EXECUTIVE SUMMARY

Since 2008, more than 5 million people have been displaced from the Federally Administered Tribal Areas (FATA) due to insecurity. As of June 2015, over 1.57 million people displaced from FATA were residing in Khyber Pakhtunkhwa (KP) province. In December 2014, the Government of Pakistan announced a plan for the return of all people displaced from FATA by the end of 2016. Bara Tehsil of Khyber Agency was de-notified as a conflict zone in January 2015 with the first phase of returns launched in mid-March 2015. As of 5 June, more than 22,586 families had returned to Khyber Agency as well as 1,045 registered families to North Waziristan Agency and 3,238 registered families to South Waziristan Agency.

The FATA Disaster Management Authority (FDMA) and the humanitarian community jointly conducted a multi-cluster needs assessment in Bara Tehsil, Khyber Agency. The aim of the assessment was to understand and prioritize the immediate needs of returnee households and to identify priority areas for humanitarian interventions. The assessment methodology was based on two types of data collection: a household survey and key informant interviews. The assessment was conducted during second week of June, 2015, with a total of 802 household surveys and 71 key informant interviews conducted. In terms of gender, 25 per cent of the respondents were female and 11 per cent of assessed households were female-headed.

Figure 1: Main concerns identified by returnees

- Lack of basic facilities: 91% - 90%
- Lack of livelihood opportunities: 81% - 84%
- Restricted movement: 52%
- Lack of services for people with disabilities: 46%
- Security issues: 21%
- Lack of female privacy: 12%
- Lack of female privacy: 8%

- Female-headed households
- Male-headed households
**Key findings**

According to the findings of the Assessment, the average household size of the returnees was 13.0 whereas family size was 6.35 people. Males and females have returned to Bara in roughly equal numbers. On average, in each household, 42 per cent of members were economically active and aged between 18 and 60 years old; this places pressure on the productive elements of the population.

Special attention was paid to gathering information on particularly vulnerable groups. The assessment revealed that 7.7 per cent of households in the community were headed by a female and 2.4 per cent were headed by a child. In most child-headed households there was also a female adult or elderly member living with the family but the child had primary responsibility for the daily affairs of the household and earning income. According to the assessment, 1.5 per cent of households were headed by an elderly person (above 60 years) with no male adult (18 to 60 years) present. A quarter of all households had at least one person with a disability.

**Health** was one of the worst affected sectors. At the time of assessment, 30 per cent of the households reported that there was no health facility available in their area while 28 per cent reported that their nearest health facility was more than 5 km away. The majority of households (70 per cent) were not able to access government health services for various reasons including financial constraints, the unavailability of staff and services (including inpatient, laboratory, X-ray and delivery), and the long distance to these facilities. Female headed households were more significantly more likely indicate financial constraints and distance as challenges. The most commonly reported health problems were diarrhea, skin infections, malaria and cold/fever.

**Education** was also badly affected with most school building either partially or fully damaged. The situation is compounded by a lack of education supplies, and security threats against students and teachers. There was a slight increase in school enrolment compared to before displacement especially for girls.

There has been a noticeable shift from agriculture based livelihoods before displacement to more unstable daily wage labour after return. Major challenges to restoring livelihoods include damaged infrastructure, an inability to access markets, a lack of credit and lack of work opportunities. The assessment also found that there had been a significant reduction in the ownership of domestic and productive assets. A third of households reported that they owned agricultural land in Bara with 65 per cent of these planning to cultivate their land. However, significant challenges to reviving agriculture and livestock based livelihoods remain including heavy damages to irrigation infrastructure, a significant reduction in ownership of small and large ruminants, and the unavailability of fodder, shelter, restocking and medication for livestock. Meanwhile, the proportion of female headed households depending on salaried incomes decreased from nine per cent before displacement to just three per cent after return.

In terms of **food security**, 59 per cent of surveyed households had an acceptable level of food consumption while 6 per cent had poor food consumption and 35 per cent were borderline. Some 61 per cent reported that food was available in the nearest market but that it was not always adequate. However, three-quarters noted that they did not have adequate resources to buy sufficient food from the markets.

For **nutrition**, the overall GAM rate for children aged 6 to 59 months was 17.2 per cent (above emergency threshold) with a SAM rate of 5.2 per cent. These represent an alarming rate of acute malnutrition that may worsen in the absence of nutrition specific and nutrition sensitive interventions. The assessment findings indicate that in 29 per cent of communities, lactating mothers had reduced breastfeeding during and after return. Children in 69 per cent of households had not received vitamin A supplementation.

As for **protection** related issues, 9 per cent of respondents reported feeling insecure in their area of return, with female respondents more likely to report feeling insecure than males (25 per cent versus 18 per cent respectively). The lack of services for people with disabilities was noted by nearly a quarter of all respondents while 43 per cent indicated that their movement was restricted.
The unavailability of WASH facilities was a major issue. While most people had access to protected water sources of satisfactory quality, many had to travel a long way to collect drinking water (26 per cent travelled more than 15 minutes and 32 per cent of people travelled more than 30 minutes). Male headed households were more likely to travel further to access water. Only 66 per cent of returnees have appropriate water containers; this is particularly problematic given the long distances travelled to access water. In terms of sanitation, a quarter of returnees defecate in the open and very few of the 75 per cent with access to latrines were using hygienic sanitation facilities.

Most community physical infrastructures have been damaged including 77 per cent of school buildings, 75 per cent of water points and 73 per cent of health centres. The most commonly cited critical infrastructure to be restored and/or rehabilitated was water channels (65 per cent). To restore community infrastructure, material and cash support were regarded as most important requirements (81 per cent and 71 per cent respectively), followed by technical support (51 per cent).

The findings of the assessment show that most returnee households have received critical, life-saving humanitarian communications about assistance (including food, shelter and NFI distributions), eligibility requirements, return processes and mechanisms to address grievances. Nearly three-quarters of respondents identified mobile phones as their preferred source of information, followed by word of mouth, mosques and radios. While female respondents were more likely to prefer word of mouth, male respondents showed a preference for mobile phones.

Recommendations

- Provide livelihood support including employment/job opportunities that respond to the needs of vulnerable households.
- Restore or revitalize health services and services for people with disabilities, and provide required resources and service providers.
- Provide safe child and adolescent friendly temporary school facilities. Reconstruct and/or repair damaged schools and provide furniture, textbooks and school supplies.
- Install or improve sanitation facilities in targeted areas, increase the availability of water, and provide households with appropriate water storage containers and WASH related NFIs.
- Establish a community based management of acute malnutrition (CMAM) programme with inbuilt infant and young child feeding component, and conduct Vitamin A supplementation and health education for communities as well as promoting breastfeeding, hygiene, immunization and health seeking practices.
- Special needs of older people and people with a persons with age and disability should be considered while designing the response activities.
- Rehabilitate community physical infrastructure and social services schemes.
SECTION 1: INTRODUCTION

1.1 Context/Background

Since 2008, more than 5 million people have been displaced from the Federally Administered Tribal Areas (FATA) due to insecurity and security operations against non-state armed groups. Repeated patterns of displacement and return movements have occurred, sometimes within the same agency or district. As of June 2015, over 262,000 families displaced from FATA were residing in Khyber Pakhtunkhwa (KP) province.

Khyber Agency is one of seven agencies in FATA. It has a total area of 2,576 km² and shares an 80 km border with Nangahar Province, Afghanistan. A majority of Khyber Agency inhabitants are from the Afridi tribe. Other tribes present include Mullagori, Shalmani, Shinwari and Bangashes. Within Khyber Agency, the plains of Bara are considered to be of particular strategic importance as they connect the rest of Khyber Agency to Peshawar, the provincial capital of KP. Both the Bara plains (Bara hereafter) and Tirah Valley are traversed by one of the key supply routes into Afghanistan.

There have been several military operations and subsequent rounds of displacements from Bara and Tirah Valley starting in June 2008. Between 2009 and 2014, insecurity in Khyber Agency forced the displacement of approximately 123,603 families (107,873 families verified with the government and 15,730 unverified families). Most of the people displaced from Khyber Agency have been residing in host communities in Peshawar and Nowshera districts of neighbouring Khyber Pakhtunkhwa (KP) province; a small number also settled in Jalozai camp. Due to the proximity of these host areas to Khyber Agency, a significant number of displaced families returned spontaneously in the 2012 to 2014 period. Many of these families continued to travel to Peshawar on a monthly basis to receive food and other humanitarian assistance.

2014 once again saw a large number of people displaced from both North Waziristan and Khyber Agencies. In October, the security forces launched Operation Khyber-1 focusing on Bara. By the end of 2014, approximately 102,864 families had been displaced from Khyber Agency and were registered with the government.

In December 2014, the Government of Pakistan announced a plan for the return of all people displaced from FATA by the end of 2016. Bara was de-notified1 as a conflict zone in January 2015 with the first phase of returns launched in mid-March 2015. As of 5 June, more than 22,586 families had returned to Khyber Agency as well as 1,045 registered families (and 237 unregistered families) to North Waziristan Agency and 3,238 registered families (and 1,551 unregistered families) to South Waziristan Agency. A total of 103,408 families are expected to return to Khyber Agency by the end of 2015. Families who have returned to their homes in FATA face infrastructure that has been devastated by years of insecurity, a lack of basic services and challenges maintaining sustainable livelihoods.

The Government and humanitarian community have conducted several assessments of displaced persons living in and out of official camps including the MIRA assessment in Bannu district, cluster-specific assessments, vulnerability assessments and the IDP Vulnerability Assessment and Profiling (IVAP) project. These needs assessments provide useful information on the priority needs of the displaced population and

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1 De-notified areas are defined as those areas that were previously notified as crisis affected that have since been de-notified and declared safe by the Government authorities.
guides the humanitarian response. While there is a body of information available about the situation of displaced people in KP, there is little available on the needs and situation of people once they return to their areas of origin in FATA. For each major round of returns, a return intention survey is conducted by the Protection Cluster as well as an inter-cluster assessment to determine whether the security situation is conducive to returns.

Given the lack of up-to-date information on the needs and situation of returnees including in Bara, the Inter Cluster Coordination Mechanism (ICCM) proposed to conduct a joint multi-cluster needs assessment in return areas. The aim of the assessment is to develop a snapshot of the situation faced by returnees, which can be used to understand and prioritize their immediate needs.

The Provincial Assessment Working Group (PAWG) was activated in Peshawar to design and launch the assessment. PAWG worked closely with the provincial clusters, FDMA and the Assessment Technical Team to develop a detailed methodology and tools for the assessment. Humanitarian Country Team (HCT) and ICCM proposed to pilot the assessment in Khyber Agency in June 2015 with the potential of carrying out similar assessments in other return areas as required. The assessment process and methodology were approved by the HCT on 15 May. The assessment was conducted jointly by FDMA and ICCM with the field-based data collection carried out between 11 to 13 June in close coordination with local authorities and the Security Forces. A total of 53 enumerators (including 40 male and 13 female) participated in the field data collection. OCHA provided overall coordination support to the process.
1.2 Objectives

Assessment was designed to achieve the following objectives:

- To understand and prioritize the immediate needs of returnee households
- To identify the key priority areas for humanitarian interventions
- To understand the specific needs of more vulnerable groups in society including people with disabilities, older people, female-headed households etc.
- To guide the evidence-based resource mobilization and response planning of the government and humanitarian community

1.3 Methodology

The assessment methodology was based on a household survey and key informant interviews. A household was defined as a group of people living together with common eating arrangements. Meanwhile, the key informant interviews were conducted with people that have a good understanding of the situation faced by their community such as the heads of tribes, Jirga representatives, school teachers, religious leaders, shopkeepers and community workers. The household survey focused on issues at the household level and the prioritization of immediate needs. The key informant interviews were used to corroborate the findings of household survey, highlight community level issues and help provide an overall snapshot of the situation in return areas.

The sampling used for the household survey ensures that the information collected is statistically significant for recent (March to June 2015) returnees to Bara, Khyber Agency. The sample of households to be surveyed was selected through a two-stage sampling technique involving both simple random and systematic sampling. At the first stage, villages were selected randomly. Within each selected village, households were then selected through systematic sampling. A sample of 770 households was considered sufficient to provide the required level of confidence of the assessment findings. To understand the specific needs of most vulnerable segments of the community, an additional cluster sample of 32 vulnerable households was covered. A total of 802 households and 71 key informants were interviewed during the assessment.

The nearly all survey teams included both male and female enumerators. This facilitated the collection of data from both female headed households and female respondents within male headed households.

1.4 Limitations

The assessment was limited to Bara Tehsil, Khyber Agency. At the time of assessment only 22,500 families had returned to the Aka Khel area of Bara with returns to other areas in progress. As a result, the assessment only covered Aka Khel returnees to Bara. However, due to the similar socio-economic situation of other tribes in Bara, the findings of the assessment provide insight into the situation faced by other IDPs returning to the Bara plains of Khyber Agency.
SECTION 2: HOUSEHOLD PROFILE

2.1 Profile of respondents

Of the 802 people that participated in the household survey, 64 per cent were the head of their household. The rest were either the spouse (16 per cent), son/daughter (15 per cent) or sister/brother (3 per cent) of the head of the household.

One quarter of all respondents were female. Of the 770 households selected at random, 8 per cent were female-headed. However, as mentioned in the methodology section, some additional households falling under the vulnerability criteria were also interviewed. As a result, a total of 11 per cent of households surveyed were female-headed.²

For the key informant interviews, most of the respondents were male (88 per cent). In terms of their role in the community, 30 per cent were community elders/tribe leaders, 20 per cent were the committee/shura members, 20 per cent were teachers and 14 per cent were social workers.

2.2. Household composition

According to the findings of household assessment, 48.3 per cent of the returnee population was female and 51.7 per cent male. This finding indicates that males and females are returning to Bara in roughly equal numbers. In terms of age, 55 per cent of returnees were below 18 years. This is in-line with the average for the region. According to the findings of assessment, the average household size was 13.03 whereas the average family size was 6.35 meaning an average of 2 families per household.

Based on the age and sex profile of the population, and given that in the cultural context of FATA women are less likely to participate in the formal economy, roughly 21 per cent of the population is expected to be economically active (males aged between 18 and 60 years). This equates to a high level of economic dependency with more than five people depending on each economically active member of the household.

² Female headed households are those in which decisions are made by females in the absence of a male member. This may be because the male members have left to work in another city/country or because the female has been widowed or divorced.
2.3 Vulnerable population

One of the prime objectives of the assessment was to identify the most vulnerable households and highlight their specific needs. The key informant survey revealed that 7.7 per cent of households in the community were headed by a female. An analysis of the needs and concerns of these female-headed households is included in each section of this report.

The findings also revealed that 2.4 per cent of returnee households were headed by children (less than 18 years of age). In most child-headed households, there was an adult female or older person in the household but a child was responsible for the daily affairs and earning income. In four cases (0.5 per cent), there was no adult present in the child-headed household. Meanwhile, 13.7 per cent of households were headed by older persons (above 60 years). Of the returnees to Bara, 1.5 per cent of households were headed by an older person and did not have an adult male present in the household. For this reason, these households were considered to be particularly vulnerable.

A quarter of all households had at least one person with a disability. The proportion of households with a male member who has a disability (23 per cent) was nearly double that of households with a female who has a disability (12 per cent). Most of those reported to have a disability were physically disabled, followed by those with an intellectual disability. Around 7 per cent of the households reported that a child in their household had lost at least one parent.
SECTION 3: CLUSTER-SPECIFIC FINDINGS

This section briefly outlines the cluster specific findings of the assessment including key findings, most pressing humanitarian needs and specific recommendations by cluster.

3.1 Health

Most morbidity and mortality in complex humanitarian emergencies occur due to preventable causes, especially increased rates of infectious diseases, malnutrition, and poor hygiene. The findings of this assessment reveal that health remains a key problem for the returnee population. Even before displacement, FATA has the worst mother and child health indicators nationally, and this has been compounded by the crisis.

3.1.1 Available health facilities

According to the findings of assessment, 30 per cent of households do not have a health facility available in their area while 22 per cent reported that the nearest health facility was a basic health unit. Meanwhile, 31 per cent reported that their nearest accessible health facility was another type (mainly private health clinic that in many cases do not have trained healthcare professionals). Very few reported that their nearest facility was a community dispensary (9 per cent) or tehsil/agency hospital (7 per cent).

The vast majority (94 per cent) of respondents reported that inpatient services (admission) were not available in their nearest health facility. The majority of respondents also noted the unavailability of laboratory/X-ray facilities (87 per cent), delivery services (83 per cent), and general outpatient services (OPD) and nurses/female medical technicians (FMT) (74 per cent). Alarmingly, 62 per cent reported that doctors were not available at health facilities. Given these findings, it is not surprising that 98 per cent of respondents reported that they were not satisfied the health services available in their area.

Female headed households were more likely to report the unavailability of services at healthcare facilities compared to male headed households, and were nearly twice as likely to cite the unavailability of doctors as an issue (98 per cent versus 58 per cent respectively). Female headed households were also significantly more likely to report the unavailability of nurses (95 per cent versus 67 per cent).

More than half of the respondents (56 per cent) had no information about where to go in case of a health emergency. The lack of public information about health services in returnee communities was also observed by the assessment teams. Respondents noted that the most common methods for receiving information about healthcare was through family and friends (56 per cent), and doctors (17 per cent). Only 10 per cent mentioned the health department as their main source of information.
A total of 69 per cent of people reported that someone in their household had required healthcare since returning to Bara but had not accessed government health services. Only 29 per cent of households had accessed health services at a government health facility since returning. The reasons given for not using government health facilities included the unavailability of staff or required services, and the long distance to the health facility. Significantly more female-headed households reported that distance and the cost of healthcare were the main reasons for not using government health services, while male-headed households were more likely to point to unavailability of staff and services.

3.1.2 Pregnant and lactating women

Pregnant or lactating women were present in 60 per cent of households. Of these, only 8 per cent were reported to have 24/7 access to a health facility to assist with birth. This may be influenced by the cultural acceptance of women giving birth at home. In addition, key informants in nearly all communities (94 per cent) reported that female doctors were not available to treat female patients. These findings give rise to the concern that pregnant women are at increased risk of adverse health effects due to the lack of healthcare facilities, or relevant services and staff.

3.1.3 Vaccinations

Of the households with children, 76 per cent reported that children in their household had received routine vaccinations (EPI). The main reasons cited by the remaining 24 per cent for not vaccinating children included the unavailability of functional vaccination services in their area and that vaccination teams had not visited their area.
3.1.4 Health problems

Diarrhea was the most commonly reported health problem in return areas, with 80 per cent reporting that at least one member of their household was suffering from diarrhea at the time of the survey. This was followed by skin issues (56 per cent), malaria (55 per cent) and cough/cold/fever (55 per cent). Tuberculosis was only present in 7 per cent of households, which is considered relatively low. Given the inadequate WASH facilities available to returnees and the seasonal prevalence of diarrhea, it is unsurprising that the rates of diarrhea were so high. These findings underscore the need for hygiene promotion sessions and appropriate WASH interventions especially as diarrhea is the leading cause of child mortality of children under 5 years old in Pakistan. Given that there have been outbreaks of diseases such as leishmaniosis in the past, there is also a need for disease surveillance and ensuring the availability of glucantime injections. Malaria can be controlled through interventions that target vectors such as the provision of bed nets.

Communicable diseases remain a major public health concern and are the prime cause of morbidity and mortality in protracted crisis/emergencies. The returnees are at high risk of epidemics due to: a lack of safe drinking water; inadequate hygiene and sanitation; overcrowded living conditions; poor socioeconomic conditions; a low level of awareness of the spread of disease; and sub-optimal vaccination coverage.

The assessment also found indications of widespread depression and anxiety amongst the returnee population. As a result, there is an urgent need for psychosocial support for returnees.

3.1.5 Recommendations

The assessment indicates that health services are one of the immediate and priority needs of families that have returned to Khyber Agency. The need for improved health services was particularly emphasized by female respondents. Based on these findings, the following activities are recommended:

Health infrastructure

- Revitalize, restore and/or rehabilitate outpatient departments and delivery rooms at basic health units (BHUs), and mother and child health centres. Provide ad hoc mobile medical teams and facilities for immediate health needs in areas where health facilities are not easily accessible, especially for women and female caretakers of people with disabilities.
- Ensure that doctors and paramedic staff are available at health facilities and can provide uninterrupted services to returnees. The inclusion of female healthcare staff is a priority.
- Provide essential medicines such as primary healthcare kits to BHUs and community dispensaries, and secondary healthcare packages for DHQ/AHQ. Also provide medicines for diseases with a high prevalence including through diarrheal disease kits and medicines to treat acute respiratory infections.
- Provide essential equipment to improve the diagnostic and medical treatment capabilities of health facilities (including lab reagents).
Disease prevention

- Implement a functioning Disease Early Warning System (DEWS) to detect and predict potential disease outbreaks, and to allow for an effective response.
- Conduct routine immunizations for children in return areas to further the advances made during displacement. Strengthen both services and infrastructure (such as cold chain, supply of vaccines and trained staff) for vaccination programmes especially polio and measles.
- Implement critical preventive and curative public health interventions for: tuberculosis (DOTS); malaria (including other vector borne diseases such as dengue, Crimean-Congo hemorrhagic fever and leishmaniosis); hepatitis; and HIV/AIDS in targeted health facilities.
- Strengthen mother and child health services through appropriate interventions including ensuring the provision of: relevant staff; basic supplies and equipment; 24/7 BMONC services and CMONC services; expanded community workforce coverage such as LHW and LHVs; and trained TBAs to help with safe deliveries. Also provide clean delivery kits.

Mental Health

- Provide counselling services and psycho-social support for returnees. A standardized criteria should be developed for diagnosing depression.

Water and sanitation

- Strengthen WASH facilities to mitigate and prevent outbreaks of waterborne diseases and other related issues especially among vulnerable groups.

Capacity Building

- Develop the capacity of healthcare providers and reporting staff on DEWS.
- Develop the capacity of paramedic staff and the community mobilizers along with the LHW and LHVs.
- Train local government, public health engineering department and health facility staff on water quality and monitoring.
- Hygiene promotion tailored to low literacy population.
- Mother and child care programs.
- Training on health care waste management.

3.2 Education

3.2.1 Key findings

Education systems have been badly affected in return areas. Education infrastructure including school buildings have been badly damaged in Bara with around 95 per cent of school buildings reported to be either partially or fully damaged. Damage to school buildings is one of the main reasons given by parents for not sending their children to school. Other reasons cited include the long distance to the nearest school, the low priority given to education, that children are needed to support their families, protection/security issues and that schools have not yet re-opened (figure 1 and 2 below). However, a significant difference among the responses of male and female headed
households was observed. For boys, male headed households reported damage to schools as the main reason for not attending school followed by a lack of prioritization of education; whereas top two reasons for female headed households not sending boys to school was the long distance to school and that they are occupied supporting the household including through work or child labour. Similarly, distance to school was the most common reason for female headed households not sending girls to school while male headed households cited security concerns.

3.2.2 Priority needs

According to the findings of the assessment, 95 per cent of government educational facilities/building are damaged. This is compounded by the lack of educational supplies, and security threats to students and teachers. In view of this situation, parents expressed concern about sending their children to school. Even many schools that are structurally intact are not in a condition to provide a conducive learning environment or quality education including due to partial damage. The restoration of educational activities is essential to promoting an overall sense of security and normalcy.

**Figure 16: Children going to school in Bara**

**Figure 17: Reasons why girls are not going to school**

- School is far away: Male-headed household - 29%, Female-headed household - 20%
- Education is not a priority: Male-headed household - 19%, Female-headed household - 15%
- Protection/security concerns: Male-headed household - 18%, Female-headed household - 14%
- Concerns about the quality of education: Male-headed household - 9%, Female-headed household - 7%
- School is damaged: Male-headed household - 5%, Female-headed household - 3%
- School are not re-opened yet: Male-headed household - 8%, Female-headed household - 7%
- Education is not worthwhile: Male-headed household - 12%, Female-headed household - 11%
- Children are busy supporting their families: Male-headed household - 2%, Female-headed household - 1%
- Other: Male-headed household - 9%, Female-headed household - 7%

**Figure 18: Reasons why boys are not going to school**

- School is far away: Male-headed household - 32%, Female-headed household - 20%
- Education is not a priority: Male-headed household - 25%, Female-headed household - 19%
- Children are busy supporting their families: Male-headed household - 23%, Female-headed household - 17%
- Protection/security concerns: Male-headed household - 20%, Female-headed household - 15%
- School is damaged: Male-headed household - 15%, Female-headed household - 12%
- Schools are not re-opened yet: Male-headed household - 15%, Female-headed household - 14%
- Education is not worthwhile: Male-headed household - 11%, Female-headed household - 9%
- Concerns about the quality of education: Male-headed household - 7%, Female-headed household - 6%
- Other: Male-headed household - 11%, Female-headed household - 9%
3.2.3 Recommendations

Immediate support is needed from humanitarian organizations, community and parents to resume educational activities in return areas. Without this support, children that are currently enrolled in school risk dropping out due to the unavailability of educational services. Taleemi Islahi Jirgas (TIJs) need to be re-activated to strengthen linkages between schools and the community. The provision of educational supplies has also been highlighted as a priority.

Educational activities in all primary and secondary schools in return areas should be resumed immediately. This will be facilitated through the provision of minimum education packages compliant with Inter-Agency Network for Education in Emergencies minimum standards. Other recommended education interventions include:

- Provide safe child and adolescent friendly temporary school facilities with WASH facilities. Repair partially damaged school buildings on priority basis.
- Conduct drives to increase the rate of enrolment among children that are not currently attending school and to prevent children dropping out. Special emphasis will be placed on the new and re-enrolment of girls into formal education services. WFP food for education programs can be used to promote higher rates of enrolment.
- Provide recreational materials (including for early child development) as part of psychosocial support in schools to raise children’s self-esteem, reinforce resilience and provide an opportunity for self-expression.
- Provide furniture, textbooks, school supplies (including school-in-a-box) and stationery.
- Monitor the availability of male and female teachers in areas of return and support recruitment for identified gaps. Train teachers about the psychosocial needs of children after return, and how to manage classes in difficult and challenging conditions.
- Support parents and communities to organize community-based structures such as TIJs that are to be actively involved in: advocacy for enrolment; providing community-level security to schools; managing schools; monitoring irregularities in schools; and ensuring quality and efficiency. These structures should aim to include both men and women in equal numbers including at the decision-making level.
- Provide psychosocial support to: teachers through appropriate training; and students through extracurricular activities for girls and boys including sports and creative arts.
- Conduct cluster specific assessments of educational opportunities and required interventions. A detailed and comprehensive education recovery and reconstruction plan with a budget should be developed in collaboration with all relevant stakeholders. The plan will support the government’s initiative to mobilize resources from development partners and international financial institutions.

3.3 Food Security

3.3.1 Livelihoods

In total, 62 per cent of households were dependent on some form of wage labour as their main source of income. Non-agricultural wage labour was the most common primary source of income (37 per cent) followed by skilled wage labour (15 per cent) and agricultural wage labour (10 per cent). Only 9 per cent of households reported that they had a regular salary, while 10 per cent depend on their own business or trade. Meanwhile, 5 per cent of respondents reported that their household depends primarily on local or foreign remittances.

There has been a significant shift in livelihoods from stable sources of income before displacement to more unstable and vulnerable sources among returnees. For example, the proportion of households reporting that they depend on non-agricultural daily unskilled labour as their primary source of income increased from 29 per cent before displacement to 37 per cent in return. On the other hand, those reporting agriculture and livestock as their main sources of income decreased from 19 per cent to 10 per cent, salaried employment decreased from 10 per cent to 9 percent, and trade/business decreased from 10 per cent to 7 percent.

1 Taleemi Islahi Jirgas are the equivalent of parent teacher committees in FATA.
Damaged infrastructure, an inability to access markets, a lack of credit and a lack of work opportunities were reported by the key informants as major challenges to restoring livelihoods. Key strategies for dealing with these adverse livelihood conditions included moving to other areas, selling assets, approaching the Government and aid agencies for support, and borrowing from others.

Female headed households were twice as likely to depend on remittances at the time of the survey compared with before displacement (6 per cent up from 3 per cent); there was no change for male headed households (5 per cent). This may indicate that since displacement the male members of some female headed households have moved to other areas to earn income. The proportion of female headed households with salaried sources of income dropped by two-thirds from 9 per cent before displacement to 3 per cent in return, while the rate for male headed households remained stable at 10 per cent. Female headed households were also more likely to depend on fewer sources of income at the time of the survey. Finally, both male and female headed household reported a similar shift in livelihoods from agricultural to daily unskilled labour. However, it is worth noting, that children are more likely to support on livelihood activities in female headed households. All of these factors tend to make the livelihoods of female headed households more vulnerable.

**Figure 19: Primary sources of livelihood**

- Non-agricultural labour (unskilled): 29% (Before) 37% (Current)
- Agriculture or livestock: 10% (Before) 19% (Current)
- Non-agricultural labour (skilled): 12% (Before) 15% (Current)
- Salaried employee: 10% (Before) 9% (Current)
- Agricultural labour (daily): 7% (Before) 10% (Current)
- Trade/business: 6% (Before) 10% (Current)
- Remittances: 5% (Before) 5% (Current)
- Handicrafts: 0% (Before) 0% (Current)
- No source: 3% (Before) 6% (Current)
- Others: 3% (Before) 4% (Current)

**Figure 20: Main challenges to restoring livelihoods**

- Damaged infrastructure: 47%
- No market access: 27%
- Lack of credit: 12%
- No opportunities: 9%
- Loss of stock: 3%
- Loss of tools: 2%
- Others: 2%

**Figure 21: Main coping mechanisms**

- Move to other areas: 46%
- Sell assets: 20%
- Approach aid agencies / government for support: 14%
- Borrow from others: 12%
- Seek employment elsewhere: 5%
- Seek alternate livelihood options: 5%
3.3.2 Asset ownership

Ownership of domestic and productive assets is a key indicator of the socio-economic status of a household. It also provides some indication of the status of livelihood activities especially those related to agriculture and skilled labour. The survey findings show a significant reduction in proportion of households owning domestic and productive asset compared with the situation before displacement (figure below). There was a notable decrease in the ownership of agricultural tools (from 53 per cent before displacement to 42 per cent in return), animal shelters (55 per cent to 36 per cent), ploughs (15 per cent to 7 per cent), sewing machines (39 per cent to 25 per cent), and farm machinery (9 per cent to 5 per cent). Only ownership of mobile phones increased (from 91 per cent to 94 per cent).

Although the proportion of household assets lost since displacement is roughly equal for male and female headed households, it should be noted that male headed households owned significantly more of nearly all types of assets than female headed households. As a result, female headed households tend to be able to depend on their assets less as a coping mechanism.

![Figure 22: Asset ownership](image)

3.3.3 Agriculture

Overall, 33 per cent of respondents reported that they owned agricultural land in return areas. Of these, 65 per cent planned to cultivate their land. The findings of the assessment also show a significant decrease in families earning income from selling livestock products and producing crops compared with before displacement.

Since displacement there has been significant damage to irrigation infrastructure in Bara with 34 per cent of households reporting that the infrastructure was damaged but can be repaired, 23 per cent reporting heavy damages, and 39 per cent reporting that irrigation infrastructure in their area was completely destroyed. Meanwhile, 46 per cent of surveyed households reported major constraints to cultivating the land including debris or shrubs on agriculture land (43 per cent), the destruction of irrigation infrastructure (35 per cent), land levelling issues (9 per cent) and restricted access to land (4 per cent).

![Figure 23: Land ownership](image)
3.3.4 Livestock

Livestock is one of the most important sectors of the rural economy in FATA. The displacement has resulted in the severe depletion of livestock including through distress selling and the loss of livestock (either lost or perished) during displacement. The average number of large ruminants owned by returnees is just 0.96 per household compared to 2.23 before displacement. The average number of small ruminants owned by each household has similarly decreased from 3.65 to 1.31. Major constraints reported by households in livestock management included the unavailability of fodder (44 per cent), unavailability of shelter (19 per cent), unavailability of water (15 per cent), restocking (11 per cent) and medication (4 per cent). There was no significant difference between female and male headed households in terms of the loss of livestock assets.

3.3.5 Income and expenditure

The average monthly income of surveyed households was reported to be PKR 21,323. However, the average monthly expenditure of households was PKR 24,589, over PKR 2,000 more than the average income. Of this expenditure, the largest portion was spent on food (40 per cent) followed by health (19 per cent), housing (10 per cent) and other non-food items (8 per cent).

3.3.6 Food consumption score

Food consumption score (FCS) is one of the most commonly used indicators to measure household food security and captures the adequacy of overall food consumption. An analysis based on a seven-day recall of the food consumed by families revealed that 59 per cent of households had acceptable food consumption while 6 per cent had poor consumption and 35 per cent were borderline. It should be noted that the FCS is based on the frequency of different food groups consumed in the seven day recall period, and does not capture the quantity and number of calories consumed. The FCS also measures food diversity (the types of food consumed) by households in the previous week. The assessment findings reveal that, on average, returnee households consume 5.4 out of 7 food groups per week. No significant difference was observed in the food consumption situation of male headed households compared with female headed households.

The survey results show that more than 60 per cent of the surveyed households were receiving cereals (wheat, maize and rice), lentils (daal, beans) and oil/ghee through humanitarian interventions. Most households (more than 80 per cent) purchased meat, poultry, vegetables, sugar and fruit at local markets.

3.3.7 Food availability and access to market

Some 29 per cent of the respondents reported that sufficient food was available in the nearest market. Meanwhile, 61 per cent reported that food was available in the nearest market but that it was not always sufficient. Only 10 per cent of respondents claimed that food was not available. Key informants reported some constraints in accessing functioning markets including the high cost of transport, damage to roads and the curfew in place. Access to food in markets was also limited by economic constraints with a majority of respondents (73 per cent) reporting that they did not have adequate resources to purchase sufficient food in the market. Interestingly, all eight female key informants noted that they did not have adequate resources to make food purchases compared to 70 per cent of male key informants.
3.3.8 Recommendations

- Continue cash and/or food assistance until returnees resume normal and stable livelihoods.
- The restoration of livelihoods is central to the stability of returnee households. Activities to support the livelihood and income of these families is recommended, with particular focus on vulnerable groups. Such activities include support for housing, agriculture and livestock, credit facilities and training.
- To restore the agricultural sector: provide agricultural inputs; rehabilitate irrigation infrastructure; restock livestock; and make vaccines, medicines, feed, and shelter for livestock available.

3.4 Nutrition

3.4.1 Key findings

Malnutrition is a well-recognized health problem which plays a significant role in elevated child morbidity and mortality rates across Pakistan. Nutrition indicators in FATA have historically tended to be worse than in other areas of Pakistan. While the nutrition findings of the assessment are consistent with the information available for KP/FATA, the assessment shows that many basic facilities including water, health, sanitation and food security need to be re-established in Bara. The lack of these services and facilities will exacerbate existing malnutrition problems among children, and pregnant and lactating women (PLW), and will potentially reach critical levels. There is a critical need for the immediate activation of the emergency nutrition programme and other basic nutrition services to mitigate this.

3.4.2 Malnutrition rates

Rates of malnourishment were assessed through MUAC testing of children aged 6 to 59 months. Based on these measurements, the overall Global Acute Malnutrition (GAM) was found to be 17.2 per cent (above the emergency threshold) with a Severe Acute Malnutrition (SAM) rate of 5.2 per cent. This trend indicates an alarming rate of acute malnutrition, which may further deteriorate in the absence of nutrition specific and nutrition sensitive interventions.

3.4.3 Breastfeeding trends

64 per cent of households reported having at least one member that was a lactating mother. Of these, 29 per cent of survey respondents reported that women in their household had experienced a reduction in breastfeeding during and after return, while 71 per cent reported no change in breastfeeding patterns. Reduced breastfeeding increases the risk of malnutrition among children less than 2 years of age, and the risk of diarrhea.

3.4.4 Uncontrolled distribution of milk powder

The distribution of milk powder (including breastmilk substitution formula) during emergencies disrupts normal infant and young child feeding practices, and is not recommended by the Nutrition Cluster. The vast majority of the households (96 per cent) have not received milk powder assistance for children aged 6 to 24 months.
3.4.5 Vitamin A supplementation
69 per cent of returnees had not received vitamin A supplements for children aged 6 to 59 months. This equates to very low coverage, increasing the risk of vitamin A deficiency that has serious consequences for children less than 5 years old.

3.4.6 Recommendations
- Establish a community based management of acute malnutrition (CMAM) programme with all components i.e. Outpatient Therapeutic Programmes, Targeted Supplementary Feeding Programmes, and Stabilization Centre in Bara to address acute malnutrition rates among children and mothers.
- Promote and monitor infant young child feeding (IYCF) practices as an integral part of nutrition programmes and health education messages.
- Establish breastfeeding corners at health facility/community centres to protect and promote breastfeeding.
- Monitor the distribution of breastmilk substitutes, and strengthen coordination networks to ensure the reporting of any cases.
- Conduct health education for communities to promote breastfeeding, hygiene, immunization and health seeking practices.
- Immediately set up vitamin A supplementation programmes.

3.5 Protection
3.5.1 Security
Of the 805 survey respondents, 19 per cent reported feeling insecure in the area of return with female respondents more likely to report feeling insecure than male respondents (25 per cent and 18 per cent respectively). Overall, 33 per cent of key informants reported security concerns in their community especially for women and children, and 43 per cent noted that movements were restricted. The key informants noted that there was little difference between male and female headed households.

3.5.2 On major concerns and challenges
Community disputes were the most commonly witnessed type of incident among household members (11 per cent) followed by specific threats (11 per cent), killings (5 per cent), and violence against women and girls (5 per cent). While the responses of male and female headed households were similar across most types of incidents, there was a significant difference on the issue of witnessing violence against women. Female-headed households were nearly three times more likely to report having witnessed violence against women than respondents from male-headed households (13 per cent to 4 per cent respectively). In total, 79 per cent of key informants noted that mine risk education activities had not been conducted in their area.
Although the percentage of separated and missing children is low, nearly all key informants indicated that there were no general child care services (93 per cent) or specialized services for orphans and separated children (99 per cent) in their area. The majority (62 per cent) of key informants noted that specific support was not made available to older people during or after return. It is important to note that 14 per cent of respondents reported that children from their family were either living alone or with other relatives. Children are made more vulnerable by a lack of educational services and high chance of working as a child labourer, with 88 per cent of key informants noting that child labour was present in their community.

Thirty-six per cent of households reported that at least one adult member of their family did not have a CNIC. This was 10 per cent more common in female-headed households. Meanwhile, the majority of people with disabilities (72 per cent) do not have a special CNIC for people with disabilities.

Of the main problems and challenges identified by respondents, the lack of services for people with disabilities was the fourth most commonly reported (23 per cent) while 16 per cent identified security issues. In addition, 9 per cent of households reported that the lack of female privacy as a challenge.

### 3.5.3 Priority needs

In terms of protection-specific priority needs, 45 per cent of female-headed households and 35 per cent of male headed households reported that adult members of their household (over 18 years) have issues related to CNIC cards. As a result, humanitarian assistance should not depend on possessing a CNIC.

### 3.5.4 Recommendations

- Special needs of older people and people with a persons with age and disability should be considered while designing the response activities including in the reconstruction of infrastructure.
- As significant number of households reported that adult members among household do not possess a CNIC. It is recommended that humanitarian assistance should not depend on possessing a CNIC card.
- There is need to strengthen the understanding of law enforcement agencies on protection issues especially those faced by the affected population in the context of returns and have them facilitate the work of protection cluster partners.

### 3.6 WASH

The household survey included questions related to existing and functional water sources, access to and the availability of water at household and communal levels, water collection and storage containers, and sanitation facilities. It also gathered information on whether communities had access to hygiene items, were sensitized on key hygiene messages, and if there had been any reports of disease outbreaks in the village or community.

#### 3.6.1 Status of water sources

A large proportion of people in return areas depend on protected water sources (94 per cent), that were reported to be not safe and free of contamination. A limited number of households (6 per cent) use unprotected sources that are assumed not to be safe or free of contamination. Random water quality tests were not conducted, but unprotected sources are vulnerable to contamination. Some 6 per cent of the returnee households rely on un-protected water sources. Existing unprotected water sources could become safe sources if household water treatment is improved. One of the major WASH issues identified, was that 90 per cent of people with a disability do not have easy access to water.
3.6.2 Observation of water quality
The direct observation of drinking water at the household level revealed that the quality of water in most houses was satisfactory. Water was considered unsafe in only 18 per cent of households. The most commonly observed issue was bad taste (7 per cent) followed by the water having a bad smell (4 per cent). Another issue identified in some cases was turbidity. Overall, the community was mostly satisfied with the quality of water.

3.6.3 Water collection/storage
In some cases, the water source was either in the house (15 per cent) or less than 15 minutes from the house (26 per cent). However, the majority of people either have to travel between 15 and 30 minutes (26 per cent), or more than 30 minutes (32 per cent) to collect drinking water.

Before displacement, communities in Bara depended on canals for water supply. The assessment found that these canals have been badly damaged and were not functional at the time of assessment. As a result, people were relying on privately owned tube-wells and often travelled long distances to access water. Most households (66 per cent) owned appropriate storage containers for drinking water. The remaining 34 per cent resort to unhygienic or inappropriate water storage methods.

3.6.4 Physical access to sanitation sources
In terms of access to sanitation facilities, 75 per cent of returnees had access to some form of latrine while 23 per cent defecate in the open. Very few returnees have access to hygienic sanitation facilities. Of those with access to a latrine, only 16 per cent have pour flush latrines with a proper septic tank, 20 per cent use pour latrines with an open drain and almost 43 per cent use traditional pit latrines which are often unsanitary. The key informant interviews supported these findings. Finally, the assessment revealed that 94 per cent of schools and health centres have limited or no access to WASH services.

3.6.4 Hand washing
The findings of the survey show a very low rate of hygiene awareness among the community. Only 28 per cent of households surveyed washed their hands with soap before eating and 7 per cent after defecation. Less than 1 per cent of mothers were reportedly washing their hands with soap before feeding their child.
3.6.5 Hygiene promotion/kits and disease trends

The majority of the population (84 per cent) have not received hygiene kits upon return. This is mainly due to the fact that hygiene kits have been distributed on the basis of the vulnerability criteria rather than to all returnees. However, only 9 per cent of female headed households reported having received hygiene kits upon return compared with 16 per cent for male headed households. In total, 81 per cent of returnees have been sensitized on key hygiene messages either during displacement or at the embarkation points during their return. The need for better hygiene practices remains high given the alarming disease trends with diarrhea present in 56 per cent of households, as well as high rates of skin infections, malaria and typhoid. Females were more likely to have received hygiene awareness training (28 per cent compared with 16 per cent for male respondents) however their hygiene practices were significantly poorer. This underscores the need for hygiene training tools to be tailored to both male and female audiences.

3.6.6 Recommendations

- Sanitation facilities need to be installed/enhanced in targeted areas especially in schools and health centres with separate facilities for males and females. The capacity of returnees to use local materials to build effective and user-friendly sanitation facilities should be strengthened. This should be done with a view to increase the sustained use of quality sanitation facilities in areas of return.
- Provide household water storage containers including small water tanks, buckets and jerry cans based on need. Significantly increase awareness of simple and innovative water treatment processes to improve water safety and hygiene.
- Support community-based hygiene promotion using multiple communication methods to allow for low literacy levels.
- Provide WASH-related non-food items (NFIs) including hygiene kits, soap, culturally acceptable sanitary items, and locally produced water containers where possible, in close cooperation with other NFI distributions (e.g. shelter).
- Provide education materials (including pictorial messages, pamphlets, brochures etc.) that highlight the linkages between hygiene, water safety and health.
- Conduct regular water quality surveillance in affected areas, and routinely disseminate microbial water quality results and trends to all WASH partners.
- Monitor the environmental health conditions (safe water surveillance, sanitary and hygiene conditions) of affected communities.

3.7 Physical infrastructure

3.7.1 Key findings

Most community physical infrastructure in Bara has been damaged with severe effects on education, health, WASH and livelihood activities. The assessment findings include reported damage to irrigation/drain channels, official buildings, shops and markets, main water points, school buildings, health centres and link roads. Respondents stressed the critical need for the immediate restoration of community infrastructure.

The most commonly reported damage was to schools building (77 per cent), followed by main water points (75 per cent) and health centres (73 per cent). Farming and other livelihood activities have been affected by the damage to irrigation infrastructure, link roads and market places.

![Figure 35: Water-borne diseases](image-url)
The most commonly cited critical infrastructure to be restored and/or rehabilitated was water channels (65 per cent). As mentioned above, almost all water points and irrigation channels have been affected, either completely or partially. This, in turn, worsens the WASH situation of households and affects agriculture-based livelihoods. The next most commonly cited critical infrastructure needs were the restoration of hospitals (60 per cent) and roads (58 per cent).

3.7.2 Priority needs

In order to restore community infrastructure, material and cash support were regarded as most important requirements (81 per cent and 71 per cent respectively), followed by technical support (51 per cent).

3.7.3 Recommendations

- Create livelihood opportunities through cash for work activities and community infrastructure schemes.
- Provide livelihood opportunities through small enterprises, and by establishing small shops and village level markets for basic necessities in return areas including for elderly and disabled family members as well as female heading households.
- Rehabilitate social services schemes including water sewers, street pavements and roads.
- Raise awareness among community members engaged in restoration activities about peace, social cohesion, social protection and risk education.
3.8 Humanitarian communications

The findings of the assessment show that most returnee households have received critical, life-saving information about available assistance, eligibility requirements, return processes and mechanisms to address grievances. A total of 73 per cent of respondents reported receiving information through mobile phones, 66 per cent through word of mouth, 60 per cent through mosques and 33 per cent over the radio. Meanwhile, the majority indicated that mobile phones were their preferred source of information (64 per cent) followed by word of mouth (42 per cent), mosques (39 per cent) and over the radio (35 per cent). A significant difference among the preferred sources of male and female respondents was reported: male respondents preferred mobile phones (73 per cent) whereas female respondents preferred to receive information through word of mouth or mosques (58 percent and 48 percent respectively).

The five most commonly cited types of information received were about food distributions (76 per cent), the distribution of other assistance such as shelter and NFIs (36 per cent), return processes (30 per cent), registration and civil documents (30 per cent) and the availability of health facilities (24 per cent). On average, less female respondents were less likely to report having received this information than male respondents.
3.9 Priority needs identified by returnees

The most commonly cited challenges faced in areas of return were a lack of basic facilities (90 per cent of households) followed by lack of livelihood opportunities (84 per cent), restricted movement (49 per cent), and a lack of services for people with disabilities (23 per cent). Other problems/challenges reported included security issues (16 per cent) and a lack of privacy for females (9 per cent). There was a slight difference among the responses, with female-headed households more likely to express their concern about security issues and a lack of services for people with disabilities.

Survey participants were also asked about their three top priority needs. The most commonly cited needs were employment opportunities (52 per cent) closely followed by health services (50 per cent) and education facilities (38 per cent). Other priority needs that were reported included housing reconstruction (36 per cent), cash support (30 per cent), livelihoods (29 per cent) and WASH facilities (25 per cent). Female-headed households were more likely to prioritize WASH facilities, cash support and food assistance.
SECTION 4: CONCLUSION AND RECOMMENDATIONS

The assessment identified a number of priority areas where interventions are required to respond to the immediate needs of returnee households. The assessment also drew attention to the particular needs of vulnerable groups. The following provides a summary of key recommendations.

4.1 Vulnerability

The findings of the assessment indicate that female headed households, child headed households and households headed by an older person tend to be particularly vulnerable in return areas. In addition, 6 per cent of the households reported that they had no source of income at the time of survey and were fully dependent on humanitarian assistance. These vulnerable groups should be targeted as a priority while their specific needs should be taken into account in planning and implementing humanitarian interventions.

4.2 Priority areas for interventions

Respondents were asked to prioritize their humanitarian needs. The following recommendations are listed (and prioritized) according to the importance placed on each type of assistance by respondents.

1. Provide livelihood support to create employment and job opportunities through: cash for work activities; support to small enterprises by establishing shops and village level markets; restore on-farm livelihoods; provide cash and credit support; and establish training facilities. These interventions should target vulnerable households in particular.

2. Restore and rehabilitate health services (including CDs, BHUs, RHCs and THQ) and provide them with required human resources, essential medicines, and medical and diagnostic equipment. A special focus on mother and child healthcare is recommended.

3. Help prevent the spread of communicable diseases by establishing a functional Disease Early Warning System, strengthening routine immunization services, and implementing preventive and curative programmes.

4. Provide safe child and adolescent friendly temporary school facilities with appropriate WASH facilities, reconstruct and/or repair damaged schools, and provide furniture, textbooks and school supplies. Food for education programs should be launched to help increase enrolments. Recreational activities and psychosocial support should also be implemented to improve the self-esteem of children and reinforce resilience.

5. Install and/or enhance sanitation facilities in targeted areas especially in schools and health centres. Increase the availability of readily accessible drinking water, and provide households with water storage containers (including small tanks and jerry cans) and other WASH related NFIs. There is also an urgent need for community based hygiene promotion.

6. Rehabilitate community physical infrastructure and social services schemes including irrigation infrastructure, sanitation lines, government buildings, street pavements and roads. Social protection and risk reduction components should be taken into account in reconstruction activities. Reconstruction through cash for work activities is recommended.

7. Establish a CMAM programme with all components and conduct Vitamin A supplementation. Also provide communities with health education to promote breastfeeding, hygiene, immunization and health seeking practices.

8. Special needs of older people and people with a persons with age and disability should be considered while designing the response activities. Response activities should also have male and female service providers to interface with female caregivers.
### ANNEX 1: HOUSEHOLD SURVEY QUESTIONNAIRE

#### General Information

1. HH identification number
2. Date of survey (dd / mm / yy)
3. Interviewer Name
4. Tribe of the respondent
5. Agency
6. Tehsil
7. Village
8. Respondent Name
9. Sex of respondent
   - 1 = Male, 2 = Female
10. Gender of head of HH
    - 1 = Male, 2 = Female
11. Relation of respondent with HH head
    - 1 = HH head, 2 = spouse, 3 = son/daughter, 4 = brother/sister, 5 = Others
12. Age of head of household
    - (in years)

#### Household Composition and Vulnerabilities

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-5 years</td>
<td></td>
<td></td>
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<tr>
<td>5-18 years</td>
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<tr>
<td>18-50 years</td>
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<tr>
<td>50-60 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Above 60 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons with disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 = Physical, 2 = Hearing/speech, 3 = Intellectual, 0 = N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children who lost both parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children who lost one parent</td>
<td></td>
<td></td>
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<tr>
<td>Separated children</td>
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</table>

#### Education

<table>
<thead>
<tr>
<th></th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children (3-5 years) going to school?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before displacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After return</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children (5-18 years) going to school?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before displacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After return</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: please ask for reasons, *If number of school going children is less than the before displacement situation*
Reason(s) for not going to school? (Please select top three reasons)
- 1 = Protection/security concerns, 2 = Education being low priority, 3 = Concerns on quality of education, 4 = Children supporting their families, 5 = Education is not worthwhile, 6 = School is damaged, 7 = School is far away, 8 = School are not reopened yet, 9 = Any other ________

#### Health

<table>
<thead>
<tr>
<th>What is the nearest health facility?</th>
<th>Doctor</th>
<th>Nurse/ FMT/ LHV</th>
<th>Medical Technician/ Dispenser</th>
<th>General OPD</th>
<th>Inpatient (admission)</th>
<th>Delivery</th>
<th>Lab / X-Ray</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Basic Health Unit, 2 = Civil Dispensary, 3 = Community Health Center, 4 = Tehsil Head Quarter, 5 = Maternal and Child Health, 6 = Agency Head Quarter 7 = Others ____</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

30. How far is the nearest health facility? | Distance (in km) | Walking Time (in hours) |

31. What is the availability of staff and services at facility? (0 = No, 1 = Yes, 2 = Yes but not regular, 3 = don’t know) | | |

32. Have you/ your family members received above health service at Govt. health facility? (0 = No, 1 = Yes, 2 = Didn’t need) | |

33. If no, reasons for not being able to get health services? (choose up to 2 options)
- 1 = Security issues, 2 = Couldn’t afford cost, 3 = It was too far, 4 = Relevant staff not available, 5 = Relevant services not available, 6 = Couldn’t afford transportation, 7 = Others)
### MULTI-CLUSTER ASSESSMENT OF FATA RETURNEES

#### Bara, Khyber Agency

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Options</th>
<th>Yes/No/NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.</td>
<td>Are there pregnant &amp; lactating women in the household?</td>
<td>(0=No, 1=Yes)</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Do the pregnant women have access to a health facility to assist with the birth?</td>
<td>24/7? (0=No, 1=Yes, 9=N/A)</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>Have your children been vaccinated under routine EPI?</td>
<td>(0=No, 1=Yes, 9=N/A)</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>If no, what was the reason? (choose up to 2 options)</td>
<td>1=center not available in area, 2=centr non-functional, 3=center is too far, 4=Teams do not visit, 5=cultural/religious beliefs, 6=consider unimportant, 7=others _______</td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>Do you(any household member experience any of these psychological issues? (0=No, 1=Yes)</td>
<td>Feeling nervous or anxious, Not being able to sleep, Worrying too much about things, Little interest or pleasure in doing things, Feeling down /depressed, Feeling tired /having little energy, Poor appetite or overeating</td>
<td></td>
</tr>
</tbody>
</table>

#### WASH

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Options</th>
<th>Yes/No/NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.</td>
<td>What is the Main source of drinking water for your family? (1=Tape water, 2=Dug well, 3=River, 4=Open Pond, 5=Water channel/canal, 6=Tube well, 7=Hand Pump, 8=Bore Hole, 9=Other _______)</td>
<td>Average time for water collection? (1=in house, 2=Less than 15 minutes, 3=15 to 30 minutes, 4=More than 30 minutes)</td>
<td></td>
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<tr>
<td>40.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>Is there any water container at your home for water storage? (0=No, 1=Yes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>Are you satisfied with the quality of water? (0=No, 1=Yes)</td>
<td></td>
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</tr>
<tr>
<td>43.</td>
<td>Observe the drinking water  (1=Appears clean, 2=Bad smell, 3=Bad taste, 4=Turbidity, 5=All the them, 6=Other _______)</td>
<td>Do you have latrine within your house? (0=No, 1=Yes)</td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45.</td>
<td>If yes, What type of latrine do you have? (1=Pour flush with Septic Tank, 2=Pour flush with open drain, 3=Traditional pit latrine, 4=VIP Latrine, 5=Other _______)</td>
<td>Presence of water borne Diseases (Choose up to top 3 diseases) (1=Typhoid, 2=Diarrhea, 3=Malaria, 4=Cholera, 5=Hepatitis, 6=Dengui, 7=Polio, 8=Eye Infections, 9=Worms, 10=Skin Infections, 11=Others _______)</td>
<td></td>
</tr>
<tr>
<td>46.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47.</td>
<td>When you/your family member wash hands? (1=Before eating, 2=Before feeding, 3=After using the latrine, 4=After cleaning child faeces, 5=All of the above, 6=Don’t wash)</td>
<td>Has hygiene kit been provided to the family after return? (0=No, 1=Yes)</td>
<td></td>
</tr>
<tr>
<td>48.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49.</td>
<td>Has you or any member of your family received any training/session on Hygiene promotion during displacement or after return? (0=No, 1=Yes)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Food Security

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Currently</th>
<th>Before displacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.</td>
<td>What are the two main sources of livelihood of this household?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1= Day labor in agriculture, 2= Agriculture/livestock, 3= Non Agro day labor (Unskilled), 4= Non Agro Labor (Skilled), 5= Remittances, 6= Salaried employee, 7=Trade/business, 8= Handicrafts business by women 9=No source, 10=Others _______)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes/No/NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>51.</td>
<td>Assets</td>
<td>Owned Before the displacement (Numbers)</td>
</tr>
<tr>
<td>52.</td>
<td>Asset</td>
<td>Owned Before the displacement (Numbers)</td>
</tr>
</tbody>
</table>
### Multi-Cluster Assessment of FATA Returnees

<table>
<thead>
<tr>
<th>53. Sewing machine</th>
<th>54. Cell phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>55. Plough</td>
<td>56. Heater</td>
</tr>
<tr>
<td>57. Farm machinery</td>
<td>58. Animal Shelter</td>
</tr>
<tr>
<td>59. Motorbike</td>
<td>60. Radio</td>
</tr>
<tr>
<td>61. Cooking stove</td>
<td>62. Television</td>
</tr>
<tr>
<td>63. Car</td>
<td>64. Agricultural tools</td>
</tr>
</tbody>
</table>

**65.** Estimate how much income did your household earned in total last month (monthly income after return, please probe for income from all sources)? (write in PKR) |  |

**66.** Food | 67. Housing (Repair, rent etc) |

**68.** Health | 69. Clothing, shoes |

**70.** Education | 71. Water for domestic use and agriculture |

**72.** Transport | 73. Ceremonies/gifts |

**74.** Agriculture inputs | 75. Reimbursement of debt |

**76.** Livestock (Fodder, feed) | 77. Other non-food items |

**78.** Do you normally cultivate land? (0 = No, 1 = Yes) If no, go to Q87 | 79. How much cultivatable agricultural land do you own? (write number of Acres) |

**80.** What is the current status of agriculture land? (1=Ready for cultivation, 2=Minor constraint in land preparation, 3=Major constraints) | 81. If constraints are reported, What are the major constraints in land preparation for cultivation? (Top 2) (1=Access to land restricted, 2=Debris or shrubs on agriculture land, 3=Land levelling issues, 4=Irrigation destroyed, 5=Land demarcation issues, 6=Land tenure issue, 7=other: ________ ) |

**82.** What is the status of irrigation infrastructure currently? (1= Totally destroyed, 2= Heavily Damaged, not useable, 3=Damaged but can be repaired, 4=Limited or no damage, 5=Not applicable/land is rain-fed) | 83. Have you cultivated/planning to cultivate land in this Kharif season? (0=No, 1=Yes) |

**84.** If yes, how much land you cultivated/plan to cultivate? (write in acres) | 85. What is the status of availability of agriculture inputs (seed, fertilizer etc.)? (1=Available, 2= available but less than requirement, 3=Not at all available) |

**86.** What are the major constraints in cultivation/agriculture farming you are facing? (Choose up to 3 options) (1 = Access to farming land restricted 2 = Land is not prepared for cultivation, 3=Irrigation damaged/destroyed, 4 = Agricultural inputs lost/unavailable, 5= Lack of manpower, 6 = Loss / lack of draught animals, 7= Soil infertility, 8=Unclear land use rights, 9= Financial constraints, 10= Loss of tools/machinery 11=other reasons (specify): ________ ) |

**87.** How much livestock do you own? | Large ruminants | Small ruminants |
| Before displacement |  |
| After return |  |

**88.** What is the major constraints/issues in livestock sector? (1=Unavailability of fodder, 2=Unavailability of shelter for livestock, 3=Unavailability of Water for livestock, 4=Medication, 5=restocking is required, 6=Others: ________ ) |

**How many days in the past seven days was the following food item eaten in the household?**

<table>
<thead>
<tr>
<th>Please consider food eaten inside house</th>
<th>Days</th>
<th>Main source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>Main source</td>
<td>Days</td>
</tr>
</tbody>
</table>
## MULTI-CLUSTER ASSESSMENT OF FATA RETURNEES

### Bara, Khyber Agency

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>89. Wheat (bread), rice, maize</td>
<td>(0= Not eaten 1= 1 day, 2= 2 days, 3= 3 days, 4 = 4 days, 5= 5 days, 6 = 6 days, 7= 7 days)</td>
</tr>
<tr>
<td>90. Meat, poultry, fish, eggs</td>
<td>(1 = own production, 2 = market/shop purchase, 3 = Food 4 = work, 4 = for work, 4 = borrowing/debt, 5= gifts, 6 = food aid, 7 = others specify_______)</td>
</tr>
<tr>
<td>91. Lentils (all types of daals), beans, peas</td>
<td>(0= Not eaten 1= 1 day, 2= 2 days, 3= 3 days, 4 = 4 days, 5= 5 days, 6 = 6 days, 7= 7 days)</td>
</tr>
<tr>
<td>92. Milk, cheese, yoghurt</td>
<td>(1 = own production, 2 = market/shop purchase, 3 = Food 4 = work, 4 = for work, 4 = borrowing/debt, 5= gifts, 6 = food aid, 7 = others specify_______)</td>
</tr>
<tr>
<td>93. Vegetables</td>
<td>94. Sugar, honey, sugar, etc</td>
</tr>
<tr>
<td>95. Fruits</td>
<td>96. Oil, ghee, butter</td>
</tr>
<tr>
<td>97. During the past month have there been times when your family had problem meeting food needs? (0=No, 1=Yes) if yes, ask following question, if no, skip to question 110</td>
<td></td>
</tr>
<tr>
<td>100. Limit portion size at meals</td>
<td>101. Selling domestic items including jewelries</td>
</tr>
<tr>
<td>102. Decrease expenses on health care</td>
<td>103. Adult ate less in order to make food available to children</td>
</tr>
<tr>
<td>104. Took children out of school for work</td>
<td>105. Rely on less preferred food</td>
</tr>
<tr>
<td>106. Skipped entire’s day meal</td>
<td>107. Did begging</td>
</tr>
<tr>
<td>108. Women ate less food than men</td>
<td>109. Sent family members to work abroad</td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td></td>
</tr>
<tr>
<td>110. Is there any lactating women in the household? (0=No, 1=Yes)</td>
<td>111. If yes, is there any change in pattern/frequency of breastfeeding during crises? (0=No, 1=YES)</td>
</tr>
<tr>
<td>112. Has there been any donations of infant formula or commercial baby foods or bottles or teats in your community? (0=No, 1=Yes)</td>
<td></td>
</tr>
<tr>
<td>114. Age and MUAC of children aged between 6 months and 5 years and pregnant/lactating women</td>
<td></td>
</tr>
<tr>
<td>Child 1 Child 2 Child 3 Woman 1 Woman 2</td>
<td></td>
</tr>
<tr>
<td>116. Sex (1=male, 2=female)</td>
<td>2 2</td>
</tr>
<tr>
<td>117. MUAC reading</td>
<td></td>
</tr>
<tr>
<td>118. Bilateral Edema</td>
<td></td>
</tr>
<tr>
<td><strong>Protection</strong></td>
<td></td>
</tr>
<tr>
<td>119. Do you feel secure staying here? (0=No, 1=Yes)</td>
<td>120. How do you feel while moving in the area? (1=restricted, 2=easy)</td>
</tr>
<tr>
<td>121. Does any household member above 18 lacking personal document (like CNIC)? (0=No, 1=Yes)</td>
<td>122. Is any of the child from your household separated due to displacement or return? (0=No, 1=Yes)</td>
</tr>
<tr>
<td>123. Have any of your household member witnessed any of the following event? (0=No, 1=Yes)</td>
<td>Threats</td>
</tr>
<tr>
<td>124. What are the three major problems/challenges that you experience after return?</td>
<td>First</td>
</tr>
</tbody>
</table>
### Multi-Cluster Assessment of Fata Returnees

#### Bara, Khyber Agency

<table>
<thead>
<tr>
<th>Question</th>
<th>Options/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>125. What are the three major needs of your households currently?</td>
<td>(1=Housing reconstruction, 2=Employment/job opportunities, 3=Wash/Hygiene facilities, 4=Education facilities, 5=Health services, 6=Livelihood, 7=Food, 8=Civil documentation, 9=Agriculture/livestock, 10=Cash support, 11=Others)</td>
</tr>
<tr>
<td>126. Mass Communication: Have you/household receive information?</td>
<td>Radio, TV, Newspapers, Word of mouth, Mobile phone, Mosque, Pamphlets, Banner/poster, Call center/desk</td>
</tr>
<tr>
<td>127. Mass Communication: What is your preferred source of information?</td>
<td>(0=No, 1=Yes)</td>
</tr>
<tr>
<td>128. Mass Communication: What kind of information have you received?</td>
<td>Distribution of Food, Distribution of other assistance (Shelter, NFI etc), Housing compensation, Targeted distribution for vulnerable groups, Availability of health facilities, GBV and information confidentiality, Registration and civil documents, Hotline for missing/unaccompanied children, Mine Risk Education, Prevention of diseases, Return process, including assistance and arrangements for persons with specific needs, Others, specify:</td>
</tr>
<tr>
<td>129. Is such information accessible for persons with disabilities?</td>
<td>(0=No, 1=Yes)</td>
</tr>
</tbody>
</table>
## ANNEX 2: KEY INFORMANT QUESTIONNAIRE

### TEAM INFORMATION

1. Date (day/month/year)  
2. Team Number:  
3. Enumerator Name  
4. Enumerator Gender □ Male □ Female

### SITE INFORMATION

5. Agency  
6. Tehsil  
7. Village  
8. Major tribe  
9. Village code:  
10. Accessibility of site: □ Easy to access □ Obstruction in access  
11. Obstruction to access: □ 1. Damage to bridge □ 2. Damage to culverts □ 3. Damage to access roads □ 4. Other □ N/A

### KEY INFORMANT

12. Name of Key Informant:  
13. Role in community  
14. Gender of Key Informant: □ Male □ Female  
15. Cell Phone No.  
16. CNIC no. (Optional)  
17. □ Key Informant consent to share information of contact details

### OVER VIEW COMMUNITY

18. Population Data  
   19. Vulnerable groups / individuals (Write numbers, or 0 in case of no vulnerable household)
      a. Total (current) population (#)  
      b. Number of households (#)  

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>a. Female headed household</th>
<th>b. Child headed household</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>c. People with Physical disabilities</td>
<td>d. People with hearing/speech disabilities</td>
</tr>
<tr>
<td></td>
<td>e. People with intellectual disabilities</td>
<td>f. Elderly people (60+ years)</td>
</tr>
</tbody>
</table>

### Food Security

20. What are the main sources of livelihood in the community? (in % of households)  
21. What are the percentage losses to each source of livelihood in the community? %

<table>
<thead>
<tr>
<th>Agricultural based - own farm or shared cropping</th>
<th>Livestock based</th>
<th>Agriculture based - own farm or shared cropping</th>
<th>Livestock based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily labourer</td>
<td>Remittances</td>
<td>Daily labourer</td>
<td>Remittances</td>
</tr>
<tr>
<td>Regular job</td>
<td>shopkeeper/trader/Business</td>
<td>Regular job</td>
<td>shopkeeper/trader/Business</td>
</tr>
<tr>
<td>Home-based work</td>
<td>Other</td>
<td>Home-based work</td>
<td>Other</td>
</tr>
</tbody>
</table>

22. What are the major hurdles in restoring to normal Livelihood /income generating activities? (Choose up to top 3 options) (1=Inability to access markets, 2=Damaged infrastructure, 3=Lack of credit, 4=Lack of work opportunities, 5=Loss of tools, 6=Loss of stock, 7=Others ________)

23. How are people coping / responding to this adverse livelihoods situation? (Choose top 3)
   (1=Moving to other areas, 2=Selling assets, 3=Borrowing from others, 4=Seeking employment elsewhere, 5=Approaching aid agencies / government for support, 6=Seeking alternative livelihood options)

24. What support is required to restore normal income generating in coming few months?
   (1=Agriculture support, 2=Livestock support, 3=Job opportunities, 4=skills/training, 5=cash/loan, 6=access to markets, 7=other)

25. Is sufficient food available in nearest markets?
   (1=Plenty (no problem), 2=Inadequate (available but not enough), 3=Not at all)

26. What is the price level of food items in nearest markets?

27. Do the people in your community have sufficient resources to buy food?
<table>
<thead>
<tr>
<th>EDUCAUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>28. Status of Educational Institutions</strong></td>
</tr>
<tr>
<td>A. Primary</td>
</tr>
<tr>
<td>B. Secondary</td>
</tr>
<tr>
<td>C. Other Vocational/Non Formal</td>
</tr>
<tr>
<td>D. Madrassa</td>
</tr>
<tr>
<td><strong>29. Number of Schools with WASH facilities</strong></td>
</tr>
<tr>
<td>Boys</td>
</tr>
<tr>
<td><strong>30. Are there any undamaged schools occupied in the area? If yes, around what proportion?</strong></td>
</tr>
<tr>
<td><strong>31. What sort of immediate life skill information is required for both teachers and student? (Top 2)</strong></td>
</tr>
<tr>
<td>(1=Psychosocial skill information, 2=Mine risk information 3=Protection/abuse/exploitation 4=Rebel attack 5=Disability awareness training, 6=Any other)</td>
</tr>
<tr>
<td><strong>32. What support to education is most essential in this community / site after return process? (Please select top 2)</strong></td>
</tr>
<tr>
<td>(1=Repairing damaged school buildings or facilities, 2=Establishing temporary spaces for learning, 3=Ensuring safety of children and teachers, 4=Providing school teaching/learning material materials, 5=Psychosocial support to teachers and students, 6=Teachers' mobility support)</td>
</tr>
<tr>
<td><strong>Health</strong></td>
</tr>
<tr>
<td><strong>33. Is the health facility accessible to the community?</strong></td>
</tr>
<tr>
<td>(0=No, 1=Yes)</td>
</tr>
<tr>
<td><strong>34. Have you satisfied with the health services in the area? (1=Very Satisfied, 2=Somewhat satisfied, 3=Not satisfied)</strong></td>
</tr>
<tr>
<td><strong>35. Are there female doctors available?</strong></td>
</tr>
<tr>
<td>(0=No, 1=Yes)</td>
</tr>
<tr>
<td><strong>36. Do you know where to go in case of health emergency? e.g. in case of complicated pregnancy (0=No, 1=Yes)</strong></td>
</tr>
<tr>
<td><strong>37. What are the recurring/ existing health problems in your family/community? (Choose top three)</strong></td>
</tr>
<tr>
<td>(1=Diarrhea, 2=Cough/cold/fever, 3=Malaria, 4=TB, 5=Measles, 6=Polio, 7=Skin infections, 8=Others_______)</td>
</tr>
<tr>
<td><strong>38. Where do you get most of the health information?</strong></td>
</tr>
<tr>
<td>(1=Doctor, 2=Health department, 3=Family/Friend 4=Hospital, 5=Newspaper/magazine, 6=TV/radio, 7=Mosque, 8=Worksite/school/college)</td>
</tr>
<tr>
<td><strong>Protection</strong></td>
</tr>
<tr>
<td><strong>39. Are there any challenges to/from movement in areas of return?</strong></td>
</tr>
<tr>
<td>(1=No, free to move, 2=Some difficulties in movement, 3=Major restriction in movements)</td>
</tr>
<tr>
<td><strong>40. Have the community received any form of Mine Risk Education?</strong></td>
</tr>
<tr>
<td>(0=No, 1=Yes)</td>
</tr>
<tr>
<td><strong>41. Do women or children in the community have particular concerns regarding safety and security? (0=No, 1=Yes)</strong></td>
</tr>
<tr>
<td><strong>42. Persons with disabilities residing in the community possess special computerized national identity card? (0=No, 1=Yes)</strong></td>
</tr>
<tr>
<td><strong>43. What are the main difficulties of person with disabilities?</strong></td>
</tr>
<tr>
<td>(Please write the main difficulties)</td>
</tr>
<tr>
<td><strong>44. Is specific support is provided to the old age people during or after return? (0=No, 1=Yes)</strong></td>
</tr>
<tr>
<td><strong>45. Are there children separated from their parents due to the displacement and the return?</strong></td>
</tr>
<tr>
<td>(0=No, 1=Yes)</td>
</tr>
<tr>
<td><strong>46. What are the main three worries of caregiver/families regarding their children in the community? (Please write)</strong></td>
</tr>
</tbody>
</table>
47. Are there any service provider/institution to support children? (0=No, 1=Yes)  
48. What are the three main stress for children in the community? (Please write)  
49. Are there any service provider/institution to support children? (0=No, 1=Yes)  
50. Do children appear to be involved in child labour? (0=No, 1=Yes)  
51. Do you know, if any children in the community living alone or with no relative? (0=No, 1=Yes)  

**WASH**  
What is the Main source of drinking water in the area?  
(1= Tape water, 2=Dug well, 3=River, 4=Open  
Pond, 5=Water channel/canal, 6=Tube well,  
7= Hand Pump, 8=Bore Hole, 9=Other )  

Are there sufficient water storage containers available in the community?  
(0=No, 1=Yes)  

Can people with disabilities of older people have easy access to water? (0=No, 1=Yes)  

Are you satisfied with the quality of water? (0=No, 1=Yes)  

Are there latrine in the houses? (0=No, 1=Yes)  

Are there WASH facilities available and functional in the schools/health facilities? (0=No, 1=Yes)  

Are there any water born Diseases in the area? (Choose up to three)  
(1=Typhoid, 2=Diarrhoea, 3=Malaria, 4=Cholera, 5=Hepatitis, 6=Dengui, 7=Polio, 8= Eye Infections,  
9=Worms, 10= Skin Infections, 11=Others_____________)  

**Community Infrastructure**  
(1= Totally destroyed; 2=Partially destroyed; 3=No damage)  
52. What is the level of damages to office buildings?  
53. What is the level of damage of shops and market place?  
54. What is the level of damages to Government offices?  
55. What is the level of damages of the main water points?  
56. What is the level of damages to school buildings?  
57. What is the level of damages of irrigation channels?  
58. What is the level of damages to health centers?  
59. What is the level of damages to link roads?  
60. What type of infrastructure is most critical to be restored?  
(1=Roads, 2=Bridges, 3=Water channels, 4=Drainage system, 5=Hospitals, 6=Schools,  
7=Markets, 8= Mosque/Religious building 9=Others:____________)  
Priority one  
Priority two  
Priority three  
61. What kind of support/assistance is required for restoration of different types of infrastructure?  
(1=Material, 2=Tools, 3=Technical support, 4=Human resources, 5=Equipment, 6=cash  
support, 7=others:__________)  
Priority one  
Priority two  
Priority three
ANNEX 3: KEY DEFINITIONS

Family
A family (or a nuclear family) consist of parents and their unmarried children. Married children are considered as a separate family even if they are still living with the parents.

Household
A household is defined as a person or a group of persons living together, having common expenditure (food and non-food), and sharing a common kitchen.

Head of household
Head of household is defined as the person responsible of taking decisions on daily affairs and may also be the main income earner.

Person with disability
Persons with disability include those who have long term physical, mental, intellectual or sensory impairments, which, in interaction with various attitudinal and environmental barriers, hinders their full and effective participation in society on an equal basis with others.

Vulnerable household
Households that fulfill one or more of the following criteria are considered vulnerable:
1. Unaccompanied child or child headed families (up to 18 years)
2. Female headed household representative (above 18) with one or more dependents, who is the primary income earner/care provider, but has no assets or reliable source income and is without adequate support from his/her own household or community
3. Single female without income and support from the community
4. Household representative with a chronic medical condition or disability (physical, mental or sensory impairment), which prevents him/her from earning an income and who lacks family/community support.
5. Household representative who is discriminated against based on his/her ethnicity, religion, sexual orientation or place of origin, resulting in an inability to access basic services and to earn income and lacking family/community support.
6. Household representative over the age of 60 years without adequate support mechanisms and income.

ANNEX 4: PARTNER ORGANIZATIONS

The Return Area Assessment for Bara, Khyber Agency was designed and conducted under the joint leadership of FDMA and HCT through a consultative process involving all relevant stakeholders. OCHA provided overall coordination support for the process. The PAWG was comprised of representatives of all relevant cluster including community restoration, education, food security, health, humanitarian communications, nutrition, protection and WASH.

The following organizations provided support in the field data collection for the assessment: AICD, CEP, CERD, CESVI, CRDO, EHSAR, HAYAT Foundation, HDOD, HUJRA, IOM, IRC-IVAP, JEN, Muslim Aid, PADO, PAWT, PEACE, RDO, SABAWON, Sarhad Organization, SAWERA, SHARED, SHED, SHID, SSP, TIES, WEO, YPF and YRC.

The following organizations provided additional logistic support to the field activity: ACTED, ADF, IRC, Pak-CPD, PRDS, RABT Development Organization and Rapid.

The assessment would not have been possible without the dedicated support from the Pakistan Army, Levis/Khasa Dar, FATA Secretariat, FATA line departments and community elders facilitated the field activity. The Center for Disaster Preparedness and Management, and the University of Peshawar also provided support on data management.
ANNEX 5: ACRONYMS

ADTF  Age and Disability Task Force
BEmONC  Basic Emergency Obstetric and Newborn Care
BHU  Basic Health Unit
CEmONC  Comprehensive Emergency Obstetric and Newborn Care
CHC  Community Health Centre
CMAM  Community based Management of Acute Malnutrition
DEWS  Disease Early Warning System
EPI  Expanded Programme on Immunization
FATA  Federally Administered Tribal Areas
FCS  Food Consumption Score
FDMA  FATA Disaster Management Authority
FMT  Female Medical Technician
GAM  Global Acute Malnutrition
GBV  Gender Based Violence
HCT  Humanitarian Country Team
HH  Household
ICCM  Inter Cluster Coordination Mechanism
IYCF  Infant and young child feeding
KI  Key informant
KP  Khyber Pakhtunkhwa
LHV  Lady health visitor
LHW  Lady health worker
MUAC  Mid Upper Arm Circumference
NFI  Non-food items
OTP  Outpatient Therapeutic Programme
PAWG  Provincial Assessment Working Group
PLW  Pregnant and lactating women
SAM  Severe Acute Malnutrition
TB DOTS  Tuberculosis Directly Observed Treatment
TH  Tehsil hospital
TIJ  Talemi Islahi Jirga
WASH  Water, Sanitation and Hygiene

For feedback, queries or comments about this survey or the report, please contact: ocha@un.org