FACTSHEET

Camp Profile: Serekaniye

November 2023
Hasakeh governorate, Syria

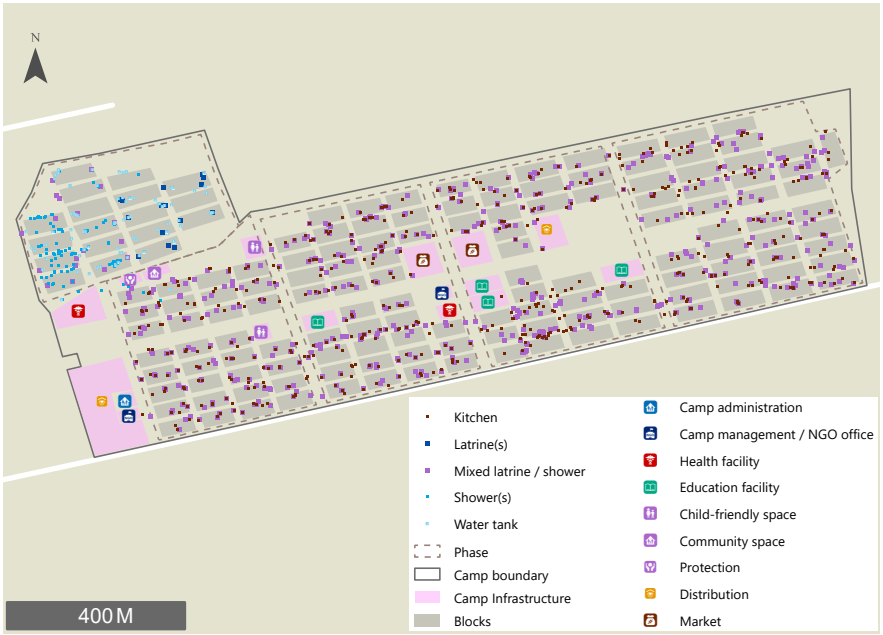
KEY MESSAGES

- Employment topped the list of reported needs, impacting access to vital services. Over 90% of HHs faced challenges affording food, 80% of HHs struggled with healthcare costs, and a third found washing essentials unaffordable.
- Households commonly coped with livelihood challenges by borrowing money (92%) and reducing non-food expenditures (87%).
- A fifth of households needing healthcare in the last 6 months faced barriers, with 81% citing unaffordable treatment. Priorities included access to medicines and treatment for chronic diseases, each reported by over half of households.

CONTEXT & RATIONALE

Serekaniye is an informal internally displaced person (IDP) camp established in Al-Hasakeh governorate in 2020 in response to the escalating conflict in Northeast Syria. The camp is located about 2 km from Al-Hasakah city. When the camp was established, it had a capacity of approximately 15,380 individuals and 2,584 households. However, the camp population kept growing; in January 2022, a new informal extension began forming outside the main camp. After incorporating extensions in the main camp, Serekaniye camp was hosting 2,575 households in November 2023. At the time of data collection, the camp was managed by an international non-governmental organization (NGO).

Camp Overview



METHODOLOGY

This profile provides an overview of humanitarian conditions in Serekaniye camp. Primary data was collected in November 2023 through a representative household (HH) survey. The assessment included 102 HHs who were randomly sampled using a spatial sampling methodology. Sample size was calculated to achieve a 95% confidence level and 10% margin of error based on population figures provided by camp management who were included in the assessment as Key Informants (KIs). KI interviews were used to support and triangulate the HH survey findings. The findings based on KIs are indicative only. For more details on the methodology, refer to page 10.

CAMP OVERVIEW

Key Informant Data

Number of individuals:	15,719
Number of HHs:	2,575
Number of shelters:	2,994
First arrivals:	December 2020
Camp area:	0.7 km²

Camp Location

DEMOGRAPHICS

Key Informant Data

Estimated population breakdown:

Male	Age	Female
2%	61+	2%
19%	18-60	24%
6%	12-17	6%
7%	6-11	7%
6%	3-5	6%
6%	0-2	9%

Household Data

Percentage of HHs belonging to vulnerable groups:

Female-headed HHs:	6%	Single heads of HH:	7%
HHs with pregnant/lactating women:	37%	Single female heads of HH:	5%
HHs with infants (0-2 years):	31%	HHs with elderly (>60 years):	15%

SECTORAL MINIMUM STANDARDS

		Target	Result	Achievement
Shelter	Average number of individuals per shelter	max 4.6	4	●
	Average covered living space per person	min 3.5 m²	4.5 m²	●
	Average camp area per person	min 45 m²	45 m²	●
Health	% of 0-5 year olds who have received polio vaccinations	100%	86%	●
	Presence of health services within the camp	Yes	Yes	●
Protection	% of HHs reporting safety/security issues in past two weeks	0%	72%	●
Food	% of HHs receiving food assistance in the 30 days prior to data collection (including vouchers and cash for food)	100%	100%	●
	% of HHs with acceptable food consumption score (FCS)[1]	100%	69%	●
Education	% of children aged 6-17 accessing education services	100%	76%	●
WASH	Persons per latrine (communal or HH)	max. 20	6	●
	Persons per shower	max. 20	6	●
	Frequency of solid waste disposal	min. twice weekly	Everyday	●

Targets based on Sphere and humanitarian minimum standards.[2]

● Minimum standard met ● 50-99% of minimum standard met ● 0-49% of minimum standard met

FOOD SECURITY

Household Data

Food Consumption

Percentage of HHs by **Food Consumption Score**[3] (FCS) category:

Acceptable	**69%**
Borderline	**25%**
Poor	**7%**

Percentage of HHs by **HH Dietary Diversity Score**[4](HDDS) category:

High	**65%**
Medium	**22%**
Low	**14%**

Food Assistance

100% of HHs had reportedly received **food assistance** (incl. vouchers and cash for food) in the 30 days prior to data collection. Percentage of HHs reached by reported **type of food assistance received** in the 30 days prior to data collection:

1. Food basket(s) — **99%**
2. Bread distribution — **98%**
3. Voucher (for food) — **21%**

Top three **food items** HHs would like to receive more of (HHs could select up to three options):

1. Vegetable Oil — **89%**
2. Sugar — **82%**
3. Rice — **36%**

Food-Based Coping Strategies

Top three **negative food-based coping strategies** reported by HHs (employed at least once in the last seven days):

1. Relied on less preferred or less expensive food — **99%**
2. Rely on food which was borrowed from shopkeepers to be paid later — **85%**
3. Reduced the number of meals eaten per day — **40%**

LIVELIHOODS

Household Data

Primary Income Sources

Top three **income sources** reported by HHs for the six months preceding data collection[5]:

1. Work outside camp — **55%**
2. Loans from non-family members — **33%**
3. Work inside camp — **26%**

Debt

93% of HHs reported that they had debt. These HHs had a median debt load amounting to **2378265 SYP** (**175 USD**).

Top three **reasons for taking on debt** reported by HHs that reported debt (HHs could select up to three options):

1. Food — **88%**
2. Healthcare — **60%**
3. Clothing or non-food items (NFI) — **47%**

Livelihood Coping Strategies

Top three **livelihood-related coping strategies** used in the 30 days prior to data collection reported by HHs (HHs could select up to three options):

1. Borrowed money to meet essential needs — **92%**
2. Reduce non-food essential expenses (health, education, etc.) — **88%**
3. Spend savings to meet essential needs — **30%**

SHELTER ADEQUACY

Key Informant Data

Average number of people per HH:* 6

Average number of shelters per HH:* 1

Occupation rate of shelters in camp:* 100%

*calculation based on KI interviews

Top three **shelter needs** reported by KIs:

1. New Tents
2. Additional Tents
3. Plastic Sheeting

Risks of **flooding** as reported by KIs:

Percentage of tents prone to flooding: 0%

Presence of water drainage channels in shelters: None

Household Data

Top three most commonly reported **shelter item needs** reported by HHs (HHs could select up to three options):

1. Plastic sheeting or Tarpaulins **75%**
2. Additional tents **60%**
3. New tents **50%**

20% of HHs reported **hazards** in their block such as **uncovered pits** (14%) and **electricity hazards** (10%).

Most commonly reported **light sources** inside shelters[5]:

1. Light powered by public electricity network **90%**
2. Light powered by shared camp generator (households contribute to running costs) **57%**
3. Light powered by solar panels **35%**

Most commonly used **kitchen types** reported by HHs:

1. Private kitchen **89%**
2. Cooking inside inhabited shelter **9%**
3. Makeshift kitchen **2%**

FIRE SAFETY

Key Informant Data

As reported by KIs, one fire extinguisher per block was available to camp residents. KIs also reported that camp management had provided camp residents with fire safety information in the three months prior to data collection.

Household Data

96% of HHs reported that they **had received information about fire safety**, of which **3%** reported difficulties with comprehending the information. **94%** reported knowing of a fire point in their block.

NFI NEEDS

Key Informant Data

Top three anticipated NFI needs for the three months following data collection, as reported by KIs:

1. Cooking fuel
2. Cooking stoves
3. Clothing, Kitchen utensils, Sources of light

WATER

Water Sources

Primary water sources reportedly used by HHs:

1. Piped connection to house (or neighbours) **72%**
2. Public tap/standpipe (e.g. from water tank) **28%**

Drinking water issues reported by HHs[5]:

1. Water had chlorine smell **64%**
2. Water tasted bad **52%**
3. People might have gotten sick after drinking the water **14%**

Water Coping Strategies

69% of HHs reportedly used **negative coping strategies** to address a lack of water in the two weeks prior to data collection.

Most commonly used negative coping strategies reported by HHs[5]:

1. Modified hygiene practices (bathe less, etc) **36%**
2. Relied on previously stored water **35%**
3. Received water from neighbour(s) as gift **13%**

SANITATION AND HYGIENE

Latrines and Shower Definitions

Communal latrines and showers are shared by more than one HH.

HH latrines and showers are only used by one HHs. This can also include informal designations which are not officially enforced.

A **shower** is defined as a designated place to shower, as opposed to bathing in a shelter (i.e., using a bucket).

Showers

Primarily used shower types reported by HHs:

1. Private showers outside shelter **64%**
2. Private showers inside shelter **22%**
3. Bathing inside shelter (not in a shower) **15%**

Latrines

Primarily used latrine types reported by HHs:

1. Pit latrine with slab **99%**
2. Pit latrine without slab / open pit **1%**

Percentage of HHs reporting members **not being able to access latrines**[5]:

1. Everyone can access toilets **97%**
2. Old persons (65+) **2%**
3. Persons with disabilities **2%**

Handwashing and Soap

23% of HHs reported they did **not have access to a private handwashing** facility.

77% of HHs reported **having hand/body soap** available at the time of data collection.

87% of HHs reported **difficulties obtaining hand/body soap**. Among all HHs:

1. Soap was too expensive **73%**
2. No soap was distributed **33%**
3. Soap was distributed infrequently **29%**

WASTE DISPOSAL

Household Data

Top three most common **waste-disposal related challenges** reported by HHs[5]:

1. Insufficient number of garbage bags within household **44%**
2. Insufficient number of bins **22%**
3. Bins were overfilled/garbage on the ground **1%**

Key Informant Data

Primary waste disposal system: Collection by NGO
Disposal location: Landfill 25km from the camp
Sewage system: Desludging

HEALTH

General Health

Key Informant Data

According to KIs, there are 2 health facilities available inside the camp. Furthermore, there is a functional, accessible health facility available 2km outside the camp.

Household Data

Of the **97%** of HHs who reportedly required treatment in the 6 months prior to data collection, **96%** reported barriers to accessing medical care. Of HHs who reported barriers, the most commonly reported barriers were:

1. Cannot afford price of medicines **86%**
2. Cannot afford treatment costs **84%**
3. Cannot afford travel costs to reach health facilities **37%**

20% of HHs reported that a **member had given birth** after moving to the camp.

Child and Infant Health

Key Informant Data

Camp management did not report that infant nutrition items had been distributed in the 30 days prior to data collection.The following **nutrition activities** reportedly took place in the 3 months prior to data collection[6]:

Screening and referral for malnutrition:	✓
Treatment for moderate-acute malnutrition:	✓
Treatment for severe-acute malnutrition:	✓
Micronutrient supplements:	✗
Blanket supplementary feeding program:	✗
Promotion of breastfeeding:	✓

Household Data

Percentage of children under five years old that were reportedly vaccinated against **polio**[7] **86%**

Percentage of children under two years old that had reportedly received the **DTP vaccine**[8] **89%**

Percentage of children under five years old that had reportedly received the **MMR vaccine**[8] **86%**

CAMP MANAGEMENT & COMMITTEES

Household Data

Top three **sources of information** for humanitarian services reported by HHs[5]:

1. Friends and neighbours (word of mouth) **47%**
2. Community leaders **46%**
3. Local Authorities **39%**

Top three **information needs** for HHs lacking sufficient info to decide on staying in the camp or returning to area of origin[5]:

1. Security situation in your area of origin (ongoing armed conflict, etc) **92%**
2. Livelihood and job opportunities in area of origin **51%**
3. Safety of your area of origin (presence of explosives, mines, etc) **46%**

All camp managers reported that a specific complaint mechanism exists. Knowledge of mechanisms reported by HHs:

Reported knowing who manages the camp:	**66%**
Reported to be unsure who manages the camp:	**23%**
Reported knowing of a complaint box in the camp:	**90%**
Reported knowing who to contact to raise concerns:	**81%**

Key Informant Data

Committees reported to be present:

Camp management	✗	Youth committee	✓
Women's committee	✓	Maintenance committee	✓
WASH committee	✗	Distribution committee	✗
Health committee	✓		

DISPLACEMENT

Household Data

Movement intentions for the 12 months following data collection reported by HHs:

Remain in the camp	**81%**
Return to area of origin	**6%**
Move to another location in Syria	**0%**
Move abroad	**0%**
Do not know	**13%**

Most commonly reported resources that would enable HHs **to leave the camp**:

1. Job opportunities in the destination **82%**
2. Provision of housing in another location **37%**
3. Rehabilitation or provision of housing in area of origin **23%**

Key Informant Data

Movement in the 30 days prior to data collection: New arrivals: 12 individuals Departures: 15 individuals

FREEDOM OF MOVEMENT

59% of HHs reportedly had experienced **barriers when trying to leave the camp** in the two weeks prior to data collection.

1. Transportation options available but too expensive **44%**
2. Insufficient transportation **37%**
3. Safety/security situation **1%**

Conditions necessary to **leave the camp,** as reported by HHs:

1. Residents can leave without providing a reason **99%**
2. Residents are not allowed to leave, even if they have a medical reason **1%**

PROTECTION

72% of HHs reported being **aware of safety and security issues** in and close to the camp during the two weeks prior to data collection.

Most common **security concerns** reported by HHs[5]:

1. Theft **55%**
2. Disputes between residents **27%**
3. Danger from snakes, scorpions, mice, dogs, etc. **25%**

3% of HHs reported a **marriage certificate** issued by either the Government of Syria or local authorities as needed but missing at the time of data collection.

7% of HHs reported a **birth certificate** issued by either the Government of Syria or local authorities as needed but missing at the time of data collection.

70% of HHs reported **protection issues.** The top reported issues among all HHs were:

1. Early marriage (girls below 18 years old) **16%**
2. Denial of resources, opportunities, or services **7%**
3. Physical violence **5%**

Child Protection

15% of HHs reported child protection concerns in the camp. Among those, the most commonly reported concerns included:

1. Early marriage (below 18 years old) **9%**
2. Child headed households **8%**
3. Children being at risk of violence inside or outside the home **5%**

43% of all HHs reported that at least one **adult** suffered or showed signs of **psychosocial distress or trauma** such as nightmare, lasting sadness, extreme fatigue, being often tearful or extreme anxiety, in the last 30 days.

30% of HHs with children aged 0 -17 reported that at least one **child** suffered or showed signs of **psychosocial distress or trauma** such as nightmare, lasting sadness, extreme fatigue, being often tearful or extreme anxiety, in the last 30 days.

Gender-Related Protection

61% of HHs with at least one woman or girl above the age of 11 reported **knowing about** designated **spaces for women and girls** in the camp.

47% of HHs reportedly knowing about designated spaces for women and girls reported that female members of their HH **attended a designated space for women and girls** in the 30 days prior to data collection.

74% of HHs with at least one child reported **knowing about child-friendly spaces** in the camp.

31% of HHs reportedly knowing about designated spaces for children reported that a child from their HH **attended a child-friendly space** in the 30 days prior to data collection.

CHILDREN WORKING

2% of HHs with **children under 12** reported that at least one child in that age group was working at the time of data collection. Among those, the most reported activities were:

1. Factory work **100%**

7% of HHs with **children between the ages of 12-17** reported that at least one child in that age group was working at the time of data collection. Among those, the most reported activities were:

1. Factory work **67%**
2. Work for others (not harsh/dangerous) **33%**

SCHOOL ATTENDANCE (CHILDREN AGED 6-17)

Household Data

76% of children aged 6-17 were reportedly **going to school either inside or outside the camp**.

84% of all **girls between 6 and 11** in the camp were reportedly going to school inside the camp. 3% were reportedly attending school outside the camp. Main barriers to education reported by HHs where at least one girl aged 6 to 11 did not attend school:

1. Fear of spread of other disease **33%**
2. Child did not want to attend **17%**
3. Education was not considered important **17%**

56% of all **girls between 12 and 17** in the camp were reportedly going to school inside the camp. 8% were reportedly attending school outside the camp. Main barriers to education reported by HHs where at least one girl aged 12 to 17 did not attend school:

1. Child did not want to attend **42%**
2. Education was not considered important **33%**
3. School was too far away / no transport available/transport too expensive **25%**

70% of all **boys between 6 and 11** in the camp were reportedly going to school inside the camp. 10% were reportedly attending school outside the camp. Main barriers to education reported by HHs where at least one boy aged 6 to 11 did not attend school:

1. Child did not want to attend **50%**
2. Children did not have the proper clothes/shoes to attend **10%**
3. Children had to work **10%**

45% of all **boys between 12 and 17** in the camp were reportedly going to school inside the camp. 14% were reportedly attending school outside the camp. Main barriers to education reported by HHs where at least one boy aged 12 to 17 did not attend school:

1. Education was not considered important **42%**
2. Child did not want to attend **33%**
3. Children did not have the proper clothes/shoes to attend **17%**

EARLY CHILDHOOD DEVELOPMENT (3-5 YEARS OLD)

Household Data

12% of 3-5 year old children in the HHs reportedly received early childhood **education**

Most commonly reported barriers to early childhood education among HHs where at least one 3-5 year old did not attend[5]:

1. No education for children of a certain age **22%**
2. Fear of spread of other disease **18%**
3. Education was not considered important **15%**

EDUCATIONAL FACILITIES

Key Informant Data

According to KIs, there were 4 in-person operational educational facility available in the camp offering a self-administrated curriculum to children aged 3 to 17 (allows out-of-school children to catch up with their peers by studying at home or in community centers with the help of volunteers or caregivers). Certification was reported to be available at facilities catering to students aged 6-17.

METHODOLOGY OVERVIEW

The data collection process for this camp profiling employed three distinct methodologies: KI interviews, HH interviews, and in-field mapping data collection. KI interviews, conducted with camp managers for each camp, provided in-depth insights and context into camp management, services, and infrastructure. HH interviews were carried out using a random spatial sampling method. Sample size was determined to achieve a 95% confidence interval and 10% margin of error. Sampling was based on population figures supplied by camp management. Given the sampling approach and sample size, data presented in this factsheet can be considered representative. The in-field mapping data collection technique involved a physical visit to camp facilities, documenting precise locations using KoBo, and assessing available services. Data collected through in-field mapping was compared with KI interviews for a holistic understanding of camp infrastructure and services. All Camps and Displacement products remain accessible on the REACH Resource Centre.

ENDNOTES

Page 2

[1] The United Nations World Food Programme (WFP). (May 2014). WFP Food Consumption Score - Technical Guidance Sheet. Retrieved from: https://fscluster.org/

[2] Sphere Handbook, Humanitarian Charter and Minimum Standards in Humanitarian Response, (2018) UNHCR Emergency Handbook.

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[3] The United Nations World Food Programme (WFP). (May 2014). WFP Food Consumption Score - Technical Guidance Sheet. Retrieved from: https://fscluster.org/

[4] UN Food and Agriculture Organisation (2011) Guidelines for Measuring HH and Individual Dietary Diversity.

[5] Households could select as many options as applicable. The sum of percentages may exceed 100%

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[6] In camp health assessments, medical facilities are typically established, enabling regular communication and the submission of comprehensive medical reports. When a camp lacks medical facilities and an IDP requires external treatment, the IDP provides medical documentation upon their return, explaining the need for their absence. This practice ensures effective health monitoring and reporting, even in camps without on-site medical services.

[7] Vaccination strategies are tailored to address the vulnerabilities of specific age groups. Children under 5 years old are particularly susceptible to polio, with most cases occurring within this age range. Immunizing children under 5 becomes imperative as it provides protection during their most vulnerable phase, effectively curbing transmission and establishing herd immunity against polio outbreaks. [Reference: World Health Organization (WHO), UNICEF, and Rotary International: https://www.unicef.org/partnerships/rotary]

[8] Infants and young children are especially at risk of diseases targeted by the DTP vaccine. Diseases like pertussis can have severe consequences for infants, making vaccination crucial before potential exposure. Vaccinating children under 2 mitigates disease outbreaks and fosters herd immunity. Conversely, the MMR2 vaccine is strategically administered later, typically around 4 to 6 years old, factoring in crucial developmental considerations. Administering certain vaccines, like the MMR vaccine, to very young children may not yield optimal immunity due to developing immune systems and maternal antibodies interference. The vaccine's timing, carefully orchestrated to minimize visits and optimize schedules, ensures its effectiveness. These tailored vaccination timelines are anchored in scientific rationale, enhancing the overall impact of immunization efforts. https://www.who.int/news-room/fact-sheets/detail/immunization-coverage

ABOUT REACH

REACH Initiative facilitates the development of information tools and products that enhance the capacity of aid actors to make evidence-based decisions in emergency, recovery and development contexts. The methodologies used by REACH include primary data collection and in-depth analysis, and all activities are conducted through inter-agency aid coordination mechanisms. REACH is a joint initiative of IMPACT Initiatives, ACTED and the United Nations Institute for Training and Research - Operational Satellite Applications Programme (UNITAR-UNOSAT).