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DREF operation update
Indonesia: Forest Fires

International Federation of Red Cross and Red Crescent Societies

DREF operation n° MDRID010	**GLIDE n° OT-2015-000148-IDN**
DREF update n° 2	**Timeframe covered by this update: 15 November to 15 December 2015**
Date of issue: 29 December 2015	
Operation manager (responsible for this EPoA): Pascal Bourcher, IFRC Community Safety and Resilience Coordinator	**Point of contact (name and title):** Arifin Muhammad Hadi, PMI Head of Disaster Management Division
Total number of people affected: 409,664 people	**Number of people to be assisted: 83,700**
Operation start date: 1 November 2015	**Operation end date: 31 January 2016**
DREF allocated: CHF 229,549	
Number of people assisted *(revised)*: 83,700	
Host National Society(ies) present (n° of volunteers, staff, branches): Indonesian Red Cross Society (Palang Merah Indonesia - PMI): 3 provincial chapters and 30 district branches; 580 volunteers have been mobilized in West Kalimantan, 576 volunteers in South Kalimantan, and 167 volunteers in East Kalimantan.	
Red Cross Red Crescent Movement partners actively involved in the operation: American Red Cross and Canadian Red Cross	
Other partner organizations actively involved in the operation: MoH, BNPB (Indonesian national disaster management agency), UN OCHA, UNICEF, WHO, WFP, OXFAM, World Vision, Caritas, LPB Muhammadiyah, Dompet Dhuafa, PKPU, Rumah Zakat, Yakkum Emergency Unit.	

Summary of major revisions made to emergency plan of action:

- The impact of haze has reduced by the arrival of heavy rains, and the number of hotspots has diminished.
- The duration of the delivery of basic medical services will be reassessed after one month of implementation, while the health education intervention will proceed for the three months period.
- Due to the modification of the timeframe for medical services, the total number of beneficiaries has been reevaluated and it is now estimated that PMI will reach 83,700 people (instead of the 106,140 people as stated in the original plan of action) through its health services (medical services and health education).
- The intervention now focuses on the province of South Kalimantan instead of the province of Riau.
- The coverage has been extended from 9 districts to 30 districts due to the increasing needs in remote areas. [1]
- All chapters and provinces have been instructed by their leadership not to implement any activity from 3 to 9 December due to potential interference with the local elections in Indonesia on 10 December, causing delays in field implementation.

A. Situation analysis

Description of the disaster

Forest and land fires in some of the islands of Borneo (Kalimantan) and Sumatra resulted in a very dense haze. The Centre for Health Crisis of Ministry of Health reported that the forest fire which caused this haze started in Riau Province and later spread into seven provinces, four in Kalimantan (West, East, South and Central Kalimantan) and three in Sumatra Island (Jambi, Riau and South Sumatera). Since September 2015, the haze has also affected neighboring countries such as Singapore, Malaysia, Thailand and the Philippines. The intensification of this disaster is the consequence of El Niño in the region, with severe droughts and significant delay of the rainy season, therefore preventing the effect of the rain on forest fires.

Hot weather conditions and thick smoke combined with the initial lack of rain due to El Niño made the air pollutant index (API) level even worse while people, especially children, pregnant women, the elderly and people with pre-

[1] The initial figure of 32 districts mentioned in DREF Update 1 has been corrected.

existing respiratory problems became more vulnerable to upper respiratory tract infection (URI), eye irritation, pneumonia, asthma, skin irritation, which resulted into a few deaths. In addition, visibility went for weeks down to between 20 to 500 meters in most of the affected area, which caused delays or even cancellation of a number of flights in various provinces. This disaster also hampered daily activities and causes schools, universities and some offices to close down. The death toll recorded so far in Sumatera and Kalimantan is eleven people.

The highest API, 1,950 µgram/m^3, was recorded on 21 October 2015 in Central Kalimantan Province (normal 0 to 50 µgram/m^3), while in other provinces the reported levels were:

- Riau: : 596 µgram/m^3
- Jambi : 407 µgram/m^3
- South Sumatera : 300 µgram/m^3 on 29 September
- West Kalimantan : 784 µgram/m^3 on 28 September
- South Kalimantan : 171.37 µgram/m^3 on 28 September

During the first half of November 2015, a few heavy rains swept some of the provinces affected by forest fires, particularly those located close to the equator. By mid-November, rains have extinguished the majority of forest and land fires throughout Indonesia. There remain some risks of reoccurring peat fires or peat fires to re-intensify if the impact of El Nino continues. Haze season is then expected to come as early as April in 2016. The API recorded on 3 November 2015 by the Centre of Health Management Crisis (MoH) is reflecting a significant improvement:

- Riau : 52.75 µgram/m^3 (moderate)
- Jambi : 21.72 µgram/m^3 (severe)
- South Sumatra : 91.13 µgram/m^3 (moderate)
- West Kalimantan : no updated data
- South Kalimantan : 33.26 µgram/m^3 (mild)
- Central Kalimantan : 46.79 µgram/m^3 (severe)
- East Kalimantan : no updated data

Despite the improvement of the situation, many people living in these affected areas continue to suffer from the effects of the previous long exposure to haze. For example, data from health services in West Kalimantan – a province affected every year by forest fires and subsequent haze – shows that the number of respiratory infections remains high even during periods with no forest fire.

The IFRC, on behalf of the PMI, would like to thank all partners for the generous contribution to the replenishment of this DREF. These include Netherlands Red Cross/ Netherlands Government (SEF) and Canadian Red Cross Society/ Canadian Government (DFATD).

Summary of current response

Overview of Host National Society

PMI has started to address the needs of the affected communities in July with the evacuation of the most at risk populations together with the disaster management local authorities (BPBD), and with the distribution of masks. PMI is working in close coordination with BPBD, BMKG and provincial health departments in conducting needs assessments, monitoring the situation, providing health services in government facilities, and socializing the use of masks and good practices to reduce the exposure of vulnerable people to the haze. In total, 602,000 masks have been distributed to the affected people by the PMI chapters and branches.

This reporting period has been dedicated to the following activities in the three targeted provinces:

- Ongoing re-evaluation of the situation after the rain started, and hotspots and fires started to decrease.
- Finalizing and distributing IEC material for all PMI chapters to provide people in affected area with key messages on how to protect themselves from the impact of haze, respiratory infection symptom and treatment, hygiene promotion, etc.;
- Mobilizing ECV master trainers in the country to be mobilized and assist the chapters and branches' volunteers to deliver key messages on health education;
- Mobilizing medical action teams (doctors and nurses for mobile clinics and emergency houses);
- Setting up reporting system via open data kit (ODK);
- Health education and reporting (ODK) trainings for PMI staff and volunteers;
- Procurement of masks as well as equipment (A/C, air purifier, medical equipment, EVOMed masks, etc.) for setting up the emergency houses and mobile clinic services;
- Delivery of health services in emergency houses in two of the selected provinces;
- Ambulance services in two of the selected provinces;
- Health education sessions in two of the selected provinces.

Overview of Red Cross Red Crescent Movement in country

The IFRC Country office in Indonesia has been monitoring the forest fire situation and providing technical support to PMI. IFRC is also assisting PMI with the coordination with other RCRC partners such as the American Red Cross, the Canadian Red Cross Society and others, as well as liaising with UN OCHA and the UN system in Indonesia.

The American Red Cross with assistance from the USAID is supporting similar activities in the four other affected provinces of Riau, Jambi, South Sumatra and Central Kalimantan.

Overview of non-RCRC actors in country

The Ministry of Health (MoH) through its Centre of Health Management Crisis has been delivering health services through MoH structures to the affected population in the seven provinces:

1. Mobilization of rapid health assessment (RHA) teams;
2. Conducting health promotion through its Primary Health Care Centres (present in each sub-district);
3. Health service centres operational 24 hours a day and 7 days a week;
4. Provincial Health Departments are conducting joint monitoring visits with other actors involved to ensure the effective implementation of health interventions in the most affected areas, including the distribution of masks and the setting up of command posts;
5. Whenever the air quality index exceeds the tolerance limit, the MoH issues a recommendation to the Education Department at provincial and district levels to close down schools;
6. Establishment of emergency houses equipped with air condition and air purifier for vulnerable groups such as infants, toddlers, pregnant women and elderly people;
7. Deployment of medical action team in severely affected areas.

The action of BNPB and BPBD has mainly been focusing on extinguishing forest fires and providing support in terms of coordination between all actors involved.

International NGOs (e.g. OXFAM, World Vision, Caritas) and Indonesian NGOs (e.g. LPB Muhammadiyah, Dompet Dhuafa, PKPU, Rumah Zakat, Yakkum Emergency Unit) have been actively involved in the forest fire/haze response in Sumatera and Kalimantan by establishing command posts, distributing masks, setting up emergency houses, deploying medical teams, and conducting health promotion sessions in the affected communities.

UNOCHA, WFP, UNICEF, WHO and IFRC are also involved in the coordination between all actors, compiling and providing relevant information about the forest fire situation in Indonesia, as well as about the impact of El Nino in general.

Needs analysis and scenario planning

Secondary data from the Ministry of Health and needs assessments have shown that a significant number of people living in these three provinces, especially children, pregnant women, elderly and people with pre-existing condition, are suffering from upper respiratory tract infection (URI, see figures in the tables below), eye irritation, pneumonia, asthma, skin irritation. Following these increasing needs and considering the extent of the needs that exceed the government response plan, PMI has decided to scale up its response by providing assistance to the affected people in seven provinces (Jambi, Riau, South Sumatera, Central Kalimantan, East Kalimantan, South Kalimantan and West Kalimantan) and by mobilizing volunteers from neighbouring districts to ensure an effective implementation.

Considering the recent rainfall in a majority of these provinces, PMI decided that the medical interventions will be re-evaluated one month after the beginning of the operation. The implementation of health education activities is confirmed until the end of January.

This plan under DREF support focuses on three provinces: East Kalimantan, West Kalimantan and South Kalimantan. Since PMI is covering the seven affected provinces, it has been deemed more relevant for the DREF operation to concentrate its effort in the three affected provinces in Kalimantan located on the same island, in order to make better use of available resources, rendering the DREF operation more efficient. This is the reason why Riau province has been replaced by South Kalimantan province in this revised operational plan. As for the PMI similar interventions in the four other provinces, they are supported by the American Red Cross thanks to a contribution by USAID.

Under the DREF operational plan, PMI will provide assistance to **83,700** affected people in the three provinces of East Kalimantan, West Kalimantan and South Kalimantan. The decrease in the total number of beneficiaries (106,140 in the original operational plan) is justified in the following chapter (“proposed strategy”). PMI intervention is covering 30 of the most affected districts as listed below:

1. East Kalimantan Province

No	District	Total pop	URI Case	Volunteer Availability
1	Kutai Kertanegara	626,286	2,115	49
2	Kutai Barat	144,018	2,500	24
3	Kutai Timur	294,216	4,138	94
	TOTAL	**1,064,520**	**8,753**	**167**

2. West Kalimantan Province

No	District	Total pop	URI Case	Volunteer Availability
1	Pontianak	617,875	10,470	214
2	Kubu Raya	566,394	10,792	16
3	Mempawah	294,623	6,051	129
4	Singkawang	230,855	3,573	14
5	Sambas	622,757	7,761	43
6	Bengkayang	266,741	2,136	14
7	Sekadau	209,381	2,121	-
8	Sintang	393,755	11,417	30
9	Melawi	222,932	1,062	33
10	Kapuas Hulu	242,795	6,179	-
11	Sanggau	467,080	8,184	17
12	Landak	388,840	3,952	38
13	Ketapang	544,309	7,151	32
14	Kayong Utara	124,395	5,576	-
	TOTAL	**5,192,732**	**86,425**	**580**

3. South Kalimantan Province

No	District	Total pop	URI Case	Volunteer Availability
1	Banjarmasin	638,114	74,611	147
2	Batola	303,699	35,313	31
3	Tanah Laut	338,449	27,912	25
4	Tanah Bumbu	305,824	18,539	12
5	Kota Baru	329,430	13,632	20
6	Banjar	645,608	38,528	104
7	Banjarbaru	233,077	15,327	90
8	HST	278,614	19,829	27
9	Balangan	142,685	11,200	15
10	Tabalong	256,043	20,040	30
11	HSU	261,570	18,135	15
12	Tapin	181,314	12,814	30
13	HSS	231,416	14,194	30
	TOTAL	**4,145,843**	**320,074**	**576**

B. Operational strategy and plan

Overall Objective

To improve the life and health conditions of 83,700 people affected by the haze (especially children, pregnant women, elderly and people with pre-existing condition) in three provinces South Kalimantan, West Kalimantan and East Kalimantan for a period of three months (from November 2015 to January 2016) through the establishment of emergency houses (rooms equipped with air purifier for respiratory purpose and provision of health education, first aid and symptomatic treatment), adapted medical services provided by PMI medical action teams in the communities via ambulance services, as well as provision of health education and masks.

Proposed strategy

PMI, with support from IFRC, has conducted a quick assessment to identify current needs after the arrival of rains in most affected areas in West Kalimantan, East Kalimantan and South Kalimantan. On the basis of the assessment, PMI has started the following activities as priorities:

For a period of one month

1. Setting up and equip 14 emergency houses in the 14 most affected districts (three units in East Kalimantan, five units in West Kalimantan and six units in South Kalimantan), covering 30 districts in total, as one-step centres to provide people in need, including people with pre-existing condition, children, the elderly and pregnant women, with:
    - First aid
    - Basic symptomatic treatment
    - Health education
    - Psycho-social support
    - Referral to health facilities when needed.

    The total number of emergency houses has increased to address the needs of affected people in remote areas as observed during the field assessment, and the administrative reorganization of districts in South Kalimantan and West Kalimantan (most of the districts have been split into two or three new and smaller districts in this area). Although the total number of emergency houses has increased, it is expected that they will be smaller and welcome a lower number of beneficiaries, which will not result in any budget increase. In addition, since the implementation of emergency houses will be for one month instead of three due to the current rain situation (to be re-evaluated after one month), it is expected that the total number of beneficiaries for the emergency houses will be around 12,600 (as opposed to 72,900 in the original plan).

    The 14 emergency houses will therefore allow PMI staff and volunteers to **provide 12,600 affected people with health education** related to the reduction of exposure to the haze at home, as well as to identify the symptoms linked to the respiratory diseases caused by the haze, and what to do in case of a symptom. The emergency houses will also act as referral centres to hospitals, with PMI ambulances serving these emergency houses to transport patients to the nearest hospitals.

2. Health services for the most severely affected regions provided by PMI medical action teams, including first aid, distribution of oxygen, vitamins, eye drops, etc. (also called mobile health clinic). For serious cases, PMI ambulances with medical action teams will refer patients to hospitals. An estimated total of **13,500 patients will be reached with 15 ambulances** covering 30 districts in a period of one month. Considering the needs of affected people in remote areas, PMI has decided to scale up the activity of its mobile clinics to reach people who don't have access to emergency houses with health services, health education, PSP and referral system (hence the increase of beneficiaries from 4,500, as originally planned, to 13,500). The ambulance service medical action teams' members (doctors and nurses) are mobilized in priority from the local districts.

3. Mobilization of skilled personnel/technical assistance from national headquarters and neighbouring provincial chapters for the initial setup of the response. It has been decided that PMI will re-evaluate the necessity to extend the above activities one month after the beginning of the operation.

For a period of two months

4. PMI decided to focus on health education considering that haze has now become an annual event and respiratory problems have the potential of becoming a chronic issue. Health education and distribution of

additional **EVOMed masks**[2] will be provided by PMI emergency response teams (locally known as “SATGANA”) to **57,600 beneficiaries** in each of the 30 affected districts, which explains the higher number of beneficiaries for this activity compared to the original operational plan (originally 30,000 beneficiaries in 9 districts). This will include sharing information about how to use the masks, type of symptoms, what to do in case of symptoms and will complement the ongoing campaigns on local media. Masks will be used for demonstration to complement the health education sessions with practice, and 30,000 will then be distributed during those sessions to the most vulnerable people (people with pre-existing condition, children, the elderly and pregnant women). PMI volunteers will visit schools to disseminate health awareness to children as well.

Considering that the situation has evolved – with rains having extinguished majority of forest and land fires – further analysis will be done in January 2016 to determine whether there will be adjustments made to the plan of action and budget. Potential adjustments will then be done and a revised plan with budget issued. Otherwise, this will be the final update, with the final report expected 90 days after the end of this DREF operation.

Operational support services

Human resources

To this day, 580 volunteers have been mobilized in West Kalimantan, 576 volunteers in South Kalimantan, and 167 volunteers in East Kalimantan.

PMI staff in concerned chapters and branches are in charge of the operation management and implementation on the field, while the PMI Disaster Management Division (particularly the head of the DM Division and the head of the disaster response sub-division) and Health Division at the national headquarter are coordinating the overall operation.

The IFRC team is providing technical support to its PMI counterparts and ensuring a smooth coordination with RCRC and external partners. Partner national societies, particularly American Red Cross and Canadian Red Cross Society, are also contributing to this operation and providing technical support to the national society.

Logistics and supply chain

Logistics support is provided by the PMI national headquarter led by its Facility and Infrastructure Bureau together with technical support from IFRC senior logistic officer specialized in warehousing, procurement and fleet management. Logistics activities will aim to effectively manage the supply chain, including procurement, clearance, storage and forwarding to distribution sites following PMI logistics procedures, with full audit trail.

All procurement related to this operation will be carried out in-country and will be following the IFRC standards procurement procedures.

IFRC will provide logistics support according to its standard procedures to timely and efficiently source, procure and deliver equipment and other materials. IFRC's regional logistics unit (RLU) in Kuala Lumpur will provide the technical support to the IFRC Country Cluster Support Team in Jakarta, Indonesia.

Beneficiary Communications

The provision of information and two-way engagement with the affected population is a key point to consider during the response operation, so that PMI activities can be adjusted according to the expectations, needs and concerns of affected communities. Beneficiary communication components and mechanisms will be incorporated across the various sectors’ activities and will be closely linked with planning, monitoring and evaluation processes in order to build an environment of transparency and accountability. PMI provincial chapters are developing short messaging services (SMS) getaway to disseminate its programme to communities as well as working with local media such as radio and social media.

Planning, monitoring, evaluation, & reporting (PMER)

The monitoring of PMI activities will help to ensure the impact and appropriateness of the services provided. It will be carried out constantly with a bottom up and top down approach. PMI assigns its staff to closely monitor the progress of the operation in each district and province. Reporting from the field will be conducted daily by the branches (district level) and submitted to PMI provinces and national headquarter.

To assess the impact of the goods and services delivered by PMI, a separate evaluation will be conducted at the end of the operation involving beneficiaries’ feedback to measure success and identify challenges. The evaluation team will consist of representatives from PMI chapters, branches, national headquarter and IFRC personnel.

Gender, Diversity and Protection

[2] Recommendation from the Indonesian MoH for their capacity to effectively filter micro particles contained in the haze. According to the MoH, EVOMed masks are more appropriate for moderate haze situations, which fits the current field context after the rains in Sumatera and Kalimantan.

Gender, diversity and protection issues will be mainstreamed in this operation, considering that thousands of people have sought temporary accommodation in evacuation centers/safe houses. Mainstreaming of gender, diversity and protection issues will also ensure that the activities are context-appropriate and that specific needs of children and women as well as of patients with chronic conditions are met. PMI will support the setup of breastfeeding stations in safe houses to address the needs of lactating women.

C. Detailed Operational Plan

Programming / Areas Common to all Sectors

Assessment			
Outcome 1 Continuous and detailed assessment and analysis is used to inform the design and implementation of the operation	**Outputs**		**% of achievement**
	Output 1.1 Needs assessments are conducted and response plans updated according to findings		100 %
Activities	**Is implementation on time?**		**% progress (estimate)**
	Yes (x)	**No (x)**	
Mobilize PMI staff and volunteers for assessments	X		100 %
Mobilize/deploy IFRC officers available in-country to support PMI in conducting assessments as needed	X		100 %
Undertake assessments to determine specific needs of beneficiaries	X		100 %
Develop a response plan with activities that will meet identified beneficiary needs	X		100 %
Outcome 1 Continuous and detailed assessment and analysis is used to inform the design and implementation of the operation	**Outputs**		**% of achievement**
	Output 1.2 Additional assistance is considered where appropriate and incorporated into the plan		75 %
Activities	**Is implementation on time?**		**% progress (estimate)**
	Yes (x)	**No (x)**	
Ensure that any adjustments to initial plans are informed by continuous assessment of needs and through established feedback mechanisms	X		100 %
Monitor and report on distributions		X	50 %

Progress towards outcomes

Relevant staff from the PMI NHQ, particularly from PMI Disaster Management Division and Health Division, are providing overall management support to the concerned PMI chapters and branches. These staff also support in conducting regular monitoring field visits to ensure interventions are implemented according to the operational plan, as well as any revision to the operational plan if necessary.

PMI chapters and branches in the three targeted provinces continue to work closely with their counterparts from health district offices and BNPB in order to analyze the evolution of the situation on the ground, as well as the potential changes in the communities' needs.

PMI has also developed a reporting system based on open data kit (ODK) to allow staff and volunteers to share regular activity reports in real time (with their mobile phones), thus ensuring a close follow up from chapters and NHQ, improving the overall monitoring significantly. In addition, PMI staff and volunteers in the three selected provinces have been trained to use ODK effectively.

The IFRC team members in Indonesia are providing full support to their PMI counterparts for the management and monitoring of the forest fire operation.

Beneficiary Communication				
Outcome 2 Beneficiaries communication and accountability components and mechanisms are incorporated across all sectors	**Outputs**			**% of achievement**
	Output 2.1 Mechanisms are in place to facilitate two-way communication with and ensure transparency and accountability to disaster-affected people			75 %
Activities	**Is implementation on time?**			**% progress (estimate)**
	Yes (x)	**No (x)**		
Provide appropriate information, including on the scope and content of projects, to disaster-affected people	X			75 %
Ensure that affected people can deliver feedback on programme activities and/or report any complaints, in confidence, and that such are actioned by PMI and its partners	X			75 %

Progress towards outcomes

The beneficiary communication component has been included in the PMI provincial operational plans. PMI chapters and branches regularly meet with key community leaders to share information and tentative schedules related to PMI services.

The national society has also developed an appropriate system to provide information about PMI services directly to the targeted communities, and for community members to deliver feedback on programme activities. PMI is using short messaging services (SMS), radio and social media as its beneficiary communication tools. The SMS gateway has been tested already and should be implemented by the second half of December 2015.

Health & care

Health & care				
Outcome 1 Affected communities are able to improve and maintain their health condition	**Outputs**			**% of achievement**
	Output 1.1 Emergency houses are equipped with appropriate health standard equipment and air purifier, and provide symptomatic treatment, health education, first aid and PSP services			55 %
Activities	**Is implementation on time?**			**% progress (estimate)**
	Yes (x)	**No (x)**		
Setting up the emergency houses		X		65 %
Provision of Health services in the emergency houses (symptomatic treatment, health education, first aid, and PSP services)		X		30 %

Progress towards outcomes

Regarding the emergency houses, this reporting period has been dedicated to finalizing the procurement process, identifying the best locations, setting up the houses, and starting the delivery of health services. The procurement process has been supervised by PMI NHQ as well as IFRC to ensure PMI internal procurement procedures are followed.

The procurement of equipment for the emergency houses is supported through the Australian DFAT fund.

In East Kalimantan, the procurement of equipment for the three emergency houses in three districts has been finalized during the last week of November 2015. The delivery of health services in the emergency house has started on 3 December in Kutai Kertanegara district, and on 14 December in Kutai Timur district. For Kutai Barat, the most remote district, the process has been delayed due to logistic issues but the delivery of health services in the emergency house should start during the next reporting period.

In West Kalimantan, the procurement at the provincial chapter level has been completed during the first half of December 2015. The delivery of health services has started on 15 December in four districts. In the ten remaining districts, the delivery of health services will start during the second half of December.

In South Kalimantan, the procurement at the provincial chapter level has suffered some important delay and is currently ongoing. The setting up of houses and delivery of health services is expected for early January 2016.

Outcome 2 The immediate health risks of the affected population are reduced through the provision of health services	**Outputs**	**% of achievement**
	Output 2.1 Communities have access to ambulance services equipped with basic health services and paramedics	65 %

Activities	**Is implementation on time?**		**% progress (estimate)**
	Yes (x)	**No (x)**	
Mobilize medical action teams and setting up the PMI ambulances	X		100 %
Visits in affected communities		X	50 %
Provision of referral services as needed		X	50 %

	Outputs	**% of achievement**
	Output 2.2 Health education and masks are provided to affected communities in health centres	70 %

Activities	**Is implementation on time?**		**% progress (estimate)**
	Yes (x)	**No (x)**	
Procurement of 30,000 masks	X		100 %
Dispatch EVOMed masks in district health centres		X	0 %
Training of PMI volunteers		X	100 %
Production and printing of IEC material for health awareness	X		100%
Health education sessions and mask distribution		X	60 %

Progress towards outcomes

Ambulance services

A total of 15 ambulances will be used by PMI to deliver basic health services in the communities in three provinces.

The procurement of equipment for the ambulances is supported through Australian DFAT fund.

	Ambulances deployed	**Procurement of ambulance equipment**	**Ambulance services**
South Kalimantan	7	Experienced delay; however the process is ongoing	Scheduled to start in early Jan 2016
East Kalimantan	3	Completed by 30 Nov	Started in Kutai Kertanegara district on 3 Dec and Kautai Timur district on 14 Dec, while Kutai Barat district is scheduled to start by end of Dec
West Kalimantan	5	Completed by 11 Dec	Started in 4 districts on 15 Dec and 6 more districts by end of Dec
Total	15		

Health education

A total of 88 volunteers in three provinces have been trained to deliver health education and distribute masks to affected people. In addition, those who are deployed with mobiles clinics will also assist doctors and nurses in

providing health and care services.

Of the 57,600 EVOMed masks to be provided, 30,000 masks have been procured through DREF support during the reporting period by all three provincial chapters (10,000 masks each).

	Trained volunteers in health education	Health education sessions	Procurement of masks	Distribution of masks
South Kalimantan	52	13 districts started on 15 Dec	Procurement of 10,000 masks to be completed during the last week of Dec	Scheduled to start by end of Dec
East Kalimantan	16	2 districts started on 5 Dec and 1 more district by end of Dec	Procurement of 10,000 masks completed by 30 Nov	Scheduled to start by end of Dec
West Kalimantan	20	7 districts by end of Dec	Procurement of 10,000 masks completed by 11 Dec	Scheduled to start by end of Dec
Total	88			

Contact information

For further information specifically related to this plan of action, please contact:

In Indonesian Red Cross Society (PMI):

- ✓ Dr. Ritola Tasmaya, Secretary General, phone: mobile: +62 811106845; email: ritola_tasmaya@pmi.or.id

In IFRC Country Cluster Support Team (CCST) in Jakarta, Indonesia:

- ✓ Giorgio Ferrario, Head of CCST; mobile: +62 811 824 859; email: giorgio.ferrario@ifrc.org
- ✓ Pascal Bourcher, Community Safety and Resilience Coordinator; mobile: +62 811 193 2159; email: pascal.bourcher@ifrc.org

In IFRC Asia Pacific Regional Office, Kuala Lumpur:

- ✓ Martin Faller, Head of Operations; email: martin.faller@ifrc.org
- ✓ Necephor Mghendi, Operations Coordinator; mobile: +60 12 224 6796; email: necephor.mghendi@ifrc.org
- ✓ Riku Assamaki, Logistics Coordinator, mobile +60 12 298 9752, email: riku.assamaki@ifrc.org
- ✓ Peter Ophoff, Head of PMER, email: peter.ophoff@ifrc.org

In IFRC Geneva:

- ✓ Christine South, Operations Quality Assurance Senior Officer; email: christine.south@ifrc.org

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How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:

Save lives, protect livelihoods, and strengthen recovery from disaster and crises.

Enable healthy and safe living.

Promote social inclusion and a culture of non-violence and peace.

Disaster Response Financial Report

MDRID010 - Indonesia - Forest Fires

Timeframe: 01 Nov 15 to 01 Feb 16
Appeal Launch Date: 01 Nov 15

Interim Report

Selected Parameters			
Reporting Timeframe	2015/11	Programme	MDRID010
Budget Timeframe	2015/11-2016/2	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

I. Funding

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
A. Budget		**229,549**				**229,549**	
B. Opening Balance							
Income							
Other Income							
DREF Allocations		*229,549*				*229,549*	
C4. Other Income		***229,549***				***229,549***	
C. Total Income = SUM(C1..C4)		**229,549**				**229,549**	
D. Total Funding = B +C		**229,549**				**229,549**	

* Funding source data based on information provided by the donor

II. Movement of Funds

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
B. Opening Balance							
C. Income		229,549				**229,549**	
E. Expenditure		-152,160				**-152,160**	
F. Closing Balance = (B + C + E)		77,389				**77,389**	

Disaster Response Financial Report

MDRID010 - Indonesia - Forest Fires

Timeframe: 01 Nov 15 to 01 Feb 16

Appeal Launch Date: 01 Nov 15

Interim Report

Selected Parameters			
Reporting Timeframe	2015/11-12	Programme	MDRID010
Budget Timeframe	2015/11-2016/2	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure						Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/ RC work	Joint working and accountability	TOTAL	
	A						B	A - B
BUDGET (C)			**229,549**				**229,549**	
Relief items, Construction, Supplies								
Teaching Materials	21,000							**21,000**
Total Relief items, Construction, Sup	21,000							**21,000**
Logistics, Transport & Storage								
Transport & Vehicles Costs	11,571							**11,571**
Total Logistics, Transport & Storage	11,571							**11,571**
Personnel								
National Staff			368				**368**	**-368**
National Society Staff	36,286							**36,286**
Volunteers	131,562							**131,562**
Total Personnel	167,848		368				**368**	**167,480**
Workshops & Training								
Workshops & Training	429							**429**
Total Workshops & Training	429							**429**
General Expenditure								
Travel	7,929		638				**638**	**7,291**
Office Costs	2,142							**2,142**
Communications	2,477							**2,477**
Other General Expenses	2,143							**2,143**
Total General Expenditure	14,691		638				**638**	**14,053**
Operational Provisions								
Operational Provisions			141,867				**141,867**	**-141,867**
Total Operational Provisions			141,867				**141,867**	**-141,867**
Indirect Costs								
Programme & Services Support Recove	14,010		9,287				**9,287**	**4,723**
Total Indirect Costs	14,010		9,287				**9,287**	**4,723**
TOTAL EXPENDITURE (D)	**229,549**		**152,160**				**152,160**	**77,389**
VARIANCE (C - D)			**77,389**				**77,389**	