

Multi Sector Need Assessment Report, Bannu

10th-14th September, 2015

EXECUTIVE SUMMARY

This multi-sector Need Assessment survey is conducted in the TDP and host population of district Kakki-2 in order to assess the ground reality of the community vis-à-vis **Livelihood, Shelter, Health** and **WASH** in order to prioritize needs to be addressed for a more targeted and effective response. The findings of the survey as well as community's stated preference (page 10) suggests WASH is the most urgent need overall. Summary of each sector is as follows.

Livelihood: Employment had dropped drastically since migration of TDPs, and TDP income has decreased markedly. New employment opportunities for TDPs were felt to be extremely scarce. 90% of the community were receiving aid in the form of government stipend and data shows a majority of community is dependent on this aid. They are also receiving food from World Food Program. However, food aid was not enough and food and shelter-related expenses combined took up an average 71% of TDP expenditure. Loan repayments also took up 10%, leaving 19% for other expenses (of which 8% on average went to medicine). **79%** respondents reported a continued deficit in spending and income.

Shelter: Non-formalized residences were very common with many families cramped in one compound, and 6-12 (or more) individuals sharing one room in most cases. Rent being paid for shelter (including to relatives) was common and amount paid was a strong burden for most TDPs. The most common problems being faced by people (by order of frequency mentioned) were 1-Water, 2-Latrines and 3-Space/Privacy/Shelter-related issues.

Health: The most pressing issue with health access was that Govt. health facilities were understaffed or not staffed at all as **99%** of TDPs said that staff was not present. Given the prevalence of diseases (shown in table 1) and lack of awareness and sanitation facilities among TDPs, this is a serious vulnerability. Currently TDPs cope by using health facilities of nearby District Headquarters Hospital, Bannu City.

WASH: i) **Water Supply:** Although water sources like hand-pump and bore-holes were available, strict availability did not tell the whole story. A startling **74%** of people in the target area reported not having enough water for their daily needs. Supporting this finding was an unexpected answer for "main source of drinking water" given by **29.5%** respondents where one main source of drinking water was visiting various alternate houses to ask for supplies. Water from sources proper (hand-pumps & bore-holes) is located more than 15 minutes away for half of respondents, and 30 minutes or more away from a fifth(**20.6%**). Given large family sizes, and subsequently large water usage, the process of fetching (and soliciting) water consumes large amounts of time and labour for households. This labour and time is overwhelmingly expended by women and children, who comprise **87%** of those tasked with fetching water. Difficulty of water supply may also discourage regular hygiene practices among TDPs.

ii) **Sanitation:** A worrying **99.3%** of respondents indicated that the males in their households *commonly* resorted to open defecation in fields for their toilet needs, as latrines available were not enough for the household's needs (according to **91%**). The available latrines were mostly reserved for women's use, however, even those were reported by **72%** to not have enough privacy (field staff report many did not even have a

door). Majority latrines were open pit-type latrines which were cleaned exclusively by women and girls, but without chemicals or water. The waste was manually removed, and to add to this appalling practice, field staff report careless disposal. Even respondents themselves admitted to common presence of children's (89%) or other (79%) solid waste lying around the house. Risk of disease transmission is judged to be extremely high due to state of affairs, especially given the extremely high number of families and individuals who are living in cramped conditions (see figure 14 and 15). Table 1 records high incidence of diseases.

iii) Hygiene: Very few respondents answered *commonly* washing hands at important intervals such as before feeding children and after cleaning children's feces. 45% did not use anything except water to wash hands while another 22% used ineffective means of disinfection. This translated predictably into high rates of diseases in children. Adult respondents had less than desirable levels of knowledge about how to prevent or treat disease like diarrhea. This suggests that a similar situation may also apply to other diseases. 86% of community had never received any WASH training whatsoever, which supports an intervention for the purpose as a means of alleviating many problems at once.

Prioritized Needs (with reference to data in above summaries):

One of the primary objectives of the Need Assessment was to prioritize needs of the target community for a more informed and targeted response. Through survey findings, needs in different sectors were assessed and presented (see above for summary and rest of report for details), and it was found that the most pressing need to the life routine of TDP were sourced in the WASH sector, in which basic and essential services were not sufficiently available. Most respondents had little or no resort for defecation other than open fields (99.3% of households, including hosts' said males used open fields "commonly"), were commonly engaged in extraordinarily alarming and unhygienic practices (e.g. solid waste, especially children's' was found commonly in up to 89% of households), had few dignified bathing spaces (especially women), and had extremely difficult and deficient access to water (49% had to spend more than 15 minutes per trip to fetch water and 74% reported not having enough water for their needs), poor or no knowledge of water purification, and alarming incidence of diseases(see table 1). In the livelihood sector, all registered TDPs were receiving food and income assistance, to some degree, and even though many felt it was not enough, it was not felt to be a crisis-level need currently (as shown on page 10 of assessment). A large amount of household's labour time was expended in fetching water supplies. In the shelter sector, the main problem TDPs encountered was extremely cramped living conditions (see figure 14 and 15 in assessment), however even given this, when asked to state freely the main problem they faced about their living spaces, responses were most frequently about lack of latrines, water and in third place TDPs identified lack of space as a pressing concern that they face in their shelters (see page 10). In the Health sector, prevalence of disease was high (however these are water-borne and hygiene-related diseases with WASH problems a main contributing factor), but the main problem with health was lack of doctors in health facilities which can be attributed to health facilities having little government funding and being used for shelter by TDPs. The coping mechanism employed by residents of Kakki-2 was usage of District Headquarters Hospital in Bannu District. Last, and most importantly, the community response about top five prioritized sectors was assessed (see table 3 on page 10), and it was established that the community feels extremely strongly that latrine access and water supply, which are essential facilities for any population, are the most pressing issues facing them, while shelter and health follow. Given that many issues being faced under health and shelter are overlapping in WASH intervention, the recommendation of this report is that the most urgent need of the community is presently WASH.

Background

Since the start of security operations in NWA in 2014, District Bannu has faced a major influx of Temporarily Displaced Persons (TDPs) leading to its infrastructure and resources being excessively overburdened. As a result, a chronic crisis of food security, housing, water, education, health and sanitation has ensued. The management of the caseload has at many times only been possible through humanitarian assistance. However, despite growing humanitarian aid flowing into the region, problems persist on the ground and several Union Councils have still not seen any significant assistance. Of these areas, UC Kakki-2 has been targeted for intervention by Tameer-e-Khalaq Foundation, and a detailed initial Multi-Sector Need Assessment Survey has been conducted.

Aims and Objectives

The multi sector Need Assessment Survey was carried out from September 10th to September 14th, 2014 in affected areas of Union Council Kakki-2 of Bannu district. The aim of the study was to assess the needs of women, children and men of the TDP community and gauge the impact of their migration on crucial needs such as water, sanitation, health, hygiene, shelter and livelihood.

Another general aim of this survey besides prioritizing needs is to establish a baseline for the expected outcomes of the interventions for provision of aid in the respective sectors. The survey aims at assessing the overall situation of the target area (UC Kakki-2) and not individual villages and therefore only looks at an overall picture. The sample size for each village is therefore small.

Methodology

Followed by initial field observation, Need Assessment was carried out in TDP dense UC Kakki-2 of Bannu district (population estimated at 9,056 TDPs and 14,169 Host community by DDMU). Quantitative research method has been applied for this Needs Assessment survey as we deal with quantitative questions in the questionnaire. This research method provides more authentic and reliable data for analysis.

Sample Design for Data Collection

Researchers used the random sampling method to obtain representative data from a large population. For this survey, a total number of 159 people (49% male and 51% female) were interviewed in 27 villages of UC Kakki-2 in district Bannu (including Kotka Sherjan, Nandar Kala, Kotka Alijan, Kuttara Kaki, Murad Kaki, Asmat Kalay, Kotka Mohib Ullah, Kotka Haji Khairullah, Kotka Dilabaza, Nowa Kala, Kotka Gul Sana Kala, Nandar Kaly, Nikam Kila, Kakhati Kala, New Baghban, Peer Khel, Baghban Kila, Sawani Kila, Qamri Kheil, Akhundana, Shahbaz Killa, etc.). This step was taken to obtain significant statistical data for quantitative analysis. Each respondent was an adult, from separate families, who were asked to give answers according to their best estimation of the situation of their own household. 136 were TDPs, and 23 were host community members. Therefore, a wide variety of answers from different areas of the UC were obtained which may be considered representative of the population. The tools, questionnaire and interview methods were designed internally with the aid of reviewing cluster tools as guides.

Data Collection and Analysis tool:

In the survey, structured interviews have been used for data collection, whereas for analysis, Microsoft Excel has been used for sorting and classifying data as well as obtaining conclusions and generalizations. In data collection itself interviewees were provided a question and told to answer without bias using the best estimation of their household situation. Considering important gender dynamics of required data; both male and female enumerators were deputed,

furthermore, considering cultural sensitivity of region, all data enumerators and supervisors were well familiar with local language (Pushto) and culture.

Discussion of Survey Results and Key Findings

EXISTING SUPPORT:

As an additional background to the situation of TDPs in target area, the **outreach of existing support** was assessed. Nearly all respondents (91%) reported that assistance was being given to their family. The remaining people who were not receiving assistance were those who had not been registered. When asked what type of assistance people were currently receiving, most people who had answered yes before predictably answered “food” (being provided by World Food Program in the target area) and “livelihood”, as these are the types of assistance being offered to any TDP with registration. A majority (57%) also answered “health” which was also being provided by nearby Rural Health Clinic (in theory only however. Findings reveal RHCs are used as shelter and are often not staffed by doctors). No NGO was reported currently operating in the area, nor was WASH support reported, although SABAWON has operated in the region within the past year and established pit latrines and hand pumps. However, the pit latrines and most of hand-pumps have long been non-functional, explaining the answers. The hand-pumps are also reported insufficient for target population, according to later questions.

WATER SUPPLY & SAFETY:

Regarding **main source of drinking water supply**, responses (illustrated in **figure 1**) showed that most of the respondents (79%) in the UC were reliant on hand pumps and bore holes for water while only a negligible minority used tap water. A proportion (29.5%) also chose “Other” as their answer. Recorded explanations of “other” were almost entirely “various people’s houses” and “water bodies” (such as streams, ponds, etc.).

According to reports, **the people who go to get water are predominantly women and children**. A combined 87% of respondents answering indicated that these groups are the ones in their households who are fetching water, and children alone comprised 52% of the answers. This is especially concerning given **the time taken to get water being 15-30 minutes or over for 49% of respondents**, as shown in figure 3.

A concerning finding was that **20.6% of respondents in target area travelled more than 30 minutes per trip to fetch water**. Given that in later questions in the survey most

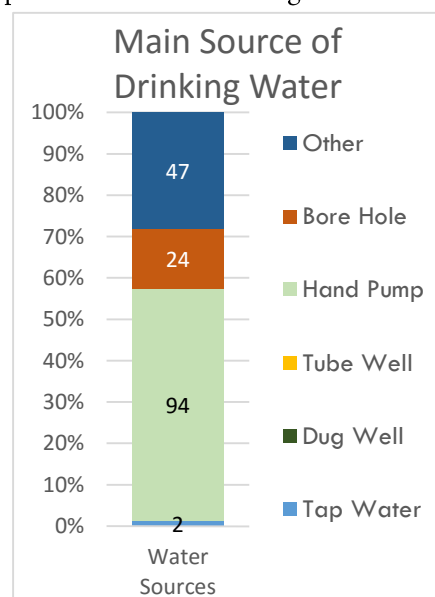


Figure 1: Main Drinking water sources

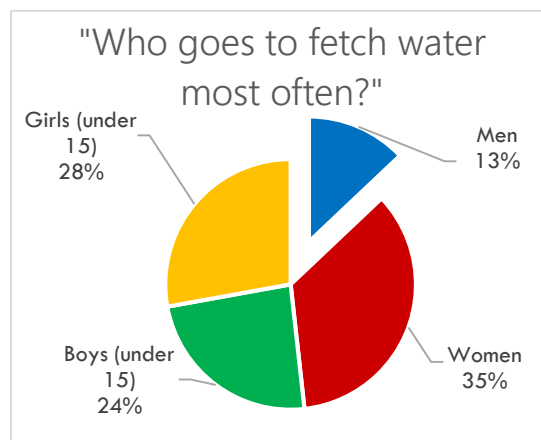


Figure 2: Groups responsible for getting water.

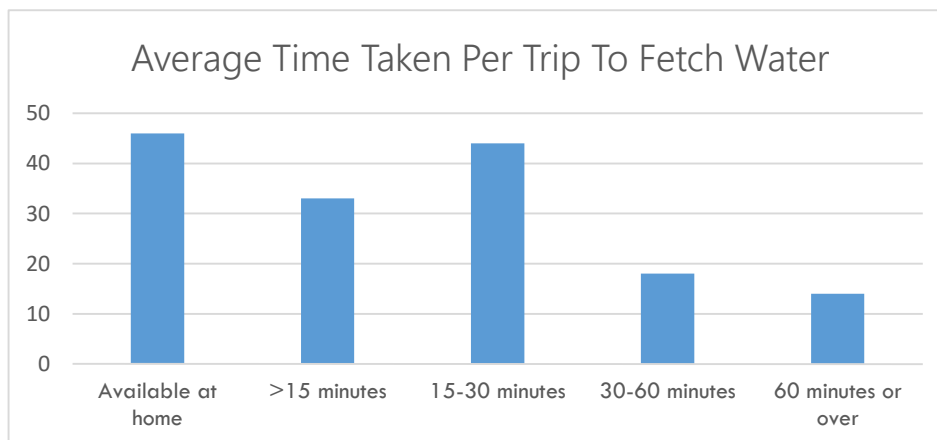


Figure 3: Time taken per trip to fetch water.

water a day, these families are probably spending several trips and dedicating a sizable portion of their labour hours to the task of fetching water. Given the demographics of the people fetching water, this also represents a considerable security risk. Lastly, it was assessed whether TDPs were adequately able to supply themselves with water given present sources. **115 out of 155(74%) respondents answered they did not have enough water available for their needs.**

Regarding **storage of the drinking water**, most families reported that they had adequate water containers in their home, however 12% did not. The vast majority of respondents used water coolers, jerry cans and buckets to store drinking water. When asked whether they also kept utensils to retrieve water from containers, 27% reported that they did not. Field staff report that the method of drinking water from containers for many families, and *especially children*, is to drink it directly from the containers. This applies even to many households who do own utensils for fetching water since many also consider it normal to retrieve water from the container directly by mouth or with bare hands. This practice presents a considerable contamination risk, as well as providing a very dangerous vector for water-borne disease transmission, such as hepatitis. Concerning attitudes like this were not uncommon. For example, when questioned about whether respondents kept water containers covered, 21.5% reported that they did not. This is especially risky for those who mainly use buckets.

When questioned about the drinkability of water available in target area, **two-thirds (66%) of respondents indicated that water that they used for drinking was unsafe.** Answers to another question (B-13) however, showed that even this figure was a conservative report of the problem as 91% of respondents (*including those who said the water was safe*) answered that they had observed odor/smell, bad taste, turbidity or other problems in the water (such as salinity, particles, etc.). The respondents who reported the water as safe but also observed symptoms of contamination may not have been given adequate awareness on water safety.

Another finding that gives weight to the assumption that knowledge of water safety was limited in target region was that **76.4% of respondents in target region answered that they did not know about effective water purification methods.** Figure 4 illustrates the answers to a subsequent question which asked which water purification methods is used most.

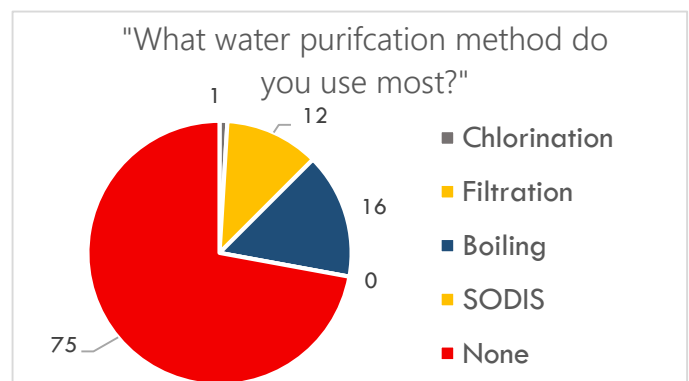


Figure 4: Which water purification methods are used most.

SANITATION

In the Sanitation section of the survey, the **TDPs' access to latrines** was assessed. It should be noted that the target area did receive assistance from SABAWON around 1 year before this assessment in sanitation facilities due to urgent. Around 80 pit latrines were built as part of the project. However, these were not designed to last longer than 6 months, and as TDPs have not relocated as planned, the situation is not much different as before the last and only intervention the area has received.

In the survey, it was found that most TDPs in the target area are reliant on traditional latrines (i.e. open pits) with 76 of 113 TDPs choosing these as the answer to "what type of latrines are you using". The second most common answer for type of latrines respondents had was "none", with 36 respondents choosing this answer. Some respondents did choose pour flush latrines in this question however none of them were TDPs.

When asked whether the latrine was functional (i.e. usable), 27% of host and TDPs further said that they weren't. Most importantly, when asked whether or not latrines were adequate for their needs, an emphatic "No" was received from 92% of respondents (including responses to host community).

Similarly, in another question, 72% of community answered that **the latrines did not afford sufficient privacy for women and girls**. However, **women and girls comprised 100% of those who were tasked with cleaning the latrines**. When asked about what they used to clean latrines, no one that that women and girls in their household used chemicals, and only 22.8% of respondents said they used water to clean latrines. The remaining answered “none”. As there is no drainage, field staff report that waste is removed manually.

However, it is worth noting that latrine use is almost exclusively limited to women in target area due to social barriers preventing them from leaving home along with insufficiency of latrines. This is illustrated very well in a question which asked specifically what males used for defecation. **An astonishing 99.3% of respondents said that males in their household made use of open fields for defecations.**

Questions which assessed **basic sanitation practices in respondent households** were also included in questionnaire. In one question, respondents were asked if there was any solid waste (i.e. human or animal excreta) in their household that they had lying around. An alarming 79% answered “yes”. A similar question about children’s feces in specific received “yes” from 89% households. Question about presence of stagnant water near house also found near half of respondents answering yes. These findings suggest risks of disease infestation within TDP homes could be dangerously high.

The last question of Sanitation section is designed to evaluate the tangible consequences (or lack thereof) from practices and attitudes assessed in this and other sections by asking about disease prevalence. The following table gives the number of respondents’ who confirmed each water-borne disease had struck their household within the past 6 months.

Diarrhea	Typhoid	Cholera
129	107	4
Hepatitis	Skin Infections	Eye Infections
13	88	55
Malaria	Dengue	Polio
100	0	2
Worms	Others (pneumonia, cough, etc)	
100	53	

Table 1: Responses about whether each disease was observed within the last 6 months in respondents’ household.

HYGIENE:

In this section, **personal hygiene practices of the target community** were assessed. Seen in **figure 5**, responses of whether or not it is common practice to wash hands before each activity is given. The responses show practices that put the community as a whole, as well as the households and its members themselves, at very high risk of disease and infection.

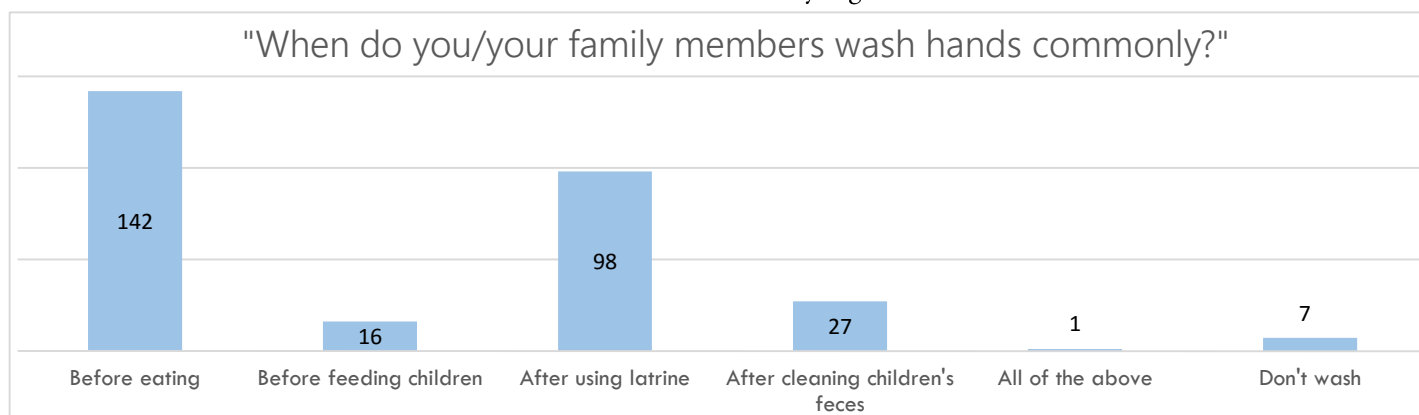


Figure 5: Habits of hand washing before eating is widespread (142 out of 155 answers), but for other points is extremely poor.

Similarly, **habits of using soap** (shown in figure 6) was also assessed and found to have considerable room for improvement. 45% said that they don't use anything besides water to wash hands, and an additional 22% used ineffective means of disinfecting hands.

Mirroring the results of Table 1 (from question C-13) from the earlier section, **70% of respondents reported having had a case of diarrhea in the household within the last month.** This time however, it was assessed who were the principle victims of poor hygiene habits. The results of the question are given in Figure 7.

Parents were also asked **what action was taken when a family member contracted diarrhea.** Results are given in figure 8.



Figure 6: Two-thirds of respondents reported using ineffective means of hand disinfection.

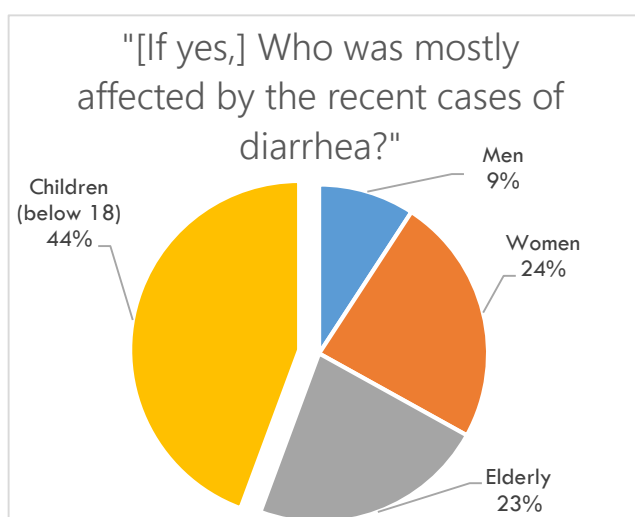


Figure 7: Children are worst-affected by bad household hygiene practices. This same effect may be being repeated for other diseases.

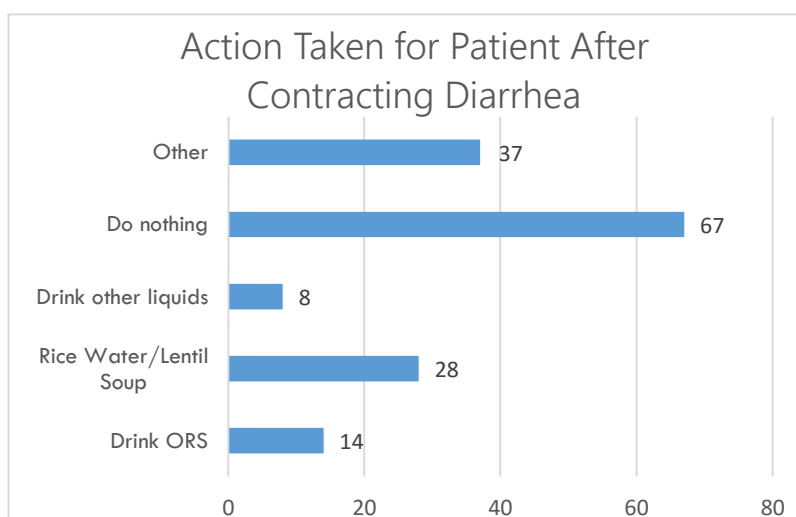


Figure 8: Although responses under "other" included over 50% instances of "consult doctor", overall, 83 of 153 responses indicated ineffective action or not taking any action (16 responses under "other" + 73).

The community was also demonstrably unaware about the causes of diarrhea. Of the 149 respondents who answered a question on the causes of diarrhea, only 50 respondents each named on their own "dirty water", "dirty hands" and "flies" as possible reasons one can contract diarrhea. 37 listed various incorrect answers while 67 (45%) said that they didn't know.

Regarding WASH assistance, in spite of SABAWON having operated in target area, 80% said that they hadn't received any WASH or hygiene kit since displacement. **86% said that they hadn't received any training or hygiene promotion since displacement** (see figure 9). This finding could be a potential explanation for concerning findings. As most of these people have not received any awareness on these issues before, orientation on these issues is a route to alleviating problems which has remained unexplored and awareness in the target population should be a focus for future interventions.

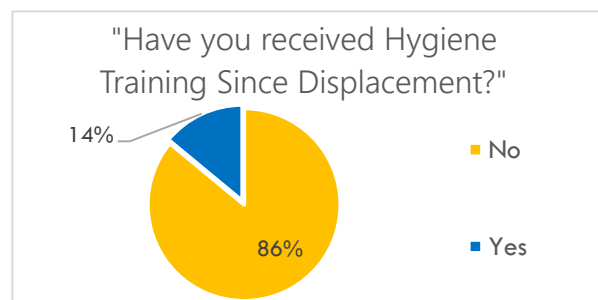


Figure 9: In line with the rest of study results, respondents indicated that they had not attended any sort of hygiene training since displacement.

LIVELIHOOD:

Despite food aid, the sphere of livelihood was found deeply linked to food security. The most important finding was **how TDPs income was affected by the migration** and why. **Figure 10** illustrates the respondent TDPs' household incomes prior to displacement as compared to their situation post-displacement. It is worth noting that (as mentioned previously in Section for Existing Support) most TDPs are receiving Govt. financial support, in the form of 12,000 PKR per month to each household registered with NADRA. Therefore, very few households have a reported income of below 12,000 PKR. What is worth noting though is how a large portion of TDP households have little to no additional income besides this assistance, shown by the large bulk in frequency around "more than or equal to 10,000". A good minority (near 10%) of the community is estimated to be without registration by local authorities, matching well with the 11 respondents who reported current income of between PKR 5-10 thousand.

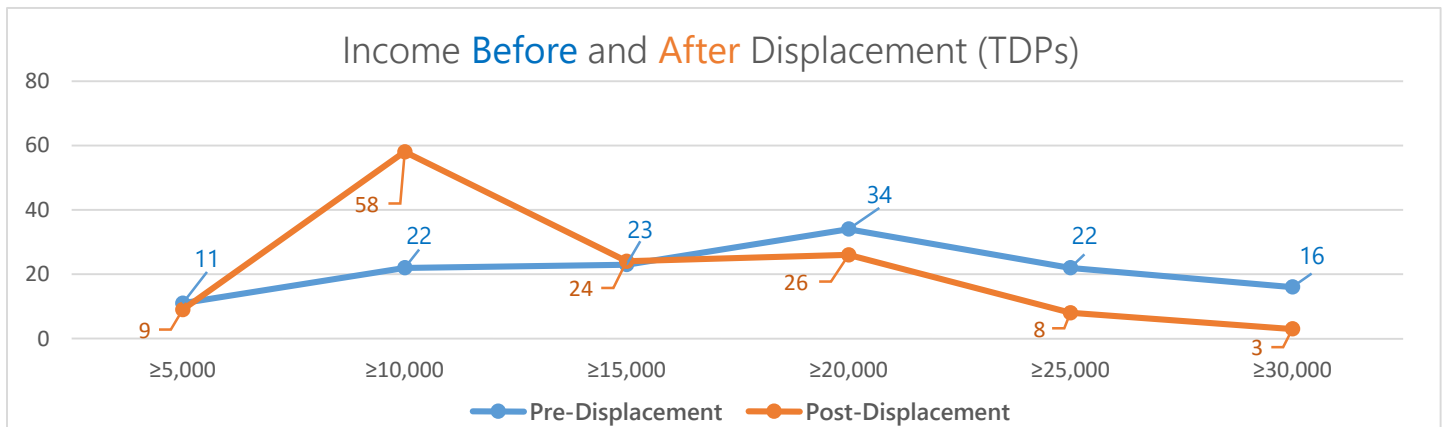


Figure 10: The distribution for TDPs' income for both before and after migration. One can see clearly the effect of Govt. financial assistance of 12,000 PKR.

In general, the household's income has tended to decrease drastically after displacement, even when Govt. assistance is included. In the target area, **Govt. assistance of 12,000 PKR to each household seems to have only put a bulwark against bankruptcy for people**, and it is easy to see how much *more* the distribution of incomes would amass at the left of the graph without it.

In another pair of questions, TDPs were asked about their **employment pre-displacement and post-displacement**. Cultural situation in target region makes it so that women rarely work (especially if work is outside the home) and would not report it if they did, therefore answers among women were insignificant and discarded. However, answers among TDP men showed 58 out of 73 (79%) reported having some form of employment prior to displacement. Post-displacement, however, the figure dropped to a paltry 17 out of 73 (23%). Of that, 8 out of 17 reported working in daily labour. **Regarding opportunities for employment available in the target area**, very few respondents were hopeful about opportunities.

Aside from income, another main area of livelihood assessed was **what respondents' households spent their income on** (shown in figure 11). As can be seen from expenditure patterns, even though food assistance is given, a large majority of income goes simply towards having enough food to feed the large family sizes. The next big drain on family income seems to be money spent on maintaining shelter. **A majority of respondents (79%) also reported a deficit between spending and income.**

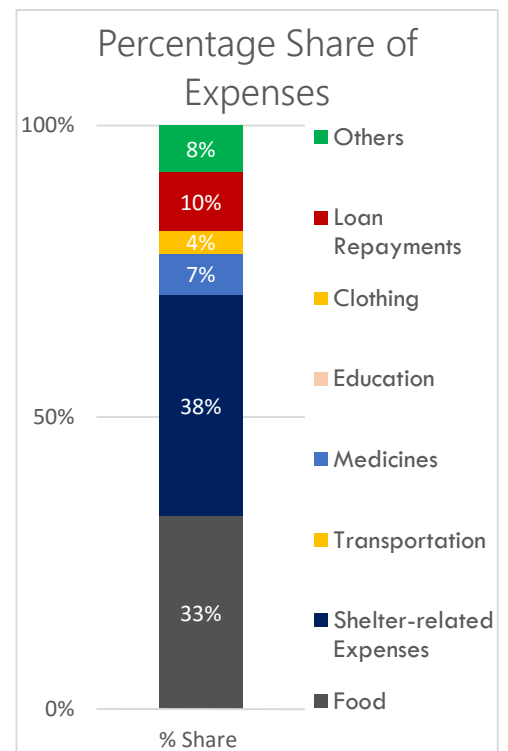


Figure 11: TDP expenditure patterns.

SHELTER:

In the first question in this section, it was asked about what **arrangements TDPs currently have for shelter**. The answers of respondents can be seen illustrated in **figure 12**. One thing to note is that all the responses for “other” are respondents who live in Rural Health Center (we estimate 30 or more families are accommodated by this building) or in other similar Govt. premises. As can be seen, **about half of respondents are dependent on relatives, living on assistance or living in tents**. Even the ones with shelter are often living in non-formal basis with many families cramped in unsuitable dwellings. It is not uncommon for additional materials and modification being used, such as cloth barriers, to alleviate lack of privacy in such cramped conditions. Of those paying rent (in rented houses, relatives’ or “other”), the reported rents are given in **figure 13**.

The most alarming findings in the survey regarding shelter however was exactly how over-capacity the shelters TDPs had were. In many cases, field staff reported that people weren’t always inside the houses, due to space issues. For this, some simply extended a cloth barrier around the house and lived within that, sometimes using the house portico (if available) as a roof. Such ad-hoc arrangements being common are very believable given the data for how many TDPs were using each compound, and how many TDPs were using each room. **Figures 14 and 15** are used to illustrate.

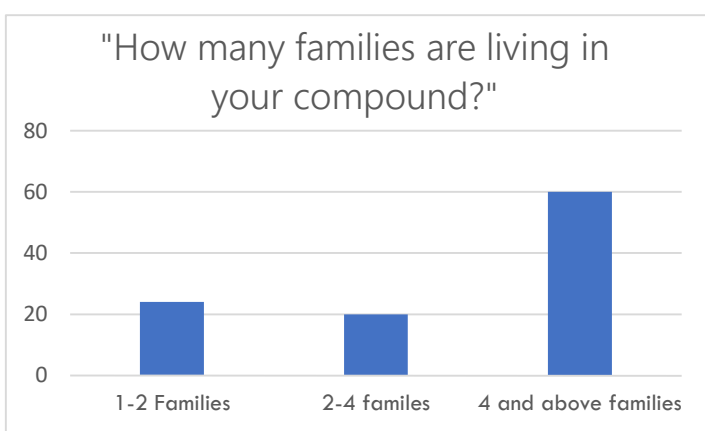


Figure 14: A very difficult situation of shelter exists for community.

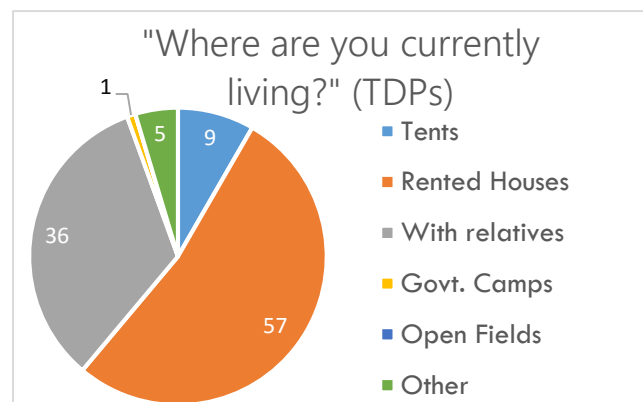


Figure 12: Current living arrangements for TDPs

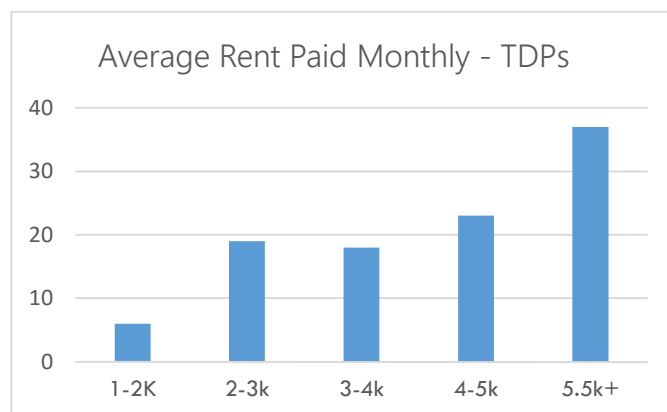


Figure 13: Rent being paid on average monthly by TDPs.

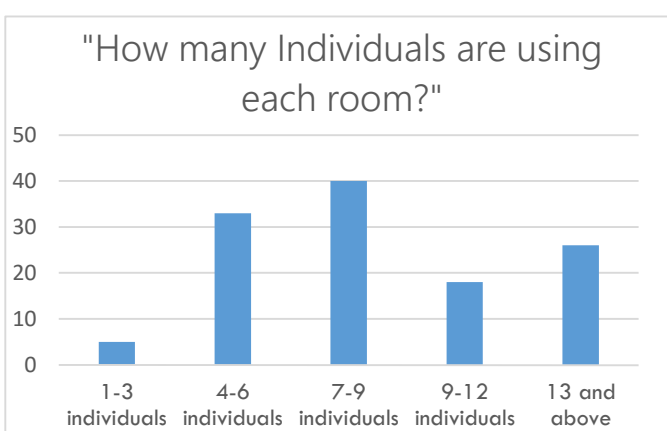


Figure 15: Rent being paid on average monthly by TDPs.

In the last question in shelter section, respondents were asked to tell interviewers the common problems they faced in rented houses. **Table 2** shows common responses for the most pressing issues people felt they were facing in their living conditions in shelters. Responses have been generalized into categories as far as possible.

Issue	Water	Latrines	Space/Privacy/Shelter-related issue	Others
No. of Reports	74	65	45	15

Table 2: Common problems faced by people in their living spaces, arranged by frequency.

Health

In the sector of health, the only health facility that exists near to target area is Rural Health Center, which is a very basic health facility even in theory. As earlier findings suggest, these are often used as shelters. Only **68.9% of respondents said that they had access to a health facility.** Figure 16 shows the reported distances to nearest health facility.

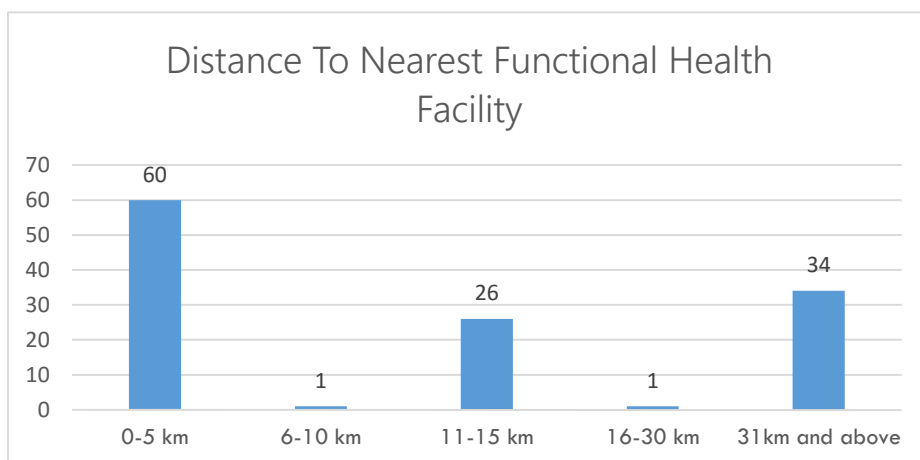


Figure 16: Distance traveled for access to health facilities.

57% of respondents also answered that the health facilities were inaccessible to

women. However, by far the worst problem plaguing health facilities was the lack of govt. medical staff available at nearby health facilities. Excluding those who marked “don’t know”, 99% reported that health facilities are not staffed by appointed medical professionals. Only 1 respondent in the whole surveyed group reported that medical staff was available at health facilities. Humanitarian groups were also reported as not having opened any mobile health clinics in area.

When asked by field staff how respondents currently coped with this almost complete lack of medical care, the community pointed to the District Headquarters Hospital in nearby Bannu City.

Community’s Prioritized Needs:

Finally, TDP respondents from UC Kakki-2 target community were asked to rate their most urgent need which they felt that they needed an intervention for by order of priority in 1st, 2nd, 3rd place and so on.

Priority Rating	WASH	SHELTER	HEALTH	LIVELIHOOD	NON-FOOD ITEMS
1 st	93%	7%	0%	0%	0%
2 nd	3%	82%	8%	7%	0%
3 rd	4%	9%	53%	33%	1%
4 th	0%	2%	37%	47%	14%
5 th	0%	0%	2%	13%	85%

Table 3: The community was given a chance to rank their priorities by placing each sector into a list ordered by urgency of need. WASH and Shelter were the firmest choices with an overwhelming 93% of respondents choosing to place WASH needs (such as latrines, water, etc.) into slot no#1 during the assessment. Shelter was chosen in 82% for slot#2, another overwhelming placement, while slot no#3 and #4 was split between health and livelihood.