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iMMAP/DFS COVID-19

Situation Analysis

Period: 20 October - 22 November 2020

SYRIA

Better Data, Better Decisions, Better Outcomes

The outbreak of disease caused by the virus known as Severe Acute Respiratory Syndrome (SARS-CoV-2) or COVID-19 started in China in December 2019. The virus quickly spread across the world, with the WHO Director-General declaring it as a pandemic on March 11th, 2020.

The virus's impact has been felt most acutely by countries facing humanitarian crises due to conflict and natural disasters. As humanitarian access to vulnerable communities has been restricted to basic movements only, monitoring and assessments have been interrupted.

To overcome these constraints and provide the wider humanitarian community with timely and comprehensive information on the spread of the COVID-19 pandemic, iMMAP initiated the COVID-19 Situational Analysis project with the support of the USAID Bureau of Humanitarian Assistance (USAID BHA), aiming to provide solutions to the growing global needs for assessment and analysis among humanitarian stakeholders.

Highlights

1. Key Developments

a. COVID-19 Cases

Reported cases have been rapidly increasing over the past few months in all areas of Syria.

By 30 September about 3,000 total cases had been reported throughout the country. This number has since increased by more than 800% to reach a total of 27,500 reported cases as of 20 November (MoH GoS, WHO, AANES). 7,100 of these were reported in GoS-controlled areas, mostly in Damascus and Aleppo governorates (MoH GoS). 13,800 of the cases were in the northwest, mostly reported in Idlib governorate, representing a four-fold increase in a month (OCHA 18/11/2020). 6,500 of the cases were in the northeast, mostly in Al-Hassakeh, Ar-Raqqa and Aleppo governorates (NES Forum 05/11/2020; OCHA & WHO 09/11/2020). Increased cases were also reported in schools following their reopening in September and in camps, with 8% of all cases in the northwest reported in displacement settings and cases confirmed in 5 locations in Al-Hol camp in the northeast (OCHA 18/11/2020; NES Forum 05/11/2020).

Cases are greatly under-reported, due to limited testing capacities, social stigma and government pressure

In northwest Syria, the recent increase of cases is in part a result of increased testing capacity, with two additional active laboratories since October. Nonetheless, test positivity rates were significantly high at 42% in northwest Syria up to 09 July and 42% in northeast Syria as of 03 November (OCHA 21/10/2020, AANES). Testing rate is still far below what would be required to more accurately detect infection prevalence. Testing capacity varies across the areas, but on average are between 500 and 1,000 daily tests, compared to 12,000 daily tests in Lebanon (MedGlobal 14/10/2020) with less than half of the population. Health authorities still struggle to keep up with the spread of the epidemic and significantly scale up their testing operations. Testing kits stock in the northeast are projected to be in short supply by the end of 2020.

The reluctance of many civilians to get tested also contributes to under-reporting. Issues with social acceptance of those infected and fear of stigmatisation, or even bullying, by the community further prevents people from seeking a test or treatment (Enab Baladi 13/11/2020, Al Jazeera 05/10/2020). Many now consider COVID-19 "shameful", and hold COVID-19 patients responsible for their infection because they did not adhere to protective measures (Enab Baladi 13/11/2020). Social stigma and patients' reluctance to go to hospitals mean that probably significant numbers of people with symptoms are not seeking care or are being treated at home, leading to further difficulty in ascertaining the true scale of the epidemic, as well as increasing the likelihood of such patients to develop more severe symptoms, decreasing their chance of survival (OCHA & WHO 29/10/2020). In GoS-held areas, fear and deep distrust of state institutions are also driving people from reporting symptoms or seeking care, as patients refuse to go to public hospitals (Enab Baladi 13/11/2020).

Considering the limited number of tests being performed in Syria and the scarcity of accurate epidemiological data, it is highly likely that cases are not being detected and that the actual number of cases and deaths far surpasses official figures. Official statistics show a rapid increase in cases, but the high positivity rate and death reports suggests that the

true scale of the epidemic is extremely underestimated. Some estimated the true number of cases around 110,000 just in the capital in September (The Conversation 17/09/2020).

Further increases in cases likely in the coming months

As 59% of the population in the northwest are internally displaced (HNAP 11/08/2020), and many living in overcrowded settlements (REACH 19/09/2020), the additional contagion potential is very high, and will soon be compounded by the risks posed by the winter season. The rapid increase in cases is likely to continue to rise in the coming months as more people will spend more time in overcrowded enclosed spaces. Already, overcrowding, inadequate shelter and poor access to basic services make it nearly impossible to properly adhere to physical distancing or other public health precautions and put IDPs at a greater risk of COVID-19 infections (Al-Araby 20/11/2020, Human Rights Watch 15/10/2020). The Ministry of Health of the Syria Interim Government in the northwest estimated that around 64,000 people are at critical risk of infection (The Syria report 14/10/2020). In the northwest, around 40% of the adult population is estimated to have comorbidities and around 76,000 people are over 60 years old. Both factors could lead to increased risk of COVID-19 and poorer outcomes (MedRxiv 07/05/2020). Nationally, 1.8 million people are over 60 (HNAP 11/08/2020).

b. Containment measures

Authorities initially closed most public services and restricted movement. Progressive relaxation of these containment measures took place during the summer. At the end of August, a new flare-up of cases led to localized closures and quarantine protocols. But since then, most activities returned to pre-COVID levels as authorities reduced and lifted containment measures. Most notable was the reopening of schools across Syria after six months of closure. However more recently a rising number of cases among staff and students led to multiple closure of schools and partial precautionary measures, notably Idlib governorate, northwest, and in the northeast.

c. Preventative measures

Not abided by as they are not reflecting the reality of most Syrians

While most people report being aware and having sufficient understanding about self-protection and preventive measures, not all community members report to be fully committed to adhering to such measures. Adherence to preventive measures remains low, as well as enforcement levels, especially in the northwest. While more than 70% of the population in northwest/northeast reports washing their hands more frequently (REACH 22/10/2020, REACH 22/10/2020), overcrowding, unaffordability, and low enforcement are contributing in most not abiding by these measures.

Money is the main barrier to adhere to preventative measures

About 40% of the population in northwest and northeast Syria reported facing barriers to preventive measures. The main ones being insufficient money to buy protective items and not being able to afford not working (REACH 22/10/2020, REACH 22/10/2020). Risk of income loss is also one of the main reasons driving people from reporting symptoms to avoid quarantine. About half of interviewed households by WFP reported not being able to purchase necessary medicines, primarily due to insufficient financial resources (WFP 30/09/2020).

Low risk perception: COVID-19 is considered one threat among many

While cumulative Risk Communication and Community Engagement efforts reached an estimated 15 million people as of the end of September, survey information and anecdotal evidence suggest that both the risk perception across Syria is very low leading to low adherence to individual preventive measures has been observed in some communities. The absence of hard enforcement measures by the authorities is another factor contributing to low-risk perception among the population. Inadequate risk communication to the population about the likely scale of undetected transmission and the prospect that the situation worsens in Syria continues to be a problem, as people are less likely to adhere more strictly to preventative measures.

2. Drivers and humanitarian consequences

a) Main drivers

Already fragile health system overwhelmed by the epidemic

Low availability of health equipment, personnel, functioning health facility, and testing capacity, is further overstretching an already weak healthcare system. This overwhelmed health system, coupled with greater challenges in accessing healthcare and stigma, is leaving many without care. As of December 2019, the health system was already unable to meet the basic health needs of the population, with about 50% of the 113 hospitals across the country considered partially or fully non-functioning (Health Cluster 04/2020, WHO HeRAMS 2019) and about 33% health centers reportedly damaged (WHO HeRAMS 2019), figures likely to have increased during the offensives in both northwest and northeast that occurred in late 2019 and early 2020. In the northeast, only 26 (9%) of 270 public healthcare facilities were functioning in April 2020 (NES Forum 16/04/2020). Major hospitals have already exceeded their capacity and are not able to cope with the influx of patients. As a result of limited supplies, sick patients are being turned away when the necessary resources are unavailable.

Of particular concern is the high number of health workers affected by the disease, representing 10 to 17% of all reported cases in the northwest and northeast. While this high ratio can be explained by the focus of the tests in the region which mostly targeted healthcare workers, the effect on the healthcare system remains devastating (NES Forum 01/10/2020). The steady increase in affected healthcare workers across the country since July highlights the fragile healthcare system, facing already insufficient numbers of qualified healthcare personnel and preventive kits resulting in overstretched healthcare capacity.

COVID-19 containment measures exacerbated the pre-existing economic situation, significantly worsening humanitarian needs

While precautionary measures against the spread of the virus were crucial to contain transmission, they exacerbated socio-economic vulnerabilities and created new humanitarian crises, by reducing availability and access to basic services and employment opportunities, adding another layer of complexity in the humanitarian response. The pre-existing and underlying fragility of the Syrian economy and the multiple shocks that occurred in between mid-2019 and 2020 had already greatly weakened the Syrian economy but COVID-19 restrictions from March to July further heavily impacted employment opportunities across the country, pushing up prices and further increasing dependence on negative coping mechanisms. Economic experts from Damascus University estimated the economic losses due to the COVID-19 lockdown measures of 1 trillion Pounds per month, amounting to four trillion in total (Al Watan 11/04/2020), representing almost half of the 2021 Syrian Government budget (Atlantic Council 01/12/2020).

As a result of the pre-existing economic crisis, coupled with COVID-19 restriction measures and, in June 2020, the implementation of new US economic sanctions, the Syrian Pound (SYP) devalued faster over the first six months of 2020 than over the past nine years of the conflict, hitting a record low in early June with an informal exchange rate of 3,200 SYP for 1 USD (World Vision 01/07/2020), compared to 434 in 2019 (WFP 15/07/2019). Regional economic downturn also resulted in broader impacts, further reducing economic flows into Syria. The estimated $1.6 billion of remittances sent to Syria each year (Syria Direct 12/04/2020) are estimated to have reduced by up to 50% (OCHA & WHO 29/10/2020).

The impact of this is expected to hit hardest for 83% of the Syrian population who were living below the poverty line even before the COVID-19 crisis (OCHA 2019). As a result, safety nets and livelihood resources are more strained than ever before, compounding the humanitarian needs of 11.7 million people, including 6.2 million IDPs, and unaffordability is now reported across sectors as the main obstacle to accessing goods and services. Based on the current trends, WFP predicts that a period of further economic contraction is to be expected, with reduced production, increased poverty rates and further food security deterioration (WFP 20/08/2020).

Basic infrastructure severely impacted by a decade of conflict

A decade of conflict, multiple displacements, economic shocks in the country and neighbouring countries, military operations, and violence had already severely affected the population and infrastructure, leading to weak capacities in handling the spread and repercussions of the disease.

About 6.7 million people remain internally displaced in 2020 and an estimated 5.65 million people across the country are in need of shelter (Shelter Cluster 17/11/2020), with poorer conditions more prevalent in Idlib, Aleppo, Rural Damascus governorates, Ar-Raqqa city and in camps in the northeast and northwest (Al-Araby 20/11/2020, Human Rights Watch 15/10/2020).

COVID-19 added more pressure on a fragile health care system, already deeply affected by almost a decade of conflict. Before the pandemic, the World Bank already had estimated that "more people may have been killed in Syria due to a breakdown of the health system than due to direct fatalities from the fighting" (World Bank 10/07/2017). Deliberate tactics targeting hospitals and medical workers have contributed to more than 70% of the healthcare workforce leaving the country, leaving Syria vulnerable to this health crisis (OCHA & WHO 07/10/2020, OCHA 06/03/2020). As a result, there has been insufficient numbers of healthcare workers remaining and even fewer in the specialties needed to handle COVID-19 patients (pulmonology, intensive care, infectious diseases, infection prevention and control, etc.) (Migration and Health 03/07/2020).

Similarly, the poor coverage and quality of WASH infrastructure has been driving up WASH needs even before the pandemic. While before the war, most urban areas had adequate sewage systems, only some of these were actually connected to treatment plants. There were only around 20 treatment facilities in Syria and their treatment did not always meet international standards (Delegation of the European Commission to Syria 04/2009). Due to the conflict, at least 50% of the sewage systems are not functional and 70% of sewage is untreated: this results in only 9% of the population still being served by functional wastewater treatment systems (HNO 2019). About 26% of water infrastructure has been damaged, including 51% of wells, 23% of water towers/tankers and 9% of pumping stations (World Bank 06/02/2019). Gap analysis indicates that across 27 sub-districts, 1.3 million people lack some form of WASH services (OCHA 21/10/2020).

As a result of the conflict, about 43% of the education infrastructure is estimated to be non-functional in Syria, with secondary and vocational schools among the most targeted, with more than 14% of the buildings fully damaged (World

Bank 10/07/2017). The number of teachers in the formal education system is less than half the pre-war level (World Bank 06/02/2019). The education system was unprepared to shift to online learning, with an unreliable electricity network, with under 10%of power infrastructure fully functioning (World Bank 06/02/2019) and, while growing, an overall low access to internet (about 30% in 2018) (Freedom House 01/11/2018).

a. Both drive other humanitarian consequences

Inability to meet basic needs

Meeting basic needs has become more difficult since the start of the pandemic. In the mVAM September survey, approximately 60% of the surveyed households reported across Syria the loss of one or more sources of income due to COVID-19 related restrictions. Almost one out of four households reported having lost more than 75% of their income (WFP 07/10/2020). As a result of price inflation, many households are forced to prioritise their spending and choose between food, heating, health or abiding by COVID-19 mitigation measures.

Increase in use of severe coping mechanisms

As the economic downturn has been impeding the ability of households to meet their basic needs, negative coping mechanisms are increasing, with children particularly exposed to protection risks due to school closure (OCHA 26/06/2020). 90% of households interviewed in September report relying on at least one coping strategy during the month (WFP 07/10/2020). Child labour, forced prostitution, abortions and early marriages are reportedly on the rise (OCHA 10/09/2020).

Reports also highlighted that community support systems are weakening, with a reduction in willingness to support others due to risk of COVID-19 infection, leaving elderly and vulnerable households, such as female-headed households, households without access to humanitarian assistance, or households without stable livelihoods or income even less able to cope (Protection Cluster 27/11/2020).

Effects from containment measures implemented earlier in the year are still felt

i) Livelihoods

The pandemic, and its related government preventive measures, added to the already worsening economic situation and caused widespread inflation across all commodities (food and non-food items), especially of imported items, since March 2020 (WFP 10/09/2020). Inflation and price fluctuations have been a major barrier for accessing key items, even among households with steady income, as the cost of living has been spiraling up while the value of their income has been decreasing. The national average reference food basket recorded a 251% increase year-on-year as of July 2020, the highest spike recorded in Idlib at 464% (Global Food Security Cluster 23/09/2020, OCHA & WHO 02/09/2020). Even with the lift of most of these measures, prices have continued to worsen (WFP 22/10/2020).

The economic effects of COVID-19 precautionary measures have been felt even more significantly among the 54% of workers in the informal labor market relying on daily income for basic goods and services and in the agriculture sector, where the percentage of informal workers reaches almost 80% (FAO & WFP 01/07/2020), as well as IDPs who almost exclusively relied on daily income (91%) in Al-Hassakeh, Ar-Raqqa, Aleppo, and Deir-ez-Zor Governorates (REACH 01/07/2020). In GoS-controlled areas, according to the Ministry of Social Affairs and Labor, more than 320,000 people

registered for the National Campaign for Emergency Social Response for assistance due to loss of work as a result of COVID-19 preventive measures.

ii) Food security

While the food security situation was worsening before COVID-19, with already the depreciation of the Syrian Pound and increases in fuel and food prices since late 2018, the deterioration has since accelerated (WFP 22/10/2020). Due to the effects of COVID-19 mitigation measures, the loss of job opportunities, particularly for those reliant on daily wage labour or seasonal work, and the continued rise in food prices, more households have been pushed into food insecurity as they have been unable to meet their food needs (WFP 20/08/2020). According to WFP, 9.3 million people in Syria are now food insecure, 46% of the country's population (WFP 29/06/2020) and this number could soon exceed 11 million (UN Security Council 27/08/2020), as over 2.2 million Syrians are at risk of slipping further into food insecurity without urgent assistance (WFP 02/09/20), with Aleppo, Deir ez-Zor, Lattakia and Ar-Raqqa governorates being the most affected.

iii) Nutrition

Monthly surveillance data has shown a deteriorating nutrition situation in northwest Syria, with increasing levels of both acute and chronic malnutrition, particularly among IDPs (OCHA 18/11/2020). In northwest Syria, the prevalence of chronic malnutrition among under-five children increased from 19% to 33% between May 2019 and September 2020, while the prevalence of acute malnutrition doubled over the same period, now reaching the serious emergency standard of 2%. For Pregnant and Lactating Women (PLW), proxy prevalence of acute malnutrition across northwest Syria is at 11%.

iv) Health

Prices of preventative equipment and testing costs have significantly increased since the beginning of the pandemic, making them unaffordable for most Syrians. The prices of masks and gloves rose three-fold and sanitizer doubled since February (WFP 07/10/2020). Most people in Syria cannot afford to buy preventive equipment, prioritising food, water, medicine and school supplies instead (Al Jazeera 02/11/2020).

v) Education

After more than 6 months of closure, schools reopened mid-September in Government-controlled areas territories, with more than 3.8 million students returning to school, and late September in the northwest for 820,000 students and in the northeast (The Syria Report 30/09/2020, Syrian Observatory of Human Rights 24/09/2020, The Syria report 16/09/2020). However, with the loss and reduction of incomes, the weakening SYP, and increase in expenditures, more children are likely to be dropping out of school, despite their reopening, to assist with generating income or because the associated expenses of education cannot be met (REACH 22/07/2020).

vi) Protection

Restrictions of movements and forced quarantine measures have impeded access to protection services. By 17 November, only 14% of psychosocial support structures were reportedly fully available in NSAG & TBAF areas. In GoS and SDF areas, while this rate was higher, it still remains well below pre-COVID levels, with 21% and 37% services available respectively (HNAP 17/11/2020). Schools, community centers, Child Friendly Spaces and Women and Girl Safe Spaces were significantly scaled down due to COVID-19 precaution measures (OCHA 10/09/2020).

Extended quarantines, curfews and other movement restriction measures also led to increased reports of domestic violence (UNFPA 01/05/2020).

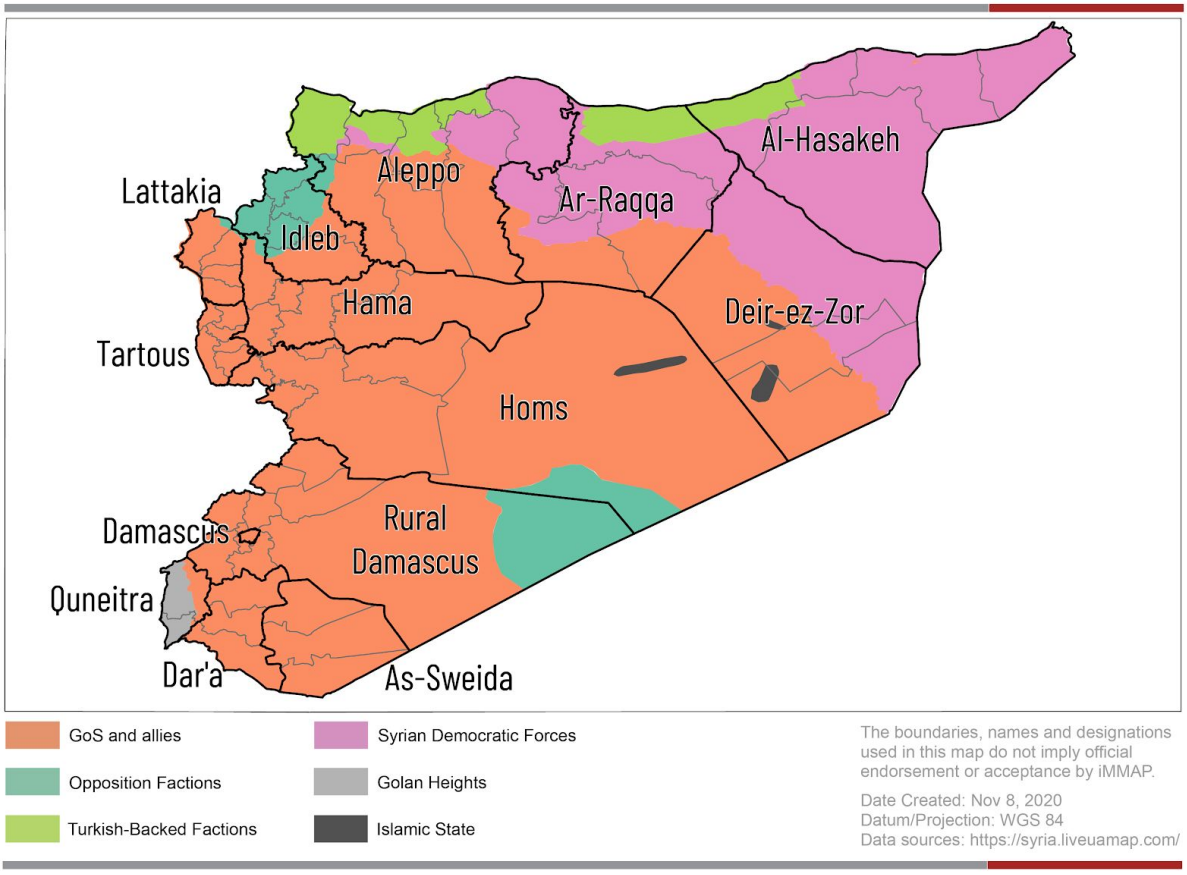
COVID-19 and widespread fears of infection are also causing social pressure, distress and increasingly social stigma. As a result of stigmatisation, bullying, social exclusion, prevention from entering shops or even leading to women being rejected by their spouse in extreme cases have been reported (Protection Cluster 27/11/2020, The Independent 26/08/2020). Social stigma associated with COVID-19, alongside pressure to maintain income and livelihood, is reportedly inducing people to hide symptoms and avoid seeking treatment or self-isolating (Protection Cluster 27/11/2020, OCHA 21/10/2020).

vii) WASH

While surveys show that practicing hygiene measures, such as handwashing, is the most widely adopted measure (75%) (GTS & HNAP 27/08/2020), access to hygiene items remains restricted. In northwest Syria, while prices of soap decreased by 20% between July and August, it still remains unaffordable by 47% of assessed communities (REACH 17/09/2020, REACH 07/09/2020). Despite water price remaining steady, it is still unaffordable, yet the main source of water for many assessed communities in the northwest (REACH 19/10/2020).

Context

Map 1: Areas of Control in Syria (Liveuamap 08/11/2020)



This report refers to three main areas of Syria as does most of the source data included in the analysis:

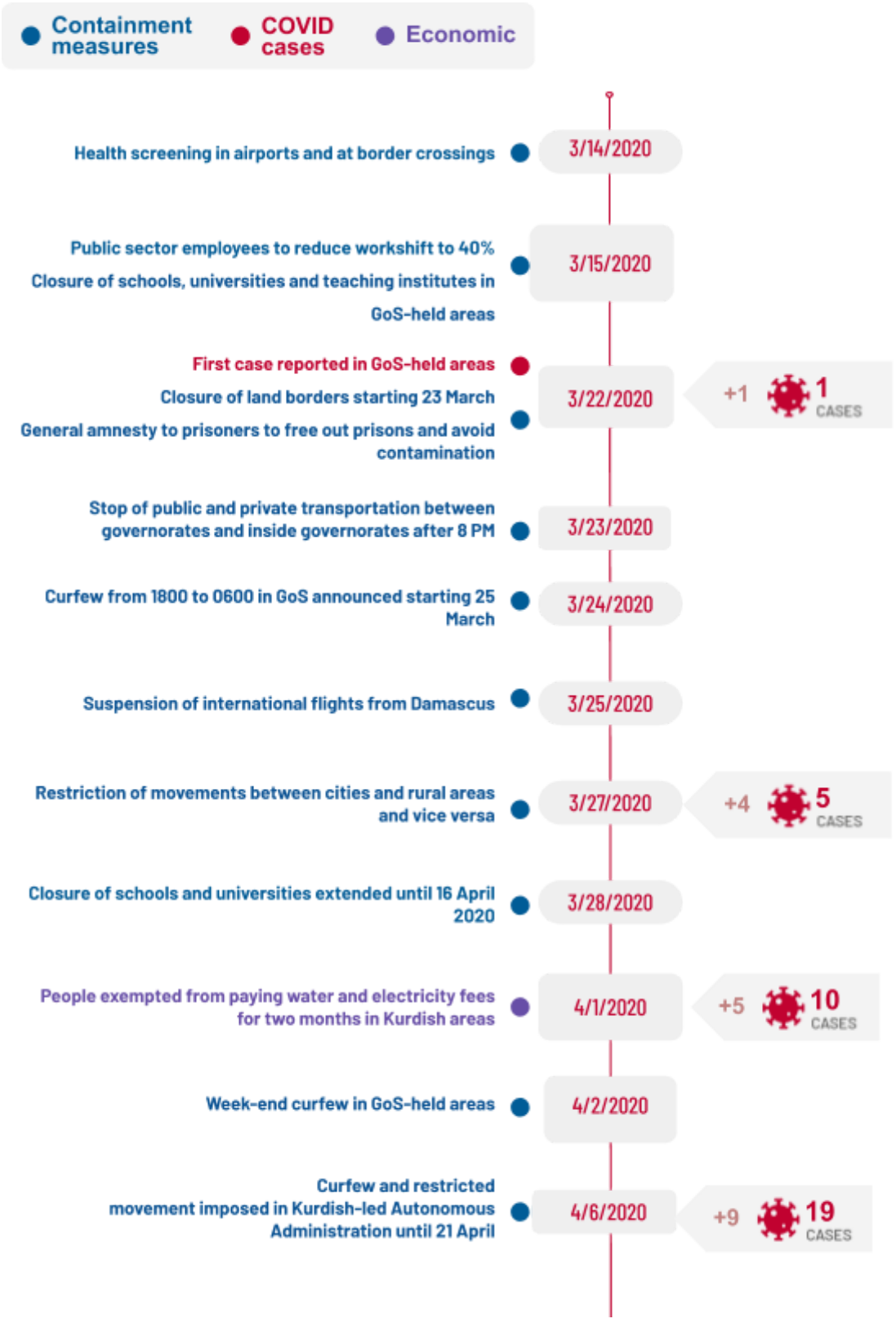
Government of Syria (GoS)-controlled areas: This refers to the area of Syria controlled by the Government of Syria and allies, primarily in cities along the western spine and central and southern Syria.

Northwest Syria: This refers to the area of Syria controlled by non-state armed groups and Turkish-backed armed forces in northern and western Aleppo governorate, a significant portion of Idlib governorate, and smaller areas of Latakia and Hama governorates.

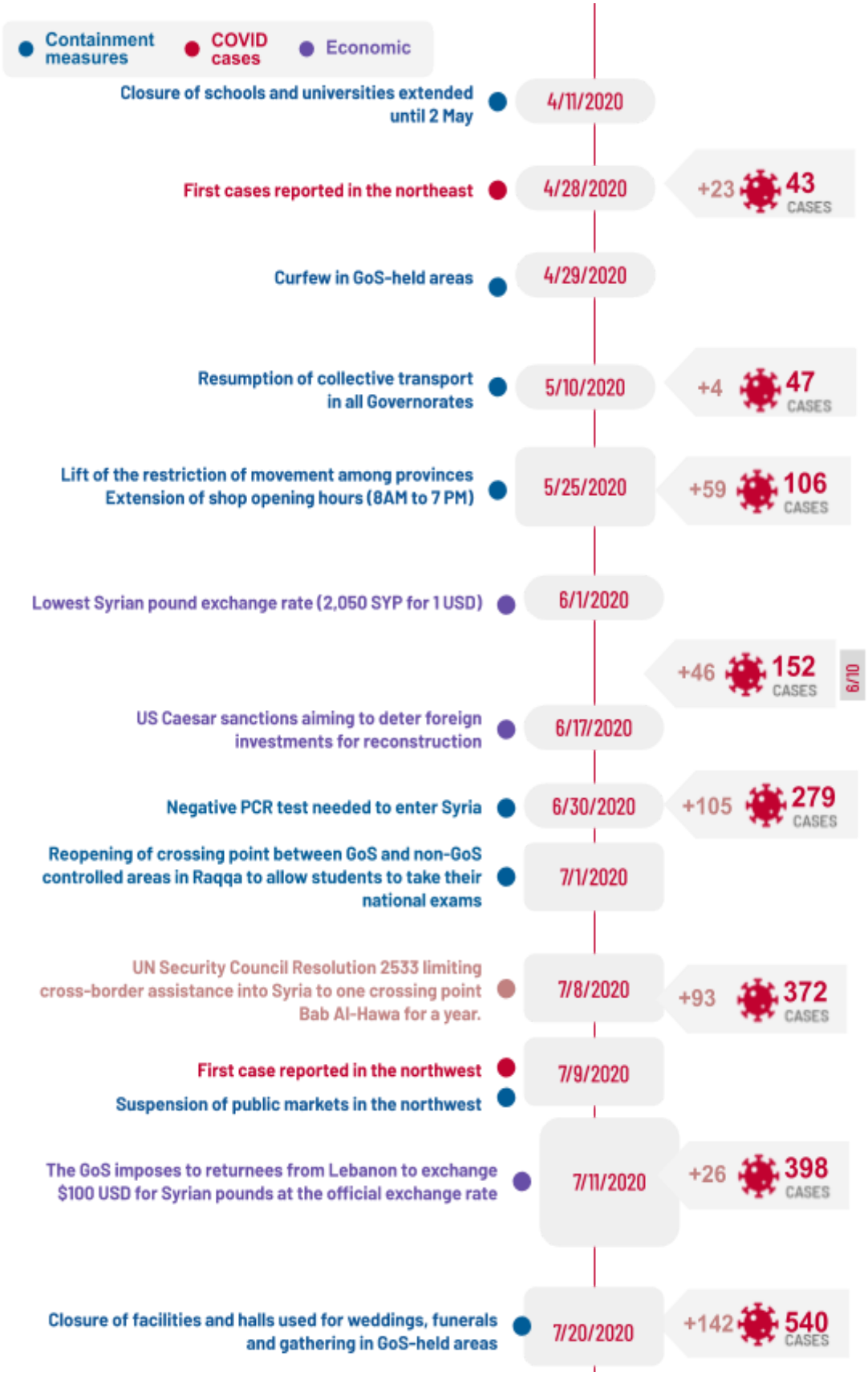
Northeast Syria: This refers to the area of Syria controlled by the Syrian Democratic Forces (SDF) and administered by The Autonomous Administration of North and East Syria (AANES).

Sources may use different definitions of these three areas depending, amongst other factors, on the time of publication. Therefore it is crucial that original sources are consulted for an accurate understanding of what areas findings of this report should be applied to.

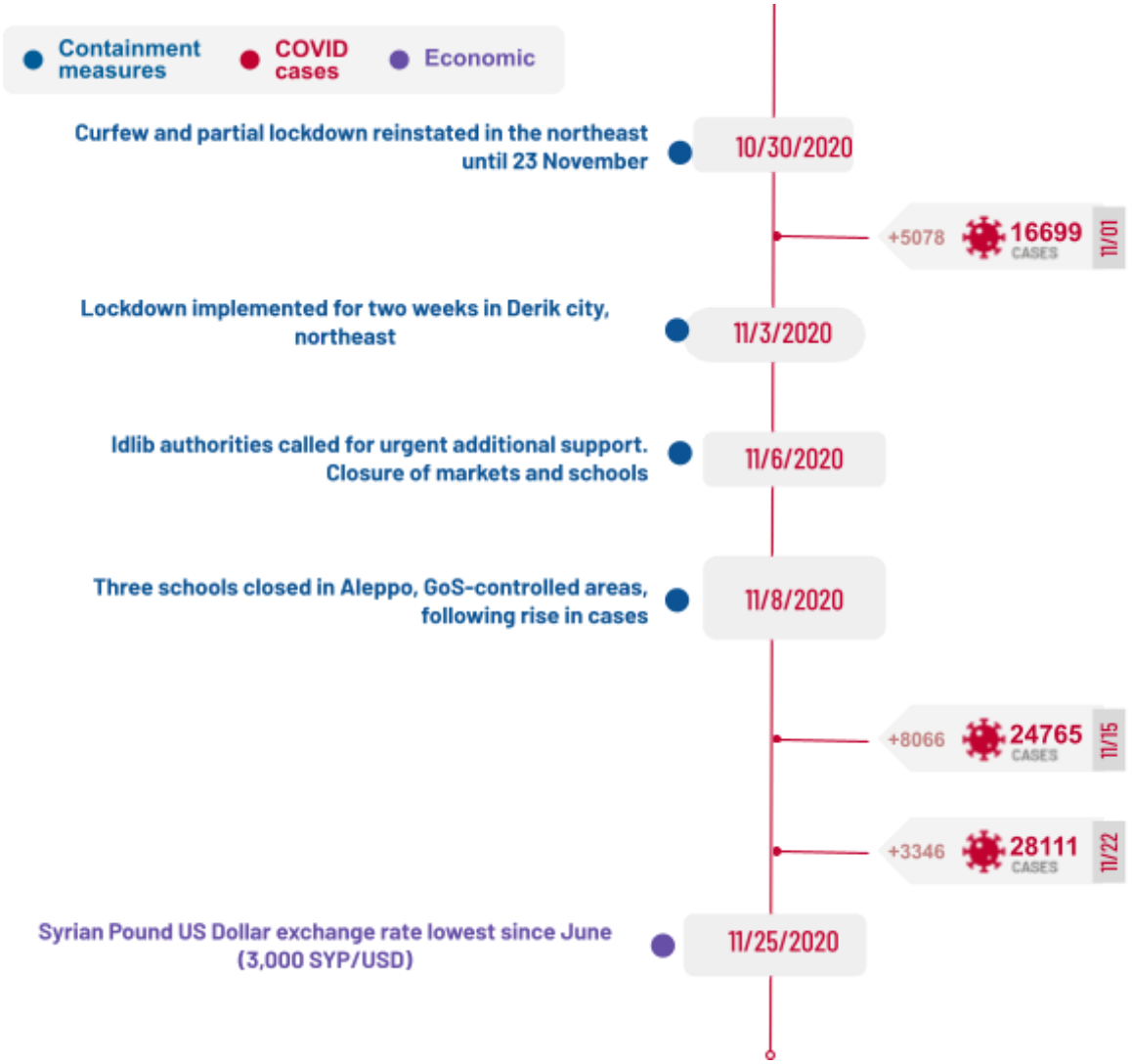
Timeline[1]



[1] Sources for epidemiological data: (MoH GoS, WHO, OCHA 20/10/2020, AANES 20/10/2020). There is a possibility for authorities in different regions to report the same cases in some instances, leading to double-counting.


Containment measures
COVID cases
Economic
Closure of schools and universities extended until 2 May
4/11/2020
First cases reported in the northeast
4/28/2020
+23 43 CASES
Curfew in GoS-held areas
4/29/2020
Resumption of collective transport in all Governorates
5/10/2020
+4 47 CASES
Lift of the restriction of movement among provinces
Extension of shop opening hours (8AM to 7 PM)
5/25/2020
+59 106 CASES
Lowest Syrian pound exchange rate (2,050 SYP for 1 USD)
6/1/2020
+46 152 CASES
6/10
US Caesar sanctions aiming to deter foreign investments for reconstruction
6/17/2020
Negative PCR test needed to enter Syria
6/30/2020
+105 279 CASES
Reopening of crossing point between GoS and non-GoS controlled areas in Raqqa to allow students to take their national exams
7/1/2020
UN Security Council Resolution 2533 limiting cross-border assistance into Syria to one crossing point Bab Al-Hawa for a year.
7/8/2020
+93 372 CASES
First case reported in the northwest
Suspension of public markets in the northwest
7/9/2020
The GoS imposes to returnees from Lebanon to exchange $100 USD for Syrian pounds at the official exchange rate
7/11/2020
+26 398 CASES
Closure of facilities and halls used for weddings, funerals and gathering in GoS-held areas
7/20/2020
+142 540 CASES


Containment measures
COVID cases
Economic
Partial curfew and ban on mass gathering reinstated in Northeast following new cases
Closure of all land border-crossings with both Iraqi Kurdistan and Government of Syria areas
7/23/2020
Jordan authorities closed their land border with Syria
8/13/2020
+1112
1652 CASES
Northeast: Reopening of shops and services
Resumption of movement between towns, cities and districts
8/27/2020
+1426
3078 CASES
More than 320,000 people registered for the National Campaign for Emergency Social Response for assistance
9/1/2020
+426
3504 CASES
Reopening of schools reopening in GoS-held areas
9/13/2020
+1141
4645 CASES
Severe fuel shortages notably due to the closure of borders, delays in imports due to the COVID-19 context and the enforcement of US sanctions in June
9/15/2020
+358
5003 CASES
Jordan authorities reopened their land border with Syria
Reopening of schools in the northeast and northwest
9/27/2020
+1438
6441 CASES
Syrians can enter Lenon provided they have residency documents, are students, obtain a personal guarantee from Lebanese citizens, or have medical appointments
9/28/2020
International flight departing from Damascus International airport after months of suspension
10/1/2020
+608
7049 CASES
New limits on bread at state-funded bakeries in GoS-held areas
10/5/2020
10/15
+2862
9864 CASES
+4572
11621 CASES
10/20


Containment measures
COVID cases
Economic
Curfew and partial lockdown reinstated in the northeast until 23 November
10/30/2020
+5078
16699
CASES
11/01
Lockdown implemented for two weeks in Derik city, northeast
11/3/2020
Idlib authorities called for urgent additional support. Closure of markets and schools
11/6/2020
Three schools closed in Aleppo, GoS-controlled areas, following rise in cases
11/8/2020
+8066
24765
CASES
11/15
+3346
28111
CASES
11/22
Syrian Pound US Dollar exchange rate lowest since June (3,000 SYP/USD)
11/25/2020

COVID-19 Epidemiological Overview

Given the limited testing across Syria and scarce information, the actual number of cases likely far exceeds official figures. Of particular concern is the number of health workers affected by the disease.

Confirmed COVID-19 cases are on the rise[2]

Reported cases have been increasing rapidly over the previous few months in all areas of Syria. 11,600 total confirmed cases had been reported across Syria since the first case was reported up until 20 October and by 20 November this had increased to 27,500 (MoH GoS, WHO, AANES).

Between 20 October and 20 November, the Ministry of Health reported that the total number of reported coronavirus cases in **GoS-controlled areas** increased from approx. 5,200 (38 per 100,000) to 7,100 (51 per 100,000), and the total number of deaths increased from 254 to 368. The highest number of cases have been reported in Damascus metropolitan governorate and Aleppo governorate (MoH GoS).

Northwest Syria saw a four-fold increase in the number of reported cases in one month between 20 October and 20 November, with 3,200 (219 per 100,000) and 13,800 (952 per 100,000) reported cases respectively. About 80% of all confirmed cases since the start of the epidemic were recorded between mid-October and mid-November (OCHA 18/11/2020). Nearly 60% of all cases have been reported in Idlib governorate and over a third of all cases in Idlib sub-district (OCHA 18/11/2020), with a spike of 300% in cases reported over the first two weeks of November (Associated Press 19/11/2020). A significant increase of positive tests has also been noted among students and teachers, weeks after the reopening of schools in September. 8% of the total number of the total number of cases have been reported in displacement camps and this number is rising (OCHA 18/11/2020). As 59% of the population in the northwest are internally displaced (HNAP 11/08/2020), and often living in overcrowded settlements (REACH 19/09/2020), the additional contagion potential is very high, and will soon be compounded by the risks posed by the upcoming winter season. In efforts to limit transmission, humanitarian partners are in the process of setting up the first quarantine centre in northwest Syria (OCHA 18/11/2020).

In **northeast Syria**, reported cases have also rapidly increased since the previous month, where the Self-Administration reports total confirmed cases increasing from 3,300 (145 per 100,000) to 6,500 (291 per 100,000) between 20 October and 20 November, and total reported deaths increasing from 103 to 184 in the same period. The majority of confirmed COVID-19 cases continues to be reported in Al-Hassakeh Governorate, in the districts of Al-Hassakeh and Qamishli. There have also been significant increases in Malakiyeh and Derik districts in Al-Hassakeh Governorate, as well as in Ar-Raqqa district in Ar-Raqqa governorate and Ain Al Arab district in Aleppo governorate (NES Forum 05/11/2020 & OCHA & WHO 09/11/2020). Cases have also been rising at the overcrowded camps in Al Hol where confirmed cases have been recorded in five separate locations, highlighting the worrying possibility of an ongoing widespread infection among the community, where contact-tracing and isolation would not be sufficient to put an end to the transmission (NES Forum 05/11/2020).

[2] Large numbers (> 1,000) have been rounded to the nearest 100 for readability.

The criteria for testing, number of tests available and used, and the accessibility, availability, and awareness of testing for the population is variable in different parts of Syria (HNAP 20/10/2020, Suwayda 24 01/08/2020, AANES 20/10/2020, WHO 20/10/2020). Increasing confirmed case numbers are indicative of the increasing spread of the virus and increasing testing capacity, but these limitations of data consistency should be taken into consideration when, for instance, comparing case rates between areas.

Risk of further infection with the upcoming winter

The rapid increase in cases is likely to continue in the coming months as the winter season continues, as more people will spend more time in enclosed and overcrowded spaces. Medical personnel in Raqqa city have already raised the alarm about the situation possibly getting out of control in the winter (Syria TV 29/10/2020). The Deputy Director of the Department of Communicable and Chronic Diseases at the Ministry of Health already warned of a possible new wave of cases, likely even more significant than the one that preceded it, as the health system has already been so severely affected by the epidemic (The Syrian Observer 04/11/2020).

Doubts remain over the true scale of the epidemic

Confirmed case numbers alone are insufficient to understand the true scale of the epidemic. While even official statistics show a rapid increase in cases, the reality is likely to be far greater.

Adequate testing capacity remains a challenge, as there have not been enough tests to track the real spread of the virus, partially due to low stocks of PCR (Polymerase Chain Reaction) tests. About 35,000 tests have been performed in Damascus as of mid-September since the first case in March, with about 300 free tests per day for people with symptoms (Associated Press 29/09/2020). In **northwest Syria**, the recent increase of confirmed cases comes alongside the more than twofold increase in testing capacity, as two additional laboratories have been active since October, taking the total to three in northwest Syria. As of 17 November 2020, 45,924 tests have been performed in northwest Syria since the beginning of the epidemic (OCHA 18/11/2020), with daily capacity between 1,000 and 1,400 tests (OCHA 18/11/2020, MSF 10/11/2020). In comparison, Lebanon and Jordan have been conducting between 12,000 and 16,000 tests per day respectively on much smaller populations than Syria (MedGlobal 14/10/2020). The testing positivity rate in northwest Syria since 09 July has been 42% (OCHA 21/10/2020). The positivity rate in Atmeh refugee camp may be up to 40% (BBC 27/10/2020).

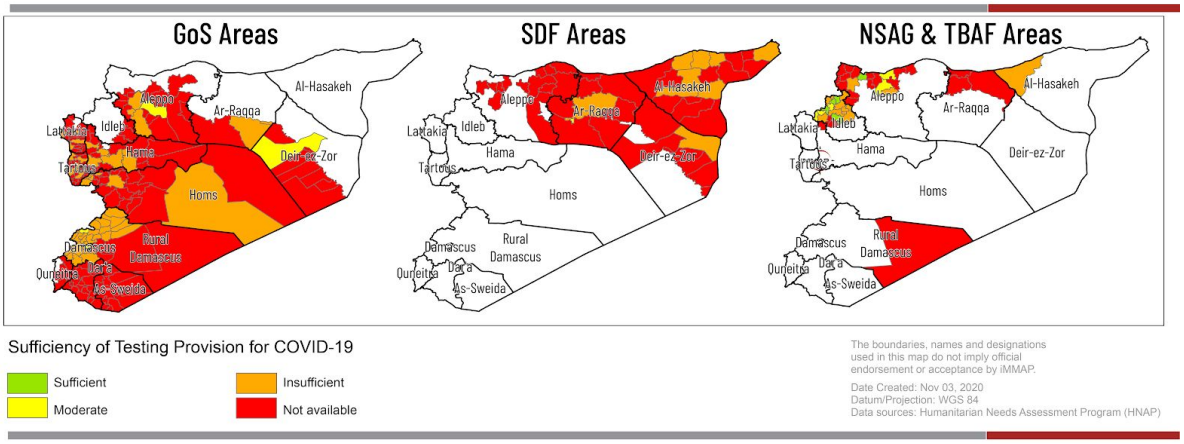
In **northeast Syria**, authorities are rationing the number of tests to keep some capacity in the event of a further surge in cases during the winter (OCHA & WHO 24/09/2020). The weekly average number of tests conducted was 343 tests as of 3 November, having increased from 100 in early October. However, most of the tests (60%) are still coming from just three districts in Al-Hassakeh (Al-Hassakeh, Qamishli, Derik) and mostly focusing on healthcare workers, leaving significant information gaps on the status of the epidemic in the rest of the region. The positivity rate also increased from 35% on 3 October to 42% as of 3 November (NES Forum 05/11/2020).

Considering the limited number of tests being performed in Syria and the scarcity of accurate epidemiological data, it is highly likely that cases are not being detected and that the actual number of cases and deaths far surpasses official figures. Most cases confirmed by the Ministry of Health in Government-controlled areas could not be traced to a known source back in August, indicating that community transmission is widespread (UN Security Council 27/08/2020). Quarantine regulations have been leniently applied, with suspected cases of COVID-19 sent back home to await test

results in order to save money rather than being immediately isolated, which further contributes to community transmission (SOHR 20/09/2020, Syria Direct 31/08/2020).

The number of confirmed cases does not provide an accurate reflection of infection prevalence. The rapidly increasing number of patients arriving in healthcare facilities and the increasing number of death notices and burials noted by the UN Security Council further indicates that actual cases well exceed official figures (UN Security Council 16/09/2020). The Assistant Director of Health in Damascus estimated in September that there could have been as many as 112,500 COVID-19 cases just in the capital and surrounding areas (The Conversation 17/09/2020). The President of the medical NGO, Medglobal, reported in August that the daily infection rate was at least around 2,000-3,000 cases, possibly even higher (Middle East Institute 06/08/2020). Research from the Northwest Syria Modelling Team at the COVID Modelling Consortium estimated the COVID-19 peak happening in mid-November if interventions remain limited (MedGlobal 14/10/2020).

Map 2: Sufficiency of testing provisions as reported by community focal points (HNAP 17/11/2020)[3]



High impact among health professionals

Of particular concern is the high number of health workers affected by the disease. In **GoS-controlled areas**, 211 reported cases have been recorded among healthcare workers, and according to the Ministry of Health 12 have died as of 9 November (OCHA & WHO 09/11/2020). However, according to the Doctors' union, already as of August, at least 61 health workers had died of the disease (Amnesty International 12/11/2020). In the **northwest**, the number of cases among healthcare workers increased from 693 as of 31 October to 1,618 by 04 December (OCHA 20/11/2020). In **northeast Syria**, as of 2 November, 860 confirmed cases of COVID-19 were recorded amongst health workers (17%), most of which in Al-Hassakeh city (AANES). While this high proportion can be explained in part by targeted testing of healthcare workers (AANES), problems in the healthcare system are also likely contributing to the high level of infection. This is also likely due to low levels of compliance with preventative guidelines through practices such as improper use of Personal Protective Equipment (PPE) when available, low physical distancing among staff, inadequacies in screening and triage protocols, in-person reporting of suspected COVID-19 symptoms rather than the utilization of remote communications, and the movement of health workers between multiple health facilities (NES Forum 13/09/2020). The steady increase in

[3] The maps display entire sub-districts where community focal points were surveyed and do not represent areas of control. Source reports and subsequent methodology are available from the Humanitarian Needs Assessment Program (http://hnap.info).

affected healthcare workers across the country since July highlights the fragile healthcare system, facing already insufficient numbers of qualified healthcare personnel and preventive measures kits resulting in overstretched healthcare capacity.

COVID-19 Containment Measures

While authorities initially reacted to news of the global spread of COVID-19 by closing most public services and heavily restricting movement, progressive relaxation of these containment measures took place during the summer. In September, a new flare-up of cases led to localized closures and quarantine protocols. However, since then, most activities have returned to pre-COVID levels as authorities have reduced and retracted public health measures, most notably was the reopening of schools across Syria after six months of closure, despite the increased number of cases. Since then, a rising number of cases among staff and students led to multiple closure of schools.

Government-controlled areas

Since July, the Government of Syria has eased the application of preventive measures, with most public spaces allowed to open as long as physical distancing is adhered to. However, even this limited preventative measure is not being enforced with 62% of sub-districts reporting no enforcement of social distancing. Despite rising cases, schools were reopened mid-September and since then, a rising number of cases among staff and students led to multiple closure of schools.

The Government of Syria began taking gradual precautionary measures at the beginning of March, three weeks before the first case was confirmed. These measures included the partial closure of borders, the suspension of the majority of unessential economic activities. Since May, the Government of Syria has eased the application of preventive measures, with most public spaces allowed to open as long as physical distancing is adhered to (OCHA & WHO 05/07/2020). The daily curfew remains lifted, as has the travel ban between and within governorates. Markets, restaurants, cafes, gyms, parks, theaters, cinemas and most leisure facilities remain open with mandated precautionary measures. Mosques and churches are allowed open as long as physical distancing is observed. Public and private transportation services have also resumed, as have universities and institutions. Only prayers have been suspended on an ad-hoc basis and wedding halls remain closed (OCHA & WHO 02/09/2020). Schools reopened mid-September in GoS areas (The Syria Report 16/09/2020), and 91% of sub districts reported that schools were completely open for all pupils and all grades, differing from other public service systems which still remain widely unavailable (HNAP 20/10/2020). Due to the high number of cases reported in Aleppo city among students and teachers, three schools were closed on 8 November (The Syrian Observer 09/11/2020).

Northwest Syria

While containment measures were temporarily lifted in August, precautionary measures, including restrictions on movements, gatherings, commercial activities, and in-person education services, notably in Idlib and Aleppo, had to be reimplemented following newly identified cases. Despite rising cases, schools were reopened mid-September. In Idlib governorate, following a significant spike in cases, in-person schooling was suspended early November.

Following the first reported case of COVID-19 in northwest Syria on 9 July 2020, the local authorities tightened the mitigation measures, including the suspension of public markets (UNHCR 19/08/2020). While these restrictions were

temporarily lifted, precautionary measures had to be reimplemented following newly identified cases at the end of August, including restrictions on movements, gatherings, commercial activities, and in-person education services, notably in Idlib and Aleppo (REACH 10/09/2020). The Salvation Government (Idlib) decided to close restaurants, wedding halls, gyms and public swimming pools, in addition to preventing markets, due to the large increase in the number of coronavirus infections, from 20 to 30 October (Syrian Observatory of Human Rights 20/10/2020). Despite rising cases, schools reopened mid-September after being closed since mid-March in Idlib and northern Aleppo governorates, with a brief reopening in June (Syrian Observatory of Human Rights 24/09/2020, OCHA 10/09/2020) and 94% of sub districts across Syria reported schools being at least partially open, while 5% did not have education services available prior to COVID-19 (HNAP 20/10/2020). However, as nearly 60% of all cases in the northeast have been reported in Idlib governorate and over a third of all cases in Idlib sub-district, the local health authorities prolonged the temporary precautionary measures, such as the closure of markets, and suspended in-person schooling early November (OCHA 18/11/2020).

Northeast Syria

Coordination of restrictions measures in the northeast has been challenging with diverging decisions across the region. Partial precautionary measures have been reinstated, but enforcement levels remain extremely low. Schools reopened early October despite rising cases. However, following significant surges in cases, a partial lockdown was reinstated from 30 October to 23 November in the region, including a two-weeks full lockdown in Malakiyeh district.

Following two months with zero confirmed cases, the announcement of four new cases in northeast Syria spurred local authorities to reinstate a partial curfew and a ban on mass gatherings on 23 July (OCHA & WHO 24/07/2020). Partial lockdowns were introduced in Ar-Raqqa and Kobane (OCHA & WHO 21/08/2020). However, despite the continuing spike in the number of infections, the Self-Administration decided to reopen wedding and funeral venues, as well as mosques and churches and allow other gatherings mid-September (Syria in context 16/09/2020). At the end of August, authorities in the Self-Administration's Jazira region lifted the lockdown measures, although mass gatherings (funerals, weddings, communal worship and parties) remained prohibited until end September (NES Forum 14/10/2020). Schools reopened in October and three health facilities reported scaling-up their activities after being limited to a bare minimum due to COVID-19 related disruptions (NES Forum 01/10/2020, The Syria Report 30/09/2020). On 30 October, a partial lockdown was reinstated by the Autonomous Administration following increased cases, first until 8 November and then prolonged until 23 November, and public health measures, such as wearing facemasks, have been imposed (AANES 09/11/2020, OCHA & WHO 09/11/2020). All major markets and public facilities have been ordered to close, except shops selling food and restaurants (for takeaway orders only). Places of worship are closed as well, except for Friday prayers and Sunday mass, and mass gatherings are also prohibited (OCHA & WHO 09/11/2020). Additionally, since 6 November, following a surge in cases in Derik in recent weeks, the Executive Council of Jazeera Canton also implemented a full 14-day lockdown in the whole of Malakiyeh District, until 19 November. Schools, shops (excluding shops selling food), places of worship, restaurants, playgrounds and private clinics were ordered to close, while movements in and out of Derik city were prohibited (excluding emergency cases and food shipments) (NES Forum 05/11/2020). With these measures, the proportion of communities complying with various mitigation measures has significantly increased since October (see table 3 and maps 4 and 5).

Table 1 - Proportion of sub-districts implementing COVID-19 mitigation measures in Government of Syria (GoS) controlled areas as reported by community focal points (HNAP 17/11/2020)

Mitigation Measures	Majory of communities	Some communities	Hardly any communities	No communities
Total Curfew	1%			99%
Partial Curfew		1%		99%
Community lockdown				100%
Home isolation for symptomatic cases	31%	12%	20%	37%
Regular temperature checks (public places, checkpo	4%	11%	60%	25%
Closure of public spaces (restaurants, shops, etc.)		1%		99%
Prohibition of social gatherings (funerals, weddings,	2%	4%	2%	92%
Compulsory mask wearing	1%	8%	49%	42%
Presence of social distancing in public places	7%	4%	18%	71%
Disinfection campaigns	4%	20%	56%	20%
Awareness campaigns	20%	27%	27%	26%

Table 2 - Proportion of sub-districts implementing COVID-19 mitigation measures in Non-State Armed Groups and Turkish-Backed Armed Forces (NSAG & TBAF) controlled areas as reported by community focal points (HNAP 17/10/2020)

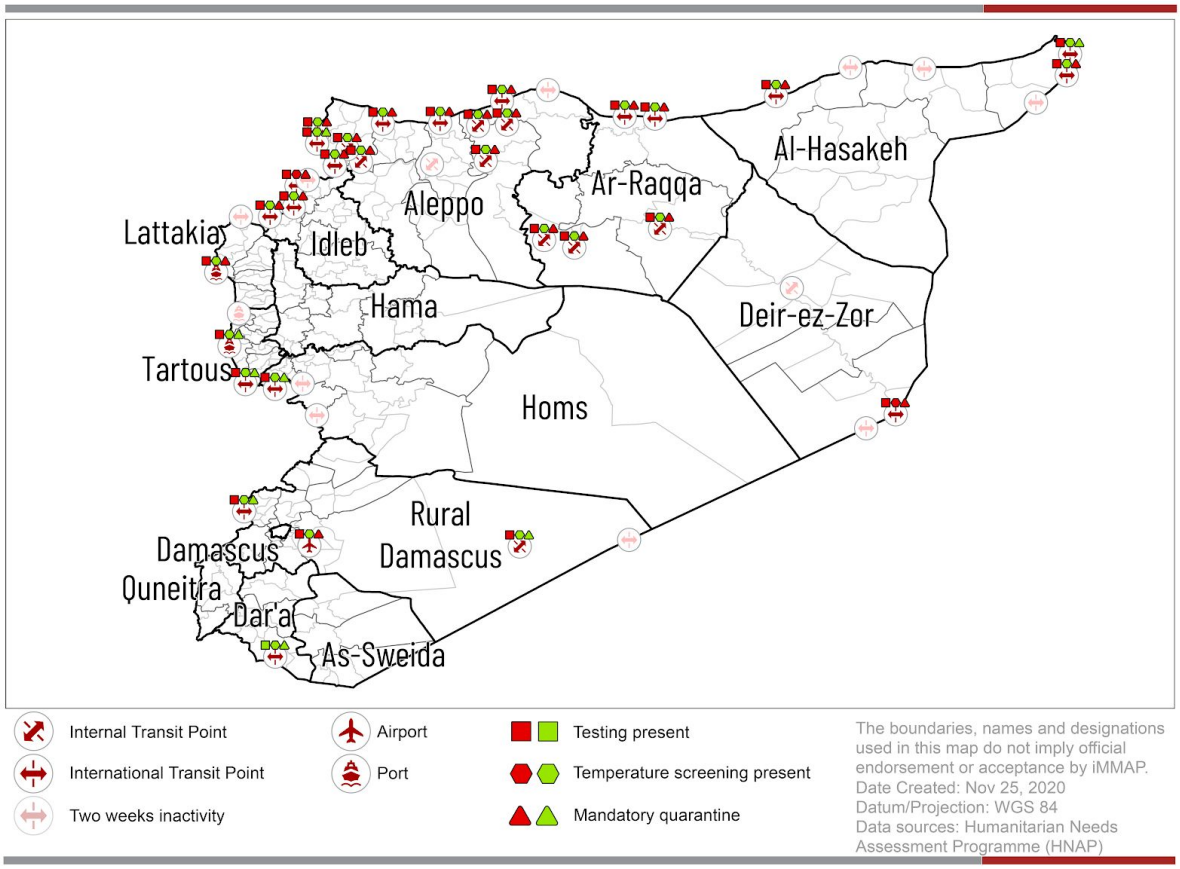
Mitigation Measures	Majory of communities	Some communities	Hardly any communities	No communities
Total Curfew				100%
Partial Curfew				100%
Community lockdown				100%
Home isolation for symptomatic cases	9%	31%	30%	30%
Regular temperature checks (public places, checkpo	14%	45%	25%	16%
Closure of public spaces (restaurants, shops, etc.)		2%	14%	84%
Prohibition of social gatherings (funerals, weddings,	5%	9%	9%	77%
Compulsory mask wearing	2%	18%	14%	66%
Presence of social distancing in public places		5%	16%	79%
Disinfection campaigns	27%	36%	14%	23%
Awareness campaigns	43%	23%	16%	18%

Table 3 - Proportion of sub-districts implementing COVID-19 mitigation measures in Syrian Democratic Forces (SDF) controlled areas as reported by community focal points (HNAP 22/09/2020)

Mitigation Measures	Majory of communities	Some communities	Hardly any communities	No communities
Total Curfew	2%			98%
Partial Curfew	54%			46%
Community lockdown	2%			98%
Home isolation for symptomatic cases	37%	13%	11%	39%
Regular temperature checks (public places, checkpo		41%	11%	48%
Closure of public spaces (restaurants, shops, etc.)	37%		4%	59%
Prohibition of social gatherings (funerals, weddings,	52%			48%
Compulsory mask wearing	2%	33%	17%	48%
Presence of social distancing in public places	37%		4%	59%
Disinfection campaigns	2%	7%	11%	80%
Awareness campaigns	43%	11%	13%	33%

Movement Restrictions

Map 3: Status of Transit Points (HNAP 17/11/2020)



Airports and seaports remain functional

Domestic and cargo flights were already operating, with some restrictions, with Damascus, Aleppo, and Qamishli airports operating normally (OCHA & WHO 09/11/2020, OCHA & WHO 21/08/2020). After months of suspension, international air traffic was reopened at Damascus International Airport with the first international flight of the Syrian Arab Airlines taking place on 1 October to Cairo (SANA 01/10/2020). Authorities are using self-sterilizing devices and implementing thermometers checks in the airport, increasing cleaning and sterilization, requiring a negative COVID-19 test result within 96 hours of arrival, and placing ground signs to achieve spacing (OCHA & WHO 09/11/2020). Syrian Airlines will initially resume scheduled flights to regional destinations including Cairo and Beirut, with a weekly flight to Khartoum and adhoc flights to Kuwait (Reuters 01/10/2020).

Tartous and Lattakia sea ports remain operational and have implemented precautionary measures, including mandatory sterilization procedures and minimum staff requirements, leading to some delays in operations (OCHA & WHO 09/11/2020).

Most land borders are still closed

Most land borders into Syria remain closed, with some limited exceptions from Jordan, Turkey and Lebanon, including commercial cargo, relief shipments, and the movement of personnel from humanitarian and international organisations (OCHA & WHO 09/11/2020). 13 of the 29 land border crossings have been fully closed since July 2020 (WFP & IOM 09/11/2020) and only 6% are considered fully operational in Syria (IOM 12/11/2020). However, frequency of movement through informal points of entry, not equipped with screening or monitoring infrastructure, reportedly remains high (NES Forum 14/10/2020). Humanitarian access remains impacted as authorities and neighboring countries continue to implement or reinforce precautionary measures in light of the increasing numbers of cases. COVID-19 containment measures, including border restrictions, have become barriers to free movement for humanitarian workers carrying out their duties and have made procuring supplies more challenging (REACH 22/10/2020). Exemptions to travel across closed border points include commercial and relief shipments and cargo, humanitarian personnel, students, and medical cases (OCHA & WHO 09/11/2020). In the **northwest**, while exemptions have been made in most instances to facilitate continued access by humanitarian staff, there have been incidents of movement restrictions on civilians seeking medical treatment across the border (REACH 22/10/2020).

Border with Jordan: The Jordanian authorities reopened their land border with Syria on Sunday 27 September, after one month of closure. While the number of people crossing between the two countries was limited, on 13 August, Jordan had decided to close the Jaber/Nassib crossing point after a dozen border officials were infected (The Syria Report 30/09/2020). In Rukban, the no-man land between Syria and Jordan, where an estimated 10,000 people are living in dire conditions, the only UN-run medical clinic, which had seen about 2,000 patients in February, has been inaccessible to the residents since mid-March due to COVID-19 restrictions (The New Humanitarian 16/09/2020). While no COVID-19 case has been reported there yet, the health situation remains very precarious.

Border with Lebanon: On 16 August 2020, the Government of Syria announced new entry requirements for individuals arriving from official border crossing points with Lebanon after a negative PCR certificate was presented at the border. Tests must have been conducted within the past 96 hours at accredited laboratories in Lebanon. Those unable to present such documentation would be quarantined (OCHA & WHO 21/08/2020). In addition, the Government of Syria also announced that Syrians wishing to transit through Lebanon abroad must reach the borders no more than 24 hours before their flight and within 96 hours of a negative PCR test. Reports indicate that testing can be obtained at five private laboratories, in addition to two new centers (Al-Jalaa and Tishreen sports city) in Damascus (OCHA & WHO 02/09/2020). In July, a policy was put in place that demands returnees from Lebanon must exchange $100 USD for Syrian Pounds at the official exchange rate, ostensibly to help the government replete its foreign currency reserves and adding another obstacle to prevent Syrians who wish to go home from returning (HRW 14/10/2020).

Border with Turkey: Only five border points - Bab Al-Hawa, Afrin, Bab Al-Salam, Al-Rai, and Jarabulus- out of 20 were fully open as of 01 September, allowing both commercial and non-commercial travel. Two other crossings were partially open: Khirbet Al-Jouz and Tal-Abyad (The Syria Report 16/09/2020). Closed before the outbreak, Ras al-Ain border crossing is still not opened, except in limited circumstances (OCHA & WHO 02/09/2020). Restrictions on movement further amplify the challenges of border-crossing, a process already hindered by the UN Security Council Resolution 2533 which was adopted in July and limits cross-border assistance to Bab Al-Hawa point for a year. The Bab al Hawa crossing alone cannot provide access for aid agencies to reach all areas in need in northwest Syria. It requires longer and riskier routes on poorer road conditions compared to the Bab-al-Salam crossing closed in July and is already operating at near maximum capacity. (CARE, HI, IRC, Mercy Corps, NRC, PIN & WVI 08/07/2020). Bab Al Hawa in Idlib

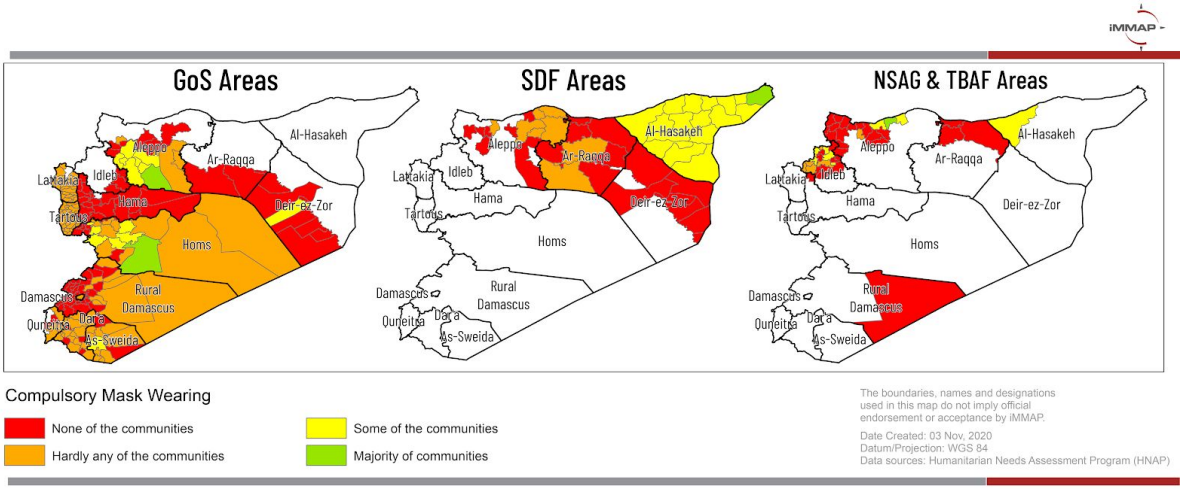
partially reopened for humanitarian workers and emergency medical cases to cross into Turkey (OCHA & WHO 02/09/2020).

Border with Iraq: As of 23 July 2020, authorities in northeast Syria formally announced the closure of all land border-crossings with both Iraqi Kurdistan and Government of Syria areas with the exception of emergency cases (NES Forum 27/08/2020). The weekly exemption for NGOs to cross into/out of northeast Syria via the Fishkabour-Semalka crossing remains in place. Additionally, the main commercial hub, the Walid crossing, remains open to transport imports into the northeast. As of 15 September, the Fishkabour-Semelka crossing was also opened for cancer cases and separated spouses to return to Syria (NES Forum 13/09/2020). The Al-Bukamal/Al-Quaem crossing, controlled by Iranian militias on the Syria side, is open for commercial and military movements. Medical cases and students are also reported to be allowed to cross with a 14-day quarantine on arrival (OCHA & WHO 02/09/2020). Northeast Syrian NGOs continue to face challenges when importing medical equipment and PPE from suppliers based in Iraqi Kurdistan as authorities have deemed certain supplies, such as face masks, to be required in the country and not allowed for export. While there is no formal directive banning the export of such items, limitations have slowed down imports of key health supplies into Syria (NES Forum 13/09/2020).

Inside Syria: Abu Zendin and Um Jloud in Aleppo as well as Akeirshi and Abu Assi in Ar-Raqqa (except for students) remain closed. Reports indicate, however, in practice crossings do occur. Local authorities in northwest have put in place sporadic restrictions at international and internal crossing points through short-term closures or limitations on the number of people allowed to cross (OCHA & WHO 07/10/2020). The Al-Dadat land crossing, under the control of the Syrian Democratic Forces and of the Syrian National Army, located between Manbij and Jarabulus was re-open from 19 to 30 September (The Syria Report 23/09/2020). Ghazawiyet Afrin and Deir Ballut in Aleppo are open for commercial, military, and humanitarian cargo movement (OCHA & WHO 07/10/2020). The Tabqa crossing point is reportedly currently open to commercial and humanitarian cargo and NES residents processing a residency card (OCHA & WHO 07/10/2020).

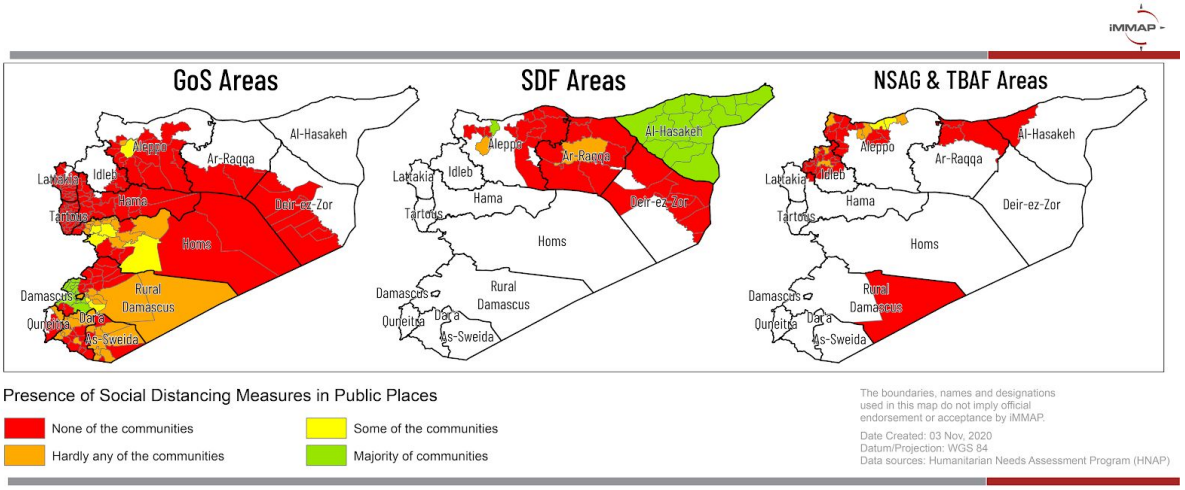
Compliance and resistance to COVID-19 measures

Map 4 - Proportion of communities enforcing mask-wearing as reported by community focal points (HNAP 17/11/2020)[4]



[4] The maps display entire sub-districts where community focal points were surveyed and do not represent areas of control. Source reports and methodology are available from the Humanitarian Needs Assessment Program (http://hnap.info).

Map 5 - Proportion of communities with presence of social distancing in public spaces as reported by community focal points (HNAP 17/11/2020)[4]



Adherence to personal preventative measures remains low in all areas

In **northwest Syria**, adherence to personal preventive measures is lower than in the northeast, with only 52% of respondents reporting having face masks, reaching an even lower rate of below 30% when being asked about actually wearing it (REACH 22/10/2020). 75% of sub-districts in the northwest report that the majority of communities are in need of masks (see WASH). While 68% of people reportedly wash hands more than normal, an increase since April where 55% reported doing so, there is overall a low rate of respondents who implement other precautionary measures such as keeping distance with others or did not visit friends and family or avoid handshake. The proportion of people reporting shaking hands more often decreased only slightly from April, from 91 to 80%, and remains quite high. Some other progresses are worth noting: the proportion of people reporting staying at home more often increased from less than 40% to 64% in September and the percentage of people reporting keeping distance increased by 10 points since April, although remaining in the low bracket, with only 22% of respondents reported doing so in September (REACH 22/10/2020) and very low enforcement among communities (see table 2). Findings from 28 focus group discussions among 140 participants in Aleppo and Idlib, shown that participants had sufficient understanding about self-protection and preventive measures, but indicated that not all community members were fully committed to adhering to such measures (Protection Cluster 27/11/2020).

In **northeast Syria** there has been limited uptake of personal preventative measures, such as use of face masks, hand-washing, physical distancing and screening at building entrances (NES Forum 14/10/2020). In comparison to the northwest, there is a higher rate of respondents who report implementing precautionary measures, with 87% reportedly washing hands more than normal. However, 81% of people still reported visiting friends and family outside the home. While 96% report having a face mask, this proportion decreases to 68% when asking about actually wearing it outside for shopping, and communities are either hardly enforcing mask wearing or not at all (see table 3). However, some progress can be noticed: the proportion of people shaking hands the week before the assessment did decrease since April, after peaking at 72% in June, but now having declined to reach 50%. Similarly, the proportion of people keeping distance increased from 16 to 49% in September (REACH 22/10/2020).

People also cited insufficient space to implement physical distancing, especially those living in highly dense sub-districts (GTS & HNAP 27/08/2020), which along with being unable to afford protective items or not being able to afford not working (REACH 22/10/2020), has reduced adherence to preventive measures.

Low levels of enforcement of measures leading to even lower levels of compliance

While measures have been announced across the country since March, they have not always translated into actual implementation and enforcement on the ground. In the **northeast**, while a directive was issued by authorities making face masks mandatory in all public spaces, adherence to this directive is extremely limited, even among officials, and enforcement is negligible (NES Forum 14/10/2020, NES Forum 13/09/2020, HNAP 20/20/10). Additionally,local coordination of containment measures has been challenging, with great divergence between districts and with the central Directorate of Health (NES Forum 13/09/2020). Since July, the authority in charge of public health decisions has been decentralized to the local civil and municipal authorities, resulting in an uneven administrative response to COVID-19 with some districts facing semi-lockdown conditions and others not implementing precautionary measures (Syria Direct 31/08/2020).

Inadequate risk communication to the population about the likely scale of undetected transmission and the prospect that the situation worsens in Syria continues to be a problem, as evidenced by only 54% of subdistricts nationally with the majority of the population having sufficient knowledge/awareness of COVID-19 risks, mitigation measures and response to cases as reported by community focal points (HNAP 17/11/2020), and as people are less likely to adhere more strictly to preventative measures (Medglobal 14/10/2020, NES Forum 01/10/2020). The absence of hard enforcement measures by the authorities (see tables 1, 2 and 3) is another factor contributing to low risk perception among the population. Following decisions to lift lockdown measures in Al-Hassakeh governorate, northeast, on 28 August, the use of face coverings in public spaces declined significantly. Anecdotally, local sources suggested that before the lift, over half of people were wearing face coverings, while this had declined to less than 10% by September (NES Forum 13/09/2020).

Money remains the main barrier to abide by preventative measures

In **northwest Syria**, 37% of respondents reported that they face barriers in taking preventive measures to mitigate the risk of contracting COVID, with the main ones being insufficient money to buy protective items and not being able to afford not working. This proportion increases to 55% in Aleppo (REACH 22/10/2020). Beyond food, 46% of interviewed households reported not being able to purchase necessary medicines, primarily due to insufficient financial resources (67%) (WFP 30/09/2020). In **northeast Syria**, 43% of respondents reported that they face barriers in taking preventive measures to the mitigate risk of contracting COVID-19, with the main ones being no money to buy protective items or not being able to afford not to work. In Al-Hassakeh governorate, this proportion increases even more with 55% of men and 61% of women reporting facing barriers (REACH 22/10/2020).

Reluctance to isolate in quarantine centres

A significant challenge in countering COVID-19 remains the difficulty of physically isolating people, notably in camp-settings. Isolation spaces have not been functioning well as people are reluctant to stay in them. Following consultations with the community, the absence of distribution of hot meals in these structures appears to be one driver of opposition (OCHA & WHO 24/09/2020). In Al-Hol Camp, **northeast Syria**, partners plan to develop and disseminate key

messages on the purpose of the isolation center which is being rebranded as a COVID-19 treatment facility (OCHA & WHO 29/09/2020). Findings from 28 focus group discussions among 140 participants in Aleppo and Idlib, **northwest Syria,** risk of income loss, coupled with fear of stigmatisation and family separation, are the main factors why isolation protocols are still not being followed (Protection Cluster 27/11/2020).

Communication and Information

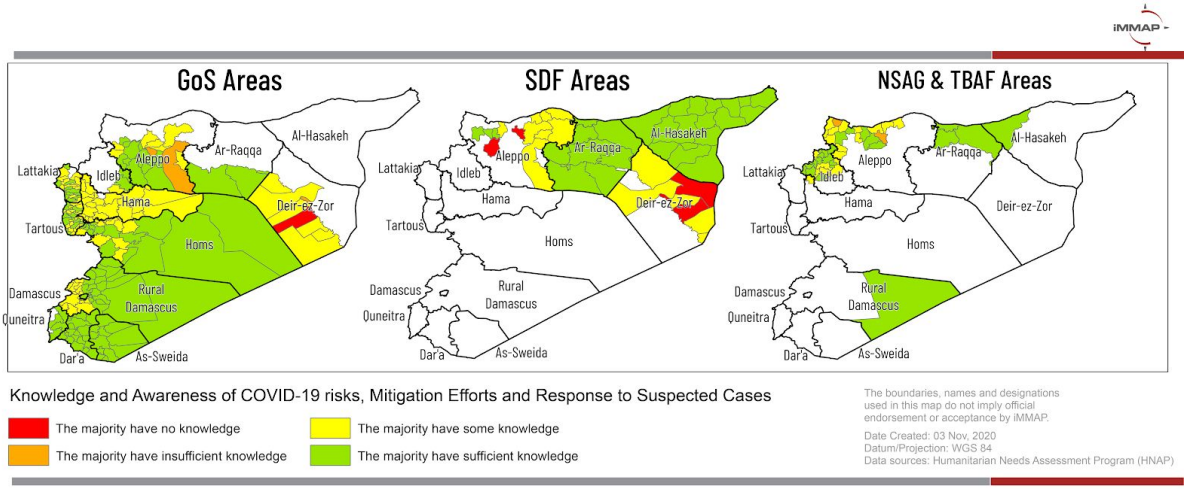
Despite multiple awareness campaigns conducted across Syria, survey results show that there are still gaps in knowledge about COVID-19 among the population *regarding how to protect oneself against the virus, what to do in case of infection or while waiting for test results.*

Information needs remain high

Awareness of the virus improving

Results of the second round of survey data collected by the Protection Cluster through its Protection Monitoring Task Force show widespread concern related to COVID-19 since the first identified case in northwest Syria (OCHA 10/09/2020). More than half of respondents (57%) in areas controlled by the Syrian Democratic Forces believed their communities have sufficient knowledge of COVID-19 risk, the highest rate in comparison to GoS-controlled areas where this proportion decreases to 49% and even lower in NSAG/TBF areas, where only 43% of the respondents believe their communities have sufficient knowledge (HNAP 22/09/2020). An assessment conducted by Ground Truth and HNAP in July 2020 found that people in lower-density sub-districts seemed to have a lesser understanding of precautionary measures. Based on consultations with community focal points, 44% of respondents from such areas believed their communities did not understand the measures, compared with 9% living in high-density sub-districts (GTS & HNAP 27/08/2020).

Map 5 - Level of knowledge and awareness of COVID-19 risks, mitigation efforts and response to suspected cases as reported by community focal points (HNAP 17/11/2020)[5]



[5]The maps display entire sub-districts where community focal points were surveyed and do not represent areas of control. Source reports and methodology are available from the Humanitarian Needs Assessment Program (http://hnap.info).

Gaps in knowledge persist

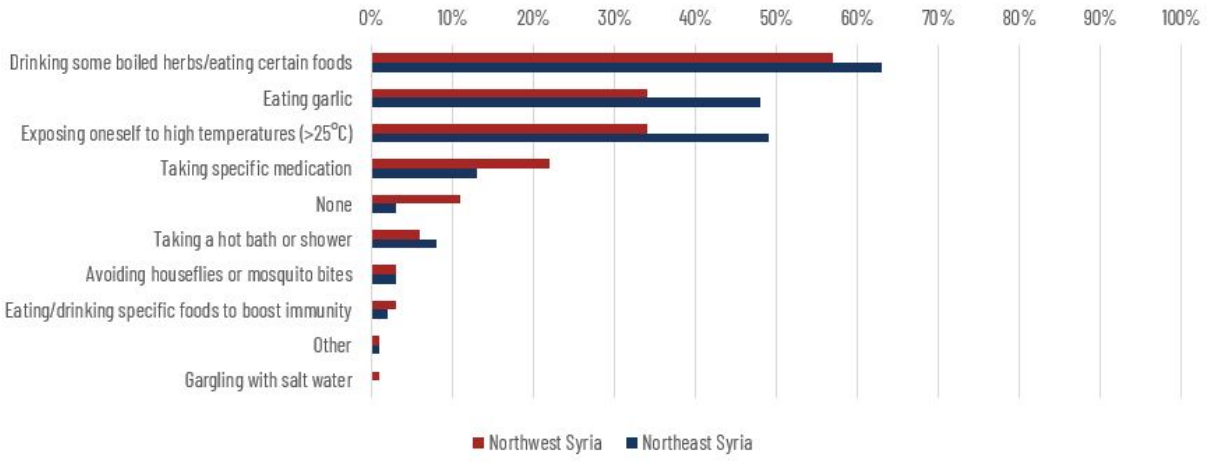
Information needs remain around treatment, testing and actions to undertake if symptoms appear. In the **northeast**, most of the callers to the regional COVID-19 hotline requested information on what to do when having symptoms or being tested positive (NES Forum 01/10/2020). In Al-Hassakeh Governorate, 50% of respondents reported incorrectly that everyone who gets COVID-19 shows symptoms (REACH 22/10/2020). 61% of subdistricts in the northeast report that the majority of their population has sufficient knowledge/awareness of COVID-19 risks, mitigation measures and response to suspected cases (HNAP 17/11/2020) (see Map 5). In the **northwest**, people's knowledge on what to do when contracting COVID-19 remains limited; only 38% of respondents report they would stay at home and isolate (REACH 22/10/2020). Findings from 28 focus group discussions among 140 participants in Aleppo and Idlib, northwest Syria, highlight that participants have little knowledge about isolation processes, reasons required for people to enter quarantine and available services and type of medical care provided in quarantine centers, resulting in misperceptions, fear and reluctance to enter such centers (Protection Cluster 27/11/2020).

While cumulative Risk Communication and Community Engagement efforts reached an estimated 15 million people as of end September, survey information and anecdotal evidence suggests the risk perception across Syria is very low and a considerably low adherence to individual preventive measures has been observed in some communities. Preparations are underway to soon launch a public opinion survey on COVID-19 with the aim to further understand public perceptions (OCHA & WHO 09/11/2020).

Rumours and misinformation prevail

The gap in knowledge surrounding treatment and what to do if infected have provided opportunities for the spread of rumours and misinformation: For example, the latest REACH Knowledge, Attitude and Practices survey found that around 60% of respondents surveyed in the NW and NE reported that drinking boiled herbs was one of the preventative measures they had heard people mention (REACH NW 22/10/2020, REACH NE 22/10/2020), a percentage similar throughout the different rounds since April.

Figure 1: Myths related to preventative measures as heard by respondents in northeast and northwest Syria (REACH NE 22/10/2020)



Findings from 28 focus group discussions among 140 participants in Aleppo and Idlib, **northwest Syria**, highlighted that knowledge about quarantine centers were mainly obtained through informal sources and rumors, increasing fear and misperceptions. Some participants in Idlib believed that the centers were spreading the virus, as people were gathered together in an enclosed space (Protection Cluster 27/11/2020).

Messaging recommendations

The following recommendations were highlighted by various actors regarding messaging and communication campaigns for **northeast Syria** in November 2020:

- Messaging campaigns debunking the myths around drinking boiled herbs, exposing oneself to the sun, and eating garlic, should be emphasized for greater efficiency, particularly among women across communities (REACH, HNAP & GTS 11/2020).
- Messaging should be targeted through health workers on COVID-19, focusing on Aleppo and rural populations specifically (REACH, HNAP & GTS 11/2020).
- Messaging about wearing gloves should be promoted as a possible safety alternative (or addition) to strict physical distancing measures (REACH, HNAP & GTS 11/2020).
- Continue using social media messaging, but also use direct follow-up by on-Governmental Organisations (NGOs) to reinforce messaging (REACH, iMMAP, HNAP & GTS 11/2020).
- Involving and mobilizing trusted community figures or institutions to disseminate information, notably regarding admission to quarantine centers, could help persuade other members of the community to be isolated (Protection Cluster 27/11/2020).
- Continue awareness COVID-19 campaigns on prevention and precautionary measures, as well as treatment procedures, including on the function of quarantine centers, through trustworthy media outlets and humanitarian frontline workers (Protection Cluster 27/11/2020).
- Conduct additional awareness campaigns addressing specifically the aim, purpose, procedures of and conditions in quarantine centers (Protection Cluster 27/11/2020).
- Shift the tone of messaging on COVID-19 towards more positive messages highlighting the need to support community and family members in difficult times, rather than only emphasizing the danger of the virus, which has been created fear of the virus and stigmatisation of the people who might carry it (Protection Cluster 27/11/2020).
- As prices of masks are unaffordable for most, communication messages should adapt to the local economic reality and focus on alternatives that can also be used to protect oneself, such as clothes (Syria Direct 09/11/2020).

Communication Channels

No high quality, prevalent and trusted source may explain rumours, misinformation and gaps in knowledge.

In **GoS-controlled areas**, the main sources of information reported end August were national government (32%) and news media (29%). Trust in the national government (25%) for COVID-19 information is second only to health providers (40%) (GTS & HNAP 27/08/2020).

In the **northwest**, the main source of information on COVID-19 was relatives and family (68%) and friends (64%), health workers (52%) and neighbours (42%). The main channels were social media (96%) and to a much lower extent, television (16%). The most trusted sources are health workers (61%), almost equal to social media (56%) (REACH

22/10/2020). Through 28 focus group discussions among 140 participants in Aleppo and Idlib, **northwest Syria**, religious leaders, health staff, humanitarian frontline staff working with the community for long periods, and de facto local authorities and councils were identified as trustworthy entities by participants (Protection Cluster 27/11/2020).

In the **northeast**, the main sources of information from whom respondents receive most of their information about COVID-19 are relatives and family (60%) and friends (42%), as well as neighbours (40%). Healthcare workers are only the main source for 30% of the respondents and trusted at a similar rate, while in April it was standing at 74%. The proportion of people reporting word of mouth as a main source of information also decreased significantly between rounds, with 84% mentioning it as a main source in April/May and only being trusted at 7% in September. Social media and television are equally heavily used to get COVID-19 information (80%) and the most trusted sources, 46% and 61% respectively (REACH 22/10/2020).

Figure 2: Proportion of respondents reporting the following sources from whom they receive most of their information about COVID-19 (REACH 22/10/2020)

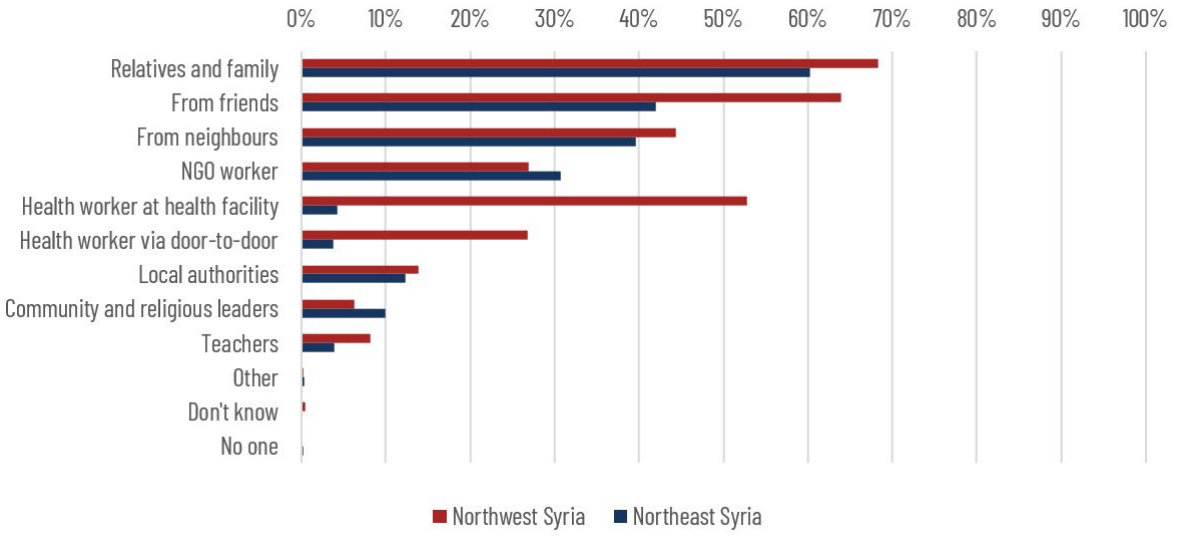
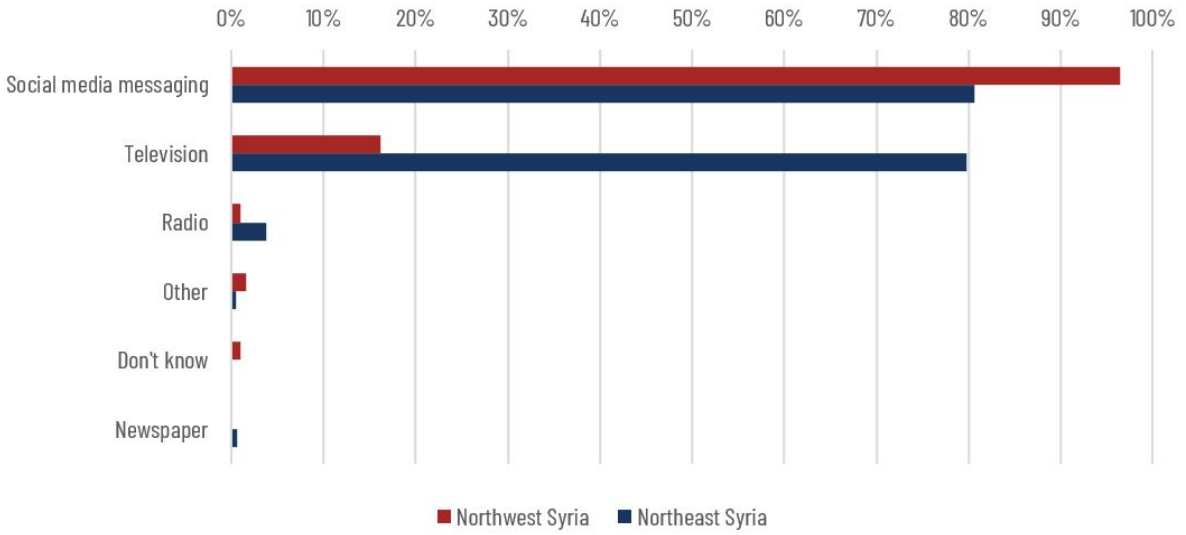
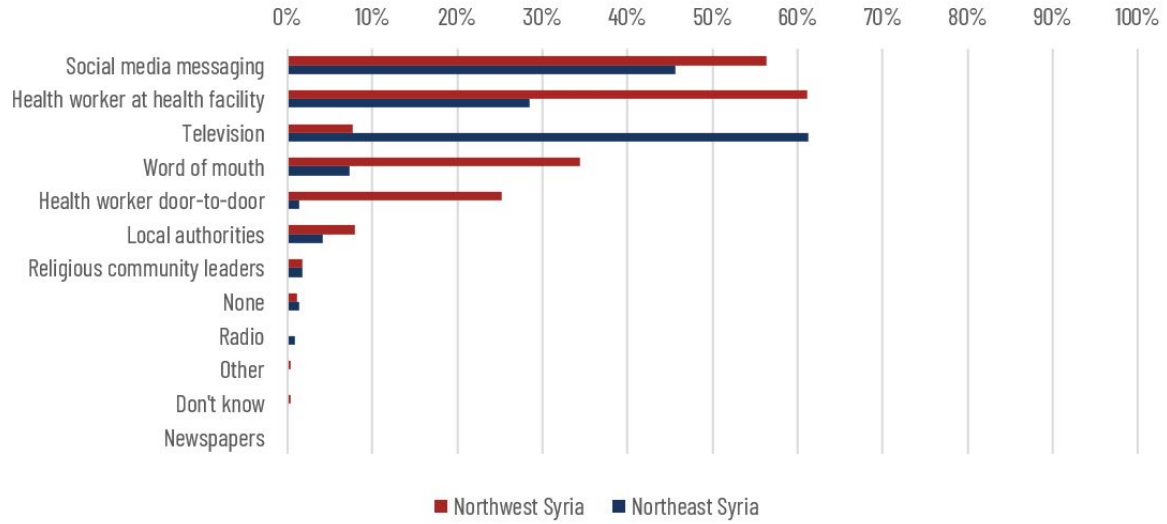


Figure 3: Proportion of respondents reporting the following sources from which they receive most of their information about COVID-19 (REACH 22/10/2020)



Overall local authorities are not very trusted, with already in August, a quarter of focal points in low-density sub-districts declared the media and local governments as their main sources of information for their communities. However, only 9% believe their communities actually trust local authorities, and only 14% trust news media (HNAP 24/08/2020). In September, in the **northeast**, local authorities are the main sources of information for 12% of the respondents and trusted only by 4%. In the **northwest**, 14% of respondents declared it as a main source of information and only 8% declared trusting them (REACH 22/10/2020, REACH 22/10/2020).

Figure 4: Proportion of respondents reporting the following as the most trusted sources to give them reliable information about COVID-19 (REACH 22/10/2020)



High reliance on social media for COVID-19 information

Social media reliance is greater in urban and high-density sub-districts where network coverage is better, than in low-density rural ones (GTS & HNAP 27/08/2020). Some 614,000 individuals were reached through WhatsApp groups, outreach volunteers and mass communication campaigns in Syria (OCHA 02/10/2020). In the **northwest**, 96% of

respondents reported that the main public medium through which they receive information about COVID-19 is social median an increase by 10 points across the rounds, and Whatsapp has indeed been widely used to communicate on health issues (REACH 22/10/2020, Journal of Public Health 24/09/2020). In the **northeast**, this proportion is slightly lower, with 80% of respondents reporting social media as their main source of information about COVID-19 (REACH 22/10/2020).

Displacement

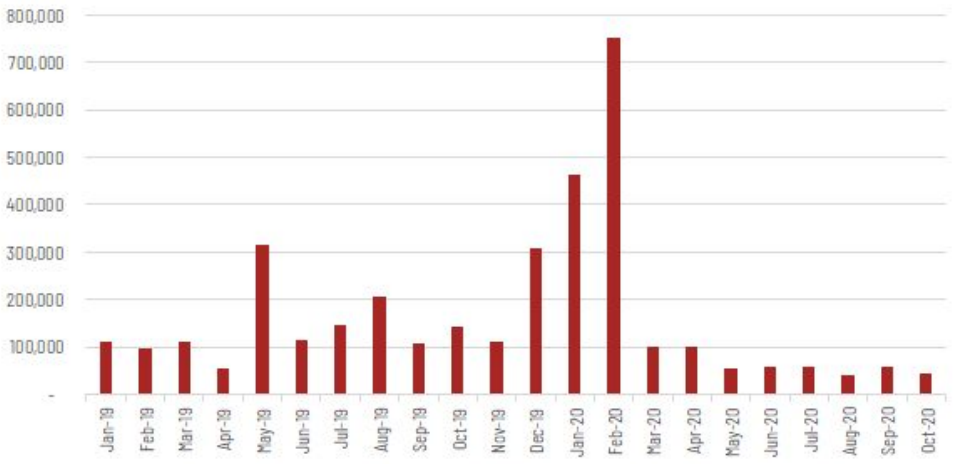
Reduced cross-border movements

Thirteen of the 29 land border crossings are fully closed since July 2020, notably due to new COVID-19 restrictions. The impact of these closures on cross-border movements has been significant: about 900 people left Syria between March and August 2020, compared to almost 6,800 during the same period in 2019 (WFP & IOM 09/11/2020).

Reduced IDPs movements

Since February 2020, IDPs movements have been significantly decreasing (see figure 5). Lockdown and other COVID-19 related movement restrictions likely reduced people's ability to move around, explaining the decrease in displacement flows and conflict intensity also reported over the same time period, with 160 'battle'[6] events recorded by ACLED in August compared to close to 400 in February (ACLED).

Figure 5: Estimated IDP movements by month, 2019-2020 (CCCM, HNAP & OCHA 10/2020)



[6] Defined by ACLED as violent interaction between two politically organized armed groups at a particular time and locations: https://acleddata.com/2019/03/14/acled-introduces-new-event-types-and-sub-event-types/

Economic developments

The pre-existing and underlying fragility of the Syrian economy and the multiple shocks that occurred in between mid-2019 and 2020 had already greatly weakened the Syrian economy. COVID-19 restrictions from March to July had a disproportionate effect on the Syrian population, heavily impacting employment opportunities across the country, pushing up prices, and further eroding household coping mechanisms, compounding the humanitarian needs of 11.7 million people, including 6.2 million IDPs (WFP 22/10/2020, UNICEF 01/07/2020).

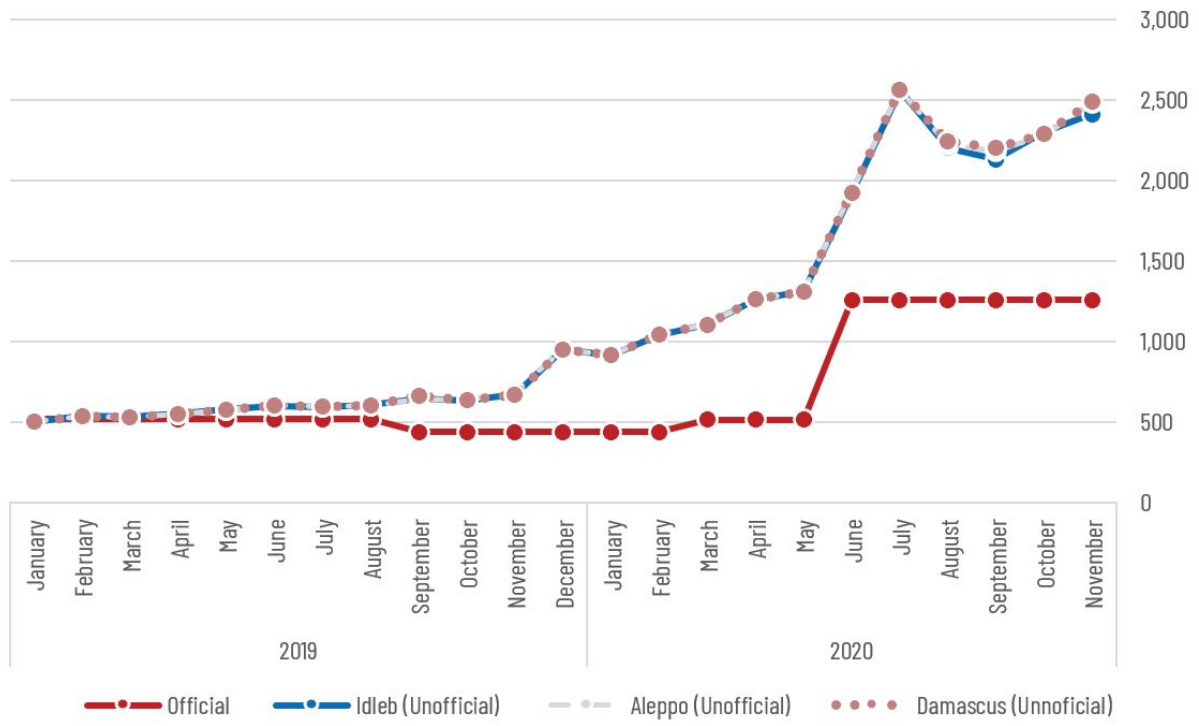
In June 2020, the economy was aggravated as a result of the political tensions and the uncertainty accompanied by the intensification of unilateral coercive measures (such as the US sanctions) (WFP 10/09/2020). Current salaries and wages are falling, as consumer prices are increasing according to the depreciation of the currency. The impact of this is expected to hit hardest for 83% of the Syrian population who were living below the poverty line even before the COVID-19 crisis (OCHA 2019). Economic experts from Damascus University estimated the economic losses due to the COVID-19 lockdown measures of 1 trillion Pounds per month (USD 1 billion), amounting to four trillions in total as measures were imposed between March and June (Al Watan 11/04/2020). Based on the current trends, WFP predicts that a period of further economic contraction is to be expected, with reduced production, increased poverty rates and further food security deterioration (WFP 20/08/2020).

Fast continued devaluation of the Syrian Pound

The Syrian Pound (SYP) devalued faster over the first six months of 2020 than over the past nine years of the conflict, hitting a record low in early June with an informal exchange rate of 3,200 SYP for 1 USD (World Vision 01/07/2020), compared to 434 in 2019 (WFP 15/07/2019). Its value recovered over the summer, until weakening even further since mid-October, reapproaching its record 3,000 SYP for 1 USD low end November (The Syria report 25/11/2020). However the official exchange rate given by the Central Bank of Syria remains at 1,250 SYP for 1 USD, which had already been changed on 16 June 2020 (WFP 15/09/2020). The loss of the Syrian Pound's caused prices to dramatically increase for many basic commodities such as food, medicine, WASH and fuel (Food Security Cluster 23/09/2020). In the **northwest**, local authorities allowed the local adoption of the Turkish Lira as an accepted currency by July, in light of the weakening SYP (OCHA & WHO 10/07/2020), a use that continues to spread, with most vendors now no longer accepting the Syrian Pound in the northwest (OCHA 21/10/2020).

The economic context poses new challenges to humanitarian assistance in-country. Humanitarian partners reported that the volatility of the informal exchange rate led to temporary suspension of local procurement, as well as redesign of budgets, and so is expected to delay programme delivery (OCHA & WHO 24/07/2020). The devaluation concurrently created a rise in severe coping strategy engagement and altered spending. While there was moderate compensation in the rise of SYP salaries, the real value of the new salaries remains comparatively low when converted to USD. Increased dependence on SMART cards and distribution sites has created extensive queues for food items, even in affluent neighborhoods, which dually undermines covid mitigation efforts such as social distancing (HNAP 24/08/2020).

Figure 6: Informal SYP/USD exchange rate on the first of each month in Damascus, Aleppo and Idlib and the formal rate of the Central Bank of Syria (sp-today 1/11/2020)[7]



Higher level of unemployment

COVID-19 related movement restrictions (see Containment measures) and external economic shocks have resulted in direct loss of employment, particularly affecting informal labourers, especially in the agricultural sector, and IDPs.

The economic effects of COVID-19 precautionary measures have been felt even more significantly among the 54% of workers in the informal labor market relying on daily income for basic goods and services and in the agriculture sector, where the percentage of informal workers reaches almost 80% (FAO & WFP 01/07/2020), as well as IDPs who almost exclusively relied on daily income (91%) in Al-Hassakeh, Ar-Raqqa, Aleppo, and Deir-ez-Zor Governorates (REACH 01/07/2020). COVID-19 related measures and external economic shocks are estimated to have resulted in the temporary or permanent closure of 60% of Syrian businesses (UN 16/09/2020).

According to mVAM data, the main problem faced by interviewed households in September was unemployment (47%), which is up 12% from August 2020 (WFP 07/10/2020). Women are likely to be the most affected in terms of job loss, because of their overrepresentation in the services sector, including hospitality and tourism, and slightly higher presence in the informal sector, which have been significantly affected by containment measures and likely to take longer to recover economically. 84% of women working in Syria are employed in the service sector, compared to 59% of working men (ILOSTAT 21/6/2020, UNCTAD 14/04/2020). An inter-agency socio-economic impact assessment of COVID-19

[7] Data is captured by partners of the source who capture the rate used by money exchangers each day in the three locations, and the first day of the month is visualised.

completed in August found that in the preceding months, an estimated 200,000-300,000 jobs had been permanently lost (OCHA & WHO 29/10/2020).

In **GoS-controlled areas**, according to the Ministry of Social Affairs and Labor, more than 320,000 people registered for the National Campaign for Emergency Social Response for assistance due to loss of work as a result of COVID-19 preventive measures. Of these, 91% are daily labourers, 10.9% are elderly, and 8% are people with disabilities (OCHA & WHO 02/09/2020).

In the **northwest,** in September, 65% of livelihood sectors in communities assessed had been partially or totally affected by the COVID-19, with trade and manufacturing the most heavily affected sectors (REACH 19/10/2020).

In the **northeast**, access to livelihoods and sources of income remains the most commonly reported priority need in Deir-ez-Zor governorate, specifically in west and north line areas where it was the top reported need. Barriers to accessing livelihoods remain widespread, with a shortage of job opportunities reported in almost 100% of assessed communities (Food Security Cluster 26/08/2020).

Increased poverty levels

The UN now estimates that 90% of people in Syria live in poverty, an increase of 10 percentage points compared to prior to the COVID-19 crisis (CSIS 06/07/2020, OCHA & WHO 02/09/2020). As the economic situation deteriorates, **northwest Syria** shows an increase in the number of overall and extreme poor compared to 2017 when overall poverty was estimated around 80-85%, to extreme poverty standing at 50 to 60% in 2020 (Turkey Health Cluster 31/08/2020). In June, the number of households that lacked sufficient income to meet basic needs had increased to 71% compared to the 61% in January (HNAP 24/08/2020). The poverty situation today, particularly affected by significant decreasing income due to the COVID-19 pandemic (HNAP 24/08/2020), is expected to further deteriorate by 2021 (ESCWA 23/09/2020).

Overview of impact and humanitarian conditions

The humanitarian situation remains dire as the additional strains related to the COVID-19 pandemic and the economic downturn in Syria continue to impact the 11.7 million people in need in Syria. A decade of conflict, multiple displacements, economic shocks in the country and neighbouring countries, military operations, and violence had already severely affected the population and infrastructure, leading to weak capacities in handling the spread and repercussions of the disease.

While precautionary measures against the spread of the virus are crucial to contain COVID-19 transmissions, they have exacerbated vulnerabilities and created new humanitarian needs by reducing availability and access to basic services and employment opportunities and adding another layer of complexity in the humanitarian response. The economic impacts of the crisis, including currency devaluation, hyperinflation, rising unemployment, and an increasing number of businesses shutting down is aggravating and leading to further humanitarian needs. Overall, safety nets and livelihood resources are more strained than ever before and unaffordability being reported across sectors as the main obstacle to accessing goods and services.

Health

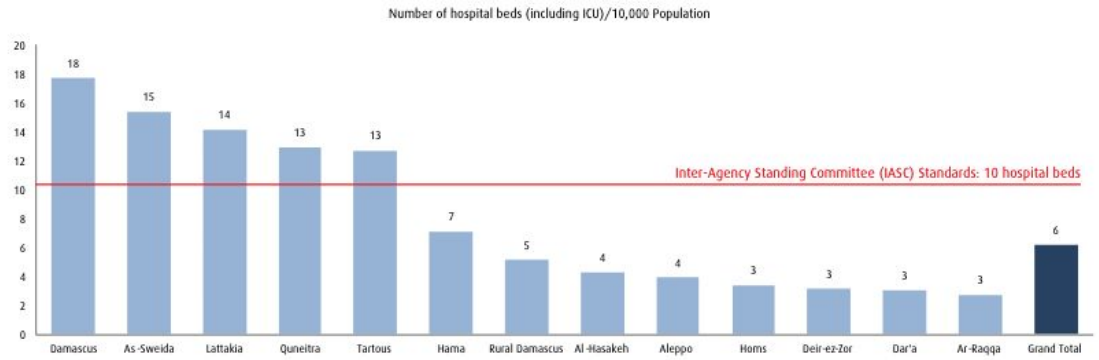
Low availability of health equipment, personnel, functioning health facility, and testing capacity, is further overstretching an already fragile healthcare system. This overwhelmed health system, coupled with greater challenges in accessing healthcare and stigma, is leaving many without care.

Many health facilities are non-functional

As of December 2019, the health system was already unable to meet the basic health needs of the population, with about 50% of the 113 hospitals across the country considered partially or fully non-functioning (Health Cluster 04/2020, WHO HeRAMS 2019) and about 33% health centers were reportedly damaged (WHO HeRAMS 2019). In the **northeast**, only 26 (9%) of 270 public healthcare facilities were functioning (NES Forum 16/04/2020).

ICU capacity is below the need and COVID-19 patients have had to wait for days or are being turned away as there was no available bed (Associated Press 19/11/2020, Amnesty International 12/11/2020). From the WHO HeRAMS assessment at the end of 2019, Hama, Rural Damascus, Al-Hassakeh, Aleppo, Homs, Deir-ez-Zor, Dar'a and Ar-Raqqa governorates were not reaching the IASC health standards of 10 hospital beds, including ICU, per 10,000 people (WHO HeRAMS 2019). In the **northeast**, more of the 35 ICU beds are in Al-Hassakeh governorate (Rojava Information Center 05/04/2020), with few in Ar-Raqqa and Deir-ez-Zor (LSE 25/03/2020). In Al-Hol camp, which hosts more than 70,00 people, only three field hospitals and 12 static medical points are present, none of which is equipped with ICU units or ventilators (WHO HeRAMS 2019).

Figure 6: Number of hospital beds (including ICU) / 10,000 population in public hospitals, December 2019 (WHO HeRAMS 2019)



Major hospitals have already exceeded their capacity and are not able to cope with the influx of patients. According to LSE calculations and considering that 5% of all cases would require critical care, Syria was only equipped to adequately treat a maximum of 6,500 hospitalised cases at the same time (LSE 25/03/2020). Reportedly seven out of eight hospitals in the **northwest** focusing on COVID-19 patients are overwhelmed as of mid-November (Associated Press 19/11/2020, Human Rights Watch 03/09/2020). Without additional international support, many humanitarian organisations have warned that the situation is likely to quickly worsen (World Vision 03/10/2020). With nearly 60% of all cases in Idlib governorate and over a third of all cases at the time in Idlib sub-district, the Idlib health authorities have called for urgent additional support (OCHA 18/11/2020).

COVID-19 has also resulted in entire facilities and staff having to exclusively focus on COVID-19 patients, and still not being able to handle the pandemic while reducing the capacity and availability of services and diverting resources away from other health facilities (NES Forum 14/10/2020, The Washington Post 25/09/2020). There have been reports of hospitals turning away COVID-19 patients to protect other patients (Syria Relief 08/10/2020). At the end of June, doctors publicly demanded on social media that government authorities shut down and sterilize Al-Mouwasat hospital in Damascus, **government-controlled areas**, after it became a COVID-19 hotspot (Syria Untold 07/11/2020, Social media 26/06/2020). As a result of limited supplies, patients reported having to bribe healthcare personnel to get a bed, medicine or ventilators (Syria Untold 07/11/2020, Middle East Monitor 28/09/2020). The diversion of resources to combat COVID-19 has also led to disruptions in routine immunizations programmes; however, data is missing on the extent and scale (UN Security Council 16/09/2020). In addition, the increase in fuel prices, notably in government-controlled areas, has led to spikes in electricity and transportation prices, further negatively impacting medical services and emergency response operations (WHO & OCHA 18/11/2020).

Scarce health equipment is hampering care

Insufficient availability of adequate equipment at medical facilities, such as swabs, tests, PPE and oxygen tanks, has been a challenge for the healthcare system. Estimates of stocks of testing kits in the northeast project a shortage by the end of the year. As a result, sick patients are being turned away when the necessary resources are unavailable.

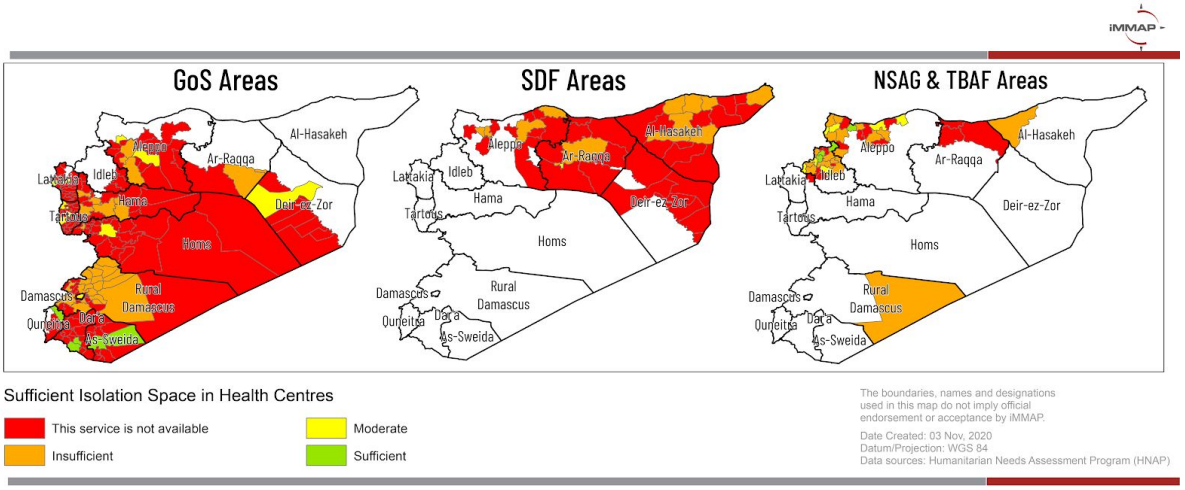
Across the country, only five laboratories are able to process COVID-19 tests (Amnesty International 12/11/2020). The Self-Administration in the **northeast** has two operational labs for testing of COVID-19 samples operating since May, with a capacity to process over 200 samples per day, which are not able to keep up with rising infection rates of the past few months (NES Forum 14/10/2020).

In **GoS**-held areas, residents reported that testing was only available to people travelling outside Syria (Amnesty International 12/11/2020). Since October, the number of examination and testing swabs in **northwest** Syria has also decreased sharply (Syria TV 24/10/2020). In the **northeast**, the lack of diagnostic supplies, including PCR and RNA extraction kits, is hampering the necessary response and scale-up of testing (NES Forum 14/10/2020). As of 1 October, the Self-Administration had an estimated 27,000 PCR tests in stocks, which could only last until the end of year with current rates of testing (NES Forum 01/10/2020). In Dar'a governorate, sources consulted by Amnesty International reported a lack of testing since June, with results taking weeks before being communicated (Amnesty International 12/11/2020). Authorities have been rationing and repurposing test kits designed for other diseases, such as polio and HIV, to cope with the low amount of testing kits (OCHA & WHO 24/09/2020, Rojava Information Center 05/04/2020). In the absence of sufficient testing, medical personnel are trying to diagnose cases based on chest X-rays and other symptoms, sending patients home without care (The Washington Post 25/09/2020).

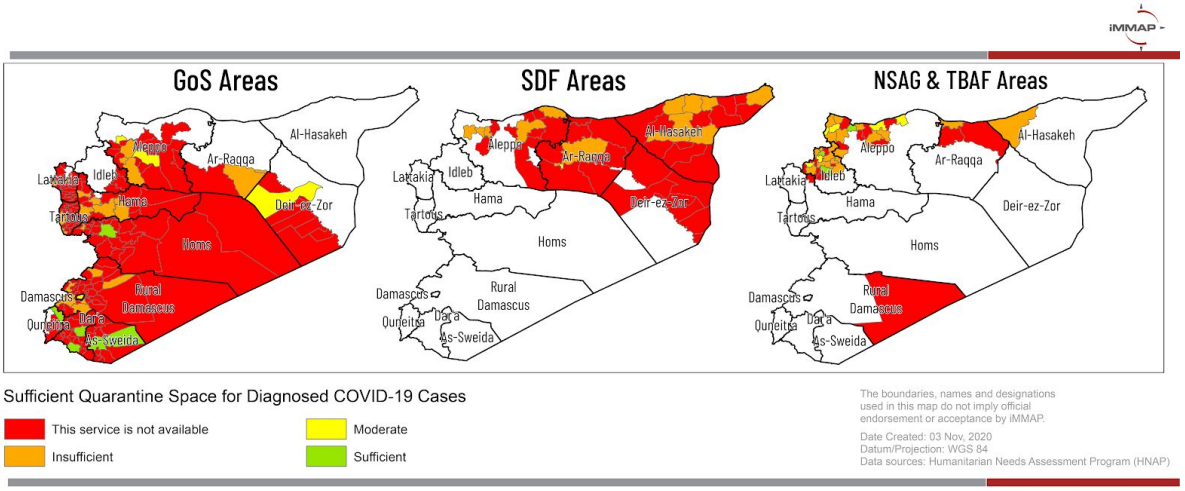
Serious shortages of Personal Protective Equipment (PPE) are still being reported across the country, with staff having to reuse and wash disposable equipment to try to protect themselves (WHO 29/10/2020, The Syria report 14/10/2020, NES Forum 01/10/2020, Human Rights Watch 02/09/2020).

A need for more oxygen tanks and ventilators in health centers has also been widely reported (Associated Press 19/11/2020, Amnesty International 12/11/2020, The Washington Post 25/09/2020). In government-controlled areas, virtual consultations and COVID-19 related Facebook groups managed by doctors have been reported to fill the healthcare gaps (Al Jazeera 05/10/2020). The rental of oxygen tanks and ventilators for private use has also been on the rise over the last couple of months, as many hospitals are lacking this basic equipment (Center for Global Policy 13/10/2020, Al Jazeera 05/10/2020).

Map 6: Sufficiency of isolation space in health centres as reported by community focal points (HNAP 17/11/2020)[8]



Map 7: Sufficiency of quarantine space for diagnosed COVID-19 cases as reported by community focal points (HNAP 17/11/2020)[7]



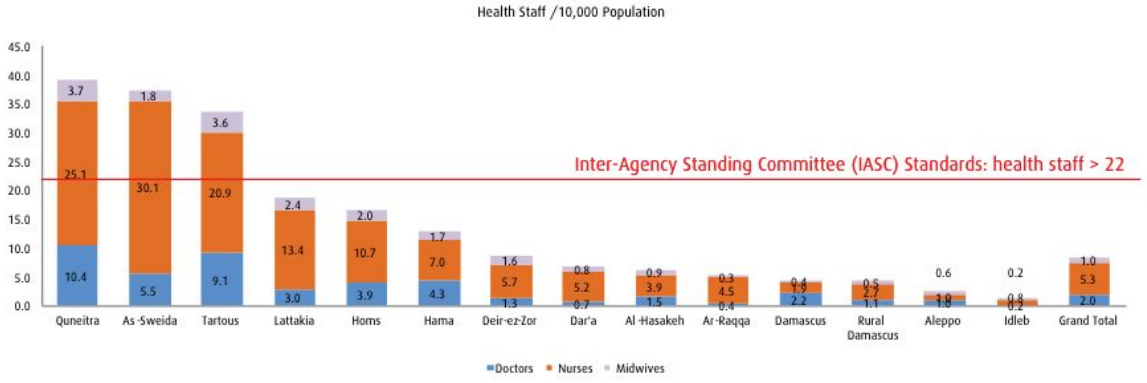
Insufficient numbers of healthcare workers remain in the country

The exodus of more than 70% of the healthcare workforce over the past nine years had already severely weakened the health system (OCHA 06/03/2020). As a result, there are insufficient numbers of healthcare workers left and even fewer in the relevant specialties needed to handle COVID-19 patients (pulmonology, intensive care, anesthesiology, infectious disease, infection prevention and control, etc...) (Migration and Health 03/07/2020). Only 50 psychiatrists are estimated to still be practising, leaving significant mental health gaps, while the pandemic significantly increased mental health needs support (Syrian Observatory for Human Rights 10/10/2020). According to the 2019 WHO HeRAMS assessment, sufficient numbers of health staff per 10,000 people, as per IASC health standards, are only available in Quneitra,

[8]The maps display entire sub-districts where community focal points were surveyed and do not represent areas of control. Source reports and methodology are available from the Humanitarian Needs Assessment Program (http://hnap.info).

As-Sweida and Tartous governorates, with serious staffing shortages in other governorates (WHO HeRAMS 2019, see graph below). The number of midwives per doctor in public health centers are almost above the Ministry of Health standards of 2 per facility everywhere, except in Hama, Aleppo and Damascus governorates (WHO HeRAMS 2019). However, this is only the case in half of the governorates in public hospitals centers (WHO HeRAMS 2019).

Figure 7: Number of health staff (doctors, nurses and midwives) per 10,000 population in public health centres, December 2019 (WHO HeRAMS 2019)



High number of cases of COVID-19 among healthcare workers

The rate of transmission among healthcare workers is likely to continue to rise over the coming weeks, raising concerns that the overwhelmed and weak health system could soon collapse.

Also see: COVID-19 Epidemiological Overview

Against the backdrop of acute shortages in health human resources, many health workers have tested positive for COVID-19. Healthcare workers account for about 15% to 30% of total reported confirmed cases in the northwest and northeast (Syrian Observatory for Human Rights 05/10/2020). More worryingly, in Al-Hassakeh city, about 40% of all confirmed cases were reported among health workers as of 1 October (NES Forum 01/10/2020). While this proportion may be overrepresented owing to targeted testing of healthcare workers, there is no doubt that they are on the front lines and face disproportionate risk of infection and have been heavily affected by the epidemic. Many have had to be placed in isolation, further limiting the number of health personnel available to cope with the influx of COVID-19 patients. In the northeast, as of 3 November, 68 staff from three health NGOs are in self-isolation or self-quarantine. 138 health staff from six NGOs have been in self-isolation or self-quarantine at some point during October (NES Forum 05/11/2020). The steady rise in transmission is disrupting the continuity of health services , further weakening the fragile health system, raising concerns that it might not be able to withstand upcoming COVID-19 waves. According to 11 NES NGOs, as of 1 October, 8 health facilities were fully closed due to widespread transmission among health workers: 1 in Raqqa, 2 Deir-ezZor and 4 in Hassakeh (NES Forum 01/10/2020).

The high level of exposure among health workers is likely due to a combination of factors, including low levels of compliance with preventive measures, inadequate screening and triage procedures at health facilities, suspected COVID-19 cases visiting health facilities in person rather than reporting symptoms remotely through public hotlines, movement of health workers between multiple health facilities and shortages or improper use of PPEs (NES Forum 01/10/2020, WHO 24/09/2020, Syria Direct 31/08/2020).

In the **northwest**, inadequate triage, as well as Infection Prevention Control measures, are a challenge: 35% of assessed health facilities reportedly have inadequate measures in place (OCHA 18/11/2020).

At points of entry and camps, implementation of screening protocols has been inadequate, with improper temperature screening, clinical assessment protocols not being applied and Rapid Diagnostic Tests conducted instead. In October, a mission at Tabqa point of entry found that among 6,000 people who had recently crossed from GoS-held areas to the **northeast**, over the previous week, none was found to have a temperature; an unlikely scenario, highlighting that temperature screening had not been conducted properly (OCHA & WHO 07/10/2020).

Weak coordination between stakeholders is affecting quality of services

Syria's health system is quite fragmented, with distinct governance structures, processes and resources depending on the regions. As a result, weak coordination between stakeholders has affected the quality of services provided to respond to the pandemic.

Problems with leadership and coordination among public, local and international health actors is affecting healthcare delivery and COVID-19 response. Weak linkages between centralised and local structures and authorities have resulted in lower responsiveness and has been hampering a rapid scale-up in both northwest and northeast. Health directorates have reportedly not been properly linked with the broader humanitarian health response, leading to potential duplication and gaps, notably in Idlib governorate (Conflict and Health 27/05/2019). In Deir-ez-Zor, the central Operations Desk and referral network have not been in close contact, hampering detection and isolation (NES Forum 01/10/2020). Local coordination challenges have been identified as a main factor behind undetected transmission in the **northeast** (WHO 24/09/2020). Tense relationships between the **GoS and authorities in the northeast** have also resulted in lack of cooperation and coordination, leading to delays in testing and isolation: the GoS took two weeks to inform the authorities of the first positive case in the northeast, as samples collected in northeast Syria had to be brought to Damascus to be tested due to absence of laboratory capacity at the time (Human Rights Watch 28/04/2020).

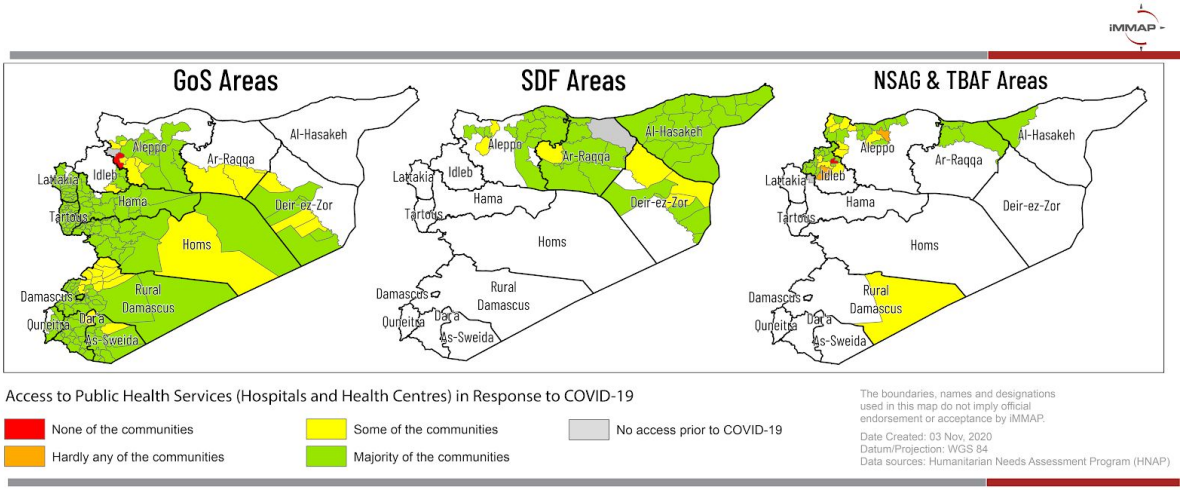
Challenges in accessing healthcare

inability to afford services, significant distance and overcrowding in health facilities are reportedly the main challenges the population face in accessing healthcare.

Inability to afford services has been reported as a barrier to access healthcare among participants interviewed by WFP, especially for women. Overall the proportion has more than doubled since May, reaching 15% in October. Affordability and distance to healthcare facilities were also reported as the main barrier among men, although at a lower rate (both 8%) (WFP 23/11/2020). Participants in Quneitra, Al-Hassakeh and As-Sweida reported the highest proportion of barriers in accessing healthcare facilities in September (above 20% of surveyed households) (WFP 04/11/2020). Refugees and IDPs interviewed by UNHCR between March and August also indicated that costs were among the greatest impediments to accessing care, which many are unable to afford (UNHCR 29/09/2020). 46% of surveyed households reported not being able to purchase the necessary medicines in September 2020, with the highest rate recorded among female-headed households (52% compared to 45% among male-headed households), largely due to lack of financial resources (67%) and shortage of medicines in pharmacies (30%) (WFP 04/11/2020).

In **GoS-held areas**, in June, pharmacies were allowed to increase the prices of some medicines, such as paracetamol, from 50 to 850 SYP (Syria Untold 07/11/2020). In the **northwest**, barriers to healthcare access were reported in 60% of communities in September, citing scarcity and high costs of transportation to health centers, medicine shortages, and overcrowding in health facilities as main challenges (REACH 19/10/2020). Girls and young women have reportedly been facing higher obstacles in reaching healthcare (European Union External Action 30/11/2020). In the **northeast**, unaffordability of health services, as well as lack of transportation to health facilities and high transportation costs, were also among the most commonly reported obstacles to accessing healthcare in July (REACH 07/09/2020). As a result of lack of functioning health facilities, patients have to drive for hours or walk long distances before being able to reach a functioning health facility, with many being turned away as they are already at maximum capacity (Associated Press 19/11/2020, Enab Baladi 28/10/2020).

Map 8: Access to public health services (hospitals and health centres) in response to COVID-19 as reported by community focal points (HNAP 17/11/2020)[9]



Stigmatisation, coupled with low trust in the health system, is leading many to hide their symptoms and not seek care

People are not reporting symptoms due to lack of trust in the health system, fear of the government institutions, and social stigma associated with the virus.

Issues with social acceptance of those infected and fear of stigmatisation, or even bullying, by the community is further preventing people to seek testing or treatment (Enab Baladi 13/11/2020, Al Jazeera 05/10/2020). **Across all areas**, many now consider COVID-19 "shameful", and hold COVID-19 patients responsible for their infection because they did not adhere to protective measures (Enab Baladi 13/11/2020). Social stigma and patients' reluctance to go to hospitals mean that a significant numbers of people with symptoms are probably not seeking care or are being treated at home, leading to further difficulty in ascertaining the true scale of the epidemic, as well as increasing the likelihood of such patients to develop more severe symptoms, decreasing their chance of survival (OCHA & WHO 29/10/2020). In the **northwest**,

[9]The maps display entire sub-districts where community focal points were surveyed and do not represent areas of control. Source reports and methodology are available from the Humanitarian Needs Assessment Program (http://hnap.info).

findings from 28 focus group discussions among 140 participants in Aleppo and Idlib, found that women hide symptoms to avoid social stigma and exclusion from the community, as well as to prevent stress or tension within the household. Men also hide symptoms fearing losing income if they disclose their condition, as well as to avoid community stigmatisation (Protection Cluster 27/11/2020). In the **northeast**, high levels of social stigma is a fundamental barrier in reporting symptoms, leading to low rates of early detection of cases (NES Forum 14/10/2020) and many patients refusing to relocate to the isolation areas, leading to further community transmission (NES Forum 01/10/2020).

In addition, in **GoS-held areas**, notably Idlib, the deteriorating quality of the healthcare system, as well as the lack of trust in government-affiliated structures, is reportedly driving people away from reporting their symptoms or seeking care, as patients fear going to public hospitals (Enab Baladi 13/11/2020). Fear of the state authorities, who are reportedly closely watching medical professionals in public health centers, is a further deterrent for patients to seek treatment, as people fear that reporting symptoms and discussing the handling of the pandemic by the government would put them at risk of being arrested (Syrian Observatory for Human Rights 05/10/2020). Local sources have also claimed that authorities deliberately killed suspected COVID-19 patients in al-Mujtahid and Mouwasat hospitals in Damascus early March to avoid officially reporting the start of the outbreak, further fuelling fear of government health and isolation centers among the population (Global Voices 16/07/2020, The Voice of the Capital 10/03/2020). Deep distrust of state institutions, as well as chronic shortages of medical equipment and supplies and poor conditions in health centers, is resulting in many patients hiding their symptoms (Al Jazeera 05/10/2020). In the **northwest**, people are reportedly scared of healthcare personnel who they think are all infected (Al Jazeera 02/11/2020) and refer to them as "spreaders of the virus", leading to a lack of trust in the capacity of healthcare workers among the community (Protection Cluster 27/11/2020). Elderly and people with disabilities especially reported being less willing to seek healthcare due to fear of contracting COVID-19 (OCHA 10/09/2020).

Risk of further infection

Preventative equipment is too expensive, making them unaffordable for most Syrians

Prices of preventative equipment and testing costs have significantly increased since the beginning of the pandemic, making them unaffordable for most Syrians.

The prices of masks and gloves have increased by 300% and sanitizer by more than 200% since February (WFP 07/10/2020). In **GoS-**held areas, even doctors can reportedly not afford high-quality face-masks; these cost about 5,000 SYP (USD 10), while the average monthly salary for a doctor is around 96,000 SYP (USD 188) (Al Jazeera 05/10/2020). Reusable masks cost more than two days of salary for average government employees as of September (The Washington Post 25/09/2020). In the **northwest**, masks can be bought in pharmacies for about 1 TYR, a cost also out of reach for many people (MSF 11/11/2020). Most people in Syria cannot afford to buy masks, sanitizers or tests, instead prioritising food, water, medicine and school supplies (Al Jazeera 02/11/2020). As a result, people have been using used masks, or pieces of old clothes instead, leaving them unprotected (MSF 11/11/2020, The Washington Post 25/09/2020). Similarly, the cost of a COVID-19 test has been prohibitive for many: in **GoS**-held areas, tests cost about 126,000 SYP (USD 246), a price unaffordable for most of the population (Al Jazeera 05/10/2020, Syria Relief 08/10/2020). The price of oxygen has also been increasing, following increased demand for private tanks (Amnesty International 12/11/2020).

The high risk of undetected transmission is compounded by limited adherence to preventive measures/lockdown, as well as limited enforcement of these measures, which makes transmission more likely (see Compliance to containment measures Section).

People at risk

Up to 41% of the adult Syrian population has a non-communicable disease e.g. hypertension, diabetes, cancer (HNO 2019). The Ministry of Health estimated that around 64,000 people are at critical risk of infection as of mid-October (The Syria report 14/10/2020). In the **northwest**, around 40% of the adult population is estimated to have comorbidities and around 76,000 people are over 60 years old, both factors that could increase their risk of COVID-19 and poorer outcomes (MedRxiv 07/05/2020). Prevalence of cigarette smoking in Syria is among the highest in the Middle East, with 51.3% among men and 8.4% among women (PLOS One 30/01/2018), which is associated with higher risk of developing a more severe COVID-19 condition. These may affect the proportion of people who develop severe or critical conditions (MedRxiv 07/05/2020).

Nine years of conflict and dire economic situation have deeply impacted the health system

COVID-19 added more pressure on a fragile health care system, already deeply affected by almost a decade of conflict, a weak economy and international sanctions.

Throughout the past nine years of conflict, deliberate tactics to target hospitals and medical workers has left the country vulnerable to this health crisis. Between March 2011 and February 2020, 595 attacks on at least 350 facilities, as well as the killing of 923 healthcare workers have been reported (Physicians for Human Rights, Syria Relief 08/10/2020, Syrian Observatory for Human Rights 05/10/2020). Medical teams and hospitals have often been targeted by government forces accusing them of treating "terrorists" - a term used to describe opposition fighters (Associated Press 19/11/2020). More recent attacks over the past months have left the north of the country without many functioning medical infrastructure (Syria relief 08/10/2020). Ongoing hostilities and high levels of explosive ordnance contamination continue to hinder humanitarian access to vulnerable areas (OCHA & WHO 07/10/2020).

Syrian authorities expressed deep concerns over the international economic sanctions, with the latest implemented mid-June, which reportedly led to additional difficulties in procuring health supplies and medicine (Syrian Arab News Agency 27/10/2020, OCHA & WHO 01/09/2020). Some of the materials required for Covid-19 testing are under sanctions but procedures for exemptions have been submitted (HRW 28/04/2020).

Livelihood

COVID-19 related movement restrictions and external economic shocks (see Economic developments) have resulted in direct loss of employment, and decreased income and purchasing power. The combination of multiple crises contributed to lowering households' and communities' capacity to cope with internal and external shocks, keeping the population's resilience to present and future shocks under constant pressure.

The COVID-19 outbreak and containment measures, the Lebanese financial crisis, the Beirut explosion, political tensions and the uncertainty accompanying the intensification of unilateral coercive measures such as sanctions, have all caused food prices to rise and increased food insecurity (UN Security Council 16/09/2020, WFP 07/10/2020). Income loss, price increases, loss of humanitarian assistance and forced business closures are communities' main concerns about the economic impact of COVID-19 in **northwest** Syria (OCHA 10/09/2020). Nationwide, community key informants believe communities cannot meet their needs due to an increase in prices (98%), fear of losing employment (54%), and lack of product availability (29%) (GTS & HNAP 27/08/2020). COVID-19 containment measures have impacted the functionality of markets in all areas throughout the year (HNAP 2020, REACH 2020, NES FSL Cluster 02/12/2020), decreasing livelihood opportunities as well as contributing to the decreasing availability and quantity of basic goods, and compounding with the effects of high inflation.

Significant income losses

Meeting basic needs has become more difficult since the start of the pandemic. In the mVAM September survey, approximately 60% of the surveyed households reported **across Syria** that they had lost one or more sources of income because of COVID-19 related restrictions, with almost one out of four households reporting to have lost more than 75% of their income (WFP 07/10/2020). Damascus, Quneitra, Homs and Latakia are the most impacted governorates, both with 71% of respondents reporting the loss of one or more income sources in the last six months. The lowest rate was 46% for respondents in Deir-ez-Zor governorate (WFP 28/09/2020). In the **northwest**, where 45% of households draw their income from daily labour, more than 70% of households say their income cannot cover their needs, an increase of 10% since January (UN Security Council 16/09/2020). In September, key informants in more than 90% of communities cited low wages as a barrier to fulfilling basic needs (REACH 19/10/2020).

The estimated $1.6 billion of remittances sent to Syria each year is declining in 2020. Total remittances into the Middle East and North Africa region is projected to fall sharply by 19.3%, and bringing in money from countries neighbouring Syria has become difficult with the closure of borders (World Bank 22/04/2020, Syria Direct 12/04/2020). Remittances are estimated to have reduced up to 50% (OCHA & WHO 29/10/2020) and about 6% of surveyed households in August reported difficulties obtaining remittances due to COVID-19 movement restrictions (WFP 07/10/2020).

Business closures rates remain high, with, in September, still 45% of businesses reporting having to be closed, 25% operating at reduced levels and 15% permanently closed in Syria (UN Security Council 16/09/2020). The meat industry has been heavily impacted, with butchers reporting an 80% decrease in lamb meat compared to last year, due to the high prices of meat and low purchasing power (WFP 22/10/2020). 57% of livelihood sectors in communities assessed in **northwest** in September have been partially affected by COVID-19 and 8% have been totally affected (REACH 19/10/2020).

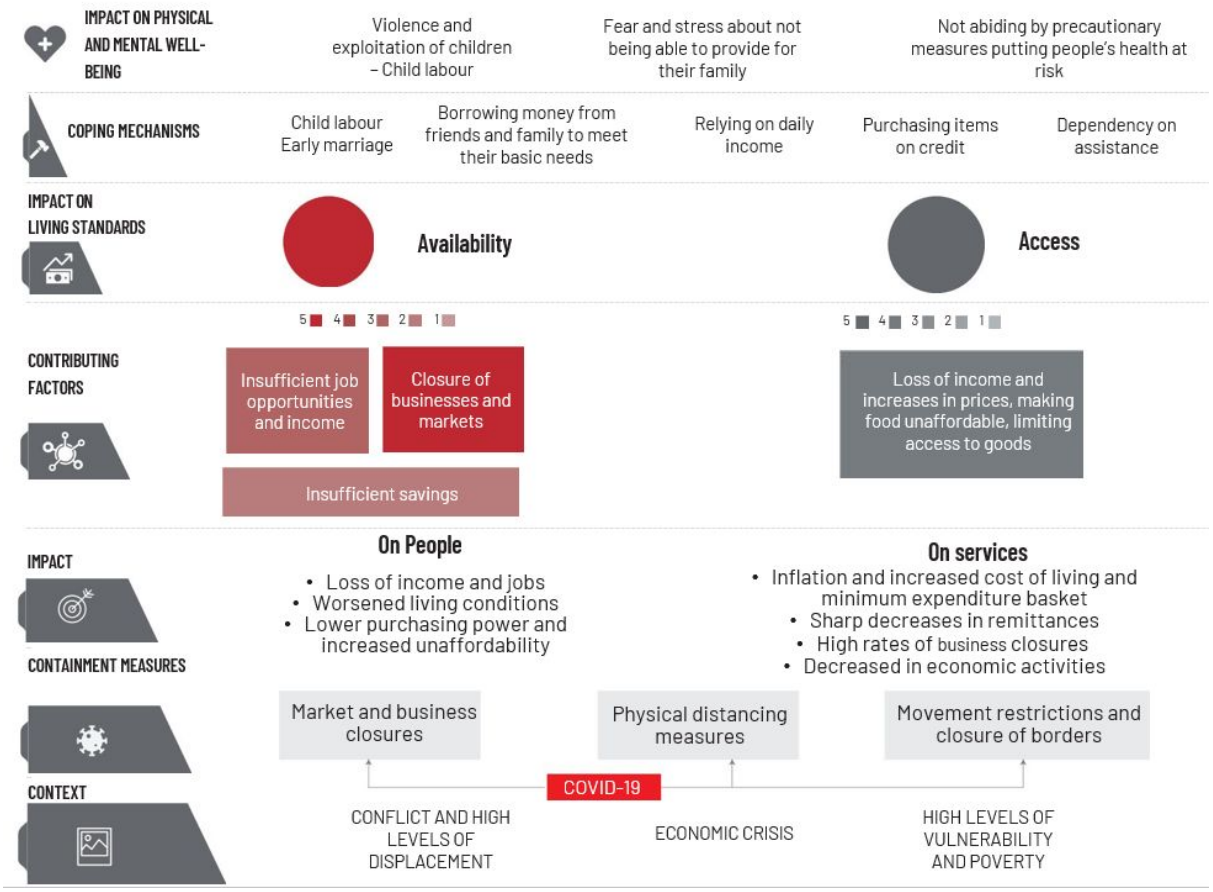
High levels of inflation

While markets are mostly functioning across the territories, besides some locations in Ar-Raqqa, Idlib and Aleppo governorates (HNAP 20/10/2020), inflation and price fluctuations have been a major barrier for accessing key items. Even households with steady income are being adversely affected as the cost of living is spiraling while the value of their income is decreasing. The national average reference food basket recorded a 251% increase year-on-year as of July 2020, reaching a cost of SYP 86,571, exceeding the highest paid official government monthly salary of SYP 80,240, with the highest spike recorded in Idlib at 464% (Global Food Security Cluster 23/09/2020, OCHA & WHO 02/09/2020). According to mVAM data, the second main problem faced by households in September after unemployment was the high price of commodities (20%) (WFP 07/10/2020). As a result of price inflation, many households are forced to prioritise their spending and choose between food, heating, health or abiding by covid mitigation measures.

Widespread use of coping mechanisms to mitigate livelihood losses

The use of negative coping strategies is widespread with 90% of households interviewed in September reporting having relied on at least one coping strategy during the month (WFP 07/10/2020). In the **northwest**, in September, borrowing money from family or friends is the most commonly reported coping strategy for households to meet their basic needs. Key informants also reported child labour as a common livelihood coping strategy among residents and IDPs in 67% and 76% of locations respectively, and was most commonly reported in Daret Azza and northern Idlib (REACH 19/10/2020). Due to high volatility of the exchange rate, traders could not afford to extend credit as much as before COVID-19 as they feared higher credit repayment default. As a result, while credit requests increased, traders reported reducing by half the number of people to which they extended credit (WFP 22/10/2020).

Problem tree



Food security

Worsening trade relations across Syria, the impacts of COVID-19 containment measures such as regular employment pattern disruptions and forced service closures, high volatility of the exchange rate, the regional banking and economic crisis notably in Lebanon, disruptions of regional supply chains, and a rise in insecurity, have all led to dramatic increase in food prices, localized food scarcity and reduced household purchasing power, resulting in negative effects on the food security of the population (WFP 10/09/2020, WHO 02/09/2020, Food Security Cluster 24/08/2020, WFP 20/08/2020).

Reduced food availability

Local supply chains were negatively affected by COVID-19 preventive restrictions to cross-border and cross-line commercial activity (REACH 07/09/2020). In addition, due to high volatility of the informal exchange rate in May and June 2020, wholesalers reduced their food supply on Syrian markets, causing retailers to temporarily shut-down shops to avoid losing profits, leading to lower capacity to secure basic food items at household levels. In Kobani, Jawadieh, the countryside of Al-Hassakeh and in Ar-Raqqa, food security partners reported closures of an estimated 90% of food shops in June (Food Security Cluster 15/06/2020). In an indicative survey of community focal points, 46% of respondents in low density areas reported that products were less available, making price hikes a primary concern (GTS & HNAP 24/08/2020).

Delays and reduction in cereal imports due to the COVID-19 context has led to critical shortages of bread in September, particularly affecting **government-controlled areas,** especially in Dar'a, Rural Damascus and Damascus governorates (WFP 29/09/2020). In September, it is estimated that only 58% of the population's minimum bread needs are being met (Global Food Security Cluster 23/09/2020). In Dar'a city, most bakeries have shut down or operate at 50% capacity (WFP 25/09/2020). People have reportedly been queuing for up to four hours to receive their entitlement from public bakeries in rural Damascus governorate (WFP 29/09/2020). In the **northwest** as well, up to 30% of bakeries are no longer operational (Global Food Security Cluster 23/09/2020).

The increase of bread prices is notably due to the delay in the arrival of 200,000 tons of wheat from Russia and the delay of a tender from European countries of the same quantity. Syria imports more than one million tons of wheat annually to meet the estimated need of 2.5 millions tons for domestic consumption. However, due to the devaluation of the currency, imports have been limited in 2020. Trade has also been further limited by US sanctions, resulting in an increase in criminal activity and unofficial trade in the black market instead. The decline in internal wheat production in Syria, from about 4 million tons last year to less than 1.5 million tons this year has also been driving wheat shortages and the increase in prices. People will likely face further shortages until the next wheat harvest in 2021 (Al Araby 14/09/2020).

Significant increase in prices, leading to most food items being unaffordable

While the food security situation was worsening before COVID-19, with already the depreciation of the Syrian Pound and increases in fuel and food prices since late 2018, the deterioration has since accelerated (WFP 22/10/2020). The outbreak of Covid-19 and its related government preventive measures added to the already worsening economic situation and caused widespread inflation across all commodities (food and non-food items), especially of imported

items, since March 2020 (WFP 10/09/2020). While the rate of food price growth slowed significantly in July, linked to a strengthening of the value of the Syrian Pound, the average price of the WFP reference food basket stood at 22.8 times the five-year pre-crisis average, still more than twice as high as at the previous peak at the height of the Syrian crisis in 2016. The price of an average food basket in July was 3% higher than June, 131% higher than in January, and 251% higher than the same time last year. The stabilization of prices from June to July was in large part due to falling prices especially of imported commodities of vegetable oil and sugar due to a more stable informal SYP/USD exchange rate as well as the arrival of the country's main harvest (WFP 20/08/2020). Even with the lift of most of these measures, prices have continued to worsen (WFP 22/10/2020).

Unaffordability of food was reported as the main barrier for about 80% of assessed communities in the **northwest** in September (REACH 19/10/2020). This was already the main barrier to accessing sufficient food for IDPs prior to COVID-19, as in February, the survival minimum expenditure basket cost 111,964 SYP, while the average daily wage for IDPs was estimated to be 2,000 SYP (REACH 01/02/2020). In early October, the average price of a survival minimum expenditure basket (SMEB) in sub-districts in the northwest was 196,285 (84 USD) had increased by 8% in one month, and by 100% in the last 6 months (REACH 12/10/2020). In the **northeast**, In early October, the average price of a survival minimum expenditure basket (SMEB) in sub-districts in the northeast was 170,475 SYP (73 USD) and had increased by 4% in one month, and by 69% in the last 6 months (REACH 12/10/2020).

Reduced access to markets

Syria heavily depends on markets for its food security. Already in 2010, over 50% of Syrians lived in urban areas, relying on markets to meet their food needs. This proportion almost doubled in 2019, with almost 90% of Syrians reporting markets as their main source of food (WFP 22/10/2020). According to September mVAM data, around 61% of households with no regular access to markets have inadequate food consumption[10], representing a 22% increase compared to August 2020 and more than double the level recorded since April 2020 (WFP 04/11/2020).

COVID-19 lockdown resulted in a decreased access to markets, with only 70% of interviewed households reporting having access to food markets in April 2020 compared to 94% of respondents in 2018 (WFP 22/10/2020). Al-Hassakeh and Ar-Raqqa governorates, in the **northeast**, reported the highest levels of market inaccessibility due to the pandemic, with more than 30% of households reported challenges in accessing markets in July and September 2020 (WFP 31/10/2020).

Road closure reportedly affected food or input supply in 38% of locations assessed (FAO 24/09/2020) but, only 5% of female-headed households and 9% of male-headed households reported that movement restrictions were the main impediment to obtain remittances and food assistance in October (WFP 23/11/2020). However, in the **northwest**, in September, insufficient transportation to markets was cited as the primary barrier to food markets among resident and IDP populations (62% and 59% respectively) (REACH 19/10/2020). This could be linked to reduced transportation due to the COVID-19 restrictions or the widespread fuel shortage in September.

[10] Food Consumption Score is the most commonly used food security indicator. It represents households' dietary diversity and nutrient intake and is calculated by inspecting how often households consume food items from the different food groups during a 7-day reference period (WFP).

Significant deterioration of food security, with increased food needs projected

Due to the effects of COVID-19 mitigation measures, the loss of job opportunities, particularly for those reliant on daily wage labour or seasonal work, and the continued rise in food prices, more households have been pushed into food insecurity as they have been unable to meet their food needs (WFP 20/08/2020). According to WFP, 9.3 million people in Syria are now food insecure, 46% of the country's population (WFP 29/06/2020) and this number could soon exceed 11 million (UN Security Council 27/08/2020), as over 2.2 million Syrians are at risk of slipping further into food insecurity without urgent assistance (WFP 02/09/20). Prevalence of insufficient food consumption is now 51.8%, a 26% increase from August, and double the level reported in September 2019 (WFP 7/10/2020, WFP 30/09/2020). Aleppo was the governorate with the highest share of households with more than 25% of them having poor food consumption levels (WFP 7/10/2020). Deir ez-Zor, Lattakia and Ar-Raqqa are also reported as the most food-insecure areas (FAO 03/08/2020, Food Security Cluster 26/08/2020).

At the end of September, the Government of Syria reduced bread subsidies, with now limits of bread packages per household - one bread package per day for households of two, two packages for families of four, three packages for families of six and no more than four packages for all other families. This latest cut in bread subsidies is further exacerbating the dire food needs in the region (The Guardian 05/10/2020).Despite the Eid celebrations in August, which typically leads to increases in the national consumption level of protein intake, around 55% of interviewed households reported that they only ate protein fewer than two times a week in August 2020. This was the lowest national average consumption level of protein over the past six months (WFP 28/09/2020). A significant increase of inadequate food consumption was reported among returnees' households, with a rate that increased by three-fold since April 2020, now reaching 70% (WFP 7/10/2020).

Higher use of negative coping mechanisms

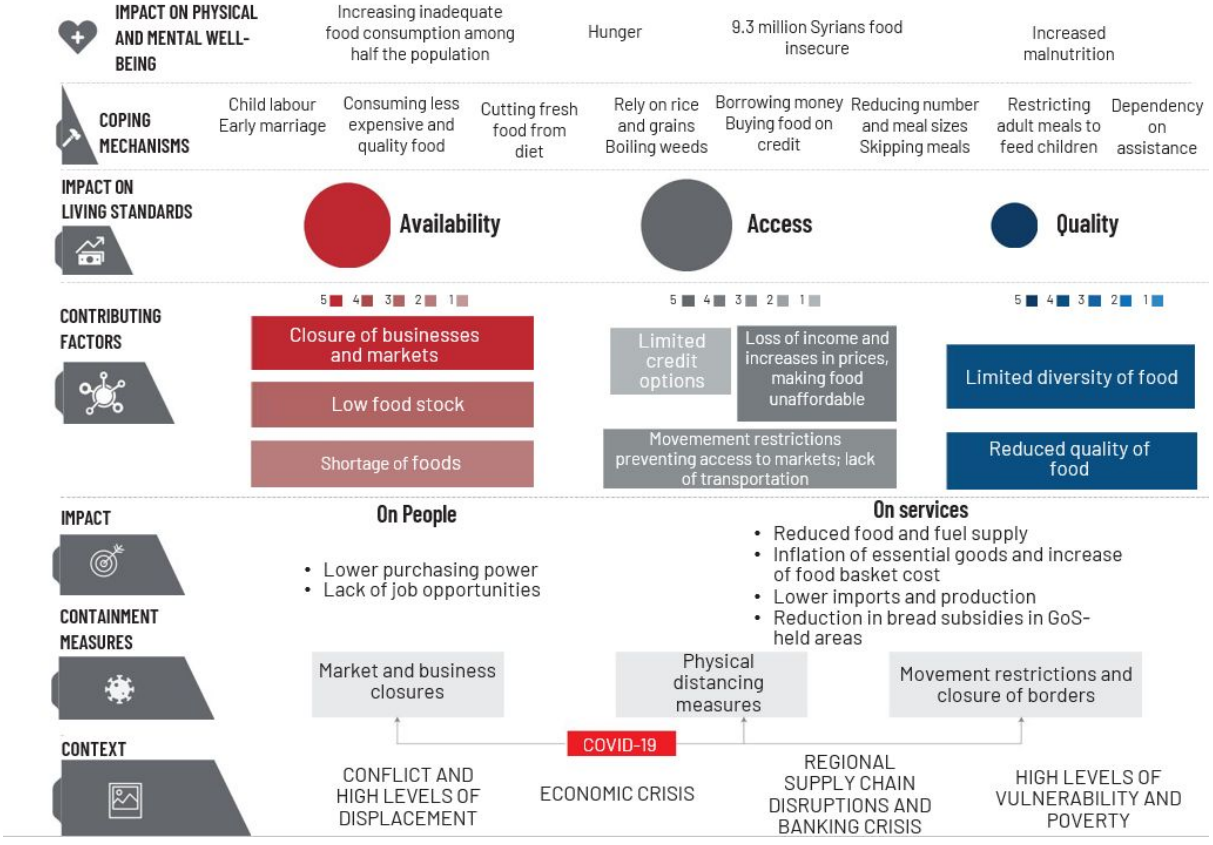
Between August and September 2020, the national average reduced Coping Strategy Index (rCSI)[11] increased from 16.8 to 17.7, driven by applying more severe food coping mechanisms by households. In September, the share of female-headed households resorting to at least one food-based coping strategy was higher (93%) than the male-headed households (86%). 88% of returnees' households reported to rely on at least one food-based coping mechanism to cover their essential food needs, compared to 90 and 84% from IDPs and residents' households, respectively, in September 2020 (WFP 7/10/2020).

Although reducing adult consumption to feed children was a strategy implemented by households to cope with increased food need, the rate has decreased from 48% in July to 39% in August (WFP 28/09/2020). 66%of households reported consumption of less expensive food in September (WFP VAM 07/10/2020). Some households have reportedly been boiling weeds to be able to sustain themselves (The Economist 26/09/2020). Most of the households in the **northeast** report cutting out fresh foods from their diets, relying instead on rice or grains for weeks (AP News 29/09/2020). COVID-19 and related restrictions are expected to exacerbate reliance on cheap staple (cereals, roots and tubers) and nutrient-poor ultra-processed foods (Save the Children 09/2020).

[11] The rCSI is an experience-based indicator measuring the behaviour of households over the past seven days when they did not have enough food or money to purchase food. The reduced CSI uses a standard set of five individual coping behaviors that can be employed by any household, anywhere. The maximal rCSI is 56 (WFP).

In September, using savings to cope with food and money shortages was still not an option for 88% of the Syrian households (WFP 7/10/2020). Borrowing money to meet basic needs or buying food with money usually used for other things was also commonly reported, by 47% of respondents, a rate higher by 15% compared to August 2020 (WFP 7/10/2020). Almost 66% of households mentioned they bought food on credit, with peaks among IDPs (70%) and returnees (68%) (WFP 28/09/2020). Between January and June, there was a 56% increase in the number of surveyed households in all governorates of Syria resorting to selling household assets, and a 29% increase in selling productive assets (HNAP 24/08/2020). In the **northwest**, in September, KIs reported negative food coping strategies among households, including: purchasing food on credit (65%), buying food with money usually used for other things (58%), reducing meal sizes (53%), and/or skipping meals altogether (52%) (REACH 19/10/2020).

Problem tree

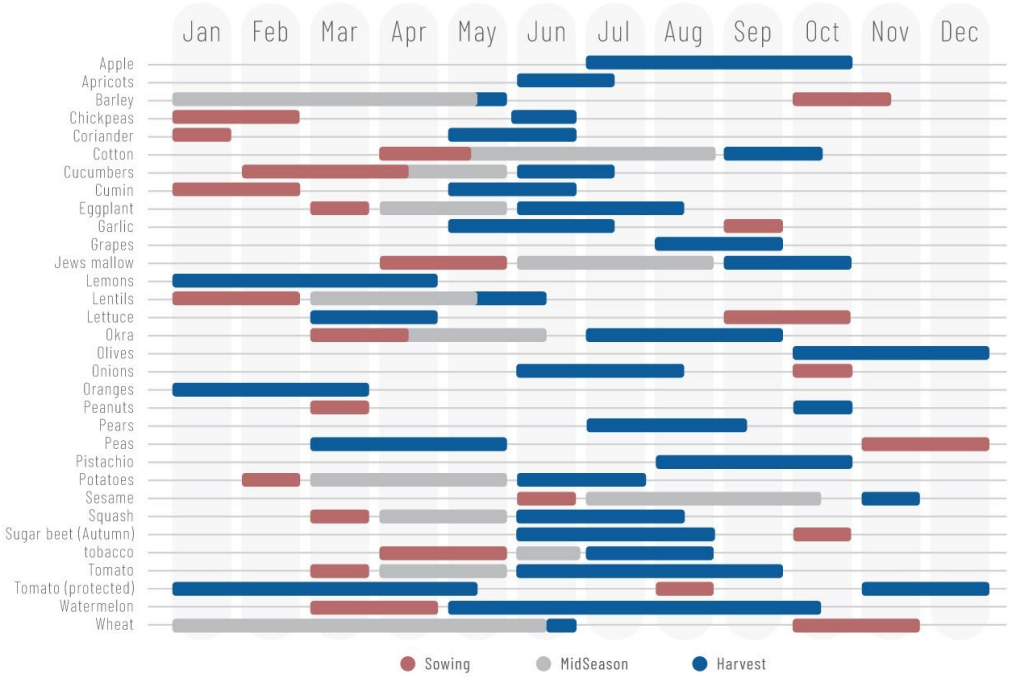


Agriculture

Limited impact on farming activity overall

Overall, limited impact on farming activities was reported due to COVID-19 and public health measures. Across the country, farmers were able to plant 70% of the land allocated for cereal production (FAO 10/04/2020). In southern rural Aleppo, **government-controlled areas**, farmers were able to cope with the knock-on effects of the epidemic and precautionary measures, such as increased price of inputs (fertilizers and pesticides), power cuts and shortage of fuel (OXFAM 01/09/2020). In the **northwest and northeast**, about 30% of community focal points reported that agriculture-based livelihoods had been partially affected by COVID-19, this is the least affected of the livelihood sectors included in the survey (REACH 10/2020). While curfew and travel between towns and cities were banned in May, exemptions were made for farmers and vehicles transporting key food supplies, limiting the impact on farming activities (The Syria Report 06/05/2020). However, the effects on the harvests are yet to be assessed, having started more recently.

Syria Crop Calendar (FAO):



Rise in inputs' prices

Importation constraints, due to COVID-19 precautionary measures, economic crisis and sanctions, have all contributed to a general rise in the prices of some agriculture inputs and products since March (FAO 24/09/2020).

The high cost of key poultry feed items, such as soybean and maize, which reportedly doubled at the end of March (FAO 30/03/2020), drove more than 70% of chicken farmers to stop production by end June according to the Ministry of Agriculture, as they could not sustain such high production costs (WFP 22/10/2020, FAO 02/11/2020). Most livestock breeders lost their productive assets due to the high prices of feed, vaccines, and veterinary treatment, as well as constraints in accessing grazing lands due to movement restrictions, which led many of them to sell their livestock (Qatar Charity 29/09/2020, FAO 30/03/2020). The impact has likely been even greater in northern Syria, and particularly Badia region, as the livestock sector is the primary source of income (WFP 22/10/2020, Qatar Charity 29/09/2020).

Farmers also suffered from the lack of agricultural inputs, especially the lack of high-quality wheat seeds (OCHA 18/11/2020), and/or high costs of these inputs, with for example pesticide prices recording a 100% increase in Hama governorate, northwest, early April (FAO 10/04/2020).

Lower production of wheat in 2020

While Syria cultivates various crops across the country (barley, cotton, tobacco, sugar beet, lentils, chickpeas, fava beans, peas, vegetables, citrus fruits, olives and herbs), its main staple has been wheat. Up to 40% of wheat grain is cultivated in Al-Hassakeh governorate, with Ar-Raqqa, Aleppo, Hama and Homs governorates contributing to most of the rest. However, over the past years, Syria has been experiencing a wheat deficit, not producing enough wheat annually to meet the food needs of its population, estimated to be of 3.7 million tonnes. In 2019, wheat production was about 60% of its requirements (2.2 million tonnes), and in 2020, the production is estimated to be about 2.8 million tonnes: 2 million tonnes produced in the northeast and only around 800,000 tonnes produced in GoS-controlled areas (WFP 22/10/2020, FAO 01/09/2020). Only 58% of the population's minimum bread needs are being met, highlighting the need for significant imports to meet the national demand. According to the Syrian Prime Minister, the amount of wheat purchased from the country's farmers was only sufficient for bread production until mid-December (Middle East Monitor 29/10/2020). Military escalation in 2020, especially in the northwest, also led to loss of farming and cropping land, which limited crop production, and further increased input prices (Food Security Cluster 23/09/2020). As a result of lower agricultural production, incomes and assets of farmers have been heavily affected.

Nutrition

Nutrition needs pre-COVID were already high

In 2020, approximately 4.7 million people were in need of nutrition assistance, most of which under-five children (Save the Children 28/09/2020). About 500,000 children were reported suffering from stunting (Save the Children 28/09/2020), with even higher proportions in the northwest, where almost 3 in 10 under-five children under the age of five were affected (Food Security Cluster 23/09/2020).

Rising cases of malnutrition

Monthly nutrition surveillance data has shown a clear deteriorating nutrition situation in **northwest** Syria, with increasing levels of both acute and chronic malnutrition, particularly among IDPs (OCHA 18/11/2020). In northwest Syria, the prevalence of chronic malnutrition among under-five children increased from 19% to 33% between May 2019 and September 2020, while the prevalence of acute malnutrition doubled over the same period, now reaching the serious emergency standard of 2%. For Pregnant and Lactating Women (PLW), proxy prevalence of acute malnutrition across northwest Syria is at 11%. Rates are generally higher among displaced persons for both under-five and PLW. Prevalence of acute malnutrition is the highest in Idlib, with 4% reported among under-five and 20% among PLW, while being the lowest in Aleppo, with 1% acute malnutrition among under-five and 2% among PLW (OCHA 21/10/2020). Other data from more than 30 health facilities in the northwest confirm these increases: severe acute malnutrition was reported at 1.3% in January and reached 5.7% in July, before witnessing a slight decrease in August. Cases of moderate acute malnutrition also were reported to be on the rise, from 4.7% in January to 8.7% in July (New Humanitarian 28/10/2020). Further economic downturn may potentially cause further deterioration of the nutrition situation during the second half of 2020 (OCHA 21/10/2020).

COVID-19 disruptions and worsened economic conditions are driving nutrition needs

Even before the pandemic, suboptimal child feeding practices, high maternal malnutrition and poor care practices, as well as high levels of conflict and insecurity, food insecurity, and lack of access to health facilities contributed to the poor nutrition status of the population (OCHA 10/09/2020). COVID-19 related disruptions, leading to dysfunctional markets, worsening economic conditions, limited livelihoods opportunities, inflation, low purchasing power, increased food insecurity, and further reductions or disruptions of health and WASH services further exacerbated the situation (OCHA 21/10/2020, IRC 22/10/2020).

With increasing levels of food insecurity throughout 2020, as a result of COVID-19 disruptions and related worsened economic conditions, diet quality and diversity have likely been deeply affected. Studies have shown that food-insecure households consume less meat and fewer fresh fruits and vegetables; a practice that, if prolonged, can result in higher risk of stunting or chronic malnutrition among children (Save the Children 28/09/2020, FAO 2020). In **government-held areas,** fewer than 42% of under-two children are consuming an adequately diverse diet, with even lower rates reported in Deir-Ez-Zor governorate and in high-displacement settings, such as in Idlib governorate (Save the Children 28/09/2020). According to a survey conducted by Save the Children, 65% of children have not had an apple, an orange,

or a banana for at least three months; in the **northeast**, almost a quarter of children said reported not having eaten these fruits in at least nine months (Save the Children 28/09/2020).

Low levels of breastfeeding potentially exposing children to further health risks

High rates of artificial feeding have increased vulnerability to respiratory and other diseases at a time where immune support is vital as diseases have become more common and frequent displacement is leading to overcrowded and unsanitary conditions (Save the Children 28/09/2020). Estimates indicate that, globally, one third of all respiratory infections and half of all cases of diarrhea could be avoided if all children were breastfed (The Lancet 30/01/2016). In Syria, only 28% of infants are exclusively breastfed during the first six months of their life (SMART Survey 2019). Rates are even lower in some areas: findings from an assessment conducted in Dara'a in 2019 show that just 3% of infants are exclusively breastfeed in some communities (HNO 2019).

Only half of people in need of nutrition treatment has been reached

Critical gaps in nutrition treatment remain with only 50% of people in need of nutrition treatment for moderate acute malnutrition have been reached as of October 2020. The proportions are higher for the provision of micronutrient supplementation (66%) and prevention of acute and chronic malnutrition (67%) (OCHA 18/11/2020). On-the-job training and supervision of frontline staff remains a challenge due to COVID-19 related restrictions, preventing a rapid scale-up of the nutrition response (OCHA 18/11/2020). In addition, mid-September, humanitarian agencies warned of continued shortages of malnutrition treatment supplies, likely resulting in even less people treated in the coming months (USAID 29/09/2020).

WASH

Poor coverage and quality of WASH infrastructure, heavily impacted by nearly a decade of conflict, coupled with insufficient income to buy hygiene items, drive up WASH needs. Gap analysis indicates that across 27 sub-districts, 1.3 million people lack some form of WASH services (OCHA 21/10/2020).

More than 1.3 million people in need of WASH services

Gap analysis reported by WASH cluster's partners indicates that, across 27 sub-districts, 1.3 million people lack some form of WASH service, including water trucking (156,278 people), connection to piped water networks (1,041,343 people), latrine construction and sewage network rehabilitation or construction (179,393 people), solid waste removal services (454,641 people), and hygiene kit distributions (62,787 people) (OCHA 21/10/2020). Most of these gaps are in Dana sub-district (31%) followed by Idlib (21%), Maaret Tamsrin (12%) and Atareb (9%). As not all partners provided information, the WASH cluster expects actual gaps to be even higher (OCHA 18/11/2020).

Inadequate infrastructure further exposing people to the virus

While water, sanitation and garbage disposal infrastructure are back to working to pre-COVID-19 levels mostly everywhere across Syria (HNAP 20/10/2020), their coverage and quality are still not enough to cater for everyone's needs, after a decade of conflict.

In the **northwest**, only 57% of water stations are functioning, of which 18% are not disinfecting their water. Observations from sites in 27 sub-districts indicate that 33% of locations receive less than 30 litres of safe water per day and 58% of locations have insufficient chlorine levels in drinking water, a proportion that drops to 34% across 83 IDPs sites. However, in densely-populated camps, 70% of IDPs continue to rely on humanitarian organisations to provide trucked water on a daily basis. Recent assessments have shown that 78% of IDPs did not have access to sufficient water during the past month, compared with just 6% in communities and neighbourhoods, reflecting the greater reliability of water services through networks compared to water trucking. Without electricity, water stations continue to be operated through costly diesel generators, with the cost of fuel accounting for an estimated 30% of the total WASH Cluster expenditures (OCHA 18/11/2020). 80% of assessed sites did not receive hygiene kits in the past three months. In terms of handwashing, 22% of camps did not have soap, 18% did not have a hand washing facility and 2.5% did not have either soap or water (OCHA 18/11/2020).

This unreliable water supply increases the risk of COVID-19 transmission, as additional water is needed for COVID-19 mitigation measures such as more frequent cleaning and handwashing (Al-araby 20/11/2020, USAID 11/09/2020). Thousands more cases of water-borne diseases were reported in September 2020 compared to the same month in previous years, with hotspots in Ar-Ra'ee and Jarablus sub-districts, reflecting the poor quality of insufficient WASH infrastructure (OCHA 21/10/2020). Ar-Raqqa city, a densely-populated city, could see an explosive situation and soon become an hotspot after few cases have already been reported, while access to water and sanitation is poor and health services scarce (MSF 27/08/2020).

Regarding sanitation, across 27 sub-districts, average latrines coverage is one for every 103 persons, 41% of locations have a coverage of more than 50 persons per latrine, and in 19% of locations latrines are not segregated by sex (OCHA

21/10/2020). In camps, according to assessments in September across 83 IDPs sites in Badama, Darkosh and Maaret Tamsrin sub-districts, on average 63 people share one latrines and latrines are not disaggregated by sex in 10% of the sites (OCHA 18/11/2020).

In the **northeast**, continual disruptions to the Alouk station are concerning given the rapid increase in COVID-19 cases across the region for which communities require reliable access to safe water to prevent further spread of the pandemic (OCHA 28/08/2020). Water supply from Alouk was interrupted at least 13 times this year, due to Turkish forces and proxies deliberately cutting access to the pump, impacting some 460,000 civilians in Al-Hassakeh governorate (OCHA 27/08/2020). While, as of 31 October, the water station was reportedly functional at almost 90% of its capacity, concerns remain about future potential cuts (SANA 31/10/2020). The Head of the Al-Hassakeh Health Directorate announced more than a thousand cases of diarrhea in August due to water coming from contaminated wells, further overwhelming health centres in the area (OCHA 28/08/2020). Additionally, waste management systems in northeast Syria are not equipped to handle the waste produced by the COVID-19 response (NES Forum 13/09/2020).

Limited access to hygiene items

While surveys show that practicing good hygiene, such as handwashing, is the most widely adopted measure (75%) to protect oneself against the virus (GTS & HNAP 27/08/2020), access to hygiene items are restricted.

Need of soap and water remains high for NSAG controlled areas, where community focal points report that 75% of the population is in need. Half of the population is reported in need of soap and water in SDF areas, and this rate drops to less than 40% in government-controlled areas. Need of masks and disinfectants is high across the areas, with more than 55% of sub-districts having a majority of communities in need in government-controlled areas, more than 70% in SDF areas and more than 75% in NSAG & TBAF areas, according to community focal points (HNAP 18/11/2020).

In 69% of locations assessed in the **northwest**, affected populations had no access to hygiene kits in the past three months (OCHA 21/10/2020). While availability of hygiene items, such as soap and sanitizer, is not reported to be an issue within **northeast** Syria with alcohol solution being present in 96% of locations assessed, gloves in 89%, hand sanitizer in 87% and masks in 83% (Cash Working Group 07/09/2020), access to such items seems to be difficult among the population.

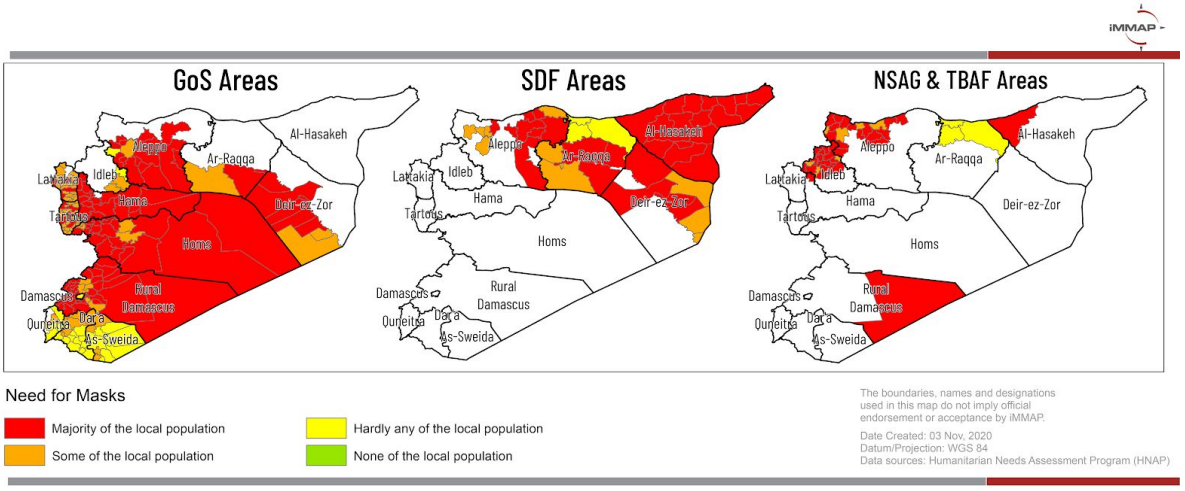
Overall in Syria, 63% indicated that the main barrier to adopt preventive measures was insufficient income to be able to stop working and to buy hygiene items (REACH 25/08/2020). On average, across Syria, the prices of hand gel, alcohol spray, bleach and soap have increased significantly since February yet have stabilized between September and October (WFP 10/2020).

Table 4 - COVID-19 items prices, SYP (WFP 10/2020)

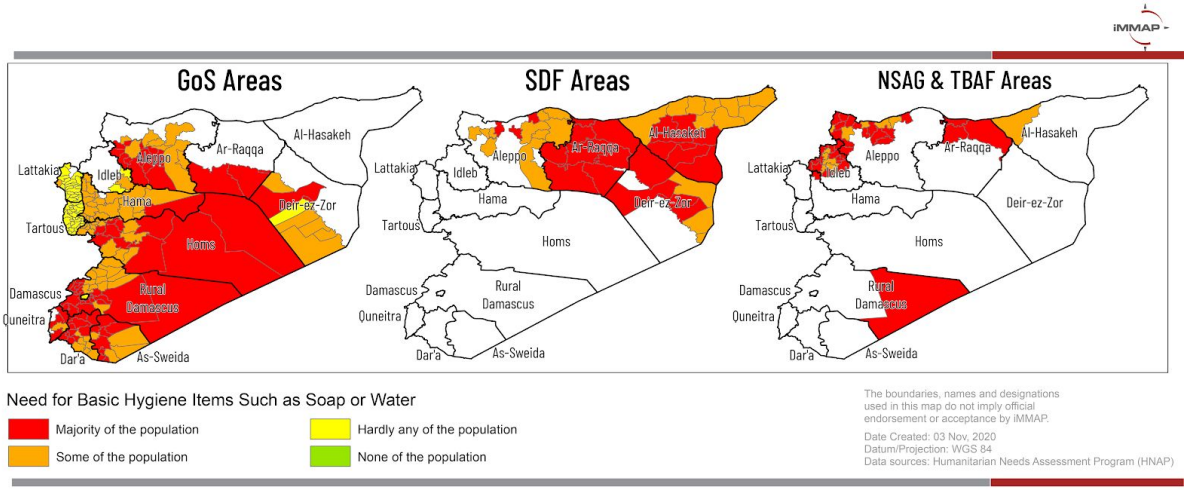
Commodity	February avg.	September avg.	October avg.	% Change (Sep-Oct)
Surgeon mask	79	371	344	-7%
Gloves (pair)	67	334	328	-2%
Alcohol spray (200ml)	418	1,608	1,564	--3%
Bleach bottle (L)	416	1,053	1,074	+2%
Hand gel (50ml)	241	927	936	+1%
Soap bar	149	373	357	-4%

58% of communities in Syria reported an increase in spending on WASH items between August and September 2020 (HNAP 09/2020). The average SYP cost of 1000L water trucking remained mostly steady in this time period (along with the SYP to USD exchange rate), yet remains far more expensive in northeast Syria (3,576 SYP) than in the northwest (1,416 SYP) and in Government-controlled areas areas (1,478 SYP). In **northwest Syria**, while prices of soap decreased by 20% between July and August, it still remains at too high of a cost to be affordable by 47% of assessed communities (REACH 17/09/2020, REACH 07/09/2020). Despite water price remaining steady, it is still unaffordable for many in the northwest yet the main source of water for assessed communities (REACH 19/10/2020). In **northeast Syria**, increased demand for items, such as soaps and disinfectants, drove up prices by 13% between July and August (REACH 17/09/2020). In As-Sweida, in southern Syria, the prices of water tanks (quantity not listed) range between 5,000 SYP and 8,000 SYP, a price not affordable by many people (Enab Baladi 26/09/2020).

Map 9: Need for masks as reported by community focal points (HNAP 17/11/2020)[12]

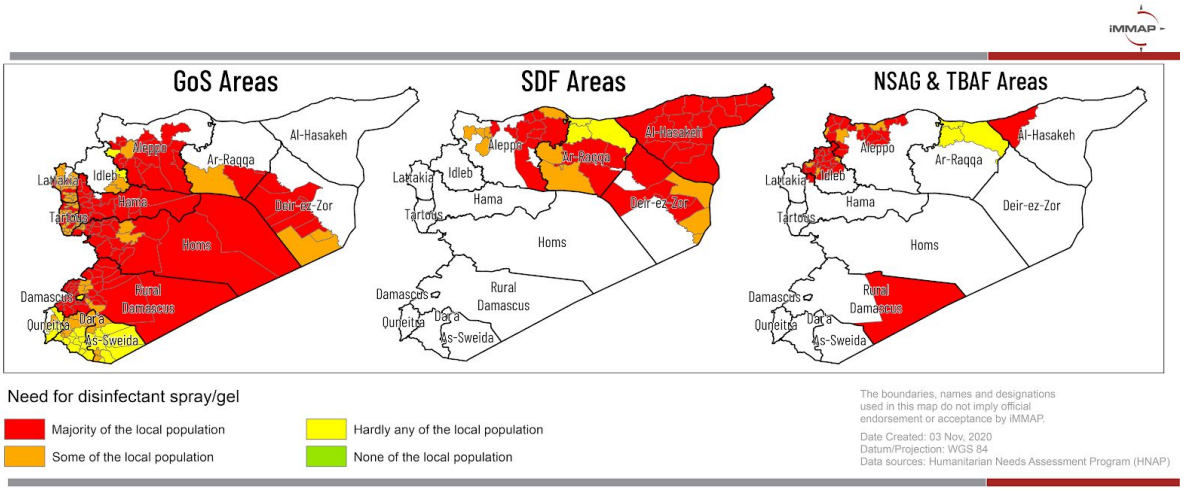


Map 10: Need for basic hygiene items such as soap or water as reported by community focal points (HNAP 17/11/2020)[12]

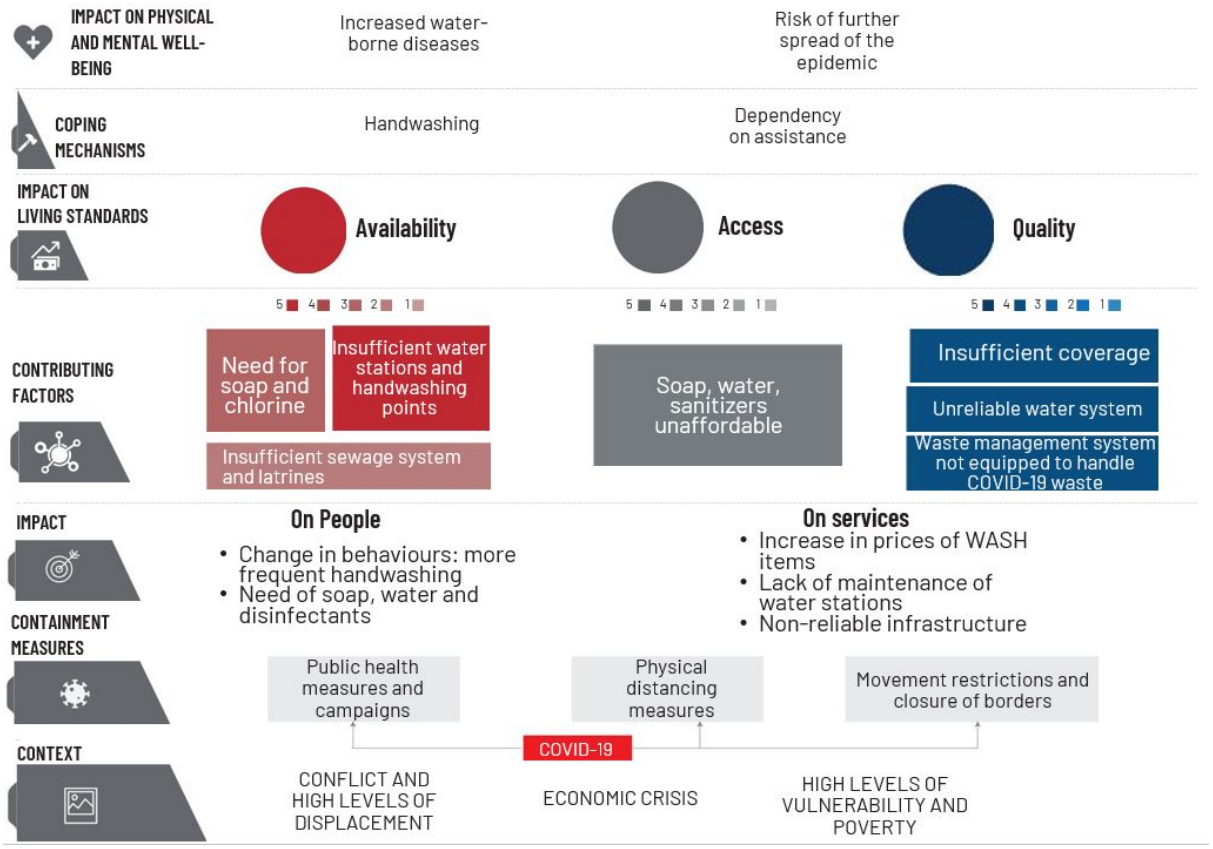


[12]The maps display entire sub-districts where community focal points were surveyed and do not represent areas of control. Source reports and methodology are available from the Humanitarian Needs Assessment Program (http://hnap.info).

Map 11: Need for disinfectant spray/gel as reported by community focal points (HNAP 17/11/2020)[12]



Problem tree



Protection

Protection issues, such as child labor, early child marriage, and gender-based violence, and negative coping mechanisms are on the rise, exposing children, women and the elderly to further threats.

Increased child protection issues

Children who have already been through extremely distressing episodes, fleeing war and persecution and seeing relatives killed, are now going through another traumatic episode that, unless tackled, can lead to serious long-term mental and physical illnesses. According to a study by NRC conducted in Syria, Iraq, Yemen and Jordan among displaced children in July, 88% of children said they were stressed because of COVID-19, of which 75% of them feared catching the disease and 48% fearing their loved one could get the virus. On average, children in Syria reported feeling 42% more stressed than before the pandemic, often due to fear of themselves or loved ones getting the virus, and because they have to stay home. The pandemic is also forcing most children to look after younger siblings, taking on adult responsibilities that are denying them of their childhood. When asked how they were spending their time, the highest number of children (42%) surveyed in the region said they were looking after their brothers and sisters. With many displaced families living in one-room homes, caravans or tents, this is leading to even further stress for many children (NRC 01/09/2020). According to interviews conducted by Women Now in Idlib and Aleppo governorates in May, 40% of women reported giving more chores to girls (Friedrich Ebert Stiftung 01/07/2020).

Increase in reports of child labour, forced prostitution, and early marriage

As the economic downturn increasingly impedes the ability of households to meet their basic needs, negative coping mechanisms are increasingly being adopted, and children have been particularly exposed to protection risks due to school closure (OCHA 26/06/2020). Child laboor, forced prostitution, forced abortions and early and forced marriages are reportedly on the rise (OCHA 10/09/2020). Child labour was a reported major protection issue faced by residents and IDPs in more than three quarters of the communities (Aleppo, Al-Hassakeh, Ar-Raqqa and Deir-ez-Zor governorates). Indeed, when income sources were not sufficient to meet basic needs, sending children younger than 15 years old to work or beg was common among residents and IDPs, as indicated by key informants in more than half of the 1,209 assessed communities (REACH 01/06/2020). As the reports of child labour were increasing during the period when schools were closed, it remains unclear if this trend is going to continue now that schools have reopened. For children from already poor and food-insecure households, the negative effects of the crisis, including extended school closures and missing out on school meals, could have lifelong effects and further perpetuate the vicious cycle of poverty and inequality (FAO & WFP 01/07/2020).

Gender-based violence instances increasingly reported

In the wake of the crisis in Syria before COVID-19, gender-based violence (GBV) had become somewhat normalised, continuing to impact women and girls throughout the country often through sexual violence, restriction of movement, forced and early marriage, and family and domestic violence, with all types of GBV unabated through 2019 and with new

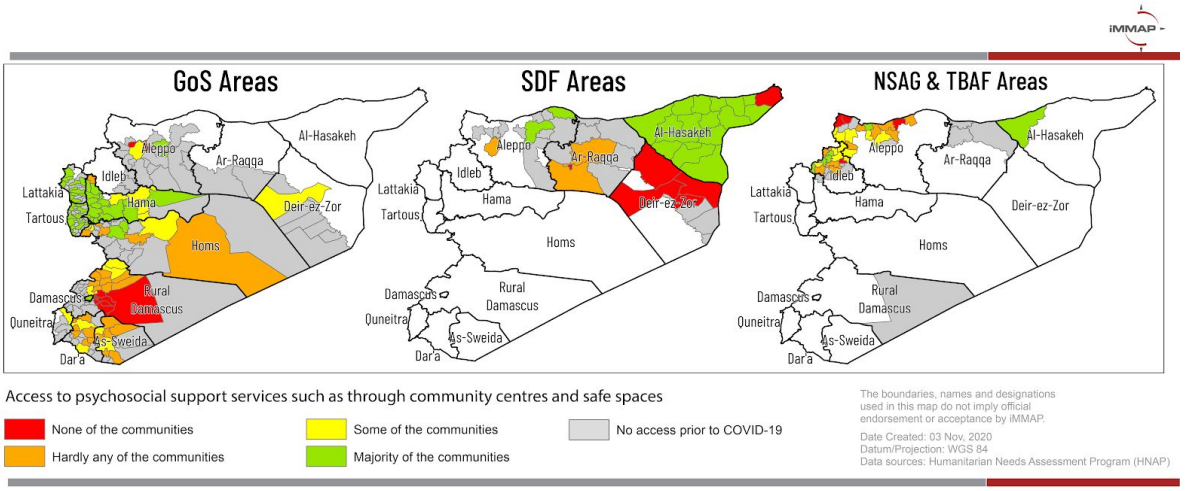
trends emerging - such as forced early puberty with hormones before early forced marriage (UNFPA & GBV AoR 2/4/2020). Forms of GBV were identified as becoming more prevalent as a result of families being forced to live together due to massive displacement and insufficient space in IDP settings, and so the increased confinement resulting from containment measures throughout the year are of critical concern: Extended quarantines, curfews and other movement restriction measures have led to increased reports of domestic violence due to forced coexistence in confined living spaces, exacerbated by the additional anxieties arising from the pandemic, including those related to the economic and health consequences (UNFPA 01/05/2020). Significant increases in different types of gender-based violence are being reported, particularly incidences of domestic violence such as marital rape, physical and emotional violence and denial of resources, with girls and women with disabilities and pregnant women especially vulnerable (OCHA 13/07/2020). According to interviews conducted by Women Now in Idlib and Aleppo governorates in May, 17% of women participants had reported being victims of gender-based violence, of which few attributed it to the pandemic and subsequent preventive measures (Friedrich Ebert Stiftung 01/07/2020). A number of media reports have also discussed a rise in cases in the capital Damascus (Friedrich Ebert Stiftung 01/07/2020, The national news 06/08/2020). The gender-based violence (GBV) area of responsibility is also reporting families marrying off their daughters repeatedly for short periods of time in exchange for money (OCHA 13/07/2020). GBV partners continue to report that male adolescents are exposed to sexual abuse, especially in orphanages, and note an increase in rates of sexual harassment and abuse against children, especially by other children (OCHA 21/10/2020). Isolated but increasing reports of suicides, including of young women, are received (OCHA 21/10/2020).

Increased reports of GBV instances may be indicative of increased accessibility, availability and quality of support services and report mechanisms, as restrictions and enforcement are relaxed, and services adapt to operating in a COVID-19 context (UNFPA & GBV AoR 26/4/2020). Therefore increased reports of GBV do not necessarily evidence increasing prevalence, the measurement of which is challenged by barriers such as lack of trust in and stigma attached to disclosing incense to private or public actors (UNFPA & GBV AoR 2/4/2020). Similarly, as services and reporting mechanisms can differ across areas and regions, reports of types of GBV occurring in one can typically be expected to also be happening in others.

Reduced Gender-based violence support services

Restrictions of movements and forced quarantine measures are impeding GBV and violence against children survivors' access to services. Schools, community centers, Child Friendly Spaces and Women and Girl Safe Spaces were significantly scaled down due to COVID-19 precaution measures. This has also made it more difficult for women and girls to disclose incidents and seek GBV services as well as for children affected by violence to be identified (OCHA 10/09/2020). By 17 November, only 14% of psychosocial support structures were reportedly fully available in NSAG & TBAF areas. In GoS and SDF areas, while this rate was higher, it still remains well below pre-COVID levels, with 21% and 37% structures available respectively (HNAP 17/11/2020). Although some GBV prevention and response activities have continued to be provided, safety measures related to COVID-19 (usage of online sessions, fewer beneficiaries per session) have caused services to be accessible for a smaller number of beneficiaries (OCHA 26/06/2020). In **northwest** Syria, some women are reported to leave their abusive relationships, but lack safe shelter elsewhere (OCHA 21/10/2020).

Map 12: Access to psychosocial support services such as through community centres and safe spaces as reported by community focal points (HNAP 17/11/2020)[13]



Gender and social inequalities may be exacerbated, leading to higher food needs among women

Due to loss of income, adult households members have had to use negative coping mechanisms to cope with their food needs. This may exacerbate discriminatory gender and social inequalities, with girls and women receiving less food than male household members, negatively impacting their nutritional status (Save the Children 29/09/2020). However, the proportion of households mentioned relying more frequently on this coping strategy has decreased from 48% in July to 39% in August (WFP 28/09/2020).

Stigma keeps people from reporting symptoms and seeking treatment

COVID-19 and widespread fears of infection are causing social pressure, distress and increasingly social stigma. As a result of stigmatisation, bullying, social exclusion, prevention from entering shops or even leading to women being rejected by their spouse in extreme cases have been reported (Protection Cluster 27/11/2020, The Independent 26/08/2020). Social stigma associated with COVID-19, alongside pressure to maintain income and livelihood, is reportedly inducing people to hide symptoms and avoid seeking treatment or self-isolating (Protection Cluster 27/11/2020, OCHA 21/10/2020).

In the **northeast**, Al-Hassakeh goernorate, a majority (89%) of respondents reported that COVID-19 is generating discrimination, mostly against COVID-19 positive persons (84%) or suspected to have COVID (30%) but also health workers (37%) (REACH 22/10/2020). Reportedly, the COVID-19 hotline in northeast Syria was not being used by patients as they did not want their neighbours to see the ambulance and spread rumours (Medglobal 14/10/2020).

[13]The maps display entire sub-districts where community focal points were surveyed and do not represent areas of control. Source reports and methodology are available from the Humanitarian Needs Assessment Program (http://hnap.info).

In the **northwest**, these proportions are overall lower compared to the northeast, with 66% of respondents believe that COVID-19 is generating discrimination, mostly against COVID-19 positive persons (50%) or suspected to have COVID (30%), but also against health workers (20%) (REACH 22/10/2020). However, findings from 28 focus group discussions among 140 participants in Aleppo and Idlib, northwest Syria, found that feelings and thoughts of fear, anxiety, deep concern, and panic, as well as shame and necessity to avoid people infected with the virus were reported in all focus groups, by all gender and displacement status and locations. While IDPs living in sites were supportive of the idea of quarantine centers given the challenges of self-isolation in camps, participants living in non-camp locations all preferred home-isolation to minimize exposure to community's stigmatization and blame, revealing how rampant stigmatisation and fear of discrimination has been (Protection Cluster 27/11/2020).

Women at higher risk of discrimination

Social pressure and stigma is even heightened for women, as they are considered by their community to be primarily responsible for the health and well-being of their families and the main duty-bearer of all house chores (OCHA 21/10/2020). Indeed, women participants in the protection focus group discussions reported being under great pressure to keep their family members, including children and elderly, safe from infections, due to community expectations. They reported that an infection in the household would be directly associated by the community and family members with a lack of cleanliness of the house for which women are responsible for. Both male and female participants reported a fear of disgrace if women in the household were to be infected, as it would be interpreted as the women or girl in question had been in unsafe environments, resulting in the women and her family being ashamed, socially excluded or bullied, and could even lead to the women being rejected by the spouse in extreme cases. Findings also show that their absence for a prolonged period of time, if isolated, could become such a serious domestic issue, that women hide their symptoms (common cold, flu, COVID-19…) from their family members to avoid tension and blame within the households and avoid stigmatisation and exclusion from their communities (Protection Cluster 27/11/2020).

Healthcare workers also stigmatised

Findings from this same assessment also highlighted that healthcare staff are also increasingly the target of stigma, as perceived and referred to as "spreaders" of the virus, and are even facing bullying (Protection Cluster 27/11/2020).

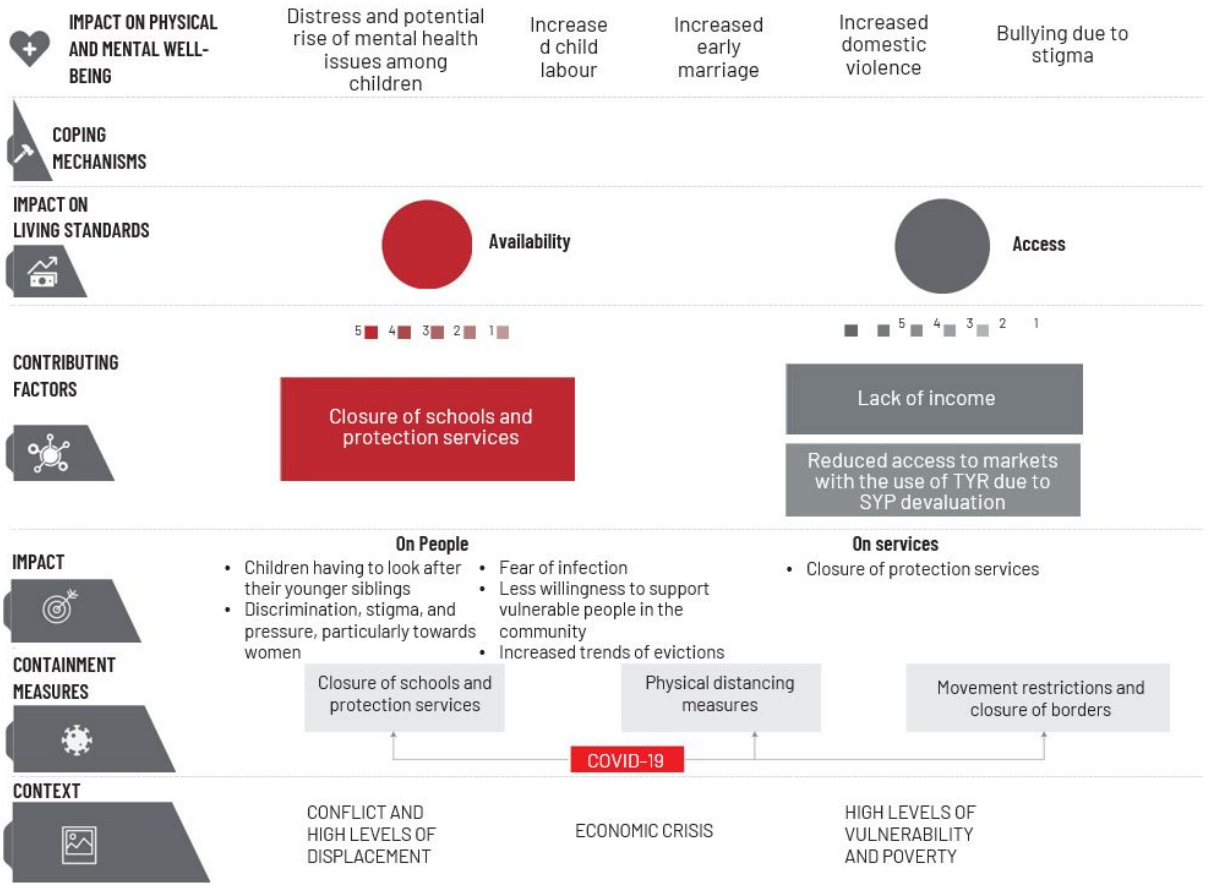
Less willingness to support others, leaving vulnerable people even more at risk

In the **northwest**, findings from focus groups discussions, negative perceptions towards people seen at a higher risk of infections, such as elderly or people with disabilities, have been growing. Male participants indicated hesitations to engage or assist these populations. It also highlighted that community support systems are weakening, with an overall gradual reduction in willingness to support others due to risk of COVID-19 infection, leaving elderly and vulnerable households, such as female-headed households, households without access to humanitarian assistance, or households without stable livelihoods or income even less able to cope (Protection Cluster 27/11/2020).

Increased trends of forced evictions

In the **northwest**, with basic commodities now reportedly priced in Turkish Lira (TRY), people without adequate access to this currently will further be excluded from markets. This has already been reported, with an increasing trend of reports of forced evictions of households unable to pay their rent in TRY (OCHA 21/10/2020).

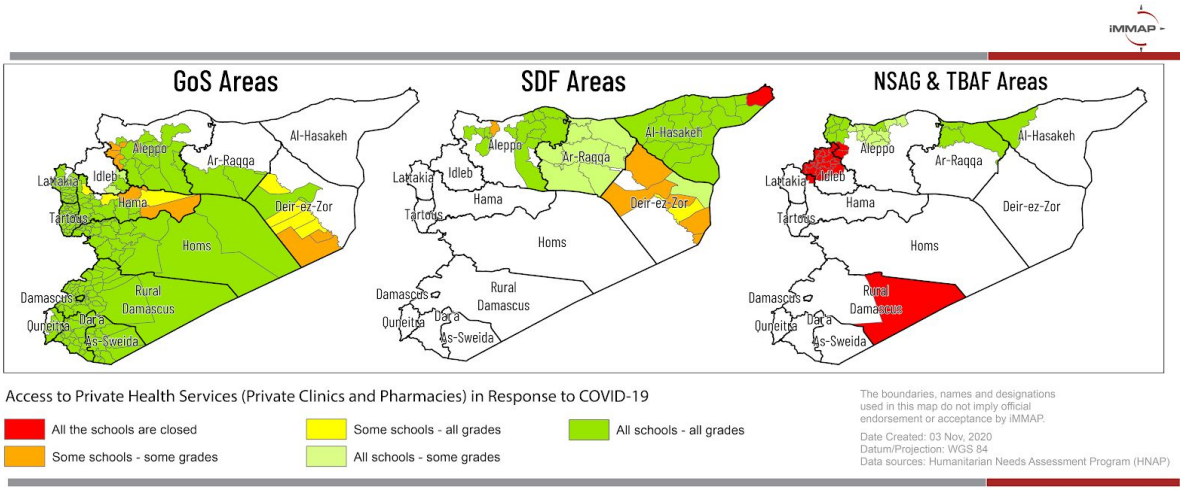
Problem tree



Education

After more than 6 months of closure, schools reopened mid-September in **Government-controlled areas** territories, with more than 3.8 million students returning to school, and late September in the **northwest** for 820,000 students and in the **northeast** (The Syria Report 30/09/2020, Syrian Observatory of Human Rights 24/09/2020, The Syria report 16/09/2020). It remains unclear how the prolonged school closure will influence attendance and school drop-out rates, as well as the quality of education.

Map 13: Access to education in response to COVID-19 as reported by community focal points (HNAP 17/11/2020)[14]



Cases are rising following schools re-opening

Notably due to the increased COVID-19 cases, as well as deteriorating security situation in some locations, more schools are closing either fully or partially (OCHA 18/11/2020). Following school re-opening in **Government-controlled areas,** concerns are rising regarding the number of positive cases already recorded in schools. Almost one quarter of tests conducted among school children and personnel in end September-early October came back with positive results (The Syria Report 07/10/2020). As of end October, the Ministry of Health reported 303 confirmed COVID-19 cases among school children and staff, of which three passed away, including one teacher in Lattakia, one school cleaner in Damascus, and one student (WHO 29/10/2020, The Syria Report 07/10/2020). Due to the high number of cases reported in Aleppo city among students and teachers, three schools were closed on 8 November (The Syrian Observer 09/11/2020). However, 91% of educational facilities remain fully open in government-controlled areas as of 17 November according to HNAP (HNAP 17/11/2020). In the **northwest**, a significant increase of positive cases has also been noted among students and teachers, following the reopening of schools in September. Due to the sharp increase in cases in Idlib governorate and sub-district, local authorities closed schools again early November (OCHA 18/11/2020). Only 27% of educational facilities were reported fully open in NSAG areas and 20% partially as of 17 November (HNAP 17/11/2020). In SDF areas, 59% of educational facilities were reportedly fully opened and 39% partially as of 17 November (HNAP 17/11/2020).

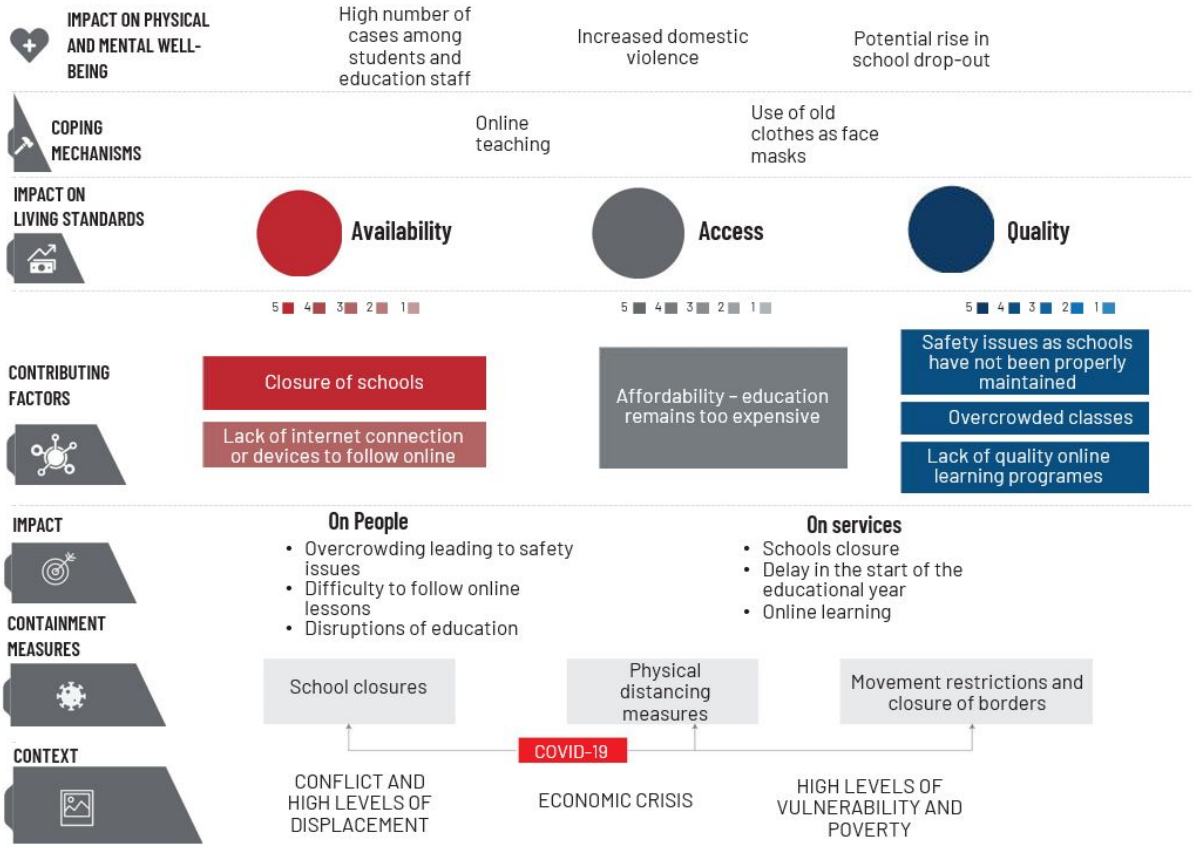
[14]The maps display entire sub-districts where community focal points were surveyed and do not represent areas of control. Source reports and methodology are available from the Humanitarian Needs Assessment Program (http://hnap.info).

Few alternatives to in-person education, such as distance learning, leaves students with no choice but to attend schools that already suffer fragile structures due to the war, which already resulted in one student killed in Homs and exposed others in Tartous to safety concerns (Syria TV 20/10/2020, Syria TV 18/10/2020). Following years of conflict and low maintenance or repair levels, there are limited educational facilities still functioning in Syria, leading to overcrowded classes. In light of the spread of the epidemic, more parents are now reluctant to send their children to school fearing they might become infected (WHO 29/10/2020, Syria TV 25/10/2020). As such, distance and blended learning support have been reported as the main priority, including provision of support to education personnel and teacher incentives and training for learning to be continued (OCHA 18/11/2020).

Affordability will now be a greater barrier to education

Before the closure of schools, affordability was already a main barrier for children to access education (OCHA 1/3/2019). Now with the loss and reduction of incomes, the weakening SYP, and increase in expenditures, child labour has become even more prevalent as a coping mechanism to meet basic needs. This suggests that while schools are now reopening, more children may be deprived of an education either to assist with generating income or because the associated expenses of education cannot be met, and could have a disproportionate impact on IDPs for which affordability is particularly challenging (REACH 22/07/2020), and for women and girls (see our Protection section). According to mVAM, in September, around 17% of interviewed households reported taking their kids out of school and to have them work instead, as they needed additional income (WFP 07/10/2020). In the **northwest**, authorities implemented mandatory facemasks wearing in schools, however without providing them for free to the students. Masks are available in local pharmacies for about 1 Turkish lira but remain out-of-reach for many households, leading to more school-children being taken out of schools (Al-araby 20/11/2020, The Washington Post 25/09/2020).

Problem tree



Shelter

Almost 6 million people in need of shelter

About 6.7 million people remain internally displaced in 2020 and an estimated 5.65 million people across the country are in need of shelter (HNO 2020). Poor shelter conditions are most prevalent in Idlib, Aleppo, Rural Damascus governorates, Ar-Raqqa city and in camps in the northeast and northwest. More than 33% of IDPs are living in inadequate shelter conditions, including emergency shelters, tents, damaged and/or unfinished buildings, public buildings such as schools, and other non- residential buildings (HNO 2020).

In the **northwest**, 1.5 million people, of which 79% are women and children, are living in 1,160 camps/sites that are often overcrowded with poor access to safe water (OCHA 21/10/2020). Of the three million people living in Idlib, nearly half live in makeshift homes and tents (Al Jazeera 02/11/2020). In the **northeast**, Al-Hol camp was originally designed to host a maximum number of 10,000 people, and is currently hosting close to 70,000 people, causing high levels of overcrowding (REACH 10/2019, WHO 03/2019).

Overcrowding and inadequate shelter expose IDPs to greater risks of COVID-19 infection

Crowded conditions in camps and poor access to basic services make it nearly impossible to properly adhere to physical distancing or other public health precautions (WHO in The Lancet 31/03/30, Al-Araby 20/11/2020, Human Rights Watch 15/10/2020). Cases have already been reported in camps, with 8% of the overall cases reported in camps in the **northwest** (OCHA 18/11/2020) and confirmed cases have also been reported in five separate locations in Al-Hol camps, in the **northeast**, highlighting the worrying possibility of an ongoing widespread infection among the community, where contact-tracing and isolation would not be sufficient to put an end to the transmission (NES Forum 05/11/2020). Inadequate shelter is estimated to increase the risk of illness and disease by 25% over the course of a person's lifetime, while overcrowded shelter conditions can greatly increase the spread of infectious diseases, putting those in need of shelter at greater health risks (Interaction 19/02/2020). Additionally, in displacement situations, intergenerational living is common, leaving elderly further exposed to potential contamination from other household members, with limited isolation possibilities.

Higher shelter and heating needs with the upcoming winter season

The health and safety impacts of overcrowding and living in damaged buildings will become even more acute during the winter season. 3.1 million people are estimated to be in need of winter assistance across Syria, with more dire needs among people living in camps, collective shelters, informal settlements and areas of high altitude and snowfall (Shelter & NFI Sector 17/11/2020). Critical gaps have also been identified in the informal settlements in the **northwest**, where most people recently displaced are living in tents and makeshift shelters, which will not withstand the harsher weather conditions. In the **northeast**, deteriorating, poorly isolated and overcrowded collective shelters will further expose the population to greater health risks with the winter season approaching. Inadequate shelters in high elevation areas frequently snowed are reported across the region, notably in Rural Damascus (Shelter & NFI Sector 17/11/2020).

Both fuel and electricity have become scarcer, and more expensive over the year. Coupled with widespread loss of income due to the COVID-19 crisis, this has been preventing people from accessing vital supplies and heating sources ahead of the winter season (Shelter & NFI Sector 17/11/2020, OCHA 21/10/2020). In the past, inaccessibility of safe heating solutions led to dangerous coping mechanisms, such as the burning of unsafe materials, which had resulted in outbreaks of fire in IDPs sites, as well as poisoned people due to the emission of toxic fumes (OCHA 18/11/2020). As prices of basic items have continued to increase, access to NFIs continues to be lifesaving, especially during winter when vulnerable families are unable to access basic items to keep them warm such as heating fuel, blankets and winter clothes.

Logistics

Fuel crisis leading to severe shortages and rise in prices

Syria domestic fuel production has not been able to meet the population's requirements, leading to external supply reliance. However, due to the closure of borders, delays in imports due to the COVID-19 context and the enforcement of US sanctions in June, external supplies of fuel have significantly decreased, leading to severe fuel shortages in the country in September. Planned maintenance work at the Banias refinery, responsible for two-thirds of all supply in government-held areas, has also severely impacted the availability of fuel in the country. (AP NEWS 17/09/2020, COAR 21/09/2020, Daily Sabah 22/10/2020, Mercy Corps 09/2020, VOA News 22/09/2020). The price of a litre of octane 95 petrol rapidly rose from SYP 575 in March to 850 in September due to limited availability of government-subsidised diesel (The Syria Report 14/10/2020), and the existence of an informal market for fuel demonstrates that the supply of government-subsidized fuel is not meeting the demand.

Fuel has become unaffordable for most households

In **Government-held areas**, the steep decrease in state-supplied fuel has led to an increase in demand on the black market, meaning that alternative market prices have skyrocketed, increasing on average by 172% for benzene, 42% for diesel, and 11% for gas canisters on average across government-held areas in less than a month in September. This price increase made fuel unaffordable for the majority of Syrians, forcing them to queue, for as long as thirteen hours, in order to buy fuel at more affordable subsidized prices (APNews 07/11/2020, Mercy Corps 30/09/2020).

In the **northwest**, limited households' purchasing power is further reducing their access to vital supplies for winterisation, such as fuel for heating (OCHA 21/10/2020). Despite decreasing since 10 November, prices remain higher than when they first began to be advertised in TRY five months ago. Per-litre prices for imported benzine (+26%), imported diesel (+23%), locally refined diesel (+23%) and gas cylinders (+30%) all increased between mid-June and mid-November (OCHA 18/11/2020).

Cost of transportation increased as a result, impacting food prices

With transportation costs rising due to fuel shortages and increased fuel prices, the cost of transporting goods to markets increased as well, further driving up essential items' prices, such as food and medicine, as rising transportation costs means increased costs of distribution which are passed on to consumers (OCHA 18/11/2020, Mercy Corps 30/09/2020).

Humanitarian actors have also been impacted

The fuel crisis affected the mobility and budget of 86% of humanitarian organisations in **Syrian government-held areas,** resulting in a rise in operational costs, as well as reduced field missions, impacting programme delivery and monitoring (Logistics Cluster 02/10/2020, Mercy Corps 30/09/2020).

Closure of border points leading to delayed shipments

The transit points within Syria are open and functioning for commercial trucks, allowing shipments to come through. The transit point from Gos to SDF and back, Gos to NSAG and back, Turkish back armed forces to SDF and back, Syria to Lebanon, Iraq, Turkey and Jordan all remain open for commercial trucks (HNAP 23/09/2020). However, due to the closure of border points and the reliance on a very restricted number of opened crossing points, humanitarian

shipments, most of which food, have been experiencing delays. Humanitarian actors also report higher costs and more complex logistics as a result (Food Security Cluster 23/09/2020).

Urgent road maintenance work due to increased traffic

In the **northwest**, given the increase in traffic from Bab Al-Hawa crossing point, the roads connecting Bab Al-Hawa to northern Aleppo require urgent rehabilitation to ensure continued access of humanitarian supplies through winter and beyond. A gap of some 10 kilometres out of 70 still needs to be rehabilitated to continue delivery of humanitarian and private supplies (Logistics Cluster 15/11/2020).

Procurement constraints

Limited market availability and reduced transportation have led to difficulties in procuring health supplies for both government authorities and WHO, preventing expanding testing activities across the country (WHO 29/10/2020). Due to the closure of borders and global procurement restrictions, the delivery of key laboratory supplies and medicines have been delayed in the **northwest** (OCHA 25/07/2020). Similarly, the procurement of basic medical items, such as PPE and medicine, has been heavily impacted in the **northeast** as the main sources were international, notably the Kurdistan Region of Iraq and international sourcing (NES Forum 01/10/2020, OCHA & WHO 05/07/2020). The latest US sanctions have also reportedly limited Syria's capacity to procure goods, leading to serious shortages in medicine (OCHA & WHO 01/09/2020).

Humanitarian actors' challenges in primary data collection and analysis

In addition to data collected in September, semi-structured interviews were conducted with five different cluster coordinators in December 2020.

Data collection activities in Syria in the COVID-19 context have faced numerous challenges, primarily affecting field-level data collection modalities and organisations' ability to gather data in a timely and efficient manner. Although primary data collection has continued, some assessments have been delayed, resulting in a lesser understanding of needs and made it difficult to evidence them when seeking funding or targeting assistance. However, the frequency of assessments increased during the second half of the year, due to the establishment of new modalities, as well as reductions in restrictions by authorities.

Assessment activity returning to pre-COVID-19 levels

At the field level, clusters and organisations working in Syria have had to significantly change the modality, scope and scale of data collection activities this year, as well as postponing some altogether due to the COVID-19 pandemic. While overall measures and restrictions put in place by authorities are becoming more relaxed and less enforced, challenges remain to ensure staff and communities are not at risk during data collection exercises. While during the summer there was an urgency to collect data quickly, as cases were rising and stricter measures were anticipated, there was some reluctance to place enumerators in the field to protect both staff and communities from possible infection. The restriction of data collection and operations to life-saving activities only, via directives from authorities and guidance from organisations at a global level, had also limited the scope and scale of assessments earlier this year and in some instances may have been used by authorities as an excuse to restrict the influence of humanitarian organisations in some areas. However, in the second half of the year, with an overall relaxation of measures, assessment activity as well as overall response have been increasing, albeit with updated methodologies to meet the new context.

Actors have now adapted to new data collection methodologies, yet still face key challenges in data coverage and quality

Alterations to the modalities of data collection to reduce risk of infection transmission among staff and populations persist, now with more established guidance, procedures, and conducted by teams that are now better equipped and more trained. Such modifications include conducting household-level interviews outside the home, for shorter periods, with the head of household only; conducting focus group discussions and key informant interviews remotely via phone or social media and messaging services such as Whatsapp; reducing the number of participants when data collection was done in parallel with aid distribution to avoid overcrowding, and instead increasing frequency and planning; dividing up focus groups in Women and Girl Safe Spaces into separate rooms but linked by video; reducing the amount of travel for staff; enforcing use of personal protective equipment; and developing plans in case of an enumerator or participant show symptoms. Assessments and operations are now also often coupled with COVID-19 risk communication and response, often including the distribution of information and/or PPE to respondents. But some of these measures have

been challenging to implement in settings such as in camps where overcrowding is hard to avoid, and have also reduced data quality and increased cost and time needed to collect the same amount of data.

Sharing and adapting guidance documents on collecting data in a COVID-19 context has been an effective strategy

In multiple instances, recommendations and guidance documentation developed by or for one organisation or setting has been successfully modified to support data collection for other organisations or in alternate settings and has been effective in saving time and to support rapid preparation for assessments. As more guidance documents, standard operating procedures, and similar products have been developed and applied particularly during the second half of the year, actors are now better equipped to more effectively plan or modify primary data collection initiatives.

However, there have been occurrences of some friction between different guidance when separate organisations, who had provided global directives to their staff in how to operate, had to collaborate on primary data collection or operations together or with authorities or national organisations, leading to some difficulties in creating plans that abide by the different recommendations. This extends also to conducting meetings as well as shared office and living arrangements, but has not significantly hampered primary data collection.

Mobilization of staff still difficult, yet coordination and analysis are now mostly back to normal

Mobilization, recruitment and relocation of staff have remained difficult with both international and national travel restrictions on individuals as well as humanitarian operations. Even in cases where humanitarian staff have had allowances or exemptions for restrictions, this often still requires additional processes or resources to arrange, with the amount varying significantly depending on the appropriate channels or authorities. This has been affecting both data collection teams in the field, as well as supporting staff working remotely either within or outside the country. The greatest impact has been on groups or organisations that were understaffed before the pandemic, further increasing the barrier to reach required staffing capacities as well as adequate and timely staff relocation. Coupled with the increase in time and resources required to train staff on COVID-19 related practices, this difficulty puts a strain on the ability of organisations to get staff where they need to be to conduct data collection safely and efficiently.

Coordination mechanisms and analysis activities are now less affected by movement restrictions and containment measures at the hub, country and global level with digital meetings and tools becoming the norm. However, communication with authorities via digital platforms, particularly where language translation is needed, has strained engagement and advocacy.

Delayed assessments have made fundraising and assistance targeting more challenging

Despite actors adapting to new modalities and assessment frequency and scope increasing, many of these assessments are delayed as they had been initially planned for earlier in the year and are happening now later than scheduled, due to restrictions and increase in resources needed. Actors now often have less information, and of a lesser quality, to inform

understanding of needs and in turn, evidencing funding requirements to donors has become more difficult and may result in less precise or delayed targeting of resources, and leading to additional difficulties in seeking funding.

What we are missing

The following section is based on 664 reports, briefings and articles reviewed. From the information collated and analysed, we are missing information related to the availability of epidemiological data, contributing impact of COVID-19 on humanitarian needs, as well as sectoral information.

Accurate epidemiological data

An accurate and harmonised number of COVID-19 cases and fatalities is not available, hampering the understanding of the true scale of the crisis. The reported number of COVID-19 cases are likely to be an underestimation of the real scale of the epidemic. There is a great difficulty to deploy efficient tracking, monitoring and response systems due to the economic crisis, impact of the ongoing conflict, the added operational difficulties due to COVID-19, and an under-resourced healthcare system. The inability of timely identification of COVID-19 clusters could lead to further spread of the epidemic.

Disruption to regular immunization programs is reported, yet we are missing data on the scope and scale of disruptions.

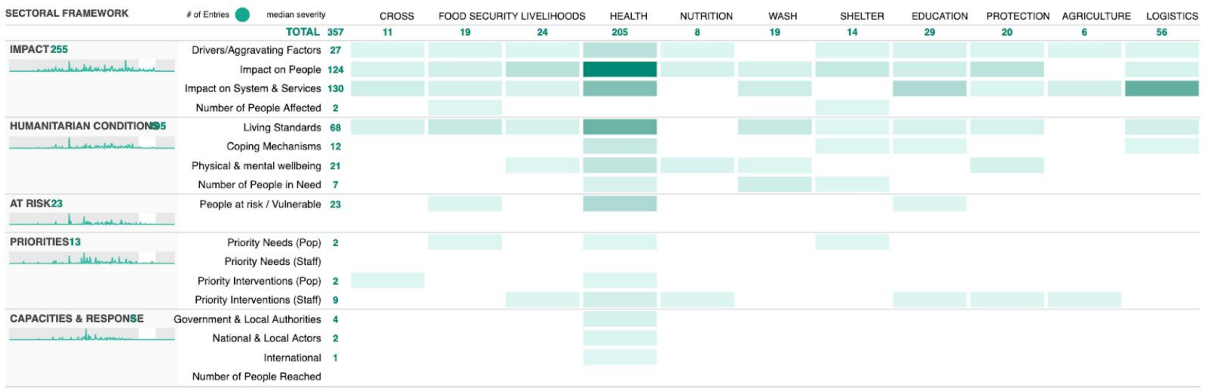
Quantification of COVID-19 impact on the deteriorated humanitarian situation

While increased disruption and unmet needs have been documented and reported since March 2020, the true extent of the COVID-19 impact on the humanitarian situation in Syria remains uncertain. It is unclear to which degree COVID-19 alone is playing a role in increasing the needs, or if the conjunction of multiple pre-COVID-19 factors, such as the economic crisis and the almost decade of conflict and political developments, are the main contributing factors to the deteriorated humanitarian situation.

Recent updates on COVID-19 information needs, channels and public perceptions in GoS-controlled areas

We know that the majority of surveyed focal points report that communities in their subdistrict have sufficient knowledge and awareness of COVID-19 risks. Yet we do not have recent data on what the information needs for those remaining communities may be particularly in GoS-controlled areas. Whereas in the northwest and northeast, where information on what to do after having symptoms or being tested positive is a main information need, it is unclear what gaps in knowledge persist in GoS-controlled areas that may aid in designing Risk Communication and Community Engagement (RCCE) initiatives. Similarly, while for example social media messaging has been identified as both a widely used and trusted source of information for northwest and northeast Syria, there is no recent update for levels of utilization and trust for different channels of communication that could inform the medium by which such RCCE initiatives can best utilize.

Figure 8: Number of tagged excerpts in DEEP for the COVID-19 Situation Analysis Project between 20 October and 22 November 2020 by Sector



SECTORAL FRAMEWORK	# of Entries / median severity	CROSS	FOOD SECURITY	LIVELIHOODS	HEALTH	NUTRITION	WASH	SHELTER	EDUCATION	PROTECTION	AGRICULTURE	LOGISTICS
	TOTAL 357	11	19	24	205	8	19	14	29	20	6	56
IMPACT 255	Drivers/Aggravating Factors 27											
	Impact on People 124											
	Impact on System & Services 130											
	Number of People Affected 2											
HUMANITARIAN CONDITIONS 95	Living Standards 68											
	Coping Mechanisms 12											
	Physical & mental wellbeing 21											
	Number of People in Need 7											
AT RISK 23	People at risk / Vulnerable 23											
PRIORITIES 13	Priority Needs (Pop) 2											
	Priority Needs (Staff)											
	Priority Interventions (Pop) 2											
	Priority Interventions (Staff) 9											
CAPACITIES & RESPONSE	Government & Local Authorities 4											
	National & Local Actors 2											
	International 1											
	Number of People Reached											

About this report

The OFDA COVID-19 support project is currently implemented by IMMAP and DFS in six countries: DRC, Burkina Faso, Nigeria, Bangladesh, Syria and Colombia. The project duration is twelve months and aims at strengthening assessment and analysis capacities in countries affected by humanitarian crises and the COVID-19 pandemic. The main deliverables of the project are a monthly country level situation analysis, including an analysis of main concerns, unmet needs and information gaps within and across humanitarian sectors.

The first phase of the project (August-November 2020) is focused on building a comprehensive repository of available secondary data in the DEEP platform, building country networks and providing a regular analysis of unmet needs as well as the operational environment within which humanitarian actors operate. As the repository builds up, the analysis provided each month will become more complete and robust.

Methodology. A comprehensive Secondary Data Analytical Framework has been designed allowing to address specific strategic information needs of UN agencies, INGOs, LNGOs, clusters and HCTs at country level. It is essentially a methodological toolbox used by Analysts and Information Management Officers during the monthly analysis cycle. The Analytical Framework:

- Provides with the entire suite of tools required to develop and derive quality and credible situation analysis;
- Integrates the best practices and analytical standards developed in recent years for humanitarian analysis;
- Offers end user's with an audit trail on the amount of evidence available, how data was processed and conclusions reached;
- Aligns with global efforts and frameworks.

The two most important tools used throughout the process are the Secondary Data Analysis Framework (SDAF) and the Analysis Workflow.

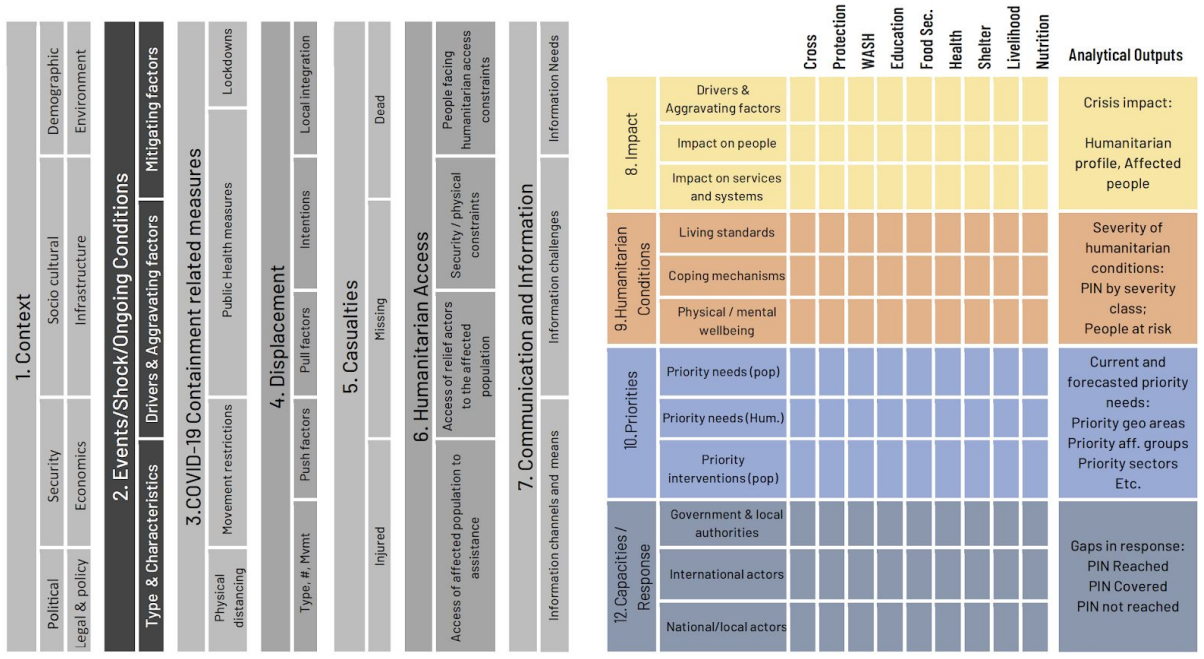
The Secondary Data Analysis Framework focuses on assessing critical dimensions of a humanitarian crisis and facilitate an understanding of both unmet needs, their consequences and the overall context within which humanitarian needs have developed and humanitarian actors are intervening. A graphic representation of the SDAF is available in figure 8.

On a daily basis, IMMAP/DFS Analysts and Information Management Officers collate and structure available information in the DEEP Platform. Each piece of information is tagged based on the pillars and sub-pillars of the SDAF. In addition, all the captured information receives additional tags, allowing to break down further results based on different categories of interest, as follows:

1. Source publisher and author(s) of the information;
2. Date of publication/data collection of the information and URL (if available);
3. Pillar/sub-pillar of the analysis framework the information belongs to;
4. Sector/sub-sectors the information relates to;
5. Exact location or geographical area the information refers to;
6. Affected group the information relates to (based on the country humanitarian profile, e.g. IDPs, returnees, migrants, etc.);
7. Demographic group the information relates to;

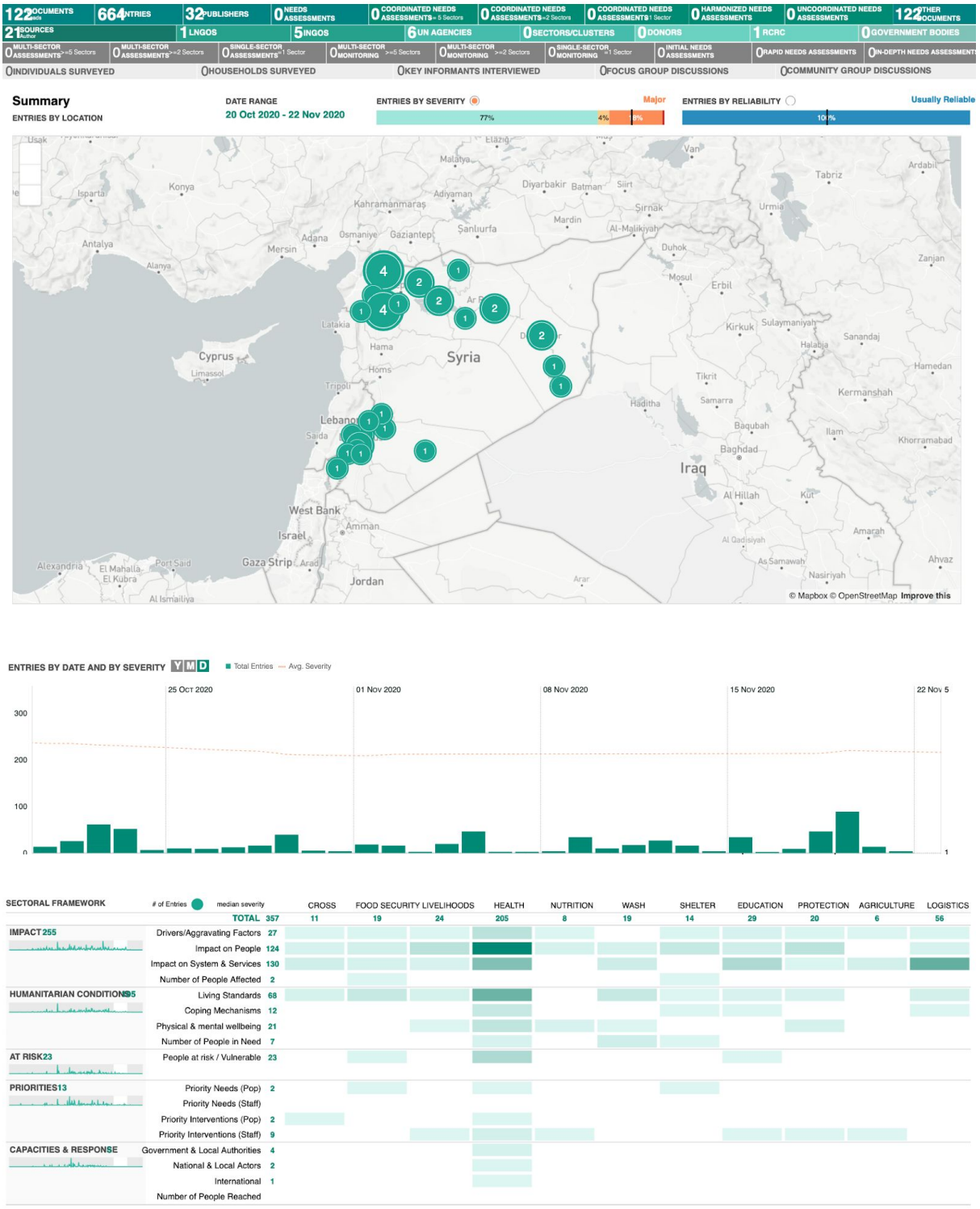
8. The group with specific needs the information relates to, e.g. female-headed household, people with disabilities, people with chronic diseases, LGBTI, etc;
9. Reliability rating of the source of information;
10. Severity rating of humanitarian conditions reported;
11. Confidentiality level (protected/unprotected)

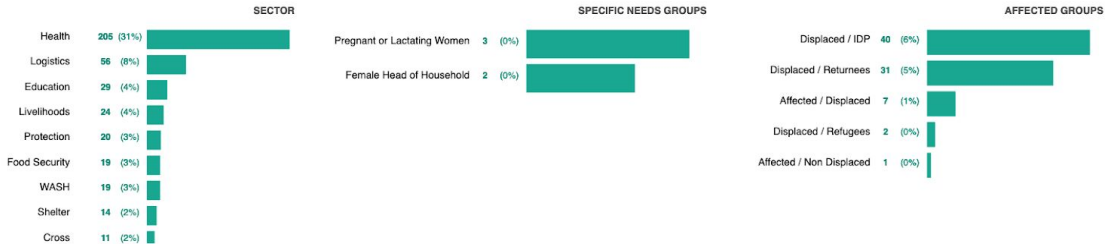
Figure 9 – Secondary Data Analysis Framework



The DEEP structured and searchable information repository forms the basis of the monthly analysis. Details of the information captured for this report are available on the next page:

Figure 4 - Information captured for Syria in DEEP between 20/10/2020 and 22/11/2020





Analysis Workflow. IMMAP/DFS analysis workflow builds on a series of activities and analytical questions specifically tailored to mitigate the impact and influence of cognitive biases on the quality of the conclusions. The IMMAP/DFS workflow includes 50 steps. As the project is kicking off, it is acknowledged that the implementation of all the steps will be progressive. For this round of analysis, several structured analytical techniques were implemented throughout the process to ensure quality results.

- The ACAPS Analysis Canvas was used to design and plan for the September product. The Canvas support Analysts in tailoring their analytical approach and products to specific information needs, research questions or information needs.
- The Analysis Framework was piloted and definitions and instructions set to guide the selection of relevant information as well as the accuracy of the tagging.
- An adapted interpretation sheet was designed to process the available information for each SDAF pillar and sub pillar in a systematic and transparent way. The Interpretation sheet is a tool designed so analysts can bring all the available evidence on a particular topic together, judge the amount and quality of data available and derive analytical judgments and main findings in a transparent and auditable way.
- Information gaps and limitations (either in the data or the analysis) were identified. Strategies have been designed to address those gaps in the next round of analysis.

Table 6 - iMMAP/DFS Analysis Workflow November 2020

iMMAP/DFS Workflow - October 2020					
	1. Design & planning	2 Data collation & collection	3. Exploration & preparation of data	Analysis & sense making	Sharing & learning
Main activities	Definitions of audience, objectives and scope of the analysis	Identification of 122 relevant documents (articles, reports)	Categorization of the available secondary data (664 excerpts)	Description (summary of evidence by pillar/sub pillar of the framework)	Report drafting, charting and mapping
	Key questions to be answered, analysis context, Analysis Framework	Identification of relevant needs assessments	Assessment registry (122 needs assessment reports)	Explanation (identification of contributing factors)	Editing and graphic design
	Definition of collaboration needs, confidentiality and sharing agreements	Data protection & safety measures, storage	Additional tags	Inerpretation (priority setting, uncertainty, analytical writing)	Dissemination and sharing
	Agreement on end product(s), mock up and templates, dissemination of products	Interview with key stakeholders	Information gaps identification	Information gaps & limitations	Lessons learnt workshop, recommendations for next analysis round
Tools	Analysis Framework	SDR Folder	DEEP (SDAF)	Interpretation sheet	Revised report template
	Analysis Canvas	Naming convention	DEEP (Assessment Registry)		Analytical writing guidance
	Data sharing agreements		Coding scheme		Lessons learnt Template
	Report template				

Contact

Global project manager:
Francesco Baldo
fbaldo@immap.org

Syria focal point:
James Whitaker
jwhitaker@immap.org