



COMPREHENSIVE CHILD FOCUSED ASSESSMENT

AZRAQ REFUGEE CAMP

JORDAN

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REACH operates under ACTED in Jordan and is a joint initiative of ACTED, IMPACT Initiatives and the UN Operational Satellite Applications Programme (UNOSAT). REACH was established by ACTED in 2010 to strengthen evidence-based decision making by aid actors through efficient data collection, management and analysis before, during and after an emergency. This contributes to ensuring that communities affected by emergencies receive the support they need. All REACH activities are conducted in support of the Government of Jordan and UN partners, for the development of the Jordan Response Plan, and are within the framework of interagency aid coordination mechanisms.

EXECUTIVE SUMMARY

Since 2011, a total of 3,978,687 Syrians have registered as refugees in neighbouring countries, including 627,287 in Jordan.¹ There are two main refugee camps situated in the north of Jordan: Za'atari refugee camp in Al Mafraq governorate, opened in 2012, and Azraq refugee camp in Zarqa governorate, more recently established in April 2014. As Za'atari refugee camp has now reached full capacity, with an estimated 82,107 residents,² the majority of new arrivals are transported directly to Azraq camp as of mid-2014.³ Villages 3 and 6 - the only inhabited Villages in Azraq camp - are now occupied by an estimated 17,967 refugees, and as the protracted crisis continues to force thousands to flee the conflict, it is anticipated that the camp population will continue to increase throughout 2015.⁴ While Azraq camp is now over a year old, it remains in the early stages of development, with some key characteristics of the resident population still unknown, such as perceptions and behaviours relating to WASH centre usage, and the proportion of children at risk of disabilities and developmental delay. Over the past six months the camp population has undergone a period of rapid expansion, increasing from 11,207 refugees in December 2014 to over 17,000 in May 2015.⁵ This is due to a number of factors, including new arrivals into Jordan, relocations to the camp from informal tented settlements, a desire for family reunification, and shifts in the humanitarian space in the host community such as reductions in food assistance and more restricted access to healthcare creating a push to live in camp settings where there is provision of shelter, healthcare and food. As is the case in Za'atari, the Azraq camp population is therefore subject to fluctuation, and movement in and out of the camp in line with these changes, as well as seasonal employment opportunities.⁶

Thus far, the only major assessments to be conducted in Azraq camp include a UNHCR shelter and public leisure spaces assessment conducted by REACH and designed to gather information on potential shelter improvements and levels of satisfaction with public leisure spaces,⁷ in addition to UNICEF's regular monitoring of WASH blocks assessing the structural integrity, access and cleanliness of WASH infrastructure in the camp. Therefore, to date, there have been no comprehensive studies conducted in Azraq camp to provide an in-depth understanding of current service provision as well as the on-going needs of residents. For this reason, in collaboration with REACH, UNICEF initiated a comprehensive child-focused assessment of every household in Azraq camp in March 2015 to assess access to and use of services across the UNICEF supported sectors of WASH, health, education, youth, disabilities and developmental delay. The exercise aimed to set a baseline for future assessments in the camp, and to offer insights into the situation for all demographic groups in Azraq, with a special focus on children. Data collected during this assessment indicates that a total of 14,742 individuals (2,956 populated households) were residing in Azraq camp at the time of the assessment, while 8,136 of these identified individuals were children aged 0-17 years. Key findings for each sector are summarised below.

Water, Sanitation and Hygiene

Azraq camp has water and sanitation facilities located in the immediate vicinity to shelters, with each WASH centre containing separate stalls designated for the latrine and bathing function. This assessment found that WASH centres are used for a wide range of functions, with just under 100% of households in Azraq camp using them for at least one purpose, including using the latrine, bathing, ablutions and washing clothes and dishes. Unlike in Za'atari camp, where 84.6% of households have built both a private shower and toilet,⁸ the majority of camp residents in Azraq are reliant upon public WASH facilities, with an average 99.8% of households using latrines and 49% using bathing facilities during day and night time.⁹ Yet, according to WASH partners operating in Azraq camp, makeshift private bathing facilities and toilets can be found in some shelters in Azraq camp,

¹ UNHCR, [Syria Regional Refugee Response data portal](#), 2015.

² Ibid.

³ In exceptional circumstances Syrian refugees can be taken to Za'atari in cases where they need special medical health care provision.

⁴ Ibid.

⁵ Ibid.

⁶ Seasonal employment opportunities refers to activities such as agricultural labour.

⁷ UNHCR/REACH, Azraq Camp Shelter Assessment, January 2015, Perceptions and Usage of Public Leisure Spaces in Azraq Camp, December 2014.

⁸ UNICEF/REACH, Comprehensive Child Focused Assessment, Za'atari camp, June 2015.

⁹ Given that Za'atari camp was first established in 2012 while Azraq camp opened in 2014 there has been comparatively more time for private WASH infrastructure to develop in the Za'atari camp setting.

constructed from materials including cement and PVC piping.¹⁰ When asked about their main source of drinking water, the majority of households reported relying on the public water supply for their main source of drinking water (87%) with the majority of households (72.3%) satisfied that the quantity of water they were receiving was enough to meet their needs. However, the distance to tap stands was considered to be too far for almost half of all households (49.2%). Of those who were dissatisfied with distance to their nearest tapstand, 60% stated that the main reason for this was that they considered the distance too far to walk, while 39.9% found it difficult to carry water to and from the tapstand due to distance.

Health

Findings show that while the majority of the targeted groups were reported to have received vaccinations for measles (72.8% of children between 9 months and 5 years of age) and Tetanus Toxoid (64.3% of girls and women aged 15 to 49 years) a significant proportion of both groups remains to be reached. Furthermore, under half of all children aged 0-5 years (42.6%) were reported to have received two doses of polio vaccine, and as a result, were not fully vaccinated. The majority of children under 5 were found not have a vaccination card, with only 17.3% of infants in possession of vaccination cards that were seen and verified by data collectors. With regards to maternal health, overall 18.4% of new mothers received the recommended number of three post-natal visits, and when disaggregated by Village, 56.5% of pregnant and/or breastfeeding women in Village 3 were reported as attending Infant and Young Child Feeding (IYCF).

Education and Child Protection

There is one formal school operating in Azraq camp, which opened in September 2014 with capacity for 5,000 students, across two shifts of 2,500 each. This assessment found that over half of school-aged children are reportedly attending formal education in Azraq camp (57%), with 56% of boys and 58% of girls reported as attending school. Children aged 9-11 years were the age-group with the highest formal attendance rates, with 76% of girls and 70.3% of boys reported as attending. The lowest attendance rates meanwhile were recorded for 16-17 year olds, with only 22.4% of girls and 31.5% of boys reportedly attending. This may be due to other commitments taking priority over school for these older children, such as family responsibilities, income generating activities and domestic labour. Formal attendance was found to be considerably higher in Village 3 than Village 6 for both boys and girls, with 64.2% of males attending in Village 3 compared to only 44.3% Village 6, and 68% of girls attending in Village 3 compared to 46.6% in Village 6. This indicates that back to school campaigns and other outreach programmes must focus on both Villages in order to raise attendance across the camp. This disparity can be attributed to the fact that the majority of Village 6 residents moved to Azraq camp after the first school semester had already started (September 2014). 43% of children aged 6-17 years in Azraq camp are currently reported to be out-of-school, indicating the need for further outreach and engagement. Crucially, the largest proportion of out-of-school children (34%) had missed 25-36 months of education, meaning that they could soon be ineligible to rejoin school without rapid and well-targeted interventions, as according to the Jordanian system, students who have been out-of-school for over three years are no longer eligible to enrol in school.

In terms of inclusive education, 56.2% children with disabilities (CWDs) or chronic illness were found to be out-of-school. Furthermore, the majority of girls and boys with disabilities and/or chronic illness were not attending school due to their stated condition (66.7% of females and 56.2% of males). This highlights that barriers to inclusive education in Azraq camp remain, and should be addressed through close coordination between education and disability actors. These barriers may include bullying, inaccessibility of the curriculum and difficulty getting to and from school, as these were found to be key challenges for CWDs in Za'atari camp.¹¹ However further research would be needed to ascertain the specific nature of barriers to inclusive education in Azraq camp.

In total 17% of school aged children living in Azraq camp were reported to be attending Informal Education (IFE). The most commonly attended type of IFE was basic learning with 76.4% of all school-aged children in IFE attending this type of IFE. This was followed by recreational activities with 23.5% of all children attending at least

¹⁰ Anecdotal evidence provided by ACTED WASH Project Manager in Azraq Camp.

¹¹ UNICEF/REACH, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

one type of IFE and vocational training with 10.5%. Girls aged 16-17 were significantly under-represented in attendance figures for IFE, with only 5.2% of this demographic attending, compared to 16.5% among boys of the same age.

Overall, 15.8% of children 6-17 years were reported to be accessing Child Friendly Spaces/Adolescent Friendly Spaces/Multi-Activity Centres (CFS/AFS/MAC). Overall, a higher percentage of boys (17.5%) than girls (13.9%) were accessing these spaces. There was a large disparity in reported attendance according to sex for children aged 16-17 years, with boys in this age group representing the demographic with the highest percentage of children attending CFS/AFS/MAC at 20.1% compared to girls 16-17 years who have the lowest attendance rate at only 7.6%. For children attending CFS/AFS/MAC, frequency of use was indicated to be relatively high, with 42% using these spaces 3-5 days a week and a further 27.9% accessing them 6-7 days a week in the seven days prior to the assessment.

Disabilities and Developmental Delay

3.5% of all children living in Azraq camp (282 individuals) were reported to have at least one disability or chronic illness.¹² A total of 160 children aged 0-17 years were reported to have a chronic illness, while the most commonly cited type of disability was physical disability (53 children), followed by difficulty communicating/understanding, which was reported for 38 children. The majority of children with disabilities or chronic illness (73%) had not previously been seen or visited by any disability-focused organisation in Azraq camp, while 94% of all children with disabilities indicated that they would like their details to be passed on to disability actors for follow up through established referral mechanisms.¹³

Youth

The vast majority of youths 16-24 (86.7%) are not engaged in any kind of training, paid employment or unpaid volunteering, 92.8% of females and 87.6% of males aged 16-18 years falling within this category compared to 88.9% of females and 80.6% of males 19-24 years. Considerably more males are currently engaged in paid employment than their female counterparts, with 5.4% of males 16-18 years in paid employment compared to only 0.3% of females within this age-group, and 15.6% of males 19-24 in paid employment compared to 5.5% of females. This highlights that both male and female youths urgently need to be incorporated into all programming around employment and IFE opportunities in Azraq camp. There was a similar observation in the Za'atari camp CCFA which found that an overwhelming majority of youths aged 16-24 years were not in paid employment, education, training or unpaid volunteering, reflecting that in both camps this demographic is particularly at risk of disengaging from the camp community. Furthermore, the majority (73.6%) of youths 19-24 years living in Azraq camp reported that they had not completed any stages of certified education, with 20.2% of youths who had completed high school and only 1.5% who had completed university. A further 5.5% of youths 19-24 years previously started university but had to drop out, likely due to the far-reaching impact of the Syria crisis.

¹² Please note that that the data is based on head of household/parental reporting and not a medical assessment. Therefore, there is a need for further verification of the reported conditions by disability specialists during the referral process.

¹³ Handicap International will do the case management (identifying, assessment, referring and follow up) for the vulnerable cases at district level using the 3Ws matrix

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Abbreviations and Acronyms

ACTED	Agency for Technical Cooperation and Development
AFS	Adolescent Friendly Space
CCFA	Comprehensive Child Focused Assessment
CFS	Child Friendly Space
CP	Child Protection
CWD	Children with Disabilities
EPI	Expanded Programme on Immunization
ESWG	Education Sector Working Group
FGD	Focus Group Discussion
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
IFE	Informal Education
IRD	International Relief and Development
IMC	International Medical Corps
IYCF	Infant and Young Child Feeding
JENA	Joint Education Needs Assessment
MAC	Multi Activity Centre
MoE	Ministry of Education
MoH	Ministry of Health
NID	National Immunization Day
SNID	Sub-National Immunization Day
UN	United Nations
UNICEF	United Nations Children's Fund
VPD	Vaccine Preventable Diseases
WASH	Water Sanitation and Hygiene

INTRODUCTION

As the conflict in Syria reaches its fifth year, and the protracted crisis continues to force millions to flee their homes, there are now almost 4 million Syrian children living as refugees in Lebanon, Turkey, Jordan and other host countries.¹⁴ Azraq camp, located in the northern governorate of Zarqa 20km from Azraq town, opened in April 2014 to provide a safe space for Syrian refugees to live and access service delivery. Unlike Za'atari camp, there are no tents in Azraq, rather shelters constructed from steel with concrete flooring. Tapstands are located at a maximum of 200 metres from shelters, while water and sanitation facilities containing latrines and bathing facilities are situated in each plot within close vicinity to the shelters. The camp is subdivided into eight Villages, of which two are currently inhabited – Village 3 and Village 6. Each of these Villages has the capacity to house 10,000 to 12,500 people, and as Za'atari camp has now reached full capacity, new arrivals are directed to Azraq camp which has the capacity to hold up to 130,000 people.¹⁵ Each Village in Azraq has its own community centre, primary health post, community police post, women and child friendly spaces and recreation grounds. The formal school, supermarket, hospital and mosque all have the capacity to accommodate refugees from several Villages. Currently, there is no electricity in Azraq camp however various solar based solutions have been introduced, including street lights and solar lanterns.

As the camp context continues to evolve, there are increasing needs for information collection and management to inform and enable partners to adapt to a rapidly evolving context. For this reason, the United Nations Children's Fund (UNICEF) has identified key information gaps in their areas of service delivery; WASH, health, education, disability and youth. Given the challenges presented by the ever changing environment in Azraq camp, this assessment, conducted by UNICEF in collaboration with REACH, aimed to broaden humanitarian partners' understanding of the camp context, enhancing their capacity to make evidence based decisions and plan well-targeted assistance programmes, with a special focus on access to and use of services and the situation in the camp for children, youth, new and expecting mothers. The broad scope of this assessment provides comprehensive findings on Children with Disabilities (CWD) in terms of type of disability and their inclusion in formal education, with a referral system incorporated into the assessment to ensure follow-up where support is requested.

This assessment was designed in close consultation with relevant working groups and coordination mechanisms to identify specific information gaps and outline key indicators to be included in the data collection. Before data collection took place there was a considerable lack of comprehensive information covering every household in Azraq camp and incorporating all demographics and sectors. Therefore, gathering information at this level presents an important opportunity to gain deeper insights into the situation of children living in Azraq camp and to analyse their access to and use of services across UNICEF-supported areas, including water supply and delivery, vaccination coverage, recreational facilities, formal and informal education. In addition, this assessment allows for the identification of key characteristics and behaviours among UNICEF's target groups; children, youths, new and expecting mothers. Data is disaggregated by variables including Village, sex and age, to provide evidence on access to and coverage of services in Azraq camp.

¹⁴ UNICEF, Syria Crisis Monthly Humanitarian Situation Report: February 2015, March 2015

¹⁵ Care, Factsheet: Azraq Refugee Camp, Jordan Syria Crisis, October 2014.

METHODOLOGY

This study was conducted through a comprehensive assessment of all households in Azraq camp. The indicators were agreed upon through extensive collaboration between UNICEF experts and sector working groups, with all sector specific terminology in the questionnaire has been reviewed and cross-checked by relevant experts at UNICEF.

Data collection was conducted using the Open Data Kit (ODK) mobile data collection platform using android smart-phones, administered by experienced mixed sex teams of Jordanian and Syrian enumerators. Face-to-face household interviews were carried out to collect individual and household level data. Wherever possible, the head of household was interviewed, however if they were not available another household member aged over 18 years was asked to participate in the survey. A household was defined as a set of individuals/families sharing a set of shelters, while a family was defined as the nuclear family consisting of parents and their children. For households with more than one shelter, all shelter numbers were recorded. Three revisits were conducted for each household that was found to be unoccupied before it was recorded as uninhabited. Data collection took place between 17th and 31st March 2015.

Comprehensive training was provided for all data collectors, including training sessions provided by education and child protection experts at UNICEF, and disability specialists, in addition to specific training on communication skills and how to administer the ODK survey delivered by senior field assessment staff.

During the assessment, if a child was reported with a disability or chronic illness, and it was indicated that this child had a need for disability support services, the data collector would then ask if the respondent was willing to provide contact information for referral of the child's condition to disability agencies operating in the camp. International Relief & Development (IRD) will do the case management (identifying, assessment, referring and follow up) for the vulnerable cases at district level using the 3Ws matrix¹⁶.

Finally, the questions which comprised the data collection tool were disaggregated by age and sex wherever appropriate to yield comprehensive household and individual level data to inform programming.

Ethics in Evidence Generation

The data collection activity adopted a 'Do no harm' approach, to avoid causing any harm or injury to assessment participants. As part of the assessment design process, the impact on both participants and the broader community throughout the research cycle from planning through to dissemination was taken into consideration. The assessment adhered to the following guiding principles to ensure that evidence generation was ethically sound:

- **Informed consent** – This assessment was conducted with respondents aged 18 years or above only. Respondents volunteered to participate in the survey and were given the option of non-response. Data collectors were trained to provide sufficient knowledge and understanding of the nature of the proposed evidence generating activity to respondents before commencing the survey.
- **Confidentiality** – This assessment ensured that the confidentiality of the information provided by respondents was respected. All personal information and case ID numbers were made anonymous in datasets and excluded from the final report. During the assessment respondents were asked if they were willing to provide contact information for referral before any personal information was gathered.
- **Ethical evidence gathering** – This assessment took into consideration the cultural context in Azraq camp and the wider Syrian refugee community. Only questions appropriate for this setting, and according to what is ethical, moral and responsible, were included in the survey. Sector specialists from relevant working groups in youth, Education, WASH, Health and Protection were consulted throughout research design.

¹⁶ A 3W matrix here refers to who is doing what, where for disability actors currently operating in Za'atari camp.

Challenges and Limitations

During data collection, the CCFA Azraq assessment was affected by a number of challenges and limitations:

- At the time of data collection Azraq camp was experiencing a dynamic period of expansion and significant movement of refugees in and out of the camp, with a large number of Syrian refugees arriving from the border.¹⁷ For this reason, not all new arrivals have been captured during the data collection period.
- Disabilities were self-reported by the head of household and not verified by a disability specialist. Therefore, all identified cases of child disability will require further verification.
- Given that the majority of surveys were conducted with the head of household, questions concerning youths and children predominantly reflect perceptions of parents or older members of the household.
- For protection reasons and due to cultural sensitivity, as part of a 'Do no harm' approach maternal health questions were only asked regarding girls and women aged 15-49 years. Girls aged below 15 years were not included in maternal health findings as it was not deemed appropriate for data collectors to ask if girls below this age were pregnant or had given birth within the past year.
- It is possible that the number of women who had given birth in the past year and/or were currently pregnant or breastfeeding was under-reported due to maternal health representing a sensitive issue, particularly for male residents who are less able to speak on behalf of female family members on this topic. Despite this challenge, it should be noted that between June and August 2014 the proportion of births attended by skilled health workers in Azraq camp was 100%.¹⁸
- Recall bias may have affected the accuracy of responses received for self-reported questions due to participants with an unreliable memory of past events, such as vaccination history (vaccination card, polio, measles or Tetanus Toxoid vaccination), number of post-natal visits received or visits by disability focused organisations, for example.

FINDINGS

Summary of key Findings:

WASH

- 87% of camp residents rely on public water as their main source of drinking water. The remaining 13% purchase bottled water for the main drinking water source.
- Of the 13% who purchased bottled water, 76.5% said they did so to avoid any perceived danger to health presented by the public water supply.¹⁹ 21.9% reported that they did not like the taste of public water and therefore opted to buy bottled water. These two reasons are closely interlinked, as negative perceptions of taste are likely to raise concerns over public water quality.
- 26.5% reported that they were either satisfied or very satisfied with the distance from their household to the nearest tap stand, while almost half of all households (49.2%) were either unsatisfied or very unsatisfied with distance to nearest tap stand.²⁰ 24.3% of households were neutral on this issue.
- 72.3% were satisfied that the quantity of water they received was sufficient or very sufficient in meeting their households' needs. Only 6% considered that the quantity of water was insufficient or very insufficient, while 21.7% were neutral.

¹⁷ During the data collection period 17th March – 31st March, a total of 1,997 individuals arrived in Azraq Camp, representing an average of 133 new arrivals per day. Of new arrivals, 1,216 were the new arrivals from across the border. In the same reporting period, 424 individuals were monitored by UNHCR leaving the camp, which represents an average departure of 28 individuals per day.

¹⁸ UNHCR, Jordan Azraq Syrian refugees: Detailed Health Report, June-August 2014.

¹⁹ There has been no evidence found that the public water supply in Azraq camp is a danger to health.

²⁰ Tapstands are on average 200 metres from each shelter in Azraq camp.

- Toilet usage was shown to be high, with 99.5% of all households using the WASH centres for this function during day and night time.
- Usage of WASH centres was lower among female camp residents for the bathing function, with 52.8% of girls reported to be using WASH centres compared to 57.2% with boys, 53.4% with women, and 62.5% with men.
- Usage of WASH centres for the toilet function was near equivalent for females and males with 99.6% of girls, 99.8% of boys, 99.5% of women and 99.2% of men reportedly using the centres for this purpose during the day, compared to 99.2% of girls, 99.5% of boys, 99.5% of women and 99.3% of men during the night.
- Usage of WASH centres for the purpose of ablutions varied according to sex, age and time of day. During the day 4.3% of girls, 3.1% of boys, 10.7% of women and 15.4% of men used WASH centres for ablutions, compared to only 1% of girls, 1.2% of boys, 1.9% of women and 4.4% of men during the night time.

Health

- 42.6% of children under the age of 5 had received more than 2 doses of polio vaccine, 27.6% had received 2 doses of polio vaccine, 13.8% had received 1 dose only, while 15.3% had not received any doses of polio vaccine.²¹ A further 0.7% did not know how many doses of polio vaccine children under 5 years living in their household had received.
- 72.8% of children aged 9 months to 5 years were reported as having been vaccinated against measles.
- 741 women were reported to be pregnant or breastfeeding in Azraq camp, which represents 23.2% of the total 3,200 girls and women aged 15-49 living in the camp.²²
- 247 (7.7% of girls and women 15-49 years) women in the camp were recorded as having given birth in the camp within the past year representing 7.7% of all girls and women aged 15-49 years living in Azraq.²³
- Of the women who gave birth in Azraq camp within the past year, 18.4% were reported to have received the recommended number of 3 post-natal visits within 6 weeks of delivery.
- 56% of pregnant or breastfeeding women in Village 3 were reported as attending Infant and Young Child Feeding (IYCF) and 57% in Village 6.
- 49.2% of children aged under 5 did not have a vaccination card, 32.9% had a vaccination card that was not seen and verified by data collectors, while 17.3% had vaccination cards that were seen. 0.7% did not know if the child had a vaccination card.

Education and Child Protection

- 57% of school aged children living in Azraq camp are currently attending formal education (56% of boys and 58% of girls aged 6-17 years).
- Children aged 9-11 years were the age-group with the highest formal attendance rates, with 76% of girls and 70.3% of boys reported as attending. The lowest attendance rates meanwhile were recorded for 16-17 year olds, with only 22.4% of girls and 31.5% of boys.
- Formal attendance is higher in Village 3 than Village 6 for both boys and girls, with 64.2% of males attending in Village 3 compared to only 44.3% Village 6 and 68% of girls attending in Village 3 compared to 46.6% in Village 6.
- Overall, 43% of children aged 6-17 years in Azraq camp are currently reported to be out-of-school (44% boys and 42% of girls within this age group).

²¹ Recall bias may have affected the accuracy of responses received for self-reported questions due to participants with an unreliable memory of past events

²² UNICEF does not have alternative figures on the number of pregnant and breastfeeding women in the camp.

²³ According to UNHCR the number of live births in Azraq since the camp opened till May 2015 is 384. It is possible that a number of these women have left the camp since they have given birth and were therefore not captured in this assessment.

- 96% of out-of-school children living in Azraq camp are still eligible to be reintegrated into formal education (96.1% of out-of-school girls and 96.5% of out-of-school boys), with only a small minority of out-of-school children (4%) having missed more than 3 years of formal education. However, the largest proportion of out-of-school children (34%) had missed 25-36 months, meaning that they could soon be ineligible to rejoin.
- Informal education (IFE) is most commonly attended by the age-group 9-11 years in Azraq camp, with 20.7% of females and 23.1% of males from this age-group reported as attending, followed by ages 12-15 years, with 19.2% of females and 17.9% of males attending from this age-group.
- The lowest attendance of IFE was recorded for females aged 16-17 years, at only 5.2%, compared to 16.5% for males in the same age-group.
- In total 17% of all school aged children were attending both formal education and IFE (16% of girls and 18% of boys aged 6-17 years). The age group with the highest proportion of children attending both types of education were 9-11 year olds, with 22% falling within this category, followed by 12-15 year olds with 18.6%. Children aged 6-8 years had the lowest number of individuals attending both formal education and IFE at 13%.
- Basic learning was the most commonly attended type of IFE attended by children in Azraq camp with 76.4% selecting this response. This was followed by recreational activities (23.5%) and vocational training (10.5%) of all children attending at least one type of IFE.
- 15.8% of children 6-17 years were reported to be accessing Child Friendly Spaces/Adolescent Friendly Spaces/Multi-Activity Centres (CFS/AFS/MAC). Overall, a higher percentage of boys (17.5%) than girls (13.9%) were accessing these spaces.
- Boys aged 16-17 years represent the demographic with the highest percentage of children attending CFS/AFS/MAC at 20.1% compared to girls 16-17 years who have the lowest attendance rate at only 7.6%.
- For children attending CFS/AFS/MAC, frequency of use was indicated to be relatively high, with 42% using these spaces 3-5 days a week and a further 27.9% accessing them 6-7 days a week in the seven days prior to the assessment.
- In 91% of households considered that it was either important or very important for school-aged girls to follow a certified education pathway, while a slightly higher percentage of households reported this to be the case for school-aged boys, at 92.7%.

Disabilities and Developmental Delay

- 3.5% of all children (282 individuals) reported to have a disability and/or chronic illness.²⁴ Of this 3.5%, 65% (184 individuals) were male and 35% (98 individuals) were female.
- Of the 3.5%, 56.7% were reported to have a chronic illness, with a total of 160 children falling within this category (47 females and 113 males aged 0-17 years).
- The first most commonly cited type of disability was physical disability (53 children) followed by difficulty communicating/understanding (38 children).
- The majority of children with disabilities or chronic illness (73%) had not previously been seen or visited by any disability-focused organisation in Azraq camp, with 66% of females who had not previously been seen compared to 77% of males overall.
- 94% of all children with disabilities (CWDs) and children with chronic diseases provided contact details for referral to disability partners.
- 56.2% of children with a reported disability and/or chronic illness are not currently attending formal education, with 50% of girls compared to only 41% of boys with reported disability and/or chronic illness currently reported as attending school.

²⁴ It is important to note that disabilities are self-reported with the data based on head of household/parental reporting and not a medical assessment. Therefore, there is a need for further verification of the reported conditions by disability specialists during the referral process.

- For 66.7% of female and 56.2% of male children with a reported disability and/or chronic illness who are not currently attending formal education it was indicated that the main reason for their out-of-school status was their reported disability or chronic illness.

Youth

- 86.7% of youths aged 19-24 were not engaged in paid employment, training or unpaid volunteering, with 92.8% of females and 87.6% of males aged 16-18 years falling within this category compared to 88.9% of females and 80.6% of males 19-24 years.
- In total, 7.8% of youths were in paid employment, while 5.2% were in training and 0.3% were undertaking unpaid volunteering. Overall, more males than females were reported as engaged in paid employment, with 5.4% of males 16-18 years in paid employment compared to only 0.3% of females within this age-group, and 15.6% of males 19-24 in paid employment compared to 5.5% of females.
- 5.2% of youths 19-24 years were in training, with 6.9% of females and 7% of males 16-18 years, compared to 5.1% of females and 3.5% of males 19-24 years. Meanwhile, only 0.3% were reported to be undertaking unpaid volunteering, with 0% of males and females aged 16-18 years falling within this category, compared to 0.4% of females and 0.3% of males aged 19-24 years.
- 5.4% of males aged 16-18 were reported to be in paid employment compared to only 0.3% of females within this age-group. Similarly, a larger proportion of 19 to 24 year old males reported to be in paid employment (15.6%) than females of this age-group (5.5%).
- The majority (73.6%) of youths 19-24 years living in Azraq camp had not completed any stages of certified education. 5.5% of youths 19-24 years previously started university but had to drop out. 20.2% of youths within this age-group had completed high school while only 1.5% reported that they had completed university.
- 78.5% of 18 year olds and 86.8% of 19-24 year olds are currently not attending any type of education in Azraq camp.
- 14.3% of 18 year olds and 8.7% of 19-24 year olds were reported as attending formal education. These youths may be attending formal education to make up for missed school years as according to the Ministry of Education (MoE), students studying for their General Secondary Education Certificate Examination (Twajhi students) are eligible to be enrolled until the age of 21 for the 11th grade. Furthermore, there are a number of partners working with this age group in Azraq camp that are operational inside the formal school, which may have caused some youths to be mis-reported as attending formal education.
- 5.8% of 18 year olds and 2.1% of 19-24 year olds were attending IFE in Azraq camp.
- 7.8% of 18 year olds were attending Child Friendly Spaces (CFS) Adolescent Friendly Spaces (AFS) and Multi-Activity Centres (MAC) while 4.8% of 19-24 year olds were attending these sites.

Demographics

Azraq camp's population has witnessed significant growth over the past 6 months due to an influx of new arrivals from the border and host community.²⁵ Data collected during this assessment indicates that a total of 14,742 individuals (2,956 populated households) were residing in Azraq camp at the time of the assessment. Meanwhile, according to UNHCR figures, there were 15,759 residents living in Azraq camp during the data collection period, representing a total disparity of 1,017 people.²⁶ This disparity can be attributed to the rapidly evolving context in Azraq camp during the assessment, with a large number of refugees arriving and registering in Azraq camp on a daily basis, while others departed the premises. For this reason, it was not possible to capture all new arrivals to the camp during the data collection period. Findings revealed that, of the total camp population, 55% were children belonging to the 0-17 age-group. Of the children assessed in this survey 56% were within the 6-17 age range, and thus of school age (representing 31% of the total camp population). 2,950 individuals were adolescents of 10-18 years, while 1,442 were youths of 19-24 years.

Figure 1: Total population of Azraq camp, by age and sex

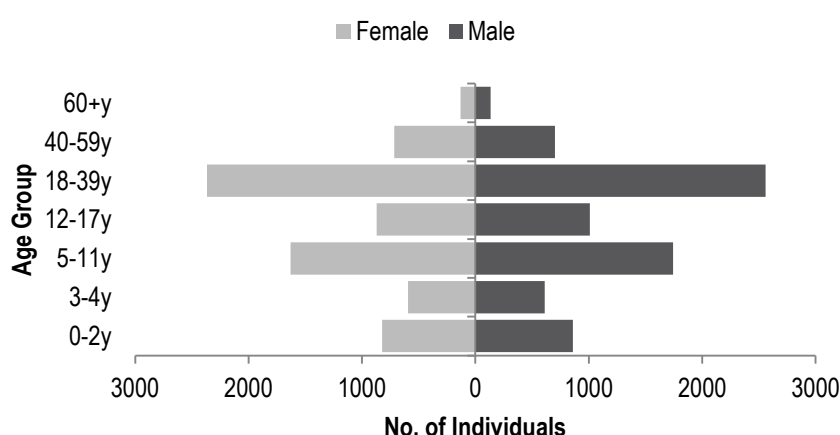


Table 1: Demographics by Village

Village	No. of people	No. of children	0-2y	3-4y	5-11y	12-17y	18-39y	40-59y	60+y
3	8580	4572	934	669	1868	1101	2994	862	152
6	6162	3564	748	534	1504	778	1930	557	111
Total	14742	8136	1682	1203	3372	1879	4924	1419	263

²⁵ During the data collection period 17th March – 31st March, there was a total movement to the camp of 1,997 individuals who arrived to Azraq Camp, which represents an average arrival per day of 133 individuals. Out of the total, 1216 were the new arrivals from the border. In the same reporting period, 424 individuals were monitored by UNHCR leaving the camp, which represents an average departure of 28 individuals per day. According to UNHCR figures the camp population increased from 11,207 refugees in December 2014 to over 17,000 in May 2015.

²⁶ UNHCR, Azraq Camp Coordination Meeting Minutes, 25 March 2015.

Figure 2: Total number of children in Azraq camp, by age and sex

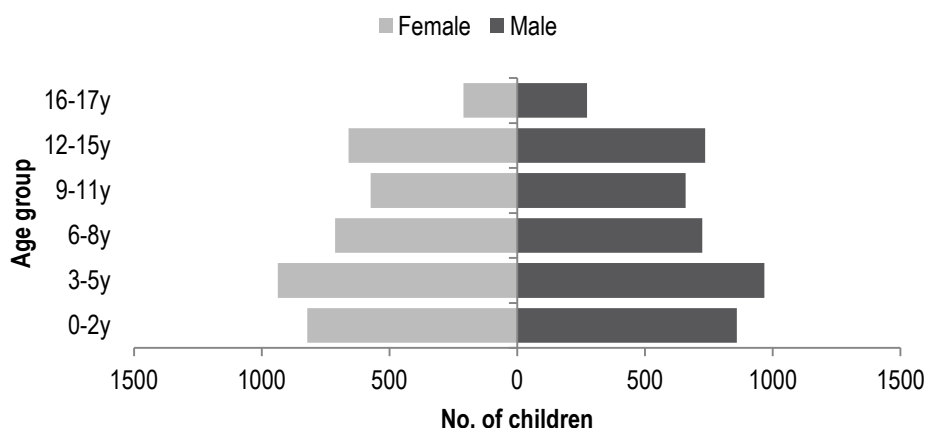


Figure 3: Total population of Azraq camp, by age and sex disaggregated by adolescents and youth

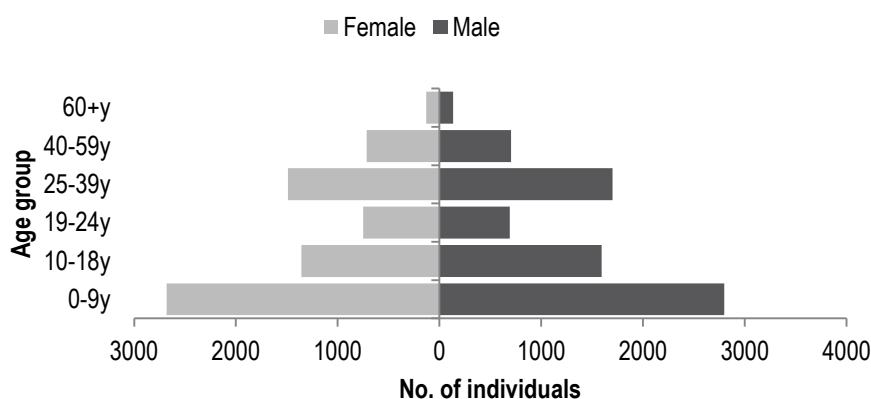


Table 2: Demographics per Village, by girls/boys/women/men

Village	No. girls 0-17y	No. boys 0-17y	No. women 18+y	No. men 18+y
3	2176	2396	1860	2148
6	1739	1825	1351	1247
Total	3915	4221	3211	3395

Once demographic data is further disaggregated, there are 3,587 children aged 0-5 years, constituting 44% of all children and 24% of all camp residents. A gender breakdown indicates that 48% of children (3,915) are female while 52% (4,221) are male. At camp level, 48.3% of all residents (7,126) were female and 51.7% (7,616) were male. Male and female adults aged 18 to 39 years constitute the largest demographic group overall, with a total of 4,924 individuals recorded in this age-group at the time of assessment. Findings indicate that children between 5 and 11 years represent the next largest group with a total of 3372 individuals falling within this age bracket. According to assessment findings there are 1,682 children aged 0-2 years currently residing in Azraq camp. This demographic group can be said to have the highest degree of dependency on adults to facilitate access to food, water and essential services.

WASH

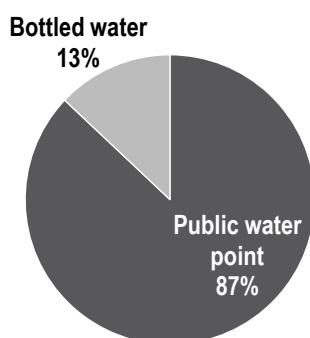
UNICEF oversees the implementation of all WASH activities in Azraq camp in coordination with their partners ACTED and World Vision. WASH activities aim to increase access to clean drinking water, safely collect and dispose of wastewater and solid waste, as well as disseminate of key messages for the purpose of hygiene promotion and awareness to protect children and their families from diseases and other health risks. In this assessment, respondents were asked a number of household-level questions related to WASH to give a comprehensive overview of the current perceptions, behaviours and usage of WASH infrastructure and water supply in Azraq camp. These questions were asked to help inform WASH programming and to ensure equitable access to water and WASH facilities for all camp residents.

Water Supply

The public water supply in Azraq camp is transported from boreholes outside the camp in water trucks and checked for water safety by WASH partners before being delivered to the main tanks inside the camp. Water supplied to Azraq camp is sterilized and treated with chlorine to kill germs and bacteria, to ensure it is safe to drink. Water teams examine water safety, check chlorine ratios in the water tanks coming into the camp, and match them to local and international standards.²⁷ Tests are also conducted to assess the water's colour, taste and smell before allowing water delivery trucks to enter the camp. The daily individual share inside the camp per person is 35 litres per person, in accordance with SPHERE standards.²⁸

Currently, on average approximately 650m³ of water a day is delivered to Azraq camp. The vast majority of households in Azraq camp rely on the public water supply for their main source of drinking water (87% of households). In the absence of an informal market, and as private trucks are not permitted to enter the camp and sell water to residents, bottled water purchased from the camp shopping mall is currently the only alternative to public supply.²⁹ Overall, 13% of households reported relying on purchased bottled water for their main drinking water supply.

Figure 4: Primary reported source of drinking water

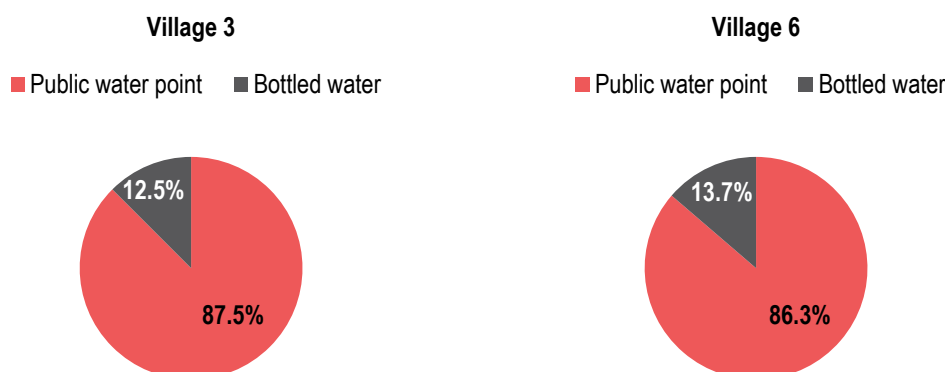


²⁷ Information provided by ACTED WASH.

²⁸ This exceeds the minimum recommended sphere standard of 15L/person/day <<http://www.spherehandbook.org/en/water-supply-standard-1-access-and-water-quantity/>>.

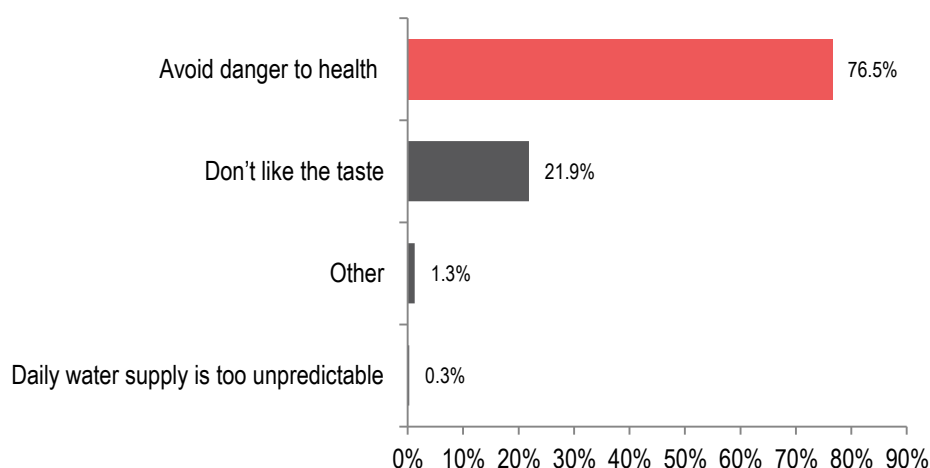
²⁹ There is only one shopping mall currently open in Azraq camp.

Figure 5: Primary reported source of source of drinking water, by Village



When disaggregating by Village there was found to be very little difference in the main reported source of drinking water, although a slightly higher proportion of residents living in Village 6 relied on bottled water as their main source of drinking water at 13.7% compared to 12.5% in Village 3.

Figure 6: Primary reported reason for relying on bottled water for drinking (households using bottled water only)

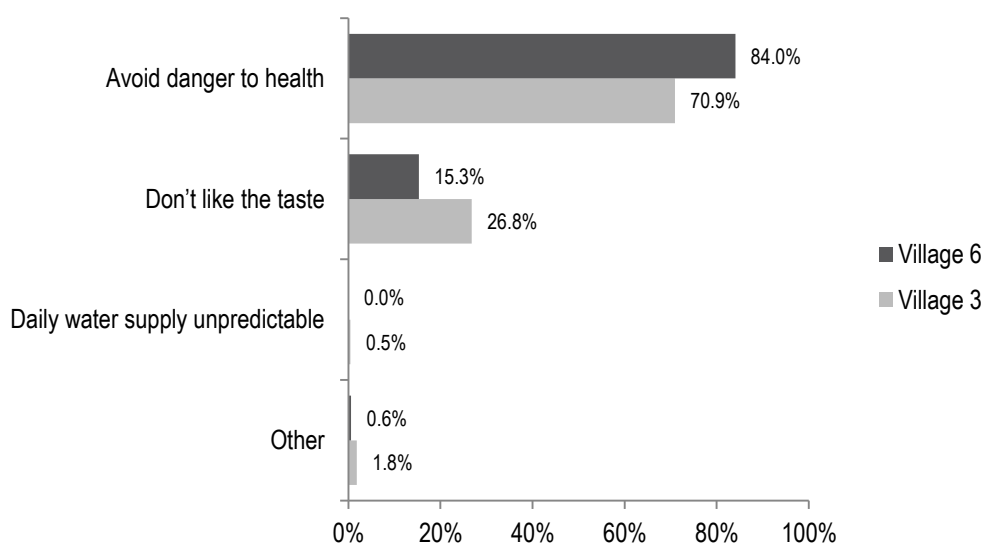


The majority of the 13% of households relying on bottled water for their main source of drinking water reported that they did so due to concerns over potential danger to their health. This is despite the fact that there were no recorded cases of camp residents falling ill from the public water supply during the time assessment.³⁰ The second most commonly cited reason for relying on a private source of drinking water among this 13% of households was that people did not like the taste. This may be due to camp residents, particularly new arrivals, not yet having adapted to the taste of the chlorinated water provided in the camp, thus dislike of the water taste is likely to be linked to perceptions of a danger to health.³¹ The identification of these negative perceptions indicates that more messaging can be done with the camp community on the issue of water supply to improve perceptions of water quality.

³⁰ The Ministry of Health, the Water Authority of Jordan, the Hospital, ACTED and World Vision conduct regular physico-chemical and bacteriological tests on the water in the camp. Some diarrhoea cases were registered among new comers because of personal hygiene issues during their trip to Azraq and some other cases related to food. The Ministry of Health confirmed that these cases were not related to water.

³¹ According to SPHERE standards Water should be treated with a residual disinfectant such as chlorine if there is a significant risk of source or post-delivery contamination. This risk will be determined by conditions in the settlement, such as population density, excreta disposal arrangements, hygiene practices and the prevalence of diarrhoeal disease.

Figure 7: Primary reported reason for relying on bottled water for drinking, by Village (households using bottled water only)

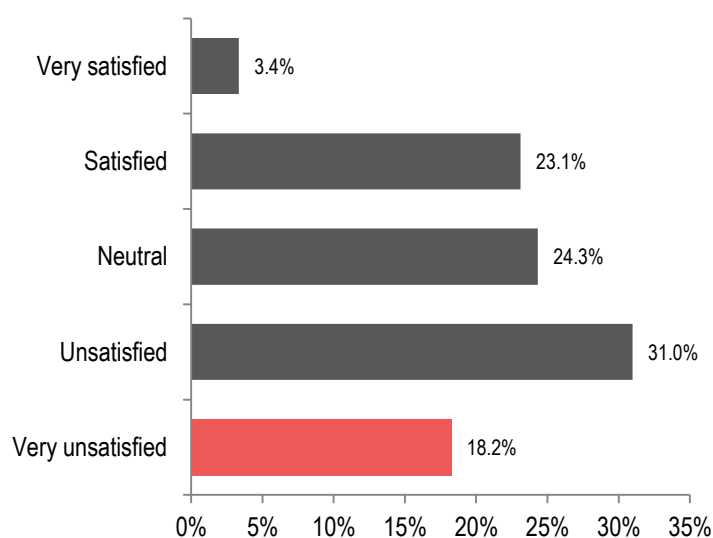


When disaggregating these findings further, there were notable differences between Village 3 and Village 6. Of those relying on private drinking water, the overwhelming majority of households in Village 6 were concerned about a danger to health (84%) compared to 70.9% of households in Village 3. However, as previously stated there have been no reported cases of illness from the public water in the camp.³² Additionally, of those who do not rely on public water 26.8% of households in Village 3 did not like the taste of public water compared to 15.3% in Village 6. This may be due to differing levels of chlorination in each of the Villages however this would require further investigation by Azraq WASH partners. Less than 1% of households cited unpredictable public water supply as the main reason for relying on a private source of drinking water.

In Azraq camp the maximum distance from shelter to tap stand is approximately 200 meters. To gauge the perceptions and levels of access to water points in Azraq all households were asked how satisfied they were with distance from their household to the nearest tap stand. It was found that marginally more households were unsatisfied than satisfied with the distance to their nearest tap stand. In total 49.2% were either unsatisfied or very unsatisfied while just over a quarter of all households stated that they were satisfied or very satisfied.

³² The Ministry of Health, the Water Authority of Jordan, the Hospital, ACTED and World Vision conduct regular physico-chemical and bacteriological tests on the water in the camp. Some diarrhoea cases were registered among new comers because of personal hygiene issues during their trip to Azraq and some other cases related to food. Ministry of Health confirmed that these cases were not related to water.

Figure 8: Reported household satisfaction with distance to nearest tap stand



When disaggregated by Village it can be seen that camp residents in Village 6 were more satisfied with distance to tap stand than Village 3, with 29.1% of households satisfied or very satisfied in Village 6 compared to 24.7% of households in Village 3. While the maximum distance from shelter to tap stand is the same for both Villages, there are 12 tap stands in Village 3 compared to 15 in Village 6, which may explain this disparity in perceptions.

Figure 9: Household satisfaction with distance to nearest tap stand, by Village

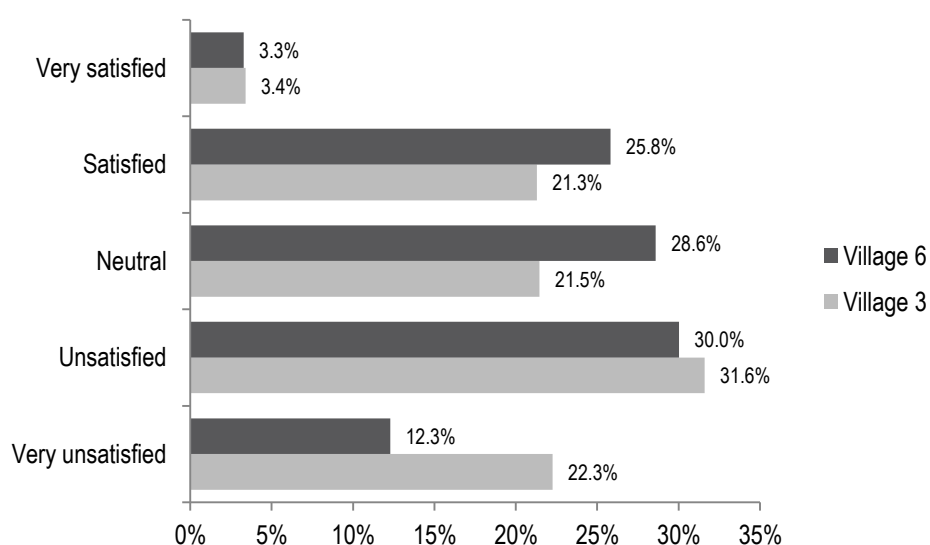
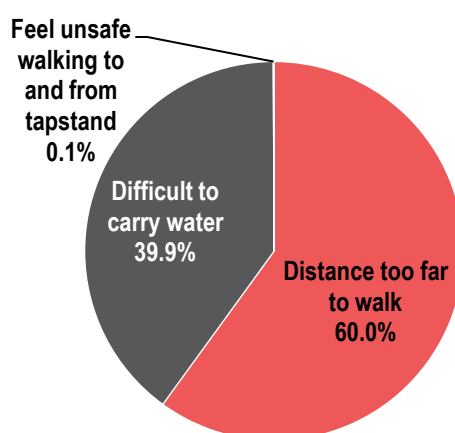


Figure 10: Reason household is unsatisfied with distance to tap stand



Respondents who indicated that they were unsatisfied or very unsatisfied with distance to tap stand were then asked to cite the main reason behind their dissatisfaction. The majority of these households (60%) stated that it was too far to walk to their nearest tap stand, followed by 39.9% of households indicating that they found it difficult to carry water to and from tap stands. These two reasons are interlinked, as difficulty in carrying water to and from tap stands is likely to increase with greater distance to tap stands. Transporting heavy water containers long distances was an issue that also arose in the UNHCR shelter assessment, during which focus group discussion participants commonly mentioned that they would like to have water taps inside their shelters for improved access to the public water supply.³³ People with disabilities who were interviewed during the same shelter assessment specifically stated that shortening the distance to water points would reduce the burden of transporting water to and from tap stands for their household. Only 0.1% of households indicated that the main reason for their dissatisfaction with distance to tap stands was that they felt unsafe walking to and from tap stands.

WASH partners have not provided any filtration tools to camp residents as the public water supply in Azraq camp is chlorinated and does not need to be treated and can therefore be safely consumed straight from tap stands. The combination of WASH partner messaging, handling and storage means that there is no need for additional treatment. For this reason, it is not surprising that, overall, only 0.7% of households reported using a water filter and 0.1% of households used solar filtration for drinking water.

The majority of households were satisfied that the quantity of water being supplied to their household was sufficient to meet their needs. Overall, 72.3% either indicated that the quantity of water that their household received was either sufficient or very sufficient. Only 6% of households considered that the quantity of water was insufficient or very insufficient, while 21.7% were neutral.

³³ UNHCR/REACH, [Azraq Camp Shelter Assessment](#), January 2015.

Figure 11: Reported sufficiency of quantity of water supplied to household to meet needs

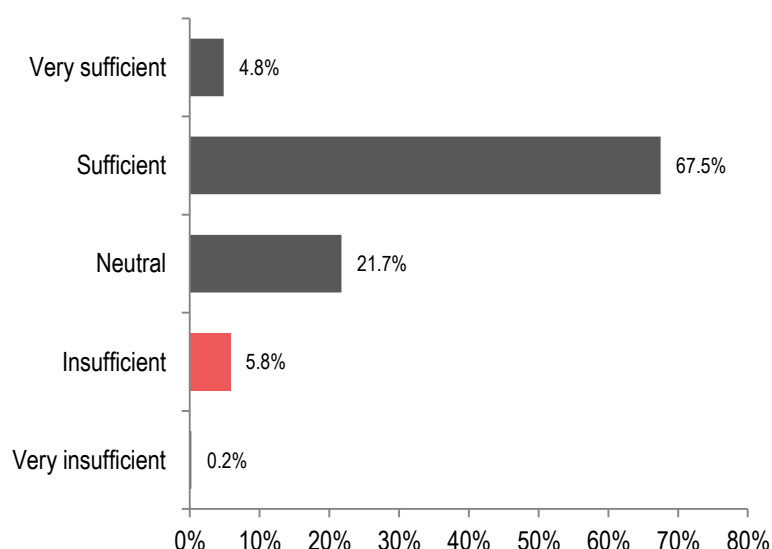
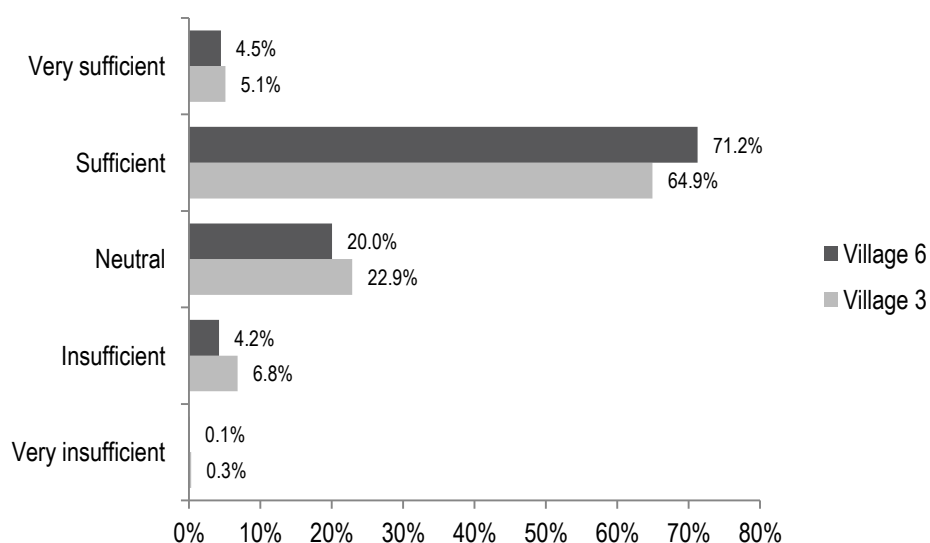


Figure 12: Reported sufficiency of quantity of water supplied to household to meet needs, by Village



Disaggregating findings by Village shows that households in Village 6 were more likely to consider that water supply was sufficient to meet their needs, with 71.2% stating that they were satisfied compared to 64.9% in Village 3. In terms of water distribution, WASH partners provide 35 litres per person for both Villages 3 and 6 but as it is a centralized system, there is no real control over individual use, while access to water is mostly restricted by tapstand numbers and water distribution times. Given that there are 12 tapstands located in Village 3, this means that there are 715 people per tapstand, compared to 15 tapstands in Village 6 with 410 people per tapstand, according to the Village-level population figures recorded during this assessment. These factors are likely to have influenced the different response rates in Village 3 and 6.

Public WASH Block Usage

Households with girls, boys, women and men were asked to cite all of the purposes that they used public WASH centres for during the day and night time to assess the overall level of usage and identify any disparities according to sex and age. During the day, WASH centre usage was high for the latrine function across all demographics. There were found to be some disparities in WASH centre usage according to age and sex. Usage of WASH centres was lower among female camp residents for the bathing function, with 52.8% of girls compared to 57.2% with boys, and 53.4% with women compared to 62.5% with men. This may be explained by the finding from the UNHCR shelter assessment of Azraq camp conducted in December 2014 that a perceived lack of privacy for female residents is likely to be affecting the level of access to WASH facilities for women and girls living in the camp.³⁴ Private showers were frequently referenced in Azraq shelter assessment FGDs as vital to protect the privacy and modesty of female household members, reflecting the survey finding that adequate privacy was most commonly cited as the second most important quality that a shelter should possess. Indeed, FGD participants reported that it is not considered appropriate that other men know when a female is bathing in Syrian culture. Therefore, findings suggest that women and girls are resorting to bathing less to avoid behaving in a way that could be perceived as culturally inappropriate.

Table 3: Purpose of WASH centre usage during the day (% households with G/B/W/M)

Demographic	Toilet	Bathing	Ablutions	Washing clothes	Washing dishes	None of the above
Girls (0-17)	99.6%	52.8%	4.3%	6.9%	4.7%	0.1%
Boys (0-17)	99.8%	57.2%	3.1%	1.1%	0.6%	0%
Women (18+)	99.5%	53.4%	10.7%	19.1%	14.6%	0%
Men (18+)	99.2%	62.5%	15.4%	1.3%	1.0%	0%

WASH centre usage during the day was higher among females than males for the domestic chores washing clothes and washing dishes. This implies that the division of domestic labour in the camp more often falls to girls and women than boys and men, with women reporting a much higher usage of WASH centres for these tasks; 19.1% washing clothes and 14.6% washing dishes compared to 1.3% washing clothes and 1% washing dishes for men. Men were more likely to use WASH centres for bathing and ablutions than all other demographic groups with 62.5% and 15.4% using WASH centres for these purposes respectively. There were also some disparities according to age, as WASH centre usage for ablutions was notably higher among adults than for children.

As might be anticipated, WASH centre usage reduced during the night time. This is likely to be due in part to reduced movement outside of the shelter during the night and a lack of public lighting in the camp. Currently, there is no electricity in Azraq camp meaning that the only sources of light are various solar based solutions including street lights and solar lanterns. However, toilet usage remained extremely high with almost 100% of all households using the WASH centres for this function, implying that most residents do not resort to open defecation at night time. The same disparities according to sex can be observed for WASH centre usage during the night, with a smaller proportion of females than males using WASH centres for the bathing function, and a larger number of households with women and girls using WASH centres to carry out domestic chores.

³⁴ UNHCR/REACH, [Azraq Camp Shelter Assessment](#), January 2015.

Table 4: Purposes of WASH centre usage during the night (% households with G/B/W/M)

Demographic	Toilet	Bathing	Ablutions	Washing clothes	Washing dishes	None of the above
Girls (0-17)	99.2%	34.3%	1.0%	0.8%	0.5%	0.4%
Boys (0-17)	99.5%	40.6%	1.2%	0.2%	0.1%	0.4%
Women (18+)	99.5%	36.6%	1.9%	2.1%	1.4%	0.1%
Men (18+)	99.3%	49.4%	4.4%	0.3%	0.2%	0%

In total, 0.1% of households did not use WASH centres for the toilet during the day while 43% did not use the WASH centre for bathing during the daytime, and 0.3% of households did not use WASH centre for the toilet during the night, while 59% did not use the bathing facilities. Households with girls, boys, women and men that did not report using WASH centres for the toilet and/or bathing function during the day and/or night were asked where instead they carried out this function; inside their own shelter, inside a neighbouring shelter or outside shelters. Findings indicate that most households falling within this category carried out these functions inside their own shelter, suggesting that they have developed their own basic private WASH facilities and wastewater outlets. According to WASH partners, private bathing facilities and places for washing dishes much more common than private toilets but both can be found. Camp residents have been reported as building small cement barriers inside the shelters to separate out one corner of the shelter. A hole is then made with PVC piping used for waste water disposal. Many use blankets or similar material to create small curtains inside this particular corner of the shelter to create a private washing area or toilet

Table 5: Alternative location reported for toilet and/or bathing function for (%) households with G/B/W/M that do not use WASH centres for these purposes during the day time

Demographic	Inside own shelter	Inside neighboring shelter	Outside shelters
Girls (0-17)	92.9%	1.9%	5.5%
Boys (0-17)	91.5%	2.0%	6.9%
Women (18+)	93.4%	2.0%	5.1%
Men (18+)	93.3%	2.2%	4.9%

Table 6: Alternative location reported for toilet and/or bathing function for (%) households with G/B/W/M that do not use WASH centres for these purposes during the night time

Demographic	Inside own shelter	Inside neighboring shelter	Outside shelters
Girls (0-17)	85.3%	1.8%	17.4%
Boys (0-17)	83.1%	2.2%	20.2%
Women (18+)	85.2%	1.3%	18.1%
Men (18+)	81.0%	1.7%	22.5%

There is a notable disparity in usage of alternative locations for bathing and toilet purposes between day and night time. A much higher proportion of households reported going outside of shelters to carry out toilet and bathing functions during the night compared to the daytime (17.4% girls, 20.2% boys, 18.1% women and 22.5% men of those who do not use WASH centres for these purposes). It is likely that some camp residents who use WASH centres for these purposes during the day choose to use outside of shelters during the night due to cover of darkness allowing these functions to be conducted in privacy, due to darkness increasing the discomfort with walking away from shelters, and to avoid disturbing other household members who may be sleeping during the night by using these facilities in the home during the night when that option is available. The higher percentage of girls, boys, women and men going outside of their shelters to carry out these WASH functions at night indicates that issues such as open defecation are more likely to occur at night time. Evidence from Za'atari camp suggests that when private WASH facilities were first established, while most households used private WASH facilities during the day and night, overall 4.1% of households with private toilets use them only at night time, with one possible explanation that these households felt unsafe using the communal WASH centres at night. Furthermore,

17.5% of households with private toilets were used only by certain household members. Of these households, the majority (57% or 579 households) reported that their private toilets were used by females and children only with privacy and protection reasons likely to explain this trend in behaviour.³⁵

Open defecation has previously been found to be an ongoing issue in Azraq camp both inside and outside of WASH facilities, and empty shelters, according to Hygiene Promotion teams and WASH centre monitoring reports.³⁶ Anecdotal evidence provided by hygiene promotion teams that are continually monitoring the issue on the ground suggests that the issue of open defecation has been reduced in recent months. Hygiene promotion programmes run by WASH partners in Azraq camp aim to tackle this issue through key messaging, as it contributes to the transfer of disease and pests and can contaminate water supply. Parents, WASH partners and the wider camp community need to take a role in reducing open defecation with the active participation of the teams of hygiene promotion and community development in the dissemination of health education messages.

³⁵ UNHCR/REACH, Za'atari Camp Shelter Assessment, June 2014.

³⁶ UNICEF/REACH. WASH Centre Monitoring in Azraq camp, August 2014-July 2015.

HEALTH

The Jordanian Ministry of Health (MoH) is closely involved in the health and nutrition response in Azraq camp, and there are a number of partners in the health sector, including UNICEF, the Red Cross, Save the Children Jordan, and International Medical Corps (IMC) that currently operate Primary Health Care Clinics and community centres for Infant and Child Feeding Programmes in the camp. As part of the Regional Response Plan (RRP6) for the Syria Crisis various coordination mechanisms support the MoH to continue to meet the needs of Syrian refugee women, girls, boys and men living in Jordan through services including emergency vaccinations, routine vaccinations, and reproductive health care. Since the opening of Azraq camp, the health sector has evolved and there have been a number of vaccination campaigns conducted. By May 2015 there had been four National Immunization Days (NIDs) and two Sub-National Immunization Days (SNIDs) for polio in Azraq camp, with the most recent SNID for polio taking place 5-7 May 2015.³⁷ Health clinics in the camp provide support for primary healthcare consultations, deliveries, and referrals for secondary or tertiary healthcare, in addition to mental health services, reproductive health consultations, and treatments for individuals suffering from severe acute malnutrition (SAM).

Vaccinations

Polio Vaccination

Jordan remained polio-free throughout 2014, due to a series of emergency polio vaccination campaigns conducted jointly by MoH, UNICEF, WHO, UNHCR and other partners as part of the polio prevention and response strategy.³⁸ In each of the NIDs, more than one million children 0-5 years, including on average 150,000 Syrians in camps and host communities and 50,000 children of other nationalities in host communities were reached with two drops of oral polio vaccine.³⁹

In two sub-NIDs in 2014 more than 200,000 children 0-5 years were vaccinated, including 75,000 Syrian children in both camps and host communities, with children in Azraq camp representing 3% of this total coverage, and 15,000 children of other nationalities in hard-to-reach areas.⁴⁰ The MoH, WHO, UNICEF and other health actors in Jordan have worked together to strengthen surveillance for acute flaccid paralysis cases, introducing environmental surveillance and enhancing social mobilization for immunization.⁴¹

The most recent polio campaign to take place in Azraq camp was conducted 5-7 May 2015 after the data collection for this assessment took place, which indicates that current vaccination coverage is likely be higher than reported in this study. Findings indicate that vaccination coverage is somewhat uneven between Village 3 and Village 6, with 39.6% of children under 5 receiving more than two doses in Village 3 compared to 43.5% in Village 6. Given that vaccination campaigns were targeted to both Villages, this disparity may be due to the larger population in Village 3 reducing access to health services for children within this age-group, with more children 0-5 years per Expanded Programme on Immunization (EPI) site. Overall, 15.3% of children within this age-group had not received any doses of polio vaccine, with less than half of children under 5 fully vaccinated against the disease.⁴² However, subsequent polio vaccination campaigns conducted in Azraq camp will have since reduced the proportion of children falling within this category.

³⁷ According to UNICEF, figures the number of children vaccinated in the 5-7 May 2015 SNID was 3631 children.

³⁸ Ibid.

³⁹ UNICEF, [Children of Syria](#), 2014.

⁴⁰ Ibid.

⁴¹ UNHCR, 2014 Syria Regional Response Plan (RRP6), November 2013.

⁴² Recall bias may have affected the accuracy of responses received for self-reported questions due to participants with an unreliable memory of past events

Figure 13: Percentage of children under 5 years old reported to be vaccinated against polio

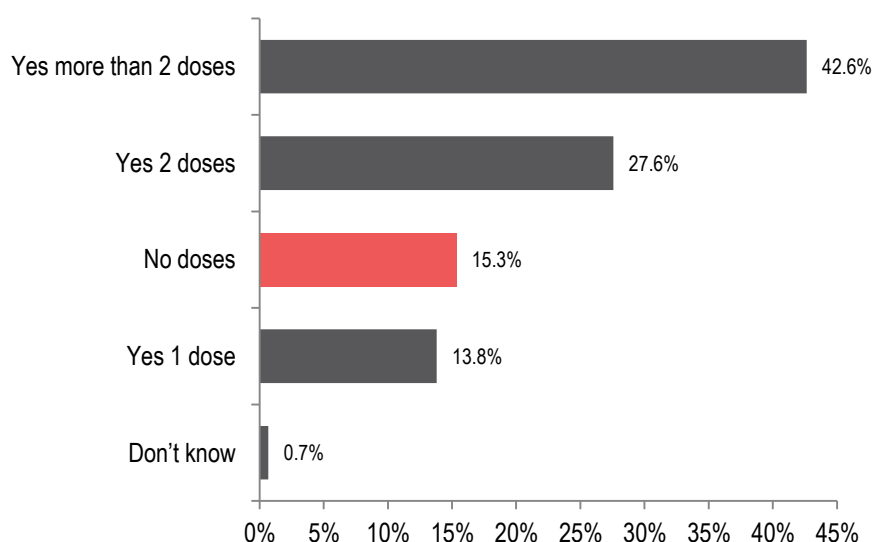
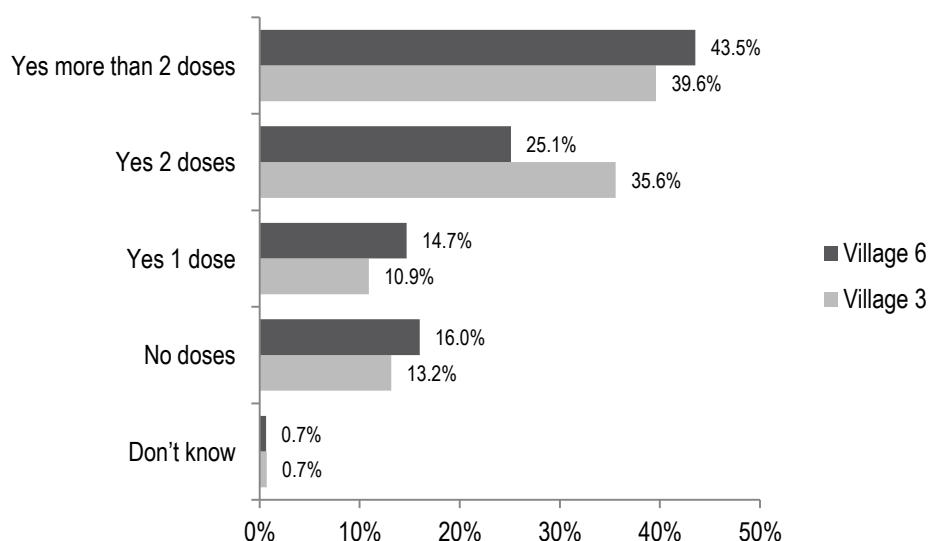


Table 7: Number of children aged under 5 reported to be vaccinated against polio, by Village

Village	More than 2 doses	2 doses	1 dose	No doses	Don't know
3	836	636	212	295	16
6	693	353	283	255	8
Grand Total:	1529	989	495	550	24

Figure 14: Percentage of children under 5 years old reported to be vaccinated against polio, by Village

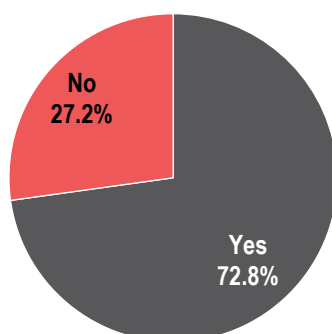


Although there are fixed Expanded Programme on Immunization (EPI) sites in both Village 3 and 6, these findings indicate that further vaccination campaigns should aim to target an equal proportion of children in both Villages in order to ensure even coverage is achieved.

Measles Vaccination

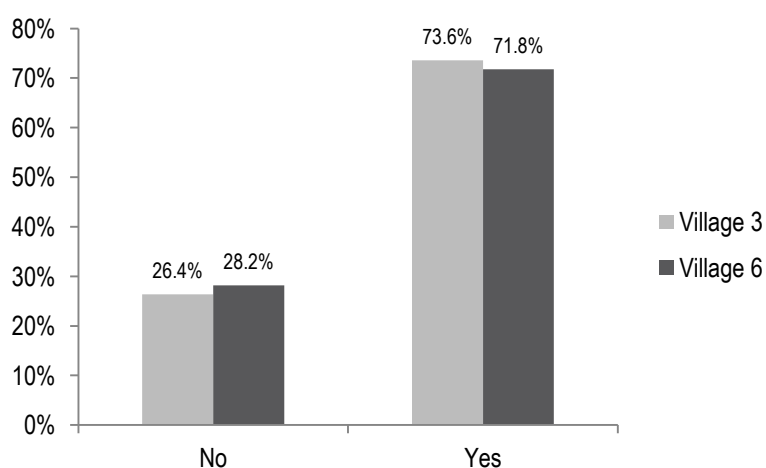
Respondents were asked if children living in their household within the target age range of 9 months to 5 years had been vaccinated against measles. According to UNICEF, no measles campaigns have been conducted in Azraq camp to date, however children 9 months – 5 years can receive measles vaccination in health clinics in Azraq camp at two EPI site locations; one in Village 3 the other in Village 6. This assessment found that the majority of children falling within this age bracket are reported as vaccinated against measles in Azraq camp, with a total of 72.8% vaccinated, while 27.2% were not.⁴³

Figure 15: Percentage of children aged 9 months - 5 years reported to be vaccinated against measles



When findings are disaggregated by Village, vaccination coverage was similar for both Villages, with 73.6% reported as vaccinated against measles in Village 3 and 71.8% in Village 6. However, with more than a quarter of all children aged between 9 months and 5 years still not fully vaccinated against measles, there remains a need for further vaccinations, perhaps including targeted vaccination campaigns to reach these at-risk children.

Figure 16: Percentage of children aged 9 months to 5 years reported to be vaccinated against measles, by Village



⁴³ Recall bias may have affected the accuracy of responses received for self-reported questions due to participants with an unreliable memory of past events.

Women vaccinated with Tetanus Toxoid

The tetanus toxoid vaccine protects mothers and new born babies from maternal and neonatal tetanus (MNT), which is preventable through immunization and hygienic birth practices.⁴⁴ Tetanus Toxoid vaccination is administered through an injection, with a total of 5 doses, and is administered for girls and women of reproductive age (defined as 15-49 years). According to MoH figures, the number of reproductive aged women (15-49 years) who received more than two doses of tetanus toxoid from fixed EPI sites in April 2015 in Azraq camp was 2,225 women (including 725 pregnant and 1,500 non pregnant women).⁴⁵

Findings indicate that the majority of girls and women of reproductive age living in Azraq camp are vaccinated against Tetanus Toxoid (64.3%), yet despite this, more than a third remain unvaccinated.⁴⁶ When disaggregated by Village, vaccination rates were almost equivalent for both Villages, with 64.5% vaccinated in Village 3 compared to 63.9% in Village 6, suggesting that current vaccination coverage is largely even.

Figure 17: Percentage of girls and women of reproductive age (15-49 years) reported as vaccinated with Tetanus Toxoid

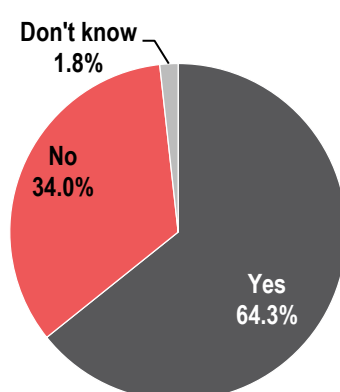
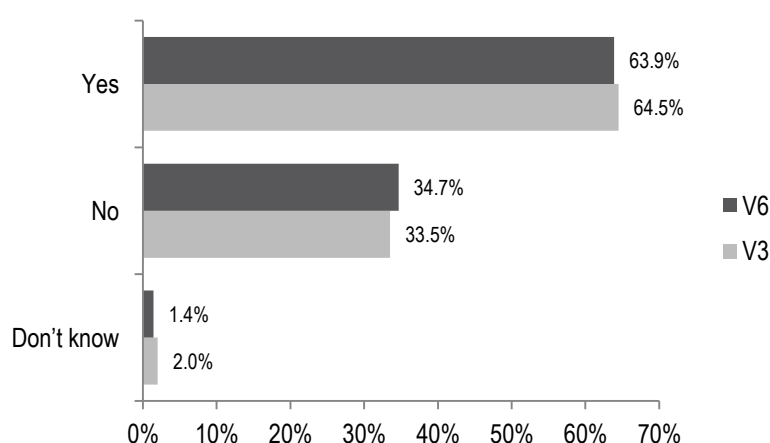


Figure 18: Percentage of girls and women of reproductive age (15-49 years) reported as vaccinated with Tetanus Toxoid, by Village



⁴⁴ UNICEF, [Maternal and neonatal tetanus](#)

⁴⁵ Ministry of Health Jordan, 2015.

⁴⁶ Recall bias may have affected the accuracy of responses received for self-reported questions due to participants with an unreliable memory of past events.

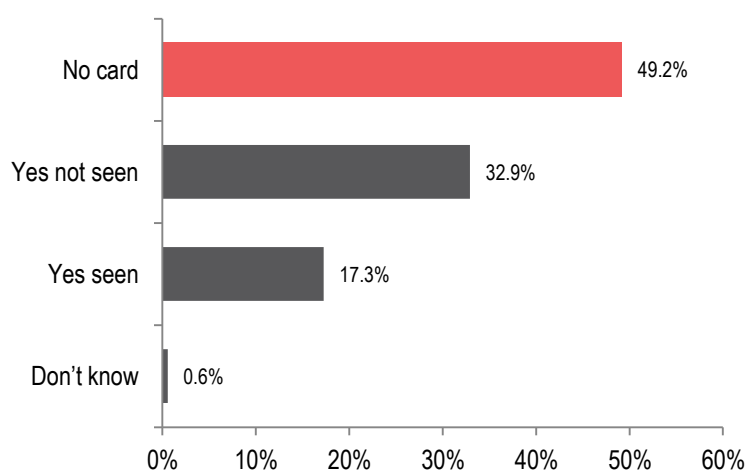
Vaccination card

Vaccination cards are a form of health documentation given to refugees in Azraq camp by the MoH that show their name, date of birth and history of vaccinations received from all health care providers, through routine immunization and supplementary immunization activities. These health records foster coordination and continuity of immunization service delivery between service providers and can also be used as an effective instrument for promoting childhood immunization, educating caregivers about their child's immunization status and stimulating demand for services.

According to the Global Alliance for Vaccines and Immunization (GAVI) child vaccination cards are often underutilized, misused or misplaced by parents and health workers.⁴⁷ This assessment therefore asked respondents to present the vaccination cards for any children under the age of 5 years living in their household. If the vaccination card was shown to the data collector, the response 'Yes seen' was recorded. If the respondent stated that the child had a vaccination card but was unable to present it to the data collector, the response 'Yes not seen' was selected.

Every child in Azraq camp should normally receive a vaccination card from health centres; which each child vaccinated receiving a unique number that is recorded in the vaccination registry log book, and available at all EPI sites to enable tracking of child's vaccine profile. However, this assessment found that almost half of all children aged under 5 years living in the camp are reported as not having a vaccination card at 49.2%. Indeed, only 17.3% of children falling within this age bracket had vaccination cards that were seen and validated by data collectors while a further 32.9% had vaccination cards that were not seen and verified. Some family members may have lost or misplaced children's vaccination cards, or they may have been with other household members who were not in the shelter at the time of assessment. Recall bias may have also played a role in family members forgetting that they possessed children's vaccination cards, causing the total number to be under-represented in findings. In order to maintain accurate vaccination records in Azraq camp alternative solutions to retaining infant vaccination information could be found – for instance in addition to using vaccination cards, vaccination information for infants aged under 5 years could be stored using technology to record iris scans and/or digital fingerprints to store the information electronically as this would be a more reliable way of retaining this data.

Figure 19: Percentage of children under 5 years, with and without vaccination cards



⁴⁷ UNICEF, [Child health, Immunization](#), April 2015.

Maternal Health

There are two Infant and Young Child Feeding (IYCF) caravans that are currently operated by Save the Children Jordan with support from UNICEF. IYCF programmes in Azraq camp provide nutritional support and guidance to mothers, including breastfeeding promotion, complementary child feeding, one-to-one counselling, and health education sessions for pregnant/lactating women. There are two breastfeeding caravans located in Azraq camp - one in Village 3 and one in Village 6. During this assessment, for every household with women of reproductive age (15-49 years) the respondent was asked how many women in the household were pregnant or breastfeeding, and how many had given birth to a baby in the camp within the past year.⁴⁸

Overall, it was found that a total of 741 women were pregnant or breastfeeding in Azraq camp. This represents 23.2% of the total 3,200 girls and women aged 15-49 living in Azraq camp. Meanwhile 247 women reported to have given birth in the camp within the past year,⁴⁹ representing 7.7% of all girls and women aged 15-49 years living in the camp. Disaggregating findings by Village shows that there were more women who were pregnant or breastfeeding in Village 3 compared to Village 6 corresponding with the larger number of women aged 15-49 years in Village 3 (1,856 compared to 1,344 in Village 6).

Figure 20: Number of women reported to be pregnant or breastfeeding, by Village

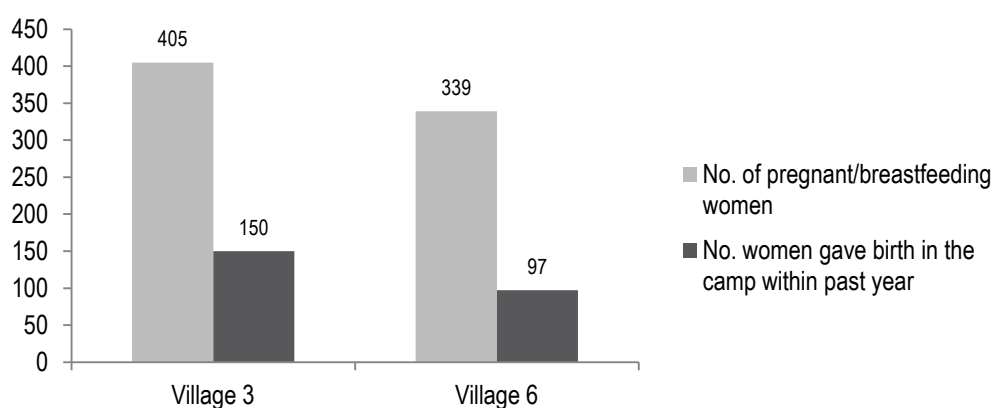
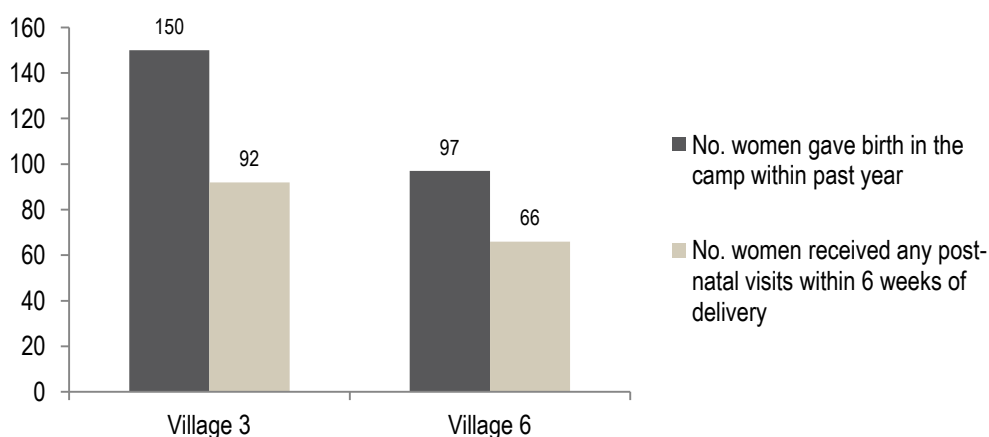


Figure 21: Number women reported to have given birth in Azraq camp within the past year, by Village



⁴⁸ For protection reasons and due to cultural sensitivity, as part of a 'Do no harm' approach maternal health questions were only asked regarding girls and women aged 15-49 years. Girls aged below 15 years were not included in maternal health findings as it was not deemed appropriate for data collectors to ask if girls below this age were pregnant or had given birth within the past year.

⁴⁹ According to UNHCR the number of live births in Azraq since the camp opened till May 2015 is 384. It is possible that a number of these women have left the camp since they have given birth and were therefore not captured in this assessment.

According to UNICEF, mothers and newborns should receive postnatal care in the health facility for at least 24 hours after birth. If their birth takes place at home, the first postnatal visit by a health specialist should be as early as possible within 24 hours of birth. At least three additional postnatal visits are recommended for all mothers and newborns, less than 24 hours, between days 7–14 after birth, and two to six weeks after birth. These visits address the care for both the mother and newborn.

It was found that of women who gave birth within the past year, 61% from Village 3 and 68% from Village 6 had received at least one post-natal visit within 6 weeks of delivery.⁵⁰ This indicates that there is scope for a greater number of follow-up post-natal visits to be delivered to new mothers in Azraq camp. In total, 18.4% of women who gave birth in Azraq camp within the past year received the recommended number of 3 post-natal visits within 6 weeks of delivery. At 44.3% the largest proportion of girls and women 15-49 years had received 1-2 visits. Meanwhile, 20.3% had 5-6 visits and a further 6.3% had reportedly received 7 or more visits.

Figure 22: Reported number of post-natal visits received by women, of women who gave birth in Azraq camp within the past year

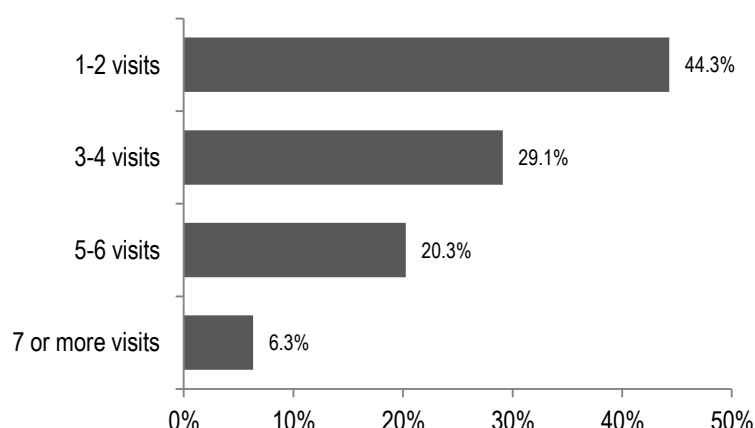
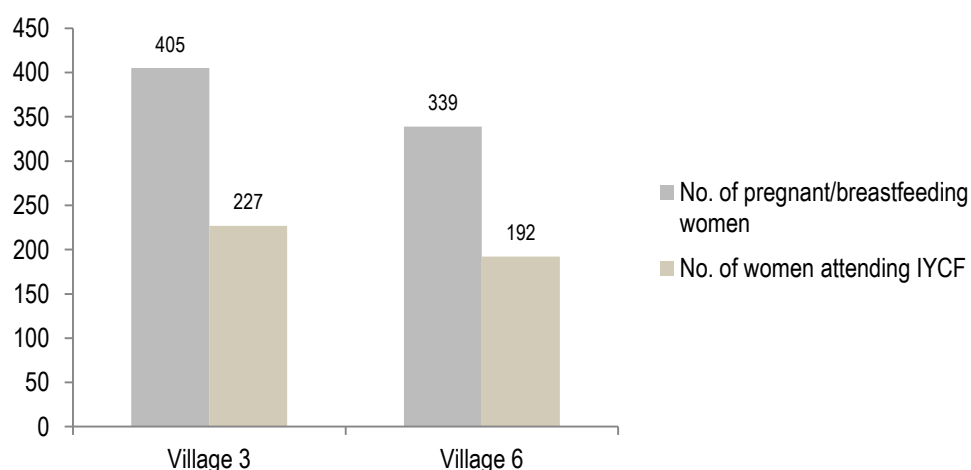


Figure 23: Number of pregnant or breastfeeding women attending Infant and Young Child Feeding (IYCF), by Village



Over half of all pregnant and/or breastfeeding women were found to be attending Infant and Young Child Feeding (IYCF). When disaggregated by Village, 56% of pregnant /breastfeeding women in Village 3 (227 individuals) were reported as attending IYCF and 57% in Village 6 (192 individuals). While over half of pregnant/breastfeeding women in both Villages are attending IYCF, more of the target demographic could be incorporated into IYCF programmes through increasing the number of IYCF caravans in Azraq camp, which currently stands at two, with one in each Village.

⁵⁰ Recall bias may have affected the accuracy of responses received for self-reported questions due to participants with an unreliable memory of past events.

EDUCATION AND CHILD PROTECTION

By December 2014, over 220,000 school-aged Syrian boys and girls were registered as refugees in Jordan. According to official enrolment records released by the Ministry of Education 127,857 Syrian children are enrolled in public schools across Jordan in the school year 2014/2015; of these 19,108 enrolled in schools in the 3 refugee camps (Za'atari, EJC and Azraq) and 1,500 children are attending public kindergartens.⁵¹ In 2014, 33,553 school-aged Syrian refugee children who were not attending formal education were assisted by UNICEF through psychosocial support and alternative and non-certified forms of education. Additionally, remedial education is provided for children attending formal education. Despite this, the number of out-of-school children in Jordan remains high, with close to 60,000 Syrian children reported as lacking access to learning opportunities.⁵²

In Azraq camp there is one formal school that operates with a double-shift system. Girls attend in the morning, from 8:00-11:30am, and boys attend in the afternoon, from 12:00 -3:30pm. The formal school, located between Village 3 and Village 6, first opened in September 2014 and has a capacity for 5,000 students, 2,500 per shift. In addition to formal schooling, Relief International and the Norwegian Refugee Council (NRC) provide various types of IFE in Azraq camp, including basic learning, technical skills/post basic education and recreational activities. Additionally, there are sites throughout Azraq camp designated as Child Friendly Spaces (CFS), Adolescent Friendly Spaces (AFS) and Multi-Activity Centres (MAC) run by Mercy Corps, International Medical Corps (IMC) and UNICEF which can be accessed by children and youths.

Table 8: Education Sector Working Group Glossary of Education Terms January 2015

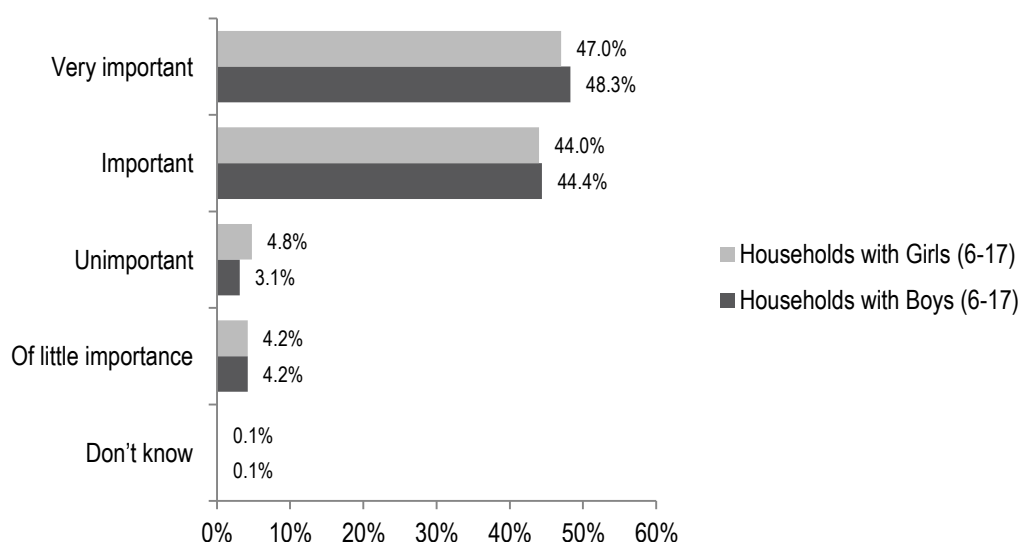
Glossary – January 2015: Education Sector Working Group, Jordan	
Term	Definition
Formal Education	<p>Lower Primary Education: This includes the first 3 grades (First, Second, and Third). The eligibility of students for first grade includes those children who were born between Jan 1st - Dec. 31st, provided that the child's age does not exceed 10 years on 31/12 for the same year.</p> <p>Higher Primary Education: This includes grades 4 to 10.</p> <p>Secondary Education: This includes grades 11 and 12 for all branches.</p> <p>Remarks: Students who have dropped-out of school can go back to formal education, provided that there is no more than 3-year- age difference between them and the other students in the grade they will be admitted in. This is to be decided based on the average date of birth of the students in that grade (from 1 Jan to 31 Dec), and based on the admission age in the first grade as a base year.</p>
Informal Education	<p>Educational activities that range from recreational activities to literacy numeracy, and life skills sessions. These educational activities are not certifiable by the Ministry of Education and not specifically bound to certain age or target group. The main categories are: 1. Basic learning; 2. Technical skills/Post Basic education; 3. Recreational activities.</p> <p>Catch-up classes: Education services designed specifically to support reintegration into formal schooling for those children who have missed out months up to 3 years of schooling.</p>
Dropped Out	Previously attended school inside the camp but no longer attending
Out of School	School-aged children not attending school, including those who have never attended school in the camp and those who have dropped out.
Eligible	Eligible to enrol in school. According to the Jordanian system, students who have been out-of-school for over three years are not eligible to enrol in school.

⁵¹ UNICEF, [Children of Syria](#), 2014.

⁵² Ibid.

To assess perceptions of education, in households with school aged children, the head of household was asked how important it was that girls and boys had a certified education pathway. A significant majority of households reported that they considered a certified education pathway either important or very important, with very little disparity according to sex (91% of households with school-aged girls, 92.7% of households with school-aged boys). The largest disparity was recorded for the response 'unimportant' with 4.8% of households indicating this response for school-aged girls compared to 3.1% of households for school-aged boys.

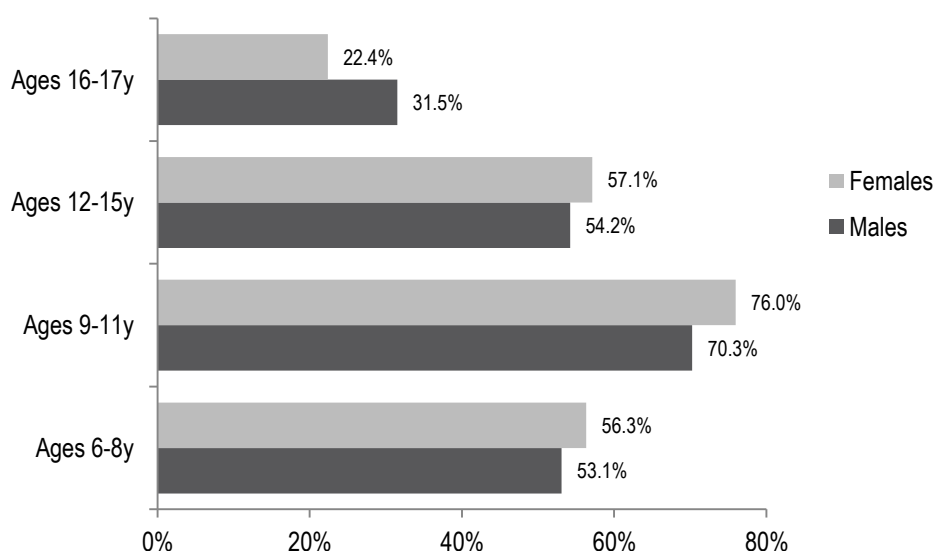
Figure 24: Perceptions of importance of certified education pathway for school-aged children



Formal Education

Overall, 57% of the 4,549 school aged children aged 6-17 years living in Azraq camp are currently attending formal education, with 56% of boys and 58% of girls reported as attending school. When findings were disaggregated formal attendance rates were found to vary greatly according to age and sex. Children aged 9-11 years were the age-group with the highest formal attendance rates, with 76% of girls and 70.3% of boys reported as attending. The lowest attendance rates meanwhile were recorded for 16-17 year olds, with only 22.4% of girls and 31.5% of boys in this age-group attending school. Across the age-groups 6-15 years there are more girls than boys in attendance of formal education. However this trend is reversed for children aged 16-17 years. The largest drop in attendance rates can be observed between the age-groups 12-15 years and 16-17 years, highlighting that there need to be targeted interventions aimed at retaining children beyond the early stages of high school.

Figure 25: Percentage of children reported as attending formal education, by age and sex



When disaggregating by Village, greater disparities in attendance rates can be identified. Namely, formal attendance is higher in Village 3 than Village 6 for both boys and girls, with 64.2% of males attending in Village 3 compared to only 44.3% Village 6, and 68% of girls attending in Village 3 compared to 46.6% in Village 6. Given that the formal school in Azraq camp is located between Villages 3 and 6, it is unlikely that distance is a major factor causing this disparity in attendance figures. However, one contributing factor is that the majority of residents in Village 6 occupied shelters after the first semester had already started. Further investigation is needed by education partners to ascertain why attendance is lower for Village 6 to plan and to implement adequate programming to enhance school attendance

Figure 26: Percentage of boys (0-17 yrs) reported to attend formal education, by Village

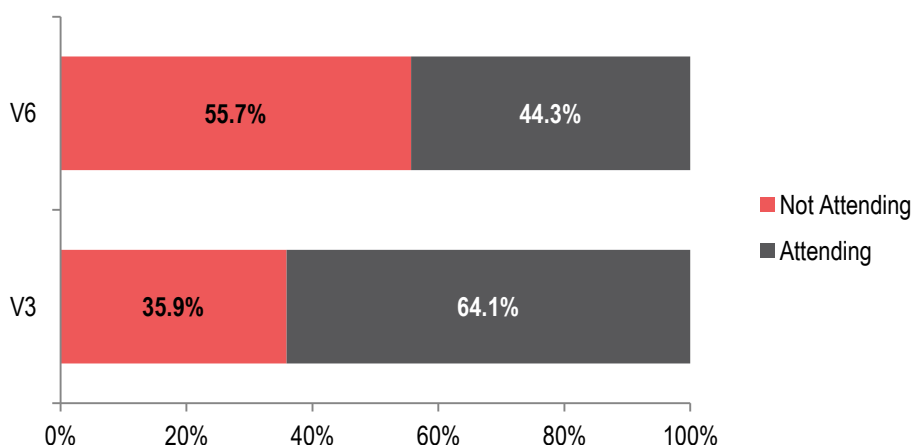
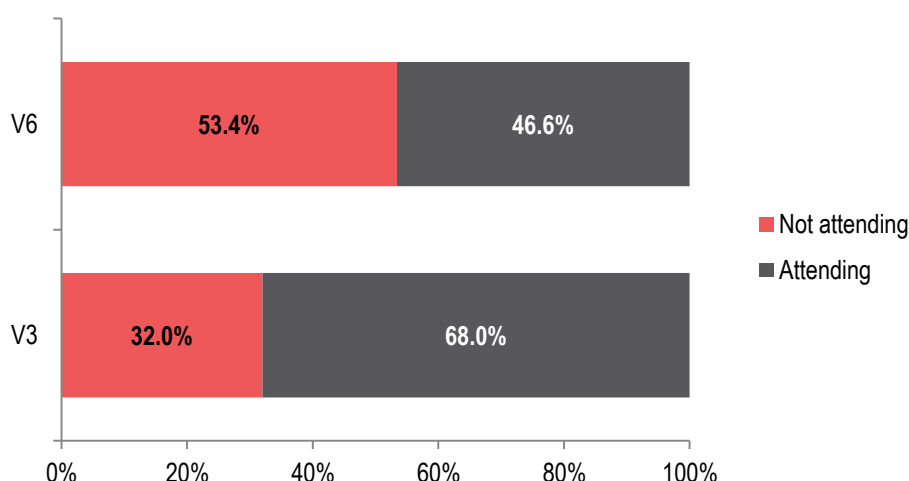


Figure 27: Percentage of girls (0-17 yrs) reported to attend formal education, by Village



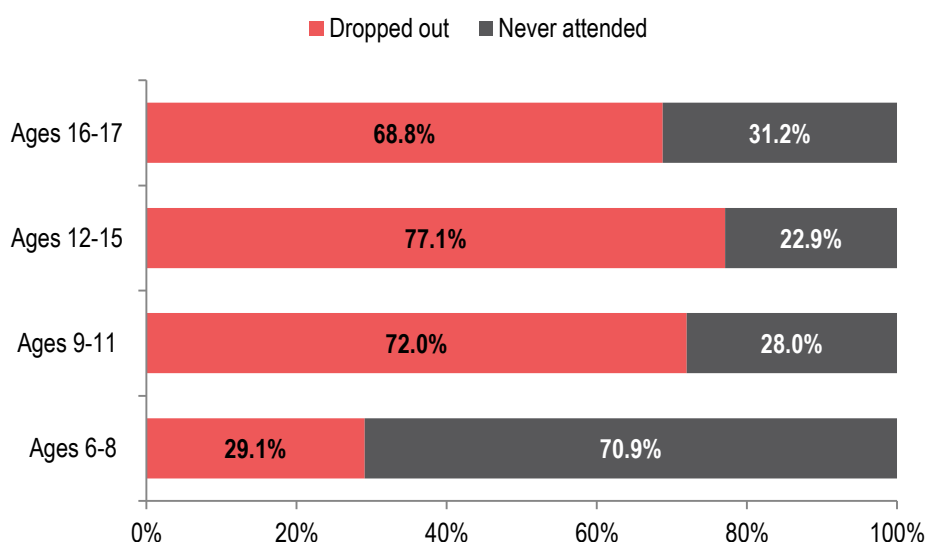
Out-of-School Children

Overall, 43% of children aged 6-17 years in Azraq camp are currently reported to be out-of-school. The majority of these children (59.5%) had previously attended formal education and then dropped out of school, with little disparity between girls, of whom 59% dropped out and 41% never attended, and boys of whom 60% dropped out while 40% never attended. When disaggregating by age there is a notable disparity between different demographic groups. A much higher percentage of out-of-school children aged 6-8, was reported to have never attended formal education before, at 70.9%. This compared with much lower percentages across all other age-groups. This may be due to children within this age-group never enrolling in formal school due to them reaching school-age around the time of leaving Syria for Jordan as a result of the Syrian refugee crisis. As children falling within this category have not yet missed 3 years of school, and given their age, are still eligible to attend. This indicates that there is a clear need for education partners to find new ways to attract and integrate this demographic into the formal system from an early age. The proportion of children who had dropped out was highest among 12-15 year olds, at 77.1%, of those not attending highlighting that this age-group must also be targeted in order to see a decrease in drop-out rates.

Figure 28: Proportion of out-of-school girls and out-of-school boys (6-17) who have never attended or dropped out of school

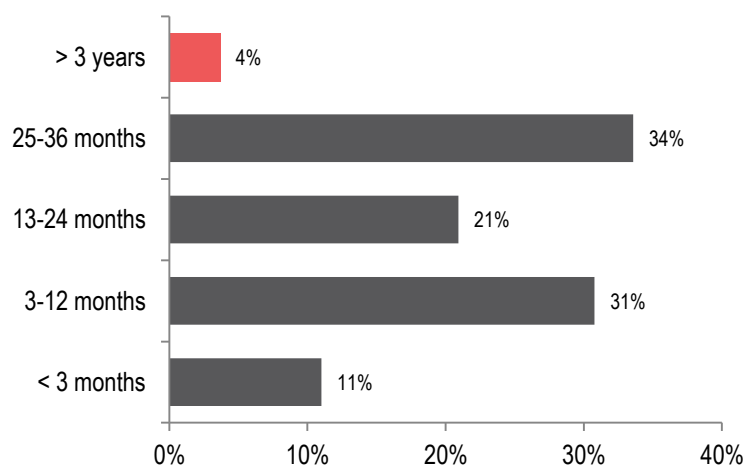


Figure 29: Proportion of out-of-school children who have never attended or dropped out, by age



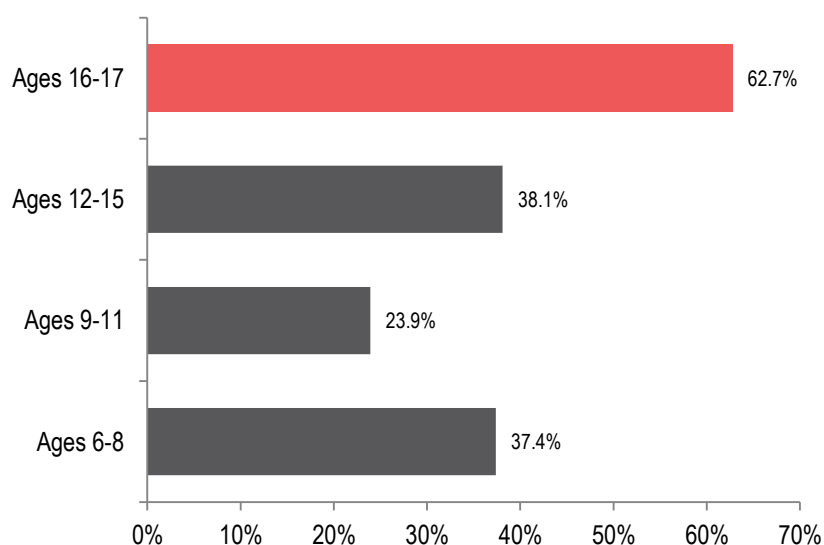
For the 59.5% of out-of-school children who had previously attended school but dropped out, households were asked how many months of formal education these children had missed. A positive finding was that 96% of out-of-school children living in Azraq camp are still eligible to be reintegrated into formal education, with only a small minority of out-of-school children (4%), having missed more than 3 years of formal education, requiring special focus. However, the largest proportion of out-of-school children (34%) had missed 25-36 months, meaning that they could soon be ineligible to rejoin school without rapid interventions and well-targeted outreach programmes, given that, according to the Jordanian education system, students who have been out-of-school for over three years are no longer eligible to enrol in school.

Figure 30: Number of months missed by out-of-school children who have attended but dropped out



When disaggregating the out-of-school children identified in this assessment as not accessing any type of education by age group, 16-17 year olds are revealed to represent by far the largest proportion of out-of-school children not attending any type of education, at 62.7% overall. This age-group can therefore be identified as particularly vulnerable and the most likely to be excluded from learning opportunities in the camp. Next were children ages 12-15 years with a total of 38.1% out-of-school, closely followed by children aged 6-8 years with 37.4% currently not accessing any learning opportunities.

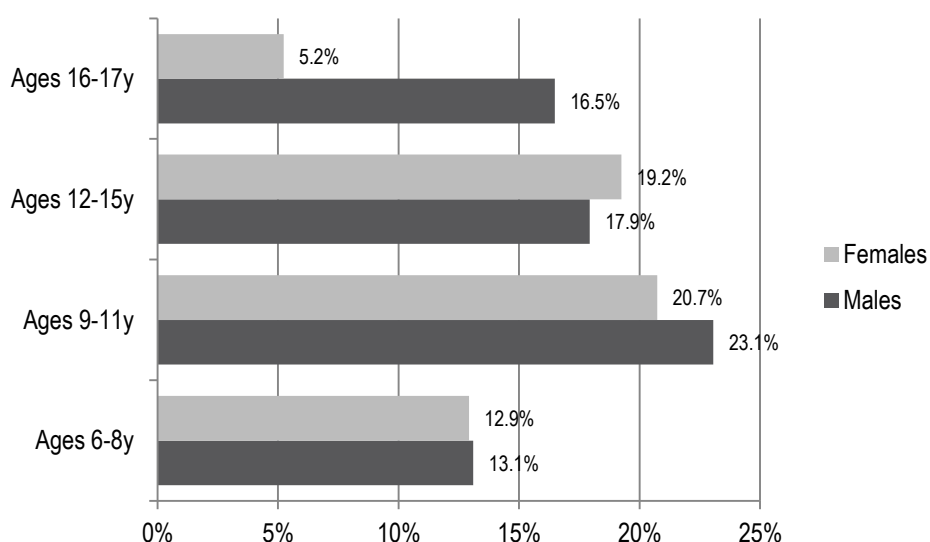
Figure 31: Percentage of out-of-school children 6-17 years who are not currently attending any type of education, by age-group)



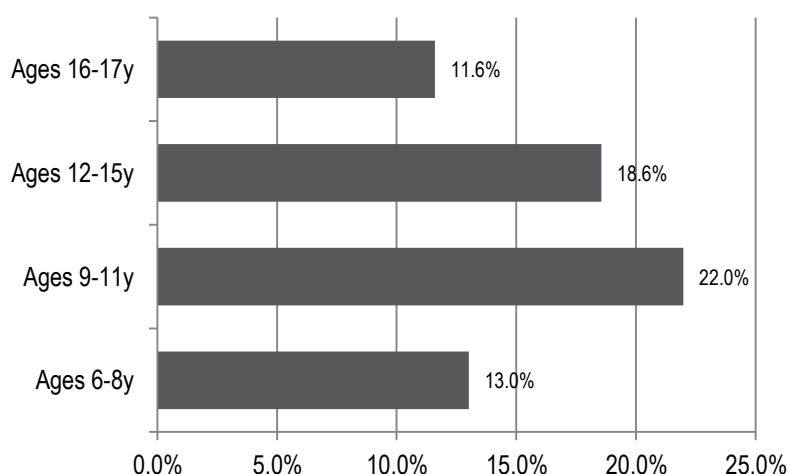
Informal Education

Informal education (IFE) offers an alternative type of learning opportunity to school-aged children particularly out-of-school children and children who are not accustomed to conventional classroom learning. IFE in Azraq camp incorporates basic learning, technical skills/post basic education and recreational activities. Education provided in mosques was included as an additional category during this assessment, as it was identified to be of interest by the Education Sector Working Group during the Joint Education Needs Assessment (JENA) conducted in Za'atari camp in 2014 and was agreed upon within the key education indicators by Azraq camp education working group.⁵³ In terms of IFE provision in Azraq camp, Relief International holds remedial education classes, while NRC runs catch-up classes for school-aged children. Findings indicate that IFE attendance in Azraq camp varies significantly according to age and sex. IFE is most commonly attended by the age-group 9-11 years, with 20.7% of females and 23.1% of males reported as attending, followed by ages 12-15 years, with 19.2% of females and 17.9% of males attending. By far the lowest attendance of IFE was recorded for females aged 16-17 years, at only 5.2%, compared to 16.5% for males of the same age. Given that this demographic also had the highest rate of out-of-school children it is clear that more outreach needs to be done to engage girls aged 16-17 years in alternative learning opportunities.

⁵³ UNICEF/REACH, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

Figure 32: Percentage of children reported as attending informal education, by age and sex

In total 17% of all school aged children were found to be attending both formal education and IFE, with 16% of girls and 18% of boys aged 6-17 years falling within this category. The age group with the highest proportion of children attending both types of education were 9-11 year olds, with 22% falling within this category, followed by 12-15 year olds with 18.6%. Children aged 6-8 years had the lowest number of individuals attending both formal education and IFE at 13%. These findings indicate that there is some overlap, particularly among children aged 9-11 years despite the fact that IFE programs are generally designed to provide alternative education opportunities for children who are unable or unwilling to go to school. Some out-of-school children are missing out on IFE learning opportunities, while others who are already attending formal school are shown to also benefitting from IFE programmes. If there are limited places on IFE programmes in Azraq camp, education partners should consider only accepting out-of-school children in order to ensure that the maximum number of school-aged children are attending at least one type of education.

Figure 33: Percentage of school aged children attending both formal education and IFE, by age

Type of Informal Education

Basic learning was the most commonly attended type of IFE attended by children in Azraq camp across all age-groups for both sexes with 76.4% of children attending at least one type of IFE selecting this response. This was followed by recreational activities with 23.5% of school-aged children attending this type of IFE and vocational training with 10.5% of all children attending at least one type of IFE. When disaggregating by age and sex there were some commonalities and differences in the type of IFE attended by school-aged children. No girls were reported to be attending religious education, yet boys aged 6-15 years were said to be attending, with attendance rates peaking at 9.5% among boys aged 6-8 years. Meanwhile, there were a notably high percentage of boys (42.2%) and girls (36.4%) aged 16-17 years attending technical skills training/post-basic education compared to other age-groups. Recreational IFE was most commonly attended by the youngest age-group (6-8 years) for both girls and boys, with 34.8% of females and 30.5% of males reported as attending.

Figure 34: Percentage of girls aged 6-17 reported as attending Informal Education (IFE), by each type of IFE

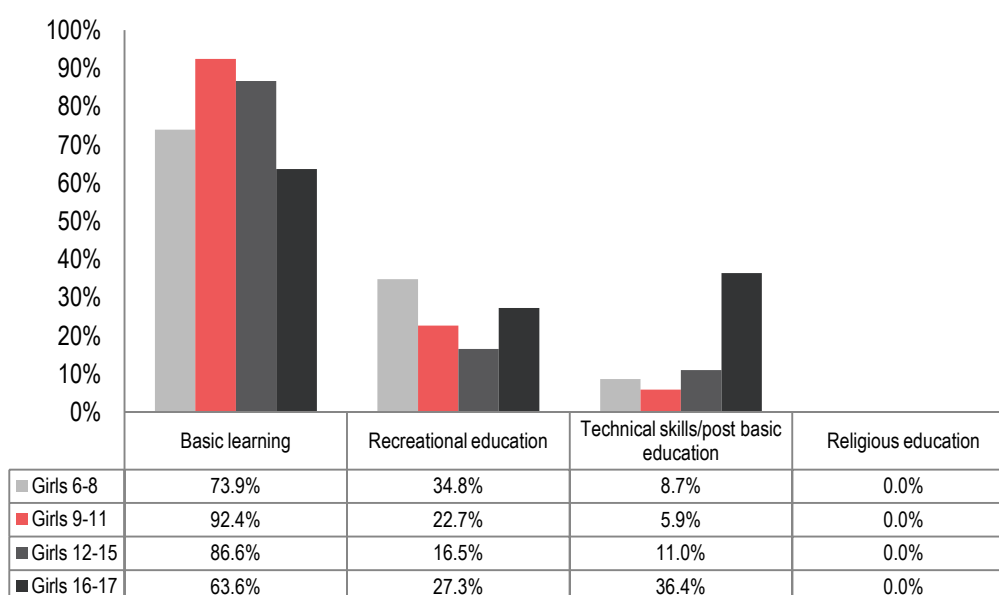
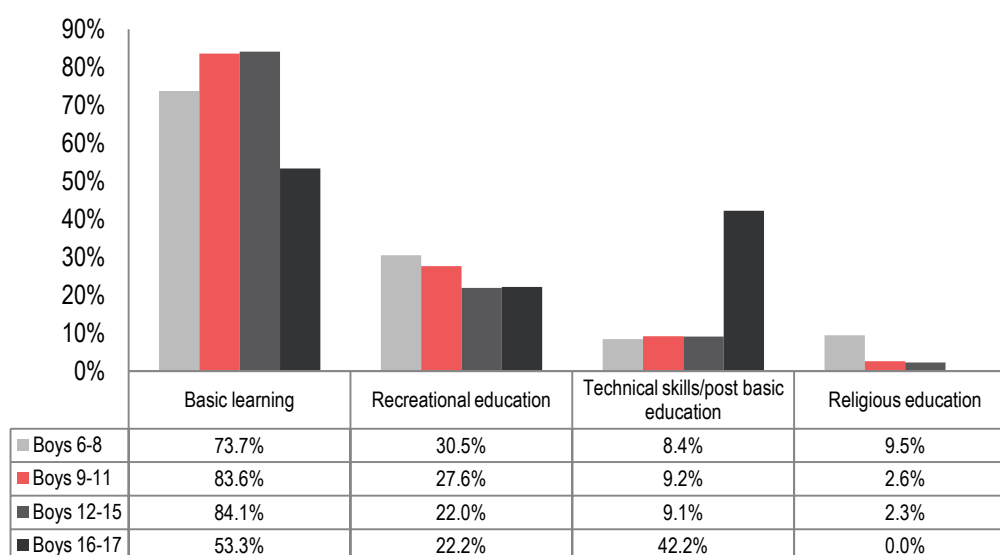


Figure 35: Percentage of boys aged 6-17 reported as attending Informal Education (IFE), by each type of IFE

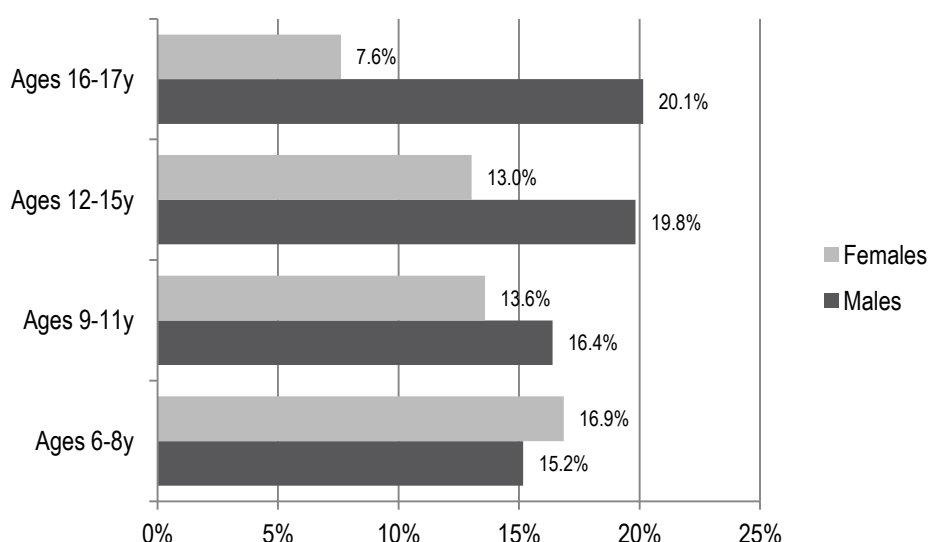


Child Friendly Spaces /Adolescent Friendly Spaces/Multi-Activity Centres

There are numerous Child Friendly Spaces (CFS), Adolescent Friendly Spaces (AFS) and Multi Activity Centres (MAC) located in Village 3 and 6 in Azraq camp, run by UNICEF, Mercy Corps and IMC. These facilities provide safe spaces for children and youths to participate in supervised activities and are recognised by UNICEF as a key child protection strategy as well as playing an important role in fostering development. These centres offer a wide range of integrated programmes including education, health, play, recreation and psychosocial support.⁵⁴

In the public leisure spaces satisfaction survey conducted by UNHCR in December 2014, Child Friendly Spaces were found to be the most frequently used public leisure space in Azraq camp, with 35% of respondents in Village 3 and 46% in Village 6 accessing this type of space.⁵⁵ Findings indicate that attendance of CFS, AFS and MAC varied significantly according to age and sex, with 15.8% of all children 6-17 years reported to be accessing these facilities. Overall, a higher percentage of boys (17.5%) than girls (13.9%) were reported to be accessing these facilities, with the largest disparity between males and females aged 16-17 years; boys aged 16-17 years represent the demographic with the highest percentage of children attending CFS/AFS/MAC at 20.1% compared to girls 16-17 years who have the lowest attendance rate at only 7.6%, in addition to the lowest attendance rate for formal education at 22.4%. Younger females were more likely to attend CFS/AFS/MAC while the reverse was true for males, with older boys more commonly cited as attending.

Figure 36: Percentage of children who use Child Friendly Spaces/Adolescent Friendly Spaces/Multi Activity Centres



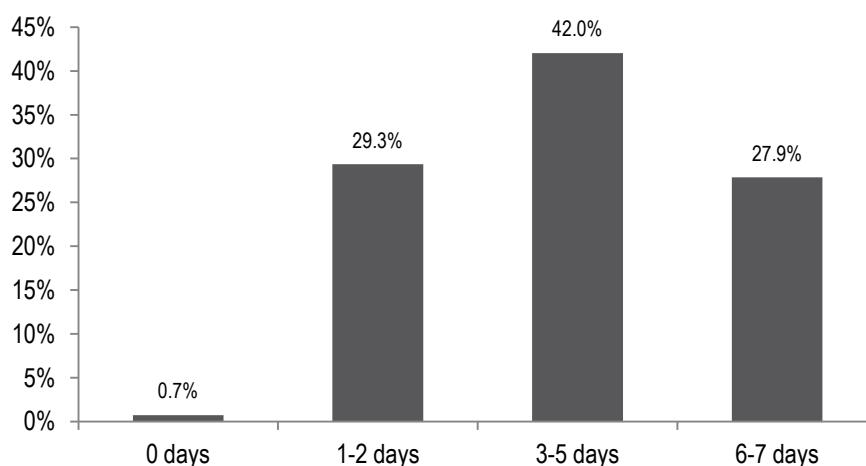
Frequency of CFS/AFS/MAC use was indicated to be relatively high, with 42% using these spaces 3-5 days a week and a further 27.9% accessing them 6-7 days a week in the seven days prior to the assessment. These findings are corroborated by the aforementioned UNHCR Azraq public leisure spaces assessment wherein 47% of respondents who attended CFS reported visiting CFSs on a daily basis.⁵⁶

⁵⁴ UNICEF, A Practical Guide for Developing Child Friendly Spaces, 2009.

⁵⁵ UNHCR/REACH, Perceptions and usage of public leisure spaces: Azraq camp, December 2014.

⁵⁶ Ibid.

Figure 37: Number of days children aged 6-17 attended Child Friendly Spaces/Adolescent Friendly Spaces/Multi Activity Centres in the last 7 days



In this assessment respondents were asked about attendance of formal education, IFE and CFS/AFS/MAC. Given the scope of the assessment, it was not possible to explore reasons for children attending different types of education or for children not attending school. Further assessments would be required to explore those reasons in-depth, and would require a qualitative component with Focus Group Discussions (FGDs), as in JENA.

DISABILITIES AND DEVELOPMENTAL DELAY

To ensure the delivery of a humanitarian response that is appropriate and accessible to people with specific needs, it is essential that information on children with disabilities and developmental delay is used to inform future assistance and services in Azraq camp. This assessment aimed to facilitate the pre-identification of boys and girls with risk factors for disabilities or developmental delay. The details of those who self-reported disabilities will be provided to partners for further assessment using the Washington Group-UN Statistics Division definitions, approved by GoJ. This assessment surveyed every household in the camp, thereby providing comprehensive findings for children with disabilities (CWD).

Respondents were asked whether children in their household had a chronic illness or experienced any of the following:

- Difficulty seeing, even when wearing glasses
- Difficulty hearing, even when wearing a hearing aid
- Difficulty with self-care, such as washing all over or dressing
- Physical difficulties including difficulty with movement, walking or loss of limb (excluding temporary injuries)
- Difficulty communicating, because of a physical mental or emotional health condition
- Difficulty remembering or concentrating

According to the World Health Organisation (WHO) a chronic illness is defined as a disease that is not passed from person to person and is of long duration and generally slow progression. The four main types of chronic diseases include cardiovascular diseases, cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.⁵⁷

All data collectors received guidance on these definitions by disability experts from Mercy Corps. The questions in this survey followed best practice for collection of disability statistics; however, it is important to note that the data is based on head of household/parental reporting and not a medical assessment. Therefore, there is a need for further verification of the reported conditions by disability specialists during the referral process.

In Azraq camp 3.5% of all children (282 individuals) were reported as having a disability and/or chronic illness. Of this 3.5%, a total of 91% of children with reported disabilities had only one disability or a chronic illness, while 9% had more than one disability and or chronic illness. Results show that there were a wide range of disabilities reported for children living in Azraq camp. The largest proportion of children was reported to have a chronic illness, with a total of 160 children falling within this category. The first most commonly cited type of disability was physical disability, with 53 children in total, followed by difficulty communicating/understanding with a total of 38 children. Overall, Village 3 had a larger proportion of total CWDs, at 60% of all CWDs in the camp. This can be attributed to the larger population size in Village 3.

⁵⁷ WHO, <www.who.int/topics/noncommunicable_diseases/en/>, March 2015.

Figure 38: Number of children with each type of reported disability or chronic illness

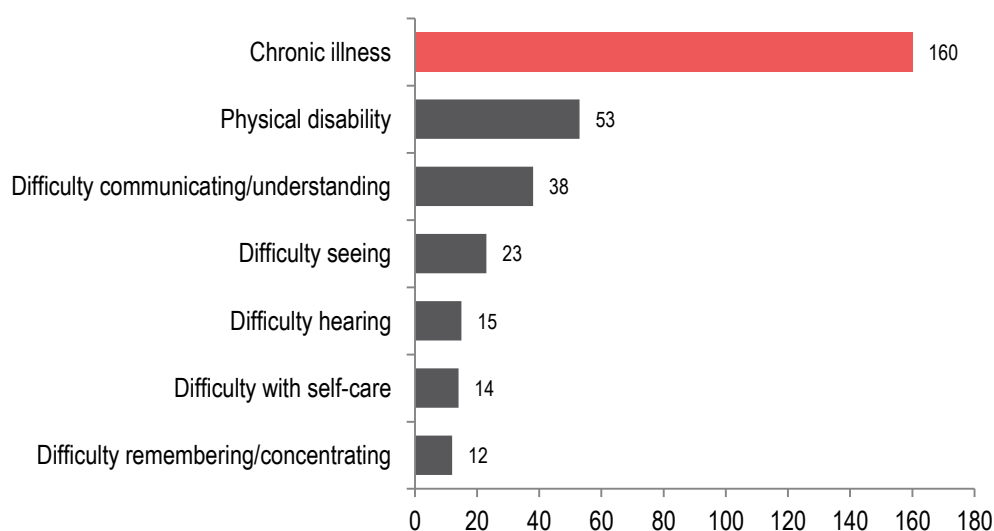
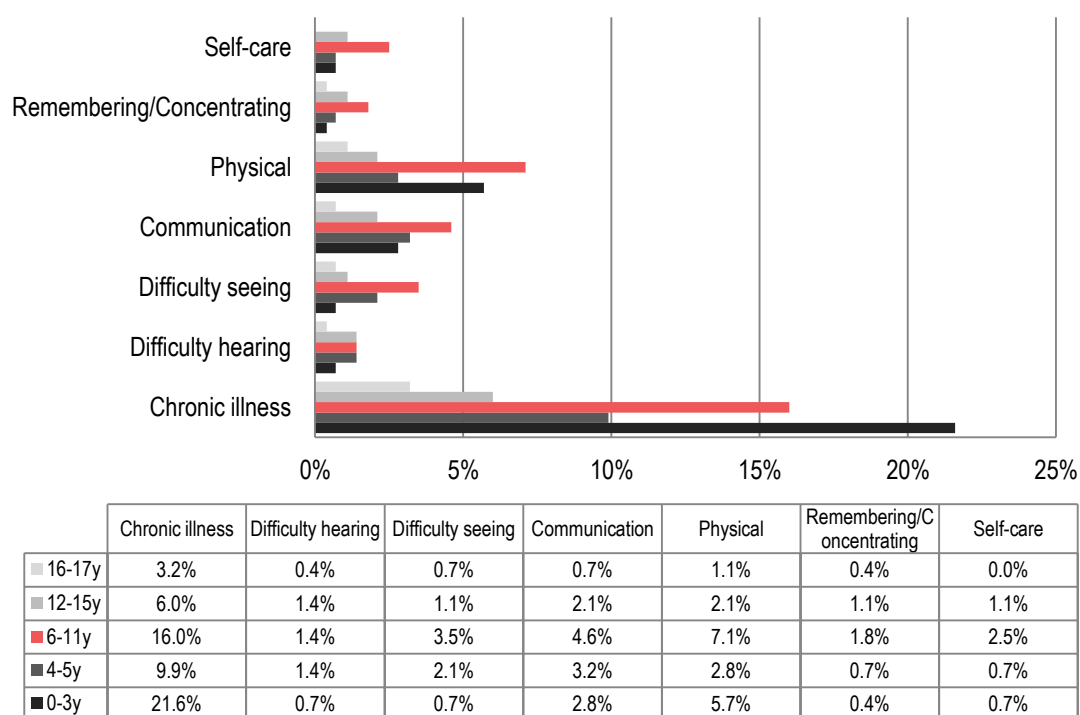


Figure 39: Percentage of children with each type of disability and chronic illness (of total children with reported disabilities), by age



When disaggregated by age, findings show that 6-11 year olds are disproportionately affected by disabilities, with the highest proportion of disabilities across all types of disability. Meanwhile, 0-3 year olds were most likely to have a chronic illness with a total of 21.6% reported within this category. There were no 16-17 year olds reported to have difficulty with self-care, and this age-group had the lowest proportion of reported disabilities and/or chronic illness overall.

Figure 40: Percentage of children with reported disability or chronic illness, by Village

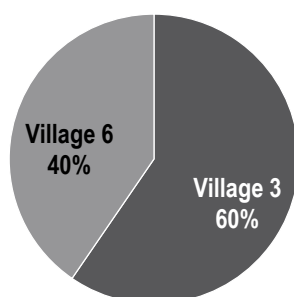
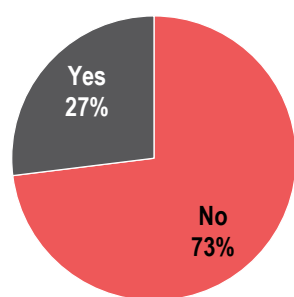


Figure 41: Percentage of children with reported disability or chronic illness who have previously been seen by a disability-focused organisation



Households reported that the majority of children with disabilities or chronic illness (73%) had not previously been seen or visited by any disability-focused organisation in Azraq camp, with 34% of females with reported disability and/or chronic illness who had previously been seen or visited compared to only 23% of males with these reported conditions. It may be the case that in the wave of recent arrivals to Azraq camp, some CWDs who have recently moved to the camp have not yet been reached by disability service providers or are not aware of the services available to support them.

Inclusive Education

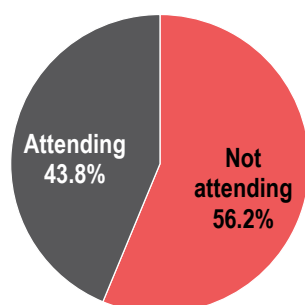
The democratic and human rights-based aim of Inclusive Education is defined as the 'recognition of the need to work towards 'schools for all' - institutions which include everybody, celebrate differences, support learning, and respond to individual needs'.⁵⁸ Inclusive education is central to UNICEF's programming approach, and involves a shift in underlying values and beliefs in addition to issues of access and capacity building for education providers.⁵⁹ In 2014, 919 refugee children with specific needs were provided with inclusive education, and integrated in public schools in both camps and host communities in Jordan.⁶⁰ However, there are still challenges to full inclusion, with barriers to access including the inaccessibility of school buildings and limited transportation to and from schools; a lack of trained teachers; and inadequate teaching/learning materials and other classroom resources for children living with disabilities. Assessment findings indicate that the majority of CWDs in Azraq camp are not attending formal education with 56.2% falling within this category – this is compared to 43% out-of-school children overall. This calls for further investigation into existing barriers to access for CWDs specific to those living in Azraq camp.

⁵⁸ UNESCO, [The Salamanca Statement and Framework for Action](#), June 1994.

⁵⁹ UNICEF, http://www.unicef.org/ceecis/education_18613.html, June 2015.

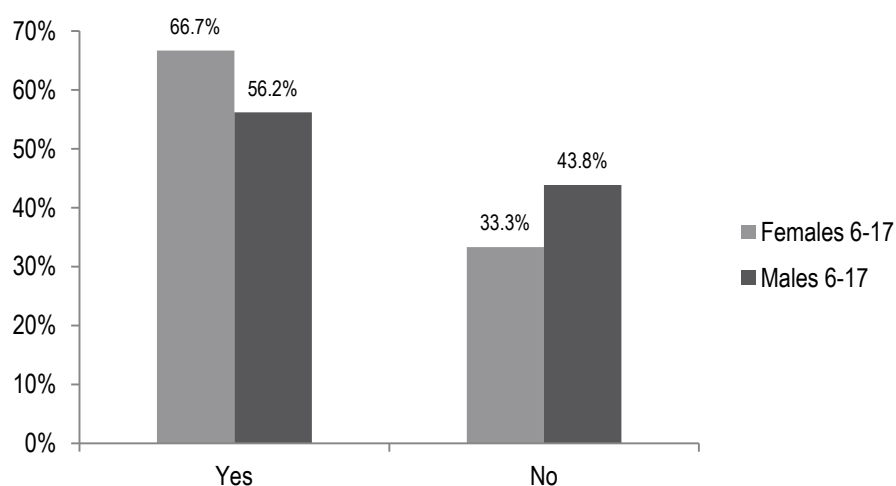
⁶⁰ UNICEF, [Children of Syria](#), 2014.

Figure 42: Percentage of school aged children (6-17 years) with reported disability and/or chronic illness attending formal education



Respondents were asked if the child's reported disability or chronic illness was the main reason for their out-of-school status. Findings indicate that for the majority of male (56.2%) and female (66.7%) CWDs this was the case. When disaggregating by sex it can be seen that female CWDs were more likely than males to be out of school due to their reported condition. Further efforts need to be made by disability actors to address this gender disparity, and to make formal education more inclusive for all CWDs.

Figure 43: Main reason child is not currently attending school is because of reported disability/chronic illness, by sex

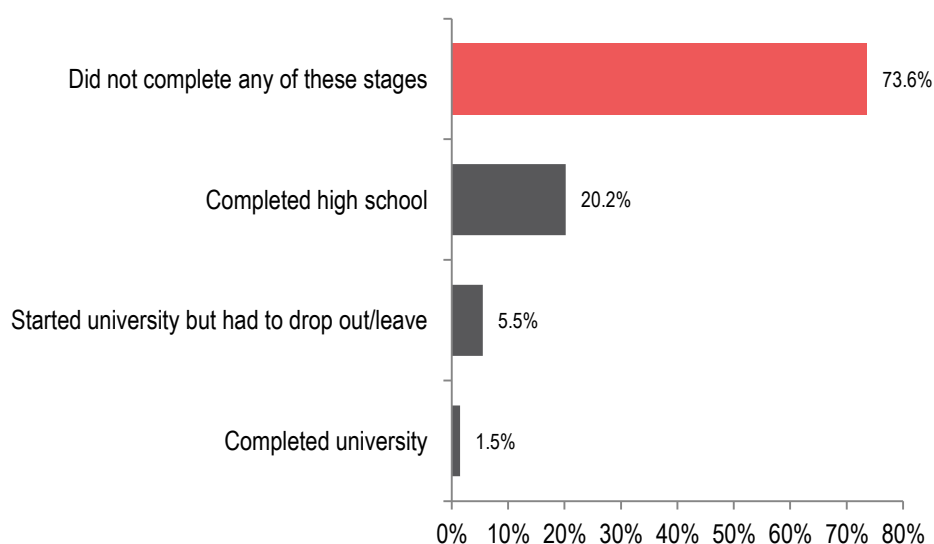


Given the scope of the assessment it was not possible to explore the specific reasons for these out-of-school CWDs, and therefore an in-depth study into barriers to access for CWDs would be beneficial to inform programming.

YOUTH

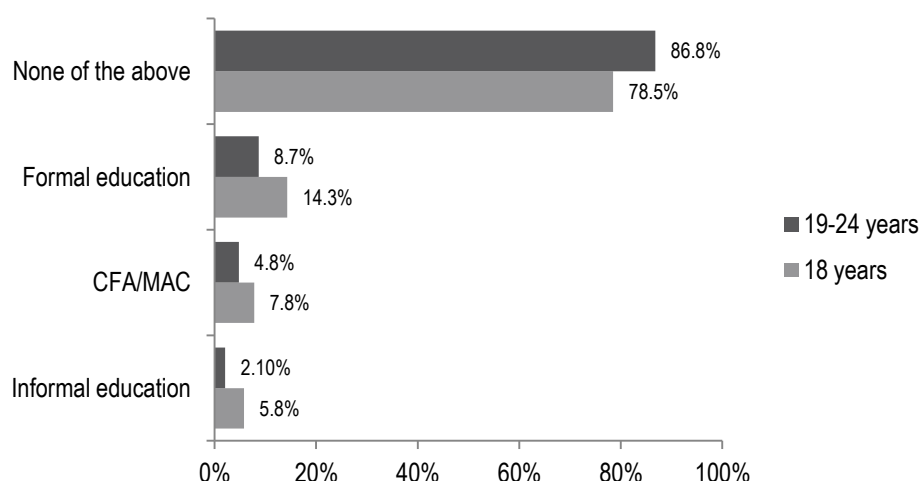
Youths 19-24 years living in Azraq camp were found to have limited formal education background, with the majority (73.6%) reported not to have completed university or high school. This group is likely to have been deprived of formal learning opportunities due to the protracted crisis in Syria interfering in their academic progress, with limited opportunities to return to full-time education, particularly for the 5.5% of youths who started university but had to drop out. For youths who started university but had to drop out there may be a need for preparatory courses for them to re-enter the formal education system. In total, 20.2% of youths within this age-group had completed high school while 1.5% had completed university. This suggests that alternative education and vocational training courses should be provided to youths in Azraq camp who have missed out on learning opportunities which may have negative long-term implications for their future employability in the job market.

Figure 44: % youths aged 19-24 that have completed secondary/tertiary education



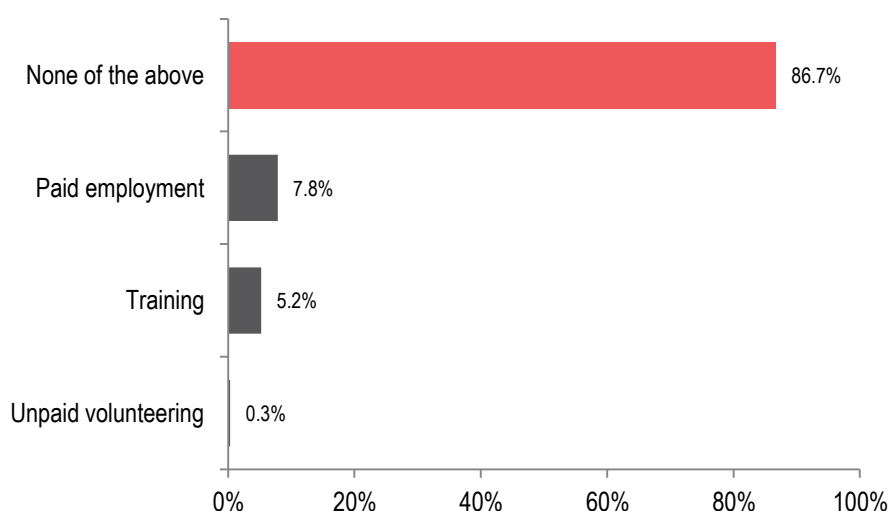
The vast majority of youths aged 18-24 living in the camp are currently not attending any type of education in Azraq camp (78.5% of 18 year olds and 86.8% of 19-24 year olds). However, overall, more 18 year olds than 19-24 year olds were accessing different types of education. 14.3% of 18 year olds and 8.7% of 19-24 year olds were reported as attending formal education. Despite the fact that the official eligibility criteria states that children 6-17 years to attend school according to MoE, students studying for their General Secondary Education Certificate Examination (Twajhi students) are eligible to be enrolled until the age of 21 for the 11th grade. Furthermore, there are a number of partners working with this age group in Azraq camp that are operational inside the formal school which may have caused some youths to be mis-reported as attending formal education. Low IFE attendance among youths indicates that there is scope for further outreach and IFE programmes specially targeted to this age-group in order to engage them in activities suitable for individuals who are not accustomed to a classroom-based learning environment.

Figure 45: % youths attending different types of education, by age



An overwhelming majority of youths 16-24 years were not engaged in any form of paid employment, training or unpaid volunteering at 86.7%.⁶¹ This implies that a large number of youths risk becoming disengaged from the camp community and resorting to negative coping strategies in order to overcome boredom and a lack of remunerative activities. In total, 7.8% of youths were in paid employment, while 5.2% were in training and 0.3% were undertaking unpaid volunteering. It is worth noting that as Azraq camp is still in the early stages of development and in the absence of an informal market place employment opportunities are mostly limited to incentive based volunteering for NGOs operating in the camp.

Figure 46: % youths aged 16-24 reported as engaged in paid employment/training/unpaid volunteering



When disaggregated by age and sex some disparities can be observed between males and females. A much larger proportion of males aged 16-24 years are engaged in paid employment than females, with 5.4% of males 16-18 in paid employment compared to only 0.3% of females within this age-group, and 15.6% of males 19-24 in paid employment compared to 5.5% of females. This gender gap is likely to reflect cultural norms and traditions, whereby males are more often expected to be the breadwinner for the household than females, who usually take on more domestic chores and responsibilities. There was less gender disparity in terms of training and unpaid volunteering with marginal differences between males and females.

⁶¹ Employment may be under-reported among youths who may perceive that this will affect their eligibility to access to services. Further, the head of household was interviewed in the majority of households rather than youths directly and may have been unaware of the employment status of youths living in their household.

Table 9: % youths 16-24 years engaged in paid employment/training/unpaid volunteering, by age and sex

Demographic	None of the above	Paid employment	Training	Unpaid volunteering
Females 16-18	92.8%	0.3%	6.9%	0%
Males 16-18	87.6%	5.4%	7.0%	0%
Females 19-24	88.9%	5.5%	5.1%	0.4%
Males 19-24	80.6%	15.6%	3.5%	0.3%

Given that the majority of youths in Azraq camp are not engaged in any productive activities, there is a risk of societal disengagement which is likely to affect this age-group more than others. Additionally, a general lack of educational attainment and vocational training among youths has significant long-term implications for the skills and employment prospects available to this group in the future. This highlights an urgent need for continued efforts to engage youths in activities where they can acquire new skills, access learning opportunities and find a productive way to spend their time.

CONCLUSION

This report has highlighted that, while Azraq camp remains relatively new and services have not long been fully established, service delivery is reaching key target groups (children, youth, new and expecting mothers) and achieving objectives, such as widespread WASH centre usage, health care outreach and enrolment in formal education. The assessment found there to be good overall access to WASH centres, as reflected by household usage among all demographics, with public toilets used by 99.5% of all households during day and night time. Furthermore, the vast majority of households (87%) are relying on public water supply for their main source of drinking water. In terms of reported IFE attendance, 20.7% of females and 23.1% of males aged 9-11 years reported as attending, followed by ages 12-15 years, with 19.2% of females and 17.9% of males attending. Additionally, there was found to be widespread uptake of routine vaccinations with the majority of children aged 9 months to 5 years vaccinated against measles (72.8%) and the majority of women and girls of reproductive age vaccinated with at least two doses of Tetanus Toxoid (64.3%). However, while many children, mothers and young people living in Azraq camp benefit from access to learning opportunities and health services, a large number still have specific unmet needs that must continue to be addressed by humanitarian actors. Further efforts need to address camp residents' dissatisfaction with distance to tap stands (total households 49.2% unsatisfied or very unsatisfied with distance), to increase vaccination coverage for both emergency and routine vaccinations, with 57.4% of children 0-5 years still not fully vaccinated against polio. Additionally there is an urgent need to reach higher formal attendance rates, particularly for 16-17 year olds of whom only 22.4% of girls and 31.5% of boys are currently attending, and to engage a larger proportion of youths in productive and remunerative activities, given that 86.7% of 16-24 year olds are reported as not in training, employment or unpaid volunteering.

WASH findings indicate widespread WASH centre usage. Public WASH centres are easily accessible for household members given their close proximity to shelters, and are used for a wide range of functions during day and night time, including the latrine, bathing, ablutions, washing clothes and washing dishes. Public water points remain the main source of drinking water for camp residents indicating that the public supply is a vital service that is heavily relied upon by the camp community. Among those 13% of households relying primarily upon purchased bottled water for drinking 76.5% were found to have negative perceptions of public water quality citing health concerns. This is an issue which key messages and hygiene promotion programmes designed by WASH actors in the camp should continue to address.

Uptake of vaccines in Azraq camp has still not achieved total coverage, indicating that key target groups may benefit from further vaccination campaigns, for both emergency and routine vaccinations. Despite the majority of infants having been vaccinated against polio and measles, and the majority of women having received at least two doses of Tetanus Toxoid, coverage remains uneven and does not cover all target groups living in the camp. Over a quarter of children (27.2%) remain unvaccinated against measles, while just over a third (34.3%) of girls and women of reproductive age (34%) have not received two or more doses of Tetanus Toxoid. Only 17.3% of respondents were able to present vaccination cards that were seen and verified for infants aged 0-5 years.

18.4% of new mothers received the recommended number of post-natal visits, and when disaggregated by Village, 56% of pregnant /breastfeeding women in Village 3 were reported as attending Infant and Young Child Feeding (IYCF) and 57% in Village 6. This indicates that maternal health services are still not reaching all the female beneficiaries in need of post-natal support, indicating a need to increase rates of post-natal visits received within 6 weeks of delivery and attendance of IYCF through promotion of greater awareness of routine medical services such as attending antenatal clinics, routine vaccinations and locations of IYCF caravans.

The majority of parents with school-aged girls and/or boys in their household perceived a certified education pathway to be either important or very important for girls and boys (91% of households with school-aged girls, 92.7% of households with school-aged boys). However, further IFE outreach could be designed to target 18-24 year olds, and females aged 16-17 years who only represent a small proportion of those currently attending IFE. CFS/AFS/MAC were used frequently by those accessing these facilities implying that they offer a valuable learning space for children in the camp. However, while the highest percentage of children attending CFS/AFS/MAC was boys aged 16-17 years at 20.1%, girls within the same age group were found to have the lowest attendance rate for these sites at only 7.6%.

There is a vital need for more Children with Disabilities (CWDs) to be reached by disability service providers through a targeted approach in the camp, with the majority of CWDs not having any previous interactions with disability partners and 94% of all CWDs and children with chronic diseases providing contact details for referral to disability partners during this assessment. Furthermore, disability was identified as the main reason for not attending school for the majority of CWDs, (56.2% of male CWDs and 66.7% of female CWDs) underscoring that further outreach and adaptations by education partners need to accommodate these children in the formal education system.

Youths of 16-24 years have been found to be a highly vulnerable group due to their lack of engagement in learning opportunities and earning potential, and limited educational background, with 73.6% not completing any stages of secondary or tertiary education. More programmes should be designed to engage them in activities that will prevent them from becoming despondent and disenfranchised from the camp community given that only 7.8% of youths aged 16-24 years are currently in paid employment. Without well-targeted interventions these youths risk missing out on job opportunities in the future. Furthermore, high youth unemployment in the camp represents an opportunity cost, as the large proportion of unemployed youths is currently an untapped resource. Youths 16-24 years should be given opportunities to acquire new skills which they can utilise both inside the camp and in their future lives.

Recommendations

Based on the report and analysis, the following list of recommendations has been developed to identify areas of priority interventions:

- Given that the majority of households were not satisfied with the distance to their nearest tap stand, a review of existing WASH infrastructure could lead to a need to increase the number of tap stands, particularly in Village 3 where satisfaction with distance to tap stand was lower than Village 6. This would shorten the distance from households to water points, increasing access and the camp community's overall satisfaction with water service delivery.
- Evidence suggests that girls and women were found to use the WASH blocks less than men and boys during both day and night time due to a perceived lack of privacy and cultural norms associated with women carrying out hygiene practices, and in particular bathing in public facilities. At night time safety and security concerns regarding a lack of public lighting may also be reducing levels of access to WASH centres among all demographics.⁶² Pre-emptive measures to enhance the privacy of public WASH centres would reduce the scope of private WASH infrastructure being built in the camp and prevent unsanitary waste-water solutions from developing, as has been the case in Za'atari camp. Improvements such as increased public lighting around WASH centres at night time, ensuring that WASH centre door locks are fully functional, and that there are no holes or gaps in WASH centre structures could help to improve levels of access among females living in the camp.
- Although the vast majority of households rely on the public water supply for drinking water, messaging around water distribution should continue to address reported health concerns and negative perceptions surrounding the public water supply that may be linked to water taste for those who rely on bottled water.
- There is a need for measles and Tetanus Toxoid vaccination campaigns to be conducted in the camp to ensure more widespread coverage for infants and girls and women of reproductive age.
- While 18.4% of women who were reported to have given birth in the camp within the past year received the recommended number of three post-natal visits within six weeks of delivery there is still scope for further expansion of the reproductive health response.
- Further outreach is needed to incorporate the 96% of out-of-school children who are still eligible to re-join formal education. In addition, while formal education attendance rates are reasonable given the short time that the formal school has been open in Azraq camp, further efforts should be made to increase formal attendance from its current rate of 57%.

⁶² UNHCR/REACH, Azraq Camp Shelter Assessment, December 2014.

- IFE programmes could be targeted to children aged 16-17, and in particular females, as this group is at risk of missing out on learning opportunities in the camp, with the highest non-attendance rate for formal education.
- Given that 17% of school-aged children are attending both formal education and IFE, better coordination – particularly between school and IFE providers - is needed to identify children with no access to learning opportunities. By improving the way that beneficiary details are recorded across different service providers, it will be easier to avoid some children attending multiple types of education while others are not attending any. For instance, if there are limited places on IFE programmes, education partners may consider only accepting out-of-school children in order to ensure that the maximum number of school-aged children are engaged in at least one type of education.
- Further efforts need to be made to accommodate children with disabilities into the formal schooling system as the majority of out of school children falling within this category cited their condition as the main reason for non-attendance.
- Given that 73% of CWDs were reported as not receiving any visits from an organisation specialising in disability it is essential that the referral information recorded during data collection is used to assess these children's specific needs and to provide targeted solutions according to age, sex and disability type.
- As 86.7% of youths aged 16-24 are not in paid employment, training or unpaid volunteering, coordinated efforts are required to meet the needs of this particularly vulnerable group.

The implementation of these recommendations requires close coordination between the Education sector, Protection, WASH and Health Working Groups, disability focused agencies and the youth Task Force to see an improvement to all aspects of life for children, young people, and new and expectant mothers living in Azraq camp.

ANNEX 1

Comprehensive Child-Focused Assessment (CCFA) of Azraq Questionnaire

الدراسة المركزة الشاملة للأطفال-أسئلة

A. Household:(أ) المنزل

A1.a Record GPS coordinates.

تحديد الموقع

A1.b Which Village are you in?

حدد في أي قرية أنت؟

- القرية 3 Village 3
- القرية 6 Village 6

A1.c Record Block حدد المربع السكني

A1.D Record Plot حدد القطعة

A2. Does someone live in this household? [If no, skip entire questionnaire]

هل هناك أشخاص يعيشون هذا المنزل؟

نعم لا

A2. Is the respondent willing to participate in the questionnaire?

هل الشخص المقيم مستعد للمشاركة في هذا الاستبيان؟

- Yes
- No
- لا

نعم

B. Demographics:

ب. التركيبة السكانية

B1.a. Are we interviewing the head of household?

Yes

No

هل المستجيب هو رب الأسرة؟

نعم لا

B1.b What sex is the head of household?

ب.1 ما هو جنس رب الأسرة؟

- Male
- Female

ذكر

أنثى

B2. How many families live in this household? No. ____

ب.2 كم عدد العائلات التي تعيش في هذا المنزل؟ رقم ____

B3. Record registration sheet number _____

سجل رقم بطاقة التسجيل

B3.a Additional registration sheet number? _____

سجل رقم اي بطاقة تسجيل اضافية

B3. How many people live in this household? No. _____

كم عدد الأشخاص الذين يعيشون في هذا المنزل؟ رقم _____

B4. How is your household disaggregated? _____

كيفية التصنيف في المنزل؟

Male	0-2y	3-4y	5-11y	12-17y	18-24y	25-30y	31-59y	>60
Female	0-2y	3-4y	5-11y	12-17y	18-24y	25-30y	31-59y	>60

>60	سنة 31-59	سنة 25-30	سنة 18-24	سنة 12-17	سنة 5-11	سنة 3-4	سنة 0-2	ذكور
>60	سنة 31-59	سنة 25-30	سنة 18-24	سنة 12-17	سنة 5-11	سنة 3-4	سنة 0-2	إناث

C. WASH:

ج. المياه والصرف الصحي

C.1

ج. 1

C1a. For what purposes do members of this household use the WASH block during the day? (Tick all that apply)

ج. 1. أ ماهي الأسباب التي تدفع أفراد هذا المنزل لإستخدام المرافق الصحية خلال النهار؟ (اختار كل ما يطابق)

Girls (0-17 yrs)

سنة (البنات 0-17)

- ☐ Shower (للاستحمام)
- ☐ Toilet (المرحاض)
- ☐ Washing clothes (غسيل الملابس)
- ☐ Washing dishes (غسيل الصحون)
- ☐ Ablutions (الوضوء)
- ☐ None of the above (لا شيء مما ذكر)

Boys (0-17 yrs)

سنة (الأولاد 0-17)

- ☐ Shower (للاستحمام)
- ☐ Toilet (المرحاض)
- ☐ Washing clothes (غسيل الملابس)
- ☐ Washing dishes (غسيل الصحون)
- ☐ Ablutions (الوضوء)
- ☐ None of the above (لا شيء مما ذكر)

Women (18+ yrs)

النساء (18+ سنة)

- ☐ Shower (للاستحمام)
- ☐ Toilet (المرحاض)
- ☐ Washing clothes (غسيل الملابس)
- ☐ Washing dishes (غسيل الصحون)
- ☐ Ablutions (الوضوء)
- ☐ None of the above (لا شيء مما ذكر)

Men (18+ yrs)

الرجال (18+ سنة)

- ☐ Shower (للاستحمام)
- ☐ Toilet (المرحاض)
- ☐ Washing clothes (غسيل الملابس)
- ☐ Washing dishes (غسيل الصحون)
- ☐ Ablutions (الوضوء)
- ☐ None of the above (لا شيء مما ذكر)

C1b. For what purposes do members of this household use the WASH block during the night? (tick all that apply) (loop: only display age categories that were indicated in the demographics section)

ج1.ب ماهي الأسباب التي تدفع أفراد هذا المنزل لإستخدام المرافق الصحية خلال الليل؟ (اختار كل ما يطابق)

Girls (0-17 yrs)

سنه (البنات 0-17)

- Shower (للإستحمام)
- Toilet (المرحاض)
- Washing clothes (غسيل الملابس)
- Washing dishes (غسيل الصحون)
- Ablutions (الوضوء المرحاض)
- None of the above (لا شيء مما ذكر)

Boys (0-17 yrs)

سنه (الأولاد 0-17)

- Shower (للإستحمام)
- Toilet (المرحاض)
- Washing clothes (غسيل الملابس)
- Washing dishes (غسيل الصحون)
- Ablutions (الوضوء المرحاض)
- None of the above (لا شيء مما ذكر)

Women (18+ yrs)

النساء (18+ سنه)

- Shower (للإستحمام)
- Toilet (المرحاض)
- Washing clothes (غسيل الملابس)
- Washing dishes (غسيل الصحون)
- Ablutions (الوضوء المرحاض)
- None of the above (لا شيء مما ذكر)

Men (18+ yrs)

الرجال (18+ سنه)

- Shower (للإستحمام)
- Toilet (المرحاض)
- Washing clothes (غسيل الملابس)
- Washing dishes (غسيل الصحون)
- Ablutions (الوضوء المرحاض)
- None of the above (لا شيء مما ذكر)

C3. What is this household's main source of drinking water? (tick one only) [If response is "public water point" skip to C.5]

- ج3- ما هو المصدر الرئيسي لمياه الشرب ؟ (اأأار واحد فقط)
- ☐ Public water point (eg. WASH block & tap stand)
نقاط المياه العامة (المرافق الصحية , نقاط الحنفيات)
 - ☐ Bottled water
زجاجات مياه
 - ☐ Other (Please specify _____)
أأر (وضح)

C4. What is the main reason for this household getting drinking water from a private source? (tick one only)

- ج4- ما هو السبب الرئيسي الذي يدفع أفراد هذا المنزل لأألب مياه الشرب من مصادر خاصة ؟
- ☐ Avoid health risks due to poor quality of water
أأأب المخاطر الصحية بسبب قلة جودة المياه
 - ☐ Don't like the taste
لا أعأبهم طعم المياه
 - ☐ Quantity of water is insufficient
عأز وقلة كمية المياه
 - ☐ Daily public water supply is too unpredictable
التزويد اليومي بالمياه لا يمكن التأبؤ به
 - ☐ Other (Please specify _____)
أأر (وضح)

C5.a How satisfied are you with the distance to the nearest tap stand from your household?

ما مدى رضائك عن المسافة بين منزلك وأأرب نقطة مياه

- ☐ Very satisfied مرأضي أأا
- ☐ Satisfied مرأضي
- ☐ Neutral عأادي
- ☐ Unsatisfied أأر مرأضي
- ☐ Very unsatisfied أأر مرأضي أأا

C5.b If unsatisfied or very unsatisfied, why is this?

إذا كان أأر مرأضي أو أأر مرأضي أأا , لماذا ؟

- ☐ Distance to tap stand is too far to walk المسافة إلى نقطة المياه طويلة أأا للذهاب إليها مشياً
- ☐ Feel unsafe travelling to and from the tap stand due to distance الشعور بعدم الأمان للأنقل من وإلى نقطة المياه
- ☐ It is difficult to carry water to and from the tap stand due to distance من الصعب أأل المياه من نقطة المياه إلى المنزل بسبب طول المسافة
- ☐ Other _____ أأر _____

C6. Does this household use any of the following water treatment methods (select all that apply):

هل أأأأأ هذا المنزل أي من الوسائل أو الطرق التالية لمعالجة المياه ؟ (أأأر أأمع الإأابات التي تنأطبأ)

- ☐ Water filter (فأأر) مرشح المياه
- ☐ Solar الطاقة الشمسية
- ☐ Chlorine الكلور
- ☐ None of the above لا أأأ من ما أأأر

C7. Does this household have a sufficient quantity of water to meet its needs?

هل لدى هذا المنزل كمية كافية من المياه لتلبية احتياجاته؟

- ☐ **Very sufficient** كافية جدا
- ☐ **Sufficient** كافية
- ☐ **Neutral** عادي
- ☐ **Insufficient** غير كافية
- ☐ **Very insufficient** غير كافية جدا

D. Education, Youth & Child Protection التعليم و حماية الاطفال والشباب

D1. How many of the school-aged children (6-17 year olds) and youths (18-24 year olds) living in your household attend the following types of education? **(select all that apply)** [loop individually child by child – linked to demographics section. If no to informal education skip to D3.]

كم عدد الاطفال (6-17) والشباب (18-24) الابين في سن الدراسة يعيشون في هذا المنزل ؟

For each age-group:

Male 6-8y 9-11y 12-15y 16-17y 18-24y

Female 6-8y 9-11y 12-15y 16-17y 18-24y

- ☐ Formal education تعليم رسمي
- ☐ Informal education تعليم غير رسمي
- ☐ Child Friendly Space/Adolescent Friendly Space/Multi-Activity Centre مساحات صديقة للأطفال/مساحات صديقة للبالغين / مراكز متعددة النشاطات
- ☐ None of the above لا شيء من ما ذكر

D2. For children that have attended **informal** education, what activities have they attended? **(tick all that apply)**

لأطفال اللذين تلقوا تعليم غير رسمي , ما هي النشاطات التي حضروها ؟

- ☐ Technical skills/post basic education (ie. vocational training) المهارات الفنية /ما بعد التعليم الاساسي (أي التدريب المهني)
- ☐ Basic learning (e.g literacy or maths classes) التعلم الاساسي (على سبيل المثال محو الأمية أو فئات الرياضيات)
- ☐ Recreational activities نشاطات ترفيهية
- ☐ Religious education تعليم ديني
- ☐ Other (Please specify _____) اخر (وضح)

D3. For school-aged children (6-17 yrs) living in this household not currently attending formal school, how many months of school have they missed? **[Link to Q.D1]**

- ☐ Never attended
- ☐ Months missed since last attended ____

للأطفال في سن الدراسة (6-17) اللذين يعيشون في هذا المنزل ولا يذهبون الى المدارس الرسمية , كم عدد أشهر الدراسة التي فاتتهم؟

لم يحضر ابدا
منذ اخر حضور _____ اشهر

Male 6-8y __months 9-11y __months 12-15y __months 16-17y __months

Female 6-8y __months 9-11y __months 12-15y __months 16-17y __months

D4. [To head of HH] Do you consider it important that school-aged children (aged 6-17) living in this household have a certified education pathway (where children receive certification)? (For Boys/Girls) Would you say it is: **(read options)**

سؤال لرب الاسرة , هل تعتبر انه من المهم للاطفال في سن الدراسة (6-17) الذين يعيشون في هذا المنزل ان يحصلو على شهادة تعليمية موثقة ؟
(اقرأ الاختيارات) (للاولاد والبنات)

- ☐ Unimportant
غير مهم
- ☐ Of little importance
القليل من الاهمية
- ☐ Important
مهم
- ☐ Very Important
مهم جدا
- ☐ Don't know
لا اعرف

D5. How many youths in this HH aged 19-24 years have **[Link to demographics section]**:

كم عدد الشباب في هذا المنزل في سن 19-24 والذين لديهم :

- ☐ Completed high school in Jordan and/or Syria? Male (19-24y) __ Female (19-24y) __
شهادة ثانوية عامة في الاردن او سوريا ؟ ذكر (19-24) ---- انثى (19-24)
- ☐ Started but dropped out/had to leave university? Male (19-24y) __ Female (19-24y) __
بدأ الدراسة ولكنه تركها / اجبروا على تركها ؟ ذكر (19-24) ---- انثى (19-24)
- ☐ Completed university? Male (19-24y) __ Female (19-24y) __
انهى الدراسة الجامعية ؟ ذكر (19-24) ---- انثى (19-24)
- ☐ None of the above لا شيء من ما ذكر

D6. How many days have children/young people in this household accessed Safe Spaces (Child Friendly Spaces/Adolescent Friendly Spaces/Multi-Activity Centres) in the last 7 days? **[Link to demographics section]**

كم يوم خلال ال 7 أيام الماضية ذهب الاطفال والشباب الذين يعيشون في هذا المنزل الى المساحات الصديقة للطفل / المساحات الصديقة للشباب / مراكز متعددة النشاطات ؟

Boys Aged 5-8: 0 days 1-2 days 3-5 days

اولاد	في	سن	8-5		0	يوم		2-1	ايام		5-3	أيام		7-6	ايام
-------	----	----	-----	--	---	-----	--	-----	------	--	-----	------	--	-----	------

Boys Aged 9-11: 0 days 1-2 days 3-5 days

اولاد	في	سن	11-9		0	يوم		2-1	ايام		5-3	أيام		7-6	ايام
-------	----	----	------	--	---	-----	--	-----	------	--	-----	------	--	-----	------

Boys Aged 12-15: 0 days 1-2 days 3-5 days

اولاد	في	سن	15-12		0	يوم		2-1	ايام		5-3	أيام		7-6	ايام
-------	----	----	-------	--	---	-----	--	-----	------	--	-----	------	--	-----	------

Boys Aged 16-17: 0 days 1-2 days 3-5 days

اولاد	في	سن	17-16		0	يوم		2-1	ايام		5-3	أيام		7-6	ايام
-------	----	----	-------	--	---	-----	--	-----	------	--	-----	------	--	-----	------

Girls Aged 5-8: 0 days 1-2 days 3-5 days

فتيات	في	سن	8-5		0	يوم		2-1	ايام		5-3	أيام		7-6	ايام
-------	----	----	-----	--	---	-----	--	-----	------	--	-----	------	--	-----	------

Girls Aged 9-11: 0 days 1-2 days 3-5 days

فتيات	في	سن	11-9		0	يوم	2-1		ايام	5-3		ايام 7-6	ايام
فتيات	في	سن	15-12		0	يوم	2-1		ايام	5-3		ايام 7-6	ايام
فتيات	في	سن	17-16		0	يوم	2-1		ايام	5-3		ايام 7-6	ايام

D7. How many young people (16-18, 19-24) in this household are currently participating in the following activities? (Select all that apply)

كم عدد الشباب في هذه المنزل (16-18, 19-24) يشاركون حاليا في النشاطات التالية؟ (اختر جميع الاجابات التي تنطبق)

- ☐ Paid employment عمل مأجور
- ☐ Unpaid volunteering عمل تطوعي غير مأجور
- ☐ Training تدريب
- ☐ None of the above لا شيء من ما ذكر

Male ذكر	16-18		19-24	
Female انثى	16-18		19-24	

E. Boys and girls with risk factors for disabilities or developmental delay:

الفتيان والفتيات مع عوامل الخطورة للإعاقات أو تأخر في النمو

E1. Do any children living in this household have a disability (physical, visual, mental, cognitive or auditory)? [If no, skip to section F. Health]

هل يعاني اي طفل في هذا المنزل من اعاقة (الحركية, البصرية, والعقلية, والإدراكية أو السمعية)؟

- ☐ Yes نعم
- ☐ No لا
- ☐ Prefer not to say افضل عدم الاجابة

E2.

E2a. How many school-aged children in this household have permanent physical disability that causes difficulty with movement, such as walking?

كم عدد الاطفال الذين في سن الدراسة في هذا المنزل لديهم اعاقات حركية دائمة تسبب صعوبة في الحركة والمشي ؟

ذكر	0-3		4-5		6-11		12-15		16-17	
انثى	0-3		4-5		6-11		12-15		16-17	

E2b. How many school-aged children in this household have difficulty communicating or understanding what people say?

كم عدد الاطفال الذين في سن الدراسة في هذا المنزل لديهم صعوبة في التواصل وعدم فهم ما يقوله الناس ؟

ذكر	0-3		4-5		6-11		12-15		16-17	
انثى	0-3		4-5		6-11		12-15		16-17	

E2c. How many school-aged children in this household have a chronic illness (a disease of long duration), such as asthma, diabetes or epilepsy?

كم عدد الاطفال الذين في سن الدراسة في هذا المنزل يعانون من امراض مزمنة (مرض يبقى لمدة طويلة) مثل الربو أو السكري أو الصرع ؟

ذكر	0-3		4-5		6-11		12-15		16-17	
انثى	0-3		4-5		6-11		12-15		16-17	

E2d. How many school-aged children in this household have difficulties seeing clearly, even when wearing glasses or contact lenses?

كم عدد الاطفال الذين في سن الدراسة في هذا المنزل يعانون من صعوبة في الرؤية , حتى مع ارتداء النظارات ؟

ذكر	0-3		4-5		6-11		12-15		16-17	
انثى	0-3		4-5		6-11		12-15		16-17	

E2e. How many school-aged children in this household have difficulties hearing things, even when wearing a hearing aid?

كم عدد الاطفال الذين في سن الدراسة في هذا المنزل يعانون صعوبة في السمع , حتى مع ارتداء السماعات المساعدة ؟

ذكر	0-3		4-5		6-11		12-15		16-17	
انثى	0-3		4-5		6-11		12-15		16-17	

E2f. How many school-aged children in this household have difficulties with self-care, such as difficulties in dressing themselves or feeding themselves?

كم عدد الاطفال الذين في سن الدراسة في هذا المنزل يعانون صعوبة في العناية بانفسهم , مثل تبديل الملابس او الاكل ؟

Male	0-3		4-5		6-11		12-15		16-17	
Female	0-3		4-5		6-11		12-15		16-17	

E2g. How many school-aged children in this household have difficulties remembering things and/or concentrating on tasks for sustained periods of time?

كم عدد الاطفال الذين في سن الدراسة في هذا المنزل يعانون صعوبة في تذكر الاشياء او التركيز على المهام لفترات من الزمن ؟

ذكر	0-3		4-5		6-11		12-15		16-17	
انثى	0-3		4-5		6-11		12-15		16-17	

E2h. (For school-aged children in this household that do not attend formal education) Is the main reason this child does not attend formal education because of the conditions (disability or chronic illness) mentioned before?

Yes

No

Don't Know

في عدم الذهاب الى --- هل السبب الرئيسي للتعليم الرسمي هو الظروف - الاعاقات او الامراض المزمنة امذكورة سابقا؟

نعم

لا

لا اعرف

Additional Screening Questions: أسئلة فحص إضافية

E2h. Has the child with reported disability/ies been seen by any organizations providing disability services? [If no, ask for contact details: address, contact number & name of person of concern, make referral]

هل تم زيارة الطفل الذي يعاني من اعاقة/ات من قبل اي منظمة وتم تقديم الخدمة اللازمة لأعاقته ؟

Yes نعم

No لا

E2i. [If yes] Are any additional disability services needed? [If yes, ask for contact details: address, contact number & name of person of concern, make referral] Follow up with UNICEF on this point.

هل يوجد اي خدمات اضافية تحتاجوا لها ؟

Yes نعم

No لا

E2.j. Are you willing to provide contact details?

Yes

No – Allow to skip contact details

هل انت على استعداد على اعطاء معلومات الاتصال ؟

نعم

لا

F.

Health

الصحة

F1. How many children under 5 yrs old in this household have a vaccination card? [Link to demographics section]
(If yes, ask to see it)

كم عدد الاطفال تحت سن ال 5 في هذا المنزل لديهم بطاقة لقاحات ؟

ذكر	نعم , لم تتم مشاهدتها	لا يوجد بطاقة	لا اعرف	
	نعم , شوهدت			

انثى	نعم , شوهدت	نعم , لم تتم مشاهتها	لا يوجد بطاقة	لا اعرف	
------	-------------	----------------------	---------------	---------	--

F2. How many children under 5 yrs old in this household have received a polio vaccination?

كم عدد الاطفال تحت سن ال 5 في هذا المنزل تلقوا لقاح شلل الاطفال ؟

ذكر	نعم , جرعة واحدة	نعم , جرعتان	نعم , اكثر من جرعتان	لا جرعات	لا اعرف
انثى	نعم , جرعة واحدة	نعم , جرعتان	نعم , اكثر من جرعتان	لا جرعات	لا اعرف

F3. How many children aged 9-59 months in this household have received a measles vaccination (one injection only)?

كم عدد الاطفال في سن 9-59 شهر في هذا المنزل قد تلقوا لقاحات الحصبة ؟ (حقنة واحدة فقط)

ذكر	No. ____
انثى	No. ____

F4.

F4a. How many women in the household are pregnant or have a child 0-1 year old? [If none, skip to F5]

كم عدد النساء الحوامل او اللواتي لديهن اطفال في عمر (0 - 1) سنة ؟

No. ____

F4b. How many of these women in the household are attending Infant and Young Child Feeding (IYCF) provided by Save the Children and/or home visits)? [Insert constraint: should not exceed value entered for Q.F4a]

كم من هؤلاء النساء الحوامل أو اللواتي لديهن اطفال في عمر (0 - 1) سنة يحضرون برامج الرضع وصغار الأطفال التي تقدمها مؤسسة إنقاذ الطفل و/أو الزيارات المنزلية ؟

No. ____

F5.

F5a. How many women in the household have given birth to a baby within the last year? [If none, skip to F6]

كم عدد النساء في هذا المنزل اللواتي أنجبن طفل خلال العام الماضي ؟

No. ____

F5b. For their last birth, how many women in the household received or attended any post-natal visits within 6 weeks of delivery? [If zero skip to F6]

للولادة الاخيرة , كم عدد النساء في هذا المنزل تلقوا او حظرو اي زيارة ما بعد الولادة خلال ال 6 أسابيع الاولى من الولادة ؟

No. ____

F5c. How many post-natal visits were received or attended?

كم عدد الزيارات التي تلقوها او حضروها ؟

No. ____

F6. How many women (15-49 yrs) in the household have received at least two doses of Tetanus Toxoid?

كم عدد الفتيات / النساء في سن الإنجاب (15-49 سنة) في المنزل تلقوا على الأقل جرعتان لمرض الكزاز؟

No. ____

لا اعرف Don't know