

UNHCR Mozambique

KAP Survey Report – Maratane Refugee Camp

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Acronyms

UNHCR - United Nations High Commissioner for Refugees

INAR - Instituto Nacional de Apoio aos Refugiados/ National Refugee Support Institute

KAP- Knowledge, Attitudes, and Practices

WASH - Water, Sanitation and Hygiene

HH - House holds

ID- Identity document

L/P/D - Liter per person per day

WASH KAP Mapper - WASH KAP (Knowledge, Attitude and Practices) Mapper

MHM - Menstrual Hygiene Management

HP - Hygiene Promotion

Executive Summary

Maratane Refugee Camp is found in Northern Mozambique, Nampula Province, and is located around 35 kms from the capital city Nampula. The camp was established in February 2001, and since 2003, it has become the only reception center and official settlement in Mozambique, where asylum seekers and refugees can be registered and assisted. Currently, Maratane Refugee camp hosts approximately 9,242 refugees, which are mainly from the Democratic Republic of the Congo, Burundi, Rwanda, Somalia and other nationalities.

Maratane Camp is the only refugee camp in the country and is managed by the Instituto Nacional de Apoio aos Refugiados (INAR). INAR is UNHCR's main government counterpart, and operates under the jurisdiction of the Ministry for Internal Affairs. INAR is divided into several units, including Protection/RSD, program, Registration and Logistics and is also UNHCR WASH partner for providing WASH service in the camp.

In order to understand the current status and level of WASH service in the camp, UNHCR had conducted a WASH KAP (Knowledge, Attitudes and Practices) survey through coordination with INAR. Accordingly, a total of 433 households from different zones of the camp were interviewed using UNHCR's standard WASH KAP survey questionnaire which was pre-tested and adapted to local context.

Summary of Key Findings

Water

The overall result indicates the average daily water consumption in the camp to be a 17.4 liter per person per day with the result showing variation per different zones of the camp and with Zone A having the lowest coverage (7L/P/D).

In terms of accessibility of water, the result shows 67% of the households to walk between 400m to 1.5 km to get water. 74% of the households interviewed have also reported for not getting enough water to meet their daily household needs and the main reason given for this, was because of the long waiting time at water points, not having enough water storage and limitation on the volume of water collected per day.

With regards to water storage capacity, 76% of the households in the camp have access to at least 10 liters per person protected storage capacity.

Sanitation

Overall, 81.1% of the households in Maratane camp have reported defecating in latrine/toilet and 77.5% of the households have access to family latrine/toilet. Nevertheless, the data obtained showed that open defecation is practiced by 30.8% of the households in the camp.

The availability of latrines for households having a disabled and elderly family member also low with 54% of the households reporting not having latrine.

With regards to latrine usage, from the household that reported having latrines, almost all the latrines were observed to be used. However, 32% these latrines were either full or approaching to be full.

Hygiene

The overall coverage of households with access to soap is 70.8 % with the result showing variations per different zones in the camp and 89% of the households interviewed are dependent on UNHCR soap distribution for getting soap to be used for their households.

Regarding the respondents' knowledge about the critical times of hand washing, the result shows 90.7% of the respondents to know at least three critical moments for washing hands. However, in terms of the availability of hand washing station at household level, only 11% have reported having a specific handwashing device/station in their households and also a soap or ash were observed to be present only in 50% of the handwashing stations which indicates that the handwashing stations are not properly used.

The result of the survey also shows significant rate on the prevalence of diarrhea in the camp with 22% of adults and 33% of children under five reported having diarrhea within the last two weeks of the survey.

INTRODUCTION

Maratane Refugee Camp is found in Northern Mozambique, Nampula Province, and is located around 35 kms from the capital city Nampula. The camp was established in February 2001, and since 2003, it has become the only reception center and official settlement in Mozambique, where asylum seekers and refugees can be registered and assisted. Currently, Maratane Refugee camp hosts approximately 9,242 refugees, which are mainly from the Democratic Republic of the Congo, Burundi, Rwanda, Somalia and other nationalities.

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UNHCR has deployed a WASH officer since beginning of November 2019, in order to reinforce the WASH service being provided in the camp and to provide technical oversight. Accordingly, among the activities planned, a KAP survey was conducted from the 25th of November to the 4th of December 2019 which would serve as a baseline of the beneficiaries' knowledge, attitudes and practices (KAP) regarding water, sanitation and hygiene related behavior.

SURVEY OBJECTIVE

The KAP survey was conducted to enable and help UNHCR and INAR to better understand the current status and level of WASH service in the camp and also to use the result of the survey as a baseline for planning and implementation of the WASH intervention. The KAP survey has looked at water supply, sanitation and hygiene behaviors practiced in the camp through the lens of community perceptions and it is expected to help on to strengthen the WASH intervention in the camp.

Below are the main objectives of the survey:

- To establish a baseline of the beneficiaries' knowledge, attitudes and practices (KAP) regarding water, sanitation and hygiene related behavior.
- To help as a basis for revising and updating the country WASH strategy and also to recommend on the activities that need to be adjusted or strengthened to improve the WASH intervention in the camp

METHODOLOGY

The KAP survey was conducted at Maratane refugee camp from the 25th of November to the 4th of December 2019 through coordination with INAR and the health center in the camp. The scope of the survey entailed recruiting and training of enumerators pre-testing and adaptation UNHCR WASH global questionnaire to local context, data collection and analysis and report writing questionnaire.

A total of 13 enumerators were recruited through coordination with camp administration, INAR and health center. The enumerators were recruited from the refugees living in the camp and also public health nurses working in the health center.

A three-day training was provided to the enumerators focusing on how to use the mobile collection system (ODK) to fill the questionnaire, in the content of the questionnaire and interviewing techniques. On the third day of the training pre-test interviews were conducted through enumerators to make them familiar with the questionnaire and also some questions were adjusted based on the feedback obtained. Though the questionnaire was in English and was not translated into the languages spoken by the refugees which are Swahili, Kirundi or Portuguese, the enumerators who all recruited from the community has assisted the team to avoid language barriers since they all speak and understand English and the other languages spoken by the refugees.

Accordingly, after provision of training, the enumerators were divided into five groups and each team were assigned to collect data from specific zones in the camp. Accordingly, the enumerators have collected data from four zones and the transit center in the camp.

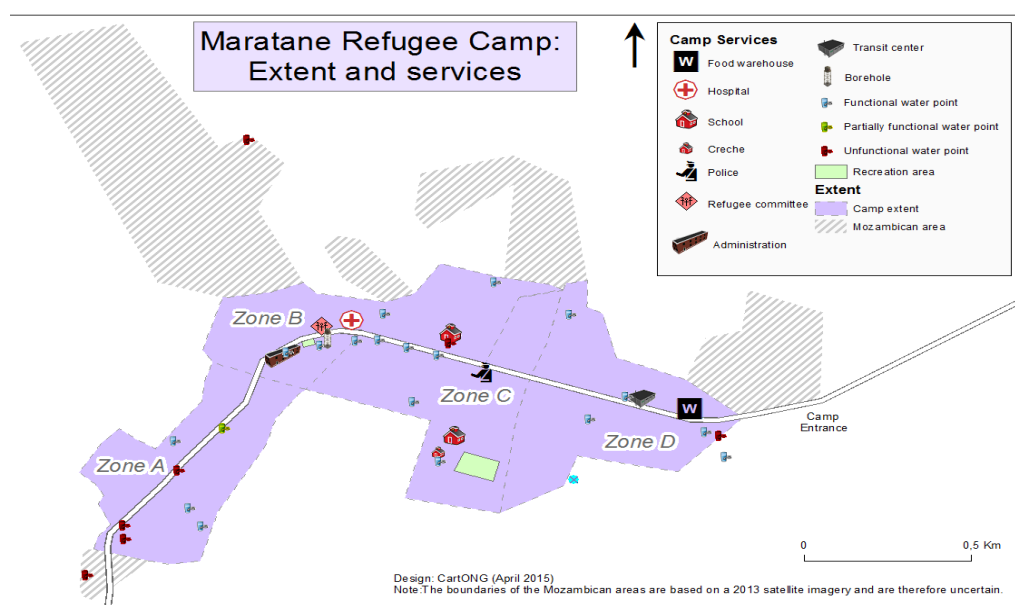


Figure 1-Map of Martane refugee camp

As per the data obtained from UNHCR registration team, there are 9,244 refugees and 2,942 HH in Maratane refugee camp. Below are the total number of households in each zone

No	Zones	Total # of HH	Remark
1	Zone A	440	
2	Zone B	564	
3	Zone c	627	
4	Zone D	857	
5	Transit center	454	Because of the resettlement of families from transit center to permanent settlement few days before the survey, the number of HH in transit center was much smaller when the survey was conducted.

Accordingly, a total of 365 HH were selected as sample size using UNHCR sample size calculator and consequently allocated proportionally to each zone and transit center based on the size of the zones. Since UNHCR does not have a compiled list of households in excel, the households to be interviewed were selected randomly using the HH address. Accordingly, the enumerators selected every second or third household to interview in their assigned zones to make it more random.

INDICATORS AND QUESTIONNAIRE ELABORATION

UNHCR global KAP questionnaire was used during the survey. As per the survey format, all questionnaires related to UNHCR main WASH indicators were included since it is not possible to change the questions in the format. Additional questions were added based on the feedback obtained from the refugees during pre-testing of the questionnaire. Changes were also made on the questionnaire to fit it into the local context and in line with the goals of the survey

ETHICS AND CONSENT

Training was provided to the enumerators on interviewing ethics that include obtaining informed consent of the person interviewed, to participate in the survey, securing the confidentiality, informing the participants on the objective of the survey as well as the organization conducting the survey. The enumerators were also provided with a temporary ID displaying their names and logos (UNHCR and INAR) of the organization conducting the surveys. As per the questionnaire, each HH to be interviewed was then asked for their consent to participate in the survey and the interview was based on their response given. The enumerators were also briefed that

they should do the interview only based on consent and they should not show negative emotions for HH that did not want to participate in the survey.

Since each interview was conducted by one male and one female enumerator, on the menstrual management part of the survey, the male data collector was asked to leave the interviewee house to provide privacy for the respondents. Therefore, this has assisted the team to address the cultural and gender related challenges on this part of the questionnaire.

DATA COLLECTION AND QUALITY CONTROL MEASURES

Each person has signed a handover form when receiving the phones. Accordingly each enumerator was given the phone every morning to do the survey and the enumerators were returning the phones at the end of the day to their supervisors which were from UNHCR, INAR and Health center. Since there is no internet connection on the phones and as the auto send setting for sending the finalized forms to the server on the mobile phone was not activated, after being reviewed by the supervisors, the phones were given to UNHCR WASH officer who is responsible for manually sending finalized forms from the phones to the server. The data obtained were checked after each day of data collection and feedback was given to the enumerators the next day to clarify any ambiguities in the data collected the day before.

DATA ANALYSIS PLAN

After uploading the data to the server, analysis was done using the functions on the platform and using UNHCR WASH KAP analyzer and KAP Mapper.

A debriefing discussion was made with the enumerators at the end of each day to hear the feedback from the community, which has assisted in increasing the understanding of the WASH situation in the camp. A one-day workshop was also organized with the WASH partner and UNHCR staffs to discuss on the findings of the survey.

LIMITATIONS, CHALLENGES AND LESSONS LEARNT

Since the mission was of short duration, it was not possible to translate the questionnaire to the language spoken by the refugees. Though measures were taken to minimize errors, it is preferable if the survey questionnaire s are translated accordingly. Thus, it is recommended if UNHCR translates the questionnaire based on the languages widely spoken in most intervention areas. In this case, questionnaire s translated to Portuguese and Swahili languages would have been useful. These languages could also be helpful in other UNHCR intervention areas like Angola, Tanzania etc.

Another challenge was that since the survey was not pre-planned and budgeted by UNHCR or the WASH partner and also as UNHCR staff deployment was undertaken at the end of the budget year (November /December), there were challenges on getting funding to do the survey and it has also impacted the implementation timeframe for the survey. Thus, it is preferable if UNHCR and WASH partners plan and allocate budget to do the survey at least once in year. If budget is not available at the country offices support should be provided by Head office for such activities during deployments.

DEMOGRAPHICS

A total of 433 households in different zones have been included in the survey conducted in Maratane camp of which 70% of the respondents interviewed were females and 30% were male.

Among the family members of the interviewed households, 17% have reported for having a family member with reduced mobility, disability and people with special needs.

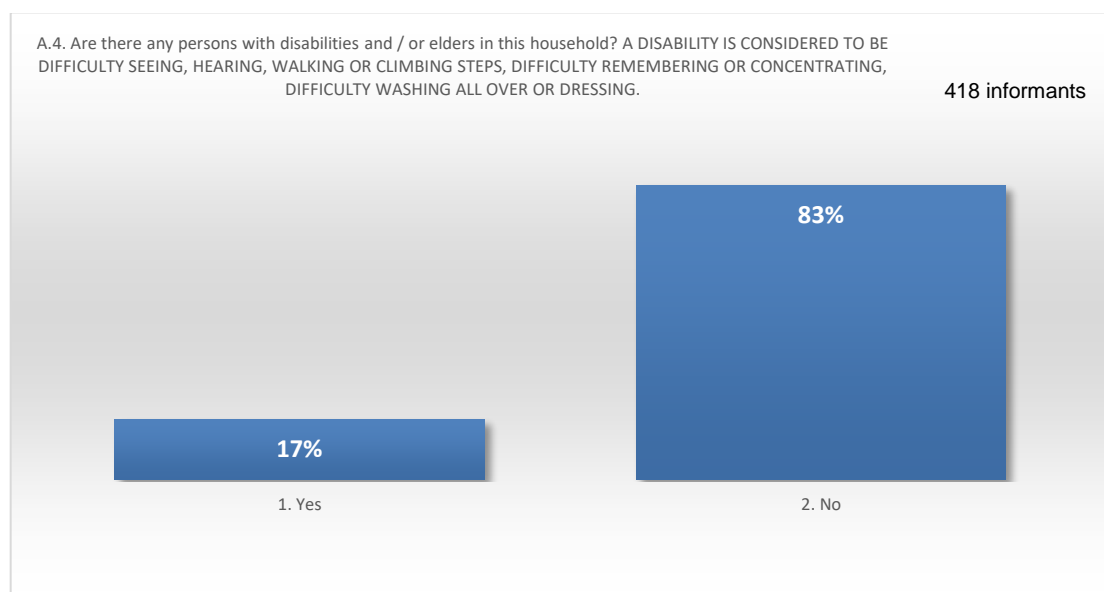


Figure2-HHs with a disabled or elderly family member

KEY RESULTS AND FINDINGS

WATER:

Water availability: Overall, 99.8% of the refugees in Maratane refuge have confirmed getting water from an improved source of which 92% of the refugees are getting water from hand pumps while the remaining HH are fetching water from the piped network. Though the result indicates the average daily water consumption at HH level to be 17.4, the result shows variation per different zones of the camp with Zone A are having the lowest coverage (7L/P/D).

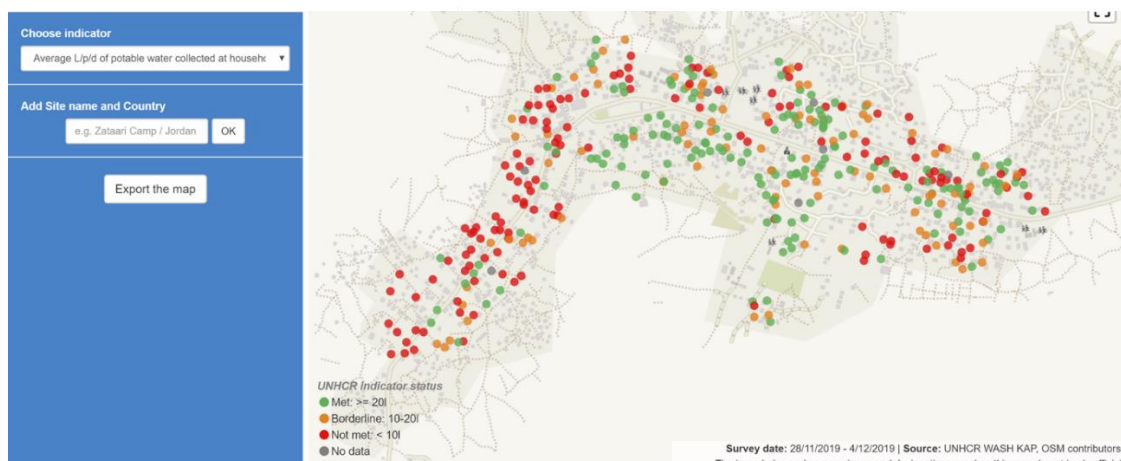


Figure 3- Average potable water consumption (L/P/D) in Maratane camp

In addition, as indicated in the graph below, 74% of the respondents reported are not getting enough water for their daily HH need¹ with Zone B, C and D having the highest percentage of the HHs that reported for not getting enough water.

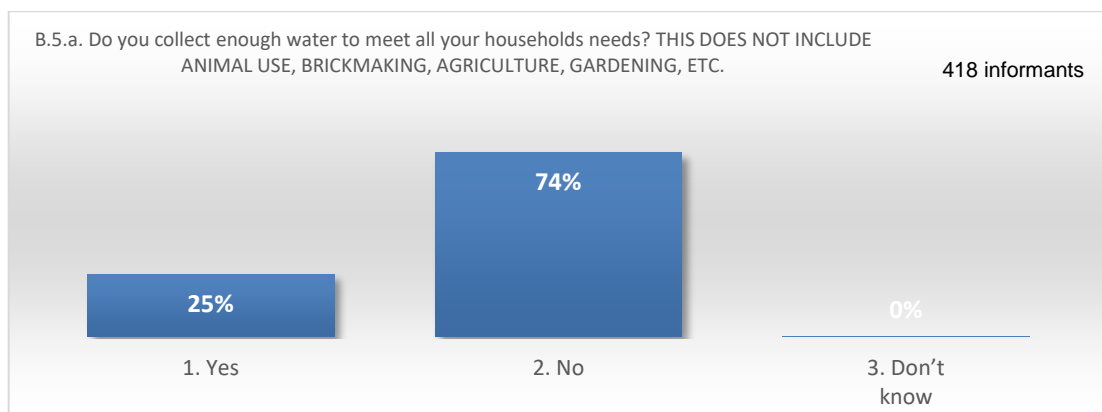


Figure4- availability of water at HH level

The participants were asked to explain the reasons why they are not able to collect enough water for their daily needs and among the main reasons given by the majority of the respondents, 39% have reported for not having enough storage container, 32% reporting long waiting time at water points followed by 12% reporting that there is limitation on the volume of water to be collected at water points. From the remaining respondents, 7% have reported shortage of water, 5% that it is long walking distance and 5% dangerous to get water².

¹ This includes water collected from both the hand pumps and piped network

² The data collectors have reported during briefing that the respondents have given this response because of the protection risks associated with the long queuing time at water points which goes in the evening time and as early as 4 a.m. in the morning

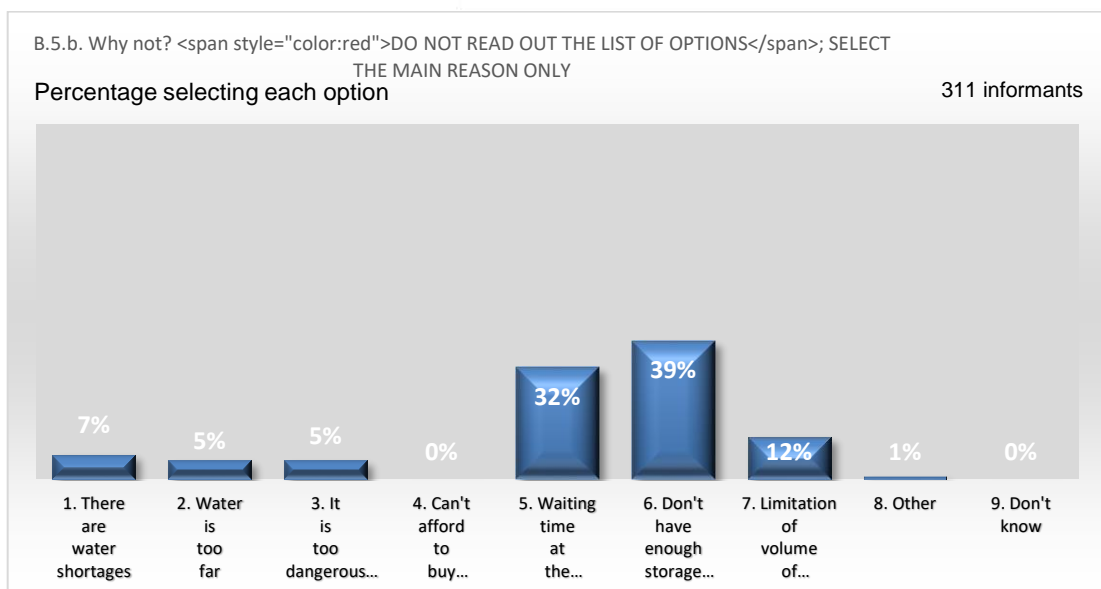


Figure5 – Reasons for not getting enough water for HH needs

Water accessibility: Concerning accessibility of water, 36% of HH interviewed reported for walking more than 500M and 31% of the HH walk between 400 and 500M. As indicated in the graph below the walking distance for the remaining HH is within acceptable UNHCR standard for protracted emergency.

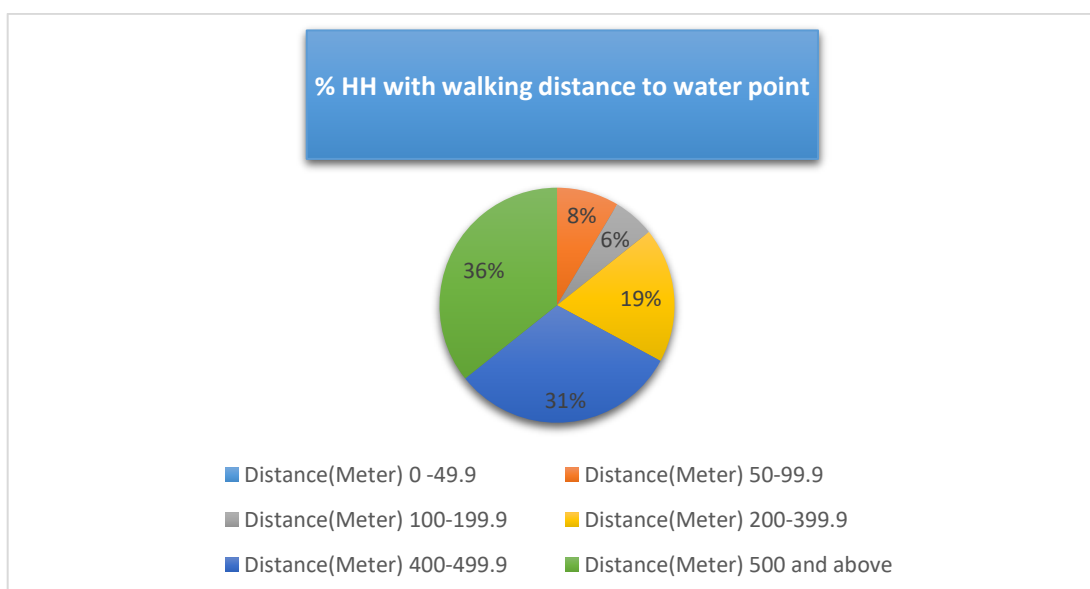


Figure6 –walking distance to water points

As indicated above, 67% of the HH walk between 400m and 1.5Km to get water, which is much less than UNHCR standard, which indicates, that protracted emergency refugees should get water within 200m distance from their households. Another factor to consider in terms of accessibility of water is waiting time at the water

sources, and from the result obtained, 32% of the respondents reported that the long waiting time at water points have prevented them for collecting enough water for their daily HH needs

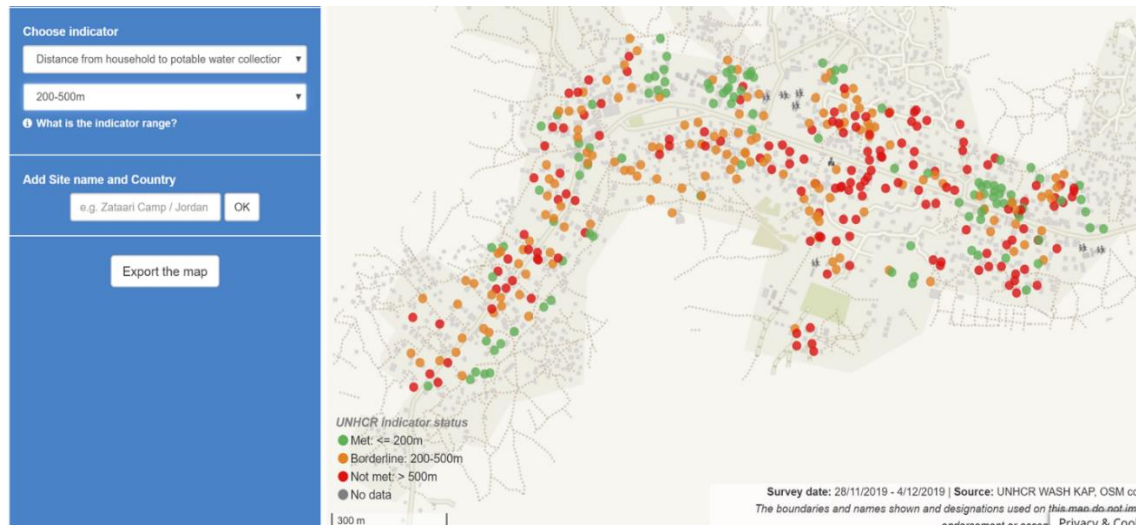


Figure7-Map of HH with walking distance to water points

Water storage capacity: With regards to water storage capacity at HH level, 75.8% of the HH have access to at least 10L/P protected storage capacity. However the result shows variation per zones with Zone A having the lowest coverage (53.2%).

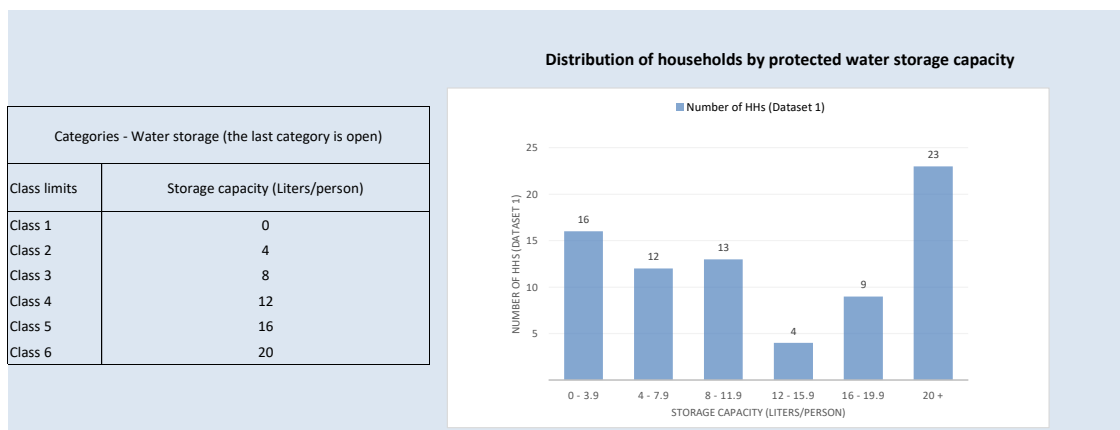


Figure8-water storage capacity at HH level

Issues identified

The overall result indicates the average potable water collected at HH level to be 17.4L/P/D with variation per different zones in the camp and with Zone A having the lowest coverage (7.1L/P/D). This shows that the average L/P/D collected at HH level is less than UNHCR standard for protracted emergency which states the average daily water consumption at HH level to be 20 L/P/D and above.

The result of the survey also highlights the main challenges related with availability and accessibility of water in Maratane refugee camp. As mentioned above, the average potable water collected at HH level varies per different zones depending on the accessibility of water in each zone and the result shows that 67% of the refugees have to walk between 400m to 1.5 KM to fetch water. This is also much less than UNHCR standard in protracted emergency which states the maximum walking distance from HH to water point to be less than 200m from their dwellings.

In addition, the long queuing time at water points and the limitation of volume of water to be collected per day (the rationing of water) to avoid overcrowding at water points, has brought significant challenge on the refugees daily HH water consumption.

From the information obtained from the refugees, the above issue has resulted from the shortage on the number of boreholes in some zones of the camp and also as only few boreholes that have fresh water are being used for drinking purpose. As reported, the remaining 60 to 70% boreholes are not used because of the salinity of the water in those boreholes (salty taste), and as a result the refugees from different zones of the camp have to walk to the boreholes with fresh water to fetch water for drinking purpose while using the other boreholes for other domestic purposes.

In addition, because of long queuing time that result from high number of users on the boreholes with fresh water, the refugees have informed the team that they have to come very early in the morning as early as 4 a.m. to avoid queuing, and to stay late in the evening to get water. Thus, some of the refugees reported not feeling safe to fetch water during early and late hours.

With regards to the water storage capacity at HH level, 75.8% of the refugees have access to at least 10 l/p protected storage capacity. However, the coverage is different per zones and also under UNHCR standard, which indicates 80% and above coverage during protracted emergencies. In addition, not having enough storage is also the main reason as (39%) of the refugees reported not getting enough water for their daily HH needs.

Way forward

UNHCR and INAR should conduct water quality test in all the boreholes in the camp and should identify boreholes having high salinity. Accordingly, measures have to be in place to replace boreholes with high salinity with new ones or provide alternative option for increasing the availability and accessibility of water in the identified zones.

Below are the possible option for increasing the quantity of water distributed:

- Upgrading the central water network: Currently, only 20 m³ water is supplied by the central water network which is connected to 11 tap stands with each

having two taps. However, the tap stands are not fully functional since water is not reaching all the tap stands because of lack of pressure, non-functionality of solar pump/panels and also as 50% of the taps are broken/nonfunctional. Therefore, appropriate funding should be allocated to upgrade the central system through increasing storage capacity at the central system³, conducting pump test and adjusting the pump size, repairing and upgrading the solar pump capacity, repairing of broken taps, connecting the pump to the electric grid etc.

- Conducting pump test and borehole forensic survey on the boreholes with good yield and upgrading the bore holes to small water networks.
- Conducting geophysical survey to understand the aquifer potential of Maratane and surrounding areas and also possible identification of suitable drilling sites which can be used to upgrade the water supply infrastructure in the future

As mentioned above, UNCHR and WASH partner has to work on increasing the quantity of water distributed and to make it more accessible to avoid the challenges related with high number of users per borehole, which as a result reduces the long queuing time at water points and avoids the protection risks by the refugees.

Water quality test should be carried out in regular interval for the boreholes at least once in a year to check for fecal coliform contamination. The central water network has to be chlorinated and the amount of free residual chlorine has to be monitored and recorded at the distribution point, taps and at HH level on a regular interval. As per the UNHCR WASH manual, results of water quality tests at chlorinated and non-chlorinated water points should also be reported upon once per month through the monthly report card of the UNHCR WASH monitoring system.

UNHCR and WASH partner should also work to establish a community-based management of the WASH facilities including hand pumps, latrines etc. in order to make it more sustainable and increase the cost efficiency on managing the facilities

UNHCR should provide sufficient technical support to INAR on various areas including conducting geophysical survey, on developing sustainable approach for upgrading the water infrastructure in the camp and on other areas as necessary.

³ There is an already existing 9m water tower with the potential to carry up to 60m³ and also a bulk storage tank which has been procured and not being used because of lack of funding and skilled manpower for installation.

SANITATION

In terms of latrine coverage, the respondents were asked where them and their family members usually go to defecate and 78% have reported having access to family latrines followed by shared latrine (18%) and communal latrine (4%).

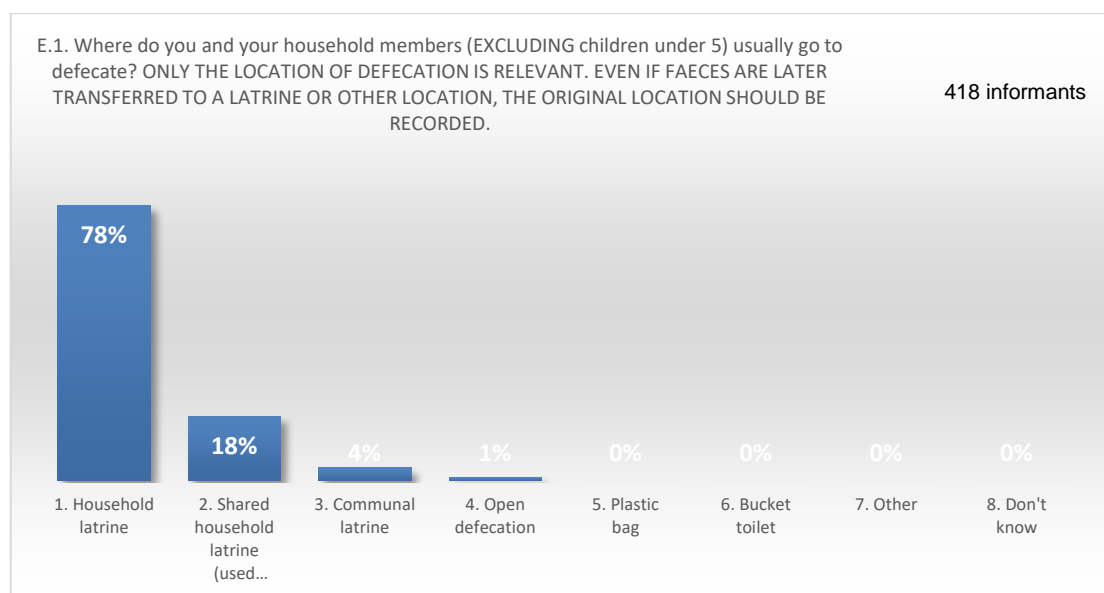


Figure9-Types of latrine used in the camp

With regards to latrine usage, the overall data obtained shows that open defecation is practiced by 30.9%⁴ of the HH in the camp and as indicated in the graph below, the rate for such practice varies per different zones with zone D having the highest percentage for practicing open defecation .

⁴ Result obtained from WASH KAP main indicators analysis producer showing results in terms of UNHCR WASH global indicator

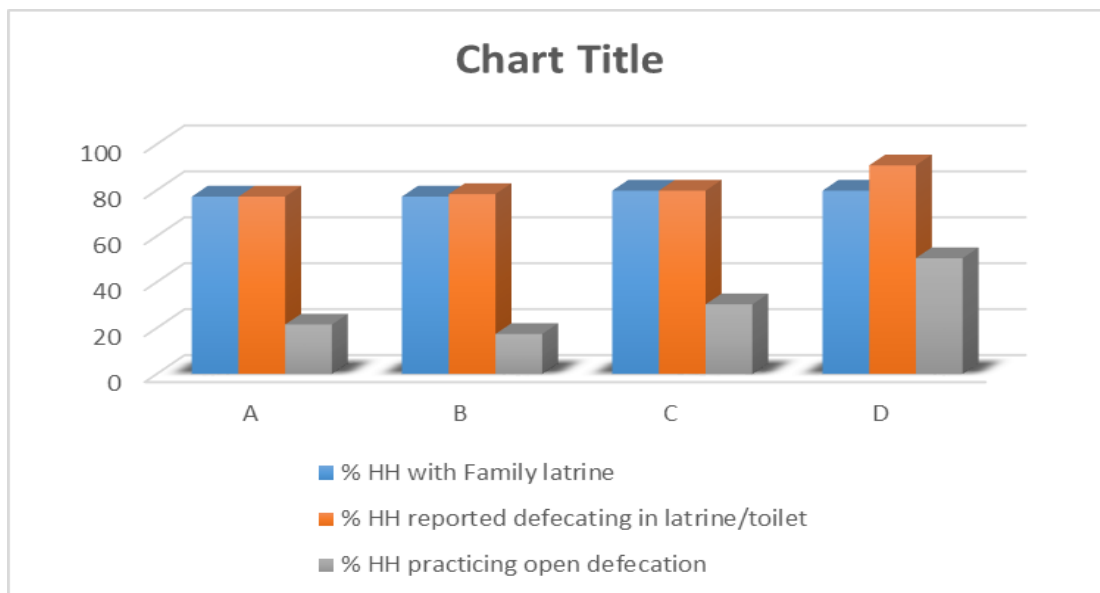


Figure10-Open defecation practice per zones

The HHs that reported practicing open defecation were then asked to list their reasons for such practice and the main reasons given by the majority of these HH is the non-availability of latrine (43%) followed by the long walking distance from HH to the latrine (20%) and non-availability of light for latrines to be used at night (10%).

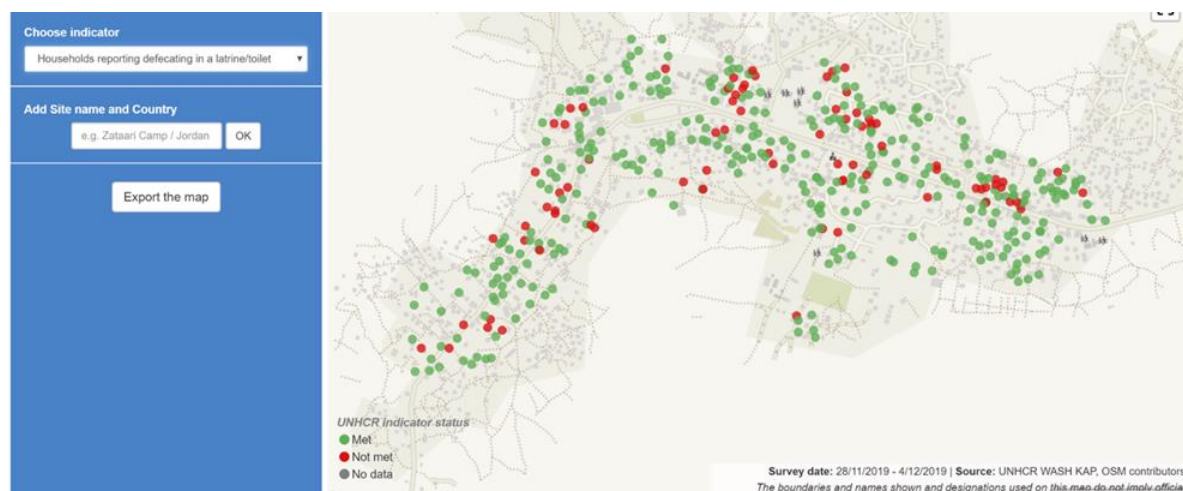


Figure11-HH practicing open defecation

Privacy and availability of latrine

When the respondents were asked if their latrines provide adequate privacy for them and their family members, 58% have reported that their latrine provide enough privacy while 41% have reported that their latrine does not provide adequate privacy for them and their family.

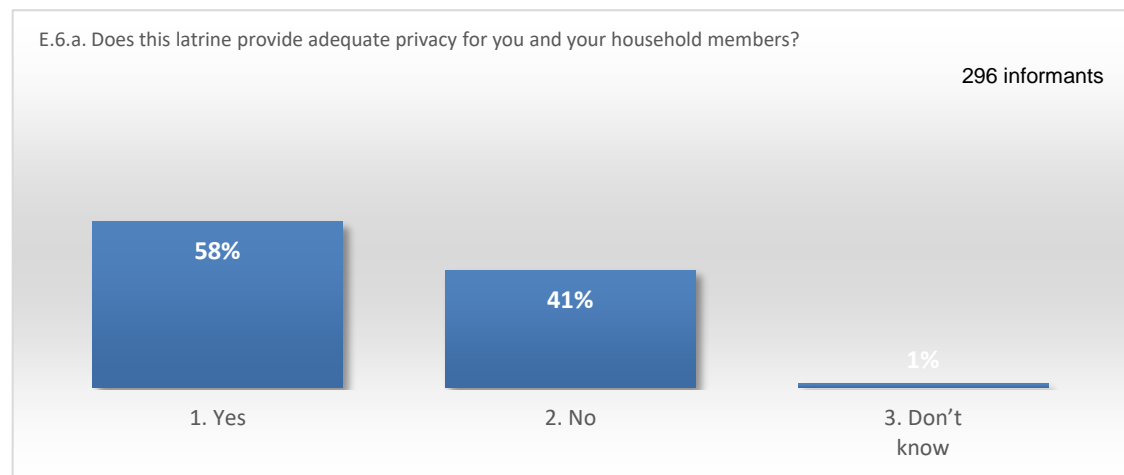


Figure12-privacy of latrines

Among the reason given by the respondents for not having adequate privacy, 66% said it is because of poor or damaged infrastructure/door, lock missing or not working (7%) and too close to the house (7%). The former answers were evident in the communal latrines and bathing shelters in transit center where the superstructure is damaged and allows visibility of the users from outside and also lack proper locks on the doors.

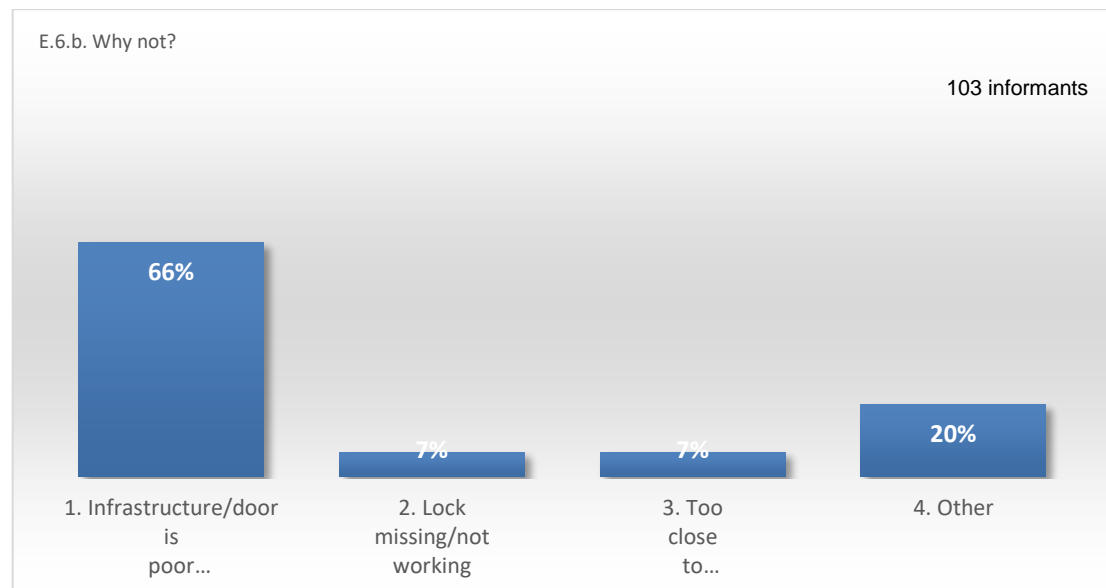


Figure13-privacy issues on WASH infrastructures

Availability of latrine by disabled and elderly people: From the HH who reported on having disabled or elderly family member, 54(%) of the HH have reported not having adequate latrine. The main reason given for this was inability to use pit latrines because they are unable to squat for the reason of old age and the type of disability they have.

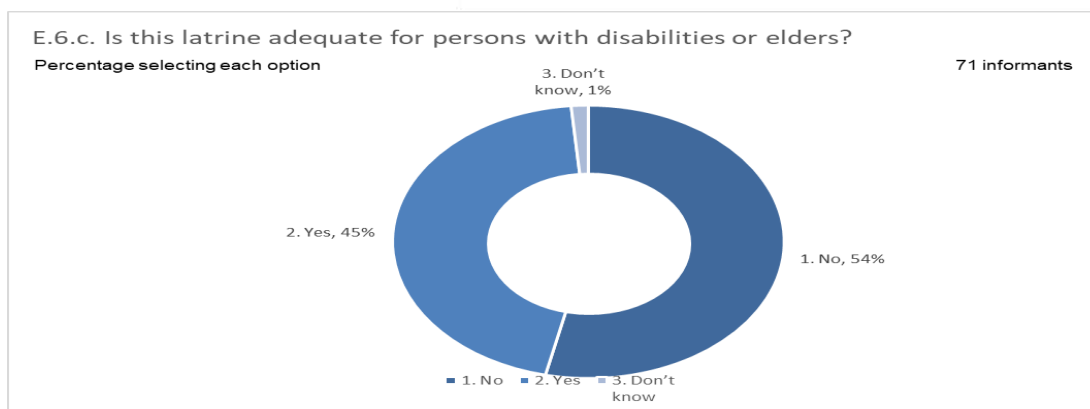


Figure14-availability of latrines for disabled and elderly

Latrine usage: In terms of usage, the enumerators have visited the latrines in the HHs that reported having family latrines and they have observed that 95% of the latrines are used, of which 32% of the latrines were observed to be either full or approaching to be full.

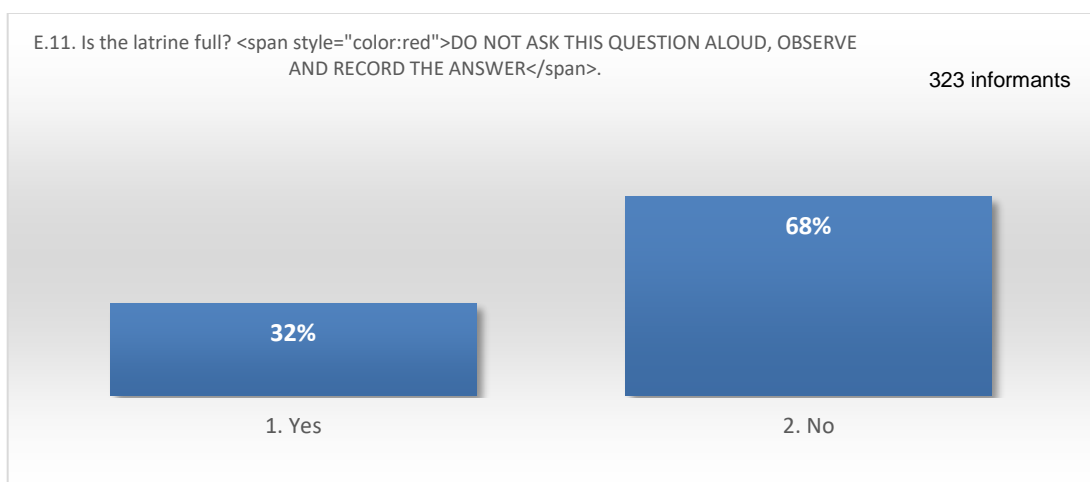


Figure15-coverage of full latrines

Hand washing stations at the latrines: Hand washing station were not available in 76% of the latrines observed.

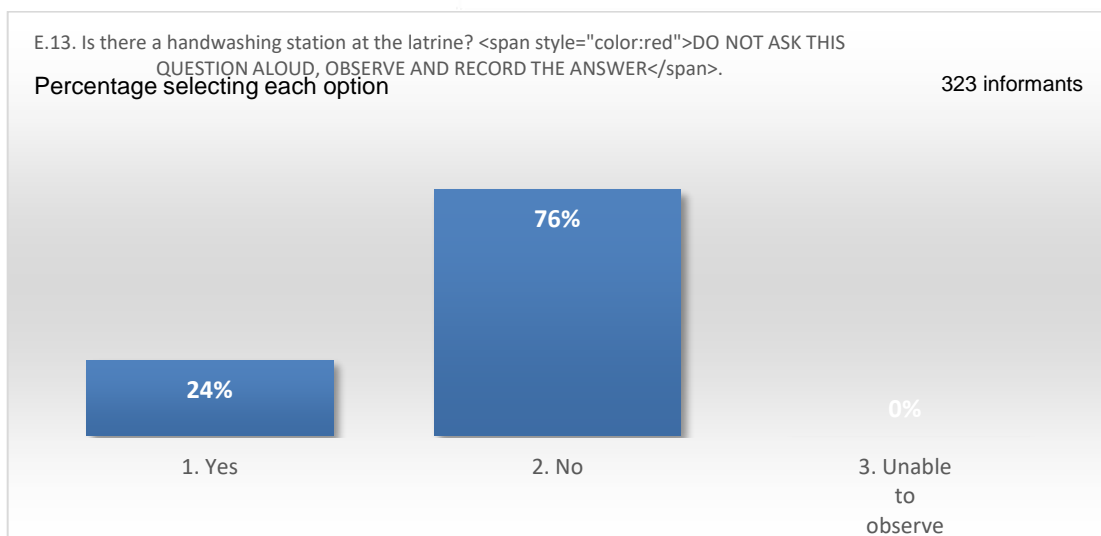


Figure16-Availibility of hand washing stations near latrines

Access to bathing shelter: When the respondents were asked if they have a designated shower/bathing facility at household level, 55% of the respondents reported having a designated shower/bathing facility while 39% of indicated not having a designated bathing facility/The result shows that access to bathing facilities varies per different part/zones of the camp, with Zone C and Transit center showing the lowest coverage.

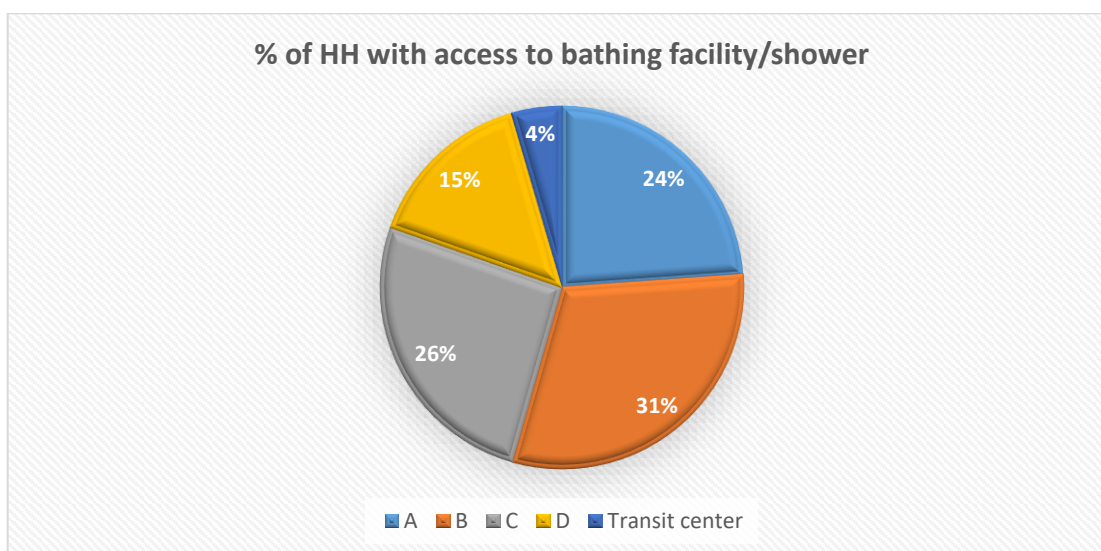


Figure17-Acces coverage of bathing facility

Solid Waste Management: As indicated in the below graph, when the respondents were asked how they dispose of their domestic waste, 37% have reported having household pit, 17% communal latrines, 12% designated open area, 13 % undesignted open area and the remaining respondents reported to either bury or burn the waste.

E.17. Where does your household dispose of domestic waste?

Percentage selecting each option

418 informants

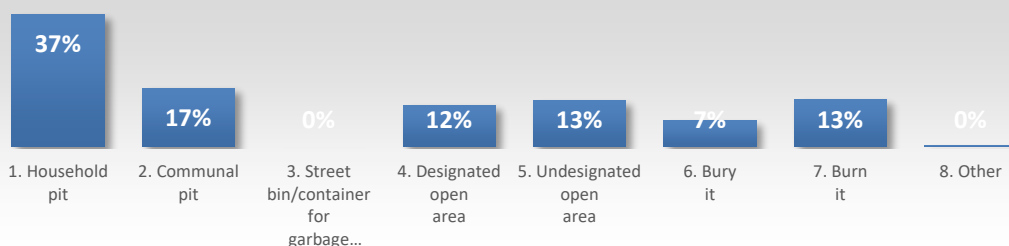


Figure18: Solid waste disposal practice

Though the overall result shows that 53.8% of the HH in the camp have access to solid waste facilities, the result shows variation in coverage per different zones in the camp with Zone A and C having the lowest coverage.

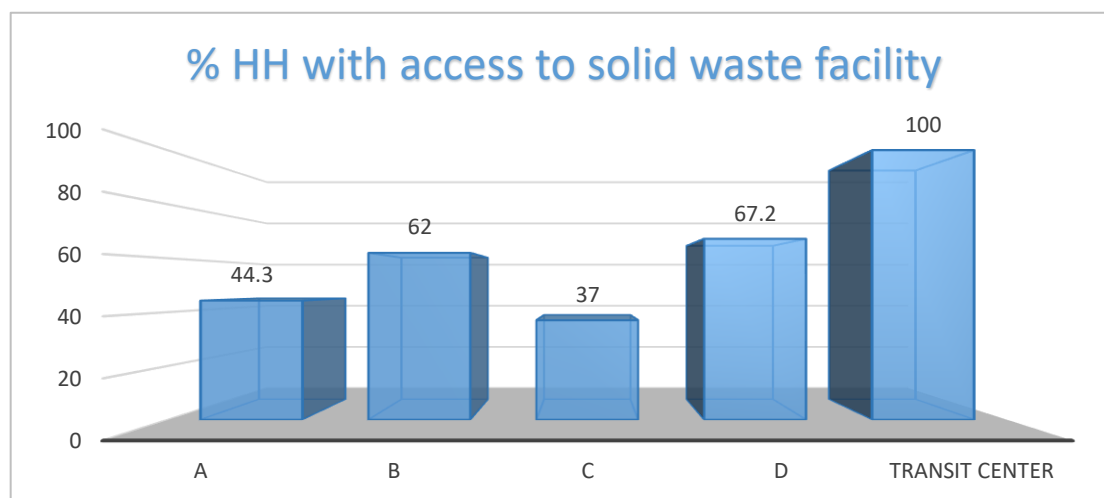


Figure19-Access to solid waste facility

Issues identified

As obtained from the data, overall 81.1% of the HHs in Maratane camp have reported defecating in latrine/toilet and 77.5% of the HH have access to family latrine/toilet of which 85% are pit latrines. Though, this is an encouraging figure, both figures above are under UNHCR standard, which states the coverage to be 85% and above during protracted emergency.

In terms of usage, the result shows that open defecation is practiced by 30.9%⁵ of the HH in the camp and among the main reasons given for such practice is lack of lighting to use latrines during evenings, not having latrine and inaccessibility of latrine because of distance between HH to latrines. The rate of open defecation practice is high and possess significant risk for disease outbreak if it is not addressed.

In addition, from the latrines visited during the survey, 32% were full or approaching to be full within a short time frame. This indicates that the latrine coverage could drop in the coming months if support is not provided to the refugees to construct new latrines or to desludge the latrines that are full.

With regards to privacy of latrines, 41% of the HH interviewed have reported that their latrine does not provide adequate privacy mainly because of infrastructure damage, which is mainly not having proper superstructure or damaged door and also because of safety related issues resulting from lack of key or locks on the WASH facilities. This issue is evident in Transit center where all the communal latrines were having damaged superstructure and doors.

Access to latrine also is a challenge for people with disability and elderly because the latrines at household level are simple pit latrines and as a result, disabled or elderly people are not able to use these latrines, as they are unable to squat because of old age and the type of disability they have.

The overall access to bathing facilities is 57.4% and it is under UNHCR standard for protracted emergency, which states 90%, and above. The situation is similar with access to solid waste facility by HHs to be 53.8%.

Way forward

UNHCR and partner should work to provide assistance to refugees with no access to HH latrine by providing slab and also introducing other cheaper and local friendly designs in order to increase HH latrine coverage. In addition, UNHCR and partner should look at ways to assist the refugees on desludging full latrines or provide assistance to replace full latrines with new ones. Interventions such as cash-for-latrine programmes can be explored to address the mentioned challenges.

UNHCR and partner should consult with representatives of people living with disabilities and the elderly to construct disability friendly latrines for HH with a disabled or elderly family member and/or provide other hygiene keeping materials (senior adult diapers) to reduce vulnerability of such individuals. Disability friendly latrines should also be provide in both primary and secondary schools in the camp.

In transit center, where communal latrines and bathing shelters are the only options to be used, UNHCR and partner should renovate or construct new communal latrines

⁵ This percentage, includes households not having access to latrines as well as households that sometimes practice open defecation because of different reasons

and bathing shelters, which are gender segregated, and have proper doors and locks to ensure that the super structure and doors provide enough privacy for the users.

Hygiene promotion activities should also target on increasing awareness of the refugees about the health problems caused by open defecation and also on proper usage of latrines to reduce such practice by both adults and children.

The WASH strategy should give direction on how to reduce challenges related with access to bathing facility/shower and solid waste management.

HYGIENE PROMOTION

Hand washing: 68% of the respondents were able to show the soap in their HH within one minute while the remaining 28% were not able to show it when asked. As indicated in the graph below the majority (89%) of the HH are dependent on UNHCR soap distribution for accessing soap they are using.

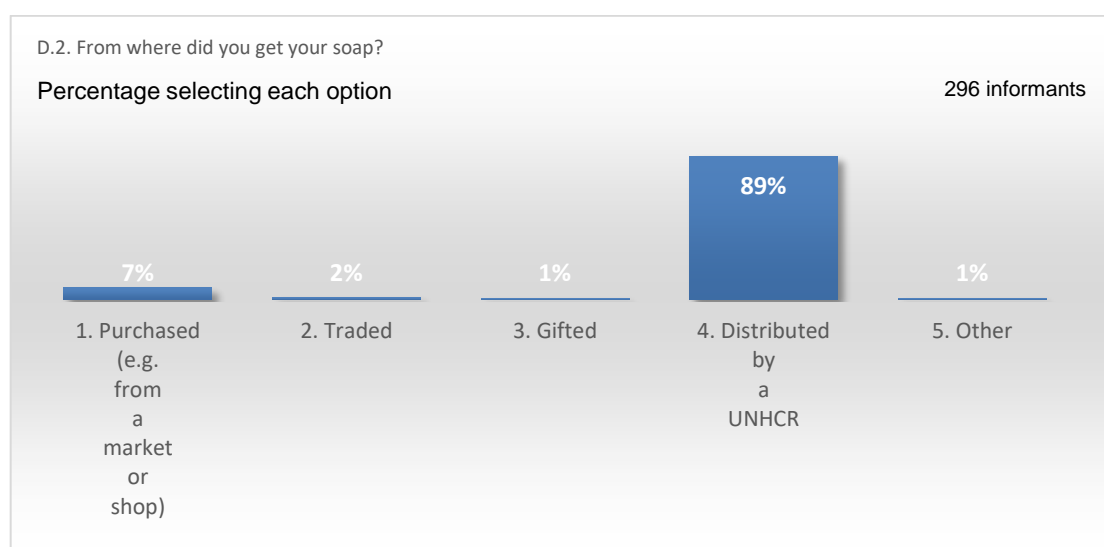


Figure20- access to soap by the refugees

Regarding the respondents knowledge about the critical times of hand washing, the majority of the respondents explained that the critical times for hand washing are before eating (93%), after defecation (87%), before cooking (67%), before feeding children (66%) and before breast feeding (49%).

In terms of the availability of handwashing station at HH level, only 11% of the HH included in the survey reported having a specific handwashing device/station in their HH and soap/ash was present only on 50% of the handwashing stations. The remaining hand washing devices in these HHs does not have soap or water, which indicates that the handwashing station are not properly used. The presence of handwashing stations near latrines are also low with only 24% of the HH interviewed having handwashing stations near their latrines.

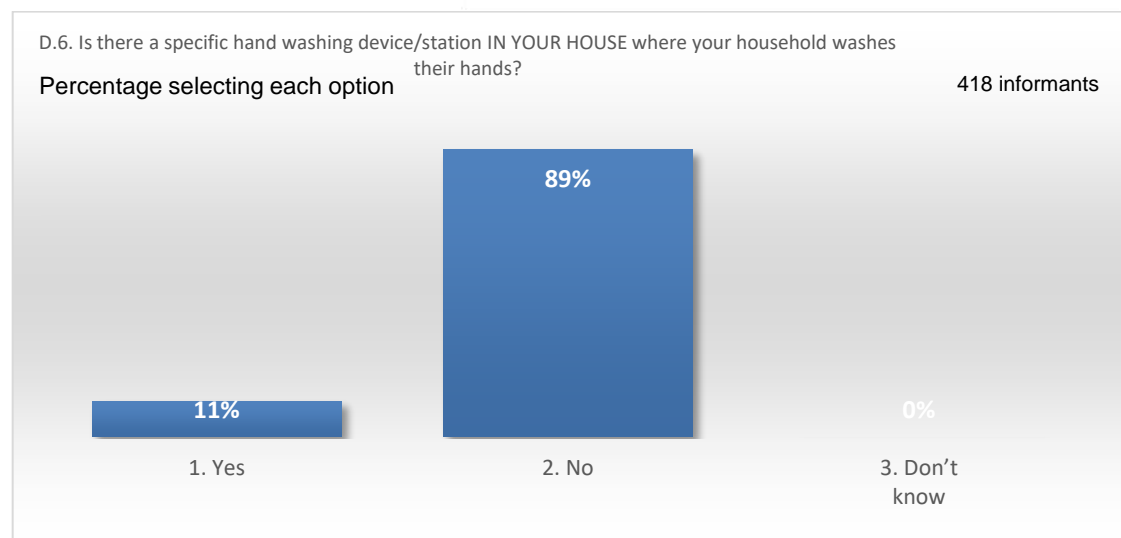


Figure21-Acces to handwashing facility at HH level

Health: The result of the survey shows 22% of adults (above 5 years of age) and 33% of under five children have had diarrhea within the last two weeks before the survey was conducted.

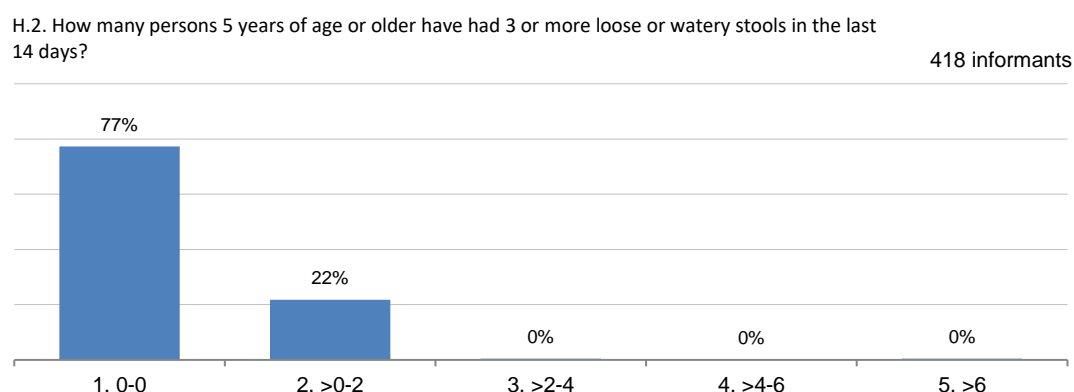


Figure22-prevalence of diarrhea

As indicated below, the result shows variation per different zones of the camp with Zone B having the highest rate diarrhea (33%) among adults followed by Zone C and D with 24%.

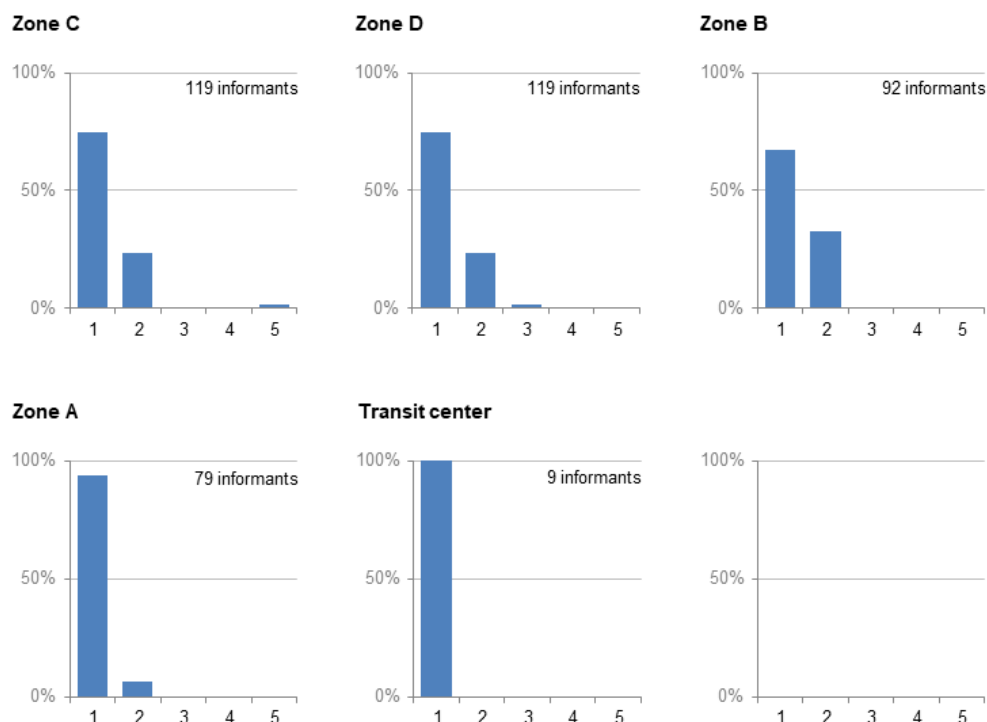


Figure 23-prevalence of diarrhea per zones

Regarding the knowledge of the respondents about the transmission routes for diarrhea, the majority of the respondents answered saying that diarrhea is transmitted through contaminated water (73%), through contaminated or under-cooked food (58%) followed by through flies (53%). Some of the respondents have also claimed that they are getting diarrhea because of the type of food they are given by the agency responsible for food distribution and also as they are eating only one type of food and are not able to eat variety of food.

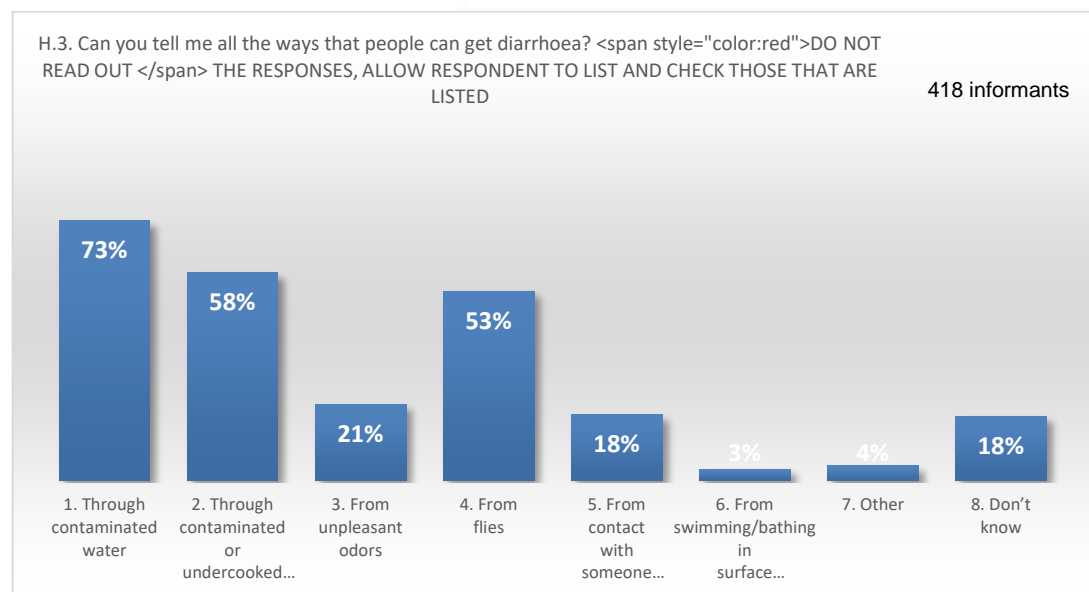


Figure 24- response transmission route of diarrhea

The knowledge regarding the prevention methods of diarrhea is also good as the majority of the respondents were able to mention the main ways for preventing diarrhea. However, the result varies per zones.

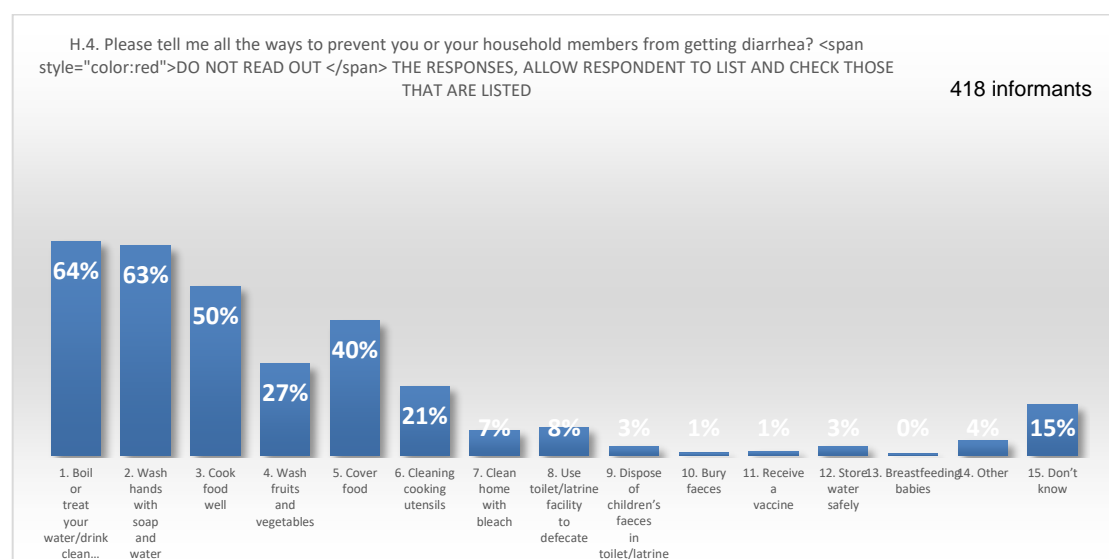


Figure 25- response on prevention method of diarrhea

Hygiene messaging: (67%) of the respondents have reported not being visited by community health worker in the last month. Though 29% of the respondents indicated that they have had a visit from community health worker from the health center in the last month, the reason was because of the rapid assessment carried out by the health center few days before the survey has started.

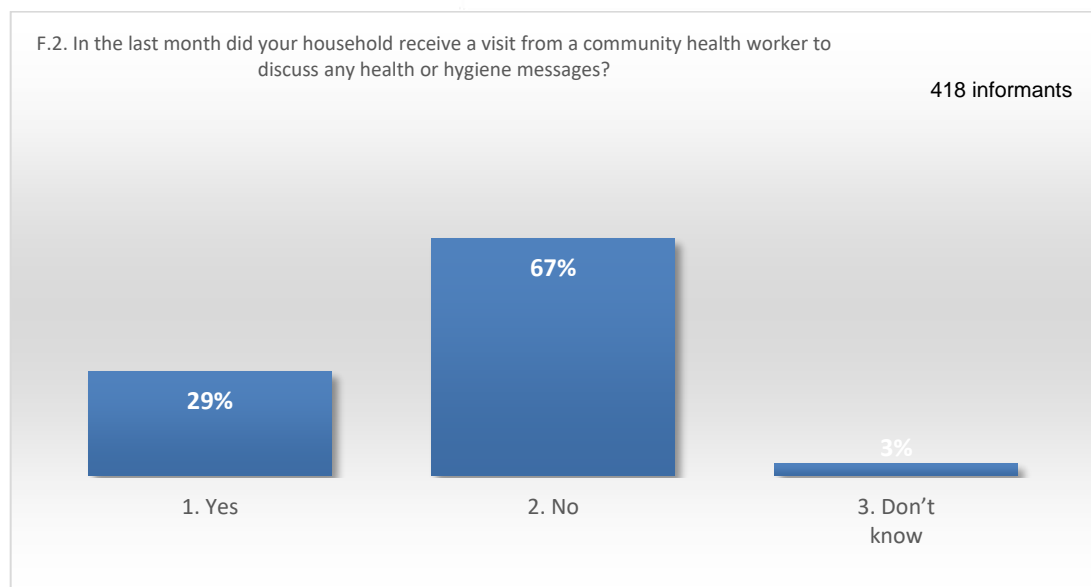


Figure26-Hygiene messaging

Issues identified

The overall coverage of access to soap in the camp is 70.8%, which is under UNHCR standard during protracted emergency, which indicates coverage to 90% and above. The coverage also shows variations per zones in the camp and also significant number of HHs (28%) where not able to show the soap in their HHs during the survey. The reason given by these HHs were the delay on UNHCR distribution of soap and as shown in the survey result almost all HHs (89%) are dependent on UNHCR distributions to get soap to be used in their HHs.

Though the respondent's knowledge on critical handwashing time is fairly good, access to handwashing station both at the HH and near to latrines was very low which might indicates handwashing practice to be low.

The result of the survey shows significant rate of prevalence of diarrhea in the camp with 22% of adults (above 5 years of age) and 33% of children under five having diarrhea within the last two weeks. With regards to the knowledge of the respondents on the transmission route and prevention methods of diarrhea, the result shows respondents knowledge to be fairly good. Nevertheless still significant number of the respondents lack knowledge on the transmission routes and prevention methods.

As shown in the data obtained, there is no hygiene promotion work in the camp, and the refugees are not mobilized to be aware or take responsibility in improving their health.

Way Forward

UNHCR should have a regular distribution schedule to constantly replenish soap for refugees as per UNHCR standards. A cash based approach can also be considered for distribution of soap in the camp.

UNHCR and WASH partner should start hygiene promotion program in the camp and should establish a staffing structure as per UNHCR standard for protracted emergency⁶, which will help to mobilize the refugees and increase their awareness on various areas.

Appropriate communication plan should be developed to mobilize all segment of the community in the camp, which should also include HP intervention in schools and health institutions in the camp

MENSTRUAL HYGIENE MANAGEMENT

From the HH included in the survey, 18 % of the respondents have reported not having any women or girl within the reproductive age (15-49years) in their family and 1% have declined to answer this part of the survey when asked for consent. The remaining HH interviewed have confirmed having women/girls within the reproductive age in their family and have given consent to respond to this part of the survey.

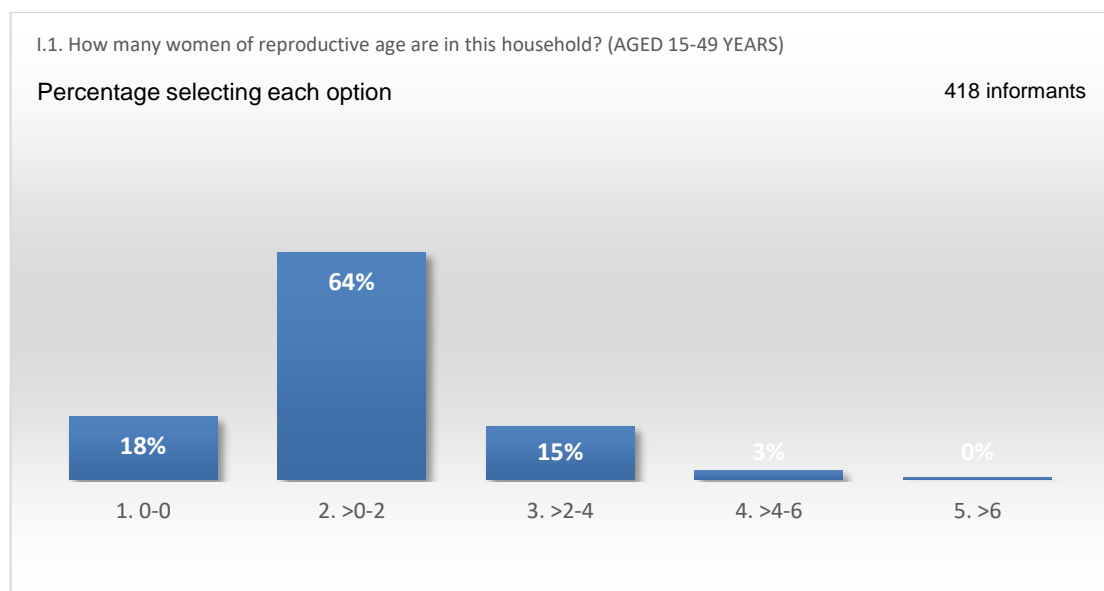


Figure27-HHs with women/girls within reproductive age

⁶ 1 community mobilizer :for 1000 individuals

The majority of the respondents (88%) have reported using disposable pad during their last monthly period followed by cotton (12%) and reusable cloth (8%) while the remaining HH have reported using reusable pad (2%), Tampon (3%) and layers of underwear (1%).

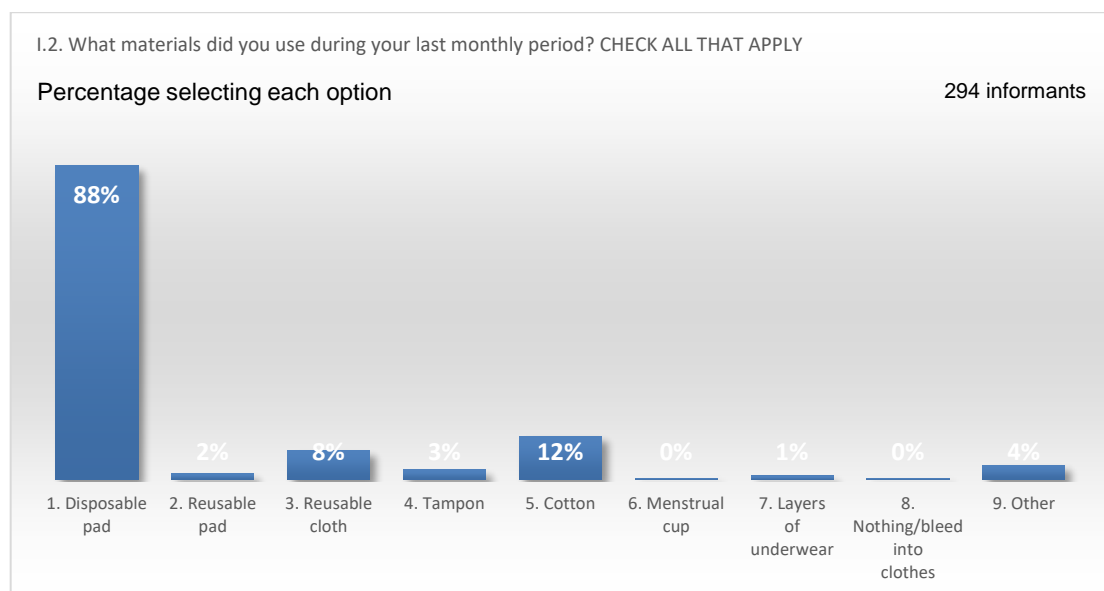


Figure28-MHM materials used in the camp

With regards to preference of women on which MHM material to use, the majority of the respondents(71%) have reported that they are comfortable to using disposable pads while the remaining has mention other items as indicated in the graph below

I.3. Would you rather have used something else?

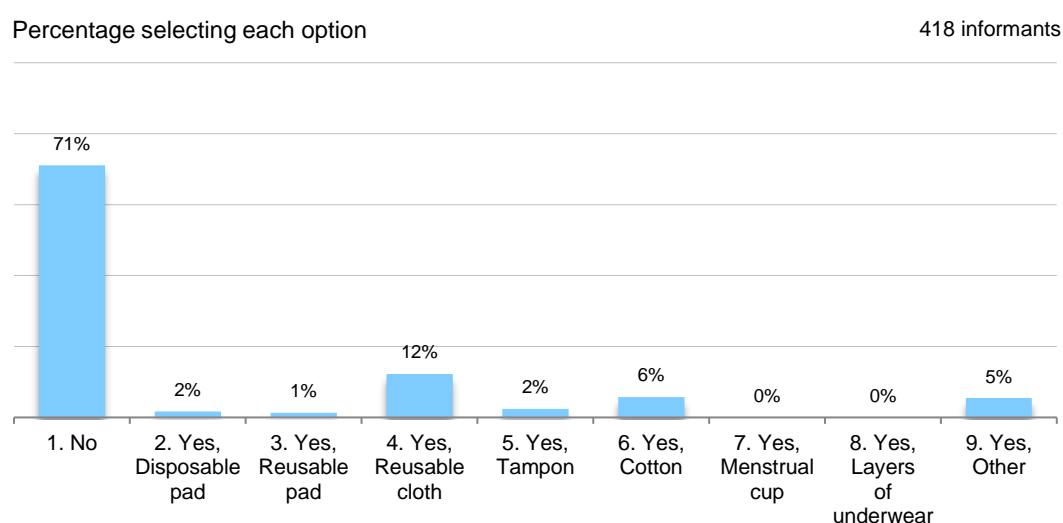


Figure29-women preference on MHM materials

With regards to privacy of women for being able to wash and change their menstrual hygiene products at home during their period, 89% reported getting privacy to change at home. The situation is different for girls in schools, which shows that 53% does not have a place to wash and change during their period.

I.4.b. During your last menstrual period were you able to wash and change in privacy while at work or school?

Percentage selecting each option

294 informants

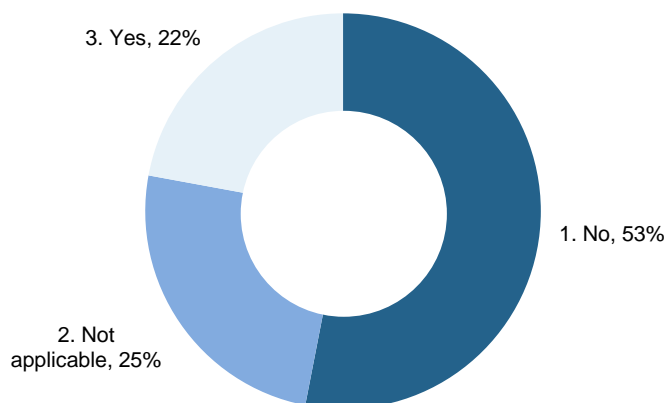


Figure30-privacy of female students to change and wash at school

With regards to availability of toilet paper/cleansing water for women to wash and change their menstrual hygiene management products, 67% of the women reported having access to such items to keep their hygiene.

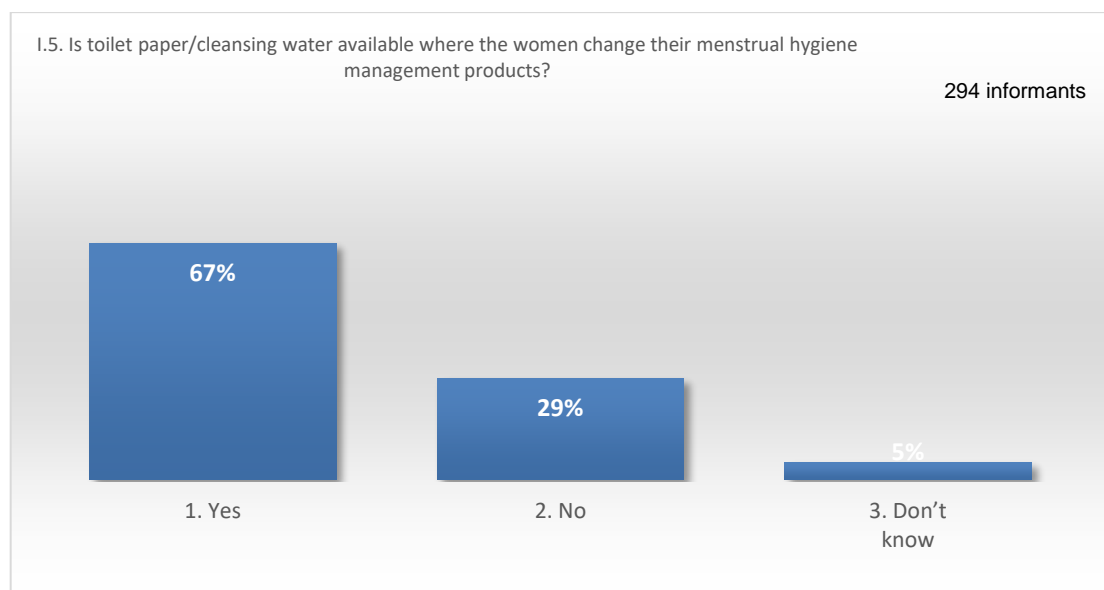


Figure31-Availability of hygiene keeping materials for menstrual hygiene

Issues identified

As the result shows, the majority of the women in the camp use disposable pads distributed by UNHCR for menstrual hygiene management. During the interview, most respondents have complained for not having enough materials to be used during their monthly period since UNHCR distribution sometimes delays and also the quantity of disposable pads distributed per HH is not sufficient. This was especially raised in HHs having more than one women/Girls within reproductive age that have said that the quantity distributed is not enough to be used by them and for their female children.

Though, most of the women included in the survey have indicated that they are comfortable and prefer using disposable pads during their period, this might have resulted as most women are dependent on UNHCR distribution of disposable pads and do not have the choice or knowledge on the other available materials listed⁷. In addition, the disposable pads also pose challenges for the solid waste management in the camp.

As indicated in the result, though most women are able to wash and change in privacy in their households, still significant number of women (29%) have expressed that they do not have the privacy to change at home. The result also shows women /girls attending schools do not have the privacy to wash and change their menstrual hygiene products in the schools.

Way Forward

UNHCR team responsible for distribution of these MHM materials (community service) should coordinate with the WASH partner and conduct a survey to verify the correct number of women within reproductive age in each HH in the camp and the result can be used for distributing sufficient number of disposal pads for women throughout the camp.

Focus group discussions should be made with women that expressed challenges (29%) on not having privacy to be able to wash and change their menstrual hygiene products at home.

Distribution schedules should be planned in regularly to avoid the challenge/complain raised by women on irregular distribution schedule.

UNHCR should consider other option, which include cash based distribution to give women the option of choosing the type of MHM materials they use. In addition since

⁷ This information was obtained from the data collectors during the debriefing session conducted at the end of each survey day.

managing the waste generated as a result of disposable pads is challenging, consideration should be given to distribute reusable pads⁸.

UNHCR and partner should provide WASH facilities (latrines) for female students attending school to be able to wash and change their menstrual hygiene management product in schools since this has an effect in schools attendance of the girls during their period.

⁸ Post distribution monitoring and focus group discussion with women should be conducted to get feedback on the preference of women on which MHM materials to use to make informed decision on regarding this issue.

Annex1: Result in terms of global indicator

1 - Global Indicators

Legend on computed indicators' colors:	Main indicators for the surveyed population							Secondary indicators for the surveyed population			
Above Emergency and Post-Emergency Standards level	1 - Average liters of potable water/per person/per day collected at HH level	2 - % HHs with at least 10 L/p protected water storage capacity	3 - % HHs collecting drinking water from protected/treated sources	4 - % HHs with family latrine/toilet	5 - % HHs reporting defecating in a toilet/latrine	6 - % HHs with access to soap	7 - % HHs with access to solid waste disposal facility	8 - % HHs with access to a specific hand-washing device	9 - % respondents knowing at least 3 critical moments when to wash hands	10 - % HHs practicing open defecation. **Includes defecating in the bush at night.	11 - % HHs having access to a bathing facility
Between Emergency and Post-Emergency Standards level											
Below Emergency and Post-Emergency Standards level											
Emergency Standards	≥ 15	≥ 70%	≥ 70%	-	≥ 60%	≥ 70%	≥ 70%	≥ 70%	≥ 60%	0%	≥ 70%
Post Emergency Standards	≥ 20	≥ 80%	≥ 95%	≥ 85%	≥ 85%	≥ 90%	≥ 90%	≥ 90%	≥ 80%	0%	≥ 90%
Population surveyed (dataset 1)	17.4	75.8%	99.8%	77.5%	81.1%	70.8%	53.8%	11.0%	90.7%	30.9%	57.4%

Annex 2: Map of sample households



Annex3: Average water collected at households level (L/P/D)

