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DREF Final Report
Indonesia: Forest Fires

International Federation of Red Cross and Red Crescent Societies

DREF operation n° MDRID010	**GLIDE n° OT-2015-000148-IDN**
Date of issue: 29 April 2016	**Timeframe covered: 1 November 2015 to 31 January 2016**
Operation start date: 1 November 2015	**Operation end date: 31 January 2016**
Operation manager (IFRC): Pascal Bourcher IFRC Community Safety and Resilience Coordinator	**Point of contact (PMI):** Arifin Muhammad Hadi PMI Head of Disaster Management Division
Total number of people affected: 409,664 people	**Number of people assisted: 91,714**
Total operation budget:	**DREF allocated: CHF 229,549**
Host National Society 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 Society	
Other partner organizations actively involved in the operation: MoH, BNPB (Indonesia's national disaster management agency), UN OCHA, UNICEF, WHO, WFP, OXFAM, World Vision, Caritas, LPB Muhammadiyah, Dompet Dhuafa, PKPU, Rumah Zakat, Yakkum Emergency Unit.	

A. Situation analysis

Description of the disaster

Forest and land fires in vast areas of Borneo (Kalimantan) and Sumatra resulted in a very dense haze starting from . The Centre for Health Crisis of the Ministry of Health reported that the forest fires started in the 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 Sumatra). Already in September 2015, the haze started affecting neighboring countries such as Singapore, Malaysia, Thailand and the Philippines. The effects of haze were increasingly amplified by the El Niño phenomenon that in the region caused a mild to severe drought and resulted in a significant delay of the rainy season, therefore delaying the beneficial effects of seasonal rains as a mitigating effect.

The forest fires and the resulting haze have been the worst ever in terms of casualties, the duration of the event, the economic loss and the wide impact on people's health and the environment.[1]The BMKG (National Meteorological, Climatology and Geophysics Agency) recorded more than 1,100 hotspots spread all over the affected area, mainly in the islands of Sumatera and Kalimantan and to a lesser extent in Papua. In Sumatera, a total of 771 hotspots were recorded as follows: 33 hotspots in Bengkulu, 99 in Jambi, 41 in Bangka Belitung, 42 in Lampung, 28 in Riau, 8 in West Sumatera and 530 in South Sumatera. In Kalimantan, a total of 332 hotspots were recorded spreading in the four provinces of West Kalimantan (22 hotspots), South Kalimantan (28 hotspots), Central Kalimantan (188 hotspots) and East Kalimantan (94 hotspots).

The air pollutant index (API) level ranged between 150 to 1,950 µgram/m^3 with the highest API (1,950 µgram/m^3) recorded on 21 October 2015 in Central Kalimantan Province (normal condition is 0 to 50 µgram/m^3). People, especially children, pregnant women, the elderly and people with pre-existing respiratory problems became more vulnerable to upper respiratory tract infection (URI), eye irritation, pneumonia, asthma, skin irritation, which resulted into 11 casualties. BNPB data shows that the people who particularly suffered from URI were located in Jambi province (around 150,000 people) and South Sumatera province (115,000 people). In the forest and land affected areas, the National Institute of Aeronautics and Space (LAPAN) recorded 2.61 million hectares of burnt land. Visibility went down to between 20 to 500 meters for weeks 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 caused schools, universities and some offices to close down.

[1] *Recent forest and Peat fire trends in Indonesia, The Latest Decade by MODIS Hotspot Data*, Nina Yulianti et al, Global Environmental Research Journal 2012

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 had extinguished the majority of forest and land fires throughout Indonesia, while in some cases the risk of peat fires to re-ignite continued due to uncertain trends of the impact of El Nino. Despite the net improvement of the situation in late 2015, many people living in these affected areas continued to suffer from the effects of the previous long exposure to haze: data from the health services in West Kalimantan show that the number of respiratory infections remained high even after the end of forest fires.

Due to protracted diminution of quantity of rain in some areas, the haze season is expected to come as early as April in 2016. To date BNPB has reported 151 hotspots in Sumatra and Kalimantan, while parts of Sumatra and Kalimantan have entered the first period of the dry season.[2]

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). The unspent balance of CHF 42,871 will be returned to the DREF pot.

Summary of response

Overview of Host National Society

PMI responded immediately to address the needs of the affected communities. Starting July 2015, the National Society mobilized volunteers to assist with the evacuation of the most at risk populations together with the disaster management local authorities (BPBD), and with the distribution of masks. PMI has worked 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, 636,000 masks were distributed to the affected people by the PMI chapters and branches during the initial phase of the response.

Mask distribution by PMI volunteers. **Credit: PMI West Kalimantan**

PMI then requested further support through the IFRC's DREF and Australia's Department of Foreign Affairs and Trade (DFAT) disaster response contingency fund to scale up the delivery of its health services to meet the needs of the community. The PMI response is estimated to have benefited **91,714 people** through the provision of emergency houses, mobile clinics and health promotion in 30 districts of three provinces in Kalimantan Island.

Through the support of its partners, including IFRC, PMI established 13 emergency houses in the provinces of West Kalimantan (5 units), East Kalimantan (3 units) and South Kalimantan (5 units). The emergency houses were used as one stop centres to provide people in need with first aid, basic symptomatic treatment, psychosocial support, health education and referral to health facilities as needed. The National Society also provided health services to the affected people deploying 15 ambulances to 30 districts in the three target provinces. The mobile clinic service aimed to treat symptomatic diseases, provide first aid, evacuation, and referral of serious cases to hospital.

[2] http://www.bnpb.go.id/berita/2853/kebakaran-hutan-dan-lahan-terus-meningkat-151-hotspot-terdeteksi

Overview of Red Cross Red Crescent Movement in country
The IFRC Country Cluster Support Team (CCST) in Indonesia monitored the forest fire situation since the beginning of its occurrence and providing technical support to PMI during the implementation of this operation. IFRC also assisted 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 relevant UN agencies and INGOs in Indonesia.

The American Red Cross, with assistance from USAID, provided similar support to PMI interventions in the four other affected provinces of Riau, Jambi, South Sumatra and Central Kalimantan.

Overview of non-RCRC actors in country
Affected provinces issued separately decrees related to the emergency phase throughout the month of September 2015 and the central Government encouraged all government bodies and international/national organizations to act upon the humanitarian needs.

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

- Mobilization of rapid health assessment (RHA) teams;
- Conducting health promotion through its Primary Health Care Centres (present in each sub-district);
- Health service centres operational 24 hours a day and 7 days a week;
- Joint monitoring visits of the Provincial Health Departments conducted 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;
- Whenever the air quality index exceeded the tolerance limit, MoH issued a recommendation to the Education Department at provincial and district levels to close down schools;
- Establishment of emergency houses equipped with air condition and air purifier for vulnerable groups such as infants, toddlers, pregnant women and elderly people;
- Deployment of medical action teams in severely affected areas.

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

INGOs (e.g. OXFAM, World Vision, Caritas) and Indonesian NGOs (e.g. LPB Muhammadiyah, Dompet Dhuafa, PKPU, Rumah Zakat, Yakkum Emergency Unit) were 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 and WHO were involved in the coordination between actors, compiling and providing relevant information about the forest fire situation as well as the impact of El Nino in general.

Needs analysis and scenario planning

Secondary data from the Ministry of Health and needs assessments showed that a significant number of people living in these three provinces, especially children, pregnant women, elderly and people with pre-existing condition, were suffering from upper respiratory tract infection (URI, see figures in the tables below), eye irritation, pneumonia, asthma, skin irritation. As most households do not have facilities to filter the air from outside, and since existing local health facilities had not been able to address all the needs from the communities, especially the most vulnerable, PMI's plan of action was developed to complement the services delivered by government facilities to those most adversely affected. PMI scaled 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.

PMI, through the IFRC's DREF and Australia's DFAT contribution, planned to provide assistance to 83,700 affected people in the three provinces of East Kalimantan, West Kalimantan and South Kalimantan. PMI also provided humanitarian assistance in four other affected provinces through a contribution received from USAID and supported by American Red Cross.

B. Operational strategy and plan

Overall Objective

The operation aimed 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 over a three-month period (November 2015 to January 2016). This would be 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 communities via ambulance services, as well as provision of health education and masks.

Strategy adopted

PMI, with support from IFRC, conducted continuous assessment to identify the developing needs after the arrival of rains in the seven most affected provinces of West Kalimantan, East Kalimantan, South Kalimantan, Central Kalimantan, Jambi, Riau and South Sumatera. On the basis of the assessment results, the strategy was then revised and reflected in the DREF operation update:

- The impact of haze was reduced by the arrival of heavy rains, and the number of hotspots diminished. The focus of PMI's emergency houses was therefore more about addressing the impact of the haze on vulnerable people rather than for "haze-free/clean air house";
- This DREF/DFAT support also covered all medicines provided to beneficiaries in other four affected provinces (Riau, Jambi, Central Kalimantan and South Sumatera Province);
- The duration of the delivery of basic medical services has shifted from 90 days to 30 days, and focusing more on spreading key messages through health education interventions for a three months period.
- Due to the modification of the timeframe for medical services, the total number of beneficiaries has been re-evaluated and estimated at 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 coverage has been extended from 9 districts to 30 districts due to the increasing needs in remote areas. [3]
- All PMI chapters and districts have been instructed by their leadership not to implement any activity from 3 to 9 December due to potential interference with the provincial elections in Indonesia on 10 December, causing some delays in field implementation.

Three main services were provided through this operation:

1. Identify the location, set up and equip 13 emergency houses in the 13 most affected districts[4] (three units in East Kalimantan, five units in West Kalimantan and five 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 service
    - Basic symptomatic treatment
    - Health education
    - Psycho-social support
    - Referral to health facilities when needed.

    Each emergency house (size of 36 m^2) was equipped with:
    - Air conditioner split 2 PK : 2 units
    - Air purifier : 2 units
    - Field bed : 4 units
    - Lather mattress rebounded Inoac : 20 pcs (10 cm x 200 cm x 90 cm)
    - Oxygen tube 2 m^3 : 3 units
    - Oxygen mask for toddler : 3 pcs
    - Oxygen mask for adult : 3 pcs
    - Nebulizer and ventolin amp : 2 pcs
    - Home isolation : 1 package
    - Generator set : 6 – 6.5 KWH

    The 13 emergency houses were set up to allow PMI staff and volunteers to **provide approximately 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 symptom. The emergency houses also act as referral centres to hospitals, with PMI ambulances serving these emergency houses to transport patients to the nearest hospitals.

2. Mobile 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 clinic). For serious cases, PMI ambulances with medical action teams will refer patients to hospitals. An estimated total of **13,500 patients should be reached with 13 ambulances**[5] 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

[3] The initial figure of 32 districts mentioned in DREF Update 1 has been revised to 30 according to field priorities.
[4] PMI merged two emergency house services in the two districts of Tanah Bumbu and Banjar located close to each other into one in Banjar.
[5] PMI South Kalimantan provinces established 5 mobile clinics instead of the initially planned 7 units under request by the local government (Primary Health Centre at Sub-district) in order to focus on the most needed areas.

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.

The ambulances have been equipped with standardized equipment to function as a mobile clinic:

- Air conditioner single blower : 1 unit
- Oxygen tube ½ m^3 : 2 units
- Nebulizer and ventolin amp : 1 pcs
- Fog lamp (yellow) : 1 set
- Mask 3M Half Face : 1 pack
- First aid kit : 1 set

3. Mobilization of skilled personnel/technical assistance from national headquarters and neighbouring provincial chapters for the initial setup of the response as well as for the health education.

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 N95 EVOMed masks will be provided by PMI emergency response teams (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. PMI volunteers will visit schools to disseminate health awareness to children as well.

Operational support services

Human resources

A total of 1,323 volunteers were mobilized: 580 in West Kalimantan, 576 in South Kalimantan, and 167 in East Kalimantan.

PMI staff in concerned chapters and branches were 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 were coordinating the overall operation.

The IFRC team provided technical support to its PMI counterparts and ensured a smooth coordination with RCRC and external partners. Partner national societies, particularly American Red Cross and Canadian Red Cross Society, also contributed to the operation and provided technical support to PMI.

Logistics and supply chain

Logistics support to implementing branches was provided by the PMI national headquarters led by its Facility and Infrastructure Bureau. Logistics activities aimed 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 was carried out in-country and followed the IFRC standards procurement procedures. IFRC provided logistics support to PMI to timely and efficiently source, procure and deliver equipment and other materials. In-country support was provided by a senior logistics officer specialized in warehousing, procurement and fleet management.

IFRC's regional logistics unit (RLU) in Kuala Lumpur provided technical support to the IFRC Country Cluster Support Team in Indonesia.

Beneficiary Communications

The provision of information and two-way engagement with the affected population was a key point during the response operation, so that PMI activities could be adjusted according to the expectations, needs and concerns of affected communities. Beneficiary communication components and mechanisms were incorporated across the various sectors' activities and closely linked with planning, monitoring and evaluation processes in order to build an environment of transparency and accountability. PMI provincial chapters developed short messaging services (SMS) gateways and utilized social media to disseminate information to communities. They also worked with local media such as radio. *More information is available under "quality programming" section.*

Planning, monitoring, evaluation, & reporting (PMER)

The monitoring of PMI activities helped to ensure the impact and appropriateness of the services provided. It was carried out continuously using a bottom up and top down approach. PMI assigned its staff to closely monitor the

progress of the operation in each district and province. Reports from the field were prepared daily by the branches (district level) and submitted to PMI provinces and national headquarter.

A review workshop was organized at the end of the operation to identify the level of achievement of the emergency operation - in terms of relevance, appropriateness, effectiveness and timeliness - as well as to collect lessons learned related to effective and less effective practices during the operation. The review also identified challenges, recommendations and/or modifications required to improve operational aspects and systems for future similar emergency operations. PMI chapters, branches, national headquarter staff and volunteers as well as IFRC personnel attended this workshop. *The report is available to partners upon request to the PMER unit (see contact information).*

Gender, Diversity and Protection

Mainstreaming of gender, diversity and protection issues ensured that the activities were context-appropriate and that specific needs of children and women as well as of patients with chronic conditions were met. PMI supported the setup of breastfeeding stations in safe houses to address the needs of lactating women.

C. Operational implementation

Quality programming

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		100 %
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		100 %
Progress towards outcomes			
From 24 October to mid-November 2015, PMI provincial chapters, together with PMI branches (district level,) conducted community assessments via household visits and focus group discussions in order to identify the most affected districts and villages, and to obtain a clearer picture of the needs created by forest fires and haze on the ground. PMI chapters and branches also consolidated the findings and secondary data from provincial health departments and BPBD.			

PMI, with support from its national headquarters, IFRC and the Canadian Red Cross, developed operational plans according to the specific needs in the affected areas of the three target provinces, the capacities of chapters and branches, and the needs for capacity building to be able to implement the plans in an effective and timely manner. Relevant staff from PMI national headquarters, particularly Disaster Management and Health divisions, were appointed by PMI leadership to provide overall management support to the concerned PMI chapters and branches.

PMI staff and volunteers were also involved in the regular monitoring and field visits to ensure that interventions were implemented according to the operational plan, as well as make any revision to the operational plan if necessary. PMI chapters and branches in the three targeted provinces worked very closely with their counterparts from health district offices and BPBD in order to analyze the evolution of the situation on the ground, as well as the potential changes in the communities' needs.

PMI 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 provinces were trained to use ODK effectively. However, the lack of a reliable mobile network connection on the targeted areas caused challenges and delays on sending the reports. Nevertheless, the testing of this online reporting tool is an added value to PMI reporting system and further improvement is needed to maximize the benefit of real time sharing information.

The IFRC team members in Indonesia provided full support to their PMI counterparts for the management and monitoring of the forest fire operation. The support to strengthen PMI's real-time data collection and analysis capacity will be continued by the CCST under the Operational Plan 2016.

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		100 %
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		100 %
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		70 %

Progress towards outcomes

The beneficiary communication component was included in the PMI provincial operational plans. Although there was no formal channel of communication dedicated specifically for community members to address comments, questions or complaints related to PMI services, PMI managed to set up a series of effective measures that proved to be effective in the many operations implemented by the National Society. Firstly, regular community meetings allowed all villagers to give their opinion and raise their concerns about the plan of action before the implementation, then at any step during the implementation. PMI has also widely distributed leaflets with all information related to the project, with a specific contact number for each province for community members who wished to give their opinion about the project. The SMS gateway, local radio and social media also allowed PMI to disseminate messages related to the main activities to a large portion of the affected people and receive feedback from the communities. All PMI chapters reported that the large majority of the feedback provided via the communication means mentioned above was very positive and emphasized that services provided by PMI had improved their quality of life. These feedback were used in operational decision to ensure the relevance of humanitarian assistance provided by PMI. However, during the review workshop it was agreed by PMI branches, chapters and national headquarters that a more specific channel of communication needs o developed in case of future emergency response. As such, participants recommended that a specific two-way beneficiary communication mechanism to be developed and ready to use in future operations.

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	100 %

Activities	**Is implementation on time?**		**% progress (estimate)**
	Yes (x)	**No (x)**	
Setting up the emergency houses		x	100 %
Provision of health services in the emergency houses (symptomatic treatment, health education, first aid, and PSP services)		x	100 %

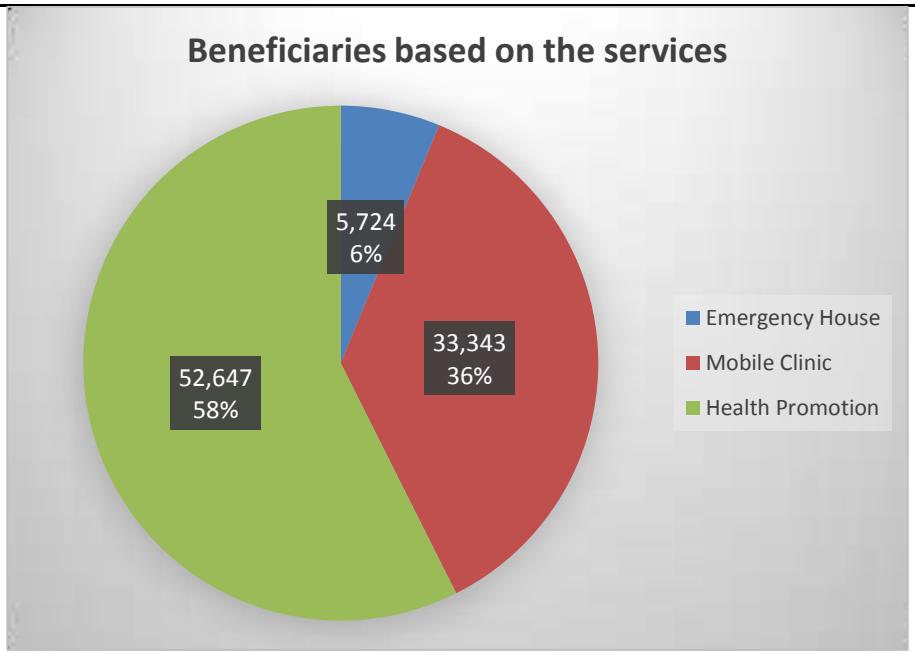
Progress towards outcomes

The strategy of establishing emergency houses was initially opted by PMI since it addressed the community needs and complemented the government's response operation. The emergency house was designed as a one-stop health centre, equipped with air purifier for clean air room as well as for basic symptomatic treatment and psychosocial support. By taking into consideration the improvement of air quality due to the heavy downpour during the first two weeks of the operation, the function of emergency house shifted. PMI focused more on utilizing the houses to provide health services to address the impact of the haze on vulnerable people's health condition rather than being mainly a facility to provide clean air to community members.

PMI established 13 emergency houses covering 30 districts in the three target provinces of East Kalimantan (3 units), West Kalimantan (5 units) and South Kalimantan (5 units). Through a good cooperation and coordination with provincial health departments, PMI was allowed to utilize public facilities to set up its emergency houses by considering the access from the community residential area to the facilities. PMI was also supported by the government through the service of health personnel from health district office in the emergency houses, which has strengthened the coordination between PMI and local governments. Utilization of the public facilities has also benefited the whole communities since most of these facilities had been abandoned and unused for quite a while and had now been reactivated thanks to PMI's action.

Aside from strengthening coordination with government, PMI provincial chapters have also expanded their capacity to respond better to forest fires impact since this is their first experience to establish health services to community. By the end of the operation, PMI is now better prepared should a similar event reoccur: appropriate equipment, prepositioning stocks, skilled personnel are ready for deployment, and the coordination with local government is pre-existing and effective.

In all, PMI assisted 5,724 people through its emergency houses, 33,343 people through its mobile clinics in 7 (seven) provinces, and 52,647 people with health promotion. The total number of beneficiaries reached by PMI's health interventions during this operation is therefore **91,714**.



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	100 %

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	100 %
Provision of referral services as needed		x	100 %

	Outputs	**% of achievement**
	Output 2.2 Health education and masks are provided to affected communities in health centres	100 %

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		100 %
Training of PMI volunteers		x	100 %
Production and printing of IEC material for health awareness	x		100%
Health education sessions and mask distribution		x	100 %

Progress towards outcomes

Mobile Clinic Services

PMI has first reviewed its existing capacity (PMI staff and volunteers) in the three selected provinces in relation to its mobile clinic activities. Upon review, PMI chapters and branches determined the needs in terms of volunteer mobilization and capacity building. The health services, PSP and health education were delivered via the deployment of 13 ambulances in the most affected areas within the 30 districts.

PMI mobile clinic services were able to reach the remotest area in the targeted provinces and proved to be complementary to the emergency houses.

In total, 13 ambulances have been used by PMI to deliver basic health services in the communities in three provinces. In addition, PMI mobilized boats to deliver health services and health education messages to communities located in districts not reachable by road.

			Health Service				Health Promotion		
Province	URI Case (Aug-Oct 2015)	District Covered	No. of Emergency House	Beneficiaries of Emergency House	Beneficiaries of Mobile Clinic	No. of Ambulance	Beneficiaries of Health Promotion	Leaflet Distribution	Local Media News
East Kalimantan	6,663	3	3	68	3,014	3	3,103	6,500	1
South Kalimantan	97,430	13	5	2,538	2,164	5	45,126	10,000	2
West Kalimantan	43,477	14	5	3,118	5,240	5	4,418	6,500	2
Central Kalimantan	52,142	3	0	0	5,978	3	0	0	0
Riau	80,263	3	0	0	6,922	4	0	0	0
Jambi	129,229	4	0	0	4,100	3	0	0	3
South Sumatera	101,333	3	0	0	5,925	3	0	0	7
Total	**510,537**	**43**	**13**	**5,724**	**33,343**	**26**	**52,647**	**23,000**	**15**

PMI reached 10,418 people with its mobile clinic services in the three provinces targeted under this operation, with East Kalimantan having the lowest number of people assisted through the emergency houses since it was the province least affected by forest fires. Moreover, PMI – with the support of IFRC's DREF and Australia's DFAT contribution – provided medical supplies for mobile clinic services to an additional 22,925 affected people in the four provinces of Central Kalimantan, Riau, Jambi and South Sumatera. The total number of beneficiaries reached by PMI's mobile clinic services in these seven provinces is therefore **33,343**.

(Top) Mobile health services by PMI staff and volunteers. **Credit: PMI West Kalimantan**
(Below) Emergency house **Credit: PMI South Kalimantan**

Health Education

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. PMI started by adapting the epidemic control for volunteers (ECV) technical guideline to this specific context to rollout the ECV toolkit in an emergency response situation. IEC materials were developed and distributed to affected people in the 30 affected districts (via mobile clinics and in health centres). The IEC materials had key messages on hygiene promotion and how people can protect themselves from the impact of haze, respiratory infections and.

Health education and distribution of additional **EVOMed masks**[6] was undertaken by PMI emergency response teams (locally known as "SATGANA"), reaching **52,647 beneficiaries** in the 30 affected districts. This included sharing information about how to use the

[6] 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 fitted the field context after the rains in Sumatera and Kalimantan.

masks, the types of symptoms, what to do in case of symptoms and complemented the ongoing PMI campaign on local media. Masks were used for demonstration to complement the health education sessions with practice, and 30,000 were then distributed during those sessions to the most vulnerable people (people with pre-existing condition, children, and the elderly and pregnant women).

PMI volunteers visited schools to disseminate health awareness to children and used the cooperation with telecommunication provider (Telkomsel) to spread health messages through short messaging service **(SMS) gateway to 11,500 beneficiaries** as well.

A total of 88 volunteers in three provinces were trained to deliver health education and distribute masks to affected people. In addition, those deployed with mobiles clinics also assisted doctors and nurses in providing health and care services.

Three PMI chapters have now become better prepared should the same event occurs in the future. The PMI stock of masks has been replenished through the IFRC's DREF and Australian's DFAT support. Since the end of the PMI forest fire/haze operation and in order to get better prepared for the next haze season, particularly in Kalimantan (the most vulnerable area for forest fires), PMI has prepositioned its stock of masks as well as the equipment for emergency houses and ambulances in the three chapters of West Kalimantan, East Kalimantan and South Kalimantan (items stocked in appropriate storage rooms), as well as in its Kalimantan regional warehouse, as shown in the table below. PMI South Kalimantan and East Kalimantan chapters have managed to preposition masks with their own resources while the PMI regional warehouse can rapidly support other provinces such as West Kalimantan as needed should a similar event reoccurs.

	Prepositioned masks			
Province	**EvoMed+**	**N95-8210**	**Surgical**	**Volunteers trained in health education**
East Kalimantan	25,000	6,000	15,000	16
South Kalimantan	211,000	25,000	82,004	52
West Kalimantan	0	0	15,000	20
Kalimantan Regional Warehouse	275,000	25,000	200,000	0
Total	**511,000**	**56,000**	**312,004**	**88**

	Ambulances available (unit)	**Emergency house equipment (set)**
East Kalimantan Chapter	3	3
South Kalimantan Chapter	7	5
West Kalimantan Chapter	5	5
Total	**15**	**13**

PMI chapters in Kalimantan are also working with local authorities to finalize the lists of public facilities available in all locations where PMI emergency houses can be set up as and when needed.

In addition, PMI and IFRC are coordinating with WHO and the MoH Crisis Centre to collect all necessary information and reinforce PMI forest fire/haze plan to be in line with the government action during the next haze season. On 15 April 2016, PMI and IFRC organized a haze preparedness coordination meeting with the MoH Crisis Centre, WHO and the ministry of internal affairs to clarify the roles and responsibilities of each actor in case of forest fire and subsequent haze in the future, as well as to map all resources and align each stakeholder's contingency plans in the coming weeks and months.

Progress towards outcomes

A review workshop organized at the end of the operation identified practices to be or not to be replicated in future interventions. Firstly, it was acknowledged that undertaking procurement at province level was much more effective – where required items were available at the province level – as it saved delivery cost and time, especially to remote districts. However, the procurement process would have been more effective PMI had activated the internal emergency status thus allowing for application of emergency procedures, which exist. Secondly, coordination with MoH ensured that delivery of health services – through PMI emergency houses and mobile clinics – complimented the services provided by local authorities and thus making best use of limited resources. Thirdly, PMI maximized its auxiliary statues and wide network to reach the most vulnerable people by mobilizing a large number of community volunteers to the smallest entity of the affected communities, especially for those in very remote areas. This capacity is crucial in delivering humanitarian assistance in similar or other crises in future. Fourthly, the use of an SMS gateway for health promotion was considered very effective since it allowed PMI to easily reach thousands of beneficiaries instantly. This capacity needs to be strengthened further. Finally, the operation has provided a solid background for PMI chapters and branches to be able to respond faster to the needs of people who may be affected by future similar situations using the equipment procured with Australia's DFAT support, the tacit and institutional knowledge gained in implementing the DREF-supported operation and application of emergency procedures.

D. Financial summary

CHF 229,549 was allocated to respond to the humanitarian needs of households affected by forest fires and the resultant haze. In all, the operation utilized CHF 186,678 or 81 per cent of the allocation. The balance of CHF 42,871 will be returned to the DREF pot.

Reference documents ↘

Click here for:

- DREF EPoA
- Operations Update n° 1
- Operations Update n° 2

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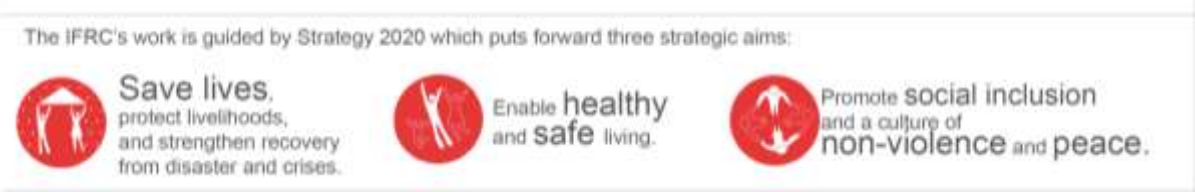
Click

1. **Here for the Final Financial Statement**
2. **Here to return to the title page**

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.



Disaster Response Financial Report

MDRID010 - Indonesia - Forest Fires

Timeframe: 01 Nov 15 to 01 Feb 16

Appeal Launch Date: 01 Nov 15

Final Report

Selected Parameters			
Reporting Timeframe	2015/11-2016/3	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		-186,678				**-186,678**	
F. Closing Balance = (B + C + E)		42,871				**42,871**	

Disaster Response Financial Report

MDRID010 - Indonesia - Forest Fires

Timeframe: 01 Nov 15 to 01 Feb 16

Appeal Launch Date: 01 Nov 15

Final Report

Selected Parameters			
Reporting Timeframe	2015/11-2016/3	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								
Medical & First Aid			3,400				**3,400**	**-3,400**
Teaching Materials	21,000		22,291				**22,291**	**-1,291**
Total Relief items, Construction, Sup	21,000		25,692				**25,692**	**-4,692**
Logistics, Transport & Storage								
Transport & Vehicles Costs	11,571		10,351				**10,351**	**1,221**
Total Logistics, Transport & Storage	11,571		10,351				**10,351**	**1,221**
Personnel								
National Staff			1,325				**1,325**	**-1,325**
National Society Staff	36,286		29,343				**29,343**	**6,943**
Volunteers	131,562		85,555				**85,555**	**46,007**
Other Staff Benefits			1,537				**1,537**	**-1,537**
Total Personnel	167,848		117,760				**117,760**	**50,088**
Workshops & Training								
Workshops & Training	429		707				**707**	**-278**
Total Workshops & Training	429		707				**707**	**-278**
General Expenditure								
Travel	7,929		1,624				**1,624**	**6,305**
Information & Public Relations			7,172				**7,172**	**-7,172**
Office Costs	2,142		8,987				**8,987**	**-6,845**
Communications	2,477		2,350				**2,350**	**127**
Financial Charges			534				**534**	**-534**
Other General Expenses	2,143		109				**109**	**2,034**
Total General Expenditure	14,691		20,775				**20,775**	**-6,084**
Indirect Costs								
Programme & Services Support Recov	14,010		11,394				**11,394**	**2,617**
Total Indirect Costs	14,010		11,394				**11,394**	**2,617**
TOTAL EXPENDITURE (D)	**229,549**		**186,678**				**186,678**	**42,871**
VARIANCE (C - D)			**42,871**				**42,871**	