Anthrologica

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

Quantitative findings
(accompanying the final report)

Prepared for IFRC, ICRC, LRC, BRC

May 2021

Contents

1. Demographics

Table 1. Sample size by governorate

Area	Sample
Akkar	1
Beirut	77
Bekaa	6
Mount Lebanon	190
North Lebanon	7
Nabatiyeh	33
South Lebanon	183
Total	**497**

Table 2. Sample size by age

Age	Sample
16 to 17 years	3
18 to 29 years	169
30 to 39 years	138
40 to 49 years	110
50 to 59 years	56
60 to 69 years	20
70 to 79 years	1
Total	**497**

Nationality and current status

Figure 1 below demonstrates that the majority of the participants were host communities (90.5%, n=450). A minority were refugees (4.8%, n= 24), 2.4% (n= 12) were internally displaced, 1.6% (n=8) were migrants and only 0.6% (n= 3) were under others including residents and tourists. As per figure two, the majority of the participants were Lebanese (93.8%, n=466), only 3.6% (n=18) were Palestinian, 1.6% (n=8) were Syrians and the remaining 1% (n=5) were from different nationalities including Columbians, Iranian, Jordanian, Swedish, and American (Figure 2 below).

Figure 1. Participants by population category

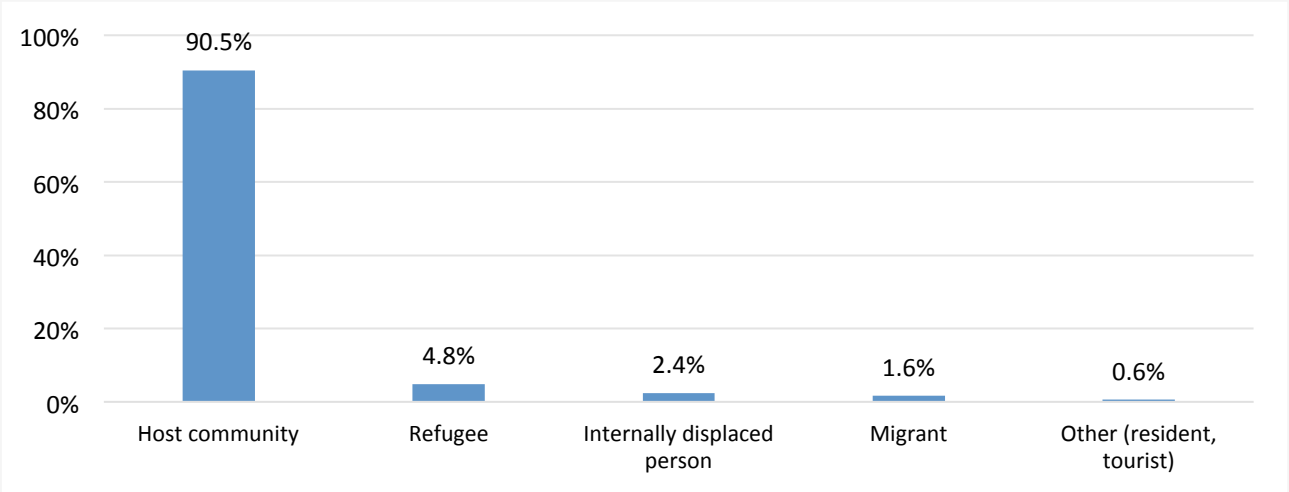
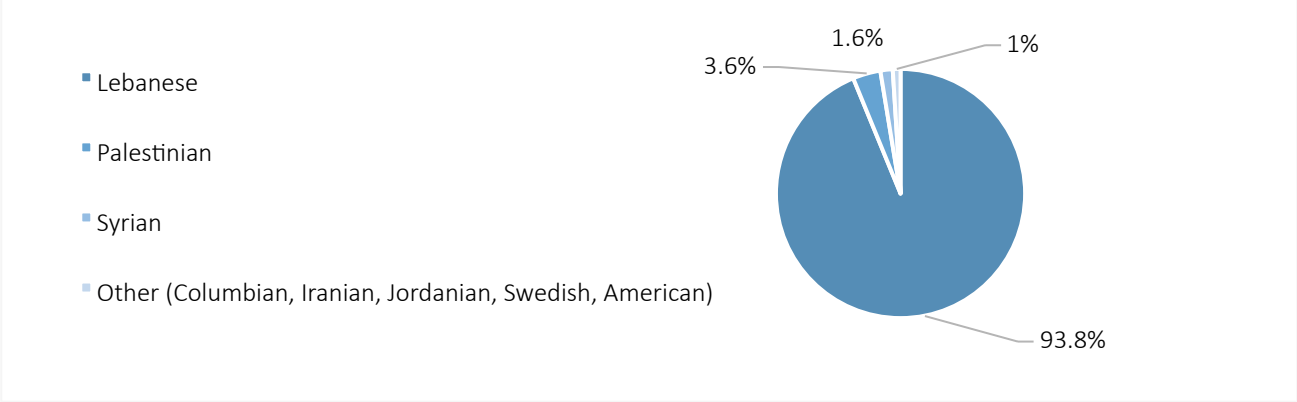


Figure 2. Participants' nationality



Gender and age

Among the participants, 34% (n=169) were 18 to 29 years, with lower percentages among those aged 30 to 39 (27.8%, n=138), then among those aged 40 to 49 years old (22.1%, n=110), followed by the group aged 50 to 59 (11.3%, n=56). Only 4% (n=20) were between 60 to 69 years and those aged between 16 to 17 years were minorities (0.6%, n= 3) followed by those aged 70 to 79 years old (0.2%, n=1) (Figure 3). The total percentage of female respondents was 62% (n=308), with lower percentages for males (37.8%, n=188) (Figure 4).

Figure 3. Participants' age

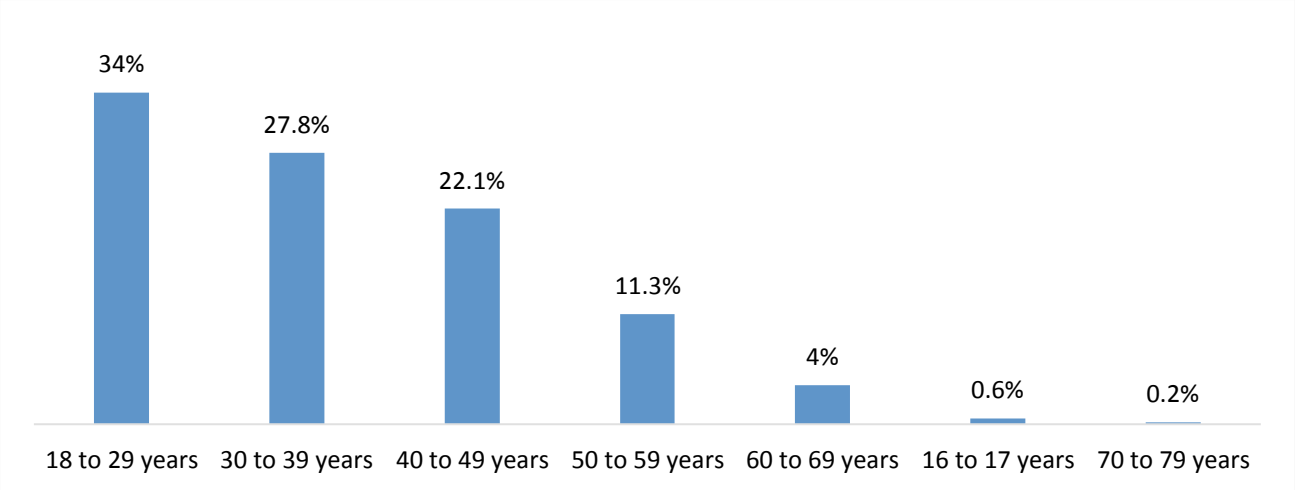
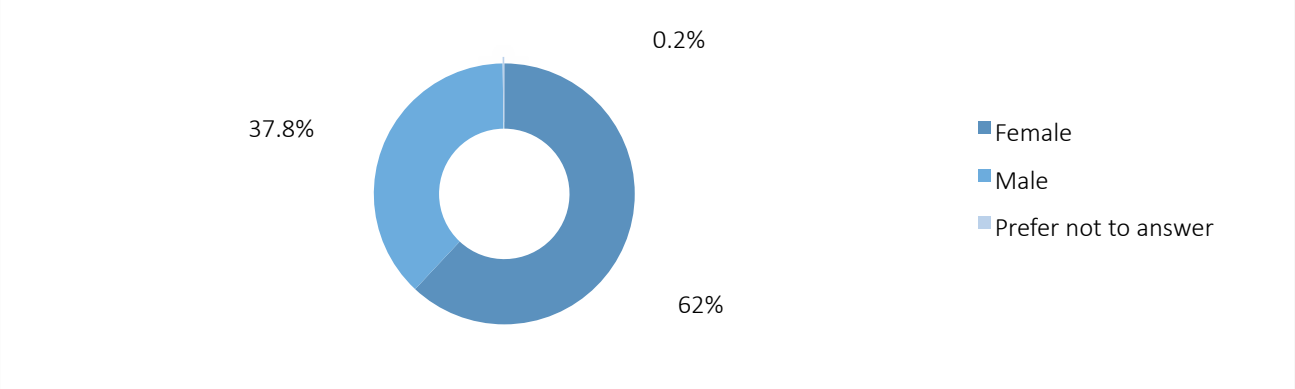


Figure 4. Participants' gender



Education and occupation

Around 51.3% (n=255) of the participants stated that they achieved university level, 27.4% (n=136) stated that they completed high school level, 17.3% (n=86) affirmed that they have achieved an advanced university level, 3% (n=15) stated that they have reached primary level, 0.4 % (n=2) mentioned that they did not have a formal education and 3 respondents were unsure of their answer (0.6%) (Figure 5). The majority were employees (61.6%, n=306), while a relatively high percentage of unemployed was also discovered (23.3%, n=116). There were 10.1% (n=50) business owners and 3.4% (n=17) who occupied different types of work under "others" and these included: engineer, agriculture, volunteer, casual worker, translator, free lancers… Only 1.6% (n=8) of the respondents were retired (Figure 6).

Figure 5. Participants' level of education

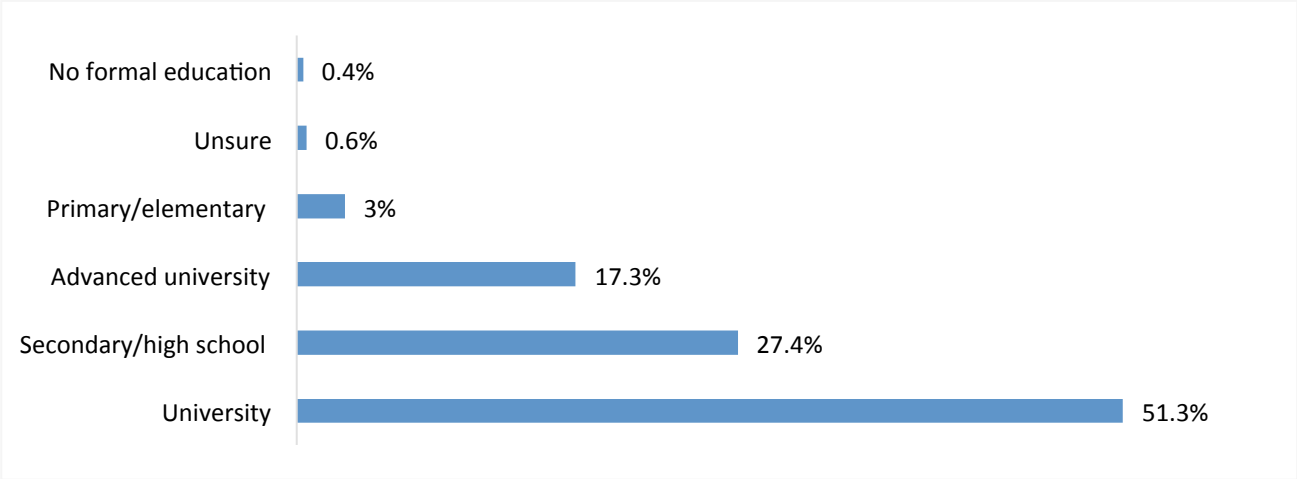
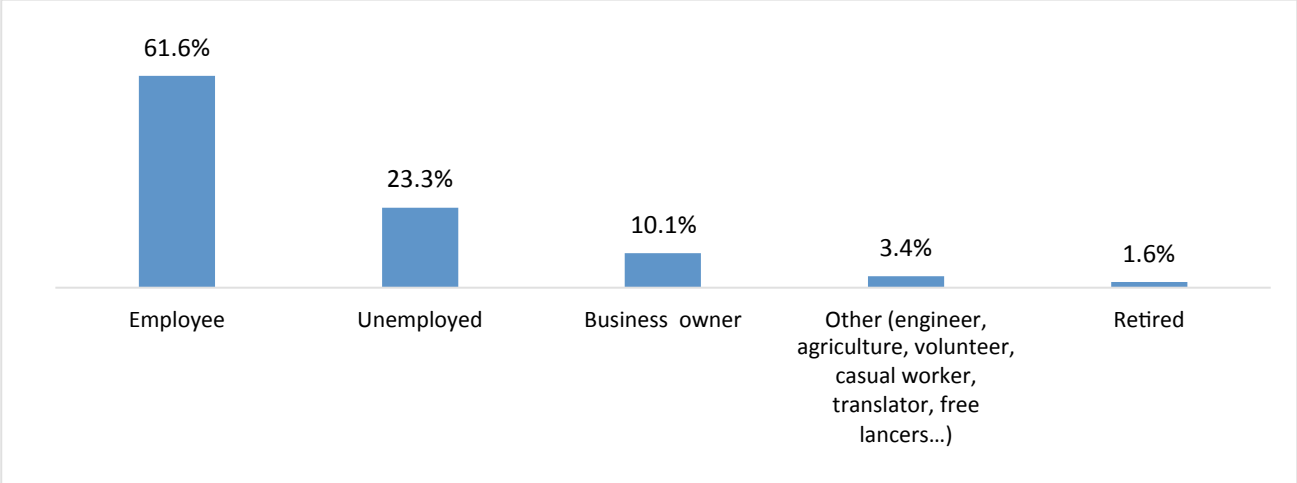


Figure 6. Participants' occupation



2. Access to health messages

Information provided

Survey participants were asked about the types of information they received; almost all participants stated receiving information on the routes of transmission and on COVID-19 symptoms (93.4%, n=464), 90.1% (n=448) mentioned receiving COVID-19 prevention measures, 80.9% (n=402) stated receiving information on the isolation measures, 75.7% (n=376) received information's on risks and complications of COVID-9, 70.2% (n=349) revealed that they received information on the process of reporting COVID-19 infection, 66.4% (n=330) reported receiving testing information, 58.6% (n=291) had contact information (hotline) for health assistance, 49.3% (n=245) confirmed receiving vaccine related information (types of vaccines, modality, safety, eligibility criteria, registration, etc.), 46.5% (n=231) affirmed receiving mental health information, 35.2% (n=175) acknowledged receiving information on new variants of COVID-19 virus and only 1.4% (n=7) stated receiving other type of information (Funeral, Safe return to work, diagnosis, treatment etc.) (Figure 7).

Figure 7. Information participants stated they received in regards to COVID-19

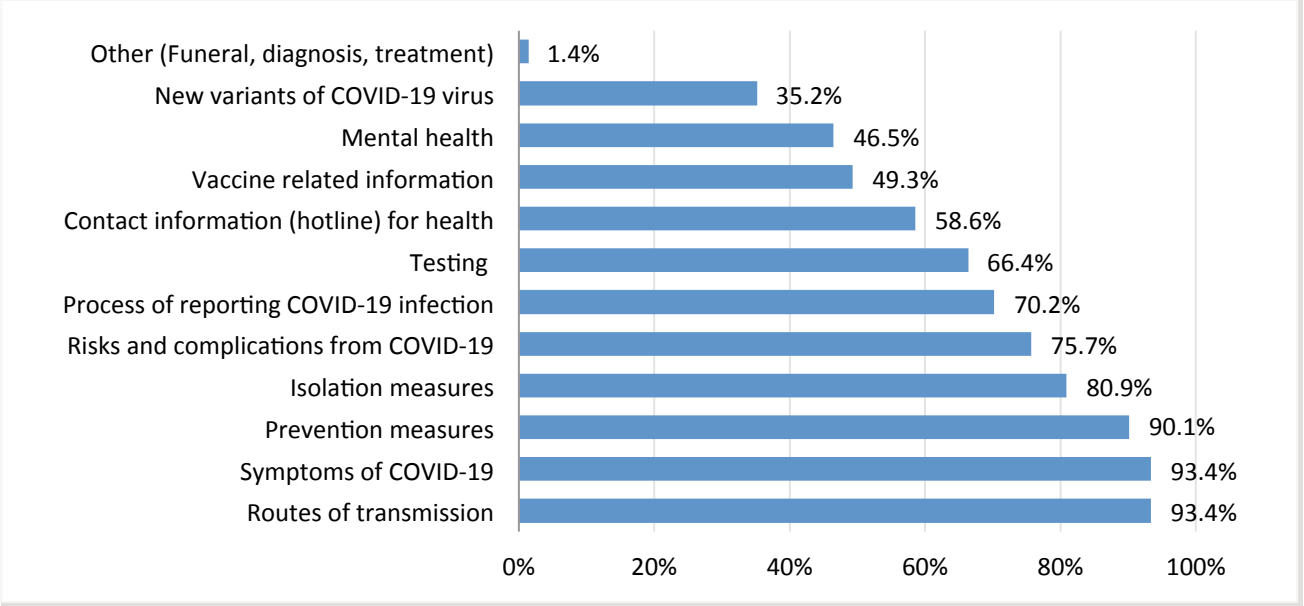


Table 3 below segregates the information received by demographic variables. Gender, age, nationality and occupation were not statistically significant with the type of information received. However, education was statistically significant with receiving information on the new variants of COVID-19 virus, testing and contact information.

- **New variants of COVID-19 virus**: there was a moderate correlation (coefficient 2.7) between education and receiving information on new variants of COVID-19 (P-value<0.01). People with university degrees were the most to report receiving information on the new variants of COVID-19 (58.3%, n=102) followed by advanced university degree holders (24%), n=42, those who completed secondary/high school education (17.1%, n=20) and those who completed primary/elementary education (0.6%, n=1).
- **Testing:** there was a weak correlation (coefficient 0.17) between education and receiving information on testing (P-value = 0.046). Similar results were seen for COVID-19 testing: University (57.3%, n=188), Secondary (21%, n=69), Advanced (19.8%, n=65) and elementary (1.8%, n=6).
- **Contact information:** there was a weak correlation (coefficient 0.14) between education and receiving contact information (P-value=0.026). A higher percentage of people reporting receiving contact

information was among university degree holders (55.5%, n=161) followed by Secondary (24.8%, n=71), Advanced (18.3%, n=53) and elementary (1.4%, n=4).

Table 3. Information received by demographic variables

Sub-groups		Routes of transmission	Symptoms of COVID-19	New variants of COVID-19 virus	Risks and complications from COVID-19	Testing	Process of reporting	Contact information (hotline)	Prevention measures	Isolation measures	Mental health	Vaccine related information	Other (Funeral, diagnosis, treatment)
No formal education	%	0.4											
	N	2											
Primary/ elementary	%	2.2	2.4	0.6	0.9	1.8	2.3	1.4	2.5	1.8	1.3	2	14.3
	N	10	11	1	7	6	8	4	11	7	3	5	1
Secondary/ high school	%	25.4	25.8	17.1	25.7	21	25.1	24.8	25.8	24.5	22.2	22.1	14.3
	N	117	119	30	96	69	87	72	115	98	51	54	1
University	%	53.6	53.1	53.8	55.5	57.3	53.9	55.5	53.8	55.3	56.1	58.2	42.9
	N	247	245	102	207	188	187	161	240	221	129	142	3
Advanced university	%	18.4	100	24	16.9	10.8	18.7	18.3	17.9	18.5	20.4	17.6	28.6
	N	85	18.7	42	63	65	65	53	80	74	47	43	2
P-value		NA***	NA***	0.004*	0.315	0.046**	0.106	0.026*	0.744	0.089	0.276	0.076	0.186
Akkar	%	0.2	0.2		0.3	0.3	100	100	100	100	100	100	
	N	1	1		1	1	1	1	1	1	1	1	
Beirut	%	15.5	15.5	14.3	14.4	13.6	57.1	46.8	87	79.2	36.4	45.5	1.3
	N	72	72	25	54	45	44	36	67	61	28	35	1
Bekaa	%	1.3	1.3	1.1	1.1	1.5	83.3	66.7	100	83.3	66.7	66.7	
	n	6	6	2	4	5	5	4	6	5	4	4	
Mount Lebanon	%	38.4	38.4	41.7	38.6	43.9	74.7	61.1	92.1	86.8	46.3	57.4	2.1
	n	178	178	73	145	145	142	116	175	165	88	109	4
North Lebanon	%	1.5	1.5	1.7	1.3	1.2	85.7	85.7	71.4	71.4	57.1	42.9	
	n	7	7	3	5	4	6	6	5	5	4	3	
Nabatieh	%	6.9	6.5	5.7	6.9	6.1	75.8	66.7	81.8	78.8	72.7	33.3	
	n	32	30	10	26	20	25	22	27	26	24	11	
South Lebanon	%	36.2	36.6	35.4	37.5	33.3	68.9	57.9	91.3	76	44.8	44.8	1.1
	n	168	170	62	141	110	126	106	167	139	82	82	2
P-value		NA***	NA***	0.155	0.967	0.044*	0.122	0.399	0.922	0.653	0.389	0.131	0.161

* Statistically significant p-value <0.05
** Border line statistical significance
*** As Almost all chose this

In addition, governorate was statistically significant with receiving information on testing (P-value = 0.04) with a weak correlation (coefficient = 0.12). Higher percentages of those who confirmed receiving this information were seen in Mount Lebanon (43.9%, n= 145) followed by South (33.3%, n=110%), Beirut (13.6%, n=45), Bekaa (1.5%, n=5), North Lebanon (1.2%, n=4) and Akkar (0.3%, n=1).

Since for the governorate variable the sample is not representative for each category such as for Akkar, re-categorizing them by including those that had small samples (Akkar, Bekaa, and North Lebanon) into one category named other could better help in analyzing the data by governorate. As seen in Table 4 below, reporting receiving information on testing, process of reporting and vaccine related information was statistically significant with respective p-values of 0.01, 0.039 and 0.043.

- For testing, highest percentage was seen in Mount Lebanon (43.9%) followed by South Lebanon (33.3%), Beirut (13.6%), Nabatiyeh (6.1%) and other (3%)
- For the information related to the process of reporting, highest percentage was noticed in Mount Lebanon (40.7%) followed by: South Lebanon (36.1%), Beirut (12.6%), Nabatiyeh (7.2%) and other (3.4%).

- For Vaccine related information highest percentages were seen in Mount Lebanon (44.5%) followed by: South Lebanon (33.5%), Beirut (14.3%), Nabatiyeh (4.5%) and other (3.3%). (Table 4)

Table 4. Information provided by Governorate

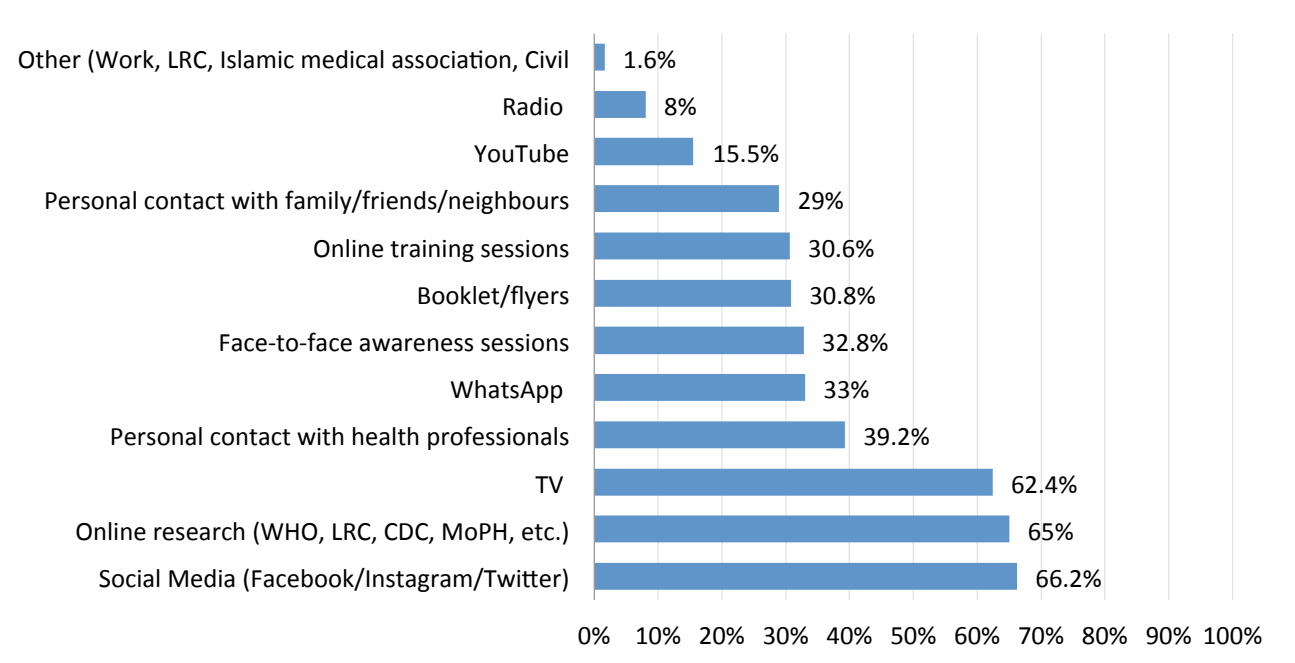
Governorate recoded		Routes of transmission	Symptoms of COVID-19	New variants of COVID-19 virus	Risks and complications from COVID-19	Testing	Process of reporting	Contact information (hotline)	Prevention measures	Isolation measures	Mental health	Vaccine related information	Other (Funeral, diagnosis, treatment)
Other (Akkar, Bekaa and, North Lebanon)	%	3	3	2.6	2.7	3	3.4	3.8	2.7	2.7	3.9	3.3	
	n	14	14	5	10	10	12	11	12	11	9	8	
Beirut	%	15.5	15.5	14.3	14.4	13.6	12.6	12.4	15	15.2	12.1	14.3	1.3
	n	72	72	25	54	45	44	36	67	61	28	35	1
Mount Lebanon	%	38.4	38.4	41.7	38.6	43.9	40.7	39.9	39.1	41	38.1	44.5	2.1
	n	178	178	73	145	145	142	116	175	165	88	109	4
Nabatieh	%	6.9	6.5	5.7	6.9	6.1	7.2	7.6	6	6.5	10.4	4.5	
	n	32	30	10	26	20	25	22	27	26	24	11	
South Lebanon	%	36.2	36.6	35.4	33.3	60.1	36.1	36.4	37.3	34.6	35.5	33.5	1.1
	n	168	170	62	141	110	126	106	167	139	82	82	2
P-value		NA**	NA**	0.091	0.847	0.01*	0.039*	0.184	0.741	0.383	0.177	0.043*	0.161

* Statistically significant p-value <0.05
** As Almost all chose this

Channels of communication

When asked about the channels they use to access COVID-19 information, participants were divided as follows: Social media (66.2%, n=329), online research (65%, n=323), TV (62.4%, n=310), Personal contact with health professionals (39.2%, n=195), WhatsApp (33%, n=164), Face-to-face sessions (32.8%, n=163), booklets/flyers (30.8%, n=153), online training sessions (30.6%, n=152), Personal contact with family/friends/neighbours (29%, n= 144), YouTube (15.5%, n=77), Radio (8%, n=40) and Other (Work, LRC, Islamic medical association, Civil defence, scout) (1.6%, n=8) (Figure 8).

Figure 8. Channels of communication through which COVID-19 information was accessed

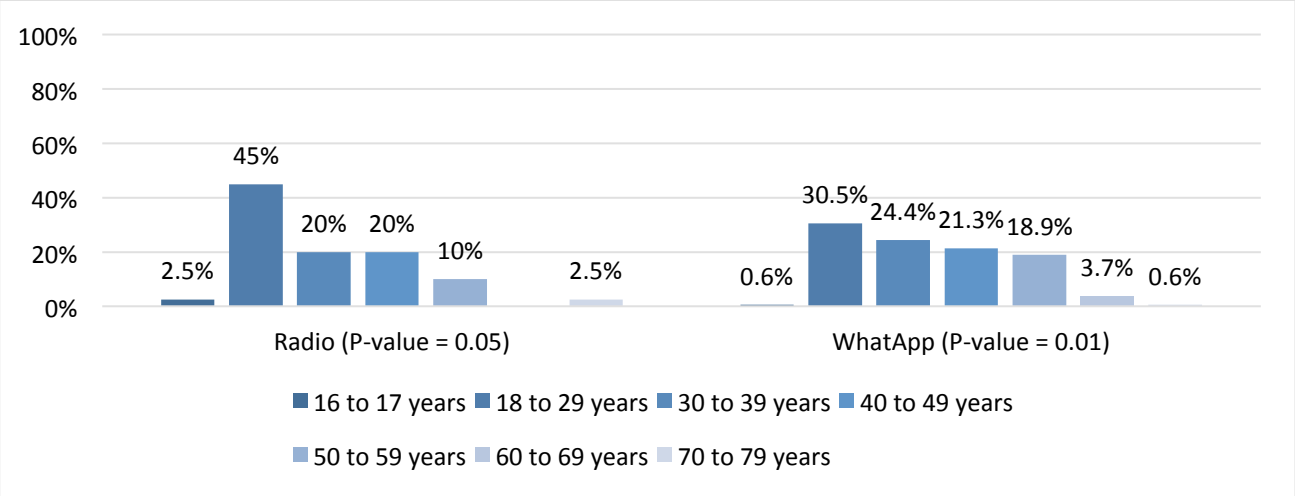


Further inferential analysis was conducted between the different channels through which people received COVID-19 information and demographic variables. Results showed that retrieving COVID-19 information through certain channels was dependent of nationality, age, gender, educational level, governorate, and occupation. Detailed results are presented below:

- **Nationality:** channels used (booklets/flyers) to receive COVID-19 information was significantly associated with Nationality (P-value <0.01). It was higher among Lebanese (92.2%, n=141) compared to Palestinians (5.2%, n=8) and other nationalities (2.6%, n=4).

- **Age:** Modality used to access COVID-19 information and age was statistically significant for radio and WhatsApp (Figure 9).
  - *Radio:* borderline significance (P-value = 0.05). Higher percentages of people using this channel was among those aged 18 to 29 (45%, n=18) followed by 30 to 39 and 40 to 49 (20%, n=8 each), 50 to 59 (10%, n=4), and 16 to 17 and 70 to 79 years old (2.5%, n=1).
  - *WhatsApp*: statistically significant P-value = 0.01. WhatsApp was mostly used by individuals aged 18 to 29 (30.5%, n=50) followed by 30 to 39 (24.4%, n=40), 40 to 49 (21.3%, n=35), 50 to 59 (18.9%, n=31), 60 to 69 (3.7%, n=6) and 16 to 17 and 70 to 79 years old (0.6%, n=1).

Figure 9. Channels of communication representation by age



- **Gender:** WhatsApp and Face-to-face channels were dependent of gender with statistically significant P-values of <0.01 each.
  - *WhatsApp* was equally likely used by Males (50%) and females (50%).
  - *Face-to-face sessions* were used by males (54%, n=88) more than females (46%, n=75).

- **Educational level:** Online search, booklet/flyers, online training sessions and personal contact with health professionals are statistically dependent on education (Figure 10)
  - *Online research*: (p-value <0.01) with a moderate relationship (coefficient = 0.32): this channel was mostly used by university degree holders (58.7%, n=189) followed by advanced university (20.5%, n=66), secondary/high school (19.9%, n=64) and primary/elementary educated people (0.9%, n=3)
  - *Booklets/flyers:* (P-value = 0.01) with a weak relationship (coefficient =0.01). Booklets were mostly used by university degree holders (58.3%, n=88) followed by advanced university (21.2%, n=32), secondary/high school (19.2%, n=29) and primary/elementary educated people (1.3%, n=2)
  - *Online training sessions:* (P-value = 0.02) with a weak relationship (coefficient= 0.12). This channel was mostly used by university degree holders (58.3%, n=88) followed by advanced university (20.5%, n=31), secondary/high school (19.9%, n=30) and primary/elementary educated people (1.3%, n=2)

– *Personal contact with health professionals*: (P-value <0.01) with a weak relationship (coefficient = 0.19). People who mostly used this channel were university degree holders (56.4%, n=110) followed by advanced university (22.6%, n=44), secondary/high school (20%, n=29) and primary/elementary educated people (1%, n=2)

Figure 10. Channels of communication representation by educational level

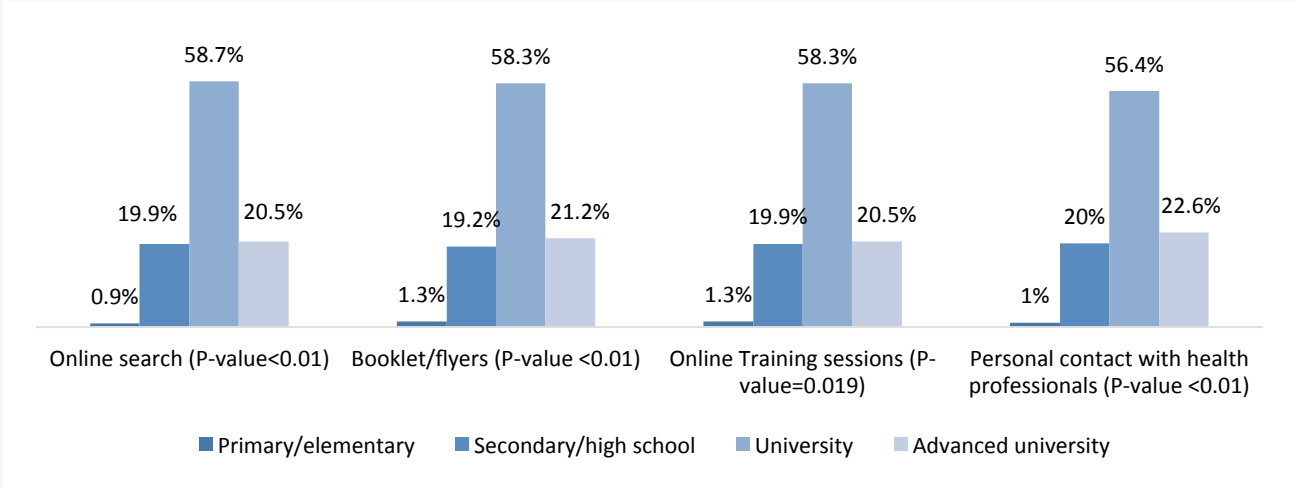
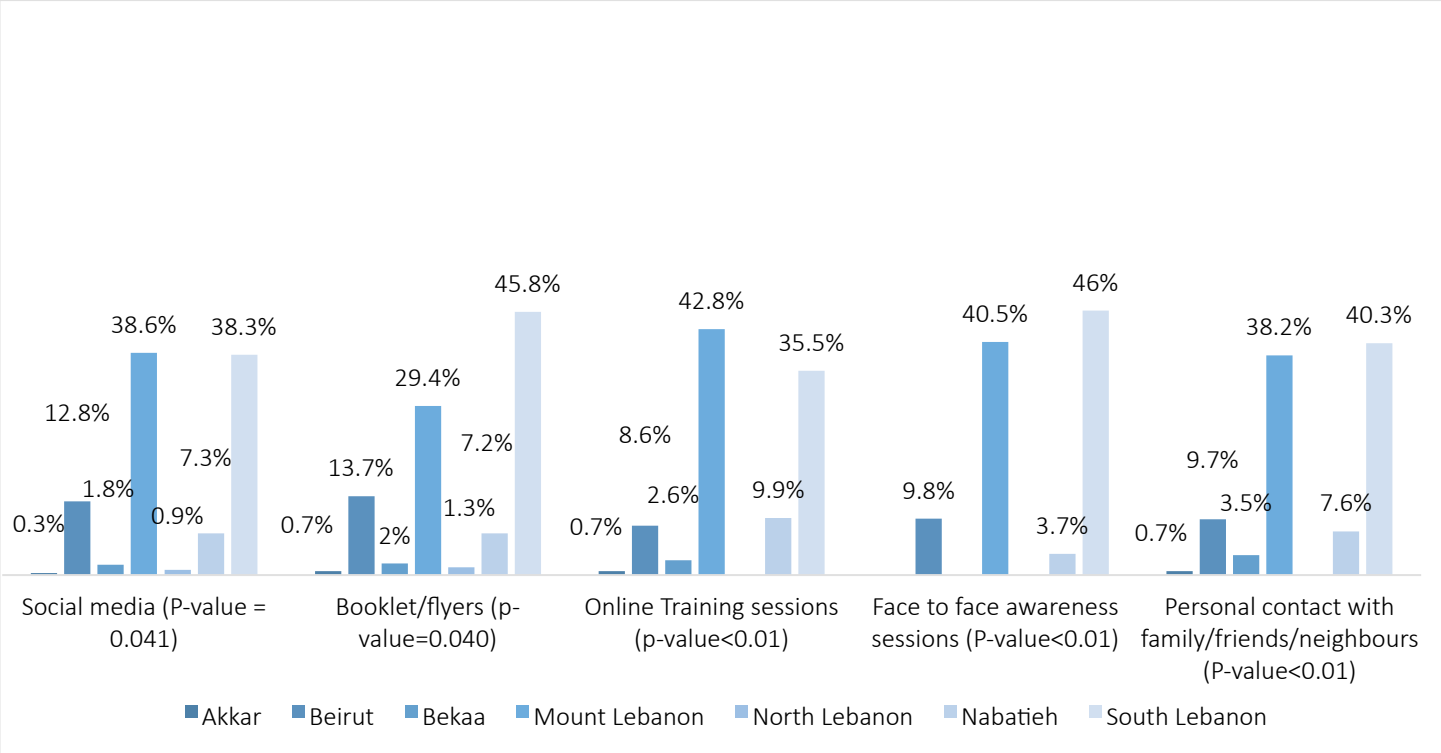


Figure 11. Channels of communication representation by governorate

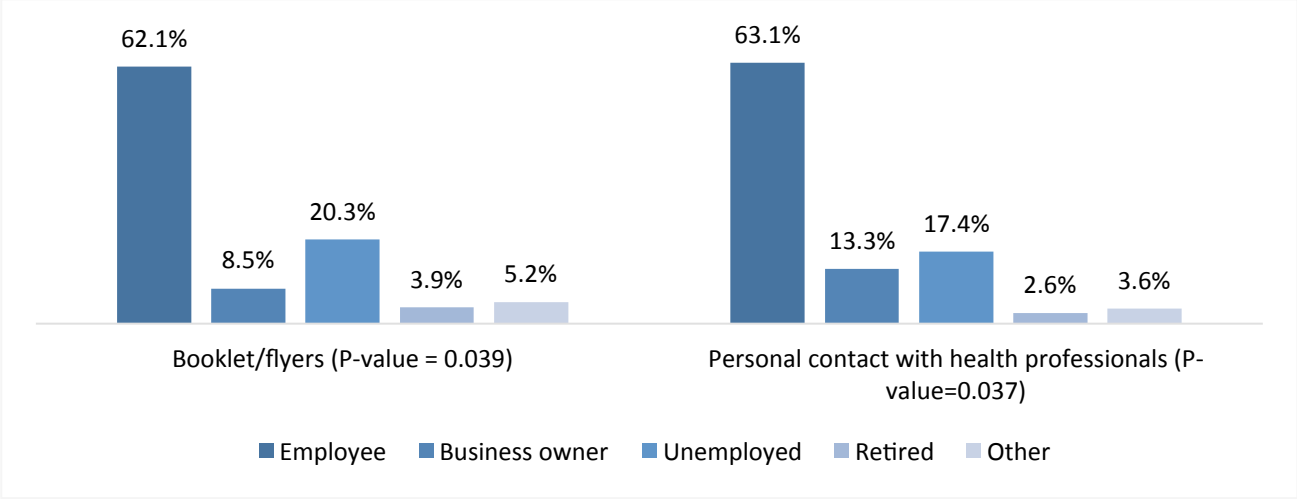


- **Governorate**: social media, booklets/flyers, online training sessions, face-to-face awareness sessions and personal contact with family/friends/neighbours dependent on Governorate. As shown in the Figure 11 above:
  – *Social Media:* (P-value = 0.04) with a weak relationship (coefficient = 0.1). This channel was mostly used by people from Mount Lebanon (38.6%, n= 127) followed by South Lebanon (38.3%, n= 126), Beirut (12.8%, n=42) Nabatieh (7.3%, n=24), Bekaa (1.8%, n=6), North Lebanon (0.9%, n=3) and Akkar (0.3%, n=1)

- *Booklets/flyers:* (P-value=0.04) with a weak relationship (coefficient = 0.16). These channels were mostly used by people from South Lebanon (45.8%, n= 70) followed by Mount Lebanon (29.4%, n= 45), Beirut (13.7%, n=21) Nabatieh (7.2%, n=11), Bekaa (2%, n=3), North Lebanon (1.3%, n=2) and Akkar (0.7%, n=1).
- *Online training sessions* (P-value<0.01) with a weak relationship (coefficient = 0.2). This channel was mostly used by people from Mount Lebanon (42.8%, n= 65) followed by South Lebanon (35.5%, n= 54), Nabatieh (9.9%, n=15), Beirut (8.6%, n=13), Bekaa (2.6%, n=4) and Akkar (0.7%, n=1).
- *Face-to-face sessions:* (P-value < 0.01) with a weak relationship (coefficient = 0.2). This channel was mostly used by people from South Lebanon (46%, n=75) followed by Mount Lebanon (40.5%, n= 66), Beirut (9.8%, n=16) and Nabatieh (3.7%, n=6).
- *Personal contact with family/friends/neighbours:* (P-value < 0.01) with a weak relationship (coefficient = 0.2). This channel was mostly used by people from South Lebanon (40.3%, n=58) followed by Mount Lebanon (38.2%, n= 55), Beirut (9.7%, n=14) and Nabatieh (7.6%, n=11) and Akkar (0.7%, n=1).

- **Occupation:** booklets/flyers and personal contact with family/friends/neighbours dependent on the occupation status of the respondents. As shown in Figure 12 below:
  - *Booklets/flyers*: (P-value = 0.039) with a weak relationship (coefficient 0.12) were mostly used by employees (62.1%, n= 95), unemployed (20.3%, n= 31), business owners (8.5%, n=13), other (5.2%, n=8) and retirees (3.9%, n=6).
  - *Personal contact with family/friends/neighbours:* (P-value = 0.037) with a weak relationship (coefficient 0.14) were mostly used by employees (63.1%, n= 123), unemployed (17.4%, n= 34), business owners (13.3%, n=26), other (3.6%, n=7) and retirees (2.6%, n=5).

Figure 12. Channels of communication representation by occupation

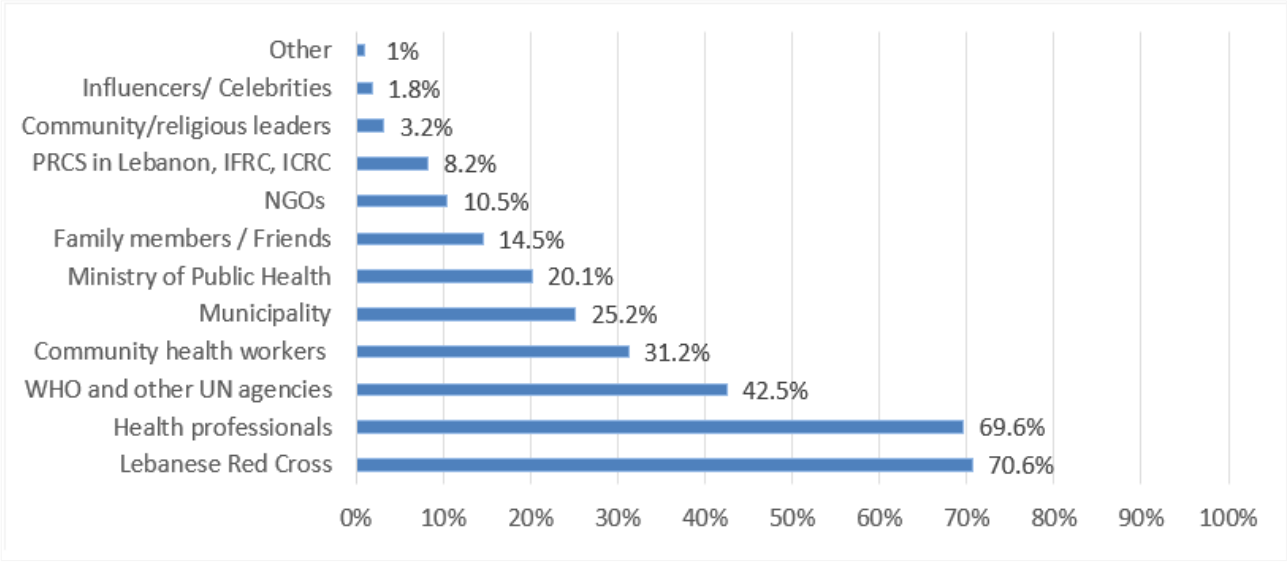


It is worth noting that all beneficiaries mentioned that the above channels were their preferred ones (100%, n=497).

Trustworthy sources of information

Trustworthy sources of information for the survey participants included: LRC (70.6%, n=351), Health professionals/physicians (69.6%, n=346), WHO and other UN agencies (42.5%, n=211), Community health workers (31.2%, n=155), municipality (25.2%, n=125), MoPH (20.1%, n=100), Family members / Friends (14.5%, n=72), International or Local Non-Governmental Organisations (10.5%, n=52), Palestinian Red Crescent Society in Lebanon, IFRC, ICRC (8.2%, n=41), Community leaders and/or religious leaders (3.2%, n= 16), influencers/celebrities (1.8%, n= 9) and Other (1%, n=5) (Figure 13).

Figure 13. Trustworthy sources of information



Bivarite analysis for trustworthy sources of information are described below:

- **Nationality:** Referring to trustworthy information from Palestinian Red Crescent Society in Lebanon and from community health workers was dependent on nationality with respective P-values of <0.01 and 0.05.
  - *Palestinian Red Crescent Society:* (P-value <0.01) with a moderate relationship (coefficient = 026). Higher percentages were seen among Lebanese (80.5%, n=33) compared to Palestinians (19.5%, n=8)

- **Gender:** Referring to trustworthy information from Other categories (Work, LRC, Islamic medical association, Civil defence, scout) and municipalities was dependent on gender (Figure 14)

- Referring to trustworthy information from Other (Work, LRC, Islamic medical association, Civil defence, scout) and municipalities were dependent on gender. (Figure 14)
  - *Other* (Work, LRC, Islamic medical association, Civil defence, scout): Higher percentages were seen among males (100%, n=5)
  - *Municipality*: Higher percentages of males (59.2%, n= 74) would refer to municipalities compared to 40.8% (n=51) females.

Figure 14. Trustworthy sources of information by gender

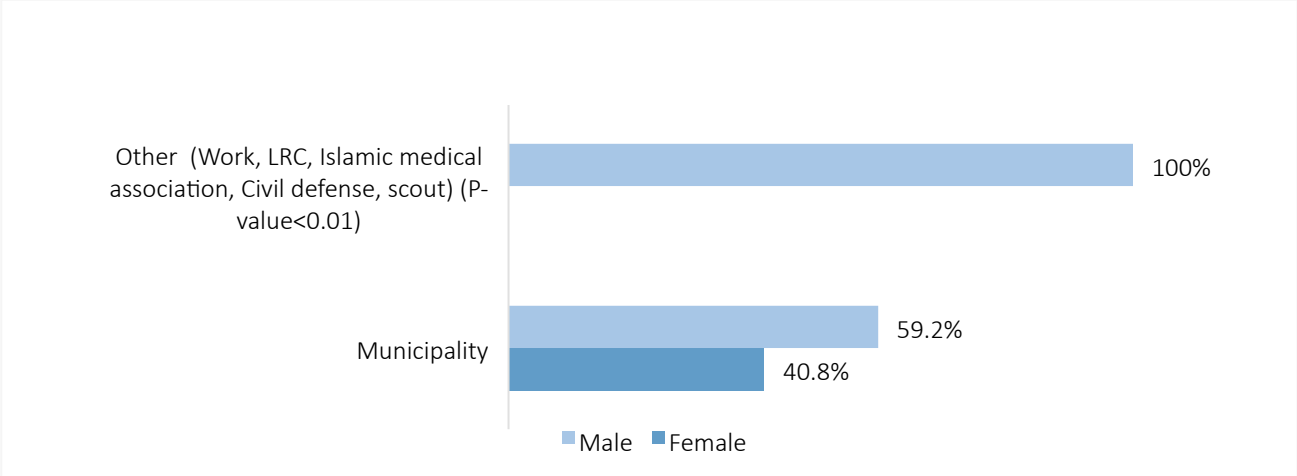


Figure 15. Trustworthy sources of information by age

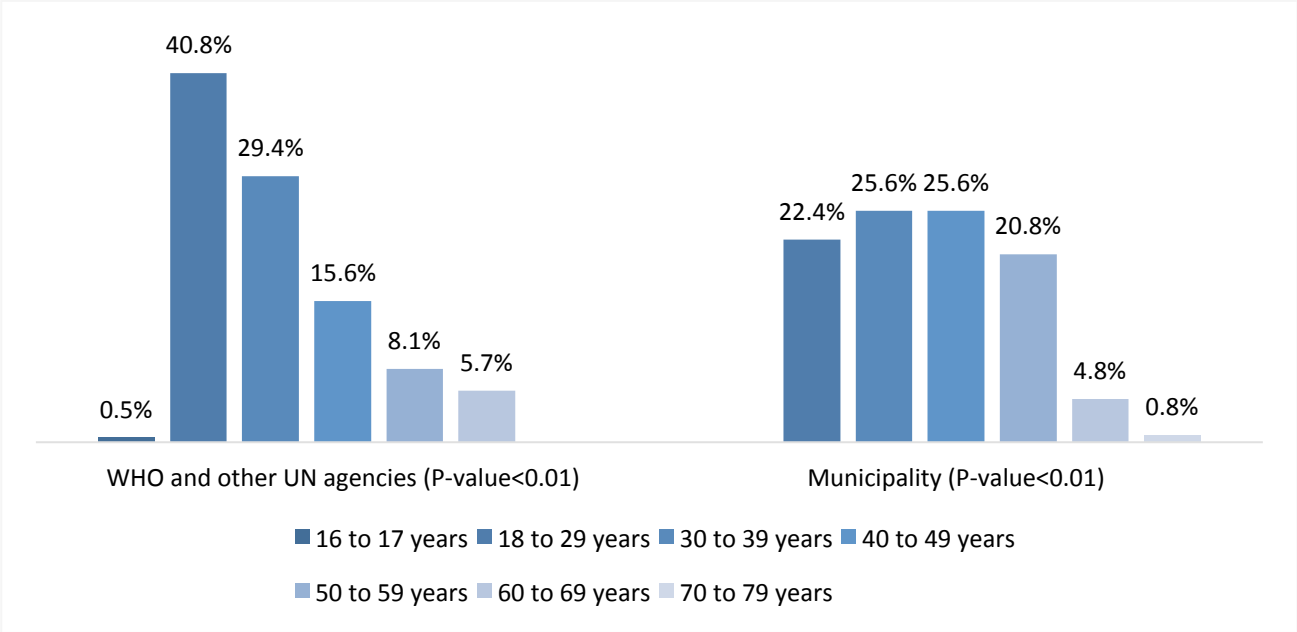


Figure 16. Trustworthy sources of information by education

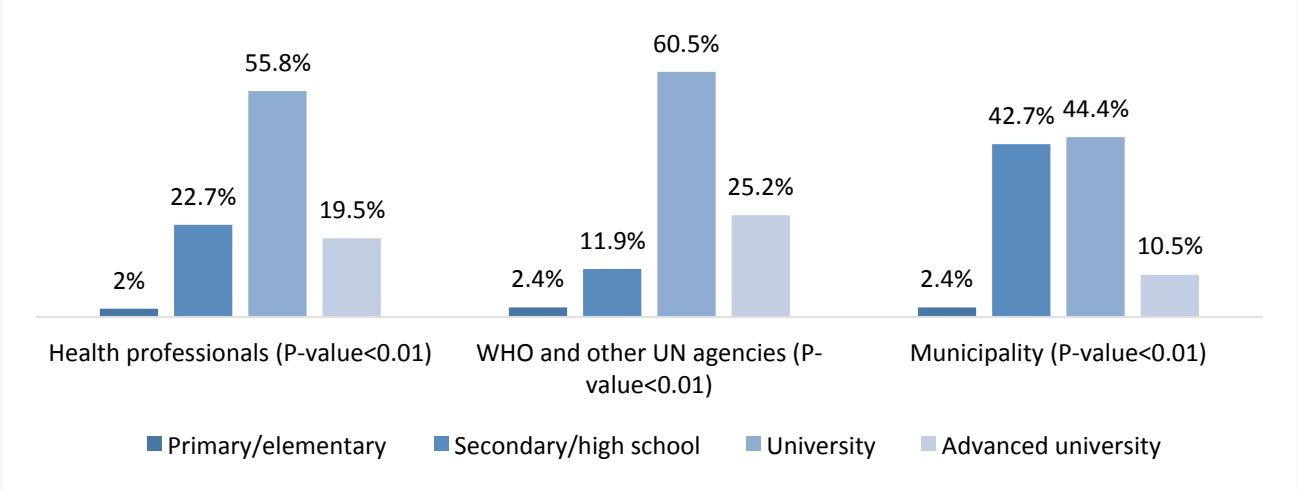
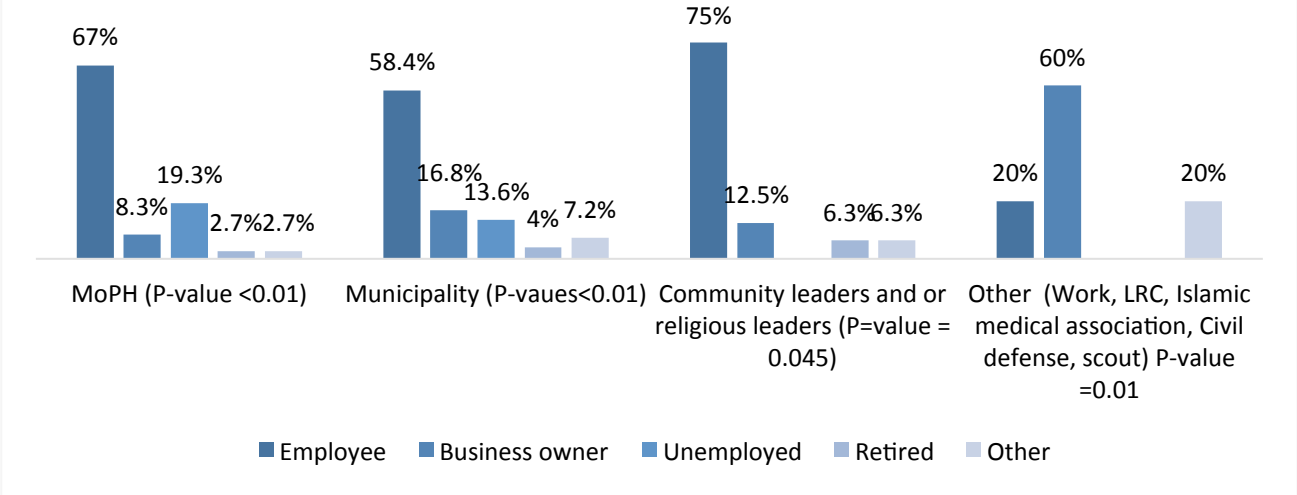


Figure 17. Trustworthy sources of information by occupation



- **Age:** Referring to trustworthy information through WHO and other UN agencies and municipalities were dependent on age (Figure 15).
  - *WHO and other UN agencies*: (P-value<0.01) with a weak relationship (coefficient = 0.2). Higher percentages were seen among people aged 18 to 29 (40.8%, n=86) followed by those aged 30 to 39 (29.4%, n=62), 40 to 49 (15.6%, n=33), individuals aged 50 to 59 (8.1%, n=17), 60 to 69 (5.7%, n=12), 16 to 17 years old (0.5%, n=1)
  - *Municipality:* (P-value<0.01) with a moderate relationship (coefficient = 0.22). Higher percentages were seen among people aged 30 to 39 and 40 to 49 (25.6%, n=32) followed by those aged 18 to 29 (22.4%, n=28), individuals aged 50 to 59 (20.8%, n=26), 60 to 69 (4.8%, n=6) and 70 to 79 (0.8%, n=1)

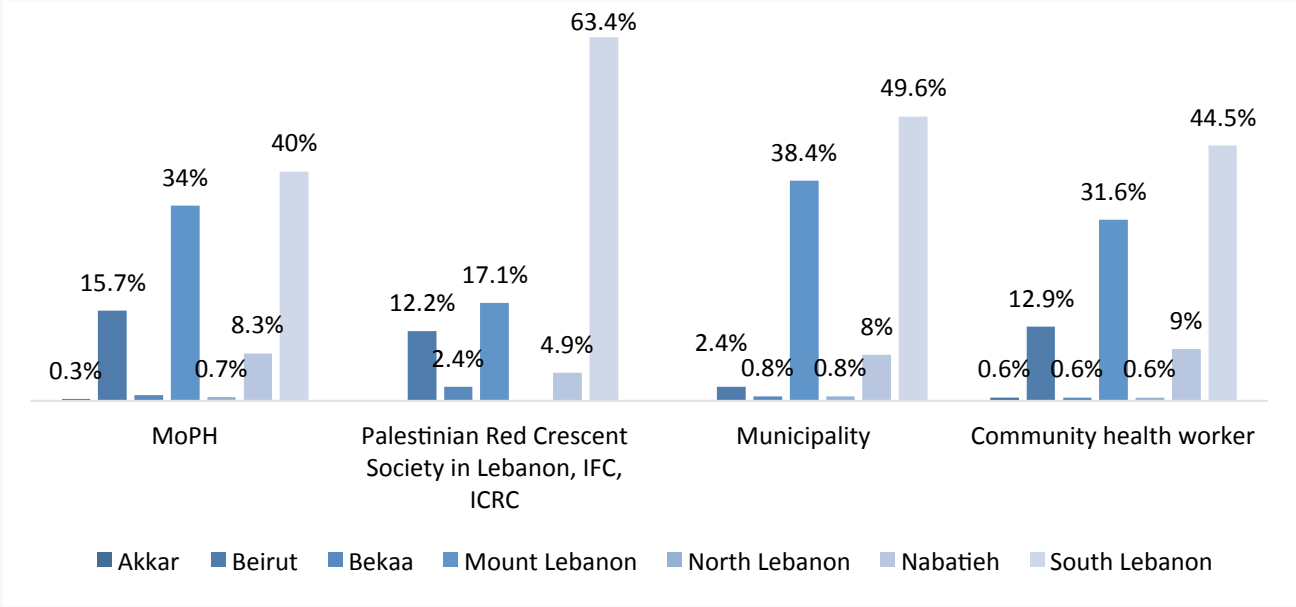
- **Education:** Referring to trustworthy information through health professionals, WHO and other agencies and municipalities were dependent on education (Figure 16).
  - *Health professionals:* (P-value<0.01) with a moderate relationship (0.22). Higher percentages were seen among people with university degree (55.8%, n=192) followed by: those holding secondary/high school degrees (22.7%, n= 78), individuals with advanced university degrees (19.5%, n=67) and people who reached primary educational level (2%, n=7).
  - *WHO and other UN agencies:* (P-value<0.01) with a moderate relationship (coefficient=0.32). Higher percentages were noticed university degree (60.5%, n=127) followed by: advanced university degrees (25.2%, n= 53), individuals with secondary/high school education (11.9%, n=25) and people who reached primary educational level (2.4%, n=5).
  - *Municipality:* (P-value<0.01) with a weak relationship (coefficient=0.2). Higher percentages were noticed among university degree holders (44.4%, n=55) followed by: individuals with secondary/high school education (42.7%, n=53) and people who reached primary educational level (2.4%, n=3).

- **Occupation:** Referring to trustworthy information through MoPH, municipalities, community leaders and or religious leaders and other (work, LRC, civil defence, scout…) were dependent on occupation (Figure 17).
  - *MoPH:* (P-value<0.01) with a moderate relationship (coefficient = 0.12). Higher percentages were seen among employees (67%, n=201) followed by unemployed (19.3%, n=58), business owners (8.3%, n= 25), and retirees & those who had other job occupations (volunteers, free lancers…) (2.7%, n=8)
  - *Municipality:* (P-value<0.01) with a weak relationship (coefficient = 0.23). Higher percentages were seen among employees (58.4%, n=73) followed by business owners (16.8%, n=21), unemployed (13.6%, n= 17), those who had other job occupations (volunteers, free lancers…) (7.2%, n=9) and retirees (4%, n=5)
  - *Community leaders and or religious leaders:* (P-value=0.045) with a weak relationship (coefficient = 0.12). Higher percentages were seen among employees (75%, n=12) followed by business owners (12.5%, n=2), and retirees & those who had other (volunteers, free lancers…) job occupations (6.3%, n=1).
  - *Other trustworthy sources (work, LRC, civil defence…):* (P-value=0.016) with a weak relationship (coefficient = 0.2). Higher percentages were seen among business owners (60%, n=3), and other & employees (20%, n=1).

- **Governorate:** Referring to trustworthy information through MoPH, Palestinian Red Crescent Society in Lebanon, municipalities, and community health workers were dependent on governorate (Figure 18).
  - *MoPH:* (P-value = 0.039) with a weak relationship (coefficient=0.16). Higher percentages were seen among South residents (40%, n=120) followed by Mount Lebanon residents (34%, n=102), Beirut (15.7%, n=47), Nabatieh (8.3%, n=25), Bekaa (1%, n=3), North Lebanon (0.7%, n=2) and Akkar (0.3%, n=1)

- *Palestinian Red Crescent Society:* (P-value = 0.013) with a weak relationship (coefficient = 0.18). Higher percentages were seen among South residents (63.4%, n=26) followed by Mount Lebanon residents (17.1%, n=7), Beirut (12.2%, n=5), Nabatieh (4.9%, n=2) and Bekaa (2.4%, n=1)
- *Municipality:* (P-value <0.01) with a moderate relationship (coefficient = 0.23). Higher percentages were seen among South residents (49.6%, n=62) followed by Mount Lebanon residents (38.4%, n=48), Nabatieh (8%, n=10), Beirut (2.4%, n=3) and Bekaa & North Lebanon (0.8%, n=1)
- *Community health workers:* (P-value =0.042) with a weak relationship (coefficient = 0.16). Higher percentages were seen among South residents (44.5%, n=69) followed by Mount Lebanon residents (31.6%, n=49), Beirut (12.9%, n=20), Nabatieh (9%, n=14), and Akkar & Bekaa & North Lebanon (0.6%, n=1)

Figure 18. Trustworthy sources of information by governorate

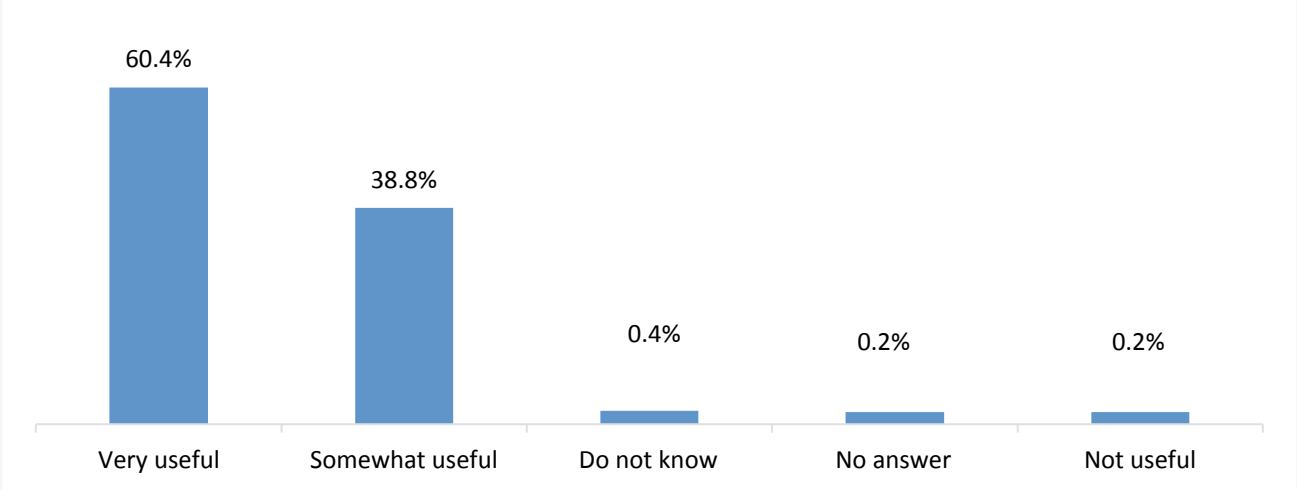


3. Appropriateness and usefulness of information

Usefulness of information

When participants were asked how useful COVID-19 information were, responses were distributed between somewhat useful and useful, where 60.4% (n=300) mentioned that they were very useful and 38.8% (n=193) stated that the information they received were somewhat useful (Figure 19). The mean for this question was 2.6 out of 3 with a standard deviation (SD) of 0.5.

Figure 19. Usefulness of COVID-19 information



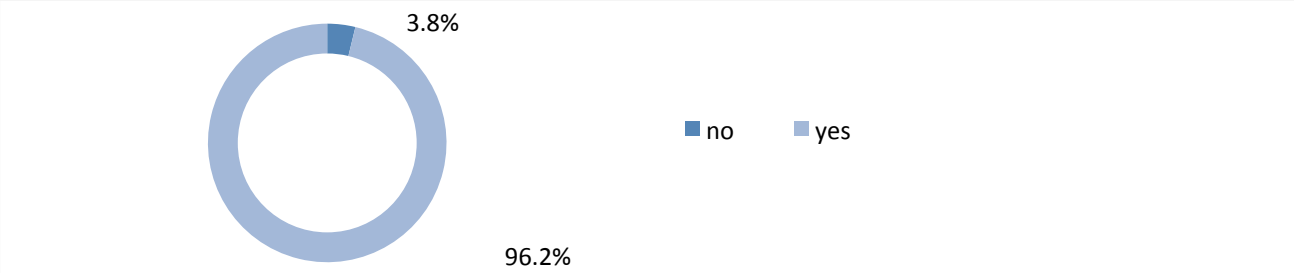
Following bivariate analysis of the usefulness of COVID-19 information received with the demographic variables, nationality and age were not statistically significant. However:

- There was a weak correlation (coefficient=0.13) between the usefulness of the information and gender; males were more likely to report that the COVID-19 information were useful (P-value<0.01)
- There was a weak correlation (coefficient = 0.12) between the usefulness of the information and governorate; People living in Akkar were more likely to report usefulness of the information followed by Beirut, Mount Lebanon and South Lebanon (P-value<0.01)
- There was a weak correlation (coefficient = 0.11) between the usefulness of the information and education. People with advanced university degrees were more likely to report usefulness of the information followed by university degree holders and people who reached secondary/high school educational level (P-value<0.01).

4. Relevance of information

Participants were then asked if the information they received were applicable and realistic and 96.2% (n=478) agreed while 3.8% (n= 19) did not (Figure 20).

Figure 20. Relevance of COVID-19 information



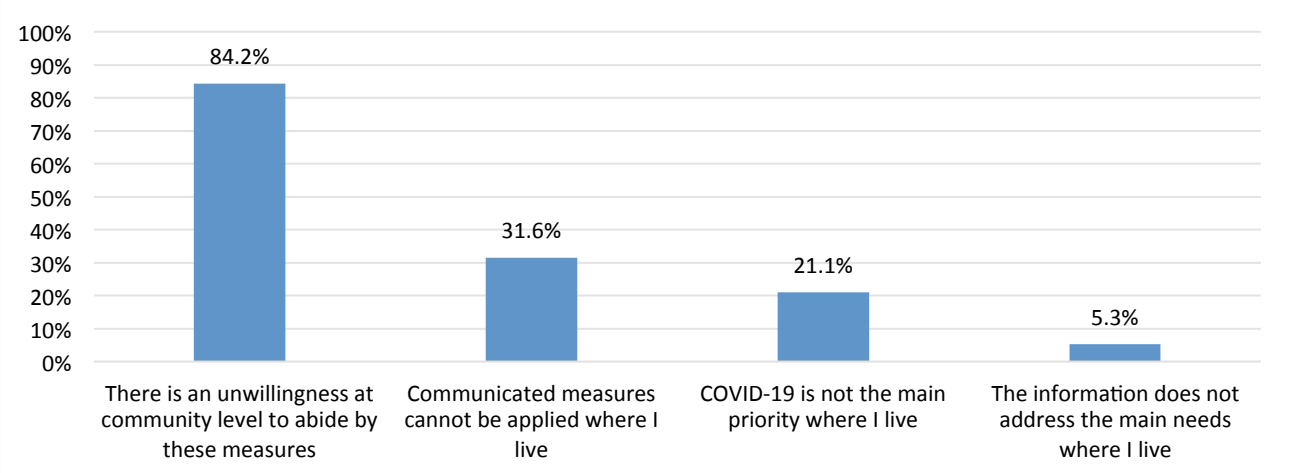
Following bivariate analysis of the relevance of COVID-19 information with the demographic variables, age, gender, education, occupation and Nationality were not correlated with how applicable and realistic the information was. Relevance was statistically significant by governorate with a P-value = 0.039. As per the table below, relevance was perceived higher in South Lebanon (38.1%, n=182), followed Mount Lebanon (37.4%, n= 179), Beirut (15.5%, n=74), Nabatieh (6.5%, n=31), North Lebanon (1.3%, n=6), Bekaa (1%, n=5), Akkar (0.2%, n=1) (Table 5).

Table 5. Relevance of COVID-19 information by Governorate

		Akkar	Beirut	Bekaa	Mount Lebanon	North Lebanon	Nabatieh	South Lebanon
Relevance by Governorate	%	0.2	15.5	1	37.4	1.3	6.5	38.1
	n	1	74	5	179	6	31	182
P-value								0.039

Participants who mentioned that the COVID-19 information were not useful (3.8%, n=19), were further asked about the reason and figure 21 below summarizes the results. Out of the 19 respondents: 84.2% (n=16) mentioned that there is unwillingness at community level to abide by the measures, 31.6% (n=6) stated that the communicated measures cannot be applied where they live, 21.1% (n=4) said that COVID-19 was not the main priority where they live and one participant listed that the information did not address the main needs where he/she lives (Figure 21).

Figure 21. Reasons why COVID-19 information are not relevant



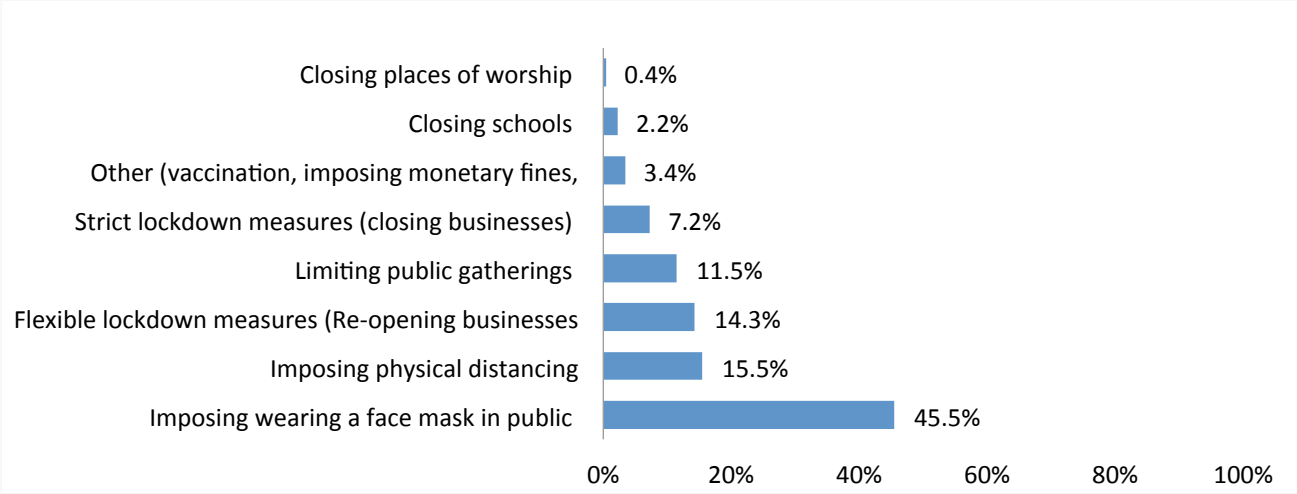
5. Community awareness about COVID-19

Prevention measures at community level

Participants were asked about the measures that should be taken to stop COVID-19 transmission at community level.

45.5% (n=226) of the respondents mentioned that imposing wearing a face mask in public would help in decreasing COVID-19 transmission at community level. 15.5% (n=77) stated that imposing physical distancing would help too. The rest of the sample was divided as follows: 14.3% (n=71) chose the flexible lockdown measures option, 11.5% (n=57) believe that public gatherings should be limited, 7.2% (n=36) thought that strict lockdown measures shuld be followed, 3.4% (n=17) stated that other means to prevent COVID-19 transimission like imposing monetary fines, increasing awarenes, vaccination etc. should be taken and only 2.2% (n=11) thought that schools should be closed (Figure 22).

Figure 22. Measures taken to stop COVID-19 transmission at community level

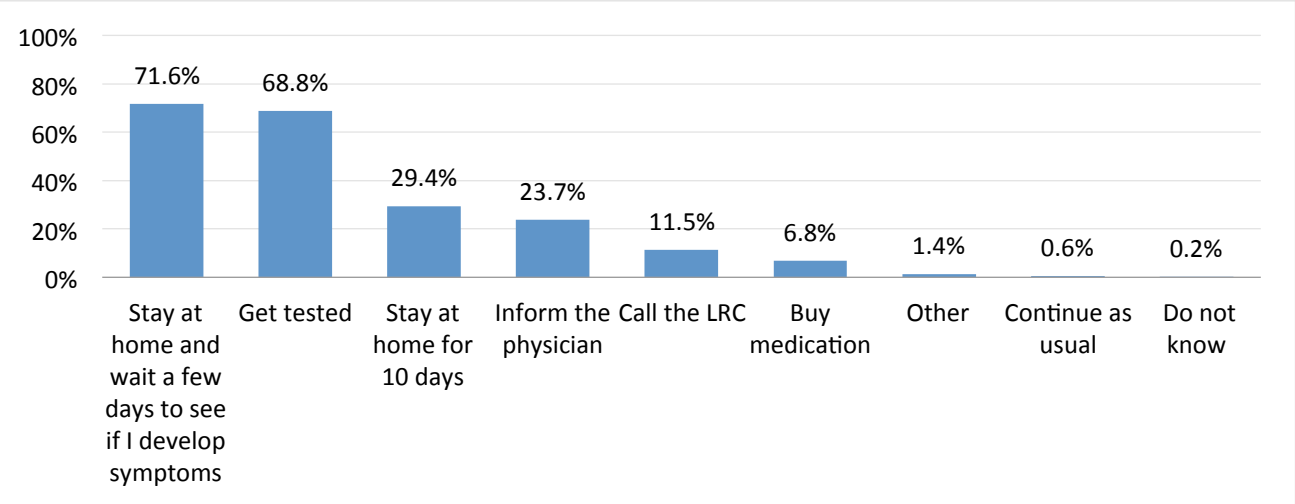


Bivariate analysis between the measures that should be taken to stop COVID-19 transmission and demographic variables revealed that the perception around COVID-19 preventive measures was independent of nationality, age, gender, governorate, education and occupation as the correlation between them was not statistically significant.

Managing cases of COVID-19

Survey participants were then asked what they would first do in case they have been in contact with someone who had COVID-19, and the majority (71.6%, n=356) stated that they would stay at home. Getting tested was also seen by 68.8% (n= 342) of the sample as the first action that one should go for. Less than the third of the sample (29.4%, n=146) would opt to stay at home for 10 days. The rest of the sample was divided as follows: 23.7% (n=118) would inform the physician, 11.5% (n= 57) would call the LRC, 6.8% (n=34) would buy medication and only 1.4% (n=7) would choose other alternatives including: staying at home for 14 days, staying at home for 5 days then getting tested etc. (Figure 23).

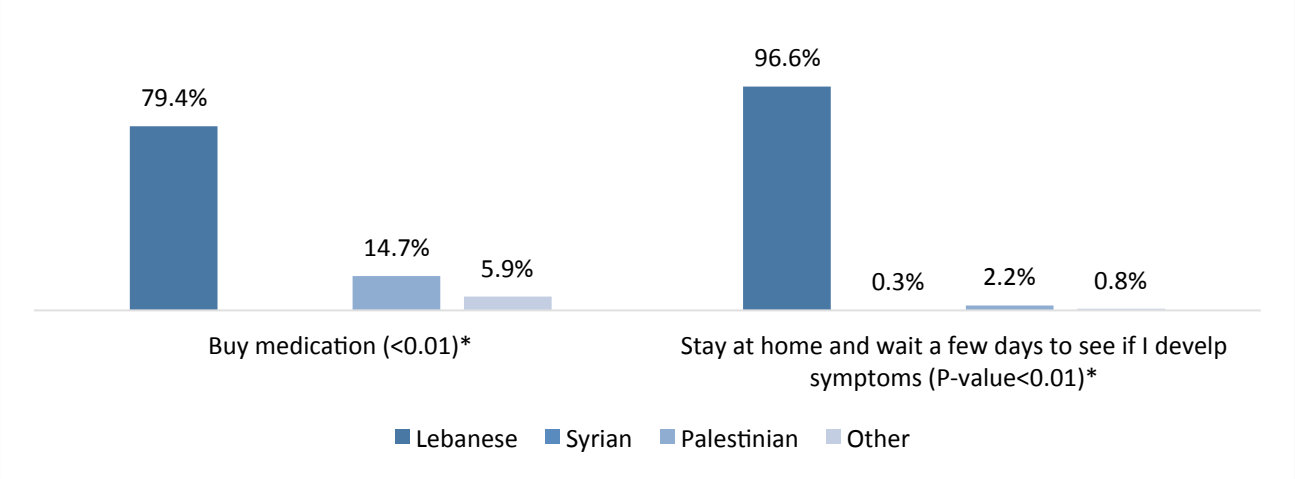
Figure 23. Action taken in case participants get in contact with a COVID-19 case



Bivariate analysis was conducted between the perception of participants regarding the action that they would take in case they were in contact with a COVID-19 case with demographic variables. Gender and education were not statistically significant with any of the options. Below are the findings for the rest of the variables.

- **Nationality:** Buying medication was dependent on nationality. Among those who chose this answer, 79.4% (n= 27) were Lebanese, 14.7% (n=5) were Palestinians and 5.9% (n=2) had other nationalities (Columbian, Iranian, Jordanian, Swedish, American) (Figure 24).
  - Staying at home and waiting a few days to see if one would develop symptoms dependent on nationality; it was chosen by 96.6% (n=344) Lebanese followed by 2.2% (n=8) Palestinians, 0.8% (n=3) other nationalities (Columbian, Iranian, Jordanian, Swedish, American) and Syrians (0.3%, n=1)

Figure 24. Managing cases of COVID-19 by nationality



- **Age:** Getting tested was statistically significant with age (P-value<0.01) with a weak relationship (coefficient = 0.2); 38.6% (n=132) were aged 18 to 29 followed by 27.2% (n=93) aged 30 to 39, 19.9% (n=68) aged 40 to 49, 9.1% (n=31) aged 50 to 59, 4.4% (n=14) aged 60 to 69 and 0.9% (n=3) aged 16 to 17 years old.

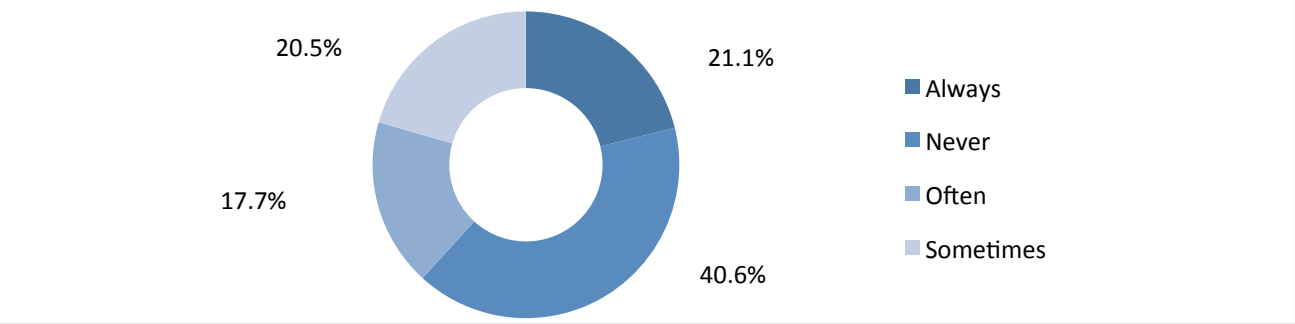
- **Governorate:** Calling LRC was statistically significant with governorate with a P-value=0.014 and a weak relationship (Coefficient =1.2). Higher percentage of people who would call LRC in case they were in contact with a COVID-19 case were seen in South (54.4%, n=31) followed by Beirut (19.3%, n= 11) Mount Lebanon (17.5%, n=10), Nabatieh (7%, n=4) and North Lebanon (1.8%, n=1).

- **Occupation:** Getting tested option was statistically significant with occupation with a P-value=0.035 and a weak relationship (coefficient = 0.1). Higher percentage of people who would get tested in case they were in contact with a COVID-19 case were seen among employees (62.6%, n= 214), followed by unemployed (24.3%, n=83), business owners (10.2%, n=35), other (volunteers, freelancers…) (2%, n=7) and retirees (0.9%, n=3).

Community engagement

Respondents were asked about the level of their engagement in the community with the purpose to address COVID-19. Less than half of the participants (40.6%, n=202) stated never being engaged in the community, 21.1% (n=105) mentioned that they are always engaged, 20.5% (n=102) were sometimes engaged and 17.7% (n=88) were often engaged. The mean of the responses on how much the participants are involved in community actions to address COVID-19 was 2.19 out of 4 with a standard deviation of 1.181 (Figure 25).

Figure 25. Level of community engagement to address COVID-19



Bivariate analysis between being engaged in the community to address COVID-19 and the demographic variables showed that nationality, age, governorate and education were not statistically significant. However, being involved in the community was dependent on gender and occupation.

- There is a moderate correlation (coefficient = 0.4) between gender and being engaged in the community. Males were more likely to be involved in community actions to address COVID-19 compared to females.
- There was a weak correlation (coefficient = 0.1) between occupation and being engaged in the community. People with advanced university degrees were more likely to be engaged in addressing COVID-19 at community level followed by holders of university degrees, people who reached secondary educational level and those who completed primary educational level.

Respondents who mentioned that they were engaged in addressing COVID-19 at community levels were asked about the type of actions they did. Results are shown in Figure 26 below: 67.5% (n=199) mentioned that they facilitated awareness sessions, 62.4% (n=84) stated that they worked on community-led actions (food/medication assistance), 34.9% (n=103) volunteered with an organisation, 26.4% (n=78) monitored the application of COVID-19 prevention measures in the community, 7.8% (n=23) developed material and 5.1% (n=15) mentioned doing other actions which included volunteering with civil defence, volunteering with LRC, visiting patients and giving them instructions and raising their motivation, working with the response unit in the municipality etc. (Figure 26).

Figure 26. Community engagement actions to address COVID-19

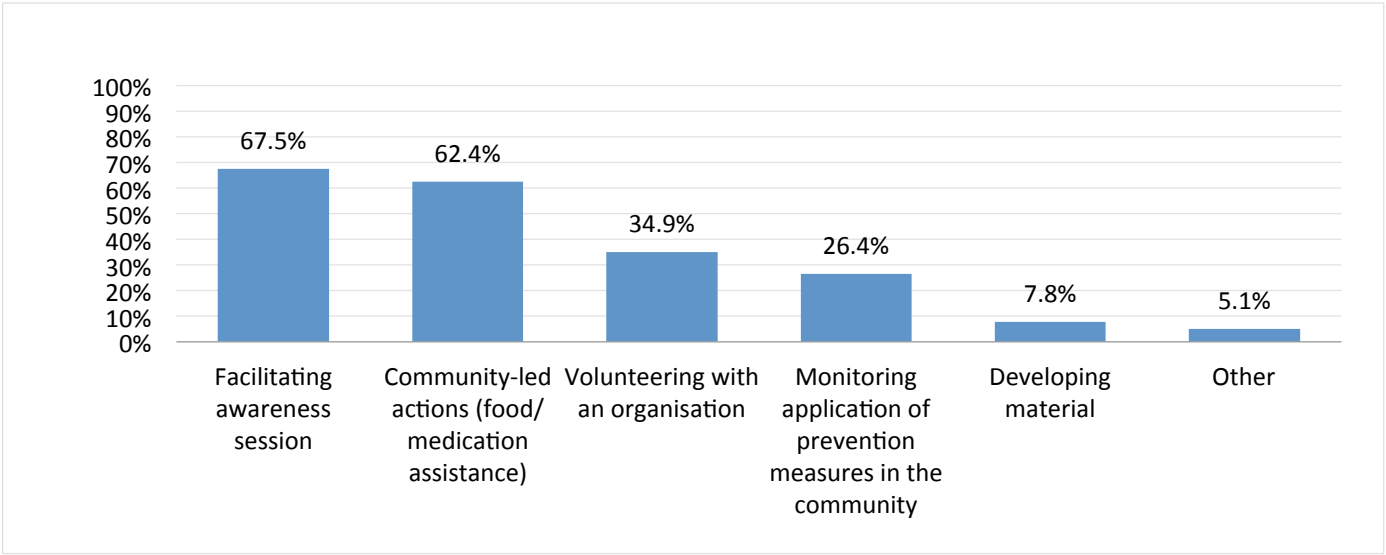


Figure 27. Community engagement actions to address COVID-19 at community level by age

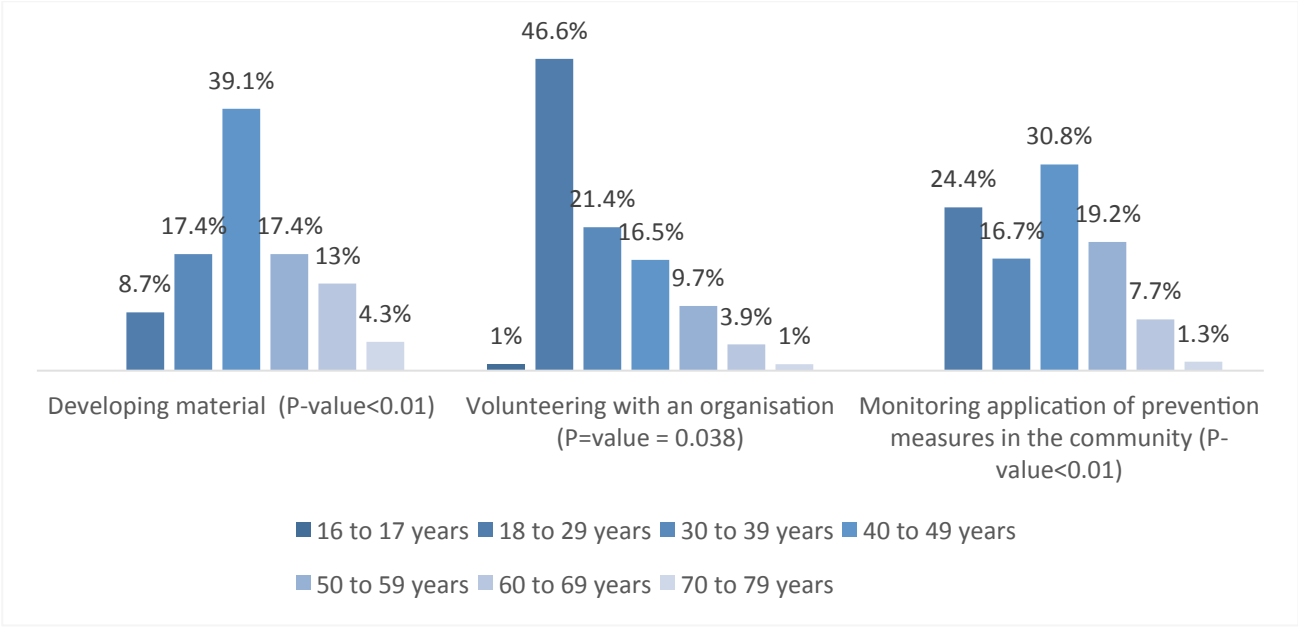


Table 6. Community engagement actions to address COVID-19 at community level by gender

Actions at community level by gender		Facilitating awareness sessions	Developing material	Volunteering with an organisation	Monitoring application of prevention measures in the community	Community-led actions (food/medication assistance)
Female	%	49.5	26.1	37.9	39	47.5
	n	98	6	39	30	87
Male	%	50.5	73.9	62.1	61	55.5
	n	100	17	64	47	96
P-value		<0.01	<0.01	<0.01	<0.01	<0.01

Bivariate analysis showed that all actions were not significantly related with education and below are the finding for the rest of the demographic variables:

- **Age**: Developing material was statistically significant with age (P-value <0.01) with a moderate relationship (coefficient = 0.3). Among those who mentioned that they developed material, the majority were aged between 40 to 49 (39.1%, n=9) followed by those aged 30 to 39 and 50 to 59 (17.4%, n=4), 60 to 69 (13%, n=3), 18 to 29 (8.7%, n=2) and 70 to 79 (4.3%, n=1) (Figure 27 above).
  - Volunteering with an organisation was statistically significant with age (P-value =0.038) with a weak relationship (coefficient = 0.2). Among those who mentioned that they volunteered with an organisation, the majority were aged between 18 to 29 (46.6%, n=48) followed by those aged 30 to 39 (21.4%, n=22), 40 to 49 (16.5%, n=17), 50 to 59 (9.7%, n=10), 60 to 69 (3.9%, n=4), and 70 to 79 along with those aged 16 to 17 (1%, n=1).
  - Monitoring the application of COVID-19 prevention measures was statistically significant with age (P-value<0.01) with a weak relationship (coefficient = 0.2). Among those who mentioned that they monitored the application of COVID-19 prevention measures, the majority were aged between 40 to 49 (30.8%, n=24) followed by 18 to 29 (24.4%, n=19), 50 to 59 (19.2%, n=15), 30 to 39 (16.7%, n=13), 60 to 69 (7.7%, n=6), and 70 to 79 (1.3%, n=1).

- **Gender:** As per the table below, the types of community engagement actions including facilitating awareness sessions, developing material, volunteering, Monitoring the application of preventive measures in the community and community-led actions (food/medication assistance) depended on gender.
  - Facilitating awareness sessions was dependent on gender (P-value<0.01) with a weak relationship (coefficient = 0.2). Males were more likely to facilitate awareness sessions (50.5%, n=100) compared to females (49.5%, n=98)
  - Developing material was dependent on gender (P-value<0.01) with a weak relationship (coefficient = 0.2). Males were more likely to develop material (73.9%, n=17) compared to females (26.1%, n=6).
  - Volunteering with an organisation was dependent on gender (P-value<0.01) with a weak relationship (coefficient = 0.26). Males were more likely to volunteer with an organisation (62.1%, n=64) compared to females (37.9%, n=39).
  - Monitoring the application of prevention measures in the community was dependent on gender (P-value<0.01) with a weak relationship (coefficient = 0.2). Males were more likely to monitor the application of prevention measures (61%, n=47) compared to females (39%, n=30).
  - Community-led actions was dependent on gender (P-value<0.01) with a weak relationship (coefficient = 0.2). Males were more likely to have conducted community-led actions (55.5%, n=96) compared to females (47.5%, n=87). (Table 6)

- **Governorate:** As per the Figure 28 below, facilitating awareness sessions, developing material, volunteering with an organisation, conducting community-led actions are statistically dependent on governorate.
  - Facilitating awareness sessions was statistically significant with governorate (P-value=0.038) with a weak relationship (coefficient = 0.16). Among those who mentioned that they facilitated awareness sessions, the majority lived in South Lebanon (43.7%, n=87) followed by those living in Mount Lebanon (38.2%, n=76), those living in Beirut (11.1%, n= 22), living in Nabatieh (4.5%, n=9), living in Bekaa and North Lebanon (1%, n=2 each) and living in Akkar (0.5%, n=1).
  - Developing material was statistically significant with governorate (P-value<0.01) with a moderate relationship (coefficient = 0.25). Among those who mentioned that they developed material, the majority lived in South Lebanon (65.2%, n=15) followed by those living in Mount Lebanon (30.4%, n=7) and those living in Akkar (4.3%, n=1).
  - Volunteering with an organisation was statistically significant with governorate (P-value=0.01) with a weak relationship (coefficient = 0.17). Among those who mentioned that they volunteered with an organisation, the majority lived in South Lebanon (43.7%, n=45) followed by those living in

Mount Lebanon (36.9%, n=38), those living in Nabatieh (9.7%, n=10), those living in Beirut (5.8%, n= 6), living in North Lebanon (1.9%, n=2 each) and living in Bekaa and Akkar (1%, n=1).

- Community-led actions was statistically significant with governorate (P-value=0.01) with a weak relationship (coefficient = 0.11). Among those who mentioned that they conducted community-led actions, the majority lived in Mount Lebanon (44.6%, n=82) followed by South Lebanon (37%, n=68) followed by those living in Beirut (11.4%, n= 21), those living in Nabatieh (4.9%, n=9), in Bekaa (1.6%, n=3) and living in Akkar (0.5%, n=1).

Figure 28. Community engagement actions to address COVID-19 at community level by governorate

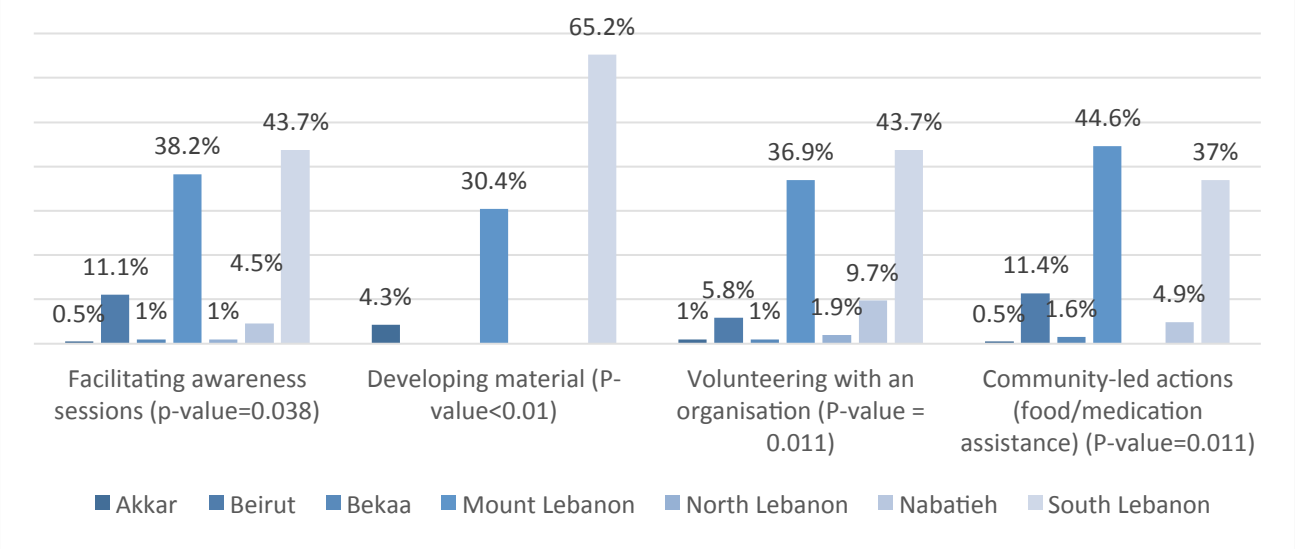


Table 7. Community engagement actions to address COVID-19 at community level by occupation

Actions at community level		Volunteering with an organisation	Monitoring application of prevention measures in the community	Community-led actions (food/medication assistance)
Employee	%	37.9	61.5	56.5
	n	39	48	104
Business owner	%	18.4	11.5	15.1
	n	19	9	29
Unemployed	%	33	15.4	20.1
	n	34	12	37
Retired	%	3.9	5.1	3.3
	n	4	4	6
Other	%	6.8	6.4	4.3
	n	7	5	8
P-value		<0.01	0.039	<0.01

- **Occupation:** Volunteering with an organisation, monitoring the application of prevention measures in the community and conducting community led actions (food/medication) were dependent of occupation (Table 7).
  - Volunteering with an organisation was statistically significant with occupation (P-value<0.01) with a moderate relationship (coefficient = 0.26). Among those who mentioned that they volunteered with an organisation, the majority were employees (37.9%, n=39) followed by unemployed persons (33%, n=34), business owners (18.4%, n=19), other occupations (volunteers, freelancers…) (6.8%, n=7) and retirees (3.9%, n=4).
  - Monitoring the application of prevention measures was statistically significant with occupation (P-value=0.039) with a weak relationship (coefficient = 0.16). Among those who mentioned that they

monitored the application of prevention measures, the majority were employees (61.5%, n=48) followed by unemployed (15.4%, n=12), business owners (11.5%, n=9), other occupations (volunteers, freelancers…) (6.4%, n=5) and retirees (5.1%, n=4).

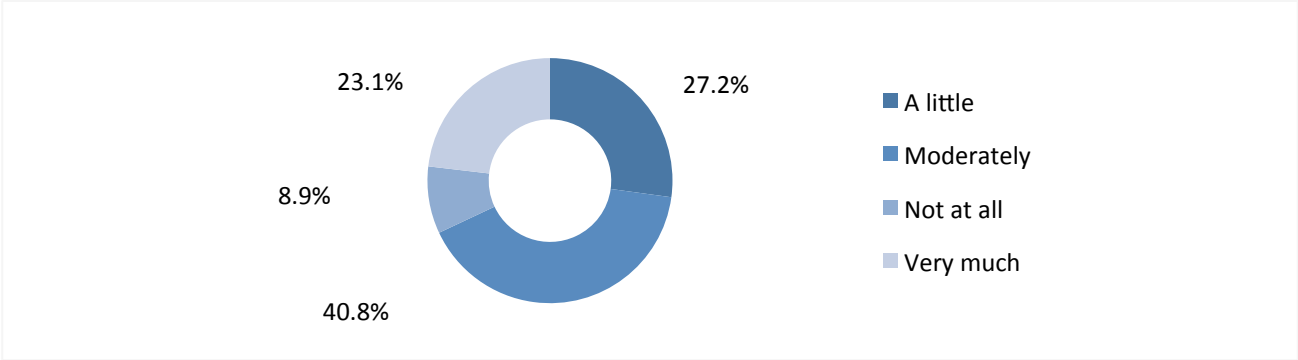
- Conducting community-led actions was statistically significant with occupation (P-value<0.01) with a weak relationship (coefficient = 0.18). Among those who mentioned that they conducted community-led actions, the majority were employees (56.5%, n=104) followed by unemployed persons (20.1%, n=37), business owners (15.1%, n= 29), other occupations (volunteers, freelancers…) (4.3%, n=8) and retirees (3.3%, n=6).

6. COVID-19 Vaccine (community awareness and perceptions)

Trust in the vaccine

When participants were asked to rate their level of trust in the vaccine, the majority (40.8%, n=203) stated that they moderately trust the vaccine, more than the quarter of the sample (27.2%, n=135) mentioned trusting the vaccine a little, only 23.1% (n=115) stated trusting the vaccine very much and 8.9% (n= 44) did not trust the vaccine at all. The mean trust level in COVID-19 vaccine was 2.8 out of 4 with an SD of 0.901. (Figure 29)

Figure 29. Trust in COVID-19 vaccine



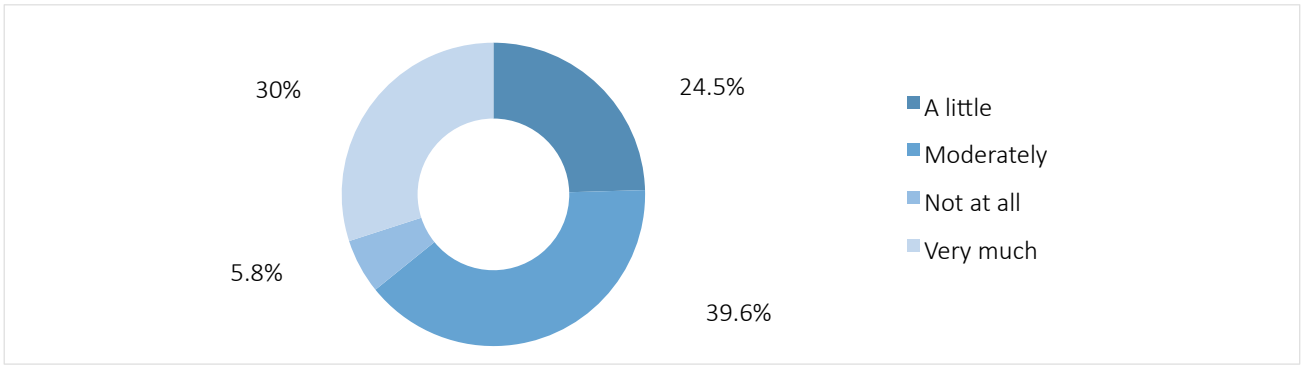
Inferential analysis between the level of trust in the vaccine and the demographic variables showed the following:

- There was a weak correlation (coefficient 0.124) between age and level of trust in COVID-19 vaccine; the higher the age the more participants would trust the vaccine. (P-value<0.01)
- There was a weak correlation (coefficient 0.112) between gender and the level of trust on the vaccine; males trust the vaccine more than females. (P-value=0.012)
- There was a weak correlation (coefficient 0.112) between gender and the level of trust on the vaccine; males trust the vaccine more than females. (P-value=0.012)
- There was a weak correlation (coefficient = 0.1) between education and the level of trust in the vaccine; the higher the level of education is, the higher the level of trust in COVID-19 vaccine would be. (P-value=0.034)
- The level of trust in the vaccine was not statistically related to nationality, governorate and occupation

Effective protection

Participants were also asked to rate their perception around the effectiveness of the vaccine in protecting them and the community from COVID-19, the majority (39.6%, n=197) stated that they moderately believe that the vaccine will protect them and their community. 30% (n=149) stated that they believe that the vaccine will protect them and the community a lot while 24.5% (n=122) mentioned that the vaccine will protect them and their community a little. And 5.8% (n= 29) did not believe at all that the vaccine will protect them and the community from COVID-19. The mean trust level in COVID-19 vaccine was 2.9 out of 4 with an SD of 0.881 (Figure 30).

Figure 30. Perception of vaccine's protection



Inferential analysis between believing that the vaccine will protect the participants and their community and the demographic variables showed the following:

- There was a weak correlation (coefficient 0.1) between nationality and believing in the vaccine's protection; Lebanese would less believe in the vaccine's protection from COVID-19. (P-value=0.034)
- There was a weak correlation (coefficient = 0.2) between education and the level of trust in the vaccine's protection, the higher the level of education is, the higher the level of trust in COVID-19 vaccine would be. (P-value<0.01)
- The level of belief in the vaccine's protection was not statistically related to nationality, governorate, age, gender, and occupation

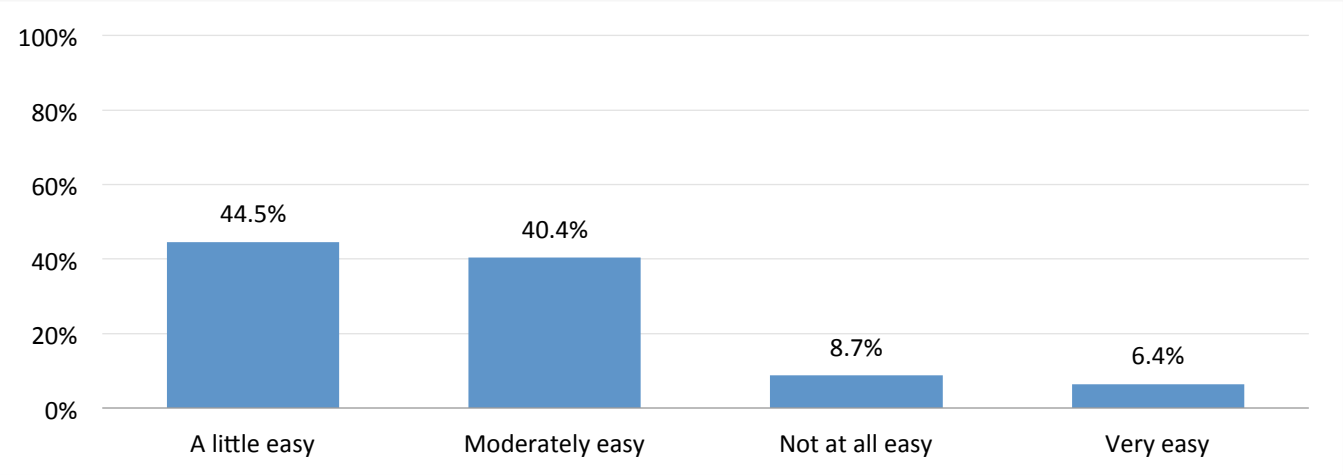
Access to the vaccine

When asked about vaccine access, 90.3% (n=449) stated that they know how to register for the vaccine compared to 9.7% (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 independent of nationality, age, gender and governorate. It was dependent on education (P-value<0.01) with a weak correlation (Coefficient = 0.252), people with advanced university degrees, university undergraduates, individuals who completed secondary level education would more know how to register for the vaccine compared to individuals who do not have a formal education and those who reached elementary/primary education. It was also dependent on occupation (P-value<0.01) with and weak correlation (coefficient = 0.2); unemployed and retirees knew 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 the vaccination services; 44.5% (n=221) stated that it was a little easy, 40.4% (n=201) mentioned that it was moderately easy and only 6.4% (n=32) stated that it was very easy (Figure 32). The mean score for how easy it is to get vaccination services was 2.45 out of 4 with an SD of 0.74. Inferential analysis between how easy participants perceived that they can get the vaccine services by themselves and the demographic variables revealed that easiness of getting COVID-19 vaccine services was independent of nationality, age, gender, governorate, educational level and occupation. (Figure 31 below).

Figure 31. Easiness of getting vaccine services



Concerns about the vaccine

When asked whether participants had concerns about the vaccine the sample was almost divided in half; where 57.5% (n=286) mentioned having concerns and the rest (42.5%, n=211) stated not having concerns.

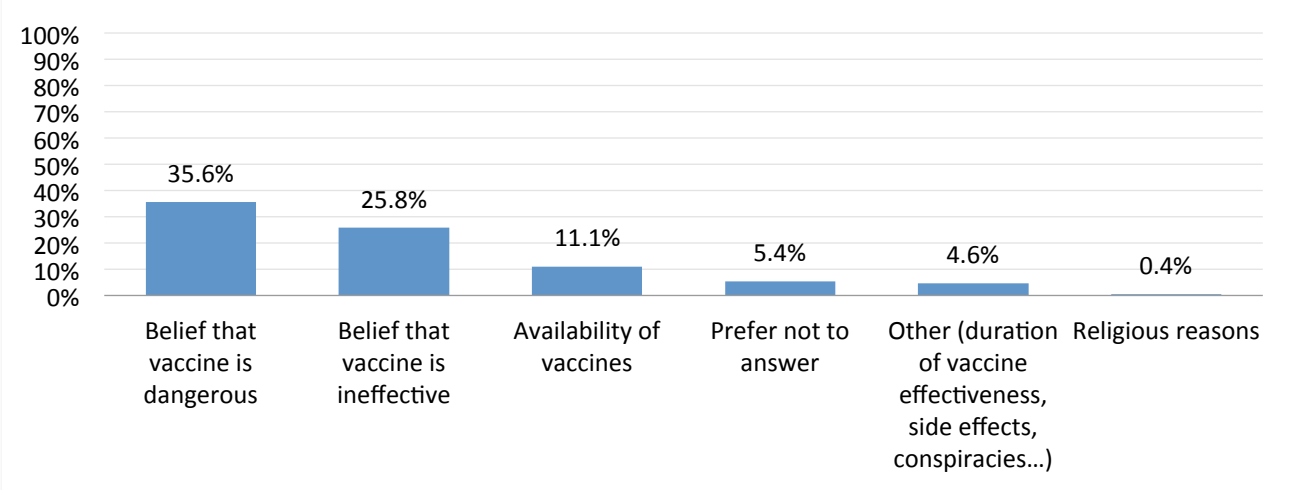
Table 11. Concerns about COVID-19 vaccine by demographics

Concerns about COVID-19 vaccine		Yes	No
Female	%	67.5	40.2
	n	193	115
Male	%	32.5	33.2
	n	93	95
P-value			<0.01
16 to 17 years	%	0.7	0.3
	n	2	1
18 to 29 years	%	35.7	23.4
	n	102	67
30 to 39 years	%	27.6	20.6
	n	79	59
40 to 49 years	%	24.8	13.6
	n	71	39
50 to 59 years	%	8	11.5
	n	23	33
60 to 69 years	%	2.8	4.2
	n	8	12
70 to 79 years	%	0.3	0
	n	1	
P-value			0.049
Employee	%	59.1	47.9
	n	169	137
Business owner	%	8.4	9.1
	n	24	26
Unemployed	%	28.3	12.2
	n	81	35
Retired	%	1	1.7
	n	3	5
Other	%	3.1	2.8
	n	9	8
P-value			0.023

As per Table 11 above, inferential analysis showed that having concerns about the vaccine was independent of nationality, governorate and education. It was dependent on age (P-value = 0.049) with a weak correlation (coefficient = 0.16), people aged 18 to 49 years old would more report to have concerns around the vaccine. It was also dependent on occupation (P-value = 0.025) with a weak correlation (coefficient =0.15), employees and business owners would more report having concerns regarding the COVID-19 vaccine. In addition, it was dependent on gender (P-value<0.01) with a weak correlation (coefficient = 0.13), females were more likely to report having concerns than males (table 8). Females (73.4%, n=130) would more believe that the vaccine is dangerous compared to males (26.6%, n=47).

Respondents were then asked what were their concerns, among those who mentioned having concerns, 35.6% (n= 177) perceived the vaccine as dangerous, 25.8% (n=128) believed that it is ineffective and 11.1% (n=55) had concerns around the availability of the vaccine (Figure 32).

Figure 32. COVID-19 vaccine concerns



Inferential analysis showed that all the mentioned concerns were independent of age, gender nationality, governorate, occupation and education, except for believing that the vaccine was dangerous and believing that it was ineffective results are explained below:

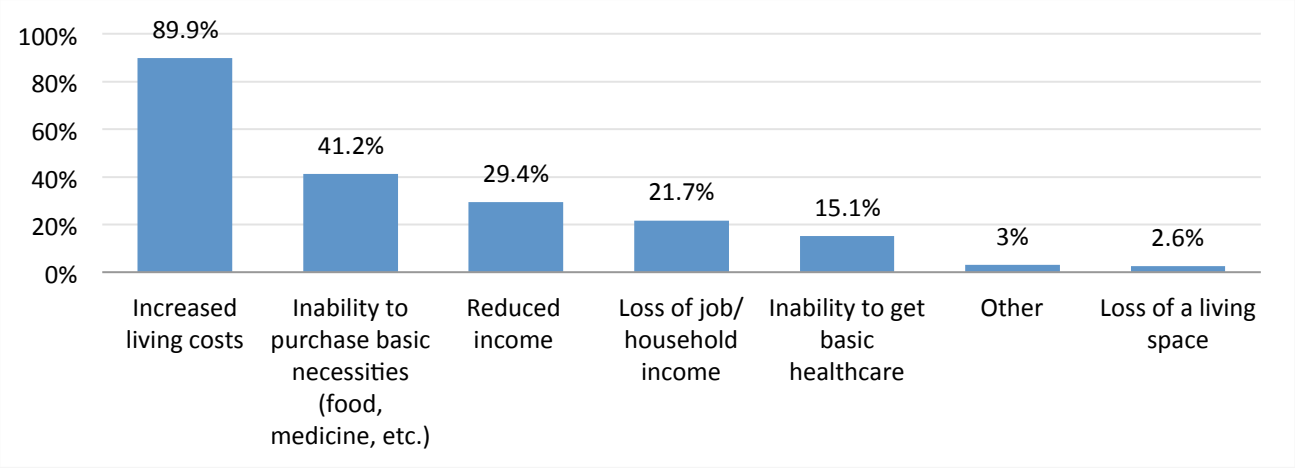
- **Age**: Believing that the vaccine was dangerous was statistically significant with age (P-value = 0.032) with a weak relationship (coefficient = 0.16). This concern was high among 18 to 29 years old (38.4%, n=68) followed by 30 to 39 (27.7%, n=49), 40 to 49 (24.3%, n=43), 50 to 59 (5.6%, n=10), 60 to 69 (2.8%, n=5) and 16 to 17 (1.1%, n=2)
- **Gender**: Believing that the vaccine was dangerous was statistically significant with gender (P-value<0.01) with a weak relationship (coefficient of 0.2). Females were more likely to believe that the vaccine is dangerous (73.4%, n=130) compared to males (26.6%, n=47).
- **Education**: was statistically significant with believing that the vaccine is ineffective (P-value = 0.26) with a weak relationship (coefficient = 0.12). The university graduate would more report this concern (55.6%, n= 70) followed by advanced university graduates (14.3%, n= 18) and those who did not complete any formal education (0.8%, n=1)

7. Impact of COVID-19, the economic crisis and the Beirut explosion

Impact of the economic crisis

Survey participants were asked how they have been impacted by the economic crisis; 89.9% (n=447) stated that the living costs have increased, 41.2% (n=205) mentioned that they were unable to purchase basic necessities (food, medicine, etc.), 29.4% (=108) have lost their jobs, 15.1% (n=75) were unable to get basic health care and 2.6% (n= 13) lost their living space. (Figure 33).

Figure 33. Impact of economic crisis on participants



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) with a moderate relationship (coefficient = 0.2); employees were more to report having reduced income 74.7% (n=109) followed by unemployed (15.1%, n=22) and business owners (6.6%, n=10).
- **Loss of job/household income** was dependent on ***gender*** (p-value=0.042) with a weak relationship (coefficient = 0.1); females were more likely to report losing their jobs (53.7%, n=58) compared to males (46.3%, n= 50). It was also dependent on ***education*** (P-value<0.01) with a weak relationship (coefficient = 0.2); people with university degrees were more to report this issue (45.4%, n=49), followed by holders of secondary/high school degrees (39.8%, n=43), people who had advanced university degrees (9.3%, n= 10) and individuals who completed primary educational level (4.6%, n=5). In addition, it was dependent on ***occupation*** (P-value<0.01) with a strong relationship (coefficient = 0.4); unemployed were more to report this problem (50%, n=54) followed by employees (25.9%, n=28) and business owners (20.4%, n=22).
- **Loss of living space:** was dependent on ***gender*** (P-value <0.01) with a weak relationship (coefficient =0.13). Males would more report this issue (76.9%, n=10) compared to females (23.1%, n=3). It was also dependent on ***governorate***; people living in Mount Lebanon would more report this problem (30.8%, n=4) followed by those living in Beirut (23.1%, n=3), those living in Bekaa (15.4%, n=2) and those living in Akkar (7.7%, n=1).
- **Increased living cost:** was dependent on ***age*** (P-value =0.028) with a weak relationship (coefficient 0.173); individuals aged between 18 and 29 were the most to report this issue (31.5%, n=141) followed by 30 to 39 (29.1%, n=130), 40 to 49 (22.6%, n=101), 50 to 59 (11.9%, n=53), 60 to 69 (4.3%, n=19), 16 to 17 (0.4%, n=2) and 70 to 79 years old (0.2%, n=1). It was also dependent on ***occupation*** (P-value=0.04) with a weak correlation (coefficient = 0.138); employees would more report this issue

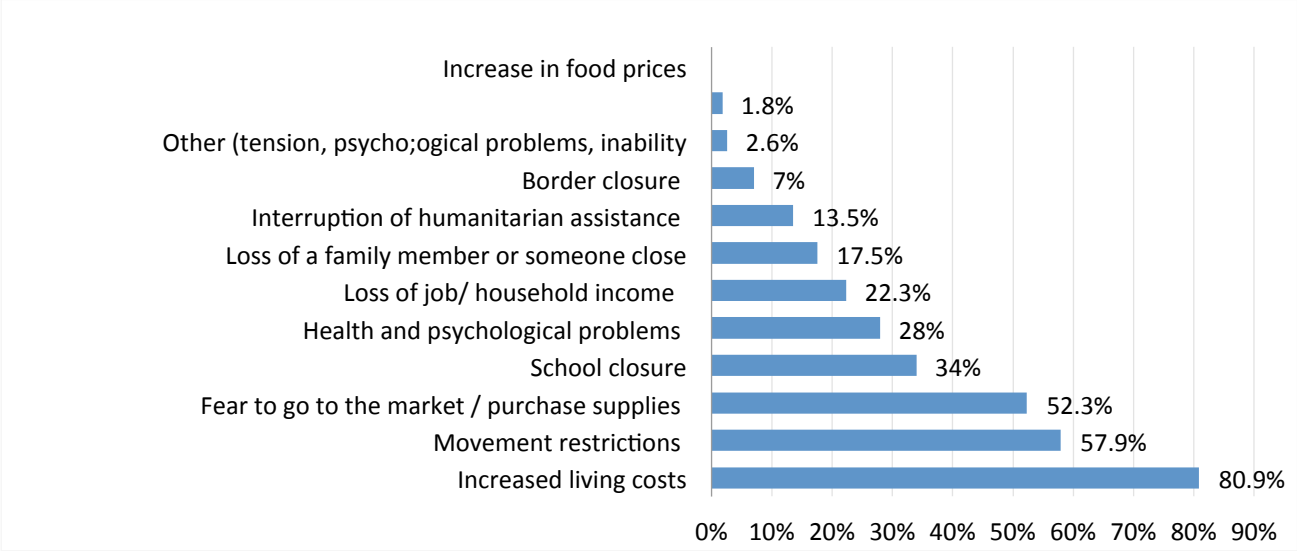
(63.5%, n=284) followed by unemployed (21.9%, n=98), business owners (9.4%, n= 42), other such as volunteers and free lancers etc. (3.4%, n= 15) and retirees (1.8%, n= 8).

- **Inability to purchase basic necessities (food, medicine…)**: was dependent on ***governorate*** (P-value = 0.05) with a weak relationship (coefficient = 0.156); people living in South Lebanon would more report this issue (42.9%, n= 88) followed by those living in Mount Lebanon (35.1%, n=72), Beirut (13.2%, n=27), Nabatieh (5.4%, n=11), North Lebanon (2.4%, n=5) and Bekaa and Akkar (0.5%, n=1 each). It was also dependent on the ***education***; individuals with university degrees would more report this problem (45.1%, n= 92) followed by those holding advanced university degrees (14.2%, n= 29), then those who completed secondary/high school (35.3%, n= 72), people who completed the primary/elementary education (4.4%, n=9) and those who do not have a formal education (1%, n=2). In addition, it was dependent on ***occupation*** where employees would more report this issue (62%, n= 127) followed by unemployed (25.9%, n= 53), business owners (6.3%, n=13), retires (3.4%, n=7) and other such as volunteers and free lancers etc. (2.4%, n=5).

Impact of COVID-19

Respondents were asked about the impact of COVID-19, 80.9% (n=402) mentioned that it increased the living costs, 57.9% (n=288) said that it restricted their movement, 52.3% (n=260) stated that it increased their fear to go to the market/purchase supplies, 34% (n=169) stated that it led to school closure, 28% (n=139) revealed that it caused health and psychological problems, 22.3% (n=111) had lost their jobs, 17.5% (n=87) lost a family member or someone close, 13.5% (n=67) had interruptions in the humanitarian assistance and the rest of the sample was divided between border closure (7%, n=35), other i.e. tension, psychological problems, inability to visit relatives, closure of entertainment venues, Inability to travel, closure of nurseries etc. (2.6%, n=13) and closure of services which are adapted to their impairment/ disability (1.8%, n=9) (Figure 34).

Figure 34. Impact of COVID-19 on participants



The bivariate analysis resulted in the following findings:

- **Loss of Job/ household income:** was dependent on ***gender*** (P-value=0.027) with a weak relationship (coefficient = 0.1); females were more likely to report on this issue (53.2%, n=59) compared to males (46.8%, n= 52). It was also dependent on ***education*** (P-value<0.01) with a weak relationship (coefficient=0.2), university graduates would more report on this issue (42.3%, n= 47) followed by people who completed secondary/high school education (40.5%, n=45), advanced university degree holders (11.7%, n= 13), people who completed primary/elementary (4.5%, n=5) and those who do not

have formal education (0.9%, n=1). In addition, it was dependent on ***occupation*** (P-value<0.01) with a moderate relationship (coefficient = 0.4); unemployed persons would more report on this issue (44.1%, n= 49) followed by employees (29.7%, n= 33), business owners (21.5%, n= 24) and other i.e. volunteers and free lancers etc. (4.5%, n=5).

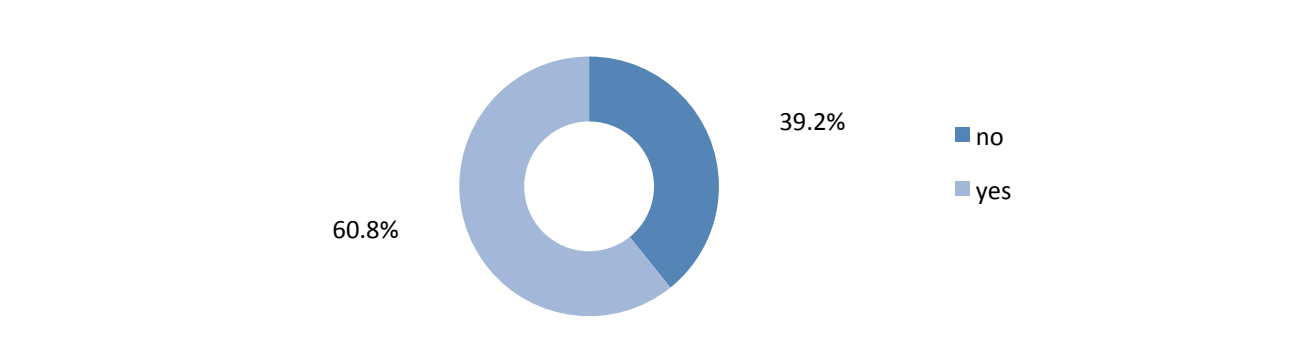
- **Health and psychological problems:** were dependent on ***gender*** (P-value=0.016) with a weak relationship (coefficient = 0.1); females were more likely to report on this issue (70.5%, n=98) compared to males (29.5%, n=41). It was also dependent on ***education*** (P-value<0.01) with a weak relationship (coefficient 0.18), university degree holders would more report on this problem (56.2%, n=77) followed by advanced university degrees (24.1%, n= 33), persons who completed secondary/high school (15.3%, n= 21), individuals who reached primary/ elementary education (3.6%, n=5) and persons who do not have formal education (0.7%, n=1).
- **Border closure:** was dependent on ***gender*** (P-value=0.38) with a weak relationship (coefficient=0.1), females were less likely to report on this issue (45.7%, n=16) compared to males (54.3%, n=19).
- **Movement restrictions:** was dependent on ***education*** (P-value<0.01) with a weak relationship (coefficient=0.26); people with university degrees would more report on this problem (58.6%, n= 167) followed by secondary/high school degrees holders (20.4%, n=58), advanced university degrees holders (20%, n=57) and people who complete primary education (1.1%, n=3).
- **Fear to go to the market/purchase supplies:** was dependent on ***gender*** (P-value <0.01) with a weak relationship (coefficient=0.1); females were more likely to mention this problem (68.8%, n=179) compared to males (31.2%, n=81). It was also dependent on ***education*** (P-value =0.015) with a weak relationship (coefficient = 0.15); university degree holders were more to state this problem, (57.5%, n= 149), followed by persons who accomplished secondary/high school education (22.8%, n= 59), advanced university degree holders (17.8%, n=46), people with primary education (1.5%, n=4) and individual who do not have formal education (0.4%, n=1). Furthermore, it was dependent on ***occupation*** (P-value <0.01) with a weak relationship (coefficient = 0.2); employees would more report this issue (67.3%, n= 175) followed by unemployed persons (22.7%, n= 59), business owners (5.8%, n= 15), retirees (1.9%, n=5) and other i.e. free lancers, volunteers, etc. (2.3%, n=6)
- **Interruption of human assistance:** was dependent on ***age*** (P-value=0.053) with a weak relationship (coefficient = 0.20). Those aged 40 to 49 would more report this issue (32.8%, n=22) followed by those aged 18 to 29 (26.9%, n= 18), 50 to 59 (11%, n= 8), 60 to 69 (6%, n= 4) and 16 to 17 (3%, n=2). It was also dependent on ***education*** (P-value <0.01) with a weak relationship (coefficient = 0.2); university degree holders would more mention this issue (47.8%, n= 32) followed by those who completed secondary/high school education (38.8%, n= 26), holders of advanced university degrees (7.5%, n= 5), and those who completed primary education along with those how did not have a formal education (3%, n=2).
- **School closure:** was dependent on ***age*** (P-value<0.01) with a weak relationship (coefficient= 0.2); people aged 30 to 39 would more mention this issue (32.5%, n=55) followed by 40 to 49 years old (27.8%, n=47), 18 to 29 (23.7%, n=40), 50 to 59 (11.8%, n= 20), 60 to 69 (3%, n= 5) and 16 to 17 years old (1.2%, n=2). It was also dependent on ***gender*** (P-value = 0.037) with a weak relationship (coefficient = 0.1); females were more likely to report on this issue (68.5%, n= 115) compared to males (31.5%, n= 53). Furthermore, it was dependent on ***governorate*** (P-value = 0.031) with a weak relationship (coefficient = 0.2); people living in South Lebanon would more report this issue (39.6%, n= 67) followed by those living in Mount Lebanon (36.7%, n=62), individuals from Beirut (10.7%, n= 18), persons from Nabatieh (7.7%, n=13), participants from Bekaa (3%, n=5), respondents North Lebanon (1.8%, n=3) and those from Akkar (0.6%, n=1). In addition, it depended on ***education*** (P-value=0.03) with a weak correlation (coefficient = 0.13); participants with university degrees would more report on this problem (55.6%, n= 94) followed by those who accomplished secondary/ elementary education (23.1%, n=39), advanced university degree holders (20.1%, n=34) and people with no formal education along with those who accomplished primary education (0.6%, n=1 each)

- **Loss of a family member or someone else:** was dependent on ***nationality*** (P-value =0.049) with a weak relationship (coefficient = 0.12); Lebanese would more report this issue (92%, n=80) followed by Palestinians (4.6%, n= 4) and by others (Columbian, Iranian, Jordanian, Swedish, American) (3.4%, n=3). It was also dependent on ***Governorate*** (P-value =0.031) with a weak relationship (coefficient = 0.173); people living in Mount Lebanon (49.4%, n= 43), followed by those living in South Lebanon (32.2%, n=28), people from Beirut (8%, n=7) Nabatieh (4.6%, n= 4), Bekaa (2.3%, n=2), Akkar (1.1%, n=1)

Impact of Beirut explosion

When asked if they were impacted by Beirut explosion, more than half of the participants mentioned that they were affected (60.8%, n= 302) and 39.2% (n= 195) were not (Figure 35).

Figure 35. Being affected by the Beirut blast



Bivariate analysis showed that being affected by Beirut's' explosion depended on:

- **Nationality** (P-value <0.01) with a weak relationship (coefficient = 0.1); Lebanese were the most who would mention being affected (94.7%, n=286) followed by Syrians (2.6%, n=8), Palestinians (1.7%, n= 5) and others (Columbian, Iranian, Jordanian, Swedish, American) (1% n= 3).
- **Age:** There was a statistically significant relationship with age and being affected by the explosion (P-value <0.01) with a weak relation (coefficient = 0.2); people aged 18 to 29 were more affected (30.1%, n= 91) followed by 40 to 49 years old (26.5%, n= 80), 30 to 39 (24.5%, n= 74), 50 to 59 (11.9%, n= 36), 60 to 69 (5.6%, n=17), 16 to 17 (1%, n=3) and 70 to 79 (0.3%, n=1).
- **Governorate:** there was a statistically significant relationship between being affected by Beirut blast and governorate (P-value <0.01) with a weak relationship (coefficient = 0.2); people from Mount Lebanon would more report being affected (37.4%, n=113) followed by those in South Lebanon (32.1%, n=97), Beirut (21.5%, n= 65), Nabatieh (6.3%, n= 19), Bekaa (1.3%, n= 4), North Lebanon (n=3) and Akkar (0.3%, n=1). These finding are not as expected as those living in Beirut should be the ones who would report being affected the most and this is mainly due to the sample division which does not represent the total population per governorate.

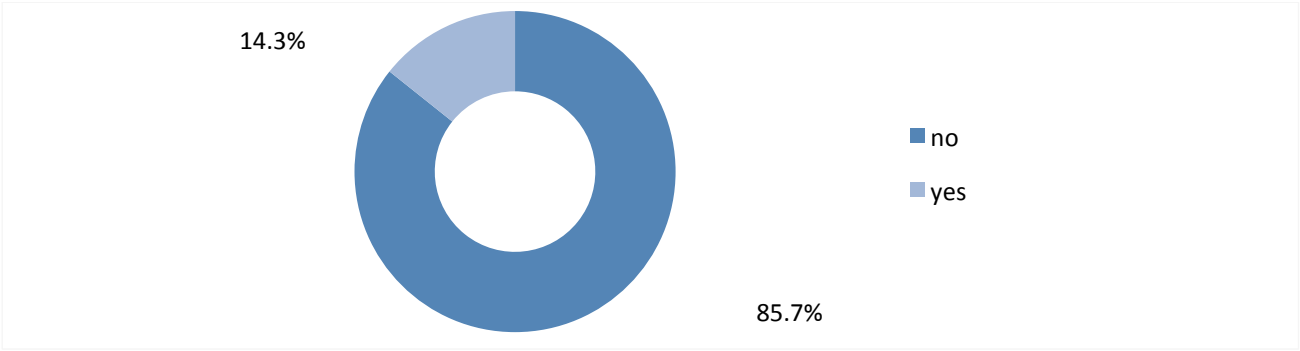
Survey respondents were then asked whether the blast affected their willingness to apply COVID-19 preventive measures and the majority (85.7%, n=426) mentioned that it did not impact their willingness to apply the prevention measures while 14.3% (n= 71) said that it did (Figure 36 below).

Inferential analysis showed that the effect of Beirut explosion on the willingness to apply COVID-19 prevention measures was dependent on:

- **Nationality**: there was a statistically significant relationship between the effect of Beirut explosion on the willingness to apply COVID-19 prevention measures and nationality (P-value = 0.016); Lebanese would more report on not willing to apply COVID-19 preventive measures (87.3%, n=62), followed by Syrians (7%, n=5), Palestinians (4.2%, n=3) and other (1.4%, n=1).

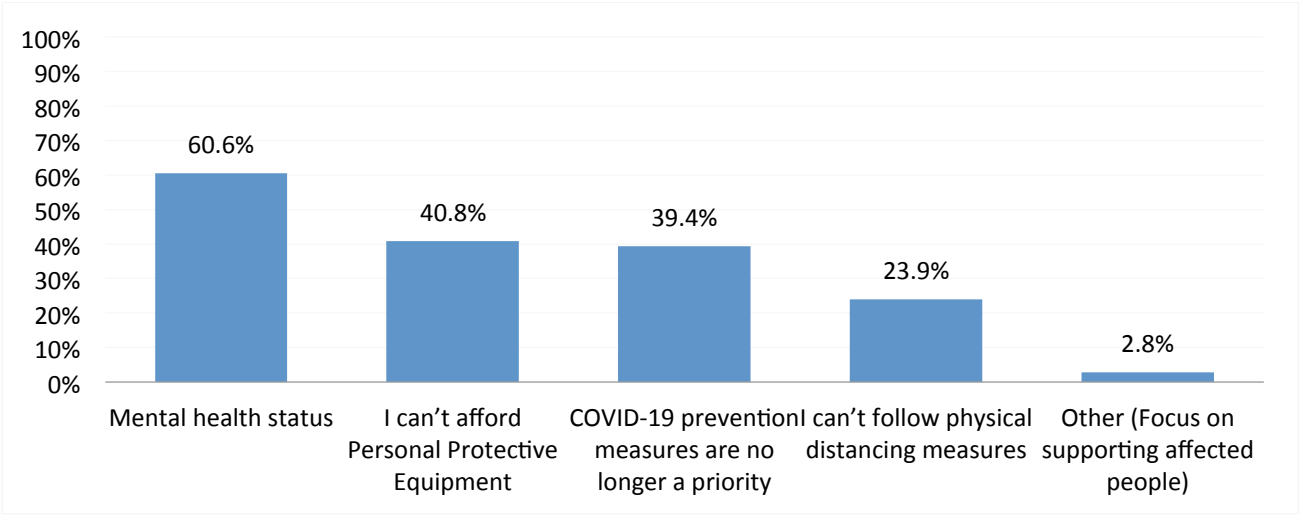
- **Age**: (P-value <0.01) with a weak relationship (coefficient = 0.2); participants aged 30 to 39 would more report on the effect that Beirut blast has on their willingness to apply COVID-19 prevention measures (40.8%, n= 29) followed by those aged 40 to 49 (28.2%, n= 20), 18 to 29 (22.5%, n= 16), 50 to 59 (4.2%, n= 3), 16 to 17 (2.8%, n= 2) and 60 to 69 years old (1.4%, n=1).
- **Education**: P-value = 0.013 with a weak relationship (coefficient = 0.2); University graduates would more report the effect of the explosion on the willingness to apply COVID-19 preventive measures (47.9%, n=34) followed by secondary/high school educated respondents (29.6%, n=21), advanced university degree holders (11.3%, n= 8) and primary/elementary participants (1.4%, n=1).

Figure 36. Effect of Beirut blast on willingness to apply COVID-19 preventive measures



Participants who mentioned that their willingness in applying COVID-19 preventive measures was affected by the blast were then asked how and responses were as follows: 60.6% (n=43) mentioned that the blast affected their mental health status, 40.8% (n=29) stated that they cannot afford the personal protective equipment, 39.4% (n=28) said that COVID-19 prevention measure were not a priority anymore, 23.9% (n=17) stated that they were not able to apply physical distancing measures and the rest 2.8% (n=2) chose the other option which included focusing on supporting the affected people (Figure 37).

Figure 37. Beirut blast effect on applying COVID-19 preventive measures

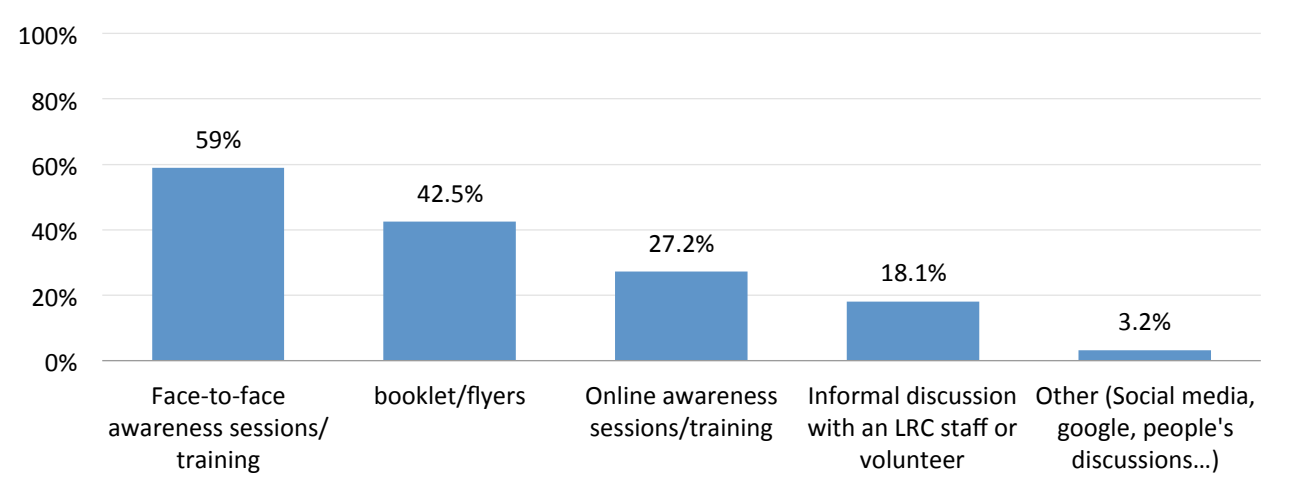


8. LRC risk communication

Information provision

Participants were asked how they received the information about COVID-19 from the LRC and more than half of the respondents (59%, n=293) stated that it was through face-to-face awareness sessions, 42.5% (n=211) mentioned that they received booklets/flyers, 27.2% (n=137) stated that they received the information through online sessions, 18.1% (n=90) stated that it was through informal discussions with LRC staff and the rest (3.2%, n=16) mentioned that it was through other modalities including google, social media, people's discussions. (Figure 38).

Figure 38. Ways of receiving COVID-19 information through the LRC



- **Receiving information through face-to-face awareness sessions:** was dependent on ***gender*** (P-value<0.01) with a weak relationship (coefficient=0.2); females were more likely (54.5%, n= 159) to report that they received information about COVID-19 from the LRC through face-to-face sessions compared to males (70.7%, n=133), it was also dependent on ***governorate*** (P-value<0.01) with a weak relationship (coefficient=0.2); people living in South Lebanon would report more that they received COVID-19 information through face-to-face sessions (42.3%, n=124) followed by those living in Mount Lebanon (37.9, n=111), individuals from Beirut (13.3%, n= 39), individuals from Nabatieh (601%, n=18) and participants from Bekaa (0.3%, n=1).

- **Receiving information through online awareness sessions:** was dependent on ***age*** (P-value<0.01) with a moderate relationship (coefficient= 0.3); people aged 18 to 29 would mention more that they received information through online sessions (54.1%, n=73) followed by 30 to 39 years old (22.2%, n=30), 40 to 49 (14.8%, n=20), 50 to 59 (7.4%, n= 10), 60 to 69 and 70 to 79 years old (0.7%, n=1 each). Furthermore, it was dependent on ***governorate*** (P-value = 0.031) with a weak relationship (coefficient = 0.2); people living in Mount Lebanon would more report that they received information through online sessions (42.2%, n= 57) followed by those living in South Lebanon (27.4%, n=37), individuals from Beirut (14.8%, n= 20), individuals from Nabatieh (8.9%, n=12), participants from Bekaa (4.4%, n=6), respondents from North Lebanon (1.5%, n=2) and those from Akkar (0.7%, n=1). In addition, it was dependent on ***occupation*** (P-value <0.01) with a weak relationship (coefficient = 0.2); employees would more report that they received information through online sessions (51.1%, n= 69) followed by unemployed individuals (36.3%, n= 49), business owners (10.4%, n= 14), other i.e. free lancers, volunteers, etc. (1.5%, n=2) and retirees (0.7%, n=1).

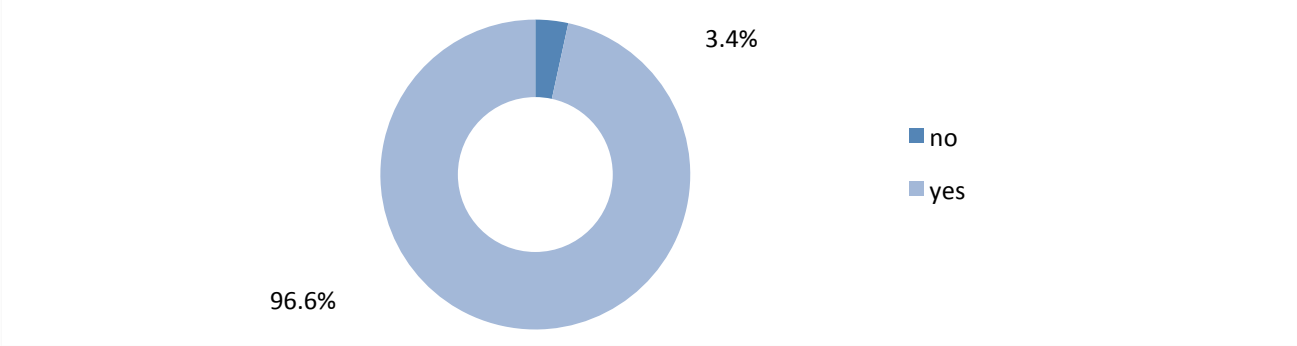
- **Receiving information through booklets/flyers:** was dependent on ***occupation*** (P-value =0.04) with a weak relationship (coefficient = 0.1); employees would more report that they received information through booklets (61.6%, n= 130) followed by unemployed persons (20.9%, n= 44), business owners (9.5%, n= 20), other i.e. free lancers, volunteers, etc. (4.7%, n=10) and retirees (3.3%, n=7).

- **Receiving information through informal discussion with an LRC staff or volunteer:** was dependent on ***age*** (P-value=0.04) with a weak relationship (coefficient=0.2); people aged 30 to 39 would more mention that they received information through informal discussion with an LRC staff or volunteer (30%, n=27) followed by 18 to 29 years old (24.4%, n=22), 40 to 49 and 50 to 59 (21.1%, n=19 each), 60 to 69 (2.2%, n=2) and 16 to 17 (1.1%, n= 1).

- **Receiving information through other channels (google, social media, people's discussions…):** was dependent on ***age*** (P-value<0.01) with a moderate relationship (coefficient= 0.3); people aged 30 to 39 would more mention that they received information through other modalities including google, social media, people's discussions… (31.3%, n=5) followed by 50 to 59 and 60 to 69 years old (25%, n=4 each), 16 to 17 and 18 to 29 also 40 to 49 (6.3%, n=1 each).

Language and dialect appropriate

When asked whether the participant received COVID-19 information with theirs preferred language 96.6% (n=480) agreed and only 3.4% (n=17) disagreed. (Figure 39).

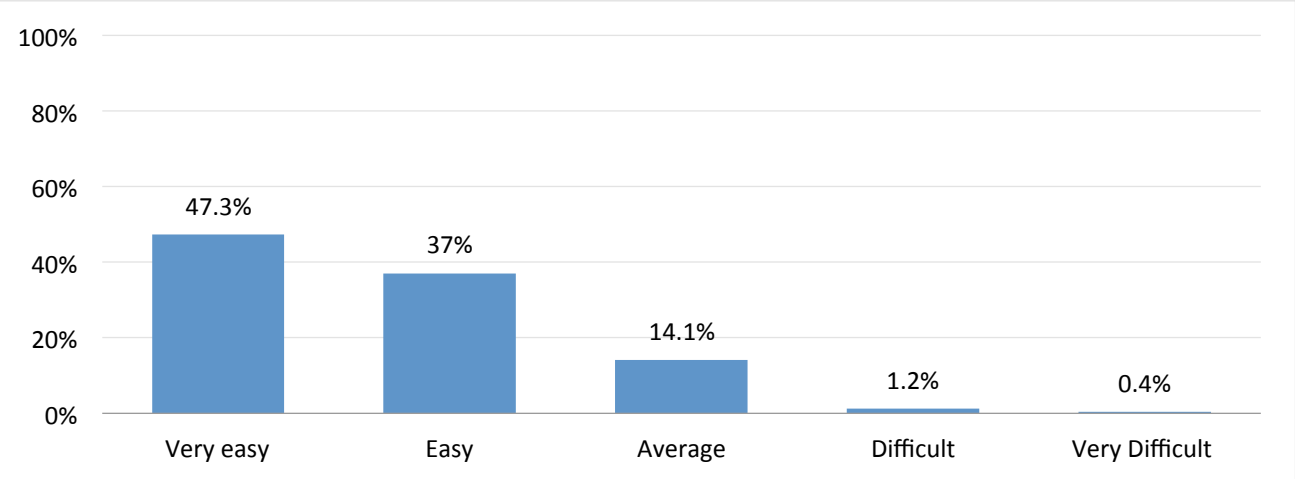


Further inferential analysis was conducted between whether the participants received the information in their preferred language and it was not dependent on any of the demographic variables which included: nationality, age, gender, governorate, education and occupation.

Access to information

With regards to accessing COVID-19 information through the LRC, just less than half of the sample (47.3%, n=235) mentioned that it was very easy, 37% (n=184) said that it was easy, 14.1% rated it as average (n=70), 1.2% (n=6) mentioned that it was difficult and less than one percent (0.4%, n=2) stated that it was very difficult (figure 42 below). The mean score for this question was 2.45 out of 5 with an SD of 0.742. Further inferential analysis was conducted between demographic variables and the ease of access to COVID-19 information through LRC which was independent of nationality, gender, age, education, occupation and governorate. (Figure 40).

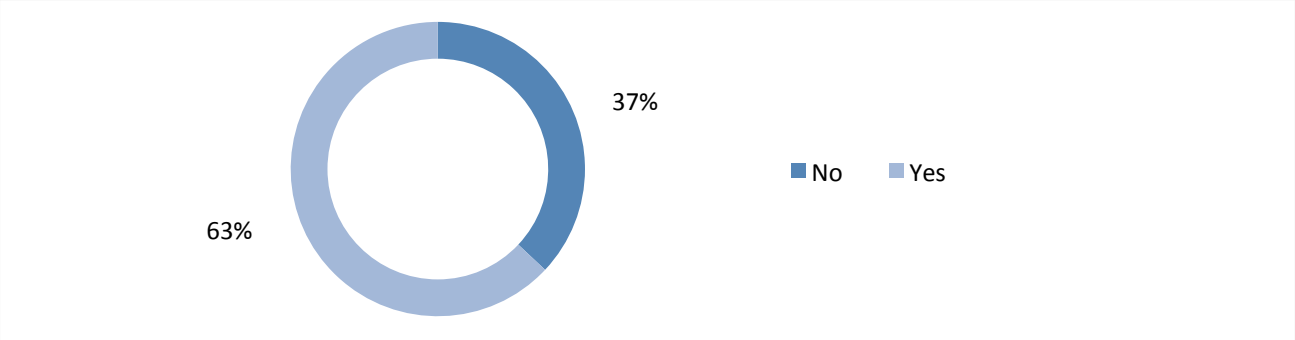
Figure 40. Ease of access to COVID-19 information through LRC



Inclusion

Respondents were asked whether the LRC's COVID-19 awareness reached all groups in the community, more than half of the participants (63%, n=313) agreed while 37% (n= 184) disagreed. (Figure 41).

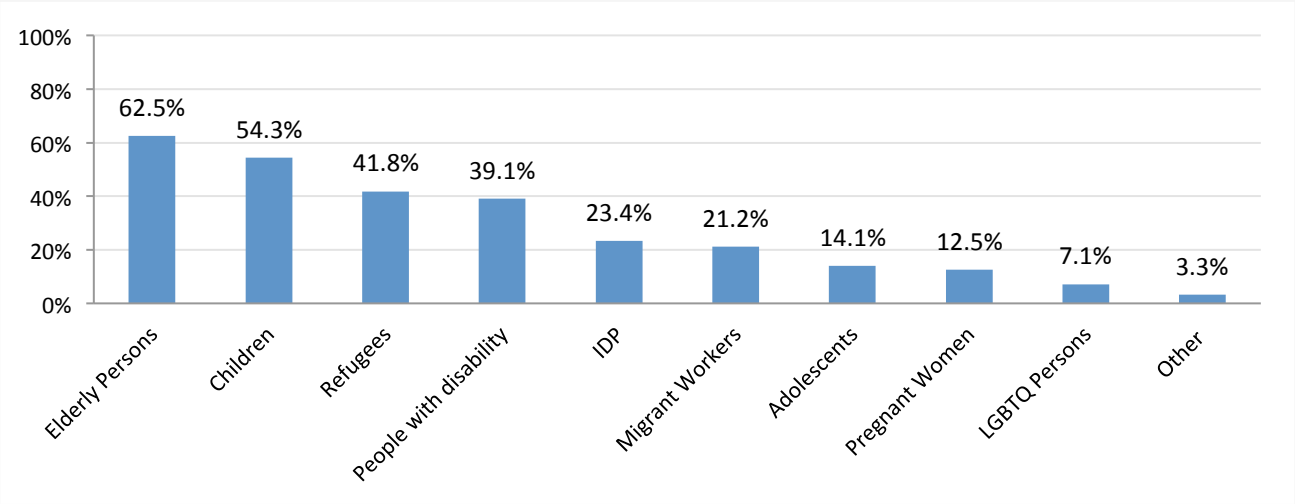
Figure 41. Inclusion of all groups in the community in LRC's COVID-19 awareness



Further inferential analysis was conducted between demographic variables and inclusion to reach all groups in the community through LRC's COVID-19 awareness showed that it was independent of nationality, gender, age, education, occupation and governorate.

Those who disagreed (n=184), were asked who were not reached and the responses were as follows: 62.5% (n=115) mentioned that elderly were not reached, 54.3% (n=100) said that children were not, 41.8% (n=77) stated that refugees were not, 39.1% (n=72) stated that people with disability were not, 23.4% (n=43) revealed that IDPs were not, 21.2% (n=39) specified that migrant workers were not, 14.1% (n=26) said that adolescents did not, 12.5% (n=23) mentioned that pregnant women were not, 7.1% (n=13) shown that Lesbians, gays, bisexuals, trans-genders and queer or questioning (LGBTQ) were not and the rest 3.3% (n=6) mentioned that other people (including people with low economic status, people who do not have means of communication, vulnerable people) were not reached. (Figure 42).

Figure 42. People not being reached by LRC's COVID-19 awareness



- **Children:** was dependent on ***gender*** (P-value=0.036) with a weak relationship (coefficient=0.1); females were more likely (53%, n= 53) to report that children were not reached compared to males (47%, n= 47).

- **Adolescents:** was dependent on ***gender*** (P-value=0.033) with a weak relationship (coefficient=0.1); males were more likely (57.7%, n= 15) to report that adolescents were not reached compared to females (42.3%, n= 11).

- **Refugees:** was dependent on ***gender*** (P-value=0.046) with a weak relationship (coefficient=0.1); females were more likely (51.9%, n= 40) to report that refugees were not reached compared to males (48.1%, n= 37). Furthermore, it was dependent on ***governorate*** (P-value = 0.014) with a weak relationship (coefficient = 0.2); people living in Mount Lebanon would more report that refugees were not reached (35.1%, n= 27) followed by those living in South Lebanon (28.6%, n=22), individuals from Beirut (20.8%, n= 16), persons from Nabatieh (6.5%, n=5), participants from Bekaa (5.2%, n=4), respondents from North Lebanon (2.6%, n=2) and those from Akkar (1.3%, n=1).

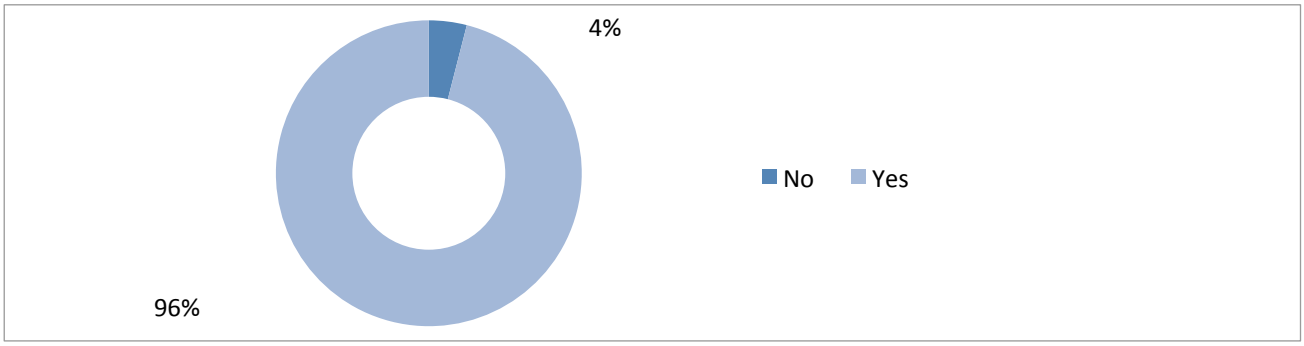
- **Internally Displaced People (IDP):** was dependent on ***governorate*** (P-value = 0.036) with a weak relationship (coefficient = 0.2); people living in Mount Lebanon would more report that IDPs were not reached (46.5%, n=20) followed by those living in South Lebanon (23.3%, n=10), individuals from Beirut (18.6%, n=8), persons from Bekaa (4.7%, n=2), participants from Akkar and North Lebanon also Nabatieh (2.3%, n=1 each).

- **Migrant Workers:** was dependent on ***governorate*** (P-value = 0.023) with a weak relationship (coefficient = 0.2); people living in Mount Lebanon would more report that migrant workers were not reached (38.5%, n=15) followed by those living in South Lebanon (38.8%, n=12), individuals from Beirut (20.5%, n=8), persons from North Lebanon (5.1%, n=2), participants from Akkar and Bekaa (2.6%, n=1 each).

Age and gender considerations

When asked whether the information received from LRC took into consideration the needs of different age groups, almost all respondents (96%, n= 477) agreed while only 4% (n=20) disagreed (Figure 43).

Figure 43. LRC taking into consideration the needs of different age groups

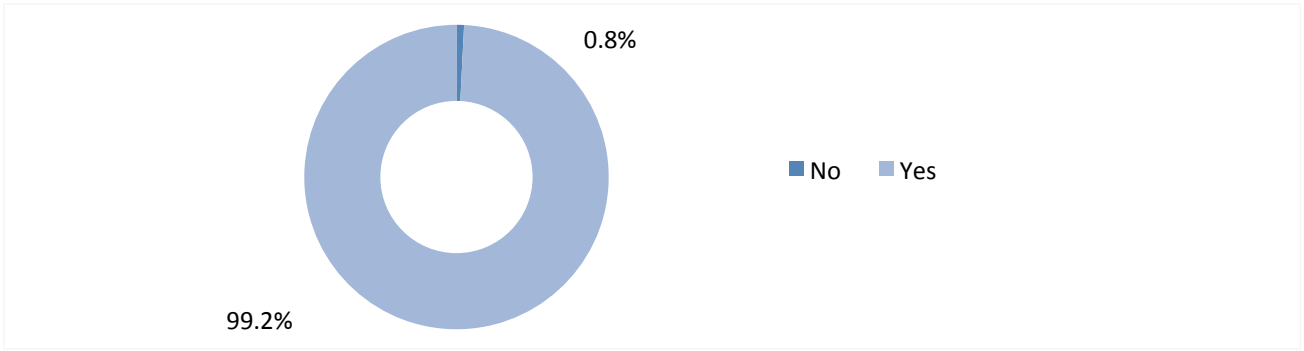


Inferential analysis showed that taking into consideration the needs of different age groups was dependent on:

- **Age:** (P-value<0.01) with a weak relationship (coefficient = 0.2); participants aged 18 to 29 would more report that LRC information provided took into consideration the needs of different age groups (34.8%, n=166) followed by those aged 30 to 39 (28.7%, n=137), 40 to 49 (21.4%, n=102), 50 to 59 (10.7%, n=51), 60 to 69 (3.6%, n=17), 16 to 17 (0.6%, n=3) and 70 to 79 (0.2%, n=1).
- **Occupation:** (P-value<0.01) with a weak relationship (coefficient = 0.2); employees would more report that LRC information provided took into consideration the needs of different age groups (62.3%, n=297) followed by unemployed persons (23.9%, n=114), business owners (9.6%, n=46), other i.e. free lancers, volunteers, etc. (2.7%, n=13) and retirees (1.5%, n=7).

When asked whether the information received from LRC took into consideration the needs of different genders, almost all respondents (99.2%, n= 493) agreed while only 0.8% (n=4) disagreed (Figure 44).

Figure 44. LRC taking into consideration the needs of different gender groups

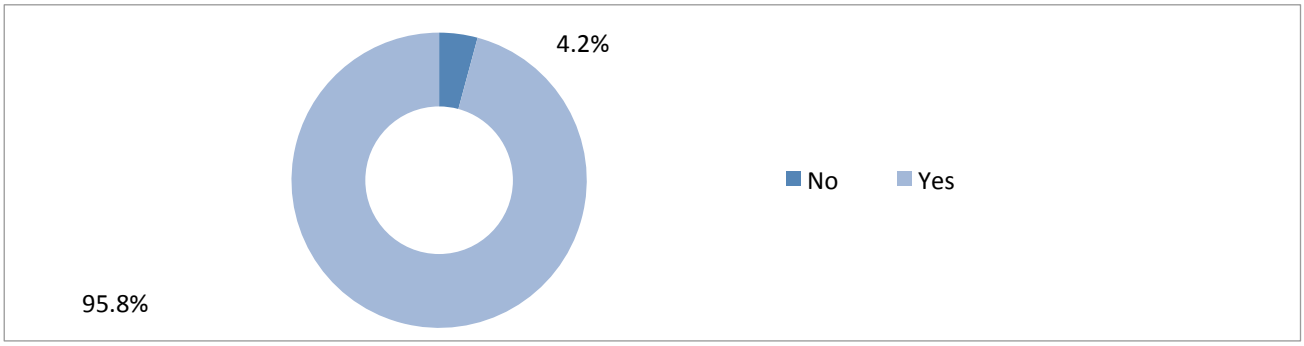


Further inferential analysis was conducted between demographic variables and whether the information received from LRC took into consideration the needs of different gender groups which was independent of nationality, gender, age, education, occupation and governorate.

Relevance

Survey participants were asked if the information received through the LRC was applicable and realistic, 95.8% (n= 476) agreed and 4.2% (n=21) disagreed. (Figure 45).

Figure 45. Relevance of LRC information



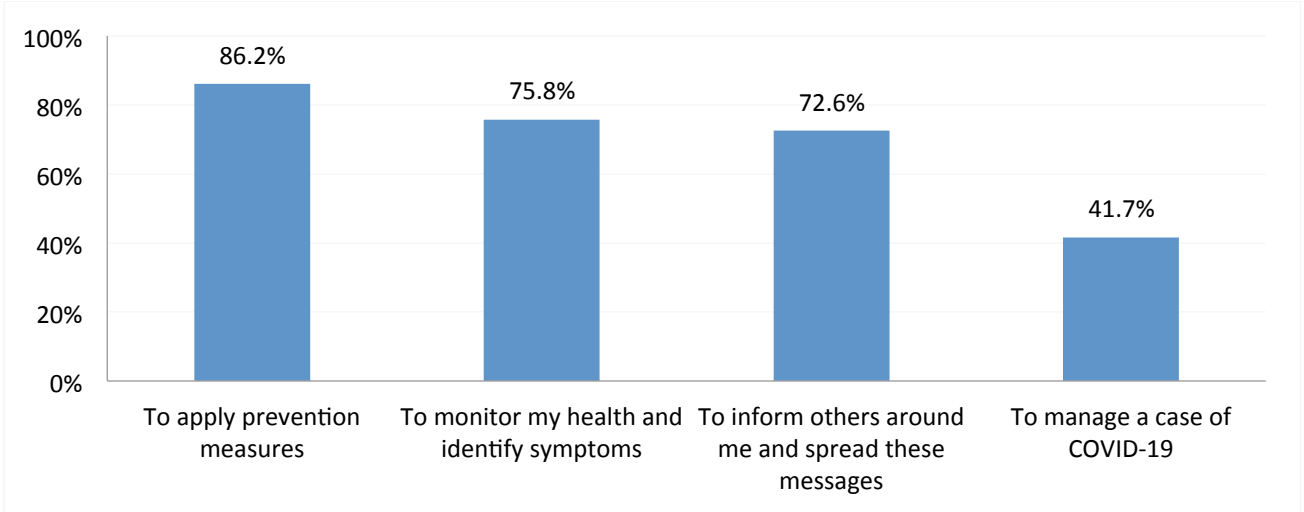
Inferential analysis showed that the relevance of LRC's information was dependent on:

- **Education:** P-value = 0.027 with a weak relationship (coefficient = 0.1); University graduates would more report the relevancy of LRC's information (52.9%, n=250) followed by secondary/high school educated respondents (26.2%, n=124), Advanced university degree holders (17.3%, n=82), primary/elementary participants (3.2%, n=15) and those who do not have formal education (0.4% 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 stated using the information were asked how they used it: 86.2% (n=424) applied the prevention measures, 75.8% (n=373) monitored their health and identified symptoms, 72.6% (n=375) informed others and spread these messages and 41.7% (n= 205) used the information to manage COVID-19 cases (Figure 46).

Figure 46. Usage of COVID-19 information provided by the LRC



The bivariate analysis resulted in the following findings:

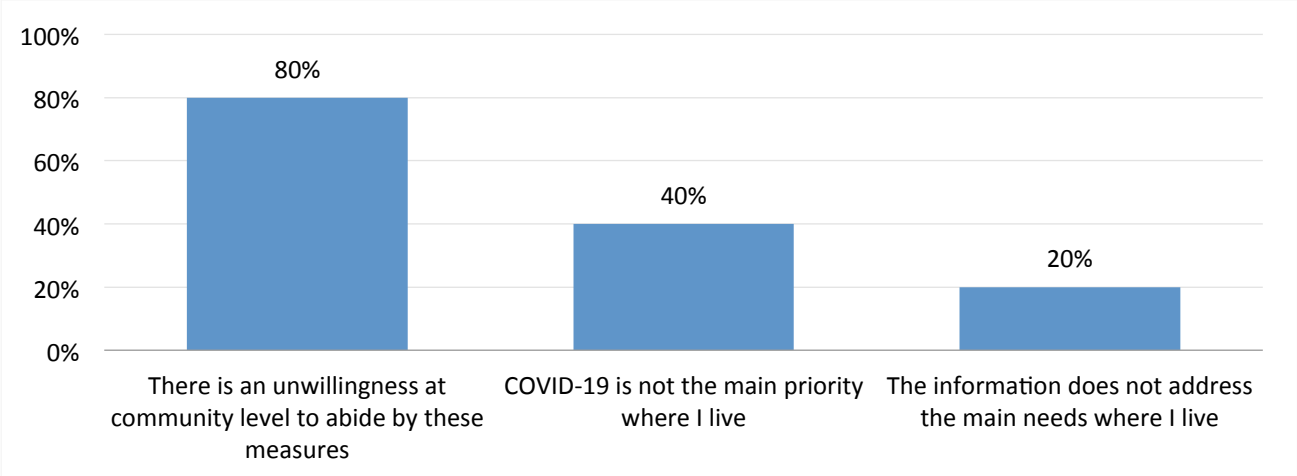
- **Monitor my health and identify symptoms:** was dependent on ***education*** (P-value=0.02) with a weak correlation (coefficient = 0.15); participants with university degrees would more report using COVID-19 information provided by the LRC to monitor their health and identify symptoms (54.2%, n=201) followed by those who accomplished secondary/ elementary education (24%, n=89), advanced university degree holders (18.9%, n=70), those who accomplished primary education (2.7%, n=10) and people with no formal education (0.3%, n= 1).

- **<u>Apply prevention measures:</u>** was dependent on ***education*** (P-value<0.01) with a weak correlation (coefficient = 0.2); participants with university degrees would more report using COVID-19 information provided by the LRC to apply prevention measures (54.6%, n=230) followed by those who accomplished secondary/ elementary education (24.7%, n=104), advanced university degree holders (18.3%, n=77), those who accomplished primary education (2.1%, n=9) and people with no formal education (0.2%, n= 1). Furthermore, it was dependent on ***occupation*** (P-value<0.01) with a weak relationship (coefficient=0.2); employees would more report using COVID-19 information provided by the LRC to apply prevention measures (63.9%, n=271) followed by unemployed persons (23.1%, n=98), business owners (7.8%, n=33), other i.e. free lancers, volunteers, etc. (3.3%, n=14) and retirees (1.9%, n=8).

- **<u>Manage a case of COVID-19:</u>** was dependent on ***gender*** (P-value<0.01) with a weak relationship (coefficient=0.16); females were more likely (52.7%, n=106) to report using COVID-19 information provided by the LRC to manage a case of COVID-19 compared to males (47.3%, n=95). Furthermore, it was dependent on ***education*** (P-value=0.01) with a weak correlation (coefficient=0.2); participants with university degrees would more report using COVID-19 information provided by the LRC to manage a case of COVID-19 (55.2%, n=111) followed by advanced university degree holders (21.9%, n=44), those who accomplished secondary/ elementary education (20.9%, n=42), those who accomplished primary education (1.5%, n=3) and people with no formal education (0.5%, n= 1). In addition, it was dependent on ***occupation*** (P-value=0.046) with a weak relationship (coefficient=0.14); employees would more report using COVID-19 information provided by the LRC to manage a case of COVID-19 (62.4%, n=126) followed by unemployed persons (22.3%, n=45), business owners (7.9%, n=16), other i.e. free lancers, volunteers, etc. (4%, n=8) and retirees (3.5%, n=7).

On the other hand, those who said that they did not use the LRC's information (n=5) were asked about the reasons, 80% (n=4) said that there had been unwillingness at community level to abide by these measures, 40% (n=2) mentioned that COVID-19 was not the main priority where they live and 20% (n=1) stated that the information did not address the main needs where they live (Figure 47).

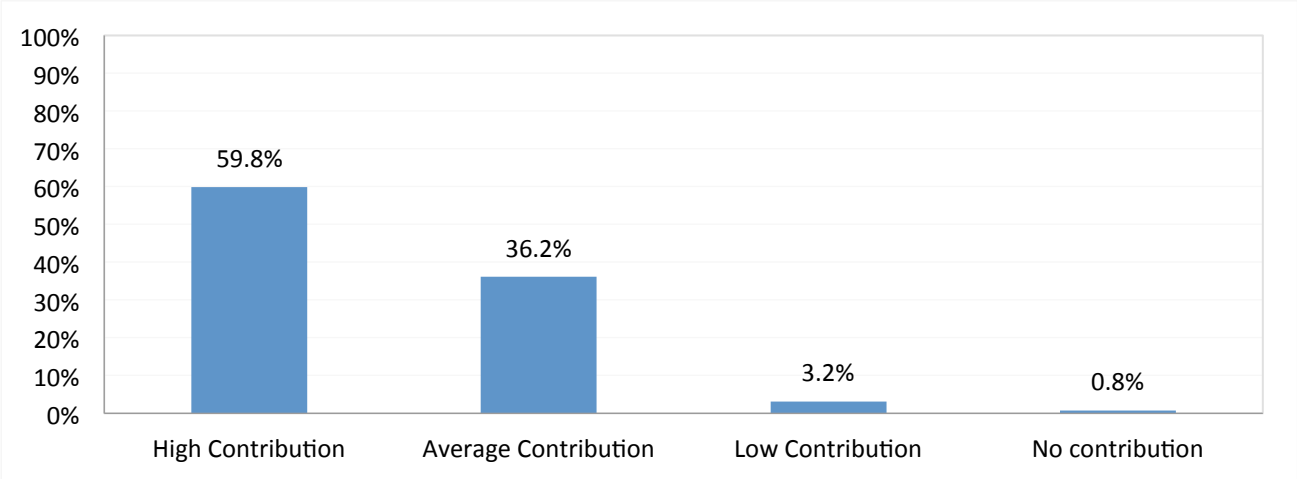
Figure 47. Reasons for not using COVID-19 information provided by the LRC



Community awareness

Participants were asked about the extent through which the risk communication provided by LRC contributed to raising community awareness about COVID-19, 59.8% (n=297) rated it as high, 36.2% (n=180) said that it was average, 3.2% (n=16) mentioned that it was low and only 0.8% (n=4) stated that it did not contribute to raising communal awareness (Figure 48).

Figure 48. Contribution to raising community awareness about COVID-19



Further inferential analysis was conducted between demographic variables and whether the information received from the LRC contributed to raising community awareness about COVID-19 and it was independent of nationality, gender, age, education, occupation and governorate.

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