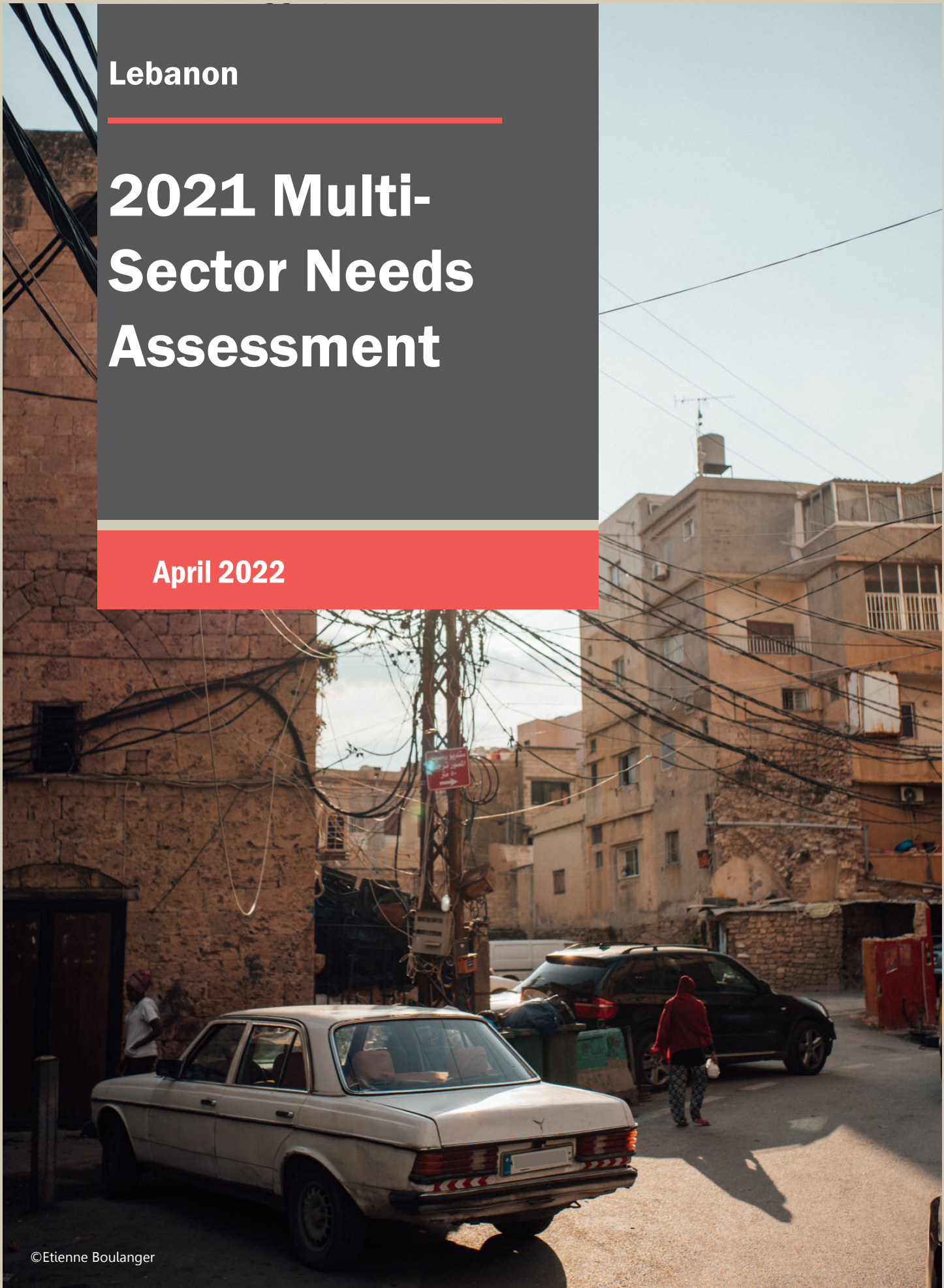
Lebanon

2021 Multi-Sector Needs Assessment

April 2022



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About REACH

REACH 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). For more information, please visit our website. You can contact us directly at: geneva@reach-initiative.org and follow us on Twitter @REACH_info.

SUMMARY

Lebanon is currently facing a multi-layered crisis characterized by an acute economic contraction caused by exchange rate collapse, rising public debt, soaring inflation, impaired banking sector; political turmoil, and governance challenges inter alia. In this context, the total inflation from December 2019 to October 2021 reached 519%, peaking **at 1874% for food and non-alcoholic beverages**[1]. This has resulted in the sharp decline of household purchasing power and increasing poverty rates across population groups[2]. In addition, the economic crisis contributed to **a gradual breakdown of public services such as health care, water, hygiene and sanitation (WASH), and education**, further worsened by the fuel crisis, which began during the summer of 2021, and has largely impacted the country's electricity supply since, with critical consequences for the health, water, transport, and telecommunication sectors.[3] While the fuel crisis eased toward the end of 2021, state electricity provision remained low, averaging less than 5 hours of electricity supply per day.[4] This situation has stretched public finances and service delivery and exacerbated existing vulnerabilities, which will likely become protracted as households struggle to satisfy basic needs as subsidies of staple foods, commodities, and medical items are progressively removed.[5] The growing economic hardship and frustration with the political system triggered frequent **widespread protests and civil unrest across the country**, most commonly by blocking roads and highways, to urge the Lebanese government to "cope with skyrocketing fuel prices"[6] and more generally to ask for concrete financial and economic actions to contain the crisis.

Furthermore, since the beginning of the protracted socio-economic crisis and the political collapse in October 2019, several additional systemic shocks have occurred. The onset of the COVID-19 pandemic further compounded prevailing vulnerabilities, placing extra pressure on an already overburdened and under-resourced health system. The pandemic has significantly contributed to the negative dynamics within the Lebanese economy[7]. In addition, the extensive containment measures to limit the spread of COVID-19 negatively impacted **women and children's safety, with acute risks related to child protection (CP) and gender-based violence (GBV)**, including increasing rates of child marriage, child labour, and perpetration of verbal, physical and sexual violence at home.[8] Access to education was also negatively affected by the pandemic, as schools were partially closed during the school year 2020-2021, to limit the spread of COVID-19.

Finally, the August 2020 Beirut Port explosions left at least 200 dead, over 6,000 injured and homeless, and caused upwards of $5 billion in damage to residential, commercial, industrial, and public infrastructure. The explosions have also resulted in further loss of economic activity, trade disruptions, loss of fiscal revenue incurred, and is compounding an already depleted economy[9]. For instance, the Beirut blast destroyed most of Lebanon's strategic grain reserves, currently causing major concerns, as Ukraine, which was the main supplier, has suspended its exportations following the conflict in Ukraine.[10] This will likely worsen the already fragile food security situation for all population groups.

Against this backdrop, the 2021 Lebanon Multi-Sector Needs Assessment (MSNA) was conducted to support evidence-based decision-making for the 2022 humanitarian planning cycle process and to support the planning among key humanitarian actors through the provision of updated information on multi-sectoral needs and priorities for crisis-affected populations in Lebanon, in complement to other needs assessments already implemented, such as the Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR).[11] To approach this objective, the MSNA was implemented in coordination with the United-Nations Office of Coordination of Humanitarian Affairs (UNOCHA). The research design and data

[1] Additional information can be found on the Central Administration of Statistics (CAS).
[2] Ibid.
[3] United-Nations (UN) News, Fuel crisis in Lebanon potential catastrophe for thousands: Senior UN official, August 2021.
[4] Mercy Corps, Lebanon Crisis Update, December 2021.
[5] Ibid.
[6] AUazeera,, Cash-strapped Lebanese drivers block roads in "Day of rage", January 2022.
[7] Plan International, COVID-19: Multi-Sectoral Needs Assessment, April 2020.
[8] UNICEF, Violent Beginnings, Children growing up in Lebanon's crisis, December 2021.
[9] United-Nations Development Programme (UNDP), Impact of Beirut Explosion on Economic Activities Located in the Affected Neighborhoods, June 2021.
[10] Additional information on this recent issue can be found on Triangle.
[11] You can find more information on the VASyR 2021.

collection were a collaborative process with the members of the Emergency Operation Cell (EOC), and the specific expertise of the International Organisation for Migration (IOM) and the United National Relief and Works Agency for the Palestine Refugees in the Near East (UNRWA) for respectively migrants and Palestine Refugees in Lebanon (PRL) groups, and UN Women for technical assistance on gender equality and social inclusion issues.

Data for the 2021 Lebanon MSNA was gathered at the household (HH) level through a nationwide HH survey. Data were collected with Lebanese HHs, PRL HHs, and migrant HHs, in 24/26 Lebanese districts[12]. The data collection was conducted from 19th October until 4th December 2021. Data was collected mostly in-person by trained enumerators from REACH Initiative (REACH), IOM, Mercy Corps, Akkar Network for Development (AND), Terre des Hommes Foundation (TdH), the Danish Refugee Council (DRC), International Rescue Committee (IRC), Intersos, Save the Children, the Norwegian Refugee Council (NRC), Humanity et Inclusion (HI) and Solidarités International (SI), with ACTED as REACH's implementing partner. The questionnaire was deployed through KOBO collection, and results were analysed after being cleaned and weighted with both R and Excel software. The results for Lebanese HHs are representative at the district level, for the assessed districts, with a level of confidence of 95% and a margin of error of 10%. For both PRL and migrant HHs, the results are not generalizable to the overall population of interest, and indicative results are reported at the regional level (for more information, please refer to the methodology section). Cleaned data and analysis tables are publicly available on the REACH Resource Centre.

Key Findings

Lebanese, PRL, and migrants are facing critical vulnerabilities related to livelihoods, as respectively 59% of assessed PRL HHs, 51% of assessed migrant HHs, and 44% of Lebanese HHs reported earning less than 2.4 million Lebanese Pound (LBP)[13] in the month prior to data collection. Among Lebanese HHs, the situation was particularly concerning in Tripoli district, where 37% of them reported earning less than 1 million LBP. Considering the average market rate during data collection being 1 USD = 22000 LBP, 37% of Lebanese HHs in Tripoli reported earning less than 45.5 USD in the month prior to data collection. Limited access to decent livelihoods, coupled with fundamental, nation-wide socioeconomic issues throughout Lebanon, could contribute to protracted and significant vulnerabilities in the area. In addition, **roughly two-third of PRL and Lebanese HHs, against 37% of assessed migrant HHs, reported having faced challenges in affording basic needs** because of a loss or reduction of employment in the 3 months prior to data collection. Moreover, findings suggest that **gender inequity with respect to livelihoods is to be significant in Lebanon**; overall, 65% of men aged 18 to 59 were found employed in the 30 days prior to data collection, against 29% of women in the same age category[14].

Findings suggest all assessed population groups face considerable difficulties to cover basic expenditures and needs, which seems to drive vulnerabilities, especially regarding access to health care, while food insecurity appears to be on the rise.[15] Indeed, the situation in terms of food security is concerning, as 16% of HHs from the three assessed population groups were categorised with severe or moderate hunger based on the MSNA results[16]. Considering the context, food insecurity among HHs in Lebanon is likely due in part to the skyrocketing inflation in the country since 2019.[17] To cope with food insecurity, **the majority of HHs from the three population groups reported reducing food expenditures**.

Furthermore, **substantial precarious health conditions** were found to be prevalent among HHs from all three population groups, **resulting from a combination of specific health vulnerabilities as well as barriers to access health care and medication**. Overall, while more than two-thirds of Lebanese

[12] Bent Jbeil and Nabatieh districts were not accessible during the data collection due to security constraints.
[13] Between October and December, the market rate was around 22000 LBP equal to 1 USD. Therefore, 2.4 million LBP was equivalent to 109 USD. (source: https://lirarate.org/)
[14] There was no distinction made between different types of contracts, this could also include daily employment.
[15] WFP and FAO, Hunger Hotspots, February 2022
[16] Due to some discomfort when answering food security related questions, the data from this section should be considered as indicative.
[17] Additional information can be found on the Central Administration of Statistics (CAS).

and assessed PRL HHs reported having at least one member with a chronic illness, access to health care appears to remain limited; 83% of Lebanese, 72% of PRL HHs, and 86% of assessed migrant HHs with at least one member in need of health care (n=1881, n=326 and n=132 respectively) reported that the member in question was not able to access health care in the 3 months prior to data collection. **Findings suggested that financial barriers, such as inability to afford treatment, were the main drivers of limited access to health care and medication** in the three population groups. In addition, findings highlighted particular pockets of vulnerabilities among Lebanese HHs in Jezzine district that were linked to the **unavailability of functional health facilities and adequate medication.**

Shelter results from the MSNA indicated that most HHs were living in apartments, houses, or rooms (respectively 98% of Lebanese and assessed PRL HHs and 89% of assessed migrant HHs). However, a considerable proportion of **these shelters were presenting enclosure issues**, including dangerous ones, as 52% of PRL, 46% of Lebanese and 22% of assessed migrant HHs reported at least one defect in their shelter. Findings suggest migrants were particularly vulnerable in this region, with 10% of assessed migrant HHs reportedly living in garages and 10% living in tents. In addition, while around one-fourth of HHs in all assessed population groups reported renting their apartment, findings suggest the perceived threat of eviction is low, with only 1-2% of assessed HHs across groups reporting feeling at risk of eviction. That said, **considering the current financial crisis in Lebanon, resulting in important LBP devaluation and currency volatility, close monitoring of Housing, Land and Property (HLP) issues for HHs renting their shelter seems critical**.

While MSNA findings suggest access to improved WASH is relatively widespread in Lebanon, some pockets of vulnerabilities were identified in certain areas, however not consistent between population groups. For instance, **assessed migrant HHs were found to be facing considerable challenges related to water and hygiene in Beirut and Mount Lebanon region**, compared to other regions. The highest proportion of assessed migrant HHs reporting both not enough drinking water (14%) and not having access to soap available in their house (12%) was found in that specific region. Assessed PRL HHs were found to have higher WASH vulnerabilities in Baalbek El-Hermel and Bekaa region, with for instance a high dependence on water assistance, with 28% of assessed PRL HHs reporting water trucking as their main source of drinking water during the data collection. In addition, Baalbek-El Hermel and Bekaa had the highest proportion of assessed PRL HHs reporting not having access to enough water to cover drinking needs (17%). Finally, among Lebanese HHs, **access to water was particularly concerning in the Chouf and Tripoli districts, where respectively 23% and 19% of Lebanese HHs reported not enough drinking water.** Furthermore, less than 5% of HHs in the three population groups reported using an unimproved source of drinking water[18], however, it soared to 14% of Lebanese HHs in the Akkar district.

Findings suggest that the multi-layered crisis in Lebanon contributed to rising protection concerns, stress, and vulnerabilities at HH and individual levels. A significant proportion of HHs reporting **fear of being kidnapped and being robbed** as the main security and safety concerns for women, girls, and boys within the community. Among PRL and migrant HHs, safety concerns for boys, girls, and women were commonly reported in North and Akkar region, which aligns with the highest proportion of Lebanese HHs reporting such concerns being found in Tripoli and Akkar districts.

The migrant population group seems to face specific difficulties in accessing education, as 43% of migrants' children were reportedly not enrolled in a formal school during the school year 2020-2021. Furthermore, Lebanese children attending school in person or at distance seemed to have been negatively impacted by the combined economic crisis and the COVID-19 outbreak, **resulting in 14% of them reportedly dropping out of school in the school year 2020-2021**. Since January 10, 2022, an ongoing strike launched by the country's public-school teachers has further paralysed the education sector, further limiting access to education for all population groups[19].

Only 34% of assessed PRL HHs, 14% of Lebanese and 4% of assessed migrant HHs reported having received assistance in the 3 months prior to data collection. A limited proportion of PRL and Lebanese HHs are assisted under the Lebanon Crisis Response Plan (LCRP)[20], based on their status of

[18] Unprotected well, unprotected spring, unprotected rainwater, surface water.
[19] AlJazeera, Lebanon teachers strike over conditions as education crisis grows, January 2022.
[20] Lebanese government and UN, Lebanon Crisis Response Plan (2017-2021), 2021 update, March 2021.

host communities, while migrants, who are already facing severe limitations in terms of access to public services, are not included in the response.

Contents

List of Acronyms

AND:	Akkar Network for Development
CwD:	Child with Disability
DRC:	Danish Refugee Council
HH:	Household
GBV:	Gender-based Violence
GPS:	Global Positioning System
IOM:	International Organisation for the Migration
KII:	Key Informant Interview
MSNA:	Multi-Sector Needs Assessment
NRC:	Norwegian Refugee Council
OCHA:	Organisation of Coordination of Humanitarian Affairs
ODK:	Open Data Kit
PPS:	Probability Proportional to Size
PRL:	Palestine Refugee in Lebanon
PSU:	Primary Sample Unit
SDG:	Sustainable Development Goals
SI:	Solidarités International
SRL:	Syrian Refugee in Lebanon
TdH:	Terre des Hommes Fondation
UNDP:	United Nations Development Programme
UNRWA:	United National Relief and Works Agency for the Palestine Refugees in the neat East
WASH:	Water, Hygiene and Sanitation
WFP:	World Food Programme

Geographical Classifications

Region:	Highest form of governance below the national level
Governorate:	Level 2 administrative unit. There are a total of 8 governorates.
District:	Level 3 administrative unit. There are a total of 26 districts.
Municipality:	Level 4 administrative unit.

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INTRODUCTION

Lebanon is currently facing a multi-layered crisis characterised by an acute economic contraction including exchange rate collapse, rising public debt, soaring inflation, impaired banking sector, political turmoil, and governance challenges inter alia. In this context, the total inflation from December 2019 to October 2021 reached 1614%, while it peaked at 1874% for food and non-alcoholic beverages.[21] This has resulted in the sharp decline of household purchasing power and increasing poverty rates. In addition, the economic crisis contributed to failures in public services such as health care, water, hygiene, and sanitation (WASH) and education, further strengthened by the fuel crisis during the summer of 2021, and largely impacted electricity supply, with critical consequences on the health, water, transport, and telecommunication sectors.[22] Despite the attenuation of the fuel crisis by the end of 2021, state electricity provision remained low during the period, averaging less than 5 hours of electricity supply per day.[23] This context has stretched public finances and service delivery and further exposed existing vulnerabilities, which will likely become chronic as households struggle to satisfy basic needs as subsidies of staple foods, commodities, and medical items are progressively removed.[24] The growing economic hardship and frustration with the political system triggered regular, widespread protests and civil unrest across the country, most commonly by blocking roads and highways, to urge the Lebanese government to "cope with skyrocketing fuel prices"[25] and more generally to ask for concrete financial and economic actions to contain the crisis. In this tense context, Lebanese households, refugees, and migrants are facing increasing vulnerabilities to access basic needs and services.

Furthermore, several additional systemic shocks have occurred since the beginning of the protracted socio-economic and political collapse in October 2019. The onset of the COVID-19 pandemic further compounded prevailing vulnerabilities, placing extra pressure on an already overburdened and under-resourced health system. It has significantly contributed to the negative dynamics within the Lebanese economy. In addition, the extensive containment measures following the outbreak of COVID-19 contributed to threaten women and children's safety, with acute risks related to child protection (CP) and gender-based violence (GBV), including increasing rates of child marriage, child labour, and perpetration of verbal, physical and sexual violence at home.[26] Access to education was also negatively affected by the COVID-19 outbreak, as schools continued to be partially closed during the school year 2020-2021, to limit the spread of COVID-19. Finally, the August 2020 Beirut Port explosions left at least 200 dead, over 6,000 injured and homeless, and caused upwards of $5 billion in damage to residential, commercial, industrial, and public infrastructure.[27] The explosions have also resulted in further loss of economic activity, trade disruptions, loss of fiscal revenue incurred, and is compounding an already collapsing economy.[28]

Against this backdrop of economic and political crisis, further aggravated by the COVID-19 outbreak and the Beirut blast, there remains a need for up-to-date, crisis-wide information on the needs of the affected populations in Lebanon to support evidence-based decision-making of the Humanitarian Country Team (HCT) and other key development and humanitarian actors. Therefore, the HCT, with support from REACH, conducted the 2021 Lebanon Multi-Sector Needs Assessment (MSNA) to provide updated data and analysis on multi-sectoral needs and priorities for crisis-affected Lebanese households, Palestine Refugees in Lebanon (PRL) and migrants. .

This report includes the main findings on the magnitude and severity of needs of Lebanese households, PRL, and migrants across Lebanon, in 24 out of 26 districts, and the drivers of those needs. The rest of the report is structured as follows: most urgent inter-sectoral needs, demographics and Washington groups findings, livelihoods, food security, WASH, shelter, health, protection, including CP and GBV findings, and accountability to affected populations (AAP), followed by the conclusion.

[21] Additional information can be found on the Central Administration of Statistics (CAS).
[22] United-Nations (UN) News, Fuel crisis in Lebanon potential catastrophe for thousands: Senior UN official, August 2021
[23] Mercy Corps, Lebanon Crisis Update, December 2021
[24] Mercy Corps, Lebanon Crisis Update, December 2021
[25] AUazeera, Cash-strapped Lebanese drivers block roads in "Day of rage", January 2022
[26] UNICEF, Violent Beginnings, Children growing up in Lebanon's crisis, December 2021
[27] REACH Initiative, MSNA 2021 Terms of Reference, May 2021
[28] United-Nations Development Programme (UNDP), Impact of Beirut Explosion on Economic Activities Located in the Affected Neighbourhoods, June 2021

METHODOLOGY

Specific objectives and research questions

The 2021 Lebanon MSNA was conducted to support evidence-based decision-making for the 2022 humanitarian planning cycle process and to enable planning among key humanitarian actors through the provision of updated information on multi-sectoral needs and priorities for crisis-affected populations in Lebanon. To approach this objective, the MSNA sought to answer the following research questions:

- What is the character of multi-sectoral humanitarian needs across Lebanon?
  - What are the magnitude, scope, and severity of humanitarian needs across specific sectors, including shelter, education, food security, health, livelihood, protection, and WASH, in Lebanon?
  - To what extent do households have inter-sectoral needs and what are the most common overlapping needs?
  - How do findings differ according to geographic area, population group (Lebanese, migrant, and PRL HHs), and vulnerability profile (age, gender, and disability) of households?

Scope

The 2021 MSNA is a nationwide, household-level assessment composed of primary data collection and secondary data review. Primary data collection consisted of a household-level survey conducted across almost the entirety of Lebanon, inclusive of all 24/26 Qa'dat/Cazas/Cadastres, which are the official administrate level 3 boundary for Lebanon. Two districts were not accessible during the data collection due to constraints related to the security of REACH and partners' enumerators: Bent Jbeil and Nabatieh.

Three population groups were considered in the 2021 REACH MSNA: Lebanese HHs, PRL HHs, and migrant HHs. While other needs assessments exist to evaluate the needs of Syrian Refugees in Lebanon (SRL)[29], very little information is available for Lebanese, PRL, and migrants, making the operational response to existing vulnerabilities difficult to implement. The need for information-based strategies at the national and regional level resulted in the selection of these 3 population groups within this MSNA, in coordination with UNOCHA, the IOM, and UNRWA.

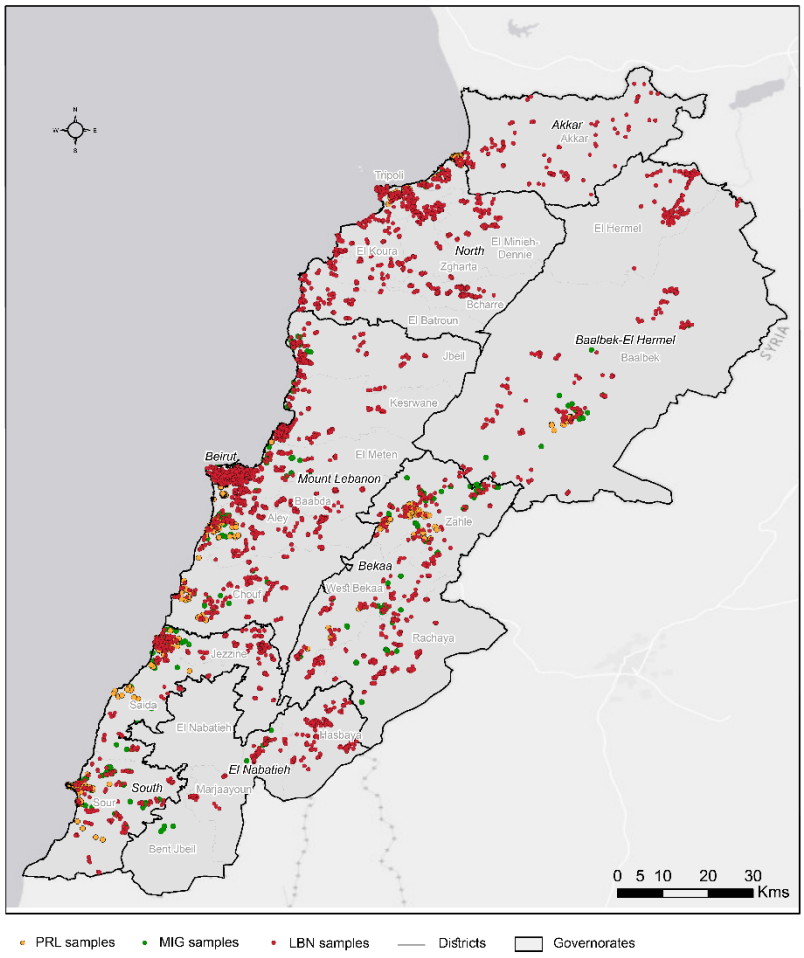
In addition, the MSNA is a multisector needs assessment; as such, it covers almost all sectors of humanitarian needs, including:

- Livelihoods
- Food security
- WASH
- Education
- Protection, including general protection, Washington group indicators, child protection, and gender-based violence (GBV)[30].
- Shelter
- Health

However, only two indicators were included in the MSNA to cover the nutrition sector's needs for information, as SMART surveys are implemented nationally by the Nutrition sector, providing data for most population groups living in Lebanon.

[29] You can find more information on the VASyR 2021.
[30] A gender approach was also adopted, to ensure the gender balance of respondents. Additional disaggregation was realised during the analysis phase to identify trends within vulnerable groups.

Map 1. Assessment coverage



Sampling strategy and data collection

For each population group, a different sampling strategy was implemented. Indeed, localisation of migrant and PRL HHs living outside of camps appeared to be challenging during the data collection phase, resulting in an adjustment of the sampling methodology for these two population groups. For all population groups, cadasters (third administrative level) served as the primary sampling unit (PSU) for this exercise. In total, 5,316 surveys were conducted, mostly in-person through face-to-face interviews. Across all three population groups, the surveys were disaggregated as follows:

Table 1. Total number of surveys by population groups and date of data collection[31]

	Number of HHs surveys	Date of data collection
Lebanese HHs	4,232	19/10/2021 – 19/11/2021
PRL HHs	668	19/10/2021/04/12/2021
Migrants HHs	713	19/10/2021/04/12/2021

Table 2. Total number of Lebanese HHs surveyed, by district

District	Number of HHs surveys
Akkar	152
Aley	178
Baabda	276
Baalbek	140
Bcharre	208
Beirut	320
Chouf	151
El Batroun	149
El Hermel	111
El Koura	157
El Metn	153
El Minieh-Dennie	193
Hasbaya	186
Jbeil	164
Jezzine	158
Keswrane	164
Marjaayoun	103
Rachaya	151
Saida	243
Sour	159
Tripoli	221
West Bekaa	161
Zahle	143
Zgharta	191
TOTAL	**4,232**

Table 3. Total number of migrant HHs surveys, by region

Region	Number of HHs surveys
Baalbek-El Hermel	135
Beirut and Mount Lebanon	372
North and Akkar	60
South and Nabatieh	146
TOTAL	**713**

[31] **The following data sources were used to inform the MSNA 2021 sampling strategy:**

- Lebanese: Labour Force and Household Living Conditions Survey (LFHLCS), 2018–2019, Central Administration of Statistics (CAS).
- Palestinian Refugees in Lebanon (PRL): UNRWA Lebanese Palestinian Dialogue Committee: Population and Housing Census in Palestinian Camps and Gatherings 2017, CAS and Palestinian Bureau of Statistics (PCBS) x 3.1974 (as growth rate from July 2017).
- Migrants: IOM, Baseline Assessment Round 1, August 2021

Table 4. Total number of PRL HHs surveys, by region

Region	Number of HHs surveys
Baalbek-El Hermel	109
Beirut and Mount Lebanon	178
North and Akkar	203
South and Nabatieh	178
TOTAL	**668**

The data collection for all three targeted population groups was conducted through an ODK/KOBO tool, with specific constraints applied for PRL and/or migrant HHs specific questions. Arabic translations were directly included in the KOBO tool. The questionnaire was collected by a pair of enumerators, mostly male/female. In addition, four regionally specific trainings were organised by REACH Initiative; enumerators from REACH and all partners were providing training on the MSNA data collection procedures, standards, and tools (such as the questionnaire), as well as special considerations related to 'Do No Harm', complaint response mechanisms (CRM), and prevention of sexual exploitation and abuse (PSEA).

Daily data cleaning started after 10 days of data collection. The cleaning was done conjointly by the REACH GIS officer and the REACH database officer, to ensure both data quality and data protection. While REACH conducted a first round of cleaning for data collected by data collection partners, the anonymised Excel file was then transmitted to those partners for inputs and additional corrections.

In mid-October, a three-day pilot was conducted in the Beirut and Mount Lebanon governorates. The purpose of the pilot was primarily to test data collection tools and the MSNA questionnaire. A fourth day was planned; however, due to localized armed clashes in Beirut on October 14th 2021, this pilot day was cancelled.

Lebanese HHs

For Lebanese households, a probability proportional to size (PPS) cluster sampling approach was implemented, in which cadastres, are first randomly selected proportional to their size, before a set number of households within each cluster was randomly selected. The minimum cluster size has been set at 4 households. Once the PSUs had been selected at random, geo-points were randomly generated within the settled areas of each cadastre, corresponding to the prescribed number of households for each cluster. REACH enumerators conducted 4,223 surveys to achieve statistical representativeness at a 95% confidence level and a +/- 10% margin of error across the 24 strata, plus a 10% buffer.

PRL and migrant HHs

Reflecting the fact that this population group is not found in all cadastres, REACH reviewed OCHA and IOM datasets to eliminate all cadastres without any Palestinian population. From the remaining cadastres, two distinct methodologies were implemented. For the PRL living in camps or adjacent gatherings, a two-stage, non-clustered stratified random sampling approach was implemented to select 297 households, to achieve statistical representativeness at a 90% confidence level and a +/- 10% margin of error across the concerned strata, plus a 10% buffer. Geo-points were then randomly generated within the settled areas of each cadastre, corresponding to the prescribed number of households for each cluster. Due to difficulties locating PRL living out of camps and in other settings, a snowballing approach was implemented, to obtain indicative findings from 200 households surveys. At the end of the data collection, a total of 668 Assessed PRL HHs were surveyed, providing indicative results in the four assessed regions.

As for PRL, the migrant population group is not found in all cadastres. Therefore, REACH reviewed OCHA and IOM datasets to eliminate all cadastres without any migrant populations. From the remaining cadastres, REACH enumerators encountered difficulties to locate migrants, especially in low density and suburban or rural areas, notably due to seasonal migration in winter. Consequently, a snowballing approach was implemented, which allowed REACH to obtain indicative findings from 713 households surveys.

GPS methodology

For Lebanese and PRL surveys requesting GPS points, the GIS team prepared an adequate buffer of GPS points to account for the possibility that an interview could not be conducted with the initially selected point. It happened for instance when a household refused to participate in the survey, was not home, withdrew from the survey, or did not belong to the population of interest. In this case, enumerators proceeded to the backup geo-point prepared. When there was no eligible household at this point or the household opted to not participate, enumerators attempted to interview with the next nearest household within the pin radius, either an adjoining shelter or a separate floor and apartment unit in the instance of multi-story shelters.

COVID-19 related adaptation measures

To ensure enumerators' safety while collecting data during the MSNA 2021, especially since the data collection was collected at the end of autumn/beginning of winter when the number of cases started to increase again, REACH implemented several adaptation measures. First, enumerators were provided with masks and hydro alcoholic gel for reducing the risks of contamination when conducting face-to-face interviews. In addition, only 2 enumerators were in each vehicle, to limit the risks of transmission within the enumerators' team during the trips.

Analysis

The data was analysed using R software. A weighting method was applied within geographical units and population groups, to ensure comparability of results. The results were shared in sectoral analysis Tables to all partners and published on the REACH Resource Centre in January 2022. Additional *ad hoc* analysis was also conducted on Excel at partners' request.

Secondary data

Secondary data was provided by EOC members to inform the MSNA analysis. In addition, REACH gathered additional secondary data to complement EOC existing studies. It also organised external engagements with the following sectors to discuss the MSNA results: Education, Shelter, Food security, Health, Protection (including child protection and GBV), Livelihoods, and WASH sectors. During these discussions, REACH presented the MSNA results, and actors identified trends, discrepancies with other available data when existing, and underlying dynamics and factors of vulnerabilities. This report is not an exhaustive review of existing secondary data, however, it incorporates several reports that served as a basis to further interpret and compare trends at the national level within the sectors and population groups.

Ethical considerations

Field officers and enumerators received training to introduce the organization's zero-tolerance policy on Protection from PSEA. The training was also provided on the protection of minors (including the prohibition on interviewing children under the age of 18). In addition, all the MSNA tools were reviewed and implement according to the Do No Harm principles.

Because data collection took place in the context of the COVID-19 pandemic, enumerators were also trained in barrier procedures and conducted all assessments with a distance of at least 1.5 meters from the interviewee, wearing a mask. REACH also ensured there would be only one team per vehicle, meaning a total of three persons by vehicle, driver included. Enumerators were also provided with hand sanitiser to use before and after each interaction with respondents.

In each region of interest, REACH recruited field officers to act as team leaders who were local to the area, to allow for culturally adapted communication with households and local stakeholders. Survey teams were recruited to meet the same criteria.

Challenges and limitations

- **Proxy reporting:** Data on the individual level was reported by proxy by one respondent per household, rather than by the particular individual household members themselves, and therefore might not accurately reflect lived experiences of individual household members, who also might be more vulnerable.
- **Subset indicators:** Findings related to a subset of the overall population may have a wider margin of error, potentially yielding results with lower precision. Any findings related to subsets are indicated as such throughout the report.
- **Respondent bias**: Certain indicators may be under or over-reported due to the subjectivity and perceptions of respondents. For instance, respondents might tend to provide what they perceive or believe others, such as employers, to perceive as to be the "right" answers to certain questions (i.e. social desirability bias, social taboo bias[32], constraint for migrants to report on some vulnerabilities when being surveyed in their employers' home in their presence, etc.). In addition, several indicators, especially those related to expenses, food consumption, menstrual hygiene, and girls and women's protection questions were reported by MSNA enumerators to create some discomfort within the three population groups. This should be taken into consideration when interpreting these results, as a potential bias linked to social taboo may have impacted the results.
- **Limitations of household surveys**:
    - While household-level quantitative surveys seek to provide quantifiable information that can be generalised to represent the populations of interest, the methodology is not suited to provide in-depth explanations of complex issues. Thus, some questions on "how" or "why" are best suited to be explored through qualitative research methods.
    - Since "households" are the unit of analysis, intra-household dynamics (including for instance intra-household power relations across gender, age, disability) cannot be captured. Users are reminded to supplement and triangulate household-level findings with other data sources. Similarly, community-level indicators, such as GBV indicators, may be biased because of the unit of analysis.
    - The methodology used to select HHs could contribute to an under-representation of HHs without a shelter within the assessment[33].
    - During data collection, high income areas had a disproportionately high non-response rate. This might have an impact on the MSNA results, through a potential over-representation of low and medium-income HHs in these specific areas.
    - HHs level surveys do not capture the situation directly in health services, nor the geoghrapical uses of health services. Similarly, the integration of supply side-related issues and bottlenecks that can pose barriers to accessing basic services, such as education, was limited due to the nature of the assessment.
    - The snowball sampling used with migrants might carry a risk of overrepresentation of certain nationalities.
    - Lebanese sampling is based on the latest data available in Lebanon, being the *Labor Force and Household Living Conditions Survey* (2018-2019) from the Central Administration of Statistics. Due to the economic crisis, many Lebanese nationals have left the country, or left rural areas to find employment opportunities in urban centers. These variations in population density are not reflected in the document, which was produced before the crisis began.

- The unavailability of data for a specific population group, especially when it is vulnerable and hard-to-reach, does not mean this population group is not present in the country and does not have important needs. For instance, while the MSNA was not able to capture sufficient data on LGBTIQ+ head-households or households with LGBTIQ+ persons to be reliable, these results should not be interpreted to suggest they do not exist or do not have specific and diverse vulnerabilities in

[32] The following questions were reported by enumerators as making HHs within the three population groups uncomfortable: expenses, debt, food consumption, capacity to cover food needs, food coping mechanisms, menstrual hygiene, security and safety for women and girls. In addition, the question on information access was difficult to understand for HHs.
[33] The question has been discussed with shelter experts in Lebanon, but no conclusive suggestions were found to minimize this bias.

Lebanon. Similarly, migrant live-in workers may present significant vulnerabilities which are not presented in this report

- **Geographic coverage**: National and regional results are not indicative of the situation for the population living in El-Nabatiyeh and Bint Jbeil and in the Southern Suburbs of Beirut in Baabda, as those districts were not covered by the assessment due to acess constraints during the data collection
- **GPS points:** In Baalbek-El Hermel, Bekaa, South, and El Nabatieh governorates, REACH and partners' enumerators were not allowed to collect GPS points at the end of the survey. Therefore, no control of GPS point locations was possible during the data cleaning for these four governorates, which limited our capacity to geospatially monitor the data collection in these specific areas.
- **Timeliness:** When interpreting findings, users are informed that the data collection took place:
    - During the global COVID-19 pandemic, which could contribute to limit access and use of services, and access to basic needs. While the consequences of the COVID-19 pandemic were integrated in the questionnaire, their effects could have contributed to worsen the situation of the assessed population groups.
    - Before the adjustment of governmental subsidies on medication by the Lebanese government in November 2021.
    - After fuel subsidies were lifted in August 2021, which directly increased both the availability and cost of fuel but indirectly impacted electricity supply, availability of water, and communications, as well as transport costs.
    - During an ongoing fuel distribution by WASH actors.
    - Education indicators refer to the 2020-2021 school year. Considering the teachers' strike which started in Lebanon in January 2022, it is expected needs will be expected to increase for the 2021-2022 school year.
    - The conflict in Ukraine could spill over and further aggravate the food insecurity in Lebanon, as more than 80% of Lebanese wheat would be imported from Ukraine[34].

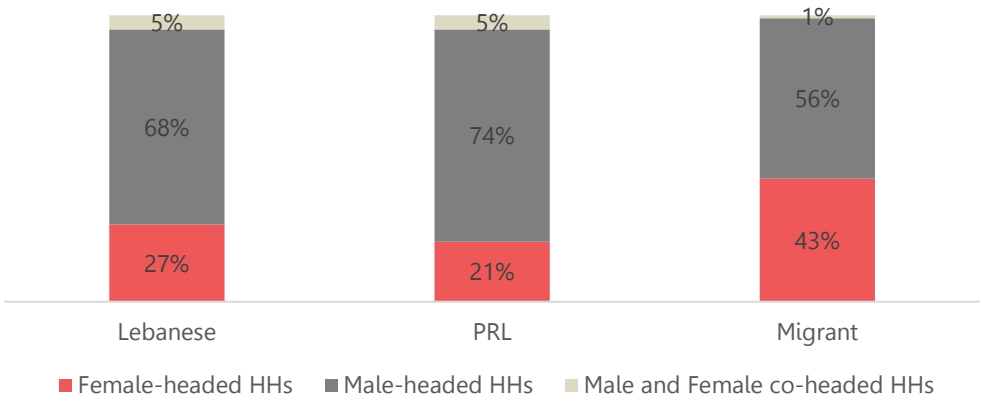
[34] Mercy Corps, Flash Update: Humanitarian Impact of Ukraine Conflict in Lebanon, March 2022.

FINDINGS

Demographics and Washington group findings

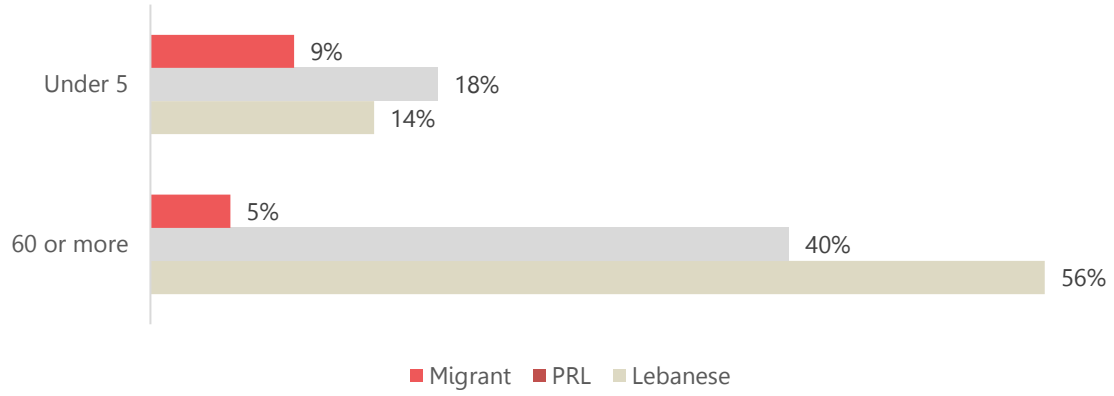
General demographic information

Figure 1. % of HHs by reported gender of head of the HHs, by population group



During the MSNA, 52% of female respondents and 48% of male respondents were surveyed. However, there was a majority of male-headed HHs in the three population groups.

Figure 2. % of HHs reporting at least one member in a vulnerable age group, by population group



The average age of respondents was roughly 50 years old for both Lebanese and PRL, against 32 years old among migrants. Regarding HHs composition, a larger proportion of Lebanese HHs reported at least one member aged 60 or more, compared to assessed PRL and migrant HHs. The results also suggest migrant age distribution is more concentrated around the age range 18-59. Migrants HHs were mostly Bangladeshi, Egyptian, and Ethiopian (respectively 23%, 23% and 20%)[35].

Washington group findings

Respectively 24% and 23% of PRL and Lebanese individuals were reported to have disabilities during the data collection[36], compared to 10% of migrant individuals. Only 4% of HHs were reporting at least

[35] Of note, data collected from migrants with Syrian nationality were intentionally excluded from this MSNA, as needs data for Syrians, both refugees and non-refugees, is covered by the VASyR.
[36] All levels of disabilities are considered here.

one member with disability 4.[37] The most common disabilities were seeing and mobility-related disabilities, both at the national and regional levels.

Among HHs with at least one child with disabilities (PRL n=29 and Lebanese n=78), the main security concern found in both population groups was bullying, reported by respectively 30% of PRL and 19% of Lebanese HHs. To be noted that 58% of Lebanese HHs and 32% of assessed PRL HHs reported no safety or security concerns for this specific population group within their community.

Livelihoods

Lebanon is currently facing a major and deep-rooted economic crisis, with availability and affordability of basic commodities and foodstuffs likely to be aggravated by the Ukrainian crisis. It appears from the MSNA results that an important proportion of the population is facing difficulties to secure sufficient livelihoods to cover for basic needs, especially among PRL and Lebanese population groups. These challenges are notably linked to limited job opportunities, resulting in substantial proportion of HHs relying on communities, saving and remittances as their main source of income, while relying on HHs debts. Furthermore, there is a high probability the situation further deteriorated since the beginning of 2022, and will continue to deteriorate in the coming months, as the Ukrainian crisis contributed to trigger another episode of inflation, specifically on fuel and grains.[38]

Employment

The combination of the economic crisis and the COVID-19 outbreak contributed to a massive contraction on the Lebanese job markets, with limited work opportunities and high unemployment rates. The employment rate was generally higher among migrant individuals, with 67% aged 18 to 59 reported as working outside of their HHs in the 30 days prior to data collection, against 45% individuals in Lebanese HHs and 35% individuals in PRL HHs. To be noted that nationally, among the three population groups, 21% of individuals aged 60 or more were reportedly working in the 30 days prior to data collection. Furthermore, MSNA findings suggest significant gender inequity related to access to livelihoods, with 29% of female HH members reportedly having worked during this period, against 65% of male members.

In addition, among individuals found not working in the 30 days prior to data collection, around 20% individuals were reportedly unemployed and seeking to work outside of the HH during the data collection. The economic contraction resulted in reduction of job opportunities nationally[39], with consequentially, a substantial proportion of HHs within the three population groups reported members who lost their jobs. In both PRL and Lebanese population groups, 28% of HHs reported at least one member had lost their job permanently or temporarily in the year prior to data collection, against 11% of assessed migrant HHs.

The situation appeared particularly critical in Baalbek El Hermel and Bekaa and Akkar and the North region, where respectively 86% and 70% of assessed migrant HHs reported at least one member of the HH had lost their work permanently or temporarily in the year prior to data collection. Furthermore, 8% of Assessed PRL HHs, 5% of Lebanese HHs, and 3% of assessed migrant HHs reported more than 2 members of the HHs had lost their job in the same period. Among HHs with at least one member with a disability, 9% of Assessed PRL HHs and 7% of Lebanese HHs reported being in this situation. 28% of assessed migrant HHs, 60% of Lebanese HHs and 43% of assessed PRL HHs reported obstacles preventing members from finding work during the data collection. The main obstacle reported was the increased competition for jobs on the employment market (Lebanese HHs: 34%, assessed PRL HHs: 33%, assessed migrant HHs: 15%)[40]. However, in Akkar and the North and Baalbek-El Hermel and Bekaa regions, respectively 19% and 17% of Assessed PRL HHs reported being under-qualified for the available jobs as the main obstacles preventing members from finding an occupation. At the district level, 16% of Lebanese HHs reported in both Bcharre and El Koura district as the main obstacle to finding a job that

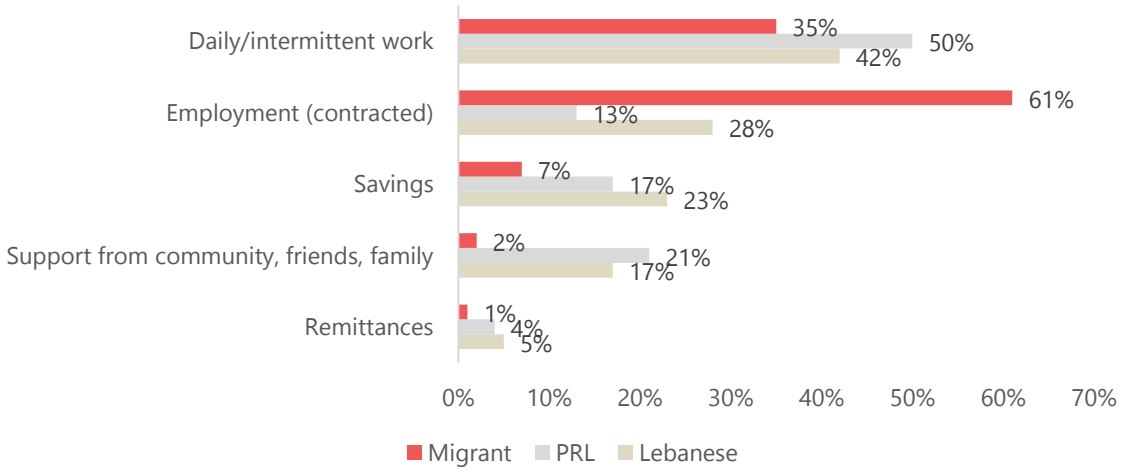
[37] Calculation was made based on the Washington Group on Disability Statistics, Analytic Guidelines, May 2020
[38] AUazeera, Lebanese fearful as fuel and wheat shortages deepens, March 2022
[39] The World Bank, Lebanon Sinking into one of the Most Severe Global Crises Episodes, amidst Deliberate Inaction, June 2021
[40] Multiple choice question: the total of percentages can exceed 100%.

only low-skilled, socially degrading, dangerous or low-paying jobs were available. In Hasbaya and Marjaayoun districts, reportedly, respectively 21% and 16% of Lebanese HHs lack employment opportunities for women, as compared to 5% of Lebanese HHs nationally.

Income and debts

As a result of this difficult economic situation, very diverse income profiles have been reported during the data collection, implying some related vulnerabilities. While PRL and Lebanese HHs reported relatively commonly reliance on savings and their community for their income, it appears assessed migrant HHs do not. This could be related to the fact that migrants generally have low savings. In addition, they often cannot rely on a strong network of friends and family, being isolated from their relatives who live abroad.

Figure 3. Main sources of income reported by HHs in the 30 days prior to data collection, by % of HHs per population group[41,42]



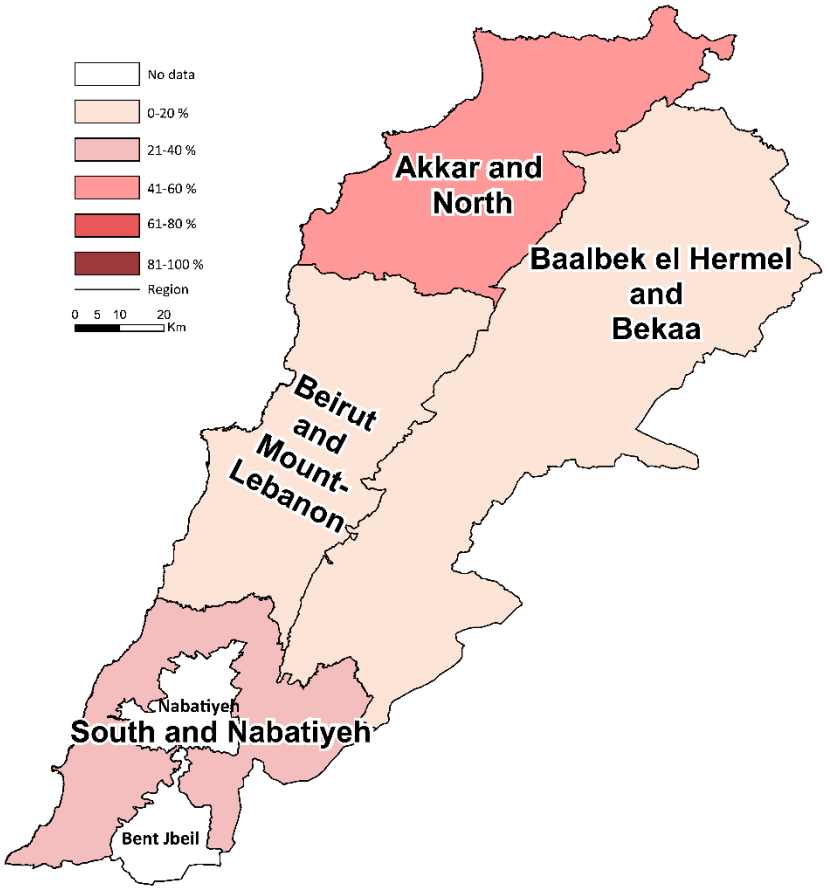
FOCUS. PRL access to legal employment

On the 8th of December 2021, Lebanon's Labour Ministry announced an amendment to labour restrictions to ease employment procedures of Lebanon born but non-Lebanese citizenship holding individuals[1]. This historic ban notably targeted PRL, preventing them from seeking employment in certain professions such as engineering, banking, and medicine. The concrete impact of this amendment is still unknown, as several syndicates and political parties are currently pushing back, as employment opportunities remain extremely limited, including for Lebanese individuals. The MSNA results highlighted the concerning situation among assessed PRL HHs, as they presented the lowest employment rate within the three population groups assessed, with 9% of HHs reporting employers preferring hiring other nationals as a main obstacle to finding a job.

1. Mercy Corps, Lebanon Crisis Update, December 2021.

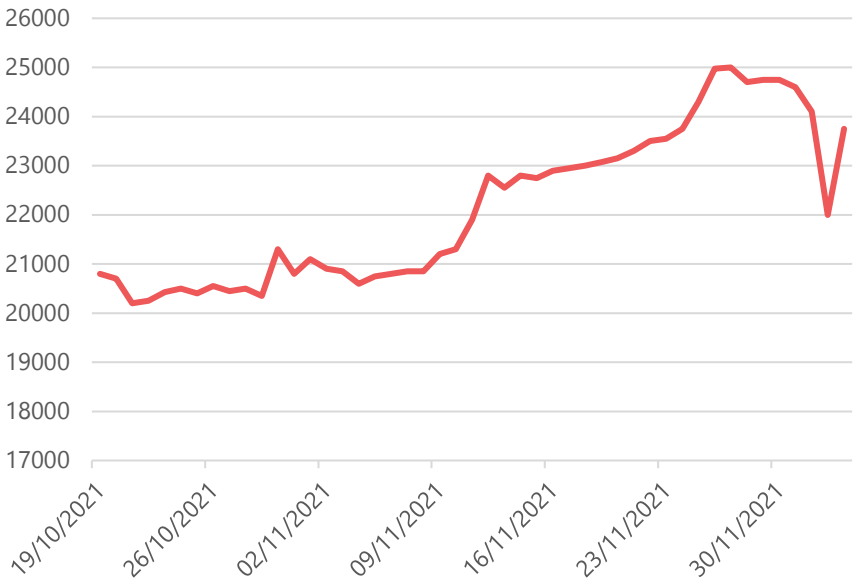
[41] Multiple choice question: the total of percentages can exceed 100%
[42] Migrants working under the Kafala system are considered under the category "Employment (contracted).

Map 2. % of migrant HHs reporting earning less than 300,000 to less than 1 million LBP in the 30 days prior to data collection



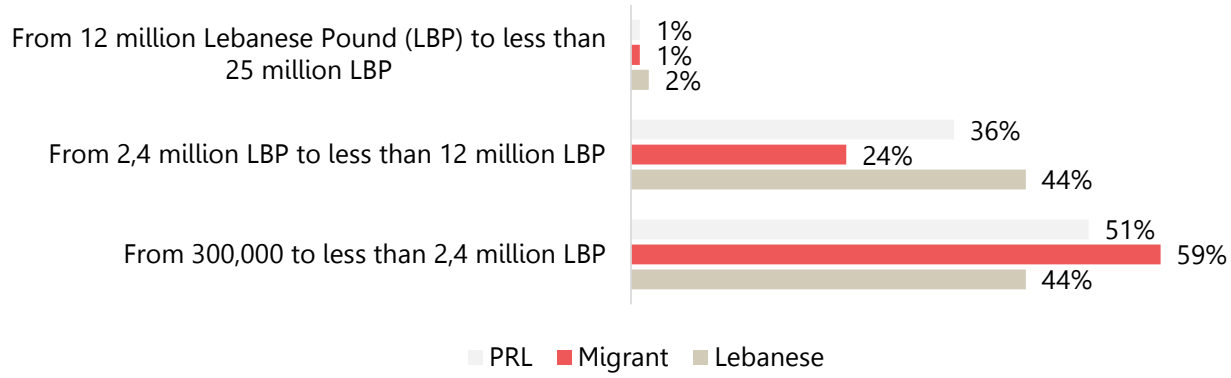
At the regional level, 17% of assessed PRL HHs in Akkar and the North region reported relying mainly on loans and debt as their main source of income. At the district level, 11% of Lebanese HHs in El Batroun district reported remittances as their main source of income. On the other hand, in Akkar district, 21% of Lebanese HHs reported retirement funds or pensions as their main source of income. Considering the sharp devaluation of the LBP, these HHs may be particularly vulnerable.

Figure 4. Evolution of the LBP rate (equivalent to 1 USD) during the data collection period (from 19th October until 4th December 2021)[43]



Indeed, the amount of income in LBP reported as earned by HHs in the 30 days prior to data collection should be considered in the light of the current volatility of the LBP, which drastically decreased the salary of HHs paid in local currency.[44] In Beirut and Mount Lebanon region, almost 30% of assessed PRL HHs reported earning less than 1 million LBP in the 30 days prior to data collection. Among assessed migrant HHs, the situation was particularly critical in Akkar and the North region, where 50% of assessed migrant HHs reported earning less than 1 million LBP in the 30 days prior to data collection. At the district level, 37% of Lebanese HHs reported earning less than 1 million LBP in Tripoli district and 32% in Hermel district. This situation is particularly concerning as LBP continued to experience substantial depreciation during the data collection period, to reach 30,000 by the end of 2021, resulting in the legal minimum wage of 675,000 LBP equalling less than 25 USD per month (see figure 4 above).[45]

Figure 5. Category of income reported by HHs in the 30 days prior to data collection, by % of HHs per population group



The LBP devaluation could generally further drive indebtedness of HHs, forcing them to take on debts to cover basic needs. Overall, 46% of both PRL and Lebanese HHs reported owing debts against only 26% of assessed migrant HHs. The majority of HHs with debts (PRL n=318 and Lebanese n=1805)

[43] More information can be obtained on the Lira Rate website.
[44] The World Bank, Lebanon Sinking into one of the Most Severe Global Crises Episods, amidst Deliberate Inaction, June 2021
[45] Mercy Corps, Lebanon Crisis Update, December 2021

reported having taken on debts to cover basic household expenditures[46] (Lebanese HHs: 49%, assessed PRL HHs: 50%, assessed migrant HHs: 51%). Among migrant HHs with debts, 26% reported having taken on debts to afford food, especially in the South and Nabatieh region (37%).

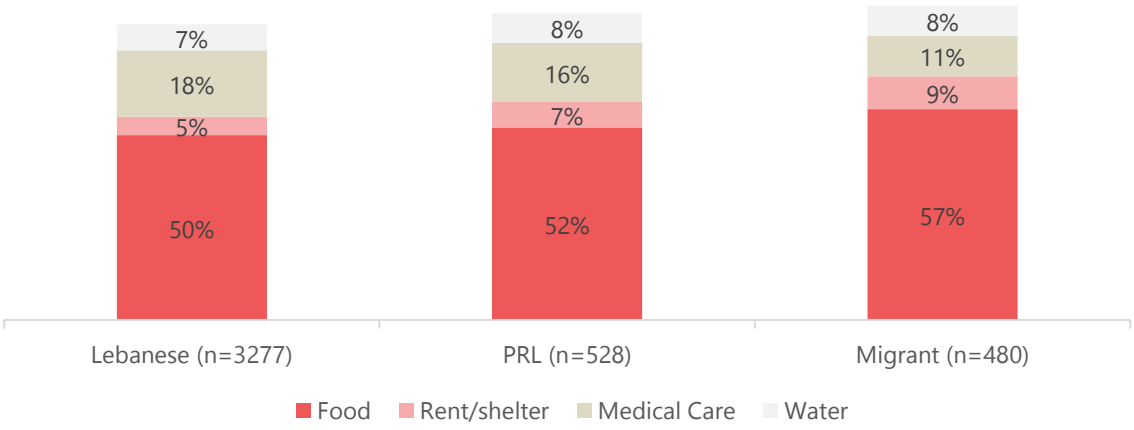
Basic needs

Despite a relative stabilisation of the LBP in early 2022[47], the currency volatility has contributed to significantly reducing HHs' purchasing power over the past years, as highlighted by the MSNA results. Around two-third of PRL and Lebanese HHs reported having faced challenges in affording basic needs because of a loss or reduction of employment in the 3 months prior to data collection, against only one-third of assessed migrant HHs. This might be related to the fact that assessed migrant HHs less commonly reported job loss or reduction in the year prior to data collection than the other assessed population groups. Particularly in South and Nabatieh region, assessed migrant HHs less commonly reported having faced challenges affording basic needs due to lost or reduced employment in the 3 months prior to data collection (only 25%), against 42% or more in the three other regions.

The main reason reported by HHs to explain difficulty in meeting essential needs was financial. However, some specific access and availability issues were reported for both health and electricity needs in the three population groups. This is likely linked to the critical vulnerabilities in accessing health care and medication (see Health section) and Lebanon's protracted electricity shortages, which became comparatively severe in 2021.[48] Following the conflict in Ukraine, global oil prices sharply increased, reflected at the national level, with a sudden 33% increase in price in less than two weeks.[49] This causes not only challenges for transportation, but also the price related to the use of electric generators has soared, which could further increase challenges in affording electricity within most vulnerable HHs. In addition, some specificities were reported in Akkar and the North region, where access and availability issues were more commonly reported in the 3 population groups compared to other regions for essential education, electricity, water, and health needs. Other concerning difficulties to access essential health needs were reported in Hasbaya and Jezzine districts, where respectively 23% and 22% of Lebanese HHs reported difficulties related to access.

Expenditures[50]

Figure 6. Average % of HH expenditure in the 30 days prior to data collection, by type of expenditures, reported by HHs who answered expenditure-related questions



Overall, food is the main expenditure item reported by HHs; on average, it represented at least 50% of HHs' expenditure within the three population groups in the 30 days prior to data collection. Most

[46] Multiple choices answer, the total percentages can exceed 100%
[47] Mercy Corps, Lebanon Crisis Update, January 2022
[48] BBC News, Lebanon left without power as grid shuts down, October 2021.
[49] AUazeera, Lebanese fearful as fuel and wheat shortages deepens, March 2022.
[50] 76% of Lebanese HHs, 85% of assessed PRL HHs and 62% of assessed migrant HHs gave their consent to answer expenditures-related questions.

Lebanese (79%), migrant (73%), and PRL (69%) HHs who reported earning less than 1 million LBP in the month prior to data collection (Lebanese n=602, PRL n=149, and migrant n=154) reported an average monthly expenditure that was higher than 1 million LBP, highlighting a considerable economic vulnerability among the lower-income segments in all assessed population groups**.**

Food security and nutrition[51]

The limited access to livelihoods and economic vulnerabilities highlighted in the previous section appear to have a considerable impact on HHs' food security. The MSNA results indicate that a significant proportion of households do not have access to adequate food. In addition, the reduction of wheat supply, and the current inflation will likely further contribute to increasing vulnerabilities regarding HHs' food security in the coming weeks and months.

FOCUS. Wheat supply in Lebanon

Cereals are the basis of Lebanon's food basket, especially wheat bread. The price of wheat flour has been steadily increasing over the past year nationally, with the highest average prices per kilos registered in South, Beirut and El-Nabatieh markets in December 2021[1]. Furthermore, most wheat reserves were destroyed by the Beirut blast, resulting in only one month wheat reserves currently available in country[2]. Considering that roughly 80% of Lebanese consumed wheat is imported from Ukraine, the Ukraine crisis could contribute to further destabilise HHs' access to cereals, with a limited supply and potentially increasing prices, and aggravate their current food-related vulnerabilities.

1. WFP, Economic explorer, Prices, 2022.
2. Mercy Corps, Flash Update: Humanitarian Impact of Ukraine Conflict in Lebanon, March 2022.

Household Hunger Scale (HHS)

In addition to the food consumption score, the MSNA allowed to obtain indicative results on the HHs' food deprivation (Household Hunger Scale, or HHS)[52]. Based on the HHS, most HHs from the 3 population groups were not considered to be facing severe hunger (HHS score 4-6) in the 30 days prior to data collection, however, a non-negligible proportion was categorised as facing moderate hunger (Lebanese HHs=13%; assessed PRL HHs=18%; assessed migrant HHs=10%). Similarly, the World Food Program (WFP) identified over 1.3 million food insecure Lebanese citizens, among whom 190,000 severely food insecure, by the end of September 2021, based on the Consolidated Approach for Reporting Indicators of Food Security (CARI) methodology.[53] Given the MSNA findings related to livelihoods, it comes as no surprise that the most critical HHS scores (moderate and severe) for both Lebanese and PRL HHs were found in north Lebanon; for example, particular HHS stress for Lebanese HHs was identified in the districts of Tripoli (36% of HHs) and Akkar (34% of HHs). Furthermore, moderate to severe hunger scores for migrant HHs were most prevalent in the Beirut and Mount Lebanon region.

Coping strategies

Reliance on negative coping strategies commonly indicates an increased vulnerability to future shocks due to the erosion of assets and coping abilities among HHs. Overall, 33% of Lebanese HHs, 32% of assessed PRL HHs and 16% of assessed migrant HHs reported having sold productive assets and/or means of transport such as sewing machines, wheelbarrows, bicycles, cars, or livestock to buy food in

[51] To be noted that during the REACH Initiative internal lesson learnt exercise, enumerators reported HHs seemed "really uncomfortable" when food security questions were asked. It is likely percentages in this section are not an accurate representation of the actual situation of HHs in the three population groups and data should be considered indicative.
[52] Food and nutrition Technical assistance (FANTA) III, Household Hunger Scale: Indicator Definition and Measurement Guide, August 2011.
[53] WFP and FAO, Hunger Hotspots, February 2022: This proportion includes Syrian refugees, who are not in the scope of this MSNA.

the 30 days prior to data collection or having already exhausted that strategy. In Jezzine district, a particularly high proportion of Lebanese HHs (23%) of HHs reported already having exhausted this coping mechanism.

Finally, during the data collection, the main coping mechanism reported by HHs was reducing food expenditures, with 89% of assessed PRL HHs, 87% of Lebanese HHs and 63% of assessed migrant HHs reporting having reduced food-related expenditures in the 30 days prior to data collection, or having already exhausted this strategy. In Jezzine district again, 19% of Lebanese HHs reported having already used this coping mechanism.

Water, hygiene, and sanitation (WASH)

Equal access to WASH is the 6th Sustainable Development Goal (SDG) of the 2030 UN Agenda.[54] It aims to promote equal access, including most vulnerable groups, to good quality water, and to tackle open defecation practices. Findings suggest a relatively stable WASH situation in Lebanon at the time of data collection, with most HHs from the three assessed population groups reporting having access to sufficient water from an improved water source, as well as access to improved facilities in dignifying conditions.

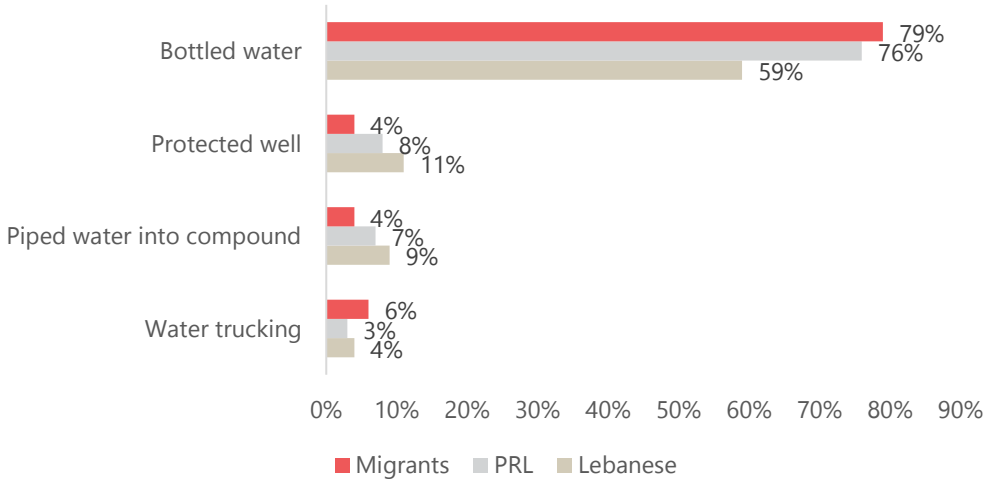
Water

1. *Primary source of drinking water*

Access to safe water is key to protect HHs from diseases and ensure respect for health and nutrition standards**.** Roughly three quarters of assessed migrant and PRL HHs and 1/3 of Lebanese HHs reported bottled water as their primary source of drinking water. Even though bottled water is considered as an improved water source, it is also subjected to price volatility caused by the current economic and financial crisis in Lebanon. In addition, the extensive quantity of plastic necessary to cover the drinking needs of HHs reporting bottled water as their primary source of drinking water is considerable. Considering bottled water contributes to pollution, as fossil fuel is necessary to produce enough plastic[55], this implies a substantial negative environmental impact. In addition, most plastic bottles are not properly recycled in Lebanon, as the waste management system is facing financial challenges in several Lebanon governorates.[56] Therefore, the plastic used to package water often ends up in nature, where it takes over 1,000 years to bio-degrade while producing toxic fumes when being burned.[57]

[54] United-Nations, Agenda 2030, March 2022
[55] Harvard University, Reasons to Avoid Bottled Water.
[56] AlJazeera, State of decay: How rubbish became Lebanon's latest dumpster fire, November 2021
[57] For more information about the environmental cost of bottled water, please consult The Water Project.

Figure 7. % of HHs reporting their primary source of drinking water, by population groups



A small proportion of HHs reported relying on an unimproved water source (e.g., surface water, unprotected spring, unprotected well, unprotected water tank) (Lebanese HHs: 4%, PRL HHs: 1% and migrant HHs: 1%), which was particularly commonly reported by Lebanese HHs in Akkar (14%) and Jezzine (13%) districts. Access to water sources seems rather stable in Lebanon, as in the six months prior to data collection, only a minority of HHs in the three population groups reported having experienced a change in their primary source of drinking water (Lebanese HHs = 13%, Assessed PRL HHs = 12% and assessed migrant HHs = 6%).

2. Water basic needs

Almost all HHs reported having enough water to cover their basic needs in terms of drinking, cooking, personal hygiene, and other domestic purposes at the time of data collection, with higher proportion of Lebanese HHs reporting challenges to cover their various water needs compared to assessed PRL and migrant HHs. At district level, the situation appeared to be the most severe in the districts of Chouf and Tripoli, where respectively 23% and 19% of Lebanese HHs reported not having access to enough water to cover their drinking needs.

Some of these water needs could notably be linked to difficulties of water supply, due to the ongoing fuel crisis. An assessment was performed in August 2021 by the WASH sector in collaboration with the 4 Water Establishments, in 1,436 cadasters.[58] The calculation was done both for Electricité du Liban (EDL) supply and Generator together and EDL. Findings from this assessment indicated that 87% of the population of Lebanon were connected to a water source that depends on EDL as the main power source. However, the median of reported EDL supply hours varied greatly across governorates, ranging from 18 hours in South and Nabatieh to only 3 hours in Mount Lebanon and 2 hours in Baalbek-El Hermel. Furthermore, roughly 60% of the population in Lebanon are reportedly receiving less than 35 L/P/D[59] in their dwelling according to KIs, considering both Generator and EDL. Considering only EDL supply (excluding generator), this percentage become much higher, reaching an estimated 98% in Hermel according to KIIs.

[58] Water Sector Information Management, Water Supply Vulnerability Mapping, 2021.
[59] The average consumption for domestic use in the National Water Sector Strategy is 125 L/c/d.

3. Coping mechanisms

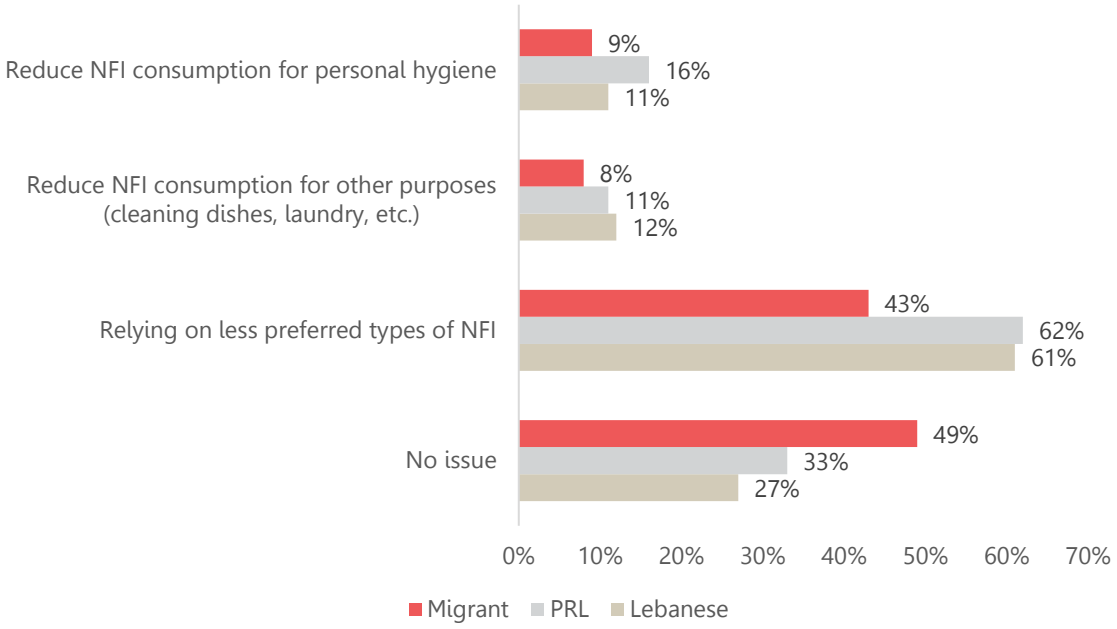
The MSNA questionnaire included questions on the types of coping mechanisms, if any, HHs resorted to when facing trouble meeting their water needs. Among HHs reporting not having been able to cover at least one water need (Lebanese n=745; PRL n=146; migrant n=126), the majority of Lebanese HHs (85%), PRL HHs (68%), and migrant HHs (59%) reported having used coping mechanisms in the 30 days prior to data collection to deal with a lack of water.[60] Among those HHs who reported an inability to cover all water needs, one of the most commonly reported coping mechanisms was to spend money usually spent on other things to buy water (Lebanese HHs: 35%, assessed PRL HHs: 20%, assessed migrant HHs: 36%). In addition, relying on different sources of water to cover some specific needs was also largely reported in the three population groups, and especially among Lebanese HHs (25%).

Hygiene

1. Access to hygiene items and coping strategies

Handwashing with soap is a critical component to reduce the risk of transmission of infectious diseases, including COVID-19.[61] Understanding the accessibility of soap within HHs is a key element to ensure efficient hygiene practices. During the data collection, 95% of HHs or more reported having soap in their HH in the three population groups. However, 17% of Lebanese HHs in El Hermel district reported not having access to soap in their HH during the data collection, a significant proportion compared to other areas. The main coping mechanisms reported by HHs to adapt to issues related to hygiene items in the 30 days prior to data collection was to rely on less preferred types of NFIs.

Figure 8. Main coping strategies reported by HHs when facing issues related to hygiene items, if any, by % of HHs per population group



2. Access to menstrual items and coping strategies

The consequent inflation over the past year has resulted in increasing difficulties for women to access menstrual hygiene products, as highlighted in the Period Poverty in Lebanon study conducted in May

[60] Multiple choices answer; the total of percentages can exceed 100%.
[61] FAQ: How does handwashing with soap remove and kill SARS-CoV-2? | COVID-19 Hygiene Hub Resources.

2021 by Plan International.[62] Among HHs with a female respondent (Lebanese n=1093; PRL n=183; migrant n=237)[63], the majority of Lebanese (84%), PRL (94%), and migrant (93%) HHs from the MSNA reported using disposal pads as their main menstrual material during their last period prior to data collection. In Baabda district, 9% of Lebanese respondents reported bleeding into their clothes. The main coping strategy to adapt to issued related to accessing menstrual items in the 30 days prior to data collection reported by these respondents was to rely on less preferred types of menstrual items,[64] which was reported by 53% PRL respondents, 44% of Lebanese respondents, and 20% of assessed migrant respondents. In Hasbaya district, a particularly high proportion of female respondents (16%) reported women were staying at home during their menstrual cycle. In the Plan International study, more than 10% of Lebanese women surveyed also reported strongly agreeing that they experienced stress and anxiety related to accessing menstrual items and that they experienced physical symptoms related to their lack of access to those items.[65]

Sanitation

1. *Sanitation facilities and wastewater draining system*

MSNA findings suggest overall sanitation-related needs are low, with almost no reports of open defecation. Almost all HHs reported flush or pour toilets as their usual sanitation facility (Lebanese HHs: 93%, assessed PRL HHs: 95% and assessed migrant HHs: 92%). Merely no case of open defecation was reported (1% of assessed migrant HHs). In Tripoli district, a comparatively high proportion (8%) of Lebanese HHs reported their latrine/toilet were not usable because of damage, being full, or because of the absence of handwashing facilities during the data collection.

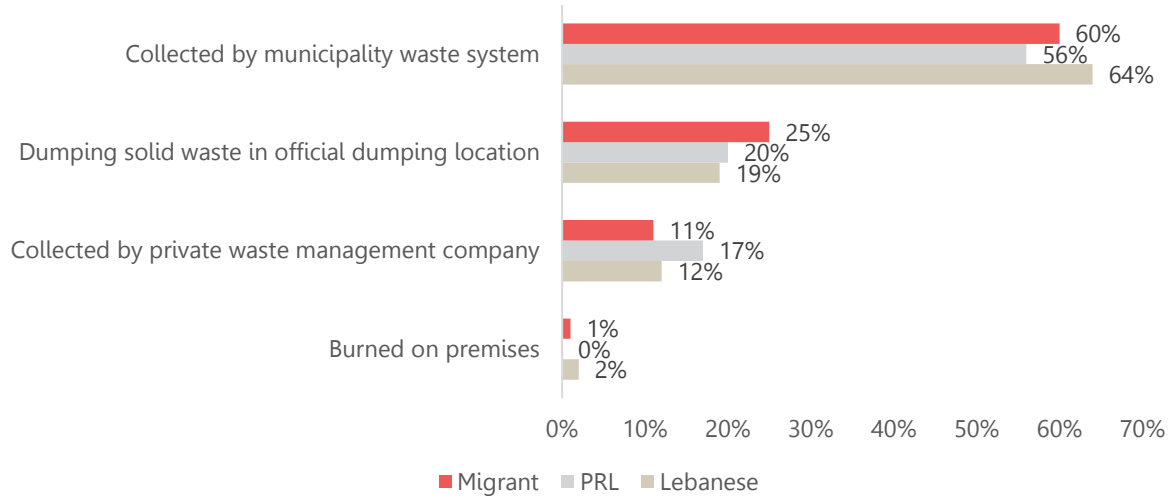
In terms of waste water draining systems, the results were also quite encouraging as most HHs in the three population groups reported their sanitation facility was connected to a communal lined drainage and to the sewage system (Lebanese HHs: 65%, assessed PRL HHs: 81%, assessed migrant HHs: 75%). However, 12% of Lebanese HHs reported a hand-dug hole in the ground was their primary wastewater draining system, especially, in El Hermel, Chouf and Akkar districts. While most Lebanese and assessed PRL HHs reported not sharing their sanitation facility (respectively 95% and 96%), 18% of assessed migrant HHs reported sharing them regularly with people that were not part of their household.

2. *Solid waste disposal*

The majority of HHs in the three population groups reported their solid waste was collected by the municipality waste system (see figure 9). In addition, around 10% of assessed PRL HHs reported solid waste disposal collection was conducted by UNRWA. The collection of solid waste contributes to fight propagation of communicable disease and reduce risks of infantile diseases.[66]

[62] Plan International, Period Poverty in Lebanon, Research study, August 2021; data are covering Lebanese, PRL and Syrian HHs, which limits our capacity to use the overall results of the study as the population groups of interest differs from the MSNA coverage.
[63] The question was also asked only when there was at least one female enumerator during the interview.
[64] Multiple choices answer: the total of percentages can exceed 100%; potentially, this could also mean relying on less preferred brands.
[65] Plan International (August 2021).
[66] For more information about WASH and health, please consult UNICEF.

Figure 9.% of HHs reporting solid waste disposal, per population groups



Shelter

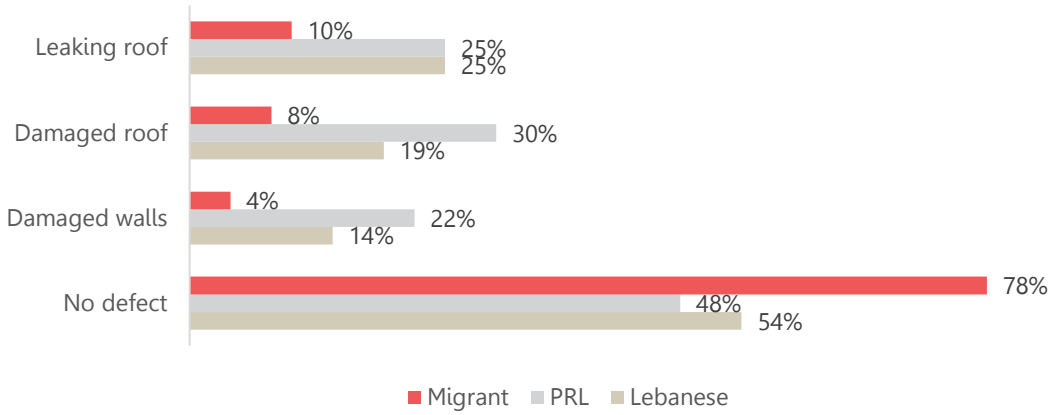
Shelter types and conditions

"Poorly constructed buildings are often the largest cause of serious injury, trauma, and death in the event of a disaster. After disasters, most families rebuild their houses relying on their own resources, with little or no support from formal institutions or the humanitarian community".[67] Understanding the type of shelters in which HHs are living and the presence of defects in these shelters is key to prevent serious injuries. Overall, most Lebanese (98%), as well as assessed PRL (98%), and migrant (89%) HHs reported living in an apartment, house, or room, which are considered as rather safe shelter types. In addition, 4% of assessed migrant HHs reported living in concierge's room in residential building, which was most reported by migrant HHs from Beirut and Mount Lebanon region (11%). Moreover, 10% of migrants from Akkar and the North reported living in tents. As the data collection was conducted at the beginning of the winter, these HHs were at particular risks of being exposed to low temperatures and adverse weather.

The types of defects reported within a shelter is also a key indicator to understand HHs' vulnerabilities;[68,69] 19% of Lebanese HHs and 30% of assessed PRL HHs reported living in a shelter with a damaged roof (compared to 8% of assessed migrant HHs), which are considered as dangerous defects, jeopardising the structure of a building. Shelter damage was especially apparent in Beirut and Mount Lebanon region (31% of assessed PRL HHs). Moreover, 14% of Lebanese HHs and 13% of assessed PRL HHs reported living in a shelter with damaged columns.

[67] Extract from the Global Shelter Cluster.
[68] Enumerators' training was different from the Vasy-R training. Therefore, comparison between the shelter defects results should be avoided.
[69] Multiple choices answer; the total of percentages can exceed 100%

Figure 10. Most commonly reported shelter defects in current shelter, by % of assessed HHs per population group



Occupancy arrangement and Housing, Land and Property (HLP) issues

The occupancy arrangement is a key element to understand housing, land, and property risks, such as eviction threats. Overall, 72% of Lebanese HHs and 59% of assessed PRL HHs reportedly own their shelter[70], against 7% of assessed migrant HHs.[71] Most assessed migrant HHs were living in a shelter provided by their employer (53%). Furthermore, 30% of assessed PRL HHs, 29% of assessed migrant HHs and 23% of Lebanese HHs reported renting their apartment. Among assessed migrant HHs, rented shelters were most commonly reported in Akkar and the North region (47% of HHs) and in Beirut and Mount Lebanon region (46%). At district level, Lebanese HHs were mainly renting their shelter in Tripoli (55%) and El Meten (40%). Among those assessed HHs renting their apartment, 26% of PRL, 19% of, and 15% of migrant HHs reported having an informal verbal lease agreement.

Despite a non-negligible proportion of HHs living under concerning occupancy arrangement, the majority of HHs in the three population groups did not report any HLP issues with their shelter during the data collection. Overall, only 2% of both Lebanese and PRL HHs reported being threatened with eviction or harassed by their landlord.[72]

Health

MSNA findings indicate access to health care is limited for all three population groups, mostly related to financial barriers, potentially further aggravated among Lebanese HHs by the disruption of public and private insurance schemes.[73] While the lift of governmental subsidies[74] could contribute to increase medication availability in country, it could also result in price increases, in a context where most HHs are already reporting cost-related barriers to access consultations, medication and treatments.

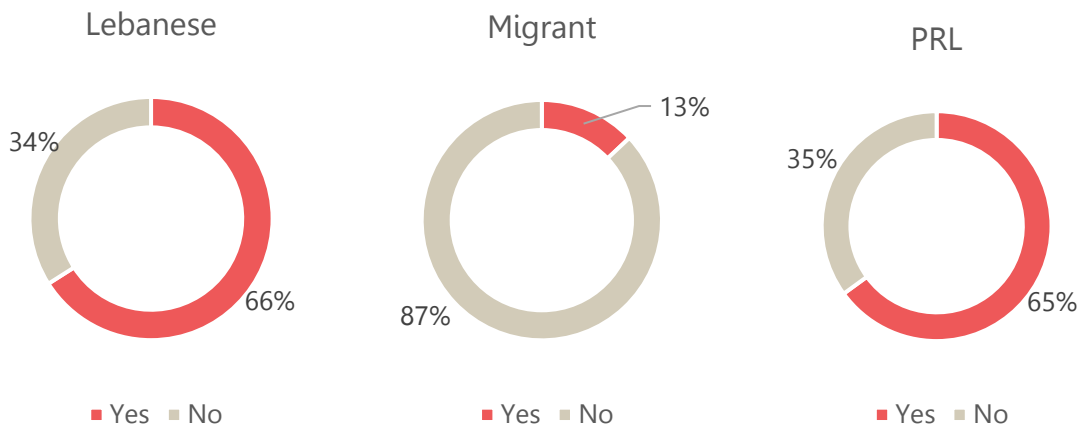
HH members with health conditions

The presence of members presenting health-related vulnerabilities seems to be quite considerable in Lebanon, especially among Lebanese and Assessed PRL HHs. In fact, around two third of HHs from both population groups reported at least one HH member with a chronic illness.[75] Among the Lebanese population group, several districts were particularly concerned by this issue, for instance in Marjaayoun

[70] Lebanese law prevents PRL to own their shelter; this high percentage of assessed PRL HHs reporting being owner of their shelter could be PRL owning shelters distributed by UNRWA.
[71] The proportion of assessed PRL HHs reporting owning their shelter is quite substantial, compared to other information collected by the shelter colleagues. It is possible the question was not fully understood by assessed PRL HHs.
[72] Multiple choices answer: the total of percentages can exceed 100%.
[73] OCHA, Joint analysis, March 2021.
[74] Mercy Corps, Lebanon Crisis Update, December 2021
[75] Chronic illness: heart disease, hypertension, blood disease, cancer, lung disease, diabetes, renal diseases.

district, more than 80% of HHs reportedly had at least one member living with a chronic illness at the time of data collection.

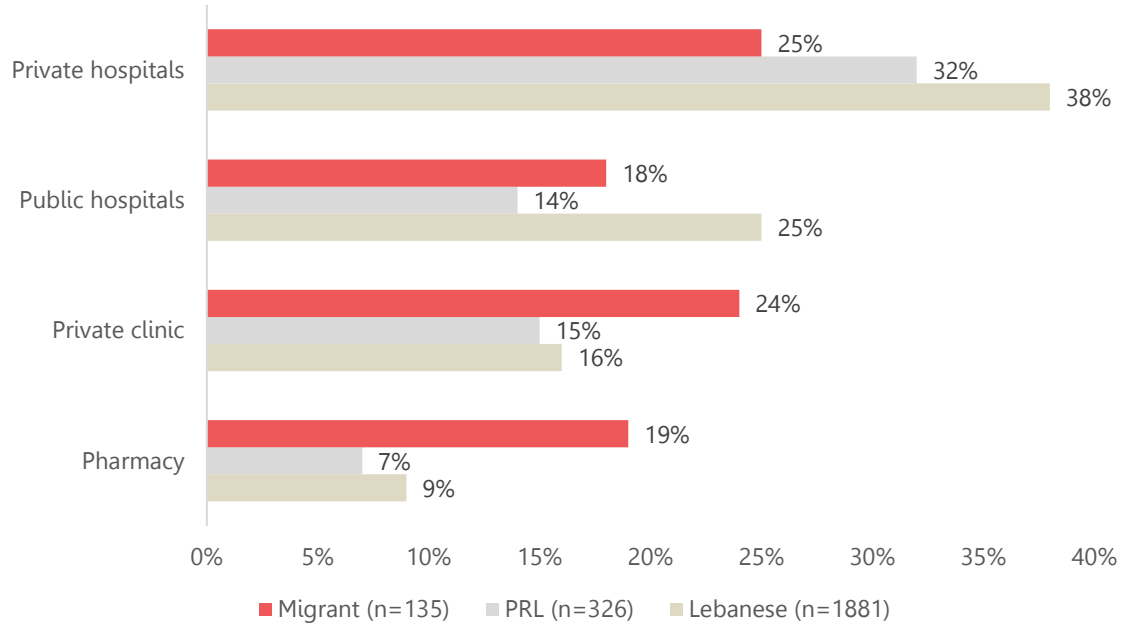
Figure 11. % of HHs reporting at least one member with a chronic illness at the time of data collection, by population group



While chronic illness seems to be quite widespread in Lebanon, especially in the PRL and Lebanese population groups, a very limited proportion of HHs reported at least one member with a medical condition whose management requires regular supply of electricity (7% of Lebanese HHs, 9% of assessed PRL HHs and 2% of assessed migrant HHs). This finding is particularly notable, given sustained. unpredictable, and geographically unequal electricity shortages, with sporadic access to public supply.[76]

Access to health care

Figure 12. Main health facilities where HHs who needed to access health care in the 3 months prior to data collection reported seeking services, by population group

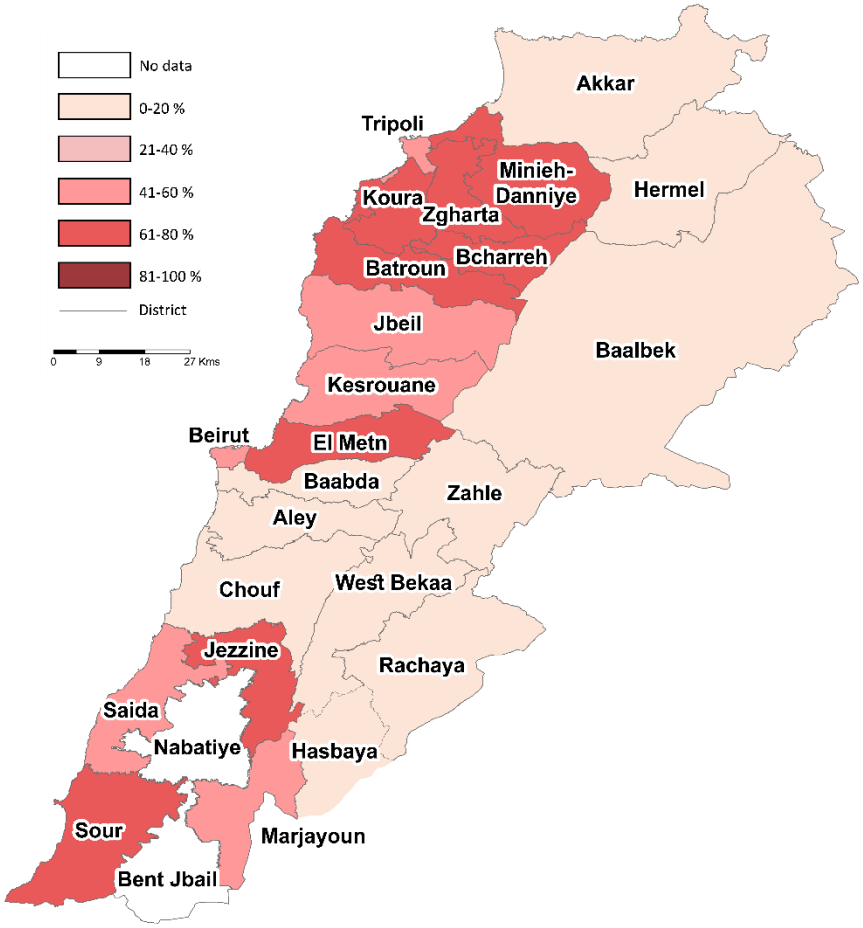


Access to health care was concerning particularly among PRL and Lebanese HHs. Among HHs who had a health problem and needed to access health care in the 3 months prior to data collection, most HHs from the three population groups reported accessing private hospitals (see Figure 12). Baalbek-El

[76] BBC News, Lebanon left without power as grid shuts down, October 2021.

Hermel and Bekaa was the only region where the proportion of HHs reporting having sought health care in government hospitals was higher than the proportion reporting private centres (34%, against 29%). HHs with at least on pregnant or lactating woman and HHs with at least one member under 5 more commonly reported seeking health care at NGO clinics, while HHs with at least one member with disability more commonly reported not seeking treatment at all or seeking treatment but not being able to access it, highlighting a particular vulnerability among this group.

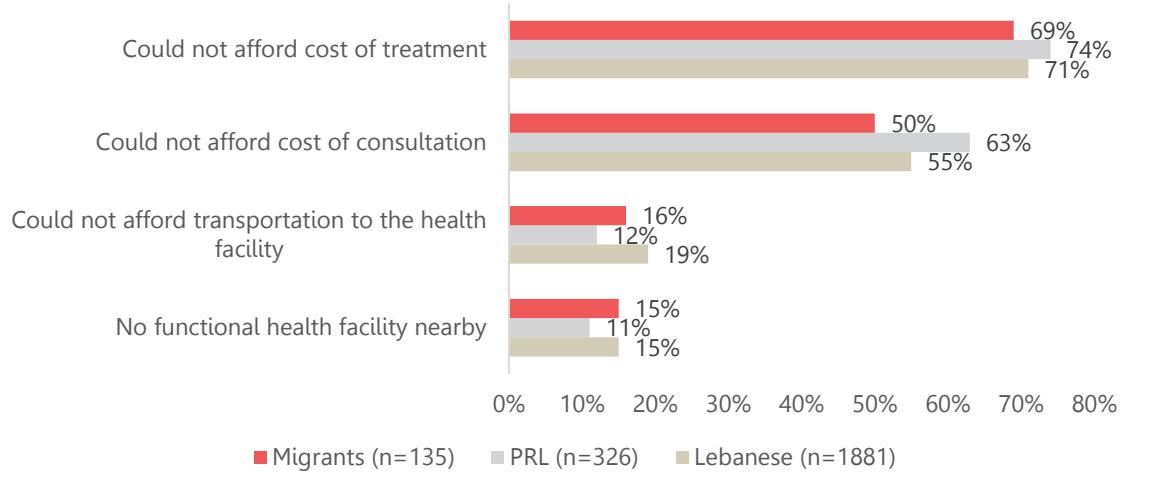
Map 3. % of Lebanese HHs reporting at least one member with a health problem and in need to access health care in the 3 months prior to data collection



While geographical barriers appeared minimal, several other types of barriers seemed to have prevented HHs from accessing health services when needed in the 3 months prior to data collection[77]. Among HHs reporting barriers preventing them from accessing health care (Lebanese n=1881, PRL n=326 and migrant n=135), the main reported barriers appeared to be cost-related rather than due to limited availability; 74% of assessed PRL, 71% of Lebanese, and 69% of migrant HHs reported they could not afford the cost of treatment,[78] while cost of consultation and cost of transportation were the two other most commonly reported barriers. That said, availability-related barriers were reported in some specific regions, for instance, among Lebanese HHs reporting barriers in Jezzine district (n=57) and Hasbaya district (n= 90), respectively 68% and 39% reported the absence of functional health facility nearby among the main barriers to accessing health care when needed.

[77] Multiple choice question: the total of percentages can exceed 100%
[78] Ibid.

Figure 13. Main barriers preventing access to health care when needed in the 3 months prior to data collection, by % of assessed HHs who needed to access health care per population group[79]



Analysis of protection results reveals that that women and girls may face particular barriers to service access. Among HHs with at least one woman or girl (Lebanese n= 1831; PRL n=256; migrant n=254)[80], the proportion of HHs reporting women and girls having access to key support services[81] within 30 minutes from their HH by their usual means of transport were extremely low, and suggested barriers in terms of both information and availability. Indeed, roughly 30% of HHs from the three population groups reported not having information about the access to the listed services. In addition, between 50% and 67% of HHs from the three population groups reported not having access to these types of services, suggesting only a small portion of HHs are actually benefiting from existing programs. The main barriers reported by HHs attempting to access these services was also cost-related in the three population groups (cost of services or transportation to go to the facility).

Coping mechanisms to access health care

Among HHs who reported at least one member not being able to access health care when needed in the 3 months prior to data collection (Lebanese n=1833, PRL n=312 and migrant n=128)[82], more than one third reported not having used any coping mechanisms to adjust to barriers in accessing health care in the 3 months prior to data collection (assessed migrant HHs: 59%, Lebanese HHs: 40%, assessed PRL HHs: 37%). Aligned with cost-related barriers reported by HHs, seeking alternatives to avoid paying treatment emerged as a common coping mechanism.[83] For instance, 25% of assessed PRL HHs, 18% of Lebanese HHs and 10% of assessed migrant HHs reported they went to a pharmacy instead of a doctor clinic,[84] which are generally perceived to be cheaper options to prevent paying hospital bills. Moreover, 17% of Lebanese HHs, 11% of assessed PRL HHs and 4% of assessed migrant HHs reported they delayed or cancelled a doctor's appointment to cope with (financial) access barriers. Financial concerns were also reflected in the type of health facilities HHs were using, as 12% of Lebanese HHs, 11% of assessed PRL HHs and 3% of assessed migrant HHs reported they switched to a public health care facility instead of a private one.

In addition, reported coping mechanisms echoed difficulties of access and cost of transportation to the health facility, as 16% of assessed PRL HHs, 13% of Lebanese HHs and 8% of assessed migrant HHs reported they adapted to barriers to access health care in the 3 months prior to data collection by

[79] Ibid.
[80] The question was also asked only when there was at least one female enumerator during the interview.
[81] The services included in the questionnaire were: psychosocial support services, reproductive health services, services for women and girls experiencing some forms of violence and recreational activities.
[82] Subset also excludes HHs who reported "do not know" and "decline to answer" to health care barriers question.
[83] Multiple choice question; the total of percentages can exceed 100%.
[84] Ibid.

switching to a health care facility closer to home. Among those Lebanese HHs in Akkar district who had not been able to access healthcare when needed (Lebanese n= 58), 17% reported having borrowed money to afford medical care in the 3 months prior to data collection.

In Baalbek district (Lebanese n=88), 21% of Lebanese HHs reported they adapted to barriers to access health care by going to a traditional healer instead of a doctor or clinic, compared to 3% of Lebanese HHs nationally.

Access to medication

Further inquiry about particular barriers to access medication revealed that 50% of assessed migrant HHs, 14% of assessed PRL HHs and 13% of Lebanese HHs reported barriers that prevented them from accessing medication when needed. In Akkar and North, 93% of assessed PRL HHs reported they faced barriers when trying to access medication while at district level, 96% of Lebanese HHs in El Hermel and Baalbek reported these barriers.

A considerable majority of HHs reporting barriers to access medication reported having employed coping mechanisms in the 3 months prior to data collection to adjust to the inaccessibility of medication in Lebanon.[85] Among assessed HHs reporting barriers to access medication (Lebanese n=3679, PRL n=572 and migrant n=425), the most commonly reported strategy was to switch to substitutes or generics (Lebanese HHs: 55%; assessed PRL HHs: 53%; assessed migrant HHs: 35%). More concerning, 28% of assessed Lebanese, 26% of PRL, and 18% of migrant HHs reported rationing their medication as a strategy.

FOCUS. The struggle to reliably secure medication in a fluctuating market

Similar to observed trends in access to health care, the primary barrier reported by HHs preventing them from accessing medication when they needed it during the 3 months prior to data collection was cost related. Following a governmental reduction in medication subsidies in November 2021, medication affordability barriers are likely to increase across all populations[1], particularly those HHs reporting at least one member living with a chronic illness. Daily medication is often required to control non-communicable diseases, leaving these patients particularly vulnerable to price increases and worsening health outcomes as they frequently resort to rationing existing medicines.[2] Between December 2021 and January 2022 alone, the price of a monthly supply of diabetes medicine increased more than 8 times.[3] Patients' access is further hindered by market scarcity: 57% of Lebanese HHs, 56% of assessed PRL HHs, and 30% of assessed migrant HHs reported medication was not available in their private pharmacy. While changes in subsidies may offer some improvement in availability, patients may increasingly struggle to afford life-saving medications. Reliance on the MoPH primary health care network has increased 225% during 2021,[4] largely driven by demand for medication support. Yet, the health system is struggling to cope with heightened utilisation and medication is sometimes not available in the health facility as reported by 38% of Lebanese HHs, 36% of assessed PRL HHs and 16% of assessed migrant HHs.

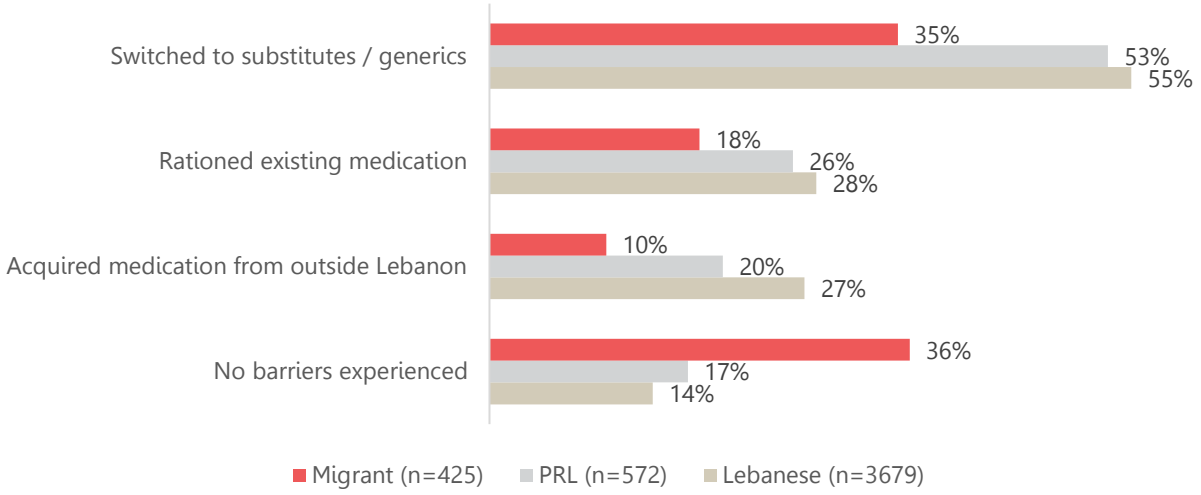
1. Reuters, 'People will be harmed' as Lebanon cuts medicine subsidies, November 2021
2. MSNA findings
3. Mercy Corps, Lebanon Crisis Update, December 2021
4. Lebanese Ministry of Public Health (MoPH), Primary Health Care (PHC) Network beneficiaries' data, 2021

In addition, as medication supply is currently limited to scarce in some areas of Lebanon[86], a non-negligible proportion of HHs reported having acquired medication from outside Lebanon as a strategy to adjust to the inaccessibility of medication in the 3 months prior to data collection (Lebanese HHs: 27%, Assessed PRL HHs: 20%, assessed migrant HHs: 10%). At district level, among Lebanese HHs who reported having experienced barriers in Aley (n=128) and Baalbek (n=124), a comparatively high proportion (16% in both districts, compared to 8% nationally) reported having resorted to borrowing

[85] Multiple choices answer, the total of percentages can exceed 100%.
[86] Lebanon: Scarce supplies of fuel and medicine push health system to the brink | Doctors Without Borders - USA

money to afford medication in the 3 months prior to data collection, and 13% of HHs in Baalbek reported having sold HH assets to afford medication.

Figure 14. Main coping mechanisms reported by HHs to adjust to barriers to access medicines in the 3 months prior to data collection, by % of HHs reporting having experienced barriers per population group



Access to Routine Immunisation[87]

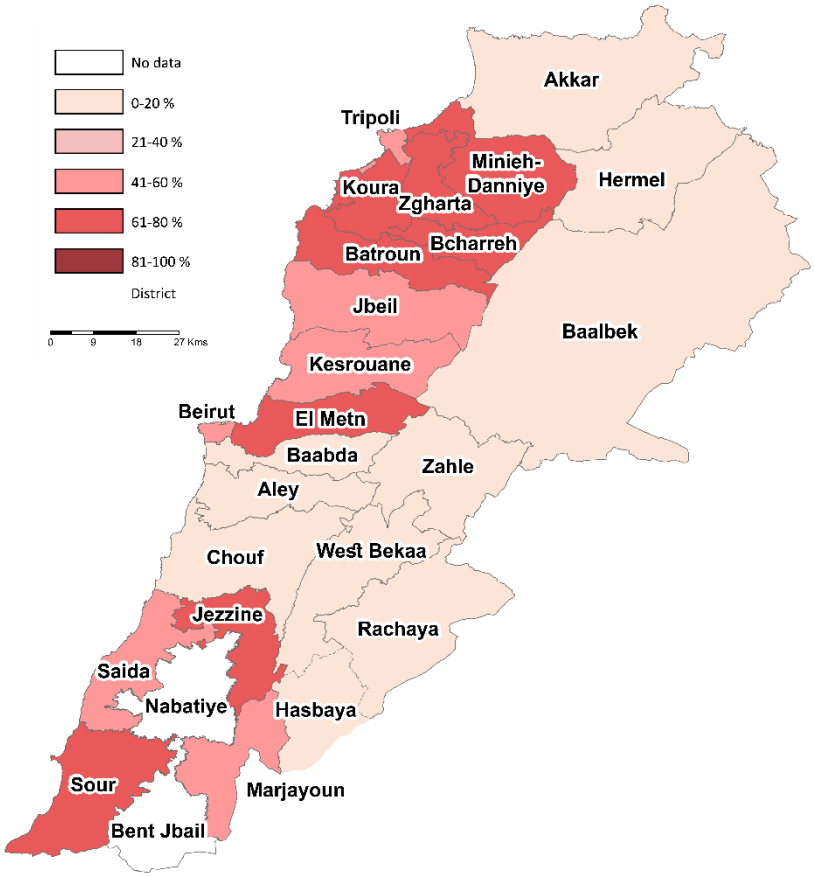
Vaccines are critical as they contribute to reducing risks of getting a disease. Immunisation through vaccination currently prevents around 3 million deaths every year from infectious diseases.[88] The majority of HHs with child(ren) aged 0-4 within the three population groups did not report having experienced any barriers in receiving vaccination for their child(ren) in the year prior to data collection. The main barrier reported by assessed Lebanese (n=594) and migrant HHs (n=57) who had reportedly experienced barriers, was the fact that vaccines were not available in their community, reported by 14% and 9%, respectively. [89]. It was particularly reported by Lebanese HHs living in Zgharta (n =34) and Akkar districts (n=32) (respectively 27% and 25%). Lebanese HHs reported additional barriers linked to access in Akkar district, where 25% of HHs reported that vaccination sites were difficult to access because they were too far away, or because of limited hours of operation.

Impact on the crisis on mental health

The current multi-layered crisis contributed to a fast deterioration of the economic and political context within Lebanon. The crisis also seems to have negatively impacted population groups at an individual level. Adults in particular were reportedly facing consequent mental distress because of the current crisis, with 50% of assessed PRL HHs, 45% of Lebanese HHs and 21% of assessed migrant HHs reporting at least one member of the HHs was negatively affected by the crisis, such as being nervous, irritable, worried, or sad, hopeless, or portraying other signs.[90] At district level, in El Batroun, El Minieh-Dennie, and Bcharre, 73%, 72% and 71% of Lebanese HHs, respectively, reported some adult HH members were in psychological distress. In addition, 10% of HHs overall reported having observed signs of distress among children, which was particularly commonly reported by Lebanese HHs in Tripoli and Saida districts (20% in both districts).

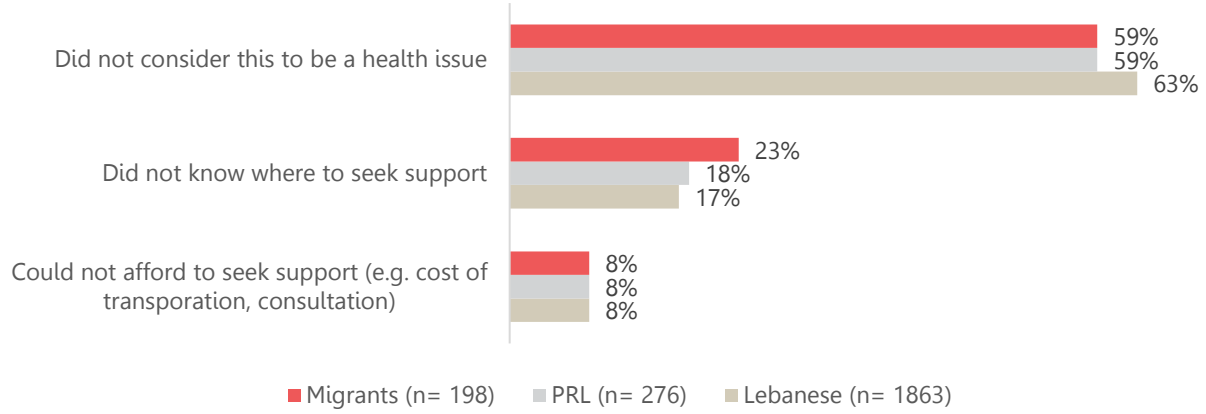
[87] This section only refers to HHs reporting at least one child aged from 0 to 4 years old during the data collection. It does not concern covid-19 vaccines.
[88] World Health Organisation (WHO)
[89] Multiple choice question, the total of percentages can exceed 100%.
[90] ibid.

Map 4. % of Lebanese HHs reporting at least one member whose mental health was negatively affected by the crisis



Among HHs reporting having at least one member who was negatively affected by the ongoing crisis in Lebanon (Lebanese n=2129, PRL n=346 and migrant n=217), only a minority reported the concerned HH member(s) sought services or support from a health care provider for this concern: 19% of assessed PRL HHs, 13% of assessed Lebanese HHs and 5% of assessed migrant HHs. Among those HHs that reported the member(s) did not seek services or support from a health care provider, the main reason reported was that the member did not consider it as a health issue.

Figure 15. Main reported reasons for not seeking support, by % of HHs with negatively affected members who reported not seeking support per population groups



Protection

Overall, MSNA findings indicated limited concerns within the three population groups in terms of protection, including GBV and CP. However, given the sensitivity of these topics, it is likely that some particularly sensitive topics were under-reported. This is especially true for assessed migrant HHs, and migrant respondents living within Lebanese HHs, who might not have felt comfortable to report on their true situation due to the presence of their employer/sponsor during data collection.[91]

Overall, it appears most HH members had an identification (ID) document at the time of data collection. Such documents are often required to access public services, such as health services, and safeguard human rights. Only 4% of assessed migrant HHs, 2% of Lebanese HHs and 1% of assessed PRL HHs reported not every person in their HH was in possession of a valid ID document, such as a national ID and/or passport, that was stored in a secure place. The highest proportion of assessed migrant HHs reporting not all HH members having an ID was found Akkar and the North region (7%), while 6% of Lebanese HHs reported the same issue in Tripoli district.

More strikingly, 42% of assessed PRL HHs and 19% of assessed migrant HHs reported the primary wage-earner in the HH not holding a valid work permit. This trend comes in addition to specific protection vulnerabilities to the migrant population group in Lebanon, as they are predominantly female (78%)[92], and work under the *kafala* system[93], which severely limits their freedom of movement and basic rights. This system also makes them more vulnerable to various forms of exploitation, such as trafficking and forced labour. For instance, in 2020 and 2021, IOM assisted 1,107 migrants in vulnerable situations, 45% of whom (503) were victims of trafficking, the majority (86%) among them had reportedly been trafficked for the purpose of forced labour.[94] Trafficked victims reported withholding of wages (79%), forced confinement (77%), and physical violence (45%) as means of control, and 12% were subject to sexual abuse.[95] These high levels of vulnerabilities might be reflected in the fact that 4% of assessed migrant HHs reported wanting to receive information on assistance to return to their country of origin from humanitarian actors.

[91] Live-in workers were most likely included in Lebanese HHs, and potentially did not talk for themselves, but rather for the Lebanese HHs to enumerators during the survey.
[92] IOM, Migrant Presence Monitoring (MPM) Baseline Assessment Round 1, June 2021
[93] The Kafala system is a sponsorship system under which "a migrant worker's immigration status is legally bound to an individual employer or sponsor (kafeel) for their contract period. The migrant worker cannot enter the country, transfer employment nor leave the country for any reason without first obtaining explicit written permission from the kafeel. The worker must be sponsored by a kafeel to enter the destination country and remains tied to this kafeel throughout their stay" (International Labour Organisation).
[94] IOM Case Data (2020-2021)
[95] Ibid.

Child protection

Child protection aims to guarantee the right of every child to grow up in a safe and inclusive environment.[96] Child protection programmes notably contribute to reduce the prevalence child marriage and child labour among other programs that aim to protect children against any form of abuse, neglect, and exploitation. Through the MSNA 2021, several indicators were collected to understand the current situation of children within the three population groups.

Child separation

The proportion of HHs reporting at least one child living outside of the HHs during the data collection was limited, with only 1% of HHs reporting being in this situation among both PRL and Lebanese population groups. In Lebanese HHs, this was reportedly due to hospitalisation, adoption inside the family, or boarding school. Not surprisingly, this proportion reached 6% among assessed migrant HHs (n=59), with the majority among them (87%) reporting their children were living back in the country of origin.

Child marriage

Among the 1% assessed PRL HHs (n=8) reporting at least one of their children was not living in the HHs during the data collection, the majority reported the child was living away because he or she was married[97]. In the overall individuals' sample of the MSNA, only 0.4% of individuals from the three population groups aged between 8 and 17 years old were reportedly married at the time of data collection. In an assessment conducted in Lebanon in 2020 by the United Nations Children's Fund and the Higher Council for Childhood[98], it was reported that 4% of Lebanese girls between the ages of 15 and 19 were married. This low proportion could be related to the sensitivity of the topic. In-depth assessments focusing on child protection and child marriage among Lebanese, migrant and PRL population groups at national level could be implemented to obtain more reliable information.

Child labour[99]

During the 2021 MSNA, reporting of child employment was very low among the assessed HHs, inhibiting any sense making on the underlying drivers and consequences of child labour in Lebanon. This might be partly due to the sensitivity of the subject, particularly as part of a multi-sector HH-level survey. Future, specialised data collection might be considered to further explore the topic of child labour in more depth.

In the 30 days prior to data collection, among children in assessed HHs aged 11 to 14 years old (n=159), 2% reportedly worked outside of their home. It reached 15% among PRL children aged 15 to 17. Similarly, 9% of respondents (both Syrian and Lebanese) from a *Child-focused Rapid Assessment (Round II)* conducted by UNICEF in Lebanon indicated at least one child out to work in the 6 months prior to their data collection.[100] A study conducted by World Vision in Akkar, Beirut and Mount Lebanon and Bekaa in February 2021[101] seems to indicate a correlation between child labour in and outside of home and limited financial resources.

[96] More information on UNICEF.
[97] While these results are shared here, the subset is too low to make any interpretations.
[98] United Nations Children's Fund and The Higher Council for Childhood, National Action Plan to Prevent and Mitigate Child Marriage in Lebanon, March 2020
[99] International Labor Organization: The term "child labour" is often defined as work that deprives children of their childhood, their potential, and their dignity, and that is harmful to physical and mental development. It refers to work that 1) is mentally, physically, socially, or morally dangerous and harmful to children; and/or 2) interferes with their schooling by: depriving them of the opportunity to attend school; obliging them to leave school prematurely; or requiring them to attempt to combine school attendance with excessively long and heavy work.
[100] UNICEF Lebanon, Child-Focused Rapid Assessment Round II, October 2021
[101] World Vision Lebanon, Caregivers Perceptions and their Influence on Child Education and Labour across Different Areas in Lebanon, February 2021

Finally, among the 613 school-aged children that were reportedly enrolled in a formal school during the school year 2020-2021 but not regularly attending school, whether in person or through distance learning, 6% aged less than 18 years old were reportedly engaged in labour outside or in the home that consistently disrupted their attendance at school.[102] In a study conducted by World Vision Lebanon in August and September 2021 in Beirut and Mount Lebanon, Akkar and Bekaa[103], 64% of participants whose children were not regularly attending school indicated a reliance on the child's financial support and contribution to the HHs' income was the main challenges to refrain them from engaging their child in begging, street vending or paid labour, while 85% of them reported the main disadvantage of refraining from child labour was the financial shortage. Finally, 74% of participants reporting their child(ren) were regularly attending school, and 97% of participants reporting their child(ren) were not regularly attending school reported financial support would help them refraining from child labour.[104].

FOCUS. MSNA and VASYR results around child marriage

The VASyR results were quite concerning regarding early marriage, as one in five Syrian refugee girls ages 15 to 19 were reportedly married during the data collection.[1] The prevalence of child marriage among Lebanese and PRL girls seemed lower, as respectively 3% of both Lebanese (n=609) and PRL (n=141) girls aged 15 to 19 were reportedly married, divorced, or widowed during the data collection. Only 5 Lebanese children (4 girls and 1 boy) aged 9 to 14 were reportedly married during the data collection. No PRL children from this age group were reportedly married.

1. UNHCR, WFP and UNICEF, VASyR, March 2022

Protection: Gender based violence

Safety and security concerns[105]

Overall, a considerable proportion of HHs reported perceiving safety and security concerns for girls (35%), boys (32%), or women (27%) in their community. HHs from the three population groups reported similar trends regarding the main concerns of boys, girls, and women, namely fear of being kidnapped and fear of being robbed. For instance, the main security concerns reported by PRL HHs with at least one girl within the HH (n=251) was girls being kidnapped (18%). Among Lebanese HHs with at least one boy (n=1219) and/or girl (n=1188), 12% in both subsets reported being kidnapped was reported as a main safety/security concern, which was a particularly commonly reported safety concern for boys Lebanese HHs in Tripoli. 10% of assessed PRL HHs reported fear of sexual harassment or violence for boys, as well as 7% of assessed migrant HHs and 5% of Lebanese HHs. Although limited, this proportion remains worrying in a country where this subject remains a taboo.

Safety and security concerns for women and girls were particularly commonly reported by HHs in Akkar governorate with women (n=247) and girls (n=110) in the HH; 49% and 51% of assessed HHs, respectively, reported having such concerns.

Findings suggest safety and security concerns somewhat contributed to limiting women and girls' access to public spaces, particularly among PRL, with 17% assessed PRL HHs, compared to 9% of Lebanese and 5% of assessed migrant HHs, reporting there are areas in their location that are generally avoided by women and girls because of feelings of unsafety. To this light, HHs particularly reported women and girls avoided the street/neighbourhood.[106] In addition, a small but noteworthy proportion of Lebanese HHs (6%) reported women and girls felt unsafe in their homes, which could suggest these women face elevated risks of domestic violence.

[102] Disruption of school attendance is defined as regularly attended less than a full week of school, stopped attending entirely for a period of time, dropped out of school.
[103] World Vision Lebanon, Barriers and Facilitators for Lebanese Children's Engagement in Child Labour, December 2021
[104] Ibid.
[105] Multiple choices question, the total of percentages can exceed 100%.
[106] Results for assessed migrant HHs are not reported as the sample size is too limited.

Education

Access to safe and quality education is a key element in ensuring a secure future for children in Lebanon. Basic education contributes to the acquisition of the knowledge and skills necessary to secure an adequate livelihood and access stable and dignified employment. Overall, education trends were quite encouraging, as most school-aged children (87%) were reportedly enrolled for the school year 2020-2021, with most of them regularly attending school in person and at distance. However, the MSNA results also highlight some of the barriers related to school closures which resulted in a high dropout rate among Lebanese HHs particularly.

Enrolment

The enrolment rate is a first step to understand the access to education in a humanitarian context, as children who are not enrolled are facing long-term vulnerabilities.[107] Among all children in assessed HHs (n=4514), 87% were reportedly enrolled in a formal school in the 2020-2021 school year.[108] Yet, there are considerable disparities among the three assessed population groups; migrants' children (n=185) appear to face particular barriers accessing education, with around 43% of them reportedly not being enrolled in a formal school for the 2020-2021 school year.

Roughly 88% of Lebanese school-aged children were reportedly enrolled during the school year 2020-2021, which reflects the findings of UNICEF in April 2021 from a rapid phone assessment with 624 Lebanese caregivers (90%).[109] The MSNA, however, revealed pockets of needs for Lebanese children in some districts. In Tripoli, among school-aged Lebanese children (n=294), 27% were reportedly not enrolled in a formal school in 2020-2021.

Among Lebanese school-aged children (n=3555) and school-aged children in assessed migrant HHs (n=170), respectively 51% and 61% were reportedly attending public schools, while among school-aged children in assessed PRL HHs (n=788) a larger proportion was reportedly attending UNRWA schools (60%). Assessed PRL households were particularly relying on UNRWA schools in two regions: in Beirut and Mount Lebanon (n=188), 81% of PRL assessed school-aged children were reportedly enrolled in an UNRWA school, and in Akkar and North (n=282), this proportion was 74%. In addition, 40% of Lebanese school-aged children were reportedly attending private schools, which was considerably less commonly reported for migrant (25%) and PRL (14%) children.

Attendance[110]

Among assessed school-aged children who were reportedly enrolled in a formal school (Lebanese n=3147; PRL n=624; migrant n=104), around 9 out of 10 reportedly attended school regularly (at least four days a week) when it was opened during the school year 2020-2021. However, the geographic analysis revealed some concerning disparities between regions. The situation appears to be particularly critical in Beirut and Mount Lebanon region for Lebanese children (n=760), PRL children (n=157) and children in assessed migrant HHs (n=38), where respectively 13%, 21% and 15% were found to not be regularly attending to school in the school year 2020-2021, even though schools were opened. Furthermore, results at district level suggested critical attendance in Hasbaya district (n=126), where 28% of Lebanese children were reportedly not attending school regularly.

The school year 2020-2021 was largely impacted by the outbreak of COVID-19, resulting in schools closing for long periods.[111] The MSNA attempted to capture access to distance learning when schools were closed, as it ensures continuity of learning despite COVID-19 related restrictions of movements and gatherings. The general trend in terms of distance learning appears similar to in-person attendance, with about 90% of assessed children from the three population groups reportedly having had access to distance learning during the period. This trend seems to indicate an improvement compared to the

[107] More information related to these specific vulnerabilities can be found on UNICEF Education.
[108] This is similar to Ministry of Education enrollment data, according to the EOC education sector.
[109] UNICEF Lebanon, Child-focused Rapid Assessment, April 2021.
[110] Enrolment is not sufficient to understand the actual state of the education, as many enrolled children may not be able to attend school regularly, especially following the COVID-19 outbreak.
[111] Norwegian Refugee Council, Lebanon: Education at a tupping point, October 2021

results obtain in a Multi-Sectoral Needs Assessment conducted by Plan International in April 2020 in the governorates of Baalbek-Hermel, North Lebanon, South Lebanon, Akkar and Nabatieh, with 249 Lebanese adolescents and 310 Lebanese caregivers,[112] which found that, during the school year 2019-2020, only 70% and 65% of Lebanese girls and boys respectively were attending distance learning. Distance learning was defined in the MSNA as engaging for at least 3 hours a day, for at least 4 days a week, in learning activities, including radio and TV broadcasts. Nevertheless, in some private schools, distance learning was mainly relying on posting videos content related to students' lessons, which has had many Lebanese parents questioned the quality of teaching.[113]

Beirut and Mount Lebanon region presented some critical results for children in Lebanese HHs (n=74), as respectively 17% of children in this region reportedly did not have access to distance learning when school were closed during the 2020-2021 school year[114]. In addition, in a Multi-Sectoral Needs Assessment conducted by Plan International in April 2021 with 110 Lebanese HHs living in Mount Lebanon and West Bekaa found that only 18% of interviewed HHs were satisfied with the quality of remote learning modalities.[115] At the district level, findings suggest that Lebanese children in El Minieh-Dennie and Tripoli districts were particularly impacted by schools closing because of COVID-19 outbreaks, as more than 2/10 did not have access to distance learning.

FOCUS. Fear of telecommunications collapse: consequences on distant learning

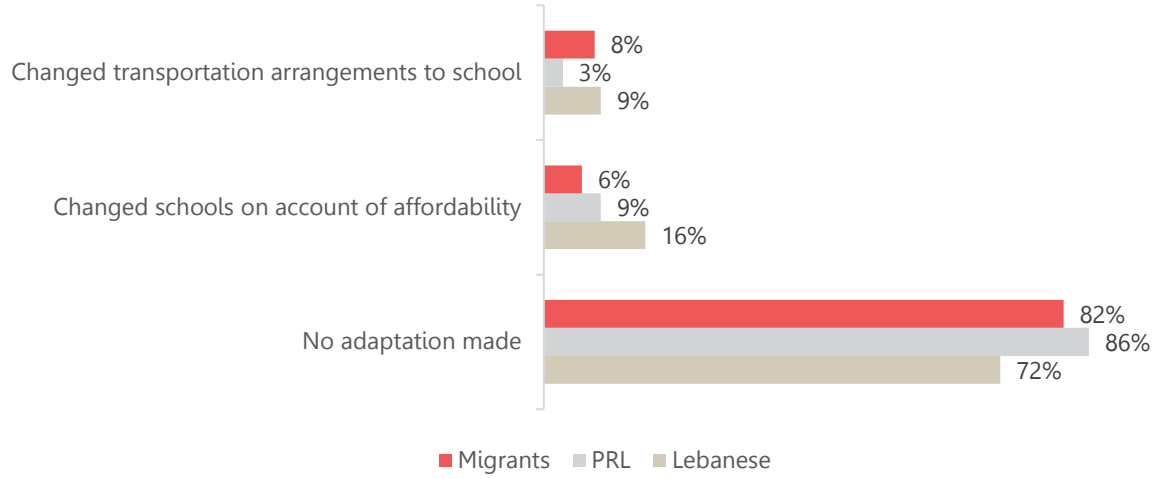
On December 19, 2021, the Minister of Telecommunications issued a warning: because of increasing cost of fuel and unpaid international fees, the telecommunication sector is at risk of collapsing. Experts suggested that the telecommunication crisis would particularly impact poor rural areas and urban areas inhabited by some of Lebanon's most vulnerable communities with poor coverage the most, notably due to increasing costs of fuel needed to run broadcast relay stations[1]. The risk of increasing price of telephonic and internet subscriptions could result in a substantial proportion of users being unable to afford these services. As remote learning is dependent on internet connection to provide distance teaching, the significant increase of the costs of internet combined with the already poor coverage in certain of the most vulnerable areas is likely to pose additional barriers to access distance learning, especially among most vulnerable HHs, on top of the tremendous consequences this would have on the economy.

1. Mercy Corps, Lebanon Crisis Update, December 2021

Even though most HHs reported they did not adapt to new or increased barriers to accessing education during the school year 2020-2021 (Lebanese n=1592; PRL n=330; migrant n=66), the main adaptation measures reported within the three population groups were cost-related, with the top one being changing schools on account of affordability (e.g., shifted from private to public). In fact, many Lebanese parents at national level could not afford to pay private schools' fees, resulting in students moving from private to public schools.[116] The second adaptation strategy reported by HHs in the three population groups was to change transportation arrangements to school (e.g., shifted from private car to carpooling, school busses, or walking).

[112] Plan International, COVID-19 Multi-Sectoral Needs Assessment, April 2020
[113] Lebanon Education Sector, Secondary data review, December 2021
[114] Subset for PRL and migrant was too small to be reliable.
[115] Plan International, Adolescents Needs Assessment in Mount Lebanon and West Bekaa, April 2021
[116] Lebanon Education Sector, Secondary data review, December 2021.

Figure 16. Main adaptation to new or increased barriers to accessing education (2020-2021 school year) reported by households, by population groups



In addition, among enrolled children in assessed Lebanese and PRL HHs who were not regularly attending school (respectively n=492 and n=107), very few (7% and 4%) were reportedly engaged in labour outside or in home that consistently disrupted their attendance at school in the school year 2020-2021. Reporting of child labour disrupting attendance to school was low among the assessed HHs, limiting sense making on the underlying drivers and consequences of child labour in Lebanon. This might be partly due to the sensitivity of the subject, particularly as part of a multi-sector HH-level survey. Future, specialised data collection might be considered to further explore the topic of child labour in more depth.

Dropout

Dropout rate can identify critical trends within the education system in a specific population group, as it could reveal a limitation in accessing education, and potentially indicate an increase in child labour. Among PRL school-aged children not regularly attending school (n=94), only 4% had reportedly dropped out of school in the 2020-2021 school year. These results seem to indicate that, despite some new challenges related to the current economic and political crises, and aggravated by the outbreak of COVID-19, PRL children are willing to continue attending schools. On the other hand, some concerning results were obtained among Lebanese enrolled school-aged children not regularly attending school (n=492), as 14% were reportedly dropping out of school in the same period.

Several reasons were reported explaining the dropout rate reported among Lebanese school-aged children (n=58). The difficulties of remote learning because of the outbreak of the COVID-19, combined with limited resources due to the current economic crisis were particularly emphasised.[117] The main reported reason was the HH did not have regular electricity or power to ensure remote learning (for 58% of dropped out Lebanese children)[118], followed by a lack of connectivity/Internet-related barriers for remote learning (57%). Moreover, 37% of children reportedly dropped out because the HH did not have the necessary equipment to attend distance learning (e.g., tablets, laptops). The same trend was observed among adolescents in education, as a substantial proportion of Lebanese HHs reported lacking the adequate material at home to access distance learning properly.[119]

[117] Considering the size of the sample, only Lebanese results are presented for this specific indicator, as other population groups' information is not reliable.
[118] Multiple choice question, the total of percentages can exceed 100%.
[119] Plan International, COVID-19 Multi-Sectoral Needs Assessment, April 2020.

Access to education of children with disabilities[120]

Among assessed Lebanese HHs with children with disabilities (n=78), only 1/3 did not report any barriers to access education for their children. The remaining two-thirds identified critical barriers, such as classrooms not being adapted**,** and teachers not having the capacity to tailor teaching to children with disabilities. Additional challenges related to distance learning were emphasised by these households, including limited access for children with disabilities, and parents not having the capacity to support home learning.

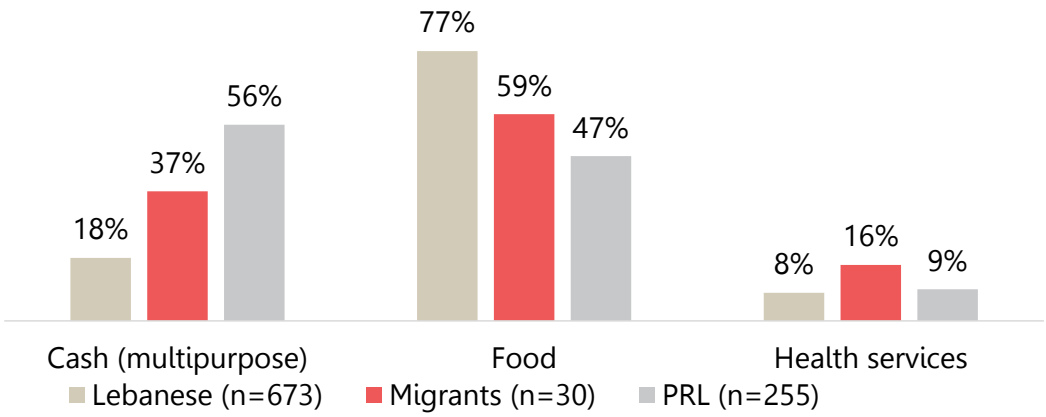
Accountability to affected populations

"Accountability refers to the responsible use of power (resources, decision making) by humanitarian actors, combined with effective and quality programming that recognizes a community of concern's dignity, capacity, and ability to be independent".[121] While Lebanon has a long history of implementing aid programs, it has usually targeted primarily Syrian refugees, and Lebanese and PRL host communities. This could explain why the proportion of HHs from the three assessed population groups having reported being assisted in the three months prior to data collection was quite limited. This was particularly the case for migrants, with only 5% of assessed HHs reporting having received assistance, despite their prevalent and long-standing protection needs.

Assistance

Among HHs who reported receiving assistance in the 3 months prior to data collection (n=958), the main types of assistance reported as received were food and cash (multipurpose) assistances. Other types of assistance were only reported by very small proportions of HHs, especially among assessed PRL HHs, such as education services (5%) and other non-food items (3%).

Figure 17. Main types of assistance reportedly received by HHs in the 3 months prior to data collection, by % of HHs who had received assistance per population group[122]



It is important to note that 47% of both Lebanese and assessed migrant HHs and 28% of assessed PRL HHs reported that they did not try to access assistance in the 3 months prior to data collection. In addition, 33% of assessed PRL HHs, 30% of assessed migrant HHs, and 26% of Lebanese HHs reported not having experienced any barriers when trying to receive assistance in the 3 months prior to data

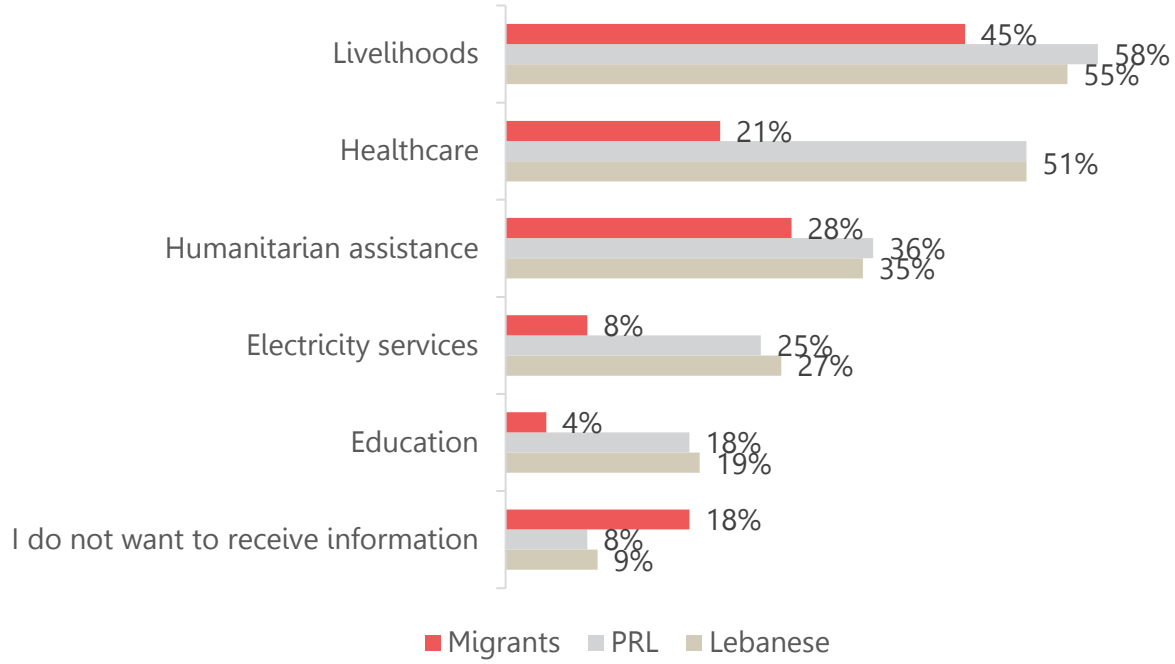
[120] Subsets for PRL and migrant HHs were not sufficient to share reliable results.
[121] Definition from the UNHCR.
[122] Multiple choice question, the total of percentages can exceed 100%.

collection. The main barrier reported by the HHs across population groups were information-related, as respectively 16% of assessed PRL HHs, 10% of Lebanese HHs and 9% of assessed migrant HHs reported not knowing how to apply. In addition, around 5% of HHs in the three population groups reported not understanding the application procedure. Despite the highest proportion of Lebanese HHs reporting having received assistance in Tripoli and Akkar (respectively 25% and 21% of Lebanese HHs) in the 3 months prior to data collection, acute humanitarian needs have been identified in these two regions among this population group during the same period.

Information

Access to information is key to ensure efficient communication on humanitarian projects' implementation and objective, including the beneficiaries' selection process, which is often a sensitive issue in humanitarian settings. The preferred type of information HHs reported they would prefer receiving from humanitarian aid actors were related to livelihoods in the three population groups. Interestingly, 18% of assessed migrant HHs reported not wishing to receive information.

Figure 18. Main types of preferred information from humanitarian aid actors reported by HHs, by population groups[123]



The preferred means (channel) of receiving information reported by HHs is through phone calls (Lebanese HHs: 92%, Assessed PRL HHs: 85%, Assessed migrant HHs: 84%), followed by television (Lebanese HHs: 23%, Assessed PRL HHs: 25%, assessed migrant HHs: 11%). Some channels were particularly reported by particular population groups; while assessed PRL and migrant HHs also relatively commonly reported preferring community leaders (26% and 23%, respectively), 23% of Lebanese HHs reported WhatsApp as their preferred communication means, against 0% of both PRL and assessed migrant HHs.

[123] Multiple choices answer, the total of percentages can exceed 100%.

CONCLUSION

The 2021 Lebanon MSNA was conducted to support evidence-based decision-making for the 2022 humanitarian planning cycle process and to support the planning among key humanitarian actors through the provision of updated information on multi-sectoral needs for Lebanese, migrants and PRL population groups. The MSNA was implemented in coordination with OCHA. The research design and data collection were a collaborative process with the members of the EOC, and the specific expertise of IOM and UNRWA for respectively migrants and PRL, and UN Women for technical assistance on gender equality and social inclusion issues.

Lebanon is experiencing a deep crisis, with particular economic consequences that are reflected in an increasing the poverty rate and soaring inflation. MSNA findings reflect this context, as they highlight a high prevalence of livelihoods-related needs among the assessed population groups across the country. For instance, one-third of HHs reported earning less than 2.4 million LBP in the 30 days prior to data collection, while during the 3 months prior to data collection, 61% of HHs reported challenges in affording basic needs as a result of lost or reduced employment. Nevertheless, findings suggest that households' needs are not limited to reduced livelihoods; although many of the barriers to accessing basic needs and services appear to be driven particularly by financial hardship, the MSNA results suggest households are facing additional barriers to meet their needs across the humanitarian sectors.

In addition to livelihoods, the health sector appears to be particularly impacted by the crisis. The health status of Lebanese and PRL households was already marked before the crisis by a high prevalence of chronic diseases, particularly among older persons. Findings suggest that difficulties in accessing basic health care services and medicines have reinforced the pronounced vulnerabilities of these households. In addition, a high proportion of households across population groups reported perceiving that the crisis has contributed to household members, both adults and children, experiencing psychological distress.

Other considerable needs were observed in the shelter sector. Although the types of shelters in which the surveyed households live appeared to be generally safe, a considerable proportion of households reported shelter damage, particularly to the structure of the dwellings. In addition, findings suggest that households commonly rent their housing and, particularly considering the volatile economic context in Lebanon, that they are vulnerable to fluctuations in rental prices (dollar/LBP rate) as well as eviction risks.

In terms of education, findings indicate that the COVID-19 pandemic has further impacted children's access to quality education, primarily due to a regular closure of schools. Although distance learning systems have been implemented to mitigate the negative impact on children's development, MSNA results nevertheless indicate a worrying dropout rate among Lebanese children, which appears to be primarily due to equipment and connectivity issues. In addition, against the backdrop of economic downturn and limited access to livelihoods, it is likely that economic reasons might further contribute to barriers to access education, increasing children's vulnerability to protection risks related with school dropouts, such as child labour and child marriage.

Finally, the WASH sector is particularly concerned by pockets of vulnerabilities, with findings suggesting overall limited humanitarian needs yet highlighting important gaps at the regional level, including a comparatively high proportion of HHs in extreme needs, especially in the North and Akkar region.

Given these vulnerabilities, their potential worsening in the coming months, and the limited data available for these three population groups at national level, additional, more specific needs assessments may be required to deepen understanding of the severity and magnitude of the needs of populations affected by the crisis in Lebanon:

- The development of needs assessments targeting **live-in workers** could be crucial to understand their current number in Lebanon, following the outbreak of the economic crisis and

the limited capacity of Lebanese HHs to afford these services. This could also contribute to have a better understanding of live-in workers' living conditions, and their intentions and capacity to return.

- **Needs assessments focusing on protection issues** seem also to be critical, as the MSNA quantitative approach is limiting the opportunities to understand the in-depth, sensitive dynamics revolving around protection issues. Specifically, specialised assessments on Lebanese, migrant, and PRL child labour and child marriage could be developed to inform actors' planning and complement the limited information obtained through the MSNA. In addition, despite MSNA's effort to include the LGBTQI+ community, the quantitative approach was not sufficient to obtain reliable data. Qualitative assessments may be better suited to understand needs among those vulnerable groups that might be less visible in society.

- The economic crisis caused a distortion of basic products supply in Lebanon, including food products supply. The crisis in Ukraine will likely further aggravate this situation by disturbing the grain supply. Therefore, a **markets monitoring assessment, with a focus on supply chain functionality,** could be key to understand the extent of this supply crisis.

- In areas with higher transversal needs, including high protection concerns, such as Tripoli, some **area-based assessments** (ABAs) using a participatory approach and qualitative methodology could be used to better understand the deterioration and challenges at local level. Information around the social cohesion in these areas could also be collected. Similarly, while communities in some particularly remote, rural areas are potentially facing elevated needs, little information is available for populations living there. ABAs could also explore those vulnerabilities to help humanitarian actors' planning and aid implementation at the local level.

- The rapid deterioration of the context in Lebanon has contributed to a significant proportion of households being in need. Understanding how the aid system is able to adjust to the crisis to meet the needs of these growing number of households in need seems necessary to understand the dynamics of the response to the crisis. In this sense, **evaluations around Accountability to Affected Population** (AAP) could inform the humanitarian strategy and contribute to adjust the ongoing response to be closer aligned to households' most urgent needs.

ANNEXES

Annex 1. Available information on the MSNA 2021

- Terms of References
- Cleaned dataset and Analysis Tables
- Dashboard
- Publications

Annex 2. Enumerators' training content

DAY 1	
Introduction to MSNA 2021: assessment objectives, coordination system, research questions	9:15 am
Session 1, part a: Humanitarian principles	10:15 am
Session 1, part b: Data collection principles: methodology and HHs interviews' best practices in the field (including PSEA, data protection and referral procedures)	11 am
Session 2: Security and safety on the field: Standard procedures and best practices	1:00 pm
Session 3: Interview techniques: introduction to ODK & Maps.me	1:45 pm

DAY 2	
Session 4: MSNA Questionnaire Part 1	9:15 am
Session 5: MSNA Questionnaire Part 2	11:00 am
Session 6: MSNA Questionnaire Part 3	1:00 pm

Annex 3. MSNA 2021 Partners

Partners	Role
United-Nations Office of Coordination of Humanitarian Affairs (UNOCHA)	Coordinating partner
Emergency Operation Cell members	Coordinating partners
International Organisation for Migrations (IOM)	Implementing Partner and migrants expert
United National Relief and Works Agency for the Palestine Refugees in the Near East (UNRWA)	PRLs expert
ACTED	Sister organisation
UN Women	Technical assistance on gender equality and social inclusion

Akkar Network for Development (AND)	Implementing Partner
Terre des Hommes Foundation (TdH)	Implementing Partner
Danish Refugee Council (DRC)	Implementing Partner
International Rescue Committee (IRC)	Implementing Partner
Intersos	Implementing Partner
Save the Children	Implementing Partner
Norwegian Refugee Council (NRC)	Implementing Partner
Humanity and Inclusion (HI)	Implementing Partner
Solidarités International (SI)	Implementing Partner
Mercy Corps	Implementing Partner