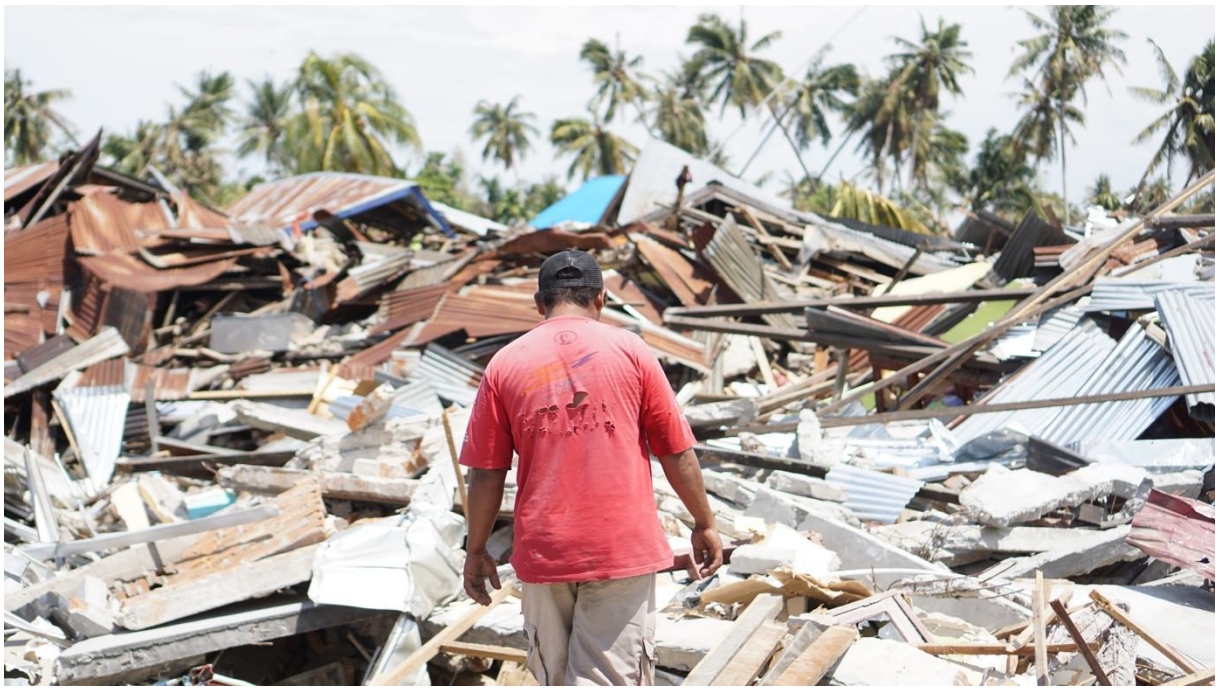
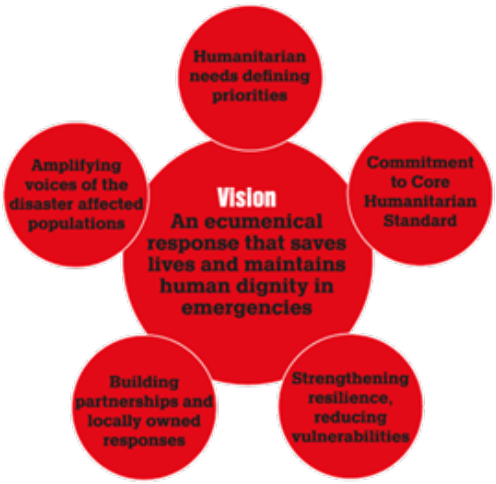
APPEAL



Emergency Assistance to People Affected by the Earthquake and Tsunami in Central Sulawesi – IDN182

Appeal Target:	US$ 5,447,299
Balance requested:	US$ 5,447,299



SECRETARIAT: 150, route de Ferney, P.O. Box 2100, 1211 Geneva 2, Switz. TEL.: +4122 791 6434 – FAX: +4122 791 6506 –

Core Humanitarian STANDARD The ACT Alliance Secretariat's continuous improvement in the application of the Core Humanitarian Standard is independently verified by HQAI

www.actalliance.org

Table of contents

Project Summary Sheet	
Project Title	Emergency Assistance to People Affected by the Earthquake and Tsunami in Central Sulawesi
Project ID	IDN 182
Location	Palu, Donggala and Sigi Districts, Central Sulawesi Province
Project Period	From 1 October 2018 to 30 September 2020 Total duration: 24 (months)
Modality of project delivery	☒ self-implemented ☐ CBOs ☐ Public sector ☒ local partners ☐ Private sector ☐ Other
Forum	ACT Indonesia Forum
Requesting members	• Church World Service (CWS) • PELKESI/ICAHS (Indonesian Christian Association for Health Services) • YAKKUM Emergency Unit (YEU)
Local partners	• Yayasan Inanta • LSM Dangau
Thematic Area(s)	☒ Shelter / NFIs; ☒ Protection / Psychosocial ☐ Food Security; ☒ Early recovery / livelihoods ☒ WASH; ☐ Education ☒ Health / Nutrition; ☐ Unconditional cash ☒ Other sector: Camp management, emergency preparedness ☐ Advocacy ☒ DRR/Climate change ☒ Resilience
Project Impact	To fulfil basic needs and right to assistance of people in Palu, Donggala and Sigi, District affected by the earthquake and tsunami, enabling them to restore their lives and livelihoods
Project Outcome(s)	A.1 Improved community capacity in safe, healthy and inclusive housing construction to rebuild shelters in accordance to applicable Sphere and government-approved standards A.2 Transitional shelters provided to target households according to Sphere standards 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 affected communities are monitored and well maintained C.1.1 Medical intervention for patients including post injured patients. C.1.2 Improved community health by reducing the number of primary diseases, controlling the potential of outbreak in IDP camps, and provision of reproductive health services C.1.3 Restoration of 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 rehabilitation F. Increased awareness of affected communities in disaster risk and preparedness
Target beneficiaries	**Beneficiary profile** ☐ Refugees ☒ IDPs ☐ host population ☐ Returnees ☒ Non-displaced affected population 100,000 affected people in Palu, Donggala and Sigi Districts, Central Sulawesi. Among of them are vulnerable groups i.e. children under five, pregnant women, nursing women, elderly and people living with disabilities.
Project Cost (USD)	5,447,299 (USD)

Reporting Schedule

Type of Report	Due date
Situation report	Quarterly
Final narrative and financial report (60 days after the ending date)	30 November 2020
Audit report (90 days after the ending date)	31 December 2020

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 country 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 Program 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 (Anoop.Sukumaran@actalliance.org)
Regional Program Officer, James Munpa (James.Munpa@actalliance.org)
ACT Forum Convener (YEU), Sari Mutia Timur (sari.mutiatimur@gmail.com)

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

Alwynn Javier
Global Humanitarian Coordinator
ACT Alliance Secretariat

1. BACKGROUND

1.1. Context

On 28 September 2018 at 17:02 WIB (Indonesian Western Time), an earthquake with a magnitude of 7.4 hit Central Sulawesi, 27 kilometers northeast of Donggala with a shallow epicenter (10 km). It was immediately followed by a tsunami warning by BMKG (Meteorology, Climatology and Geophysics Agency). This earthquake triggered a tsunami that hit the coast at 17:22 WIB. 2 provinces were directly affected by the earthquake and tsunami: Central Sulawesi Province (4 districts/city; Donggala, Palu City, Sigi and Parigi Moutong) and West Sulawesi Province (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.

According to the most updated information about the impacts of this disaster from the ASEAN Coordinating Centre for Humanitarian Assistance on Disaster Management (AHA Centre), as of 26th October, there were already 2,081 casualties, with 1,309 missing or feared to be buried, and 4,438 major injuries. As many as 206,494 displaced persons are sheltered in 122 evacuation site, with 68,451 houses significantly damaged. According to ASEAN Specialized Meteorological Centre (ASMC), the sub-seasonal forecast indicates that Central Sulawesi may still experience rains and wetter conditions in the coming period.

Much of the death toll was caused by the rubble of collapsed buildings, and also as a direct impact of the tsunami in coastal areas. In addition, there was also a liquefaction phenomenon that submerged houses and buildings. The Governor of Central Sulawesi, Longki Djanggola, declared a state of emergency for 28 days, from 28 September 2018 to 26 October 2018, with an emergency transition status to Recovery for 60 days (27 October-25 December 2018). The Governor appointed the Commander of Korem (Resort Military Command) 132 /Tadulako as commander of emergency response, so the main command post on the ground is directed to Korem 132/ Tadulako.

1.2. Needs

According to the Joint Needs Assessment conducted by the Emergency Capacity Building Consortium in collaboration with Humanitarian Forum Indonesia on 3–8 October 2018 in 242 sites in 4 District (Palu, Donggala, Sigi and Parigi Moutong), 29 Sub-districts and 107 Villages, the main findings are the following:

1. Emergency shelter (only makeshift tents with limited availability of mattresses, blankets)
2. Lack of protection measures in the IDP camps make the situation become difficult especially for girls, adolescent and other people at risk (elderly, pregnant and lactating mother).
3. Overcrowded tents with limited number of latrines (no separate space for men and women and many IDP camps do not have latrines at all),
4. Lack of water and private space for shower/bathing, which makes the situation uncomfortable for girls and women. Poor sanitation and the lack of clean water supply have a health impact on IDPs with many cases of infectious diseases such as diarrhea and dermatitis.
5. 63% of visited sites said health facilities were not functioning. Health service is needed to fill the gap in the role of public health centers that have not been able to function normally and village health services that are still collapsed. Intervention for newly disabled persons is also concern, in addition to other vulnerable groups.
6. Many girls and boys indicate psychosocial distress including anxiety, routinely expressing worries, crying, displaying fearful reaction, clinging to parents, lack of sleep, loss of appetite, and other sickness.
7. Need to map security and protection issues involving vulnerable groups such as children, women and persons with disabilities
8. Without a proper camps coordinator, the management in the camps become messy. The affected communities, including health services should be well prepared. Preparedness programs remain relevant and important for communities and health facilities.

1.3. Capacity to respond

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 have experience in large emergency response operations in Indonesia, for example the Indian Ocean Tsunami 2004, Yogyakarta earthquake 2006, West Sumatra earthquake 2009, and Mentawai earthquake 2010. CWS also has experience working in Central Sulawesi from 2000 to 2013, from emergency response programs to development. CWS and YEU are members of the Humanitarian Forum Indonesia, which is a member of the Humanitarian Country Team (HCT).

CWS has its organizational and partner EPRPs in place, and local staff are trained to be deployed in emergency response. CWS at the regional level has capacity to support with their emergency response roster of 20 staff members. Currently it has 5 staff on the ground and has started emergency relief operations in water distribution and distribution of other relief items. CWS is partnering with two local NGOs.

2. PROJECT RATIONALE (*see Logical Framework, Annex 3*)

2.1. Intervention strategy and theory of change

The combined efforts of CWS, PELKESI and YEU will contribute to meet the basic needs of the most vulnerable groups affected by the earthquake and tsunami, who have very limited resources to recover from the impact of the disaster. The proposed intervention targets 100,000 persons mostly affected by the earthquake and tsunami in the district of Palu, Sigi and Donggala. The intervention will take place in two phases: emergency response, and early recovery/rehabilitation. The emergency response phase will focus on fulfilling the basic needs of the affected population in:

shelter (providing shelter kit and NFI), WASH (providing water supply, hygiene promotion, hygiene kits distribution, excreta disposal/latrine construction and waste management), Health (health service and promotion, physiotherapy for potential disability conditions, distribution assistive device), Psychosocial support (facilitating learn and play activities for vulnerable groups), and Camp Management (shelter management session).

During the early recovery/rehabilitation phase, the focus will be on supporting the communities to rehabilitate the lives and livelihoods of affected communities. This will be done by focusing on Shelter (transitional shelter so they can live safe and secure until the government permanent housing program is completed), WASH (rehabilitation of community water supply which includes improving their main water sources such as wells and gravitation system, providing family or communal latrines); Health (strengthen churches' health programs care through capacity building); Psychosocial support, and Emergency Preparedness (awareness, training and simulation).

The intervention strategy for recovery includes a gap mapping in the community starting from the village government and relevant stakeholders such as the Public Health Center and the Health Office. ACT members will play a role in filling the gap and use a strategic step in maximizing the role of government institutions in restoring the health status of IDPs. On the other hand, Pelkesi will also strengthen the church's health care unit, which will be collaborated as a referral hospital .

2.2. Impact

To promote the well-being of 100,000 most vulnerable people affected by the earthquake and tsunami through fulfilment of basic needs and basic rights, improve their capacity for preparedness, and restore their lives and livelihoods.

2.3. Outcomes

A.1 Improved community capacity in safe, healthy and inclusive housing construction to rebuild shelters properly

A.2 Transitional shelters for target households meeting Sphere standards

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 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

2.4. 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

B.1. Communities have access to safe water and sanitation facilities

B.2. Improved awareness on hygiene 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. Elimination of primary diseases' causative 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. Community members have access to livelihood development supports 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

2.5. Preconditions / Assumptions

Funds are available and released in a timely manner; right quality and enough quantity of shelter kits; NFI kits and hygiene kits are available; security and safety situation is manageable; evacuated families are able to return to their homes or areas; government has relocation sites available for families who need relocation; local government commits to guide the process and respect project deadlines. The health sector project receives support from the provincial health department, district health department, public health centers and local government through regional health system. Regional and or District coordination to ensure health care service to IDPs in accordance with Kepmenkes No. 145/MENKES/SK/I/2007 on Guidelines for the health sector Disaster Management. Community ownership of program is high, including participation of people with disability, their families and communities.

2.6. Risk Analysis

Risk factors identified to affect the implementation response include: disruption of activities due to weather condition that disrupts road access (landslides); political risk (lack of support from the government); and funds are insufficient or do not arrive on time. To minimize these risks, requesting members will carry out mitigation strategies in close coordination with relevant stakeholders, especially the local government as well as partners. Natural hazards, particularly severe weather conditions, are a major factor affecting the implementation of the project. Existing conditions in Sigi District area which has a high rainfall occurrence and erosive soil structure is an obstacle to reach

the intervention areas. Similarly, Donggala District is potentially accident-prone due to landslides. Some places are also endemic for tropical diseases. Cases of theft and robbery occur in several places. To mitigate crime, requesting members will coordinate with local security officers.

2.7. Sustainability / Exit strategy

The program emphasizes the role of local communities in the emergency response in ensuring a consultative process and community-led response. Requesting members will make sure that communities, local government and partners are well informed of the response plans including timelines and expectations. The implementation process will consider local capacities using a 'do no harm approach' to promote and strengthen community resilience and ensure the goals and targets are achieved. The sustainability program after the intervention will be referred to PELKESI member hospitals in Central Sulawesi, e.g. Samaritan Hospital and Woodward Hospital, through the development of extramural hospital services.

2.8. Building capacity of national members

YEU will provide capacity building to local and national partners and also church and local interfaith communities. The topics will be discussed and agreed upon to match their conditions and needs.

3. PROJECT IMPLEMENTATION

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

CWS and YEU have Child Safeguarding Policies that will ensure and guide staff, partners and volunteers in dealing with children. CWS and YEU will make sure that all staff, partners and volunteers are inducted and sign the policy, and a complaint mechanism will be in place within service delivery areas and through the local partners. The Child Safeguarding Policy includes a screening process of staff recruitment, non-hiring of children, acquiring informed consent from parents before photos, videos or stories are used for communications/media purposes. YEU also has a vulnerable adult protection policy which includes the obligation to protect not only children but also vulnerable adults such as the elderly and persons with disabilities.

3.1. ACT Code of Conduct

CWS and YEU Staff, partners and volunteers will be inducted to and required to sign the ACT Code of Conduct to prevent sexual exploitation and abuse, fraud and corruption, and abuse of power. A complaints mechanism will be in place in CWS and YEU service delivery areas as well as through partners in consultation with communities on the best ways and method to ensure access and confidentiality. Sensitive cases will be regulated through a whistle blower policy.

3.2. Implementation Approach

In the relief phase, the proposed intervention aims to support the affected population to meet their basic survival needs in Shelter, WASH, Health and psychosocial support. CWS will implement through local partners Yayasan Dangau in Palu and Sigi district, and Yayasan Inanta in Donggala district . Pelkesi YEU will directly implement the response, in coordination with relevant stakeholders.

In the early recovery and rehabilitation phase, the program will support the affected communities in their transitional phase to early recovery of livelihoods while the government is preparing for their relocation (if needed) and rebuilding of their homes.

3.3. Project Stakeholders

Project stakeholders include the affected communities, the local, district and national government units, and agencies who hold the prime responsibility to respond to the needs of the affected population.

3.4. Field Coordination

CWS and YEU are active in WASH and Shelter sub-clusters, including in the technical working groups of these sub-clusters. In the sub-clusters, the response is coordinated to fulfill gaps, avoid overlapping, and tackle issues on the ground. CWS and YEU will also coordinate with Humanitarian Forum Indonesia, whose members have their team on the ground and have established a base of operation, and have developed a joint response plan. Pelkesi and YEU will collaborate with the Provincial and District Health Offices as guided by an MoU. Project implementation will be reported quarterly to the Health Service. At the national level, coordination is carried out through the Health Cluster / Health Cluster Working Group. YEU is also active in the protection cluster.

3.5. Project Management

A project manager from each member will report the progress of implementation monthly to the Field Forum Coordinator and will be compiled through SitReps. An Emergency Coordinator/Appeal Coordinator and other relevant staff will be hired by the requesting members to provide overall management and coordination of the response.

3.6. Implementing Partners

CWS will work through implementing partners Yayasan Dangau (in Palu and Sigi district), and Yayasan Inanta (in Donggala district).

3.7. Project Advocacy

Advocacy will be done through the humanitarian coordination mechanism at different levels, especially at the cluster and sub-cluster level (WASH, Shelter, Health, Protection and displacement), where issues and gaps are identified so that other actors who have the capacity (including government) could address the need.

3.8. Engaging faith leaders

Churches are encourage to enhance the capacity of health disaster risk reduction through their health services. Faith leaders are engaged to support in promoting health practices to the church congregation.

Simplified Work Plan

Emergency Assistance to People Affected by the Earthquake and Tsunami in Central Sulawesi- IDN182

actalliance

	Activities	Year 1												Year 2											
		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Shelter																									
A.1.1	Distribution of Emergency Shelter kits to #affected HHs																								
A.2.1	Distribution of emergency shelter tool kit																								
A.3.1	Earthquake-resistant construction and disability-inclusive transitional shelter training and info session for community members (representative of target HHs or local craftsmen)																								
A.4.1	Construction of #disability-inclusive transitional shelters																								
A.5.1	Coordination meetings with local authorities																								
Water, Sanitation & Hygiene (WASH)																									
B.1.1	Distribution of Hygiene/NFI kits to #affected HHs																								
B.2.1	Distribution of clean water supply to #affected HHs																								
B.2.2	Rehabilitate and clean xx existing wells in xx targeted villages/communities																								
B.2.3	Build xx new boreholes in targeted communities/villages																								
B.2.4	Train #community members for borehole repair																								
B.2.5	Set up #water points management committees																								
B.2.6	Train xx Water management committees members																								
B3.1	Construct # latrines in targeted villages/communities																								
B3.2	Equip xx latrines with hand washing facilities																								
B3.3	Set up latrine management committees																								
B3.4	Train # committee members on hygine and sanitation good practices																								
B3.5	Conduct # awareness sessions on hygiene, water points maintenance, sanitation, nutrition and and hand washing good practices																								
B3.6	Waste management facilities at least in 10 concentrated areas are provided																								
B3.7	xx trainings on waste management is delivered in targeted communities																								
	Health / Nutrition																								
	Medical treatments for patients including post-injured patients																								
	Health care outreach for susceptible and high-risk groups																								
	Mobile clinics operation																								
	Health promotion campaign Feminine kits distribution																								
	Training on health reproduction and waste management for female both mature and teenager Health system information for primary health care intervention through medical record mobile application																								
	Materials support to monitoring of patient medical record through an mobile application																								
	Materials support to encourage totality health prevention and promotion																								
	Epidemiological surveillance																								
	Minimal physical rehabilitation to ensure patients safety																								
	Supporting basic medical equipment																								
	Supporting essential medicine																								
	Supporting non-medical equipment																								
	IT setup (hardware and software) Human resource temporary deployment from other health unit (medical doctor, nurse, etc)																								
	Piloting of excellence referral hospital Capacity building to fulfill minimal quality standard through hospital disaster plan																								
	Capacity building for outreach services and PHC to enhance Health DRR																								
	Supplementary nutrition support																								
	Supporting of community health center activation																								
	Assessment 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 assisted 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																								
DRR and Livelihood																									
C.1.1	Implementation of income generating activities (IGA) for 500 beneficiaries																								
C.1.2	Livelihood training for 10 target community groups																								
Emergency Preparedness Training																									
	Emergency DRR training																								
	PVCA (participatory vulnerability capacity assessment) Workshop including the identification of vulnerable groups with 40 participants in each local faith communities,																								
	Workshop Develop Village Action Plan and integrate DRR action plan in village planning																								
	Workshop to develop Village Contingency Plan and Disaster Task Force																								
	Medical First Aid training																								
	Table top exercise and disaster mock drill in District level																								

4. PROJECT MONITORING

4.1. Project Monitoring

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 the monitoring framework built for this program. Such framework refers to the overall workplan 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.

PELKESI/ICAHS will be responsible with the monitoring and evaluation in health and nutrition sector. The program will be monitored by the coordinator weekly and will be reported to Project Manager. The Project Manager will ensurie the achievement of outputs and outcomes through supervision. Supervision will be conducted monthly and reported to Program Director. The reports will be analyzed and cross-checked with the situation in the field by PMEL Staff to identify the program's achievements, analyze the gaps and recommend the next steps. The recommendation from the program's evaluation will be delivered to the village government and community health centers to inform the village's health programs. Monitoring will be conducted eight times and the evaluation will be conducted two times during the project period.

YEU will be responsible for overall Appeal monitoring and evaluation. The project manager will supervise the implementation of activities to ensure achievement of outputs and outcomes that will be reported to the emergency coordinator. The emergency coordinator will carry out close monitoring and cross-checking in the field for the progress reported, analyzing any gaps and identifying further humanitarian needs.

4.2. Safety and Security plans

1. Ensure all staff and volunteers receive relevant, correct, and updated security information
2. Provide a systematic safety briefing for all staff and volunteers
3. Provide training for all staff members upon the specific risks of each region such as armed conflicts, earthquakes and other state of insecurity
4. Report to the head office any occurrence of insecure situation
5. Make sure there is effective communication internally and with other agencies regarding the security situation.

Based on the security risk assessment, we found the following threats:

- Natural Hazard (flood, landslide, flash flood; Mitigation: monitor early warning updates
- Health issue: outbreaks (diarrhea, malaria, dengue); Mitigation: epidemiology surveillance
- Social conflict (religious resistance, terrorism); Mitigation: local government advocacy and collaborate with local interfaith communities
- Road Access; Mitigation: use 4WD cars
- Crime (theft, robbery); Mitigation: Coordination with local security officer

4.3. Knowledge Management

Lessons and good practices from the intervention will be shared with the intention of enriching and sharing knowledge. Information management and communication protocols will be set up so that all sensitive information will be kept completely confidential, and important information will be efficiently disseminated following data protection laws and policies. At the end of the project, an evaluation with local partners will be conducted to particularly look at the outputs and effectiveness of the interventions provided. The project team will identify the main lessons learned highlighting the innovations or good practices applied, and formulate recommendations based on the weaknesses and gaps encountered for the enhancement of future projects.

5. PROJECT ACCOUNTABILITY

5.1. Mainstreaming Cross-Cutting Issues

The program will be designed to respond and prioritize the identified risks and needs of vulnerable and marginalized communities or categories of people (women, girls, men, boys, elderly and people living with disabilities). This project will promote gender equality by allowing equal participation and decision-making opportunities for men, women and children (boys and girls) and marginalized and vulnerable groups in all project activities. Requesting members will also disseminate information on government plans to ensure vulnerable groups are well-informed.

Complaints handling mechanisms will be established to address protection issues, among others, related to the assistance, which should be effective, accessible and safe for intended beneficiaries, disaster-affected communities, staff, humanitarian partners and others.

Participation: Analyses of needs, priorities and decisions are conducted together with the communities. Communities are not only involved, but are the main actors since the pre-design of the program, starting from problem identification using participatory rural appraisal methods, to ensure that the design of the program fulfils the needs of the community and increases the sense of ownership towards the program. For the planning phase, decision making and M&E also use participatory approaches. The project will also increase community resilience to disasters, and ensure environmental care through proper waste management and disposal activities.

5.2. Conflict sensitivity / do no harm

All service delivery will seek to strengthen communities' own capacity for recovery and resilience. Interventions will consider local cultural practices, household roles, and ensure that the aid is provided in a way that promotes dignity and builds existing local strengths. CWS local partners, YEU and PELKESI will also coordinate with other key stakeholders such as the local government, other INGOs, NGOs and CSOs from national level up to the local level to avoid duplication of responses, and maximize resources to reach the unserved communities.

5.3. Complaints mechanism + feedback

Complaints mechanisms will be established for beneficiaries to address, among others, protection issues related to service delivery. The complaints mechanisms will be discussed with the communities, and identify practical approaches considering access as well as confidentiality.

5.4. Communication and visibility

The project will provide timely reports with photographs and features that illustrate project activities. Information about the activities will be shared among the BNPB, ACT Alliance, and the Humanitarian Forum Indonesia mailing list as well as uploaded on the website. In addition, RMs agree to produce ACT Alliance visibility materials adhering to co-branding principles, such as banners for specific trainings, bulletins, information boards, staff IDs, shirts, vests and posters.

6. PROJECT FINANCE

6.1. Consolidated Budget

	Appeal Budget *IDR*	Appeal Budget USD
DIRECT COSTS		
PROGRAM STAFF		
Total national program staff	9,803,200,000	682,034
TOTAL PROGRAM STAFF	**9,803,200,000**	**682,034**
PROGRAM ACTIVITIES		
Shelter and settlement / Non-food items	19,461,500,000	1,342,172
Water, sanitation & hygiene (WASH)	5,620,000,000	387,586
Health / Nutrition	11,015,000,000	774,655
Protection / Psychosocial support	426,000,000	23,586
Early recovery & livelihood restoration	7,950,000,000	548,276
Emergency Preparedness / Resilience	510,000,000	35,172
Camp Management	90,000,000	6,207
TOTAL PROGRAM ACTIVITIES	**45,072,500,000**	**3,117,655**
PROGRAM IMPLEMENTATION		
TOTAL PROGRAM IMPLEMENTATION	**4,950,000,000**	**342,130**
PROGRAM LOGISTICS		
Transport (of relief materials)	3,234,000,000	224,774
Warehousing	987,000,000	68,419
Handling	1,041,000,000	71,793
Office	300,000,000	20,690
TOTAL PROGRAM LOGISTICS	**5,562,000,000**	**385,676**
PROGRAM ASSETS & EQUIPMENT		
TOTAL PROGRAM ASSETS & EQUIPMENT	**3,995,000,000**	**277,920**
OTHER PROGRAM COSTS		
SECURITY		
TOTAL SECURITY	**135,000,000**	**9,398**
FORUM COORDINATION	**573,000,000**	**39,517**

STRENGTHENING CAPACITIES		
TOTAL STRENGTHENING CAPACITIES	**1,100,250,000**	**76,317**
TOTAL DIRECT COST	**71,190,950,000**	**4,930,646**
INDIRECT COSTS: PERSONNEL, ADMINISTRATION & SUPPORT		
Staff salaries		
Salaries 20 % for Country Representative	332,972,640	22,964
Salaries for Programme Director	444,620,000	30,838
Salaries for Finance Director	370,800,000	25,695
Salaries 30 % for Iinformation and Secretariat Director	84,000,000	5,793
Salaries for accountant and other admin or secretarial staff	252,000,000	17,502
Salaries 20% Operation Director	217,100,000	14,972
Salaries 20% HR Director	276,400,000	19,062
Salaries 30 % for Emergency Coordinator	72,000,000	4,966
Salaries 20% HR Officer	88,400,000	6,097
Salaries for Operation Officer	137,800,000	9,503
Office Operations		
Office rent	960,222,222	66,467
House rent	720,000,000	50,180
Office Utilities	630,758,000	44,025
Office stationery	273,320,000	19,024
Communications		
Telephone and fax	258,730,440	18,018
Other		
Insurance	41,500,000	2,888
TOTAL INDIRECT COST: PERSONNEL, ADMIN. & SUPPORT	5,160,623,302	357,994
	7%	**7%**
TOTAL EXPENDITURE exclusive International Coordination Fee	**76,351,573,302**	**5,288,640**
INTERNATIONAL COORDINATION FEE (ICF) - 3%	2,290,547,199	158,659
TOTAL EXPENDITURE inclusive International Coordination Fee	**78,642,120,501**	**5,447,299**
BALANCE REQUESTED (minus available income)	**78,642,120,501**	**5,447,299**

Emergency Assistance to People Affected by the Earthquake and Tsunami in Central Sulawesi- IDN182

Annex – Logical Framework

Logical Framework			
IMPACT To promote the well-being of 100.000 the most vulnerable people which affected by the earthquake and tsunami through fulfilment of basic needs and basic rights for the saving life and the Improvement capacity for preparedness and to restore their life and livelihoods.			
OUTCOME(S)	**Objectively verifiable indicators**	**Source of verification**	**Assumptions**
A.1 Improved community capacity in safe, healthy and inclusive housing construction to rebuild their shelter properly	80% of affected HHs used emergency shelters kits for temporary shelter needs	Needs Assessment/Baseline Report	Funds are available and released in a timely manner
A.2 Transitional shelters for target households meeting Sphere	80% of affected HHs who move to transitional shelter (HUNTARA) # individuals in target communities including community leaders, village office staffs and related stakeholders have received information on disaster risk reduction and management 100% of affected HHs used the Hygiene/NFI kits	Reports of CWS and local partners (i.e activity, assessment, monitoring) and situation updates. UN OCHA reports Cluster reports (WASH and Shelter) Field monitoring and evaluation report Photo documentation Final/End of Project Report	Local markets are functional Suppliers for quantity and quality materials for NFI/Shelter kits are available Security situation is manageable
B. Increased access of affected persons to safe water and sanitation facilities, and improved practice in hygiene promotion that meet Sphere Standards constructed	80% of affected HHs get access to and consume safe water during emergency and early recovery phase	Baseline Survey	Affected areas remain accessible and distributions can take place without logistical challenge No extreme weather event or emergency situation will disrupt emergency relief and

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	80% of HHs get access to and use sanitation facilities during the emergency and recover phase C.1.1. a. Mobile outreach for the prevention, diagnosis and treatment of communicable disease and metabolic syndrome (non-communicable) disease b. Home visit for treatment to post-injured patients C.1.2. a. Top 5 diseases found in the IDP's camps or community are reduced b. Preventing and or controlling the potential of communicable diseases and infectious outbreak found in the camps or community before they become epidemics c. Increasing awareness of health reproduction for women and adolescent during the crisis C.1.3. a. Medical Equipment, Human resources to ensure the function of the church health services	1.Medical record 2.Health information system application 1. Medical Record 2. Quarantine camp for infectious diseases patient 3.Epidemiology surveillance 4.Women daily reproductive hygiene checklist Assessment report on the function of Hospital health processed	early recovery response activities Local government commits to guide the process and respect to the project's deadline. Regional health system support from the provincial health department, district health department, public health centers and local government. Regional and or District coordination to ensure health care survive to IDP's Kepmenkes No. 145/MENKES/SK/I/2007 on Guidelines for the health sector Disaster Management No other Disaster before the preparedness system is in place

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.	b. Enhancing capacity of church health service in Health DRR c. Piloting of disaster resilient church health service C.1.4. The health care activity in integrated health center are running normally The healthcare system in public health center and village health center are restored Supplementary food for infant, children, pregnant women, nursing women and elderly C.1.5. Enhancing local capacity in health disaster risk reduction C.2 People with disabilities are able to do their activities of daily living D. Vulnerable groups can continue their normal activity through psychosocial intervention	1. Integrated health center activity report 2. Routine progress report to the public health center 3. Beneficiaries data recording form Standard for Disaster-Resilient Village (Destana) in health sector are set up in rehabilitation and reconstruction plan. C.2 Activities of daily living checklist D. 1.Activities Report 2. Development card	Effectiveness of Action plan from training are implemented and monitored by health department and community health center Gained knowledge from trainings and awareness raising is applied. Community ownership to program is high High participation and contribution from people with disability, their family and community. Compliance of CHS in all quality of emergency response

E. Strengthened local livelihood alternatives that support post-disaster situation F. Increased awareness of affected communities in disaster preparedness	80% of 500 HHs in ten communities able to rebuild their livelihoods and develop a capacity to mitigate the effect of any further damage/disaster Affected communities are provided with orientation on DRR and DRM Community led groups supported and mentored are prepared to respond to disaster	E. Activities Report F. Pre test and post test	
OUTPUT(S)	**Objectively verifiable indicators**	**Source of verification**	**Assumptions**
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	# affected HHs receiving emergency shelter kits # of Hhs receiving transitional shelters # of representatives (women and men) taking part in Transitional Shelter training	Need Assessment/Baseline Survey Report List of beneficiaries, distribution records, attendance sheets, and participants logs	Availability and timely release of funds Local markets are functional
B.1. Communities have access to safe water and sanitation facilities B.2. Improved awareness on hygiene promotion and healthy environment	500 affected HHs receiving hygiene/NFI kits Amount of water distributed # of well cleaned and rehabilitated # of borehold are built	Delivery and acknowledgment receipts, actual assessment reports	Suppliers for quantity and quality materials for NFI/Shelter kits are available

	# of water management committee groups established # of community latrines are built # of waste facilities, available Sphere Standards # of families (women, men, girls and boys) benefiting from the water supplies #of water supplies built and used # of awareness sessions conducted related to hygiene good practices # of participants (women and men) of the trainings/awareness sessions	Field visit and monitoring evaluation reports Signed agreements between local partners and community groups Documentation FGD, KII of beneficiaries Participation and attendance in community meetings organized by LGUs/Clusters Training outputs and documentation Satisfaction surveys End line survey	Security situation is manageable Affected areas remain accessible and distributions can take place without logistical challenge No extreme weather event or emergency situation will disrupt emergency relief and early recovery response activities Local government, patners commits to guide the process and respect to the project's deadline.
C.1.1 a. The spread of diseases including infection among injured patients is prevented by 70%	C.1.1. 100 injured patient are treated through home visit	C.1.1. 1.Medical record.	Local goverment and public health center willing to cooperate

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	Patient with potential infectious disease are referral to be quarantine from camps Vulnerable and high risk potential patient are referred to health facilities C.1.2. 9.400 patient visit are treated to reducing the metabolic syndrome (non-communicable) disease found in community 10.600 patient of communicable and infectious disease are treated 10.000 women and teenage girl receive feminine kit 10.000 female both mature and teenager are informed reproductive health and feminine waste management Communities are informed on health promotion on primary health care C. 1.3 80% availability of standard of essential health equipment 100% essential medicine for Emergency & Rehabilitation 80% non-medical equipment procurement support ensure the patient safety evacuation	2.Report and database. 3.List of patients C.1.2. 1. Medical record. 2. Report and database. 3. List of participants. 3. Medicine supply 4.Referal patient for communicable and infectious disease to health facility 5,IEC distribution 6.Feminine hygiene distribution C.1.3. 1.Minimal government standard Ina DRG standard 2. Hospital disaster plan as the standard of accreditation 3. Mobile clinic service report	Permitted to access data information from local government and public health center Commitment of church health service to be piloting of disaster resilient hospital Health Department and community health center are willing to cooperate. High participation and contribution from affected communities

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	80% mobile clinic function at Hospitals Catchment areas and Congregations 80% IT setup for medical records and administration 80 % standard of human resources fulfilled Piloting of excellence referral hospital Fulfillment government standard accreditation towards hospital disaster plan Satellite health clinic revitalized to activated PHC programs in intervention area after the disaster C.1.4. The activities community health center are running normally Integrated health center are routinely performed monthly activities Vulnerable groups receive nutrition food C.1.5. Community and church health cadres are trained	4. Information and technology standard 5. Competency of medical team resource 6. Hospital management system 7.Level of accreditation status PHC Program Monev C.1.4. 1. Record form of number of visitation to integrated health center (D/S) 2.List of participant 3.Report and database C.1.5 1.List of participants 2.Action plan 3.Report and database	

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. Community members have access to livelihood development supports Training/Workshop on livelihood for affected population	C.2 People with disabilities are able to do their activities of daily living D. Vulnerable groups can continue their normal activity through psychosocial intervention E. # of individuals implemented Income Generating Activities (IGA) # of community groups implanted # of people participated in cash for work activities F. Affected population have increase their knowledge and skill about disaster preparedness	4.Minutes of meeting C.2.1 Physiotherapy records C.2.2 Activities of daily living checklist C.2..3Handover document of the assistive device. D.1.Agreed social protection mechanism D.2. Activities report E. 1 Activities Report E.2 Monitoring card	

F.1 Community based disaster preparedness systems are in place F.2 Communities have the capacity in preparedness and disaster response		F. Agreed Disaster Preparedness system	

Activities

Activities will include:
A.1.1 Distribution of Emergency Shelter kits to # affected HHs
A.2.1 Earthquake -resistant construction and disability-inclusive transitional shelter training and info session for community members (representative of target HHs or local craftsmen)
A.3.1 Construction of # disability-inclusive transitional shelters

B.1.1 Distribution of Hygiene/NFI kits to # affected HHs
B.2.1 Distribution of clean water supply to # affected HHs
B.2.2 Rehabilitate and clean xx existing wells in # targeted villages/communities
B.2.3 Build # new boreholes in targeted communities/villages
B.2.4 Train 20 community members for borehole repair
B.2.5 Set up # water points management committees
B.2.6 Train # Water management committees members
B.3.1 Construct # latrines in targeted villages/communities
B.3.2 Equip # latrines with hand washing facilities
B.3.3 Set up latrine management committees
B.3.4 Train # committee members on hygiene and sanitation good practices
B.3.5 Conduct # awareness sessions on hygiene, water points maintenance, sanitation, nutrition and and handwashing good practices
B.3.6 Waste management facilities at least in # concentrated areas are provided
B.3.7 # trainings on waste management is delivered in targeted communities

C.1.1. Mobile Clinic
a. Medical treatments for patients including post-injured patients.
b. Mobile clinic and home visit.
c. Healthcare outreach for susceptible and high-risk diseases groups on the found primary diseases.

C.1.2. Primary Health Care

Pre-conditions

Sufficient fund received on time

Validated needs assessment data are available

Target communities are accessible, secured and all logistical need are met

The government commits to guide the process and respect to the project's deadline

Coordination with BNPB/BPPB, other humanitarian actors and cluster groups are maximized

No conflicting timeline between the project and government that potentially cause

a. Healthy living habit promotion for community b. Health education for early-age and school-age children. c. Health reproduction and waste management for female both mature and teenager d. Feminine kits distribution e. Providing material support to encourage totally health prevention and promotion f. Monitoring of patients with metabolic syndrome (non-communicable) disease to decrease morbidity g. Health system information for primary health care intervention through medical record mobile application h. IEC materials distribution through Integrated Health center i. Epidemiological surveillance of communicable diseases to decrease the potential for outbreaks in camps and communities j. Campaign of health preventive and promotive toward religious leader C.1.3. Recovery of Church Health Service a. Supporting basic medical equipment b. Supporting essential medicine c. Supporting non-medical equipment d. IT setup (hardware and software) e. Mobile clinics operation f. Human resource temporary deployment from other health unit (medical doctor, nurse, etc) g. Piloting of excellence referral hospital h. Capacity building to fulfill minimal quality standard for Universal access partnership soon after recovery through hospital disaster plan i. Capacity building for outreach services and PHC to enhance Health DRR including fulfillment satellite clinic hospital resources C.1.4 Local Healthcare System Normalization - Revitalization of Integrated Health Center a. Supporting of community health center activation b. Assessment on integrated health center data c. Monitoring on routine visitation to integrated health centers(D/S) d. Supplementary nutrition support. C.1.5. Strengthening of The Local Capacity on Disaster Risk Reduction in Health Sector a. Emergency first aid training for community b. Asset-based community development training for health cadres c. Training on feeding for infants and children	delays in project implementation No limited supply of materials and local labors Partners and staff have received induction on humanitarian standards and code and conduct Data on population Data of integrated health services. Observational report Human resources Committment and support from religious leader and husbands for women attending meeting and participate in the activities .

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.1.1 Identification of community assets E.1.2 Implementation of income generating activities (IGA) for 500 beneficiaries E.1.3 Livelihood training for 10 target community groups F.1.1 Conduct DRR Training F.1.2 PVCA (participatory vulnerability capacity assessment) Workshop including the Identification of \ vulnerable groups with 40 participants in each local faith communities, F.1.3 Workshop Develop Village Action Plan and integrate DRR action plan in village planning F.1.4 Workshop to develop Village Contingency Plan and Disaster Task Force F.1.5 Medical First Aid training F.1.6 Table top exercise and disaster mock drill in District level	

Annex – Risk Analysis

Risk	Internal / External	Likelihood of occurring *(high / Medium / low)*	Impact on project implementation *(high / Medium / low)*	How the risk is monitored and mitigation strategy in place to minimize this risk
Weather	External	High	High	Weather early warning updates on target service locations
Tropical disease endemic area	External	Medium	Medium	Epidemiology surveillance
Social Conflict : Religious resistance, terrorism	External	Medium	High	Local government advocacy and collaborate with local interfaith communities
Road Access	External	Medium	High	Using 4 WD car
Crime : theft and robbery	External	Medium	Low	Partnering to local security officer

Annex – Summary Table

Summary	Church World Service (CWS)	PELKESI/ICAHS (Indonesian Christian Association for Health Services)	YAKKUM Emergency Unit (YEU)
Implementation period	From 1 October 2018 to 30 September 2020 Total duration: 24 (months)	From 1 October 2018 to 30 September 2020 Total duration: 24 (months)	From 1 October 2018 to 30 September 2020 Total duration: 24 (months)
Geographical area	Palu district ● Sub-district: Tatanga ○ Village/Location: Palupi (BTN), Duyu ● Sub-district Mantikulore ○ Village/Location: Kawatuna (BTN), Talise (STQ) Sigi district ● Sub-district Biromaro ● Village/Location: Sidera, Pombewe/Jono Oge, Loru, Lolu ● Sub-district Dolo ● Village/Location: Kabobona, Langaleso, Karawana ● Sub-district Marawola ● Village/Location: Baliase (BTN), Tinggede ● Sub-district Dolo Selatan Village/Location: Bangga, Baluase	Palu district Baiya Village, Taweli Sub-district Kayumalue Pejako, North Palu Sub-distric Sigi district Tuva Village, Gumbasa Simoro Village, Gumbasa Sub-district North Sibalaya, Tanambulava Sub-district West Sibalaya, Tanambulava Sub-district Donggala district Enu Village, Sindue Sub-district Lerotatari Village, Sindue Sub-district	Palu district Silae Village, Ulujadi Subdistrict Sigi District Jono Oge Village, Sigi Biromaru Puroo Village. Lindu Sub-distirct Bolapapu Village, Kulawi Sub-district Binangga Village. Marawola Sub-district Mpanau Village, Sigibiromaru, West Dolo, Sub-district Sambo Village, South Dolo Sub-distric Lolu Village, Biromaru Sub-district

	Donggala district ● Sub-district: Sindue ● Village/Location: Lero	Wani I Village, Tanantovea Sub-district, Wani II Village, Tanantovea Sub-district	Donggala district ● Lerotatari, Village, Sindue Sub-district ● Wombo Village, Tanantovea Sub-district
Sectors of response	☒ Shelter / NFIs ☐ Protection / Psychosocial ☐ Food Security ☒ Early recovery / livelihoods ☒ WASH ☐ Education ☐ Health / Nutrition ☐ Unconditional cash ☒ Other sector: DRR	☐ Shelter / NFIs ☐ Protection / Psychosocial ☐ Food Security ☐ Early recovery / livelihoods ☐ WASH ☐ Education ☒ Health / Nutrition ☐ Unconditional cash	☒ Shelter / NFIs ☒ Protection / Psychosocial ☐ Food Security ☐ Early recovery / livelihoods ☒ WASH ☐ Education ☒ Health / Nutrition ☐ Unconditional cash ☒ Other sector: Camp management and Emergency Preparedness
Targeted beneficiaries	40.000 individuals	30.000 individuals	30.000 individuals
Requested budget (USD)	US$ 2.118.818	US$ 1.434.112	US$ 1.609,393

Summary	ACT Indonesia Forum Coordination Office
Requested budget (USD)	US$ 125,944