Concept Note

Section 1: Overview of response	
Project Title	Emergency assistance to people affected by the earthquake and tsunami in Central Sulawesi – IDN182
Location	Palu, Donggala and Sigi District, Central Sulawesi, Indonesia
Project start date	1 October 2018
Duration of project	12 (months)
Budget (USD)	3,026,202 (USD)
Sector(s)	☒ Shelter / NFIs ☐ Food Security ☒ Health / Nutrition ☒ Protection/Psychosocial ☒ WASH ☒ Education ☐ Early recovery / Livelihoods ☐ Unconditional Cash ☒ Other sector Emergency preparedness and camp management
Forum	ACT Indonesia Forum
Requesting members	• Church World Service (CWS) • PELKESI/ICAHS (Indonesian Christian Association for Health Services) • YAKKUM Emergency Unit (YEU)
Local partners	Local churches and local interfaith communities
Impact (overall objective)	To fulfil basic need and basic right people in Palu, Donggala and Sigi, District affected by the earthquake and tsunami through fulfilment of basic needs and basic rights.
Target beneficiaries	100,000 affected communities in Palu, Donggala and Sigi District, Central Sulawesi. Among of them are vulnerable groups i.e. children under five, pregnant women, nursing women, elderly and people living with disabilities.
Expected outcomes	A.1 Improved community capacity in safe, healthy and inclusive housing construction to rebuild their houses properly A.2 Transitional shelters for target households meeting Sphere standards constructed B. Increased access of affected persons to safe water and sanitation Facilities, and improved practice in hygiene promotion that meet Sphere Standards C.1 Health and hygiene of the affected communities are monitored and well maintained C.1.1 Medical intervention for patients including post injured patients.

	C.1.2 The quality improvement of community health by reducing the number of primary diseases, controlling the potential of outbreak in IDP camps and reproductive health services C.1.3 Restoration of church health services C.1.4 Restoration of local community health systems C.1.5 Improvement of local capacity through health-based disaster risk reduction. C.2 People with disabilities are empowered and supported by their families and communities to be able to function well in their daily activity. D. Affected communities regain a sense of normalcy, stability and hope through psychosocial interventions. E. Strengthened local livelihood alternatives that support post-disaster situation F. Increased awareness of affected communities in disaster preparedness G.1 Increased knowledge and skills of staff and partners on programmatic, administrative, financial and logistical issues G.2 Improved quality of program implementation capacity
Expected outputs	A.1 Communities know the basic principles and techniques in construction using approved building codes and standards A.2 Affected households are able to cope with basic needs on temporary shelter needs during emergency situation A.3 Community working groups (Pokja) are established in each village B.1. Communities have access to safe water and sanitation facilities B.2. Improved awareness on hygiene promotion and healthy environment C.1.1 a. The spread of diseases including infection among injured patients is prevented by 70% b. High-risk disease patients can be referred to health facilities, patients who need advanced treatment, and cannot be served only with a mobile clinic, will be referred to hospitals C.1.2 a. The elimination of the primary disease's causatives factors by 70% b. Infectious patients are quarantined to prevent an outbreak c. Management of reproductive health for women and adolescents d. Providing information on health and disease prevention C.1.3

	a. Functional rehabilitation of Woodward & Samaritan Hospital to ensure patient safety, retrofitting hospital building so the building is safe to operate serving patients b. Essential hospital equipment are functional c. Availability of essential medicines fulfilled d. Full operation of Mobile Clinics e. Installation of IT systems to ensure MIS and medical services f. Emergency human resource support (temporarily assign doctors, nurses and health workers from other hospitals because the existing health workers have not been able to work optimally because of the large number of patients who need to be treated) g. Capacity building to fulfil quality standards for universal access partnership soon after recovery, and increased capacity of hospitals to deal with future disasters by establishment of hospital plans and systems. h. Outreach service and PHC to enhance Health DRR in their catchment areas C.1.4 a. Recovery of community health center systems b. Recovery of healthcare system in village integrated health centers c. Supplementary feeding for vulnerable groups (children under five, pregnant women, nursing women and elderly C.1.5. The local capacity of village health cadres and churches is strengthened C. 2.1 People with disability have improved knowledge about their health and actively participate C.2.2 Family and community members have increased awareness about disability C.2.3 Physical barriers for people with disability are reduced D.1 Family and community members are trained on psychosocial care and support D.2 Children have safe space and protected environment to develop, learn, play and build resilience after emergency D.3. Community social protection mechanisms are in place E. Training/Workshop on livelihood for affected population F.1 Community based disaster preparedness systems are in place F.2 Communities have the capacity in preparedness and disaster response G. Training conducted for staff and partners to improve program quality and delivery
Main activities	A.1 Distribution emergency shelter kit (tarpaulins, blankets, matrasses, etc) A.2 Distribution of emergency shelter tool kits A.3 Earthquake-resistant construction training and info-session for community members (representatives of target households or local craftsmen)

	A. 4 Awareness raising on ''healthy house" through dissemination of brochure/poster on healthy house. A.5 Provide transitional shelters for most affected households and people with disability B.1 Distribution of water supply (water bladders, jerrycans) to distribution points B.2 Cleaning, repair and building of wells B.3 Waste management and disposal in concentrated areas B.4 Protect spring water and construct catchment tanks/ gravity-fed system B.5 Construct semi-permanent communal latrines B.6 Capacity building training for mothers, health cadres and other stakeholders on water borne diseases and hygiene and sanitation practices B.7 Distribution of hygiene kits C.1.1Mobile Clinic 1. Medical treatments for patients including post-injured patients 2. Mobile clinic and home visits 3. Healthcare outreach for groups at high risk and susceptible to to primary diseases. C.1.2 Primary Health Care 1. Healthy living habit promotion for community 2. Health education for early-age and school-age children. 3. Reproductive health and waste management knowledge and skills for women and adolescents 4. Feminine kits distribution C.1.3 Recovery of Church Health Service 1. Functional physical rehabilitation to ensure patient safety 2. Supporting basic medical equipment 3. Supporting essential medicine 4. IT setup (hardware and software) 5. Mobile clinics operation 6. Human resource temporary deployment from other health unit (medical doctor, nurse, etc) 7. Capacity building to fulfil minimum quality standards for universal access partnership soon after recovery 8. Capacity building for outreach service and PHC to enhance Health DRR in catchment areas C.1.4 Local Healthcare system normalization - revitalization of the integrated health centers 1. Support to community health center activation 2. Assessment on integrated health center data. 2. Monitoring on routine visitation to integrated health canters (D/S). 4. Supplementary nutrition support. C.1.5 Strengthening of the local capacity on disaster risk reduction in health sector. 1. Emergency first aid training for community

	2. Asset-based community development training for health cadres. 3. Training on feeding for infants and children. C.2 1. Physiotherapy for potential disability conditions 2. Provide assisted Device 3. Disability handling training for the community D. 1 Training on psychosocial care and support D. 2 Session on self-protection and essential information to access basic services D. 3 Facilitating learn and play activities for children E.1. Knowledge and skills training on alternative or improved livelihoods activities. E.2 Provide tools & materials to start livelihood activities for affected households F.1 Facilitating the development of disaster preparedness plan F.2 Training on emergency preparedness and response skills G. To provide capacity building training for staff and partners in the areas of program, administration and finance

Section 2: Narrative Summary

Background

An earthquake with a magnitude of 7.4 with the shallow epicenter (10 km) located at 27 km northeast of Donggala occurred at 17:02 WIB (Indonesian Western Time) on 28 September 2018 followed by a tsunami warning by BMKG (Meteorology, Climatology and Geophysics Agency). This earthquake triggered a tsunami that occurred around 17:22 WIB, and BMKG revoked the tsunami warning at 17:38 WIB. There are 2 provinces were directly affected by the earthquake and tsunami: 1. Central Sulawesi Province, there are 4 districts / city; Donggala District, Palu City, Sigi District and Parigi Moutong District; 2. West Sulawesi Province, there is 1 district; North Mamuju District.

According to the Central Sulawesi Earthquake Response Plan (as of 4 October) prepared by the Humanitarian Country Team (HCT), the earthquake and tsunami effectively cut off much of Palu and Donggala from the outside world for several days. Electricity and telecommunications were cut. The airport runway and control tower were both severely damaged. The seaport, which the region relied on for fuel supplies, lost its crane for loading and unloading cargo. Debris and landslides blocked sections of the main roads leading north from Makassar, east from Poso and south from Garontalo. Whole villages were submerged when the land they were built upon liquified. As of 4 October, power had been restored in some parts of Palu. However, fuel is in short supply and vehicles, generators and water pumps are unable to run. People in Palu report having to queue for up to two hours to access water. Shops and markets largely remain closed, and health facilities are reportedly running low on essential medicine and supplies. On 1 October, the Government of Indonesia, through the national disaster management agency (BNPB) and Ministry of Foreign Affairs, welcomed specific offers of international assistance in line with identified humanitarian needs on the ground. The Government of Indonesia has significant experience and capacity to manage natural disasters, but given the scale and complexity of this emergency, UN agencies and NGOs are working closely with Government ministries to provide all the necessary technical support.

Data obtained as of 8 October 2018, at 20:00 WIB, was as follows; 1,948 dead casualties. As many as 74,444 displaced persons are sheltered in 147 evacuation site. The death toll was caused by the rubble of the collapsed building due to the earthquake and there was also a tsunami damaging the coastal areas. In addition, there was also liquefaction phenomenon that submerged houses and buildings in Petobo Village, in Jl. Dewi Sartika - South Palu, in Biromaru village - Sigi, and in Sidera village - Sigi. The Governor of Central Sulawesi, Longki Djanggola, declared the state of emergency of response period for the next 14 days, valid from 28 September 2018 to 11 October 2018. The Governor appointed Commander of Korem (Resort Military Command) of 132 / Tadulako as commander of emergency response to earthquake and tsunami in Central Sulawesi. So the main command post on the ground is directed to Korem 132 / Tadulako.

Humanitarian Needs	**Capacity to Respond**
Based on rapid assessments made by ACT Alliance members and partners, the following are the most pressing needs of the affected population: 1. Clean water for consumption, bathing, washing and toileting 2. Portable toilets in shelters 3. Food supply, especially for babies and elderly 4. Non-food items distribution, such as shelter kits (tarpaulin, mattress, etc.), hygiene kits (blanket, toiletries, specific needs for babies, under-5, expectant, women, elderly and persons with disability), proper lighting in shelters, equipment for the clean-up, and carpentry utensils for constructing temporary shelters. 5. Continue mobile health service 6. Psychosocial support for children and adults 7. Shelter management to prepare the rainy season	PELKESI and YEU were in Palu since September 30, 2018. Previous experience was a joint response in the Pidie Jaya Earthquake, Nanggroe Aceh Darussalam, December 2016 and Lombok District Earthquake. CWS and YEU has experienced in large emergency response operation in Indonesia, for example the Indian Ocean Tsunami 2004, Yogyakarta earthquake 2006, and West Sumatera earthquake 2009. CWS also has experience working in Central Sulawesi in 2000 to 2013, from emergency respond program to development. CWS has its EPRP and local staffs trained in emergency respond to be deployed. CWS at the regional has capacity to support with our emergency respond roster. Currently we have staff on the ground and has started our emergency relief operation in water distribution. Action already taken : 1. Assessment focused on health, WASH, and psychosocial support. 2. YEU and PELKESI have started health service. 4. Water distribution 5. Distributing Non Food item : blanket and tarpaulins 6. Psychosocial support

Proposed response

Does the proposed response honour ACT's commitment to Child Safeguarding? ☒ Yes ☐ No

In collaboration with relevant stakeholders, YEU have identified a gaps in fulfilling the basic supplies in temporary shelters to accommodate the needs and accessibility of vulnerable groups. YEU will

provide immediate basic needs for around 10,000 people displaced by the strike of earthquake and tsunami through fulfilling immediate needs for shelter and settlement/Non-food items; water-sanitation and hygiene promotion; health/nutrition; protection/psychosocial support; emergency preparedness/resilience and camp management

PELKESI program will be targeting on around 21,870 people from all age groups in health sector adjust to the capacity for response. Government's healthcare systems which are still collapsed as the result of the earthquake and tsunami has cause the fulfilment of basic needs in health sector as one of the community's post-disaster primary needs. Most healthcare unit's area still unable to operate and some biggest hospital had major physical damage, therefore delaying the handling process for the victims. Two of these hospitals are PELKESI/ICAHS's hospital members, i.e. Woodward Hospital and Samaritan Hospital. Even though physically the Woodward Hospital's building is still standing, however the safety of the building is still questionable. While for Samaritan Hospital, it has ceased to operate due to the unsafe of the hospital building and also because the limited of medical workers and supplies. For healthcare service, PELKESI will provide mobile clinics, aimed to outreach those whose haven't been touch by any healthcare services due to the minimum of available healthcare services and also due to the collapsed government's healthcare system. There are many churches congregations which are still isolated and untouched by logistic and healthcare aid. These will be one of the targets for mobile clinic services as the catchment areas of hospital intervention.

CWS target areas are Palu, Donggala, Sigi districts with plan to cover 10,000 household with overall goal is to provide relief and recovery assistance to the affected population with following objective: (1) to provide shelter and NFI for 500 affected households, (2) to provide access to water supply, sanitation and hygiene promotion (WASH) for 5,000 affected HH. (3) to provide tools, material and capacity which supports livelihood recovery to 300 most affected micro-entrepreneurs HH, (4) to provide capacity building for staff and partners. Expected result are: (1) 500 HH received shelter kits and NFI kits, (2) 5,000 HH have access to safe water, sanitation facilities and received hygiene information/education, (3) 500 HH have started their livelihood activities (4) staff and partners capacity building workshop done. Activities will include: (1) shelter kits and NFI kits distribution, (2) Water distribution, latrine contractions, waste management, & hygiene promotion/education, (3) livelihood trainings, seeds & tools distribution, (4) staff and partners capacity building workshops.

Due to the lack of logistics and food supplies, many aid trucks were stopped in the middle of the road by survivors, and they plundered the contents due to hungry. So safety aspects should also be considered in the distribution of aid.

Coordination

The overall ACT response (ACT Appeal and Total ACT Response) will be supported by a full-time Appeal Coordinator, with reporting lines both to the ACT Forum and the ACT Secretariat. This item is included as part of the appeal budget. The full utilization and engagement of this role will be defined further by the ACT Forum with the ACT Secretariat. In addition, other coordination and surge capacity needs will be defined to determine how to maximize the available support from various ACT members within Indonesia and globally.

YEU, CWS and PELKESI will continue its very active participation in the coordination meetings established by national cluster and local authorities. YEU, CWS and PELKESI also will encourage local churches, Jakomkris and local partner to be involved in coordination meetings. Information is also share within the ACT Indonesia Forum.

ACT Indonesia Forum (ACTIF) implementation will be coordinated as a comprehensive program. The activities will be implemented by the medical team in coordination with the local stakeholders, health cadres, village midwives, women's groups, elderly groups and the local authorities.

Basic implementation plan

Activities	1	2	3	4	5	6	7	8	9	10	11	12
Shelter management sessions												
Distribution of emergency shelter kit												
Distribution of emergency shelter tool kit												
Earthquake resistant construction training												
Provide Transitional Shelter												
Provide inclusive prototipe house for people with disability												
Coordination meetings with local authorities												
Water, sanitation & hygiene (WASH)												
Distribution of hygine kits												
Distribution of Water Supply (water trucking & distribution points)												
Well cleaning, repair & build												
Emergency Latrines												
Waste management & disposal												
Spring water protection/construction catchment tanks/gravity fed system												
Capacity building/infosesion on hygiene and sanitation practices												
Health / Nutrition												
Medical treatments for patients including post-injured patients												
Health care outreach for susceptible and high-risk												
Health promotion campaign												
Minimal physical rehabilitation to ensure patient savety												
Supporting basic medical equipment												
Supporting essential medicine												
IT setup (hardware and sofware)												
Human resource temporary deployment from other health unit (medical doctor, nurse, etc)												
Hopital Outreach Service Coaching & Programs for 2 hospitals												
Quality Standart fulfilment /Accreditation Coaching												
Suplementary nutrition support												
Supporting of community health center activation												
Assesment on integrated health centers' data												
Integrated health centers activation: Monitoring on routine visitation to integrated health centers(D/S)												
Emergency first aid training for community												
Asset-based community development training for health cadres												
Training on feeding for infants and children												
Physiotherapy for potential disability conditions												
Provide assissted Device												
Disability handling training for the community												
Protection / Psychosocial support												
Training on Psychosocial care and support for cadres												
Session on self-protection and essential information to access basic services												
Facilitating learn and play activities for vulnerable groups												
Establish community based child protection mechanism												
Early recovery & livelihood restoration												
Knowledge and skills training on alternative/improved livelihoods activities												
Provide tools & materials for livelihood activities												
Emergency Preparedness / Resilience												
Emergency Preparedness Training												
Camp Management												
Shelter management session												

Monitoring and evaluation

- YEU will be responsible for overall monitoring and evaluation. The overall monitoring plan includes the following components: The project manager will supervise the implementation

of activities to ensure achievement of outputs and outcome that will be reported to the emergency coordinator. The emergency coordinators will carry out close monitoring and cross-checking in the field for the progress reported, analysing any gaps and identifying further humanitarian needs.

- PELKESI/ICAHS will be responsible with the monitoring and evaluation in health and nutrition sector. Health coordinator as the person in charge of the health program will be ensuring the achievement of outputs and outcomes through supervision. Supervision will be conducted monthly and will be reported to a project manager and PHC-Advocacy program director. The reports will be analysed and will be cross-checked with the situation in the fields to identify the program's achievements based on the outputs and the outcomes, analyse the gap and recommend the next needs. The recommendation from the program's evaluation will be delivered to the village's government and to the community health centers to be a recommendation for the village's programs in health sector. These monitoring and evaluation will be conducted during the project's period.
- CWS program will be monitored daily by field implementation officers who will then report to Program Officers. The Field and Program Officers conduct program monitoring and reporting based on monitoring framework built for this program. Such framework refers to the overall work plan and implementation matrixes which lay out progress and achievement indicators. Monthly field monitoring will be carried out by Program Officers who will provide monitoring reports to the Program Manager. AN evaluation will be done at the end of the program.

Section 3: Budget Summary

		Appeal Budget IDR	Appeal Budget USD
DIRECT COSTS			
1	**PROGRAM STAFF**		
1.1.	Appeal Coordinator	540,000,000	38,028.
1.2.	Total international program staff	0	0
1.3.	Total national program staff	4,033,600,000	276,873
	TOTAL PROGRAM STAFF	**4,033,600,000**	**314,901**
2	**PROGRAM ACTIVITIES**		
2.1.	Shelter and settlement / Non-food items	9,746,500,000	686,373
2.2.	Food security	0	0
2.3.	Water, sanitation & hygiene (WASH)	4,540,000,000	319,718
2.4.	Health / Nutrition	8,161,550,000	574,757
2.5.	Protection / Psychosocial support	396,000,000	24,084
2.6.	Early recovery & livelihood restoration	1,200,000,000	84,507
2.7.	Education	0	0
2.8.	Emergency Preparedness / Resilience	240,000,000	16,901
2.9.	Unconditional CASH grants	0	0
2.10.	Camp Management	90,000,000	6,338
	TOTAL PROGRAM ACTIVITIES	**24,374,050,000**	**1,712,680**
3	**PROGRAM IMPLEMENTATION**		
	TOTAL PROGRAM IMPLEMENTATION	**1,503,000,000**	**105,845**
4	**PROGRAM LOGISTICS**		
	Transport	1,624,000,000	114,366
	Warehousing	684,000,000	48,169
	Handling	512,000,000	36,056
	TOTAL PROGRAM LOGISTICS	**2,820,000,000**	**198,592**
5	**PROGRAM ASSETS & EQUIPMENT**		
	TOTAL PROGRAM ASSETS & EQUIPMENT	**3,982,000,000**	**280,423**
6	**OTHER PROGRAM COSTS**		
6.1.	**SECURITY**		
	TOTAL SECURITY	**125,000,000**	**8,803**
6.2.	**FORUM COORDINATION**		
6.2.1.	Kick-start workshop	50,000,000	3,521
6.2.2.	Mid-review workshop	50,000,000	3,521
6.2.3.	Learning workshop	50,000,000	3,521
6.2.4.	Visibility / fundraising	25,000,000	1,761
6.2.5.	Staff trainings	200,000,000	14,085
6.2.6.	Joint Office	1,020,000,000	71,831
6.2.7	Joint Monitoring Visit	78,000,000	5,493
6.2.8	ACT Coordination meeting	120,000,000	8,451
	TOTAL FORUM COORDINATION	**1,593,000,000**	**112,183**
6.3.	**STRENGTHENING CAPACITIES**		
	TOTAL STRENGTHENING CAPACITIES	**920,250,000**	**64,806**

TOTAL DIRECT COST	**39,350,900,000**	**2,798,232**
INDIRECT COSTS: PERSONNEL, ADMINISTRATION & SUPPORT		
. Staff salaries		
Salaries for Programme Director	210,310,000	14,811
Salaries for Finance Director	179,400,000	12,634
Salaries 30 % for Information and Secretariat Director	42,000,000	2,958
Salaries for accountant and other admin or secretarial staff	156,000,000	10,986
Salaries 20% Operation Director	108,550,000	7,645
Salaries 20% HR Director	138,200,000	9,732
Salaries 20% Sr. HR Officer	44,200,000	3,113
Salaries 100% Operation Officer	68,900,000	4,852
Office Operations		
Office rent	540,000,000	38,028
House rent	180,000,000	12,676
Office Utilities	120,000,000	8,451
Office stationery	96,000,000	6,761
Communications		
Telephone and fax	84,000,000	5,915
Other		
Insurance	18,000,000	1,268
TOTAL INDIRECT COST: PERSONNEL, ADMIN. & SUPPORT	1,985,560,000	139,828
	5%	**5%**
TOTAL EXPENDITURE exclusive International Coordination Fee	**41,336,460,000**	**2,938,061**
INTERNATIONAL COORDINATION FEE (ICF) - 3%	1,240,093,800	88,142
TOTAL EXPENDITURE inclusive International Coordination Fee	**42,576,553,800**	**3,026,202**
BALANCE REQUESTED (minus available income)	**42,576,553,800**	**3,026,202**

Please kindly send your contributions to either of the following ACT bank accounts:

US dollar
Account Number - 240-432629.60A
IBAN No: CH46 0024 0240 4326 2960A

Euro
Euro Bank Account Number - 240-432629.50Z
IBAN No: CH84 0024 0240 4326 2950Z

Account Name: ACT Alliance
UBS AG
8, rue du Rhône
P.O. Box 2600
1211 Geneva 4, SWITZERLAND
Swift address: UBSWCHZH80A

Please note that as part of the revised ACT Humanitarian Mechanism, pledges/contributions are **encouraged** to be made through the consolidated budget of the national forum, and allocations will be made based on agreed criteria of the forum. For any possible earmarking, budget targets per member can be found in the "Summary Table" Annex, and detailed budgets per member are available upon request from the ACT Secretariat. For pledges/contributions, please refer to the spreadsheet accessible through this link http://reports.actalliance.org/. The ACT spreadsheet provides an overview of existing pledges/contributions and associated earmarking for the appeal.

Please inform the Head of Finance and Administration, Line Hempel (Line.Hempel@actalliance.org) and Senior Finance Officer, Lorenzo Correa (Lorenzo.Correa@actalliance.org) with a copy to the Regional Programme Officer, James Munpa (James.Munpa@actalliance.org) of all pledges/contributions and transfers, including funds sent direct to the requesting members.

We would appreciate being informed of any intent to submit applications for EU, USAID and/or other back donor funding and the subsequent results. We thank you in advance for your kind cooperation.

For further information please contact:
ACT Regional Representative, Anoop Sukumaran (ask@actalliance.org)

ACT Website: http://www.actalliance.org

Alwynn Javier
Global Humanitarian Coordinator
ACT Alliance

Logical Framework			
IMPACT To promote the well-being of the most vulnerable people in 12 villages affected by the earthquake and Tsunami through fulfilment of basic needs and basic rights for the saving life, disease prevention and recovery the Health Status, The Normalization of The Church Health Service o And The Improvement Of The People's Capacity For Health Preparedness.			
OUTCOME(S)	**Objectively verifiable indicators**	**Source of verification**	**Assumptions**
A.1 . Improved community's capacity in safe, healthy and inclusive housing construction to rebuilt their houses properly A.2 Transitional shelters for target households meeting Sphere standards constructed	A.1 Increased community's capacity in housing construction according to building codes and building standers	A. 1. Pre-test and post test 2. Practicum evaluation	1. Compliance of Government Regulation Number 21 Year 2008 On Disaster Management. 2. Compliance Regulation of National Board for Disaster Management Number 03 Year 2018 On Refugee Management at the Time of Disaster Emergency.
B. Increased access of affected person to safe water and sanitation facilities and practices hygiene promotion that meet Sphere Standards	B. Affected people have access to safe water and sanitation facilities and practice hygiene promotion	B. Activities report	3. Compliance Decree of Minister of Health Number 145/Menkes/SK /I/2007On Guidelines for Disaster Management in Health Sector.
C.1 Health and hygiene of the affected communities are monitored and well maintained			4. Compliance of Decree no .... on the status of Earthquake and tsunami in Central Celebes
C.1.1.Medical intervention for patients including post Injured patients.	C.1.1 The patients and post-injured patients receive treatments	C.1.1 Medical Record.	4. Resource availability as reflected on ACT Alliance member participation in this Appeal
C.1.2 The quality improvement of the community health by reducing the number of the	C.1.2. a. Reduction of the top 5 diseases found in the IDP's camps.	C.1.2 1. Medical Record 2. Quarantine camp for	5. No other Disaster before the preparedness system is in

primary diseases found in the location, controlling the potential of outbreak in the IDP's camps and reproductive health services	b. Preventing and or controlling the potential of infectious diseases outbreak found in the camps. c. Increasing awareness of reproductive health for women and adolescents during the crisis	infectious diseases patients 3. Women daily reproductive hygiene checklist	place 6. Effectiveness of Action plan from training are implemented and monitored by health department and community health center 7. Gained knowledge from trainings and awareness raising are applied.
C.1.3. The recovery of Church Health service	C.1.3. Functional physical rehabilitation, Medical Equipment, Human resources to ensure the function of the church health services.	C.1.3. assessment report on The function of Hospital health processes	8. Community ownership to program is high 9. High participation and contribution from people with disability, their family and community.
C.1.4. The recovery of Local community health system	C.1.4 a. The healthcare activity in integrated health censers are running normally b. The healthcare system in auxiliary public health centers and village health centers is restored.	C.1.4 Integrated health canters and auxiliary public health centers activity report	10.Complience of CHS in all quality of emergency response
C.1.5. The improvement of local capacity through health-based disaster risk reduction.	C.1.5. The improvement of local capacity in Health disaster risk reduction.	C.1.5 Standard for Disaster-Resilient Village (DESTANA-DesaTangguh Bencana)in Health Sector are set up in rehabilitation and reconstruction plan.	
C.2 People with disabilities are empowered and supported by their family and communities to be able to function well in their daily activity.	C.2 People with disabilities are able to do their activities of daily living	C.2 Activities of daily living checklist	

D. Affected communities regained a sense of normalcy, stability and hope through psychosocial interventions. E. Strengthened local livelihood alternatives that support post-disaster situation F. Increased awareness of the affected communities in disaster preparedness G.1. Increased knowledge and skills of staff and partners on programmatic, administrative, financial and logistical issues G.2 Improved quality of program implementation capacity	D. Vulnerable groups can continue their normal activity through psychosocial intervention E. Communities get support to start livelihood activities F. Affected population have increase their knowledge and skill about disaster preparedness G. Staff and partner have increase their skill and knowledge to improve the program quality	D. 1.Activities Report 2. Development card E. Activities Report F. Pre-test and post test G. 1. training for staff and partner 2. Activities Report	
OUTPUT(S) A. 1.Community knows the basic principles and techniques in construction using the building codes and standards 2. Affected households are able to cope with basic needs on temporary shelter need during emergency situation 3. Community Working Group (Pokja) is established in each hamlet	**Objectively verifiable indicators** A 1. # of households receiving transitional shelter 2. # of transitional shelters built	**Source of verification** A. Handover document of the kit and shelter built.	**Assumptions** 1. Government Regulation Number 21 Year 2008 On Disaster Management. 2. Regulation of National Board for Disaster Management Number 03 year 2018 On Refugee Management at the Time of Disaster Emergency. 3. Decree of Minister of Health Number 145/Menkes/SK /I/2007 On Guidelines for Disaster Management in Health Sector.

B.1Community have access of safe water and sanitation facilities B.2 Improved awareness raising on hygiene promotion and healthy enviroment	B. Community can access their safe water and sanitation facilities and practice healthy living habit	B. 1.Handover document 2. Activities report	4. Health Department and community health center are willing to cooperate. 5. High participation and contribution from affected communities
C.1.1. a. The spreading of diseases including infectious, and injured patients are prevented by 70% b. High risk disease patients can be referred to the health facilities	C.1.1. 21.870 patients from susceptible and high risk disease including post injured patients receive treatment through mobile clinic	1. Medical record. 2. Report and database. 3. List of patients	
C.1.2. a. The elimination of the primary disease's causatives factors by 70% b. Infectious patients are quarantined to prevent an outbreak c. Management of reproductive health for women and adolescents d. Applying information about health promotion	C.1.2. a. 21.870 patients are treated to reducing the primary disease found in community b. Special treatment for the outbreak potential patients c. 13.122 women and adolescent are informed of feminine waste management d. 21.870 patients are informed on health promotion	1. Medical record. 2. Report and database. 3. List of participants. 4. Medicine supply 5. Quarantine room for the infectious patients. 6. IEC distribution. 7. Feminine hygiene distribution	
C.1.3. a. Functional physical rehabilitation of Woodward & Samaritan Hospital to ensure patient safety	C. 1.3 a. Save hospital building for health service	C.1.3 a. Building assessment	

b. The function of essential health equipment recovered c. Availability of essential medicine fulfilled	b. 80% availability of standard of essential health equipment c.100% essential medicine for Emergency & Rehabilitation	b. Minimum government standard c. Ina DRG standard	
d. Full operation of Mobile Clinics	d. 80% mobile clinic function at Hospitals Catchment areas and Congregations	d. Mobile Clinic service service report	
e. The function of IT system to ensure MIS and medical services	e. 80% IT setup for medical records and administration	e. IT standard	
f. Emergency human resource support (deployment from other members or units)	f. 80 % standard of human resources fulfilled	f. Government standard	
g. Capacity building to fulfil minimum quality standards for universal access partnership soon after recovery	g. Full Government accreditation of the hospital	g. Level of Accreditation Status	
h. Outreach service and PHC to enhance Health DRR in their catchment areas	h. Active PHC programs in their catchment areas after the disaster	h. PHC Program Money	
C.1.4. a. The recovery of healthcare system in community health center b. The recovery of healthcare system in integrated health center in village c. Supplementary feeding for vulnerable groups (children under five, pregnant women, nursing women and elderly	C.1.4. a. The activities in community health centers are running normally b. Integrated health centers perform routine monthly activities. c. Vulnerable groups receive healthy food	C.1.4 1. Record form of number of visitation to integrated health centers (D/S). 2. List of participants. 3. Report and database.	

C.1.5. The local capacity of the village health cadres and churches are strengthen	C.1.5. The church/ health cadres are trained.	C.1.5 1. List of participants. 2. Action plan. 3. Report and database. 4. Minutes of meeting.	
C.2.1 People with disability have improved knowledge about their health and actively participate to achieve good health C.2.2 Family and community member have increased awareness about disability. C.2.3 Physical barrier for people with disability is reduced.	C2 People with disability and their family and community have increased the capacity about handling people with disability	C.2.1 Physiotherapy records C.2.2 Activities of daily living checklist C.2..3Handover document of the assistive device.	
D.1. Social safety net (family and community members) are trained on Psychosocial care and support D.2 Children have safe space and protected environment to develop, learn, play and build resiliency after emergency. D. 3 Community social-protection mechanism is in place	D. Social protection for children and other vulnerable people established	D.1.Agreed social protection mechanism D.2. Activities report	
E. Training//Workshop on livelihood for Affected population	E. 1. 3 times Training/workshop will be held E. 2. Community start their livelihood activities	E. 1 Activities Report E.2 Monitoring card	

F.1 Community based disaster preparedness system is in place F.2 Community have the capacity in preparedness and disaster response G. Tainings conducted for staff and partner to improve program quality	F. Disaster Preparedness system established G. training conducted	F. Agreed Disaster Preparedness system G. pre and post test	
Activities A.1 Distribution emergency shelter kit (tarpaulins, blankets, matrasses, etc) A.2 Distribution of emergency shelter tool kits A.3 Earthquake-resistant construction training and info-session for community members (representatives of target households or local craftsmen) A. 4 Awareness raising on healthy house through dissemination of brochure/poster on healthy house. A.5 Provide transitional shelters for most-affected households and people with disability B.1 Distribution of water supply (water bladders, jerry cans) to distribution points B.2 Well cleaning, repair/build B.3 Waste management & disposal in concentrated areas B.4 To protect spring water and construct catchment tanks/ gravity-fed system B.5 to construct semi-permanent communal latrines B.6 Capacity building training for mothers, health cadres and other stakeholders on water borne diseases and hygiene and sanitation practices B.7 hygiene kits are distributed C.1.1Mobile Clinic 1. Medical treatments for patients including post-injured patients. 2. Mobile clinic and home visit. 3. Healthcare outreach for susceptible and high-risk diseases groups on the found primary diseases. C.1.2 Primary Health Care 1. Healthy living habbit promotion for community 2. Health education for early-age and school-age children.			**Pre-conditions** 1. Data on population 2. Data of integrated health services. 3. List of medical record. 4. Observation report. 5. Human resources 6. Training &awareness raising Materials 7. Commitment and support from religious leader and husbands for women attending meeting and participate in the activities 8. Assistive device

3. Reproductive health and waste management knowledge and skills for women and adolescents 4. Feminine kits distribution C.1.3. Recovery of Church Health Service 1. Functional physical rehabilitation to ensure patient safety 2. Supporting basic medical equipment 3. Supporting essential medicine 4. IT setup (hardware and software) 5. Mobile clinics operation 6. Human resource temporary deployment from other health unit (medical doctor, nurse, etc) 7. Capacity building to fulfil minimum quality standards for universal access partnership soon after recovery 8. Capacity Building for Outreach service and PHC to enhance Health DRR in their catchment areas C.1.4 Local Healthcare system normalization - revitalization of the integrated health centers. 1. Support to community health center activation 2. Assessment of integrated health centers' data. 2. Monitoring on routine visitation to integrated health centers(D/S). 4. Supplementary nutrition support. C.1.5. Strengthening of the local capacity on disaster risk reduction in health sector. 1. Emergency first aid training for community 2. Asset-based community development training for health cadres. 3. Training on feeding for infants and children. C.2 1. Physiotherapy for potential disability conditions 2.Provide assisted Device 3. Disability handling training for the community D. 1 Training on psychosocial care and support D. 2 Session on self-protection and essential information to access basic services D. 3 Facilitating learn and play activities for children E. 1.Knowledge and skills training on alternative or improved livelihoods activities. E.2 Provide tools & materials to start livelihood activities for affected households	

F. 1 Facilitating the development of disaster preparedness plan F.2Training on emergency preparedness and response skills G.To provide capacity building training for staff and partners in the areas of program, administration and finance	

Summary Table

Summary	CWS	PELKESI/ICAHS	YAKKUM Emergency Unit/YEU
Implementation period	From **1 October 2018** to 30 September 2019 12 (months)	From **1 October 2018** to 30 September 2019 12 (months)	From **30 September 2018** to 30 September 2019 12 (months)
Geographical area	Central Sulawesi: Palu, Sigi, Donggala, Parigi Mountong districts	Palu, Sigi, Donggala and Parigi Moutong District, Central Sulawesi, Indonesia	Palu, Sigi and Donggala District, Central Sulawei
Sectors of response	☒ Shelter/ NFIs ☐ Unconditional CASH ☒ ER[1]/ Livelihoods ☐ Protection/ Psychosocial ☒ WASH ☐ Food Security ☐ Health ☐ Community resilience ☐ Education ☐ Nutrition	☐ Shelter/ NFIs ☐ Unconditional CASH ☐ ER/ Livelihoods ☐ Protection/ Psychosocial ☐ WASH ☐ Food Security ☒ Health ☐ Community resilience ☐ Education ☐ Nutrition	☒ Shelter/ NFIs ☐ Unconditional CASH ☐ ER/ Livelihoods ☒ Protection/ Psychosocial ☒ WASH ☐ Food Security ☒ Health ☒ Community resilience ☐ Education ☐ Nutrition
Targeted beneficiaries (per sector)	10,000 HH	21.870 persons	10.000 HH
Requested budget (USD)	827.421 (USD)	1.007.064 (USD)	1,037,000 (USD

1 ER = Early Recovery

Summary	ACT Indonesia Forum Coordination
Implementation period	From **1 October 2018** to 30 September 2019 12 (months)
Geographical area	Central Sulawesi
Sectors of response	☐ Shelter/ NFIs ☐ Unconditional CASH ☐ ER[2]/ Livelihoods ☐ Protection/ Psychosocial ☐ WASH ☐ Food Security ☐ Health ☐ Community resilience ☐ Education ☐ Nutrition
Targeted beneficiaries (per sector)	
Requested budget (USD)	154,718 (USD)

2 ER = Early Recovery