FACTSHEET

Camp Profile: Roj - Syrian and Iraqi zone

July 2023
Al-Hasakeh governorate, Syria

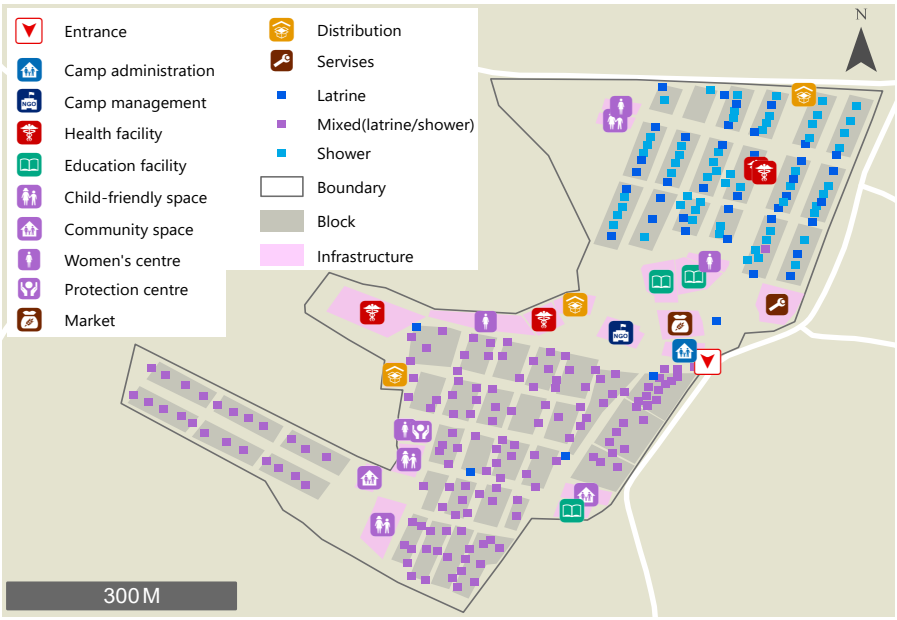
KEY MESSAGES

- Key Informants (KIs) and households (HHs) agreed that **new tents** and **additional tents** in the top-three essential needs for shelter. **Washing powder for clothes** was in the top-three essential requirements for non-food items (NFIs).
- **Debt amounting** to **29 USD** was the average liability carried by HHs, where **51% of HHs had borrowed money** in the 30 days leading up to the data collection.

53% of HHs reported that they are not planning to leave the camp.

67% of HHs reported that they experienced difficulties in obtaining hand/body soap.

Camp mapping conducted in July 2023. Detailed infrastructure map available on REACH Resource Centre.



CONTEXT & RATIONALE

Roj is a formal camp that was established in 2015 near the village of Al-Hakamiya, east of the city of Al-Malikia, to accommodate displaced families from the city of Al Hasakeh. However, shortly after its opening, the camp site was relocated to the village of Tal Aswad, southeast of Al-Malikia, due to HLP related issues. During that same year Iraqi families fleeing from Mosul, Anbar, and Salah al-Din settled in the camp. Those families stayed in the camp until the end of 2017. In June 2020, authorities moved foreign families in batches from Al-Hol's annex to Roj's new expansion. The month of July 2021 saw Roj's Expansion 2 initiated by the Self-Administration for Al-Hol's Third Country Nationals (TCN) households. Currently, the camp is managed by an NGO.

METHODOLOGY

This profile provides an overview of humanitarian conditions in the Iraqi and Syrian zone of Roj camp. Primary data was collected on 6 July 2023 through a representative HH survey. The assessment included 49 HHs who were randomly sampled in this zone to achieve a 95% confidence level and 10% margin of error based on population figures provided by camp management. For some indicators, a reduced sample of households answered the question as a result of a skip logic in the questionnaire. In some of these cases, the reduced sample of households also resulted in non-representative findings, which are indicated throughout the factsheet with the icon▼. In July 2023, REACH had one KI interview with the camp management regarding the Iraqi and Syrian zone in particular. These interviews were used to support and triangulate the HH survey findings.

CAMP OVERVIEW AS REPORTED BY KIs (FOR SYRIAN AND IRAQI ZONE)

Number of individuals:	384
Number of HHs:	84
Number of shelters:	105
First arrivals:	5/1/2015
Area:	0.013 km² (of a total of 0.23 km²)

Camp Location

DEMOGRAPHICS

Figure 1: Average estimated population breakdown as reported by KIs:

Male	Age	Female
0.3%	60+	1%
19%	18-59	23%
22%	5-17	23%
0-4 *(No gender split)*		11%

Percentage of HHs by groups in vulnerable position *(self-reported by HHs and not verified through medical records)*

Female-headed HHs:	16%	Single parents/caregivers:	5%
Chronically ill persons:	9%	Persons with serious injury:	2%
Pregnant/lactating women:	3%	Head of HH with disability:	4%

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	7 m²	●
	Average camp area per person	min 45 m²	92 m²	●
Health	% of 0-5 year olds who have received polio vaccinations	100%	69%	●
	Presence of health services within the camp	Yes	Yes	●
Protection	% of HHs reporting safety/security issues in past two weeks	0%	55%	●
Food	% of HHs receiving assistance in the 30 days prior to data collection	100%	100%	●
	% of HHs with acceptable food consumption score (FCS)[1]	100%	88%	●
Education	% of children aged 6-17 accessing education services	100%	50%	●
WASH	Persons per latrine (communal or HH)	max. 20	8	●
	Persons per shower	max. 20	8	●
	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

Top three HH reported negative consumption-based coping strategies:

1. Rely on less preferred and less expensive foods	33%
2. Restrict consumption by adults in order for small children to eat	16%
3. Reduce number of meals eaten in a day	12%

FOOD DISTRIBUTION

100% of HHs had received a food basket, bread distribution, cash, or vouchers in the 30 days prior to data collection.

% of HHs reached by reported type of food assistance received in the 30 days prior to data collection:

Bread distribution	100%
Food basket(s)	96%
Voucher (for food)	67

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

1. Vegetable oil	80%
2. Sugar	76%
3. Rice	59%

FCS Interpretation

FCS measures HHs' current food consumption status based on the number of days per week a HH is able to eat items from nine standard food groups, weighted for their nutritional value.[3]

HHs were asked to report the number of days per week nutrient-rich food groups were consumed, from which nutrient consumption frequencies were derived.

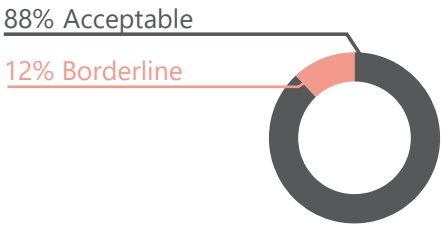
Poor food consumption: (score between 0-28): This category includes HHs that are not consuming staples and vegetables every day and never or very seldom consume protein-rich food such as meat and dairy.

Borderline food consumption (score between >28-42): This category includes HHs that are consuming staples and vegetables every day, accompanied by oils and pulses a few times a week.

Acceptable food consumption (score >42): This category includes HHs that are consuming staples and vegetables every day, frequently accompanied by oils and pulses and occasionally meat, fish and dairy.

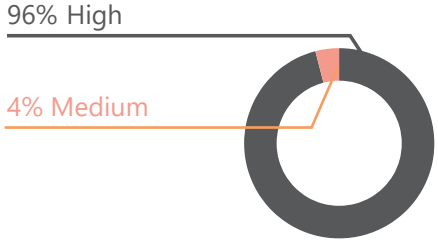
FOOD CONSUMPTION

Figure 2: Percentage of HHs by FCS category:



DIETARY DIVERSITY

Figure 3: Percentage of HHs by HH Dietary Diversity (HDD) score level:



HDD Interpretation[4]

The HH Dietary Diversity Score measures how many of 8 of the 9 FCS are consumed during the same 7-day reference period (condiments and spices are not included in this score).

Number of Food Groups consumed in a 7 day period:
Low (Food groups < 4.5)
Medium (Food groups >4.5-6)
High (Food groups >6)

LIVELIHOOD

HH income

Average monthly HH income in the 30 days prior to data collection*: **1,516,980 SYP (171 USD)**

HH expenditure

Average monthly HH expenditure in the 30 days prior to data collection*: **957,163 SYP (108 USD)**

* The effective exchange rate for northeast Syria was reported to be 8887.5 Syrian Pounds to the US dollar in July 2023[5].

Figure 4: **Top three HH reported primary income sources** *(HHs could select as many options that applied meaning the sum of percentages may exceed 100%)*:

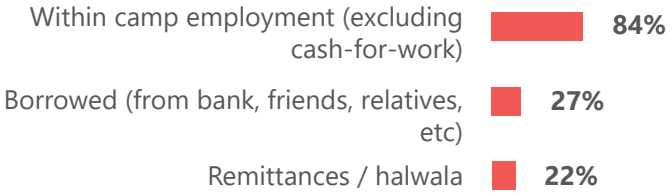
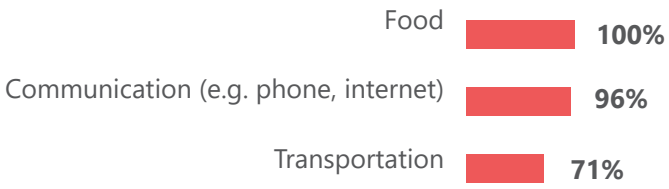


Figure 5: **Top three reported expenditure categories for HHs** *(HHs could select as many options that applied meaning the sum of percentages may exceed 100%)*:



HH DEBT

51% of HHs reported that they **borrowed money** in the 30 days prior to data collection. On average, these HHs had a debt load amounting to **255,510 SYP** (**29 USD**).

Figure 6: **Top three reported reasons for taking on debt*:**

Figure 7: **Top reported creditors*:**

***by % of HHs that reported taking debt** *(HHs could select up to three options)*

COPING STRATEGIES

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

1. Borrowed money — **27%**
2. Sold some items received through humanitarian assistance — **14%**
3. Reduced spending on non-food expenditures, such as health or education — **12%**

SHELTER ADEQUACY

Average number of people estimated per HH: 5

Average number of shelters estimated per HH: 1

Average number of people estimated per shelter: 4

Estimated occupation rate of the shelters in the camp: 100%

Calculation is based on data gathered from KIs

Top three reported shelter needs as reported by KIs:

1. New tents
2. Plastic sheeting
3. Additional tents

Risks of flooding as reported by KIs:

- **Percentage of tents prone to flooding 0%**
- **Presence of water drainage channels in shelters: Yes, in all shelters**

Most commonly reported kitchen types used as reported by HHs:

1. Camp built kitchen (private or communal) **14%**
2. HH improvised cooking facility (makeshift kitchen, cooking outside shelter, cooking inside inhabited shelter) **86%**

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

1. New tents	**45%**
2. Tarpaulins	**35%**
3. Additional tents	**31%**

HHs reported **hazards in their block** such as **uncovered pits** (**4%**) and **electricity hazards** (**4%**).

Most commonly reported sources of light inside shelters *(HHs could select as many options that applied meaning the sum of percentages may exceed 100%)*:

Light powered by public electricity network	**100%**
Light powered by solar panels	**8%**
Cell phone light	**4%**

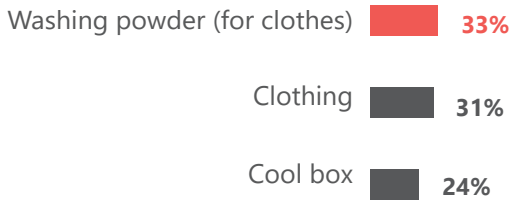
NFI NEEDS

Top three KI reported anticipated NFI needs for the three months following data collection:

1. Washing powder for clothes
2. Mattresses sleeping mats
3. Cooking fuel

As reported by KIs, several fire extinguishers per block were available and actors in the camp **informed** residents with **information on fire safety** in the three months prior to data collection.

Figure 8: Top three HH reported anticipated NFI needs for the 3 months following data collection *(HHs could select up to three options)*:



96% of HHs reported that they **had received information about fire safety**, of which **0%** reported difficulties with comprehending the information. **98%** reported knowing of a fire point in their block.

WATER

The **public tap/standpipe** was reportedly used by **76%** of HHs for drinking water.

% of HHs by reported drinking water issues *(HHs could select as many options that applied meaning the sum of percentages may exceed 100%)*:

Water tasted/smelled/looked bad	6%
People got sick after drinking	2%

Coping Strategies

49% of HHs reportedly used negative strategies to cope with lack of water in the two weeks prior to data collection.

Most commonly reported negative strategies by HHs *(HHs could select as many options that applied meaning the sum of percentages may exceed 100%)*:

- Relied on previously stored water (43%)
- Modified hygiene practices (bathe less, etc) (16%)
- Reduced drinking water consumption (8%)

Self-reported by HHs and not verified through medical records, **0%** of HHs reported having at least one HH member suffering from **diarrhoea.**

WASTE DISPOSAL AS REPORTED BY KIs

Primary waste disposal system: Garbage collection NGO

Disposal location: at a landfill, 2 km away from the camp

Sewage system: sewage network

WASTE DISPOSAL AS REPORTED BY HHs

Top three most commonly reported garbage challenges in the past 2 weeks prior to data collection *(HHs could select up to three options)*:

1. Insufficient number of garbage bags within household 12%

HYGIENE

67% of HHs reported they did **not have access** to a private handwashing facility.

88% of HHs reported having **hand/body soap** available at the time of data collection.

67% of HHs reportedly experienced difficulties in obtaining hand/body soap.

Main difficulties reported included:

Soap distributed was not enough	57%
Soap was too expensive	29%
Soap was distributed infrequently	22%

LATRINES & SHOWERS

According to mapping data and as reported by KIs:

319	Number of communal latrines♦
297	Number of communal showers♦
0	Number of HH latrines♦
0	Number of HH showers♦♦

♦**Communal latrines and showers** are shared by more than one HH,

♦**HH latrines and showers** are used only by one HH. This can also include informal designations that is 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).

Percentage of HHs by reported used latrines types *(HHs could select as many options that applied meaning the sum of percentages may exceed 100%)*:

1. HH latrine	**69%**
2. Communal latrine	**31%**

HEALTH

Healthcare availability as reported by KIs

Number of healthcare facilities in the Syrian and Iraqi zone of the camp: 1

Types of facilities: Public hospital clinic

Available services at the accessible health facilities:

	In camp	Outside camp
Outpatient department:	YES	YES
Reproductive health:	YES	YES
Emergency:	YES	YES
Minor surgery:	NO	NO
X-Ray:	YES	YES
Lab services:	YES	YES

The average distance of health facilities located outside the camp: 7 Km

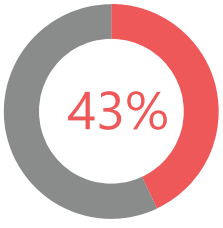
Healthcare accessibility as reported by HHs:

Of the **41%** of HHs who required treatment in the 30 days prior to data collection, **85%** reportedly faced barriers to accessing medical care.▼

Most commonly reported barriers to accessing medical care:▼

- Unaffordability of health services (88%)
- High transportation costs to health facilities (71%)
- Lack of medicines at the health facilities (29%)

Figure 9: Percentage of HHs reporting that a member had given birth since living in the camp:



CHILDREN AND INFANT HEALTH

Percentage of children under five years old that were reportedly vaccinated against **polio**[6]	**69%**
Percentage of children under two years old that had reportedly received the **DTP vaccine**[7]	**100%**
Percentage of children under two years old that had reportedly received the **MMR vaccine**[7]	**100%**

The camp management reported that infant nutrition items had **not** been distributed in the 30 days prior to data collection. The following **nutrition activities** have reportedly been undertaken in the past 3 months prior to data collection[8]:

Screening and referral for malnutrition:	YES
Treatment for moderate-acute malnutrition:	YES
Treatment for severe-acute malnutrition:	YES
Micronutrient supplements:	NO
Blanket supplementary feeding program:	YES
Promotion of breastfeeding:	YES

DISPLACEMENT

Top three areas of origin of HHs as reported by KIs:

Country	Governorate	Sub-district	
Syria	Ninewa(Iraq)	Sinjar	**85%**
Syria	Deir-ez-Zor	Al Mayadin	**15%**

Displacement history as reported by HHs:

Number of diplacements before arriving to this camp	**3**
Percentage of HHs who have been in displacement longer than one year	**100%**

Movement in the past 30 days prior to assessment as reported by KIs:

New arrivals	**0**
Departures	**0**

Movement Intentions

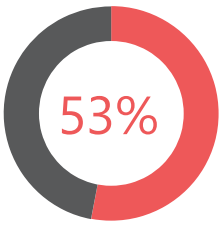
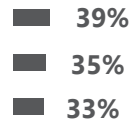


Figure 11: Percentage of HHs reporting **not planning to leave** the camp.

53% of HHs had no intention to leave the camp, because they reported **I don't have the option to decide this** (47%), **waiting for area of origin to be safe** (32%) and **there were food distributions in the camp** (26%).▼

CAMP MANAGEMENT AND COMMITTEES

Figure 10: **Top three reported sources of information as reported by HHs:**



All camp managers reported that a complaint mechanism exists. **As reported by HHs:**

12%	Reported not knowing who manages the camp
14%	Reported not sure
82%	Reported knowing of a complaint box in the camp
82%	Reported knowing who to contact to raise concerns or issues.

Present committees according to KI:

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

Top three reported information needs *(HHs could select up to three options)*:

1. How to find job opportunities	**51%**
2. Information about returning to area of origin	**45%**
3. Sponsorship programs	**18%**

PROTECTION

55% of HHs reported being aware of safety and security issues in the camp during the two weeks prior to the assessment.

The most commonly reported security concerns were:▼

- Danger from snakes, scorpions, mice, dogs, etc. (**51%**)
- Theft (**22%**)

18% of HHs reported at least one member suffering from **psychosocial distress**; as reported by HHs themselves.

HHs' assessed symptoms included: persistent headaches, sleeplessness, and more aggressive behaviour than normal towards children or other HH members.

16% of HHs with children aged 3-17 reported that at least one child had exhibited **changes in behaviour** (changes in sleeping patterns, interactions with peers, attentiveness, or interest in others) in the two weeks prior to data collection.

At the time of data collection, **no interventions** were addressing the needs of older persons or persons with disabilities, **as reported by KIs.**

DOCUMENTATION

6% of HHs reported having at least one married person who was not in possession of their **marriage certificate**.

21% of HHs with children below the age of 17 reported that at least one child did not have any **birth registration documentation**.

FREEDOM OF MOVEMENT

As reported by KIs, **residents** who need to leave the camp temporarily **were able** at the time of data collection

73% of households reported not being able to leave for a medical reason without disclosing the reason

94% of HHs reportedly had experienced **barriers when trying to leave the camp** in the two weeks prior to data collection.

Most commonly reported barriers:

- Site departure conditions (need approval) (**88%**)
- Transportation options available but too expensive (**35%**)
- Insufficient transportation (**14%**)

GENDER RELATED PROTECTION CONCERNS

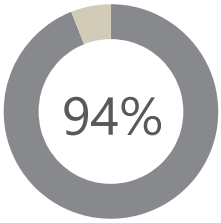


Figure 12: Percentage of HHs reporting **knowing** about any designated space for **women and girls** in the camp

61% of the above subset reported that a girl or woman from their HH **attended one** in the 30 days prior to data collection.

27% of HHs reporting **men and boys** avoiding camp areas for safety and security reasons

20% of HHs reporting **women and girls** avoiding camp areas for safety and security reasons

20% of HHs reported **protection issues.**The top reported issues reported were (*HHs could select as many options that applied meaning the sum of percentages may exceed 100%*):▼

- **12%** denial of resources, opportunities, or services
- **10%** emotional violence
- **10%** physical violence

CHILD PROTECTION

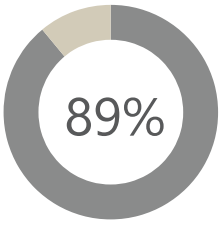


Figure 13: Percentage of HHs reporting **knowing** about any **child-friendly space** in the camp

74% of the above subset reported that a child from their HH **attended one** in the 30 days prior to data collection.

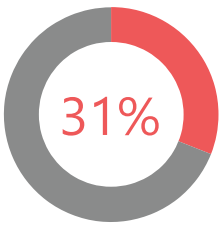


Figure 14: Percentage of HHs reporting **the presence of child protection concerns** in the camp; mainly, children working **31%**, and domestic violence **14%**.▼

CHILDREN WORKING

Most commonly reported types of children working by gender *(HHs could select as many options that applied meaning the sum of percentages may exceed 100%):* ▼

	Boys (100% reportedly were aware of boys working)	Girls (0% reportedly were aware of girls working)
Work for others (not harsh/dangerous)	60%	-
Transporting people or goods	47%	-

Findings refer to the **31%** subset of HHs who reported that they were **aware of children under the age of 11 working within the camp** in the 30 days prior to data collection

EDUCATIONAL FACILITIES

Number of educational facilities and available certification in the camp per age group, as reported by KIs at the time of data collection:

Age group	Educational facility	Certification availability
3-5	1	No
6-11	1	No
12-14	1	No
15-17	1	No
Total	1	

54% of girls reported going to school inside the camp compared to the total number of girls in the HH.

47% of boys reported going to school inside the camp compared to the total number of boys in the HH

Figure 15: % of girls attending school, inside the camp, relative to total in that age group in that HH*. ▼

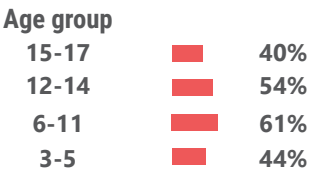
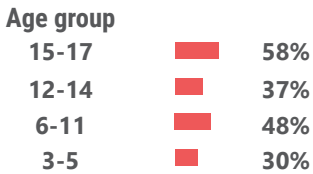


Figure 16: % of boys attending school, inside the camp, relative to total in that age group in that HH*. ▼



* No children attended schools outside of the camp

Available WASH facilities in schools\temporary learning facilities (TLSs) as reported by KIs:

Latrines	Yes, in all schools/TLSs (all segregated)
Handwashing facilities:	Yes, in all schools/TLSs
Safe drinking water:	Yes, in all schools/TLSs

SCHOOL-AGED CHILDREN (6-17 YEARS OLD)

50% of school-aged children in the HHs were reported to receive education

The most commonly reported barriers to access education for these HHs were *(HHs could select as many options that applied meaning the sum of percentages may exceed 100%):* ▼

- Child did not want to attend (45%)
- Schools closed/educational services suspended due to summer holiday (23%)
- Temperatures (too hot/too cold) (18%)

EARLY CHILDHOOD DEVELOPMENT (3-5 YEARS OLD)

39% of 3-5 year old children in the HHs reportedly received early childhood **education**

Most commonly reported barriers to early childhood education *(HHs could select as many options that applied meaning the sum of percentages may exceed 100%):* ▼

- Child did not want to attend (50%)
- Schools closed/educational services suspended due to summer holiday (25%)
- Temperatures (too hot/too cold) (25%)

METHODOLOGY OVERVIEW

The process of data collection for camp analysis employs three distinct methodologies: KI interviews, HH interviews, and on-field mapping data collection. KI interviews serve as a primary source of information, providing insights into camp management, services, and infrastructure. Each camp is subject to one KI interview, conducted with the camp managers. HH interviews are carried out using a random sampling method. The goal is to achieve a 95% confidence while maintaining a 10% margin of error. This approach is founded upon population figures supplied by the camp management.

The on-field mapping data collection technique involves physically visiting camp facilities, documenting precise locations using KoBo, and assessing available services. Collected data from on-field mapping is compared with KI interviews for a holistic understanding of camp infrastructure and services. The infrastructure map corresponding to the current cycle for the camp can be accessed here. All Camp and displacement products remain accessible on the REACH Resource Centre.

ENDNOTES

[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.

[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] Reach Initiative, NES Market Monitoring Exercise 22-November

[6] 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]

[7] 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

[8] 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.

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).