Multi-Sector Needs Assessment Lebanese Households in Lebanon

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).

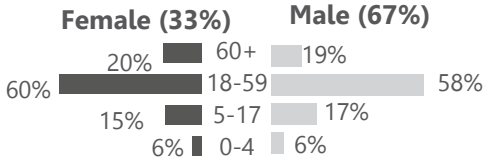
METHODOLOGY

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 Lebanese households specifically.**

The assessed Lebanese HHs were selected by means of a Probability Proportional to Size (PPS) cluster sampling approach where population hexagons (of 1km on each side) were the primary sampling units whose number of clusters (minimum 6 in each hexagon) was based on population density data (divided by average household size). This allowed to have a total sample of 3,944 HHs representative of the Lebanese HHs population at a district 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: 3,944 households*

Demography of HHs members



Single female-headed households: 21%

Average household size: 3.6

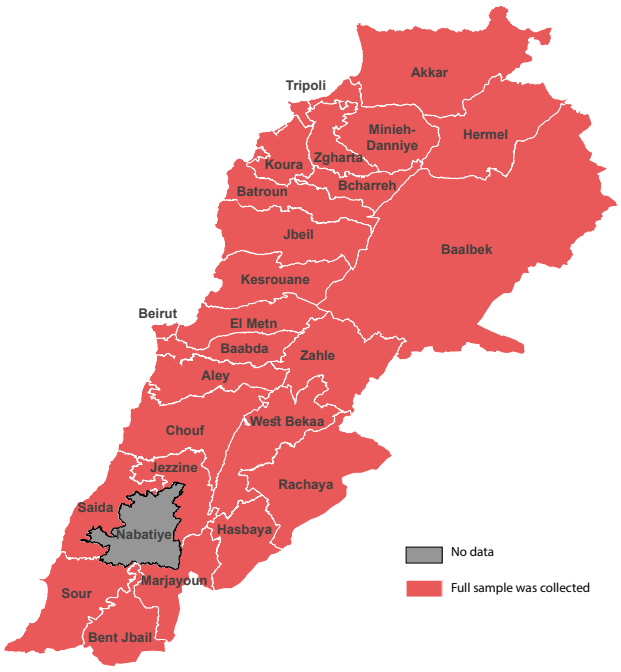
41% of households were with at least one child below 18 years

41% of households were with at least one person above 60 years

22% 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 14,214 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. This will be indicated throughout the factsheet.
- The majority of Lebanese 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 Lebanese HHs within Lebanon. While 2022 MSNA identified needs for Lebanese HHs across all sectors, the most reported essential needs that HHs had trouble meeting were food needs (as reported by 57% of the HHs), health needs (56%) and electricity needs (28%) – often due to financial issues (76%). Moreover, particular concerns were found in terms of livelihoods, with low employment rates and income, while many households reported to be in debt and using (unsustainable) coping mechanisms to get by.

LIVELIHOODS & FOOD SECURITY

Employment - Nearly two-thirds of the Lebanese individuals reported being not working for pay, with 38% 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 fewer women (24%) compared to men (53%) were reportedly working for someone else for pay in the 7 days prior to data collection. Only 11% of those not invloved in income-generating activities 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 (55%), followed by jobs being too far away or the commute being too expensive (37%) and employers preferring to hire individuals of other nationality (20%).

Income, debts and coping mechanisms – Most Lebanese HHs reported generating a very low income in the 30 days before data collection, with one-fifth of HHs (19%) reporting having earnt less than 3 million LBP (±100 USD at the time of data collection), and another third (31%) between 3 and 6 million LBP. The most common sources of income reported by HHs were daily or intermittent work (42%), contracted employment (35%) and support from friends and/or family inside the country (20%). Moreover, 19% of HHs reported relying on savings. Nearly a third (29%) of HHs reported being in debt at the time of data collection, with an average debt of approximately 11.6 million LBP. Reported reasons for taking on debt were often to buy food (55%) and to pay for healthcare (52%), echoing the reported essential needs that Lebanese HHs had trouble meeting.

Food Security - Food was reported as a top three priority need among the majority of Lebanese HHs (71%). Indeed, 2022 MSNA findings found that one-fifth of assessed HHs were either "borderline" (14%) or "poor" (5%) in terms of food consumption score (FCS) and moderate (7%) or severe (1%) hunger, as per the Household Hunger Scale, was found in various assessed HHs as well. The vast majority of HHs (82%) 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 (81%), limiting portion sizes at mealtimes (57%) and reducing the number of meals eaten in a day (39%). Additionally, more than half of households (60%) reported resorting to at least one livelihood coping strategy, including "emergency" type of strategies such as accepting high risk, dangerous or exploitative work (4%), involving school-aged children in income generating activities (3%), and selling their house or land (1%).

HEALTH

Health needs - Healthcare was reported as a top three priority need among the majority of Lebanese HHs (76%). One-fifth of Lebanese individuals (19%) reportedly had a health need requiring care in the 3 months before data collection of whom more than a fourth (27%) 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 (67%), followed by hospital-based laboratory or diagnostic procedures (10%).[5] When asked where HH members sought care, most reported to have been examined or have visited in private clinics and other private medical facilities for secondary health care (67%), and the government health centres for primary health care services (24%).

Health barriers – The vast majority of HHs (59%) 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 (78%), cost of consultation (58%) and cost of transportation to the health facility (9%) were the most frequently reported barriers to accessing health care. The cost of medication (53%) and the lack of availability of medication in the pharmacy (50%) or health facilities (e.g. hospital, primary health care center) (39%) were reported as the main barriers to accessing medication.

SHELTER

Shelter types and issues - At the national level, 96% of households reported living in an apartment/house or room, while 2% reported living in concierge room in a residential building and 1% in an active construction site. Numerous households (40%) reported having issues with their shelter, with the most common issues related to a leaking roof (24%), followed by rottenness in the walls or floors (15%). Moreover, 7% of HHs reported having a damaged structure in their shelter. Among those, the highest damages reported were in the roofs followed by in the walls. When asked about issues related to living conditions in their shelters, seventeen percent (17%) reported having at least one issue, such as being unable to keep the shelter warm or cool (5%) and having at least one member of the HHs who sleeps outside or on the floor (4%).

Occupancy arrangements - Several HHs (14%) reported informally leasing or owning a shelter and 17% reported renting a shelter. While the overall average expenditure on accommodation (incl. mortgage, rent, etc.) was reportedly 480.000 LBP per month, HHs renting shelters reported an average monthly rent cost of 2,000,000 LBP, over four times higher. Most HHs (95%) did not report any problems related to housing, land and property, with the most frequently reported problems being inheritance dispute (1%), dispute with tenants (1%) and unlawful or informal occupation (1%).

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

SUMMARY OF KEY FINDINGS

WATER, SANITATION AND HYGIENE (WASH)

Water – While the majority of Lebanese HHs reported having enough water for their various needs, a concerning proportion also reported not having enough water for drinking purposes (3%), personal hygiene purposes (20%) and/or other domestic purposes (37%). Consequently, Lebanese households reported adopting negative coping mechanisms, such as reducing water consumption on other things to drink more (22%) and drinking less water (8%). Nearly all HHs (99%) reported using an improved water source as main source of drinking water, most commonly bottled water (53%), followed by a piped connection to the house (23%).

Sanitation - Most Lebanese HHs reported having a flush or pour/flush toilet (95%) and were not sharing their sanitation facilities with other households (98%). While the majority of households managed their wastewater safely through a connection to a communal lined drainage and sewage system (72%) or through covered and lined septic tanks (20%), a concerning 8% also reported to use a hand dug hole in the ground.

Hygiene – Three percent of Lebanese households (3%) reported not using good hygiene practices to wash their hands, meaning they were lacking handwashing facilities or soap at the facilities.Nearly half of the HHs reported facing issues in accessing hygiene non-food items (NFI) (42%), resulting in HHs relying on less preferred types of hNFI (30%) or relying on substitutes (sand, clothing, etc.) (4%). Particularly in terms of menstrual hygiene materials (MHM), over a quarted (27%) of households with female members reported problems in obtaining MHM due to the high cost. Lastly, most HHs were relying on municipalities to collect their dumpsters (87%) or on NGOs (9%). At the same time, nearly a third of HHs (30%) 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 Lebanese children aged 5-17 were reportedly not enrolled in a formal school during the 2021-2022 school year, with the highest proportion of children not being enrolled found in Hermel (10%) and Tripoli (8%) districts. Reasons cited for having children not enrolled in school varied from the expensive cost of education, being enrolled in a non-formal school or the age of the child being inappropriate for school. Children who were enrolled in formal schools mostly went to public schools (48%) or private schools (46%) and most were reportedly attending school regularly (at least 4 days per week) (97%). Roughly half of Lebanese HHs (54%) reported schools had been closed during the 2021-2022 school year, among whom 50% had access to distance learning, using mainly online live classes with teachers (84%).

[6] Information International, Lebanese emigrants 815,000 in three decades, November 2022

PROTECTION

Vulnerabilities – Overall, over half of Lebanese HHs (52%) reported having at least one member with a vulnerability, meaning a member with a disability (22%), a member older than 60 years (43%) or a female member who was pregnant or lactating at the time of data collection (6%).

Safety and security – Overall, safety and security concerns have been reported across all gender and age groups (i.e., for boys, girls, woman 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 and Tripoli districts, followed by the South and the North.

Gender-based violence (GBV) and protection from sexual exploitation and abuse (PSEA) – One-tenth of Lebanese HHs reported that girls and women avoid certain areas because they feel unsafe there (11%). Overall, markets, streets and public transportation were reported as the main locations of concern. Moreover, it was reported by 8% of HHs that children with a disability suffered from non-sexual physical harassment or violence and by 1% of HHs that they suffered from sexual harassment or violence, most commonly reported in Tripoli district. Several HHs also reported that women (4%) and girls (3%) suffered from non-sexual physical harassment or violence.

POPULATION MOVEMENT

Since the start of the crisis, many Lebanese have left the country. Information International estimates that a total of 875,000 people have left the country between 2019 and 2022, compared to 600,000 people who left between 1992 and 2018.[6] The MSNA found that 6% of Lebanese HHs were expecting to move to another country outside of Lebanon within the three months after data collection and another 13% reported not to know yet if they would move. Among the HHs who did not expect to leave within the 3-month timeframe, 6% did expect to move to another country within the next 12 months, indicating that the wave of emigration is likely to continue throughout the next year.

ENERGY AND COMMUNICATION

At the time of data collection, 4% of assessed Lebanese HHs reported having had no network coverage at all, with the highest percentage being in Akkar district (10%). In terms of electricity, most HHs reported using the main network (77%) and the neighbourhood generator (73%) which provided an average of 12 hours of electricity per day while a considerable number of HHs (14%) also reported receiving less than 5 hours of electricity per day. Consequently, one-third (30%) of HHs reported having adopted at least one strategy to cope with electricity shortages, most often reducing electricity consumption (21%) or having to get electiricty from outisde of the HH (4%).

LIVELIHOODS

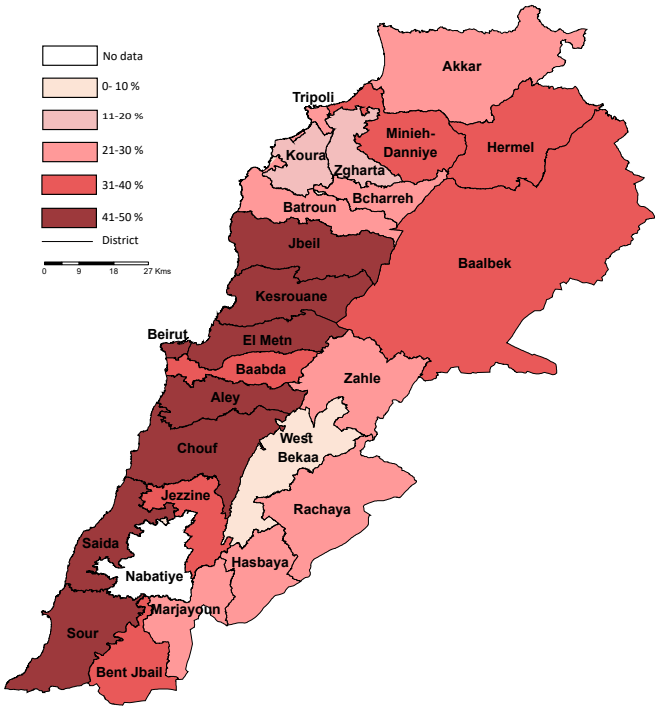
LIVELIHOOD AND EMPLOYMENT

71% **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

38% **of working age individuals were** reportedly working for someone else for pay in the week prior to data collection

24% of female working age individuals were reportedly working for someone else, compared to 53% of male working age individuals.

% of individuals working for someone else for pay in the 7 days prior to data collection, by district:



In addition to individuals working for someone else:

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

Out of 62% (n=6,881) of individuals who were reportedly not involved in income-generating activities:

11% 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 Zahle (27%) and West Bekaa (18%), while the lowest proportions were found in Saida, Sour an Bent Jbeil districts (5% each).

A comparably higher proportion of individuals looking for jobs was reportedly among males (17%) than among females (7%).

82% 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 (25%), than females (14%).

Among the HHs who reported having at least one unemployed working-aged member who was seeking for a job (n=606), top reported barriers to employment were*:

Increased competition, not enough jobs	55%
Jobs too far away/ commute too expensive	37%
Employers preferred someone of other nationality	20%

ABILITY TO MEET BASIC NEEDS

82% **of HHs reported having troubles meeting essential 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	57%
Health needs	56%
Electricity	28%

Most frequently reported reasons driving difficulties in meeting essential needs, among 82% of HHs reporting such difficulties*:

Financial issues	76%
Loss or reduced employment	14%
Access/availability issues	10%

*Multiple answers allowed

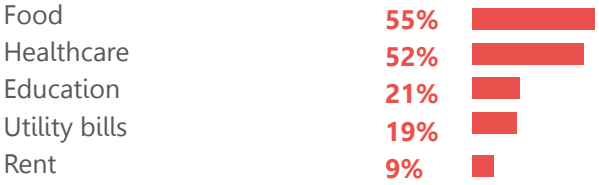
LIVELIHOODS

HOUSEHOLD'S DEBTS

29% **of HHs reported having informal debt from borrowing money, that has not been paid back yet[7]**

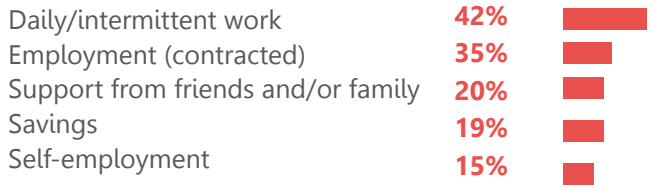
11,605,646 LBP was the average reported debt value, and 18% of HHs reported taking informal debt for an amount higher than 6,000,000 LBP[8]

Among the HHs having informal debt (n=1,363), the main reported reasons were[*]:



HOUSEHOLD'S INCOME

Top five reported sources of income in the 30 days prior to data collection[*]:



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

51% of HHs reported an average monthly income lower than 6,000,000 LBP

Generally, female-headed HHs reported having a lower income in the 30 days prior to data collection than male-headed HHs.

HOUSEHOLD'S EXPENDITURES

Reported average HH expenditures, by expenditure type:

	Average amount[9] 30 days prior to d.c.	Proportion to total spending**
Total expenditure (past 30 days)	**7,785,224**	**100%**
Accommodation (rent, mortgage, etc)	477,167	6%
Medicine & health products	1,492,994	19%
Water	721,823	9%
Hygiene Items	584,564	8%
Energy for cooking (gas & others)	538,570	7%
Communication	639,595	8%
Electricity	2,286,875	29%
Other (e.g.: transport, tobacco, entertainment)	1,290,283	17%
	Average amount 6 months prior to d.c.	-
Debt repayment	3,598,359	-
Health services (excluding medicine)	1,880,122	-
	Average amount 12 months prior to d.c.[4]	-
Education (tuition, transportation, etc)	5,222,375	-

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

[*] Multiple answers allowed
[7] Debt from borrowing money (informal debt) (from friends, relatives, landlord, shopowners) that has not yet been paid back. Based on 3,683 answers, excluding NA
[8] At the time of data collection, 1USD= circa 30.000 LPB, as per www.lirarate.org
[9] Please note that respondents were not asked about the amount spent on food and therefore food category is not included in this table.

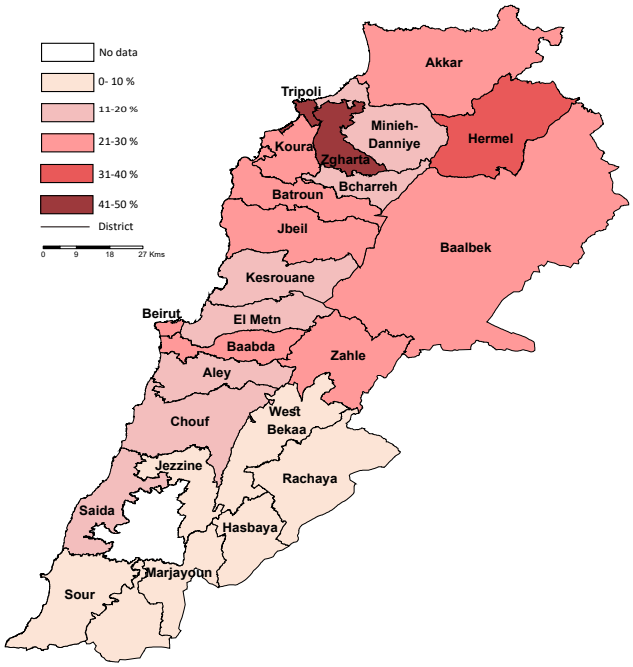
FOOD SECURITY & LIVELIHOODS (FSL)

FOOD CONSUMPTION SCORE

% of HHs by Food Consumption Score (FCS):

80% acceptable | 15% borderline | **5% poor**

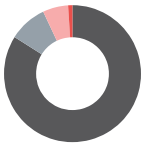
% of HHs with poor or borderline FCS, by district:



Most HHs with poor FCS score were found in Tripoli (23%), Zgharta (16%), and Akkar (16%) districts.

HOUSEHOLD HUNGER SCALE[13]

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



No hunger in the household (85%)

Little hunger in the household (8%)

Moderate hunger in the household (6%)

Severe hunger in the household (1%)

USE OF COPING MECHANISMS

% of HHs by Livelihood Coping Strategy (LCS[10]) category in the 30 days prior to data collection[11]:

36% None | **32% Stress** | **25% Crisis** | **7% Emergency**

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

Reduced non-food expenditures on health	**23%**
Reduced non-food expenditures on education	**16%**
Sold productive assets and/or means of transport	**13%**
Accepted high risk, dangerous or exploitative work	**4%**

Emergency coping strategies were most often reported in Hermel (26%) and Baalbek (22%) districts.

% of HHs by average coping Strategy Index (rCSI[12]):

28% Low | 48% Medium | **24% High**

Twenty seven percent (24%) of HHs was highly relying on consumption-based coping strategies. The district presenting the highest percentage of HHs with a high rCSI score was Akkar (47%).

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 **(81%)**	**4.4**
Limited portion sizes at meal times **(57%)**	**2.8**
Reduced the number of meals eaten in a day **(39%)**	**1.8**
Borrowed food/relied on help from others **(24%)**	**1.1**
Restricted adults consumption so children can eat **(24%)**	**0.8**

[10] 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.

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

[12] 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.

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

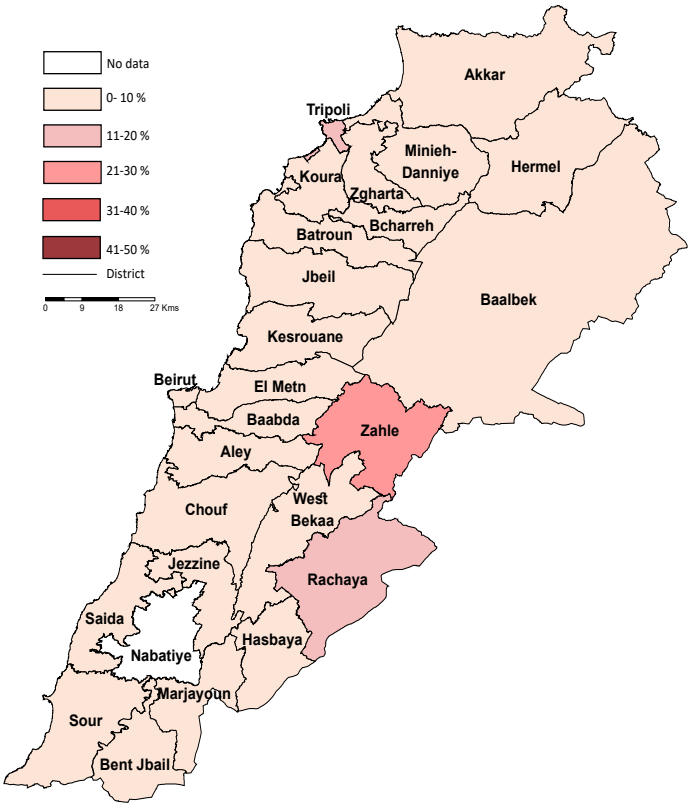
HEALTH

HEALTH CARE NEEDS: ACCESS AND BARRIERS

48% 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.

19% 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 district:



Out of 19% of individuals in need of accessing health care services (n=3,130), **72% and 27% respectively reported Primary Health Care (PHC) and Secondary Health Care (SHC)** as their main need.[14]

Out of 19% of individuals with health care needs, **27% were not able to obtain health care** when they felt they needed it:

- **26% of individuals with reported PHC need** were not able to obtain health care
- **30% 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=3,129):

Consultation for medication, prevention, check-up, acute or chronic disease or diagnosis	67%
Other specialized services or non-hospital care	2%
Ante-natal or postnatal services	1%

Type of SHC services needed, among individuals reportedly in need of accessing healthcare services (n=3,129):

Hospital-based laboratory/ diagnostic procedures	10%
Elective non-life saving surgery	5%
Emergency life saving surgery (trauma care...)	5%

Most frequently reported facilities where individuals sought PHC and SHC services, among individuals with health care needs (n=3,129):

For PHC services:

Private clinic or other private facility	34%
Government health centre	24%
NGO clinic including UNRWA	2%

For SHC services:

Private hospital	15%
Governmental hospital	9%
NGO clinic including UNRWA	<1%

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:

	Private clinic/ medical facility	Gov. health center	Private hospital
Akkar (n=206)	24%	47%	6%
Baalbek-Hermel (n=340)	24%	46%	10%
Beirut (n=91)	48%	16%	18%
Bekaa (n=453)	35%	25%	12%
Mount-Lebanon (n=463)	34%	13%	19%
Nabatieh (n=337)	32%	27%	7%
North (n=914)	27%	37%	10%
South (n=313)	45%	22%	16%

[14] 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 48% HHs with health care needs:

The highest proportions of households with unmet healthcare needs were reported in **Baabda district** (56%) and **Chouf district** (40%).

The average time spent by the HHs to reach the nearest functional health facility by the usual mode of transportation was **13 minutes**.

Top five self-reported barriers to accessing health care, among HH members reporting unmet health care need (n=438)*:

Cost of treatment	78%
Cost of consultation	58%
Tranportation to health facility	9%
Unavailability of specialized treatment	9%
Long waiting time service	8%

% of HHs by self-reported coping mechanisms for barriers to access health care, among HHs that experienced such barriers (n=438)*:

Delayed/cancelled treatment/doctor visit	40%
Switched to a public HC instead of private	22%
Delayed/cancelled diagnostic procedures	25%
Went to pharmacy instead of clinic	16%
Home remedy	18%

59% of HHs reported **not having any type of health insurance**

Types of health insurance reported among Lebanese HHs:

None	59%
Yes, National social security funds[15]	15%
Yes, private insurance-self pay	11%
Yes, public (army, security forces...)	9%
Yes, public, health sector staff	4%
Yes, private insurance-through employer/ professional syndicate	3%

MEDICATION: ACCESS, BARRIERS & COPING MECHANISM

Out of 48% (n=2,023) HHs with health care needs:

95% of HHs reported **the need to access medication** in the 3 months prior to data collection.

41% 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=2,023)*:

Cost of medication	53%
Medication not available in pharmacy	50%
Medication not available in health facility	39%

% of HHs by self-reported coping mechanisms for inaccessibility of medication, among HHs who reported barriers to accessing medication (n=1,728)*:

Switched to substitutes /generics	76%
Got medication from outside Lebanon	30%
Rationed existing medication	28%

SEXUAL & REPRODUCTIVE HEALTH

5% **of women 15-49 years old** were reportedly **pregnant or lactating at the time of data collection**

3% **of women 15-49 years old** were reported to **have given birth in the 2 years prior to data collection**

% of women who gave birth in the 2 years (n=143) prior to data collection by type of facilities where women reportely gave birth:

Private hospital	61%
Public hospital	34%
NGO hospital/center includes UNRWA	1%
At home with professional care	1%
At home with non professional care	1%
Other	1%

Out of the 143 women who have given birth in the 2 years prior to data collection, 26% had reportedly received antenatal care less than 4 times during pregnancy.

*Multiple answers allowed

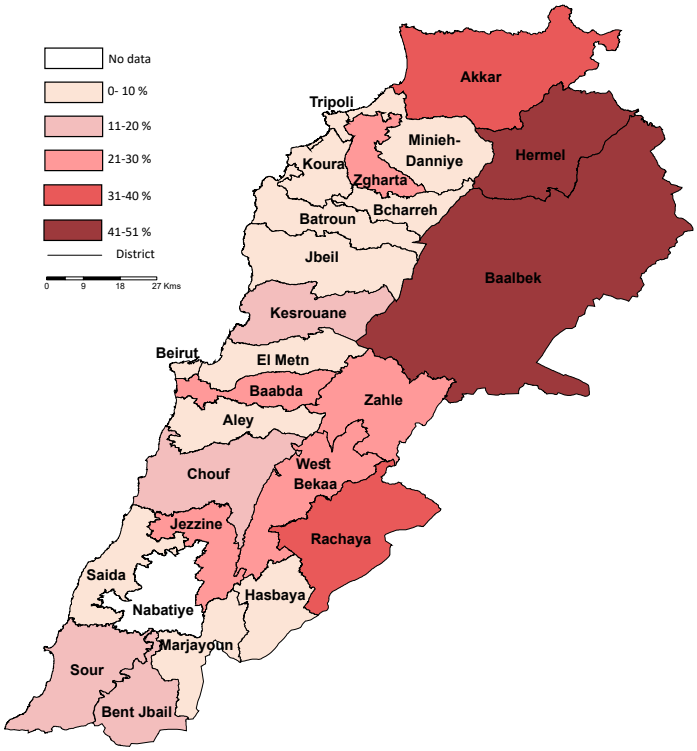
[15] NSSF coverage is based on the old LBP - USD exchange rate and offers very limited insurance.

VACCINATION AND NUTRITION

ROUTINE VACCINATION: ACCESS, & BARRIERS

20% of 1,543 HHs with children reported **experiencing barriers to receiving routine vaccination** for their child (other than COVID-19) 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 COVID-19) in the 6 months prior to data collection, by district:



% of HHs by **self-reported barriers to receiving routine vaccination (other than COVID-19)** for their child, among HHs with children (n=1,543)*:

Cost of receiving vaccines (transportation...)	9%
Unavailability of vaccine in the community	5%
Fear of vaccine side effects	3%

5% of HHs with children **reported vaccination hesitancy as barrier to receiving routine vaccination for their child / children**[16]

NUTRITION

There were 152 infants (children under 1 year of age) in the assessed households. Of them,131 were breastfed.

% of breastfed children, by the time they were put to breast after birth (n=131)

Immediately / within the 1st hour of birth (68%)

After 1st hour and during the first day (22%)

After 1st day (after 24 hours) (9%)

Dont know (1%)

Out of 115 infants aged between 6 and 23 months, **53% (n=52) were reported to have met Minimum Dietary Diversity.**

* Multiple answers allowed

[16] 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"

SHELTER

SHELTER TYPES AND OCCUPANCY ARRANGEMENTS

2% of HHs reported living in impermanent and non-residential shelters[17]

% of HHs, by shelter types:

Apartment/house/room	96%
Concierge's room in residential building	2%
Active construction site	1%

% of HHs, by type of occupancy arrangement:

Ownership	65%
Rental agreement (after 1992)[18]	12%
Informal verbal lease agreement	7%
Informal ownership	7%
Rental agreement (before 1992)	5%

The highest percentage of HHs reporting informal verbal lease agreement as their occupancy arrangement was in Baabda district (13%).

HOUSING, LAND AND PROPERTY (HLP) ISSUES

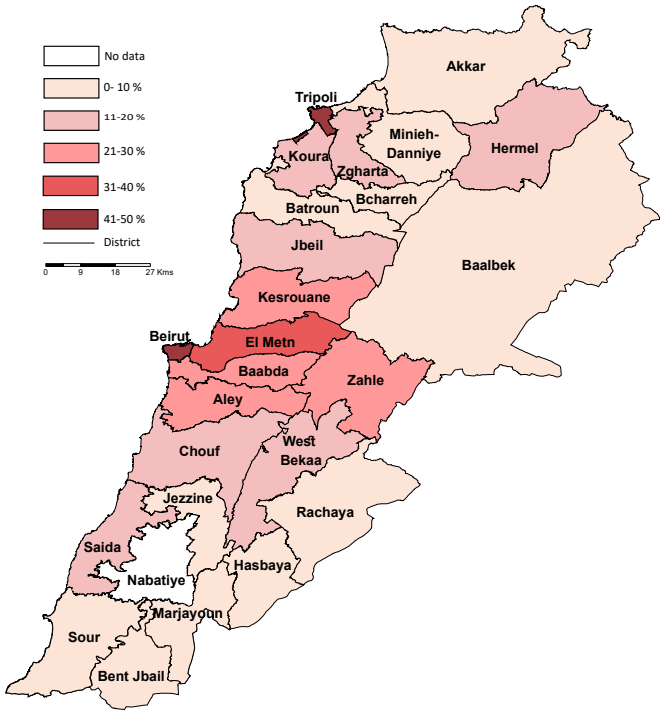
95% of HHs did not report any problems related to housing, land and property

Reported problems were ownership dispute with third party (1%), inheritance disputes (1%), dispute with tenants (1%) and unlawful/secondary/informal occupation (1%)

1% of HHs reported living under a threat of eviction of living under an eviction notice (a total of twenty households)

23% of HHs reported living in a rented shelter at the time of data collection[19]

% of HHs living in rented shelters, by district:



Average reported monthly rent cost in LBP for households' accommodation was 1,971,445 LBP at the time of data collection.

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

[18] 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

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

SHELTER

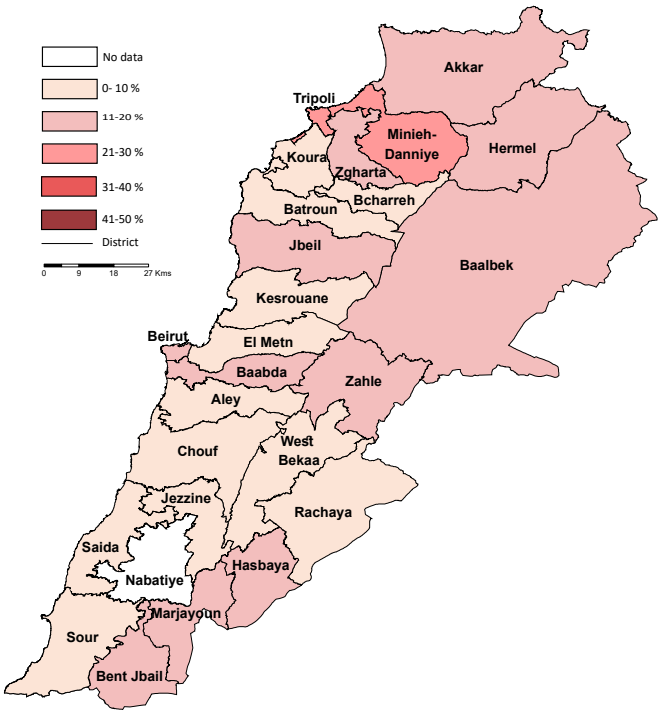
SHELTER DEFECTS, ISSUES AND DAMAGES

12% of HHs were found to live in inadequate shelter standards conditions at the time of data collection[20]

Main reported types of shelter damage, defects, or issues*:

Leaking roof	24%
Leakage/ rottenness in the walls/ floors	15%
Damaged structure (roof, wall, columns)	7%
Lack of insulation from the cold	3%
Windows/doors not sealed	3%
None of the above	60%

% of HHs found to live in inadequate shelter standards conditions[20] at the time of data collection, by district:



% of HHs, among 7% of HHs (n=264) that reported damaged structure, by type of reported damage*:

Damage in the roof	79%
Damage in the walls	69%
Damage in the columns	24%

17% **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 were:

- Being unable to keep the shelter warm or cool (5%)
- Having at least one member of the HHs who had to sleep outside or on the floor (4%)
- Being unable to cook or store food (3%)
- Unable to store water properly (insufficient water containers) (2%)

9% of HHs in Beirut reported not feeling protected in their shelters.

SHELTER SPACE AND CROWDEDNESS

On average, there were 1.34 persons reported per one room in Lebanese households.[21]

11% of HHs reported more than 2 persons per one room in their shelter

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

* Multiple answers allowed

[20] 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

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

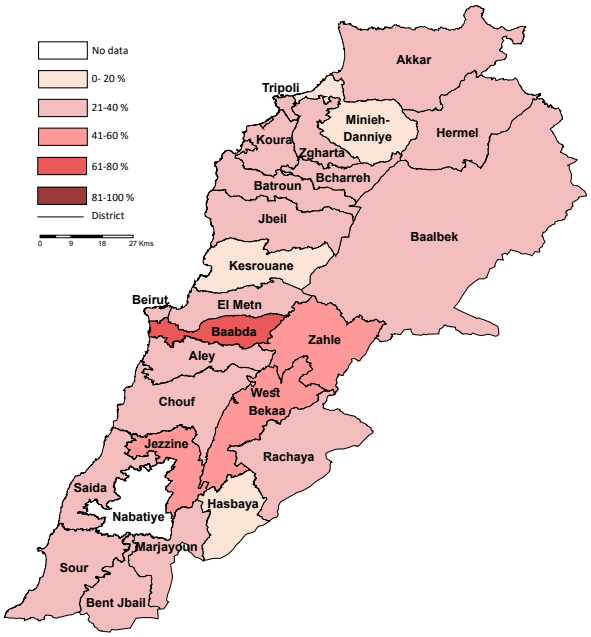
WATER, SANITATION & HYGIENE (WASH)

WATER ACCESS AND AVAILABILITY

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

Drinking	97%
Cooking	96%
Personal hygiene	80%
Other domestic purposes	63%
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 district:



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

Fetch water at a source further away	26%
Reduce water consumption for drinking	22%
Drink less	8%

MAIN SOURCES OF WATER

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

Bottled water	53%
Piped connection to house	23%
Protected spring	8%
Protected borehole or tubewell	5%
Tanker-truck	4%

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	73%
Bottled water	14%
Piped connection to house	4%
Public tap/standpipe	3%
Tanker-truck	3%

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

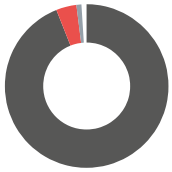
Water on premises	50%
Less than 5 min.	24%
Between 5 and 15 min.	13%
More than 16 min.	2%

% of HHs by person who usually fetches water, as reported by the 50% of HHs who did not have water on the premises*:

Men	60%
All	30%
Women	12%
Boys	6%
Girls	1%

SANITATION

% of HHs by reported sanitation facility used:



Flush or pour/flush toilet (95%)
Pit VIP Toilet (4%)
Pit latrine with a slab and platform (1%)

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

No (98%)
Yes (2%)

Number of HHs that share a sanitation facility with other HHs (74 HHs) reporting that their shared facility:

Can be locked from the inside	n=45
Has adequate lighting	n=40
Has a safe and well-lit route to it	n=30
Segregated by gender	n=3
None of the above	n=12

*Multiple answers allowed

WATER, SANITATION & HYGIENE (WASH)

SANITATION

% of HHs by reported wastewater management system:

Connected to a communal lined drainage and to the sewage system	72%
Covered and lined septic tank/cesspool	20%
A hand dug hole in the ground	8%

WASTE MANAGEMENT

% of HHs by reported waste management method:

Collected by municipality	87%
Collected by NGO	9%
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 (67%)
No (30%)
Don't know (3%)

% of HHs reporting sorting waste, per waste category:

Not sorting any waste	89%
Yes, recyclable waste	6%
Yes, organic waste	5%
Do not know	2%

HYGIENE

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

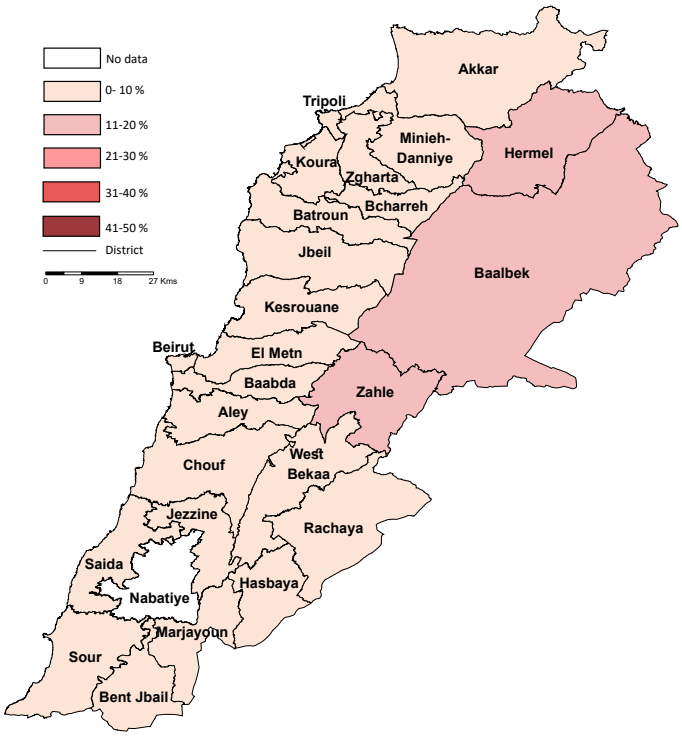
No issues	58%
Relied on less preferred types of hNFI	30%
Had issues but did not try to adapt	6%
Relied on substitutes (sand, clothing,etc)	4%
Bought hNFI at a market place further away	3%
Reduced usage for personal hygiene	2%

% of HHs reporting access to hand-washing facilities[22]:

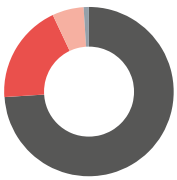
Yes - available with water and soap	95%
Yes - available with only water	2%
No permission to see facility	2%

3% of HHs reported not using good hygiene practices[23] to wash their hands

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



% of HHs with female HH members of menstruating age[24] (n=2,254) by type of problem that female members had to accessing menstrual material



No problem (63%)
MHM were too expensive (27%)
Quality of MHM not preferred (6%)
No woman was available to answer (3%)

* Multiple answers allowed
[22] In addition to that, for 4% of HHs enumerators reported no permission to see hand-washing facility.
[23] 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.
[24] 15-49 years old

EDUCATION

SCHOOL ENROLMENT & ATTENDANCE[25]

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

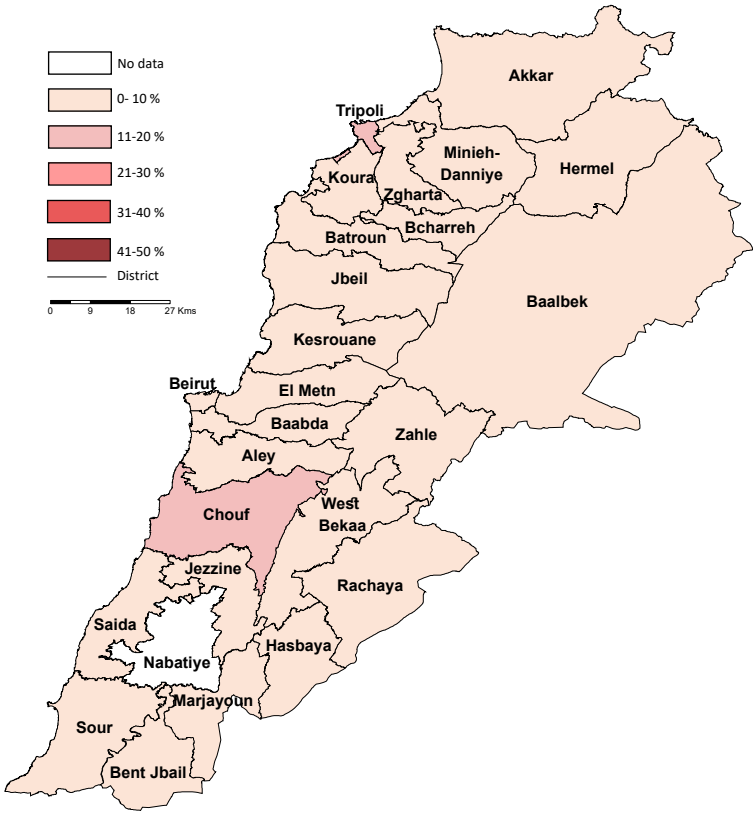
There were, reportedly, 2,467 school-aged children in the assessed households.

94% of school-aged children were reportedly enrolled in a formal school during the 2021-2022 school year.

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

Girls	Boys
95%	94%

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



% of school-aged children enrolled in formal school for the 2021-2022 school year (n=2,330), by type of formal schools:

Public school	48%
Private school	46%
Semi-private school	4%

% 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	3%
From private to public school	13%

Of the 6% children not enrolled in a formal education (n=136), most commonly cited reasons for children not being enrolled:**

Cost of education	52%
Child did not enroll due to disability	7%
Child did not enroll due to work	7%
Age is not appropriate	6%

97% of children enrolled in school (n=2,467) were reported to have attended school regularly during the last school year (2021-2022).

Main reasons for school-aged children not attending school, either in person or at distance, among children enrolled but not having attended school in 2021-2022 school year (n=158):

1	Difficulties with curriculum	31%
2	Cost of education	18%
3	Fear of COVID-19	18%
4	Don't know	12%

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

[25] 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.

EDUCATION

DROP OUT OF SCHOOL

112 out of the 136 children who were not enrolled in formal 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.

Number of school-aged children dropping out of school (n=112) per age and sex group:

Age	Girls	Boys
5-9 years	11	13
10-14 years	5	21
15-17 years	26	36

Of those 112 children that dropped out, 12 had a disability.

Main reported reasons for drop out, as reported by HHs with at least one school-aged child that dropped out of school in the previous school year (n=78)*:

1	Cost of education	53%
2	Age is not appropriate	14%
3	Child does not go due to disability	9%
4	Child does not go due to work	8%

SCHOOL CLOSURE & DISTANCE LEARNING

Among children enrolled in school (n=2,330):

- **46%** reported the **school remained open** throughout the school year
- **50%** were accessing **online education while the school was closed.**
- **4% were not accessing online education while the school was closed**

% of school-aged children accessing distance education, by gender:

Girls	Boys
95%	91%

% of HHs with at least one school-aged child who accessed distance learning (n=609), by most common modalities used for remote / home-based learning*:

Online live classes with teachers (video/audio)	84%
Phone/WhatsApp communication with teachers	32%
Learning app on phone/tablet	13%
School textbooks	3%
Online materials	2%

* Multiple answers allowed

PROTECTION

POPULATION MOVEMENT

3% of Lebanese HHs reported having relocated from one location/district to another inside Lebanon since 2019 as a result of the crisis

6% of HHs reported expecting to leave Lebanon within the 3 months after data collection

13% of HH reported not knowing whether they would leave Lebanon within the 3 months after data collection

Household's movement expectations over the next 12 months, among HHs who did not expect to leave Lebanon in the 3 months after data collection:

Remain in the current location	89%
Moving to another location, outside Lebanon	6%
Moving to another location, inside Lebanon	1%
Prefer not to say	<1%
Don't know	3%

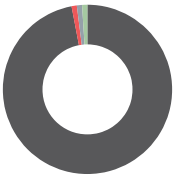
Top reported locations HHs expected to move to, among HHs who expected to leave Lebanon in the 12 months after data collection (n=278):

Don't know	18%
Canada	16%
Germany	13%
France	12%
Saudi Arabia	8%

7% of HHs reported counting at least one member who was expecting to move to another location inside or outside of Lebanon in the 12 months after data collection

DOCUMENTATION

% of HHs reporting every person in the household had an ID document[26]:



Yes	98%
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%

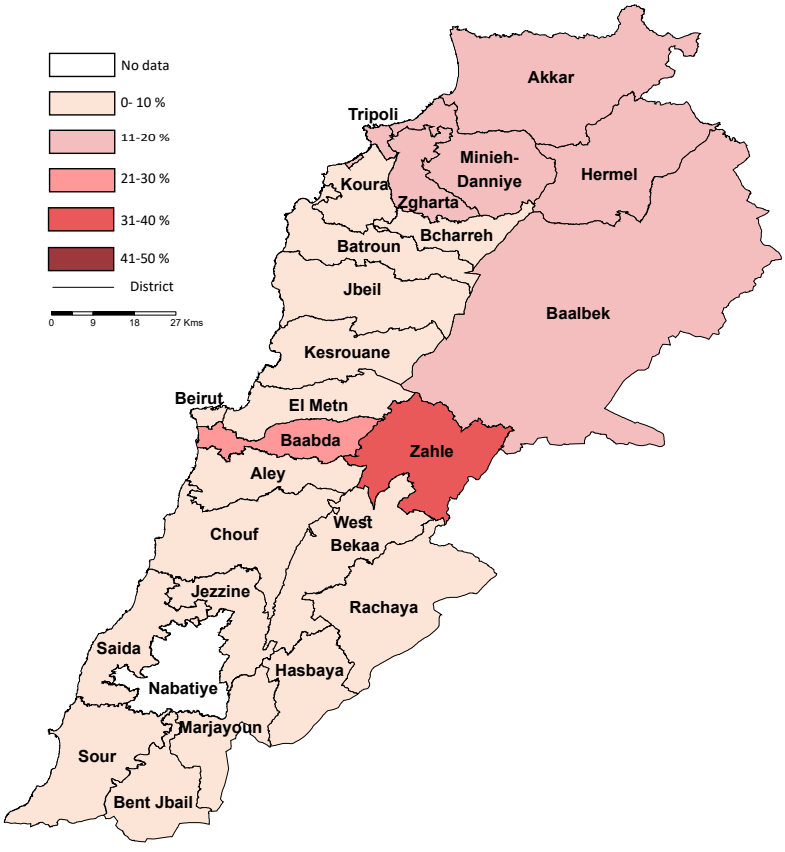
5% of HHs in Sour district reported at least one HH member without an ID document in their possession.

SAFETY & SECURITY CONCERNS FOR WOMEN IN CERTAIN AREAS

11% 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 more often than female headed households (12% vs. 8%).

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



Top three areas avoided by women and girls, as reported by the 11% of HHs (n=328) who reported that certain areas were being avoided*:

On the street/in the neighbourhood	73%
In public transportation	24%
Markets	23%

*Multiple answers allowed

[26] This means the person has it, it is valid and it is stored in a secure place

PROTECTION

SAFETY & SECURITY CONCERNS

30% **of HHs reported at least one safety and security concern for women in their area[27]**

Top three safety and security concerns for women*:

Being robbed	28%
Verbal harassment	4%
Kidnapping	3%

Safety and security concerns for women were most often reported in Baalbeck district (only 45% reported having no concerns) and least often in Hasbaya district (99% reported having no concerns).

31% **of HHs reported at least one safety and security concern for men in their area[1].**

Top three safety and security concerns for men*:

Being robbed	29%
Kidnapping	3%
Threatened with violence	2%

In Baalbeck district, safety and security concerns for men were mostly reported, particularly risk of being robbed (53%).

CHILD PROTECTION

26% **of HHs reported at least one safety and security concern for girls (females aged < 18 years)[1].**

Top three safety and security concerns for girls*:

Being robbed	21%
Verbal harassment	5%
Kidnapping	4%

Safety concerns for girls were most frequently reported in Baalbeck district as well, with 50% of HHs there having reported risk of being robbed, 6% risk of verbal harassment, and 5% risk of physical harrassment.

25% **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	22%
Kidnapping	4%
Threatened with violence	2%

Security concerns for boys, as well were most often reported in Baalbeck district, i.e, 48% of HHs there reported risk of being robbed, kidnapping (2%), and extortion/bribery (2%).

[27] The response option "Don't know" was excluded from safety and security concerns

*Multiple answers allowed

Top three safety and security concerns for children with disability, as reported by HHs with at least one child with a disability (64 HHs)*:

Being robbed	26%
Verbal harassment	10%
Threatened with violence	9%

2% **of HHs reported the presence of a child engaged in child labour outside of the home** in the 3 months prior to data collection

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

6% of HHs reported **at least one safety concern related to GBV for women** in their communities

2% of HHs reported **at least one safety concern related to GBV for men** in their communities

7% **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	4%	1%
Suffering from physical harassment or violence (not sexual)	3%	1%
Discrimination or persecution (because of gender identity or sexual orientation)	<1%	< 1%
Sexual harassment or violence	2%	1%

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

	Girls	Boys
Suffering from verbal harassment	4%	2%
Suffering from physical harassment or violence (not sexual)	4%	2%
Discrimination or persecution (because of gender identity or sexual orientation)	<1%	<1%
Sexual harassment or violence	2%	1%

% of HHs with child with disability (n=64), per reported security concerns for children with disability related to GBV:*

	Children with disability
Suffering from verbal harassment	10%
Physical harassment or violence	8%
Sexual harassment or violence	1%

ENERGY AND TELECOMMUNICATION

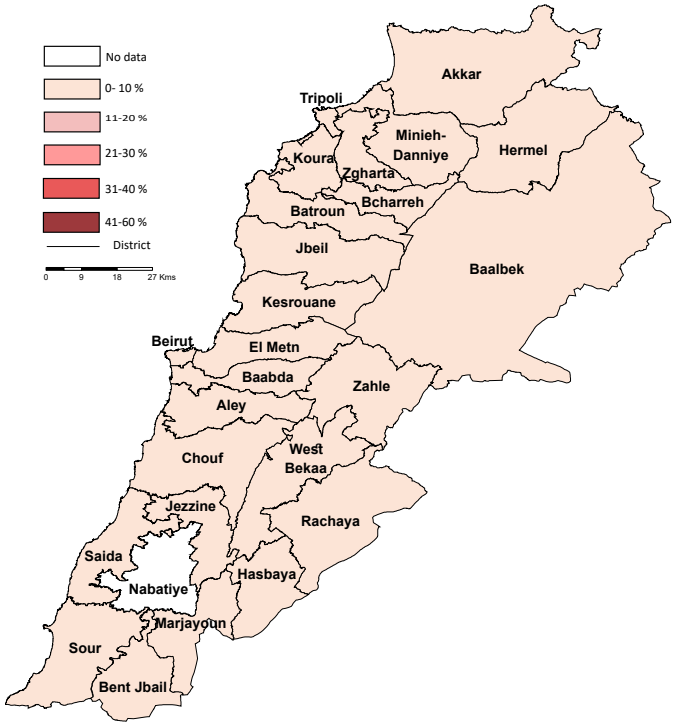
NETWORK COVERAGE

% of HHs per network coverage category:

4%	No coverage at all
11%	Internet coverage only
29%	Voice calls and SMS coverage only
56%	Voice calls, SMS and Internet coverage

No network coverage to use the mobile phone was most frequently reported in Akkar (10%) and Jezzine (9%) districts.

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



ENERGY SOURCES

100% **of HHs reported using gas as the energy source for cooking**

In addition to that, 5% of HHs reported using wood and 2% of HHs reported using electric powered cooker.

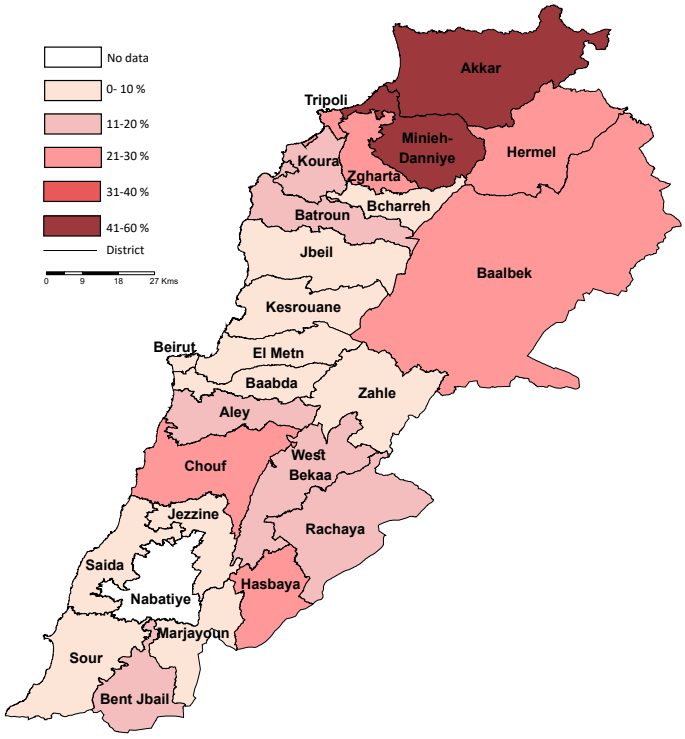
% of HHs by main source of electricity*:

Main network: Electricité du Liban	77%
Neighbourhood generator	73%
Solar panels	9%

Main network was least often used in Baalbek (33%), where 40% of HHs reported using neighbourhood generator and 33% reported using solar panels.

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

% of HHs reporting having an average of 5 hours of electricity or less per day, by district



COPING MECHANISMS

30% **of HHs reported having adopted at least one strategy to cope with electricity shortages**

32% **of HHs reported not using any coping mechanisms because they did not need to**

38% **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	21%
Got electricity from outside the HH[28]	4%
Spent money usually spent on other things	3%

*Multiple answers allowed

[28] Meaning: charging the phone elsewhere, storing food elsewhere, etc...

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:

ACTED

IOM UN MIGRATION

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About REACH:
REACH Initiative facilitates the development of information tools and products that enhance the capacity of aid actors to make evidence-based decisions in emergency, recovery and development contexts. The methodologies used by REACH include primary data collection and in-depth analysis, and all activities are conducted through inter-agency aid coordination mechanisms. REACH is a joint initiative of IMPACT Initiatives, ACTED and the United Nations Institute for Training and Research - Operational Satellite Applications Programme (UNITAR-UNOSAT).