Northeast Syria
Barriers to COVID-19 Related Health-Seeking Behaviour
May 2021

Introduction

Over a year into the global COVID-19 pandemic, cases across Syria have continued to rise, compounding the vulnerability of individuals dually impacted by the over decade-long conflict.[1] Following a significant increase in reported cases of COVID-19 across Northeast Syria (NES) in March 2021,[2] REACH and the Humanitarian Needs Assessment Programme (HNAP) endeavoured to **improve humanitarian understanding of community perceptions of COVID-19, the barriers hindering effective mitigation, as well as community knowledge or acceptance of future vaccination campaigns.** To achieve this, HNAP and REACH relied on a community focal point (CFP) methodology across the region. To better analyse the results and inform future programming, the findings of this assessment have systematically been disaggregated according to focal point type (healthcare workers and non-healthcare workers), as well through a geographic breakdown by governorate and and urban/rural disaggregation (see Annex 2 for more details). Additional analysis has been conducted overlaying data from the Northeast Syria COVID-19 Dashboard with the data that was conducted for the assessment.

Since the start of the pandemic, both HNAP and REACH have invested significant effort to enhance humanitarian knowledge about mitigation measures present and community knowledge of COVID-19 through various assessments such as the HNAP Rapid Assessments, Vulnerability Reports and Transit Point Monitoring and REACH Knowledge, Attitudes, and Practices Survey. However, critical gaps persist related to the type of barriers preventing individuals from engaging in mitigation measures. **The following report addresses this gap and enhances the humanitarian community's understanding of the barriers preventing individuals from engaging in COVID-19 mitigation efforts or seeking care, including both physical and social hindrances, such as the lack of access or discrimination.**

Methodology

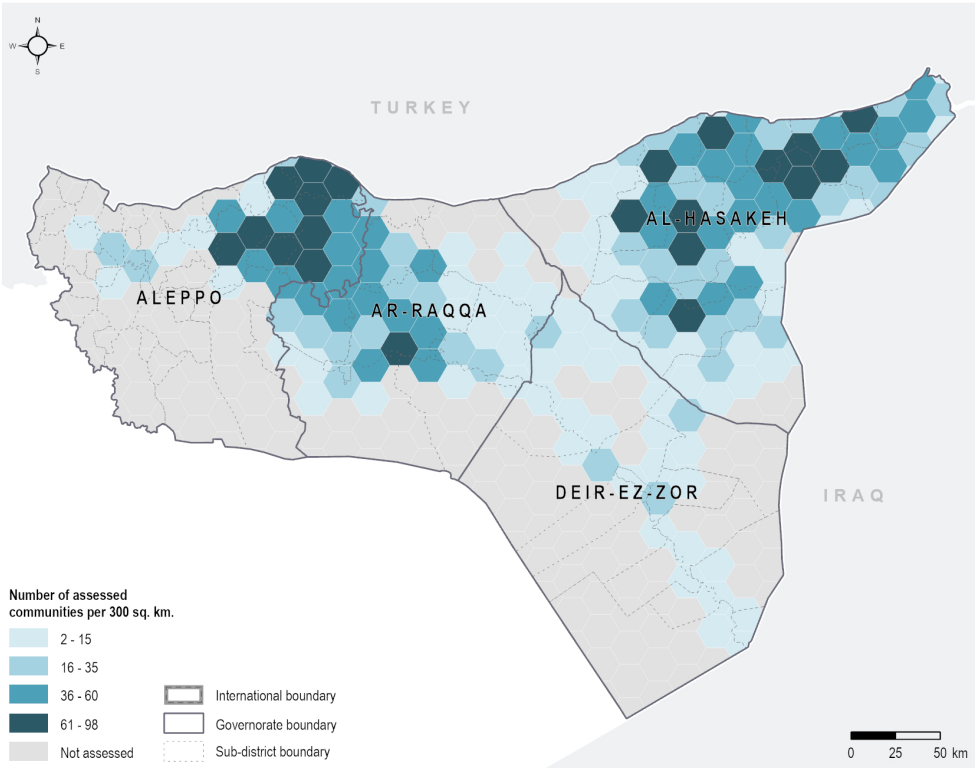
A community focal point (CFP) interview methodology was employed for this survey. Data collection took place between 27 March and 23 April 2021 in 2,317 communities across 12 districts in four governorates: Al-Hasakeh (AH), Aleppo (Al), Ar-Raqqa (AR), and Deir-ez-Zor (Dez). Enumerators were instructed to purposively select CFPs based on their knowledge of resident populations in the community, focusing on collecting information from one healthcare worker (HCW) and one other community member (non-HCW). CFPs were then instructed to respond to the sections of the questionnaire that best fit their sector-specific expertise. Enumerators contacted CFPs and potential CFPs by phone and in person. Non-HCW CFPs included community leaders, teachers, local administration, IDP (internally displaced persons) representatives, camp managers and social workers. In total, 4,730 interviews were conducted (2,357 HCW and 2,373 non-HCW).

Data from the survey has been analysed and reported on at the governorate level. All analysis was conducted using R analytical software, and supplemented with maps created using Arc GIS. Further notes can be found in Annex 2.

Context

The total number of reported cases in NES as of 31 March was 10,973 (474 per 100,000),[3] with most cases being centred in Al-Hasakeh Governorate (see Map 1 in Annex). At the start of the pandemic, the NES COVID-19 Task Force and local authorities established resources such as public hotlines, dedicated COVID-19 hospitals, and COVID-19 testing centres to provide early diagnosis and mitigate high morbidity and mortality rates. However, the exceptional surge of COVID-19 cases in NES in March 2021 has raised significant concerns regarding barriers to understanding, accessing and utilising COVID-19 care. Reports indicate that existing resources were minimally utilised, with late or non-reporting of symptoms, and low hospitalisation rates, calling into question the efficacy of certain mitigation efforts.

Coverage Map



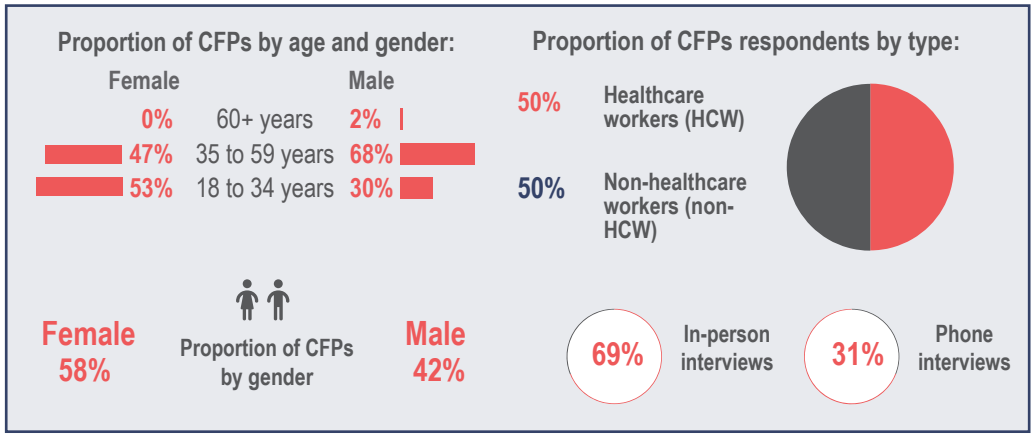
Limitations

Efforts were made to cover as many communities as possible. In addition, HNAP and REACH sought to obtain a more distributed sample of CFPs, according to their role in the community and gender. As a result, while a larger number of communities were covered, these protocols as well as various logistical constraints resulted in a longer data collection period, adding variability to the data.

Data presented in this report is dependent on CFP feedback and is therefore based on the perceptions of targeted individuals, and does not reflect the views or perceptions of HNAP or REACH. During the time of data collection, COVID-19 rates and curfews shifted considerably. As such, it should be noted that not all communities have representation from the intended three CFPs due to challenges in finding willing participants during the lockdown period. Maps have been drawn up to try to address the variability, by providing an illustration of how people's perceptions relating to COVID-19 have changed over time, in tandem with increasing COVID-19 cases on the ground. However, these maps too should be considered indicative only.

Number of CFPs interviewed per community	Number of communities covered
1	27
2	2,167
3	115
4	8
4,730	2,317

Sample Details



Presentation of Findings

The survey questionnaire was divided into four sections focusing on assessing knowledge of COVID-19, COVID-19 practices, attitudes towards COVID-19, and barriers related to usage and access of resources. The full tool and dataset can be found here.

These four sections have been broken down further into 8 themes: 1) perception of COVID-19 within the community, 2) community perception of the COVID-19 vaccine, 3) behaviour based on COVID-19 symptoms, 4) knowledge of COVID-19 related resources, 5) COVID-19 related health-seeking behaviour, 6) perception of quality of available resources for COVID-19 treatment, 7) attitudes and practices based on perception of COVID-19 severity, and finally, 8) barriers to healthcare seeking behaviour.

Themes 1, 2, and 8 (perception of COVID-19 within the community, community perception of the COVID-19 vaccine, and barriers to healthcare seeking behaviour) were addressed to all CFP types in an effort to capture potential differences between HCW and non-HCW CFPs, while theme 3 (behaviour based on COVID-19 symptoms) focused on capturing the views of HCW CFPs to shed light on the kind of symptoms, conditions, and advice that encourages or prevents community members from seeking medical care. Themes 4, 5, 6, and 7 (knowledge of COVID-19 related resources, COVID-19 related health-seeking behaviour, perception of quality of available resources for COVID-19 treatment, and attitudes and practices based on perception of COVID-19 severity) focused on non-HCW CFPs for a more in-depth understanding of the ways in which non-medical persons identify risk and take action related to COVID-19.

Findings have been divided and presented in three main sections to match respondent type: All CFPs, HCW CFPs and non-HCW CFPs with the above mentioned themes. The analysis presented includes an overall analysis across NES, and findings disaggregated by governorate, gender (male/female), or demography (urban/rural) where relevant.

Additional analysis has been conducted and presented in the form of maps to supplement findings and provide cross-analysis based on COVID-19 rates across districts (based one the NES COVID-19 dashboard). These maps can be found in Annex 1 and a detailed explanation of the methodology can be found in Annex 2.

Highlights

Overall, among all CFPs, **36%** cited that compared to the prior three months, their community's level of **concern regarding COVID-19 had somewhat increased**; 39% of HCW CFPs reported that concern levels had somewhat increased, while 32% of non-HCW CFPs reported the same.

- In general, CFPs from urban communities were more likely to report higher levels of concern amongst community members, compared to their rural counterparts.

71% of non-HCW CFPs reported that the majority of members in their community would be **willing to get the COVID-19 vaccine** if it was available to them, and **65%** of HCW CFPs reported the same.

- Of the percentage that reported that community members would not be willing to get the vaccine, CFPs cited lack of trust in the vaccine and its side effects as the main cause (94%).

Difficulty breathing, loss of taste/smell and fever were identified by HCW CFPs as the three major symptoms that would encourage community members to seek medical care (77%), although 21% still mentioned that community members would self-isolate at home with these symptoms.

- CFPs in urban communities were found to be more likely to report that community members would seek care with the above symptoms (100%) when compared to rural communities (77%).

63% of HCW CFPs identified that community members would primarily seek **medical care at public hospitals, private clinics, or regular health facilities**. Dedicated COVID-19 facilities and the public hotline were almost never mentioned in the top three places in which community members would seek care.

- Healthcare being too expensive was cited as the main barrier to seeking care by HCW CFPs.
- 42% of HCW CFPs identified a lack of severity of symptoms as a reason for community members' unwillingness to seek care.

Generally speaking, **satisfaction rates for all forms of facilities were high**, with the cost of usage being the main reason for dissatisfaction.

- Non-HCW CFPs in Aleppo mentioned that community members were not satisfied with the public hotline due to a lack of connectivity and the calls not being answered.

Nearly two-thirds (63%) of non-HCW CFPs reported lack of belief in the severity of COVID-19 as the main reason individuals do not report their symptoms, or seek care. Meanwhile half also reported a lack of awareness of symptoms and 38% indicated lack of financial capital to afford cost of access to essential health resources.

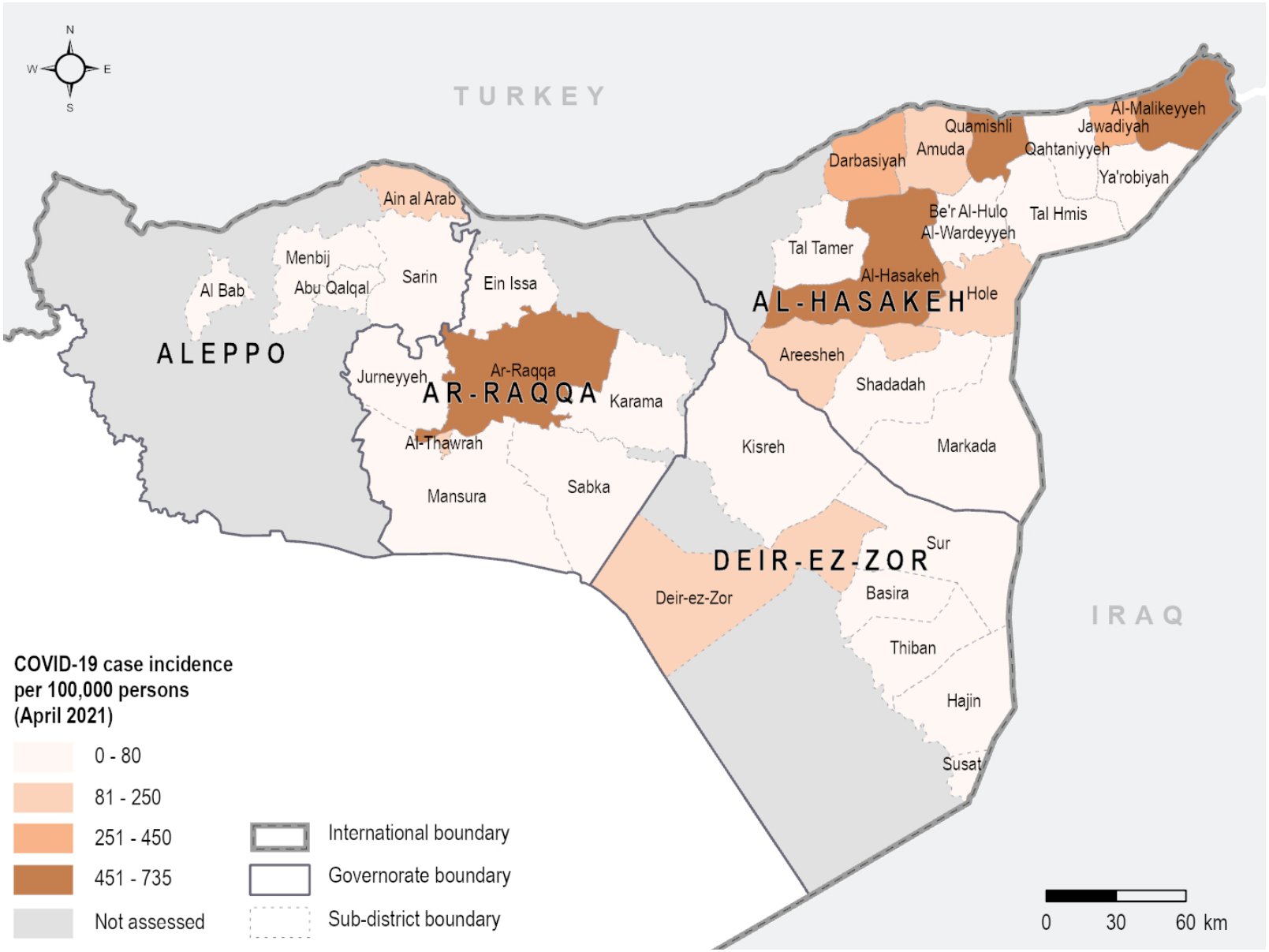
- Discrimination may also deter reporting/seeking healthcare assistance; about half (49%) of CFPs reported instances of discrimination/ stigmatisation of individuals and households who have/ have had COVID-19.

Recommendations

The following recommendations have been proposed based on findings from the data, following a review of the analysis by HNAP and the COVID-19 Task Force, with the objective of providing partners specific areas that could be focused on to improve the response. These recommendations are not exhaustive and should be explored in detail prior to any implementation.

1. Differences in the reported levels of concern related to COVID-19 between urban and rural communities suggests increased need for information sharing in rural environments, focusing on the severity of COVID-19 and the types of assistance available.
2. Continued messaging on the symptoms associated with COVID-19, the possibility of asymptomatic transmission, and the importance of self-isolating or testing in case of symptoms is vital across NES, with an emphasis on targeting rural areas.
3. Provide more awareness of the ways in which dedicated COVID-19 facilities and public hotlines are essential in identifying and treating suspected and confirmed cases of COVID, ensuring connectivity issues do not exist, and providing for monetary support to facilitate access to healthcare.
4. Encourage more immediate health-seeking behaviour by emphasizing that severity related to symptoms can change very fast and death can be prevented with immediate hospitalisation/ care-seeking.
5. Scale-up hotline awareness efforts through community or religious leaders, while also investing in less-formal modalities, like social media.
6. Provide financial assistance to facilitate access to healthcare facilities or patient transport, especially for individuals in rural communities, keeping in mind losses incurred while staying out of work as well.
7. Utilise the assistance of local community leaders, healthcare workers, other community-based leaders to reduce discrimination/stigma surrounding seeking care for COVID-19.
8. Explore ways in which communities can provide increased child support structures for those who are ill to alleviate the double-burden and risk of contagion.
9. Increased vaccine sensitization, particularly focused on increasing trust, is essential to ensuring a smooth roll-out for immunization. Trust in the vaccine was found to be lowest in Aleppo, followed by Dier-ez-Zor, Ar-Raqqa and then Al-Hasakeh.

CONTEXT MAP | COVID-19 INCIDENCE ACROSS SUB-DISTRICTS



*Data for the map was taken from the Northeast Syria COVID-19 Dashboard and represents COVID-19 figures for the month of April, 2021

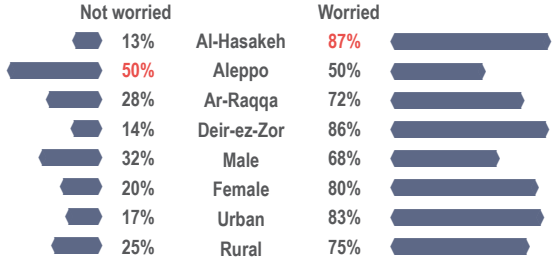
Perception of COVID-19 within the community

Over half (59%) of CFPs reported that the level of concern related to COVID-19 has somewhat, or significantly increased in the previous three months. In general, female focal points were far more likely than their male counterparts to indicate a general increase (somewhat or significant) in concern, 69% as compared to 44% of males. Concurrently, 83% of urban CFPs reported the majority of their community members are worried about contracting COVID-19 (compared to only 75% of rural CFPs).

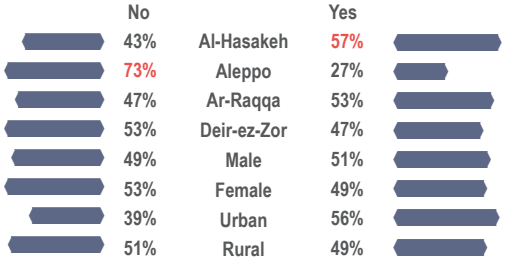
36% of all CFPs estimated that their community's level of concern surrounding COVID-19 has somewhat increased in the previous three months (39% HCW CFPs; 32% non-HCW CFPs), while 25% said it was the same (30% HCW CFPs; 20% non-HCW CFPs), and 23% said it had significantly increased (16% HCW CFPs; 31% non-HCW CFPs):

- 61% of CFPs in Deir-ez-Zor reported it somewhat increased, and 15% said it had significantly increased
- 40% of female CFPs across NES said concern levels had somewhat increased (vs. 29% of male), and 29% said significantly increased (vs. 15%)

75% of all CFPs reported that they view that, in their view, the majority of members in their community are currently worried about contracting COVID-19 (81% HCW CFPs; 69% non-HCW CFPs):



49% of all CFPs reported that they view the majority of their community members perceive COVID-19 as a deadly disease (47% HCW CFPs; 51% non-HCW CFPs):



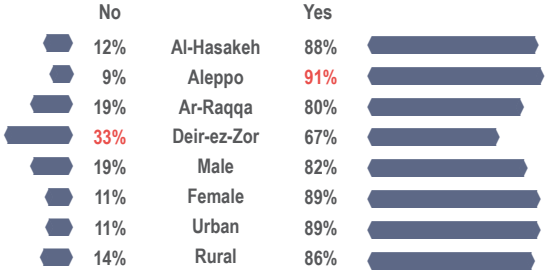
96% of all CFPs reported that they think it is likely that they or someone in their community could contract COVID-19 in the next month.

- 100% of CFPs in Deir-ez-Zor reported this
- 98% of female CFPs reported the same, in comparison to 93% of male CFPs

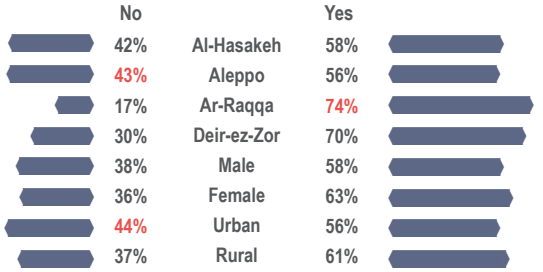
Community perception of the COVID-19 vaccine

The majority of CFPs (86%) reported that community members are generally aware of the COVID-19 vaccine. However, more than a third did not think community members would be willing to receive a vaccine, citing significant lack of trust in the vaccine and the presumed side-effects.

86% of all CFPs reported that they think community members are aware that there is a vaccine that can protect against COVID-19 (82% HCW CFPs; 90% non-HCW CFPs):



61% of all CFPs reported that they think the majority of members in their community would be willing to get the COVID-19 vaccination if it was made available to them (65% HCW CFPs; 57% non-HCW CFPs):



Of the 37% who reported community members may not be willing to get vaccine (2% reported "do not know"), CFPs identified the following top three reasons for why community members may not want to get vaccinated:[4]

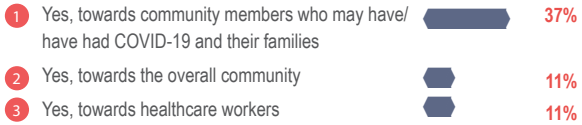
- Female CFPs were more likely to cite "do not feel it is necessary" more as a reason in comparison to men (35% vs. 26%)
- CFPs in Aleppo cited cost much less than other governorates (7% vs. 51% in AH, 17% in AR, 63% in Dez)
- Lack of trust was cited least by CFPs in Al-Hasakeh (87% vs. 98% in Al, 97% in AR, 95% in Dez)

- Al= Aleppo
- AH= Al-Hasakeh
- AR= Ar-Raqqa
- Dez= Deir-ez-Zor

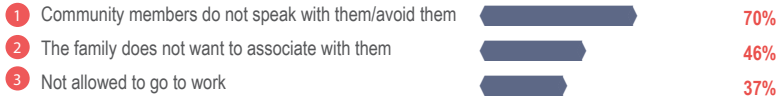
Barriers to Seeking Healthcare Assistance

Stigmatisation against those who have had, or have, COVID-19 is highly prevalent, with almost half (49%) of CFPs reporting instances of stigmatisation/discrimination against affected individuals and their households. This prevalence is deeply concerning and could pose a potential risk to ensuring regular reporting and/or health-seeking behavior for individuals who feel they may have COVID-19 in the future. While the vast majority of CFPs who felt there is discrimination/ stigmatisation cite community members avoided affected individuals (70%), a concerning 37% reported that community members could not access employment. Such economic discrimination indicates that beyond the immediate and long-term health concerns, COVID-19 may risk the financial stability of impacted households, while also undermining the resilience of local economies.

49% of CFPs view there to be discrimination/stigmatisation against community members who may have/have had COVID-19 and their families, the overall community, and healthcare workers:[4]

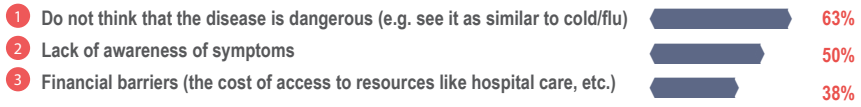


Of the 49% that reported there is discrimination, CFPs reported that discrimination primarily takes place as the following:[4]



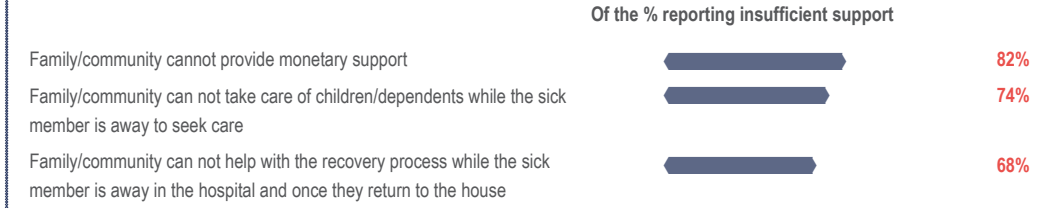
- 74% of CFPs from Al-Hasakeh reported that community members do not speak to the groups that are being discriminated against (vs. 66% in Al, 65% in AR, 64% in Dez); 83% of female CFPs reported the same (vs. 54% males)
- 49% of CFPs from Al-Hasakeh reported that community members would not allow the groups that groups to go to work (vs. 11% in Al, 31% in AR, 40% in Dez)

CFPs reported the following as the top three factors that prevent community members in their community who may have symptoms or think that they have COVID-19 from reporting the disease or seeking treatment:[4]



- 79% of CFPs from Deir-ez-Zor and 77% of CFPs from Aleppo reported that community members do no think the disease is dangerous (vs. 55% in AH, 62% in AR)
- 79% of CFPs from Deir-ez-Zor reported lack of awareness (vs. 52% in AH, 38% in Al, 52% in AR); 57% of female CFPs cited the same (vs. 41% of males)
- 38% of CFPs in rural areas cited financial barriers (vs. 22% of urban)

43% of CFPs reported community members do not have sufficient community/social support if they were to seek medical care:[4]

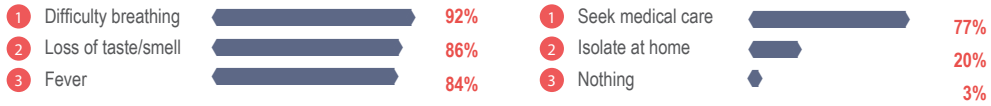


- Of the 57% of CFPs that reported that community members would have sufficient support if they were to seek medical care, 61% of CFPs from Ar-Raqqa reported that community members could provide monetary support (vs. 84% in AH, 83% in Al, 95% in Dez); female CFPs reported that monetary support would be available more than male CFPs (89% vs. 71%)
- 54% of CFPs from Deir-ez-Zor reported that community/family support would be available in terms of childcare/ taking care of dependents (vs. 62% in AH, 96% in Al, 85% in AR)
- 74% of CFPs in rural settings said community/family care for children/dependents would be available (vs. 67% in urban); a higher percentage of CFPs from urban settings reported that family/community members would be available to help with the recovery process compared to CFPs in rural settings (92% vs. 68%)

Behaviour related to symptoms

According to HCW CFPs, community members reported a decent knowledge of the COVID-19 symptoms; the vast majority reported that difficulty breathing (92%), loss of taste/smell (86%) and fever (84%) would cause concern related to COVID-19. Consistent with reports from non-HCW CFPs, of those CFPs who reported that community members would not take any action if they thought they were symptomatic, the majority cite healthcare expenses as the main deterring factor (81%). Concurrently, of the 24% who would not seek medical attention, HCW CFPs reported that financial assistance would likely encourage more individuals to seek care.

CFPs reported the following symptoms as the three main symptoms that would cause community members concern regarding COVID-19 and the following actions they would take if they were to show these symptoms:[4]



- 99% of CFPs in Aleppo and 96% in Deir-ez-Zor reported that they would seek medical care if they had the above symptoms (vs. 69% in AH, 66% in AR)
- 100% CFPs in urban settings reported community members would seek care with the above symptoms (vs. 77% in rural)

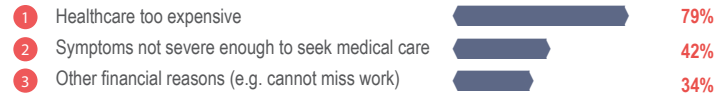
Of the 77% of CFPs that said community members would seek medical care in case they experienced the above symptoms, the majority reported community members would go to private clinics or public hospitals. The 3% of CFPs that said community members would be unwilling to seek care primarily attributed this to healthcare being too expensive:[4]

- No CFPs in Aleppo or Deir-ez-Zor reported that community members would do nothing in case of symptoms
- 48% of CFPs in Al-Hasakeh cited that community members may not seek care as they do not view COVID-19 as dangerous; 38% said members did not think they were in the "vulnerable" category, and also out of fear of discrimination/stigma from the community
- 46% of male CFPs cited discrimination/stigma from community (vs. 4% of females)

When asked if community members would be likely to seek medical care if they had COVID-19 specific symptoms (fever, loss of taste/smell, difficulty breathing, flu-like symptoms), 76% of CFPs reported they would. Public hospitals, private clinics, and regular health facilities were identified as the places in which community members would seek care:[4]

- 97% of CFPs from Deir-ez-Zor reported that members would seek care for the above symptoms (vs. 78% in AH, 68% in Al, 75% in AR)
- 47% of CFPs in Al-Hasakeh cited that community members would seek care at dedicated COVID-19 facilities as the third most likely location for care; 30% of CFPs from Deir-ez-Zor cited public primary health centres
- 100% of CFPs from urban settings reported community members would seek care (vs. 76% in rural)

Of the 24% of CFPs that said community members would not seek medical care in case they had COVID-19 specific symptoms, 79% cited healthcare being too expensive as the main barrier:[4]



- 60% of CFPs in Al-Hasakeh cited other financial reasons, and 24% cited not knowing what resources exist
- 98% of CFPs in Aleppo cited a lack of severity of symptoms, and 48% of CFPs said community members do not seek care because they are not sure what to do
- 56% of CFPs in Al-Hasakeh said community members were not sure what to do and 40% said community members did not have access to health facilities
- 46% of male CFPs cited discrimination/stigma from community (vs. 4% of female CFPs)

Furthermore, of the 24% who reported community members would not seek medical care, CFPs identified the following as the top three symptoms and circumstances that would need to change to encourage community members to seek medical care:[4]

- 77% of CFPs in Aleppo cited difficulty getting out of bed and moving as the third most important change in symptoms; only 9% cited high fever, 87% cited severe chest pain
- 61% in Al-Hasakeh said normal symptoms would have to worsen as the third most important change in symptoms (instead of severe chest pain), 67% said the same in Deir-ez-Zor
- Confidentiality mechanisms were the second most cited in terms of a change in circumstance by 70% of CFPs in Al-Hasakeh, and 67% in Deir-ez-Zor
- Financial help was cited by 100% of CFPs in Deir-ez-Zor and 98% in Aleppo

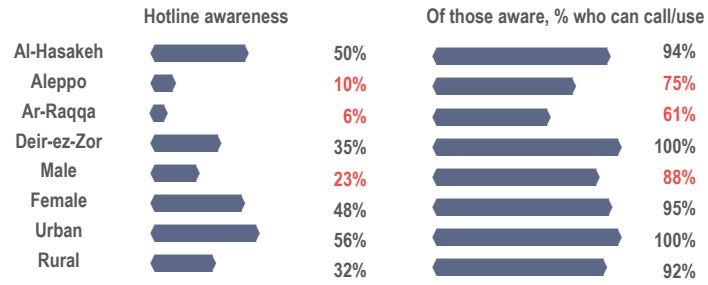
77% of CFPs reported community members would take a doctor's advice if they recommended that, either due to the severity of a community member's symptoms or underlying conditions (including age), they should be referred to a dedicated hospital for treating COVID-19. Rumors of the dangers of treatments administered at medical facilities was cited most as the reason for why the remaining 23% would not go:[4]

- 41% of CFPs cited they had heard the quality of care is lower than at normal hospitals, 39% said these facilities are too far away from their homes and they would not be able to travel there
- Discrimination and stigma was identified by 48% of CFPs in Al-Hasakeh; 49% in Ar-Raqqa reported that community members would not listen to the doctor as they were worried that if a family member passes away in the hospital, they would not get their body back

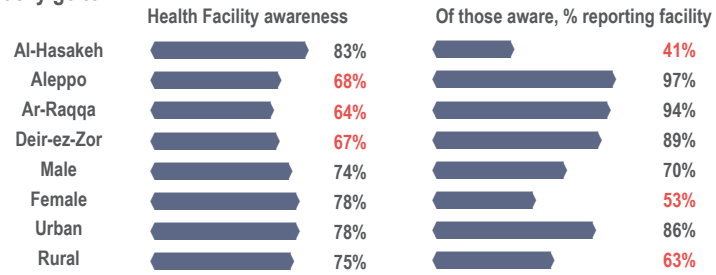
Knowledge of Resources for COVID-19

Less than a third (32%) of CFPs' reported that the majority of their respective communities were aware of the COVID-19 hotline. While the rate was somewhat improved in urban areas (56%) there remains significant gaps in awareness. Overall, about three-quarters of CFPs indicated that the majority of their community members were aware that they could get a COVID-19 test at designated hospitals and that there were hospitals designated to treat symptomatic patients. Of those that were aware of reporting resources, the majority (85%) heard about these resources from friends and family, followed by 66% reporting social media.

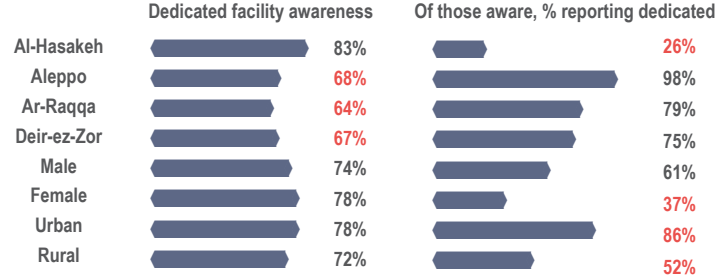
32% of CFPs reported that the majority of members in their community have heard of the COVID-19 reporting hotline; of this population 92% reported that community members would know how to call it.



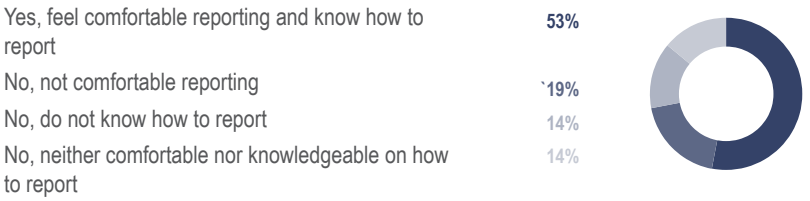
75% of CFPs reported community members are aware that they can go to a regular health facility to a COVID-19 test, of this population 63% have reported that there is a facility closeby that members of their community can easily go to.



72% of CFPs reported that the majority of members in their community are aware that there are dedicated hospitals that have been established to treat COVID-19 cases free of charge. Of this population, 52% have reported that there is a dedicated COVID-19 facility closeby that members of their community can easily go to.

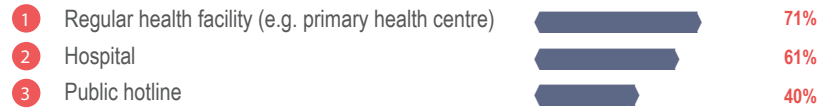


CFPs' views on whether the majority of members in their community would feel comfortable and know how to report symptoms or seek treatment if they thought they had COVID-19:[4]



- 27% of CFPs in Al-Hasakeh reported that they did not think the majority of members in their community were comfortable reporting (5% in Al, 17% in AR, 19% in Dez)
- 12% CFPs in Aleppo and Al-Hasakeh reported that they did not think the majority of members in their community knew how to report (25% in AR, 17% in Dez)
- 22% of female CFPs reported that members of their community were not comfortable reporting, in comparison to 18% of male CFPs

Of the 53% above, CFPs reported the following as the top three resources community members may make use of:[4]



- CFPs in Aleppo (26%) and Ar-Raqqa (46%) identified dedicated COVID-19 facilities as the third resource
- 12% CFPs in Aleppo and Al-Hasakeh reported that they did not think the majority of members in their community knew how to report symptoms (25% in AR, 17% in Dez)
- 22% of female CFPs reported that members of their community were not comfortable reporting symptoms, in comparison to 18% of male CFPs

Of 53% above, CFPs reported the following as the top three sources where community members may have learned about each resource:[4]

- 70% of CFPs in Deir-ez-Zor identified non-governmental organisations (NGO) and international NGOs (INGOs) as the third resource

Behaviour related to seeking care for COVID-19

Only just over half (54%) of CFPs reported sufficient awareness of COVID-19 related resources for when individuals begin feeling symptoms. In the instance of feeling symptoms, 89% of CFPs believed that the majority of members in their community would either seek treatment and/or report their illness. The most significant barriers for reporting or seeking treatment when symptomatic were related to healthcare expenses.

54% of CFPs reported that they think that the majority of members in their community are aware (compared to very few and no members) of the resources available in case of COVID-19 infection/ in case they are experiencing symptoms:[4]

- 60% of CFPs in Deir-ez-Zor expressed that that very few members of their community are aware
- 63% of CFPs in Aleppo identified that expressed that that the majority of members of their community are aware

CFPs' views on whether the majority of members in their community would seek treatment or report their issue in case of COVID-19 infection/ experiencing symptoms:[4]

Yes, would seek treatment	64%
Yes, would report	5%
Yes, would seek treatment and report	20%
No	11%

- 4% of CFPs in Deir-ez-Zor expressed that majority of members in their community would seek treatment and report their issue in case of COVID-19 infection/ in case they are experiencing symptoms (15% in AH, 35% in Al, 21% in AR). 92% said they would seek treatment (64% in AH, 61 in Al, 59% in AR)
- 4% of female CFPs said community members would report (vs. 8% male)

Of the 11% who reported that community members would not seek treatment or report their issue in case of of COVID-19 infection/experiencing symptoms, CFPs reported the following as the top three reasons for why people would not be willing:[4]

1	Healthcare too expensive	47%
2	Symptoms not severe enough in their opinion to seek medical care	41%
3	Discrimination/stigma from community overall	37%

- 46% of CFPs in Al-Hasakeh identified that community members were "not worried about COVID-19 and do not feel it is important to report symptoms" as a third reason
- 31% of CFPs in Raqqa identified "no access to health facilities" as a second, and "worried it could affect ability to work" as a third
- 1% of CFPs in Deir-ez-Zor expressed that the majority of members in their community would not seek treatment and report their issue in case of COVID-19 infection/ in case they are experiencing symptoms, identifying "not sure what to do" as a third reason

Perception of quality of available resources for treatment of COVID-19

Over half (59%) of non-healthcare worker CFPs believed the majority of local community members would have relied on the following resources when symptomatic: health facilities, hospitals and the public COVID-19 hotline. 79% were satisfied with the services received. Hospitals however, had the lowest satisfaction rate (47%) indicating a worrying concern for the second-most common provider of assistance.

59% of CFPs reported that community members made use of of available resources (mentioned below) in case of symptoms:[4]

- 29% of CFPs in Ar-Raqqa reported community members used available resources (67% in AH, 62% in Al, 61% in Dez)
- 40% cited cost and a lack of trust of local resource options as a reason for why resources were not utilised

Of the 59% above, CFPs reported the following as the top three resources people in their community have used while seeking treatment or reported their issue in case of COVID-19 infection/in case of symptoms:[4]

Regular health facility (e.g. primary health centre)	55%
Hospital	45%
Public hotline	25%

- 18% CFPs in Ar-Raqqa identified dedicated COVID-19 facilities as the third

Of the percentage that reported community members would use the specific resources above, the majority of CFPs stated that community members were generally satisfied with regular health facilities and the public hotline; satisfaction rates are reportedly lowest for hospitals:[4]

Public hotline	86%
Regular health facility (e.g. primary health centre)	79%
Dedicated COVID-19 hospital	72%
Hospital	47%

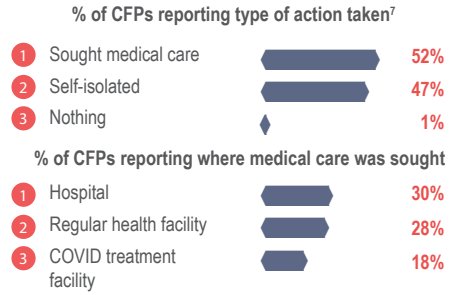
- 100% of CFPs in Aleppo who identified that community members would use the public hotline reported that "the connection being weak/no answer" was the main reason for dissatisfaction; 98% said they would recommend COVID-19 dedicated hospitals
- 92% of CFPs in Deir-ez-Zor and Ar-Raqqa who identified that community members would use dedicated COVID-19 facilities, reported that community members were satisfied; 100% of CFPs in Raqqa said they would recommend the hotline
- 67% in Al-Hasakeh who identified that community members would use the hospital reported that community members were not satisfied due to it being expensive (48%) and affecting one's ability to work (19%). Only 26% of users said they would recommend the service. 91% of public hotline users said they would recommend the public hotline.
- General usage costs (resource being too expensive), resource affecting the ability to work, and the cost of transportation to medical facilities being unaffordable were cited by CFPs as the three main reasons for a lack of satisfaction

ATTITUDES AND PRACTICES BASED ON PERCEPTION OF COVID-19 SEVERITY

Findings evidence the continued contagion potential across Syria and the region, as over a third of non-HCW CFPs' reported the presence of symptomatic individuals in their communities. Reports of cases are most severe in urban centres (all of whom reported the presence), while over three-quarters of the non-HCW CFPs' reported similar prevalence in Deir-ez-Zor. Overall, findings indicate that community members are more likely to seek medical care only when symptoms are severe enough to necessitate hospitalisation, at whatever facility is available to them. Of the 10% of non-HCW CFPs who reported deaths from COVID-19, a significant proportion sought medical assistance at hospitals (63%) demonstrating that a severity of symptoms determines willingness to seek medical care.

Severity Level 1[6] | Symptoms only

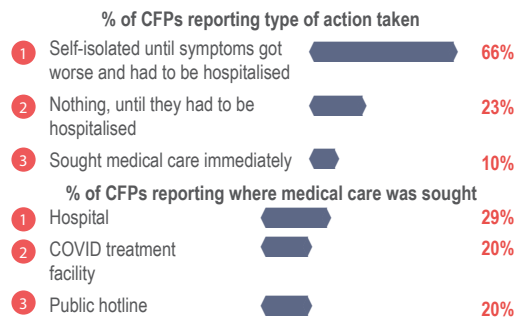
35% of CFPs reported that there are members in their community who have COVID-19 symptoms; 52% reported community members sought medical care at a hospital, regular health facility, or dedicated COVID-19 testing centre following symptoms:



- 88% of CFPs in Aleppo reported that community members sought medical care (vs. 47% in AH, 38% in AR, 70% in Dez); CFPs in Al-Hasakeh (52%) and Ar-Raqqa (61%) reported higher rates of self-isolation post symptoms, as opposed to seeking medical care
- CFPs in urban settings reported a higher rate of seeking medical care at 67% (vs. 52% in rural)
- 81% of CFPs reported that families described their overall experience of seeking care for COVID-19 as good, and 43% reported that others were more likely to seek treatment as a result of hearing about their experience (41% in AH, 58% in Al, 45% in AR, 36% in Dez)

Severity Level 2[6] | Hospitalisation

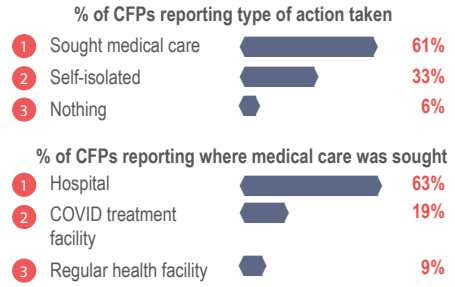
18% of CFPs reported that there are members in their community who have been hospitalised at various facilities due to COVID-19 symptoms; the majority of whom self-isolated until symptoms got worse and they had to be hospitalised. Those who sought care immediately primarily utilised hospitals:



- 21% of CFPs in Aleppo reported community members sought medical care immediately (vs. 10% in AH, 8% in AR, 8% in Dez)
- CFPs in Al-Hasakeh (69%) and Deir-ez-Zor (71%) reported higher rates of self-isolation prior to symptoms worsening, as opposed to seeking medical care care
- CFPs in urban settings reported a higher rate of seeking medical care at 22% (vs. 10% in rural); 24% of CFPs from rural settings also reporting taking no action prior to hospitalisation
- 87% reported that families described their overall experience of seeking care for COVID-19 as good (43% reported bad in Aleppo), and 66% reported that others were more likely to seek treatment as a result of hearing about their experience (68% in AH, 81% in Al, 36% in AR, 63% in Dez)

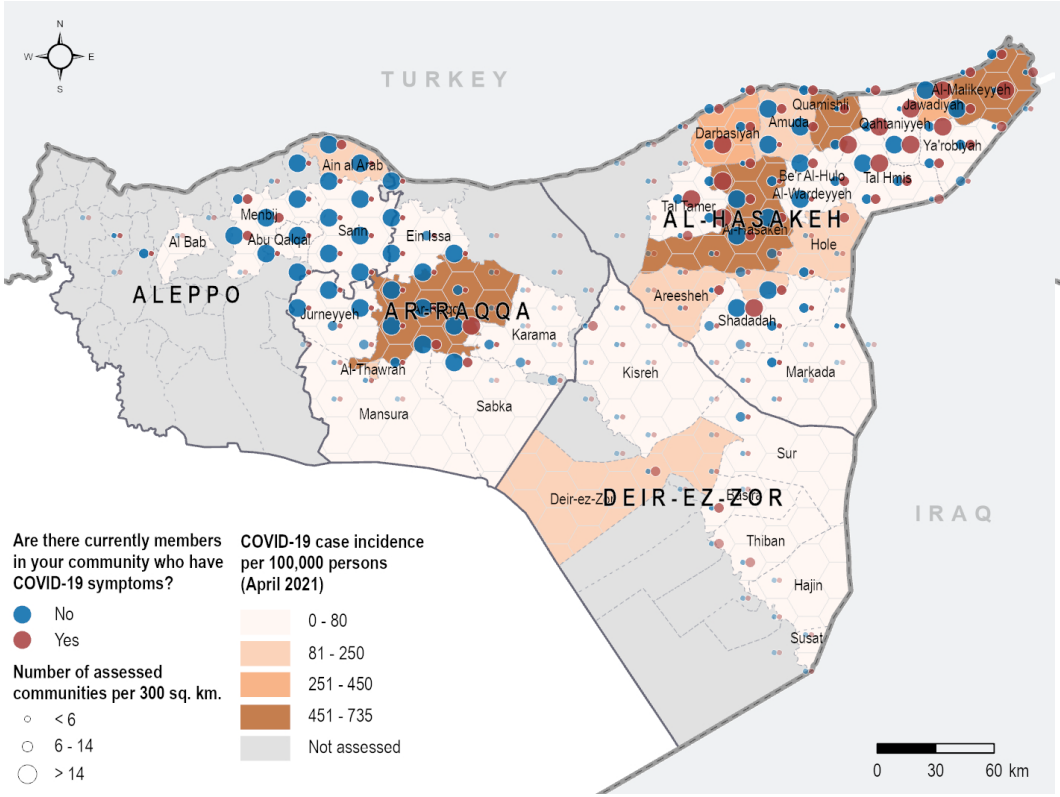
Severity Level 3[6] | Death

10% of CFPs reported that there are members in their community who have died of COVID-19 symptoms; the majority of whom sought medical care at a hospital prior to their death:

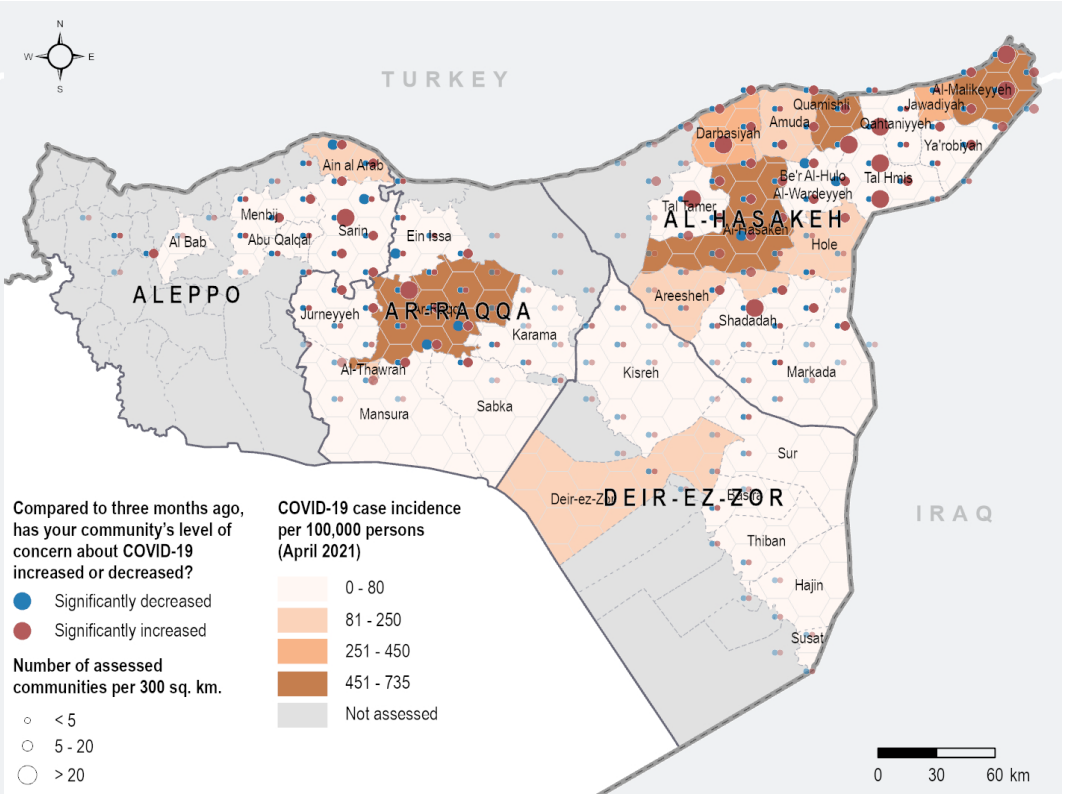


- 89% of CFPs in Aleppo reported community members sought medical care prior to death (vs. 55% in AH, 49% in AR, 76% in Dez); only 6% of CFPs overall reported that community members were unwilling to seek care
- CFPs in Al-Hasakeh (35%) and Ar-Raqqa (46%) reported higher rates of self-isolation post symptoms, as opposed to seeking medical care
- CFPs in urban settings reported a higher rate of seeking medical care at 86% (vs. 60% in rural)
- 62% reported that families of the deceased described their overall experience of seeking care for COVID-19 as bad (57% reported good in Aleppo), and 70% reported that others were more likely to seek treatment as a result of hearing about their experience (77% in AH, 66% in Al, 32% in AR, 79% in Dez)

KNOWLEDGE OF COVID-19 AND ACTUAL INCIDENCE OF COVID-19



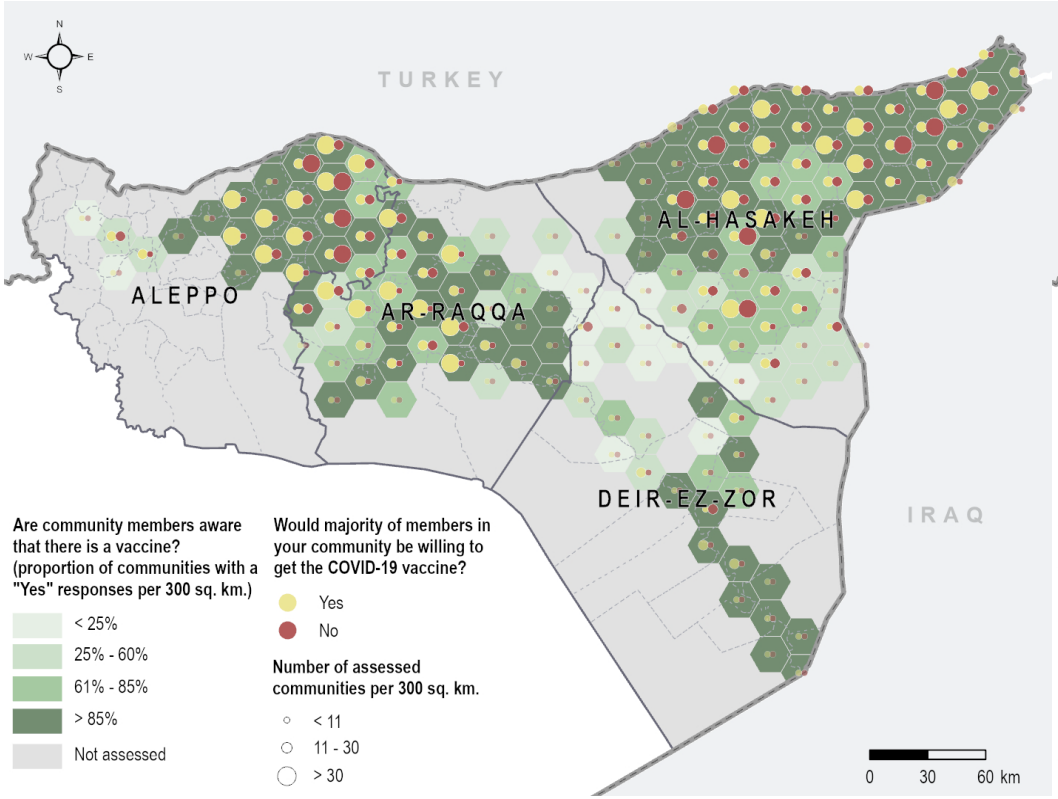
CONCERN LEVELS IN RELATION TO INCIDENCE OF COVID-19 CASES



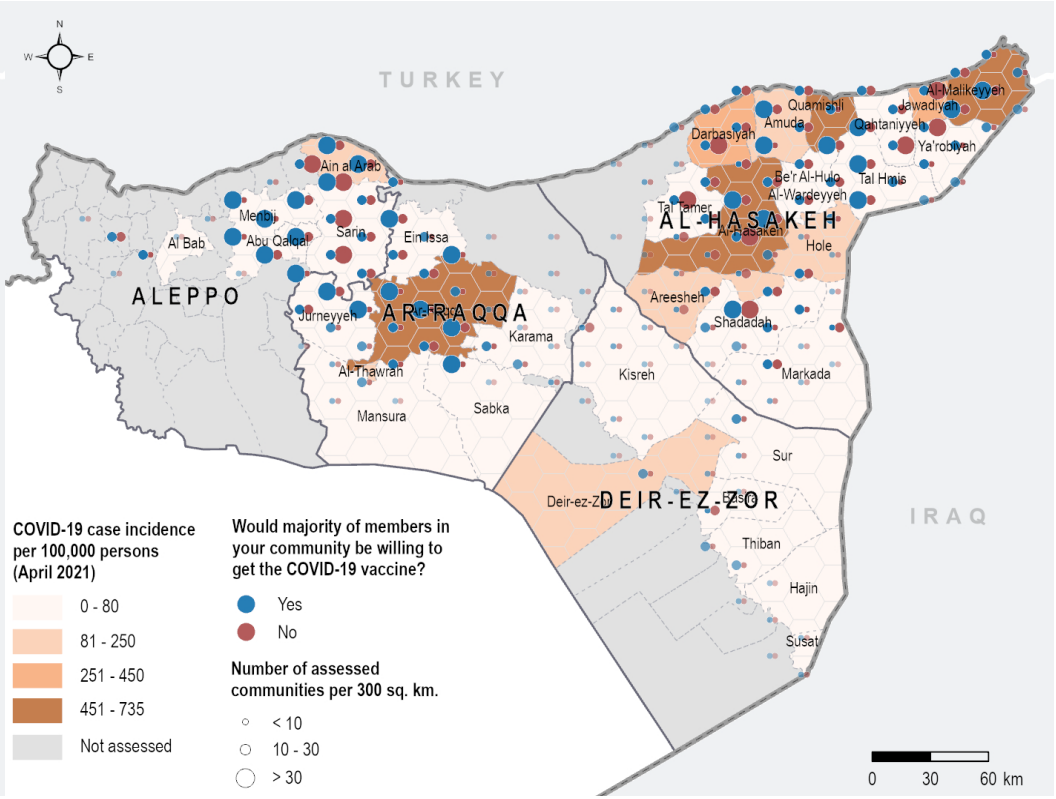
- There are communities where CFPs are unaware that there are community members who have COVID-19 despite recorded cases of infected people. Examples include communities in Aleppo (Ain al Arab) and Ar-Raqqa (Ar-Raqqa).
- CFPs in Al-Hasakeh are more aware of members in their community who have COVID-19 symptoms, in line with recorded incidents of COVID-19.

- Overall concern levels surrounding COVID-19 have significantly increased regardless of incidence of COVID-19 cases.
- Despite high numbers of recorded cases of COVID-19, there are communities in which CFPs have identified that their community's concern level has significantly decreased (ex. Aleppo (Ain al Arab) and Ar-Raqqa (Ar-Raqqa)).
- In other cases, such as in Al-Hasakeh, concern levels have significantly increased (Al-Malikeyyeh) along with high recorded rates of COVID-19, and in other areas (ex. Shaddah and Qahtaniyyeh) despite low recorded case incidents.

KNOWLEDGE OF THE COVID-19 VACCINE AND WILLINGNESS TO GET VACCINATED



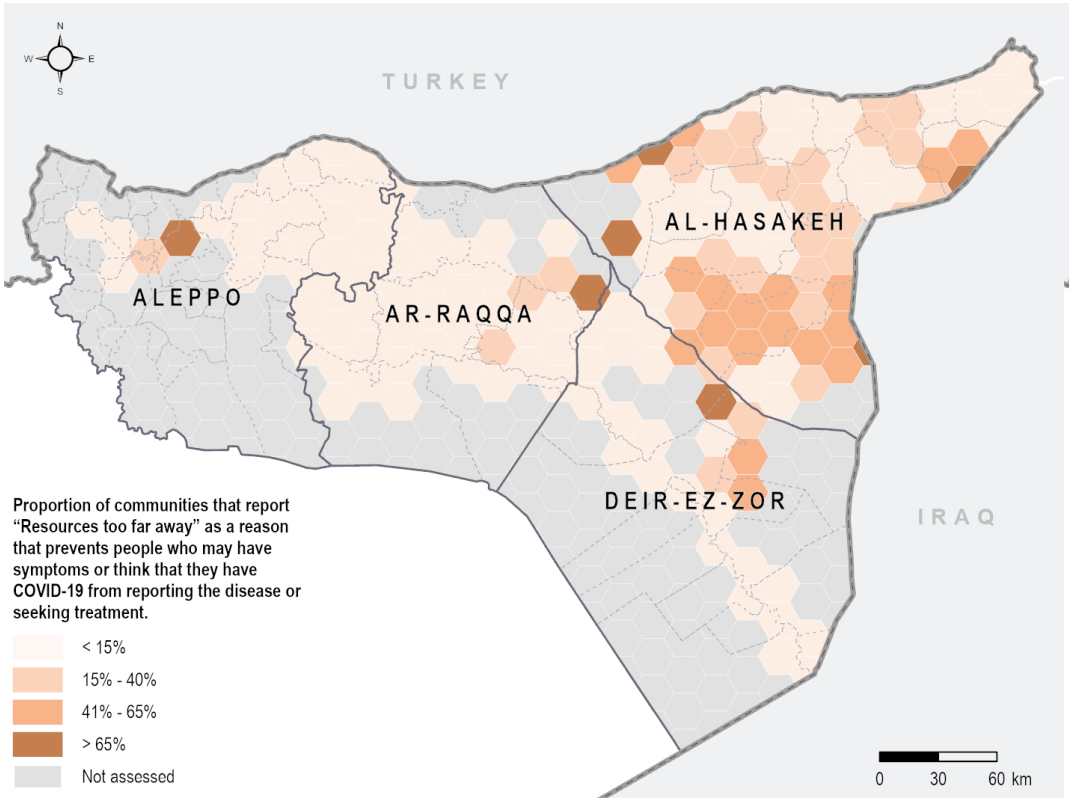
WILLIGNESS TO GET VACCINATED AND INCIDENCE OF COVID-19 WITHIN COMMUNITIES



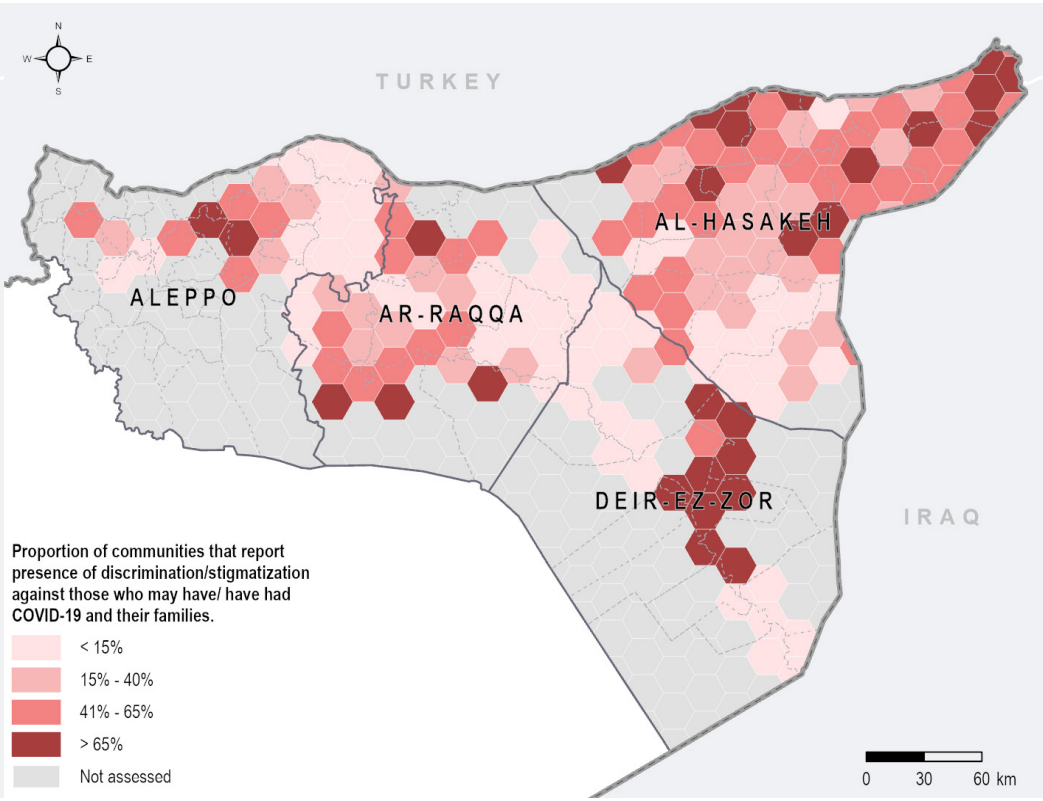
- The majority of assessed communities are aware that there is a COVID-19 vaccine
- Most of the communities that are unaware, are distributed between Deir-ez-Zor and Al-Hasakeh.
- CFPs across NES have mostly indicated that community members are willing to get vaccinated in areas where there is high levels of knowledge of the vaccine.

- CFPs in Aleppo and Ar-Raqqa have generally expressed that community members are willing to get vaccinated against COVID-19; willigness seems more split in Al-Hasakeh and parts of Aleppo
- There seems to be some correlation between community members' willingness to get the vaccine and incidents of COVID-19 in Ar-Raqqa. However, there is very little correlation in Al-Hasakeh.

DISTANCE AS A BARRIER TO ACCESSING COVID-19 RELATED HEALTHCARE



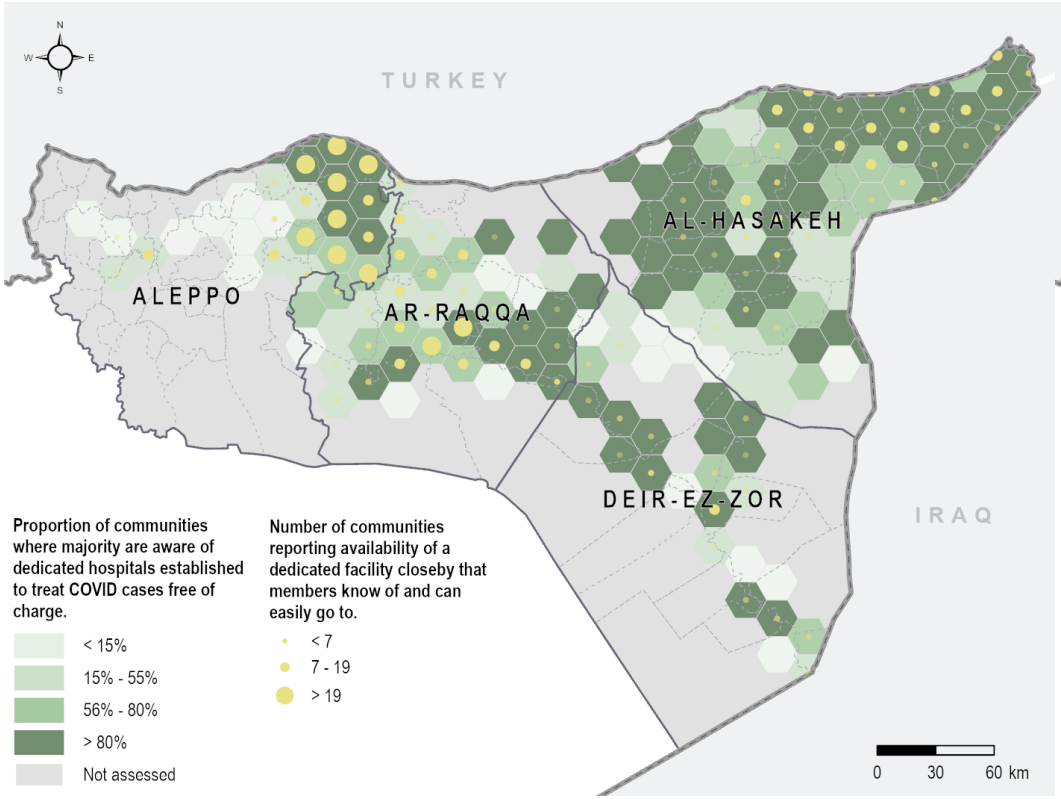
FEELINGS OF DISCRIMINATION/STIGMA FROM COMMUNITY AS A BARRIER TO ACCESSING COVID-19 RELATED HEALTHCARE



- The majority of assessed communities do not indicate distance as a barrier to accessing healthcare.
- Of the CFPs that reported that distance was a barrier to accessing healthcare, the majority are distributed across Al-Hasakeh.

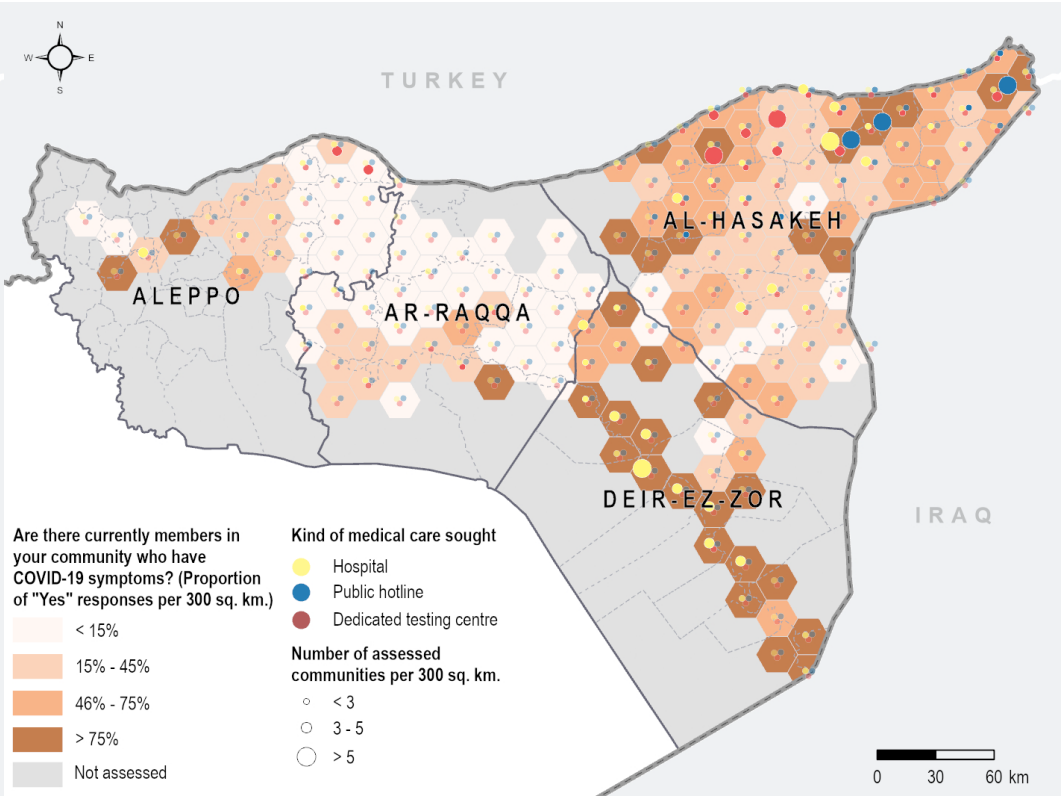
- Overall, responses indicate that discrimination/stigma is a factor in community members' willingness to seek care.
- A fairly large percentage of CFPs in Deir-ez-Zor expressed discrimination/stigma to be a barrier to healthcare-seeking behaviour.

AWARENESS OF COVID-19 DEDICATED FACILITIES AND EXISTENCE OF FACILITIES CLOSEBY



- Communities are generally aware of the existence of dedicated COVID-19 facilities.
- Of the CFPs that reported that community members are aware of dedicated COVID-19 facilities, CFPs in Aleppo, Al-Hasakeh and Ar-Raqqa generally indicated the existence of a dedicated facility closeby.
- There is least awareness of dedicated COVID-19 facilities in the west of Aleppo

FACILITIES WHERE COMMUNITY MEMBERS SEEK CARE IN COMMUNITIES WHERE CFPS HAVE IDENTIFIED THERE ARE MEMBERS WITH COVID-19 SYMPTOMS



- Most of the awareness of COVID-19 cases is distributed across Al-Hasakeh and Deir-ez-Zor.
- CFPs in Deir-ez-Zor indicated that community members are most likely to use hospitals, while there was more variation of the kind of facility/care used in Al-Hasakeh, with a large usage of dedicated COVID-19 testing centres, and the public hotline.

Classification of urban/rural

Assessed communities were classified as small (population less than 2,000), medium (population between 2,000 and 20,000), and large (population greater than 20,000) based on population figures from HNAP. Small and medium communities were then classified as "rural" while large communities were classified as "urban".

Map-based analysis methodology

GIS mapping was based on an aggregation of responses to a 300 square km grid, and overlaying the symbology representing the responses of interest. A combination of colour, size, and transparency has been used to visualize intensity and quantity. ArcGIS Pro version 2.7 software was used for the GIS analysis. The COVID-19 Incidence data, aggregated at sub-district level, reflects data for the month of April and was downloaded from Northeast Syria COVID-19 dashboard on 9th May 2021. April data was selected based on the fact that the majority of data collection took place in April, keeping in mind that survey data and the data from the dashboard does not necessarily match timeframes or the opinions of the community focal points perfectly. The maps provides estimations and should be considered indicative only.

ENDNOTES

The complete dataset for the Barriers to COVID-19 Related Health-Seeking Behaviour is available here.

1. Northeastern Syria: Hospitals run out of funds and supplies as second COVID-19 wave hits region, MSF, May 2021, https://www.doctorswithoutborders.org/what-we-do/news-stories/news/northeastern-syria-hospitals-run-out-funds-and-supplies-second-covid
2. A Crisis on Top of a Crisis: COVID-19 Looms over War-Ravaged Idlib, Refugee International, April 2020, https://reliefweb.int/report/syrian-arab-republic/crisis-top-crisis-covid-19-looms-over-war-ravaged-idlib
3. Northeast Syria COVID-19 Dashboard
4. Respondents could select more than one answer; total may be greater than 100%.
5. Subset of 3% of CFPs that reported that community members were unwilling to seek medical care
6. Severity levels have been defined in three stages: symptoms only, hospitalisation, and death. The main goal of including severity levels and a modified but repeated sequence of questions was to identify whether people's behaviour would change based on their perception of the severity of COVID-19 and its impacts
7. Subset of 35% of CFPs that reported that there are members in their community who have COVID-19 symptoms

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