Rapid Response Fund

Approval

Project Code **15/2025**

Project Name **Immediate Relief Support to Restore Essential Normalcy for Communities Affected by Floods and Landslides in North Sumatra**

The ACT Secretariat has approved the use of **USD 361,629** from its Global Rapid Response Fund (GRRF25) and would be grateful to receive contributions to wholly or partially replenish this payment.

Reporting Deadlines	
SitRep *(one month after approval)*	5 Jan 2026
Final Reports (narrative and financial)	31 May 2026
Audit Report *(for projects >USD50,000)*	31 June 2026

For further information please contact:

National Forum Convenor	Tiurma Pohan (tiurma@cdrmcds.org)
ACT Regional Representative	Alwynn Javier (Alwynn.Javier@actalliance.org)
ACT Humanitarian Programme Officer	Waqas Muhammad (waqas@actalliance.org)

Rapid Response Fund

Project Proposal

Do you have an EPRP	Yes
When was the last update?	
Assessment for this response?	Yes

Please submit this form to the Humanitarian Coordinators in your region	Date submitted to ACT Secretariat
	11/30/2025

Section 1 Project Data

Project Information

Project Name	Immediate Relief Support to Restore Essential Normalcy for Communities Affected by Floods and Landslides in North Sumatra
Project Code	*15/2025*
Country Forum	Indonesia
ACT Requesting Member *(if there are more than one member, please use ALT+<Enter> to add another member)*	1. CDRM & CDS 2. PELKESI 3. YEU
Name of person leading the project	Nelson Sinaga
Job Title	Program Manager
Email	nelson@cdrmcds
Location(s) of project (city / province)	North Sumatera Province, Indonesia
Project start date (dd/mm/yyyy)	01/Dec/2025
Project end date (dd/mm/yyyy)	31/Mar/2026

Which sectors your response activities most relate to

(please indicate number of planned beneficiaries per organisation in each sector where you plan to give assistance)

Sectors	CDRM & CDS		PELKESI		YEU	
	Male	Female	Male	Female	Male	Female
Cash/ Vouchers						
Food	423	427	251	249		
Health			1505	3495		
Household items						
Livelihood						
Psychosocial			200	300	100	200
Shelter	1690	1710			3022	2978
WASH	1690	1710			3022	2978

Section 2 Project Description

2.1 Context

1. CHS Commitment 1. Summarize the crisis event and how it is likely to develop over the duration of the project *(extend rows 43, 44 and 45 if more space is needed)*

Since 25 November 2025, severe flooding and landslides triggered by prolonged heavy rainfall have affected widespread areas of North Sumatra Province. Initially impacting seven districts and municipalities, the disaster rapidly expanded, and by 27 November 2025 had reached 13 districts, including the provincial capital. The western and southern regions, such as Pakpak Bharat, Padang Sidempuan, North Tapanuli, Sibolga, South Tapanuli, Central Tapanuli, and Mandailing Natal remain the most severely affected.

The floods and landslides have caused significant human and infrastructure impacts. As of 28 November 2025, NDMA reported 116 fatalities, 42 people still missing, and more than 3,800 families displaced in North Sumatra. These figures continue to evolve as several areas remain isolated. Evacuation center in North Tapanuli is concentrated in the local church sheltering 600 families. While in Central Tapanuli, the government managed evacuation center in Sports Hall (GOR Pemda), hosting around 1,100 families. In South Tapanuli, 250 families have been evacuated; in Sibolga City, 200 families; in Humbang Hasundutan, 150 families; and in Mandailing Natal, 1,500 displaced families are spread across four evacuation centers. Extensive damage has also been reported, including damaged homes, collapsed bridges, and more than 15 hectares of submerged rice fields. Disruptions to electricity, communication systems, and road access, especially in over 15 urban villages, continue to isolate several communities.

Response efforts face multiple challenges due to access constraints and limited communication. Many of the hardest-hit areas remain difficult to reach, slowing search and rescue efforts and delaying comprehensive needs assessments. Communication breakdowns have also restricted coordination and timely updates from local and national authorities.

Key gaps requiring urgent attention include:
a) The availability of disaggregated data on affected populations;
b) Access to drinking and clean water;
c) Safe and accessible temporary shelters;
d) Adequate food assistance;
e) Nutrition-sensitive soup kitchens tailored for at-risk groups
f) Protection measures to ensure most at risk groups' rights are upheld during the disaster

BMKG (Meteorology Agency) forecasts that moderate to extreme rainfall will continue across North Sumatra, Aceh, and West Sumatra until December. The government has carried out weather modification operations to support evacuation efforts and the clearing of blocked access routes. As of 28 November 2025, the road from North Tapanuli to Sibolga remains cut off but is expected to reopen in the next few days. Access to Central Tapanuli is currently passable only by motorcycle or on foot, which limits the delivery of aid. In addition, communication and internet networks in Central Tapanuli have not yet been fully restored.

2. CHS Commitment 1,2,3,4. Explain the impact of the crisis specific to the people you want to help. Why did you choose to give aid to them and what makes them vulnerable?

The floods and landslides in North Sumatra have severely affected communities across multiple districts, creating widespread disruptions that disproportionately impact the most vulnerable groups.

Infrastructures impacts. The disaster has caused major damage to essential infrastructure. Electricity and communication networks have collapsed in many areas, and road access in more than 15 urban villages has been cut off due to landslide materials. Several key access routes between Central Tapanuli, Sibolga, and Tarutung have been completely severed, leaving communities isolated and reachable only by air or sea. These conditions isolate communities and delay rescue and relief delivery. More than 1,955 houses were damaged, two bridges collapsed, and 15 hectares of farmland were inundated, which affected household livelihoods and access to basic services.

Health impacts. An isolated access to Central Tapanuli, Sibolga, and Tarutung has obstructed access to health facilities. Several community health centers (Puskesmas) are unable to operate due to flood damage. A hospital in Sibolga has also reported declining oxygen supplies and limited medical logistics due to blocked supply routes, according to reports received via satellite communication. Although disease surveillance updates are not yet available, the risk of waterborne

received via satellite communication. Although disease surveillance updates are not yet available, the risk of waterborne disease outbreaks is expected to rise significantly once access improves. Deteriorating water quality, poor sanitation conditions, and crowded evacuation sites have sharply increased the risk of disease transmission. Older persons are especially vulnerable to waterborne illnesses and injuries due to frailer physical conditions and pre-existing health issues. For older people with chronic diseases, regular treatment has been disrupted because medicines were damaged by the floods and access to health services remains inadequate.

Psychosocial impacts. The disaster-affected communities are enduring traumatic flash floods, prolonged isolation, and continued heavy rainfall, which is expected until late November. These factors cause high stress, insecurity, and fear, especially for children, women, older persons, and people with disabilities. Interrupted communication, restricted movement, and ongoing uncertainty heighten distress, trauma, and gender-based violence risk. Immediate psychosocial support is essential to stabilize emotional well-being and mitigate protection risks.

Limited Access to Clean Water and Sanitation. The floods and landslides have damaged and contaminated local water sources, resulting in a severe shortage of clean water. Drinking water is scarce, and some evacuees have resorted to collecting and drinking rainwater in order to survive.

Food and Nutrition impacts. The disaster-affected communities are experiencing severe disruptions in food supply due to the disruption of key access routes. The public kitchens are struggling to meet needs due to shortages and logistical challenges. They also have an urgent need for healthy food, their specific nutritional requirements, and texture preferences for the at-risk group, not only ready-to-eat food. Therefore, it is imperative to manage public kitchens effectively to meet the dietary needs of the at-risk group.

Displacement and Protection Concerns. Thousands of people have been displaced, and available emergency shelters and essential non-food items (NFIs) are insufficient to meet current needs. Affected communities are dispersed across multiple evacuation points, both in formal camps and in informal or self-organized shelters. This scattered displacement poses challenges for compiling accurate data on affected populations, particularly those with urgent special needs. With the rainy season ongoing and continued difficulties in delivering assistance, there is an urgent need to strengthen camp coordination and camp management to ensure effective and equitable service delivery.

At-risk groups face the greatest barriers to immediate safety and protection:

3. CHS Commitment 9. Explain the availability of funding each of your organisation can access for this crisis.

ACTIF national members currently have limited emergency funds available to support assessment activities. To address this constraint, they have begun internal fundraising efforts within their respective organizations. For example, PELKESI is mobilizing contributions from all its member institutions, not only in the form of financial support but also through in-kind assistance such as medical personnel, medical supplies, and other health-related resources.

In addition to accessing the ACT Alliance RRF, YEU is using institutional funds and donations from church networks to deploy a response team on 1 December 2025. This team will conduct further assessments, coordinate with relevant stakeholders in North Sumatra, and distribute essential relief items.

Given the scale of the disaster, the number of affected people, and the urgent need to provide emergency assistance, particularly for at-risk groups, ACTIF will implement a joint response through three national members: CDRM & CDS, PELKESI, and YEU. These organizations will apply for the ACT Alliance RRF and carry out interventions in different geographic areas and sectors to avoid overlap and ensure comprehensive coverage.

ACTIF national members are also open to forming partnerships with non–ACT Alliance actors to secure additional resources, whether in cash or in-kind, to strengthen the overall response effort.

2.2 Activity Summary

1. CHS Commitment 1, 2, 4. Explain your proposed project and why you have selected this particular response to the crisis and the length of time needed to respond. *If multiple members are responding, please explain the role of each member in the coordinated response as indicated in your EPRP Contingency Plan.*

The response are aims to support at least 2.050 HH affected by the floods and landslides in North Sumatra for a 4-month response period. Assistance will cover key sectors, such as Health, Psychosocial Support, Food, Shelter, and WASH. A period of 4 months is considered appropriate to stabilise health conditions, support basic needs, and ensure continuity of care during the immediate recovery phase. The response will be implemented jointly by CDRM & CDS, PELKESI, and YEU.

CDRM & CDS is located in North Sumatra, where many of our church partners in the affected areas are also present, and will serve as the RRF lead for this response. CDRM & CDS will focus its intervention on the Food and Nutrition, WASH, and Shelter sectors, targeting 800 households, approximately 3,200 people, across three villages in North Tapanuli and five villages in Central Tapanuli. These sectors were prioritized based on assessments from partners and coordination with other actors, which indicate that several roads remain inaccessible, communication networks are disrupted, and displaced families are experiencing increasing challenges in meeting their basic daily needs. CDRM & CDS will coordinate closely with church partners such as HKBP, GKPS, GKLI, GPP, and other local churches in the affected areas, as well as strengthen coordination with PGI–Wilayah Sumatera Utara to ensure an effective and well-aligned response.

PELKESI will focus its response on Health, Food and Nutrition, and Psychosocial Support, prioritising communities in the most affected and hard-to-reach areas. PELKESI will activate a referral health system to strengthen access to essential medical care, particularly in the three areas of North Tapanuli, Central Tapanuli, and Sibolga. Specialist doctors will be deployed to support referral services at HKBP Balige Hospital. PELKESI will also deploy Mobile clinic services to extend healthcare access to communities with limited availability, while simultaneously conducting triage for patients requiring referral. The Mobile Clinic will coordinate closely with the health cluster, under the supervision of the local health office. Through these interventions, PELKESI aims to reach approximately 3,000 patient visits during the project period. Around 2,000 IDPs of women and girls will receive menstrual hygiene kits containing sanitary pads, underwear, small towels, disposal bags, and pouches to support their menstrual hygiene management. The B3 waste bin will also help ensure safe and dignified menstrual hygiene management in evacuation. PELKESI will also prepare and distribute 100 maternity kits, including maternity pads, maternity underwear, corsets, sarongs, and baby swaddles for pregnant women in evacuation sites. For Psychosocial Support, PELKESI will organise child-focused activities in evacuation centres to help reduce stress, restore a sense of safety, and support early emotional recovery among children affected by the disaster. In Food and Nutrition, supplementary nutrition will be provided for 500 IDPs over a two-month period, prioritising at-risk groups in evacuation centres.

YEU will target 1,500 households in Central Tapanuli across three sectors, namely Shelter, WASH, and Protection, through the provision of shelter kits, hygiene kits, and protection support, including psychosocial assistance and the fulfillment of specific needs for 300 at-risk individuals (persons with disabilities, older persons, pregnant and breastfeeding women). This response is crucial given that government-distributed humanitarian assistance remains limited to displaced communities concentrated in government-managed evacuation centers, while communities across

2. CHS Commitment 2. Explain how you will start your activities promptly. *Project implementation should start within two weeks. The project should be a maximum of 6 months.*

The ACT Indonesia Forum (ACTIF) has activated coordination to ensure all planned response begin promptly. As soon as the RRF is approved, the ACTIF national members who involve in the RRF Implementation (CDRM & CDS, PELKESI, and YEU) will immediately mobilise existing networks, personnel, and local resources already present in North Sumatera. Because CDRM & CDS are located in the affected province, the forum can rapidly initiate field coordination, deploy assessment teams, and begin early-stage interventions without delay. CDRM & CDS, as the lead agency, will lead the coordination overall response planning and facilitate joint operational meetings among the implementing members. PELKESI will promptly mobilise its network of member hospitals and health personnel, as well as deploy both mobile clinics and medical teams to priority areas. YEU will immediately engage with local churches and volunteer networks to begin shelter, WASH, and protection measures where access allows.

3. CHS Commitment 6. How are you co-ordinating and with whom? *Coordination ensures complementarity of interventions within forum members and other humanitarian actors to maximise the use of our resources and will address all unmet needs*

As the forum convenor, CDRM & CDS serves as the project holder, coordinating forum members and ensuring programmatic and financial implementation follows ACT Alliance standards. The ACT Indonesia Forum is coordinating closely with local churches (HKBP, GBKP, GKPS, GKPI, HKI), PGIW North Sumatera, PGI, Jakomkris, Indonesia Humanitarian Coordination Platform (IHCP) and other relevant stakeholders. Coordination is maintained through regular information-sharing within these networks to update the latest situation and monitor government interventions. This process supports actor mapping, prevents duplication, and ensures interventions complement each other. ACT Indonesia Forum will prioritize a systematic and well-coordinated approach in working with government agencies and other humanitarian actors to collect essential data on damages and needs. At present, updates from local authorities remain limited due to communication constraints in several affected areas, and government clusters have not yet been activated. All coordination is still centralized at the provincial command post in Medan.

4. CHS Commitment 3, 9. Where are you planning to procure your goods or services? Please tick boxes that apply. *Goods and services procured locally supports and revitalises economic activity either as livelihood for people or*

Locally or within the affected areas	x	Nationally	x	Regionally or neighbouring countries		Internationally	

Do you have a procurement policy? What factors did you consider when you made this decision?

Yes, each requesting member has its own procurement procedure which is linked to the finance SOP. Requesting members will strictly follow the policy and procedures in all purchases under the project. The relief items will be procured after the procurement team/logistician conducted vendor analysis, price analysis, quality, availability of goods, speed of time, service facilities such as on-site transportation and other procurement arrangement.

All requesting members adhere to the financial management and procurement procedure of goods and services in the project implementation.

2.3 Description of Target Population

1. CHS Commitment 1, 9. How do you calculate the participants of this project? *For example, food and hygiene kits given to 2500 families, and 1 family = x beneficiaries.*

The beneficiary numbers are calculated based on the rapid needs assessment, which includes sex, age, and disability-disaggregated data (SADDD). Based on the statistic, each families has 4 members, the total number of beneficiaries is estimated. The project aims to reach 3.100 households (HHs), equivalent to 12.400 individuals , distributed as follows:

- CDRM & CDS: 850 HHs (3,400 project participants) in North Tapanuli , Adian Koting Sub District (3 villages) and Central Tapanuli, Pandan, Tuka, Kolang and Sarudik Sub Ditricts (4 villages)
- PELKESI: 750 HHs (5,000 project participants, of which 2,000 participants in the mobile clinic can also become YEU/CDRM beneficiaries) in Central Tapanuli, Sibolga, and North Tapanuli
- YEU: 1500 HHs (6,000 project participants) in Central Tapanuli including 300 most at risk groups (older people, people with disabilities, children, pregnant women, breastfeeding mother, and other minority groups) in the evacuation center (GOR) and 13 affected sub-districts.

Target selection is based on identified needs and the commitment to gender equality and social inclusion (GEDSI) in emergencies. Coordination with the affected communities will guide the determination of specific needs, including the type and quality of items, as well as appropriate intervention strategies such as distribution mechanisms, do/no-harm considerations, and identification of key actors to be involved.

All decisions will be made in consultation with affected communities and relevant stakeholders, ensuring that interventions remain accountable, inclusive, and responsive to the actual needs on the ground. Besides that, the implementing members will closely coordinate each other to ensure no project participants received same assistance from different implementing members, particularly those located in same regency.

5. CHS Commitment 4. Explain how the target population is involved in the planning of your proposed intervention? How will they be involved in the implementation and the rest of the project cycle?

The project places affected communities at the centre of all stages of the response. From the outset, community participation begins during the initial assessment, where key representatives in evacuation centres play an active role in data collection, identification of priority households, and ensuring the inclusion of at-risk groups such as older persons, people with disabilities, individuals with chronic illnesses, and female-headed households. Building on this collaborative approach, village authorities together with community representatives and volunteers will take part in applying and validating the agreed beneficiary-selection criteria.

To maintain accountability and relevance, the project establishes clear channels for communities to provide feedback and manage complaints regarding the type and quality of goods, distribution arrangements, and conditions in the evacuation camps. This feedback mechanism ensures that interventions can be adapted based on community inputs.

Monitoring is conducted systematically through a Post-Distribution Monitoring (PDM) process within a specific timeframe to measure the adequacy, relevance, and efficiency of the assistance delivered. At least 75% of the targeted families are expected to participate in the PDM, to ensure their role as key partners in planning, implementation, and monitoring.

Local volunteers also play a vital supporting role, including verifying the quality of relief materials, assisting in psychosocial activities, and participating in PDM efforts. Their involvement strengthens community ownership and contributes to a more effective and accountable response.

2.4 Expected Results

1. What will this project's success look like based on your time frame? *Please write your activities milestones including dates.*

Overall objective: Increasing recovery of the people affected by floods and landslides by fulfilling basic needs in an accountable and inclusive manner.

Outputs:

1. People affected by the floods and landslides get a comprehensive health service while evacuating, especially for at-risk groups.
2. The nutrition of at-risk groups affected by floods and landslides fulfilled, to prevent the risk of decreasing nutritional status during the emergency.
3. People affected by the floods and landslides can carry out a self-coping mechanism after experiencing psychosocial activity.
4. Basic needs for shelter and hygiene for affected population is provided

Main Activities:

1. Health

1.1. Mobile clinic (Month 1-3)
1.2. Local health system strenghtening (Month 1-2)
1.3. Menstrual hygiene kit distribution and MHM promotion (Month 1-3)
1.4. Maternity kit support for pregnant mother (Month 1-3)
1.5. Health promotion to prevent post-disaster potential disease in camp (Month 1-4)

2. Food and Nutrition

2.1. Supplementary nutrition food for at-risk groups (Month 1-2)
2.2. Food distribution (dry food) for affected HH

3. Psychosocial

3.1. Psychosocial support activities for children (Month 1-4)
3.2. Psychosocial support for older people, people with disabilities, and other at-risk adults (Month 2-4)

4. Shelter

4.1. Providing shelter kits packages to affected HH (Month 1-3)

5. WASH

2. What are the factors that may stop you from achieving the targets of this project? How will you manage them?

Forum members have identified risk factors that may hamper the successful implementation of the project as well as their mitigation measures:

1. **Risk:** Limited access to transportation to deliver relief
Mitigation: Coordinate with local authorities, churches, and partner networks to secure transportation support, consider alternative transportation options where feasible, and pre-position supplies near affected locations.

2. **Risk:** Limited availability of relief materials in local markets
Mitigation: Identify multiple suppliers early, expand procurement to neighboring districts/provinces, and pre-procure essential items to avoid shortages.

3. **Risk:** Restricted communication access in hard-to-reach areas
Mitigation: Use multiple communication channels (radio, satellite HT, Starlink) and deploy field volunteers for manual information sharing.

4. **Risk:** Health risks due to a potential outbreak, limiting staff/volunteer movement and interventions to the community.
Mitigation: Provide PPE, ensure safety protocols are enforced, including infection prevention and control, coordinate with health authorities for safe access, and adjust healthcare activities.

5. **Risk:** Lack of data on most at-risk groups
Mitigation: Use snowball sampling by community leaders, health cadres, and local networks to identify vulnerable individuals and have multiple sources cross-verify.

6. **Risk:** Rapid community mobilization to unregistered evacuation centers
Mitigation: Work closely with community leaders, health cadres, and church volunteers to identify and continuously update beneficiary lists, and adapt the response based on real-time information.

7. **Risk:** High rainfall causing another landslides/flood cut off transportation routes, delay implementation of the project and affect staff and communities' safety
Mitigation: Monitor early warning update from BMKG and NDMA to minimize the risk of staff and or

2.5 Monitoring, Accountability & Learning

1. CHS Commitment 7. Describe how you will monitor the project. What monitoring tools and process will you use? How will you gather lessons from the project?

ACT Indonesia Forum will establish the MEAL team responsible for designing, implementing, and analyzing monitoring activities across all implementing members. This team consists of ACTIF's national and/or international members who are not involved in direct implementation and are organized under the PMEAL Core Team.

All monitoring processes will adhere to the Core Humanitarian Standard (CHS), particularly commitments 7.1, 7.2, and 7.5, ensuring inclusivity, gender sensitivity, accountability, and responsiveness to community feedback and complaints. Lessons learned will be documented throughout the project cycle and compiled into formal reports following the overall project evaluation.
Each implementing organization will monitor its own activities using the joint work plan and implementation matrix, which details progress and achievement indicators, led by the RRF leader and coordinated through regular forum meetings.

After relief distributions, ACTIF implementing members will conduct Post-Distribution Monitoring (PDM) to evaluate the appropriateness, effectiveness, and coverage of distributed items. Findings will be used to strengthen ongoing and future humanitarian interventions.

2. CHS Commitment 8. Does your organisation have a Code of Conduct? Have all staff and volunteers signed the Code of Conduct? *We may ask you to submit copies of the signed Code of Conduct. You can use ACT Alliance's Code of Conduct if your organisation does not have one.*

Each forum member has their own Code of Conduct where all staffs and volunteers should sign it. Anybody engaged at the project site will sing the Code of Conduct and will abide by it. The new staff if recruited for this particular project, will be oriented on it and made to sign. Forum members also abide by the zero-tolerance policy, child and vulnerable adult safeguarding, and gender mainstreaming.

3. How will you ensure you and all stakeholders will be accountable to the affected population. How will you share information. How will you collect and use feedback and complaints? CHS 4 and 5

Each ACTIF implementing member will apply its own accountability system in alignment with the CHS. Orientation sessions will be conducted with all relevant stakeholders, including government departments, local authorities, and community members, to explain the project's objectives, targets, and expected outcomes.

As ACTIF's accountability commitment, a Complaint and Feedback Mechanism (CFM) will be set up to enable participants and stakeholders to safely and easily share concerns, feedback, or complaints by each of the implementing members. The CFM will provide multiple access channels, including direct communication with staff, complaint boxes, email, and a dedicated phone number/whatsapp number. The project team will explain the purpose of the CFM, the types of complaints that can be submitted, and how feedback will be managed and responded to. To enhance accessibility and awareness, banners in local languages containing CFM information will be displayed at all intervention sites.

The implementing members will ensure that all complaints are reviewed and, where appropriate, responded to in a timely manner to maintain a complete feedback loop. To uphold the Do No Harm principle in accordance with CHS Commitment 4, all staff and community participants will be guided to ensure safe, respectful, and conflict-sensitive engagement throughout the project.

The Forum will utilize established communication platforms to share situational updates and identified gaps with key networks, including the Health Cluster, Sub-Cluster of Older People, People with disabilities, and other at-risk groups (LDR), Sub-Cluster Psychosocial Support (PSS), Jakomkris, and HFI. Where gaps in service provision are identified, referrals will be made to organisations with the relevant expertise. All reports and findings will be shared with government authorities in support of a coordinated humanitarian response.

actalliance

Rapid Response Fund

Consolidated Financial Report

Project Code 15/2025
Project Name Immediate Relief Support to Restore Essential Normalcy for Communitie

Budget Exchange rate (local currency to 1 USD)
Please use exchange rate from this site:

		Total Budget	Budget		
			CDRM & CD	PELKESI	YAKKUM En
1	**Total Project Staff Costs**	**30,342**	**9,464**	**11,672**	**9,205**
2	**Project Activities**	**236,725**	**74,155**	**73,223**	**89,347**
2.1	Cash/Vouchers	-	-	-	-
2.2	Camp Management	-	-	-	-
2.3	Education	-	-	-	-
2.4	Food/Nutrition	34,596	25,571	9,025	-
2.5	Health	57,279	-	57,279	-
2.6	Household items	-	-	-	-
2.7	Livelihood	-	-	-	-
2.8	Psychosocial	10,529	-	6,919	3,610
2.9	Shelter	77,765	28,128	-	49,637
2.10	WASH	56,557	20,457	-	36,100
3	**Project Implementation**	**11,010**	**5,716**	**3,008**	**2,286**
3.1.	Forum Coordination	3,008	1,805	-	1,203
3.2.	Capacity Development	8,002	3,911	3,008	1,083
4	**Quality and Accountability**	**17,930**	**5,355**	**6,618**	**5,956**
5	**Logistics**	**23,886**	**8,062**	**7,882**	**7,942**
6	**Assets and Equipment**	**7,370**	**3,068**	**2,286**	**2,016**
Direct Costs		**327,264**	**105,821**	**104,690**	**116,753**
Staff Salaries		9,017	3,277	2,792	2,948
Office Operations		25,348	8,062	7,298	9,988
Indirect Costs		**34,365**	**11,339**	**10,090**	**12,936**
Total Budget		**361,629**	**117,160**	**114,780**	**129,689**