



COMPREHENSIVE CHILD FOCUSED ASSESSMENT ZA'ATARI 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 the outbreak of the civil war in Syria in March 2011, approximately 3,961,704 refugees have fled into neighbouring countries, 627,295 of those individuals hosted in Jordan¹. Children make up over half of all Syrian refugees in the country, with 322,395 registered Syrian refugees under the age of 18, and 107,672 under the age of 5.² The ongoing conflict has had profound implications on the lives of this vulnerable group, affecting educational attainment, youth employment, psychological and physical well-being and future development. In light of this, the United Nations Children's Fund (UNICEF) has been working with implementing partners in Jordan to provide vital services which aim to minimise the negative implications of forced displacement on families and their children. This includes the provision of formal and informal educational programmes, health services, water delivery, sanitation and hygiene promotion activities, programmes for children with disabilities, and psychosocial support through child, youth and adolescent friendly spaces. In order to assess the access to and use of these services, and the situation in camps across areas of UNICEF support, a comprehensive child-focused assessment was conducted in both Za'atari and Azraq camp in February and March 2015 in collaboration with REACH. This report outlines the findings from the Za'atari assessment.

Za'atari refugee camp, situated in the northern governorate of Al Mafraq, remains the largest refugee camp in Jordan, with a population of 83,817 people³. Although many families have now lived in the camp for over 2 years (63% all households)⁴ the context of Za'atari has continued to evolve. Since the last child focused assessment of this scope over a year ago, new programmes, facilities and services have been established, structural changes have been on-going, and the flow of people into and out of the camp continues to fluctuate in response to external factors in the host community such as reductions in food assistance, a shift in access to public health provision outside of the camp, and seasonal employment opportunities. Further, residents' knowledge and expectations of services have changed over time, with a need to monitor whether programmes and activities are effectively matching the changing needs of the community. Therefore, this assessment aims to fill these information gaps, with a focus on UNICEF-supported programming areas of water, sanitation and hygiene (WASH), health, education, youth, and people with disabilities. The assessment covered all households in the camp, representing 75,878 individuals⁵, more than half (57%) of whom were reported to be children.⁶ Meanwhile, 6,696 individuals were youths aged 19-24 years, representing 9% of the total camp population. Key findings for each sector are for summarised below.

Water, Sanitation and Hygiene

Assessment findings indicate that residents have become less reliant on public WASH facilities compared to previous assessments but many continue to depend on humanitarian actors for their household's main drinking water supply. Private WASH infrastructure in Za'atari camp was found to be extensive, with 31% of all households using private water tanks and an overwhelming majority of 84.6% reporting both private toilet and shower facilities. This is in contrast to the UNHCR-REACH shelter assessment of Za'atari camp⁷ conducted in February 2014 which found that 40.6% of all households in Za'atari had private toilets. This suggests a significant shift away from public WASH centre usage in favour of individual household facilities, mirroring the trend towards private rather than public kitchen usage in the camp. Indeed, public WASH centre usage appears to be extremely low, with an average of 89% of households reporting that they had not used a public WASH centre at all in the 7 days prior to the assessment.

When public WASH centres were used, this was most commonly for toilet facilities, by 9.4% of all households, followed by ablutions (2.6%) and then showering (1.3%) for both day-time and night-time usage. Frequency of usage was slightly lower during the night than during the day, which may be due to heightened safety and

¹ UNHCR, [Syria Regional Refugee Response data portal](#), 26 March 2015.

² Ibid, January 18 2015.

³ Ibid, 23 February 2015

⁴ UNICEF/REACH, [Za'atari Camp Population Count](#), January 2015.

⁵ Although this figure differs from the registered population of the camp of 83,501 people cited earlier, this does not include those who may remain registered but were not residing in the camp at the time of the assessment; those who declined to participate, or those who were not present at their household upon three re-visits and were therefore unable to be assessed.

⁶ A total of 43,417 individuals were under the age of 18 at the time of assessment.

⁷ UNHCR/REACH, [Al Za'atari Refugee Camp Shelter Assessment](#), June 2014.

security concerns during hours of darkness. There were no large disparities when disaggregating findings by day-time and night-time usage, sex and age. However, men aged 18 years or more were the demographic group reported to be using public WASH centres the most frequently. There was a higher rate of WASH centre usage in the camp districts that have been established most recently (i.e. contain the most new arrivals)⁸, districts 5, 6, 7, 8, 9, 10, which may be attributed to the comparatively newer WASH infrastructure in these areas, and also due to the fact that there are fewer private toilets and showers reported in these districts.

The public water supply was found to be the main source of drinking water for households in Za'atari camp with 56.1% selecting this response, followed by refill at the market with 23.1% and then refill of private tanks directly by UNICEF/ACTED trucks, 18.6%.⁹ This result implies that public water points continue to be the most easily accessible source of potable water for camp residents, likely due to their proximity to dwellings, the cost of purchasing private water tanks, and the fact that publicly supplied water remains free of charge.

Health

Health findings indicate that the majority of children below 5 years of age living in Za'atari camp have been vaccinated with more than two doses of polio vaccine (76.2%), and the majority of children aged between 9 months to 5 years had received a measles vaccine (82%). However this indicates that almost a quarter of all children in this age bracket remain unvaccinated. Furthermore, only 29% of children under 5 years of age had a vaccination card that was seen and verified by data collectors, while 24% responded that they had vaccination cards but were not able to present them, and 46% responded they had no card.¹⁰ As a result, the majority of respondents were unable to provide evidence of any vaccinations for 71% of children, so data collectors were unable to verify reported vaccinations.

Given that the last major maternal health assessment with findings generalisable at the camp district level was conducted over a year ago, in December 2013, the CCFA assessment was designed to provide up-to-date information on reproductive health in Za'atari camp. The majority of girls and women aged 15-49 years (71%, 12,372 individuals) were reported to have previously been vaccinated with at least two doses of tetanus toxoid vaccine,¹¹ which protects mothers and new born babies from maternal and neonatal tetanus. However, there remains scope for outreach and targeting of out-of-school girls of reproductive age who may be unable to access the vaccine. The vaccine is currently provided to girls in grade 10 in Za'atari schools.¹² In total, 3,541 women were reported to have given birth to a baby in Za'atari within the past year and just under a quarter of these women (24.6%) received the recommended number of three post-natal visits within six weeks of delivery. In total, 1,767 girls and women aged 15-49 reported receiving at least one post-natal visit within six weeks of delivery.¹³ This underlines the need for further follow up visits for new mothers by health specialists and continued maternal health outreach and service provision.

Education

Since the joint education needs assessment (JENA) was conducted in June 2014, several changes have been identified related to formal education. There has been an overall increase in reported formal attendance in comparison with JENA findings,¹⁴ and a narrower gender disparity was recorded in schools, while challenges remain in ensuring inclusive education, closing the gender gap further and achieving more even attendance for formal education across demographic groups.¹⁵ While reported rates formal attendance vary according to district,

⁸ District 8 saw the largest influx of new arrivals in 2014 at 32%, of the District population followed by District 7 at 17%. Meanwhile, Districts 1 and 2 had the largest proportion of residents with the longest period of residency, with 19% and 24% of households reporting 2012 as their year of arrival in Za'atari camp consecutively.

⁹ Given that ACTED water trucks also deliver to public water points 74.7% of households are receiving drinking water from ACTED water trucks.

¹⁰ Upon recommendation of health experts, parents or carers were asked to present child vaccination cards to data collectors. If a vaccination card was not presented there may have been a number of possible reasons for this, including the card being misplaced, lost, or with another household member who was not available at the time.

¹¹ According to UNICEF, in Za'atari camp in 2014, a total of 3,728 pregnant women received one dose of Tetanus Toxoid, and 4,938 received 2 doses, while 5,037 non-pregnant women received one dose and 10,814 received two doses.

¹² According to UNICEF, this is currently the only outreach vaccination campaign for tetanus toxoid in Za'atari camp although the vaccine is also available in some health clinics.

¹³ According to UNHCR data, the total number of women who received post natal visits was 3,776 between January and June 2013. For 2013 a total of 1,628 women received post natal visits.

¹⁴ It should be noted that overall, according to data from the Ministry of Education (MoE) attendance has been recorded by UNICEF as diminishing between September 2014 and April 2015.

¹⁵ It should be noted that education attendance was reported by parents or respondents aged 18 years or more who participated in the assessment.

age, sex, and distance from school, overall reported school attendance was found to have increased from the 51.6% recorded in June 2014, to 64.6% of all school-aged children in Za'atari camp. When disaggregating by sex, reported attendance was considerably higher for girls, at 68%, compared to boys, at 62%, and across all age categories, with the sex difference least pronounced in the age groups of 6-8 years and 16-17 years. This shows a significant decrease from the gender gap of 15% identified in the JENA, in which 59% of school aged girls were found to be attending formal education, compared to only 44% of boys.¹⁶ Formal attendance is reportedly lowest among boys of 16-17 years (22%), closely followed by girls in the same age group (26%).

The majority of parents (71%) reported that they had not attended a structured recreational session with their children, which may be due in part to a lack of awareness of these sessions, given that 23% answered that they did not know if they had attended a structured recreational session. 30% of all school-aged children aged 6-17 years are not currently accessing any type of education according to this assessment, representing a considerable improvement on the 38.6% of school-aged children recorded as not attending any form of education in JENA. The proportion of "out-of-school" children, who are not attending formal education, was found to be 35.4% of all school-aged children, compared to 48.4% in JENA. Of this group, 80% of out-of-school children aged 6-17 years had never attended school before and 20% were reported to have dropped out. This is compared to 75% of out-of-school children recorded in JENA as never attending school in Za'atari camp and 25% reported to have dropped out. Overall, 11.9% of school-aged children were recorded as having dropped out of school in JENA compared, to 7.1% in this assessment. The majority of out-of-school children, 72.5%, fall within the 16-17 year age group, indicating a need for specific interventions targeting this demographic. Of the out-of-school children that had attended but dropped out, the vast majority (98%) are still eligible to reintegrate into the formal education system, having missed less than 3 years of school. This serves to highlight the continuing importance of outreach campaigns, catch up classes and other programmes targeting out-of-school children across all age groups. More needs to be done to ensure that high attendance rates are reached across all age groups and districts for both girls and boys, as well as to re/integrate out-of-school children who have never attended or dropped out.

There were lower rates of attendance for informal education (IFE) with a total 6% of school-aged children currently attending. Overall, 7% of out-of-school children were found to be currently attending IFE in contrast with JENA that identified 20% of out-of-school children 6-17 years to be attending this type of education. This decrease in IFE attendance may be attributed to the higher percentage of children now reported as attending formal education, with an increase of 13% recorded as compared to JENA. The most popular type of IFE was religious education, with 47.4% of all those in IFE attending. The JENA also found this to be the most commonly attended type of IFE, recorded to be attended by 33.9% and 40% of 6-11s and 12-17s attending some form of IFE respectively. Focus group discussions (FGDs) were conducted during the JENA where it was found that religious education is popular due to the wide range of IFE activities on offer and a religious atmosphere. This assessment revealed that basic learning was the second most commonly attended type of IFE with 31.0% of all IFE attendance, followed by recreational activities at 18.8% and technical skills/post-basic education at 14.1%. Basic learning was also found to be the second most commonly attended type of IFE for 6-11 year olds in JENA. Assessment results indicate that the highest rates of attendance for Child Friendly Spaces were among the youngest age group of children aged 6-8 years with 6% of boys and 7% of girls in this age category reportedly using these centres.

Disability

Some 3.3% of all children living in Za'atari camp (1,448 individuals) were reported to have at least one disability or chronic illness. Overall, 664 children were reported to have a chronic illness, while the most commonly reported type of disability was permanent physical disability, with 274 children reported in this category. The least commonly indicated was difficulty with self-care, with a total of 87 children. Disaggregating by age revealed that children aged 6-11 years are disproportionately affected by disabilities and chronic illness compared to other age groups and across all types of disability reported. While, 16-17 year olds had the lowest proportion of children with reported disabilities or chronic illness.¹⁷ The main reason for the majority of out-of-school children aged 6-17 with a disability or chronic illness not attending formal education was due to their reported condition, with 66.7%

¹⁶ UNICEF/REACH, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), Jordan, September 2014

¹⁷ 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.

of females and 60.5% of males indicated in this response. This highlights an urgent need for education and disability actors to coordinate closely to overcome remaining barriers to access to formal education for children with disabilities (CWDs), which JENA found to include a range of issues including bullying, inaccessibility of the curriculum and difficulty getting to school.

Youth

This assessment identified a total of 17,327 adolescents aged 10-18 years (8,496 females and 8,831 males) and 6,696 youths aged 19-24 years (3,658 females and 3,038 males). The vast majority of youths aged 16-24 (92.4%) are currently not in employment, training or unpaid volunteering, with 98.7% of females and 89.3% of males 16-18 years and 96.7% of females and 84.5% of males aged 19-24 years falling within this category. Furthermore 83.2% of youths aged 19-24 have not completed either high school or university, of which when disaggregated by sex, 82.6% of females and 84% of males within this age group had not completed any stages of certified education. There is therefore scope for programmatic solutions to address the needs of this group, such as the provision of interventions aimed at engaging youth in productive and/or remunerative activities, particularly as a similarly large proportion of youths aged 18-24 years are not attending Child Friendly Spaces, Adolescent Friendly Spaces, Multi Activity Centres, or formal or informal education (92.5% in total; 93.1% females and 91.8% males). Overall, 16.3% of females and 13.9% of males aged 18 years, and 4% of females and 4.1% of males aged 19-24 years were reported to be attending formal education; an unexpected finding given that school-age is defined as 6-17 years. A possible explanation for this could be that these youths are catching up on missed years of formal education by attending school in the camp beyond the predefined age range prescribed for formal education. Furthermore, according to the MoE, students studying for their General Secondary Education Certificate Examination (Twajhi students) are eligible to be enrolled for the 11th grade until the age of 21. These findings point to challenges in ensuring youths do not feel disenfranchised and demotivated due to lack of opportunities and activities that they are currently engaged in.

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Abbreviations and Acronyms

AFS	Adolescent Friendly Space
CCFA	Comprehensive Child Focused Assessment
CFS	Child Friendly Space
CP	Child Protection
CWD	Children with Disabilities
ESWG	Education Sector Working Group
FGD	Focus Group Discussion
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
GoJ	Government of Jordan
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
MDM	Médecins du Monde
MoE	Ministry of Education
MoH	Ministry of Health
NGO	Non Governmental Organisation
ODK	Open Data Kit
SRAD	Syrian Refugee Affairs Directorate
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	Water Sanitation and Hygiene

INTRODUCTION

With the conflict in Syria now entering its fifth year, the impact of the refugee crisis on children has been far-reaching. Almost 2 million Syrian children are living as refugees in Lebanon, Turkey, Jordan and other neighbouring countries.¹⁸ Za'atari refugee camp, located 10 km east of Mafraq in northern Jordan was first opened on July 28, 2012 to host Syrians fleeing violence in the ongoing Syrian civil war. In 2015 it continues to provide a safe haven for thousands of children who make up over half of the camp population and represent one of the most vulnerable demographic groups, given their dependence on adults for protection and access to basic services. While all new arrivals to Jordan are now directed to Azraq camp since its opening in April 2014¹⁹, the Za'atari camp context continues to shift and evolve and implementing partners must adapt their approach accordingly to ensure that the most vulnerable beneficiaries continue to be reached.

In February and March 2015 UNICEF, in partnership with REACH, conducted a comprehensive child focused assessment in Za'atari camp, designed to address existing information gaps in UNICEF-supported programming areas including WASH, education, health, disability and youth. The findings in this report provide actionable and up-to-date information that will be used to assess progress and change over time according to key indicators, to facilitate the planning and implementation of programming, and to ensure that activities and services effectively target and meet the needs of children and their families. Although a wealth of data has been gathered to date, structural developments, fluctuations in the camp population, external factors such as changes in government policy, and on-going changes in the expectations and needs of the community as Za'atari evolves into a more permanent settlement have created a need to update and contribute to information which currently exists.

The last assessment which gathered information on private WASH facilities in Za'atari was released by UNHCR-REACH in June 2014, over 9 months ago. Given significant planned and on-going changes in the WASH infrastructure of the camp, including the development of an interim simple-sewerage system and camp-wide water network, the CCFA will play an important role in contributing to informing the scope and nature of WASH provision in the camp, with current information on the use and coverage of private and public WASH facilities.

While the joint education needs assessment (JENA) 2014²⁰ provided evidence on children and education levels in Zaatari, focusing on reported attendance, barriers to education and perceptions of education within the camp, the sample size for the survey was 390 households and was representative at camp level, rather than district level. The CCFA, on the other hand, accounts for every household unit in Zaatari, and assesses education indicators not covered in the JENA such as access to safe spaces, disability, and activities for youth aged 19-24 years. In addition, due to the small number of children with disabilities included in the JENA 2014 household sample (124 individuals), children with disability (CWD) and education related data from the assessment could not be generalized and could only be considered as indicative. Therefore, the increased scope of this study provides for representative CWD findings in terms of participation and inclusion with the education system, with a referral system incorporated into the assessment to ensure follow-up where support was requested. Similarly, although Za'atari health facility reports provide some important evidence on key health indicators, health actors identified a need for current information on vaccination coverage and maternal health in the camp.

The CCFA assessment was designed in close coordination with relevant sector working groups operating in Za'atari camp, who contributed to identifying priority information needs. All sector-specific questions were reviewed by experts in education, WASH, health and child protection to ensure that they were measurable, relevant and followed a 'Do no harm' approach. This report is structured according to the different sectors that were assessed during the CCFA, beginning with an overview of demographic data and followed by in-depth analysis of findings related to WASH, health, education, disability and youth. Data is disaggregated by variables such as location within the camp, sex and age, to provide evidence on access to and coverage of services.

¹⁸ UNICEF, Syria Crisis Monthly Humanitarian Situation Report: February 2015, March 2015

¹⁹ A headcount activity was carried out in May/June by REACH and UNICEF but has become out dated due to the changing nature of the street boundaries in the camp and households moving in the camp.

²⁰ UNICEF/REACH, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), Joint Education Needs Assessment, September 2014.

METHODOLOGY

This study was conducted through a comprehensive assessment of all households in Za'atari camp. The indicators measured were agreed upon through extensive collaboration between UNICEF and sector working groups, addressing information gaps either because information was outdated; did not already exist; or was only representative at camp level rather than allowing for the disaggregation of findings by district. 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/caravans while a family was defined as the nuclear family consisting of parents and their children. Three revisits were conducted for each household that was found to be unoccupied before it was recorded as uninhabited. Data collection took place between 9th February and 5th 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 and Development (IRD) social workers in each district will carry out the referral process for the vulnerable cases at district level using the 3Ws matrix²¹. Disability organisations will then conduct the follow up for each case, case management, assessment, and provision of services for vulnerable cases.

Finally, the questions in the data collection tool were disaggregated by age and sex wherever appropriate in order 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 Za'atari 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.

²¹ A 3W matrix here refers to who is doing what and where in terms of disability actors currently operating in Za'atari camp.

Challenges and Limitations

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

- A total of 72 households declined to participate in the Za'atari CCFA. This is likely to be due to the length of the survey and due to the sensitive nature of some questions relating to disability, children and maternal health. In addition there were 1,132 households which were unable to be assessed, either as they were verified by neighbours as uninhabited or no one available to respond, after 3 re-visits.
- Storm Jana hit Jordan on the 19th February, during data collection. The camp population is particularly vulnerable to such extreme weather, and it is known through community discussions that as a result many residents went to stay with friends and family in host communities during this period, meaning that some members of the camp population were not present to be assessed during data collection.²²
- 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.²³
- 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.
- 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 (possession of child vaccination card, polio, measles, or Tetanus Toxoid vaccinations), number of post-natal visits or visits by disability focused organisations, for example.

²² Population counts indicate that there are seasonal fluctuations in camp population, consistent with a reduction in camp residents over the winter period [UNICEF/REACH, Za'atari Camp Population Count](#), January 2015.

²³ It was agreed by UNICEF, during the assessment design, that it was not appropriate for data collectors to ask girls younger than 15 years about pregnancy or giving birth due to protection reasons and with respect to cultural sensitivity.

FINDINGS

Summary of key Findings:

WASH

- Overall, 31% of households in Za'atari reported having a private water tank.
- 56% of households rely on the camp's public water supply for their main source of drinking water, indicating that there is still high demand for this supply. This was followed by 23% who refill at the market. 18.6% who rely on refill of private water tanks directly by ACTED trucks, 1.1% bottled water and 0.8% private water trucks.
- Of the 44% households who relied on private sources for their main supply of drinking water 64.7% indicated that the main reason for this was that they were concerned about danger to their health followed by 15.4% who reportedly did not like the taste of the public water. These two issues may well be linked, as camp residents who do not like the taste of water may consider this as indicative of inadequate water quality. The next most commonly cited reason was to avoid carrying water, with a total of 14% selecting this response.
- An overwhelming majority of households (84.6%) indicated that they have both a private shower and toilet, while 6.1% have neither a private shower nor toilet.
- The majority of households did not use public WASH centres for any of their key functions (shower, toilet, ablutions, washing clothes, washing dishes). On average 89.9% of girls, boys, women and men living in households did not use public WASH centres for any of these purposes during the day, and 91% did not use them for any purposes during the night-time.
- Similarly, on average 89.2% of girls, boys, women and men living in households did not use public WASH centres at all in the 7 days prior to the assessment, indicating infrequent usage of these WASH facilities.

Health

- 76.2% of children aged under 5 years have reportedly received more than 2 doses of polio vaccination, 10.2% have received 2 doses, 6.1% 1 dose and 6.0% no doses.²⁴
- 82% of children aged 9 months to 5 years have been vaccinated against measles indicating a high uptake of the vaccine, but a lack of total coverage for the target age group living in the camp.
- 71% of females of reproductive age (15-49 years) have been vaccinated with at least 2 doses of tetanus toxoid.²⁵
- 3,541 women of reproductive age (15-49 years) were reported as giving birth in the camp within the past year.²⁶
- 1,767 women (15-49 years) who gave birth in the camp within the past year reported to receive at least one post-natal visit within 6 weeks of delivery, however just under a quarter (24.6%) of these women received the recommended three visits.²⁷
- Data collectors asked respondents to present vaccination cards for children aged under 5 years. In total, 46% of children aged under 5 years were recorded as not having a vaccination card, while 29% had a vaccination card that was seen and verified by data collectors and 24% reported to have a card but it was not seen by data collectors.

²⁴ Recall bias may have affected the accuracy of responses received for self-reported questions due to participants with an unreliable memory of past events

²⁵ According to UNICEF, in Za'atari camp in 2014 a total of 3,728 pregnant women received one dose of Tetanus Toxoid, and 4,938 received 2 doses, while 5,037 non-pregnant women received one dose and 10,814 received two doses.

²⁶ According to UNHCR figures, there were 3,546 live births in Za'atari camp in 2014, including deliveries in the JHAS, Missouri Foundation for Health (MFH) and referred deliveries to MoH.

²⁷ According to UNHCR data, the total number of women who received post natal visits was 3,776 between January and June 2013. For 2013 a total of 1,628 women received post natal visits.

Education and Child Protection

- 64.6% of school-aged children were found to be attending formal education – 33% of girls and 31.6% of boys of 6-17 years indicating an increase in overall attendance since the JENA assessment where average attendance was 51.6%. However, it should be noted that according to figures provided by MoE and Save the Children Jordan attendance rates for formal education have been diminishing in Za'atari camp since September 2014, dropped from 15,979 in September 2014 to 13,051 in April 2015.²⁸ To further caveat findings, Save the Children's formal attendance figures were reported by teaching assistants whereas the attendance figures included in this assessment were reported by parents.
- 35.4% of children in the camp are currently not attending school, of whom 80% had never attended and 20% dropped out. However, encouragingly, 98% of these children are still eligible to reintegrate into the formal education system having missed less than 3 years of school. Overall, the total proportion of school-aged children who were reported to have dropped out was 7.1%.
- 6% of school-aged children are attending at least one type of informal education. Of children attending IFE 16% were found to be attending multiple types of IFE. Religious education was found to be the most popular type of IFE attended by children at 47.4% of children attending IFE.
- Assessment results indicate that the highest rates of attendance for Child Friendly Spaces/Adolescent Friendly Spaces/Multi Activity Centres were among the youngest age group of children aged 6-8 years with 6% of boys and 7% of girls in this age category reportedly using these centres.
- Encouragingly, 92.3% of households with school-aged boys and 92% of households with school-aged girls identified a certified education pathway as either important or very important.
- Only 6% of parents reported having attended at least one structured recreational session in the month prior to the assessment highlighting a lack of engagement with or knowledge about these sessions and scope for raising awareness of their availability in the camp.

Disability

- In total 3.3% of children (1,448 individuals) were reported to have at least one disability and/or a chronic illness. 89% of these children had either a chronic illness or one disability only, while the remaining 11% were reported to have more than one disability and/or chronic illness.
- Children aged 6-11 years were found to be disproportionately affected by disabilities and chronic illness compared to other age groups and across all types of disability reported. Meanwhile, 16-17 year olds had the lowest proportion of children with reported disabilities or chronic illness.
- The largest proportion of children was reported to have a chronic illness, with a total of 664 individuals.
- The most commonly reported type of disability was permanent physical disability with 274 children reported in this category, followed by difficulty seeing clearly, 231 cases, and difficulty communicating/understanding with 206 reported cases.²⁹
- The majority of children with a chronic illness (with no reported disability) (72%) were not reported as receiving any visits from an organisation specialising in disability. Meanwhile 58% CWDs with a disability or reported to have a disability *and* chronic illness had previously been seen by a disability organisation.
- Of the 911 school-aged children (6-17 years) in Za'atari camp with reported disabilities or chronic illness, 490 or 53.8% were found to be attending formal education - 10.8% below the camp-wide average reported attendance of 64.6%. For 66.7% of out-of-school girls and 60.7% of out-of-school boys at risk of disability or developmental delay it was reported that their condition was considered the main reason for their out-of-school status.

Youth

- 83.2% of youths aged 19-24 have not completed either high school or university, indicating a low level of educational attainment across this age group.

²⁸ MoE and Save the Children Jordan, Attendance trend in Za'atari camp, September 2014 – April 2015.

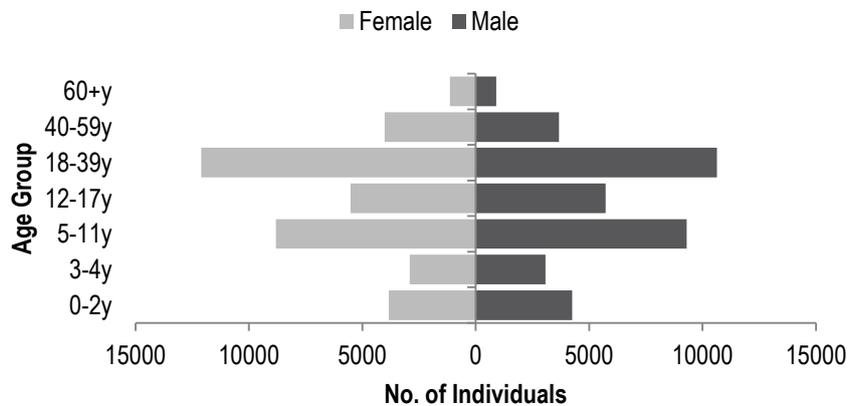
²⁹ Disability was defined using Washington Group-UN Statistics Division definitions, approved by Government of Jordan (GoJ).

- 92.5% of youths aged 16-24 are not in any form of employment training or unpaid volunteering,³⁰ while 5.9% are in paid employment. This suggests that the majority of youths are not involved in any productive or remunerative activities.
- 42.5% of adolescents aged 10-18 years are currently reported as not attending formal education, (46% males, 38.8% females). Of this 42.5% of out-of-school individuals, 75% of females in this category had never attended and 25% had dropped out, while 75.7% of males had never attended and 24.3% had dropped out.
- Rates of paid employment were considerably higher among males than females, with 13.8% of males aged 19-24 years currently in employment compared to 2.2% of females in the same age group and 0.1% of females 16-18 years in paid employment compared to 7.2% of males.
- 3% of children aged 10-18 years (520 individuals) were reported as having a disability and/or chronic illness.

Demographics

Data collected during the Comprehensive Child-Focused Assessment (CCFA) indicates that a total of 75,878 individuals (13,926 populated households) were residing in Za'atari camp at the time of the assessment.³¹ Findings revealed that, of the total camp population, 57% were children belonging to the 0-17 age group, thus suggesting an average dependency of 3.1 children per household. Of the children assessed in this survey, 60% were within the 6-17 age range, and thus of school age (representing 34% of the total camp population). Once demographic data is further disaggregated, there are 17,328 children aged 0-5 years, constituting 40% of all children and 23% of all camp residents. A gender breakdown indicates that 48.5% of children (21,061) are female while 51.5% (22,356) are male. At camp level, 50.5% of all residents (38,305) were female and 49.5% (37,573) were male, giving a male-to-female ratio of approximately 1:1.

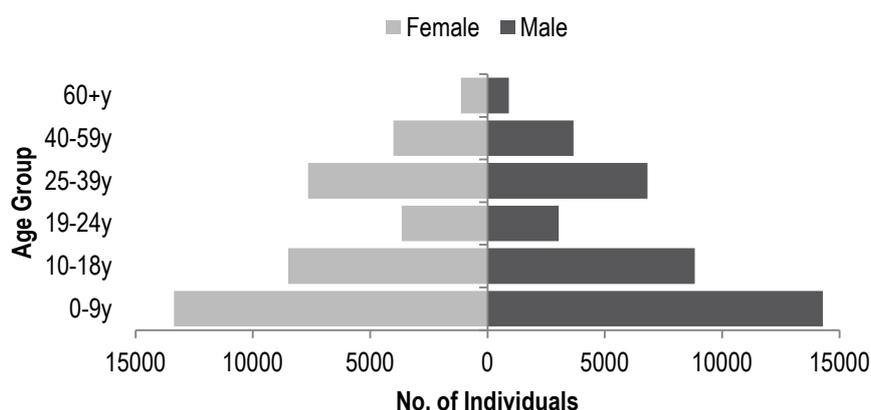
Figure 1: Total population of Za'atari camp, by age and sex



³⁰ Youths in paid volunteering are subsumed under the category paid employment.

³¹ There are camp wide fluctuations in population due to seasonal changes, cases of extreme weather and external shocks, such as changes to government policies and the amount of humanitarian assistance being provided in the host communities. Accordingly, these figures differentiate from official registration figures as they do not include those who may remain registered but were not residing in the camp at the time of the assessment; those who declined to participate, or those who were not present at their household upon three re-visits and were therefore unable to be assessed. It should be noted that the total number of households assessed (13,926) does not include shelters that were found to be uninhabited by field teams at the time of assessment.

Figure 2: Total population of Za'atari camp, by age and sex disaggregated for adolescents and youth

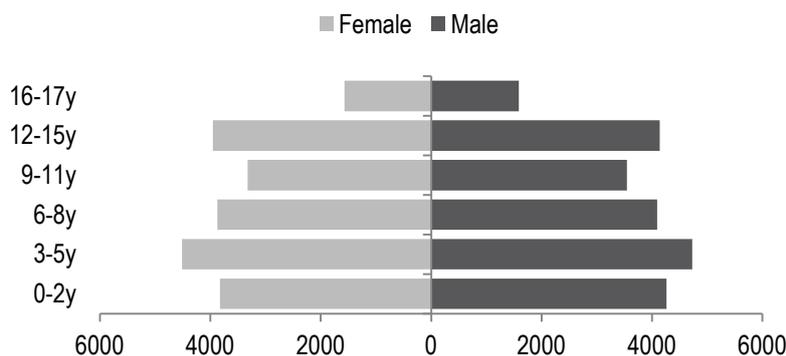


Male and female adults aged 18 to 39 years constitute the largest demographic group overall, with a total of 22,729 individuals recorded in this age group at the time of assessment. Findings indicate that children between 5 and 11 years represent the next largest group with a total of 18,106 individuals falling within this age bracket.

Table 1: Demographics per district by girls/boys/women/men

District	No. of girls 0-17y	No. of boys 0-17y	No. of women 18+y	No. of men 18+y
D1	1767	1822	1540	1359
D2	2031	2137	1774	1588
D3	1343	1441	1197	1046
D4	1167	1351	1018	892
D5	1529	1576	1182	1045
D6	1985	2191	1572	1369
D7	1847	2021	1626	1396
D8	2254	2369	1685	1497
D9	1384	1354	1064	943
D10	1804	1940	1392	1252
D11	2352	2487	1903	1703
D12	1598	1667	1291	1127
Grand Total	21061	22356	17244	15217

Figure 3: Total number of children in Za'atari camp, by age and sex



According to assessment findings there are 8,086 children aged 0-2 years currently residing in Za'atari 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. Districts 8 and 11 have the largest number of children falling within this age class, with 903 and 989 individuals aged 0-2 years respectively.

Table 2: Demographics by district

District	No. people	No. children	0-2y	3-4y	5-11y	12-17y	18-39y	40-59y	60+y
D1	6488	3589	629	491	1441	1028	2010	697	192
D2	7530	4168	728	534	1696	1210	2285	851	226
D3	5027	2784	498	366	1142	778	1521	562	160
D4	4428	2518	465	342	1063	648	1331	463	116
D5	5332	3105	597	463	1310	735	1579	529	119
D6	7117	4176	804	586	1724	1062	2053	684	204
D7	6890	3868	744	529	1611	984	2184	645	193
D8	7805	4623	903	658	2023	1039	2301	705	176
D9	4745	2738	476	377	1185	700	1423	474	110
D10	6388	3744	632	521	1569	1022	1833	651	160
D11	8445	4839	989	699	1983	1168	2542	833	231
D12	5683	3265	621	409	1359	876	1667	592	159
Total	75878	43417	8086	5975	18106	11250	22729	7686	2046

WASH

As UNICEF is the lead agency for water, sanitation and hygiene (WASH) in Jordan, it oversees the implementation of all WASH activities in Za'atari camp in coordination with key partners ACTED, JEN and Oxfam. Each district in the camp has a designated WASH lead partner: ACTED - Districts 1, 2, 9, 10, 11, 12, JEN – Districts 3, 4, 5, Oxfam - Districts 6, 7, 8.³² Every day, UNICEF and implementing partners provide approximately 3,800m³ of water to Za'atari camp (using the standard of a minimum of 35 litres per person per day, in addition to seasonal buffers). A fleet of some 120 water tankers and desludging tankers operate in the camp each day to ensure adequate water supply, and maintenance of sanitary conditions. In addition, regular operation and maintenance, water quality monitoring, and hygiene promotion is carried out by WASH partners.³³

Za'atari WASH sector minimum standards dictate that public water points provide potable water and are located within 100m of all households to enable use of the minimum water requirement. In addition, as a minimum standard, there must be provision of safe and hygienic sector-provided WASH facilities which include toilets, areas for bathing, and external tap points for water supply. Women, men, girls and boys should have adequate, appropriate and acceptable toilet facilities, sufficiently close to their shelters, to allow rapid, safe and secure access at all times, both day and night. Minimum standards also state that public WASH centres should be no more than 100m from shelters to allow for adequate access.³⁴

UNICEF and WASH partners address the WASH needs of Syrian refugee children and their families on a daily basis. Access to clean drinking water, the safe collection and disposal of wastewater and solid waste, as well as the dissemination of key messages for the purpose of hygiene promotion and awareness protects children and their families from diseases and other health risks, as well as preventing the camp environment from becoming contaminated.³⁵ 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 in Za'atari 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 and Storage

Despite the fact that the WASH Sector provides water to Za'atari camp on a daily basis,³⁶ while the majority of households did not report having a private water tank (69%), just under a third of all households (31%) did. These findings indicate that some households have opted to increase their water storage capacity by installing private water tanks.³⁷

³² UNHCR / UNICEF, Minimum Standards for Za'atari WASH sector, September 2014.

³³ UNICEF, [Children of Syria](#), 2014.

³⁴ UNHCR / UNICEF, Minimum Standards for Za'atari WASH sector, September 2014.

³⁵ UNICEF, [Water, Sanitation and Hygiene Project Brief](#), April 2015.

³⁶ UNHCR / UNICEF, Za'atari Camp WASH Facilities Management Intro and FAQ, June 2014.

³⁷ These findings were cross-checked with WASH partners in Za'atari. ACTED field teams estimate 40% private water tanks in their districts (1, 2, 9, 10, 11 & 12) and this assessment found that the average percentage of water tanks in the same districts closely aligned with this at 45%.

Figure 4: Percentage of households that own private water tanks in the camp³⁸

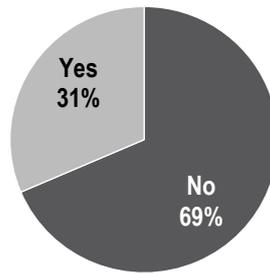
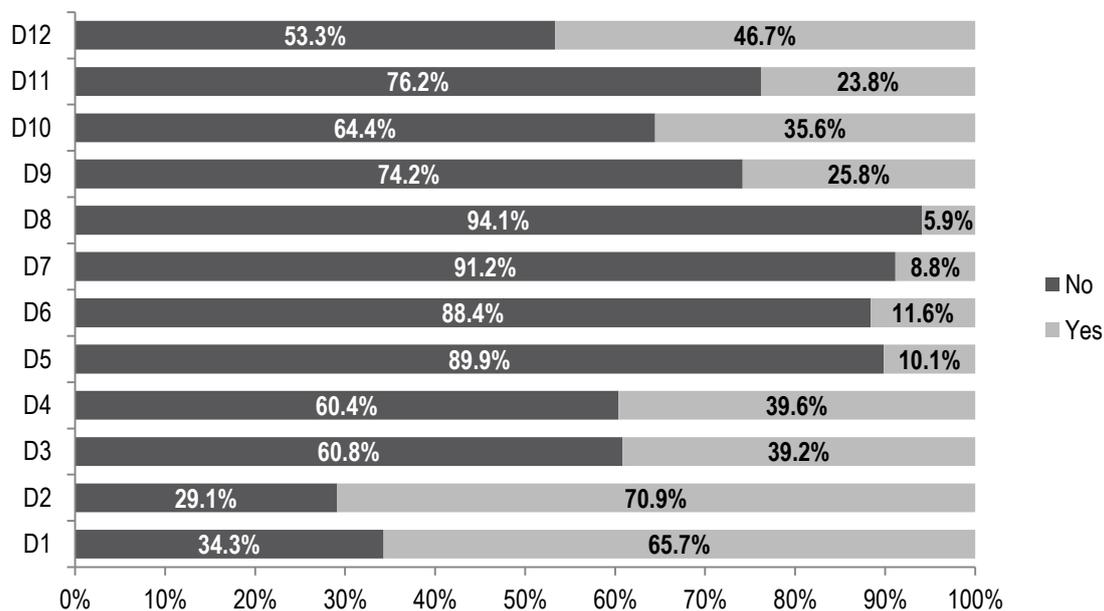


Figure 5: Percentage of households that own private water tanks by camp district



Once disaggregated further, findings show that there is a large degree of variation in the proportion of households reporting ownership of private water tanks across districts. Overall, the older, more established districts in the camp (Districts 1, 2, 3, 4, and 12) had a higher percentage of households with private water tanks, with the exception of District 11 where the total stood at 23.8%. Camp residents living in these districts have had a longer period of tenancy in which to source and construct private household facilities, such as private water tanks. Findings indicate that District 2 had the largest proportion of households with private water tanks at 70.9% followed by District 1 with 65.7%, while District 8 had the smallest proportion of households with private water tanks at 5.9%.

While UNICEF is responsible for providing potable water for all refugees in Za'atari camp, its capacity is limited to 35 litres per capita per day. Despite the fact that this allocation fulfils the minimum Sphere standards in camp settings, some camp residents, for commercial and other socioeconomic purposes require more than the allocated 35 litres per person per day, so opt to supplement public water supply with water from private sources.

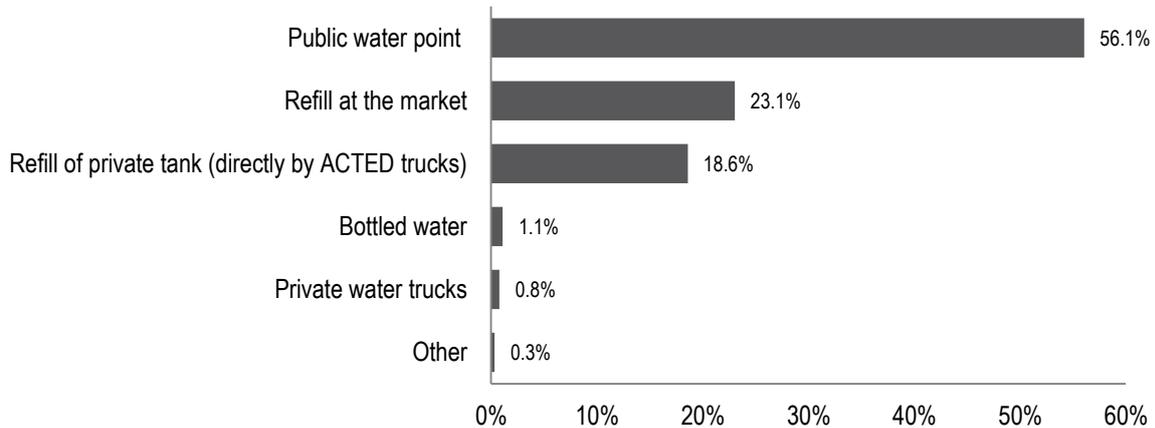
Under such circumstances, refugees and private trucks are not prevented from bringing in additional water into the camp. However, to ensure that water consumed in the camp is within acceptable standards, private water trucks must first obtain the necessary permission from the Syrian Refugees Affairs Directorate (SRAD) who

³⁸ It should be noted that private water tanks were not observed by data collectors but simply inquired about in the survey, therefore it may be that they were under-reported by respondents due to perceptions that possession of a private water tank may affect water distribution in the camp. It is also likely that some households have other private water storage vessels such as water barrels and bottles that are not incorporated in this finding.

manage the camp, and regardless of source or ownership, all water entering the camp is subject to the same water quality monitoring process as the public water supply.³⁹

Survey participants were asked to indicate the main source of drinking water for their household. The response options agreed upon by the Za'atari WASH sector included: public water point, refill at the market, refill of private tank directly by ACTED trucks, bottled water, private trucks or other.

Figure 6: Main source of drinking water, % households



Findings reveal that the majority of households (56%) use public water points in the camp as their main source of drinking water. The next most commonly cited response was for households to refill their drinking water supply at the market (23.1%), followed by the refilling of private tanks directly by ACTED trucks (18.6%). Only 1.1% of households cited bottled water as their main source of drinking water and 0.8% private water trucks.

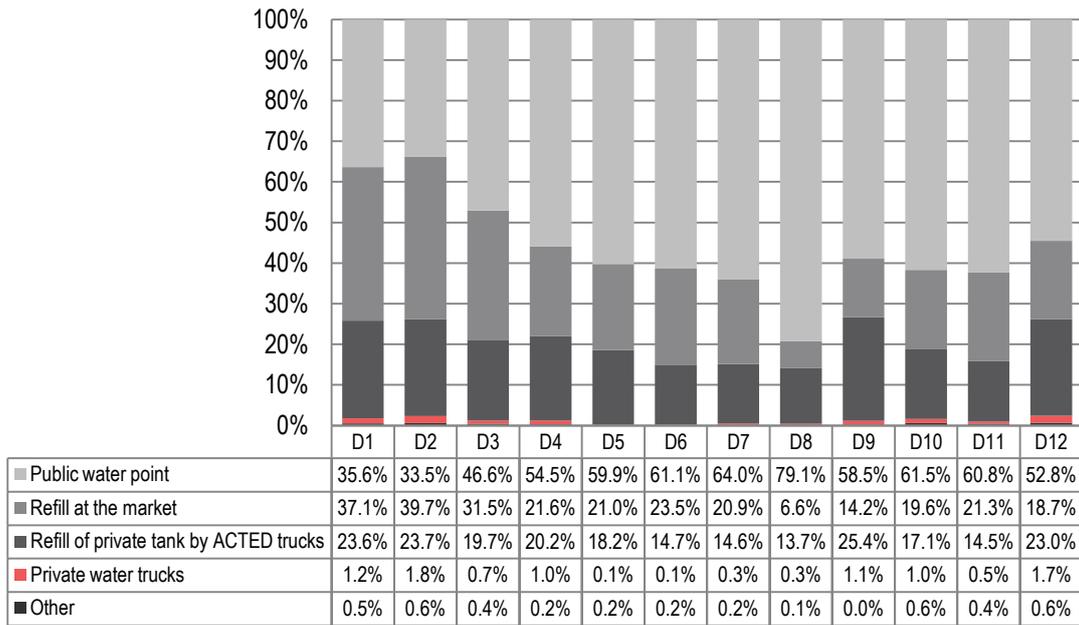
Public water points may be the most popular source of drinking water as they are free of charge and, on the whole, easily accessible to camp residents. Private sources of drinking water, such as bottled water and water from private trucks will incur a cost, so are less likely to appeal to camp residents who have a limited income.

When disaggregated by district there was a large degree variation across the camp, specifically between the old and new districts (see Figure 7).⁴⁰ A lower proportion of households in the older camp districts relied on public water supply as their main source of household drinking water than in the newer camp districts. This disparity can in part be attributed to the higher concentration of private water tanks reported in all but one of the more established districts (Districts 1, 2, 3, 4, and 12).

³⁹ UNHCR / UNICEF, Standard Operating Procedures (SOP) for Water Supply in Za'atari Camp, January 2015.

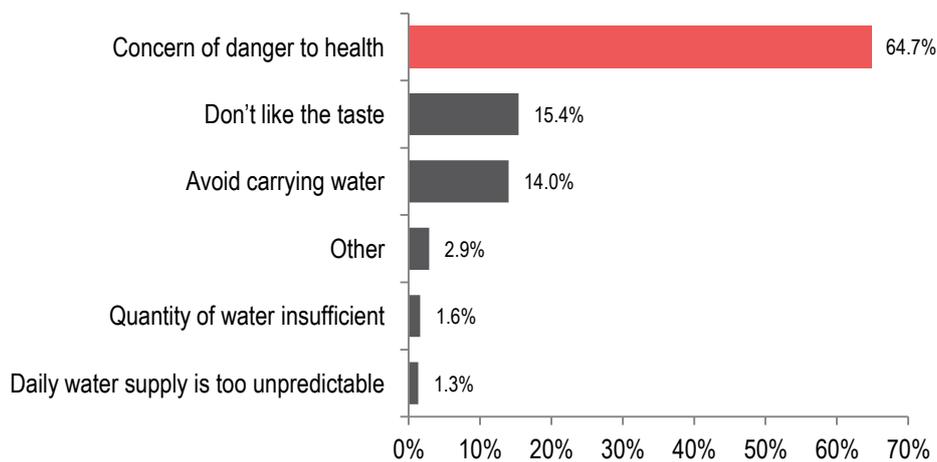
⁴⁰ In Za'atari camp some districts have been inhabited for longer than others according to patterns of new arrivals. They can be categorized into "Old Districts": 1,2,3,4,11,12; and "New Districts": 5,6,7,8,9,10.

Figure 7: Main source of household drinking water, by district



In order to gauge perceptions of public water supply in Za'atari camp, those respondents who reported that their household's main source of drinking water came from a private source were then asked to indicate the main reason behind this preference. Of the 43.9% of respondents who did not use the public water points as their main source of drinking water, 64.7% indicated that they were concerned about the public water supply representing a danger to their household's health, suggesting that negative perceptions of water quality exist among the camp community. The next most commonly cited reason was that households did not like the taste of the water supplied publicly, at 15.4%, closely followed by respondents who indicated that their household members wanted to avoid carrying water, at 14%.

Figure 8: Main reason for household relying on a private source of drinking water



Notably few households cited a water supply deficit or water supply unpredictability as the main reason for resorting to a private water source, which is a positive finding for partners engaged in water distribution. Health concerns regarding the public water supply may be linked to negative perceptions of taste – the second most commonly cited reason for relying on a private source of drinking water. Camp residents who dislike the taste of public water may associate this with inadequate water quality that could be perceived as detrimental to their health, therefore these two reasons are likely to be closely interlinked with one feeding into the other. This is in spite of no evidence of poor quality public water being provided to the camp.

Table 3: Main reason reported by HH relying on private source of drinking water, by district

District	Concern of danger to health	Don't like the taste	Avoid carrying water	Quantity of water insufficient	Daily water supply unpredictable
D1	65.2%	15.4%	13.1%	1.6%	2.5%
D2	68.8%	11.6%	13.6%	1.1%	1.9%
D3	73.7%	12.8%	7.6%	1.2%	1.0%
D4	61.9%	14.3%	15.6%	1.1%	2.6%
D5	61.9%	20.1%	9.3%	1.5%	1.5%
D6	63.3%	20.2%	11.5%	1.2%	1.0%
D7	63.5%	21.2%	10.9%	1.0%	0.4%
D8	57.4%	20.5%	18.5%	2.0%	0.7%
D9	54.1%	19.6%	22.0%	1.1%	0.8%
D10	68.6%	9.4%	17.2%	2.1%	0.5%
D11	67.9%	14.1%	13.1%	1.8%	0.7%
D12	59.3%	12.2%	20.5%	4.4%	1.3%

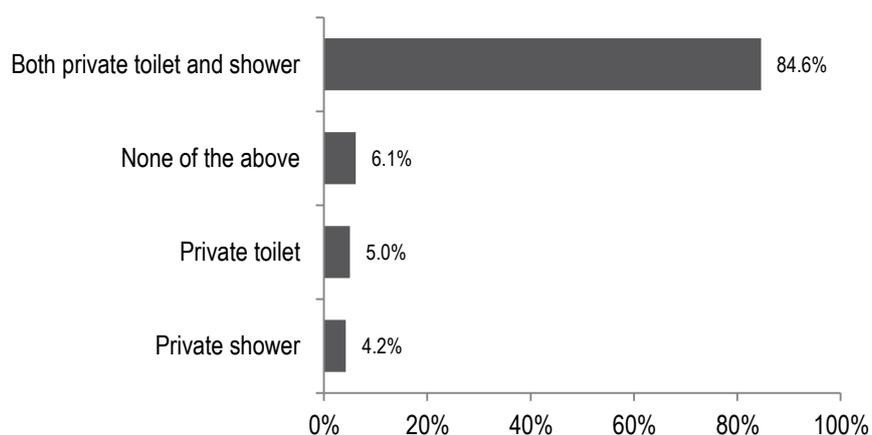
When findings are disaggregated further, it is possible to see that reasons vary according to district. District 3 has the highest proportion of households citing health concerns as the main reason for using a private source for the main supply of drinking water at 73.7%. The proportion of households indicating that they do not like the taste of public water ranges from 9.4% in District 10 to 21.2% in District 7. Overall, the newer camp districts have a higher percentage of households reporting dissatisfaction with water taste. This may be due to camp residents in these districts not yet being accustomed to the water being supplied in the camp. There was also a great degree of variability across districts with regards to the response 'Avoid carrying water', indicating that distance to water point is likely to influence the main source of drinking water opted for by households - only 7.6% of households from District 3 cited this reason compared to a total 22% of households in District 9. However, given that the minimum standard in Za'atari is that 100% of households are located within 100m of the nearest functional external water point, it is more likely that distance is considered a barrier to access due to other factors. For example, real and perceived levels of safety and security in walking to and from water points may be influenced by issues such as youths gathering in public areas, crowded streets, and navigating open cesspits, which differ across districts.

Private WASH Facilities

As Za'atari camp becomes a more established settlement, there is a continuing trend for unsupported and unregulated private WASH facilities in individual households that has begun driving and defining many of the planned infrastructure projects, such as the wastewater collection network project and household connections project to ensure that households have better access to potable water and more sustainable wastewater drainage.⁴¹ In order to give an indication of the scope of private WASH infrastructure in the camp, respondents were asked if their household had a private shower, a private toilet or both. The vast majority of households in Za'atari camp (84.6%) reported having both private toilet and shower facilities, with only 6.1% selecting the response 'None of the above' (see Figure 9).

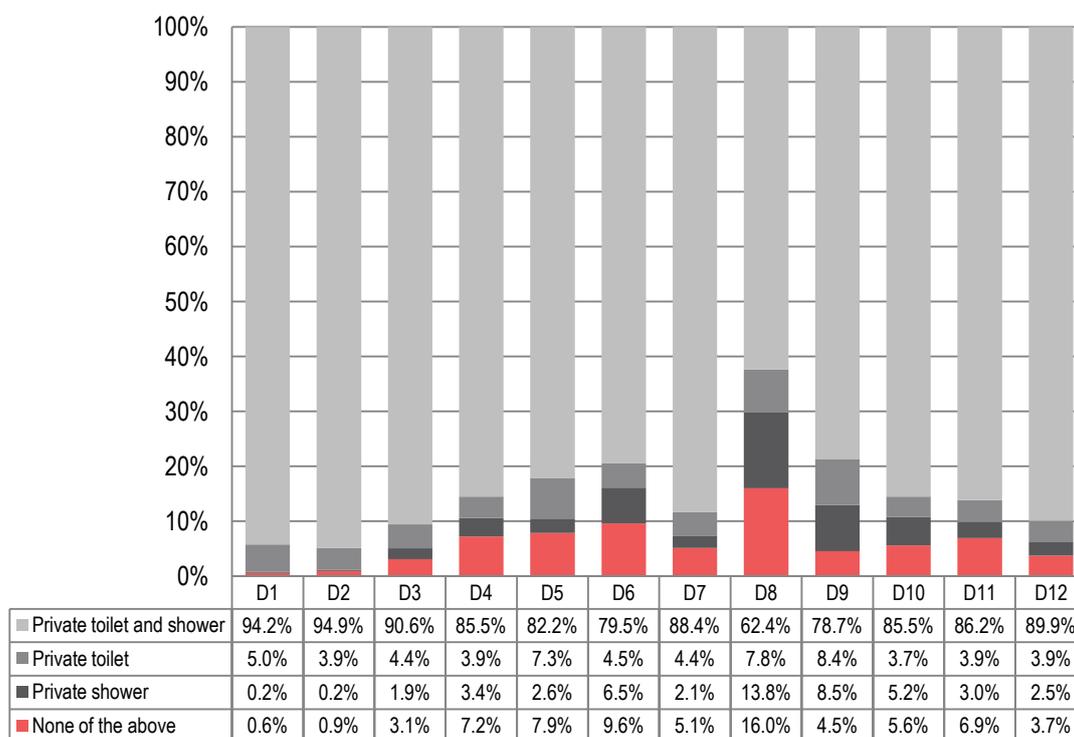
⁴¹ UNHCR/UNICEF, Minimum Standards for Za'atari WASH sector, September 2014.

Figure 9: % Households with private WASH facilities



It is likely that camp residents have built their own WASH facilities to allow for greater privacy, security and ease of access to these facilities for their household members.⁴²

Figure 10: % Households with private WASH facilities (by district)



Syrian refugee women and girls living in Azraq camp have reported that they require more privacy than is offered by public WASH facilities,⁴³ and it may be that this is also the case in Za'atari camp, given that a large proportion of residents in both camps share the same or similar cultural background. Furthermore, according to Share's, 'Violence gender and WASH: A Practitioner's Toolkit', women and girls are more vulnerable to harassment and sexual assault than boys and men when using WASH facilities, which may reflect both real and perceived dangers in using public WASH facilities, and subsequently impact the use amongst these demographic groups.

⁴² Share, Violence gender and WASH: A Practitioner's Toolkit, December 2014.

⁴³ UNHCR/REACH, [Azraq Camp Shelter Assessment](#), January 2015.

The large number of private WASH facilities in the camp serves to highlight the importance of wastewater solutions, as there will be a large volume of grey and black water produced on a daily basis by these private showers and toilets. A recent UNHCR-REACH wastewater assessment of districts 1, 2, 3, 4, 11 and 12 found that on average 52% of households produced both black and grey water, with 11,347 wastewater outlets identified in these districts alone.⁴⁴ Given that Jordan's largest aquifer is located beneath Za'atari camp, the large volume of wastewater being produced by residents represents a pressing concern for the camp community given the health risks that it poses. However, the interim wastewater network currently being designed by camp partners will help to mitigate the contamination of groundwater and prevent open run-off and exposed wastewater outlets from becoming a greater risk to hygiene and safety.

WASH Centre Usage

In order for WASH projects in Za'atari to have a positive impact on public health, women, girls, boys and men of all ages must be equally incorporated into programme design. For this reason, questions on WASH centre usage in the assessment were disaggregated by age and sex. Respondents were asked how often they and their household members had used the public WASH centres in the 7 days prior to participating in the survey.

Table 4: Frequency of WASH centre usage in the last 7 days (% households with G/B/W/M)

Demographic	Never	Several times a day	Once every few days	Once a day	Once a week
Girls (0-17)	90.1%	8.7%	0.7%	0.4%	0.1%
Boys (0-17)	89.8%	8.8%	0.8%	0.5%	0.1%
Women (18+)	88.9%	9.5%	0.9%	0.6%	0.1%
Men (18+)	88.3%	10.2%	1.0%	0.5%	0.2%

An overwhelming majority of respondents indicated that girls, boys, women and men in their household had not used WASH centres at all in the 7 days prior to the assessment (see Table 4 & 5). Men (18+ years) represented the demographic group with the highest frequency of usage of WASH centres, followed by women (18+ years). Girls (0-17 years), meanwhile, were reported as the least frequent users of WASH centres in the camp. However, there was only a small disparity between all four demographic groups.

Table 5: Frequency of public WASH centre usage, by district (% households)

District	Never	Once a day	Once a week	Once every few days	Several times a day
D1	99.5%	0.0%	0.1%	0.0%	0.4%
D2	99.4%	0.0%	0.0%	0.0%	0.5%
D3	95.8%	0.3%	0.1%	0.6%	3.3%
D4	88.4%	0.8%	0.1%	2.5%	8.2%
D5	90.8%	0.2%	0.1%	0.2%	8.7%
D6	83.0%	0.4%	0.1%	0.5%	15.9%
D7	92.0%	0.5%	0.1%	0.1%	7.3%
D8	69.5%	0.9%	0.1%	0.1%	29.4%
D9	87.0%	0.6%	0.4%	0.2%	11.9%
D10	90.7%	0.3%	0.1%	0.2%	8.6%
D11	87.4%	0.9%	0.1%	3.4%	8.1%
D12	91.7%	1.0%	0.2%	2.4%	4.8%

⁴⁴ REACH/UNHCR, [Al Za'atari Refugee Camp Wastewater Assessment](#), February 2015.

There was a higher rate of WASH centre usage in the newer camp districts, which may be attributed to the comparatively newer WASH infrastructure in these areas, and also due to the fact that there are fewer private toilets and showers reported in these districts. Public WASH centre usage peaked in District 8 with 29.4% of households frequenting these facilities several times a day, followed by District 6 with 15.9% of households responding within this category. Overall, the low proportion of camp residents indicated as using public WASH centres on a regular basis is corroborated by the large number of households across all districts reporting both private toilet and shower facilities. This was also a key finding from the UNHCR-REACH shelter assessment conducted in Za'atari camp in June 2014, which identified a high proportion of households that had constructed their own private latrines (40.6%).⁴⁵ However, the low proportion of camp residents accessing public WASH centres may also be attributed to real or perceived protection and safety issues related to their usage, and concerns over privacy. Furthermore, according to community discussions many camp residents do not use public WASH centres during the night due to a lack of public lighting.

Respondents were also asked for what purpose they used WASH centres at day and at night, with the options of toilet, ablutions, showering, washing clothes, washing dishes, or 'none of the above'. After the response 'None of the above' toilets were the most commonly cited purpose for WASH centre usage for girls, boys, women and men, with 9.4% of all households, followed by ablutions with 2.6% of households and showering with 1.3%. The finding that most households were not using public WASH centres for any of their designated functions is corroborated by the vast majority of households that had not used WASH centres in the 7 days prior to the assessment. Indeed, 99% of households with girls, women, boys and men who selected the response 'None of the above' for WASH centre usage during both day and night also indicated that they had not used public WASH centres at all in the 7 days prior to the assessment. This finding is largely attributable to significant proportion of households with both shower and toilet facilities

Table 6: Purpose of WASH centre usage during the day (% households with G/B/W/M)⁴⁶

Demographic	None of the above	Toilet	Ablutions	Shower	Washing clothes	Washing dishes
Girls (0-17)	90.8%	9.0%	2.1%	1.5%	1.0%	0.6%
Boys (0-17)	90.3%	9.5%	2.3%	1.8%	0.2%	0.1%
Women (18+)	89.5%	10.2%	3.1%	2.0%	1.9%	1.3%
Men (18+)	88.8%	11.0%	4.5%	2.4%	0.3%	0.2%

Toilets were the most commonly cited purpose for WASH centre usage across all demographic groups (girls 9%, boys 9.5%, women 10.2%, men 11%), followed by ablutions (see Table 6). These are both functions that are carried out more than once a day, corresponding with the finding that those who did use WASH centres in the 7 days prior to the assessment were most likely to have frequented them several times a day. A limited proportion of residents reported using WASH centres for showers, and an even smaller proportion used WASH centres to wash clothes or dishes. It is worth noting that a slightly higher percentage of females than males used WASH centres for these domestic chores.

Table 7: Purpose of WASH centre usage during the night (% households with G/B/W/M)

Demographic	None of the above	Toilet	Ablutions	Shower	Washing clothes	Washing dishes
Girls (0-17)	92.0%	7.9%	1.6%	0.5%	0.4%	0.2%
Boys (0-17)	91.4%	8.5%	2.0%	0.7%	0.1%	0.0%
Women (18+)	90.8%	9.0%	2.3%	0.7%	0.5%	0.2%
Men (18+)	89.6%	10.2%	3.1%	1.0%	0.2%	0.1%

⁴⁵ UNHCR/REACH, [Al Za'atari Refugee Camp Shelter Assessment](#), June 2014.

There was a slight decrease in WASH centre usage reported during the night for all demographic groups and across all WASH centre functions, with toilet usage dropping to 7.9% for girls, 8.5% for boys, 9% for women and 10.2% for men (see Table 7). This is likely due to camp residents feeling more vulnerable during hours of darkness for reasons such as a lack of public lighting, as well as personal safety and security concerns contributing to decreased levels of access.

HEALTH

The Jordanian Ministry of Health (MoH) is closely involved in the health response in Za'atari camp, and there are a number of partners in the health sector, including UNICEF, Jordan Health Aid Society (JHAS), UNFPA, UNHCR, the Qatari Red Crescent, the Noor Hussein Foundation, Médecins Sans Frontières (MSF), Médecins du Monde (MDM), Syrian clinic, and International Medical Corps (IMC) that are currently operating in the camp. There are also coordination mechanisms in place at the Mafraq and Amman levels tying into the Regional Response Plan (RRP6 for the Syria Crisis that aim to 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 Za'atari camp, the health sector has evolved in coordination with MoH. There are now numerous facilities that provide primary health care, including clinics run by MDM, the JHAS and MSF in Districts 3, 4, 5 and 6. In the camp, secondary care is being supplied through the Moroccan and Jordan–Italian military field hospitals located in District 3.⁴⁷ Tertiary care needs are referred outside the camp to the hospital in Mafraq. Health surveillance and preparedness of outbreak in Za'atari has greatly improved since the opening of the camp, with the early warning systems being strategically enforced.⁴⁸ The potential spread of disease has also been mitigated through the implementation of widespread vaccination campaigns.⁴⁹

Vaccinations

Polio Vaccination

Jordan remained polio-free throughout 2014, conducting a series of emergency polio vaccination campaigns - four National Immunization Days (NIDs) and two sub-NIDs - jointly by MoH, UNICEF, WHO, UNHCR and partners as part of the polio prevention and response strategy.⁵⁰ 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.⁵¹

In two sub-NIDs in June and August 2014 more than 200,000 children 0-5 years were vaccinated, including 41,065 Syrian children in camps (Azraq, Za'atari and Emirati-Jordanian Camp), and 102,604 Syrian children in host communities, as well as 278,642 Jordanian children vaccinated in hard to reach area in addition to 26,098 from other nationalities. 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.⁵²

There have been a total of eight polio vaccination campaigns in Za'atari camp since its opening, with the last campaign conducted in December 2014. As part of this survey, respondents were asked how many doses of polio vaccine children in their household aged 0-5 years had received, if any.⁵³ Oral Polio Vaccine is the WHO-recommended vaccine for polio eradication. One dose of OPV is two drops, taken orally. Children need at least three doses of oral polio vaccine before they are fully immunized against polio. WHO recommends that the first dose to be given at 2 months and the others at least four weeks apart.⁵⁴

⁴⁷ REACH, General Infrastructure: Health, April 2015.

⁴⁸ WHO, [Al Za'atari: an overview of health services in the camp](#), October 2013

⁴⁹ UNHCR, [2014 Syria Regional Response Plan \(RRP6\)](#), November 2013.

⁵⁰ Ibid.

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

⁵² UNHCR, [2014 Syria Regional Response Plan \(RRP6\)](#), November 2013.

⁵³ It is important to note that it was most often the head of household who was asked to respond to this question and this person may not have always been the most knowledgeable about the child's vaccination record.

⁵⁴ UNICEF, [Polio Immunization](#), accessed April 2015.

Figure 11: % children aged under 5 reported as vaccinated against polio

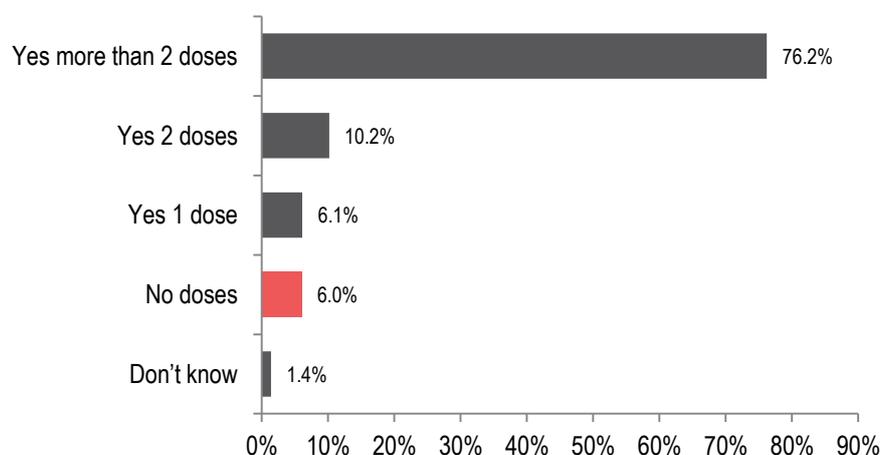


Table 8: Number of children aged under 5 reported as vaccinated against polio, by district

District	More than 2 doses	2 doses	1 dose	No doses	Don't know
D1	914	90	61	47	8
D2	1028	103	60	58	13
D3	626	87	73	69	9
D4	576	104	60	56	11
D5	837	86	52	69	16
D6	1066	143	68	97	16
D7	988	96	74	93	22
D8	1185	148	80	115	33
D9	712	53	47	37	4
D10	879	126	61	65	22
D11	1228	239	112	93	16
D12	681	158	116	48	27
Grand Total:	10720	1433	864	847	197

Findings reveal that the majority of children falling within this age bracket (76.2%) were reported as having received more than 2 doses of polio vaccine, so were fully immunized against the disease.⁵⁵ A further 10.2% were reported to have received 2 doses and 6.1% 1 dose. Only 6% of children were reported as having received no doses of the oral vaccine. This indicates that overall 23.8% still need to be fully immunized against polio in order to reach the target of 100% vaccination coverage for this age group.⁵⁶

When disaggregating findings at district level, coverage is shown to be somewhat uneven across the camp, relative to the total number of children 0-5 years in each district. District 9 has the largest proportion of children with more than 2 doses of polio vaccine, at 83.5% of all children of 0-5 years, followed by District 1 with 81.6% and District 2 with 81.5%. District 12 contained the lowest percentage of children vaccinated proportional to the

⁵⁵ Recall bias may have affected the accuracy of responses received for self-reported questions due to participants with an unreliable memory of past events

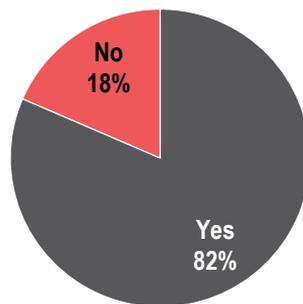
⁵⁶ UNICEF, [Children of Syria Campaign](#), June 2014.

total number of children living in the district falling within this age bracket, with more than 2 doses relative to the total number of children aged 0-5 years at 66.1%, followed by District 4 with 71.4% and District 3 with 72.5%. While over half of District 12 is located 400-799m from the nearest health centre, it is somewhat surprising that there are lower rates of vaccination coverage in Districts 3 and 4 given their close proximity to a number of health centres at a distance of no more than 200-399m. This suggests that factors other than distance have played a role in the lower vaccination rate across these districts, potentially indicating uneven coverage of vaccination campaigns and outreach programmes, given that all polio vaccination campaigns have been camp-wide in scope.

Measles Vaccination

A measles outbreak in Jordan, in April 2013, was successfully contained with two mass campaigns jointly conducted by MoH, UNICEF, WHO, UNHCR and UNRWA in Za'atari camp, as well as in host communities in Mafraq and Irbid Governorates. As a result, 82% of children aged between six months to 15 years in Za'atari were vaccinated against measles.⁵⁷ The last measles vaccination campaign to be conducted in Za'atari camp took place in November 2013 – there was no measles campaign in 2014. Furthermore, new arrivals to Za'atari camp falling within the target age group receive measles vaccinations from camp health clinics. Respondents were asked if children living in their household aged 9 months to 5 years had been vaccinated against measles. Findings indicate the majority of children within this age group (82%) had received the measles vaccine; however, coverage was not total with 18% reportedly remaining unvaccinated.⁵⁸

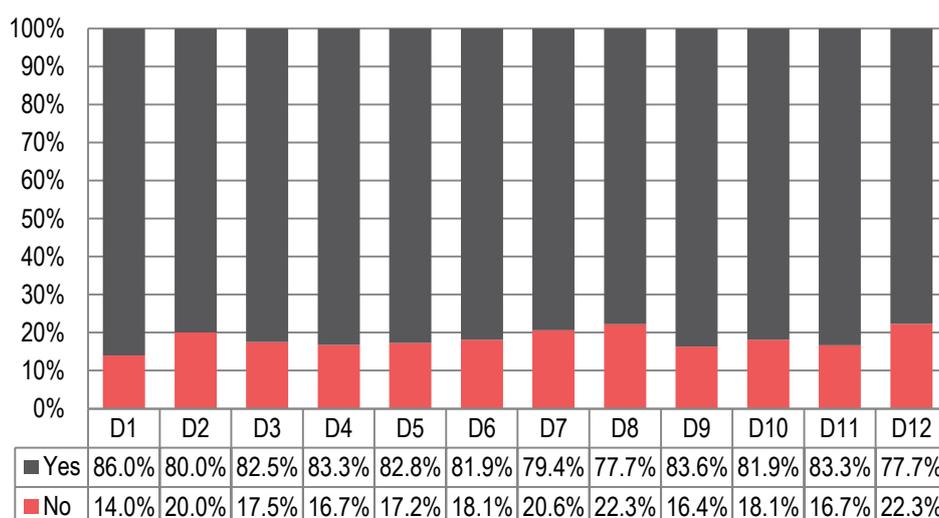
Figure 12: % children aged 9 months to 5 years reported as vaccinated against measles



⁵⁷ UNHCR, [2014 Syria Regional Response Plan \(RRP6\)](#), November 2013.

⁵⁸ 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: % children 9 months to 5 years reported as vaccinated against measles, by district



Once disaggregated by district, coverage was found to be completely even, with the proportion of vaccinated children ranging from 77.7% in District 12 and District 8 to 86.0% in District 1 (see Figure 13). On average, total coverage in the old camp districts (1, 2, 3, 4, 11 & 12) was slightly higher at 82% than in the newer districts (5, 6, 7, 8, 9 & 10) at 81%.⁵⁹ As with polio vaccination coverage, distance to health centre may have influenced the comparatively low rate of vaccination in District 12.

Vaccination card

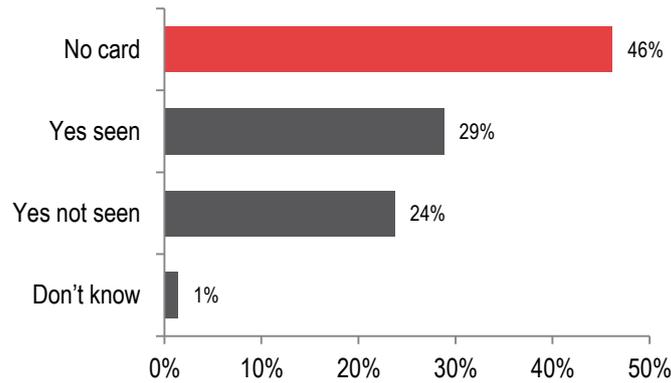
Vaccination cards are a form of health documentation given to refugees in Za'atari camp by the MoH that show their name, date of birth and history of vaccinations received from all health care providers, through routine immunization and supplementary immunization activities. These health records foster coordination and continuity of immunization service delivery between service providers, facilitate communication between health workers and caregivers, and support public health monitoring. They 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.⁶⁰ In 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.⁶¹

⁵⁹ UNICEF, Za'atari Camp Population Count, Jordan, January 2015 found that most new arrivals resided in Districts 8 (32% of new arrivals in 2014) and District 7 (17% of new arrivals in 2014).

⁶⁰ UNICEF, [Child health, immunization](#), accessed April 2015.

⁶¹ 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 14: Percentage of children under 5 years living in the household that have a vaccination card



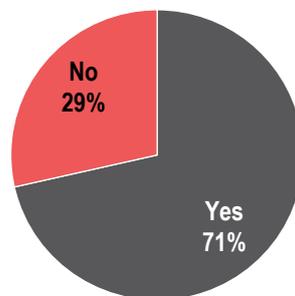
Findings show that just under half of children 0-5 years did not have a vaccination card (46%). Over a quarter of all children (29%) in this age group had vaccination cards that were seen and verified by data collectors, and a further 24% were said to have the card but the respondent was unable to present it at the time of assessment. It is important to note that, although further verification is needed, it was often reported by respondents in the 'Yes not seen' category that other household members who were not at home when the survey was conducted were in possession of the vaccination card along with other documentation. Nevertheless, given that 46% of children were recorded without a vaccination card this suggests that greater attention needs to be focused on improving the availability, retention and utilization of home-based vaccination records and enhancing immunization data quality. However, given the high level of vaccination coverage recorded in Za'atari camp for emergency vaccines polio and measles, it is likely that rather than children never having received vaccination cards, some cards had been lost by carers or were in the possession of relatives elsewhere. This is also likely due to routine immunization and emergency campaigns for measles and polio vaccines being conducted at different times in Za'atari camp, meaning that vaccination cards have a bigger chance of being misplaced or lost in transit between the household and the clinic.

Maternal Health

Tetanus Toxoid Vaccination

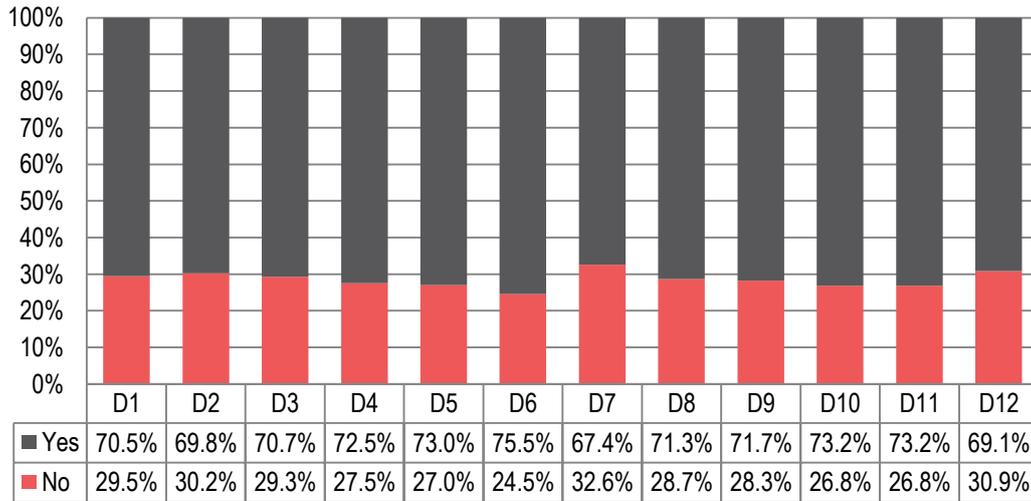
The tetanus toxoid vaccine protects mothers and new born babies from maternal and neonatal tetanus (MNT), which is preventable through immunization and hygienic birth practices.⁶² Tetanus Toxoid vaccination is administered through an injection, with a total of 5 doses, and is administered for girls and women of reproductive age (defined as 15-49 years).

Figure 15: % of females of reproductive age (15-49 years) reported as vaccinated with at least two doses of tetanus toxoid



⁶² UNICEF, [Immunization: Maternal and Neonatal Tetanus](#), May 2015.

Figure 16: % females of reproductive age (15-49) reportedly vaccinated with at least two doses of tetanus toxoid, by district



The Tetanus Toxoid vaccine has been provided for all female students in grade 10 in Za'atari schools in 2014 and 2015, indicating that out-of-school girls of this age group may have missed out on receiving the vaccine. Respondents were asked if girls and women aged 15-49 years living in their household had been vaccinated with at least two doses of tetanus toxoid. Results show that the majority of girls and women of reproductive age (71%, or 12,372 individuals) were reported to have received this number of doses.⁶³ When disaggregating results further, coverage was even across the camp, although there was some variation between districts. The lowest vaccination coverage was found in District 7, where 32.6% of all females aged 15-49 were reportedly unvaccinated, followed by District 12 with 30.9% falling within the unvaccinated response. District 7 is the district located furthest from any health clinic which may help to explain this low rate of vaccination coverage. District 6, meanwhile is within much closer proximity to a number of health clinics, and had the highest vaccination coverage with some 75.5% of females of reproductive age reported to be vaccinated with at least two doses of tetanus toxoid.⁶⁴

For every household with women of reproductive age (15-49 years) the respondent was asked how many women in the household had given birth to a baby in the camp within the past year.⁶⁵ Assessment findings indicate that, in total, 3,541 women had given birth to a baby in Za'atari within the past year, representing 20.5% of all women aged 15-49 years living in the camp. When disaggregated by district, District 11 stands out as having the most births in the past year with 423 women, followed by District 8 with 341 women (see Figure 16). District 9 had the lowest recorded number of women who had given birth with a total of 207. On average, 295 women per district had given birth in the camp within the past year. This figure may be lower than anticipated as 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.⁶⁶

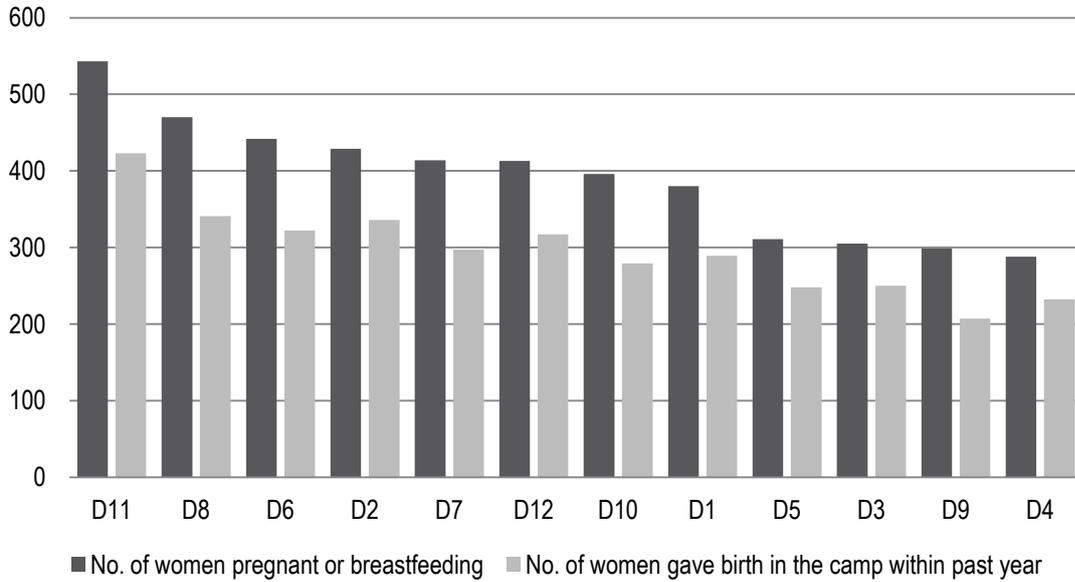
⁶³ According to UNICEF, in Za'atari camp in 2014 a total of 3,728 pregnant women received one dose of Tetanus Toxoid, and 4,938 received 2 doses, while 5,037 non-pregnant women received one dose and 10,814 received two doses.

⁶⁴ Recall bias may have affected the accuracy of responses received for self-reported questions due to participants with an unreliable memory of past events

⁶⁵ 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.

⁶⁶ According to feedback from data collectors, male household members expressed that they were uncomfortable discussing the topic of maternal health as this infringed on the privacy of female household members. For this reason, it may be that in some cases male respondents did not feel that it was appropriate to share this information.

Figure 17: Number of pregnant/breastfeeding women and women who have given birth in Za'atari camp within the past year, by district

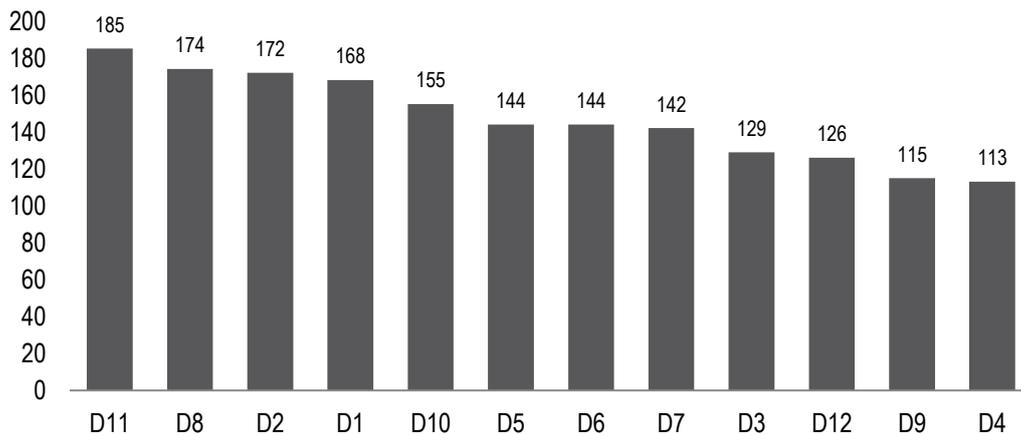


The vast majority of households where women were reported to have given birth within the past year had only one woman living in the household falling into this category (97.1% of households), followed by households containing 2 women who had given birth in the camp within the past year (2.6% of households) and then those with 3 women who had given birth in Za'atari in the past year (0.3% of households).

A similar pattern can be observed across all districts for the number of pregnant and breastfeeding women cited by households, but with a slightly greater number of women in every district. The highest number of women who were pregnant or breastfeeding was found in District 12 (543 women), which correspondingly had the highest number of women who had given birth to a baby in the camp within the past year. The lowest rate of pregnant and breastfeeding meanwhile was found in District 4 with 288 women. Once again, the overwhelming majority of households with women who were pregnant or breastfeeding only contained one woman falling within this category (96.7% of households) followed by households with two women who were either pregnant or breastfeeding (3% of households).

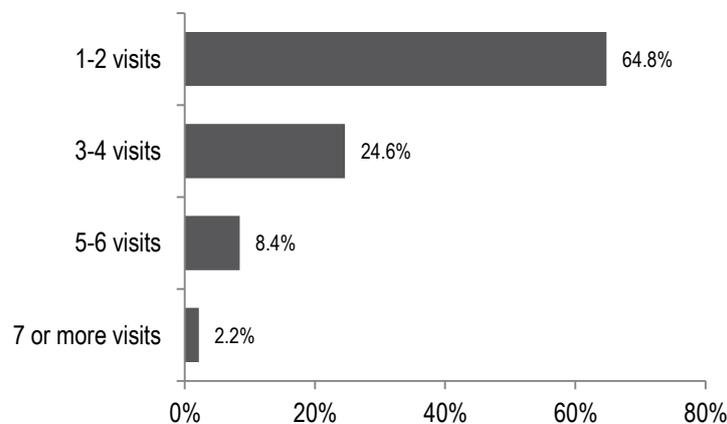
According to UNICEF, mothers and newborns should receive postnatal care in the health facility for at least 24 hours after birth. If their birth takes place at home, the first postnatal contact should be as early as possible within 24 hours of birth. At least three additional postnatal contacts are recommended for all mothers and newborns, on day 3 (48–72 hours), between days 7–14 after birth, and six weeks after birth. These visits address the care for both the mother and newborn.

Figure 18: Number of women reporting having received any post-natal visits within 6 weeks of delivery, by district



In total, 1,767 women⁶⁷ were reported as receiving one or more post-natal visits within 6 weeks of delivery.⁶⁸ The district with the largest number of women who had received at least one post-natal visit within 6 weeks of delivery was District 11 with 185 women recorded, followed by District 8 with 174 women. The district with the least women reported as having received a post-natal visit was District 4 with 113 women, followed by District 9 with 115 women. Of these women the majority (64.8%) had received one or two post-natal visits within 6 weeks of delivery, followed by 24.6% who had received 3-4 visits. Given that the target for each woman is 3 post-natal visits, just under a quarter of women who had given birth in the camp within the past year (24.6%) received the recommended number of visits.

Figure 19: Number of post-natal visits received by women, of women who gave birth in Za'atari camp within the past year

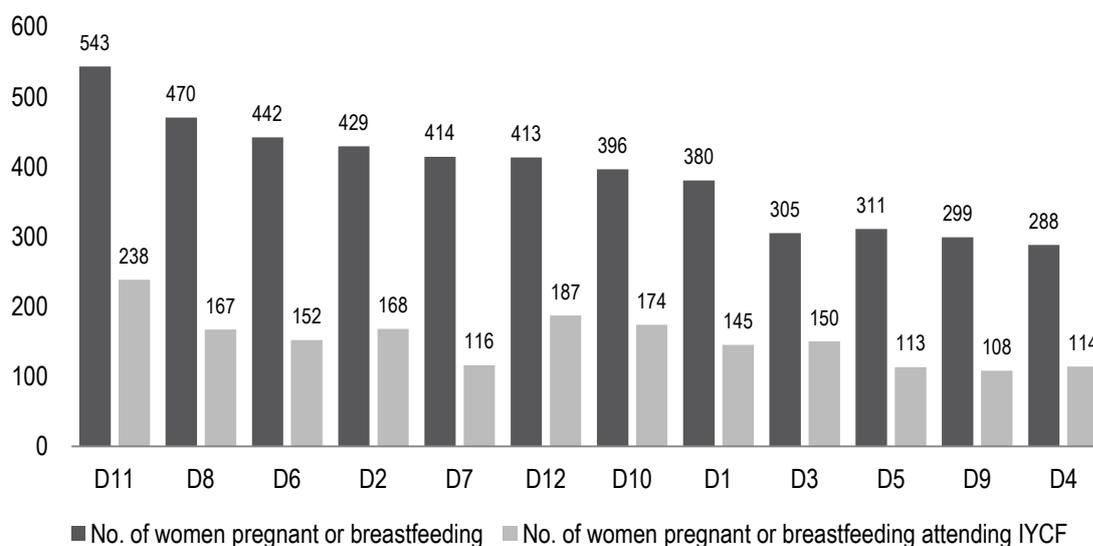


Infant and Young Child Feeding (IYCF) programmes in Za'atari camp provide nutritional support and guidance to mothers, including breastfeeding promotion, complementary child feeding, one-to-one counselling, and health education sessions for pregnant/lactating women. Thus far, three IYCF caravans have been established in Za'atari camp in District 3, 4 and 8. In addition to providing these services, routine vaccinations for children under 5 and Tetanus Toxoid vaccines are also offered. In 2014, UNICEF recorded 8,208 first time visits to IYCF caravans in Za'atari camp and 2,456 mothers receiving initial counselling.

⁶⁷ According to UNHCR data, the total number of women who received post natal visits was 3,776 between January and June 2013. For 2013 a total of 1,628 women received post natal visits.

⁶⁸ 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 20: Number of pregnant or breastfeeding women attending Infant and Young Child Feeding (IYCF), by district



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 129,342 Syrian children are enrolled in public schools across Jordan in the school year 2014/2015; of these 23,227 enrolled in schools in the 3 refugee camps (Za'atari, EJC and Azraq) and 1,500 children are attending public kindergartens.⁶⁹ 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. The number of out-of-school children in Jordan is considerably high, with close to 60,000 Syrian children reported as lacking access to learning opportunities.⁷⁰ This assessment found that 26,091 school-aged children are currently living in Za'atari camp.

There are currently four schools in Za'atari camp operating on a double-shift system, with girls attending in the morning and boys attending in the afternoon. These include two schools in District 3, the Saudi school in District 5 and the Qatari school in District 8. The construction of two further schools funded by the Kuwaiti government is under way in Districts 3 and 12, while a school located in District 7 is soon to be completed. In addition to formal schooling, a number of NGOs provide various types of informal education in Za'atari camp, including basic learning, technical skills/post basic education and recreational activities and there are Child Friendly Spaces (CFS), Adolescent Friendly Spaces (AFS) and Multi-Activity Centres (MAC).

Between May and July 2014, REACH conducted a Joint Education Needs Assessment (JENA) in Za'atari camp in partnership with UNICEF⁷¹, designed by the Education Sector Working Group (ESWG) in close collaboration with the Ministry of Education (MoE), to identify immediate education sector response priorities. The assessment provided an analysis of the needs, motivations, activities, perceptions and priorities of Syrian refugee children aged 3 to 18 years and their parents. The study looked at formal and informal education in the camp, as well as disability and inclusive education. The Comprehensive Child-Focused Assessment aims to update some of the quantitative data gathered during the JENA assessment and to fill further information gaps relevant to education programming. Below is a glossary of terms adopted by the ESWG which will be used in this section of the report.

⁶⁹ UNICEF, [Children of Syria](#), 2014.

⁷⁰ Ibid.

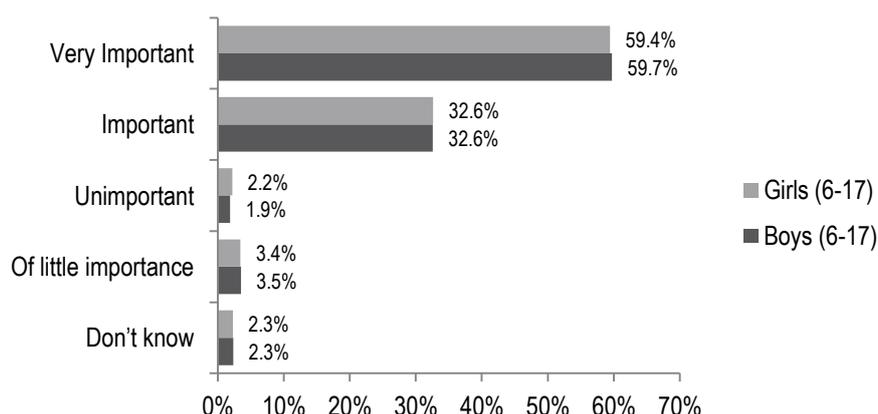
⁷¹ REACH/UNICEF, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

Table 9: Education Sector Working Group Glossary of Education Terms, January 2015

Glossary – January 2015: ESWG, 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 in Za'atari camp but no longer attending
Out of School	School-aged children not attending school, including those who have never attended school in Za'atari 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.

In order to gauge 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. The results revealed that there was very limited disparity in perceptions of the importance of females and males following a certified education pathway. The vast majority of respondents considered that it was either important or very important that boys (92.3%) and girls (92%) had a certified education pathway, indicating positive perceptions towards formal education. Only 3.5% of respondents considered that a certified education pathway was of little importance for boys, followed by 3.4% selecting this response for girls, while a minority of respondents indicated that they thought a certified education pathway was unimportant (see Figure 21).

Figure 21: How important is it that school-aged girls/boys (6-17 years) have a certified education pathway? ⁷²



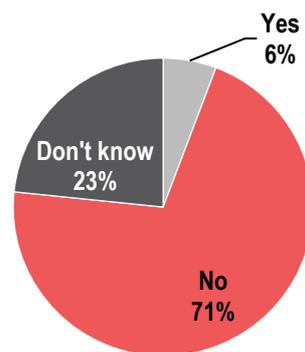
This key finding is encouraging given the vital role that parents play in influencing the educational path taken by their children and suggests that the majority of parents understand the importance of formal education in shaping their children's future prospects, and highlights that there is strong demand for certified education to be provided

⁷² This question was asked of the head of household wherever possible. If the head of household was not present or available then a respondent of 18 years or more was asked to participate in the survey.

for girls and boys living in the camp. In the JENA, when asked to rate the importance of education in general, there were also positive perceptions with 82.3% of 12-17 year olds expressing that school is either 'important' or very 'important'. However, despite high demand for formal education from parents, just over a third of all children are still reported to be out-of-school. Reasons for missing school identified in the JENA assessment included family responsibilities, work responsibilities, bad weather and other recreational activities. In JENA FGDs with out-of-school children, some children mentioned family responsibilities taking priority while other stated that they would not benefit from attending school due to perceived poor quality of education, despite the fact that they were very enthusiastic about learning. Other out-of-school children expressed a sense of the pointlessness of education as they had limited hope for their future prospects. Distance to school was another major factor found to affect reported formal attendance across the camp, with children living further from schools less likely to attend.⁷³

The majority of parents (71%) had not attended a structured recreational session with their children. In almost a quarter of households (23%) it was not known if parents had attended a structured recreational session or not, indicating that there may be a lack of awareness about these sessions and what they entail, which may also explain the low proportion of parents reporting that they had attended at least on structured recreational session (6%). This finding is one indication of a low level of engagement among parents in their children's education. Of those parents who had attended a structured recreational session the vast majority (76.9%) had attended one session only in the last month, followed by 12.9% who had attended two sessions, while a further 2.3% had attended a total of three sessions. 7.3% who had previously attended at least one structured recreational session did not attend any in the month prior to the assessment.

Figure 22: % parents attended a structured recreational session in the last month



Formal Education

According to assessment findings, reported education attendance in Za'atari camp has increased from 51.6% in the last JENA in 2014 to 64.6% of school-aged children (33.0% girls, 31.6% boys 6-17 years).⁷⁴ This means that 35.4% of all school-aged children in the camp are still out of school, although this is an improvement on the 48.4% of out-of-school children identified in JENA. However, a caveat to these findings is that they are set against a trend of diminishing attendance rates for formal education in Za'atari camp. According to MoE the rate of enrolment for formal education in Za'atari camp has remained at 20,081 between September 2014 and April 2015, yet figures from Save the Children Jordan show that attendance rates have dropped from 15,979 in September 2014 to 13,051 in April 2015.⁷⁵ This assessment recorded a total of 16,862 school-aged children as attending formal education, representing 2,867 more children than were reported in Save the Children's formal attendance figures. Notably, Save the Children's attendance figures were reported by teaching assistants working in the formal schools in Za'atari camp while the figures included in this assessment were reported by parents. The disparity between these figures may therefore be explained by parents reporting on the total number of children who were enrolled in school, rather than only those who were actually attending, with some

⁷³ REACH/UNICEF, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

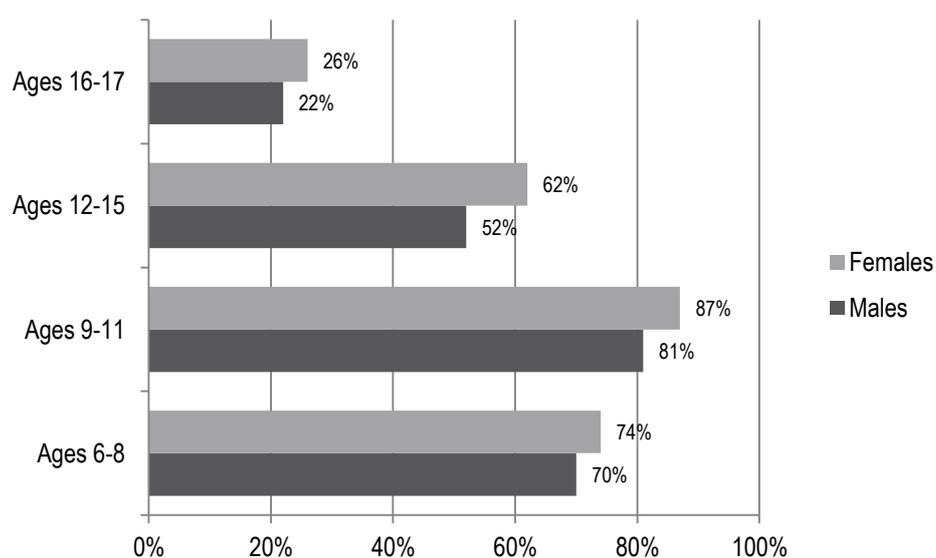
⁷⁴ It should be noted that overall, according to MoE data attendance has been recorded by UNICEF as diminishing between September 2014 and April 2015.

⁷⁵ MoE and Save the Children Jordan, Attendance trend in Za'atari camp, September 2014 – April 2015.

parents likely to be unaware of children in their household who are missing school. Alternatively, parents who had pulled children out of school to take on other responsibilities, such as work or domestic chores may have not felt comfortable reporting that their children were not attending. With regards to decreasing formal attendance, Save the Children Jordan have explained that harsh weather conditions were a major factor contributing to diminishing attendance rates over the winter period, exacerbated by distance to school and no electricity in schools meaning limited heating. Child labour was also linked to decreasing formal attendance figures. Given that the refugee crisis in Jordan is protracted and in some cases savings are now limited, some families are resorting to negative coping strategies, including sending children to earn money in order to contribute to needs and expenses.⁷⁶

Reported attendance was considerably higher for girls at 68% compared to boys 62%, and across all age categories, with the sex difference least pronounced in the age groups 6-8 years and 16-17 years. JENA findings identified the same pattern of higher reported attendance among girls, although with a greater disparity according to sex.⁷⁷ Assessment findings indicate that children aged 9-11 years represented the age group with the largest proportion of girls and boys attending formal education. Meanwhile, girls and boys aged 16-17 were the least likely to attend. These results show that reported attendance decreases with age after 9-11 years, with the sharpest drop in attendance for both sexes between the 12-15 and 16-17 age groups (see Figure 23). As there is a sharp decline for children aged 12 and above, this group is more vulnerable to dropping out and thus education programmes should focus on this age group.

Figure 23: % children reported as attending formal education, by age and sex



While the overall school attendance rate of 64.6% represents an improvement on the JENA in 2014 (51.6%), there remains a need for continuing interventions to address the lower reported attendance among older age groups and the disparity in attendance between girls and boys, with over a third of school-aged children still out of school in Za'atari camp. Targeted interventions should aim to attract more boys to join formal education, particularly among older age group that are currently underrepresented, and should reduce the rate of drop-outs leaving formal education, with a special focus on children aged over 12 years.

When school attendance is further disaggregated by district, reported attendance varies from 54.0% in District 7 to 75.2% in District 1 (see Figure 24).⁷⁸ As in JENA, findings from this assessment indicate that reported attendance is generally higher in the old camp districts where refugees have been settled for longer, and therefore have more established lives, with attendance in Districts 1 and 2 significantly above the camp average at 75.2% and 74.4% respectively. Furthermore, distance to school is another key factor that has been found to influence attendance rates. The fact that District 7 is located the furthest distance away from schools in Za'atari

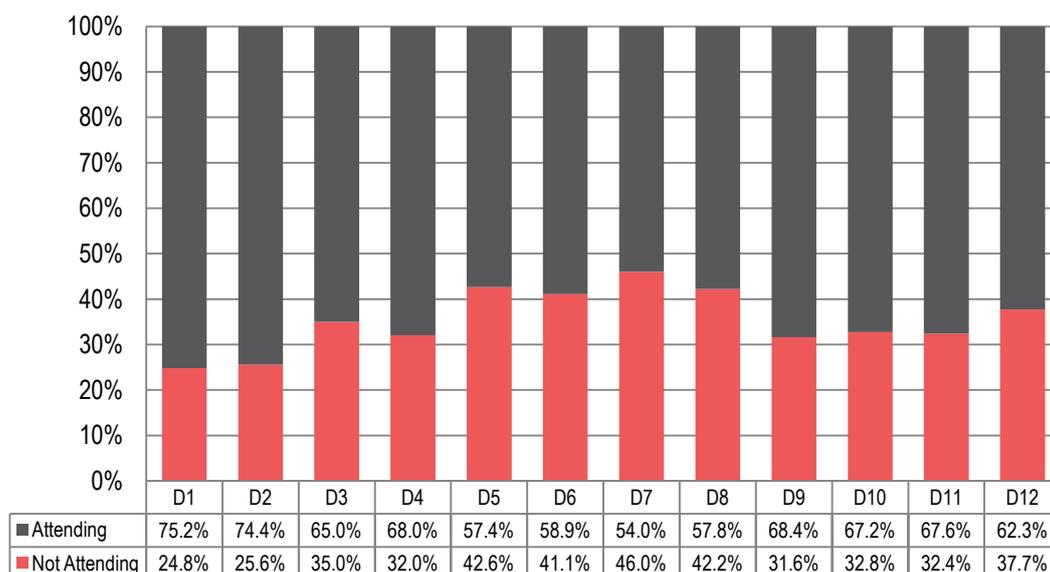
⁷⁶ Information provided by Save the Children Jordan.

⁷⁷ REACH/UNICEF, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

⁷⁸ UNHCR attendance figures for District 7 in April 2015 were 48%.

camp (800m+ from nearest school) helps to explain why it has the lowest reported attendance for formal education, meanwhile Districts 1 and 2 are both older districts and within close proximity to the Bahraini school.⁷⁹

Figure 24: Reported formal education attendance among all school-aged children (6-17 years), by district



To further contextualise findings, JENA found that for boys and girls aged 6-17, the two key reasons for attending school were to learn and gain knowledge and to receive certification. Of 6-11 year olds, 82% stated that learning or gaining knowledge was the main reason for attending school, while 82.8% of girls aged 12-17 and 70.7% of boys aged 12-17 identified this as the main reason.⁸⁰ Improving future job prospects was the third most commonly cited reason for both girls and boys.

Out-of-School Children

Overall 35.4% of school-aged children were found not to be attending formal education. This is a considerable improvement on the 48.4% of school-aged children identified as out-of-school by JENA. Of the 35.4% children in the camp currently not attending school, 80% had never attended and 20% had dropped out. This is compared to 75% of out-of-school children recorded in JENA as never attending school in Za'atari camp and 25% reported as dropping out. There was very little disparity between girls and boys, as shown by Figures 25 and 26 below. Some 79.6% of girls aged 6-17 were reported as never attending compared to 80.3% of boys. However, analysing drop-out rates by age shows that there was some variation across different age groups (see Figure 26).

The drop-out rate was substantially lower for 6-8 year olds than any other age group at only 5.3%. The 94.7% of children in this age group, who have never attended school, yet are still eligible to attend having missed less than 3 years, points to a continued need for outreach campaigns and activities designed to attract and integrate children into the formal system from an early age. Drop-out rates were almost equivalent for age groups 9-11 and 12-15 with 26.2% and 26.3% respectively, but decreased to 21.7% for children aged 16-17 years.

For JENA focus group discussions (FGDs) were conducted with children who had dropped out of school. The majority of these children reported that they had siblings who were still attending school and often explained that these siblings were either in lower grades or were male, and therefore the family prioritised their education. Many FGD participants considered that dropping out was a negative experience as they felt bored without school, and missed the opportunity to meet and spend time with other children. For some, losing the structure and purpose of school after all their other losses was extremely difficult.⁸¹ In the JENA, children who had never attended school in Za'atari camp were asked if they would like to go to school. The result was that the vast majority of the girls said yes but that boys were more divided in opinion. Boys' reasons for never attending school included general

⁷⁹ UNICEF/REACH, Map of Za'atari Camp Distance to School, January 2015.

⁸⁰ UNICEF/REACH, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

⁸¹ Ibid.

barriers to education such as family responsibilities, negative perceptions of poor quality of education in the camp, and the general impression that education was pointless.⁸² JENA findings indicated that 89.9% of parents of school-aged children reported that they perceived education as either 'important' or 'very important'. As part of JENA, parents' perceptions of formal education were explored in FGDs during which parents stated that discipline had improved, homework was now being given and had previously not been, and that students were now more motivated to attend.⁸³

Figure 25: Proportion of out-of-school girls and boys (6-17) who have never attended or dropped out of school

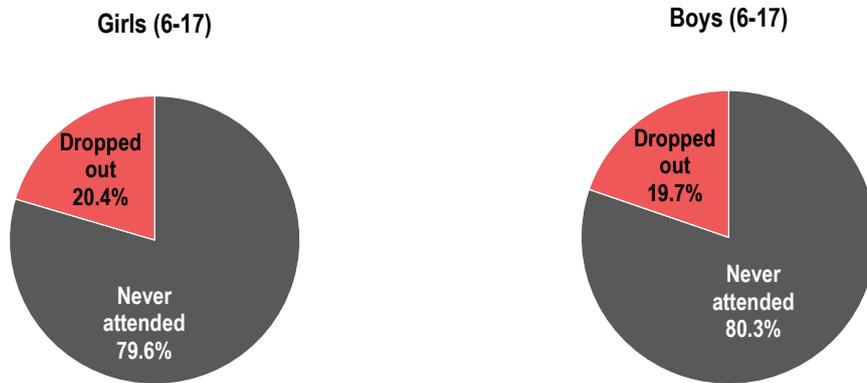
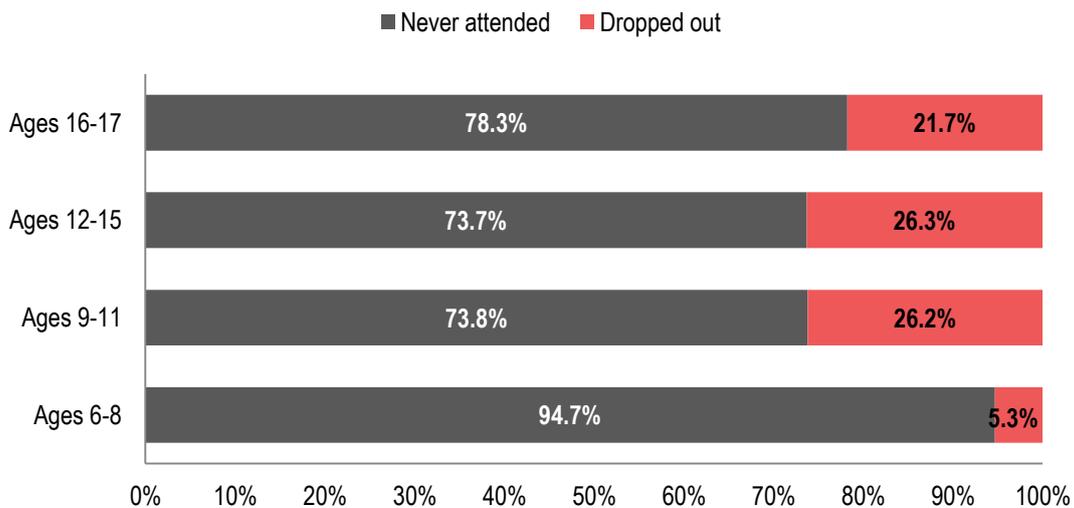


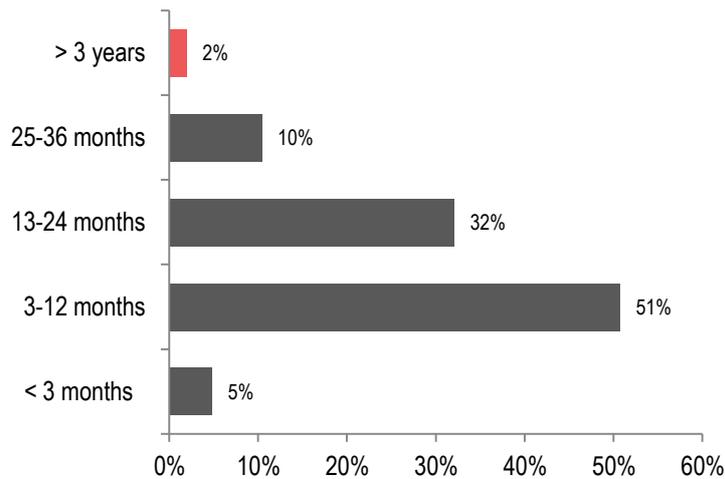
Figure 26: Proportion of out-of-school children who have never attended or dropped out of school, by age



⁸² UNICEF/REACH, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014

⁸³ Ibid.

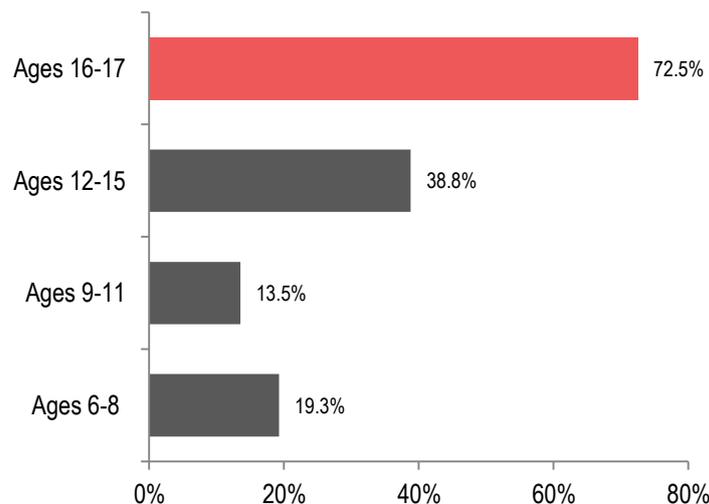
Figure 27: Number of months missed for out-of-school children who have attended but dropped out



Of the 20% of out-of-school children who had attended but dropped out only 2% had missed more than 3 years of school, indicating that 98% of these children are still eligible to attend school. Furthermore, the majority of out-of-school children who had dropped out (51%) were reported to have missed 3-12 months. This underlines the importance of continued outreach initiatives, catch-up classes and other programmes aimed at reintegrating out-of-school boys and girls into the formal education system in Za'atari camp – specifically the 98% of the 20% out-of-school children who dropped out and are still eligible to rejoin formal school.

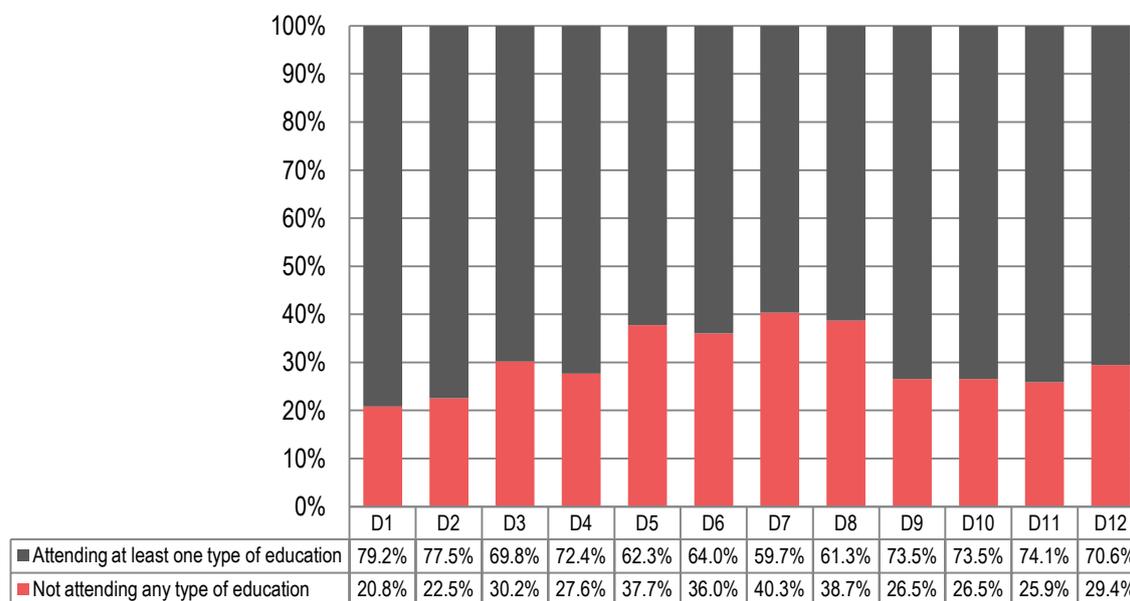
Overall, 30% of school aged children living in Za'atari camp were reported as not attending any type of education (including formal, informal education and CFS/AFS/MAC). This finding highlights that there remains a large number of children who are not currently accessing any learning opportunities, and are therefore particularly vulnerable and at a disadvantage to their peers. The majority of these children fell into the age group 16-17 years at 72.5%, as figure 28 shows, mirroring lower reported attendance of formal education among this demographic.

Figure 28: % Out-of-school children 6-17 years who are not currently attending any type of education, by age group (of total children who are not attending any type of education)



When analysing the data by district, it can be observed that a higher proportion of school-aged children living in the new camp districts are reported as not attending any type of education, peaking at 40.3% in District 7. Again, it is likely that the distance of District 7 from the schools in Za'atari camp has affected the lower attendance for formal education, and thus knowledge and awareness of other learning opportunities. In order for this gap to be closed, there is a continued need for back-to-school campaigns and other educational initiatives geared towards further outreach and integration, particularly across Districts 5, 6, 7, and 8.

Figure 29: % school aged children (6-17 years) not attending any type of education, by district



Informal Education

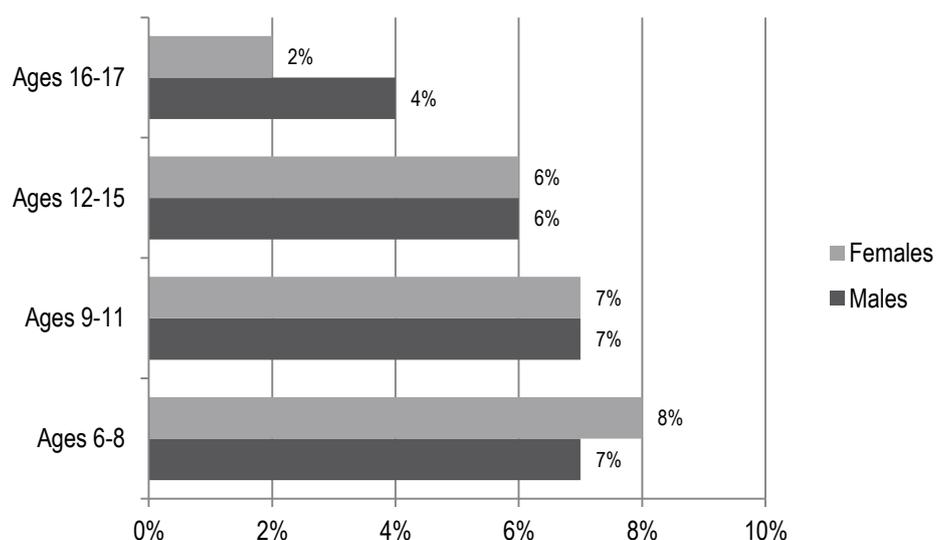
Informal education (IFE) in Za'atari camp incorporates basic learning, technical skills/post basic education and recreational activities. Education in mosques⁸⁴ was included as an additional category during the CCFA, as it was in JENA, given its importance in the Za'atari camp context, a strong interest from the Za'atari Education Sector Working Group, and the JENA finding that it was the most commonly attended type of IFE by school-aged girls and boys.⁸⁵ During JENA FGDs participants of IFE programmes expressed very positive perceptions, describing IFE programmes as offering a safe and friendly space, a place to seek advice or guidance, and an opportunity to participate in recreational activities including art, sport and music among other benefits.

According to assessment findings, 6% of school-aged children were currently attending at least one type of informal education. Overall, 7% of out-of-school children were found to be currently attending IFE, which contrasts with the JENA, that identified 20% of out-of-school children aged 6-17 years to be attending IFE. This disparity may be attributed to the higher percentage of children now reported as attending formal education, with an increase of 13% from the formal attendance figure recorded in JENA. The age group with the largest proportion of girls attending informal education was 6-8 years at 8%, while for boys it was equivalent for age groups 6-8 and 9-11 years at 7%. While more females were reported as attending informal education in the youngest age group, this trend was reversed for the oldest age group (16-17 years) with the proportion of males attending double that of females. Reported IFE attendance for both boys and girls are shown to decline with age, reflecting the same trend in reported formal education attendance among older children, as was observed in JENA. Although further exploration is required, this may suggest that older children have additional responsibilities outside of school, such as work or domestic labour, which reduce their likelihood of attending informal education. Alternatively, it could be an indication that these opportunities are targeted toward younger children or that activities designed for older children are less appealing.

⁸⁴ According to JENA FGD findings Mosques offered a range of learning opportunities to boys and girls in addition to Qur'anic study, including general education, with subjects such as Arabic, history and sport being taught, in addition to offering vocational education.

⁸⁵ REACH/UNICEF, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014

Figure 30: % children reported as attending informal education (IFE), by age and sex



Despite IFE programmes generally being targeted towards out-of-school children who are unable or unwilling to attend formal education, over half of the children who were reported to be attending IFE were also attending school (60%).

In order to increase attendance of IFE programmes, education actors should address potential areas for improvement highlighted by JENA including WASH provision, verbal and physical violence on the way to/from IFE centres, other students using bad language at the centres, high teacher turnover, and IFE centres being too far away from homes.⁸⁶ It should be noted that a lack of physical and verbal violence from teachers working in IFE programmes, compared to those in formal schools, was identified in JENA FGDs by children who had dropped out of school as a reason for attending IFE as an alternative to formal education.

Type of IFE

Of children attending IFE 16% were found to be attending multiple types of IFE. Education provided in mosques was found to be the most popular type of IFE attended by children at 47.4%. This was also a key finding in JENA, where FGDs conducted as part of the assessment revealed that programmes in mosques were attractive to children as they offered a range of learning opportunities to boys and girls including general education, with subjects such as Arabic, history and sport being taught, in addition to offering vocational education, such as sewing classes. Further, children attending this type of education mentioned that they received certificates, and there were awards for the best students, while parents reported that they were comfortable with sending their children to mosques due to the added value of the 'religious atmosphere' of the learning environment'.⁸⁷

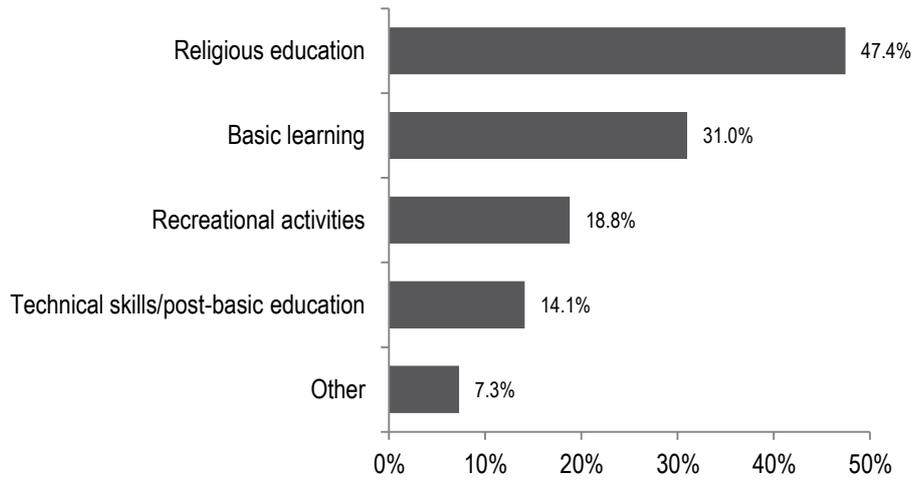
Community leaders who participated in FGDs reported that the main advantage of religious education over formal education was the religious atmosphere provided, however they also explained that classes could be overcrowded and that funding was limited. In JENA it was also reported by a large number of children that there were sometimes financial incentives for children to attend religious education classes.⁸⁸ Religious education programmes were said to be financed through private institutions, including the Qatari RAF foundation.

⁸⁶ In JENA children reported that some Quranic schools gave 15JD as motivation to attend, as well as the chance to receive money for memorising the Qur'an.

⁸⁷ REACH/UNICEF, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

⁸⁸ REACH/UNICEF, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

Figure 31: % children aged 6-17 reported as attending informal education (IFE), by each type



The second most commonly attended type of IFE was Basic learning, which incorporates educational activities such as maths and literacy classes, with 31.0% of all IFE attendance, followed by recreational activities at 18.8% and technical skills/post-basic education at 14.1%. Once findings are disaggregated by age and sex some disparities in attendance can be observed between the different types of IFE.

Figure 32: % girls attending each type of informal education (IFE), by age (of total girls 6-17 attending IFE)

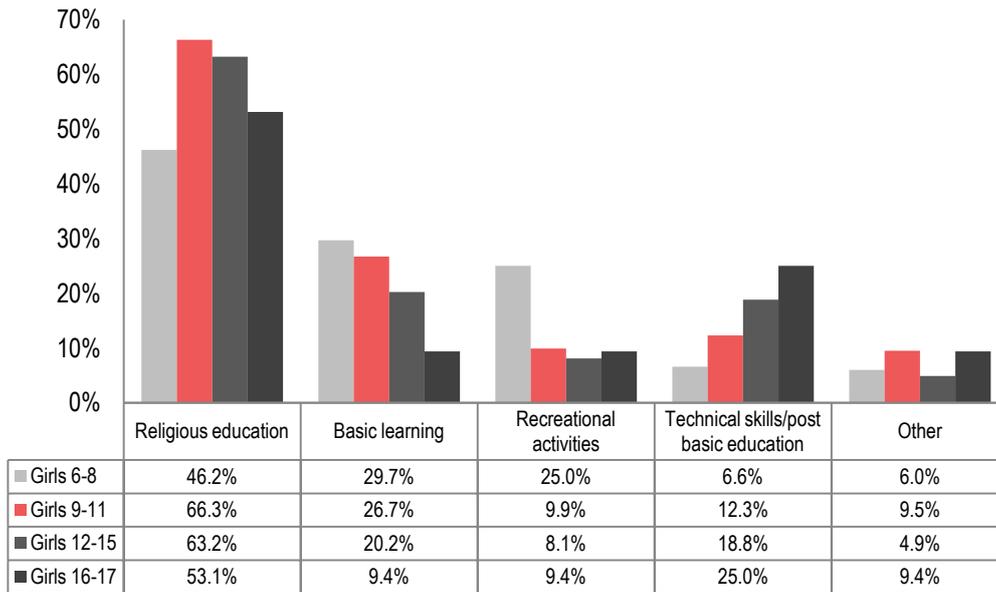
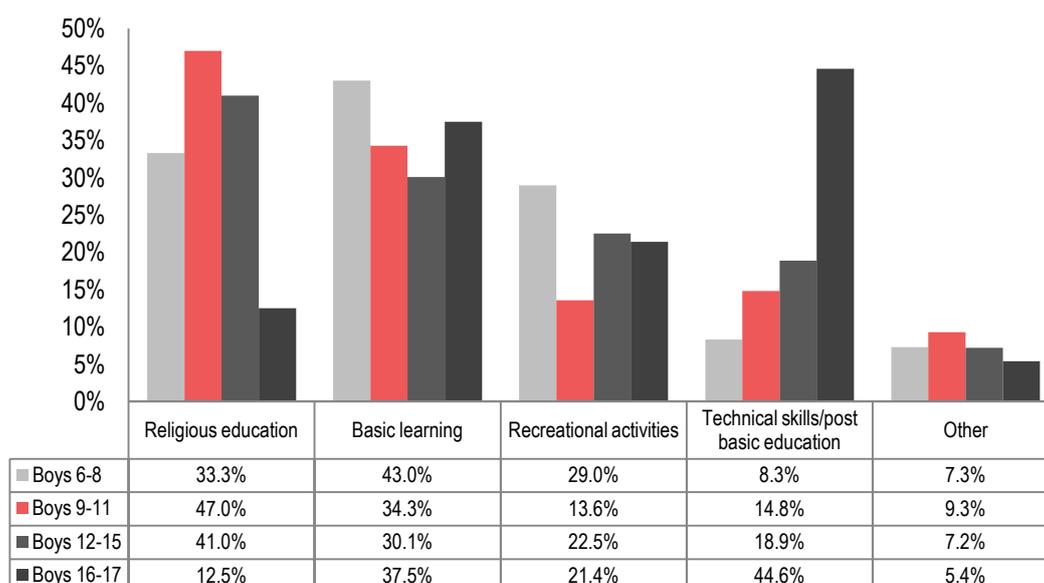


Figure 33: % boys attending each type of informal education (IFE), by age (of total boys 6-17 attending IFE)



The proportion of girls attending religious education was higher than that of boys, peaking in the 9-11 age group at 66.3% (see Figure 32). Reported attendance for religious education decrease after ages 12-15 for both boys and girls, a finding that is corroborated by JENA FGDs in which participants explained that the cut-off point for children’s classes was around 14 or 15 years.⁸⁹ One finding that stands out is boys aged 16-17 years who have a comparatively high reported attendance for technical skills/post basic education at 44.6% (see Figure 33). Participation in recreational activities was notably high for both boys and girls falling within the age bracket 6-8 years with 29% and 25% respectively. It is self-evident that many recreational activities will be suitable for children of a younger age, while technical skills/post basic education is more likely to be tailored towards older children at a more advanced stage of development. Religious education and basic learning, meanwhile, may have a more universal appeal.

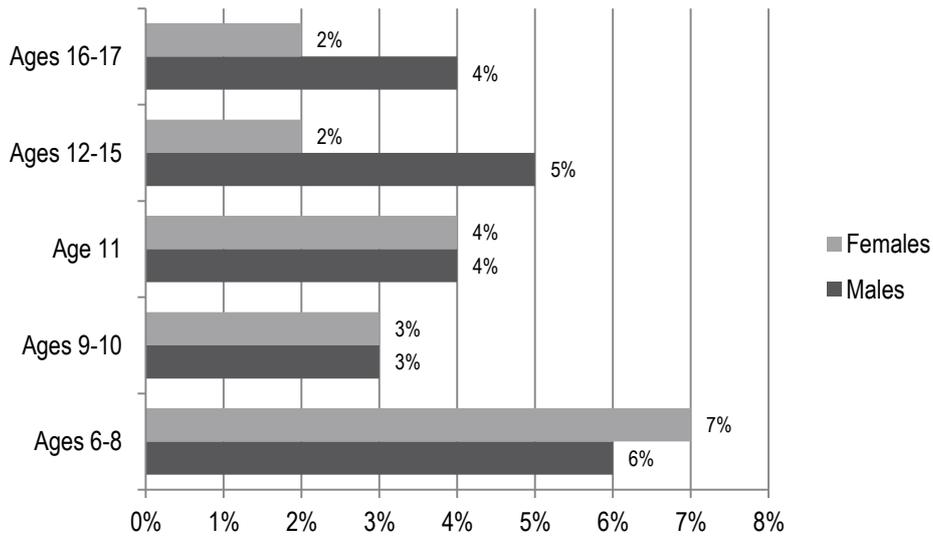
Child Friendly Spaces, Adolescent Friendly Spaces, and Multi-Activity Centres

There are numerous Child Friendly Spaces, Adolescent Friendly Spaces and Multi Activity Centres located throughout Za'atari camp, run by the organisations Save the Children International, International Rescue Committee (IRC), Mercy Corps and International Medical Corps. 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.⁹⁰

⁸⁹ REACH/UNICEF, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

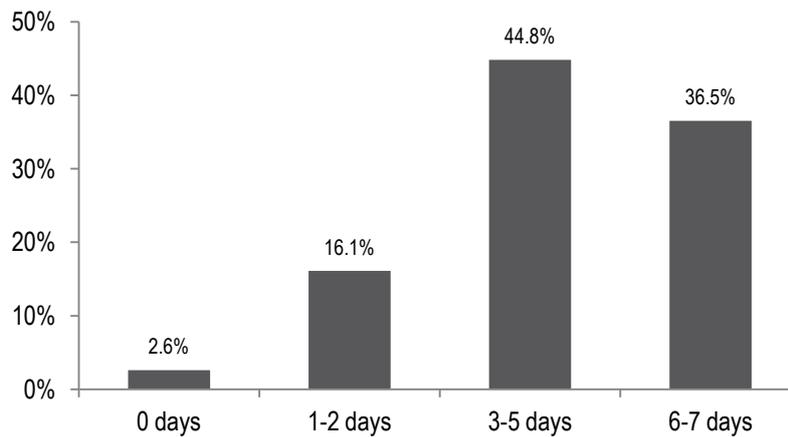
⁹⁰ UNICEF, *A Practical Guide for Developing Child Friendly Spaces*, 2009.

Figure 34: % children aged 6-17 reported as attending CFS/AFS/MAC, by age and sex



Assessment results indicate that the highest rates of attendance for CFS/AFS/MAC were among the youngest age group of children aged 6-8 years with 6% of boys and 7% of girls (517 individuals) in this age category reportedly using these centres. This is likely to be due to these facilities being particularly suitable for children at a less advanced stage of education. This was followed by males aged 12-15 years at 5% (216 individuals), and then males and females age 11 at 4% (81 individuals) and males aged 16-17 years also at 4% (59 individuals). Respondents were then asked how many days each child had visited the CFS/AFS/MAC in the last 7 days. Most users of CFS/AFS/MAC were reported as visiting them on a regular basis, with the most commonly cited response 3-5 days a week at 44.8% followed by 36.5% reported as attending 6-7 days in the last week (see Figure 36).

Figure 35: Number of days children aged 6-17 attended CFS/AFS/MAC in the last 7 days



DISABILITIES AND DEVELOPMENTAL DELAY

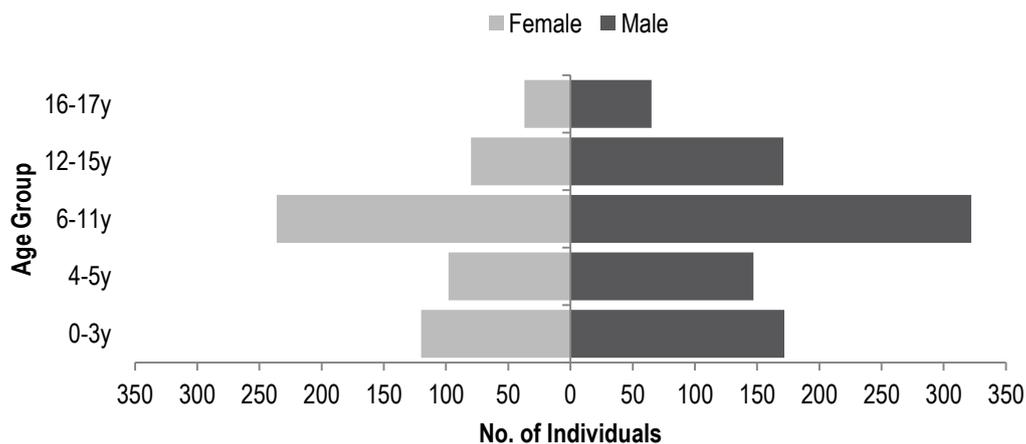
To ensure the delivery of a humanitarian response that is appropriate and accessible to people with specific needs, it is essential that information on children with disabilities and developmental delay is used to inform future assistance and services in Za'atari camp. This assessment aimed to facilitate the pre-identification of boys and girls with risk factors for disabilities or developmental delay which will be referred to partners for assessment and referral using Washington Group-UN Statistics Division definitions, approved by GoJ. Due to the small number of children with disabilities included in the JENA 2014 household sample (124 individuals), children with disability (CWD) and education related data from the assessment could not be generalized. However, the increased scope of the CCFA, which accounted for every household unit in Za'atari camp, provides for representative CWD findings.

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, 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.⁹¹ All data collectors were trained 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.

Figure 36: Reported number of children with disabilities or chronic illness, by age/sex



In total 3.3% of children (1,448 individuals) were reported to have at least one disability and/or a chronic illness. 89% of these children had either a chronic illness or one disability only, while the remaining 11% were reported to have more than one disability and/or chronic illness. The largest proportion of children was reported to have a chronic illness, with a total of 664 individuals. This may be due to the term chronic illnesses incorporating a wide

⁹¹ WHO, [Noncommunicable diseases](#), March 2015.

range of other non-communicable diseases, including asthma which is a common disease among children.⁹² The most commonly reported type of disability was permanent physical disability with 274 children reported in this category, while the least commonly indicated was difficulty with self-care, with a total of 87 children.

Figure 37: Reported total number of children with chronic illness and each type of disability

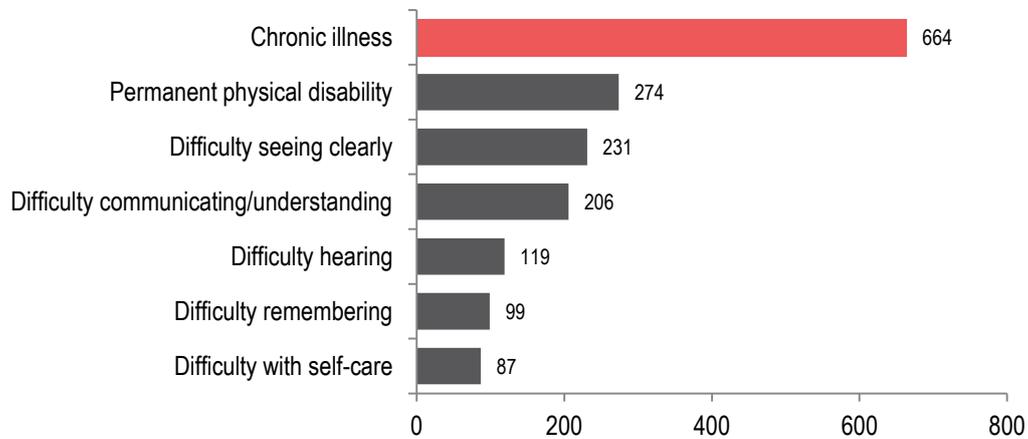
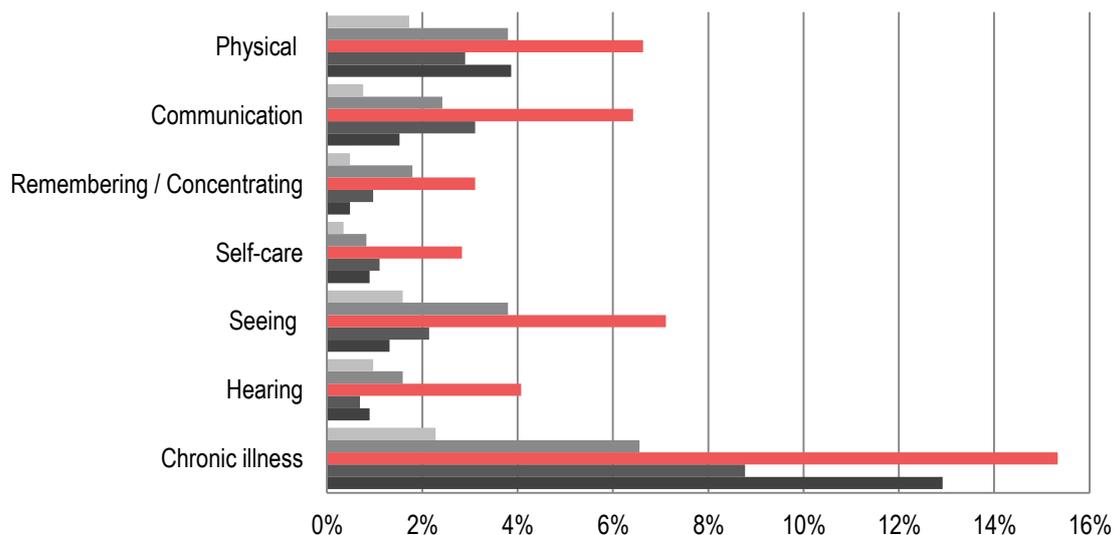


Figure 38: Percentage of children with each type of disability and chronic illness (of total children with reported disabilities), by age



	Chronic illness	Hearing	Seeing	Self-care	Remembering / Concentrating	Communication	Physical
16-17y	2.28%	0.97%	1.59%	0.35%	0.48%	0.76%	1.73%
12-15y	6.56%	1.59%	3.80%	0.83%	1.80%	2.42%	3.80%
6-11y	15.33%	4.07%	7.11%	2.83%	3.11%	6.42%	6.63%
4-5y	8.77%	0.69%	2.14%	1.10%	0.97%	3.11%	2.90%
0-3y	12.91%	0.90%	1.31%	0.90%	0.48%	1.52%	3.87%

Once disaggregated by age it is possible to see that children aged 6-11 are disproportionately affected by disabilities and chronic illness compared to other age groups and across all types of disability reported. Meanwhile, the age group 16-17 had the lowest proportion of children with reported disabilities or chronic illness. It is worth noting that there were a particularly high proportion of infants aged 0-3 years reported with chronic illnesses at 12.91%.

⁹² WHO, [Asthma Key Facts](#), November 2013.

There was some variation across districts with the proportion of children at risk of disability or developmental delay ranging from 2.4% in District 1 to 4.5% in District 11. The proportion children reported with a disability or chronic illness was also higher than average in District 3 at 4.1%.

Figure 39: % children with reported disability or chronic illness, by district

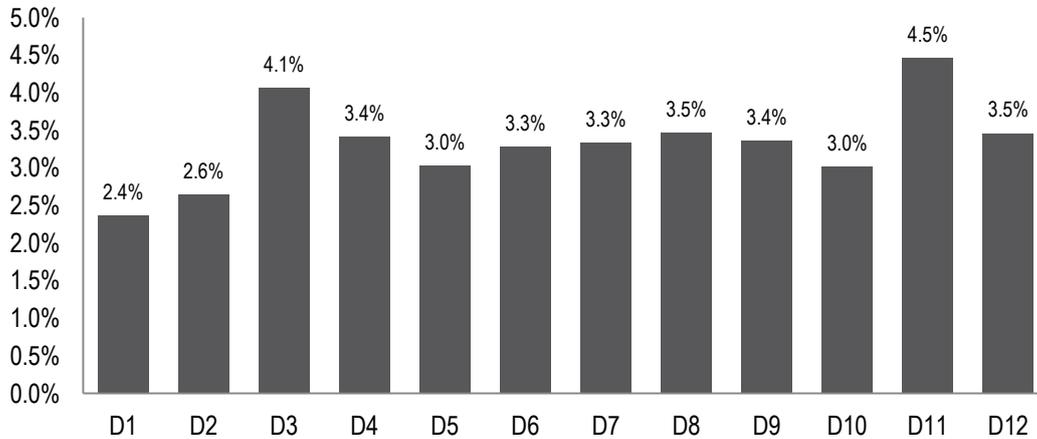
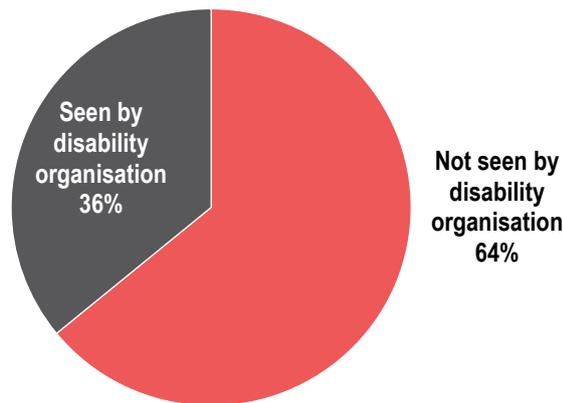


Figure 40: % Children with disabilities (CWDs) previously seen by an organisation providing disability services



As part of the agreed upon referral process, respondents in households with CWDs were asked if the child had previously been seen by any organisation providing disability services (see Figure 41). Results show that the majority of CWDs (64%) were not reported as having received any visits from an organisation specialising in disability, indicating that many CWDs have been overlooked or unidentified, and highlighting an urgent need for further outreach by disability actors, who are able to utilize the referral information gathered during this assessment.

Inclusive Education

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.⁹³ 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.

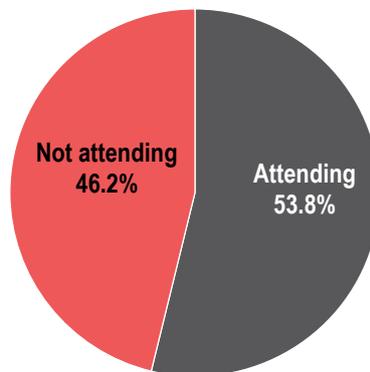
⁹³ UNICEF, [Children of Syria](#), 2014.

During the JENA, FGDs were held with parents and teachers to identify the main barriers to accessing formal education for children with disabilities (CWDs). Findings from FGDs with parents highlighted that challenges for children with disabilities included bullying at school by other students which was the most common response (chosen by 26%), while a further 5% identified loneliness as the top issue. Other issues identified as the main difficulty for CWD attending school as the inaccessibility/unsuitability of the curriculum (16%),⁹⁴ as well as difficulty getting to and from school (16%), difficulty concentrating due to their impairment (11%), and the teacher not being trained to include CWD in the lessons (11%). Parents of 6-11 girls with disabilities also cited distance as the main reason for their non-attendance.

Meanwhile, in the JENA the number one need identified by teachers was the need for specialists, particularly psychologists. Some male teachers discussed how difficult it was to deal with students with behavioural issues, particularly in overcrowded classrooms without specialist staff. They also recommended having a small clinic and a nurse at the school. Female teachers and school counsellors identified the need to have better student records detailing disability information and enhanced communication with parents, given that teachers were not always informed about students' special needs.⁹⁵ The provision of specialist training to assist teachers to identify disabilities, is one option to help address this issue. Such training would allow teaching strategies to be better tailored to match the different learning needs in the class, or alternatively, to refer CWDs to the appropriate disability services made available at schools by other partners.

Of the 911 school-aged children (6-17 years) in Za'atari camp with reported disabilities⁹⁶ or chronic illness, 490 or 53.8% were found to be attending formal education – 10.8% below the camp-wide average reported attendance of 64.6%. In addition, 37 children with reported disabilities or chronic illness were reported to be currently attending informal education and 36 CFS/AFS/MAC. Of the 911 a total of 381 or 41.8% were not attending any type of education.

Figure 41: % of school aged children (6-17 years) with reported disability and/or chronic illness attending formal education



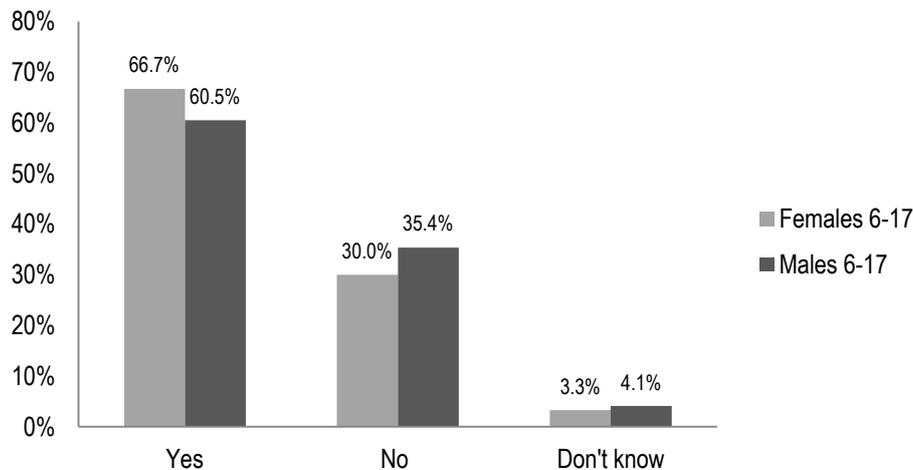
⁹⁴ 'Inaccessible' or 'unsuitable' curriculum could refer to lacking policy for inclusive education teaching strategies and teacher training on inclusive education here.

⁹⁵ UNICEF/REACH, [Access to Education for Syrian Refugee Children in Za'atari Camp](#), September 2014.

⁹⁶ Range of disabilities outlined in the above section.

As part of this assessment, respondents were asked if the main reason for non-attendance among out-of-school children with reported disabilities or chronic illness was due to their reported condition.

Figure 42: Reason child is out-of-school is because of reported disability/chronic illness, by sex



As Figure 43 shows, for the majority of girls (66.7%) and boys (60.7%) at risk of disability or developmental delay, their reported condition was considered the main reason for their out-of-school status. This highlights the urgent need for further interventions to help re/integrate a greater number of disabled children into the formal education system and indicates that there remain barriers to access and inclusive education.

YOUTH

Key findings reveal that an overwhelming majority of youths aged 19-24 have not completed either high school or university with 83.2% selecting this response (see Figure 44). While 10.1% had reportedly completed their secondary education in Syria or Jordan, only a minority of youths (1.6%) had completed university. Notably, 5.2% of youths started university but had to drop out or leave. For many of these youths a lack of education may be attributed to the conflict in Syria interrupting the stages of formal education, putting them at a disadvantage in terms of future job prospects that require a certified education pathway.

Figure 43: % youths aged 19-24 that have completed secondary/tertiary education

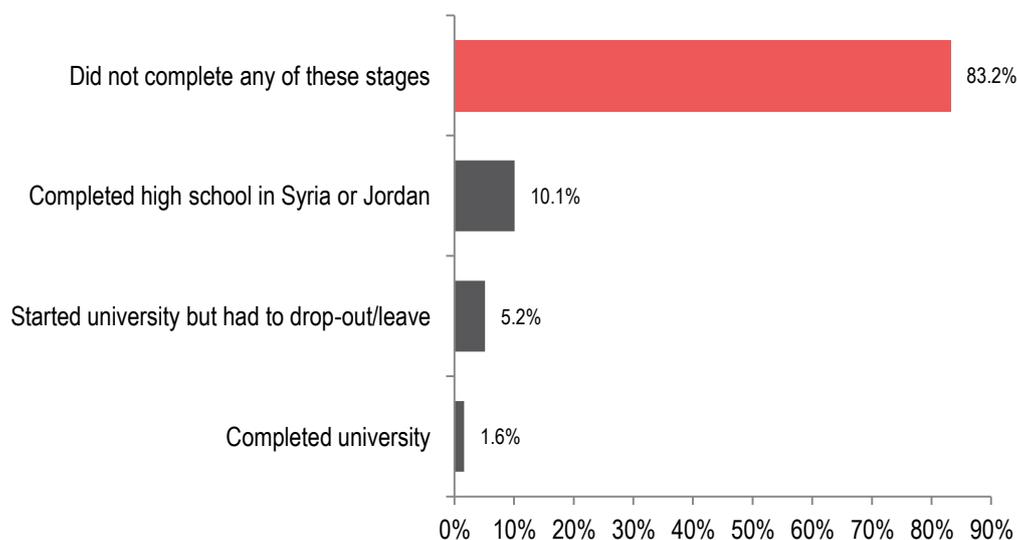
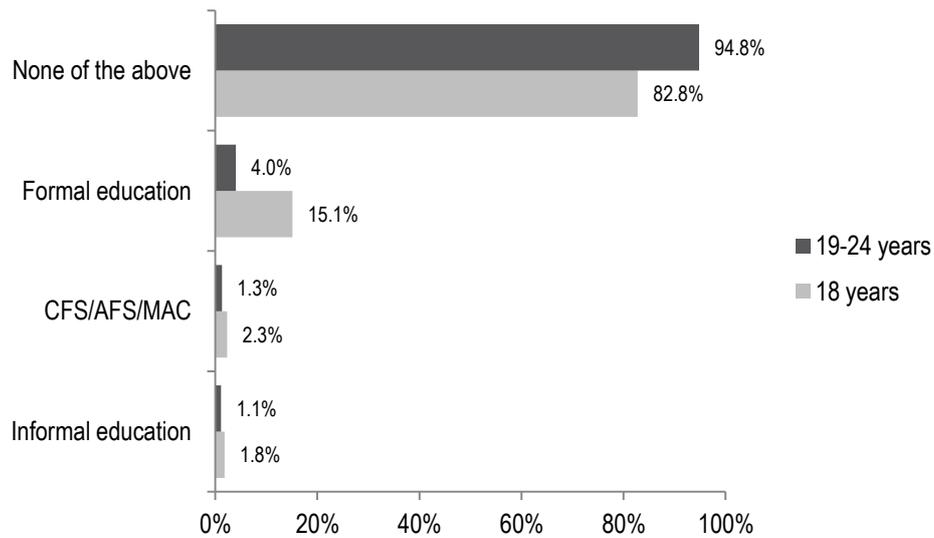
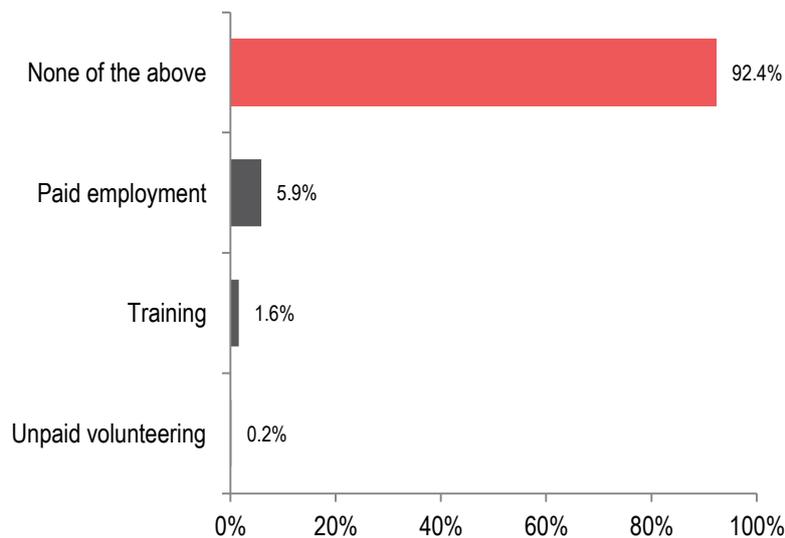


Figure 44: % youths attending different types of education, by age



Similarly, the majority of youths were not reportedly attending any type of education. Reported attendance was highest in both age groups for formal education, followed by CFS/AFS/MAC and then informal education. The 15.1% of 18 year olds and 4% of 19-24 year olds reportedly attending formal education was not expected given that school-age is defined as 6-17 years of age. It may be that these youths have missed a year or more of school so are catching up on their education by attending school in the camp beyond the predefined age range prescribed for formal education. Additionally, 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. In terms of vocational activities, according to assessment findings an overwhelming majority of youths aged 16-24 years living in Za'atari camp were found not to be currently engaged in employment, training or unpaid volunteering (see Figure 45).⁹⁷

Figure 45: % youths aged 16-24 reported as engaged in paid employment, training, or unpaid volunteering



⁹⁷ Employment may be under-reported among youths due to some remunerative activities being illegal or perceived as such. Furthermore, 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. It should be noted that information on youth living in Za'atari camp is scarce and therefore these findings are not comparable with any recent assessments.

Findings show that rates of paid employment were considerably higher among males than females, with 13.8% of males aged 19-24 years currently in employment, compared to a mere 2.2% of females in the same age group. There was also a large disparity between males and females aged 16-18 years, with 0.1% of females in paid employment compared to 7.2% of males (see Table 10). This serves to underscore the importance of further initiatives and interventions designed to engage a higher number of female youths in remunerated work. Indeed male youths were found to have higher rates of participation than females in paid employment and training across both age groups.

Table 10: % youths in paid employment/training/unpaid volunteering by age and sex

Demographic	None of the above	Paid employment	Training	Unpaid volunteering
Females 16-18	98.7%	0.1%	1.1%	0.1%
Males 16-18	89.3%	7.2%	3.3%	0.2%
Females 19-24	96.7%	2.2%	0.9%	0.2%
Males 19-24	84.5%	13.8%	1.6%	0.2%

The vast majority of youths were reportedly unemployed and not engaged in any form of education, presenting a challenge to social cohesion in the camp, with a real risk that this vulnerable group may become frustrated, resort to illegal activities for remuneration, or form gangs in the streets due to a lack of alternative activities, experiencing a sense of exclusion from the wider community. This indicates broad scope for programmes that target disenfranchised youths who are currently not participating in any form of employment, training or unpaid volunteering.

CONCLUSION

Given that children make up over half of Za'atari camp's population and represent one of the most vulnerable demographic groups, they must be carefully considered in programming across all sectors. This report has highlighted that there have been significant improvements in some areas of service delivery, including an increase of 13% in reported formal education attendance compared to the 2014 Joint Education Needs Assessment (JENA), and a reduction in the gender disparity in formal education attendance, as well as high uptake of emergency and routine vaccinations camp-wide. However, while many children and young people living in Za'atari camp were found to 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. In this regard, there is a continued need for efforts to ensure total vaccination coverage and maternal health provision, engaging youths in vocational and learning activities, and achieving higher levels of reported attendance across all types of education.

WASH findings indicate a broad shift away from public facilities towards private ones, as Za'atari becomes a more established settlement and over 60% of people have been resident in the camp for over 2 years. Public WASH centres have become infrequently used as most households have opted build their own WASH facilities for day-to-day hygiene practices. This is likely to be due to private WASH facilities being more easily accessible for household members thanks to their location within the shelter structure, offering a greater degree of privacy, safety and security than public WASH centres. Yet, public water points remain the main source of drinking water for camp residents indicating that the public supply is a vital service that is still relied upon by the majority of households. The biggest challenge to perceptions of public water was found to be health concerns regarding the quality of the water. This is an issue which public messaging designed by UNICEF and other WASH actors in the camp must continue to address.

This report provides key information on uptake of routine and emergency vaccinations in Za'atari camp. Although uptake of vaccines is reportedly high, there is still scope for further outreach as vaccination coverage is still not universal. While the majority of infants are reported as being vaccinated against polio and measles, findings suggest that vaccination campaigns have not achieved even coverage as some districts contain a higher proportion of vaccinated individuals than others. The same applies for women and girls of reproductive age (15-49 years) who have been vaccinated with at least two doses of Tetanus Toxoid.

While almost a quarter of new mothers received the recommended number of post-natal visits, maternal health services are not reaching all the female beneficiaries in need of post-natal support. Findings indicate a demand for further outreach in order to increase rates of post-natal visits received within 6 weeks of delivery and attendance of IYCF, in addition to a need for greater awareness and promotion of routine medical services such as attending antenatal clinics, routine vaccinations and attendance of IYCF.

The educational landscape in Za'atari camp has evolved, and while barriers to accessing learning opportunities in Za'atari camp remain, the overall increase in attendance rates across the camp as compared to JENA findings reflects the success of education actors in improving access to education in Za'atari camp, and highlights the importance of ongoing interventions aimed at integrating the 35.4% of out-of-school children into the formal education system. However, a caveat to these findings is that according to Save the Children Jordan reported formal attendance has dropped from 15,979 in September 2014 to 13,051 in April 2015 due to harsh weather conditions combined with distance to school and a lack of electricity, and child labour among other factors.⁹⁸ As Save the Children's formal attendance figures, reported by teaching assistants, were higher than attendance figures reported by parents in this assessment, this suggests either that some parents may be unaware of children in their household who are missing school or that parents who had pulled children out of school to take on other responsibilities, such as work or domestic chores may have not felt comfortable reporting that their children were not attending.

Despite this positive finding, many children and young people remain at risk of missing out on learning opportunities. Formal attendance was lowest among boys of 16-17 years, closely followed by girls in the same age group. Furthermore, 72.5% of children who are currently not attending any type of education fall within the 16-17 year age group. This suggests that there needs to be a targeted approach to increase attendance rates for

⁹⁸ MoE and Save the Children Jordan, Attendance trend in Za'atari camp, September 2014 – April 2015.

older students across all types of education. Parents and families have an important role to play as they influence young people's decisions about education, training and work. In this regard, it is encouraging that the majority of parents with school-aged girls and/or boys in their household had positive perceptions of a certified education pathway and considered it either important or very important for their children.

In JENA FGDs young people gave highly positive accounts of informal education (IFE), which they described as supportive and engaging. Yet reported IFE attendance is only 6% overall, suggesting that further IFE programmes and outreach initiatives could be developed as an alternative to school, particularly for the 2% of children who are ineligible to attend formal education. As in JENA, religious education was once again found to be the most commonly attended type of education indicating the continued importance of coordination between mosques and other informal education providers in the camp. CFS, AFS and MAC were accessed by a larger proportion of children among the youngest age group (6-8 years) suggesting that their appeal is greater for children at a less advanced stage of development

The needs of the 3.3% of children with disabilities reported across the camp must be incorporated by all agencies when designing programming. A targeted approach is required to address the needs of CWDs of different demographics, with 6-11 year olds representing the age group with most reported cases of disability and chronic illness. While over half of CWDs were reported as currently attending formal education (53.8%), access to education was still indicated to be lacking for these children. Disability was identified as a key factor in reported non-attendance among CWDs, highlighting that there remain barriers to inclusive education and further efforts need to be made for these children to be fully accommodated by the formal education system. Additionally, 64% of CWDs were not reported as not having received any visits from an organisation specialising in disability, highlighting an urgent need for further interventions by disability specialists operating in Za'atari camp.

Youths of 16-24 years have been revealed to represent one of the most vulnerable groups. This is due to their lack of engagement in learning opportunities and productive activities, posing a threat to social cohesion in the camp and puts them at a severe disadvantage with regards to re/joining the workforce. While it is encouraging that 13.8% of males aged 19-24 are currently in paid employment, rates of employment were considerably lower among other youth demographics assessed. This group is at real risk of becoming disenfranchised and resorting to negative coping mechanisms in order to seek out livelihoods and deal with their difficult situation.

Recommendations:

Based on the report and analysis, UNICEF and REACH have developed the following list of recommended priority interventions:

- Given the low rates of usage of public WASH centres during both day and night time and across all demographic groups, it is feasible that some could be phased out over the coming year.
- Messaging around water distribution urgently needs to address reported health concerns and negative perceptions surrounding the public water supply and its suitability for drinking in order to stymie any unfounded rumours about inadequate water quality.
- There is a pressing need for wastewater networks to be constructed in the camp to prevent the contamination of ground water and to mitigate safety and security hazards given that the majority of households have both private shower and toilet facilities that produce a large volume of black and grey water.
- Vaccination coverage in Za'atari camp is reasonable, but remains uneven across districts and demographics. Further vaccination campaigns and health awareness campaigns are needed to ensure that all infants are vaccinated against polio and measles and that girls and women of reproductive age are vaccinated with at least two doses of Tetanus Toxoid, particularly in areas of the camp at a greater distance from health facilities, and for out-of-school girls who are unable to access the vaccines administered for females attending grade 10 in Za'atari schools.
- 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.
- Only 24.6% 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. This indicates that there

is scope for further expansion of the reproductive health response with a greater number of follow-up post-natal visits for new mothers.

- The proportion of children not attending any form of education remains high at almost a third of all school-aged children (30%). There need to be more outreach programmes aimed at integrating out of school children, particularly given that the vast majority are still eligible to rejoin formal education.
- Outreach and Back to School programmes should aim to attract more boys to join formal education, particularly among older age groups, as males were found to have lower reported formal education attendance than girls across all age groups,
- Targeted interventions should reduce the rate of children dropping-out of formal education, with a special focus on children aged over 12 years, where the sharpest drop-out rate can be observed.
- There is scope for greater IFE outreach and programme development as reported IFE attendance is indicated to have dropped by 14% since the JENA assessment. Additionally, education actors need to coordinate closely with mosques located in Za'atari that currently offer different types of IFE to children.
- 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. Barriers to access must be addressed and special arrangements made to ensure that a higher proportion of CWD are able to thrive in the school environment.
- As 64% of CWD 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.
- Humanitarian actors in the camp must develop effective strategies to keep young people at risk of disengagement from learning on track to make positive transitions. Developing informal learning and volunteering opportunities would be particularly beneficial for the large proportion of young people who were unable to complete high school education. The majority of youths living in Za'atari need help to develop skills and qualifications in order to make the transition to the labour market in the future.⁹⁹ This type of intervention would be particularly beneficial for female youths aged 16-24 years who are under-represented in the proportion of youths engaged in paid employment.
- Developing alternative and flexible learning opportunities would be particularly beneficial for children and youths who have not benefitted from a conventional classroom experience, providing targeted or specialised support, and developing soft skills such as confidence, self-esteem, and responsibility.

The implementation of these recommendations requires close coordination between the education sector, protection, WASH and Health, disability focused actors, 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 Za'atari camp.

⁹⁹ OECD, Jobs for Youth Review, 2010.

ANNEX 1

Comprehensive Child-Focused Assessment (CCFA) of Zaatari Questionnaire

الدراسة المركزه الشامله للأطفال-أسئلة مخيم الزعتري

A. Household:

أ) المنزل

A1. Record GPS coordinates.

أ.1 تحديد الموقع

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

أ.2 هل هناك أشخاص يعيشون هذا المنزل؟

Is the respondent willing to participate in this survey? [If no, skip entire questionnaire]

هل الشخص المقيم مستعد للمشاركة في الاستبيان؟ هذا

B. Demographics:

ب. التركيبة السكانية

B1. What sex is the head of household?

ب.1 ماهو جنس رب الأسرة؟

- Male
- ذكر
- Female
- أنثى

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

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

B4. How is your household disaggregated?

ب.5 كيف تصنف افراد منزلك حسب الفئات العمريه التاليه ؟

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	سنه 31-59	سنه 25-30	سنه 18-24	سنه 12-17	سنه 5-11	سنه 3-4	سنه 0-2	ذكور
>60	سنه 31-59	سنه 25-30	سنه 18-24	سنه 12-17	سنه 5-11	سنه 3-4	سنه 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) [Loop: only display age categories that were indicated in the demographics section]

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

Girls (0-17 yrs)

البنات (سنه 0-17)

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

Boys (0-17 yrs)

الاولاد (سنه 0-17)

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

Women (18+ yrs)

النساء (18+ سنه)

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

Men (18+ yrs)

الرجال (18+ سنه)

- Shower (للإستحمام)
- Toilet (المرحاض)
- Ablutions (الوضوء)
- Washing clothes (غسيل الملابس)
- Washing dishes (ا غسيل لصحون)
- 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)

ج.1.ب ماهي الأسباب التي تدفع أفراد هذا المنزل لإستخدام المرافق الصحيه خلال الليل؟ (اختار كل ما يطاب

Girls (0-17 yrs)

البنات (سنه 0-17)

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

Boys (0-17 yrs)

الاولاد (سنه 0-17)

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

Women (18+ yrs)

النساء (18+ سنه)

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

Men (18+ yrs)

الرجال (18+ سنه)

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

C2. How often did the individuals living in this household use the WASH block during the last 7 days? (tick one only)

ج2- كم بالعادة يستخدم افراد هذا المنزل المرافق الصحية خلال ال 7 ايام الماضية ؟

- Several times a day
عدة مرات في اليوم
- Once a day
مرة في اليوم
- Once every few days
مرة كل عدة ايام
- Once a week
مرة في الاسبوع
- Never
ابدا

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 ؟ (اختار واحد فقط

- Public water point (eg. WASH block & tap stand)
نقاط المياه العامة (المرافق الصحية , نقاط الحنفيات)
- Private water trucks
صهاريج مياه خاصة
- Bottled water

- زجاجات مياه
- Refill at the market
التعبئة من السوق
 - Refill of private tank by ACTED trucks
التعبئة في خزان خاص من صهاريج اكتيد
 - Other (Please specify _____)
اخر (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 افراد هذا المنزل لجلب مياه الشرب من مصادر خاصة ؟

- Concern of danger to health
تجنب المخاطر الصحية
- Don't like the taste
لا يعجبهم طعم المياه
- Quantity of water in insufficient
عجز وقلة كمية المياه العامة
- Daily water supply is too unpredictable
التزويد اليومي بالمياه العامة لا يمكن التنبؤ به
- Other (Please specify _____)
اخر (وضح)

C5.

C5a. Does this household have a private water tank?

ج5- هل يمتلك هذا المنزل خزان مياه خاص ؟

- Yes نعم
- No لا

C5b. Does this household have a private toilet or shower facility?

هل يمتلك هذا المنزل مرحاض او مكان استحمام خاص ؟

- Yes نعم
- No لا

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) ال ايين في سن الدراسة يعيشون في هذا المنزل ؟

كم عدد الاطفال (6-17) والشباب (18-24) الذين في سن الدراسة يعيشون في هذا المنزل و يلتحقون في انواع التعليم التاليه ؟

For each age group: لكل من الفئات العمريه التاليه

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

Female انثى 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 للاطفال/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)

بالنسبة للأطفال الذين التحقوا بالتعليم الرسمي ما هي النشاطات التي حضروها؟

- Technical skills/post basic education (ie. vocational training)
المهارات الفنية / ما بعد التعليم الأساسي (أي التدريب المهني)
- Basic learning (e.g literacy or maths classes)
التعلم الأساسي (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?

للاطفال في سن الدراسة (6-17) الذين يعيشون في هذا المنزل ولا يذهبون الى المدارس الرسمية , كم عدد اشهر الدراسة التي فاتتهم؟

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

Female انثى 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)? Would you say it is:

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

- 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:

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)

D6. How many days have children in this household accessed Child Friendly Spaces/Adolescent Friendly Spaces/Multi-Activity Centres in the last 7 days?

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 6-8/9-10/11/12-15/16-17: □ 0 days □ 1-2 days □ 3-5 days □ 6-7 days

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

Girls Aged 6-8/9-10/11/12-15/16-17: □ 0 days □ 1-2 days □ 3-5 days □ 6-7 days

فتيات في سن 17-6 | 0 يوم | 2-1 ايام | 3-5 ايام | 6-7 ايام

D7. How many parents in this household attended a structured or recreational session with Mercy Corps, Save the Children International or IMC in the last month?

كم عدد الاباء والامهات في هذا المنزل الذين حضروا الجلسات المنظمة او الترفيهية مع الميرسي كوربس او حماية الطفل او الهيئة الطبية الدولية خلال الشهر الماضي؟

___ parents

D8. How many young people in this household are not currently in paid employment/training/unpaid volunteering?

كم عدد الشباب في هذه الأسرة ليسوا حالياً في العمل / التدريب / التعليم الرسمي أو غير الرسمي؟

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 اعاقه (الحركية, البصرية, والعقلية, والإدراكية أو السمعية)؟

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

E2.

E2a. How many 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 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 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 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 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 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 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	

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 اعاقه/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

F. Health الصحة

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

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

ذكر Male	نعم , شوهدت	Yes seen	نعم , لم تتم مشاهتها	Yes not seen	لا يوجد بطاقة	No card	لا اعرف	Don't know
انثى Female	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 (in doses)?

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

ذكر Male	نعم , جرعة واحدة	Yes 1 dose	نعم , جرعتان	Yes 2 doses	نعم , اكثر من جرعتان	Yes more than 2 doses	لا جرعات	No doses
انثى Female	نعم , جرعة واحدة		نعم , جرعتان		نعم , اكثر من جرعتان		لا جرعات	

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	Yes/No ==
انثى	Yes/No ==

F4.

F4a. How many women in the household are pregnant or breastfeeding? [If none, skip to F5]

كم عدد النساء الحوامل او المرضعات في هذا المنزل ؟

Number: ____

F4b. How many of these pregnant or breastfeeding 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 المرضعات في المنزل 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 حضرو اي زيارة ما بعد الولادة خلال ال6 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 girls/women of child bearing age (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. ____

ANNEX 2

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