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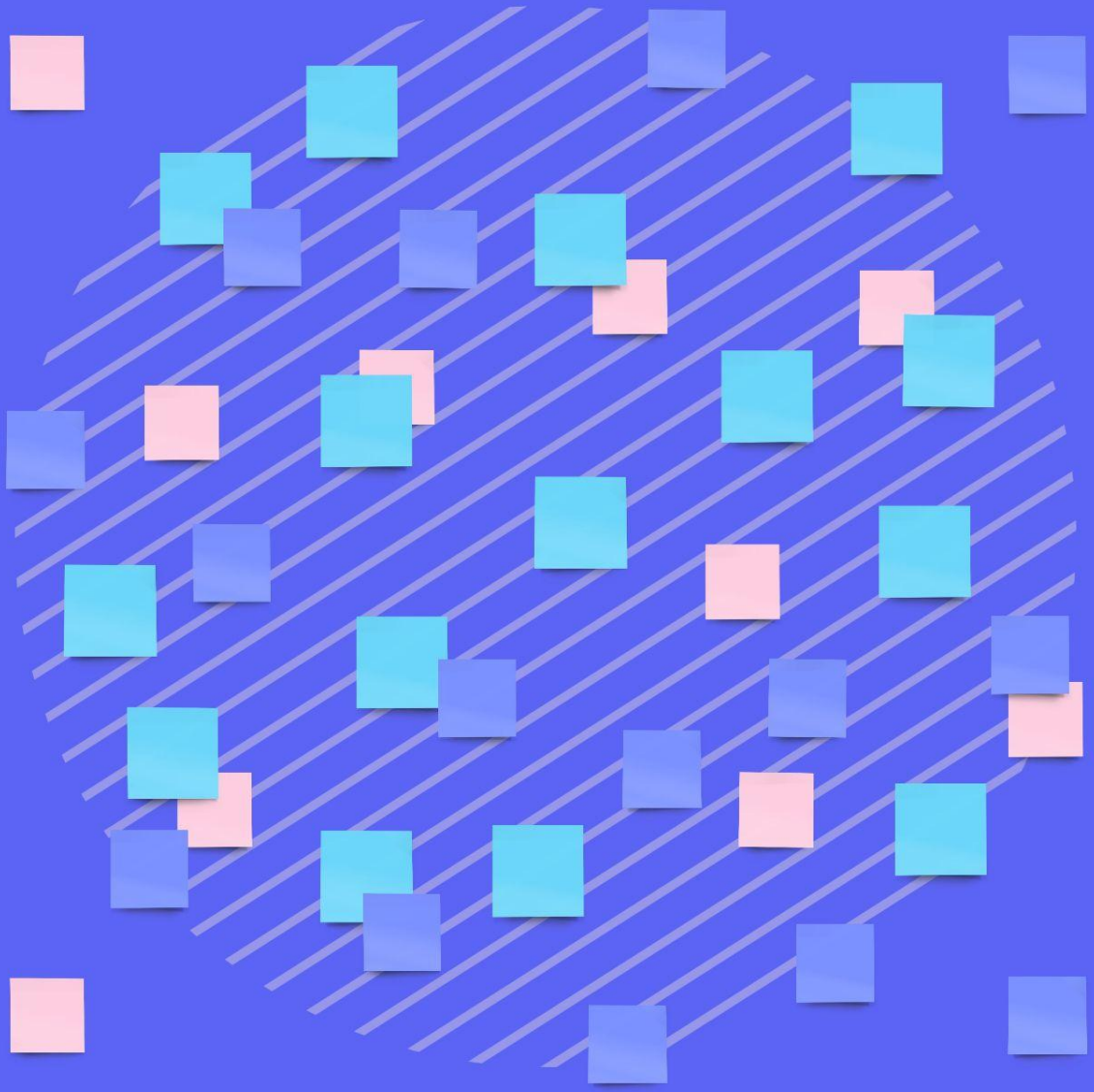
COMMON THREAD

RESEARCH AGENDA

Social and Behavioural data to inform Syria's SBC Strategy for COVID-19 mitigation



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Introduction

Social data is critical to designing evidence-based policies and behavioural interventions, and determining if they work.
To understand how to prevent and mitigate COVID-19 (and other diseases), we must understand people: what they think and feel, how they behave, and what motivates them to behave better.
Yet, as critical as people are to designing effective public health programmes and policies, the collection of behavioural and social data is often the most under-resourced — and oftentimes forgotten — component of public health programmes.

This agenda provides guidance to UNICEF Syria on where social data collection efforts and resources should be focused over the next few years to help prevent and mitigate COVID-19.
The recommendations have been informed by the process of designing the SBC strategy and the data gaps identified throughout.

The behavioural model underpinning the strategy has been used to prioritize data and research needs, as these will be critical to monitoring, adjusting, and evaluating the efficacy of the strategy.

Recommendations

There are five priority areas to focus future data collection efforts. Each priority area includes a series of research questions that should be considered.

1 Get more granular with epidemiological analysis

RATIONALE

Behavioural interventions always need to move alongside — and ideally ahead of — the epidemiological map. Understanding the details of the virus and how it is being transmitted should be an essential companion to the behavioural strategy.

As time goes on and vaccination increases, outbreaks will also become more localized. This will require more focused behavioural interventions and even more in-depth understanding of local epidemiological and social context.

METHODS AND SOURCES

→ Epidemiological data and case/outbreak investigation reports

FOCUS

Ensure RCCE colleagues have a continuous understanding and briefing on:

- Epidemiology — case counts, trends and analysis
- Geographic locations — which areas are at highest risk?
- What populations are at highest risk?
- Are particular settings (ie. schools, markets, mosques etc) driving transmission?
- Are particular behaviours driving transmission?

Incorporate social data into epidemiological investigations.

2 Conduct regular behavioural surveys (~every 6 months) to gauge community insights at scale

RATIONALE

Studies to gauge knowledge and attitudes to COVID-19 prevention are currently ad-hoc. They often focus on specific groups (IDPs seem to be oversampled) or geographical areas, they are irregular, carried out by multiple organizations, and questions are not standardised, making it hard to compare indicators across time and settings. Much of the available data is also out-of-date given the rapid pace with which attitudes surrounding COVID-19 continue to change.

In addition, very little qualitative data has been gathered about the drivers shaping people's perceptions and actions. There is also a lack of community feedback mechanisms, such as social listening via social media or feedback forms during service delivery (e.g. food distribution, camps, etc).

Although a large number of COVID-19-related humanitarian needs assessments were conducted in Syria between January and April 2021, most were based on limited samples of key informant interviews. Generalisations tend to be made based on studies conducted in regional centres, whereas the data may not be transferable between urban and rural areas.[1]

METHODS AND SOURCES

→ Behavioural Surveys

FOCUS

Focus on measuring the specific determinants identified in the behavioural model for each behavior: Knowledge and Awareness, Attitudes, Efficacy, Trust, and Intention for all 5 behaviours.

Standardize indicators and methods across agencies, and aim to collect consistent data at designated time periods (quarterly or bi-annually). A one time investment to establish a data collection infrastructure will enable you to launch subsequent surveys consistently, with very little added effort. Ensure data can be segmented by demographics, gender, and geography at a minimum. To allow for segmentation, large sample sizes will be needed to provide adequate power for sub-analyses. Depending on the number of analyses you would like to do, we suggest completing a power analysis in advance of the survey launch to understand the number of participants required.

Mixed method surveys that combine quantitative data (what is happening) with qualitative data (why it is happening) will provide the most holistic understanding.

3 Between large-scale surveys, use rapid qualitative methods to collect local insights

RATIONALE

Large data sets take time to organize and analyze. Naturally, programming will continue to take place between data sets, and it is important to have local, rapid insights that can help shape interventions effectively, and adjust them to respond to people's needs. Ideally, this methodology should also be used to help communities co-create their own solutions.

Use this method for very local, community-based insights.

METHODS AND SOURCES

→ Includes methods like individual interviews, focus groups, user journeys and photowalks.

FOCUS

Use these methods to understand the communities you're designing interventions for: their daily lives, their journeys to work, power dynamics, influencers, people's journey to social and vaccination services.

You can use this method to capture people's emotional state of mind and dig deeper into motivations and barriers. It is a useful method to build empathy among policy makers and programmers. Use this method also to facilitate a dialogue that allows people to prioritize their own problems and design their own solutions.

4 Deep dive into 2 important topics: The role of religion and misinformation/disinformation narratives

RATIONALE

Religion and social media are two important behavioural influences in the Syrian context that came out in the literature review. However, we have not identified studies that unpack the landscape of each, and how these drivers can be leveraged to mitigate COVID-19 rumours and misinformation, and promote positive change. It is possible these studies exist in Arabic, and there may be more generic studies that review these landscapes for other interventions. In English, there were notable gaps, and particularly for COVID-19:

1

The role of religion: religious texts have been interpreted in various ways to advocate for or against protection against the virus. More investigation may be needed to understand how religion and religious influencers in the Syrian context can be leveraged for positive behaviour change.

2

The misinformation landscape online and offline: more needs to be understood about the types of COVID-19 rumours circulating on social media and within the community about the vaccine, how these affect vaccine perceptions, and who are the most powerful influencers spreading misinformation about vaccination.

FOCUS

To understand **the role of religion** as a driver of COVID-19 prevention or misinformation, focus on:

- How does religion influence compliance with COVID-19 mitigation strategies?
- Are there religious teachings or beliefs that can be harnessed to encourage specific preventive behaviours?
- Who are influential religious leaders at national and local levels? Do they have digital presence and influence?

To understand the **misinformation landscape,** focus on:

- What types of messages about the virus, mask wearing, and the vaccine are circulating on social media? Offline in the community?
- What is the influence of these rumours on people's perceptions of the vaccine and intention to take the vaccine?
- What are the most important platforms, channels and influencers to leverage?

METHODS AND SOURCES

→ Qualitative research (interviews) on religion and COVID-19 and misinformation

→ Social listening monitoring to continuously monitor and track rumours online and offline

5 Test Interventions

RATIONALE

There are a considerable number of reports that address the regulations and measures taken by local authorities to stop the spread of COVID-19. [2,3,4,5,6,7,8,9,10,11,12,13] Interventions implemented by CSOs, local NGOs and other organizations to support the response have also been documented.[14,15,16] However, few studies address the actual implementation of mitigation measures and the level of compliance with these measures.

Particularly given the gaps in data that existed to design the SBC strategy, it is more important than ever to use data to inform and test efficacy and acceptability of interventions locally before and during their implementation. Knowing what interventions work is useful in scaling up interventions across a region or amending them so they are more effective.

FOCUS

Based on the strategy, a few things that intervention testing can focus on include:

- To what extent do bottom-up mechanisms, like community mask production, increase mask supply and mask wearing?
- How much (if at all) do well-placed, well-timed cues work to increase physical distancing, mask wearing and ventilation?
- What is the vaccine process and where are the entry points to “make it easier”?

METHODS AND SOURCES

→ Pre-post quantitative studies
→ Randomized control trials
→ Evaluation

Data Landscape

This section provides an overview of what data exists when it comes to COVID-19 in Syria and what data is missing.

1 Epidemiological Context and Perception of disease and risk

Existing data: Epidemiological data in Syria is standardized with the WHO Syria dashboard acting as the main source of information on COVID-19 case numbers and fatalities. This dashboard is updated regularly and is cited in most reports. In addition to this dashboard, OCHA, USAID and iMMAP[17] also provide reports on the COVID-19 epidemiological situation as it pertains to camps and collective shelters.[18]

Data Gaps: There is an absence of accurate data provided in the WHO Syria dashboard. The on-going conflict, economic crisis and COVID-19 pandemic has led to insufficient health personnel and limited resources to track, trace and monitor COVID-19. As such, the number of confirmed cases and fatalities are unlikely to reflect the reality on the ground.

In addition to inaccurate data, there is little available evidence on settings where COVID-19 outbreaks are taking place and the population groups that are most affected. The studies that do exist are either limited in scope, ad-hoc, or out-dated given the fast pace of the pandemic. Consistent, accurate and up-to-date data on different settings (such as hospitals, schools, markets, etc.) and affected and at-risk population groups (such as refugees, IDPs, elderly, healthcare workers, et al.) is needed at national and sub-national levels.

2 Mask Wearing Behaviour

Existing individual data: A few studies have been conducted to understand Syrian residents' levels of awareness, knowledge, attitudes and behaviour when it comes to mask-wearing. Data has been collected using a variety of methods including KAP surveys,[19,20] rapid assessment methods,[21] and focus group discussions[22] via social media[23], house visits,[24] and over the phone.[25]

Data Gaps: Data is sporadic in terms of what is being asked and measured, geographic focus, methodology and timeframe. Much of this data is outdated and more recent data is needed to assess overall knowledge about mask-wearing.

There is a lack of detail on attitudes toward mask wearing, in particular the reasons behind why people do or do not wear a mask. More in-depth research should be done amongst the general population to understand specific constructs (e.g. attitudes, intention, risk, etc), with the potential for segmentation.

Existing social data: Since self-reported mask wearing, physical distancing and handwashing act as a proxy for community social norms, several studies have been conducted to evaluate norms. Regular studies have been conducted on mask wearing, indicating how mask wearing norms change over time and setting.[26,27,28,29]

Data Gaps: There is conflicting evidence on how religion influences compliance with COVID-19 mitigation strategies and more research is needed to understand the extent to which religious beliefs and religious leaders influence mask wearing and whether religious teachings can be harnessed to encourage positive behaviours. For example, some scholars have interpreted Quranic verses and hadiths and highlighted ways in which these align with recommended public health measures. Other essays have discussed the ways in which individuals and groups have used Islamic teachings as evidence for their messages about prevention, but there is little evidence documenting the actual effects of such messages on behaviour.

Limited data exists on actual mask wearing behaviour, with most social norm data coming from self-reported data. This is a significant gap because what people say they do and what they actually do are two separate measurements.

Existing environmental data: Assessments on the extent to which sub-districts are implementing compulsory mask-wearing policies in different parts of the country is limited.[30,31,32,33] Only a small number of studies report on access to masks. These include studies in the Northeast,[34] the Northwest,[35] in camps and informal settlements,[36] in Rural Damascus,[37] and nationally.[38]

Data Gaps: Limited evidence on the extent of supply shortages, and who/what areas are most affected.

Limited evidence on whether bottom-up mechanisms for overcoming a lack of supply, such as local manufacturing are useful.

3 Physical distancing Behaviour

Existing individual data: Data on knowledge and awareness about physical spacing and social distancing (staying at home, avoiding crowded places, isolation) was generated through a cross-sectional online questionnaire[39] and one focusing on pharmacists.[40] Assessments in the Northeast, gauged levels of awareness about distancing measures among IDP populations and host communities.[41]

A couple of national surveys highlighted the need to earn money as a key barrier to staying at home or self-isolating.[42] Data was also collected on specific geographical areas including Government of Syria controlled areas, [43] Aleppo, where income was found to be a dominant barrier,[44] and Rural Damascus, where social obligations were a significant barrier to physical distancing.[45]

> **Data Gaps:** Studies on social and physical distancing are irregular, have focused on small groups in certain geographical areas, and the data is often out-dated. More data is needed on actual physical distancing behaviour across all regions.

Existing social data: A number of studies asked people to self-report their behaviour with regard to distancing, and explored barriers to adhering to such measures.[46,47,48] Other studies have shown that social norms and traditions in Syria, like providing psychosocial support, prevail over physical distancing.[49,50,51,52]

> **Data Gaps:** Physical distancing initiatives have been carried out in mosques and other religious centres. Evidence is needed to understand how impactful these initiatives have been.

Existing environmental data: Several studies emphasize the challenges associated with physical spacing in crowded places.[53] In IDP camps in the Northwest, overcrowding and a dependency on humanitarian organisations for aid were found to be important barriers.[54] In the Northeast, overcrowding was also reported as a barrier to distancing, particularly in camp settings.[55,56] Academic studies carried out prior to or during the pandemic also point to the overcrowded and unsanitary conditions in camp settings as barriers to preventing the spread of disease.[57]

> **Data Gaps:** There is ample evidence that overcrowding in camp settings and crowded residential areas is a barrier to distancing, but less efforts have been made to pinpoint instances in which different forms of distancing might be possible or appropriate in such settings.
>
> Although there has been an increase in the number of education needs assessments since the reopening of schools in September 2020, more data is needed on behaviours such as physical distancing in schools.

4 Vaccine Uptake

Existing individual data: To date, there is little evidence on the population's attitudes and perceptions towards the COVID-19 vaccine(s). In January 2021, a newspaper ran a poll on vaccine perceptions,[58] and a small number of studies have focused on knowledge and perceptions in specific geographical areas (e.g., Rural Damascus [59]), or in particular groups (e.g., pharmacists [60]). Some data are available on Syrian refugees residing in other countries.[61] The impact of trust on vaccination campaigns in Syria is touched on in several news articles, [62] and

one study analyses of Twitter conversations.[63] One academic article discusses the effects of conflict and politics on polio vaccination campaigns in Syria,[64] and a nation-wide KAP survey asked about trust toward immunisation teams.[65]

> **Data Gaps:** Available evidence suggests confidence in the COVID-19 vaccine is low, but very few studies have explored vaccine intentions or the reasons behind hesitancy. A number of studies have focused on refugees in neighbouring countries, while more evidence is needed about the perceptions, intentions and behavioural drivers of those residing within Syria, segmented by governorate.
>
> More needs to be understood about the level of public trust in vaccination campaigns and immunisation teams (the last national survey took place in 2019), the impact of political allegiances on vaccine confidence, and whether prior adverse events influence intentions.

Existing social data: There is no data on social norms surrounding COVID-19 vaccination. Given the limited number of vaccine doses available, however, it is assumed that there is not a strong COVID-19 vaccination norm in the country.

> **Data Gaps:** Research is needed to understand the extent to which religious beliefs and discourse influence vaccine uptake.
>
> More also needs to be understood about the types of messages circulating on social media and within the community about the vaccine, how these affect vaccine perceptions, and who are the most powerful influencers for vaccination.

Existing environmental data: There is limited data on the average proximity to vaccine distribution sites. Most data speaks to the number of distribution sites, mobile teams and limitations in cold-storage and health worker capacity.

A considerable number of reports and news articles have addressed vaccine roll-out and administration in Syria since it was initiated on 17 May 2021 in line with the National Deployment and Vaccination Plan.[66,67,68,69,70,71] Concerns raised about the Syrian government controlling the national distribution of vaccines and the impact this may have on vaccination roll-out in the Northeast and Northwest, particularly in access-constrained areas and areas of disputed control, were highlighted in a few reports[72,73] and news articles.[74,75] Additionally, several sources reported the number of AstraZeneca vaccine doses administered to date.[76]

> **Data Gaps:** There is limited information about the vaccination process itself, including registration, whether people outside the priority groups are being vaccinated, the collection of personal data from those getting vaccinated, follow-up post vaccination, etc. One report produced by the Qatar Red Crescent Society (QRCS) documented its monitoring of the COVAX vaccination campaign in Northern Syria. More information on the vaccination process is needed.

5 Communication and Media Environment

Existing individual data: Multiple studies and assessments have focused on access to COVID-19 information by the Syrian population and levels of trust in the information shared. Many of these studies focused on the Northeast (including camps and informal settlements)[77,78,79,,80,81,82,83,84] two studies were conducted at the national level,[85,86] one in Rural Damascus,[87] one in the Northwest amongst IDPs[88] and one focused on pharmacists.[89] These studies and assessments addressed issues including access to sufficient and accurate information, the dominant and most common sources of information, and the most trusted sources of information.

Data Gaps: Several studies and assessments have been conducted on the communication environment and particularly on access to COVID-19 information and trust in this information. However, such studies are either irregular, outdated or focused on small groups in specific geographical areas. Data is mostly available for population groups and areas that have higher connectivity and more regular access to other types of information.

More nuanced and granular data on levels of access, utilisation and trust for different sources and channels of communication that could support RCCE initiatives related to COVID-19 is urgently needed. In particular, data is needed on the communication preferences of hard-to-reach communities (e.g., rural communities without internet access) and ways to reach these groups, including the most vulnerable.

Research is also needed to better understand how trust differs by population based on the information source and the type of information being shared. For example, people may trust their religious leaders generally, but may not trust them to provide accurate information on vaccination.

Lastly, research is needed to understand the ways in which different groups communicate and influence each other.

Methodologies

A number of methods are identified above to address each recommendation. The selection of each methodology will depend on the resources available, and the objectives of the research.

Given the rapid nature of the pandemic, a mixed method approach combining at least one qualitative and one quantitative method should be completed at a minimum of every 6 months, together with rapid localized methods to co-create or test specific interventions.

Below is more detail on the methods identified above and when to use each.

1 Case & Outbreak Investigation Reports

What is a Case Study Investigation?

Health departments often have legal mandates to investigate cases of communicable disease and a duty to notify contacts that they were exposed. In the Syrian context, it's important to understand who is responsible for conducting case investigation reports in each locality (in some instances, it may be WHO), and to ensure the interview guides collect behavioral and social data that can help inform a more targeted response. Social data that will be important to obtain from case investigation reports include:

- The case patient's socio-demographic characteristics. At a minimum, this should include age, sex, ethnicity, and language spoken
- Travel history and details
- Number of people in the household
- Exposure locations (including events and gatherings with unknown contacts).
- Preventative behaviour practiced (mask wearing, handwashing, distancing, etc

Types of Case Investigation:

- **Telephone:** When possible and appropriate, case interviews and contact elicitation should be conducted via telephone call or another distance-based application to ensure the safety of the case investigator and efficient use of program resources.
- **In-person:** Where cases are identified after hospital or clinic admission, these investigations will take place face to face.

When should I use a Behavioural Survey?

Ideally, all known cases should be investigated with a form, and entered into a health information system. This data should be aggregated and analyzed for trends that can reveal important characteristics about who, where, and how people are being infected. If caseloads get too high and this becomes impossible, large outbreaks should be investigated more thoroughly to understand potential superspreader dynamics, or other dynamics that lead to large outbreaks. It is important that RCCE colleagues are integrated into epidemiological briefings, data collection instruments, and data presentations. They should be aware of this data, and contribute to its analysis and quality.

Things to consider

Establishing trust and rapport between a case investigator and a patient diagnosed with COVID-19 is critical to obtain accurate information and ensure trust throughout the investigation. Personnel assigned to investigate patients with COVID-19 should be trained in interviewing methods. Interviewers should be matched in gender, language, cultural background and locale to the interviewee to the extent possible. Where language matching isn't possible, interpreters should accompany the team. When possible, RCCE/C4D colleagues should be involved in case investigations, though this may not be possible given the scale. However, for large outbreaks, it is recommended to have a mixed team of epidemiologists and behavioral specialists conducting the investigation(s).

2 Behavioural Surveys

What is a Behavioural Survey?

A behavioural survey is a set of structured questions that are looking to understand attitudes, social norms, emotions and intentions. Question responses in a behavioural survey are usually given on 7-point scales with 0 being disagreement with a statement and 7 being complete agreement.

Example of Behavioural Surveys

- Knowledge, Attitude and Practices survey
- Opinion Polls

Types of Behavioural Surveys

There are several different ways you can administer a behavioural survey including:

- Online (e.g. Google forms, SurveyMonkey, Qualtrics, Typeform)
- Phone survey
- Face to face polling

Pros/Cons of a Behavioural Survey

- **Pros:** Fast, can reach a large number of people quickly, easy to analyze data, cost-efficient.
- **Cons:** Does not capture cultural or social context; does not capture actual behaviours e.g. what people say they do, and what they really do are often very different; focuses mainly on the role of knowledge, attitudes and perceptions as drivers of behaviours; does not allow for open ended questions or nuances in answers.

When should I use a Behavioural Survey?

Behavioural surveys are designed to collect and record information from many people, groups or organisations in a consistent way. Polls can be designed to capture consistent data repeatedly at key points in time. Designing and implementing a comprehensive and consistent behavioural survey or poll for COVID-19 behaviours would be a significant contribution to the knowledge base in Syria.

Conducting these surveys face to face is most likely to ensure the most representative sample, depending on how Syrians are used to being surveyed (in some contexts, people are used to telephone surveys and these can be equally reliable).

3 Interviews

What is an Interview?
Interviews are structured conversations guided by a series of open-ended questions. They tend to collect individual or group insights on attitudes, perceptions and intentions and are particularly useful if you want to dive in further to explore interesting findings from surveys, or if you want to dig deep into a topic or attitude. Interviews often provide context or the "why" to people's behaviours.

Types of Interviews

There are two main types of interviews:

- **In-depth interviews** (IDIs), which are interviews between the researcher and one other person
- **Focus group discussions** (FGDs)**,** which are interviews between the researcher and a group of people
- **In-context interviews,** describe researchers going to specific sites to conduct a survey, or observe people's daily lives and experiences — such as during vaccination, or on transportation (e.g. an experience going to work and barriers to mask wearing or distancing

Pros/Cons of Interviews

- **Pros**: Higher likelihood to build trust and rapport with participants through this method. FGD's can also help identify the prevalence of beliefs or attitudes and demonstrate power dynamics or social hierarchy within communities
- **Cons**: Very resource-intensive and can lead to smaller sample sizes. Response bias may be significant in FGDs when people are asked their views in a social peer group.

When should I use an Interview?
IDIs: Use an in-depth interview to collect individual insights. They are useful when you want to understand why people behave in certain ways, to unpack complex attitudes and beliefs, or to test acceptability to an idea or intervention. They allow for new ideas, constructs, or models to come up organically, and are useful to gain insight into how to structure quantitative instruments, and what language to use. People will generally be able to offer quality information for 30-45 minutes.

FGDs: Think of a FGD like a group interview. They are an excellent way to collect nuanced information from a larger sample of participants, and to test how prevalent ideas or beliefs are that came up in in-depth interviews. Focus Groups will be most effective if they are kept to one hour or less, and generally with 8 to 12 people.

In-context interviews: Use an in-context survey to gauge rapid insights from the general population about a service or a particular context.

4 Human Centred Design (HCD) Approaches

What is HCD?
An interactive approach that allows researchers to understand people's lived realities first-hand.

Types of HCD Approaches
There are several types of HCD approaches. Two of the most common are photowalks and user journeys.

- **Photowalks:** A small group of participants (~8-10 people) are brought to a workshop and briefed on how to use a camera and what to capture based on a research guide. They're provided with disposable or polaroid cameras or asked to use the cameras on their phone to capture what they see in their community. At the end of the day all participants reconvene for a workshop, aimed at facilitating discussion around the photograph/footage that has been taken.
- **User Journeys:** Participants create maps of the steps they take, the experiences they have and how they feel while receiving a service.
- **User Shadowing:** Researchers observe people's behaviour in-context.

Pros/Cons of HCD approaches

- **Pros**: Uses visual cues to understand context and behaviour, which can be more revealing than verbal cues; focuses on context; it is highly engaging and respondents often enjoy this methodology; effective in building empathy.
- **Cons**: It is less traditional, may take some time to analyze and explain.

When should I use HCD approaches?
Photowalk: Use a photowalk to build empathy with your target population and understand what is actually going on in their context. This helps reduce respondent bias, and can also help researchers understand what is important to community members, based on what they choose to photograph.

User journey: Use a journey mapping exercise to understand the physical and psychological steps that someone takes in order to complete an activity. This methodology helps researchers understand the process from the users perspective and the users' lived reality.

User Shadowing: Use user shadowing when you want to understand what people actually do as opposed to what they say they do. This methodology provides critcial contextual understanding of how people move through experiences in real-time.

5 Social Listening and Monitoring

What is Social Listening and Monitoring?
Keeping track of information and ongoing narratives in online and offline settings.

Types of Social Listening and Monitoring
There are several types of social listening and monitoring including:

- **Automated social media surveillance:** Use social media surveillance when you want to quickly capture online discussions, rumours, misinformation and disinformation. To create an automated surveillance system you must have the technical knowledge to set it up.
- **Manual social media surveillance:** Use manual social media surveillance when you want to quickly capture online discussions, rumours, misinformation and disinformation, but you don't have the technical knowledge of how to set up an automated system.

Pros/Cons of Social Listening and Monitoring

- **Pros**: Fairly easy and rapid monitoring of online conversations
- **Cons**: Does not capture rumours circulating offline.

When should I use HCD approaches?
Automated: While automated social media surveillance requires specialized skills to set up, once it is programmed, monitoring is very easy.

Two platforms exist to help with monitoring: Crowdtangle and Talkwalker. These platforms allow researchers to input keywords to monitor on public social media platforms like Facebook, Twitter, Instagram, Reddit etc. The platform generates sources where these keywords are detected and rumours can then be logged and tracked in an excel sheet.

Manual: Manual social media surveillance provides the same outputs as automated surveillance, with the only difference being the amount of time and energy required to track online information. In this methodology, researchers must independently scan different media platforms for keywords and flag any rumours, misinformation or disinformation that they come across. This process takes longer and is more time and resource intensive.

6 Community Feedback Mechanisms

What are Community Feedback Mechanisms?

Opportunities to gain direct insight into offline narratives/information shared in communities. It should be conducted continuously and embedded into the regular monitoring system.

Types of Community Feedback Mechanisms

- **Digital reporting:** To understand offline discussions and what rumours, misinformation and disinformation may be circulating in a community. It is also a useful methodology to monitor existing perceptions, beliefs, attitudes and behaviours.
- **In-person reporting:** The integration of reporting in other everyday activities, like door-to-door visits

Pros/Cons of Community Feedback

- **Pros**: Captures a wider range of community perspectives; actively engages communities in social listening.
- **Cons**: Relies on frequent and accurate reporting from volunteers; can be time intensive at the beginning to recruit and train volunteers.

When should I use Community Feedback Mechanisms?

Community feedback mechanisms describe when workers or volunteers in communities use a tool called U-report, a dedicated hotline number, text message or house-to-house visits to report any mis/disinformation they have heard or seen to a centralized body. The centralized body is then responsible for aggregating the insights collected to identify which narratives are consistently emerging.

Community feedback mechanisms can also be integrated into regular interventions. For example, casual conversations during regular awareness-raising household visits can be used to collect data on community members' beliefs, behaviour and practices relevant to COVID-19.

7 Testing

What is testing?

A methodology that measures whether interventions work.

Types of Testing Methodologies

- **Pre-post studies:** Researchers select a specific location and measure people's behaviour before an intervention is implemented and after it is implemented. Any difference in behaviour before vs. after is attributed to the intervention.
- **Randomized control trials:** People are randomly assigned to one version of an intervention or a message. The intervention is always compared to a control group, which is the current state of affairs. Participant groups only experience one intervention (e.g. EITHER the control or the intervention) and not both.

Pros/Cons of Testing

- **Pros:** Pre-post studies are lower cost, more convenient and easier to implement relative to a randomized control trial
- **Cons:** Because the groups are not randomized in a pre-post study, it can be more challenging to identify whether differences in measured behaviour are due to the intervention itself or due to other unrelated factors like policy changes, conflict etc.

When should I use different testing methodologies?

Pre-post study: A pre-post study is a useful methodology to measure the impact of newly implemented interventions. It helps you identify whether the intervention achieved the desired behaviour change.

RCT: A randomized control trial (RCT) is the gold standard in experimentation. It provides researchers with the greatest confidence as to whether an intervention does or does not work. If time and resources allow, conducting a RCT is always recommended to measure whether an intervention has its desired effect

8 Evaluation

What is evaluation?
A methodology to assess the Syria SBC COVID-19 strategy focusing on five key factors.

Five key factors of evaluation

1. **Relevance** - Are the interventions relevant to each locality in which they are being implemented? Are they timely?

2. **Applicability** - Do the interventions address the real problems? Is data available to support problem analysis and solution generation?

3. **Efficiency** - Are the interventions implemented using a reasonable cost/impact ration? Do they solve the problem most effectively with the least amount of time and money?

4. **Effectiveness** - Do the interventions have their intended effect? Are the interventions leading to the desired objective? (Assuming they are implemented as articulated in the strategy)

5. **Sustainability** - Is behaviour change sustainable beyond the duration of the COVID-19 pandemic? Does it encourage the creation of habitual behaviours for relevant behaviours (e.g. handwashing, mask wearing, etc)

Things to consider

Evaluation is a standard best practice to measure the impact of the Syria SBC COVID-19 strategy. It is important before embarking on an evaluation to ensure the strategy is evaluable before implementation. This means clearly identifying the results that are to be achieved, and ensuring interventions are carried out in the way the strategy advises (e.g. with adequate data at local level, resource investment, continuous monitoring and testing, and community feedback to iterate and improve on implementation). It also should be used as a lens by which all strategies are evaluated using the same five key criterion.

Endnotes

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