KNOWLEDGE, ATTITUDES AND PRACTICES (KAP) TOWARDS COVID-19 IN LEBANON

27 APRIL 2020 – 22 MAY 2020
The opinions in this report reflect the findings of the data collection and cannot be attributed to UNICEF or to any other organization.

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Nudge Lebanon is a nongovernmental and non-profit organization committed to utilizing the methods and applications of behavioral science for social and behavioral change. At Nudge Lebanon, we use a variety of rigorous qualitative and quantitative research methods, including experimental methods to solve complex social problems and promote positive behavioral change. For more information about Nudge Lebanon and its work, visit www.nudgelebanon.org

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On 30 January 2020, the World Health Organisation (WHO) declared the novel coronavirus (COVID-19) outbreak a Public Health Emergency of International Concern. The virus continued to spread throughout the world, and was finally declared a pandemic on 11 March 2020. On 21 February 2020, Lebanon confirmed its first case of COVID-19, after which the disease spread rapidly throughout the country, with the first death reported 18 days after the first case was reported. A state of general mobilization was declared by the government on Sunday, 15 March 2020 to slow down and contain the outbreak.
As of 30 June 2020, Lebanon recorded 1,778 cases, 34 deaths and 1,153 recoveries. The majority of the confirmed cases belonged to Lebanese nationals (87%), with Mount Lebanon recording the highest number of cases (41%), followed by Beirut (17%) and North Lebanon (16%). The remaining 25% were distributed across the five other governorates. Adults, aged 20 to 39, were the most susceptible to the virus (41%), followed by the 40 to 59 age group (26%).
Despite the successful efforts expended by the government, Ministry of Public Health (MoPH) and various international organizations (WHO, UNICEF, UNHCR, UNRWA, etc.) in containing the initial spread of the virus (as evidenced by the relatively small number of confirmed COVID-19 cases relative to other countries), very little is known about the knowledge, attitudes and practices of the general population in Lebanon.

To complement the ongoing COVID-19 outbreak response, a rapid Knowledge, Attitudes and Practices (KAP) Study was carried out to evaluate the level of knowledge about the disease, risk perceptions, and current as well as intended individual efforts to prevent and contain the spread of the disease. This study was carried out to provide insights that could better inform communication and community engagement interventions aimed at promoting protective behaviors and practices at the community and household level.
A phone-based KAP survey using a computer-assisted telephone interview (CATI) mode was conducted in eight governorates (Akkar, Baalbek-Hermel, Bekaa, Beirut, Mount Lebanon, Nabatieh, North Lebanon and South Lebanon) between 27 April 2020 and 22 May 2020. A Random Digit Dialing (RDD) technique with a quota sampling method was initially used to recruit a nationally representative sample. However due to the low response rates, a snowball sampling technique was adopted, which increased the response rate at the expense of representativeness.\textsuperscript{1}
RDD Sampling

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
<th>Valid %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random Numbers Called</td>
<td>753</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Valid Phone Numbers</td>
<td>462</td>
<td>61.4%</td>
<td>61.4%</td>
</tr>
<tr>
<td>Answered Phone Calls</td>
<td>353</td>
<td>46.9%</td>
<td>76.4%</td>
</tr>
<tr>
<td>Eligible Respondents</td>
<td>348</td>
<td>46.2%</td>
<td>98.6%</td>
</tr>
<tr>
<td>Consent Given</td>
<td>131</td>
<td>17.4%</td>
<td>37.6%</td>
</tr>
<tr>
<td>Fully Completed Surveys</td>
<td>100</td>
<td>13.3%</td>
<td>76.3%</td>
</tr>
<tr>
<td>Partially Completed Surveys</td>
<td>31</td>
<td>4.1%</td>
<td>23.7%</td>
</tr>
</tbody>
</table>

Calls were placed all day, Monday to Saturday, by well-trained interviewers. Any person who was at least 18 years old, was Lebanese, Syrian or Palestinian, and had proper communication skills was eligible to participate in the survey. Respondents were informed that the call was for free, names were not collected, and data was confidential. Respondents were also asked to give their consent to continue with the call. In certain cases, the interviewers were requesting respondents to hand their phones to a family member, who was fulfilling specific, hard-to-obtain, requisite criteria (specifically in the oldest age group).

Snowball Sampling

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers called</td>
<td>1,943</td>
<td>100.0%</td>
</tr>
<tr>
<td>Fully Completed Surveys</td>
<td>1,921</td>
<td>98.9%</td>
</tr>
<tr>
<td>Partially Completed Surveys</td>
<td>22</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Data from 2,074 interviews were collected, of which 97.4% were fully complete. While the use of quotas for governorates and age groups yielded demographic characteristics that are comparable to the census population structure, the use of snowball sampling - a non-probability sampling technique - compromises the representativeness of the study, thereby limiting the ability to generalize findings beyond the sampled population.
In the absence of a national database or sampling frame, and the limitations of an RDD technique (low response rate), a non-probabilistic (snowball) sampling method, with a priori age-region distribution, was used to recruit participants. While this may have compromised the generalizability of the study findings, the results are still indicative of the knowledge, attitudes and practices of the sampled population, and provide valid baseline indicators for future replications that use similar sampling approaches.

Even though phone-based surveys are subject to a selection bias—by excluding population groups that do not have access to a telephone (e.g. the homeless, people living in elderly homes, enclosed facilities or institutions)—it does not compromise the validity of the study findings as at least 86% of the population in Lebanon has access to or shares a mobile phone.

Despite thorough preparations by the interviewers to make participants feel comfortable, and although participants were explicitly asked to be honest in their responses, readers should account for a potential social desirability bias whereby some respondents may have under-reported some behaviors (e.g. lack of reporting due to social stigma or fear of being quarantined) and over-reported others (e.g. ability and willingness to self-isolate and compliance with preventive measures).

The data was collected during the national lockdown period in Lebanon when the government prohibited group gatherings. Now that the lockdown has been lifted, certain measures such as avoiding social gatherings and staying at home are no longer applicable. Moreover, public vigilance and risk perceptions may have diminished since then judging by the rapid increase in the number of confirmed cases. Accordingly, the findings of the survey are only indicative of the situation at the time of data collection, and should be considered as a baseline for future KAP studies.
COVID-19
BE AWARE, PREVENTION

- Wash hands frequently with soap
- Wear a mask if you have a cough or runny nose
- Cover your mouth with a tissue paper when coughing or sneezing
- See a doctor if you feel unwell

SUMMARY OF KEY INSIGHTS
KNOWLEDGE

There was generally good knowledge about the main transmission methods, prevention measures, symptoms, risk groups, and even some aspects of reporting protocol. However, there were clear gaps in knowledge and/or misinformation in each of these areas, especially with regard to technical aspects of these areas like definitions or exact protocol.

Transmission

- The overwhelming majority of respondents (96% to 99%) were aware that COVID-19 can be transmitted through direct contact with respiratory droplets of symptomatic and asymptomatic individuals, and through touching contaminated surfaces. However, 39% and 50% also believed that the virus could transmit from a mother to her child during pregnancy and breastfeeding, respectively, and up to 30% simply did not know.
Symptoms

- Most respondents identified the common COVID-19 symptoms: fever (96%), cough (90%) and shortness of breath (83%). However, less than half mentioned diarrhea and body aches, two symptoms that have been featured in MoPH communication materials.

- Akkar and North Lebanon were less aware with the common and uncommon symptoms than other governorates.

Preventive measures

- The overwhelming majority of respondents (97% to 99%) were aware of the main hand hygiene, respiratory hygiene and physical distancing preventive measures.

Risk groups

- Most respondents identified either the elderly (92%) or individuals with pre-existing conditions (76%) as being at risk of developing severe symptoms. However only 49% strictly identified both these groups. A significant proportion (20%) considered pregnant women to be at risk of developing severe symptoms, while 13% cited children.

- Palestinians were significantly less likely to identify elderly (68%) or individuals with pre-existing conditions (60%).

Protocol to follow if experiencing COVID-19 symptoms

- Majority of respondents knew that they should “self-isolate” (75%) if they were experiencing symptoms, while 58% knew that they should call MoPH. Less than half (47%) knew that they should do both, report and self-isolate if they were experiencing symptoms.

Self-isolation

- An overwhelming majority of respondents had a poor understanding of how to self-isolate. Only 9% of respondents strictly identified the correct descriptions of self-isolation. The remaining respondents identified a mixture of correct and wrong descriptions, with around 80% reporting that leaving the house when necessary, ‘while maintaining a safe distancing from others’, or ‘wearing a face mask’, is effective self-isolation.
ATTITUDE / RISK PERCEPTIONS

Perceptions about individual susceptibility to COVID-19 and the severity of an infection deviated considerably from reality, with many respondents either underestimating the likelihood of contracting COVID-19, overstating its severity, or both.

- Slightly more than half of the respondents (57%) believed they were likely to get the disease, and more so amongst the older age groups. As expected, there was a gap between personal susceptibility to the disease and community spread, with the latter being judged as more likely by around 10% of the respondents. The gap was particularly significant for youth, reaching 20%.

- Mount Lebanon, the largest governorate in Lebanon, and the one with the highest number of confirmed cases, was the least likely to show personal susceptibility to the disease, with less than half the respondents (49%) reporting a high likelihood to contract COVID-19.

- According to MoPH data only 5% of the confirmed COVID-19 cases are severe or critical. However, over a third of respondents believed that if they were to get the virus, their symptoms would be severe or life threatening, and this percentage increased significantly with age. Meanwhile, less than a tenth expected to show no symptoms, which is considerably lower than the actual 40% of asymptomatic cases reported by MoPH.

PRACTICE

There was generally high compliance with preventive measures, although physical distancing measures in particular were practiced relatively less often than personal hygiene measures. There was also high willingness to comply with self-isolation measures if necessary. However, more than half of the respondents reported at least one barrier that could limit their ability to self-isolate properly. Meanwhile, willingness to report suspected cases of COVID-19 to MoPH was more likely for severe than mild symptoms.

General preventive measures
(Physical distancing and personal hygiene)

- Up to a fifth of respondents reported noncompliance with three physical distancing measures: avoiding social events (81%), maintaining a distance of 1 meter from others (83%) and hand shaking (84%).

- There was severe and significant non-compliance in the Akkar and Northern governorates in particular, with respondents from these regions being up to 40% less likely to comply with personal hygiene and physical distancing measures.
• Perceived personal susceptibility was positively correlated with reported compliance with personal hygiene and physical distancing measures.

Handwashing

• At least half of the respondents reported four moments of handwashing throughout the day, whilst over a third reported seven moments. Most people reported no barriers to handwashing whilst 27%-30% cited ‘lack of access to soap and water’ as a barrier. The latter was particularly true for Syrian respondents with 45% lacking access to clean water.

Staying at home
(as per government directive)

• Most people observed the government stay-at-home order before it was lifted, and a majority of them did so because of the fear of contracting the virus (85%), whilst a third were motivated by modelling good (citizen) behavior.

• A third admitted to leaving their homes during the lockdown because they had to go to work.

Self-isolation

• Most people (83%-92%) were willing and able to “self-isolate” if they contracted the virus. However almost half of the respondents reported either ‘impact on mental health’, or difficulty separating from others’ as a barrier to effective self-isolation.

• Most of the Syrian respondents reported one or more barriers to self-isolation, with loss of income being the most reported barrier (74%)

Reporting

• The likelihood of reporting suspected COVID-19 cases was highly correlated with the severity of symptoms, ranging from 58% for mild cases to 94% if the symptoms were severe. Though all age groups were equally likely to report to MoPH if their symptoms were severe, there was more variation across age groups in the case of mild symptoms, with the youngest being the least likely to report.

• Most people reported no barriers to reporting symptoms. However, a fifth of respondents did not know what number to call.
ACCESS TO INFORMATION

There were high levels of trust in communication by those deemed to be experts in healthcare.

• Healthcare workers, international organizations (IOs) and the MoPH were the most trusted sources of information about COVID-19, with at least 89% of respondents reporting they trust these organizations/individuals. However, less than half of the respondents completely trusted the MoPH with information about COVID-19.

• Having complete trust in MoPH was positively correlated with higher compliance in personal hygiene and physical distancing measures.

Around half of the respondents always relied on television channels (50%) or social media (44%) for information about COVID-19.

• Those who always relied on social media and/or television channels were also more likely to report personal susceptibility to the disease, risk of community spread, compliance with personal hygiene measures, and compliance with physical distancing measures.
The sample comprised of 78% Lebanese (n = 1,618), 13% Syrian (n = 262) and 9% (n = 194) Palestinian respondents.

More than half of the Syrian and Palestinian respondents were residing in host communities, while the rest of the participants were living in Syrian ITS located in Akkar, Baalback-Hermel and Bekaa, and in Palestinian refugee camps located predominantly in the South, North and Mount Lebanon.

The gender distribution was roughly equal with 49% males and 51% females. However, Syrian females were significantly underrepresented, comprising 28% of the Syrian respondents.
Most of the respondents were from the 25-44 age group (39%), followed by the 44-64 age group (29%). The elderly (14%) and the youngest age group (19%) comprised a minority of the sample.

Almost half the respondents (47%) were university graduates, and younger participants were more likely to have a university degree than older ones.

Most of the respondents resided in Mount Lebanon (41%), followed by South Lebanon (13%) and North Lebanon (13%), while the remaining governorates, including the capital Beirut, comprised less than 10% each.

<table>
<thead>
<tr>
<th>Governorate</th>
<th>Respondents</th>
<th>Percentage of Respondents</th>
<th>Lebanon (%)</th>
<th>Syrians (%)</th>
<th>Palestinians (%)</th>
<th>University Degree (%)</th>
<th>Monthly Income (%)</th>
<th>People Living with Respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Lebanon</td>
<td>264</td>
<td>12.7%</td>
<td>82%</td>
<td>11%</td>
<td>7%</td>
<td>52%</td>
<td>20%</td>
<td>4.2 ± 2 people living with respondent</td>
</tr>
<tr>
<td>Beirut</td>
<td>150</td>
<td>7.2%</td>
<td>69%</td>
<td>12%</td>
<td>19%</td>
<td>56%</td>
<td>8%</td>
<td>3.5 ± 2 people living with respondent</td>
</tr>
<tr>
<td>Mount Lebanon</td>
<td>841</td>
<td>40.5%</td>
<td>89%</td>
<td>6%</td>
<td>5%</td>
<td>52%</td>
<td>10%</td>
<td>3.3 ± 1.6 people living with respondent</td>
</tr>
<tr>
<td>South Lebanon</td>
<td>841</td>
<td>12.9%</td>
<td>61%</td>
<td>4%</td>
<td>37%</td>
<td>36%</td>
<td>22%</td>
<td>3.8 ± 1.6 people living with respondent</td>
</tr>
<tr>
<td>Akkar</td>
<td>129</td>
<td>6.2%</td>
<td>67%</td>
<td>30%</td>
<td>3%</td>
<td>32%</td>
<td>30%</td>
<td>5.1 ± 2.5 people living with respondent</td>
</tr>
<tr>
<td>Baalbek-Hermel</td>
<td>162</td>
<td>7.8%</td>
<td>59%</td>
<td>41%</td>
<td>3%</td>
<td>43%</td>
<td>23%</td>
<td>4.2 ± 2.2 people living with respondent</td>
</tr>
<tr>
<td>Bekaa</td>
<td>137</td>
<td>7.8%</td>
<td>96%</td>
<td>4%</td>
<td>37%</td>
<td>49%</td>
<td>15%</td>
<td>3.5 ± 1.3 people living with respondent</td>
</tr>
<tr>
<td>Nabatieh</td>
<td>123</td>
<td>5.9%</td>
<td>67%</td>
<td>30%</td>
<td>3%</td>
<td>43%</td>
<td>30%</td>
<td>5.1 ± 2.5 people living with respondent</td>
</tr>
</tbody>
</table>
TRANSMISSION

Most respondents correctly identified the direct and indirect COVID-19 transmission modes irrespective of their socioeconomic background. However, only a minority were knowledgeable about transmission specific to pregnant and lactating women (PLW), with 32% and 33% correctly reporting that the virus does not transmit from a mother to child during pregnancy and through breastfeeding, respectively.

Percentage of respondents who correctly identified the main transmission modes

<table>
<thead>
<tr>
<th>Transmission</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact with a symptomatic person</td>
<td>99%</td>
</tr>
<tr>
<td>Contact with contaminated surfaces</td>
<td>98%</td>
</tr>
<tr>
<td>Contact with an asymptomatic person</td>
<td>96%</td>
</tr>
</tbody>
</table>
In general, none of the governorates had good knowledge about transmission specific to PLW. Bekaa was significantly less knowledgeable than the other governorates, with only 9% and 10% having correct knowledge about transmission during breastfeeding and pregnancy, respectively.

SIGNS AND SYMPTOMS OF COVID-19

There was good awareness about the main COVID-19 symptoms in general, and in particular, fever, cough and shortness of breath. In fact, most respondents (85%) mentioned between three to five symptoms. However, awareness of the less common symptoms like diarrhea, body aches and runny nose was relatively low, which could compromise an individual's ability to report and/or seek treatment.

The probability to report all the common symptoms (fever, cough & shortness of breath) was around 60% in Akkar and North Lebanon, compared to an average of 80% in Nabatieh, Mount Lebanon and South Lebanon, and around 90% in Bekaa.
Syrians were significantly less aware of the common symptoms (65%) compared to Lebanese (78%) and Palestinians (79%).

**RISK GROUPS**

Most respondents were aware that the ‘elderly’ (92%) are at risk of becoming seriously ill if they contract COVID-19, whilst a smaller majority correctly identified ‘individuals with preexisting health conditions’ (76%). Meanwhile, a significant proportion considered ‘pregnant women’ (20%) to be at risk of developing severe symptoms. Some respondents also placed children (13%) and everyone (11%) in the high risk group.

**49% OF RESPONDENTS STRICTLY IDENTIFIED THE CORRECT RISK GROUPS: THE ELDERLY & INDIVIDUALS WITH PRE-EXISTING HEALTH CONDITIONS**

- Only one third of the Palestinians correctly identified the two risk groups compared to 45% and 51% of the Syrians and Lebanese, respectively.

- A third of the Palestinians believed that everyone was at risk of developing severe symptoms, compared to less than 10% amongst the other nationalities.

- Only a third of the respondents from Nabatieh and South Lebanon identified the correct risk groups.
PROTOCOL TO FOLLOW IN CASE OF COVID-19 SYMPTOMS

A majority of respondents (75%) were aware that they should self-isolate if they experience COVID-19 symptoms. However, only 58% knew that they should call MoPH to report these symptoms, and less than half (47%) knew that they should do both, self-isolate and call MoPH.

- Less than half of the residents of Akkar, North Lebanon and Baalbek-Hermel knew that they should call MoPH if they experience COVID-19 symptoms, compared to more than two thirds in Beirut, Bekaa, Nabatieh, and South Lebanon.
- Respondents with a university degree were 7.7ppt more likely to know that they should call MoPH than those with less education. They were also 4.1ppt more likely to know that they should self-isolate.
- Respondents who thought they were highly susceptible to the disease were 9.0ppt more likely to know that they should call MoPH and 9.1ppt more likely to know that they should self-isolate. Interestingly, being asymptomatic was associated with a lower likelihood to self-isolate.
- The likelihood to go to the hospital to get tested was negatively correlated with age. Likewise, it was negatively correlated with perceived severity of the symptoms, and the perceived susceptibility to the disease.
- Half the respondents in Beirut said they should consult with a doctor if they experience COVID-19 symptoms compared to an average of around 30% across the other governorates.

KNOWLEDGE OF THE MAIN PREVENTIVE MEASURES

An overwhelming majority of respondents (97% to 99%) were aware of the main preventive hygiene and physical distancing measures. There were no significant differences across age groups, governorates or nationalities.

Percentage of respondents who knew the main preventive hygiene measures

- Hand wash regularly with soap and water: 99%
- Avoid touching eyes, nose and mouth with unwashed hands: 98%
- Disinfect surfaces in your home: 98%
- Disinfect store bought products: 98%
- Cover the mouth and nose with a tissue or bent elbow: 97%
- Use hand sanitizer: 98%
- Wear a face mask in public: 97%
KEY FINDINGS

Percentage of respondents who knew the main preventive physical distancing measures

- Avoiding crowded places: 98%
- Avoiding people who have a fever or respiratory symptoms: 98%
- Maintaining a distance of 1 meter with others: 98%
- Avoiding social events: 99%

B | ATTITUDES & RISK PERCEPTIONS

INDIVIDUAL SUSCEPTIBILITY AND RISK OF COMMUNITY SPREAD

A slight majority (57%) agreed or completely agreed that they are very likely to contract the disease. Surprisingly, this did not vary much with age, with the exception of respondents in the 18 – 24 age group who were less likely to agree (51%) compared to other age groups. Note that according to MoPH, individuals who are 20 - 29 years old are the most susceptible to COVID-19, making up around 25% of the confirmed cases, followed by those aged 30-39 (16% of the confirmed cases) and 40-49 (14% of the confirmed cases).³

As expected, there was a gap between personal susceptibility and perceived risk of community spread, with the latter being judged as more likely by around 10 percentage points among respondents (67%). The gap was particularly significant for youth, reaching 20 percentage points.

Likelihood of personal susceptibility & risk of community spread

<table>
<thead>
<tr>
<th>PERSONAL SUSCEPTIBILITY</th>
<th>COMMUNITY SPREAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly Agree</td>
<td>18%</td>
</tr>
<tr>
<td>Agree</td>
<td>49%</td>
</tr>
<tr>
<td>Disagree</td>
<td>16%</td>
</tr>
<tr>
<td>Highly Disagree</td>
<td>6%</td>
</tr>
</tbody>
</table>

Women were 5.8ppt less likely to report susceptibility to the disease compared to men.
Palestinians were more likely to perceive themselves as susceptible to the disease (70%) compared to Lebanese (56%) and Syrians (50%). In addition, a higher proportion of Palestinian respondents (78%) believed the virus was likely to spread in their community compared to Lebanese (67%) or Syrians (60%).

Interestingly, 9 out of 10 Palestinians living in communities believed there was a high risk of community spread compared to 6 out of 10 living in refugee camps.

In Bekaa, Nabatieh and South Lebanon around 70% or more of respondents in each region believed they were highly susceptible to the disease, compared to 49% in Mount Lebanon, 52% in Akkar, and 54% in Baalbek-Hermel.

70% or more agreed that the virus is very likely to spread within their communities, with the exception of Baalbek-Hermel (50%) and Mount Lebanon (60%).

Mount Lebanon, which has the highest number of confirmed COVID-19 cases in Lebanon, reported the lowest ratings for personal susceptibility, and the second lowest for risk of community spread.
PERCEIVED SEVERITY OF DISEASE

According to MoPH data only 5% of the confirmed COVID-19 cases are severe or critical. However, over a third of respondents believed that if they were to get the virus, their symptoms would be severe or life-threatening, and this percentage increased significantly with age. Meanwhile less than a tenth expected to show no symptoms, which is considerably lower than the actual 40% of asymptomatic cases reported by MoPH.

Perceived severity of the disease

- Life-threatening: 15%
- Severe: 19%
- Moderate: 35%
- Mild: 20%
- No symptoms: 6%

Perceived severity of the disease and age

Perceived levels of severity were positively correlated with age, such that 68% of the 65+ age group believed their symptoms would be severe or life-threatening if they contracted the disease, compared to 16% of those aged 18-24.

Percentage of respondents by age group who thought the disease would be life threatening and severe.

- 18-24: 16%
- 25-44: 26%
- 45-64: 39%
- 65+: 68%

Respondents who thought they were highly susceptible to the virus were 14.3ppt more likely to believe their symptoms would be severe or life-threatening if they were to catch the virus.

Respondents with university degrees were 10ppt less likely to think their symptoms would be severe or life-threatening compared to those with lower levels of education.

Palestinians were 8.6ppt less likely than Lebanese to believe their symptoms would be severe or life-threatening.
C | PRACTICE: PREVENTIVE MEASURES

C.1. GENERAL PREVENTIVE MEASURES

KNOWLEDGE AND PRACTICE OF GENERAL PREVENTIVE MEASURES

An overwhelming majority of respondents (97% to 99%) were aware of the main preventive hygiene and physical distancing measures. Despite that, the adoption of some measures was lower than others, with up to a fifth of respondents reporting noncompliance with three out of the five physical distancing measures: avoiding social events (81%), maintaining a distance of 1 meter from others (83%) and hand shaking (84%).

Respondents were less compliant with physical distancing measures than with personal hygiene measures.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Knowledge</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover mouth and nose with a tissue or bent elbow</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>Hand washing regularly with soap and water</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td>Avoid touching eyes, nose and mouth with unwashed hands</td>
<td>98%</td>
<td>94%</td>
</tr>
<tr>
<td>Wear a face mask in public</td>
<td>97%</td>
<td>92%</td>
</tr>
<tr>
<td>Use hand sanitizer</td>
<td>98%</td>
<td>94%</td>
</tr>
<tr>
<td>Disinfect surfaces in your home</td>
<td>98%</td>
<td>92%</td>
</tr>
<tr>
<td>Disinfect store bought products</td>
<td>98%</td>
<td>91%</td>
</tr>
<tr>
<td>Avoid people who have a fever or respiratory symptom</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td>Avoid crowded places</td>
<td>99%</td>
<td>96%</td>
</tr>
<tr>
<td>Avoid social events</td>
<td>81%</td>
<td>98%</td>
</tr>
<tr>
<td>Maintain a distance of at least 1 meter between you and others</td>
<td>83%</td>
<td>98%</td>
</tr>
</tbody>
</table>
To contain the outbreak and prevent further spread of the virus, individuals and communities must be willing to adopt and comply with all the recommended personal hygiene and physical distancing measures. The figures below show the reported compliance with these measures across governorates.

Accordingly, the probability of a respondent from Akkar and North Lebanon to fully comply with all personal hygiene measures was 41% and 47%, respectively. This was significantly lower from the other governorates, which reported at least 80% compliance with the recommended measures.

Likewise, the probability of full compliance with all physical distancing measures was significantly lower for Akkar, North Lebanon and Baalbek-Hermel than the other governorates.

Full compliance with personal hygiene and physical distancing measures were highly correlated with 48% of the respondents who complied with one set of measures also complying with the other.

 Respondents who believed they were susceptible to the virus were also 4.0ppt more likely to comply with the recommended physical distancing measures, and 8.5ppt more likely to comply with personal hygiene measures.
Compliance with the recommended preventive measures also varied across age groups. In general, respondents in the 25 – 44 and the 45 – 64 age groups were more compliant than those younger than 25 and older than 65.

The 18–24 age group was less likely to comply with personal hygiene measures compared to the other age groups.

The 25–44, 45–64 and 65+ age groups were 6.5ppt, 9.6ppt and 20ppt more likely to comply with hygiene measures if they perceived themselves more susceptible to the disease.

Meanwhile, compliance in the 18–24 age group was the same irrespective of the levels of susceptibility to the disease.

The 25 – 44 and 45 – 64 age groups were more likely to comply with physical distancing compared to those younger than 25, and those aged 65+.

Interestingly, those who are 65+ and perceived themselves as more susceptible to the disease were 10ppt more likely to comply with the physical distancing measures than to those who did not perceive themselves susceptible.

None of the other age groups revealed a significant change.

C.2. HANDWASHING

KNOWLEDGE AND PRACTICE OF HANDWASHING

86% KNEW THAT HANDS MUST BE WASHED FOR AT LEAST 20 SECONDS.

There appears to be good knowledge about handwashing as a majority of respondents were aware of the appropriate handwashing duration, and at least half of the respondents reported four moments that warrant handwashing, whilst over a third reported seven moments. The frequency of various moments that warrant handwashing is an indicator of the moments which are salient on people’s minds. As such, it was surprising to note that despite consistent official communication, less than half reported washing their hands after blowing their nose, sneezing or coughing.
Reported key handwashing moments

<table>
<thead>
<tr>
<th>Moment</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before eating</td>
<td>74%</td>
</tr>
<tr>
<td>After using the toilet</td>
<td>65%</td>
</tr>
<tr>
<td>After returning home</td>
<td>65%</td>
</tr>
<tr>
<td>Before &amp; after food preparation</td>
<td>56%</td>
</tr>
<tr>
<td>After handling garbage</td>
<td>42%</td>
</tr>
<tr>
<td>After coughing or sneezing</td>
<td>39%</td>
</tr>
<tr>
<td>When visibly dirty</td>
<td>36%</td>
</tr>
<tr>
<td>After touching animals</td>
<td>18%</td>
</tr>
<tr>
<td>Before &amp; after caring for the sick</td>
<td>14%</td>
</tr>
<tr>
<td>Before &amp; after holding a baby</td>
<td>13%</td>
</tr>
<tr>
<td>Before &amp; after changing diapers</td>
<td>10%</td>
</tr>
</tbody>
</table>

BARRIERS TO HANDWASHING

Most respondents did not report barriers that would limit their ability to wash their hands regularly, and those who did cited structural rather than behavioral barriers.

Percentage of respondents who reported barriers to handwashing

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of access to clean water</td>
<td>30%</td>
</tr>
<tr>
<td>Lack of access to hygiene products</td>
<td>28%</td>
</tr>
<tr>
<td>Forgetfulness</td>
<td>18%</td>
</tr>
<tr>
<td>Inconvenience</td>
<td>7%</td>
</tr>
</tbody>
</table>

Up to 45% of Syrian respondents reported having difficulties accessing clean water and soap on a regular basis compared to a third of the Lebanese and Palestinian respondents.

Palestinians reported 5.7 moments on average compared to 4.2 and 3.5 moments by Lebanese and Syrians, respectively.

Akkar and North Lebanon reported 3.8 moments each compared to 4.5 and 5 moments in Nabatieh and South Lebanon, respectively. All other governorates reported an average of 4.2 to 4.4 moments.
C.3. STAYING HOME DURING THE GENERAL STATE OF MOBILISATION

COMPLIANCE WITH THE STAY-AT-HOME REQUIREMENTS

During the initial phases of the general state of mobilization, residents were required to stay at home unless necessary. A third of respondents complied, and about a third who reported leaving the house, did so to carry out activities considered necessary (going to work; going to the pharmacy; and going to the doctor).

Reasons for compliance

The overwhelming majority of people (84%) were motivated to comply with the general mobilization requirements because they were worried about getting infected with the virus. About a third of respondents were also motivated by a sense of civic responsibility and in particular, a desire to observe the law, and to set a good example for others.

- Fear of infection: 84%
- Set an example/Be a good citizen: 33%
- Public places are closed: 30%
- Not wanting to break the law: 21%
- Most people are complying: 12%
- I’m not complying: 3%

Reasons for leaving the house during the stay-at-home order

- Pharmacy visits: 35%
- Work: 34%
- Doctor visits: 28%
- Bank / ATM trips: 16%
- Meeting friends / family: 13%
- Physical exercise: 9%
- None (stayed at home): 31%
75% KNEW THAT THEY SHOULD SELF-ISOLATE IF THEY EXPERIENCED COVID-19 SYMPTOMS.

Even though a majority of respondents were aware that they should “self-isolate” if they were experiencing COVID-19 symptoms, there seems to be a lack of clarity on what effective self-isolation entails. Whilst most respondents (95%) correctly identified that self-isolation requires the infected person to separate themselves from others, around 80% also believed that an infected person can leave the house if necessary, while making sure they have protective gear and/or maintain a safe distance from others.

Palestinian respondents were 10ppt and 20ppt more likely to affirm incorrect statements about self-isolation than Lebanese and Syrian respondents, respectively.

Correct Knowledge About Effective Self-Isolation

- Stay in an enclosed and well-ventilated room: 95%
- Limit contact to a single healthy person in the house: 79%

Misconceptions about Self-Isolation

- Wear gloves & face mask when leaving the house: 80%
- Maintain a safe distance from others when outside the house: 79%

ONLY 9% STRICTLY IDENTIFIED THE CORRECT SELF-ISOLATION MEASURES
83% REPORTED ABILITY TO SELF-ISOLATE IF THEY HAD COVID-19.

Most respondents reported a willingness and ability to self-isolate if they contracted COVID-19, and this was largely consistent across age groups, nationalities and governorates.

Note: For consistency and comparability, all respondents were provided with the correct definition of self-isolation following the knowledge section.

92% WERE ALSO WILLING TO SELF-ISOLATE IF NECESSARY

Percentage of respondents who reported a willingness to self-isolate

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very willing</td>
<td>84%</td>
</tr>
<tr>
<td>Willing</td>
<td>33%</td>
</tr>
<tr>
<td>Unwilling</td>
<td>30%</td>
</tr>
<tr>
<td>Very unwilling</td>
<td>21%</td>
</tr>
</tbody>
</table>

BARRIERS TO EFFECTIVE SELF-ISOLATION

Despite the reported ability and willingness of most respondents to self-isolate if necessary, half the respondents reported at least one barrier to self-isolation

74%, 69% and 63% of Syrian respondents cited loss of income, difficulty of getting supplies and the need to take care of dependents as a barrier to self-isolation, respectively.

58% of respondents aged 65+ years cited the impact on their mental health as a barrier, while more than half of the respondents in the 25-44 age group reported experiencing loss of income and difficulty with separating themselves from others. Those in the 18-24 age group were the least likely to report barriers to self-isolation.
Respondents who have a university degree were 12ppt more likely to be aware that they should report COVID-19 cases to MoPH than those with less education.

Less than 10% of Palestinians cited the municipality as a source to report suspected cases to, and relatively low proportions cited MoPH (62%) and LRC (48%). However, a significant proportion (29%) cited UNRWA.

Mount Lebanon, Bekaa and Nabatieh had particularly high proportions citing the municipality, ranging from 35% to 47%.

D.2. REPORTING SUSPECTED COVID-19 CASES

KNOWLEDGE OF REPORTING PROTOCOL

Most respondents (71%) were aware that they should call the MoPH, to report suspected cases of COVID-19, whilst 73% cited the Lebanese Red Cross (LRC) and 31% cited the municipality.

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRC</td>
<td>73%</td>
</tr>
<tr>
<td>MoPH</td>
<td>71%</td>
</tr>
<tr>
<td>Municipality</td>
<td>31%</td>
</tr>
<tr>
<td>ISF</td>
<td></td>
</tr>
<tr>
<td>UNHCR</td>
<td></td>
</tr>
<tr>
<td>UNRWA</td>
<td></td>
</tr>
</tbody>
</table>

Most of the respondents (78%) who were not aware that they should report COVID-19 cases to MoPH referred to LRC instead.

Percentage of respondents who were aware that they should call MoPH to report suspected COVID-19 cases across governorates

<table>
<thead>
<tr>
<th>Governorate</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nabatieh</td>
<td>84%</td>
</tr>
<tr>
<td>Beirut</td>
<td>81%</td>
</tr>
<tr>
<td>Bekaa</td>
<td>79%</td>
</tr>
<tr>
<td>South</td>
<td>72%</td>
</tr>
<tr>
<td>Akkar</td>
<td>71%</td>
</tr>
<tr>
<td>Mount Lebanon</td>
<td>69%</td>
</tr>
<tr>
<td>Baalbeck</td>
<td>64%</td>
</tr>
<tr>
<td>North</td>
<td>63%</td>
</tr>
</tbody>
</table>
REPORTING SUSPECTED CASES OF COVID-19 TO MOPH

Likelihood to report suspected cases of COVID-19 to MoPH by severity of symptoms

The likelihood to report suspected COVID-19 cases was highly correlated with the severity of symptoms, ranging from 58% for mild cases to 94% if the symptoms were severe.

Probability to report suspected COVID-19 cases to MoPh across nationalities

Respondents who were aware that they should report suspected COVID-19 cases to MOPH were also 16ppt to 24ppt more likely to report.

Palestinians were consistently less likely to report to MoPH than the Lebanese or Syrians, irrespective of the severity of symptoms; while Syrians were more likely to report than Lebanese.

51% OF THE 18 – 24 AGE GROUP WOULD NOT REPORT TO MOPH IF THEIR SYMPTOMS WERE MILD.

The likelihood to report increased significantly with age when symptoms were mild. In fact, less than half of the respondents in the 18 – 24 age group were willing to report to MoPH compared to 57%, 61% and 70% of the 25 – 44, 45 – 64 and 65+ age groups, respectively.

They were, however, as likely to report if the symptoms were
moderate (74%) relative to the 25 – 44 (76%) and 45 – 64 (77%) age groups, but less likely to do so compared to the 65+ age group (83%).

All age groups were equally likely to report to MoPH if their symptoms were severe.

**Likelihood to report mild symptoms to MoPH by age groups**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Very Likely</th>
<th>Likely</th>
<th>Unlikely</th>
<th>Very Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>21%</td>
<td>17%</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td>25-44</td>
<td>27%</td>
<td>40%</td>
<td>32%</td>
<td>10%</td>
</tr>
<tr>
<td>45-64</td>
<td>37%</td>
<td>41%</td>
<td>30%</td>
<td>8%</td>
</tr>
<tr>
<td>65+</td>
<td>49%</td>
<td>41%</td>
<td>23%</td>
<td>6%</td>
</tr>
</tbody>
</table>

**BARRIERS THAT COULD LIMIT THE ABILITY TO REPORT**

Most people reported no barriers to reporting symptoms. Those who did, either did not know what number to call (19%), do not have sufficient funds to make phone calls (13%) or were afraid of being quarantined in the hospital (13%).

- **Respondents from Baalbek-Hermel** were three times more likely to report ‘lack of social support’ as a barrier relative to the average. They were also the most likely to report lack of awareness about the number to call (29%) and not having sufficient funds to make phone calls (21%).

- A third of Syrian respondents, and twice as many Palestinians (18%) as Lebanese (8%) cited ‘lack of sufficient funds’ as a barrier to reporting.

- Meanwhile twice as many Palestinians (22%) as Syrians (12%) or Lebanese (12%) reported ‘fear of quarantine’ as a barrier to reporting. Likewise, twice as many Palestinians (12%) reported ‘lack of social support’ compared to Syrians (6%) and Lebanese (5%).

- More than a quarter of Syrians (26%) did not know what number to call to report suspected COVID-19 cases compared to 21% of Palestinians and 18% of Lebanese.
E | ACCESS TO INFORMATION

TRUSTED SOURCES OF COVID-19 INFORMATION

Consistent with behavioral science literature on levels of trust in various sources, there were high levels of trust in those deemed to be experts in healthcare. Healthcare workers, international organizations (IOs) and the MoPH were the most trusted sources of information about COVID-19, with at least 89% of respondents reporting ‘trust’ or ‘completely trust’ with these organizations/individuals.

Percentage of respondents who reported ‘complete trust’ or ‘trust’ in various sources of information:

<table>
<thead>
<tr>
<th>Source</th>
<th>Complete Trust</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Organizations</td>
<td>65%</td>
<td>27%</td>
</tr>
<tr>
<td>Healthcare workers</td>
<td>44%</td>
<td>48%</td>
</tr>
<tr>
<td>Ministry of Public Health (MoPH)</td>
<td>48%</td>
<td>41%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>17%</td>
<td>45%</td>
</tr>
<tr>
<td>Family members or friends</td>
<td>11%</td>
<td>33%</td>
</tr>
<tr>
<td>Community Leaders</td>
<td>21%</td>
<td>24%</td>
</tr>
<tr>
<td>Religious leaders</td>
<td>16%</td>
<td>20%</td>
</tr>
</tbody>
</table>

REPORTED TRUST IN IOS

IOs were the most trusted source of information about COVID-19, with 65% and 27% of the respondents reporting ‘complete trust’ and ‘trust’ in these organizations, respectively.

Bekaa, where a significant number of IOs are present, reported the highest levels of trust across the eight governorates with 82% of respondents reporting ‘complete trust’ in IOs (98% overall). Beirut (58%), North Lebanon (52%) and South Lebanon (58%) reported the lowest levels of ‘complete trust’ in IOs, however, the overall trust levels remained high at 89%, 86% and 91%, respectively.

Interestingly, only 29% of the Palestinian respondents reported ‘complete trust’ in IOs compared to 68% of Lebanese and 76% of Syrians. Despite that, 83% of the Palestinians reported trust in IOs overall.
REPORTED TRUST IN MOPH

While the reported overall trust in the MoPH was remarkably high (89%), less than half of respondents completely trusted the MoPH with information about COVID-19. In fact, there were significant discrepancies across governorates, with 87%, 71% and 71% of respondents from Beqaa, Nabatieh and Baalbek-Hermel reporting ‘complete trust’ in MoPH, compared to 34%, 36% and 38% in Beirut, Mount Lebanon and North Lebanon.

Syrians were the most likely to have complete trust in the MoPH (67%) followed by the Lebanese (48%) and the Palestinians (23%). Despite that, all three nationalities reported high levels of overall trust ranging between 88% and 93%.

The 18 – 24 age group was 8.1ppt, 10.2ppt and 11.9ppt less likely to have complete trust in MoPH compared to the 25 – 44, 45 – 64 and 65+ age groups, respectively.
Respondents who reported ‘complete trust’ in the MoPH and in IOs were 6.7ppt and 8.6ppt more likely to comply with every personal hygiene measure, respectively. Likewise they were 5.1ppt and 9.4ppt more likely to comply with physical distancing measures, respectively. Having complete trust in other information sources was not associated with compliance to personal hygiene measures or physical distancing measures, with the exception of trust in healthcare workers, which was positively associated with the adoption of hygiene measures.

More than half of Lebanese respondents distrust religious leaders compared to a third of Syrians and a fifth of Palestinians.
RELIANCE ON VARIOUS SOURCES OF INFORMATION

An overwhelming majority (89%) of respondents relied on television for information about COVID-19, whilst a significant majority relied on social media (78%). A significant proportion also relied on SMS messages (38%) and word of mouth (40%).

Percentage who reported that they ‘always’ or ‘sometimes’ rely on the following sources of information

<table>
<thead>
<tr>
<th>Source of Information</th>
<th>Always</th>
<th>Sometimes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Television channels</td>
<td>51%</td>
<td>38%</td>
<td>89%</td>
</tr>
<tr>
<td>Social media</td>
<td>44%</td>
<td>34%</td>
<td>78%</td>
</tr>
<tr>
<td>In person / Word of mouth</td>
<td>9%</td>
<td>32%</td>
<td>40%</td>
</tr>
<tr>
<td>SMS messages</td>
<td>17%</td>
<td>21%</td>
<td>38%</td>
</tr>
<tr>
<td>Daily or weekly newspapers</td>
<td>8%</td>
<td>23%</td>
<td>31%</td>
</tr>
<tr>
<td>Radio / Radio shows</td>
<td>24%</td>
<td>28%</td>
<td>52%</td>
</tr>
</tbody>
</table>

As expected, the 65+ age group was less reliant on social media (64%) than all other age groups (79%- 82%). Reliance on television increased with age such that the youngest age group was the least reliant on television (82%), the 25-64 age group was more reliant (86%- 93%) and the elderly were the most reliant (95%). In fact, 66% of the elderly always relied on television channels for information compared to 35% of respondents in the 18 – 24 age group.

Palestinians were about 10% more reliant on social media than Syrians (76%) and Lebanese (78%), whilst Syrians were up to 9% more likely to rely on television than Palestinians (91%) and Lebanese (89%).

Respondents who always relied on social media, television channels and SMS messages for information were 8.2ppt, 3.8ppt and 10.4ppt more likely to fully comply with personal hygiene measures, respectively. Likewise, they were 7.4ppt, 4.8ppt and 6ppt more likely to fully comply with physical distancing measures.
COVID-19 IN LEBANON

Misunderstanding information
Social pressure
Information overload
Overconfidence

Procrastination
Poor self-control
Forgetfulness
Inconvenience

KNOWLEDGE
ATTITUDES
PRACTICES
The traditional approach to social and behavioral change communications strategies presume that awareness raising, through the provision of information about the risks and consequences of a given disease, will lead to the formation of positive attitudes towards preventive and containment measures, and consequently to the adoption of these measures.

Humans, however, are much more complex. Even when information is available, individuals may fail to process it properly, not take it seriously, become overwhelmed by it, or succumb to the social pressures of family and friends who are spreading misinformation (e.g. COVID-19 is a western conspiracy). Accordingly, the type of information and the way it is communicated and presented affects the extent to which it becomes individual knowledge and influences attitudes. However, even when individuals have the right knowledge and attitude, the decision to comply with the desired practices and behaviors are often mediated by psychological biases and barriers (e.g. poor self-control), as well as structural ones (e.g. lack of access to water or hygiene products).
This section builds on the main findings from the current KAP study, as well as insights from behavioral science literature, to propose communications tools that UNICEF could use to:

1. **Address knowledge gaps and rectify misconceptions about the novel coronavirus, with a focus on transmission specific to PLW, COVID-19 signs and symptoms, risk groups, proper self-isolation and reporting practices.**

2. **Adjust risk perceptions to maintain vigilance even when the levels of public concern start to diminish as the novelty of and uncertainty around the virus wears off.**

3. **Reduce mental and psychological barriers that could prevent individuals from adopting the recommended preventive and containments measures.**

**A | ADDRESS KNOWLEDGE GAPS & RECTIFY MISCONCEPTIONS ABOUT COVID-19**

It is clear from the findings of the KAP study that the campaigns delivered by the MoPH, WHO, UNICEF and other stakeholders have been successful at raising public awareness about COVID-19, as illustrated by the good levels of knowledge about the main modes of transmission, main preventive measures, availability of treatment, and the common symptoms.

However, it appears that not all this information was consumed equally, as there were gaps in information about the less common symptoms and reporting protocols, as well as misinformation about risk groups, transmission specific to PLW, and self-isolation.

**TRANSMISSION SPECIFIC TO PLW**

Even though there was very good knowledge about the general transmission modes, there were severe misconceptions about transmission unique to pregnant and lactating women. In particular, 51% and 39% thought that COVID-19 could be transmitted through breastfeeding and during pregnancy, and many were not sure. Less than a third of respondents were properly informed about the lack of viral transmission during pregnancy and breastfeeding. Such gaps in knowledge could negatively affect the decision of families to have children, or breastfeeding during this time.
SYMPTOMS OF COVID-19 AND REPORTING

Whilst many respondents were knowledgeable about the three most common symptoms (fever, cough, shortness of breath), less than half were aware of the less common symptoms like *diarrhea*, *runny nose* and *body aches*.

Additionally, the findings revealed that a significant minority (42%) did not know that they should call MoPH if they experienced COVID-19 symptoms, around 30% were not aware that they should call MoPH to report COVID-19 cases, and 20% did not know what number to call.

RISK GROUPS

Though an overwhelming majority of respondents knew that the elderly are prone to becoming seriously ill if they contract COVID-19, a lower majority placed individuals with pre-existing health conditions in the high risk group. This could limit the psychological capability of this group to take adequate precaution and further, for those outside of this category to act accordingly to protect these high risk groups.

With respect to misconceptions, at least 20% and 13% of respondents placed pregnant women and children in the high risk category, respectively, which may cause undue and counterproductive panic amongst households with such groups.

WHICH GROUPS WERE THE LEAST KNOWLEDGEABLE?

*Palestinians* were the least aware about the correct risk groups, especially individuals with preexisting health conditions. They also revealed higher levels of misconceptions, with one third placing everyone in the high risk group.

The *25 to 44 age group* were the least aware that individuals with health conditions are in the high risk group, but the *youngest – aged 18 to 24* – had the highest levels of misconceptions, with a third placing pregnant women in the high risk group.

*Bekaa* and *Nabatieh* were the least likely to place individuals with preexisting conditions in the high risk group, however, *most governorates* revealed significant misconceptions.

**COMMUNICATION OBJECTIVES**

- Increase awareness of less common symptoms
- Increase awareness of protocol to follow in the event of symptoms (who to call, what number to call, when to call)

**COMMUNICATION OBJECTIVES**

- Increase awareness of high risk categories other than the elderly
- Increase awareness about relative risk levels of pregnant women and children
SELF-ISOLATION

Most respondents were aware that they should self-isolate if they experience COVID-19 symptoms, and the vast majority claimed that they were willing and able to do so. However, there was a clear misunderstanding about what exactly self-isolation entails. Almost 80% thought self-isolation involved leaving the house when necessary, whilst wearing gloves, a mask and keeping a safe distance. Misinformation about what self-isolation entails indicates a limited capability to effectively self-isolate if necessary.

WHICH GROUPS WERE THE LEAST KNOWLEDGEABLE?

Syrians were slightly better informed than Palestinians or Lebanese, but in general all groups, irrespective of age, governorate or nationality, revealed significant misconceptions about self-isolation.

COMMUNICATION OBJECTIVES

• Increased awareness about what self-isolation is
• Increased awareness about how and when to self-isolate
• Promote understanding of efficacy of self-isolation in reducing the spread of COVID-19

QUARANTINE
BEHAVIORAL INSIGHTS & TOOLS TO RAISE AWARENESS

All the communication objectives in this section are geared towards increasing knowledge and awareness about risks of PLW; breastfeeding; risk groups; less common symptoms; reporting protocol; self-isolation; self-isolation protocol. Though there is good general awareness of these topics, it appears that where there are gaps in awareness, tend to be the more technical and more specific areas of the topics. Behavioral tools can enhance address these gaps in awareness by (1) Making the information easier to understand, recall and apply (3) Addressing misinformation and making information more credible (3) Easing access to/visibility of information.

RAISE AWARENESS BY:  
Making information easier to understand, recall and apply.

BEHAVIORAL INSIGHTS

Throughout the pandemic, individuals have been exposed to a lot of information, some of which may be confusing, contradictory and even wrong. Moreover, in a time where resources and attention is stretched thinly, cognitive functions may be impaired and individuals may be less able to process and recall information. As such, it is imperative to utilize behavioral tools to simplify complex information, prioritize and emphasize the most important information, attract attention to the relevant information, and contextualize information so that people can easily understand and use it.

EXAMPLES OF BEHAVIORAL TOOLS

Risk Groups: Only half of the respondents correctly identified the two risk groups: elderly and individuals with preexisting medical conditions.

• Use visual profiles/characters that audiences can relate to in order to illustrate those who fall under each risk group.

Symptoms & Reporting: Less than half were familiar with the uncommon symptoms, and a significant proportion was not aware that they should report to MoPH if they experience COVID-19 symptoms.

• Utilize catchy phrases or mnemonics or other strategies to help people retain information about symptoms. For example, associate symptoms with body parts accompanied by consistent visual images or audio to help individuals remember both the common and less common symptoms.
• Breakdown reporting protocol into simplified steps with bold visuals outlining who to call, when to call and what to dial.
SELF-ISOLATION: Most had misunderstandings about what effective self-isolation entails, amalgamating it with physical distancing.

- Provide a simple checklist of things to avoid whilst in self-isolation
- Provide a simple checklist to distinguish between physical distancing and self-isolation
- Tailor self-isolation advice and visuals to various living environments (e.g. If multiple people sleep on the floor in one room, show visuals that convey self-isolation in that setting)
- Produce a typical ‘day in isolation’ schedule, with real life or intuitive examples of how individuals should go about their daily activities whilst in isolation (e.g. how to use bathrooms, how to dispose of utensils, and how to interact with others in the household)
- In any communication about self-isolation, say exactly what it is early, ideally in the first sentence or subject line

BEHAVIORAL INSIGHTS

With the COVID-19 pandemic came an infodemic, which has seen a surge in rumors and misinformation around COVID-19. This study in particular finds areas of misinformation related to transmission specific to PLW, self-isolation protocol, and risk groups of COVID-19. In a time of such uncertainty and significance, where people lack information, they depend on rumors to fill in gaps in their information and calm anxiety. As such, communication needs to actively preempt and/or address any misinformation, by emphasizing facts over myths or building the ability of individuals to discern information appropriately. Additionally, individuals are heavily influenced byfrom whom they receive information, and this can be leveraged to convey correct information about COVID-19.

EXAMPLES OF BEHAVIORAL TOOLS

Pregnancy & Breastfeeding: Most were not aware that the virus does not transmit during pregnancy or breastfeeding, and a significant proportion believed that pregnant women are at risk of developing severe symptoms if they contract COVID-19.

- Prompt individuals in communication materials to always question information about transmission and risk profiles, using rules of thumb that are easy to follow. For example, “Always check the source of claim” or “Only rely on subject-matter experts”.
- Utilize current best available data on pregnancy-related transmission, and acknowledge uncertainties.

RAISE AWARENESS BY:

Addressing misinformation and making information more credible

• Counter myths by leading with facts, and showing data that confirms the low risk of viral transmission to babies during pregnancy or breastfeeding. In such communications, do not emphasize or repeat myths/misconceptions, so as to avoid perpetuating them.
• Utilize testimonials from pregnant or breastfeeding women who have contracted COVID-19 to assuage fears around this topic.
• Leverage proximity of and affinity towards people like doctors, nurses, and midwives to convey correct information about pregnant women and COVID-19.

BEHAVIORAL INSIGHTS AND TOOLS

The ease with which individuals can access necessary information will contribute to their greater awareness and application if it. The more hassle involved in accessing information, the less likely individuals are to seek it. Communication to raise awareness should be easily accessible and easy to see in any environment, as well as present in diverse environments to be able to reach various target groups.

EXAMPLES OF BEHAVIORAL TOOLS

Reporting: A significant minority were not aware that they should report suspected cases of COVID-19 to MoPH, and only one fifth knew what number to call in order to do so.

• Prompt individuals to store MoPH COVID-19 hotline/COVID-19 chatbot number, or add it to their speed dial immediately. For instance, MoPH could circulate a nationwide SMS or WhatsApp message with a Virtual Contact File or vCard of the COVID-19 hotline number and/or COVID-19 chatbot number.
• Store the MoPH hotline and WhatsApp chatbot number on SIM cards by default. This can be implemented in collaboration with the Ministry of Telecommunication and the two telecom operators who can install the numbers on existing SIM cards and/or new SIM cards.
B | ADJUST INDIVIDUAL RISK PERCEPTIONS

Perceived risk is one of the leading drivers of health behaviors, especially in times of a pandemic. This is clearly evidenced by the results of the KAP study, whereby reported compliance with hygiene and physical distancing measures was positively correlated with perceived personal susceptibility to COVID-19.

Individuals, however, have biased risk perceptions. For instance, many often judge the likelihood of an event by the ease with which it comes to mind – a psychological process known as the “availability heuristic”. For example, evidence from a multi-wave analysis of communications on Zika virus cases revealed that risk perceptions and compliance with preventive measures were highly correlated with the volume of traditional and social media coverage. This is consistent with findings from the current KAP study, whereby personal susceptibility to the disease, risk of community spread, compliance with personal hygiene measures, and physical distancing measures were all positively correlated with reliance on social media and television channels for information about COVID-19.

Some individuals overestimate the probability of unlikely events. For instance, one third of the respondents believed their symptoms would be severe or life-threatening if they were to contract COVID-19, when in reality less than 5% of the confirmed cases in Lebanon are severe or critical, and only 1% of the confirmed cases globally are categorised as such.

Some individuals have optimism bias. According to the KAP study findings, almost a third of the respondents did not think they were susceptible to the disease, and one fifth did not believe it could spread within their communities. Moreover, there was a significant gap between personal susceptibility and perceived risk of community spread, especially amongst the youth.

Finally, risks are judged to be greater when they have more emotional impact – the “affect heuristic”. Fear increases risk perceptions, while anger tends to reduce it. As the economic situation in Lebanon deteriorates further, fear from contracting the virus will be replaced by anger towards the government. Such emotional reactions will most likely lead to lower risk perceptions towards the virus, and as a result, lower compliance with government efforts to contain the virus.

WHICH GROUPS WERE THE MOST BIASED?

- Mount Lebanon, which is the largest governorate, and the one with the highest number of confirmed COVID-19 cases, was the least likely to perceive personal susceptibility (48%), and second lowest, after Baalbek-Hermel, to judge risk of community spread as high (61%).
- Syrians and Lebanese were less likely to judge themselves and their communities as susceptible to the disease, compared to Palestinians.
- Between 40% to 49% of all age groups did not believe they were very likely to contract the disease.
- All respondents significantly underestimated the likelihood of being asymptomatic if they contracted the disease.

“COMMUNICATION OBJECTIVES”

- Update perceptions about likelihood of asymptomatic cases
- Update perceptions of individual susceptibility
- Update perceptions about the severity of the disease
- Steer attitudes towards compliance
As the state of general mobilization is gradually eased, and individuals become more adaptive to the virus, their perceptions of susceptibility and severity of COVID-19 will decrease. Furthermore, as the general sentiment in Lebanon turns from fear of COVID-19 towards anger at the government, individuals will run the risk of underestimating their likelihood of contracting the disease and as such, may be less receptive to public health advice.

Communicating about the risks of a pandemic in times of economic uncertainty is one of the most, if not the most, challenging task for public health officials. Downplaying the risks may lead to a careless public response towards the disease, and undermine efforts to change behavior, while amplifying these risks could cause undue panic and fear, as well as increase economic and social costs. Regardless, it is important for public health officials to communicate risks about COVID-19 honestly, as failing to do so may damage a much needed public trust in government officials.

Behavioral insights and accompanying tools could help to adjust individual risk perceptions by using real risk information to counter some of the most common heuristics and biases (e.g. availability heuristic, optimism bias, affect heuristic, …) perpetuating these unrealistic risk perceptions. These tools could also be employed to expand individual notions of risk and help them consider the risk to others. For instance, a study with American and British participants revealed a higher willingness to stay at home when they were informed that going to work risked infecting an elderly co-worker who would suffer a serious illness.

Emphasizing reality of COVID-19 risk

The availability heuristic may lead individuals to judge their likelihood of contracting the disease by how easily it springs to mind, while optimism bias may cause individuals to believe that they are less likely to catch COVID-19 than everyone else. Behavioral tools can be employed to organize and present data to change attitudes around risk.

Examples of behavioral tools

- Create a color-coded risk dashboard (green for mild, yellow for moderate, red for severe/critical) available on information websites about the rate of spread in different areas.
- Use numbers and ranges to communicate risks. To confront uncertainty and imbue trust, emphasize that the middle of the range is most likely.
- Emphasize the fact that the virus does not discriminate, and that everyone is at risk, and support this with the use of influencers with whom the target population can identify.
Researchers tested communication strategies to promote social distancing via an online experiment (N = 500) commissioned by Ireland’s Department of Health. A control group saw a current informational poster about social distancing and treatment groups saw similar posters with messages that highlighted:
1- the risk of transmission to identifiable persons vulnerable to COVID-19;
2- the exponential nature of transmission.

After viewing the posters, participants were asked about their stated intent to undertake marginal behaviors (behaviors that people were not sure whether were advisable, such meeting others outdoors, or visiting parents). Results showed that the thought of infecting vulnerable people or large numbers of people can motivate social distancing. Both treatments increased participants’ caution about marginal behaviors by up to 10%.


**ADJUST RISK PERCEPTIONS**

**BY:** Emphasizing gains to self and to others

**BEHAVIORAL INSIGHTS AND TOOLS**

Behavioral science research shows that people are motivated to comply with a behavior when they believe it is having a desired effect. Communication can be designed to show individuals and communities that practices of self-isolation, reporting and physical distancing have been effective in reducing the spread of the disease. Additionally, certainty about risk to others has shown to be an effective driver of pro-social behavior, as opposed to uncertainty about how actions might impact others. Communications can effectively leverage both these concepts to expand an individual’s notions of risk beyond themselves and inspire them to adhere to physical distancing measures that they otherwise may not take to protect themselves.

**EXAMPLES OF BEHAVIORAL TOOLS**

- Communication should highlight the opportunities afforded by physical distancing—rather than emphasizing the freedom that has been lost. Where relevant, highlight opportunities to adopt new habits, or connect digitally with old friends and family.
- Compare data-driven case scenarios of spread with and without self-isolation or physical distancing.
- Frame “social / physical distancing” as “healthy distancing” to emphasize the benefits of the action.
- Emphasize collective action by using small communities (e.g. Household or village) as a unit of change and rally individuals to protect these communities.
- Emphasize compliance as care for specific groups (e.g. Wash your hands to protect your parents / grandparents).
- Emphasize collective responsibility to observe preventive measures by sharing stories of those who are vulnerable or sick thanking their communities for physically distancing for their sake.

**BEHAVIORAL INSIGHTS AND TOOLS**

People take cues from their social environment to understand what is ‘normal’ or socially desirable, and adapt to fit in. Behavioral tools can leverage an individual’s social nature to encourage pro-social behavior by popularizing compliance with these behaviors and appealing to an individual’s desirable notions of themselves and their identity.

- Bring positive social norms to light by emphasizing that most people are compliant with physical distancing measures.
- Use reciprocity as a tool to motivate others to comply with preventive measures. Highlight that recipients of the communication are safe because others around them have taken measures to protect them, and they can return the favor.
- Frame compliance as a moral obligation to appeal to individual moral attitudes. Enhance this moral obligation by using passages in religious text that celebrated those who act to save the lives of others.
C | REDUCE PSYCHOLOGICAL BARRIERS TO COMPLIANCE

The majority of respondents had good knowledge about the main preventive measures, hand washing protocols, sources to report suspected COVID-19 cases to, and to self-isolate if experiencing symptoms. Additionally, the majority of respondents affirmed the efficacy of physical distancing measures, and also expressed a willingness to comply with self-isolation and to report suspected cases. Despite all this, throughout the survey, significant minorities of varying proportions either revealed that they practiced measures insufficiently, or that they faced behavioral barriers to practicing these measures. These barriers may prevent individuals from acting in spite of their illustrated knowledge and intention to act in a compliant manner.

HANDWASHING

Though half of the respondents could refer to at least four moments throughout the day in which they would wash their hands, the fact that some groups within the sample could recall up to six moments while other could recall at most three, may be an indication that there are opportunities to improve the salience of key handwashing moments to individuals and by implication, the frequency with which they wash their hands. Additionally, though results from the study showed that most people know to wash their hands frequently for at least 20 seconds, 30% reported limited access to clean water, and 18% reported ‘forgetfulness’ as a barrier to frequent handwashing, which could limit their ability to wash hands, despite their knowledge of the protocol.

WHICH GROUPS WERE MORE LIKELY TO REPORT BARRIERS TO HANDWASHING?

Syrians were the least likely to recall key handwashing moments, and the most likely to report limited access to clean water (45%).

A third of respondents from all governorates, with the exception of Baalbek-Hermel, Nabatieh and South Lebanon, reported limited access to water.

The youngest age group (18 – 24) was the most likely to report structural and behavioral barriers to handwashing.

• Increasing the salience of important handwashing moments
• Enhance ease with which individuals remember to wash hands

COMMUNICATION OBJECTIVES
PHYSICAL DISTANCING MEASURES

Even though most respondents agreed with the efficacy of physical distancing measures to prevent the spread of COVID-19, the adoption of some measures, and within certain subgroups, was relatively low, with up to a fifth of respondents reporting non-compliance with three out of five stated physical distancing measures. In addition, a third of the respondents admitted to leaving their homes during the national lockdown period, while a smaller proportion visited friends or family.

WHICH GROUPS WERE LESS LIKELY TO COMPLY WITH THE PHYSICAL DISTANCING MEASURES / STAY AT HOME DURING NATIONAL LOCKDOWN?

In general, compliance with physical distancing measures was significantly lower in Akkar, North Lebanon and Baalbek-Hermel than the other governorates. Almost half the respondents from Beirut admitted to leaving their homes during the national lockdown period to go to work. While the youngest (18 – 24) and the oldest (65+) were less likely to comply with physical distancing measures in general, the middle age groups were more likely to leave their homes during the national lockdown to go to work. All nationalities were equally likely to comply with physical distancing measures.

SELF ISOLATION

Although most people correctly identified correct statements about effective self-isolation, and most people were willing to isolate, at least half of the respondents perceived negative consequences of isolation, in particular, ‘impact on mental health’, and ‘difficulty separating from others’, both of which could hinder voluntary self-isolation when necessary. Moreover, stated intention to self-isolate is not the same as action, and as such, there is a need to increase the chance of action.

WHICH GROUPS WERE MORE LIKELY TO REPORT BARRIERS TO SELF-ISOLATION?

Most Syrians reported barriers to self-isolation, including ‘impact on mental health’, ‘difficulty separating from others’, the ‘need to take of others’ and ‘loss of income’.

Bekaa and Nabatieh were more likely to report barriers to self-isolation than other governorates.

The elderly (65+) were more likely to cite ‘impact on mental health’, and ‘difficulty separating from others’ as barriers; while the middle age groups (25 – 44 and 45- 64) were more likely to cite ‘loss of income’ and ‘the need to take care of others’.
REPORTING SUSPECTED CASES

Majority of respondents were aware that they should call MoPH to report suspected cases of COVID-19, and 60-90% were willing to report depending on the severity of the symptoms. Additionally, most respondents reported no barriers to reporting symptoms to MoPH. However, stated intention to report is not the same as action, and as such, there is a need to increase the chance of actual action in this regard, especially amongst youth.

WHICH GROUPS WERE LESS LIKELY TO REPORT TO MOPH?

Youth (18 – 24) were less likely to report suspected cases of COVID-19 to MoPH, and even less so if the symptoms were mild. They were also the least likely to know what number to call.

Respondents from Baalbek-Hermel were the least likely to report if their symptoms were mild or moderate. They were also the most likely to report barriers to reporting, including not knowing what number to call, not wanting to be quarantined in hospital and not having the support of people important to them.

Palestinians were consistently less likely to report to MoPH than the Lebanese or Syrians, irrespective of the severity of symptoms; while Syrians were more likely to report than Lebanese.

COMMUNICATIONS OBJECTIVES

• Dispel fears and misconceptions around who and when one should be admitted / quarantined in the hospital
• Nudge individuals who have symptoms to report
• Enhance ease with which individuals remember to report symptoms

BEHAVIORAL INSIGHTS TO REDUCE MENTAL AND PSYCHOLOGICAL BARRIERS TO COMPLIANCE

Communication objectives seek to make the target behaviors easier to enact and improve people’s ability to overcome stated barriers. Behavioral tools and insights can be employed to increase ease and enhance ability.

REDUCE MENTAL BARRIERS

BY:

Enhancing ease

Even when individuals believe they should practice these behaviors and have every intention of doing so, seemingly minor things that make the task more difficult could be the difference between doing it and not doing it. Behavioral tools can be employed to ease the performance of handwashing, reporting, self-isolation and physical distancing by those who intend to do these things but find it difficult to do so.
A study at a highway service station in the United Kingdom tested different types of visual messaging on hand washing rates. The researchers set up an electronic message board over the entrance of both the male and female restrooms. One of the most effective messages utilized social norms, asked “Is the person next to you washing with soap? Though only one quarter of women and one third of men in the exposure survey reported seeing the message board, the social norms messaging still increased handwashing compliance by 12% for men and 11% for women.


**EXAMPLES OF BEHAVIORAL TOOLS**

**Handwashing:** Sometimes, individuals forgot to wash their hands, and there was some variability in the number of times individuals reported washing their hands within the day, which could be an indication of relatively insufficient handwashing

- Refer to specific moments of hand washing in communication to make it easier to remember key moments of hand washing
- Utilize peer pressure/ desire to conform to social norms in communications about handwashing in public bathrooms

**Reporting:** Individual’s willingness to report varied with level of severity, and though 70% knew that MoPH was who to call to report symptoms, much less than that said they would

- If the need to call MoPH is based on different levels of severity, be explicit about what mild, moderate or severe symptoms are
- Utilize decision trees in communication to help people make the right decision in unfamiliar or uncertain contexts (e.g., what to do if experiencing COVID-19 symptoms).
- Utilize a questioning format about symptoms (*e.g.* Have you felt three of any of these symptoms?), in communication about reporting symptoms in order to prime individuals into calling and help them make the right decision if uncertain
- Prompt individuals to save the MoPH COVID-19 hotline on their SIM cards, or install by default through the telecom operators.

**Physical distancing:** Up to a fifth of respondents reported noncompliance with some physical distancing measures

- Provide specific alternatives to undesirable behavior. For example, to avoid people shaking hands, advise them to nod and wave, instead of telling them not to shake hands.
- Provide or suggest that individuals put signs up on doors to remind people how to use their space.
- Communicate specific forms of socializing in this new context. For example, highlight games that require no contact, like charades.
Studies show that feeling able to protect oneself against COVID-19 and knowing about effective measures are predictors of protective behaviors. Whilst most respondents reported a high willingness and ability to self-isolate and report, they also reported barriers to practicing these behaviors or doing so effectively. As such, communication should seek to empower individuals to overcome barriers they face, and use behavioral tools to enhance the effectiveness of these efforts.

**EXAMPLES OF BEHAVIORAL TOOLS**

**Self-isolation:** At least half of the respondents reported either ‘impact on mental health,’ and ‘difficulty separating from others’ as a barrier to effective self-isolation. Other highly reported barriers included accessing supplies.

- Provide practical tips on how to cope in self-isolation, with differentiation for different ages
- Provide concrete activities for family members to carry out if they have an elderly family member self-isolating to help them adjust to the isolation
- Engage telecommunications companies to offer free credit or discounted bundles to people who are self-isolating, and leverage this as an incentive for compliance, and basis on which to highlight the opportunity to connect with others digitally during self-isolation
- In communication about self-isolation, provide context-specific alternatives to getting supplies for those who have to self-isolate
- Supply and advertise additional mental health services, including support lines and advice, for people who undergo isolation
- Prompt recipients to establish a social commitment by letting friends or family know that they are following government advice to self-isolate. This increases accountability and enhances the likelihood of following through on commitment. Liaise with the national hotline database to target those required to self-isolate.
- Prompt employers to offer support to employees who are self-isolating
- Create planning prompts to maintain aspects of routine (e.g. working hours, workout time…) to reduce uncertainty and anxiety during isolation.