Multi-Sector Needs Assessment Palestine Refugees in Lebanon (PRL)

November 2022

CONTEXT

Lebanon is facing a **multi-layered crisis** resulting from years of economic mismanagement, structural vulnerabilities including poor infrastructure, a weak public sector and deteriorating social services, as well as the effects of the Covid-19 pandemic and the 2020 Beirut blast.[1] These factors have contributed to civil unrest, high poverty rates and limited functionality of public services, and have driven household (HH) vulnerability more generally.[2] The ongoing crisis has multiple consequences that affect the population groups present in Lebanon with different levels of severity. In this complex context, humanitarian actors showed the need for up to date information to guide their programming.

To support an **evidence-based humanitarian response**, the United Nations (UN) Office for the Coordination of Humanitarian Affairs (OCHA) and REACH Initiative (REACH), with support from the Emergency Operation Cell (EOC), have therefore conducted a country-wide Multi-Sector Needs Assessment (MSNA), funded by the European Civil Protection and Humanitarian Aid Operations unit (DG-ECHO) and the Lebanese Humanitarian Fund (LHF).

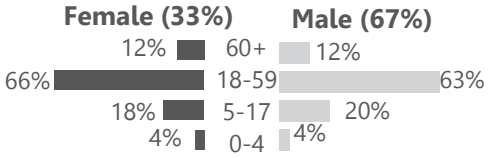
METHODOLOGY

Quantitative data was collected through a household-level survey assessing three population groups: Lebanese households (HHs), Palestine Refugees in Lebanon (PRL) HHs, and Migrant HHs.[4] Data collection took place between 27 July and 26 November 2022. **This factsheet is presenting the findings for in-camp PRL households specifically.**

The assessed PRL HHs were selected by means of a two-stage stratified sampling approach where the 12 PRL official camps in Lebanon were the primary sampling units and whose boundaries (comprehensive of the population living in the camps' immediate surroundings) were detected by means of remote sensing techniques. This allowed to have a total sample of 590 HHs representative of the in-camp PRL HHs population at a governorate level and at a national level with a 95% level of confidence and a 10% margin of error. For more information on the methodology, please refer to the Terms of Reference.

Sample: 590 households*

Demography of HHs members



Single female-headed households: 14%

Average household size: 3.4

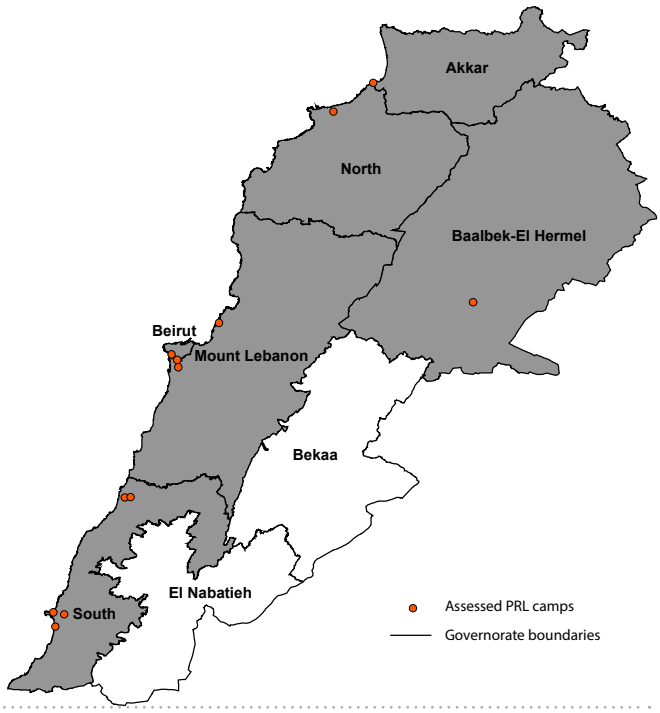
41% of households were with at least one child below 18 years

33% of households were with at least one person above 60 years

33% of households were with at least one person with disability

* For some sections, respondents were asked to answer questions repeatedly about each member of their household. Including respondents, there were 1,923 household (HH) members covered by the assessment.

GEOGRAPHIC COVERAGE



LIMITATIONS

- Data on the individual level was reported by proxy by one respondent per household, rather than by the individual HH members themselves. As a result, it might not accurately reflect lived experiences of individual HH members.
- For some findings, subsample size was smaller than 30 units, leading to a larger margin of error. In such cases results should be considered as indicative only.
- The majority of PRL respondents were men (67%), as such the male perspective might be overrepresented throughout the findings

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[1] Lebanon - country overview. Source: World Bank website
[2] Lebanon Economic Monitor. Source: World Bank website
[3] Lebanon: 2021 Multi-Sector Needs Assessment - April 2022
[4] Syrian refugees residing in Lebanon have not been included among the targeted groups of the MSNA because their needs and the effects that the country crisis is having on them are assessed through other research projects, e.g. VASYR 2021, WFP Lebanon Situation Report, UNHCR Protection Monitoring

OCHA

REACH Informing more effective humanitarian action

SUMMARY OF KEY FINDINGS

Overall, both 2021 and 2022 MSNA findings have shown that the socio-economic collapse has had and will likely continue to have a tremendous negative impact on the Palestinian population within Lebanon. While 2022 MSNA identified needs for PRL across all sectors, the most reported essential needs that PRL HHs had trouble meeting were food needs (as reported by 63% of the HHs), health needs (52%) and electricity needs (39%) – often due to financial issues (72%). Moreover, protection concerns were commonly flagged among PRL HHs, particularly in comparison with other population groups. In the below summary, some of the key findings across all sectors are highlighted.

LIVELIHOODS & FOOD SECURITY

Employment - The majority of adult PRL individuals reported being not being involved in income-generating activities, with only 21% of the working-aged individuals reporting having worked for someone else for pay in the 7 days prior to data collection. Another 6% reporting being involved in other type of income generating activities such as farming or helping in the family business. Notably less women were reportedly working for someone else for pay in the 7 days prior to data collection (9%).. Despite the high percentage of individuals reporting being not invloved in income-generating activities, only 9% of individuals reported having looked for work in the month prior to data collection. Among those who were seeking for a job, increased competition or not enough jobs was the most frequently reported barrier to employment (45%), followed by reported employers' preference for individuals with Lebanese nationality (26%).

Income, debts and coping mechanisms – Most PRL HHs reported generating a very low income in the 30 days before data collection, with one-third of HHs (33%) reporting having earnt less than 3 million LBP (±100 USD), and another third (35%) between 3 and 6 million LBP. The most common sources of income reported by HHs were daily or intermittent work (48%), savings (24%) and international remittances (23%). Moreover, some HHs reported relying exclusively on humanitarian assistance (3%) or remittances (4%) as their income source. Over half of HHs (58%) reported being in debt at the time of data collection, with an average debt of approximately 3.3 million LBP. Reported reasons for taking on debt were often to buy food (71%) and to pay for healthcare (52%), echoing the reported essential needs that PRL HHs had trouble meeting.

Food Security - Food was reported as a top three priority need among the majority of PRL HHs (78%). Indeed, 2022 MSNA findings found that over half of assessed HHs were either "borderline" (29%) or "poor" (27%) in terms of food consumption score (FCS) and moderate (8%) or severe (1%) hunger, as per the Household Hunger Scale, was found in one out of every ten assessed HHs. The vast majority of HHs (77%) reported to use at least one negative food coping strategy to cope with a lack of food or money to buy it, most commonly relying on less preferred/less expensive food (76%), limiting portion sizes at mealtimes (63%) and reducing the number of meals eaten in a day (52%). Additionally, roughly half of households (49%) reported resorting to at least one livelihood coping strategy, including "emergency" type of strategies such as accepting high risk, dangerous or exploitative work (8%), begging (6%) and involving school-aged children in income generating activities (4%).

[5] If a person visited more than one healthcare location, the respondent was asked to report the "highest" level of care.

[6] To note that each PRL camp has at least one UNRWA health facility on the premises.

HEALTH

Health needs - Healthcare was reported as a top three priority need among the majority of PRL HHs (84%). Thirty-one percent of PRL individuals (30%) reportedly had a health need requiring care in the 3 months before data collection, of whom a fifth (22%) was unable to obtain the care they needed. Primary health care consultation for medication, prevention, check-ups, acute or chronic disease or diagnosis was the most reported health care need (56%), followed by hospital-based laboratory or diagnostic procedures (68%).[5] When asked where HH members sought care, most reported to have visited NGO or The United Nations Relief and Works Agency (UNRWA) clinics for both primary (48%), and secondary (16%) health care services.

Health barriers – Likely resulting from their current legal and political status in Lebanon, the vast majority of HHs (95%) reported not being covered by any type of health insurance. Consequently, the affordability of healthcare and medication was cited as a key barrier to accessing it. Cost of treatment (45%), lack of functional facilities nearby (26%)[6] and lack of specialized treatment or devices (25%) were the most frequently reported barriers to accessing health care. The cost (60%) and the lack of availability of medication in the pharmacy (61%) or health facilities (38%) was also reported as the main barriers to accessing medication.

SHELTER

Shelter types and issues - At the national level, 97% of households reported living in an apartment/house or room, while 2% reported living in agricultural/engine/pump room and 1% in an active construction site. Sixty-six percent (65%) of households reported having issues with their shelter, with the most common issues related to a leaking roof (31%), followed by lack of insulation (22%). Moreover, 13% of HHs reported having a damaged structure in their shelter. Among those, the highest damages reported were in the walls followed by in the roofs. When asked about issues related to living conditions in their shelters, half of the HHs (50%) reported having at least one issue, such as being unable to keep the shelter warm or cool (20%) and having at least one member of the HHs who sleeps outside or on the floor (11%).

Occupancy Arrangements - Over a third (37%) of HHs reported informally owning a shelter and 19% reported renting a shelter. While the overall average expenditure on accommodation (incl. mortgage, rent, etc.) was reportedly 350.000 LBP per month, HHs renting shelters reported an average monthly rent cost of 1,000,000 LBP, nearly three times higher. Most HHs (81%) did not report any problems related to housing, land and property, with the most frequently reported problems being inheritance dispute (2%), dispute with tenants (1%) and unlawful or informal occupation (1%).

SUMMARY OF KEY FINDINGS

WATER, SANITATION AND HYGIENE (WASH)

Water – While the majority of PRL HHs reported having enough water for their various needs, a concerning proportion also reported not having enough water for drinking purposes (9%), cooking purposes (12%), and/or for personal hygiene (20%). Consequently, PRL households reported adopting negative coping mechanisms, such as reducing water consumption for other than drinking purposes (27%) and reducing drinking water (18%). Nearly all HHs (99%) reported using an improved water source as main source of drinking water, most commonly bottled water (41%), followed by a piped connection to the house (25%).

Sanitation - Most PRL HHs reported having a flush or pour/flush toilet (92%) and were not sharing their sanitation facilities with other households (93%). While the majority of households managed their wastewater safely through a connection to a communal lined drainage and sewage system (71%) or through covered and lined septic tanks (23%), a concerning 6% also reported to use a hand dug hole in the ground.

Hygiene – One-tenth of PRL households (10%) reported not using good hygiene practices to wash their hands, meaning they were lacking handwashing facilities or soap at the facilities. Roughly a third of HHs reported facing issues in accessing hygiene non-food items (hNFI) (33%), resulting in HHs relying on less preferred types of hNFI (8%) or having to buy them at marketplaces further away (3%). Particularly in terms of menstrual hygiene materials (MHM), one-fifth (21%) of households with female members reported problems in obtaining MHM due to the high cost. Lastly, most HHs were relying on NGOs to collect their dumpsters (49%) and a slightly smaller proportion on municipalities (48%). However, over a third of HHs (37%) said the solid waste in their area was not being collected on a regular basis in the month prior to data collection, leading to waste piling up at the location.

EDUCATION

Six percent (6%) of PRL children aged 5-17[7] were reportedly not enrolled in a formal school during the 2021-2022 school year (6%), with the highest proportion of children not being enrolled found in Akkar (23%) and North (19%) governorates. Reasons cited for having children not enrolled in school varied from the child's age not being considered appropriate for school, the child having to work or the child having a disability. Children who were enrolled in formal schools mostly went to UNRWA schools (79%) or public schools (14%) and most were reportedly attending school regularly (at least 4 days per week) (97%). Roughly half of PRL HHs (44%) reported schools had been closed during the 2021-2022 school year, among whom 92% had access to distance learning, using mainly online live classes with teachers (66%).[8]

[7] Children start their learning at UNRWA schools from the age of six. However, of the 20 assessed PRL children of the age of five, only four were reportedly not enrolled in school at the time of data collection.
[8] UNRWA schools had not closed during the 2021-2022 school year, as reported by UNRWA partners.

PROTECTION

Vulnerabilities – Overall, over half of PRL HHs (57%) reported having at least one member with a vulnerability, meaning a member with a disability (33%), member older than 60 years (33%) or a female member who was pregnant or lactating at the time of data collection (11%).

Safety and security – Safety and security concerns were reported across all gender and age groups (for boys, girls, women and/or men). Generally, top reported safety and security concerns were similar for girls, boys, men and women, except for suffering from sexual harassment or violence, which was mainly reported for girls and women. Security concerns for all groups were most frequently reported by HHs in Akkar governorate, followed by the South and the North governorates.

Gender-based violence (GBV) and Protection against sexual exploitation and abuse (PSEA) – Over one-fifth of PRL HHs reported that girls and women avoid certain areas because they feel unsafe there (25%). Overall, markets, streets and the route to school were reported as the main locations of concern, though notably in Baalbeck-Hermel public transportation was also indicated as unsafe for women by 77% of HHs and 13% of HHs in Mount Lebanon reported that women and girls feel unsafe in their own homes. Moreover, it was reported by various HHs that women (7%) and girls (10%) were suffering from physical harassment or violence (non-sexual) and by 3% of HHs that adult women were suffering from sexual harassment or violence, most commonly in Akkar and Baalbeck-Hermel governorates.

ENERGY AND COMMUNICATION

At the time of data collection, 21% of assessed PRL HHs reported having had no network coverage at all, with the highest percentage being in the North (59%). In terms of electricity, most HHs reported using a neighbourhood generator (81%) and the main network (56%) which provided an average of 14 hours of electricity per day while a considerable number of HHs (20%) also reported receiving less than 5 hours of electricity per day. Consequently, one-third (37%) of HHs reported having adopted at least one strategy to cope with electricity shortages, most often reducing electricity consumption (18%) or having to spend on electricity money which was usually spent on other things (9%).

LIVELIHOODS

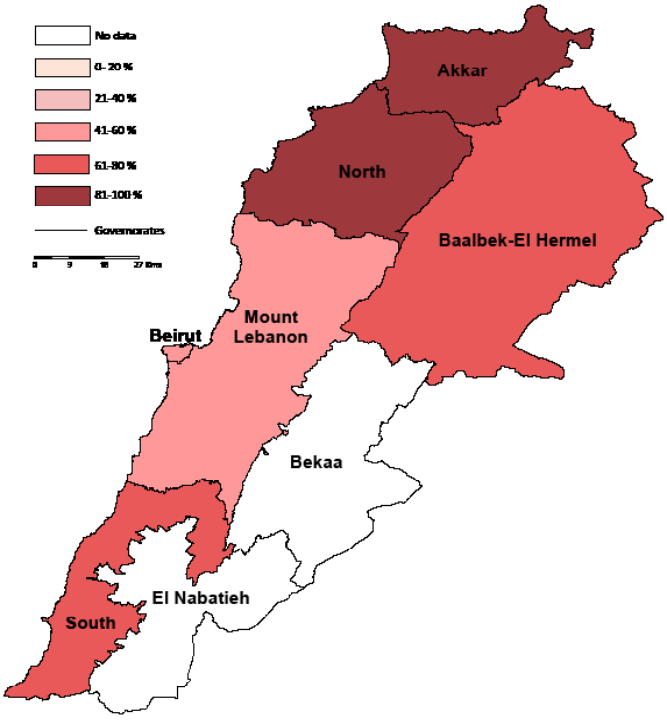
LIVELIHOOD AND EMPLOYMENT

50% **of HHs** reported **at least one working age member (>15 years)** having worked for someone else for pay in the week prior to data collection

21% **of working age HH members were** reportedly working for someone else for pay in the week prior to data collection

Only 9% of female working age members were reportedly working for someone else, compared to 34% of male working age members.

% of individuals not working for someone else for pay in the 7 days prior to data collection, by governorate:



In addition to individuals working for someone else:

- **5%** of individuals were reportedly **running some kind of business, farming, or other activity to generate income;**
- **1%** of individuals **were helping in family business or farm.**

Out of 70% (n=1,129) of individuals who were reportedly not involved in income-generating activities:

9% were looking for a paid job or tried to start a business in the last month prior to the data collection

The highest proportion of individuals who were reportedly looking for a job was found in Beirut (24%) and Baalbek Hermel (18%), while the lowest proportions were found in North and South (6% each).

A comparably higher proportion of individuals looking for jobs was reportedly among males (14%) than among females (5%).

75% were not ready to start working in the next 2 weeks, if a job opportunity became available

More males were reportedly ready to start working (37%), than females (14%).

Among the HHs who reported having at least one unemployed working-aged member who was seeking for a job (n=118), top reported barriers to employment were*:

Increased competition/ not enough jobs	45%
Employers preferred someone of other nationality	26%
Jobs too far away/ commute too expensive	23%

ABILITY TO MEET BASIC NEEDS

Most frequently reported essential needs HHs had trouble meeting because of lost or reduced employment, financial or availability issues in the three months prior to data collection*:

Food needs	63%
Health needs	52%
Electricity	39%

Most frequently reported reasons driving difficulties in meeting essential needs, among 84% of HHs reporting such difficulties*:

Financial issues	72%
Loss or reduced employment	22%
Access/availability issues	4%

*Multiple answers allowed

LIVELIHOODS

HOUSEHOLD'S DEBTS

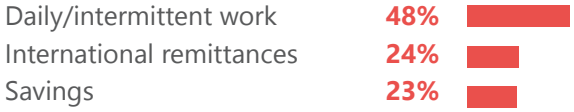
46% of HHs reported having informal debt from borrowing money, that has not been paid back yet[9]

3,943,542 LBP was the average reported debt value, and 8% of HHs reported taking informal debt for an amount higher than 6,000,000 LBP[10]

Among the HHs having informal debt (n=341), the main reported reasons were*:

HOUSEHOLD'S INCOME

Top three reported HHs sources of income in the 30 days prior to data collection*:



3% of HHs reported relying exclusively on humanitarian assistance as their main source of income

4% of HHs reported relying exclusively on remittances as their main source of income

% of HHs by reported total income in LBP in the 30 days prior to the data collection:

67% of HHs reported an average monthly income lower than 6,000,000 LBP

HOUSEHOLD'S EXPENDITURES

Reported average HHs expenditures, by expenditure type:

	Average amount[11] 30 days prior to d.c.[12]	Proportion to total spending**
Total expenditure (past 30 days)	**5,500,601**	**100%**
Electricity (incl. private generator)	1,920,975	35%
Medicine & health products	1,097,738	20%
Other (e.g.: transport, tobacco, entertainment)	630,045	11%
Energy for cooking (gas & others)	513,989	9%
Hygiene items	356,553	6%
Accommodation (rent, mortgage, etc.)	348,110	6%
Water	344,499	6%
Communication	326,797	6%
	Average amount 6 months prior to d.c.[12]	-
Debt repayment	2,890,075	-
Health services (excluding medicine)	1,470,102	-
	Average amount 12 months prior to d.c.[12]	-
Education (tuition, transportation, etc.)	1,943,932	-

**For each category, proportion was calculated by dividing the average expenditure by total expenditure

* Multiple answers allowed
[9] Debt from borrowing money (informal debt) (from friends, relatives, landlord, shopowners) that has not yet been paid back. Based on 504 answers, excluding NA
[10] At the time of data collection, 1USD = circa 30.000 LBP, as per www.lirarate.org
[11] Please note that respondents were not asked about the amount spent on food and therefore food category is not included in this table.
[12] data collection

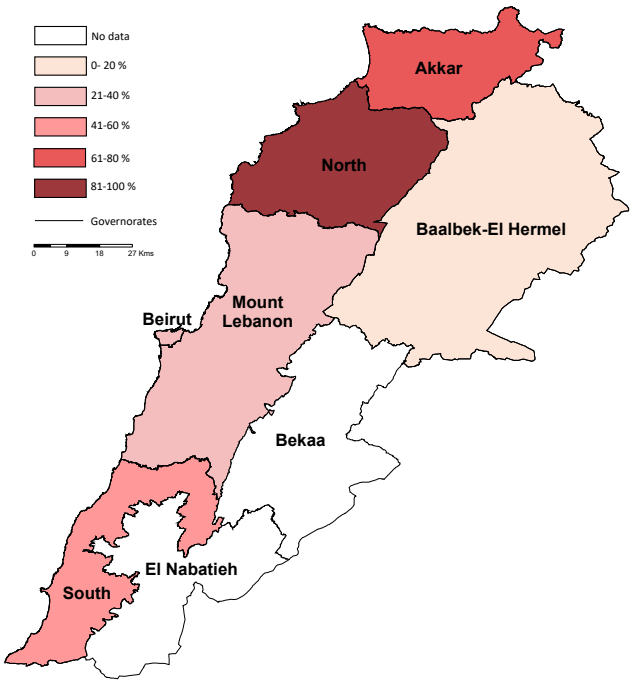
FOOD SECURITY (FSL)

FOOD CONSUMPTION SCORE

% of HHs by Food Consumption Score (FCS):

44% acceptable | 29% borderline | 27% poor

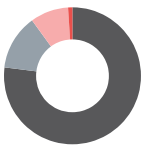
% of HHs with poor or borderline FCS, by governorate:



Most HHs with poor FCS score were reported in North (51%), Akkar (40%), and South (25%) governorates.

HOUSEHOLD HUNGER SCALE[16]

% of HHs by no, little, moderate or severe reported hunger in the HH



No hunger in the household (79%)

Little hunger in the household (12%)

Moderate hunger in the household (8%)

Severe hunger in the household (1%)

USE OF COPING MECHANISMS

% of HHs by Livelihood Coping Strategy (LCS[13]) category in the 30 days prior to data collection[14]:

47% None | 20% Stress | 24% Crisis | 10% Emergency

The most commonly adopted crisis and emergency coping strategies in the 7 days prior to data collection:

Reduced non-food expenditures on health	25%
Reduced non-food expenditures on education	21%
Sold productive assets and/or means of transport	9%
Accepted high risk, dangerous or exploitative work	8%

% of HHs by average Concumption-based Coping Strategy Index (rCSI[15]):

36% Low | 49% Medium | 15% High

Fifteen per cent (15%) of HHs was highly relying on consumption-based coping strategies. The governorate presenting the highest percentage of HHs with a high rCSI score was Akkar (31%).

The most commonly adopted coping strategies in the 7 days prior to data collection:

Strategy adopted (% of HHs)	Average number of days per week per strategy
Relied on less preferred/less expensive food **(74%)**	1.9
Limited portion sizes at meal times **(63%)**	1.6
Reduced the number of meals eaten in a day **(52%)**	1.3
Borrowed food/relied on help from others **(49%)**	0.9
Restricted adults consumption so children can eat **(41%)**	0.9

[13] Livelihood Coping Strategies Index (LCS) is an indicator used to understand medium and longer-term coping capacity of households in response to lack of food or lack of money to buy food and their ability to overcome challenges in the future. The indicator is derived from a series of questions regarding the households' experiences with livelihood stress and asset depletion to cope with food shortages. Read more here.

[14] Households could select multiple livelihood coping strategies. The graph shows the most severe LCS selected by the household

[15] rCSI - The reduced Coping Strategies Index (rCSI) is an indicator used to compare the hardship faced by households due to shortage of food. The index measures the frequency and severity of the food consumption behaviours the households had to engage in due to food shortage in the 7 days prior to the survey. The rCSI was calculated to better understand the frequency and severity of changes in food consumption behaviours in the household when faced with shortage of food. The rCSI scale was adjusted for Lebanon, with low index attributed to rCSI <=3, medium: rCSI between 4 and 18, and high rCSI higher than 18, with the average rCSI being 9.7. Read more here.

[16] Household Hunger Scale (HHS)—a new, simple indicator to measure household hunger in food insecure areas. Read more here.

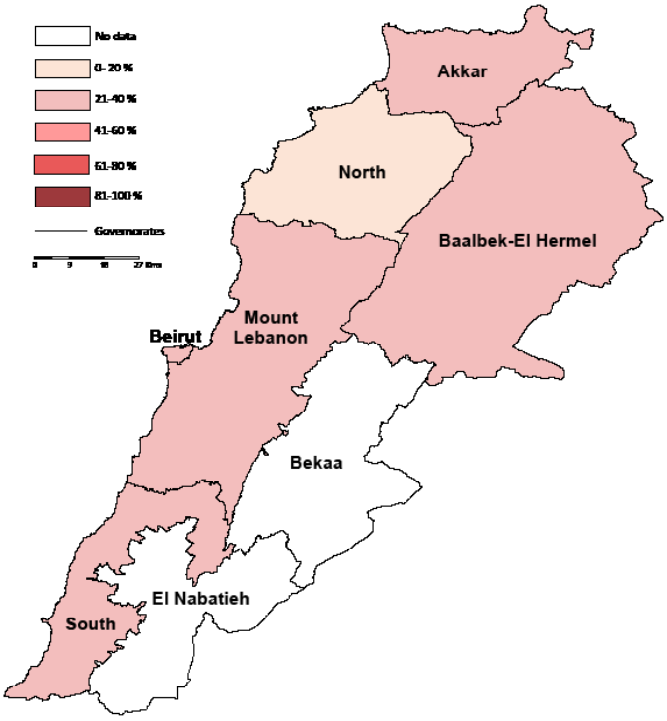
HEALTH

HEALTH CARE NEEDS: ACCESS AND BARRIERS

60% of HHs reported **having had at least one member with a health problem and in need to access healthcare** in the 3 months prior to data collection.

30% of individuals reportedly had a health problem and were in need to access health care in the 3 months prior to data collection.

% of individuals in need to access health care in the 3 months prior to data collection, by governorate:



Out of 30% of individuals in need of accessing health care services (n=514), **71% and 28% respectively reported Primary Health Care (PHC) and Secondary Health Care (SHC)** as their main need.[17]

Out of 30% of individuals with health care needs, **22% were not able to obtain health care** when they felt they needed it:

- **25% of individuals with reported PHC need** were not able to obtain health care
- **13% of individuals with reported SHC need** were not able to obtain health care

Type of PHC services needed, among individuals reportedly in need of accessing healthcare services (n=514):

Consultation for medication, prevention, check-up, acute or chronic disease or diagnosis	56%
Other specialized services or non-hospital care	8%
Dental services	4%

Type of SHC services needed, among individuals reportedly in need of accessing healthcare services (n=514):

Hospital-based laboratory/ diagnostic procedures	16%
COVID-19 treatment	4%
Elective non-life saving surgery	3%

Most frequently reported facilities where individuals sought PHC and SHC services, among individuals with health care needs:

For PHC services:

NGO clinic including UNRWA	48%
Private clinic or other private facility	15%
Government health centre	6%

For SHC services:

NGO hospital including UNRWA	16%
Private hospital	7%
Governmental hospital	4%

Top three types of facilities per governorate where individuals sought health care, among individuals with health care needs, in the 3 months prior to data collection:

	NGO clinic including UNRWA	NGO hospital including UNRWA	Private clinic/ medical facility
Akkar (n=102)	75%	9%	8%
Baalbek-Hermel (n=111)	48%	7%	20%
Beirut (n=50)	36%	14%	18%
Mount-Lebanon (n=99)	27%	10%	23%
North (n=35)	31%	20%	3%
South (n=114)	40%	21%	17%

[17] If a person visited more than one healthcare location, the respondent was asked to report the "highest" level of care.

HEALTH

HEALTH CARE NEEDS: ACCESS AND BARRIERS

% of HHs with at least one member with an unmet health care need, among the 60% HHs with health care needs:

The highest proportions of households with unmet healthcare needs were reported in **North governorate** (43%) and **Akkar governorate** (31%).

The average time spent by the HHs to reach the nearest functional health facility by the usual mode of transportation was **14 minutes**.

Top five self-reported barriers to accessing health care, among HHs reporting unmet health care need (n=94)*:

Cost of treatment	46%
No functional health facility nearby	25%
Unavailability of specialised treatment	23%
Cost of consultation	19%
Personnel specialised in treatment not available	15%

% of HHs by self-reported coping mechanisms for barriers to access health care, among HHs that experienced such barriers (n=73)*:

Switched to a public health care	53%
Went to pharmacy instead of clinic	23%
Delayed/cancelled treatment/doctor visit	21%
Home remedy	20%
Delayed/cancelled diagnostic procedures	16%

95% of HHs reported **not having any type of health insurance**

2% of HHs reported having **private, self pay insurance** and 1% having **private insurance through employer.**

MEDICATION: ACCESS, BARRIERS & COPING MECHANISM

Out of 60% (n=331) HHs with health care needs:

97% of HHs reported **the need to access medication** in the 3 months prior to data collection.

85% **of HHs reported at least one barrier in accessing medication when needed.**

Most often self-reported barriers to accessing medication, among HHs with health care needs (n=331)*:

Medication not available in pharmacy	61%
Cost of medication	60%
Medication not available in health facility	38%

% of HHs by self-reported coping mechanisms for inaccessibility of medication, among HHs who reported barriers to accessing medication (n=276)*:

Switched to substitutes /generics	56%
Got medication from outside Lebanon	39%
Reduced non-medical HHs expenses to afford medication	20%

SEXUAL & REPRODUCTIVE HEALTH

11% **of women 15-49 years old** were reportedly **pregnant or lactating at the time of data collection**

5% **of women 15-49 years old** were reported to **have given birth in the 2 years prior to data collection**

In the assessed households, all the women who had reportedly given birth in the 2 years prior to data collection (n=23), **were assisted by skilled birth attendant(s).**

Nine women reportedly gave birth in a public hospital, eight - in private hospital, and six - in NGO hospital/ UNRWA.

Out of 23 women who have given birth in the 2 years prior to data collection, four had reportedly received antenatal care less than 4 times during pregnancy.

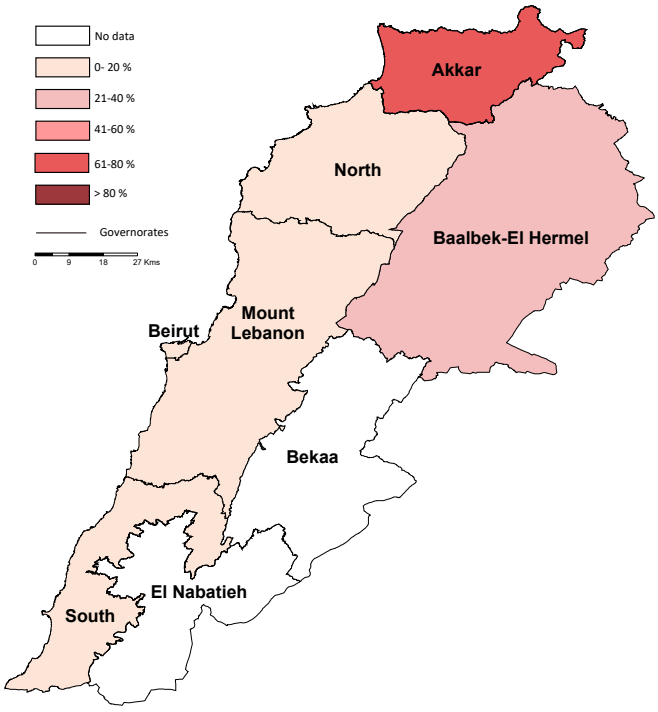
*Multiple answers allowed

VACCINATION AND NUTRITION

ROUTINE VACCINATION: ACCESS, & BARRIERS

18% of 204 HHs with children reported **experiencing barriers to receiving routine vaccination** for their child (other than COVID19) in the 6 months prior to data collection.

% of HHs with children reporting having experienced barriers to receiving routine vaccination for their child (other than COVID19) in the 6 months prior to data collection, by governorate:



% of HHs by **self-reported barriers to receiving routine vaccination (other than COVID19)** for their child, among HHs with children (n=204)*:

I'm worried about side effects of vaccines	6%
Fear of COVID-19 exposure at vaccination site	4%
Long waiting time for the service	3%

8% of HHs with children **reported vaccination hesitancy as barrier to receiving routine vaccination for their child / children**[18]

NUTRITION

There were 24 infants (children under 1 year of age) in the assessed PRL households. Of them, 21 were breastfed.

Out of 21 breastfed children, twelve were put to the breast within one hour of birth, six after first hour and during the first day, one - after first day and for remaining two infants, respondent did not know.

Out of 18 infants aged between 6 and 23 months, **28% (n=4) were reported to have met Minimum Dietary Diversity.**

[18] Vaccination hesitancy included answers: "I'm worried about side effects of vaccines", "I do not want to vaccine children / prefer to delay vaccination for my child", "Fear or distrust of health workers at vaccination site" and "I have concerns about safety or quality of vaccines at vaccination site"
* Multiple answers allowed

SHELTER

SHELTER TYPES AND OCCUPANCY ARRANGEMENTS

3% of HHs reported living in temporary and non-residential shelters[19]

% of HHs by shelter types:

Apartment/house/room	97%
Active construction site	2%
Room in agricultural field, or room where the pump or engine is located	1%

% of HHs, by type of occupancy arrangement:

Informal ownership	39%
Ownership	37%
Informal verbal lease agreement	11%
Rental agreement (after 1992)[20]	7%
Hosted for free	1%

The highest percentage of HHs reporting informal verbal lease agreement as their occupancy arrangement was in Baalbek Hermel governorate (20%).

The percentage of female headed households reportedly owning a shelter was almost twice higher than the corresponding one for male headed households (58% vs 30%).

HOUSING, LAND AND PROPERTY (HLP) ISSUES

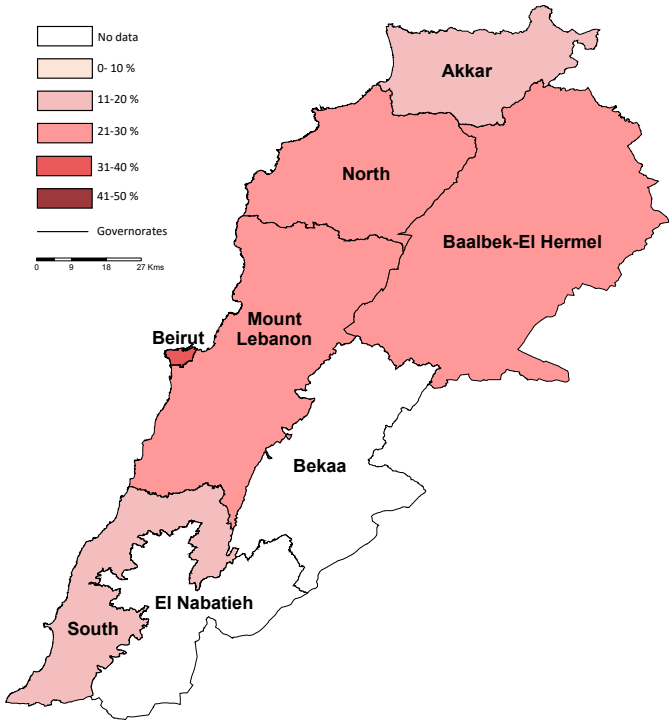
81% of HHs did not report any problems related to housing, land and property

Most frequently reported problems were: **inheritance dispute (2%)**, **dispute with tenants (1%)** and **unlawful or informal occupation (1%)**.

Five HHs reported living under a threat of eviction or living under an eviction notice.

19% of HHs reported living in a rented shelter at the time of data collection[21]

% of HHs living in rented shelters, by governorate:



Average reported monthly rent cost in LBP for households' accommodation was 1,006,328 LBP at the time of data collection.

[19] Temporary and non-residential shelters options included: factory, workshop, farm, active construction site, shop, agricultural/engine/pump room, warehouse, school, tent, prefab unit

[20] Lease agreements signed before 22 July 1992 were bound by the provisions of the Law no. 160/1992 and its amendments, which established rent control, to regulate a process of urban renewal and protect disadvantaged populations in the post-conflict period. Lease agreements signed after 22 July 1992 are bound by the provisions of the Law no.159/1992 in virtue of which lease can be freely agreed between property owners and tenants based on their mutual consensus. Source: Guidance Note on Housing, Land and Property Rights in the context of the Beirut Port Blast Response

[21] Rented shelter: rental agreement before 1992 or rental agreement after 1992 or informal verbal lease agreement

SHELTER

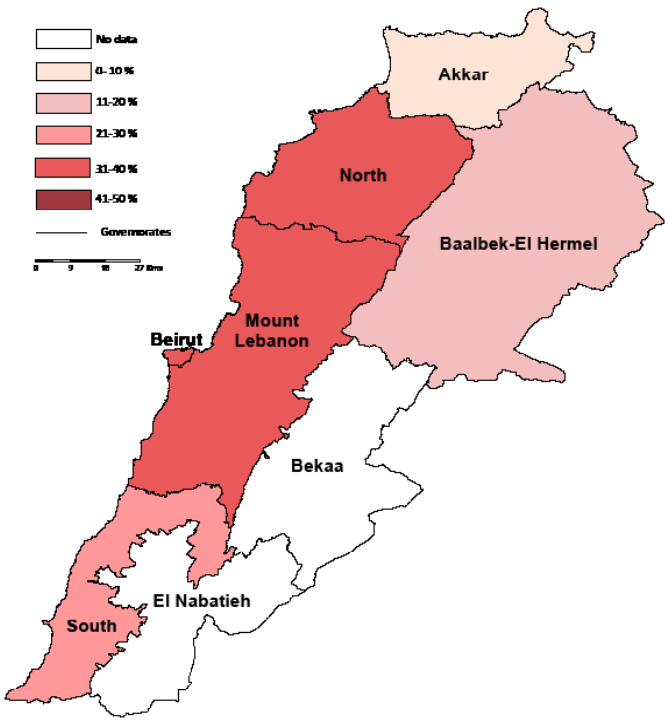
SHELTER DEFECTS, ISSUES AND DAMAGES

21% of HHs were found to live in inadequate shelter standards conditions at the time of data collection[22]

% of HHs by main reported types of shelter issues*:

Leaking roof	31%
Lack of insulation from the cold	22%
Leakage/ rottenness in the walls/ floors	14%
Damaged structure (roof, wall, columns)	13%
Windows/doors not sealed	11%
None of the above	35%

% of HHs found to live in inadequate shelter standards conditions[22] at the time of data collection, by governorate:



% of HHs, among 14% of HHs (n=80) that reported damaged structure, by type of reported damage:

Damage in the walls	84%
Damage in the roof	84%
Damage in the columns	39%

50% **of HHs reported facing at least one issue related to living conditions in their shelter at the time of data collection**

The most frequently reported issues, among all HHs (n=590):

- Being unable to keep the shelter warm or cool (20%)
- Having at least one member of the HH who had to sleep outside or on the floor (11%)
- Being unable to store water properly (8%)
- Being unable to cook or store food (7%)
- Lack of possibility to adequately perform personal hygiene (lack of bathing facilities, bathing facilities unsafe, insufficient hygiene kits) (5%)

The incidence of issues related to living conditions seemed to be higher in South, where 13% of HHs reported **at least one member of the HH having had to sleep outside or on the floor** and 29% reported being **unable to keep the shelter warm or cool**.

SHELTER SPACE AND CROWDEDNESS

On average, there were 1.6 persons reported per room in PRL households.[23]

15% of HHs reported more than 2 persons per room in their shelter

6% of HHs reported more than 3 persons per room in their shelter

[22] Inadequate shelter conditions were calculated based on thresholds provided by shelter experts, based on a combination of shelter type and shelter issues, including damage to the shelter. This indicator covers the physical conditions of the shelter and not the rental costs or protection-related concerns/ risks linked with the shelter

[23] Calculated by dividing household family size by number of rooms reported

* Multiple answers allowed

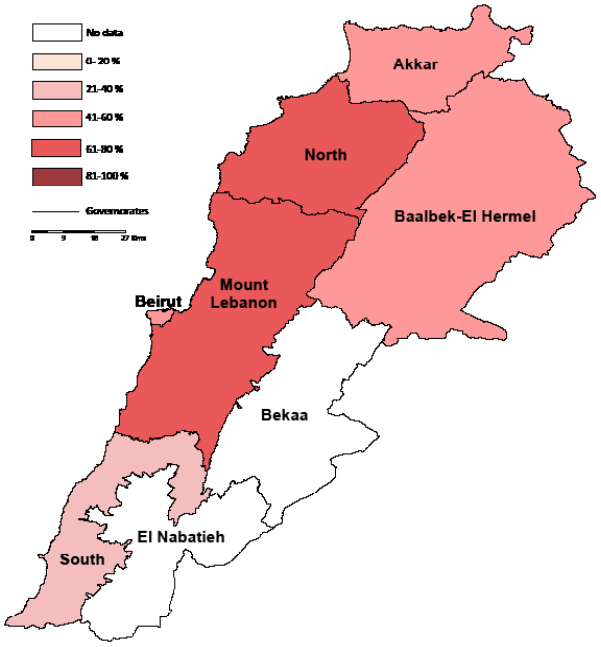
WATER, SANITATION & HYGIENE (WASH)

WATER ACCESS AND AVAILABILITY

% of HHs that reported having enough water to meet the following needs:

Drinking	91%
Cooking	88%
Personal hygiene	80%
Other domestic purposes	58%
None of the above	1%

% of HHs reporting NOT having enough water for at least one need (drinking, cooking, personal hygiene, other domestic purposes), by governorate:



% of HHs engaging in coping mechanisms for water insufficiency - by types of coping mechanism*:

Reduce water consumption for non-drinking purposes	27%
Reduce drinking water consumption	18%
Fetch water at a source further away	17%

MAIN SOURCES OF WATER

% of HHs by type of primary source of drinking water*:

Bottled water	41%
Piped connection to house	25%
Protected spring	21%
Public tap/standpipe	9%
Piped connection to neighbour's house	1%

1% of HHs reported using an unimproved source of water as main source of drinking water.

% of HHs by type of secondary sources of drinking water*:

Not using secondary sources	67%
Bottled water	19%
Public tap/standpipe	5%
Piped connection to house	5%
Tanker-truck	3%

% of HHs by reported time taken to go to main water source, fetch water, and return:

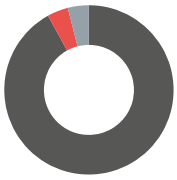
Water on premises	49%
Less than 5 min.	20%
Between 5 and 15 min.	21%
More than 16 min.	3%
Do not know	7%

% of HHs by person who usually fetches water, as reported by the 54% of HHs who did not have water on the premises*:

Men	71%
All	10%
Boys	17%
Women	7%
Girls	2%

SANITATION

% of HHs by reported sanitation facility used:



Flush or pour/flush toilet (92%)
Pit VIP Toilet (4%)
Other / do not know (4%)

% of HHs that reported sharing a sanitation facility with other HHs:

No (93%)
Yes (6%)
Do not know (1%)

Number of HHs that share a sanitation facility with other HHs (27 HHs) reporting that their shared facility:**

Can be locked from the inside	n=27
Has adequate lighting	n=9
Has a safe and well-lit route to it	n=5
Segregated by gender	n=1
None of the above	n=3

*Multiple answers allowed
** The sample size for the subgroup for this indicator amounts to less than 30 HHs, therefore the results might not be reliable.

WATER, SANITATION & HYGIENE (WASH)

SANITATION

% of HHs by reported wastewater management system:

Connected to a communal lined drainage and to the sewage system	71%
Covered and lined septic tank/cesspool	23%
A hand dug hole in the ground	6%

WASTE MANAGEMENT

% of HHs by reported waste management method:

Dumpsters/barrels collected by NGO	49%
Collected by municipality	48%
Collected by private collector	1%
Dumpsters/barrels not collected	1%

% of HHs that reported solid waste being collected on a regular basis in the 30 days prior to data collection:

Yes (59%)
No (37%)
Don't know (4%)

% of HHs reporting sorting waste, per waste category:

Not sorting any waste	91%
Yes, recyclable waste	6%
Yes, organic waste	3%
Do not know	1%

HYGIENE

% of HHs engaging in coping mechanisms for hygiene non-food items (hNFI) e.g. soaps, cleaning products, diapers, etc.) access issues - by type of coping mechanism*:

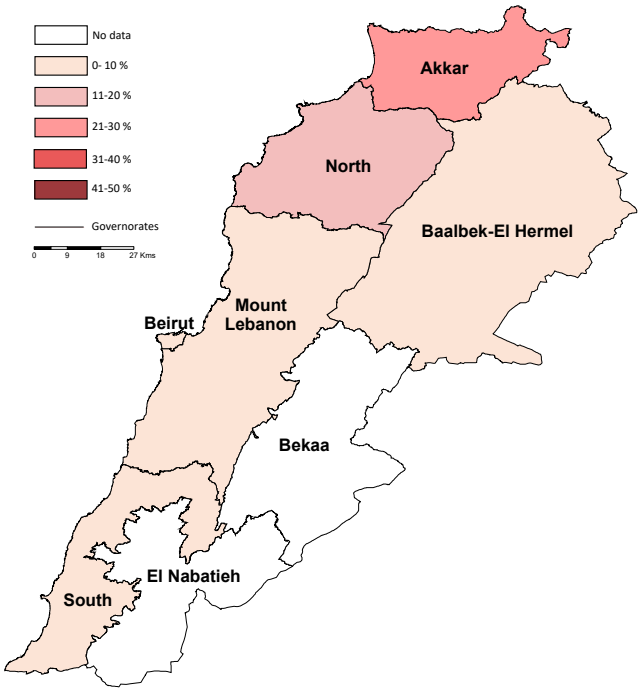
No issues	67%
Had issues but did not try to adapt	14%
Relied on less preferred types of hNFI	8%
Bought hNFI at a marketplace further away	3%
Reduced usage for other than personal hygiene purposes	3%
Reduced usage for personal hygiene	2%

% of HHs reporting access to hand-washing facilities[24]:

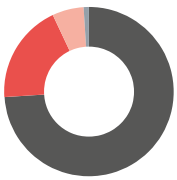
Yes - available with water and soap	86%
Yes - available with only water	8%
No hand-washing facility available	1%

10% of HHs reported not using good hygiene practices[25] to wash their hands

% of HHs not reporting adopting good hygiene practices, per governorate:



% of HHs with female HH members of menstruating age[26] (n=292) by type of problem that female members had to accessing menstrual material (MHM):



No problem (71%)
MHM were too expensive (21%)
Prefer not to answer (7%)
Do not know (1%)

* Multiple answers allowed

[24] In addition to that, for 4% of HHs enumerators reported no permission to see hand-washing facility.

[25] Lack of good hygiene practices was identified when HHs reported at least one of the following: decreased usage of hygiene items in the last 30 days, or not having soap or not having access to menstrual health materials.

[26] 15-49 years old

EDUCATION

SCHOOL ENROLMENT & ATTENDANCE

35% of PRL HHs reported to have at least one school-aged child (5-17 years old)

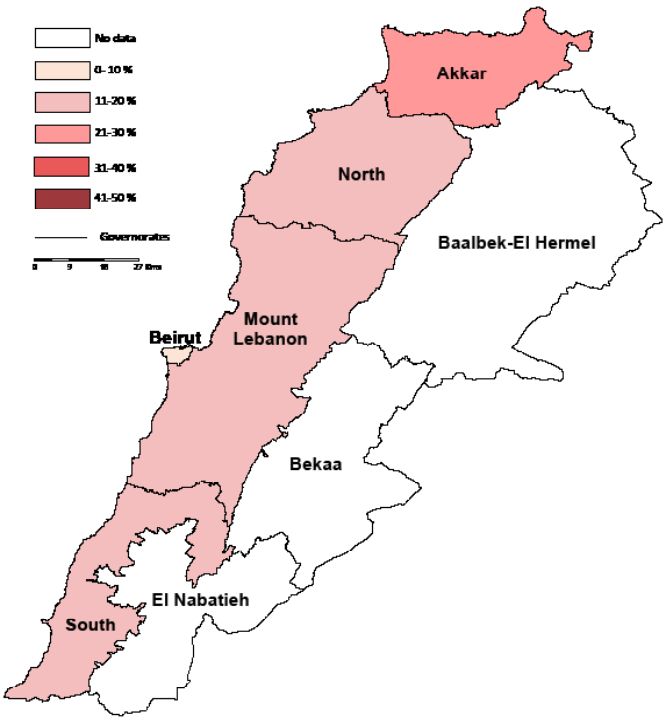
There were, reportedly, 320 school-aged children in the assessed PRL households.

93% of school-aged children were reportedly enrolled in a formal school during the 2021-2022 school year.[27]

% of school-aged children enrolled in a formal school for the 2021-2022 school year, by gender:

Girls	Boys
91%	86%

% of school-aged children not enrolled in formal schools, by governorate:



% of school-aged children enrolled in formal school for the 2021-2022 school year (n=286), by type of formal schools:

UNRWA	79%
Public school	14%
Private school	6%

% of HHs where at least one child was transferred between public and private school in the last two academic years:

From public to private school	2%
From private to public school	1%

Of the 7% children not enrolled in a formal education (n=33), most commonly cited reasons for children not being enrolled:**

Age not appropriate	32% (n=9)
Child did not enroll due to work	10% (n=3)
Child did not enroll due to disability	8% (n=3)
Prefer not to answer	17% (n=3)

Not appropriate age was reported among the reasons above only for children between 5 and 7 years of age (n=6).

98% of children enrolled in school (n=286) were reported to have attended school regularly during the last school year (2021-2022).

% of school-aged children attending school regularly (at least 4 days a week) in the 2021-2022 school year while schools were open, by gender[27]:

Girls	Boys
99%	98%

** The sample size for the subgroup for this indicator is small, and therefore the results should be considered indicative only

[27] Children start their learning at UNRWA schools from the age of six. However, of the 20 assessed PRL children of the age of five, only four were reportedly not enrolled in school at the time of data collection.

EDUCATION

DROP OUT OF SCHOOL[28]

12 out of the 33 children who were not enrolled in formal school education reportedly **dropped out of school in the previous school year,** meaning they were enrolled in a given grade at a given school in the 2020-2021 school year but have not been enrolled in the current/2021-2022 school year:

- **Four girls**, including two girls with disability
- **Eight boys**, including one boy with disability

Main reasons for drop-out were*:

- Child dropped-out due to **disability** (n=2)
- Child enrolled / attending non-formal or informal education program; no school in the area/too far from residence; dropped-out due to work; dropped out due to cots of education; age not appropriate for the intended grade level **(each reason reported by one household).**

SCHOOL CLOSURE & DISTANCE LEARNING

Among children enrolled in school (n=286):	
44%	reported the school remained open throughout the school year
51%	were accessing online education while school was closed
4%	were not accessing online education while school was closed

% of HHs with at least one school-aged child who accessed distance learning (n=88), by most common modalities used for remote / home-based learning*:

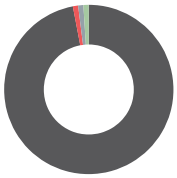
Phone/WhatsApp communication with teachers	**66%**
Online live classes with teachers (video/audio)	**60%**
Learning app on phone/tablet	**24%**
Online materials	**8%**
School textbooks	**8%**

[28] Indicators presented in this fact-sheet focus on formal education and therefore are not indicative on trends concerning non-formal education. Non-formal education programs can however be an important tool for the integration and inclusion of children who are unable to access mainstream education systems.
* Multiple answers allowed

PROTECTION

DOCUMENTATION

% of HHs reporting every person in the household had an ID document[29]:



Yes	97%
No, all HH members have ID but it is not currently in their possession	1%
No, not all HH members have an ID	1%
Don't know	1%

14% of HHs in North governorate reported at least one HH member without an ID document in their possession.

98% **of HHs reported that all HH members had legal residency in Lebanon**

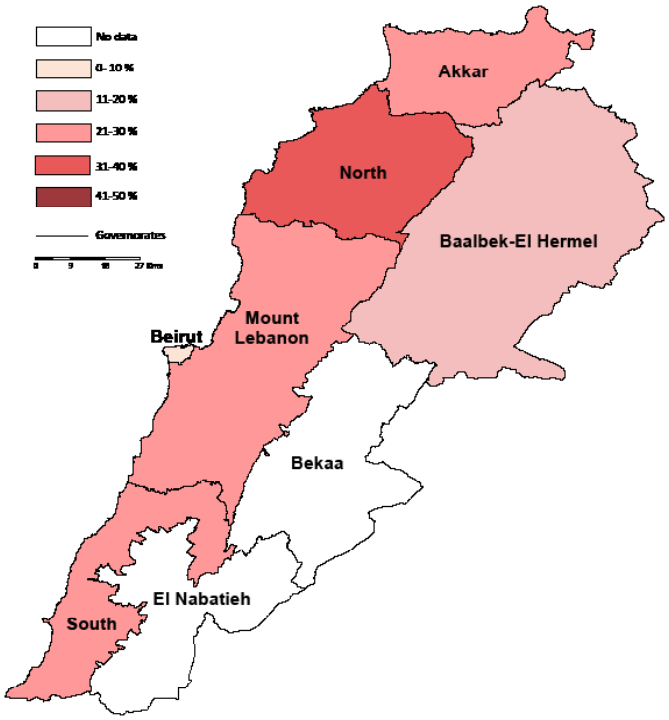
Among 2% of HHs (n=17) without legal residency in Lebanon, the main reason for not having legal residency was being unable to obtain a Lebanese sponsor or pay the fees, as reported by 13 out of 17 HHs.

SAFETY & SECURITY CONCERNS FOR WOMEN IN CERTAIN AREAS

25% **of HHs reported that women and girls avoided certain areas in their location because they felt unsafe there.**

Male headed households reported that women and girls avoid areas and feel unsafe in certain areas almost twice more often than female headed households (27% vs. 17%).

% of HHs reporting areas in their location that women and girls avoided because they felt unsafe:



Top three areas avoided by women and girls, as reported by the 25% of HHs (n=138) who reported that certain areas were being avoided*:

Markets	71%
On the street/in the neighbourhood	45%
On their way to schools	25%

[29] This means person have it, it is valid and it is stored in a secure place
* Multiple answers allowed

PROTECTION

SAFETY & SECURITY CONCERNS

52% **of HHs reported at least one safety and security concern for women in their area**

Top three safety and security concerns for women*:

Being robbed	30%
Verbal harassment	20%
Kidnapping	13%

Safety and security concerns for women were most often reported in Akkar governorate (only 10% reported having no concerns) and least often in Baalbek-Hermel (78% reported lack of concerns).

43% **of HHs reported at least one safety and security concern for men in their area**

Top three safety and security concerns for men*:

Being robbed	24%
Threatened with violence	12%
Kidnapping	15%

In Akkar governorate, safety and security concerns were frequently reported, particularly: **risk of being robbed (52%), being kidnapped (35%) and being threatened with violence (29%).**

CHILD PROTECTION

48% **of HHs reported at least one safety and security concern for girls (females aged < 18 years)**

Top three safety and security concerns for girls*:

Being robbed	24%
Verbal harassment	23%
Kidnapping	14%

Safety concerns for girls were most frequently reported in Akkar governorate, with 56% of HHs having reported risk of being robbed, 30% risk of verbal harassment, and 48% risk of kidnapping.

38% **of HHs reported at least one safety and security concern for boys (males aged < 18 years)**

Top three safety and security concerns for boys*:

Being robbed	26%
Kidnapping	16%
Threatened with violence	10%

Security concerns for boys as well were most often reported in Akkar governorate, i.e., the risk of being robbed (52%), kidnapping (49%), and being threatened with violence (28%).

Top three safety and security concerns for children with disability, among 2% of HHs (n=14) that had at least one child with disability*:

Sexual harassment	27%
Verbal harassment	25%
Kidnapping	4%

1% **of HHs reported the presence of a child engaged in child labour outside of the home** in the 3 months prior to data collection among PRL households with at least one child below 18 (n=204).

SAFETY & SECURITY CONCERNS RELATED TO GENDER-BASED VIOLENCE (GBV)

33% of HHs reported **at least one safety concern related to GBV for women** in their communities

3% of HHs reported **at least one safety concern related to GBV for men** in their communities

35% **of HHs reported at least one safety concern related to GBV for children** in their communities

% of HHs, per reported specific security concerns for women and men related to GBV:

	Women	Men
Suffering from verbal harassment	20%	2%
Suffering from physical harassment or violence (not sexual)	7%	1%
Discrimination or persecution (because of gender identity or sexual orientation)	3%	1%
Sexual harassment or violence	3%	1%

% of HHs, per reported security concerns for girls and boys related to GBV:

	Girls	Boys
Suffering from verbal harassment	23%	8%
Suffering from physical harassment or violence (not sexual)	10%	2%
Discrimination or persecution (because of gender identity or sexual orientation)	3%	2%
Sexual harassment or violence	7%	2%

Number of HHs with child with disability (n=14), per reported security concerns for children with disability related to GBV:*

	Children with disability
Sexual harassment or violence	n=3
Suffering from verbal harassment	n=2

*Multiple answers allowed

ENERGY AND TELECOMMUNICATION

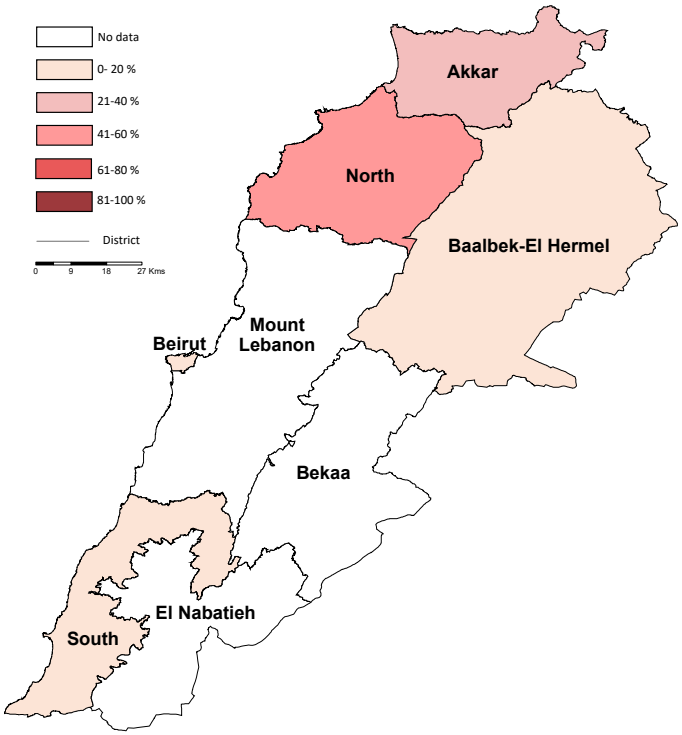
NETWORK COVERAGE

% of HHs per network coverage category:

21%	No coverage at all
19%	Internet coverage only
15%	Voice calls and SMS coverage only
45%	Voice calls, SMS and Internet coverage

No network coverage to use the mobile phone was most frequently reported in North (59%) and Akkar (26%) governorates.

% of HHs with no network coverage to use the mobile phone most days, by governorate:



ENERGY SOURCES

98% **of HHs reported using gas as the energy source for cooking**

In addition to that, 6% of HHs reported using electric powered cooker, and 1% of HHs reported using wood

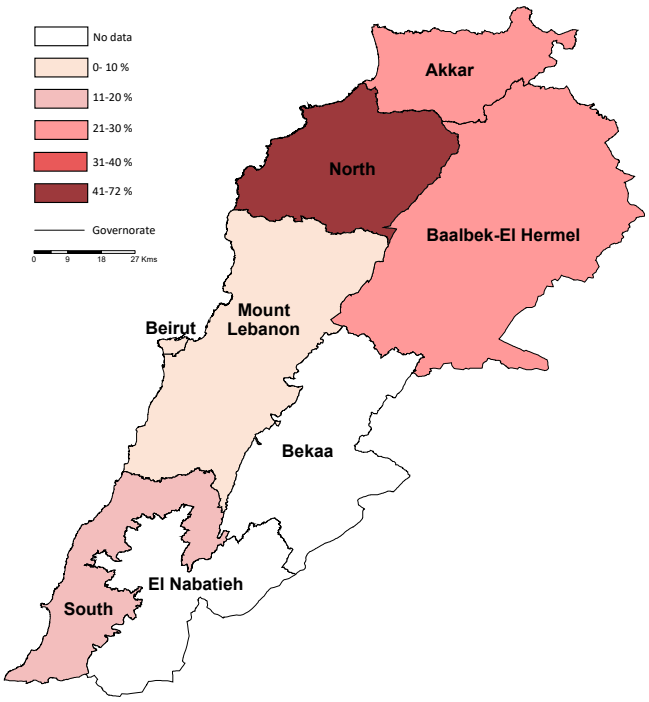
% of HHs by main source of electricity*:

Neighbourhood generator	81%
Main network: Electricité du Liban	56%
Private generator	12%

Main network was least often used in Baalbek Hermel (26%), where 85% of HHs reported using neighbourhood generator and 12% reported using solar panels.

14 **was the average number of hours per day during which HHs reportedly had access to electricity**

% of HHs reporting having had 5 hours of electricity or less per day, by governorate:



COPING MECHANISMS

37% **of HHs reported having adopted at least one strategy to cope with electricity shortages**

35% **of HHs reported not using any coping mechanisms because they did not need to**

24% **of HHs reported not using any coping mechanisms because they had already exhausted all of them**

% of HHs by type of coping mechanisms for electricity shortages reportedly used*:

Reduced electricity consumption	18%
Spent money usually spent on other things	9%
Shared bill with neighbours[30]	6%

*Multiple answers allowed

[30] Meaning: divided the 5 AMP from private/neighbourhood generator between two households

ASSESSMENT CONDUCTED IN THE FRAMEWORK OF:

OCHA United Nations Office for the Coordination of Humanitarian Affairs

FUNDED BY:

LHF Lebanon Humanitarian Fund

USAID FROM THE AMERICAN PEOPLE

Co-funded by the European Union

WITH THE SUPPORT OF:

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