MULTI-SECTOR NEEDS ASSESSMENT

Full Report 2026

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LIST OF ACRONYMS

Acronym	Full Term
ANC	Antenatal Care
CARI	Consolidated Approach to Reporting Indicators of Food Security
CHW	Community Health Worker
CI	Confidence Interval
CMAM	Community-based Management of Acute Malnutrition
CVA	Cash and Voucher Assistance
FAO	Food and Agriculture Organization
FCS	Food Consumption Score
FES	Food Expenditure Share
FGD	Focus Group Discussion
FSI	Food Security Index
GAM	Global Acute Malnutrition
HH	Household
HHH	Head of Household
ICS	Innovation Consulting & Solutions
IDDS	Individual Dietary Diversity Score
IDP	Internally Displaced Person
IFA	Iron and Folic Acid
IYCF	Infant and Young Child Feeding
JMP	Joint Monitoring Programme
KAP	Knowledge, Attitudes, and Practices
LCSI	Livelihood Coping Strategy Index
MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MDD	Minimum Dietary Diversity
MDD-W	Minimum Dietary Diversity for Women
MEAL	Monitoring, Evaluation, Accountability & Learning

MEL	Monitoring, Evaluation, and Learning
MIYCN	Maternal, Infant and Young Child Nutrition
MMF	Minimum Meal Frequency
MPC	Multi-purpose Cash
MSNA	Multi-Sector Needs Assessment
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organization
OR	Odds Ratio
PLW	Pregnant and Lactating Women
rCSI	Reduced Coping Strategy Index
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SDG	Sustainable Development Goal
TOR	Terms of Reference
U5	Under 5 (Children under 5 years of age)
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WGSS	Washington Group Short Set (disability indicators)
WHO	World Health Organization

ACKNOWLEDGEMENTS

This Multi-Sector Needs Assessment (MSNA) reflects the collaborative efforts of GOAL, its partner organisations, and Innovation Consulting & Solutions (ICS). We would like to express our sincere appreciation to GOAL for leading the design of the assessment tools, managing and coordinating the data collection process, and working closely with partners to ensure field implementation across the assessed governorates.

We are especially grateful to the partner organisations, enumerators, supervisors, and field teams whose dedication made large-scale data collection possible under complex operational conditions. We also extend our thanks to the households and community members who participated in the assessment and shared their experiences and perspectives.

Innovation Consulting & Solutions (ICS) was responsible for analysing the dataset, interpreting the findings, drafting the report, and formulating the recommendations. We hope this report will contribute to more effective, evidence-based, and vulnerability-sensitive humanitarian programming in Syria.

EXECUTIVE SUMMARY

This Multi-Sector Needs Assessment (MSNA) provides a broad evidence base on food security, nutrition, and WASH conditions across 11 governorates of Syria at a time of continued humanitarian fragility. The raw dataset comprised 6,687 household interviews across 44 districts; following data cleaning and quality assurance, the final analytical dataset included 5,302 households across 39 districts.

Overall, 91% of households surveyed were classified as food insecure, of which 44% were moderately or severely food insecure according to the Consolidated Approach to Reporting Indicators of Food Security (CARI) framework. Food insecurity is driven less by physical food availability than by affordability: 44% of households reported relying on cheaper or less preferred foods, 22% reduced the number of meals eaten, and 36% spent more than half of total household expenditure on food. Half of all households were using Crisis or Emergency livelihood coping strategies, indicating that many are meeting current food needs only by eroding future resilience. Severity was particularly high in As-Salamiyeh (Hama), Abu Kamal (Deir-ez-Zor), Hama district (Hama), Al Makhrim (Homs), Ar-Rastan (Homs), and As-Suqaylabiyah (Hama). Female-headed households, households headed by persons with disabilities, and internally displaced persons (IDPs) consistently showed worse food security outcomes than comparison groups.

Nutrition findings point to substantial dietary vulnerability. Among children aged 6–23 months, only 18% met the Minimum Acceptable Diet standard, with low dietary diversity emerging as the principal constraint. Among assessed women, only 31% met Minimum Dietary Diversity for Women. Infant feeding practices were mixed: while 82% of infants aged 0–5 months were reportedly breastfed in the previous 24 hours, only 31% were breastfed within the first hour after birth, and 39% received pre-lacteal feeding. Broader nutrition results, together with qualitative evidence, indicate meaningful nutritional risk and significant barriers to treatment access.

WASH findings reveal relatively high headline access to basic services, but serious weaknesses in reliability, infrastructure quality, and environmental health. Using strict World Health Organization (WHO)/ United Nations Children's Fund (UNICEF) Joint Monitoring Programme (JMP) 2017 definitions, 78% of households accessed an improved water source, but 22% relied primarily on water tankers. More importantly, 57% of households reported interruptions to water supply in the previous three months, and 14% experienced frequent interruptions. Sanitation coverage was high overall, yet specific districts showed major gaps, including no-toilet access in As-Sweida district (As-Sweida) and severe open sewage problems in Al-Qusayr (Homs), Tall Kalakh (Homs), Darayya (Rural Damascus), and Al Bab (Aleppo). Solid waste collection was absent for 27% of households, and hygiene promotion coverage was extremely low at just 9%. Diarrhoea prevalence among households with children under five was 14% overall, with major hotspots in Darayya (Rural Damascus), Abu Kamal (Deir-ez-Zor), Al-Haffa (Lattakia), Ar-Rastan (Homs), and Harim (Idleb).

The assessment recommends an integrated, area-based response that combines food security, nutrition, and WASH interventions in the districts with the highest severity, particularly As-Salamiyeh (Hama), Abu Kamal (Deir-ez-Zor), Hama district (Hama), Al Makhrim (Homs), Ar-Rastan (Homs), and As-Suqaylabiyah (Hama). Given that affordability rather than food availability is the main driver of need, unrestricted cash and voucher assistance should be prioritised and regularly adjusted to market prices, while also covering essential non-food needs. Programmes should explicitly prioritise female-headed households, households headed by persons with disabilities, and IDP households, as these groups consistently face more severe food insecurity, weaker dietary outcomes, and greater access barriers across sectors.

To prevent further erosion of resilience, emergency assistance should be complemented by livelihoods support, especially in areas where Crisis and Emergency coping strategies are widespread. Small-scale income-generating activities, home-based businesses, and women-friendly livelihoods opportunities should be promoted to reduce reliance on negative coping such as child labour, school dropout, and distress borrowing. For returnees, integrated support packages that combine food assistance, livelihood recovery, and rehabilitation of basic services are particularly important.

In nutrition, the response should expand community-based malnutrition screening and treatment, especially in districts where poor child dietary diversity and treatment barriers are most acute. Nutrition services should be made more accessible through community outreach, home-based approaches, and financial support to offset treatment and transport costs. Infant and young child feeding interventions should focus on reducing pre-lacteal feeding, promoting early breastfeeding initiation, and improving complementary feeding through a combination of counselling and support for access to diverse foods. Maternal nutrition should also be strengthened through improved iron and folic acid supplementation, better access to antenatal care, and targeted support in districts with the lowest dietary diversity among women.

In WASH, the priority is to rehabilitate water systems in districts with poor network access and frequent interruptions, while reducing dependence on water trucking. Immediate sanitation improvements are needed in areas with severe open sewage problems and in IDP settings where toilet access remains inadequate. Solid waste management services should be expanded in underserved districts, particularly where collection systems are weak or absent. Hygiene promotion should be urgently scaled up, especially in diarrhoea hotspots, using trusted community-based channels and female outreach workers.

Across all sectors, programmes should be designed as integrated packages rather than stand-alone interventions. Districts facing overlapping food insecurity, dietary vulnerability, and WASH deficits should receive combined assistance that addresses the full set of household needs. Finally, future monitoring should strengthen district-level tracking of food security trends and improve nutrition measurement, particularly MUAC data collection, to support more precise targeting and more robust evidence for programme adaptation.

1. INTRODUCTION AND BACKGROUND

1.1 CONTEXT

Syria's humanitarian context in 2024–2025 was shaped by overlapping crises: protracted conflict, mass displacement, economic collapse, the deterioration of essential services, and further compounded by the political transition that followed the fall of the Assad government in December 2024. While this transition generated cautious hope for recovery, humanitarian needs remained severe across sectors. This MSNA was conducted across 11 governorates to provide district-level evidence on food security, nutrition, and WASH needs.

The political transition did not result in immediate humanitarian relief. In 2025, the United Nations (UN) estimated that 16.5 million people required assistance, while damaged infrastructure, weak electricity supply, and disrupted public services continued to affect daily life[1]. At the same time, insecurity persisted, with clashes in Aleppo governorate and northeast Syria continuing to drive displacement and constrain humanitarian access into early 2026[2]. The evacuation of major displacement sites, including al-Hol camp, also introduced additional protection risks[3].

Displacement remained one of the defining characteristics of the crisis. In 2025, around 7.2 million people were internally displaced, while refugee and return movements increased significantly[4]. United Nations High Commissioner for Refugees (UNHCR) projected up to one million refugee returns in 2026, in addition to large-scale returns already underway since late 2024[5]. However, return conditions remained difficult, as many households faced damaged infrastructure, weak services, and limited livelihood opportunities[6]. These dynamics are central to this MSNA, which disaggregates findings by host community, IDP, and returnee status.

Food insecurity remained widespread and severe. Only a small proportion of households were considered food secure, with displacement-affected populations among the most vulnerable[7]. By 2025, UNICEF estimated that 14.6 million people were experiencing food insecurity, while World Food Programme (WFP) estimated that 9.1 million people were food insecure[8]. This was driven by economic collapse, drought, reduced agricultural production, damaged irrigation systems, and funding shortfalls in food assistance[9].

[1] UNICEF (2025). Syria Humanitarian Situation Report — Mid-Year 2025. https://www.unicef.org/media/173091/file/Syria-Humanitarian-SitRep-Mid-Year-2025.pdf
[2] OCHA (2026). Flash Update No. 2 — Humanitarian Situation in East Syria, 26 January 2026
[3] UNHCR (2026). Al-Hol Camp Operational Update. https://data.unhcr.org/en/documents/details/121289
[4] ReliefWeb / WHO (2026). Syria WHO Health Emergency Appeal 2026. https://reliefweb.int/report/syrian-arab-republic/syrian-arab-republic-who-health-emergency-appeal-2026
[5] UNHCR (2026). Operational Update Syria, January 2026. https://reliefweb.int/report/syrian-arab-republic/operational-update-syria-january-2026
[6] OCHA (2026). Flash Update No. 2 — Humanitarian Situation in East Syria, 26 January 2026. https://www.unocha.org/publications/report/syrian-arab-republic/flash-update-no-2-humanitarian-situation-east-syria-26-january-2026
[7] ReliefWeb (2025). Syrian Arab Republic: Humanitarian Overview Issue No. 1, October 2025. https://reliefweb.int/report/syrian-arab-republic/syrian-arab-republic-humanitarian-overview-issue-no-1-october-2025-enar
[8] WFP (2025). Syria Country Brief. https://www.wfp.org/countries/syrian-arab-republic
[9] WFP (2025). WFP Syria External Situation Report, December 2025. https://reliefweb.int/report/syrian-arab-republic/wfp-syria-external-situation-report-december-2025

Malnutrition remained a serious public health concern, particularly for children under five and PLW[10]. Although nutrition services expanded in 2025, they remained constrained by limited funding and access challenges. For this reason, the MSNA includes household-level nutrition indicators such as Mid-Upper Arm Circumference (MUAC), Minimum Acceptable Diet (MAD), Minimum Dietary Diversity for Women (MDD-W), and Maternal, Infant and Young Child Nutrition (MIYCN) Knowledge, Attitudes, and Practices (KAP) to support district-level programming. Health services remained overstretched throughout 2024–2025, with disease outbreaks, gaps in therapeutic nutrition services, and weak health system recovery compounding vulnerability[11].

WASH conditions also remained fragile. Water and sanitation systems in many areas continued to operate below capacity, while shortages in funding affected chlorination, water trucking, and sanitation services[12]. These challenges were especially acute in conflict-affected and returnee areas, damaged infrastructure increased health risks and vulnerability.

Across sectors, the humanitarian response combined emergency assistance with resilience-oriented support, including cash, voucher assistance, and livelihood recovery. However, persistent funding shortfalls continued to limit the scale and sustainability of the response.

1.2 PURPOSE AND SCOPE

The primary purpose of this MSNA is to generate rigorous, actionable evidence on the food security, nutrition, and WASH needs of communities across assessed areas of Syria. These sectors were selected because the humanitarian situation continues to create particularly acute and interlinked vulnerabilities affecting household well-being, service access, and coping capacity. In addition, the assessment seeks to understand the relationship between household food security and the nutritional status of children aged 6–59 months and PLW, and to identify barriers to accessing and adhering to malnutrition treatment. These objectives are described in detail in the following section.

The assessment achieved broad geographic reach across Syria, covering 11 governorates. The raw dataset included 6,687 household interviews conducted across 44 districts. Following data cleaning and quality assurance, the final analytical dataset comprised 5,302 household interviews across 39 districts. This represents substantial coverage in the Syrian context and provides a strong evidence base for district-level analysis.

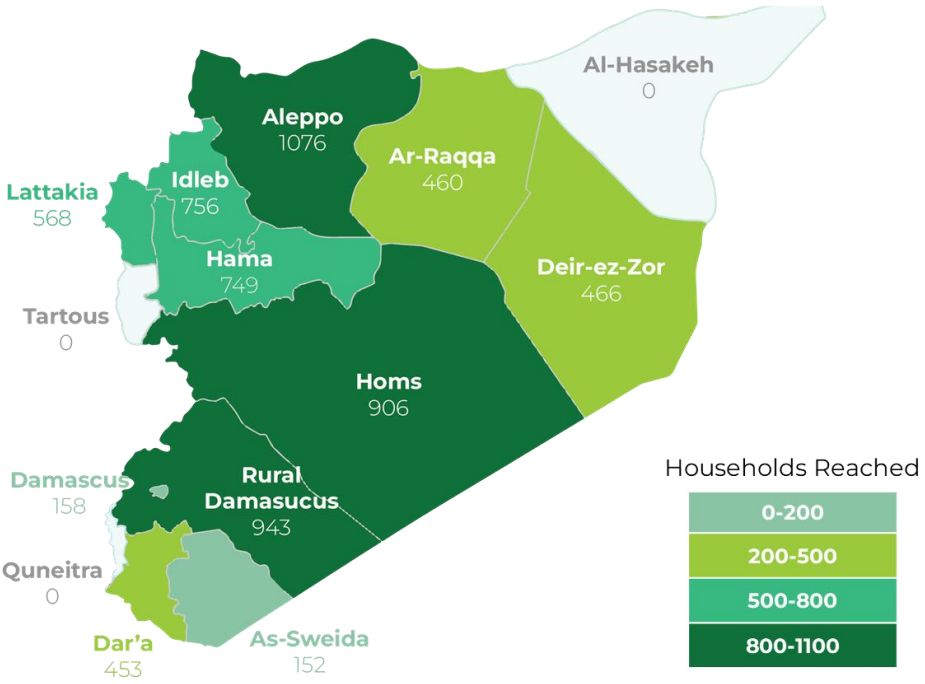
Within this wider scope, a distinct geographic emphasis is placed on estimating the prevalence and severity of food insecurity and malnutrition in Idleb governorate and North Aleppo. Findings for these two areas are therefore given particular prominence throughout the report, while results for other governorates are presented separately at district level in line with the final cleaned sample and to preserve the integrity of the analytical approach.

[10] UNICEF (2025). Syrian Crisis Emergency Overview. https://www.unicef.org/emergencies/syrian-crisis
[11] WHO Health Cluster (2025). Syria Health Sector Bulletin, August 2025. https://healthcluster.who.int/publications/m/item/syria-health-sector-bulletin-august-2025
[12] ReliefWeb / IFRC (2025). Complex Emergency Syria — Flash Update 1, North–Northeast Escalation (MDRSY014). https://reliefweb.int/report/syrian-arab-republic/complex-emergency-syria-flash-update-1-north-northeast-escalation-mdrsy014

Table 1: Distribution of Surveyed Households by Governorate and Number of Districts

Governorate	District	#	Governorate	District	#
Homs	Tadmor	145	Hama	Muhradah	150
	Tall Kalakh	143		Masyaf	147
	Ar-Rastan	142		Hama	144
	Al-Qusayr	106		As-Suqaylabiyah	140
	Al Makhrim	102		As-Salamiyeh	117
Idleb	Idleb	156	Aleppo	Jebel Saman	142
	Jisr-Ash-Shugur	151		Afrin	134
	Al Ma'ra	149		As-Safira	132
	Harim	149		A'zaz	131
	Ariha	138		Al Bab	109
Rural Damascus	Yabroud	149	Deir-ez-Zor	Al Mayadin	144
	Darayya	128		Abu Kamal	123
	Duma	118		Deir-ez-Zor	105
	An Nabk	101	Ar-Raqqa	Ath-Thawrah	155
Dar'a	Dar'a	156		Ar-Raqqa	149
	Izra'	149		Tell Abiad	137
	As-Sanamayn	149	As-Sweida	As-Sweida	131
Lattakia	Lattakia	207	Damascus	Damascus	146
	Jablah	106			
	Al-Haffa	50			

Figure 1: Sampling map at district level



Each district constitutes an independent sampling domain. Any cross-district or governorate-level summaries are presented as pooled estimates and are clearly labelled; deviations from the targeted district sample size are documented in the Limitations section.

1.3 ASSESSMENT OBJECTIVES

The MSNA is structured around four objectives. Each objective carries specific analytical and reporting obligations and maps to a corresponding section of this report.

Objective 1 — Estimate the prevalence and severity of food insecurity and malnutrition, and identify the main contributing factors, with a focus on Idleb and North Aleppo.

Objective 2 — Measure the strength of association between household food security status and the nutritional status of children aged 6–59 months and PLW.

Objective 3 — Identify barriers to accessing and adhering to malnutrition treatment among households with malnourished children (6–59 months) and PLW, and assess the financial burden of treatment on affected households.

Objective 4 — Assess WASH vulnerabilities and gaps, including access to clean water, sanitation, and hygiene services, and identify opportunities for improvement and sustainability.

2. METHODOLOGY

The MSNA employed a cross-sectional, mixed-methods design combining a representative quantitative household survey with an embedded qualitative component in the form of Focus Group Discussion (FGDs). This approach was selected to meet the distinct analytical demands of the four assessment objectives: the quantitative survey provides district-representative, statistically reliable estimates of indicator prevalence across all assessed governorates; the FGDs provide explanatory depth, triangulation of quantitative patterns, and community-level insight into barriers and dynamics that survey data alone cannot capture.

Gender, disability, and household type in the study design

The sampling design explicitly required identification of household head gender and disability status (via the Washington Group Short Set) at the point of data collection. FGD sessions included persons with disabilities where possible, and participant selection criteria encouraged inclusion across sex, age, and displacement status. These design choices are reflected consistently in the disaggregated analysis presented throughout the findings.

2.1 SAMPLING DESIGN

2.1.1 Sampling Frame and Unit

The household was the primary sampling unit across 44 districts. Population frames were derived from community-identified household lists and available administrative records, supplemented where necessary by community-level mapping. Households were selected using random sampling from these frames, ensuring equal probability of selection within each sub-district. Following data cleaning and application of quality thresholds, the final analytical dataset retained 5,302 household interviews across 39 districts.

2.1.2 Sample Size and Domain

Table 2: Sample methodology

Parameter	Value
Sampling domain	District (independent sample per district)
Confidence level	95%
Margin of error	8%
Target HH per district	151 households
Total districts	44 districts
Total target sample	6,644 households
Actual sample achieved	6,687 completed surveys. The full cleaned dataset contains 5,302 records.

2.2 DATA COLLECTION TOOLS

Data collection combined a structured quantitative household questionnaire with a qualitative FGD guide. Both instruments were administered in Arabic by trained enumerators affiliated with GOAL and seven partner Non-Governmental Organization (NGOs) — Aid Gate Organization (AGO), Elaf Relief and Development (Elaf RD), Hand in Hand for Aid and Development (HiHFAD), Action for Humanity (AFH), Ihsan Relief and Development (Ihsan RD), Shafak, and Takaful Al Sham (TAS) — under the oversight of the GOAL MEL team. The instruments covered the following thematic areas:

Table 3: Data Collection Tools

Module	Key indicators / content
Household demographics	HH size and composition by sex and age; head of household gender, age, marital status; displacement status (host community, IDP, returnee); disability screening using Washington Group Short Set (WGSS)
Food security	Food Consumption Score (FCS) 7-day recall by food group; Reduced Coping Strategy Index (rCSI) 7-day frequency of five stress behaviours; Livelihood Coping Strategy Index (LCSI); food and non-food expenditure (7-day, 30-day, 6-month) as CARI inputs
Nutrition	Mid-Upper Arm Circumference (MUAC) — children 6–59 months and PLW; exclusive breastfeeding (children 0–5.99 months); Minimum Acceptable Diet (MAD) and Minimum Diet Diversity (children 6–23 months); Minimum Dietary Diversity – Women (MDD-W) / Individual Dietary Diversity Score (IDDS); MIYCN Knowledge, Attitudes, and Practices (KAP); malnutrition treatment access, uptake, and cost
WASH	Primary drinking water source and treatment; sanitation facility type and usage; solid waste disposal method; diarrhoea morbidity (2-week recall); water service fee payment and affordability

Note on gender and disability in data collection tools: The household questionnaire explicitly captures respondent sex, head of household sex, and disability status of the head of household and other household members using the Washington Group Short Set. FGD participant selection criteria stipulated inclusion of persons with disabilities and participation across sex and age groups. These design decisions enable the disaggregated analysis of needs by gender, disability status, and household type that is required by the TOR and applied consistently throughout the Findings section.

2.1.3 Qualitative Data Collection — Focus Group Discussions (FGD)

FGDs were conducted in Dar'a, As-Sweida, Hama, Aleppo, and Idleb governorates between 23 and 29 December 2025. Sessions were facilitated using a structured FGD guide organized around thematic areas directly linked to the assessment objectives, covering service access and equity, humanitarian assistance coverage and targeting, WASH gaps, and community-level social dynamics.

Sessions were disaggregated by sex where operationally possible to allow participants to discuss sensitive topics, including gender-differentiated access to resources and services, in a safe environment. Facilitators recorded responses in Arabic, and notes were reviewed and summarized by the GOAL MEL team.

2.1.4 Data Management and Quality Assurance

Quantitative data were collected digitally using CommCare and submitted to a central server managed by the GOAL MEL team. Primary data cleaning and initial quality review were conducted by the GOAL MEL team prior to handover to the ICS analysis team. The ICS analysis team applied the following additional quality assurance steps prior to analysis:

- Review of the dataset for completeness, duplicate records, and out-of-range values for key indicators (FCS component days, MUAC measurements, rCSI frequencies);
- Cross-checking of achieved sample sizes against the target of 151 households per district, with deviations flagged and documented;
- Consistency checks between related variables (e.g., CARI component inputs, household composition totals);
- Alignment of variable labels and response codes against the data collection tool, conducted with GOAL MEL team support to resolve ambiguities arising from Arabic-language data collection.

2.3 ANALYTICAL APPROACH

Quantitative analysis was conducted in Excel and PowerBI, Qualitative analysis applied a framework approach, with themes structured around the assessment objectives. The analytical approach for each indicator domain is summarized below and described full in the relevant Findings sub-sections.

Table 4: Summary of analytical approaches by indicator domain

Indicator domain	Analytical approach
Food security (FCS, rCSI, CARI)	Descriptive statistics (means, distributions, category prevalence); CARI index computed from FCS, rCSI, and food expenditure share; results disaggregated by governorate, district, HH type, sex of head of Household (HHH), displacement status, and disability status
Nutrition (MUAC, breastfeeding, MAD, MDD-W, MIYCN KAP)	Prevalence estimates for each indicator with 95% confidence intervals; MUAC-defined acute malnutrition rates for children 6–59m and PLW; association testing as specified under Objective 2 (Section 5.2)
Objective 2 association testing	Cross-tabulations of CARI category × MUAC category with chi-square tests; Spearman rank correlation (continuous FCS/rCSI × MUAC); logistic regression (acute malnutrition outcome, CARI exposure, controlling for district, HH size, displacement status) where the sample size (n) permits
WASH	Prevalence of access to improved water, sanitation, and solid waste services; diarrhoea morbidity rates; disaggregated by governorate, HH type, and displacement status
Qualitative (FGDs)	Framework analysis: thematic coding against assessment objective themes; triangulation with quantitative findings; Arabic-language notes reviewed with GOAL MEL team support

3. SAMPLE DESCRIPTION

3.1 HOUSEHOLD DEMOGRAPHICS

A total of 5,302 household surveys were completed and included in this analysis, conducted across 90 sub-districts in 11 governorates. Key household demographic characteristics are summarized below.

5,302
Households surveyed
90 sub-districts, 11 governorates

4.8
Avg. household size
members per household (N=5,302)

45.1
Mean respondent age
years | N=5,302

77%
Male respondents
N=4,080 | Female: 23% (N=1,222)

65.4%
Host community
IDP: 10.5% | Returnees: 24.1%

18%
Head of Household with disability
WGSS; N=964 of 5,302

3.1.1 Respondent Sex and Marital Status

Of the 5,302 surveyed households, 77% of respondents were male (N=4,080) and 23% were female (N=1,222). This reflects the predominance of male household heads as primary survey respondents, a pattern common in household surveys in the Syrian context. The large majority of respondents were married (77%). Widowed respondents accounted for 17% of the sample. A further 4% were divorced or separated, and 2% were single.

3.1.2 Displacement Status

The surveyed population reflects the mixed displacement profile characteristic of Syria's current humanitarian situation. The majority (65%) are members of the host community — households that have not been displaced from their area of origin. Returnees — households that have come back after displacement — account for 24% of the sample, and IDPs represent 11%.

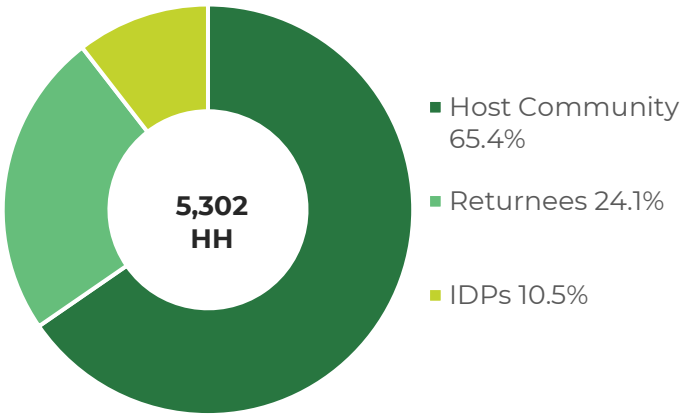


Figure 2: Displacement Status

3.1.3 Disability Status

Functional difficulties among heads of household were assessed using the Washington Group Short Set (WGSS), which captures reported difficulty across key domains of functioning rather than self-identified disability status alone. Based on WGSS responses, 18% of surveyed households (N=964) had a head of household reporting at least one functional difficulty, while 82% (N=4,338) reported no functional difficulty. Among those identified with functional difficulties, 775 were male and 189 were female. The most commonly reported domains were mobility (29% overall), seeing (23%), and self-care (15%), while lower proportions were reported for hearing (12%), memory/concentration (11%), and communicating (9%). These findings highlight the importance of disaggregating analysis by functional difficulty status throughout the report.

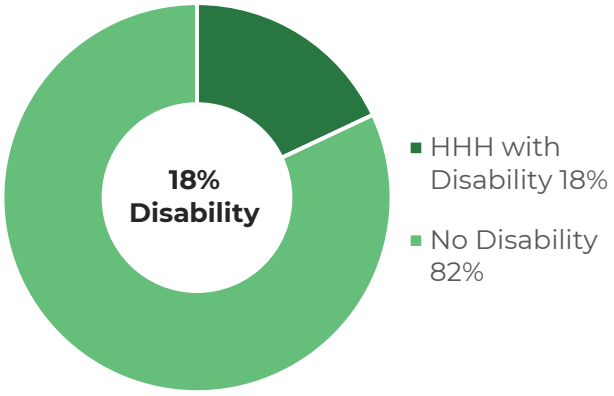


Figure 3: Disability Status among heads of HH

3.2 SOCIOECONOMIC PROFILE

3.2.1 Income Sources

The distribution of primary income sources varies considerably across the 11 surveyed governorates, reflecting differences in economic structure, conflict history, and recovery trajectory. Unskilled labour dominates in Aleppo (45%) and As-Sweida (47%), while formal employment and salaried work are proportionally stronger in Lattakia (41%), Dar'a (30%), and Rural Damascus (32%). Damascus stands out with the highest reliance on skilled labour (27%) and petty trade (25%), consistent with its comparatively more functional urban economy. Pension income is notably higher in Hama (18%) and Lattakia (10%). Community charitable transfers are most prevalent in Hama (11%) and Homs (10%), suggesting higher humanitarian dependency in these areas.

Primary Income Source by Governorate

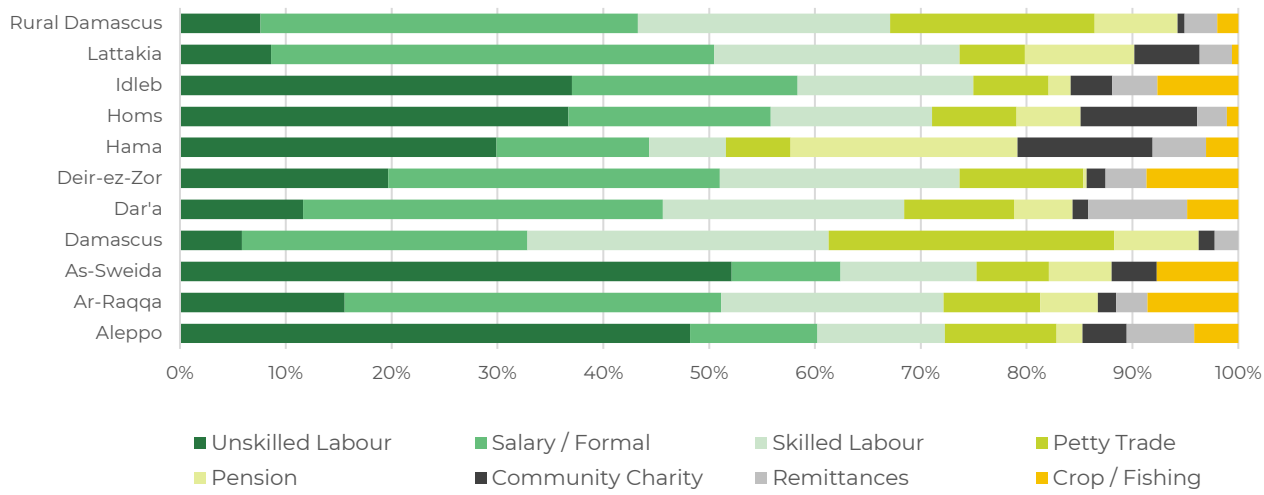


Figure 4: Primary Income Source by Governorate

3.2.2 Income Sources by Respondent Gender

Gender disaggregation reveals meaningful differences in reported income sources between male and female respondents. Female respondents report a higher rate of unskilled labour as their primary income source (28%) compared to males (22%) and are more likely to report community charitable transfers (7% vs 4%). Male respondents report substantially higher rates of skilled labour (18% vs 12%), crop production/fishing (5% vs 3%), and pension income (7% vs 6%). Salary and formal employment are nearly equal between sexes (22% male, 23% female). These patterns suggest that female-headed households face structurally more precarious and lower-skill income profiles, with greater dependency on informal transfers — a finding with direct implications for food security and nutrition vulnerability.

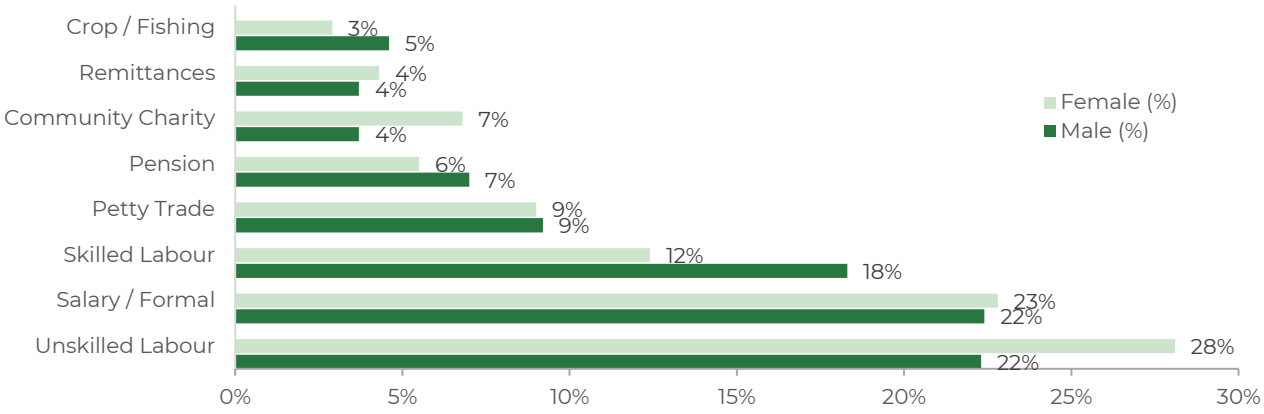


Figure 5: Primary Income Source by Gender

Female respondents were disproportionately reliant on unskilled labor (+5.8 percentage points compared to males) and community charitable transfers (+3.1 percentage points), while being notably less represented in skilled labor (-6.1 percentage points). This weaker income profile reinforces the importance of disaggregated food security and nutrition analysis throughout Section 5 and has implications for gender-sensitive livelihoods and assistance programming.

3.2.3 Housing Type and Tenure

The vast majority of surveyed households (85%) reside in houses or apartments. A significant minority live in substandard or transitional accommodation: 12% in unfinished or damaged buildings, 2% in tents, and 1% in houses with temporary roofs. Very small numbers report living in caravans (N=22), collective shelters such as schools or public buildings (N=19), or other arrangements (N=7). Only 1% of respondents (N=56) reside in camps; 99% are located in towns or villages.

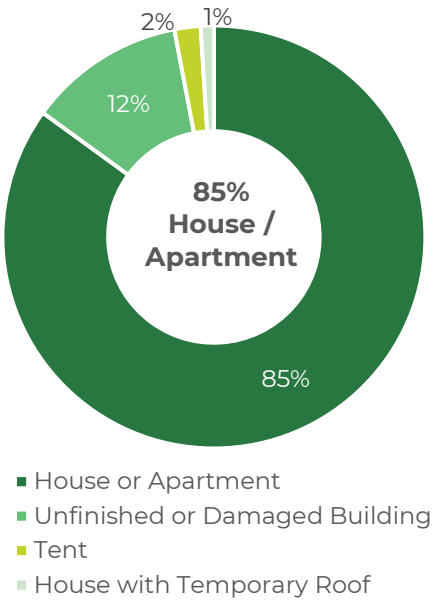


Figure 6: Housing Type

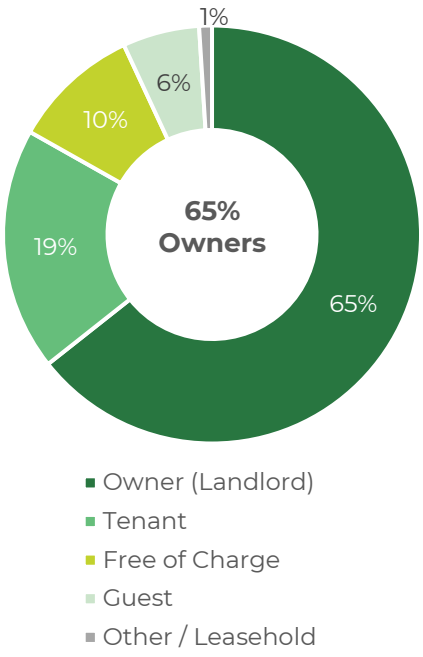


Figure 7: Housing Tenure

Regarding accommodation tenure, 65% of respondents (N=3,428) report being homeowners (landlord/owner). A further 19% (N=984) are tenants paying rent, 10% (N=531) live free of charge (e.g. in family-owned property), and 6% (N=309) are guests. A small proportion report leasehold or other arrangements (N=49). This tenure profile, while suggesting relative stability for the majority, conceals significant vulnerability: homeownership may include damaged or partially habitable structures, and the 15% living in transitional shelter arrangements face ongoing housing insecurity.

3.2.4 Housing Type and Tenure by Sex of Head of Household

Housing type profiles are broadly similar across male and female-headed households, with both groups reporting approximately 85% residing in houses or apartments (85% male Head of Household, N=3,456; 84% female Head of Household, N=1,031) and 12% in unfinished or damaged buildings. Tenure patterns show a more notable gender gap. Female-headed households report lower homeownership rates (62%) compared to male-headed households (65%), and higher rates of being guests (8% vs 5%).

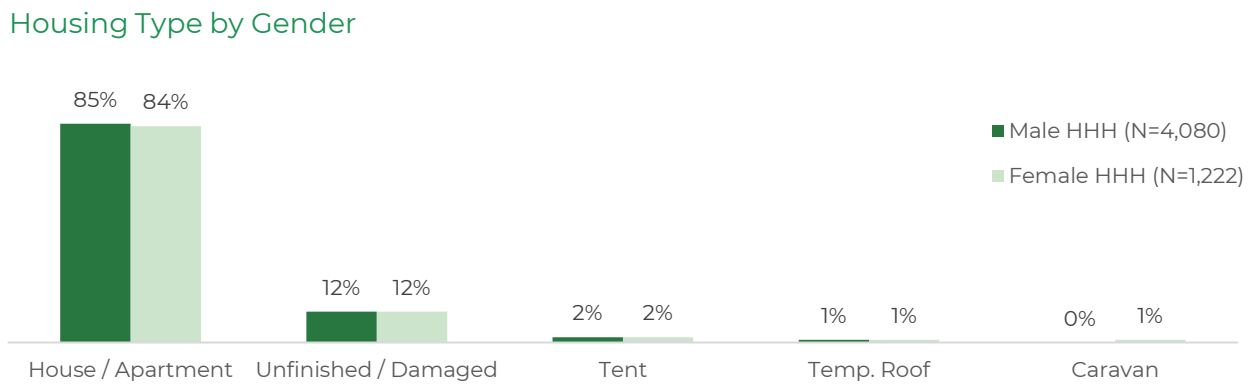


Figure 8: Housing Type by Gender

4. LIMITATIONS AND CHALLENGES

The assessment covered 11 out of the 14 governorates in Syria based on the operational presence and access of the participating organizations. As a result, findings may not fully represent needs in governorates or districts that were not included in the assessment.

Following data cleaning and the removal of records with significant internal inconsistencies related to food groups consumption, food or non-food expenditures or the lack off, the final dataset included 5,302 valid interviews across 39 districts, compared to the initially targeted 44 districts. District samples that fell below the required sample size threshold (resulting in a margin of error exceeding 10%) were excluded from the analysis. Consequently, findings do not represent those excluded districts.

The nutrition component included questions related to food group consumption among specific household members such as pregnant and lactating women and children under five. Accurate classification of foods into standardized food groups requires a certain level of familiarity with nutrition concepts. Despite training provided to enumerators, there is a possibility of misclassification of food items during data collection.

Data collection was conducted between November and December 2025. Household consumption patterns, income sources, and expenditures may vary seasonally; therefore, findings represent conditions during the data collection period and may not fully capture seasonal variations.

5. FINDINGS

5.1 FOOD SECURITY

Food security assessment in this MSNA applied the Consolidated Approach to Reporting Indicators of Food Security (CARI) framework, combining four indicator components — Food Consumption Score (FCS), Reduced Coping Strategy Index (rCSI), Livelihood Coping Strategy Index (LCSI), and Food Expenditure Share (FES) — into a composite Food Security Index (FSI) that classifies households into four severity categories: Food Secure, Marginal, Moderate, and Severe food insecurity.

This section presents findings for each indicator component before synthesizing results into the FSI severity classification. All indicators are disaggregated by governorate, sex of household head, and displacement status where sample size permits. Disaggregation by disability status and household type is presented in the accompanying statistical annex.

KEY FINDINGS

44%
Moderately or severely food insecure
FSI categories 3+4 — N=2,333

91%
Food Insecure
FSI Marginal, Moderate or Severe

8%
Poor food consumption
FCS <21 — dietary crisis threshold

50%
Using Crisis or Emergency coping
LCSI categories 3+4

36%
High or very high food expenditure share
IDP: 10.5% | FES — spending >50% on food

44%
Rely on cheaper, less preferred foods
Most-used rCSI behaviour

5.1.1 Food Consumption Score (FCS)

The Food Consumption Score measures dietary diversity and food frequency over the preceding seven days, weighting eight food groups by nutritional importance. A score below 28 indicates **Poor** food consumption; 28.5–42 is **Borderline**; above 42 is **Acceptable**. Across the full assessment sample (N=5,302), the distribution was as follows:

FCS Distribution — All Assessed Households

Table 5: Food Consumption Score (FCS)

FCS Category	% of households
Poor (<28)	8% *(N=424)*
Borderline (28.5–42)	24% *(N=1,273)*
Acceptable (>42)	68% *(N=3,605)*
Total	**100%**

68% achieved an Acceptable FCS, indicating comparatively adequate dietary diversity and frequency over the previous seven days. However, 32% of households fell below the Acceptable threshold.

District-level variation is pronounced (Table 6). The highest prevalence of Poor food consumption is observed in Al Makhrim (34% Poor), followed by As-Safira (27%) and Al Bab (27%). Afrin also shows elevated Poor consumption (25%). Several districts record zero Poor FCS in the sample, including Izra', Jisr-Ash-Shugur, Tall Kalakh, and Yabroud. Refer to Annex I for FCS for all districts.

Table 6: Food Consumption Score (FCS) by top 10 Districts

Governorate	District	Poor (<28)	Borderline (28.5–42)	Acceptable (>42)
Homs	Al Makhrim	34%	30%	36%
Aleppo	As-Safira	27%	30%	42%
Aleppo	Al Bab	27%	35%	39%
Aleppo	Afrin	25%	31%	45%
Aleppo	A'zaz	18%	32%	50%
Ar-Raqqa	Tell Abiad	15%	16%	69%
Lattakia	Lattakia	13%	27%	60%
Hama	As-Suqaylabiyah	13%	47%	40%
Deir-ez-Zor	Abu Kamal	11%	47%	41%
Lattakia	Jablah	11%	9%	79%

FGDs participants confirmed that food physical availability is not the binding constraint — affordability is. Participants in Dar'a stated that food is easy to access in markets, but that high prices are the main barrier to consumption (Female FGD, Dar'a, December 2025). In Safira (Aleppo), FGD participants noted that people are unable to purchase basic food items due to lack of purchasing power, with 70% of the sub-district population dependent on agriculture, which is itself constrained by weak market conditions and input unavailability.

Female participants in Harim district (Idleb governorate) described an explicit food-education trade-off: three participants reported withdrawing children from school and placing them in work or apprenticeships because families could not cover school costs, and prioritized food over education. One widowed IDP participant also in Harim reported that she could not provide adequate food and heating for her children simultaneously, as her daughter's medical treatment (approximately $50/month) consumed the household budget.

In Jisr Ash-Shogur (Idleb), female FGD participants linked the current crisis directly to rising prices and the complete absence of household income ('غلاء الأسعار وعدم وجود دخل للأسر'), indicating that the dietary downgrading captured in rCSI data reflects economic necessity rather than preference. FGD evidence from Muhradah (Hama) identified a near-total absence of humanitarian food interventions as a compounding factor, with no food assistance or NGO presence reported across multiple Hama-governorate FGDs (Hama, Masyaf, Muhradah, Salamiyeh, Al-Suqaylabiyah) directly contextualising the extreme Poor FCS rates in Suran (92%) and other Hama sub-districts.

Market activation through cash assistance was highlighted as a community priority in Jisr Ash-Shogur district (Idleb), where participants noted that cash transfers had stimulated local market activity, suggesting that liquidity — not supply — is the primary food access constraint in most assessed areas.

5.1.2 Reduced Coping Strategy Index (rCSI)

The rCSI measures the frequency with which households used five stress-related food coping behaviours in the preceding seven days, weighted by severity. A higher score indicates greater food-related stress. The distribution of coping behaviours indicates the predominance of cost-driven strategies.

Table 7: rCSI Coping Behaviours Reported by Households (7-Day Recall)

rCSI Behaviour (7-day recall)	% using	Relative frequency
Rely on less preferred/cheaper foods	44%	
Reduce number of meals per day	22%	
Limit portion sizes	14%	
Reduce adult consumption for children	11%	
Rely on aid from friends/family	10%	

Table 8: rCSI Coping Behaviors Reported by Households (7-Day Recall) - top 20 districts

Governorates	District	Less Preferred / Cheaper Foods (%)	Reduce Number of Meals (%)	Limit Portion Sizes (%)	Reduce Adult Consumption (%)	Aid from Friends / Family (%)	Avg rCSI Score
Homs	Homs	29%	22%	19%	15%	15%	22
Latakia	Al-Haffa	43%	19%	1%	33%	4%	21
Homs	Tadmor	30%	30%	25%	13%	2%	20
Rural Damascus	Darayya	28%	21%	17%	19%	15%	18
Homs	Al-Qusayr	34%	21%	18%	7%	19%	17
Aleppo	Al Bab	34%	24%	15%	12%	16%	16
Latakia	Jablah	42%	32%	12%	7%	7%	16
Homs	Tall Kalakh	31%	27%	25%	17%	1%	15
Deir ez-Zor	Abu Kamal	32%	23%	19%	13%	13%	14
Homs	Al Makhrim	31%	23%	19%	18%	9%	14
Homs	Ar-Rastan	32%	24%	17%	14%	14%	14
Latakia	Lattakia	40%	18%	14%	14%	13%	14
Aleppo	A'zaz	37%	27%	13%	11%	12%	13
Idleb	Idleb	47%	17%	15%	17%	3%	13
Hama	As-Salamiyeh	45%	21%	10%	5%	19%	12
Aleppo	Jebel Saman	48%	31%	7%	4%	9%	12
Hama	As-Suqaylabiyah	45%	22%	10%	6%	16%	11
Rural Damascus	Duma	51%	18%	12%	11%	8%	11
Hama	Hama	49%	21%	11%	6%	13%	11
Hama	Masyaf	46%	23%	10%	6%	15%	11
Hama	Muhradah	50%	23%	8%	6%	12%	11

Across the assessed sample, the most common coping behaviour is reliance on less preferred or cheaper foods (44%), reflecting widespread compromise on dietary quality. Reducing the number of meals per day is the second most common strategy (22%), followed by limiting portion sizes (14%). Reducing adult consumption so children can eat is reported by 11% of households, while relying on support from friends or family is reported by 10%.

The concurrent use of dietary downgrading alongside meal-reduction and portion-limitation behaviours indicates compounding food stress: households are adjusting both the quality and quantity of consumption, suggesting that coping has shifted from preference-based adjustments toward necessity-driven strategies for a substantial proportion of households.

FGD evidence reinforces these patterns. In Izra' (Dar'a governorate), participants described rising living costs and insufficient income as key drivers of food stress, with households relying on supplementary work and family support networks—consistent with the reported reliance on friends/family support (10%). In Dar'a, participants reported limited recent food assistance, increasing dependence on market purchase and informal coping mechanisms. In Harim (Idleb), female participants described the cumulative burden of low and unstable income, health expenses, and disability-related costs, which constrains food access and contributes to multi-stress coping. In Muhradah (Hama), participants highlighted unemployment and weak local economic conditions as structural drivers of food-related coping, with food needs closely linked to livelihood constraints.

5.1.3 Livelihood Coping Strategies

The Livelihood Coping Strategies Index (LCSI) classifies households according to the severity of livelihood-based coping mechanisms used to manage food or income shortfalls: No Strategies, Stress, Crisis, and Emergency. Unlike the rCSI, which captures short-term food consumption coping, the LCSI captures coping behaviors that may erode household assets and weaken longer-term resilience.

LCSI Distribution — All Assessed Households (N=5,302)

Across all assessed households (N=5,302), 16% reported no livelihood coping strategies, 34% were classified in the Stress category, 27% in Crisis, and 23% in Emergency. Combined, this indicates that 50% of surveyed households were relying on Crisis or Emergency livelihood coping strategies, pointing to substantial pressure on household resilience and limited capacity to absorb further shocks.

District-level variation is pronounced. Table 13 presents the ten districts with the highest prevalence of combined Crisis and Emergency livelihood coping. The highest levels are observed in Abu Kamal (84%) and Al-Haffa (82%), followed by Ath-Thawrah (73%) and Harim (73%). High prevalence is also recorded in Duma (71%), As-Sweida (69%), Al Bab (65%), Idleb (63%), As-Suqaylabiyah (62%), and Ariha (61%).

These findings suggest that in several districts, a large share of households is relying on severe livelihood coping strategies that may undermine future recovery capacity. The concentration of high Crisis+Emergency prevalence across multiple districts highlights the depth of livelihood stress in the assessed areas. Full district-level results are presented in the Annex III.

Table 9: Livelihood Coping Strategies Per District

Governorates	District	No Strategies (%)	Stress (%)	Crisis (%)	Emergency (%)	Crisis and Emergency (%)
Deir ez-Zor	Abu Kamal	10%	7%	37%	47%	84%
Latakia	Al-Haffa	2%	16%	70%	12%	82%
Ar-Raqqa	Ath-Thawrah	8%	19%	38%	35%	73%
Idleb	Harim	5%	22%	51%	22%	73%
Rural Damascus	Duma	6%	23%	24%	47%	71%
As-Sweida	As-Sweida	11%	19%	48%	21%	69%

Aleppo	Al Bab	3%	32%	27%	39%	65%
Idleb	Idleb	17%	20%	31%	32%	63%
Hama	As-Suqaylabiyah	6%	32%	36%	26%	62%
Idleb	Ariha	10%	29%	34%	27%	61%

5.1.4 LCSI by District and Sex of Household Head

The table below presents LCSI category distribution disaggregated by governorate and sex of household head. Gender-differentiated patterns in livelihood coping are important for targeting: female-headed households in several governorates show markedly different coping profiles from male-headed households, reflecting differential access to livelihoods, assets, and social support.

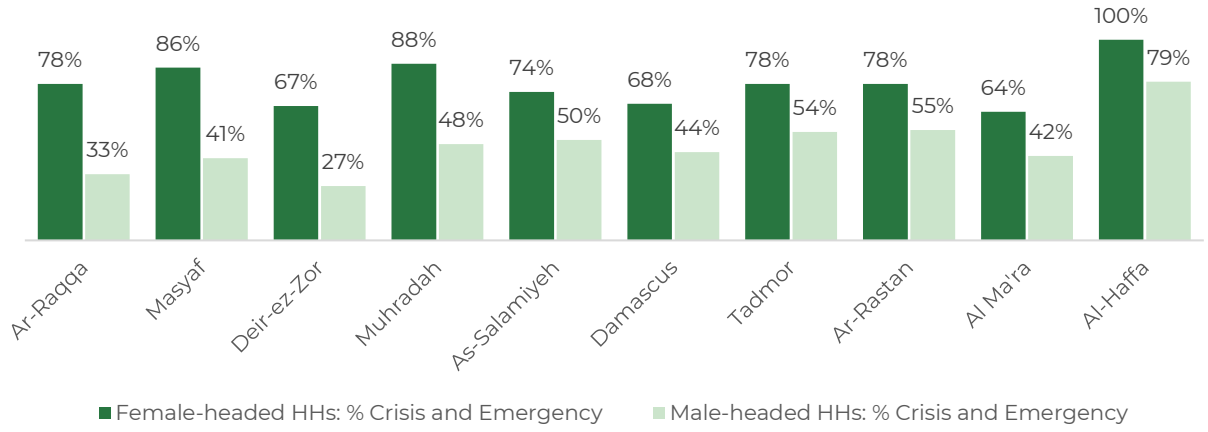


Figure 9: Top 10 Districts with Largest Gender Gaps in Crisis and Emergency Livelihood Coping

Gender Disparities in Crisis and Emergency Livelihood Coping Across Districts

Female-headed households show higher Crisis + Emergency coping than male-headed households in a number of districts, but the most important pattern is the size of the disparity between the two groups. The largest gaps are observed in Masyaf (86% for female-headed households versus 41% for male-headed households; +45 percentage points) and Ar-Raqqa (78% vs 33%; +45 pp), followed by Muhradah (88% vs 48%; +40 pp) and Deir-ez-Zor (67% vs 27%; +40 pp). Substantial differences are also evident in As-Salamiyeh (74% vs 50%; +24 pp), Damascus (68% vs 44%; +24 pp), and Ar-Rastan (78% vs 55%; +23 pp). In contrast, the pattern is reversed in some districts, including Harim (63% vs 75%) and Al Bab (59% vs 66%), while in Afrin the rates are identical for female- and male-headed households (41% each). These findings suggest that gender differences in severe livelihood coping are highly location-specific and should be interpreted with attention to subgroup sample size. Cells marked "–" indicate insufficient sample for reliable disaggregation

Triangulated Evidence on Structural Drivers of Severe Livelihood Coping

The shift from Stress to Crisis and Emergency livelihood coping — affecting 50.1% of households in the quantitative data — is reflected in FGD narratives as a structural, not purely situational, deterioration. In Harim (female FGD), participants described child labour and school dropout as livelihood coping strategies, with three participants reporting withdrawing children from school and placing them in apprenticeships or informal work due to inability to cover school costs ('ثلاث مشاركات قاموا بإخراج أولادهم من

.(المدرسة) These narratives illustrate how severe livelihood pressures translate into negative coping choices at household level.

Gender-specific coping pressures also emerged in female FGDs. In Harim (Idleb), widowed or sole-provider women described the difficulty of meeting food, heating, and health-related costs simultaneously on informal and unstable wages, including heightened reliance on charity and remittances in the absence of stable livelihood options. This is consistent with the higher Crisis and Emergency coping observed among female-headed households in several assessed locations.

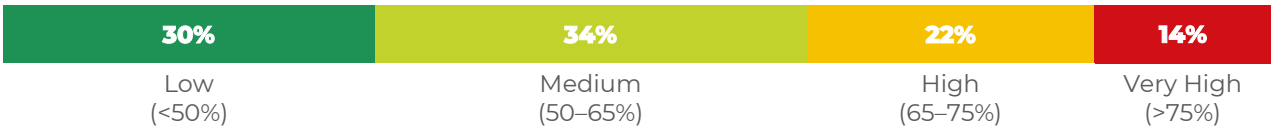
In Ariha (Idleb) (male FGD), participants highlighted small microprojects (e.g., sewing, grocery, home gardening, handicrafts) as a preferred pathway to self-reliance and reducing dependence on aid. This reflects a community recognition that severe coping is unsustainable, while structural barriers—limited employment opportunities and lack of capital—constrain recovery from crisis-level strategies.

Across FGDs, recurring themes include unstable informal labour markets, insufficient income relative to living costs, and the compounding burden of health-related expenditures, which together intensify the likelihood of Crisis and Emergency coping.

5.1.5 Food Expenditure Share (FES)

The Food Expenditure Share measures the proportion of total household expenditure dedicated to food. A high food expenditure share indicates constrained economic capacity — households spending a disproportionate share of income on food have little remaining capacity to meet non-food needs including WASH, health, and shelter. Refer to Annex IV for full FES per district.

Food Expenditure Share Distribution — All Assessed Households



Food expenditure pressure varies considerably across districts. The table below presents the ten districts with the highest combined share of households in the High (65–75%) and Very High (>75%) food expenditure share categories. In these locations, a large proportion of households are allocating more than 65% of their total expenditure to food, leaving limited resources available for other essential needs such as health, WASH, shelter, and education. This pattern highlights the extent to which food affordability is constraining overall household well-being and increasing vulnerability to further shocks.

Table 10: Food Expenditure Share Distribution Per Top 10 Districts

Governorate	District	Low (<50%)	Medium (50–65%)	High (65–75%)	Very High (>75%)
Lattakia	Jablah	11%	19%	32%	**38%**
Hama	Masyaf	16%	32%	16%	**37%**
Ar-Raqqa	Ath-Thawrah	10%	28%	26%	**36%**
Hama	As-Salamiyeh	7%	19%	43%	**32%**
Homs	Tall Kalakh	20%	24%	25%	**31%**
Hama	Hama	19%	22%	29%	**31%**

Hama	As-Suqaylabiyah	24%	29%	19%	**29%**
Deir-ez-Zor	Deir-ez-Zor	30%	22%	20%	**28%**
Lattakia	Lattakia	26%	23%	26%	**26%**
Deir-ez-Zor	Al Mayadin	15%	42%	23%	**20%**

The FGD data provides qualitative texture to the food expenditure burden captured in FES. In Jisr Ash-Shogur (Idleb) (female FGD), participants described the current situation as characterised by the combination of rising prices and complete absence of household income ('غلاء الأسعار وعدم وجود دخل للأسر'). Participants also noted that current cash assistance levels are insufficient given price inflation, and called for assistance to be calibrated to market prices. This is consistent with the 36.4% of households in High/Very High FES, where food is consuming over 65% of total household expenditure — leaving no buffer for health, shelter, or non-food needs.

In Izra' (Dar'a), participants identified inadequate monthly income relative to cost of living as the primary economic stressor, with households relying on overtime work and family assistance as coping. The Muhradah FGD identified food, water, and employment as the three most cited community priorities — with multiple participants independently ranking them in the same order, reinforcing the finding that food affordability (rather than supply) is the binding constraint. Participants in Idleb FGD cited free or subsidised bread as one of the top three preferred forms of support, reflecting the role of staple food costs in the overall expenditure burden.

The Safira FGD (Aleppo) documented that people are unable to purchase basic food due to low purchasing power, and participants reported high reliance on agriculture alongside constraints related to markets and input availability — creating a dual exposure where both income and own-production are insufficient to sustain food needs. This structural income-expenditure imbalance helps contextualise why FES classifications show high or very high food expenditure shares even in areas where FCS scores appear relatively less acute.

5.1.6 CARI Food Security Classification

The Consolidated Approach for Reporting Indicators of Food Security (CARI) synthesizes the Current Consumption Status (FCS + rCSI) with the Coping Capacity score (LCSI + FES) to produce a four-tier severity classification. CARI is the primary food security severity indicator for programming and response targeting in this assessment. Full computational methodology, input thresholds, and missing-data handling rules are documented in Annex II. All figures are computed on the analytic dataset of N = 5,302 completed surveys (quality-flagged records excluded; see Section 2 for cleaning protocol).

Overall Food Security Classification

Table 11: CARI food security classification

CARI Category	Food Secure (1)	Marginally food insecure (2)	Moderate (3)	Severe (4)
All households (N = 5,302)	9%	47%	40%	4%
Food Insecure (Marginal + Moderate + Severe)		**91% of assessed households**		
Moderate and Severe food insecure			**44% of assessed households**	

At the district level, severity varies substantially. The highest combined Moderate and Severe prevalence is observed in As-Salamiyeh (85%), Abu Kamal (81%), and Hama (76%), followed by Al Makhrim (69%), Ar-Rastan (64%), As-Suqaylabiyah (64%), and Ath-Thawrah (63%). Several districts show comparatively lower Moderate and Severe prevalence, including As-Sanamayn (14%), Izra' (14%), Dar'a (15%), and Tall Kalakh (17%). While Marginal food security remains the dominant category in many districts, the presence of high Moderate and Severe shares in multiple locations indicates widespread severity beyond borderline vulnerability.

Table 12: CARI Severity by District

Governorates	District	Secure (%)	Marginal (%)	moderate and severe (%)
Hama	**As-Salamiyeh**	1%	15%	85%
Deir ez-Zor	**Abu Kamal**	2%	17%	81%
Hama	**Hama**	1%	24%	76%
Homs	**Al Makhrim**	0%	31%	69%
Homs	**Ar-Rastan**	1%	35%	64%
Hama	**As-Suqaylabiyah**	1%	34%	64%
Ar-Raqqa	**Ath-Thawrah**	5%	32%	63%
Aleppo	**Al Bab**	0%	38%	62%
Hama	**Masyaf**	2%	37%	61%
Aleppo	**As-Safira**	4%	36%	60%

5.1.7 CARI by Household Type: Sex, Displacement Status, Disability

Female-headed households and households with a disabled head of household show 15–16 percentage-point higher Moderate and Severe food insecurity than their respective comparison groups, while IDP households show an ~8 percentage-point higher Moderate andSevere rate than host community and returnee households. These groups converge at 51–57% Moderate and Severe compared to the whole-sample average of 44%.

Table 13: CARI by Household status, Gender, Displacement and Disability

Household Type		N	Food Secure	Marginal	Moderate	Severe	Mod and Severe
SEX OF HOUSEHOLD HEAD							
Female-headed HH		1222	6%	39%	50%	6%	56%
Male-headed HH		4080	10%	50%	36.7%	3%	40%
DISPLACEMENT STATUS							
IDP		553	6%	43%	47%	5%	51%
Returnee		1279	8%	48%	40%	4%	44%
Host community		3470	10%	48%	39%	4%	43%
DISABILITY STATUS OF HOUSEHOLD HEAD (Washington Group Short Set)							
Head of Household with disability		964	4%	39%	50%	6%	57%
Head of Household without disability		4338	10%	49%	37%	3%	41%
DISABILITY STATUS OF HOUSEHOLD HEAD (Washington Group Short Set) per gender							
Head of Household with disability (N=964)	Male	775	**5%**	41%	48%	6%	54%
	Female	189	3%	**30%**	58%	9%	67%
DISABILITY STATUS OF FAMILY Member (Washington Group Short Set) per gender							
Family Member with disability (N=1179)	Male	461	**3%**	17%	17%	2%	19%
	Female	718	**4%**	29%	24%	4%	28%

Unpacking IDP Vulnerability: It is a key finding that Returnee (44%) and Host Community (43%) households show nearly identical rates of Moderate and Severe food insecurity, while IDP households are the only displacement group to exceed fifty percent (51%). This heightened vulnerability is driven by compounding environmental and access barriers. IDP households are far more likely to reside in informal settlements, reflected in a "no-toilet" rate of 5% (compared to <1% for host and returnee households). Furthermore, qualitative evidence from focus groups indicates that IDPs face specific barriers related to humanitarian entitlements and assistance access, particularly for newly displaced families who fall outside of established distribution networks. These systemic service gaps—combined with the disruption of social support networks—force IDPs into more severe coping mechanisms and constrain their food access.

Unpacking Female-Headed Household (FHH) Vulnerability: Female-headed households face a Moderate and Severe food insecurity rate of 56%, compared to 40% for male-headed households. This disparity is deeply rooted in structural economic disadvantages. Female respondents rely disproportionately on precarious, unskilled labor (28% vs. 22% for males) and community charitable transfers (7% vs. 4%), while having less access to skilled labor. They also experience greater housing instability, with lower homeownership rates (62% vs 65%) and a higher likelihood of living as guests. Widows, who make up 17% of the total surveyed respondents, face compounded burdens. Focus group

discussions with widowed and sole-provider women revealed the near-impossibility of meeting food, heating, and healthcare costs simultaneously on unstable informal wages. To cope, these women frequently resort to emergency strategies, including withdrawing children from school for informal labor, and routinely reduce their own dietary intake (evidenced by very low Minimum Dietary Diversity) so that their children can eat.

Unpacking Disability-Headed Household Vulnerability: Households headed by a person with a disability recorded the highest aggregate food insecurity severity, with 57% facing Moderate or Severe conditions. The primary driver of this disparity is the extreme financial burden of specialized healthcare, which heavily crowds out the household food budget. Focus group participants with disabled household members reported spending approximately USD 50 per month on treatments, medications, and physiotherapy—an insurmountable cost in an economy where monthly incomes often fall below USD 50–100. Consequently, food and nutrition are systematically deprioritized when medical costs escalate. This financial strain also creates a vicious cycle for nutrition: households with two or more disabled members showed markedly reduced malnutrition treatment-seeking behaviors (33%) and an elevated rate of treatment delays explicitly due to financial barriers (67%).

5.1.8 CARI by Governorate

Hama records the highest Moderate and Severe rate (67%) with only 1% Food Secure. Aleppo (53%; 8% Severe) is the second most affected, while As-Sweida (49.3%) is third. At the other extreme, Dar'a records 14% Moderate and Severe with 22% Food Secure — the most favourable governorate-level profile in the assessed sample. Idleb records 36% Moderate and Severe and 1% Severe; these differences may reflect variation in livelihoods, market conditions, and assistance coverage across governorates.

Table 14: CARI by governorate

Governorate	N	Food Secure	Marginal	Moderate	Severe	Mod and Severe
Hama	698	1%	32%	58%	9%	67%
Aleppo	648	6%	41%	45%	8%	53%
As-Sweida	131	9%	42%	47%	2%	49%
Lattakia	363	5%	47%	45%	4%	48%
Homs	810	5%	47%	43%	4%	47%
Ar-Raqqa	441	14%	43%	42%	2%	44%
Damascus	146	12%	45%	40%	4%	43%
Deir-ez-Zor	372	10%	48%	38%	5%	43%
Idleb	743	7%	58%	35%	1%	36%
Rural Damascus	496	18%	54%	26%	3%	28%
Dar'a	454	22%	64%	13%	1%	14%

Hama governorates the highest Moderate and Severe rate in the dataset (67%) and the lowest Food Secure share (1%) — was covered by FGDs in five locations (Hama city, Muhradah, Masyaf, Salamiyeh,

Al-Suqaylabiyah). Across these discussions, participants consistently reported very limited humanitarian food and cash assistance and emphasized that households rely primarily on market purchase and informal support networks in a context of high unemployment and low wages. These qualitative findings align with the high food insecurity severity observed in Hama.

In Aleppo (53% Moderate and Severe; 8% Severe), the Safira FGD highlighted affordability constraints and weak purchasing power as key drivers of food stress; participants also noted high reliance on agriculture and constraints related to markets and input availability. IDP households — the only displacement group exceeding 50% Moderate and Severe (51%) — also face barriers described in FGDs, including challenges related to entitlements and assistance access, which may compound vulnerability.

The female-headed household differential (56% vs 40% Moderate and Severe) is consistent with Harim FGDs describing constrained and unstable income among widowed/sole-provider households and difficult trade-offs between food, heating, and health expenses, including reliance on negative coping such as school withdrawal and child labor.

Across FGDs, recurring drivers include: (1) reported limited assistance coverage in parts of Hama; (2) heavy reliance on casual/informal labor and unstable incomes; and (3) price inflation eroding purchasing power. These structural pressures help contextualize why 91% of the assessed population is classified as food insecure.

5.2 NUTRITION

This section presents findings on child and maternal nutritional status, infant and young child feeding (IYCF) practices, Minimum Dietary Diversity for Women (MDD-W), and access to malnutrition treatment services. All indicators are disaggregated by district, displacement status, and sex of the head of household (HHH) where sample sizes permit. Data are drawn from 5,302 nutrition-module records collected as part of the MSNA survey across eleven governorates. Qualitative triangulation draws on FGD transcripts conducted in Harim, Jisr-Ash-Shugur, Ariha, Idleb, and Ma'ra (Idleb).

5.2.1 Infant and Young Child Feeding (IYCF)

This sub-section presents three core IYCF indicators: breastfeeding practices among infants aged 0–5.99 months; Minimum Acceptable Diet (MAD) among children aged 6–23 months; and Minimum Dietary Diversity for Women (MDD-W). Each indicator is disaggregated where relevant by district, displacement status, sex of child, and breastfeeding status.

Breastfeeding Practices (0–5.99 Months)

A total of 220 households reported a child aged 0–5.99 months at the time of interview. Among these, 82% (180/220) reported that the infant had received breast milk in the preceding 24 hours. This reflects any breastfeeding, rather than exclusive breastfeeding.

Two additional indicators provide further context on early feeding practices. Early initiation of breastfeeding within one hour of birth was reported for 31% (69/220) of infants, while 84% (184/220) were reported to have been first breastfed within 24 hours of birth. Pre-lacteal feeding was reported for 39% (85/220) of infants, indicating that a substantial share of newborns received food or liquids other than breast milk during the first two days after birth.

Table 15: IYCF Practice Indicator

IYCF Practice Indicator	Numerator	Denominator	Rate
Any breastfeeding (0–5.99 months)	180	220	82%
Early initiation of breastfeeding (<1 hour of birth)	69	220	31%
Breastfeeding initiated within 24 hours of birth	184	220	84%
Pre-lacteal feeding (other food/liquid in first 2 days)	85	220	39%

Early initiation within one hour of birth — the recommended WHO standard associated with improved neonatal outcomes — was recorded for only 31% of infants with relevant data. Pre-lacteal feeding was reported by 39% of caregivers, indicating that more than one-in-three infants in the sample received something other than breastmilk in the first two days of life (water, infant formula, anise water, or sugar water being the most common).

Table 16: IYCF Practice Indicator by Displacement Status

Disaggregation	n	Any BF (24-hr recall)	Pre-lacteal feeding
Host community	144	77% (111/144)	38% (54/144)
IDP	28	89% (25/28)	50% (14/28)
Returnee	48	92% (44/48)	35% (17/48)
Total	220	82% (180/220)	39% (85/220)

Displacement status reveals an important divergence: IDP and returnee households record higher breastfeeding rates (89% and 92% respectively) than host community households (77%), suggesting breastfeeding is sustained or even reinforced in displacement contexts — likely reflecting lower affordability of infant formula. However, IDP households simultaneously record the highest pre-lacteal feeding rate (50%), more than twelve percentage points above host community (38%) and returnee (35%) rates. This indicates that while IDP caregivers continue breastfeeding once established, they are significantly more likely to introduce non-breast-milk feeds in the critical first 48 hours after birth. Traditional practices and misinformation represent the primary barriers to optimal breastfeeding in displacement settings.

Minimum Acceptable Diet — MAD (6–23 Months)

MAD measures whether children aged 6–23 months received the recommended minimum dietary diversity (MDD: ≥4 food groups from non-breast-milk sources in the preceding 24 hours) alongside minimum meal frequency (MMF: age- and breastfeeding-status-adjusted meal frequency thresholds). A total of 500 households reported a child in the 6–23-month age group.

23%
Minimum Acceptable Diet (MAD) met (n=116 / 500)

29%
MDD met (≥4 groups) (n=144 / 500)

61%
MMF met (n=307 / 500)

Only 23% of children aged 6–23 months met the MAD standard — substantially below global benchmarks (approximately 40% in lower-middle-income countries) and indicative of widespread inadequate complementary feeding.

Dietary diversity appears to be the principal constraint. Only 29% of children consumed foods from at least four food groups during the previous day, indicating limited access to diverse foods. In comparison, 61% met the minimum meal frequency requirement, suggesting that children are often fed multiple times per day but with limited diversity in the foods provided.

Breastfeeding Status and MAD

MAD requirements differ slightly for breastfed and non-breastfed children, particularly in relation to minimum meal frequency and milk feed requirements.

- Among the 500 children aged 6–23 months, breastfeeding status was reported for 500 children. Of these, 277 were breastfed and 223 were non-breastfed.

- Among breastfed children, 29% met Minimum Dietary Diversity (MDD), 60% met Minimum Meal Frequency (MMF), and 26% met Minimum Acceptable Diet (MAD).

- Among non-breastfed children, 29% met MDD, 63% met MMF, and 20% met MAD, after applying the additional requirement of at least two milk feeds.

While MDD and MMF levels are broadly similar across both groups, MAD is lower among non-breastfed children due to the additional milk feeding requirement. This highlights the added vulnerability of non-breastfed children in achieving adequate feeding standards.

Table 17: Breastfeeding Status and MAD

Indicator	Breastfed (n=277)	Non-breastfed (n=223)
MDD	79 (29%)	65 (29%)
MMF	167 (60%)	140 (63%)
MAD	71 (26%)	45 (20%)

MAD prevalence is higher among breastfed children (25.6%) compared to non-breastfed children (20.2%). While MDD and MMF levels are broadly comparable across both groups, the lower MAD among non-breastfed children reflects the additional requirement of adequate milk feeding. This suggests that non-breastfed children face greater challenges in meeting overall feeding adequacy.

Overall, the results indicate that dietary diversity remains the primary constraint affecting complementary feeding, as reflected in consistently lower MDD compared to MMF across groups. However, for non-breastfed children, the additional requirement of adequate milk feeding further constrains the likelihood of achieving a Minimum Acceptable Diet.

Table 18: Minimum Acceptable Diet (MAD) by district (selected districts with n≥10)

Governorate	District	n	MDD met	MMF met	MAD met
Dar'a	As-Sanamayn	10	70%	100%	70%
As-Sweida	As-Sweida	16	38%	56%	25%
Dar'a	Dar'a	11	55%	73%	36%
Deir-ez-Zor	Deir-ez-Zor	34	50%	76%	47%
Idleb	Idleb	12	58%	92%	33%
Idleb	Jisr-Ash-Shugur	16	56%	94%	50%
Idleb	Harim	18	6%	56%	6%
Aleppo	As-Safira	25	4%	48%	4%
Ar-Raqqa	Ar-Raqqa	10	30%	80%	30%
Deir-ez-Zor	Abu Kamal	19	5%	79%	5%
Homs	Al Makhrim	16	12%	25%	12%
Homs	Ar-Rastan	18	11%	50%	11%
Homs	Homs	12	33%	58%	25%
Hama	Hama	10	30%	40%	20%
Idleb	Al Ma'ra	15	33%	93%	33%
Dar'a	Izra'	10	70%	80%	70%

Several districts continue to record very low MAD prevalence, including Harim, As-Safira, and Abu Kamal, where fewer than 10% of children meet the MAD threshold. In these locations, extremely low MDD levels indicate that inadequate dietary diversity remains the primary constraint affecting complementary feeding practices.

Across most districts, MMF levels are substantially higher than MDD, reinforcing that while children are being fed with sufficient frequency, the quality and diversity of diets remain insufficient. This pattern highlights that improving access to and consumption of diverse, nutrient-rich foods is the key challenge in achieving adequate child feeding outcomes.

Table 19: MAD by Displacement Status and Gender

Sex of child	number	MDD met	MMF met	MAD met
Male	287	30%	59%	24%
Female	213	27%	64%	22%
Total	**500**	**29%**	**61%**	**23%**

Male FGD participants in Ariha and Ma'ra (Idleb) consistently described inadequate diet diversity among young children as driven primarily by economic constraints rather than lack of knowledge. Participants

reported that families understood the importance of providing varied foods — including protein sources, vegetables, and dairy — but were unable to afford them, particularly in contexts where household income was irregular or absent.

In Ariha, participants noted that cereal-based foods (bread, bulgur, rice) dominated children's diets by necessity, with animal-source foods and fresh produce described as "luxuries" that appeared on the table "once a week at most." This pattern is consistent with the quantitative finding that only 29% of children 6–23 months met the MDD threshold.

Participants also noted that displacement and loss of livelihood had eroded food culture and traditional practices around complementary feeding, with some families relying on powdered milk as a complementary food well beyond recommended age due to its perceived availability and affordability through in-kind aid distributions.

Minimum Dietary Diversity for Women — MDD-W

MDD-W was assessed for 598 women (pregnant, lactating, or of reproductive age) using a 24-hour dietary recall based on the updated Food and Agriculture Organization FAO 10-food-group methodology. Under this standard, women are considered to have met minimum dietary diversity if they consumed foods from at least 5 of 10 defined food groups during the previous day.

Overall, 31% of women met the MDD-W threshold (188/598), while 69% did not, indicating that most women in the assessed sample consumed diets with insufficient diversity in the preceding 24 hours.

To further understand dietary quality, analysis of food group consumption was conducted. The table below presents the frequency of consumption of selected key food groups among surveyed women.

Table 20: food group consumption

Food Group	Number of Women Consuming	Approximate Share of Sample (%)
Cereals / Grains	552	High (majority)
Vegetables	411	Moderate–high
Dairy Products	404	Moderate–high
Eggs	303	Moderate
Legumes	196	Low–moderate
Fruits	172	Low

The consumption profile indicates a strong reliance on staple foods, particularly cereals and grains, which form the foundation of most diets. While vegetables and dairy products are relatively commonly consumed, intake of nutrient-dense food groups such as fruits, legumes, and animal-source proteins remains limited.

This pattern suggests that while caloric needs may be partially met, diets are often lacking in key micronutrients. In particular:

- Low fruit and vegetable diversity may contribute to inadequate vitamin A and vitamin C intake
- Limited consumption of legumes and eggs suggests potential gaps in protein and iron intake
- Dependence on staples indicates diets are energy-sufficient but not nutrient-dense

These findings are consistent with the relatively low proportion of women meeting the MDD-W threshold and point to diet quality constraints rather than absolute food availability alone.

When interpreted alongside Food Consumption Score (FCS) findings (Section 5.1), the results indicate that acceptable household food consumption does not necessarily translate into adequate individual dietary diversity. This highlights the importance of considering intra-household food allocation, dietary practices, and food choice constraints when assessing nutritional outcomes.

31%

Met Minimum Dietary Diversity for Women

(≥5 of 10 food groups)
(n=188 / 598)

69%

Did not meet Minimum Dietary Diversity for Women

(n= 410 / 598)

To better understand dietary diversity among women at critical stages, MDD-W was disaggregated by status. In this dataset, the women assessed were pregnant, lactating, or pregnant and lactating at the same time.

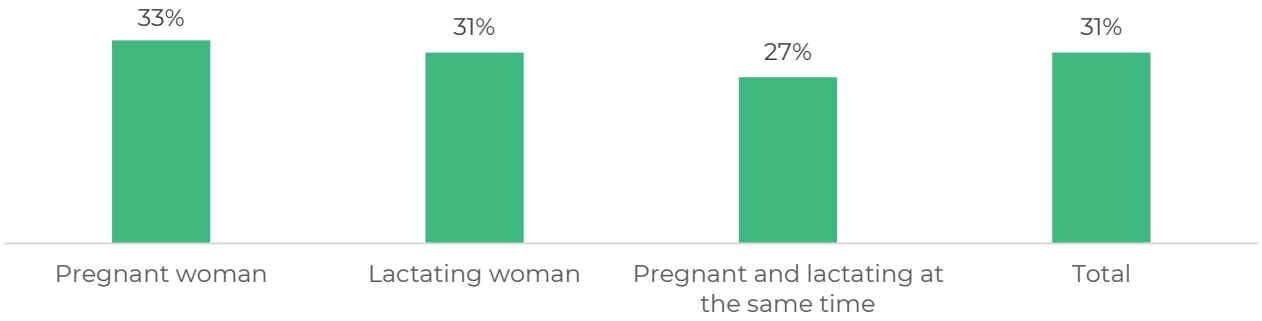


Figure 2: Minimum Dietary Diversity for Women by Status

MDD-W compliance was low across all categories. Pregnant women recorded the highest compliance (33%), followed by lactating women (31%), while women who were both pregnant and lactating recorded the lowest compliance (27%), although this subgroup is small.

District-level variation is pronounced. The lowest MDD-W compliance is observed in Abu Kamal (3%), Ar-Rastan (3%), and Tadmor (6%), while As-Safira (9%) also records very low dietary diversity among women. In contrast, Dar'a (82%), Izra' (76%), and Jisr-Ash-Shugur (73%) show substantially higher compliance.

Table 21: Minimum Dietary Diversity for Women for Top 10 Districts

Governorate	District	N=	Minimum Dietary Diversity for Women met (≥5 groups)	Notable pattern
Dar'a	Dar'a	27	82%	Highest compliance
Dar'a	Izra'	25	76%	High compliance
Idleb	Jisr-Ash-Shugur	15	73%	Above average
As-Sweida	As-Sweida	19	63%	Above average
Deir ez-Zor	Deir-ez-Zor	17	59%	Above average
Idleb	Harim	33	21%	Below average
Aleppo	As-Safira	34	9%	Low compliance
Deir ez-Zor	Abu Kamal	29	3%	Lowest compliance
Homs	Ar-Rastan	31	3%	Lowest compliance
Homs	Tadmor	33	6%	Very low compliance

Triangulation

Participants across female FGDs in Harim and Jisr-Ash-Shugur (Idleb) described a diet almost entirely composed of bread, legumes, and seasonal vegetables — consistent with the very low MDD-W compliance rates quantified for these districts. In Harim, participants described going "days without protein" and relying on dried legumes when they were available through aid distributions.

Female participants identified their own dietary needs as the last priority within household food allocation. Several participants stated that they reduced their own food intake before limiting the food given to children or other male household members, which is a classic intra-household allocation pattern associated with maternal malnutrition risk.

The seasonal nature of food access was also highlighted: during winter months, fresh vegetables became scarce and expensive, further constraining dietary diversity. Participants in Jisr-Ash-Shugur noted that even when food was available, inability to afford cooking fuel sometimes prevented preparation of nutritious food, highlighting compounding barriers beyond food access alone.

5.2.4 MIYCN Knowledge, Attitudes and Practices (KAP)

The MIYCN KAP component assessed caregiver awareness of and stated attitudes towards recommended infant and young child feeding practices, alongside antenatal care (ANC) attendance and iron and folic acid (IFA) supplementation among pregnant women. This provides insight into the knowledge and behavioral drivers of the feeding outcomes documented in Sections 5.2.1–5.2.3.

Caregiver Awareness and Breastfeeding Motivations

Among caregivers of infants aged 0–5.99 months who reported that the child was currently being breastfed, the most commonly stated reason for breastfeeding was that it is “a complete meal for the child,” cited by 85% of respondents. Awareness of the protective benefits of breastfeeding was also evident: disease prevention and immune protection were frequently mentioned, as were the hygiene

and safety advantages of breastmilk. Cost was cited less frequently as a motivation, but was still mentioned by a minority of caregivers, suggesting that affordability also shapes infant feeding choices in some households.

Taken together, these responses suggest that basic awareness of the value of breastfeeding is relatively strong among surveyed caregivers. However, this awareness does not consistently translate into recommended practice. Earlier findings showed that only 31% of infants aged 0–5.99 months were reported to have initiated breastfeeding within the first hour of birth, while 38.6% received pre-lacteal feeding during the first two days of life. This gap between awareness and practice indicates that poor infant feeding outcomes cannot be explained by knowledge deficits alone.

The coexistence of strong stated awareness of breastfeeding benefits with low early initiation and relatively high pre-lacteal feeding points to an implementation gap. Caregivers may understand that breastfeeding is beneficial, while still following feeding behaviours that interrupt optimal practice in the immediate postnatal period.

The data suggest that pre-lacteal feeding is likely shaped by social norms and customary practices, including the use of anise water, sugar water, or infant formula in the first hours or days after birth. In this sense, the issue appears to be less a lack of awareness of breastfeeding itself and more the persistence of behaviours that are socially accepted or practically embedded in early newborn care.

The KAP findings also show that some caregivers introduce complementary foods earlier than recommended. Among infants aged 0–5.99 months, 31 of 220 (14%) had reportedly been introduced to solid or semi-solid foods at 5 months, and 16 of 220 (7%) at 4 months, both earlier than the recommended 6-month threshold. By contrast, 140 of 220 caregivers (64%) reported that complementary foods had not yet been introduced, which is broadly appropriate for this age group.

This indicates that while many caregivers are following age-appropriate feeding timelines, a sizeable minority begin complementary feeding too early. This matters because early introduction of foods can reduce exclusive breastfeeding and increase exposure to infection, especially where water quality, hygiene conditions, or food preparation practices are inadequate.

Among the 598 women for whom pregnancy-related data were collected, 70% (417/598) reported attending at least one antenatal care visit during their most recent pregnancy. While this indicates that many women had some contact with maternal health services, it also suggests that a substantial proportion did not access ANC at all, and the data further indicate that many attendees had limited numbers of visits.

IFA supplementation was reported as always taken by 39% (235/598) of women and sometimes taken by 27% (164/598). Combined, this indicates that 67% reported at least some IFA supplementation during pregnancy. At the same time, 5% reported taking supplements rarely, 14% reported never taking them, and a further 14% did not know or could not confirm whether supplementation had been taken.

These findings suggest that maternal care contact and supplementation coverage are partial rather than universal. This is important because ANC is a key entry point for counselling on breastfeeding, complementary feeding, and maternal nutrition. Gaps in ANC and inconsistent IFA supplementation therefore help explain why awareness of recommended practices may coexist with weaker implementation in practice.

ANC Attendance and IFA Supplementation

Among 598 women for whom pregnancy-related data were collected, 70% reported attending at least one antenatal care (ANC) visit during their most recent pregnancy.

Analysis by pregnancy stage shows that ANC attendance is already relatively high in early pregnancy (78% in the first trimester) and increases modestly in later stages (82% in the second trimester and 84% in the third trimester). This pattern suggests that access to ANC services is not limited to later stages of pregnancy and that most women engage with services early.

However, despite relatively high rates of at least one ANC visit, this does not necessarily indicate adequate coverage in line with recommended care schedules. The findings point to potential gaps in the continuity, frequency, and completeness of ANC visits across pregnancy, rather than in initial access.

Table 22: ANC Attendance by Pregnancy Stage

Pregnancy stage	n	≥1 ANC visit	Interpretation
1st trimester (0–3 months)	60	78%	Early-stage attendance already relatively high
2nd trimester (4–6 months)	119	82%	Attendance increases as pregnancy progresses
3rd trimester (7–9 months)	82	84%	Highest attendance observed
Total (with valid data)	261	82%	—

While ANC attendance shows relatively early contact with maternal health services, Table 23 places this finding alongside reported IFA supplementation in order to assess the broader consistency of maternal nutrition support during pregnancy.

Table 23: Antenatal Care (ANC) Attendance and Iron–Folic Acid (IFA) Supplementation

ANC and IFA Indicator	n	Rate	Notable pattern
ANC attendance (at least 1 visit)	417 / 598	70%	ANC attendance (at least 1 visit)
IFA supplementation — Always	235 / 598	39%	IFA supplementation — Always
IFA supplementation — Sometimes	164 / 598	27%	IFA supplementation — Sometimes
IFA supplementation — Always or Sometimes (combined)	399 / 598	67%	IFA supplementation — Always or Sometimes (combined)
IFA supplementation — Rarely	32 / 598	5%	IFA supplementation — Rarely
IFA supplementation — Never	81 / 598	14%	IFA supplementation — Never
IFA supplementation — Do not know	86 / 598	14%	IFA supplementation — Do not know

Note: "Do not know" responses (86/598, 14.4%) are included in the IFA table above. These respondents could not confirm or deny supplementation — a category distinct from non-supplementation — and are reported separately to ensure denominators sum to 100%.

IFA supplementation was reported as "always" or "sometimes" taken by 67% of pregnant women, leaving one-third without consistent supplementation coverage. Among women who rarely or never supplemented, primary cited barriers included cost, unavailability of supplements, and lack of

awareness of their importance. Among those who did supplement, the primary stated benefits cited were prevention of iron-deficiency anaemia, support for foetal growth and prevention of low birth weight, and maintenance of maternal energy.

Female participants in Harim (Idleb) demonstrated strong theoretical awareness of the importance of breastfeeding and nutritious food for children under two. However, participants repeatedly framed their inability to implement recommended practices as a resource constraint rather than a knowledge gap — "we know what children should eat, but we cannot afford it."

ANC attendance was described qualitatively as being affected by transportation costs and the limited availability of functioning primary health care in some areas. Participants also noted that IFA tablets were sometimes received through aid distributions but described these as irregular and insufficient to cover the full duration of pregnancy. These qualitative findings suggest that access may be episodic and shaped by service availability and affordability, though the quantitative data do not permit firm conclusions about adequacy of ANC attendance relative to pregnancy stage.

Several women described reducing their own dietary intake during pregnancy to ensure other household members ate, a practice they did not link to risk but which is a direct driver of maternal nutritional vulnerability as measured by MUAC and IFA inadequacy.

Malnutrition Treatment — Access and Barriers (Objective 3)

This sub-section examines treatment-seeking behavior, cost burden, and barriers to malnutrition treatment among households where malnutrition in a child 6–23 months or a PLW was confirmed or suspected. A total of 125 households met this criterion and are the denominator for treatment-related indicators.

66%	34%	56%
Sought treatment (n=83/125)	Did not seek treatment (n=42/125)	Delayed treatment due to financial reasons (n=70/125)

Barriers to Seeking Malnutrition Treatment

Among the 42 households that did not seek treatment, the two most frequently cited barriers were cost of treatment and distance or travel time to the facility. Geographic patterns in treatment barriers are uneven rather than uniform. Cost-related barriers were most concentrated in Darayya (Rural Damascus) and As-Suqaylabiyah (Hama), while distance and travel time barriers were reported across a wider spread of districts, including Darayya (Rural Damascus), Ar-Raqqa, As-Suqaylabiyah, Ar-Rastan (Homs), Dar'a, Izra' (Dar'a), Tadmor (Homs), and Tell Abiad (Ar-Raqqa). Some barriers were more localised: lack of medicines or tests was reported in districts such as Afrin (Aleppo), Al Makhrim, Al-Qusayr (Homs), As-Suqaylabiyah (Hama), Damascus, Hama, Jablah (Latakia), and Masyaf (Hama); low perception of malnutrition severity was most evident in Al-Qusayr (Homs) and Jablah (Latakia); and caregiving-related constraints, such as the absence of someone to care for other children, were particularly noted in Darayya (Rural Damascus) and Damascus. These findings suggest that while financial and access barriers are important across multiple locations, the combination of constraints varies by district. Below are the Reported Barriers to Seeking Treatment for Malnutrition

- Cost of treatment (direct and indirect)
- Distance / time to facility
- Low perception of malnutrition severity

- Facility lacks required medicines / tests
- No one to care for other children at home
- No one to accompany caregiver to facility
- Other / unspecified
- Queues too long at facility

Malnutrition Treatment Costs

Among the 83 households that reported seeking malnutrition treatment, direct treatment costs were most commonly associated with medical consultations (42 households), followed by scans or test fees (33 households) and nutritional supplements (28 households). Indirect costs were dominated by transportation (43 households), with additional burdens linked to lost wages due to time away from work (16 households) and childcare for other children at home (10 households).

Table 24: Reported Weekly Cost of Treatment Among Households

Weekly Cost Category	n	Proportion of those with costs
Less than USD 20/week (direct costs)	21	32%
USD 20–49/week (direct costs)	22	34%
USD 50–99/week (direct costs)	5	8%
USD 100+/week (direct costs)	1	2%
Do not know	10	15%
Not applicable (no costs)	6	9%

The majority of households with treatment costs spent between USD 20–49 per week on direct costs alone, a significant burden in a context where household incomes are often below USD 50–100 per month. Only 12% of households with a malnourished child or PLW had received any financial assistance (cash or vouchers) for malnutrition treatment (n=15/125), indicating a substantial gap between demand for financial support and supply of targeted nutrition cash assistance.

The data show that treatment-related financial pressure is not evenly distributed. Delayed or avoided treatment due to financial reasons was most concentrated in Darayya (13 households), followed by Ar-Rastan (8), Tell Abiad (7), Duma (6), and Jablah (5). These locations stand out as the clearest concentrations of financial access barriers in the sample.

The data show that treatment-related financial pressure is unevenly distributed across districts, with clear geographic variations in both access barriers and service utilization. Delayed or avoided treatment due to financial constraints is concentrated in specific locations, while treatment-seeking is observed across a broader range of districts, indicating varying ability to access care. Financial assistance for treatment remains limited and unevenly distributed. The following table shows the distribution of reported cases by district and indicator:

Table 25: distribution of reported cases by district and indicator

Governorate	District	Indicator	Households
Rural Damascus	Darayya	Delayed/avoided treatment (financial reasons)	13
Homs	Ar-Rastan		8
Ar-Raqqa	Tell Abiad		7
Rural Damascus	Duma		6
Latakia	Jablah		5
Ar-Raqqa	Tell Abiad	Treatment-seeking	10
Rural Damascus	Duma		8
Deir ez-Zor	Al Mayadin		6
Homs	Tadmor		6
Rural Damascus	Darayya	Financial assistance received	5
Ar-Raqqa	Tell Abiad		3
Homs	Ar-Rastan		3
Homs	Tadmor		2

Malnutrition Treatment Access by Disability and Gender of Head of Household

Households with two or more members with a disability showed markedly reduced treatment-seeking (33%) and an elevated rate of financial barriers causing delays (67%), consistent with the compounding burden of disability-related healthcare costs documented qualitatively in the Harim (Idleb) female FGD. Notably, households with one disabled member showed the highest treatment-seeking rate in the sample (74%), suggesting that disability may motivate initial engagement with services while the financial burden remains a persistent deterrent.

Female participants described a treatment environment characterised by significant geographic and financial barriers. In Harim, the absence of any free nutrition services within the town meant that accessing treatment required travel to access treatment. Participants also noted that even without travel, out-of-pocket costs for treatment could still be prohibitive. For households with disabled members already spending USD 50/month on medical costs, adding nutrition treatment costs was described as "impossible."

Gender-specific barriers were prominent. Female caregivers without male accompaniment described social and safety constraints on travelling to distant facilities. Widowed women and female heads of household stated that they could not leave their children unattended while seeking treatment, and that the absence of community-level childcare support was a decisive barrier.

Participants also reported a tendency to delay or avoid formal diagnosis of child malnutrition, rationalising low weight and stunting as "normal given the situation." This aligns with the quantitative

finding that 6/42 households not seeking treatment for malnutrition cited low perceived severity as a barrier, and points to a need for community-level awareness raising alongside service provision.
Male FGD participants in Idleb similarly acknowledged cost as the primary barrier to nutrition services, with several noting that GOAL's programming represented the only accessible nutrition support in the area. Participants called for expanded home-based treatment options (ready-to-use therapeutic food distributed at community level) and reduced facility-based requirements, particularly for mothers with young children and limited mobility.

Nutrition Indicators

All nutrition indicators are computed using WHO/WFP-aligned protocols applied to the analytic sample of N = 5,302 households. Eligible sub-populations are defined based on survey-reported age and household composition. Indicators are disaggregated, where relevant, by sex of child, displacement status, governorate, and breastfeeding status in Section 5.2. The table below presents indicator definitions, denominators, and computed results in a single consolidated reference.

Table 26: Key Nutrition, IYCF, and Maternal Health Indicators

Indicator	Denominator	Result
Infants 0–5.99 months — IYCF practices		
Infants aged 0–5.99 months	220 infants	—
Any breastfeeding (24-hour recall)	220	180/220 (82%)
Early initiation of breastfeeding (<1 hour after birth)	220	69/220 (31%)
Breastfeeding initiated within 24 hours of birth	220	184/220 (84%)
Pre-lacteal feeding (first 2 days)	220	85/220 (39%)
Children 6–23 months — complementary feeding		
Children aged 6–23 months	500 children	—
Minimum Dietary Diversity (MDD)	500	144/500 (29%)
	Consumption of ≥4 food groups in the previous 24 hours, as applied in this assessment	
Minimum Meal Frequency (MMF)	500	307/500 (61%)
	Age- and breastfeeding-status-adjusted meal frequency thresholds, as applied in this assessment	
Minimum Acceptable Diet (MAD)	500	116/500 (23%)
	Combined MDD and MMF indicator, with the additional milk-feed requirement applied for non-breastfed children	
Breastfed children aged 6–23 months	277	—
MDD among breastfed children	277	79/277 (29%)

MMF among breastfed children	277	167/277 (60%)
MAD among breastfed children	277	71/277 (26%)
Non-breastfed children aged 6–23 months	223	—
MDD among non-breastfed children	223	65/223 (29%)
MMF among non-breastfed children	223	140/223 (63%)
MAD among non-breastfed children	223	45/223 (20%)
Women — dietary diversity and maternal care		
Women assessed for MDD-W	598 women	—
MDD-W met	598	188/598 (31%)
	Consumption of ≥5 of 10 food groups in the previous 24 hours	
ANC attendance (at least 1 visit during pregnancy)	598	417/598 (70%)
IFA supplementation — Always	598	235/598 (39%)
IFA supplementation — Sometimes	598	164/598 (27%)
IFA supplementation — Rarely	598	32/598 (5%)
IFA supplementation — Never	598	81/598 (14%)
IFA supplementation — Don't know	598	86/598 (14%)
Malnutrition treatment access		
Households in malnutrition treatment module	125 HH	—
Sought malnutrition treatment	125	83/125 (66%)
Delayed or avoided treatment due to financial reasons	125	70/125 (56%)
Received financial assistance (cash/vouchers) for malnutrition treatment	125	15/125 (12%)

Methodological Notes:

- The infant IYCF denominator (n=220) includes all households in which an infant aged 0–5.99 months was recorded in the household composition. This section reports any breastfeeding rather than exclusive breastfeeding.
- The complementary feeding denominator (n=500) includes all children aged 6–23 months captured in the nutrition module. MDD was calculated using a threshold of at least 4 food groups consumed in the previous 24 hours, consistent with the approach used in the body of this report. MMF was calculated using breastfeeding-status-specific thresholds. MAD was calculated as the proportion of children meeting both MDD and MMF, with the additional milk-feed requirement applied for non-breastfed children.

- Among children aged 6–23 months, 277 were breastfed and 223 were non-breastfed in the cleaned analytic dataset used for the corrected complementary feeding calculations presented in Section 5.2.3.
- The MDD-W denominator (n=598) includes all women for whom the dietary diversity module was completed. MDD-W met is defined as consumption of at least 5 of 10 food groups in the previous 24 hours.
- The treatment module denominator (n=125) includes all households with a yes/no response to the financial delay and financial assistance questions. This includes 124 households with a confirmed diagnosis and 1 additional household that completed the module without a confirmed diagnosis.

5.3 ASSOCIATION BETWEEN FOOD SECURITY AND NUTRITIONAL STATUS (OBJECTIVE 2)

This section addresses Objective 2 of the MSNA Terms of Reference: to measure the strength of association between household food security status and the nutritional status of children aged 6–59 months and pregnant and lactating women (PLW). Analyses include cross-tabulation with chi-square testing, Spearman rank correlation, and binary logistic regression with covariate adjustment. Throughout, association is distinguished from causation; the cross-sectional survey design precludes causal inference.

5.3.1 Dietary Adequacy Among Children and Women in Relation to Household Food Consumption

To complement the household-level Food Consumption Score analysis, this assessment examined child and women's diet adequacy in relation to household food consumption status. Two composite indicators were reviewed: MAD among children aged 6–23 months in conjunction with household FCS, and MDD-W in conjunction with household FCS.

The results show a clear divergence between household food consumption and individual diet adequacy, particularly for young children. Although 68% of households in the overall sample achieved an acceptable FCS, only 23% of children aged 6–23 months met the Minimum Acceptable Diet, and only 19% both met MAD and lived in households with acceptable FCS. This indicates that adequate household food consumption does not automatically translate into age-appropriate child feeding. In practice, the nutritional gap for young children appears to be driven not only by food access constraints, but also by suboptimal infant and young child feeding practices, low child dietary diversity, and likely intra-household constraints in the allocation and preparation of suitable foods.

A different pattern is observed among women. Among pregnant and lactating women in the nutrition sample, 31% met MDD-W, while 28% both met MDD-W and lived in households with acceptable FCS. This suggests a closer relationship between household food consumption and women's dietary diversity than is observed for children. However, the gap between acceptable household FCS and adequate women's dietary diversity remains substantial, indicating that household food security alone is not sufficient to ensure nutritionally adequate diets for women either.
Taken together, these findings reinforce the interpretation emerging from the wider food security analysis: the binding constraint in many assessed areas is affordability, but food access alone does not fully explain nutritional outcomes. For children in particular, the relatively low prevalence of MAD even among households with acceptable FCS suggests that programme responses should not assume that

improvements in household food consumption will automatically improve infant and young child feeding. Food assistance and cash-based support therefore need to be complemented by targeted maternal, infant and young child nutrition outreach, behaviour change support, and context-appropriate counselling on child feeding practices.

For women, the results point to a somewhat stronger link between household food consumption and individual dietary diversity, but still show that many women in food-secure households do not consume sufficiently diverse diets. This may reflect cost barriers to nutrient-dense foods, dietary monotony within otherwise acceptable household consumption patterns, and household-level prioritisation dynamics that are not captured by FCS alone. The findings therefore support continued integration of food security and nutrition programming, particularly in locations where FCS appears relatively stable but nutrition indicators remain weak.

Table 27: Composite child and women indicators in relation to household FCS

Indicator	Denominator	Met indicator	Met indicator and acceptable FCS	% of denominator
Children 6–23 months: MAD	500	116 (23%)	97	19%
Pregnant and lactating women: MDD-W	598	188 (31%)	170	28%

5.4 WASH – VULNERABILITIES, GAPS AND OPPORTUNITIES FOR IMPROVEMENT (OBJECTIVE 4)

5.4.1 Water Supply

Access to clean drinking water was assessed through primary and secondary source type, interruption frequency, coping mechanisms, and household satisfaction. The JMP definition of improved drinking water sources (piped/network, bottled water, protected spring, and protected public well) was applied as the primary benchmark, with water trucking/tankers also considered improved in the humanitarian context per WASH Cluster Syria norms.

Access To Improved Water Sources

96%
of households use an improved drinking water source (including water tankers)

73%
use strictly improved sources (piped network, bottled, protected spring/well)

67%
rely on the piped/mains network as their primary source

The piped water network is the dominant primary source, serving 67% of surveyed households. Water tankers constitute the second most common source at 22%, followed by private wells (4%), bottled water (4%), and public/communal wells (3%). Collectively, 96% of households draw from an improved source when water tankers are classified as improved, reflecting strong formal infrastructure coverage. However, these aggregate masks important quality and reliability deficiencies described below. Table

below presents selected districts with the most severe water access and reliability gaps, while full district-level results are provided in Annex VI.

Table 28: Household Water Source Access and Reliability by District

Governorates	District	n (HH)	Improved Water (%)	Network (%)	Tanker (%)	Any Interruption (%)	Frequent Interr. (%)
Aleppo	As-Safira	132	85%	38%	47%	35%	2%
Ar-Raqqa	Ar-Raqqa	149	100%	98%	2%	97%	41%
Ar-Raqqa	As-Sweida	131	92%	13%	79%	86%	12%
Deir-ez-Zor	Al Mayadin	144	100%	88%	12%	94%	39%
Homs	Al Makhrim	102	80%	64%	17%	69%	32%
Homs	Al-Qusayr	106	82%	78%	4%	76%	26%
Homs	Ar-Rastan	142	39%	26%	13%	74%	14%
Homs	Tall Kalakh	143	62%	53%	8%	57%	13%
Lattakia	Al-Haffa	257	100%	98%	1%	88%	33%
Rural Damascus	Darayya	128	98%	68%	30%	96%	20%
Rural Damascus	Duma	119	55%	6%	11%	72%	22%

Interruptions in Water Provision

57%
of households reported at least one interruption in the past 3 months

14%
experienced frequent interruptions (5 or more times per month)

Service continuity is a critical vulnerability: more than half of surveyed households (57%) reported interruptions to their primary water source in the three months preceding the survey. Nearly one in seven households (14%) experienced high-frequency disruptions of five or more times per month, indicating near-chronic unreliability for a significant minority. When interrupted, households primarily rely on secondary water sources (1,621 mentions), followed by water conservation measures (1,238 mentions). A smaller but economically vulnerable share (103 mentions) resort to borrowing money to purchase water, underscoring affordability stress when networks fail.

Table 29: Interruption Frequency in Water Provision (Last 3 Months)

Interruption Frequency	Households (n)	Share (%)
No interruptions	2,261	43%
Once a month	1,008	19%
2–4 times a month	1,282	24%
5–7 times a month	377	7%
More than 7 times a month	374	7%

Water Quality Satisfaction

74%
satisfied or very satisfied with primary water source quality

14%
dissatisfied or very dissatisfied with water quality

Three-quarters of households (74%, n=3,924) report satisfaction with primary source water quality, a figure that reflects reasonable confidence in the network system for those who have it. Nonetheless, 14% (n=768) express dissatisfaction, and the remaining 12% are neutral — pointing to a sizable minority with quality concerns. Among the affordability constraints driving water insecurity, the most common reasons households cannot access sufficient water are: the high price of water (n=341), inadequate household storage capacity (n=314), and weak water pressure (n=245).

Disaggregation by Displacement Status

Access to improved water sources is broadly high across all displacement categories, though returnee households show a comparatively lower rate (93% improved) versus host community (96%) and IDP households (97%). This reflects the likely degradation of infrastructure in areas of return and the lower availability of fallback sources for returnees who may not yet have re-established household networks.

Table 30: Improved Water Access by Displacement Status

Displacement Status	Improved Source (%)	Non-Improved (%)
Host community	96%	4%
IDP	97%	3%
Returnee	93%	7%

5.4.2 Sanitation

Sanitation access was assessed through toilet availability, facility type, sewage system connectivity, and the presence of open sewage channels. The JMP improved sanitation definition was applied: access to a private toilet (flush/pour flush or pit latrine) is classified as improved; shared latrines are partially improved; and no access to a toilet represents an open defecation risk context.

99%	98%	1%	78%	20%
of households have access to some form of functional toilet	have exclusive private toilet access (highest JMP category)	report no access to a toilet (open defecation risk context)	of village households have access to functioning sewer lines	of households report open sewage channels in their area

Aggregate sanitation coverage is high, but As-Sweida district stands as a critical outlier: 21% of households report no functioning toilet access, almost certainly driven by IDP settlement conditions. Al Bab 4% and As-Suqaylabiyah 3% also exceed the 2% alert threshold. All remaining districts record rates below 2%.

Open sewage channels are reported by 20% of sampled areas overall. The most severe situations are Al-Qusayr (82%), Tall Kalakh (41%), Darayya (38%), and Al Bab (38%) — all exceeding the 30% critical threshold. Al-Qusayr's near-universal open sewage represents a critical infrastructure failure. Table 31 presents the districts with the highest open sewage prevalence; full district-level sanitation and diarrhoea results are provided in Annex VII.

Table 31: Top Districts with the Highest Open Sewage Prevalence

Governorates	District	n	Private Toilet (%)	No Toilet (%)	Sewer Access (%)	Open Sewage (%)	Diarrhea Prev. (%)
Aleppo	Afrin	134	99%	0%	84%	24%	6%
Aleppo	Al Bab	109	84%	4%	79%	38%	9%
Deir-ez-Zor	Al Mayadin	144	99%	0%	63%	24%	3%
Deir-ez-Zor	Deir-ez-Zor	105	99%	0%	88%	29%	10%
Hama	As-Suqaylabiyah	140	97%	3%	71%	32%	2%
Hama	Muhradah	150	100%	0%	79%	29%	2%
Homs	Al-Qusayr	106	97%	0%	51%	82%	32%
Homs	Tall Kalakh	143	100%	0%	48%	41%	0%
Rural Damascus	Darayya	95%	0%	99%	38%	64%	95%
Rural Damascus	Qatana	100%	0%	94%	26%	7%	100%

Infrastructure and Sewage Systems

While 78% of village households (n=4,141) are connected to functioning sewer lines, over one in five households (20%, n=1,043) live in areas with open sewage channels. This creates serious public health risks including contamination of water sources, vector breeding, and disease transmission. FGD evidence from Safira specifically noted that 90% of the sewage network requires replacement, illustrating the severity of underlying infrastructure degradation in conflict-affected areas.

Disaggregation by Displacement Status and Gender

The no-toilet rate is strikingly higher among IDP households (5%) compared to host community (<1%) and returnee households (<1%), reflecting IDP settlement conditions (camps and informal sites) where communal or absent sanitation is more common. Female-headed households face compounded risks given the lack of separate or safe sanitation facilities in such settings. No significant difference in no-toilet rates was observed by gender of respondent (female: 1%, male: 1%), though this likely reflects household-level reporting rather than individual-level access differences.

Female FGD participants across governorates raised significant concerns about privacy, safety, and dignity in communal sanitation contexts, particularly in IDP settlement areas. The absence of gender-segregated facilities was cited as a barrier to toilet use, especially at night. Women in Harim noted that widows and female-headed households without a male breadwinner have greater difficulty securing access to and maintenance of basic sanitation. In Safira, the near-total collapse of sewage infrastructure was described by participants as a community-wide crisis affecting health, hygiene, and dignity equally across groups.

5.4.3 Solid Waste Management

73%	77%	27%
of households have access to a functioning waste collection system	have a designated waste disposal point in proximity to their home	lack any functioning waste collection service

Access to solid waste collection services is available to nearly three-quarters of households (73%, n=3,862), with 77% (n=4,060) reporting a designated waste disposal point within proximity. However, more than one in four households (27%, n=1,440) have no functioning waste collection system, a significant gap with direct implications for environmental health, vector control, and disease transmission. Official landfills serve only 51% of areas (n=2,709), with 14% (n=765) confirmed without a landfill and 35% (n=1,828) uncertain of their waste disposal endpoint — suggesting that even where collection exists, the final disposal chain is weak.

Official landfills serve only 51% of assessed areas, and 35% of households are uncertain of their waste disposal endpoint, suggesting significant final-chain gaps even where collection nominally exists. Eight of 36 districts record collection rates below 50%, with five concentrated in Homs Governorate (lowest governorate average: 55%). Idleb Governorate, by contrast, has uniformly strong collection rates, ranging from 91% (Ariha) to 100% (Jisr-Ash-Shugur, As-Sanamayn). Table below presents the ten districts with the lowest waste collection coverage. Full district-level results for waste collection, open sewage, access to hygiene items, and hygiene promotion are provided in Annex VIII.

Table 32: Top 10 districts for waste collection for solid Waste Collection

Governorate	District	n	Waste Collection (%)	Open Sewage (%)	Cannot Access Hygiene Items (%)	Received Hygiene Promotion (%)
Aleppo	Al Bab	109	58%	38%	9%	1%
	As-Safira	132	12%	17%	20%	3%
As-Sweida	As-Sweida	131	1%	9%	12%	3%
Dar'a	Izra'	149	44%	13%	6%	5%
Homs	Al-Qusayr	106	37%	82%	40%	22%
	Tadmor	317	47%	21%	30%	2%
	Tall Kalakh	143	27%	41%	43%	0%
Rural Damascus	Darayya	128	13%	38%	37%	16%
	Duma	119	58%	29%	29%	7%
	Qatana	146	58%	26%	25%	3%

5.4.4 Diarrhea Morbidity

Diarrhea morbidity was assessed using the standard two-week recall method. Among households with children aged 6–59 months providing a definitive yes/no response (n=2,075), the overall prevalence is 13.6%. District-level analysis reveals marked variation that closely tracks WASH infrastructure quality.

64% Darayya (Rural Damascus) diarrhea prevalence

46% Abu Kamal (Deir-ez-Zor)

43% Al-Haffa (Lattakia)

41% Ar-Rastan (Homs)

33% Harim (Idleb)

Darayya is the most severe outlier at 64%, coinciding with a 96% interruption rate and only 13% waste collection access — a triple WASH burden. Harim (Idleb) records elevated diarrhea (33%) despite relatively high improved water access, suggesting hygiene behaviour and coping practices contribute beyond source type alone. Conversely, As-Sanamayn (Dar'a) with 100% waste collection and moderate interruption (46%) — records only 5% diarrhea prevalence, among the lowest in the sample.

FGD participants in multiple sites described limited understanding of the link between water quality, hygiene practice, and diarrheal illness in children. Caregivers frequently attributed childhood diarrhoea to food quality or seasonal illness rather than water source quality or handwashing. Female participants in several governorates noted that handwashing materials (soap) are often prioritised away due to cost pressures, with 19.9% of surveyed households (n=1,056) reporting they were unable to access needed hygiene items in the past 30 days. Only 9.2% of households (n=490) had received any hygiene promotion session in the previous three months, indicating critically low coverage of behaviour change communications across the assessed population.

5.4.5 WASH Indicators

WASH indicators are derived from the survey WASH module, applied to all N = 5,302 households. Water source classification follows the JMPimproved/unimproved framework. Sanitation follows the JMP 2017 ladder. Diarrhea morbidity uses the WHO 1993 standard two-week recall definition. Disaggregation by displacement status, governorate, and sex of household head is presented in Section 5.4.

Table 33: WASH Indicators – Access to Drinking Water (JMP 2017 Classification, N = 5,302 HH)

Indicator	Denominator	Result
Access to Drinking Water — JMP Improved/Unimproved Classification		
Improved drinking water source (JMP 2017) Sources classified as improved: piped network, private/public wells, bottled water, protected spring, harvested rainwater. Water tanker/trucking classified as UNIMPROVED per JMP 2017 strict criteria (not protected from contamination at source).	5,302 HH	4,113/5,302 (78%)
Unimproved — Water tanker/trucking Water tanker is the primary source for 1,170 HH (22.1%); classified as unimproved per JMP. This is a critical service gap warranting programmatic attention.	5,302 HH	1,170/5,302 (22%)
Unimproved — Other (unprotected wells, other unspecified)	5,302 HH	19/5,302 (<1%)
Sanitation — Facility Type (JMP Ladder Classification)		
Improved sanitation — Private toilet access Private toilet facilities (flush/pour-flush or pit latrine). Classified as improved per JMP 2017.	5,302 HH	5,178/5,302 (98%)
Limited sanitation — Shared latrines Shared with other households; classified as 'limited' per JMP SDG 6.2.1 framework (not fully improved).	5,302 HH	83/5,302 (2%)
No functioning toilet / Open defecation (OD) No access to any functioning toilet facility. SDG 6.2.1 OD indicator. Elevated risk for IDP sub-group.	5,302 HH	41/5,302 (1%)
Solid Waste Management — Service Availability		
Access to a functioning waste collection system	5,302 HH	3,862/5,302 (73%)

Any formally operating municipal or NGO-led waste collection service in the area.		
No functioning waste collection system	5,302 HH	1,440/5,302 (27%)
Diarrhea Morbidity — Children Under 5, Two-Week Recall (WHO 1993)		
Diarrhea episode in past 2 weeks (Children under 5 years of age **(U5))** ≥3 loose stools in one day in the preceding 2 weeks; any child aged 6–59m in the household. Denominator: HH with 6–59m child with definitive yes/no response (excludes 'no child' and 'don't remember' responses).	2,075 HH	283/2,075 (14%)
No diarrhea episode reported (eligible HH - households with a child aged 6–59 months and a valid response)	2,075 HH	1,792/2,075 (86%)

Methodological Notes:

- Water source classification: JMP 2017 strict definitions applied. Water tanker/trucking is classified as UNIMPROVED (not a protected source per JMP), giving an improved water access rate of 78%. Note: some Syria WASH Cluster analytical products classify tanker as improved in conflict settings; this document follows JMP 2017 SDG monitoring definitions. Both figures (77.6% JMP strict; 92.9% including tanker) are reported in Section 5.4.
- Sanitation: JMP 2017 sanitation ladder applied. Private toilets = improved. Shared latrines = limited (basic). Open defecation = no service. Sewage connection data collected separately and disaggregated in Section 5.4.
- Solid waste management: service availability (functioning collection) is the primary indicator. Frequency, cost, and landfill proximity are analysed as sub-indicators in Section 5.4.
- Diarrhea denominator (n=2,075): excludes HH with no child aged 6–59 months (n=2,763) and HH where respondent could not recall (n=464). This conservative denominator avoids recall bias inflation.

6. RECOMMENDATIONS

6.1 FOOD SECURITY

6.1.1 Geographic Targeting and Emergency Assistance

Scale immediate food assistance to the districts and governorates recording the highest CARI Moderate and Severe rates: As-Salamiyeh (Hama) (85%), Abu Kamal (Deir ez-Zor) (81%), Hama (76%), Al Makhrim (Homs) (69%), Ar-Rastan (Homs) (64%), and As-Suqaylabiyah (Hama) (64%). District-level CARI severity maps should be the primary targeting instrument, used to sequence and prioritise response coverage within each governorate.

Unrestricted CVA is the recommended primary modality. Affordability — not food availability — is the binding constraint across the assessed population: 71% of households spend more than half their income on food, and the most common coping behaviour (44%) is reliance on cheaper or less preferred foods. Transfer values must be calibrated against current market prices and adjusted quarterly, ensuring households can meet food and non-food needs simultaneously.

6.1.2 Vulnerable Household Targeting

Female-headed households (56% Moderate and Severe), households with a disabled head of household (57%), and IDP households (51%) consistently record 15–17 percentage-point higher food insecurity than comparison groups and must be explicitly captured in registration and targeting systems. Standardised vulnerability identification tools should be applied at the point of household registration to ensure these groups are enrolled across all assistance modalities. Female-headed households face a structurally weaker income profile — higher reliance on unskilled labour (+5.8 pp vs males), lower homeownership (62% vs 65%), and greater dependency on community charitable transfers — which reduces their resilience and increases the speed of deterioration under economic shocks.

6.1.3 Protecting Household Resilience

Fifty percent of assessed households are deploying Crisis or Emergency livelihood coping strategies, including selling productive assets, withdrawing children from school, and emergency borrowing. Relief programming must move quickly enough to halt this erosion: once productive assets are sold and children are removed from school, recovery is slow and costly. The 47% of households currently classified as Marginally food insecure — who are meeting basic needs but have zero resilience buffer — represent an additional priority group for protective assistance before they deteriorate into Moderate or Severe food insecurity.

6.1.4 Livelihoods and Self-Reliance

Complementary livelihoods programming must accompany food assistance, particularly in high-CARI districts where Crisis and Emergency coping is most prevalent. Small-scale income-generating activities — sewing, grocery retail, home gardening, handicrafts — were consistently identified by FGD participants in Ariha and other locations as preferred and realistic pathways to reducing aid dependency. Programming should prioritise women and female-headed households, for whom the consequences of negative coping are most severe: FGD evidence from Harim documents child labour, school withdrawal, and early marriage of daughters as active Emergency coping strategies among the most food-insecure households. Livelihoods grants and business development support should be

sequenced alongside food assistance in the highest-severity districts to begin enabling graduation from emergency dependence.

Furthermore, just as qualitative evidence highlighted the absence of community-level childcare as a decisive barrier preventing widowed women and female heads of household from accessing health and nutrition treatments, this lack of childcare similarly limits their capacity to participate in time-intensive livelihood activities. Therefore, livelihoods programming should incorporate or subsidize childcare support specifically to enable female-headed households to engage in income generation. Finally, further targeted research must be conducted to fully map the distinct barriers to meaningful employment faced by female-headed households, internally displaced persons (IDPs), and households headed by persons with disabilities. As the assessment data indicates, these highly vulnerable groups face vastly different structural, financial, and social constraints—from precarious unskilled labor markets for women to insurmountable medical costs for disabled populations—requiring heavily tailored livelihood interventions.

6.2 NUTRITION

6.2.1 Immediate Nutrition Response

Within the MSNA, districts such as As-Safira (Aleppo), Tadmor (Homs), Harim (Idleb), and Abu Kamal (Deir-ez-Zor)show very weak child feeding outcomes and/or pronounced affordability-related constraints, indicating the need for strengthened outreach, active case-finding, and improved community-level access to nutrition services. Outreach should prioritise hard-to-reach sub-districts and integrate ready-to-use therapeutic food (RUTF) distribution and follow-up at community level to reduce the need for repeated facility visits, which evidence identifies as a key barrier.

Integrate targeted nutrition cash assistance or vouchers into CMAM treatment protocols to address direct and indirect treatment costs. Currently only 12% of households with a malnourished child or PLW reported receiving any financial support for treatment. Transfer values should cover at minimum the documented USD 20–49 per week direct cost burden and transportation costs. Disability-affected households should be fast-tracked for this support given their compounding cost burden.

6.2.2 Infant and Young Child Feeding (IYCF)

Address pre-lacteal feeding (39% prevalence) and delayed breastfeeding initiation (only 31% within 1 hour) through community-based IYCF counselling reaching caregivers at ANC visits, postnatal contacts, and through trained community health workers. Counselling should emphasise the 'first hour' message and target the cultural practices (anise water, sugar water, infant formula) most commonly cited as pre-lacteal feeds. IDP households, which record the highest pre-lacteal feeding rate (50%), should be specifically targeted, as displacement-related factors—including disrupted access to antenatal and delivery care, reliance on informal advice networks, stress and uncertainty around breastfeeding, and increased exposure to breastmilk substitute use—are likely to contribute to suboptimal early feeding practices.

Complementary feeding support should be designed around economic access rather than knowledge deficit: FGD evidence and MAD data (only 23% compliance) consistently show that caregivers are generally aware of recommended practices but are constrained by limited purchasing power and affordability of diverse foods. Interventions should therefore combine behaviour change counselling with measures that improve economic access to nutritious foods. This includes targeted food vouchers for protein-rich foods, fresh vegetables, and dairy, alongside efforts to improve household access to

income and labour opportunities, including facilitating access to local job markets where feasible. Prioritisation should focus on districts with the lowest MAD and MDD levels, where economic constraints most directly translate into poor dietary quality.

6.2.3 Maternal Nutrition and ANC

Strengthen IFA supplementation coverage: 33% of pregnant women did not receive consistent supplementation, with cost and availability as primary barriers. IFA should be integrated into existing community health worker distributions and community-level distribution points, reducing reliance on facility visits that are inaccessible for many women due to transportation costs. Districts with the lowest MDD-W compliance Abu Kamal (Deir-ez-Zor) (3%), Ar-Rastan (Homs) (3%), and As-Sanamayn (Dar'a) (0%)should be priority areas for maternal nutrition support.

Design female-friendly service delivery modalities — including home visits and community outreach — to address the gendered access barriers documented across FGDs and quantitative data. Female-headed households record 25% MDD-W compliance versus 36% for male-headed households and face additional social and safety constraints on facility access. Female hygiene promoters and community health workers from within the community were consistently cited as the most trusted service delivery agents.

6.2.4 Malnutrition Treatment Access

A significant proportion of households with acutely malnourished children do not seek or discontinue treatment due to cost barriers — transportation expenses represent the primary reported obstacle. Programming should address this directly by covering transport costs or issuing vouchers to facilitate access to Community-based Management of Acute Malnutrition (CMAM) services. Where facility access remains constrained, expanding home-based treatment and community outreach through CHWs can reduce barriers and improve timely care-seeking. Households with disabled members require particular attention: community-based nutrition services and targeted financial assistance should be extended to these households, who face compounding barriers to accessing facility-based treatment. Community awareness activities should run alongside service expansion to ensure caregivers understand when and where to seek treatment.

6.3 WASH

6.3.1 Water Supply Rehabilitation

Prioritise rehabilitation of piped water distribution networks in districts with the lowest improved water access rates: Ar-Rastan (Homs) (39%), Duma (Rural Damascus)(55%), Tall Kalakh (Homs) (62%), Al-Qusayr (Homs) (82%), and Al Makhrim (Homs) (80%). Rehabilitation should address pumping stations, storage tanks, and pressure management infrastructure to reduce the 57% interruption rate across the assessed population. Returnee areas, where infrastructure was damaged during conflict and access is lower (93% improved versus 96% for host community), should receive accelerated attention.

Reduce dependency on water tankers, which is economically unsustainable for the 22% of households relying on them as a primary source. Network extension to underserved neighbourhoods should be costed and sequenced in district-level investment plans. In As-Sweida, where 79% of households rely on tankers, piped network restoration is the single most urgent water intervention. FGD communities across multiple governorates identified affordable, reliable water supply as a top priority.

6.3.2 Sanitation Infrastructure

Address the critical open sewage situation in Al-Qusayr (Homs) (82% open sewage, 32% diarrhoea prevalence), Tall Kalakh (Homs) (41%), Darayya (Rural Damascus) (38%), and Al Bab (Aleppo) (38%), all of which exceed the 30% alert threshold. In Al-Qusayr, near-universal open sewage represents an emergency infrastructure failure requiring immediate remediation. FGD evidence from As-Safira indicates that up to 90% of the sewage network in that district requires replacement — a finding that should be verified through rapid technical assessment and costed for rehabilitation.

IDP settlements require dedicated sanitation investment: 5% of IDP households report no access to any toilet facility, compared to less than 1% for host community and returnee populations. Gender-segregated sanitation facilities in IDP settlements must be prioritised to address the safety and dignity concerns raised by female FGD participants across multiple governorates, particularly in areas where communal facilities are shared across sexes.

6.3.3 Solid Waste Management

Expand solid waste collection services to the 27% of households without any functioning system, with priority given to the eight districts recording collection rates below 50%: As-Sweida (As-Sweida) (1%), As-Safira (Aleppo) (12%), Darayya (Rural Damascus) (13%), Izra' (Dar'a) (44%),and several Homs governorate districts (Al-Qusayr 37%, Tadmor 47%, Tall Kalakh 27%). Homs governorate has the lowest average collection rate and should be the focus of governorate-level solid waste planning and investment coordination.

6.3.4 Hygiene Promotion and Behaviour Change

Scale hygiene promotion programming urgently: only 9% of households received any hygiene promotion session in the three months prior to the survey, while 14% diarrhoea morbidity among under-5 households and near-zero handwashing soap access for 20% of households create high transmission risk. Priority areas include Darayya (Rural Damascus) (64% diarrhoea, 96% interruption rate, 13% waste collection), Abu Kamal (Deir-ez-Zor) (46% diarrhoea), Al-Haffa (Lattakia) (43%), and Ar-Rastan (Homs) (41%).Hygiene promotion should be delivered through female community health workers and peer promoters, school-based channels, and water distribution contact points — all identified as high-reach, high-trust delivery mechanisms in FGDs. Integration with GOAL's nutrition programme delivery creates further reach efficiencies.

Establish or strengthen community WASH governance committees with gendered representation, linking to local council structures for accountability and sustainability. Female FGD participants in Jisr-Ash-Shogur called explicitly for formalised local governance of waste services with community oversight — a demand that should be incorporated into WASH programming design.

6.4 CROSS-CUTTING

6.4.1 Integrated Multi-Sector Programming

The evidence base from this MSNA strongly supports integrated multi-sector programming that addresses food insecurity, dietary poverty, and WASH deficits within the same household and geographic priority areas. The documented links between poor household food access, inadequate dietary diversity, barriers to treatment, and WASH deficits underscore the compound risks facing households exposed to multiple vulnerabilities. Districts where high CARI Moderate and Severe prevalence coincides with elevated diarrhoea rates and low waste collection — including Abu Kamal

(Deir-ez-Zor), Hama district (Hama), and As-Salamiyeh (Hama) — represent priority areas for integrated food security, nutrition, and WASH programming packages.

6.4.2 Targeting Vulnerable Household Types

Female-headed households, households headed by persons with disabilities, and IDP households should be explicitly and systematically targeted across all programme components. These groups consistently record 15–17 percentage-point higher Moderate+Severe food insecurity than comparison groups, lower dietary diversity, higher treatment barriers, and reduced access to WASH services. Standardised targeting tools in registration and vulnerability verification must capture these categories to ensure they access all relevant assistance. Female-headed households face particular structural disadvantage: higher reliance on unskilled labour (+5.8 pp vs males), lower homeownership rates (62% vs 65%), and greater dependency on informal support transfers — all of which reduce resilience and increase food insecurity risk.

Households with two or more disabled members (n=6 in the treatment sub-sample) show particularly acute compounding vulnerability: reduced treatment-seeking (33%), high financial delay rates (67%), and documented healthcare expenditures that crowd out food and nutrition spending. Fast-track registration and targeted financial assistance protocols should be developed for this group.

6.4.3 Livelihoods and Resilience Programming

The scale of Crisis and Emergency livelihood coping — affecting 50% of all assessed households — represents a structural erosion of household resilience that emergency food assistance alone cannot reverse. Complementary livelihoods programming must be integrated with food security assistance, with a particular emphasis on income-generating activities accessible to women, persons with disabilities, and labour-constrained households. Small-scale microprojects — sewing, grocery retail, home gardening, handicrafts — were specifically identified by FGD participants in Ariha as preferred pathways to self-reliance and reducing aid dependency. Systematic support for these activities, including small grants and business development services, should be piloted in high-LCSI districts.

Livelihoods support for returnees — who make up 24% of the assessed sample — requires specific attention: returnees frequently encounter damaged WASH infrastructure, limited livelihood opportunities, and insufficient access to nutrition and health services upon return. Integrated return support packages combining food assistance, WASH rehabilitation, and livelihoods start-up grants are needed to prevent rapid post-return deterioration into Moderate or Severe food insecurity.

Furthermore, given the high reliance on agricultural livelihoods in specific areas (such as As-Safira sub-district (Aleppo), where 70% of the population depends on farming) the lack of access to agricultural inputs and damaged irrigation systems are major barriers to food production. In these areas, households face a dual exposure where both income and own production are insufficient to sustain food needs because agricultural activities are constrained by weak market conditions and input unavailability. Therefore, livelihoods programming in agricultural-dependent governorates must incorporate targeted agricultural support, including the provision of essential inputs (such as seeds and fertilizers) and the rehabilitation of farming infrastructure, to restore local food production capacity and reduce market dependency.

6.4.4 Evidence and Monitoring

District-level monitoring systems should track CARI severity trends over time, enabling early detection of deterioration in Marginal households (47% of the current sample) before they transition to Moderate or Severe categories. Monthly rapid market monitoring and quarterly food security updates, integrated

with programme targeting data, are recommended to ensure transfer values and coverage remain adequate in a volatile economic environment.

7. CONCLUSION

This MSNA presents the most comprehensive district-level evidence base on food security, nutrition, and WASH conditions in Syria available as of early 2026. Based on 5,302 household surveys across 44 districts in 11 governorates, the findings paint a consistent and deeply concerning picture: the overwhelming majority of Syrian households — 91% — are food insecure, and the structural drivers of this crisis — economic collapse, livelihood destruction, inadequate purchasing power, and degraded public services — show no signs of rapid resolution even following the political transition of December 2024.

Food insecurity at Moderate and Severe levels (44% of households) is not a fringe phenomenon but a widespread condition affecting virtually all population types and geographic areas, with particular intensity in Hama, Aleppo, Homs, and Deir-ez-Zor. The documented shift from Stress to Crisis and Emergency livelihood coping — affecting half the assessed population — signals that household resilience is being actively eroded at scale, with consequences that extend well beyond immediate food access into education, child labour, asset depletion, and long-term recovery capacity. Without immediate scale-up of assistance and complementary livelihoods support, this erosion will generate needs that are increasingly costly to address.

The nutrition findings, only 23% of children aged 6–23 months met the Minimum Acceptable Diet standard, and only 31% of women met the MDD-W dietary diversity threshold — findings that demand integrated food and nutrition programming that addresses purchasing power alongside behaviour change. The treatment access barrier — with one-third of households with a malnourished child not seeking care due to cost — underscores that nutrition outcomes cannot improve without addressing the financial burden of care within the existing service infrastructure.

WASH findings reveal a fragile infrastructure landscape with significant pockets of acute vulnerability: 57% interruption rates in water supply, critical diarrhoea burdens in Darayya (Rural Damascus), Abu Kamal (Deir-ez-Zor), and Al-Haffa (Lattakia), near-complete sewage system failure in Al-Qusayr (Homs),, , and hygiene promotion coverage at 9% — all indicating that WASH services require both immediate remediation in the most affected areas and sustained investment in infrastructure rehabilitation and community governance.

Across all three sectors, the analysis consistently identifies female-headed households, households with disabled members, and IDP households as facing compounding vulnerability at the intersection of food insecurity, nutritional risk, and WASH service gaps. Programming must be explicitly designed to reach these groups and to remove the barriers — cost, distance, social norms, physical access — that prevent them from accessing available services.

The evidence generated by this assessment is intended to directly inform GOAL's 2026 programme design, including the geographic and household targeting of food security assistance, the expansion and design of nutrition services, and the prioritisation of WASH infrastructure rehabilitation. It should also contribute to sector-wide response planning through the Food Security, Nutrition, and WASH Clusters, providing district-level evidence to support coordinated targeting and gap analysis.

ANNEXES

ANNEX I: FOOD CONSUMPTION SCORE BY DISTRICT

Governorate	District	Poor (<28)	Borderline (28.5–42)	Acceptable (>42)
Deir-ez-Zor	Abu Kamal	11%	47%	41%
Aleppo	Afrin	25%	31%	45%
Aleppo	Al Bab	27%	35%	39%
Homs	Al Makhrim	34%	30%	36%
Idleb	Al Ma'ra	1%	19%	79%
Deir-ez-Zor	Al Mayadin	1%	11%	88%
Lattakia	Al-Haffa	4%	36%	60%
Homs	Al-Qusayr	8%	18%	75%
Rural Damascus	An Nabk	10%	13%	77%
Idleb	Ariha	1%	17%	83%
Ar-Raqqa	Ar-Raqqa	3%	16%	81%
Homs	Ar-Rastan	8%	45%	47%
Aleppo	As-Safira	27%	30%	42%
Hama	As-Salamiyeh	9%	64%	27%
Dar'a	As-Sanamayn	3%	10%	87%
Hama	As-Suqaylabiyah	13%	47%	40%
As-Sweida	As-Sweida	8%	24%	69%
Ar-Raqqa	Ath-Thawrah	1%	19%	81%
Aleppo	A'zaz	18%	32%	50%
Damascus	Damascus	8%	16%	76%
Dar'a	Dar'a	1%	6%	93%
Rural Damascus	Darayya	4%	18%	78%
Deir-ez-Zor	Deir-ez-Zor	7%	11%	82%
Rural Damascus	Duma	6%	21%	73%
Hama	Hama	3%	56%	41%

Idleb	Harim	5%	26%	69%
Homs	Homs	8%	17%	76%
Idleb	Idleb	2%	13%	85%
Dar'a	Izra'	0%	7%	93%
Lattakia	Jablah	11%	9%	79%
Aleppo	Jebel Saman	1%	31%	68%
Idleb	Jisr-Ash-Shugur	0%	4%	96%
Lattakia	Lattakia	13%	27%	60%
Hama	Masyaf	10%	42%	48%
Hama	Muhradah	6%	42%	52%
Homs	Tadmor	6%	36%	59%
Homs	Tall Kalakh	0%	9%	91%
Ar-Raqqa	Tell Abiad	15%	16%	69%
Rural Damascus	Yabroud	0%	11%	89%
	Average	8%	25%	67%

ANNEX II: CARI SEVERITY BY DISTRICT

District	Secure	Marginal	Moderate	Severe	Mod+Severe
Abu Kamal	2%	17%	69%	12%	81%
Afrin	8%	34%	48%	10%	58%
Al Bab	0%	38%	53%	9%	62%
Al Makhrim	0%	31%	56%	13%	69%
Al Ma'ra	18%	56%	25%	1%	26%
Al Mayadin	20%	58%	21%	1%	22%
Al-Haffa	0%	60%	40%	0%	40%
Al-Qusayr	18%	39%	39%	5%	43%
An Nabk	15%	56%	23%	6%	29%
Ariha	3%	51%	45%	1%	46%
Ar-Raqqa	13%	52%	35%	1%	36%
Ar-Rastan	1%	35%	61%	4%	64%
As-Safira	4%	36%	47%	13%	60%
As-Salamiyeh	1%	15%	74%	10%	85%
As-Sanamayn	14%	72%	13%	1%	14%
As-Suqaylabiyah	1%	34%	51%	13%	64%
As-Sweida	9%	41%	47%	2%	50%
Ath-Thawrah	5%	32%	60%	3%	63%
A'zaz	6%	40%	45%	8%	53%
Damascus	16%	49%	32%	3%	34%
Dar'a	25%	60%	15%	0%	15%
Darayya	18%	48%	34%	1%	34%
Deir-ez-Zor	6%	69%	25%	1%	26%
Duma	8%	50%	38%	3%	42%
Hama	1%	24%	72%	3%	76%
Harim	2%	53%	44%	1%	45%
Homs	5%	47%	45%	3%	48%
Idleb	10%	60%	29%	1%	31%

Izra'	27%	59%	13%	1%	14%
Jablah	8%	49%	38%	5%	42%
Jebel Saman	9%	57%	34%	0%	34%
Jisr-Ash-Shugur	1%	67%	32%	0%	32%
Lattakia	4%	43%	49%	4%	53%
Masyaf	2%	37%	50%	11%	61%
Muhradah	1%	45%	48%	5%	53%
Tadmor	1%	52%	43%	4%	47%
Tall Kalakh	8%	75%	17%	0%	17%
Tell Abiad	25%	45%	30%	1%	31%
Yabroud	23%	59%	16%	2%	18%

ANNEX III: LIVELIHOOD COPING STRATEGIES PER DISTRICT

District	No strategies	Stress	Crisis	Emergency	Crisis+Emergency
Afrin	23%	36%	28%	13%	41%
Al Bab	3%	32%	27%	39%	65%
As-Safira	11%	40%	23%	25%	48%
A'zaz	18%	26%	25%	31%	56%
Jebel Saman	21%	32%	33%	14%	47%
Ar-Raqqa	13%	49%	23%	15%	38%
Ath-Thawrah	8%	19%	38%	35%	73%
Tell Abiad	20%	52%	12%	16%	28%
As-Sweida	11%	19%	48%	21%	69%
Damascus	21%	32%	32%	16%	47%
As-Sanamayn	24%	61%	5%	10%	15%
Dar'a	15%	50%	20%	15%	35%
Izra'	30%	25%	33%	12%	45%
Abu Kamal	10%	7%	37%	47%	84%
Al Mayadin	51%	29%	4%	16%	20%
Deir-ez-Zor	30%	41%	18%	10%	29%
As-Salamiyeh	6%	34%	32%	28%	60%
As-Suqaylabiyah	6%	32%	36%	26%	62%
Hama	6%	33%	38%	23%	61%
Masyaf	10%	34%	41%	16%	56%
Muhradah	13%	28%	33%	26%	59%
Al Makhrim	10%	39%	34%	17%	51%
Al-Qusayr	7%	45%	21%	27%	48%
Ar-Rastan	2%	39%	23%	37%	59%
Homs	10%	37%	27%	26%	53%
Tadmor	14%	26%	31%	28%	59%
Tall Kalakh	15%	66%	16%	3%	20%
Al Ma'ra	11%	44%	15%	30%	45%

Ariha	10%	29%	34%	27%	61%
Harim	5%	22%	51%	22%	73%
Idleb	17%	20%	31%	32%	63%
Jisr-Ash-Shugur	24%	29%	30%	17%	47%
Al-Haffa	2%	16%	70%	12%	82%
Jablah	51%	7%	39%	4%	42%
Lattakia	19%	39%	27%	15%	42%
An Nabk	27%	35%	17%	22%	39%
Darayya	20%	25%	9%	47%	55%
Duma	6%	23%	24%	47%	71%
Yabroud	34%	35%	15%	17%	32%

ANNEX IV: LCSI CATEGORY DISTRIBUTION BY DISTRICT AND GENDER OF HOUSEHOLD HEAD

District	Gender	No strategies	Stress	Crisis	Emergency	% Emergency+Crisis	Gap (F–M, pp)
Ar-Raqqa	Female	11%	11%	44%	33%	78%	+45
	Male	13%	54%	20%	13%	33%	
Masyaf	Female	-	14%	74%	12%	86%	+45
	Male	14%	44%	24%	18%	41%	
Deir-ez-Zor	Female	0%	33%	33%	33%	67%	+40
	Male	31%	41%	18%	10%	27%	
Muhradah	Female	2%	10%	61%	27%	88%	+40
	Male	17%	35%	22%	26%	48%	
As-Salamiyeh	Female	4%	21%	30%	45%	74%	+24
	Male	7%	43%	33%	17%	50%	
Damascus	Female	14%	18%	36%	32%	68%	+24
	Male	23%	34%	31%	13%	44%	
Tadmor	Female	9%	13%	53%	25%	78%	+24
	Male	16%	30%	25%	29%	54%	
Ar-Rastan	Female	-	22%	19%	59%	78%	+23
	Male	3%	43%	23%	31%	55%	
Al Ma'ra	Female	18%	18%	36%	27%	64%	+22
	Male	10%	48%	12%	30%	42%	
Al-Haffa	Female	-	-	75%	25%	100%	+21
	Male	2%	19%	69%	10%	79%	
Izra'	Female	21%	14%	57%	7%	64%	+21
	Male	31%	26%	30%	13%	43%	
Lattakia	Female	24%	49%	16%	12%	28%	-21
	Male	17%	35%	32%	17%	49%	
Darayya	Female	10%	23%	4%	63%	67%	+20
	Male	26%	26%	12%	36%	47%	

Hama	Female	9%	16%	30%	44%	74%	+19
	Male	4%	41%	42%	14%	55%	
Abu Kamal	Female	-	4%	31%	65%	96%	+16
	Male	12%	7%	38%	42%	80%	
Al-Qusayr	Female	7%	36%	20%	36%	57%	+15
	Male	6%	52%	21%	21%	42%	
As-Suqaylabiyah	Female	2%	26%	49%	23%	72%	+15
	Male	8%	35%	29%	28%	57%	
Idleb	Female	13%	13%	50%	25%	75%	+14
	Male	18%	21%	29%	33%	61%	
As-Sanamayn	Female	13%	63%	13%	13%	25%	+13
	Male	27%	61%	3%	9%	12%	
Jebel Saman	Female	14%	29%	40%	17%	57%	+13
	Male	23%	33%	31%	13%	44%	
Harim	Female	4%	33%	56%	7%	63%	-12
	Male	5%	20%	50%	25%	75%	
Al Mayadin	Female	20%	50%	5%	25%	30%	+11
	Male	56%	26%	4%	15%	19%	
As-Safira	Female	22%	39%	22%	17%	39%	-11
	Male	10%	40%	24%	26%	50%	
Homs	Female	2%	38%	33%	27%	60%	+10
	Male	13%	37%	24%	26%	50%	
Tall Kalakh	Female	17%	57%	20%	6%	26%	+10
	Male	13%	71%	13%	2%	16%	
Duma	Female	-	22%	43%	35%	78%	+9
	Male	7%	23%	19%	51%	69%	
Jisr-Ash-Shugur	Female	-	45%	27%	27%	55%	+9
	Male	26%	28%	31%	16%	46%	
Ariha	Female	-	32%	42%	26%	68%	+8

	Male	12%	29%	33%	27%	60%	
A'zaz	Female	6%	31%	25%	38%	63%	+8
	Male	21%	24%	25%	29%	55%	
Al Bab	Female	0%	41%	12%	47%	59%	-7
	Male	3%	30%	29%	37%	66%	
Tell Abiad	Female	15%	52%	15%	19%	33%	+6
	Male	21%	52%	12%	15%	27%	
As-Sweida	Female	17%	17%	45%	21%	66%	-5
	Male	10%	20%	49%	22%	71%	
Ath-Thawrah	Female	-	23%	32%	45%	77%	+5
	Male	10%	19%	40%	32%	72%	
Dar'a	Female	7%	61%	14%	18%	32%	-5
	Male	18%	46%	22%	14%	37%	
Al Makhrim	Female	15%	32%	38%	15%	53%	+3
	Male	7%	43%	32%	18%	50%	
An Nabk	Female	24%	36%	20%	20%	40%	+2
	Male	28%	34%	16%	22%	38%	
Yabroud	Female	27%	43%	14%	16%	30%	-2
	Male	36%	32%	15%	17%	32%	
Jablah	Female	54%	2%	39%	4%	43%	+1
	Male	48%	10%	38%	3%	42%	
Afrin	Female	21%	38%	31%	10%	41%	0
	Male	24%	35%	28%	13%	41%	

ANNEX V: FOOD EXPENDITURE SHARE DISTRIBUTION PER DISTRICT

District	Low (<50%)	Medium (50–65%)	High (65–75%)	Very high (>75%)
Abu Kamal	6%	42%	33%	19%
Afrin	10%	41%	40%	9%
Al Bab	31%	38%	24%	7%
Al Makhrim	31%	29%	22%	18%
Al Ma'ra	61%	23%	11%	5%
Al Mayadin	15%	42%	23%	20%
Al-Haffa	32%	60%	8%	0%
Al-Qusayr	37%	29%	27%	7%
An Nabk	43%	25%	20%	13%
Ariha	17%	40%	31%	12%
Ar-Raqqa	30%	30%	28%	11%
Ar-Rastan	23%	37%	33%	7%
As-Safira	33%	28%	27%	11%
As-Salamiyeh	7%	19%	43%	32%
As-Sanamayn	15%	54%	29%	2%
As-Suqaylabiyah	24%	29%	19%	29%
As-Sweida	40%	35%	14%	11%
Ath-Thawrah	10%	28%	26%	36%
A'zaz	40%	29%	24%	7%
Damascus	43%	34%	11%	12%
Dar'a	44%	42%	12%	3%
Darayya	33%	52%	13%	2%
Deir-ez-Zor	30%	22%	20%	28%
Duma	55%	33%	10%	2%
Hama	19%	22%	29%	31%
Harim	29%	43%	21%	7%
Homs	26%	25%	32%	17%
Idleb	37%	48%	11%	4%
Izra'	44%	46%	8%	2%

Jablah	11%	19%	32%	38%
Jebel Saman	35%	39%	20%	7%
Jisr-Ash-Shugur	16%	46%	28%	10%
Lattakia	26%	23%	26%	26%
Masyaf	16%	32%	16%	37%
Muhradah	31%	36%	16%	17%
Tadmor	38%	34%	19%	9%
Tall Kalakh	20%	24%	25%	31%
Tell Abiad	49%	36%	9%	6%
Yabroud	45%	31%	15%	9%
Average	**29%**	**34%**	**22%**	**14%**

ANNEX VI: WATER ACCESS AND RELIABILITY HOTSPOTS PER DISTRICT

District	n (HH)	Improved Water (%)	Network (%)	Tanker (%)	Any Interruption (%)	Frequent Interr. (%)
Aleppo						
A'zaz	92	99%	53%	44%	55%	9%
Afrin	134	87%	37%	37%	45%	13%
Al Bab	109	100%	60%	40%	76%	4%
As-Safira	132	85%	38%	47%	35%	2%
Jebel Saman	287	99%	61%	29%	38%	5%
Ar-Raqqa						
Ar-Raqqa	149	100%	98%	2%	97%	41%
Ath-Thawrah	155	100%	97%	3%	43%	0%
Tell Abiad	91	98%	96%	2%	59%	18%
As-Sweida						
As-Sweida	131	92%	13%	79%	86%	12%
Dar'a						
As-Sanamayn	149	99%	88%	11%	46%	0%
Dar'a	156	95%	64%	31%	77%	2%
Izra'	149	100%	84%	16%	75%	7%
Deir-ez-Zor						
Abu Kamal	169	92%	87%	5%	66%	12%
Al Mayadin	144	100%	88%	12%	94%	39%
Deir-ez-Zor	105	98%	82%	16%	84%	12%
Hama						
As-Salamiyeh	117	99%	50%	49%	25%	0%
As-Suqaylabiyah	140	96%	71%	25%	77%	27%
Hama	144	100%	51%	41%	44%	6%
Masyaf	147	100%	81%	19%	45%	12%
Muhradah	150	100%	79%	21%	60%	21%

Homs						
Al Makhrim	102	80%	64%	17%	69%	32%
Al-Qusayr	106	82%	78%	4%	76%	26%
Ar-Rastan	142	39%	26%	13%	74%	14%
Tadmor	317	94%	70%	6%	55%	27%
Tall Kalakh	143	62%	53%	8%	57%	13%
Idleb						
Al Ma'ra	149	96%	20%	63%	13%	1%
Ariha	138	92%	27%	65%	16%	1%
Harim	149	96%	60%	33%	30%	1%
Idleb	156	98%	60%	37%	11%	3%
Jisr-Ash-Shugur	150	99%	91%	8%	21%	2%
Lattakia						
Al-Haffa	257	100%	98%	1%	88%	33%
Rural Damascus						
An Nabk	101	99%	97%	0%	32%	8%
Darayya	128	98%	68%	30%	96%	20%
Duma	119	55%	6%	11%	72%	22%
Qatana	146	96%	90%	5%	69%	24%
Yabroud	149	99%	97%	2%	73%	27%

ANNEX VII: OPEN SEWAGE PREVALENCE AND RELATED SANITATION RISKS PER DISTRICT

District	n	Private Toilet (%)	No Toilet (%)	Sewer Access (%)	Open Sewage (%)	Diarrhea Prev. (%)
Aleppo						
A'zaz	92	100%	0%	97%	14%	0%
Afrin	134	99%	0%	84%	24%	6%
Al Bab	109	84%	**4%**	79%	**38%**	9%
As-Safira	132	99%	0%	64%	17%	6%
Jebel Saman	287	100%	0%	76%	19%	11%
Ar-Raqqa						
Ar-Raqqa	149	99%	1%	60%	13%	12%
Ath-Thawrah	155	97%	0%	85%	10%	10%
Tell Abiad	91	99%	0%	90%	22%	10%
As-Sweida						
As-Sweida	131	70%	**21%**	18%	9%	19%
Dar'a						
As-Sanamayn	149	99%	0%	67%	5%	5%
Dar'a	156	99%	1%	79%	10%	11%
Izra'	149	98%	1%	79%	13%	12%
Deir-ez-Zor						
Abu Kamal	169	94%	0%	53%	22%	**46%**
Al Mayadin	144	99%	0%	63%	24%	3%
Deir-ez-Zor	105	99%	0%	88%	29%	10%
Hama						
As-Salamiyeh	117	100%	0%	97%	14%	0%
As-Suqaylabiyah	140	97%	**3%**	71%	**32%**	2%
Hama	144	100%	0%	96%	17%	5%
Masyaf	147	99%	1%	90%	22%	2%
Muhradah	150	100%	0%	79%	29%	2%

Homs						
Al Makhrim	102	94%	1%	83%	21%	7%
Al-Qusayr	106	97%	0%	51%	**82%**	**32%**
Ar-Rastan	142	96%	0%	86%	15%	**41%**
Tadmor	317	100%	0%	72%	21%	15%
Tall Kalakh	143	100%	0%	48%	**41%**	0%
Idleb						
Al Ma'ra	149	100%	0%	71%	11%	**24%**
Ariha	138	99%	0%	69%	9%	18%
Harim	149	100%	0%	87%	4%	**33%**
Idleb	156	99%	0%	89%	8%	16%
Jisr-Ash-Shugur	150	100%	0%	99%	3%	13%
Lattakia						
Al-Haffa	257	97%	0%	95%	18%	**43%**
Rural Damascus						
An Nabk	100%	0%	87%	20%	11%	100%
Darayya	95%	0%	99%	**38%**	**64%**	95%
Duma	98%	0%	88%	29%	16%	98%
Qatana	100%	0%	94%	26%	7%	100%
Yabroud	100%	0%	89%	11%	16%	100%

ANNEX VIII: WASTE COLLECTION, OPEN SEWAGE, ACCESS TO HYGIENE ITEMS, AND HYGIENE PROMOTION PER DISTRICT

Governorate	District	n	Waste Collection (%)	Open Sewage (%)	Cannot Access Hygiene Items (%)	Received Hygiene Promotion (%)
Aleppo	A'zaz	92	84%	14%	13%	1%
	Afrin	134	75%	24%	5%	13%
	Al Bab	109	58%	38%	9%	1%
	As-Safira	132	12%	17%	20%	3%
	Jebel Saman	287	80%	19%	14%	4%
Ar-Raqqa	Ar-Raqqa	149	89%	13%	6%	27%
	Ath-Thawrah	155	85%	10%	45%	28%
	Tell Abiad	91	95%	22%	8%	15%
As-Sweida	As-Sweida	131	1%	9%	12%	3%
Dar'a	As-Sanamayn	149	100%	5%	1%	1%
	Dar'a	156	84%	10%	3%	7%
	Izra'	149	44%	13%	6%	5%
Deir-ez-Zor	Abu Kamal	169	93%	22%	16%	1%
	Al Mayadin	144	76%	24%	5%	35%
	Deir-ez-Zor	105	65%	29%	13%	19%
Hama	As-Salamiyeh	117	94%	14%	26%	3%
	As-Suqaylabiyah	140	73%	32%	39%	21%
	Hama	144	68%	17%	32%	10%
	Masyaf	147	97%	22%	28%	14%
	Muhradah	150	77%	29%	29%	23%
Homs	Al Makhrim	102	81%	21%	30%	10%
	Al-Qusayr	106	37%	82%	40%	22%
	Ar-Rastan	142	97%	15%	31%	5%
	Tadmor	317	47%	21%	30%	2%
	Tall Kalakh	143	27%	41%	43%	0%

Idleb	Al Ma'ra	149	95%	11%	13%	7%
	Ariha	138	91%	9%	15%	0%
	Harim	149	99%	4%	30%	1%
	Idleb	156	93%	8%	21%	5%
	Jisr-Ash-Shugur	150	100%	3%	7%	0%
Lattakia	Al-Haffa	257	90%	18%	6%	21%
Rural Damascus	An Nabk	101	84%	20%	23%	3%
	Darayya	128	13%	38%	37%	16%
	Duma	119	58%	29%	29%	7%
	Qatana	146	58%	26%	25%	3%
	Yabroud	149	92%	11%	17%	3%

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