁷³ Kuper, H. Heydt, P. (2019). The Missing Billion: Access to Health Services For 1 Billion People With Disabilities.

⁷⁴ World Health Organization. (2022). Global Report on Health Equity for Persons with Disabilities.

⁷⁵ Meaney-Davis, J., Lee, H. and N. Corby. (2020). The impacts of COVID-19 on people with disabilities (No. 35). London, UK: Disability Inclusion Helpdesk. Available online: <https://www.sddirect.org.uk/media/1909/disability-inclusion-helpdesk-query-35-covid-19-rapid-evidence-review.pdf>

⁷⁶ The Health Foundation. (2021). 6 out of 10 people who have died from COVID-19 are disabled (health.org.uk)

⁷⁷ World Health Organization. (2022). Global Report on Health Equity for Persons with Disabilities.

⁷⁸ UNFPA Disability Inclusion Strategy 2022-2025, pg 7.

⁷⁹ UN Department of Economic and Social Affairs. (2016). State of the World's Indigenous Peoples: Indigenous Peoples' access to health services. New York.

⁸⁰ Gilmour, B et al. (2022). The prevalence of HIV Infection in minority Indigenous populations of the South-East Asia and Western Pacific Regions: A systematic review and meta-analysis. *AIDS and Behaviour*, 27, 226-2242.

⁸¹ Gilmour, B et al. (2022). The prevalence of HIV Infection in minority Indigenous populations of the South-East Asia and Western Pacific Regions: A systematic review and meta-analysis. *AIDS and Behaviour*, 27, 226-2242.

⁸² UN Department of Economic and Social Affairs. (2016). State of the World's Indigenous Peoples: Indigenous Peoples' access to health services. New York.

⁸³ Horwood, P et al (2019). Health challenges of the Pacific Region. *Front Immunol*, 13(10), 2184.



foreign policy and support First Nations engagement in delivery of the initiative, drawing on the expertise of First Nations peoples of Australia. The inclusion of marginalised Indigenous and ethnic minorities⁸⁴ in Southeast Asia and the Pacific in accessing and benefiting from PHR investments will also support efforts of Australia to progress, promote and protect the rights of Indigenous Peoples, including the right to health. PHR acknowledges that the inclusion of Indigenous Peoples should take account of the complexity of different country environments, and that definitions of indigeneity will vary.

GEDSI AND FIRST NATIONS ENGAGEMENT IN PHR

The HSI supported some positive progress on gender equality and disability inclusion. However, internal and independent reviews at mid-term and end-term have highlighted a need to more strongly embed and communicate GEDSI commitments, resourcing and strategies to enable improved outcomes.

PHR investments will align and contribute to the relevant policy objectives and commitments made by Australia and our partner countries on GEDSI. This includes any forthcoming policies, in addition to DFAT's Gender Equality and Women's Empowerment Strategy, Development for All 2015-2020: Strategy for strengthening disability-inclusive development in Australia's aid program, Australia's emerging First Nations approach to foreign policy, and international frameworks ratified by the Australian Government and many partner countries in the Indo-Pacific region.⁸⁵ Investments under PHR also further support commitment to the 2030 Agenda for Sustainable Development to "leave no one behind", contributing in particular to progress against SDG 3 on health; SDG 5 on gender equality and SDG 10 related to reducing inequalities.

As cross-cutting priorities, gender equality, disability and social inclusion and First Nations engagement will be integrated across the initiative, with an IO embedded into the program logic specifically on GEDSI, and references to equity integrated throughout end of program outcomes. Gender equality is also targeted through EOPO3, which has a priority focus on advancing the SRHR of women and girls.

PHR will adopt the 'significant' gender equality and disability OECD DAC marker⁸⁶, which acknowledges gender equality and disability inclusion as important objectives but not the principal reason for undertaking the initiative. The design has accounted for the minimum criteria for assessing gender equality as a 'significant' objective.

While GEDSI will be mainstreamed across all PHR investments, the internal HSI GEDSI review and the GEDSI Analysis (see [Annex 3](#)), both conducted in 2022, highlighted specific opportunities for investment. PHR will fund projects that directly pursue and support gender equality and inclusive development outcomes, in addition to projects that reflect and embed Australia's emerging First Nations approach to foreign policy (indicative allocation of approximately \$10 million).

PHR will specifically seek to support:

- Innovative approaches to delivery of services and information; data collection and analysis; workforce development and leadership;
- Partnerships with organisations in our region, including representative and rights organisations (including, for example, women's rights groups, organisations of persons with disabilities and First Nations organisations), that provide specialised advisory and/or brokering services;

⁸⁴ There is significant diversity within Indigenous populations. As such, no universal definition of Indigenous Peoples is recognised. Self-identification by Indigenous Peoples and establishing an understanding of Indigenous Peoples in the local context is important. Where a partner government does not recognise the status of its Indigenous Peoples, PHR will strive to apply the Indigenous Peoples safeguard to identify, assess and manage impacts. Acknowledging the global reach of the Australian aid program, PHR will use terms utilised by respective partner governments when referring to Indigenous Peoples (for example 'ethnic minorities') in their territories.

⁸⁵ This includes the UN Convention on the Rights of Persons with Disabilities and the UN Convention on the Elimination of All Forms of Discrimination Against Women and UN Declaration on the Rights of Indigenous Peoples.

⁸⁶ The OECD uses the DAC marker to track and analyse development financing in support of gender equality and women's rights.

- Investments that consider sex, gender, disability, ethnicity, age and other sociodemographic factors in product development research and facilitating access to health products, and associated safety information;
- Investments that could contribute to the evidence base on issues of inclusion and equality and which support translation of evidence into practice;
- Investments that facilitate the engagement of First Nations peoples of Australia in thematic programming of PHR.

In addition to the aforementioned funding for GEDSI projects, support on delivering on PHR GEDSI strategy is included in the delivery support budget (see [Annex 11](#)).

Continuing to engage DFAT stakeholders and programs on GEDSI will be critical, including linking PHR with flagship gender programs in the Pacific and Southeast Asia. GHD will work closely with posts in this endeavour and leverage GEDSI elements within our bilateral health programs and seek engagement of relevant DFAT policy areas in the HMG at certain touchpoints.

PHR MEL Framework will embed accountability and seek disaggregated quantitative data (by sex and disability at a minimum) in addition to qualitative data on processes, outputs and outcomes. Attention will be given to embed learnings and support course correction as needed.

To support a strategic, consistent and integrated approach to these cross-cutting themes, a GEDSI and First Nations engagement strategy for the Initiative has been developed ([Annex 4](#)). This outlines principles to the GEDSI approach underpinning the initiative, which includes reference to meaningful participation, partnerships and engaging lived experience, GEDSI expertise and First Nations voices in program delivery, governance and monitoring and evaluation processes, with attention to intersectionality.

E.2 ONE HEALTH

The health of humans, animals and the ecosystem are interdependent. In the last two decades, One Health has evolved as an approach to address these interconnected issues, requiring collaboration between human, animal and ecosystem health actors and communities.

The importance of adopting a One Health approach has gained increasing recognition in the wake of highly pathogenic avian influenza (H5N1), SARS, Ebola, and now COVID-19 that demonstrated the interconnections and vulnerabilities between human, animal and ecosystem health. Key issues and threats that call for a One Health approach include emerging, re-emerging, and endemic zoonotic diseases; neglected tropical diseases; vector-borne diseases; AMR; food safety and food security; environmental contamination; climate change; and other health threats shared by people, animals, and the ecosystem.

During the course of HSI (2017-2022), DFAT supported targeted One Health projects while also including One Health as a cross-cutting priority. Examples of One Health projects included investments in veterinary epidemiologist workforces, new surveillance approaches at high-risk sites for zoonotic spill over (e.g. wet markets), animal health system and laboratory strengthening, and a One Health water quality project aimed at reducing the incidence of infectious disease in rural areas. Through these projects and other investments, DFAT recognised our partners required time and support to invest in building One Health partnerships.

PHR will build on partnerships and progress made in One Health under the HSI, again seeking opportunities to support targeted One Health projects while also mainstreaming One Health as a cross-cutting theme. We will do this by looking for key opportunities to:

- Support targeted One Health projects which work across human, animal and ecosystem sectors and foster transdisciplinary approaches, including engaging with communities to address complex health issues.
- Build the One Health workforce, and strengthen One Health surveillance, diagnostics and disease prevention and control systems for chronic, endemic and emerging disease issues.

- Strengthen epidemiological capacity in the human, animal and ecosystem sectors, including through field epidemiology training.
- Improve recognition, reporting and stewardship of animal and environmental health issues at the community level.
- Prevent or mitigate the risk of future spill over events at or as close to their source as possible by working with communities and across human, animal and ecosystem health domains.
- Support effective communication, collaboration and coordination that assists in generating evidence and building the understanding of the benefits, risk and opportunities associated with a One Health approach, including through economic analyses.

The PHR One Health Strategy is provided in [Annex 6](#). One Health is included as a cross-cutting theme within the PHR Program Logic and will be measured and reported on through the initiative's MEL framework.

E.3 CLIMATE CHANGE

Climate and environmental changes affect livelihoods, food security and health systems, and can influence the emergence, resurgence, and distribution of infectious diseases around the world. Changing temperatures and rainfall patterns for example, are expected to alter the frequency, seasonality and geographic distribution of vector-borne diseases such as malaria, dengue and Japanese encephalitis.⁸⁷

More frequent and severe environmental disasters such as cyclones, droughts, and floods can influence human and animal migration patterns, reduce access to clean water and sanitation, and increase risks of water-borne diseases such as typhoid and cholera. Ecological degradation could bring animals and humans physically closer, increasing the risk of spill over events of zoonotic disease. Climate change impacts can also increase susceptibility to or exacerbate NCDs through, for example, high temperatures, air pollution, and reduced food security.⁸⁸ Indoor and outdoor air pollution significantly increases the risk of respiratory diseases, stroke, ischaemic heart disease, lung cancer and type 2 diabetes,⁸⁹ as well as further contributing to rising temperatures and heat waves which thereby increase the risk of cardiovascular events such as heart attack and stroke.⁹⁰ Crop yields are expected to be affected by warming temperatures, erratic rainfall and extreme weather events, resulting in increased food and financial insecurity and affecting access to healthy and traditional diets.⁹¹

We will seek opportunities to increase attention to climate change within the PHR thematic investments by supporting projects and partners that:

- Invest in health projects and programs that respond to direct and indirect threats to health from climate change, climate variability, and environmental change, with the goal of improving the overall climate resilience of health systems in partner countries and across the region.
- Take a proactive approach to considering short- and long-term climate and disaster risks including by conducting climate and disaster risk screening and incorporating measures to strengthen the resilience of health investment activities against the potential impacts of climate change and disasters.
- Consider how activities aimed primarily at preventing disease and enhancing health system resilience may also provide co-benefits to climate change mitigation or adaptation efforts, including disaster risk reduction, preparedness and resilience building.

⁸⁷ Rocklöv, J. and Dubrow, R. (2020). Climate change: an enduring challenge for vector-borne disease prevention and control. *Nature Immunology*, 21, 479-483.

⁸⁸ World Health Organization. The Global Health Observatory. (who.int)

⁸⁹ Cuschieri, S, Agius, J. (2020). The interaction between diabetes and climate change - A review on the dual global phenomena. *Early Hum Dev*, 155, 105220.

⁹⁰ Liu, J. et al. (2022). Heat exposure and cardiovascular health outcomes: a systematic review and meta-analysis. *The Lancet Planetary Health*, 6(6), E484-95.

⁹¹ Fanzo, J, Downs, S. (2021). Climate change and nutrition-associated diseases. *Nature Reviews Disease Primers*, 7, 90.

Further detail is included in the Climate and Environmental Change Strategy in [Annex 7](#). Climate change is also included as a cross-cutting theme within the PHR Program Logic.

F. BUDGET AND RESOURCES

F.1 BUDGET OVERVIEW

PHR is budgeted as a \$620million investment over five years⁹².

The following table shows the overall estimated expenditure against high-level cost categories. A detailed budget is provided in [Annex 11](#).

Table 1: PHR Budget Summary

BUDGET COMPONENTS	INDICATIVE FUNDING AMOUNT
Communicable diseases <i>Includes product development partnerships, strategic partnerships, project-based funding, public sector partnerships, and funding for international multilateral and regional organisations focused on the detection, control and response of both endemic diseases and diseases of pandemic potential.</i>	\$316 million (51% of total budget)
Non-communicable diseases and mental health <i>Includes strategic partnerships and project-based funding targeted at health promotion to address NCD risk factors, early screening and treatment, and mental health and suicide prevention.</i>	\$50 million (8% of total budget)
Projects targeting GEDSI as a cross cutting priority <i>Includes projects related to GEDSI and First Nations peoples engagement.</i>	\$10 million (2% of total budget)
Sexual and Reproductive Health and Rights (SRHR) <i>Includes partnerships with leading SRHR agencies, providing core funding and supporting several SRHR investments.</i>	\$158 million (25% of total budget)
Resilient health systems <i>Includes partnerships with organisations and whole of government agencies with a primary focus on regulatory strengthening and data for decision making.</i>	\$53 million (9% of total budget)
Program delivery support <i>Includes human resourcing, MEL, GEDSI related costs, and other operational costs.</i>	\$33 million (5% of total budget)
TOTAL	\$620 million

⁹² Note, PHR is referred commonly as a \$620million initiative but has an indicative total funding envelope of \$620.47million. Further detail on the budget is provided in Annex 11.

Note: For the purpose of presenting a summary of the PHR budget, the above figures have been either rounded up or down to the nearest million. These figures are indicative allocations and subject to change. For further detail, refer to [Annex 11](#).

Funding for communicable disease programming is drawn from an existing commitment to the prevention, control and response of infectious disease threats and ongoing support to strengthen of health systems, following the end of the Health Security Initiative. New programs will be undertaken to combat NCDs, with \$50 million allocated to respond to the NCD related health needs of the region. PHR will also deploy existing ODA funds to continue strong and effective partnerships with global SRHR agencies to support strategic interventions and ongoing commitments to quality, rights-based services and education which advance SRHR in the Indo-Pacific region. To advance Australia's gender equality and disability inclusion and First Nations engagement commitments, \$10 million is allocated for new programs aimed at promoting greater access to health through targeted efforts to progress inclusive development and gender equality, as well as projects which reflect and embed Australia's emerging First Nations approach to foreign policy.

Any expansion over time (for example, of additional activities or into additional countries in the region) would likely be modest, incremental, and require additional budget.

IMPLEMENTATION AND ADDITIONAL RESOURCES

Implementation of PHR will be managed in-house with program management, partnership management functions and technical advisory inputs performed by GHD staff in DFAT. Key aid quality functions including performance monitoring, risk management and advisory inputs on cross-cutting themes (including GEDSI and One Health) will also be managed in-house. The PHR budget will enable GHD to seek surge support on a needs basis. Functions and work functions which this may support is expected to include:

- Surge support for monitoring, evaluation and reporting efforts;
- Facilitating workshops and learning forums with partners;
- Undertaking discrete pieces such as collating baseline information, and completing thematic or mid-term reviews and evaluations;
- Undertaking audit spot checks;
- Supporting key functions on a needs basis including, for example, risk and financial management
- Additional technical support, engagement of representative groups, and targeted monitoring related to GEDSI and First Nations engagement;
- Support on other cross cutting themes including One Health and climate and environmental change;
- Support of other program management functions as directed by senior management;

Resources will be deployed into the region to support implementation and monitoring efforts. These roles are expected to support briefing, monitoring, providing strategic advice and management of stakeholder relations. Resourcing complement will differ by region, support needs, final programming decisions in addition to regional partnerships and centres (for example, the forthcoming ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED) hubs). This will likely include a mix of locally engaged staff in addition to two full-time PHR co-ordinators. Final resourcing decisions will be informed by consultations with the Office of the Pacific (OTP), Office of Southeast Asia (OSA) and DFAT posts in the region.

F.2 VALUE FOR MONEY

PHR capitalises on the traction, relationships, expertise, and reputation developed under HSI and VAHSI, and enables DFAT to advance impact more broadly across public health. The PHR initiative has been developed with close reference to the successes and lessons of HSI and capitalises on DFAT's earlier investments. Critical features of the PHR design to achieve value for money include:



EFFICIENCY

- Competitive selection processes will consider and compare competing methods and partners to select options that offer the optimal mix of costs and benefits for the program.
- Competitive calls for proposals will build in value for money considerations into selection criteria.
- Efforts will be made to standardise and keep administration and management fees to 10% for partners implementing projects and strategic partnerships, and 15% for product development partners.
- Public sector partnerships with trusted whole-of-government agencies will reduce the need for commercial procurement.
- Scaling activities and budget carefully over time, particularly in newer areas of investment such as NCDs, is intended to minimise the risk of inefficient use of resources.

EFFECTIVENESS

- Strategic partnerships will be formed with leading health institutions, consolidating activities, and providing increased flexibility.
- An adaptive management approach will support the initiative to adapt to learnings, results, changing contexts, emerging challenges, and opportunities in order to maximise results.
- Strong coordination with posts and partners who have established local networks, knowledge, and expertise will support PHR to contextually appropriate.
- Funding support to multilateral institutions and global PDPs enables Australia to advocate for pooled resources to be directed to our region.
- Public diplomacy opportunities generated through PHR provide DFAT with entry points to progress relationships with stakeholders and engage them in dialogue on DFAT's policy agenda.

SUSTAINABILITY

- Integration of localisation and partnership principles will foster local ownership and locally appropriate solutions, systems, and technology.
- Workforce training investments carried over from HSI will have a focus on supporting the translation of training into measurable improvements in capacity and forging ongoing mentoring arrangements.
- Public health deployments will seek to incorporate a sustainability plan and embed strong monitoring and reporting processes to support effective capacity building and avoid capacity substitution.
- Mechanisms will be established to sustain laboratory networks capacities and equipment built through HSI, seeking investment from other donors so support the diversity and sustainability of funding sources.
- A sustainability lens will be integrated into the annual strategic review, mid-term review and evaluation processes.

G. RISK MANAGEMENT AND SAFEGUARDS

G.1 RISK MANGEMENT

While the initiative is high value (>\$100million) and carries some inherent operational and strategic risks, the initiative has been indicatively assessed as medium risk. The ambitions of the initiative are high, the scope is broad, and the post COVID-19 context will bring challenges. The ability of PHR to contribute to the capacity and resilience of health systems will be contingent on many factors beyond the control of the initiative. PHR builds on the strong foundation of HSI, VAHSI and long standing SRHR programming, and will support investment delivery partners that have a strong presence in the region and proven capability and expertise. The partnership management role of GHD, the adaptive management approach, and the coordination arrangements proposed with other areas of DFAT will help to mitigate and manage risks.

The DFAT Risk Factors Screening Tool has been completed and a risk register developed to provide a thorough assessment of risks for the initiative, and to propose controls and treatments. Based on this assessment, it is expected that a medium risk effort will be needed to manage risks effectively.

Key risks include:

- **Resourcing:** The broadened scope and increased funding allocation of PHR increases demands on GHD. There is a risk that GHD's operating structure, and administrative and management capacity is not strong enough to ensure effective program management of a large aid investment. To help mitigate this risk, there is intention to expand resources available to support program management, risk, reporting and aid quality functions and to source surge support if required.
- **Centralised program management:** PHR will be primarily managed from Canberra and have a relatively small program management footprint in the region. Recognising variable capacity to engage in regional and global programs at our posts, PHR will allocate resources into select posts in the region, on advice from geographic divisions. However, this will need to be managed closely to ensure sufficient expertise is secured in a timely manner.
- **Fraud:** While DFAT has robust systems and procedures in place to protect public money from fraud and corruption, fraud remains a risk across PHR's initiatives and partnerships. Fraud risks and controls are outlined in the PHR Risk Register, with fraud risks to be managed in accordance with DFAT's Fraud Policy Statement and Fraud Control Toolkit for Funding Recipients. Anti-fraud will be the responsibility of all PHR program managers. GHD senior management will have oversight over PHR's management and monitoring of fraud against PHR's fraud control plan. GHD will conduct due diligence checks on all partners and contractors as part of procurement processes and include mandatory fraud control provisions in contracts and grant agreements and monitor compliance with these requirements. All funded partners will be required to conduct a fraud risk assessment, clearly articulate their fraud controls and implement methods to prevent, detect, and respond to fraud. Funding recipients are required to pass on obligations to any downstream partners and sub-contractors. All funding recipients will be required to report any suspected or real incidents of fraud and corruption within five (5) business days, and address occurrences promptly in accordance with DFAT protocols. GHD will actively communicate with partners to raise awareness of DFAT's fraud requirements, reinforce expectations, and promote use of the Fraud Control Toolkit through inception workshops, partner forums and partnership discussions.
- **Bilateral relationships and alignment with the needs of the region:** While PHR has been informed by extensive consultation, there remains a risk that it becomes misaligned with the strategic priorities of the region, particularly as new needs or priorities emerge. There is the added reputational damage or risk to bilateral relationships where partners may not be cognisant of the local political economy, or may not value and invest in local structures, capacity, and people. PHR will continue to engage posts and partner countries to help inform programming and set out mechanisms to embed



strong ongoing communication with posts and geographical divisions and support alignment with country priorities and contexts.

GHD will monitor and manage risk at an initiative level with emerging risks and changes to the risk profile being escalated to the attention of GHD management and the HMG. Recognising the value of risk management being integrated into the day-to-day operations of the initiative, risk management will be operationalised at the investment level and held by project and partnership managers. It is expected that investment level risk registers will be developed at agreement and investment level, drawing from and informed by PHR Risk Factors Screening Tool. Such registers will also be reviewed and updated quarterly and integrated into DFAT's aid management system.

GHD's engagement with DFAT staff at posts and across geographic divisions, including through the DFAT Health Network, will contribute to the initiative's risk management by facilitating the sharing of information on emerging or changing risks specific to the context, and supporting risk mitigation efforts. It is expected that the on-the ground insights offered by key internal and external stakeholders will feed into regular updates to the initiative's risk management framework. Risk will remain a key agenda item for the HMG and for regular meetings amongst DFAT program managers to support collaboration on risk and enable the escalation of risks. A risk escalation pathway will be developed and clearly articulated for use by GHD program managers, posts and geographic divisions.

Investment delivery partners will be required to have robust risk management systems in place with those prospective partners applying for funding through competitive processes required to provide detail on risks specific to their proposed activities when submitting proposals. Partner-led investment-specific risk assessments and management frameworks will be developed during negotiations and reviewed by DFAT program managers. Partner due diligence evaluations undertaken by DFAT centrally will further inform risks and safeguards assessments and support our risk management processes. All partners are expected to comply with DFAT's core risk and safeguards policies and report on risk and safeguards through standard reporting processes.

A focal point for risk and safeguards at the initiative level will be allocated and is expected to work closely with the performance monitoring and aid quality functions (currently located within the Health Systems Branch of GHD).

G.2 SAFEGUARDS

PHR seeks to bring a stronger focus on community engagement compared to HSI and will aim to enhance access to public health programming for underrepresented groups at increased risk of safeguarding concerns. PHR will set clear expectations of partners to embed a 'do no harm' approach and to ensure social safeguard measures are in place which protect women and girls, people of diverse SOGIESC, people with disabilities, ethnic minorities and Indigenous Peoples from social safeguarding risks including sexual exploitation and abuse.

Safeguarding risks include:

- **Poor outcomes on GEDSI, potential exacerbation of marginalisation or partnerships risk for GEDSI or First Nations organisations** A risk exists that partners make minimal progress on cross-cutting priorities related to GEDSI resulting in poor outcomes and potential exacerbation of inequalities for people from groups who experience marginalisation. Additionally, where partnerships with representative organisations such as women's rights organisations, organisations of persons with disabilities and First Nations organisations, are not meaningful, respectful, mutually beneficial and culturally safe, there is a partnership and resourcing risk to these organisations. This may occur if, for example, partners lack the capacity to effectively integrate GEDSI considerations. Stronger requirements of partners have been set to address this issue, with GEDSI considerations mandated in all calls for proposals, selection criteria, project designs, contracting and budgets, MEL and reporting. Technical support and funding will be made accessible to partners to strengthen their



capacity to advance GEDSI and First Nations engagement and to manage associated safeguarding considerations.

- **Child safeguarding:** At an initiative level PHR is unlikely to work directly with children, and therefore, a full child risk assessment is not required at this point in time. However, GHD will track child protection risks, embed controls, and revisit the need for an assessment once selection process of projects and strategic partners has been completed and final programming decisions have been made. Protection systems are in place as per DFAT's Child Protection Policy which applies to all partners. Funded partners, including multilateral organisations and bilateral donor partners, are expected to act in accordance with the policy principles and abide by relevant international declarations, conventions and agreements. GHD will promote greater awareness among partners of Child Protection requirements, including of reporting requirements, through partnership discussions and policy briefing sessions during, for example, inception workshops and partner forums. GHD staff working on PHR must adhere to the DFAT's Child Protection Policy and APS Code of Conduct.
- **Sexual exploitation, abuse and harassment (SEAH):** PHR recognises that unequal power dynamics and gender inequality will exist in many development activities and expects there is a medium risk of SEAH occurring in PHR funded activities. It is expected that all partners will have a Preventing sexual exploitation, abuse, and harassment (PSEAH) policy or other documented policies and procedures in place which states how downstream partners and sub-contracted entities will comply with the policy. Partners are expected to have a clear documented approach to how SEAH incidents will be managed, reported and investigated including how an organisation's governance structures will engage on SEAH incidents. Similar to efforts on child safeguarding, GHD will communicate expectations on PSEAH to partners regularly through, for example partnership discussions and partner forums. GHD staff working on PHR must adhere to DFAT's PSEAH Policy and APS Code of Conduct.
- **Climate and environmental risks:** A risk exists that the initiative may contribute to harm to the environment and possible climate change risks, through for example, not being responsive to climate change risks or contributing to healthcare waste that the region is unable to process effectively. Investment delivery partners will be required to identify, manage, and report on environmental risks in their risk assessments, as well as through regular reporting. The Initiative will also seek to support investments which address the risks associated with climate and environmental change.

H. ANNEXES

ANNEX 1: CONSULTATIONS ON FUTURE PRIORITIES FOR REGIONAL HEALTH PROGRAMMING IN THE INDO-PACIFIC REGION

This annex outlines consultations undertaken by DFAT in support of future health programming in the Indo-Pacific region. This includes providing a broad overview of the themes discussed in over 100 meetings with partner governments, health experts and program stakeholders, including identifying challenges and priorities for future investment in health in the Indo-Pacific.

DFAT conducted consultations from April to November 2022 and will continue further consultation, particularly with partner governments, to inform final programming decisions. A summary of these consultations is included below.

Table 2: Summary of consultations

Partner governments	International and regional organisations, and likemindeds	Australian organisations and partners	Thematic consultations
Partner governments in the Pacific and Southeast Asia (SEA) including ministries of health, agriculture, and foreign affairs officials. Countries consulted by November 2022 included: Papua New Guinea, Fiji, Kiribati, Timor-Lese, Nauru, Tonga, Tuvalu, Vanuatu, Indonesia, Vietnam, Philippines. Further consultation to inform programming decisions is planned.	Meetings held with headquarters and regional offices of key organisations including WHO, The Pacific Community (SPC) and the ASEAN Secretariat. Bilateral meetings with US, UK, Japan, New Zealand and Republic of Korea to explore opportunities for co-ordinated efforts.	Roundtable and side meetings in capital cities around Australia engaged over fifty different organisations including existing implementing partners in addition to prospective new partners. Briefings were held with Australian Council for International Development (ACFID) and the Australian Global Health Alliance membership with details of all public consultations disseminated through their networks. Consultations with whole of government agencies included: Department of Health and Aged Care; CSIRO; Department of Defence; Australian Centre for International Agricultural Research; National Health and Medical Research Council; Department of Agriculture, Fisheries and Forestry; Australian Institute of Health and Welfare.	Ten thematic consultations with Australian and regional bodies. Themes included: infection prevention and control and antimicrobial resistance; laboratory strengthening; data for decision making and surveillance; field epidemiology; vector-borne disease control; outbreak preparedness and response; community engagement; health product development; HIV & sexually transmitted infections (STIs); and One Health. Targeted consultations on gender equality, disability and social inclusion, including a roundtable with gender equality and disability inclusion focused organisations; and consultations with First Nations organisations and programs, and regional organisations of people with disabilities (Pacific Disability Forum; and ASEAN Disability Forum).

These discussions explored the health challenges facing the region – both throughout the COVID-19 pandemic and now as countries move into the recovery phase – what capacities exist to combat health challenges and what opportunities there are to further build capability in the region. DFAT will continue further consultations, particularly with partner governments, to inform final programming decisions.



INFECTIOUS DISEASES, NON-COMMUNICABLE DISEASES AND SEXUAL, REPRODUCTIVE AND HEALTH RIGHTS

Consultations highlighted the importance of an overall systems approach to strengthening health across the Pacific and Southeast Asia. Partners considered that the success of programming and COVID-19 response to be in part due to the ability to bring together various functions of the system (e.g. surveillance, laboratories and health information management) in a coordinated manner. Stakeholders emphasised that DFAT should continue to take a health systems approach, noting the importance of systems to be resilient, flexible and responsive in the face of various emerging health threats.

Consultations were focused on understanding the capabilities, gaps and needs around communicable diseases. Partner governments and stakeholders acknowledged and appreciated Australia's efforts to pivot regional health security support to combat COVID-19 at the height of the pandemic and agreed that addressing infectious disease threats should remain a focus of Australia's future support to the region.

But the pandemic also underscored the significant, ongoing challenges posed by non-communicable diseases (NCDs) in the region. Though discussion of NCDs was not the key focus of consultations, several stakeholders raised the ongoing impact of NCDs including the increased vulnerability if and as COVID-19 waves take hold in countries and health services are stretched. Ongoing discussions with partners and other stakeholders also continue to identify sexual and reproductive health and rights (SRHR) and service provision is not improving in some countries in the Indo-Pacific region.

ROUTINE IMMUNISATION AND IMMUNISATION POLICY, FINANCING AND MANAGEMENT

Immunisation policy and planning was noted by stakeholders as a key need (in the Pacific region in particular), noting the drop in vaccine coverage of vaccine preventable diseases. Stakeholders noted a key opportunity of maximising and extending COVID-19 gains in immunisation infrastructure and capabilities to broader immunisation programming. Opportunities likely lie in the implementation of immunisation research, undertaking serosurveillance studies of vaccine-preventable diseases, and building regional capacity in social and behavioural science to inform vaccine programming decision-making, address vaccine hesitancy and increase vaccine uptake.

HEALTH WORKFORCE AND CAPACITY

Workforce capacity and development featured as a key theme in discussions. Human resource constraints, high staff turnover and task shifting (either caused by or exacerbated by COVID-19) were noted as key challenges. There was particular interest in the sustainability of capacity development opportunities and in ensuring capacity development activities do not place additional strain on workforces by extracting key personnel from the workplace and exacerbating staff shortages. Investing in the current workforce and supporting partner countries to plan for and address workforce shortages were encouraged.

Consultations affirmed various capacity development models including online training, short courses (e.g. Australian Awards Fellowships Program), scholarships to higher education, mentoring (both informal and formal) and facilitating the sharing of expertise in-country and within the region. Exchange opportunities and higher degree scholarships were thought to be effective in building strong long-term relationships. There was an additional recommendation for training to be embedded into local academic institutions to support localisation of capacity development efforts; and for mentoring type approaches which focus on integrating training and learning 'on-the-job' as more sustainable approaches to capacity development.

Where training is offered, ensuring training is contextual to the community in which it is being delivered was encouraged by stakeholders. Increased co-ordination of workforce training within and between countries that creates a sense of community between countries, including cross-regional training opportunities, was further supported. Training should also take into account issues of workforce retention, motivation and burnout. Leadership support of workforce development opportunities was considered critical; and bridging the gap between capacity built in-country and the use of that capacity by policy and decision-makers was noted as a need.



Frontline health workers – with some discussions placing a particular emphasis on the nursing workforce – were noted as key target cohorts for capacity development opportunities. These cohorts faced the greatest risk and strain on their capacity during the COVID-19 outbreak. During some consultations, training outside formal settings (including within the community) was encouraged. Training in infection prevention and control (IPC), disease recognition, surveillance and treatment referral were all noted as areas of particular need.

Field epidemiology was raised in several discussions, particularly in light of the handling of COVID-19 outbreaks in the region. Increased sustainability and standardisation of field epidemiology training was noted as a key need, including the development of more high-quality workplace supervisors. Field epidemiology programming that considers political and social science, engages communities and informs policy was also highlighted as an ongoing gap - and opportunity.

LABORATORY STRENGTHENING

Discussions on laboratory strengthening acknowledged the gains made in laboratory capabilities across the region during the COVID-19 pandemic. It was suggested that new technologies may assist in building linkages between work being done on different diseases including, for example, molecular serology which can identify the presence of multiple pathogens. Continued support to maintain capabilities developed during COVID-19 will be critical.

Stakeholders highlighted the need in some contexts to support the establishment or organisation of laboratory systems, including national or reference public health laboratories – while some underscored the opportunity for scaling up of some laboratory programs and possible translation to other country contexts. There was a further suggestion that investing in laboratory networks between countries would support regional capacity building. Within countries, linking health information systems within hospital and clinical settings and laboratories was recommended. Laboratory strengthening was also noted as a key component of enabling availability of quality data for decision-making.

DEPLOYABLE HEALTH CAPABILITY AND OUTBREAK PREVENTION AND CONTROL

Deployments and access to technical expertise, particularly in public health, were considered by stakeholders as key modalities to address health priorities in the region. Building Australia's deployable health capability and having access to a pool of seasoned public health experts who can provide short, medium, and long term support, including health crisis response, was considered valuable.

Developing in-country and regional public health emergency response capabilities (beyond rapid response/deployable teams) was further noted as a need. Limited emergency response capacity, re-deployment of human resources and task shifting were noted as key challenges during the COVID-19 pandemic, hampering the health systems ability to respond effectively and maintain routine services. Extending support to Emergency Operations Centres in provincial centres was thought to be important in strengthening capacity for a co-ordinated and comprehensive response. Strategic planning that accounts for surge capacity was also recommended, including improving linkages between national Emergency Medical Teams and public health response teams, such as Rapid Response Teams for outbreaks.

Some discussions emphasised hospital oxygen systems and access to oxygen within the region as a cost-effective intervention to reduce child mortality from both infectious and non-infectious causes, particularly during outbreaks. Systemic barriers included the access to and availability of oxygen as well as the ability to effectively administer, monitor and adjust oxygen delivery. The provision of training, ongoing support and mentoring for healthcare workers were noted as key mechanisms to improve capabilities in this area.

Capacity in biomedical technology was identified in some discussions as a gap across the region (particularly in Pacific Island Countries), with current training courses producing few graduates. The increased sustainability of investments in training was suggested as a means to address this issue. Furthermore, development in biomedical technology was highlighted as necessary to address issues related to oxygen systems and access to oxygen.



VECTOR-BORNE DISEASE CONTROL

Discussions on vector-borne disease control highlighted the need to extend training beyond vector surveillance to include training on proactive (e.g. community clean up) and reactive (e.g. indoor residual spraying) control measures. Some discussions highlighted the expansion of the dengue virus in the region as a particular concern with antigenic variation, strain drift and emergence as key related issues.

ANTIMICROBIAL RESISTANCE (AMR)

Antimicrobial resistance (AMR) was seen as a priority with discussions pointing to the need for a multifaceted approach across surveillance and clinical support. Stakeholders suggested the priority needs in relation to AMR included: strengthened surveillance of antimicrobial use and resistance in humans, animals and the environment; improved diagnostics; and the promotion of stewardship activities such as improving national policies and guidelines related to antimicrobial use.

INFECTION PREVENTION AND CONTROL (IPC)

While there have been some gains on IPC during COVID-19, stakeholders noted a gap in relation to foundational IPC programs – including on training and policy – for many countries in the region. Discussions underlined the need for: a collaborative, system strengthening approach; support for governance and the development of IPC protocols from ministry to community level; and mentorship programs for health worker training to sustain interventions.

COMMUNITY ENGAGEMENT

Community engagement and building trust within the community of the health system was highlighted across forums as being key to supporting the reach and acceptance of health programs. Working beyond formal systems to engage communities was encouraged, including a recommendation to seek out those groups in-country that have strong links to local communities and exploring non-traditional means for engagement. Community engagement was noted as critical for a range of programs including: TB, vector control, communication efforts (e.g. provision of information, education and communications materials), health literacy and IPC. Discussions noted that integration between community surveillance networks and national coordination centres remained important, particularly during outbreaks.

Discussions also highlighted the need to prioritise delivery models that promote local capacity development and ownership to support sustainable outcomes. This includes not only community consultation, but the need for broader discussions related to governance structures. Participatory methods were encouraged, including in all aspects of planning, implementing, and monitoring of programs. This could, for example, include prioritising mentoring and education for communities, funding of local organisations, and supporting local leadership.

HEALTH DATA COLLECTION, ANALYSIS, SURVEILLANCE AND EPIDEMIOLOGY

Stakeholders noted COVID-19 pandemic supported digital maturity of health systems in several countries. This included the use of mobile technologies and other digital infrastructure for surveillance, health service delivery monitoring and emergency preparedness. Improving health information systems and data for decision-making was seen as important for promoting long-term sustained health planning and monitoring.

Emerging from this, integrated data management and use of data for decision-making was highlighted as a key opportunity, including supporting the visualisation and use of data that supports policy advice and decision making, and informs national resource allocation. Strengthening data literacy capabilities and involving communities and engaging local leadership was encouraged. There was further recognition of the value and need to build in interoperability of data systems within countries. Discussions also placed additional attention on the need to extend support to the requisite data infrastructure including, for example, hardware, software and necessary human resources.

Investment in multi-source surveillance and real time feedback loops remains important to stakeholders, including at the community level, in the clinical setting and within laboratories. Some discussions



emphasised the need to strengthen surveillance systems which incorporate clinical information and community transmission dynamics to enable data triangulation and better use of data for decision-making. Additionally, there was a recognition that drawing the link between surveillance data and policy dialogue and development is an opportunity that could be strengthened. Efforts to support surveillance to take a One Health approach and extend to the examination of critical control points in pathways from animal to human transmission was encouraged, particularly to prepare for future outbreaks. The capacity of the workforce to support multi-source surveillance systems was noted as critical and the value of a contextual approach was noted (e.g. in regards to vector surveillance, country context which provides detail on mosquitos and insecticide resistance was considered key by stakeholders). Uptake and engagement on modelling in the region were reported as being challenging, compounded by limited availability of data.

RESEARCH, PRODUCT DEVELOPMENT AND REGULATORY SUPPORT

Discussions on Product Development Partnerships (PDPs) included acknowledgement of the global reach of these partnerships and the value of ensuring Australia has a voice within these consortia to be able to advocate for the needs of our region. There was also acknowledgement of the relationships that PDPs have with Australian institutions and the mutual opportunity this presents for PDPs to work more effectively in the region as well as providing an avenue for Australian organisations to make global contributions. While there was recognition that PDPs have been effective in creating a pipeline for new treatments (e.g. Malaria), it was highlighted that challenges remain in incorporating new treatments into country planning and practice. Additionally, cost was identified as a significant barrier to the introduction and procurement of products in the region (including the cost of diagnostics and vaccines).

Stakeholders reinforced the need to consider product access and implementation as a key element of PDPs. Effective malaria and TB drugs and diagnostics already exist, for example, yet these drugs face significant access barriers across the region. Stakeholders suggested that product access requires support from other organisations, with strong coordination with PDPs to avoid over-burdening partner governments. Future product development programming opportunities for DFAT that were highlighted by stakeholders included: supporting local and regional capacity for good manufacturing practices, technology transfers, regulatory strengthening (in both countries with and without established regulators), quality and risk assurance and market surveillance, product introduction and deployment activities, and improving procurement and supply chain systems and stockpiles. The issue of substandard and falsified medical products, particularly in Southeast Asia, was also raised, in addition to the correct use and administration of treatments.

ONE HEALTH AND CLIMATE CHANGE

Discussions noted the socioenvironmental threats to health security, including those caused by climate change and biodiversity loss, and the need for a more integrated approach to health security that incorporate human, animal, and ecosystem health. Consultations pointed to a greater focus on zoonoses as being critical in addressing the root causes of epidemic and pandemic outbreaks.

Participants across consultations encouraged DFAT to support a holistic approach to health through a One Health lens and to facilitate improved co-ordination of efforts across human, animal and ecosystem health sectors, including in areas of surveillance. Stakeholders recommended supporting the One Health workforce and seeking to invest in community capabilities related to animal and ecosystem health (in addition to human health capabilities).

Climate change was also raised frequently. Discussions noted that the impacts of climate change, and climate-sensitive infectious diseases were likely to disproportionately burden lower income countries. Food insecurity and changing patterns of vector-borne diseases brought on by the impacts of climate change were seen as threats to health security in the region and stakeholders recommended a multi-sectoral response.

GENDER EQUALITY, DISABILITY AND SOCIAL INCLUSION, AND FIRST NATIONS ENGAGEMENT

Consultations reinforced the increased risk certain groups face to health issues, including infectious diseases, and the critical importance of investing in gender equality and inclusive development. A lack of investment in data related to gender, age, disability and ethnicity was raised by stakeholders as a key gap in health



systems, rendering some groups less visible in policy development and resource allocation. Access to information and services were highlighted as critical barriers for programs to address, as was supporting the engagement of diverse groups including women and people with disabilities, in informing policy and decision making.

Stakeholders encouraged attention to capacity building of stakeholders and investment in women in leadership. Engaging organisations of people with disabilities and women's rights organisations from the inception of programming was strongly encouraged, particularly to support community engagement efforts, accessible communications and improving reach, access and inclusion of those at risk of being left behind. Attention was also drawn to the need to strengthen health services recognised as critical to progressing gender equality, including sexual and reproductive health services, and to support continuation of these services in times of health emergencies.

Stakeholders considered there to be a strong foundation and opportunity for reciprocal sharing of knowledge and learning on health from the First Nations context within Australia into and within region. The shared value placed on the environment and its influence on health, the centrality of culture and community to wellbeing, the role of traditional knowledge systems and the experience of reaching hard-to-reach populations (including in regional and remote locations) were highlighted as opportunities for knowledge transfer and learning. Other experience within the First Nations health sector in Australia noted as transferable or shareable with the region included: community-controlled health programs; principles of community engagement, local leadership and self-determination; and the cross-cultural experience and skills of First Nations peoples.

Stakeholders reinforced the critical nature of embedding technical support on GEDSI and First Nations engagement into future programming and recommended embedding expertise into advisory functions to support program implementation. There was further recognition of the value in sharing lessons learned and good practice to support progress and outcomes on GEDSI and First Nations engagement in the health sector.

COLLABORATION AND PARTNERSHIP APPROACHES

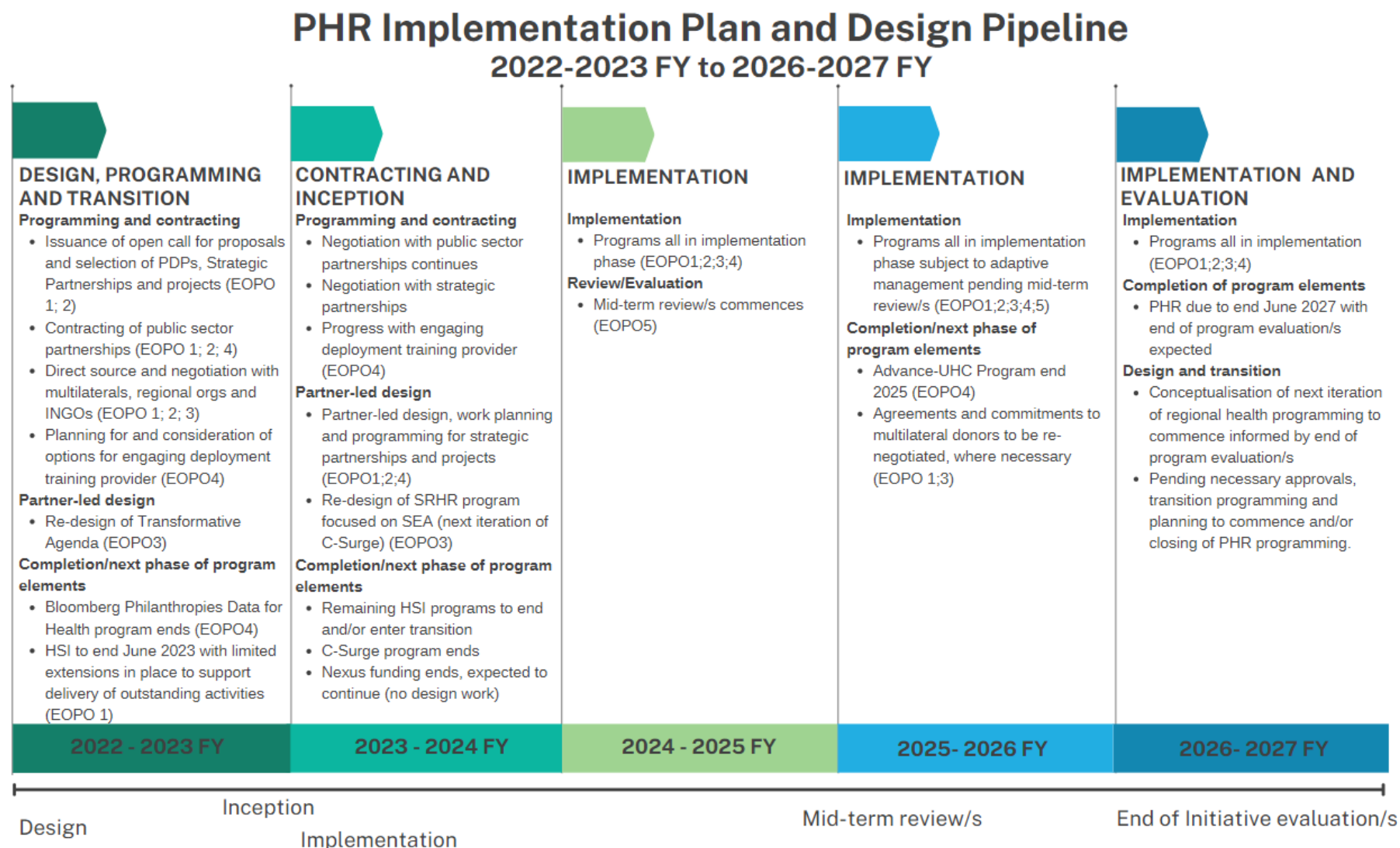
Discussions highlighted the importance of collaboration on health between countries in the region. Ensuring the capacities built during the pandemic are not lost and supporting a networked approach to knowledge sharing and mentoring was seen as critical.

Greater collaboration and stronger networks between investment delivery partners was also seen as important. Many of the organisations working on health that took part in consultations expressed a keen interest in developing greater links with one another. Better coordination and communication between partners were suggested as being important in limiting duplication, reducing inefficiencies, and maximising investments – with the partner forums supported by DFAT's Health Security Initiative (2017-2022) as a positive example that supported these linkages.

While expertise of Australian institutions and deployment of health specialists was valued by partner countries during HSI and the pandemics, stakeholders encouraged a focus on longer term capability in-country and reduced reliance on 'fly-in-fly-out' models.

ANNEX 2: IMPLEMENTATION PLAN

Figure 5: PHR Implementation Plan and Design Pipeline





ANNEX 3: GEDSI ANALYSIS EXECUTIVE SUMMARY

Gender and social inequalities are significant determinants of health, influencing both vulnerability for ill-health in terms of exposure, transmission and susceptibility to disease, as well as access to and uptake of healthcare. In developing PHR SIF, a situational GEDSI analysis was conducted through a rapid desktop scoping review, intended to inform the design of regional public health programming in the Indo-Pacific region. The analysis considered the evidence regarding both the linkage between GEDSI and health outcomes in the region, as well as existing barriers, opportunities and enablers for improved gender equality and disability and social inclusion in relation to public health.

WHAT IS THE EVIDENCE REGARDING THE LINKAGE BETWEEN GEDSI AND HEALTH OUTCOMES IN THE INDO-PACIFIC REGION?

Health outcomes related to both communicable and non-communicable diseases, as well as sexual and reproductive health, are inextricably linked to GEDSI.

The Indo-Pacific region bears a significant portion of the global burden of infectious diseases, including TB, HIV and malaria.⁹³ The region accounts for 44% of the TB incidence worldwide⁹⁴ with prevalence studies consistently showing that while TB affects men more than women, they are less likely to have their disease diagnosed.⁹⁵ HIV is another priority disease in the region, disproportionately affecting key populations including sex workers and their partners, men who have sex with men, people who inject drugs, transgender people and their partners. Minority Indigenous populations are also at greater risk for HIV infection compared to other groups in the WPRO region, and people with disabilities are understood to have higher incidence of both TB and HIV.^{96 97 98} Malaria also remains persistent in the region, affecting rural poor communities where outdoor and agricultural-related activities pose the highest risk.⁹⁹ Prevalence in the region is reportedly highest among men due to more frequent work in fields and forests, however, women are also at risk due to responsibilities related to cooking and collecting water and fuel.^{100 101} Pregnant women also have a disproportionately higher risk of malaria related illness due to reduced immunity during pregnancy.¹⁰²

Non-communicable diseases (NCDs) constitute an increasing burden of disease in the region, with gender an important influence on many of the drivers and risk factors for such diseases. In the Pacific, for example, being overweight or obese is more common among girls, while key health risk behaviours such as tobacco smoking and binge drinking are more common among adolescent boys.¹⁰³ At the same time, household air pollution generated by the use of polluting fuels and stoves for cooking and poor ventilation in homes is a primary contributor to excess risk for NCDs such as respiratory disease, with exposure particularly high for

⁹³ The Economist Group. (2021). Infectious and non-communicable diseases in Asia-Pacific: The need for integrated healthcare. London.

⁹⁴ Infectious diseases in the South-East Asia region. Centre for Disease Dynamics, Economics and Policy.

⁹⁵ World Health Organisation. (2022). Global tuberculosis report. Geneva.

⁹⁶ Gilmour et al. (2022). The prevalence of HIV infection in minority indigenous populations of the South-East Asia and Western Pacific regions.

⁹⁷ WHO. (2022). Global report on health equity for persons with disabilities.

⁹⁸ The Missing Billion. (2022). Reimagining health systems that expect, accept and connect 1 billion people with disabilities..

⁹⁹ Das, S et al. (2022). Building a gender-responsive framework for malaria elimination in the Asia-Pacific. *The Lancet*, 22, 100448.

¹⁰⁰ Das, S et al. (2022). Building a gender-responsive framework for malaria elimination in the Asia-Pacific. *The Lancet*, 22, 100448.

¹⁰¹ Das, S et al. (2022). Building a gender-responsive framework for malaria elimination in the Asia-Pacific. *The Lancet*, 22, 100448.

¹⁰² Das, S et al. (2022). Building a gender-responsive framework for malaria elimination in the Asia-Pacific. *The Lancet*, 22, 100448.

¹⁰³ UNICEF. (2019). Gender counts: A quantitative assessment of gender inequality and its impact on girls and boys in the Pacific. Bangkok: UNICEF East Asia and the Pacific.

women and children who tend to bear the greatest burden.^{104 105} Mental health conditions are another important consideration. People with disabilities in particular are reported to be at greater risk, with increased rates of diagnosis of conditions such as anxiety and depression compared to people without disabilities.¹⁰⁶

Access to sexual and reproductive health has improved over the past years, yet there remain inequalities across the region. High rates of preventable maternal death and unmet family planning remains a significant issue and many women are also unable to access safe abortions.^{107 108} Child marriage is common in the region, and gender-based violence and intimate partner violence are also linked to adverse maternal and perinatal health outcomes in the region.^{109 110 111 112} Women, girls and gender diverse people with disabilities in particular often face multiple and intersecting forms of discrimination with respect to realising their sexual and reproductive health and rights.^{113 114 115}

WHAT IS THE EVIDENCE REGARDING EXISTING BARRIERS, OPPORTUNITIES, AND ENABLERS FOR PEOPLE OF DIVERSE GENDERS, INDIGENOUS POPULATIONS, AND PEOPLE WITH DISABILITIES IN RELATION TO HEALTH SECURITY?

Informal barriers and enablers include those social norms, beliefs and attitudes that influence how people engage in risk and/or health seeking behaviours, as well as divisions of labour in society, among other things. Harmful gender norms and constructions of ‘masculinity’ for example, are understood to contribute to men being more likely to engage in TB-related risk behaviours such as tobacco smoking and drug and alcohol consumption, while also reducing health-seeking behaviours and therefore leading to late or missing diagnosis and lower rates of treatment.^{116 117 118} Gendered social norms and practices that influence divisions of labour also see men overrepresented in occupations that increase their risk for TB, such as mining.¹¹⁹ Meanwhile, the burden of unpaid care work in the region, including household and caring responsibilities, is disproportionately borne by women and girls which often has direct health implications.^{120 121 122} These may include greater exposure to disease due to being primary caregivers to ill family members, a greater mental

¹⁰⁴ World Health Organization. (2022). Factsheet Household air pollution. Geneva.

¹⁰⁵ UN Women (2022). Gender equality and sustainable energy: Lessons from Pacific Island countries and territories. New York.

¹⁰⁶ World Health Organization. (2022). Global report on health equity for persons with disabilities.

¹⁰⁷ Davies, S. (2018). Gender empowerment in the health aid sector: Locating best practice in the Australian context. *Australian Journal of International Affairs*.72(6): 520-534.

¹⁰⁸ Wilson, Spotswood, Hayman et al. (2020). Improving the quality of maternal and newborn care in the Pacific region: A scoping review. *The Lancet Regional Health Western Pacific*, 3: 100028.

¹⁰⁹ United Nations Population Fund. (2015). Sexual and reproductive health of young people in Asia and the Pacific: A review of issues, policies and programmes. Bangkok.

¹¹⁰ Waites, N. (2015). Maternal mortality and GBV in the Pacific: Common drivers call for collaborative approaches. Dev Policy Blog.

¹¹¹ World Health Organization. (2013). Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva.

¹¹² Nagashima-Hayashi, M., Durrance-Bagale, A., Marzouk, M. et al. (2022). Gender-based violence in the Asia-Pacific Region during COVID-19: A hidden pandemic behind closed doors. *International Journal of Environmental Research and Public Health*, 19(4), 2239.

¹¹³ United Nations Department of Economic and Social Affairs. (2018). Disability development report. New York.

¹¹⁴ UN Women. (2022). Women, girls, and gender non-conforming people with disabilities: You’re your rights! New York.

¹¹⁵ UN Women. (2022). Women, girls, and gender non-conforming people with disabilities: You’re your rights! New York..

¹¹⁶ The Global Fund. (2020). Technical brief: Tuberculosis, gender and human rights. Geneva.

¹¹⁷ Silva, Munoz-Torrico, Duarte, et al. (2018). Risk factors for tuberculosis: Diabetes, smoking, alcohol use, and the use of other drugs. *Jornal Brasileiro de Pneumologia*.; 42(4), 145-152.

¹¹⁸ The Global Fund. (2020). Technical brief: Tuberculosis, gender and human rights. Geneva.

¹¹⁹ The Global Fund. (2020). Technical brief: Tuberculosis, gender and human rights. Geneva.

¹²⁰ United Nations Economic and Social Commission for Asia and the Pacific. (2019). Social Development Policy Papers: Unpaid work in Asia and the Pacific. Bangkok.

¹²¹ UNESCAP. (2019). Unpaid work in Asia and the Pacific.

¹²² CARE International. (2020). CARE Rapid Gender Analysis COVID-19: Pacific Region. Geneva.



health burden, and increased risk of gender-based violence.^{123 124 125} Indeed, gender inequality increases risks for violence, stigma and discrimination for all people, but particularly for women and girls, people with disabilities, and people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC).¹²⁶

It is not only social norms and attitudes that influence health risks and outcomes; there are also formal barriers to gender equality and social inclusion including those related to laws and policies, health care system accessibility, workforce participation and leadership, education, social and material resources, and data availability. Laws and policies for example, may contribute to the violence and discrimination experienced by many groups in vulnerable situations. For example, the criminalisation of gender-identity and expression of transgender people, same-sex relationships, and sex work remain a major barrier to achieving equality in several countries across the region.¹²⁷ This has direct impacts on health, including through reducing access to and uptake of safe healthcare services.^{128 129 130} Non-inclusive health services remains a key issue for HIV care for example. While coverage of testing, diagnosis and treatment of HIV in the region continues to improve, there are still large gaps in service coverage among key populations, owing also to widespread stigma and discrimination.^{131 132 133} For people with disabilities, barriers to care are even more pronounced, with these groups experiencing greater unmet health needs and facing additional physical, communication, attitudinal and financial barriers to accessing health care.^{134 135 136}

Gender inequality and social exclusion can also be seen in political and civic participation, and educational outcomes across the region. Labour participation for women is reported to be nearly 35 percentage points lower than for men across Asia and the Pacific, and several countries also impose certain restrictions on women's employment, as many other countries do globally.^{137 138} For people with disabilities in the region, barriers to employment are significant as they are between two and six times less likely to be employed than people without disabilities.¹³⁹ Average representation of persons with disabilities in national parliaments in the region is 0.4 per cent, while the percentage of women in parliaments stands at 21 per cent.^{140 141}

¹²³ United Nations Economic and Social Commission for Asia and the Pacific. (2021). Social development policy papers: The COVID-19 pandemic and violence against women in Asia and the Pacific. Bangkok.

¹²⁴ Seedat, S., Rondon. M. (2021). Women's wellbeing and the burden of unpaid care work. *BMJ*, 374, n1972.

¹²⁵ UN Women. (2022). Gender equality and sustainable energy. New York.

¹²⁶ UN Women Asia and the Pacific. (2020). The COVID-19 outbreak and gender: Regional analysis and recommendations from Asia and the Pacific. Bangkok.

¹²⁷ Human Dignity Trust. (2015). Criminalising homosexuality and public health: Adverse impacts on the prevention and treatment of HIV and AIDS. London.

¹²⁸ CARE International. (2020). Rapid gender analysis during COVID-19 pandemic: Mekong sub-regional report. Geneva.

¹²⁹ Asia Pacific Network of Sex Workers (APNSW). (2020). Global Network of Sex Work Projects: Promoting health and human rights webpage.

¹³⁰ Human Dignity Trust. (2015). Criminalising homosexuality and public health: Adverse impacts on the prevention and treatment of HIV and AIDS. London.

¹³¹ Infectious diseases in the South-East Asia region. Centre for Disease Dynamics, Economics and Policy.

¹³² UNAIDS. (2022). In Danger: UNAIDS Global AIDS Update 2022. Geneva.

¹³³ UNAIDS. (2022). In Danger: UNAIDS Global AIDS Update 2022. Geneva.

¹³⁴ United Nations Department of Economic and Social Affairs. (2018). Disability development report: Realizing the Sustainable Development Goals by, for and with persons with disabilities. New York.

¹³⁵ The Missing Billion Initiative. (2022). Reimagining health systems that expect, accept and connect 1 billion people with disabilities.

¹³⁶ The Missing Billion Initiative. (2022). Reimagining health systems that expect, accept and connect 1 billion people with disabilities.

¹³⁷ UNESCAP. (2022). Female labour force participation and the care economy in Asia and the Pacific: Policy Paper. Bangkok.

¹³⁸ World Health Organization. (2019). Delivered by women, led by men: A gender and equity analysis of the global health and social workforce. Geneva.

¹³⁹ United Nations Economic and Social Commission for Asia and the Pacific. (2018). Building disability-inclusive societies in Asia and the Pacific. Bangkok.

¹⁴⁰ Inter-Parliamentary Union. (2022). Women in parliament in 2021: The year in review. Geneva.

¹⁴¹ United Nations Economic and Social Commission for Asia and the Pacific. (2018). Building disability-inclusive societies in Asia and the Pacific. Bangkok.



Inequalities in health leadership are also visible, despite evidence globally that gender equality and diversity in leadership is important for achieving improved health outcomes.^{142 143 144}

Education is another key modifiable determinant of health, strongly associated with improved life expectancy and health behaviours, and reduced morbidity.¹⁴⁵ Secondary school constitutes an important source of sexual and reproductive health education however, the content of such programs is varied. In both the Pacific and Southeast Asia, girls have higher attendance and completion rates for secondary school than boys, however, are less likely to be in employment, education or training in adolescence and early adulthood.^{146 147} For people with disabilities, access to education is significantly limited with physical, information and other discriminatory barriers contributing to an almost 53% drop in enrolment rate between primary and secondary schooling.¹⁴⁸

Access to material and social resources is another consideration highlighted in the literature. In some countries in the region, it is reported that women are less likely to be covered by health insurance than men, while coverage for people with disabilities in government-funded health care and disability benefit programmes are as low as 30% and 28% respectively with social protection often limited to those in formal employment.¹⁴⁹ Moreover, inequalities in access to digital technologies, personal income and savings, as well as property ownership may place women, people with disabilities and other marginalised groups at increased risk of adverse health outcomes and accompanying economic pressures.^{150 151 152 153} Loss of access to land, traditional knowledge and food systems also have significant health consequences for Indigenous populations in particular.¹⁵⁴

The analysis finally considered the availability and comparability of data as another formal barrier to gender equality and social inclusion in the region, particularly for people with disabilities. Data on disability prevalence in the region for example, is difficult to determine owing to differing definitions and approaches to data collection, as well as access barriers, among other factors.^{155 156} There are also significant differences in capacities across the region to monitor disability-inclusion indicators relating to healthcare access across

¹⁴² United Nations. (2020). Women's leadership in promoting global health and well-being. New York.

¹⁴³ World Health Organization. (2020). Consultation on policy brief on gender, equity and leadership in the global health and social workforce: Call for consultation. Geneva.

¹⁴⁴ Baston, A., Rao Gupta, G., Barry. M. (2021). More women must lead in global health: A focus on strategies to empower women leaders and advance gender equality. *Annals of Global Health*; 87(1), 67.

¹⁴⁵ Education: A neglected social determinant of health. *The Lancet Public Health*. 2020; 5(7): 361.

¹⁴⁶ UNICEF East Asia and the Pacific. (2019). Gender counts: A quantitative assessment of gender inequality and its impact on girls and boys in the Pacific. Bangkok.

¹⁴⁷ UNICEF East Asia and the Pacific. (2019). Gender counts: A quantitative assessment of gender inequality and its impact on girls and boys in the Pacific. Bangkok.

¹⁴⁸ United Nations Economic and Social Commission for Asia and the Pacific. (2018). Building disability-inclusive societies in Asia and the Pacific. Bangkok.

¹⁴⁹ United Nations Economic and Social Commission for Asia and the Pacific. (2018). Building disability-inclusive societies in Asia and the Pacific. Bangkok.

¹⁵⁰ ADB and UN Women. (2022). Two years on: The lingering gendered effect of the COVID-19 pandemic in Asia and the Pacific.

¹⁵¹ UN Women Asia and the Pacific. (2020). The COVID-19 outbreak and gender: Regional analysis and recommendations from Asia and the Pacific. Bangkok.

¹⁵² United Nations Economic and Social Commission for Asia and the Pacific. (2018). Building disability-inclusive societies in Asia and the Pacific: Assessing progress of the Incheon Strategy. Bangkok.

¹⁵³ Social Institutions and Gender Index 2021 regional report for Southeast Asia. Paris: Organisation for Economic Co-operation and Development; 2021. Available at: https://www.oecd-ilibrary.org/development/sigi-2021-regional-report-for-southeast-asia_236f41d0-en

¹⁵⁴ FAO. (2018). Indigenous Peoples in the Asia-Pacific Region. Rome.

¹⁵⁵ United Nations Economic and Social Commission for Asia and the Pacific. (nd). Disability in Asia and the Pacific: The facts. Bangkok.

¹⁵⁶ United Nations Economic and Social Commission for Asia and the Pacific. (2018). Building disability-inclusive societies in Asia and the Pacific: Assessing progress of the Incheon Strategy. Bangkok.



the region.¹⁵⁷ Data pertaining to the health of Indigenous populations across the region, as well as for people of diverse SOGIESC is also often lacking, limiting the capacity for evidence-informed and inclusive health policymaking.

CONCLUSION

The rapid desk-based gender analysis aimed to explore the evidence related to the intersection between gender equality and social inclusion and health outcomes in the region, and to broaden understanding of the underlying barriers, enablers and determinants of health.

The findings underscore the importance of integrating considerations on gender and social equality into public health and development programming. It is essential that programs are responsive to the ways in which social inequalities and environments can influence public health outcomes, and indeed how health and social systems can reinforce inequalities. Ensuring GEDSI as a cross-cutting priority for future regional health programming regardless of the primary focus and aim of the program is critical – including by ensuring social safeguards are in place. This will support more equitable and inclusive outcomes and contribute to strengthening the evidence base as program partners undertake GEDSI analyses and report on GEDSI-related outcomes through their work.

¹⁵⁷ UNFPA Asia-Pacific Office. (2022). Are persons with disabilities included in the effort to leave no-one behind? Mapping disability data in development in Asia and the Pacific.

ANNEX 4: GEDSI AND FIRST NATIONS ENGAGEMENT STRATEGY

PURPOSE

This document details the strategic approach to supporting the integration of gender equality, disability, social inclusion (GEDSI) and First Nations engagement across the breadth of the Partnerships for a Healthy Region (PHR) initiative. It outlines principles and approaches as to how these cross-cutting priorities will be progressed through program delivery, policy dialogue, partnerships, people-to-people links and diplomacy efforts. It will seek to communicate expectations and strategies on GEDSI; and will be supplemented by other PHR documents and guidance documents which will support downstream design, work planning and reporting on gender equality, disability and social inclusion.

This Strategy integrates findings from the [Health Security Initiative \(HSI\) Mid-Term Progress Report 2017-2019](#); the internal HSI rapid review and GEDSI review conducted in 2022; and integrates evidence captured through the GEDSI analysis conducted to support the PHR design process. It is a living document and will be reviewed on an annual basis, seeking to be adaptive to changes in the programming context.

BACKGROUND

Gender and social inequalities are of fundamental importance to health, with pre-existing inequalities influencing health outcomes.¹⁵⁸ Gender, sex, sexuality, disability, age, indigeneity, ethnicity, socio-economic background and geographical location can create or contribute to barriers to health care and increased risk associated with exposure and susceptibility to infectious disease and chronic conditions.¹⁵⁹ The COVID-19 pandemic has further reinforced the disproportionate impact that health emergencies have on the health and wellbeing of women, girls, people with disabilities and other groups who identify as marginalised.^{158,159,160}

The HSI Mid-Term Progress Report 2017-2019 indicated that the quality of monitoring and reporting and incorporation of the HSI's cross-cutting priorities of gender equality and disability inclusion was variable across investments with disability inclusion particularly lagging behind. The internal HSI GEDSI review conducted in 2022 noted that efforts were made following the Mid-Term Progress Report, largely instigated by DFAT's project managers, with positive progress made by several partners. Progress, however, remained slow with the trend noted in the mid-term review largely endured. Concerted effort will be needed to invest in and grow the GEDSI capability in order to contribute to equitable and inclusive outcomes under PHR.

STRATEGY: OUR APPROACH TO GEDSI AND FIRST NATIONS ENGAGEMENT

The PHR initiative will build on the strengthened awareness on GEDSI made under HSI (2017-2022) with heightened ambitions under PHR. As cross cutting priorities, gender equality, disability and social inclusion and First Nations engagement will be firmly integrated across the initiative. The initiative will also set aside funding for projects that directly pursue and support gender equality and inclusive development outcomes, in addition to projects which will reflect and embed Australia's emerging First Nations approach to foreign policy. PHR investments will align and contribute to the relevant policy objectives and commitments made by Australia and our partner countries on GEDSI.¹⁶¹ PHR will adopt the 'significant' gender equality and disability DAC marker- acknowledging gender equality and disability inclusion as important objectives but not the principal reason for undertaking the initiative.

¹⁵⁸ UN Women. (2020). Policy Brief: The Impact of COVID-19 on women.

¹⁵⁹ UNFPA. (2022). Gender-Based Violence and COVID-19: Actions, Gaps and the Way Forward.

¹⁶¹ This includes any forthcoming policies, in addition to DFAT's Gender Equality and Women's Empowerment Strategy; Development for All 2015-2020: Strategy for strengthening disability-inclusive development in Australia's aid program; Australia's emerging First Nations approach to foreign policy; international frameworks ratified by the Government of Australia and majority of countries in the Indo-Pacific region and the 2030 Agenda for Sustainable Development to "leave no one behind".

PHR will be intentional in focusing on gender equality, disability inclusion and engagement of First Nations peoples of Australia. Attention to other domains of social inclusion and intersectionality will be encouraged and supported.

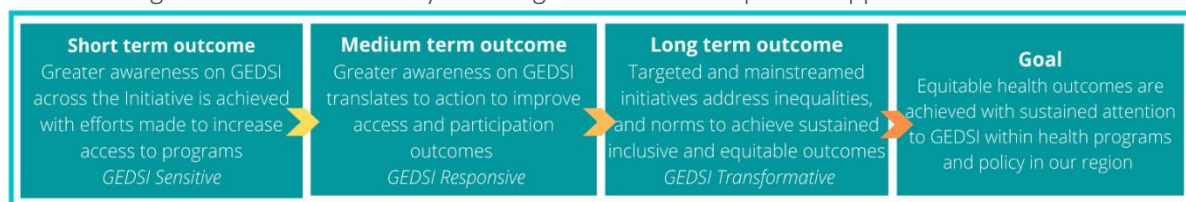
PRINCIPLES

We will look to lay the foundations required to build successively stronger programming over time by embedding the following core principles:

- **Value placed on diversity:** Lived experience, GEDSI expertise and First Nations voices will be valued and engaged in program delivery, governance and review processes.
- **Meaningful participation and partnerships:** Partnership models with organisations representing people with disabilities, gender equality and First Nations peoples will be supported and expected to be of mutual benefit, to support self-determination, and facilitate public health engagement and leadership opportunities.
- **Collaboration, Capability and Learning:** GEDSI capability development, cultural competency and learning is acknowledged as critical to success. An adaptive approach that integrates learnings will be adopted - facilitating the sharing of experiences between partners, government agencies and program managers. Linkages with other DFAT programs in the Pacific and Southeast Asia will be sought, including leveraging GEDSI elements within our bilateral health programs.
- **Strengths based approach:** A culture of celebrating progress will be established with progress on GEDSI acknowledged and leveraged for greater gains and improved outcomes.
- **Attention to unequal norms and barriers:** Delivery partners will be expected to analyse, understand and address social and gender norms and barriers that certain groups face, with particular attention to: decision-making and power relations; accessible information; accessible health services; and discrimination within the health system, in policies and laws and in workplaces which limit participation.

THEORY OF CHANGE

The following outlines a basic theory of change that will underpin our approach to GEDSI:



The initiative will aim to achieve progress towards transformative and sustained change, noting this is based on the following assumptions:

- The market responds to calls for targeted GEDSI and First Nations related projects.
- Partner selection sufficiently accounts for GEDSI capability.
- Partners undertake sufficient GEDSI analysis which enables an understanding of social norms and identification of GEDSI strategies.
- Partners value GEDSI and invest sufficiently in their capability to deliver on the strategy.
- There is leadership within GHD and amongst partners that supports and champions GEDSI.
- Partners have the skill set to engage with in-country counterparts in a way which facilitates and integrates GEDSI practice.
- There remains dedicated technical advisory support and GEDSI resourcing within GHD.
- Partners are kept accountable to GEDSI related requirements.

STRATEGIES

At a **partnership and project level**, GEDSI will be expected to be mainstreamed within all programming with additional attention to targeted activities alongside mainstreaming efforts. Partners will be expected to embed our core principle related to addressing unequal norms and barriers and to undertake their own GEDSI analysis to identify and address norms specific to their activity and the context.

The internal HSI GEDSI review and the GEDSI Analysis has highlighted particular gaps and opportunities for investment. We will seek key opportunities to support and fund the following:

- Innovative approaches to delivery of services and information; data collection and analysis; and workforce development, with particular attention to supporting women in leadership.
- Partnerships with organisations in our region, including representative and rights organisations, that provide specialised advisory and/or brokering services – aligned with the core principle of ‘nothing about us without us’.
- Consideration of sex, gender, disability, ethnicity, age and other sociodemographic factors in product development research and facilitating access to health products, and associated safety information.
- Initiatives that could contribute to the evidence base on issues of inclusion and equality and support translation of evidence into practice. For example: addressing evidence gaps on disease burden and utilising this data to influence policy; capturing information on social norms which affect access to services and the strategies that support transformative change; capturing data on immunisation coverage and the influence gender or disability, for example, may have on vaccine acceptance and/or access, etc.
- Investments that facilitate engagement of First Nations peoples of Australia in thematic programming of PHR, embedding First Nations perspectives, experiences and interests and connecting First Nations peoples of Australia with the region through, for example, community-led health programming, environmental land management practices, and Indigenous knowledge of food systems.

Partners will be expected to embed a ‘do no harm’ approach and to ensure social safeguard measures are in place which protect women and girls and people of diverse SOGIESC, including those with disabilities, from sexual exploitation and abuse.

To achieve GEDSI related outcomes, **at an initiative and operational level**, PHR will look to strengthen attention to GEDSI and support engagement of First Nations peoples of Australia, through the following:

- **Capacity building and technical support:** Support will be provided to GHD and partners on GEDSI, strengthening their capacity to integrate GEDSI throughout the aid programming cycle, with particular attention to support at the design stage.
- **Resource allocation:** GEDSI support will be firmly embedded into PHR budget and supported with technical resourcing.
- **Contracting:** GEDSI commitments will be embedded into contracting processes and partnership management, including explicit references and requirements on GEDSI, building in hard gates where there are risks, and integrating support and accountability measures for partners through reporting and partnership health checks.
- **Governance and management structures:** GEDSI specialist/s and a First Nations voice that brings Indigenous health expertise will be invited to provide expert technical input as part of the membership of technical reference groups for the initiative.
- **Monitoring and evaluation:** GEDSI will be strongly embedded into the performance and risk architecture for the Initiative and within the MEL frameworks for individual projects and partnerships, with greater attention to seeking reporting on outcomes, supported by evidence (see below [Review: Monitoring progress and embedding learnings](#)).

- **Policy dialogue:** DFAT will seek to draw attention to and advocate for GEDSI in bilateral development discussions; and meetings and forums with partners and key GEDSI stakeholders.

RESOURCING: SUPPORTING THE IMPLEMENTATION OF THE STRATEGY

The PHR initiative, which is being implemented by DFAT's Global Health Division (GHD), will be supported by GHD's GEDSI Advisor, who will oversee the implementation of the strategy with support provided by GHD's First Nations Focal Point. The GEDSI advisor will be responsible for providing technical advisory support at an initiative level, and to support the in-house capability of GHD to deliver on this Strategy.

The GEDSI advisor and the First Nations Focal Point will liaise with DFAT's policy and technical lead areas to seek specialist and policy input as needed. DFAT's specialised technical advisory services on gender equality, disability inclusion and health will be utilised on a 'needs basis' with GHD in-sourcing additional GEDSI expertise if required.

GEDSI operational support is embedded into the budget of the initiative. Through competitive calls for proposals, PHR will additionally allocate funding for projects that directly pursue and support gender equality and inclusive development outcomes, and projects that will reflect and embed Australia's emerging First Nations approach to foreign policy.

Partners will be expected to resource GEDSI and to integrate into budgets and workplans. The responsibility of growing GEDSI capability will lie with partners. GHD will, however, play a supportive role by providing good practice guidance, embedding this guidance into program documentation and templates, offering discrete technical support and inputs, and delivering capacity development sessions.

REVIEW: MONITORING PROGRESS AND EMBEDDING LEARNINGS

As a cross cutting theme, GEDSI is embedded into the initiative's Program Logic as an intermediate outcome. Gender equality is also targeted through EOPO3, which has a focus on advancing the SRHR of women, girls and people with diverse SOGIESC. These outcomes are supported by indicative indicators to support measurement. Indicators related to GEDSI will be finalised during inception.

GEDSI will be embedded into annual strategic reviews, PHR mid-term review and final evaluation/s. Attention will be given to embedding additional review points and specific evaluations that capture learnings on GEDSI and/or First Nations engagement, support course correction and invest in strengthening particular areas if required.

Partners will be supported to integrate GEDSI into their Monitoring, Evaluation, and Learning Frameworks with consideration given to GEDSI in reporting templates. It will also be embedded into partner learning dialogues and PHR communications to enable a learning environment which supports development of capability and acknowledges progress.

ANNEX 5: PROGRAM LOGIC

Further description of the program logic including a narrative summary of each intermediate outcome is provided in this section.

Goal of PHR: Pacific and Southeast Asian countries deliver better health outcomes for all.

Strategic objective: Australia is a trusted health partner in the Pacific and Southeast Asia, with stronger institutional linkages and high value placed on our public health expertise.

Development objective: Pacific and Southeast Asian countries have more resilient and equitable public health systems with greater capability to respond to health emergencies.

To support the achievement of PHR's goal and strategic objective, the investment will seek to contribute to five end of program outcomes (EOPOs):

1. **Communicable diseases prevention and control:** Australian assistance contributes to improved ability of partner countries to anticipate, prevent, detect and control communicable disease threats and to address equity in the delivery of these functions.
2. **Non-communicable diseases prevention and control:** Australian assistance contributes to improved capacity of partner countries to prevent and control non-communicable disease in an equitable way.
3. **Sexual and reproductive health and rights:** Australian assistance contributes to increased capacity of partner countries to advance equitable and comprehensive SRHR, particularly for women and girls.
4. **Resilient Health Systems:** Australian assistance contributes to partner countries' improved regulatory mechanisms, data systems, and capabilities to deliver equitable public health action.
5. **Effective partnerships and delivery:** Australia's regional health assistance is flexible, responsive and meets the needs of partner countries.

Each EOPO is underpinned by a set of associated Intermediate Outcomes (IOs). IOs provide further specificity on the changes that will be targeted within each end of program outcome. PHR will integrate a set of cross-cutting IOs including: One Health and Climate Change; GEDSI; and Community Engagement. These cross cutting IOs are supported by a set of strategy documents.

At a programmatic level PHR will work to strengthen core health systems and functions. This includes, for example, strengthening of laboratories, investing in data for decision making and investing in health screening and early detection – all functions which are useful in contributing to a range of health outcomes. Working at this health systems level strengthens the capacity of partner countries to address and respond to a range of health challenges and builds resilience to withstand shocks. Some activities may work within a broad category (CDs, NCDs, SRHR) in a manner that is disease agnostic - while other activities may strengthen health functions and also target a particular disease, such as addressing drug resistant HIV in PNG. This approach sets common parameters for a regional program, while giving flexibility to target activities at a country level, to address health systems challenges as outlined in WHO JEE reports, and target particular disease burdens affecting partner countries.

EOPO1: AUSTRALIAN ASSISTANCE CONTRIBUTES TO IMPROVED ABILITY OF PARTNER COUNTRIES TO ANTICIPATE, PREVENT, DETECT AND CONTROL COMMUNICABLE DISEASE THREATS AND TO ADDRESS EQUITY IN THE DELIVERY OF THESE FUNCTIONS

PHR will work with partners to embed a health systems strengthening approach that builds International Health Regulation (2005) functions.¹⁶² Our work will seek to strengthen capacity to prepare, prevent, detect

¹⁶² The IHR 2005 are designed to prevent the international spread of infectious diseases and provides an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies with the potential to cross borders.



and respond to infectious disease threats. Many investments under this EOPO are expected to work at a thematic level, building core public health functions such as surveillance and laboratory strengthening which strengthen capacities to address both pandemic, epidemic and endemic communicable disease threats.

Intermediate Outcome 1.1: Strengthened capacity and systems to respond to epidemic and endemic communicable disease threats

PHR will support work on endemic diseases such as TB, malaria and HIV/AIDS. We will also enhance investment in projects which address other infectious disease challenges of high priority to partner governments - for example, dengue, antimicrobial resistance, and neglected tropical diseases.

To support control of endemic communicable disease threats, PHR will seek to support and extend investment in the strengthening of laboratories, including through capacity building, laboratory networking, accreditation and standards, supporting appropriate technology, and multi-sectoral collaboration. We will look for opportunities support the strengthening of vector control systems through increased technical capacity, research and improved infrastructure. Surveillance capacity of antimicrobial resistance, vector-borne disease and STIs including HIV is expected to be strengthened, with a focus given to community-based surveillance and strengthening the use of data for decision making. PHR is well placed to provide support to enhance the policy and institutional environment for infection prevention and control, and support community level programming that leverages the increased attention which COVID-19 brought to the individual and community's role in managing and prevent disease outbreaks. Field Epidemiology Training Programs will also be a key focus. PHR will also support routine and catch-up immunisation programs by building technical and workforce capacity and work to improve community demand for vaccines.

Intermediate Outcome 1.2: Strengthened pandemic preparedness and outbreak response systems and capacity

The emergence of COVID-19 has highlighted the need for approaches to outbreak preparedness and response that are timely, flexible, financed, coordinated, multi-sectoral, and adaptive. Australia will continue to strengthen core capacities for preparedness and outbreak response at the community, national and regional levels. This will be achieved by supporting multilateral bodies, including WHO's Health Emergencies Programme, specifically to support WHO's regional offices covering Southeast Asia and the Pacific. We will also seek to support WHO's Global Outbreak and Response Network which trains and deploys outbreak responders to health emergencies, drawn from public health institutions across the world. This would be supported by separate and co-ordinated funding to a public health deployment training provider to deliver outbreak response training in Australia and within the Indo-Pacific region, supporting the availability of a pool of deployment-ready public health specialists. In addition, we will seek to support regional public health emergency deployment capability, including through the ASEAN Centre for Public Health Emergencies and Emerging Diseases ACPHEED.

Funding channelled to WHO would also support their role in leading the Joint External Evaluations of countries' health security capacities, and the preparation or updating of national action plans for health security. This would be in addition to targeted support to providers with proven capability in strengthening public health emergency operation centres in the region. Investment in the newly established global Pandemic Fund will also provide a dedicated stream of additional, long-term financing to help strengthen national, regional and global pandemic preparedness and response.

Areas of investments to address disease control and support strengthening of health systems will be critical to supporting preparedness and provide a critical foundation for response efforts. These include investment in: surveillance; disease modelling; field epidemiology; data for decision making including genomic sequencing; laboratory strengthening related to outbreak preparedness; immunisation for novel diseases or campaigns in response to outbreaks; and infection prevention and control.

The IHR (2005) are legally binding on 196 countries and requires them to build core capacities in public health prevention, preparedness and response, and report certain disease outbreaks and public health events to the WHO.

Intermediate Outcome 1.3: Increased development, trialling, registration of and access to new or modified medical products

Investment in PDPs (drugs, vaccines, diagnostics, vector control and other prevention, diagnostic and treatment health technologies) is core to the prevention and treatment of some of the highest burden infectious diseases in the region, and addresses product market failure for neglected diseases that affect the poorest in society. PDPs are publicly-funded global research and development organisations that drive the development of life-saving medical products for use in developing country settings. Several PDPs draw on the strengths of Australian health and medical research institutions, particularly for the conduct of pre-clinical and clinical trials. Australia is part of a longstanding core group of like-minded donor governments and organisations who have supported the work of PDPs. Reporting from 2023 by twelve of the world's leading PDP organisations estimate that PDPs have supported the development of 79 new health technologies from PDPs since 2010, reaching 2.4 billion people mostly in low- and middle-income countries.¹⁶³

As of 2021 there were a total of 192 products in the research and development pipeline stemming from HSI-supported initiatives across COVID-19, malaria and TB. Under PHR, Australia will invest in development of new PDP products and progress the existing PDP pipeline to ensure products are safe, fit for purpose and accessible in our region. Activities delivered by PDPs will include facilitation of clinical trials, operational research, updating policies and guideline and identifying regulatory pathways for approvals. Particular attention will be given to ensuring new products are safely and appropriately introduced, following approval. This will be promoted through, for example, the engagement of NGOs to promote community acceptance and take up, and through monitoring to ensure new products are being accessed by those in need, generating health impacts, and addressing priority disease burdens within our region. Funding will also be provided to the Coalition for Epidemic Preparedness Innovation to support the development of vaccines.

EPO2: AUSTRALIAN ASSISTANCE CONTRIBUTES TO IMPROVED CAPACITY OF PARTNER COUNTRIES TO PREVENT AND CONTROL NON-COMMUNICABLE DISEASE IN AN EQUITABLE WAY

Initial investments under this EPO will be modest as GHD establishes initial projects and partnerships, scaling up resourcing over time based on lessons and results.

For the greatest gains, non-communicable disease programming requires a focus on equitable access to preventative, early, integrated and people centred care to help avoid the high cost of treatment at a later stage.¹⁶⁴ NCDs need to be tackled through approaches that support overall health systems strengthening and integrated service delivery. Accordingly, we will seek to work across three core aspects of the health systems continuum – from influencing behaviour for prevention – to screening and detecting – to supporting early treatment.

PHR will also seek to ensure project-funded investments are appropriately nested into formal health systems and are complementary to bilateral and regional investments funded by DFAT to the SPC Public Health Division.

Intermediate Outcome 2.1: Effective health promotion, policy and regulatory reform focused on NCD risk factors resulting in changes in behaviour

PHR will seek to fund investments that support health promotion measures targeted at reducing major NCD risk factors including tobacco use, harmful use of alcohol, unhealthy diets and limited physical exercise; and supporting mental health and suicide prevention. Health promotion efforts will be focused on supporting the better management of NCDs and may include supporting evidence-based and cost-effective interventions focused on policy, regulation or legislation reform intended to influence lifestyle choices, prevent ill-health and protect health. We will also support multi-sectoral efforts encouraging the health sector to engage non-health sectors in advocating for a system that promotes health, supports individual healthy behaviours and

¹⁶³ Keeping the promise 2023 Update: PDPs continue to keep the promise.

¹⁶⁴ World Health Organization. (2021). Saving lives, spending less: the case for investing in noncommunicable diseases.



facilitates longer, healthier and more productive lives. There will be ongoing collaboration with the work of likemindeds, multilaterals and DFAT's bilateral programs in the region on NCD related programming including on health promotion efforts such as supporting fiscal and taxation reform to influence positive consumer choice, policy development and community engagement efforts to influence lifestyle choices.

Intermediate Outcome 2.2: Strengthened screening, early detection and management of NCDs

PHR will target screening, early detection and management of NCDs for which there are existing treatments and health infrastructure to support detection and management. Specific priorities in the screening, detection and treatment category include cardiovascular disease (screening for hypertension), diabetes and cervical cancer. The focus will be on strengthening the quality of existing systems and treatments and assisting partner countries to reach and treat more people, thus seeking to reduce disease burden.

Screening and management of NCDs at the primary health care level may include:

- NCD screening and early management integrated into essential health packages;
- evolving the content of pre-service and in service training so staff have the requisite screening competencies;
- adapting essential drug lists to include NCD drugs plus consideration of how they will be financed;
- adapting service delivery models to accommodate ongoing contact with patients near to where they live rather than episodic contact with patients when sick; and
- effective and affordable referral mechanisms;

Through partnerships with Australian Government agencies, including for example the TGA, DFAT will also support strengthening of regulatory environments which test and support registration and access to medical products, including those to manage NCDs. Associated investments will align with relevant bilateral health programs.

Intermediate Outcome 2.3: Effective models of care are supported which promote physical and psychosocial wellbeing

PHR recognises that mental health conditions and their associated comorbidities with communicable and non-communicable disease contribute to the global burden of disease. People with mental health conditions and psychosocial disabilities are likely to face stigma and discrimination, are more susceptible to having their human rights violated and abused, and also have an increased risk of other non-communicable diseases and therefore higher rates of morbidity and mortality. Noting this, integrated responses to the rising prevalence of mental health conditions requires, a multi-sectoral and whole-of-system approach. Effective models of care which promote physical and psychosocial wellbeing and respect human rights are essential in supporting people at risk of or affected by NCDs and mental ill-health across the lifecycle.

PHR will support programs which focus on promotion of mental health throughout the life course, aligning with global and regional guidance on best practice and cost effectiveness to promote and improve mental health and well-being at the population level. Through existing essential service packages, PHR will identify opportunities to develop and support rights-based models of care which seek to improve mental health and support people with psychosocial disabilities, reduce NCD risk and prevent suicide – through a focus on integrated services which promote well-being. This is expected to include models which support early access to advice, information and education, including through community-based services and a continuum of care throughout the life-course. PHR will also support the adoption of innovative strategies to provide more specific and tailored interventions. PHR will explore ways to develop or strengthen models of care in line with the Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030, and look to support mental health systems that are more resilient to future health emergencies.



EPO3: AUSTRALIAN ASSISTANCE CONTRIBUTES TO INCREASED CAPACITY OF PARTNER COUNTRIES TO ADVANCE EQUITABLE AND COMPREHENSIVE SRHR, PARTICULARLY FOR WOMEN AND GIRLS

DFAT has made significant gains in the last four years by building trusted, effective partnerships in this sector, particularly in the Pacific. Changes are slow given cultural and political sensitivities, for example, in providing adolescent contraception. Investments need to be realistic and long term to have an impact. GHD's partnerships and core funding arrangements with SRHR agencies such as IPPF, MSI Reproductive Choices, and UNFPA, help underpin regional programming by strengthening global and national enabling environments. Our funding investments in UNFPA and IPPF are long standing and are a key signal of Australia's support for SRHR as a human right, gender equality and health issue.

Intermediate Outcome 3.1: Improved systems and capabilities to deliver comprehensive, rights based SRH services and quality information and education

Supporting partner governments to have the human resource capacity, systems and capability is critical to supporting advancement of comprehensive and universal access to SRHR. Core to this process is ensuring services are delivered by healthcare workers in a manner which empowers women and girls and reinforces their uptake of SRH services. Workforce development will be a core area of focus, facilitated through ongoing training and supportive supervision to drive critical behaviour change in communities, improve service provision and support increased demand.

PHR will support projects in our region that improve access to quality sexual and reproductive health information, education and services. For example, the Transformative Agenda, implemented in partnership with UNFPA will be continued and is expected to be expanded. We will continue our work instigated by the SRHR COVID-19 Surge program through a planned investment re-design, with an expected focus on Southeast Asia.

Key SRHR interventions under PHR will improve data to drive better, more responsive decision making and fill critical gaps in services and evidence-based education, particularly for groups who experience heightened vulnerability and marginalisation – including women and girls with disabilities. PHR investments will also explore opportunities to work at the community level and support effective delivery through, for example, supporting engagement of key community leaders to enable appropriate and effective community engagement on SRHR.

Intermediate Outcome 3.2: Australia and partners advocate for and support strengthened legislative and policy environments that advance universal, equitable SRHR

Through PHR, we will continue to partner with global institutions, including through core funding to UNFPA, MSI, IPPF and the SRHR Nexus Initiative. These partnerships support the advancement and protection of the normative language and frameworks that anchor SRHR work. In collaboration with trusted partners, we will contribute to advocate for and support policy and legislation that is necessary to enable progressive realisation of SRHR. For example, we will provide funding to IPPF to support legislative and policy change, and to UNFPA to enhance data availability and quality, and strengthen demographic analysis to drive improved public policy. To support policy dialogue outcomes, PHR will also support partner engagement in international fora to help drive progress towards universal access to SRHR and support the realisation of related SDG targets (3.7 and 5.6).

Intermediate Outcome 3.3: Improved quality, range and availability of SRH commodities, particularly for women and girls

PHR seeks to support availability of SRHR commodities in our region to provide women and girls with access to and choice of quality products, primarily through UNFPA managed investments. We will seek to strengthen supply chains and support targeted countries to access a reliable supply of essential SRH and maternal health commodities - including contraceptive supplies to support family planning. This will be



enabled through UNFPA Supplies Program which has an increasing focus on domestic resource mobilisation and sustainability of national commodity provision; and through our support to the SRHR COVID-19 Surge investment which also works to strengthen family planning supply chain systems.

EOPO4: AUSTRALIAN ASSISTANCE CONTRIBUTES TO PARTNER COUNTRIES' IMPROVED REGULATORY MECHANISMS, DATA SYSTEMS, AND CAPABILITIES TO DELIVER EQUITABLE PUBLIC HEALTH ACTION

EOPO 4 targets core functions of health systems including regulatory authorities, data systems and workforce capabilities, which are in turn expected to build capability to address priority health issues, contributing to the achievement of EOPOs 1, 2 and 3. For example, improved regulatory systems are expected to enhance the access and uptake of health products, strengthened data systems will be critical in supporting surveillance and policy and decision making for endemic and infectious diseases, and enhanced workforce capacity cuts across priority health concerns.

Intermediate Outcome 4.1: Improved regulatory systems increase the availability of high-quality, safe, effective and essential medicines and products

PHR will strive to increase the number of cost effective, lifesaving drugs available and authorised for use in partner countries our region. National regulatory agencies (NRAs) are important gatekeepers of the supply chain of medical products such as pharmaceuticals and medical devices. Regulatory strengthening work under PHR will continue to support the capability of NRAs in our region to increase the availability of safe and effective medicines and products through improved testing and authorisation practices and regional collaboration.

To achieve this, it is expected that PHR (primarily working through Australia's TGA) will be responsive to requests for support from NRAs in Southeast Asia and the Pacific. This work will be focused on engaging bilaterally with NRAs to increase efficiency of approval processes in addition to supporting regional collaborative mechanisms. PHR will also support deployments into the region that will deliver capacity building and advisory support services on product regulation. We will also support interested countries to access digital platforms that will assist with product evaluation and registration pathways.

Intermediate Outcome 4.2: Strengthened data systems, with quality data increasingly informing evidence-based decision making to enhance health policy and programming

COVID-19 generated high demand for strong health data systems pushing governments to ramp up efforts to digitalise their health data. PHR will support investments that improve the quality and availability of country and regional health data. Importantly, it will seek to develop analytical and translational capability to support improved public health planning, policy, and outcomes, and to monitor and evaluate the effectiveness of policy implementation.

Data system investments will include capacity building of public health workers and health information system professionals, and the digitisation of health records and electronic health system record keeping, to improve access to real time data and allow for more rapid and accurate surveillance and disease mapping. PHR will use existing resources and partnerships to support data interoperability, improve information standards, and support strong coordination mechanisms for data governance and information management within partner countries and across the region. For example, a public sector partnership with Australian Institute for Health and Welfare (AIHW) will support scaling up their work in the Pacific on health information management and improve information standards underpinning regionally comparable statistical reporting for the health sector.

Intermediate Outcome 4.2: Workforce skills enhanced across key areas, addressing partner government priority needs

The health workforce has a profound impact on the quality, accessibility, effectiveness and sustainability of a health system. Workforce support and capacity development are essential in combatting burn out and high



staff turnover as well as addressing gaps in training programs required to ensure the region has the necessary skills in public health, including in areas of clinical application, immunisation, risk communication, laboratory skills, field epidemiology, and infection prevention and control. PHR will seek to improve the depth of regional public health expertise through regional training provision and support to strengthen public health deployment capability within the region. We will work with posts, bilateral programs and partners to track country specific training gaps and seek to tackle knowledge gaps as well as assist in retention of the current workforce.

We will also invest in workforce capacity, targeted to the priority needs of participating countries through a range of options including: face to face training, online training, short courses and scholarships to higher education (through, for example, the Australian Awards Fellowships program), mentoring (both informal and formal), on the job learning opportunities, and facilitating the sharing of expertise in-country and within the region. Frontline health workers, in particular the nursing workforce, will be key target cohorts for capacity development opportunities as they continue to face the greatest strain on their capacity in the wake of COVID-19.

Intermediate Outcome 4.3: High quality advice made available to meet partner needs, including by deployees

PHR will provide flexible and responsive technical support to partner countries and across DFAT through the provision of advice by GHD's own health specialists, supplemented and supported through a technical advisory service; the Specialist Health Service. Additionally, targeted deployments will respond to country partners requests for assistance spanning the scope of the initiative including preparedness, and response to health security emergencies, immunisation programs to support prevention and control of outbreaks, health promotion activities to target NCDs risk factors, or long-term health systems strengthening support. Deployments will be aligned with the PHR Program logic and seek to contribute to EOPOs under PHR. The focus of deployments under PHR will be on medium and long-term assignments, with short term deployments supported on an as needs basis. PHR will compliment Australian Medical Assistance Teams (AUSMAT) and GOARN deployments, working in close collaboration with DFAT's Humanitarian Division and WHO.

PHR will also focus on expanding the pool of deployment-ready public health and allied discipline specialists by supporting deployment training provision in Australia and the Indo-Pacific region.

This work aims to strengthen PHR's ability to expand and support coordination of Australian-supported long-term public health capacity building. Clear standards, selection criteria and strong monitoring will be used to ensure deployments contribute to national and regional priorities, support localisation and avoid capacity substitution to the greatest extent possible.

EOPO5: AUSTRALIA'S REGIONAL HEALTH ASSISTANCE IS FLEXIBLE, RESPONSIVE AND MEETS THE NEEDS OF PARTNER COUNTRIES

In addition to bringing about development outcomes across EOPOs 1 to 4, PHR will need to be delivered in a manner which enables it to achieve its strategic intent: positioning Australia as a trusted health partner in the Pacific and Southeast Asia, with stronger institutional linkages and high value placed on our public health expertise. This will require DFAT to invest strongly in a partnership approach spanning a diversity of partners; and to be flexible, strategic, and responsive to learnings, requests and emerging opportunities.

Intermediate Outcome 5.3: Partnerships across Government and Australian institutions which support the provision of Australian health expertise into the region

Under PHR, DFAT will fund a range of partnerships that support the provision of Australian health expertise into the region. DFAT will support partnerships with leading health institutions and assist in connecting them to our region. We will also work with a range of Australian government agencies which provides opportunity to leverage co-funding arrangements and in-kind resources – and which will need strong coordination efforts.



To build strong partnerships, we will dedicate time to build an understanding of our partners' respective roles, and explore how we can best work together to support and amplify policy dialogue, advocacy and public diplomacy efforts.

Intermediate Outcome 5.2: Coordinated action and policy dialogue across global, regional and Australian partners and with posts

PHR will seek to facilitate and support a strongly coordinated and joined up Australian approach to engagement in the health sector from a regional perspective. Close engagement with posts and geographic divisions to understand partner country needs and provide responsive and flexible support, such as deployments, will be key to success. We will take a coordinated approach to identify potential areas for collaboration on policy and regulatory reform that promote stronger health outcomes and investment in our region. GHD will be responsive to requests from DFAT posts in our region for support in their bilateral policy dialogue as well as supporting opportunities for regional policy dialogue alongside geographic divisions. PHR will work with Australian, regional and multilateral partners and likemindeds to identify opportunities where Australia's contribution to policy dialogue complements and bolsters the work of others, including Quad partners. DFAT will also work closely with other donors on governance of PDPs (including CEPI). Policy dialogue outcomes will be monitored and reported on as part of the PHR MELF.

Intermediate Outcome 5.3: Efficient Program Delivery

To be successful, PHR must be highly responsive and flexible, while managing a diverse portfolio of projects and partnerships. The initiative uses an adaptive programming approach, rather than rigidly implementing a set of pre-determined activities. Flexible programming approaches are required to enable the initiative to: a) select proposals that are aligned with the needs and priorities of the region; and b) to support future design work. GHD will primarily be responsible for implementation and program management, with the Health Systems Branch of GHD housing MEL, reporting, risk management, GEDSI and broader aid functions. Close collaboration between these aid programming functions and thematic and partnership leads in GHD will track results that can feed into overall initiative decision making and support learning.

CROSS CUTTING OUTCOMES

GHD will drive the integration of cross-cutting themes into PHR investments with investment delivery partners required to capture data and report against associated IOs (further detail on cross cutting themes is available in the associated strategy documents).

Cross Cutting Intermediate Outcome 1: Greater adoption of One Health approaches and integration of climate change considerations

PHR will look to strengthen the integration of One Health into investments. PHR will also support investment in projects that respond to threats to health that are impacted by climate change, climate variability and environmental change. Climate and disaster risk screening and mitigation measures will be implemented across investments, and resilience building strengthened across our health systems work.

Cross Cutting Intermediate Outcome 2: Stronger GEDSI integration and outcomes across PHR investments

PHR will support the mainstreaming of GEDSI across all investments in addition to supporting targeted GEDSI projects. By strongly integrating GEDSI considerations across the initiative and supporting partners to address GEDSI, we expect to see investments bring about tangible GEDSI-related development outcomes. PHR investments will align with and contribute to the relevant policy objectives and commitments made by Australia and our partner countries on GEDSI.

Cross Cutting Intermediate Outcome 3: Increased community engagement across PHR investments

Where relevant, partners are expected to develop community engagement plans to support the inclusion of diverse and marginalised groups in programming. The integration of community engagement is particularly important for interventions related to health promotion addressing NCD risk factors and supporting mental health; community-based surveillance of infectious diseases; risk communication including related to infection prevention and control; and immunisation communication and social mobilisation. The integration of community engagement plans across relevant activities is expected to enhance the voice of community members, ensure investments are closely calibrated to the diverse needs and contexts of community groups; and strengthen health programming outcomes.

The diagram on the following page (Figure 6) features the PHR architecture and outlines the suite of processes and implementation arrangements that will be used to bring about PHR outcomes.



Figure 6: Partnerships for a Healthy Region Design, Implementation and Program Management Arrangements

PHR initiative Design, Implementation and Program management				
Design, performance assessment and reporting Design: DFAT-led Strategic Initiative Framework (SIF) with downstream investment design summaries and partner-led design at project and partnership level Program logic and MELFs: Initiative level program logic with interconnected downstream program logics and MELFs Results framework: Initiative level PAF with key indicators and performance questions Reporting: Annual summary report supported by reporting at agreement level and investment monitoring reports, mid-term reviews and end of program evaluation to be integrated in line with DFAT standards		Risk management Initiative level risk and safeguards assessment at design Risk registers managed at the ‘investment level’ during implementation Risk management at the ‘agreement level’	Governance and advisory functions Internal: DFAT intra-departmental health management group (HMG) External: Technical Reference Group (TRG)	Cross cutting strategies Gender equality, disability and social inclusion and First Nations Engagement Climate and environmental change One Health
Communicable diseases	Non-communicable diseases	Sexual and reproductive health and rights		
Priority areas of work Health product development; Immunisation policy and planning; Laboratory strengthening; Field Epidemiology; Vector control; Infection prevention and control; Antimicrobial resistance; Disease surveillance; Outbreak preparedness and response; One Health; Workforce development	Priority areas of work Health promotion measures targeted at risk factors of tobacco use, harmful use of alcohol, diet and physical activity; Mental health and wellbeing; Screening and early detection of priority diseases including cardiovascular disease, diabetes, cancers and chronic respiratory diseases	Priority areas of work: Advocacy to support realisation of sexual and reproductive health and rights; Supporting equitable access to quality SRH services; Family planning; Strengthen supply chains to ensure access to commodities; GBV prevention and case management		
Programming Pathway Product Development Partnerships (PDPs) Public sector partnerships with whole of government agencies Strategic partnerships Project partnerships Multilateral and regional organisations	Programming Pathway Strategic partnerships competitive calls Project partnerships competitive calls Implementation possible through public sector partnerships multilateral and regional organisations	Programming Pathway Building on existing investments delivered through UNFPA, IPPF and MSI		
Resilient health systems				
Priority areas of work: Data for decision making; Universal health coverage; Regulatory strengthening; Workforce development; Medical supply chains; Public health deployment capability; Specialist health advice				
Programming pathway: Existing investments or renewed investments delivered through known partners with expertise in UHC, data for decision making and regulatory strengthening, including sole sourced partnerships (TGA, World Bank). Public health deployment capability provided by: training provider sourced through limited tender process, WHO GOARN partnership and targeted deployments through existing arrangements with managing contractors.				
Enabling effective partnerships and efficient delivery				
Priority areas of work: Partnership brokerage, negotiation and management; Co-ordination with likemindeds, donors and Australian government agencies; Monitoring, evaluation, learning and accountability; Transparent reporting of results.				
Programming pathway: Partnership and program management through DFAT’s Global Health Division				

ANNEX 6: ONE HEALTH STRATEGY

PURPOSE

Animal, ecosystem and human systems are interdependent, and this interdependence influences the emergence, resurgence, and distribution of disease, with wide-ranging implications for health and well-being. This recognition is reflected by One Health which has evolved as an approach to addressing these interconnected issues; an approach requiring collaboration between human, animal and ecosystem health actors and communities.

This strategy seeks to support the integration of One Health approaches into the Partnerships for a Healthy Region (PHR) initiative.

BACKGROUND: THE IMPORTANCE OF A ONE HEALTH APPROACH

The One Health High level Expert Panel defines One Health as ‘an integrated, unifying approach that aims to sustainably balance and optimise the health of people, animals, and ecosystems’. The approach mobilises multiple sectors, disciplines and communities at varying levels of society to work together to foster well-being and tackle threats to health and ecosystems, while addressing the collective need for clean water, energy and air, safe and nutritious food, acting on climate change, and contributing to sustainable development.¹⁶⁵

The importance of adopting a One Health approach has gained increasing recognition in the wake of highly pathogenic avian influenza (H5N1), SARs, Ebola and now COVID-19 which has again demonstrated the interconnections and vulnerabilities between human, animal and ecosystem health. Zoonotic disease and the drivers that facilitate disease emergence and spread are now in the minds of health leadership, creating opportunities to engage on One Health.

A One Health approach requires multisectoral collaboration. Facilitating this approach requires investment in relationships, and supporting representatives from human, animal and ecosystem health sectors and other relevant communities to participate in planning, delivery and decision-making. Dealing with the drivers of zoonotic disease emergence also requires engagement with broader sectors such as population and land-use planners, agriculture and extractive industries.

The Pacific and Southeast Asia have seen some major progress towards implementing One Health approaches. Within the Indo-Pacific region there is, however, great variability in the level of development of human, animal and ecosystem health sectors, and how community engagement and development is undertaken. There also remain differences in how useful One Health approaches are considered in different sectoral and country contexts with further opportunities available to invest in building awareness, capability and relevant local examples of the value of One Health approaches.

STRATEGY: OUR APPROACH TO ONE HEALTH UNDER PHR

PHR will build on partnerships and progress made in One Health under HSI (2017-2022), seeking opportunities to support targeted One Health projects while also mainstreaming One Health as a cross-cutting theme. Through collaborative programs across human, animal and ecosystem health, the initiative can support the strengthening of One Health systems and approaches.

To effectively mainstream One Health within PHR we will need to encourage partnerships and projects to recognise the added value that a One Health approach, that strengthens links between human, animal and ecosystem health sectors, might bring to their investment.

At an initiative level, PHR will look to strengthen the integration of One Health through the following strategies:

¹⁶⁵ One Health High Level Expert Panel (OHHLEP). (2021). OHHLEP Annual Report. p 13.

- Supporting partners to demonstrate a One Health approach by providing guidance and learning opportunities.
- Facilitate and build partnerships and engagement through, for example, joint learning opportunities which bring community, technical experts and decision makers from different sectors together.

At a partnership and project level, we will look for key opportunities to support the following:

- Targeted One Health projects which work across human, animal and ecosystem sectors to integrate key elements of One Health; and which foster transdisciplinary approaches, including engagement with communities to address complex health issues.
- Building the One Health workforce, One Health surveillance, diagnostics and disease prevention and control systems for chronic, endemic and emerging disease issues.
- Field training and epidemiological capacity in the human, animal and ecosystem sectors.
- Improved recognition, reporting and addressing of animal and ecosystem health issues and stewardship at the community level.
- Projects that prevent or mitigate the risk of future spill over events at or as close to their source as possible working with communities and across human, animal and ecosystem health domains.
- Effective communication, collaboration and coordination that assists in generating evidence and building the understanding of the benefits, risk and opportunities associated with a One Health approach.

RESOURCING: SUPPORTING THE IMPLEMENTATION OF THE STRATEGY

PHR is being implemented by GHD within DFAT, supported by a multidisciplinary team that provide technical advisory input alongside partnership and program management. GHD supports partners in implementing a One Health approach through the provision of technical advisory input, guidance and facilitation of mutual learning opportunities. GHD's One Health specialists play a key role in brokering linkages within DFAT and between whole-of-government partners to support an enhanced understanding of One Health and contribute to implementation of the strategy. The PHR [One Health Guidance Note](#) outlines good practice on integrating One Health considerations and activities into the design of proposals and work plans under the PHR initiative. Partners submitting investment designs for PHR funding will be encouraged to use this One Health Guidance Note as well as referring to the [One Health High Level Expert Panel's One Health Theory of Change](#) and [Quadripartite One Health Joint Plan of Action \(2022-2026\)](#).

REVIEW: MONITORING PROGRESS AND EMBEDDING LEARNINGS

As a cross cutting theme, One Health is embedded alongside climate change into the PHR Program Logic as an Intermediate Outcome: Greater adoption of One Health approaches and integration of climate change considerations. Indicative indicators to support measurement of this Intermediate Outcome are included in the PHR Performance Assessment Framework.

Early in implementation, the indicators related to One Health which will support measuring progress on the relevant intermediate outcome will be finalised based on final programming decisions. Partners taking targeted or mainstreamed approaches to One Health will be supported to integrate One Health into their Monitoring, Evaluation, and Learning Frameworks with consideration given to One Health in reporting templates.

ANNEX 7: CLIMATE AND ENVIRONMENTAL CHANGE STRATEGY

PURPOSE

Human, animal and environmental systems are closely linked. Climate change alters biodiversity, changes temperatures and increases frequency of extreme weather events, disrupts food and water systems, and alters animal behaviour. These impacts are likely to threaten livelihoods, food security and health systems, as well as influence the emergence and resurgence of disease.

Understanding how climate change directly and indirectly impacts health and wellbeing in the Pacific and Southeast Asia will be critical for effectively supporting national, regional and global partners to protect health. This Climate and Environmental Change Strategy seeks to provide high level guidance to support attention to climate and environment change under Partnerships for a Healthy Region (PHR). It is intended to align with and support the implementation of DFAT's Climate Change Action Strategy (2020-25),¹⁶⁶ and to be implemented in tandem with other cross-cutting and thematic priorities for PHR including One Health.

BACKGROUND: THE INTERSECTION BETWEEN CLIMATE CHANGE AND HEALTH

Not all diseases will be influenced by climate change, nor do all health interventions impact climate mitigation¹⁶⁷ and adaptation¹⁶⁸ efforts. Furthermore, not all environmental drivers that increase the risk of disease emergence and transmission (such as urban and agricultural encroachment, biodiversity loss, and human/animal waste entering the environment) are directly related to climate change. Nevertheless, evidence of negative effects of a changing climate on health continues to grow.¹⁶⁹

In relation to communicable diseases, for example, changing temperatures are expected to alter the transmission dynamics and geographical distribution of vector-borne diseases such as malaria, dengue and Japanese encephalitis – increasing the risk in some locations, and decreasing in others.¹⁷⁰ Changing temperatures as well as rising sea levels and more extreme weather events may also result in increased frequency of environmental disasters such as cyclones, droughts, floods and extreme heat, which can influence migration and displacement,¹⁷¹ reduce access to clean water and sanitation, and increase risks of water-borne and water-related diseases.¹⁷² In Fiji, for example, researchers found that heavy rainfall explains most of the variance in the occurrence of diarrhoea syndromic conditions – which is relevant because in Fiji climate change is predicted to lead to increased intensity and frequency of days with extreme rainfall.¹⁷³ In some settings, land-use change and ecological degradation may bring humans and animals such as bats into closer contact,¹⁷⁴ increasing the risk of zoonotic disease.¹⁷⁵

¹⁶⁶ DFAT Climate Change Action Strategy (2020-25).

¹⁶⁷ Mitigation: the reduction of greenhouse gases released into the atmosphere, including through activities that remove or reduce emissions—either through natural systems such as forests which absorb carbon emissions, or through technologies such as carbon capture usage and storage, where carbon dioxide can be sequestered. The main source of greenhouse emissions is from burning fossil fuels for energy, but emissions also arise from other sources such as land use, transport, waste, building materials and industrial processes (DFAT Climate Change Action Strategy (2020-25), p.9).

¹⁶⁸ Adaptation: the ability to adjust to climate change to minimise potential impacts, take advantage of opportunities or to cope with the consequences. This means anticipating and planning for the impacts across areas affected by climate change (DFAT Climate Change Action Strategy (2020-25), p.9).

¹⁶⁹ WHO. Climate change and health (who.int)

¹⁷⁰ Rocklöv, J. and Dubrow, R. (2020). "Climate change: an enduring challenge for vector-borne disease prevention and control". *Nature Immunology*, 21, 479-483.

¹⁷¹ McMichael, C., Barnett, J., & McMichael, A.J. (2012). "An ill wind? Climate change, migration and health". *Environmental Health Perspectives*, 120(5), 646-54.

¹⁷² Cann., K.F. et al. (2012). "Extreme water-related weather events and waterborne disease". *Epidemiology and Infection*, 141(4), 671-686.

¹⁷³ Nelson, S. et al. (2022). "Predicting climate-sensitive water-related disease trends based on health, seasonality and weather data in Fiji". *The Journal of Climate Change and Health*, 6, 100112.

¹⁷⁴ Eby, P. et al. (2022). "Pathogen spillover driven by rapid changes in bat ecology". *Nature*.

¹⁷⁵ Zoonotic disease: disease caused when a pathogen transmits from a non-human vertebrate to a human.



Increased air pollution, high temperatures and threats to food security, among other factors, are also likely to increase the burden of some NCDs.¹⁷⁶ Indoor and outdoor air pollution significantly increase the risk of respiratory diseases, stroke, ischaemic heart disease, lung cancer and type 2 diabetes,¹⁷⁷ as well as further contributing to rising temperatures and heat waves which increase the risk of cardiovascular events such as heart attack and stroke.¹⁷⁸ According to 2019 data published by the Global Burden of Disease study, 70 per cent of deaths due to exposure to PM_{2.5} air pollution occurred in the East Asia, the Pacific and South Asia regions.¹⁷⁹ The yield of crops is expected to be affected by warming temperatures, erratic rainfall and extreme weather events, resulting in increased food and financial insecurity.¹⁸⁰ Modelling suggests LMICs in Africa and Southeast Asia are expected to experience the greatest reductions in food availability as a result of climate change, leading to an estimated 529,000 climate-related deaths in adults by 2050; the majority of these climate-related deaths are projected to occur in Southeast Asia and the Western Pacific.

STRATEGIC APPROACH: OUR APPROACH TO CLIMATE CHANGE UNDER PHR

Under PHR, we will invest in projects and programs that respond to direct and indirect threats to health that are impacted by climate change, climate variability and environmental change, towards the goal of improving the overall climate resilience of health systems in partner countries and across the region. The WHO defines a 'climate resilient health system' as "one that is capable to anticipate, respond to, cope with, recover from and adapt to climate-related shocks and stress, so as to bring sustained improvements in population health, despite an unstable climate".¹⁸¹ This is in line with the overarching PHR goal of supporting more resilient and equitable health systems.

We will seek opportunities to support attention to climate change within PHR thematic investments by supporting projects and partners that:

- take a proactive approach to considering short- and long-term climate and disaster risks including by conducting climate and disaster risk screening and incorporating measures to strengthen resilience of investment activities against potential impacts of climate change and disasters.
- consider how activities aimed primarily at preventing disease and enhancing health system resilience may also provide co-benefits to climate change mitigation or adaptation efforts (including disaster risk reduction, preparedness and resilience building).

The PHR [Climate Guidance Note](#) outlines good practice on integrating climate change considerations and activities into the design of proposals and work plans under the PHR initiative. The Guidance note outlines the ten components of the [WHO Operational Framework for Building Climate Resilient Health Systems](#) (2015), which are consistent with the [WHO WPRO Pacific Islands Action Plan on Climate Change and Health 2019-2023 \(2018\)](#). Partners submitting investment designs for PHR funding will be encouraged to use this Climate Guidance Note and the DFAT Climate Change Action Strategy.

¹⁷⁶ Friel, S. et al. (2011). "Climate change, noncommunicable diseases, and development: the relationships and common policy opportunities". *Annual Review of Public Health*, 32, 133-147.

¹⁷⁷ World Bank. (2022). *The Global Health Cost of PM_{2.5} Air Pollution: A Case for Action Beyond 2021*. (International Development in Focus series). Washington, DC: World Bank

¹⁷⁸ Liu, J. et al. (2022). Heat exposure and cardiovascular health outcomes: a systematic review and meta-analysis. *The Lancet Planetary Health*, 6(6), E484-95.

¹⁷⁹ World Bank. (2022). *The Global Health Cost of PM_{2.5} Air Pollution: A Case for Action Beyond 2021*. (International Development in Focus series). Washington, DC: World Bank. Chapter 3, p.10-17. Note: while China (East Asia and the Pacific [EAP] region; 1.8m deaths) and India (South Asia region; 1.6m deaths) accounted for the greatest number of deaths due to PM_{2.5} exposure in these regions and globally, high numbers of deaths are also experienced in Indo-Pacific countries including Indonesia (184k deaths) and Philippines (75k deaths); Myanmar has the second-highest number of deaths per 100,000 population in the EAP and within the top 10 countries globally (134 deaths per 100k), and deaths from PM_{2.5} exposure as a proportion of all deaths made up 18% of deaths in PNG and 17% of deaths in Myanmar.

¹⁸⁰ Fanzo, J., Downs, S. (2021). Climate change and nutrition-associated diseases. *Nature Reviews Disease Primers*, 7, 90.

¹⁸¹ WHO *Operational Framework for Building Climate Resilient Health Systems* (2015), p.8



REVIEW: MONITORING PROGRESS

This PHR Climate Change strategy will be reviewed in line with the Monitoring, Evaluation and Learning Framework for PHR including in annual reviews and relevant evaluations. Responsibility for implementing the strategy across PHR investments will be overseen by the Health Systems Branch, GHD, in consultation where required with other units across DFAT including the Climate and Development Integration Unit.

ANNEX 8: THEMATIC STRATEGIES AND PRIORITY NEEDS

These strategies are intended to provide further guidance to GHD to support programming decisions. They provide a summary of potential focus areas and are intended to provide strategic direction to guide programming decision making under PHR. They are not definitive, acknowledging that final programmatic decisions need to account for a range of different factors, including the local context.

HEALTH PRODUCT DEVELOPMENT

A) Overview

The availability of prevention, diagnostic and treatment health technologies (drugs, vaccines, diagnostics, vector control and other prevention, diagnostic and treatment health technologies) for high burden infectious diseases and neglected tropical diseases is an unmet need for many countries in the Indo-Pacific region. These technologies either often do not exist or are not fit-for-purpose. Product Development Partnerships aim to counter the lack of commercial incentives to develop new products for diseases that typically affect low and middle- income countries.

B) Background

As of 2021 there were a total of 192 products in the combined research and development pipeline of DFAT's existing PDP investments targeting endemic, high burden diseases including malaria and TB and diseases of epidemic potential.

The priority health needs in the region for PDP investment will continue to include disease of epidemic potential (Disease X, H1N1, Ebola, MERS, Zika, Marburg, Nipah, Chikungunya, Ebola, COVID-19); endemic diseases (TB, diarrheal diseases, dengue, malaria) and sexually transmitted diseases (HIV/AIDS and human papillomavirus (HPV)). To complement PDP investments, learnings from HSI highlighted the importance of integrating a focus on product access and implementation, including regulatory pathways for new product introduction and addressing community hesitancy and access barriers. PHR will continue to support the development of new products and progress the existing PDP pipeline to support access and uptake of safe and effective products in a timely manner, safeguarding populations through adherence to regulatory pathways.

C) Strategic approach

PROGRAMMATIC FOCUS

- Continue to advocate for increased global investment in new or modified PDPs that are fit for purpose to address diseases of high burden and/or epidemic risk in our region.
- Ensure products are safe and fit for purpose through support of clinical trials and testing in our region.
- Promote enhanced accessibility, affordability and sustainability of new products in partner countries that have positive health technology assessments (with attention to appropriate storage and transportation infrastructure).
- Support for national approval and registration of new products by regulatory bodies and inclusion on procurement lists.
- Support to scale approved new products into health programs, including through the engagement of local partners and NGOs to promote community acceptance and uptake.
- Strengthen monitoring to support new products being accessed, addressing health priorities of our region.
- Support the revision and promulgation of treatment guidelines, including through training of healthcare personnel on the use of guidelines.

REGULATORY STRENGTHENING

A) Overview

National Regulatory Agencies (NRAs) are important gatekeepers of the supply chain of medical products such as pharmaceuticals and medical devices. Manufacturers require NRA authorisation to bring products to market. NRAs review the safety and efficacy data on products and/or rely on another NRA's assessment to approve and authorise medical products. Weak NRAs can contribute to an increased risk of harm to populations. This risk is caused by under-regulated or poorly regulated medicines and devices, including substandard and fake medicines and devices. Fiji and PNG are the only PICs with an NRA, with other PICs discharging this function within Ministries of Health. All Southeast Asian countries have an NRA, which have differing years of experience.

B) Background

DFAT's support to Australia's Therapeutic Goods Administration (TGA) under HSI and VAHSI has worked to strengthen the capability of NRAs in our region. These programs aimed to increase the timely availability of safe and effective medicines and other medical products through improved regulatory practices and regional collaboration. Support has broadened beyond the registration of new treatments, to encompassing all aspects of health product regulation including post-market surveillance. Partner governments have acknowledged the support of the TGA in supporting the registration process of COVID-19 vaccines and providing other forms of responsive support during the pandemic. PHR will continue support to NRAs in our region to improve quality and timeliness of their own regulatory processes and foster collaborative regional regulatory networks for product recognition and knowledge sharing.

C) Strategic Approach

PROGRAMMATIC FOCUS

- Work bilaterally with NRAs to increase efficiency in the time taken to lodge and review applications.
- Support regional collaborative mechanisms to facilitate more efficient access to safe medicines and diagnostics and support capacity building of NRAs.
- Support to increase the capacity of National Reference Laboratories in Southeast Asia.
- Regulatory support for all Pacific countries including regulatory strengthening activities for NRAs in PNG & Fiji and support of the establishment of WHO led sub-regional platforms, as appropriate.
- Support deployments in the region to deliver capacity building and advisory support services.
- Support interested countries to access digital platforms to help with product evaluation and registration pathways.

IMMUNISATION

A) Overview

Many COVID-19 vaccination programs in Southeast Asia and the Pacific were enabled by existing routine immunisation infrastructure and staff – often diverting resourcing away from routine vaccination programs. As a result, coverage of childhood vaccines in the Indo-Pacific region has regressed with the largest sustained decline seen in 30 years.¹⁸² Drops in coverage present a risk of outbreaks – and with it, a risk of increased child morbidity and mortality. It also presents a significant development opportunity. With restoring routine immunisation coverage a pressing priority of partner countries, support to immunisation policy and planning will be a priority for PHR.

¹⁸² UNICEF. (2022). COVID-19 pandemic fuels largest continued backslide in vaccinations in three decades (unicef.org).

B) Background

Prior to the pandemic, GHD primarily supported routine immunisation in our region through our multilateral funding to Gavi, the vaccine alliance and a HSI grant supporting immunisation coverage monitoring in the Pacific. DFAT will continue its support to the region to increase vaccine coverage for COVID-19 and seek to increase support for routine and catch-up immunisation programs, including under VAHSI (program to end 2024), PHR and through ongoing support to Gavi. To address vaccine preventable disease outbreak risk, immunisation investments under PHR will likely need to focus on: targeted investment in cold-chain, strengthening service delivery mechanisms, health workforce development, electronic immunisation systems, good governance, effective evidence-based policy, vaccine demand assessment, and consideration of behavioural and social drivers of vaccination.

C) Strategic Approach

PROGRAMMATIC FOCUS

- Improving access to accurate and timely immunisation data, in addition to other geographic and social factor data, to help inform immunisation program roll-outs and policy decisions.
- Strengthening national immunisation systems and workforce capacity (health centres, outreach capacities to support remote communities, electronic immunisation registers, logistics, and workforce development).
- Supporting country partners to secure long-term supply and shaping vaccine markets to increase equitable, affordable and sustainable vaccine use.
- Supporting country-led coordination of vaccination campaigns with streamlined communications, and behavioural and social determinates assessment, demand generation, messaging and communications to reduce vaccine hesitancy.
- Partnerships with PDPs to support the development of new vaccines and clinical trials.

VECTOR SURVEILLANCE AND CONTROL

A) Overview

Vector-borne diseases of significance in the Indo-Pacific region include the parasitic diseases of malaria and lymphatic filariasis, and the Arthropod-borne viral (arboviral) diseases of chikungunya, dengue, Japanese encephalitis, West Nile fever, and Zika virus.¹⁸³ These diseases are spread by vectors, primarily mosquitos and predominantly either Anopheles, Aedes, and Culex mosquitoes. The combined burden of neglected tropical diseases (which include dengue, chikungunya, and Zika infections) and malaria were estimated to be 132 DALYs per 100,000 population across the Asia-Pacific region, making these the seventh leading disease burden category.¹⁸⁴ Many vector-borne diseases are preventable through vector control measures, effective vector surveillance and community mobilisation.¹⁸⁵

B) Background

Under HSI, investments aimed to reduce the number of people who get sick from vector-borne diseases by partnering with product developers to investigate more effective drugs, undertaking research to understand mosquito biting behaviour, tracking the spread of mosquitos and diseases, and assisting countries in our region to effectively manage vector control programs and strategies. Despite project progress in partner countries, sustained investment is needed to elevate vector borne diseases and vector control as a public health priority. PHR will look for opportunities to support the strengthening of effective and locally adaptive vector control systems through increased technical capacity, improved infrastructure, strengthened monitoring and surveillance systems, greater community mobilisation, and an increase in applied research

¹⁸³ World Health Organization. (2020). Vector-Borne Diseases.

¹⁸⁴ Matthews, R.J. et al. (2022). Pathogens 11:74.

¹⁸⁵ World Health Organization. (2020). Vector-Borne Diseases.

and innovation. Under PHR, the partnership will be continued with the Asia Pacific Malaria Leaders Alliance (APLMA) and the Asia Pacific Malaria Elimination Network, (APMEN) to continue their work to accelerate malaria control and elimination – in addition to seeking to support vector surveillance control through projects and partnerships, including with product development partners.

C) Strategic approach

PROGRAMMATIC FOCUS

- Enhance local scientific and implementation capacity in entomology and vector borne disease control.
- Support partners to design and implement effective vector-borne disease control strategies.
- Increase understanding of vector control needs (and arthropod borne diseases) through enhanced needs assessments.
- Enhance leadership and investment in capacity and capability to keep vector borne diseases and vector control as a public health priority.
- Expand the toolbox of vector control innovations/tools and approaches that will be most impactful in the region.
- Enhance procurement and supply chain management for vector-borne disease diagnostics and vector control commodities.
- Strengthen reporting systems and compliance with agreed standards, drawing on the Pacific Outbreak Manual, regional public health networks and the Pacific Public Health Surveillance Network (PacNet).

INFECTION PREVENTION AND CONTROL

A) Overview

The COVID-19 pandemic has demonstrated the critical role of infection prevention and control (IPC) programs and practices in ensuring community and healthcare worker safety during the response to outbreaks. Effective IPC programs have also been shown to reduce endemic health-care-associated infections, minimise the spread of antimicrobial Resistance (AMR), and contribute to the containment of emerging pathogens. Ongoing support is required to systemically implement regional IPC guidelines at the national and sub-national level and develop standard operating procedures for IPC, including preparedness and response outbreak plans, at facility level.

B) Background

DFAT funded a range of IPC initiatives under HSI, providing support to develop IPC Guidelines, training to improve IPC in healthcare settings, and support to strengthen the Pacific Infection Control Network (PICNet) through deploying an IPC Advisor to The Pacific Community (SPC). DFAT also responded to PICs' needs throughout the pandemic by providing technical support for the development of IPC standard operating procedures and training of health care workers through AUSMAT deployments, and by providing PPE, medical supplies, equipment and consumables. Learnings from previous investments emphasise that long term investment in IPC is required that supports a more strategic and coordinated approach, tailored to each country context.

C) Strategic approach

PROGRAMMATIC FOCUS

- Strengthen national and healthcare facility level capacity to better respond to public health disease outbreaks and disease threats, including through:

PROGRAMMATIC FOCUS

- the development and implementation of IPC guidelines and standard operating procedures, seeking alignment with regional frameworks and approaches.
- addressing training needs and supporting workforce capacity.
- Strengthen and support IPC leadership and governance programs, such as infection control committees at the national and healthcare facility level.
- Support links with WASH programs, particularly where WASH infrastructure is weak (noting the intersection between IPC and WASH).
- Support increased access to WASH and medical waste management in health-care facilities.
- Strengthen availability of IPC supplies (e.g., hand hygiene supplies, personal protective equipment) through medical supply chain support.
- Strengthen community health networks and tools established through COVID-19 response activities and which support community's role to manage and prevent disease outbreaks.

ANTIMICROBIAL RESISTANCE

A) Overview

The Asia Pacific region is considered a regional hot-spot for the emergence and spread of antimicrobial resistance (AMR).¹⁸⁶ Within the region, the Southeast Asian countries were estimated to have the highest risk of emergence and spread of AMR among all WHO regions. AMR includes resistance to antibiotics, antivirals, antifungals and antiparasitics and undermines efforts in improving health in the region, including in relation to the burden of drug-resistant TB which continues to threaten progress on TB.¹⁸⁷¹⁸⁸

B) Background

Under HSI, in Timor-Leste, Fiji, Papua New Guinea, Samoa, Solomon Islands, Indonesia, Papua New Guinea and Vietnam, DFAT supported partner countries to identify and track AMR and improve diagnosis, prescribing and dispensing practices. Furthermore, funding to PDPs supported the development of new treatments to combat drug-resistant TB.

A 2021 review of ASEAN National AMR Action Plans (NAPs) identified specific areas that should be strengthened to help address AMR including: accountability, sustained engagement, equity, behavioural economics, sustainability plans and transparency, international collaboration, and integration of the environmental sector. Further research from 2020 focused on the Pacific recommended the following areas of focus: governance and cross-sectoral collaboration through the establishment of NAPs; optimising surveillance through strengthening laboratory capacity, and improved AMR awareness through community education activities and provision of standard treatment guidelines for clinicians.¹⁸⁹

C) Strategic approach

PROGRAMMATIC FOCUS

- Support for National AMR Action Plans and strengthening the policy and regulatory environment, including environmental and clinical governance.
- Support links with WASH programs, particularly where the AMR burden is high.
- Support for cross-sectoral and collaborative projects, including, for example, those that work with the private sector, or which incorporate economic assessments.

¹⁸⁶ Yam et al. (2019). Antimicrobial Resistance in the Asia Pacific region: a meeting report.

¹⁸⁷ World Health Organization. (2019). Global Tuberculosis Report 2019.

¹⁸⁸ The Review on antimicrobial resistance. (2016). Tackling drug-resistant infections globally: Final report and recommendations

¹⁸⁹ Loftus. (2020). Antimicrobial resistance in the Pacific Island countries and territories. BMJ Global Health 2020;5:e002418.

PROGRAMMATIC FOCUS

- Laboratory strengthening (human, animal, environmental), including application of genomics where appropriate (and economically sustainable).
- Surveillance and training in epidemiology which supports the availability of data on AMR.
- Ongoing support to PDPs on the development of treatments, diagnostics and insecticides which account for and address AMR related health issues.
- Support for community education activities.

OUTBREAK PREPAREDNESS AND RESPONSE

A) Overview

Outbreak preparedness and response requires robust surveillance systems, a well-trained public health response workforce and emergency operation frameworks. Several international initiatives are being progressed to strengthen and reform global architecture for pandemic preparedness and response, including negotiation of a pandemic treaty, amendments to the International Health Regulations (2005) and establishment of a Pandemic Fund, as well as proposed mechanisms to support equitable access to medical countermeasures. COVID-19 has highlighted the importance and effectiveness of community led outbreak response activities and the value of integrating community surveillance networks and national coordination centres.

B) Background

DFAT provided substantive support for improved outbreak preparedness and response under HSI, including: investment in the WHO Health Emergencies Programme, support of public health emergency operation centres; deployment of public health experts to over 12 countries; support of WHO's Global Outbreak Alert and Response Network; support to CEPI for the development of COVID-19 vaccines; investment in the ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED); and support of the newly established Pandemic Fund. PHR will continue to strengthen core capacities for preparedness and outbreak response at the community, regional, national and global levels. This will include ongoing support of WHO's Health Emergencies Programme and WHO GOARN. Public health deployment training and strengthening of public health emergency operation centres, including through ASEAN ACPHEED, would further bolster regional public health emergency capability. Other areas of support related to surveillance, laboratory strengthening, product development and community engagement are also expected to contribute to outbreak preparedness and response.

C) Strategic approach

PROGRAMMATIC FOCUS

- Contribute to strengthening IHR (2005) core capacities of partner countries for preparedness, surveillance and response.
- Strengthen the role and functioning of IHR national focal points and national notification and alert systems during an outbreak.
- Support for community strengthening programs including community level upskilling in surveillance for early detection and community response activities.
- Strengthen the integration of community surveillance networks and national coordination centres.
- Increase the quantity, and capability of public health employees available to meet the medium and longer-term needs of our region.
- Improve surge capacity of multisectoral workforce.
- Strengthen public health emergency operation centres in the region.

FIELD EPIDEMIOLOGY

A) Overview

Field Epidemiology Training Programs (FETP) including for veterinarians (FETPV), are important for strengthening routine surveillance and response to outbreaks. There is variability in the quality and scope of FET courses in the Indo-Pacific, with some programs offering basic training in field epidemiology while others encouraging rigorous assessment and analysis. FETP-Vs are well established in Southeast Asia. The SPC-led Strengthening Health Interventions Pacific Data for Decision Making (SHIPP-DDM) is the Pacific regional Field Epidemiology Training Program.

B) Background

DFAT funded six field epidemiology training projects across the region under HSI. Approximately one third of these projects provide support to veterinary and paraveterinary epidemiology training resources for the Pacific, with the remainder projects supporting human FETP. There was additional support for field epidemiologists to access advanced courses through the ASEAN-Australia Health Security Fellowship program. Over the course of the COVID pandemic, there has been a proliferation of online training available. Consolidation of materials, finding a sustainable, accessible hosting mechanism and integrating these trainings into national FETP/V training programs would be useful to streamline and capitalise the multiple online training options. Lessons from programming highlight the need for closer coordination with key donors, particularly in Southeast Asia. There are also opportunities to support the integration of veterinary and One Health field epidemiology training into the Pacific's existing accredited program (SHIPP-DDM), and to continue to promote recognition of qualifications obtained through national and regional courses.

C) Strategic approach

PROGRAMMATIC FOCUS

- Strengthen FETPs through a range of possible interventions:
 - supporting countries to establish targets for the number of trained surveillance officers and epidemiologists including for animal health and other sector enrolments in FETP;
 - supporting/advocating for appropriate salary structures for graduates;
 - supporting mentors and program leaders to help strengthen the teaching cohort;
 - support impact studies tracking the career trajectories of graduates;
 - invest in regional and national programs and networks, such as South Asia Field Epidemiology and Technology Network (SAFETYNET), to support the development of regional and national human and veterinary epidemiology workforce plans to provide agreed targets for countries, donors and implementers to work towards.
- Increase access to advanced courses and consider twinning arrangements with Southeast Asian and Pacific universities to improve regional teaching quality and capacity.
- Sustain FETPV outcomes through support to and coordination with FAO in: implementing the Field Epidemiology Roadmap, developing national workforce projections through Epi Mapping Tool missions and creating a Virtual Learning Centre to host online training modules.
- Consider piloting pre-frontline field epidemiology training at the community level.
- Support SPC to deliver and strengthen the regional FETP in the Pacific, supporting the coherence of programs between frontline and alternative programs (such as paravet training) and post-graduate courses.

SURVEILLANCE

A) Overview

Surveillance systems provide data to inform response and interventions to disease outbreaks and evaluate whether disease control programs are working. Data can be drawn from sentinel surveillance, case-based and syndromic surveillance, laboratory-based diagnoses, publicly available information including media sources and insights from community health workers. Surveillance is reliant on well-trained health workers being able to collect and analyse data, strong public health and diagnostic laboratories and sufficiently skilled epidemiologists who are able to interpret and advise decision makers on implications of the data.

B) Background

Approximately 15 projects under HSI aimed to improve surveillance systems. Examples included: the provision of Pacific-tailored health information systems and supply chain reform (Beyond Essential Systems); support for eight sentinel surveillance sites and modelling for rapid identification and containment of malaria and other vector-borne diseases; support for surveillance and laboratory training, research opportunities and development of National Guidelines on Notifiable Diseases in Timor-Leste; and strengthening of disease surveillance and response systems in Laos, Cambodia, Myanmar, and now Vietnam. The COVID-19 pandemic has provided greatly expanded molecular diagnostic capacity in the region, including through HSI projects, which will be capitalised on going forward to improve laboratory surveillance for a range of pathogens in line with country priorities. PHR Investments will seek to support the translation of training into measurable improvements in surveillance capacity and application of appropriate technologies and health information systems. We will also pursue opportunities to strengthen a One Health approach.

C) Strategic approach

PROGRAMMATIC FOCUS

- Advocate and support prioritisation of and budget for establishing and strengthening surveillance functions in-country.
- Enhance international, national and community-based surveillance networks.
- Harness molecular and genomic surveillance for a range of pathogens beyond COVID-19.
- Support implementation and embedding of fit-for-purpose and interoperable surveillance and data collection, transfer and analysis tools consistent with health information system strategies and integrated with training.
- Strengthen research capabilities, including nationwide studies such as serosurveys and operational research.
- Provide capacity building and mentoring to improve the skills of public health workers to:
 - analyse data, including frontline data;
 - incorporate and use integrated data from clinical and laboratory services, public health surveillance and disaster response into everyday decision making;
 - support data communication, including through data visualisation.
- Increase the timeliness and quality of routinely collected data and strengthen capacity to analyse and use the data, and share data between sectors.
- Strengthen research capabilities, including nationwide studies such as serosurveys and operational research.

LABORATORY STRENGTHENING

A) Overview

Diagnostic and reference laboratories are essential components of health systems and public health infrastructure. The COVID-19 pandemic impacted laboratory capacity in every country and many HSI programs had to pivot to support development of COVID-19 testing and provision of equipment. This support expanded laboratory capacity in many countries, and in some countries, enabled molecular diagnosis (PCR – polymerase chain reaction) for the first time. Laboratory twinning and mentor type programs in Southeast Asia were included in HSI, with technical partners seeking sustained support for such programs. In the Pacific, with a very small laboratory workforce, there is a need for multi-skill and flexible teams.

B) Background

DFAT support for public health laboratories was crucial to frontline efforts to detect COVID-19 outbreaks and to guide initial government responses. HSI funded 15 investments supporting laboratory strengthening, with majority of these investments in the Pacific. Most investments supported public health laboratories however there were several investments which supported animal health laboratories (or both animal health and public health). Under PHR, there is opportunity to use existing support to key laboratories as the basis to support countries to organise laboratories at a broader scale, and to build regional laboratory capacity and networks.

C) Strategic approach

PROGRAMMATIC FOCUS

- Support twinning and mentoring type programs that enable institution to institution linkages, particularly in Southeast Asia.
- Support laboratory technologies that are appropriate and fit for purpose for the local context. This may, for example, require examination of solar power or battery-operated options to support technologies in rural and hard to reach areas.
- Support diagnostic laboratories in the Pacific to better meet diagnostic standards and achieve and maintain accreditation.
- Support genomic testing capacity, including the use of information.
- Support laboratory network systems and co-ordination and collaboration with other donors.
- Strengthen laboratory networks for multisectoral collaboration between animal and human health diagnostic capabilities to optimise resource use.

DATA FOR DECISION MAKING

A) Overview

Robust health data and information systems, coupled with the accompanying legal and regulatory frameworks, appropriate information technology, data literate workforces, and leadership, are key building blocks to support the availability of quality data. The COVID-19 pandemic highlighted the critical role of data to health, with governments requiring comprehensive, timely and sufficiently detailed data to support decision making in a rapidly changing situation.

B) Background

Through a range of programs, including HSI, SRHR and health systems strengthening investments, DFAT has sought to improve the quality, capture, reporting and translation of data to support policy decisions. These investments have supported tailored health information systems; strengthened supply chain reform in select PICs; supported the development of innovative methods and tools for adaptive decision making; and

enabled the use of research data to inform policy development. Investments under PHR will seek to improve the quality and accessibility of country and regional health data and develop analytical capability to support improved public health planning, policy, and outcomes.

C) Strategic approach

PROGRAMMATIC FOCUS

- Strengthen health information systems, data and modelling capability with attention to supporting platforms which can be sustainably implemented and maintained.
- Strengthen the availability and presentation of information to support informed decision making for health policy and planning.
- Support the digitisation of health records to improve the availability of real time data and allow for more rapid and accurate surveillance and disease mapping.
- Leverage existing resources and partnerships to support data interoperability and improve information standards underpinning regionally comparable statistical health reporting.
- Support the development and strengthening of coordination mechanisms for data governance and information management within partner countries and across the region.
- Support health system functions including, for example, procurement and supply, workforce availability and facility mapping.
- Support data collection, analysis, reporting and decision making that supports GEDSI related programming and outcomes.

NON-COMMUNICABLE DISEASES AND MENTAL HEALTH

A) Overview

NCDs are the leading cause of mortality and morbidity in Southeast Asia and the Pacific, accounting for 75 per cent of deaths and the largest proportion of the burden of disease in the Pacific; and 69 per cent of deaths in Southeast Asia. During the COVID-19 pandemic, more than three-quarters of countries globally reported significant disruption to NCD services.¹⁹⁰ Promotion of healthy behaviour and improvements in early prevention, screening and treatment of NCDs are necessary to prevent continuing increase in NCD related illness, disability and death across the region. The pandemic also highlighted the growing issue of mental ill health across the region. SDG target 3.4 covers promotion of mental health and well-being alongside reducing premature mortality from NCDs, highlighting the importance of both for effective models of care which promote physical and psychosocial wellbeing.

B) Background

To date, DFAT's NCD related programming has largely been at a bilateral level or incorporated within broader programs such as the World Bank Advance Universal Health Coverage (UHC) or Bloomberg Philanthropies Data 4 Health (improving data on NCDs). In the Pacific, DFAT funding has enabled SPC to establish regional monitoring of implementation of NCD prevention interventions (the MANA dashboard) and comparing of country progress. It has also enabled SPC to provide technical support to governments on NCD prevention and management, from addressing healthy eating behaviours, to taxation policy interventions on tobacco and sweetened beverages. PHR support on NCDs will be nested into country's national health strategies and policies and essential health packages.

DFAT is funding broader health initiatives, which contain elements of mental health support, and a Mental Health Cooperation program with ASEAN. But donor support for mental health investments is still minimal.

¹⁹⁰ World Health Organization. (2020). The impact of the COVID-19 pandemic on noncommunicable disease resources and services: results of a rapid assessment.

PHR will seek to support programs that promote mental health, in line with the Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030.

C) Strategic approach

PROGRAMMATIC FOCUS

- Support evidence-based and cost-effective interventions to reform policy, regulations or legislation to influence positive lifestyle choices and avoid preventable illness and death.
- Strengthen screening, detection and early management of NCDs for which there are existing affordable treatments and health infrastructure to support management.
- Strengthen screening, detection and early management of NCDs in primary health care, through training, adapting essential drug lists, and supporting affordable referral mechanisms.
- In line with regional frameworks, support effective models of care which promote physical and psychosocial wellbeing, including a focus on community-based services.
- Increase health literacy to empower communities to make informed decisions on their health.
- Strengthen mental health awareness to tackle stigma and reduce barriers to service access.
- Support multi-sectoral efforts and engagement on policy development and reform (including fiscal and taxation reform) which supports positive consumer choice and healthy behaviours.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

A) Overview

SRHR remains a key element of universal health coverage and essential to health, education, economic productivity, and gender equality. The Pacific and Southeast Asia have high rates of unmet need for essential SRHR services and information, exacerbated by the COVID-19 pandemic driving adverse health and gender equality outcomes. Partner countries continue to face critical challenges in responding to service provision disruptions, gaps in family planning supply chain systems, and data quality for improved public health responses. Partners require support to advance sexual and reproductive health rights and to enhance the delivery of comprehensive, rights-based services. Core to this process is ensuring services are delivered by health workers in a rights-based, client focused approach that empowers women and girls and supports their choice.

B) Background

GHD's partnerships with multilateral agencies such as the IPPF, MSI Reproductive Choices, and the UNFPA, deliver effective and strategic interventions in our region and strengthen global and national enabling environments. These investments complement Australia's priorities in SRHR, helping to drive accountability for international commitments to quality, comprehensive and rights-based services, information, and education. PHR will continue to build on existing investments delivered through relevant multilateral agencies with strong presence in the region. Program learnings emphasise that change is slow given cultural and political sensitivities. Investments need to be realistic and long term to drive positive change and foster the ownership of government and community in the development of SRHR strategies.

C) Strategic approach

PROGRAMMATIC FOCUS

- Accelerate advocacy with national governments for enhanced policy and legislation.
- Improve systems and capabilities to enhance access to quality and comprehensive SRH services.

PROGRAMMATIC FOCUS

- Strengthen demand for SRHR through universal, accessible and quality information and education including comprehensive sexuality education and behaviour change communication strategies.
- Support workforce development, including training in line with international good practice and supportive supervision to drive critical behaviour change.
- Improved reporting and use of quality data to drive better decision making.
- Enhance access to a reliable supply of essential SRH and maternal health commodities including contraceptive supplies.

WORKFORCE DEVELOPMENT

A) Overview

The ability of a country to meet its health goals is dependent on the knowledge, skills, motivation and deployment of the people responsible for organising and delivering health services.¹⁹¹ Many countries in our region face long-term human resource constraints, exacerbated by the COVID 19 pandemic. Further, animal health workforces, consisting of veterinarians, para-veterinarians, and veterinary nurses, are typically less resourced in number, skills and deployment capacity than human health workforces. Investing in the health workforce is essential in combatting burn out and high staff turnover as well as addressing gaps in training programs required to ensure the region has the necessary public health, clinical, immunisation, laboratory, field epidemiology and animal health skills.

B) Background

A range of workforce investments were supported under HSI including: technical assistance provided through in-country deployments or remote assistance; refresher training and hands-on skills development in animal and human infectious disease prevention; One Health and biosecurity; training of field epidemiologists to conduct co-ordinated disease surveillance, outbreak investigation and implementation of public health interventions; and training of a cohort of veterinarians to work at the animal-human interface. Workforce development in PHR refers to increasing the size, quality, skills, efficiency and/or allocation of the health workforce. Workforce development activities in PHR will respond to country priorities by cadre, skill and training pathway. Opportunities for training of clinical and non-clinical human and animal health workforce will include supporting programs such as field epidemiology, outbreak preparedness and response, and immunisation. It will additionally seek to dovetail support to established programs that are focused on capabilities of emergency medical teams (EMTs), health emergency personnel and health workforce in the Pacific.

C) Strategic approach

PROGRAMMATIC FOCUS

- Working alongside bilateral programs, support development and/or implementation of health workforce development strategies that articulate pathways to fund, educate, train, employ, regulate, and support the health workforce.
- Support targeted workforce capacity development through a range of capacity development models including online training, short courses, scholarships and fellowships to higher level training institutions, formal and informal mentoring, and 'on-the-job' learning opportunities which support embedding of learning. These opportunities should be made available both in the region and in Australia.

¹⁹¹ World Health Organization. (2008). Monitoring the building blocks of health systems: A handbook of indicators and their measurement success.

PROGRAMMATIC FOCUS

- Seek opportunities to support partner countries in their retention of frontline health workers who faced the greatest strain on their capacity during COVID-19, in particular the nursing workforce.
- Increase coordination of workforce training within and between countries to create cross-regional training opportunities and peer to peer learning and strengthen institutional partnerships, including, for example, through twinning arrangements.
- Deployment of technical experts into the region to support public health programming and health system strengthening, building in longer term mentoring to support the development of local capabilities and skills transfer.

COMMUNITY ENGAGEMENT

A) Overview

Community engagement is an approach to advancing health and wellbeing outcomes and addressing the social determinants of health. It is a process of developing relationships that support stakeholders to work together to enable changes in policies, programs and practices which promote well-being and achieve positive health outcomes.¹⁹² Throughout the COVID-19 pandemic, communities played a key role in detecting outbreaks and responding at the local level. They were also critical in the spread of information on countermeasures, such as vaccines – sometimes as champions for immunisation but on other occasions as vectors for vaccine disinformation and misinformation.

B) Background

In HSI community engagement was the focus of a small number of investments. In 2022, sector consultations with NGOs and research institutions recommended stronger community engagement approaches in the next phase of investments. Future work on community engagement will be guided by WHO's key focus areas, ensuring communities are: informed and mobilised to participate in addressing health outcomes; consulted and involved in improving access to health; engaged in setting priorities and making decisions on health; and empowered to implement interventions and develop sustainable mechanisms for health promotion. Engaging communities in this manner will have benefits across all areas of programming, supporting increased health literacy, earlier detection of disease and promoting health-seeking behaviour. In the context of PHR, a good community engagement strategy is likely needed in all projects and partnerships, as well as being the principal focus of some projects and partnerships.

C) Strategic approach

PROGRAMMATIC FOCUS

- Tailor programming to respective community contexts based on consultations with diverse community members and participatory approaches.
- Partner with organisations who have pre-established relationships with communities, including local organisations.
- Improve access to accurate and timely health messaging (e.g. through trusted public figures, community leaders etc.).
- Enhance the leadership and capacity of governments to develop their own health policies and interventions which support inclusive community engagement.
- Support the inclusion of diverse groups experiencing marginalisation, in community engagement plans.

¹⁹² World Health Organization. (2020). Community Engagement. (who.int)

ANNEX 9: MANAGEMENT AND GOVERNANCE ARRANGEMENTS

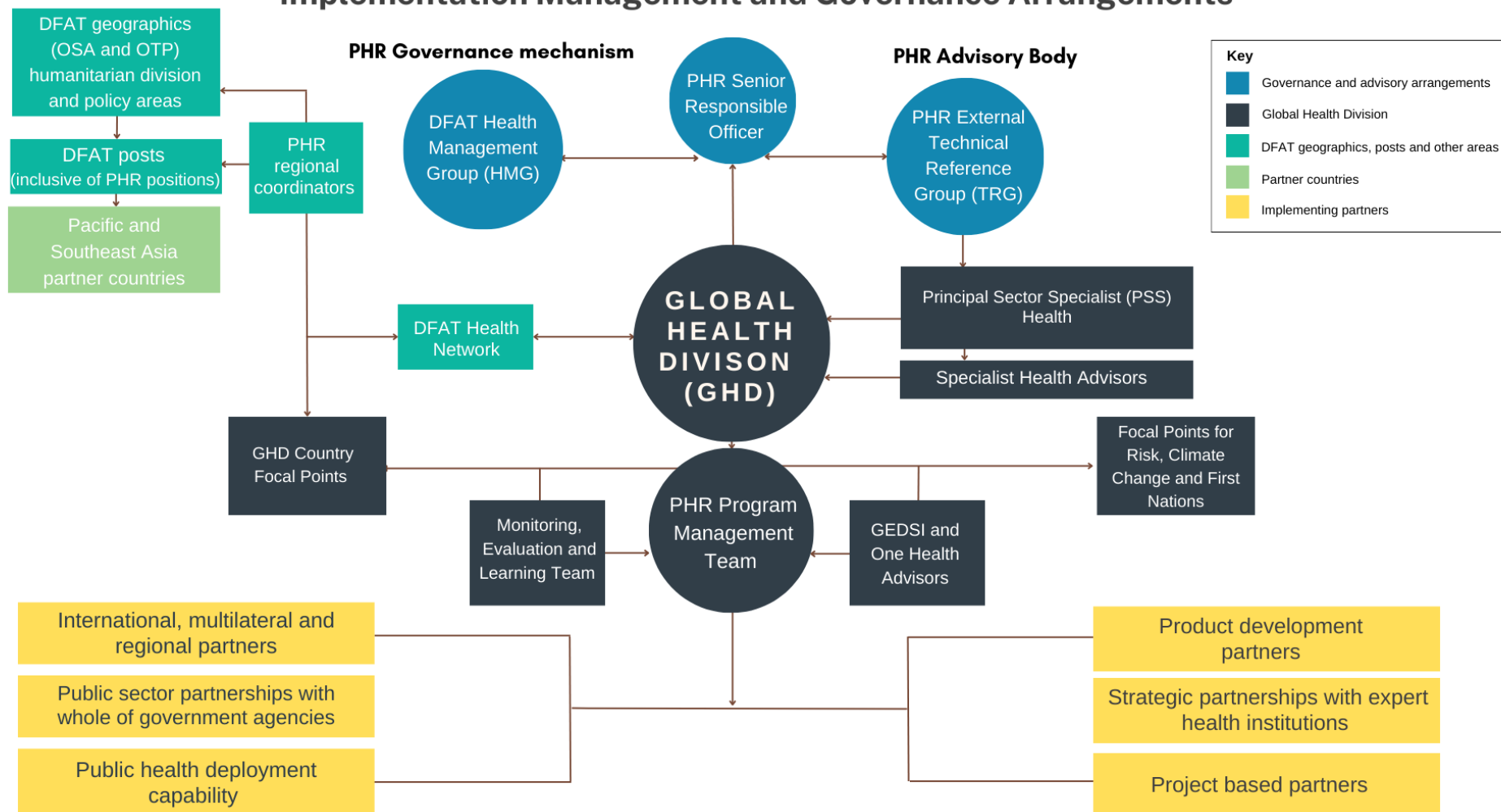
The following management arrangements are proposed to support the implementation and governance of PHR:

- DFAT's GHD will hold overall responsibility for the management of PHR through the following functions:
 - **Operational function:** undertake program management across PHR's suite of investments. This includes performance monitoring and reporting, risk management, management of the PHR budget, integration of cross-cutting themes and implementation of aid quality functions.
 - **Strategic function:** ensure PHR remains strategically focused and responsive to the needs of the region; and engage in policy dialogue in close collaboration with posts, geographic divisions and partners.
 - **Technical function:** facilitate the provision of health technical advisory support across the breadth of PHR programming to inform thematic strategies, programming priorities and investment decisions.
 - **Partnerships function:** ensure effective management of partnerships with multilateral and regional organisations; public sector partners; product development partners; strategic partners; and project-based partners; and broker links between organisations to support co-ordination and maximise impact.
- A senior responsible officer within GHD will be nominated to provide oversight over and be responsible for governance arrangements, financial management, risk, fraud, safeguarding, GEDSI and performance reporting. Working closely with other members of the GHD senior executive, they will play an important role in linking PHR with health diplomacy efforts and supporting co-ordination and collaboration efforts with other donors and likemindeds.
- The Health Management Group (HMG) will be responsible for providing strategic inputs to support implementation, monitoring, and coordination across DFAT. Membership will comprise of senior management representation across DFAT divisions primarily including GHD, the Office of the Pacific, the Office of Southeast Asia and the Humanitarian Division. Additional engagement will be invited from the Development Policy Division, the Gender Equality, Disability and Social Inclusion Branch, and the Office of First Nations engagement.
- The Technical Reference Group (TRG) will provide technical advice across PHR. Membership will be comprised of external representatives that are acknowledged as experts in areas of public health across the breadth of PHR programming. Membership will look to support principles of diversity and gender equality and embed regional representation. A Terms of Reference for the TRG is provided within this annex.
- DFAT posts have the primary role in managing relationships with partner country governments and organisations. GHD will aim to give posts a high level of visibility to PHR activities and seek to co-ordinate with posts and geographic divisions and pursue alignment with country priorities and contexts. This will be facilitated by PHR regional co-ordinator positions and through country co-ordination calls between GHD country focal points, posts, desks, OSA and OTP. Engagement with posts will also be supported by the DFAT Health Network which will convene health leads from across posts, geographic divisions and GHD on a regular basis and support collaboration and information sharing between regional and bilateral health programs.
- GHD will convene the HMG, TRG and DFAT Health Network.

Figure 7: Implementation Management and Governance Diagram

The diagram below provides a visual representation of the implementation, management and governance arrangements for PHR. It is intended to provide a high-level overview of the various actors engaged in implementation and management of PHR.

Partnerships for a Healthy Region (PHR) Implementation Management and Governance Arrangements



DFAT Partnerships for a Healthy Region Technical Reference Group – Terms of Reference

June 2023

Background: Partner government demand for Australian health support remains high, even as the region moves beyond the acute phase of COVID-19. The pandemic's impacts on health service delivery – including routine immunisation and sexual and reproductive health services (SRHR) – have been severe. Disease burden for both communicable and non-communicable disease remains high in our region. Partner governments have conveyed a strong desire to collaborate further with Australian institutions that they see as some of the most capable and accessible in the world. The Partnerships for a Healthy Region (PHR) initiative will provide flexible and high-quality support, and effectively connect Australia's expertise to respond to the needs of the region. PHR encompasses Australia's regional health investments across communicable and non-communicable diseases, SRHR and strengthening of health systems functions. DFAT has established a Technical Reference Group (TRG) to provide strategic and technical advice across PHR to Global Health Division.

Key roles and responsibilities of members:

- Provide strategic and technical advice to the Global Health Division (GHD) shape the delivery of Partnerships for a Healthy Region, review its progress, and recommend adjustments.
- Provide strategic and technical advice to the Global Health Division (GHD) on emerging public health issues as required and provide their expertise on specific issues on request.
- Amplify the reach and impact of DFAT's Partnerships for a Healthy Region initiative, by calling on their domestic and international networks.

Membership criteria

1. Members must be prominent and well regarded in their respective fields.
2. The TRG should have a breadth of experience and expertise across fields relevant to public health. These include:
 - a. Communicable disease prevention, response, and control in human and animals, including One Health;
 - b. Health product development and access;
 - c. Non-communicable disease (NCD) including mental health;
 - d. Sexual and reproductive health and rights (SRHR);
 - e. Gender equality, Disability, and Social inclusion and First Nations engagement.
3. The TRG should contain sufficient Indo-Pacific and international experience, including with the World Health Organization, vertical funds and the multilateral development banks.
4. The TRG membership should represent a breadth of regional networks reaching into development organisations, academic/research institutions, the private sector and civil society.
5. The TRG should be gender-balanced, seek representation from the Indo-Pacific region and promote diversity in appointed experts, including inviting First Nations engagement and representation from a regional organisation of persons with disabilities.

Arrangements

1. TRG membership is voluntary.
2. TRG positions are honorary, unpaid positions unless a strong case can be made that a member should be paid consulting fees. DFAT will meet any costs associated with participating in TRG meetings, including any costs needed associated with providing reasonable accommodations.
3. DFAT will be the Secretariat.
4. Frequency of meetings will be discussed with members early in the inception of the TRG. It is expected that additional meetings may be called on a needs basis where urgent technical inputs are necessary.

- 
5. DFAT's First Assistant Secretary (FAS), Global Health Division and/or thematic ambassador for health will chair the meetings.
 6. Members will be invited to participate for a minimum of 12 months up to the duration of the Partnerships for a Healthy Region (2022-23 to 2026-2027).
 7. TRG membership, composition and Terms of Reference will be reviewed on an annual basis to ensure appointments, arrangements and responsibilities remain fit for purpose and continue to meet the needs of both Members and DFAT.
 8. The TRG is expected to provide advisory or reporting functions to DFAT's Global Health Division only. GHD will be responsible for engagement with and reporting to other areas of the department, other Australian government agencies, ministerial offices, and working through posts to engage with partner governments.

Conflicts of interest

Members will be invited on the basis of their individual skills and expertise, not institutional affiliation. Individuals may, however, be linked to institutions who receive DFAT funding and as such, real or perceived conflicts of interest may arise. A conflict of interest is defined as any interest or relationship that may affect or be seen to affect a members' impartiality. In the interests of transparency, DFAT will request that TRG members disclose any financial and professional relationships with other people or organisations that could present actual conflicts prior to the first meeting, and on an ongoing basis as items for consideration arise.

Conflicts of Interest will be declared and managed in accordance with DFAT's Ethics, Integrity and Professional Standards Policy and [DFAT Conduct and Ethics Manual](#). Actions to manage a conflict of interest will be determined by the Chair, factoring in the nature and extent of the conflict, and may include:

- seeking the member's agreement to divest themselves of conflicting interests;
- asking the member to exclude themselves from relevant discussions and technical engagements so they are no longer engaging in a manner which may potentially put them in a conflict situation; or
- allowing the member to continue to engage and provide technical inputs, implementing appropriate safeguards which address the real or apparent conflict of interest.

Members will be required to sign confidentiality agreements and codes of conduct.

ANNEX 10: MONITORING, EVALUATION AND LEARNING

PRINCIPLES

The initiative's approach to Monitoring Evaluation and Learning (MEL) will reflect the principles of adaptive management and partnership and aims to embed and support the following:

- **Outcomes focused:** The MEL system is outcomes-focused, particularly across a diverse portfolio. It is structured against a hierarchy of outcomes building from individual activities, through to the End of Program Outcomes (EPOOs) of the initiative.
- **Fit for purpose:** The MEL system is designed to support a diversity of partners and programs, whereby expectations for MEL and reporting will scale to match the value and significance of partnerships and activities.
- **Values and embeds GEDSI:** GEDSI is incorporated into all aspects of the MEL framework and resources are allocated to measure progress against the PHR GEDSI Strategy, and to support partners in GEDSI-sensitive qualitative and quantitative data collection and analysis. Attention will also be given to embedding additional review points and evaluations that capture learnings on GEDSI and invest in strengthening particular areas.
- **Sensitive to local context:** MEL enables ongoing analysis of regional and country contexts, and provides opportunities for GHD to maintain flexibility and shape the PHR portfolio to respond to changes in context and emerging priorities, and learnings throughout implementation.
- **Collaborative:** MEL processes are structured to enable DFAT posts and geographic divisions to contribute, as well as PHR's implementing partners, ensuring management and decision making is informed by the experiences, perspectives, and expertise of all those involved in program delivery.

AUDIENCE

The primary audiences of PHR's MEL include:

- **DFAT GHD:** to support grant and partnership monitoring and management, inform initiative -level decisions, oversee implementation, identify opportunities for collaboration, identify and manage risks, to report on initiative performance via IMRs and communicate impact internally and externally.
- **PHR governance and advisory bodies (Health Management Group and Technical Reference Group):** to support engagement in oversight, strategic direction setting, decision making and technical input into Australia's public health programming in the region.
- **DFAT posts, geographic divisions and thematic areas:** to support the identification of opportunities for collaboration, and ensure strategic alignment to partner country priorities and visibility to posts.
- **PHR partners:** to inform direction setting, activity development, identify opportunities for collaboration, sharing of lessons, challenges, successful approaches, and to enhance understanding of PHR investments, approaches and results.
- **Australian Public:** to uphold the principles of transparency and accountability and provide visibility as to the use of Australian Government funds, and to support an enhanced understanding of the results and impact associated with Australia's development program.

STRUCTURE

The MEL system will be structured against the PHR Program Logic, and operate at three levels:

- **Initiative level:** bringing together information from across programming areas to understand how PHR is achieving IOs and EOPOs and performing overall. Initiative-level MEL is supported by a high-level program logic, Performance Assessment Framework (PAF) and key questions. GHD will assess progress against cross-cutting strategies, including the GEDSI and First Nations Engagement Strategy, One Health Strategy, and Climate Change and Environmental Change Strategy.
- **Investment level:** to examine the efficacy of core PHR elements of our work such as communicable diseases, PDPs, NCDs and health systems strengthening approaches. GHD may also examine the effectiveness of programming pathways (including public health deployments), thematic strategies and partnership approaches.
- **Partner level:** partners will develop their own activity level program logics, MEF and MEL plans, selecting indicators that align with the PHR PAF. Partners will use their internal M&E systems to capture and analyse qualitative and quantitative data, and provide evidence-based reporting aligned with reporting expectations of DFAT.

The approach set out in this annex is high-level, as much of the detail needs to sit at investment and partner levels. Downstream design work will confirm the appropriate outcomes, indicators, and methods across all levels. Significant effort will be invested within the first six months to build a system that connects across these levels and addresses the PHR's strategic and cross-cutting priorities. Dedicated MEL positions for PHR will lead this work.

MEASURING PROGRESS TOWARDS DEVELOPMENT OUTCOMES

As public health is multifaceted, impacted by multiple drivers and dynamic social, economic and political contexts, PHR will be looking to measure plausible contribution rather than attribution to EOPOs, and assess how it has added value to improvements in health systems and outcomes, leveraging Australia's resources and expertise. Methods for contribution analysis will be established in the PHR's MEL plan. This will likely rely strongly on qualitative methods and data, such as narrative based methods and case studies.

The performance, monitoring and risk functions within the Health Systems Branch of GHD will prepare an annual summary report describing progress towards PHR IOs and EOPOs. Mid-term reviews and end of program evaluations are expected to be conducted as per DFAT standards and will also serve as opportunities to measure progress towards outcomes. Measurement against outcomes will largely be informed by partner reporting, and as such, partner MEL plans will need to establish clear outcomes, and methods to measure progress.

Each project should demonstrate a clear and realistic pathway towards at least one IO, and establish indicators and measures to track progress and feed into GHD's analysis and reporting on outcomes. The PHR PAF includes an indicative and proxy set of key indicators for each EOPO and IO. These key indicators are the lynchpin that connect all partner reporting directly to IOs and EOPOs. These indicators will be reviewed following selection of projects and partnerships to ensure indicators remain aligned with programming. These indicators will be integrated (as relevant) into partners' MEL plans, so that consistent information is reported across activities. Key indicators are intended to capture a snapshot across the portfolio, and do not represent the breadth of partner activities.

GHD will commission an independent impact-focused evaluation¹⁹³ towards or after completion of the PHR initiative, as per DFAT standards. It is expected that the evaluation will address all EOPOs with the potential to also examine some EOPOs separately and in more detail. To support an assessment of the extent to which PHR contributed to outcomes, GHD will assess the availability of baseline information to provide an

¹⁹³ This may comprise multiple evaluations that examine a single outcome area (CDs, NCDs, SRHR).



assessment of the public health landscape within the first twelve months. This will include drawing from existing reports or datasets where possible.

KEY FEATURES

The initiative will use an adaptive programming approach, rather than rigidly implementing a set of pre-determined activities. The Program Logic and PAF do not provide a set of a detailed list of activities, outputs, and targets but provide outcomes and guiding indicators as a starting point. The PAF constitutes a high-level framework that will be further developed early in implementation once programming decisions are finalised. It will continue to be refined over the course of implementation.

The full PHR MEL system will be further developed by the team within GHD responsible for performance and MEL. A MEL plan, including a MEL framework and setting out the MEL system, will be developed within six months. It is expected that the MEL system be fully operationalised by twelve months. As part of developing the plan, dedicated MEL positions for PHR will:

- Support building out investment level MEL as activities and outputs are identified, by further developing and refining indicators. GHD will provide technical advice and oversight to ensure partners collect and report methodologically robust data that links to the PHR MEL framework and feeds into the production of reports that synthesise and analyse progress towards outcomes. Data collected and reported by partners will be disaggregated by sex and disability at a minimum, with further disaggregation integrated into MELFs where possible and appropriate (e.g. by age, gender identity, ethnicity).
- Finalise indicators and establish methods to monitor the regional public health context to support the positioning of PHR, including by identifying global and country level indicators on the public health status of our region that can be used to inform an assessment of PHR contribution to regional public health outcomes.
- Develop a framework for how we approach monitoring and evaluation of partnerships to support measuring the strength and effectiveness of our partnerships. Methods should be tailored to the different partners and span informal and structured approaches, and single or multi-partner discussions. Partnership check-ins should be designed to capture feedback, measure mutual benefit, and seek to enhance our partnership approach. Additional and discrete reviews may also be carried out to assess the efficacy of partnership types (i.e., strategic partnerships).
- Develop a learning agenda that supports deep dives and enquiry into the assessment of cross-cutting strategies, other PHR elements such as programming pathways and thematic strategies. Opportunities should be forged to deepen knowledge of core strategies and models including related to One Health, GEDSI and First Nation engagement.
- Facilitate annual reviews, synthesising and presenting findings against key questions in a consolidated summary document.

PARTNER ENGAGEMENT IN MEL

Partners have a critical role in PHR's MEL processes. They will be responsible for implementing PHR investments and collecting the majority of the data that the MEL system requires, with DFAT's assessment of progress against outcomes reliant on their reporting.

Partners will provide a program logic in designs and workplans submitted to DFAT, setting out how their activity contributes towards IOs and EOPOs for PHR. Partners will be expected to develop a MEL plan within the inception period for their activity. The main component of the MEL plan will need to include the following:

- The relevant outcomes and key indicators from PHR that the project/partnership expects to contribute to. Indicators should be developed to measure outcomes, in addition to outputs and



activities. Quantitative and qualitative GEDSI indicators that enable reporting on inclusion outcomes, and the quality of the inclusion process, should also be included.

- Additional outcomes and indicators specific to the project/partnership including GEDSI disaggregated data (including sex and disability at a minimum with other disaggregation where feasible, for example, age).
- Details of what data will be collected and reported.
- An outline of how implementation, including challenges, safeguarding issues and risks (including fraud) will be monitored and reported on. This includes consideration of ‘do no harm’ and the risks associated, for example, with gender-based violence.

Partner MEL plans will be assessed against, and are expected to meet, the DFAT Design and Monitoring and Evaluation Standards. DFAT will provide technical advice during inception to support standards to be met.

Partners are expected to adhere to the reporting standards set out in DFAT’s Design and Monitoring and Evaluation Standards, with DFAT taking a proactive approach in communicating these expectations throughout the initiative. Partners will provide reports using a standardised reporting template which will provide information on progress towards outcomes, challenges and risks, implementation progress, and learning. Reporting requirements include:

- Six-month progress reporting to DFAT covering 1 January to 30 June; and 1 July to 31 December each year.
- A final report on project completion.

PERFORMANCE ASSESSMENT AND REVIEW

GHD will prepare an annual summary report describing progress towards the EOPOs and will complete IMRs annually, with the intention to consolidate IMRs under EOPOs as new programming is developed. IMRs will draw on consolidated data from partner reporting against key indicators and outcomes, learning dialogues and any relevant evaluations and MEL products. An internal operational and strategic review will be conducted annually. The team within GHD who holds responsibility for performance monitoring and MEL will provide a consolidated summary of findings against the key performance questions (drawn from monitoring data) and facilitate a participatory reflection process. This is intended to support analysis and decision making by senior GHD management.

Indicative operational and strategic review questions include:

1. Is PHR on track to achieving results in each of five EOPOs, and is the portfolio of activities under each outcome likely to yield tangible results by the end of the program period?
2. Are there activities and IOs that have seen limited progress, blockages, or sustainability challenges? Should these be discontinued, adapted or subject to management action?
3. What changes have taken place in the Indo-Pacific context, and has PHR appropriately responded to changing needs, priorities and requests? Are there opportunities to scale up activities, work with new partners, and strengthen coordination with stakeholders including posts?
4. Is GHD performing its functions (operational, technical, strategic, partnerships) optimally? Does it have the skills, resources and competencies required, or should changes be made?
5. How well is GEDSI and other cross-cutting priorities being progressed? Are the associated strategies and resources proving effective in building capacity across partners and driving GEDSI integration and outcomes?
6. Have areas for PHR policy dialogue progressed? What areas are gaining traction, and are new strategies required, or should new areas of policy dialogue be progressed?



These questions will be further defined as part of the consultative process developing the PHR MEL plan. The PHR MEL PAF will be framed by the program logic. This evidence base will feed into the evaluation question that will form part of the external PHR mid-term review and final evaluation.

While the scope and focus of these evaluative exercises will be determined closer to the time, an indicative set of key evaluation questions include:

1. How effectively has PHR contributed to each IO and EOPO?
2. What are PHR's key successes and achievements? Which strategies and program approaches have been most successful in strengthening health systems and outcomes?
3. What challenges and issues have been encountered, what could have been done better, and what lessons can be learned about strengthening health systems in our region?
4. How effectively has PHR progressed cross-cutting priorities, including GEDSI, First Nations engagement, One Health, Climate Change and community engagement? Are PHR strategies, resources and grant requirements effectively supporting integration and driving associated outcomes?
5. Is PHR working with the right range of partners in the right ways? Is the initiative of mutual benefit to partners and are partnership approaches appropriate?
6. How effectively has GHD nurtured links between Australian institutions and in-country partners, including repeated engagements, mentoring, forging of professional connections?
7. Is PHR achieving optimal alignment and complementarity, including to the needs and priorities of partner countries, with posts and bilateral programs, and other donor agencies?
8. How well are MEL, management and governance arrangements supporting the performance of PHR?
9. What is the likely legacy of PHR's work and sustainability of its benefits?

The PHR PAF provides a framework for synthesising information across a diverse portfolio to understand and enable reporting on outcomes. The PAF will be a tool to summarise progress towards the EOPOs by drawing together information across the IOs. The PAF is not intended to cover all aspects of PHR programming, however, each partner activity must contribute directly towards at least one intermediate outcome in the PAF. The PAF is expected to remain live and subject to updates aligned with an adaptive approach, and be refined and adapted based on analysis, review, and learning.

ANNEX 11: BUDGET

Referred to as a \$620 million initiative, PHR has an indicative total funding envelope of \$620.47 million. This will enable programming across a spectrum of public health programming and will support a diverse set of programming pathways. A budget summary is provided below by thematic, or category, of investment (Figure 8) and by programming pathways (Figure 9), with a more detailed breakdown of indicative allocations by programming pathway provided in Table 4, accompanied by cost assumptions, and detail on program delivery support budget provided in Table 4.

Figure 8: Partnerships for a Healthy Region Budget Summary by thematic (as a percentage of total budget)

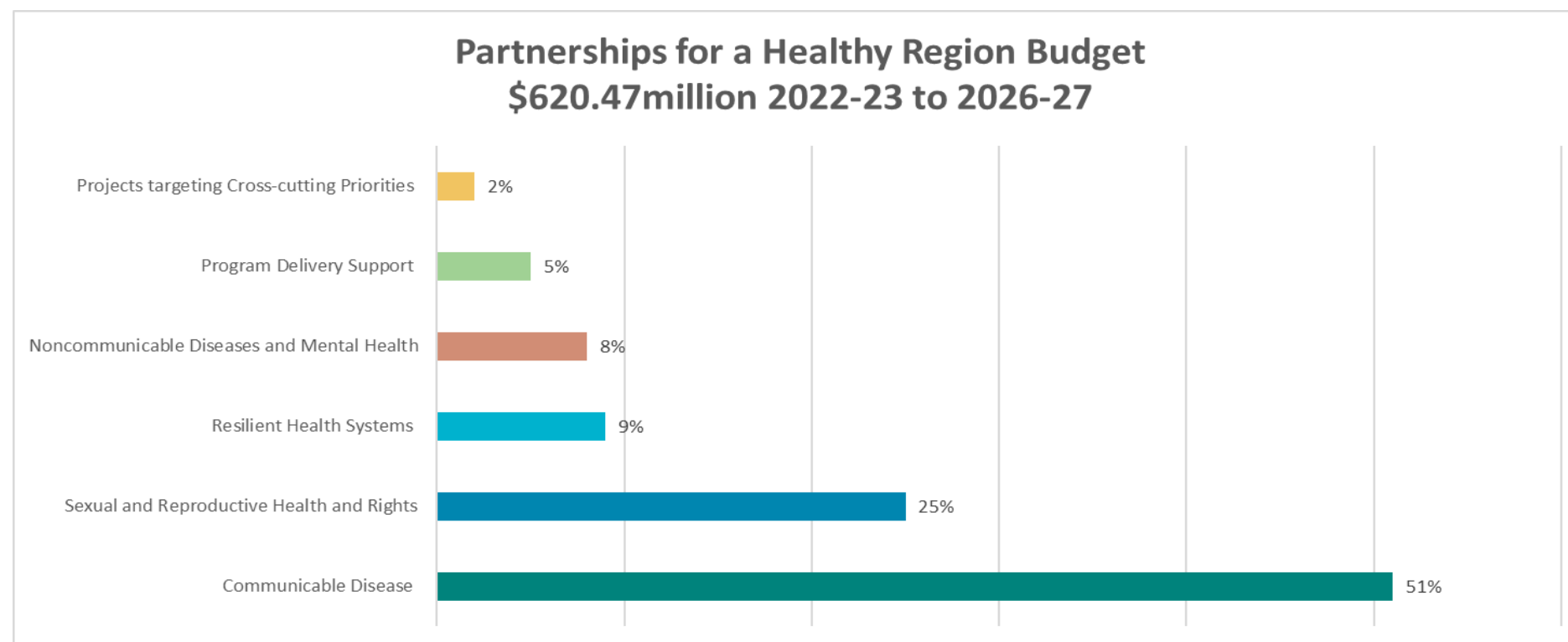


Figure 9: Partnerships for a Healthy Region Budget Summary by programming pathway (as a percentage of total budget)

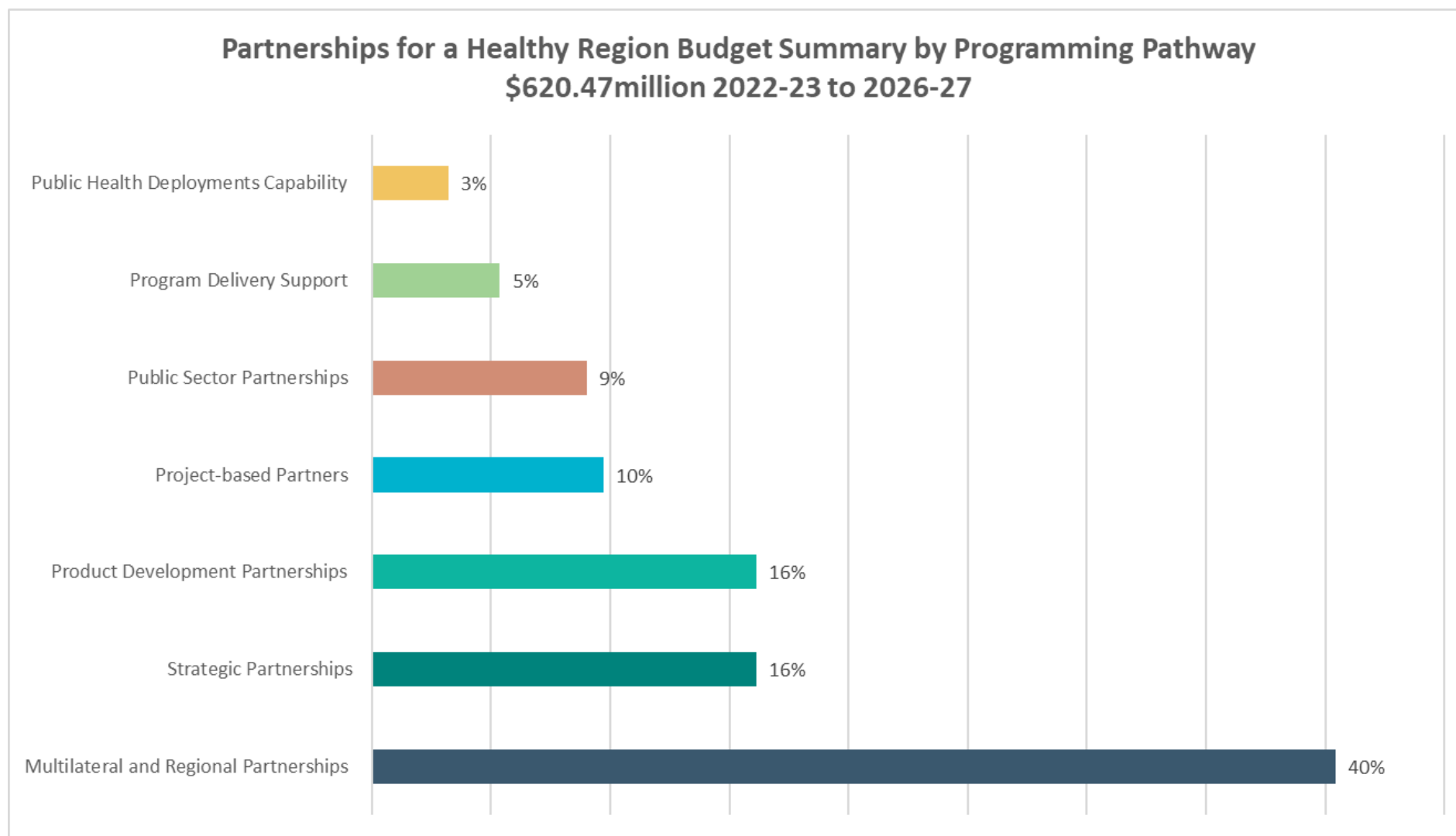


Table 4: Partnerships for a Healthy Region Detailed Budget

Programming pillar	Budget item	Five year totals 2022-23 to 2026-27
Communicable disease	Multilateral partnerships (through regional offices)	\$ 35,000,000.00
	Regional organisations	\$ 19,500,000.00
	Public sector partnerships with whole of government agencies (sole-sourced)	\$ 41,600,000.00
	Product development and access partnerships (competitively-sourced; includes commitment to CEPI)	\$ 100,000,000.00
	Strategic partnerships (competitively-sourced)*	\$ 70,000,000.00
	Project based funding (competitively-sourced)+	\$ 30,500,000.00
Non-communicable disease	Strategic partnerships (competitively-sourced)*	\$ 30,000,000.00
	Project based funding (competitively-sourced)+	\$ 20,000,000.00
Cross-cutting priorities	Project based funding to support GEDSI and First Nations specific projects (competitively sourced)	\$ 9,720,000.00
Public health deployments and response cadre	Provider to support regional deployment capability (limited tender modality or grant-based approach); Funding of long term deployees (existing agreement with managing contractor)	\$ 20,000,000.00
Sexual and reproductive health and rights	Partnerships with leading SRHR agencies (sole sourced)	\$ 157,710,000.00
Resilient Health Systems	Public sector partnerships with whole of government agencies; and partnerships with regional and international organisations (sole-sourced)	\$ 53,050,000.00
Program delivery support	Inclusive of staffing, operations, administration, travel, aid programming, MEL and GEDSI (see Table 5 for detail)	\$ 33,388,826
TOTALS		\$ 620,468,826

* Strategic partnerships indicatively funded at \$10m/each over 5 years

+ Projects indicatively funded at \$5m/activity over 5 years

It is expected that funding allocations are inclusive of management fees, agreed with partners and standardised across PHR

Note, these allocations are indicative only and may change due to:

- programming decisions made following competitively sourced processes;
- strategic reviews and adaptive processes recommend a shift in investment decisions;
- program adjustments arising from shifts in partner government priorities and the investment decisions of other development partners;
- the leveraging of additional availability of funds from other sources such as the bilateral aid program resulting in an increase in the quantum of funds being applied.

Given the scale and scope of PHR, there will need to be sufficient resourcing to support administration, program delivery, monitoring and other aid quality functions. Detail is provided below in relation to the program delivery support budget with intention to review this budget early in implementation to determine what additional resourcing may be required to manage, implement and deliver PHR. The Monitoring and Evaluation budget line is intended to support discrete pieces including baseline assessments, mid-term reviews and evaluations. Additionally, four full time staff will be allocated to support monitoring and evaluation of the initiative with surge support on MEL contracted in or engaged through DFAT's Specialist Health Service on a needs basis. Monitoring and reporting will be integrated into the role of all partnerships and program managers with partners expected to adequately resource MEL.

Table 5: PHR administration and program delivery support budget with yearly breakdown

	2022-23	2023-24	2024-25	2025-26	2026-27	Five year totals 2022-23 to 2026-27
PHR Program delivery support budget						
Human resources (includes contracted staff, secondees and regionally-based staff)	\$ 3,800,000.00	\$ 3,800,000.00	\$ 3,800,000.00	\$ 3,800,000.00	\$ 3,800,000.00	\$19,000,000
Monitoring and Evaluation (non- staffing costs)	\$ 375,000.00	\$ 375,000.00	\$ 375,000.00	\$ 375,000.00	\$ 375,000.00	\$1,875,000
GEDSI (non-staffing costs)	\$ 187,500.00	\$ 187,500.00	\$ 187,500.00	\$ 187,500.00	\$ 187,500.00	\$937,500
Administration, Aid Programming, Travel and Operational costs	\$ 2,376,326.25	\$ 2,300,000.00	\$ 2,300,000.00	\$ 2,300,000.00	\$ 2,300,000.00	\$11,576,326
TOTALS	\$ 6,738,826.25	\$ 6,662,500.00	\$ 6,662,500.00	\$ 6,662,500.00	\$ 6,662,500.00	\$ 33,388,826.25