Inter-Agency Knowledge, Attitudes and Practices Study of Syrian Refugees in Host Communities in North Jordan

Study Report

Contents

Executive summary (top lines):

A study was conducted in March-April 2013 to assess the knowledge, attitudes and practices of refugees living in host communities in Jordan regarding water, sanitation and hygiene. The following key findings were found:

- Registration does not affect whether family / refugee receives further aid assistance from other agencies (for example through in-kind distribution)
- Most reported that their monthly income does not cover their monthly expenditure, with the burden experienced greatest by lower-income households. Household expenditure is primarily targeting food and rent, with WASH needs not being prioritised in household expenditure.
- More than three quarter of the survey population face issues in accessing hygiene items. They are coping either by sacrificing other things like education or they rely on charities, friends and / or relatives. People purchase mostly soap, laundry soap and shampoo as most essential hygiene items. The main income sources of those families are casual labour or WFP food vouchers. The number of small children does not impact whether the households face issues in obtaining hygiene items.
- More than half of the assessed refugee population report difficulties to bathe. Main barriers for bathing are the cost of soap and lack of water.
- Key times for hand washing are “before cooking food” (78%) and “whenever they look / feel dirty” (78%), only 43% report to wash their hands before eating. People use water and soap for hand washing (84%) which has been mainly confirmed through the household observation (soap was in 75% of assessed households present). However, a considerable number (45%) reports to face hand washing issues which is primarily due to the cost of soap (34%) and lack of water (24%).
- Food is kept mostly hygienically at household level (62%). Those households storing meat in unhygienic conditions consume leftovers mainly within 8 hours (66%).
- A large majority use the municipal solid waste system (84%), more than a half of those households (55%) uses it to avoid any spread of diseases.
- Most of the survey participants rate the condition of their toilets as “good” (72%). The main issue observed is the bad smell (15%).
- Food is mainly purchased through cash or WFP food vouchers, a larger percentage also reports to use credit.
- More than half of the survey respondents (65%) indicate to eat less than compared to Syria. Regardless of the age, people have mostly three meals a day. Overall, the diet can still be considered as healthy: milk products and vegetables are on average consumed four days per week , cereals on a daily basis; meat / poultry, fruits and fish / seafood are eaten only once per week.
- Few respondents know about causes of diarrhoea, especially in terms of faeces and dirty hands. The majority treat diarrhoea at health centre level, followed by ORS.

- The majority of survey respondents (61%) access health information through informal channels such as family and/or friends or community discussions, although most of them express the preference to receive such information through TV spots /shows or in hospitals / clinics.

1. Introduction:

The study seeks to better understand the situation of the estimated 168,538 registered and 113,444 unregistered refugees living outside Zaatari camp in March 2013. The focus is on water, sanitation, and hygiene (WASH), with a secondary focus on basic demographics, livelihoods, shelter, and food security. The findings are beneficial to the humanitarian community at large engaged in relieving the effects of the Syrian crises. While the KAP study was undertaken in March/April 2013, humanitarian organisations working in host communities perceive that the knowledge, attitudes and practices of the refugee population has not changed substantially. There has been expansion in the number of organisations and scope of humanitarian assistance being provided to off-camp refugee populations, however there are still gaps remaining.

With substantial resources still required to support the emergency response to the Syrian crisis, the KAP survey seeks to identify the most vulnerable Syrian populations, the key risk factors, and the specific needs of the refugee population. The UNHCR has projected that over 1 million Syrian refugees could seek shelter in Jordan by December 2013.

The survey is the collaboration of the WASH working group partners including Relief International, Oxfam, and ACTED. UNICEF primarily funded the survey and collaborated as the sector lead for WASH. Co-contributions and joint-implementation of the study were conducted by Relief International, Oxfam and ACTED. The study investigated demographics as well as the categories of water, personal hygiene, and hygiene non-food items (NFIs). This report summarizes the findings and includes recommendations for action.

At the time a lot of information was known about the needs and context of refugees in Za'Atari camp, however little was known about the majority of refugees actually living off-camp, spread out in host communities across Jordan. These remain relatively hard-to-reach populations and are more difficult to locate for assistance. In addition, unregistered refugees do not receive the tents, NFIs, medical care, and food vouchers registered refugees receive upon arrival into the camps. With limited jobs available, increased rent prices in North Jordan, and the Syrian crises persisting into a third year, refugees living outside of the camp are exhausting their resources.

2. Survey Methodology

The methodology was based on a common and collaborative approach, developing the study focus based on collective experience working with the target population. Survey was designed to assess different dimensions affecting refugee's wellbeing, feeling of dignity, public health risks, and coping capacities. Specific topics covered include:

- Demographics and livelihoods
- Water
- Personal hygiene and access to hygiene items

- Solid waste and environmental sanitation
- Food sources, food consumption and food hygiene
- Health
- Channels of communication

The study used quantitative and observational study techniques, assessing the needs of the sample population of over 2475 surveys. The target population for the survey was Syrian refugees living in urban and rural Irbid, Ajloun, Jerash, Mafraq and Balqa.

Sample population

Random sampling of the REACH database of refugees in host communities was undertaken to derive a representative sample of the refugee population living in different contexts in host communities. The random sampling methodology and the selected sample size guarantees statistically representative results for sub-groups living in rural and urban areas of each governorate. A confidence level of 95% was aimed at, and 99% of the intended sample size (2500) was reached.

From each area, households (HHs) were randomly selected to be included in the survey. Refugees residing inside the refugee camps were excluded as previously stated. Refugees were not excluded based on registration status with the UNHCR, amount of time in Jordan, financial status, etc.

Geographical Coverage

The assessment focused on the north area of Jordan, where the largest number of refugees currently lives in the country. The survey covered the urban and rural areas of Irbid, Ajloun, Jerash, Mafraq and Balqa.

Survey implementation

The content and geographic area of the survey was planned and continually updated during the weekly WASH working group meetings. Oxfam led the two-day training on February 27 and 28 for the 20 enumerators representing Relief International. There were 5 males and 15 females. Half of the enumerators were Jordanian and half were Syrian. The training was in Arabic and English and instructed the enumerators on the purpose of the survey, survey questions, proper survey techniques, and the resolution of potential obstacles.

To further strengthen and streamline the surveys, the enumerators also attended a workshop on March 6, 2013, where they were able to discuss effective survey methods and any unique situations they encountered while conducting the surveys.

Data Collection

The survey took place from March to April with twenty enumerators piloting the survey for 80 households on March 3, 2013. Based on the feedback from the enumerators and WASH working group members, a final version of the survey was created and launched on March 4, 2013. Enumerators initially surveyed 3-5 households per day until they were more experienced and could complete eight per day with each survey taking 30 to 45 minutes. Surveys were taken and recorded in Arabic and took place in confidential settings of the respondent's choice.

Governorate	End of assessment	# of HHs	Sample Size
Irbid Urban	March	5106	225
Irbid Rural	March	3794	379
Jarash Urban	March	529	121
Jarash Rural	March	501	73
Aljun Urban	April	56	37
Aljun Rural	April	638	277
Balqa' Urban	April	174	80
Balqa' Rural	April	1329	243
Mafraq Urban	Dec	1573	309
Mafraq Rural	Dec	1411	303

Data-entry and analysis

The paper-form was submitted to ACTED/REACH who undertook the data-entry and database compilation. Relief International engaged the support of *Palantir* to support in database management and data analysis utilising their patented software and complemented by additional excel analysis. Joint data analysis and results finding and compiling the report was undertaken by Relief International, ACTED and Oxfam.

3. Analysis and Key Findings

3.1 Demographic Profile

Basic demographic information was collected about surveyed households and the respondent. 51% of respondents were female and 49% male. 52% of respondents were 18-35 years of age, 40% were 36-59 years and 8% over 60 years.

The registration status of households surveyed demonstrates a potential vulnerability and barrier of access to services, with 10.4% of households reporting no UNHCR registration, and 22.9% reporting that they were awaiting registration. 67% reported registration with UNHCR.

Status of UNHCR registration amongst survey respondents	
Awaiting registration	22.90%
Not registered	10.40%
Registered	66.69%

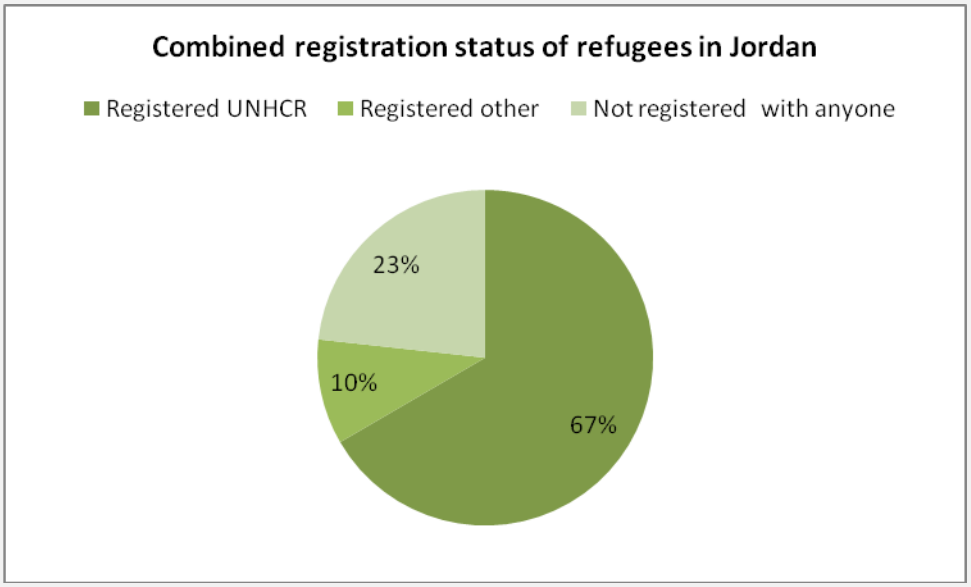
There was substantial variation in reported registration levels across the governorates – with only 49% of respondents from Balqa reporting UNHCR registration and 32% awaiting registration. This is compared to Mafraq where 71% of respondents reported UNHCR registration and 20% awaiting

registration. There was higher rates of UNHCR registration reported in urban areas (73%) compared to 63% in rural areas.

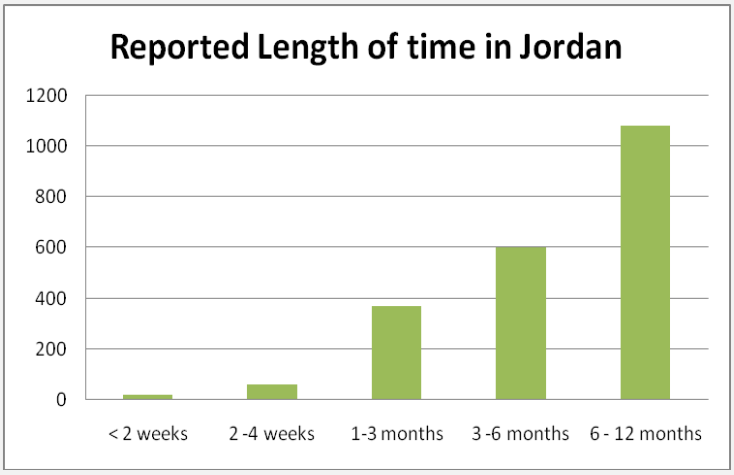
UNHCR registration status by Governorate						
	Ajloon	Balqa	Irbid	Jarash	Mafraq	Total
Awaiting registration	24.26%	32.12%	18.00%	29.33%	19.68%	22.90%
Not registered	8.85%	18.18%	6.51%	13.49%	9.64%	10.40%
Registered	66.89%	49.70%	75.49%	57.18%	70.68%	66.69%

42% of respondents reported being registered with or receiving assistance from organisations other than UNHCR, with the lowest rate recorded in Balqa (24%) and the highest rate in Jerash (49%). The low levels of registration with both UNHCR and other organisations in Balqa demonstrate a potential vulnerability for refugees residing there. A range local, national, and international organisation was referenced.

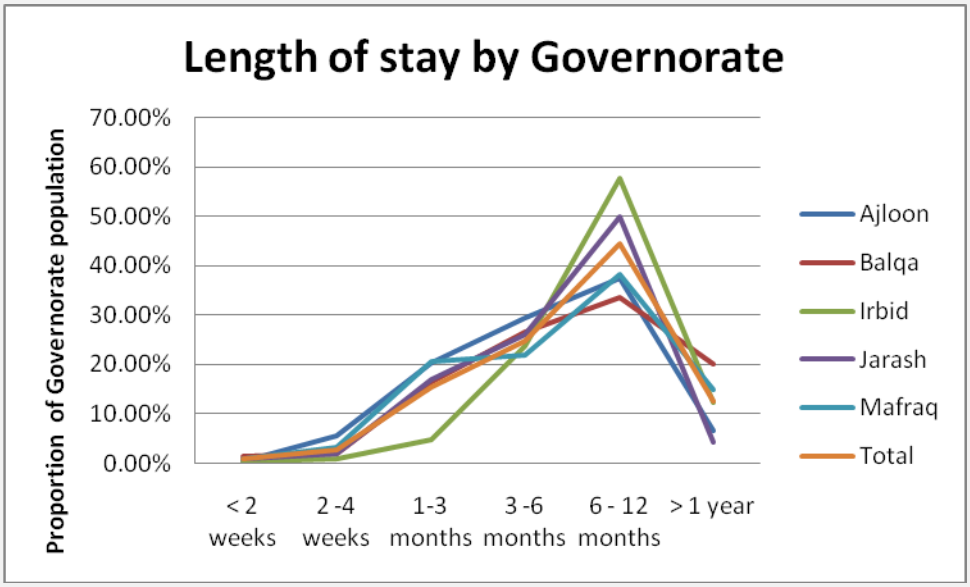
Of all respondents 67% reported registration with UNHCR, 10% registration with other organisations, and 23% not registered at all.



The majority of respondents reported having lived in Jordan for 6-12 months (46%) and 3-5 months (25%). Very few respondents were new arrivals to Jordan (6%).



The length of stay trends by governorate were similar, with on average 56% of respondents reporting living in Jordan for over 6 months. Irbid reported a greater proportion of longer-term residents (70%) and Ajloon the lowest (44%). Ajloon reported the greatest proportion of new arrivals (26.4%) compared to 6% in Irbid and a national average of 19%.



During this time 41% of respondents had not left their initial place of residence in Jordan, 33% had previously lived in Za'Atari camp or other transit facilities, and 26% reporting having lived in another location. Of those living in urban areas, a smaller proportion reported having lived in Za'Atari camp (23%) compared to 34% of rural respondents. This could infer a slightly different demographic moving to urban areas compared to rural areas.

16% of respondents reported that a member of their household had a disability – the majority of which was physical disability (62.5%).

3.2 Shelter and Accommodation

Renting was the primary accommodation arrangement of respondents (85%). This varied slightly between rural (82%) and urban (89%). 8% of total respondents reported other – living in tents. This

was also much more likely amongst rural respondents (13% of rural respondents compared to 1% of urban respondents).

Shelter type reported by respondents	
Type of shelter	Proportion of respondents
Hosted by Charity/relief Organization	1.4%
Hosted By Jordanian Family	1.6%
Hosted by Syrian Family	2.2%
Hosted in Jordanian Gov't building	0.2%
Living in Vacant/Unfinished property	0.5%
Not Answered	1.4%
Tent	7.6%
On a farm	0.5%
Renting (JD/Month) Specify	84.6%

The study observed that 80% of respondents were residing in apartments or homes, with an additional 4% living in single rooms in an apartment or house. 8% of respondents were observed living in tents/temporary shelters.

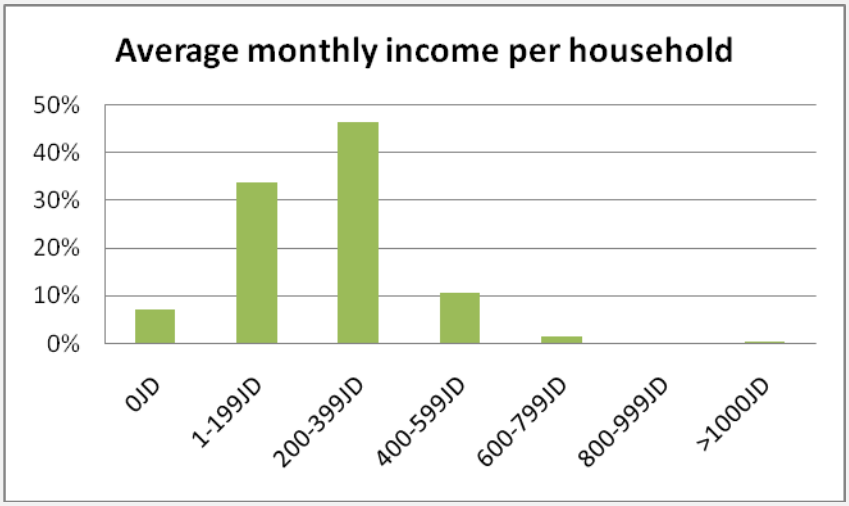
3.3 Income and Expenditure

Respondents were asked to rank their main source of income generation. Of the 2239 respondents who answered the question, 56 (less than 1%) reported no income source at all. The primary income sources that were identified as at least 1 source of income for the household was casual labour (42%), WFP cash/ food vouchers (40%), drawing down on savings (21%), support from family and friends (19%), and other NGO charities (18%). 11% of respondents reported selling assets as one of their income sources. The least reported income source was small business (1%) and skilled labor opportunities (5%). These results indicate that the Syrian refugee population has very little formal income-generating opportunity; however there appears to be informal work opportunities in the host community markets. In aggregate, the primary support is coming from institutional support or relying on their existing resources (savings, family/friends).

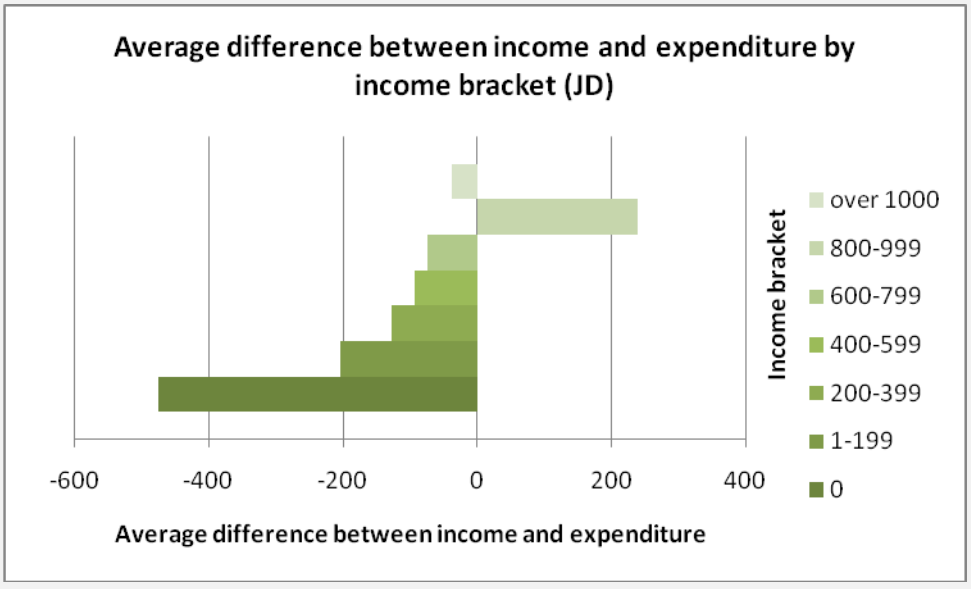
Proportion of respondents who reported the income source as at least 1 of their income sources	
Income Source	Proportion
Small business	1%
Skilled labor	5%
Sell/donate items	6%
Remittance	7%

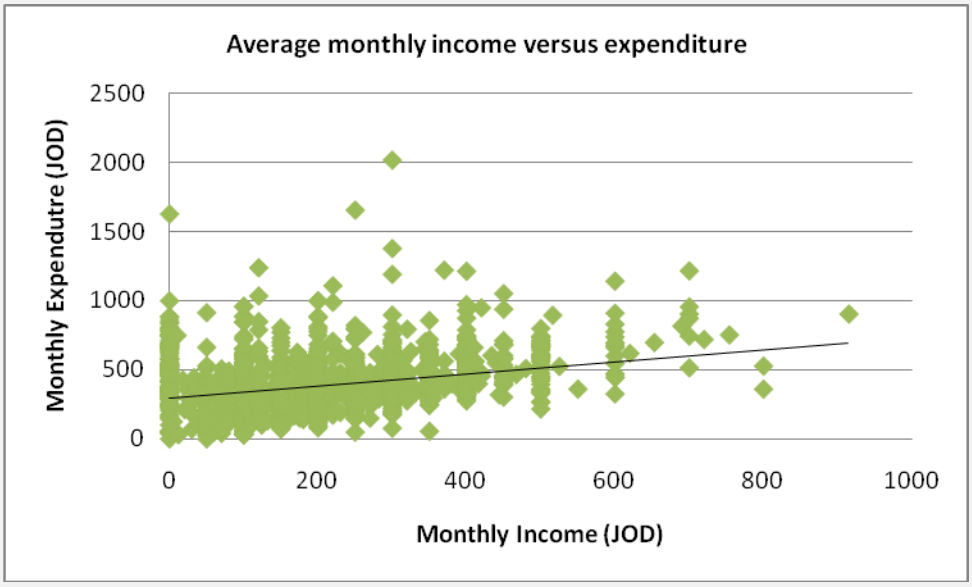
Cash assistance	10%
Sold assets	11%
Other NGO charity	18%
Family/Friends	19%
Savings	21%
WFP cash/food vouchers	40%
Casual labor	42%

The majority of respondents (46%) reported incomes of 200-399JD per month, 34% of respondents reported monthly incomes of under 200JD per month, and 7% reported no income at all.

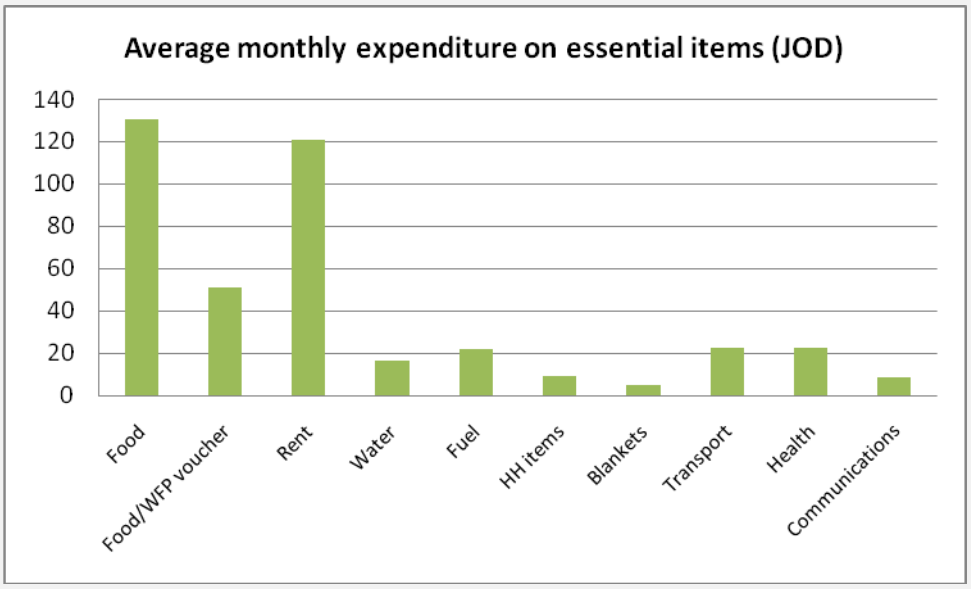


The average difference between income and expenditure across the respondents was -172JD, implying that most households are spending more than they earn.





Most respondents said they incurred the highest expenditure on food (130JD), rent (121JD), and food WFP vouchers (51JD).



The self-reported coping capacity was reported as very low by most respondents – with 97% of respondents reporting that with their current sources of income, support and accessible resources could manage for less than a month. There was no significant variation between rural and urban respondents or across the governorates (ranging from 93% in Irbid and 98% in Mafraq).

Based on your current sources of income and support and accessible resources, for how long can you continue to manage to live where you are?	
Length of coping time	Proportion of respondents
< 2 weeks	49.33%
1 - 2 months	15.08%
2 - 3 months	3.68%
2 - 4 weeks	28.55%
3 - 4 months	1.43%

4 - 5 months	0.78%
More than 5 months	1.15%

3.4 Access to clean drinking water.

Typical question asked: Where does your HH get water for drinking and bathing/washing (all other uses)?

- 77% of respondents reported receiving piped water (1861/2421), 31% of whom reported receiving piped drinking water and 69% only for other purposes.
    - Ajloon and Jerash had the highest number of respondents receiving piped water (91% and 87% respectively) compared to Balqa where 55% were receiving piped water. The proportion of respondents receiving piped water in Irbid and Mafraq were both 76%. The rest of the population in Ajlon, Jerash, Balqa and Mafraq get water from unknown sources.
    - Respondents in urban areas were more likely to have access to piped water (all purposes) than rural areas in all governorates (average 60% in rural areas compared to 40% in urban areas reported receiving piped water).
- 61% of respondents reported purchasing bottled water for drinking. It was least common to purchase water in Mafraq (38%) and Balqa (56%), whereas in the other governorates approximately ¾ of respondents reported purchasing bottled water. Refugees living in urban environments were more likely to purchase bottled water for drinking than those living in rural areas (68% in urban compared to 55% in rural). Very few reported purchasing bottled water for purposes other than drinking (4%). *Purchasing bottled water for cooking/cleaning/bathing could imply high vulnerability of water access – 60% of those reporting purchasing water for purposes other than drinking reported total monthly incomes of 200JD or less.*
- Only 30% of respondents reported purchasing water from a private water tanker (it was more common in rural areas (33%) than urban areas – (21%). Balqa and Ajloon had the highest rate of water tank use (39% and 34%) compared to the other governorates (Mafraq – 28%, Irbid – 27% and Jerash 24%). The majority of households were using it not for drinking but for other purposes.
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Typical question asked: Does your HH have access to enough water to meet basic needs?

- Half of total respondents reported they had access to enough to meet basic needs, while the other half reported they did not. The most commonly reported coping mechanism for people without adequate water to meet basic needs was to purchase water (72%), followed by receiving from neighbours (18%), and followed by waiting (10%). There was no substantial difference between perceptions of adequacy of water across the governorates. However Urban respondents across all governorates reported higher levels of adequacy of water access compared to rural areas (41%-rural compared to 59% urban).

Household Perception of water quality

- The majority of respondents reported perceptions of water quality as average, with slightly more respondents reported their water qualities as good/very good quality (29%) compared to those that reported their water qualities as bad or very bad(24%). Only 7% of respondents had their perceptions of their water qualities as “very bad”. Jerash and Mafraq had slightly lower perceptions of water quality (67% and 70% of respondents reported average/good/very good water) compared to Ajloon, Balqa and and Irbid (74% of respondents reported average/good/very good water quality perception).

For those reporting Bad/Very bad water quality – primary actions taken:	
Boil	3.99%
Buy bottled water	0.19%

Filter	1.52%	
Other	0.76%	
Think it is bad/very bad but do nothing	27.76%	
Use bottled water instead	65.78%	
Grand Total		**100.00%**

Current waiting times taken by households to fetch water.

- The wait time for respondents to access water was reported as follows:

Wait time	Number	Proportion
<20mins	192	10%
21-40mins	51	3%
41-60mins	64	3%
>60mins	102	5%
NA - piped water	1659	83%
Total	2006	100%

3.5 Household Water Storage Practices.

- Respondents reported the following types of water storage systems being utilized. Jerry cans were identified as the primary water storage device (45%) followed by large covered containers (21%) and covered buckets/pots/containers (13%).

Water Storage Device	Relative use of water storage devices reported by respondents
Bucket/pot/container covered	13%
Bucket/pot/container uncovered	2%
Jerry can	45%
Large covered container	21%
Large uncovered container	2%
Plastic bottles	7%
Other	10%
Grand Total	100%

The analysis of sizes of household water storage devices reported by respondents that do not have access to piped water are outlined in the table below, with the majority of respondents reporting household water storage capacity of 21-40litres (54%) followed by 18% who have 121-140 litres. The survey didn't find any correlation between household size and water storage capacity.

Water storage capacity at household level	
101 - 120 litres	2.07%
121 - 140 liters	5.20%
21 - 40 liters	15.50%
41 - 60 liters	1.16%
61 - 80 liters	2.31%
81 - 100 liters	2.50%
Not Applicable (has piped water)	71.26%

Grand Total	**100.00%**

Cleanliness of household water storage containers

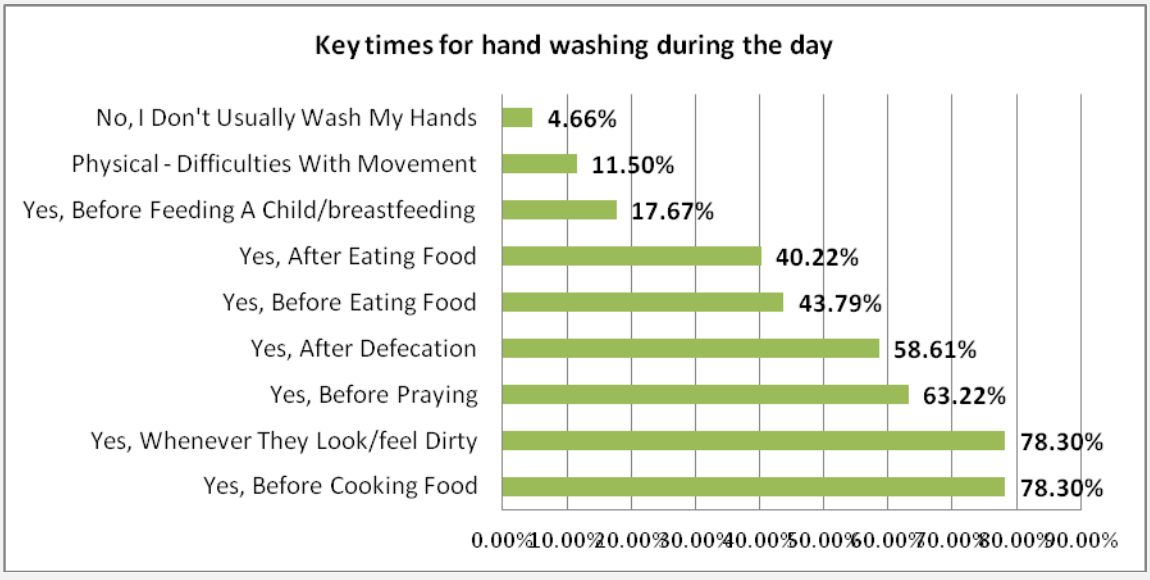
- The majority of respondents reported poor practices of maintaining cleanliness of small water storage devices, either never washing their small water storage containers (38%) or washing them less than once a week (16%). 22% reported washing them every day and 24% a few times a week.
- Cleanliness of large water storage devices reported by respondents was worse – with nearly 80% reported either never washing their storage units or washing them less than once a year. 7% reported washing them 1-2 times a year and 15% reported washing them 3-4 times a year.

Household Water collection practices.

- As noted previously, the majority of respondents (65%) had access to piped water in their home and so reported not using water collection devices. Of those who were collecting water from public water points, the vast majority reported using jerry cans as their main water collection device (70%) followed by buckets or other open containers (15%) and plastic water bottles (15%).
- Of those collecting water, 83% reported using the same container to collect and store water, with only 17% maintaining safe/hygiene separation of water collection and storage devices.

3.6 Current Hand-Washing Practices.

The majority of the survey participants practice hand washing before food preparation (78.3%) and whenever they look or feel dirty (78.3%).



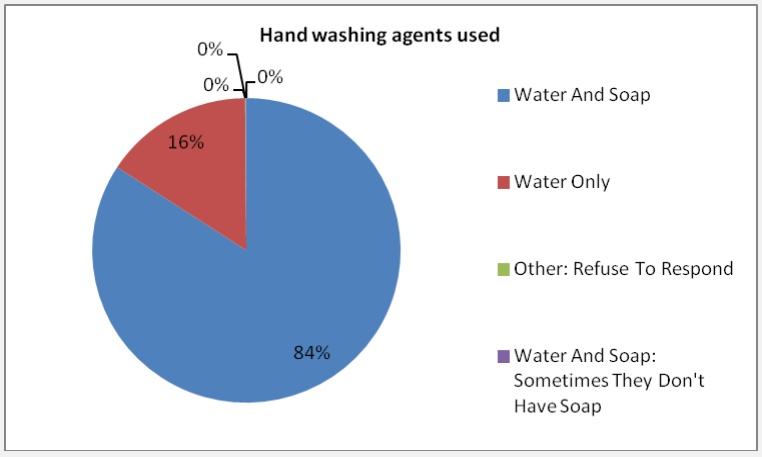
The results also show that a larger number of respondents considers hand washing before praying more important than before eating. More than a half of the respondents indicate to wash their hands after defecation (58.61%). A smaller percentage washes their hand before feeding a child /

breastfeeding (17.67%). The analysis against the urban and rural survey population shows that there generally slightly more urban respondents wash their hands on key times. For example, whilst 43% of the urban survey participants wash their hands before eating, 49% of the urban reported to do so.

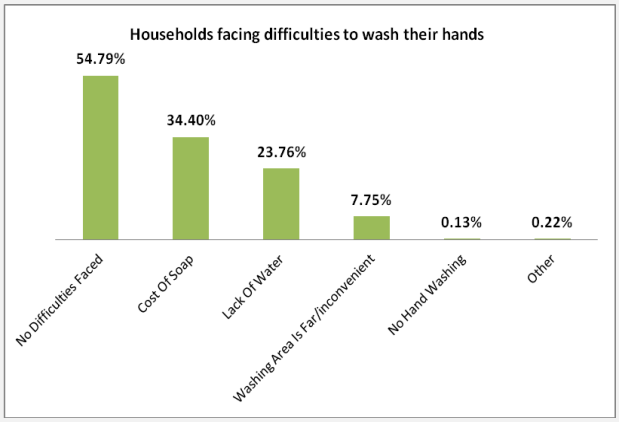
Hand washing moments according to gender		
Moment	Male	Female
Before cooking	48.71%	51.29%
Whenever they look / feel dirty	48.71%	51.29%
Before praying	48.04%	51.96%
Yes after defecation	49.43%	50.66%
Yes before eating	47.36%	52.64%
Yes after eating food	46.96%	53.04%
Yes before feeding a child / breastfeeding	31.40%	68.60%

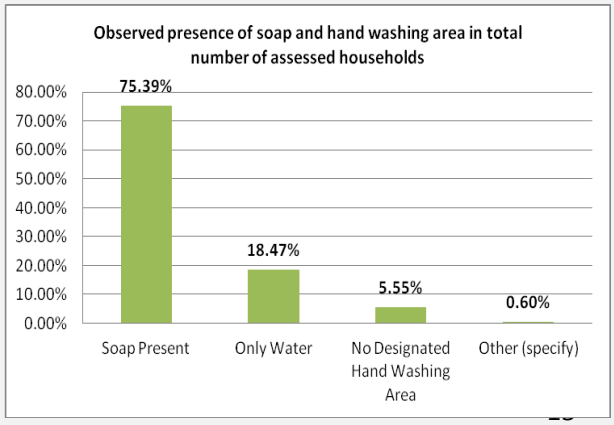
Slightly more women than men wash their hand at key moments such as before eating, after defecation or before food preparation. The only exception represents the moment before feeding the child / breastfeeding which is less surprising considering the cultural context in which women are mainly responsible for children's care.

A large number of respondents point out to wash their hands with water and soap, slightly more of them are urban. These results are mainly confirmed by the household observation, as in the majority of the households soap was present when the enumerator asked to wash the hands.



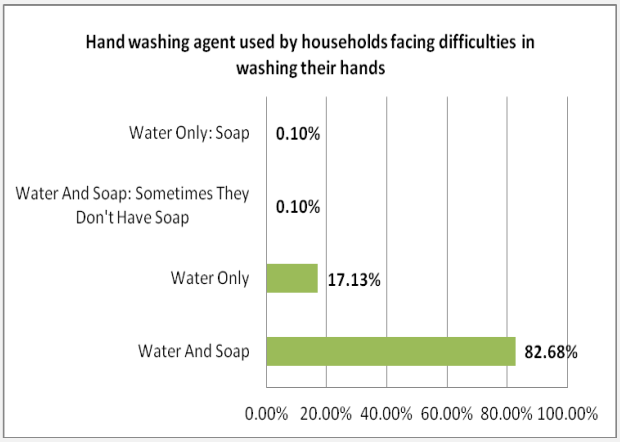
In 18.47% of the cases hand washing seems to be carried out with water only. 32% of the respondents reporting to wash their hands with water only are facing difficulties to access soap due to the cost. The observation revealed further that only a small percentage of the assessed household does not have access to a designated hand washing area. In rural areas a lower percentage had soap present (65% against 77% in urban settings. More than a half of the survey respondents indicate to not face any difficulties for washing their hand. Interestingly, those

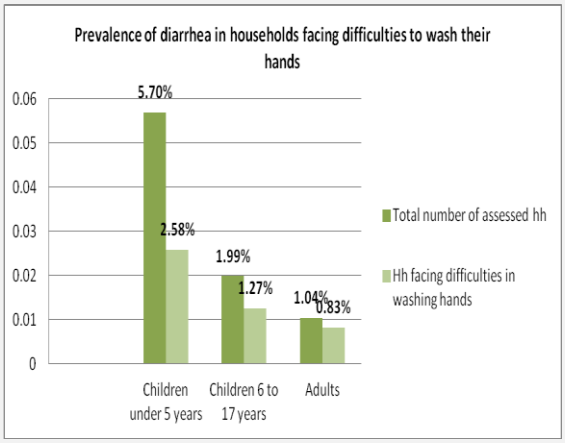




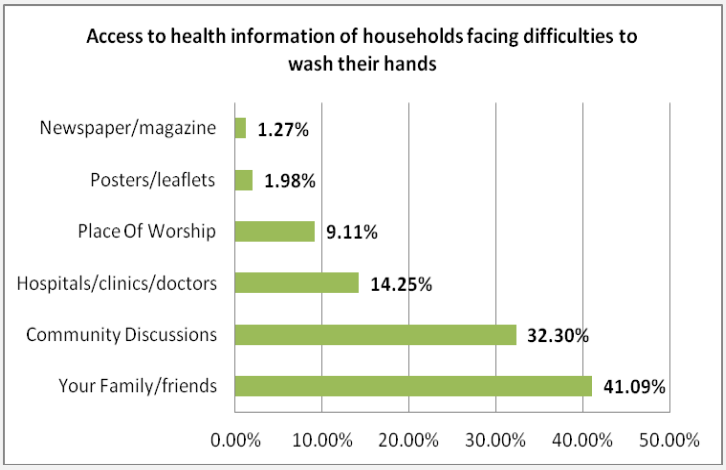
reporting problems accessing soap, reported to wash their hands after defecation than those who did not identify the cost of soap as barrier to hand washing. Those who report that hand washing is problematic identify the cost of soap and the lack of water as main barriers for hand washing at key times. Small number indicates that the washing area is either too far or inconvenient to practice hand washing at key times during the day.

Households facing difficulties to wash their hands report still to wash hands with water and soap although soap is becoming too expensive. The observation revealed that in 64.36% of the households soap was present. In 10.67% of the households assessed no designation hand washing area was available.





The incidence of diarrhoeal diseases in households facing difficulties to wash their hands is not significant in comparison to the total number of diarrheal cases.

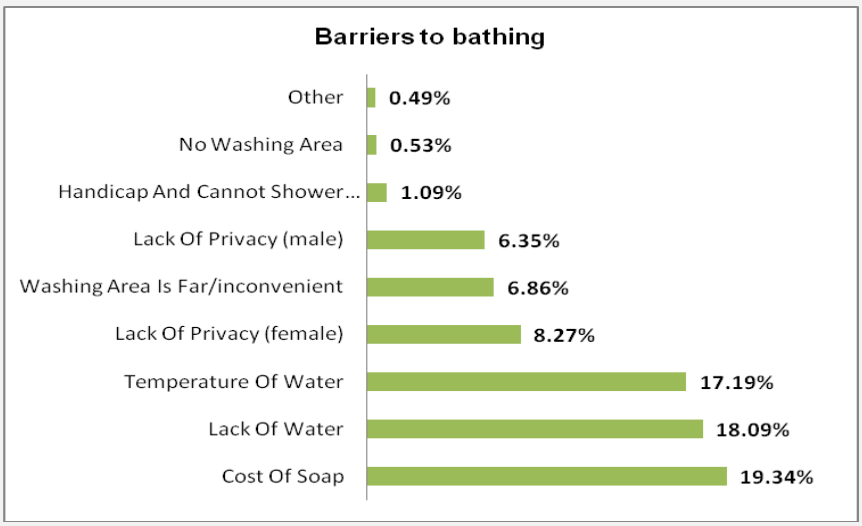


In relation to households who have difficulties in obtaining hygiene items, 41% of the respondents indicate that the main barrier to hand washing is due to the lack of water and 42% due to the cost of soap.

A fewer number (17%) of the survey participants explain that the lacking hand washing area is the main reason for facing issues washing hands.

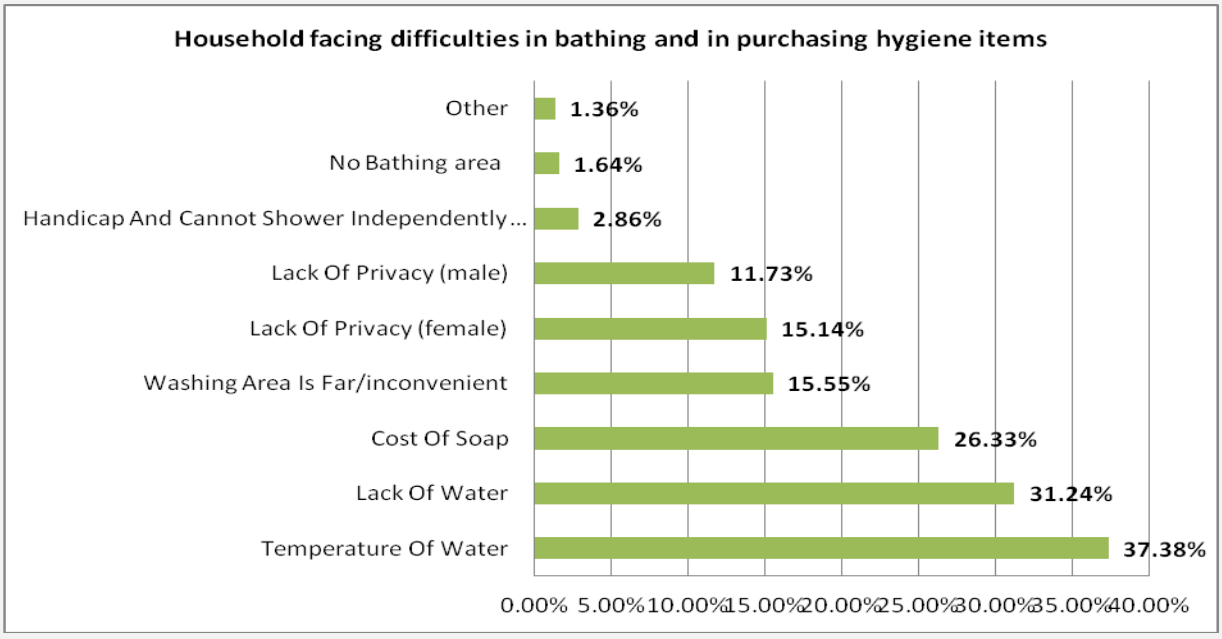
The majority of the households reporting issues to wash their hands receive health information mainly through informal channels. Most of them get informed by family and friends (41.09%) or community discussions (32.30%).

3.7 Finding on Personal Hygiene Practices.



More than the half (59.23%) of the survey population faces issues to bath on a regular basis**.** The main barriers for bathing are the cost of soap (19.34%), followed by the lack of water (18.09%). When comparing answers of urban and rural survey population and those facing difficulties in bathing due to the coast of soap, the survey results show that there are no significant differences. However, rural respondents reported higher difficulties to bath due to the lack of water (37% compared to 27%). The lack of privacy is rather an issue for women (8.27%) than for men (6.35%).

A small percentage (6.86%) also indicates that the place of the washing area is either far or inconvenient (for example for those living in a tent). Those households which report to face difficulties in purchasing hygiene items and also in bathing identify the water temperature as main obstacle (37.38%) [1]as well as the lack of water (31.24%). More than a quarter (26.33%) indicate that the cost of soap makes it difficult for them to bath on a regular basis, while 15.55% thinks that the washing area is too far or too inconvenient. The number of women feeling that the lack of privacy is an issue is higher for those who have limited access to purchase hygiene items on a regular basis (15.14%).

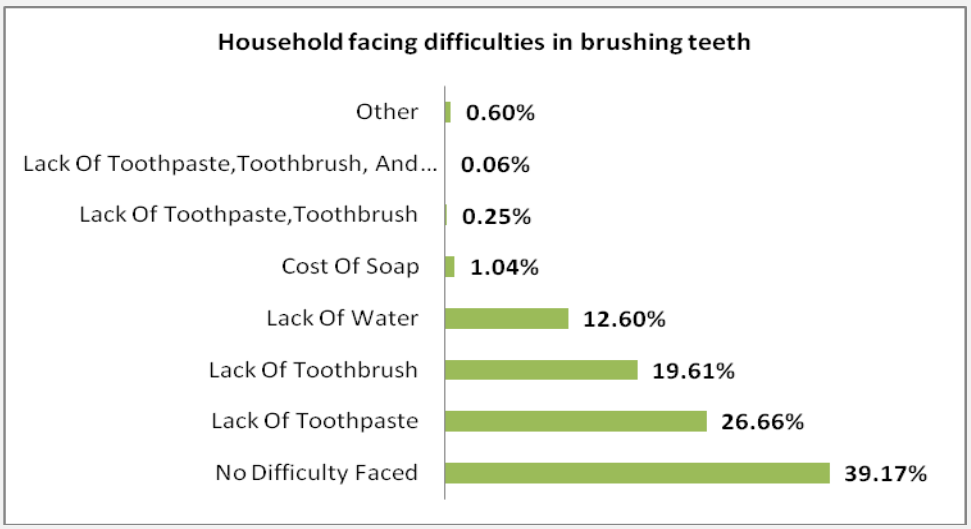


[1] During the start of the survey period in beginning of March the outside temperature were still low.

Households having issues to brush their teeth	
Purchased Toothpaste	60%
Purchased Toothbrush	54%
Received Toothbrush	7%
Received Toothpaste	8%
Having difficulties to obtain hygiene items	59%

Among the total number of assessed households 31% report to face difficulties in bathing due to lack of water.

The majority of the assessed households do report to have issues to brush their teeth. The difficulty is primarily linked to the lack of toothpaste (26.66%) and toothbrush (19.61%). The results lead further to the conclusion that also the lack of water constitutes a major barrier to teeth brushing (12.6%)



The table highlight the fact that those households with difficulties to brush their teeth, only a small percentage received toothpaste and toothbrush, hence more than the half of the this survey population group purchased these items. Among those who inidcate to have difficulties to rush their teeth also have limited access hygiene items.

3.8 Findings on Personal Hygiene Practices

Hygiene items received through distribution	
No Items Received	23.86%
Soap	13.05%
Washing Powder	12.61%
Shampoo	10.52%
Toothpaste	7.40%
Toothbrush	6.38%
Sponge	3.26%
Comb	3.21%

Jerry Cans	2.63%
Disposable Childs Diapers	2.58%
Towels	2.48%
Buckets/basins	2.39%
Nail Clippers	1.90%
Brush	1.80%
Disposable Sanitary Napkins	1.80%
Washing Cloths	1.22%
Wet Wipes	0.97%
Household Water Storage	0.73%
Ear Swabs	0.54%
Dish Soap	0.10%
Other	0.58%

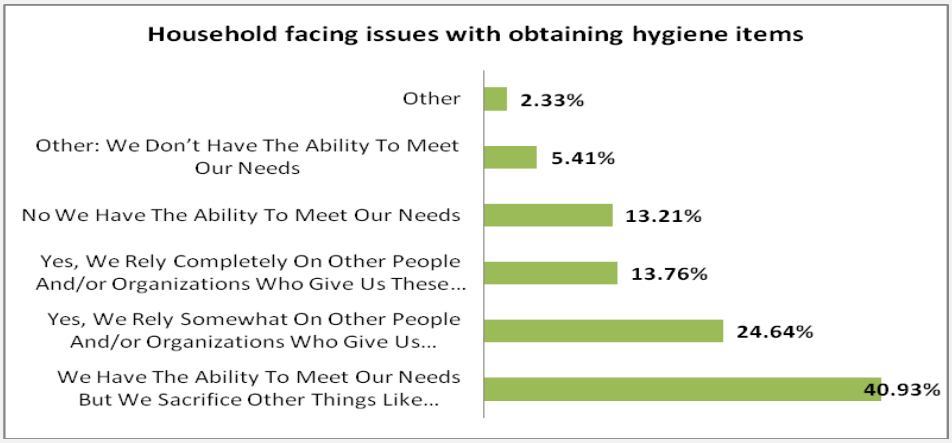
More than three quarter of the survey participants have received hygiene items through distribution. However, the answers suggest that the hygiene items haven't been distributed in an equal and standardized manner.

For example, soap is one of the basic hygiene items and according to Sphere Standards the minimum amount shall cover the monthly needs of one person (250gr), however only 13% of the assessed households received soap. Very few households were supported in terms of baby items (2.58%) and the needs in terms of female hygiene are far from being met, as only 1.8% reported to have received sanitary napkins (disposable).

The survey results show further that there is a significant difference among the urban and rural population having received hygiene items, due to the higher proportion of rural survey participants. Whilst 9% of the rural population received soap, 16% were urban, which indicates an under provision of the rural population. This represents the average among those items which were most distributed.

More than the half of the households (57%) which haven't received any hygiene items are registered with UNHCR, 31% is waiting for registration and 12 % unregistered. This leads to the assumption that the refugee status does not have a direct impact on receiving aid assistance in terms of NFI distributions.

Further, the survey results reveal that the majority of the survey participants are not able to meet their needs in terms of hygiene items. A large percentage (40%) indicates to have the ability to meet their needs in terms of hygiene items only by scarifying other things like education, clothing or heating. This is consistent among the rural and urban setting the survey participants are living in and also the case for the other answer categories assessed.



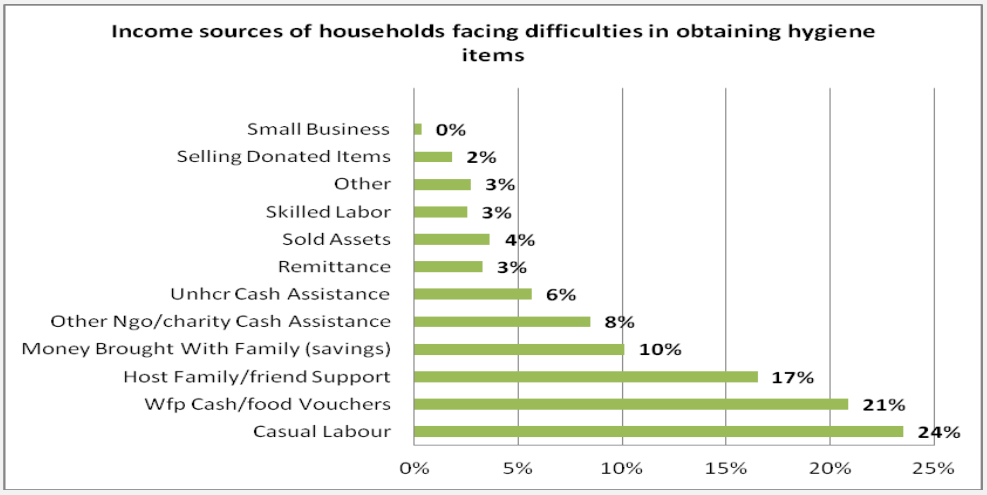
One quarter (24.64%) have the ability to meet their needs but partly relying on what other organizations and / or people provide to them. A smaller percentage (13.76%) reports to rely completely on other people and / or organizations. 26.3% of those who face issues with obtaining hygiene items report to face also difficulties in terms of bathing because of the lack of soap.

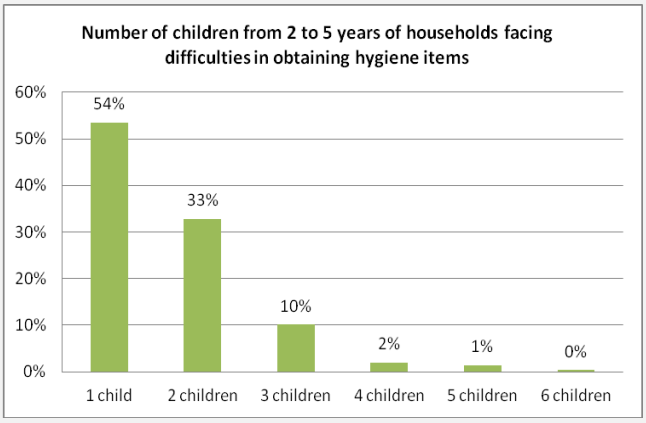
Hygiene items purchased for personal or HH use	
Soap	77%
Washing Powder	94.28%
Shampoo	87.15%
Toothpaste	52.59%
Disposable Childs Diapers	47.90%
Toothbrush	47.05%
Comb	46.34%
Jerry Cans	46.30%
Sponge	43.55%
Nail Clippers	40.36%
Disposable Sanitary Napkins	34.47%
Brush	30.93%
Towels	30.44%
Buckets/basins	27.25%
Washing Cloths	26.23%
Ear Swabs	25.34%
Wet Wipes	22.29%
Household Water Storage	11.79%
Dish Soap	0.53%
No Items Purchased	0.62%
Other	0.40%

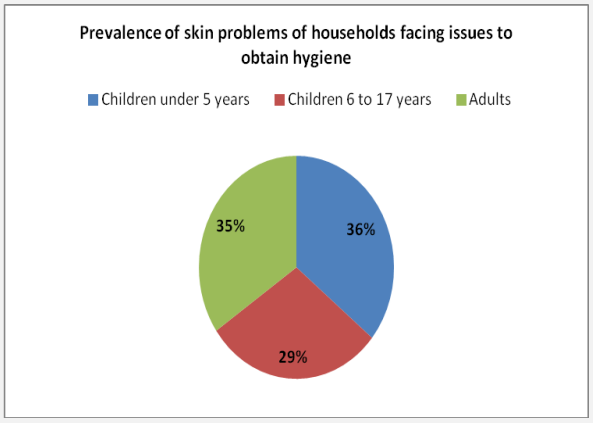
According to the survey results, soap, washing powder and shampoo are considered as top priority hygiene items.

More than the half of these households (52.59%) purchase toothpaste and 47.05% toothbrush.. One third (34.47%) indicate to purchase disposable sanitary napkins. Baby diapers also belong as well to the items mostly purchased at household level (47.09%), especially in those counting with small children.

The income sources of the household which facing limited access to hygiene items do vary. Most of them draw financial resources from casual labour (24%) or WFP Food vouchers (21%). Informal support channels also constitute an important income factor, either provided by the host family or friends (17%). A smaller percentage has still access to saving (10%) whilst only few get cash assistance either through other NGO's / charities (8%) or UNHCR (6%). Only a small percentage is living from remittances or sold assets and 2% admit to sell donated items to make their survival.







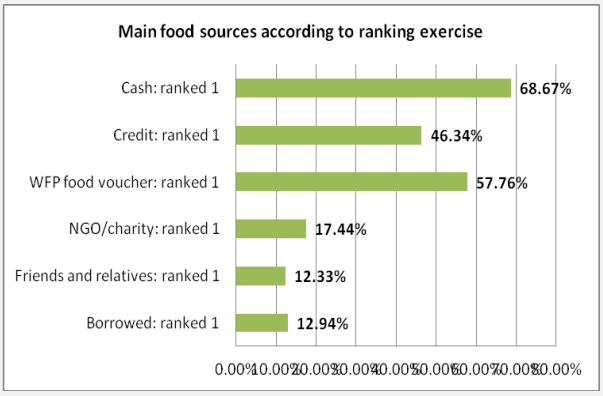
More than one half of the households with young children facing difficulties to obtain hygiene items count one child (54%), followed by households with two young children (33%).

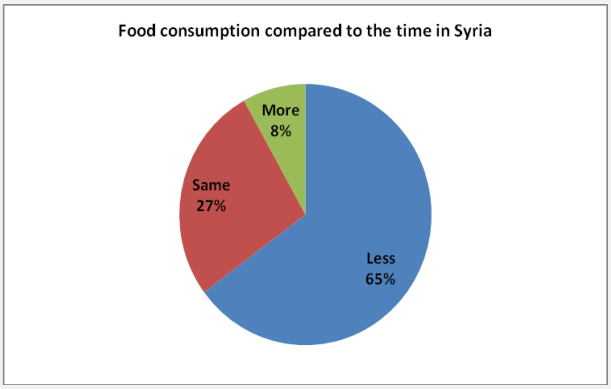
Within the households reporting limited access to hygiene items mostly children under 5 years (36%) and adults are suffering from skin problems.

3.9 Food Consumption Patterns

Food sources

The households assessed rank “cash” as main source to purchase food (68.67%), this is the case for both, urban and rural survey population group. This result is followed by the purchase of food through WFP vouchers (57.76%). More households in urban areas (29%) report to use WFP food vouchers (24% in rural areas). A large percentage purchases food as well on credit (46.34%). Only few people count (17.44%) on the support from NGO / charities when ranking the main food sources. Some (12.33%) get support from friends and relatives and 12.94% borrow money to purchase food.

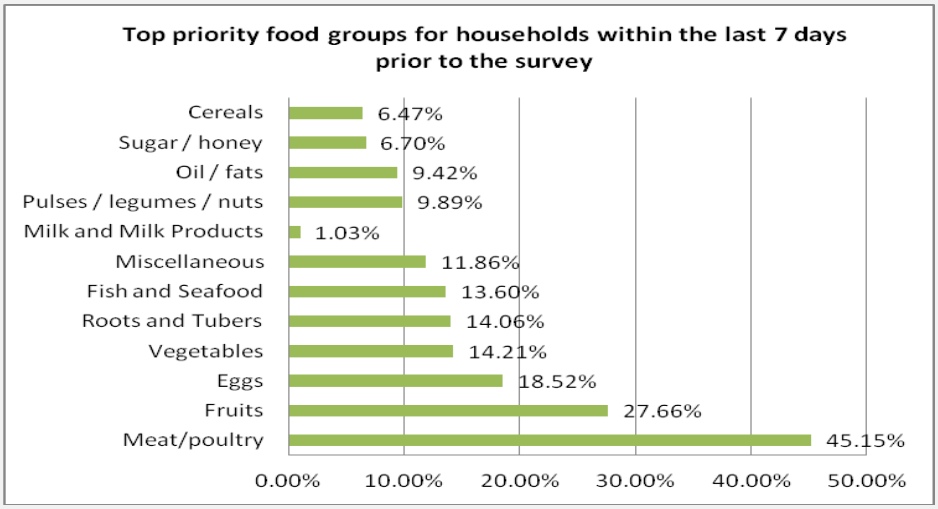




A large number of the survey participants consider their food consumption as “less”(65%) compared to the time back when thet lived in Syria. More than one quarter (27%) consider their food intake as the “same”, whilst 8% report that they even consume more food than before. The analysis across the urban and rural setting does not reveal any significant differences in terms of the food consumption pattern.

A large percentage of children under 5 years (49.01%) have three meals or more per day. There are no significant differences when comparing number of meals of urban and rural respondents. Children aged between 6 and 17 years mostly have 3 meals per day (83.26%), 13.86% two meals a day. Compared to children less than 5 years this number is significantly higher and could be explained by the fact that family care prioritises very young children when it is about food intake. Compared to children between 6 and 17 years, fewer adults have three meals per day (79.91%) and more only two meals a day (17.26%).

“Meat/ poultry” belong to the top priority food groups according to the households assessed. Fewer households (27.66%) consider “fruits” as important. The survey results indicate further that vegetables (14.21%) and pulses / legumes / nuts (9.89%) are not considered as most important food groups.



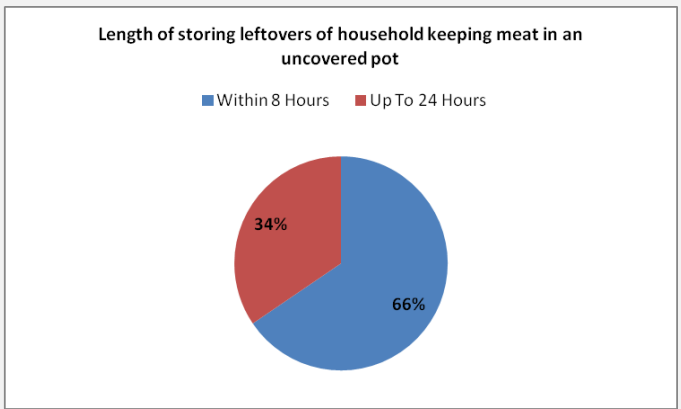
People generally report to have difficulties to eat meat / poultry on a regular basis and report to have eaten it only one day during the last 7 days prior to the survey. More than half of the assessed households (52.25%) indicate to use oil / fat on every day during the last 7 days. The majority of those who had consumed fish and seafood did it once per week (83%), whilst cereals have been used on a daily basis during the last seven days.

Average consumption of different food groups during the last 7 days prior to the survey	
Food groups consumed 1 day	Fish and seafood, fruits, meat and poultry
Food groups consumed 3 days:	Roots and tubers, eggs, legumes, pulses, nuts
Food groups consumed 4 days	Milk / milk products, vegetables
Food groups consumed 5 days	Oil / fat
Food groups consumed 6 days	Sugar, honey, Miscellaneous
Food groups consumed 7 days	Cereals

3.10 Findings on Food Hygiene Practices.

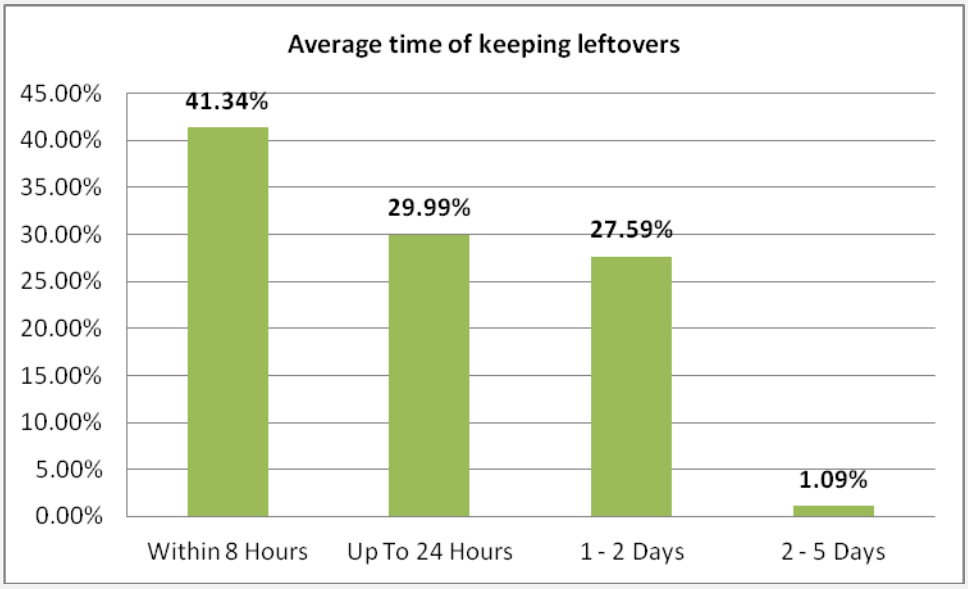
In a large majority of the assessed households (86%), meat is stored hygienically, either in a fridge (54.32%) or in a covered pot or container (31.75%). A large majority of the survey respondents who store meat in the fridge is urban (70% compared to 49% for rural). People from rural areas store meat mainly in a covered container or pot (38% in rural against 21% urban).

Storage of meat at household level	
Fridge	54.32%
Covered Container Or Pot	31.75%
Bag On Ground	5.55%
Bag Off Ground	3.89%
Uncovered Container Or Pot	1.46%
At neighbour's place	3.03%



Those households storing meat either in a bag, uncovered and / or on the ground

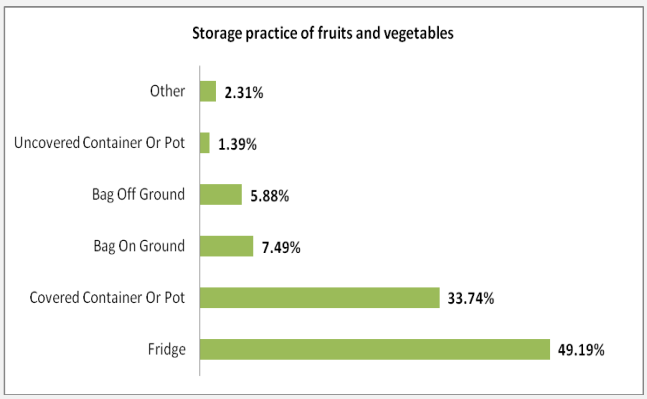
consume it within the 8 hours. Over one third (34%) keeps it up to 24 hours. During winter time this storage length is less likely to imply any health risks; however, with raising temperatures hygiene promotional activities shall stress the point to store meat for the small amount of time to prepare it for cooking. Further it should be cooked thoroughly.

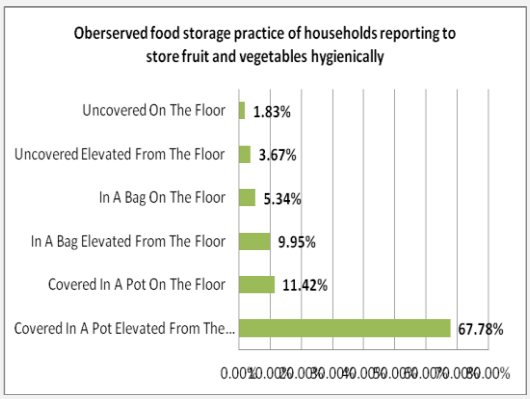


The table above shows that most of the food is consumed at the very same day which is also linked to the fact that the amount purchased and cooked are limited. A smaller number (27.59%) keeps food longer than one to two days. In those households the leftovers are mainly kept in a covered pot elevated from the floor (61.87%). Almost one quarter (24.71%) store leftover food in a less hygienic manner, either directly on the floor and / or uncovered.

Observed household food storage practices	
Covered In A Pot Elevated From The Floor	61.87%
Covered In A Pot On The Floor	13.42%
In A Bag Elevated From The Floor	9.82%
In A Bag On The Floor	6.71%
Uncovered Elevated From The Floor	5.56%
Uncovered On The Floor	2.62%

As for the meat, fruit and vegetables are stored either in the fridge or in a pot covered on the floor.





Those who report to keep vegetables in the fridge are mainly from urban areas (65% against 43%). The primary alternative practice used of urban survey respondents to store vegetables is a covered container or pot.

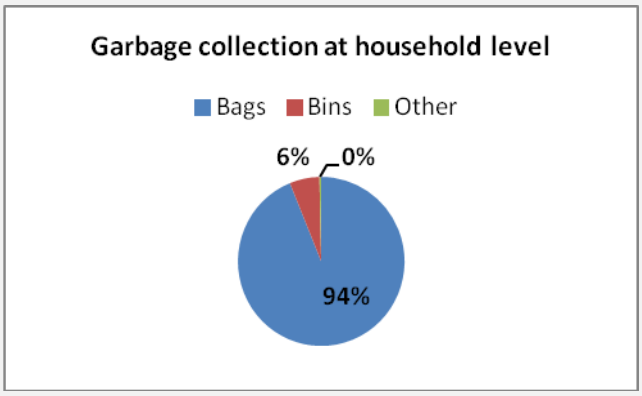
However, the observation revealed that in those households mentioned above, fruit and vegetables are not at all stored in the fridge but rather in a covered pot elevated from the floor. This suggests a certain knowledge-behaviour gap and reflects at the same time the elevated educational background of the survey population providing answers as socially it would have been expected.

3.11 Findings on household Environmental Sanitation Practices– Solid Waste Management.

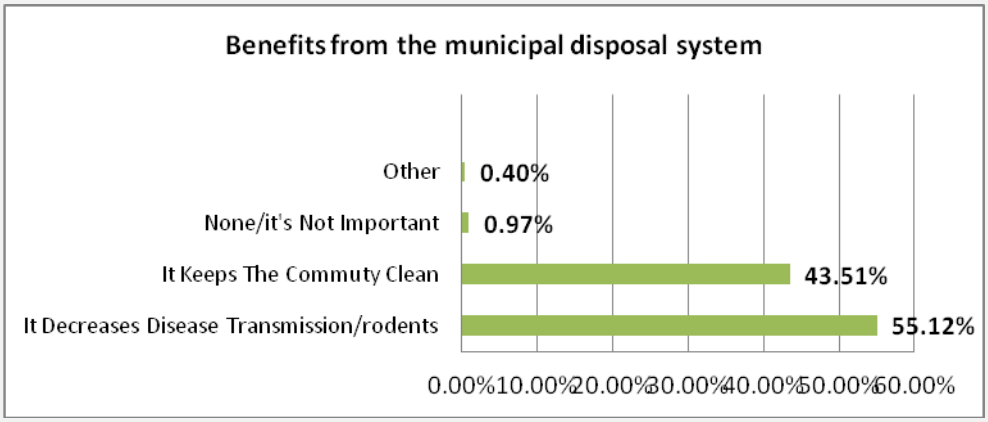
Environmental sanitation

Most of the households assessed dispose the solid waste in bags, only a few numbers collect it directly in bins. A large majority (84.6%) use the municipal collection system, whilst 14.46% drop it anywhere outside.

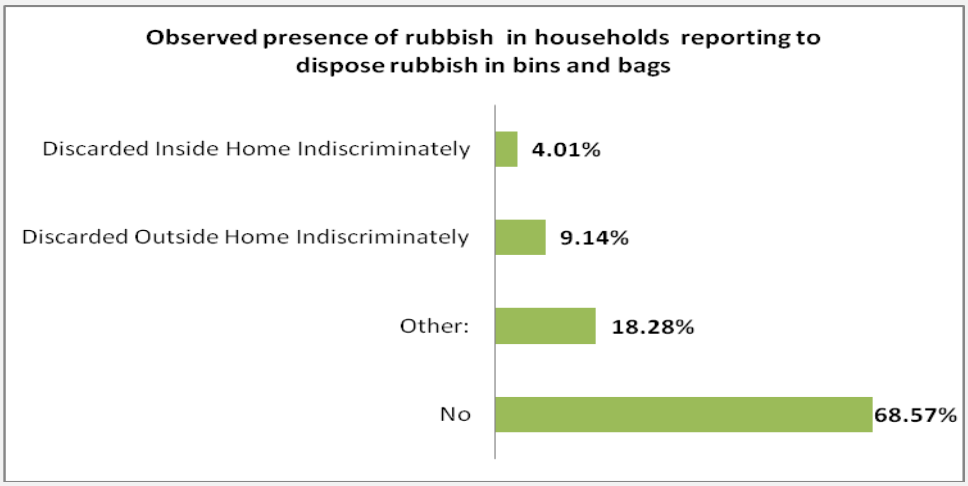
Those households which indicate to use the municipality system see the benefit mainly in the preventing diseases.



A large percentage of the survey respondents consider the cleanliness of the community also as advantage of using the municipal disposal system.



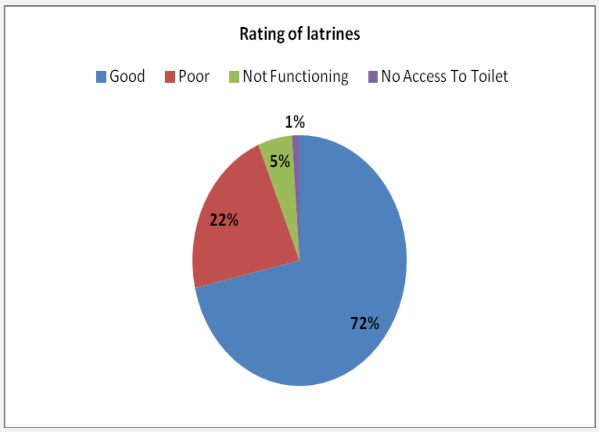
More than half of the households indicate to dispose diapers in a separate bin and / or bag, 40% use the same trash and 5% do not use do not have diapers.

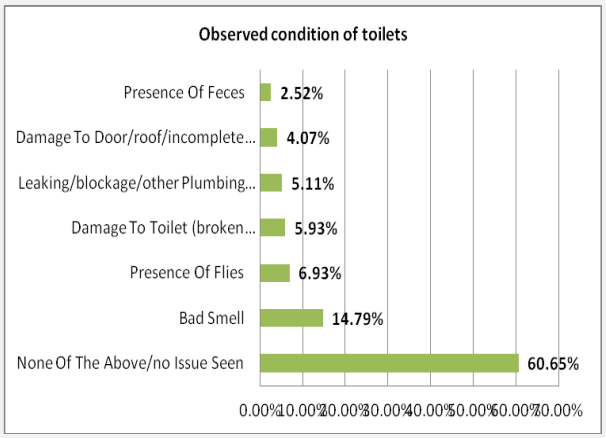


The observation of the households confirmed that solid waste handling at household level is mainly done in a hygienic manner. When observing waste at household level it was mostly found outside from the home (9.14%). No rubbish was observed in 76% of the rural households and 85% in urban households. Rubbish is slightly more discarded inside rural homes (5% of urban households rubbish compared to 3% in rural households). Solid waste disposal outside of the house is rather problematic in rural areas (13% against 6% in urban areas).

3.12 Findings on Household Sanitation Practices.

The majority of the survey participants rate their toilets as functional and in a good structural state (71%), less than a quarter consider

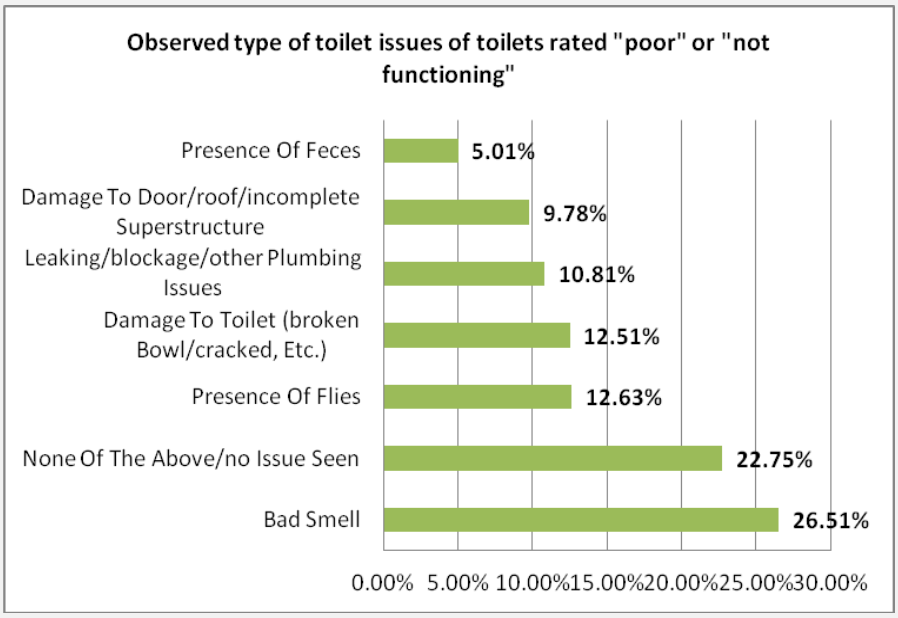




the condition of their toilet as "poor" (22%). A small percentage of the respondents do not their toilets because they are not functioning (5%). 78% of urban respondents rated their toilets as "functional and in good structural state" compared to 69% in rural areas.

In the majority of households assessed the overall conditions were good (60.65%). The main issues which could be identified with the bad smell (14.97%).

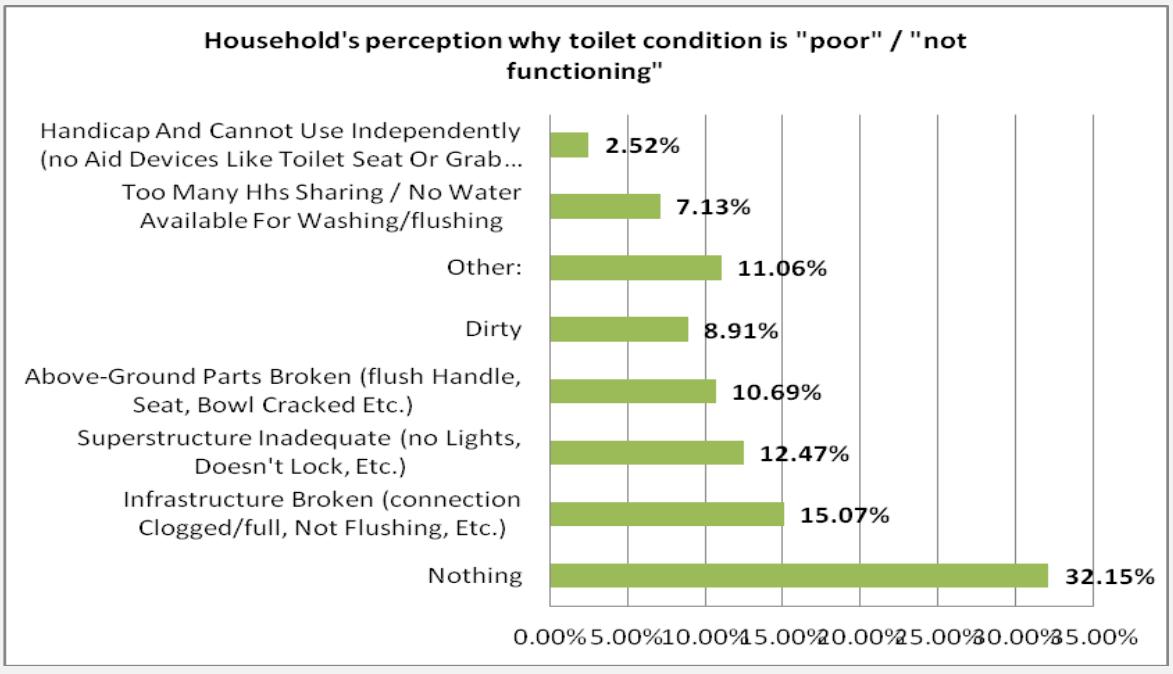
These results are very much in line compared to the observation reports in households reporting poor or not functioning sanitation conditions. Generally, those toilets are mainly hygienic except the presence of smell (16.51%).



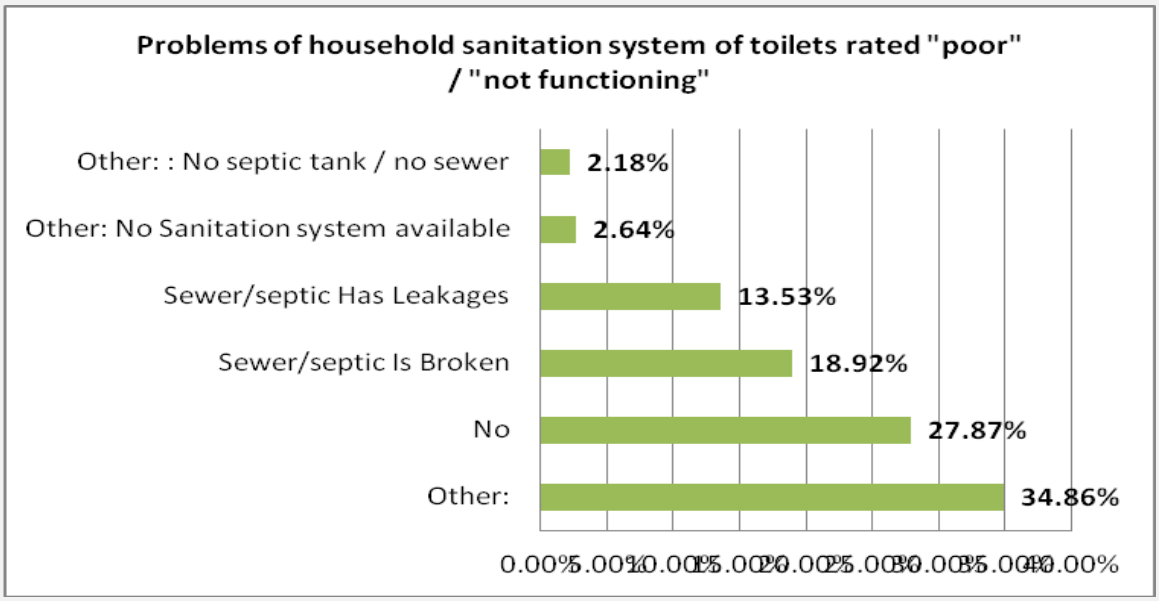
In 12.63% of those assessed households flies were present and almost the same number (12.51%) faces difficulties in sanitation access due to damages. In a smaller number of visited households (10.81%) leakages, plumbing issues or blockage could be found. In a small number of toilet facilities observed, faeces were present.

According to the survey participants who rated the toilet facilities as poor or not functioning the main reason are a broken infrastructure (15.07%) and inadequate infrastructure (12.47%).

For a smaller number of assessed households (7.13%) the fact that they need to share the toilet with a various number of people and/ or water for flushing is not available represents a serious issue.



During the observation main household sanitation problems identified were due to leaking sewer / septic tank (13.53%) or a broken sewer / septic tank system (18/29%). Only in very few households no septic tank or connection to the sewage system was observed (2.18%).



A higher percentage of the urban households assessed reporting poor or not functioning had no observed damage (53% compared to 39% in rural areas). No substantial difference was observed in terms of a broken sewage or septic tank (14% of urban households against 17% rural households). In terms of broken toilets it seems rather problematic in urban areas (22% in urban compared to 18% in rural settings).

3.13 Health – Communicable Disease Prevalence at Household Level

Disease prevalence in the household

There are always issues with self-reported disease data. However, the information included in the table below is an indication of major diseases to be focused on for prevention priorities. Seasonality impacts on disease experience of households, and it's important to note that this data reflects the experience of refugees for the first few months of the year (Jan – March). It could be considered that colds/flues/ARI would be more highly represented compared to diarrhoea and skin infections (more common in warmer months). ARI and diarrhoea in children is the priority issue (18% of households reported prevalence of coughing in children and 7% of diarrhoea.

Reported disease prevalence in households						
	Adults		Adolescents		Children	
	None	Yes	None	Yes	None	Yes
Fever	94%	6%	94%	6%	87%	13%
Coughing	91%	9%	87%	13%	82.0%	18%
Vomiting	99%	1%	99%	1%	97.0%	3%
Diarrhoea	99%	1%	97%	3%	93.0%	7%
Stomach pain	96%	4%	99%	1%	98.0%	2%
Skin problems	94%	6%	96%	4%	96.0%	4%
Eye infection	98%	2%	99%	1%	98.0%	2%

Diarrhoea

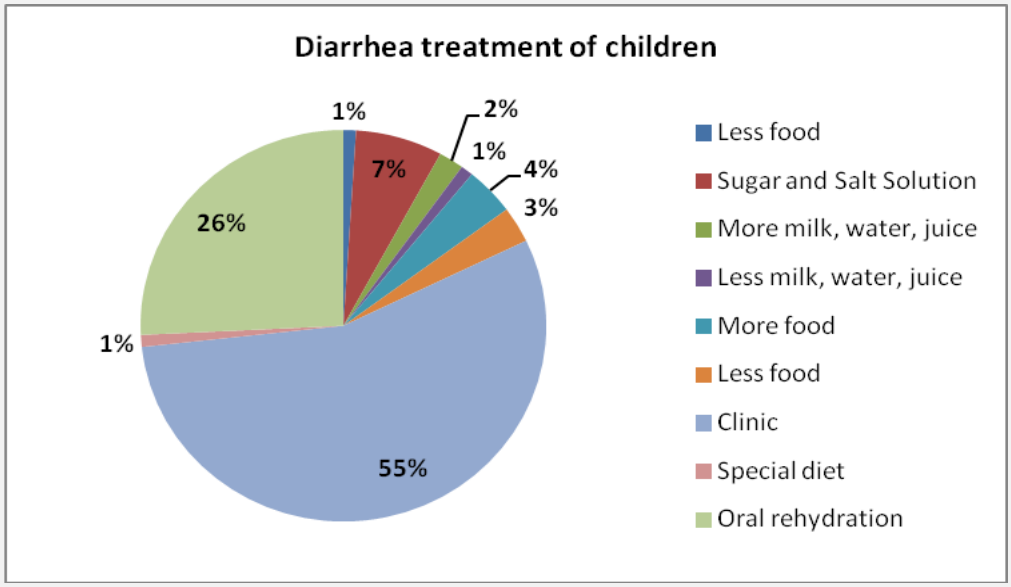
Table: Number of households members with diarrhea in the last 2 weeks				
Number of household members	Age range			
	>18yrs	6-18yrs	2-5yrs	<2yrs
0	99.33%	97.69%	93.78%	93.56%
1	0.62%	1.78%	5.15%	6.08%
>1	0.04%	0.53%	1.07%	0.36%

Prevalence of diarrhoea reported in adult members of households was low across the population (0.66% of households for >18yrs and 2.31 for 6-18yrs). Diarrhoea reported in under children less than 2 years was reported by 7% of households.

There was slight variation across governorates in the prevalence of diarrhoea in children less than 2 years reported, ranging between 3.5% in Jerash and 7.2% in Mafraq. Respondents in Urban Ajloun reported higher than average number of households with children less than 2 years experiencing diarrhoea (13.9%). However the sample size for this location is smaller. Rural Mafraq also reported relatively higher numbers of household with diarrhoea in children less than 2 years (8.0%).

Prevalence of diarrhea in children under 2 years in the last 2 weeks by governorate and rural areas					
	No Diarrhea		Diarrhea		Total
Ajloon	**274**	94.2%	17	5.8%	**291**
Rural	243	95.3%	12	4.7%	255
Urban	31	86.1%	5	13.9%	36
Balqa	**281**	94.3%	17	5.7%	**298**
Rural	213	94.7%	12	5.3%	225
Urban	68	93.2%	5	6.8%	73
Irbid	**496**	93.1%	37	6.9%	**533**
Rural	324	93.1%	24	6.9%	348
Urban	172	93.0%	13	7.0%	185
Jarash	**164**	96.5%	6	3.5%	**170**
Rural	64	95.5%	3	4.5%	67
Urban	100	97.1%	3	2.9%	103
Mafraq	**657**	92.8%	51	7.2%	**708**
Rural	403	92.0%	35	8.0%	438
Urban	254	94.1%	16	5.9%	270
Grand Total	**1872**	**93.6%**	**256**	**12.8%**	**2000**

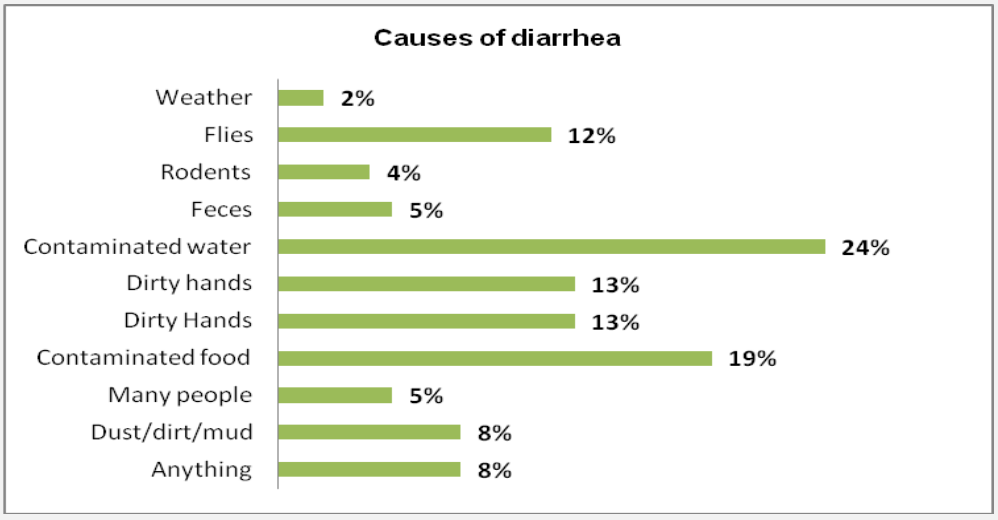
The majority of respondents did not report what actions they usually took the last time their child experienced diarrhoea. The reported actions for responding to diarrhoea involved the following:



More than half of the respondents do seek medical assistance for diarrhoeal cases, whilst 26% opt to rehydrate the child with ORS. Home-made sugar and salt solution is less common; few respondents do choose engage in risk practices to treat diarrhoea amongst young children by providing either more fluid containing sugar or less water.

The knowledge and awareness of the causes and risk factors for diarrhoea of respondents were low. Most respondents were unable to provide a response to the question of "what do you or members of your family think can cause diarrhoea." The most common risk factors identified were unsafe water (24% of responses) and contaminated food (19% of responses). Only 13% of responses were "unclean hands", and 5% were "faeces".

Reporting of knowledge and awareness of prevention of diarrhea measures were also quite low, in particular those associated with critical times for hand-washing.



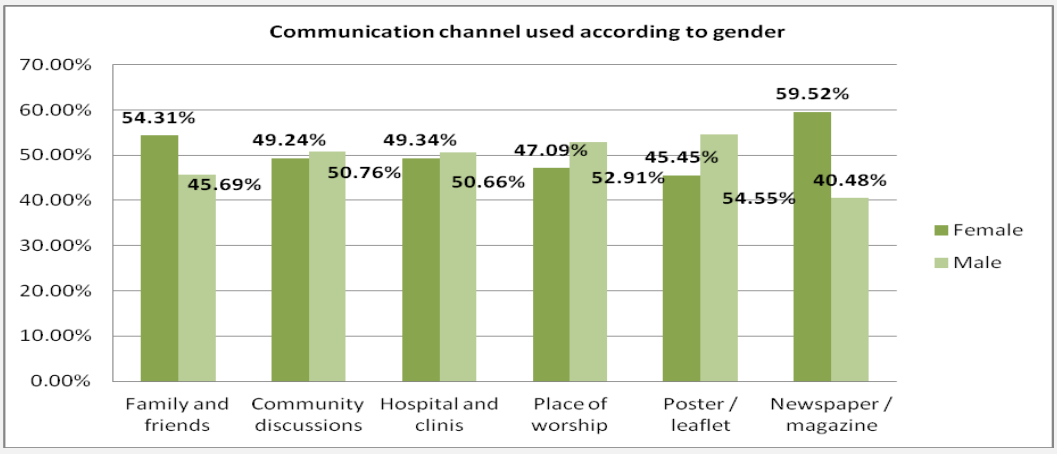
3.15 Access to Communication

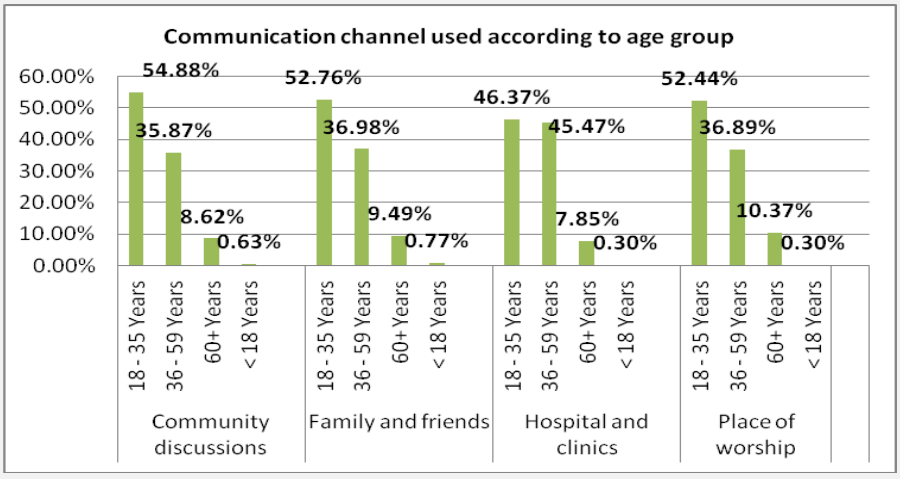
Communication / access to health information

More than half of the survey respondents access health information through informal channels (61%), either through friends and/or family (33%) or through community discussions (28%). According to the results hospitals and clinics also play an important role in terms of health information dissemination (24%). When comparing the major sources in terms of health and hygiene there are no significant differences between the urban and rural areas.

Communication: where do you get your health information from	
Your Family/friends	33%
Community Discussions	28%
Hospitals/clinics/doctors	24%
Place Of Worship	11%
Posters/leaflets	2%
Newspaper/magazine	2%
Total	

The table below reveals that there are no significant differences in terms of accessing health information according to gender. Slightly more women get health information through family and/or friends (54% compared to 46% of male respondents), except regarding newspapers. In this respect a larger percentage of women (19%) receive information related to health matters.

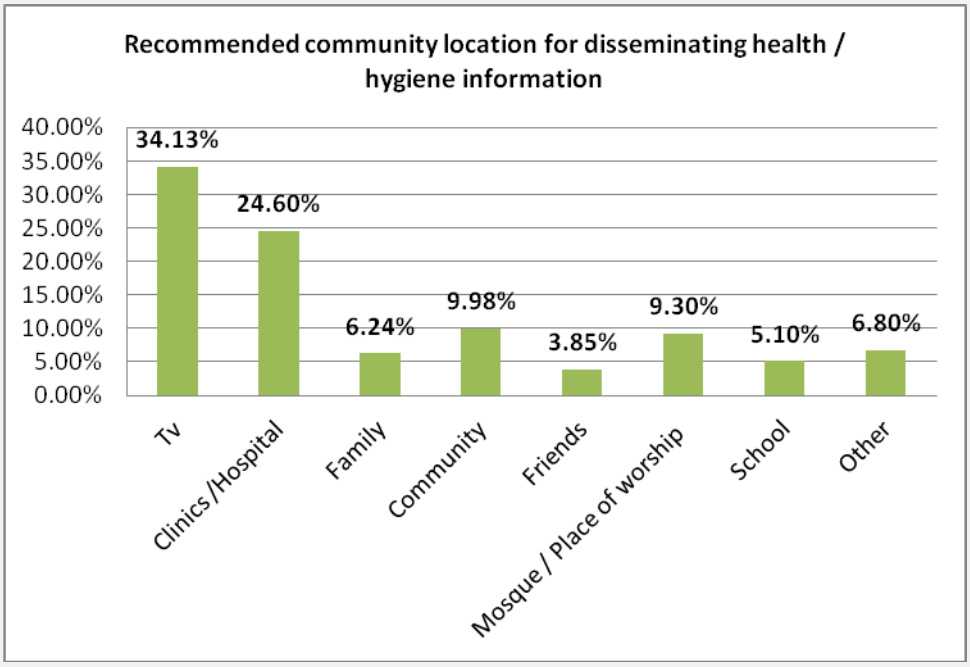




Survey respondents ranging between the age of 18 and 35 years represents the largest group accessing the main channels of health information mentioned by the total number of assessed households. This can be also linked to the fact that this age group has the easiest

access to different health channels as it is the most active one in comparison for example to elderly people (more than 60 years). The small percentage of younger people receiving health information can be explained by the fact that they constitute the smallest number of survey respondents.

Interestingly most of the survey respondents refer to preferred communication channels which are currently only relatively few or not at all used. For example, 34% of the assessed households expressed the interest to get health and/or hygiene information through TV spots or shows. A quarter of households (25%) confirm that hospitals and clinics constitute an essential source for further information dissemination. The results suggest further, that communal channels such as community groups or places of worship shall play a less important role when planning for further health/hygiene awareness rising.



4. *Conclusion, Policy Recommendations and Key Challenges*

The survey results show that most of the survey participants benefitted from some in-kind distribution. However, only a small percentage has been covered by essential hygiene items such as soap for hand washing or laundry. This suggests that until now the distribution of NFI kits does not follow sector agreed standards detailing which items shall be included in a hygiene kit and that humanitarian assistance is far from meeting the needs of vulnerable refugee households. Moreover, the refugee status does not facilitate further inter-agency support for example in terms of NFI kits. This can be linked to the fact that UNHCR data is not shared on an individual basis as well as the number of unregistered refugees is still unknown and difficult to track. However, the overall coordination sector needs to undertake continuous efforts to identify and assist most vulnerable refugees who are above of all those who are not yet registered or awaiting registration. Support to those households is crucial as a large majority faces issues to obtain hygiene items on a regular basis which makes it difficult to maintain the required level of personal hygiene and hence can result in increased public health risks. Hygiene items which are mostly purchased do include basic items such

as soap. However, the average hygiene kit does not consider shampoo and dish soap as being essential and therefore not part of the standardised host community hygiene kit. It is still under discussion whether in-kind support is cost effective or not compared to a hygiene voucher system or direct cash support. Further decision-making is mainly influenced by the number of beneficiary who shall receive assistance as well as the shopkeepers' capacity and retailers' product costs. Alternatively, additional cash support to those households can be provided. However, as long as it is not clear how decision-making power is allocated at household level and unconditional cash support is provided, it risks not be allocated for hygiene items. [2]

A large number of survey participants face issues in terms of maintaining personal hygiene. The cost of soap and lack of water constitutes for vulnerable households one of the main barriers to bath. Hence, humanitarian WASH agencies shall identify mechanisms to support households in accessing essential hygiene items as well as water for diseases prevention but also to ensure people's feeling of wellbeing and dignity.

Key hand washing moments are generally understood by the survey population, especially the moment before food preparation. Nonetheless, hygiene promotional activities should focus on raising awareness about crucial hand washing times and the importance of hand washing for diseases prevention. Generally, when planning any hygiene promotional activities they need to take into account that this emergency response takes place in a middle income context in which the crisis affected population is mainly well educated and aware about their preferences. Public health promotion strategies for host community settings need to be differentiated when targeting people living in standard accommodation or those in tent-based communities.

Channels for health/hygiene information dissemination should take into account that more than one third of the survey respondents prefer to receive health / hygiene information through TV spots and/or emissions. The planning of hygiene promotion should still consider the importance of community discussions and apply a participatory approach but be combined with mass messaging using TV channels for example for larger public health campaigning. Furthermore, hospitals and clinics should be actively integrated in the promotional activities by organising specific community discussions to epidemiological data patterns and / or according to subjects people express their main interest in (reproductive health, water-born related diseases etc.).

In terms of environmental sanitation further assistance should look into ways to support the municipal system to deal with an increased amount of waste as a large part of the survey population collect garbage in a hygienic manner also in view of decreasing the spread of diseases.

The survey results show that access to sanitation facilities is less problematic in this context of emergency response, except for people living in informal settlements. Agencies working in host community settings should investigate further in the sanitation conditions and assessing toilet issues reported by the targeted population. The decision whether to give infrastructural support at household level needs be carefully analysed as any household improvement work also risks resulting in an increased rental price and falls actually rather under the responsibility of the respective landlord.

[2] If those fields are being considered as basic life needs it will be less problematic, however, the issue remains that crucial personal hygiene items won't be purchased which can lead to an increased incidence of WASH diseases.

Smaller plumber work can be carried out, for example by providing capacity building of local associations and spare parts for the toilet structure (flush repairmen, seat etc.). In case that household assessment reveals broken or leaking sewer systems, any work should be undertaken in collaboration with the respective water authority to increase the awareness about potential contamination of water supply networks. Leakage mapping of water supply networks (either larger distribution pipes or household distribution network) could be extended to the sanitation system as well in order to plan for timely response management.

As the majority of households indicate to purchase food by cash and WFP food vouchers the food consumption pattern is likely to change especially for those household which are unregistered or awaiting registration. According to the survey results the crisis affected population is still able to maintain an acceptable level of nutritional dietary balance. The survey outcomes lead also further to the assumption that reducing the average number of meals is not yet an applicable coping strategy. However, when dealing with an extensive number of refugees not having access to legal employment the situation risks to worsen as current coping strategies (loans from relatives / shop owners, selling assets etc.) will be soon exhausted. Further advocacy work needs be undertaken to draw more attention on the current risk situation of Syrian refugees in order to raise more funding for this population group and facilitating the access to livelihood opportunities.

	Key Findings	Recommendations
WATER	• The majority is connected to the water supply system those in urban areas have an increased access to piped water compared to the rural population. • Half of the respondents have difficulties to access enough water to meet basic needs through the water supply network. • A large percentage purchases filtered water for drinking. • The water quality is generally rated as average; those who perceive it as very bad normally purchase bottled water. • Cleanliness of water storage devices is mainly poor as they are cleaned either never or only once per year.	• WASH agencies should actively engage with respective water authorities to identify priority interventions to increase access to water; alternatively water access can be increased through distribution of water vouchers and/or paying water bills of most vulnerable which requires thorough (market) monitoring; • Increasing access to water at household level through household repair work or increasing water storage capacity can be assessed, weighing costs and impact; • Water quality testing shall be undertaken, based on results and people's preference water filters can be distributed; • Hygiene promotional activities can evolve around best practices for water conservation, assessing feasible and low-cost options for water treatment and focus on promotion of safe water chain, especially at storage level.
HYGIENE ITEMS	• Registration does not affect whether family / refugee receives further aid assistance from other agencies (for example through in-kind distribution) • Only a small percentage has been covered	• Overall coordination sector needs to undertake continuous efforts to identify and assist most vulnerable refugees who are above of all those who are not yet registered or awaiting registration.

	by essential hygiene items such as soap for hand washing or laundry • More than three quarter of the survey population face issues in accessing hygiene items, either they sacrifice other things like education or they rely on charities, friends and / or relatives. • People purchase mostly soap, laundry soap and shampoo as most essential hygiene item. The main income sources of those families are casual labour or WFP food vouchers. • The number of small children does not impact whether the households face issues in obtaining hygiene items. However, mostly children under 5 years are suffering from skin problems.	• Hygiene kit distribution shall follow sector agreed standards to ensure that the most essential hygiene needs are covered. In host community settings where people living in fix housing conditions the feasibility and cost-effectiveness of introducing hygiene vouchers should be alternatively assessed. • Humanitarian WASH agencies shall identify mechanisms to support households in accessing essential hygiene items as well as sufficient water for diseases prevention but also to ensure people's feeling of wellbeing and dignity.
PERSONAL HYGIENE	More than half of the assessed refugee population report difficulties to bath. Main barriers for bathing are the cost of soap and lack of water. • Key times for hand washing are "before cooking food" and "whenever they look / feel dirty", only 43% report to wash their hands before eating. • People use water and soap for hand washing (84%) which has been mainly confirmed through the household observation (soap was in 75% of assessed households present.) • A considerable number (45%) reports to face hand washing issues which is primarily due to the cost of soap (34%) and lack of water (24%).	• Hygiene promotional activities should focus on raising awareness about crucial hand washing times and the importance of hand washing for diseases prevention. For the existing knowledge- behaviour gap the appropriate behaviour change communication strategy needs to be identified. • Generally, when planning any hygiene promotional activities they need to take into account that this emergency response takes place in a middle income context in which the crisis affected population is mainly well educated and aware about their preferences. • Public health promotion strategies for host community settings need to be differentiated when targeting people living in standard accommodation or those in tent-based communities.
SANITATION	• A large majority use the municipal solid waste system (84%), more than a half of those households (55%) uses it to avoid any spread of diseases. • Most of the survey participants rate the condition of their toilets as "good" (72%). The main issue observed is the bad smell (15%).	• Agencies should investigate further in sanitation conditions and assessing toilet issues reported by the targeted population. The decision whether to give infrastructural support at household level needs be carefully analysed as any household improvement work also risks resulting in an increased rental price and falls actually rather under the responsibility of the respective landlord. • Smaller plumber work can be carried out, for example by providing capacity building of local associations and spare parts for the

		toilet structure (flush repairmen, seat etc.). In case that household assessment reveals broken or leaking sewer systems, any work should be undertaken in collaboration with the respective authority to increase the awareness about potential contamination of water supply networks, taking as well into account the mobility of the refugee population.
FOOD CONSUMPTION	• Food is mainly purchased through cash or WFP food vouchers, a larger percentage also reports to use credit. The food consumption pattern is likely to change especially for those household which are unregistered or awaiting registration as they do not have access to WFP vouchers or cash. • More than half of the survey respondents (65%) indicate to eat less than compared to Syria. Regardless the age, people have mostly three meals a day. • The crisis affected population is still able to maintain an acceptable level of nutritional dietary balance. Reducing the average number of meals is not yet an applicable coping strategy.	• When dealing with an extensive number of refugees not having access to legal employment the situation risks to worsen as current coping strategies (loans from relatives / shop owners, selling assets etc.) will be soon exhausted. Further advocacy work needs be undertaken to draw more attention on the current risk situation of Syrian refugees in order to raise more funding for this population group and facilitating the access to livelihood opportunities.
HEALTH	• During the survey period children were mainly suffering from ARI, followed by diarrhoea. Skin infections are mainly reported by adults. • The knowledge level of diarrhoeal transmission routes is poor, especially in terms of faeces and dirty hands. • The survey population treat diarrhoea among young children either at clinics level or through rehydration.	• During the summer months when water supply is likely to be insufficient the prevalence of skin diseases is estimated to be higher across all age groups. Hygiene promotion approaches shall consider developing together with the targeted communities' key actions to maintain the personal hygiene whilst the hardware side seeks to increase access to water and basic hygiene items. • Hygiene promotion should focus on diarrhoea prevention through increasing knowledge about transmission routes in a creative an d participatory manner.
COMMUNICATION	• The majority of survey respondents (61%) access health information through informal channels such as family and/or friends or community discussions, although most of them express the preference to receive such information through TV spots /shows or in hospitals / clinics.	• The planning of hygiene promotion should still consider the importance of community discussions and apply a participatory approach but be combined with mass messaging using TV channels for example for larger public health campaigning. • Hospitals and clinics should be actively integrated in the promotional activities by organising specific community discussions to epidemiological data patterns and / or according to subjects people express their main interest in (reproductive health, water-born related diseases etc.).

Income and expenditure	• Most households reported expenditure rates that exceeded their income, indicating that the refugee population's current arrangements in host communities is unsustainable and that coping mechanisms and resilience resources are being stretched. The burden is greatest in lower income households where the difference between income and expenditure rates is greatest. • Respondents reported high levels of dependence on humanitarian assistance, but with differential access reported geographically. • Food and rent are the two primary categories of expenditure. • Given the large difference between expenditure on food and rent as compared to meeting needs for household items and medical/health needs – it implies that trade-offs are being made with essential needs such as water and hygiene items.	• Cash assistance is a relevant and appropriate form of assistance to address vulnerability. • Food and rent assistance are key target areas for support • WASH-related NFI distributions (hygiene items, water, etc) are appropriate as they are not currently being prioritised in respondent's expenditure prioritisation.