Anthrologica

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

Literature review
(accompanying final report)

Prepared for IFRC, ICRC, LRC, BRC

May 2021

Contents

Introduction

The following review a rapid synthesis of the existing qualitative and quantitative data relevant to COVID-19 prevention, detection and response behaviours in Lebanon, and related RCCE efforts. The purpose of this desk review is to inform the design of the qualitative and quantitative study tools for the project. The review is based on the key documents provided by IFRC and LRC, including programmatic documents outlining RCCE efforts undertaken by LRC in Lebanon, as well as a broader literature search using academic databases.

While the review does not claim to be comprehensive, a rapid search found that there is limited evidence related to COVID-19 behaviours and the efficacy of RCCE strategies in Lebanon. In addition, and as identified in Anthrologica's recent literature review on norms, beliefs and practices relevant to COVID-19 prevention behaviours in the Middle East and North Africa, much of the available data is quantitative (online surveys), with little qualitative evidence (Anthrologica, 2020). There are generally challenges with the representativeness of online methods, as certain sectors of the population, such as the elderly and some migrant worker groups, may not have ready access to the Internet or are not digitally literate (Kerbage et al. 2021) , and online surveys are limited as to the extent to which they can interrogate the underlying reasons for people's behaviours. There are also some inconsistencies within the literature with regard to some determining factors for prevention behaviours, as discussed below.

This section briefly summarises the available literature on the communication environment and RCCE efforts in Lebanon, community perceptions and knowledge about COVID-19, social and cultural drivers for COVID-19 behaviours, environmental and political drivers for COVID-19 behaviours, and specific evidence relevant to vulnerable populations and implications for reaching these populations through RCCE. The review finishes with a profile of community-led responses to COVID-19 in Lebanon.

The communication environment and RCCE response to COVID-19

The ways in which people access, receive, interpret and act on information is influenced by a number of factors, including the broader political and social context, as well as the availability and accessibility of evidence and the extent to which people trust the sources of those messages (Makhoul, Kabakian-Khasholian, and Chaiban 2021). In addition to official government sources, information related to COVID-19 has been shared through a plethora of channels in Lebanon, including television, social media, UN agencies and INGOs. Along with accurate information, much of this has been misinformation, (Chamat 2020) highlighting the importance of understanding the preferred and most trusted channels through which to engage people and share information about COVID-19.

Access to information and communication preferences

People's communication preferences and access, in terms of information source, channel, format and language, differ widely depending on the local and social context. In the broad Lebanese context, people use their social networks to disseminate health information through trusted sources.(Makhoul, Kabakian-Khasholian, and Chaiban 2021). An online survey conducted in Jordan, Tunisia and Lebanon found that social media, local news, and the WHO were the primary sources of information on COVID-19 across the three countries (Faour-Klingbeil et al. 2021a), while an online listening exercise undertaken by UNICEF in Lebanon in January 2021 found that most people preferred to source information from private social media accounts, such as the Twitter accounts of celebrities and influencers, rather than organisational social media accounts (UNICEF 2021). A large telephone-based UNICEF Knowledge, Attitudes and Practices (KAP) study carried out in the first half on 2020 with over 2000 respondents found that around half the respondents always relied on television channels or social media for information about COVID-19, and this cohort was more likely than others to comply with distancing and personal hygiene measures (UNICEF 2020).

Some populations, such as low-resource, rural or elderly residents, may find it easier to access more traditional or offline communication channels due to either Internet connectivity issues or lack of digital literacy skills. One successful example of an off-line RCCE campaign in a small town in rural Lebanon involved sharing prevention information during Christian church masses every Sunday (Kerbage et al. 2021). However, these religious gatherings became prohibited under law during full lockdown periods. The elderly are generally less likely to use digital media; however, older Lebanese have increasingly become more active users of social media and applications such as WhatsApp in the past few years. This trend has increased further since the start of the pandemic, as older people were driven to find ways to stay in touch with their loved ones without being able to see them in person (Khoury and Karam 2020). Online support groups and webinars have become more common for older people, and these networks could present a good opportunity to communicate with elderly Lebanese people about COVID-19 prevention measures.

Refugees and migrant workers may have specific communication needs and require communications to be in their preferred language. The Bangladesh and Philippine embassies in Lebanon have posted COVID-19-related information on their Facebook pages in the appropriate native languages (Makhoul, Kabakian-Khasholian, and Chaiban 2021). These populations may also require different messages, for example, that they can seek medical help without being penalised for lack of legal residence status if they experience COVID-19-like symptoms (Human Rights Watch 2020b). Migrant workers in precarious labour arrangements may not be able to access important health messages if denied access to the Internet by their guarantors (Makhoul, Kabakian-Khasholian, and Chaiban 2021).

The UNICEF KAP study referred to above assessed people's levels of trust in different sources of information about COVID-19 in Lebanon. There was found to be a high level of trust in those considered to be healthcare experts. This included healthcare workers, international organisations, and the Ministry of

Public Health (MoPH), with 89% of respondents saying they trusted these actors. Less than half the respondents, however, completely trusted the MoPH. This varied across governorates, with 87%, 71% and 71% of respondents from Beqaa, Nabatieh and Baalbek-Hermel reporting 'complete trust' in the MoPH respectively, compared to 34%, 36% and 38% in Beirut, Mount Lebanon and North Lebanon. A similar pattern emerged across governorates with regard to trust in healthcare workers. Those that did have complete trust in the MoPH were more likely to comply with hygiene and distancing recommendations (UNICEF 2020). Another study carried out in Jordan, Tunisia and Lebanon found that less than half the respondents overall considered information from local authorities about COVID-19 to be trustworthy, timely and clear, and participants from Lebanon showed a less positive attitude to the local risk communication they had received than their Jordanian counterparts (Faour-Klingbeil et al. 2021a). Another survey found that participants preferred to contact a healthcare provider for health advice (60%), followed by the MoPH (50%), and social media (20%) (Domiati, Itani, and Itani 2020).

On the other hand, an internal real-time evaluation of RCCE interventions by the Lebanese Red Cross (LRC) found high levels of trust in the national society. In many geographical areas, the LRC was the first entity to provide COVID-19 awareness, and the evaluation found that it was considered the leader in COVID-19 awareness provision and a reliable and trusted source for relevant information. The fact that LRC volunteers adopted the recommended COVID-19 prevention measures while delivering awareness sessions enhanced their credibility (Lebanese Red Cross Disaster Risk Reduction 2020).

The RCCE response to COVID-19 in Lebanon

Following confirmation of the first case of COVID-19 in Lebanon, a national Risk Communication and Community Engagement (RCCE) consortium was established, made up of the Lebanese MoPH, the Ministry of Education and Higher Education (MEHE), WHO, UNICEF, and the LRC (Lebanese Red Cross Disaster Risk Reduction 2020). Plans have been developed and efforts made with regard to RCCE; however, the government's approach has been largely top-down and unidirectional, and has not addressed the feasibility of complying with public health measures such as distancing and isolation. The delay in provision of information and the dissemination of contradictory messages have eroded public trust in these measures (Makhoul, Kabakian-Khasholian, and Chaiban 2021).

More recently, a committee has been formed, comprised of the MoPH, the Ministry of Information (MoI), UNICEF, WHO and the UNHCR, to implement an awareness campaign on vaccinations. The campaign will involve the dissemination of materials to increase demand for a COVID-19 vaccine via the print media, television, radio, social media and mobile messages. A key part of the communication plan involves increasing demand for the vaccine among healthcare workers who, as early recipients of the vaccine, will be able to advocate for its use. The strategy will also involve engaging trusted influencers such as faith-based organisations, youth advocates, university students and journalists. It is acknowledged that the government, NGOs and municipal institutions all have a key role in encouraging uptake of the vaccine. Consultations will be undertaken with community members, municipalities, military personnel, academics, healthcare workers, and vulnerable groups such as women, the elderly, refugees, and people with disabilities or underlying medical conditions (Republic of Lebanon Ministry of Public Health 2021).

The LRC has been instrumental in providing COVID-19-related RCCE to the Lebanese people since the outbreak began. This has involved a number of interventions, including: providing awareness sessions; distributing IEC material, safety and hygiene equipment to relevant stakeholders; developing web-based games about COVID-19 for children; and establishing an E-learning platform (Lebanese Red Cross Disaster Risk Reduction 2020). Specific awareness sessions were tailored for schools and nurseries, vocational education institutions, municipalities, prisons, general community members, and security forces and workplaces, and specific sessions were held focusing on dead body management and quarantine guidelines. The sessions were rolled out nationally across all districts, with a total of 131,135 people reached through 6,663 sessions (Lebanese Red Cross Disaster Risk Reduction Unit 2021).

A real-time evaluation of LRC's RCCE response found that there was a high demand for the awareness sessions among the public, and that participants found the content valuable, relevant, clear and useful. During lockdown, sessions had to be adapted to an online setting, which presented some challenges, including technical and connectivity issues, low digital literacy among some groups, and the inability to interact with participants to see if they were engaging with the material (Lebanese Red Cross Disaster Risk Reduction 2020).

Perceptions, knowledge and actions with regard to COVID-19

A small number of online surveys have been conducted to understand the perceptions, knowledge and behaviours of Lebanese people relevant to COVID-19 (Qahoush 2020)(Domiati, Itani, and Itani 2020) (Sakr et al. 2020)(Faour-Klingbeil et al. 2021b). These were mostly carried out between April and August 2020, and not all have been peer-reviewed. Due to their online nature, these have by necessity included only people with Internet access, and an over-representation of people with high levels of education (such as university degrees). A UNICEF KAP study carried out between April and May 2020 involved over 2000 telephone interviews, attempting to reach a nationally representative sample, although initial low response rates led to the use of a less representative sampling technique (UNICEF 2020). UNICEF has also carried out social listening by analysing social media posts on specific topics (UNICEF 2021). It should be noted that knowledge levels and prevention behaviours for other groups, such as refugees or elderly people, are likely to be different to those elucidated in the online surveys (see section on vulnerable populations below).

Knowledge about COVID-19

In general, the online surveys found respondents to have a good level of knowledge about the existence of COVID-19, its main transmission methods, symptoms and risk factors (UNICEF 2020) (Domiati, Itani, and Itani 2020). In terms of risk perception, one survey found that 38% of Lebanese respondents thought the virus presented a serious threat to their health (Qahoush 2020), while another found that 98% of respondents considered COVID-19 to be dangerous (Sakr et al. 2020). One author reports that some citizens are fatalistic, choosing not to take precautions in the belief that they will die anyway (Abdo-Katsipis 2020).

Knowledge and practice of prevention measures

Studies found that a majority of respondents have good knowledge of COVID-19 prevention measures, and self-reportedly practise these to a good extent (UNICEF 2020) (Domiati, Itani, and Itani 2020)(Sakr et al. 2020). This included covering the mouth when coughing or sneezing, discarding used tissues, and handwashing (Domiati, Itani, and Itani 2020). One study found that there had been an increase in the use of chlorine and soaps for cleaning fresh fruit and vegetables, although handwashing before food preparation had not increased substantially. The same study showed that Lebanese people were more likely to adopt prevention measures and hygiene practices than their counterparts in Jordan and Tunisia (Faour-Klingbeil et al. 2021b).

A high percentage of survey respondents reported wearing face masks if they were sick or in a crowded place (Domiati, Itani, and Itani 2020)(Sakr et al. 2020), and 61% of Lebanese respondents in one study thought people should continue to wear face masks in public even after the pandemic was over (Qahoush 2020). In one study, 97% of respondents believed it was important to isolate people who had contracted COVID-19 (Sakr et al. 2020). UNICEF social listening found that most people in the MENA region were in favour of strict physical distancing rules (UNICEF 2021), although up to one fifth of respondents of the UNICEF KAP survey reported noncompliance with some physical distancing measures. At least half of the respondents found mental health issues, difficulty of being separated from others, and restricted access to supplies to be barriers to self-isolation (UNICEF 2020).

Attitude toward vaccines

Sixty-six per cent of respondents to a survey in Lebanon from early 2020 said that they were likely to take a COVID-19 vaccine as soon as it was developed (Qahoush 2020). More recently, activity on social media

across the MENA region between December 2020 and January 2021 showed a majority of negative sentiments related to vaccines, indicating that a significant number of people are sceptical about getting vaccinated. During that period, mentions around COVID-19 vaccines increased by 31% from the previous listening period, with conversations about vaccines contributing to 23.5% of all conversations about COVID-19 (UNICEF 2021).

Knowledge and practice of reporting protocol and treatment measures

Most survey respondents from the UNICEF KAP study (71%) were aware they should call the MoPH to report suspected cases of COVID-19, although a much smaller number said they would do this. A higher number (73%) cited the Lebanese Red Cross (LRC) as the organisation to report to, and 31% the municipality. Willingness to report suspected cases depended on the level of severity of the symptoms (UNICEF 2020). Another survey found that 52.7% of participants would call the LRC to report symptoms and seek assistance in being transferred to the assigned hospitals, while 25% would visit any hospital and 10.5% would seek help from a doctor or pharmacist (Domiati, Itani, and Itani 2020).

In one study conducted in August 2020, 11% of respondents said they would self-medicate without seeking professional medical advice if they experienced COVID-19-like symptoms, and 10% would take Hydroxychloroquine, with 50% believing the drug did not have any side effects (Domiati, Itani, and Itani 2020).

Social and cultural drivers for COVID-19 behaviours

Health behaviours can be driven by multiple social and cultural influences such as social and moral norms, gender ideologies and social cohesion (Petit 2019). There is little evidence with regard to the sociological drivers of COVID-19 behaviours in Lebanon. The following section presents the evidence revealed by the literature review.

Social relationships and family structure

Lebanon has a collectivist culture, in which social relationships are defined through immediate and extended family networks and fictive kinship structures. Since the formation of the Lebanese state in the 1920s, people have relied on family structures for economic support and security. Extended families often live together, and social visits and gatherings are important aspects of every-day life. This has implications for public health and social measures such as physical distancing and limiting of gatherings (Makhoul, Kabakian-Khasholian, and Chaiban 2021). It also has implications for the protection and shielding of elderly citizens at risk of COVID-19 infection, who often live in multi-generational households and spend time taking care of grandchildren, as well as participating in social gatherings and attending religious services (Khoury and Karam 2020)

Localised spread of COVID-19 has been reported in several villages where social ties are strong and extended families live communally or in close proximity. In the remote rural community of Bcharri, a cluster of COVID-19 infections was attributed to social visits among extended family members. Communal gatherings are common to celebrate such events as community members returning from travel, and even to share news of negative COVID-19 test results. In one such instance, a community member who had returned a false negative test result became a potential source of infection to people who had visited him at home. Likewise, the notion of personal space is not highly valued in collectivist societies and in fact choosing not to interact with others in a shared space can cause negative reactions. This has clear implications for compliance to physical distancing recommendations (Makhoul, Kabakian-Khasholian, and Chaiban 2021).

Another implication of the collectivist culture is that social behaviours tend to be based on group norms rather than on personal attitudes. This can be both a barrier and an enabler to the practice of healthy behaviours. While incorrect information or unhealthy practices can be easily adopted and spread, so can healthy or safe practices. In one positive example, a community mobilised itself to follow the instructions given by the local municipality and ministry officials regarding quarantine, travel restrictions and night curfew, and was thus able to limit the spread of the virus. Villagers living away from home provided moral support to the community through social media (Makhoul, Kabakian-Khasholian, and Chaiban 2021).

Cultural practices

Waterpipe smoking is a common practice in Lebanon, as in other countries in the region. It is a communal practice, in which not only do people gather in proximity to one another, but a single mouthpiece and hose is often shared between users. Although there are anecdotal reports that practices related to waterpipe smoking have changed since the onset of the COVID-19 pandemic, it has not been customary for cafés to clean waterpipe equipment after each smoking session. The risk of transmitting disease through waterpipe smoking in an indoor setting may be even higher. In response to the COVID-19 pandemic, 15 countries in the Eastern Mediterranean Region introduced new measures to ban waterpipe use in all public places. However, the ban does not extend to waterpipe use in the home, and in some places, people are able to rent waterpipes, which are delivered to their homes, facilitating access during the COVID-19 pandemic (WHO EMRO 2020).

Social determinants of prevention behaviours

Studies have shown that a number of factors are associated with a greater likelihood of practising hygienic prevention measures, including having a higher education level, having an intermediate income, and being married (El Othman et al. 2021)(Sakr et al. 2020)(Domiati, Itani, and Itani 2020). Younger age (below 18) has been shown to be associated with lower awareness levels (Domiati, Itani, and Itani 2020). Having higher levels of depression and practising religion have also been found to be significantly associated with a lower likelihood of practising hygienic prevention measures (El Othman et al. 2021). People living in urban areas were found to have better knowledge than their rural counterparts in one study (Sakr et al. 2020), while in another, Mount Lebanon residents had a significantly higher score than those in Beirut, Bekaa and in the North and South areas (Domiati, Itani, and Itani 2020).

There is inconsistency across studies with regard to some determining factors. Being male has been found to be associated with lower frequency of prevention practices in one study (El Othman et al. 2021), and higher frequency in another (Domiati, Itani, and Itani 2020). Older age has been associated with lower prevention knowledge levels (Domiati, Itani, and Itani 2020) and higher knowledge levels (Sakr et al. 2020) in different studies. In one study, health care workers had better knowledge scores and more frequent prevention practices than other participants (Sakr et al. 2020), while another study found, surprisingly, that medical field workers had a significantly lower score than non-medical field workers and unemployed people (Domiati, Itani, and Itani 2020). The UNICEF KAP study found that there was no significant difference in awareness of prevention measures according to age group, place of residence or nationality (UNICEF 2020).

Environmental drivers for COVID-19 behaviours

Broader societal and environmental behavioural drivers include structural factors such as living conditions and access to services, as well as trust in governing entities (Petit 2019). It is increasingly understood that it is not just the content of messages that is important, but also how the political, economic and social context may affect how these messages are received and interpreted. In Lebanon, the collectivist nature of society discussed above, the socioeconomic conditions of the country, the historical performance of the state, state-citizen relations, and a generalised mistrust in the national health system all affect people's reception of and reaction toward public health recommendations and mandates (Makhoul, Kabakian-Khasholian, and Chaiban 2021).

Living conditions

People living in precarious and low-resource settings find it particularly challenging to adhere to public health measures such as physical distancing and stay-at-home orders. Many people in both urban and rural areas in Lebanon live in crowded conditions, where they are unable to maintain physical distance, effectively quarantine or self-isolate, or maintain adequate hygiene standards (Kerbage et al. 2021). In addition, people who rely on informal daily work for an income are unable to comply with stay-at-home orders when there is no alternative means of securing food and other supplies. These people continue to leave the house to work, despite the threat of fines (Makhoul, Kabakian-Khasholian, and Chaiban 2021) (Abdo-Katsipis 2020).

The pandemic has resulted in a further slow-down of the economy, with many businesses shutting down and unemployment and poverty increasing. For many people, hunger has become a more pressing concern than COVID-19, and street protests against the government have continued even as COVID-19 cases continue to rise (Mizrahi et al. 2020).

Access to and quality of resources and services

Services such as COVID-19 testing are not readily available to all. Although testing is free at public hospitals, only symptomatic patients are tested, and the cost of tests at private clinics is around USD 100. The high cost discourages many people from being tested (Abdo-Katsipis 2020). With regard to the COVID-19 vaccine, only 15% of the population are likely to receive the vaccine for free from the MoPH, while another 20% should be covered by the international COVAX programme. For those who are not covered, the cost of the vaccine is likely to be more than twice the minimum monthly wage, making this prohibitive for most people. Furthermore, it is not certain that there will be enough vaccines for everyone, even if people had the ability to pay (Hilal et al. 2021). Meanwhile, prices for goods such as hygienic wipes have increased considerably, with no government regulation to prevent price-gouging (Abdo-Katsipis 2020).

Political instability and trust in government and service providers

COVID-19 reached Lebanon during the midst of political upheaval in the country. The Lebanese state has collapsed several times in modern history, with the civil war ending only thirty years ago. As a result of these historical events, there is a low level of trust in the government and service providers (Makhoul, Kabakian-Khasholian, and Chaiban 2021).

A theory has also circulated that the pandemic is a hoax created by the state to attract relief funding for the country's economic problems, with obvious implications for people's willingness to follow public health measures as prescribed by the government (Makhoul, Kabakian-Khasholian, and Chaiban 2021). One study

of young people across Lebanon has attempted to gauge levels of trust in measures taken by the local government to contain the epidemic. The survey found that 53% had complete trust in the measures implemented by the government, while 19.5% did not trust them (Sakr et al. 2020).

Dealing with multiple crises and competing priorities

The COVID-19 pandemic created an additional challenge to a country that was already suffering from political instability and social unrest, an impending economic breakdown and sky-rocketing inflation, a banking sector collapse, and a refugee crisis (Hilal et al. 2021). In August 2020, an explosion of ammonium nitrate at Beirut's waterfront was added to the list of ongoing crises. The blast resulted in over 200 deaths, thousands of injuries and widespread damage to property and infrastructure (Safi 2020). It exacerbated an already tense and challenging situation for many people in the country, as many people lost their possessions, homes, businesses and livelihoods. There were reports of shortages and hoarding of medical supplies (IFRC and LRC 2020).

The blast had the secondary effect of a surge of COVID-19 cases. Two of Beirut's hospitals were damaged, one of which was acting as a COVID-19 facility. The remaining hospitals were only able to assist the most critical patients. Saving lives in the immediate term became the priority for individuals and humanitarian organisations, rather than following COVID-19 protocols such as physical distancing or isolation. For many, these measures became impossible to follow (IFRC and LRC 2020).

The Beirut blast occurred in a densely populated area that was home to people from a wide range of socioeconomic and ethnic backgrounds, highlighting the value of an in-depth understanding of the target population for humanitarian assistance and RCCE. Given the diversity of the people needing assistance, LRC carried out a multi-sector needs assessment to target assistance according to individual families' needs, and through this discovered that people were embarrassed to participate in relief distributions in front of their neighbours. LRC thus adapted their approach to carry out door-to-door relief distribution (IFRC and LRC 2020). This lesson can be transferred to many other areas, such as communication about COVID-19 prevention, and provision of services such as testing and healthcare.

Vulnerable and hard-to-reach populations

Different populations may experience specific challenges with relation to COVID-19, potentially affecting their ability to follow preventive measures and seek care if they become sick. They may also have different communication needs from other sectors of the population. In addition to people with few resources, these include rural residents, elderly people, refugees and displaced people, migrant workers, women and people with different sexual orientation.

Rural residents

During emergencies such as a pandemic, scarce government resources tend to be directed to the capital and other urbanised and crowded areas. As a result, rural and remote areas may be left without or with minimal support. Residents of rural areas have been found to have less access to information about COVID-19, as well as a lack of access to services such as testing, healthcare and mental health support (Woertz 2020)(Khoury and Karam 2020). This may be compounded for elderly people living in rural areas, who may have even less access to online information and services than their younger counterparts and may require a different approach to RCCE and service provision (Kerbage et al. 2021).

Elderly people

Lebanon currently has the highest proportion of adults aged 65 years and above (10%) among all Arab countries, with only a small proportion of these people living in care facilities (Khoury and Karam 2020). An estimated 64% of elderly people in Lebanon suffer from at least one chronic disease, and due to low coverage of pension schemes, a large percentage of people continue to work until 70 or 80 years of age. Older people who are unmarried, widowed or have no children are particularly socially and economically vulnerable due to a lack of social support (Kronfol, Rizk, and Sibai 2015). These factors have implications for the risk posed by COVID-19 to elderly people, and for their ability to maintain protective measures, such as staying at home and shielding.

Elderly people may be particularly vulnerable in situations of conflict or post-conflict. They may find themselves widowed, socially isolated, forced into retirement, homeless or displaced as a result of the conflict. Conflict and political instability can also lead to an exodus of young people, disrupting the social fabric that was based on multi-generational living and reciprocal support between younger and older members of the extended family. Research has shown that more than 20% of older women in the Southern governorate of Lebanon, which has been the site of recurrent occupations and wars, live alone. This is around twice the national average (Kronfol, Rizk, and Sibai 2015). These dynamics, such as a loss of support from family members, will affect elderly people's access to information and services. More generally, elderly people are likely to have different communication needs and preferences than younger groups.

Refugees and internally displaced people

Lebanon, a country of only 6.8 million people, currently hosts more than 1.7 million refugees. 1.5 million of these are estimated to be from Syria, 200,000 from Palestine and 13,500 from Iraq. All live in precarious socioeconomic conditions, experiencing marginalisation, social inequality and discrimination, and a lack of social protection (Makhoul, Kabakian-Khasholian, and Chaiban 2021). They often live in crowded conditions with inadequate hygiene, increasing the risk of COVID-19 transmission and making it difficult to comply with distancing requirements (Duclos and Palmer 2020). Studies have found that Syrian refugees' access to health care and medication in Lebanon was worse than the host communities, the primary barrier being cost (Lyles et al. 2018)(Human Rights Watch 2020b).

In the context of the COVID-19 pandemic, refugees have been subject to discriminatory practices, such as the restriction of their mobility beyond the government-sanctioned curfew hours and in excess of the restrictions experienced by host community members. Refugees were threatened with confiscation of their identity cards if they were found to be leaving their homes to carry out tasks not deemed 'necessary'. As a result, refugees have reported concerns about being able to access healthcare and information about COVID-19 prevention measures, and there is a worry this may lead to members of this group not reporting or seeking care if experiencing COVID-19-like symptoms (Makhoul, Kabakian-Khasholian, and Chaiban 2021) (Human Rights Watch 2020b).

Refugees may have different communication preferences and access to information than other groups. Studies conducted with Syrian refugees in Bekaa and Tripoli in March 2020 found that their knowledge and awareness of COVID-19 and its preventive measures were minimal (Human Rights Watch 2020b). Interestingly, one study has found a higher risk perception of community spread of COVID-19 among Palestinians living in communities (90% thought there was a high risk) than among those living in refugee camps (60%)(UNICEF 2020). When considering how to reach and communicate with refugees and internally displaced people, it is also important to take into account that many people displaced by conflict may not be residing in camps, but may be staying with friends or relatives in private houses (Kabakian-Khasholian, Shayboub, and El-Kak 2013). Although they have often been excluded from COVID-19 response task forces, refugee or displaced person organisations may be important in reaching and communicating with displaced populations through trusted interlocutors (Duclos and Palmer 2020).

Migrant workers

Lebanon is home to more than 250,000 migrant workers from Africa and Asia. They work predominantly in households, local business and industries. These workers often experience social exclusion and inequitable access to healthcare services (Makhoul, Kabakian-Khasholian, and Chaiban 2021). In particular, it is a growing trend within Arab countries to employ migrants as full-time live-in domestic workers and carers. These workers may lack adequate qualifications, for example for the care of elderly people, and be subject to discriminatory labour practices such as the kafala sponsorship system. This system ties migrants' legal residency to their employer, leaving them open to exploitation and with no recourse to demand their rights. These practices are part of a broader system of global inequalities based on ethnicity, gender and class (Kronfol, Rizk, and Sibai 2015). They have implications for migrants' ability to protect themselves from COVID-19 infection, seek care, and access relevant information.

Prisoners

Prisoners are particularly vulnerable to COVID-19 in that they are often housed in crowded and unhygienic conditions. The largest detention site in Lebanon has more than 4000 prisoners living in crowded, unventilated cells, and sleeping in corridors. The same bathroom is used by 120 prisoners (Makhoul, Kabakian-Khasholian, and Chaiban 2021). Distancing and maintaining good hygiene is impossible in such situations.

Women

Women experience particular challenges, including carrying the largest burden in terms of caregiving to older relatives, children and sick people (Kronfol, Rizk, and Sibai 2015), and with regard to their decision-making autonomy. Women may need to gain permission from family members (such as the husband or mother-in-law) to seek healthcare or preventive medicine such as vaccines. This has also been found to be a barrier for Syrian refugees in Lebanon (Tappis et al. 2017). In addition, women may not have the same level of access to information as their male counterparts. Lockdown measures due to COVID-19 have also had the secondary effect of increasing levels of gender-based violence, particularly for women and girls, as

they are unable to escape abusive partners, and household stress levels are increased due to confinement, loss of income and other stresses (National Commission for Lebanese Women et al. 2020).

Community-led responses

The COVID-19 pandemic, coupled with the Beirut wharf blast, brought into sharp relief the importance of community and citizen-led responses, particularly in the absence of a strong and coordinated response from government. As a case in point, in the small town of Bcharri, healthcare workers, local associations and the municipality took matters into their own hands and collaboratively prepared for an outbreak of COVID-19, even before the first case was reported in the town. Most of the proactive response measures implemented in Bcharri were locally developed and executed. They were effective because the local response team knew their community and were aware of its weaknesses and strengths. They were able to work to fill gaps in capacity prior to the outbreak and make strategic decisions based on local knowledge, such as choosing to communicate with citizens at churches rather than through social media. The local response involved a range of local actors working together, including municipalities, citizen-led initiatives, NGOs, clergy, private sponsors and activists. Finally, contact tracing was facilitated because local residents, who all knew each other, felt a responsibility to assist the response team (Kerbage et al. 2021).

Lebanon can be considered unique in that the COVID-19 response is largely shared between state and civil society. The state has limited its role to mandating and enforcing the stay-at-home order and increasing resources for treatment. Meanwhile, citizens, communities and civil society organisations have been instrumental in providing crisis support resources, including food, shelter, financial assistance, and even medical care. “Baytna Baytak” is a citizen initiative that finds free accommodation for medical staff and Red Cross members, which helps them to avoid exposing their families to the virus. The accommodation is provided by private citizens and hotel owners (Abdo-Katsipis 2020). Following the Beirut blast, organisations such as the LRC distributed food parcels and hygiene items, while local residents quickly organised themselves to offer accommodation and other assistance to those affected (IFRC and LRC 2020). During the COVID-19 pandemic, community emergency response teams previously trained by the LRC supported the municipalities by following up with quarantined people and confirmed cases, providing food parcels and hygiene kits, and working to disinfect households (Lebanese Red Cross Disaster Risk Reduction 2020). In any emergency, it is important to understand local social and aid structures, to work with them and communicate through them, rather than in parallel (Duclos and Palmer 2020; Kerbage et al., 2021).

Anthrologica