NORTHWEST SYRIA: MULTI-SECTORAL RAPID NEEDS ASSESSMENT COVID-19 ZOOM-IN

Focused on COVID-19-related indicators in IDP-hosting areas of northwest Syria, March 2020

CONTEXT

In December 2019, Idleb and Aleppo governorates saw a sharp escalation in hostilities, shelling, and airstrikes, preventing access to essential services and endangering the safety of those living in areas close to conflict lines, particularly in communities in southeastern Idleb and western Aleppo.[1] This drastic rise in hostilities led to mass displacement of civilians across the region with nearly 1 million displaced reported since 1 December.[1]

Syria reported its first case of COVID-19 on 22 March, and as of 2 April had 16 cases and 2 fatalities.[2] An outbreak in overcrowded camps, sites, and communities that also rely on a health system weakened from years of conflict would be disastrous. A potential outbreak of novel COVID-19 adds further challenges to a humanitarian context already characterized by mass displacement, harsh winter conditions and the volatility of the Syrian pound.[3] Communities situated along the Syrian-Turkish border have witnessed high numbers of internally displaced person (IDP) arrivals putting increased pressure on already strained infrastructure and services. Many IDPs are facing multiple displacements which in turn erode resilience and intensify existing vulnerabilities.[1]

Despite the implementation of a ceasefire on 6 March, the need for humanitarian assistance to meet the existing needs of IDP and host community populations remains a challenge. Further, the humanitarian response should now additionally comprise preparedness measures required for COVID-19, which represents a unique and grave situation.[3]

REACH conducted a rapid needs assessment (RNA) aimed at providing a multi-sectoral overview of the humanitarian situation for IDPs and host communities in areas having experienced high displacement between December 2019 and the onset of the ceasefire on 5 March 2020. This RNA was deployed to support operational actors across northwest Syria to address humanitarian ongoing needs as well as COVID-19 preparedness. This factsheet outlines COVID-19 specific information obtained from the RNA, and is supplemented by COVID-19 relevant information from previous REACH assessments in northwest Syria, such as the Humanitarian Situation Overview in Syria (HSOS) and a camps and sites household multi-sectoral needs assessment.

METHODOLOGY

Regular monitoring of this region is available from REACH, including a series of multi-sectoral RNAs following episodes of escalation in conflict in **February 2019**, **May 2019** and **July 2019**.

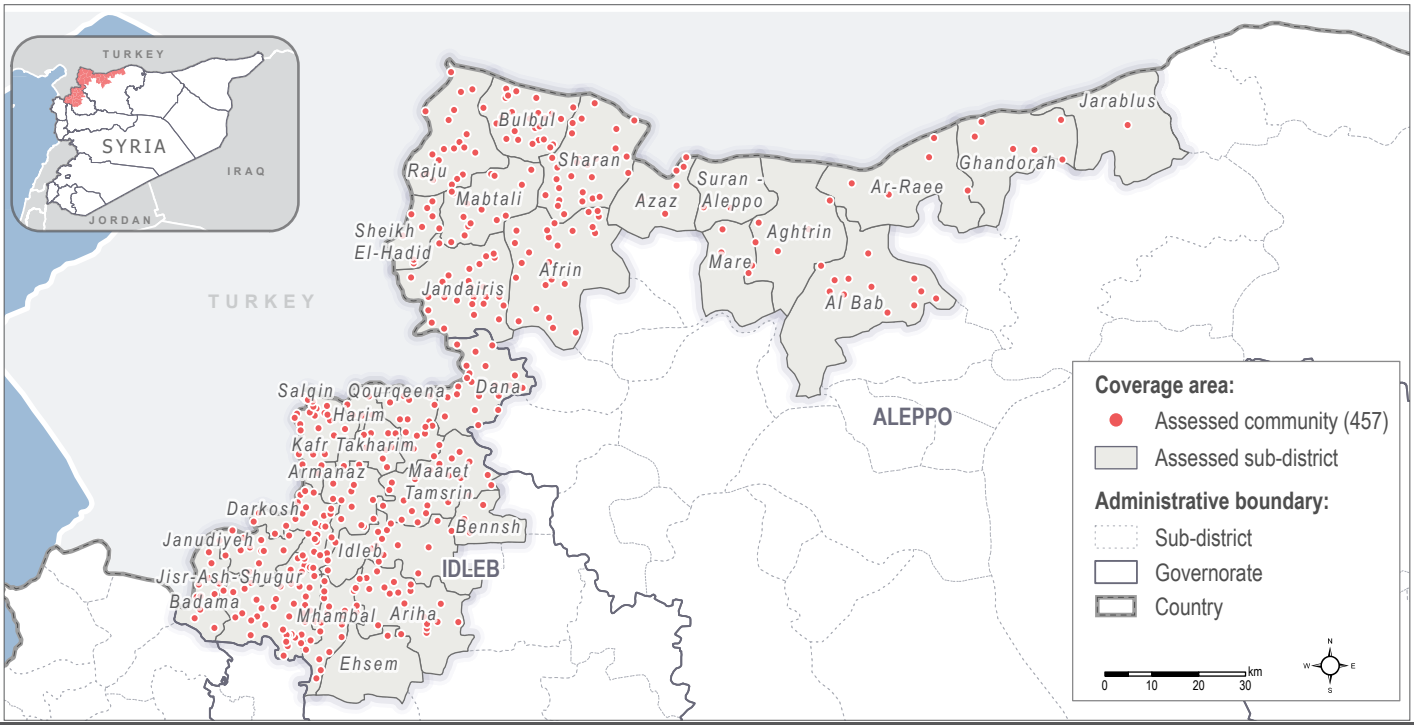
To provide timely updates on the humanitarian situation, REACH conducted an RNA in all opposition-held and accessible communities in Idleb governorate and in communities of western Aleppo governorate that witnessed more than 100 IDP arrivals since 1 December 2019. Data was collected via community-level key informant (KI) interviews between 26 and 29 March 2020, in 461 opposition-controlled communities (including 4 neighbourhoods in Idleb city) in 26 sub-districts.

This report focuses on findings from the RNA, and all findings mentioned in this report are from RNA KIs, unless stated otherwise. Findings from other assessments REACH conducted in northwest Syria in February and March are also included to give a more complete picture of the situation with regards to COVID-19 in northwest Syria. These assessments were conducted prior to the declaration of the COVID-19 pandemic, but provide COVID-19 relevant information on health and non-health conditions in areas of northwest Syria that go beyond data collected through the RNA.[5]

When discussed, these other data sources will be referred to as HSOS data, and camps and sites household data. More details on these products and their respective methodologies can be found in the **data source and methodology section** at the end of this report.

ASSESSED COVERAGE AREA

461 communities assessed [4]



KEY FINDINGS

Data collection for this RNA began on 26 March, four days after the first COVID-19 case was reported by the Government of Syria on 22 March, and communities had already begun to respond. Sixteen per cent (16%) of assessed communities had reportedly not implemented any measures to combat the spread of COVID-19; most of these were in Ma'btali and Qourqeena sub-districts. Ten per cent (10%) of KIs reported that everyone in their community saw COVID-19 as an important issue, and 33% reported that 75% of community members saw COVID-19 as an important issue. Thirty-eight per cent (38%) of KIs reported that at least 75% of the community population had received information about protecting themselves from COVID-19, including 12% of KIs stating the entire community had received information. Sub-districts where information was less prevalent included Afrin, Ar-Ra'ee, Armanaz, and Ghandorah. The most commonly cited communication means to receive information among communities which had been informed of COVID-19, was social media (reported by 96% of KIs).

KIs in 386 assessed communities (84%) reported that local authorities have put COVID-19 preventive measures in place. Among these communities, the most commonly cited preventive measures were related to social distancing, including asking people to stay at home (reported by 58% of KIs) and closing non-essential services and businesses (reported by 56% of KIs). Areas where these measures were less prevalent included Aghtrin, Idleb, Qourqeena, and Sheikh El-Hadid sub-districts for staying at home, and northwest Aleppo for closing non-essential businesses. Fifty-six per cent (56%) of KIs reported that local authorities have disseminated general preventive messages on COVID-19, although less dissemination was reported in Harim and Ghandorah. KIs in 418 assessed communities (91%) reported measures were put in place by the population to protect themselves and others form COVID-19. The most commonly reported measures among these communities were related to hygiene, particularly washing hands more regularly and covering nose and mouth when coughing (reported in 76% and 54% of assessed communities, respectively). KIs in Bulbul and Raju sub-districts reported lower levels of regular handwashing.

Despite the preventive measures reportedly put in place by authorities and communities, the conditions in northwest Syria highlight the need for immediate action to decrease the risk of a potential catastrophic COVID-19 outbreak. Fifty-two per cent (52%) of KIs reported that people in their communities were unable to access health facilities and the number one reason was a lack of transportation. The areas where access reportedly was most difficult were Ehsem, Ma'btali, and Sheikh El-Hadid. Eighty per cent (80%) of KIs also reported that overcrowding at health facilities has become a more pronounced health access barrier since the recent escalation in conflict, which is particularly concerning given the importance of social distancing. Overcrowding was consistently reported across sub-districts. Seventy-four per cent (74%) of KIs estimated that up to 26% of people in their communities did not have sufficient access to water, and 6% reported that soap was unavailable in their communities. Access to water reportedly was more challenging in Aghtrin, Badama, and Ghandorah, and to soap in Ariha, Ehsem, and Sheikh El-Hadid. IDPs were more frequently reported to live in overcrowded shelters than host communities, particularly in Harim, Jarablus, Kafr Takharim, and Salqin.

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 only. The rapidly evolving context in the assessed area, especially with regards to the COVID-19 situation, also means that findings are only indicative of the situation at the time the data was collected (26 to 29 March 2020).

Due to the different coverage and methodologies employed, findings from other assessments are not directly comparable with findings from the RNA and are only mentioned to complement RNA findings and bring together available information for a better-informed response.

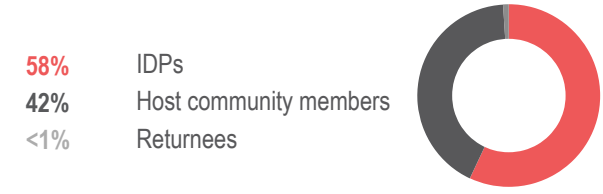
As analysis was conducted at the community level, specific camp/site conditions are not highlighted, especially the conditions of those living in small sites with only a few households. Female KIs provided information for 10% of the assessments.

Demographics

Of all the 461 assessed communities, 445 (97%) were hosting IDPs, according to KIs. Moreover, in 51% of communities where IDP presence was reported, KIs also reported the arrival of new IDPs in the month prior to data collection (i.e. arrivals occuring from 26 February - 26 March 2020). KIs in 11% of assessed communities reported the arrival of returnees in the three months prior to data collection (i.e. returns occurring from 26 December 2019 - 26 March 2020).

According to KIs, IDPs, host community members and returnees constituted 58%, 42% and <1% of the total population, respectively. The high proportion of IDPs in assessed communities may indicate higher pressure on key services such as water supply and health facilities, in areas where such services are already overstretched.

Proportions of IDPs, host community members and returnees in the total estimated population, as reported by KIs in assessed commmunities (by % of overall total population):



Estimated proportion of total population in assessed communities by age and gender, as reported by KIs (by % of overall total population):

Top 6 vulnerable groups in assessed communities, as reported by KIs (by % of assessed communities where selected):

1	Female-headed households	60%
2	Children with disabilities	44%
3	Older persons (+60)	42%
4	Persons with chronic illness, injuries or mental health conditions	38%
5	Adults with disabilities	36%
6	Pregnant/lactating women	24%

Across assessed communities, elderly people were reported as 7% of the total population and persons with chronic illness were reported as 1% of the total population. These two population groups are also more vulnerable to severe medical complications if infected by COVID-19. Findings also showed that the most prevalent vulnerable groups in assessed communities were female-headed households (reported in 276 assessed communities, 60%), children with disabilities (reported in 201 assessed communities, 44%) and elderly people (reported in 195 assessed communities, 42%).

The presence of vulnerable groups among specific population subsets in assessed communities was reported by KIs as shown in the table below:

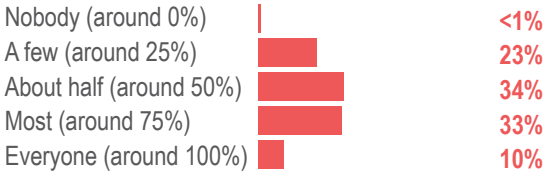
Vulnerable groups reported in assessed communities (by % of each population subset):[6]

Pregnant/lactating women	14%
Older persons (+60)	7%
Female-headed households	3%
Adults with disabilities	2%
Children with disabilities	1%
Persons with chronic illnesses	1%
Unaccompanied children	1%

COVID-19 Knowledge and preparedness

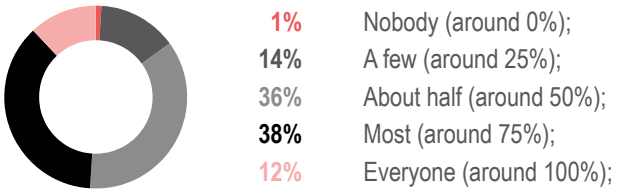
16% **of KIs reported that no measures to combat COVID-19 had been put in place by local authorities in the assessed communities**

Estimated proportion of people in assessed communities that consider COVID-19 an important issue (by % of assessed communities where reported):



COVID-19 knowledge and preparedness existed in most communities assessed. KIs in 10% of assessed communities reported that everyone in their community saw COVID-19 as an important issue, and less than 1% reported that nobody in the community felt this was an important issue. Sixteen per cent (16%) of KIs reported that no measures to combat COVID-19 had been put in place by local authorities in their community. At the sub-district level, over 40% of KIs in Ma'btali and Qourqeena reported no measures had been taken in their communities. Other communities had taken at least some measures: 56% of KIs said that preventive messaging had been disseminated by local authorities, athough this varired by sub-district. KIs in both Harim and Ghandorah sub-districts reported that authorities had disseminated messaging in 20% or less of communitites. Most KIs felt that at least some people in their communities had received information about protection from COVID-19. While 12% of KIs reported that everyone in their community had this information, 36% reported that at least half had this information. At the same time, 40% or more of KIs in Afrin, Ar-Ra'ee, Armanaz, and Ghandorah reported that less than 25% of people in their communities had this information. The most commonly reported communication means to receive information about COVID-19 was social media, as 96% of KIs reported this as an information source.

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



56% **of KIs reported that preventive messages had been disseminated by local authorities in the assessed communities**

Most commonly reported means to receive information about measures to fight COVID-19 (by % of assessed communities where reported):[7]

Healthcare

52% **of KIs reported that households were unable to access health facilities at location in the week prior to data collection**

52% of KIs reported that households in their communities were not able to access health facilities in their community in the past week, although 79% of assessed communities were reportedly located within 5 km (or one-hour walking distance) of the nearest health facility. In Afrin, Ar-Ra'ee, Ehsem, Ma'btali, Sharan, and Sheikh El-Hadid sub-districts, over 80%

14% **of communities reportedly have no health facility within 5 km or one-hour walking distance**

of KIs reported that health facilities were inaccessible in their areas. At the same time, 40% or more of KIs in Afrin, Aghtrin, Kafr Takharim, and Sharan sub-districts reported no health facility within 5 km. Recent camps and sites household data showed that 73% of households could not access a health facility in their camp or site, but 1% lived further than 5 km from the nearest health facility.

Seventy per cent (70%) of IDP and sixty-seven per cent (67%) of host KIs reported that the number one barrier to healthcare access (among those reporting access barriers) was transportation. Also related to health facility location was the number three barrier, which was distance to the health facility (among those reporting barriers: 53% of both IDPs and host community KIs). This is in contrast to camps and sites households, where the top two healthcare access barriers were lack of medicine and overcrowding. Healthcare access barriers did vary by sub-district. While KIs in most sub-districts consistently reported lack of transportation and lack of medicine as main barriers, 83% of KIs in Azaz and 62% of KIs in Raju also reported that lack of medical personnel was a top barrier, and over 60% of KIs in Qourqeena and Sheikh El-Hadid reported that low quality healthcare was a top barrier.

Top 5 most commonly reported barriers to accessing healthcare services for IDPs and host community members across the 238 communities where access barriers were reported (by % of assessed communities where access barriers were reported):[7]

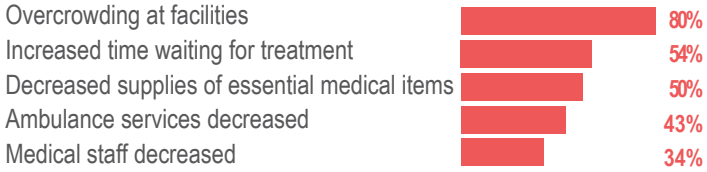
	IDPs	Host community members
1	Lack of transportation (**70%**)	Lack of transportation (**67%**)
2	Lack of medicine/medical items (**67%**)	Lack of medicine/medical items (**65%**)
3	Distance to facility is too far (**53%**)	Distance to facility is too far (**53%**)
4	Lack of facilities (**33%**)	Lack of facilities (**31%**)
5	Lack of medical personnel (**26%**)	Lack of medical personnel (**28%**)

KIs reported primary care facilities and private clinics as the most commonly available health services (reportedly available in 75% and 58% of assessed communities respectively). Neither RNA data nor HSOS data showed high availability of mobile clinics (reported by KIs in 35% of RNA-assessed communities and 17% of HSOS communities). Indeed, mobile health clinics could be utilised to increase both access to and availability of health services across the assessed communities while better respecting principles of social distancing.

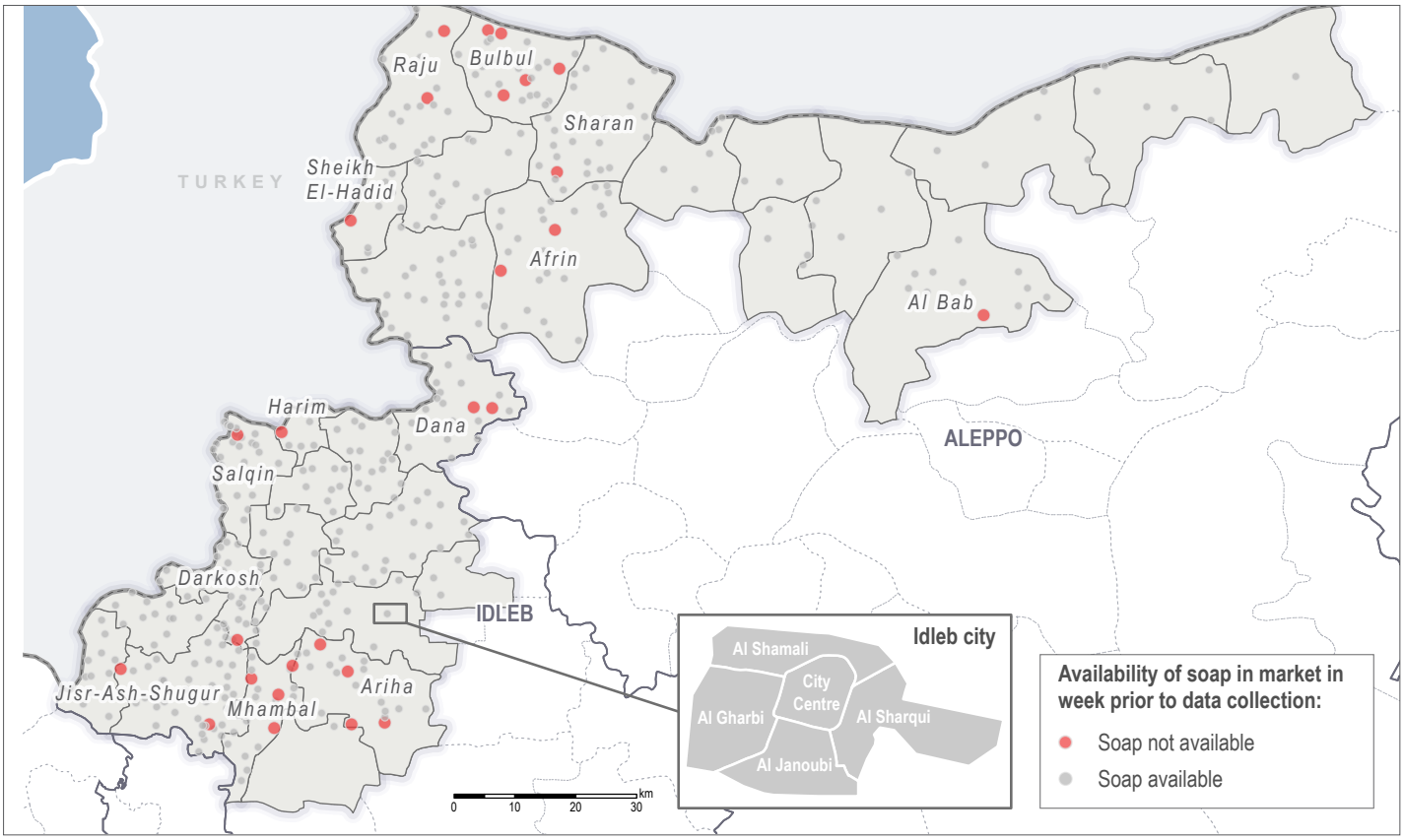
38% **of KIs reported that health facilities in the assessed communities do not have hand-washing stations outside**

Prevention measures in health facilities are critical for limiting the spread of COVID-19. Most health facilities in assessed communities reportedly had hand-washing stations set up outside of the facility, but 38% of KIs reported no hand-washing stations at health facilities in their community. KIs in Bennsh, Darkosh, Kafr Takharim, Ma'btali, Mhambal, and Raju sub-districts all reported that more than 60% of their communities had health facilities with no hand-washing stations. Also concerning was the consistent reporting of overcrowding at health facilities: HSOS KIs reported that the third most common barrier to healthcare access among communities reporting access barriers was overcrowding at health facilities (48% of KIs in assessed communities reporting access barriers) and it was the second most commonly reported barrier for households living in camps and sites (reported by 34% of households which had experienced access barriers). Both HSOS and camps and sites data, which came from February 2020, showed a baseline of overcrowding that only intensified in March. Indeed, 80% of RNA KIs reported that overcrowding at health facilities was the biggest change in access to healthcare since the influx of IDPs due to 1 December - 5 March hostilities. This was consistent across all sub-districts, except in Aghtrin and Ariha (where changes in overcrowding were reported by 50% or less of KIs).

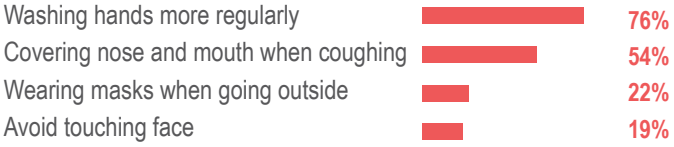
Top 5 most commonly reported ways in which access to healthcare changed since the hostilities of 1 December 2019 - 5 March 2020 (by % of assessed communities where reported):[7]



Handwashing and hygiene



Protective measures related to hand washing and hygiene reportedly put in place at the community level against COVID-19 (By % of 418 assessed communities where protective measures were reported):[7]

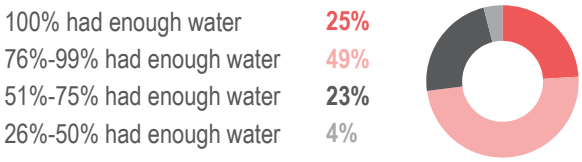


Top most reported measures related to hand washing and hygiene put in place by local authorities against COVID-19 (By % of 386 assessed communities where protective measures were reported):

1. Prevention messages — 56%
2. Setting up hand-washing stations — 3%

Hand washing with soap is a key prevention measure against COVID-19, and among communities where protective measures had been taken, 76% of KIs reported that people in their communities were already washing their hands more regularly than normal. This was not due to the increased presence of hand-washing stations, which was reported by KIs in 3% of communities. Increased hand-washing practices were consistently reported across sub-districts, except in Bulbul and Raju, where less than 40% of KIs reported that people were washing their hands more regularly than normal. Fifty-six per cent (56%) of KIs from communities where authorities had put in place prevention measures reported that prevention messages had been disseminated by authorities. At the community level other measures such as covering nose and mouth when coughing, wearing masks, and avoiding touching face were reported by up to half of KIs.

Estimated % of population in assessed communities that reportedly had enough water to meet their needs over the week prior to data collection (by % of assessed communities where reported):



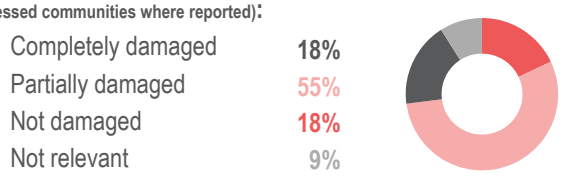
Most commonly reported reasons households cannot access water (By % of 348 assessed communities where barriers to water access were reported):

1. High price of water trucking (**88%**)
2. Main network is in a state of disrepair due to damage (**48%**)
3. Water pumps only functional for a few hours per day (**19%**)
4. Alternative sources not available (**17%**)
5. Not enough pressure to pump sufficient water (**17%**)

Seventy-four per cent (74%) of KIs reported that 76% or more of their communities had enough water to meet their needs in the week prior to data collection. HSOS KIs and camps and sites households reported similar or greater water access. In three sub-districts, Aghtrin, Badama, and Ghandorah, 17% of KIs reported that less than 50% of their communities had access to water. The most common barrier to water access reported by KIs from communities with water access barriers was the high price of water trucking, as 88% of KIs reported this as a barrier in their communities. In the one sub-district where this was not the case, Ghandorah, KIs reported the largest barrier was insufficient water pump pressure (67%). Across communities covered by the RNA, HSOS communities, and camps and sites households, the most commonly reported source of water was water trucking, and high trucking prices were consistently reported as a barrier. REACH market monitoring data shows that the Survival Minimum Expenditure Basket (SMEB) price of water[8] has been increasing by a few hundred SYP each month, and most recently increased from 4,770 to 5,018 SYP between February and March 2020. According to HSOS wage data, the average daily wage across the region reportedly is 2,200 SYP per day.

The second most common water source reported among communities was connection to a water network. KIs in 55% of assessed communities reported that water supply networks had been partially damaged due to conflict, and 18% of communities reportedly had a network that had been completely damaged. Networks were particularly damaged in Badama, Ghandorah, Janudiyah, and Jarablus, where over half of KIs reported that water supply networks were completely damaged. These findings show that if water trucking prices increase, households have few alternate options for accessing water.

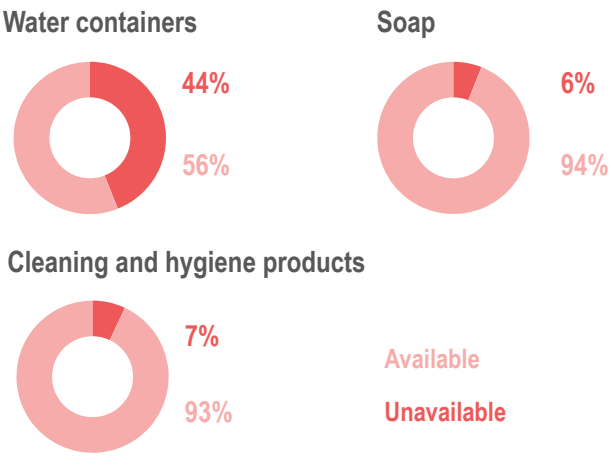
Proportion of assessed communities where water supply networks have reportedly been directly impacted by conflict (by % of assessed communities where reported):



Seventy-seven per cent (77%) of KIs reported their communities had no problems accessing soap, and 94% of KIs reported that soap was available in their communities. Sub-districts where more than 50% of KIs reported issues accessing soap were Ariha, Ehsem, and Sheikh El-Hadid, and where more than 20% of KIs reported that soap was unavailable in the market were Ariha, Bulbul, and Harim. Consistent soap access was also seen across HSOS communities and camps and sites households. HSOS data measures affordablility of non-food items (NFIs), and found that soap was affordable for the majority of people in 67% of communities. Soap was less affordable in Raju, Mabtali, Afrin, Bulbul, and Ghandorah sub-districts. According to REACH's market monitoring data, the price of a piece of bathing soap reportedly was 125 SYP in February and March 2020, but the price has increased by 66% from 75 SYP in November 2019.

Although most KIs reported no problems accessing or using soap, 32% of KIs reported that one access problem was the distance to the market. In Ariha, Darkosh, Harim, and Sheikh El-Hadid sub-districts, over 60% of KIs reported distance to the market as an access barrier. Distance to

Reported availability of household and hygiene items for COVID-19 preparedness (by % of assessed communities where reported):



markets may be a problem in camps and sites as well, as 38% of camps and sites households reportedly had access to a market providing non-food items within their camp or site.

Other relevant NFIs, such as cleaning and hygiene products, were reportedly widely available across all communities. Water containers were also available, although to a lesser extent than hygiene items.

Most commonly reported problems when accessing or using soap (by % of assessed communities where reported):[7]

1	No problems	77%
2	The market is too far away	32%
3	People do not like the quality of the soap	6%

Social Distancing

Social distancing is one of the key preventive measures recommended by global health bodies for controlling the spread of COVID-19. While 43% of all KIs in assessed communities reported that lack of space was a shelter issue (particularly for IDP communities in Harim, Jarablus, Kafr Takharim, and Salqin sub-districts, and for host communities in Darkosh and Jarablus sub-districts), the burden of overcrowded shelters was greater among IDPs than among host communities. KIs from 7% of host communities, mostly in Mhambal and Jisr-Ash-Shugur sub-districts, reported that 26-100% of their populations were living in overcrowded shelters. KIs from 29% of IDP communities, particulalry in Azaz, Armanaz, Dana, Idleb, and Jandairis sub-districts, reported that 26-100% of their populations were living in overcrowded shelters.

43% **of KIs in assessed communities reported lack of space as a shelter adequacy issue**

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

13%	0%	50%
55%	1-25%	43%
25%	26-50%	6%
4%	51-75%	1%
0%	76-100%	0%
3%	Don't know	0%

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

Reliance on communal latrines constitutes another difficulty for effective social distancing. Among KIs from 429 communities reporting access to latrines, 84% reported that household latrines were accessible. Sixteen per cent (16%) said communal latrines were accessible, and 30% reported both types of latrines were accessible. Camps and sites household data goes beyond accessibility to provide information about latrine use. This data showed that 53% of households were reportedly using a shared latrine, and 39% were using a household latrine. Thus, shared latrines in camps settings may be important intervention points for actors looking to address the potential spread of COVID-19.

Challenges associated with social distancing are also an issue in health facilities, which were shown above to have increased and high levels of overcrowding. The potential for overcrowding will only increase if COVID-19 spreads at rates similar to those seen in other countries.

Top measures put in place by local authorities in assessed communities were mostly related to social distancing. Among communities where authorities had put in place preventive measures, the two most commonly reported measures were asking people to stay home (reported by 58% of KIs) and closing non-essential services and businesses (reported by 56% of KIs). At the sub-district level, less than 25% of KIs in Aghtrin, Idleb, Qourqeena, and Sheikh El-Hadid reported that people had been asked to stay home, and less than 33% of KIs reported that non-essential businesses had been closed in Jandairis, Ma'btali, Qourqeena, and Sharan. Essential group gatherings, such as food distributions, were also reportedly staggered* to prevent congregating in 12% of communities, at higher proportions in Armanaz, Maaret Tamsrin, Mare', and Suran sub-districts.

Top most commonly reported measures regarding social distancing put in place by local authorities against COVID-19 (by % of assessed communities, among 386 communities where measures were reported):[7]

1	Asking people to stay at home	58%
2	Close non-essential services and businesses	56%
3	Prevention messages	56%
4	Staggering groups for essential services such as food distributions	12%

When KIs were asked about protective measures that had been put in place by community members, social distancing measures were also reported. While the top two most reported measures were related to personal hygiene, the third and fourth most reported measures were related to social distancing. Among KIs reporting that community measures had been put in place in their communities, 44% of KIs reported people were staying home when possible (although no KIs from communities in Al Bab, Ehsem, Ghandorah, Harim, and Jarablus reported this measure) and 29% of KIs reported that community members were limiting physical contact (although no KIs of communities in Ar-Ra'ee, Ariha, Bennsh, Ehsem, Jarablus, and Ma'btali reported this measure).

Protective measures regarding social distancing reportedly put in place at community level against COVID-19 (by % of assessed communities, among 418 communities where measures were reported):[7]

Avoiding touching other people (handshake, etc.)	Staying at home as much as possible
29%	44%

* Staggering was explained by enumerators to mean that distributions or other essential group gatherings are conducted in stages, with smaller groups of people serviced at different points of time, rather than a large group serviced at the same time.

ENDNOTES

The complete northwest Syria Inter-cluster RNA dataset is available here.

1. OCHA, 'Syrian Arab Republic: Recent developments in North-west Syria - Flash Update' 2 April 2020
2. At the time of publication on 16 April 2020, Syria had 33 confirmed cases and 2 deaths. From the COVID-19 Dashboard by the Center for Systems Science and Engineering at Johns Hopkins University
3. OCHA, 'Syrian Arab Republic: Covid-19 - Humanitarian Update No.04,' 2 April 2020
4. 461 communities comprising 457 communities and 4 neighbourhoods in Idleb city.
5. Assessed sub-districts of northwest Syria camps and sites needs assessment:
Al Bab, Azaz, Badama, Dana, Harim, Maaret Tamsrin, Salqin
Assessed sub-districts of Humanitarian Situation Overview in Syria:
Afrin, Aghtrin, Al Bab, Ariha, Arima, Armanaz, Ar-Raee, Atarab, Azaz, Badama, Bensh, Bulbul, Dana, Daret Azza, Darkosh, Ehsem, Ghandorah, Harim, Idleb, Jandairis, Janudiyeh, Jarablus, Jisr-Ash-Shugur, Kafr Takharim, Maaret Tamsrin, Mabtali, Mare, Mhambal, Qourqeena, Raju, Salqin, Sharan, Sheikh El-Hadid, Suran-Aleppo, Tadaf
6. Figures refer to proportion of population subset: Pregnant/lactating women as % of female population, Female-headed household as % of female population, Adults/children with disability as % of adults/children, persons with chronic illness as % of total population, Unaccompanied Children as % of children.
7. KIs could select multiple answer options so findings might exceed 100%.
8. The SMEB includes the price of 4,500 litres of water. For more details, please refer to **REACH Market Monitoring monthly products** (factsheet and dataset).

Data sources and 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 March for the referral period of February and is available upon request, the January factsheet and dataset are available **here.**

REACH Household-level Camps and Sites Assessment in Northwest Syria

To address an information gap around the needs of IDPs in northwest Syria, REACH, in partnership with the Humanitarian Needs Assessment Programme (HNAP), conducted a household-level survey in both registered and unregistered sites in 7 sub-districts of northwest Syria. Data for this assessment was conducted through the HNAP enumerator network from 30 January - 19 February 2020. Sub-districts were selected based on number of IDPs and operational relevance, and camps and sites were selected based on random population probabilities. The dataset and initial findings factsheet for this assessment can be found **here**.

REACH and Cash-Based Response Technical Working Group (CBR-TWG) Market Monitoring (MM)

To inform humanitarian cash programming, REACH, in partnership with the Cash-Based Responses Technical Working Group (CBR-TWG), conducts monthly MM exercises in northern Syria to assess the availability and prices of 36 basic commodities that comprise of the Survival Minimum Expenditure Basket (SMEB), that are typically sold in markets and consumed by average Syrian households, including food and non-food items, water, fuel, and cell phone data. Each enumerator aims to assess three to five shops of each type in the main market in their assigned sub-district, using surveys to collect information about the three cheapest prices of each item. In sub-districts where direct surveying by enumerators is not possible, data collection is conducted remotely through KIs such as shop owners, suppliers and consumers.

MM data referred to in this report comes from the March 2020 dataset, which is available **here.**

CONTACT

Laura Thisted,

REACH Syria Country Coordinator

Email: laura.thisted@reach-initiative.org

REACH Informing more effective humanitarian action