NORTHEAST SYRIA: COVID-19 MULTI-SECTORAL RAPID NEEDS ASSESSMENT

Focused on COVID-19 related indicators in communities across northeast Syria, April 2020

CONTEXT

Syria reported its first case of COVID-19 on 22 March, and as of 2 May had 44 cases and three fatalities.[1] There has been one reported fatality from COVID-19 in northeast Syria and two additional cases were confirmed in Al-Hasakeh city on 30 April.[1] Humanitarian organisations have warned that an outbreak of COVID-19 in the region would be disastrous.[2] In March, a series of decrees concerning precautionary measures to prevent the spread of the virus were issued by local authorities in northeast Syria. This includes a lockdown that has been extended until 11 May.[3]

Nine years of conflict has led to major deficiencies in the region's health system with many health facilities no longer functioning and those that remain open already struggling to respond to existing medical needs prior to the outbreak of COVID-19.[2] In addition, sporadic conflict escalation since October 2019 has contributed to mass displacement across northeast Syria and severe overcrowding in many internally displaced person (IDP) camps in turn leading to challenges relating to infection prevention and control (IPC).[4] Humanitarian agencies have also reported water access constraints due to damage to the Allouk water station which provides water to an estimated 460,000 people across Al-Hasakeh governorate.[5]

As such, providing humanitarian assistance to meet the existing needs of IDP and host community populations across NES remains challenging. Further, the humanitarian response should now additionally comprise preparedness measures required for COVID-19, which represents a complex and grave challenge.

REACH conducted a rapid needs assessment (RNA) between 14 and 16 April 2020 aimed at providing a multi-sectoral overview of the humanitarian situation for IDPs and host communities in northeast Syria. This RNA was deployed together with REACH's monthly **Humanitarian Situation Overview in Syria (HSOS)**, to support operational actors across northeast Syria. The assessment aims to provide a regional understanding of the existing measures and atittudes of residents, and to also identify the preventative and response capacity of communities in order to better inform humanitarian programming. This factsheet outlines COVID-19 specific information obtained from the RNA, and is supplemented by COVID-19 relevant information from previous REACH assessments in northeast Syria, such as HSOS and Market Monitoring Exercise (MME), where relevant.

METHODOLOGY

To provide essential information on the level of community awareness and on the preventive and response capacities with regards to COVID-19 in communities across northeast Syria, REACH conducted an RNA in 492 locations (including 28 neighbourhoods in Al-Hasakeh city and 13 neighbourhoods in Quamishli city). Data collection was conducted in parallel with HSOS data collection. As such, data from these two assessments is complementary and relevant information from the HSOS assessment has been used to inform this report.[6] Data was collected via community-level key informant (KI) interviews with an average of three KIs per community, between 2 and 16 April 2020 for HSOS, and between 14 and 16 April for the RNA. The complete dataset is available **here**.

Regular monitoring of northeast Syria is available through REACH's monthly HSOS. REACH also deployed an RNA covering communities in **Hasakeh governorate in December 2019**, and an RNA covering **Ar-Raqqa, Aleppo** and **Deir-ez-Zor** governorates in December 2019. REACH also coordinated a joint RNA focusing on **IDPs in host communities in Hasakeh governorate**, in February 2020. Finally, REACH recently produced a **report on the impact of COVID-19 on markets in northern Syria**.

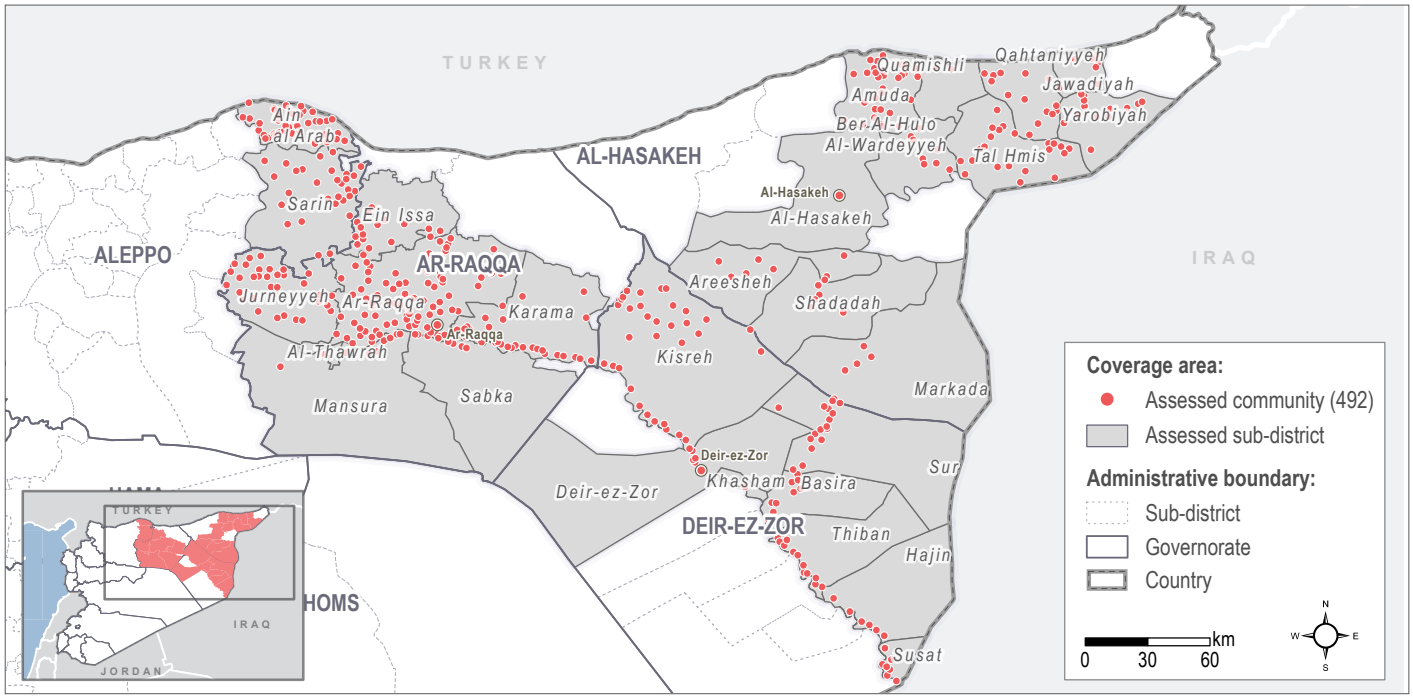
LIMITATIONS

Due to the KI methodology used, findings are not statistically representative and should only be considered as indicative of the situation in assessed communities. The rapidly evolving context in the assessed area, especially with regards to the COVID-19 situation, means that findings are only indicative of the situation at the time the data was collected (2 to 16 April 2020).

As analysis was conducted at the community level, specific camp/site conditions are not highlighted, especially the conditions of those living in small sites with only a few households.

ASSESSED COVERAGE AREA

492 communities assessed [7]



KEY FINDINGS

- **Community knowledge and practices**: KIs in 426 communities (87%) reported that three quarter or more of people in their respective community were aware of COVID-19. Similarly, COVID-19 was reportedly considered as an important issue for most people or everyone in the community in 293 assessed communities (60%).

- **COVID-19 preventive measures**: It was reported in only 26 assessed communities (5%) that no protective measures against COVID-19 had been put in place by people at community level. These communities were mostly located in Areesheh and Tal Hmis sub-districts. The top three most reported types of measures put in place by community members were staying at home as much as possible (reported in 392 communities, 84%), washing hands more regularly (329 assessed communities, 71%) and covering nose and mouth when coughing (295 assessed communities, 63%). Moreover, it was reported in only one assessed community that authorities had not put in place any measure to tackle the spread of COVID-19.

- **Social distancing**: KIs in 237 assessed locations (48%) reported that less than half of the people in the community were aware of the concept of social distancing. In assessed communities where at least some people were reportedly aware of this concept, 67% of KIs reported that between 25% and 50% of people were practicing social distancing. Social norms and traditions was the most commonly reported problem faced by people with regard to social distancing, as reported by KIs in 311 assessed communities (68%).

- **Handwashing and hygiene**: While they constitute similarly critical components of the mitigation efforts to prevent the spread of COVID-19, adequate access to hand-washing facilities and access to soap and hygiene items were reportedly not guaranteed in all assessed locations. KIs in 33 assessed communities (7%) reported that nobody had access to a functioning handwashing facility, while it was reported in 90 assessed communities (18%) that less than half of the population had access to such facilities in a functioning state. Access to water could pose additional difficulties, as KIs in just over half of assessed communities (257 assessed communities) reported that all of the community had enough water for their needs. KIs however reported that crucial hygiene items such as soap, cleaning and hygiene products were available in the majority of assessed communities, with soap reportedly available in 487 communities (99%).

- **Access to healthcare**: The lack of functioning and accessible health facilities presents a considerable challenge to providing adequate healthcare services to cope with a potential COVID-19 outbreak. KIs in 102 assessed communities (21%) reported that there was no functional health facility within 5km or a one-hour walking distance. Additionally, over half of assessed communities reportedly have health facilities without handwashing facilities.

- **Impact on access to basic services**: As a result of COVID-19 and the subsequent restrictive measures put in place by local authorities, KIs reported a lot of key services to be closed/non-functioning or only partially open/functioning during data collection. KIs in 485 assessed communities (99%) reported education services to be closed, while legal services and psychosocial support services were both reportedly closed in 180 (37%) and 183 assessed communities (37%), respectively.

- **Impact on access to markets and accessing food**: Functioning markets were reportedly open only partially in 288 assessed communities (59%). KIs in 290 assessed communities (59%) reported that food sourcing patterns have been disrupted by COVID-19, and among them, KIs in 269 communities (93%) reported higher prices in markets. Moreover, the absence of alternatives to going to markets to obtain basic items was reported in 370 assessed communities (75%). In **March 2020, REACH monthly Market Monitoring Exercise** recorded the highest Survival Minimum Expenditure Basket (SMEB) value since 2015, with a 41% increase from September 2019 alone. With prices reportedly rising and COVID-19 restrictive measures impacting livelihoods, this poses a risk of households being unable to afford basic commodities.

COVID-19 Knowledge and preparedness

60% **of KIs reported that most people (around 75%) or everyone in their community considered COVID-19 as an important issue**

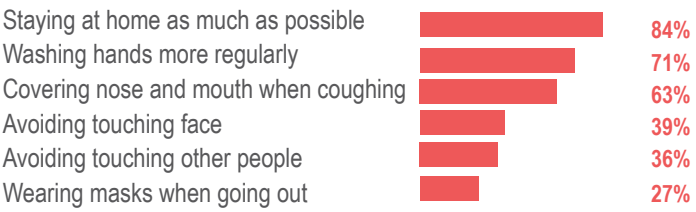
KIs in 426 communities (87%) reported that three quarters or more of people in their respective community were aware of COVID-19. This was notably lower in some sub-districts such as Areesheh where, in all 8 assessed communities (100%) it was reported that a few people (around 25%) were aware of COVID-19. Similarly in Tal Hmis KIs in 6 communities (27%) reported around 25% of the population to be aware of COVID-19. The lack of awareness reported by KIs in Al-Hasakeh city is of particular concern, with KIs in 17 assessed neighbourhoods (11%) reporting that a few (around 25%) people were aware of COVID-19; these neighbourhoods combined had an approximate 110,000 residents, of which 51% are IDPs.[8]

COVID-19 was reportedly considered as an important issue for most people or everyone in 293 assessed communities (60%). KIs in 5 assessed communities (1 %) – with 1 of them located in Sarin sub-district and 4 in Tal Hmis – reported that nobody in the community considered COVID-19 as an important issue.

32% **of KIs reported that everyone in their community had received information about COVID-19 and what to do to protect themselves and other community members.**

Regarding COVID-19 protective measures put in place by people at the community level, it was reported in 26 assessed communities (5%) that no measures had been put in place. This was of particular concern in Areesheh and Tal Hmis sub-districts, where 100% (8 communities) and 41% (9) of assessed communities reported that no protective measures had been put in place by community members.

Most commonly reported protective measures against COVID-19 put in place by people at community level (by % of the assessed 466 communities where some measures were reported):*



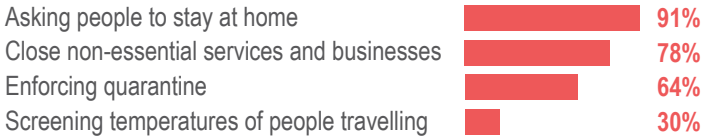
**Multiple answers were allowed, thus findings may exceed 100%.*

Among the 466 communities (95%) where measures were reportedly put in place by people, the top three most reported types of measures were staying at home as much as possible (reported in 392 communities, 84%), washing hands more regularly (329 assessed communities, 71%) and covering nose and mouth when coughing (295 assessed communities, 63%).

78% **of KIs reported that local authorities in their community had asked non-essential services and businesses to stay closed to protect people from COVID-19**

Regarding local authorities' initiatives to protect the community from COVID-19, it was reported in only one assessed community that authorities had not put in place any measures. Across the 491 other communities where some measures were reportedly put in place, the top three most reported measures were asking people to stay at home (reported in 446 assessed communities, 91%), closing non-essential services and businesses (382 assessed communities, 78%) and enforcing quarantine (316 assessed communities, 64%).

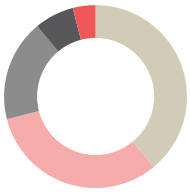
Top 4 most commonly reported protective measures against COVID-19 put in place by local authorities at community level (by % of the 491 assessed communities where some measures were reported):*



Multiple answers were allowed, thus findings may exceed 100%.

Across all assessed communities, it was reported in 347 (71%) that most people (around 75%) or everyone (around 100%) had received information about COVID-19 and what to do in order to protect themselves and others from it. However, this varied by sub-districts: in Areesheh, Hajin, Kisreh, Markada, and Susat sub-districts, KIs reported that nobody (around 0%) or a few people (around 25%) had received information about COVID-19 in 8 (100%), 5 (63%), 18 (53%), 5 (100%) and 6 (86%) assessed communities, respectively.

Estimated proportion of people in assessed communities that have received information about how to protect themselves from COVID-19 (by % of all assessed communities where reported):



39% Most (around 75%);
32% Everyone (around 100%);
18% About half (around 50%);
7% A few (around 25%);
4% Nobody (around 0%);

The most commonly reported modalities through which information was received were social media, internet, and communication by government officials, that were selected by KIs in 437 (93%), 333 (71%) and 147 (31%) assessed communities, respectively. It was reported in 288 assessed communities (61%) that people had no problems understanding COVID-19 related information, if any had been received. However, across the remaining 184 assessed communities, lack of clarity, insufficiency of materials provided, and a lack of trust in the emitting source were the most commonly reported problems with understanding information received, as reported in 98 (53%), 86 (47%) and 84 (46%) assessed communities.

Finally, among the 492 KIs interviewed across northeast Syria, 470 of them (96%) reported that they knew what to do if they were to come across a suspected case of COVID-19 in their community. Among them, 402 (82%) reported that they would go to the hospital, while 46 (9%) and 22 (4%) would reportedly call the doctor and stay home until symptoms worsen, respectively. As per the World Health Organisation (WHO) recommendations, seeking early medical care is always advised, however, it is preferable to avoid going to hospitals if symptoms are mild. Findings thus highlight the need for additional and clearer prevention messages on how to adequately and concretely react to a potential COVID-19 case.

Social Distancing

48% **of KIs in assessed communities reported that less than half of the people in their respective communities were aware of the concept of social distancing.**

While social distancing constitutes a key preventive measure recommended by global health bodies for controlling the spread of COVID-19, KIs in 237 assessed locations (48%) reported that less than half of the people in the community were aware of the concept of social distancing. Among the 487 assessed communities where at least some people were reportedly aware of this concept, KIs in 51 of them (10%) reported that nobody was actually engaging in social distancing in their community, while 207 (42%) and 122 (25%) reported that a few people (around 25%) or about half of people (around 50%) were practicing social distancing, respectively.

10% **of KIs in communities where at least some people were aware of the concept of social distancing reported that nobody was practicing it.**

While KIs in 32 assessed communities (7%) reported no problems with practicing social distancing, the most commonly reported problem faced by people in engaging in social distancing was social acceptance by other members of the community, which was reported in 311 assessed communities (68%). This refers to the fact that engaging in social distancing with relatives can be difficult or oddly perceived due to social norms and practices. Community members not believing in the importance of social distancing and living conditions preventing proper engagement in such practices, were reported by KIs as a problem in performing social distancing in 203 (44%) and 299 (65%) assessed communities respectively. The latter was highly reported in assessed communities in Aleppo and Deir-ez-Zor governorates, with KIs in 51 assessed communities (80%) in Aleppo and 66 assessed communities (73%) in Deir-ez-Zor, reporting living conditions as a problem to respect proper social distancing.

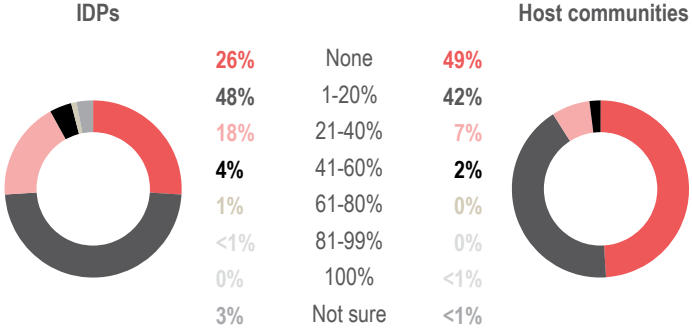
Top most commonly reported problems with social distancing (by % of the 460 assessed communities where problems were reported):*

1. Social acceptance — 68%
2. Living conditions not allowing for social distancing — 65%
3. Social distancing not considered important by people — 44%
4. Reason for social distancing is unclear for people — 18%

*Multiple answers were allowed, thus findings may exceed 100%.

Challenges to practicing social distancing can be related to overcrowded conditions. It was reported in 254 assessed communities (71% of IDP hosting communities) that at least some IDPs were reportedly living in overcrowded shelters, while KIs in 251 assessed communities (51%) reported that at least some host communities' members were living in overcrowded shelters.

Estimated proportion of population reportedly living in overcrowded shelter (by proportion of total IDP population and host community population in assessed locations):



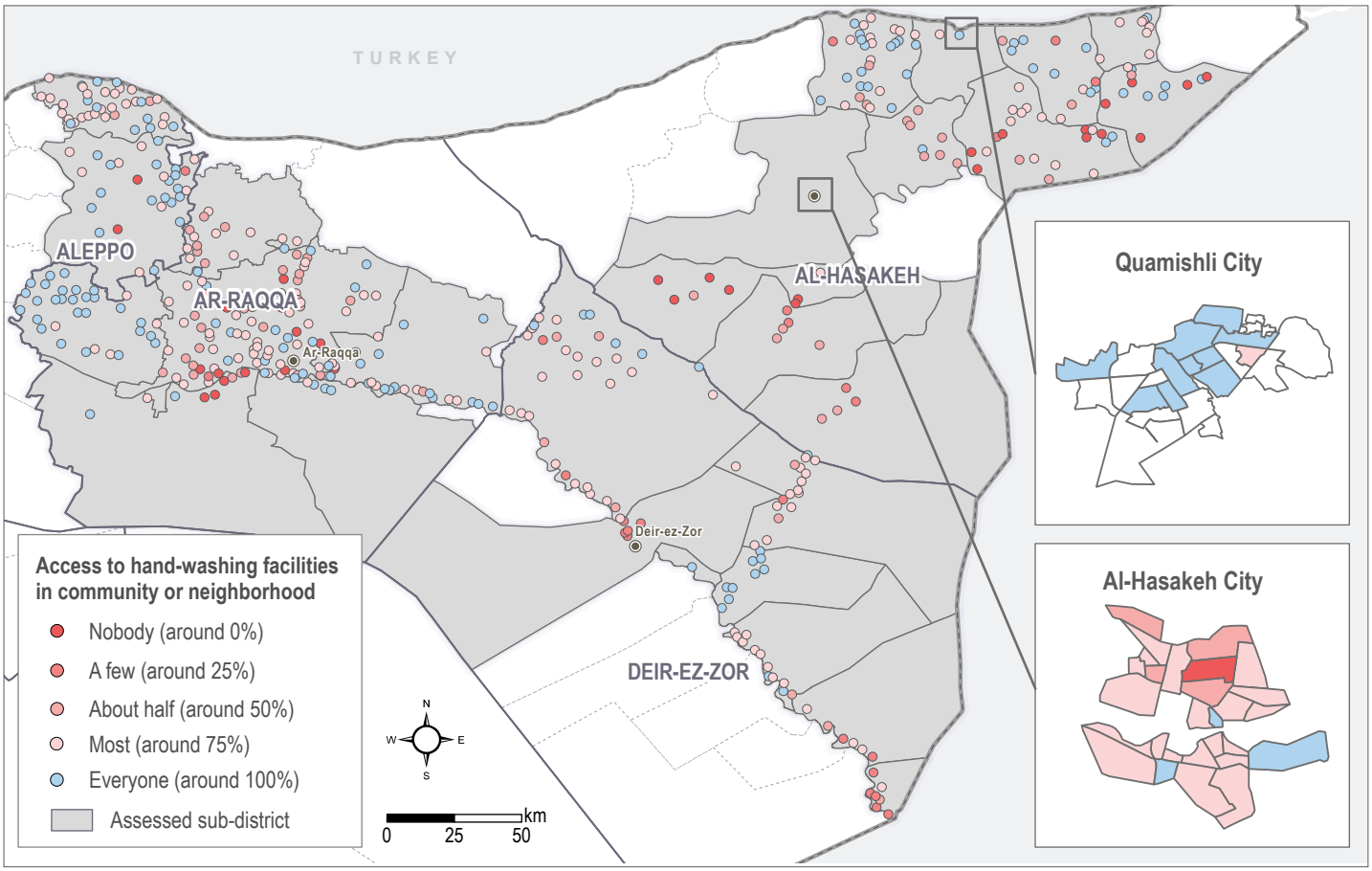
66% **of KIs in IDP hosting communities reported that between 1 and 40% of IDPs were living in overcrowded shelters.**

Moreover, social distancing is more likely to be difficult for people to engage in if facilities such as latrines are shared. Communal latrines were reportedly used by people together with household latrines in 38 assessed communities (8%). These were mostly reported in Ar-Raqqa and Deir-ez-Zor governorates, with 22 communities (12%) reporting communal latrines and household latrines in Ar-Raqqa and 15 in Deir-ez-Zor (16%).

Protective measures against COVID-19 related to social distancing were significantly reported across assessed communities, whether being put in place by community members or by local authorities: the most reported protective measure put in place by people at community level across all assessed communities was staying at home as much as possible, reported in 392 assessed communities (84%). Avoiding touching other people was reported as a measure put in place by people at community level by KIs in 170 assessed communities (36%). Further, the top three most commonly reported protective measures put in place by local authorities to prevent the spread of COVID-19 were all related to social distancing, with asking people to stay home being reported in 446 assessed communities where measures were reported (91%), closure of non-essential services and businesses reported in 382 assessed communities (78%) and enforcing quarantine reported in 316 assessed communities (64%).

Handwashing and hygiene

Access to functioning hand-washing facilities for populations in assessed communities:

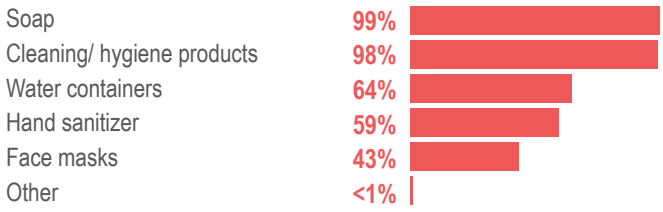


The WHO has outlined that hand-washing is crucial in preventing the spread of COVID-19.[9] As such, it is critical that IDP and host community populations across northeast Syria have adequate access to hand-washing facilities both at home and in public as well as adequate access to soap and hygiene items.

KIs in 441 assessed communities (90%) reported that markets did not have hand-washing stations and only 14 assessed communities (3%) reported that other public locations had hand-washing facilities outside. Furthermore, KIs in 18 communities (12%) in Al-Hasakeh governorate reported that no households in the community had access to functioning hand-washing facilities. KIs in 13 assessed communities (7%) in Ar-Raqqa governorate reported that households did not have access to functioning hand-washing facilities.

KIs reported that crucial hygiene items such as soap and cleaning and hygiene products were available in the majority of assessed communities. Soap was reportedly available in 487 communities (99%). However, soap was reportedly unavailable in the following communities: Bweir Qahtaniya, Hdeibiyeh, Al Hamam, Kherbet Elahmir and Shahid Ellah. Moreover, despite being available in the majority of communities, KIs reported that soap was not affordable for the majority of the community in 213 assessed communities (44%). Hand sanitizer and face masks were also less readily available across assessed communities with KIs reporting the availability of these items in just 292 assessed communities (59%) and 210 assessed communities (43%) respectively.

Availability of essential hygiene items in assessed communities (by % of all assessed communities where reported):*

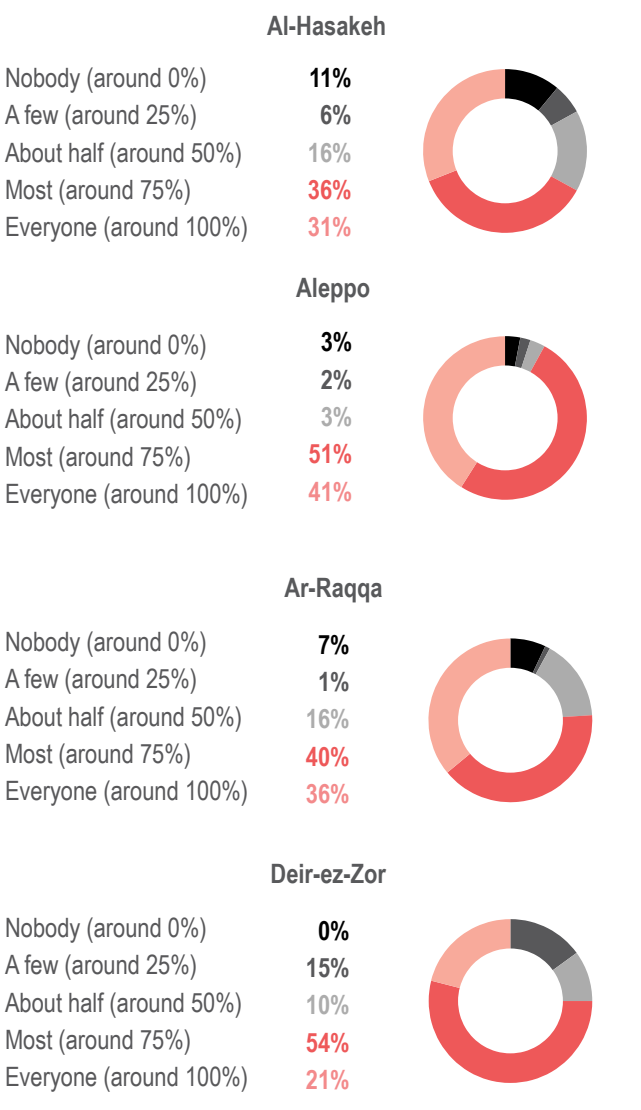


Multiple answers were allowed, thus findings may exceed 100%.

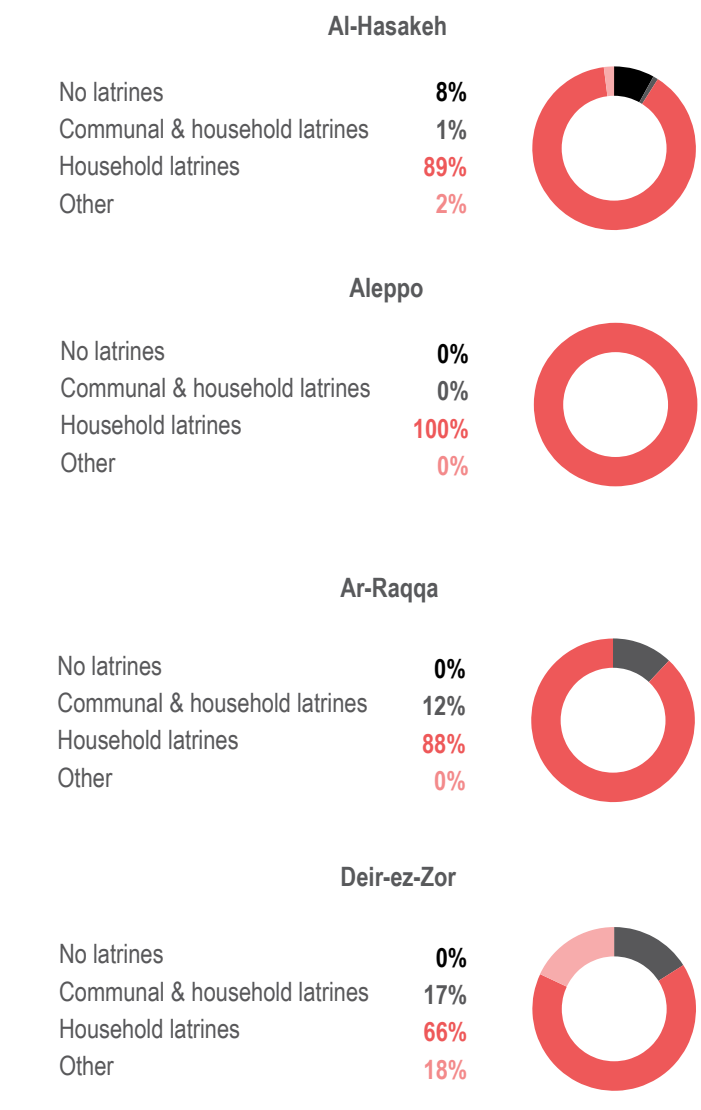
Water, Sanitation and Hygiene (WASH) was reported as a priority need for host community populations in 209 assessed communities (42%) and was reported as a priority need for IDPs in just 82 IDP hosting assessed communities (23%). KIs in just over half of assessed communities (257 assessed communities) reported that everyone in the community had enough water for their needs. KIs in 13 assessed communities (3%) reported that just 1%-25% of the population had sufficient water and KIs in 74 assessed communities reported that 51% -75% of the population had enough water. The main factors affecting water access were: not enough pressure to pump sufficient water (49%), high price of water trucking (47%) and main network completely or partially not functioning due to damage (46%).

Access to functioning latrines is also critical for limiting the spread of COVID-19 and other infectious diseases. KIs in 13 assessed communities (8%) in Al-Hasakeh reported that households did not have latrines.

Proportion of communities where households currently have access to functioning hand-washing facilities by governorate (by % of all assessed communities where reported):[6]



Proportion of communities by type of latrine used by the majority of the community by governorate (by % of all assessed communities where reported):



Healthcare

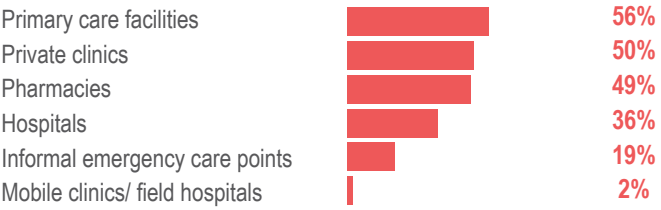
Health was reported as a top three priority need for IDPs in 171 assessed communities (48% of all assessed IDP hosting communities). Health was reported as a priority need for host community populations in a significantly higher proportion of communities with KIs reporting health as a top three host community priority need in 407 assessed communities (83%).

KIs reported that both IDP and host community households faced challenges in accessing healthcare facilities. KIs reported challenges for IDPs in 342 assessed IDP hosting communities (96%) and for host community residents in 470 assessed communities (96%). KIs in 102 assessed communities (21%) reported that there was no functional health facility within 5km or a one-hour walking distance and KIs in 198 assessed communities (40%) reported that households were unable to access health facilities in the assessed location. The lack of accessible healthcare in many communities evidently presents a considerable challenge to the COVID-19 response.

Moreover, there was a significant regional variation in terms of healthcare access between governorates with KIs in Deir-or-Zor governorate reporting considerably better access to healthcare where 99% of KIs in assessed communities reported access to healthcare compared to just 28% in Aleppo governorate.

Over half of assessed communities (52%) reportedly have health facilities without handwashing facilities outside raising concerns over infection prevention within facilities.

Most commonly reported healthcare facilities available in the week prior to the assessment (by % of the 390 assessed communities where some functioning facilies were reported):*

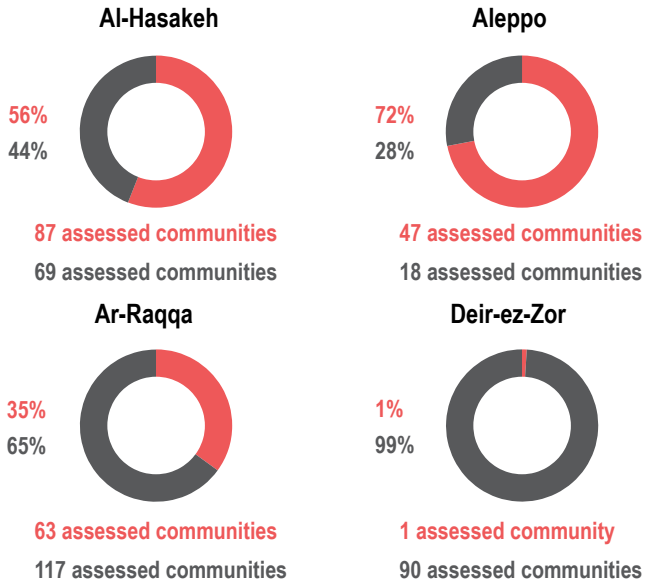


*Multiple answers were allowed, thus findings may exceed 100%.

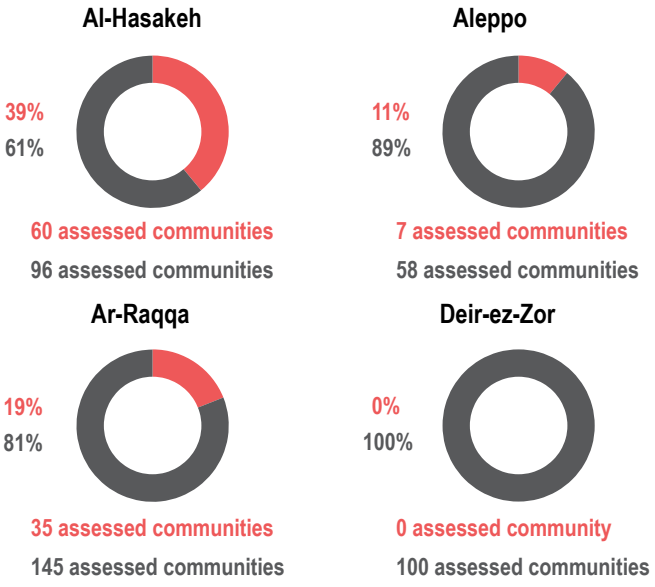
Average travel time to most commonly used health facility (by % of all assessed communities where reported):*

*Multiple answers were allowed, thus findings may exceed 100%.

Proportion of communities where households are currently able to access health services at facilities in assessed communities by governorate (by % of all assessed communities where reported):*



Proportion of communities where households are currently able to access health services at facilities within 5km or one-hour walking distance in assessed communities by governorate (by % of all assessed communities where reported):*



No - households cannot access healthcare in assessed communities
Yes - households can access healthcare in assessed communities

No - households cannot access healthcare within 5km
Yes - households can access healthcare within 5km

Most commonly reported barriers to accessing healthcare services for IDPs (by % of the 342 IDP hosting assessed communities where barriers to accessing healthcare for IDPs were reported):*

1. Lack of transportation (**64%**)
2. Lack of medicine/ medical items (**49%**)
3. Lack of facilities (**41%**)
4. Lack of medical personnel (**37%**)
5. Distance to health facilities (**36%**)
6. Healthcare is of low quality (**24%**)
7. Lack of female doctors (**23%**)

*Multiple answers were allowed, thus findings may exceed 100%.

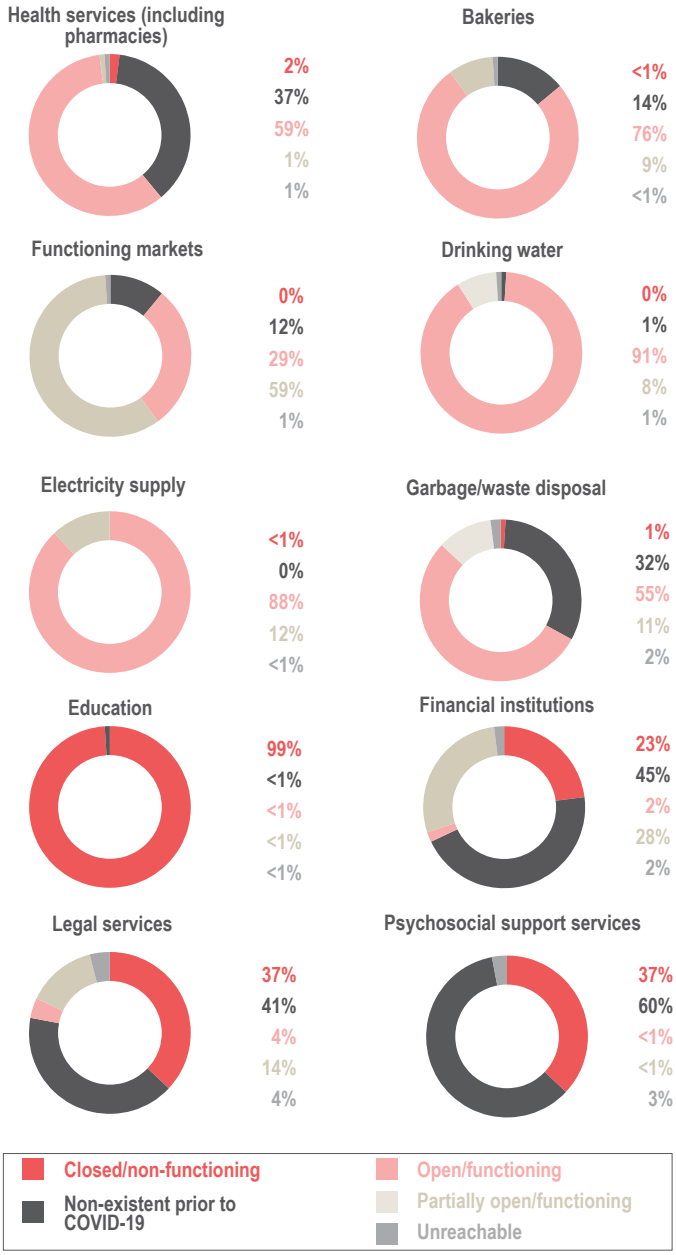
Most commonly reported barriers to accessing healthcare services for host community populations (by % of the 470 assessed communities where barriers to accessing healthcare for host community populations were reported):*

1. Lack of transportation (**59%**)
2. Lack of medicine/ medical items (**47%**)
3. Distance to facilities (**43%**)
4. Lack of facilities (**41%**)
5. Lack of medical personnel (**37%**)
6. Healthcare of low quality (**32%**)
7. Healthcare is not accessible to all community members (**31%**)

*Multiple answers were allowed, thus findings may exceed 100%.

Considering the ten types of key services covered by this assessment that are detailed in the graphs below, KIs in only one community among all 492 assessed reported no impact of COVID-19 on any of these services. For all other communities, at least one key type of service was reportedly closed or not functioning as a result of COVID-19. This coincides with the high proportion of assessed communities that reported closure of non-essential services and asking people to stay home as measures put in place by local authorities to prevent the spread of COVID-19.

Status of key basic services in assessed communities or in other/nearby communities at time data was collected, as a result of COVID-19 (by proportion of all assessed communities where reported):



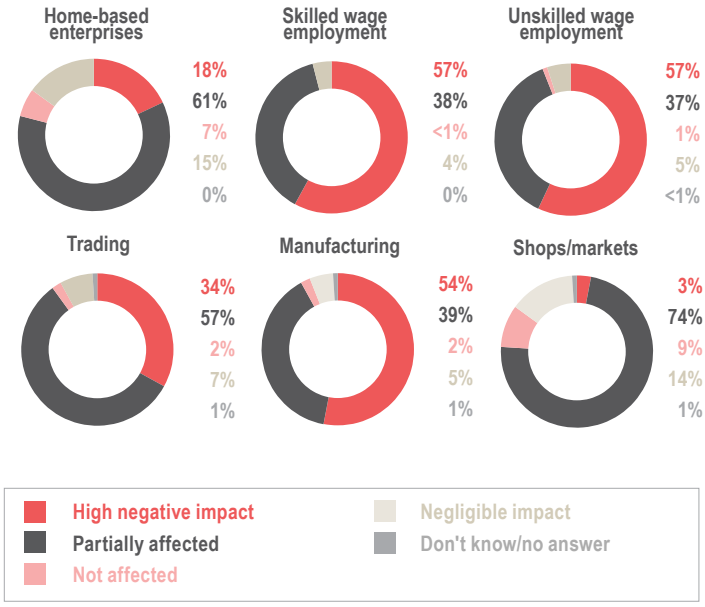
KIs in 487 assessed communities (99%) reported education services to be closed at the time data was collected (14 to 16 April 2020) as a result of COVID-19. These closures are likely to have been enforced during the month of March, given that data collected via HSOS in April showed that 170 assessed communities (35%) had been closed by local authorities due to COVID-19.

Regarding access to markets in assessed communities, KIs in 120 of them (24%) reported that markets were not accessible at location during the month of March. Furthermore, KIs in 288 assessed communities (59%) reported markets to be partially open at time data was collected.

Typical food sourcing patterns have reportedly been disrupted due to COVID-19 in 290 assessed communities (59%). Among them, KIs in 269 (93%) reported markets to be open but with higher prices, while KIs in 40 (14%) reported markets to be open but with no stock. Moreover, the most commonly reported barrier to markets functioning over the past month was the lack of consumers to support markets in the assessed location, which was reported in 102 assessed communities (86%). In a context of movement restrictions enforced by local authorities, this kind of barrier to markets functioning is likely to further impact this type of services. More details on the impact of COVID-19 on markets across northern Syria are available in a separate REACH report of the impact of COVID-19 on markets in northern Syria overview.

For each of the below six categories of livelihoods considered by this RNA, KIs in more than 70% of assessed communities reported that COVID-19 had had a negative impact, with these livelihoods being partially or totally affected by COVID-19. Higher prices of goods sold at markets are thus of particular concern taking into account that COVID-19 related restrictions are also reportedly impacting livelihoods in assessed communities. These are likely to negatively impact purchasing power and ability to meet basic needs for population in assessed areas. In March 2020, REACH monthly Market Monitoring Exercise recorded the highest Survival Minimum Expenditure Basket (SMEB) value since 2015, with a 41% increase from September 2019 alone.

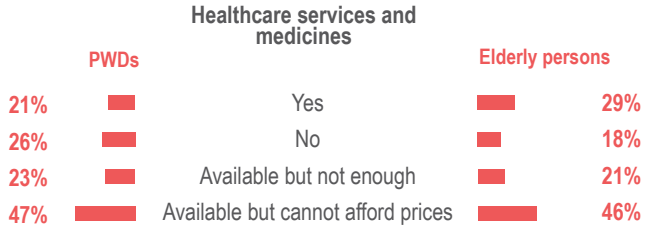
Impact severity of COVID-19 on livelihoods in assessed communities at time data was collected (by proportion of all assessed communities where reported):



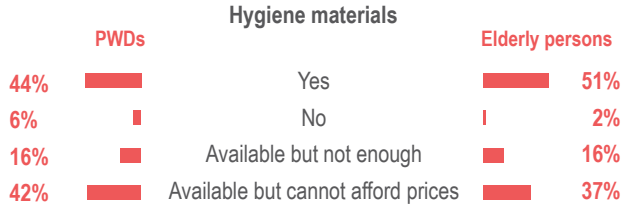
No potential alternatives to markets to meet basic needs were reported by KIs in 370 assessed communities (75%). For the 118 assessed communities where alternatives to going to the markets were reported, the most common options were humanitarian assistance (reported in 77 assessed communities, 65%) and deliveries by local authorities (reported in 26 communities, 22%). In addition, KIs in 16 communities reported water delivery services to be available.

KIs reported that high prices were also a barrier for persons with disabilities and elderly people to access supplies and services that are critical in protecting these vulnerable groups that are more at risk with regards to COVID-19. For instance, KIs in 101 assessed communities (26%) and 83 assessed communities (18%) reported that healthcare services and medicines could not be accessed by persons with disabilities (PWDs) and elderly people, respectively. Further, KIs in 187 assessed communities (47%) reported that healthcare services were available for persons with disabilities but that they could not afford prices, while this was reported in 208 assessed communities (46%) for elderly people. Similarly, availability of transportation services but inability of persons with disabilities and elderly people to afford these services was reported in 174 assessed communities (44%) and 169 assessed communities (37%), respectively. This could represent a significant barrier to accessing healthcare for these vulnerable groups, knowing that KIs in 198 assessed communities (40%) reported that households are not able to access health services in the assessed locations, and KIs in 102 assessed communities (21%) reported no functional health facility within 5 kilometres or one-hour walking distance.

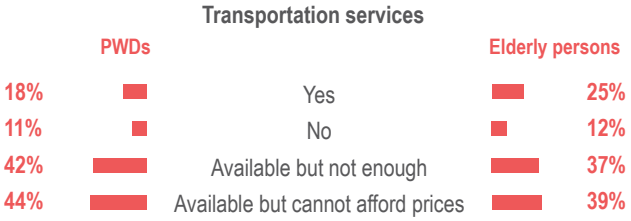
Ability of persons with disabilities (PWDs) and elderly persons to access critical supplies and services at location or in other communities, according to KIs (by proportion of assessed communities where PWD and elderly persons were reported, respectively):*



*Multiple answers were allowed, thus findings may exceed 100%.



*Multiple answers were allowed, thus findings may exceed 100%.



*Multiple answers were allowed, thus findings may exceed 100%.

ENDNOTES

The complete northeast Syria COVID-19 RNA dataset is available here, while the complete HSOS March 2020 dataset will be available here.

1. OCHA, 'Syrian Arab Republic: COVID-19 Humanitarian Update No.08 as of 2 May 2020,' 2 April 2020
2. MSF, 'Concerns mount over COVID-19 response in northeast Syria,' 22 April 2020
3. Hawar news Agency, 'New decisions related to curfew, al-Hasakah is excepted', 30 April 2020.
4. Human Rights Watch, 'Turkey/ Syria: Weaponizing water in Global Pandemic?' 31 March 2020
5. Unicef, 'Interruption to key water station in the northeast of Syria puts 460,000 people at risk as efforts ramp up to prevent the spread of Coronavirus disease,' 23 March 2020
6. HSOS covered a few more communities than the RNA, but HSOS findings are only reported on communities that were covered by both assessments.
7. 492 communities comprising 451 villages/towns, 28 neighbourhoods in Al-Hasakeh city and 13 neighbourhoods of Quamishli city.
8. HNAP, Movement Needs Monitoring, February 2020.
9. WHO, 'Interim recommendations on obligatory hand hygiene against transmission of COVID-19,' 1 April 2020

HSOS methodology

REACH Humanitarian Situation Overview in Syria (HSOS)

HSOS is a monthly assessment that provides comprehensive, multi-sectoral information about the humanitarian conditions and priority needs inside Syria. Data is collected for the HSOS through an enumerator network in accessible locations throughout Idleb, Aleppo, and Hama governorates. Data for this assessment is collected over a 10 day period at the beginning of the month, and refers to the situation in the previous month. REACH enumerators are based inside Syria and interview, either directly or remotely (via phone) depending on security, KIs located in the communities that they are reporting on. KIs are chosen based on their community-level and sector-specific knowledge. The HSOS project has monitored the situation in Syria since 2013, and its methodology and procedures have evolved significantly since that time.

While HSOS data referred to in this report is taken from unpublished internal figures collected at the beginning of April for the referral period of March and is available upon request, the February factsheet and dataset are available **here.**

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