Australia Indonesia Health Security Partnership Mid-Term Review Final Report June 2023

Acronyms

ACDP	Australian Centre for Disease Preparedness (CSIRO-ACDP)
ACPHEED	ASEAN Centre for Public Health Emergencies and Emerging Diseases
AEFI	Adverse Event Following Immunisation
AESI	Adverse effect of special interest
AIHSP	Australia Indonesia Health Security Partnership
AIP-EID	Australia Indonesia Partnership for Emerging Infectious Diseases
AMR	Anti-Microbial Resistance
ASEAN	Association of Southeast Asian Nations
ASF	African swine fever
BAPPENAS	*Badan Perencanaan Pembangunan Nasional* (Ministry of National Development Planning)
BNPB	*Badan Nasional Penanggulangan Bencana* (National Agency for Disaster Management)
BPBD	*Badan Penanggulangan Bencana Daerah* (Regional Disaster Management Agency)
BPMSOH	*Balai Pengujian Mutu Dan Sertifikasi Produk Hewan* (Centre for Quality Testing and Certification of Veterinary Drugs)
BRIN	*Badan Riset dan Inovasi Nasional* (National Research and Innovation Agency)
COVID-19	Coronavirus disease 2019
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DAFF	Australian Department of Agriculture, Fisheries and Forestry
DFAT	Australian Department of Foreign Affairs and Trade
DGLAHS	Directorate General, Livestock and Animal Health Services
DHIS2	District Health Information Software v.2
DIC	Disease Investigation Centre
DTO	Digital Transformation Office
EID	Emerging Infectious Disease
EOC	Emergency Operations Centre
EOPO	End-of-Program Outcome
EWARS	Early Warning Alert and Response System
FAO	UN Food and Agriculture Organisation
FMD	Foot and Mouth Disease
FTE	Full-time equivalent (employees)
GEDSI	Gender Equality, Disability and Social Inclusion
GISAID	Global Initiative on Sharing Avian Influenza Data
GoI	Government of Indonesia
HEOC	Health Emergency Operations Centre
HIS	Health Information System
HSS	Health systems strengthening
IDCOMM	Indonesia Communications (a private communications firm)
IDDS	USAID's Infectious Disease Detection and Surveillance project
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations
INDOHUN	Indonesia One Health University Network
iSIKHNAS	Indonesia's Integrated Animal Health Information System
iVLAB	Indonesian Veterinary Labs Information System
IVMA	Indonesian Veterinary Medical Association
JEE	Joint External Evaluation
JRA	Joint risk assessment
Kemenko PMK	*Kementerian Koordinator Bidang Pembangunan Manusia dan Kebudayaan* (Coordinating Ministry for Human Development and Cultural Affairs)
KEQ	Key evaluation question
KOMPAK	*Kolaborasi Masyarakat dan Pelayanan untuk Kesejahteraan Kemitraan Pemerintah Australia-Indonesia* (funded by DFAT)
KPI	Key Performance Indicator
KSI	Knowledge Sector Initiative (funded by DFAT)
LAMP	Loop-mediated Isothermal Amplification
LIMS	Laboratory Information Management System

LSD	Lumpy Skin Disease
MERLA	Monitoring, Evaluation, Research, Learning and Adaptation
MoA	Ministry of Agriculture
MoEF	Ministry of Environment and Forestry
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
MoWECP	Ministry of Women Empowerment and Child Protection
NAPHS	National Action Plan on Health Security
NDVP	COVID-19 National Deployment and Vaccination Plan
NGO	Non-Governmental Organisation
NIHRD	National Institute of Health Research and Development
NTT	Nusa Tenggara Timur Province
OH	One Health
OIE	World Organisation for Animal Health (originally 'Office International des Epizooties')
OPD	Organisations of persons with disabilities
ORV	Oral Rabies Vaccine
OT	Operational Tool
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PHO	Provincial Health Office
PHEOC	Public Health Emergency Operations Centre
PMI	*Palang Merah Indonesia* (Indonesian Red Cross Society)
Posyandu	*Pos pelayanan terpadu (*Integrated health service delivery post)
PRISMA	Australia Indonesia Partnership for Promoting Rural Incomes through Support to Markets in Agriculture
PROSPERA	Australia Indonesia Partnership for Economic Development
Pusdatin	*Pusat Data dan Informasi* (Health Data and Information Centre)
Puskesmas	*Pusat kesehatan masyarakat* (Community health centre)
Puskeswan	*Pusat kesehatan hewan* (Animal health centre)
RCCE	Risk communication and community engagement
RCPA	Royal College of Pathologists of Australasia
RMCP	Indonesia-Australia Partnership on Food Security in the Red Meat and Cattle Sector
RPJMN	*Rencana Pembangunan Jangka Menengah Nasional* (Medium-Term National Development Plan)
SatuSehat	One Health (Indonesia's integrated health data system)
SIAP SIAGA	Australia-Indonesia Partnership in Disaster Risk Management
SISHIS	Secure & Interoperable Surveillance and Health Information System
SIZE	Information System for Zoonotic and Emerging Infectious Disease
SKDR	*Sistem Kewaspadaan Dini dan Respon* (Early Warning and Response System – EWARS)
SOP	Standard Operating Procedure
TA	Thematic area (in the AIHSP MERLA Framework)
TAD	Transboundary Animal Disease
TOT	Training of trainers
TWG	Technical working group
TZG	Tripartite Zoonoses Guide
UNICEF	United Nations Children's Fund
VAHSI	DFAT's Vaccines Access and Health Security Initiative
VIRAT/VRAF 2.0	WHO's Vaccine Introduction Readiness Assessment Tool/World Bank's Vaccine Readiness Assessment Framework
VSB	Veterinary Statutory Body
WGS	Whole genome sequencing
WHO	World Health Organisation
WOAH	World Organisation for Animal Health (formerly OIE)

Cover photo courtesy of the Australia Indonesia Health Security Partnership

Table of Contents

Acknowledgements

Note: This report has been adapted by DFAT prior to publication.

Executive Summary

Introduction

This is the Mid-Term Review (MTR) Report of the Australia Indonesia Health Security Partnership (AIHSP) as well as the Australian-funded COVID-19 response work of UNICEF and WHO in Indonesia. AIHSP was launched as an AUD$14 million, five-year bilateral health security program in February 2020 in partnership with Indonesia's Ministry of Health (MoH) and the Ministry of Agriculture (MoA). Since then it has significantly expanded in scope and has a current budget of AUD48 million, covering 20 districts in five provinces. The aim of AIHSP is to strengthen Government of Indonesia (GoI) systems to prevent, detect and respond to public health and animal health emergencies and strengthen national coordination responses to health threats. Australia funded WHO (AUD10.7 million) and UNICEF (AUD15.4 million) for COVID-19 response activities commencing in June 2020.

The purpose of the MTR (February 2020 to March 2023) was to assess whether Australia's health security partnership with Indonesia (activities managed by DT Global (AIHSP), UNICEF and WHO herein referred to as 'partners') is on track to achieve program outcomes and how it is contributing to the Indonesian health sector. In addition, the MTR sought to explore future considerations and provide recommendations for the remainder of this phase of the program as well as Australia's future support to the Indonesian health sector. Five key evaluation questions (KEQs) were identified. An independent MTR Team gathered evidence through a review of 112 documents *(see annex 9.2)*, and conducted face-to-face interviews and remote interviews with 194 representatives of partners and sub-partners, DFAT, DAFF, GoI, community groups including women's groups and organisations of persons with disabilities, and other donors to Indonesia *(see annex 9.3)*. The MTR's time frame and resourcing limited the number of documents that could be reviewed, excluding documents on other donors. This fact, coupled with the limited interview time, meant that the MTR Team could not assess Australia's contribution in relation to the work of other donors in Indonesia.

The results

The following are the results of the MTR for KEQs 1-4.

1. Progress towards outcomes

KEQ1.1: Are AIHSP intermediate outcomes (IOs) and EOPOs on track?

Overall, from February 2020 to March 2023, AIHSP made good progress towards its end of program outcomes (EOPOs). This is despite a significant and effective pivot and scale-up of activities due to COVID-19 and animal disease outbreaks including foot and mouth disease (FMD) and lumpy skin disease (LSD). AIHSP's progress needs to be viewed with these contextual challenges in mind.

The MTR Team assessed and rated AIHSP's progress against its December 2022 MERLA Framework[1]. EOPO ratings are presented in Table 1 below.

Table 1: AIHSP end of program outcome MTR ratings[2]

Outcome	Rating
EOPO 1.1: Prepare and prevent	Good
EOPO 1.2: Detect	Good
EOPO 1.3: Respond and recover	Good
EOPO 2.1: Coordinate	Acceptable

Under **EOPO1.1**, which aimed to support government regulations and systems, community behaviours and private sector practices to reduce the impact of disease, greatest progress was made in supporting the development and/or modification of government regulations or policy and planning documents such as the FMD Roadmap (complete), the National Action Plan for improving laboratory capacity (in progress) and the National Health System Review which will inform Indonesia's next medium and long-term development plans. The evidence for this was strong and this progress resulted in the **Good** rating. WHO facilitated the development of 10 technical guidelines (e.g. COVID-19 vaccination of priority populations) and built the capacity of primary

---

[1] Australia Indonesia Health Security Partnership 2022, *Monitoring, Evaluation, Research, Learning and Adaptation (MERLA) Plan*, December.
[2] The AIHSP rating scale for EOPOs includes: excellent, good, acceptable, poor/insufficient evidence, too early to assess.

health workers to deliver essential health services in puskesmas. UNICEF supported training for health workers and health promoters in routine immunisation at puskesmas and posyandu (integrated health service delivery posts) in multiple provinces as part of the National Child Immunization Month campaign.

Under **EOPO 1.2,** aimed at supporting surveillance systems for detecting emerging disease threats, AIHSP's work on the laboratory information system iVLAB and its incorporation into iSIKHNAS resulted in a more integrated system, enhanced early warning and reporting, and increased system security. There was evidence that iSIKHNAS was valuable in tracking the spread of, and informing responses to, the FMD and LSD outbreaks. The progress of three AIHSP-supported systems was mixed: ASIK used for monitoring health at a primary health care (PHC) level had been accessed by 94% of all puskesmas; the Secure and Interoperable Surveillance and Health Information System (SISHIS) remained at pilot stage; progress of the interoperable One Health surveillance data exchange, SIZE, had been slow. The iVLAB and iSIKHNAS work in particular resulted in the **Good** rating, and there was strong evidence to support this.

WHO supported 31,000 health facilities at puskesmas level with capability for antigen-rapid diagnostic testing (Ag-RDT), 1,300 laboratories to conduct PCR testing and 1,034 laboratories for external quality assurance for COVID-19 diagnostics. UNICEF supported the RapidPro digital platform which identified 35,814 children who lost their parents/caregivers due to COVID-19.

EOPO 1.3 aimed to improve the ability of the government, community and private sector to respond to disease outbreaks. Under this EOPO, AIHSP's response to COVID-19 and animal disease outbreaks including FMD, LSD and rabies was timely and flexible. As at March 2023, a total of 263,559 men and women, including 39,350 elderly[3] and 1,684 people with disabilities were vaccinated against COVID-19 through AIHSP. Inclusive vaccination events were held but as of March 2023, vaccination rates for people with disabilities and the elderly remained lower than expected. AIHSP supported the development of Health Emergency Operations Centres (HEOCs) in four provinces, with mixed results. Australia contributed 435,000 doses of the LSD vaccine and 4 million doses of the FMD vaccine. However, more holistic disease control strategies were needed in combination with more vaccines, and so the diseases continued to spread. Despite this, the strong evidence and efficacy of Australia's contribution to the disease outbreak responses resulted in the **Good** rating.

WHO provided support for the COVID-19 response through sentinel surveillance and contact tracing activities while UNICEF supported procurement and administration of COVID-19 vaccines, risk communication and community engagement (RCCE) and the GoI's COVID-19 website.

EOPO 2.1 focused on relevant government bodies using a One Health approach and collaborative working. Under this EOPO, AIHSP promoted a One Health approach through the development of 16 multistakeholder structures at provincial, district and village level. However, while multiagency communication on health security improved, there was limited evidence of the structures operationalising for an emergency response except for rabies in Bali. AIHSP supported the G20 One Health Side Event in Indonesia which helped increase the visibility of a One Health approach. The rating of **Acceptable** for this EOPO is based upon early but limited progress of One Health activities, but evidence was not as strong as for the other EOPOs.

WHO and UNICEF contributed to COVID-19 working groups and the donor coordination forum for COVID-19. In 2021, WHO supported the MoH to develop a One Health training module.

2. Contribution to Indonesia's health sector

2.1 Contribution to the COVID-19 response

KEQ 2.1: How have the DFAT-funded AIHSP, UNICEF and WHO activities contributed to Indonesia's COVID-19 response?

Australia made a significant, timely and comprehensive contribution to Indonesia's COVID-19 response through AIHSP and its funding of UNICEF and WHO. Funding was allocated through DFAT's regional Vaccine Access and Health Security Initiative (VAHSI) and bilaterally for COVID-19. AIHSP partners provided significant support to surveillance, laboratory and information systems,

---

[3] *Elderly* is the term used commonly in Indonesia.

strengthening health emergency operations centres, RCCE and vaccination. Both WHO and UNICEF supported development of Indonesia's National Deployment and Vaccination Plan, vaccine readiness assessments, dashboards for monitoring vaccination and administering vaccines. WHO supported national strategies and guidance, for example in sentinel surveillance, and supplied rapid diagnostic tests. UNICEF supported vaccine procurement and RCCE. All partners provided support for inclusive vaccination, particularly for women, people with disabilities and the elderly *(see also KEQ 4.1 below)*.

The MTR Team mapped these activities to the GoI's National Action Plan for Health Security Indonesia (NAPHS) 2020-2024[4] and this demonstrated a holistic contribution by Australia to improving the country's health security. COVID-19 provided an opportunity to strengthen health systems, such as information systems, and many will be sustained for managing other diseases. However, vaccination rates for the elderly and people with disabilities were lower than expected and results of some pilot activities were limited. Australia continued its support during COVID-19 transition, including through last mile vaccination.

2.2 Contribution to strengthening health systems

KEQ 2.2: How have the DFAT-funded AIHSP, UNICEF and WHO activities contributed to the strengthening of human and/or animal health systems and response to infectious disease outbreaks in Indonesia?

The MTR Team assessed Australia's contribution to Indonesia's health systems using WHO's health systems strengthening building blocks[5] with the addition of a One Health component. The MTR found that through AIHSP, WHO and UNICEF, Australia made a significant contribution to the building blocks of service delivery, health information systems, health workforce and One Health. It made less contribution to leadership/governance and access to essential medicines and no contribution to health financing[6], which is consistent with what was planned. Under service delivery, the main areas that Australia supported were human and animal health surveillance and laboratory strengthening. Australia's support for animal health information management systems centred on continued development of iSIKHNAS, and in human health information management systems centred on COVID-19, including strengthening real time data collection for vaccination. Most Australian-funded activities under multisectoral One Health Coordination involved establishing mechanisms for One Health collaboration at the sub-national level. Each of these building blocks included activities such as training which strengthened the human and animal health workforce.

Many of the short-term health systems improvements for disease outbreak responses now need to be sustained and translated to detecting and responding to other infectious disease outbreaks. Australia should focus on supporting this in its areas of comparative advantage including surveillance, animal health laboratories, health information systems, policy reforms for preparing for and managing infectious disease outbreaks and One Health implementation.

3   Efficiency

KEQ 3.1: Did increased funding impact the efficiency of AIHSP?

AIHSP performed remarkably in scaling up rapidly to respond to COVID-19 and animal disease outbreaks in Indonesia. According to MTR interviewees, Australia's flexibility and responsiveness to GoI requests for support as well as to the needs of partners was highly appreciated. However, this rapid scale up came at a cost, as AIHSP's management structure and human resourcing was not designed for programming at the scale it was operating. This impacted on AIHSP's communication and coordination with GoI, sub-partners and other actors at a national and sub-national level, resulting in missed opportunities for more efficient implementation of activities, a disconnect between AIHSP's national planning and subnational implementation and some duplication with other donors/entities. AIHSP's resourcing was increased in December 2022. The increase in Australian funding to AIHSP, WHO and UNICEF over 2021-2022 also placed a significant administrative strain on DFAT's Health Team in Jakarta, decreasing its ability to coordinate and monitor partner activities and engage strategically with relevant GoI ministries.

---

[4] Government of Indonesia, *National Action Plan for Health Security Indonesia 2020-2024*, available at: chrome-extension://efaidn bmnnnibpcajpcglclefindmkaj/https://extranet.who.int/sph/sites/default/files/document-library/document/INDONESIA%20NAPHS.PDF
[5] WHO 2010, *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies.*
[6] Australia is funding the World Bank's work on health financing in Indonesia through a separate investment.

DFAT made a strategic and effective choice of modalities (AIHSP, UNICEF and WHO) for the provision of support for COVID-19 and the animal health disease outbreaks from 2020 to 2022. This choice was limited – AIHSP was the main DFAT health investment that could enable a response to COVID-19 and animal diseases, and WHO and UNICEF were both playing pre-established and complementary roles in the COVID-19 response. While WHO and UNICEF had a broad scope of work nationally and sub-nationally, AIHSP addressed specific technical needs, enabled clear Australian branding of activities and supported capacity gaps at a national level and in the five priority provinces. The MTR found clear instances of efficient collaboration between the partners, as well as with DFAT, GoI and other donors/actors. Given the tight time frames for implementing activities, at times the accountability of sub-partners was weak and there was limited evidence of collaboration between sub-partners working on similar activities to capitalise on each other's expertise and strengths.

4   Health outcomes for community groups

KEQ 4.1: Are the programs contributing to aspects of the health system that will likely result in improved health outcomes for a) women and girls b) people with disabilities c) the elderly? d) other at-risk groups? How?

AIHSP's work in implementing inclusive service delivery for COVID-19 at the provincial level was a key strength and resulted in some tangible health outcomes. UNICEF and WHO also worked to ensure appropriate and accessible service delivery during COVID-19 for at-risk groups[7].

AIHSP's sub-partners worked systematically with women's groups and organisations of persons with disabilities (OPDs) to design and implement inclusive COVID-19 vaccination events in the five AIHSP priority provinces. Interviewees from these groups confirmed the events were effective in enabling target groups to be vaccinated. A total of 1,684 people with disabilities were vaccinated against COVID-19 with AIHSP support (up until March 2023). While the work of AIHSP and UNICEF increased vaccine coverage for at-risk groups, progress fell well short of sub-partner vaccination targets, which may have been overestimated. The GoI expressed interest in AIHSP sharing its learning in inclusive COVID-19 vaccination. UNICEF mitigated the negative impacts of COVID-19 on routine service delivery for women and children through continued routine vaccination, training government officials in child protection and frontline volunteers in gender-based violence. However, available evidence on how the activities directly contributed to outcomes was limited.

AIHSP implemented activities that reflected both tracks of its Gender Equality, Disability and Social Inclusion (GEDSI) Strategy but some planned activities, such as GEDSI awareness in leadership programs, have not yet occurred. This is to be expected mid-way through a program.

Future considerations and recommendations

Future considerations

The MTR noted several political, strategic and health developments that should be considered in Australia's future support for the health sector in Indonesia. These include the imminent release of Australia's new Development Policy, its Partnerships for a Healthy Region initiative, the Indonesian elections in February 2024 and Indonesia's new Medium-Term Development Plan (2024-2029) and Long-Term Development Plan (2025-2050) to be launched in 2023.

Recommendations

KEQ 5: What does the Mid-Term Review findings suggest for DFAT's future assistance to the health sector in Indonesia?

The MTR provides recommendations for existing programming with a one-year extension until January 2026 and for a new, future health investment from February 2026. Only key recommendations are listed below with further recommendations included in sections 8.2 and 8.3.

---

[7] At-risk groups for COVID-19 in Indonesia included the elderly, people with disabilities, women, children, people living in remote communities and ethnic minorities.

Current program

1. **Consolidate and embed project activities:** AIHSP to continue activities supporting surveillance and information management systems, animal health laboratory strengthening, targeted support for animal health disease outbreaks, inclusive access to health care and a One Health approach. After detailed analysis, AIHSP to consider discontinuing plans and/or activities in public health laboratory strengthening, health emergency operations centres (but continue support to One Health approaches), RCCE, some pilot activities and private sector collaboration (but continue for emergency response). AIHSP to consider limiting planned puskesmas strengthening activities.
2. **Share lessons and advocate for systematic use of inclusive service delivery:** AIHSP to share lessons learnt on its inclusive COVID-19 vaccination for at-risk populations with the MoH and the MoHA and to advocate for embedding these approaches in other health service delivery.
3. **Continue targeted support for animal health disease outbreaks** with AIHSP DFAT, in coordination with the Department of Agriculture, Fisheries and Forestry (DAFF)
4. **Improve partner processes, capacity, collaboration and monitoring:** AIHSP to improve its regular communication and coordination with GoI and implementing partners and ensure its managerial structures and administrative capacity is sufficient to support the current scale of activities.
5. **Improve capacity, collaboration and coordination between DFAT and DAFF-funded programs:** DFAT in Jakarta to strengthen its Health Team so that it has the capacity and technical and strategic capability commensurate with the size and complexity of Australia's health investments in Indonesia. DFAT to continue regular meetings between DFAT and DAFF programs.

Australia's future health investment

Given the Indonesian elections in 2024, the MTR Team recommends DFAT consider a possible one-year funded extension to January 2026**.** Following this, Australia is to embark on a new phase of consolidated health sector programming, with a reduced scope of activities and emphasis on health systems strengthening. DFAT to approach the market to select a managing contractor for this next phase of investment. WHO and UNICEF will likely continue to be funded by DFAT through existing regional and global agreements.

<u>Key recommendations</u> for a new Australian investment in the Indonesian health sector from the end of the program period and how this investment could be managed are outlined below. Additional recommendations are included in section 8.3.

1. **DFAT health strategy** - DFAT Jakarta to develop a strategy for Australia's bilateral funding of the health sector in Indonesia, involving both human and animal health, in consultation with GoI.
2. **DFAT emergency response mechanism** – DFAT to establish a flexible emergency response mechanism for rapid funding of human and animal infectious disease outbreaks. This could be separate to the modality for funding health systems strengthening under a new investment.
3. **GoI engagement -** Australia to progress partnerships with MoH and MoA. Australia to also consider arrangements with MoEF, MoHA, Kemenko PMK and BAPPENAS, as ministries responsible for areas relevant to Australia's new health investment.
4. **One Health -** DFAT to support practical application of a One Health approach to respond to human or animal health disease outbreaks, encourage application of a One Health lens around future policymaking on preparedness and prevention and continue to support Indonesia's leadership on One Health in Southeast Asia.

In addition to One Health, the MTR recommends that Australia focuses its new health investment on human and animal health surveillance and information management systems, animal health laboratory strengthening and embedding an inclusive service delivery approach across the health system. Further detail on these and other recommendations is in section 8.3.

1. Introduction

The Australia Indonesia Health Security Partnership (AIHSP) was launched as a five-year (2020-2025) AUD14 million bilateral program funded by the Department of Foreign Affairs and Trade (DFAT) to continue the Australian Government's support for the health sector in Indonesia. AIHSP is the successor to previous health support under the Australia Indonesia Partnership for Emerging Infectious Diseases (AIP-EID, 2010-2018). AIHSP has since expanded in scope, with a current budget of AUD48 million as a result of additional funding to support the COVID-19 response in Indonesia, AUD810,000 to respond to an outbreak of Lumpy Skin Disease (LSD) and an AUD10 million biosecurity package to support Indonesia's FMD and LSD response from DFAT with the Department of Agriculture, Fisheries and Forestry (DAFF). COVID-19 response funding has included the Last Mile Delivery of COVID-19 Vaccinations Program (AUD2.6million) and DFAT's Vaccine Access and Health Security Initiative (VAHSI) funding (AUD3.3million).

AIHSP's work has focused on five priority provinces: Bali, Central Java, South Sulawesi, Yogyakarta and East Nusa Tenggara (NTT - added in June 22). It has worked primarily in partnership with the Ministry of Health (MoH) and the Ministry of Agriculture (MoA). The program is now being implemented in 20 districts across five provinces. Australia also funded WHO (AUD10.7 million) and UNICEF (AUD15.4 million) for COVID-19 activities from June 2020 to June 23/24. WHO and UNICEF's activities and outcomes described in this report were funded by Australia as well as other donors.

DFAT commissioned this Mid-Term Review (MTR) to assess whether AIHSP (activities managed by DT Global from February 2020 to March 2023) is on track to achieve its end of program outcomes (EOPOs) and how, along with Australian funding to WHO and UNICEF, this funding has contributed to the Indonesian COVID-19 response, health systems strengthening and health outcomes for at-risk groups. The MTR also examined options for a future Australian investment in the health sector in Indonesia. The MTR provides recommendations for the remaining period of implementation with an extension (to January 2026) and for future Australian investment in the Indonesian health sector from February 2026. The independent MTR Team consisted of two Australian and two Indonesian consultants with expertise in health security, health systems strengthening, the Indonesian human and animal health sectors, veterinary epidemiology and evaluation.

1.1 Key Evaluation Questions and Methodology

1.1.1 Key evaluation questions

Five key evaluation questions (KEQs) and related sub-questions were identified for the MTR. The KEQs are listed in Table 2.

Table 2: MTR key evaluation questions and sub-questions

Key evaluation questions	Evaluation sub-questions
Effectiveness KEQ1: Are programs making progress towards expected outcomes?	• KEQ1.1: Are AIHSP intermediate outcomes (IOs) and EOPOs on track?
Effectiveness & relevance (coherence and impact[8]) KEQ2: How are the programs contributing to the health sector in Indonesia?	• KEQ 2.1 How have the DFAT-funded AIHSP, UNICEF and WHO activities contributed to Indonesia's COVID-19 response? • KEQ 2.2: How have the DFAT-funded AIHSP, UNICEF and WHO activities contributed to the strengthening of human and/or animal health systems; and control of infectious disease outbreaks in Indonesia?
Efficiency KEQ3: How efficient have the programs been?	• KEQ 3.1: Did increased funding impact the efficiency of AIHSP? • KEQ 3.2: Did mixed modalities impact the efficient delivery of responses to COVID-19 or other health security threats?
At-risk groups & relevance KEQ4: Are the programs implementing activities that will lead to improved health outcomes for at-risk groups in Indonesia?	• KEQ 4.1: Are the programs contributing to aspects of the health system that will likely result in improved health outcomes for a) women and girls b) people with disabilities c) the elderly? d) other at-risk groups? How?

---

[8] The KEQ addresses this OECD DAC criteria to a limited extent only. Impact is defined as *"The extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects"* (OECD DAC), usually over a period >5 years. Many of the activities have been implemented for <5 years, so the MTR will only address impact as "*the holistic and enduring changes in systems or norms, and potential effects on people's well-being, human rights, gender equality, and the environment" (OECD DAC).*

Key evaluation questions	Evaluation sub-questions
Future options KEQ5: What does the Mid-Term Review findings suggest for DFAT's future assistance to the health sector in Indonesia?	N/A

1.1.2 MTR approach and methods

The MTR involved a retrospective review of implementation from February 2020 to March 2023, as well as limited prospective mapping of issues and options to inform future Australian investment in the Indonesian health sector. The MTR Team drew on appreciative inquiry and culturally responsive evaluation approaches for the MTR and ensured adherence to DFAT's Monitoring & Evaluation Standards[9] as well as DFAT's strategies for gender equality[10] and disability inclusiveness[11].

A mixed methods approach for data collection was used. This included reviewing 112 documents, mainly partner and DFAT designs, plans and reports *(see annex 9.2)* as well as additional quantitative and qualitative data from partners. It also included face-to-face and online semi-structured interviews and focus groups with a purposive sample of 194 people working in and linked to the activities of AIHSP, WHO and UNICEF. Selection criteria were used to choose interviewees, to ensure that diverse perspectives would be captured. Interviewees included staff from: AIHSP, UNICEF and WHO at a national and sub-national level, DFAT, DAFF, GoI at a national, provincial, district, and village level, other Australian government departments and programs in Indonesia, sub-partners, disabled people's organisations, women's organisations and other donors *(see annex 9.3)*.

Tailored interview guides were developed based upon initial findings and identified gaps from the document review. The interviews and focus groups were conducted in English and Indonesian by members of the MTR Team either face-to-face in Jakarta, South Sulawesi (Makassar and Maros) and Bali (Denpasar, Buleleng) or remotely in Australia between 20 February and 8 March. Simultaneous translation and sign language interpreters were used to ensure the interviews were accessible. At the end of the Indonesian visit, an aide memoire with preliminary findings and recommendations from the interviews was developed and discussed with the DFAT Health Team Jakarta.

Different frameworks were used to analyse the data for KEQs 1.1, 2.1, 2.2 and 3.1 *(see annex 9.4)*. KEQs 3.2 and 4.1 were analysed to assess the DAC criteria of efficiency and relevance. The MTR Team used the findings from KEQs 1-4 to inform the recommendations in KEQ5. A sense-making workshop was conducted with the DFAT Health Team Jakarta to clarify information and to ensure the recommendations were fit for purpose.

1.1.3 Limitations

The MTR time frame and resourcing limited the number of documents the MTR Team was able to review. As this was primarily a review rather than a scoping exercise, the MTR prioritised documents from AIHSP, UNICEF, WHO and some from the GoI. Documents related to the work of other donors/partners were excluded, and inquiry on their work during interviews was necessarily limited. As a result, there was insufficient evidence to assess: Australia's relative contribution to Indonesia's COVID-19 response and health systems strengthening; duplication of effort; or alternative modalities that could have been used for delivery of Australian-funded activities.[12] While the MTR did recommend activities to continue and discontinue based upon available information, it noted that further analysis of the work of other donors and GoI should be undertaken before such decisions.

---

[9] Australian Government Department of Foreign Affairs and Trade 2022, *Design and Monitoring & Evaluation Standards,* available at: https://www.dfat.gov.au/about-us/publications/Pages/dfat-monitoring-and-evaluation-standards.

[10] Australian Government Department of Foreign Affairs and Trade 2016*, Gender Equality and Women's Empowerment Strategy,* available at: https://www.dfat.gov.au/about-us/publications/gender-equality-and-womens-empowerment-strategy.

[11] Australian Government Department of Foreign Affairs and Trade 2015, *Development for All 2015-2020: Strategy for strengthening disability-inclusive development in Australia's aid program*, available at: https://www.dfat.gov.au/about-us/publications/development-for-all-2015-2020.

[12] The design noted that the ability to assess this contribution would be limited by the information available through the document review.

2. Overall context

2.1 Relevance of AIHSP

Indonesia is among the most vulnerable countries in the world to the impacts of emerging infectious diseases (EIDs) and zoonoses, with many of the risk factors that drive disease emergence and rapid spread. In 2017, the GoI undertook the WHO-supported Joint External Evaluation (JEE) of their capacity to implement the International Health Regulations (IHR), resulting in the development of the National Action Plan for Health Security Indonesia 2020-2024 (NAPHS).

Given its location and high level of international travel and trade, infectious diseases in Indonesia pose a significant threat to other countries in the Asia-Pacific region, including Australia. The Australian Government has developed strong partnerships in the region to strengthen health security capability to prepare for, detect and respond to disease outbreaks.

The AIHSP design states that it will assist Indonesia to address the JEE recommendations and that its activities will align with the NAPHS. AIHSP's goal is to increase health security in Indonesia and reduce the impacts of EIDs and zoonoses.

2.2 COVID-19

AIHSP, originally designed as a health security program, had only commenced in February 2020 when the first two positive COVID-19 cases were confirmed in Indonesia on March 2, 2020. Within a month, Indonesia's official count of COVID-19 cases had reached 1,790 with 170 fatalities, among the highest mortality rate in the world at 9.4%.[13] It took less than nine months for the country to surpass half a million COVID-19 cases in November 2020.[14] On December 22, 2020, President Joko Widodo replaced the Health Minister as COVID-19 deaths continued to increase. New Minister Budi Gunadi Sadikin was assigned to bolster government efforts against the outbreak and has since instigated a transformation of the Indonesian health system (2021-2024), requesting support from other countries including Australia.

Last mile vaccination efforts in 2022 have focused on reaching at-risk groups including the elderly and people with disabilities, as vaccination rates for these groups remain significantly lower than for the general population. While last mile activities have had some success, barriers such as beliefs that COVID-19 is no longer an issue or that further vaccination is unnecessary have hampered efforts. Limited disaggregated data collection for COVID-19 vaccination of at-risk groups has restricted the ability to identify and follow up individual cases to ensure they complete a full course of vaccination. Meanwhile, UNICEF reported routine vaccination coverage dropped from 80% in 2020 to 50% in Indonesia in 2021 due to COVID-19.

2.3 MoH transformation agenda and restructure

In 2021, MoH established the Digital Transformation Office (DTO) to transform healthcare in Indonesia through data and technology. In the MoH there are more than 450 health information applications. At the puskesmas (community health centre) level, staff are required to input data into more than 70 different health information applications. Digitisation presents novel challenges for effective implementation, as puskesmas and health workers across the country have different levels of digital literacy and access to the internet. Currently, 700 puskesmas have no access to the internet, and 1,400 insufficient access. In February 2022, MoH undertook a major organisational restructure, including changes to some of the key departments that AIHSP works with. The restructure resulted in delays to some AIHSP activities, including work with public health laboratories and emergency operations centres.

2.4 Transboundary animal disease outbreaks

The implementation of AIHSP has been affected by major transboundary animal disease (TAD) outbreaks in Indonesia. First cases of lumpy skin disease (LSD) occurred in January 2022 and foot and mouth disease (FMD) in April 2022. This meant that government partners, such as the MoA, shifted priority to outbreak response over health system strengthening (HSS). A national emergency was

---

[13] Available at: https://www.thejakartapost.com/news/2020/04/03/indonesias-coronavirus-cases-may-reach-more-than-10 6000-by-july-according-to-spy-agency.html
[14] Available at: https://www.thejakartapost.com/news/2020/11/23/indonesia-surpasses-half-a-million-coronavirus-cases.html

announced for the FMD outbreak in June 2022 and a National Task Force under BNPB (National Disaster Management Agency) was established to coordinate the response. The GoI did not declare a national emergency for LSD, but the MoA did declare an outbreak of LSD which enabled the release of funds from their existing budget for an emergency response. Current legislation restricts provinces from receiving and storing vaccines until an outbreak has occurred.

On April 3, 2023, the government revoked the declared emergency status for FMD and announced the pandemic (epizootic) was over. The government also declared a joint task force of FMD and COVID-19 that will operate until June 2023.[15] It is too early to determine how this will impact implementation of the FMD response. In 2022, there were confirmed cases of rabies disease with cases of other diseases also reported including African swine fever (ASF), Brucellosis, Anthrax, Avian Influenza and Leptospirosis.

2.5   Visibility of a One Health approach

Indonesia demonstrated its leadership and commitment to health security at a global and regional level through promotion of a One Health (OH) approach during its Presidency of the G20 and has continued this during its Chairmanship of ASEAN in 2023.

2.6   Continued Australia-Indonesia health cooperation

In June 2022, Australia-Indonesia health cooperation and post COVID-19 support was reinforced by Prime Minister Albanese to Indonesian President Jokowi in the Indonesia-Australia Annual Leaders meeting. A Memorandum of Understanding on Health Cooperation between Australia and Indonesia was signed in 2022[16], and a Joint Plan of Action is in development.

See also 8.1 Future Considerations for future trends and developments that will impact on Australia's support for the Indonesian health sector.

---

[15] KOMPAS Daily, Monday 3 April 2023. *Pemerintah Cabut Status Darurat Penyakit Kuku dan Mulut* (kompas.com), accessed 6 April, 2023.
[16] Available at: https://kemlu.go.id/portal/en/read/3664/siaran_pers/joint-communiqu-indonesia-australia-annual-leaders-meeting

3. Mid-Term Review Findings

3.1 Progress against outcomes

KEQ 1.1: Are AIHSP intermediate outcomes (IOs) and EOPOs on track?

This section assesses AIHSP's progress towards its planned outcomes. The MTR Team used the AIHSP's Monitoring, Evaluation, Research, Learning and Adaptation Framework (MERLA) to assess this progress, noting that this might be revised. As UNICEF and WHO's activities are not part of this MERLA, their progress was described separately under each end of program outcome (EOPO) and were not included in the ratings, which were for AIHSP activities only.

The MTR Team assessed the overall progress of AIHSP as **good** for EOPOs 1.1 (health systems, community behaviours), 1.2 (surveillance) and 1.3 (emergency response) and **acceptable** for EOPO 2.1 (government coordination and One Health). The strength of evidence available to the MTR Team was strong for EOPOs 1.1, 1.2 and 1.3 and more inconsistent for 2.1. **AIHSP's progress against its intermediate outcomes and EOPOs is generally on track.** There has been demonstrable progress against 23 of AIHSP's 38 indicators (61 percent). Most of the progress is related to EOPOs 1.2 and 1.3 in the areas of surveillance, laboratory strengthening and disease outbreak response. The program used significant resources to respond to COVID-19 and the FMD and LSD outbreaks, and as such, its intended progress in strengthening health systems has understandably been mixed.

The MTR Team found that there was ample scope to elevate the focus on strengthening health systems in line with the original design for the remaining period of implementation. Accelerated implementation would be helpful. It is significant that in interviews, staff of the participating government agencies and partners of AIHSP frequently said that they expected AIHSP to expedite its implementation. There was evidence of a high level of trust between AIHSP and GoI partners. The maintenance of this trust depends upon several factors, including how comprehensively activities can be implemented according to plan, such as those activities that may have come to a standstill due to COVID-19 and responses to animal disease outbreaks. The rating key and progress summary are provided in Tables 3A and 3B respectively.

Table 3A: Rating key for the assessment of progress

Excellent	Good	Acceptable	Poor	Insufficient evidence	Too early to assess
Progress is evident on all indicators in thematic area	Progress is evident on at least 2 indicators	Progress evident on 1 indicator	No progress on any indicator	Insufficient evidence to assess	Too early to assess progress

Table 3B: AIHSP's progress ratings for the EOPOs in the MERLA

Outcome	Progress Rating
EOPO 1.1: Government regulations, systems and procedures, community behaviors and private sector practices are modified to reduce the incidence and impact of disease on animals and people. Human resources, health systems and public communications systems are in place.	Good
EOPO 1.2: Government decision makers are using reliable, representative, real-time information from a surveillance system that tracks targeted animal and human diseases and syndromes of concern and can detect emerging health threats.	Good
EOPO 1.3: Government, communities, and the private sector are able to mount an effective, proportionate, timely and well-coordinated response to detected and verified health threats. They jointly conduct after-action reviews and other learning activities, using the results for policy and planning.	Good
EOPO 2.1: All relevant government bodies to harmonise Prevent, Detect and Respond across sectors, between levels of government and with relevant non-governmental entities in a One Health approach, routinely using formal and informal means of information sharing and collaborative working.	Acceptable

3.1.1 Progress towards EOPO 1.1: Prepare and Prevent

AIHSP

EOPO 1.1. has two thematic outcomes, i.e., T.1 Puskesmas Strengthening and T.2 Control of Priority Animal Disease, as well as two cross-cutting outcomes related to (1) human resources capacity development in puskesmas and control of priority animal diseases; and (2) improvements in government communication, community engagement and public messaging related to T1 and T2. Under this EOPO, greatest progress was made in supporting the development and/or modification of government regulations or policy documents and control of priority animal diseases. Community behaviour change activities were ongoing, but activities under T.1 had not yet started and private sector activities were still at an early stage of delivery. Under the cross-cutting themes for EOPO 1.1, no learning events for puskesmas strengthening had yet been conducted, but there were training activities in One Health and risk communications held in some of the AIHSP pilot provinces and districts. While the evidence for this EOPO was generally strong, the degree of progress to date resulted in an overall **Good rating** for **EOPO 1.1.** *(see EOPO 1.3 for AIHSP's contribution to the FMD and LSD responses and EOPO 1.2 for progress on iSIKHNAS).*

AIHSP supported at least 13 regulatory and policy activities related to the improvement of health security in Indonesia. These included a contingency plan for LSD, the FMD Roadmap, National Animal Health Surveillance Guidelines (draft pending final approval), the National Action Plan for Improving Laboratory Capacity (in progress), Guidelines/SOPs for zoonotic diseases, and the Lombok G20 One Health Policy Brief. Most of these have yet to be implemented. At the sub-national and district level, COVID-19 behaviour change communication strategies were developed with AIHSP support.

AIHSP funded the National Health System Review (completed in March 2023) jointly in partnership with BAPPENAS to inform the formulation of the National Medium Term Development Plan (RPJMN 2025-2029) to be completed in 2024 and the National Long-Term Development Plan (RPJPN 2025-2045) to be completed in 2023 (Sept/Oct). This review considered whether to revise the Perpres 72/2012 regarding the National Health System (SKN).

AIHSP's contribution to the development of important policy documents represents a significant role in supporting the GoI's planning for future disease outbreaks, and reflects Australia's standing as a trusted partner. AIHSP could make a strategic choice on which policies it will continue to advocate for or support through to implementation, such as the FMD Roadmap. Consideration could be given to outbreak response for partnering to strengthensystems that support disease prevention and control.

Significant activity to strengthen capacity at a puskesmas level had been planned by AIHSP, including revised roles for primary health care and systems for referrals and planning, but few activities had commenced. Given there is a need to scale back, this could be an area where proposed activities are not progressed or are limited. It is noted that given the scale of the puskesmas workforce in Indonesia, the work of AIHSP would still need to be limited to pilot provinces with a view to being scaled up by the GoI. Planned AIHSP private sector activities were also at early stages.

WHO and UNICEF

WHO contributed to puskesmas capacity and guidance. In 2020-2021, WHO supported the development of 10 guidelines and built the capacity of primary health workers to deliver essential health care. WHO assisted MoH with a training curriculum to perform rapid diagnostic tests (RDTs). In 2022, UNICEF supported training for routine immunisations at puskesmas and posyandu as part of the National Child Immunization Month campaign.[17] WHO also supported the National Committee Management and Assessment of AEFI (Adverse Event Following Immunisation) to develop and disseminate AEFI and AESI (Adverse Effect of Special Interest) surveillance guidance. WHO more recently developed and disseminated key COVID-19 technical guidelines and FAQ for health workers. These documents were used by the health workers.

This improved capacity and guidance could continue to support the health system beyond COVID-19 and the current DFAT investment. In supporting the COVID-19 response, both WHO and UNICEF

---

[17] Posyandu (*Pos Pelayanan Terpadu*) is a service unit or post aimed to provide health care for maternal and child health, usually at the village and sub-village level.

were able to draw upon their knowledge of international developments, emerging COVID-19 good practice, vaccination and the Indonesian health system as well as pre-existing strong relationships with the GoI. Australia's choice in supporting these partners enabled it to effectively contribute the latest international expertise to extensive grass-roots support for Indonesia's COVID-19 response. This would have been difficult to achieve in a rapid time frame except through these partners, and as such the choice of partners was appropriate. For the remaining period of implementation, the focus should continue to be on supporting last mile vaccination of at-risk groups and embedding targeted puskesmas capacity for future disease outbreaks.

3.1.2 Progress towards EOPO 1.2 (Detect)

AIHSP

Considerable progress was made by the GoI with support from AIHSP in improving surveillance and laboratory systems, especially in animal health. More limited progress and results were achieved in human health surveillance. Under EOPO 1.2, there are two thematic outcomes, i.e., T3 Information and Surveillance and T4 Laboratories, and two human resources and communication related cross-cutting outcomes. The demonstrable progress in improving surveillance and laboratory systems, and the strong evidence of this, resulted in an overall **Good rating** for **EOPO 1.2.**

In animal health, AIHSP's work with the GoI on iSIKHNAS and iVLAB resulted in a more integrated system, enhanced early warning and reporting, and increased system security. MoA, the District Animal Office and Disease Investigation Centre (DIC) staff working with surveillance and/or laboratory systems in four pilot provinces were trained to update their skills in using the systems. More frequent reporting through iSIKHNAS (especially during the FMD outbreak) and use of iVLAB was noted by interviewees. This increase was also likely the result of the mandatory order made by the MoA to report through iSIKHNAS and to use iVLAB. Laboratories now have access to iSIKHNAS data which may improve case management and diagnoses. The UN Food and Agriculture Organisation (FAO) also contributed to this work.

Responses to recent outbreaks benefited from a more functional iSIKHNAS. Information from iSIKHNAS was used by the GoI (MoA and the National Task Force) during the FMD outbreak in 2022 to monitor spread of the disease and vaccination. iSIKHNAS picked up the first FMD cases relatively quickly. iSIKHNAS was also used by the MoA to monitor and report on LSD.

All DICs, specialist laboratories, Pusvetma, the National Veterinary Drug Assay Laboratory and Balitvet participated in the AIHSP-supported workshop and extension program run by the Australian Centre for Disease Preparedness (CSIRO-ACDP) on biosafety and biocontainment practices. DIC staff interviewed in Maros said the training had increased their knowledge but the MTR Team was unable to cite evidence of this training outcome. Support was also provided by CSIRO-ACDP to DIC Wates to develop gene sequencing and bioinformatics capability, resulting in increased testing capability.

Despite this progress, there were clearly areas that could be strengthened. The number of reported cases for FMD has decreased in recent months, with some provinces even reporting no cases. While this may reflect a decreasing disease incidence, it has also been associated with decreased use of iSIKHNAS in some areas, coupled with a reluctance by farmers to report cases and pressure for regions to achieve case eradication. Given this, it may be pertinent for AIHSP to continue to advocate for developing better evidence-based decision making based on more accurate disease data. Over time, this may encourage increased use of iSIKHNAS and align with AIHSP's plan to commence support for community-based surveillance.

In the area of human health, progress and results were mixed. Most of the planned activities for public laboratories had not yet commenced. Given the US and other donors are working to support public laboratories, and there is a need for AIHSP to scale back, this could be an area to discontinue. However, further analysis of the support from other donors would first be needed.

AIHSP's progress was more evident in human health surveillance work. The AIHSP-supported ASIK (My Health Application) and WhatsApp chatbot were mandated by GoI to record electronic data on the routine immunisation of children and non-communicable diseases (NCDs). ASIK has been accessed by 94% of puskesmas in Indonesia and has continued to strengthen surveillance and

facilitate MoH engagement with puskesmas to monitor national health data. How this progress will be used to shape MoH policy and improve the health of the population was not yet clear.

AIHSP supported the Secure and Interoperable Surveillance and Health Information System (SISHIS) with a pilot in two districts in Bali (Badung and Buleleng). The current phase of activity finished at the end of March 2023. The puskesmas staff interviewed said the application was helpful for monitoring health cases. SISHIS, however, has been costly to implement with little evidence of GoI's acceptance of it. A more thorough assessment of the effectiveness of this support will be needed, including its likelihood of being scaled up and the degree of GoI support for it.

In 2021, a prototype tool called PathSBeacon was developed by CSIRO to support whole genomic sequencing (WGS) and bioinformatic analysis that could be used for surveillance of future infectious diseases. This work has not been progressed or taken up by GoI. While piloting new tools is important, this shows that any support needs to be relevant for the GoI and that there needs to be the technical capacity and political will to proceed.

The progress of the interoperable One Health surveillance data exchange, known as SIZE, was slower than expected. AIHSP made a limited investment in SIZE, with support mainly provided by USAID and WHO. The GoI agreed for the data from iSIKHNAS to feed into SIZE. There was also a USAID-funded plan to feed the data from the Early Warning and Response System (EWARS) into iSIKHNAS. EWARS and Sehat Satli, the wildlife health surveillance system, are not operating in real time. Achieving one integrated human and animal health surveillance, the focus of EOPO 1.2, will not only need timely and good quality data collection, but also effective coordination and planning between institutions (MoH, MoA and MoEF), and collaboration between donor agencies supporting these systems. This could be one of the priorities for the remaining period of AIHSP implementation.

WHO and UNICEF

WHO and UNICEF made a significant contribution to surveillance and laboratory systems, especially as part of the COVID-19 response. A surveillance system using a sentinel approach was instigated in March 2021 and then rolled out with support from WHO. WHO also provided technical assistance to implement national SARS-CoV-2 genomic sequencing which successfully assisted with the early detection and control of Omicron cases. In 2021, UNICEF supported GoI in the finalisation and roll-out of a maternal perinatal death surveillance system. In 2022, UNICEF assisted the establishment of the RapidPro digital platform database for children who lost their parents/caregivers to COVID-19.

WHO supported at least 31,000 health facilities and 1,300 laboratories to perform COVID-19 antigen-rapid diagnostic tests (Ag-RDTs) and Polymerase Chain Reaction (PCR) tests. Australia also partially contributed to the WHO procurement of one million antigen-rapid diagnostic tests (RDTs). This resulted in a significant increase in testing rates. VAHSI funding also enabled WHO to provide external quality assurance support for COVID-19 diagnostics for 1,034 laboratories.

To a certain degree, the systems that have been strengthened by WHO and UNICEF are likely to be sustained over the short to medium term, with decreasing relevance and probably influence as the COVID-19 response transitions to routine health service delivery. WHO and UNICEF staff interviewed highlighted the need to sustain this capacity through more comprehensive systems strengthening activities. Continued support by AIHSP, WHO and UNICEF to GoI in COVID-19 transitioning will be important to ensure that gains made to the health system are translated for use with other diseases. That means improved workforce capacity will likely need further support, including reinforcement of the testing and tracing capacity at the puskesmas and local medical facility levels.

3.1.3   Progress towards EOPO 1.3 (Respond and Recover)

AIHSP

EOPO1.3 has one thematic outcome, i.e., T5 Emergency Preparedness and Response, with two cross cutting outcomes. AIHSP put considerable resources into COVID-19 and animal disease outbreak responses, including FMD and LSD. AIHSP did an outstanding job in responding to GoI requests for immediate assistance to these disease outbreaks and this was highly appreciated by the Government. Evidence of outputs for EOPO 1.3 was strong and these outputs have contributed to the current high visibility of Australia's health sector support. AIHSP's responsiveness and flexibility, along with progress against most of qualitative indicators, resulted in a **Good rating** for **EOPO 1.3**. As

this EOPO is focused on response, outcomes are expected to be more immediate and it is acknowledged that some but not all activities will result in long-term systems change.

Australia's contribution to the FMD and LSD responses was significant and included the procurement of a large quantity of vaccines, technical assistance and systems support. FMD was first detected in April 2022 with a national emergency announced by the GoI on 29 June. This announcement justified the formation of a National FMD Task Force under the National Disaster Management Agency (BNPB) and allowed access to emergency funds. By 1 July 2022, at least 22 of the 37 provinces in Indonesia were infected with FMD.[18] Australia quickly offered technical expertise and supplied four million vaccines in 2022. The contributions from Australia made a significant difference, especially in provinces such as Bali, where high vaccination coverage directly reduced the spread of disease. The MTR noted that the vaccination progress in Bali was expedited due to pressure related to the imminent G20 meeting. FMD vaccines supplied from Australia arrived in August. AIHSP supported vaccination training for FMD and LSD for 1,000 people in 24 districts in Bali and South Sulawesi, who then administered the vaccines.

Australia provided LSD vaccines early in the response (435,000 doses in total in 2022)[19].There are some parallels between the responses to LSD and FMD. Other donors appear to have been less involved than Australia in FMD and LSD control in Indonesia, and in the case of the recent outbreaks, the MTR Team assessed Australia's contributions as proportionate and appropriate.

In human health, AIHSP contributed to Indonesia's COVID-19 response mainly through the Last Mile project, risk communication and community engagement (RCCE) and development of Health Emergency Operation Centres (HEOCs). At the time of the MTR, a total of 263,559 men and women, including 39,350 elderly and 1,684 people with disabilities were vaccinated against COVID-19 by the Last Mile project, with considerable contribution from VAHSI and Quad funding. This was achieved by holding inclusive vaccination campaigns in some puskesmas and villages in four provinces, involving OPDs and women's groups in the design and implementation of RCCE *(see section 7 for more detail)*. These events were well attended. According to the government staff interviewed, this approach was replicated with government funding in other non-AIHSP districts.

There was some evidence that vaccination rates for people with disabilities and the elderly were higher in the areas supported by AIHSP than in other districts, although the evidence was not conclusive. However, the vaccination rates were still lower than expected. Reasons for this are explored in section 7 and include some reasons within the control of AISHP but many beyond its control.

In four AIHSP provinces, a provincial-level Health Emergency Operation Centre (HEOC) Response Plan was established with involvement of universities and OPDs. The plans included risk communication SOPs that outlined how to meet the specific needs of vulnerable groups. However, none of the four provinces had tested their HEOC Plan in an actual emergency response setting.

In 2021, AIHSP contracted CSIRO to complete two trials using big data for epidemiological modelling of human mobility in Jakarta and Bandung and monitoring of social media to determine COVID-19 transmission and economic recovery. These were considered pilots and how this work will continue is unclear. Unless there is a high likelihood that this work will be supported and used by GoI, discontinuation of this activity should be considered.

WHO and UNICEF

Contributions from WHO and UNICEF were instrumental during the COVID-19 response. WHO support was particularly significant in the areas of national planning and guidelines, authorisation of vaccines, testing, case investigation, contact tracing, vaccination, monitoring and conducting an intra action review and follow-up meetings. UNICEF's strongest support was in national planning, RCCE, developing the GoI's COVID-19 website and procuring and administering vaccines. Further description and analysis are presented in the COVID-19 response section 4.

---

[18] By end of January 2023, FMD cases had been reported in 27 provinces.
[19] Australia has announced that another one million doses of LSD vaccine will be delivered to Indonesia in the coming months.

3.1.4 Progress towards EOPO 2.1 (Coordinate)

AIHSP

Under EOPO 2.1, AIHSP promoted a One Health approach and established a multi-stakeholder forum with government agencies, civil society actors and other members of the community. AIHSP supported the G20 One Health Side Event, including the development of a policy brief which informed the Health Ministers' Action Plan to Strengthen Global Health Architecture declared in Bali in October 2022. In 2023, the GoI supported a similar declaration for ASEAN under its Chairmanship. At the national level, however, One Health remains at an early point of development, with questions remaining as to how it will be progressed and which ministry is coordinating One Health. Of the two thematic outcomes under EOPO 2.1, i.e., government coordination and pentahelix coordination, progress was still very much at the output level, with weak evidence of outcomes in One Health or multi-stakeholder engagement. This resulted in an **Acceptable rating** for **EOPO 2.1**.

AIHSP and multilaterals including WHO, OIE and FAO facilitated meetings with their GoI counterparts on the implementation of One Health and supported the refinement of related guidelines. AIHSP should continue to work with other relevant actors to promote the One Health agenda. For example, it could support Kemenko PMK in implementation of the recently developed Kemenko PMK Regulation No.7/2022 on the Zoonosis and Infectious Diseases Control Guidelines.[20] This could be done through identifying disparities between One Health regulations and their implementation.

In 2022, at the request from the MoH, a One Health Training of Trainers (ToT) for government staff based on MoH curricula was rolled out with support from AIHSP, WHO, FAO and USAID-Infectious Disease Detection and Surveillance (IDDS). AIHSP supported this ToT in four provinces. Several staff interviewed said their knowledge had improved and new relationships built as a result of training. The longer-term outcomes remain to be seen. The MTR notes that training often needs to be reinforced with ongoing support and follow-up training in order to bring about tangible change.

No formal government and private sector forum were established as per the AIHSP design. However, AIHSP commenced support for the establishment of the Veterinary Statutory Body (VSB) and public private partnerships with the Indonesian Veterinary Medical Association (IVMA). Formal regulations were being prepared.

Approximately 16 structures to promote multi-stakeholder collaboration and a One Health approach were established in the AIHSP priority provinces. However, there was limited evidence, at the time of preparing the MTR, of these structures implementing One Health in actual emergencies or for health security programming. The only instance was the rabies response in Buleleng, Bali which involved a joint response by different government (DHO, District Agricultural Office, village government) and non-government (traditional village council) actors. This resulted in the joint decision to mandate all puskesmas to be designated as rabies centres and expedited vaccination of dogs. More than 80% of dogs have now been vaccinated.

While acknowledging the difficulty of maintaining health emergency structures in non-emergency times, there are documents that explicitly describe how national actors can achieve this. Specifically, the Tripartite Zoonoses Guide (TZG)[21] provides countries with operational guidance and tools for the implementation of a multisectoral, One Health approach to address zoonotic diseases and other shared health threats at the human-animal-environment interface.

In Bali, AIHSP supported the TISIRA (Rabies Alert Teams), a community, village-based surveillance for rabies control. This was promising progress in community mobilization, as TISIRA teams reported helping strengthen cases reported and monitoring of rabies in their neighborhoods. In Buleleng district, local leaders instructed all villages to issue regulations to establish TISIRA. The monitoring role of TISIRA was considered important as this role was difficult for the DHO or the primary animal health care office (puskewan) to perform thoroughly by themselves due to a limited number of staff. Despite the momentum of this activity, the MTR Team noted an uneasiness among a TISIRA team that was interviewed due to the high number of official visits to their village and speaking invitations

---

[20] The Permenko delivers further guidelines for the implementation of the Presidential Instruction No.4/2019 on One Health.
[21] Available at: https://www.who.int/initiatives/tripartite-zoonosis-guide

arranged by AIHSP. At the same time, rabies had not been completely controlled in their village. This appeared to be placing undue pressure and expectation on the TISIRA and their village.

WHO and UNICEF

WHO and UNICEF contributed to working groups and a donor coordination forum for COVID-19 *(see section 4)*. WHO has long been an advocate for a One Health approach in Indonesia and worked with Australia on applying such an approach during phase 2 of AIP-EID (2015-2018). In 2021, WHO supported the MoH to develop a One Health training module and cascade the training on Joint Risk Assessment (JRA) to a sub-national level.

3.1.5 Monitoring, evaluation and learning (MERLA)

As the scope of AIHSP grew, the MTR Team understands it was a challenge to ensure MEL for the program kept pace. In using the current iteration of the MERLA, the MTR Team found that:

- The theory of change and results framework is complicated and difficult to use. The line of sight between all activities and results is not clear and reporting on the outcomes of activities was not always backed by clear evidence of causation and was prone to subjective measurement.
- Some of the qualitative indicators are duplicative and unclear. For example, there appears to be multiple indicators that measure the results for iSIKHNAS.
- The MERLA has 38 qualitative indicators and 19 KPIs (key performance indicators). This is a large number of indicators that are disproportionate for the size of the program. The number of indicators makes reporting burdensome and could duplicate or dilute progress and results.
- Sub-partners were not appropriately informed and resourced to monitor and report on activities, when assessed against the MERLA and the DFAT M&E Standards. This meant there was a risk of inaccurate reporting, including overstating or underestimating outcomes. It meant that the sub-partners were likely not sufficiently accountable for the funding received.

The MTR noted a revision of the AIHSP MERLA was in progress. The MTR Team noted that it is important the revised MERLA is commensurate with the size and complexity of the investment. It also noted that this is needed to reduce the reporting burden and to increase emphasis on reporting outcomes. The theory of change will need to be updated and simplified based upon the consolidation of activities for the remainder of this phase, and a narrative provided. Program monitoring will also need to be improved by AIHSP supporting its sub-partners to implement the MERLA, collect robust data that clearly demonstrate how activities contribute to outcomes and report in line with requirements in the DFAT M&E Standards.[22]

---

[22] A thorough assessment of the MERLA was not within the scope of the MTR. However, the MTR team can provide further MERLA feedback directly to AIHSP.

4. Contribution to Indonesia's COVID-19 response

4.1   Partners' contribution to Indonesia's COVID-19 response

KEQ 2.1: How have the DFAT-funded AIHSP, UNICEF and WHO activities contributed to Indonesia's COVID-19 response?

Australia's contribution to Indonesia's COVID-19 response was significant. However, it was not without its challenges. Despite targeted last-mile vaccination efforts, vaccination rates for the elderly and people with disabilities remain lower than expected, due to several factors beyond the control of the program *(see section 7 for more detail)*. CSIRO described its work in epidemiological modelling of the spread of COVID-19 to inform human mobility policy (funded by AIHSP) in Jakarta and Bandung as a 'proof of concept' exercise. It noted that further work was needed to refine the model and that due to time constraints, collaboration with Indonesian counterparts beyond sharing results was negligible. While piloting activities is a vital part of improving pandemic preparedness, it was unclear whether this activity would continue and whether the modelling would be refined to inform future disease outbreak management. Unless it is likely that this activity will be supported by GoI and used to inform decision-making going forward, discontinuation should be considered.

Many Australian-funded activities through AIHSP, WHO and UNICEF to support the COVID-19 response in Indonesia resulted in health system improvements that are likely to be sustained and used for the management of other diseases. These are detailed in section 5 *Strengthening Health Systems*. Australian-funded activities contributed to 17 out of 19 of the Technical Areas (TA's) in the GoI National Action Plan for Health Security Indonesia 2020-2024 (NAPHS), further evidence that the activities simultaneously supported emergency response *and* more sustainable strengthening of Indonesia's health security capability. This contribution to the NAPHS is also evidence of Australia's ongoing commitment to supporting the GoI's priorities in the health sector in Indonesia. Table 4 lists significant activities conducted by AIHSP, WHO and UNICEF in support of the GoI's COVID-19 response. These are grouped by NAPHS technical area, noting *not all* TAs supported have been included. A full list of AIHSP, WHO and UNICEF activities supporting the NAPHS is in annex 9.5 and activities that addressed the JEE recommendations in the NAPHS are described in annex 9.6.

Table 4: Examples of significant activities by AIHSP, UNICEF and WHO in support GoI's COVID-19 response by NAPHS Technical Area

National legislation/policy	IHR coordination/ communication	Reporting
• Developed COVID-19 policy guidance and training modules e.g. Ag-RDT use [WHO]	• Developed NDVP [WHO/UNICEF] • Co-chaired RCCE working group [UNICEF]	• Produced monthly situation reports [WHO]
Biosafety and security • Trained in biosafety for laboratories and DICs [AIHSP]	**Antimicrobial resistance** • Developed National Costed Roadmap for Hand Hygiene for All and National Task Force [UNICEF]	**Emergency response operations** • Supported Public Health Emergency Operation Centre and its dashboard [WHO]
Preparedness • Implemented vaccine readiness assessment and dashboard using VIRAT tools[23] • Modified RapidPro digital platform to identify children who lost parents due to COVID-19 [UNICEF]	**Laboratories** • Quality assured the COVID-19 testing laboratory network [WHO, AIHSP] • Supported 1,300 laboratories to do PCR testing [WHO]	**Workforce development** • Developed and disseminated COVID-19 technical guidelines and FAQ for health workers in all 34 provinces.
Surveillance • Developed and disseminated AEFI and AESI (Adverse Effect of Special Interest) surveillance guidance [WHO] • Developed an active surveillance system using a sentinel approach [WHO]	**RCCE** • Reached 53 million people with service messages, and to combat misinformation through social media and chat-bots [UNICEF] • RCCE to at-risk groups such as elderly and people with disabilities in 5 target provinces [AIHSP]	**Linking public health and security authorities** • Pulse Lab developed a risk assessment map to inform social mobility policy [AIHSP] • Developed guidelines on community-based isolation and quarantine [WHO, UNICEF]

---

[23] WHO's Vaccine Introduction Readiness Assessment Tool and the World Bank's Vaccine Readiness Assessment Framework (VIRAT/VIRAF 2.0)

Medical countermeasures	Immunisation	
• Supported FDA/BPOM issuing emergency use authorisation for COVID-19 vaccines [WHO]	• Implemented last mile COVID-19 vaccination, including for elderly and people with disabilities [AIHSP] • Trained health workers including in vaccine handling [WHO] • Facilitated delivery of 104M doses of COVAX COVID-19 vaccine [UNICEF]	

Australia has continued its support as Indonesia moves to a transition phase for COVID-19. According to the Australian Strategic Framework for Transitioning COVID-19 Measures, transition activities should include ongoing support to minimise the level of severe COVID-19 and death, continuing to promote the importance of vaccinations, consideration of scaling down, ceasing or continuing certain activities; returning to use of existing systems; and ensuring the capability of systems to respond to future waves.[24] Future pandemic preparedness, including multisectoral coordination that involves private sector and civil society, robust assessment of capacity against benchmarks set by the WHO and risk communication strategies, were also identified as priorities in other transition literature.[25]

Australia-funded activities supporting this transition include: the continued roll-out of last-mile COVID-19 activities for the vaccination of at-risk groups by AIHSP; WHO's support to the MoH for the COVID-19 surveillance transition plan including integrating COVID-19 into existing surveillance systems; AIHSP's support for a transdisciplinary One Health approach for Health Emergency Operations Centres at provincial level; UNICEF, WHO and AIHSP's ongoing work in RCCE; and AIHSP's plans for engagement at a primary health care level. These demonstrate that Australian support reflects good practice in transition and continued responsiveness to GoI priorities. A future Australian investment in the Indonesian health sector should continue to support GoI priorities in areas of Australian technical expertise. This could include improvements in surveillance, animal health laboratory systems and One Health that will be vital for responses to future infectious disease outbreaks.

---

[24] Australian Government 2022, *Strategic Framework for Transitioning COVID-19 Measures*, National Cabinet, available at: https://federation.gov.au/national-cabinet/media/2022-12-09-strategic-framework-transitioning-covid-19-measures
[25] The Independent Panel for Pandemic Preparedness and Response 2021, *COVID-19: Make it the Last Pandemic*, available at: https://theindependentpanel.org/

5. Strengthening health systems

## 5.1 Partners' contribution to Indonesian health systems strengthening

KEQ 2.2: How have the DFAT-funded AIHSP, UNICEF and WHO activities contributed to the strengthening of human and/or animal health systems and response to infectious disease outbreaks in Indonesia?

This section assesses activities implemented by AIHSP, WHO and UNICEF that have contributed to strengthening human and animal health systems (HSS) in Indonesia. The activities included emergency response activities that have simultaneously built longer-term capability. These activities are mapped to the building blocks in the WHO's Health Systems Framework[26] (Figure 1) to demonstrate how DFAT has contributed to holistic health system improvements.

For the purpose of this MTR, the WHO framework has been adapted to include One Health. Globally, the Quadripartite consisting of WHO, FAO, World Organisation for Animal Health (WOAH) and the United Nations Environment Programme (UNEP) has endorsed One Health and are working together to mainstream One Health to better prepare to prevent, predict, detect, and respond to global health threats and promote sustainable development. As such, at a national level, multisectoral One Health coordination is now a key component of strengthening health systems and has thus been included in the MTR's framework of analysis.

In mapping Australian-funded activities against the WHO's Framework, the MTR Team found that Australia's funding for COVID-19 as well as other health sector support had made a significant contribution to the strengthening of human and animal health systems in Indonesia in certain areas. The focus of HSS activities has been in the building blocks of service delivery, health information systems, One Health and health workforce, with less of a focus on leadership/governance and access to essential medicines and no focus on health financing (although this was planned and has been supported by Australia through work undertaken by the World Bank).

Figure 1: WHO building blocks of a health system with the addition of One Health
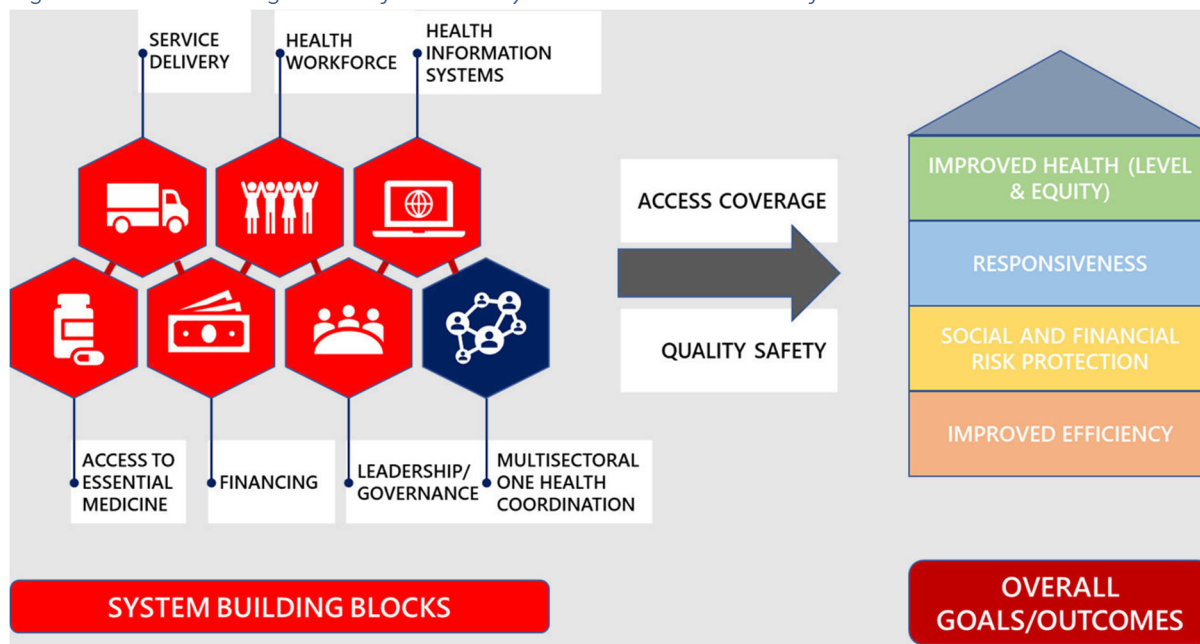
Under the service delivery building block, the main areas that Australia supported were in human and animal health surveillance and laboratory strengthening. Human health surveillance capacity was strengthened as a result of COVID-19, particularly in diagnostic capability, sentinel site surveillance, contact tracing and child protection. Work in animal health surveillance included integrating zoonoses surveillance platforms including iSIKHNAS under SIZE, although SIZE itself received greater support through WHO and USAID. Human health laboratory strengthening occurred for the COVID-19 response, including improved capability in PCR testing, WGS, investigation of AEFIs

---

[26] WHO 2010, *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies.*

and participation in external quality assurance. This capability developed for COVID-19 is transferable for use with other diseases and emergencies. However, there has been limited progress and mixed response to the integration of platforms under SIZE.

Under the health information system building block, Australia supported the continued strengthening of iSIKHNAS, including integrating iVLAB and a logistics management system. However, uptake of iSIKHNAS and timely data entry of all cases still needs to be improved. Australian support for human health information management systems centred on COVID-19, including data collection for vaccination and contact tracing. Australia also supported systems for monitoring disease outbreaks more broadly, including zoonoses, at a primary health care level.

Australia's support under the leadership and governance building block focused on long-term planning in health, digitalisation, national development and for specific animal diseases such as FMD through support to the development of the FMD Roadmap. While the digital transformation agenda is well underway, planning documents supported by AIHSP, WHO and UNICEF are still being finalised or are at early stages of implementation.

Most activity under the One Health building block was in establishing mechanisms for One Health collaboration at a sub-national level. Creating and formalising these mechanisms as well as lines of transdisciplinary communication are important early steps in adopting a One Health approach. How these mechanisms work to coordinate an emergency response is yet to be seen, except in the case of rabies control in Bali.

The service delivery, health information systems and One Health building blocks all included activities that contributed to strengthening the health workforce building block, including training, mentoring and other capacity and capability development. For example, training was conducted in many areas including in the use of iSIKHNAS and iVLAB, vaccination for FMD and LSD, laboratory biosafety, COVID-19 vaccine handling and One Health. Evidence of the outcomes of this training was more apparent in the responses to human and animal disease outbreaks than in other areas.

The MTR Team found that Australia has contributed to short-term, holistic strengthening of the health sector in Indonesia, with activities supporting most of the WHO's HSS building blocks. However, while many activities had provided immediate results in response to COVID-19, such as in surveillance and diagnostics, or were in their early stages such as the policy work, the onus is now on the partners to work with the GoI to translate these short-term improvements into sustainable, long-term changes to the health sector. As noted in the COVID-19 transition and HSS literature, this will require broadening of capability beyond COVID-19 to other diseases, integration of stand-alone COVID-19 processes into routine and pre-existing health processes and systems, follow through in implementation of policy reform and ongoing training, follow-up, mentoring, supervision and support to the health workforce. For the remainder of this phase and for the design of a new investment, this consolidation should be a priority, focusing on the comparative advantage of Australian partners in surveillance, animal health laboratories, health information systems, certain areas of policy reform such as the FMD Roadmap and One Health implementation.

6. Efficiency

6.1 Efficiency of partners

KEQ 3.1: Did increased funding impact the efficiency of AIHSP?

6.1.1 Expansion of AIHSP

AIHSP did a remarkable job in scaling up rapidly to respond to COVID-19 and the animal disease outbreaks in Indonesia. Its flexibility and responsiveness to GoI requests for assistance were highly appreciated by the government. AIHSP began as a AUD14million program in February 2020, and subsequently received additional tranches of funding through VAHSI for COVID-19 and to respond to LSD and FMD. This brought the total program budget to AUD31.5million during 2021-22. Since then, the program has continued to expand and the current program budget is AUD48 million (March 23).

Most of the additional funding was for emergency response and hence necessitated the rapid disbursement of funds in areas of work outside of the original AIHSP design. This was required of an organisational structure unprepared for managing and implementing the scale and nature of funding provided. According to evidence identified by the MTR, this unique set of circumstances came at a considerable cost. AIHSP's communication with GoI, its coordination with partners and the team managing activities were negatively impacted by the increases in funding and scope of work. According to AIHSP reporting, meeting minutes and DFAT, there was also delayed identification of an overspend of AUD700,000 (Feb 22 to March 23) due to delayed payments, late VAT submissions to GoI and inaccurate budget forecasting and planning by AIHSP. DFAT noted that the overspend was resolved by an additional AUD16.5million in top-up funding for the LSD and FMD response in January 2023 and AIHSP staffing has been strengthened to prevent further occurrences of this nature.

During that same period 2020-2022, the DFAT Health Team at the embassy in Jakarta, which consisted of 5 FTE, did not have adequate capacity to manage the number of agreements and amendments and rapid disbursement of funds that the tranches of funding required. This overstretched the Health Team and limited their ability to maintain oversight of grants and to communicate and strategically engage with the Indonesian Government. The specific implications for efficiency that the increased funding had for the AIHSP are described below. Opinions are attributed to organisations, types of organisations or other information sources in square brackets [] in this section only.

6.1.2 Contextual factors that impacted on efficiency

The MTR found that there were several contextual factors that are likely to have impacted on the efficiency of AIHSP including:

- The rapid succession of disease outbreaks (COVID-19, FMD and LSD) that needed to be managed concurrently.
- The multiple tranches of funding that needed to be rapidly disbursed.
- Political pressure from Indonesia and Australia to expedite the FMD response in Bali due to the imminent G20 meeting and risks to the beef industry in Australia.
- Limited donor coordination by GoI in the early stages of the COVID-19 response that is likely to have reduced efficiency and resulted in some duplication.
- Several GoI requests for AIHSP to expand into new areas of work.

These competing demands meant that optimal administration of agreements and oversight of programs by DFAT and efficient management of programs by AIHSP was not always possible. However, the MTR Team recognises that particularly during COVID-19, the conditions that DFAT and AIHSP were working under were extraordinary and it would have been extremely difficult to maintain efficient administration and management of all programming.

6.1.3 Resourcing by partners and within DFAT

AIHSP

AIHSP's management structure and human resourcing was designed to support a AUD14 million program which subsequently more than tripled in size during 2021-2023. There were 16 FTE staff working for AIHSP in Jakarta during 2021-2022 and no administrative staff working at a sub-national

level (only short-term advisors). However, much of the funding from VAHSI and for the animal health disease outbreaks was designated for programming only and therefore could not be used to increase resourcing for the administration and management of activities. The roll out of successive increases in funding put a significant strain on the AIHSP team [AIHSP reporting, AIHSP staff, DFAT]:

"This ongoing expansion placed a huge strain on AIHSP's very small management and administration teams." - AIHSP Annual Report 2022-23.

In late 2022, DFAT was finally able to provide funding to bolster the senior management, administration and MEL capacity of AIHSP, and administrative positions were recruited at the provincial level. AIHSP now has 46 full-time equivalent employees (FTEs) and 27 long-term but part-time staff/advisers; and several additional shorter-term STA staff/advisers. This includes 6 FTE in Bali (1 vacant), 8 FTE in Central Java, 8 FTE in South Sulawesi, 5 FTE in Yogyakarta and 3 FTE in NTT (2 vacant) (March 2023).

DFAT

The pressure on the DFAT Health Team in Jakarta to respond to disease outbreaks by rapidly identifying and negotiating agreements with partners, disbursing funding, coordinating with GoI ministries and managing investments created a significant additional administrative workload. This increased the risk of administrative error and reduced DFAT's ability to be able to adequately coordinate or monitor the activities of partners [DFAT – multiple][27]. This resulted in limited time for DFAT to engage with GoI, including strategic engagement, as well as to identify and capitalise on synergies between partners and with other DFAT programs [DFAT, partners].

UNICEF and WHO

As partners with a long-term presence in Indonesia, pre-existing good working relations with GoI, established emergency response mechanisms, a high level of technical capability among their staff and COVID-19 response planning developed in the early stages of the pandemic in close collaboration with the GoI, the choice by DFAT to fund these partners and the process for doing so was straightforward. DFAT funding enabled the partners to finance unfunded parts of their planning [DFAT]. Given the scale of their work, both WHO and UNICEF were able to readily absorb additional tranches of money as they became available and use them for implementing activities that were highly supportive of the COVID-19 response in Indonesia [DFAT, UNICEF and WHO reporting].

6.1.4   Timeliness of activities

A number of actors cited the flexibility and responsiveness of DFAT's support to the GoI for COVID-19, and for the FMD and LSD responses. This was appreciated by the GoI as well as WHO and UNICEF. DFAT's support enabled the partners to broaden the scope of their support [GoI, WHO, UNICEF].

As noted, AIHSP was able to rapidly pivot and scale-up activities for the COVID-19, FMD, LSD and other disease outbreaks. The multiple tranches of funding enabled AIHSP to allocate funding through the most relevant and available mechanisms at the time [DFAT]. However, there were challenges. For example, by the time reagents supplied by DFAT for ASF detection had reached Indonesia they had expired. According to information available to the MTR Team, this meant that the new LAMP test[28] could not be used, rendering DFAT's support ineffective. This delay in the supply of reagents was likely due to administrative processes for approving the import of diagnostic materials into Indonesia.

6.1.5   Process of implementation

A significant number of interviewees noted inefficiencies in the implementation of AIHSP during 2020-2022 that were likely, at least in part, due to its insufficient management and administrative capacity.

Scope and strategic direction: Some interviewees thought that the increased scope of AIHSP's activities meant that its strategic direction was unclear and that in the future, it risked: diluting its impact; not following through with scaling up pilot activities; or not having sufficient technical

---

[27] In sections 3.1 and 3.2, attribution of opinions is provided in brackets. DFAT and the partners (UNICEF and WHO) are named or referred to as 'partners', but other organisations are not. Instead, the type of organisation is provided.

[28] The ASF loop-mediated isothermal amplification (LAMP) test is a validated test that can be used as a point of care test for ASF in the field.

expertise to implement all activities [MoA, MoH, AIHSP, other actors]. One interviewee noted that AIHSP's strategic engagement with other actors in animal health was not very well planned. Its messaging they said was confusing and its governance reactive [partner, DFAT]. Another interviewee pointed to a mismatch between AIHSP's original design which was to strengthen a One Health approach and its focus instead on animal health disease outbreak response and human health and animal health programming [DFAT]. However, there has been some progress in the formation of One Health mechanisms at a sub-national level. While the response activities were needed and appreciated by GoI, the interviewee did note that AIHSP had been pulled in different directions and this had impacted on the original intent of its program.

Communication and coordination: Several interviewees noted that AIHSP and its sub-partners' communication and coordination with GoI, partners as well as other actors working in the same sectors could have been stronger. A few interviewees cited lack of involvement of relevant actors in AIHSP's detailed work planning or their lack of visibility of AIHSP activities, implying that there have been missed opportunities for receiving valuable input (such as for the National Health System review), identifying potential collaborations and/or programming complementary activities [GoI ministries, other donor, partners]. Another example cited was an AIHSP sub-partner's lack of coordination with district authorities for COVID-19 vaccination campaigns – resulting in increased community demand for vaccination but not enough vaccinators on duty to meet the demand [partner]. GoI interviewees noted that AIHSP could improve its coordination with government and visibility of activities at a national and sub-national level by holding regular meetings (which were appreciated when held) and through written updates. Further, they noted a disconnect between AIHSP's central-level plans and what was actually being implemented at a sub-national level [MoH, MoA]. A few actors noted duplication of activities as a result inadequate communication, such as in the work of FAO and AIHSP, the rabies response work by GoI and donors in Bali and Reconstra's initial work alongside the DTO's work on the integrated health data system Satusehat[29] [DAFF, GoI].

Grants: AIHSP noted that while using grants was a necessary and efficient mechanism for disbursing funding to sub-partners for emergency response activities, there were some drawbacks. There were limited requirements for accountability of funds and little incentive for sub-partners to provide information and reporting once they had received the funds. This was also observed by the MTR Team who found that several sub-partners did not provide evidence of the efficacy of activities, such as whether training had been used or research findings acted upon. More rigorous MEL and reporting from sub-partners and performance-based funding could be required going forward.

Payments and approvals: A few interviewees said that some payments and approvals from AIHSP had been significantly delayed [partner, sub-partner]. In one example, IEC materials developed by a sub-partner took months to be approved by AIHSP and could therefore only be used for a very short time before the project ceased. With extra staff hopefully such delays will be reduced.

Cross-program collaboration: A potential inefficiency observed by the MTR Team is that the programs managed by DT Global do not meet to identify and work on synergies and points of collaboration. They do meet to share information on programs.

6.1.6   Responsiveness to emerging needs of GoI
AIHSP has repeatedly responded to requests for support from the GoI beyond the scope of its original design, including for COVID-19, FMD, LSD, work in primary health care and improved surveillance for emerging infectious diseases at the wildlife interface. This has been highly appreciated by the GoI and signifies a level of trust and value that the GoI has placed in Australia [DFAT, MoH, MoA]. However, this has also set high GoI expectations and risks diluting the impact of AIHSP's activities.

"Expectations need to be managed, as AIHSP does not have the resources to be able to respond to all the requests coming in from GoI for further support." - AIHSP Annual Report 2022-23.

Going forward, the program will need clearer boundaries. Responding to GoI needs will need to consider AIHSP capacity and capability and will require DFAT to communicate to GoI when a request

---

[29] Since this report was initially drafted, Indonesia's COVID-19 contact tracing app PeduliLindungi has been transformed into the public health application called SatuSehat Mobile (April 2023).

isn't able to be met. Some interviewees suggested that AISHP should re-focus on core areas of health security where there is strong Australian technical expertise – such as surveillance, laboratory strengthening and in One Health. These core areas could be applied to reform of primary health care – which is central to the GoI's health transformation agenda and a key component of DFAT's new Partnerships for a Healthy Region. In contrast, the multilateral partners were generally well placed to respond to GoI requests in relation to COVID-19 and did so in multiple instances.

6.2   Implementation modalities

KEQ 3.2 Findings: Did mixed modalities impact the efficient delivery of responses to COVID-19 or other health security threats?

DFAT made a strategic and effective choice of modalities for the provision of support for COVID-19 and the animal health disease outbreaks from 2020 to 2022. Given the imperative for DFAT to respond quickly and at scale, and that it had a pre-existing health program [AIHSP] and agreements with WHO and UNICEF, DFAT's funding of these modalities for the disease outbreaks was arguably the only choices available. WHO and UNICEF played well-established and complementary roles in the COVID-19 response, which were informed by the latest international developments in the disease. Meanwhile, AISHP addressed additional technical needs, enabled clear Australian branding of activities and supported capacity gaps at a national level and in the five priority provinces. DFAT provided additional support through the World Bank, TGA and other partners. The combination of WHO, UNICEF and AIHSP for the most part worked well, with some instances where efficiency was negatively impacted. *See section 4 for more detail on the roles played by AIHSP, UNICEF and WHO in the COVID-19 response.*

6.2.1   Partner collaboration

WHO and UNICEF collaborated on several COVID-19 activities which contributed to the efficient delivery of the response and took complementary and mutually supportive roles in many areas. For example, they both contributed to the development and revision of the COVID-19 National Deployment and Vaccination Plan (NDVP) and associated technical guidance. They also both assisted the GoI to measure the country's preparedness for delivering COVID-19 vaccines using the VIRAT tool and to establish a VIRAT Dashboard. Prior to the COVID-19 vaccination rollout, WHO provided technical input into a vaccination acceptance study conducted by UNICEF (late 2020). WHO then supported the emergency use authorisation and UNICEF contributed to the procurement, administration and cold chain distribution of vaccines. WHO requested UNICEF's technical support for vaccination supervision, conducting a coverage survey, and for the behavioural and social drivers of vaccination survey. UNICEF led the technical development of information materials for COVID-19 vaccination, with WHO supporting their production and distribution. AIHSP also collaborated with WHO and UNICEF, working with WHO on the One Health training and One Health Side Event at the G20 in Bali and shared information with UNICEF through the RCCE Working Group.

In some instances, such as vaccinating the elderly for COVID-19 or maintaining health services for women during COVID-19, the partners played complementary roles. WHO and UNICEF worked at a national level by supporting guidelines and online platforms while AIHSP (and UNICEF) supported on-the-ground implementation. This demonstrates the efficacy of the modalities DFAT supported, where activities were mutually reinforcing by working at different levels of the health system.

6.2.2   Partner coordination with donors and actors

The partners collaborated with donors and implementing agencies in order to optimise response efforts and minimise duplication. AIHSP coordinated with the Fleming Fund, US CDC, JICA, USAID and others on improving surveillance/information systems, laboratory strengthening and emergency responses across human and animal health [DFAT]. AIHSP convened a series of donor meetings for the Reconstra survey on surveillance systems and piloting of SISHIS. AIHSP and JICA jointly conducted a training needs assessment, with JICA adding their provinces to the assessment.

There was some coordination with UN agencies on emergency preparedness and response. AIHSP collaborated with FAO and WHO on the development and delivery of MoH's One Health training. The Fleming Fund worked with Prevalensi to develop basic sample handling protocols in labs and to develop batch/AMR data handling/reporting functionality. AIHSP collaborated with FAO on the oral rabies vaccine trial in Bali, iSIKHNAS/epi training, linking iSIKHNAS with SIZE and the FMD and LSD

emergency responses. However, as noted in section 6.1.5 above, AIHSP's communication and coordination with other actors could have been stronger and likely led to inefficiencies.

DFAT/AIHSP (alongside USAID) initiated a regular donor coordination meeting for the Indonesian COVID-19 response, which was subsequently coordinated by the WHO. This enabled visibility and consistency in donor support for the GoI, as well as for UNICEF and WHO.

UNICEF co-chaired the RCCE Working Group with IFRC. This group included GoI, NGO, multilateral and other representatives with lines of communication from a national to a sub-national level. Multiple interviewees cited the effectiveness of this group in terms of sharing information and coordinating messaging. This messaging first addressed COVID-19 prevention and the 3M messaging for the public to wear masks, wash hands and socially distance. It later encouraged the public to get vaccinated. Coordinating this messaging optimised its reach and impact and minimised the potential for confusion caused by mixed messaging. However, it was noted, that despite this working group, there was still some duplication of activities [UNICEF].

6.2.3   Partners and DFAT

There were multiple examples of collaboration between the partners, DFAT and other DFAT-funded programs. This aspect of programming was effective and enabled DFAT-funded programs to leverage each other's strengths and amplify and/or expediate impact. AIHSP collaborated with PRISMA on mobile testing for ASF. AIHSP and PRISMA jointly provided LAMP equipment, training and protocols for validation and use. Together with the Indonesia-Australia Partnership on Food Security in the Red Meat and Cattle Sector (RMCP) and the private sector, AIHSP supported vaccines for the FMD and LSD outbreaks. With the Australia-Indonesia Partnership in Disaster Risk Management (SIAP SIAGA), AIHSP supported the development of emergency management systems for non-natural disasters. It also coordinated with the Australia Indonesia Partnership for Economic Development (Prospera), KOMPAK (Governance for Growth) and the Knowledge Sector Initiative (KSI) on health issues. With Prospera, a series of coordination meetings involving senior DFAT management were conducted to address potential partnership around primary health care strengthening and human resources reform to support the MoH. However, there were a few instances where coordination between DFAT-funded programs could have been improved, e.g. Prospera and AIHSP were both working with the MoH, which initially caused some tension and a lack of clarity for MoH [AIHSP].

UNICEF facilitated discussion between DFAT and the MoH over DFAT's commitment to deliver 10.2 million doses of Pfizer COVID-19 vaccines (which were subsequently not required) and also completed delivery of over 40,000 Australian-donated rapid antigen tests to Indonesia [UNICEF, DFAT]. WHO provided updates in regular meetings with DFAT and found these meetings helpful. WHO also provided weekly briefings to the ambassadors of US, Canada, Australia, UK, New Zealand during COVID-19 from mid-2020 to June 2022, and then fortnightly until November 2022.

6.2.4   Sub-partners

Sub-partner activities funded through AIHSP, WHO, UNICEF for the COVID-19 response were able to rapidly provide many types of support from a national to a village level across Indonesia. The scale and complexity of Australia's support through these sub-partners in a very short time was significant and effective. However, many sub-partner grants were short-term in nature and given the rapid roll-out and limited budgets, most did not build in evaluation of outputs and their intermediate outcomes. This was coupled with the limited capacity of DFAT to maintain sufficient oversight of activities. Thus, there is little evidence (apart from anecdotal) as to how effective many of these grant-based activities were and as noted earlier, there was reduced incentive for the sub-partners to report once they had received the funding. It is likely that some activities were ineffective or were not translated into the intended meaningful support for the infectious disease outbreak responses.

Some sub-partners appeared to be doing similar activities (e.g. RCCE) in different locations but were reinventing the wheel rather than learning from each other and capitalising upon each other's strengths. While partners were coordinating through the RCCE working group, implementation of many activities seemed to occur in isolation. This potentially led to inefficiencies as sub-partners were not able to learn from others' mistakes and capitalise on each other's strengths.

6.2.5 GoI partner coordination

Prior to COVID-19, Indonesia did not have a development partner coordination mechanism and as COVID-19 emerged, GoI coordination between donors and implementing partners was initially challenging [multilateral]. This was compounded by several changes in the GoI management structure. The COVID-19 Handling Task Force (*Satuan Tugas Penanganan COVID-19*] at a national level and sub-national taskforces helped to improve coordination among actors involved in the response, including across sectors, and led to increased efficiency and reduced duplication. WHO supported the national taskforce and this assisted partners with efficient implementation.

WHO also supported and participated in Indonesia's Intra Action Review of the COVID-19 response conducted in August 2020 and subsequent IAR monitoring meetings in November 2020, February, April and August 2021, and February and November 2022. This IAR and the subsequent meetings encouraged greater coordination at a national and sub-national level [WHO).

7. Targeted community groups

KEQ 4.1: Are the programs contributing to aspects of the health system that will likely result in improved health outcomes for a) women and girls b) people with disabilities c) the elderly? D) other at-risk groups? How?

Gender, sex, age, disability, ethnicity, geographic location and other factors can impact people's risk of disease burden.[30] During 2020-2023, and particularly during COVID-19, groups considered more at risk of negative health outcomes in Indonesia included women and girls, people with disabilities, the elderly, children, youth, refugees and those living in remote areas. This section focuses on the first four of these groups based on partner activities and the evidence available.

7.1   Context

Approximately half of the population (49.6%) in Indonesia is female.[31] A gender analysis[32] conducted by AIHSP in the initial four priority provinces (Central Java, Yogyakarta, South Sulawesi and Bali) found women carried a heavier burden than men in managing both household duties and employment, indicating a need for flexible access for women to health services. All locations noted that women had challenges accessing health care. A high proportion of women played a role in decision-making about their health care in all four provinces, indicating that health care messages targeting women only could be effective. However, generally limited access to the internet for women across the provinces, except Yogyakarta, demonstrated the need for multimodal communication. Violence against women and children was a concern in all four provinces and globally such forms of violence have intensified since COVID-19.[33]

Approximately 14.2% of Indonesia's population have a disability.[34] The WHO estimates that 16% of world's population live with some form of disability.[35] Disability data is not systematically collected by the health system in Indonesia, and hence it is largely non-existent or very limited.

Approximately 10.7% of Indonesia's population is elderly.[36] A significant proportion of elderly people and people with disabilities are yet to be vaccinated with their third COVID-19 dose. According to a few interviewees working at a district level in South Sulawesi, there is still significant resistance to vaccination among the elderly and people with disabilities, as these groups and others believe that COVID-19 is no longer an issue, they confuse other vaccinations with those for COVID-19, and/or they are prone to believing vaccine hoaxes. Intermittent supply of vaccines, limited capacity of health care workers to promote vaccination, lack of understanding of educational information, negative attitudes of local leaders to vaccination and reaching at-risk groups in remote areas have also been issues for achieving sufficient last mile vaccination of the general population.[37]

Children are particularly vulnerable to the impacts of COVID-19. The socio-economic impact caused an increase in child severe wasting due to the deteriorating quality of diets and interruptions in nutrition and other essential services. Violence against children intensified. UNICEF reported that routine vaccination coverage dropped from 80% in 2020 to 50% in 2021 due to COVID-19.

7.2   Overall progress on gender equality, disability and social inclusion

AIHSP's GEDSI Strategy has two tracks – the first track aims to mainstream GEDSI issues and the second track delivers specific activities to better understand and address gender inequalities, disability and social exclusion related to health security. The MTR found that AIHSP had implemented some activities in the Strategy that reflected both tracks and had responded to

---

[30] Australian Government Department of Foreign Affairs and Trade 2023, *Partnerships for a Healthy Region: Gender equality, disability and social inclusion (GEDSI) and First Nations Engagement - Guidance note,* available at:
https://indopacifichealthsecurity.dfat.gov.au/sites/default/files/2023-02/DFAT%20Partnerships%20for%20a%20Healthy%20Region%20-%20GEDSI%20and%20First%20Nations%20engagement%20Guidance%20Note.docx
[31] World Bank 2021, Population, female (% of the total population) – Indonesia, available at:
https://data.worldbank.org/indicator/SP.POP.TOTL.FE.ZS?end=2021&locations=ID&start=1960&view=chart
[32] AIHSP 2021, Gender Equality, Disability, and Social Inclusion Strategy 2021-2024.
[33] UN Women 2023, The Shadow Pandemic: Violence against women during COVID-19, available at:
https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19
[34] National Socioeconomic Survey – SUSENAS, 2018.
[35] World Health Organisation 2022, *Global Report on health equity for persons with disabilities,* available at:
https://www.who.int/publications/i/item/9789240063600
[36] Badan Pusat Statistik - Central Statistics Bureau, 2020.
[37] AIHSP 2023, *Last-Mile COVID-19 Vaccine Delivery Project - Report of the Pilot Phase.*

inequalities found in their gender analysis, while other activities had not yet been actioned. For example, the Strategy includes work to ensure GEDSI-disaggregated data is included in information management systems, and evidence of this was not identified by the MTR. By contrast, there was clear evidence that AIHSP-supported RCCE for COVID-19 had been designed and implemented by provincial-level women's groups and OPDs to meet their needs. Given that this is a mid-term review, it is expected that only some of the planned activities in the Strategy would have been completed.

In general, AIHSP, WHO and UNICEF's work in inclusive service delivery was one of the primary strengths of DFAT's health funding from February 2020 to March 2023. This involved meaningful participation by community group members including women and people with disabilities in the design and implementation of RCCE materials and events encouraging at-risk groups to be vaccinated for COVID-19. There are some concrete examples of tangible differences to the health outcomes of these groups as a result of these activities. For example, the coverage of the third COVID-19 vaccine dose in the elderly increased three-fold in Central Java and South Sulawesi over an 8-9 month period. As of January 2023, vaccination coverage rates in 13 out of 14 AIHSP districts had outperformed non-supported districts among the elderly in South Sulawesi.[38,39]

However, there was little to no evidence in AIHSP's reporting of the outcomes of some activities. For example, it was unclear whether encouraging women to be vaccinated for COVID-19 actually contributed to increased vaccination rates or whether training of government partners resulted in improvements in practice regarding gender equality.

There were some early, positive signs of inclusive service delivery outcomes being sustained, such as the South Sulawesi government replicating the inclusive approach to RCCE in all other districts in the province. In another example, AIHSP sub-partner ID.COMM worked with government and community groups to develop a guidebook for conducting inclusive vaccination events and risk communication campaigns for local governments. This guidebook addresses the needs of the elderly and people with disabilities. The guidebook could enable the learning from AIHSP's inclusive vaccination events to be replicated beyond the five provinces and translated to other health service delivery. During the interviews, the MoH expressed an interest in AIHSP sharing its approach with the ministry. However, it was unclear how widely this guidebook had been disseminated or used.

While during an emergency, monitoring of outcomes is challenging, AIHSP should improve its MEL reporting of GEDSI outcomes. AIHSP's employment of a GEDSI Advisor and GEDSI Coordinator, evidence of allocation of resources to specific activities addressing GEDSI and a GEDSI budget line item in later reporting demonstrate a commitment by AIHSP to adequately resourcing GEDSI.

7.3   Gender equality

From 2020 to 2022, AIHSP, WHO and UNICEF all addressed gender equality through targeted activities. AIHSP focused on improving women's access to COVID-19 vaccination, promoting awareness of rabies among women and involving transgender and women's organisations in design and delivery of activities. Sub-partner gender-specific activities provided guidance for isolation and informed health emergency preparedness coordination and interpersonal communication capacity building for government partners in infectious diseases including COVID-19. These activities demonstrated a gender mainstreaming approach to programming (track one of the GEDSI Strategy) and used targeted activities (track two). This approach was reinforced by AIHSP through monthly GEDSI training for staff to incorporate a gender lens into programming and administration. However, as noted above, there was little available evidence that these activities resulted in their intended outcomes, such as changes in behaviour of women in response to the rabies communication.

UNICEF's work yielded some effective results. It collaborated with the Indonesian Breastfeeding Mothers (AIMI) and Fathers (AyahASI) Associations to support MoH in establishing the first-ever national online platform to report violations against the International Code of Marketing of Breastmilk Substitutes. Since the platform's launch, 926 verified cases of Code violations were reported by the public. These were compiled and shared with MoH and the Food and Drug Association for follow-up action (2021). Also in 2021, UNICEF provided technical support to finalise

---

[38] MoH 2023, *Vaccination dashboard data*, March.

[39] The focus on results for the elderly is partly due to the fact that COVID-19 vaccination data was disaggregated for this group, but not for other at-risk groups including people with disabilities.

antenatal care guidelines which led to an increase in the average number of antenatal contacts from four to six visits. This helped to maintain maternal and newborn services during COVID-19.

From 2020, UNICEF ensured that over 2.7 million women and children remained connected to critical basic health services during COVID-19 including pre- and postnatal care, medical care for childhood illnesses and life-saving vaccination. In 2021, UNICEF supported GoI to finalise and roll out a system for maternal perinatal death surveillance. However, the MTR Team did not have access to health service data to be able to verify how effective the basic health service activities had been nor how widely the surveillance system had been used.

In 2020, UNICEF teamed with Yayasan Teman Baik (Friends International – Indonesia or YTB) to train civil society staff in gender-based violence (GBV) risk mitigation and protection from sexual exploitation and abuse (PSEA). These staff then trained 6,000 frontline volunteers, health providers, psychologists and teachers working with children and other at-risk groups. WHO collaborated with UNIFEM and UNFPA to develop the RESPECT tool to combat violence against women. However, the MTR Team did not find causal evidence that this tool and the training had translated into improved risk mitigation and protection from GBV for women in Indonesia.

It is possible that at least some of these activities, such as the platform for reporting breastmilk substitutes, the antenatal care guidelines and the RESPECT Tool might continue to be used beyond this program. This will require ongoing monitoring of the guidelines and promotion of the platform and tool. Training will need to be followed up, repeated and supported. The MTR encourages reporting by the partners on the outcomes of these activities and how they will be sustained.

7.4   People with disabilities

From 2020 to 2022, a key strength of AIHSP's programming was the promotion of meaningful involvement of people with disabilities in health activities. In 2022, AIHSP ran planning workshops and training in South Sulawesi for OPDs and district and provincial health offices on developing disability inclusive approaches to COVID-19 vaccinations. AIHSP ensured input from OPDs in every risk communication activity. This included co-development of knowledge products and train-the-trainer for people with disabilities to train peers in COVID-19 health promotion. As a result, risk communication materials produced by government agencies and other partners were more inclusive. OPD representatives interviewed in South Sulawesi confirmed that the knowledge products they designed were accessible for people with disabilities and that their role as peer trainers in health promotion for COVID-19 was appropriate and effective.

The workshops and involvement of people with disabilities resulted in disability inclusive COVID-19 vaccination events which increased the proportion of people with disabilities being registered and vaccinated (AIHSP). AIHSP reported that a total of 1,684 people with disabilities were vaccinated against COVID-19 through the AIHSP Last Mile project and with VAHSI support (March 2023). While this is commendable, this likely represents a small proportion of the population of people with disabilities in the targeted districts.

AIHSP's approach to disability inclusiveness in the COVID-19 response appears to have been meaningful and systematic. There is the potential for longer-term outcomes from this work. As AIHSP supported the registration of people with disabilities alongside vaccination, this will assist those registered with future access to health services. AIHSP's activities have likely improved the capacity of people with disabilities as well as government offices to take a disability inclusive approach to future social and behaviour change activities in health. However, this will require follow-up and support during the remainder of the program to be sustained.

Despite these significant achievements, AIHSP sub-partner targets for COVID-19 vaccination for people with disabilities were not met. For example, Central Java PMI had a combined vaccination target of 144,000 elderly and people with disabilities for Central Java and IKM-IKK Unhas had a combined target of 50,000 elderly and people with disabilities in Maros (South Sulawesi).[40] By January 2023, only 21,142 elderly and 229 people with disabilities were vaccinated in Central Java; and 1,386 elderly and 45 people with disabilities in Maros. According to several interviewees, this is for the reasons outlined in section 7.1 and are largely out of the control of the program. However,

---

[40] This target was calculated from the National and Provincial COVID-19 Vaccine Dashboard.

AIHSP reported that partners need to strengthen their approaches to reaching people with disabilities and the elderly. Targets are also likely to have been overestimated, given limited district capacity. This points to the need for improved support by AIHSP for last mile vaccination.

Another challenge is the limited disability data available. COVID-19 vaccination and other health service delivery data is currently not disaggregated for people with disabilities. This makes it challenging for local authorities to locate and follow-up people with disabilities who are still in need of COVID-19 vaccination and more generally, for national and sub-national planning to accurately identify, monitor and address the health needs of people with disabilities. This is a systemic issue that needs to be addressed at a national level. AIHSP could advocate alongside WHO, UNICEF and others for disability data to be collected for health service delivery.

UNICEF implemented a limited number of activities to address disability inclusion. In developing the GoI's official COVID-19 website <covid19.go.id>, UNICEF ensured that it was accessible for people with disabilities. UNICEF also advocated for a field for disability data in the COVID-19 PeduliLindungi mobile app which at the time of the MTR was to be included. However, there was no evidence available to the MTR Team on how and if this data was subsequently used.

7.5   The elderly

The elderly was an early priority group for COVID-19 vaccination in Indonesia and as such, partner activities focused on this. WHO developed guidance for GoI for vaccination of population groups including the elderly. Meanwhile, UNICEF (2022) provided technical expertise for the roll-out of booster doses, initially prioritising the elderly, front-line workers and other at-risk groups.

AIHSP and UNICEF worked to ensure accessibility of the vaccine for elderly people in priority provinces. They took an effective, complementary approach. A total of 39,350 elderly people were vaccinated against COVID-19 through the AIHSP Last Mile project and with VAHSI support (March 2023). The tangible outcomes of this work are noted in section 7.2.

However, AIHSP supported activities to vaccinate the elderly fell short of AIHSP and GoI targets for the reasons outlined in section 7.1 and only took place in a limited number of districts and provinces *(see section 7.4 above)*. Further work will be needed to increase vaccination rates among the elderly for the remainder of the program. However, in only working in four to five provinces, AIHSP's impact on elderly vaccination rates in Indonesia will be nonetheless limited.

7.6   Children

UNICEF played a critical role in offsetting the damaging secondary impacts of COVID-19 on children in Indonesia. It supported the Ministry of Women Empowerment and Child Protection (MoWECP) to identify children who lost their parents/caregivers due to COVID-19 using the RapidPro digital platform. A total of 1,026,661 persons (330,803 children, 695,858 caregivers), including 472,264 girls and women, were reached with targeted mental health and psychosocial support (MHPSS) messages. Front-line workers and government officials were trained in child protection and psychological first aid (PFA) by the WECP Provincial Office (2021).

UNICEF supported MoH to promote the catch-up of routine vaccination. In 2022, 26 million children had received a catch-up dose of the measles-rubella vaccine. UNICEF trained more than 1,600 community health volunteers and 5,640 parents/caregivers nationally on home-based early detection of child wasting. More than 16 million people were reached with nutrition messages.

In combatting violence against children which increased during COVID-19, UNICEF and CSOs in Central Java and East Java trained social workers, government officials and others on positive parenting, PFA, how to identify vulnerable groups and how to prevent and manage child victims of violence and child marriage. This support reached over 100,000 girls and boys with improved child protection and welfare services through early detection and referrals for child protection cases.

As much of UNICEF's reporting was centred around training and messaging, it would be useful to understand the longer-term outcomes of such activities on child mental and physical health.

8. Future Considerations and Recommendations

8.1 Future considerations

This section outlines key developments and trends that need to be considered in Australia's future support for the health sector in Indonesia. These provide the context for, and have informed the MTR recommendations.

8.1.1 Australia's strategic direction

Australia will release its new Development Policy in the coming months. It recently launched its Partnerships for a Healthy Region (PHR) initiative (2022-23 to 2026-27) which outlines Australia's regional priorities for development aid in health. Thematic priorities in communicable disease control include, but are not limited to, infection prevention and control, surveillance, emergency operations and laboratory strengthening. Higher priority will be given to programming related to health information systems, community-based disease prevention and preparedness, immunisation and vaccine risk communication. Non-communicable diseases has also been included as a priority. Cross-cutting priorities include One Health, climate and environmental change, gender equality, disability and social inclusion and First Nations perspectives.[41]

8.1.2 Indonesian elections

The Indonesian elections will decide the country's president, vice president, People's Consultative Assembly (MPR) and members of local legislative bodies at a provincial and district level. The election will be held on 14 February 2024 and inauguration in Oct 2024. This will impact current aid programming decisions by donors and will influence this phase of programming for partners as well as the design context for AIHSP, including whether policy/legislative work can be completed.

8.1.3 Indonesia's strategic direction

Indonesia's new Medium-Term Development Plan (2024-2029) and its Long-Term Development Plan (2025-2050) will inform the Indonesia's future development priorities. Strengthening health systems emerged as a priority out of the sectoral review conducted by BAPPENAS for health which will inform the plans. A new JEE will be conducted this year, which might also impact Indonesia's strategic direction in health security.

8.1.4 One Health

Indonesia has embraced a One Health approach and has increased its engagement in a range of activities that bring together various sectors involved in human, animal and environmental health, including the wildlife sector. The major emphasis has been on establishing multisectoral mechanisms largely consistent with the principles outlined in the Tripartite Zoonoses Guide.[42] Three operational tools were developed to support national GoI staff in these efforts and Indonesia was one of the first countries in the region to pilot some of these tools. In addition, Indonesia has demonstrated its leadership in One Health in the region by hosting a One Health side event at the G20 in 2022 and promoting One Health during its Presidency of ASEAN in 2023. However, these are early steps in a much longer journey to apply a whole One Health approach in Indonesia.

8.1.5 Australia's work with GoI

Australia's bilateral health program currently has Subsidiary Arrangements with the MoH and MoA, which will need to be renewed soon. Other Australian programs have arrangements to coordinate with one or two other ministries and there are many options for doing so. Kemenko PMK (Ministry for Human Development and Culture) monitors the implementation of Presidential Instruction No.4/2019 on One Health and the subsequent Permenko PMK Regulation No.7/2022 on the Pedoman Pencegahan dan Pengendalian Penyakit – Disease Prevention and Control Guidelines for Zoonoses and Infectious Diseases. MoHA has responsibility for primary health care at the posyandu level, while MoEF is involved in the wildlife interface and One Health disease surveillance as well as climate change/land use and health alongside other ministries. BAPPENAS (Ministry of National

---

[41] Australian Government Department of Foreign Affairs and Trade 2023, *Application Guidelines for Regional Health Partnerships,* available at: https://indopacifichealthsecurity.dfat.gov.au/strategic-partnerships-projects-call

[42] Tripartite, FAO-WHO-WOAH. (2019). Taking a Multisectoral, One Health Approach: A Tripartite Guide to Addressing Zoonotic Diseases in Countries.

Development Planning) is responsible for Indonesia's national development plans. These ministries are likely to be relevant to Australia's future support to the Indonesian health sector.

8.1.6   The health transformation agenda

The MoH has been implementing a radical transformation of the health sector in Indonesia which is being progressed through an imminent new loan between GoI and the World Bank. A new Multi-Donor Trust Fund will support the roll-out of this loan. The reform agenda includes a shift in focus to: primary health care including tripling the number of puskesmas; building more hospitals; health worker and health technology transformation; health financing; increasing domestic drug manufacturing capacity in active ingredients, medical products and vaccines; and a reorientation of focus from treatment to prevention. In relation to primary health care, future Australian support could involve areas of technical strength such as community-based surveillance or district and puskesmas-level laboratory strengthening. Such support would require working with the Ministry of Home Affairs, which is responsible for posyandu-level health care. The MTR Team notes the importance of the current development of an Omnibus Health Bill that will potentially bring sweeping changes to the health sector in Indonesia.

8.1.7   Geographic spread

AIHSP-funded activities have concentrated in the Eastern provinces. There is significant unmet need in the Western provinces, particularly Western Sumatra as a key entry point for animal infectious diseases.

8.1.8   Animal vaccine procurement and operational support

Australia has supported several animal health disease outbreaks in Indonesia with emergency supplies of vaccines. For the remainder of this phase of AIHSP, and for a new investment in health, there is likely to be emphasis on health systems strengthening. Generally, Australia has limited its operational support to the supply of consumables, vaccine distribution planning and training of vaccinators. Some provinces and districts have funded operational support for animal vaccines. As with vaccine procurement, any future consideration of this area should factor in models that are sustainable.

8.1.9   Animal vaccine production

Globally, multinational companies produce many animal vaccines. DAFF has previously hired a technical consultant to scope out what would be needed for Pusvetma (Directorate General of Livestock and Animal Health) to improve its vaccine production. The MoA is interested in increasing Pusvetma's capacity to manufacture vaccines, including for FMD. It is understood by the MTR Team that considerable infrastructure support and the involvement of private enterprise would be needed, and FMD vaccines are difficult to produce. Substandard vaccine production could risk rapid loss of the trust of farmers in domestically produced vaccines. There is interest by other donors in building local vaccine manufacturing capacity.

8.1.10   Digital health transformation

The DTO's implementation of the Digital Transformation Agenda will continue for the remainder of the current phase of AIHSP and beyond. According to the DTO, in 2023 the focus will be on the implementation of integrated healthcare and focuses will include puskesmas and hospitals. In 2024, the information systems of integrated health facilities will be expanded, and laboratories, clinics, pharmacies and more primary health care facilities will be integrated. Beyond 2024, the DTO will look to integrate animal health and non-communicable diseases. This digital transformation will need to be supported with strengthened capacity in governance, human resources and training to improve digital literacy to the village level, processes that will take time to achieve.

8.1.11   Regional surveillance network

The ASEAN Centre for Public Health Emergencies and Emerging Disease (ACPHEED) surveillance and risk assessment pillar will be based in Indonesia. Future Australian support in areas such as surveillance and laboratory networking should consider collaboration, alignment and potential integration with ACPHEED.

8.1.12 Infodemic management

RCCE and infodemic management in human health will continue to be important in Indonesia, including in the lead up to the elections. Since COVID-19, the number of actors working in this space has expanded significantly, and include UNICEF, PMI, USAID, World Bank, Gavi and Johns Hopkins.

8.2 Recommendations for the Current Phase of Activity

KEQ 5: What does the Mid-Term Review findings suggest for DFAT's future assistance to the health sector in Indonesia?

The following outlines two sets of recommendations. The first set of recommendations is for existing AIHSP, UNICEF and WHO programming. This programming was set to continue until January 2025, but if the MTR recommendation to extend is adopted, then these recommendations apply to AIHSP until January 2026, and UNICEF and WHO until 2025. A January 2026 end date is assumed in all of the following recommendations for AIHSP, so the second set of recommendations is for a new phase of Australian-funded bilateral programming commencing in February 2026. These recommendations are given time and priority ratings to assist with the design of the new phase. All recommendations should be read in conjunction with *8.1 Future Considerations* section above and changes to activities should only be implemented following further assessment of: the geopolitical context, impacts on target populations, implications for partners and sub-partners, potential for future scale-up of pilots, risks and the work of other actors.

The following recommendations are for existing programming by AIHSP, WHO and UNICEF .

1. Consolidate and embed project activities
AIHSP to continue implementing activities related to **surveillance and information management systems, animal health laboratory strengthening, inclusive access to health care,** targeted support for **animal health disease outbreaks** and a **One Health approach**.

AIHSP to assess and consider discontinuing or no longer commencing activities in public health laboratory strengthening, health emergency operations centres (but continue support to One Health approaches)**,** RCCE, private sector collaboration (except continue for emergency response) and pilots such as SISHIS, CSIRO's epidemiological modelling of human mobility, PathSBeacon and Reconstra. AIHSP to consider limiting planned activities in puskesmas strengthening.

AIHSP to transition activities to be discontinued during this phase. To contribute to post-COVID-19 transition, AIHSP to also consider the balance between health systems strengthening and emergency response activities *(see section 4.1)*.

In 2023-2024, partners to improve national and sub-national capacity at a technical and managerial level and support finalisation and implementation of policies, legislation, strategies and guidelines given the period of uncertainty around the elections in 2024.

2. Strengthen laboratory capacity
AIHSP, through CSIRO-ACDP and others, to continue to support animal health laboratory strengthening in alignment with Kemenko PMK's Guidelines for the Prevention and Control of Zoonoses and New Infectious Diseases[43] *(see section 8.1.5).*

WHO to continue to support human health laboratory capacity for COVID-19 and transition this capacity for use with other diseases, including for tracing and testing capacity at the puskesmas and local medical facility level.

3. Continue to strengthen human and animal health information systems and surveillance
AIHSP to support:
- Integration of human health surveillance information systems;
- Development, uptake and timely reporting into iSIKHNAS, linking it with Identik PKH;
- Approval of regulations for animal identification and traceability;
- Information integration, including for iVLAB into iSIKHNAS;

---

[43] The issuance of Permenko PMK No. 7 of 2022 is the implementation of Presidential Instruction No. 4 of 2019 concerning Capacity Building in Preventing, Detecting, and Responding to Disease Outbreaks, Global Pandemics, and Nuclear, Biological, and Chemical Emergencies.

- Integration of human and animal health surveillance systems, involving coordination with MoH, MoA and MoEF and collaboration between donor agencies;
- Development of animal health surveillance guidelines and diagnostics capability in collaboration with CSIRO-ACDP and DFAT's Centre for Health Security.

WHO to continue supporting the roll out of sentinel site surveillance for influenza and novel viruses *(see section 3.1.2).*

4. Share lessons and advocate for systematic use of inclusive service delivery:

AIHSP to share lessons learnt on its inclusive COVID-19 vaccination for at-risk populations including people with disabilities and the elderly with the GoI, primarily the MoH and the MoHA. AIHSP to also advocate for, and support these approaches being embedded within these ministries so that they can be systematically applied to other health service delivery. This could include implementation of the guidebook for conducting inclusive vaccination events and risk communication campaigns developed by ID.COMM *(see section 7.2)* and updating national and sub-national service delivery guidelines.

AIHSP, WHO and UNICEF to continue to advocate for the collection of disaggregated data for health service delivery for each at-risk group, including for people with disabilities by sex *(see section 7.2).*

5. Support One Health initiatives:

AIHSP to continue supporting development of the One Health multistakeholder structures at provincial, district and village level, including testing of capabilities in an emergency response. AIHSP to continue to support the GoI's national and regional leadership in One Health, including its Chairmanship of ASEAN and application of a One Health lens to policymaking on preparedness and prevention.

Support should draw on the Tripartite Zoonoses Guide (TZG) and include table-top exercises and advocating to GoI to incorporate the structures into the evolving One Health Multisectoral coordination mechanisms for zoonoses *(see section 3.1.3).*

6. Continue targeted support for animal disease outbreaks:

AIHSP and DFAT, in coordination with DAFF, to continue to increase focus on animal health systems strengthening and DFAT to support this transition through consultations with government departments in Australia and with the GoI *(see section 3.1.1).*

7. Improve partner processes, capacity, collaboration and monitoring:

AIHSP to improve its regular communication and coordination with GoI, implementing partners and other stakeholders, particularly at a sub-national level. AIHSP, WHO and UNICEF to strengthen collaboration and learning between each other as well as between their sub-partners – to improve good practice and maximise efficiency *(see sections 6.1.5 and 6.2.1).*

AIHSP and DFAT to ensure that AIHSP's managerial structures and administrative capacity are sufficient to lead and support the current scale of activities *(see sections 6.1.1, 6.1.3 and 6.1.5).*

AIHSP to continue to strengthen the technical and strategic planning capacity of its staff. AIHSP to organise regular meetings for DT Global programs to identify synergies and promote collaboration. AIHSP and WHO to improve the monitoring and reporting of sub-partners. AIHSP to simplify the AIHSP MERLA and ensure indicators align with activities *(see sections 6.1.3, 6.2.4 and 3.1.5).*

8. Improve capacity, collaboration and coordination between DFAT and DAFF-funded programs:

DFAT Jakarta to strengthen its Health Team so that it has the capacity and technical and strategic capability commensurate with the size and complexity of Australia's health investments in Indonesia.

DFAT Jakarta to continue to hold regular meetings to identify potential points of collaboration and to share good practice between DFAT programs as well as with DAFF-funded programs *(see section 6.2.3).*

8.3 Recommendations for Future DFAT Health Sector Support

Given the Indonesian elections in 2024 which will result in uncertainty in health policy and direction next year, the MTR Team recommends that DFAT consider a possible one-year funded extension for AIHSP to January 2026. This means that an end of program evaluation, development of a health strategy and design of a new health investment could commence in late 2024 and continue through 2025 when there should be greater clarity following the elections. It would also allow for time for Australia to establish relationships with new, relevant leadership and to understand their priorities.

As such, at the end of the current implementation period, Australia is to embark on a new phase of consolidated health sector programming with a greater emphasis on health systems strengthening than emergency response. Given the MTR recommends a significant change to the current AIHSP design, this would require DFAT to approach the market to select a managing contractor for the new phase.

The MTR notes that Australia is likely to continue funding WHO and UNICEF through existing regional and global agreements, with both likely to support activities that align with a new Australian investment in health.[44]

The following MTR recommendations are based on the findings in the preceding sections of this report as well as the *Future Considerations* section *8.1*. They focus on areas of the Indonesian health sector that Australia could support for five years from AIHSP's completion as well as how it might efficiently manage a future health investment. In Table 5 below, each recommendation is given a rating based upon the recommended time frame for implementation and priority (see explanatory table below). Sections of the report that have informed the recommendation are provided in brackets.

Table 5: AIHSP MTR Recommendations for a new health investment

No.	Recommendation	Timeframe Rating	Priority Rating
1	**DFAT health strategy** [6.1.6, 8.1] DFAT Jakarta to develop a **strategy for Australia's bilateral funding of the health sector in Indonesia, involving both human and animal health,** in close consultation with GoI. The strategy should align with Australian and Indonesian Government strategies and plans and focus on zoonoses and other EIDs. It should identify synergies with other bilateral programs, ensure there is no duplication with other donors and describe how DFAT will address gender equality, disability and social inclusion. The strategy is to be developed **mid-2024 to mid-2025** so that it can inform the design of a new health investment. All future health-related investments in Indonesia would contribute to the health strategy, which would set clear boundaries for requests for new work and focus policy influence. The strategy is to be flexible to meet emerging needs. Internal DFAT capacity for strategic influence in human and animal health should be strengthened to assist in implementing the strategy.	**SHORT**	**HIGH**
2	**DFAT emergency response funding mechanism** [6.1.1-6.1.3] DFAT to introduce a **flexible emergency response mechanism** to rapidly disburse funding to partners for human and animal disease outbreaks. The funding and mechanism could be **separate to the modality used for a new health investment in health systems strengthening** and have clear parameters for access and use of the funding. It might, however, still be managed by the same managing contractor, but with discreet funding and staffing.	**SHORT**	**HIGH**
3	**GoI engagement** [8.1.5] Australia to progress partnerships with MoH and MoA. It is to continue to support embedded advisors in the MoH and resume full-time technical	**SHORT**	**HIGH**

---

[44] The MTR examined the efficacy of the current Australian-funded modalities for health sector support in Indonesia including UNICEF and WHO but detailed exploration of alternative modalities for a future phase was out of scope.

	support embedded in the MoA. Australia to consider its engagement with MoEF, MoHA, Kemenko PMK and BAPPENAS, as ministries responsible for areas related to the new health investment.		
4a	**Human surveillance and health information systems** [3.1.2, 4.1, 5.1, 8.1] DFAT to continue to support human surveillance and health information systems including strengthening capacity of primary health care workers in: integrated health information management systems; referral systems; diagnostics; data collection and community-based surveillance. It should prioritise supporting service provision for and by groups in the community such as women, people with disabilities and the elderly. Work could also include strengthening sub-national capacity in data analysis, data governance and management, and translating data for decision-making.	MEDIUM	HIGH
4b	**Animal surveillance and health information systems** [3.1.2, 4.1, 5.1, 8.1] DFAT to continue to support development of, and timely reporting into iSIKHNAS, its uptake at a sub-national level and integration with other animal and human health surveillance systems. It is to support data collection, data governance, and translating data for decision making from puskeswan to a national level. DFAT to support MoA in developing animal identification and tracing systems and monitoring wildlife disease, in coordination with CSIRO-ACDP and FAO.	MEDIUM	MEDIUM
5	**Laboratory strengthening** [3.1.2, 4.1, 5.1, 8.1] DFAT, through CSIRO-ACDP and others, to build on CSIRO-ACDP's efforts and increase the scope of this support by expanding to other animal health laboratories, including ISO accreditation of laboratories and building reference laboratory and Indonesian laboratory leadership capacity in Southeast Asia.	MEDIUM	HIGH
6	**Inclusive health service delivery** [7.2-7.6, 8.1] DFAT to continue to support the embedding of an inclusive service delivery approach across the health system, including: active involvement of groups in the community such as women and people with disabilities in service delivery design, implementation and monitoring; updating service delivery guidelines; and collecting and using disaggregated data for community groups to inform decision-making.	LONG	HIGH
7	**One Health** [3.1.4, 5.1, 8.1] DFAT to support capacity and sustainability of One Health structures and mechanisms, including at a village level, to respond to human or animal health disease outbreaks. This should involve engagement with the MoEF to address the role of ecosystems in disease regulation and MoHA. DFAT to work with FAO and others to encourage the application of a One Health lens for future national and sub-national policymaking on preparedness and prevention and continue to support Indonesia's leadership on One Health in Southeast Asia.	MEDIUM	HIGH
8	**Animal health vaccine procurement and distribution** [3.1.3, 8.1.8] DFAT to continue providing support to the sub-national animal health workforce in vaccination planning, disease detection and tracing capability and administering vaccines. DFAT to support implementation of the FMD Roadmap.	MEDIUM	MEDIUM
9	**Animal vaccine production** [8.1.9] DFAT, together with DAFF, CSIRO and other stakeholders, to conduct a thorough risk assessment and mapping of the geopolitical context prior to considering support for domestic production of animal vaccines.	MEDIUM	MEDIUM
10	**Monitoring, evaluation and learning (MEL)** [3.1.5, 6.1.5, 7.2] DFAT to move to performance-based funding for partners. The managing contractor to ensure that a robust but simple MEL system is developed for the new health investment, including for sub- partners. DFAT and the	SHORT	MEDIUM

	managing contractor to ensure there is appropriate resourcing to monitor and support the MEL of sub-partners. DFAT to provide clearer MEL guidance to partners, including choice of indicators and requirements for GEDSI monitoring and reporting.		

Explanation of Ratings

The timeframe rating indicates the time for achieving change in the recommended activity.

Rating key for timeframe

Long	Medium	Short
Five years	2-5 years	1-2 years

The priority rating indicates the level of priority for Australia's investment in the Indonesian health sector.

Rating key for priority

High	Medium	Low
Should implement	Need to implement	Could implement