Relevance Study: Risk Communication and Community Engagement (RCCE) Approach in Palestine During the COVID-19 Response

FINAL REPORT

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Acknowledgments

This project has been commissioned by the International Federation of Red Cross and Red Crescent Societies (IFRC) and implemented by the Palestine Red Crescent Society (PRCS).

This evaluation report covers the results of quantitative surveys and focus groups discussions with community members and key informant interviews conducted with stakeholders between January and February 2022. The purpose of the study is to learn about community members' perspectives of the importance of health information provision related to COVID-19 and their access to it in conflict and protracted crisis-affected regions.

The survey findings presented in the report are the sole responsibility of UDA Consulting and do not necessarily reflect the opinions of IFRC and PRCS. This report is the property of IFRC and PRCS.

UDA Consulting wishes to thank the staff of the implementing organization PRCS for their assistance and cooperation.

Abbreviations List

FGD	Focus Group Discussion
IFRC	The International Federation of Red Cross and Red Crescent Societies
KII	Key Informant Interview
MOH	Ministry of Health
NIS	New Israel Shekel
PRCS	Palestine Red Crescent Society
PWD	People with disabilities
RCCE	Risk Communication Community Engagement
SD	Standard Deviation
WB	West Bank

Executive Summary

Introduction

The novel coronavirus pandemic that emerged in late 2019 (COVID-19) has affected all health systems around the world and has produced a significant disparity in global risk. Countries with fragile health care systems, in conflict areas, and developing countries, which suffered from inadequate physical capital and human resources, are at high risk of being overwhelmed. At the same time, the COVID-19 pandemic has intensified poverty in poor communities (Buheji et al., 2020, Sumner et al., 2020).

Psychosocial health problems affected adherence to healthy attitudes during emergencies. However early evidence suggests that the majority of governments ignored the psychological and social impacts of health epidemics (Cullen et al., 2020). Further, the COVID-19 disturbed children's well-being in terms of education, recreational activities, health, and obstructing their social life,

As a result, it is necessary that governments in Risk Communication and Community Engagement (RCCE) engage in efforts to properly develop materials to address needs during emergency cases like the COVID-19 pandemic (Lancker & Par`olin, 2020,).

This paper presents the results of a study conducted in January and February 2022 to analyze the perceptions COVID-19 and COVID-19 information sources among community members residing in conflict and protracted crisis-affected areas in Palestine.

The research design included a desk review, a quantitative survey with 692 respondents, as well as 10 focus group discussions (FGDs) with community members and 15 key informant interviews (KIIs) with stakeholders. Data collection was conducted in Nablus, Qalqilya, Ramallah and Al-Bireh, Jerusalem, and Hebron Governorates.

Sample Profile

Overall, 55% of respondents were male and 45% were female. Almost half of the respondents were between 41-65 (51.4%), while 37.9% were aged 26-40. Sampling was proportional to the size of the target population. As a result, almost one-third of the respondents were in Jerusalem – Old Town (29%), followed by Dura (26.8%) and Beita (13.9%). The majority (54.6%) of the respondents were in urban settings, followed by city (29.3%) and rural areas (12.4%). Nearly half of the respondents (45.8%) had a university degree (45.8%), while 32.4% of respondents had a secondary/high school degree and 14.7% had a primary/elementary education. Almost half of the respondents were employees (48.3%) and 22% reported owning business. Nearly a quarter (23.7%) of the respondents were unemployed. The average monthly income was 3,563.6 NIS ($1,103.3 USD).[1]

The majority of the respondents had no difficulty seeing (75.9%), hearing (89.3%), walking 81.1%), remembering (81.8%), with self-care (89%), or communicating (94.4%), however 7% of the respondents met the criteria for persons with disabilities (PWD).

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[1] Exchange rate of $1 USD = 3.23 NIS on March 17, 2022 (https://www.bloomberg.com/quote/USDILS:CUR)

Among the respondents, 53.9% reported that someone in their family had contracted COVID-19, and 37% reported that they had contracted COVID-19 themselves.

Perceptions of COVID-19

Approximately half of the respondents reported that they were concerned about their health during the COVID-19 pandemic. The concern level significantly varied by gender, location, education, and having been contracted infected by COVID-19. Female respondents were more likely to be concerned or very concerned about their health compared to male respondents (56.8% and 50.1%, respectively). Respondents in Al-Arroub were the most likely to report concern about their health (88%), while respondents in Qaryout (24.2%) and Jerusalem (32.4%) were the least likely to report concern.

Most respondents (61%) felt that COVID-19 was dangerous or very dangerous. The respondents living in Al-Arroub were the most likely to report that COVID-19 was dangerous (92%), while 38.5% of the people in Beita perceived it as not dangerous. As the education level increased, the proportion of respondents that felt COVID-19 was dangerous increased.

The most commonly cited channels for accessing COVID-19 information were social media (66.5%), television (51.7%), and internet searches (49.6%). Television was the preferred channel for respondents in Jerusalem (63.7%) but was preferred by only 20% of respondents in Al-Arroub. As the level of education increased, the proportion of respondents that used television as a channel for COVID-19 information decreased. Respondents with higher levels of education were more likely to report use of internet/web searches and mobile applications.

Respondents were most likely to report that health units/health care workers (45.2%), social media (29.8%), and television (29%) were most likely to be viewed as reliable sources for receiving information related to COVID-19.

The overwhelming majority of respondents believed that the COVID-19 does not generate stigma against particular groups of people (92.3%).

Relevance

The majority of the respondents (91.5%) found the information they received about COVID-19 was useful or very useful. The respondents who found the information about the COVID-19 to be useful stated to use this information helped them to take preventative measures (80.6%), to keep track of health and recognize symptoms (75.2%), and to deal with a COVID-19 infection (59.1%).

Among the respondents who did not find the information about COVID-19 useful, the most commonly stated reasons were that it did not assist in reducing the number of cases in their areas (36.4%), that measures could not be implemented where they live (34.1%) and that there was a community-wide unwillingness to follow rules related to COVID-19 (31.8%).

Community Engagement

Respondents engaged in a rage of COVID-19 prevention measures, most commonly reporting that they washed their hands regularly using alcohol or soap and water (83.8%), wore a face mask in public (77.9%), and/or covered their mouth and nose when coughing or sneezing (76.2%) to avoid infection.

To learn about COVID-19, the respondents stated the most available ways as government (33.5%), and health organizations (31.6%). One third of the respondents (32.1%) stated that they could find someone if they wanted to learn more about COVID-19. The results significantly differ by location and disability status of respondents.

Almost two-thirds of participants (68.8%) said that they had not been contacted by any implementing partners about how COVID-19 could be better prevented in their area. The percentage of respondents engaging in any activities was the highest among the respondents aged between 18-25 (31.9%), and among respondents who had a family member who had contracted COVID-19 (56.3%). Respondents without disabilities were almost twice as likely as those with disabilities to have participated in activities (31% and 17.6% respectively).

Perceptions of COVID-19 Vaccines

Only 26% of respondents thought the COVID-19 vaccinations were "reasonably safe" (36.3%) or "very safe" (4.8%). One-third of the respondents thought the vaccines were unsafe (24%), or unsafe at all (12.6%). Beita (54.1%) and Azzun (50.8%) had the highest percentage of respondents who thought the COVID-19 vaccines were reasonably safe or safe, while Ni'leen (12.7%) and Qaryout had the lowest percentage (18.2%). Those who were concerned and very concerned about their health were twice as likely to believe the COVID-19 vaccines were safe as respondents who were not concerned at all (57.4%, 46.2%, and 24.2%, respectively).

More than half of the respondents believed that the COVID-19 vaccine provided no protection (20.8%) or only a little protection (32.7%). However, almost every respondent knew where and how to register to get themselves vaccinated (97.3%).

The most frequently reported factors influencing respondents' choice to get the COVID-19 vaccination were suggestions from doctors or health authorities" (53.1%), the number of COVID-19 cases" (30.9%), and the number of deaths caused by COVID-19 (29%). The main reasons for not getting the vaccine were a belief that the vaccine was not effective" (46%), that the vaccines weren't safe because they were developed too quickly (45.3%), and the vaccines had negative side effects (42.9%). Some respondents reported that anti-vaccine information in the media was a factor (26.1%).

Risk Communication

The majority of the respondents considered it important to take actions to prevent the spread of COVID-19 in their communities (83.8%). As the level of education increased, the proportion of respondents who considered it important to take actions also increased.

In the event that respondents or a member of their household developed symptoms of COVID-19, more than half reported that they would go to the hospital/health facility (57.7%) or remain in quarantine (52.9%).

The majority of respondents reported that they would disclose if they had COVID-19 in all cases. Among those who would not disclose a COVID-19 diagnosis in all cases, the most common reasons were a fear that the quarantine would harm their family (49.7%) and concern about losing their job (37.9%).

Despite this, the majority of the respondents stated that they would get tested if they have symptoms of COVID-19 immediately (49.3%) or if the symptoms continued for 4-5 days (43.8%). Those who were very concerned about their health tended to do a test immediately if they have symptoms of COVID-19 (54.4%), and this rate dropped to 44.1% for respondents not concerned at all.

Engagement and Needs

Respondents requested more information on whether vaccines worked against the Omicron variant (55.1%), whether treatments worked against the Omicron variant (48.3%), and Omicron variant transmission rates (47.5%).

Almost three quarters of the respondents thought awareness sessions, trainings and information provision on COVID-19 reaches all groups in the community (76.9%). Similarly, almost three quarters of the respondents considered that the information received from the Palestine Red Crescent Society (PRCS) took into consideration the needs of the different age groups (72.5%), and nearly three quarters of the respondents considered that the information received took into consideration the needs of gender (74.1%). 71% of the respondents stated that the information that they received from the Palestine Red Crescent Society (PRCS) was applicable and realistic in their context. Notably, only 33.3% of respondents with no formal education stated information they received by PRCS was applicable and realistic.

Recommendations

This study identified a number of recommendations for future interventions, notably recommending that organisations consider:

- Employing communications strategies using multiple channels and a range of trusted sources to reach the broadest range of targeted community members: The results of this study suggest that there is no "one size fits all" solution for communication of information about COVID-19 community members residing in conflict and protracted crisis-affected areas in Palestine. Among the target population, community members use a wide range of channels and rely on a wide range of trusted sources for information about COVID-19. Preferred channels and trusted sources varied by respondents' age, gender, education level, location, and disability status.

- Developing communications strategies that incorporate personal connections to COVID-19 or employ popular figures to discuss COVID-19 experiences and share prevention strategies: Respondents who had contracted COVID-19 or knew a family member who had contracted COVID-19 were more likely to feel COVID-19 was dangerous, believing that COVID-19 vaccines were safe and to have received at least COVID-19 vaccine dose compared to those with no personal or family history. these results suggest that personal connections can play an important role in community members' perceptions of COVID-19 vaccine safety and influence their decision to get vaccinated.

- Using messaging that emphasises social or moral responsibility to get vaccinated and take other preventative measures: Many respondents were swayed by messaging and beliefs focus on the social or moral responsibility to get vaccinated. These respondents felt that getting vaccinated and engaging in other prevention strategies was a duty in order to protect others, particularly those at heighten risk of serious complications.

- Expanding communications on topics of interest to survey respondents: Survey respondents reported that they would like more information related to t how the Omicron variant was spread, and how effective vaccines and treatments were for the Omicron variant.

- Additionally, study respondents reported a number of strategy recommendations to better controlling COVID-19 in their areas, including increasing national awareness (70.1%), developing vaccine campaigns (50%), and increasing support for the creation of COVID-19 community groups (49.6%). Some respondents noted that community members with limited incomes and single-income households should be targeted for support, since they would be most affected by a COVID-19 infection. These recommendations should be considered when planning future activities.

Project Background

The objective of the study is to understand the perceptions of community members residing in conflict and protracted crisis-affected areas in Palestine regarding the perceptions of the community around the relevance of the health information provision related to COVID-19, and their access to such information.

The study was developed to provide insights into the relevance of the RCCE approaches followed in areas with protracted conflict and crisis within the West Bank, and learnings to improve the RCCE response and achieve better outcomes for communities of crisis and conflict areas

More specifically, this study answers the following key research questions:

1. What are the perceptions of the community members regarding COVID-19 and vaccination? Explore the rumors, misperceptions, misinformation regarding the virus and vaccines?

2. How relevant is the health information provided, and the community engagement initiatives to the community members?

3. What Community Engagement mechanisms are existing? Is the community usually consulted/ engaged when designing, planning, and implementing RCCE activities? If not, how would you and/or like the community to be engaged?

4. Where and how do the community members access such information, and how do they describe access and use?
   4.1 What is the level of community awareness about COVID-19 and the information provision related to safety/prevention/handling measures including vaccination?
   4.2 How communities would like to engage in receiving information about the future of COVID-19 like possible variants, another wave, and the vaccine? (Trusted channels for communication, information provision approaches… etc.)

5. To what extent are these communication approaches proper and convenient?
   5.1 To what extent were and is still gender and age considerations followed within the RCCE approaches to ensure comprehensive inclusiveness and reach?
   5.2 What gender and age barriers are hindering RCCE activities to be as much inclusive as possible?

6. What are the topics that should be considered in RCCE activities (as prioritized by the communities)? And how would the level of community engagement be improved in future RCCE activities?

Methodology

This project employed a mixed methods approach that included a quantitative survey, focus group discussions and key informant interviews. Prior to data collection, the research team conducted a desk review focused on the RCCE global approach to alleviate COVID-19. More detailed information about the desk review can be found here.

The research design started with a desk review (more information [here](#)) followed by a quantitative survey, focus group discussions and in-depth interviews. In total, 692 individuals were interviewed, along with 10 focus group discussions (FGDs) with community members and 15 key informant interviews (KIIs) with stakeholders. This methodology was chosen to create a complementary design intended to permit triangulation and in-depth exploration of key topics.

Sampling Methods

For this study, communities in section C, close to the separation wall, and Israeli settlements in West Bank that are served by the Red Crescent society. The study covers Nablus, Qalqilya, Ramallah and Al-Bireh, Jerusalem, and Hebron Governorates.

Quantitative surveys were conducted with 692 people (out of a target population of 98,074 in Qaryout, Beita, Azzun, Kafr Qaddum, Ni'leen, Jerusalem Old Town, Dura, and al-Arroub). The sample size allocated to each location was proportionate to the total population (see Table 1). This sample size produced results with a 3.8% of margin of error at 95% confidence level. The sampling frame was community members over the age of 18, living in project target locations. Households selected to participate in the survey were chosen by enumerators using a random walk technique.

Table 1 Survey sample size, number of FGDs, and in-depth interviews weighted by location

Governorate	Population	Targeted Locations	Target Location Population	Percent of Population	Survey Sample Size	Number of FGDs
Nablus	321,493	Qaryout	2,740	2,8%	33	1 Female
		Beita	12,503	12,7%	96	
Qalqilya	91,046	Azzun	10,034	10,2%	63	1 Male
		Kafr Qaddum	3,551	3,6%	29	1 Female
Ramallah and Al-Bireh	278,018	Ni'leen	5,116	5,2%	55	2 Male
Jerusalem	362,521	Old town	30,260	30,9%	201	2 Male, 1 Female
Hebron	551,129	Dura	31,942	32,6%	186	1 Male
		Al-Arroub	1,928	2,0%	25	1 Female
Total	1,604,207		98,074	100%	692	10 FGDs

The selection of participants for the qualitative interviews and focus group discussions (FGDs) was purposeful and stratified. Interviews (KIIs) were conducted with stakeholders and FGDs were conducted with community members. Given the prevailing social norms among targeted communities, the research team interviewed beneficiaries in sex-segregated groups so that participants would feel comfortable to articulate their views freely. Focus group discussions were held in groups of up to 10 people, allowing all participants to have their opinions heard. Each focus group lasted approximately 90 minutes.

Quantitative Tools

The questionnaire was developed by UDA Consulting and uploaded on UDACAPI, a digital data collection tool developed by UDA Consulting for conducting face-to-face surveys. The quantitative questionnaire consisted of 60 questions covering topics including COVID-19 symptoms, prevention, and treatment choices. The survey also covered accessibility challenges and communication methods used in light of conflict and mobility restrictions experienced In Palestine. The quantitative survey was designed with questions adapted from internationally accepted tools, and WHO guidelines in RCCE.

Qualitative Tools

Key concepts covered in the qualitative research included perceptions about the virus, communication methods and the gaps in that methods, main risks, the community engagement, and the strategy to enhance RCCE in Palestine. The questions design was based on internal and WHO guidelines in RCCE; see below the themes of the qualitative part.

Table 2 Main concepts of the qualitative part

Theme	Main Concepts Addressed
Perception	Stigma, rumors, beliefs, personal health ability measurements, transition perception around the virus, the perception around vaccine
Communication	Information sources, level of trust of these sources, accessibility to access the government platforms to report, complain
Risk	People's attitude toward virus, transition, social distance, willingness to test and vaccinate Impacts of COVID on target communities
Engagement	People's participation in COVID prevention, type of community contribution
Strategies	What main recommendations could work in the future to enhance the RCCE in Palestine.

Enumerator Training

Comprehensive training was conducted with 18 enumerators recruited from the Arabic-speaking PRCS volunteers. The training lasted for two days. The first day was about quantitative research and the second day was about qualitative research. The training was given by an Arabic speaker consultant of UDA's team. At the training workshop, the participants learned about the aim and scope of the project, study objectives, sampling frame, method of approaching households, interviewing techniques, research ethics, data protection, and security and went over the survey with enumerators in detail to ensure their full understanding of the questions. UDACAPI, which was mobile data collection platform used for data collection was also introduced in the training. After the training, the enumerators gained familiarity with the survey by conducting a pilot study among themselves and with the people they could reach.

Data Collection Approach

UDA's data collection tool, UDACAPI, was used for quantitative data collection. To ensure high-quality data, UDA Consulting employed a multi-stage system for data monitoring and cleaning.

1. **Questionnaire programming:** The questionnaire was programmed to include skip logic and answer constraints to reduce the risk of data entry errors. The questionnaire was designed so that only relevant questions are asked to respondents, and limits are imposed on the answer options available for the enumerators. During the programming stage, consistency checks were developed along with the questionnaire to provide another source for checking data quality.

2. **Data monitoring:** As data were submitted, daily data checks were conducted to identify outlier results, inconsistent responses, spelling and formatting errors, and missing data.

3. **Data cleaning:** Following the data collection phase, all the results were compiled and checked using STATA software. Again, the data were checked for accuracy, consistency, and clarity. For this project, no surveys were removed or replaced during the data cleaning process.

The enumerators used tablets/mobile telephones with an android application while interviewing participants face-to-face. The questionnaire was computed through an android application on tablet devices and was filled out online. Before filling out the questionnaire, the enumerators got verbal consent from potential participants. During the COVID-19 pandemic, the UDACAPI data collection method is coming progressively popular as it manages time, more personal safety, reduces human errors, ensures more data safety and accuracy. Through the internet, data on the tablets were immediately transported to a server. UDACAPI allowed our experts to apply quality control and monitoring mechanisms throughout the data collection process and enables its clients (IFRC and PRCS) to monitor data in real-time through the UDACAPI online dashboard.

During the qualitative interviews, facilitators informed participants about the study objectives, and the modalities of the interviewees. Participants were further informed that interview results will be anonymous and treated confidentially.

Interviewees opened the discussion with warm-up questions. Also, they considered giving enough time for each participant and ensuring that the interview was not dominated by specific participants. Also, teams considered carefulness around cultural and body language, for example, avoiding any glace of supporting one idea rather another one, and keeping their facial expression neutral. PRCS volunteers asked follow-up questions to understand the participant's ideas/views better

Data Analysis

After data cleaning, descriptive analyses were performed using STATA and SPSS. Descriptive analysis included frequencies and percentages and, where possible, means and standard deviations for responses. During the data analysis phase, relevant frequency tables and cross tables with chi-square values were produced. The data analysis process entailed careful reflection and triangulation. Correlation tests were performed to assess differences according to demographic factors such as gender, age, and location.

Qualitative data analysis was conducted using a structured approach based on identifying key themes. Where possible, findings were triangulated from multiple sources, including the survey, KIIs and FGDs.

Ethical Considerations

The research team aimed to ensure confidentiality and independence during the quantitative surveys, key informant interviews, and focus group discussions. In FGDs, the groups were same-sex groups, and participants were informed about this beforehand. For both the qualitative and quantitative surveys, a consent form was read to the respondents to get their consent.

The main ethical aspect took into consideration:

- **Personal respect:** All respondents were treated as autonomous agents, in order not to cause any unintended harm and not to put any participant at risk. Participants were not pressured to respond to answer any question.
- **Fairness in distribution:** Fair selection of study participants was applied. Selection was not systematically draw from certain classes simply because of availability or compromised position. The study did not inappropriately include people from groups that are unlikely to be among the beneficiaries of the research results.

Data Protection

UDA Consulting adheres to the ISO 9001 data quality and ISO 27001 data privacy certificates which lay out the specifications for implementing an information security management system (ISMS).

UDA Consulting data security and quality systems are audited by independent auditors every second year. Relevant UDA consulting staff are regularly trained as part of the ISO certificate programs. UDA Consulting data quality and data privacy rules to all of its contractors. The data collection system is password protected where authorized persons have access to the survey data. After the final report is approved by IFRC and PRCS, the entire data is cleaned from UDA Consulting cloud system immediately.

IFRC and PRCS were able to download the survey data from www.udacapi.com anytime during the survey by using the username and password provided given by the UDA team. UDACAPI platform is password protected.

Limitations

Specific challenges and limitations encountered include:

- **Sampling error:** While the sampling methods were designed to minimize the risk of sampling error, there is always the possibility that the participant survey results are subject to sampling error, which may bias the outcomes.

- **Non-sampling error:** This type of error includes all types of bias and error stemming from enumerators and translators. The information from the qualitative discussion relied on the capacity of the translators (Arabic to English), including any potential negative and/or positive bias on their part. While efforts were taken to minimize the risk of such bias during training, it is possible this type of bias could still be present in the data.

- **Contextual factors due to COVID-19 pandemic:** First of all, due to the course of the pandemic and its widespread, data collection was delayed. Also, the RCCE study coincided with the Warm Winter Campaign implemented by PRCS, slowing down data collection. The data collection process was also delayed by a few days due to a snowstorm on January 27th. Due to some respondents' perceptions of COVID-19 and denial of the virus and the effects of the vaccine, it was difficult to give detailed answers in some #.

- **Under reporting:** Although enumerators were instructed to remind the respondent's data safety and privacy, respondents might have declined to participate due to security reasons and concerns about entering enumerators into their houses. Also, the qualitative data did not contain much detail, which prevented adequate triangulation of the quantitative data.

Findings

Demographic Information

In total, 692 respondents participated in the quantitative survey. Slightly more than half (55%) of the respondents were male, and 45% were female. Approximately half (51.4%) of the respondents were between the ages of 41-65 years old, while 37.9% of respondents were aged 26-40. The average age of the respondents was 42.9 (SD= 12.3).

Figure 1 Gender distribution of respondents by age (%)
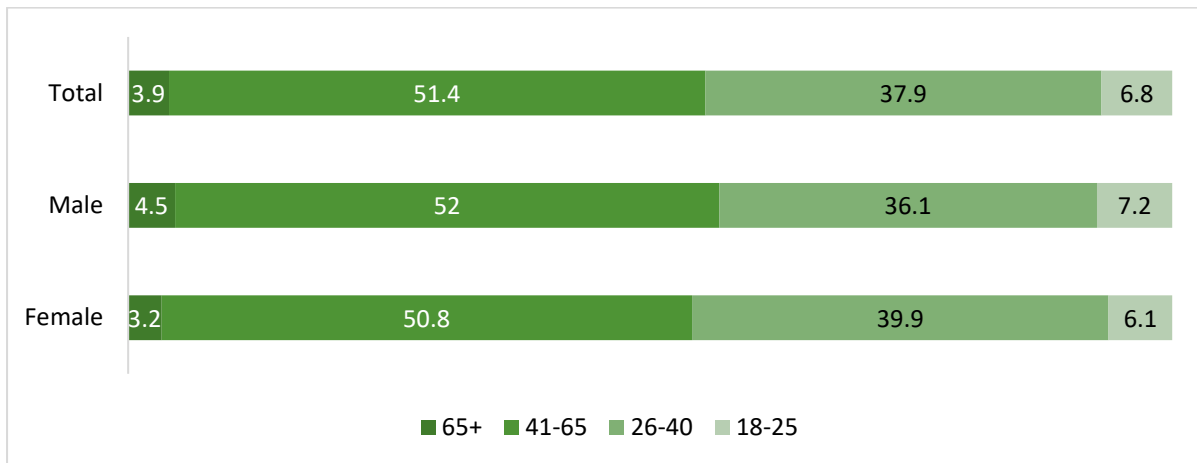
Table 3 Age profile of survey participants

	Mean Age	Median Age	SD	Max	Min	#
Gender						
Male	43.5	43.0	12.6	85	21	379
Female	42.2	42.0	11.9	77	19	313
Location						
Al-Arroub	39.4	33.0	10.8	62	26	25
Azzun	38.7	38.0	9.3	56	23	63
Beita	44.1	45.0	13.1	73	23	96
Dura	39.2	38.5	11.2	72	20	186
Jerusalem (Old Town)	47.6	47.0	12.8	85	22	201
Kafr Qaddum	42.1	42.0	11.6	67	23	29
Ni'leen	44.6	46.0	9.6	63	24	55
Qaryout	40.1	42.0	12.9	67	19	33
Other	43.5	43.0	14.7	59	29	4
Total	42.9	42.0	12.3	85	19	692

The age distribution of respondents varied by location. In Al-Arroub, nearly two-thirds of the respondents were between the ages of 26 and 40 years, while in Ni'leen, only 20% of respondents were

in that age range. The largest proportion of respondents over the age of 65 was in Jerusalem (Old Town) at 9%).

Figure 2 Location distribution by age groups
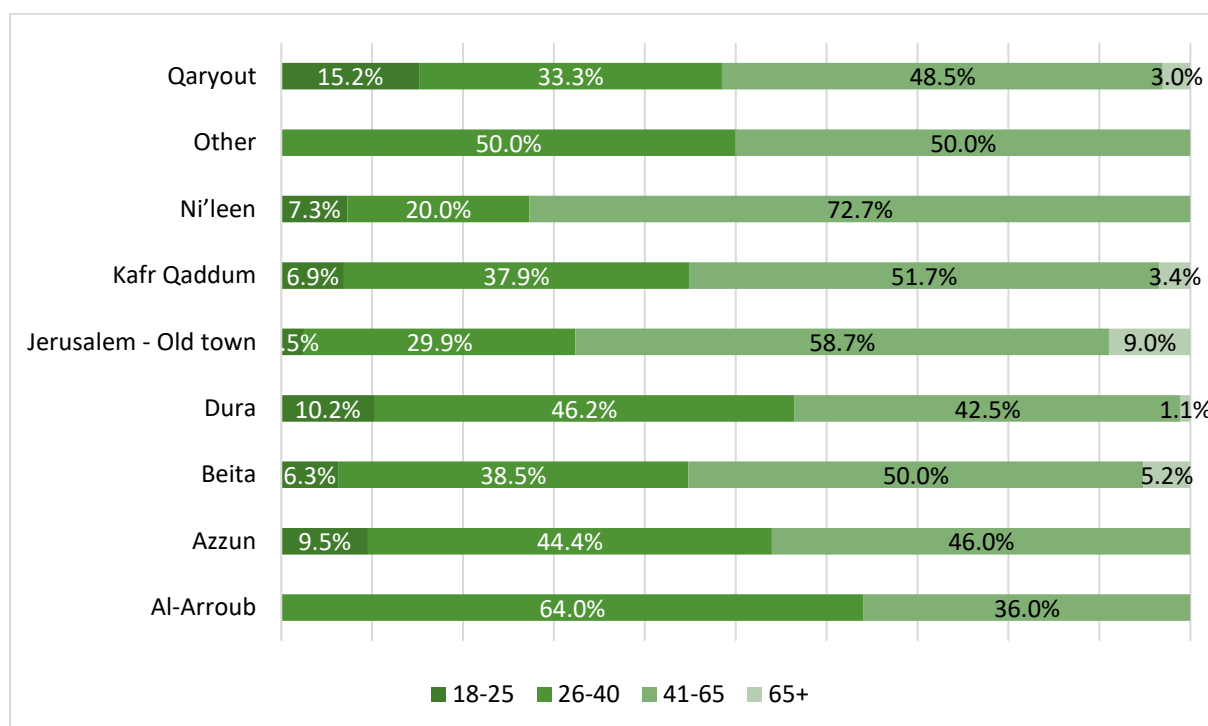
The majority (54.6%) of the respondents were residing in urban areas, followed by city areas (29.3%) and rural areas (12.4%). While only 3.6% of respondents overall were located in camps, all of the respondents in Al-Arroub (100%) lived in a camp. Male respondents were more likely than female respondents to report residing in urban areas compared to female respondents (58.6% compared to 49.8% respectively).

Table 4 Respondent location by gender, age, and location

	Camp		City		Rural		Urban		Total	
	#	%	#	%	#	%	#	%	#	%
Gender										
Male	9	2.4	103	27.2	45	11.9	222	58.6	379	100
Female	16	5.1	100	31.9	41	13.1	156	49.8	313	100
Age Group										
18-25	-	-	17	36.2	11	23.4	19	40.4	47	100
26-40	16	6.1	86	32.8	35	13.4	125	47.7	262	100
41-65	9	2.5	96	27.0	37	10.4	214	60.1	356	100
65+	-	-	4	14.8	3	11.1	20	74.1	27	100
Location										
Al-Arroub	25	100	-	-	-	-	-	-	25	100
Azzun	-	-	-	-	-	-	63	100	63	100
Beita	-	-	-	-	5	5.2	91	94.8	96	100
Dura	-	-	164	88.2	20	10.8	2	1.1	186	100
Jerusalem (Old Town)	-	-	38	18.9	-	-	163	81.1	201	100
Kafr Qaddum	-	-	-	-	29	100	-	-	29	100

Ni'leen	-	-	-	-	1	1.8	54	98.2	55	100
Qaryout	-	-	0	0.0	28	84.8	5	15.2	33	100
Other	-	-	1	25.0	3	75.0	-	-	4	100
Household size										
5 or less	17	4.6	126	34.3	37	10.1	187	51.0	367	100
More than 5	8	2.5	77	24.0	49	15.3	187	58.3	321	100
Total	25	3.6	203	29.5	86	12.5	374	54.4	688	100

Respondents had a mean household size of 5.59 individuals (standard deviation 2.2, including the respondent). The average household size in Palestine in 2020 was 5.1 individuals.[2] Slightly more than half of the respondents (53%) lived in households with 5 or fewer household members. The average household size was the lowest among respondents aged 26-40 (4.94), it was the highest in the age group of 65 and above (6.62). The average household size was the lowest in Al-Arroub (4.96), while it was the highest in Kafr Qaddum (6.24).

The majority (81.4%) of respondents reported that they were married. A small number of respondents reported never being married (9.1%), divorced or separated (4.6%), and 4.8% were widowed.

Nearly half of the respondents (45.8%) reported that their highest level of education was university (45.8%), followed by a secondary/high school (32.4%) and a primary/elementary (14.7%). A significant statistical difference was detected across age (p<0.001) and location (p<0.001). The majority of both female (47.9%) and male (44.1%) respondents had a university degree.

Younger respondents were more likely to reported university education. The majority of respondents aged between 18-25 (55.3%) and of respondents aged between 26-40 (63.4%) had a university degree, while 34.6% of respondents aged 41-65 and only 7.4% of respondents aged 65 and over completed university.

Figure 3 Distribution of education level (%)
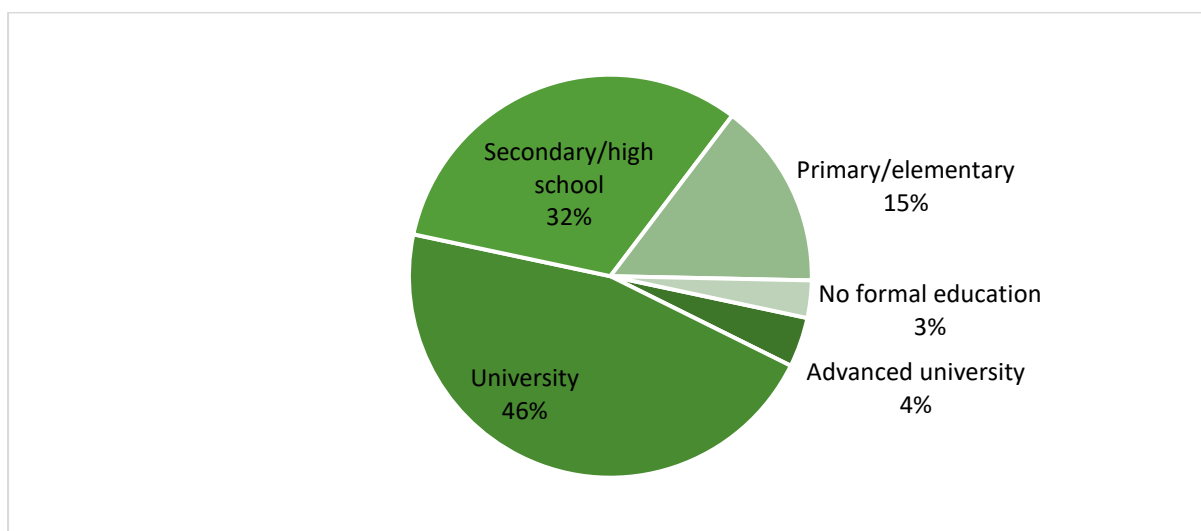
The Washington Group Short Set on Functioning (WG-SS) was used to identify a disability. As suggested by Washington Group,[3] persons who stated that they had "a lot of difficulties" in any of these categories or they "cannot do at all" any of these were identified as people with disabilities (PWD). The majority of the respondents had no difficulty seeing (75.9%), hearing (89.3%), walking 81.1%), remembering (81.8%), with self-care (89%), and communicating (94.4%). According to this analysis, 7% of the respondents were PWD (n=51), while 93% of them were people with no disability. While 9.3% of the female respondents were PWD, the ratio of PWD among male respondents was 5.8%.

Table 5 Difficulties faced by the respondents while doing certain activities

		A lot of difficulty	Cannot do at all	Do not know	No difficulty	Did not answer	Some difficulty	Total
Do you have difficulty seeing, even wearing glasses?	#	19	-	10	525	-	138	692
	%	2.7	-	1.4	75.9	-	19.9	100
Do you have difficulty hearing, even if you use hearing aid(s)?	#	5	2	12	618	1	54	692
	%	0.7	0.3	1.7	89.3	0.1	7.8	100
Do you have difficulty walking or climbing steps?	#	29	2	-	561	1	99	692
	%	4.2	0.3	-	81.1	0.1	14.3	100
Do you have difficulty remembering or concentrating?	#	12	1	-	566	1	112	692
	%	1.7	0.1	-	81.8	0.1	16.2	100
Do you have difficulty with self-care (washing, dressing)?	#	11	-	-	616	2	63	692
	%	1.6	-	-	89	0.3	9.1	100
Using your usual (customary) language, do you have difficulty communicating, understanding, or being understood?	#	2	-	-	653	1	36	692
	%	0.3	-	-	94.4	0.1	5.2	100

The majority of the respondents reporting working in some capacity. Nearly half of the respondents reported working as employees (48.3%) and 22% reported that they were business owners. Nearly a quarter of the respondents (23.7%) were unemployed. A significant statistical difference was detected across gender, age groups, and location (p<0.001 for all). The unemployment rate was the highest among respondents aged 65 and above (44.4%) and the lowest among respondents aged between 26-40 (21%). Over a third of respondents 18-25 (38.3%) were unemployed including students as well.

The unemployment rate was almost five times higher among female respondents (41.9%) compared male respondents (8.7%). Among male respondents, 30.3% were business owners and 53.6% of them were employee, while these rates for female respondents were 11.8% and 41.9% respectively.

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[3] See https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/WG_Implementation_Document__1_-_Data_Collection_Tools_Developed_by_the_Washington_Group.pdf

Figure 4 Employment status by gender (%)

	Business owner	Employee	Retired	Unemployed
Female	11.8	41.9	4.5	41.9
Male	30.3	53.6	7.4	8.7
Total	22	48.3	6.1	23.7
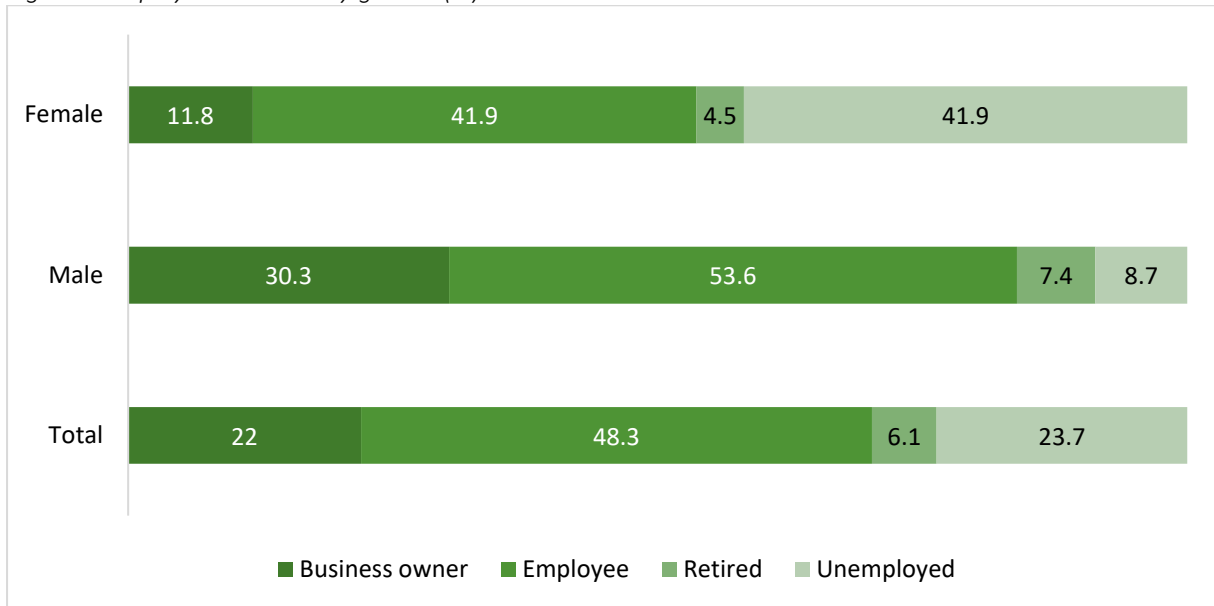
Figure 5 Employment status by age group (%)

	Business owner	Employee	Retired	Unemployed
65+	7.4	7.4	40.7	44.4
41-65	25.6	43.5	8.7	22.2
26-40	19.1	59.9		21
18-25	19.1	42.6		38.3
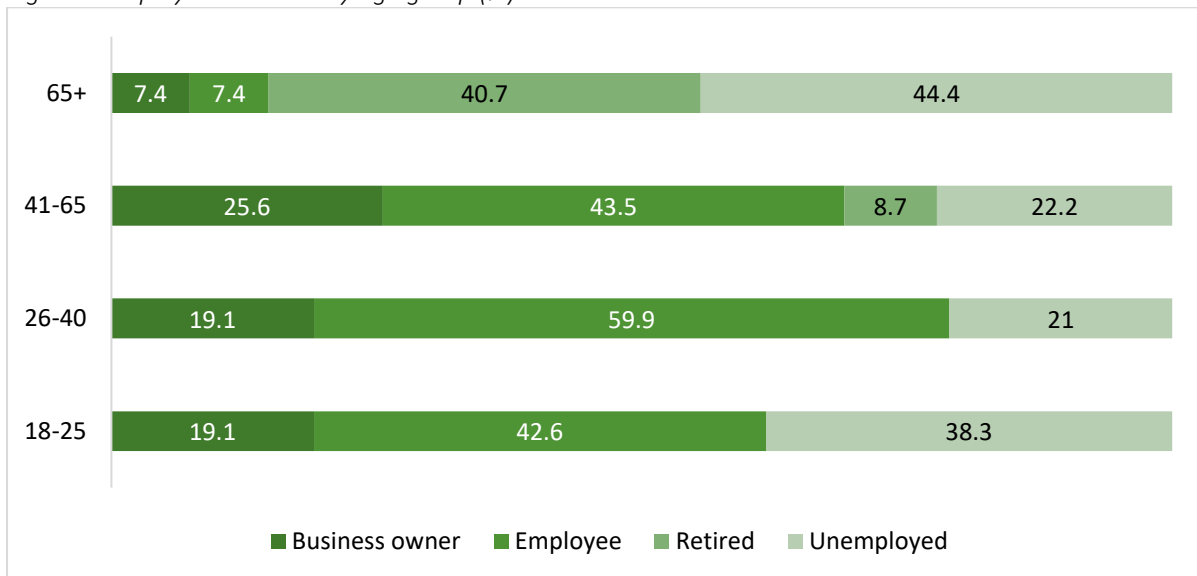
Figure 6 Employment status by location (%)
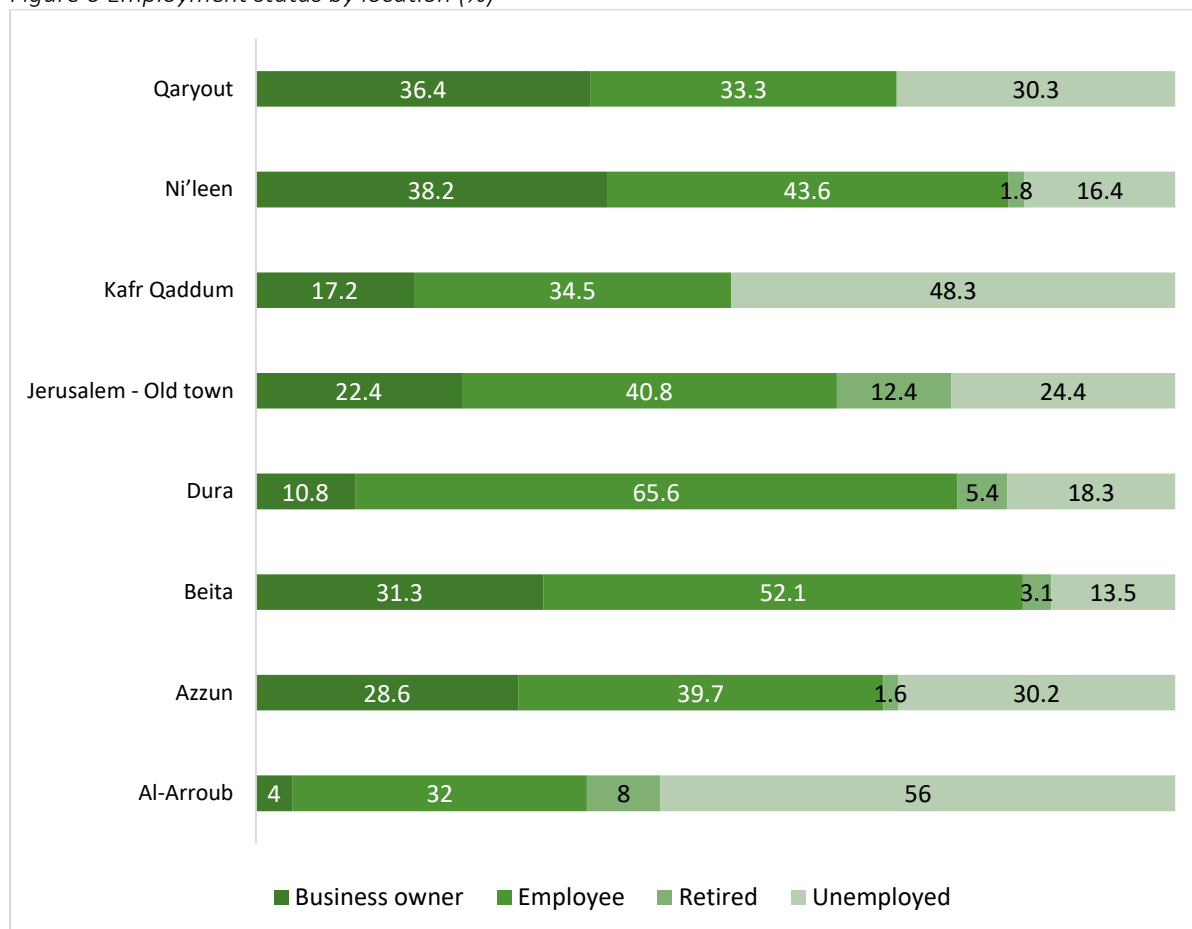
The average monthly income was 3,563.6 NIS or $1103.3USD (standard deviation=2,352.6 NIS). The average monthly income of male respondents was higher than female (3,904.5 NIS or $1,208.8 USD and 3,126.1 NIS or $967.8 USD respectively). Also, respondents in Jerusalem had averagely the highest monthly income (5386.2 NIS or $1,667.5 USD).

Table 6 Descriptive statistics of monthly income by gender, age, and location

	Mean (NIS)	Median	SD	Max	Min	#
Gender						
Male	3904.5	3100.0	2561.7	30600.0	500.0	267.0
Female	3126.1	3000.0	1974.5	15000.0	300.0	208.0
Location						
Al-Arroub	2430.0	2250.0	878.2	4000.0	1000.0	10.0
Azzun	2860.0	2400.0	1836.0	9000.0	300.0	20.0
Beita	3505.1	3000.0	2224.4	15000.0	1000.0	79.0
Dura	3101.7	3000.0	1485.8	12000.0	500.0	181.0
Jerusalem (Old Town)	5386.2	5000.0	2164.8	10000.0	1800.0	91.0
Kafr Qaddum	5284.7	3000.0	7254.5	30600.0	850.0	15.0
Ni'leen	2455.6	2000.0	986.5	6000.0	1000.0	54.0
Qaryout	2836.0	2500.0	1721.9	7000.0	500.0	25.0
Total	3563.6	3000.0	2352.6	30600.0	300.0	475.0

Perceptions of COVID-19

This section investigates the perceptions of respondents regarding COVID-19, including respondents' health concerns, risk perception, health information sources and trust.

Almost half of the respondents reported that they had been concerned or very concerned about their health during the COVID-19 pandemic (28.5% and 24.7% respectively). A significant statistical difference was detected across gender, location, education, and having been contracted COVID-19 (p=0.02, p<0.001, p=0.05, p<0.001, respectively).

Female respondents were more likely to report that they were concerned or very concerned about their health during the COVID-19 pandemic compared to male respondents (56.8% and 50.1%, respectively). The respondents in Al-Arroub were the most likely to report concern about their health during the COVID-19 pandemic (88%), while respondents in Qaryout (24.2%) and Jerusalem (32.4%) were the least likely to report concern.

As respondents' level of education increased, the concern level of the respondents increased. Respondents with no formal education had the lowest concern (33.4%), while respondents with university degree had the highest (60.9%).

The majority of respondents (71.5%) who had contracted COVID-19 were concerned or very concerned about their health, while 60.6% of the respondents who had a family member who had contracted COVID-19 reported concern, and only 37% of the respondents with no family or personal history of the COVID-19 were concerned or very concerned.

Table 7 How concerned were you about your health during the COVID-19 pandemic?

	Not concerned at all		Not really concerned		Neither concerned nor unconcerned		Concerned		Very concerned		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Gender												
Male	90	23.7	55	14.5	44	11.6	108	28.5	82	21.6	379	100
Female	46	14.7	55	17.6	34	10.9	89	28.4	89	28.4	313	100
Location												
Al-Arroub	-	-	2	8.0	1	4.0	2	8.0	20	80.0	25	100
Azzun	17	27.0	8	12.7	10	15.9	20	31.7	8	12.7	63	100
Beita	37	38.5	8	8.3	6	6.3	32	33.3	13	13.5	96	100
Dura	15	8.1	7	3.8	7	3.8	55	29.6	102	54.8	186	100
Jerusalem (Old Town)	44	21.9	51	25.4	41	20.4	48	23.9	17	8.5	201	100
Kafr Qaddum	1	3.4	10	34.5	5	17.2	9	31.0	4	13.8	29	100
Ni'leen	8	14.5	13	23.6	4	7.3	24	43.6	6	10.9	55	100
Qaryout	13	39.4	8	24.2	4	12.1	7	21.2	1	3.0	33	100
Other	1	25.0	3	75.0	-	-	-	-	-	-	4	100
Education												
No formal education	5	27.8	4	22.2	3	16.7	3	16.7	3	16.7	18	100
Primary/elementary	21	20.6	22	21.6	18	17.6	23	22.5	18	17.6	102	100
Secondary/high school	53	23.7	38	17.0	24	10.7	57	25.4	52	23.2	224	100
University	54	17.0	39	12.3	31	9.8	104	32.8	89	28.1	317	100

Advanced university	3	9.7	7	22.6	2	6.5	10	32.3	9	29.0	31	100
Have you or someone in your family been contracted COVID 19?												
Yes (self)	28	10.9	27	10.5	18	7.0	89	34.8	94	36.7	256	100
Yes (family member)	54	14.5	47	12.6	46	12.3	108	29.0	118	31.6	373	100
No	65	29.8	44	20.2	28	12.8	44	20.2	37	17.0	218	100
Total	136	19.7	110	15.9	78	11.3	197	28.5	171	24.7	692	100

The majority of respondents reported that they (37%) and/or a family member (53.9%) had previously contracted COVID-19. The results were statistically significant by location (p<0.001). Respondents in Dura were most likely to report that a family member had contracted COVID-19 (77.4%) and least likely to report the same in Al-Arroub (20.0%) and Azzun (20.6%).

Table 8 B2. Have you or someone in your family been contracted COVID 19? (Location)

Covid Diagnosis		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni'leen	Qaryout	Total
Yes (family member)	#	5	13	41	144	120	17	26	7	373
	%	20.0	20.6	42.7	77.4	59.7	58.6	47.3	21.2	53.9
Yes (self)	#	4	15	19	126	66	8	13	3	256
	%	16.0	23.8	19.8	67.7	32.8	27.6	23.6	9.1	37.0
No	#	16	37	48	19	49	6	16	25	218
	%	64.0	58.7	50.0	10.2	24.4	20.7	29.1	75.8	31.5
Total[4]	#	25	63	96	186	201	29	55	33	692

The majority of respondents (57.6%) reported that COVID-19 was dangerous (31.1%) or very dangerous (256.5%). One in five participants (21.2%) reported that COVID-19 was not dangerous. Differences in perception of danger was statistically significant by gender (p-=0.04), location (p<0.001), education status (p=0.001), and tendencies to engage in activities to better prevent COVID-19 (p=0.002) and prior COVID-19 experience (p<0.001).

Female respondents were more likely to report that COVID-19 was dangerous compared to male respondents (64.2% and 58.3%). Respondents in Al-Arroub (92.0%) and Dura (91.4%) were the most likely to view COVID-19 as dangerous, while respondents in Beita (38.5%) and Kafr Qaddum (27.6%) were the most likely to view COVID-19 as not dangerous.

Respondents with higher levels of education were more likely to report viewing COVID-19 as dangerous. The study results show that 68.1% of the respondents with university degree thought COVID-19 dangerous or very dangerous, while 46% of respondents with primary school education reported the same.

Respondents with higher levels of concern for their health were more likely to report that COVID-19 was dangerous compared to respondents with lower health concerns. Almost all respondents who reported being very concerned about their health perceived the COVID-19 risk as dangerous or very dangerous (96.5%), while respondents who were not concerned at all about their health were far less likely to rate COVID-19 as dangerous (26.5%).

Respondents with a family history of COVID-19 were more likely to view COVID-19 as dangerous. Among respondents who contracted COVID-19, 73.4% perceived COVID-19 to be dangerous or very dangerous.

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[4] In the table of multiple answer questions, "#" represent the number of the respondents, while "#" shows how many times the relevant option was stated by the respondents in total. Since these questions allow the respondents to state more than one answer, the sum of the #s may exceed the case number.

Similarly, 65.9% of the respondents with a family member that contracted COVID-19 reported it was dangerous or very dangerous. By contrast, less than half (49.6%) of the respondents with no family history of the COVID-19 viewed the virus as dangerous or very dangerous.

In FGDs, participants reported that their perception of risk for COVID-19 changed over time. Many participants reported that they had not taken COVID-19 seriously that at the beginning of the pandemic. Some participants reported that they thought that the virus had been produced in the laboratory, while others did not believe the virus would spread. However, as news of the virus spreading emerged, participants' perception of risk increased. FGD participants had varying perceptions of the COVID-19. Some participants compared it to the flu (influenza) while others #ered that the virus posed a greater risk. because it is more severe than the flu, has different physical symptoms, and is highly contagious. Participants in FGDs noted that the risks of COVID-19 were not exclusive to the elderly and infirmed and noted that young, healthy people were also dying from COVID-19.

Table 9 How dangerous do you think the COVID-19 risk is?

	Very dangerous		Dangerous		Neither dangerous nor not dangerous		Not dangerous		Not dangerous at all		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Gender												
Male	88	23.2	133	35.1	73	19.3	43	11.3	42	11.1	379	100
Female	91	29.1	110	35.1	62	19.8	34	10.9	16	5.1	313	100
Location												
Al-Arroub	20	80.0	3	12.0	1	4.0	-	-	1	4.0	25	100
Azzun	8	12.7	27	42.9	17	27.0	7	11.1	4	6.3	63	100
Beita	12	12.5	41	42.7	6	6.3	17	17.7	20	20.8	96	100
Dura	104	55.9	66	35.5	9	4.8	7	3.8	-	-	186	100
Jerusalem (Old Town)	20	10.0	59	29.4	70	34.8	29	14.4	23	11.4	201	100
Kafr Qaddum	1	3.4	9	31.0	11	37.9	6	20.7	2	6.9	29	100
Ni'leen	9	16.4	26	47.3	10	18.2	7	12.7	3	5.5	55	100
Qaryout	5	15.2	11	33.3	8	24.2	4	12.1	5	15.2	33	100
Other	-	-	1	25.0	3	75.0	-	-	-	-	4	100
Education												
No formal education	5	27.8	4	22.2	5	27.8	4	22.2	-	-	18	100
Primary/elementary	18	17.6	29	28.4	33	32.4	10	9.8	12	11.8	102	100
Secondary/high school	56	25.0	74	33.0	36	16.1	29	12.9	29	12.9	224	100
University	90	28.4	126	39.7	52	16.4	32	10.1	17	5.4	317	100
Advanced university	10	32.3	10	32.3	9	29.0	2	6.5	-	-	31	100
How concerned were you about your health during the COVID-19 pandemic?												
Not concerned at all	10	7.4	26	19.1	26	19.1	32	23.5	42	30.9	136	100
Not really concerned	8	7.3	28	25.5	45	40.9	17	15.5	12	10.9	110	100
Neither concerned nor unconcerned	2	2.6	23	29.5	40	51.3	12	15.4	1	1.3	78	100
Concerned	32	16.2	128	65.0	21	10.7	15	7.6	1	0.5	197	100
Very concerned	127	74.3	38	22.2	3	1.8	1	0.6	2	1.2	171	100
Have you or someone in your family been contracted COVID 19?												

Yes (self)	95	37.1	93	36.3	38	14.8	23	9.0	7	2.7	256	100
Yes (family member)	124	33.2	122	32.7	73	19.6	37	9.9	17	4.6	373	100
No	37	17.0	71	32.6	43	19.7	32	14.7	35	16.1	218	100
If no, would you like to be engaged?												
Yes	27	25.7	38	36.2	22	21	9	8.6	9	8.6	105	100
No	72	22.6	97	30.4	72	22.6	46	14.4	32	10.0	319	100
I do not know	27	51.9	13	25.0	7	13.5	3	5.8	2	3.8	52	100
Total	126	26.5	148	31.1	101	21.2	58	12.2	43	9.0	476	100

In the qualitative interviews, people need psychological support due to the effects of the ongoing pandemic conditions for more than 2 years. These needs were mainly caused by the long-term stress of people with chronic diseases, limited socialization of children, marital problems, including acts of violence. During the COVID-19 pandemic, which is not only difficult in terms of health but also psychologically, there is a need for psychological support studies.

There isn't a shadow of a doubt that the pandemic has also forced people economically. Although none of the participants mentioned of a decrease in their income or reported that they lost employment, it was clear that many had experienced economic difficulties due to increased prices (e.g., food, transportation costs, etc.) and taxes. In addition, they talked about the economic difficulties experienced by sectors such as shops and factories, which were closed especially in the first period. It can be said that economic support is also important in the pandemic. In addition to the disadvantaged groups such as the disabled and refugees, the needs of some groups may arise due to the nature of the pandemic. For example, in households where only one person works, if that person is contracted COVID-19, the already limited income can be severely affected.

"The current danger is an economic one. I can't find bread to feed my children with. Because the bills you are looking forward to are big." (Ni'leen, Male, FGD)

"In the beginning, it was physical, psychological, and economic. Today's risks are mostly economic, afraid of the economy or death." (Ni'leen, Male, FGD)

COVID-19 Knowledge

Nearly all respondents reported that they had received some information about COVID-19 (97.4%). The majority of respondents reported that they had received information on what to do if symptomatic (60.8%), symptoms of COVID-19 (79.2%), prevention measured (83.7%), and how COVID-19 is transmitted (69.2%). Less than half of the respondents reported that they had received information about vaccinations (44.7%), risks and complications of COVID-19 (44.4%), and the process of reporting COVID-19 (40.6%).

Respondents aged 18-25 were less likely to report receiving information about COVID-19 compared to other age groups. A low proportion of respondents aged 18 to 25 had received information about vaccination (25.5%), testing (36.5%), symptoms of COVID-19 (63.8%), and what to do if symptomatic (44.7%). Respondents aged 65 and above received the least information about risk and complications (29.2%).

Respondents in Jerusalem and Beita were more than twice as likely to have received information about what to do if symptomatic compared to respondents in Ni'leen and Azzun (79.6%, 75%, 29.1%, and

33.3%, respectively). Respondents in Jerusalem were eight times more likely to report receiving information about testing compared to respondents in Al-Arroub (81.1% and 12% respectively). Respondents in Jerusalem (91%) and Beita (89.6%) were the most likely to report that they had received information about symptoms of COVID-19. Almost all respondents in Beita (99%), Jerusalem (96%) and Al-Arroub (96%), and all of respondents in Kafr Qaddum received information about COVID-19 prevention strategies, while this rate dropped to almost half in Ni'leen (56.4%). Similarly, the majority of respondents in Jerusalem (86.6%) and Beita (82.3%) received information about how the virus is transmitted, while this rate was 38.1% in Azzun and 38.2% in Ni'leen. The respondents with disabilities were slightly more likely to report receiving information about prevention strategies compared respondents with no disabilities (88.2% and 83.3%, respectively).

Differences were statistically significant for age groups (p-value= 0.001), location (p<0.001) and disability status (p=0.002).

Table 10 Information about COVID-19 received by respondents by age group

		18-25	26-40	41-65	65+	Total
COVID-19 symptoms	#	21	164	218	18	421
	%	44.7	62.6	61.2	66.7	60.8
Vaccine related information	#	12	128	158	11	309
	%	25.5	48.9	44.4	40.7	44.7
Testing	#	17	134	197	17	365
	%	36.2	51.1	55.3	63.0	52.7
Symptoms of the COVID-19	#	30	210	284	24	548
	%	63.8	80.2	79.8	88.9	79.2
Risks and complications	#	14	121	164	8	307
	%	29.8	46.2	46.1	29.6	44.4
Received no information at all	#	3	8	7	-	18
	%	6.4	3.1	2.0	-	2.6
Process of reporting COVID-19	#	16	113	140	12	281
	%	34.0	43.1	39.3	44.4	40.6
How it is transmitted	#	28	184	244	23	479
	%	59.6	70.2	68.5	85.2	69.2
Isolation measures	#	14	135	184	16	349
	%	29.8	51.5	51.7	59.3	50.4
How to protect yourself from the COVID-19	#	41	223	289	26	579
	%	87.2	85.1	81.2	96.3	83.7
Other	#	1	8	15	1	25
	%	2.1	3.1	4.2	3.7	3.6
Total	#	47	262	356	27	692

Table 11 Information about COVID-19 received by respondents by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni' leen	Qaryout	Total
What to do if you have the symptoms	#	9	21	72	104	160	15	16	23	421
	%	36.0	33.3	75.0	55.9	79.6	51.7	29.1	69.7	60.8

Vaccine related information	#	11	16	63	51	109	12	33	14	309
	%	44.0	25.4	65.6	27.4	54.2	41.4	60.0	42.4	44.7
Testing	#	3	14	62	69	163	10	22	21	365
	%	12.0	22.2	64.6	37.1	81.1	34.5	40.0	63.6	52.7
Symptoms of the COVID-19	#	14	41	86	128	183	26	39	28	548
	%	56.0	65.1	89.6	68.8	91.0	89.7	70.9	84.8	79.2
Risks and complications	#	9	21	50	79	102	5	25	16	307
	%	36.0	33.3	52.1	42.5	50.7	17.2	45.5	48.5	44.4
Received no information at al	#	-	1	-	16	1	-	-	-	18
	%	-	1.6	-	8.6	0.5	-	-	-	2.6
Process of reporting COVID-19	#	5	11	60	59	119	5	4	18	281
	%	20.0	17.5	62.5	31.7	59.2	17.2	7.3	54.5	40.6
How it is transmitted	#	17	24	79	118	174	20	21	25	479
	%	68.0	38.1	82.3	63.4	86.6	69.0	38.2	75.8	69.2
Isolation measures	#	13	25	62	60	145	10	19	15	349
	%	52.0	39.7	64.6	32.3	72.1	34.5	34.5	45.5	50.4
How to protect yourself from the COVID-19?	#	24	50	95	125	193	29	31	29	579
	%	96.0	79.4	99.0	67.2	96.0	100	56.4	87.9	83.7
Other	#	-	1	-	23	-	1	-	-	25
	%	-	1.6	-	12.4	-	3.4	-	-	3.6
#	#	25	63	96	186	201	29	55	33	692

Figure 7 Information about COVID-19 received by respondents by disability status (%)

	PWD	Not-PWD
How it is transmitted	66.7	69.4
How to protect yourself from the COVID-19? (Hygiene, use of masks, social distancing, etc,)	88.2	83.3
Isolation measures	33.3	51.8
Other	2	3.7
Process of reporting COVID-19	25.5	41.8
Received no information at all		2.8
Risks and complications	25.5	45.9
Symptoms of the COVID-19	74.5	79.6
Testing	41.2	53.7
Vaccine related information	31.4	45.7
What to do if you have the symptoms	60.8	60.8

Sources of Information

The most commonly cited sources of information about COVID-19 respondents reported were social media (Facebook, Twitter, Instagram) (66.5%), television (51.7%), and Internet searches (49.6%). The results were statistically significant across age groups (p<0.001), location (p<0.001), education (p<0.001), and disability status (p<0.001).

For the respondents aged 18-65, social media (76.6%, 74% and 61.5%) were the most preferred channels to access information about COVID-19. While respondents aged 65 and above preferred television and radio more than other age groups (77.8% and 40.7%).

Respondents reported different sources of information based on their location. Television was preferred by most respondents in Jerusalem (63.7%) but was cited by only a minority of respondents in Al-Arroub (20%). Social media reported by the majority of respondents in Beita (81.3%), but only one-third of respondents in Al-Arroub stated it (36%). Internet searches were the most preferred source for respondents in Dura (59.7%) and Jerusalem (59.2%), however, only 12% of respondents in Al-Arroub stated so. A plurality of respondents in Al-Arroub reported receiving information from health units or health care workers (48%) and community health workers (44%).

Table 12 Sources used to access COVID-19 information by age group

		18-25	26-40	41-65	65+	Total
Television	#	20	112	205	21	358
	%	42.6	42.7	57.6	77.8	51.7
Traditional midwives	#	-	1	2	-	3
	%	-	0.4	0.6	-	0.4
Traditional healers	#	-	1	3	-	4
	%	-	0.4	0.8	-	0.6
Social Media (Facebook, Twitter, Instagram)	#	36	194	219	11	460
	%	76.6	74.0	61.5	40.7	66.5
Religious leaders	#	1	4	3	-	8
	%	2.1	1.5	0.8	-	1.2
Radio	#	5	38	87	11	141
	%	10.6	14.5	24.4	40.7	20.4
Mobile apps (WhatsApp, Viber, Telegram, Signal)	#	17	117	143	9	286
	%	36.2	44.7	40.2	33.3	41.3
Call to trusted medical services providers	#	11	48	77	3	139
	%	23.4	18.3	21.6	11.1	20.1
Internet search	#	30	135	167	11	343
	%	63.8	51.5	46.9	40.7	49.6
Health unit, health care workers	#	9	101	148	10	268
	%	19.1	38.5	41.6	37.0	38.7
Family, friends, and neighbors	#	7	50	68	2	127
	%	14.9	19.1	19.1	7.4	18.4
Face-to-face awareness sessions	#	4	32	59	5	100
	%	8.5	12.2	16.6	18.5	14.5
Community leaders	#	-	10	12	-	22
	%	-	3.8	3.4	-	3.2
Community health workers	#	3	48	51	1	103
	%	6.4	18.3	14.3	3.7	14.9
Booklets or flyers	#	4	46	81	8	139
	%	8.5	17.6	22.8	29.6	20.1
Other	#	-	-	1	-	1
	%	-	-	0.3	-	0.1
#	#	47	262	356	27	692

Respondents with lower levels of education showed a preference for television as a source of COVID-19 information. The majority of respondents (77.8%) having no formal education received COVID-19 information from television compared to 49.8% for respondents with a university degree. Conversely, social media was a preferred source of information among respondents with higher levels of education. Social media was the least cited source among respondents with no formal education but was cited as a source by the majority of respondents with secondary/high school (70.1%) and a university education (69.7%). The use of the internet and mobile applications to access information about COVID-19 increased with the level of education. Internet was stated as a source by 30.4% of respondents having primary level and 56.8% of respondents with a university degree. Mobile apps were cited by 27.8% of respondents with no primary education and 45.7% of respondents with a university education and 45.2% of advanced university level respondents.

Respondents with no disability were mostly likely to cited social media (68.6%) as a source of information, while the respondents with disabilities were most likely to report television as a source (64.7%).

The most used channel in all income levels was social media. (68.3%) In addition, channels that cost money including internet search, television, and mobile applications usage were stated less at the lowest income level (34.7%, 42.7%, and 27.4%). It was observed that free tools such as community leaders, community health workers, and booklets were used more frequently by respondents in the lowest income category (6.5%, 14.5%, and 18.6).

Table 13 Sources used to access COVID-19 information by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni'leen	Qaryout	Total
Television	#	5	23	50	105	128	13	23	10	358
	%	20.0	36.5	52.1	56.5	63.7	44.8	41.8	30.3	51.7
Traditional midwives	#	-	-	1	-	2	-	-	-	3
	%	-	-	1.0	-	1.0	-	-	-	0.4
Traditional healers	#	-	-	1	1	2	-	-	-	4
	%	-	-	1.0	0.5	1.0	-	-	-	0.6
Social Media (Facebook, Twitter, Instagram)	#	9	41	78	121	133	16	38	23	460
	%	36.0	65.1	81.3	65.1	66.2	55.2	69.1	69.7	66.5
Religious leaders	#	-	1	2	1	2	-	2	-	8
	%	-	1.6	2.1	0.5	1.0	-	3.6	-	1.2
Radio	#	2	5	25	37	56	2	8	5	141
	%	8.0	7.9	26.0	19.9	27.9	6.9	14.5	15.2	20.4
Mobile apps (WhatsApp, Viber, Telegram, Signal)	#	6	12	42	60	125	18	8	13	286
	%	24.0	19.0	43.8	32.3	62.2	62.1	14.5	39.4	41.3
Call to trusted medical services providers	#	-	3	17	68	45	2	2	2	139
	%	-	4.8	17.7	36.6	22.4	6.9	3.6	6.1	20.1
Internet search	#	3	17	48	111	119	10	17	15	343
	%	12.0	27.0	50.0	59.7	59.2	34.5	30.9	45.5	49.6
Health unit, health care workers	#	12	22	32	42	123	8	16	13	268
	%	48.0	34.9	33.3	22.6	61.2	27.6	29.1	39.4	38.7
Family, friends, and neighbors	#	1	17	42	36	15	3	5	8	127
	%	4.0	27.0	43.8	19.4	7.5	10.3	9.1	24.2	18.4
Face-to-face awareness sessions	#	2	5	14	29	27	12	7	4	100
	%	8.0	7.9	14.6	15.6	13.4	41.4	12.7	12.1	14.5
Community leaders	#	-	-	3	9	3	2	3	2	22
	%	-	-	3.1	4.8	1.5	6.9	5.5	6.1	3.2
Community health workers	#	11	5	13	27	27	5	5	9	103
	%	44.0	7.9	13.5	14.5	13.4	17.2	9.1	27.3	14.9
Booklets or flyers	#	3	3	23	25	59	6	15	5	139
	%	12.0	4.8	24.0	13.4	29.4	20.7	27.3	15.2	20.1
Other	#	-	-	-	-	1	-	-	-	1
	%	-	-	-	-	0.5	-	-	-	0.1
#	#	25	63	96	186	201	29	55	33	692

Table 14 Sources used to access COVID-19 information by education level

		No formal education	Primary/elementary	Secondary/high school	University	Advanced university	Total
Television	#	14	57	115	158	14	358
	%	77.8	55.9	51.3	49.8	45.2	51.7
Traditional midwives	#	-	-	-	2	1	3
	%	-	-	-	0.6	3.2	0.4
Traditional healers	#	-	1	-	2	1	4
	%	-	1.0	-	0.6	3.2	0.6
Social Media (Facebook, Twitter, Instagram)	#	8	53	157	221	21	460
	%	44.4	52.0	70.1	69.7	67.7	66.5
Religious leaders	#	-	-	3	3	2	8
	%	-	-	1.3	0.9	6.5	1.2
Radio	#	6	24	43	60	8	141
	%	33.3	23.5	19.2	18.9	25.8	20.4
Mobile apps (WhatsApp, Viber, Telegram, Signal)	#	5	34	88	145	14	286
	%	27.8	33.3	39.3	45.7	45.2	41.3
Call to trusted medical services providers	#	4	10	40	75	10	139
	%	22.2	9.8	17.9	23.7	32.3	20.1
Internet search	#	6	31	107	180	19	343
	%	33.3	30.4	47.8	56.8	61.3	49.6
Health unit, health care workers	#	9	26	90	130	13	268
	%	50.0	25.5	40.2	41.0	41.9	38.7
Family, friends, and neighbors	#	-	20	47	57	3	127
	%	-	19.6	21.0	18.0	9.7	18.4
Face-to-face awareness sessions	#	1	13	30	51	5	100
	%	5.6	12.7	13.4	16.1	16.1	14.5
Community leaders	#	-	-	8	12	2	22
	%	-	-	3.6	3.8	6.5	3.2
Community health workers	#	-	9	25	60	9	103
	%	-	8.8	11.2	18.9	29.0	14.9
Booklets or flyers	#	3	15	45	67	9	139
	%	16.7	14.7	20.1	21.1	29.0	20.1
Other	#	-	-	1	-	-	1
	%	-	-	0.4	-	-	0.1
#	#	18	102	224	317	31	692

Table 15 Sources used to access COVID-19 information by disability status

		Not-PWD	PWD	Total
Television	#	325	33	358
	%	50.7	64.7	51.7
Traditional midwives	#	3	-	3
	%	0.5	-	0.4
Traditional healers	#	4	-	4
	%	0.6	-	0.6
Social Media (Facebook, Twitter, Instagram)	#	440	20	460
	%	68.6	39.2	66.5
Religious leaders	#	8	-	8
	%	1.2	-	1.2
Radio	#	125	16	141
	%	19.5	31.4	20.4
Mobile apps (WhatsApp, Viber, Telegram, Signal…)	#	269	17	286
	%	42.0	33.3	41.3
Making a call to trusted medical services providers	#	135	4	139
	%	21.1	7.8	20.1
Internet searches	#	326	17	343
	%	50.9	33.3	49.6
Health Unit/Health care worker	#	249	19	268
	%	38.8	37.3	38.7
Family, friends, and neighbors	#	123	4	127
	%	19.2	7.8	18.4
Face-to-face awareness sessions	#	96	4	100
	%	15.0	7.8	14.5
Community leaders	#	20	2	22
	%	3.1	3.9	3.2
Community health workers	#	96	7	103
	%	15.0	13.7	14.9
Booklet/flyers	#	133	6	139
	%	20.7	11.8	20.1
Other	#	1	-	1
	%	0.2	-	0.1
#	#	641	51	692

Table 16 Sources used to access COVID-19 information by income category

	300-2000 NIS/ 92.8-619,2 USD	2001-3000 NIS/ 619,5-928,8 USD	3001-4000 NIS/ 929,1-1238,4 USD	4001+ NIS/ 1238,7+ USD	Total
Radio	13.7	20.8	24.5	25.2	20.7
Television	42.7	52.1	58.5	59.5	52.6
Mobile apps (WhatsApp, Viber, Telegram,	27.4	38.2	43.6	49.6	39.1
Internet searches	34.7	58.3	48.9	61.3	51.0
Social Media (Facebook, Twitter, Instagram)	62.9	75.0	67.0	66.7	68.3
Health unit or health care workers	31.5	31.9	35.1	44.1	35.3
Making a call to trusted medical services	18.6	29.9	22.3	23.4	23.9
Booklet or flyers	18.6	18.8	16.0	34.2	21.8
Face-to-face awareness sessions	14.5	16.0	13.8	17.1	15.4
Family, friends, and neighbors	20.2	23.6	24.5	15.3	20.9
Community health workers	14.5	16.0	10.6	22.5	16.1
Community leaders	6.5	3.5	2.1	4.5	4.2
Religious leaders	0.8	2.1	-	2.7	1.5
Traditional healers	-	-	1.1	2.7	0.9
Traditional midwives	-	-	-	2.7	0.6
Other	-	-	-	0.9	0.2

The most trusted sources of information related to COVID-19 were health units or health care workers (45,2%), social media (Facebook, Twitter, Instagram) (29.8%), and television (29%). The results were statistically significant by gender (p=0.005), age groups (p<0.001), location (p<0.001), education (p=0.003) and disability (p=0.01).

Female respondents were more likely to report trust face-to-face and personal sources of information like health units and health care workers (48.2% and 42.7%), trusted medical professionals (19.8% and 16.1%), and face-to-face awareness sessions (15.2% and 9.5%). Male respondents were more likely to report trusting web and mobile sources like mobile apps (18.7% and 13.7%), internet searches (29.3% and 24.3%) and social media (32.5% and 26.5%).

Older respondents were the most likely to report trusting television (40.7%), radio (29.6%), face-to-face sessions (14.8%) and community health workers (29.6%). Younger respondents (18 to 25 years) were the most likely to trust mobile apps (23.4%).

Trusted sources varied by location. Respondents in Dura were more likely to trust television (43%) compared to those in 17.7% in Beita. While almost half of respondents in Ni'leen felt social media was trustworthy (49.1%), only 12.7% of the respondents in Azzun stated so. The majority of respondents in Al-Arroub (68%) and Jerusalem (62.7%) trusted health units/health care workers, while only 24.1% of the respondents in Kafr Qaddum did so.

Respondents with lower level of education were more likely to trust television - 38.9% of respondents having no formal education trusted television, while 19.4% of respondents with advanced university

degree did so. Those having no formal education were two times more likely to trust health unit/health care workers compared to respondents with primary education (61.1% and 31.4%, respectively).

The respondents with disabilities were more likely to view television as trustworthy compared to respondents with no disability (43.1% and 27.9%, respectively).

The quantitative and qualitative findings were similar. The respondents of FGDs usually used and trusted media channels including local media, the Ministry of Health, health centers, local community, social media as a source of information to learn about COVID-19. Although they receive useful information from social media, they are generally skeptical of information coming from it. They also stated that because the virus is new and therefore the research on the virus is new, the information they have learned has changed over time. This situation has led people to be skeptical of the information obtained.

"Some information about the illness turned out to be wrong. The illness is new. Thus, it requires time until we can reach the correct information. It is possible that we will discover that not all the information we have currently is correct." (Male, Jerusalem, FGD).

In addition, the respondents care about the source of the information when obtaining information from television or another channel. However, they were less trusted channels such as social media and mobile applications as their source is not specific and controlled.

"The Ministry of Health and the World Health Organization gave us information through television and newspapers and other methods to reached people, and it really changed how people deal with the procedures." (Azzun, Male, FGD)

Figure 8 Trusted sources of information related to COVID-19 by gender (%)
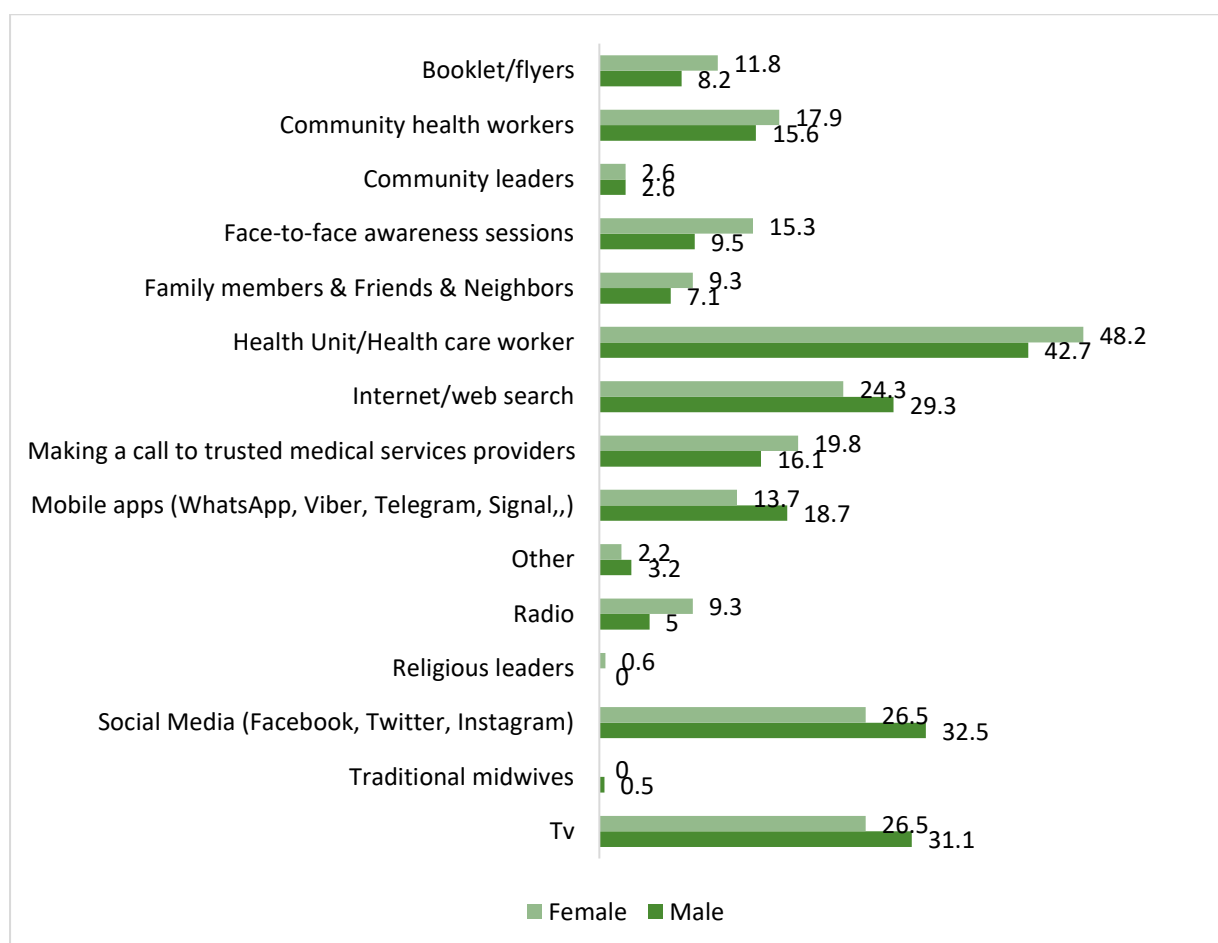
Table 17 Trusted sources of information related to COVID-19 by age group

		18-25	26-40	41-65	65+	Total
Television	#	10	63	117	11	201
	%	21.3	24.0	32.9	40.7	29.0
Traditional midwives	#	-	2	-	-	2
	%	-	0.8	-	-	0.3
Social Media (Facebook, Twitter, Instagram)	#	15	88	100	3	206
	%	31.9	33.6	28.1	11.1	29.8
Religious leaders	#	1	-	1	-	2
	%	2.1	-	0.3	-	0.3
Radio	#	5	11	24	8	48
	%	10.6	4.2	6.7	29.6	6.9
Mobile apps (WhatsApp, Viber, Telegram, Signal...)	#	11	41	56	6	114
	%	23.4	15.6	15.7	22.2	16.5
Making a call to trusted medical services providers	#	8	55	56	4	123
	%	17.0	21.0	15.7	14.8	17.8
Internet searches	#	11	79	95	2	187
	%	23.4	30.2	26.7	7.4	27.0
Health Unit/Health care worker	#	20	121	161	11	313
	%	42.6	46.2	45.2	40.7	45.2
Family, friends, and neighbors	#	2	19	32	3	56

	%	4.3	7.3	9.0	11.1	8.1
Face-to-face awareness sessions	#	2	34	44	4	84
	%	4.3	13.0	12.4	14.8	12.1
Community leaders	#	1	11	6	-	18
	%	2.1	4.2	1.7	-	2.6
Community health workers	#	4	43	60	8	115
	%	8.5	16.4	16.9	29.6	16.6
Booklet/flyers	#	4	29	30	5	68
	%	8.5	11.1	8.4	18.5	9.8
Other	#	2	3	13	1	19
	%	4.3	1.1	3.7	3.7	2.7
#	#	47	262	356	27	692

Table 18 Trusted sources of information related to COVID-19 by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni'leen	Qaryout	Total
Television	#	5	16	17	80	47	7	19	10	201
	%	20.0	25.4	17.7	43.0	23.4	24.1	34.5	30.3	29.0
Traditional midwives	#	-	-	1	-	1	-	-	-	2
	%	-	-	1.0	-	0.5	-	-	-	0.3
Social Media (Facebook, Twitter, Instagram)	#	4	8	42	55	46	12	27	11	206
	%	16.0	12.7	43.8	29.6	22.9	41.4	49.1	33.3	29.8
Religious leaders	#	-	-	-	-	1	-	1	-	2
	%	-	-	-	-	0.5	-	1.8	-	0.3
Radio	#	6	1	3	12	15	1	4	6	48
	%	24.0	1.6	3.1	6.5	7.5	3.4	7.3	18.2	6.9
Mobile apps (WhatsApp, Viber, Telegram, Signal...)	#	6	4	10	26	46	12	4	6	114
	%	24.0	6.3	10.4	14.0	22.9	41.4	7.3	18.2	16.5
Making a call to trusted medical services providers	#	2	6	8	70	31	2	3	1	123
	%	8.0	9.5	8.3	37.6	15.4	6.9	5.5	3.0	17.8
Internet searches	#	2	9	12	74	55	9	13	12	187
	%	8.0	14.3	12.5	39.8	27.4	31.0	23.6	36.4	27.0
Health Unit/Health care worker	#	17	34	31	57	126	7	27	13	313
	%	68.0	54.0	32.3	30.6	62.7	24.1	49.1	39.4	45.2
Family, friends, and neighbors	#	2	16	8	13	5	2	5	5	56
	%	8.0	25.4	8.3	7.0	2.5	6.9	9.1	15.2	8.1
Face-to-face awareness sessions	#	5	7	3	31	15	9	11	3	84
	%	20.0	11.1	3.1	16.7	7.5	31.0	20.0	9.1	12.1
Community leaders	#	1	-	-	13	-	1	2	1	18
	%	4.0	-	-	7.0	-	3.4	3.6	3.0	2.6
Community health workers	#	8	9	13	39	29	3	7	6	115
	%	32.0	14.3	13.5	21.0	14.4	10.3	12.7	18.2	16.6

Booklet/flyers	#	3	1	4	20	22	2	14	2	68
	%	12.0	1.6	4.2	10.8	10.9	6.9	25.5	6.1	9.8
Other	#	-	1	6	4	4	2	-	1	19
	%	-	1.6	6.3	2.2	2.0	6.9	-	3.0	2.7
#	#	25	63	96	186	201	29	55	33	692

Table 19 Trusted sources of information related to COVID-19 by education level

		No formal education	Primary/ elementary	Secondary /high school	University	Advanced university	Total
Television	#	7	36	58	94	6	201
	%	38.9	35.3	25.9	29.7	19.4	29.0
Traditional midwives	#	-	1	-	1	-	2
	%	-	1.0	-	0.3	-	0.3
Social Media (Facebook, Twitter, Instagram)	#	5	23	74	97	7	206
	%	27.8	22.5	33.0	30.6	22.6	29.8
Religious leaders	#	-	1	1	-	-	2
	%	-	1.0	0.4	-	-	0.3
Radio	#	2	12	13	17	4	48
	%	11.1	11.8	5.8	5.4	12.9	6.9
Mobile apps (WhatsApp, Viber, Telegram, Signal…)	#	4	10	39	56	5	114
	%	22.2	9.8	17.4	17.7	16.1	16.5
Making a call to trusted medical services providers	#	4	8	41	62	8	123
	%	22.2	7.8	18.3	19.6	25.8	17.8
Internet searches	#	3	13	58	102	11	187
	%	16.7	12.7	25.9	32.2	35.5	27.0
Health Unit/Health care worker	#	11	32	108	146	16	313
	%	61.1	31.4	48.2	46.1	51.6	45.2
Family, friends, and neighbors	#	-	9	24	20	3	56
	%	-	8.8	10.7	6.3	9.7	8.1
Face-to-face awareness sessions	#	2	8	22	47	5	84
	%	11.1	7.8	9.8	14.8	16.1	12.1
Community leaders	#	-	1	6	10	1	18
	%	-	1.0	2.7	3.2	3.2	2.6
Community health workers	#	-	18	33	55	9	115
	%	-	17.6	14.7	17.4	29.0	16.6
Booklet/flyers	#	1	12	24	27	4	68
	%	5.6	11.8	10.7	8.5	12.9	9.8
Other	#	-	3	11	5	-	19
	%	-	2.9	4.9	1.6	-	2.7
#	#	18	102	224	317	31	692

Figure 9 Trusted sources of information related to COVID-19 by disability status (%)

Respondents were most likely to report that Ministry of Public Health (80.2%), Health professionals/physicians (54.2%), and the Palestinian Red Crescent (45.4%) as trusted sources of information about COVID-19 and the Omicron variant. Differences were statistically significant by age groups (p=0.03), location (p<0.001), education (p=0.01) and disability status (0.002).

Respondents aged 65 and above referred health professionals/physicians (70.4%) to get trustworthy/reliable information about COVID-19. While Ministry of Public Health was the most trustworthy/reliable source of information for respondents aged 18-25 (63.8%), 26-40 (80.2%), and 41-65 (83.7%).

The Ministry of Health was stated the most by the respondents in Al-Arroub (88.9%) and the least in Qaryout (57.6%). Health professionals/physicians were stated to be a trustworthy/reliable source of information at most by the majority in Jerusalem (74.6%) but only 28% of respondents in Azzun and 28.6% of respondents in Al-Arroub. The Palestinian Red Crescent Society was viewed to be trustworthy by five times more respondents in Kafr Qaddum compared to Jerusalem (75.9% and 17.4%, respectively).

While 50.5% of respondents with university degree stated Palestinian Red Crescent Society as a trustworthy/reliable source of information, this rate was 35.5% for respondents with an advanced university degree and 37.3% for respondents with primary/elementary degree. The Palestinian Red Crescent Society and Ministry of Public Health were stated to be a trustworthy/reliable source of information by the respondents with no disability (47% and 81.1% respectively) more than PWDs (25.5% and 68.6%).

Table 20 Most trustworthy/reliable sources of information about COVID-19 including Omicron by age group

		18-25	26-40	41-65	65+	Total
WHO and UN agencies	#	7	55	45	3	110
	%	14.9	21.0	12.6	11.1	15.9
The International Federation of Red Cross and Red Crescent Societies (IFRC)	#	7	39	37	1	84
	%	14.9	14.9	10.4	3.7	12.1
The International Committee of the Red Cross (ICRC)	#	5	25	17	1	48
	%	10.6	9.5	4.8	3.7	6.9
Palestinian Red Crescent Society	#	20	127	155	12	314
	%	42.6	48.5	43.5	44.4	45.4
Municipality	#	-	16	21	1	38
	%	-	6.1	5.9	3.7	5.5
Ministry of Public Health	#	30	210	298	17	555
	%	63.8	80.2	83.7	63.0	80.2
International or Local Non-Governmental Organizations	#	2	8	15	1	26
	%	4.3	3.1	4.2	3.7	3.8
Influencers/ Celebrities	#	-	3	2	1	6
	%	-	1.1	0.6	3.7	0.9
Health professionals/physicians	#	26	141	189	19	375
	%	55.3	53.8	53.1	70.4	54.2
Family or friends	#	2	18	24	1	45
	%	4.3	6.9	6.7	3.7	6.5
Community leaders and/or religious leaders	#	1	5	8	1	15
	%	2.1	1.9	2.2	3.7	2.2
Community health workers	#	2	30	32	4	68
	%	4.3	11.5	9.0	14.8	9.8
#	#	47	262	356	27	692

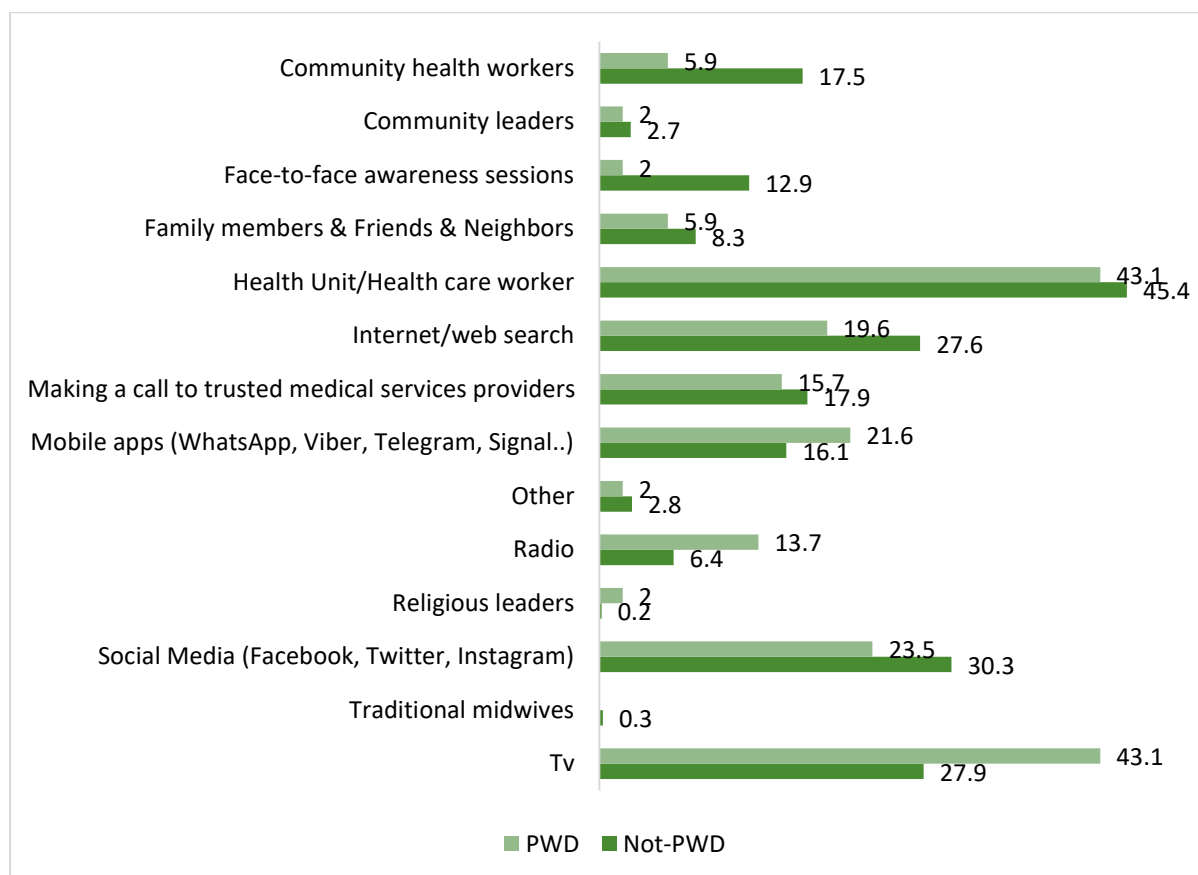*Table 21 B7. Trusted sources of information related to COVID-19 by location*

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni'leen	Qaryout	Total
WHO and UN agencies	#	6	6	8	61	9	8	6	5	110
	%	9.5	24.0	8.3	32.8	4.5	27.6	10.9	15.2	15.9
The International Federation of Red Cross and Red Crescent Societies (IFRC)	#	7	2	3	44	8	9	5	6	84
	%	11.1	8.0	3.1	23.7	4.0	31.0	9.1	18.2	12.1
The International Committee of the Red Cross (ICRC)	#	1	1	3	35	3	1	-	4	48
	%	1.6	4.0	3.1	18.8	1.5	3.4	-	12.1	6.9
Palestinian Red Crescent	#	26	11	48	125	35	22	25	21	314
	%	41.3	44.0	50.0	67.2	17.4	75.9	45.5	63.6	45.4
Municipality	#	2	1	6	6	15	-	7	1	38
	%	3.2	4.0	6.3	3.2	7.5	-	12.7	3.0	5.5
Ministry of Public Health	#	56	19	70	149	170	24	47	19	555
	%	88.9	76.0	72.9	80.1	84.6	82.8	85.5	57.6	80.2
International or Local Non-Governmental Organizations	#	-	1	2	13	4	1	4	1	26
	%	-	4.0	2.1	7.0	2.0	3.4	7.3	3.0	3.8
Influencers/ Celebrities	#	-	1	-	2	1	-	-	2	6
	%	-	4.0	-	1.1	0.5	-	-	6.1	0.9
Health professionals/physicians	#	18	7	51	99	150	9	24	16	375
	%	28.6	28.0	53.1	53.2	74.6	31.0	43.6	48.5	54.2
Family or friends	#	13	1	19	3	1	1	2	4	45
	%	20.6	4.0	19.8	1.6	0.5	3.4	3.6	12.1	6.5
Community leaders and/or religious leaders	#	-	1	3	8	3	-	-	-	15
	%	-	4.0	3.1	4.3	1.5	-	-	-	2.2
Community health workers	#	4	6	9	31	10	3	2	3	68
	%	6.3	24.0	9.4	16.7	5.0	10.3	3.6	9.1	9.8
#	#	63	25	96	186	201	29	55	33	692

Table 22 Trusted sources of information related to COVID-19 by education level

		No formal education	Primary/ elementary	Secondary /high school	University	Advanced university	Total
WHO and UN agencies	#	1	5	33	61	10	110
	%	5.6	4.9	14.7	19.2	32.3	15.9
The International Federation of Red Cross and Red Crescent Societies (IFRC)	#	1	5	27	45	6	84
	%	5.6	4.9	12.1	14.2	19.4	12.1
The International Committee of the Red Cross (ICRC)	#	-	4	19	22	3	48
	%	-	3.9	8.5	6.9	9.7	6.9
Palestinian Red Crescent	#	7	38	98	160	11	314
	%	38.9	37.3	43.8	50.5	35.5	45.4
Municipality	#	1	7	13	13	4	38
	%	5.6	6.9	5.8	4.1	12.9	5.5
Ministry of Public Health	#	14	80	184	253	24	555
	%	77.8	78.4	82.1	79.8	77.4	80.2
International or Local Non-Governmental Organizations	#	-	4	6	12	4	26
	%	-	3.9	2.7	3.8	12.9	3.8
Influencers/ Celebrities	#	-	1	1	3	1	6
	%	-	1.0	0.4	0.9	3.2	0.9
Health professionals/physicians	#	10	48	126	174	17	375
	%	55.6	47.1	56.3	54.9	54.8	54.2
Family or friends	#	2	5	19	18	1	45
	%	11.1	4.9	8.5	5.7	3.2	6.5
Community leaders and/or religious leaders	#	-	2	3	8	2	15
	%	-	2.0	1.3	2.5	6.5	2.2
Community health workers	#	-	9	19	36	4	68
	%	-	8.8	8.5	11.4	12.9	9.8
#	#	18	102	224	317	31	692

Table 23 Trusted sources of information related to COVID-19 by disability status

		Not-PWD	PWD	Total
WHO and UN agencies	#	108	2	110
	%	16.8	3.9	15.9
The International Federation of Red Cross and Red Crescent Societies (IFRC)	#	81	3	84
	%	12.6	5.9	12.1
The International Committee of the Red Cross (ICRC)	#	48	-	48
	%	7.5	-	6.9
Palestinian Red Crescent	#	301	13	314
	%	47.0	25.5	45.4
Municipality	#	36	2	38
	%	5.6	3.9	5.5
Ministry of Public Health	#	520	35	555
	%	81.1	68.6	80.2
International or Local Non-Governmental Organizations	#	25	1	26
	%	3.9	2.0	3.8

Influencers/ Celebrities	#	5	1	6
	%	0.8	2.0	0.9
Health professionals/physicians	#	345	30	375
	%	53.8	58.8	54.2
Family or friends	#	45	-	45
	%	7.0	-	6.5
Community leaders and/or religious leaders	#	14	1	15
	%	2.2	2.0	2.2
Community health workers	#	63	5	68
	%	9.8	9.8	9.8
#	#	641	51	692

Relevance and Usefulness of COVID-19 Information

In this section, the respondents were questioned to understand the usefulness and relevancy of information dissemination provided to the community.

The majority of the respondents found the information they received about COVID-19 useful or very useful (53.5% and 38%). The results did not vary significantly by gender, age group, location, and education significantly ($p>0.05$), but there was a significant difference by disability status ($p=0.02$). The respondents with no disability thought the information they received about COVID-19 was very useful or useful slightly more than PWDs (91.9% and 86.3%).

Figure 10 Respondents' ratings of information usefulness by disability status (%)
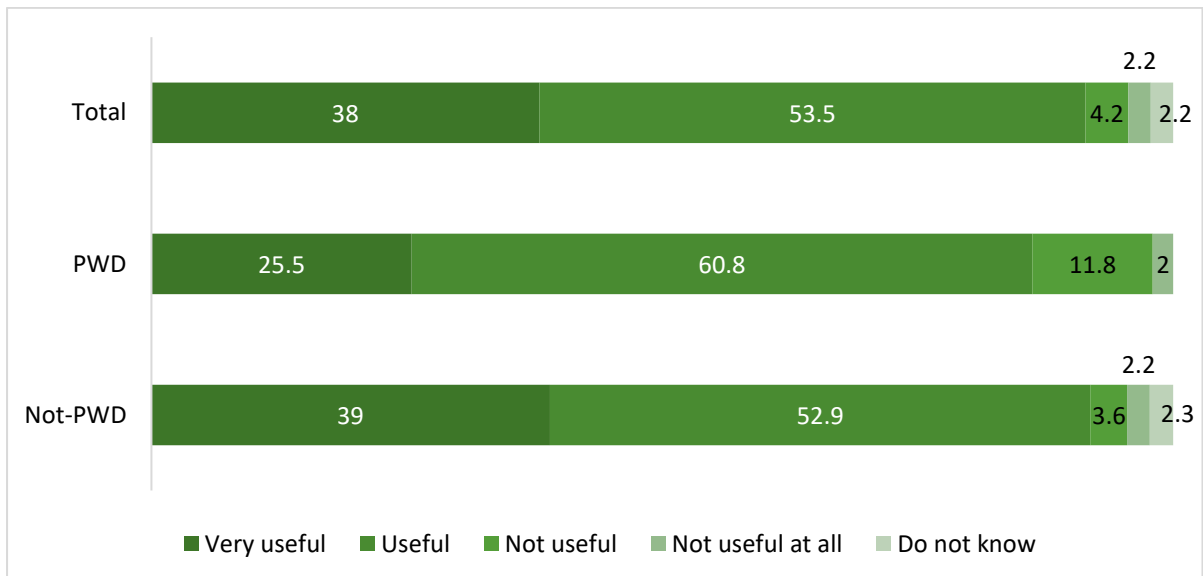
Among respondents who reported that information about COVID-19 was useful or very useful stated that they had used the information:
- To take preventative measures (80.6%)
- To keep track of my health and recognize symptoms (75.2%)
- To deal with a COVID-19 infection" (59.1%).

The results did not vary significantly by gender, age group, and disability status significantly (p>0.05), but there is a significant difference by location and education (p<0.001).

Respondents in Beita were the most likely to report information on COVID-19 was useful to take preventative measures Beita (89.2%) and the least among respondents in Azzun (70.4%). Respondents in Jerusalem were the most likely to report information on COVID-19 was useful to keep track of my health and recognize symptoms (87.7%) while it was stated by half of those in Qaryout (50%). Respondents in Al-Arroub were most likely to report that information was useful to deal with a COVID-19 infection.

Figure 11 Most common uses of COVID-19 information by location (%)
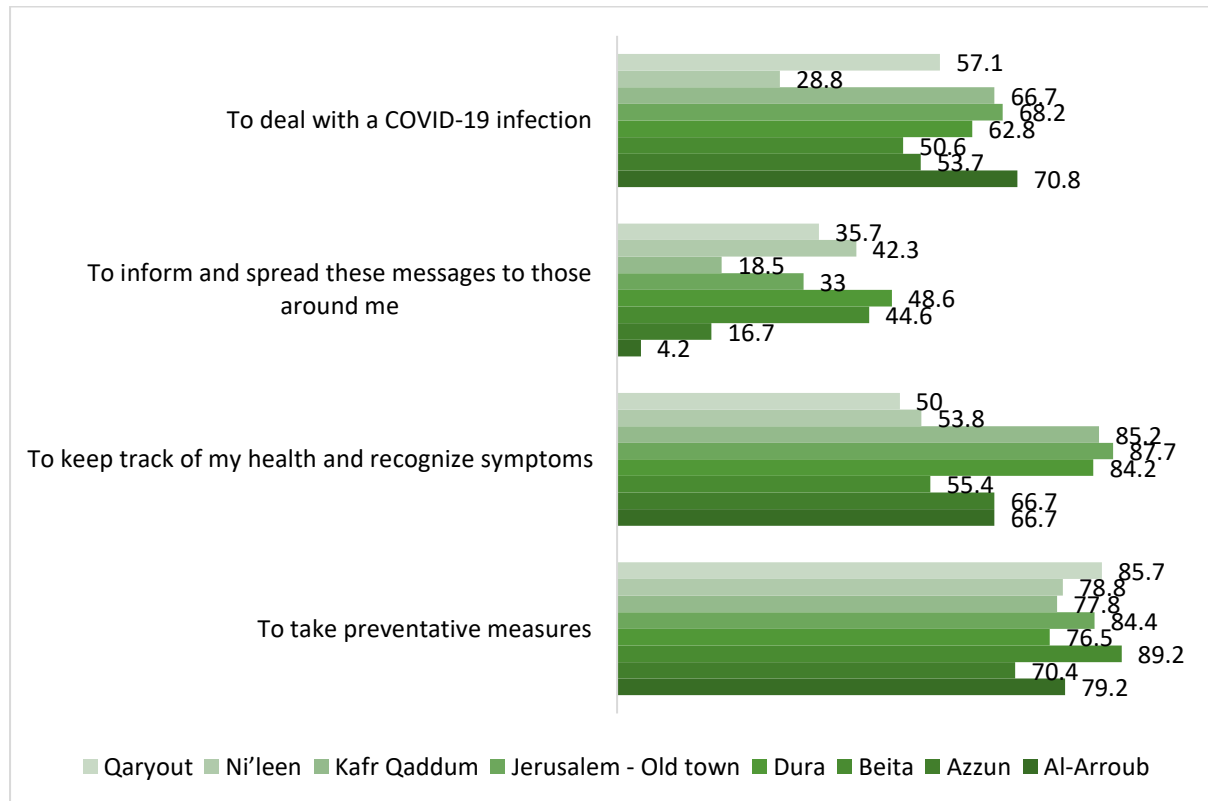
Figure 12 Most common uses of COVID-19 information by highest education level (%)

To deal with a COVID-19 infection
- 56.7
- 64.4
- 61.3
- 37.4
- 60

To inform and spread these messages to those around me
- 36.7
- 40.3
- 35.7
- 29.7
- 20

To keep track of my health and recognize symptoms
- 66.7
- 76.5
- 78.4
- 63.7
- 93.3

To take preventative measures
- 93.3
- 79.5
- 83.4
- 78
- 53.3

Legend: Advanced university · University · Secondary /high school · Primary/ elementary · No formal education
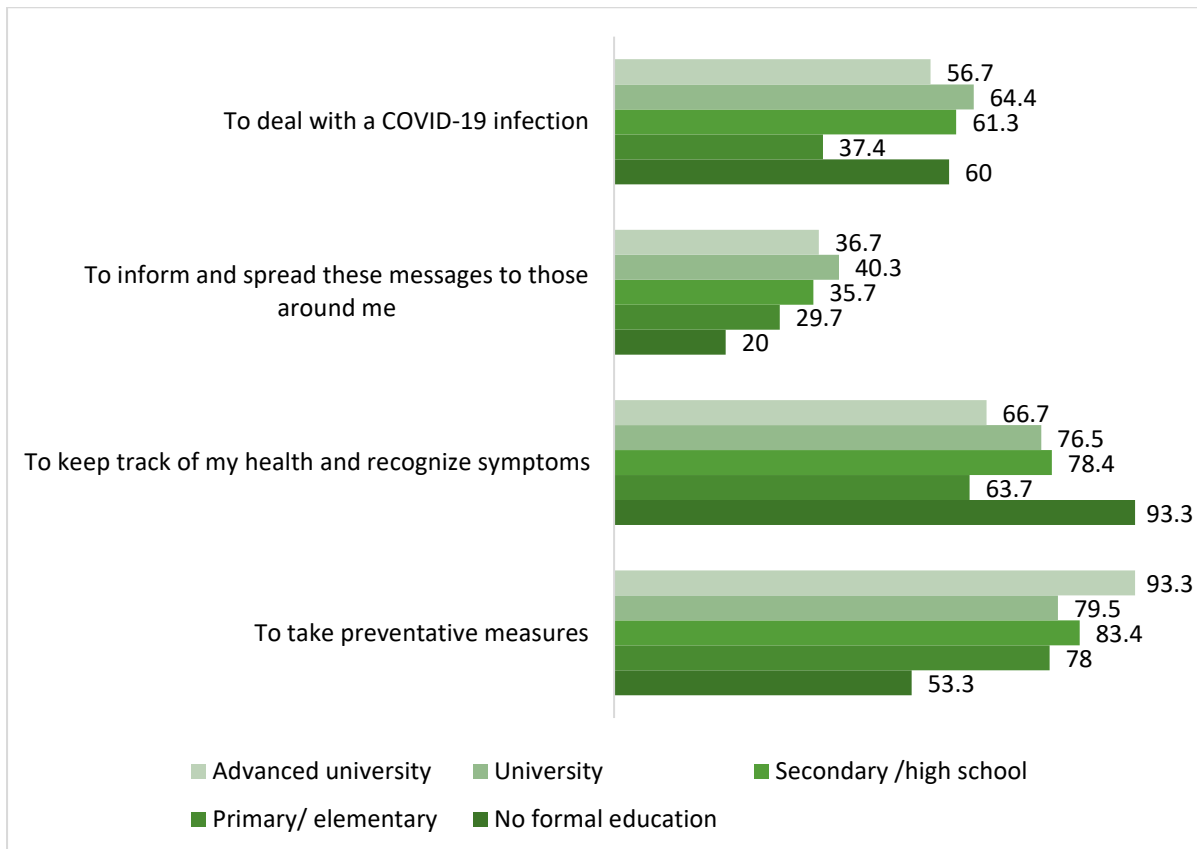
Those who did not find the information about COVID-19 useful reported a number of reasons, including:
- "It did not assist in reducing the number of cases in my area" (36.4%)
- "Measures that have been communicated cannot be implemented where I live" (34.1%)
- "There is a community-wide unwillingness to follow these rules" (31.8%).

There was no significant difference among gender, age groups, location, education level, and disability (p>.05).

Figure 13 Reasons respondents did not find COVID-19 information useful (%)
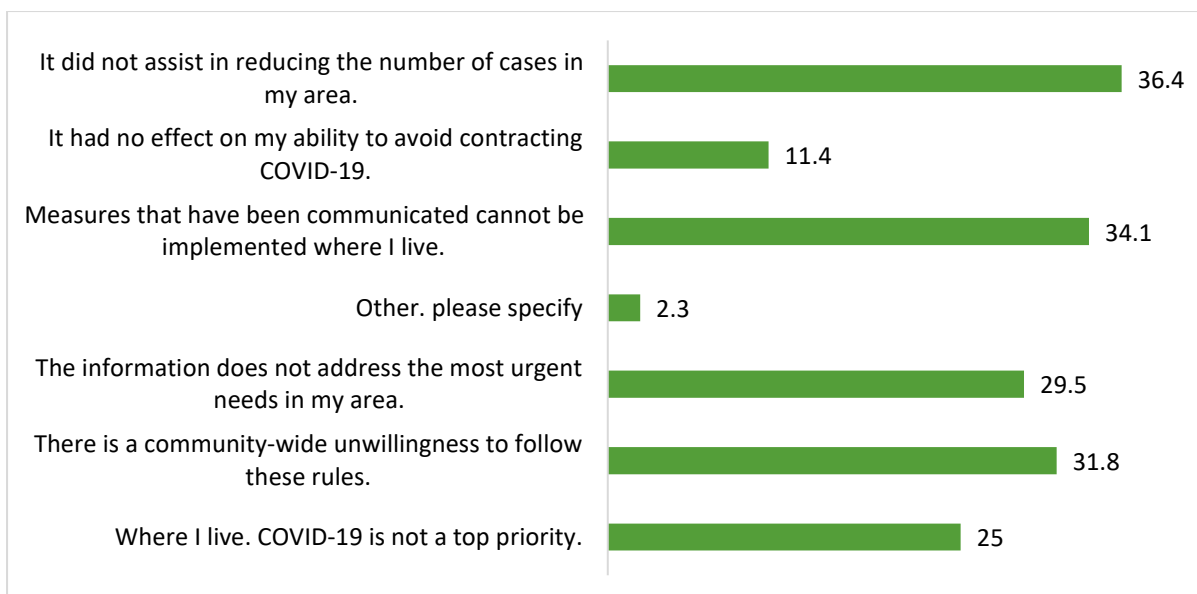
It did not assist in reducing the number of cases in my area. — 36.4

It had no effect on my ability to avoid contracting COVID-19. — 11.4

Measures that have been communicated cannot be implemented where I live. — 34.1

Other. please specify — 2.3

The information does not address the most urgent needs in my area. — 29.5

There is a community-wide unwillingness to follow these rules. — 31.8

Where I live. COVID-19 is not a top priority. — 25

The majority of the respondents stated that the information they receive is applicable and realistic in their context (91.8%). The results change across gender (p=0.03), age groups (p=0.03), location (p<0.001), education level (p<0.001) and disability status (p=0.002). In the following paragraph, the significant findings are discussed.

Female respondents stated that the information was applicable and realistic more than males (94.2% and 89.7%, respectively). The rate of the respondents stating the information was applicable and realistic was the lowest among those aged 65 and above (77.8%). Also, stating the information was applicable and realistic was the highest among the respondents in Dura (98.4%), while it was the lowest among respondents in Al-Arroub (80%) and Beita (80.2%). The respondents who had university and advanced degrees stated the information was applicable and realistic more than those with primary/elementary school degrees (94.3%, 100%, and 80.4%, respectively). While 92.4% of those with no disability answered this question "Yes", 84.3% of PWDs replied "Yes".

Figure 14 Respondents' rating of information applicability by gender (%)
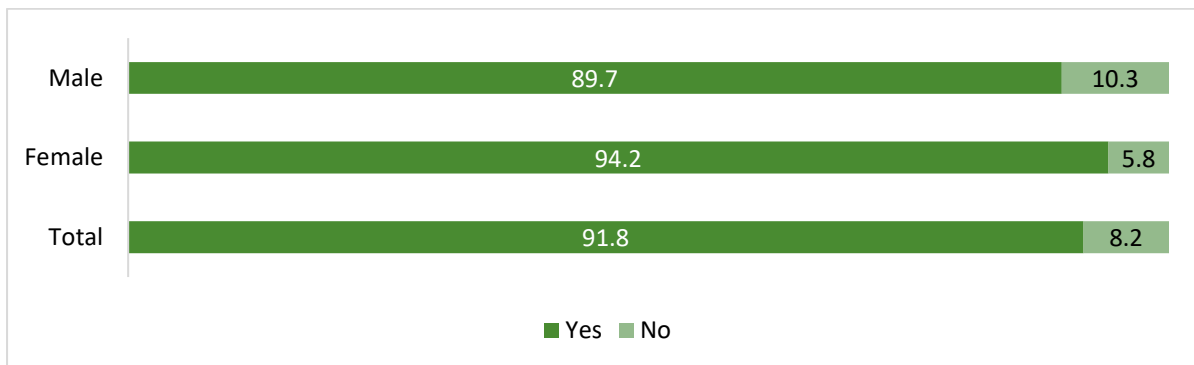
Figure 15 Respondents' rating of information applicability by age group (%)
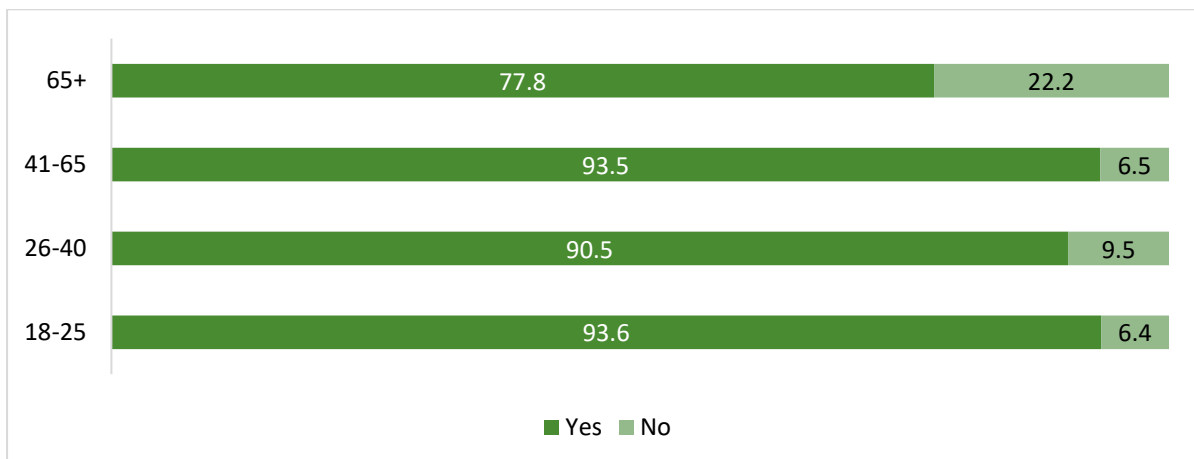
Figure 16 Respondents' rating of information applicability by location (%)
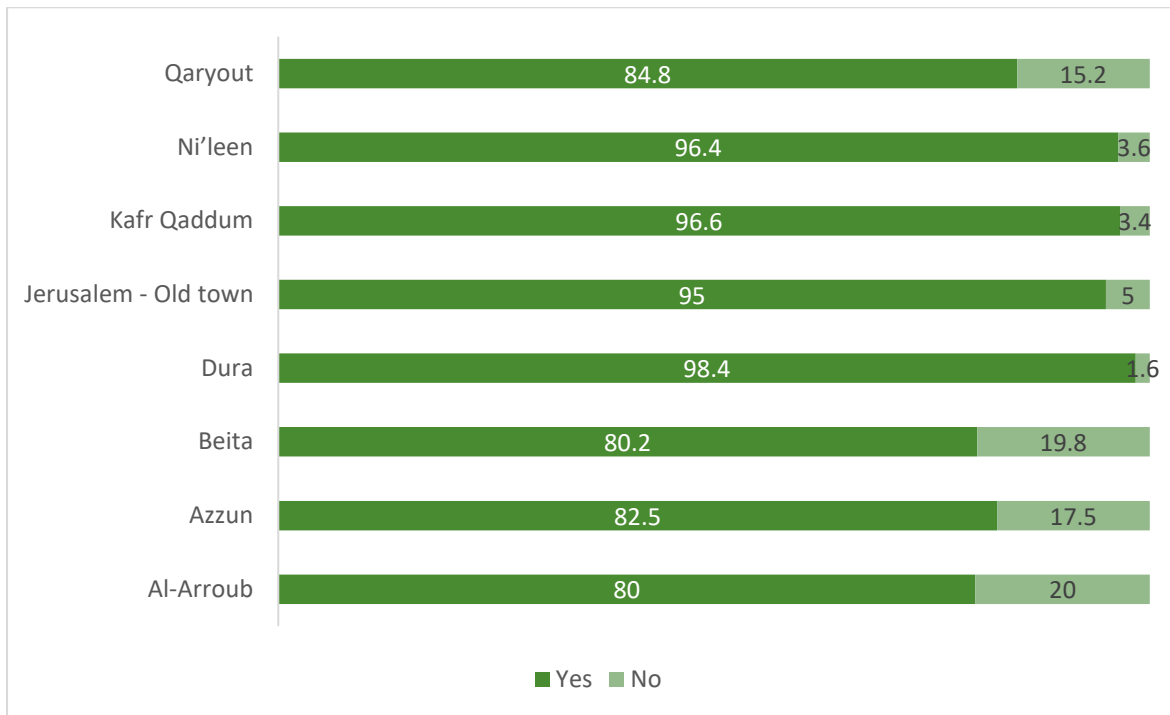
Figure 17 Respondents' rating of information applicability by education level (%)
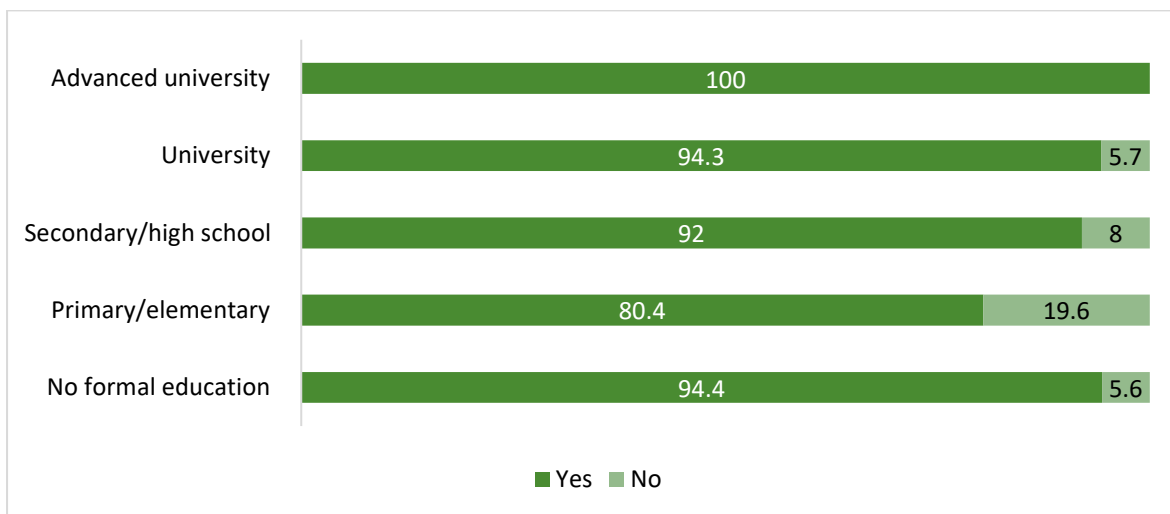
Figure 18 Respondents' rating of information applicability by disability status (%)
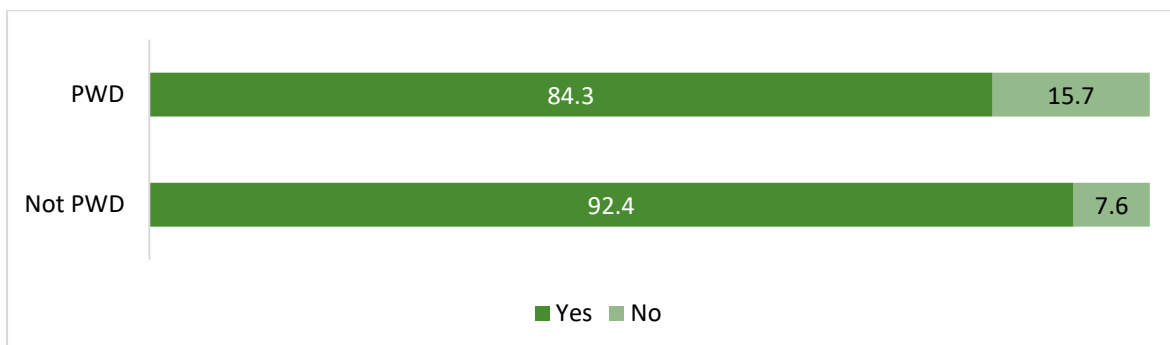
Among respondents that did not find COVID-19 information relevant, the most commonly cited reasons were:
- "There is an unwillingness at the community level to abide by these measures" (66.7%)
- "Communicated measures cannot be applied where I live" (36.8%, n=21).

The results did not vary significantly by gender, age group, location, and education significantly (p>0.05), but there is a significant difference by disability status (p=0.002). Respondents without disability were more likely to report that there was an unwillingness at the community level to abide by COVD-19 measures compared to respondents with disabilities (73.5% and 25%). Respondents with disabilities were more than twice as likely to report that communicated measures could not be applied where they lived compared to respondents with no disability (75% and 30.6%, respectively).

Table 24 Reasons COVID-19 measures were not applied in respondents' communities

		Not PWD	PWD	Total
There is an unwillingness at the community level to abide by these measures	#	36	2	38
	%	73.5	25.0	66.7
The information does not address the main needs where I live	#	4	2	6
	%	8.2	25.0	10.5
Communicated measures cannot be applied where I live	#	15	6	21
	%	30.6	75.0	36.8
COVID-19 is not the main priority where I live	#	5	3	8
	%	10.2	37.5	14.0
Other	#	1	-	1
	%	2.0	-	1.8
Total	#	49	8	57

COVID-19 Prevention Measures

The most commonly cited measures respondents used to prevent the spread of COVID-19 included washing hands regularly using soap and water or alcohol (83.8%), wearing a face mask in public (77.9%) and employing proper cough etiquette (76.2%). Differences were statistically significant by gender (p=0.01) and location (p<0.001.

Female respondents were more likely to report washing their hands regularly, wearing a mask, and following the cough etiquette (86.6%, 81.8%, and 78%) compared to male respondents (81.5%, 74.7, and 74.7%). All respondents in Kafr Qaddum (100%) reported washing their hands compared to 66.1% of respondents in Dura. Wearing a face mask and following the cough etiquette was reported by nearly all respondents in Kafr Qaddum (96.6% and 100% respectively).

Table 25 Reported methods to prevent COVID-19 by gender

		Male	Female	Total
Wearing a face mask in public	#	283	256	539
	%	74.7	81.8	77.9
Wash your hands regularly using soap and water or alcohol	#	309	271	580
	%	81.5	86.6	83.8
Vaccination	#	179	150	329
	%	47.2	47.9	47.5

Strict lockdowns	#	127	88	215
	%	33.5	28.1	31.1
Schools closure	#	112	76	188
	%	29.6	24.3	27.2
Limiting public gatherings	#	130	98	228
	%	34.3	31.3	32.9
Imposing physical distancing	#	268	243	511
	%	70.7	77.6	73.8
Don't believe in taking any action	#	20	7	27
	%	5.3	2.2	3.9
Don't know	#	1	-	1
	%	0.3	-	0.1
Cover your mouth and nose when coughing or sneezing	#	283	244	527
	%	74.7	78.0	76.2
Avoid unprotected direct contact with live animals and surfaces in contact with animals	#	193	170	363
	%	50.9	54.3	52.5
Other	#	9	6	15
	%	2.4	1.9	2.2
Total	#	379	313	692

Table 26 Reported methods to prevent COVID-19 by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni'leen	Qaryout	Total
Wearing a face mask in public	#	21	44	80	131	176	28	28	27	539
	%	84.0	69.8	83.3	70.4	87.6	96.6	50.9	81.8	77.9
Wash your hands regularly soap and water or alcohol	#	23	46	87	123	190	29	47	31	580
	%	92.0	73.0	90.6	66.1	94.5	100	85.5	93.9	83.8
Vaccination	#	11	23	54	47	130	14	37	12	329
	%	44.0	36.5	56.3	25.3	64.7	48.3	67.3	36.4	47.5
Strict lockdowns	#	2	9	17	51	124	4	4	3	215
	%	8.0	14.3	17.7	27.4	61.7	13.8	7.3	9.1	31.1
Schools closure	#	5	12	25	41	93	-	10	2	188
	%	20.0	19.0	26.0	22.0	46.3	-	18.2	6.1	27.2
Limiting public gatherings	#	16	22	40	41	86	8	8	7	228
	%	64.0	34.9	41.7	22.0	42.8	27.6	14.5	21.2	32.9
Imposing physical distancing	#	13	38	65	120	187	18	42	25	511
	%	52.0	60.3	67.7	64.5	93.0	62.1	76.4	75.8	73.8
Don't believe in taking any action	#	-	2	3	14	7	-	-	1	27
	%	-	3.2	3.1	7.5	3.5	-	-	3.0	3.9
Don't know	#	-	1	-	-	-	-	-	-	1
	%	-	1.6	-	-	-	-	-	-	0.1
Cover your mouth and nose when coughing or sneezing	#	17	37	79	122	192	29	20	28	527
	%	68.0	58.7	82.3	65.6	95.5	100	36.4	84.8	76.2

Avoid unprotected direct contact with live animals and surfaces in contact with animals	#	8	23	38	88	168	4	17	15	363
	%	32.0	36.5	39.6	47.3	83.6	13.8	30.9	45.5	52.5
Other	#	-	-	-	13	1	-	-	1	15
	%	-	-	-	7.0	0.5	-	-	3.0	2.2
Total	#	25	63	96	186	201	29	55	33	692

The most commonly cited prevention measures used by respondents and their families in recent days were washing hands regularly with soap and water using an alcohol-based cleaner (77.3%), wearing a face mask in public (74.6%), and covering the mouth and nose when coughing or sneezing (72.7%). The results changed across gender (p=0.001), age groups (p=0.03), and location (p<0.001) were statistically significant.

Again, female respondents were more likely to report that they and their family wore masks (79.9%), washing hands regularly (78%), and covering mouth when coughing or sneezing (73.5%) compared to male respondents (70.2%, 76.8%, and 72%).

Washing hands was the most used action the prevent COVID-19 among those aged 18-25 (78.7%), 26-40 (75.2%), and 41-65 (77.8%), while those aged 65 and 65 wore a face mask at most (85.2%).

Washing hands was stated at most those in Kafr Qaddum (96.6%) and at least by those in Azzun (58.7%). Wearing a face mask was stated at most by those in Kafr Qaddum (89.7%), at least by those in Dura (67.2%) and Qaryout (66.7%).

Respondents in the FGDs and KIIs reported similar findings to the respondents in the quantitative survey. FGD and KII participants also reported going out less frequently, making fewer visits to mosques, and participating in fewer social events (like weddings) to prevent the spread of COVID-19.

Table 27 Reported measures taken by respondents and their families to prevent COVID-19 in recent days by gender

		Male	Female	Total
Wearing a face mask in public	#	266	250	516
	%	70.2	79.9	74.6
Washing hands regularly using soap/water or an alcohol-based cleaner	#	291	244	535
	%	76.8	78.0	77.3
Limit/ reduce going to public places	#	193	167	360
	%	50.9	53.4	52.0
Imposing physical distancing	#	240	228	468
	%	63.3	72.8	67.6
Get vaccinated	#	226	206	432
	%	59.6	65.8	62.4
Don't believe in taking any action	#	15	2	17
	%	4.0	0.6	2.5
Don't know	#	2	-	2
	%	0.5	-	0.3
Covering mouth and nose when coughing or sneezing	#	273	230	503
	%	72.0	73.5	72.7
Avoid unprotected direct contact with live animals and surfaces in contact with animals	#	186	150	336
	%	49.1	47.9	48.6

Other	#	2	3	5
	%	0.5	1.0	0.7
Total	#	379	313	692

Table 28 Reported measures taken by respondents and their families to prevent COVID-19 in recent days by age group

		18-25	26-40	41-65	65+	Total
Wearing a face mask in public	#	29	195	269	23	516
	%	61.7	74.4	75.6	85.2	74.6
Washing hands regularly using an alcohol-based cleaner or soap/water	#	37	197	277	24	535
	%	78.7	75.2	77.8	88.9	77.3
Limit/ reduce going to public places	#	20	142	183	15	360
	%	42.6	54.2	51.4	55.6	52.0
Imposing physical distancing	#	19	175	252	22	468
	%	40.4	66.8	70.8	81.5	67.6
Get vaccinated	#	26	167	224	15	432
	%	55.3	63.7	62.9	55.6	62.4
Don't believe in taking any action	#	-	9	8	-	17
	%	-	3.4	2.2	-	2.5
Don't know	#	-	1	1	-	2
	%	-	0.4	0.3	-	0.3
Covering mouth and nose when coughing or sneezing	#	36	191	254	22	503
	%	76.6	72.9	71.3	81.5	72.7
Avoid unprotected direct contact with live animals and surfaces in contact with animals	#	22	121	174	19	336
	%	46.8	46.2	48.9	70.4	48.6
Other	#	-	1	4	-	5
	%	-	0.4	1.1	-	0.7
Total	#	47	262	356	27	692

Table 29 D2. Reported measures taken by respondents and their families to prevent COVID-19 in recent days by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni' leen	Qaryout	Total
Wearing a face mask in public	#	18	48	71	125	170	26	33	22	516
	%	72.0	76.2	74.0	67.2	84.6	89.7	60.0	66.7	74.6
Washing hands regularly using an alcohol-based cleaner or soap/water	#	23	37	87	102	183	28	42	30	535
	%	92.0	58.7	90.6	54.8	91.0	96.6	76.4	90.9	77.3
Limit/ reduce going to public places	#	14	27	64	116	108	10	7	10	360
	%	56.0	42.9	66.7	62.4	53.7	34.5	12.7	30.3	52.0
Imposing physical distancing	#	11	37	57	103	182	21	34	20	468
	%	44.0	58.7	59.4	55.4	90.5	72.4	61.8	60.6	67.6
Get vaccinated	#	15	34	61	103	146	16	43	13	432
	%	60.0	54.0	63.5	55.4	72.6	55.2	78.2	39.4	62.4
Don't believe in taking any action	#	-	1	4	3	6	1	1	1	17

		Al-Arroub	Azzun	Beita	Dura	Jerusalem	Kafr Qaddum	Ni'leen	Qaryout	Total
	%	-	1.6	4.2	1.6	3.0	3.4	1.8	3.0	2.5
Don't know	#	-	1	-	-	1	-	-	-	2
	%	-	1.6	-	-	0.5	-	-	-	0.3
Covering mouth and nose when coughing or sneezing	#	18	38	78	105	185	27	23	25	503
	%	72.0	60.3	81.3	56.5	92.0	93.1	41.8	75.8	72.7
Avoid unprotected direct contact with live animals and surfaces in contact with animals	#	7	18	39	79	169	2	13	8	336
	%	28.0	28.6	40.6	42.5	84.1	6.9	23.6	24.2	48.6
Other	#	-	-	-	4	1	-	-	-	5
	%	-	-	-	2.2	0.5	-	-	-	0.7
Total	#	25	63	96	186	201	29	55	33	692

Respondents had a range of opinions about COVID-19 and information availability:
- 33.5% of respondents reported that the information they received from government and health organizations improved their prevention measures against COVID-19
- 32.1% of respondents reported that they could find people to answer their questions about COVID-19
- 31.6% of respondents reported that health organizations provided health information leaflets (31.6%)

Differences were statistically significant by location (p<0.001) and disability (p=0.05).

Table 30 Reported methods available to respondents to learn about COVID-19 by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni' leen	Qaryout	Total
We receive phone calls to ask about my family's health.	#	5	3	23	12	57	2	15	4	122
	%	20.0	4.8	24.0	6.5	28.4	6.9	27.3	12.1	17.6
Volunteer teams build in my community to support us during look down in COVID-19.	#	11	18	40	25	41	14	21	12	182
	%	44.0	28.6	41.7	13.4	20.4	48.3	38.2	36.4	26.3
Usually, I could find anyone for my questions about COVID-19.	#	4	9	11	83	77	4	20	13	222
	%	16.0	14.3	11.5	44.6	38.3	13.8	36.4	39.4	32.1
The information that I received from government and health organizations improve my practicing a high level of preventing my infection against COVID-19.	#	7	32	36	45	80	12	9	10	232
	%	28.0	50.8	37.5	24.2	39.8	41.4	16.4	30.3	33.5
Steering committee established from community to coordinate with government and health organizations to help people during COVID-19.	#	12	17	19	12	35	12	34	11	153
	%	48.0	27.0	19.8	6.5	17.4	41.4	61.8	33.3	22.1
Health organizations provide health information leaflets.	#	13	16	33	26	79	18	16	16	219
	%	52.0	25.4	34.4	14.0	39.3	62.1	29.1	48.5	31.6
None of them	#	-	7	13	50	7	1	-	1	79
	%	-	11.1	13.5	26.9	3.5	3.4	-	3.0	11.4
Total	#	25	63	96	186	201	29	55	33	692

Table 31 Reported methods available to respondents to learn about COVID-19 by disability status

		Not PWD	PWD	Total
We receive phone calls to ask about my family's health.	#	107	15	122
	%	16.7	29.4	17.6
Volunteer teams build in my community to support us during look down in COVID-19.	#	161	21	182
	%	25.1	41.2	26.3
Usually, I could find anyone for my questions about COVID-19.	#	208	14	222
	%	32.4	27.5	32.1
The information that I received from government and health organizations improve my practicing a high level of preventing my infection against COVID-19.	#	218	14	232
	%	34.0	27.5	33.5
Steering committee established from community to coordinate with government and health organizations to help people during COVID-19.	#	139	14	153
	%	21.7	27.5	22.1
Health organizations provide health information leaflets.	#	204	15	219
	%	31.8	29.4	31.6
None of them	#	74	5	79
	%	11.5	9.8	11.4
Total	#	641	51	692

Community Engagement

Very few respondents felt that the COVID-19 pandemic had generated stigma against specific people (6.7%). Respondents that reported having contracted COVID-19 were more likely to report that the pandemic had led to stigma compared to respondents that had not contracted COVID-19 (9.2% and 5.9% respectively, p=0.05).

In FGDs, some participants reported that people with COVID-19 were excluded from society and made to feel guilty and ashamed, especially at the beginning of the pandemic. These participants reported that stigma towards those with COVID-19 was the result of rumors and perceptions that people who contracted COVID-19 were "defective".

"It affected the psychological aspect of the person. Anyone who suffers from this disease is as if he is a spy. People will stay away from him as an outcast person in society. In the beginning, one was ashamed and ashamed to say to be injured, it was a defect." (Ni'leen, Male, FGD)

Table 32 Respondents' views of whether COVID-19 is generating stigma against specific people by COVID-19 status

Contracted COVID-19?	Yes		No		I am not sure/ I do not know		Total	
	#	%	#	%	#	%	#	%
Yes (self)	4	1.6	241	94.1	11	4.3	256	100
Yes (family member)	8	2.1	349	93.6	16	4.3	373	100
No	6	2.8	198	90.8	14	6.4	218	100
Total	17	2.5	639	92.3	36	5.2	692	100

The majority of respondents reported that they had not been contacted by implemented partners about their views on how COVID-19 could be better prevented in their area (68.8%). Differences were statistically significant by age groups (p=0.01), location (p=0.001), education (p=0.01) and status of being contracted COVID-19 (p=0.5).

The rate of those engaging in any activities was the highest among the respondents aged between 18-25 (31.9%) and among those in Ni'leen (56.4%). While 56.3% of those having a family member who has been contracted COVID-19 engaged in any activities, only 26.9% of those or their family members who have not been contracted stated so. The respondents with no disability have engaged in activities two times more than PWDs (31% and 17.6% respectively).

Table 33 Distribution of respondents that have been engaged or consulted by any implementing partners on how COVID-19 could be better prevented in their area

	Yes		No		I do not know		Total	
	#	%	#	%	#	%	#	%
Age Group								
18-25	15	31.9	30	63.8	2	4.3	47	100
26-40	81	30.9	175	66.8	6	2.3	262	100
41-65	109	30.6	247	69.4	-	-	356	100
65+	3	11.1	24	88.9	-	-	27	100
Location								
Al-Arroub	7	28.0	17	68.0	1	4.0	25	100
Azzun	14	22.2	46	73.0	3	4.8	63	100
Beita	35	36.5	61	63.5	-	-	96	100
Dura	53	28.5	130	69.9	3	1.6	186	100
Jerusalem (Old Town)	47	23.4	153	76.1	1	.5	201	100
Kafr Qaddum	7	24.1	22	75.9	-	-	29	100
Ni'leen	31	56.4	24	43.6	-	-	55	100
Qaryout	13	39.4	20	60.6	-	-	33	100
Other	1	25.0	3	75.0	-	-	4	100
Have you or someone in your family been contracted COVID 19?								
Yes (family member)	117	31.4	255	68.4	1	0.3	373	100
Yes (self)	75	29.3	179	69.9	2	0.8	213	100
No	56	25.7	157	72.0	5	2.3	218	100
Education								
No formal education	4	22.2	14	77.8	-	-	18	100
Primary/elementary	27	26.5	75	73.5	-	-	102	100
Secondary/high school	52	23.2	169	75.4	3	1.3	224	100
University	108	34.1	204	64.4	5	1.6	317	100
Advanced university	17	54.8	14	45.2	-	-	31	100
Total	208	30.1	476	68.8	8	1.2	692	100

Those who have been engaged by any implementing partners primarily participated in awareness sessions around COVID-19 and vaccination (69.7%). In focus groups, the participants stated actions such as distributing aid, collecting donations, participating in information seminars.

Figure 19 Reported means respondents used to provide feedback (%)
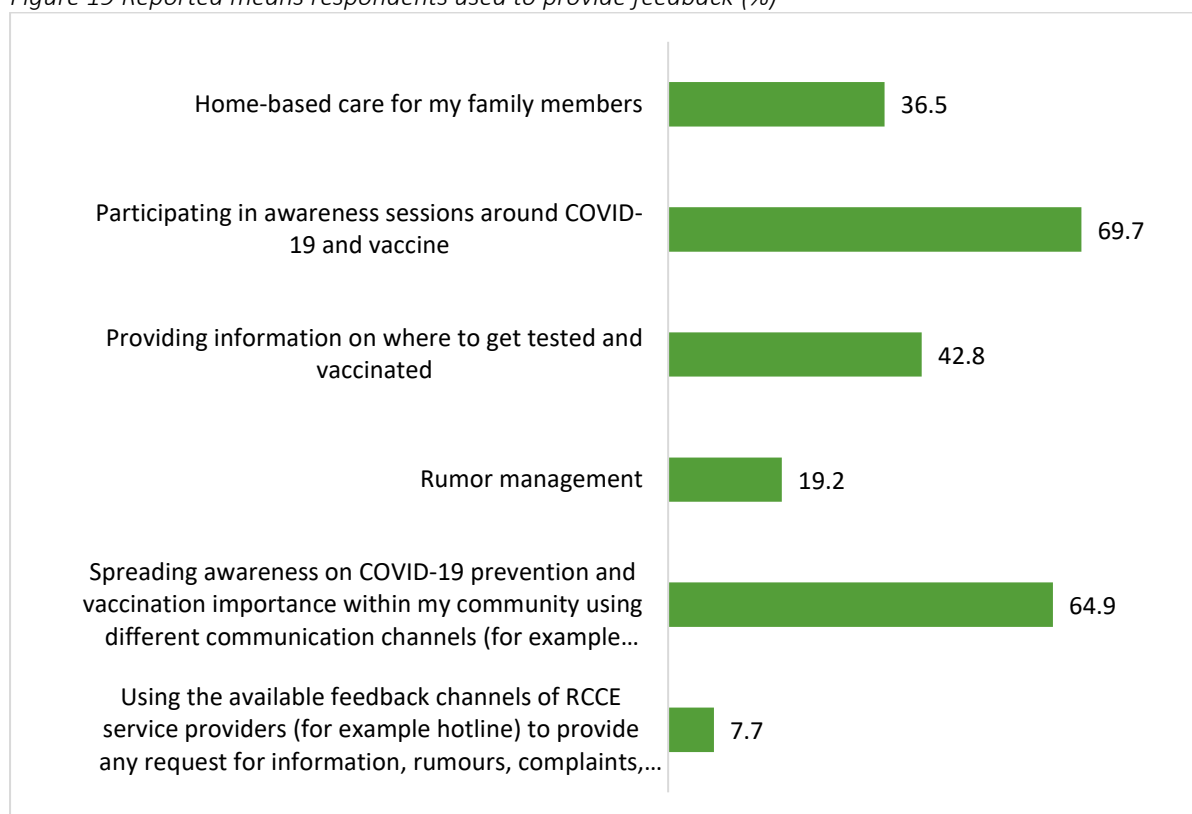
The majority of respondents who had not been engaged by any implementing partners stated they would not like to be engaged (67%). The results changed across location (p=0.003) and concern level of the respondents about their health (p=0.01).

Table 34 Respondents' interest to be consulted or engaged by implementing partners to provide feedback (among respondents that have not yet been consulted or engaged)

	Yes		No		I do not know		Total	
	#	%	#	%	#	%	#	%
Location								
Al-Arroub	1	5.9	14	82.4	2	11.8	17	100
Azzun	8	17.4	30	65.2	8	17.4	46	100
Beita	18	29.5	40	65.6	3	4.9	61	100
Dura	26	20.0	76	58.5	28	21.5	130	100
Jerusalem (Old Town)	36	23.5	111	72.5	6	3.9	153	100
Kafr Qaddum	4	18.2	16	72.7	2	9.1	22	100
Ni'leen	8	33.3	15	62.5	1	4.2	24	100
Qaryout	4	20.0	14	70.0	2	10.0	20	100
Other	-	-	3	100	-	-	3	100
How concerned were you about your health during the COVID-19 pandemic?								
Not concerned at all	17	19.3	66	75.0	5	5.7	88	100
Not really concerned	15	20.0	55	73.3	5	6.7	75	100
Neither concerned nor unconcerned	15	23.4	46	71.9	3	4.7	64	100

	#	%	#	%	#	%	#	%	#	%
Concerned	33	26.6	76	61.3	15	12.1	124	100		
Very concerned	25	20.0	76	60.8	24	19.2	125	100		
Total	105	22.1	319	67	52	10.9	476	100		

Perceptions of COVID-19 Vaccines

Respondents had mixed views about the safety of COVID-19 vaccines. While 36.6% reported that vaccines were reasonably or very safe, while 41.1% felt that vaccines were not safe or not safe at all. Differences were statistically significant by location (p<0.001), respondents' concern level about their health (p<0.001), and respondents' prior COVID-19 diagnosis (p=0.06).

Respondents in Beita (54.1%) and Azzun (50.8%) were the most likely to report that the COVID-19 vaccines were "reasonably safe" or "very safe" while those in Ni'leen (12.7%) and Qaryout (18.2%) were the least likely to report feeling COVID-19 vaccines were safe. More than half (57.4%) of respondents who were concerned and 46.2% of respondents were very concerned about their health thought the COVID-19 vaccines are reasonably safe or very safe, and this was two times higher than respondents who did not concern at all (24.2%). The respondents who had contracted COVID-19 believed that the vaccines were safe slightly more than respondents who had no family or personal history with COVID-19 (45.7% and 38.1% respectively).

Table 35 Respondents' perception of COVID-19 vaccine safety

	Not Safe at all		Not Safe		Neither Safe nor Unsafe		Reasonable Safe		Very Safe		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Location												
Al-Arroub	1	4.0	7	28.0	9	36.0	7	28.0	1	4.0	25	100
Azzun	4	6.3	7	11.1	20	31.7	31	49.2	1	1.6	63	100
Beita	25	26.0	11	11.5	8	8.3	49	51.0	3	3.1	96	100
Dura	25	13.4	56	30.1	12	6.5	83	44.6	10	5.4	186	100
Jerusalem (Old Town)	20	10.0	42	20.9	66	32.8	59	29.4	14	7.0	201	100
Kafr Qaddum	4	13.8	4	13.8	9	31.0	11	37.9	1	3.4	29	100
Ni'leen	2	3.6	28	50.9	18	32.7	6	10.9	1	1.8	55	100
Qaryout	4	12.1	11	33.3	12	36.4	4	12.1	2	6.1	33	100
Other	2	50.0	-	-	1	25.0	1	25.0	-	-	4	100
How concerned were you about your health during the COVID-19 pandemic?												
Not concerned at all	33	24.3	33	24.3	37	27.2	26	19.1	7	5.1	136	100
Not really concerned	13	11.8	26	23.6	35	31.8	31	28.2	5	4.5	110	100
Neither concerned nor unconcerned	6	7.7	13	16.7	36	46.2	22	28.2	1	1.3	78	100
Concerned	15	7.6	41	20.8	28	14.2	100	50.8	13	6.6	197	100
Very concerned	20	11.7	53	31.0	19	11.1	72	42.1	7	4.1	171	100
Have you or someone in your family been contracted COVID 19?												
Yes (self)	25	9.8	68	26.6	46	18.0	104	40.6	13	5.1	256	100
Yes (family member)	44	11.8	97	26.0	77	20.6	136	36.5	19	5.1	373	100
No	38	17.4	47	21.6	50	22.9	72	33.0	11	5.0	218	100

Total	87	12.6	166	24	155	22.4	251	36.3	33	4.8	692	100

The majority of the respondents (53.5%) reported that they felt that vaccines offered limited protection against the virus, A statistically significant relation was only detected across the location (p<0.001). Respondents in Ni'leen (72.7%) were the most likely to report that vaccines were not protective at all or had little effect.

Table 36 Respondents' perceptions of the extent to which COVID-19 vaccines will protect themselves and others in their community

	Not at all		A little		Moderately		A lot		Fully protect		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Location												
Al-Arroub	8	32.0	9	36.0	8	32.0	-	-	-	-	25	100
Azzun	8	12.7	18	28.6	33	52.4	4	6.3	-	-	63	100
Beita	35	36.5	14	14.6	40	41.7	3	3.1	4	4.2	96	100
Dura	32	17.2	78	41.9	59	31.7	11	5.9	6	3.2	186	100
Jerusalem (Old Town)	36	17.9	53	26.4	91	45.3	13	6.5	8	4.0	201	100
Kafr Qaddum	9	31.0	6	20.7	13	44.8	1	3.4	-	-	29	100
Ni'leen	5	9.1	35	63.6	13	23.6	2	3.6	-	-	55	100
Qaryout	10	30.3	11	33.3	10	30.3	2	6.1	-	-	33	100
Other	1	25.0	2	50.0	1	25.0	-	-	-	-	4	100
Total	144	20.8	226	32.7	268	38.7	36	5.2	18	2.6	692	100

Almost all of the respondents knew where and how to register to get themselves vaccinated (97.3%). Differences were statistically significant by age groups (p=0.03) and disability status (p=0.001). All of respondents aged 18-25 (100%) reported knowing where and how to register to get vaccinated, but the proportion dropped to 88.9% among respondents aged 65 and above.

Figure 20 Distribution of whether respondents know where and how to get vaccinated by age group (%)
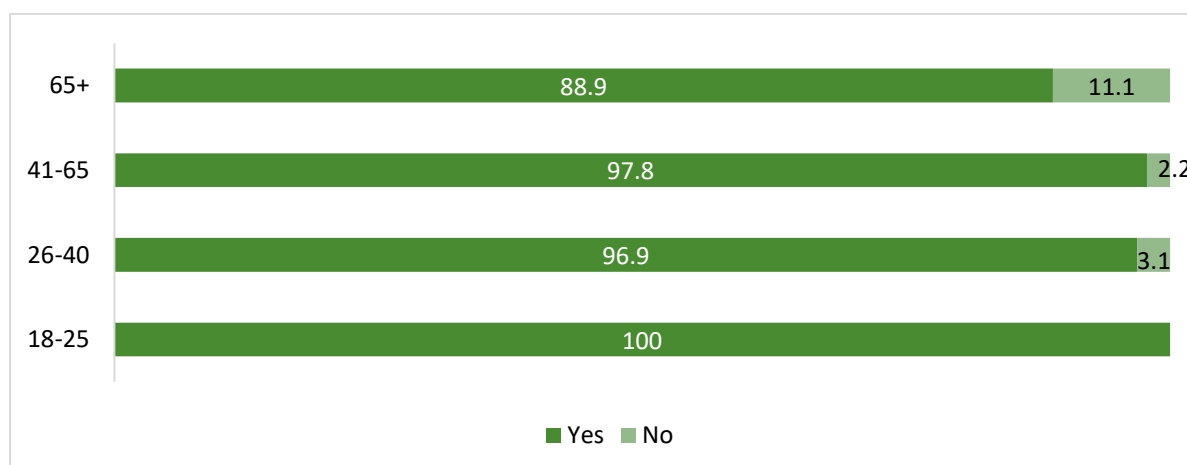
Figure 21 Distribution of whether respondents know where and how to get vaccinated by disability status (%)
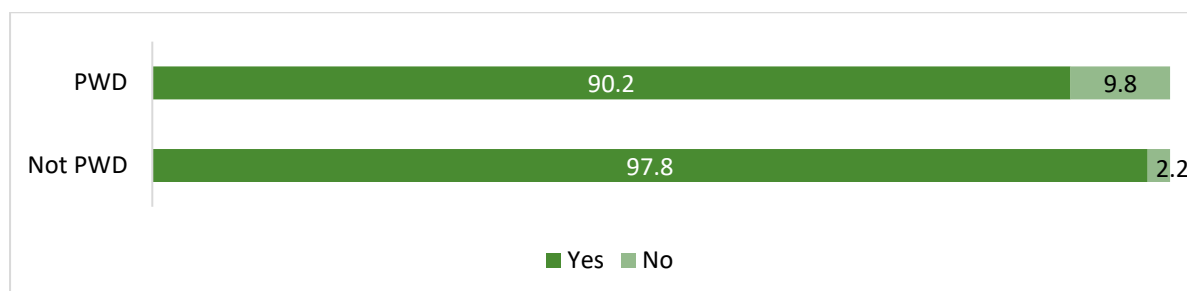
For the majority of the respondents, accessing vaccines was viewed to be moderately easy (19.8%) or very easy (61.7%). The results significantly differed by location (p<0.001). Respondents in Dura (93%) and Kafr Qaddum (93.1%) were the most likely to report that accessing vaccines was moderately or very easy, while only 44% of respondents in Al-Arroub felt the same.

Table 37 Respondents' ratings of how easy it is to get vaccinated

	Not at all easy		A little easy		Moderately easy		Very easy		Total	
	#	%	#	%	#	%	#	%	#	%
Location										
Al-Arroub	5	20.0	9	36.0	7	28.0	4	16.0	25	100
Azzun	3	4.8	21	33.3	14	22.2	25	39.7	63	100
Beita	9	9.4	6	6.3	20	20.8	61	63.5	96	100
Dura	2	1.1	11	5.9	24	12.9	149	80.1	186	100
Jerusalem (Old Town)	6	3.0	17	8.5	22	10.9	156	77.6	201	100
Kafr Qaddum	-	-	2	6.9	16	55.2	11	37.9	29	100
Ni'leen	1	1.8	25	45.5	24	43.6	5	9.1	55	100
Qaryout	4	12.1	7	21.2	10	30.3	12	36.4	33	100
Other	-	-	-	-	-	-	4	100	4	100
Total	30	4.3	98	14.2	137	19.8	427	61.7	692	100

The majority of the respondents have been vaccinated with at least one dose of a COVID-19 vaccine, while 44.5% of respondents reported that they had received two doses of a COVID-19 vaccine. Nearly a quarter of the respondents reported that they had not received any COVID-19 vaccinations (23.3%). Among all respondents, 15.5% stated that they did not plan to ever get vaccinated against COVID-19. The results significantly differed by location (p<0.001), education level (p=0.003), perceptions about vaccine safety (p<0.001), tendencies to engage in activities to better prevent COVID-19 (p=0.007) and having contracted COVID-19 (p=.01).

Respondents in Al-Arroub (88%) were most likely to report being vaccinated, while those in Qaryout (48.5%) were the least likely to report one vaccine. While 93.6% of the respondents with advanced university degree had been vaccinated against COVID-19 at least once, this rate was 65.7% for respondents with primary/elementary degree.

In line with the views on the vaccine, almost all of the respondents (97%) who perceived the COVID-19 vaccines as very safe had been vaccinated against COVID-19 at least one dose, while this rate was only 39% among respondents who perceived the vaccines as not safe at all. Similarly, respondents that reported engaging in activities to prevent COVID-19 were more likely to report being vaccinated compared to respondents had not (84.8% and 69.3%, respectively). The majority (80.5%) of the respondents with a personal history of COVID-19 and 79.4% of those with a family history of COVID-19

had been vaccinated against COVID-19 with at least one dose, while this rate was 69.3% among respondents having no family or personal COVID-19 history.

Some respondents were influenced to get vaccinated despite feeling it had limited protective effect. As people who attended focus groups noted, many employed people had to be vaccinated to keep their jobs. Also, vaccination was a necessity to be able to travel.

"All the young people I heard about are afraid of the job. They are not afraid of the disease. I took the vaccine so that I could continue my life, not because I was afraid of the disease." (Male, Jerusalem Old Town)

"I took the vaccine; it is mandatory, and it is forbidden to miss unless you breastfeed." (Female, Jerusalem)

"But there are emergency cases that require the vaccination, especially for travelers, and we did not want to ask ourselves whether the vaccine is effective and in fact it is ineffective." (Male, Dura)

Table 38 Distribution of respondents' by COVID-19 vaccination status

	Yes, I did all the doses		Yes, but I have not completed all the doses		No, but I will		No, I won't		No, I'm not sure		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Location												
Al-Arroub	11	44.0	11	44.0	3	12.0	-	-	-	-	25	100
Azzun	35	55.6	9	14.3	6	9.5	10	15.9	3	4.8	63	100
Beita	48	50.0	20	20.8	8	8.3	17	17.7	3	3.1	96	100
Dura	82	44.1	60	32.3	7	3.8	36	19.4	1	.5	186	100
Jerusalem (Old Town)	100	49.8	73	36.3	11	5.5	17	8.5	-	-	201	100
Kafr Qaddum	11	37.9	10	34.5	1	3.4	7	24.1	-	-	29	100
Ni'leen	7	12.7	36	65.5	5	9.1	7	12.7	-	-	55	100
Qaryout	13	39.4	3	9.1	2	6.1	11	33.3	4	12.1	33	100
Other	1	25.0	1	25.0	-	-	2	50.0	-	-	4	100
Education												
No formal education	8	44.4	7	38.9	2	11.1	1	5.6	-	-	18	100
Primary/elementary	30	29.4	37	36.3	13	12.7	20	19.6	2	2	102	100
Secondary/high school	103	46.0	60	26.8	18	8.0	40	17.9	3	1.3	224	100
University	146	46.1	111	35.0	9	2.8	45	14.2	6	1.9	317	100
Advanced university	21	67.7	8	25.8	1	3.2	1	3.2	-	-	31	100
How safe do you believe the COVID-19 vaccines are?												
Not safe at all	19	21.8	15	17.2	5	5.7	47	54	1	1.1	87	100
Not safe	52	31.3	52	31.3	17	10.2	42	25.3	3	1.8	166	100
Neither safe nor unsafe	64	41.3	67	43.2	9	5.8	12	7.7	3	1.9	155	100
Reasonable safe	150	59.8	80	31.9	12	4.8	5	2.0	4	1.6	251	100
Very safe	23	69.7	9	27.3	-	-	1	3.0	-	-	33	100
Would you like to be engaged? (Unengaged respondents)												

Yes	47	44.8	42	40.0	6	5.7	10	9.5	-	-	105	100
No	126	39.5	95	29.8	23	7.2	72	22.6	3	0.9	319	100
I do not know	19	36.5	17	32.7	2	3.8	11	21.2	3	5.8	52	100
Have you or someone in your family contracted COVID 19?												
Yes (self)	118	46.1	88	34.4	14	5.5	34	13.3	2	0.8	256	100
Yes (family member)	163	43.7	133	35.7	18	4.8	56	15.0	3	0.8	373	100
No	93	42.7	58	26.6	15	6.9	46	21.1	6	2.8	218	100
Total	308	44.5	223	32.2	43	6.2	107	15.5	11	1.6	692	100

The most commonly cited reasons for vaccination among survey respondents were to protect from contracting COVID-19" (57.8%), to prevent transmission (52.5%), and to travel freely (42.6%).

Among respondents in Jerusalem, 81% of respondents reported getting vaccinated to protect from contracting COVID-19, while 74.6% reported they were vaccinated to prevent transmission. To travel freely was stated half of respondents in Beita (52.9%) and Dura (51.4%), while this rate was 27.3% for respondents in Al-Arroub. Transmission prevention was the most cited reason to get vaccinated among respondents with no formal education (66.7%) and an advanced university degree (62.1%).

In qualitative interviews, vaccination was seen as a social responsibility, while some held religious views about vaccination.

"From a religious perspective, we do what is needed and then rely on God. The vaccine is a means of protection. Anyone who is not vaccinated has sinned and bears [religious] responsibility if anyone contracts COVID-19 because of him. If the contracted person dies due to this careless person, the careless person would be considered a murderer. I think such people who are not vaccinated and infect other people should be considered as murderers and treated as such". (Female, Qaryout).

Table 39 Respondents' reasons for getting vaccinated by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni'leen	Qaryout	Total
To travel freely	#	6	13	36	73	62	12	17	6	226
	%	27.3	29.5	52.9	51.4	35.8	57.1	39.5	37.5	42.6
To protect from contracting COVID-19	#	11	20	41	61	119	17	26	10	307
	%	50.0	45.5	60.3	43.0	68.8	81.0	60.5	62.5	57.8
To prevent transmission	#	16	14	18	50	129	15	28	7	279
	%	72.7	31.8	26.5	35.2	74.6	71.4	65.1	43.8	52.5
Return to normal	#	10	21	20	9	93	1	4	6	164
	%	45.5	47.7	29.4	6.3	53.8	4.8	9.3	37.5	30.9
End COVID-19 pandemic	#	5	17	22	33	96	10	2	6	192
	%	22.7	38.6	32.4	23.2	55.5	47.6	4.7	37.5	36.2
Benefits over risks	#	3	3	10	10	43	2	3	3	77
	%	13.6	6.8	14.7	7.0	24.9	9.5	7.0	18.8	14.5
Being in a high-risk group	#	1	1	5	51	12	-	9	1	80
	%	4.5	2.3	7.4	35.9	6.9	-	20.9	6.3	15.1
Other	#	2	5	8	18	12	3	-	2	50
	%	9.1	11.4	11.8	12.7	6.9	14.3	-	12.5	9.4
Total	#	22	44	68	142	173	21	43	16	531

Table 40 Respondents' reasons for getting vaccinated by education level

		No formal education	Primary/ elementary	Secondary /high school	University	Advanced university	Total
To travel freely	#	1	26	74	113	12	226
	%	6.7	38.8	45.4	44.0	41.4	42.6
To protect from contracting COVID-19	#	9	37	86	157	18	307
	%	60.0	55.2	52.8	61.1	62.1	57.8
To prevent transmission	#	10	31	82	138	18	279
	%	66.7	46.3	50.3	53.7	62.1	52.5
Return to normal	#	6	16	54	77	11	164
	%	40.0	23.9	33.1	30.0	37.9	30.9
End COVID-19 pandemic	#	7	13	59	98	15	192
	%	46.7	19.4	36.2	38.1	51.7	36.2
Benefits outweigh risks	#	2	7	21	40	7	77
	%	13.3	10.4	12.9	15.6	24.1	14.5
Being in a high-risk group	#	1	-	22	52	5	80
	%	6.7	-	13.5	20.2	17.2	15.1
Other	#	1	7	14	26	2	50
	%	6.7	10.4	8.6	10.1	6.9	9.4
Total	#	15	67	163	257	29	531

In a related question, the most cited factors that influence the respondents' decision to take the COVID-19 vaccine were the suggestions from doctors or health authorities (53.1%), the number of COVID-19 cases (30.9%), and the number of deaths caused by COVID-19 (29%). The results significantly vary by location ($p<0.001$) and education ($p=0.001$).

Suggestions from doctors or health authorities were stated the most respondents in Jerusalem (72.3%) and by the least respondents in Kafr Qaddum (23.8%). The number of COVID-19 cases was a factor for the majority of respondents in Kafr Qaddum (71.4%), while only 9.1% of respondents in A-Arroub felt this was a factor. Similarly, while the majority of respondents in Kafr Qaddum (71.4%) stated that the number of deaths caused by COVID-19 was a factor, only 6.3% of respondents in Qaryout and 9.1% in Al-Arroub (9.1%) felt the same.

Suggestions from doctors or health authorities were a factor reported at most of the respondents with no formal education and at least by respondents with a primary education (73.3% and 47.8%). As the level of education increased, the proportion of respondents stating the number of COVID-19 cases and the number of deaths caused by COVID-19 were a factor in their decision to get vaccinated also increased.

Table 41 Respondents' reasons for getting vaccinated by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni' leen	Qaryout	Total
Type of vaccine	#	1	-	7	4	11	1	4	1	29
	%	4.5	-	10.3	2.8	6.4	4.8	9.3	6.3	5.5
Suggestions from doctors or health authorities	#	13	22	28	62	125	5	19	7	282
	%	59.1	50.0	41.2	43.7	72.3	23.8	44.2	43.8	53.1
Suggestion from friends or family members	#	-	13	36	19	40	9	10	6	134
	%	-	29.5	52.9	13.4	23.1	42.9	23.3	37.5	25.2
Pro-vaccine information in the media	#	-	-	5	37	18	2	2	-	64
	%	-	-	7.4	26.1	10.4	9.5	4.7	-	12.1
Number of deaths caused by COVID-19	#	2	8	17	60	38	15	12	1	154
	%	9.1	18.2	25.0	42.3	22.0	71.4	27.9	6.3	29.0
Number of COVID-19 cases	#	2	22	16	40	49	15	16	3	164
	%	9.1	50.0	23.5	28.2	28.3	71.4	37.2	18.8	30.9
My health status	#	9	5	14	31	42	2	20	1	124
	%	40.9	11.4	20.6	21.8	24.3	9.5	46.5	6.3	23.4
Effectiveness	#	1	5	3	10	54	-	5	3	82
	%	4.5	11.4	4.4	7.0	31.2	-	11.6	18.8	15.4
Duration of protection	#	-	-	2	2	13	2	6	2	27
	%	-	-	2.9	1.4	7.5	9.5	14.0	12.5	5.1
Adverse effects of COVID-19	#	4	9	12	22	30	7	5	1	91
	%	18.2	20.5	17.6	15.5	17.3	33.3	11.6	6.3	17.1
Other	#	3	5	9	23	4	2	-	-	46
	%	13.6	11.4	13.2	16.2	2.3	9.5	-	-	8.7
Total	#	22	44	68	142	173	21	43	16	531

Table 42 Respondents' reasons for getting vaccinated by education level

		No formal education	Primary/ elementary	Secondary / high school	University	Advanced university	Total
Type of vaccine	#	1	1	10	16	1	29
	%	6.7	1.5	6.1	6.2	3.4	5.5
Suggestions from doctors or health authorities	#	11	32	83	136	20	282
	%	73.3	47.8	50.9	52.9	69.0	53.1
Suggestion from friends or family members	#	2	20	49	56	7	134
	%	13.3	29.9	30.1	21.8	24.1	25.2
Pro-vaccine information in the media	#	2	4	23	32	3	64
	%	13.3	6.0	14.1	12.5	10.3	12.1
Number of deaths caused by COVID-19	#	2	13	38	92	9	154
	%	13.3	19.4	23.3	35.8	31.0	29.0
Number of COVID-19 cases	#	2	15	42	94	11	164
	%	13.3	22.4	25.8	36.6	37.9	30.9
My health status	#	3	27	32	53	9	124
	%	20.0	40.3	19.6	20.6	31.0	23.4
Effectiveness	#	4	2	25	45	6	82

	%	26.7	3.0	15.3	17.5	20.7	15.4
Duration of protection	#	1	5	7	13	1	27
	%	6.7	7.5	4.3	5.1	3.4	5.1
Adverse effects of COVID-19	#	1	5	25	55	5	91
	%	6.7	7.5	15.3	21.4	17.2	17.1
Other	#	-	3	15	26	2	46
	%	-	4.5	9.2	10.1	6.9	8.7
Total	#	15	67	163	257	29	531

Among respondents who had not been vaccinated against COVID-19, the most commonly cited reasons were a belief that the vaccine was not effective (46%), a belief that vaccines aren't safe because they were developed quickly (45.3%), and a belief that vaccines had negative side effects (42.9%). Concerns about the safety of vaccines were also highlighted by unvaccinated participants in the FGDs and KIIs.

"If you want to talk about a vaccine, you sit for a year or two and you talk about it, make it, and prepare it… How is possible to make a COVID-19 vaccine in six months or a year?" (Female, Qaryout)

The major factors that influenced the respondents' decision not to get vaccinated against COVID-19 were a belief that the vaccines were ineffective (54.7%), concern about adverse effects (37.3%,) and belief in anti-vaccine information in the media (26.1%).

Table 43 Respondents' reasons for not getting the COVID-19 vaccine by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni' leen	Qaryout	Total
You can get COVID-19 from the vaccines.	#	-	-	1	3	-	4	-	-	8
	%	-	-	3.6	6.8	-	50.0	-	-	5.0
Vaccine is not effective	#	1	3	8	25	11	8	7	9	74
	%	33.3	15.8	28.6	56.8	39.3	100	58.3	52.9	46.0
Trouble accessing vaccine	#	-	-	-	1	-	-	-	-	1
	%	-	-	-	2.3	-	-	-	-	.6
They have negative side effects.	#	2	12	10	14	13	7	3	8	69
	%	66.7	63.2	35.7	31.8	46.4	87.5	25.0	47.1	42.9
The vaccines aren't safe because they were developed quickly.	#	2	8	9	24	15	3	6	6	73
	%	66.7	42.1	32.1	54.5	53.6	37.5	50.0	35.3	45.3
Risks outweigh benefits	#	-	-	6	15	8	7	2	6	45
	%	-	-	21.4	34.1	28.6	87.5	16.7	35.3	28.0
Pregnant/lactating	#	-	1	-	1	-	-	-	-	2
	%	-	5.3	-	2.3	-	-	-	-	1.2
People with underlying conditions or suppressed immune systems shouldn't get vaccinated	#	-	2	3	8	2	-	-	-	15
	%	-	10.5	10.7	18.2	7.1	-	-	-	9.3
Mistrust of vaccine companies	#	2	3	14	22	7	2	4	8	63
	%	66.7	15.8	50.0	50.0	25.0	25.0	33.3	47.1	39.1
I've already had COVID-19, so I don't need to get vaccinated.	#	-	1	2	4	-	1	-	-	8
	%	-	5.3	7.1	9.1	-	12.5	-	-	5.0
	#	-	2	4	7	-	2	-	1	17

I don't need to get vaccinated because I'm young and healthy.	%	-	10.5	14.3	15.9	-	25.0	-	5.9	10.6
Allergic to vaccine	#	-	-	-	1	2	-	4	3	10
	%	-	-	-	2.3	7.1	-	33.3	17.6	6.2
Other	#	-	1	3	2	1	-	-	-	7
	%	-	5.3	10.7	4.5	3.6	-	-	-	4.3
Total	#	3	19	28	44	28	8	12	17	161

Table 44 Respondents' reasons for not getting the COVID-19 vaccine by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni' leen	Qaryout	Total
Type of vaccine	#	-	1	2	2	3	-	4	2	14
	%	-	5.3	7.1	4.5	10.7	-	33.3	11.8	8.7
Suggestions from doctors or health authorities	#	-	1	-	26	6	-	3	2	38
	%	-	5.3	-	59.1	21.4	-	25.0	11.8	23.6
Suggestion from friends or family members	#	-	-	-	8	1	-	-	2	11
	%	-	-	-	18.2	3.6	-	-	11.8	6.8
Number of deaths caused by COVID-19	#	-	1	4	17	1	5	5	1	34
	%	-	5.3	14.3	38.6	3.6	62.5	41.7	5.9	21.1
Number of COVID-19 cases	#	-	2	5	11	6	5	4	4	38
	%	-	10.5	17.9	25.0	21.4	62.5	33.3	23.5	23.6
My health status	#	-	5	2	2	2	2	4	3	20
	%	-	26.3	7.1	4.5	7.1	25.0	33.3	17.6	12.4
Ineffectiveness	#	3	10	16	28	10	7	5	8	88
	%	100	52.6	57.1	63.6	35.7	87.5	41.7	47.1	54.7
Duration of protection	#	-	1	2	1	1	4	3	1	14
	%	-	5.3	7.1	2.3	3.6	50.0	25.0	5.9	8.7
Anti-vaccine information in the media	#	-	-	4	30	2	5	-	1	42
	%	-	-	14.3	68.2	7.1	62.5	-	5.9	26.1
Adverse effects	#	-	5	9	16	12	6	2	9	60
	%	-	26.3	32.1	36.4	42.9	75.0	16.7	52.9	37.3
Other	#	-	1	4	2	1	-	-	1	9
	%	-	5.3	14.3	4.5	3.6	-	-	5.9	5.6
Total	#	3	19	28	44	28	8	12	17	161

Risk Communication

The majority of the respondents considered it important to take actions to prevent the spread of COVID-19 in their community (83.8%). There was a statistically significant difference across gender (p =0.03), age groups (p =0.003), location (p<0.001), education (p<0.001) and disability (p<0.001).

Female respondents were more likely to report that it was important to take actions to prevent the spread of COVID-19 compared to male respondents (87.9% and 80.5%). While respondents aged 26-40

were the most likely to report that it was important to take action, respondents aged 65 and above were the least likely to report the same.

Almost all of the respondents in Al-Arroub (96%) and Dura (93%) considered it important to take actions to prevent the spread of COVID-19, compared to three quarters of respondents in Kafr Qaddum (75.9%) and Qaryout (75.8%).

As the level of education increased, the proportion of respondents who considered it important to take action to prevent the spread of COVID-19 also increased - 88.6% of respondents with a university degree and 87.1% of respondents with an advanced university degree considered it important to take actions to prevent the spread of COVID-19, while only 55.6% of respondents had no formal education and 74.5% of respondents with primary/elementary did so. The respondents with no disability were more likely to report that they considered it important to take actions more than PWD (85.2% and 66.7%, respectively).

Table 45 Distribution of whether respondents feel it is important to take actions to prevent the spread of COVID-19 in their community

	Yes		No		I do not know		Total	
	#	%	#	%	#	%	#	%
Gender								
Male	305	80.5	45	11.9	29	7.7	379	100
Female	275	87.9	22	7	16	5.1	313	100
Age Group								
18-25	38	80.9	4	8.5	5	10.6	47	100
26-40	227	86.6	23	8.8	12	4.6	262	100
41-65	300	84.3	32	9	24	6.7	356	100
65+	15	55.6	8	29.6	4	14.8	27	100
Location								
Al-Arroub	24	96	1	4	-	-	25	100
Azzun	51	81	2	3.2	10	15.9	63	100
Beita	75	78.1	19	19.8	2	2.1	96	100
Dura	173	93	1	0.5	12	6.5	186	100
Jerusalem (Old Town)	155	77.1	35	17.4	11	5.5	201	100
Kafr Qaddum	22	75.9	4	13.8	3	10.3	29	100
Ni'leen	51	92.7	3	5.5	1	1.8	55	100
Qaryout	25	75.8	2	6.1	6	18.2	33	100
Other	4	100	-	-	-	-	4	100
Education								
No formal education	10	55.6	3	16.7	5	27.8	18	100
Primary/elementary	76	74.5	19	18.6	7	6.9	102	100
Secondary/high school	186	83	24	10.7	14	6.3	224	100
University	281	88.6	19	6	17	5.4	317	100
Advanced university	27	87.1	2	6.5	2	6.5	31	100
Disability								
Not-PWD	546	85.2	53	8.3	42	6.6	641	100
PWD	34	66.7	14	27.5	3	5.9	51	100
Total	580	83.8	67	9.7	45	6.5	692	100

If the respondents or someone in their family had symptoms of COVID-19, respondents most commonly reported that they would go to the hospital/health unit (57.7%) or stay in quarantine (52.9%). The results differed significantly by location (p<0.001).

Respondents in Kafr Qaddum (75.9%), Azzun (73%) and Al-Arroub (72%) were the most likely to report that they would go to the hospital/health unit. Respondents in Ni'leen (47.3%), Qaryout (48.5%) and Dura (49.5%) were the least likely to report that they would go to the hospital/health unit. Respondents in Kafr Qaddum (86.2%) were the mostly and respondents in Azzun (30.2% the least likely to report that they would quarantine if they had COVID-19 symptoms.

Respondents were most likely to report that, if they came into contact with someone with COVID-19, they would get tested (62.3) or stay at home and wait a few days to see if symptoms developed (39.6%). The results vary significantly by location (p<0.001) and education (p=0.005).

Table 46 Respondents' plans if they or a family member developed COVID-19 symptoms by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni' leen	Qaryout	Total
I would stay in quarantine	#	16	19	52	84	125	25	28	14	366
	%	64.0	30.2	54.2	45.2	62.2	86.2	50.9	42.4	52.9
I will look for the traditional healer	#	-	-	9	7	26	-	2	3	48
	%	-	-	9.4	3.8	12.9	-	3.6	9.1	6.9
I will look for a more experienced relative to advise me on what to do	#	6	6	24	43	50	7	17	10	164
	%	24.0	9.5	25.0	23.1	24.9	24.1	30.9	30.3	23.7
I will go to the neighborhood nurse	#	1	2	10	4	31	-	15	6	70
	%	4.0	3.2	10.4	2.2	15.4	-	27.3	18.2	10.1
I will go to the hospital/health unit	#	18	46	47	92	130	22	26	16	399
	%	72.0	73.0	49.0	49.5	64.7	75.9	47.3	48.5	57.7
I will buy medicines at the market	#	3	7	13	40	38	5	13	5	126
	%	12.0	11.1	13.5	21.5	18.9	17.2	23.6	15.2	18.2
Other	#	-	-	1	2	1	-	-	-	4
	%	-	-	1.0	1.1	0.5	-	-	-	0.6
Total	#	25	63	96	186	201	29	55	33	692

Respondents in Jerusalem were three and half times more likely to report that they would get tested in they came in contact with someone that had COVID-19 (84.1%) compared to those in Qaryout (24.2%). While 55.6% of respondents in Azzun reported that they would stay at home and wait a few days to see if they develop symptoms, only 18.2% of respondents in Ni'leen reported the same. The majority of respondents with an advanced university degree reported that they would get tested I they came in contact with someone with COVID-19, while slightly more than half of those with a primary education reported the same (83.9% and 54.9%).

Table 47 Distribution of what respondents' feel is an acceptable response if they came in contact with someone with COVID-19 by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni' leen	Qaryout	Total
Stay at home for 10 days	#	1	9	13	33	61	17	13	7	156
	%	4.0	14.3	13.5	17.7	30.3	58.6	23.6	21.2	22.5
Stay at home and wait a few days to see if symptoms develop	#	7	35	40	60	96	7	10	16	274
	%	28.0	55.6	41.7	32.3	47.8	24.1	18.2	48.5	39.6
I get tested	#	19	34	31	108	169	17	43	8	431
	%	76.0	54.0	32.3	58.1	84.1	58.6	78.2	24.2	62.3
I asked to report about that	#	10	6	15	10	50	4	7	10	112
	%	40.0	9.5	15.6	5.4	24.9	13.8	12.7	30.3	16.2
Do not know	#	2	3	1	3	3	4	-	1	17
	%	8.0	4.8	1.0	1.6	1.5	13.8	-	3.0	2.5
Continue as usual	#	-	5	20	48	15	-	4	4	96
	%	-	7.9	20.8	25.8	7.5	-	7.3	12.1	13.9
Other	#	-	-	-	8	-	1	-	-	9
	%	-	-	-	4.3	-	3.4	-	-	1.3
Total	#	25	63	96	186	201	29	55	33	692

Table 48 Distribution of what respondents' feel is an acceptable response if they came in contact with someone with COVID-19 by education

		No formal education	Primary/ elementary	Secondary /high school	University	Advanced university	Total
Stay at home for 10 days	#	6	17	52	73	8	156
	%	33.3	16.7	23.2	23.0	25.8	22.5
I stay at home and wait a few days to see if I develop symptoms	#	9	42	79	133	11	274
	%	50.0	41.2	35.3	42.0	35.5	39.6
I get tested	#	14	56	140	195	26	431
	%	77.8	54.9	62.5	61.5	83.9	62.3
I asked to report about that	#	5	8	35	55	9	112
	%	27.8	7.8	15.6	17.4	29.0	16.2
Do not know	#	1	6	4	4	2	17
	%	5.6	5.9	1.8	1.3	6.5	2.5
Continue as usual	#	-	14	38	43	1	96
	%	-	13.7	17.0	13.6	3.2	13.9
Other	#	-	-	2	7	-	9
	%	-	-	0.9	2.2	-	1.3
Total	#	18	102	224	317	31	692

If respondents contracted COVID-19, the most commonly cited responses were to inform the people respondents came in contact with (72.2%) and/or strictly follow the quarantine rules (51.6%). At gender and age groups the estimates did not vary significantly (p>0.05).

Figure 22 Distribution of respondents' views of acceptable responses if they contracted COVID-19 (%)

The majority of respondents stated that they would share their diagnosis results if they tested positive for COVID-19 in all cases (78.9%). Respondents in Ni'leen (49.1%) were the most likely to report that they might not share positive test results, while those in Dura (86%) were the most likely to report that they would share positive test results in all cases.

Figure 23 Distribution of whether respondents would not disclose a positive test result or symptom by location (%)
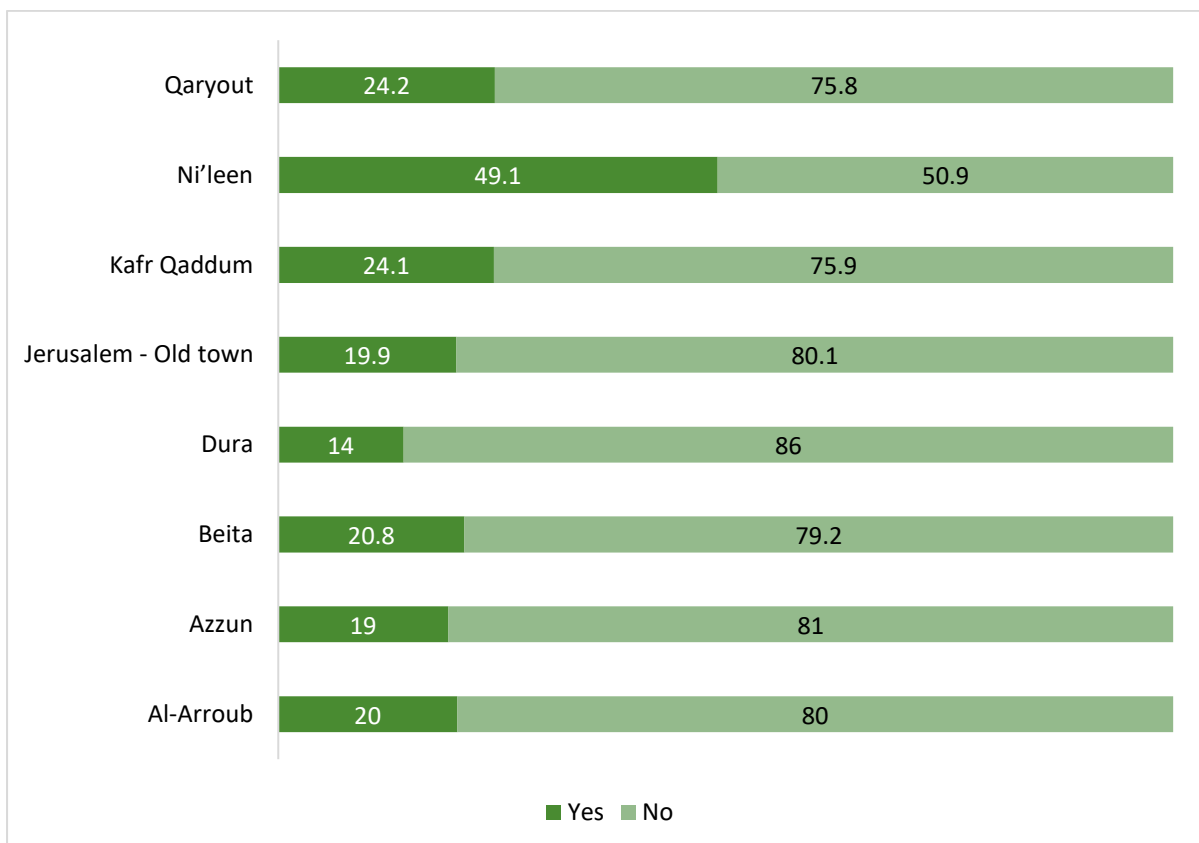
Among respondents who reported that they may not disclose a positive diagnosis, the most commonly cited reasons were a fear that disclosing results would cause loved ones to quarantine and quarantining would be harmful to them (49.7%) and a fear that disclosing their positive results would cause them to lose their jobs (37.9%). There was a statistically significant difference across locations (p<0.001).[5]

Figure 24 Distribution of cases where respondents would not disclose COVID symptoms or a positive test result (%)
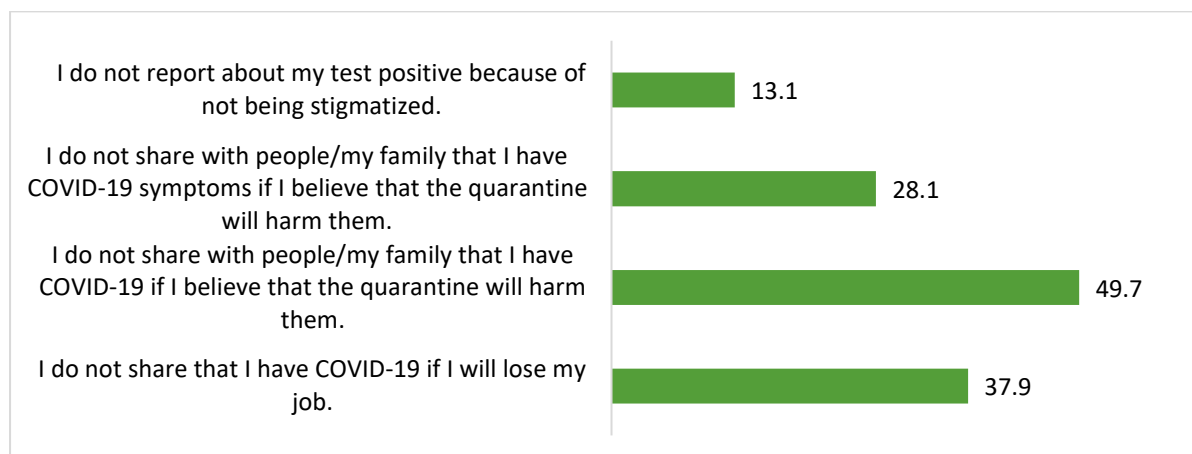
The majority of the respondents reported that they would get tested if they had symptoms of COVID-19 immediately" (49.3%) or if symptoms continued for 4-5 days (43.8%). The results significantly varied by respondents' level of concern about their health (p=0.003), prior COVID-19 experience (p=0.001), location (p<0.001), and disability (p=0.01). Respondents who were concerned or very concerned about their health tended to do a test immediately if they have symptoms of COVID-19 (54.4%), while the proportion dropped to 44.1% among respondents who reported no concern at all. Respondents in Al-Arroub were the most likely to report that they would test immediately, while those in Qaryout (24.2%) were the least likely to report that they would test immediately.

Participants in FGDs reported that it was difficult to obtain a COVID-19 test for a range of reasons, including remote testing locations, limited testing availability, and high testing costs. FGD participants reported that it had recently become easier to get tested this was reflected in people's willingness to get tested if they were symptomatic.

"Testing has become easy in recent months. But [before] it was difficult, especially when testing documents were required for travel" (FGD, Male, Azzun)

"[Early in the pandemic] there were few tests in the villages. Patients had to go to the city to get test, but this was difficult for people with symptoms." (Kafr Qaddum, Female, FGD).

"The test costs 150 shekels and it is not easy to go to the center unless a large group from the neighbour can be organised to go together." (Kafr Qaddum, Female, FGD).

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[5] Since the number of observations per cell is low, it is not meaningful to make a comparison on the basis of location.

Table 49 Distribution of whether respondents would test if symptomatic for COVID-19

	Would test immediately		Would test if symptoms continued for 4-5 days		Would not test due to cost		Would not test due to time and distance		Total	
	#	%	#	%	#	%	#	%	#	%
Location										
Al-Arroub	19	76.0	5	20.0	1	4.0	-	-	25	100
Azzun	21	33.3	36	57.1	2	3.2	2	3.2	63	100
Beita	40	41.7	47	49.0	-	-	2	2.1	96	100
Dura	74	39.8	106	57.0	-	-	1	.5	186	100
Jerusalem (Old Town)	127	63.2	59	29.4	9	4.5	4	2.0	201	100
Kafr Qaddum	17	58.6	10	34.5	-	-	1	3.4	29	100
Ni'leen	33	60.0	18	32.7	1	1.8	3	5.5	55	100
Qaryout	8	24.2	22	66.7	1	3.0	1	3.0	33	100
Other	2	50.0	-	-	-	-	-	-	4	100
Not concerned at all	60	44.1	56	41.2	4	2.9	6	4.4	136	100
Not really concerned	56	50.9	41	37.3	6	5.5	2	1.8	110	100
Neither concerned nor unconcerned	38	48.7	37	47.4	1	1.3	2	2.6	78	100
Concerned	94	47.7	94	47.7	2	1.0	3	1.5	197	100
Very concerned	93	54.4	75	43.9	1	0.6	1	0.6	171	100
Yes (family member)	112	43.8	133	52.0	4	1.6	3	1.2	256	100
Yes (self)	184	49.3	171	45.8	7	1.9	3	.8	373	100
No	103	47.2	91	41.7	4	1.8	9	4.1	218	100
Disability										
Not PWD	315	49.1	284	44.3	12	1.9	10	1.6	641	100
PWD	26	51.0	19	37.3	2	3.9	4	7.8	51	100
Total	341	49.3	303	43.8	14	2.0	14	2.0	692	100

Strategies

Respondents reported that they were most interested in learning more about whether vaccines would work against the Omicron variant (55.1%), whether treatments would work against the Omicron variant (48.3%), and how easily the Omicron variant spread (47.5%). There was a statistically significant difference by location (p<0.001), education (p=0.006) and disability (p=0.02).

Table 50 Topics respondents would like more information about by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni' leen	Qaryout	Total
Vaccines effective against the Omicron variant	#	17	32	72	103	97	11	34	14	381
	%	68.0	50.8	75.0	55.4	48.3	37.9	61.8	42.4	55.1
Treatments for the Omicron variant?	#	15	18	60	96	98	12	21	13	334
	%	60.0	28.6	62.5	51.6	48.8	41.4	38.2	39.4	48.3
What to do if you have symptoms	#	5	7	13	77	49	6	12	7	177

	%	20.0	11.1	13.5	41.4	24.4	20.7	21.8	21.2	25.6
Symptoms of the COVID-19	#	8	11	15	64	56	20	18	13	207
	%	32.0	17.5	15.6	34.4	27.9	69.0	32.7	39.4	29.9
Most at-risk groups	#	8	12	23	100	57	7	8	7	223
	%	32.0	19.0	24.0	53.8	28.4	24.1	14.5	21.2	32.2
How to treat COVID-19	#	5	10	24	91	52	11	10	9	214
	%	20.0	15.9	25.0	48.9	25.9	37.9	18.2	27.3	30.9
How to protect yourself from COVID-19	#	7	10	17	91	67	24	12	13	245
	%	28.0	15.9	17.7	48.9	33.3	82.8	21.8	39.4	35.4
How it COVID-19 transmitted	#	8	8	15	97	69	21	9	8	238
	%	32.0	12.7	15.6	52.2	34.3	72.4	16.4	24.2	34.4
How easily does the Omicron variant spread?	#	17	20	61	114	53	16	31	16	329
	%	68.0	31.7	63.5	61.3	26.4	55.2	56.4	48.5	47.5
Other	#	-	1	5	19	12	-	-	2	39
	%	-	1.6	5.2	10.2	6.0	-	-	6.1	5.6
Total	#	25	63	96	186	201	29	55	33	692

Table 51 Topics respondents would like more information about by education level

		No formal education	Primary/ elementary	Secondary /high school	University	Advanced university	Total
Will vaccines work against the Omicron variant?	#	8	62	122	170	19	381
	%	44.4	60.8	54.5	53.6	61.3	55.1
Will treatments work against the Omicron variant?	#	7	52	105	153	17	334
	%	38.9	51.0	46.9	48.3	54.8	48.3
What to do if you have the symptoms	#	4	18	66	79	10	177
	%	22.2	17.6	29.5	24.9	32.3	25.6
Symptoms of the COVID-19	#	3	30	70	93	11	207
	%	16.7	29.4	31.3	29.3	35.5	29.9
Most at-risk groups	#	2	17	73	120	11	223
	%	11.1	16.7	32.6	37.9	35.5	32.2
How to treat it	#	1	21	78	105	9	214
	%	5.6	20.6	34.8	33.1	29.0	30.9
How to protect yourself from the disease?	#	6	28	83	117	11	245
	%	33.3	27.5	37.1	36.9	35.5	35.4
How it is transmitted	#	4	27	78	118	11	238
	%	22.2	26.5	34.8	37.2	35.5	34.4
How easily does the Omicron variant spread?	#	4	43	107	158	17	329
	%	22.2	42.2	47.8	49.8	54.8	47.5
Other	#	2	5	10	22	-	39
	%	11.1	4.9	4.5	6.9	-	5.6
Total	#	18	102	224	317	31	692

Table 52 G1. What more would you like to know about the disease? (Multiple responses – Disability)

		Not PWD	PWD	Total
Will vaccines work against the Omicron variant?	#	357	24	381
	%	55.7	47.1	55.1
Will treatments work against the Omicron variant?	#	316	18	334
	%	49.3	35.3	48.3
What to do if you have the symptoms	#	164	13	177
	%	25.6	25.5	25.6
Symptoms of the COVID-19	#	191	16	207
	%	29.8	31.4	29.9
Most at-risk groups	#	213	10	223
	%	33.2	19.6	32.2
How to treat it	#	204	10	214
	%	31.8	19.6	30.9
How to protect yourself from the disease?	#	223	22	245
	%	34.8	43.1	35.4
How it is transmitted	#	219	19	238
	%	34.2	37.3	34.4
How easily does the Omicron variant spread?	#	313	16	329
	%	48.8	31.4	47.5
Other	#	38	1	39
	%	5.9	2.0	5.6
Total	#	641	51	692

The majority of respondents thought that awareness sessions, trainings, and information provision was reaching all groups in the community (76.9%). A statistically significant difference was only detected among locations (p<0.001). The vast majority of respondents in Ni'leen (90.9%) and Jerusalem (89.6%) thought that awareness sessions were reaching all groups, while only 57.8% of respondents in Dura thought the same.

Among respondents who thought the awareness sessions were *not* reaching all groups stated that mostly elderly (38.5%) and people with disabilities (28%) were not being reached.

Figure 25 Respondent perceptions of whether awareness sessions, trainings, and information provision on COVID-19 was reaching all groups in the community by location (%)
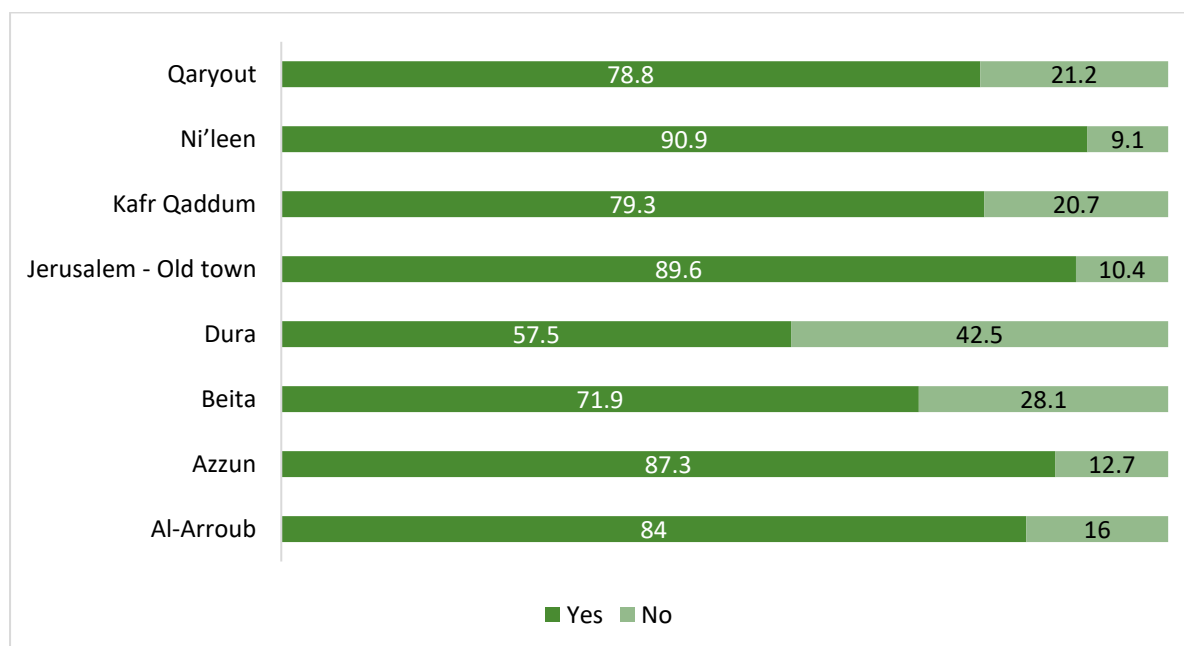
Figure 26 Respondents' perceptions of groups not reached by COVID-19 outreach (%)
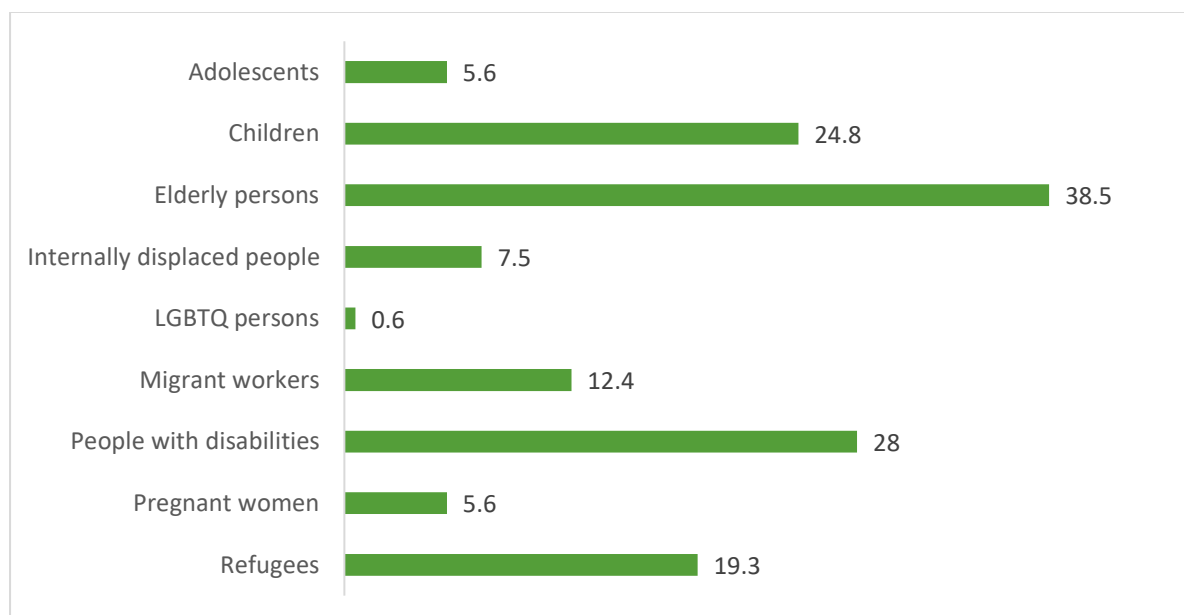
Almost three quarters of respondents reported that the information received from the Palestine Red Crescent Society (PRCS) took into consideration the needs of the different age groups (72.5%). The results significantly differed among location (p<0.001) and education (p=0.001).

Almost all of the respondents in Qaryout (93.9%) felt that information received from the Palestine Red Crescent Society (PRCS) took into consideration the needs of the different age groups, while half of the respondents in Jerusalem (54.2%) felt the same.

Figure 27 Distribution of respondents who believe information from the Palestine Red Crescent Society (PRCS) took into consideration the needs of the different age groups by location (%)
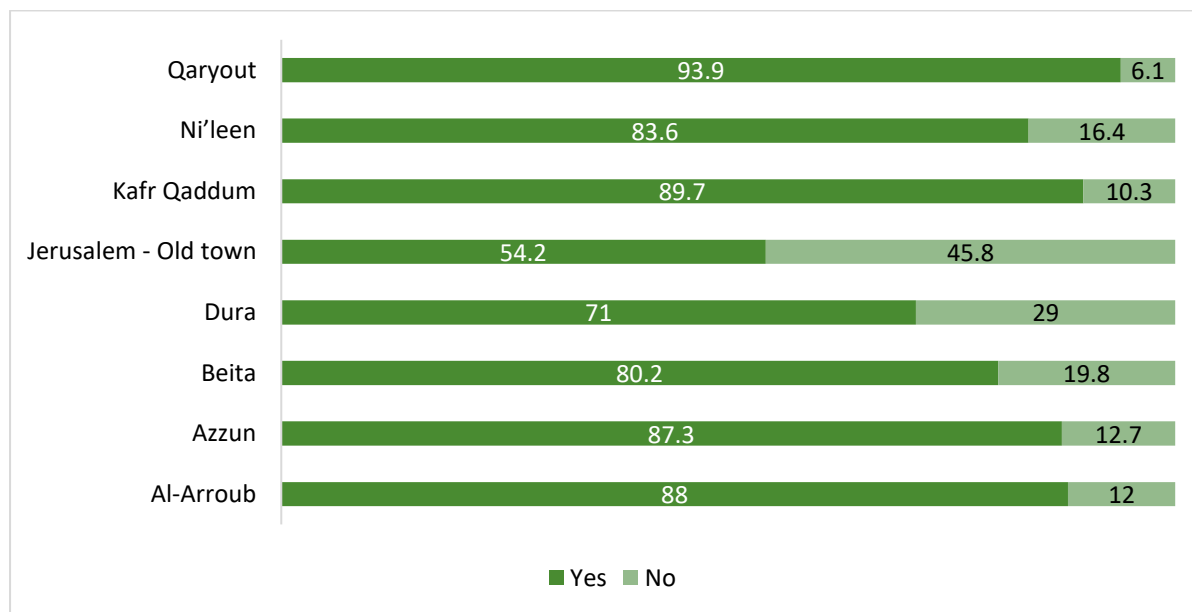
Figure 28 Distribution of respondents who believe information from the Palestine Red Crescent Society (PRCS) took into consideration the needs of the different age groups by education level (%)
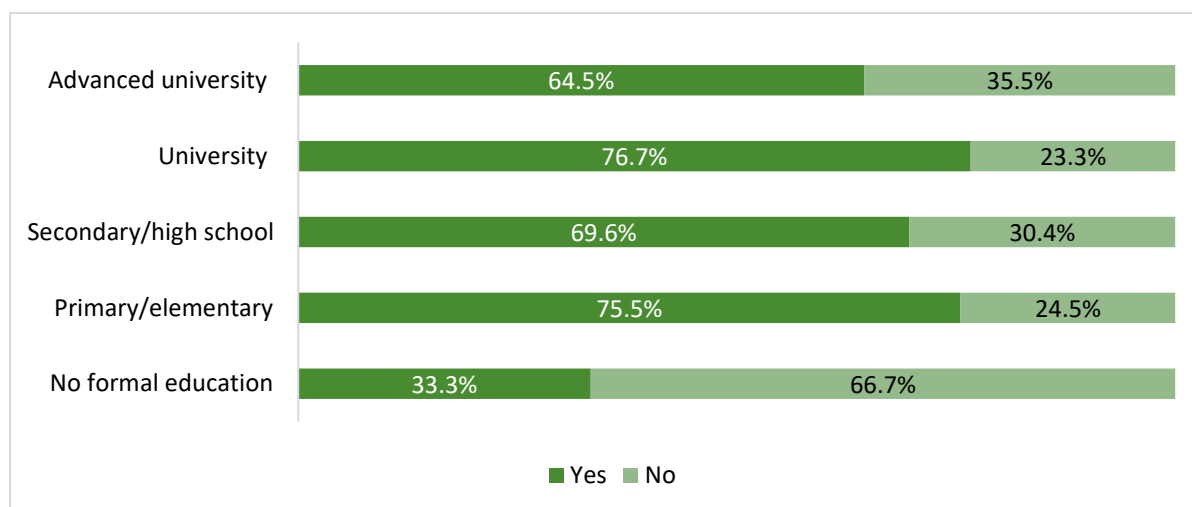
Nearly three quarters of the respondents felt that the information received was appropriate for different gender needs (74.1%). The results differed significantly by location (p<0.001) and education (p=0.002).

Almost all respondents in Kafr Qaddum (96.6%) considered that the information received took into consideration the needs of gender, while 59.7% of respondents in Jerusalem reported the same. The proportion of respondents that felt the information received took into consideration gender-based needs was the highest among respondents with a university degree (78.5%) and primary/elementary degree (76.5%) and the lowest among respondents with no formal education (38.9%).

Figure 29 Distribution of respondents who believe information from the Palestine Red Crescent Society (PRCS) took into consideration the needs of the different genders by location (%)
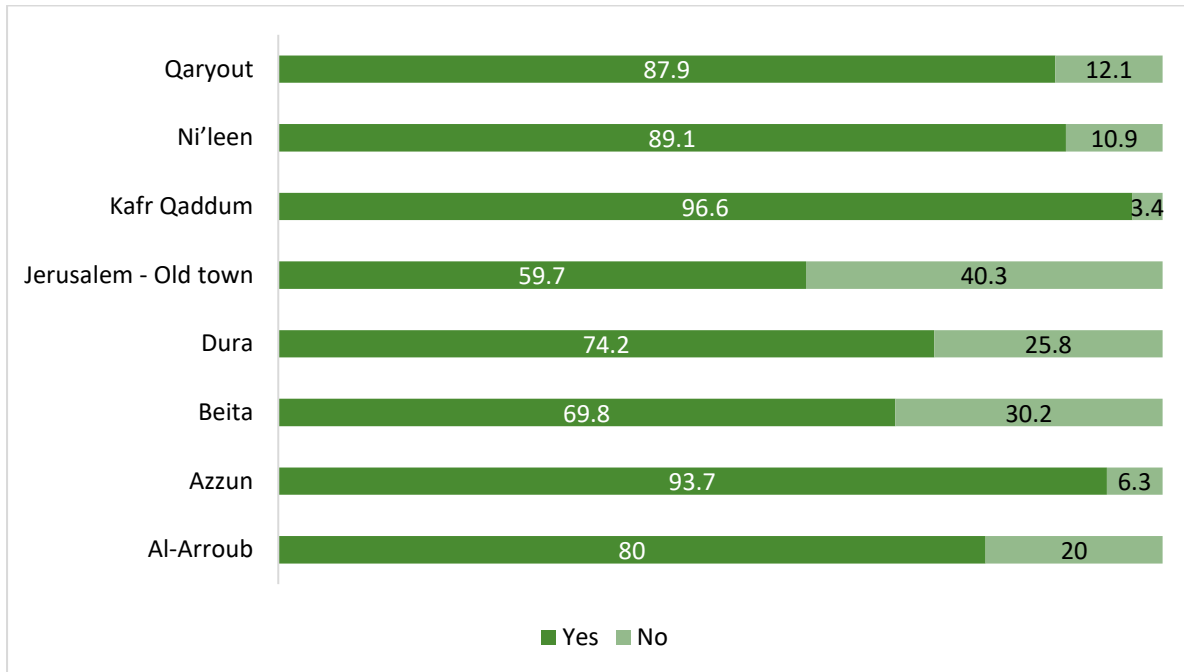
Figure 30 Distribution of respondents who believe information from the Palestine Red Crescent Society (PRCS) took into consideration the needs of the different genders by education level (%)
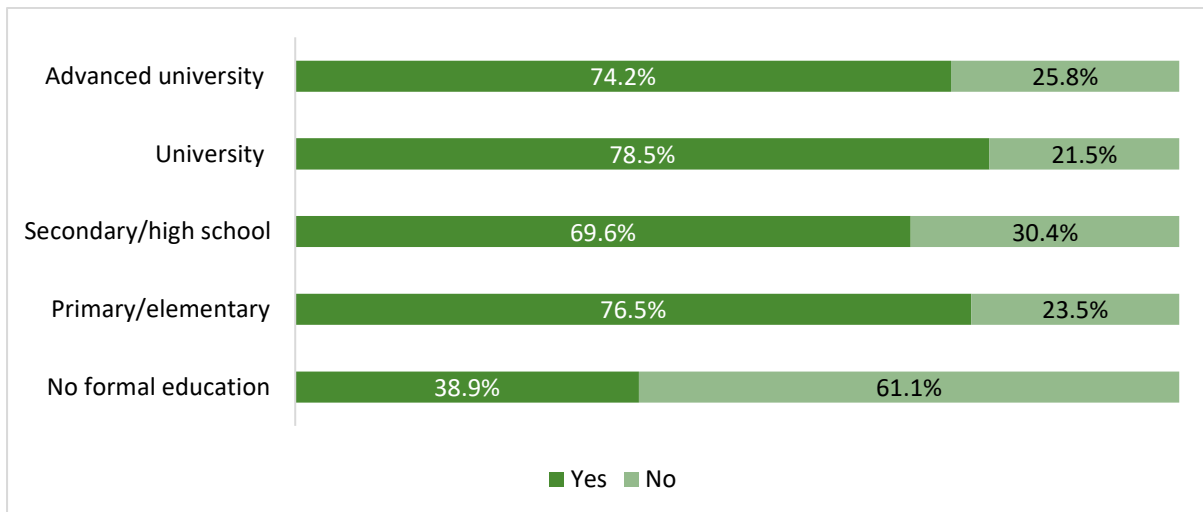
The majority (71%) of the respondents stated that the information that they received from the Palestine Red Crescent Society (PRCS) was applicable and realistic in their context. The results significantly varied among location (p<0.001) and education (p=0.001).

Almost all of the respondents in Kafr Qaddum (93.1%) stated that the information they received by PRCS was applicable and realistic, while only 47.3% of respondents in Jerusalem reported the same. Only 33.3% of respondents with no formal education stated information they received by PRCS was applicable and realistic, on the other hand, the majority of others stated so.

Figure 31 Distribution of respondents who believe information from the Palestine Red Crescent Society (PRCS) was applicable and realistic to their context by location (%)
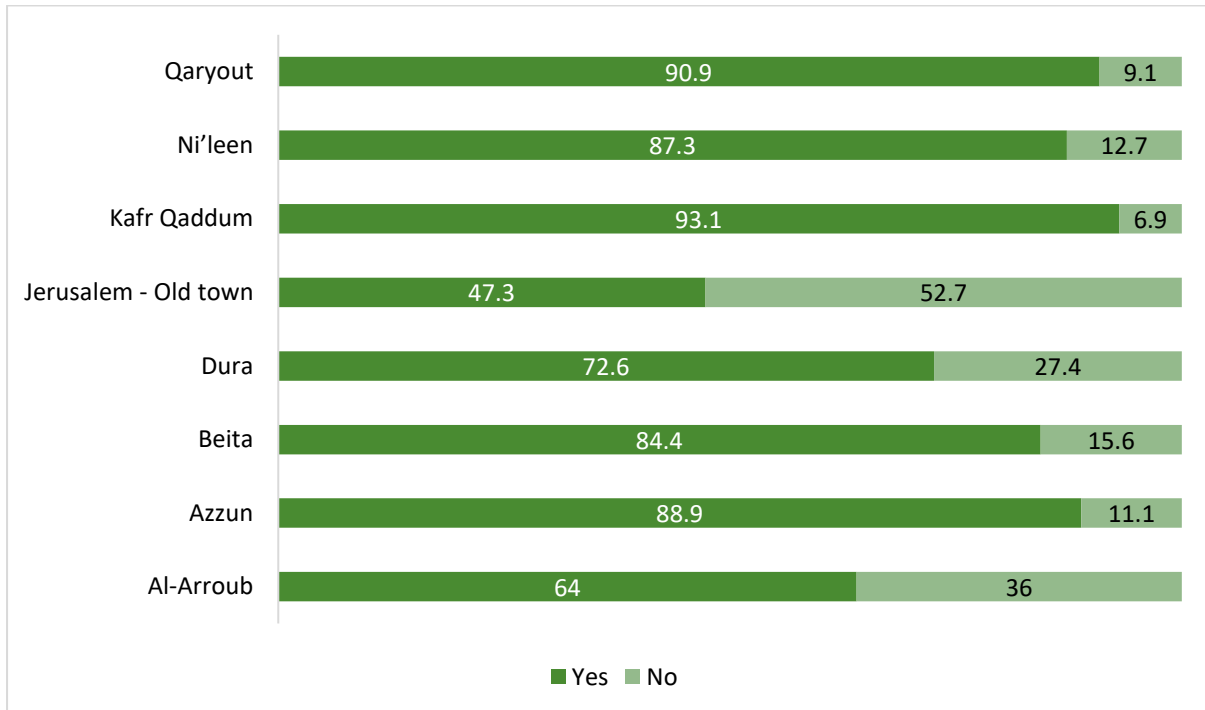
Figure 32 Distribution of respondents who believe information from the Palestine Red Crescent Society (PRCS) was applicable and realistic to their context by education level (%)
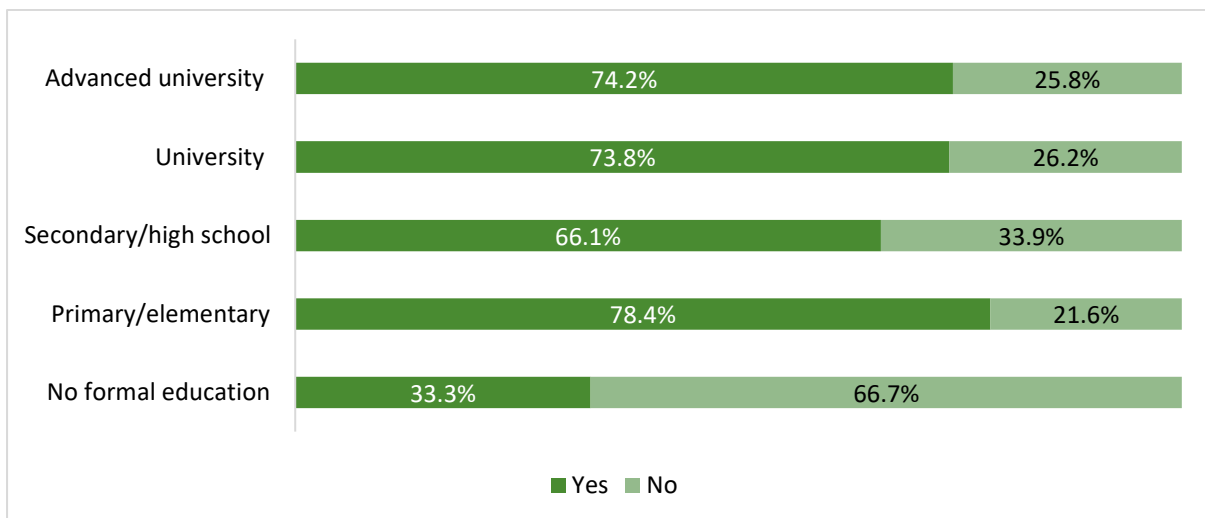
One-third of the respondents thought that the risk communication provided by the Palestine Red Crescent Society contributed to raising community awareness about COVID-19 to an average extent (34.5%). Also, 30.9% of respondents evaluated this contribution as high. A significant statistical difference was detected across age groups (p=0.03), location (p<0.001), disability (p=0.01) and education (p<0.001). However, the variation responses at the gender level do not vary significantly (p>0.05 for both). In the following paragraph, the significant findings are explained.

Table 53 Distribution of respondents' perception that risk communication provided by the Palestine Red Crescent Society (PRCS) contributed to raising community awareness about COVID-19

	High Contribution		Average Contribution		Low Contribution		No contribution		Total	
	#	%	#	%	#	%	#	%	#	%
Age Group										
18-25	15	31.9	20	42.6	7	14.9	5	10.6	47	100
26-40	86	32.8	97	37.0	35	13.4	44	16.8	262	100
41-65	110	30.9	115	32.3	70	19.7	61	17.1	356	100
65+	3	11.1	7	25.9	10	37.0	7	25.9	27	100
Location										
Al-Arroub	14	56.0	9	36.0	2	8.0	-	-	25	100
Azzun	37	58.7	16	25.4	8	12.7	2	3.2	63	100
Beita	47	49.0	38	39.6	6	6.3	5	5.2	96	100
Dura	72	38.7	73	39.2	29	15.6	12	6.5	186	100
Jerusalem (Old Town)	9	4.5	26	12.9	68	33.8	98	48.8	201	100
Kafr Qaddum	5	17.2	22	75.9	2	6.9	-	-	29	100
Ni'leen	13	23.6	35	63.6	7	12.7	-	-	55	100
Qaryout	16	48.5	17	51.5	-	-	-	-	33	100
Other	1	25.0	3	75.0	-	-	-	-	4	100
Disability										
Not PWD	206	32.1	223	34.8	106	16.5	106	16.5	641	100
PWD	8	15.7	16	31.4	16	31.4	11	21.6	51	100
Education										
No formal education	2	11.1	2	11.1	5	27.8	9	50.0	18	100
Primary/elementary	26	25.5	34	33.3	28	27.5	14	13.7	102	100
Secondary/high school	68	30.4	70	31.3	42	18.8	44	19.6	224	100
University	106	33.4	126	39.7	39	12.3	46	14.5	317	100
Advanced university	12	38.7	7	22.6	8	25.8	4	12.9	31	100
Total	214	30.9	239	34.5	122	17.6	117	16.9	692	100

The most commonly cited recommendations to prevent the spread of COVID-19 were to increase national awareness (70.1%), organise vaccination campaigns (50%), and supporting the creation of COVID-19 community groups (49.6%). There was a significant difference among gender (p=0.02), age groups (p=0.01), location (p<0.001), and education (p<0.001). Female respondents were more likely than male respondents to recommend vaccine campaigns (54%) and increasing national awareness (75.1%). Respondents in Kafr Qaddum (96.6%) were the most likely to recommend increasing national awareness, while those in Ni'leen were the most likely to recommend vaccination campaigns.

Table 54 Respondents' recommendations for ways to better control COVID-19 in their areas by gender

		Male	Female	Total
Vaccination Campaigns	#	177	169	346
	%	46.7	54.0	50.0
Support the creation of COVID-19 community Committee groups	#	186	157	343
	%	49.1	50.2	49.6
More advertisement to raise awareness	#	160	133	293
	%	42.2	42.5	42.3
Increase national awareness	#	250	235	485

	%	66.0	75.1	70.1
Other	#	27	13	40
	%	7.1	4.2	5.8
Total	#	379	313	692

Table 55 Respondents' recommendations for ways to better control COVID-19 in their areas by age groups

		18-25	26-40	41-65	65+	Total
Vaccination Campaigns	#	21	130	183	12	346
	%	44.7	49.6	51.4	44.4	50.0
Support the creation of COVID-19 community Committee groups	#	24	130	185	4	343
	%	51.1	49.6	52.0	14.8	49.6
More advertisement to raise awareness	#	15	117	155	6	293
	%	31.9	44.7	43.5	22.2	42.3
Increase national awareness	#	25	183	257	20	485
	%	53.2	69.8	72.2	74.1	70.1
Other	#	2	14	22	2	40
	%	4.3	5.3	6.2	7.4	5.8
Total	#	47	262	356	27	692

Table 56 Respondents' recommendations for ways to better control COVID-19 in their areas by location

		Al-Arroub	Azzun	Beita	Dura	Jerusalem (Old Town)	Kafr Qaddum	Ni'leen	Qaryout	Total
Vaccination Campaigns	#	15	27	41	88	107	19	38	10	346
	%	60.0	42.9	42.7	47.3	53.2	65.5	69.1	30.3	50.0
Support the creation of COVID-19 community Committee groups	#	18	25	37	139	81	13	24	4	343
	%	72.0	39.7	38.5	74.7	40.3	44.8	43.6	12.1	49.6
More advertisement to raise awareness	#	13	15	57	109	50	12	18	15	293
	%	52.0	23.8	59.4	58.6	24.9	41.4	32.7	45.5	42.3
Increase national awareness	#	21	53	65	114	142	28	39	19	485
	%	84.0	84.1	67.7	61.3	70.6	96.6	70.9	57.6	70.1
Other	#	-	-	5	27	6	-	-	2	40
	%	-	-	5.2	14.5	3.0	-	-	6.1	5.8
Total	#	25	63	96	186	201	29	55	33	692

Table 57 Respondents' recommendations for ways to better control COVID-19 in their areas by education level

		No formal education	Primary/ elementary	Secondary/ high school	University	Advanced university	Total
Vaccination Campaigns	#	10	45	103	173	15	346
	%	55.6	44.1	46.0	54.6	48.4	50.0
Support the creation of COVID-19 community Committee groups	#	2	35	105	182	19	343
	%	11.1	34.3	46.9	57.4	61.3	49.6

More advertisement to raise awareness	#	2	43	98	138	12	293
	%	11.1	42.2	43.8	43.5	38.7	42.3
Increase national awareness	#	9	67	169	216	24	485
	%	50.0	65.7	75.4	68.1	77.4	70.1
Other	#	1	3	15	19	2	40
	%	5.6	2.9	6.7	6.0	6.5	5.8
Total	#	18	102	224	317	31	692

Conclusions

This study identified a number of important findings:

Respondents reported diverse experiences with COVID-19

The majority of respondents surveyed had got at least one dose of the COVID-19 vaccine (68.8%). Only 15.5% of respondents reported that they outright refused to be vaccinated against COVID-19. The percentage of people who had received at least one dose of vaccination was highest in Al-Arroub (88%) and lowest in Qaryout (48.5%). W

While 93.6% of respondents with an advanced university degree had received at least one dose of COVID-19 vaccination, only 65.7% of respondents with primary or elementary education had done so. Nearly all of respondents who thought the COVID-19 vaccines were very safe (97%) had received at least one dose, whereas only 39% of respondents who thought the vaccines were not safe at all had received at least one dose.

The majority of respondents believed that the COVID-19 does not create a stigma against specific individuals (92.3%). Most respondents reported that they would inform persons they came in contact with if they had COVID-19 (72.2%) and rigorously observe the quarantine laws (51.6%). The main reasons respondents would not disclose their COVID-19 status were fears that they would lose their jobs (37.9%) and that quarantining would negatively affect family (49.7%).

The majority of respondents have concerns and perceive COVID-19 as dangerous

Roughly half of the respondents reported that they had concerns for their health during the COVID-19 pandemic (53.2%). Respondents in Al-Arroub (88%) were the most likely to express concern, while respondents in Qaryout (24.2%) and Jerusalem (32.4%) were the least likely to express concern. Respondents' level of concern increased as their education level increased - respondents with no formal education were the least concerned (33.4%), while respondents with a university diploma were the most concerned (60.9%).

Most respondents (60%) reported that they felt that COVID-19 was dangerous or extremely dangerous. As with health concern, respondents' likelihood of reporting that COVID-19 was dangerous increased as education level increased. COVID-19 was deemed as dangerous or extremely dangerous by 68.1% of respondents with a university degree compared 46% of respondents with a primary school education.

Respondents engaged in a range of risk prevention measures

Respondents reported a number of COVID-19 prevention measures, including regularly washing hands with soap, water, and alcohol (83.8%), waring face masks in public (77.9%), and covering their mouth and nose when coughing or sneezing (76.2%).

The majority of respondents reported that taking actions to prevent COVID-19 in their communities was important (83.8%). Again, as the level of education increased, so did the percentage of people who thought it was important to take action to prevent COVID-19 increased. Only 55.6% of respondents with no formal education compared to 88.6% of respondents with a university degree.

More than half of the respondents reported that they would go to the hospital/health unit (57.7%) and/or remain in quarantine (52.9%) if they or a member of their family showed symptoms of COVID-19. Most respondents in Kafr Qaddum (75.9%), Azzun (73%), and Al-Arroub (72%) stated they would go

to the hospital/health unit, while less than half of the respondents in Ni'leen (47.3%), Qaryout (48.5%) and Dura (49.5%) reported the same.

If they came in contact with someone who had COVID-19, respondents most commonly reported that they would be tested (62.3%) or stay at home and wait a few days to see whether to develop symptoms (39.6%).

Different respondents seek and trust information from different sources

Respondents were most likely to report receiving information about how to protect from the COVID-19?" (83.7%), symptoms of the COVID-19 (79.2%), and COVID-19 is transmitted (69.2%). The respondents between 18-25 were the least likely to have received information about vaccination (25.5%) and respondents aged 65 and above received at least information about risk and complications.

Those who receive information about what to do if they have the symptoms and about testing have changed dramatically across locations. Respondents in Jerusalem and Beita were almost twice as likely as respondents in Ni'leen and Azzun to receive information about what to do if they had the symptoms (79.6%, 75%, 29.1%, and 33.3%, respectively). People in Jerusalem were also eight times more likely to receive information regarding testing than respondents in Al-Arroub.

Respondents most commonly reported receiving information about COVID-19 from social media (66.5%), television (51.7%), and internet searches (49.6%). There are changes in information source preferences according to age groups. Social media and internet/web searches were the preferred means for accessing the information on COVID-19 among respondents aged 18-25 (76.6% and 63.8) and 26-40 (74% and 51.5%). While respondents aged 65 and above preferred television and radio more than other age groups (77.8% and 40.7%).

The most trusted channels to receive information related to COVID-19 were health unit/health care workers (45,2%), social media (29.8%), and television (29%). Those aged 65 and older had a higher level of trust in television (40.7%) and radio (29.6%), compared to other age groups.

The vast majority of respondents found the information regarding COVID-19 to be useful or very useful (53.5% and 38%). Those who found the COVID-19 information useful stated they would use it "to take preventative actions" (80.6%), "to keep track of my health and spot symptoms" (75.2%), and "to deal with a COVID-19 infection" (59.1%).

The majority of the respondents stated that the information they receive is applicable and realistic in their context (91.8%). Those who did not find this information applicable mostly stated that there was unwillingness at the community level to abide by these measures (66.7%) and felt that communicated measures cannot be applied where they lived" (36.8%).

Respondents have mixed perceptions about vaccines

Only 26% of respondents thought the COVID-19 vaccinations were "reasonably safe" (36.3%) or "very safe" (4.8%). One-third of the respondents thought the vaccines were unsafe (24%), or unsafe at all (12.6%). Beita (54.1%) and Azzun (50.8%) had the highest percentage of respondents who thought the COVID-19 vaccines were reasonably safe or safe, while Ni'leen (12.7%) and Qaryout had the lowest percentage (18.2%). Those who were concerned and very concerned about their health were twice as likely to believe the COVID-19 vaccines were safe as respondents who were not concerned at all (57.4%, 46.2%, and 24.2%, respectively).

More than half of the respondents believed that the COVID-19 vaccine provided no protection (20.8%) or only a little protection (32.7%). However, almost every respondent knew where and how to register to get themselves vaccinated (97.3%).

Among vaccinated respondents, the most commonly cited reasons for vaccination were to protect from contracting COVID-19 (57.8%), to prevent transmission (52.5%), and to travel freely (42.6%). Reasons for vaccination varied by location. In Jerusalem, to prevent against contracting COVID-19 was mentioned nearly twice as much as in Dura (81% and 4Half of respondents in Beita (52.9%) and Dura (51.4%) said they were vaccinated so they could travel freely, compared to 27.3% in Al-Arroub.

Among respondents who were not vaccinated, the most common reasons were a belief that vaccines were not effective" (46%), the vaccines weren't safe because they were developed too quickly (45.3%), and a concern about negative side effects (42.9%) Anti-vaccine information in the media (26.1%) was also a factor that influenced respondents' decisions not to take the COVID-19 vaccine.

Respondents view engagement with PRCS positively

Two-thirds of the participants (68.8%) said they had not been engaged by any implementing partners on how COVID-19 could be better prevented in their area, Respondents who have been engaged by an implementing partner mainly participated in awareness sessions around COVID-19 and vaccines (69.7%).

Only one-fifth of respondents who have not been engaged by any implementing partners stated they would like to be engaged (22%). Those who stated they would like to be engaged reported an interest in participating in awareness sessions around COVID-19 and vaccines (69.5%) and spreading awareness on COVID-19 prevention and vaccination importance within their communities using different communication channels (53.3%).

Most respondents felt that COVID-19 awareness seminars, training, information provision, and other activities, were reaching all groups in the community (76.9%).

Respondents had positive perceptions of services provided by the Palestine Red Crescent Society (PRCS). Almost three-quarters of the respondents thought the information provided by the Palestine Red Crescent Society (PRCS) considered the needs of various age groups (72.5%). Similarly, almost three fourth of the respondents thought the information they got was tailored different gender-based needs (74.1%). The majority of respondents (71%) said the information provided by the Palestine Red Crescent Society (PRCS) was relevant and practical in their context. One-third of respondents surveyed said that the Palestine Red Crescent Society's risk communication helped to raise community knowledge about COVID-19 on average (34.5%). In addition, 30.9% of respondents rated this contribution as high.

Respondents reported a need for additional information, most commonly requesting information on whether vaccines work against Omicron variant?" (55.1%), whether treatments work against the Omicron variant (48.3%), and whether the Omicron variant will cause more severe illness (47.5%).

Recommendations

The results of this study suggest that there is no "one size fits all" solution for communication of information about COVID-19 community members residing in conflict and protracted crisis-affected areas in Palestine. Among the target population, community members use a wide range of channels and rely on a wide range of trusted sources for information about COVID-19. Preferred channels and trusted sources varied by respondents' age, gender, education level, location, and disability status. These results suggests that to be effective, organisations like the PRCS and IFRC should consider deploying a range of communication channels (including television, internet sources, social media, and messaging apps) and sources (including trust doctors, and community health workers).

A trend observed in the study results was the influence of a personal or family history of COVID-19. Respondents who had contracted COVID-19 or knew a family member who had contracted COVID-19 were more likely to feel COVID-19 was dangerous. These respondents were also more likely to report believing that COVID-19 vaccines were safe and to have received at least COVID-19 vaccine dose. These results suggest that personal connections can play an important role in community members' perceptions of COVID-19 vaccine safety and influence their decision to get vaccinated. At the same time, very few respondents reported that individuals with COVID-19 faced stigma. Communication strategies should consider ways to incorporate personal connections to COVID-19 or employ popular figures to discuss COVID-19 experiences and share prevention strategies.

While the study found that many respondents are skeptical of COVID-19 vaccine safety and efficacy, the majority have been vaccinated are open to getting vaccinated. While many respondents report that they get vaccinated for employment reasons or to travel, others were swayed by messaging and beliefs focus on the social or moral responsibility to get vaccinated. These respondents felt that getting vaccinated and engaging in other prevention strategies was a duty in order to protect others, particularly those at heighten risk of serious complications. Furthermore, including information about the efficacy of vaccines in communications should be considered. Holding awareness meetings can also be considered a useful strategy in targeted communities.

Survey respondents reported that they would like more information related to COVID-19 and the Omicron variant. Respondents were interested to know more about how the Omicron variant was spread, and how effective vaccines and treatments were for the Omicron variant. Furthermore, this study identified the need for more information on COVID-19 prevention strategies, and vaccine safety and efficacy. These topics should be considered for inclusion in future information and communication strategies in targeted communities.

Additionally, study respondents reported a number of strategy recommendations to better controlling COVID-19 in their areas, including increasing national awareness (70.1%), developing vaccine campaigns (50%), and increasing support for the creation of COVID-19 community groups (49.6%). Some respondents noted that community members with limited incomes and single-income households should be targeted for support, since they would be most affected by a COVID-19 infection. These recommendations should be considered when planning future activities.

"All groups needed support, but from my point of view, the most group are people with limited income, because in the event of being contracted COVID-19 of head of the household, they have no income because the head of the family cannot go out." (Dura, Male, FGD).

Annexes

Annex A: Desk Review Summary

RCCE global approach to alleviate COVID-19 effect

To reduce the transmission of COVID-19 and care more for people from affecting by the virus, WHO supports the governments to implement the Risk Communication Community Engagement (RCCE) method for COVID-19 avoidance. RCCE will be as early-line community prevention before establishing the treatment and vaccine. Guidance in RCCE for COVID-19 was produced by various partners' contributions and published by WHO in March 2020. WHO extended consideration to the diversity of communities in terms of local facilities, for that WHO announced that RCCE guidance could be adjusted to produce the maximum purpose of RCCE (WHO, 2020); RCCE purposes are; to assist teams in carrying out tasks with communities immediately during the COVID-19 pandemic. RCCE is a process that is tailored to provide a preventive health community approach based on #ries' capabilities and includes all local partnerships, community members at risk to be hand-in-hand in building up strategies to #er COVID19 spread. Based on the WHO reports, the RCCE effective approach contributed to providing accurate in time information and promoting ward off all misinformation concerning the virus outbreak (WHO, 2020).

The RCCE approach includes identifying the places of entrance #, screening diseases and management healthcare resources, laboratory diagnosis, and clinical management of COVID-19 patients. Based on the studies' assessment of RCCE demonstrated that a powerful and fruitful approach requires an efficient map of all partners, regulating the community resources accurately, improving the precision system of health data, establishing an appropriate and trustful channel of communication, and being a sensitive approach in responding to all vulnerable people, and serve comprehensive training for public health sector attended by the community leaders, to pursue all entry point # (Adebisi et al., 2021). Questionably, the part of coordination by combining all healthcare accommodation and health bodies is one of the practical steps in RCCE (OXFAM, 2020). Integrating the RCCE in the healthy body's system is a vital landmark that reinforces the level of #ering COVID-19 spreads. Implementing this approach at the earliest of any pandemic will enhance the health system's resilience against the outbreak (Elder et al., 2016). Also, appropriate health information is an efficient policy to mitigate the COVID-19 health consequences. Understanding the Knowledge-Attitude-Perception (KAP) against the virus among the community around COVID-19 will reinforce the preparation for the health system and future intervention (Jeanna Parsons Leigh et al., 2020).

The importance of RCCE from the evidence of assessment studies

Various surveys were conducted to figure out people's opinions and judgments concerning COVID-19. These studies aim to know how people portrayed COVID-19, how people identified COVID-19 in terms of the status of danger, and their opinions around channels for information also tried to know people's self-capacity to care for themselves and to what degree this disease is looked at as a stigma (Adebisi et al., 2021). The local system needs to learn the reasons behind the negative attitudes against COVID-19 and the gaps in information and services during this pandemic. This type of survey helped in improving health plans, channels of communication for the inaccessible localities and increasing the standard of service response and developing confidence between state and health bodies and communities (Liliana Cori et al., 2020). The primary variables to consider in RCCE surveys; are anxiety, the image around the source of information, the standard of confidence in these sources, people's attitude around the health

avoidance measure, the perception around COVID-19 history, what kind of adaption of personal health measures, and reasons behind these notions (WHO, 2021b).

The crucial factor that plays a role in raising or reducing the risk perception is mobilizing the voluntarism approach by opening the door to people to be part of RCCE, this will provide a sense of ownership of the community members. Participation of people in confronting the pandemic hand in hand with the government will prosecute commitment and adherence toward implementing health measurements (Liliana Cori et al., 2020). A study demonstrated the influence of social listening approach that tracking social health behaviors and gather much information respecting complaints and community information, the survey marked out Eastern and Southern Africa that social media platforms could be tools for immediate information among communities, these platforms reduce people's worries and suffering and promote people healthy behaviors, farther it will be useful in undermining the stigma around the virus (Sommariva et al., 2021).

Palestine situation under COVID- 19

Palestine is a #ry under occupation with low capabilities. COVID-19 affected all facilities in Palestine, including the escalating rate of poverty among Palestinian. Due to the occupation and scarcity of resources and population, WHO consider Palestine is a #ry at risk (Abed et al., 2021). According to the MOH 2021 annual report, the total COVID # in West Bank during 2020 was 107,791, the high incidence reported in Jerusalem Governorate followed by Jericho and Al-Ghwar Governorate, according to age, the most affected age group was the age between 20-29, followed by 30-39, lowest number is age 80 years and above. Bethlehem recorded a high mortality rate among the corona population, while the loss rate was recorded in Tubas. The death rate due to COVID-19 is 1.1% of total death #. (Palestine Ministry of Health, 2021).

Ten treatment centers provide services for COVID-19 #, the Ministry of Health (MOH) has opened 6 laboratories to examine COVID-19 in the governorates of Ramallah, Al-Bireh, Bethlehem, Hebron, Nablus, Jenin, and Jericho (Palestine Ministry of Health, 2021).

Palestine faced an economically vigorous situation during COVID-19, according to the OCHA report $42.4 million was required to meet Palestine's demands to enter the COVID pandemic. A study conducted to explore the health workers' preparations to confront COVID-19, the study revealed that health workers are at risk in terms of inadequate information and avoidance methods (Alser et al., 2021).

The Palestinian Central Bureau of Statistics in the final report about the impact of the COVID-19 demonstrated that the main income earner out of six income earners (17%) has stopped working during the lockdown period, 80% of the main income earners experienced a decrease in the workload (fewer working hours than the usual). In terms of accessing to health services during the pandemic is at needed health services and were unable to access health services, the lowest percentages were in Tubas & Northern Valleys and Deir Al-Balah, where their percentages were 1% or below for each (Palestinian Central Bureau of Statistic, 2021). Different studies conducted in Palestine; KAP studies conducted to examine the Bedouin community awareness material for COVID-19 demonstrate that Bedouin has modest information referring to COVID-19 and the Bedouin communities did not look at that communicating or reporting about COVID-19 to the MOH emergency line is a prominent issue. (Doctors of the World, 2020). In another study, women search for health information via social media platforms, but their access to the MOH information web was less than other social media (CARE Palestine West Bank/Gaza, 2020).

MAP study also revealed that health workers faced both stigma and lack of professional skills to deal with COVID-19, people perception that health workers are the source of COVID -19 infection, Palestinian were under stress and could not access the heaths services fair enough, their fear and anxiety increased especially if they have family member has disease (MAP, 2021).

The main approach to the COVID-19 pandemic in Palestine – Gaps and Challenges in Palestine Health System

Palestine is one of the main fragile #ries that faced high challenges in encountering COVID-19 and WHO is rank Palatine as a #ry of high risk due to unique circumstances as a #ry under occupation. The Palestinian Prime Minister's Office has formed a National Coordination Committee to secure that the health system is ready when a vaccine is created (OCHA, 2020). The PA announced the emergency state of emergency on 5 March 2020, which included closing all non-essential facilities, PA started coordination with all international partners to support Palestine with main medical equipment and to involve them in training to encounter the virus outbreak. Screening tests have been done for all travelers coming from outside, asking for the # without symptoms to have quarantine for 14 days and providing a quarantine center in each governorate for # with symptoms. Daily national communication speech to update people about Palestine's situation during COVID-19. (Palestine's COVID-19 response plan, Retrieved May 25, 2020). For risk communication and community engagement, the Palestinian Ministry of Health set up a task force comprising WHO, UNICEF, the Bank of Palestine, and the Palestinian International Cooperation Agency, with representation from other United Nations agencies and non-governmental organizations that developed national health information system to raise people awareness regarding the COVID-19, still needed to strengthen the coordination between health bodies, need to enhance monitoring and reporting about the equality of accessing services (WHO, 2021a). The health situation in Palestine has become more challenged under the dusty humanitarian conditions during the COVID-19 (OCHA, 2021).

Palestinian health services were fragmented and lack of preparedness to confront the pandemic, in addition, the geopolitical obstacles that Palestine faced contributed to increase the challenges in health service level, the weakness of the health system at a financial level, the negative impact of equipment on the quality of service in Palestine (Moss & Majadle, 2020). Israeli occupation exacerbates these barriers by controlling all borders and restricting the Palestinian movement and this factor is considered a risk factor during COVID-19, Palestinian social habits such as their participation in wedding parties are another risk factor (Abed et al., 2021). The lack of coordination among health bodies did not effectively work and the need to focus on building effective started with all partners, also the information system must think about new ways to support the health public measures against COVID-19 (AlKhaldi et al., 2020). 73% of Palestinians reported that coronavirus increased their expenses in terms of health measures and use of hygiene stuff, MOH needs to include all stakeholders to develop an effective method for batting virus, still a gap between community and government in reporting # and complaints (Abuzerr et al., 2021).

Annex B: Survey Questionnaire

Introduction

Hello. My name is _____. I am working with UDA CONSULTING, an independent research consultancy firm hired by PRCS and IFRC to conduct a survey aiming to understand and analyze the perceptions of community members residing in conflict and protracted crisis-affected areas regarding the perceptions of community around the relevance of the health information provision related to COVID-19, and their access to such information so that PRCS and IFRC will make the necessary adjustments to their RCCE approaches.

Your identity will remain anonymous, and your answers will be used for research purposes only. The survey would take around 15 minutes, and the participation in this survey is on a voluntary basis; if you feel uncomfortable, you can skip any questions you don't want to answer and end the survey. All the information you provide will be confidential, anonymous and no information will be shared with anyone other than our research team.

We hope you will agree to answer the questions, as your views are important.

A. Demographics
  A1. Gender of the respondent
     - Male
     - Female

  A2. What is your age? _____

  A3. Where do you live?
     - Qaryout
     - Beita
     - Azzun
     - Kafr Qaddum
     - Ni'leen
     - Jerusalem (Old Town)
     - Dura
     - al-Arroub

  A4. In which part of the province do you live?
     - Rural area (village)
     - Urban settings
     - City
     - Camp

  A5. What is your highest completed level of education/school?
     - No formal education
     - Primary/elementary
     - Secondary/high school
     - University (BA, BS, etc.)
     - Advanced university (MA, Ph.D., MD, etc.)
     - Other, please specify

A6. How many members does your household have? (Including you)

_____

A7. What is your marital status?
- Never married
- Married
- Cohabiting
- Separated/divorced
- Widowed

A8. What is your employment status?
- Employee
- Business owner
- Unemployed
- Retired
- Other, please specify:

A9. What is your monthly income level?

_____

The interviewer read: "The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM."

A10. Do you have difficulty seeing, even wearing glasses?
- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Did not answer
- Do not know

A11. Do you have difficulty hearing, even if you use hearing aid(s)?
- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Did not answer
- Do not know

A12. Do you have difficulty walking or climbing steps?
- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Did not answer
- Do not know

A13. Do you have difficulty remembering or concentrating?
- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

- Did not answer
- Do not know

A14. Do you have difficulty with self-care, such as washing all over or dressing?
- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Did not answer
- Do not know

A15. Using your usual (customary) language, do you have difficulty communicating, for example, understanding or being understood?
- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Did not answer
- Do not know

B. Perceptions of COVID-19
B1. How concerned were you about your health during the COVID-19 pandemic?
- Not concerned at all
- Not really concerned
- Neither concerned nor unconcerned
- Concerned
- Very concerned

B2. Have you or someone in your family been contracted COVID 19?
- Yes (self)
- Yes (family member)
- No

B3. How dangerous do you think the COVID-19 risk is?
- Very dangerous
- Dangerous
- Neither dangerous nor not dangerous
- Not dangerous
- Not dangerous at all

B4. What kind of information have you received about the COVID-19? (You can select all that apply)
- How to protect yourself from the COVID-19? (Hygiene, use of masks, social distancing, etc.)
- Symptoms of the COVID-19
- How it is transmitted
- What to do if you have the symptoms
- Testing
- Process of reporting COVID-19
- Isolation measures

- Vaccine related information
- Risks and complications
- Received no information at all
- Other, please specify

B5. **How do you usually access information about COVID-19? What channels?** (You can select all that apply)
- Radio
- Tv
- Mobile apps (WhatsApp, Viber, Telegram, Signal...)
- Internet/web search
- Social Media (Facebook, Twitter, Instagram)
- Health unit/Health care worker
- Making a call to trusted medical services providers
- Booklet/flyers
- Face-to-face awareness sessions
- Family members & Friends & Neighbors
- Community health workers
- Community leaders
- Religious leaders
- Traditional healers
- Traditional midwives
- Other, please specify

B6. **Which channel/who do you trust the most to receive information related to COVID-19**? (You can select all that apply)
- Radio
- Tv
- Mobile apps (WhatsApp, Viber, Telegram, Signal...)
- Internet/web search
- Social Media (Facebook, Twitter, Instagram)
- Health unit/Health care worker
- Making a call to trusted medical services providers
- Booklet/flyers
- Face-to-face awareness sessions
- Family members & Friends & Neighbors
- Community health workers
- Community leaders
- Religious leaders
- Traditional healers
- Traditional midwives
- Other, please specify

B7. **Which of the below do you refer to the most to get trustworthy/reliable information about COVID-19 including the new variant Omicron?** (You can select all that apply)
- Health professionals/physicians
- Ministry of Public Health
- Palestinian Red Crescent
- The International Federation of Red Cross and Red Crescent Societies (IFRC)
- The International Committee of the Red Cross (ICRC)

- WHO and UN agencies (like UNICEF, UNRWA)
- International or Local Non-Governmental Organizations
- Municipality
- Community health workers
- Community leaders and/or religious leaders
- Family members / Friends
- Influencers/ Celebrities
- Other, please specify

C. Relevance

C1. How useful is the information you received about COVID-19?
- Very useful
- Useful
- Not useful
- Not useful at all
- Do not know

C2. If you found the information about COVID-19 to be useful, how did you use it? (You can select all that apply)
- To keep track of my health and recognize symptoms
- To take preventative measures
- To deal with a COVID-19 infection.
- To inform and spread these messages to those around me.
- Other, please specify

C3. Why don't you find this information useful? (You can select all that apply)
- Measures that have been communicated cannot be implemented where I live.
- Where I live, COVID-19 is not a top priority.
- The information does not address the most urgent needs in my area.
- There is a community-wide unwillingness to follow these rules.
- It had no effect on my ability to avoid contracting COVID-19.
- It did not assist in reducing the number of cases in my area.
- Other, please specify

C4. Is the information that you receive applicable and realistic in your context?
- Yes
- No

C5. If not, why not? (You can select all that apply)
- Communicated measures cannot be applied where I live
- COVID-19 is not the main priority where I live
- The information does not address the main needs where I live
- There is an unwillingness at the community level to abide by these measures
- Other, please specify

D. Community Engagement

D1. Do you know how to prevent COVID-19? (You can select all that apply)
- Wash your hands regularly using alcohol or soap and water
- Cover your mouth and nose when coughing or sneezing
- Imposing physical distancing

- Avoid unprotected direct contact with live animals and surfaces in contact with animals
- Wearing a face mask in public
- Strict lockdowns
- Schools closure
- Limiting public gatherings
- Vaccination
- Don't know
- Don't believe in taking any action
- Other, please specify

D2. What have you and your family done to prevent COVID-19 in recent days? (You can select all that apply)
- Washing hands regularly using an alcohol-based cleaner or soap/water
- Covering mouth and nose when coughing or sneezing
- Imposing physical distancing
- Avoid unprotected direct contact with live animals and surfaces in contact with animals
- Wearing a face mask in public
- Limit/ reduce going to public places
- Get vaccinated
- Don't know
- Don't believe in taking any action
- Other, please specify

D3. Which ones are available to you to learn about COVID-19? (You can select all that apply)
- Usually, I could find anyone for my questions about COVID-19.
- We receive phone calls to ask about my family's health.
- Volunteers' groups build in my community to support us during look down in COVID-19.
- Steering committee established from community to coordinate with government and health organizations to help people during COVID-19.
- Health organizations provide health information leaflets.
- The information that I received from government and health organizations improve my practicing a high level of preventing my infection against COVID-19.
- None of them

D4. Do you think the COVID-19 is generating stigma against specific people?
- Yes
- No
- I am not sure/ I do not know

D5. (If yes) **Which group is being discriminated in your community because of coronavirus?**
_____

D6. Have you been engaged (for example consulted, given the chance to share your opinion heard, participated) by any implementing partners on how COVID-19 could be better prevented in your area?
- Yes
- No

- I do not know

D6.1 If yes, how? (You can select all that apply)

- Participating in awareness sessions around COVID-19 and vaccine
- Spreading awareness on COVID-19 prevention and vaccination importance within my community using different communication channels (for example WhatsApp, social media, phone calls, visits...)
- Providing information on where to get tested and vaccinated
- Rumor management
- Home-based care for my family members
- Using the available feedback channels of RCCE service providers (for example hotline) to provide any request for information, rumors, complaints, suggestions around COVID-19
- Other, please specify

D6.2 If no, would you like to be engaged?

- Yes
- No
- I don't know

D6.2.1 If yes, how? (You can select all that apply)

- Participating in awareness sessions around COVID-19 and vaccine
- Spreading awareness on COVID-19 prevention and vaccination importance within my community using different communication channels (for example WhatsApp, social media, phone calls, visits...)
- Providing information on where to get tested and vaccinated
- Rumor management
- Home-based care for my family members
- Using the available feedback channels of RCCE service providers (for example hotline) to provide any request for information, rumors, complaints, suggestions around COVID-19
- Other, please specify

E. Perceptions of COVID-19 Vaccines

E1. How safe do you believe the COVID-19 vaccines are?

- Not Safe at all
- Not Safe
- Neither Safe nor Unsafe
- Reasonable Safe
- Very Safe

E2. How much do you think getting a COVID-19 vaccine for yourself will protect you and other people in your community from COVID-19?

- Not at all
- A little
- Moderately
- A lot
- Fully protect

E3. Do you know where and how to register to get yourself vaccinated?

- Yes
- No

E4. **How easy is it to get vaccination services for yourself?**
- Not at all easy
- A little easy
- Moderately easy
- Very easy

E5. **Have you been vaccinated against COVID-19?**
- Yes, I did all the doses
- Yes, but I have not completed all the doses
- No, but I will
- No, I won't
- No, I'm not sure

E6. **(If yes) What were your reasons for getting vaccinated?** (You can select all that apply)
- To prevent transmission
- To protect from contracting COVID-19
- End COVID-19 pandemic
- Return to normal
- Benefits outweighs risks
- To travel freely
- Being in a high-risk group
- Other, please specify

E7. **(If yes) What were the factors that influence your decision to take the COVID-19 vaccine?**
(You can select all that apply)
- Effectiveness
- Suggestions from doctors or health authorities
- Suggestion from friends or family members
- Number of COVID-19 cases
- Number of deaths caused by COVID-19
- Adverse effects of COVID-19
- My health status
- Duration of protection
- Type of vaccine
- Pro-vaccine information in the media
- Other, please specify

E8. **(If no) What were your reasons for not getting the vaccine?** (You can select all that apply)
- They have negative side effects.
- The vaccines aren't safe because they were developed quickly.
- Mistrust of vaccine companies
- Risks outweighs benefits
- Vaccine is not effective
- You can get COVID-19 from the vaccines.
- Allergic to vaccine
- Against religious beliefs
- The COVID-19 vaccines will alter your DNA.
- It makes people infertile.
- I don't need to get vaccinated because I'm young and healthy.

- I've already had COVID-19, so I don't need to get vaccinated.
- Pregnant/lactating
- Trouble accessing vaccine
- People with underlying conditions (such as heart disease or diabetes) or suppressed immune systems (such as from cancer treatments or autoimmune diseases) shouldn't get vaccinated.
- Other, please specify

E9. **(If no) What were the factors that influence your decision not to take the COVID-19 vaccine?** (You can select all that apply)
- Ineffectiveness
- Suggestions from doctors or health authorities
- Number of COVID-19 cases
- Number of deaths caused by COVID-19
- Adverse effects
- My health status
- Duration of protection
- Type of vaccine
- Suggestion from friends or family members
- Anti-vaccine information in the media
- Other, please specify

F. Risk Communication
F1. **Do you consider it important to take actions to prevent the spread of COVID-19 in your community?**
- Yes
- No
- I do not know

F2. **What to do if you or someone from your family has symptoms of this disease?** (You can select all that apply)
- I will look for a more experienced relative to advise me on what to do
- I will go to the hospital/health unit
- I will go to the neighborhood nurse
- I will buy medicines at the market
- I will look for the traditional healer
- I would stay in quarantine
- Other, please specify

F3. **Which would be acceptable to you in case of being in contact with someone who has COVID-19?** (You can select all that apply)
- I asked to report about that
- I get tested
- I stay at home and wait a few days to see if I develop symptoms
- Stay at home for 10 days
- Continue as usual
- Do not know
- Other, please specify

F4. **Which would be acceptable to you in case of being contracted COVID-19? (**You can select all that apply)

- I share with health authorities the names of people you had been in contact with.
- I inform the people I come in contact with
- To avoid stigma, I do not inform the people I come in contact with
- I'll take medicines prescribed by health professionals
- I try healing advice of my friends'/family members'
- I strictly follow the quarantine rules
- Other, please specify

F5. Is it possible that you will not share a positive test result or symptom in any case?
- Yes
- No

F6. If yes, in which cases would you not share? (You can select all that apply)
- I do not share with people/my family that I have COVID-19 if I believe that the quarantine will harm them.
- I do not share that I have COVID-19 if I will lose my job.
- I do not share with people/my family that I have COVID 19 symptoms if I believe that the quarantine will harm them.
- I do not report about my test positive because of not being stigmatized.
- Other, please specify

F7. If you have symptoms of COVID-19, would you get tested?
- I do a test immediately.
- I do a test if the symptoms continue for 4-5 days.
- I do not do a test, because the test costs money.
- I do not do a test COVID-19, it needs time and I live far from health centers.
- Other, please specify

G. Strategies
G1. What more would you like to know about the disease? (You can select all that apply)
- How to protect yourself from the disease?
- Symptoms of the COVID-19
- How it is transmitted
- What to do if you have the symptoms
- Most at-risk groups
- How to treat it
- How easily does the Omicron variant spread? Will the Omicron variant cause more severe illness?
- Will vaccines work against the Omicron variant?
- Will treatments work against Omicron variant?
- Other, please specify

G2. Do you think the awareness sessions, training, information provision, etc. on COVID-19 is reaching all groups in the community (especially the most vulnerable groups such as children, elderly, people with disability, etc.)?
- Yes
- No

G3. If not, who is not being reached? (You can select all that apply)
- Children

- Adolescents
- Elderly persons
- People with disabilities
- Pregnant women
- Internally displaced people
- Refugees
- Migrant workers
- LGBTQ persons
- Other, please specify

G4. Do you consider that the information received from the Palestine Red Crescent Society (PRCS) took into consideration the needs of the different age groups?
- Yes
- No

G5. Do you consider that the information received took into consideration the needs of gender (females versus males)?
- Yes
- No

G6. Is the information that you received from the Palestine Red Crescent Society (PRCS) applicable and realistic in your context?
- Yes
- No

G7. To what extent do you think that the risk communication provided by the Palestine Red Crescent Society (PRCS) contributed to raising community awareness about COVID-19?
- High Contribution
- Average Contribution
- Low Contribution
- No contribution

G8. What do you think can be done better to control COVID-19 in your area? (You can select all that apply)
- Increase national awareness
- Support the creation of COVID-19 community Committee groups
- Vaccination Campaigns
- More advertisement to raise awareness
- Other, please specify

Annex C: Focus Group Discussion Guide

Date:	Time:
Location:	
Moderator:	Reporter:

Participant Code	Age	Gender	Education Level	Employment status

Consent Statement:

Hello! My name is ……………. We have invited you here today because we would like to learn about your thoughts understanding their perceptions about COVID-19 and vaccine-related issues. During today's discussion, we would like to ask you questions about COVID-19 and vaccines. This discussion will take about 90 minutes.

During the discussion, we would like to take notes based on what you and others say. These notes will be used in our reporting, but your personal information will remain confidential. Whatever information you provide will be kept strictly confidential and no information will be shared with anyone other than our research team. You do not have to answer any questions you do not want to answer, and you are free to leave at any time. If you have any questions about the discussion today, you can ask us now or at any time during or after the discussion.

At this time, do you want to ask me anything about the survey?
Do you have any questions now?
Do you agree to participate in the discussion?

Rules for the FGD:

To have a productive discussion and allow everyone to share their ideas and experiences, there are a couple of rules that we need to discuss. These rules help to create a safe space for focus group participants by establishing shared expectations and a positive tone/structure for the discussion.
1. WE WANT YOU TO DO THE TALKING.
   · Let's hear from everyone!
   · One person at a time.
   · I may call on you if I haven't heard from you in a while
2. THERE ARE NO RIGHT OR WRONG ANSWERS.
   · Everyone's ideas and experiences are valuable
   · It's important to hear all sides – including both positives and negatives.
   · We will not always agree, but we must always show respect for one another
3. WHAT IS SHARED IN THIS ROOM STAYS IN THIS ROOM
   · We will be recording this session, so we don't miss anything
   · Please keep everything you hear today confidential
   · We will summarize themes without identifying individuals by name.

Perceptions about COVID 19 and vaccine
1. I like to invite you to share us your experience during COVID-19.
   - Access to COVID-19 health preventions information
   - Access to health services in general (chronic disease, cancer any normal health case)
   - Access to do the COVID-19 test

- Access to buy home stuff (food, child needs…)
2. What kind of stories do people build about COVID-19?
   - Origin of the virus
   - Prevention/self-care ways
   - Symptoms of the disease
   - Transmission of the disease
   - Treatment of the disease
   - Risks/complications
   - How these rumours affected people's perceptions of COVID-19
3. COVID-19 information and news channels/resources
   - What are the sources?
   - How reliable are the sources?
   - Sources of misinformation
4. Risks of COVID-19
   - Personal risk perception
   - Risk group perception
5. Perceptions of vaccine: What people view about the COVID19 vaccine
   - Whether they have been vaccinated
   - Reasons for getting/not getting vaccinated: The health centre is far away, Not affected by it, Religion believes, Political views
   - What influenced their decision
   - What kind of views:
     - not necessary
     - Worries about health side effects
     - What kind of rumours around the vaccine's effectiveness?

Community engagement
6. Please could me let know about community contributions during COVID-19.
   - How they provide support to the government
   - Any local committee established to coordinate with the government in preventing COVID-19
   - Provide financial donation or technical assistance or kind of assistance to support preventing COVID-19
7. What kind of process –programs, workshops that have been government or health organizations or NGOS ask your community to be part of it to prevent COVID?
   - Health local committee build in your community
   - Gather the community in one workshop to plan for prevention COVID-19
8. How do people report about COVID-19 cases or how they ask about any kind of support related to COVID-19 information?
   - Channel of access to information
   - How they report about cases (COVID-19)
   - How they report misinformation
   - How they report about emergency cases

Risk communication of community engagement
9. What kind of challenges that people faced during COVID-19?
   - Health service
   - Economic
   - Violence
   - Social support

- Government lack support
- Education
- Transportation
- Israeli soldiers attack

10. How do people cope with these challenges, what kind of coping strategies do people do to reduce these challenges?
    - Coordinate with government
    - Coordinate with health or NGOs organizations
    - Ask for support from relatives
    - Ask for community local support

11. What are the most marginalized people that required support during COVID-19?
    - Disability
    - Women
    - Elderly
    - People with chronic disease
    - Big families
    - Then ask more about main locations or community required assistance and why?

A good strategy in community engagement

12. I like it if you could share with us what kind of things must be done to reduce all these challenges you mentioned before
    - health challenges; means access to all types of services
    - Challenges to access to tests
    - Challenges to access to vaccine
    - Challenges in the economic sector
    - Transportation challenges
    - Marginalized communities s what kind of models their needs to help them

13. What do you think about community participation in preventing COVID-19? Please let us know how the community could work with the government in the future to prevent any COVID-19 new wave?
    - In terms of awareness
    - In terms of health services
    - In terms of communication

Annex D: Key Informant Interview Guide

Introduction

Hello. My name is _____. I am working with UDA CONSULTING, I am working with UDA CONSULTING, an independent research consultancy firm hired by PRCS and IFRC. We are conducting an interview aimed to understand the perspectives of stakeholders and providing insights into the achievements and lessons learned.

Your identity will remain anonymous, and your answers will be used for research purposes only. The survey would take around 40 minutes, and the participation in this survey is on a voluntary basis; if you feel uncomfortable, you can skip any questions you don't want to answer and end the survey. All the information you provide will be confidential, anonymous and no information will be shared with anyone other than our research team.

We hope you will agree to answer the questions, as your views are important.

Date:	Time:
Location:	
Interviewer:	Reporter:

Gender of the interviewee:
Interviewee age:
Interviewee occupation/position:
Level of education:

1. Please could share with us the strategies that your organization applied during COVID-19 since 2020?
   - Staff preparation
   - Lab test
   - Using community resources
   - Materials and information
   - Medication for people with chronic diseases
   - Emergency cases
   - Budget
2. What kind of training do you get during COVID-19 to improve your roles in the community –or in your work
   - Type of training –logistic –medical interventions
3. During COVID-19 –how does your organization coordinate with other partners at the national level or community level
   - Coordination
   - Sharing data
   - Exchange equipment's
   - Hire some people specialist
   - If there is a regular meeting happened between the partners
4. How your organization develop the information material about COVID-19?
   - Please ask about who participated in preparing those materials –community –universities etc.
5. What are the main communication methods in reporting about cases, access to the right information that applied to the prevention of COVID-19? And are those considered trusted channels
   - Probe about providing information to vulnerable people and communities

- How people report cases
- How people access if they have emergency cases
- How people complained about any medical mistake or misinformation
- How people report in case of mismanagement
- Establish a hotline
6. Who are the main trustful sources of information around COVID-19 in your community? (Probe: medical centers, MOH, National Doctors, international doctors, PRCS, IFRC, ICRC, WHO, UNICEF...) and why?

7. During COVID19, what type of methods your organization use to reach the marginalized communities and marginalize people
- Area C
- Jordan valley
- Disability
- People with chronic diseases
8. What do think must have been done during COVID-19 that could reduce cases and reach all vulnerable communities and people
   Probe about
- Communication
- Open the door for community participation

9. Are people usually engaged (Consulted, listed to, provide their opinions.) when designing and implementing RCCE strategies and activities? If yes how? İf not why not, and do you think they should be engaged?

Annex E: References

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