AHP Australian Humanitarian Partnership

Learning Workshop Report

AHP Indonesia COVID-19 Response: Pulih Bersama End-of-Program Learning Event

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Australian Aid

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RINGKASAN EKSEKUTIF

The Australian Humanitarian Partnership (AHP) adalah program kemanusiaan dan mekanisme koordinasi yang didanai oleh Departemen Luar Negeri dan Perdagangan (DFAT) Pemerintah Australia dan melibatkan enam LSM kemanusiaan terkemuka Australia, dan mitra mereka. Respons COVID-19 AHP Indonesia, senilai $5 juta, disampaikan oleh dua konsorsium, World Vision Australia dan Church Agencies Network Disaster Operations (CAN DO), mencakup 12 provinsi dan 56 kabupaten di Indonesia, dengan fokus di Aceh dan bagian timur Indonesia, untuk mendukung respons kesehatan daerah terhadap COVID-19 dan membangun ketahanan masyarakat.

Berdasarkan diskusi pembelajaran selama lokakarya, baik Wahana Visi (WVI) dan CAN DO mengklaim telah **melampaui target dan mencapai hasil yang diharapkan**. **Keberhasilan proyek** Indonesia COVID-19 Surge Response (*ICSR*), yang dilaksanakan oleh WVI dan mitra dapat dikaitkan dengan beberapa faktor, termasuk penggunaan RCCE standar WHO dan penyesuaian dengan konteks lokal, investasi dalam membangun kapasitas mitra lokal, memanfaatkan kekuatan yang berbeda dari beragam mitra, dan keterlibatan aktif tokoh masyarakat, tokoh agama, petugas kesehatan, dan pemerintah. WVI dan mitra juga bekerja dalam mengintegrasikan komunitas agama dan komunitas kesehatan. Sedangkan keberhasilan proyek Pulih Bersama yang dilaksanakan oleh CAN DO Consortium dapat dikaitkan dengan beberapa faktor, antara lain penerapan pendekatan penta-helix yang melibatkan seluruh pemangku kepentingan untuk berkolaborasi, memposisikan komunitas, perempuan, dan tokoh agama sebagai *influencer*, serta menjawab tantangan yang ditimbulkan oleh keragaman pendapat dan keyakinan di antara para pemimpin agama dengan mempromosikan pesan kesehatan masyarakat berbasis bukti. Selain itu, bekerja melalui mekanisme konsorsium memungkinkan CAN DO berbagi keahlian dan menyesuaikan strategi program agar sesuai dengan konteks geografis.

Selama lokakarya, WVI membahas **tantangan utama** selama program, yaitu bekerja dengan mitra yang memiliki berbagai ragam jenis organisasi dimana WVI perlu menyediakan dukungan yang sesuai dengan kebutuhan peningkatan kapasitas masing-masing lembaga, memastikan staf mitra sesuai dengan peran yang dibutuhkan, dan mengatasi tantangan koordinasi dan menanggapi kebutuhan masyarakat di konteks lokal yang berbeda. Konsorsium CAN DO membahas bahwa tantangan utama mereka adalah mengkonsolidasikan berbagai ide dalam sebuah konsorsium, memperhatikan konteks lokal, berinovasi dalam proses pengumpulan data selama pandemi, mengatasi konsepsi yang keliru tentang COVID-19, serta menangani kekurangan vaksin dan konflik distribusi dengan bekerja bersama pemerintah lokal.

Dalam **merefleksikan apa yang dapat dilakukan Konsorsium WVI dan CAN DO secara berbeda**, WVI dan mitra menyarankan peningkatan kapasitas sesuai kebutuhan dan penyelarasan struktur organisasi dengan model kemitraan untuk implementasi program di masa depan. Sementara Konsorsium CAN DO merespons kebutuhan peningkatan kapasitas melalui proses pengambilan keputusan dan memperluas aspek kesiapsiagaan, serta menekankan pentingnya keberlanjutan dari program pemulihan COVID-19 ke program pembangunan untuk memberikan dukungan ekonomi yang lebih berkelanjutan untuk membantu masyarakat membangun ketahanan dan mengurangi kerentanan terhadap krisis di masa depan.

Kepada DFAT, WVI dan para mitra merekomendasikan pertemuan rutin lintas lembaga dan komunikasi dini tentang potensi perubahan dukungan untuk memfasilitasi koordinasi yang lebih baik dan implementasi yang lebih kuat. **CAN DO Konsorsium merekomendasikan** untuk terus mendukung keberlanjutan program, meningkatkan koordinasi dan komunikasi, serta mengusulkan perubahan rencana kerja atau anggaran kepada AHP Support Unit karena situasi COVID-19 yang cepat berubah. Staf DFAT mencatat rekomendasi tersebut dan menyampaikan pentingnya fleksibilitas dan keterbukaan terhadap umpan balik untuk pelaksanaan program di masa depan.

Sehubungan dengan sistem **Monitoring dan Evaluasi (M&E)** di Pulih Bersama, baik Konsorsium WVI dan CAN DO telah membentuk sistem untuk menghasilkan data dan bukti atas kinerja proyek, yang meliputi peningkatan kapasitas melalui pertemuan rutin dengan mitra/anggota, mengembangkan sistem pendataan dan pelacakan data, dan mengadakan pertemuan pembelajaran dan M&E.

Selama lokakarya, Konsorsium WVI dan CAN DO mencerminkan **beberapa pembelajaran** penting berikut:

Dalam **pendekatan inovatif**, Konsorsium CAN DO menggunakan pendekatan inovatif untuk mencapai tujuan mereka, yaitu mengembangkan M&E dan manajemen pengetahuan melalui dasbor online yang memberikan insentif bagi anggota untuk berkinerja, dan menerapkan strategi komunikasi yang dibentuk dengan melalui masukan tokoh masyarakat, perempuan, dan agama sebagai *influencer*. WVI dan mitra memanfaatkan pendekatan inovatif melalui adaptasi dan kontekstualisasi lokal RCCE (*risk communication and community engagement*), dengan mengembangkan strategi

komunikasi dengan pesan yang disesuaikan dengan konteks lokal dan membangun mekanisme umpan balik. Selain itu, dashboard monitoring dan evaluasi online juga digunakan.

Dalam pelaksanaan proyek, baik WVI maupun Konsorsium CAN DO memprioritaskan **Kesetaraan Gender, Disabilitas dan Inklusi Sosial (GEDSI)** karena perempuan, kelompok minoritas, dan penyandang disabilitas di daerah sasaran lebih rentan terhadap dampak pandemi karena ketidakadilan. kesenjangan sosial dan ekonomi yang sudah ada. WVI menerapkan beberapa strategi untuk mencapai hasil GEDSI, termasuk bekerja bersama OPD, membangun kesadaran tentang pentingnya data inklusif, melakukan asesmen terkait kebutuhan GEDSI, dan mengembangkan materi Informasi, Edukasi & Komunikasi yang disesuaikan untuk penyandang disabilitas. Sementara Konsorsium CAN DO menerapkan pendekatan GEDSI yang ditargetkan dengan memberikan bantuan transportasi untuk vaksinasi, pelatihan bagi tokoh masyarakat agar peka terhadap GEDSI, melakukan penilaian sosial ekonomi, memilah data proyek berdasarkan jenis kelamin, umur dan disabilitas (SADD), dan berfokus pada kontribusi dan keterlibatan aktif komunitas yang terpinggirkan dalam upaya advokasi.

Strategi World Vision International (WVI) untuk **pelokalan** berfokus pada pembangunan kapasitas, peningkatan komunikasi, pengaturan kemitraan, dan proses pengelolaan data, selaras dengan strategi nasional WVI. WVI memberikan dukungan penguatan kelembagaan melalui peningkatan kapasitas dan asesmen kapasitas mitra untuk membantu mereka mengenali kekuatan dan area yang perlu ditingkatkan. Konsorsium CAN DO menekankan pentingnya perspektif pelokalan untuk desain dan implementasi program. Konsorsium memprioritaskan kolaborasi dan penguatan kapasitas, dengan pengambilan keputusan yang menekankan proses perubahan yang dipimpin mitra lokal sendiri. Strategi pelokalan menekankan pada pembangunan kemitraan, pembangunan kapasitas, koordinasi dan upaya saling melengkapi, serta partisipasi mitra lokal dalam pengambilan keputusan.

Konsorsium WVI dan CAN DO mendiskusikan bahwa **organisasi berbasis agama dan pemimpin agama memainkan peran penting** dalam Pulih Bersama. Menurut WVI dan mitra, pemuka agama mengambil peran penting dalam mempromosikan informasi dan literasi dalam menghadapi pandemi, tetapi meningkatkan kesadaran dan mengubah pola pikir dapat menjadi tantangan, karena tidak semua pemuka agama percaya pada COVID-19. Berkolaborasi dengan komunitas agama membuka peluang tentang berbagai cara untuk bereaksi dan berkontribusi secara sensitif. Konsorsium CAN DO juga mengakui peran organisasi berbasis agama, dengan pendekatan penta-helix memungkinkan kolaborasi antara pemuka agama dengan pemerintah, komunitas, akademisi, media, dan aktor lainnya. Pemuka agama memiliki potensi untuk memberikan layanan holistik kepada masyarakat, termasuk literasi teologi, literasi kesehatan, dan dukungan psikososial, serta dapat meningkatkan kesadaran tentang inklusivitas melalui ajaran tentang GEDSI.

Selama lokakarya, Konsorsium WVI dan CAN DO menyoroti **pelajaran penting lainnya**. Dalam proyek Pulih Bersama, WVI dan Konsorsium CAN DO pentingnya beradaptasi dan memberikan peningkatan kapasitas kepada mitra selama pandemi COVID-19. Mereka menggunakan beragam solusi seperti penggunaan platform online, peningkatan keterampilan TIK dan digital, dan bekerja dengan tokoh masyarakat untuk mengembangkan pesan untuk kampanye sosial. Kemitraan kolaboratif dengan mitra lokal dan mekanisme konsorsium memiliki manfaat dan tantangan, tetapi WVI dan Konsorsium CAN DO menekankan pentingnya kontekstualisasi pelokalan melalui model kemitraan yang berbeda dan membangun tata kelola dan sistem organisasi yang lebih kuat. Pemerintah Australia dapat mengambil manfaat dari menganalisis model kemitraan yang berbeda ini untuk menciptakan lingkungan yang mendukung pelokalan di setiap program.

EXECUTIVE SUMMARY

The Australian Humanitarian Partnership (AHP) is a humanitarian and coordination mechanism that brings together the Australian Government's Department of Foreign Affairs and Trade (DFAT), six leading Australian humanitarian NGOs, and their partners. The AHP Indonesia COVID-19 response, worth $5 million, was delivered by two consortiums, World Vision Australia and Church Agencies Network Disaster Operations (CAN DO), covering 12 provinces and 56 districts in Indonesia, with a focus on Aceh and the eastern part of Indonesia, to support the sub-national health response to COVID-19 and build community resilience.

Based on the lessons learned discussions during the workshop, both Wahana Visi (WVI) and CAN DO have exceeded their targets and achieved their intended outcomes. The success of the Indonesia COVID-19 Surge Response (ICSR) project, implemented by WVI and partners can be attributed to several factors, including the use of the WHO standard of risk communication and community engagement (RCCE) and contextualisation of the tool to fit the local context, investing in capacity building for local partners, leveraging the different strengths of diverse partners, and active involvement of community leaders, religious leaders, health workers, and the government. WVI and partners also pay attention to integrating faith and medical communities. Factors contributing to the success of CAN DO Consortium's *Pulih Bersama* project include implementing a penta-helix approach that involves collaboration of all stakeholders, positioning community, women, and religious leaders as influencers, as well as addressing challenges posed by diverse opinions and beliefs among religious leaders by promoting evidence-based public health measures. In addition, working through the consortium mechanism allowed CAN DO to share expertise and adapt program strategies to fit geographical contexts.

During the workshop, WVI discussed key challenges including working with partners from different organisational types, investing in a range of support to meet their capacity building needs, ensuring that partner staff match the required roles, and facing challenges with coordination and responding to community needs in different local contexts. CAN DO Consortium outlined key challenges including consolidating different ideas in a consortium, paying attention to local context, innovating data collection processes during the pandemic, addressing misconceptions about COVID-19 and vaccinations, and dealing with vaccine shortages and distribution conflicts by working with local authorities.

In reflecting on what WVI and CAN DO Consortium can do differently, WVI and partners suggest regular capacity building and alignment of organisational structures with partnership models for future program implementation. The CAN DO Consortium addressed the need to improve decision-making processes and extend preparedness and sustainability aspects of the COVID-19 recovery program into development programs to provide more sustainable economic support to help people build resilience and reduce vulnerability to future crises.

Recommendations for DFAT, WVI and partners include regular cross-agency meetings and early communication of changes to facilitate improved coordination for strengthened implementation. CAN DO Consortia recommends continuing to support program sustainability, improving coordination and communication with partners, and the option of changes to work plans or budgets through the AHP Support Unit due to changing COVID-19 circumstances. DFAT staff noted the recommendations and are flexible and open to feedback for future program implementation.

With regards to the monitoring and evaluation (M&E) system in *Pulih Bersama*, both WVI and CAN DO Consortium established a centralised M&E system to generate data and evidence on their performance. They also conducted regular capacity building meetings with partners/ members and held regular learning and M&E sessions.

During the workshop, WVI and CAN DO Consortium reflected on key lessons for innovation, inclusion, locally-led humanitarian response and the role of faith-based organisations. These are elaborated below.

The CAN DO Consortium utilised innovative approaches to achieve their goals, including developing M&E and knowledge management via an online dashboard which provided incentives for members to perform, and implementing communication strategies that were shaped by using community, women, and religious leaders as influencers. WVI and partners utilised innovative approaches through adapting and localising risk communication and community engagement, including developing a communication strategy with messages tailored to the local context, and establishing feedback mechanisms. In addition, an online monitoring and evaluation dashboard was also utilised.

Both WVI and CAN DO Consortium prioritised Gender Equality, Disability and Social Inclusion (GEDSI), recognising that women, minority groups, and people with disabilities in the targeted underdeveloped regions are more vulnerable to the

impacts of the pandemic due to pre-existing social and economic inequalities. WVI implemented several strategies to achieve GEDSI results, including working with Organisations of People with Disabilities (OPDs), building awareness on the importance of inclusive data, conducting a GEDSI needs assessment, and developing Information, Education & Communication (IEC) materials tailored for people with disabilities. CAN DO Consortium implemented a targeted GEDSI approach by providing transportation assistance for vaccinations, GEDSI sensitivity training for community leaders, conducting socioeconomic assessments, disaggregating project data by Sex, Age and Disability Disaggregated Data (SADDD), and focusing on the valued contribution and active involvement of marginalised communities in advocacy efforts.

WVI's strategy for localisation focused on capacity building, communication, partnership arrangements, and data management processes, aligned with their national strategy. They invested in supporting institutional strengthening through capacity building and partner capacity assessments to help partners recognise their strengths and areas for improvement. The CAN DO consortium emphasised the importance of a localisation perspective for program design and implementation. The consortium prioritised collaboration and capacity strengthening, with decision-making centred around a partner-led change process that took into account local partners' experience. Their localisation strategy emphasised partnership building, capacity building, coordination and complementary efforts, and participation of local partners in decision making.

Both WVI and CAN DO Consortium noted that faith-based organisations and religious leaders played a significant role in *Pulih Bersama*. According to WVI and partners, religious leaders played important role in promoting literacy and information to deal with the pandemic. However, raising awareness and changing mindsets can be challenging, as not all religious leaders believe in COVID-19. Collaborating with religious communities allowed for suggestions on different ways to react and contribute sensitively to communication around the pandemic. The CAN DO Consortium also recognised the role of faith-based organisations, with the penta-helix approach allowing for collaboration between religious leaders and government, community, academia, media, and other actors. Religious leaders have the potential to provide holistic services to the community, including theological literacy, health literacy, and psychosocial support, as well as raising awareness on inclusiveness through teachings on GEDSI.

Other key lessons highlighted by WVI and CAN DO Consortiums during the *Pulih Bersama* project included the need to adapt and provide capacity building to partners during the COVID-19 pandemic. The Consortiums used diverse solutions such as online work, improved ICT and digital skills, and working with community leaders to develop online social and behaviour campaign messages. Collaborative partnerships with local partners and consortia mechanisms had both benefits and challenges, but both WVI and the CAN DO Consortium emphasised the importance of accelerating localisation through different partnership models and establishing stronger governance and organisational systems. The Australian Government could benefit from analysing different partnership models to create an enabling environment for localisation.

1. BRIEF OVERVIEW OF AHP PULIH BERSAMA PROJECTS

The Australian Humanitarian Partnership (AHP) is a humanitarian and coordination mechanism that brings together the Australian Government's Department of Foreign Affairs and Trade (DFAT), six leading Australian humanitarian NGOs and their local and national partners. It is currently in its second five-year phase (2022-2027).

Running from November 2021 to January 2023, the $5 million AHP Indonesia COVID-19 response was part of a wider package of pandemic support to Indonesia through the *Pulih Bersama* (Recover Together) program. The AHP Indonesia response was delivered by two consortiums: World Vision Australia, through Wahana Visi Indonesia (WVI) with 13 Indonesian NGO partners; and Church Agencies Network Disaster Operations (CAN DO) consortium, including Adventist Development and Relief Agency (ADRA) Indonesia, Catholic Relief Services, Church World Services (CWS), and Maha Bhoga Marga. The activation covered 12 provinces and 56 districts, from Aceh to Tanah Papua, with a strong focus on the eastern islands of Indonesia. Its key goals were supporting the sub-national health response to COVID-19 and building community resilience.

Image: Workshop participants.

2. REFLECTIONS ON PROGRAM IMPLEMENTATION

2.1 Key Results

WVI and CAN DO Consortium presented reflections on the extent that program implementation achieved the intended outcomes. The consortiums also provided insights into implementation processes, factors influencing program achievements, and any unintended effects.

WVI and CAN DO Consortium have met their intended outcomes and exceeded the targets from their project design, according to their workshop presentations. Both quantitative and qualitative data were presented to support the claim. The supporting evidence should be verified and assessed during the completion reporting process.

2.2 WVI and partners

WVI and partners have directly reached 58,227 people through the Indonesia COVID-19 Surge Response (ICSR) project, exceeding their direct target of 51,170 people (14% above the initial target). Through reaching 58,227 people, ICSR also managed to indirectly reach 450,804 people. They presented the following key results:

- OUTCOME 1: To strengthen community health response to support COVID-19 prevention and vaccine promotion in five target provinces.
  - 58,227 people (including 2,600 people with disabilities) reached directly through gender and disability inclusive COVID-19 preventive-promotive messaging.
  - 450,804 people indirectly reached with gender and disability inclusive COVID-19 preventive messaging.
  - 620 faith leaders trained to disseminate correct information on COVID-19 prevention and control measures.
  - 713 local COVID-19 task force and Civil Society Organisations (CSOs), Faith-Based Organisations (FBOs), and Organisations of Persons with Disabilities (OPDs) trained on inclusive health promotion and risk communication, including vaccine roll-out.
- OUTCOME 2: Vulnerable households and children impacted by COVID-19 have improved access to social protection and safe education.
  - 19,640 people (including 8,657 women/girls and 2,653 people with disabilities (PWD)) assisted with cash and voucher assistance.
  - 4,579 people (including 1,828 women/girls and 1,867 PWD) received access to financial services.
  - 8,683 children (including 4616 girls) reached through psycho-social information, education and communication materials, and COVID-19 support at community or school level.
  - 12 districts involved in dissemination of the National Education Contingency Plan.
- OUTCOME 3: Women and people with disability have increased capacity to catalyse inclusive livelihood recovery.
  - 1,421 people (including 1,321 women and 34 PWD) trained on business management and financial/digital marketing.
  - 208 people involved in the dissemination of a Gender and Disability Inclusive Business Continuity Plan Guideline.

There were a range of factors that helped them to achieve the intended outcomes, outlined below.

(1) As a member of the National Risk Communication and Community Engagement (RCCE) led by the Ministry of Health, WVI applied the WHO standard of RCCE and contextualised the tool to fit with the local context, with inputs from the stakeholders involved in *Pulih Bersama* project. The constructive implementation of RCCE was the key success of the program as WVI shared the resources, localised the tool, and conducted joint coordination and consultations to adapt and implement the tool through a multi-stakeholder forum, involving the government (health workers), religious leaders, community leaders and CSOs/Community-based organisations (CBOs) as well as representatives from vulnerable communities.

(2) Investing in capacity building for local partners was an important part of WVI's localisation strategy. The local partners have a significant role in providing the context of local issues and identifying strategic engagements with local leaders. WVI put them at the forefront of decision making on project implementation, while providing value-add by building their capacity.

(3) Leveraging the different strengths of their diverse partners was another key to successful program implementation for WVI. Wahana Visi paid particular attention to different strengths and weaknesses among their 13 local partners and leveraged the different strengths offered by FBOs, CSOs and OPDs. WVI adds value by garnering collaboration among them and introducing evidence-based humanitarian and operational tools to achieve intended outcomes using the contributions of different partners.

(4) Active involvement from community leaders, religious leaders and health workers, as well as the government, also helped the program to achieve results. WVI and partners paid particular attention to the incentives to integrate faith and medical communities, as religious views strongly influence how people relate to illness, health, and healing.

2.3 CAN DO Consortium

CAN DO Consortium reached around 241,600 people under this project - more than double the initial target of 120,407 people. During the workshop, they presented the following key results:

- OUTCOME 1: People in target communities, especially priority groups have improved knowledge, attitudes, and practices on the issues and impacts of the COVID-19 pandemic.
  - 703 people (including 43 PWD and 21 people with non-binary gender) who were community leaders/influencers joined the Effective COVID-19 and Vaccine Safety Community Engagement (VSCE) Training.
  - 104,438 people (including 1,913 PWD and 1,711 people with non-binary gender) participated in 2,009 interactive sessions facilitated by 703 community leaders/influencers who were trained previously.
  - 56 radio talk shows, TV shows, and social media posts were made as part of a digital campaign about COVID-19 and Vaccine Safety.
- OUTCOME 2: Sub-national health authorities manage the spread and impact of COVID-19 through increased uptake of vaccines targeting priority groups.
  - 856 people (including 4 PWD and 14 people with non-binary gender) were trained on vaccine related issues (e.g. vaccination, event management).
  - 74,906 people (1,083 PWD and 996 people with non-binary gender) were vaccinated in 836 vaccination events supported by *Pulih Bersama*.
  - 28,299 of the vaccinated people received transportation or logistics assistance to access vaccination.
- OUTCOME 3: Local communities affected by COVID-19 are able to access psychosocial first aid and/or referrals, appropriate to their need.
  - 1,088 people (including 25 PWD and 33 people with non-binary gender) community leaders/influencers joined Psychosocial First Aid (PFA) Training.
  - 3,392 people (including 42 PWD and 40 people with non-binary gender) received remote/in-person counselling conducted by their peers who were the participants of PFA training.
  - 418 people (including 9 PWD and 1 person with non-binary gender) were referred to professional psychologists after receiving counselling. The counsellors were given tools to measure an individual's condition/stress level.
- OUTCOME 4: People with livelihoods affected by COVID-19 have improved access to livelihoods support to meet basic needs.
  - 3,493 micro-small entrepreneurs (including 26 PWD and 29 people with non-binary gender) were assisted in accessing a cash assistance program through sessions organised by consortium members and partners.
  - 1,827 people (including 214 PWD and 37 people with non-binary gender) received short-term income relief and livelihood support.
  - 565 people (including 65 PWD and 20 people with non-binary gender) joined training/sessions about livelihood related topics.

The key factors that helped them to achieve the intended outcomes are outlined below:

(1) Local partners had strong pre-established relationships with local stakeholders, while the CAN DO Consortium added value by drawing in broader stakeholders. CAN DO Consortium utilised a penta-helix approach that involves all

stakeholders, ranging from local government, academia, media, social entrepreneurs, and, most importantly, the local community, with active involvement from religious leaders.

(2) Skills sharing and networking across different areas was a strength of the consortium approach. Collaboration among CAN DO Australia consortium members, CAN DO Indonesia consortium members, and local partners provided positive opportunities to share relevant skills, experience, and expertise. It also enabled networking across different geographical areas for complementary program implementation.

(3) Positioning community leaders, women leaders, and religious leaders as influencers allowed CAN DO to empower them to raise awareness and influence attitudes, behaviour, and practices. This approach has great potential in helping the program to shape social values in line with faith-based teachings for health promotion.

It is important to note that religious leaders, like any other group of people, hold diverse opinions and beliefs, and not all religious leaders share the same conceptions about COVID-19. Some of the misconceptions that have been reported among religious leaders include: (1) a belief that COVID-19 is a punishment from God and that life and death are in the hands of God, (2) conspiracy theories about the origins of COVID-19, (3) misinformation about the effectiveness of preventive measures, (4) resistance to public health measures. In dealing with these challenges, CAN DO encouraged religious leaders to be well-informed about the science of COVID-19 and to promote evidence-based public health measures. They played a vital role in encouraging their communities to take preventive measures and in dispelling misinformation and conspiracy theories.

2.4 Challenges of program implementation

2.4.1 WVI's key challenges

During the workshop, WVI discussed the following challenges:

(1) Working with partners with different organisational types, such as FBOs, CSOs, and OPDs, meant that WVI was exposed to different capacity building needs. Wahana Visi had to invest in a range of support including introducing standard operating procedures (e.g. on ethics, safeguarding, and conflict of interest), budget management and procurement process.

(2) The number of partner staff sometimes did not match the roles required by the project. Thus, WVI needed to make sure that certain roles could be recruited, trained, and performed well to help achieve the expected outcomes, while adhering to the organisational values.

(3) As WVI worked in five provinces and 12 districts during the pandemic, there were some challenges with regards to coordination and ensuring that each project operating in a different local context responded to the community's needs.

(4) Only two of 13 local partners in this program had previously worked with WVI in project management. WVI used its resources to build understanding about the program and the capacity of local partners in program management while they adapted to WVI's ways of working and standard operating procedures.

2.4.2 CAN DO Consortium's key challenges

CAN DO Consortium discussed the following challenges:

(1) Working in consortium, the members needed to consolidate different ideas from each organisation in order to establish common ground.

(2) Working with diverse groups and different geographical areas, each member of the consortium needed to pay extra attention to the local context so they could reach target groups.

(3) During the pandemic, the data collection process was challenging. Consortium members and partners needed to be innovative in data collection and recording and ensure the safety of the staff during data collection.

(4) Misconceptions about COVID-19 and vaccinations in targeted areas was a product of customs and culture. Therefore, working with local influencers and coordinating with local stakeholders was of paramount importance to changing attitudes. In addition, CAN DO intervened via social media to disseminate evidence-based information and educate people about the virus.

(5) There was a shortage of stock of some vaccine types due to vaccine distribution and availability in different areas, conflicting with advice that people needed to get the same type of vaccine to be protected. CAN DO needed to work closely with the local health authorities and government to educate people and work through these issues.

2.5 What can we do differently?

WVI and partners noted the following key points on potential changes for future program implementation:

(1) Regular capacity building and coordination with local partners at least 3 months prior to the project's early stage (caveat is timing this with grant awards).

(2) Ensure partners have sufficient staff to carry out the roles required by the project.

(3) Understand more on organisation structure and capacities (i.e. FBO, CSO and DPO) and align them with the partnership model (target and budget-wise).

CAN DO Consortium noted the following points on what they could do differently:

(1) Achieve effective and timely decision making while working through consortium models with different geographical areas and time zones.

(2) Continue an interfaith approach, because religious communities and institutions play a big role in most contexts.

(3) The elements of preparedness in the COVID-19 recovery program and the sustainability aspects of economic and psychosocial support should be extended into the development program. *Pulih Bersama* provided cash voucher assistance to provide immediate relief to people in need. Through this intervention, basic level training and assistance were provided. However, a more sustainable economic program that provides people with opportunities to build their livelihoods and become self-sufficient is needed to help people build their resilience and reduce their vulnerability to future crises.

2.6 Recommendations to DFAT

The following recommendations to DFAT were provided by WVI and partners and the CAN DO Consortia.

From WVI and partners:

- Conduct regular meetings for cross-agencies learning that move beyond presentations and facilitate improved coordination for strengthened implementation.
- Communicate changes early (regarding evaluation studies and learning events) so that projects can make the necessary adjustments.

From CAN DO Consortia:

- Continue to support program sustainability, especially community livelihood programs.
- DFAT and partners should develop a program or strategy about pandemic risk reduction, so communities will be prepared to face similar pandemics in the future.
- Improve coordination and communication with partners, especially supporting advocacy activities, to develop a sustainable environment which supports COVID-19 mitigation at the national and local levels.

DFAT staff are open to feedback during program implementation and maintain flexibility to changes in the field. The AHP partners can propose changes to work plans or budgets to the AHP Support Unit, particularly due to the changing context of COVID-19.

3. PERFORMANCE, MONITORING, EVALUATION, AND REPORTING

There were two sessions on performance, monitoring, evaluation and reporting (PMER) to reflect on WVI and CAN DO Consortia's systems to generate consistent and credible information to inform decision-making and how they might be improved. Both organisations have built a strong monitoring and evaluation (M&E) system with a dashboard to track program performance.

3.1 WVI and partners

WVI and partners have established the following system to generate data and evidence on their performance:

- Conducting initial meetings with partners to gain a common perspective and understanding of the project.
- Conducting regular capacity building (monitoring, evaluation and learning training, developing logframes, means of verification, business processes, reporting, finance, procurement, and compliance/safeguarding).
- Holding monthly learning meetings at the district/provincial level.
- Developing a centralised indicator tracking table (including a project performance dashboard).
- Providing a data repository that is simple, easy to understand and accessible by partners (including the means of verification and beneficiary tracking table).
- Holding monthly M&E meetings for verification of data and evidence provided by local partners.
- Carrying out monthly reviews of the Monitoring Tracking Table.
- Conducting six-monthly reviews of Indicator Tracking Table records and achievements.

WVI noted the need for capacity building with local partners to ensure that they understand the M&E standards and framework.

3.2 CAN DO Consortium

The CAN DO Consortium built an online dashboard. Church World Services, as the organisation in charge, developed the activity tracker and designed the dashboard. The system captures cause and effect links between interventions and outcomes on COVID-19 issues and vaccinations. It uses evidence such as improvement in knowledge, attitude, and practices. There are multiple sources of verification, such as Knowledge, Attitude and Practices (KAP) baseline-endline, pre- and post-tests, focus group discussions, and in-depth interviews.

In its initial development, CWS tried the tool and dashboard internally with the partners involved in *Pulih Bersama*. After some improvements, CWS presented the tool and dashboard to consortium members. At the beginning and throughout the program, CWS conducted training on how to use the tools, generate the dashboard, and obtain common understanding.

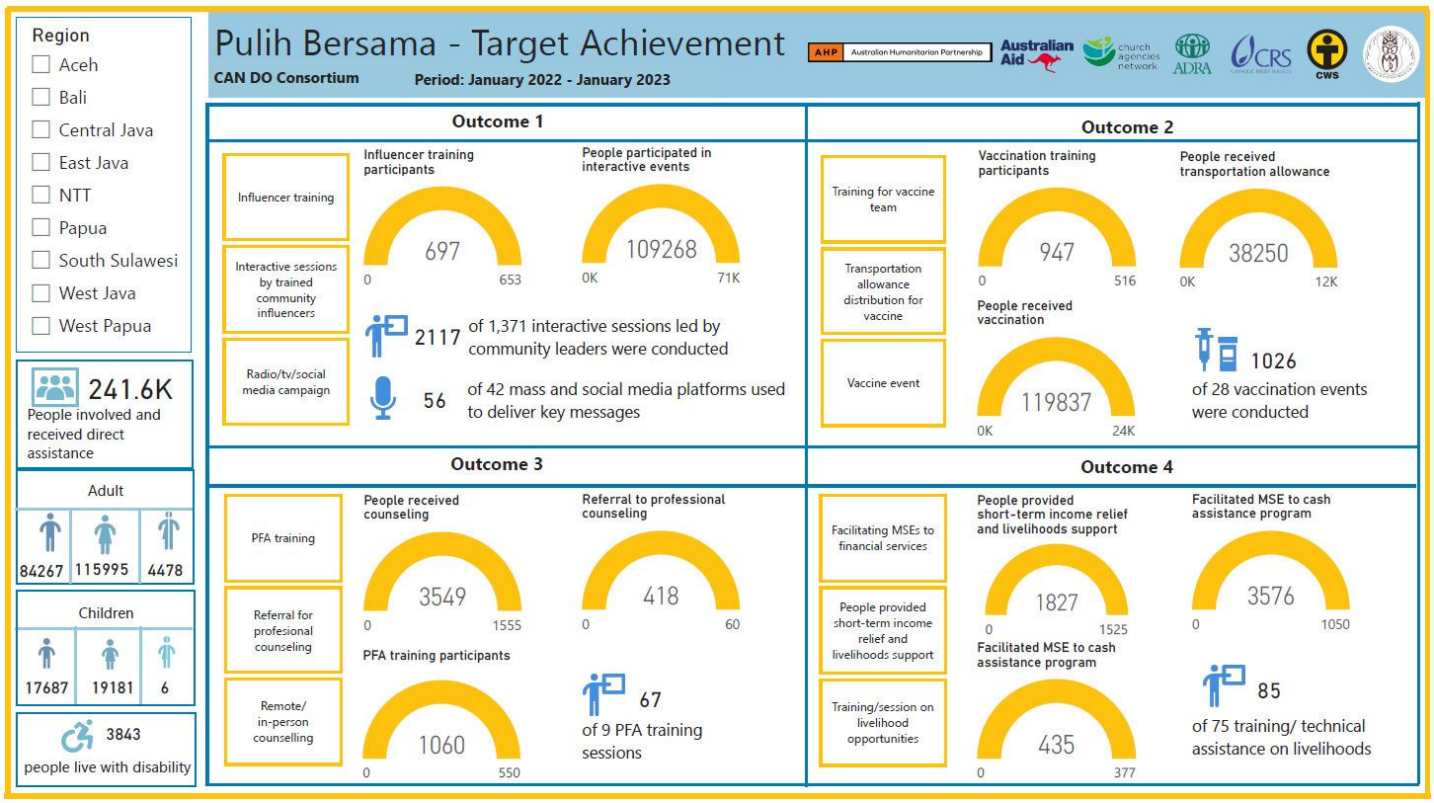

Figure 1. Online PMER Dashboard of CAN DO Consortium

A monthly M&E process was conducted to ensure that the system generated relevant data and evidence:

(1) Every M&E officer verified data/evidence from their own partner(s) and filled in the activity tracker.

(2) Each M&E officer shared their activity tracker with a CWS M&E Officer in the first or second week of the month.

(3) A CWS M&E Officer compiled the activity tracker and generated the dashboard.

(4) The data was presented every third week of the month in a monthly meeting with Indonesian and Australian consortium members. In the meetings there was discussion about the reach, challenges, solution, and future plans.

4. KEY LESSONS

4.1 Innovative approaches

4.1.1 WVI and partners

- WVI engaged closely with communities through risk communication and community engagement. At baseline, the three most trusted source of COVID-19 information were those extended by health workers (80.5%), the local government (36.3%) and religious leaders (13%). The endline study showed that the dissemination of IEC provided clear information on COVID-19 prevention that supported increased community awareness and changed behaviours.

  In localising the RCCE tool, WVI conducted the following strategy:

  - Conducting a baseline study and consulting with health workers (government), local leaders (religious leaders, community leaders, OPD, etc) and other stakeholders to understand the local context, including cultural norms, beliefs and practices, and the communication channels used by the community. Through a multi-stakeholder forum, WVI gathered information on the key issues and concerns related to COVID-19 in the local context, including the misconceptions about the virus, fear of getting tested, vaccine hesitancy, and stigma related to COVID-19.
  - Developing a communication strategy with tailored messages that addressed the key issues and concerns identified in the local context. The communication strategy took into account the communication channels and the format of education materials that were most effective in reaching the local community.
  - Engaging with local stakeholders, including community leaders, religious leaders, and healthcare workers, in adapting and implementing the delivery of information to ensure that they were involved in the RCCE Action Plan.
- Collaborative partnerships encouraged adaptation to program strategies when needed. Partners were encouraged to bring their situational awareness of the current local context to program implementation.
- The MEL dashboard was an innovative way to provide online monitoring and evaluation. The Monthly Monitoring Table (MTT) dashboard also required capacity building with local partners. The MTT dashboard allowed WVI to capture real-time data and provided an online monitoring and evaluation system that established an incentive mechanism to encourage local partners to meet their targets. The establishment of the dashboard in July 2022 helped increased partner achievements by 17 per cent.
- The project leveraged established WVI and local partner feedback mechanisms through helpdesks, face-to-face meetings, suggestion boxes, WhatsApp, and direct engagements with community and faith leaders. This mechanism allowed project staff to monitor and respond to feedback in a safe and confidential manner. Feedback was also lodged in a logbook and the SMAP application to be analysed and reported on to improve project quality. ICSR received 801 responses from 252 men, 538 women, and 11 non-identified persons.

4.1.2 CAN DO Consortium

- Innovation was delivered through good knowledge management (dashboard projects, learning workshop reports, education materials) and an online dashboard helped to achieve this. The development of an online dashboard with open access for the partners was innovative as it provided incentives to perform and motivated partners through their own achievements.
- Positioning community leaders, women leaders, and religious leaders as influencers shaped communication strategies. Beneficiaries were reached through the influencers via social media (Instagram, YouTube).
- The penta-helix approach allows CAN DO to be mindful of a multi-stakeholder approach to every activity. This also helps with acknowledging different contributions to reach the shared outcomes.
- Working through the consortium mechanism was useful for sharing expertise and considering program adaptations. It allowed partners to adapt program strategies that fit to their geographical context and share expertise during program implementation.

4.2 Approach to Gender Equality, Disability and Social Inclusion (GEDSI)

4.2.1 WVI and partners

WVI and partners worked with local governments and community leaders to identify the barriers experienced by people with disabilities and begin to involve them in decisions that affect their lives.

There was evidence that some local governments started to include the most vulnerable groups during program implementation. For example:

- The local government of Alor, Kupang, and East Lombok supported WVI and partners on the initiative to assist poor families in obtaining an ID Card, so that they could eventually get access to the government's social protection program.
- The Inclusive Population data of vulnerable groups was updated for the local government of East Lombok.

WVI and partners also have interventions that target vulnerable communities, such as:

- a cash voucher program in Sigi district of central Sulawesi for people with disability.
- a cash voucher program in the leprosy village in North Halmahera to enable access to vaccine and health services.
- assistance for people with a disability and poor families to gain access to the government's social protection program, empowering the community to advocate to the local government.

Several strategies were implemented to achieve these results:

- WVI worked with three OPDs in *Pulih Bersama* Program, GERKATIN Sulawesi Tengah, GARAMIN and PPDI Papua, to achieve inclusion.
- WVI built awareness on the importance of inclusive data to the local government.
- WVI conducted a GEDSI needs assessment alongside its baseline to obtain preliminary information and capture the actual needs of women, girls, and people with disabilities, in order to inform implementation.
- WVI developed Information, Education & Communication materials that emphasised the importance of Gender Equality, Disability and Social Inclusion (GEDSI).

4.2.2 CAN DO Consortium

The GEDSI approach was integrated in the design and project implementation through the logframe and selection of external collaborators who focused on the issues of disability, LGBTQI+, people living with HIV/ AIDS, and other marginalised communities. The program implementation focused significant attention on access and services for excluded and vulnerable communities.

Several interventions with targeted GEDSI approach were:

- Providing people with transportation/logistics assistance to access vaccinations, particularly for those living in remote areas, people with disability, women, and other vulnerable groups. In addition, CAN DO also helped organise vaccination activities that were close to where the target groups were located.
- Training for community leaders/influencers whose voices could reach vulnerable groups. For example, ADRA worked with SUARA KITA, who could reach the LGBTQI+ community, and with various community leaders, such as local authorities, community leaders, women leaders, and leaders who worked with people with disability. CWS, together with East Nusa Tenggara Disaster Management Community Association (PMPB) and Community Resilience Innovation (INANTA), conducted outreach to leprosy groups, street children, LGBTQI+ groups, and scavenger communities. The communication strategy was tailored to respond to different needs of the target groups.

- Socioeconomic assessment was conducted to better understand the demographic factors that influenced target groups' preconceptions of COVID-19. The socioeconomic assessment also allowed CAN DO to respond to the need to build back the local economy. As such, CWS together with INANTA helped small businesses to connect to cooperatives and small and medium enterprises (SMEs) to get business registration numbers.
- Project data on the MEL dashboard applied Sex, Age and Disability Disaggregated Data (SADDD).
- Advocacy was focused on the valued contribution of women, people with disability, LGBTQI+, and other marginalised communities.

4.3 Localisation strategies

Both WVI and partners and the CAN DO Consortium mentioned that localisation strategies enabled activities to be designed and implemented according to the needs of interest groups in particular geographical areas.

4.3.1 WVI and partners

Working with a wide range of local partners enabled WVI to focus on capacity building while partners identified needs and implemented interventions in their contexts. WVI provided support to 13 different types of local partners nationwide ranging from FBOs, CSOs, and OPDs, who implemented interventions on child protection, education, and livelihoods services.

WVI's strategy for localisation involved capacity building, communication, and partnership arrangements as well as data management processes that were in line with WVI's national partnership operating model. Through this partnership operating model, WVI invests in longer-term institutional strengthening support through capacity building and partner capacity assessment that helps the partners involved to recognise their strengths and areas for improvements.

Capacity building for local partners included:

- training on WVI standard operational procedures on ethical behaviour, safeguarding and conflicts of interest;
- training on MEL (including logframe, business processes for monitoring and evaluation, and standard reporting), finance, procurement of goods and services;
- training related to project implementation and cross-cutting issues: Gender Equality, Disability and Social Inclusion, Testing-Tracking-Treatment on COVID-19, Cash and Voucher Assistance, Cash and Voucher Programming, Last Mobile Mile Solution, Channel of Hope, Small and Medium Enterprise, Psychosocial Support, and Business Continuity Plan.
- A monthly team learning session on program implementation and monitoring and evaluation was conducted at the district/provincial level.
- Data management storage was developed to be easy to understand and accessible to partners.
- A Partnership Performance Health Check was completed and followed up with capacity building.
- Regular meetings were held with local partners to help them understand the logframe, expected performance, budget management, and discuss challenges, learning, and solutions.

Results of the localisation process:

- All partner staff showed their commitment to child and adult protection policies, ethical standards, and conflicts of interest.
- All partners performed at 90 -100% against their target based on the Indicator Tracking Tool.
- Partner budget performance achieved a burn rate of 100%.
- A partner capacity assessment conducted by CIRCLE in January 2023 showed that 12 local partners experienced an increase from 2.68 to 3.25 on a four-point scale, which means they moved from the 'growing phase' to the 'maturing phase'.

4.3.2 CAN DO Consortium

CAN DO acknowledge that consortiums can be challenging to coordinate and to reach consensus within, but a localisation perspective is important for program design and implementation. CAN DO Australia consortium members, CAN DO Indonesia consortium members, and local partners place an emphasis on collaboration and capacity strengthening**.** Decision making in the CAN DO Consortium places a partner-led change process at the centre, taking account of local partners' experience.

CAN DO Consortium implemented the following elements in a localisation strategy:

- Partnership building
  - Each consortium member uses organisational resources and networks to implement the program, including cooperating with local partners for program implementation.
  - In each program location, there is collaboration with local governments. Memorandum of Understandings (MOUs) were developed to guide consortium partners in their program implementation. MoUs were also made with external parties (local health centres, COVID-19 task force and community groups) in every province and district.
  - Consortium members helped each other to achieve the agreed mandate outcomes as well as being a guide for local partners through coordination meetings and trainings.
- Capacity building
  - The program started with a kick-off meeting with partner institutions to develop a common understanding about the program (achievements and strategies).
  - Trainings and workshops were held with partner institutions on issues such as protection from sexual exploitation and abuse, disability and inclusiveness, PDM training and monitoring and evaluation.
  - Consortium members work guidelines were completed by consortium unit performance management determined by indicators and targets for the program.
- Coordination and complementarity
  - The *Pulih Bersama* Program linked with pre-existing leadership and coordination forums at the national and regional levels.
  - The *Pulih Bersama* Program mobilised consortium members and local partners in each program location and coordinated with local governments to achieve the vaccine targets set in those areas.
- Participation
  - The community was involved in determining those entitled to receive business development assistance (Micro-, Small and Medium-sized Enterprises).
  - Field officers and local partners in the field provided information about the program to affected target communities, religious leaders, local government, and other actors collaborating in the program as educators and counsellors.
  - Feedback mechanisms were also available to, socialised with, and accessed by beneficiaries. Target beneficiaries were also involved in the final evaluation process as informants and respondents and provided an assessment of the program.

CAN DO consortium members also developed localisation approaches to work with their local partners. The partnership included:

- CWS worked with East Nusa Tenggara Disaster Management Community Association (PMPB) and Community Resilience Innovation (INANTA), implementing localisation through a focus on partnership, capacity building, coordination and participation.

- Adventist Development and Relief Agency's (ADRA) localisation strategy was to expand partnerships. At the beginning of the program, ADRA worked with Savings and Loans Cooperative for the Poor (KOMIDA), the Evangelical Christian Church in Timor (GMIT), the Seventh Day Adventist (SDA) Church and CSO Our Voice (SUARA KITA), working on LGBTQIA+ issues. ADRA supported operational costs and shared policies, personnel and knowledge about ADRA emergency management. As the project progressed, ADRA expanded its collaboration with DPOs, local churches, and organisations of people living with HIV/ AIDS.
- Catholic Relief Services (CRS) localisation strategy was to work with Human Initiative (HI) which has 13 branch offices throughout Indonesia. CRS and HI jointly decided on the target area and intervention approach. HI were then supported to appoint staff, coordinate with key stakeholders and select community-based organisations to train educators, vaccination volunteers, and peer counsellors on Psychosocial First Aid.
- Uniting World (UW) worked in partnership with Maha Bhoga Marga (MBM). UW Southeast Asia Regional Office (UW SEARO) has worked in partnership with MBM since 2012. For the *Pulih Bersama* program, UW shared 91 per cent of the budget with MBM. Uniting World provided capacity building and sharing of expertise. Both partners leveraged their combined resources and contacts to implement the project collaboratively and network with other consortium members.

4.4 The role of faith-based organisations

Based on the reflections provided by WVI and partners, faith-based organisations have an important role in implementing a program such as *Pulih Bersama*.

- Religious leaders have a significant role to promote literacy and information to deal with the pandemic (i.e. vaccinations, livelihoods). The challenge is to raise awareness and change mindsets as not all religious leaders believe in the issue of COVID-19.
- The collaboration with religious communities allows WVI and partners to suggest different ways to react and contribute sensitively on COVID-19.

The CAN DO Consortium also provided reflections on the role of faith-based organisations in the pandemic response.

- The penta-helix approach allowed religious leaders, faith-based organisations and volunteers to work together and alongside government, community, academia, media and other actors.
- Religious leaders provide theological literacy, health literacy, and psychosocial support as part of holistic services to the community. In addition, they have also learned about GEDSI, where their teachings can raise awareness on inclusiveness.

4.5 Lessons for partners and consortiums

Focus group discussions during the learning workshop highlighted some key lessons from the *Pulih Bersama* project.

- During the COVID-19 pandemic, WVI and CAN DO Consortiums were able to be adaptive and provide capacity building to partners to assist program implementation. They also employed diverse solutions to combat the pandemic through working online as a viable option. This included: improving ICT and digital skills in knowledge management and monitoring and evaluation; working with community leaders as influencers to develop and share online social and behaviour campaign messages, and mobilising volunteers online.
- Collaborative partnerships working with local partners and consortia mechanisms provided benefits and unique challenges. Despite the challenges, both WVI and partners and the CAN DO consortium discussed the importance of accelerating localisation through different partnership models and the establishment of stronger governance and organisational systems. There would be value in the Australian Government undertaking further analysis of different

partnership models that help accelerate the localisation agenda and the development of actionable recommendations to create an enabling environment for localisation. Despite the increase in consortium-managed projects, there is a paucity of information on how to set up and manage partnerships and consortia effectively, with little comparative analysis of consortia case studies and limited peer-reviewed literature (Gonsalves 2014: 2; Fowler and McMahon 2010; CRS 2008)[1].

- GEDSI was a key focus of the *Pulih Bersama* Program and local partners worked in less developed regions and remote areas with limited access to government COVID-19 support. The impact of COVID-19 on health and education widened barriers to equality of access and heightened regional disparities. Local partners worked with government and other stakeholders to assist marginal groups' access to health, educational, and psychosocial services.
- The program demonstrated that religion can be used as a practical means to help combat the spread of COVID-19. WVI and the CAN DO Consortium actively engaged with local partners and youth to develop social media messages to raise awareness about preventative measures among their congregations. Together with religious leaders and faith-based organisations, they became influencers who could advocate for social change in a time of crisis. There is potential for these local partners, religions leaders and faith-based organisations, who have been empowered with strong GEDSI understanding, to use their moral authority to advocate for the empowerment of women, and access to education and health facilities for the marginalised communities.
- WVI and CAN DO Consortiums focused on ensuring their partnership approach recognised local contexts and actors and respected the inclusion and voluntarism of local stakeholders. Neither consortium prescribed a one-size-fits-all approach and both consortiums worked to empower the local partner as an enabling agency for multi-stakeholder initiatives. Both WVI and CAN DO invested in capacity building, a better understanding of partnering processes and governance, and a more attuned approach to funding, monitoring and evaluation, which ensured systematic and adequate support to partnerships.

[1] Reference:

- Gonsalves, A. (2014). Lessons learned on consortium-based research in climate change and development. CARIAA Working Paper no. 1. Ottowa: International Development Research Centre and London: UK Aid. https://www.idrc.ca/en/article/lessons-consortium-based-researchclimate-change-and-development
- Fowler, A. and McMahon, J. (2010). Insights from the enhanced livelihoods in the Mandera triangle programme – ELMT/ELSE. Policy brief. Working as a consortium – benefits and challenges. http://www.fao.org/fileadmin/user_upload/drought/docs/ELMT_Consortium_Policy_BriefFINAL_1_.pdf
- Catholic Relief Services (2008). Consortium Alignments Framework for Excellence. Baltimore: Catholic Relief Services. https://usaidlearninglab.org/library/crs-consortium-partnership-cafeconsortium-alignments-framework-excellence-0

ANNEX 1 – WORKSHOP PROGRAMME

Background of the Workshop

In line with AHP Evaluation Policy, any AHP response over $3 million may be subject to an independently led evaluation. In this instance – in consultation with and in accordance with DFAT needs and priorities – a learning event was deemed the most appropriate end of program activity. The learning event was managed by the AHP Support Unit in Australia and led by an independent facilitator in Indonesia.

Purpose of the Workshop

The general objective of the Learning Event was to draw out lessons from the implementation of the AHP *Pulih Bersama* response in Indonesia (November 2021 - January 2023). The learning event brought together Wahana Visi Indonesia (WVI) and CAN DO consortia members to share their work, provide an overview of research conducted as part of the program, and develop lessons learned from project implementation. A series of reflections from World Vision and CAN DO consortia members were provided, as well as communication and engagement materials developed during the response.

General Outcomes

The workshop, hosted by the AHP Support Unit, brought together 36 people from World Vision and partners, CAN DO Consortia, DFAT, Government of Indonesia and the International Federation of Red Cross and Red Crescent Societies (IFRC). Participants provided presentations and engaged in in-depth discussions on program implementation. All participants agreed that the learning event will assist them with insights for their final program reporting. Wahania Visi and CAN DO Consortia were also able to share their knowledge products with each other, the Government of Australia, the Government of Indonesia and IFRC during the workshop through project displays and online sharing.

Workshop Agenda

Time	Agenda	Facilitator/ Presenter
08.30 – 09.00	1. Registration Please arrive to the meeting room before 9AM as we aim to start on time.	
9.00 – 9.15	2. Introduction • *Ice-breaker* • Explaining the workshop objective • Setting the purpose and expectations for the workshop	Primatia Romana Wulandari
09:15 – 9.30	3. Opening remarks • DFAT Representative: Sarah Stein (DFAT) • GoI Representative: Pambudi Suroyo Jati (BNPB)	Primatia Romana Wulandari
9.30 – 9.45	4. An overview of the PULIH BERSAMA program • Program background • Expected outcomes	TBC
9.45 – 10.00	Coffee break	

10.00 – 11.00	5. Reflection on Project Implementation Each consortium to provide a 15-minute presentation, reflecting the following: • Effectiveness: to what extent have we achieved the results that we expected? • Relevance: to what extent are the current strategies fit for purpose in the context of COVID-19? Also, on approaches to GEDSI, localisation and protection. • Performance, Monitoring and Evaluation: to what extent was there a system to generate consistent and credible information to inform decision-making? • Forward looking: o What can we do differently? (3-5 points) o Recommendations and feedback to DFAT for future programming (e.g. reflecting on: the design, governance arrangements, coordination and communication, and whether the program implementation is successful/ sustainable). Questions and Answers (30 minutes) *Ice breaker before the next agenda*	Primatia Romana Wulandari Presenters: • WVI • CAN DO *Ice breaker by WVI*
11.00 – 12.00	6. Understanding the gaps in our evidence • *Homework:* Each consortium will review the outcomes and identify evidence gaps: come prepared with a list of outcomes and the available data to verify them. You should also reflect on whether new data is needed or data is already available. If data is available, where can we find those? What are the next steps to ensure robust evidence is provided on each outcome? • Presenting the evidence gaps and action plan (15-minute presentation) • Discussion for input from the workshop participants	Primatia Romana Wulandari Presenters: • WVI • CAN DO
12.00 – 13.00	*Lunch break*	
13.00 – 13.45	7. Group discussion Each consortium will discuss the following topics in a small group: (1) project innovation in COVID-19 context (e.g. RCCE, coordination, MEAL dashboard, etc), (2) GEDSI, (3) localisation, (4) the role of faith-based organisations (including volunteerism) and other key thematic areas: • What important lessons emerged from the implementation? • What do these lessons mean for the consortium?	Primatia Romana Wulandari
13.45 – 15.15	8. Round robin for input from other participants One member of the group presents to the audience and documents the inputs as the participants go through the flipchart developed during the group discussion.	Primatia Romana Wulandari
15.15 – 15.30	*Coffee break*	
15.30 – 16.00	9. Presenting the lessons learned *Ice breaker* Each consortium presents the results of their discussions on the lessons learned on thematic areas	Primatia Romana Wulandari *Ice breaker by CAN DO*
16.00 – 16.30	10. Next steps and closing	

ANNEX 2 – ATTENDANCE LIST

No.	Organisation	Role	Position	Name
1	ADRA Indonesia	CAN DO In-Country Partner	Program Director	D. Karlo Purba
2	ADRA Indonesia	CAN DO In-Country Partner	Program Manager	Yosephine Bidi
3	ADRA Indonesia	CAN DO In-Country Partner	Project Officer	Gracia Wenas
4	ADRA Indonesia	CAN DO In-Country Partner	Photographer	Elvin Bidi
5	ADRA Indonesia	CAN DO In-Country Partner	Photographer	-
6	Gereja Masehi Injili di Timor (GMIT)	Local Partner	Partnership Officer	Rev. Emil Hauteas
7	Perkumpulan Suara Kita (Our Voice)	Local Partner	Director	Bambang Prayudi
8	ADRA Australia	Parent ANGOs	Emergency Management Program Manager	Andrew Lowry
9	Catholic Relief Services (CRS)	CAN DO In-Country Partner	Country Manager	Yenni Suryani
10	Catholic Relief Services (CRS)	CAN DO In-Country Partner	Senior Project Officer	Frederikus Sundoko
11	Human Initiative (HI)	Local Partner	Vice President (Operations)	Andjar Radite
12	Human Initiative (HI)	Local Partner	Programme Manager	Rizka Azharini
13	Church World Service (CWS)	CAN DO In-Country Partner	Country Representative	Dino Satria
14	Church World Service (CWS)	CAN DO In-Country Partner	Program Manager	Vincent Surma
15	Church World Service (CWS)	CAN DO In-Country Partner	MEAL Officer	Vina Arimbi

No.	Organisation	Role	Position	Name
16	Church World Service (CWS)	CAN DO In-Country Partner	Project Coordinator – CAN DO Consortia in-country partners	Arie Setiawan
17	PMPB	Local Partner	Director	Chris Nggelan
18	Yayasan INANTA	Local Partner	Executive Director	Leonardy Sambo
19	Yayasan Bunga Bali (DPO)	Local Partner	Foundation board member/ disability-rights advocate	Ni Ketut Dessiani
20	Gereja Kristen Protestan di Bali (GKPB)	Local Partner	Head of Regional Synod GKPB for North Badung, Badung District	Rev. Dr. Ni Luh Suartini, M.Th
21	Maha Bhoga Marga (MBM)	CAN DO In-Country Partner	Programme Manager	Pipit Purwadi Nyoto Prakoso
22	Uniting World (UW)	Parent ANGOs	Program Manager - Southeast Asia	Hindra Sulaksono
23	World Vision Indonesia	In-country partner	MEL Coordinator	Rista Sambalagi
24	World Vision Indonesia	In-country partner	Humanitarian Emergencies and Affairs Director	Yacobus Runtuwene
25	World Vision Indonesia	In-country partner	Grant Contract and Acquisition Manager	Yohana Benu
26	World Vision Indonesia	In-country partner	Project Officer	Steady Zalukhu
27	World Vision Indonesia	In-country partner	Provincial Coordinator	Alfian Leonard
28	Gerakan untuk Kesejahteraan Tuna Rungu in Central Sulawesi	Local partner	Health Promotion Facilitator	Sari Knoduwes
29	Yayasan Alfa Omega in NTT	Local partner	Project Manager	Petrus Yohanes Adu
30	Gereja Masehi Injili di Timor in NTT	Local partner	Monitoring Evaluation Coordinator	Leony Pah
31	Australian Government DFAT	Government	First Secretary (Disaster and Climate Resilience)	Sarah Stein
32	Australian Government DFAT	Government	DFAT	Gloriana Panjaitan

No.	Organisation	Role	Position	Name
33	Australian Government DFAT	Government	DFAT	Henry Pirade
34	Government of Indonesia	National Agency for Disaster Countermeasure (BNPB)	Head of Sub Unit Monitoring and Evaluation	Pambudi Suroyo Jati
35	Government of Indonesia	BNPB	Government of Indonesia	Intan Palupi
36	IFRC	Stakeholder	Planning, Monitoring, Evaluation and Reporting Officer	Puput Ertiandani
37	Supporting		Note taker	Tita Adelia
38	Supporting		Sign language interpreter	Magfiratul Adawiyah
39	Supporting		Facilitator	Dr Primatia Romana Wulandari

AHP Australian Humanitarian Partnership

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