PNG Rapid Gender Analysis COVID-19: November 2020

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Tap in PNG

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Acronyms

ARB	Autonomous Region of Bougainville
COVID-19	Novel coronavirus 2019
GBV	Gender Based Violence
GoPNG	Government of PNG
LGBTQI+	Lesbian, gay, bisexual, transgender and queer or Intersex
NCDs	Non-Communicable Diseases
PMV	Public Motor Vehicle
PNG	Papua New Guinea
RGA	Rapid Gender Analysis
SME	Small Market Enterprise
SOE	State of Emergency
SRMH	Sexual, Reproductive & Maternal Health
UNDP	United Nations Development Program
UNFAO	United Nations Food & Agricultural Organisation
UNFPA	United Nations Populations Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

Executive Summary

Novel coronavirus 2019 (COVID-19) was first detected in China's Hubei Province in late December 2019, and was declared a global pandemic on 11th March 2020. COVID-19 is having devastating impacts globally. As of 22 November 2020, there are approximately 57.8million globally confirmed cases and over 1.3 million deaths have been recorded across 216 countries, territories or areas. To date, Papua New Guinea has recorded 612 cases, 588 have recovered and 7 deaths[1].

Upon confirmation of its first COVID-19 case in March, the Government of PNG declared a state of emergency and restrictions were put in place, initially for 14 days and then extended to late June. With an increase of 98 COVID-19 cases over 17 days, the Government of PNG is implementing a range of recommendations and measures[2], which although critical in slowing the spread of the disease, can themselves impose significant social and economic costs on PNG.

The impacts – direct and indirect – of the COVID-19 pandemic fall disproportionally on the most vulnerable and marginalized groups in society. PNG presents a range of contextual challenges, including difficult geography. Access to quality health services is limited, due to a lack of infrastructure, equipment, and qualified personnel[3]. Services are easily stretched or overwhelmed, and provision of specialised services and intensive care is limited. In the current situation, this can pose a problem of access to care if the number of infected people increases[4]. Coupled with gender inequality, which remains pervasive across the Pacific, in particular in the critical domains of leadership and decision making, access to and control of resources and gender-based violence[5], the public health response to COVID-19 can become immeasurably more complex[6].

Key recommendations

1. Ensure an enabling environment to collect data from women as well as men by considering factors such selecting a time suitable for women and girls, when they are not busy conducting chores.
2. Ensure active outreach to collect feedback from persons with disabilities, which can involve organisations of persons with disabilities in data collection.
3. Ensure availability of sex, age and disability disaggregated data, including on differing rates of infection, differential economic impacts, differential care burden, and incidence of domestic violence and sexual abuse
4. Ensure meaningful participation of and decision-making by women, people with disabilities and marginalised groups in all COVID-19 decision-making on response and recovery at the community, national, district levels, including their networks and organisations, to ensure efforts are not further discriminating and excluding those most at risk.

Key Findings

Women's care burden has increased due to the closures of schools, increase in restrictions and limited mobility and as health systems became less accessible in the shift to COVID-19 responses.

Access to gender-based violence support and sexual and reproductive health services reduced due to restrictions in movement and implementation of isolation and quarantine measures.

Gender-based violence is likely to increase with the implementation of isolation and quarantine measures and with GBV facilities having shifted focus to Covid-19 response and prevention.

Women's economic status is affected due to restriction in movement as most are engaged in informal trade, where they earn less and have no social safety nets and those engaged in the formal labour market are experiencing job losses.

Women have limited decision making in their household, communities and in governance and policy making bodies. There has been limited engagement of women in COVID-19 decision making processes.

Women in urban settlements/areas are particularly vulnerable as they do not have access to land for cultivation of crops to sell for income.

The small number of people in PNG who have been diagnosed as having COVID-19 have faced intense stigma and discrimination, which has also affected their families and others within their community.

An increase in the demand for WASH facilities has led to an increase in workload for women and girls who collect (and queue for) water.

5. Ensure continuity of essential health services for women and girls and marginalised groups such as people with disabilities, including counselling and SRHR services and the safety and accessibility of WASH facilities during the response to COVID-19.

6. Develop mitigation strategies specifically targeting food security and the economic impact of the pandemic on women, men, people with disabilities, and other marginalised groups and work to build economic resilience.

7. Prioritise services for prevention and response to gender-based violence in communities affected by COVID-19 and consider different ways people can access services and how services can be more inclusive of people with disabilities and people in rural and remote areas.

8. Prioritise provision of WASH facilities in schools and health centres and ensure availability of water for regular hand washing and other hygiene and sanitary practices.

9. Develop Covid-19 programing through an integrated approach that embraces the new normal and promote community mobilisation in response and prevention at all levels

10. Expand existing social protection schemes to meet the specific needs of women, people with a disability, informal workers, people in remote rural communities, and other marginalised group

Introduction

Background information – COVID-19 and PNG

Novel coronavirus 2019 (COVID-19) was first detected in China's Hubei Province in late December 2019, and was declared a global pandemic on 11th March 2020. COVID-19 is having devastating impacts globally. As of 2 August 2020, there are about 17.6million confirmed cases and over 680 894 deaths have been recorded across 216 countries, territories or areas.[7]

The first confirmed COVID-19 case entered Papua New Guinea on 13 March 2020.[8] In total, PNG has 645 officially confirmed cases to date; 588 have recovered and 7 deaths. At this stage, 16 of the 22 provinces in the country have confirmed cases of COVID-19. Of the 645 cases, 356 are from the NCD, 204 are from Western, 42 from West New Britain, 13 from Eastern Highlands, 7 from Central, 6 from Morobe, East Sepik and Enga has 3 each, East New Britain, Milne Bay and New Ireland has 2 each and West Sepik, Southern Highlands, Autonomous Region of Bougainville, Hela and Western Highlands Province has 1 each. [9]

With the confirmation of the first case in the country, the Government of PNG (GoPNG) declared a state of emergency (SoE) and put in place regulations that restricted movement of people, enforced by security forces, as a measure to contain the spread. These measures included closing national and provincial borders, closing markets – including informal markets (betel nut and street vendors), closing schools and education institutions, stopping all domestic and international travel and introducing social distancing measures. The state of emergency took effect on 22 March, initially for 14 days, and was later extended until 2 June. The GoPNG set up a Ministerial Committee consisting of key ministries and at the operational level, and activated the National Emergency Operations Center (NEOC)[10]. On 21 April 2020, the SoE Controller David Manning announced PNG's transition into the "new normal" way of life in the context of COVID-19, and several restrictions under the SoE were relaxed[11]. The National Department of Health released a detailed document, "*PNG Covid19 Prevention and Control: Guide to 'New Normal' in the time of Pandemic*[12]", detailing its public health social measures.

Globally, including in PNG, development and humanitarian settings pose particular challenges for infectious disease prevention and control[13]. PNG presents a range of contextual challenges, including difficult geography. Access to quality health services is limited, due to a lack of infrastructure, equipment, and qualified personnel[14]. Services are easily stretched or overwhelmed, and provision of specialised services and intensive care is limited. In the current situation, this can pose a problem of access to care if the number of infected people increases[15]. Coupled with gender inequality, which remains pervasive across the Pacific, in particular in the critical domains of leadership and decision making, access to and control of resources and gender-based violence[16], the public health response to COVID-19 can become immeasurably more complex[17].

While COVID-19 is primarily a health crisis, it is having profound economic ramifications and socioeconomic disruptions, has caused disruptions to healthy lifestyles and has had impacts on food systems and food security for the PNG population especially the most vulnerable[18], which includes women and girls and people with disabilities.

Public health messaging for COVID-19 has focussed on good hygiene practices such as washing hands. However, across the Pacific there is significant variation in WASH (Water, Sanitation and Hygiene) access with much lower access in rural areas. As a region the Pacific has the lowest water coverage and the second lowest sanitation coverage globally.[19] The availability of soap is challenging, especially in more

remote communities. Additionally, in the Pacific, women consistently raise significant difficulties with access to sanitation and their experience of violence whilst accessing sanitation facilities.[20]

The Rapid Gender Analysis Objectives and Methodology

Objectives: This Rapid Gender Analysis (RGA) provides information about the potential different impacts, needs, capacities and coping strategies of women, men, boys and girls and other vulnerable groups in PNG in light of the COVID-19 pandemic.

Methodology: The PNG COVID-19 Rapid Gender Analysis comprised of both primary and secondary data collection and analysis.

Secondary data: This included existing COVID-19 data and articles, previous disaster reports and evaluations, existing data regarding vulnerable groups

Primary data collection: Key Informant Interviews (KII) were conducted by CARE staff with Community Members, Key Stakeholders in Communities and Stakeholders in Health, Education and Livelihoods in four provinces in the Highlands Region – Eastern Highlands, Simbu, Jiwaka and Western Highlands and in Bougainville in two Districts – Buka and Tinputz. The interviews were carried out in communities where CARE has existing project activities in both Highlands Region and Bougainville.

Tool	Number of Respondents		
	Male	Female	Total
1. KII –Community members	23	18	41
2. KII- Stakeholders	14	4	18
3. KII- Education Sector	8	6	14
4. KII –Health Sector	1	10	11
5. KII- Livelihood and Food security	6	3	9
TOTAL	**52**	**41**	**93**

Ethical considerations: Informed consent was provided by all participants and 'Do no harm' principles were adhered to. All GoPNG guidance was followed, and health and well-being of participants and staff was prioritised. Interviews were conducted face-to-face at a safe distance.

Primary data analysis: Analysis was done by a team of 15 staff in the Highlands and 5 staff in Bougainville, during day-long 'sense-making' workshops.

Limitations of data:

Poor representation of women in the Highlands (only 22% of interviewees in the Highlands were women). This was attributed to the lack of time that women had available due to their domestic chores coupled with women's low confidence and literacy leading to a reluctance to be interviewed. Additionally many communities were fearful of CARE (due to risks of COVID-19) as CARE staff were coming from outside the community) and women were less likely to speak to the team. In some communities less women were around – they were more likely to stay home, or stay in their 'garden houses' away from the main village and the community leaders and government representatives were mostly men.

No people living with a disability were interviewed due to the lack of access to people with disabilities in the community. To address Instead the team interviewed health providers to provide disability specific perspectives.

Demographic profile – PNG

Sex and Age Disaggregated Data

PNG is one of the most culturally diverse countries in the world. Its estimated population of 8.5 million people[21] (52% male/48% female[22]) belong to over 1,000 distinct ethnic groups, speak over 800 languages, and live across the mainland (eastern half of the West Pacific island of New Guinea) and over 600 smaller islands and atolls. 85%[23] of Papua New Guineans live in rural communities that are often difficult to reach. PNG shares a 720-km land border with Indonesia on the west and sea borders with Australia on the south and Solomon Islands on the southeast through which traditional border crossers travel daily.

PNG has three official languages - English, Tok Pisin and Hiri Motu - with Tok Pisin, a creole language, the most widely used by the population.

Life expectancy in PNG is 66 years for women and 63 years for men[24]. Less than 5% of the population is over the age of 60 (3% in urban areas, 5% in rural areas), with 59% of the population under the age of 25 years[25]. 12% of households are headed by women[26]. The average household size is 5.3 people[27]. Adolescent fertility rates are high, with 65 births per 1000 from women aged between 15-19 years old.[28]

It is estimated that at least 15% of Papua New Guineans have some form of disability[29]. While data for PNG is scarce, across the Pacific region, less than 10% of children with disabilities attend school, compared to 70% of children who do not have a disability. The rate of unemployment for persons with a disability in the region ranges from 50% to 90%. PNG ratified the Convention on the Rights of Persons with Disabilities in 2011 and launched a new National Policy on Disability in 2015.

Non-communicable diseases including cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases, represent the single largest cause of premature mortality in the Pacific and are estimated to account for 56% of all deaths in PNG.[30] These statistics are significant given that those at higher risk for severe illness from COVID-19 are those with these non-communicable diseases related underlying health conditions.[31] In PNG, 37% of men smoke compared to only 15% of women[32].

More than two thirds of women in PNG have experienced family violence, and in some parts of the country, 80% of men admit they have been responsible for sexual violence against their partner[33]. 21% of girls are married before they turn 18[34].

Findings and analysis

Although one of the most ethically, culturally and linguistically diverse nations, PNG is a patriarchal society in which women across the country continue to face severe inequalities in all spheres of life: social, cultural, economic and political. Gender inequality is a critical development issue in PNG: The country ranks 155 out the 189 countries in the 2019 Human Development Index[35]. Gender based violence, in particular, has reached pandemic levels.

The findings and analysis from the review indicate the following:

A COVID-19 outbreak in PNG could disproportionately affect women and girls in a number of ways including adverse impacts to their education, food security and nutrition, health, livelihoods, and protection. In PNG, women are the primary care givers in the family and are also the key frontline responders in the health care system placing them at increased risk and exposure to infection. Women's maternal and sexual reproductive health (SRH) needs continue in an emergency, but these can be overlooked or deprioritised. COVID-19 risks increasing this already over-burdened workload for women with caring for children who are unable to attend school as schools close as well as caring for the sick (both at home and as workers within the health system).

Additionally, as with all crises, there is the potential for an increase in family violence in a country where pre-existing rates of violence against women are already very high. Primary data collection also found that fear of COVID-19 was very strong in communities.

There are specific considerations about men's gender roles and norms which need to be taken into account in relation to the COVID19 response in order to ensure that men are properly targeted to help reduce their vulnerability to illness and to leverage their roles as leaders and decision makers in the home and in the community to help prevent the spread of the disease.

PNG occupies the eastern half of the West Pacific island of New Guinea and has a young and growing population. With over 85% of the population living in rural areas, agriculture plays a vital role in the country's economy which is largely dominated by subsistence farming. The country's growth trajectory and abundant resource potential provides a strong platform for greater economic engagement abroad.

PNG has complex cultural dynamics deeply rooted in tribal and ethnic identity, traditional social institutions, and relationship to land. These contribute to both the country's unique challenges as well as its considerable resilience.

There are limited formal job opportunities for the growing employment age population and other risks include environmental management, population growth, political fragmentation, inequalities in PNG's resource dominated economy, and social exclusion of some groups.

All of these factors pose significant challenges for COVID-19 preparedness and response and are outlined in further detail below.

Gender Roles and Responsibilities

Division of household labour

While the PNG Constitution grants women and men equal rights and equal protection under the law, deeply rooted cultural, social and gender norms relegate women to the domestic sphere and associated types of labour[36]. In rural areas, the majority of women and girls work an arduous and long day, combining their role as primary caregivers with their responsibilities for food gardens (for consumption and sale) and other subsistence needs of the family, such as water collection, fuel for cooking and caring for domestic animals[37]. It is common for men to think that the payment of bride price gives him authority over his wife's labour and fertility[38].

Across the Asia Pacific region, we are seeing that women are more likely to experience increases in unpaid domestic and unpaid care work since the spread of COVID-19. For example, with the closure of schools, women are taking on additional childcare burden[39].

Primary data analysis found that in PNG there generally, has not been much change to the household chores in terms of division of labour within family. Women continue to do most of the unpaid household labour though the increased household work is in many cases being done by children who are home from school, in particular by girls**.** However, people reported an increase in responsibilities for mothers and young girls in water collection due to increase need for regular hand washing, cleaning of toilets and general hygiene practise.

Primary data also found that the closure of formal and informal markets particularly for fresh produce has meant that women are now spending more time at home doing household chores and other work such as working in food gardens which have increased in size and number as a preparedness plan for families should the SoE measures continue they will have enough supply of food as well as childcare responsibilities with children not going to school. In coffee growing areas (highlands) the work of coffee picking which is usually being done by women, in some cases is now being shared by children who are home from school due to SoE school closures, and even shared by husbands who are home more often, too. Men are working extra hard to meet family needs now that the main source of income for many rural women which is the informal cash economy is being affected through closure of markets. Women cannot sell their produce for an income to contribute to the family needs.

Economic empowerment

Although participation rates in the labour force are relatively even, men are almost twice as likely as women to hold a wage job in the formal sector and women are three times more likely than men to work in the informal sector[40]. Women traditionally tend to focus on food gardens, which generate relatively lower incomes compared to men's cash crops like coffee, cocoa and oil palm. Women are often expected to share their earned income with their husband, however men are not expected to do this in return[41]. Women in polygamous marriages, which make up almost a third of marriages in the Highlands, are at even higher risk of economic hardship, as their husband may distribute resources inequitably[42].

People in rural areas tend to use money for buying essential items (soap, cooking oil, salt, spices, rice), and education costs for their children. Men may spend money on family needs, or on things like alcohol, gambling, socialising and beetle nut. For daily consumption, people tend to rely on their food gardens.

Globally we are seeing profound economic impacts, including temporary and permanent business closures, loss of employment, and reduced trade. An economic downturn in Papua New Guinea would reduce government funds and lead to either increased foreign debt or decrease in revenues which could lead to cuts in funding to essential services[43].

Primary data analysis found that in the highlands, income generation has slowed for both men and women. For cash crops (coffee) people reported that they were getting a lower price, as they had to sell within their village and couldn't go to town where they would get a better price. In some communities, coffee farming families are worried they won't be able to sell their coffee beans at all. Increased cost of transport is affecting profit margins, even where people are able to go to town. Women who earn money selling cooked food by the roadside reported stopping their business for fear that someone may get sick with COVID-19 and blame them, leading to violence against the women and her family. Both men and women expressed worry about cash crops, such as carrots, that they have been unable to harvest and sell, because they are unable to access markets. In some cases, women have set up market stalls within their communities, where they have not been able to travel to their usual marketplace to sell. Ban on informal and formal Small Market Enterprises (SME) such as Public Motor Vehicle (PMV) operation, closure of fresh produce and cash crops markets has greatly affected access to these services leading to loss of income for many families. Women who do marketing of fresh produce and other goods will have low income due to market closure.

Primary data also found that both men and women are affected in their salaries being cut due to reduced working hours especially urban areas and also an indication of loss of job due to COVID-19. Some families have experience some level of stress due to COVID-19. Those who were mostly affected were parents especially those who lost their jobs or had their income reduced or affected. The stress was mainly about how to provide for family now that income was affected.

Decision Making

Decision making within the household

Men tend to dominate the majority of household decisions, including about expenditure of household income, allocation of daily family labour, food utilisation, sexual and reproductive health (including family planning), and participation in income earning opportunities.

Primary data analysis found that there has been no change to this during the COVID-19 pandemic with men dominating decisions in the home, and when discussions between men and women do occur, men are the ones who have the 'last say'. Many families claim that decision making shared between man and woman and that is generally understood as discussion with man making final decision or man making decision and women agreeing. It was reported that women were taking lead in decision making around WASH in the home as they were in charge of family hygiene. Some families are reporting an increase in family cohesion, as they have reconnected while spending time together at home.

Decision making in the community

Men tend to dominate community decisions. There are significant economic, social, cultural and educational barriers to women's participation[44]. Primary data noted that whilst some communities have seen women taking the lead in COVID-19 awareness activities, more men have reported to be involved in the COVID-19 awareness and preparedness in the communities as opposed to women. It was noted that churches have also played a key awareness role.

Decision making in public is now being made by community leaders as most community groups ceased activities and in most cases, community leaders are males. In AROB, despite women being equally represented at ward and community government levels, they are not as recognized as men. Some communities reported lack of leadership structure in terms of addressing COVID-19 and community preparedness.

Primary data found that prior to COVID-19 women were present in public even if unheard. With COVID-19, women became invisible in public. While few women were vocal in decision making processes, most decisions were made by men. Customs practice and education were noted as are barriers to women participating.

Participation in public decision-making

Women are largely absent from political forums in PNG, especially at the higher levels. PNG is one of only three countries in the world with zero women members of parliament[45]. The Autonomous region of Bougainville Government (ABG) has instituted a 50-50 representation of women and men in its Community Government structure but it is still in a nascent stage. While National Disaster Management Offices, Provincial Disaster Committees, Clusters and other mechanisms include women representatives, they continue to be heavily male dominated which leads to male dominated government decisions about COVID-19 preparedness & response plans and resource allocations.

Control of and Access to Resources and Services

Food and essential items

PNG is listed by the UN's Food & Agriculture Organisation as a "Low-Income Food-Deficit Country"[1] with more than half of the population in PNG (57 percent) experiencing moderate to severe food insecurity – ranging a high of 73 percent in Western Province to a low of 35 percent in Madang Province (PNG Demographic Health Survey Report, 2016-18). The rural population do not seem to have access to sufficient, safe and nutritious food to meet their dietary intake (National Food Security Policy 2018-2027)[46].

Coping mechanisms, in time of food shortages, involve eating fewer meals and eating smaller amounts. Because of the lower status of women compared to men, when food is scarce, women are less likely to have access to highly valued food high in protein and rich in fat. Widows and female-headed households, in crisis situations, face particular pressure handling food security problems on their own[47]

PNG's State of Emergency (SoE) has disrupted market supply chains, trade of food and agricultural produce. However, as 87% of PNG's population live in rural areas and grow their own food[48] increased scarcity of foods due to COVID-19 related restrictions may not be an issue in these areas. Urban dwellers however, who have lost their work and do not have access to gardens are more vulnerable to shortages of food and essential items and do not have financial reserves required to stockpile.

Primary data noted that restrictions put in place as part of SoE affected food supplies, trade, daily consumption and income. Most people interviewed did not experience any change to their supply of household food during COVID-19. The few that did express having seen shortage or experienced changes in food supply was around store items such as cooking oil and salt for rural population and this was mainly due to closure of fresh produce markets, supermarkets and loss of income.

[1] http://www.fao.org/countryprofiles/lifdc/en/

In the rural areas in the Highlands, people reported minimal impact on their daily food security. They reported having access to fresh produce from their gardens, such as greens, sweet potato, bananas and peanuts to meet their daily food needs. People did report reduced or no access to items such as salt, spices, cooking oil, soap and rice that they would usually purchase. This is due to SoE restrictions limiting movement of goods and people that has caused small shops in villages to run out of these items and has restricted people's movement to town to purchase from bigger shops. People are adapting by replacing salt and spices with locally grown and available items such as ginger and shallots. If access to necessities like salt and oil continue into the longer term, there will likely be impacts on people's nutrition and health. In the event of a widespread outbreak of COVID-19, that lack of availability of soap will be an issue.

Primary data noted that in areas where such essential items are still available, there has been an increase in price at shops and markets, and for transport getting to/from nearest town. Many families are into subsistence farming, making gardens and planting more food and looking after livestock just to be prepared if the restrictions continue. Both men and women contribute to providing food for the house however in most households food is mostly provided by women. Some households had all members of the family working together to provide food for the family. Food restriction was mostly common in the Autonomous Region of Bougainville (ARoB) and was mainly for pregnant and breastfeeding women who are restricted from consuming certain seafood and food cooked in coconut milk. There is also certain food restriction during mourning of a deceased person.

Land/house ownership

In most parts of PNG, including the Highlands, land inheritance is patrilineal - passed from father to son - which means it is difficult if not impossible for women to own land. Women-headed households are particularly vulnerable as land ownership is often granted by male family members[49].

Primary data found that in rural areas of the Highlands, some families reported that they have move to their 'garden houses' to minimise their risk of catching COVID-19. 'Garden houses' are usually small huts build inside people's food gardens where they use to rest, prepare meals and at times they spend the night in. Usually, people's gardens are away from the village and depending on the geographical terrains, it takes them minutes to hours of walk from the village to their gardens. In particular, women and children are staying isolated in their garden house, while men move around as needed.

Mobility

Women's mobility in rural PNG relates to household responsibilities, with extensive distances travelled for water and firewood collection, food gathering in gardens, as well as getting children to schools and taking them to hospitals[50].

With the State of Emergency restrictions, women and men's access to public spaces and services has been affected. GoPNG requested that people stop gathering for social events such as church, weddings, cultural events, family gatherings etc. and is closing schools until further notice. Domestic air travel and public transport has been restricted, international travel has ceased.

Primary data found that people's ability to move freely was affected by the fear of contracting the virus as well as the restrictions imposed by the authorities were movement was restricted for both for urban and rural. In rural areas of Highlands, fear of the virus is very, very strong. Many remote communities had to cut down trees to block access to their community, and even restricted access to their own community members who had travelled away from the community. Communities are starting to open up again. As noted above, many families opted to move away from their community and stay in their garden houses, which affected women and children's mobility even more as men were the ones to return to the community to gather news or for other reasons. Some women who would usually go into town with their husbands, are staying home for fear of catching COVID-19, while their husband goes to town to get what the family needs. Some communities reported an increase in people attending church, especially young men who might usually engage in gambling and drinking and not bother about church (as people are fearful of COVID-19).

Public transport for movement has scale down and social distancing practices meant less people getting on PMV. Primary data found that restrictions on public transport placed additional challenges for women who had to take sick children and elderly to aid-posts and clinics and pregnant women who had to go for antenatal

check-ups because they had to pay higher fares due to social distancing practices on PMVs. In some cases, women had to walk for distances due to no PMV operation.

Primary data found that the restriction of movement has also affected people's access to basic services such as health and other social and recreational activities. There is also indication of changes to food security due to restriction of movement and people not able to access fresh produce market and trade store.

Health Services

Health services in PNG are poor, particularly in rural areas where most of the population live[51]. Health workers are scarce (with .5 doctors and 5.3 nurses/midwives for every 10,000 people[52]), there are no intensive care facilities in several provinces, and there is reportedly just one ventilator per 600,000 people[53]. Communicable diseases are a major health challenge, with malaria, tuberculosis, diarrhoeal diseases, and acute respiratory disease the major causes of morbidity and mortality[54]. The incidence of tuberculosis is among the highest in the world[55] and is the major cause of death of women between 15-44 years[56]. During this pandemic period, it is important that TB prevention and care continue uninterrupted to avoid a spike in prevalence and worsening drug resistance[57]. Routine vaccination in PNG is already a challenge, as evidenced by the recent polio outbreak, and COVID-19 poses a serious risk of further disrupting vaccine delivery[58]. PNG continues to experience a HIV epidemic, mainly spread through heterosexual transmission and fuelled by high incidence of sexual aggression and other forms of violence against women[59].

Due to its young population with relatively few people over the age of 70 – the age-range most likely to develop serious complications from COVID-19 – it is possible that the virus will not take hold in PNG as it has in other countries. However, this is not guaranteed, as life is hard in PNG, and this may affect immune systems as much as age. Non-communicable diseases are also a major issue in many Pacific countries, which increases risk[60].

Around 50% of both men and women chew betelnut on a daily basis[61]. Spitting of betel nut juice indiscriminately in public places transmits and spreads respiratory infections.[62] These practices are hazardous in the context of a virus spread by respiratory droplets and close contact with others. Primary data did find however that in urban areas in the Highlands, there have been some decrease in drinking, chewing of beetle nut and other social activities due to the COVID-19 restrictions.

Primary data found that the small number of people in PNG who have been diagnosed as having COVID-19 have faced intense stigma and discrimination, which has also affected their families and others within their community.

Primary data found that health facilities such as aid-posts, clinics and hospitals were operating during COVID-19 lockdown. In many of these health facilities, mainly the general outpatients were serving clients. Facilities were operating on their normal work roster with changes being made by the health authorities. Health facilities are accessible to frail and vulnerable groups noting however that it is usually caregivers seeking healthcare and treatment on behalf of the vulnerable groups and people with disabilities. Women were able to clearly identify changes in the way health facilities operate as they mostly accessed health services since COVID-19 for antenatal checks and taking sick children to the health facilities. Scaled down health services due to COVID-19 preparedness and response was noted as well as access to health services due to COVID-19 restriction of movement put in place by the government, social isolation measures and loss of trust in the health system in preventing COVID-19.

Primary data found that access to health information available to all (male and female) and with COVID-19, there was positive change in people's attitude towards basic health and hygiene. Many families and communities adapted health and hygiene practices such as hand washing which became a regular and common practice for many families and practicing good personal hygiene.

Sexual, Reproductive & Maternal Health

Rates of infant and child mortality in PNG are high compared to other countries in the Asia Pacific region, and its maternal death rate of 215 per 100,000[63] is the highest in the Pacific region and among the worst in the world. Gender norms and women's low status affect women's ability to make decisions over sexual and

reproductive health and family planning. Girls and women are infected with Sexually Transmitted Infections at a younger age than boys and men, with twice as many women as men infected in the 15-29 age group. Girls between 15 and 19 have the highest rate of HIV/AIDS in the country; four times that of boys the same age. Trans-generational infection routes are common and customary practices enhance girls' and women's vulnerability. In addition, condom use is low and marriage is not a protective institution for women, and women struggling to access information and treatment around sexual, reproductive health[64].

COVID-19 may result in the gap between low access and high demand for SRMH services increasing, with disrupted supply of contraceptives[65], increased difficulties accessing antenatal care, fear of seeking health care due to exposure to COVID-19 and decreased mobility due to lockdowns. Myths and misinformation associated with COVID-19 may also add to the barriers to receiving a supervised and safe birth[66].

Both men and women interviewed noted that SRH services were not accessed during COVID-19 due to movement restriction and also health workers in SRH sections were being reassigned to COVID-19 prevention work.

People with disabilities

The PNG National Policy on Disability 2015-2025[67] estimates that PNG's disability population matches or exceed the World Health Organisation (WHO) global estimates that around 15% of any population have some form of disability. Women and girls with disabilities are more likely to experience a wider range of violence, to receive less support and be less able to defend themselves compared to those without disabilities. The vast majority of injuries in all women presenting at health facilities in Papua New Guinea (80–90 per cent) are reported to be the result of violence in the home, with many women acquiring a permanent disability from the violence they experience[68].

Underlying negative attitudes and structures exist in society that not only negatively affect the health and social well-being of people with disabilities, but also limit their opportunities and participation and mean that the voices of people living with disabilities in PNG often go unheard[69].

People with disabilities may be at higher risk of contracting COVID-19 as they may experience barriers to accessing preventative information and hygiene, may have reliance on physical contact with the environment or support people, and may have pre-existing health conditions[70].

Primary data noted that health facilities were accessible for all though usually caregivers seek healthcare and treatment on behalf of the vulnerable groups and PWD. It was noted that students with disability would face challenges as the schools may not be able to cater for their needs. It was also noted that WASH facilities especially water points and sanitation facilities are safe and accessible for the majority in but not so for PWD

Access to information

Men have higher levels of education and literacy than women in PNG[71]. Men often go to awareness sessions or go to town to receive information, and the messages may be incorrectly passed on to women or are misinterpreted. Access to mobile phones in remote and rural communities is lower for women than men[72].

Primary data analysis found that in the highlands, people in rural areas reported getting their information about COVID-19 from social media and via word of mouth. The availability of information depended on location as well as literacy and mobility. In urban areas, information was shared through newspaper, television, radio, social media, mobile phone messaging and awareness. In rural areas, information was mostly shared through radio, face to face, awareness mostly by churches and some through mobile phone messaging and social media where the mobile network is good. Due to movement restrictions, women were not able to travel thus restricted their access to information. They relied on their male members of their family who went to urban areas or who had access to information through radio or phone to share information with them. Awareness and message on radio played a vital role in information dissemination. Almost all of the respondents had access to a radio or a phone or both thus many preferred communicating information through radio and mobile messages. There was not much difference in information received by men and women. During awareness both men and women receive information together, however information through social media is mostly accessed by young people especially men who have access to smart phones and are using social media.

Local beliefs and practices did not have any significant impact on how messages on COVID-19 was received and people seeking medical health however, interpretation of COVID-19 messaging was influenced and interpreted along with religious beliefs, church doctrines and bible. This resulted in people reporting an increase in the number of people going to church compare to before.

Access to WASH services

Access to clean water and adequate sanitation facilities is a major challenge; with 89% of people in urban areas and just a third in rural areas having access to safe water, and 57% of urban and only 13% of the rural population having access to basic sanitation[73]. Women continue to bear the drudgery of fetching water for hours, taking up time that could be spent getting an education, undertaking economic activities and engaging in social interaction. Women and girls are disproportionately affected by lack of water because they have increased WASH needs during menstruation and pregnancy.

According to the GoPNG WaSH in Schools Policy 2018-2023[74], prior to the COVID-19 Pandemic, only 10% of schools promoted handwashing with soap. Most schools rely on rainwater to meet the drinking and hygiene needs of students, only half of schools have access to water, and less than a third have access to sanitation. Health facilities exhibit similar challenges to accessing adequate hand washing, water and sanitation facilities[75].

Primary data noted that existing WASH facilities in rural communities especially community shared facilities such as water tanks are unable to keep up with increased demand for handwashing due to COVID-19. Women and girls are spending longer collecting water, as they are needing to wait in line.

Primary data found that with increased need to self-isolate and the increased need for hand washing and good hygiene practice during the response to COVID-19, the workload for women and girls in collecting water has increased. Women and girls are fetching more water than they usually do. There were no long term WASH facilities set up in communities since COVID-19 except tippy taps which were mostly taught by CARE and other NGO groups.

Most families have basic WASH practices such as hand washing, personal hygiene and having a toilet. WASH facilities especially water points and sanitation facilities are safe and accessible for the majority but not so for people with disabilities especially to walk distance or over mountainous terrain to access water.

Many people were able to access water for regular hand wash in both the urban and rural communities. However, access to water is an on-going challenge for communities that do not have big rivers or creeks and rely on the rain for water. In these communities, parents control the use of water in family setting and village chief or elder control the use of water for community shared facilities such as water tanks. For communities that have big rivers and creeks, they were able to access water easily for regular hand wash and hygiene practice however, access to soap and disinfectants was a challenge. Often they wash hands with water only.

Women are mostly in charge of WASH management in the household but in community WASH management, it was mainly the community leaders who in most cases are men.

Access to Education

Reach and quality of basic education in PNG are ongoing challenges, with public funding insufficient to deliver core education services[76] and the government struggling to provide adequate facilities, enough learning materials, competent teachers, and effective management and supervision. There is a significant gender gap in literacy[77] and a persistent gender gap in access and completion of school, with the proportion of boys in school increasing as year levels progress.

Primary data found that COVID-19 did have implication on the education of the children. Implications commonly stated include school closure resulting in disruption to the academic year and children's learning as students missed class and lessons. The majority of the children were not able to continue their studies at home during COVID-19. Some parents were able to support their children with their learning at home by reminding them to read books or do revision work or assignments, There is mixed feelings from parents about sending their children back to school with great concern regarding WASH facilities at school for children's health and hygiene as many schools do not have good facilities for hand washing and preventative measures. The schools are

overcrowded which will be challenging to practice social distancing and the parents are also worried if their children will catch up on their lessons or not.

A majority of the respondents said they didn't withdraw their children from school, while few of the respondents said parents may withdraw their children because of the missed lessons and will be hard for children to catch up, want the children to start fresh and also because some children have lost interest in school. Many schools do not have measures in place to prevent and respond to COVID-19 such as having adequate wash facilities and access to water for regular hand washing and good sanitation and hygiene and training of teachers to prevent and response to COVID-19

Protection

Gender Based Violence (GBV)

Rates of family and sexual violence in PNG are among the highest in the world. In 2012, MSF noted that rates of gender-based violence in PNG are similar to those found in protracted conflict zones. Extensive research on domestic violence by the PNG Law Reform Commission found that on a national average intimate partner violence, commonly referred to in PNG as 'wife beating', affected two out of every three wives. Research by the PNG Institute of Medical Research found that over half the women interviewed had experienced sexual violence, whether by their husbands or by other men. To a large extent, the criminal law provisions already in place in PNG enable the state to prosecute and punish acts of violence against women, but the state structures and protections to do so either do not exist or lack a capacity to prosecute[78]. Critical gaps in the treatment of survivors of domestic and sexual violence place thousands of women at serious physical and psychological risk in PNG, even without the added pressures of a disaster.[79] Practices such as 'bride price' and polygamy contribute to levels of violence within families.

Belief in sorcery is widespread across PNG, with accusations of sorcery and violence often directed at poor, marginalised and older women.

While girls and women are the most confronted to violence, such violations are a reality for boys and men too; 44% of sexual abuse victims under 15 years old are boys and a study of GBV indicated that 7.7% of men admit to having perpetrated male rape[80].

The PNG criminal code criminalised consensual sexual intercourse between two adult men, and this reinforced the negative views towards LGBTI (lesbian, gay, bisexual, transgender and queer or Intersex) people, in particular towards men who have sex with men[81].

Evidence suggests that rates of GBV have increased globally because of the COVID-19 pandemic. This is due to a combination of factors, including a reduced access to support services by GBV survivors due to lockdown measures and fear of infection, disruption to social and protective networks, and stress and loss of oncome. The WHO has warned that where people are encouraged or required to stay at home, the risk of intimate partner violence is likely to increase, as women and children are confined with their abusers[82].

During the State of Emergency, many family and sexual violence (FSV) services in PNG closed or limited their operations. Police focused their attention on the State of Emergency, and reduced focus on FSV work.

Primary data found that with the liquor ban as one of the restrictions during SOE, there was increase in homebrew intake by youth particularly in Bougainville, which in some cases and in some communities was disturbing and became a concern. This concern was especially for women and girls in terms of their safety in moving around freely as it may lead to incidents in the community and possibly violence against women and girls.

Some communities in Bougainville have reported an increase in community police cooperating with community leader to deal with law and order issues and this has led to decrease crime and violence within the community

Fear of the virus created a lot of tension within families and communities. People moving in and out of their communities and those with flu and cough were perceived to be vulnerable to stigma and discrimination by community members.

Loss of income due to COVID-19 led to challenges in families such as decline in food supply which created tension in families. However, violence was not explicitly mentioned

People felt that authorities such village court and church group were safe places for people to raise concerns in communities as they were mostly present in the communities.

Child Protection

Many children in PNG are unsafe in their homes and communities, facing violence on a daily basis, including physical, sexual and emotional violence as well as neglect. Recent research conducted by ECPAT International on the sexual exploitation of children in the Pacific[83] found that about one-third of victims are boys and two-thirds are girls with 93% of offenders being male and 32% of 'enablers' being female. Offenders were most likely to be from the child's extended family, including grandparents, uncles/aunts, cousins, and siblings. Parents/step-parents and community members were the next most common categories of perpetrators. The research noted a strong stigma attached to being a victim of sexual exploitation, cultural taboos around discussing sex and the fear of further judgement by communities and other family members as limiting children's ability to speak out and report offending against them.

The child protection system in PNG is ineffective, with limited financial and human resources capacity; weak governance and coordination mechanism, inadequate access to both preventive and responsive services as well as lack of reliable data .

Child marriage is a common form of family and sexual violence, with marriages involving girls as low as 14 accepted by many communities, and almost a third of all girls in PNG married before they turn 18.

COVID-19 presents a risk of exacerbating these risks to children, as schools close and they are left home, and possibly alone, if their mother is working in health care. Additional risks are posed if families are forced to self-isolate.

Previous crises in Pacific countries have found several serious child protection issues including instances of neglect, separation, abandonment, abuse, economic exploitation, illegal adoption and trafficking, physical, sexual and other forms of violence.[84]

Parents interviewed reported using violence in order to keep their children at home, for fear they will get sick with the virus if they roamed around as they usually would. Closure of schools meant that parents had to take their children everywhere. They were reluctant to leave their kids alone in their homes. They are afraid their children might become victims of youths who take drugs. Women were more concerned with protecting their children from COVID-19.

Sexual Exploitation and Abuse

An overall economic downturn can result in a spike in sexual exploitation and abuse, where at-risk groups (particularly woman, child heads of households and single women living in poverty, widows, adolescent girls, sex workers, LGBTQI+ populations, and disabled men and women among others), who are struggling in terms of income and employment opportunities, may be forced or coerced to provide sex in exchange for food.[85] Emerging evidence suggests that the COVID-19 pandemic has the potential to increase the risks of sexual exploitation and violence[86] as women and girls may be forced to exchange sexual services for essential goods, something which is not uncommon in the PNG even in non-crisis times.

Capacity and Coping Mechanisms

Livelihoods and Agriculture

Approximately 85% of PNG's rural population rely primarily on subsistence farming, hunting, fishing and gathering for their livelihood. Women are highly active in agriculture and in small-scale income generation, such as market selling. Nationally, while women contribute 50-70 percent of agricultural labour, particularly in activities such as clearing, planting, weeding, harvesting, processing, transporting, storing and marketing, crops typically cultivated by women earn much less than crops thought of as men's crops[87]. Despite their key role in agriculture and food security, much of their work is undervalued, generally unpaid and confined to the domestic realm. Food crop production is generally associated with women's work, and cash crop production with men's work[88].

The FAO reports that temporary closure of urban fresh food markets, due to SoE restrictions, have negatively impacted on livelihoods of smallholders and people who depend on the informal sector. Urban residents, hotels and supermarkets who depend on sales of fresh produce from urban main markets, were also affected. The SOE lock-down has restricted transportation of fresh produce from subsistence farmers in peri-urban areas to main markets in urban centers and also from towns, the increased number of road blocks i.e. more than 50 roadblocks on the Highlands highway has caused high prices on processed foods such as rice, tinned fish, biscuits and disrupted the food supply chain. The prices of fresh produce in urban areas were observed to have increased by 50 to 60%, the price of processed food in trade stores have increased as a result of increased roadblocks pass fees. The rural population have resorted to selling and buying at roadside markets for fresh produce however, crop variety is very limited at these smaller roadside markets. Prices of food at the roadside market have gone low to sell fast their produce, as they fear fresh produce to perish hence decrease of cash flow in villages. Large quantities of fresh produce is grown in the Highlands provinces of Papua New Guinea, and this sold to a range of markets, including the coastal cities of Port Moresby, Lae and Madang. The quality of food at supermarkets in main centres (Lae, Port Moresby) were observed to dropped drastically during the first 14 days and this has continued in the quarantined provinces during the continuous lock down. There is a greater demand for fresh food produce in urban areas, cities and towns. The flow of food chain is limited due to lock down in major cities and has slightly increased pricing on food crops and vegetables. There has also been a n increase in the road side markets by since the closure of the markets E.g. resellers of bundles of greens would sell at a price of K5.00 a bundle rather than its usual price of K2.00 or K1.00 at the local market. Others are forced sell bags of produce for lesser price than required to prevent produce from perishing and rotting.[89]

Primary data analysis found that in rural areas, there is evidence that people are increasing their food gardens. One male respondent said that he and his family had increased from one to three food gardens. Though not common, one respondent reported that his family members who usually live in town had moved to his home in a rural area, due to fear of covid, and this had increased the burden on his family's food garden and resources. Most respondents are involved in livelihood activities such as copra, coffee, cocoa, poultry and piggery, selling of vegetable and other goods and fishing. Many of these livelihood activities were affected by restricted access to market due to COVID-19 that led to loss of income for many families. Responses to the control of livelihood assets varied with some saying that both men and women controls the livelihood assets while some said men controls most of the livelihood assets. This did not change since COVID-19. Some of the coping mechanisms used during the crisis was people doing SME business on road sides/residential area, and also they budget wisely on their available resources they have. The living standard of the people in the community changed, and they were more concerned about their personal health and hygiene despite of the different challenges they faced.

Savings

An estimated 90% of the PNG population remains unbanked and with a majority of bank accounts held by males of the households, women have little control over financial services and activities[90]. The 'wantok' system (translated 'wantok' means 'one talk') describes the strong social bonds that brings together communities to share obligations such as debt, cost of funerals or bride price.

Primary data from the Highlands noted that some respondents reported saving money by cutting down on expenses. People are not spending the money they usually would when they went to town and to the market.

Household capacity

The reciprocal relationships and obligations of the "wantok" system is the safety net under which family and clan members are required to support each other. Economic consequences of COVID-19 pandemic may be cushioned by this community social safety net and by people's ability to grow their own food, although urban residents returning to rural homes may place pressures on available land and resources.

Primary data found that most people did not experience any major change to the supply of food in their household during COVID-19 as majority of them live daily on fresh produce either from their own garden or from local fresh produce market. People in rural areas are making more gardens and planting food to sustain them should the lockdown continues. Store goods ran out in rural locations and people experience shortage of basic goods such as rice and salt. People are also depending largely on income to procure store goods as well as fresh produce for those who do not have gardens.

In most households it is women's general responsibility to procure food for the household and with the restrictions on movement, transport and closure of markets, families had to make adjustments such as limiting number of meals in a day or limiting amount of food cooked for a meal. Women also reported trying to sell produces and other goods at local roadside or community market but it was not adequate for a good income.

In some households, family members work together to provide food for the family but parents are mainly responsible for procuring food for the household.

Conclusion and Recommendations

As of 22 November 2020, there are 612 recorded COVID-19 cases in PNG[91]. COVID-19 is affecting women and girls in a number of ways including adverse impacts to their education, food security and nutrition, health, livelihoods, and protection. In PNG, women's care burden is likely to increase due to the closures of schools, increase in restrictions and limited mobility and as health systems become less accessible in the shift to COVID-19 responses. Access to gender-based violence (GBV) support and sexual and reproductive health services will be reduced due to restrictions in movement and implementation of isolation and quarantine measures. Gender-based violence may increase with the implementation of isolation and quarantine measures. Women's economic status will be affected due to restriction in movement as most are engaged in informal trade, where they earn less and have no social safety nets and those engaged in the formal labour market are experiencing job losses. Women have limited decision making in their household, communities and in governance and policy making bodies. There has been limited engagement of women in COVID-19 decision making processes. Women in polygamous marriages, which make up almost a third of marriages in the Highlands, are at even higher risk of economic hardship, as their husband may distribute resources inequitably. Women-headed households are particularly vulnerable as land ownership is often granted by male family members. An increase in the demand for WASH facilities has led to an increase in workload for women and girls who collect (and queue for) water. The small number of people in PNG who have been diagnosed as having COVID-19 have faced intense stigma and discrimination, which has also affected their families and others within their community.

There are specific considerations about men's gender roles and norms which need to be taken into account in relation to the COVID19 response in order to ensure that men are properly targeted to help reduce their vulnerability to illness and to leverage their roles as leaders and decision makers in the home and in the community to help prevent the spread of the disease.

Recommendation 1: **Ensure an enabling environment to collect data from women as well as men by considering factors such selecting a time suitable for women and girls, when they are not busy conducting chores and ensure interviews are conducted in the local dialect (s) to ensure their meaningful participation and understanding.**

Globally documented evidence indicates that due to preexisting roles and responsibilities and social and cultural norms, disasters affect men and women in different ways. Therefore it is essential to enable the collection of data from women by ensuring that data collection in conducted in a gender sensitive way. This includes considerations such as the time of day and the composition of the data collection team i.e. having women talk with women.

Recommendation 2: Ensure active outreach to collect feedback from persons with disabilities, which can involve organisations of persons with disabilities in data collection.

People with disabilities have specific needs, risks, vulnerabilities and capacities which may not be captured with a general community survey. To ensure disability data is collected, data collection teams should work with disability organisations to both receive training in disability data collection and also to work alongside them in the collection of disability data.

Recommendation 3: Ensure availability of sex and age disaggregated data, including on differing rates of infection, differential economic impacts, differential care burden, and incidence of domestic violence and sexual abuse[92]

Given the gender dynamics of COVID-19 impacts, it is important to collect data that is disaggregated by sex, age and disability (using Washington Group Questions) and if possible also captures data on female headed households, pregnant and lactating women and people of diverse SOGIESC

COVID-19 will not only have impacts on health, and therefore data should also be collected on impacts on livelihoods, wellbeing, gender based violence and child protection. This enables the monitoring of these key societal issues which have negative impacts on certain community members.

Recommendation 4: Ensure meaningful engagement of women and girls in all COVID-19 decision making on preparedness and response at the national, provincial and community levels, including their networks and organizations, to ensure efforts and response are not further discriminating and excluding those most at risk.[93]

Response agencies should engage local women organisers, not just as recipients of the support but as leaders in the response, facilitating their collective agency. Responders should ensure equal voice for women in decision making in the response and long-term impact planning by reaching out to women's organisations, networks and women leaders in the community. Decision-makers and those coordinating response efforts should use existing gender analysis and include gender, GBV and SRH specialists at regional, national and local levels to inform decision-making processes and preparedness and response planning. Better inclusion of women frontline workers in health and other sectors (e.g. GBV) in all decision-making and policy spaces can improve health security surveillance, detection, gender GBV patterns and prevention mechanisms.[94]

Responding agencies should also provide priority support to women on the frontlines of the response, for instance, by improving access to women-friendly personal protective equipment and menstrual hygiene products for healthcare workers and caregivers, and flexible working arrangements for women with a burden of care.

Given women's front-line interaction with communities and their participation in much of the care work, they face a higher risk of exposure. With such proximity to the community, women are also well placed to positively influence the design and implementation of prevention activities and community engagement.[95]

Recommendation 5: **Ensure continuity of essential health services for women and girls and marginalised groups such as people with disabilities, including counselling and SRHR services and the safety and accessibility of WASH facilities during the response to COVID-19.**

Sexual and reproductive health and rights is a significant public health issue that requires high attention during pandemics. Safe pregnancies and childbirth depend on functioning health systems and strict adherence to infection prevention. Provision of family planning and other SRH commodities, including menstrual health items, are central to women's health, empowerment, and sustainable development and may be impacted as supply chains undergo strains from pandemic response. Continuity of care must be ensured in case of severe facility service interruption or other disruption in access for women and girls of reproductive age. Obstacles and

barriers must be addressed, enabling women's and girls' access to services, including psychosocial support services, especially those subject to violence or who may be at risk of violence in quarantine. [96]

Recommendation 6: **Develop mitigation strategies specifically targeting food security and the economic impact of the pandemic on women, men, people with disabilities, people of diverse SOGIESC and other marginalised groups and work to build economic resilience[97]**

COVID-19 has the potential, if not already, to affect the ability for women to earn an income. This will affect a household's ability to purchase essential items including food and hygiene products and will also place additional stresses on the household which may lead to an increase in family violence. Therefore responding agencies need to consider economic recovery activities ensuring that any strategies have considered gender impacts. For example, any cash based programming should take into account the changing gender dynamics due to COVID-19 and increased GBV risk so as not to perpetuate these risks.

Recommendation 7: Prioritise services for prevention and response to gender-based violence in communities affected by COVID-19 and consider different ways people can access services and how services can be more inclusive of people with disabilities and people in rural and remote areas[98]

PNG has some of the highest rates of GBV in the world. Referral services and response mechanisms will need to be resourced and strengthened to be able to respond to the increase in violence due to COVID-19. Women and girls may be at higher risk of GBV due to increased tensions in the household, particularly if isolation, quarantining and lock-down measures are put in place. As systems that protect women and girls, including community structures, may weaken or break down or become inaccessible due to COVID-19 impacts, specific measures should be implemented to protect women and girls from the risk of GBV[99] including ensuring that information is circulated on how to access services in the constrained environment. Gender based violence referral pathways must be updated to reflect changes in available care facilities, while key communities and service providers must be informed about those updated pathways.[100] Responding agencies and coordination mechanisms should also engage GBV service providers and protection services, such as the police, in development of IEC materials and other awareness. Funding should be ensured to continue existing services and ensure they are not disrupted due to re-allocation of resources to COVID-19.

Recommendation 8: Prioritise provision of WASH facilities in schools and health centres and ensure availability of water for regular hand washing and other hygiene and sanitary practices

Access to clean water and adequate sanitation facilities is a major challenge; with 89% of people in urban areas and just a third in rural areas having access to safe water, and 57% of urban and only 13% of the rural population having access to basic sanitation.

According to the GoPNG WaSH in Schools Policy 2018-2023, prior to the COVID-19 Pandemic, only 10% of schools promoted handwashing with soap. Most schools rely on rainwater to meet the drinking and hygiene needs of students, only half of schools have access to water, and less than a third have access to sanitation. Health facilities exhibit similar challenges to accessing adequate hand washing, water and sanitation facilities.

Recommendation 9: Develop Covid-19 programing through an integrated approach that embraces the new normal and promote community mobilisation in response and prevention at all levels

With COVID-19, women, people with disability and old people became invisible in public. While few women were vocal in decision making processes and participating in community response and prevention, most decisions were made by men. Customs practice and education were noted as are barriers to women participating.

Some communities have seen women taking the lead in COVID-19 awareness activities however, more men have reported to be involved in the COVID-19 awareness and preparedness in the communities as opposed to women. Some communities reported lack of leadership structure in terms of addressing COVID-19 and community preparedness.

Recommendation 10: **Expand existing social protection schemes to meet the specific needs of women, people with a disability, informal workers, people in remote rural communities, and other marginalised groups.**

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