

# PROTECTING REFUGEES FROM COVID-19

Identifying Barriers to Safer Practices During Humanitarian Assistance in Turkey, Jordan, and Lebanon



**From the Minimizing COVID-19  
Spread in Refugee Humanitarian  
Interventions Project**

**MAY 2021**

**Publication Date: May 2021**

Authors: Stephanie J. Nawyn, Ezgi Karaoğlu, Stephen P. Gasteyer, Adnan Hammad, Mahmoud Durid, Ali Ghassani, Rania Mansour, and Ayat Nashwan.

Funding for this project was provided by Elrha and Michigan State University. More information can be found at [refugeescovid19.org](http://refugeescovid19.org).

The Minimizing COVID-19 Spread in Refugee Humanitarian Interventions is a collaboration of Michigan State University, Global Health Research, Management & Solutions, Amel Association, Altkaful Charity Association, Jordanian Pioneering Center, National Institution for Social Care and Vocational Training, and Safa for Development.





# TABLE OF CONTENTS

Executive Summary .....	1
Minimizing COVID-19 Spread in Refugee Humanitarian Interventions: An Introduction .....	2
Regional Context .....	3
Data Used in This Project .....	4
Refugee Population and the Services Provided .....	4
Patterns of Adherence and Non-Adherence to Protocols .....	6
How Good is Safety Adherence in Different Situations? .....	8
Which Refugee Populations Are Most Impacted? .....	11
What Are the Barriers to Limiting Infection Spread? .....	11
How Can Refugees Be Better Protected from COVID-19? .....	14
Recommendations .....	15
Appendix .....	16

# LIST OF TABLES

Table 1: Refugee Populations Served (Interviews) .....	4
Table 2: Refugee Populations Served (Observations) .....	5
Table 3: Social Distancing and Mask Wearing during <b>Medical</b> Services .....	8
Table 4: Social Distancing and Mask Wearing during <b>Non-Medical</b> Services .....	8
Table 5. Frequency of Washing Hands Before Services .....	11
Table 6: Availability of Resources .....	12

# LIST OF FIGURES

Figure 1: Adherence to Social Distancing Protocols .....	6
Figure 2: Adherence to Mask Wearing Protocols .....	7
Figure 3: Frequency of Adherence to Hand Hygiene Protocols .....	7
Figure 4: Adhering to Social Distancing Protocols for Refugees .....	9
Figure 5. Adhering "All of the Time" to Safety Protocols Before and After the Beirut Blast <b>(In Beirut)</b> .....	10
Figure 6: Adhering "All of the Time" to Safety Protocols Before and After the Beirut Blast <b>(In Turkey and Jordan)</b> .....	10
Figure 7: Comments Suggesting COVID-19 Skepticism .....	13



# EXECUTIVE SUMMARY

To improve the safety of refugees during the COVID-19 pandemic, humanitarian NGOs have instituted safety protocols to minimize the risk of infection spread during services to refugees. For those humanitarian NGOs, it is imperative to understand when protocols are not followed, what the possible barriers to adherence are, and how those barriers can be overcome. This study aimed to address these questions and provide guidance and recommendations for humanitarian stakeholders.

Through a collaboration between university researchers and humanitarian assistance providers, we collected data on refugees' and staff's adherence to safety protocols (social distancing, mask wearing, and hand hygiene measured as hand washing and using hand sanitizer) through interviews with NGO staff and non-participant observations during service provision. The NGOs operated in three countries (Lebanon, Jordan, and Turkey) and provided a variety of services to different refugee populations.

## **This research identified several key findings:**

- All NGOs instituted safety protocols designed to reduce the risk of infection of the SARS-CoV-2 virus, but adherence to those protocols varied by type of service, refugee population served, and type of safety protocol.
- Adherence to protocols was better in contexts that staff and refugees likely felt were riskier, and worse in context that staff and refugees felt safer.
- Resource availability was a barrier to protocol adherence in some situations, but having resources available did not always equate to those resources being used.
- The explosion in Beirut, while destroying significant infrastructure and causing additional strain on assistance not to mention loss of life, had only a marginal effect on COVID-19 safety protocol adherence.
- Skepticism about the existence or seriousness of COVID-19 is apparent among refugee beneficiaries and even a small number of staff; this might be a barrier not just to better protocol adherence but may inhibit refugees' willingness to be vaccinated.

Please use the following format for citing this report: Nawyn, Stephanie J., Ezgi Karaoğlu, Stephen P. Gasteyer, Adnan Hammad, Mahmoud Durid, Ali Ghassani, Rania Mansour, and Ayat Nashwan (May 2021). "Protecting Refugees from COVID-19: Identifying Barriers to Safer Practices during Humanitarian Assistance in Turkey, Jordan, and Lebanon." *Minimizing COVID-19 Spread in Refugee Humanitarian Settings Comprehensive Report*.

# MINIMIZING COVID-19 SPREAD IN REFUGEE HUMANITARIAN INTERVENTIONS: AN INTRODUCTION

Humanitarian NGOs face significant challenges to limiting infection spread while assisting refugees. This project investigates how well humanitarian NGO staff and the refugees that they serve are able to follow safety protocols intended to reduce infection risk, and what barriers exist to better protocols adherence. The goal of the project is to describe protocol adherence in the day-to-day work of refugee assistance in the Middle East and North Africa (MENA) region, and provide useful recommendations for improving adherence that can be implemented in this and other regions.

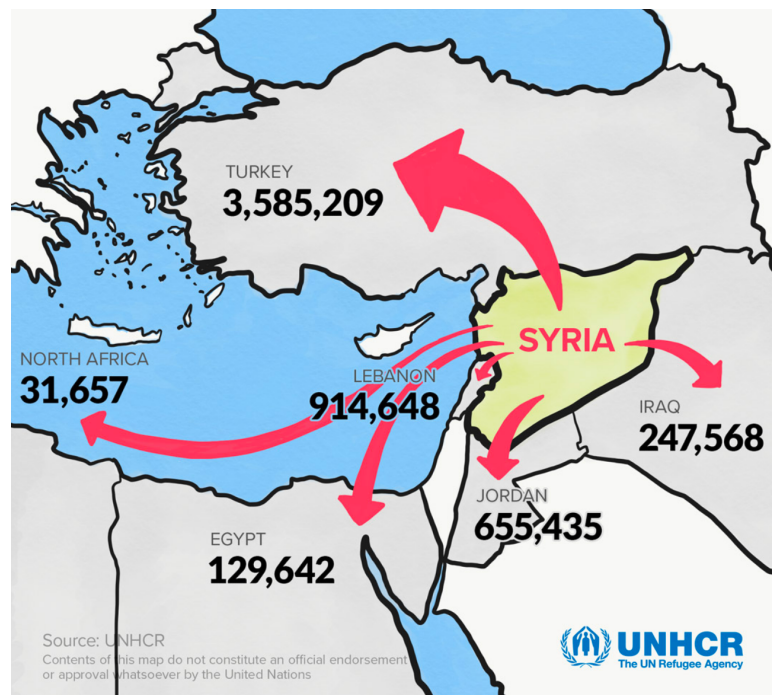
## **This report addresses the following questions:**

- How are humanitarian NGOs attempting to limit infection spread while assisting refugees?
- What are the barriers to limiting infection spread?
- In what kinds of services are those barriers most intractable?
- Which refugee populations are most impacted?
- What interventions could be implemented that would mitigate those barriers and slow the spread of COVID-19 among refugee populations?

This project is a collaboration between Michigan State University, Global Health Research, Management & Solutions, Altkafal Charity Association, Amel Association, National Institution of Social Care and Vocational Training (NISCVT), and Safa for Development. This report represents more than 10 months of stakeholder-engaged research and was carried out by a team of scholars and practitioners (including some individuals who embody both roles). The research focuses on countries that currently host some of the largest refugee populations in the world. These countries have faced numerous challenges during the COVID-19 pandemic, some of which are described in this report. The research is ongoing; additional research products will be made available on the project website: <https://refugeescovid19.org>.

# REGIONAL CONTEXT

Lebanon, Turkey, and Jordan are among the top refugee hosting countries in the world,<sup>1</sup> together providing protection to approximately 7.9 million refugees. These three countries host large populations of Syrian and Palestinian refugees, as well as smaller populations of refugees from Iraq, Afghanistan, Iran, and very small populations from other countries. In Turkey, most refugees are Syrian and live in urban settings, outside of camps. In Lebanon and Jordan, Palestinians make up large proportions of refugee populations, along with Syrians, and many live in long-settled camps that function much like urban settings.



All three countries are facing economic stressors, particularly Lebanon which also experienced a large explosion that affected much of the capital city, Beirut, and a complete turnover in government shortly after the explosion. Despite these challenges, all three countries have provided humanitarian assistance to refugees.

The impact of COVID-19 across these three countries has varied. Turkey experienced the earliest wave of COVID-19, with identified infections starting in March 2020 and continuing to increase over time (with changes in data reporting making it difficult to identify trends). In Jordan, the daily numbers of new infections were stable and relatively low from March 2020 through most of the summer. Infections increased slowly starting in mid-August through early September, with new infections numbering around 50-75 daily. After the first week of September new infections increased sharply, and Jordan has since experienced two waves of infection. In Lebanon, daily infection rates increased earlier, starting in the first week of July and increasing sharply through the beginning of 2021. In all three countries, mitigation strategies were implemented which included stay-at-home orders, curfews, and other forms of limits on people's interactions with others in public.

<sup>1</sup> Amnesty International, "The Worlds' Refugees in Numbers" <https://www.amnesty.org/en/what-we-do/refugees-asylum-seekers-and-migrants/global-refugee-crisis-statistics-and-facts/>

# DATA USED IN THIS PROJECT

This study uses data collected from humanitarian assistance organizations serving refugees in Lebanon (Amel Association and NISCVT), Turkey (Safa for Development), and Jordan (Altkaful Charity Association). Data were collected through interviews with the NGO staff directly providing services (N=1,466) and non-participant observation of services (N=215, totally 358 hours). Data were collected on how well people practiced social distancing (keeping two meters distance between each other), wore face masks, and washed or sanitized hands and surfaces during services provided to refugees. It included services provided in 14 different locations where the NGO partners assist refugees (see Appendix for additional methodological details).

## REFUGEE POPULATION AND THE SERVICES PROVIDED

The NGO partners served a variety of refugee populations. Table 1 shows the populations served from the interview data (because multiple populations can be served in any given service, percentages do not add up to 100):

**Table 1. Refugee Populations Served (Interviews)**

	Number	Percent
Adult women	886	60%
Adult men	586	40%
Pregnant women	283	19%
Children	842	57%
Youth	527	36%
Elderly	354	24%
Physically disabled	163	11%
Syrians	828	56%
Palestinians	421	29%
Refugees other than Syrians and Palestinians	75	5%



Table 2 shows the populations served from the observation data (because multiple populations can be served in any given service, percentages do not add up to 100):

**Table 2. Refugee Populations Served (Observations)**

	Number	Percent
Adult women	161	90%
Adult men	102	68%
Pregnant women	46	37%
Children	106	71%
Youth	55	45%
Elderly	59	48%
Physically disabled	18	16%
Syrians	15	91%
Palestinians	86	55%
Refugees other than Syrians and Palestinians	17	15%

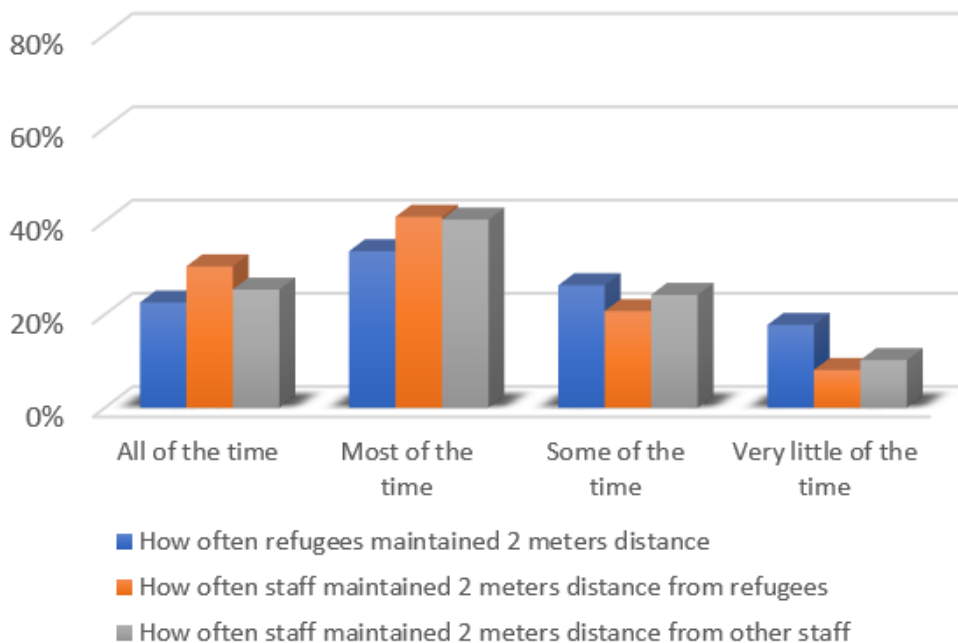
A wide variety of services were sampled for data collection, in order to capture a broad array of service conditions and potential gaps in protocol adherence. The most frequent services included in data collection from interviews were group training (29%), medical services (21%), direct aid (12%), and other (which included a wide variety of services; 22%). The most frequent services included in the observations were medical services (52%), group training (18.14%), other (which included a wide variety of services such as educational workshops, hair salon services, and fitness classes; 13%), and direct aid (9%).



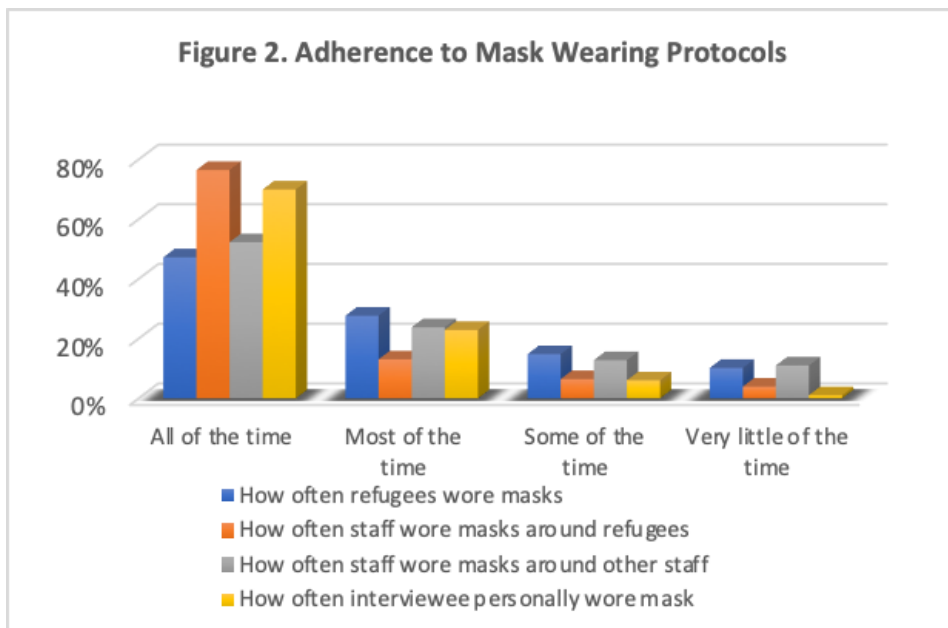
# PATTERNS OF ADHERENCE AND NON-ADHERENCE TO PROTOCOLS

At all service locations in the sample, the official policies were for everyone to wear face masks, maintain social distancing as much as possible, and to wash or sanitize hands frequently (particularly in between seeing refugee clients for NGO staff). It is probably not surprising that staff were better at following those safety protocols than refugees. Figure 1 shows that staff were more likely than refugees to maintain social distancing, although staff more closely followed this protocol when around refugees compared to when they were around other staff.

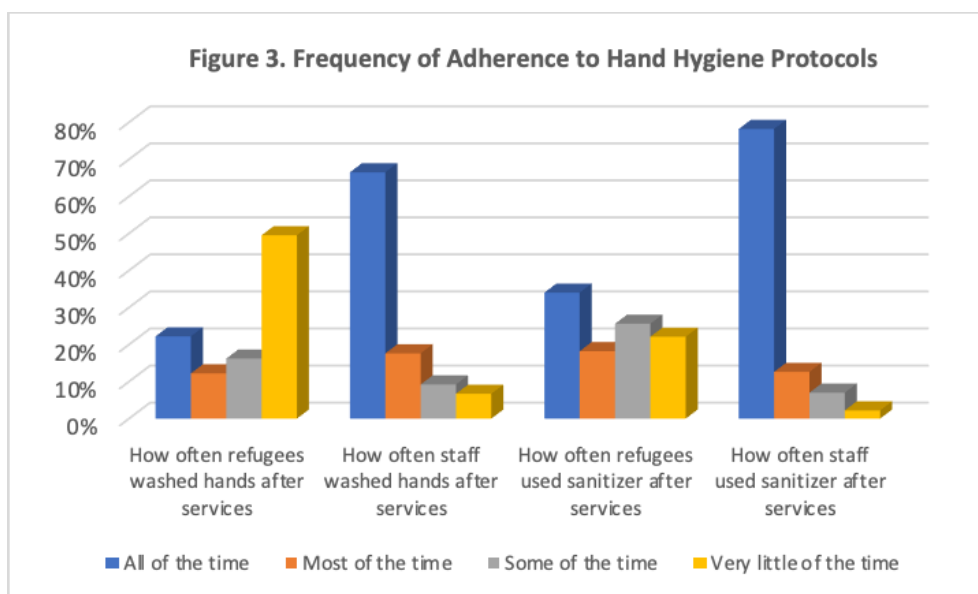
**Figure 1. Adherence to Social Distancing Protocols**



The findings on adherence to mask wearing and hand hygiene were similar, as shown in Figures 2 and 3. Again, staff more consistently wore masks when they were around refugees than when they were around other staff. In interviews, staff tended to report that they personally wore their mask more consistently than other staff, especially compared with staff-to-staff interactions.



For both staff and refugees, washing hands was most frequently done at the completion of services, and hand sanitizer was used most commonly by staff after services were completed (refugees more commonly used hand sanitizer before services). Figure 3 shows the adherence to hand hygiene protocols after services were completed. Large percentages of staff reported washing their hands and using hand sanitizer after services (with similarly large numbers doing so before services as well), but refugees were much more inconsistent with hand hygiene protocols. Given that nearly 50% of staff interviews indicated that refugees washed their hands after services “very little of the time,” this is a disturbing pattern indicating a clear area for improvement.



# HOW GOOD IS SAFETY ADHERENCE IN DIFFERENT SITUATIONS?

The data indicate a pattern in which people better adhere to safety protocols when they perceive the risk to be greater, and tend to be more lax in adherence in situations they perceive to be safer.

An example of this dynamic is illustrated in Tables 3 and 4, which depict the proportion of people who violated social distancing and mask wearing protocols during medical services versus non-medical services. Because of the necessity of close proximity in medical services, most people consider medical services to be higher risk for infection. Staff in medical services reported the necessity of close proximity to be one of the most common barriers to their own adherence to social distancing.

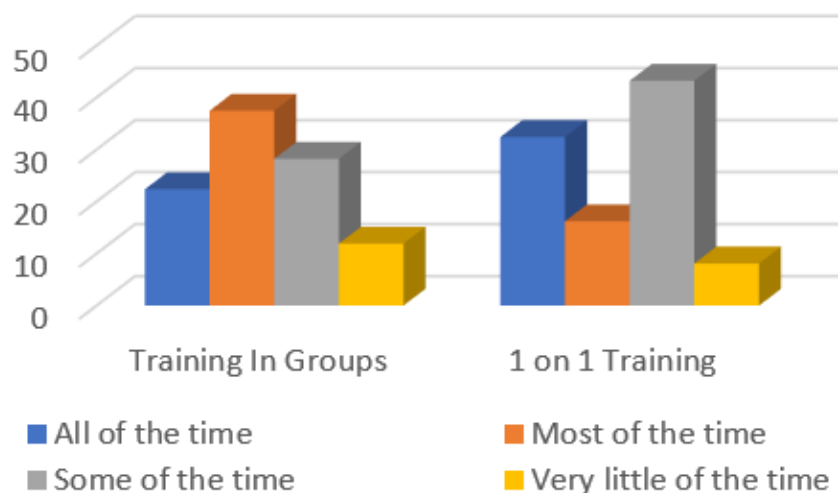
However, observation data indicated that both refugees and staff violated social distancing more frequently in non-medical services compared to medical services. The average proportion of refugees present who violated social distancing during medical services was .76, compared to .91 during non-medical services. Staff violations of social distancing were even more pronounced; during medical services the average proportion of staff present who violated social distancing was 4.13 while the proportion during non-medical services was 5.29 (both of these proportions indicate that individual staff violated social distancing multiple times).

Table 3. Social Distancing and Mask Wearing during <b>Medical</b> Services		Table 4. Social Distancing and Mask Wearing during <b>Non-medical</b> Services	
	Mean		Mean
Proportion of refugees violating social distancing	0.76	Proportion of refugees violating social distancing	0.91
Proportion of staff violating social distancing	4.13	Proportion of staff violating social distancing	5.29
Proportion of refugees not wearing masks	0.29	Proportion of refugees not wearing masks	0.41
Proportion of staff not wearing masks	0.22	Proportion of staff not wearing masks	0.39

So while medical services often require close proximity to patients, the data indicate that other services that may have not required close proximity had even more instances of social distancing violations. Hand hygiene was generally better in medical services, although the differences among staff were small and staff more often used surface disinfectant during non-medical services.

Another example of this was in the adherence to social distancing during group trainings vs. one-on-one trainings. It was in group trainings (which presented greater chances of infection spread) that refugees more consistently followed social distancing protocols. In almost 60% of the interviews, staff indicated that refugees maintained social distancing either “All of the time” or “Most of the time” in group trainings (59.85%) compared to less than 50% of the interviews (48.65%) in one-on-one trainings.

**Figure 4. Adhering to Social Distancing Protocols for Refugees**

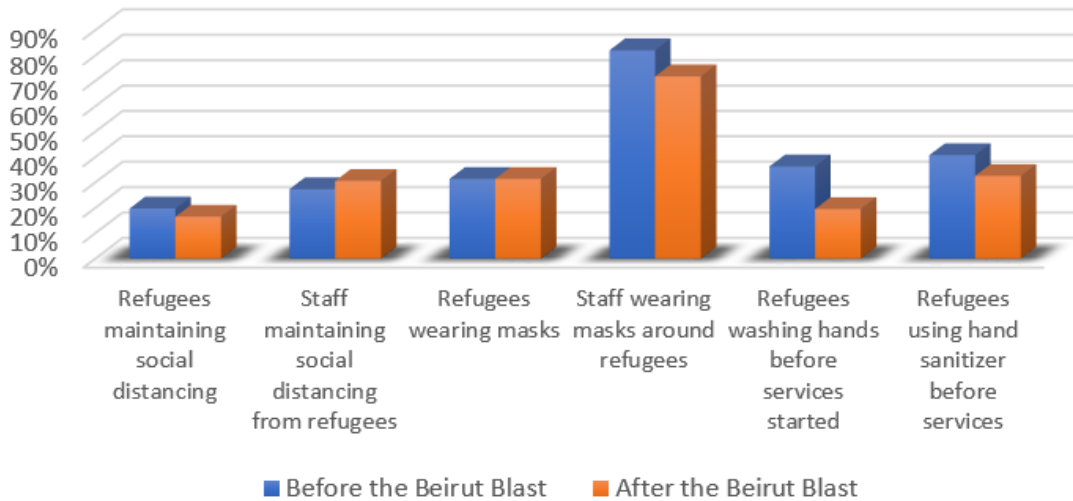


Similar patterns emerged in services provided outdoors vs. indoors. During services provided outdoors, refugees less consistently maintained social distancing and wore masks compared to when services were provided indoors.

### ***Effects of Major Regional Events on Adherence***

On August 4, 2020, a massive explosion in a warehouse along Beirut’s port occurred that leveled a large section of the city and caused major disruptions in a number of city services (which included among other things the destruction of three hospitals). Figure 5 displays adherence for a number of different protocols, showing percentages of staff who indicated that the protocol was followed “All of the time.”

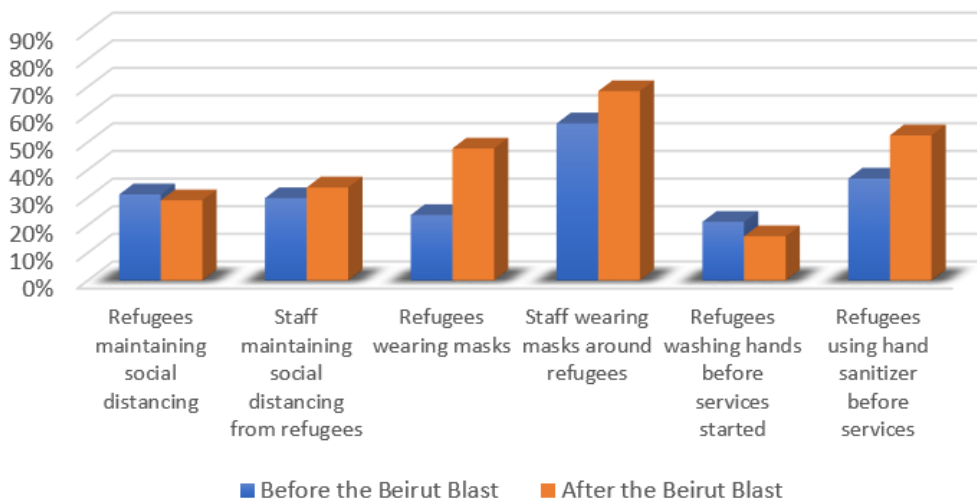
**Figure 5. Adhering "All of the Time" to Safety Protocols Before and After the Beirut Blast (In Beirut)**



There were small or no differences in protocol adherence in Beirut comparing before and after the explosion. The largest difference was in refugees washing their hands before services, with a decrease of 14 percentage points after the explosion.

Comparing these results to patterns that were found in Turkey and Jordan suggests that regionally there was a general and slight improvement in protocol adherence over time. In Turkey and Jordan, most protocol adherence improved at least slightly, with any decreases in adherence being small.

**Figure 6. Adhering "All of the Time" to Safety Protocols Before and After the Beirut Blast (In Turkey and Jordan)**



These findings suggest that while the Beirut explosion may not have caused a major disruption in the adherence to safety protocols, it may have stunted what was otherwise a regional improvement in protocol adherence over time.

# WHICH REFUGEE POPULATIONS ARE MOST IMPACTED?

There were not many differences across different refugee populations, in part because most services include a mix of populations. One clear difference was with protocol adherence during services for children. Refugee children tended to be more segregated in service provision than other groups (such as adult women and men, for whom there were many services that included both groups). There were stark differences in protocol adherences during these services, particularly in hand hygiene. Whereas across all populations staff reported that in over 57% of services refugees washed their hands very little of the time before services began, they reported that 40% of the time children washed their hands all of the time before services. Notably, staff were also more likely to wash their hands before services to children than services to other populations.

**Table 5. Frequency of Washing Hands Before Services**

	All of the time	Most of the time	Some of the time	Very little of the time
<i>Children</i>				
Refugees	40.6%	21.5%	14.2%	23.7%
Staff	70.8%	14.8%	9.5%	4.9%
<i>All populations</i>				
Refugees	16.6%	9.7%	15.8%	57.9%
Staff	51.9%	23.0%	15.0%	10.1%

# WHAT ARE THE BARRIERS TO LIMITING INFECTION SPREAD?

## ***Barriers to Adherence for Refugees***

Common barriers to social distancing that were identified in the interviews with staff were a lack of physical space, refugees' lack of knowledge about COVID-19, the requirement to be close to people during services, and attitudes about COVID-19. Attitudes included not taking the virus seriously but also carelessness, fatigue, and boredom with the protocols. For mask wearing, staff also thought refugees' lack of understanding of COVID-19 was a barrier, but also frequently cited the monetary costs of masks.

Service centers did not always have masks available for refugees, and the cost of masks as well as other forms of PPE skyrocketed during the summer of 2020. Discomfort wearing masks, especially due to the heat, was also a very common barrier cited by staff.

NGO staff cited refugees’ lack of knowledge about COVID-19 as the most common barrier to following hand hygiene protocols as well.

**Barriers to Adherence for Staff**

While staff commonly attributed refugees’ lack of protocol adherence to internal barriers (such as lack of knowledge, carelessness, or skepticism that COVID-19 was a serious disease), staff explained their own lack of protocol adherence to factors external to themselves. For maintaining social distancing, a lack of sufficient physical space and services requiring close proximity were reported as the most common perceived barriers. Staff were also much more likely to indicate that there were no barriers to protocol adherence for themselves and their staff colleagues.

**Availability of Resources**

While many people expect limitations of physical structures and resource availability to be the most important barriers to limiting infection spread, these were not always the most significant factors. In protocols related to hand hygiene (washing hands and using hand sanitizer), resource availability was almost never a barrier.

<b>Table 6. Availability of Resources</b>			
	Water	Soap	Hand sanitizer
From interview data	90%	88%	92%
From observation data	77%	75%	93%

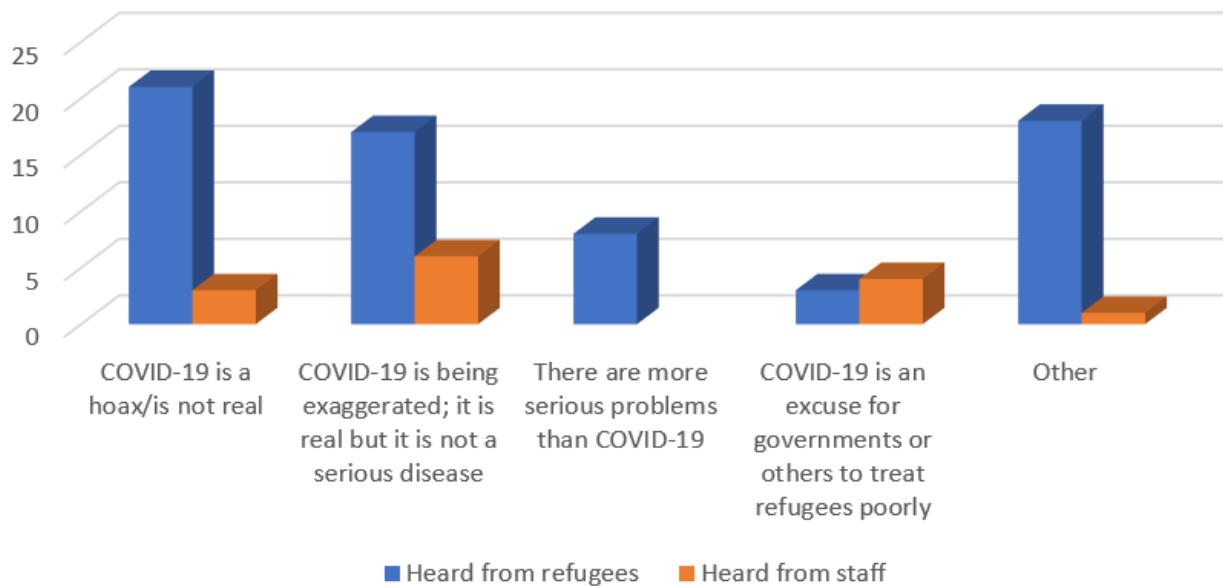
Across all locations, 90% of the staff interviewed reported that water was available in the services they conducted, 88% reported that soap was available, and 92% reported that hand sanitizer was available. Observation data indicated more limited resource availability: data collectors observed that water was available 77% of the time, soap was available 75% of the time, and hand sanitizer 93% of the time. However, refugees infrequently washed their hands, with staff indicating that half the time refugees washed their hands before services “very little of the time.” They used hand sanitizer more frequently, but staff indicated that refugees only used hand sanitizer before services 50% of the time.



## COVID-19 Skepticism

Another barrier that emerged was “COVID skepticism.” Some refugees (and even a small number of staff) did not seem to take the pandemic seriously, and did not find it necessary to change their behaviors in order to reduce infection risk. In over a third of the observations, data collectors heard at least one refugee make a comment that they did not take COVID-19 seriously (67 observations total). Among those observations, a third involved comments indicating that the refugees thought COVID-19 was a hoax, a quarter thought that the seriousness of COVID-19 was exaggerated, and 12% indicated that refugees considered COVID-19 to be a less serious problem than other concerns they had (such as a lack of food or safe shelter).

**Figure 7. Comments Suggesting COVID-19 Skepticism**  
(number of observations where comments were heard)



There were only a small number of observations in which data collectors overheard COVID-19 skepticism from NGO staff (14 observations out of 215 observations total). These comments most often expressed a belief that the seriousness of COVID-19 was exaggerated, or that the pandemic was being used as an excuse to treat refugees poorly. In interviews with staff, some asked the data collectors why they were asking questions about COVID protocols because they were not convinced that the virus was real, with one referring to it as “a rumor” and a data collector noting that most of the people in a particular service center “don’t believe in the existence of Corona.” However, that was a small minority of staff; a larger proportion expressed frustration and anger at the lax adherence to safety protocols that others exhibited.

While the most common barrier that staff thought kept refugees from following protocols was a lack of knowledge, staff themselves didn't always have accurate understandings of infection risk. A number of staff in open-ended questions indicated that they did not need to wear masks around other staff because the risk was lower. Many staff expressed a sense of trust with their colleagues, describing contact with refugees as a legitimate concern but that there was no need to maintain safety protocols around other staff.

**"As employees we are confident that none of us have been in contact with infected people."**

-Staff member of NGO in Lebanon, explaining why staff do not always maintain social distancing from each other

## HOW CAN REFUGEES BE BETTER PROTECTED FROM COVID-19?

While there have been many experts positing that refugees are particularly vulnerable to contracting and spreading COVID-19 because of overcrowded conditions, the findings indicate that other factors might be just as important. One of the more concerning findings of this study was the prevalence of COVID skepticism among refugees. Humanitarian service providers will need to consider how COVID skepticism might affect not just their refugee clients' adherence to safety protocols, but also their willingness to be vaccinated in the future. The findings also suggest that local cultures emerge around COVID-skepticism and adherence to different safety protocols. Humanitarian NGOs need to consider the specifics of each site as a local culture that might be quite different from others. They should not assume that protocols are followed in the same way across all of their service centers, or that because one protocol is followed well that others are too.

In terms of the limits of physical space, findings from the qualitative data indicate that where limited space creates problems with social distancing, it is specifically within waiting areas, or places where refugee clients queue before receiving services. The data did not clearly indicate that any particular kind of service itself was inherently riskier than others, because of how people behave differently within different services. For example, focusing on medical services as a critical infection vector could detract from efforts to address the more lax adherence to protocols that is happening in non-medical services.

# RECOMMENDATIONS

Based on the findings of this study, we make the following recommendations:

**1 Ensure that resources are available, but also that they are used.**

We found gaps in the availability of some resources, such as masks, and with the increasing cost of masks and other PPE it will be necessary for those resources to be provided to refugees rather than expecting all service recipients to purchase their own. However, as we found with the availability of water, soap, and hand sanitizer, just because resources are available does not mean that they will be used. Humanitarian service providers should pay attention to how resources are used and not assume that making resources available will be sufficient for ensuring protocol adherence.

**2 Emphasize protocol adherence as a habit, not a choice.**

If refugees and staff are following protocols more closely when they assess that a situation is riskier, that indicates that they are making choices about when to follow protocols and when not to. Instead, protocols should be integrated as a habit of service provision rather than an individual choice about whether or not a given situation presents sufficient risk. This may require shifting discourse from “we enacted these protocols to reduce the risk of infection” to “we follow these protocols because this is how we provide and receive services.”

One indication that this shift in emphasis works is in the greater protocol adherence during services to children. Children thrive on routines and habits, and services to refugee children are almost certainly highly routinized; the children will know that they are expected to do certain things at certain times. Those same expectations should be emphasized as a norm of service provision, which will likely improve protocol adherence among staff as well as refugee beneficiaries.

**3 Address COVID skepticism for achieving greater protocol adherence and minimizing vaccine hesitancy.**

We found widespread skepticism among refugees and even some service providers about the seriousness of COVID-19 and the necessity of following protocols. We are continuing more detailed analysis to see if greater COVID skepticism leads to less frequent protocol adherence, but on the surface it is a cause for concern. Additionally, COVID skepticism might also lead to hesitancy to get vaccinated. Addressing skepticism now could not only improve protocol adherence (which will be needed in the foreseeable future), but also might decrease vaccine hesitancy and thus increase vaccination rates.

# APPENDIX - METHODOLOGY

This study collected data from humanitarian assistance organizations serving refugees in Lebanon (Amel Association and NISCVT/Beit Atfal Assumoud), Turkey (Safa for Development), and Jordan (Altkaful Charity Association). Data were collected on how well people practiced social distancing (keeping two meters distance between each other), wore face masks, and washed or sanitized hands and surfaces during services provided to refugees. It included services provided in 14 different locations where the NGO partners assist refugees. There were five locations for Amel Association, four for Beit Atfal Assumoud, two for Safa for Development, and three for Altkaful Charity Association.

Data came from interviews with staff providing services and from direct observations of services. Fifteen data collectors conducted interviews, asking a series of closed-ended and open-ended questions to staff either in person, over the phone, or in a few cases through video conferencing. The questions referred to the services that the staff provided either earlier that day or the previous day (depending upon what time the interview was collected). In observations, data collectors positioned themselves unobtrusively and recorded the adherence to safety protocols that they observed. In interviews with staff, we asked general questions about how frequently or infrequently safety protocols were followed; in observations the data collectors recorded the number of times safety protocols were followed or not followed as well as the number of people in the service space.

Our findings are based on 1,466 interviews and 215 observations conducted between July 6 – September 15. For Amel there were a total of 331 interviews and 43 observations, for NISCVT there were 445 interviews and 90 observations, for Safa there were 464 interviews and 29 observations, and for Altkaful there were 209 interviews and 53 observations. Data collectors entered interview and observational data into Qualtrics, so that data monitoring could occur in real time throughout the data collection period. In addition to the three primary safety protocol behaviors, we collected data on the location where services were provided, the kind of service provided, the primary refugee populations being served, the availability of soap/water/hand sanitizer, the staff's awareness of NGO and government policies regarding safety protocols, and the perceived barriers to better adherence to safety protocols (the perception of either the staff or the data collector). We also recorded the day and time of the interview or observation, so that we could track changes over time.

The authors of this study wish to thank the data collectors who worked on the ground to ensure rapid and high-quality data collection: Hala Safieddine, Lamees Kashmar, Abdelmenhem Amhaz, Roxana Farhat, Zahra Abdul Latif, Amal Ibrahim, Layla al Jendawi, Ashwak Al Shabi, Asmaa Ali Alshawah, Alaa Ali Assaf, Rima Al-Zoubi, Reem Gramo, Fahed M. Al Oqaili, Abdallah A. Mryyan, and Sajeda Al Saleh.

We also wish to thank Natalie and Natalynn Qaji, who assisted with the production of the project website and qualitative data analysis, and Katie Paulot, who designed and formatted this report.