HUMANITARIAN NEEDS AND PRIORITIES

HIGHLANDS VIOLENCE

PAPUA NEW GUINEA

AUG 2022 - MAY 2023

ISSUED
09 AUG 2022

Photo: UNDP/C. Hawigen

Contents

At a Glance

PEOPLE AFFECTED	PEOPLE TARGETED	REQUIREMENTS (US$)
265K	78K	$16.6M

VICTIMS OF VIOLENCE

400 KILLED

30 WOMEN AND GIRL VICTIMS OF GBV/SARV

PEOPLE DISPLACED

2K PEOPLE INSIDE CARE CENTRES

87K PEOPLE OUTSIDE CARE CENTRES

ESSENTIAL SERVICES

125 SCHOOLS AFFECTED

25K LEARNERS UNABLE TO ATTEND SCHOOL

37 HEALTH FACILITIES AFFECTED

558K PEOPLE UNABLE TO ACCESS BASIC HEALTH SERVICES

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Map Sources: HDX, OSM Map created: 23 July 2022

STRATEGIC OBJECTIVE 1

In support of the government, provide principled, targeted, and coordinated lifesaving and protection assistance to 78,000 conflict-affected people within the three months of the emergency.

STRATEGIC OBJECTIVE 2

In support of the government, address evolving needs resulting from prolonged displacement and toward recovery.

STRATEGIC OBJECTIVE 3

Advocate for durable solutions conducive to peacebuilding and normalization efforts.

$16.6M
FUNDING REQUIREMENTS (US$)

78K
PEOPLE TARGETED

CCCM/Shelter/NFI	6.5M	78K
Education	1.2M	26K
Food Security & Agriculture	2.1M	50K
Health	2.0M	78K
Sexual & Reprod. Health	0.8M	20K
Nutrition	0.2M	37K
Child Protection	0.3M	50K
Gender-based Violence	0.6M	60K
WASH	2.3M	78K
Coordination	0.6M	78K

Foreword by the Resident Coordinator

As Papua New Guinea approached its national general elections this year, outbreaks of violence began to escalate in parts of the Highlands region and other areas of the country. While in most places the elections were conducted peacefully and successfully, the violence against civilians—and especially women and children—in parts of Enga, Hela, and Southern Highlands has been atrocious. As a result of this violence, hundreds of people have been killed, thousands have fled their homes, and schools and health facilities have been shuttered for months. Whole districts have been cut off from the movement of goods, services, and people.

Together with the Government of Papua New Guinea, we are still grasping to understand the full impact on the lives of communities and on the economy. An estimated 265,000 people in five districts are affected, leaving about 105,000 most vulnerable people in need of assistance.

Needs are high. Thousands of Papua New Guineans now depend on our solidarity. Women and girls require protection from violence and abuse. People whose homes were destroyed or looted require safe, temporary shelter and materials to repair or rebuild their homes. Many of them require food, potable water, and medicines. People need access to sanitation and hygiene facilities. Learners and teachers need to return to school and medical staff to health facilities. We must also link our efforts to peacebuilding and development to mitigate this kind of violence in the future

The Director of the National Disaster Centre, Col. Carl Wrakonei, asked the UN Resident Coordinator and the Disaster Management Team to coordinate the response of the humanitarian community partners in support of government relief efforts.

I am proud to say that humanitarian partners under the Disaster Management Team are ready to act. They prepared for a possible situation such as this through contingency planning in May. Provided enough funding is available and in line with the Government's invitation to scale up collective efforts of in-country capacities, the DMT plans to support urgently needed assistance to at least 78,000 people. Most activities benefit people in the most-affected areas of Enga, Hela, and Southern Highlands provinces from August 2022 to May 2023.

International and local non-governmental and faith-based organizations are the core of this response. I am mindful of the opportunity to show our commitment to strengthen local response mechanisms with people at the center of the response as I appeal to our development and private sector partners to contribute through this plan.

Themba Kalua

Resident Coordinator, a.i.

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Situation Overview

Photo: UN in PNG

Between May and July 2022, the period of the national general election, violence has escalated in parts of the Highlands region. The presence of security personnel in the conflict-affected areas is limited, tensions remain high, and outbreaks of new violence could continue at least through the end of the August during the period for challenging election results. While in most areas, the violence is directly related to the election, in some places it has resurfaced from long-standing issues, including land disputes, retribution, and unsettled disputes between clans, who are using the instability around elections to re-ignite fights.

The areas believed to have the greatest humanitarian needs are Porgera, Laiagam, and Kompiam districts in Enga province; Magarima district in Hela province; and Nipa district in Southern Highlands province. While the commercial airport serving Enga province remains closed, Mission Aviation Fellowship has resumed regular flights to parts the province, and roads are passable with coordinated security escorts.

Officials and partners have reported killings, including of women and children; sexual violence against women and girls; sorcery accusation-related violence against women; destruction of homes, schools, churches, hospitals, businesses, and agricultural warehouses; and violence and destruction of homes and properties of communities and churches hosting displaced persons.

Due to the ongoing insecurity in these areas, needs assessments cannot currently be conducted. Projected populations, disaggregated by sex and age group, including certain vulnerable populations, also serve as an indicator of overall affected populations. The estimated figure on affected population is uncertain at this stage; however, the overall population of these affected districts is estimated to be 529,181 people or 98,349 households. The CCCM/Shelter/NFI cluster estimates around 50 percent of the population

or 264,590 people or 49,175 households have been affected. The cluster further estimates that one third of those—87,315 people or 16,227 households—could be displaced from their homes.

In some places, churches, considered safe havens, are hosting displaced populations; six churches in Enga province are hosting about 2,000 people, mostly women and children. Estimates from organizations and government officials in the affected districts and provinces indicate that about 21,000 people are displaced in or have fled from the conflict-affected areas as of the end of July, but this figure is believed to be largely undercounting the actual number of people who have fled or have been displaced. Most of those displaced have fled to other communities in and outside the respective provinces or to neighboring mountains. There is pressure on churches and communities hosting displaced persons, which include sexual violence victims in some cases, to meet basic needs and health care.

Businesses, schools, and hospitals in these areas have closed, and several have been damaged or destroyed in the fighting. Current estimated catchment populations for health facilities and school enrolment figures are indicators of the populations affected by lack of access to basic health services and education: about 25,700 students are unable to attend school and about 557,800 people have no or limited access to basic health services due to damaged facilities, lack of staff who have fled the violence, disrupted supply chains, and other impacts from the violence.

The Director of the National Disaster Centre wrote to the UN Resident Coordinator, as co-chair of the Disaster Management Team, on 26 July welcoming assistance from international partners. He also requested the Police Commissioner, who is coordinating election-related security in the Highlands, that a humanitarian corridor be established to allow for the safe delivery of essential relief goods and services. The Commissioner has identified a coordinating focal point but acknowledges that security forces are limited in capacity.

Private sector businesses and members of the Highlands Humanitarian Hub have coordinated at least two convoys of trucks to a church in Porgera hosting about 300 women and children, including rape survivors, to deliver emergency food and non-food-items, as well as post-rape treatment kits.

Churches and NGOs who are working with affected communities and displaced people in these provinces have indicated the following urgent needs:

- Lack of food items, including fresh produce and protein, as well as store items, and fuel
- Lack of medicines and medical supplies, as well as lack of medical services, especially for victims of rape and sorcery accusations
- Lack of shelter, clothing, hygiene items, and other relief items, especially for those displaced
- Lack of access to education for school-aged children

To address these critical needs, a multisectoral humanitarian response is required in five districts– across camp coordination and camp management, shelter, and non-food items (CCCM/Shelter/NFI; water, sanitation, and hygiene (WASH); protection, especially gender-based violence (GBV) and child protection (CP); food security; education; and health, including sexual and reproductive health.

While initial response planning may rely on estimated figures and secondary data, assessments will need to be conducted when it is safe to do so, to further tailor and refine response actions. As part of the assessments, the Displacement Tracking Matrix and Solution and Mobility Index may be employed

Planning figures

Table 1. Estimated displacement figures (CCCM/Shelter/NFI Cluster)

Location	Estimated displacement
Enga – Porgera/Paiela	19,613
Enga – Lagaip	12,981
Enga – Kompiam	11,206
Hela – Magarima	13,355
Southern Highlands – Nipa	30,159
TOTAL	**87,314**

Table 2. Health facility catchment populations (UNICEF)

Location	Facility	Catchment
Enga – Porgera/Laiagam	8	225,452
Hela – Magarima	12	129,957
Southern Highlands – Nipa	17	202,445
TOTAL	**37**	**557,854**

Table 3. School enrolment (UNICEF)

Location	Schools	Enrolment		
		M	F	Total
Enga – Porgera/ Paiela	33	4,803	3,847	8,650
Hela – Magarima	38	3,824	3,159	6,983
Southern Highlands – Nipa	54	5,727	4,335	10,062
TOTAL	**125**	**14,354**	**11,341**	**25,695**

Timeline of events

6-12 May – Fighting erupted between 2 clans in Paiam Station, Porgera, Enga province. The fighting claimed at least 14 lives. About 2,000 people injured, 100 houses, school dormitory and teacher housing burned. At least 3,000 people fled. Schools, hospital, businesses close.

8-13 June – At least 3 people, including 2 women, shot in Porgera. Reports of women being raped.

20 July – At least 18 new killings in Porgera. 2 villages hosting IDPs attacked. At least 300 women, including 12 rape victims, and children sheltering in a church in Porgera.

21 July – 120 troops staged in Wabag, Enga, for forward deployment to hot spots in Enga, including Porgera, Laiagam, Kompiam.

22 July – Ad hoc DMT and ICCG meetings. Updated info indicates 400+ deaths in affected districts in Enga, Hela, SHP and at least 19,000 people displaced. Supplies, fuel, and cash shortages due to roadblocks and fighting.

26 July – NDC Director requests assistance, activates NEOC

28 July – DMT agrees to response plan

6-12 June - Fighting erupted between 2 villages in Margarima, Hela province. At least 3 children (boys) were killed, and several houses burnt down. About 3,000 people fled.

17-29 July – Election-related violence between 2 villages in Nipa, Southern Highlands province. At least 2 deaths reported and 3,000 people fled. MP's home among those destroyed. Road access restricted by roadblocks of warring groups. Schools suspended indefinitely. Health facilities limited functionality.

23 July – CSOs, businesses in Mt Hagen coordinate delivery of initial relief items for women staying in church in Porgera

Response Strategy

It is the obligation of the national government to lead the humanitarian response, safe return of displaced residents, and recovery planning within a framework of laws and policies, as well as with resources to provide protection and humanitarian assistance to the conflict-affected people.

The DMT will advocate for the government's optimum use of its institutional and financial capacities, and will collaborate with government, national and local counterparts both strategically at the national level and operationally at the local level. It will operate with national and local partners through offering technical advice and support, including direct humanitarian assistance for those least served, to meet the lifesaving needs of the most vulnerable and marginalized of those who remain displaced and the immediate needs of those who have returned to their places of origin. It will aim to mitigate the influence of local political alliances on the distribution of assistance.

Particular attention will be placed on protection-related needs, including sexual and reproductive health care, and GBV prevention and response services, restoring access to schools and health facilities, while addressing the food security, water, sanitation, and hygiene needs of those still displaced.

The DMT also recognizes the importance of an inclusive, well-planned, and coordinated transition to recovery, development, and peacebuilding. The DMT will enhance its collaboration with recovery, peacebuilding, and development partners to prioritize on the one hand actions that help people affected by the conflict achieve durable solutions, and on the other reduce the underlying risks and vulnerabilities of conflict, including a lack of socioeconomic prospects.

The DMT will work closely with local and national authorities and development partners to advocate for actions that promote social inclusion, sustainable peace, equitable economic recovery, and development for all, and mitigate the impact of possible future conflict events on the most vulnerable and at-risk populations.

The DMT highlights protection issues of the conflict-affected people as a cross-cutting priority in its response strategy. It will work with national and local authorities and humanitarian partners to advocate for and support the protection rights of girls, boys, women, and men affected by the conflict. This includes promoting the safe, sustainable, and voluntary return of displaced people to their places of origin; protection from and mechanisms for addressing gender-based violence, sexual exploitation, and abuse; and supporting grievance mechanisms and solutions for conflict-affected people, as well as a renewed focus on community socio-economic healing, resilience, and recovery

Photo: UN in PNG

Strategic objectives

The Resident Coordinator and the DMT are responsible for the implementation of the activities outlined in this plan, which aims to achieve the following strategic objectives.

SO1. In support of the government, provide principled, targeted, and coordinated lifesaving and protection assistance to 78,000 conflict-affected people within the first weeks of the emergency.

- Distribute immediate, life-saving humanitarian assistance and services to address emergency food, shelter, health, WASH needs
- Ensure that displaced people have adequate protection, including through women- and child-friendly spaces, referral mechanisms and access to information/ communication channels
- Ensure that shelters are adequately equipped with segregated WASH and waste management facilities, access to health services and referrals, and temporary learning spaces

SO2. In support of the government, address evolving needs resulting from prolonged displacement and toward recovery.

- Engage all community members in identifying evolving needs and solutions toward restoring livelihoods and essential services in affected communities
- Assist national counterparts and partners in implementing activities that restore economies in affected communities
- Ensure community members are engaged in and leading their response and recovery

SO3. Advocate for durable solutions conducive to peacebuilding and normalization efforts

- Assist national partners in identifying and implementing activities that will support peacebuilding, reconciliation, and normalization
- Synergize humanitarian efforts with existing programmes and inform new area programming toward sustainable peace and development

Scope of the response

Emergency conditions are expected to last about three to six months, with another three to six months for transition to recovery and rehabilitation. Given logistical constraints to reach rural communities and remote areas, the likelihood of volatile conditions to be unpredictable, and political sensitivities in this context, the DMT will initially prioritize delivery of relief items through churches and local partner organizations managing care centres and affected populations. Clusters will determine beneficiary selection criteria based on their priorities.

Immediate assistance will focus on core relief items, including emergency food, water purification tablets and containers, tarpaulins, and non-food items, such as kitchen, hygiene, and dignity kits. In-country stockpiles of relief items are concentrated in Port Moresby and Lae, with a smaller stockpile in Mt Hagen, and so most relief items would need to be transported. The Highlands Humanitarian Hub has been reactivated to locally coordinate the response.

Logistical and security arrangements will need to be coordinated with NDC and private sector partners. The use of PNGDF and RPNGC assets for logistics and escorting the transport of relief items will be coordinated with NDC and Western Command. Cluster members have their own internal procurement arrangements.

Cash programming may be considered in local areas where feasibility has been assessed by members of the DMT Cash Working Group. Individual organizations may employ cash programming as part of their relief and early recovery activities, but the activities must be coordinated with the DMT Cash Working Group.

Distribution and monitoring during the emergency phase will be in close coordination with NDC. Clusters will determine if additional partners, training, equipment, or tools are required.

Planned assessments

A core Needs Assessment Standby Team composed of Government and DMT partners has been established and trained to conduct a multi-agency needs assessment. The team has adopted common forms for need assessment, focus group discussions, and key informant interviews. The team is activated and led by the National Disaster Centre and includes representatives of key clusters.

While security risks and political sensitivities inhibit the immediate conduct of a needs assessment, the DMT recognize the importance of assessments in determining needs. As soon as it is safe to do so, the DMT will conduct a rapid needs assessment to further tailor the ongoing response to the specific needs on the ground. Following the initial rapid needs assessment, clusters and organizations with specific focuses may conduct additional, more specialized assessments over the next three to four months.

When permissible to do so, we will undertake a multi-sectoral conflict analysis to inform future interventions. Ownership and accessibility of land and natural resources is one the main drivers for conflict in PNG, and populations displaced by conflict or natural disasters. The conflict analysis can help us understand the drivers of the conflict and identify longer term solutions to mitigate future humanitarian crises.

Response and operational capacity

DMT members, including UN organizations, international NGOs, and the Red Cross Movement have limited presence and capacity in the affected provinces. The DMT maintains an operational presence and response dashboard indicating their locations, prepositioned stockpiles, tools and resources, agreements, and humanitarian staffing. It also maintains stockpiles on the regional Pacific Logistics Mapping platform. Initial humanitarian assistance and relief workers will come from country offices and programmes in PNG.

Vulnerable groups for targeted humanitarian assistance include girls and boys aged 0 to 14, adolescent girls and women, pregnant and lactating women, single caregivers), the elderly, and persons with disabilities.

Efforts will be made to establish two-way communication (including complaint and feedback mechanisms) with affected communities, and to ensure that Information be inclusive to reach all groups and levels of the population. Some groups, like youth and people in remote areas, were most vocal in their request for information.

Gaps and constraints

Security and humanitarian access will remain outstanding issues faced by responding humanitarian organizations. The DMT complies with the security protocols established by and coordinates closely with national, regional, and local government partners. While the primary security of international humanitarian organizations rests with the host government, in a conflict setting, humanitarian organizations will exercise their core humanitarian principles of neutrality, impartiality, humanity and independence in reaching the most vulnerable people in need.

Considering this, initial lifesaving, emergency assistance will substantively rely on national

and local partner organizations, including churches and civil society organizations that remain in conflict-affected areas. DMT member organizations will ensure they have appropriate arrangements, agreements, and relationships with local organizations in at-risk provinces.

Logistics and transportation are the two greatest constraints to reaching people in need with life-saving humanitarian assistance and protection. The high cost of transportation, fuel, and security will affect the cost of delivering humanitarian assistance.

The DMT lacks a functional government-led logistics cluster in the country. In past responses, logistics has been coordinated on an ad hoc basis. In-country stockpiles are largely concentrated in Port Moresby and Lae, with smaller stockpiles of limited relief items in Mt. Hagen. The DMT will explore with UNICEF to coordinate overall logistics for movement of goods from Port Moresby to the Highlands.

Coordination and management

The DMT is the highest strategic body in Papua New Guinea for coordinating international humanitarian assistance in the country. It is co-chaired by the National Disaster Centre director and the United Nations Resident Coordinator. Its membership includes UN agencies and international NGOs representing sectors within which the DMT operates, The Red Cross Movement, NGOs, and faith-based organizations. Standing invitees include the UN Department for Safety and Security, Office of the High Commissioner on Human Rights, and five key development partners.

The DMT oversees the Inter-Cluster Coordination Group, comprising the Government and UN/INGO operational leads for CCCM/Shelter/NFI, Education, Food Security, Health (including sexual and reproductive health), Nutrition, Protection (including child protection and gender-based violence) and WASH, and representatives for persons with disabilities, NGOs, churches, and the private sector. The ICCG considers cross-cutting themes of cash, community engagement, inclusion, gender, and recovery.

Highlands Humanitarian Hub

The Highlands Humanitarian Hub was originally organized for the 2018 Highlands Earthquake. Its current membership includes the Highlands provincial disaster coordinators, faith-based and non-governmental organizations, and private sector entities operating in the Highlands region. It is based in the regional city of Mt. Hagen. For this response, CARE and Baptist Union are coordinating the Highlands Humanitarian Hub.

Information management and response monitoring

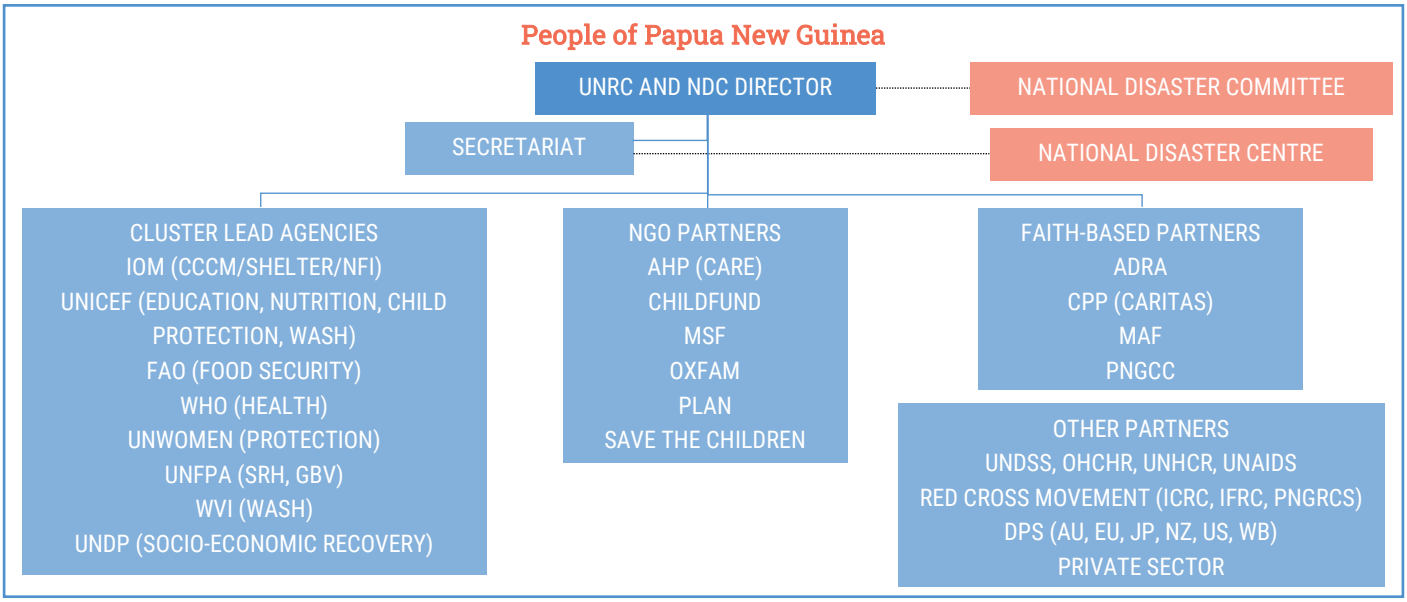
Clusters will designate an information management focal point to participate in an ad hoc information management working group to focus on data collection, analysis and information sharing among clusters. Contact lists, meeting schedules and common operational datasets will be maintained on HumanitarianResponse.info.

The DMT Secretariat will oversee the collection, maintenance and sharing of information for the 4Ws (who is doing what, where, and for whom) and needs-response-gaps forms to monitor cluster responses and gaps. Clusters undertake their own monitoring, as well, and will regularly provide data and information to cluster partners, the DMT and government.

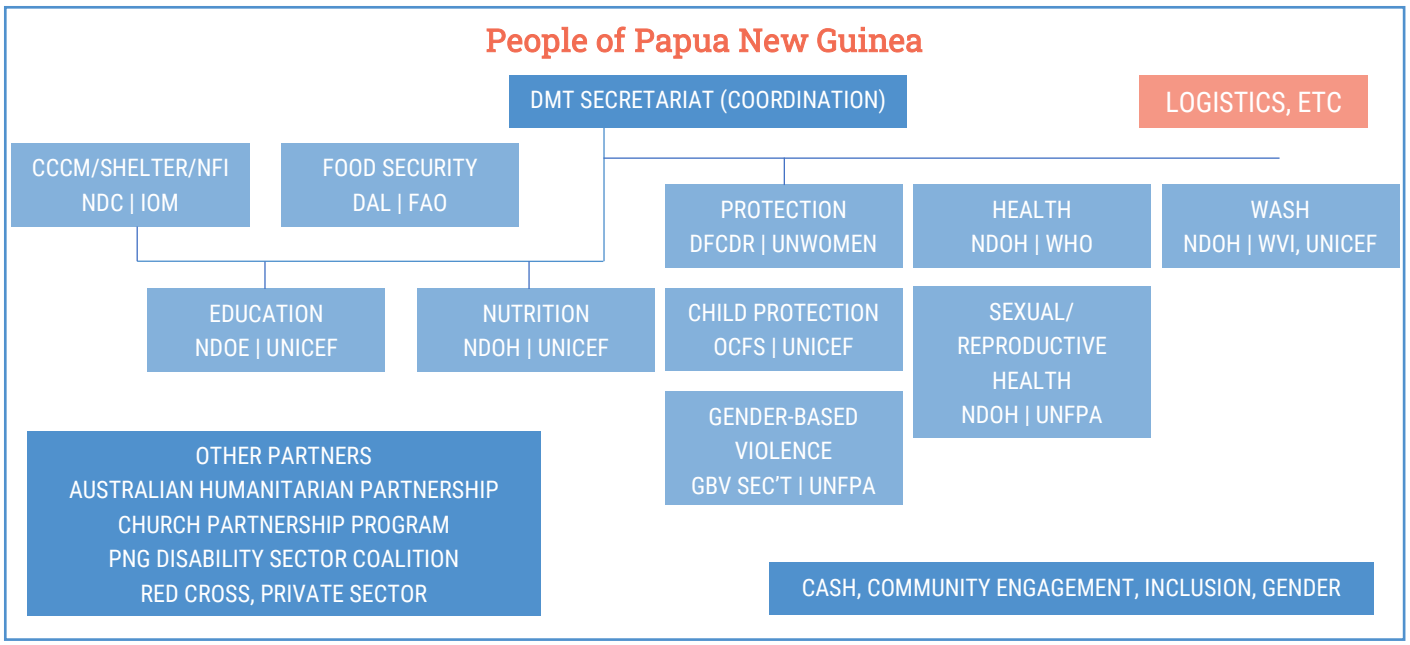
At the three-month and six-month points, the DMT clusters will evaluate the response to date and adjust their response plans accordingly. Following the humanitarian response phase, the DMT Secretariat will lead an after-action review to evaluate the response and the transition to peacebuilding and development.

Coordination architecture for international humanitarian assistance in PNG

Disaster Management Team



Inter-Cluster Coordination



Cluster Plans

CCCM/Shelter/NFIs

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
78K	10	6.5M

Humanitarian analysis

Between May and July 2022, violence escalated in Papua New Guinea, and the displacement crisis has progressively worsened in parts of the Highlands region. While in most areas, the violence is related to the election, in others, it has resurfaced from long-standing issues, including land disputes, retribution, and unsettled disputes between clans, who are using the instability around elections to re-ignite fights. The presence of security personnel in the conflict-affected areas is limited, while tensions are expected to remain high, and outbreaks of new violence could continue at least through the end of the election period.

The violence is pronounced in parts of Hela, Southern Highlands, and Enga provinces, and the situation could continue to escalate. Local authorities and partners have reported killings, including of women; sexual and gender-based violence against women and girls; sorcery accusation-related violence; destruction of homes, schools, churches, health facilities, and agricultural warehouses; and violence and destruction of properties of communities hosting displaced persons

Response strategy / concept of operations

The proposed response will address the critical emergency needs of the most vulnerable people through emergency shelter and NFI assistance, as well through assistance that enable populations to recover from the devastation, and eventually to form resilient communities.

Interventions will adopt an area-based approach rather than status-based in consideration of community dynamics with beneficiary selection based on vulnerability. The most vulnerable population groups will be targeted including female headed households, unaccompanied and separated minors, and persons with disabilities.

Beneficiary selection will be facilitated through engagement with community-based networks including private sector partners, churches, women and youth volunteer groups, and others for best outreach to the affected population particularly in hard-to-reach areas.

The emergency shelter and NFI intervention in those groups address the immediate needs and reduce the protection risks.

Priority response – Phase 1 (0-3 months)

- Activate IOM Displacement Tracking Matrix and Solutions and Mobility Index tools to target locations and gather evidence on the displacement situation to inform planning, response, recovery, and durable solution
- Procure and distribute NFIs and shelter kits in coordination with local authorities.
- Identify and manage sites hosting displaced persons in consultation with churches, traditional community leaders and local authorities.

Priority response – Phase 2 (4-6 months)

- Identify and manage care centers or sites hosting displaced persons, activation of CCCM in consultation with the local authorities
- Provide materials for emergency shelter construction
- Provide in-kind assistance during the establishment of care-centers

Priority response – Phase 3 (7-9 months)

- Training of identified stakeholders, including beneficiaries, community leader, LLG representatives, Peace-and-good order committee, PDC on building back safer in shelter construction
- Pilot transition, recovery and resilience-building initiatives, link or scaling up the ongoing community-based initiatives to contribute to peaceful coexistence and resilience to enable durable solutions.
- Raise beneficiary awareness, including providing technical and/or material support to promote the attainment of durable solutions including site planning to support returns where possible and permanent shelter

Coordination structure

CCCM, ES, and NFI in PNG is jointly made up of the Government and non-government actors to establish a common platform for coordination of Camp Management Camp Coordination (CCCM), Emergency and NFI Interventions.

At the national level is co-chaired by the Government and represented by National Disaster Center (NDC). IOM is a Co-chair of the cluster and responsible for ensuring Cluster Coordination Support, Facilitation & Technical Expertise. IOM, in addition to the head office at POM, has field offices in Hela, SHP, East Sepik, Morobe, Western Highland, AROB, and East New Britain.

Cluster partners (contributing members) are made up of NGOs, Red Cross Movement (Red-cross PNG), and Churches and they are key partners in contributing to field information, distribution networks, and technical support

Inter-cluster collaboration

Education, Health, Protection, WASH

Contact

Government Lead: NDC, Andrew Emilio Oaego (aeoaego@gmail.com) l DMT Lead: IOM, Getachew Mekuria (gmekuria@iom.int)

Photo: UN in PNG

Education

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
78K	3	1.2M

Humanitarian analysis

Children in PNG enjoy fewer legal protections than those in surrounding jurisdictions. Children living with a disability, those in very remote locations, those engaged in child labour and other minority populations are often the least visible. Tracking out of school children and monitoring attendance is challenging, making it difficult to target assistance in times of crisis. To date, ongoing violence in Enga estimates that 25,700 school aged children unable to attend school and are facing a range of vulnerabilities.

General administrative capacities and governance across the sector has its challenges which is compounded by the inaccessibility into the affected areas due to security concerns in rural and remote areas with the least access to limited resources. Static factors, e.g., poor infrastructure, often leads to delays in delivering assistance during times of crisis, amplifying existing vulnerabilities. Matters are complicated by political and social attitudes which often lead to a failure to recognize the importance of minimizing disruption to education services, particularly in times of broader social stress triggered by election related violence and other such events.

The Education cluster aim to mobilize resources and coordinate through members/ partners, authorities, local contacts, and stakeholders to ensure a sense of normalcy is prioritized with PSS support and education services made available

Priority response – Phase 1 (0-3 months)

- Distribute psychosocial support messaging/kits (parenting in emergencies)
- Distribute home learning packs, remote learning support
- Distribute school-in-a-box, tents, early childhood development kits to establish temporary learning spaces (making this child-friendly with WASH support in coordination with the WASH cluster)

Priority response – Phase 2 (4-6 months)

- Psychosocial support services
- Repair school premises
- Establish alternative education where needed (e.g., neighbouring schools, temporary learning spaces, home learning, Flexible Open & Distance Education, out-of-school children, and youth)
- Back to school campaigns

- Remediation, boosters in lost learning
- Train teachers on play-based learning, clubs
- Establish child-friendly spaces
- Supply assistive devices for children with disabilities
- Ensure safe transport/passage for children to/from schools.

Priority response – Phase 3 (7-9 months)

- Advocate for repairs of school premises
- Strengthen WASH facilities in schools
- Advocacy messages on peace building, conflict resolution, safe and fair elections and the continuity of learning and education services.
- Community awareness on the function/neutrality of schools, normalcy of routine as protection, key to recovery.
- Education on democracy, safe and fair elections
- Updated school data (school location, students, teachers, housing, WASH facilities)
- Stockpile home learning packs.

Coordination structure

Under the leadership of the NDOE and supportive coordination from UNICEF and Save the Children, the Education Cluster, consisting of at least 27 members will meet weekly during initial assessments for response in coordination with the PDOE of Enga province.

The Education Cluster operates under the guidance of an agreed Terms of Reference and a Standard Operating Procedure. Members provide updates on presence, reach and activities as well as contributing to and providing feedback on technical, advocacy messages and knowledge products. On a strengths-based approach, members provide in-kind technical support for timely response and recovery

Inter-cluster collaboration

CCCM/Shelter/NFI on displaced children and teachers and temporary learning centres in emergency shelters, Child Protection on safety reporting and referral pathways, WASH on WASH in schools

Contact

Government Lead: National Department of Education, Boio Name (Boio_Naime@education.gov.pg)

DMT Lead: UNICEF, Michelle Mefeae (mmefeae@unicef.org)

Food Security and Agriculture

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
50K	13	2.1M

Humanitarian analysis

Papua New Guinea is challenged with triple burden of malnutrition (undernutrition, overweight and obesity, micronutrient deficiencies. Stunting (45%) and wasting (16%) are alarmingly high, threatening national development and progress of PNG to achieving the SDG by 2030. The agriculture sector continues to provide for income, food, and nutrition for over 80 percent of the rural disadvantage population and yet remains the most vulnerable sector, exposed to life threatening impact of disasters and emergencies. Over half (57%) of the population have experienced moderate to severe food insecurity assessed using the Food Security Index Score.

Over the past 120 years, PNG has experienced 13 episodes of severe drought impacting food security, livelihood, and water. The last drought occurrence of 2015-2016 was disastrous to estimated 2 million households. Global emergency such as the outbreak of COVID 19, agriculture pests and diseases, war and natural disasters have been known to impact on the food production, marketing, and consumption.

The recent escalation of conflict in the Upper Highlands Provinces of Enga, Southern Highlands and Hela have affected an estimated population of 250,000 of which 150,000 are predicted to be displaced according to IOM estimates. Further reports from partners in the affected areas also indicated at least over 19,000 population are displaced. A further report received from FAO sources from the Magarima District in Hela, Lower Wage LLG reported number of shops burnt down and entire food gardens that provide food and livelihoods of estimated 5,000 (1,000 households) have been destroyed entirely because of election related conflicts. The actual magnitude of the food security situation is yet to be fully assessed in the respective areas.

Response strategy / concept of operations

Food security and nutrition are among core agendas of the government through enacting of the various global agendas to national context in the form of the Medium-Term Development Plan (MTDP 3), National Nutrition Policy 2016-2026 and the Food Security Policy 2015. Having a continuous supply of nutritious food whole year around is fundamental for the households to meet their nutritional needs, prevent malnutrition and promote quality of life.

Food and nutrition situation often worsens during emergencies and are most immediate needs of the affected population. A displaced

population have less access to a diversified diet and water, sanitation and hygiene that increases the risks of diarrheal diseases, malnutrition, and risks of death especially in children, pregnant and lactating mothers. It is paramount that short term food relief as well as recovery interventions are prioritized among other immediate needs. The following responses outlines the strategies for the FSC clusters:

- Provide short term blanket food relief to the 15,000 displaced population in care centres for the first 3 months to prevent acute malnutrition in children and support food security, prioritizing the most vulnerable (young children pregnant/lactating mothers, people with disabilities, elderly). Food provision also reduce risks of women and girls who are subjected to violence when they seek food outside of their shelter.

- Provide agriculture inputs such as seeds, equipment, and training to the targeted displaced 10,000 households or 50,000 population in the recovery phase from 4 -9 months post conflicts. Priority response – Phase 1 (0-3 months)

- Rapid Mapping of Displaced Population and Registration

- Purchase food relief from minimum food baskets

- Distribute minimum emergency food baskets and Multiple Micronutrient Powders to the 15,000 displaced from purchased or donations.

Priority response – Phase 1 (0-3 months)

- Purchase food relief from minimum food baskets

- Distribute minimum emergency food baskets and Multiple Micronutrient Powders

Priority response – Phase 2 (4-6 months)

- Rapid food security assessment in the affected areas

- Assessment of the availability of land for the displaced people and its ownership and accessibility to land by the displaced people for farming.

- Purchase and distribute readily available food sources from Model Farmers with provincial DAL and NARI (Highlands provinces) to 15,000 displaced population.

- Purchase and distribute seedlings (early maturity, nutrient rich crops) and agricultural tools (knives, spades) seedlings, planting materials and agricultural inputs and tools for 50,000 people (10,000HH) in affected areas.

Priority response – Phase 3 (7-9 months)

- Establish livelihood, nutrition sensitive programs and market access, training, and capacity building program to the 50,000 population (10,000 households)

- Establishment and planning on long-term recovery programs, do resettling of displaced communities for recovery program and activities for long term response for 50,000 people or 10,00 households.

Coordination structure

The Food Security Cluster (FSC) in PNG is jointly made up the Government and non-government actors to establish a common platform for coordination of Relief Food and Agriculture Recovery Interventions. The structure of the FSC cluster in PNG is articulated in three layers below,

- At the leadership level is maintained by the government, represented by Department of Agriculture and Livestock.
- FAO is responsible for ensuring Cluster Coordination Support, Facilitation & Technical Expertise. FAO in addition has field offices in Hela, SHP, Simbu and EHP.
- Cluster partners (contributing members) is made up of NGOs, Donors, Private Sector, Red Cross Movement (ICRC, IFRC, Red-cross PNG) and Churches. They are key partners in contributing to field information, distribution networks, and technical capacity

Inter-cluster collaboration

CCCM/Shelter/NFI, Health, Nutrition, WASH

Contact

Government Lead: DAL, Brown Konabe (bkonabe@gmail.com)

DMT Lead: FAO, Lazarus Dawa (lazaruz.dawa@fao.org)

Photo: UNDP in PNG

Health

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
78K	80	2.1M

Humanitarian analysis

The conflict in the Highland Provinces of Enga, Hela and Southern Highland has resulted in a population that has been directly affected by the conflict and a population that has been displaced. The direct effect of this conflict has seen a surge of trauma cases particularly victims of violence both sexual and non- sexual. In addition, vulnerable populations such as pregnant mothers, children under 5 years and persons with disability will be more adversely affected. The closing of health centres due to attacks or absence of staff will result in almost 558000 people having no access to healthcare. Persons who require long term treatment such as HIV, tuberculosis patients and non-communicable diseases will not be able to access the medication they need for indefinite periods. The cases of inflicted violence, rape, sorcery related torture and the destroying of homes and livelihoods will also have mental health consequences on the populations affected.

The displaced population particularly those living in crowded shelters will have to be monitored for communicable disease. After an initial response phase of prioritization of immediate medical needs, there is a need to also look at recovery and rehabilitation strategies.

Response strategy / concept of operations

- Establish open lines of communication with PHA management in affected provinces
- Establish consistent meetings and working groups with partners (both health and non-health) operating within the areas of conflict or natural disaster
- Ensure that the NDOH are involved in broader decision making regarding the establishment of phase related response
- Engage private sector partners within affected province/s with regards to the mobilization of key resources and include these partners on all communications where relevant
- Align the response with the NCC enacted standard operating procedures to as to respond in a COVID-19 safe manner

Priority response – Phase 1 (0-3 months)

- Procurement of health emergency supplies to affected sites (including essential medical supplies, emergency supplies and general medical supplies

- Integrated outreach service delivery (Advocacy, MNCAH and Immunization)
- Pregnancy kits and rape kits
- Production of IEC items for improving demand to integrate health services and basic life-saving hygiene promotion
- Health rehabilitation and assistive technology services
- Mental health and psychosocial support (mobilization of mental health teams within the province)
- Surveillance activities for outbreaks in displacement centres.

Priority response – Phase 2 (4-6 months)

- Integrated outreach service delivery (Advocacy, MNCAH and Immunization)
- Pregnancy kits and rape kits
- Mental health and psychosocial support (mobilization of mental health teams within the province)
- Surveillance activities for outbreaks in displacement centres.
- Repair of health facilities
- Provide remote TA on implementation of activities/services delivered to affected areas for rehabilitation and recovery program.

Priority response – Phase 3 (7-9 months)

- Integrated outreach service delivery (Advocacy, MNCAH and Immunization)
- Pregnancy kits and rape kits
- Mental health and psychosocial support (mobilization of mental health teams within the province)
- Surveillance activities for outbreaks in displacement centres
- Provide remote TA on implementation of activities/services delivered to affected areas for rehabilitation and recovery program
- Implement trainings on pre- disaster response regarding the health context
- Conduct environmental health analysis of the area (Food and crop supplies, Water testing, and soil sampling).

Coordination structure

The Health Cluster is chaired by the Health Cluster Coordinator, currently a short-term consultant with the WHO. Meetings, both in person and online are held monthly with an average of 40-50 participants representing different organizations and partners.

Inter-cluster collaboration

Cluster, Cluster, Cluster, Cluster

Contact

DMT Lead: WHO, Jack O'Shea (osheaj@who.int), B Priya T Balasubramaniam (bpr@who.int)

Sexual and Reproductive Health

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
19.5K	10	0.8M

Humanitarian analysis

Sexual and Reproductive Health (SRH) of women, adolescent girls, people living with HIV, and people with disabilities is a core component of primary health care. However, they are often forgotten or ignored in times of emergency or crises. Conflict and political unrest increase the vulnerability of women and girls and create barriers to accessing reproductive and maternal health services. Sixty (60) percent of preventable maternal deaths take place in settings of conflict, displacement, and natural disasters. Without access to proper care, crises can increase the risks of sexually transmitted infections, unwanted pregnancy, and pregnancy-related complications that can lead to illness and death for mother and child. The breakdown in social norms and protective structures increases girls and women's exposure to gender-based violence (GBV) and its consequences. When facing an unwanted pregnancy, it is not uncommon for women to perform self-induced abortions, which may result in death without post-abortion care. Consequently, access to basic sexual and reproductive health services including family planning, emergency obstetric, and gender-based violence services is necessary for saving lives in these difficult contexts.

The intended beneficiaries of SRH initiatives include pregnant and postpartum mothers and newborns and girls, these initiatives intend to ensure access to quality and timely maternal and reproductive health services and family planning and in turn, ensure safe birth, prevent unwanted and unplanned pregnancies, birth complications and complications of unsafe abortion and delivery. Health care workers and health facilities providing SRH services will also have strengthened capacities to provide emergency obstetric and new-born care and clinical care to survivals of sexual violence with a referral pathway for emergency transport. Community members including men will have the right information and be supported to access SRH services including family planning services, prevention and management of STIs and HIV. RH Supply chain for emergency response in the region will be strengthened and monitored to prevent uninterrupted commodity access. Where needed, RH equipment and supplies will be made accessible to the health workers providing both static and outreach SRHR services.

Response strategy / concept of operations

During conflict the disruption of daily life including accessibility of sexual and reproductive health services is heightened leading to Insufficient lifesaving reproductive health supplies in service delivery points including referral hospitals. Hence, procurement

and distribution of these supplies will enable the provision of quality emergency obstetric and neonatal care as well as for other reproductive, maternal, neonatal, child, and adolescent health care services. Many women and girls of reproductive age in crisis-affected areas are not served or underserved. To address these gaps, there is a need to form, equip and mobilize Mobile Health Teams (MHTs) in the target Provinces. The proposed MHT activities will address the immediate need for increased access to health care services including reproductive Health, family planning, and Gender Based Violence/ psychosocial support services. Further, immediate support in accessing supplies and commodities [as part of Inter-Agency Emergency RH Kits] are needed to ensure availability of services at community-based level, as well as at the referral hospital level.

Priority response – Phase 1 (0-3 months)

- Risk Communication and Community Engagement on the impact of displacement on pregnancy, delivery and newborn health, signs of complications during pregnancy- especially those due to poor nutrition; the importance of delivery with a skilled birth attendant, newborn care, and family planning.
- Procurement and distribution of Inter-Agency Emergency RH Kits, to mitigate the effects of possible fragmentation of the supply chain and inaccessibility to regular commodities and supplies
- Distribution of lifesaving, post-abortion supplies [AMF1] (ARHKIT 8), rape kits (ARH KIT 3), Post-Exposure Prophylaxis (PEP kits) and dignity kits for women in target area health facilities and referral hospitals.
- Dissemination of IEC materials to communities on access to essential services and risk mitigation.
- Support for additional outreach personnel including psychosocial support counsellors.
- SRH Clinical Outreach services to communities for Antennal & Postnatal Care; Family Planning information and services; STI prevention and Treatment; well- baby services and counselling and referral for complicated delivery cases and SGBV survivors.

Priority response – Phase 2 (4-6 months)

- Continue the SRH Clinical Outreach services through mobile health teams (MHTs) to communities for Antenatal & Postnatal Care; Family Planning services and information; STI prevention and Treatment; well- baby services and counselling and referral for maternal health complicated cases and SGBV survivors.
- Establish a 24 hours per day, 7 days per week referral system to facilitate transport and communication from the community to available health centres and hospitals.
- Continuously support the distribution of supplies including Inter-Agency Emergency RH Kits, and PEP to meet health facilities and community SRH needs.
- Establish confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.

Priority response – Phase 3 (7-9 months)

- Continue direct out-patient mobile services, outreach (MHTs) and static support to provide integrated primary health-care services including MHPSS services.
- Continue to support to make clinical care and referral to other supportive services available for complicated maternal health cases and survivors of sexual violence.
- Continuous community and facility monitoring and supportive supervision.
- Train frontline and referral health facilities health workers on Minimum Initial Service Package, BEMONC, supply chain management and psychosocial counselling.

Coordination structure

The SRH sub cluster will report its activities to the larger health cluster monthly; and a member of the Health Cluster will participate in the GBV sub cluster meetings to ensure cluster coordination and integration.

Inter-cluster collaboration

Health, Gender-based Violence

Contact

DMT Lead: UNFPA, Julianna Lunguzi (lunguzi@unfpa.org), Debbie Kupesan (kupesan@unpfa.org)

Nutrition

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
37K*	10	0.3M

* Children <5YO; pregnant women; adolescents

Humanitarian analysis

The biggest immediate vulnerability is an increase in wasting that may result into children becoming severely or moderately wasted. There is also an ever-present vulnerability of children under five years and women of reproductive age falling into micronutrient deficiencies especially Vitamin A and Iron. With about 14 percent of children under five years wasted in PNG and about 50 percent of them being Anemic, the situation of children could quickly deteriorate in times of humanitarian situations

Response strategy / concept of operations

The Nutrition cluster's primary concern in the event of a disaster are the children under five years as well as pregnant and lactating women. These vulnerable target populations groups are highlighted in the National Nutrition Policy 2016-2026.

In humanitarian situations, the following are the key interventions for the nutrition cluster.

- Treatment of Severe Acute Malnutrition.
- Micronutrient supplementation for pregnant and lactating women and children under five years of age (Age appropriate: Multiple micronutrients, Iron folate, deworming).
- Promotion of appropriate Infant and Young Child Feeding practices.

The implementation strategies will include

- provision of re services through static facilities and centers where open
- outreach services access and security permitting
- at community level (household) through Village Health Assistants access and security permitting.

Priority response – Phase 1 (0-3 months)

- Care for children with wasting.
- Micronutrient supplementation.
- Promotion of appropriate Infant and Young Child Feeding (IYCF).
- Orientation of front-line service providers on delivering nutrition services.

Priority response – Phase 2 (4-6 months)

- Care for children with wasting.
- Micronutrient supplementation.
- Promotion of appropriate Infant and Young Child Feeding (IYCF).
- Food security interventions as led by the food security cluster (social protection).

Priority response – Phase 3 (7-9 months)

- Continue provision of nutrition in emergency interventions started in phase 1.
- Mainstreaming nutrition interventions in relevant sectors (social protection for nutrition, nutrition for school age children, community nutrition).

Coordination structure

The nutrition cluster is led by the cluster lead from UNICEF who works closely with the Government co-lead. The lead coordinates the cluster related actions in country and ensures that it's fit for purpose in responding to humanitarian situations. The membership of the cluster is comprised of Government agencies, Civil Society Organizations, Faith-Based Organizations, Academia as well as business Partners. Cluster meetings are held frequently as need be especially in times of humanitarian crisis.

Inter-cluster collaboration

Food security, Health, Protection, WASH

Contact

Government Lead: Department of Health, Wilson Karoke (wilsonkaroke@gmail.com)
DMT Lead: UNICEF, Margaret Rombuk (mrombuk@unicef.org)

Child Protection

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
50K*	15	0.3M

*30,000 children and adolescents; 20,000 parents and caregivers

Humanitarian analysis

Disasters and or emergency situations such as conflicts, present a timely opportunity to establish a government-coordinated system for an appropriate child protection in emergency preparedness, response and recovery strategy, reintegrating children, and their families back into their communities once the immediate impact of the emergency has eased. Some of the main protection-related risks include neglect and lack of parental care, psychosocial distress, and an increase in exposure to violence, including sexual violence and physical and emotional abuse. Children may be without parental care if their caregivers die during the disaster or fall ill and are hospitalized.

Response strategy / concept of operations

The response will be part of a coordinated effort by the United Nations (UN) in collaboration with other partners, both international and national. Therefore, a concerted effort will be made for open communication and linking up with relevant partners to efficiently deliver the needed supplies and services to the targeted beneficiaries.

The CP sub-cluster members will work through the partnership established through the National Office for Child and Family Services and the Enga Provincial Council for Child and Family Services. This network will be used as the channels of operation and communication. The UN partnership through the PNG Disaster Management Team (DMT) will also be counted on to use its connection to deliver the needed supplies and services in a timely manner.

Priority response – Phase 1 (0-3 months)

- Social mobilization, advocacy, and communication – protective messages and violence prevention
- Advocate immediately for family-based care for separated children, and work to prevent separation during displacement and extreme economic hardship
- Targeted emergency interventions in partnership with other sectors–e.g., Child Friendly Spaces
- Assistive devices for children with disabilities and special needs, e.g., wheelchairs, crutches, hearing aid, eyeglasses, potty chairs, etc.

Priority response – Phase 2 (4-6 months)

- Arrange Child Friendly Spaces (CFS) in main IDP camps, including integration of psycho-social support and other protection responses for children
- Procure and distribute CP recreational kits/ECD kits/Dignity/Hygiene Kits and support existing community-based safe spaces for children and women, such as CFS and schools, and provide support for early childhood development activities and life skills education for children and adolescents.
- Capacity building to Child Protection Sector and Partners on Mental Health Psychosocial Support (MHPSS).
- Continuous follow up and case management of children identified with vulnerabilities.

Priority response – Phase 3 (7-9 months)

- Mobilize children's and women's existing social support networks and support the resumption of age, gender, and culturally appropriate structured MHPSS activities, including psychosocial education, life skills, and social support.
- Strengthen involvement and/or leadership by government counterparts and other national partners in coordination structures through capacity building and supporting national welfare systems
- Re-establish links to community structures and mechanisms, in addition to links with emergency hubs and service points.

Coordination structure

The Office for Child and Family Services and UNICEF co-lead/co-chair the Child Protection sub-cluster. The regular meetings are currently held every month and attended by at least 15 member organizations. Depending on the urgency of the situation, the sub-cluster will revert to fortnightly or even weekly meetings purposely for coordination and providing updated information and schedules. Deliberate efforts are also made to link with relevant sectors such as Education, Health, WASH, and Food Security by attending their meetings for important updates, collaboration, and partnership

Inter-cluster collaboration

Education, Health, Nutrition, WASH

Contact

Government Lead: OCFS, Obed Jiara, (fobed23@gmail.com)
DMT Lead: UNICEF, Bernadette Haro (bernharo@gmail.com)

Gender-based Violence

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
60K*	21	0.6M

*Women and girls of reproductive age

Humanitarian analysis

For gender-based violence, the most vulnerable persons are women and adolescent girls, displaced women and girls, widows, elderly women, pregnant and lactating women, female-headed households, women and girls with a disability, women and girls of diverse gender identities and sexual orientations and those from minority clans. During conflict, women and girls experience extreme risk of sexual violence including conflict-related sexual violence through the targeting of women and girls with retributive violence. There is a greater risk of intimate partner violence and reliance on harmful practices, including child, early and forced marriage. Conflict increases the risk of trafficking and sexual exploitation and abuse. The GBV sub-cluster addresses gender-based violence through coordination of preparedness, response, and recovery, with emphasis on ensuring uninterrupted access to minimum essential services.

Response strategy / concept of operations

During conflict, pre-existing inequality and discrimination places women and girls at greater risk of GBV. The disruption of daily life including access to food and shelter causes strain on families and communities, which increases the risk of intimate partner violence. Lack of access to education and sexual and reproductive health services is associated with an increase in early and unplanned pregnancy including because of GBV, especially adolescent girls. Customary conflict resolution practices contribute to child, early and forced marriage, as does early pregnancy. General insecurity and the targeting of women and girls in public spaces greatly inhibits their safe access to essential lifesaving services. The long-term consequences of GBV risk further entrenching gender inequality and thus, women's and girls' risk of further violence without targeting actions to advance equality through recovery actions.

Priority response – Phase 1 (0-3 months)

- Monitor GBV services in affected areas and advocate for non-interruption of services where challenges identified •
- Distribute Post Rape and STI treatment kits for provision of essential services
- Distribute Dignity Kits with information sharing sessions to women and girls in affected communities •
- Disseminate IEC on access to essential services and risk mitigation
- Orientation of PSEA Training for first responders to the affected areas.

Priority response – Phase 2 (4-6 months)

- Continued distribution of Dignity Kits and post-distribution monitoring to support ongoing customization.
- Support access to remote case management and MHPSS to the affected population especially women and girls
- Where none exists, establish women and girls' safe spaces in identified areas that are safe and easy access for all
- Deployment of mobile integrated SRH-GBV teams in locations where freedom of movement is challenged
- Train front line service providers especially in the health sector on safe response and referral of GBV survivors including in context where no specialized service exists

Priority response – Phase 3 (7-9 months)

- Strengthen multi-sector referral pathway for women and girls' access to essential services
- Work with Clusters to ensure gender responsive recovery actions
- Establish and strengthen robust GBV data management systems as per affected areas

Coordination structure

The Gender-Based Violence sub-cluster is led by the GBV Secretariat, of the Department of Community Development and Religion and co-chaired by UNFPA. The sub-cluster meets quarterly to achieve its objective and purpose to provide technical advice and oversight on GBV prevention and response activities in humanitarian settings in PNG. In times of emergencies, sub-cluster meetings are held weekly and/or on an ad hoc basis at the request of chairs or members to address urgent matters

Inter-cluster collaboration

The protection clusters coordinate with all other clusters as protection, GBV, PSEA, and AAP are cross-cutting themes.

Contact

DMT Lead: UNFPA, Rena Dona (Interim) (dona@unfpa.org), Keren Bun (bun@unfpa.org)

Water, Sanitation and Hygiene

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
78K	12	2.4M

Humanitarian analysis

PNG's National Water, Sanitation and Hygiene (WASH) Policy 2015-2030 estimates 33% access to safe water and 13% access to improved sanitation in rural areas (comprising 87% population). Bottlenecks include insufficient funding allocation, scarcity of skilled human resources and weak institutional systems. PNG's WASH conditions are reflected in its health indicators with high rates of infectious diseases.

P N G has been affected by emergencies from natural disasters to conflict situations, often impacting a sizable proportion of the population for long periods of time, requiring interventions to provide immediate relief, but also to mitigate potential long-term impacts. COVID-19 pandemic has exacerbated existing challenges and has increased the need for WASH at all levels.

WASH is lifesaving in emergencies and thus, the interruption or degradation of WASH services during times of crisis affects health, nutritional status, and the safety and dignity of children and women

Response strategy / concept of operations

People exposed to conflict are most likely to be affected in 4 areas as follows:

- Human – social: Fatalities, injuries, loss of income or employment as well as homelessness.
- Physical: Homes will be damaged and other structural damage or collapses to buildings as well as water catchments or storage facilities.
- Economic: Interruption of business due to damage to buildings and infrastructure. Loss of productive workface through fatalities, injuries, and relief efforts. Capital costs of response and relief.
- Cultural Environment: Sedimentation, pollution, destruction of water sources and cultural heritage.

For the cluster, we will have to take into consideration the vulnerabilities and consider the barriers that will affect WASH delivery as follows:

- Limited government service provision and high logistics costs to access remote locations in Papua New Guinea
- Lack of funding at community level for appropriate infrastructure.
- Majority of communities are isolated from government services and assistance

Priority response – Phase 1 (0-3 months)

- Printing of IEC Materials for Awareness purposes
- Procurement of hygiene kits, water containers and water purification tablets.
- Logistics and security costs for assessment and distribution
- Coordination of WASH activities for the first 6 months of the response

Priority response – Phase 2 (4-6 months)

- Distribute IEC Materials and hygiene promotion
- Procure construction materials and contractors services for rehabilitating WASH facilities in Health Centres, Schools, and host communities

Priority response – Phase 3 (7-9 months)

- Coordination of WASH activities for the last 3 months of the response
- Monitoring and evaluation of the WASH activities
- Transition planning to early recovery.

Coordination structure

The WASH Cluster is led by World Vision and Co-led by UNICEF. The government counterpart for the WASH cluster is the environmental health team within the National Department of Health, with the WASH Program Management Unit from the Department of Planning and Monitoring is also a member of the cluster. The WASH cluster has membership from IFRC, IOM, WaterAid, Plan International, Live and Learn, WHO, Care and Oxfam, amongst others.

Monthly meetings conducted by WASH Cluster provides an opportunity for members to give an update of their programmatic and response activities, and documents in relation to WASH response activities are shared widely within the cluster members for constructive review and documentation.

The WASH Cluster is looking to coordinate WASH activities by all partners from the Highlands Humanitarian Hub and from the National Emergency Operations Centre, to ensure maximum coverage of WASH activities, and to avoid redundancy of activities.

Inter-cluster collaboration

Education, Health, Protection

Contact

DMT Lead: WVI, Sonya Yeung (washclusterpng2019@gmail.com) | UNICEF, Martin Worth (mworth@unicef.org)

Coordination

PEOPLE TARGETED	PARTNERS	REQUIREMENTS (US$)
78K	30	0.6M

Response strategy / concept of operations

Coordination at the National Emergency Operation Centre and at the Highlands Humanitarian Hub are critical to an effective and efficient humanitarian response. The Humanitarian Advisory Team serves as the secretariat for both the Disaster Management Team and the Highlands Humanitarian Hub. We will continue to serve as the humanitarian advisor to the Resident Coordinator on the ongoing response. We have two Information Management Officers to develop and maintain the 4Ws, financial tracking, and any other dashboards; produce maps and other infographics on the response; and maintain the PNG page at HR.info as a hub for information sharing. The HAT will continue to provide technical advice to the clusters on inter-cluster coordination, cluster management, community engagement, response monitoring and evaluation, and other elements relevant to coordinating the overall response.

The HAT members will be based at the National Disaster Centre's Emergency Operations Centre and deploy to Mt Hagen as required to provide technical advice and support

Priority response – Phase 1 (0-3 months)

- Facilitate regular and ad hoc meetings of the Disaster Management Team, Inter-Cluster Coordination Group, and the Highlands Humanitarian Hub.
- Coordinate with NDC, PNGDF, and RPNGC on security escorts for the safe delivery of relief items and aid workers to affected areas
- Provide technical assistance and support to clusters on inter-cluster coordination, cluster management
- Develop and maintain information management products and dashboards, including 4Ws, financial tracking, flash updates, situation reports, maps, and infographics on the ongoing response
- Facilitate training on the use of standardized needs assessment tools used by the National Disaster Centre

Priority response – Phase 2 (4-6 months)

- Facilitate regular and ad hoc meetings of the Disaster Management Team, Inter-Cluster Coordination Group, and the Highlands Humanitarian Hub.

- Coordinate with NDC, PNGDF, and RPNGC on security escorts for the safe delivery of relief items and aid workers to affected areas
- Provide technical assistance and support to clusters on inter-cluster coordination, cluster management
- Develop and maintain information management products and dashboards, including 4Ws, financial tracking, flash updates, situation reports, maps, and infographics on the ongoing response
- Facilitate training on communication, community engagement, and accountability in humanitarian contexts.
- Review and assess the progress of civil-military coordination in PNG and provide recommendations for long-term action

Priority response – Phase 3 (7-9 months)

- Facilitate regular and ad hoc meetings of the Disaster Management Team, Inter-Cluster Coordination Group, and the Highlands Humanitarian Hub.
- Coordinate with NDC, PNGDF, and RPNGC on security escorts for the safe delivery of relief items and aid workers to affected areas
- Provide technical assistance and support to clusters on inter-cluster coordination, cluster management
- Monitor the transition of the humanitarian response to peacebuilding and development
- Conduct an after-action review of the response.

Contact

DMT Secretariat (dmt.pg@one.un.org)

Photo: UN in PNG

Annex – Advocacy Messages

CCCM/Shelter/NFI

Together we can build a peaceful society and better home

Education

Ensuring children and youth continue to go to school during times of election for their continuity of learning, healthy development, protection, and access to essential services including safe water and sanitation facilities at school.

Prioritizing children's continued access to education during crises will mitigate the cycle of violence and promote free, fair, and safe elections and the democratic process for the future.

Food security and agriculture

Encourage that children, pregnant, breastfeeding mothers, people with disabilities, and elderly be given priority in food, water, protection, and shelter.

Encourage breastfeeding of infants and consumption of diversified diet where possible.

Put uncooked or dry food in a safe and dry place, away from outdoor weather, rain, rats, and insects

Health

Ensure that all those requiring routine medicinal support continue to receive this from their regular health centres where possible.

Priorities maternal and child health during times of conflict or natural disaster.

Engage with Health Cluster and supporting partners via PHA management for external support if/when required.

Promote safe health delivery and activities during the conflict or natural phases

Sexual and reproductive health

Sexual and reproductive health services remain critical during emergency response. Continuity of essential health services including SRH & GBV services is critical, lifesaving and must be treated as urgent

Nutrition

Nutrition interventions are critical during humanitarian situation to avert long term negative impacts and need to be prioritized.

Donors should set aside resources for the delivery of nutrition services during humanitarian situations.

A breastfeeding mother should take a balanced diet daily of adequate growth food (proteins), energy-giving food (carbohydrates) and protective food (vitamins and necessary minerals).

A pregnant mother should also take at least 90 tablets of additional iron, frolic acid to prevent anemia

Exclusively breastfeed the baby on breast milk for first six months to grow healthy and strong. Breast milk provides all the nutrients from 0-6 months and baby does not need any food or drink, including water.

Beginning at six months of age, in addition to breast milk, start giving the baby soft foods and thick porridge to ensure it grows strong and healthy.

Protection

The Government of Papua New Guinea and defector authorities have a responsibility to protect civilians in conflict and conflict-prone areas.

The Government should create and preserve humanitarian corridors for the humanitarian actors to provide humanitarian assistance to provide humanitarian assistance to conflict-affected populations.

Donors should ensure flexible funding for allowing adaptions of projects based on growing and changing needs and for multi-sectoral programming that recognizes the centrality of protection and the need for specialized programmes supporting the inclusion of marginalized groups, including People with Disabilities (PWDs), older people, female-headed households, single women, and other marginalized groups.

Humanitarian organization should identify and fulfil critical gaps in the protection response, complementing and/or strengthening the actions of both national and local authorities in areas with limited presence or response capacity.

Humanitarian organizations should disaggregate data by disability, gender, and age.

Humanitarian organizations should address the specific needs of people with disabilities, older persons, women, and other marginalized groups Humanitarian organizations should consult and put the affected populations at the center of their planning, particularly the most vulnerable groups including the elderly and People with disabilities to better incorporate their needs in their response planning.

Protection risks are severe, particularly for women and girls, while access to needed services are limited.

Child protection

Children need extra care. Help them feel safe and loved, give them extra care and attention, encourage them to talk with you, return to everyday routines and send them to child friendly spaces and or temporary learning spaces.

Ensure children are with a trusted adult when working or playing away from home or when using latrines or bathing areas.

Ensure as far as possible that all households have access to basic relief supplies and other services, including education.

Where people are moving or being evacuated, facilitate the movement of whole families, rather than splitting families up.

Avoid the removal of children from their families for any reason unless they need urgent medical care.

Girls and boys remain extremely vulnerable to various life-threatening protection risks and ensuring children are protected from these violence, abuse, and exploitation in emergency is life-saving assistance that needs to be addressed immediately.

Prioritize actions to prevent and address child protection risks and harmful practices that exacerbate and emerge in humanitarian settings and impact well-being and development of children of all genders, abilities, and backgrounds.

Ensure continuity of child protection, including social protection and mental health services, always before, during, and after humanitarian crisis.

Gender-based violence

During conflict, women and girls are at great risk of experiencing GBV. GBV is life-threatening and can also include sexual violence. GBV services must be considered essential and prioritized as part of any response.

Women and girls face additional barriers to essential services due to the risk of GBV in emergencies. All actors including GBV providers must ensure women's and girls' access to essential services, for example through safe transportation and mobile service delivery.

All humanitarian actors have an obligation to ensure that their actions do not place women and girls at further risk of violence. All humanitarian actors must integrate risk mitigation actions in their response to ensure this. Women have a right to equal participation in every aspect of the response; this also helps ensure effective risk mitigation.

Gender equality and the protection of women and girls must be central to the humanitarian response from preparedness through to recovery. Recovery efforts must explicitly integrate gender

WASH

Ensuring that those affected by the conflict have access to clean drinking water and sanitation facilities to carry out good hygiene behaviour will reduce the health and protection risks brought on by such events.

Practice frequent hand washing with soap especially before preparing food, before eating, after using toilet, and after cleaning baby's bottom.

Build proper toilets and use them, and proper disposal of child faeces.

Boil water for drinking and store it in clean containers/buckets, etc.

Annex – Participating Organizations

CLUSTER	CLUSTER LEAD, CO-LEADS	PARTICIPATING ORGANIZATIONS
CCCM/SHELTER/NFI	NATIONAL DISASTER CENTRE INTERNATIONAL ORGANIZATION FOR MIGRATION	PNG RED CROSS ADRA CHILDFUND WORLD VISION SAVE THE CHILDREN OXFAM CARE CARITAS
EDUCATION	DEPARTMENT OF EDUCATION, UNICEF, SAFE THE CHILDREN	
FOOD SECURITY	DEPARTMENT OF AGRICULTURE AND LIVESTOCK FOOD AND AGRICULTURE ORGANIZATION	ADVENTIST DEVELOPMENT AND RELIEF AGENCY CARE INTERNATIONAL NATIONAL AGRICULTURE RESEARCH INSTITUTE FRESH PRODUCE DEVELOPMENT AGENCY OXFAM INTERNATIONAL ORGANIZATION FOR MIGRATION PRIVATE SECTOR UNICEF DEPARTMENT OF DEFENCE WORLD VISION NAQIA
HEALTH	DEPARTMENT OF HEALTH WORLD HEALTH ORGANIZATION	
NUTRITION	DEPARTMENT OF HEALTH UNITED NATIONS CHILDREN'S FUND	PROVINCIAL HEALTH AUTHORITIES WORLD VISION SUSU MAMAS SAVE THE CHILDREN ACADEMIA NATIONAL DEPARTMENT OF PLANNING AND MONITORING DEPARTMENT OF AGRICULTURE, UNITED NATIONS CHILDREN'S FUND CATHOLIC CHURCH HEALTH SERVICES
CHILD PROTECTION	OFFICE FOR CHILD AND FAMILY SERVICES	SAVE THE CHILDREN EQUAL PLAYING FIELD CHILDFUND

CLUSTER	CLUSTER LEAD, CO-LEADS	PARTICIPATING ORGANIZATIONS
	UNITED NATIONS CHILDREN'S FUND	WORLD VISION INTERNATIONAL WOMEN'S DEVELOPMENT AGENCY INTERNATIONAL ORGANIZATION FOR MIGRATION OXFAM PIKININI WATCH CHESHIRE DISABILITY SERVICES UNITED CHURCH IN PNG CHURCH PARTNERSHIP PROGRAM EASTERN HIGHLANDS FAMILY VOICE DEPARTMENT OF JUSTICE FEMILI PNG FAMILY SEXUAL VIOLENCE AND ACTION COMMITTEE
GENDER-BASED VIOLENCE	DEPARTMENT FOR COMMUNITY DEVELOPMENT AND RELIGION GBV SECRETARIAT UNITED NATIONS POPULATION FUND	INTERNATIONAL ORGANIZATION FOR MIGRATION UNWOMEN UNIITED NATIONS CHILDREN'S FUND UNITED NATIONS DEVELOPMENT PROGRAMME UNITED NATIONS REFUGEE AGENCY WORLD HEALTH ORGANIZATION UNAIDS INTERNATIONAL DEVELOPMENT WOMEN AGENCY BEL ISI CHILDFUND EASTERN HIGHLANDS PROVINCE FAMILY VOICE PNG ASSEMBLY OF DISABLED PERSONS INTERNATIONAL COMMITTEE OF THE RED CROSS FHI360 FAMILY AND SEXUAL VIOLENCE ACTION COMMITTEE PLAN INTERNATIONAL DEPARTMENT OF JUSTICE SUSU MAMA PACIFIC WOMEN
WASH	DEPARTMENT OF HEALTH WORLD VISION UNITED NATIONS CHILDREN'S FUND	NATIONAL DEPARTMENT OF PLANNING AND MONITORING INTERNATIONAL ORGANIZATION FOR MIGRATION WATERAID PLAN INTERNATIONAL LIVE AND LEARN WORLD HEALTH ORGANIZATION PNG RED CROSS

CLUSTER	CLUSTER LEAD, CO-LEADS	PARTICIPATING ORGANIZATIONS
		CARE OXFAM

Annex – Cluster Budgets

CCCM/Shelter/NFI

Phase 1 (0-3 months) priority response actions	Implementing Agency	People targeted	Total required USD
Activate IOM Displacement Tracking Matrix and Solutions and Mobility Index tools to target locations and gather evidence on the displacement situation to inform planning, response, recovery, and durable solution	IOM, NDC, NDOH, COMDE, DJAG, PNGRC, WHO, UNFPA, UNWOMEN, UNICEF, DMT, PDC, Peace and good order committee, DA rep,	78,000	285,000
Procure and distribute NFIs and shelter kits to the displaced and host communities	IOM, local Churches, ADRA, Child Fund, World Vision, Save the Children, OXFAM, CARE, Caritas	50,000	3,399,947
Identify and manage sites hosting displaced persons in consultation with churches, traditional community leaders and local authorities	IOM, NDC, PDC, Churches, Peace, and good order committee,	50,000	190,000
		TOTAL	**3,874,947**

Phase 2 (4-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
Identify and manage care centers or sites hosting displaced persons, activation of CCCM in consultation with the local authorities	IOM, PDC, Churches, Peace and good order committee	50,000	411,000
Provide materials for shelter construction	IOM, local Churches, ADRA, Child Fund, World Vision, Save the Children, OXFAM, CARE, Caritas	50,000	1,500,000
		TOTAL	**1,911,000**

Phase 3 (7-9 months) priority recovery actions	Implementing Agency	People targeted	Total required USD
Raise beneficiary awareness, including providing technical and/or material support to promote the attainment of durable solutions	IOM, local Churches, ADRA, Child Fund, World Vision, Save the Children, OXFAM, CARE, Caritas, PDC, NDC	78000	68,000
		TOTAL	**630,000**

Education

Phase 1 (0-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
ECD kit (Part Elementary) (50 per kit)	UNICEF	3,432	9,428.85
School in a Box kit (Elementary, Prim, Sec, Voc) (40 per kit)	UNICEF	22,263	73,351.33
Recreational kit (90 per kit)	UNICEF	19,460	28,760.40
Tent (72m2)	UNICEF	8,650	159,667.20
Local procurement and repackaging of pencil case with basic stationery and ex. Books per child	UNICEF	25,695	128,475.00
HLP printed per child	UNICEF/ Save the Children	25,695	128,475.00
Shipment from Brisbane to POM (20% of the Goods value)	UNICEF		105,631.56
Domestic logistics and transport costs (20% of the Goods value)	UNICEF		105,631.56
Security and storage costs (8% of the Goods value)	UNICEF		42,252.62
Planning, assessment, monitoring, awareness raising, outreach	UNICEF		78,167.35
		TOTAL	**$859,840.87**

Phase 2 (6 - 12 months) priority response actions	Implementing Agency	People targeted	Total required USD
Logistics and distribution of response materials	UNICEF		210,162
Security and storage costs	UNICEF		37,087
		TOTAL	**$247,249**

Phase 3 (12+ months) priority recovery actions	Implementing Agency	People targeted	Total required USD
Inservice teacher training: Implementation of HLPs/Boosters and remediation, protection and safeguarding messaging, peace building and conflict resolution, safe democratic elections, WASH in Schools, disaster risk reduction and resilience.	UNICEF/ Save the Children		105,963
		TOTAL	**$105,963**

Food security

Phase 1 (0-3 months) priority response actions	Implementing Agency	People targeted	Total required USD
Purchase of Relief Food Items	FAO	15,000	841,200
Logistics Costs of Distribution	FAO, Partners (Churches, NGOs, Local Authority)		75,000
Security and Escorts	Security Firms, Security Forces		45,000
Operations Cost (Travel etc.)	FAO, Partners		45,000
Human Resources (short terms staff)	FAO, Partners		45,000
		TOTAL	**1,051,200**

Phase 2 (4-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
Purchase of Relief Food Items	FAO	15,000	150,000
Purchase of Agriculture Seeds and Tools	FAO	50,000 (10,000HH)	90,000
Distribution of Food and Agriculture Inputs	FAO, Partners (Churches, NGOs, Local Authority)		45,000
Security and Escorts	Security Firms, Security Forces		45,000
Operations Cost (Travel etc.)	FAO, Partners		45,000
Human Resources (short terms staff)	FAO, Partners		45,000
		TOTAL	**420,000**

Phase 3 (7-9 months) priority recovery actions	Implementing Agency	People targeted	Total required USD
Livelihood and Recovery Program	FAO, Partners (Churches, NGOs, Local Authority)	50,000 (10,000HH)	270,000
Trainings	FAO, Partners (Churches, NGOs, Local Authority)		180,000
Distribution of Agriculture Inputs	FAO, Partners (Churches, NGOs, Local Authority)		45,000
Security and Escorts	Security Firms, Security Forces		45,000
Operations Cost (Travel etc.)	FAO, Partners		45,000
Human Resources (short terms staff)	FAO, Partners		45,000
		TOTAL	**630,000**

Health

Phase 1 (0-3 months) priority response actions	Implementing Agency	People targeted	Total required USD
Rapid needs assessment with PHAs of affected provinces (3 persons x 6 days for all 3 provinces)	WHO		9,120
Establish provincial focal point for communication (phone credit USD 60 x 3 PHA x 3 months)	WHO/UNICEF	3 focal points	540
Procurement of health emergency supplies to affected sites (including essential medical supplies, emergency supplies and general medical supplies (**for overall response)**	WHO/UNICEF	50,000	727,187
In-country logistics cost for supply distribution (including security)	WHO/UNICEF	78,000	100,000
International freight costs	WHO	50,000	400,000
Integrated outreach service delivery (Advocacy, MNCAH and Immunization)	UNICEF/WHO/UNFPA	30,000	50,000
Production of IEC items for improving demand to integrate health services and basic life-saving hygiene promotion	UNICEF	78,000	20,000
Health rehabilitation and Assistive technology services (for overall response)	WHO/NDOH (National Orthotic and Prosthetic Services)	Known population 1487 (for children)	160,330
Mental health and psychosocial support (mobilization of mental health teams within the province)	WHO		30,000
Surveillance activities for outbreaks in displacement centres.	WHO		13,000
		TOTAL	**1,510,177**

Phase 2 (4-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
In-country logistics cost for supply distribution (including security)	WHO/UNICEF	78,000	100,000
Integrated outreach service delivery (Advocacy, MNCAH and Immunization)	UNICEF/WHO/UNFPA	30,000	50,000
Mental health and psychosocial support (mobilization of mental health teams within the province)	WHO	78,000	30,000
Surveillance activities for outbreaks in displacement centres.	WHO		13,000
Repair of health facilities	WHO	4 health facilities	100,000
Provide remote TA on implementation of activities/services delivered to affected areas for rehabilitation and recovery program (phone data credit USD60 x 3 PHA x 3months)	WHO/UNICEF	3 PHAs	540
Monitoring and evaluation activities (1 M and E person to travel to each province)	WHO		8,300
		TOTAL	**301,840**

Phase 3 (5-9 months) priority response actions	Implementing Agency	People targeted	Total required USD
Integrated outreach service delivery (Advocacy, MNCAH and Immunization)	UNICEF/WHO/UNFPA	30,000	50,000
Mental health and psychosocial support (mobilization of mental health teams within the province)	WHO		30,000
Surveillance activities for outbreaks in displacement centres	WHO		13,000
Provide remote TA on implementation of activities/services delivered to affected areas for rehabilitation and recovery program (phone data credit USD60 x 3 PHA x 3months)	WHO/UNICEF		540
Identify challenges faced and implement trainings on pre- disaster response regarding the health context	Health cluster	20 participants per province for 3 provinces + 3 trainers from POM	20,000
In consultation with other relevant clusters, conduct environmental health analysis of the area (Food and crop supplies, Water testing, and soil sampling)	WHO		50,000
Monitoring and evaluation activities (1 M and E person to travel to each province)	WHO		8,300
		TOTAL	**171,840**

Sexual and reproductive health

Phase 1 (0-3 months) priority response actions	Implementing Agency	People targeted	Total required USD
Risk Communication and Community Engagement on the impact of conflict displacement on pregnancy, delivery and newborn health, pregnancy danger signs especially those due to poor nutrition; the importance of delivery with a skilled birth attendant, newborn care, and family planning.	UNFPA/PHA/IPPPNG Family Health Association	780000	50,000
Procurement and distribution of Inter-Agency Emergency RH Kits, to mitigate the effects of possible fragmentation for supply chain and inaccessibility to regular commodities and supplies. (Kit- 2A, Kit-2B, Kit-3, Kit-4, and Kit-5, KIT 6A&6B, Kit-8, Kit-9, Kit-10, Kit-10, KIT 11A&11B, IARH KIT 12)	UNFPA/PHA	780000	80,000
Distribute lifesaving, post-abortion supplies and care in health facilities.	UNFPA	19500	50,000
Disseminate IEC materials to communities on access to essential services and risk mitigation	UNFPA/PHA/IPPF FHA	780000	50,000
SRH Clinical Outreach services to communities for Antennal & Postnatal Care; Family Planning; STI Treatment; well- baby services and counselling and referral for SGBV survivors.	PNG FHA/ UNFPA	780000	50,000
Logistical and Security costs for the distribution and movement of items into the affected areas.	UNFPA	780000	60,000
		TOTAL	340,000

Phase 2 (4-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
Continue SRH Clinical Outreach services to communities.	PNG FHA/ UNFPA	100,000	60,000
Establish a 24 hours per day, 7 days per week referral system to facilitate transport and communication from the community to the health centre and hospital.	PHA/PHA	780000	70,000
Continuously support the distribution of supplies to meet health facilities and community SRH needs.	UNFPA/PHA	780000	50,000

Phase 2 (4-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
Establish confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.	UNFPA/ PHA	390000	50,000
		TOTAL	230,000

Phase 3 (7-9 months) priority recovery actions	Implementing Agency	People targeted	Total required USD
Continue direct out-patient mobile services, outreach and static for SRHR services.	PNG FHA/ UNFPA	780000	50,000
Continue to support to make clinical care and referral to other supportive services available for survivors of sexual violence.	UNFPA/PHA	390	50,000
Continuous community and facility monitoring and supportive supervision	UNFPA/PHA	78000	40,000
Train front line workers on MISP	UNFPA/IPPFFHA/NDOH/PHA	50	60,000
		TOTAL	200,000

Nutrition

Phase 1 (0-3 months) priority response actions	Implementing Agency	People targeted	Total required USD
Care for children with wasting.	UNICEF/NDOH/ PHA/CSO	Children <5YO; pregnant women; adolescents	30,000
Micronutrient supplementation.	UNICEF/NDOH/ PHA/CSO		20,000
Promotion of appropriate Infant and Young Child Feeding (IYCF).	UNICEF/NDOH/ PHA/CSO		50,000
Orientation of front-line service providers on delivering nutrition services.	UNICEF/NDOH/ PHA/CSO		50,000
		TOTAL	**150,000**

Phase 2 (4-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
Care for children with wasting.	UNICEF/NDOH/ PHA/CSO	Children <5YO; pregnant women; adolescents	10,000
Micronutrient supplementation.	UNICEF/NDOH/ PHA/CSO		10,000
Promotion of appropriate Infant and Young Child Feeding (IYCF).	UNICEF/NDOH/ PHA/CSO		15,000
Orientation of front-line service providers on delivering nutrition services.	UNICEF/NDOH/ PHA/CSO		15,000
		TOTAL	45,000

Phase 3 (7-9 months) priority recovery actions	Implementing Agency	People targeted	Total required USD
Continue activities from Phases 1 & 2	UNICEF.NDOH PHA/CSO	Children <5YO; pregnant women; adolescents	50,000
		TOTAL	**50,000**

Child protection

Phase 1 (0-3 months) priority response actions	Implementing Agency	People targeted	Total required USD
Logistical support to the Core Committee for Enga Provincial Council for Child and Family Services to provide initial assessment			5,000
Social mobilization, advocacy, and communication – protective messages and violence prevention			20,000
Advocate immediately for family-based care for separated children, and work to prevent separation during displacement and extreme economic hardship			10,000
Targeted emergency interventions in partnership with other sectors–e.g., Child Friendly Spaces			40,000
Assistive devices for children with disabilities and special needs, e.g., wheelchairs, crutches, hearing aid, eyeglasses, potty chairs, etc.			25,000
		TOTAL	**100,000**

Phase 2 (4-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
Arrange Child Friendly Spaces (CFS) in main IDP camps, including integration of psycho-social support and other protection responses for children			20,000
Procure and distribute CP recreational kits/ECD kits/Dignity/Hygiene Kits and support existing community-based safe spaces for children and women, such as CFS and schools, and provide support for early childhood development activities and life skills education for children and adolescents.			30,000
Capacity building to Child Protection Sector and Partners on Mental Health Psychosocial Support (MHPSS).			20,000
Continuous follow up and case management of children identified with vulnerabilities			10,000
		TOTAL	**80,000**

Phase 3 (7-9 months) priority recovery actions	Implementing Agency	People targeted	Total required USD
Mobilize children's and women's existing social support networks and support the resumption of age, gender, and culturally appropriate structure activities, including education and training, and social support.			30,000
Strengthen involvement and/or leadership by government counterparts and other national partners in coordination structures through capacity building and supporting national welfare systems			20,000
Re-establish links to community structures and mechanisms, in addition to links with emergency hubs and service points			20,000
		TOTAL	**70,000**

Gender-based violence

Phase 1 (0-3 months) priority response actions	Implementing Agency	People targeted	Total required USD
Monitor GBV services in affected areas and advocate for non-interruption of services where challenges identified	UNFPA	78000	40,000
Distribute Post Rape and STI treatment kits for provision of essential services	UNFPA	2500	60,000
Distribute Dignity Kits with information sharing sessions to women and girls in affected communities	UNFPA	39000	60,000
Disseminate IEC to community on access to essential services and risk mitigation	UNFPA	78000	50,000
Orientation on PSEA for the first responders to be deployed to the affected population	UNFPA	100	20,000
Conduct GBViE Rapid Assessment	UNFPA	78000	30,000
Logistical and Security costs for the distribution and movement of items into the affected areas.		78000	40,000
		TOTAL	**300,000**

Phase 2 (4-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
Continued distribution of Dignity Kits and post-distribution monitoring to support ongoing customization	UNFPA	39000	55,000
Support access to remote case management and Mental Health and Psycho-Social Support (MHPSS) to the affected population especially women and girls.	ChildFund /UNFPA	39000	40,000
Establish women and girls' safe spaces in identified areas that are safe and easy access for all	UNFPA	39000	50,000
Deployment of mobile integrated SRH-GBV teams in locations where freedom of movement is challenged	UNFPA/ PNG FHA	78000	60,000
Train front line service providers especially in the health sector on safe response and referral of GBV survivors including in context where no specialized service exists	UNFPA	50	30,000
		TOTAL	**235,000**

Phase 3 (7-9 months) priority recovery actions	Implementing Agency	People targeted	Total required USD
Strengthen multi-sector referral pathway for women and girls' access to essential services	UNFPA	59587	20,000
Work with Clusters to ensure gender responsive recovery actions	UNFPA	59587	5,000
Establish and strengthen robust GBV data management systems as per affected areas.	UNFPA	59587	10,000
		TOTAL	**35,000**

WASH

Phase 1 (0-3 months) priority response actions	Implementing Agency	People targeted	Total required USD
Printing of IEC Materials for Awareness purposes	World Vision, CARE PNG		17,000
Procurement of hygiene kits, water containers and water purification tablets.	World Vision, CARE PNG, UNICEF,		350,000
Logistics and security costs for assessment and distribution	World Vision, IOM, CARE PNG, Oxfam, UNICEF,		120,000
Coordination of WASH activities for the first 6 months of the response	World Vision		42,000
Carrying out needs assessment	Multi-agency		5,000
		TOTAL	**534,000**

Phase 2 (4-6 months) priority response actions	Implementing Agency	People targeted	Total required USD
Distribution of IEC Materials and hygiene promotion	World Vision, CARE PNG, UNICEF		250,000
Logistics costs for assessment and distribution of non-food items	CARE PNG		20,000
Procurement of construction materials and contractors service fee for rehabilitating WaSH facilities in Health Centers, Schools, and host communities	CARE, UNICEF, Church partners		1,500,000
Monitoring and evaluation of the WASH activities, including needs assessments	Multi-agency		5,000
		TOTAL	**1,775,000**

Phase 3 (7-9 months) priority recovery actions	Implementing Agency	People targeted	Total required USD
Coordination of WASH activities for the last 3 months of the response	World Vision		21,000
Monitoring and evaluation of the WASH activities	Multi-agency		5,000
Transition planning to early recovery	World Vision		10,000
		TOTAL	**36,000**

HUMANITARIAN NEEDS AND PRIORITIES

HIGHLANDS **VIOLENCE**

PAPUA NEW GUINEA