Multi-Sector Needs Assessment Migrant Households in Lebanon

November 2022

Key Sectoral Findings

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.

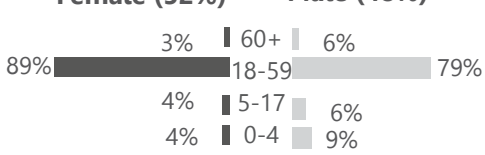
To support an **evidence-based humanitarian response**, the United Nations (UN) Office for the Coordination of Humanitarian Affairs (OCHA) and REACH Initiative (REACH), with support from the Emergency Operation Cell (EOC), have therefore conducted a country-wide Multi-Sector Needs Assessment (MSNA), 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.[7] This factsheet is presenting the findings for migrant households specifically, for which the data was collected by IOM (International Organisation for Migration). The assessed migrant HHs were selected by means of a Probability Proportional to Size (PPS) cluster sampling approach where 18 neighborhoods were the primary sampling units and whose boundaries were based on the latest Migrant Presence Monitoring (MPM)[6] exercise finalized by IOM prior to the MSNA data collection. Both live-in and live-out migrant HHs have been included in the MSNA. Where relevant, findings will be presented for live-in and live-out HHs separately.[5]

Sample: 1,125 households*

Demography of HHs members



% of Migrant HHs
Live-in[5] 70%
Live-out[5] 30%

Average household size: 1.5

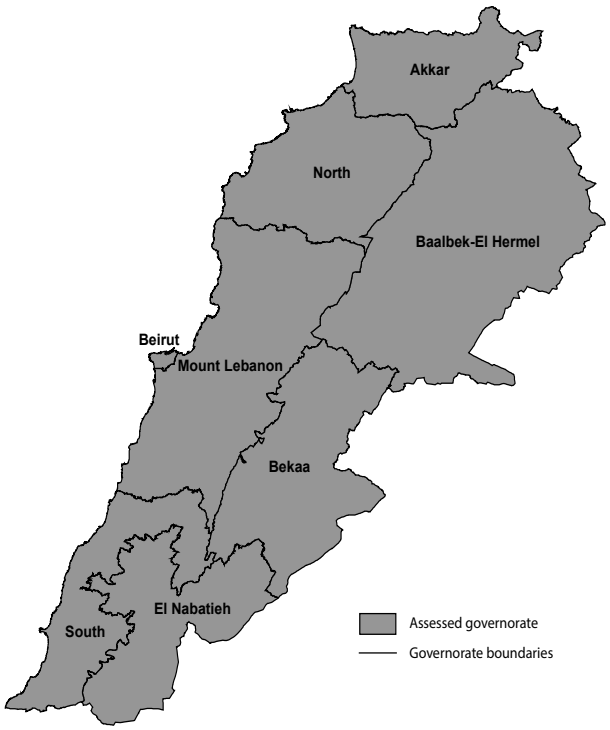
13% of households were with at least one child below 18 years

3% of households were with at least one person above 60 years

5% 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 1,529 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 - as indicated throughout the factsheet.
- A higher number of refusals for live-in (female) migrants was observed in richer areas (especially in Beirut and Mount Lebanon) resulting in an overrepresentation of live-out, male respondents in these areas and an under representation of female migrants in general.
- Data collection took place during August and September which are known as high season months where work is usually more available for freelancers (availability of paid labour, wages etc.)
- While the MSNA samples on a household level, many migrants have moved to Lebanon without family members and are thus one-member households.

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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 affected population has 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
[5] Live-in migrant HHs (n=775) refer to migrant HHs, and predominantly female domestic workers, who live in the same residence as their employer. Live-out migrant HHs (n=322) might have their residence paid for or provided by their employer, or rent it themselves, but it is separate from their employer's residence.
[6] IOM, Migrant Presence Monitoring (MPM), October 2022 link
[7] Data collection for Migrants specifically took place from 17 August to 19 September 2022

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SUMMARY OF KEY FINDINGS

Following the socio-economic collapse of the country and loss of employment opportunities in Lebanon more broadly, the number of migrants residing in Lebanon has decreased significantly from an estimated 207,696 migrants in 2021 compared to 135,420 migrants as per October 2022.[8] The 2021 and 2022 MSNA found concerning and increasing needs among the migrant population residing in Lebanon. While 2022 MSNA identified needs for migrants across all sectors, the most reported essential needs that migrant HHs had trouble meeting were food needs (43%), communication needs (28%) and health needs (24%)– often due to financial issues (79%). Identified needs differed between live-in, often female migrants (migrants living with their employer) and live-out, more often male migrants.

DEMOGRAPHICS AND MIGRATION

Demographics – As part of the MSNA 2022, migrants of 27 different nationalities have been surveyed, the majority of them being Ethiopian (29%), Sudanese (22%), Bangladeshi (19%), and Egyptian (8%). Other nationalities included migrants from the Philippines, Sri Lanka, Sierra Leone, Iraq, Ghana, Kenya, and Nepal. With an average household size of 1.5, many households (82%) consisted of only one member, often individuals who moved to Lebanon to seek employment.

Movement intentions – In line with the exit trend identified by IOM, according to MSNA data, 15% of migrant HHs were expecting to either return to their country of origin (10%) or move to another location outside of Lebanon (5%) in the three month after data collection. Additionally, among those who expected to remain in Lebanon for at least the 3 months post data collection, another third (35%) of HHs expected to leave Lebanon within 12 months after data collection. Particularly among live-out HHs, where 20% expected to return to their country of origin willingly, a concerning 5% also expected to be returning to their country of origin against their will and another 15% expected to move to another location outside of Lebanon within this time period.

HEALTH

Health Needs - Healthcare was reported as a top three priority need among half of HHs (46%). One out of five individuals (21%) reportedly had a health need requiring care in the 3 months before data collection of whom 28% were unable to obtain the care they needed. Primary health care consultation for medication, prevention, check-ups, acute or chronic disease or diagnosis (65%) was the most reported health care need, followed by hospital-based laboratory or diagnostic procedures (6%).[9] When asked where HH members sought care, most live-in migrant HHs reported visiting private facilities (57%), while live-out HHs often reported going to public facilities (32%) or not seeking healthcare at all (14%).

Health Barriers –The majority of live-out HHs (68%) reported not being covered by any type of health insurance while most live-in HHs reported having a private insurance through their employer. Among both groups, the affordability of healthcare and medication was cited as a key barrier to accessing it. Cost of treatment, cost of consultations and the cost of transportation to the facility were most frequently reported barriers to accessing health care, and the cost of medication as the main barriers to accessing medication.

[8] IOM, Migrant Presence Monitoring, October 2022.

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

LIVELIHOODS & FOOD SECURITY

Employment – Over half of adult individuals reported being employed, with 58% of the working-aged individuals reporting having worked for someone else for pay in the 7 days prior to data collection and another 3% reporting being involved in other type of income generating activities such as farming or helping in the family business. Slightly more adult males were reportedly working for someone else for pay (62%) compared to females (51%) and most households had at least one HHs member working in the week prior to data collection (70%). Among those not involved in income-generating activities, 21% reported looking 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, followed by employers' preference for individuals with Lebanese nationality.

Income, debts and coping mechanisms – Overall, HHs reported generating a very low income in the 30 days before data collection. Almost three quarter of live-out HHs (73%) reported earning less than 6 million LBP (±200 USD), with 36% reporting having earned between 3 and 6 million and 37% even reported earning less than 3 million LBP in the month prior to data collection. The most common sources of income reported by HHs were contracted employment (70%) and daily or intermittent work (32%). Numerous HHs (28%) reported being in debt at the time of data collection, with an average debt of approximately 0.6 million LBP for live-in and 5.8 million LBP for live-out HHs. Reported reasons for taking on debt were often to buy food (68%) and to pay for healthcare (29%), echoing the reported essential needs that migrant HHs had trouble meeting. Some migrant HHs also reported having migration-related debt (12%).

Food Security - Food was reported as a top three priority need among the majority of HHs (64%). Indeed, 2022 MSNA findings found that a third of assessed HHs were either "borderline" (23%) or "poor" (9%) in terms of food consumption score (FCS) and moderate (17%) or severe (1%) hunger, as per the Household Hunger Scale, was found in one out of every five assessed HHs. The vast majority of HHs (63%) reported using 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 (61%), limiting portion sizes at mealtimes (48%) and reducing the number of meals eaten in a day (36%). Additionally, roughly half of households (51%) reported resorting to at least on livelihood coping strategies, including "emergency" type of strategies such as accepting high risk, dangerous or exploitative work (9%), begging (4%) and involving school-aged children in income generating activities (1%).

SUMMARY OF KEY FINDINGS

SHELTER

Shelter types and issues - At national level, the vast majority of live-in HHs (95%) reported living in an apartment/house or room, while only two-third of live-out HHs reported living in a house/apartment (64%) and the other third reported living in a concierge room in a residential building room (34%). Nearly half (49%) of live-out HHs reported having issues with their shelter, with the most common issues related to leakage or rottenness in the walls and floors (24%), leaking roof (23%), followed by lack of insulation (8%). Moreover, 4% of migrant HHs reported having damaged structure in their shelter. Among those, the highest damages reported were in the walls and roofs. Overall, most migrant HHs reported no issues in terms of the living conditions inside their shelters (89%), though one-tenth of live-out HHs reported being unable to keep the shelter warm or cool (12%) and some also reported having at least one member of the HH who sleeps outside or on the floor (7%).

Occupancy arrangements - Most live-in and live-out HHs reported that their shelter was being provided by their employer (54% and 44% respectively). Moreover, a third (29%) of live-in HHs reported being hosted for free, while live-out migrants often had a formal (24%) or informal verbal (19%) rental agreement with an average monthly rent cost of 1,349,000 LBP. Most HHs (97%) did not report any problems related to housing, land and property, however some HHs reported being under threat of eviction (2%) and having disputes with tenants (1%) or unlawful or informal occupation (1%) – both reported by live-out migrants only.

EDUCATION

Among the assessed migrant HHs only 5% reported having at least one school-aged child (aged 5-17), resulting in an overall subgroup of 89 school-aged children. As such education related findings should be considered indicative only. Twelve (12) out of the 75 school-aged children were reportedly not enrolled in a formal school during the 2021-2022 school year. Reasons cited for having children not enrolled in school varied from the cost of school, having to work or there being no space in the school. All 12 out of 12 children who were not enrolled in formal education reportedly dropped out of school in the previous school year. Children who were enrolled in formal schools went to both public (46%) and private (40%) schools and all were reportedly attending school regularly (at least 4 days per week). Most migrant HHs (82%) reported schools had been closed during the 2021-2022 school year, among whom 76% had access to distance learning, mainly through phone or Whatsapp communication with teachers.

WATER, SANITATION AND HYGIENE

Water – While the majority of HHs reported having enough water for their various needs, a few HHs also reported not having enough water for drinking purposes (1%), personal hygiene (6%) and for other domestic purposes (18%). Consequently, migrant households reported adopting negative coping mechanisms, such as reducing water consumption for other than drinking purposes (18%) and relying on less preferred (unimproved/untreated) water sources (17%). Nearly all HHs (99%) reported using an improved water source as main source of drinking water, most commonly bottled water (62%), followed by a piped connection to the house (13%).

Sanitation - Most HHs reported having a flush or pour/flush toilet (96%) and were not sharing their sanitation facilities with other households (79%). While most households managed their wastewater safely through a connection to a communal lined drainage and sewage system (47%) or through covered and lined septic tanks (46%), a concerning 6% also reported to use a hand dug hole in the ground.

Hygiene – Several households (15%) reported not using good hygiene practices to wash their hands, meaning they were lacking handwashing facilities or soap at the facilities. Moreover, numerous HHs reported facing issues in accessing hygiene non-food items (hNFI) (40%), resulting in HHs relying on less preferred types of hNFI (24%) or having to buy them at marketplaces further away (7%). Specifically in terms of menstrual hygiene materials (MHM), one-tenth (8%) of live-in and more than half (54%) of live-out HHs with female members reported problems in obtaining MHM, mainly due to the high cost. Lastly, most HHs were relying on municipalities to collect their dumpsters (89%) and a small proportion on NGOs (7%). However, over a third of HHs (25%) 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.

SUMMARY OF KEY FINDINGS

PROTECTION

Vulnerabilities – Overall, only few HHs (11%) reported having a member with a vulnerability, meaning a member with a disability (5%), member older than 60 years (3%) or a female member who was pregnant or lactating at the time of data collection (8%).

Safety and security – Safety and security concerns were reported for all gender and aged 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, namely being robbed and being threatened with violence. For girls and women specifically, suffering from sexual harassment or violence was also among top reported concerns. Security concerns for all groups were most frequently reported by HHs in Akkar governorate. Among households with a child (<18), 3% had reported the presence of a child engaged in child labour outside of the home and 11% reported having an underaged member involved in early marriage.

Gender-based violence (GBV) and protection from sexual exploitation and abuse (PSEA) – Over one-tenth of live-out HHs (11%) and 5% of live-in HHs reported that girls and women avoid certain areas because they feel unsafe there. Overall, markets, streets and public transportation were reported as the main areas of concern, particularly in Beirut, North and Akkar governorates.

Documentation – While the majority of live-in households reported every person in their HHs had an ID document at the time of data collection (98%), a quarter of live-out HHs reported having members without ID documentation (22%), particularly in Beirut and Mount Lebanon governorates. Furthermore, nearly half of live-out migrants (45%) reported having HH members without legal residency in Lebanon, most commonly because they were unable to obtain a Lebanese sponsor or to pay the fees (45%), their residency expired and it is not renewable (18%) or because they had entered through unofficial border crossing (17%).

ENERGY AND COMMUNICATION

At the time of data collection, 5% of assessed migrant HHs reported having had no network coverage at all, with the highest percentage being in the Bekaa (9%) and North (7%) governorates. In terms of electricity, most HHs reported using the main network (73%) and a neighbourhood generator (42%) which provided an average of 14 hours of electricity per day. Consequently, one-fifth of live-out HHs (20%) of HHs reported having adopted at least one strategy to cope with electricity shortages, most often reducing electricity consumption (8%) or getting electricity from outside the household (charge phone elsewhere, store food elsewhere...) (4%). Concerningly, nearly a third of live-out migrant HHs (28%) reported not using any coping mechanisms not because they did not need to, but because they had already exhausted their options (48%).

LIVELIHOODS

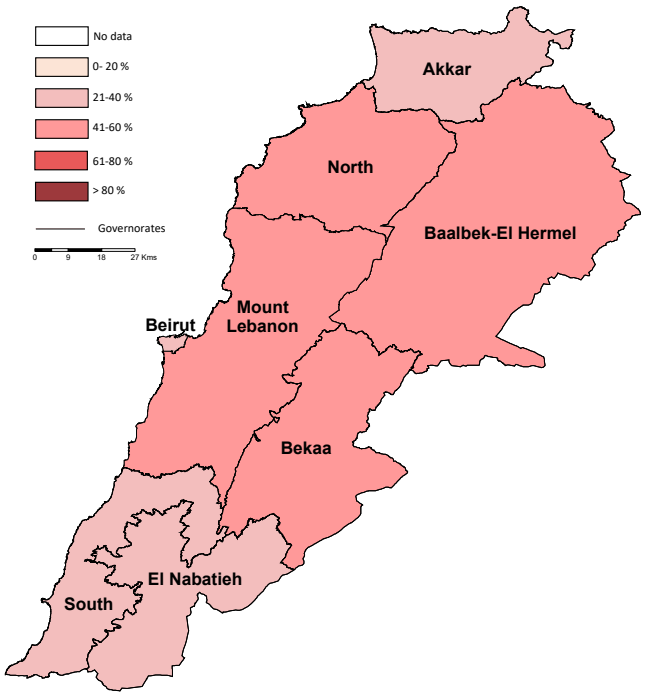
LIVELIHOOD AND EMPLOYMENT[10]

70% **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

58% **of working age HH members were** reportedly working for someone else for pay in the week prior to data collection

51% of female working age members were reportedly working for someone else, compared to 62% 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:

- **3%** of individuals were reportedly **running some kind of business, farming, or other activity to generate income;**
- **Less than 1%** of individuals **were helping in family business or farm.**

Out of 38% (n=210) of individuals who were reportedly not involved in income-generating activities:

21% were looking for a paid job or tried to start a business in the last month prior to the data collection

A comparably higher proportion of individuals looking for jobs was reportedly among females (23%) than among males (17%).

47% 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 (66%), than females (37%).

Among the HHs who reported having at least one unemployed working-aged member who was seeking for a job (n=47), top reported barriers to employment were*:

Increased competition/ not enough jobs	65%
Employers preferred someone of other nationality	29%
Jobs too far away/ commute too expensive	20%

ABILITY TO MEET BASIC NEEDS[11]

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*:

Live-in	Live-out
1. None **(86%)**	1. Food **(57%)**
2. Communication **(9%)**	2. Health **(36%)**
3. Food **(9%)**	3. Communication **(35%)**

Most frequently reported reasons driving difficulties in meeting essential needs, among 60% of HHs reporting such difficulties*:

Financial issues	79%
Access/availability issues	12%
Loss or reduced employment	7%

Only 5% of live-out migrant HHs reported having difficulties meeting needs because of access/availability issues compared to 30% of live-in migrant HHs.

*Multiple answers allowed

[10] This section shows findings on 30% of migrant households (n=322) that were not living with employer at the time of data collection

[11] This section shows findings on all migrant HHs

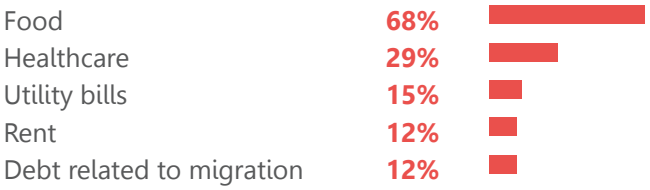
LIVELIHOODS

HOUSEHOLD'S DEBTS

28% of HHs reported having informal debt from borrowing money, that has not been paid back yet[12]

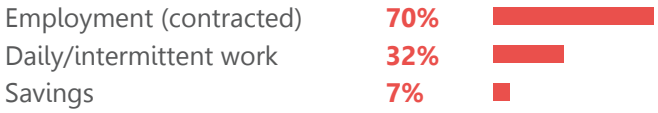
2,806,547 LBP was the average reported debt value, and 9% of HHs reported taking informal debt for an amount higher than 6,000,000 LBP[13]

Among the HHs having informal debt (n=195), the main reported reasons were*:



HOUSEHOLD'S INCOME

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



Only 47% of live-out migrant HHs reported contracted employment as their main source of income in the 30 days prior to data collection in comparison to 93% of live-in migrant HHs.

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

< 1,500,001	8%
1,500,001 to 3,000,000	22%
3,000,001 to 6,000,000	35%
6,000,001 to 15,000,000	32%
>15,000,000	3%

73% of live-out migrant HHs were earning an average monthly income lower than 6,000,000 LBP compared to 41% of live-in migrant HHs.

HOUSEHOLD'S EXPENDITURES

Reported average HHs expenditures, by expenditure type:

	Average amount[14,**] 30 days prior to d.c.[15]	Proportion to total spending***
Total expenditure (past 30 days)	**2,892,291**	**100%**
Accommodation (rent, mortgage, etc)	550,836	15%
Medicine & health products	332,646	11%
Water	302,127	13%
Hygiene Items	244,050	11%
Energy for cooking (gas & others)	343,251	16%
Communication	308,750	12%
Electricity	435,305	10%
Other (e.g.: transport, tobacco, entertainment)	417,362	12%
	Average amount 6 months prior to d.c.[15]	-
Debt repayment	713,562	-
Health services (excluding medicine)	311,896	-
	Average amount 12 months prior to d.c.[15]	-
Education (tuition, transportation, etc)	368,573	-

**Expenditures do not include remittances sent to the country of origin

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

* Multiple answers allowed
[12] Debt from borrowing money (informal debt) (from friends, relatives, landlord, shopowners) that has not yet been paid back. Based on 1,103 answers, excluding NA
[13] At the time of data collection, 1USD = circa 30.000 LBP, as per www.lirarate.org
[14] Please note that respondents were not asked about the amount spent on food and therefore food category is not included in this table.
[15] Data collection (d.c.)

FOOD SECURITY & LIVELIHOODS (FSL)

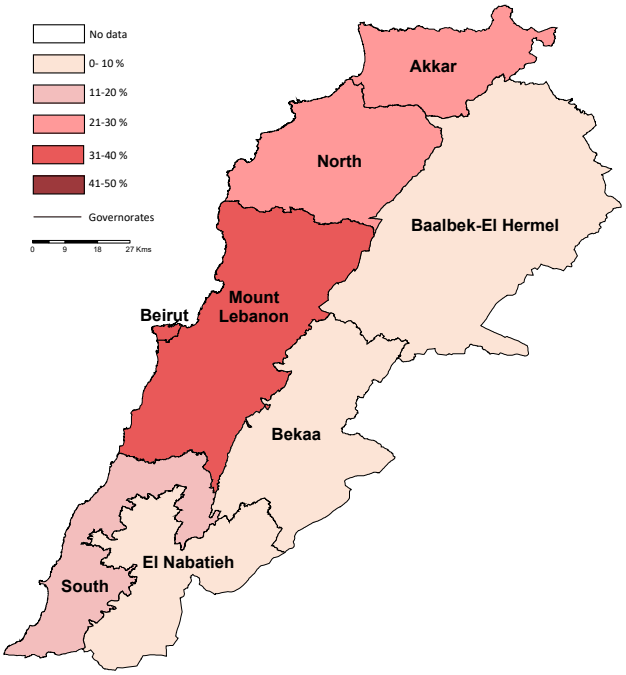
FOOD CONSUMPTION SCORE

% of HHs by Food Consumption Score (FCS):

68% acceptable 23% borderline **9% poor**

Live-out migrants HHs were much less food secure, with 14% having poor, 27% -borderline, and 59% -acceptable (compared to 1%, 8%, and 91% respectively for live-in migrant HHs).

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



Most HHs with poor FCS score were reported in Beirut and Mount Lebanon governorates (12% each).

HOUSEHOLD HUNGER SCALE[19]

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

No hunger in the household (69%)

Little hunger in the household (13%)

Moderate hunger in the household (17%)

Severe hunger in the household (1%)

USE OF COPING MECHANISMS

% of HHs by Livelihood Coping Strategy (LCS[16]) category in the 30 days prior to data collection[17]:

41% None 26% Stress 26% Crisis **7% Emergency**

12% and 31% of live-out migrant HHs reported respectively using emergency and stress coping stratetgies in comparison to 1% and 3% of live-in migrant HHs

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

Strategy adopted	Live-out migrants	Live-in migrants
Reduced non-food expenditures on health	39%	3%
Reduced non-food expenditures on education	27%	2%
Sold productive assets and/or means of transport	15%	2%
Accepted high risk, dangerous or exploitative work	14%	1%

% of HHs by average Consumption-based Coping Strategy Index (rCSI[18]):

45% Low 36% Medium **19% High**

The governorate presenting the highest percentage of HHs with a high rCSI score was Beirut (43%).

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 **(61%)**	2.8
Limited portion sizes at meal times **(48%)**	2.0
Reduced the number of meals eaten in a day **(36%)**	1.6
Borrowed food/relied on help from others **(32%)**	0.9
Restricted adults consumption so children can eat **(10%)**	0.4

Live-out HHs had to rely on less preferred and less expensive food 3.8 days on average, compared to 0.6 days among live-in HHs.

[16] 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.

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

[18] rCSI - The Consumption-based 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.

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

HEALTH

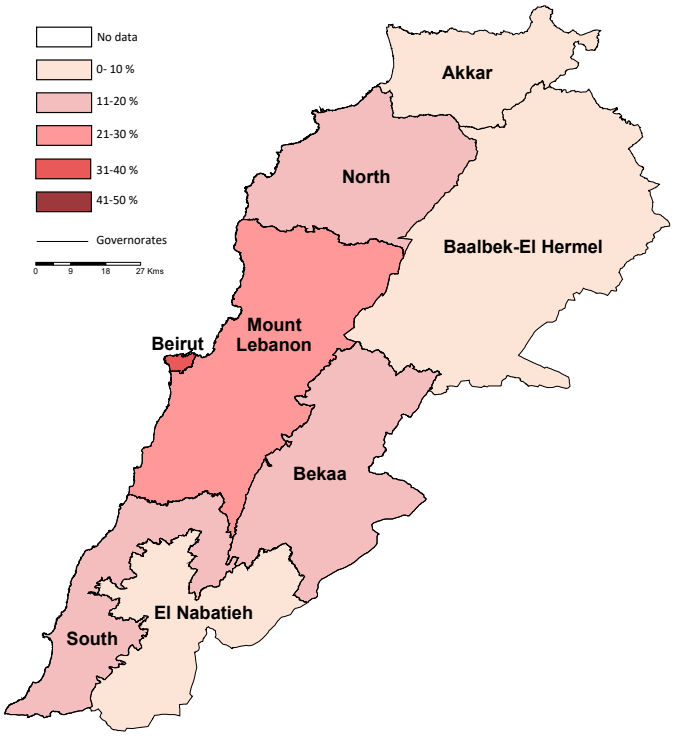
HEALTH CARE NEEDS: ACCESS AND BARRIERS

29% 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.

21% of individuals reportedly had a health problem and were in need to access health care in the 3 months prior to data collection.

Live-in individuals (9%)	live-out individuals (25%)

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



Out of 21% of individuals in need of accessing health care services (n=243), **74% and 25% respectively reported Primary Health Care (PHC) and Secondary Health Care (SHC)** as their main need.[20]

Out of 21% of individuals with health care needs, **28% were not able to obtain health care** when they felt they needed it:

- **31% of individuals with reported PHC needs** were not able to obtain health care
- **15% of individuals with reported SHC needs** were not able to obtain health care

Type of PHC services needed, among individuals reportedly in need of accessing healthcare services:[20]

Consultation for medication, prevention, check-up, acute or chronic disease or diagnosis	65%
Ante-natal or post-natal services	4%
Dental services	2%

Type of SHC services needed, among individuals reportedly in need of accessing healthcare services:

Hospital-based laboratory/ diagnostic procedures	6%
Elective non-life saving surgery	5%
Other specialized services at hospital	5%

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

For PHC services:

Private clinic or other private facility	29%
Government health center	14%
NGO clinic including UNRWA	9%

For SHC services:

Private hospital	14%
Government hospital	6%
NGO hospital including UNRWA	3%

Top five types of facilities where individuals sought health care, among individuals with health care needs (n=243), in the 3 months prior to data collection:

Healthcare facility	Live-out individuals	Live-in individuals
Private clinic/other private health facility (n=60)	19%	37%
Government health center (n=44)	20%	16%
Did not go to seek health care (n=20)	12%	1%
Private hospital (n=29)	8%	17%

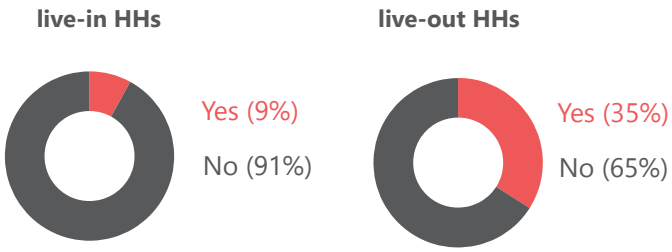
Live-in HHs mostly reported seeking health care in private facilities (57%), while live-out HHs often reported going to public facilities (32%) or not seeking healthcare at all (12%).

[20] 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 28% HHs with health care needs:



Highest proportion of households with unmet healthcare needs was reported in **South governorate** (38%) and **North governorate** (34%).

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 HHs reporting unmet health care need (n=64)*:

Cost of treatment	77%
Cost of consultation	44%
Cost of transportation to health facility	38%
Insurance not honored	19%
Specialised treatment/device unavailable	5%

% of HHs by self-reported coping mechanisms for barriers to access health care, among HHs that experienced such barriers (n=49)*:

Went to pharmacy instead of clinic	34%
No coping mechanisms available to HH	30%
Delayed/cancelled treatment/doctor visit	25%
Home remedy	17%
Switched to a public healthcare	15%

45% of HHs reported **not having any type of health insurance**[21]

Types of health insurance reported among live-in and live-out migrant HHs**

Types of health insurance	Live-out migrant HHs	Live-in migrant HHs
Don't know	<1%	0%
No	68%	9%
Yes, private insurance-self pay	5%	8%
Yes, private insurance-through employer/professional syndicate	27%	83%

MEDICATION: ACCESS, BARRIERS & COPING MECHANISM

Out of 29% (n=207) HHs with health care needs:

91% of HHs reported **the need to access medication** in the 3 months prior to data collection.

100% 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=207)*:

Cost of medication	50%
No barriers to access medication	35%
Insurance not honored	14%

% of HHs by self-reported coping mechanisms for inaccessibility of medication, among HHs who reported barriers to accessing medication (n=112)*:

Borrowed money to afford medication	37%
Switched to substitutes/generics	35%
No coping mechanisms available to the HH	26%

SEXUAL & REPRODUCTIVE HEALTH

8% **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**

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).**

Thirteen women reportedly gave birth in a public hospital, seven- in private hospital, and three- in NGO hospital/UNRWA.

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

* Multiple answers allowed

** The sample size for the subgroup for this indicator is small, and therefore the results are only indicative.

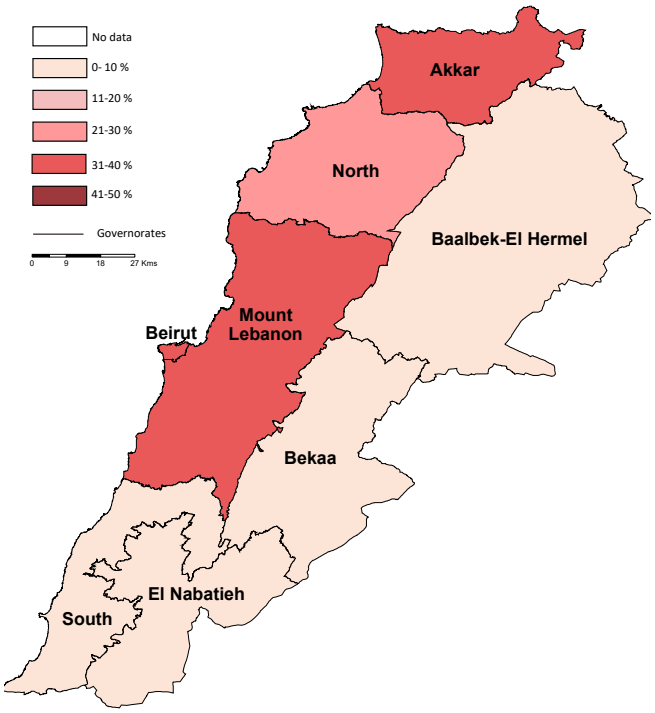
[21] Employers through the kafala system are required to provide health insurance to migrant employees, however, the standard insurance schemes offered to migrants/employers provide little to no coverage. Migrants might not have any insight into this aspect of their contract, the details of their coverage, or even whether they have insurance at all.

VACCINATION

ROUTINE VACCINATION: ACCESS, & BARRIERS

38% of 85 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 reported having experienced barriers to receiving routine vaccination for their child (other than COVID-19) in the 6 months prior to data collection, by governorate:



% of HHs by **self-reported barriers to receiving routine vaccination (other than COVID-19)** for their child, among HHs with children (n=85)*:

Child is not old enough[22]	12%
Vaccine is not available in the community	7%
Long waiting time for the service	6%

3% of HHs with children **self-reported vaccination hesitancy as barrier to receiving routine vaccination for their child / children[23]**

[22].Children in Lebanon start receiving vaccinations from the age of 0 onwards. This might indicate a lack of awareness among HHs reporting "children are not old enough" as a barrier to accessing vaccinations.
[23].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

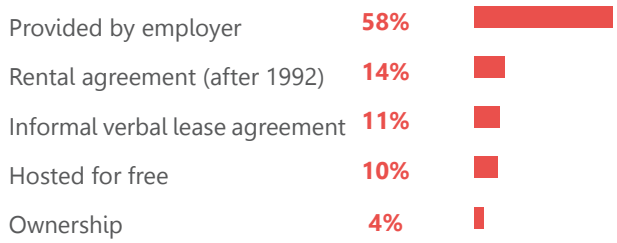
SHELTER TYPES AND OCCUPANCY ARRANGEMENTS

2% of HHs reported living in temporary and non-residential shelters[24]

% of HHs by shelter types:

	Live-in HHs	Live-out HHs
Apartment/house/room	95%	64%
Concierge room in residential bldg	2%	34%

% of HHs, by type of occupancy arrangement:[25]



The highest percentage of HHs reporting informal verbal lease agreement as their occupancy arrangement was in Beirut governorate (23%).

The percentage of female headed households reportedly owning a shelter was higher than the corresponding one for male headed households (9% vs <1%).

29% of live-in HHs reported being hosting their shelter for free compared to only 4% of live-out HHs.

46% of live-out HHs reported renting a shelter in comparison to only 3% of live-in HHs.

HOUSING, LAND AND PROPERTY (HLP) ISSUES[27]

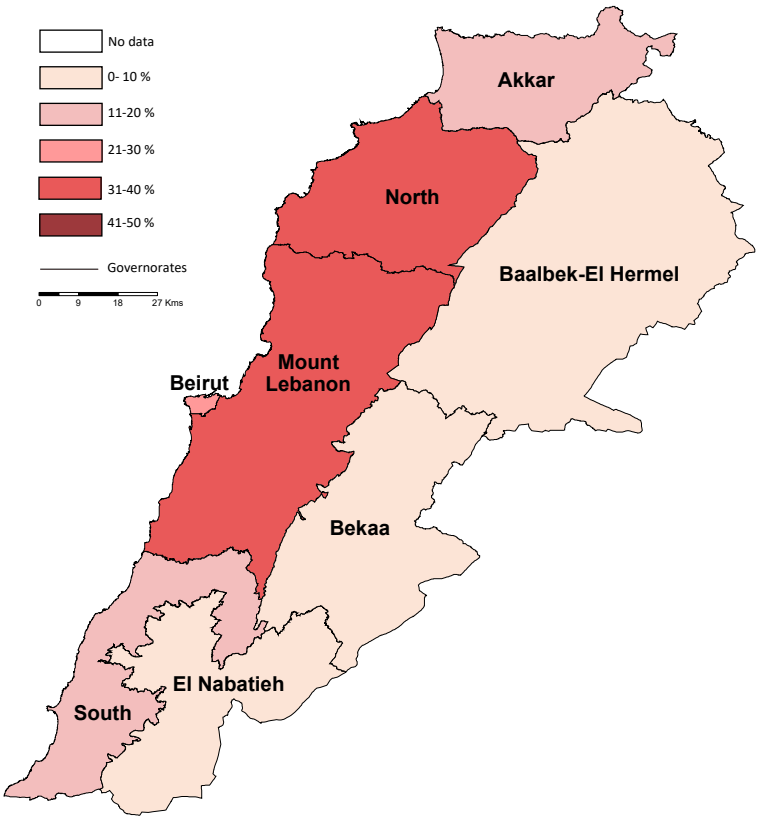
97% **of HHs did not report any problems related to housing, land and property**

Most frequently reported problems were **threat of eviction (2%)** and **dispute with tenants (1%)**.

Five migrant HHs, all live-out HHs, reported living under a threat of eviction or living under an eviction notice

26% **of HHs reported living in a rented shelter at the time of data collection[26]** 46% of live-out migrant HHs and 3% of live-in migrant HHs

% of HHs living in rented shelters, by governorate:



Average reported rent cost in LBP for households' accommodation was 1,348,550 LBP at the time of data collection[27].

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

[25] 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

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

[27] This section shows findings for the 30% of migrant households (n=341) that were not living with employer at the time of data collection.

SHELTER

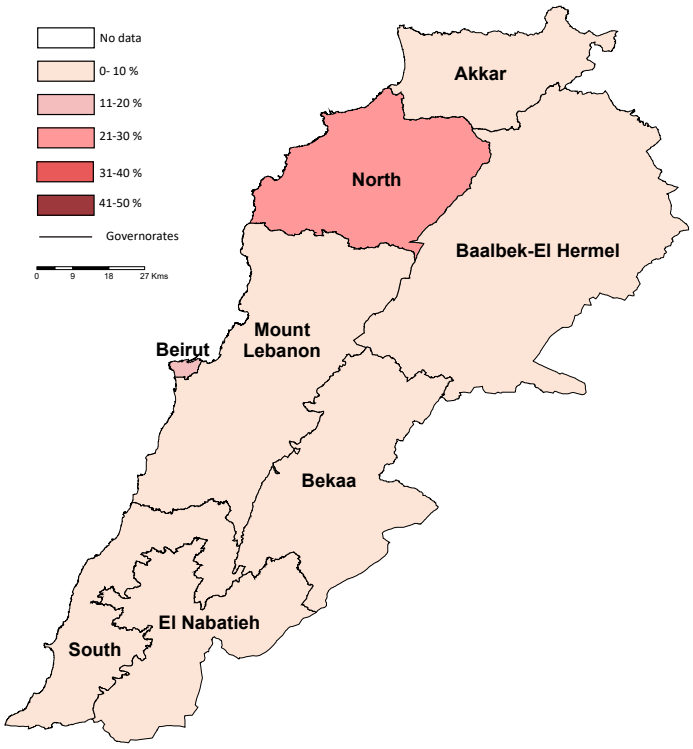
SHELTER DEFECTS, ISSUES AND DAMAGES

18% of live-out and 3% of live-in HHs were found to live in inadequate standard shelter conditions at the time of data collection[28]

% of HHs, by main reported types of shelter damage, defects, or issues*:

Leakage/ rottenness in the walls/ floors	13%
Leakage roof	11%
Lack of insulation from the cold	5%
Damaged structure (roof, wall, columns)	4%
Windows/doors not sealed	4%

% of HHs found to live in inadequate shelter standards conditions[28] at the time of data collection, by governorate:



% of HHs, among 4% of HHs (n=42) that reported damaged structure, by type of reported damage:

Damage in the walls	86%
Damage in the roof	58%
Damage in the columns	12%

11% of HHs reported facing issues related to living conditions in their shelters at the time of data collection

The most frequently reported issues, among HHs (n=1,125):

- Being unable to keep the shelter warm or cool (7%)
- Having at least one member of the HH who had to sleep outside or on the floor (4%)
- Being unable to store water properly (1%)
- Being unable to cook or store food (1%)

SHELTER SPACE AND CROWDEDNESS

On average, there were 1.3 persons reported per one room in live-out migrant households and 0.8 persons in live-in migrant HHs.[29]

8% of live-out HHs reported more than 2 persons per one room in their shelter

2% of live-out HHs reported more than 3 persons per one room in their shelter

1% of live-out HHs reported more than 4 persons per one room in their shelter

1% of live-in HHs reported more than 2 persons per one room in their shelter

[28] 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

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

* Multiple answers allowed

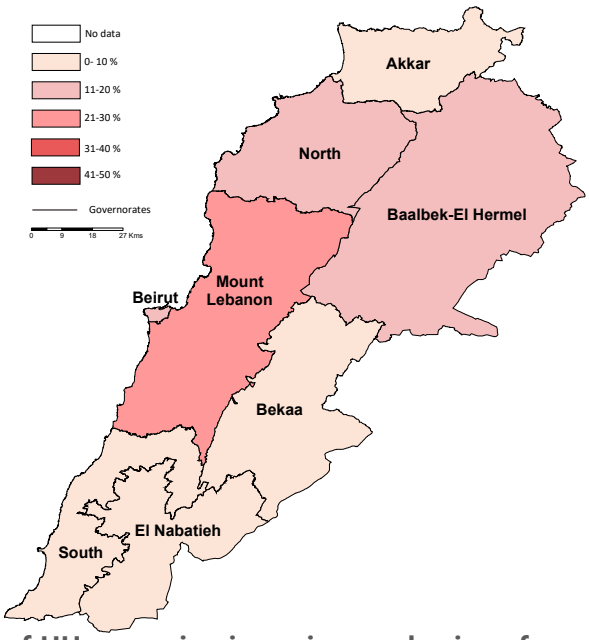
WATER, SANITATION & HYGIENE (WASH)

WATER ACCESS AND AVAILABILITY

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

Drinking	99%
Cooking	96%
Personal hygiene	94%
Other domestic purposes	82%

% 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	18%
Rely on less preferred (unimproved/un-treated) water sources	17%

MAIN SOURCES OF WATER

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

Bottled water	62%
Protected well	13%
Piped connection to the house	12%
Protected spring	9%

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	76%
Bottled water	11%
Piped connection to house	10%
Public tap/standpipe	3%
Protected borehole or tubewell	2%

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

Water on premises	41%
Less than 5 min.	36%
Between 5 and 15 min.	17%
More than 16 min.	3%
Do not know	3%

% of HHs by person who usually fetches water, as reported by the 43% of HHs who did not have water on the premises*:

Men	67%
Women	36%
All	10%
Girls	1%

SANITATION

% of HHs by reported sanitation facility used:

Flush or pour/flush toilet (96%)
Pit latrine with a slab and platform (2%)
Pit VIP Toilet (2%)

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

No (79%)
Yes (21%)
Do not know (1%)

Number of HHs that share a sanitation facility with other HHs (221 HHs) reporting that their shared facility:

Can be locked from the inside	n=189
Has adequate lighting	n=163
Has a safe and well-lit route to it	n=160
Segregated by gender	n=37
None of the above	n=12

* 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	47%
Covered and lined septic tank/cesspool	46%
A hand dug hole in the ground	6%

WASTE MANAGEMENT

% of HHs by reported waste management method:

Collected by municipality	89%
Dumpsters/barrels collected by NGO	7%
Collected by private collector	2%

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

Yes (74%)
No (25%)
Don't know (2%)

% of HHs reporting sorting waste, per waste category:

Not sorting any waste	96%
Yes, recyclable waste	3%
Yes, organic waste	2%
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*:

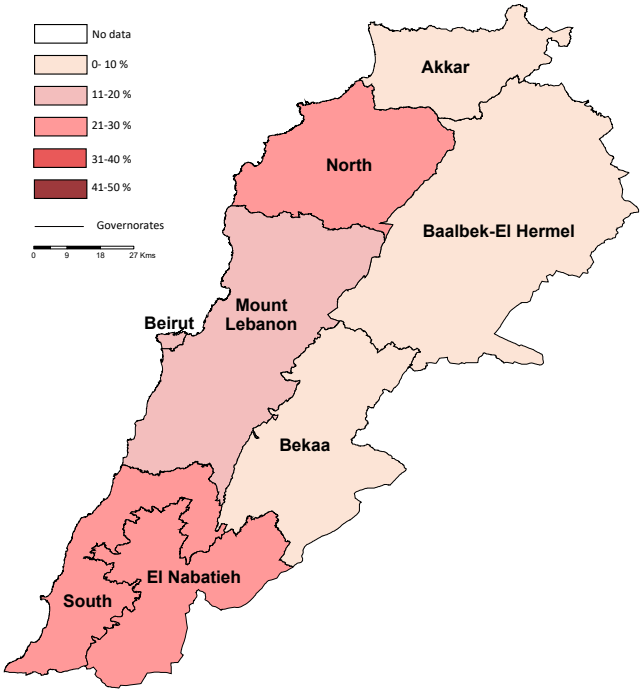
	Live-in	Live-out
No issues	90%	43%
Relied on less preferred types of hNFI	5%	36%
Bought hNFI at a marketplace further away	1%	9%
Reduced usage for personal hygiene	0%	7%
Reduced usage for other than personal hygiene purposes	0%	6%
Had issues but did not try to adapt	1%	6%

% of live-out HHs reporting access to hand-washing facilities[30,31]:

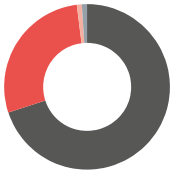
Yes - available with water and soap	83%
Yes - available with only soap	5%
No hand-washing facility available	6%

15% **of live-out HHs reported not using good hygiene practices to wash their hands[32]**

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



% of HHs with female HH members of menstruating age[33] (n=894) by type of problem that female members had to accessing menstrual material (MHM):



No problem (70%)
MHM were too expensive (29%)
Too far away markets (1%)
No women were available in the HH (1%)

59% of live-out HHs reported female members had problems accessing MHM, most commonly due to the high cost of the materials (54%).

* Multiple answers allowed

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

[31] Questions about hygiene practices were only asked to live-out migrant households

[32] 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.

[33] 15-49 years old

OCHA

REACH Informing more effective humanitarian action

EDUCATION

SCHOOL ENROLLMENT & ATTENDANCE[34]

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

Overall, there were 75 school-aged children reported in the migrants households.

84% of school-aged children were reportedly enrolled in a formal school during the 2021-2022 school year[1].

% of school-aged children enrolled in formal school for the 2021-2022 school year (n=63), by type of formal schools:

Public school	46% (n=38)
Private school	40% (n=20)
Don't know	10% (n=4)

Of the 16% of children not enrolled in a formal education (n=12), most commonly cited reasons for children not being enrolled:**

Cost of education	n=4
Child did not enrol due to work	n=1
No space in school	n=1
Age being not appropriate	n=1

Not appropriate age was reported as reason for children between 5 and 7 years of age (n=1).

100% of children enrolled in school (n=63) 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=2)[35]:

1	Health problems (diseases)	n=1
2	Cost of education	n=1

DROP OUT OF SCHOOL

12 out of 12 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:

- **Five girls,** without disability
- **Five boys,** without disability
- **Two boys**, with disability

Main reasons for drop-out were*:

- Child dropped-out due to cost of education (n=3)
- Child does not go to school due to work (n=1)
- No space in the school (n=1)
- Other (n=3)

SCHOOL CLOSURE & DISTANCE LEARNING

Among children enrolled in school (n=63):

- **18%** reported the **school remained open** throughout the school year
- **76%** were accessing **online education while the school was closed**
- **7% were not accessing online education while the school was closed**

% of HHs with at least one school-aged child who accessed distance learning (n=28), by most common modalities used for remote / home-based learning*:

Phone/WhatsApp communication with teachers	n=16
Online live classes with teachers (video/audio)	n=15
Online materials	n=1
Audio/MP3 classes	n=1
Learning app on phone/tablet	n=3

SCHOOL TRANSFER

% of HHs where at least one child was transferred between public and private school in the last two academic years (n=42):

From public to private school	<1%
From private to public school	26%

[34]Indicators presented in this factsheet 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.
[35] Feedback from partners, migrant community members and schools indicates that a major barrier to education is lack of documentation and legal residency which may have been underreported due to protection and security concerns.
* Multiple answers allowed
**The sample size for the subgroup for this indicator is small, and therefore the results might not be reliable.

PROTECTION

POPULATION MOVEMENT

15% **of migrant HHs reported expecting to leave Lebanon within the 3 months after data collection.**

- **10%** expected to **return to their country of origin** willingly.
- **5%** expected to **move to another location outside of Lebanon.**

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:

	Live-out	Live-in
Remain in the current location	59%	69%
Return to area/country of origin willingly	20%	18%
Return to country of origin unwillingly	5%	0%
Moving to another location, outside Lebanon	15%	2%
Moving to another location, inside Lebanon	2%	0%
Don't know	7%	12%

DOCUMENTATION

% of HHs reporting every person in the household had an ID document:[36]

Live-in	ID document	Live-out
98%	Yes	77%
1%	No, all HH members have ID but it is not currently in their possession	1%
1%	No, not all HH members have an ID	22%
<1%	Don't know	0%

46% of HHs in Beirut and 16% in Mount Lebanon governorates reported at least one HH member without an ID document in their possession.

45% **of live-out migrant HHs reported that not all HH members had legal residency in Lebanon**[37]

Among the 45% of live-out HHs (n=132) without legal residency in Lebanon, **the main reasons for not having legal residency were :**

Unable to obtain a Lebanese sponsor/pay the fees	45%
Residency expired and it is not renewable	18%
Entering through unofficial border crossing	17%
Lack of ID documents	6%
GSO kept telling me to come back another time	3%

SAFETY & SECURITY CONCERNS FOR WOMEN IN CERTAIN AREAS

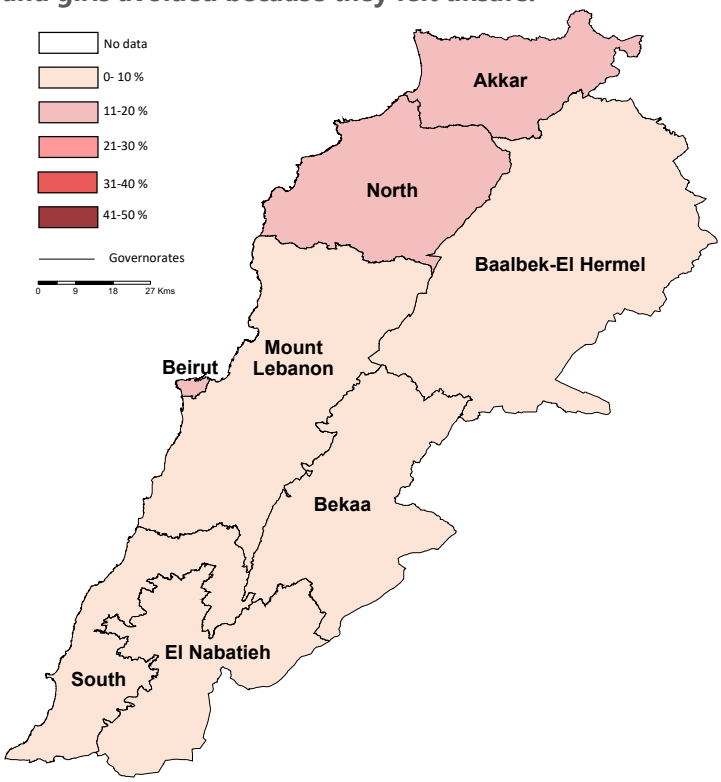
7% **of HHs reported that women and girls avoided certain areas in their location because they felt unsafe there.**

Live-in HHs	vs	Live-out HHs
5%		11%

Top three areas avoided by women and girls, as reported by the 7% of HHs (n=80) who reported that certain areas were being avoided*:

On the street/in the neighbourhood	67%
Public transportation	23%
Markets	10%

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



[36] This means person have it, it is valid and it is stored in a secure place
[37] Questions about legal residency in Lebanon were only asked to live-out migrant households
*Multiple answers allowed
**The sample size for the subgroup for this indicator is small, and therefore the results might not be reliable.

PROTECTION

SAFETY & SECURITY CONCERNS

20% **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	17%
Being threatened with violence	3%
Verbal harassment	3%

Safety and security concerns for women were most often reported in Akkar governorate (only 44% reported having no concerns) and least often in South governorate (93% reported having no concerns).

20% **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	18%
Threatened with violence	2%
Being kidnapped	1%

In Akkar governorate, safety and security concerns for men were most frequently reported, particularly: risk of being robbed (31%), being threatened with violence (15%), and being kidnapped(11%).

CHILD PROTECTION

13% **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	11%
Threatened with violence	2%
Being kidnapped	2%

Safety concerns for girls were most frequently reported in Akkar governorate, with 21% of HHs reporting the risk of being robbed, 27% risk of kidnapping, and 17% risk of verbal harassement.

12% **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	10%
Being kidnapped	3%
Threatened with violence	1%

Security concerns for boys as well were most often reported in Akkar governorate, i.e., 20% of HHs there reported risk of being robbed, kidnapping (35%), the risk of being robbed (20%), and verbal harassement (15%).

No HHs reported having a member with disability.

Among migrant HHs with at least one child below 18 years (n=85):

4% **of HHs reported at least one child (<18) not residing in the HH** in the 3 months prior to data collection

5% **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)

4% of HHs reported **at least one safety concerns related to GBV for women** in their communities

1% of HHs reported **at least one safety concerns related to GBV for men** in their communities

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

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

	Women	Men
Suffering from verbal harassment	2%	3%
Suffering from physical harassment or violence (not sexual)	0%	1%
Discrimination or persecution (because of gender identity or sexual orientation)	1%	< 1%
Sexual harassment or violence	1%	< 1%

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

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

*Multiple answers allowed

**The sample size for the subgroup for this indicator is small, and therefore the results might not be reliable.

ENERGY AND TELECOMMUNICATION

NETWORK COVERAGE

% of HHs per network coverage category:

5%	No coverage at all
12%	Internet coverage only
5%	Voice calls and SMS coverage only
77%	Voice calls, SMS and Internet coverage

8% of live-out migrant HHs reported having no coverage at all, compared to 3% of live-in HHs.

No network coverage to use the mobile phone was most frequently reported in Bekaa (9%) and North (7%) governorates.

ENERGY SOURCES

99% **of HHs reported using gas as the energy source for cooking**

In addition to that, 5% of HHs reported using electric powered cooker and 1% of HHs reported using wood.

% of HHs by main source of electricity*:

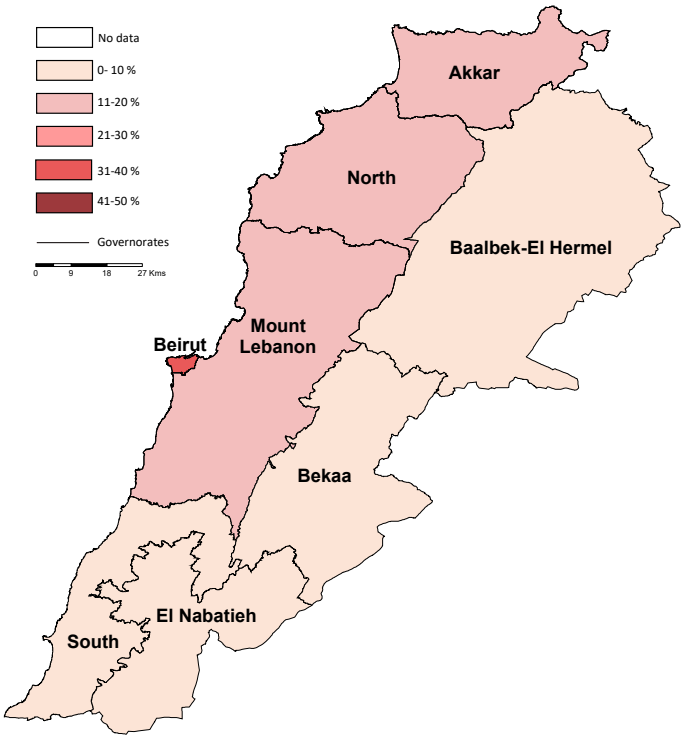
Main network: Electricité du Liban	73%
Neighbourhood generator	42%
Private generator	34%

Main network was least often used in Nabatieh (56%), where 53% of HHs reported using neighbourhood generator and 48% reported using solar panels.

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

The average number of hours per day during which live-in HHs reportedly had access to electricity was 19 in comparison to 11 for live-out HHs.

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



COPING MECHANISMS

20% **of live-out and** **13%** **of live-in migrant HHs reported having adopted at least one strategy to cope with electricity shortages**

28% **of live-out and** **71%** **of live-in migrant HHs reported not using any coping mechanisms because they did not need to**

48% **of live-out and** **7%** **of live-in migrant 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	8%
Got electricity from outside the HH[38]	4%
Spent money usually spent on other things	2%

*Multiple answers allowed

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

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