Humanitarian Operational Plan (HOP)
January to December 2012

Revision April 2012

OCHA/Stacey Winston

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1. EXECUTIVE SUMMARY

Humanitarian Operational PlanJanuary to December 2012 (HOP) reflects discussions on the outstanding needs of vulnerable populations in Khyber Pakhtunkhwa (KP) province and the Federally Administered Tribal Areas (FATA) in north-western Pakistan. The HOP articulates the agreed operational priorities, based on a set of defined planning assumptions.

The Humanitarian Country Team has identified two broad beneficiary groups that must continue to be prioritized: IDPs in KP and FATA, and returnees and "stayees" (people who were never displaced) in FATA. Groups in 'transition',either as they become IDPs or return to 'normal life' in their areas of origin in FATA or elsewhere, are particularly vulnerable and require significant support from the humanitarian community.

This document does not cover any humanitarian needs related to the floods which occurred in2010 or 2011.

Whilst all Agencies[1] in FATA are included in the background and contextual analysis sections, only responses to humanitarian needs (both relief and early recovery) of Kurram Agency in FATA, are included in the HOP. The early recovery needs of returnees and stayees from Bajaur, Mohmand, Orakzai and South Waziristan agencies are covered in the Early Recovery Assistance Framework for FATA[2]. Together, the HOP and Early Recovery Assistance Framework for FATA comprehensively cover the full scope of needs currently created by the complex emergency in both KP and FATA without duplication or gap (see map 1 below).

KP/FATA is characterized by phases of displacement in response to security operation or sectarian violence in FATA agencies and subsequent returns when calm is restored, during which populations struggle to resume normal life.

In this challenging environment, the local authorities have requested support from the humanitarian community to assist in meeting the needs of affected populations. The scope of required support is broad and includes: reception and protection of new IDPs; support for large numbers of IDPs in camps and among host families; managing returns and enabling re-settling populations inside FATA to re-establish their livelihoods and meet basic needs.

Whilst significant humanitarian interventions are ongoing many humanitarian needs remain unmet. Thisinter-cluster plan provides guidance to facilitate an increasingly holistic approach to meet outstanding humanitarian needs, factoring in anticipated shifts and changes over the next 9 months.

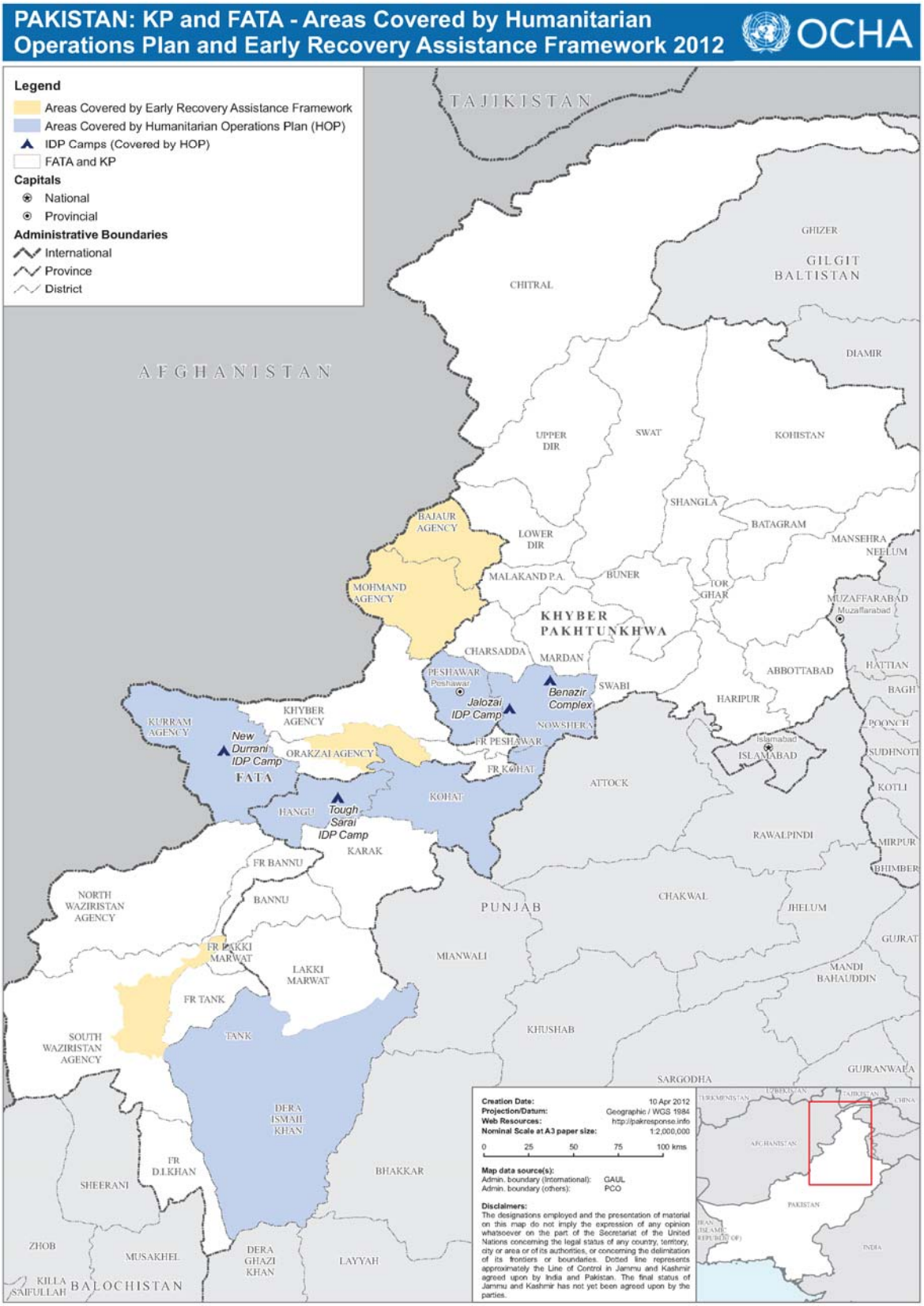
During the time of the revision of this document in April 2012, the humanitarian community is supporting a recent influx of more than 200,000 registered IDPs displaced from Khyber Agency. According to the Government, the displacement may last for sixto nine months with a manifold increase indicated in the displacement figures.

Over the past four years, security operations by the Government against non-state armed groups and sectarian violence have led to significant population movement in Khyber Pakhtunkhwa (KP) and FATA. The recent influx of IDPs to Jalozai camp for registration began in mid-January and intensified in March due to increased security operations. A minority of families are choosing to reside in Jalozai Camp, with the majority choosing to remain off camp in hosted situations.

[1] Agencies when referred to with a capital A, indicate the geographic location.

[2] The Early Recovery Assistance Framework for FATA, has been developed by the FATA Disaster Management Authority with UNDP and Humanitarian Clusters to articulate the comprehensive needs of returnees and 'stayees' to Mohmand, Bajaur, Lower Orakzai and the eastern area of South Waziristan Agencies.

Map 1-Geographical Coverage of the Humanitarian Operational Plan and Early Recovery Assistance Framework for FATA



2. CONTEXT AND BACKGROUND

Since July 2008, Pakistan's north-western areas of Khyber Pakhtunkhwa (KP) and FATA have experienced significant population movement as a result of security operations between government armed forces and non-state armed groups as well as sectarian violence. At the peak of the crisis in April/May 2009, nearly three million people fled their areas of origin, including populations from KP.

Whilst the majority of IDPs have voluntarily returned to their homes since July 2009, significant humanitarian needs persist.

The humanitarian community witnessed the following developments in 2011:

- Continued and fresh displacement from parts of FATA which are still insecure, including in Mohmand, Kurram and Khyber.
- The establishment of IDP camps inside FATA agencies of Mohmand and Kurram.[3]
- Returns of approximately 40,000 families[4]to parts of FATA that have become more secure.
- A mix of IDPs living inside and outside of camps, in both KP and FATA.[5]
- Continued instability in parts of FATA, affecting livelihoods and infrastructure and limiting access to basic services.
- Restricted access to FATA and areas of KP continues to limit humanitarian assistance.

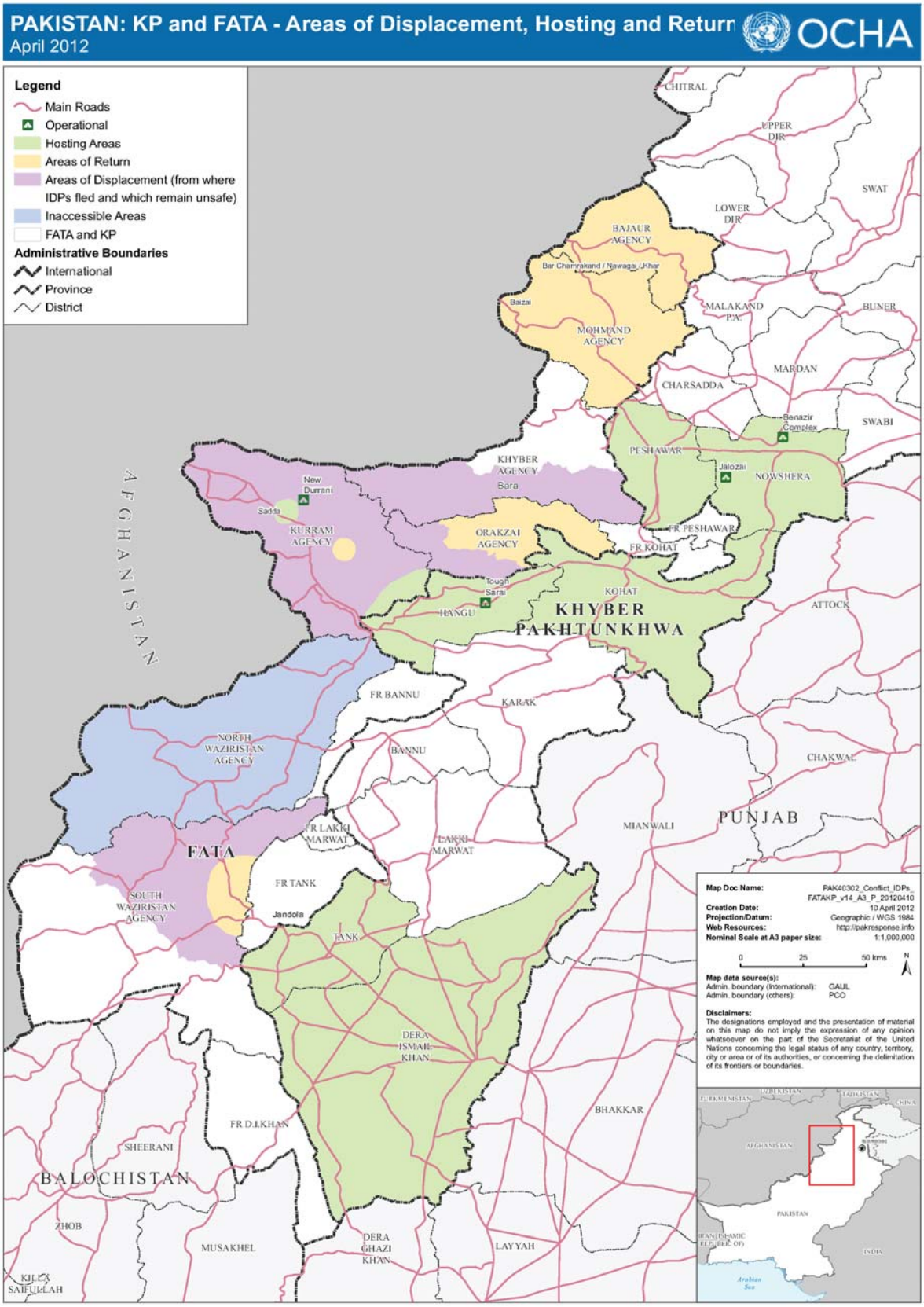
The humanitarian situation in parts of Khyber Pakhtunkhwa (KP) and the Federally Administered Tribal Areas (FATA) has deteriorated in early 2012 as instability and security operations in the area have resulted in an on-going exodus from the Khyber Agency of FATA.

In the first three months of the current year, the humanitarian community saw a new wave of displacement from Khyber Agency to Jalozai camp which intensified during mid-March with as many as 10,000 families having arrived at the camp in that week. Around 26,000 IDP families have been registered since January 2012, some19% of whom are living in Jalozai Camp. Authorities indicate a further influx of over 50,000 more families in the displacement figures are expected prior to July 2012.Displacement currently anticipated to last for six to nine months.

The registration of the new arrivals and provision of humanitarian assistance continue with priority being given to the most vulnerable people.

The new arrivals at Jalozai Camp add to the 104,000 families that remained displaced from FATA as of the beginning of the year, according to figures verified by local authorities. Some 29,000 further unregistered families remain displaced in Hangu. These families are being assessed for registration in April 2012.

[3]Since December 2009, around 56,000 families from Kurram and Orakzai agencies have fled to the hosting districts of Kohat and Hangu. To accommodate some of them, Nahqi and Danishkol camps were established on 29 January 2011. Danishkol, which hosted 1,623 families, was closed on 4 March 2011, while Nahqi, which hosted 8,418 families, was closed on 14 October 2011. In June and July 2011, security operations against non-state actors in Central Kurram Agency sparked a new influx of approximately 13,500 families in New Durrani camp in Lower Kurram. Around 400 families have returned to their places of origin, while around 13,100 families are still displaced, according to UNHCR and FDMA.
[4]Since December 2009, around 56,000 families from Kurram and Orakzai agencies have fled to the hosting districts of Kohat and Hangu. So far 22,868 families have returned to Orakzai Agency and 4,169 families have returned to Kurram Agency, according to the FDMA. In total, around 40,000 families are estimated to have returned to Bajaur, Mohmand, Kurram, Orakzai and South Waziristan. By 25 November 2011, a total of 10,348 families had returned to their homes in Bajaur and Mohmand agencies, according to PDMA. In Khyber Agency, 600 of 3,000 displaced families had returned by December 2011, according to UNHCR. In South Waziristan Agency, 6,580 of 41,563 families that fled to the districts of Tank and DI Khan have returned home, according to FDMA.
[5]See table in paragraph 3.


PAKISTAN: KP and FATA - Areas of Displacement, Hosting and Return
April 2012
OCHA
Legend
Main Roads
Operational
Hosting Areas
Areas of Return
Areas of Displacement (from where IDPs fled and which remain unsafe)
Inaccessible Areas
FATA and KP
Administrative Boundaries
International
Province
District
CHITRAL
UPPER DIR
LOWER DIR
SWAT
BAJAUR AGENCY
Bar Chamrakand / Nawagai / Khar
Baizai
MOHMAND AGENCY
MALAKAND P.A.
BUNER
MARDAN
CHARSADDA
Benazir Complex
SWABI
PESHAWAR
Jalozai
NOWSHERA
KHYBER AGENCY
Bara
New Durrani
Sadda
KURRAM AGENCY
ORAKZAI AGENCY
FR PESHAWAR
FR KOHAT
Tough Sarai
HANGU
KOHAT
KHYBER PAKHTUNKHWA
ATTOCK
AFGHANISTAN
FR BANNU
KARAK
NORTH WAZIRISTAN AGENCY
BANNU
CHAKWAL
MIANWALI
PUNJAB
FR LAKKI MARWAT
LAKKI MARWAT
FATA
FR TANK
SOUTH WAZIRISTAN AGENCY
Jandola
TANK
DERA ISMAIL KHAN
BHAKKAR
FR D.I.KHAN
SHEERANI
BALOCHISTAN
ZHOB
MUSAKHEL
DERA GHAZI KHAN
LAYYAH
KILLA SAIFULLAH
Map Doc Name: PAK40302_Conflict_IDPs_FATAKP_v14_A3_P_20120410
Creation Date: 10 April 2012
Projection/Datum: Geographic / WGS 1984
Web Resources: http://pakresponse.info
Nominal Scale at A3 paper size: 1:1,000,000
0 25 50 kms
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Map data source(s):
Admin. boundary (International): GAUL
Admin. boundary (others): PCO
Disclaimers:
The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.
AFGHANISTAN
PAKISTAN
INDIA
Arabian Sea

3. HUMANITARIAN SCENARIO FOR 2012

Under guidance of the local authorities[6], the humanitarian community foresees the following scenario unfolding in the remainder of 2012 (see Annex 2 for details):

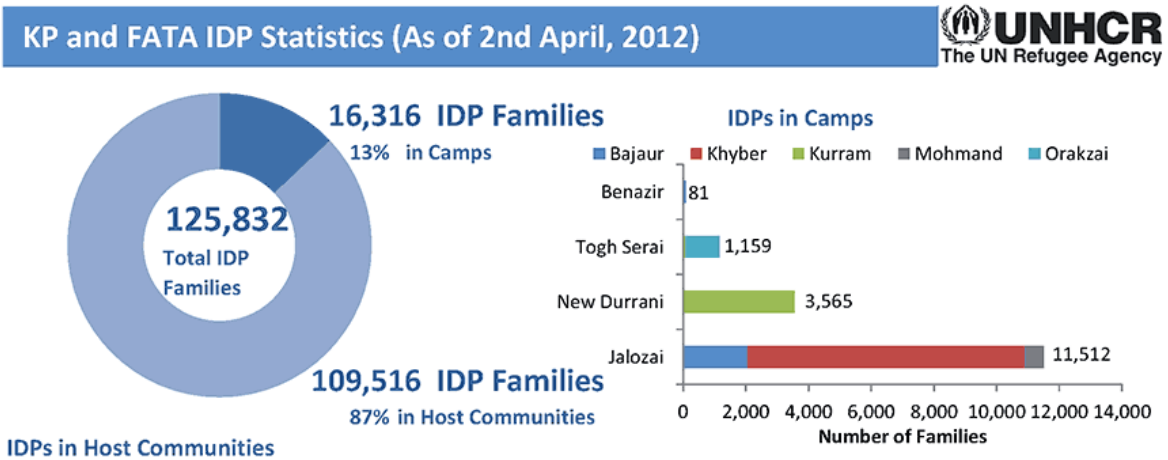
More than 580,000 people are currently displaced in KP and FATA. Population movements continue as more families are displaced and others return. Some additional 66,000 families are expected to be registered in camp and host communities as a result of security operations in the insecure agencies of FATA. Currently there are around 125,000 families displaced in both camp and off camp areas. During 2012, it is anticipated that approximately 78,000 families will return to their areas of origin as the situation allows (includes long and short term IDPs and families displaced by sectarian violence).An estimated147,000 families willremain displaced at the end of the year.

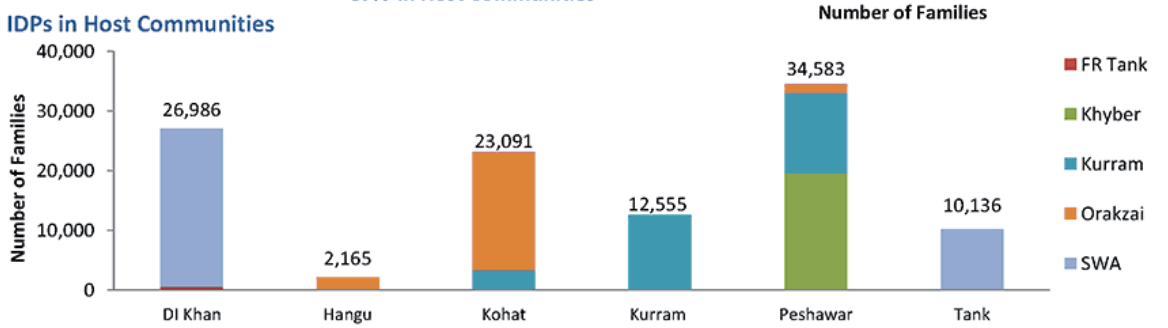
1. Continued GOP security operations in FATA, leading to anexpected displacement of 33,000 new IDP families from Bara,18,000 families from Tirah Valley, Khyber, an additional 10,000 newly registered families in Hangu(previously supported by ICRC) plus another 5000 newly registered families previously displaced from various parts of FATA, with a projected displacement timeline of six months or more[7].
2. Continued instability in parts of both KP and FATA that will limit regular or reliable access.
3. Continuation of relief activities to more than 78,000 IDP families in the return areas will be necessary until early recovery activities begin and livelihoods and basic services are at least partially restored.

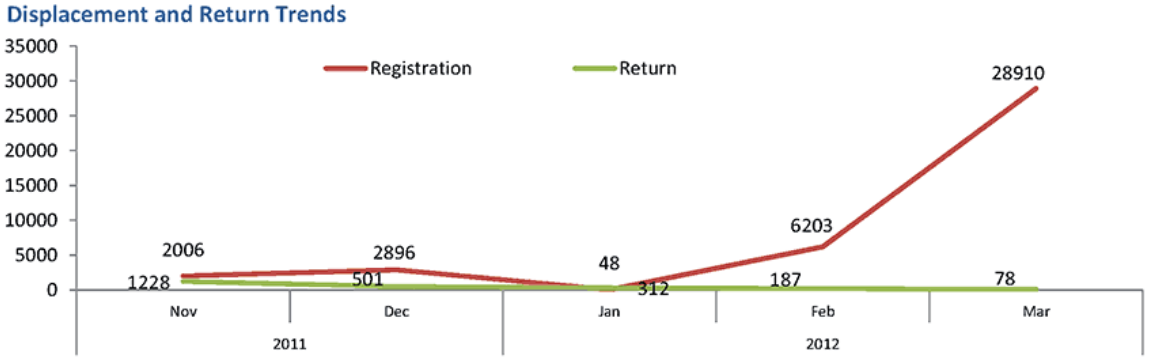
[6] FDMA and PDMA provided updated planning assumptions for 2012 to the Peshawar based Humanitarian Regional Team (HRT) on 5 April 2012.

[7] Humanitarian partners have developed a Contingency Plan for addressing increased humanitarian needs that may be caused by expected displacements due to continued security operations.

The tables below provide figures of IDPs living in and outside camps, and their areas of origin, as of 2 April 2012 (UNHCR):







Currently Registered IDP Families by Location (Camp and Off-Camp)

Place of Displacement		Agency of Origin							Total
		Bajaur	FR Tank	Khyber	Mohmand	Kurram	Orakzai	SWA	
DI Khan	Off Camp		532			1		26,453	**26,986**
Hangu	Camp					*84*	*1,075*		**1,159**
	Off Camp					*109*	*2,056*		**2,165**
	Total					193	3,131		**3,324**
Kohat	Off Camp					3,337	19,737	17	**23,091**
Kurram	Camp					*3,565*			**3,565**
	Off Camp					*12,555*			**12,555**
	Total					16,120			**16,120**
Nowshera	Camps	*2,138*		*8,830*	*624*				**11,592**
Peshawar	Off Camp			19,624		13,424	1,444	91	**34,583**
Tank	Off Camp							10,136	**10,136**
Grand Total		**2,138**	**532**	**28,454**	**624**	**33,075**	**24,312**	**36,697**	**125,832**

Note 1: Bajaur and Mohmand IDP families at Jalozai are under a process of verification by PDMA/UNHCR

Note 2: New Registrations include IDPs registered at Jalozai, New Durrani, and Off-camp areas of Kurram and KP including those surveyed by IVAP and registered by UNHCR

4. NEEDS ASSESSMENT & ANALYSIS

Needs of IDP families differ according to the length of their displacement and whether they are staying in a camp or off-camp setting. This document assumes immediate humanitarian needs in fresh displacement situations include both in-kind assistance packages (food as well as emergency non-food items, with particular attention to the needs of vulnerable groups) and the provision of basic services (such as health, nutrition, protection and emergency education). While basic services, as well as shelter solutions, such as rental accommodation, may already be established in off-camp situations, services need to be reinforced or augmented to adequately service an increased caseload. Meanwhile, camp displacements generally require the distribution of shelter materials and basic household items, as well as the establishment or maintenance of public health structures and other emergency services. In both camp and off-camp scenarios, agenciesmust consider women's access to distribution points, services, assistance and information, as well as the particular health and hygiene needs of women and girls.

Experience has shown humanitarian needs related to protracted displacement must be analysed separately from fresh displacement needs. In 2010, the humanitarian community launched an inter-agency initiative known as the IDP Vulnerability Assessment and Profiling (IVAP) initiative, which aimed to assess each IDP family's vulnerability at the household level to better tailor assistance in a way that promotes self-reliance and where possible allows for durable solutions. The initiative confirmed high levels of household-level vulnerability amongst both camp IDPs and families living in off-camp situations. It also helped to distinguish between the most vulnerable and "borderline" vulnerable people, thereby allowing a more accurate targeting of certain types of assistance.

IDPs in Jalozai, ToghSarai, Benazir[8] and New Durrani camps are amongst the most vulnerable of all IDP families. IVAP data shows that families in Jalozai and Benazircamps have an average monthly family income of PKR 2900 (approximately $0.21 per person per day).These families generally do not possess assets, and have a high number of dependents, with two out of six family members belonging to a vulnerable dependent group (i.e. elderly, disabled, chronically ill, etc.) Monthly food assistance has allowed most families to maintain a "borderline" food consumption score.

For off-camp families, the IVAP also detected high levels of vulnerability, distinguishing between a "vulnerable" group (around 60 per cent of the IDP population) and a "borderline" group. Similar to the camp group, off-camp vulnerable IDP families have very low family incomes (PKR 3100 per month, or $0.23 per person per day), and generally do not own assets. Dependency ratios are even higher than in camps, and food consumption scores range from "poor" to "borderline". Anecdotal evidence indicates that the presence of such large numbers of IDPs is having a negative impact on service availability to host communities.

Around 40 per cent of protracted IDPs fall into "borderline" vulnerable IDP families, with an average income that is almost twice as high as that of the most vulnerable. These families are likely to own at last some assets, and have "borderline" to "acceptable" food consumption scores. Most families have at least one vulnerable dependent family member, and occasionally resort to a negative coping strategy.

The IVAP allowed humanitarian agencies to map the exact concentrations of remaining IDPs in the Peshawar Valley, including specific vulnerabilities and needs in each area. The assessment revealed, for example, that water is consistently available to more than 80 per cent of households in most hosting tehsils, but that there are significant gaps in water availability in Tank, Hangu, and Kohat. Similarly, access to health care was mapped, and found to be most lacking in Mardan, TakhtBhai, and Town-4 tehsils in Peshawar.

While 90 per cent of protracted IDPs indicate a desire to return to their areas of origin[9], many could not doso due to insecurity and 'notification'[10] of their area as an operational military zone by Government of Pakistan. Land and housing damage/problems and a lack of job opportunities in areas of origin were also

[8]Planned to close in April 2012

[9]Source: IDP Vulnerability Assessment and Profiling (IVAP) data of families interviewed in Charsadda, Kohat, Hangu, Mardan, Nowshera, Peshawar and Swabi districts between May 2010 and present.

[10]According to the National Calamities (Prevention and Relief) Act of 1958, the Government has the authority to notify a district as calamity hit, therefore recognizing a district as a disaster-affected area. It acknowledges the humanitarian needs of the notified districts, and therefore that humanitarian response is required. It also entitles the notified district to fiscal indulgences and compensations.

cited as significant obstacles to return. In terms of immediate needs in their area of displacement, besides food, the majority of IDPs expressed an interest in job opportunities and assistance with rent.

Back in the areas of origin, there are significant humanitarian needs amongst both the returnees and the 'stayees'.

In most areas, security operations and/or sectarian violence have caused significant damage and destruction, particularly in relation to housing and community infrastructure (such as schools and health clinics) and in terms of loss of livelihoods.Absence and lack of maintenance during consecutive winters has resulted in the degradation of traditional mud dwellings, many of which have been rendered uninhabitable as a consequence. While there is evidence of need in each of the Agencies where return has taken place, the precise degree of damage and destruction of homes and community infrastructure varies significantly across the affected areas, with some areas (such as, the seven villages known as the "Loisam Corridor", in Bajaur Agency) which were razed to the ground entirely, while other villages have seen only minor damages. Although early recovery is the priority in returns areas, relief activities remain vital until the results of early recovery enable populations to re-establish livelihoods and basic services are restored.

Food is cited as a priority need by fresh returnees in almost all Agencies. Many returnee families have received a dedicated returns assistance package (25,000 rupee cash grant from the Government, and six months of food rations, shelter materials, and non-food items from the humanitarian community), but there has been an insufficient focus on the rehabilitation of livelihoods and services that both returnees and stayees require in their villages of origin.

Continuity of education (especially for girls), malnutrition therapy, mother and child care, including vaccination programmes during and following return, are difficult to ensure.

The humanitarian community foresees that the Government and security operationsaffected communities will require support from the international community in response to ongoing population movements - displacement as well as return.

In light of Government projections, this revised strategy document will use the following planning figures, agreed by the local authorities (PDMA and FDMA) and endorsed by the Peshawar based Humanitarian Regional Team (HRT)at the IDP Planning Workshop on 5 April 2012, for the international response required in the current year 2012 (see Annex 2):

- **April – June 2012**: Relief assistance for 125,832 increasing to 176,887IDP families plus a mix of relief and Early Recovery assistance for 26,277 families during 'transition' from IDP status back to 'normal life'.
- **July – December 2012**: Relief assistance for 176,887 decreasing to 146,994 IDP families plus 52,561 families during transition from IDP status back to 'normal life'.

5. STRATEGIC RESPONSE GOALS

Based on the current context and expected scenarios as well as updated needs assessments, the humanitarian community has jointly developed the following strategic goals to address humanitarian needs in KP and FATA in 2012:

1. Support the GOP to provide relief to IDPs in camps and host communities, to minimum SPHERE /INEE standards.
2. Support the GOP to provide assistance to IDP families as they transition to 'normal life'.
3. Support the GOP to continue relief support in areas of origin phasing into Early Recovery activities being established and meeting livelihoods and public service needs.
4. Prepare to support the government to provide appropriate and timely response to new displacement or other humanitarian needs related to security operations.
5. Support to GOP to develop and upscale protection mechanisms and to address the different needs of women and men, boys and girls in humanitarian response.

NB: Support to the GOP for the provision of Early Recovery initiatives to re-establish livelihoods and provide sustainable basic services is not included within the HOP but is dealt with separately in the Early Recovery Assistance Framework for FATA. The Early Recovery Assistance Framework for FATA and this Humanitarian Operational Plan complement each other and together provide a holistic response to the full scope of both Relief and Early Recovery humanitarian needs arising from the complex emergency.

6. CLUSTER RESPONSE PLANS

Agriculture

Cluster lead agency	Food and Agriculture Organization (FAO) of the UN
Implementing agencies	FAO, UNIDO, UNOPS, ICRC, KADO, IDEA, ZDO, IDRAK, KKT, AICD, Islamic Relief, SHID, ACTED, CEDO, S&S, The Edifiers, KhwendoKor& SSTD
Number of projects	N/A
Revised cluster objectives	Improve food security and livelihoods of security operations affected families dependent on agriculture
Beneficiaries	• 11,243 IDP's in camps (HH) • 44,597 off camp IDPs/Host communities (HH) • 13,451 returnees families
Funds requested	$7.9 million
Contact information	Andrea Berloffa, Senior Cluster Coordinator (andrea.berloffa@fao.org) 03468544177 Ruby Khan / Khalid Khan, Provincial Cluster Coordinators (khalid.khan@fao.org)

Category	Affected population				Beneficiaries (if different)			
	Female	Male	HH	Total (HH)	Female	Male	HH	Total (HH)
IDPs (in camp)*			22,486	**22,486**			11,243	**11,243**
IDPs (off camp)/Host Families*			127,419	**127,419**			44,597	**44,597**
Returnees**			44,838	**44,838**			13,451	**13,451**

*Male and Female ratio might be based on a 48 / 52 %, but it is advisable to use HH for beneficiaries' identification.
**Particular focus should be given to female headed household (widows and / or separated).

Needs analysis

Since July 2008, Pakistan's north-western areas of Khyber Pakhtunkhwa (KP) and FATA have experienced significant population movement as a result of security operations between Government Armed Forces and non-state armed groups as well as sectarian violence. At the peak of the crisis in April/May 2009, nearly three million people had fled their areas of origin, including populations from KP. The displacement trend was dynamic in the years 2010 through 2012 due to security operations in different parts of FATA. Internally displaced within KP and FATA number into the hundreds of thousands with very little hope for support as the security operations has lasted over several years, with fresh displacements occurring every few months due to ongoingsecurity operations against militants, and bouts of sectarian violence plaguing the area.

Agriculture (including livestock) is the single most important source of food and livelihood for the people of FATA. According to the PCNA conducted in October 2010, 80% of the population relies on agriculture for a large part of their income and agriculture and livestock were identified as the most critical sectors in restoring employment and livelihood opportunities across the region. Since many men work away from home, large numbers of women are engaged in agriculture while simultaneously managing households with limited access to support services. In FATA, most people are involved in subsistence agriculture and livestock rearing. Due to the harsh agro-climatic conditions, the rural economy is mainly pastoral, with agriculture only practiced in a few valleys.[11]

The security operations caused severe damages to the agriculture, socioeconomic condition, and cultural and sustainable development of FATA. The agriculture and livestock, once the backbone of tribal livelihoods, have suffered badly due to security operations and unrest. Agricultural activities were banned

[11]Post Crisis Needs Assessment, October 2010, World Bank

and the movements of the people were restricted. Large numbers of livestock were either lost or sold at lower prices, their shelters were destroyed and a substantial amount of animal feed resources in the form of wheat straw, maize stock and fodder seeds has been damaged. The reported damages to the livestock sector due to insurgency (loss or distress sales during displacement) are estimated at PKR. 7,751 Million[12].

In IDP camps that host FATA displaced families, there are none or limited shelter, feed and watering facilities, as well as veterinary services. Grazing areas around the camp are mostly barren and not sufficient to provide sustenance for the existing livestock.[13] For displaced families the possibility of retaining their animals determines the choice of living in or outside the camp. Among IDPs in KP and FATA only in New Durrani, IDPs can retain their livestock in the camp.

According to the latest progress report for the Agriculture Cluster ERF project in New Durrani Camp, the animal population has steadily increased over the last few months 2,000 animals over 5,300 animal heads (including poultry).Almost 70% of households own at least one small or one large ruminant and an average of every household owns at least one poultry bird.

Around the area of Sadda, near the New Durrani camp, 12,000 IDP families are registered with UNHCR. Estimates of livestock holdings with off camp IDP families are at least an equivalent to in camp IDPs (70%) if not greater, as they have the space to keep their livestock and access to grazing lands. Since the time of displacement, many of the IDP families are staying with host families in the area. The majority of these hosting families are small land holders that depend on agricultural subsistence farming and livestock rearing.

The protracted emergency in FATA and new influx recently, resultant in an increasing number of IDP from Khyber Agency where whole of Bara Tehsil is notified due to ongoingsecurity operation. The planning workshop on the updated status of IDP's (organized by PDMA/FDMA with active facilitation of OCHA) came to an agreement that displacements would accumulated to surpass 150, 000 families in the year 2012 with nominal returns. Agriculture based livelihoods would suffer the most with lost productivity of standing crops and physical infrastructure while negative coping strategies badly impact livestock assets. Upon returning to their place of origin, displaced population should face the challenges of damaged agriculture infrastructure and lack of inputs for reviving their seasonal crops, and unavailability of feed, shelter and graze-land for their surviving livestock.

In the aftermath of the emergency in FATA, family separation and loss of either male or female expertise in agriculture and livelihoods is a threat to food security as men and women work as partners in subsistence and small-holder farming, often sharing tasks and performing activities that the other sex does not.

Proposed strategy

The Agriculture Cluster strategy aims at addressing the most urgent livelihoods needs of displaced families living inside and outside the IDPs camps: ToghSarai and Jalozai camps in KP and New Durrani camp in FATA as well as host communities and returnees. The strategy presents valuable options for livelihoods support for IDPs, hosting communities and returnees according to the FATA Disaster Management Agency planning scenarios for 2012.

The livelihood support will be conducted with awareness of protection issues within the link between power and vulnerability and the relationship between the (political) economy and livelihoods in order to prevent neglect, exclusion and exploitation of those who may not have a voice or power to be represented, including displaced, women, elderly, disabled and other vulnerable groups. Moreover, a principled, humanitarian approach will be pursued so that the sensitivities of assisting various groups displaced in various communities (including different sects, tribes, and other considerations) is respected when delivering assistance to prevent further exacerbation of tensions and security operations.

Livestock is an integral part of rural livelihoods and a supplemental food source of nearly all security operations affected areas in FATA, and acts as a way to obtain cash quickly for poorer households, which serves to enhance their capacity to cope with shocks and reduce their economic vulnerability. For many

12 FATA Secretariat, Livestock Department and FDMA
13 FAO site visit report, September 2011

IDPs livestock and poultry are the only productive asset they have. Often when livestock is sold, though, displaced families will not be in the position to purchase new animals for themselves when in the process of returning to their homes.

Furthermore in the tribal areas of Pakistan, livestock is often the only asset to which women have real access and on which women have some degree of control. Leaving this source of livelihood unprotected would create a gender gap in the assistance. Since women and female headed households as beneficiaries form a central component in the strategy, appropriate interventions targeting these women are a must and livestock is one of the most effective sub-sectors in this context.

Protecting the small and large ruminants and poultry of IDPs in and outside of camps is critical to preserve "living assets" which support IDPs in their source of livelihood and food security. Healthy, strengthened livestock and poultry will provide IDPs, in camps and off camps (as well as with host families) enhanced household food security and increase protein and calcium component of their diet, by providing additional source of milk, meat and eggs to families, which is important for children, pregnant and lactating women and elderly, in particular. In addition, livestock and poultry can provide a vital source of supplementary income to purchase food and other basic items.

Over a protracted period of displacement, IDPs can strain hosting families' resources as they themselves have meagre incomes, hosting can cause them to stretch their resources. Therefore, support to livestock health and supplementary agricultural support will serve to enhance the food security (and livelihoods) of hosting as well as IDP families.

Agriculture-dependent returnee families will be supported with agricultural and livestock support packages to ensure the rapid recovery of food security and livelihood upon return. The Cluster will liaise with Government and other stakeholders (i.e. UN Agencies) to identify the most suitable package composition according to the area of return and predominant livelihood patterns. Packages should be distributed at the sites of return based on information provided by the Authorities.

Revised cluster objectives by beneficiaries groups

Objective: Improve food security through protection of livestock/poultry assets and support to agricultural livelihoods for immediate earning of income for IDPs in camps[14]		
Outcomes	**Indicator**	**Activities**
Protection of livestock assets	• **% of Livestock /poultry in camp provided with quality feed** • **% Livestock in camp vaccinated/treated**	Provision of Livestock/Poultry • Feed packages+ containers for feed • Health: vaccinations + treatment +care (mostly females) • Animal Shelter—semi permanent for protection from rain, cold and extreme sun)
Improved food security for targeted security operations affected IDPs	• **Improved food diversity (protein intake)** • **Number of HHs/Individuals receiving awareness training**	Provision of: • Equipment for hygienic collection and storage of animal products (milk, eggs, yogurt) • Nutritional, Food preparation & Dietary awareness: sessions with HH (mostly females)
Objective: Improve food security through protection of livestock/poultry assets and support to agricultural livelihoods for immediate earning of income for off camp IDPs/host families		
Outcomes	**Indicator**	**Activities**

[14] In camps where Authorities allow livestock to be retained

Protection/Improvement of livestock assets	• % of Livestock provided with quality feed • % Livestock vaccinated/treated • Number of Poultry Packages distributed	Provision of Livestock/Poultry • Feed packages+ containers for feed • Health: vaccinations + treatment +animal keeping awareness sessions with females • Shelter—semi permanent for protection from elements • Needs assessment of female headed households and their access to provision and protection of livestock/poultry assets • Restocking of Poultry Birds + Package
Improved food security for targeted security operations affected IDPs/hosting families	• Number of HH receiving awareness training • Improved food diversity in HHs	Provision of: • Vegetable/Pulse/Legume Packages • Equipment for hygienic collection, (production) and storage of animal products (milk, eggs, yogurt) • Nutritional , Food preparation & dietary awareness: sessions with HH—mostly females
Objective: Improve food security of men and women through protection of livestock/poultry assets and support to agricultural livelihoods for immediate earning of income for returnees/vulnerable 'stayee' families		
Outcomes	**Indicator**	**Activities**
Improved food security for targeted security operations affected IDPs/hosting families	Number of returnee/stayee HH supported with packages Improved food diversity in HHs	Provision of: • Livestock input Packages (feed, fodder, seeds, equipment, etc) • Vegetable/Pulse/Legume Packages • Poultry restocking packages
Improved agricultural production	Increase in income from agricultural production	Provision of: • Agricultural input packages • Land rehabilitation/preparation, repair of irrigation, and repair of access roads through CFW

Camp Coordination and Camp Management

Cluster lead agency	**UNHCR**
Implementing agencies	UNHCR IOM NRC
Number of projects	N/A
Revised cluster objectives	• Support GoP to provide life saving assistance to meet the immediate needs of male and female IDPs in camps and host communities • Enable sustainable safe and dignified return of IDPs to their place of origin • Provide safe and dignified return transport and return assistance package
Beneficiaries	Up to 717,000 people, including: • 382,800 IDPs (87,700 families) • 343,200 IDP returnees (78,000 families govt assumptions for return 20k SWA, 10 k Orakzai, 1.8 k Bajaur, 15 k security operations and 34 k Sectarian in Kurram) (**see detailed beneficiary table below**)
Funds requested	USD 38,008,473 against USD 51,151,910 overall requirement for 2012
Contact information	lynchc@unhcr.org, Phone: +92(0)3008153684

Category	**Affected population**			**Beneficiaries (if different)**		
	Female	**Male**	**Total**	**Female**	**Male**	**Total**
IDPs				358,500	358,500	717,000
Host communities						
Other						

Needs Analysis

Needs of Camp Populations Camps and Newly Arrived IDPs
At the start of the year there were approximately 10,000 families in IDP camps, JalozaiToghSarai and New Durrani. An influx of IDPs from Khyber began in mid January. To date some 50,000 have been displaced and a further 15,000 families from Khyber and 18,000 families from Tirah are expected in the coming months. All will seek registration and will need assistance but only 15% will seek shelter in camps. Nevertheless, new IDPs are likely to arrive without household or personal items. Basic life saving requirement is the provision of emergency shelter and household assistance and fuel for cooking as well as support required to develop their self reliance whilst in camps while household items are required for those finding shelter off camp in the host community.

Needs of Returning of IDPs
The returns of IDPs are guided by a Returns Policy Framework and Standard Operating Procedure, through the Returns Task Force, to ensure their principled nature. Some 79,000 families are estimated to seek return in 2012. Return needs vary from one place of displacement or place of origin to the next and depend also on the degree of vulnerability and duration of absence from their homes. However, in general, most IDP families require transport, and additional household items to sustain their return.

South Waziristan
The majority of IDPs from South Wazirstan are scattered amongst host communities in DI Khan and Tank. There is very limited transport available on routes to return areas in the south east of the Agency. Careful management is needed to ensure return is conducted in phases ensuring safe and dignified return. Mounting/transit centres are needed to gather, process returnee documentation and allocate transport.

Kurram
In Kurram, the two caseloads IDP face differing needs:
Some 15,000 families displaced since June 2011 as a result of security operations are expected to be able to return in the course of 2012. Of these 3,500 (16%) are living in New Durrani Camp. As areas are declared safe, IDP return for both on and off camp populations can be managed in a phased process with organised convoys from New Duranni camp and off camp temporary mounting sites.

Some 34,000 IDPs displaced by inter sectarian violence over 4 years since 2008, are making a sporadic return supported by short and medium term assistance by the authorities. Significant numbers whose homes and possessions were destroyed will need emergency shelter and household items to sustain their gradual return.

Orakzai Some 10,000 IDP families are anticipated to return to places of origin in Upper Orakzai. Camp based returnees (the most vulnerable) and an estimated 40% of off-camp potential returnees have limited transport resources. All returnees require NFIs.

Bajaur and Mohmand The homes of some 1,838 families the Loisam Corridor are completely destroyed and government security regulations prevent them from reconstructing houses on their original land. Government support is being provided to purchase new land on which to build. Some 600 families remaining in Jalozai will also return to Mohmand. Transport will facilitate their journey. NFIs and emergency shelter is needed to sustain their immediate return.

Proposed strategy

Camps: For provision of camp facilities the highest priority will be given to meeting the immediate needs of the most vulnerable who seek assistance in camps by providing emergency shelter and NFIs within the secure and well managed environments of the 3 existing camps; Jalozai,ToghSarai and New Durrani, and working alongside government authorities fulfilling their role in Camp Administration. CCCM will be conducted in the closest coordination with Protection, Health, Education, Nutrition and Food Security Clusters. CCCM meetings, with implementing partners, will be held both at the Peshawar provincial level as well as at camp level on a weekly basis. Currently all camps are accessible by national and international NGO implementing partners.

Return: For return, priority will be given to the provision of transport to vulnerable camp populations except in South Waziristan where public transport is not available. Emergency shelter/tents will be a priority for those returning to South Waziristan and Kurram. NFIs including tools both for domestic and agricultural use will help sustain initial return.

Given the differing circumstances in each place of displacement and return, detailed coordination of support to return with health, shelter and food security clusters as well as with FDMA is exercised through the Return Task Force. Furthermore, coordination is crucial with the FATA Early Recovery Working Group particularly with regard to protection, shelter and livelihood schemes for returnees, by time location and function.

Guided by the Return Policy Framework agreed with the authorities, programmes will be based on ensuring that return is informed, voluntary and safe. Thorough monitoring is possible as far forward as the dispersal points and forward distribution hubs.

Revised cluster objectives

<table>
<tr><th colspan="3">Objective 1: Support GoP to provide life saving assistance to meet the immediate needs of IDPs in camps</th></tr>
<tr><th>Outcomes</th><th>Indicator</th><th>Activities</th></tr>
<tr><td rowspan="2">20,005 families have access to emergency shelter and household assistance</td><td rowspan="2">Percentage of families seeking assistance in camps and verified eligible receive emergency shelter</td><td>1. Development and maintenance of 3 existing camps</td></tr>
<tr><td rowspan="2">2. Procurement , storage and distribution of emergency shelter and NFIs</td></tr>
<tr><td>70,040 families living off camp have access to household assistance</td><td>Percentage of families seeking assistance off camp and verified eligible receive household assistance</td></tr>
</table>

Objective 2: Enable sustainable safe and dignified return of IDPs to their place of origin Provide safe and dignified return transport and return assistance package		
Outcomes	Indicator	**Activities**
78,000 IDP families able to return in safety and dignity	# of families on camp receiving transport assistance	3. Procure and provide transportation to on camp IDPs
	# of families off camp receiving transport assistance	4. Procure and provide transportation for off camp IDPs
	# of mounting sites established	5. Establishing and maintaining mounting sites in Tank and DI Khan
	# of on camp families receiving NFI package	6. Procure and provide return NFI package to on camp IDPs
	# of off camp families receiving NFI package	7. Procure and provide return NFI package to off camp IDPs

Table of proposed coverage per site

SITE / AREA	ORGANIZATIONS
Camps: Jalozai, New Durani, ToghSarai	UNHCR NRC UNICEF WFP WHO
Return to South Waziristan	UNHCR UNICEF and IOM
Return to Kurram	UNHCR UNICEF and IOM
Return to Orakzai	UNHCR UNICEF and IOM
Return to Bajaur	UNHCR UNICEF

Education

Cluster lead agency(ies)	UNICEF and Save the Children
Implementing agencies	NRDF, HRDS, Blue Veins, Hayat Foundation, HRDN, NIRM, WFP, UNICEF, UNESCO, UNOPS, Save the Children, IRC, KWH, HOPE, NPO, IRC, Muslim Aid, CAP, Pro-Growth, BFO, Education Department (KP and FATA).
Number of projects	N/A
Cluster objectives	The overall objective is to ensure access to quality education in Child Friendly Inclusive Schools with protective environment for emergency affected children. Specific Objectives by the end of 2012: • Ensure that all children, adolescents and young people affected by the complex emergency have access to safe and well equipped learning opportunities. • Ensure that the FATA / KP Education Cluster coordinates all strategies and activities effectively with other clusters, as well cross cutting themes in close collaboration with the Government of Pakistan. • Provide PTA/TIJs and education authorities with skills to support teaching and learning for teachers and children in emergency and recovery situations.
Beneficiaries	123,654 children (3-18 years) including approximately 55,644 girls and women in camps, host communities KP and FATA: 123,654 Beneficiaries in camp schools: 47,323 (39,183 in KP and 8,140 in FATA) IDP beneficiaries in host communities: 76,331 **Children:123,654** **Teachers : 4,300** **Total Beneficiaries : 127,954**
Funds requested	KP/FATA: Camp schooling: 1,419,704 (1,175,494 for KP, 244,210 for FATA) KP/FATA: Host community schooling: $3,816,540 Total : Budget : $ 5,236,244
Contact information	Nor Shirin Md. Mokhtar. Education Specialist (KPK/FATA) United Nations Children's Fund Pakistan Country Office 14-A-1, Park Road, University Town Peshawar, Pakistan. Telephone: 92-91-5701311 Ext. 3141 Facsimile: 92-91- 5701301 Mobile: 92-345- 500 6526

Category	School Going age Children 3 to 18 years			Cluster Target Beneficiaries 70% in Camps and 15% in Off camp		
	Boys	**Girls**	**Total**	**Boys**	**Girls**	**Total**
Jalozai Camp, Nowshera	28,706	23,486	52,192	20,094	16,440	36,534
ToghSarai, Hangu	2,081	1,703	3,784	1,457	1,192	2,649
New Durrani camp, Kurrum	6,396	5,233	11,629	4,477	3,663	8,140
IDPs in Off camps KP/FATA	279,880	228,992	508,872	41,982	34,349	76,331
Total	**317,062**	**259,415**	**576,477**	**68,010**	**55,644**	**123,654**

Needs analysis

Approximately,576,477 children of school going age have been displaced by the security operations and are currently living in camps and host communities in KP and FATA. With new influx from Khyber, thechildren living in the IDP camps (in Jalozai, ToghSarai and New Durrani camps) will reach to 67,605 (including 30,422 girls) at the age of 3-18 years.Approximately508,872 school age children including 228,992 girls are living in host communities of KP and FATA. The numbers may increase as the operation in FATA is on-going, which will result in further displacement. The Education cluster aims to reach out to approximately 123,654displaced by the security operations living in KP and FATA (this is 70% camp children and 15% off-camp IDP children). These children are affected by the on-going security operations and need immediate response to engage them in educational activities to save their precious time. Restoration of education services to the IDPs in camps and hosting communities is crucial to continue students' education in a safe and protective environment. Through educational assistance, the children will have access to the educational services to have life-saving information. This education response will include setting up camp schools, training teachers and establishing/re-activating PTCs/SMCs under the guideline of CFS and the Inter-Agency Network for Education in Emergencies Minimum Standards.

Revised strategy

The Cluster aims to reach the caseload of123,654 children through a minimum package (INEE standard) basic education services till December 2012. The intervention will ensure maximum enrolment of girls' and boys' students in the schools. The strategy will include:

a) Support IDP camp Schools in Jalozai Camp, ToqhSarai Camps Hangu and New Durrani Camp in Kurram; including additional case load from Khyber agencies.
b) Establish second shift primary to secondary schools in the affected host communities of KP and FATA.

The education package will include provision of teachers, education supplies, School in a Box, recreational kits, student's stationeries, and relevant educational equipment's. More over parents and mother support groups will be established and trained to support the schools and increase the enrolment.

Cluster will also ensure safe and child friendly temporary school facilities including latrines and water facilities that are gender/age sensitive in design. Teachers with minimum qualifications will be hired and trained on child friendly schools, life skill based education and emergency response.

Within the camp schools for the age of 3-6 years children, ECE Centres with minimum learning facilities will be established on successful intervention in the country. Teachers' particularly female teachers/caregiver will be trained on ECE approach.

The main strategic directions would be access to quality education. To identify the most vulnerable, children community mobilization campaign will be launched to enrol the children. Moreover community and parents will be sensitized on child rights and importance of children education.

To ensure accountability and sustainability of the activities different stakeholders including community, relevant government district education department, camp authorities, FDMA and PDMA will be involved to play an active role in children education. For this purpose PTCs/TIJs, student councils and community level committees comprising of parents, *Shura*members, religious leaders, camp administration and children, will be formed.

Prioritized Cluster Activities: The following activities have been prioritized to respond to the urgentneeds of children to continue learning, resume their disrupted schooling and experience somenormalcy in their lives:

- Initially, non-formal schooling will be started for children in camps which would later be converted into formal primary, middle and secondary level schools.
- Organize second shift primary, middle and secondary level classes in existing Government schools for IDP children in host communities in KP and FATA.
- Support for reactivation and strengthening of non-formal basic primary education in Kurram Agency and 1IDP camp.
- Organize functional literacy classes with follow-up programmes in camps and in host communities for youths and adults, especially adolescent girls and women.
- Procure and distribute assorted school supplies to all categories of children and teachers.

Revised cluster objectives

• **Objective:** Children have access to quality education through child friendly schools in the target camps to bring them to normalcy		
Outcomes	**Indicator**	**Activities**
Children in IDP camps and host communities have access to basic education services in safe and secure environment	# of children in IDP camps and # of children in host community have access to the camp and out of camp schools	- Identification and assessment of school age children - Establishment of schools and provision of basic educational supplies
Establish/Strengthen ECE section for the children of age group of (3-6) years of the total 8% target group;	# of children have access to ECE facility	- Establish/Strengthen ECE section by improving the learning environment in ECE standard - Train teachers on ECE
4,300teachers are trained in child friendly teaching techniques	# of teachers are responding to CFS teaching including basic life skills education and emergency response	Organize 3-days training workshop and refresher courses to 4,300teachers on Child Friendly schools, life skill based education and on emergency response.
Establish/strengthen and train School management Committees (SMCs)	# of SMCs established and trained on their roles and responsibilities	- Establish/strengthen SMCs in the camp and out of camp schools - Train SMC members on roles and responsibilities in all the proposed schools
• **Objective:** Child friendly learning and physical environment is developed in the schools to ensure enrolment and retention in the schools.		
Outcomes	**Indicator**	**Activities**
Provision of tents/rented building with basic facilities in and out of camp schools	# of camp and out of camp schools have child friendly physical learning environment	- Re-open schools though temporary arrangement (in tents or rented building)
Provision of missing facilities/ minor repair of the existing government schools hosting the IDP children	# of schools repaired/provided missing facilities	- School repair initiated through PTCs with small grand

Table of proposed coverage per site

SITE / AREA	ORGANIZATIONS
IDP camp Toghsarai, Hangu	NGOs, INGOS, District Education Department
IDP Camp Jalozai, Nowshehra District	NGO/INGO, Government Education Department
IDP Camp New Durrani, Kurram Agency	NGO, Government Education Department
Host communities in KP, FATA	NGOs/INGOs, Government Education Department

Food

Cluster lead agency	**World Food Programme**
Implementing agencies	WFP
Number of projects	
Revised cluster objectives	**To save lives, protect livelihoods and restore access to other socio-economic opportunities** 1. To save lives and avert hunger among conflict-affected families, and prevent declines in the nutritional status of the most vulnerable (infants and young children) 2. To improve household food consumption 3. To increase access to income-generating opportunities and recover productive assets 4. To increase enrolment and retention of children in assisted primary schools
Beneficiaries	Up to **191,832 conflict-affected families** (or **1.3 million individual beneficiaries**), including: • 125,832 existing registered IDP families and recent returnees • 51,000 newly-displaced families from Khyber (Bara Tehsil and the Tirah Valley) • 10,000 displaced families in Hangu (pending registration and previously assisted by ICRC) • 5,000 IVAP-identified displaced families pending registration Note that approximately 12,000 families returning to Kurram during the year will be supported through food-for-work and school feeding activities (included in the above)
Funds requested	**2012 Gross Requirements: US$164,152,220** **2012 Current Shortfall: US$63,927,087 (39%)**
Contact information	WFP Diplomatic Enclave Islamabad Pakistan

Category	**Affected population (Est.)**			**Beneficiaries (if different)**		
	Female	**Male**	**Total**	**Female**	**Male**	**Total**
Conflict-Affected IDPs and Returnees	657,984	684,840	1,342,824	657,984	684,840	1,342,824

Needs analysis

Since late-2008, protracted fighting across Pakistan's Khyber Pakhtunkhwa (KP) province and the Federally Administered Tribal Areas (FATA) led to mass internal population displacement: severely and abruptly compromising the food security of affected groups and resulting in considerable destruction of assets and productive capacity. WFP immediate response actions are designed, in the first instance, to save lives and avert hunger through the conduct of unconditional relief food distributions. With a majority of those who had earlier been displaced since voluntarily returning to their homes, alternative forms of food assistance have also been required. Over a longer planning horizon, the potentiality of protracted de-stabilization and entrenching vulnerability have called for both the continued provision of life-saving relief assistance to those still displaced, and robust early recovery support in areas of origin to sustain the return process and help restore access to livelihoods and other socio-economic opportunities.

Following the most recent incidences of population displacement from FATA's Khyber Agency (amid an expansion of security operations in new areas), close to 177,000 families are estimated to currently be displaced from their homes. With the addition of 15,000 recent-returnee families (still requiring support), it is expected that life-saving relief food assistance will be required for a total of close to 192,000 families over the next 6-9 months.

Of this total, some 51,000 families are newly-displaced from the Bara Tehsil and Tirah Valley of Khyber (of which, an estimated 85 percent will likely require assistance in off-camp areas). In addition to some 10,000 families still to be registered in Hangu (and for whom assistance was previously provided by ICRC), the UN IDP Vulnerability Assessment and Profiling (IVAP) exercise has identified 5,000 families for whom registration documentation is being sought and will thereafter also be provided with food assistance. As such, the Food Cluster response plan includes an additional 66,000 newly-displaced and/or newly-registered families not accounted for in previous plans.

A range of assessment exercises have continued to advocate emergency food assistance as a key priority response for those still displaced or only recently able to return home. The recently-conducted inter-agency rapid needs assessment of off-camp Khyber IDPs in April 2012 revealed that food remains a priority need amongst 80 percent of displaced families. The survey also noted the inadequate availability of complementary food for infants among the affected population. A July 2011 UN IDP Vulnerability Assessment and Profiling (IVAP) exercise (periodically conducted with the aim of assessing household-level vulnerability amongst residually-displaced groups) determined that food remained the highest priority need requested by IDPs, and that some 65 percent of the surveyed population continued to suffer from either a poor or borderline Food Consumption Score. The displaced population is also characterised by IVAP as economically marginalised (some 70 percent are found to be living below the national poverty line). As observed by both the IVAP and the rapid needs assessment of off-camp Khyber IDPs, a majority of current IDPs are living outside camps and are reliant on temporary and irregular daily wage labour opportunities to meet their basic needs: risking greater deteriorations in food security and nutritional status.

Proposed Strategy

Families displaced from their areas of origin by conflict or only recently able to return home, and holding necessary documentation as a result of passing through a rigorous registration and verification process, are eligible for WFP relief food assistance. This includes those displaced for protracted periods and found still to be vulnerable and in need of external assistance by the IVAP exercise.

Relief food distributions are conducted on a monthly basis, with the general family food basket consisting of: fortified wheat flour, pulses, salt, and vegetable oil. Blanket supplementary feeding for infants and young children is conducted alongside general distribution of the family food basket. Ready-to-Use Supplementary Food (RUSF) is supplied to children between the ages of 6 and 23 months, and those aged 2-12 years receive High Energy Biscuits (HEB). Based on average observed population statistics, each family receives rations of RUSF for one child and HEB for two.

WFP plans to maintain emergency food distributions during the anticipated period of displacement and thereafter supplemented by a return package of assistance. The latter will be crucial in facilitating the return process by ensuring that basic needs continue to be met despite adverse availability and access conditions at home, and allowing complementary recovery efforts to proceed unhindered by immediate food security concerns.

Distributions are conducted on a monthly basis, in order to balance meeting the immediate food needs of beneficiary groups with the logistical challenges associated with wide-scale activity in insecure locations.

Beneficiaries receive their household rations directly from distribution points within camps or from 'humanitarian hubs' (established by WFP in close proximity to where conflict-affected groups are residing). These hubs help to reach even the most isolated communities, and also serve as a platform for the supply of non-food items and other humanitarian services.

The overarching strategy for implementing food delivery and distribution is as follows:

- Establishing and managing in-camp distribution points and humanitarian hubs at suitable sites;
- Managing the logistics chain, including milling and fortification of wheat;
- Identifying and building capacity among cooperating partners, to ensure the timely and effective delivery of assistance according to established distribution plans;
- Distributing food assistance to eligible beneficiaries;
- Monitoring food distributions; and
- Reporting on the progress of food distributions, including through the cluster/working group forum.

WFP explicitly aims to facilitate the receipt of relief rations by women and female-headed families (an estimated 10 percent of all those supported). Separate distribution counters and waiting areas are established for women at distribution points, and at which female staff are deployed. Assessment teams aim to include women where possible and beneficiary data is disaggregated by gender.

WFP will continue to work closely with a multiplicity of stakeholders, including: other humanitarian providers engaged in food assistance activities; counterpart agencies sharing common coordination and response mechanisms; and relevant government departments. The Food Cluster forum (led by WFP) will be used to maximize coordinative opportunities and ensure effective and timely joint responses.

Alongside the escalating return process – symptomatic of some stabilization across areas of origin – WFP is additionally implementing a range of early recovery activities for conflict-affected groups. These aim to simultaneously maintain adequate food consumption and forestall more protracted socio-economic declines. Through educational support measures, schools are used as a mechanism to target the most vulnerable families with staple food rations, while additionally encouraging children to return to school. Marginalized farmers and landless households are targeted for participation in food-for-work (FFW) activities aimed at rebuilding livelihoods and community and household assets, and provided with family food rations in compensation for their labour inputs. Targeted nutritional support initiatives treat screened cases of moderate acute malnutrition amongst young children and pregnant/lactating women, while promoting greater access to and utilization of healthcare services.

WFP will maintain relief food distributions for all currently-displaced and returnee families in KP and FATA (the latter for up to 6 months within their places of origin). This includes the newly-displaced and/or newly-registered identified above, and will be provided in accordance with an ongoing re-assessment of food needs. Targeted nutritional support will additionally be provided to moderately acute malnourished children aged 6-59 months and pregnant and lactating women, as outlined and budgeted for under the Nutrition Cluster. Livelihood and school feeding support will be supplied to returnees in FATA's Kurram Agency[15]. These early recovery activities are also imbued with explicit gender equity objectives: with girls' facilities in many areas targeted for priority assistance under the school feeding programme, nutritional support initiatives addressing women's needs specifically, and livelihood-support activities involving female community members in project design even where cultural norms restrict their participation in actual implementation.

Although additional new and previously-unforeseen population displacement may occur during the remainder of the year, it remains unclear at what scale this might occur and in what manner (whether in KP or FATA, or whether into camps or hosting areas etc.) At the same time, a greater number of families is expected to return to places of origin (particularly to Kurram, Orakzai and South Waziristan), though the precise timeframe and pace remains unclear at this point.

This fluidity in the overarching situation, in addition to changes in the food commodity pipeline, would necessitate regular adjustments in WFP's distribution infrastructure (both in camps and off-camp areas of KP and FATA), so that the food needs of affected populations are effectively addressed both during times of displacement and return.

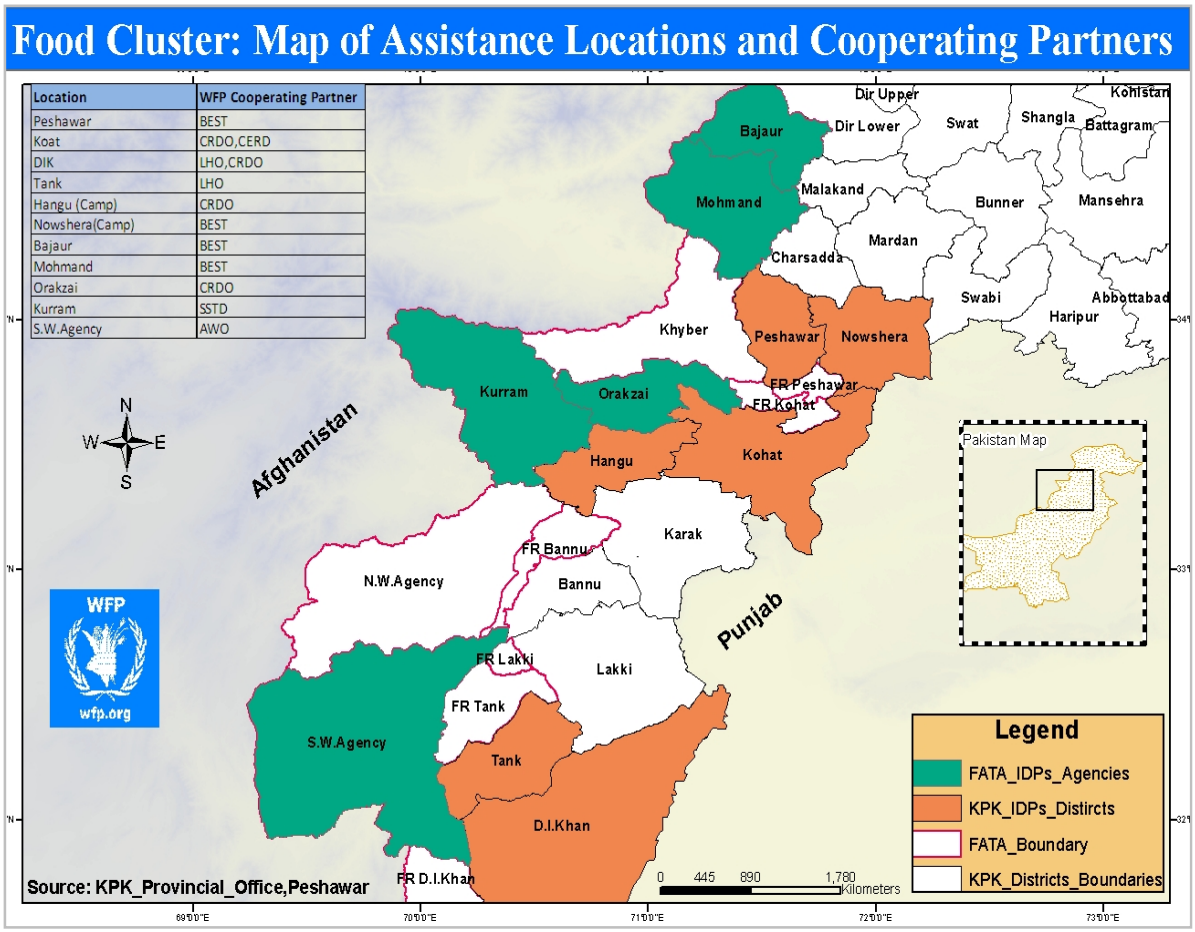
[15] **HOP Executive Summary:** "...All humanitarian needs for Kurram Agency, Kurram (both relief and early recovery), are included as there is no current Early Recovery plan for that agency."

Revised cluster objectives

Objective: Increased food security (Restore and Rebuild Lives and Livelihoods in Post-Conflict, Post Disaster or Transition Situations).		
Outcomes	**Indicator**	**Activities**
General Food Distributions		
Improved food consumption over the assistance period for targeted conflict-affected persons	• 80% of Households will have acceptable Food Consumption Score • Number of women, men, girls and boys receiving food, as a percentage of planned • Tonnage of food distributed, as a percentage of planned	Unconditional (relief) food distributions
Improved/stabilized nutritional status of infants and young children	• Number of children given food under blanket supplementary feeding • Quantity of supplementary foods distributed • Mid-Upper Arm Circumference (MUAC)	Unconditional (relief) food distributions: blanket supplementary feeding
Food for Assets (Livelihoods Early Recovery)		
Livelihoods of the affected population improved through recovery of critical assets and generating livelihoods opportunities.	• Each recipient HH will receive food basket (91 kg)[16]per month in lieu of their able bodied man and women participation in livelihoods early recovery activities. • Based on criteria 10% recipient families (vulnerable) will get unconditional food. • 20% recipient will comprise of Food For Training (FFT), • 7% of women participants will rehabilitate kitchen gardens. • Crop cultivation of 60% of the total affected farmers will be restored. • 60% of the critical livelihoods physical infrastructure.	Food for Work (FFW) and Food for Training (FFT)
Food for Education		
Enrolment of girls and boys in assisted schools in crisis affected areas are stabilised at pre-crisis levels and make progress towards the national average	• 25,000 of girls and boys receiving take home ration (Vegetable Oil 4.5 kg bi-monthly) • 25,000 of pre-primary and primary school girls and boys receiving fortified HEBs. • Retention, net enrolment and attendance rates of boys and girls reaches pre-crisis levels in 80% of WFP-assisted schools • Enhance 15% gender ratio in WFP-assisted schools • 80 WFP-assisted schools • 25,000 families receiving take-home rations • Tonnage of food distributed as percentage of planned, by commodity	Food for Education (FFE)

16) Food Basket 91kg: Fortified Wheat Flour: 80 kg, Pulses: 4kg, Vegetable Oil: 4.5kg, Salt: 1kg & RUSF: 1.5 kg)

Table of proposed coverage per site



Health

<table>
<tr><td>Cluster lead agency</td><td>World Health Organization</td></tr>
<tr><td>Implementing agencies</td><td>WHO, UNICEF, UNFPA, UNOPS, DoH KP and FATA, national and international NGO partners</td></tr>
<tr><td>Cluster objectives</td><td>The overall objective of the Health Cluster response plan is to improve the health conditions of IDPs and hosting population in hosting districts of Kohat, DI Khan, Tank, Hangu, Peshawar and Nowshera of KPK and IDPs in Jalozai, New Durrani and ToghSaray camps, supporting the returning population of agencies in FATA through strengthening, provision of/and maintaining essential life saving health services interventions reducing morbidity and mortality.

Specific objectives:
• To ensure the provision of essential life saving Primary Health Care (PHC) services (including Maternal New-born and Child Health /Reproductive health, mental health and psycho-social support) at community level and in facilities for all crisis affected population especially for women and children, elderly, and people with disabilities;
• To address the emerging public health threats in a timely and appropriate manner by implementing and expanding the Disease Early Warning System (DEWS) and response to all the affected areas of displacements and camps;
• To ensure the delivery of the health response in a coordinated manner and according to SPHERE, Global Health Cluster and National Health Standards.</td></tr>
<tr><td>Beneficiaries/
Population caseload</td><td>
<table>
<tr><td>Expected IDP population caseload:</td><td>Families</td><td>Size</td><td>Individuals</td></tr>
<tr><td>A. Population on 02/4/2012</td><td>125,832</td><td>7</td><td>880,824</td></tr>
<tr><td>B. Population on 01/7/2012</td><td>176,887</td><td>7</td><td>1,238,209</td></tr>
<tr><td>C. Population on 31/12/2012</td><td>146,994</td><td>7</td><td>1,028,958</td></tr>
<tr><td></td><td>Average</td><td></td><td>1,049,330</td></tr>
</table>
</td></tr>
<tr><td></td><td>Demographic Estimation of Health in Emergencies
<table>
<tr><td></td><td>Context Population</td><td colspan="2">Programming Groups</td><td>%</td></tr>
<tr><td>Total Population</td><td>1,049,330</td><td colspan="2" rowspan="2"></td><td></td></tr>
<tr><td>1. Male (52%)</td><td>545,652</td><td>52%</td></tr>
<tr><td>2. Female (48%), including:</td><td>503,678</td><td>257,883</td><td></td><td>48%</td></tr>
<tr><td>A) Child bearing age (48.8% of female)</td><td></td><td>245,795</td><td>48.8%</td><td></td></tr>
<tr><td>Sub-total:</td><td>1,049,330</td><td colspan="2"></td><td>100%</td></tr>
<tr><td>3. Population below 15 years, including:</td><td>455,409</td><td>221,933</td><td></td><td>43.4%</td></tr>
<tr><td>A) Newborns 7% of total Pop under 15 years</td><td></td><td>78,175</td><td>7.45%</td><td></td></tr>
<tr><td>B) Children (Below 5 years excluding newborns)</td><td></td><td>155,301</td><td>14.8%</td><td></td></tr>
<tr><td>4. Population 15 - 64 years, including:</td><td>557,194</td><td>518,369</td><td></td><td>53.1%</td></tr>
<tr><td>A) Pregnant Women 3.7 % of 15 - 64 population</td><td></td><td>38,825</td><td>3.7%</td><td></td></tr>
<tr><td>5. Elderly (Above 65 years)</td><td>36,727</td><td colspan="2" rowspan="2"></td><td>3.5%</td></tr>
<tr><td>Total:</td><td>1,049,330</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>Funds requested</td><td>US$18,827,792</td></tr>
<tr><td>Contact information</td><td>Dr. Jorge Martinez, Chief of EHA Operations/Health Cluster Coordinator
WHO Islamabad
Email: martinezj@pak.emro.who.int,

Dr. Azret Kalmykov
Health Cluster Coordinator KP/FATA
WHO Peshawar</td></tr>
</table>

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Needs analysis:
In the aftermath of the influx of IDPs in Khyber Pakhtunkhwa and FATA, Health Cluster placed a great emphasis in ensuring that risks related to lack of safe water, proper sanitation and hygiene get recognized early and properly managed, so as to ensure the control of communicable diseases, with special focus on the vulnerable IDPs camps, hosting districts and the devastated returnee areas.

The latest influx of IDPs from Khyber Agency and settlement in and around "Jalozai" IDP camp in the district of Nowshera raised significant concerns and issues for health cluster to be put in place to ensure the preparedness and response of local health care system to the increased burden of already weakened health services.

A rapid assessment was conducted by WHO field teams in the IDP hosting health facilities (UC's were identified by IVAP) in DI Khan, Tank, Hangu and Kohat from 31-01-12 till 01-02-12. The objectives of the assessment weretoassess the overburdened health facilities in selected union councils as identified by OCHA/ IVAP in the four IDP hosting districts (DI Khan, Tank, Hangu and Kohat); to assess the health service delivery network in the districts, to collect, compile and analyze as much information as possible to identify gaps in terms of provision of services, disease trends, human resource, equipment, essential drugs and referral services; and to analyze the coverage and needs in respect to the provision of adequate and appropriate health care services in the IDP hosting areas.

A total of 65 public health facilities were assessed in four districts of KP, including district headquarter hospitals, tehsil HQ hospitals, rural health centers, basic health units and civil dispensaries.

In addition, in April 2012 WHO completed the HeRAMS (Health Resources Availability Mapping System) for all 25 districts of KP. A special focus was made on health care system gaps and weakness in the district of Nowshera, including 3 union councils (Dag Ismail Khel, Dag Behsood and Jalozai) hosting most of off camp IDP population from latest influx from Khyber Agency.

Influxes of population due to displacement have further increased the burden on the already under-resourced health care system of the districts of KP including Kohat, Hangu, Tank, DI Khan, Nowshera and Peshawar as well as in Kurram Agency. If a timely assistance is not provided, the mortality rates are likely to increase, mainly due to the lack of the access to the health care, especially for trauma and infectious diseases. There are evident gaps in the capacity of the health care providers in handling emergency situations. The provision of comprehensive primary health care services is urgently required for the returnees and displaced populations of the affected areas of KP and FATA. There is also a need to support the supply chain mechanism of the essential medicines. This includes both provision of medicines in adequate quantity and emergency infrastructural support to ensure necessary storage practices. Special attention and assistance needs to be given to the vulnerable groups including elderly, pregnant women, disabled etc. Large numbers of IDPs are still staying in three camps i.e. Jalozai (Nowshera), ToghSarai (Hangu) and New Durrani Camp (Kurram) while the predominant number is in host communities of DI Khan, Tank, Kohat, Hangu, Nowshera and Peshawar districts.

The already resource constrained health facilities report increased number of IDPs applying for regular health care, and, especially, specialized paediatric services. There is a definite need to strengthen these hospitals through filling of human resource, supply, equipment and technical capacity gaps.

Preventive programs especially Lady Health Workers Program, MNCH Program and EPI are the most affected. Due to many factors, including security situation and restriction on movement of females, community health workers (LHWs) are not able to perform their duties optimally. There is a need to revitalize LHW Program to provide PHC services at the doorstep of the affected communities. Similarly Community Midwives of MNCH program need strengthening through provision of midwifery kits, other relevant supplies and refresher trainings.

Under the immunization coverage during the displacement, most vaccination services and activities were interrupted in the government-run health facilities due to weak or non-functional facilities; unavailability of electricity or fuel for generators; movement restrictions in insecure areas (specially Tank, DI Khan and Hangu) affecting the distribution and delivery of vaccines; and shortage or absenteeism of health facility or field staff.

Water quality monitoring and control is also of paramount importance in controlling the spread of water borne diseases. Water quality monitoring and treatment should be conducted to avert waterborne diseases and health education and hygiene campaigns will be conducted to educate the communities on hygiene and safe drinking water

and effective health seeking behaviour. In addition, viable technical strategies for waste disposal will be promoted to ensure patient safety and local environmental health.

Health Cluster partners under the leadership of WHO work in partnership with government are focusing on primary health care (PHC) service delivery, early detection and response to outbreaks, rehabilitation of health facilities with appropriate water supply and latrines, warehousing of contingency medical supplies and equipment, referral system strengthening, and provision of life-saving drugs. A standardized package of PHC service delivery has been developed and cluster partners are helping existing public healthcare facilities to cater for the health needs of most vulnerable population including women, children and elderly. The health cluster partners are contracted for provision of PHC services where government resources are inadequate.

Overall primary health care (PHC) services delivered in targeted districts in for IDPs in KP are assessed as poor. This is coupled by the fact that first referral health facilities as well lack the very essential services required to improve and promote the health of groups at risk such as mothers and children. The service delivery deteriorates in all IDP districts as compared with similar study in 2009/2010 and remains stagnant considering increased number and influx of IDPs in the area. Health facilities in IDP hosting districts illustrate a lack of resources including unavailability of qualified HR, services, equipment and supplies as major factors which lead to their continuous overburdening. Unless intensive interventions and commitment of partners little progress will be witnessed to address the needs of IDPs and reduce maternal and child mortality.

Assessing communicable diseases and outbreaks in IDP hosting districts there is a clear indication of similarities of trends of seasonal diseases. The proportional morbidity for Acute Diarrhea shows two peaks – one in spring and one in late summer. The seasonal trend for Acute Respiratory Infections (ARI) shows a consistent peak in late January each year. The analysis showed that 2010 summer was worst for AWD/ cholera while measles and pertussis were prominent threats in spring and winter of 2011. Both AWD and Measles spread rapidly where population is congested and poverty-stricken, conditions existing in camps and areas where IDPs have joined hosting populations for temporary stays. Control of cholera depends on awareness and capacity of communities to find safe drinking water. Measles epidemics threaten where children have not been immunized, and measles mortality is worst in under-nourished children. There is an increasing risk for cholera and measles in the camps and hosting districts.

Communicable disease always put significant percentages on overall disease burden as well as mortality rates and availability of essential medicines always vital to response not only epidemics but also can serve basic health needs of the majority of the population. It is quite alarming that supplies of key essential medicines at first level health care facility averaged less than 50% of all the health facilities assessed.

Water and sanitation infrastructure need urgent attention. More than 50% of hospitals dump away their waste without any safety control measures as proper healthcare waste management is not implemented posting a threat to the surrounding population, with the risk of contaminating the ground water and other environmental health risks. Water supply is available in 74% of health facilities and electricity for 81%. 40% of health facilities do not have any functioning toilets. 80% of HF have damaged/blocked sewerage system and water supply pipes. 90% of water samples collected from assessed hospitals have shown microbiological contamination. District Tank has acute shortage of drinking water problems as the water table is very low. Sanitary staff is available only in 10% of the hospitals. General hygiene and safe drinking water are of major concerns requiring immediate health education awareness campaigns in all districts.

Response strategy:

i. Health Cluster Coordination, Emergency Preparedness and Humanitarian Response and Disaster Risk Management

In support to the provincial and FATA Directorates of Health, the World Health Organization as the Health Cluster lead, along with cluster partners, is ensuring that:

- A coordinated response is put in place to ensure delivery of health services to the most vulnerable;
- The communicable disease surveillance and outbreak response system is expanded and is robust for timely detection of disease, and prevention of outbreaks;
- Stocks of necessary medicines and supplies are delivered to warehouses, as requested by the health authorities;
- Water and sanitation condition is improved in the targeted agency/areas.

The Health Cluster has set up an effective and efficient mechanism of coordination at provincial and national level whereby the health partners share/map the information, produce situation reports and 'who is doing what and where' matrix. The information is used to identify the gaps and plan the response activities. Information management activities will also be strengthened at all levels to guide decision making, identify needs and critical gaps, and monitor impact of interventions. Communication and information Management (C&IM) will provide continuous updates on health cluster interventions by developing Who, What and Where (3W), and health maps using GPS coordinates. Newsletters, Health Bulletins, situational reports and web sites will be produced to inform partners as well as the general public on health interventions and needs. Communications will be responding to, and lobbying for effective collaboration and sensitization of media as well as utilizing their resources to address the wider audience. Brochures, information, education and communication messages (IEC material), pictorial coverage of health cluster initiatives, outbreaks, disaster reports, video interviews, documentaries as well as developing need / human interest, success stories and messages via channels of mass media communication will be used.

Under the health response in emergencies health cluster has to ensure provision of support to national and provincial health authorities in strengthening their capacity in risk reduction, emergency preparedness and timely and efficient response to disasters. The DRM support will help in reducing, mitigating, preparing for and respond to public health risks to vulnerable populations and hence prevent avoidable mortality and morbidity through improving access to health care for affected populations and putting effective disease control measures in place.

HeRAMS (Health Resources & Services Availability Mapping System) is a standardized approach supported by a software-based IT Platform that aims at strengthening the collection, collation and analysis of information on the availability of health resources and services in humanitarian emergencies. It supports WHO, Department of Health, and health partners better achieve the provision of equitable, relevant and efficient health services and better allocate resources towards fulfilling humanitarian needs and ensuring their sustainability beyond humanitarian interventions.

ii. Provision and strengthening of essential package of Primary Health Care services (including live saving medicines and supplies)

Ensuring that government health facilities in the affected areas are made operational through provision of essential medical equipment and provision of necessary medical male and female staff through health cluster partners and support to health department. Continuation of provision of essential primary health care (PHC) services including activities within the Minimum Initial Service Package (MISP) for reproductive health will be ensured. Mass vaccinations/immunization campaigns and awareness campaigns of healthy practices for the masses would be launched for the community.

The foremost requirement that has been identified is the dearth of human resource which immediately needs to be addressed. Therefore, relevant health personnel would be duly appointed at the targeted health facilities and special incentives would be given to female staff working in the security compromised areas. This could also be carried out by out sourcing to partner NGOs with due consultation of Department of Health.

Provision of emergency health services, for basic care of under-five children, would be ensured by establishing under 5 clinics in all health facilities where Integrated Management of Newborn and Childhood Illness (IMNCI) strategy will be implemented. Maternal and Newborn care would be provided through Basic Emergency Obstetric Care (BEmOC) and Essential Newborn Care (ENC) packages respectively. The health care providers would be trained on IMNCI, ENCC and Basic EmOC for enhancement of their skill and knowledge through the outsource partners.

Routine vaccination would be accelerated by increasing the number of vaccination sites with specific emphasis to Polio, Measles vaccination, Maternal TT and vitamin A supplementation. Moreover, mass communication and social mobilization activities would also be undertaken for awareness of the masses on healthy practices and protection from diseases.

Rehabilitation/ reconstruction of assessment identified partially damaged and full destroyed health facilities including water supply and storage and/or setting up of ad-hoc temporary health facilities to revitalize the primary health care services will be ensured with the support of the Department of Health.

Provision of life saving essential medicines and supplies

Uninterrupted and sustained provision of essential medicines, medical supplies, and equipment has been critical to health delivery at all levels of health service delivery. The Essential Medicine package provided during the relief

phase covers the treatment for communicable diseases, non-communicable diseases, MNCH related medicines, paediatric preparation and item for the minor surgery, as well as maintained the contingency stock of key medicines for preparedness and response to alerts. These lifesaving interventions played a vital role in reducing the incidence of morbidity and mortality. In addition the provision of essential medicines increased the utilization of underutilized public health facilities evident from the consultation data (increased from 0.12 visits per capita per annum to 0.8 visits per capita per annum).

Essential medicines and supplies will be provided on regular basis to avoid any lapse in the delivery of essential healthcare. Geographic stockpiling will be planned for in a way that allows immediate response to outbreak alerts as well as for the district. Medicines will be bought and imported in accordance with the National and WHO essential medicines list. In order to reach population faster, medicines and equipment will be purchased and dispatched in ready-to-deploy kits. Some kits will require international air shipment to ensure timely availability and delivery.

Capacity of the health partners and Department of Health staff will be enhanced on medicine management. The essential medicines team set up within the coordination mechanism will monitor the rational use, storage and dispensing activities. The Logistic Support System (LSS) installed at district for transparency and traceability of supplies will be expanded. Essential Medicine Team (Pharmacists) is working to check the rational utilization of medicines and capacity building of the health care providers (implementing partners and government health department) on evidence based quantification and adherence to the standard treatment protocols.

iii. Communicable Diseases Control, including Diseases Surveillance and Response, Environmental Health, control of Malaria, Leishmaniasis and Dengue.

In view of the threats of water-borne diseases such as Cholera and Dysentery and the vaccine-preventable diseases such as Measles, Pertussis and Dysentery, support to the Disease Early Warning System (DEWS) for early detection and response to epidemics is crucial for reducing morbidity and mortality from communicable disease in the camps and among the IDPs in the hosting districts.

While in some areas of the country, the provincial governments are taking on the challenge of running DEWS, in the targeted IDP hosting districts of Khyber Pakhtunkhwa and in FATA, the government does not have the resources or capacity to implement DEWS. WHO requires funding to continue support to DEWS for 2012 to respond to the epidemic threats in the areas of greatest risk due to: crowding, poverty, under-nutrition, poor coverage of immunization and health services, unsafe water supply, and inadequate sanitary facilities – the vulnerable IDP populations in camps and hosting districts.

DEWS teams will continue efforts to mitigate morbidity and mortality caused by epidemic-prone diseases through alert and outbreak detection and timely and effective response. DEWS team includes an Environmental Health Engineer to address water-borne disease outbreaks, and implementation will be linked to efforts by the Nutrition and WASH Clusters, and other Health Cluster stakeholders to provide an integrated response to prevent and control spread of communicable diseases. Support to DEWS operations requires logistical support for investigation of alerts and response to outbreaks and for active surveillance and data collection from peripheral facilities.

In addition to control of communicable disease, DEWS provides public health professionals on the ground in the targeted districts and agencies for immediate reporting of any public health event to the health partners as well as weekly reporting of disease trends seen in the health facilities. DEWS team analyzes data on a weekly basis and disseminates a report to all government and non-government partners. The new “eDEWS” or electronic online DEWS will be introduced in the targeted districts to further streamline the information collection system and timely alert detection and response.

By sharing weekly analysis of disease trends and disease alerts and outbreaks at provincial and FATA Directorate levels, DEWS will also play a role in health education for care of newborns and young children; advocacy for immunization; prevention and control of waterborne diseases; infection control in hospitals; vector control; water quality testing; sanitation and hygiene promotion. DEWS focal persons in each health facility and district/Agency team will be nominated by the local authorities and will be trained on standard case definition, data collection, alert generation, and reporting and will jointly investigate and respond to outbreaks.

Prevention and control of waterborne diseases

Sanitation facilities and hygiene conditions amongst the affected population and in the assessed health facilities is very poor. Hygiene and safe drinking water is a major concern. Health education awareness campaigns should be increased in all the districts.

The following activities will be implemented:

- Improve water quantity and quality of the healthcare facilities serving affected communities;
- Improve water quality and quantity and sanitation facilities addressing specially needs of women (keeping privacy);
- Health facility sanitation services of critical units of the health facility will be improved, with repair of existing latrines where necessary, with female health workers and patients access to appropriate and separate (male/female) sanitation facilities ensured;
- Provision/repair of hand-washing facilities in critical units of the health facility, where needed as per accepted standards;
- Provision of soaps, detergents and other health facility disinfectant chemicals, to improve overall hygienic conditions and infection control mechanisms of the critical units of the health facility;
- Equipment, hand tools and other supplies (waste bins of different sizes, brooms etc) needed for the collection, transport and safe disposal of healthcare waste will be provided;
- Personal protective gears (clothes, gloves, boots, aprons, etc) will be supplied to sanitary workers;
- Conduct healthcare hygiene promotion and awareness raising trainings in each health facility, for senior medical staff, nurses and sanitary worker, with focus on infection control;
- Provision of hygiene and healthcare infection control education materials (messages, pamphlets, brochures etc)
- Adequate detailed information regarding the hazardous nature of waste material to persons responsible for its handling, transport, treatment, storage or disposal will be provided;
- Hazardous wastes handling staff will be provided with appropriate safety devices such as safety masks, goggles, hand gloves, and boots;
- Adequate Occupational Health and Safety (OHS) standards will be introduced at facilities handling hazardous wastes
- Conduct regular water quality surveillance affected areas, and routinely disseminate microbial water quality results and trends with all WASH partners;
- Monitor the environmental health conditions (safe water surveillance, sanitary and hygiene conditions) of affected communities, with special focus on inside camps IDPs;
- Support water borne diseases alert response, through water quality testing, disinfection and hygiene promotion.

Provision of life saving essential medicines and supplies

Uninterrupted and sustained provision of essential medicines, medical supplies, and equipment has been critical to health delivery at all levels of health service delivery. The Essential Medicine package provided during the relief phase covers the treatment for communicable diseases, non-communicable diseases, MNCH related medicines, paediatric preparation and item for the minor surgery, as well as maintained the contingency stock of key medicines for preparedness and response to alerts. These lifesaving interventions played a vital role in reducing the incidence of morbidity and mortality. In addition the provision of essential medicines increased the utilization of underutilized public health facilities evident from the consultation data (increased from 0.12 visits per capita per annum to 0.8 visits per capita per annum).

Essential medicines and supplies will be provided on regular basis to avoid any lapse in the delivery of essential healthcare. Geographic stockpiling will be planned for in a way that allows immediate response to outbreak alerts as well as for the district. Medicines will be bought and imported in accordance with the National and WHO essential medicines list. In order to reach population faster, medicines and equipment will be purchased and dispatched in ready-to-deploy kits. Some kits will require international air shipment to ensure timely availability and delivery.

Capacity of the health partners and Department of Health staff will be enhanced on medicine management. The essential medicines team set up within the coordination mechanism will monitor the rational use, storage and dispensing activities. The Logistic Support System (LSS) installed at district for transparency and traceability of supplies will be expanded. Essential Medicine Team (Pharmacists) is working to check the rational utilization of medicines and capacity building of the health care providers (implementing partners and government health department) on evidence based quantification and adherence to the standard treatment protocols.

iv. Health Promotion and Protection, including Maternal, Newborn, Child Adolescent Health, Non Communicable Diseases and Mental Health, Health Promotion and Nutrition.

Under the Health Promotion and Protection the dissemination of key health messages including risk awareness, mental health counselling, disaster management and first aid support among the affected communities will be ensured to prevent major health risks among the affected population. The response will address major health risks including Hygiene Promotion; Malnutrition; Malaria and Dengue Fever; Mother and Child Health; vaccine preventable diseases and snake bites among the affected displaced population. Development of a Manual on Community-based Disaster Risk Management (CBDRM) for the health sector is one of the core activities for health promotion during emergency response.

The following activities would be undertaken in IDP camps and hosting communities under the leadership of UNICEF and in partnership with Government, UN organizations and NGOs:

a) Assisting Department of Health through provision of technical inputs and actualization of the decisions made in and by the health cluster;

b) Strengthening of Routine EPI through provision of cold chain equipment (ILRs, Solar refrigerators, Deep freezers, cold boxes and vaccine carriers) and capacity building of staff and filling of HR gaps;

c) Children 6-59 months receive measles immunization & Vitamin A supplementation (268,161 children;

d) Under-five children & their mothers living in IDP camps and hosting communities will be provided a standard package of maternal, child health and newborn care services (ANC, vaccination, multi micro nutrient supplementation and deworming), NFIs (newborn kits, clean delivery kits and LLINs), and information through Mother and Child Days/Weeks;

e) Emergency affected families receive messages on diseases preventions, home care and care-seeking in illnesses;

f) Community based health programs (LHW and MNCH programs) will be revitalized through provision of supplies and incentives along capacity building so that emergency affected communities have access to basic Maternal, Newborn and Child Care services at their doorstep;

g) Emergency affected communities in IDP camps and hosting communities in Khyber Pakhtunkhwa have access to 24/7 basic & comprehensive emergency obstetric care & newborn care services;

h) Strengthening of MCH services including Basic and Comprehensive EmONC in selected public sector health facilities through filling of HR, supplies and equipments gaps and capacity building of the relevant staff;

i) Strengthening of specialized pediatric services in DHQ Hospitals of DI Khan and Tank.

The following activities will be implemented by UNFPA and partners:

UNFPA along with partners and DoH will be at the forefront to fulfill the life saving Reproductive Health needs of IDPs to prevent excess maternal and newborn morbidity by implementing Minimum Initial Services Package (MISP) for which the following activities are being proposed:

1. Equipping and strengthening of selected service delivery points, including RHCs, THQs and DHQ hospital to facilitate the provision of 24/7 Basic and Comprehensive EmOC services

2. Establishing Referral Pathway to strengthen the community- based referral system by ssupporting the LHS, LHWs.

3. Provision of essential RH medicines, kits (RH/ hygiene and newborn)and equipment that have been identified as deficient by partners through assessments conducted

4. Conduct awareness-raising sessions on RH with focus on addressing first two delays to improve health seeking behavior of the affected population to ensure that men, women and girls are aware of safe motherhood interventions

5. Enhance capacity of the relevant staff in MISP and other life-saving competency based trainings to ensure provision quality RH services

6. Conducting RH/GBV information sessions for women, men and youth.

Response objectives:

Objective 1: Continuation and strengthening of essential PHC services, including essential life saving medicines and other medical supplies in all affected areas and camps for filling gaps and unmet needs in the health response.		
Outcomes	**Indicator**	**Activities**
Continuation and immediate restoration of the essential life saving primary health care services, availability of essential life-saving medicines, supplies and equipment and strengthening of referral mechanisms along with mobile health units coverage.	# of static health units re activated for provision of essential PHC services # of active mobile units in the affected districts # of LHWs reached # of EHKs, DTKs, ARI kits LLINs, procured and distributed.	- Reactivation/strengthen static health units with provision of necessary essential medicines, essential medical supplies. - Filling gaps in the establishing referral system from primary to secondary and tertiary health facilities - Conducting campaigns (measles, polio, vitamin A supplementation & deworming tablets etc). - Revitalization of services by addressing LHWs needs
Accessibility to essential PHC services including MNCH/RH and immunization coverage to the affected population.	# of health units operationalized # of consultations related to MNCH/RH and other key diseases undertaken #of complicated cases referred # of coordinated health promotion activities delivered # No of CBDRM training courses held/ no of volunteers trained # of LHWs and Community Health Workers(CHWs) trained on CBDRM #No of HOPE training courses held/ no of health and hospital staff trained	- Provision of health services 24/7 a week in communities with referral system to static health units for complicated cases - Provision of essential medical equipment - Establishing mobile teams in line with essential minimum mobile team standards - Endorsement of health promotion guidelines for emergencies by health department. - Facilitate dissemination of guidelines and IEC materials through Government and non-government partners - Facilitate coordination of health promotion activities, through Government, at district level - Facilitate endorsement, dissemination and implementation of Community-Based Disaster Risk Management Manual for the health cluster - Training of LHWs and Community health workers on Community-Based Disaster Risk Management Manual developed for health cluster - Training of Health Cluster and hospital officials & staff for hospital operational preparedness for emergencies (HOPE)
Objective 2: Continuous communicable disease surveillance and response to mitigate morbidity and mortality among the security operations affected population		
Outcomes	**Indicator**	**Activities**
Prevention against emerging health threats and outbreaks through early detection and response and strengthening of speedy, timely, effective and coordinated joint health interventions.	# of alerts and outbreaks identified and responded within 48 hours. #No of training courses held for communities and health workers on DEWs # of workers trained in each	- Active surveillance in all affected areas through surveillance officers - Remedial actions to mitigate the outbreak - Carrying out laboratory tests for confirmation of an outbreak - Weekly analysis of consultation reports data from implementing partners

Waterborne diseases surveillance and identification of affected communities facing greatest health risks from water borne diseases identified and appropriate response mechanisms put in place.	course # of Rapid Response Teams deployed # of water samples collected, tested and reported	- Deployment of rapid response teams (male and female members) to investigate alerts and outbreaks - Training of Communities & health workers for strengthening of DEWs - Speedy dissemination of IEC materials for mass awareness - Conduct regular water quality surveillance affected areas, and routinely disseminate microbial water quality results and trends with all WASH partners;
Objective 3: Coordinate and streamline health response within the cluster mechanism and in partnership with local authorities and other actors		
Outcomes	**Indicator**	**Activities**
Coordination meetings and federal, provincial, agency and district level	# of health cluster meetings held per month at federal/provincial/district/agency level	- Continuation of the health cluster at federal, provincial and district/agency level - Coordination with the government counter-part for chairing the coordination meeting - Active information sharing and participation from all implementing partners in the meeting for effective coordination
HeRAMS activation and regular updates information sharing in the form of bulletins and situation reports	# of health facilities reporting to HeRAMS. # of Health Cluster bulletins published/month	- Active updates from health Cluster partners Collection and compilation of 4W matrix and HeRAMs Collation of information and development of the monthly Health Cluster bulletin

Cluster Monitoring Strategy

Health Cluster partners will monitor health interventions according to the indicators outlined above disaggregated by sex and age, and conduct evaluations and assessments to measure the impact of the interventions and to facilitate improvement / changes where required. Specific areas of focus such as the DEWS will deploy surveillance officers in the districts affected for close monitoring and supervision of the disease trends and investigate any alerts and outbreaks to provide the timely and appropriate response. The essential drugs team will monitor the rational use, storage and dispensing activities and capacities of the department of health and all the proposing organisations through the deployment of a pharmacist in each district.

Joint monitoring visits along with the EDO Health are one of the successful mechanisms for the monitoring of cluster activities. Health Cluster uses IASC standard indicators for communicable and non-communicable diseases, including average population coverage, emergency obstetric care, maternal and neonatal care, etc. Health Cluster uses different data collection tools and methods for the assessment of health facilities like HeRAMS (Health Resources Availability and Mapping) and IRA (Initial Rapid Assessment).

Table of proposed coverage per site

ORGANIZATIONS	SITE / AREA
WHO, UNICEF, UNFPA and national and international NGOs partners	DI Khan, Tank, Kohat, Hangu, Nowshera and Peshawar. IDP camps: Jalozai, ToghSaray in Hangu, New Durrani in Kurram Agency, and population in return areas in FATA

Note: DoH-KP, DoH-FATA and NGO partners will also be part of the response in the affected areas.

Nutrition

Cluster lead agency(ies)	UNICEF
Implementing agencies	Department of Health, UN Agencies (UNICEF, WFP, WHO, UNOCHA) and I/NGOs (Merlin, Relief Pakistan, RAHBAR, PEACE, CERD, CDO, IDEA, Abaseen Foundation, FPHC, SAHARA, AMAN, HRDO & PRIME Foundation)
Number of projects	

Cluster objectives	**Overall Objective:** The overall objective of the Nutrition Cluster for KP and FATA is to ensure that GAM (Global Acute Malnutrition) rate in the IDP camps of KP and FATA is maintained below the 10% by improving nutritional status through provision of effective nutritional services at the community and facility level; that meet national and internationally recommended minimum standard of care for population affected by emergency. Also to monitor and ensure that the GAM of IDPs living outside the camps does not fall below that of the 'norm' in hosts communities. **Specific Objectives** 1. To ensure provision of lifesaving nutrition services for acutely malnourished children (boys and girls) less than five years of age and pregnant and lactating women (PLW) suffering from acute malnutrition through community and facility based nutritional management approach [IDPs in camps=145,075, IDPs outside camps in KP=1,092,000, Host communities in KP=1,274,756, IDPs outside camps in Kurram Agency=228,333, host communities/returnees/stayees in Kurram Agency= 551,166] through 2012. 2. To prevent malnutrition in early childhood through promotion of improved infant and young child feeding, care giving, and care seeking practices at the facility, community and family level and to prevent and control the donation and distribution of breastmilk substitutes in emergency affected areas [All of the above affected population]. 3. To prevent and treat micronutrient deficiency disorders in children and women through provision of multiple micronutrient supplementation, Vitamin A and deworming campaigns [All of the above affected population]. 4. To provide refresher trainings to DoH and NGOs for effective implementation of nutrition interventions; ensure effective and timely implementation of nutrition interventions through enhanced coordination and information gathering; nutrition surveillance, surveys, monitoring of trends and status of malnutrition in the target population.
Beneficiaries	The total target population is 3,292,030 including current and newly expected IDPs in Camps=145,075 [Jalozai, Tough Sarai& New Durrani Camp], IDPs Outside Camps=1,092,000 in KP [DIK, TANK, Kohat, Hangu& Peshawar], Host Communities=1,274,756 in KP [DIK, TANK, Kohat, Hangu and Peshawar] and host communities/returnees/ stayees in FATA [Kurram Agency] = 780,199. Nutrition Cluster is aiming at reaching to 60% of the target population by end of 2012 [i.e. 1,975,218 out of 3,292,030 individuals] and as a consequence the estimated direct beneficiaries for nutrition interventions for complex emergency in KP and FATA are 391,222. This includes 233,204 under five years children [Girls=114,279 and Boys=118,934]*, and 158,018 pregnant and lactating women. The detailed breakdown of estimated numbers of beneficiaries is as follows: – Total children (6-59 months @14%) to be screened- 233,204 [KP-180,547 & FATA-52,657] – Severely acute malnourished children- 20,405 [KP-15,798 & FATA-4,607] – Moderately acute malnourished children- 40,811 [KP-31,596 & FATA-9,215] – Total pregnant and lactating women to be screened- 158,017 [KP-119,730 and FATA-38,947] – Pregnant and lactating women at risk to be supported through SFP-41,480 [KP- 31,335 & FATA- 10,145] – Children (6-59 months) provided with micro nutrient supplements -163,243 [KP-126,383 & FATA- 36,820] – Pregnant and lactating women to receive micro nutrient supplements-158,017 [KP-119,3370 & FATA- 38,647] *target includes 51% Boys and 49% Girl
Funds requested	Total Cost= US$- 11,105,766 [Supplies= 5,930,609 (53%) + Cash= 5,175,657 (47%)]
Contact information	Aien Khan Afridi [Nutrition Cluster Coordinator for KP and FATA] Email: akafridi@unicef.org, Phone# +92-300-500 2598, +92-91-570 1311-5 (Ext# 3168)

Category	Affected Population			Population i(if different)		
	Female	Male	Total	Female	Male	Total
Children (6-59 months) for Screening	190,450	198,224	388,674	114,270	118,934	233,204
MAM Children	33,329	34,689	68,018	19,997	20,813	40,811
SAM Children	16,664	17,345	34,009	9,999	10,407	20,405
Children (24-59 m) for Deworming	121,857	39,453	79,042	47,425	49,361	96,786
Children (6-59 months) for MM Supplementation	210,638	61,433	133,315	79,989	83,254	163,243
Pregnant & Lactating Women for Screening	198,950	64,412	263,362	158,017		158,017
Pregnant & Lactating Women for SFP and MMS	52,224	16,908	69,133	41,480		41,480

Needs analysis:

Infant mortality and maternal mortality ratio in Khyber Pakhtunkhwa (KP) and FATA remain very high as compared to rest of the country (IMR at 87 deaths per 1,000 live births, and MMR at 380 deaths per 100,000 live births). Generally, child malnutrition rates throughout Pakistan remain persistently high. The history of National Nutrition surveys conducted in the last 3 decades *(NNS 1985-87, NNS 2001-02, MICS 2007 and NNS 2011)* depicts a worrying situation of malnutrition in Pakistan. The National Nutrition Survey conducted in 2011 documented Global Acute Malnutrition (GAM) rate of 15.1% across Pakistan with GAM rate of 17.2% and Severe Acute Malnutrition (SAM) rate of 6% in Khyber Pakhtunkhwa and GAM rate of 10% and SAM of 6% in FATA. The reported figures for GAM and SAM are higher than the International Emergency Threshold of 15% GAM and 4% SAM. The children with severe acute malnutrition have a high risk of mortality; severely malnourished children are 9 times more prone to mortality compared to healthy children. NNS 2011 estimates 47.8% to be severely stunted (<-2 SD) and 24.1% are underweight. Similarly food insecurity still remains a major concern in Pakistan; World Food Programme (WFP) Pakistan has also shown concern this year over the high food prices. The food insecurity in the region further compounds the problem of malnutrition and ill health.

In addition to the overall precarious nutrition situation in areas from where the IDPs have come and areas where these IDPs are living, the various nutrition assessment and/or surveys conducted in the last couple of year's shows a worsening nutrition situation of IDPs as compared to the hosting community. The McRAM[17] assessment conducted in March 2010 for IDPs residing with host community in Kohat and Hangu reported 18.2% GAM (SAM=10.3% and MAM=7.9%), moreover 21% of mothers reported having stopped breastfeeding and 24% reported reduction in the frequency and rate of breastfeeding and feeding practices after the displacement. Similarly >70% of the IDPs reported non availability of food stock and 27% reported having food stock for less than one week. The IVAP[18][Internally Displaced Persons Vulnerability Assessment & Profiling] analysis showed 65% of the surveyed IDPs have poor or border line food consumption score, only around 34% had acceptable food consumption score. More than 50% of the surveyed individuals reported their children had 2 or <2 meals eaten per day, the standard for children is 4- meals per day.Due to drastic changes in feeding practice, lack of safe drinking water & sanitation, and inadequate health services due to the influx of IDPs, acute malnutrition rate is expected to increase in these areas.The data provide evidence of vulnerability of the IDPs in comparison to the general population in the province. On the basis of the current affected population, there will be an expected 102,027 acutely malnourished children [girls=49,993 and boys=52,034] who will need treatment for malnutrition during 2012.

Gradually increasing food insecurity, hikes in the prices of food commodities, lack of antenatal and postnatal counselling and traditionally poor infant and young child feeding practices contribute to the increased prevalence of acute malnutrition in most areas of Pakistan. Furthermore, the gender biased environment, poor agricultural reforms and isolation could amplify the food insecurity affecting the vulnerable population. The lack of access to basic health care services, high morbidity rates, damaged infrastructure and price hike further compound these issues and have the potential to affect the nutrition wellbeing of the population. Diarrhoea and malaria are common in the affected population (cited as major health concerns in the assessment) and these diseases have a negative synergy with malnutrition. It is expected that all of these factors will adversely impact and further worsen the nutritional status of pregnant women and the youngest and most vulnerable children especially the displaced persons.

[17] http://oneresponse.info/countries/pakistan/im/publicdocuments/McRAM%20analysis%20kohat%20(version%205)-draft.zip
[18] http://www.ivap.org.pk/

These children have already very low immune system. Frequent interruptions in the infant feeding practices due to displacement, and poor hygienic/ sanitation environment, and limited access to health facilities further increased the vulnerability of acutely malnourished children. Providing treatment and care for the malnourished children, pregnant and lactating women at risk is one of the main lifesaving activities both in IDP camps and communities where IDPs are staying with the host families.

Proposed Strategy:

The proposed strategy for nutrition is designed to ensure the provision of lifesaving nutrition services for acutely malnourished children (boys and girls), pregnant and lactating women in camps and off-camp; to prevent poor nutritional outcome through rigorous promotion of optimal infant feeding practices, proper hygiene/sanitation and improved maternal nutrition; micronutrients supplementation and nutrition education on locally available foods; setting up of a robust reporting and information system and monitoring mechanism; establishment of a strong surveillance system, and emphasis on capacity development of health care providers for all target areas to be implemented in partnership with the district Department of Health (DoH) and provincial nutrition cells in KP & FATA.

The proposed nutrition interventions will be co-ordinated through the Nutrition Cluster with PDMA/FDMA/UNDP and other relevant clusters including Health, Food and WASH, and will be implemented through I/NGOs and Departments of Health with support from UNICEF, WFP and WHO. UNICEF (The Cluster Lead Agency) will ensure close collaboration with Health, Food Security, WASH, Camps and Child Protection Clusters in order to ensure that all cross cutting issues are well addressed. The locations of nutrition project interventions will be adjusted as per the movement of the affected population to ensure the continuity of services.

(1) Establishment of Life saving nutrition services for acutely malnourished children (boys and girls) less than five years of age and pregnant and lactating women (PLW) suffering from acute malnutrition through community and facility based nutritional management approach i.e. CMAM (Community Management of Acute Malnutrition) Approach comprising;

(a) Community Outreach:

Community Outreach Workers (COWs) will be trained in the identification of acutely malnourished children using mid-upper-arm circumference (MUAC), and will be responsible for referring clients to health centres, or to agreed-upon locations for the visits of mobile nutrition teams, on the assigned day of the mobile clinic team visit. In addition to identification of acutely malnourished children, COWs will communicate promotion messages on health and nutrition, will follow-up with defaulters, and will identify pregnant and lactating women for SFP and care during pregnancy and in the immediate postnatal period. Simultaneously, COWs will identify cases of acute malnutrition in the community through active case searches. In each area at village level a nutrition support committee will be formed, and sensitized through regular meetings. In meetings nutrition education sessions will be conducted to prevent malnutrition and adopt healthy behaviour in childcare. Behaviour change communication through health, hygiene and nutrition promotion is the vital component for sustainability. This endeavour is designed to promote Infant Young Child Feeding (IYCF) practices with more emphasis on exclusive breastfeeding and proper complementary feeding. COWs will work in close association with the community, form committees of females in the community and will conduct sessions to disseminate key messages.

(b) Supplementary Feeding Program (SFP):

Children with moderate acute malnutrition (MAM) identified through community outreach will be registered with SFPs and will be provided Acha Mum/Supplementary Plumpy to take home twice a month. Every two weeks children in the SFP will present at the nutrition center, or other designated location; where they will have their nutritional status checked, and where they will be provided with Supplementary Plumpy, deworming and micronutrient supplementation. Pregnant and lactating women will also be included in the SFP, as per CMAM guidelines. Moreover, High Energy Biscuits will be provided to one sibling of each SAM and MAM case admitted in SFP/OTP. Malnourished PLWs will be provided with FBFand Vegetable Oil. A total of 67 SFP sites will be established in the affected areas of KP while 16 SFP sites will be established in FATA. SFP will be implemented with support from WFP.

(c) Outpatient Therapeutic Program (OTP):

Children with severe acute malnutrition (SAM) with appetite and without complications will be treated with ready-to-use therapeutic foods (RUTF) and symptomatic outpatient medications in the fixed health centers. The severely malnourished child will come to the health center or designated location every week for a medical examination and treatment, and to receive RUTF. Children without appetite and/or with complications will be

referred immediately to inpatient care in Stabilization Centers until they are stable to be discharged. These children then continue treatment at home in the OTP with RUTF, +/- outpatient medications. On discharge from the OTP, children will be referred to the SFP as moderately malnourished children.

A total of around 67 OTP sites will be established in the affected areas of KP (DI Khan=20, Tank=10, Kohat=10, Hangu=10, Peshawar=10, Jalozai=6 and Tough Sarai=1) and 16 OTP sites will be established in FATA (Kurram Agency =16). DoH staff will run the OTP Program while NGOs will provide support in OTP/SFP activities. The DoH staff will be responsible for operationalization of the OTP services as per National CMAM protocols.

(d) Stabilization Care (SC):

Children without appetite and with complications will be treated as inpatients at Stabilization Centers established in Peshawar, DI Khan, Kohat, Hangu and Kurram Agency until they are stable for transfer to an OTP. Participating NGOs will refer clients and will ensure they are treated in the stabilization center established at various districts. To the fullest extent possible discharged children will be referred to an OTP once they are stabilized. Nutrition Supplies [RUTF, F-75 * F-100 Milk and Plumpy Nut] and medicines are provided by UNICEF and Operational Cost and Technical Support is provided by WHO (as part of the UNICEF/WHO collaboration).

(2) Establish services for prevention of malnutrition in early childhood through protection and promotion of appropriate infant feeding practices by strengthening skills/knowledge of health workers, creating breastfeeding corners/safe heavens in the affected areas, and conduct regular nutrition and hygiene education sessions for mothers and caregivers of children under five years of age;

(3) Prevention and treatment of micronutrient deficiency disorders in children and women through provision of multiple micronutrient supplementation, Vitamin A and deworming campaigns.

(4) Strengthening technical capacity of the DoH and NGOs for effective implementation of nutrition interventions; ensure effective and timely implementation of nutrition interventions including CMAM and IYCF Approach.

(5) Establish Health and Nutrition Sentinel Site Surveillance System (HANSS) in sites fitting the criteria for surveillance of the main target group of children aged 0-59 months. The objectives of this HANSS will be to assess on a continuous basis the nutritional and related health status of children aged 0 to 59 months in selected sites, to identify and highlight the evolution and projected trends towards a nutritional and health emergency as related to food crisis and to allow sufficient time to advocate for and appropriately respond to an impending crisis.

(6) Continue coordination role for nutrition working group, including strategy and plan, capacity development of members through orientations/training and monitoring trends and address critical nutritional gaps, and contingency strategy with supplies and distribution plan for emergency nutrition interventions.

Revised cluster objectives

Expected Outcomes	Outputs	Indicators	Activities
Objective 1. To ensure provision of lifesaving nutrition services for acutely malnourished children (boys and girls) less than five years of age and pregnant and lactating women (PLW) suffering from acute malnutrition through community and facility based nutritional management approach.			
1. CMAM services are available in target areas for the management of identified acute malnourished children and PLW	1.1 Initial Screening/ Rescreening conducted and reports shared 1.2 Around 83 fixed nutrition sites are established for provision of CMAM interventions in the target health facilities/areas 1.3 Around 166 health care providers (HCPs) of the DoH and 166 from participating NGOs receive trainings on CMAM/ IYCF protocols for the management of malnutrition. 1.4 Around 249 COWs trained & equipped COWs continue community mobilization, screening and identification of acute malnourished children, pregnant women and lactating mothers, and follow-up to ensure enrolment. Across the camps, host communities and areas of return in KP and FATA Around 233,204 children and 158,017 PLW are screened in the community for assessment of acute malnutrition using criteria of MUAC and Oedema. 1.5 HCPs of the DoH and NGOs in their respective centers register around 40,811 MAM children & 41,480 PLW in SFP for supplementary food (supported by WFP) and 20,405 SAM children in OTP for therapeutic foods, as per CMAM protocols, in coordination with the community	- # of UCs where Nutrition Assessment conducted using Oedema and MUAC criteria. - # of nutrition SFP/OTP/IYCF sites established/maintained & are providing CMAM services and IYCF information - # of SFP/OTP sites has the necessary anthropometric equipments and tools. - % of HCPs (DoH) identified, trained & involved in CMAM/IYCF activities against set targets. - % of target children & PLWs screened for assessment of malnutrition and referred to supplementary feeding/treatment centres - # of community mobilization sessions conducted by the Outreach Workers. - % of referred children registered in appropriate feeding programs in the health facilities by the trained HCPs - % of SAM children with complications facilitated to be treated in SCs - % of acute malnourished children (SAM & MAM) recovered (>75%) - % of acute malnourished children (SAM and MAM) defaulted from	1a. Trainings of Facility and Community Based Health Care Providers and Workers on CMAM 1b. Conduction of rapid nutrition assessments in the target areas using criteria of MUAC and Oedema tap to establish baseline information. 1c. Setting up community based nutrition management sites (SFP/OTP) in the target health facilities in collaboration with WFP. 1d. Conduction of community mobilization sessions & screening for assessment of acute malnutrition in the community through outreach workers 1e. Referral of identified malnourished children and PLWs for appropriate care and active follow ups of beneficiaries in the community 1f. Community outreach activities for mobilization, sensitization, absentee and default tracing and home visits. 1g. Screening and registration of clients in appropriate feeding program as per CMAM protocols by the HCPs 1h. Provision of supplementary and therapeutic foods to the identified clients as per protocols. 1i. Referral and follow up of SAM children with complications and no appetite to the identified SC for further treatment. 1j. Education of mothers/caretakers on proper use of the provided food and medication. 1k. Reporting of progress on weekly and monthly basis 1l. Setting up facility-based management sites (stabilization centre) in target districts of KP

Expected Outcomes	Outputs	Indicators	Activities
	outreach and concerned centres. 1.6 Around 4,081 severe acute malnourished children with underlying medical complications are treated in the supported stabilization centre.	treatment (<15%) - Average LOS (Length of Stay) in the program	and FATA in collaboration with WHO for the lifesaving critical emergency treatment of severely acute malnourished children with medical complications.
Objective 2.	**To prevent malnutrition in early childhood through promotion of improved infant and young child feeding, care giving, and care seeking practices at the facility, community and family level and to prevent and control the donation and distribution of breastmilk substitutes in emergency affected areas.**		
2. Healthy nutrition behaviours promoted at the facility and community level for prevention of malnutrition in early childhood	2.1 Around 188,041 mothers/ caretakers are educated on importance of early initiation of breastfeeding, exclusive breastfeeding up to six months of age, appropriate complementary feeding, good nutrition during pregnancy and lactation and improved hygiene practices through Behaviour Change Communication (BCC) approach. 2.2 80% of the targeted beneficiaries (188,041 mothers) receive key messages on the importance of early initiation of breastfeeding, exclusive breastfeeding up to six months from birth, appropriate complementary food after six months, and hygienic practices.	- # of HCPs and outreach workers trained on IYCF - # of BF corners established & functional, providing SRA, full assessment &referral services for management of lactation failure. - # of community mobilization sessions held - # of community members who participated in mobilization sessions - # of mothers reached with key messages on IYCF & Health education.	2a. Trainings of Facility and Community Based Health Care Providers and Workers on IYCF 2b. Establishment of Breastfeeding promotion Corners (safe heavens) in the target areas especially camps. 2c. Conduction of nutrition awareness and hygiene promotion sessions in the health facilities and communities [To support mothers in maintaining appropriate infant and young child feeding practices (IYCF) by promoting early initiation of breastfeeding, exclusive breastfeeding practices up to six months and timely introduction of complementary food at the age of six months] 2d. Provision relevant IEC material to the health facilities, outreach staff & community. 2e. Monitoring of unsolicited free distribution of Infant Feeding Formulas in the facilities and communities. 2f. Establishment/reinforcement and training of Mother Support Groups for IYCF promotion. 2g. Developing liaison with DoH for coordinated effort for implementation of IYCF component
Objective 3.	**To prevent and treat micronutrient deficiency disorders in children and women through provision of multiple micronutrient supplementation, Vitamin A and deworming campaigns.**		
3. Micronutrient deficiencies	3.1 Around 163,243 children and 158,017 mothers are	- % of target children and PLW provided	3a. Registration and referral of target children and PLW for

Expected Outcomes	Outputs	Indicators	Activities
disorders in children & women prevented/ treated in the target population	provided with multi-micronutrient (MM) supplements 3.2 Around 96,786 children receive de-worming treatment and vitamin A dose as per national guidelines.	MM sachets and tablets. - # of target mothers educated on use of MM supplements - # of eligible children de-wormed. - # of children provided with vitamin-A dose.	MM supplementation 3b. Distribution of MM supplements to the target children & PLW as per protocols 3c. Education of mothers/caretakers on the proper use of MM supplements 3d. Registration of target children for deworming treatment and vitamin A supplementation 3e. Ensuring deworming of all eligible children
Objective 4.	**To strengthen technical capacity of the DoH and NGOs for effective implementation of nutrition interventions; ensure effective and timely implementation of nutrition interventions through enhanced coordination and information gathering; monitoring of trends and status of malnutrition in the target population.**		
4. Technical Capacity of selected health facilities strengthened for the management of acute and chronic malnutrition and sustainability, coordination mechanism established.	4.1 Develop essential capacity of DoH (around 166) staff for sustaining the CMAM & IYCF services after CDO's exit 4.2 Updated Nutrition information system is available for reporting and monitoring as per needs. 4.3 Effective Coordination mechanism ensures provision of services to the target population and helps avoid duplication of services. 4.4 Effective Health and Nutrition Sentinel Surveillance System(HANSS) in the target district to be able to provide trends on nutrition for allowing sufficient time to advocate for and appropriately respond to an impending crisis	- # of health facilities capable of continuing OTP & SFP services and HANSS after CERF support is withdrawn - # of DoH Staff actively involved in provision of nutrition interventions and HANSS. - # of DoH receives training on CMAM/IYCF and HANSS before withdrawal of CERF support - # of monitoring visits made by DoH representatives. - Functional Nutrition Information Sharing System linked to District MIS - # of relevant staff of NGOs and DoH trained on Nutrition Information System, Data Management and Reporting Mechanism - # of coordination meetings conducted - Updated 3 Ws Matrices are available for avowing duplications	4a. Engagement of DoH staff in all stages of planning and implementation 4b. Training of DoH staff on CMAM & IYCF and HANSS 4c. Provision of anthropometric equipments and necessary supplies to the target health facilities 4d. Advocacy and lobbying with DoH for integration of CMAM and HANSS in the public healthcare. 4e. Setup a system of monitoring of nutrition centres for data & supplies management 4f. Training of relevant staff of NGOs and DoH on Nutrition Information System, Data Management and Reporting Mechanism 4g. Ensuring regular coordination of relevant DoH, UN Agencies and NGOs coordination through regular meetings [Monthly Basis] and electronic transformations.

Nutrition Cluster Target Population for Humanitarian Operation Plan [2012] **Family size: 7**

S#	Description	KP		FATA	
		IDPs	Hosting	IDPs	Hosting/ Returnees
1	Outside Camps Population*	1,092,000	1,274,756		228,333
2	Inside Camps Population	120,120	-	24,955	
3	Returnees (Kurram)	-	-	-	551,866
	Subtotal Population	**1,212,120**	**1,274,756**	**24,955**	**780,199**
	Subtotal KP&FATA	**2,486,876**		**805,154**	
	Grand Total Population	**3,292,030**			

Outside Camp IDPs	Population	Families
DI Khan	188,902	26,986
Tank	70,952	10,136
Hangu	15,155	2,165
Kohat	161,637	23,091
Peshawar	242,081	34,583
Kurram Agency	87,885	12,555
Kurram Agency	325,388	46,484
Total	**1,092,000**	**156,000**

Camp Based IDPs	Population	Families
Jalozai	112,000	16,000
Tough Sarai	8,120	1,160
New Durrani	24,955	3,565
Total	**145,075**	**20,725**

Areas of Return	Population	Population
FATA [Kurram]	228,333	32,619
Total	**228,333**	**32,619**

Areas of Return	Population	Population
FATA [Kurram]	551,866	78,838
Total	**551,866**	**78,838**

Host Communities	Population
DI Khan (20 UCs)	359,421
Tank (10 UCs)	76,846
Hangu (10 UCs)	254,835
Kohat (10 Ucs)	250,750
Peshawar (10 Ucs)	332,904
Total	**1,274,756**

Protection (also including child protection and protection from gender based violence sub-clusters)

Cluster lead agency(ies)	UNHCR and IRC Co-Lead the protection cluster UNICEF coordinates child protection sub-cluster and UNFPA coordinates GBV sub-cluster. UN Habitat and UNDP have recently established Housing, Land and Property and Rule of Law sub-clusters respectively. UN Women coordinates Thematic Group on Gender
Implementing agencies	Includes PDMA, FDMA, NRC, IRC, CERD, FRD, Intersos, RIPORT , IOM, KhwendoKor, Kado, EHSAR, the edifiers, PADO, Just Peace, SPADO, Hayat Foundation and many others
Number of projects	Protection: In addition to registration services, UNHCR/IRC protection project in Jalozai, ToghSarai and New Durrani camps, and NRC run ICLA centres in Peshawar, Kohat, Bajaur and Mohmand (through UNHCR and other donors). Child protection: UNICEF PLaCES interventions in Jalozai, ToghSarai, New Durrani, Hangu, DI Khan and Tank. UNICEF runs a child protection related grievance desk in Peshawar valley. GBV: Women friendly spaces in New Durrani, ToghSarai, Kohat, Jalozai, Peshawar, DI Khan, Tank, Lower Dir TGG: Mission to ToghSarai and Jalozai Camps to ascertain the need for Women Friendly Spaces (WFS) and identify future needs of women and girls in the camp. UN Women to facilitate relocation of 12-16 WFS (out of the existing 20 in KP and FATA) in Jalozai as per request of PDMA
Cluster objectives	1. Registration of all IDPs (in camp and off camp) for assistance and 2. Equitable access to assistance and protection from rights abuses through protection monitoring, interventions and advocacy 3. Access to safe, voluntary and dignified return and other durable solutions for IDPs 4. Ensure that children at risk at each stage of the displacement cycle are provided with adequate support and timely response 5. Provide holistic multi-sectoral response to GBV and ensure survivor centred services
Beneficiaries	Total IDP population
Funds requested	Protection – $5,890,000; child protection - $5,491,716; GBV response – $4,738,225. **Total requested = $16,119,941**
Contact information	Murat Yucer (Yucerm@unhcr.org); Lauren Aarons (Lauren.aarons@rescue.org) For Child protection – kbkhan@unicef.org and for GBV aman@unfpa.org

Needs analysis

Fresh displacements

1. Registration

All IDPs must be registered in order to be able to access humanitarian assistance. As such, the first priority for all newly displaced IDPs is registration, to be conducted in the Jalozai camp as well as in selected locations off-camp.

In the past a significant number of IDPs have been unable to register.[19] These barriers must be overcome to enable all IDPs to be included in the registration process. Barriers to registration identified, including through protection cluster assessment missions and IDP Vulnerability And Profiling (IVAP), include lack of documentation (particularly for separated/widowed women); and lack of information or difficulties in obtaining civil documentation.

IDPs without civil documentation in particular need to be assisted in accessing CNICs and to be advised on the process and the procedure to obtain it.

2. Protection monitoring during all cycle of displacement and Rapid Protection Assessments
Protection monitoring to further understand the dynamics of displacement in areas or origin and to determine protection issues during flight and on arrival is needed, including to better shape the subsequent interventions.

3. Information needs
IDPs need to be provided with information about the registration process, their rights and entitlements and about assistance and services available to them, both in the context of displacement and before the return process

<u>Protracted displacements</u>

1. Registration:
Unregistered IDPs who missed their "registration window" must be identified and then registered. In 2011, IVAP identified some 40,000 IDPs who are unregistered. Some 12,000 of these "IVAP identified" IDPs – those that meet the eligibility criteria of having CNIC with addresses from currently notified areas - have since been registered. However, the remainder remain unregistered, including some 10,000 IDPs who do not have CNICs. This group need to be provided with assistance to access CNICs. Additional unregistered IDPs who are identified by IVAP 2[20] will also need to support to access registration.

2. Exclusion from humanitarian assistance:
IDPs are "blocked" from accessing humanitarian assistance (largely food assistance) for a number of reasons; in most cases it is because their status is not "verified" by the National Database and Registration Authority (NADRA), who screen registration data to avoid duplication, among other things,. However, occasionally some genuine cases are also affected by exclusion, (e.g. a wife may be blocked if she is abandoned by her husband who is living elsewhere and claiming assistance with a second wife – to NADRA this will look as if the family is claiming twice). While there is no data on such cases across displacement areas, in Kurram Agency alone there are 600 "blocked" cases in New Durrani camp and FDMA has raised concerns that some 1000 IDP families are "blocked" in off-camp areas in Sadda.

3. Barriers to access government services and issues of discrimination for off-camp IDPs:
The protection cluster assessment mission to Kurram Agency in December 2011 was informed that off-camp IDP children often face barriers in accessing government schools due to overcrowding and lack of absorption capacity or because children are not able to produce official school leaving certificates from areas of origin. The protection cluster mission to Kohat in February 2012 learnt that some IDP families are being denied access to medical facilities on the basis that they are not perceived to be nationals of Pakistan and they had no documents to prove their citizenship. Furthermore, in both missions, concerns were raised with protection cluster members on episodes of harassment of IDP families by security forces. Systematic monitoring and action on such concerns is required to better identify the incidence of such cases and whether trends can be inferred on which to intervene with the authorities.

[19] According to IVAP, some 34 per cent of IDPs in protracted displacement are not registered
[20] Currently underway

4. Information needs
Provision of timely and accurate information to the IDPs regarding life-saving assistance and policy level decisions on entitlements and processes by the government becomes a challenge in absence of a coherent system of information dissemination for the IDPs, targeted to the profile of the audience, including groups with specific needs.

Transitional period

In line with the commitment undertaken by the Government (FDMA) in the 2010 "IDP Return Framework", safeguards need to be incorporated into the returns process to ensure that returns are safe, voluntary and dignified. The protection cluster has incorporated these safeguards also in the return SOPs, guiding the humanitarian interventions in the context of IDP return. Likewise, it has also negotiated an implementation plan with humanitarian and government stakeholders to ensure that IDPs are not pre-maturely de-registered in displacement areas, and disqualified from food assistance, until these key safeguards have been put in place. These include:

1. Assessment of situation in areas of return and ongoing protection monitoring of returnees
An independent assessment of returns areas is required before the humanitarian community supports the Government in assisting the return or before humanitarian assistance is stopped in displacement areas. Ongoing monitoring of return areas is also required to assess the sustrainable character of return and ensure that the situation remains conducive for returns. Independent monitoring of the safe, informed and voluntary nature of the return process is also required through Return Intention Surveys.

2. Identification of individual cases at risk
Individuals who would be at risk returning or who need additional assistance before return (due to access to land, tenure and occupancy issues) must be identified and provided with continued assistance in displacement areas until a durable solution is found. .

3. Access to information
IDPs need to obtain information about the safety and suitability of the returns areas, the returns process and their rights to access an alternative durable solution in order to make a voluntary decision. Likewise, IDPs need to be informed when humanitarian assistance will be terminated in displacement areas. IDPs who declare to be at risk if returning need to be informed about the mechanism in place to identify and facilitate continued support in displacement areas.

4. Additional interventions to support safe and sustainable returns
Mine risk awareness is important prior to return, particularly for children. Likewise, as are programs targeting vulnerable groups including women and young people in life skills, vocational skills and self protection – as prevention of potential recruitment. Support is also required to strengthen government structures such as the Child Protection Units in Social Welfare Department and the Police to increase their capacity to monitor and respond to identified protection, child protection and GBV issues.

Revised strategy

The focus of the protection cluster's strategy is on extending emergency services beyond the areas where they currently exist to identify and support IDPs with priority protection concerns. These priorities include ensuring IDPs are supported in registration, have an unhindered and non-discriminatory access to humanitarian assistance, and are protected from being returned to situation where their life would be at risk. Information campaigns and protection monitoring will focus on priority locations in order to support these priorities. It is essential that on the basis of results of protection need assessment, the identification of and outreach to people with specific needs/EVIs is ensured.

a. Cluster coordination, information collection and advocacy

UNHCR and IRC will maintain and strengthen the coordination of the protection cluster in 2012. UN-Habitat and UNDP will take the lead in coordinating the protection work related to HLP and access to justice/rule of law, in addition to the longstanding GBV and CP sub-clusters led by UNFPA and UNICEF respectively. Dedicated working groups will concentrate on specific issues, e.g. registration, assessment/information management and mine risk education. In addition to focused trainings provided to the provincial cluster and government stakeholders, district level coordination mechanisms, established in 2011, will be strengthened. The protection cluster will continue to liaise with government authorities in KP and FATA, particularly PDMA and FDMA.

In order to ensure that basic information is available on the protection needs of IDPs, the protection cluster has initiated, developed and trained a roster of volunteers ready to undertake rapid protection assessments and return monitoring. Protection cluster volunteers have also undertaken assessment missions on an ad hoc basis where no such programmes exist. While this is no replacement for a much needed systematic monitoring and assessments, this will ensure that some of the key information needs of the cluster are met.

b. Registration

UNHCR with the support of the protection cluster is working to technically upgrade the registration process. A “paper-free” technology is being applied, through the use of Personal Digital Assistants. In addition, to ensure complete out-reach and coverage of the displaced population and de-congest the registration desks in the Jalozai camp, an off-camp registration stations are being set up in coordination with the Government. The child protection sub-cluster will continue to act to ensure that all children are registered, regardless of their vulnerability, and that the key opportunity to collect disaggregated data is not missed during the registration process.

c. Protection desks/grievance mechanisms for key concerns

Protection/grievance desks – staffed by trained male and female staff- must be available as a top priority in camp and off camp communities to address priority issues. These desks will focus on the needs of IDPs who are unable to register, are excluded from humanitarian assistance or who may be under pressure to return to areas where they consider that their personal safety would be at risk, through the termination of assistance in areas of current displacement. They are required in each camp and in off-camp food hubs.

Information will be collected and the desk will provide advice and/or referrals. Data of IDPs in need of continued humanitarian assistance but who may be at risk of being discontinued from Government support in areas of displacement will be shared with the protection cluster after a personal consultation at the Grievance Desk. A system has recently been put in place where the protection cluster works with PDMA, UNHCR and WFP to consider and act on cases collected at the grievance desks.

d. Case management including legal/administrative advice and support with access to documentation

In order to respond to all different legal issues presented by the IDPs and extend consultations beyond the grievance desks, further case management support is required. Where feasible, interventions will include advice and support to access civil documentation, assistance with legal documents or legal aid consultations. Grievance desks will refer cases to these legal aid centres where additional follow-up will be provided by specialised actors.

e. Monitoring:

Monitoring during all stages of the displacement cycle is crucial to identify groups and individuals with specific needs and other protection concerns. Monitors can refer vulnerable IDPs to specialised services, solve problems locally, where possible, and share information on persistent concerns and identified patterns of violations with the protection cluster for follow-up and advocacy as appropriate.

Monitoring the returns and pre-returns process is a priority to ensure that de-notified areas are safe for return and that IDP returns are based on a well informed and voluntary decision. Monitoring of fresh displacements to determine protection concerns during flight and to determine unmet protection needs of IDPs upon arrival in areas of displacement is also a priority. As stated above, in the absence of any dedicated and funded protection monitoring programs, members of the cluster will undertake joint assessment missions on an ad hoc basis where they have access. Systematic monitoring, with good human resources and access, remains however the main goal.

f. Humanitarian Communications:

Humanitarian Communications will focus on meeting the information needs around the registration and transition process to inform IDPs on policies and decisions that affect their life, on assistance available and on available redress mechanisms. Communicated messages will be rights-based in character and theoir content and audience will be coordinated with the protection cluster. This will ensure the prompt addressing of key needs and issues such as prevention of separation of children, mine risk awareness, prevention and response to GBV and available services.

g. Priority intervention to support children at risk (Child Protection sub-cluster)

Some 620,000 children are considered in the HOP. Of these, 60% are considered to be vulnerable and need to be prioritised with access to services. Total needs of the CP sub-cluster are US$ $ 5,491,716 through which a total of 312,051 children can be targeted if the funding is secured. There will be a gap 50 %unmet needs from within the total caseload of children that will remain unsupported with a specific child protection intervention even after total requested amount is attained. The sub-cluster is not responsible to attain a full coverage of the total caseload. Currently, with $1,002,346, UNICEF is able to reach out to less than 20% of the vulnerable children. The aim of the cluster is to scale up protective services for children across the camps, in the hosting districts and inside Kurram to assist with the returns. Priority is given to ensure that universal birth registration takes place, that all children are registered and that their status is monitored.

To respond to the protection needs of children, the Protective Learning and Community Emergency Services (PLaCES) will offer child protection, education, recreation and community-engagement activities, and are also raising awareness about the protection needs of children and women, including the need to be protected from early and forced marriage. In addition, strengthening the capacity of agency and district governments and of the local communities to respond to child protection needs remains a priority.

h. Priority interventions to support women at risk of or experiencing GBV (GBV sub-cluster)

The GBV sub-cluster aims to reach approximately 20,000 women which is 25% of the total women case load in camps and some 182,000 women, 31% of the off camp women case load. The targets set by the GBV sub-cluster is based on need and also the accessibility and feasibility of each area. Currently, the GBV response and prevention services are only able to target 42,579 women (in camp & off camp) which is 14% of the total women case load.

To respond and prevent GBV, Women Friendly spaces will be created in camp-settings. A “Women Friendly Space” is a place where women and adolescent girls can come and spend their time in a productive and safe environment. Women and adolescent girls will be skilled at different vocational skills. Skilled staff will provide psychosocial support. Women and girls will be sensitized on health issues, human and women rights. Survivors of violence will be provided with the required support.

The following multi-sectoral interventions will be provided at the WFS: Medical services; Psychosocial support; Vocational Skills training, GBV case management (with confidentiality ensured); and distribution of hygiene kits. The WFS will also be an essential chain (and entry point) of the referral pathway.

Revised cluster objectives

Objective one: All IDPs are registered		
Outcomes	**Indicator**	**Activities**
Technically advanced registration and data management	Upgrade in Technology in use (hardware and software)	Solicitation and delivery of available PDAs
	Decrease in labour intensive data management	Software and database development
	Complete and timely monthly fact sheets issued by registration working group	Training for local authorities and IPs
	Disaggregated date of women and children (under 18)	Additional/consistent data collection during registration
Registration of new and protracted IDPs	80 per cent of fresh IDPs registered Percentage of unregistered IDPs drops from 34 per cent	Registration including mobile units and monitoring
		Advocacy and support (including to remove barriers to registration or re-open registration desks)
		Follow-up support to IDPs who have not been able to register e.g. because they do not have CNIC
Objective two: IDPs have equitable access to assistance and are protected from rights violations		
Outcomes	**Indicator**	**Activities**
Identification of vulnerable IDPs and protections concerns	Number/nature of vulnerable groups identified and documentation of protection concerns	Monitoring and advocacy
		Referrals/mapping of service providers and the quality of services
IDPs are supported to access services	IDPs using services; number of grievance desks; number of advocacy interventions	Humanitarian communications
		Grievance desks
		Follow-up support
IDPs protected from rights abuses including discrimination, GBV and violations of children's rights	Concerns addressed through advocacy and cases managed through protection centre in each district	Monitoring and advocacy
		Case management
Objective three: IDPs able to access to safe and voluntary durable solution		
Outcomes	**Indicators**	**Activities**
IDPs are protected from return to situations where their life may be at risk	Number of FGDs undertaken with IDPs notified to return; number of assessments of safety of return areas; number of eligible cases from the grievance desk for whom advocacy with the authorities to continue assistance in successful	Return monitoring including FGDs with transition IDPs; independent assessment of situation in return areas
		Grievance desks for IDPs who would be returned to risk and follow-up
		Hum communications and rights awareness to ensure IDPs know their rights and remedies, and provision of area of origin information
IDPs are assisted to return or to access another durable solution	Number of percentage of off-camp IDPs that benefit from humanitarian assistance to return number of individual concerns regarding return addressed; number of assistance packages that	Hum communications and rights awareness to ensure IDPs know their rights and remedies
		Advocacy to ensure vulnerable off-camp IDPs provided with return support and that camp and on-camp IDPs who need special

	enable IDPs to make their own choice of durable solutions to reintegrate or resettle	assistance to return can access support
		Advocacy to ensure that transition support is also available to de-registered IDPs who wish to resettle/reintegrate
Objective four:Ensure that children at risk in each stage of displacement and transition are provided with adequate support and timely response		
All children are reunited and enjoy the care of their families; separated and unaccompanied children are in family-based or an appropriate alternative care	Percentage of separated / unaccompanied children that are united with their families or receiving appropriate alternative care	Monitoring of risks to children
		Grievance redressal and referral
		Rolling out of SOPs on separated, mission and unaccompanied children at district level.
Strengthened child protection mechanisms at community, camp and in communities who are returning.	Number of children participating in recreational and psychosocial activities in camp and return areas	Community based child protection centres, protection spaces for women and children in an integrated approach
Targeted response to needs of children in protracted displacement situations and in transition to areas of return.	Number of children participating in recreational and psychosocial activities in off-camp locations and return areas	Community based child protection centres, protection spaces for women and children in an integrated approach
Objective five: Provide holistic multi-sectoral response to GBV and ensure survivor centred services for IDPs in displacement and transition		
GBV Case Management: survivor-centered and multi sector response to GBV survivors is ensured: a functional referral mechanism is in place, to facilitate the survivors who reported cases of violence;	-Linkages developed with the other sectors like health, protection, Food etc - GBV cases are linked to health services while 80% of the cases get psychosocial support.	Strong referral linkage with the other sectors so as to ensure holistic multi-sectoral GBV response and to facilitate service-delivery to women through the Women Friendly Spaces (will be integrated/linked with protective child friendly spaces)
		Initiate GBV case management to ensure improved access of GBV survivors to secure and appropriate reporting, follow up and protection
		Provide health services providers (Reproductive Health) with relevant training and supplies(Rape Treatment Kit & PEP kits) and ensure that appropriate psychosocial support is offered to survivors
Vulnerable groups are provided with psychosocial support	70% of Vulnerable groups/individuals are provided with psychosocial support	Women/child friendly spaces
		Provision of psychosocial support to women and adolescent girls from conflict-affected areas, with special focus on survivors of gender based violence;
Livelihood, skills development opportunities available for the women and adolescent girls.	Number of women and adolescent girls provided with vocational skills trainings	Vocational skills training
		20 Women Friendly Spaces established in KP and FATA with the support of UN Women provide skills development trainings.

Table of proposed coverage per site

	2012 needs (for year)	Current funding	Gap	Comments
Coordination co-ordination, information gathering and advocacy	250,000	60,000	190,000	Gaps relates to one UNHCR protection cluster coordinator position past June (international), IM staff person (national) and support for RPA roster and protection assessments
Registration	880,000	346,726	533,274	Relates to additional needs for Bara IDPs and contingency for any newly identified protracted IDPs
Protection/grievance desks	985,000	461,000	524,000	Current funding ends in June Women Desk established at FDMA with the support of UN Women to guide the women in registration, assistance in hubs and resolution of issues being faced by them Protection units established with the support of UN Women in Peshawar, Swabi and Nowshera to provide psycho-social support for those young girls and/or women who were directly or indirectly affected of complex emergencies.
ICLA centres for further case management	2,000,000	300,000	1,700,000	Currently funded in Peshawar and Kohat
Protection monitoring, profiling and return intention surveys	575,000	180,000	395,000	
Returns monitoring	800,000	200,000	600,000	Gaps relates to denotified areas of SWA, Orakzai and Kurram. Note: funding for SWA and Orakzai have also been requested under FATA ERAP
Humanitarian communications for off-camp IDPs	400,000	0	400,000	
Child protection interventions – PLaCES	5,491,716	1,002,346	4,489,370	Present coverage is 20% of the caseload. The increase in funding will aim to meet 50% of the caseload. The funds will ensure response to fresh IDPs, continuation of services for camp population, in addition to initiating services for the protracted IDP caseload. In addition, monitoring and profiling of children in Kurram as part of the support to returns will also be achieved if funding is funnelled through.
Women friendly spaces	4,738,225	609601	4,128,624	GBV SC targets to cover 25% of the in camp women. Gap in terms of funding is 4,83794 for camp population. GBV SC targets to cover 31% of women off-camp i.e 182,375 women. Budget required to cover 31

				% off camp is 3,644, 831 20 WFS set up by UN Women in KP and FATA. 12-16 of these will be relocated to Jalozai Camp as per PDMA request.

Child Protection Planning Figures

A total of 619,500 children are affected in KP and FATA. Of these, 60% (317,700 children) are considered to be vulnerable and need to be prioritised with access to services. Of the 619,500 children, 175,000 children who are currently in KP and Kurram will be returning to Kurram- this caseload is not added on to the total caseload to avoid double counting.

The total needs of the CP sub-cluster are US$ $ 5,491,716 including $315,756 for assistance to returns. If the total funds are secured, only a total of 312,051 (50%) children in camps and host communities can be assisted, in addition to 105,000 children assisted during returns.

There will be a 50% gap of children with unmet needs from within the total children caseload that will remain even after total requested amount is attained. The cluster is not responsible for coverage of 100% of the total caseload. Currently UNICEF with $1,002,346 is able to reach out to less than 20% of the vulnerable children. They are the only cluster member with funding. The aim of the cluster is to scale up service for children across the camps, in the hosting districts and inside Kurram to assist with the returns. UNICEF will respond through PLaCES concept: these are Protective Learning and Community Emergency Services' (PLaCES), which offer child protection, education, recreation and community-engagement activities, and are also raising awareness about the protection needs of children and women, including the need to be protected from early and forced marriage. Cluster members will also respond through similar responses- integrated services for children, adolescent girls and women through intervention in camps and hosting districts.

Amount of Funds requested by CP Sub-cluster: $ 5,491,716
Total Funding Available: (UNICEF) $1,002,346
Total Cluster Gap : $4,489,370

The CP cluster will therefore follow the below guidelines for all future planning in KP and FATA:

Family size: 7
Male:Female ratio: 48:52
50% of total population is children under the age of 18.
60% of total population is vulnerable
10% of total population is extremely vulnerable

Cost of services
For this exercise, the cluster decided the following, after using the UNICEF program as a guideline. It was decided that the cost to UNICEF may be a little less, so the cluster members advocated for a per unit cost to be slightly higher than the UNICEF costs.

- UNICEF PLaCES is $17.5/person for 6 months; in addition- cost of a profiling and registering exercise costs $3/ head
    - PLaCES model is as follows: 1 PLaCES responds to needs of 500 people: 370 children, 130 women catered for 6 months at $8,746
- Cluster Costs PLaCES like intervention is $20/person for 6 months. The cost of profiling children was costed at $3/child.

I: Planning Figures
A : Total Displacements = 177,000 Families
16,000 Families in Jalozai including the ones from Baj, Mohmand, and old Khyber
62,633 Khyber Displacements off camp
44,869 Kurram and Orakzai displacements into Sadda, Kohat and Hangu • 12,555 conflict IDPs Kurram • 3,565 Kurram in New Durrani • 1,159 in Tog Sarah

• 2,165 in Hangu Host • 23,091 in Kohat • 10,000 additional in Hangu • Minus 7,666 who will return
30,456 from SWZ into DI Khan and Tank • 26,986 DI Khan • 10,136 Tank • Minus the 6,666 returned
18,000 Tirah Displacements
5,000 Other displacements
B: Total numbers in camp = 20,724 Families
16,000 Families in Jalozai
1,159 in ToghSarai
3,565 in New Durrani
C: Total numbers in host communities in KP and Sadda =156,234 Families
62,633 Khyber off camp families in Peshawar Valley
27,590 Families in Kohat and Hangu 12,165 families in Hangu (including the ICRC 10,000 and 2,165 Hangu) 23,091 Families in Kohat Take away the 7,666 familes that will return- will give you total caseload of 27,590 in Kohat and Hangu
30,456 Families in DI Khan and Tank 26,986 in DI Khan 10,136 in Tank Take away the 6,666 who will return will leave 30,456 families caseload
23,000 Families from Tirah and others
12,555 Families from Kurram who are in Sadda

Priorities:

1. Khyber IDPs- on and off camp
2. Continuing services in all three camps
3. Protracted IDP caseload in host communities
    i. Tank
    ii. DI Khan
    iii. Hangu
    iv. Kohat
4. Host community and returns area in Kurram – Sadda
5. Support to returns inside Kurram

Total Numbers Displaced		
In camp	20,724 Families	72,534 children
Off camp	156,234 Families	546,966 Children

Camps – Cost of Response

Camp name	**Total number of children**	**Total targeted**	**Gap (children)**
Jalozai	56,000	30,000	26,000
ToghSarai	4,057	2,118	1,939
New Durrani	12,478	8,112	4,366
Total	72,535	40,230	32,305

Total Jalozai = 16,000 families; 112,000 individuals ; **56,000 children**				
Response	**Beneficiaries**	**Cost**	**Available**	**Gap**
UNICEF 27%	15,000	$ 358,608	$256,320	102,378
Cluster target 27%	15,000 @ $20/head	$ 300,000	0	300,000
Remaining Gap	26,000 Children			

Total ToghSarai = 1,159 Families = **4,057 Children**				
Response	**Beneficiaries**	**Cost**	**Available**	**Gap**
UNICEF Target 25% through PLaCES	1,014	$37,500	$37,500	$0
Cluster Target 25%	1,104	$22,080	$0	$22,080
Remaining Gap 50%	2,024			
Total New Durrani = 3,565 Families = **12,478 Children**				
Response	**Beneficiaries**	**Cost**	**Available**	**Gap**
UNICEF targets 40%	5,000	$126,097	$126,097	$0
Cluster Targets 25%	3,112	$62,240	$0	$62,240
Remaining Gap 35%	4,366			

Host Communities – Cost of Response

Response to off camp Khyber IDPs = 62,633 Families = **219,216 Children**				
Response	**beneficiaries**	**Cost**	**Available**	**Gap**
UNICEF 30% : profiling, grievances desks, monitoring. No direct services. This cost is $3/head	74,500	$224,590	$74,590	$150,000
Cluster targets 25% of total caseload with **direct services**	54,804	$1,096,080	$0	$1,096,080
Gap remains 75% without direct services	164,412			
Response to Off camp in DI Khan and Tank=30,456 Families = **106,596 Children**				
Response	**Beneficiaries**	**Cost**	**Available**	**Gap**
UNICEF reaches 15% through Protection Centers in DIKhan and tank	15,580	$262,000	$262,000	$0
Cluster Targets 40%	42,639	$852,768	$0	$852,768
Remaining Gap 53%	112,335			
Response to Off Camp population in Hangu= 2,165 Families= **7,578 Children**. Please note that the 10,000 former ICRC caseload- **35,000** children is not considered in this as a priority				
Response	**Beneficiaries**	**Cost**	**Available**	**Gap**
UNICEF 25%	1,894	$112,194	$112,194	$0
Cluster targets 40%	3,031	$60,620	$0	$60,620
Remaining Gap 35%	2,653			
Response to Off camp population in Kohat =23,091- 7,666 that have returned = 15,425 Families =**53,988 Children**				
Response	**Beneficiaries**	**Cost**	**Available**	**Gap**
UNICEF	-	-		
Cluster 40%	21,596	$431,904	$0	$431,904
Gap 60%				
Response to Kurram Off Camp inside Sadda = 12,555 Families = **43,943 Children**				
Response	**Beneficiaries**	**Cost**	**Available**	**Gap**
UNICEF 19% of children	8000 children, 500 women	$133,735	$133,735	$0
Cluster intervention is 40%	17,577	$351,544	$0	$351,544
Gap is 41%	18,366			
Response to Tirah and Other Displacement = 23,000 families = **80,500 Children**				
Response	**Beneficiaries**	**Cost**	**Available**	**Gap**
UNICEF	-	-		
Cluster Intervention 40%	32,200	$644,000	$0	$644,000
Gap 60%	48,300			

Support to Returns in Kurram

Response to returns inside Kurram : 34,000 Sectarian IDP Families +12,555 Conflict IDP families+ 3,565 IDPs from New Durrani = 50,120 Families =**175,420 Children**				
Response	**Beneficiaries**	**Cost**	**Available**	**Gap**
Cluster to respond by supporting returns through protection monitoring, grievance redressal/desks, profiling of vulnerable children. Target 60% vulnerable	105,252 @ $3/person	$315,756	$0	$315,756

ASSESSMENTS: COST : An additional $100,000 to be costed into the cluster budget to assist with conducting rapid needs assessments

GBV Planning Figures

There is a need to add a dollar figure for needs assessments that should be a part of any emergency response plan.

Family size: The cluster members discussed what an appropriate size to have was. It was agreed that the CP , GBV cluster will consider average family size to be 7. The census was out dated, the statistics differed a lot- ranging from 4.2 to 9 for some agencies. The cluster decided that because of the lack of clarity, and because their field experience indicated that 7 would be an appropriate number.

The GBV Sub cluster will therefore follow the below guidelines for all future planning inside KP and FATA:

Family size: 7
Male: Female ratio: 48:52
50% of total population is children under the age of 18.
10% of total population is extremely vulnerable

Cost of services

There was a lot of discussion that it is very difficult to consider a unit cost for protection services- and so coming up with a budget for protection services was not as clear cut as a technical cluster may be. In some cases, the cost may be higher depending on the location, and the complexity of the situation. Initiating services and continuing services will also imply a varying cost. Similar services in and off camp will also have a varying cost. There is a need to have the GBV Sub cluster standardize costs to the extent possible.

I: NEW DISPLACEMENTS
Fresh Displacements = 85,633 families = 599,431 individuals = >311704 women
62,633 Khyber Displacements
18,000 Tirah Displacements
5,000 Other displacements
Total Women Case Load: 311704 women (100%)
In camp:
Total Families in Jalozai = 11,592+4,950 = 16,542 =115,794 individuals **=>60213 women**
UNFPA targets 22% of women in Jalozai (60213) = 13050 women **($89698)**
Cluster will target 25% of women in Jalozai: 15,053 women (15,053*25$= **$376325**)
Remaining Gap in Jalozai= 53% for government to consider.
Off Camp: 249,363 Out of 311704 women, approx. 62341(20%) are in camp and 249,363 women off camp
UNFPA Interventions: 0% of off camp
Cluster Target : 40% of caseload with direct services = >99745 women **($2493000) women** through WFS approach Gap is 60% => 149617 women

II : CONTINUING SERVICES IN CAMP
Continuation of services in ToghSarai and New Durrani: ToghSarai 1,159 Families,8113 individuals => 4,218 women New Durrani 3,565 Families, 24955 individuals => 12,977 women
ToghSarai
UNFPA WFS to target 40% of 4218 women ➔ 1687 women Cluster Target 25% of 4218 women → 1055 women (**$26363)** Remaining gap is 35% → 1476 women
New Durrani
UNFPA: WFS to target 40% of 12977 women ➔ 5190 women Cluster Target 25% of 12977 women → 3244 women (**$81106)** Remaining gap is 35% → 4542 women
III PROTRACTED CASELOAD in Tank, DI Khan and Hangu
Tank 10, 136 families = 70,952 individuals = **36895 women**
Di Khan 26, 986 families = 188,902 individuals= **98229 women**
Total Women in Tank and DI Khan = 135124 women.
UNFPA Interventions: 10% of the total population = 13512 women through Women friendly Spaces till June 2012
Cluster Target: 25% of 135124 =>33781 women **($844,525)** Remaining Gap: **65% => 87831 women, for Government to consider**
Hangu 2,165 families ,15155 individuals = > 7881 women UNFPA in host community:0% Cluster intervention is 40% of (7881) = 3152 women **($78806**) Remaining Gap = 60% => 4729 women

IV Kurram Caseload
Host communities and return Areas:
Kurram 12, 555 families , 87885 individuals ➔ 45,700 women in host communities in Sadda and Kurram
UNFPA In host community is 20% of 45700=> 9140 women Cluster Target is 20 % → 9140 women (9140 * 25== **$228,500**) Remaining Gap is 60% => 27420 women

GBV SC has detailed discussion to fix the % of women that GBV SC will respond to. The cluster member agreed to cover 25% of women in camps and 31% of the women off camp in terms of GBV activities. The agreement comes to on basis of need in terms of GBV, and also considering the accessibility and feasibility to the cluster members to intervene the activities..In areas where presently there is no GBV projects, clusters members agreed to fput a maximum % to cover women group.

Strategy of GBV SC:
To response and prevent GBV, Women Friendly spaces will be adopted."Women Friendly Space" is a place where women and adolescent girls can come and spend their time in a prolific manner. Women and adolescent girls become skilled at different vocational skills. Skilled are available for provision of psychosocial support to women and adolescent girls, in need of .WFS right holders will be sensitized on health, human rights, and women rights .Women and adolescent girls identified as survivors of violence will be provided with the required support

Following an emergency, there is a need to bring the affected population back to the normalcy as soon as possible. WFSs make it possible to establish daily routines, as well as to facilitate the resumption of customary activities by supporting the resilience and well-being of women and adolescents through community organized inter-sectoral activities conducted in a safe, stimulating environment.

WFSs as a gateway for multi-sectoral interventions
WFSs provide a space for a variety of services including:

- Medical services

- Psychosocial support
- Vocational Skills training
- GBV case management
- GBV Multisectoral Referral Pathways focal point
- Distribution of Hygiene Kits

Available fund with UNFPA for GBV is **609,601 USD**

Funding Gap of GBV SC:
In camps:
GBV SC targets to cover 25% of the in camp women. Gap in terms of funding is : 483,794USD for in camps(New Durrani,Toghserrie and Jalozai)

GBV SC targets to cover 31% of women i.e 182,375 women. Budget required to cover 31 % off camp is : 3,644,831USD.

Total Funding Gap is: 4,128,624 USD

Shelter and Non-Food Items (NFIs)

Cluster lead agency - KP	**UNHCR / FDMA**
Implementing agencies	IOM, NRC, FRD, CAP, BFO, SNS, UNHCR, AHO
Number of projects	2 Projects, e.g. **10,128 Transitional shelter** for 5 Tribal Agencies, (i.e. one transitional shelter unit per 2 households composed of one emergency tent + other transitional shelter components) **9,830Shelter repair kits** for 1 Tribal Agency**,** (i.e. one shelter repair kit per eligible vulnerable family in Kuram Agency, Note: a.) The FATA - Early Recovery Plan for 4 Tribal Agencies does not include Kuram Agency) b.) NFI support for IDPs in camps will be covered under the CCM proposal c.) Improvement of Basic Community Facilities in host communities will have to be covered under IDP hosting Community Programme, (e.g. Community Restoration Cluster)
Revised cluster objectives	Access to "**transitional shelter**" for returnees who are confronted with uninhabitable damaged homes at their place of origin in 5 FATA Agencies, (e.g. for vulnerable families who have no choice but to stay in transitional shelter at their family compound until the results of early recovery facilitate rehabilitated / reconstructed durable shelter.) Access to **Shelter repair kits** for returnees who are confronted with severely damaged homes at their place of origin in Kuram Agency, (e.g. for vulnerable households who are willing to repair one or two dwelling units of a fully damaged family compound, while waiting for assistance under the early recovery programme.)
Beneficiaries	Direct and indirect **Beneficiaries** of "**transitional shelter** assistance" for 5 Agencies: 20,256 households (HHs) or up to 121,536 people. (e.g. two vulnerable HHs receive together one "transitional shelter" for emergency accommodation) Direct **Beneficiaries of Shelter Repair Kit** assistance (i.e. in Kuram Agency only): 9,830 House Holds (HHs) or up to 58,980 people. **Total Beneficiaries**: 30,086 House Holds (HH) or up to 180,516 people ***Note****: See attached planning assumptions.*
Funds requested	Transitional shelter for 5 Agencies: = USD 4,557.600,(i.e. 10,128 Tents + other transitional shelter components @ USD 450 per Unit) Shelter repair kits for Kuram Agency only: = USD 8,847.000,(i.e. 9,830 shelter kits + cash for work @ USD 900.00 per unit) **Total funds required: = USD 13,404,600**
Contact information	Werner Schellenberg, Shelter Cluster Coordinator, e-mail: schellen@unhcr.org, Cell: 03018550527 Abbas Khan, SCC Assistant, e- mail: khamuham@unhcr.org Cell: 03008153699

Category	**Affected population**			**Beneficiaries (if different)**		
	Female	**Male**	**Total**	**Female**	**Male**	**Total**
Beneficiries eligible for Transitional shelter (i.e. Tents + other transitional shelter components for 5 Tribal Agencies				58,338	63,198	121,536
Beneficiries eligible for Shelter repair kits (i.e. for				28,310	30,670	58,980

Category	Affected population			Beneficiaries (if different)		
	Female	Male	Total	Female	Male	Total
Kuram Agency only)						
Total				**86,648**	**93,868**	**180.516**

Needs analysis

KP and FATA are characterized by phases of displacement and subsequent returns in response to securityoperation or sectarian violence in FATA Agencies, during which populations struggle to resume normal life. In this challenging environment, the local authorities have requested support from the humanitarian community to assist in meeting the needs of affected populations, both during displacements and during the transitional phase of return.

Back in the areas of origin, there are significant humanitarian needs amongst both the returnees and the stayees.

In most areas, security operations and/or sectarian violence have caused significant damages and destruction, particularly in relation to housing and basic community infrastructure. Absence and lack of maintenance, during consecutive winters has further contributed to increase the degradation of the mud build traditional shelter structures rendering many dwellings uninhabitable and completely destroyed as a consequence. Field observations and shelter damage assessment reports indicate that up to 76% of the housing stock in affected areas of return are either severely damaged or fully destroyed. Whilst peace building and early recovery assistance is key to durable solutions, it remains vital to also kick start essential self – help initiatives at places of return with transitional shelter solutions until more durable shelter solutions are accessible through the early recovery programme

Enhancement of the return process, specifically for those IDPs who are confronted with total shelter damage at their place of return, will be possible with transitional shelter support (i.e. tailored transitional shelter assistance for beneficiaries who will be identified based on damage assessment and vulnerability criteria). It is suggested to tailor a transitional assistance package with two complementary components, e.g. with tents and with shelter repair kits. The tent component will address basic shelter protection needs and provide transitional protection from weather impact to those most vulnerable family members who are forced to survive without shelter in transition from the date of return to the time when alternative shelter solutions are accessible through the early recovery programme. The provision of shelter repair kits will support initial self – help repair works on recoverable dwelling units, will mitigate further weather damage on severely destroyed shelter structures, and will contribute to facilitate minimum SPHERE standard shelter space in severely damaged or fully damaged family compounds. The need for Tents / other transitional shelter is identified for all 5 Tribal Agencies of return in FATA and will have to be covered under the HOP programme. The need for complementary shelter repair kits is also identified however, only marginally included under the early recovery programme for 4 return Agencies. It will be therefore necessary to cover this component for Kuram Agency under HOP.

As traditional family compounds in Kuram accommodate an average of 20 to 30 family members, (i.e. 4 to 5 households) it is suggested to assist under the HOP programme a maximum of two households in one family compound with a shelter repair kit and to complement this support with a maximum of two tents for the remaining three households.

Proposed strategy

Access to shelter has been identified as a basic protection need and is regarded to facilitate durable solutions for FATA returnees under the HOP and ER initiative.

The specific objective under the HOP initiative is to enhance the return process of IDPs with transitional shelter support that will assist returnees to kick start self- help initiatives and to facilitate minimum protective shelter space to most vulnerable families who are confronted with fully damaged shelter compounds at their place of return, and in doing so to bridge the time until early recovery support for more durable housing solutions is made available.

To quantify the transitional shelter needs it is suggested to work along the following guidelines:

- anticipate a total case load of 93,525 returnee families for 2012
- consider 76% of the shelter stock needed for this case load as partly to fully damaged
- assume that a significant proportion of the assessed housing stock is severely to fully damaged
- quantify the fully damaged housing stock by applying a damage factor of 47, 5 %, (i.e. a research based damage factor for weather exposed and little or unmaintained traditional mud structures, specifically where unmaintained over a period of one to three years)

- assume that 40% to 47 % of the fully damaged housing stock will be replaced by self - help investment provided by damage affected returnees and property owners.
- bridge the remaining shelter gap with minimum shelter securing interventions funded by various programme initiatives, e.g. HOP, ER, CERF.

Beneficiary selection for transitional shelter assistance:
As stated in the shelter strategy, the priority for shelter assistance will support the most vulnerable returnees who are affected by fully damaged dwellings in their family compounds at places of return.

Summary conclusions of the "Strategic Workshop on the Complex Emergency" anticipate for 2012 a total return of 93,525 families.

Using the Protection Cluster's vulnerability guidelines, it is suggested to include the most fragile households as potential beneficiaries, e.g. including:

- Female headed households
- Child headed households
- Older person headed households
- Households headed by person with disabilities (physical, intellectual, sensory)
- Households headed by person with a chronic disease
- Households who fail to obtain the financial means for kick starting initial shelter repair works on their fully damaged homes

Technical guidelines:
The technical guidelines for the "transitional" shelter interventions have been endorsed by the Shelter Cluster. The guidelines recommend a minimum SPHERE standard living space of 3.5 m square meter per person per tent or per dwelling unit. SPHERE guidelines have been adopted for the one room shelter repair kit design specifications and BoQs, respectively for "transitional" shelter interventions.

Design considerations:
A. The transitional shelter component, (i.e. Tents + other transitional shelter components) as proposed for 5 Tribal Agencies, will be used to facilitate transitional shelter and weather protecting temporary overnight accommodation for some 6 to 12 persons. The supply of tents will be limited to two units per fully damaged family compound. Additional material components may be supplied, (e.g. for repair works on Parda walls, for repair works on livestock shelter and fodder sheds, etc.), as deemed to be essential for livelihood building support, and subject to availability of funding.

B. The shelter repair kit component is proposed for Kuram Agency only.
The repair kit is designed to repair / rehabilitate one room for a 6 person household. The kit consists of durable / high quality shelter repair material, including material for roof reconstruction, and material for door and window repair works. A Cash for Work component and a set of building tools will be added to each kit and enable beneficiaries to complement expenditures for labour and transport costs. The repair kit will enable beneficiaries to merge traditional mud building techniques with disaster risk (DR) mitigating technologies and in achieving this task reduce potential disaster impact and decrease potential maintenance costs in future.
Note: It is suggested to restrict the distribution of shelter kits to maximum of two households,or two units per family compound (i.e. in cases where several households live together in one fully damaged compound) fully damaged

Revised cluster objectives

Objective: Provide security and protection to vulnerable groups returning to FATA areas through provision of transitional shelter and shelter repair kit components		
Outcomes	**Indicator**	**Activities**
30,086 House Holds (HH) or up to 180,516 beneficiaries received transitional shelter and shelter repair kit support for covering emergency shelter needs and for enhancement of self-help initiatives for repair/ rehabilitation works on a fully damaged family compound.	The most vulnerable IDP returnees in FATA provided with transitional shelter and dwelling repair kits.	• Identification of eligible beneficiaries, based on assessed/ verified shelter needs and vulnerability criteria • Distribution and implementation monitoring of transitional shelter and shelter repair kits at places of return inside FATA

Table of proposed coverage per site

SITE / AREA	ORGANIZATIONS
Bajour	UNHCR,NRC, IOM
Mohmand	UNHCR,FRD,NRC, IOM
Orakzai	UNHCR,SRSP, AHO,CAP, IOM
South Waziristan	UNHCR, SRSP, NRC, IOM
Kurram	UNHCR,FRD, BFO,SNS, IOM

Water, Sanitation & Hygiene (WASH)

Cluster lead agency	**UNICEF**
Implementing agencies	WHO, UNICEF, UNHABITAT, OXFAM, SSD, ACF,HRDS and other National and International NGO's
Number of projects	
Revised cluster objectives	The WASH Cluster Strategy 2012 has defined a response to meet the identified needs and is guided by humanitarian principles and priorities, including Sphere Guidelines. The WASH strategic objectives are defined as follows: • Ensure access and provision of safe drinking water, appropriate sanitation, and promotion of safe hygiene practices to 144,000 IDPs in camps through 2012 • Support efforts to ensure access to safe drinking water, sanitation and hygiene promotion activities benefiting 1,000,000 IDPs living in host communities and 1,000,000 hosting population through 2012. • Support provision of return package (hygiene kit) to 552,000 returnees (including Kurram IDP's) during the year 2012. • Ensure effective coordination of the humanitarian response programme in the WASH cluster in close collaboration with other clusters and Government, including ensuring complementarities of interventions through information management • Enhance protection of affected communities from preventable illnesses, through routine water quality surveillance and disinfection and capacity building of local water service providers.
Beneficiaries	**2,690,000** (IDPs living in camps and out of camps , host families and affected returnees) including female population
Funds requested US $	25.9 Million USD ($ 15 Million UNICEF, $ 1.9 Million WHO, $ 9 Million by Other Cluster Members) UNICEF through 15 million USD will cover 150,000 IDPs in camps, 650,000 IDPs off camp and 300,000 returnees.
Contact information	Syed Jamal Shah ;(jshah@unicef.org);0322-9916261

Category	**Affected population**			
	Children	**Women**	**Men**	**Total**
IDPs	630,000	188,700	181,300	1,000,000
Host communities	630,000	188,700	181,300	1,000,000
Camps	90,720	27,173	26,107	144,000
Returnees	140,490	42,080	40,430	223,000
Kurram IDPs	207,270	62,082	59,648	329,000

Needs analysis

WASH response in any humanitarian emergency forms part of life saving interventions and, due to the dynamic nature of the KP and FATA emergency, WASH interventions are expected to remain a priority area of response through 2012. As the situation extends into 2012, more than 1.1 Million IDP's are expected to continue to reside or be new IDPs in camps or in hosting districts off of camps. Based on information from government and registration data, approximately 148,244 families have returned to their places of origin and yet others still reside in crisis areas. WASH interventions and services are basic pre-requisites for the health and reduced vulnerability of all of these population segments.

In IDP camps,WASH facilities are basic pre-requisites in camps and must be maintained throughout the camp lifetime. Over 2012, approximately 144,000 individuals are expected to reside in minimum three IDP camps; these IDP's would have to be provided all lifesaving WASH facilities as per SPHERE standards. Where IDP populations have taken, or are expected to take, refuge in host communities, and often water and sanitation coverage is already below standard, the increased burden on drinking water supplies and sanitation infrastructure, if existing, can increase vulnerabilities to water, sanitation and

hygiene-related diseases. Based on the most likely scenario, through 2012, approximately 2 million IDPs and hosting communities may require WASH response. Although the response will vary as per needs i.e. from just soap distribution to a full WASH package as per needs (determined through the WASH assessment and IVAP) corresponding to SPHERE.

Outbreaks of waterborne diseases continue to occur in the affected areas, leading to loss of life, disease and economic burden for vulnerable affected communities. Bacteriological contamination of drinking water represents a serious health issue in the affected areas, with resulting diarrhea and worm infestation being two major waterborne public health threats. Regular water quality monitoring and control in all affected areas, is thus of paramount importance in blocking the spread of water borne diseases. WHOs' regular testing of drinking water in affected communities in IDP camps and return areas is one of the measures available to ensure the provision of a safe water supply in affected areas. Water quality monitoring serves as a check that barriers to contamination are working effectively.

For the returnee population the WASH Cluster has estimated that 31,838 families would need to be provided with WASH NFI's while an estimated 47,000 IDP families in Kurram agency would be in need of WSAH support. This figure is based on the expected humanitarian scenario through 2012 and do not include populations who never left these areas during the crisis. The restoration of WASH services and interventions is one of the conditionality for return and forms an integral part of the early recovery for the affected populations.

Assessments:

Several assessments ofWASH needs in various areas of IDP's hosting communities have been undertaken through WASH Cluster and government line departments. Based on the WASH Cluster assessment conducted through consultancy firm NESPAK and the IVAP the following facts are established.

1. 25 % of the affected population is using surface water sources for drinking purposes.
2. 22 % of the affected population is using highly contaminated water
3. 8 % of the affected population has to bring water from a distance of more than 500 meters.
4. 40 % adult women, 6 % female children and 8 % male children are responsible for water collection.
5. More than 30 % of the affected population has no water storage facilities at the household level.
6. More than 50 % of the affected population do not have access to safe excreta disposal facilities.
7. More than 70 % of the affected population do not use soap for Hand washing.

Over 2011, the Cluster has also, in coordination with the Health Cluster responded to several outbreaks of WASH related disease. Throughout 2012, readiness must also be ensured and extended to other life-saving WASH interventions required by the newly displaced. Coordination of the WASH emergency and early recovery programmes through the WASH Cluster, throughout 2012, remains a priority to ensure an effective, coordinated and timely response to meet the WASH needs of the affected populations.

Prioritization:

The prioritisation of WASH response intends to meet the needs of most vulnerable of the target caseloads immediately where circumstances may not allow for comprehensive response.

This includes populations

1. residing in IDP camps, where services of safe drinking water and adequate sanitation, hand washing and bathing facilities are provided. Interventions must also ensure solid waste management and appropriate drainage in proximity to WASH facilities. Similarly, hygiene conditions amongst the affected population are poor and intensive hygiene promotion activities must be maintained. The operation, maintenance of these camp facilities and the

decommissioning of camps, in an environmentally appropriate manner, upon closure must be ensured.

2. IDPs residing with host families and the hosting communities. Priority will be given to the most vulnerable, especially female, elderly, and child headed households, widows families with more than six children of school age;in combination with the WASH needs i.e. on the basis of lack of safe/clean drinking water, walking distance, safe excreta disposal facilities etc.

All activities will be designed and carried out with due regard to gender, children, the vulnerable, cultural sensitivities and practices and environmental considerations.

Significant challenges are expected during the implementation period: the complex nature of the emergency may render inaccessible certain areas of return and lead to the new displacement of populations; the summer season when water, sanitation and hygiene related disease rates are expected to rise and the monsoons which cause areas of KP to flood annually may require emergency response through the year. The overall heightened security risks magnify all other challenges in these areas and increase associated operational costs.

Proposed strategy

The implementation of WASH response as defined above is guided by the following strategies:

- Coordinate effective delivery of WASH response to the affected populations through the Cluster Approach, including coordination with government, key partnerships within the Cluster and across related Clusters including:
  - Health Cluster: WASH in health facilities, diarrhoeal disease reporting, outbreak response
  - Education Cluster: WASH facilities in schools, hygiene education for school-going children
  - Protection Cluster: identification of vulnerable persons and areas for prioritised response
  - CCCM and Shelter: camp site selection and development, camp management
- Whilst meeting immediate needs, WASH interventions should seek to establish from the outset linkage to and be guided by longer term development efforts where possible, including guidance from WASH related policies and strategies
- Proactive commitment to ensure that cross-cutting issues of human rights, gender, environment and refugees are addressed in the immediate response and in on-going prioritization of projects; address WASH priorities with special emphasis on the needs of women, children, the disabled and the elderly
- Utilization of participatory and rights-based approaches, efforts will be made to ensure consultation with women, men and children and all segments of the population resulting in the overall promotion and empowerment of these populations and in particular that of women.
- On-going assessments will continue to aid in the prioritisation of activities. in these areas which may include installation / restoration of water supply to supplement existing schemes, technical support and installation of sanitation facilities, intensive social mobilization / hygiene promotion for improved hygiene and sanitation coverage, distribution of WASH related NFIs for safe household water storage and treatment, support for water and sanitation facilities in schools and health centres. These actions are being planned and prioritized, in coordination with government counterparts and other Clusters, including Camp Coordination, Health, Education and Protection Clusters, for an effective and efficient response aimed at reaching those identified as most vulnerable.

- Capacity development of government and communities in emergency preparedness, response and coordination to enhance the resilience to deal with the emergency situation and ensure the ability to execute and maintain the WASH early recovery programme
- Establishment of multi-faceted and robust monitoring and reporting mechanisms to measure the effectiveness and impact of the WASH response

Types of Intervention:

- In IDP camps full package of WASH services including provision (or continuation) of Water for drinking, cooking, hygiene etc. as per SPHERE guidelines (already recommended by Cluster Technical Working group), provision of toilets, bathing places, laundry points, solid waste management, hygiene promotion and WASH NFI's.
- Within the hosting areas prioritize functionalization of non-functional drinking water systems to ensure that the IDP's and hosting communities get a minimum quantity of water as per SPHERE.
- Through repair of water source, storage reservoir, pipe networks, leakage control etc. ensure that quality and wastage of water is controlled in the IDP's hosting areas.
- Provision of Hand pumps, extension of any existing system etc. if water availability is less then SPHERE and provision of House hold water treatment if the water available is contaminated.
- Provision of House hold water storage capacity through provision of small water tanks, buckets and Jerry can as per requirements.
- Provision of toilets, solid waste management and WASH NFI's as per requirements corresponding to SPHERE.
- Focus on ground-water scarce areas where access to safe drinking water is limited, and continue emergency supply until sustainable alternatives are restored;
- Would support provision of safe water and sanitation in temporary schools, basic health units and communal facilities;
- Support community-based hygiene promotion using multiple communication methods;
- Strengthen community water-sanitation committees in operation, maintenance and ,management of water supply and sanitation systems
- Monitor progress made in improving availability and access to safe water through surveys in comparison to government pre-crisis baselines;
- Support and strengthen community-led processes;
- Provide WASH-related NFI's including hygiene kits, soap, culturally acceptable sanitary items, and locally produced water containers to the maximum extent feasible in close cooperation with other NFI distributions (e.g. shelter).
- Conduct regular water quality surveillance in affected areas, and routinely disseminate microbial water quality results and trends with all WASH partners;
- Monitor the environmental health conditions (safe water surveillance, sanitary and hygiene conditions) of affected communities and people living in IDP camps and temporary shelters;
- Support water borne diseases alert response, through water quality testing, disinfection and hygiene promotion;
- Provision of water quality testing kits and water disinfection chemicals.
- Provision of hygiene and water safety and health inter-linkages education materials (messages, pamphlets, brochures etc.)
- Support affected areas water supply service providers in water quality monitoring, through the provision of basic water physio-chemical testing, including water testing kits, supplies and reagents; including water disinfection chemicals; in-order to prevention or control water related diseases outbreaks
- Conduct graded water quality surveillance and treatment trainings for water supply service providers, senior managers, executive engineers, technicians and operators; including awareness sessions on waterborne diseases and the inter-linkages between ill health and water quality; basic aspects of surveillance, monitoring, chlorination procedures, sanitary inspections and use of testing equipment;

Revised Cluster Objectives.

<table>
<tr><th colspan="3">Objective 1: Ensure access and provision of safe drinking water, appropriate sanitation, and promotion of safe hygiene practices to 144,000 IDPs in camps through 2012</th></tr>
<tr><th>Outcomes</th><th>Indicators</th><th>Activities</th></tr>
<tr><td>144,000 IDPs residing in camps have access to:</td><td rowspan="2">Number of IDPs in camps with access to functional latrines (disaggregated by sex)</td><td rowspan="2">Continuous provision of water through bore holes/pipe networks. Water Tankering if required.</td></tr>
<tr><td>15 liters per person per day of safe drinking water</td></tr>
</table>

Adequate sanitation facilities, ensuring separate and private facilities for women and girls, maximum of 20 persons/latrine		Maintenance of existing latrines in camps Installation of new latrines, if required. Hygiene promotion and solid waste management.
Basic hygiene materials (kits) and knowledge of key hygiene behaviours		
Camp schools and health facilities have WASH facilities		
Objective 2: Support efforts to ensure access to safe drinking water, sanitation and hygiene promotion activities benefiting 1,000,000 IDPs living in host communities and 1,000,000 hosting population through 2012		
2 million IDPs and hosting communities have improved access to safe drinking water, sanitation and are enabled to practice improved hygiene behaviour as per needs established through WASH assessments and IVAP corresponding to SPHERE.	Number of IDP's and hosting communities has access to improved WASH facilities.	Rehabilitation of existing non – functional water sources and/or installation where appropriate Support for social mobilization to support improved sanitation coverage in host areas, including technical guidance on low-cost, sustainable designs, Etc.
Objective 3: Support provision of return package (hygiene kit) to 552,000 returnees (including Kurram IDPs) through 2012		
552,,000 returnees provided with hygiene kit as return package	Number of Returnees population has been provided with return package (hygiene kit)	Provision of hygiene kit as a return package Etc.

Table of proposed coverage per site

SITE / AREA	ORGANIZATIONS
IDP Camps (Jalozai, Togh Serai, New Durrani)	WHO, UNICEF through implementing partners
DI Khan	WHO,UNICEF, Oxfam, IRC, Government line agencies and other Cluster partners
Tank	WHO,UNICEF Government line agencies
Kohat	WHO,UNICEF, ACTED, OXFAM, Line agencies
Hangu	WHO,UNICEF, Line agencies, other Cluster partners
Kurram Agency	WHO,UNICEF and Line agencies

ANNEX 1.HUMANITARIAN OPERATIONAL PLAN FINANCIAL GAP ANALYSIS AND CERF CONTRIBUTION

Cluster	Total Amount Needed in 2012 (USD)	Amount Available (USD)	Gap (USD)	CERF Underfunded Window Contributions (USD)	CERF Rapid Response Contributions (USD)	Total Funds Available after CERF Contributions (USD)	Percentage of Needs Available	Funding Gaps after CERF Contributions (USD)
Agriculture	$7,918,999	$397,538	$7,521,461	$1,107,491	$349,600	$1,854,629	23%	$6,064,370
CCCM*	$51,151,910	$7,399,367	$43,752,543	$1,478,783	$4,265,287	$13,143,437	26%	$38,008,473
Education	$5,236,244	$749,821	$4,486,423	$59,920	$0	$809,741	15%	$4,426,503
Food	$164,152,220	$91,894,226	$72,257,994	$4,696,260	$3,634,647	$100,225,133	61%	$63,927,087
Health	$18,827,792	$1,198,074	$17,629,718	$531,323	$1,453,203	$3,182,600	17%	$15,645,192
Nutrition	$11,105,766	$396,601	$10,709,165	$101,262	$315,636	$813,499	7%	$10,292,267
Protection	$16,119,941	$2,257,834	$13,862,107	$812,141	$213,775	$3,283,750	20%	$12,836,191
Shelter*	$13,404,600	$1,950,000	$11,454,600	$2,173,619	$0	$4,123,619	31%	$9,280,981
WASH	$25,900,000	$600,000	$25,300,000	$3,884,931	$1,738,337	$6,223,268	24%	$19,676,732
Coordination	$750,000	$0	$750,000	$0	$0	$0	0%	$750,000
Total	**$314,567,472**	**$106,843,461**	**$207,724,011**	**$14,845,730**	**$11,970,485**	**$133,659,676**	42%	**$180,907,796**

* To achieve consistency in management of IDP returns, NFIs are captured under CCCM

ANNEX 2:PLANNING WORKSHOP FOR REVISION OF THE HUMANITARIAN OPERATIONS PLAN (HOP)

Time Frame	Place of Displacement » (All figures are in number of familes)	Nowshera	Peshawar	Kurram	Hangu	Kohat	D.I. Khan	Tank	Multiple Districts	Total
02 Apr 2012	IDPs in Camps	11,592		3,565	1,159					16,316
	IDPs in Host Communities		34,583	12,555	2,165	23,091	26,986	10,136		109,516
	Total IDPs	**11,592**	**34,583**	**16,120**	**3,324**	**23,091**	**26,986**	**10,136**		**125,832**
	Already Returned									148,244
02 April to 30 June 2012	Expected New Registrations	4,950	28,050	0	10,000	0	0	0	23,000	66,000
	Expected IDP Returns	613	0	7,666			6,666		0	14,945
	Expected Sectarian Violence IDP Returns			11,332						11,332
	Place of return	Moh/Baj		Kurram	Kurram, Orakzai		SWA			
	Remaining IDPs	**15,929**	**62,633**	**44,869**			**30,456**		**23,000**	**176,887**
	Already Returned									174,521
1 July to 31 December 2012	Expected New Registrations	0	0	0	0	0	0	0	0	0
	Expected IDP Returns	1,225	0	15,334			13,334		0	29,893
	Expected Sectarian Violence IDP Returns			22,668						22,668
	Place of return	Moh/Baj		Kurram	Kurram, Orakzai		SWA			
	Remaining IDPs	**14,704**	**62,633**	**29,535**			**17,122**		**23,000**	**146,994**
	Already Returned									227,082
02 April to 31 December 2012	Expected New Registrations	4,950	28,050	0	10,000	0	0	0	23,000	66,000
	Expected IDP Returns	1,838	0	23,000			20,000			44,838
	Expected Sectarian Violence IDP Returns			34,000						34,000
	Place of return	Moh/Baj		Kurram	Kurram, Orakzai		SWA			
	Remaining IDPs	**14,704**	**62,633**	**29,535**			**17,122**		**23,000**	**146,994**
	Already Returned									227,082

Planning Assumptions					
New IDPs		Expected new arrivals from Bara, Khyber:	33,000	Families	Currently 30,000 families registered (4,000 pre Jan 12 and 26,000 since Jan 12). 18,000 more pending registration. 15,000 additional arrivals expected. Assuming a maximum of 100% displacement
		Expected new arrivals from Tirah Valley, Khyber:	18,000	Families	Plan for 50% displacement based on total population of 36,000 families in the area. Location of displacement not yet known
		Expected number in Jalozai Camp:	15%		Previously 20%; 5,128 in camp out of 26,672 total new registrations
		Expected time frame for new arrivals:	3 months		
		Estimated number of new registrations in Hangu (IDPs previously being supported by ICRC):	10,000	Families	ICRC was providing support to 29,000 families in Hangu
		Other expected IDPs:			
		Kurram	0	Families	
		Hangu	0	Families	
		Kohat	0	Families	
		D.I. Khan	0	Families	
		Tank	0	Families	
		Multiple Districts	5,000	Families	Currently unregistered IDPs being facilitated by protection cluster in obtaining CNIC numbers
Returns		Bajaur and Mohmand	1,838	Families	1,238 to Bajaur (1,100 from Jalozai and 138 from Benazir), 600 to Mohmand
		Khyber	0	Families	Khyber IDPs are not expected to return in 2012
		Orakzai	10,000	Families	3,000+ have already returned
		SWA	20,000	Families	
		Kurram	13,000	Families	800 have already returned
		Kurram (Secterain violence)	34,000	Families	3000 already returned
		Total Returns	**78,838**	**Families**	
		Number of returnees in the past year	148,244	Families	(141,444 from previous HOP + 3,000 to Orakzai, 800 to Kurram, and 3,000 secterian violence IDPs to Kurram)

Other Assumptions	
	Average Family Size is defined by cluster
	Rate of return spread evenly over 9 months
	All new registrations during the first 3 months, nil thereafter

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