العمل ضد الجوع
ACTION AGAINST HUNGER

PERSISTING NEEDS

PERCEPTIONS OF COVID-19 RESPONSE BY SYRIAN REFUGEES

MAY 2020

CONTENTS

With over 840 cases and 26 deaths as of 11/05, Lebanon is starting to ease lockdown-related restrictions after significant social pressure. The deterioration of the economic situation has accelerated and "hunger" protests take place, as labelled by the media. Refugees have been subject to additional municipal-level movement restrictions and are particularly affected by the lack of access to basic services.

The threat of the spread of the virus to overcrowded settlements and the limited possibility for refugees to isolate or quarantine adequately reinforces the crucial role of awareness-raising sessions. In this context, Action Against Hunger has been seeking to assess the impact of its activities and the appropriateness of the response. Some of these activities are carried through the Lebanon Protection Consortium, supported by ECHO.

The present document seeks to explore three themes:

- Levels of COVID-19 preparedness
- Changes in living conditions
- Appropriateness of the response

To answer this, the present document synthetizes knowledge drawn from three different rounds of data collection done by ACF teams, including during routine messaging effectiveness assessments, to ensure right-holders are not overburdened with additional COVID-19 related assessments.

While the findings cover a wide-range of themes, a main finding is that messaging is effective but gaps in knowledge remain. Refugees have limited sources of information. The most urgent recommendations relate to the need to continue to hold awareness-raising sessions, through various formats, and to provide more food and cash assistance - not only for quarantine and isolation centers.

METHODOLOGY

This report includes comparison of three rounds of data collection:

- Round 1: ACF conducted a total of 35 surveys with ITS WASH (Water Sanitation and Hygiene) focal points in Aarsal (15) and Ghazzé (20). Data collection took place between 18th and 19th of March. Respondents were randomly selected households who had participated in FGDs conducted throughout the community protection approach (CPA)[1] process.
- Round 2: A second wave of data collection took place between April 1st and 8th, in Aarsal (n=9), Jeb Janine (n=9) and Soultan Yaacoub Faouqa (n=3). The LPC team randomly called a mix of households who had participated in FGDs conducted throughout the CPA process and households who had received assistance through the Emergency response or the acute needs response mechanisms prior to the COVID-19 specific response.
- Round 3: ACF conducted a total of 160 assessments with distribution recipients in West Bekaa (160). Data collection took place between 14th and 24th of April. All respondents were recipients of UNICEF soap distributions. These assessments were conducted by the MEAL team.

1 The Community Protection Approach is a method to produce a context-specific risk protection analysis, which informs an integrated response.

Table 1: ITSs sampled in ACF COVID-19 phone assessments

Row Labels	# of ITSs sampled	# of phone surveys conducted	# of ITSs sampled	# of phone surveys conducted	Count of Cadastral	# of ITSs Sampled
Aarsal	15	15	9	9	0	0
Baaloul BG	0	0	0	0	10	5
Ghazzeh	20	20	0	0	58	16
Joubb Jannine	0	0	9	9	19	10
Kafraiya BG	0	0	0	0	4	4
Kamed El-Laouz	0	0	0	0	24	12
Mansoura BG	0	0	0	0	31	22
Souairi	0	0	0	0	4	2
Soultan Yaacoub Faouqa	0	0	3	3	7	4
Tall Znoub	0	0	0	0	3	2
TOTAL	35	35	0	21	160	

The assessment aims to collect the following information:

- Levels of COVID-19 preparedness (awareness, needs and effects)
- Changes in living conditions of beneficiaries due to COVID-19
- Appropriateness of response i.e. needs met, timeliness and quality of humanitarian assistance

The report includes limited review of trends across time as the COVID-19 response and awareness levels change. In making these comparisons it is essential to note the differences in type of respondents and sample size:

- **Differences in type of respondent:** Round 1 and 2 data includes beneficiaries of the community protection approach activities, separate of COVID-19 specific responses. These beneficiaries did not necessarily receive COVID-19 effectiveness messaging from ACF. For round 3 beneficiaries, all were UNICEF soap distribution recipients, for which COVID-19 awareness messaging was a standard part of the activity.
- **Difference in location of respondents:** The sample in round 1 and 2 is dominated by respondents from Aarsal. There are no respondents from Aarsal in Round 3 data collection. The difference in reported needs/impacts/etc. may differ substantially by location. Therefore, it is not possible to isolate time as a factor driving change as results are likely influenced by location as well.
- **Difference in sample size:** Round 1 and 2 samples were extremely limited (round 1 n=35, round 2 n=21). Findings from these respondents cannot be generalized to the overall population. For round 3, the sample size of 160 allows for a representative sample of UNICEF soap beneficiaries with a Confidence Interval (CI) of 95% and Margin of Error (MoE) of ±10% for West Bekaa overall. No representative results by cadaster are available with this sample size. Trends by cadaster are reported to highlight variations. However, they should not be interpreted as representative of the area as a whole.

For all rounds, all calls were conducted in Arabic. Respondents were informed of the purpose of the assessment and informed that their participation was voluntary, anonymous and optional.

In addition, they were reminded that they had the right to withdraw at any point during the assessment. The tool was developed in conjunction with the Lebanon Protection Consortium MEAL Technical Reference Group.

FINDINGS

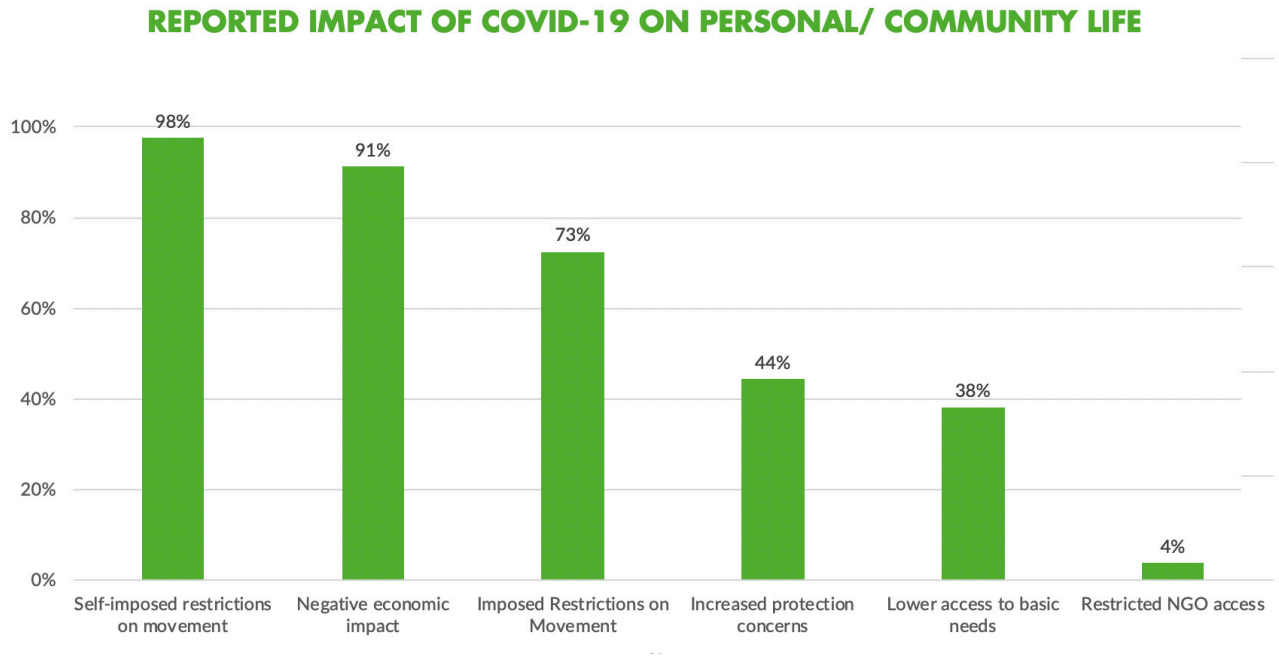
EFFECT OF COVID-19 ON THE COMMUNITY

When asked how COVID-19 is affecting their lives, all respondents reported at least one change to their daily lives. This is consistent with findings from previous rounds of data collection where over 95% reported at least one change to their lives.

Effects on daily lives can be grouped into several categories. Of these, respondents were most likely to report self-imposed restrictions on movement[2] (98%) or negative effects on the economic situation[3] (91%). Restrictions imposed by external authorities (municipality, landlord, and/or community leader, 73%), increased protection concerns[4] (44%), and decreased access to basic services[5] (38%) were also highly reported.

As of April, very few respondents reported restricted NGO access to their communities (4%).

Figure 1 Reported impact of COVID-19 on personal/community lives of refugees



As illustrated in Table 2 below, there were some noticeable changes in reported life changes between March and April. There were no reports of imposed restrictions in March or first round of April (with the exception of one respondent reporting school stopping in March), compared to high reports of municipal restrictions (72%) and some reported restrictions enforced by landlord/community leaders (12%) in the 3rd round of data collection.

2 Not going outside unless necessary, stopping social gatherings

3 Loss of livelihood and/or increase in prices

4 Increase in tensions with host community, inside community, cases of SGBV/violence against children and/or stress/panic

5 Access to shops for basic needs, water, desludging, and/or healthcare

Reports of self-imposed restrictions, specifically not going outside unless necessary, continued to increase between March (23%) and the 3rd round of data collection (80%). **Access to healthcare has decreased (with 19% of the refugees reporting it in April compared to 0 in March), and so has access to shops for basic needs (32% reporting decreased access compared to 0 in March). In April, nearly 80% of the respondents noted that the prices had increased – compared to 0% in March.** Decreased access to services, compounded with economic impacts of the crisis, will continue to exacerbate existing pressures on refugees to meet their basic needs. Assistance needs are likely to increase; funding appeals must remain relevant to changes in needs.

Table 2: Effect of COVID-19 on daily lives of refugees

	Round 1 March		Round 2 April		Round 3 April	
	#	%	#	%	#	%
Self-Imposed Restrictions					157	98%
Not going outside unless necessary	8	23%	10	48%	128	80%
Social gatherings and activities stopped	19	54%	0	0%	110	69%
Imposed Restrictions					117	73%
Municipal restrictions on movement	0	0%	0	0%	115	72%
Landlord restrictions and/or community leader restrictions on movement	0	0%	0	0%	19	12%
Schools Stopped	1	3%	0	0%	1	0.5%
NGOs restricted from entering community	0	0%	0	0%	6	4%
Reduced Access to Basic Needs					61	38%
Less access to healthcare	0	0%	0	0%	30	19%
Less access to water	0	0%	0	0%	1	1%
Less access to desludging	0	0%	0	0%	2	1%
Markets/Shops closed /Shortage in basic needs	0	0%	6	29%	51	32%
Increased Protection Concerns					70	44%
Increased tension with host community	0	0%	0	0%	30	19%
Increased tension within the community	0	0%	0	0%	3	2%
Increased cases of SGBV/violence against children	0	0%	0	0%	1	1%
Panic and Stress	25	71%	1	5%	64	40%
Children afraid, bored / becoming aggressive	1	3%	0	0%	0	0%
Economic Impacts					146	91%
Loss of Livelihood	17	49%	2	10%	82	51%
Price increases	1	3%	0	0%	126	79%
Other economic impact	0	0%	0	0%	2	1%
Other						
More handwashing and HP practices/ Cleaning	0	0%	1	5%	0	0%
Other changes	1	6%	5	24%	1	0.5%
No change	2	0%	0	0%	0	0%

Of the 'other' response in the third round of data collection, the respondent mentioned not being able to access cheaper shops outside of the village but did not specify who was imposing the movement restrictions.

Only one respondent in the three rounds mentioned changes in hygiene practices/cleaning as a result of the Corona outbreak on their daily lives. This is a surprising finding given that messaging and distribution items in the Corona response have been tailored to improve cleaning/hygiene practices. However, the fact that 91% of respondents report handwashing as a measure they are taking to prevent the Corona outbreak (see Table 5 below) indicates that low reporting of more handwashing/cleaning within this question does not mean that beneficiaries have actually not changed their hygiene practices. Rather, it is more likely that, because households were already practicing some handwashing/hygiene practices before Corona, they do not see the activity as a change, rather only a prevention practice.

Results from round three indicate some cadasters where decreased access to essential services are more acute.

- **Decreased access to healthcare** was reported by at least some participants in all cadasters (except Soultan Yaacoub Faouqa) indicating it is a prevalent problem. It was particularly reported by at least half of respondents in Joubb Jannine (58%, n=11) and Souairi (50%, n=2).

  ➔These cadasters may need special attention by health service actors.

- **Increased protection concern**s were reported by at least half of respondents in Baaloul (60%, n=6), Ghazzeh (76%, n=44), Souairi (75%, n=3) and Kamed El-Laouz (50%, n=12). The specific protection concern reported differed by area. For example, in Ghazzeh where an incident between Lebanese and Syrians had just happened, 64% of protection concerns related to tension with the host community (this was not reported in any other cadaster except Joubb Janine, where two respondents reported the issue).

  ➔MEAL and field staff must be trained to appropriately refer and respond to protection concerns where applicable.

  ➔Humanitarian actors involved in the COVID-19 response need to ensure it remains conflict-sensitive to ensure it does not create further tensions between refugee and host populations. Humanitarian actors thus need to provide assistance based on needs and without discrimination based on nationality. They should include support to municipalities and host communities as much as possible.

- **Movement restrictions** imposed by the municipality were reported in several cadasters where respondents were interviewed – by all respondents in Baaloul and over three-quarters of respondents in Joub Janine (84%), Ghazzeh (90%), Kamed El-Laouz (88%), and at least a quarter of respondents in Souairi (50%), Soutan Yaacoub Faouqua (43%), Mansoura BG (32%) and Kafraiya BG (25%). No restrictions were reported in Tall Znoub. Restrictions by community leaders/landlords were reported in Joubb Jannine (26%, n=4), Ghazzeh (17%, n=10), Baaloul (10%, n=1), Souairi (25%, n=1), and Kamed El-Laoz (8%, n=2). These survey findings have been confirmed by field teams observations. Local authorities in West Bekaa have been stricter in terms of movement and have set up small checkpoints to avoid gatherings and unnecessary movements. In Ghazze, an incident took place during the week of April 13th and a conflict occurred between young people from Ghazze and Syrian refugees residing in an IT, causing casualties, further movement restrictions caused to both NGOs and refugees, multiple further incidents and high tension in the village. The situation has later been resolved.

➔**Response modalities must remain flexible to changes in context. Imposed movement restrictions will be of special importance in determining the appropriateness of cash/ voucher distribution over in-kind delivery.**

➔**Humanitarian agencies will need to monitor and coordinate to refer cases where populations are experiencing specific barriers.**

➔**In their effort to address COVID-19, authorities need to adopt impartial decisions affecting all residents and not specific populations only.**

Six respondents in the 3rd round data collection reported that they were possibly (n=3) or definitely (n=3) planning to change their residence due to the spread of the COVID-19. No respondent in March and all but one respondent in April (who mentioned the COVID-19 could possibly lead to a change in living area) mentioned that the COVID-19 would influence their decision to remain in Lebanon or move from the area they are currently living. Respondents were not asked whether they intended to return to Syria or move within Lebanon.

EXPOSURE TO COVID-19 MESSAGING/AWARENESS SESSIONS

The vast majority of respondents (92%) had received information and/or attended awareness raising sessions about COVID-19. Of those that had received information, 100% reported receipt from ACF teams during distribution and all reported that the information was sufficient to understand how to protect themselves and their household members from getting the COVID-19. Importantly, all NGO activities should include some messaging on COVID-19. **Field teams will need to continue ensuring that messaging is conducted and understood by communities where we work.**

Besides ACF distribution teams, provision of information was reportedly extremely limited with only two other sources reported: two respondents had also received information from a health sector NGO (MSF, Lebanese Red Cross, etc.), two had received a call from UNICEF and one other had received information from a community mobilizer after distribution. **Limited information sources, besides ACF distribution teams, might be related to the geosplit, and or to the fact that not all agencies share awareness messages during distributions.**

KEY MESSAGE DISSEMINATION IN THE COMMUNITY

Ninety-two percent of respondents reported that they had attended an awareness session or received IEC materials on COVID-19. This continues the upward trend from previous data collection rounds where 81% (n=17) of respondents reported information provision in 2nd round of data collection up from 26% of respondents within the refugees sampled in the first round (March). Importantly, in the first round of April data collection and March, respondents included FGD participants whereas the current data collection only included beneficiaries of ACF distribution - an activity which should always include information provision.

Despite high coverage rates of information provision, results from the 1st round of information collection in April, where nearly half of these respondents (48%, n=10) identified specific information that would be beneficial regardless of previous participation in sessions, indicates that there are topics that still need further information. This question was not asked in the third round of data collection.

Respondents in the first two rounds of data collection were asked what additional information they needed. The most frequent response in both April and March was the need for 'general' information without specifics provided (see Table 4).

Table 4: Information needs to make decisions (round 1 and 2 only)

	March		April	
	#	%	#	%
Symptoms	2	6%	2	10%
Modes of transmission	0	0%	0	0%
Precaution measures	6	17%	2	10%
Facts and news in Lebanon	1	3%	3	14%
Distribution/activity information	1	3%	0	0%
General information (not specified)	11	31%	4	19%
No answer	2	6%	0	0%

➔Agencies should continue messaging refugees with general information on COVID-19, through different channels and including face-to-face when possible, but also news or social media.

COVID-19 MESSAGING EFFECTIVENESS

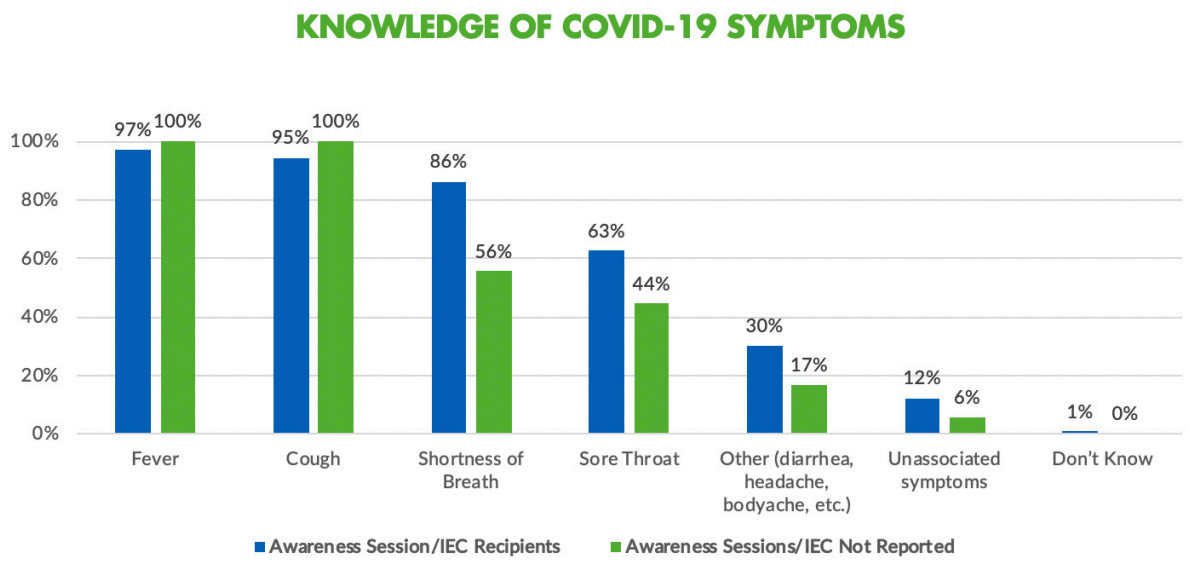
This section explores knowledge of key topics among those respondents that report exposure to awareness-raising/IEC on COVID-19. All of these participants received their information, at least in part, from the ACF team during distribution. Therefore, recommendations based on findings are most directly related to improving ACF-led awareness sessions.

KNOWLEDGE OF COVID-19 SYMPTOMS

Of awareness session participants, only one (1%) reported that they did not know what the symptoms of COVID-19 were and 12% (n=18) reported symptoms not identified by the WHO (mostly sneezing, chills and ear/eye itching). Not all symptoms were as well-known, notably sore throat (63%).

100% of respondents who had not attended sessions were able to identify fever and cough as symptoms but they were slightly less likely to be able to identify shortness of breath and sore throat as symptoms of Corona, when compared to awareness session attendees.

Figure 2: Known symptoms of COVID-19



Results indicate high levels of understanding of the main symptoms of COVID-19 (fever, cough and shortness of breath) among awareness session recipients.

The report of unassociated symptoms (mostly sneezing, chills and ear/eye itching) and lower awareness of some symptoms (notably sore throat) highlights the need to continue disseminating information needed for refugees to accurately identify suspected cases.

Awareness session recipients were more likely to know shortness of breath and sore throat as relevant symptoms of the COVID-19. However, the sample size of non-attendees (n=13) is too small to draw broad conclusions on the effectiveness of awareness sessions comparing to those who have not received them.

KNOWLEDGE OF NATIONAL PROTOCOL

There was a large increase in the percentage of respondents correctly able to identify calling the MoPH as the appropriate response measure if they identified a suspected case of the COVID-19 between rounds one and three of data collection. In round one and two, less than 20% of respondents reported the need to call the MoPH compared to 74% of respondents in round 3. Reported need to quarantine was also much higher: 41% in round three of data collection compared to 17% of respondents in round one.

Table 6: Response if COVID-19 symptoms identified

	Phase 1 March		Phase 2 April		Phase 3 April	
	#	%	#	%	#	%
Go/refer to PHC/ doctor/ pharmacy/ hospital	13	37%	1	5%	34	21%
Personal assessment of symptoms	0	0%	0	0%	0	0%
Call MoPH #	5	14%	4	19%	118	74%
Call LRC, Hospital, health center	6	17%	5	24%	57	36%
Quarantine affected persons	6	17%	0	0%	65	41%
Contacting municipality	2	6%	13	62%	2	1%
Other (Specified)	8	23%	6	29%	24	15%
Don't Know	3	9%	0	0%	0	0%

Importantly, only 25% of respondents correctly identified the need to quarantine and call the MoPH, without going to a health center/pharmacy. Twenty-one percent of respondents reported that they would go to a health center/pharmacy.

Awareness session participants/IEC recipients were slightly less likely to know to call the MoPH (73%) or that they should not go to a health center/pharmacy (80%). However, they were more likely to know to quarantine affected persons at home (42%) compared to those that had not received awareness sessions/IEC materials.

In phase three, the majority of 'other' responses were to call UNHCR (37%, n=22). Two people reported the need to call UNICEF. In phase two, the 'other' responses were to contact UNHCR/use the numbers provided by UNHCR (14%, n=3) or tell the Army (14%, n=3). The 'other' responses in March included informing the 'focal point' or concerned authorities (n=4), calling the UN (n=2), or seeking medical care (unspecified location), n=2).

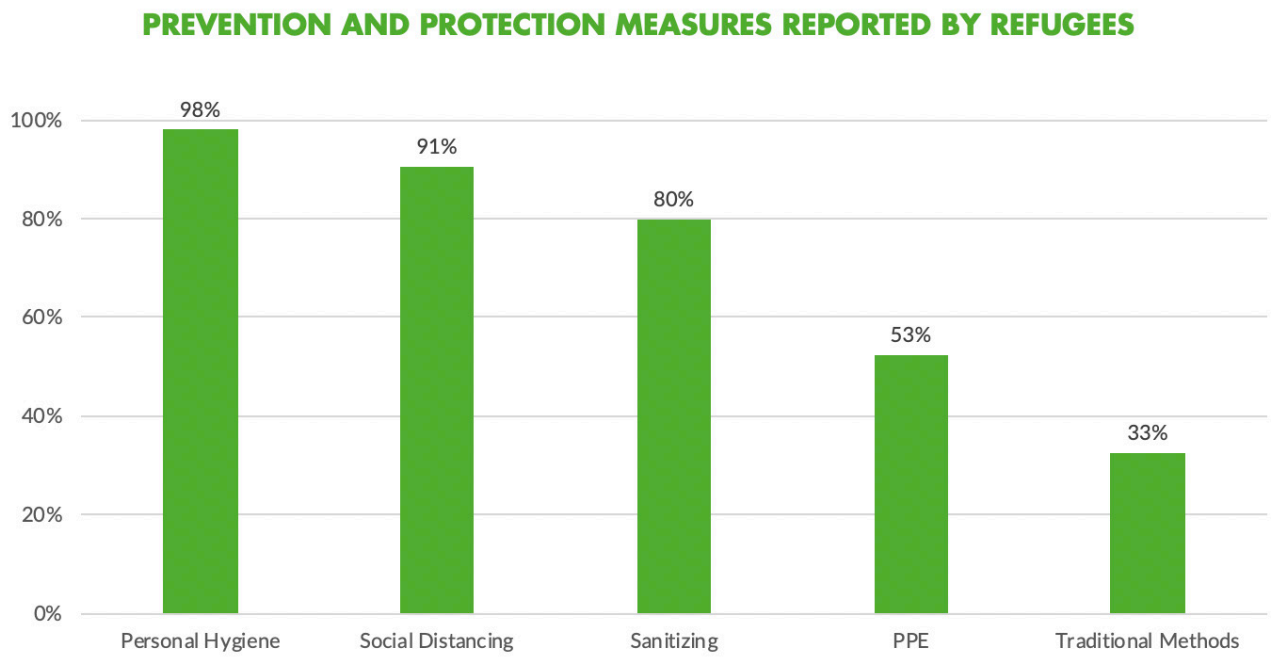
It is concerning that so few respondents were able to correctly identify the correct national policy indicating a serious need for additional information provision on how to respond to suspected cases.

MEASURES TAKEN BY THE COMMUNITY

When asked if they take some kind of prevention and protection measures, nearly all respondents in the three rounds of data collection reported taking some sort of action. Measures taken can be grouped into several categories: personal hygiene measures[6], social distancing[7], wearing PPE[8], sanitizing household and personal items, and traditional measures[9].

As illustrated in Figure 2 below, personal hygiene (98%), social distancing (91%) and sanitizing items (80%) were the most prevalent methods of prevention.

Figure 3: COVID-19 prevention and protection measures reported by refugees



Trends for prevention measures were consistent between March and April with the majority of respondents focusing on social distancing/isolation (98% in 3rd round of April, 81% in 2nd round, 74% in 1st round). However, there were noticeable increases in the percent of respondents practicing handwashing/personal hygiene measures (23% in round 1, 91% in round 3), using sanitizers (26% in round 1, 80% in round 3), and using PPE (3% reported wearing gloves/masks in round one compared to 45% wearing gloves and 40% always wearing a mask).

6 Handwashing, covering nose/mouth with elbow or tissue when sneezing, practicing food safety, avoiding touching eyes/nose/mouth

7 Isolation, avoiding crowds/gatherings, staying 1-2 meters from other persons, social distancing from everyone in the household, avoiding kissing/contact with others, avoiding children leaving the house, limiting number of households moving in community

8 Always wearing a mask, wearing a mask only when sick/caring for sick persons, wearing gloves

9 Eating foods or drinking drinks that prevent COVID-19, sanitizing with traditional methods (vinegar, sun, salt)

Table 5: Personal habits to reduce COVID-19 exposure

	March		April		April	
	#	%	#	%	#	%
Personal Hygiene						
Handwashing/ Personal Hygiene	8	23%	6	29%	145	91%
Avoid touching eyes, nose and mouth	0	0%	0	0%	36	23%
Cover mouth/nose while coughing or sneezing	1	2%	0	0%	19	12%
Practicing home food safety	0	0%	0	0%	9	6%
Using sanitizers or detergents/ethanol/ bleach/dettol for personal hygiene	9	26%	0	0%	128	80%
Social Distancing						
Isolation	25	74%	17	81%	63	39%
Avoid crowds/gatherings	14	40%	0	0%	125	78%
Stay 1-2 meters from other people	0	0%	0	0%	62	39%
Keep social distance from everyone in the HH	0	0%	0	0%	11	7%
Avoid children going outside	1	3%	1	5%	0	0%
Avoid Kissing/ Contact with others	2	6%	7	33%	95	59%
Limit number of HHs in community able to move	0	0%	6	29%	2	1%
Shopkeeper providing goods to households individually	0	0%	0	0%	4	3%
Wearing PPE						
Using gloves/masks	1	3%	3	14%	Asked separately	Asked separately
Wearing gloves	0	0%	0	0%	72	45%
Always wearing a mask	0	0%	0	0%	64	40%
Wearing a mask only if caring for sick person or sick	0	0%	0	0%	15	9%
Other	4	11%	0	0%	1	1%
Traditional Methods						
Sanitizing with traditional methods (vinegar/water and salt/sun)	0	0%	0	0%	52	33%
Eating specific foods/drinks that prevent COVID-19	2	6%	0	0%	1	1%

It is positive that there are relevant prevention measures mentioned.

➔Relevant support will be needed to maintain these measures. The high percent of respondents avoiding contact (either through avoiding crowed/gathering, self-isolation or avoiding direct contact with others) may require support to ensure access to essential needs, for example through hibernation kits basic hygiene items and even promoting shielding - self-isolation of the most vulnerable - at this early stage. For the latter, similar means should be

provided, potentially including a proper/new shelter where to isolate.

➔ The large increase in the percentage of respondents reporting handwashing as a preventative measure is a positive indication of understanding of key prevention measures but will require ensuring continued access to soap/sanitizers and sufficient water to be effective.

The results also highlight gaps in knowledge and/or preparedness that should be addressed in further tailoring the response:

- **Use of traditional cleaning agents:** the fact that 33% of respondents are using traditional cleaning agents (salt and water, vinegar, etc.) to protect against COVID-19, which have not been proven effective, highlights the need to ensure both the knowledge that these measures are not effective as well as provision of effective sanitizing agents.
- **Lower utilization of some key hygiene practices (covering sneeze/cough, avoid touching face, practicing food safety):** These elements of COVID-19 transmission may be less understood. UNICEF has developed messaging on all of these topics. However, low reported use of these prevention measure may indicate a need for increased focus on these strategies in ACF communications.
- **Correct use of PPE:** in context monitoring, ACF has identified requirements of shopkeepers that customers wear PPE, regardless of effectiveness. PPE is expensive for already economically deprived households. Correct and effective use of PPE, especially the use of gloves, should be further emphasized as well as communicated to authorities to support more rational requirements and sound prioritization for PPE use.

The mention of preventing outsiders from entering the camp in the first round of data collection highlights the need for effective acceptance strategies for future COVID-19 responses to prevent blocking from the community. Though this was not mentioned in later rounds of data collection, the continued focus on isolation and other means of limiting contact still point to a focus on reducing contact, and therefore possible resistance to entry of outsiders. **NGOs will need to remain vigilant to how they are perceived by communities and respect guidelines to prevent transmission.**

COMMUNITY NEEDS

Like when asked how COVID-19 is affecting their lives, there were noticeable differences between responses in March and April when respondents were asked "What would you need to feel secure and supported?"

Two of the most noticeable changes were the **large increases in requests for food assistance** (no respondents in March to **88% of respondents** in the 3rd round of data collection) and **cash/financial support** (9% to **76%**). This is in line with feedback from the Protection Working Group held on 21st April where there was increased reporting of food as a concern and difficulty in accessing food due to limited financial means and movement restrictions. The Food Security Sector also presented during this working group identifying an additional 405,000 individuals who are in need compared to VASyR figures. Already, UNHCR has increased the amount of financial assistance to cover additional 11,000 households for three months.

In parallel, requests for hygiene items (86% to 31%) and gloves and masks (63% to 11%) have decreased between the first and 3rd round of data collection.

Table 3: Community needs to feel secure and supported

	Round 1 March		Round 2 April		Round 3 April	
	#	%	#	%	#	%
Awareness session	5	14%	0	0%	5	3%
Hygiene Items distribution (e.g. detergents, bleach etc.)	30	86%	4	19%	50	31%
Cash assistance/ Financial support	3	9%	0	0%	122	76%
Increasing water supply for household	4	11%	0	0%	7	4%
Food Distribution	0	0%	0	0%	141	88%
Providing gloves and masks	22	63%	2	10%	17	11%
Medical support (Specialists and doctors' availability, and medications)	1	3%	2	10%	28	18%
Financially Supporting PHC / Hospitals to receive refugees/Coverage of medical costs for refugees	0	0%	1	5%	6	4%
Isolation	0	0%	10	48%	0	0%
Other	5	14%	2	10%	8	5%

➔The changes in reported priorities of refugees, from hygiene/protective equipment to cash and food assistance highlights **the need to review distribution modalities**, including **in-kind distribution of food**, as refugees increasingly rely on isolation as a primary coping strategy and municipalities enforce increasingly strict restrictions on movement.

When asked whether the assistance was useful to meet their urgent need and to solve the problem in the immediate term, 54% reported that the assistance was 'fully' useful/solved their problem in the immediate term. The remaining participants reported that the assistance was only 'partially' (42%) or 'not at all' (4%) useful. Future iterations of the assessment will collect further details for those that do not feel the assistance is 'fully' useful in order to provide further guidance on possible revisions to the response.

GENERAL ACCESS TO HEALTH (PHASE 1 AND 2 ONLY)

In phase one and two of data collection, ACF asked two questions concerning intention to visit a health center:

1. Whether respondents were likely to report to or visit a health centre if needed (in general)
2. What would you do if you, a member of your family or a neighbour developed symptoms? (Corona specific)

In phase one, 29% of respondents said they would go to a health center if needed (as a general question) while 37% reported that they would seek medical care if they suspected a case of Corona. In phase 2, 33% of respondents said they would, in general, visit a health center if needed while only 5% reported that they would seek some sort of medical care if a member of their family or neighbor developed symptoms.

The relatively small proportion of respondents reporting an intention to go to a health center when needed might indicate knowledge of the need to call the MoPH hotline in case of symptoms. It does

not seem to be related to lack of access to health centers, with 95% of phase two and 86% of phase three respondents reporting access to a health center. Respondents in these two phases were also asked if they faced any barriers to accessing health services (in general, not Corona-specific). 76% of phase two and 74% of phase one respondents reported no barriers to accessing health centers.

Of the 24% of respondents mentioning barriers in April, all reported quarantine measures as the barrier. Respondents in March mentioned more diverse barriers: lack of transport reported by 14%, distance (9%), lack of internet (9%), and financial barriers, reported by 6%.

Table 7: Barriers to health centers

	March		April	
	#	%	#	%
Financial	2	6%	0	0%
Transportation	5	14%	0	0%
No medication available	0	0%	0	0%
Curfews	3	9%	0	0%
Distance to hospitals	3	9%	0	0%
Quarantine	0	0%	5	24%
Other	4	11%	0	0%
No barriers	26	74%	16	76%

Of the 'other' responses in March, one respondent reported a fear of using public transport/going to hospitals. Access to the internet was also reported as a need to access health centers which is somewhat difficult to understand. Unfortunately, no follow up questions were asked to understand why this was a need but may be related to a general lack of information availability for those that do not have internet.

Limited intentions to visit health centers if symptoms developed may be more related to opinions of service, rather than barriers to access though there is limited feedback with no feedback provided by 52% of April respondents or 49% of March respondents. 29% of April respondents and 14% of March respondents mentioned that they were average, good or very good. Those respondents who provided some negative opinions focused on limited medical support (April=14%, March=29%) and cost of medicine (April=0%, March=20%).

Table 8 Reported Opinion/Feedback on Health Centers

	March		April	
	#	%	#	%
Expensive	2	6%	1	5%
Average/Good/ Very Good	5	14%	6	29%
Medication not always available freely/ shortage	7	20%	0	0%
Limited medical support	10	29%	3	14%
Bad attitude towards Syrians/ staff misbehavior/ Bad service	1	3%	0	0%
Very Crowded	0	0%	0	0%
Doctors not always available	0	0%	0	0%
No feedback	17	49%	11	52%
Other	1	3%	0	0%

Based on the above findings, recommendations are as follows:

- Actors engaged in awareness-raising sessions need to continuously highlight that:

  ➔people in need of respiratory support may call MOPH's hotline ahead of seeking medical assistance;

  ➔people in need of other/general medical assistance are encouraged to visit nearby health centers as services are still ongoing. Actors need to remind beneficiaries that seeking medical support is crucial in spite of quarantine measures (especially obtaining medications, immunization, regular follow-ups, etc.) and that measures (such as using masks) can be followed to protect themselves on their way and in the center.

- These actors should distribute a list of the services that are maintained, and explore if they can cover the remaining cost of the health services;

CONCLUSION

Ninety-two percent of respondents reported exposure to information about COVID-19. This messaging seems to be effective in promoting understanding of symptoms of COVID-19 and knowledge of national protocols. However, **there are still clear gaps in knowledge that need to be further emphasized.**

Knowledge of sore throat (63%) and shortness of breath (86%) was less prevalent compared to fever (97%) and cough (95%). Furthermore, 12% of respondents reported unassociated symptoms (mostly sneezing, chills and ear/eye itching). **Stressing shortness of breath and sore throat, as well as clarifying unassociated symptoms should remain a priority.**

Trends in knowledge of national protocol are encouraging with 73% of awareness-session recipients and 74% of the sample overall) knowing to call the MoPH if there is a suspected case. This compares to only 19% of phase two respondents correctly identifying the need to report to the MoPH hotline if symptoms are identified. However, the fact that a quarter of respondents did not know that they needed to call the MoPH, only 41% knew to self-quarantine possible cases and 21% reported that they would go directly to a health center/pharmacy highlights the **need for further information dissemination on correct protocol for reporting suspected cases.**

Besides ACF distribution teams, the number of other sources providing information was reportedly extremely limited – probably because of the geosplit - highlighting the importance for ACF to continue to provide key information about COVID-19 to affected populations.

Positively, the majority of respondents were already practicing effective prevention measures, specifically the high percent of respondents avoiding contact (either through avoiding crowed/gathering, self-isolation or avoiding direct contact with others). The upward trend in reported prevalence of handwashing (91% compared to 29% in phase two and 23% in phase one) is also positive. However, the fact that 33% of phase three respondents report using traditional 'sanitizing' methods (vinegar and water, salt and sun, etc.) highlights the need to expand knowledge on effective sanitizing methods and ensure supply refugees with required resources to effectively prevent COVID-19 (sufficient quantity of water, soap, reliable disinfection materials, PPE for infected populations/populations caring for

infected populations). Provision of prevention materials is especially needed in the current context where the COVID-19 has compounded social and economic problems exacerbated by the political revolution which began in October.

The most significant change is the large increase in requests for food assistance and cash, increasing for food assistance from no mention of it in March to 88% of the respondents mentioning it in the 3rd round of data collection, and for cash/financial support from 9% to 76%. This is in line with feedback from other surveys.

The changes in reported priorities of refugees, from hygiene/protective equipment to cash and food assistance highlights the need to review distribution modalities, including in-kind distribution of food, as refugees increasingly rely on isolation as a primary coping strategy and municipalities enforce increasingly strict restrictions on movement.

Increased protection concerns were reported by 44% of respondents, differing by area. Tensions with host communities have risen in some cadasters. MEAL and field staff must be trained to appropriately refer and respond to protection concerns where applicable. Furthermore, the response needs to target all to ensure it does not create further tensions between refugee and host populations.

RECOMMENDATIONS

The below recommendations are based on findings from the calls to community members. In light of this, recommendations should be taken as general guidance, pending further information collection and triangulation with other data sources.

To enhance the effectiveness of prevention measures and limit the impact of the lack of access to accessing essential services

- NGOs and UN to rapidly scale up in-kind food assistance, hibernation kits and cash assistance urgently, especially for the most vulnerable. Donors should be ready to fund such distributions.
- UN and NGOs should continuously advocate to Lebanese authorities to avoid discriminatory measures targeting refugees.
- NGOs to regularly assess the status of the protection environment of those most vulnerable and or affected by displacement.
- NGOs and UN to consider cash modalities for those affected by displacement to cover transport and medical fees related to COVID-19.
- WHO and UNHCR to request that the Ministry of Health provides equal access to health and mental health services to all nationalities, as needed and without discrimination – in Primary health centers, clinics, and national hospitals - especially to Syrian refugees without legal status and exposed to higher protection risks. They should also ensure that breastfeeding related recommendations are always mainstreamed as part of food parcel distributions given its life-saving impact on infants.

To enhance COVID-19 prevention and the effectiveness of awareness-raising activities,

- NGOs and UN need to prioritise and increase community outreach to promote prevention of COVID-19. The following needs to be prioritised: social distance, self-isolation and respiratory etiquette, caregiver protocol, disinfection and appropriate handwashing. Results indicate the information should also be shared through TV/Social Media given high use of these means to collect information so far.
- NGOs & UN should continue to circulate information on the national protocol, on what to do if one develops symptoms or is a caregiver for a suspected case, and the number of the Ministry of Public Health hotline.
- NGOs & UN need to ensure awareness activities focus on effective strategies of prevention, particularly handwashing. Addressing incorrect information on the prevention, treatment and spread of the disease should remain a priority. Specific messages need to be added to address stigma.
- Government of Lebanon, NGOs & UN to include Solid Waste Management and water trucking at ITS level as an essential activity and liaise with municipalities to ensure collection of waste and its safe disposal.
- Donors need to be ready to increase funding to the water sector so that refugees residing in ITSs can have access to 60L of water per person per day, that desludging takes place more frequently and that solid waste management is adequately supported.
- Donors and UN to continue exploring connection of the ITSs to existing water and sanitation networks.
- UN and NGOs need to provide continuous blanket distributions of soap to all ITSs as well as a prioritized distribution of disinfection kits to the most vulnerable ITSs to COVID-19 following the agreed criteria by the water sector.

ACTION AGAINST HUNGER
LEBANON

CONTACT

Beatriz Navarro-Rubio
Country Director
bnavarro@lb.acfspain.org