

Study on perceptions of risk communication and community engagement for COVID-19

IN LEBANON

Final report

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Abbreviations

ANOVA	Analysis of Variance
BRC	British Red Cross
CDC	Centres for Disease Control and Prevention
CERT	Community Emergency Response Team
COVID-19	Coronavirus disease 2019
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
FGD	Focus Group Discussion
GIS	Geographic Information System
ICRC	International Committee of the Red Cross
IDP	Internally Displaced People
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International Non-Governmental Organisation
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interview
LBCI	Lebanese Broadcasting Corporation International
LGBTQ	Lesbian, gay, bisexual, transgender and queer or questioning
LRC	Lebanese Red Cross
MoPH	Ministry of Public Health (Lebanon)
MTV	Murr Television
NGO	Non-Governmental Organisation
RCCE	Risk Communication and Community Engagement
SPSS	Statistical Package for the Social Sciences
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

Background

Lebanon has been experiencing a refugee crisis for over a decade, exacerbated by a protracted and deteriorating economic crisis. In 2020, the situation was further compounded by COVID-19 and a catastrophic blast in Beirut that left many people homeless and without resources. These multiple emergencies interact, making it difficult for the population to sustain COVID-19 prevention measures. The International Red Cross and Red Crescent Movement – including the International Federation of Red Cross and Red Crescent Societies (IFRC), the International Committee of the Red Cross (ICRC), British Red Cross (BRC) and Lebanese Red Cross (LRC) – therefore sought to assess people’s perceptions towards the relevance and usefulness of their approaches to risk communication and community engagement (RCCE) for COVID-19, and whether people have adequate access to the information they need.

A key component of LRC’s RCCE approach has been awareness sessions tailored for different audiences, including community members, nurseries, educational institutions, conservatories, health workers and frontliners, and different workplaces. The sessions had been face-to-face, but due to the surge in COVID-19 cases, online awareness dissemination was introduced. As well as providing basic COVID-19 information, a number of sessions dealt with how to safely return to normal activities following lockdown. These sessions were part of a broader RCCE approach that includes online children’s games, an E-Learning platform, distribution of IEC materials, support for municipalities to create and implement Municipal Response and Action Plans, distribution of PPE and other materials and ongoing infection prevention control (Lebanese Red Cross Disaster Risk Reduction Unit 2021).

Purpose of the study

This mixed methods study explored community perceptions of the relevance of COVID-19 health messages disseminated by Red Cross Red Crescent in Lebanon, and people’s access to such information. The findings and recommendations are designed to be used by Red Cross Red Crescent and other actors working in the COVID-19 response in Lebanon strengthen RCCE in disease outbreaks. Specifically, the study sought to:

- Assess perceptions of the relevance of the RCCE approaches in the study areas; access to and awareness of COVID-19 RCCE information;
- Identify learning and recommendations to improve the RCCE activities and approaches and achieve better outcomes for communities of crisis and conflict areas.

Report structure

Following the introduction, the study’s methodology is outlined in brief (a more detailed description is included in the project’s inception report). The report is then structured in three main chapters. The first presents a summary of the findings from the quantitative survey. The complete quantitative findings have been submitted as an accompanying report. The second chapter presents the qualitative research findings, and the third chapter the discussion in which findings from the quantitative and qualitative research and the literature review are triangulated and reflected upon. The final section details the conclusion, lessons learnt and recommendations for strengthening the RCCE response in Lebanon. In addition, demographic details for the qualitative research participants, quantitative and qualitative study tools, and the literature review are included as accompanying documents.

Study methodology

The mixed method study followed combined qualitative and quantitative methods to maximise representativeness with triangulation and elaboration through in-depth interpretations. A literature review informed the design of the study tools. It provided a brief synthesis of the existing qualitative and quantitative data and grey literature relevant to COVID-19 behaviours and related RCCE in Lebanon. Quantitative and qualitative tools were developed and informed by the literature reviewed, the relevant RCCE materials provided by LRC, and the list of stakeholders to be targeted.

Quantitative methods

The quantitative online survey was informed by the global behaviour change framework included in the COVID-19 Global RCCE Strategy (IFRC, UNICEF, and WHO 2020). The survey covered the following areas: participant demographics; access to health messages; appropriateness and relevance of health messaging; community awareness on COVID-19; community awareness and perceptions around the vaccine; impact of COVID-19; the economic crisis in Lebanon; the Beirut Explosion; and the LRC's RCCE approach. The final section incorporated questions proposed by the SESAME Workshop (a US-based not-for-profit) to gather the perceptions of parents of children aged three to eight years with regards to the relevance of RCCE approaches for this age-group (the analysis of the SESAME Workshop data does not fall under the requirements of this study and has not been included in the study findings).

Data Collection: The survey questionnaire was translated into Arabic, pilot tested, modified, then disseminated by the LRC via the Geographic Information System (GIS) among residents aged 16 years or over in Beirut, Mount Lebanon, Tyre and Saida who had taken part in the awareness, capacity building and training activities provided by the LRC since the COVID-19 pandemic started in Lebanon. A sample size of 480 participants (120 per area) was planned, taking into consideration gender, age and nationality. In order to ensure that 480 surveys were collected, the LRC team sent the survey by text message to around 2,500 beneficiaries randomly selected by the LRC in alignment with the selection criteria. The survey was disseminated between 24 March and 5 April 2021. In total, 507 surveys were recorded.

Quality assurance and monitoring: Four LRC volunteers in each of the four study areas provided follow-up to the survey over a period of 5 days. The volunteers made telephone contact with 1,787 of the 2,500 beneficiaries who received the survey to ensure it was completed or to encourage completion (1,183 of the 1,787 calls were answered). During this period, Anthrologica coordinated with IFRC and LRC focal points on a daily basis to track the data collection progress and resolve any issues. IFRC and Anthrologica cleaned the data for the 507 records collected, and 497 complete surveys were taken forward for analysis (10 were excluded as they did not provide consent).

Data analysis: The quantitative data (497 surveys) were analysed using SPSS software. Descriptive statistics were used to describe and summarise the properties of the quantitative data where the frequencies and percentages for categorical variables were reported. Bivariate analysis was conducted using independent sample t-test. One-way ANOVA test was used to assess the association between categorical variables, and Chi-square test was used throughout the analysis to associate between two different categorical variables. A Pearson correlation test displaying the correlation coefficient "r" was used to determine the association between two continuous variables. A p-value ≤ 0.05 was used to indicate significance in all cases.

Qualitative methods

To complement the quantitative survey, two Focus Group Discussions (FGDs) with LRC Disaster Risk Reduction (DRR) Unit staff and DRR Unit volunteers were conducted online via Microsoft Teams. Seven Key Informant Interviews (KIIs) were also conducted online with community level stakeholders in the

four study areas who had had some level of involvement in LRC's awareness and capacity building sessions, whether as participants or in a coordinating or other role. The interviewees were identified by the LRC. The FGDs and KIIs used semi-structured question frameworks that echoed the questions in the quantitative tool to enable triangulation. The frameworks were tailored to the role of the participant to ensure the most pertinent information was collected.

LRC scheduled the FGDs and KIIs and Anthrologica conducted them between 24-31 March 2021. Verbal consent was given by all participants for the sessions to be recorded. The sessions were then transcribed into English, with support from LRC volunteers. A data extraction matrix was created in Excel including codes relevant to each of the research questions. The analytic codebook was developed in English and detailed notes from the FGDs and KIIs were read through and relevant data extracted and placed in the matrix under each code. Coding was iterative. Key descriptive themes were identified and data labelled under these themes. Qualitative research findings were then triangulated with the findings of the quantitative survey to build a coherent justification for the themes/evidence emerging from the interviews. The analysis also reflected how the findings related to the secondary documentation considered during the desk review.

Training

A five-hour training package was developed and provided by Anthrologica on the 19 March 2021 to 12 LRC volunteers identified by the LRC team along with the IFRC and LRC focal points and 3 LRC field officers. The training included an overview of research methods and a session specifically tailored to the current study to ensure the volunteers understood the research questions and were able to assist participants who needed help with the survey. This session included role play as well as a reflection about what worked well, what did not, and what should be modified in the tools.

Reporting

An online validation workshop was held on 7 May 2021 to share and discuss initial findings, conclusions, and recommendations with relevant stakeholders. Feedback resulting from the validation workshop was incorporated into the final version of the report.

Challenges and limitations

A low response rate was anticipated and then observed during the quantitative data collection. It required LRC volunteers to intensify efforts and conduct 1,787 random phone calls to beneficiaries targeted by the survey to ensure the sample size was reached. Among the beneficiaries reached by telephone follow up, some stated that they had not completed the survey because either they did not notice the initial notification including the link to the survey, or were not sure what the survey was about. The inability to conduct face-to-face meetings can make it more difficult to engage effectively with participants and build a rapport between researcher and interviewee.

There were also a number of limitations to the study. The limited number of interviews and type of respondent (all qualitative research participants had a leadership role in the community) might have affected the diversity of the opinions/findings. The self-administration of the survey via a link over a smart phone excluded people with no access to devices or internet or who are technologically illiterate. The self-administration of the survey with minimal interviewing facilitation might have led to more human-made errors and thus more time spent on data cleaning. Due to budget and time constraints, the small sample size adopted (initial target of 480 participants and only selected from four governorates) was not aligned with the national outreach of the LRC in regards to COVID-19 RCCE across Lebanon. The findings are therefore not representative (the sample size was not representative of governorate, age nor nationality) and this affected the generalisability of the findings to the wider

community in the targeted areas. In addition, respondents were mainly from Mount Lebanon and South Lebanon affecting the generalisability of findings to the national level. There was also a potential response bias due to the fact that respondents had all been involved with LRC awareness sessions and it was understood the study was being conducted for LRC. Finally, there was a miscommunication with the LRC team following the survey's pilot test that resulted in a question being omitted from the survey version that was disseminated to targeted beneficiaries. There was therefore missing data about participants' perception on the different measures that should be taken to stop transmission of COVID-19 within the community; only the follow-up question about the first measure to take was retained.

Findings: quantitative data

This section details significant quantitative findings from the survey data. The full analysis of quantitative data is presented in an accompanying document.

Demographics

Nationality and current status

The majority of survey respondents were from host communities (91%, n=450). A minority were refugees (5%, n=24), 12 were internally displaced, eight were migrants and only three participants reported to be in the 'others' category including residents and tourists. With regards to nationality, the majority of the participants were Lebanese (94%, n=466), 4% (n=18) were Palestinian, 2% (n=8) were Syrian and 1% (n=5) were from other nationalities including Columbian, Iranian, Jordanian, Swedish, and American.

Gender and age

The sample consisted of 62% (n=308) female and 38%, (n=188) male (one participant preferred not to specify his/her gender). Of the participants, 34% (n=169) were 18 to 29 years, 28% (n=138) were aged 30 to 39 years, 22% (n=110) were aged 40 to 49 years old, and 11% (n=56) were aged 50 to 59 years. Only 4% (n=20) were between 60 to 69 years, and one participant was aged between 70 and 79 years old. Three were aged 16 to 17 years.

Education and occupation

Regarding education level, 17% (n=86) of participants affirmed that they have achieved an advanced university level, 51% (n=255) of participants stated that they achieved university level, 27% (n=136) stated that they completed high school level, 3% (n=15) stated that they have reached primary level, two participants reported that they did not have a formal education and three participants were unsure of their answer. In terms of occupation, the majority were employees (62%, n=306), although a relatively high percentage of participants reported to be unemployed (23%, n=116). Business owners accounted for 10% (n=50) of the sample, and 3% (n=17) of participants had 'others' occupations including: engineer, agriculture, volunteer, casual worker, translator, freelancers, etc. Only eight respondents were retired.

Perceptions of LRC awareness interventions

Information provision

Participants were asked how they received information about COVID-19 from the LRC, and more than half of the respondents stated that it was through face-to-face awareness sessions (figure 1).

Receiving information through **face-to-face** awareness sessions was dependent on **gender** (P-value<0.01) and **governorate** (P-value<0.01); females (55%, n=159) and people living in the South (42%, n=124) were more likely to report that they received COVID-19 information through face-to-face sessions. Receiving information through **online** awareness sessions was dependent on **age** (P-value<0.01) and **governorate** (P-value = 0.031); people aged 18 to 29 (54%, n=73) and those living in Mount Lebanon (42%, n=57) were more likely to report that they received information through online sessions.

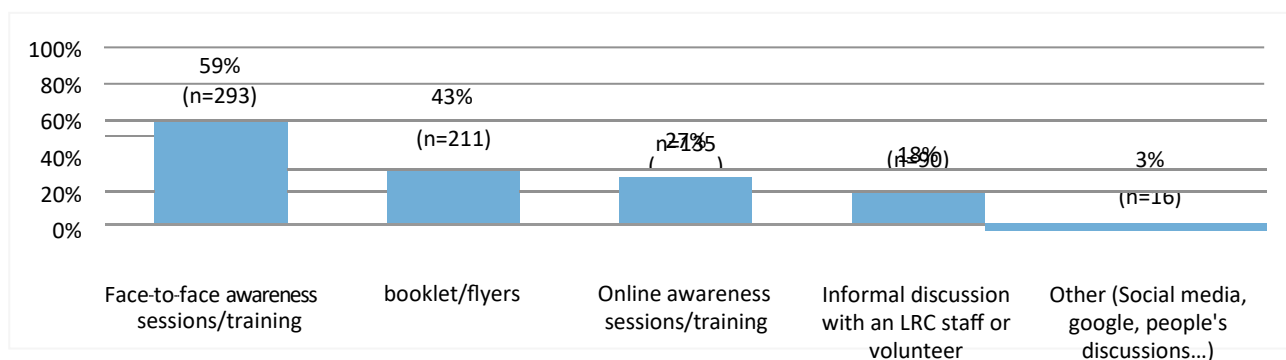


Figure 1. Ways of receiving COVID-19 information through the LRC

Receiving information through **booklets/flyers** and **online sessions** was dependent on **occupation** (P-value =0.04 and <0.01 respectively); employees were more likely to report that they received information through booklets (62%, n=130) and through online sessions (51%, n=69).

Receiving information through **informal discussion with an LRC staff or volunteer** and **through other channels (google, social media, people's discussions etc.)** were dependent on **age** (P-value=0.04 and <0.01 respectively); people aged 30 to 39 were more likely to report that they received information through informal discussion with an LRC staff or volunteer (30%, n=27) and through other channels (31%, n=5).

Participants could identify one or more channels; 63% (n=312) chose only one option, while 37% (n=185) stated they were reached through more than one channel.

Language and dialect appropriate:

When asked whether they received COVID-19 information in their preferred language, 97% of participants (n=480) agreed that they did, and 3% (n=17) disagreed.

Access to information

With regards to accessing COVID-19 information through the LRC, 47% of participants (n=235) mentioned that it was very easy, 37% (n=184) said that it was easy, 14% (n=70) rated it as average, 1% mentioned that it was difficult (n=6) and two participants stated that it was very difficult.

Inclusion

Respondents were asked whether the LRC's COVID-19 awareness-raising reached all groups in the community. Over half of the participants (63%, n=313) agreed that it did, while 37% (n=184) disagreed. Those who disagreed (n=184), were asked which groups were not reached and their responses are displayed in figure 2 below.

Children, refugees and adolescents not being reached was dependent on **gender** (P-value=0.036, 0.046 and 0.033 respectively); females were more likely to report that children (53%, n=53) and refugees were not reached (52%, n=40) and males were more likely to report that adolescents were not reached (58%, n=15). Furthermore, it was dependent on **governorate** (P-value = 0.014); people living in Mount Lebanon were more likely to report that refugees (35%, n=27), IDPs (47%, n=20) and migrant workers (39%, n=15) were not reached.

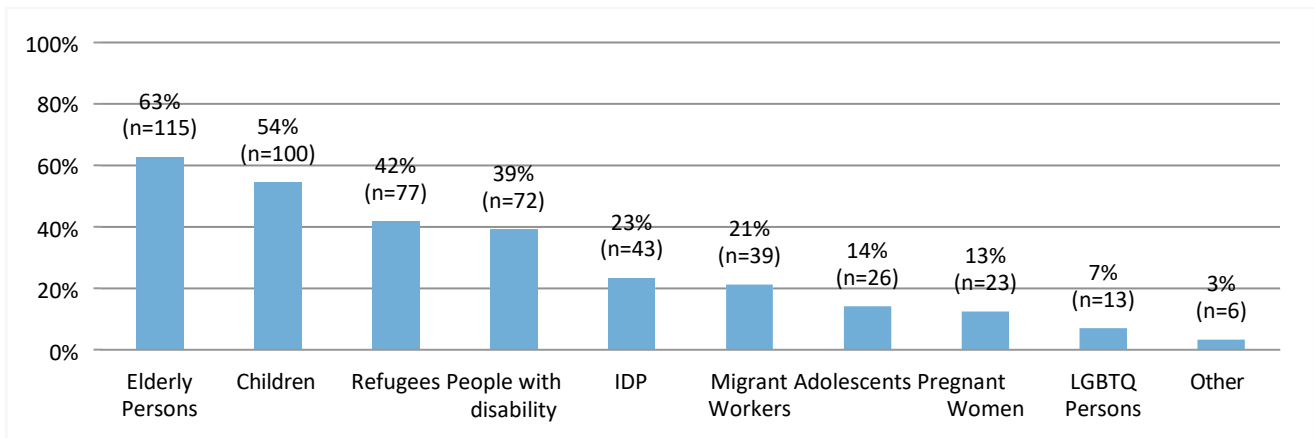


Figure 2. People not being reached by LRC's COVID-19 awareness

Age and gender considerations

When asked whether the information received from the LRC took into consideration the needs of different age groups, almost all respondents (96%, n=477) agreed that it did, and only 4% (n=20) disagreed. Inferential analysis showed that taking into consideration the needs of different age groups was dependent on **age** and **occupation**. Participants aged 18 to 29 years (35%, n=166) followed by those aged 30 to 39 years (29%, n=137), and 40 to 49 years (21%, n=102) and employees (62%, n=297) followed by unemployed (24%, n=114), and business owners (10%, n=46) would be more likely to report that the LRC information provided took into consideration the needs of different age groups. When asked whether the information received from the LRC took into consideration the needs of different genders, almost all respondents (99%, n=493) agreed, and only four disagreed.

Relevance

Survey participants were asked if the information received through the LRC was applicable and realistic; 96% (n=476) agreed and 4% (n=21) disagreed. Inferential analysis showed that the relevance of the LRC's information was dependent on **education** (P-value = 0.027); university graduates were more likely to report the relevance of LRC's information (53%, n=250) followed by secondary/high school educated respondents (26%, n=124), advanced university degree holders (17%, n=82), primary/elementary school educated participants (3%, n=15) and those who do not have formal education (n=2).

Use of information

Respondents were asked if they used the information provided by the LRC, 99% (n=492) said yes and 1% (n=5) mentioned not using it. Those who confirmed using the information were asked how they used it and their responses are displayed in figure 3 below.

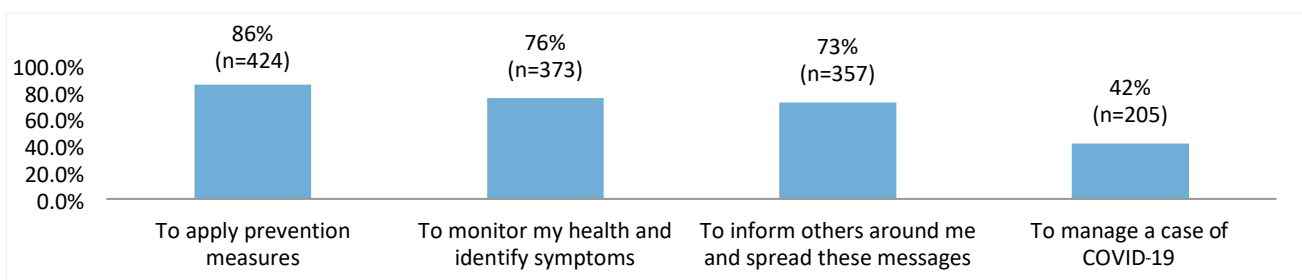


Figure 3. Using COVID-19 information provided by the LRC

Monitoring health and identifying symptoms, applying preventive measures and managing a case of COVID-19 were dependent on **education** (P-value=0.02, <0.01 and 0.01 respectively); participants with university degrees were more likely to report using COVID-19 information provided by the LRC to monitor their health and identify symptoms (54%, n=201), apply prevention measures (55%, n=230) and manage a case of COVID-19 (55%, n=111).

Applying prevention measures and managing a case of COVID-19 was dependent on **occupation** (P-value<0.01 and 0.046 respectively); employees were more likely to report using COVID-19 information provided by the LRC to apply prevention measures (64%, n=271) and to manage cases of COVID-19 (62%, n=126).

Managing a case of COVID-19 was dependent on **gender** (P-value<0.01); females were more likely to report using COVID-19 information provided by the LRC to manage a case of COVID-19.

Those who reported to not use the LRC’s information (n=5) were asked about the reasons for not doing so. The majority (n=4) said that there had been unwillingness at community level to abide by these measures; two participants mentioned that COVID-19 was not the main priority where they lived; and one participant stated that the information did not address the main needs where they lived.

Community awareness

Participants were asked about the extent to which the risk communication provided by LRC contributed to raising community awareness about COVID-19; 60% (n=297) rated it as high, 36% (n=180) said that it was average, 3% (n=16) mentioned that it was low and only four participants stated that it did not contribute to raising communal awareness.

Broader communication environment and general awareness about COVID-19

Access to health messages

Information provided: Figure 4 describes the information participants reported to have received related to COVID-19.

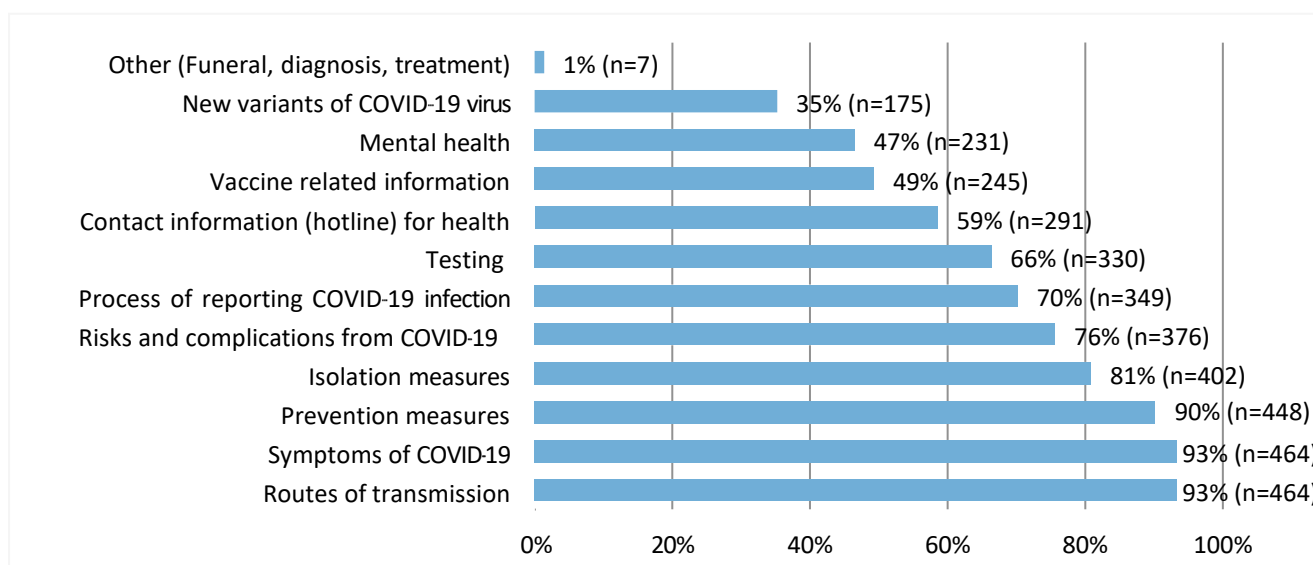


Figure 4. Information participants stated they received in regards to COVID-19

Receiving information on new variants of COVID-19 was significantly associated with **education** (P-value<0.01). People with university degrees were the most likely to report receiving information on the new variants of COVID-19 (58%, n=102) followed by advanced university degree holders (24%, n=42) and secondary/high school (17%, n=20). Education correlated with receiving information on testing (P-value = 0.046) whereby university degree holders (57%, n=188) were the most likely to report having information on testing, followed by secondary (21%, n=69) and advanced (20%, n=65) educated respondents. Furthermore, education also correlated with receiving contact information for health assistance (P-value=0.026) whereby a higher percentage of people who reported receiving contact information were university degree holders (56%, n=161) followed by secondary (25%, n=71) and advanced (18%, n=53) educated participants. University degree and secondary educated individuals might know how to access such information through different channels and hence the need to better support people who are less educated. The **governorate** in which participants resided was correlated with receiving information on testing (P-value = 0.04). Higher percentages of those who reported receiving this information lived in Mount Lebanon (44%, n=145) followed by South (33%, n=110) and Beirut (14%, n=45).¹ This could be related to the fact that the number of participants in the survey was skewed towards Mount Lebanon (n=190/497) and South Lebanon (183/497) residents.

Channels of communication: Participants were asked about the channels they use to access COVID-19 information (not necessarily through LRC). The findings are presented in figure 5. It is worth noting that all beneficiaries mentioned the channels they selected to be their preferred one(s) (n=497).

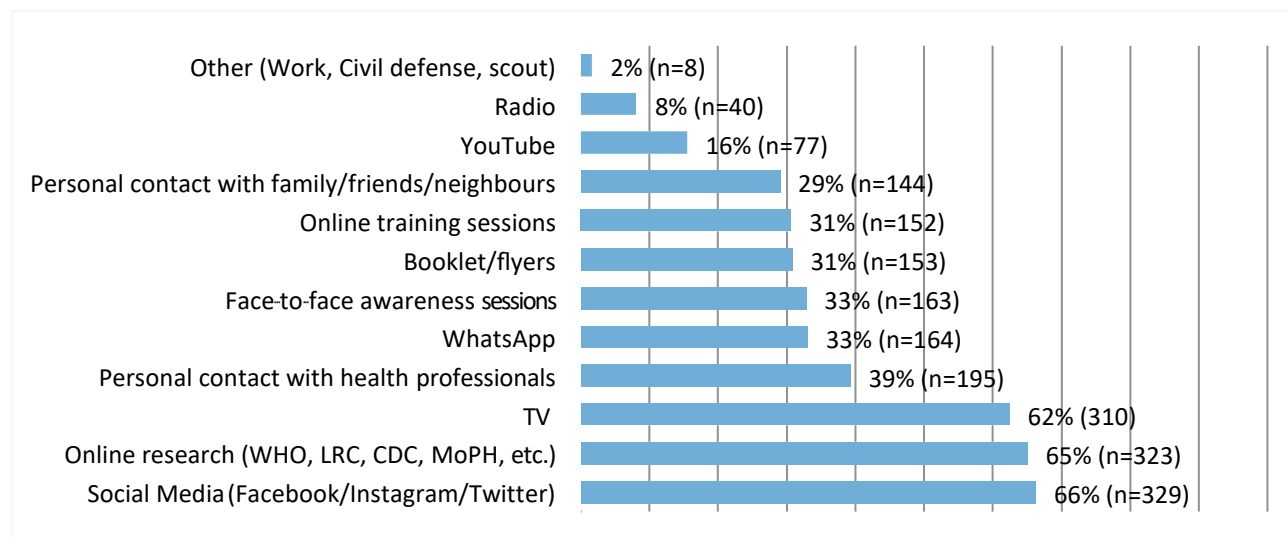


Figure 5. Channels through which COVID-19 information was accessed

Use of WhatsApp and face-to-face awareness sessions to access information were dependent of **gender** with statistically significant P-values <0.01 for each. WhatsApp was used equally by males (50%) and females (50%), but face-to-face sessions were used by males (54%, n=88) more than females (46%, n=75).

Online searches, booklet/flyers, online training sessions and personal contact with health professionals were statistically dependent on **education**. University degree holders were most likely to report using online research (59%, n=189), booklets/flyers (58%, n=88), online training sessions (58%, n=88) and personal contact with health professionals (56%, n=110) to access COVID-19 information.

¹ Since for the governorate variable the sample is not representative for each category, re-categorising them could better help in analysing the data. Receiving information on testing, process of reporting and vaccine related information were statistically significant with governorate with respective p-values of 0.01, 0.039 and 0.043.

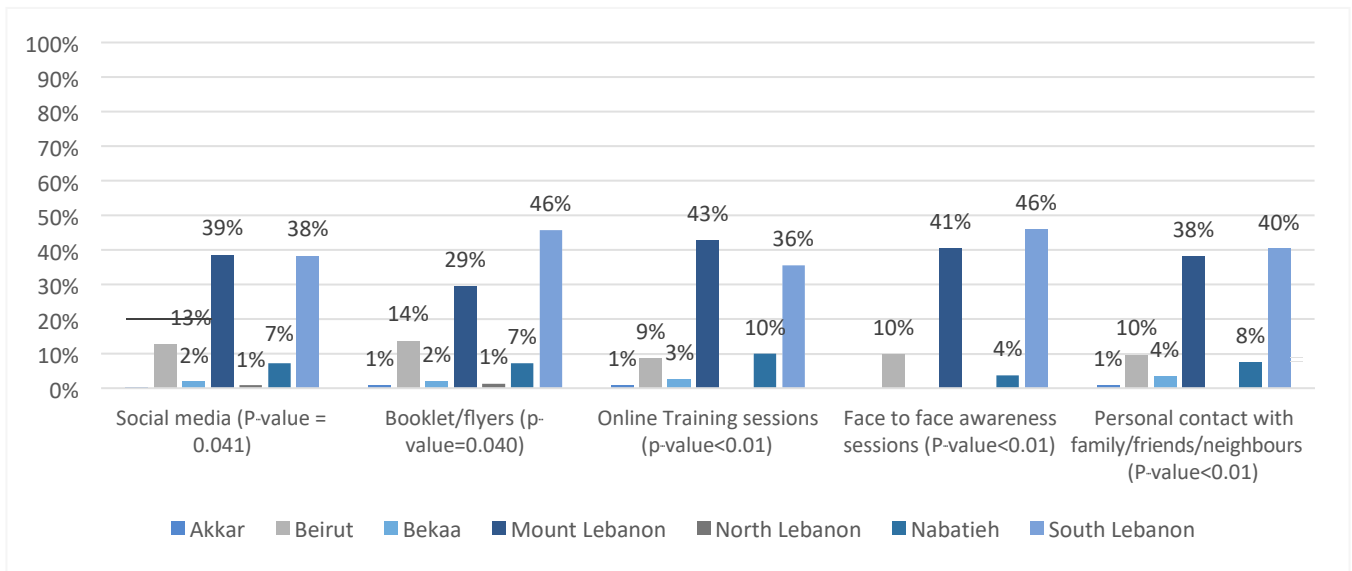


Figure 6. Channels of communication representation by governorate

Social media, booklets/flyers, online training sessions, face-to-face awareness sessions and personal contact with family/friends/neighbours also depended on **governorate**. As shown in figure 6 below, social media was mostly referred to by people from Mount Lebanon (39%, n=127). Booklets/flyers were mostly referred to by people from the South (46%, n=70). Online training sessions were mostly referred to by people from Mount Lebanon (43%, n=65). Face-to-face sessions were mostly referred to by people from South Lebanon (46%, n=75). Personal contact with family/friends/neighbours was mostly referred to by people from South Lebanon (40%, n=58). These results could be related to the division of the sample which was not representative of each governorate, and higher numbers of participants were from Mount and South Lebanon. The results could also be linked to the fact that South Lebanon is a more rural context compared to Mount Lebanon.

Trustworthy sources of information: The sources of information that the survey participants considered trustworthy are described in Figure 7. LRC and health professionals were the most trusted sources.

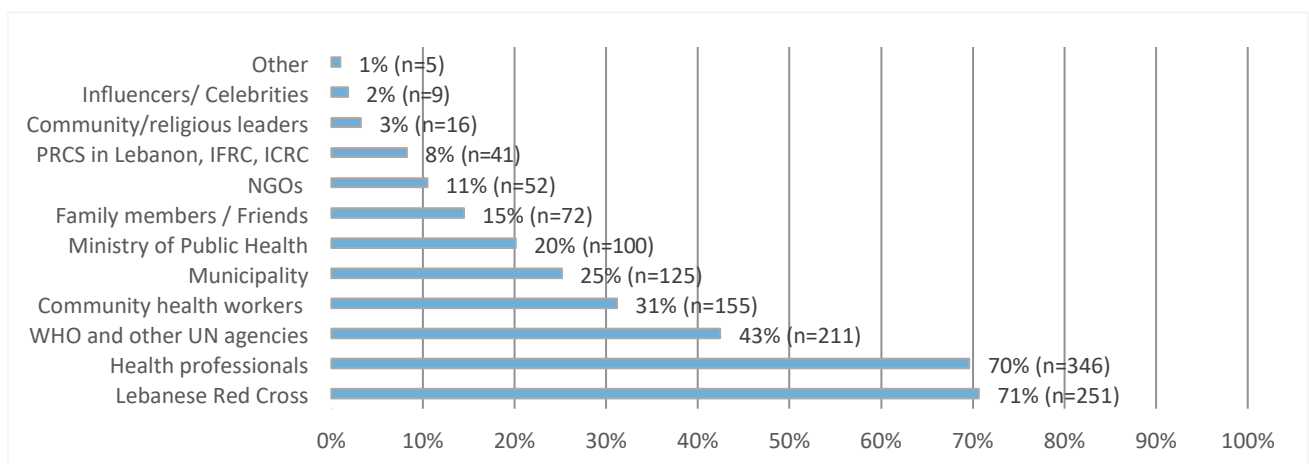


Figure 7. Trustworthy sources of information

Municipality as a trustworthy source of information was statistically significant with **gender** with higher percentages among males (59%, n=74) compared to 41% (n=51) females. The World Health Organization (WHO) and other UN agencies were more often reported to be trusted sources by participants aged 18 to 29 (41%, n=86). Municipality was mostly considered to be a trustworthy source of information by people aged 30 to 39 years (and 40 to 49 years (both groups 26%, n=32) and by

university degree holders (44%, n=55). Higher percentages of participants trusting health professionals and trusting WHO and other UN agencies were seen among university degree holders (56%, n=192 and 61%, n=127 respectively). Employees were most likely to refer to the Ministry of Public Health (MoPH), municipalities, community leaders and or religious leaders and other (work, LRC, civil defence, scout etc.) for trustworthy information related to COVID-19. Respondents from the South were the most likely to report referring to trustworthy information on COVID-19 through MoPH, the Palestinian Red Crescent Society in Lebanon, IFRC, International Committee of the Red Cross (ICRC), municipalities, and community health workers. Note that the survey participants were mainly residents from Mount Lebanon (n=190), South Lebanon (n=183) and Beirut (n=77) which might have skewed the data on this variable.

Appropriateness and relevance of health messages

Usefulness of information: When participants were asked how useful COVID-19 information was, responses were distributed between somewhat useful and very useful, where 60% (n=300) mentioned that the information was very useful and 39% (n=193) stated that the information they received was somewhat useful. Following bivariate analysis of the usefulness of COVID-19 information received with the demographic variables, gender, governorate and education were found to be significant. Males participants and people living in Akkar and with advanced university degrees were most likely to report that COVID-19 information was useful.

Relevance of information: 96% (n=478) of participants agreed that the information they received was applicable and realistic, while 4% (n=19) did not. The relevance of the information received was found to be higher perceived in the South (38%, n=182), followed by Mount Lebanon (37%, n=179) and Beirut (16%, n=74).

Participants who mentioned that the COVID-19 information was not useful (4%, n=19) linked it to unwillingness at the community level to abide by measures (84% (n=16), to the fact that the communicated measures could not be applied where they lived (32% (n=6), to COVID-19 not being the main priority where they lived (21% (n=4), and one participant stated that the information did not address the main needs where they lived.

Community awareness about COVID-19

Prevention measures at community level: The measures that respondents thought should be taken to stop COVID-19 transmission at the community level are described in Figure 8. Wearing a face mask in public was the most chosen option.

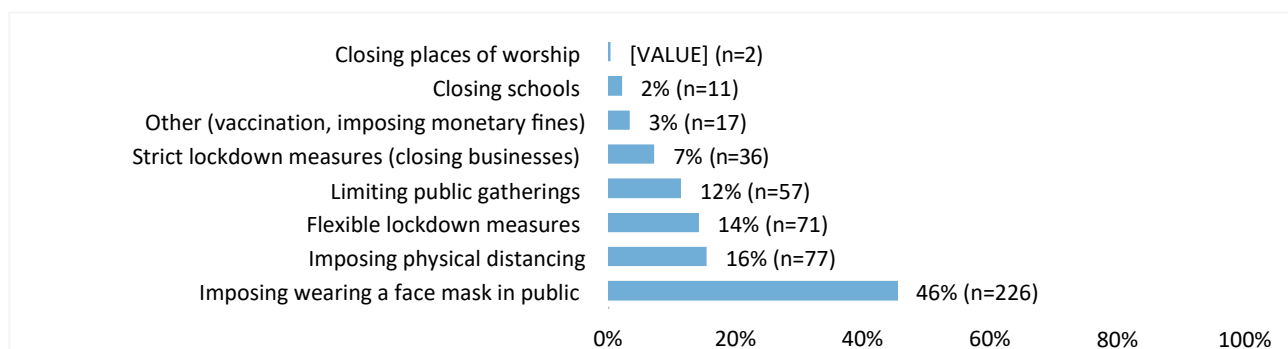


Figure 8. Measures taken to stop COVID-19 transmission at community level

Managing cases of COVID-19: Survey participants were asked what they would do first if they had been in contact with someone who had COVID-19. The majority (72%, n=356) stated that they would stay at home. Get tested was also reported by 69% (n=342) of the sample as the first action to be taken. Less than one third of the sample (29%, n=146) suggested that they would opt to stay at home for 10 days. The rest of the sample was divided as follows: 24% (n=118) would inform the physician, 12% (n=57) would call the LRC, 7% (n=34) would buy medication, and only seven participants would choose other alternatives including: staying at home for 14 days, staying at home for five days then get tested, etc.

Bivariate analysis was conducted between the perceptions of participants regarding the action that they would take in case they were in contact with a COVID-19 case with demographic variables. It revealed that buying medication was dependent on **nationality**. Among those who chose this answer, 79% (n=27) were Lebanese. Staying at home and waiting a few days to see if one would develop symptoms depended on nationality and was picked by 344 Lebanese (97%) followed by Palestinians and other nationalities. Getting tested was statistically significant with **age** (P-value<0.01) with a weak relationship and highest percentage was seen among participants aged 18 to 29 (39%, n=132). Calling LRC was statistically significant with **governorate**, showing higher percentage of participants in the South who would call LRC in case they were in contact with a COVID-19 case (54%, n=31) followed by Beirut (19%, n=11) and Mount Lebanon (18%, n=10). The getting tested option was statistically significant with **occupation** whereby employees mostly reported that they would get tested in case they were in contact with a COVID-19 case (63%, n=214).

Community engagement: Respondents were asked about the level of their engagement in the community with the purpose to address COVID-19 and the responses are detailed in figure 9.

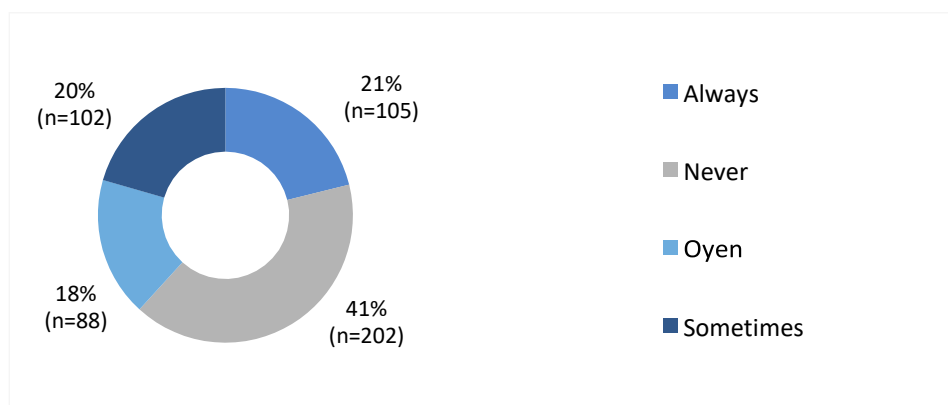


Figure 9. Level of community engagement to address COVID-19

Being engaged in the community was found to be associated with **gender** and **education** whereby males and participants with advanced university degrees were more likely to report being involved in community actions to address COVID-19. Respondents who mentioned that they were engaged in addressing COVID-19 at the community level were asked about the types of actions they did and their responses are described in figure 10 (below).

The majority of participants who reported that they volunteered with an organisation were aged between 18 and 29 years (47%, n=48), and the majority of those who reported monitoring the application of COVID-19 prevention measures were aged between 40 and 49 years (31%, n=24).

The types of community engagement actions people undertook depended on their **gender**. Males were more likely to facilitate awareness sessions (51%, n=100) compared to females (50%, n=98), more likely to develop materials (74%, n=17), to volunteer with an organisation (62%, n=64), to monitor the application of prevention measures (61%, n=47) and to conduct community-led actions (56%, n=96).

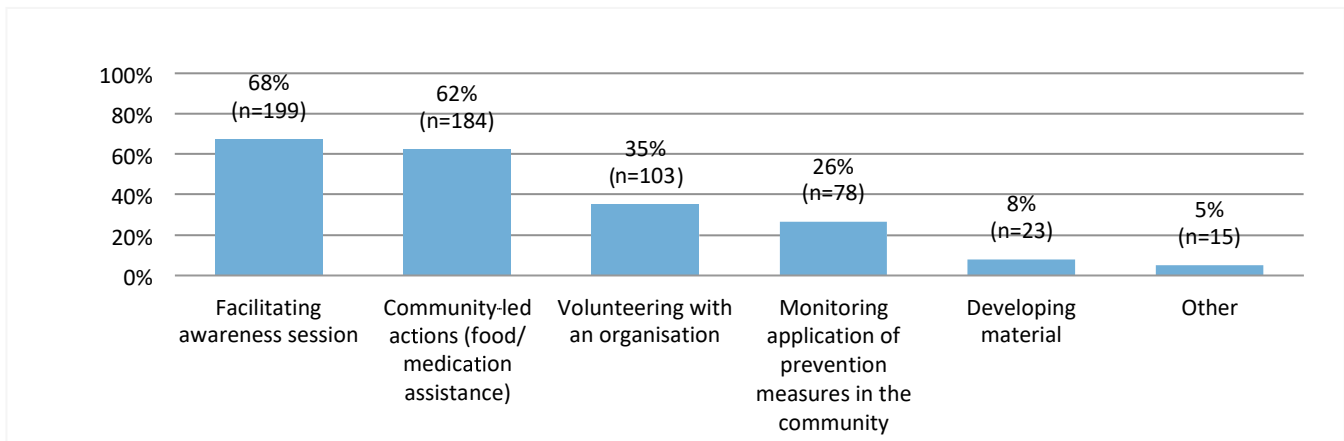


Figure 10. Community engagement actions to address COVID-19

Facilitating awareness sessions, developing material, volunteering with an organisation and conducting community-led actions were statistically dependent on **governorate** (figure 11). Participants residing in South Lebanon were most likely to report facilitating awareness sessions (44%, n=87), developing materials (65%, n=15), and volunteering with an organisation. Among those who reported to conduct community-led actions, the majority lived in Mount Lebanon (45%, n=82).

Volunteering with an organisation, monitoring the application of prevention measures in the community and conducting community led actions (food/medication) was dependent of **occupation**. Employees were the most likely to report volunteering with an organisation (38%, n=39), monitoring the application of prevention measures (62%, n=48), and conducting community-led actions (57%, n=104).

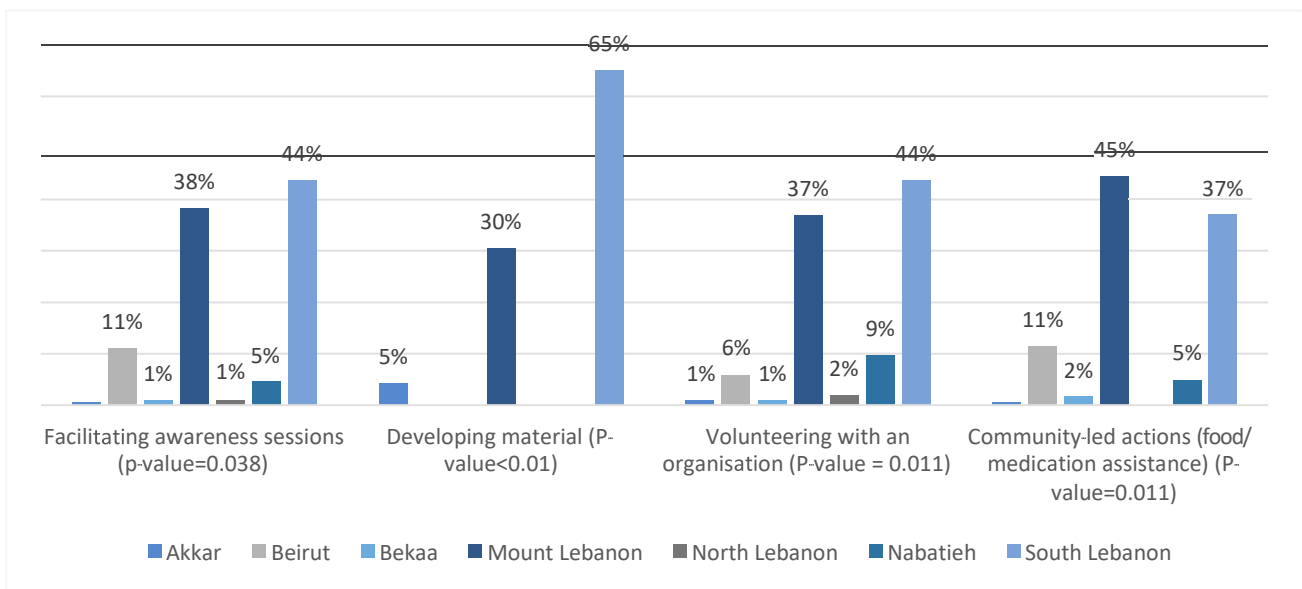


Figure 11. Community Engagement Actions to address COVID-19 at community level by governorate

COVID-19 Vaccine (community awareness and perception)

Trust in the vaccine: When participants were asked to rate their level of trust in the vaccine, 23% (n=115) stated trusting the vaccine very much. The majority (41%, n=203) stated that they had moderate trust in the vaccine; 27% (n=135) mentioned trusting the vaccine a little, and 9% (n=44) did not trust the vaccine at all. Inferential analysis between the level of trust in the vaccine and the demographic variables indicated that the higher the age the more participants would trust the vaccine (P-value<0.01); males trusted the vaccine more than females (P-value=0.012); and the higher the level of education, the higher the level of trust in COVID-19 vaccine would be (P-value=0.034).

Effective protection: Participants were also asked to rate their perception of the effectiveness of the vaccine in protecting them and the community from COVID-19; 30% (n=149) stated that they believed the vaccine would protect them and the community a lot; 40% (n=197) stated that they moderately believed that the vaccine would protect them and their community, 25% (n=122) mentioned that the vaccine would protect them a little, and 6% (n=29) did not believe at all that the vaccine would protect them and the community from COVID-19. Inferential analysis between believing that the vaccine would protect the participants and their community and the demographic variables indicated that: Lebanese participants were less likely to believe the vaccine offered protection from COVID-19 (P-value=0.034); whilst the higher the level of education, the higher the level of trust in COVID-19 vaccine protection (P-value<0.01).

Access to the vaccine: When asked about vaccine access, 90% (n=449) stated that they knew how to register for the vaccine compared to 10% (n=48) who stated that they did not know. Bivariate analysis with the demographic variables showed that knowing how to register for the vaccine was dependent on **education** with people with advanced university degrees, university undergraduates, individuals who completed secondary level education being more likely to know how to register for the vaccine compared with individuals who did not have a formal education and those who reached elementary/primary education. It was also dependent on **occupation** (P-value<0.01) with unemployed and retirees knowing less about how to register for the vaccine compared to employees and business owners. Participants were then asked how easy it was for them to get vaccinated; 45% (n=221) stated that it was a little easy, 40% (n=201) mentioned that it was moderately easy and only 6% (n=32) stated that it was very easy.

Concerns about the vaccine: When asked whether they had concerns about the vaccine, the sample was almost divided in half with 58% of participants (n=286) reporting to have concerns, while the rest (43%, n=211) did not. Inferential analysis showed that having concerns about the vaccine was dependent on **age** (P-value = 0.049), **occupation** (P-value = 0.025) and **gender** (P-value<0.01). People aged 18 to 49 years, females, employees and business owners were more likely to report having concerns regarding the COVID-19 vaccine.

Respondents were then asked what their concerns were. Of those who mentioned having concerns, 36% (n=177) perceived the vaccine to be dangerous, 26% (n=128) believed that it was ineffective and 11% (n=55) had concerns around the availability of the vaccine. Believing that the vaccine was dangerous was statistically significant with **age** (P-value = 0.032) and **gender** (P-value<0.01). This concern was high among 18 to 29 year olds (38%, n=68) and among females (73%, n=130). Those who had concerns and believed that the vaccine was ineffective was statistically significant with **education** (P-value = 0.26). Participants who were university graduates report this concern the most (56%, n=70) followed by advanced university graduates (14%, n=18).

Dealing with multiple emergencies – the economic crisis, COVID-19 and the Beirut explosion

Impact of the economic crisis

Survey participants were asked how they had been impacted by the economic crisis; 90% (n=447) stated that living costs have increased, 41% (n=205) mentioned that they were unable to purchase basic necessities (food, medicine, etc.), 29% (n=108) had lost their jobs, 15% (n=75) were unable to get basic health care and 13 participants had lost their living space.

Inferential analysis was conducted between the impact of the economic crisis and the demographic variables. **Reduced income** was dependent on **occupation** (P-value<0.01); employees were more likely to report having reduced income 75% (n=109). **Loss of job/household income** depended on **gender** (p-value=0.042), **education** (P-value<0.01) and **occupation** (P-value<0.01); females were more likely to report losing their jobs (54%, n=58) compared to males (46%, n=50); people with university degrees were more likely to report losing their job (45%, n=49); and employees (26%, n=28) and business

owners (20%, n=22) were likely to report being affected by job loss. **Loss of living space** was dependent on **gender** (P-value <0.01); males were more likely to report this issue (77%, n=10). It was also dependent on **governorate**; people living in Mount Lebanon reported this problem more frequently (31%, n=4). **Increased living cost** was dependent on **age** (P-value =0.028) and **occupation** (P-value=0.04). Individuals aged between 18 and 29 years were the most to report this issue (32%, n=141); and employees (64%, n=284). **Inability to purchase basic necessities** (e.g., food, medicine) was dependent on **governorate** (P-value = 0.05); people living in South Lebanon were more likely to report this issue (43%, n=88). It was also dependent on the **education**; individuals with university degrees were more likely to report this problem (45%, n=92). In addition, it was dependent on **occupation** with employees more likely to report their inability to purchase basic necessities as an issue (62%, n=127).

Impact of COVID-19

Respondents were asked about the impact of COVID-19. Their responses are presented in figure 12. The majority of respondents mentioned that it increased living costs.

Loss of Job/ household income was dependent on **gender** (P-value=0.027), **education** (P-value<0.01) and **occupation** (P-value<0.01); and females (53%, n=59), university graduates (42%, n=47) and the unemployed (44%, n=49) were more likely to report this issue.

Health and psychological problems were dependent on **gender** (P-value=0.016) and **education** (P-value<0.01); females (71%, n=98) and university degree holders (56%, n=77) were more likely to report these issues.

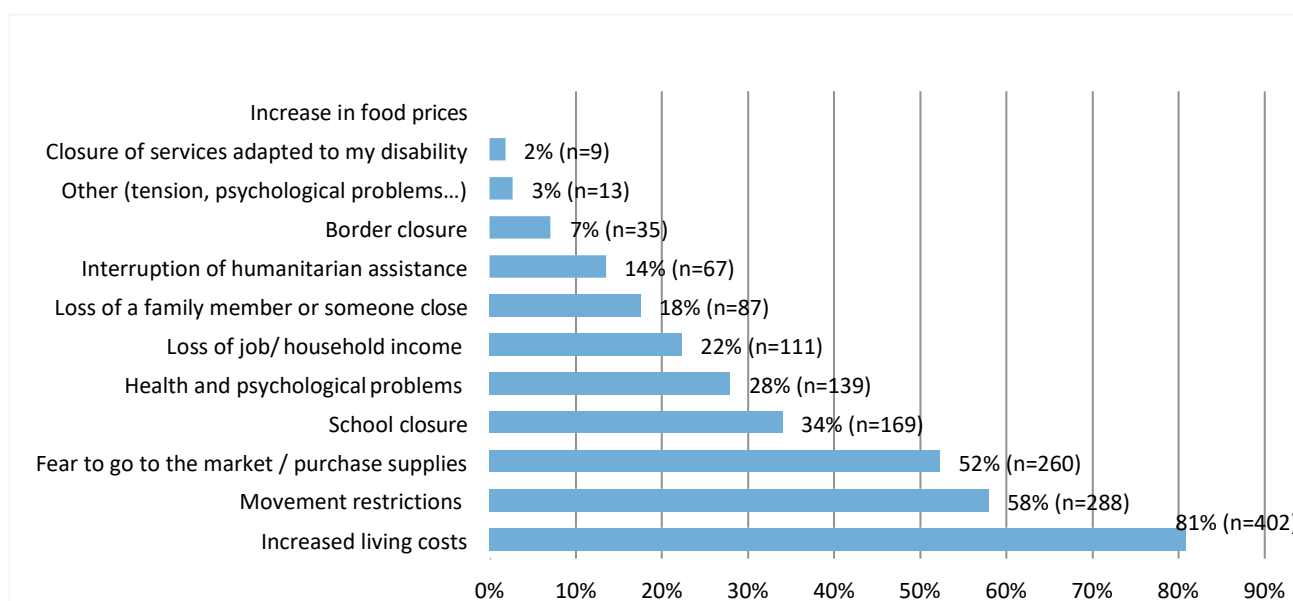


Figure 12. Impact of COVID-19 on participants

Border closure was dependent on **gender** (P-value=0.38); females were less likely to report this issue (46%, n=16) compared to males (54%, n=19).

Movement restrictions were dependent on **education** (P-value<0.01); people with university degrees were more likely to report this problem (59%, n=167).

Fear to go to the market/purchase supplies was dependent on **gender** (P-value <0.01), **education** (P-value =0.015) and **occupation** (P-value <0.01); females (69%, n=179), university degree holders (58%, n=149) and employees (67%, n=175) would more often report this issue.

Interruption of human assistance was dependent on **age** (P-value=0.053) and **education** (P-value <0.01). Those aged 40 to 49 years (33%, n=22) and university degree holders were more likely to mention this issue (48%, n=32).

School closure was dependent on **age** (P-value<0.01), **gender** (P-value = 0.037), **governorate** (P-value= 0.031) and **education** (P-value=0.03); people aged 30 to 39 years (33%, n=55), females (69%, n=115), people living in South Lebanon (40%, n=67) and participants with university degrees (56%, n=94) were more likely to report school closure as a problem.

Loss of a family member or someone else was dependent on **nationality** (P-value=0.049) and on **governorate** (P-value =0.031); Lebanese (92%, n=80) people living in Mount Lebanon (49%, n=43) were more likely to report this.

Impact of Beirut Explosion on COVID-19 measures

When asked if they were affected by the Beirut explosion, more than half of the participants mentioned that they were (61%, n=302), although 39% (n=195) were not. Bivariate analysis showed that being affected by Beirut’s explosion depended on **nationality, age and governorate**. Lebanese nationals (95%, n=286) and people aged 18 to 29 years (30%, n=91) were the groups most likely to report being impacted by the Beirut explosion. In addition, there was a statistically significant relationship between being affected by the Beirut blast and **governorate** (P-value <0.01); people from Mount Lebanon were more likely to report being affected (37%, n=113) followed by those in South Lebanon (32%, n=97), Beirut (22%, n=65), Nabatieh (6%, n=19), Bekaa (n=4), North Lebanon (n=3) and Akkar (n=1). These findings were not as expected as those living in Beirut should have reported being the most affected, and it is likely an abbaration of the survey sample which did not represent the total population per governorate.

Survey respondents were asked whether the blast affected their ability and willingness to apply COVID-19 preventive measures (see figure 13). The majority (86%, n=426) reported that the blast did not impact their willingness to apply prevention measures, whilst 14% (n=71) said that it did. Inferential analysis showed that the effect of the Beirut explosion on the willingness to apply COVID-19 preventive measures was dependent on **nationality, age and education**. Lebanese (87%, n=62), participants aged 30 to 39 years (41%, n=29) followed by those aged 40 to 49 years (28%, n=20) and university graduates (48%, n=34) followed by secondary/high school educated respondents (30%, n=21) were most likely to report that the Beirut explosion affected their ability or willingness to apply COVID-19 preventive measures. A majority of participants (61%) reported that the Beirut blast affected their mental health.

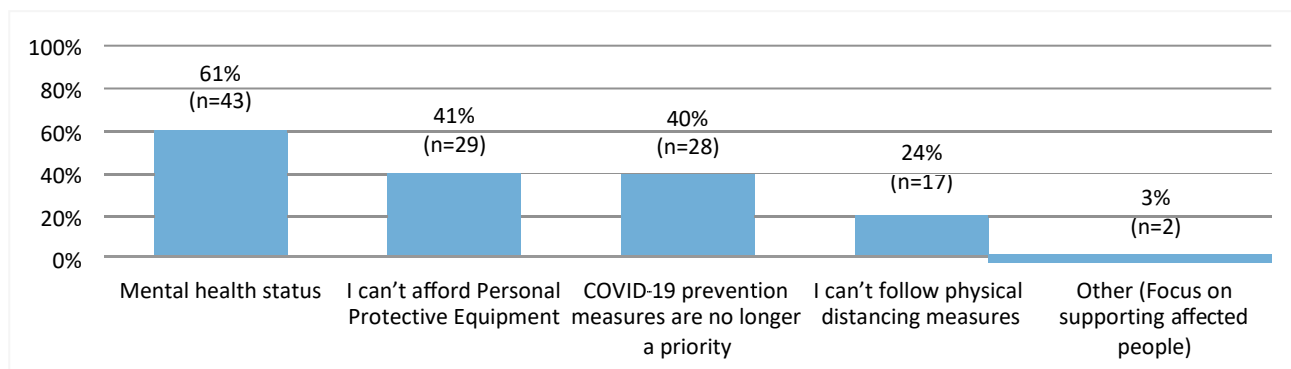


Figure 134. Beirut blast effect on applying COVID-19 preventive measures

Findings: qualitative data

Demographics

Seven key informant interviews were conducted with individuals who were involved with some aspect of the LRC awareness sessions, from a municipality (1), Union of Municipalities (2), Governorate (1), Community Emergency Response Team (CERT) (1), not-for-profit organisation (1) and nursery (1). They were all of Lebanese nationality and resided in their respective communities. In addition, two FGDs were conducted, one with LRC DRR Unit volunteers, all of whom resided in the city of their respective DRR branch, and one with LRC DRR Headquarters staff.

Figure 14. Interview and focus group discussion participants

	Organisation / entity	Role	Residence
Key informant interviews	Choeifat municipality	Head of Communication	Choeifat
	South Governorate	DRM South Governorate Focal Point	Saida
	Hariri Foundation	General Director of crisis risk management	Saida
	Union of Tyr Municipalities	Head of the Administrative Department of the Union of Municipalities of Tyr (Managing Director)	Tyr
		Director of the Disaster Management Unit of the Federation of Municipalities of Tyr	Tyr
	Bric a Brac Nursery	Director and owner	Sehaileh
	CERT Burj Chemali	Head of the CERT in Tyre -- Ali Manna'a	Burj Chemali, Tyre
	Union of Kesrwan Municipalities	Head of Department of local development office	Kesrwan
Focus group discussions	LRC, DRR volunteers	Volunteer, DRR Tripoli branch	Tripoli
		Volunteer, DRR Baalback El Hermel branch	Baalback El Hermel
		Paramedic and volunteer, DRR Jezzine branch	Jezzine
		Volunteer, DRR Saida	Saida
		Volunteer EMS, DRR and trainer, Tyre branch	Tyre
		Volunteer, DRR Kesrwan branch	Kesrwan
	LRC, DRR Unit Staff	DRR Unit Director	Beirut
		Training and Development Officer	Beirut
		National Field Coordinator	Beirut

Perceptions of LRC awareness interventions

This section outlines the participants' perspectives of the awareness interventions described in the introduction of this report.

Rationale of the RCCE approach

Key findings: Interventions were targeted to specific groups, based on needs and requests; content and method were continually adapted based on feedback and new information; existing approaches were built on and continually adapted to the changing context; the approach was holistic and viewed COVID-19 within a broader context of needs and priorities.

A number of the DRR volunteers and staff members offered their perspectives on the rationale for the LRC's RCCE approach, in terms of content and delivery methods. They recounted that the awareness sessions were often provided as a response to requests for support and were based on communities' needs and the demand for information. For example, through coordination with relevant national stakeholders, municipal response and action plans were disseminated to over 920 municipalities. These supported the establishment of crises units for responding to COVID-19, and included sharing

information on quarantine guidelines amongst other topics. The sessions were tailored for different audiences, and materials were constantly adapted based on feedback from the community and trainers. To be responsive to the evolving COVID-19 pandemic, sessions were also continually adapted in light of new and changing information. It became clear that sessions which focused only on basic information about COVID-19 and its prevention measures were no longer of interest, so sessions were adapted to focus more on the measures and procedures different entities need to have in place, and how people need to adapt as they return to their usual activities post-lockdown. Sessions have also had to adapt to incorporate other emergencies, such as the Beirut blast, with the Youth Initiative being taught to stay safe from COVID-19 at the same time as dealing with the dangers of structurally unsafe buildings during rescue operations. Changes occur in near real-time to ensure the interventions are the best possible fit at any given point. The approach was also broader than just information provision – LRC continued to work with municipalities to build response teams, to design and implement response and action plans, and to provide ongoing support to partners.

The interventions built on a long-standing community-based approach that has covered many topics in the past. An important aspect of the approach's success is the solid relationships LRC has built with different partners over time. In addition, to reduce confusion and maintain trust among the community, key partners all agreed to share consistent messages about COVID-19.

Relevance and usefulness of key messages

Key findings: Basic COVID-19 awareness sessions were highly relevant at the time they were delivered; the context and priorities changed; interventions were relevant and useful because they were targeted towards specific groups, based on needs and requests; awareness sessions were useful for correcting misinformation; awareness sessions were useful as part of a broader community engagement approach.

Participants thought that the awareness sessions on COVID-19 and its preventive measures had been highly relevant at the time they were delivered, giving the *“right piece of advice at the right time”*, and correcting misinformation circulating in the community. There was, however, a sense that the same content would no longer be relevant now, since general awareness about COVID-19 had greatly increased over the past year, and people were no longer seeking basic information about the virus and precautionary measures. Instead, people were seeking information about how to adapt to the *“new normal”*, and to continue to go about their lives safely.

Participants thought that, overall, the sessions contributed to increasing community awareness about COVID-19 and highlighted instances of observed and self-reported behaviour change, which they believed was a result of the sessions.

“At first people showed up without masks, then throughout these sessions people were learning, benefitting, and applying the needed preventive measures”. (Hariri Foundation)

“These awareness sessions and the efforts to make it inclusive for the community has been effective to the extent that the behaviour change was noticed among Tyr residents who started practicing COVID-19 preventive measures by respecting physical distancing in public gatherings and crowded areas (shops and supermarkets), and more people were wearing masks on the streets”. (Union of Tyr Municipalities)

The sessions that had been provided to municipalities about how to form a response unit, and its roles and responsibilities, were emphasised as being highly relevant and useful.

The participant who worked at a nursery confirmed that the sessions had the added value of providing additional confidence that their approach to COVID-19 was a good one. However, she also highlighted barriers to complying with the suggested prevention measures, such as maintaining physical distancing between children and preventing toys being shared.

It was generally perceived that awareness sessions focusing on the COVID-19 vaccine would be highly pertinent now, particularly in terms of correcting misinformation, and encouraging and facilitating uptake. Participants also recommended that there needed to be communication about the importance of maintaining precautionary measures between doses. They suggested that refresher sessions about COVID-19 prevention measures were needed and should include the most up-to-date information. Volunteers highlighted a need for more specific information on response to COVID-19 cases, and on plasma donation.

Effectiveness of the broader community engagement approach

Key findings: Coordination and leveraging existing networks and partnerships was important for an effective response; ongoing support and communication from LRC was key to improving the response; LRC's broader approach and capacity-building helped to raise awareness, including about municipal roles and responsibilities; interventions were targeted based on needs.

The qualitative research highlighted that the value of LRC's approach is that it is not just about messaging or raising awareness, but that the awareness interventions are part of broader community engagement that involves providing support for the creation and implementation of response and action plans, the formation of emergency response units, training municipalities on how to respond to COVID-19, and providing ongoing support and monitoring. As emphasised by one of the DRR Unit staff, *"it's not just about the messages, it's also about creating a system to support this."* LRC's approach to coordination, leveraging networks, building on existing partnerships and making use of the different organisations' skillsets and strengths was also thought to have contributed to the success of LRC's response, and avoided duplication of effort.

Respondents mentioned that LRC's capacity-building work and support for the creation and implementation of response and action plans, and the formation of response units, helped to raise awareness among municipalities about their roles and responsibilities. This, along with the ongoing support, monitoring and communication based on need, was thought to have improved municipal responses to COVID-19. In particular, providing guidance to municipalities on how to distribute tasks according to expertise, how to reflect on their own capacities, how to leverage networks and how to monitor the status of COVID-19 was thought to have yielded positive results. The ongoing capacity-building of LRC volunteers themselves was also seen to be an important and constructive aspect of the approach.

A key element for raising awareness amongst different population groups in the community was the support LRC provided to municipalities to make direct contact with people by visiting shops, supermarkets and other institutions, and to pass on information in a tailored way. Messages received from LRC were shared onwards through community interventions run by municipalities and other organisations, as well as by LRC volunteers. It was noted that workshop participants also passed on information directly to friends and family members.

Respondents cited low or decreased COVID-19 case numbers in their geographical area or institution as an indicator of the effectiveness of LRC's broad RCCE approach.

"Our relationship and cooperation with the LRC started in 2010 and we didn't work only on COVID-19 awareness sessions, therefore we consider them valuable partners. Our partnership with the LRC is special, there is a continuous high level of coordination with them that is not present with any other organisation. They are a part of our small kitchen that cooks (preparing, planning and operating) everything that needs to be delivered to the community". (Union of Tyr Municipalities)

Accessibility and appropriateness of awareness interventions

Key findings: LRC's awareness interventions had wide coverage; using multiple channels and formats, and leveraging and building networks all contributed to the wide reach; interventions were targeted towards specific groups; the onwards sharing or cascading of information by session participants contributed to the wide reach; simple, clear delivery in an appropriate language and format made the sessions accessible; online interventions were not accessible to all; there was a preference for face-to-face delivery; refugees, elderly and youth were harder to reach and engage.

Respondents considered that LRC's awareness interventions had wide coverage across the Lebanese population. A number of factors were thought to contribute to this. The LRC used multiple channels and formats to deliver the information, including a hotline, social media and WhatsApp, television, games for children, and awareness sessions targeted to different groups, such as unions of municipalities, municipalities and CERT teams and schools. This broad approach, together with the leveraging of existing networks, allowed for greater reach, as each contact point shared the information further through the community via their own networks.

Interventions were targeted to specific groups in order to ensure the language and format were appropriate, and the delivery was clear and simple to ensure comprehension. Sessions were delivered by local trainers who were versed in the local context and idioms. In addition, LRC coordinated with the unions to ensure presentation materials were appropriate and used participatory methods to fully engage participants. They ensured ample time for discussion and questions, and adapted materials based on feedback received.

A general preference for face-to-face interventions was acknowledged, but this was impossible during periods of lockdown. LRC therefore made the switch to online sessions, adapting existing training materials (PowerPoint presentations) for online delivery. While DRR staff and volunteers highlighted that this allowed for a larger number of people to be included in each session, and even allowed for people outside the country to be reached, it was well understood that there were particular groups which had difficulty accessing online sessions or content. Not everyone had a stable Internet connection, and there were frequent power cuts. The elderly were thought to have limited technologically literacy, and it was likely that Syrian refugees living in camps may not have Internet access or be able to afford phone data. To overcome these challenges, LRC tried to use diverse channels, including leveraging their connections with local authorities and local institutions, distributing flyers and posters, and sending messages on WhatsApp. As much as possible, LRC still try to use face-to-face methods for low-tech communities whilst clearly observing COVID-19 safety precautions.

Engaging youth presented a different challenge. LRC volunteers recounted that while the elderly seemed engaged and interested in the content, young people did not always seem to take the sessions seriously. Other challenges that existed in reaching a wide audience included finding a convenient time for people to participate outside of their work commitments, and the lack of CERT field staff to disseminate information to communities.

Trust in the Lebanese Red Cross

Key findings: LRC were widely trusted; they were considered neutral, experienced and knowledgeable; they were seen to be accessible, dependable and provided ongoing support based on needs and requests; they had strong local networks and a community-based approach; consistent messaging among key players built trust.

All participants emphasised that LRC is well-known and widely trusted across Lebanon. Common reasons given for this high level of trust were the LRC's neutrality and lack of political affiliations, and its experience, capacity and knowledge built up over decades working across the country. Participants also mentioned the importance of LRC's local connections and networks, with volunteers coming from and residing in local communities. LRC was also praised for its accessibility as participants described the

level of ongoing and consistent support provided by LRC during the COVID-19 pandemic and the fact that the organisation could be depended upon to respond to requests for assistance at any time of the day or night.

“LRC is the most trusted organisation by the people. The trust in LRC ranks number one”. (Choeifat municipality)

“Every family in Saida has at least one person active with the LRC, whether in the EMS, DRR, blood bank, etc”. (South Governorate)

“LRC never rejected a request from the municipality, whether in management or in guidance. Several times the municipality contacted LRC in the middle of the night and even around around 3 and 4 a.m. in the morning for support with COVID-19 cases, because at first things were very worrying and the municipality didn’t have the expertise”. (Choeifat municipality)

DRR Unit staff and the Governorate Focal Point concluded that the fact larger entities (including UNDP’s Disaster Risk Management Unit at the Presidency of the Council of Ministers, UNICEF, WHO and LRC) all coordinated to provide consistent messaging about COVID-19 helped to build people’s trust both for these organisations and the response in general during the COVID-19 pandemic. DRR staff thought the LRC’s ongoing service provision (Emergency Medical Services, blood banks, DRR) over many years had helped to build the community’s trust in the organisation, and that the existing trust helped to facilitate LRC’s ongoing work.

In general, respondents thought LRC’s response to the COVID-19 pandemic had been highly effective, and that the provision of information was timely. It was suggested that further in-kind support (such as masks and sanitiser) could enhance the response by making it more feasible for people to put the information received into action.

Broader communication environment and general awareness about COVID-19

The following section provides an account of participants’ perspectives on the general level of community awareness about COVID-19 and the COVID-19 vaccine, and people’s access to information and preferences for communication.

Community awareness about COVID-19

Key findings: At the time of the study there was a high level of basic COVID-19 awareness in the population; conspiracy theories persisted about the non-existence of COVID-19; people had changed their views / perceptions as a result of personal experience.

Participants thought that over the course of the last year, the community’s basic awareness about COVID-19 had improved and was at a high or acceptable level at the time of the study. Despite this, it was made clear that some people continued to believe that COVID-19 was part of a conspiracy and that the virus did not exist. Similarly, not everybody adhered to prevention measures. It was thought that people’s belief in the existence of COVID-19 and their compliance with public health measures had increased partly due to personal experience, as people began to see family members becoming infected or dying from COVID-19. Awareness was thought to remain lower amongst some groups, including refugees and young people.

“At first people weren’t accepting that COVID-19 exists but after the new year celebrations and the high increase in COVID-19 cases throughout Lebanon, many people got infected with COVID and others realised that they are at danger of testing positive which pushed them to adopt preventive behaviours to stay safe or keep their families safe”. (Union of Kesrwan Municipalities)

“Now the situation is much better, community awareness increased, I would still see some people being reckless, but the majority is now adopting prevention measures due to fear, and worry from seeing their loved ones suffer or die from COVID”. (CERT Burj Chemali, Tyre)

Community perceptions of the COVID-19 vaccine

Key findings: There was a lot of misinformation circulating about the COVID-19 vaccine; people were concerned about possible side effects and specific vaccines; awareness about the COVID-19 vaccine had increased to some extent due to awareness efforts.

Although awareness had improved, participants highlighted that there continued to be a high degree of misinformation circulating about the COVID-19 vaccine. There were many doubts within the community about specific vaccines and concerns about possible side effects, including that the vaccine was “*killing people*”. An enduring belief amongst some of the population that COVID-19 does not exist was also seen to contribute to the sense that the vaccine was not necessary. The media was thought to be contributing to confusion among the community and generating doubts. Municipalities have tried to combat misinformation by referring to authoritative sources such as the Ministry of Public Health (MoPH), WHO and LRC. The need for further awareness interventions regarding the vaccine was emphasised. LRC volunteers stated that when they engage people in discussion about the vaccine, people show a high level of interest in the topic.

Communication preferences and access to accurate and usable information

Key findings: LRC is thought to be a preferred source of information for the community; a wide range of communication channels were used to access information; the onwards sharing of credible information by the municipalities and local organisations was key at the community level; different groups preferred different communication channels; accurate information was readily available, but people’s ability to distinguish between accurate and false information was questionable.

LRC was most often cited as a preferred source of information within the community, however there may be some response bias due to the fact that respondents had all been involved with LRC awareness sessions and it was understood this study was being conducted for LRC. A plethora of other channels of information were also mentioned including social media, television, roaming cars with loudspeakers, other media, different organisations that disseminate information through brochures or awareness sessions, doctors (not always qualified), Google and other websites, word-of-mouth, telephone messages from the Ministry of Public Health, hotlines, the police force and direct communication inside supermarkets, pharmacies and gyms. (Preferences at the national level or among specific groups are not identified in the data set). The WHO, MoPH, DRM and UNICEF were all regarded as trusted sources of information, and along with LRC were providing consistent messaging and information to reduce confusion and misinformation.

The onwards sharing of information from the WHO, MoPH and UNICEF and by other entities at the community level was key. The DRM unit shared information with the Governorate, which shared it with the unions of municipalities and municipalities for further dissemination through Municipal Emergency Response Units, face-to-face groups, social media pages, online and television networks (Murr Television (MTV) and the Lebanese Broadcasting Corporation International (LBCI). Local organisations, including political organisations, also played a key role in disseminating information at the community level, often through brochures. Town crisis cells were considered to be reliable and trustworthy information sources for many community members.

Different groups were thought to have a different preference for communication channels. For example, the elderly and refugees were seen to have a preference for face-to-face communication,

while young people may be more inclined to use social media. Television was thought to be a key medium for people who could not attend training sessions.

Participants suggested that although credible information about COVID-19 was readily available, there continued to be a lot of misinformation circulating, both through the media and informal channels. There was some difference of opinion among respondents as to the extent to which media literacy had improved. It was thought that people were still struggling to differentiate between credible and unreliable information, and continued to share misinformation. Positive behaviour change had been observed, indicating that the information received was being actioned; however, participants also reported a need for more in-kind support, such as masks, to facilitate people's adherence to the recommended measures. As the South Governorate Focal Point concluded, "When you ask people to wear a mask, they ask you to provide them with a mask".

"People are not able to differentiate between reliable info and misinformation, and this is leading to rumours. There is a lot of misunderstanding towards this subject". (Bric a Brac Nursery)

"Surely, there is always a huge amount of misinformation circulating among the community, however people now know how to differentiate between fake and reliable information; people learned that there is a need for them to double check the information before they disseminate it with others and now they know who to refer to when they need reliable information...". (CERT Burj Chemali, Tyre)

"Although people know now how to access reliable information, they still listen to each other and have a role in spreading rumours or false information and the media doesn't help much here". (Union of Kesrwan Municipallities)

Dealing with multiple emergencies – the economic crisis, COVID-19 and the Beirut explosion

In order to understand whether LRC's RCCE approach continued to be relevant in the face of multiple simultaneous emergencies, respondents were asked about the effect the economic crisis and the Beirut blast had on their ability to carry out their roles, and on people's abilities and interest in complying with COVID-19 prevention measures or attending awareness sessions.

Effect on the work of local authorities and responders

Key findings: Decreased municipal revenue and lack of resources affected normal work and reduced COVID-19 response capacity; the economic crisis and Beirut blast caused a shift in priorities.

Decreased municipal revenue due to the economic crisis and the Beirut blast reduced the capacity of municipalities to provide regular services such as healthcare and medicines. They also impacted the ability of municipalities to adequately respond to the pandemic by providing COVID-19 testing and in-kind support such as face masks and hand sanitiser. Municipalities found they had to shift their focus from providing services to coordinating donations from other organisations. One respondent suggested that funds designated to municipalities to assist people in need had to be redirected to pay the operational costs / debts of the municipalities, and funds were not assigned to the most vulnerable in the community.

The blast caused a shift in priorities and need, with both municipalities and non-governmental organisations having to focus on rescue and recovery efforts, as well as finding shelter and food for affected people (often including their own staff). The concurrent crises interact with each other such that the lockdown compounded an already acute economic crisis, and both the economic situation and the blast contributed to an environment in which virus transmission accelerated.

Effect on people's ability to follow prevention measures and attend awareness sessions

Key findings: A lack of resources and in-kind support reduced people's ability to follow measures such as mask-wearing and handwashing; at the time of the study people were more interested in receiving in-kind support than information; people could not always comply with lockdown or quarantine as they needed to work; the psychological impact of the Beirut blast caused people to change their priorities and worry less about COVID-19.

The economic crisis, compounded by COVID-19 and the blast, led to a situation in which individuals did not have the resources required to be able to comply with measures such as mask-wearing and handwashing. Similarly, municipalities did not have the resources to provide in-kind support or services such as COVID-19 testing. In addition, people struggled to comply with lockdown measures and quarantine due to the need to leave home to work. LRC provided food parcels to those needing to stay home, but participants called for more in-kind support to enable people to comply with public health measures.

The Beirut blast also had a significant psychological impact on the population, causing a shift in their priorities. In worrying primarily about the emergency at hand, their loss (both personal and economic) and uncertainty about the future, COVID-19 became less important. As a result, COVID-19 transmission increased and there was a surge in cases.

"The psychological impact that the Beirut blast had on the Lebanese delayed the response to COVID-19 and resulted in the surge in cases not only in Beirut but throughout Lebanon". (Union of Kesrwan Municipalities Focal Point)

"With the explosion, people changed their interests. They lost their families, their belongings. So they were not really wearing face masks, etc. That increased the number of positive cases". (DRR Unit HQ)

"For the Beirut Blast, it had a psychological impact on every single Lebanese; it created a psychosocial perception among people not knowing what the future holds for them anymore. Their focus was shattered towards the consequences of the blast and insecurity reigned among Lebanese who were worried about their safety and the safety of their families, forgetting the COVID-19 pandemic". (Hariri Foundation)

It was noted that, at the time of the study, people already had a high degree of knowledge and were more interested in receiving in-kind support to be able to adhere to prevention measures they are aware of, rather than receiving information. It was reported that some people attended awareness sessions primarily to receive in-kind incentives such as face-masks, hand gel and food. Conversely, the lack of time to attend sessions and the cost of transport were thought to be barriers to participation. As a result, municipalities have shifted the focus of their awareness sessions to more social aspects such as cash for work, rather than COVID-19. LRC has redesigned awareness sessions for groups going to respond to the blast, to incorporate both information about how to be safe from COVID-19 and wear correct personal protective equipment whilst responding to the emergency, at the same time as being safe from the dangers of unstable structures and rubble. As such, the delivery of COVID-19 information was made relevant given the changing context.

"The number of people willing to attend awareness sessions has greatly decreased amidst the economic situation and after Beirut explosion as receiving information is not a priority anymore". (Union of Tyr Municipalities Focal Point)

Community consultation about COVID-19 prevention measures

Key findings: There was limited capacity for community consultation at the governorate and municipal levels; there was a need for in-kind support rather than just messaging; local organisations and response teams were able to collect feedback through their regular activities and through partners, to enhance the response and build trust.

Participants at the governorate and municipal levels reported that they had not collected community perception data about COVID-19 prevention measures due to their limited capacity. The Union of Tyre Municipalities Focal Point suggested an app or form for collecting feedback could help facilitate this. However, even without having formally collected feedback, respondents felt that there was a need for in-kind support for communities rather than just messaging if they were to comply with recommended measures such as mask-wearing. The Hariri Foundation leveraged its community networks to collect insights from diverse areas through the Crisis Management Committee. Partners that provided feedback included the security forces, LRC, hospitals, municipalities, and NGOs. The Burj Chemali CERT continuously gathered community perceptions during their activities, including hosting quick discussions at which notes were taken. This feedback and information about the community's needs and experiences were shared and discussed at meetings with LRC, and integrated into the COVID-19 response, thereby enhancing the response and awareness raising efforts, and building trust.

Discussion

The following section provides a discussion of the findings, including triangulation between the quantitative and qualitative data sets and the findings of the literature review. It considers perceptions of LRC interventions; the broader communication environment and general awareness about COVID-19; and the affect of dealing with multiple emergencies. Discrepancies in the data are also reflected upon.

Perceptions of LRC awareness interventions

Relevance and usefulness of key messages

The majority of survey participants (96%) thought the information received through LRC was applicable and realistic and 99% stated that they used the information, either by applying prevention measures, monitoring their health and identifying symptoms, sharing messages with others, or managing COVID-19 cases. This was in line with the qualitative data, in which participants revealed observed and self-reported changes in behaviour to apply COVID-19 prevention measures. Participants themselves self-reported changes in their own behaviour (such as implementing changes to prevention practices in the nursery, being able to more adequately respond to COVID-19 cases as part of an emergency response team, or being able to more competently share correct information with the community). LRC volunteers also reported observed changes in the community; for example, volunteers who returned to monitor schools where they had conducted awareness sessions found that the staff were applying the knowledge shared. Volunteers also attributed generally improved prevention practices in the community to the wide reach of LRC's awareness sessions.

Women were more likely than men to report using COVID-19 information provided by LRC to manage a case of COVID-19. This was not surprising, since women generally carry a higher burden of care for sick family members (Kronfol, Rizk, and Sibai 2015). In general, people in employment were more likely to report using COVID-19 information provided by LRC to apply prevention measures. This may be because employees were continually having this information reinforced by their employers. University degree holders were more likely to report using the COVID-19 information provided by LRC to monitor their health and identify symptoms, apply prevention measures and manage COVID-19 cases. University degree holders also had additional access to other sources of information, such as university portals, and may have had constant reinforcement of messages via their universities. The small number of survey participants who said that they (or their communities) did not use LRC's information suggested this was because of an unwillingness at the community level to abide by the measures, or because COVID-19 was not the main priority where they live.

Almost 60% of survey respondents thought the interventions had greatly contributed to raising community awareness about COVID-19. This correlates with the findings of the qualitative research, in which participants highlighted that the sessions were relevant, useful and raised awareness about COVID-19. Other research has highlighted mistrust in the government as a factor contributing to non-compliance with public health measures (Makhoul, Kabakian-Khasholian, and Chaiban 2021). With regards to LRC, however, levels of trust remain high, and this appeared to be a contributing factor to people's willingness to adhere to their recommended measures. In addition, the decision to align messages between key RCCE players, including the government, was thought to have increased trust in messaging.

When the research participants attended awareness sessions was not recorded. The qualitative research highlighted, however, that while basic COVID-19 awareness sessions had been relevant and useful at the time they were held, the context and priorities had since changed. At the time of the study, people were more aware about COVID-19 and sought information about how to resume their everyday activities under changed circumstances. In addition, the economic crisis and Beirut blast shifted the demand from information to in-kind support, such as food, face masks and hand sanitiser.

Only people who had already attending an awareness session were included in the study, and it was unclear whether some groups, such as refugees, IDPs, migrant workers, those living in rural areas, elderly people and those with fewer resources were being effectively reached by the interventions. As such, further research should be conducted to better understand the relevance of key messages for these groups, taking into account social and cultural factors, social determinants such as education, age, gender and income, and environmental factors such as living conditions and access to services. This is particularly important given some of the inconsistencies in the existing data (El Othman et al. 2021; Domiati, Itani, and Itani 2020).

Accessibility of interventions

The majority (97%) of survey respondents stated that they received information from LRC in their preferred language. This was not surprising, since most of the survey respondents (including refugees) were Arabic speakers and the sessions were conducted in Arabic. Qualitative survey respondents mentioned the wide reach and the efforts made to target as many different groups as possible. Of the survey participants, 84% reported that it was “very easy” or “easy” to access information through LRC, although again it should be noted that all survey participants had attended an LRC awareness session and the survey was not designed to include those who had not. In line with the qualitative findings, however, several groups were identified as not being reached by the awareness sessions. Participants highlighted that refugees and the elderly were specific groups that were hard to reach, and that youth were difficult to engage. Survey respondents also mentioned that LRC awareness sessions did not effectively reach the elderly, children, refugees, people with disabilities, IDPs, migrant workers, adolescents, pregnant women and the LGBTQ community.

Broader communication environment and general awareness about COVID-19

Community awareness about COVID-19

Interview and focus group discussion participants thought that there was an adequate level of COVID-19 awareness among the public at the time of the study. This finding was aligned with the results of other online surveys (UNICEF 2020), however the study’s quantitative data revealed that low numbers agreed with the imposition of measures such as the wearing of face masks, physical distancing, lockdown and limiting public gatherings. It was not clear whether this was more to do with a rejection of imposed measures by the government; a belief that adherence to the measures was not feasible for many people; or because of the perception that measures were essentially ineffective. A number of online surveys conducted prior to the Beirut blast indicated high levels of self-reported compliance with measures such as mask-wearing, and strong support for the introduction of compulsory measures such as physical distancing and quarantine (UNICEF 2020; Domiati, Itani, and Itani 2020; Faour-Klingbeil et al. 2021; Sakr et al. 2020; UNICEF 2021). However, the survey results from this study which was carried out after the blast, paint a different picture.

The majority of survey participants (72%) stated that they would stay home if they had been in contact with someone who had COVID-19, and 69% also said they would get tested, indicating a reasonable level of awareness. The highest percentage of those who would get tested was among the younger age bracket (18 to 29) and among employees. The qualitative data also revealed the perception that misinformation and conspiracy theories about COVID-19 continued to circulate, and that one of the key reasons that awareness of and belief in the virus had increased was due to personal experience, as people’s friends and family members had been infected.

Communication preferences

Interestingly, while most survey participants stated that they preferred to access information via social media (66%), online research (65%) or television (62%), with a smaller number preferring face-to-face sessions (33%), interview and focus group participants were of the opinion that most people preferred face-to-face communication. This may be due to the participant demographics of the survey, with online participants being mostly younger, mostly Lebanese (few refugees) and necessarily having access to a phone and being literate. Both the qualitative study and the literature review revealed a variety of channels used by people to access information, including official government sources, traditional media, social media, UN agencies and international non-governmental organisations. A small number of previously published studies conducted in Lebanon found social media and television to be important communication channels, although the majority of these studies were conducted online, meaning that they were not representative of the population who may not have access to the Internet (Faour-Klingbeil et al. 2021; UNICEF 2021; UNICEF 2020). Elderly people were generally less likely to use social media, although one study indicated an increase in digital activity by elderly people since the start of the pandemic (Khoury and Karam 2020). It has been frequently highlighted that refugees and migrant workers are likely to have restricted access to information and have specific communication needs (Makhoul, Kabakian-Khasholian, and Chaiban 2021 ;Human Rights Watch 2020). These findings suggest there is a need for greater understanding of the communication ecosystem across Lebanon and how different groups prefer to receive and provide information.

Most survey respondents confirmed they referred to social media, online research and television to access COVID-19 related information. The data indicated that retrieving COVID-19 information through certain channels was dependent of nationality, age, gender, educational level and governorate. Lebanese participants (92%) reported to opt for booklets/flyers to retrieve information about COVID-19 but this could be related to the fact that the majority of survey participants was Lebanese. Respondents aged 18 to 29 years were the most likely to report using radio and WhatsApp. WhatsApp was likely to be used by both males and females equally, while face-to-face sessions were preferred by males (54%) compared to female participants (46%). This could be related to the fact that females who work and/or take care of the house might not have time to participate in face-to-face sessions. University degree holders mostly reported using online research (59%), booklets/flyers (58%), online training sessions (58%), and personal contact with health professionals (56%) to access COVID-19 information. This could be explained by the fact that the sample had the highest number of university degree holders, or it could be that university degree holders would use different trusted channels to search for COVID-19 information. Social media, booklets/flyers, online training sessions, face-to-face awareness sessions and personal contact with family/friends/neighbours depended on Governorate. Social media and online training sessions were mostly referred to by Mount Lebanon residents, while booklets/flyers, face-to-face sessions, and personal contact with family/friends/neighbours were mostly referred to by South Lebanon residents. These results could be related to the division of the sample which was not representative of each governorate, where the higher proportions of participants were from Mount Lebanon (38%) and South Lebanon (37%). The results could also be linked to the fact that South Lebanon is more rural than Mount Lebanon.

The qualitative analysis that indicated LRC was the most trusted source of information was in line with the survey results, as 71% of respondents selected LRC as their most trusted source. This findings is also supported by the internal real-time evaluation of RCCE interventions by LRC, which revealed high levels of trust in the society (Lebanese Red Cross Disaster Risk Reduction 2020). Again, the risk of response bias should be noted. Other trusted sources included health professionals (reported by 70% of the survey respondents), and the WHO and other UN agencies (reported by 43%). These were also mentioned as trusted sources during the qualitative research. Similarly, a Knowledge, Attitudes and Practices (KAP) study conducted by UNICEF in 2020 found that there was a high level of trust in healthcare workers, international organisations, and the MoPH. Community health workers were also mentioned as being trustworthy by 31% of the survey respondents. The municipality was cited as the least trusted source (only mentioned by 25% of respondents), a finding aligned with another study that concluded there was a low level of trust in information received from local authorities about COVID-19

(Faour-Klingbeil et al. 2021). Conversely, one interviewee from a Community Emergency Response Team stated that because of their close work with LRC, their capacity had improved, and along with their endeavours to collect and incorporate community feedback, people had come to trust the CERT and referred to them as authorities on COVID-19 matters. Further research should investigate this further, but it may be a useful case study on how to improve and build community trust in local authorities.

The WHO and other UN agencies were trusted the most by people aged 18 to 29 years (41%) and by university degree holders. Municipalities were trusted more by males than females, and most trusted by people aged 30 to 49 years and by holders of a university degree. University degree holders were more likely than others to trust health professionals. Referring to trustworthy information through the MoPH, municipalities, community leaders and religious leaders and other (work, LRC, civil defence, scouts) was dependent on occupation. Referring to trustworthy information through MoPH, Palestinian Red Crescent Society in Lebanon, IFRC, ICRC, municipalities, and community health workers was dependent on governorate and was mostly cited by South respondents. Once again, there is potential bias in these findings as the survey respondents were resident in Mount Lebanon (n=190) South Lebanon (n=183) and Beirut (n=77) governorates.

Access to accurate and useful information about COVID-19

Whilst the survey did not reveal the sources of specific information or the accuracy of information received, the majority of survey participants (more than 80%) stated that they had received information on the routes of transmission and on COVID-19 symptoms, prevention measures, and isolation measures. Most (ranging from 58 to 76%) stated that they had received information on risks and complications of COVID-19, on the process of reporting COVID-19 infection, testing information, and contact information (hotline) for health assistance. Almost half of the respondents stated that they had received vaccine-related information and mental health information. Only 35% of survey participants stated that they had received information on the new variants of concern, and those with university degrees were most likely to have received information on this topic. Participants in the qualitative study felt that misinformation continued to circulate about the COVID-19 vaccine, and that more awareness was needed on this topic. This was also reflected in the literature (Chamat et al. 2020). Interview and focus group participants had varying opinions as to the extent to which people had the ability to distinguish between inaccurate and correct information.

Most of the survey participants (96%) thought that the information they received about COVID-19 was applicable and realistic, and the majority thought that it was “very useful” or “somewhat useful”. Male respondents were more likely to report that the information was useful, as were people with a higher level of education. The small percentage of respondents who did not find the information to be useful linked it to the unwillingness at community level to abide by the measures, to the inapplicability of the communicated measures where they lived, and to the fact that COVID-19 was not the main priority where they lived.

Community perceptions of the COVID-19 vaccine

Only 23% of survey respondents said that they trusted the vaccine “very much”, whilst 41% had moderate trust in it, and 9% did not trust the vaccine at all. Another study from early 2020 found that 66% of respondents were likely to take a COVID-19 vaccine as soon as it was developed (Qahoush 2020), but more recent social media activity indicated a trend of increasing negative sentiment towards the vaccine (UNICEF 2021). This is in line with the findings of this study. The quantitative survey found that older people, males, and those with a higher education level were more likely to trust the vaccine. Only 30% thought the vaccine would protect them and their community a lot. Lebanese reported to believe less in the vaccine’s protection from COVID-19 compared to other nationalities. Of the total survey respondents, 90% stated that they knew how to register for the vaccine. Respondents with advanced university degrees, university undergraduates and individuals who completed secondary level education

were more likely to know how to register for the vaccine compared to individuals who did not have a formal education and those who had reached elementary/ primary education. Unemployed respondents and retirees knew less about how to register for the vaccine compared to employees and business owners.

More than half of the survey's respondents had concerns about the vaccine (58%). The younger cohort (18 to 29 years: 38%), employees and business owners, and females (73%) were more likely to report having concerns around the vaccine. Of these, 36% perceived the vaccine to be dangerous and 26% thought it was ineffective. The younger cohort (18 to 29 years) and females were more likely to believe that the vaccine was dangerous. This was in line with the qualitative findings, in which participants suggested that there was a high degree of misinformation circulating about the vaccine and people were concerned about its safety. The qualitative data also linked the perception that the vaccine was ineffective to the notion that COVID-19 did not exist, pinpointing the media as contributing to confusion and misinformation about the vaccine.

Dealing with multiple emergencies – the economic crisis, COVID-19 and the Beirut explosion

Effect on people's ability to follow COVID-19 prevention measures

The qualitative and quantitative data both indicated that people were struggling to purchase basic necessities and access basic healthcare due to the multiple emergencies. However, there was disparity between the two data sets with regards to whether the Beirut blast had affected people's ability or willingness to apply COVID-19 preventive measures. In line with an case study on the blast by IFRC (IFRC and LRC 2020), interview and focus group participants suggested that people did not have the resources to be able to comply with measures such as mask-wearing, handwashing and staying at home. Yet, 86% of survey respondents said that the blast did not affect their ability or willingness to comply. Participants aged 30 to 39 years were the least likely to be willing to apply measures, followed by those aged 40 to 49 years, as well as those with a higher level of education. This discrepancy be due to the sampling, as the people struggling the most to access basic items or most affected by the multiple emergencies may not have been in a position to complete the survey.

Of those who did not feel able or willing to apply prevention measures, 61% of survey respondents confirmed that the blast had affected their mental health, 41% said that they could not afford personal protective equipment, 39% said that COVID-19 prevention measures were not a priority anymore, and 24% stated that they were not able to apply physical distancing measures.

Conclusions and recommendations

LRC interventions

Study participants reported that information received through the LRC was **relevant, applicable and realistic, that it raised awareness among the community**, and that it **is being used** by the community either to apply prevention measures, monitor their health and identify symptoms, share messages with others, or manage COVID-19 cases. The qualitative data revealed observed and self-reported changes in behaviour to applying COVID-19 prevention measures, which was thought to be attributable to LRC's awareness interventions. The small percentage who **did not find the information useful** linked it to an unwillingness at the community level to abide by the measures, to the inapplicability of the communicated measures where they lived, and/or to the fact that COVID-19 was not the main priority where they lived.

The qualitative research highlighted that while basic COVID-19 awareness sessions had been relevant and useful at the time they were held, the context and priorities had since changed. At the time of the study, it was acknowledged that people were more aware about COVID-19 and instead of seeking information about the virus were focused on securing information about how to resume their everyday activities under changed circumstances. In addition, the economic crisis and Beirut blast shifted the demand from information to in-kind support, such as food, face masks and hand sanitiser.

LRC was considered to have a wide reach, and efforts to target as many different groups as possible had some success. LRC's longstanding presence and access across Lebanon, their established networks and outreach and the high level of trust in which they are held, were important factors. However, it was thought that several groups were **not being effectively reached** by the awareness sessions. In particular, these included **refugees, IDPs, migrant workers, the elderly, youth, children, people with disabilities, pregnant women and the LGBTQ community**. In fact, LRC has reached out to refugees, children and youth through its various RCCE interventions, and it may be that the study participants were not aware of these interventions or did not link them to LRC. In order to effectively reach these groups, more research may be needed to better understand their communication access and preferences. Their needs and priorities and the barriers and enablers to complying with prevention measures need to be well understood in order to design relevant key messages, taking into account social, cultural and environmental factors.

A key aspect of LRC's response is that it is about more than just messaging. The broader community engagement approach that involves building the capacity of municipal response teams and other actors, and providing ongoing support to these actors as required, has been crucial. One study participant felt that the community's trust in the municipality had been directly improved by their work with LRC, which in turn improved people's coping mechanisms and adherence to prevention measures.

Recommendations

- Constantly monitor and continue to adapt and tailor content taking into account:
 - emerging scientific evidence (e.g., about new variants of concern)
 - tackling rumours, mis- and dis-information as they emerge
 - people's current priorities (e.g., the shift from demand for information to demand for support to assist them to apply the information received)
 - the barriers and enablers to complying with protective measures including social, cultural and environmental factors
 - the different information needs of specific groups (e.g., men and women, the unemployed, less educated people, hard-to-reach groups)
 - the need to continually reinforce the need to practice protective measures

- that knowledge does not necessarily translate into action particularly when protective measures may not seem feasible or to be of high priority.
- Confirm findings about hard to reach groups. This will require triangulating the perception data reported here (that some groups may not be accessed) against LRC programme data to confirm if there are indeed gaps in reaching certain groups. And, if necessary intensify efforts to reach hard-to-reach groups, this should consider refugees, IDPs, migrant workers, the elderly, youth, children, people with a disability, and LGBTQ people,
- Identify the specific needs and concerns of these groups first hand, ideally through qualitative assessment using methods such as interviews, FGDs and participatory methods tailored to the specific group, so interventions do not depend on their reported needs by other groups.
- Foster collaboration between different stakeholders and continue to build partnerships to share research findings and work on complementary activities

The communication environment

There is a perception that most people prefer face-to-face interactions, although this was not supported by the survey findings. The survey and other studies (Faour-Klingbeil et al. 2021; UNICEF 2021; UNICEF 2020) reported a preference for social media, online research and television. However, most of these surveys were carried out online or via mobile phone, and therefore fail to represent the population who did not have access to these channels, including refugees, elderly people or illiterate people. More needs to be understood about the communication preferences of harder-to-reach groups, and creative efforts made to engaged them, including using off-line methods. Those with a higher level of education may have access to more diverse channels to receive information about COVID-19, so particular attention should be paid to those with a lower level of education. The survey indicated that the younger age bracket can be reached through radio, and that men can be reached through municipalities and other community-based channels such as the scouts.

LRC is widely reported to be a highly trusted, if not the most trusted, source of information on COVID-19. This finding is aligned with the World Bank Group's recent study findings, which rank LRC as the most trusted entity in Lebanon (World Bank Group 2020). Health professionals, the WHO and other UN agencies were also highly trusted. In particular, the WHO and other UN agencies were most trusted by younger people and more educated people. Data sources revealed a low level of trust in municipalities, but when they were trusted, the study revealed that they were more trusted by men than women. Interview participants suggested, however, that the community had come to have a greater level of trust in the municipality as a result of their close work with LRC.

Recommendations

- Support the development of a more comprehensive understanding of the communication ecosystem across Lebanon and how different groups prefer to receive and provide information, and track which groups are/are not accessing LRC information. Interventions can then be adapted and targeted accordingly.
- Understand the communication needs for harder-to-reach groups, including the elderly, refugees and migrant populations (who were underrepresented in this study) and less educated people. Consider the Internet penetration of these groups and adapt communication techniques to engage with groups who may have fewer communication options.
- Use diverse channels, recognising that preferred channels were dependent on nationality, age, gender, educational level and governorate.
- Continue to work with municipalities and other local organisations to build their capacity to improve community-led responses, provide accurate information, and to increase public trust. Trust building

should capitalise on the high level of trust communities have in LRC. LRC can corroborate the communication efforts of other well-placed organisations, and should ensure alignment with official guidance and encourage acceptance of government measures.

Community awareness of COVID-19

The study showed that people had received basic information on transmission routes, symptoms, prevention measures and isolation measures. Slightly lower numbers reported having received information about what to do to report a COVID-19 infection, testing, and contact information for health assistance. Less than half of survey participants had received information on the COVID-19 vaccine (49%), mental health information (47%) and new variants of concern (35%). In general, people were thought to have an adequate level of basic awareness and knowledge about COVID-19, and to be seeking further information about how to resume their everyday activities safely under changed circumstances.

The qualitative study highlighted that mis- and dis-information and conspiracy theories about COVID-19 continue to circulate, and there remains a high degree of uncertainty about the COVID-19 vaccine. One of the key reasons that awareness of and belief in the virus had increased was due to personal experience, as friends and family members had become infected.

Recommendations

- Provide information about the need to get tested for COVID-19 and how to do it in all governorates, especially Beirut, Bekaa and North Lebanon where lower percentages of survey respondents reported having received information about testing.
- Increase provision of information about what to do and who to contact if they or someone they know shows symptoms of COVID-19.
- Collaborate with research partners, or invest in qualitative research to understand why some groups are more likely than others to apply their knowledge about COVID-19 and abide by public health and social measures.

Community perceptions of the COVID-19 vaccine

Although previous studies indicated greater enthusiasm for the COVID-19 vaccine, this study was in line with more recent online listening activities in revealing a **decreased level of trust in the vaccine**. In particular, **younger people, women, and those with a lower level of education were less likely to trust the vaccine**. Those with a lower level of education and those who were unemployed or retired were also less likely to know how to register for the vaccine. Elderly people, a priority group for the vaccine, may need special assistance to register for the vaccine online.

More than half of the survey respondents had concerns about the vaccine. Younger people, women, employees and business owners were more likely to report having concerns about the vaccine. This was in line with the qualitative research, which highlighted that people lack information about the side effects and safety of the vaccine and about the different vaccines. There is also a continuing belief among a small portion of the population that COVID-19 does not exist, which obviates the need for a vaccine. Participants suggested that the media contributes to confusion and misinformation about the vaccine. There is a **clear need for further awareness interventions on the vaccine**.

Recommendations

- Increase provision of information about the COVID-19 vaccine, including about its side effects, different vaccines, effectiveness, safety, and how to register for and receive the vaccine.
- Proactively and quickly dispel conspiracy theories and myths about the vaccines. This could be complemented by engaging with mainstream media outlets in the country to promote accurate information.
- Develop specific awareness materials tailored to younger people to encourage vaccine uptake among this age group, responding to the specific concerns they identify.
- Intensify efforts to reach less educated people, unemployed people and retirees and undocumented migrants to support them to register for the vaccine.
- Continue to provide support to the municipalities to assist people, particularly the elderly and other groups with limited technology literacy and technology access, to register for the vaccine.

Dealing with multiple emergencies - the economic crisis, COVID-19 and the Beirut explosion

People were **struggling to purchase basic necessities and access basic healthcare** due to the multiple emergencies faced in Lebanon. There was some disagreement across the data sets as to whether the Beirut blast had affected people's ability or willingness to apply COVID-19 preventive measures; however this may be due to the sample of the quantitative survey. Interview and focus group participants and anecdotal evidence reported in the literature review suggest that people **do not always have the resources to be able to comply with measures such as mask-wearing, handwashing and staying at home.**

The small number of survey participants who did not feel able or willing to apply prevention measures stated that the blast had **affected their mental health, that they were not able to afford personal protective equipment or apply physical distancing measures, and that COVID-19 prevention measures were not a priority anymore.** The same applied to people's ability or willingness to attend awareness sessions.

Recommendations

- Contextualise awareness sessions and information provision so that COVID-19 information is received as part of a broader information package. To ensure the sessions are perceived as relevant by participants, they could incorporate aspects such as guidance for mental healthcare, rather than standalone COVID-19 information.
- Where feasible, consider providing basic items such as face masks, hand sanitiser and food at awareness sessions, taking into account the high cost of these items. Collaborate and share information with other partners to emphasise this need.

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