



Social protection in Lebanon: a review of social assistance

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Acronyms

AUB	American University of Beirut
BCG	Boston Consulting Group
CAS	Central Administration of Statistics
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CERD	Center for Educational Research and Development
CMU	Central Management Unit
CODI	Core Diagnostic Instrument
CP	Child Protection
CRI	Consultation & Research Institute
CRPD	UN Convention on the Rights of Persons with Disabilities
CSO	Civil society organisation
DOAWG	Disability & Older Age Working Group
DOPS	Direction d'Orientation Pédagogique et Scolaire
EDL	Electricite de Liban
ESCWA	United Nations Economic and Social Commission for Western Asia
EU	European Union
GBV	Gender-Based Violence (GBV)
GDP	Gross domestic product
GoL	Government of Lebanon
HBS	Household Budget Survey
HH	Household
HRS	Health Response Strategy
ILO	International Labour Organization
IPC-IG	International Policy Centre for Inclusive Growth
IRC	International Rescue Committee
ISF	Internal Security Forces
ISPA	Interagency Social Protection Assessments
IWSAW	Institute for Women's Studies in the Arab World
KIIs	Key Informant Interviews
LAF	Lebanese Armed Forces
LBP	Lebanese Pound
LCRP	Lebanon Crisis Response Plan
LFS	Labour Force and Household's Living Conditions Survey
MEHE	Ministry of Education and Higher Education
MENA	Middle East and North Africa
MICS	Multiple Indicators Cluster Survey
MOEHE	Ministry of Education and Higher Education

MoET	Ministry of Economy & Trade
MoEW	Ministry of Energy and Water
MoL	Ministry of Labour
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs
NCDA	National Council for Disability Affairs
NCLW	National Commission for Lebanese Women
NGO	Non-Governmental Organization
NPTP	National Poverty Targeting Programme
NSDSL	National Social Development Strategy of Lebanon
NSSF	National Social Security Fund
NSSS	National Social Security System
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PDC	Personal Disability Card
PHC	Primary Healthcare Centres
PMT	Proxy-means test
PRL	Palestine Refugees in Lebanon
PRS	Palestine Refugees from Syria
PSS	Psycho-social support
PWD	Persons with disabilities
RACE	Reaching all Children with Education
REBAHS	Reducing Economic Barriers to Accessing Health Services
RPA	Rural Payments Agency
SA	Social assistance
SDC	Social Development Centre
SI	Social insurance
SND	Special Needs Department
SOP	Standard Operating Procedures
SOWC	The State of the World's Children
SP	Social protection
SSN	Social Safety Net
UHT	Ultra High Temperature
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency
US\$	US Dollar
WEF	World Economic Forum
WFP	World Food Programme
WHO	World Health Organization

Executive summary

Recent developments in Lebanon have drawn renewed interest and attention to the country's social protection system. High and increasing levels of inequality, alongside low economic growth and sluggish economic prospects, have highlighted some of the defining features of social and fiscal policies in Lebanon, including the comparatively low levels of social assistance. The Syrian crisis and high number of refugees in the country - an estimated 1.5 million displaced Syrians among an estimated Lebanese population of 4.1 million - have raised additional concerns for the wellbeing and livelihoods of Lebanese, Syrians and other population groups in the country. The additional pressures on basic services and labour markets associated with this crisis have drawn attention to the role of social protection and its (potential) effectiveness in both providing support to particular vulnerable population groups and making progress on wider promotive and transformative objectives.

This report contributes to this renewed interest, and related policy dialogue, through a mapping and analysis of social protection in Lebanon, with a focus on social assistance.¹ It draws on a review of the literature and on interviews with key informants conducted over the course of 2017-2018 to: provide an overview of poverty, inequality and social policy in Lebanon; map the main elements of social protection in Lebanon; and provide a detailed mapping and review of social assistance, specifically of the country's three primary social assistance programmes: programmes and services for people with disabilities, the programme for children in social institutional care, and the National Poverty Targeting Programme (NPTP). As such, this study's primary focus is on the main social assistance policies administered by Lebanon's Ministry of Social Affairs (MoSA). To enable this mapping and review, the study relies on the Core Diagnostic Framework (CODI) instrument elaborated by the Inter-Agency Social Protection Assessment Initiative (ISPA).

Available poverty estimates for Lebanon indicate poverty (headcount measure) hovered around 27% and 29% between 2004 and 2016. There is concern that recent macroeconomic developments and the Syrian crisis are exacerbating poverty among Lebanese households, through a combination of rising unemployment (especially among low paid workers), decreasing wages and demand on public services exceeding the capacity of institutions and infrastructure to meet needs. Income and wealth inequality are high; Lebanon has one of the highest levels of concentration of wealth in the world, with the top decile of wealth holders accounting for 70 percent of total wealth. Poverty is strongly correlated with gender, age and disability. Unemployment is twice as high among women as men, and women and girls face specific risks of gender-based violence and early marriage, with long-term detrimental impacts on well-being and economic opportunities. Poverty is also especially pronounced among children, with an estimate indicating close to half (47%) of Lebanese living below the poverty line are children. Among displaced Syrians in Lebanon, more than 70% are living below the poverty line. A majority of these are children.

Social policy and social protection in Lebanon display some key distinguishing features. Across all social sectors, there is high involvement and reliance on the private sector, civil society and faith-based organisations. In health and education, the high presence of the private sector is reflected in the comparatively low social spending in both sectors. This in turn has implications for inequality across a range of dimensions, including

¹ Social assistance is understood as the component of social protection financed through general taxation, as opposed to employer and employee contributions-financed social insurance, and that generally aims to reach disadvantaged population groups, in some cases through a means or asset test.

significant disparities in the utilisation and quality of services in education and health across different income groups. In health, out-of-pocket payments lie well above 50% of total health expenditures. They are especially burdensome for poorer population groups and linked to financial hardship and impoverishment. Social insurance coverage of workers is low (less than 50% covered). No full pension plans are available to the public sector, rather, end of service agreements.

Social assistance spending, coverage and levels of support are comparatively low, accounting for around 1% of GDP on non-subsidy social assistance; 4% of GDP when subsidies, including to electricity subsidies to *Electricité du Liban* (2.9%), are included. In terms of composition, fee waivers and education and health subsidies account for a significant share of social assistance spending against limited social assistance in the form of in-kind transfers (0.2% of GDP) and no provision in the form of direct cash transfers. In the administration and delivery of social assistance, there is high reliance on partnerships with NGOs. Available evidence points to the overall low effectiveness of Lebanon's social safety net as a result of low spending and associated low levels of social assistance and low population coverage; fragmentation and weak coordination across ministries including MoSA, the Ministry of Education and Higher Education (MEHE) and the Ministry of Health (MoPH); as well as data and information constraints.

The three main social assistance programmes of the Ministry of Social Affairs, accounting for most of MoSA expenditures and population reach, are: its social institutional care for children, its disability programme, and the National Poverty Targeting Programme (NPTP). For these three programmes, this study carries out a detailed review using the CODI and available data to capture policy legislation, design and implementation.

- MoSA's programme and services for persons with disabilities counts 103,262 people registered with a disability and Personal Disability Card (PDC), accounting for approximately 2.6% of the population. Services provided include access to care through specialised institutions providing a package of care, education, therapy services, specialised equipment as well as residential care provided through MoSA-contracted institutions. Legislation also stipulates rights for people with disabilities through quotas in public and private employment and fiscal exemptions and tax benefits.
- Traditionally accounting for two-thirds of MoSA's budget, institutional care constitutes a fundamental pillar of the formal infrastructure for services for children. MoSA finances the provision of institutional care through MoSA-contracted institutions for children in vulnerable families, identified as such by social workers and institutions on the basis of national guidelines in Decision 121/2004. Around 23,000 children - 2% of all children in Lebanon - are in residential institutions contracted by MoSA; while a total of 35,000 children are in residential care more widely, amounting to a total of 3-4% of all children.
- The National Poverty Targeting Programme (NPTP) is a tool to identify and direct social assistance to Lebanon's "extreme poor". At its core, it is a database of information on Lebanon's poorest households. Information on applicant Lebanese households is collected via social workers at Social Development Centres and used to compute a score on the basis of a proxy-means test which in turn is used to rank households by poverty level and to determine whether a household is eligible for social assistance programmes that rely on the NPTP database. In 2017, 105,850 households were *Halla*, later renamed *Hayat*, card holders, eligible for NPTP-related programmes, specifically education and health subsidies. Following recertification in 2017-18, this number dropped to 43,000 households. The three main programmes the NPTP is used for to deliver social assistance via MoSA are: education subsidies (take-up of 13,800 in 2017), health subsidies (take-up of 16,700 in 2017) and e-vouchers (transfers a monthly

allowance of \$27 per person capped at 5 persons per household to buy foodstuff at registered shops; a total of 10,000 delivered in 2017).

The report identifies and discuss key recommendations for the three MoSA programmes in terms of: legislation, regulation and policy framework; policy design; implementation; coordination; financing; and monitoring and evaluation, summarised in Table 1 below.

The following priorities for strengthening Lebanon's social protection system are identified:

- *Social protection objectives and definitions*: through informed policy dialogue, and reliance on policy regulation and legislation as required (e.g. through improved implementation of existing plans and legislative tools or legislative reform), identify and agree on social protection policy objectives and priorities, clarify the role and mandates of key stakeholders, importantly the State, the private sector and charity or faith-led organisations;
- *Institutional mandates and coordination among ministries*: building on the above, clarify institutional mandates and coordination between ministries, including MoSA, MEHE, MoPH;
- *Fiscal space*: building fiscal space for social protection through the establishment of a progressive tax system, including through the taxation of undertaxed resources; strengthening of contributory social insurance and improved collection of employer and worker contributions; and reallocation of resources, for instance through the reform of subsidies to EdL;
- *Addressing social protection policy gaps (coverage and adequacy)*: building on Lebanon's categorical social assistance programmes, strengthening the provision to population groups such as children and people with disabilities, while developing further the NPTP to help ensure resources reach disadvantaged and excluded groups; stepping up efforts to extend social insurance through adjustments to policy regulation and work formalisation;
- *Coordination with and learning from the humanitarian sector*: harness the opportunity for learning, coordination and implementation, including on social assistance programme management and delivery, provided by initiatives in the humanitarian sector linked to the Syria crisis.

Table 1: Emerging recommendations for Lebanon’s three main MoSA social assistance programmes: a summary

Area	Disability	Institutional care for children	National Poverty Targeting Programme
<i>Legislation, regulation, policy framework</i>	Adjust the definition of disability by ratifying the CRPD. Review the existing criteria for classification of disabilities. Promote participation and inclusiveness of people with disabilities e.g. in MoSA National Strategic Plan, LCRP.	Building on Decision 121 and the SOP of Law 422, further elaborate the conceptual and regulatory distinction between child protection and social protection for children.	Step up efforts to establish clear GoL regulation and legislation of the NPTP to strengthen government ownership and secure continuity. Promote discussion on NPTP’s purpose and scope to achieve the above. Promote efforts to utilise the NPTP database beyond the programmes it is currently used for to inform policy reform and administration (e.g. the Primary Healthcare Restoration Project).
<i>Policy design</i>	Address critical service gaps identified e.g. early intervention for children under 4 years. Improve provision of services nationwide and geographic coverage. Improve quantity and quality of ‘external’/non-residential care services.	Promote discussion and decisions on the respective roles of MoSA, MoSA-financed institutions and other private and/or civil society institutions in the financing, coordination and delivery of social protection to children. Promote debate on and consider options of continued reliance on social care institutions in the provision of social protection for children and role of direct support to households.	Promote discussion of, and agreement on, what services and transfers to deliver using the NPTP, based on experience to date, needs assessment and wider social protection plans. Expand outreach and coverage of the NPTP, beyond information on the “extreme poor”, to enable its potential to be inclusive and responsive, including in contexts of shocks.
<i>Policy implementation</i>	Improve awareness of the PDC and related services to improve coverage and take-up Invest in SDC infrastructure, training Set standards to ensure quality of specialised services.	Adequate training to social workers on MoSA regulations and standardisation efforts.	Implement new outreach campaign to ensure potentially eligible households apply and improve the public’s awareness and understanding of the NPTP and wider social protection rights. Improve regulation – e.g. through adoption of official agreements, legislation – of recertification process, frequency and modality. Introduce regular basic monitoring and basic analysis of NPTP information including trends in numbers of recipients by type of service/programme, household profiles etc., among other things to permit basic diagnostics on poverty profile and NPTP performance.
<i>Policy coordination</i>	Strengthen existing mechanisms, increased coordination between MoSA, MoPH and MEHE.	Clear mapping of financing and services provided by MoSA and MEHE to private and civil society institutional care providers in the provision of education and care services required to clarify roles, funding sources and related concerns of duplication of efforts.	Improve regularity and frequency of communication between CMU and MoSA. Improve link between the NPTP database and wider social policy services. E.g. potential coordination and information exchange on children in institutional care and the NPTP recipient households.

<i>Financing and fiscal capacity</i>	A more detailed monitoring and analysis of MoSA spending on disability, spending requirements and related options for addressing financial constraints to deliver appropriate services to people with disabilities is required.	An analysis of the financial implications of the current arrangements (i.e. MoSA covering 66% of the cost for children from low-income/vulnerable families in social care, the institution covering the remaining cost) is required to address claims of the most “cost effective” option.	Fiscal capacity constraints can be addressed as outlined above on wider efforts to raise revenue in the first instance and reallocate spending. Reliance on donor financing should continue to strengthen and improve technical capacity and NPTP database management.
<i>Monitoring and evaluation</i>	Address data gaps regarding people with disabilities, both PDC card holders and non-card holders	Establish and maintain an electronic registry of information on children that enter institutional care collected via the SDCs (this exists only in paper form). Systematise and maintain electronically, information on MoSA-contracted institutions as well as ones that are not MoSA-contracted, for a more complete picture.	Improve efforts to regularly carry out and disseminate basic NPTP monitoring information to inform policy decision making, transparency, accountability and programme – including wider social protection – legitimacy. Commission a monitoring and assessment study of the NPTP by an independent researcher/institute.

1 Introduction

1.1 Motivation and Objectives

Recent renewed commitment to strengthening social protection in Lebanon has stemmed from a) the growing recognition of Lebanon's comparatively weak provision of formal social protection; b) low economic growth and weak economic prospects accompanied by high income and wealth inequality; and c) concerns for the wellbeing and livelihoods of both vulnerable Lebanese and refugees in the context of the Syrian crisis.

From a comparative perspective, Lebanon's social assistance, or social safety net (SSN), is characterised by low spending and coverage (Silva et al., 2013; World Bank, 2015; World Bank, 2018).² The share allocated to non-subsidy SSN spending was less than 1 percent of GDP in 2013.³ This is low by international standards, which are about 2 percent of GDP on average and lower than the average in the MENA countries, which stands at 1.7% of GDP (Karam et al., 2015; IMF, 2012).

The already stretched and weak public services have experienced additional pressures from the large influx of Syrian refugees in recent years - about 1.1 million displaced Syrians have crossed the border and officially registered with the UNHCR, representing over 25 percent of the Lebanese population (World Bank, 2015). The crisis has raised questions about the adequacy of the national safety net in supporting vulnerable Lebanese households and communities that are hosting the refugees as well as about their role in providing support to refugees (where there is agreement that public services should be covering them too). Moreover, recent developments in social assistance and humanitarian provision have opened-up discussions about potential opportunities for enhancing the coordination and alignment across humanitarian and social protection efforts.

Against this backdrop, this study:

- Maps the main elements of Lebanon's social protection policies or 'system', with a focus on social assistance, non-contributory policies, also known as social safety nets (SSNs);
- Based on a review of the available literature and key informant interviews, discusses the effectiveness of social assistance policies in terms of poverty and vulnerability, paying attention to the child- and gender-sensitivity of programmes;
- Informs and contributes to country dialogue on how to strengthen social assistance/SSNs, broader social protection policy and identify policy implications and issues to take forward; promote exchange and coordination between national and international partners.

² Social assistance, or social safety net, tax-financed component of social protection, aimed to reach particular vulnerable and poor population groups, as opposed to employer and employee contributions-financed social protection, known as social insurance.

³ These include (i) social services and programmes targeted to certain categories of the population (e.g., disabled persons, juvenile delinquents, school dropouts, orphans) provided by MOSA with the majority of its budget distributed to NGOs and welfare associations; and (ii) fee waivers for hospitalization in public and private hospitals which is for use of hospital services by those not covered by the National Social Security Fund and lacking the means to purchase insurance (World Bank, 2015).

1.2 Definitions

Social protection, social assistance and safety nets

Social protection is understood to include the set of public social policies that directly aim to reduce poverty and provide assistance to low-income and vulnerable groups, deliver support in the face of contingencies and risk over the life-cycle and redistribute resources.

The study's main focus are Lebanon's social assistance and non-contributory programmes, that is, the country's social safety net: the set of policies that include a primary and explicit objective in terms of poverty reduction and providing support to poor and disadvantaged Lebanese households. In contrast with contributory programmes that are generally financed out of employer and employee contributions, social assistance and, non-contributory programmes are typically financed through general taxation or donor assistance.

In this study, Lebanon's social assistance schemes are situated in the context of the wider 'system' of social protection provision including social insurance and health and education policies. Following an initial overview of this wider context, the study then narrows its attention to selected social assistance/safety net programmes managed and financed by the Ministry of Social Affairs (MoSA). As clarified below, the Core Diagnostic Instrument (CODI) is used to guide the full study, while its specific modules on programme design and implementation are applied to the three MoSA programmes reviewed in detail by this study.

Public actors, private actors and civil society

This study is concerned with the public provision of social assistance and broader social protection, that is, on policies that are managed and/or supported financially by the government. In Lebanon, the private sector (non-state actors that aim to make a profit or achieve cost coverage) and civil society (groups seeking to advance specific common interest, usually out of values that can emanate from religious beliefs, political or charitable goals) play an active and important role in providing essential services to the population⁴. Moreover, for the provision of some services in particular, the government relies on NGOs and private actors, directly financing their work. For instance, the Government of Lebanon subsidizes schools maintained by civil society, although with relatively limited control on curricula and teaching methods. It also funds hospitals and clinics that are managed by civil society (ESCWA, 2013).

This can pose a challenge to disentangling the 'public' from 'private' and 'civil society' based social protection. Throughout the study, given Lebanon's 'welfare mix', special attention is paid to highlighting the range of actors involved and to documenting arrangements across different players, while focusing on the public provision of social assistance, that is, those services and transfers that can be directly attributed to government financing and administration. In particular, issues which will be considered include the implications of this configuration (i.e. strong partnerships with and high reliance on the private sector and civil society) for population coverage and access to services, policy fragmentation, inequality and the social contract.

Poverty, risk and vulnerability, inequality

Using available information, this study discusses the effectiveness of social assistance policy using criteria including inclusiveness, adequacy, responsiveness – see more on this below – against the primary outcomes of interest here: poverty, equality, risk and vulnerability.

⁴ Civil society is understood here to include: faith-based organisations; social assistance and targeted support programmes (e.g. zakat); family associations; other civil society including non-affiliated organisations (e.g. Amel Association, Lebanese Red Cross) and private foundations.

Poverty is understood as multidimensional, to encompass monetary measures as well as wider human capital development and inclusion measures. It is also understood as dynamic, reflecting that people's circumstances change over time and that people may experience spells of poverty and move in and out of poverty over their lifetimes. The study also pays attention to policy implications in relation to risk and vulnerability. Risk (or shocks and stresses) can be covariate (affecting whole communities, such as floods) or idiosyncratic (affecting individuals or households, such as illness). Vulnerability captures the likelihood that an individual or household will become poor (or poorer) in the future and considers both the exposure to risk and the ability to cope with risk. The study pays special attention to whether and how social assistance policies take gender and age patterns of poverty and vulnerability into account. Finally, the study also considers social protection policy's role in tackling inequality.

Gender and age are strong determinants of poverty and vulnerability in Lebanon. Available data indicate that households with children and headed by widows are over-represented among the poor (e.g. UNDP and MOSA, 2007). Women face specific barriers to earning an income with unemployment twice as high among women as men; women's labour force participation is characterised by comparatively high gender pay gaps in the private sector and informal work (see section 2.3 below). Moreover, women and adolescent girls are also at risk of other forms of discrimination and disadvantage, including gender-based violence and early marriage, which is seen to be increasing (IRC, 2012; World Bank, 2015b).

This study's concern for poverty, risk, vulnerability and inequality, as outlined above, reflects the multiple objectives of social protection. It also justifies the study's focus not just on social assistance programmes that directly and explicitly pursue a poverty-reduction function, but also on policies such as categorical, non-means-tested services and transfers that play a critical role in supporting disadvantaged population groups. As such, this study investigates the ways in which social protection policy addresses poverty, risk and vulnerability and inequality, reviews the available evidence of its effectiveness and discusses emerging policy implications.

1.3 Methodology

This study provides: a) an overview of social protection in Lebanon; b) a detailed mapping of MoSA's three main public social assistance/social safety net programmes; c) an review of policy effectiveness relying on available information; and d) a discussion of emerging policy implications.

To guide the overall study and the detailed policy mapping, the study relies on the Core Diagnostic Instrument (CODI), one of the instruments designed as part of the Inter-Agency Social Protection Assessment initiative with the objective of providing a single, common platform for policy practitioners and analysts to map and analyse social protection systems and programmes (see: <http://ispatools.org/>).

The CODI is made up of a standard questionnaire used to map, monitor and assess policy and programmes. We used the tool's Programme Inventory Module and Modules 2-3 on Programme Design and Implementation, to carry out a detailed mapping of MoSA's main social assistance/SSN programmes (see <http://ispatools.org/core-diagnostic-instrument/>). The CODI's social protection programme assessment criteria were used to guide the analysis of the three MoSA programmes as well as the review and discussion of wider social protection schemes.

The mapping and analysis relied on:

- A review of the literature and official documents, including published and unpublished research reports. The literature was collected from a range of sources, including from Key Informant Interviews (KIIs) in Lebanon (see below), snow-balling techniques (using relevant references to follow up on further resources), and relevant internet searches.

- Interviews with key informants. KIIs were held with experts across government, international development partners, and civil society organisations in Lebanon, identified jointly with UNICEF Beirut. See Annex 1 for the list of KIIs.

Policy mapping

The overview of social protection in Lebanon and the detailed mapping of three main MoSA programmes was designed around the CODI social protection ‘policy’, ‘programme design’ and ‘programme implementation’ framework, see Table 2.

Sectors covered by the initial overview include social insurance, social protection-related health and education policy, subsidies, tax allowances and social assistance. Key elements covered include national plans, policy legislation and regulation; institutional responsibility allocation and processes; public spending and financing.

Table 2: Key elements of social protection systems and programmes

Policy	Programme Design	Programme Implementation
1. Legal & Policy Framework 2. Alignment of Policies with Needs of Population 3. Policymaking Process 4. Policy Implementation & Capacity 5. Public Expenditure & Financing 6. Information Dissemination & Raising Awareness 7. Monitoring & Evaluation Systems	8. Eligibility Criteria 9. Benefit Design 10. Expenditures & Financing 11. Incentives	12. Identification 13. Eligibility Verification 14. Enrolment 15. Benefit Delivery 16. Monitoring & Evaluation 17. Complaint & Appeals Mechanism 18. Information Dissemination & Raising Awareness

Source: CODI What Matters Guidance Note

At the project inception stage, it was agreed that the detailed mapping and review of MoSA programmes would cover the Ministry’s:

- programmes and services for people with disabilities;
- programme for children in social institutional care;
- National Poverty Targeting Programme (NPTP).

For these three sets of policies, we undertook a detailed mapping and review using the CODI’s Programme Inventory Module and Modules 2-3 on Programme Design and Implementation. This led to the completion of three background papers which feed into this report and are summarised in Chapter 4 and 5 here.

For programme design, the study maps out the key design features of the selected MoSA social assistance/SSN programmes, covering, as relevant: eligibility criteria, service/benefit design (including duration of benefits, exit rules and benefit conditions), expenditures and financing, and incentives.

For programme implementation, with available information, the study covers implementation and delivery processes, processes for determining eligibility for the three programmes, the costs associated with programme take-up and participation, mechanisms to track, monitor and feedback on delivery and adequacy of social assistance. The key elements covered are: identification of beneficiaries, eligibility verification, enrolment, delivery of the benefit/transfer, monitoring and evaluation, complaint and appeal mechanisms, and information dissemination and raising awareness.

Specific features of the CODI tool (for instance a focus on cash-based benefits), coupled with the key defining characteristics of Lebanon's social assistance, meant that we had to make adjustments to the tool to facilitate a meaningful use of the instrument.

Policy analysis

The analysis of social assistance programmes relied on the CODI performance assessment criteria (see Annex 4 for the list and definitions used here). Specifically, we restricted the criteria to 9 out of the 10 proposed by CODI. These are: inclusiveness, adequacy, appropriateness, respect for dignity and rights, governance and institutional capacity, financial and fiscal sustainability, coherence and integration, responsiveness, and incentive compatibility.

These criteria were used to guide the policy analysis along the seven policy elements outlined by the project's TORs and discussed in this study in terms of 'enablers and constraints':

- Legislation, regulation and policy framework
- Policy design
- Policy implementation
- Policy coordination
- Participation and process
- Financing, fiscal capacity and sustainability
- Measurement, data and M&E

2 Poverty and Inequality

2.1 Monetary measures

Poverty

According to available household survey data, between 2004 and 2016, poverty has hovered at between 27% and 28.7% (see Table 3). Based on the 2004/5 CAS survey, around 1 million Lebanese are poor; the RPA 2016 estimates around 1,2 million people live under the poverty line of US\$8.4 per capita per day (UNDP, 2016; assuming a total Lebanese population of 4.1 million people).⁵

Box 1: Lebanon population Census and population data

The degree of uncertainty and dispute on demographic statistics in Lebanon arises in part from the fact that the last Census was carried out in 1932. Any population estimates and surveys carried out to measure living standards and wellbeing are based on updates of the 1932 Census.

In terms of total Lebanese population alone, there are a number of different estimates cited by studies and official documents. For example, the Lebanese Crisis Response Plan 2017-2020 (LCRP) reports an estimated population of 5.9 million people living in Lebanon in January 2017; of which:

- 4.1 million are Lebanese,
- 1.5 million Syrians who have fled the conflict in Syria (including 1 million registered as refugees with the UNHCR),
- 278 thousand Palestine refugees pre-Syria conflict in Lebanon,
- 31 thousand Palestine refugees from Syria, and
- 35 thousand Lebanese returnees from Syria (GOL and UN, 2017).

These compare with estimates of the Lebanese population by the World Bank based on the HBS 2011, of 3.78 million, and by the CAS HBS 2005 of 3.75 million (CAS, <http://www.cas.gov.lb/>; and IPC-IG 2017).

The absence of regular censuses means that all calculations for planning and information purposes rely on 'probable' figures – in a country that since the last full national census has seen high mortality due to civil war, wars with Israel and major displacements. The lack of a reliable periodic total headcount of residents impacts on planning tools such as poverty surveys and gender responsive budgeting (EuropeAid, 2015).

According to the CAS and UNDP 2004/5 survey, 8% of the Lebanese population were extreme poor (CAS and World Bank, 2015). This percentage drops to 3,6% in 2016 according to the RPA, indicating that around 147,600 Lebanese were living below the extreme poverty line of US\$3.6 per capita per day in 2016 (UNDP, 2016).

Of note, NPTP records for 2017 (pre-recertification) – based on the administrative tool used to identify extreme poor Lebanese households eligible for social assistance – identify 105,849 extreme poor Lebanese households (around 460,200 individuals according to World Bank, 2017) across the country. Following the 2018

⁵ Study yet to be published.

recertification process, the number of extreme poor households identified via the NPTP and card holders is 41,372 (MoSA personal communication November 2018; see Chapter 4).

Table 3: Poverty estimates: a summary

Source	Survey year	Poverty line	Extreme poverty line	Poverty rate %	Extreme poverty %	N of poor (individuals)	N of extreme poor (individuals)
Living conditions and household budget survey (CAS and UNDP) 2004/5	Feb 2004- April 2005	USD 4/pc/day	USD 2.4/pc/day	28.5	8	1,000,000	
Household budget survey (CAS and World Bank) 2011/12	Nov 2011- Nov 2012	USD 8.5/pc/day	N/A	27	N/A		N/A
Rapid poverty assessment (UNDP 2016)	2016	USD 8.4/pc/day	USD 3.6/pc/day	28.7	3.6	1,176,700	147,600

Source: UNDP (2008); CAS and WB (2015); UNDP (2016), World Bank (2015b)

Note: These figures are not strictly comparable due to differences in the underlying data, data collection instruments, sample design, methodology for constructing the welfare aggregate and methodology for estimating the poverty line. Data from the HBS 2011-12 could not be used to update extreme poverty rates.

Geographically, poverty and extreme poverty are concentrated in Akkar (located in the North), the rest of the North, the South, Baalbek-Hermel (located in Beqaa) and Nabatieh (UNDP PRA 2016; HBS 2005). Beirut and Mount Lebanon are the wealthier governorates. Out of the overall poor population, 38 percent of total poor were concentrated in the North (with 46 percent of the extremely poor population located in the North region), and 27.3 percent concentrated in relatively affluent Mount Lebanon (World Bank, 2015b; based on 2004-05 multipurpose household survey, UNDP, 2008). Poverty analysis by cadasters also shows the concentration of poverty in specific pockets of the country: the majority of deprived Lebanese (67 percent) and persons displaced from Syria (87 percent) live in the country's 251 most vulnerable cadasters, out of a total of 1,653 cadasters (GOL and UN, 2017).

Moreover, Lebanon is a largely urbanised country, with an estimated 88 percent of the population living in urban areas. This is where the majority of Lebanon's poor are located, with poverty levels highest in small, dense pockets in the suburbs of large towns. The entire rural population of Lebanon represents a fraction of the population living in poor urban areas in Lebanon (30 percent in 2004) (World Bank, 2015b).

Whilst the majority of the poor live in urban areas, poverty is particularly acute in rural areas and among agricultural households. Compared to Lebanon's overall poverty rate of 8 percent, over 20 percent of households engaged in agriculture fall below the poverty line. A second category at high poverty risk are construction workers. Agricultural workers and construction workers represent 38 percent of all the poor (El Laithy et al, 2008).

Certain individual and household characteristics are also associated with poverty. Households with no earning adult male members, female-headed households, households with children, and larger households having lower incomes are at high poverty risk. Various surveys have identified that households with children and headed by widows are over-represented among the poor (IPC 2017 feasibility study; Kukrety and al Jamal, 2016; UNDP PRA, 2016; UNDP and MOSA, 2007; World Bank, 2015b). Some studies also show higher prevalence of poverty among the elderly (UNDP and MOSA, 2007), and others also show a strong link between poverty and disability (Chaaban and el Khoury, 2015; Lakkis et al., 2015; to Rebuild Lebanon, 2007; UNDP RPA, 2016).

Box 2: Household survey data and measuring poverty in Lebanon

The estimates from available household survey data reported in this study need to be treated with some caution and are generally not directly comparable due to variations across surveys in data collection instruments, population sample, methodologies for formulating the welfare aggregates and for calculating poverty lines. Even the basic target population and definition of Lebanese households varies across surveys. For instance, the CAS/UNDP 2004-5 survey sample covered de facto the whole population except the Palestinian population living in refugee camps, while the 2016 RPA covers Lebanese households defined as those in which at least one of its members holds the Lebanese nationality (CAS and World Bank, 2015; UNDP 2016).

A primary constraint to clear and timely poverty profiles and estimates in Lebanon has traditionally been the limited supply of household survey data. Lebanon has lagged behind in the collection of micro data compared to other upper middle-income countries (World Bank, 2015b). Recent efforts to address this shortfall include the planned MICS (2019), HBS (2019) and LFS underway. A second, related constraint concerns the consistency and comparability of survey instruments and data. The variations across surveys implemented to date and their underlying methodological approaches limits the comparability of estimates over time. Finally, challenges in the implementation stages of surveys, including high non-response rates (e.g. in the 2011 HBS) have been a constraint to providing accurate poverty estimates for Lebanon (CAS and World Bank, 2015; UNDP, 2016).

There is widespread concern that the impact of the Syrian crisis and the macro-economic and political environment are exacerbating poverty among the Lebanese population, through a combination of factors including rising unemployment (especially among the low skilled), decreasing wages, and demand on public services exceeding the capacity of institutions and infrastructure to meet needs (World Bank, 2013; World Bank, 2015b). An estimate for five years ago, reports that the Syrian conflict is estimated to have pushed an additional 170,000 Lebanese into poverty in 2014 and made those already poor even poorer (World Bank, 2015b). The deterioration in livelihood conditions is thus a concern for those living under the poverty line as well as for those immediately above the upper poverty line and who are highly sensitive to shocks (NPTP report, 2017). The geographic distribution of refugees further aggravates the vulnerable situation of poor Lebanese as their presence is concentrated in areas already characterised by high poverty rates: from the beginning of the crisis, the highest concentration of Syrian displaced was in the North, followed by the Bekaa and Mount Lebanon, with growing numbers moving into Mount Lebanon (World Bank, 2013; Karam et al., 2015). The high number of displaced Syrians seeking jobs in rural areas has contributed to reduced wages in the agricultural sector. Unlike other sectors, there is no legal restriction concerning agricultural labour and no minimum wage requirements for displaced Syrian (World Bank, 2015).

With respect to the population of non-nationals, according to the 2017 Lebanon Crisis Response Plan (LCRP), more than 70 percent of displaced Syrians are living below the poverty line, along with 65 percent of Palestine Refugees in Lebanon and 90 percent of Palestine Refugees from Syria (one of the most vulnerable groups in the region) (GOL and UN, 2017; Kukrety and al Jamal, 2016: 9).

Box 3: The Syria crisis

The conflict in Syria has significantly impacted Lebanon's social and economic growth, caused deepening poverty and humanitarian needs, and exacerbated pre-existing development constraints in the country.

The estimated 1.5 million displaced Syrians, half of whom are women and children, along with 31,502 Palestine Refugees from Syria (PRS), have joined a pre-existing population of 277,985 Palestine Refugees in Lebanon (PRL) as well as 1.5 million vulnerable Lebanese. An estimated 35,000 Lebanese have also returned from Syria since 2010.

The presence of an estimated 1.5 million displaced Syrians has increased demand on infrastructure and social services, which lack the capacity to meet increased needs. The distribution of the displaced Syrian population in areas with a high concentration of Lebanese poor has also compounded an already problematic economic situation, increasing poverty and social tensions between different communities while deepening the country's socio-economic disparities.

Source: GOL and UN, 2017; World Bank 2013a.

Assessments also find that, among the Syrian displaced population poverty is particularly high amongst households headed by women, which account for 17% of all Syrian displaced households (UNICEF, UNHCR and WFP, 2016). These are found to be more food insecure, poorer, and to adopt more severe coping mechanisms (Ibid.; Harvey et al, 2013). Poverty among Palestinian children is also high (poverty is higher among children and adolescents ages 6-19 years) and increases with the number of children in a household, although extreme poverty decreases with the number of children in the family because of the contribution of young family members to the livelihoods of the poor family, often through child labour (Chaaban et al., 2010).

Inequality

Lebanon has one of the highest levels of income and wealth concentration in the world. According to Assouad (2017), the top 10 and 1 percent of the adult Lebanese population receive approximately 55 and 25 percent of total national income respectively, placing Lebanon among the countries with the highest levels of income concentration. In terms of wealth, the top decile and top percentile of wealth holders account respectively for 70 and 40 percent of total wealth (Assouad, 2017).

In addition to wider political economy and human mobility trends, fiscal and social policy play a critical direct role in such inequality levels. Lebanon's opting for laissez faire economic policies and minimal state intervention since its independence in 1943 has played an important role (Assouad, 2017). With regards to the tax system, Assouad highlights the high reliance on indirect taxes, major tax breaks and exemptions implemented in the 1980s and 90s, along with the near absence of a progressive inheritance tax regime, as contributing factors to Lebanon's high income and wealth inequality (Assouad, 2017; Assouad et al., 2018). These comparatively high inequality figures highlight the potential for establishing and strengthening mechanisms of redistribution, fiscal reform and investments in health, education and infrastructure.

2.2 Children and youth

Poverty in Lebanon is especially pronounced among children. The LCRP reports that of the 1 million Lebanese living below the poverty line, 470,000 are children (GoL and UN, 2017). The poverty rate increases from 8 percent in households without children to 24 percent in households with more than four children (World Bank, 2015b).

Box 4: International legislation on the rights of children

Lebanon ratified the Convention on the Rights of the Child in 1990, and the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography in 2002.

Source: CRC, 2016.

Monetary poverty compounds other forms of child poverty. For example, school drop-out and non-enrolment of both extremely poor and poor children taken together represent 72% of the out of school children in Lebanon (IPC, 2017).

Pulling children out of school, especially in secondary school, is a coping mechanism used by both Lebanese families and refugees (UNHCR, 2014a). The ILO and Government of Lebanon report that Lebanon may have one of the highest proportions of working children aged 10 to 17 in the world, with over 100,000 children in the country subject to child labour and trafficking (ILO and MoL, 2013). Furthermore, UNICEF's SOWC 2017 report 3% of boys, and 1% of girls are engaged in child labour. Children from low-income families, refugee children and street children are particularly vulnerable to exploitative labour practices (ILO and MoL, 2013). High numbers of Lebanese children (boys) work in the agricultural sector in Akkar, Hermel and Baalbek, where they tend to work alongside family members (ILO and MoL, 2013). Girls, however, are more likely to drop out of school because of early marriage (UNDP PRA, 2016). The 2017 VASyR reports that 4.8% of displaced Syrian children aged 5 to 17 reporting working.

Nearly half of those affected by the Syrian crisis are children and adolescents: at least 1.4 million children under 18, including Lebanese, Syrians and Palestinians, are currently growing up at risk, deprived, and with acute needs for basic services and protection (GOL and UN, 2017). It is estimated that 54% of the 1.5 million displaced Syrians are children (GOL and UN, 2017).

Future prospects for Lebanese youth look challenging. Youth unemployment stands at 34 percent and is reportedly “alarmingly high”, three to four times higher than the overall unemployment rate (GOL and UN, 2017). Slow economic growth and the impact of the Syrian conflict are key challenges to youth employment (World Bank, 2015b). The economic downturn has had a disproportionate effect on young people and others who are entering the workforce. According to the World Bank (2013a) as a result of the Syria crisis, an additional 220,000- 324,000 Lebanese, primarily unskilled youth, are expected to become unemployed.

2.3 Women and girls

Gender inequality in Lebanon is considered to be particularly stark. According to the Gender Gap index, Lebanon ranks third to last in the Middle East and North Africa (MENA) region (ranked at 135). Only Syria and Yemen have a worse gender gap ranking, 142 and 144 respectively (WEF, 2016). Since 2010, Lebanon has seen a consistent decline in its global index rank and relative gender gap score primarily as a result of low scores on economic participation and scores consistently close to zero in political empowerment (WEF, 2016). In terms of political participation, while women are as active as men in voting, women are severely underrepresented in political and decision-making roles (EuropeAid, 2015).

Box 5: Legal and constitutional reforms to tackle gender inequality

Compared to other Arab countries, the Lebanese legal system is considered to be comparatively progressive. There are no legal restrictions limiting women in engaging in income-generating activities. In terms of legal and constitutional reforms, a brief historical excursus points to: 1953, when Lebanon became one of the first countries in the Arab region to accord women equal rights to participate fully in politics; 1996, when Lebanon ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the late 1990s, when Lebanon adopted gender mainstreaming in the collection and analysis of gender statistics.

However, implementation is another matter. On CEDAW for example, despite formal State endorsement, reservations by the Lebanese government on articles related to personal status laws and nationality rights of women citizens effectively deny women the same rights as men in instances of marriage, divorce, and family matters and uphold the ban on Lebanese women from passing their nationality to their husbands and children. The reservations are intended to maintain the current personal status law, which is under the mandate of religious courts, rather than civil courts. Amendments to such reservations are essential to eliminating gender discrimination and inequality.

Source: Avis, 2017; EuropeAid, 2015.

In terms of economic participation, the low rates are mainly due to relatively low levels of female participation in the workforce (male to female ratio of 3:1) and low estimated earned income for women (female to male ratio of 0.27) (World Bank, 2015). Indeed, although there are increasing trends in women's labour force participation, unemployment is twice as high among women as among men (World Bank, 2016).

Moreover, a disproportionate number of women are either outside the labour force or are invisible in statistics concerning economic activity (working in the informal economy). Women only constitute a quarter of the (visible) economically active population aged 15 years or above, although they are more numerous than men in the age groups where economic activity and political participation are significant (EuropeAid, 2015).

Women's labour market participation is also characterised by pay gaps in the private sector, and informal work (EuropeAid 2015; Gohlke-Rouhayem, 2016; UN Women, 2016). Moreover, differences between employment rates among men and women widens after age 34 (Gohlke-Rouhayem, 2016; World Bank, 2016). Regional differences are also apparent. The level of economic participation among women is lower in South Lebanon (25%) than in the North, Bekaa and Beirut (40%) (SWMENA, 2011).

Poverty also matters. There is a significant gap in the labour participation of poor and wealthier women: female unemployment rates are at 26.6% among the poor, and 8.2% among the non-poor (MoSA, UNDP and CAS 2006 cited in Karam et al., 2015).

Evidence suggests that these challenges are due to a combination of women's educational status, lack of experience / exposure and socio-cultural gendered roles - such as the continuing influence of perceptions that married women's place is in the home unless economic pressures force them to work - which prevent women from working (EuropeAid, 2015; Kukrety and al Jamal, 2016).

Policy design and regulation play a role. With regards to women's participation in paid employment, type of work undertaken and inequalities in work-related outcomes, although there are no legal restrictions limiting women in engaging in income-generating activities, in practice, policy design and legislation, including on employment and social protection, still include elements of discrimination. These may arise as a result of explicit bias, whereby laws and regulations reserve differential treatment for women and men, or implicit bias, for instance when social protection laws and regulations are based on assumptions about gendered roles (e.g. of men as primary earners in the household) or interact with existing inequalities to reinforce differential outcomes. Recent years have witnessed positive changes in favour of women's rights on issues related to labour code, the social protection and social security code and state employment regulations (e.g. Avis, 2017).

Despite the low gender equality rates in the economic and political spheres, Lebanon performs comparatively well and has achieved significant improvements in gender equality in the areas of education and health. In particular, Lebanon has made significant progress in closing the gender gap in secondary and tertiary education (World Bank, 2015). However, the statistics on the gender gap in primary school enrolment vary according to different sources. The recent UNDP RPA (2016) shows that, at elementary school level (ages 6-12) 99.1% of girls were enrolled compared to 97.4% of boys. However, data from UNICEF SOWC 2017 (data from 2011-2016) and World Bank 2015 show girls' enrolment in primary education is lower than boys'. The World Bank (2015) for instance, reports that boys primary school enrolment exceeded 97% whilst girls' enrolment was 90%.

The statistics point to concerns around boys' education, especially in the transition to secondary school, and the higher drop-out rates for boys in secondary education to start working (UNICEF SOWC, 2017; RPA, 2016). For girls, the main reason for not attending school is marriage (RPA, 2016). Despite closing the gender gap in school enrolment post-primary level, women's literacy rates are lower than men's (17.6% of female population is illiterate compared to 9.3% of male population (based on living standard survey 2007) (RPA, 2016).

In terms of health care, sex rate at birth and healthy life expectancy are almost equal between men and women (World Bank, 2016). Moreover, Lebanon has also made significant improvements in the delivery of health care services over the last two decades. Reproductive health became a part of primary health care in 2003, and the maternal mortality rate in Lebanon is low at 15 per 100,000 live births (UNICEF SOWC, 2017).

However, there is concern that significant gaps still exist in the delivery of health services, and also over the quality of services provided especially in remote rural areas (IWSAW 2016). For example, some regions (Bekaa and North Lebanon) have pockets of low socioeconomic and associated health status, and health inputs exhibit similarly stark geographic inequality (World Bank, 2016: 79). The Syrian conflict has also placed considerable pressure on the health care system in the country (Ibid.). Those most affected by limited and poor services tend to be women and girls, especially those from poor social backgrounds or rural areas (World Bank, 2016; IWSAW, 2016).

Finally, gender-based violence and early marriage are a concern for girls. Approximately 6% of girls in Lebanon are married by the age of 18 (UNICEF SOWC, 2017). The RPA (2016) finds that 8.5% of girls who have dropped out of school do so because of marriage (compared to 0.4% of boys). Economic pressures are resulting in changing behaviours for refugee population too - child marriage is reportedly increasing among the girl Syrian

displaced population (CARE 2015⁶, cited in Latif; IRC, 2012). A rapid GBV survey of displaced Syrians in Lebanon found that adolescent girls stated that early marriages have increased (and the age has decreased – some as young as 12), most frequently framed as efforts by families to “protect” girls from being raped, or to ensure that they are “under the protection of a man” (IRC, 2012).

⁶ http://insights.careinternational.org.uk/media/k2/attachments/CARE_Child-marriage-in-emergencies_2015.pdf

3 Social protection

3.1 A brief history

Defining characteristics

Key distinguishing features of social protection in Lebanon include:

- Across all sectors, high involvement and reliance on the private sector, civil society and faith-based organisations;
- In health and education, high involvement of the private sector (reflected in the comparatively low social spending in both sectors), with implications for equity in the utilization and quality of services in education and health for poorer and vulnerable groups;
- Low social insurance coverage of workers in Lebanon (less than 50% covered); no full pension plans available to the private sector, rather end of service agreements;
- Comparatively low social assistance spending, coverage and levels of support; fee waivers and education and health subsidies account for a significant share of social assistance programmes; limited social assistance in the form of in-kind transfers and no cash transfers; high reliance on NGOs for the delivery and administration of social assistance services.

Historically, Lebanon's economic and social model is based on minimum state intervention justified in part by the objective of guaranteeing a multi-confessional and open society. The idea that in order to protect the country's cultural and religious diversity State intervention should be minimal partly explains Lebanon's minimalist state and fiscal structure (Assouad, 2015).

This approach, together with the conflicts Lebanon has experienced and related interruptions in public services provision, has contributed to the high reliance on private sector and non-governmental organisations in the delivery of services, including social protection. Low government spending on social assistance, as reported in the next section, reflects this arrangement and points to the weak tradition of State-provided assistance in Lebanon (KIIs).

Interestingly, this historical configuration does not seem to be reflected in low demand for publicly provided services, including social assistance. According to perceptions surveys carried out in 2011 and 2013, a large majority - approximately 80 percent - of Lebanese citizens interviewed believe the primary responsibility to help the poor rests with government. An equally large majority agreed with the statement that their government should provide social safety nets to the poor. Moreover, Lebanon was the country in the MENA region with the lowest level of citizen's satisfaction with government assistance to the poor. Lebanese citizens' demand for and expectation that the government should intervene are high (Silva et al., 2013).

Legislation and policy frameworks

Two national plans adopted over the last decade outline specific policy gaps and actions to be taken moving forward on social protection, and social assistance specifically: Lebanon's 2007 *National Social Action Plan Toward Strengthening Social Safety Nets and Access to Basic Social Services* and the 2010 *National Social Development Strategy* (NSDSL).

The Government of Lebanon's 2007 *National Social Action Plan* outlines a detailed road map for social policy reform and key interventions including the implementation of a targeting mechanism, based on a proxy means test for identifying low-income households.

Its stated objectives are to: (a) reduce poverty and improve the quality of education and health indicators; (b) improve the efficiency of social spending while preserving budgetary allocations at an appropriate and sustainable level; and (c) minimize regional disparities and achieve better dissemination of allowances allocated in the national budget for social intervention.

It identifies key interventions, including: (i) cash transfers to poor senior citizens, poor disabled and poor female-heads of households; (ii) school feeding, books, stationary, and transportation facilities to students living in poor locations and at risk of dropping out of basic education; and; (iii) free hospitalization for all households under the poverty line as well as those suffering from chronic diseases, while ensuring an effective identification of qualified beneficiaries.

The *National Social Action Plan* followed on from the publication of Lebanon's first-of-its-kind national survey report on inequality in 2007 which in turn directly contributed to the reform processes launched at the Paris III conference that year. In terms of stated intent, the Plan contrasts with the country's long tradition of market-oriented policies and policies directed toward reconstruction rather than social services (Assouad, 2017).

Lebanon's 2010 NSDSL calls for the establishment of an effective social safety net targeted to the poor and vulnerable and improvements in health, education and employment opportunities.

With regards to international legislation, Lebanon has not signed the ILO social security conventions, including the ILO's Social Security (Minimum Standards) Convention, 1952 (No. 102) and the ILO Social Protection Floors Recommendation, 2012 (No. 202) (Karam et al., 2015).

3.2 Health and education

Lebanon exhibits relatively strong education and health outcomes. In education, it outperforms its upper-middle income and MENA peers. Total spending in education is comparatively high, primarily through high private spending. Similarly, in health, Lebanon reports relatively good health status among the population. Both sectors are characterised by comparatively weak public provision and high-quality private provision, with significant implications for inequality by geography/area, income and gender as concerns the access to and quality of services (World Bank, 2015).

Both in education and health, the high reliance on the private sector for the provision of social services has grown over the years, partly in response to the conflict and the collapse of the state, providing services in times of crisis, as well as in response to demands for better quality services that the public sector had not met (ESCWA, 2013; World Bank, 2015). Lebanon also has a long tradition of civil society provision of social

services, predating the civil war. As a result, non-state actors had the capacity to step in when conflict interrupted public service provision and their role in social services provision remains high (ESCWA, 2013).

Health

The composition of health expenditures reflects the configuration outlined above. Public health expenditures make up 1.6% of GDP (one of the lowest in the region) while out-of-pocket payments are high and lie well above 50 per cent of total health expenditures (ESCWA, 2013; World Bank, 2015).

This raises equity concerns as it is mostly the poorer parts of the population who are not covered by health insurance schemes, and at the same time, are most exposed to more hazardous working and living conditions. Out-of-pocket payments are especially burdensome for them and subject a large proportion of the population to financial hardship, even impoverishment (World Bank, 2015). In the region, the share of households which incur so-called ‘catastrophic payments’ ranges between 7 and 13 per cent of the population, with the highest share of 13 per cent in Lebanon (ESCWA, 2013).

In Lebanon, the private sector actually leads in health-care provision. In 2008, 92 of the 149 hospitals in the country were private and for-profit. There were only 5 public hospitals and the rest were run by various civil society organizations. Public-private collaboration also occurs via public funding of private health-care provision. This is done either through subsidies from the public to the private sector or through coverage of health-care treatment in the private sector by public health insurance (ESCWA, 2013).

Studies of the impoverishment effects related to health highlight the role of health care costs and related increases in poverty headcount ratios post-illness. According to Silva et al (2013), in Lebanon, out-of-pocket health care spending contributes to a 4.1 percentage point increase in the poverty headcount (from 27.5 percent to 31.6 percent), one of the highest in the MENA region. Despite health fee waivers and services provided by the State as discussed below, they often face implementation challenges, and households continue to incur high out-of-pocket expenditures.

Box 6: The Syria crisis and health care

The conflict in Syria is impacting Lebanon's health system through: (1) increased demand for health care services; (2) increased unpaid commitments of the Ministry of Public Health (MOPH) to contracted hospitals; (3) shortages in health workers including specialists and nurses; (4) a sharp rise in communicable diseases (the number of measles cases, for example, increased from 9 in 2012 to 1,456 in 2013) and the emergence of previously absent diseases; and (5) increased risks of epidemics such as waterborne diseases, measles, and tuberculosis.

Overcrowding, lack of water and sanitation infrastructure and other poor environmental conditions also pose significant risks to increased infections, as outbreaks of lice and scabies among refugees have shown. Thus, demand for health services has markedly increased. In December 2012 alone, 40 percent of primary health care visits were for Syrian refugees.

In addition, strong demand for hospital care is crowding hospitals and compromising access to healthcare, thus exerting financial pressure on hospitals, increasing costs, and generating medication shortages. In the medium- to long-term, the impact of delayed health care could result in increased overall levels of morbidity, particularly for the vulnerable.

Source: World Bank, 2013a.

Inequity in access to and quality of health services arise as a result of different policy design and implementation factors. A number of measures have been adopted by the government to address these issues. As the private sector's provision of social services is often on a fee-for-service basis, the private sector may reject those who are not able to pay. Unequal coverage of employment-based and private health insurance mostly stems from differences in employment status: men are more often covered than women and the wealthier more often than the poor. Health care insurance funds as part of social insurance funds reimburse costs for medical treatment in public and sometimes also private clinics. The Ministry of Public Health serves as the insurer of last resort for 53 per cent of the population, those who are not covered by employment-based or private health insurance (ESCWA, 2013; World Bank 2015).

A number of regulations and reforms introduced in more recent years aimed at ensuring quality standards and reducing out-of-pocket expenditures include: the introduction of flat rates for consultations and surgical procedures (although these price regulations mainly benefit those who have the ability to pay for the private services in the first place; price regulations disproportionately benefit the non-poor) and a financial ceiling for each contract with a hospital (discouraging hospitals from 'overtreating') (ESCWA, 2013).

Finally, the role of faith-based organisations and faith-based socio-political movements in the provision of health care is also significant. In 2008, 43 per cent of the country's 149 hospitals were run by faith-based or faith-affiliated parties or organizations. At least 44 per cent of all clinics and dispensaries were run by faith-based organizations or parties (ESCWA, 2013).

Education

As in health, the private sector, NGOs and faith-based organisations play an important role, with implications for equity in access to quality of services. In Lebanon, 73 per cent of primary students and 61 per cent of secondary students were enrolled in private schools. While in other countries private enrolment tends to be higher at the secondary level than at the primary level, which reflects endeavours by countries to guarantee basic education to all, in Lebanon private education at the primary level exceeds private education at the secondary level (ESCWA, 2013).

The differences in enrolment in type of school by wealth background is stark: only 5 per cent of poor students attend private schools as opposed to 66 per cent of students from wealthier households. The poor quality of public schools has large negative implications for the poor and efforts to escape poverty (World Bank, 2015). Out of 1,000 students who enrol in private school at the first grade, 225 reach the baccalaureate without repeating a year, but out of 1000 students who enter the public school system, only 9 will reach the baccalaureate without repeating a year (Kawar and Tzannatos, 2012, p. 3, quoted in ESCWA 2013). Private schools may offer education free of charge if they are subsidised by the Government (or financed by civil society).

During the academic year 2007/08, 14 per cent of all students were enrolled in private schools with public financing – compared to 53 per cent in purely private schools and 33 per cent in fully public schools. While subsidized private education mainly targets low-income families, schools tend to maintain separate classrooms or even separate buildings for subsidized and non-subsidized students, which raises additional concerns about a two-tier system (ESCWA, 2013).

Lebanon stands out as a case where faith-based organizations play a particularly large role in the provision of education. This can be traced back to Article 10 of the Constitution, which guarantees all religious denominations and sects the right to maintain their own schools. Forty-one per cent of private schools in Lebanon are maintained by faith-based organizations, representing almost all religious groups in Lebanon. The Maronite church is the largest provider of education among faith-based organizations. The second largest number of schools is attributed as “Sunnite” and there are several providers of schools to the Sunni population (ESCWA, 2013).

Initiatives to address the system’s limitations include the adoption, in 2011, of Act No. 150, which made education compulsory and free for the basic education cycle (15 years) in public schools. It was followed by operational steps, including: a draft operational decree for the Act to identify mechanisms and responsibilities of all official stakeholders (the Ministry of Education and Higher Education, the Ministry of Social Affairs, the Ministry of Interior and Municipalities, the Ministry of Justice, etc.); exempting parents from paying registration fees from the first grade until the ninth grade in public schools; distribution of textbooks free of charge for pupils in kindergarten and primary education in public schools through the budget of the Ministry of Education and Higher Education, and Decree 11212/2014 (financial donation from the British international development agency DFID for the period 2013-14).

Despite such provisions, however, the challenges and inequities of the schooling system in Lebanon persist, reflecting in part the persistent low public expenditure in the sector (UNICEF, 2016). The Syrian crisis has also exacerbated existing weaknesses in the education system. Box 7 reports on how the government of Lebanon and development partners have sought to strengthen the system and respond to the increased demands on the education system for both Lebanese and Syrian children.

Box 7: The Syria crisis and education: Reaching all Children with Education in Lebanon (RACE)

Available evidence points to the increase in demand for education services associated with the high number of displaced Syrian children and, relatedly, to mounting fiscal costs, adverse effects on the quality of public education, and a significant need for non-formal education.

Since the onset of the Syrian conflict, and the increased number of refugees in the country, the Ministry of Education and Higher Education (MEHE) provided open access to refugees in its public-school system. In 2012, 40,000 refugee children were accommodated in public schools for a budgetary cost of USD29 million. Indeed, since 2011, approximately 48% of students enrolled in Lebanon's schools from kindergarten to Grade 9 are non-Lebanese. This has almost doubled school enrolment for this cohort since the beginning of the Syria crisis (RACE II Factsheet, 2017). Data from 2017/18 show that 213,358 non-Lebanese are enrolled in public schools in first or second shifts in the same cohort, with 209,409 Lebanese enrolled (RACE II Factsheet, 2018).

In response, the MEHE and international partners developed an education response plan the Reaching All Children with Education (RACE I) Strategy (2014-2016). RACE made education compulsory and free for the basic education cycle (15 years) in public schools. Currently, RACE II is being implemented from 2017-2020, aiming to increase equitable access to education and learning for all children and youth aged 3-18 years in Lebanon and \$87 million has been provided by international support MEHE directly. This funding includes the salaries and training of teachers, as well as running, administration and rehabilitation costs of second-shift schools (Inter-Agency Coordination, 2017).

Sources: CRC, 2016; LCRP 2017-20; MEHE, 2017; MEHE, 2018; World Bank, 2013a.

3.3 Social insurance

The National Social Security System

Lebanon displays comparatively low expenditures on pensions and is an exception in the region as it does not provide pension plans to private sector workers (more below). Total public pension expenditures are at 3 percent of GDP (IMF, 2016).

Lebanon's National Social Security System (NSSS) is composed of:

- the National Social Security Fund (NSSF),
- Public Servants Cooperation (also referred to as Cooperative of Public Sector Employees)
- Security Sectors Insurance (LAF and Internal Security Forces/ISF)
- Insurance companies/schemes covering specific professional sectors
 - Mutual funds (Members of Parliament; Employees of Lebanese Parliament; Judges; Judges' aides; Islamic Tribunal Judges)
 - Syndicates (Order of Engineers and Architects in Beirut and Tripoli; Beirut and Tripoli Associations (for lawyers); Private Schools Solidarity and Pension Funds)
- Private insurance companies.

Although some form of national legislation exists covering sickness, maternity, old age, employment injury, invalidity, survivors, and family allowances, unemployment remains unaddressed (Karam et al, 2015).

The NSSS achieves low coverage of Lebanese households, relative to the country's income level in comparative

terms (Robalino et al., 2005). More than half the population, 53.3 per cent, is not covered by any type of social insurance scheme. Moreover, it is characterised by a multiplicity of institutions and overlaps in coverage. A beneficiary may be covered by more than one scheme, while some category of workers and of risks remain entirely uncovered (Karam et al, 2015)

The core of the social insurance system is managed by the National Social Security Fund (NSSF) which provides to private sector formal workers (and some contractual workers from the civil service) health insurance, an End of Service Indemnity (EOSI) and Family Allowance – not a full pension plan. As of today, Lebanon does not have an actual pension system offering old-age, disability or survivorship annuities. Private sector workers not covered by the NSSF or the civil service (around 50 per cent of the labour force, including informal wage earners and the self-employed) can, in principle, obtain health coverage from the Ministry of Public Health (Robalino and Sayed, 2013).

The EOSI has a unique design that combines defined benefit and defined contributions formulas. Active individuals contribute to individual accounts managed by the NSSF. Upon retirement, the NSSF pays to eligible members a lump sum that has two components: an earnings-related defined-benefit component and a defined-contribution component. When employees leave a company, they receive the capital accumulated in their individual account with past employers plus a lump sum proportional to the number of years spent with the last employer. The programme is financed by payroll taxes and individual contributions. It does not seem to face problems of solvency. In 2009, the EOSI was running a cash surplus (Robalino and Sayed, 2013)⁷.

With regards to contractual workers and workers in state-owned enterprises and public companies, these enrol in the scheme for civil servants. The military join the fund for civil servants and enjoy special provisions. Self-employed or part-time workers do not enjoy any contributory social insurance coverage (Robalino et al, 2005).

There have been a number of recent changes to the social security code and labour code which have favoured women's rights. These include the passing of the law in April 2014 that extended maternity leave from 49 to 79 days, extended benefits of retirement pension to both husband and wife, granting Lebanese women the legal right to open bank accounts for their minor children (until then only fathers had this right under the pretext of minors' guardianship) (IWSAW, 2016; NCLW). However, there are also numerous challenges. The absence of tangible laws and policies that support women in the labour force further exacerbates the provision of social benefits, taxation, and access to services especially for workers in the non-formal sector. Also, there are no laws in Lebanon which recognize paternity leave, accord support services for women (childcare services etc.) or prohibit sexual harassment (IWSAW, 2016).

Family and education allowances

Family allowances via the NSSF transfer a monthly amount of US\$ 40 to every employee that has a non-employed spouse, plus US\$ 22 for each child up to 5 children. Given the low participation rate of women in the labor market (26% as of 2013), in terms of welfare, the spouse benefit partially compensates the unpaid care work of women in the household (IPC-IG, 2017).

⁷ Note: the Lebanese government submitted to Parliament a draft law closing the current EOSI scheme to new entrants and creating a new institution that will manage a fully funded, defined-contribution pension system for private sector workers. Parliament approved this law. Part of the motivation in Lebanon was the realization that the EOSI program did not provide adequate protection for workers during old age and operated poorly as an income protection system for workers (Robalino and Sayed, 2013).

3.4 Social assistance

3.4.1 Lebanon's social assistance policies: an overview

Social assistance or social safety net (SSN) programmes in the form of services and transfers to disadvantaged or income/asset poor population groups include (Karam et al., 2015; Silva et al., 2013):

1. Social welfare services to specific categories of vulnerable groups (e.g. older persons, children in care, people with disability) mostly provided by MOSA-contracted NGOs, financed by MOSA.
2. Price subsidies for diesel, bread, domestic production of tobacco, and subsidies to Electricité du Liban (EdL); financed by MOF, MOET, and the Ministry of Energy and Water (MoEW).
3. Fee waivers for hospitalisation in public and private hospitals; financed by MoPH.
4. Education grants and school support programmes to poor households via the MEHE and MoSA.

In 2010, prior to the Syria crisis, government spending on SSNs, including subsidies, in Lebanon amounted to about 4% of GDP (about 1% for non-subsidy SSNs, including social services and hospitalisation fee waivers, and 3% for subsidies) (IMF, 2012; World Bank, 2013; see Table 3).

While subsidies are listed here, and by the IMF, as elements of Lebanon's social safety net, the EdL component could be considered and are viewed by some to be more appropriately classified as subsidies to the electricity company, used to cover the company's deficit.

Table 4: Spending on social safety nets (as % of GDP), 2010

Government spending on SSNs and subsidies in Lebanon	Cost (% of GDP)
SSNs	1.0
Social services	0.20
Price subsidies	0.23
Fee waivers for hospitalisation	0.57
Subsidies	3.0
Transfers to EdL	2.92
Wheat subsidy	0.03
Sugar beet subsidy	0.00
Agricultural export subsidy	0.08

Source: IMF 2012

The share allocated to SSNs, excluding subsidies, is less than 1% of GDP. This is small by international standards and lower than the MENA average (IMF, 2012; Karam et al., 2015; Silva et al., 2013). According to Silva et al (2013), Lebanon has the lowest spending in social safety nets, including subsidies, in the MENA region. A comparative analysis of the composition and mix of non-subsidy programmes by type and number of programmes highlights Lebanon's comparatively high reliance on fee waivers, education and health benefits (reflecting what was outlined above in the education and health sections) and complete absence of cash social assistance transfers (Silva et al., 2013 ; ESCWA, 2013).

Price subsidies

In 2013, price subsidies (diesel, bread, and domestic production of tobacco) accounted for a negligible 0.03 percent of GDP. If electricity subsidies, in the form of transfers to Electricité du Liban, are included, spending

on social safety nets increases considerably to above 5.6 percent of GDP (World Bank, 2015b).

The electricity subsidy is perceived by some as a social safety net for the Lebanese poor with a progressive tariff fixed in 1996. According to the World Bank, as electricity subsidies suffer from high leakage and offer a small benefit value to the poor, the programmes' efficiency as a social safety net is weak (2015b, p. 64). The World Bank and IMF have proposed a gradual elimination of the electricity subsidy and its replacement with better-targeted and more efficient social safety net programmes (IMF, 2018; World Bank, 2015b).⁸

Box 8: Electricity sector reform and electricity subsidies

The sector absorbs 3-4% of GDP. On top of it, consumers pay additional amounts for energy security, accompanied by poor quality of service.

The IMF and World Bank point to the potential benefits, in terms of budget savings, of reform through subsidy-reducing measures alongside efforts to expand capacity to protect vulnerable or poor consumers and the expansion of social assistance programmes to mitigate the impact of raised tariffs on low-income households. According to the IMF (2018a), still relatively low oil prices present an opportunity to move ahead with such reforms.

Source: World Bank, 2008; IMF 2018a.

Among price subsidies, Kukrety et al (2016) highlight the important social safety net role of the wheat subsidy: “the biggest and most under-acknowledged support mechanism provided by the government is the wheat subsidy which controls the price of bread and reduces seasonal variations in the prices. When the going gets tough, poor households survive on affordable food i.e. bread and tea.” (Kukrety et al, p. 22). The Ministry of Economy and Trade's wheat subsidy programme has seen a sharp increase in volume consumed since the onset of the Syrian crisis (World Bank, 2013).

Health and education fee waivers

Health and education waivers make up the bulk of social assistance spending in Lebanon (see Tables and Figures above). This reflects the configuration of health and education services outlined above. The MoPH provide fee waivers to households not covered by NSSF. These include waivers for hospitalisation costs (at 85% of hospital care costs) and immunisation services, for example through the Expanded Programme on Immunization (EPI). This programme aims to guarantee effective and safe vaccines to every child in Lebanon, regardless of social status or parent's education level. The programme pays special attention to those children living in remote and underprivileged areas through outreach activities.

The MEHE administers enrolment fee waivers for all students in basic education. A common concern is that fee waivers do not in fact benefit the poorest Lebanese. There are various reasons why this occurs. One of these is related to the process of reimbursement of service providers via the line ministry. Delays and slow response from the central line ministry to the provider in the provision of reimbursement may lead providers to turn down requests to waive fees at the point of use and/or to demand a payment to at least partially cover costs, penalising the poorest.

⁸ Lebanon: Staff Concluding Statement of the 2018 Article IV Mission, February 12, 2018

3.4.2 Ministry of Social Affairs (MoSA): structure and programmes overview

Established in 1993, MOSA is the main provider of social assistance in Lebanon. According to Law 212/93, it assumes the following functions:

- Conduct studies and plan for social policies.
- Provide welfare and social assistance services to certain under-privileged groups, either directly or through contracts with civil society organisations (CSOs) NGOs.
- Promote local development through a network of social development centres (SDCs) and joint projects with CSOs and local administration.
- Enhance social development through sectoral programmes that target specific groups or specific sectors implemented through parallel projects or joint initiatives with international organisations or CSOs.

MOSA, as the main government entity responsible for the provision of SSNs, provides vulnerable groups with services either through its SDCs or through contracted NGOs or contracted social welfare institutions. MOSA also makes contributions to relief operations during emergencies.

The budget allocated to MOSA represents a small share of the national budget: 1.1%. The bulk of MoSA's annual budget (60-70%) supports the provision of services through NGOs and welfare institutions (Karam et al, 2015).

The figure in Annex 3 displays MOSA's organigram (as of November 2017). Its organisational structure reflects the Ministry's main areas of work and target population groups. Its main programmes include (CRI, 2016 and KIIs): Social assistance programmes for people with special needs/disability; National programme for adult education; The national programme to support the victims of landmines; The national programme of local social and economic development; The national programme for the prevention of addiction.

Emanating projects, managed and financed with support from international donors, include the National Poverty Targeting Programme (NPTP). The NPTP was established by Ministerial decree and made an official unit within MoSA. It includes a registry of households used to identify extreme poor Lebanese and to manage social assistance programmes and, increasingly, efforts from other sectors (e.g. health) to promote the extension of services to the poorest and excluded Lebanese.

This report focuses on three of MoSA's main programmes: services for people with disabilities, institutional social care for children and the National Poverty Targeting Programme (NPTP). For these three programmes, it carries out a detailed mapping and analysis (using the CODI programme modules) as reported in Chapters 4 and 5 of the report.

Social Development Centers

SDCs are the channel through which MoSA implements its social development policies at the local level (Decree No. 5734 dated 29 September 1994 cited in Karam et al., 2015). They constitute the backbone of social assistance delivery in Lebanon and are a major asset in terms of infrastructure and capacity to deliver programmes and services to a significant number of the population, reaching hundreds of thousands of people. The provision of services via SDCs is coordinated by the various departments at MoSA. SDCs provide services to both the Lebanese and non-Lebanese population, although some services are restricted to specific groups and social assistance schemes such as those covered by this report are limited to the Lebanese.

Currently, MoSA has 220 SDCs distributed in different regions of the country. The network of SDCs provides the Ministry with a structure that allows “a wide coverage to poor populations across the country” because, other than municipalities, SDCs are the only permanent government institutions at the grassroots level (WB 2013a cited in Karam et al, 2015).

The SDCs are mandated to:

- Establish a comprehensive development strategy (education, health, social, development) based on the identification of available resources/ needs within local community;
- Gather and keep updated demographical/ economic data on the targeted area;
- Promote community-based development;
- Implement capacity building programs for the community (handicraft training);
- Coordinate with civil society and local authorities (Routier, 2008⁹ cited in Kukrety et al., 2016).

In terms of the provision of services, SDCs mainly deliver health services (the majority of services delivered) alongside social services, training services, and education services.

For example, in 2017, SDCs provided approximately 708,903 health services, 266,239 social services, 13,090 training services, and 2,932 educational services. In 2013, the SDCs were serving over 300,000 beneficiaries yearly (World Bank, 2013a) – given the increased number of Syrian displaced in the country it is expected that this number has also increased, although the exact figures are not currently available.

SDCs face common challenges. Financing constraints, limited staff capacity and uneven geographical spread of centres and their services which do not reflect the spread of poverty and vulnerability across the country all restrict the SDCs effectiveness (Karam et al., 2015; Kukrety et al., 2016; Routier, 2008). For example, investments in staff core competencies are required in the protection system delivered by SDCs and the most disadvantaged North and Beka'a regions were only served by 75 SDCs out of the 220 SDCs in 2013 (Maestral International and CRI, 2017; MOSA, 2013 cited in World Bank, 2013). In addition, the performance of the SDCs tends to be uneven across the country, reflecting inconsistent standards (in terms of mandates) and varying financial and human resource capacity, including appropriately trained staff (World Bank, 2013).

Moreover, the pre-existing weaknesses in the system have been exacerbated by the increased usage of services by refugees over the last few years. Around 2013, MoSA noted a 40% increase in the utilisation of its health and social programmes as a result of the Syria crisis (WB 2013a cited in Karam et al., 2015). This has made it increasingly difficult for the SDCs to meet the demand of the local population, despite previous attempts to strengthen the SDC capacities and activities (Kukrety et al., 2016; UNDP 2012). Such initiatives aimed at strengthening the capacity of SDCs to meet increased need include financial support from international donors to provide additional staff within the SDC network, training staff to facilitate local dialogue and conflict prevention initiatives, and training staff in child protection, such as on early identification and referral and best interest determination for refugee children (Inter-Agency Coordination, 2017).

In addition to these implementation challenges, there is also concern over the appropriateness of services provided to meet the need of the population the SDCs serve. Recent reports, and discussed more below, suggest that there a number of gaps in the provision of service in relation to needs (e.g. services for children with disability), and inefficiencies in the existing systems which can be overcome by developing alternative and more appropriate services (e.g. reducing reliance on residential care and increasing availability of specialised

⁹ Routier, M. (2008) State Social Services at Community Level in Lebanon: An Institutional Analysis of Social Development Centres. Lebanon: DIA - Organization de Solidarite Internationale, 2008

services) (Maestral International and CRI, 2017). Moreover, since 2007, and within the budget allocated to SDCs, there has been a gradual diversion of funds towards medical services, which has come at the expense of funding for family support and care services, psychosocial support, and child care services, despite persisting needs (World Bank, 2013; Karam et al., 2015).

In this context, recent reports recommend that MoSA phases out services that should be provided by other sectors, such as health (Maestral International and CRI, 2017), and there are a number of initiatives underway to reform the SDCs to achieve greater effectiveness. For example, MOSA has requested UN support in the assessment of overall SDC capacity with the possibility of reducing their number and streamlining services provided (KII).

3.4.3 Evidence of effectiveness and emerging issues

Assessments of Lebanon's social safety net in comparative perspective rank it among the weakest in the world (World Bank, 2015). The available evidence indicates that there is limited impact on poverty alleviation and on the provision of support to vulnerable Lebanese (World Bank 2013a, World Bank 2013b; Karam et al., 2015). Lebanon's social protection programmes (including social insurance) reach only a small share of the population and are considered inadequate in addressing the needs of the poor.

Key factors hampering its effectiveness include (Karam et al, 2015; Silva et al, 2013; World Bank, 2005; World Bank, 2013b; World Bank 2015):

- low expenditure: in terms of social assistance spending, the share allocated to SSNs, excluding subsidies, is less than 1% of GDP, small by international standards;
- low coverage and poorly targeted resources: price subsidies either reach a small number of beneficiaries (e.g. 2,400 tobacco farmers) or are distributed universally, with significant benefit leakages to some distributors and suppliers (e.g. in the case of diesel subsidies); fee waivers for hospitalisation are criticised for not being well targeted to the poor;
- low levels of support and type of support provided: fee waivers and subsidies in practice not providing the level of support required;
- fragmented and uncoordinated approach: such as overlaps and duplications in the provision and financing of services between MoSA activities in the areas of education, training and health with those provided by the MEHE and MoPH;
- limited reliable and consistent data.

3.4.4 Humanitarian interventions-social assistance linkages

There has been an unprecedented response to the Syrian crisis in Lebanon, spurred by the high number of displaced Syrians - 1.5 million in a country of a population of around 4 million (EU, 2018). Increasingly, response efforts have also been motivated by the growing pressure the crisis is exerting on national systems. This in turn has exacerbated pre-existing weaknesses in Lebanon's service delivery, further aggravating poverty and vulnerability among the Lebanese population.

Crisis response efforts have focused on reaching both refugees (over one million Syrian displaced, Palestinian refugees from Syria) and over a million affected Lebanese (see LCRP, 2015-16; LCRP 2017-20). The response has covered different sectors, including education, health, water, sanitation and hygiene (WASH), cash transfers and protection (EU, 2018). Significantly, the crisis response plans have increasingly adopted a medium-term framework and stepped up efforts to align with national government strategies. For example, the second

Lebanon Crisis Response Plan (LCRP 2017-20) outlines a four-year plan and is aligned with government strategies such as the MEHE's RACE Strategy and the Ministry of Social Affairs (MoSA)'s National Plan to Safeguard Children and Women in Lebanon.

There are an increasing number of examples of how efforts to strengthen the humanitarian-development nexus outlined above is taking place via social protection instruments. Examples include:

- efforts to extend Lebanese social policies and social assistance programmes to deliver services and support to non-nationals,
- reliance on humanitarian-initiated interventions to provide social assistance to vulnerable Lebanese households, and
- initiatives to strengthen national social protection system components to deliver services and support to both non-nationals and Lebanese.

Non-nationals and GoL social protection and wider social policy

The social protection programmes of the Government of Lebanon do not automatically extend to non-nationals in Lebanon, including refugees and displaced populations. With regards to social assistance schemes, such as the three main MoSA schemes reviewed in this report – services for people with disabilities, social care for children via MoSA-contracted institutions and the NPTP database and related schemes (i.e. health and education subsidies, e-food voucher) - non-nationals are not eligible. With regards to social insurance, eligibility critically depends on work opportunities and residency documentation. In 2010, Palestine refugees from Lebanon were granted the right to benefit from the end-of-service provisions under NSSF. However, they are still not covered by illness, maternity and family indemnities. It is not clear whether this provision extends to PRS or not. As the residency permits for PRS are not being renewed now, it is likely that they are excluded from the social security provisions that are enjoyed by other refugee and displaced groups (Syrians and PRL) (Kukrety et al., 2016). Work restrictions further hamper whether refugees and displaced populations are able to access social insurance in practice. The two sectors for which there is no legal restriction for Syrian labourers - agriculture and construction (El Laithy et al., 2008) - are also ones with the highest levels of informality and low social insurance coverage.

With regards to wider social policy, since the outset of the Syrian crisis, significant efforts have been made by the GoL and international donors to secure the provision of basic services to refugees and the displaced.

MoSA has the legal mandate to oversee the crisis response in collaboration with international partners, and national stakeholders (NGOs, private sectors, civil society etc.). MoSA leads the development and implementation of the Lebanon Crisis Response Plan (LCRP) in partnership with these stakeholders which aims to address national objectives and priorities to respond to the impact of the Syrian crisis through a four-year strategic planning framework (LCRP; 2019).

In education, the MEHE, working with international partners, developed an education response plan the Reaching All Children with Education (RACE I) Strategy (2014-2016), making education compulsory and free for the basic education cycle (15 years) in public schools. RACE has seen positive programming impacts enrolling non-Lebanese children in public education and non-formal education. RACE II furthers these plans, with key objectives including subsidizing registration and education related costs.¹⁰ A key concern discussed further below, is the uncertainty of whether external funding will continue to support free basic education.

¹⁰ Specifically, the full or partial subsidy of enrolment fees for children in formal education (pre-primary, primary, secondary education, or TVET) and regulated Non Formal Education (NFE) programme, and non-tuition fee costs related to education in either formal or NFE will be partially or fully subsidized.

In the health sector, the MoPH Response Strategy (HRS), drafted in 2015, and updated in 2016, serves as the guiding policy for the LCRP health response plan and includes aims to increase access to healthcare services to reach as many displaced persons and host communities as possible, prioritising the most vulnerable. In practice, displaced Syrians rely on the infrastructure used by Lebanese to access public health services. They access primary healthcare services through the MoPH network of 220 Primary Healthcare Centres (PHCs), the 220 MoSA SDCs and through an estimated 700 health outlets/dispensaries (most of which are NGO clinics). In the identified facilities, medical consultations can be received for a nominal fee. In approximately 100 health outlets, subsidised services are provided to displaced Syrians and a limited number of Lebanese. The subsidised or free services include financial subsidies for consultations, subsidies for laboratory and diagnostic tests for pre-defined vulnerable groups, free vaccinations, free acute and chronic medication, as well as two free ultrasounds for pregnant women. This is financed through MoPH with the support of partners (LCRP, 2017-2020). Initiatives are underway to strengthen access to such services, including primary health care, community health and mental health services for Syrian displaced and other vulnerable populations, such as the pilot REBAHS programme (Reducing Economic Barriers to Accessing Health Services in Lebanon).

Reliance on humanitarian-initiated interventions to provide social assistance to vulnerable Lebanese

There are examples of two types of initiatives that rely on humanitarian-initiated interventions to provide social assistance to vulnerable Lebanese. The first concerns the extension of basic assistance for Syrian displaced to vulnerable Lebanese. There are examples relating to both cash and in-kind transfers.

Multi-purpose cash was the largest sector in the 2017 Lebanon Crisis Response Plan (LCRP), representing over US\$550 million out of a total appeal of US\$2.7 billion (EU, 2018). As of 2018, 64,000 displaced Syrian households received a multi-purpose cash assistance package consisting of \$175 cash aimed at bridging the gap between what households receive in forms of food assistance (\$27/person/month) in addition to the amount assumed to be generated from work or through a remittance (\$125) to reach a survival level of expenditures (\$435/ family/month). Such cash transfers were also paid to the most vulnerable Lebanese: in 2016, LCRP partners targeted around 1,800 Lebanese households with multi-purpose cash. Eligibility criteria are defined by the NPTP (KIIs).

With regards to in-kind transfers, school feeding programmes aimed at enhancing school attendance and retention rates, as well as food and nutrition security objectives, were implemented by LCRP partners in collaboration with the MEHE, targeting displaced Syrian children [enrolled in formal primary schools with double-shift systems located in the most vulnerable communities across the country (focused in the North, Akkar and Bekaa)] as well as Lebanese students. The WFP in partnership with MEHE delivers daily school snacks and monthly nutrition education sessions. The school snacks consist of a piece of fresh fruit and a carton of UHT milk to 17,000 students in 38 primary schools (WFP n.d.). Students are also provided monthly nutrition education sessions conducted by school health educators (Ibid.)

A second example of how humanitarian interventions have been utilised to provide social assistance to Lebanese concerns the reliance on WFP infrastructure and stores to deliver the e-voucher component of the NPTP to 10,800 Lebanese households – see NPTP section of this report.

Initiatives to strengthen national social protection system components to deliver services and support to both non-nationals and Lebanese

Underpinning the sectoral programming objectives which increasingly see linkages between crisis response activities and social protection, are a number of administrative and implementation tools which are explicitly being used by both social protection and humanitarian actors to promote efficiency gains in delivering programmes for the refugee and displaced populations and the poor Lebanese population, and in establishing a longer-term national social protection system.

International support for the development of Lebanon's national social assistance system includes initiatives in collaboration with MoSA to strengthen and harmonise targeting instruments (with a focus on the NPTP), delivery mechanisms, monitoring and the elaboration of a longer-term strategy (EU, 2018; LCRP, 2017). In the case of the NPTP, the partnership between NPTP and the crisis response plan is maintained through the active participation of the NPTP in the sector discussions as well as technical support from the sector partners on areas that are jointly identified (LCRP, 2017). Moreover, a range of international donors are providing technical advisory support and directly financially supporting the NPTP – see section below.

Efforts to improve the cost efficiency of the delivery of social assistance have benefitted from innovations in the delivery of humanitarian support, for instance via a common card. The WFP, UNHCR and UNICEF common card used to reach approximately 185,000 Syrian displaced in Lebanon in 2016 is an example. The distribution of e-cards to 10,800 extreme poor Lebanese households via the NPTP to be used at WFP-contracted shops across the country is an example of efforts to step up coordination and cost efficiency gains in the delivery of assistance to vulnerable households via innovations in the humanitarian sector (EU, 2018). Recent studies have also pointed to efficiencies in the type of mechanism delivered too, demonstrating that cash transfers are more effective at meeting food-related objectives for refugees than vouchers (BCG, 2017).

Finally, there are plans to continue support to the SDCs as discussed above, critical to both Lebanese and refugees in the coordination and delivery of services at the local level. The number of services provided by SDCs increased from 338,000 in 2011 to about 380,500 in 2012 and to about 480,000 in 2013 (Karam et al., 2015).

Issues and challenges

Coverage. Currently the basic assistance packages and relevant social protection assistance schemes fall short in terms of coverage. Whilst there is progress being made and intentions to increase coverage, as of 2018, 64,000 displaced Syrian households received the multi-purpose cash assistance. However, in 2017, the number of households in need exceeded 125,000, and in 2018 reports suggested that the support has not been sufficient to “reverse the deterioration of their overall livelihoods situation” (LCRP, 2017; LCRP, 2018: 113). Moreover, almost 106,000 Lebanese households are considered socio-economically vulnerable and therefore in need of assistance, with 35,000 households living in extreme poverty – according to the NPTP database in 2016, while only around 1,800 households were reached with multi-purpose cash in 2017 (Ibid. and KIIs). There is also a concern with geographic coverage, with some areas receiving more support than others. For instance, the spatial distribution of public schools is also not in line with population density - in some areas, public schools are significantly under-utilized while in other areas schools are over-crowded. Similar challenges are also evident in health services, with Akkar and Bekaa, as traditionally underserved areas, and hosting respectively around 10 percent and 25 percent of the displaced Syrians are in need of more institutional support (LCRP, 2017).

Adequacy of addressing need and exclusion concerns. In a context of increasing prices of commodities and services in Lebanon, there is concern that the current level of assistance is inadequate to meet the needs of refugees and displaced populations (Kukrety et al., 2016). Moreover, there are challenges of exclusion

regarding the provision of assistance to both non-nationals and Lebanese. Concerning the former, for example, whilst the current targeting approach factors in gender and disability considerations including female-headed households and/or households with members with disabilities, a study of the Winter Cash Programme¹¹ found that children with disability were at risk of exclusion from the programme and that the scheme did not adequately take the additional needs of such children into account: “*Other beneficiaries, especially in Bekaa, Mount Lebanon and Akkar governorates expressed their dissatisfaction as the programme did not take into account the special needs of families who have children with disabilities. They emphasised that this should be included as one of the key selection criteria, especially because these families incur higher expenses for additional care and medication.*” (Morsy, 2017: 36).

Capacity and service delivery. Public social institutions face constraints that limit their ability to respond. The SDCs have seen increase in demand, pressurising already stretched resources and capacity. Since 2012, and in an attempt to address the weaknesses in SSN system, MoSA committed to reform, reinforce, and capacitate its SDCs to enable them to fulfil their mandate, including relief work (Karam et al., 2015). In the education system, uneven geographic spread of schools, and an increased reliance on an under-qualified and unskilled teaching force are having negative effects on the learning outcomes of children in the public school system. Moreover, primary healthcare and hospital services across the country are increasingly strained as a result of increased demand on services due to the crisis (LCRP, 2017).

Sustainability. Since the beginning of the crisis, international humanitarian funding has increased substantially from US\$44 million in 2011 to US\$1.3 billion in 2016 and US\$1.9 billion in 2017 (OCHA Financial Tracking Service, December 2017 cited in EU, 2018). However, sustainability of funding is a key concern. As EU (2018:3) note “with a negative outlook for continued high levels of external financing for refugees, it is evident that there is a need to focus on longer-term resilience with an emphasis on cost efficiency and systems strengthening”. Unpredictable funding for support to refugees and displaced populations has also been raised as a key concern by refugee populations, whilst appreciating the support they have received from donors through UN agencies, they have raised concerns about humanitarian assistance becoming increasingly unpredictable. Households indicated that at times, limited information is shared at a late stage with refugees on the reasons for withdrawing or reducing some entitlements (Kukrety et al., 2016). In this context, it is noteworthy that as it is unlikely that high levels of external financing can be sustained over the long term, that moving from short-term emergency safety nets to a longer-term system to alleviate poverty becomes a priority (EU, 2018).

¹¹ Designed through a collaborative process between UNICEF, National Poverty Targeting Programme (NPTP), Ministry of Social Affairs (MoSA), and World Food Programme (WFP), the Office of the Prime Minister and the Lebanese Presidency of the Council of Ministers (PCM))

4 MoSA social assistance programmes

4.1 Overview

This section provides a mapping and review of MoSA’s three main social assistance programmes: Disability; Institutional care for children; and the National Poverty Targeting Programme. Following an overview of the three programmes, the section discusses the available evidence on the effectiveness of the three programmes and an analysis of the main enablers and constraints, grouped around the following sets of issues: legislation, regulation and policy framework; policy design; policy implementation; administration and coordination; participation and process; finances and fiscal capacity; measurement, monitoring and evaluation.

Table 5: MoSA selected programmes: a snapshot

Programme	Disability	Social and institutional care for children	National Poverty Targeting Programme
Where in MoSA?	MoSA’s Division of People with Disabilities, Rights and Access Programme, Model Center for the Disabled (Emanating Projects)	MoSA’s Division of Social Welfare (65-70% of MoSA’s budget is spent on institutional care)	MoSA Emanating Project
Objectives and services	Identifies people with disabilities, issues Personal Disability Cards (PDC). PDC holders eligible for access to services by MoSA-contracted/approved institutions and by other ministries incl. tax exemptions, care and rehabilitation services, and education	Mostly provides ‘social welfare’ residential care/shelter, related services and transfers including education, food, clothing to children from disadvantaged families. For the majority of children in MoSA-supported ‘institutional care’ in practice such institutions act as boarding schools.	Information registry of social assistance applicants used to identify the extreme poor; used to administer health, education subsidies and e-voucher to Halla (now named Hayat) card holders
Coverage	103,262 PDC holders, approx. 2.6% of the population (December 2017)	N. of children in institutional care: approx. 23,000 in MoSA-supported institutions; 35,000 total (3-4% of total population of children) N. of institutions contracted by MoSA: 194 (2018)	N. HHs in registry: 150,000; 105,849 Halla/Hayat card holders (2017); following the 2017-18 recertification process, the number of card holders is 41,372 (2018) Take up: Hospitalisation subsidies: 32,066 (2016) and 16,736 (2017); Education subsidies: 19,457 (2016) and 13,813 (2017); E-vouchers: 10,008 (2016)

Source: Authors, multiple documents; MoSA personal communication, November 2018

Disability

MoSA's programmes and services for people with disabilities make up one of Lebanon's largest categorical social schemes. Officially, as of December 2017, 103,262 persons with disability had registered and received the Personal Disability Card (PDC), accounting for approximately 2.6% of the population (UNICEF, 2018). The Ministry is responsible for identifying people with disabilities and issuing the Personal Disability Card (PDC), which enables a person with disabilities to benefit from targeted in-kind support and services, including those provided by MoSA-contracted institutions.

Law 220/2000 on the Rights of Disabled Persons regulates the integration of citizens with disabilities into social and economic life through employment, transport and housing quotas and guarantees of education and health services (UNICEF, 2016). It is considered an advanced and progressive law on disability. However, there remains criticism that the interpretation of disability in Lebanon is "medical" rather than social, with important implications for eligibility for the PDC and associated services. The low disability prevalence rate based on PDC card holder numbers – compared with international rates of 10-15% - reflects the prevailing medical definition of disability (Lakkis et al., 2015), as well as other challenges related to accessing the PDC.

The Rights and Access Programme is the overarching programme which identifies people with disability and delivers the PDC, as well as delivering some services to PDCs through the Rights and Access centres. MoSA started issuing the PDC in July 1995 (UNICEF, 2016). Institutions are contracted by MoSA to deliver services to PDC holders. The Rights and Access Programme and the Division of Disabled Affairs operate separately institutionally, although their objectives are complementary.

The main services and support available to PDC card holders and persons with learning difficulties via MoSA's Division of Disabled Affairs, its Rights and Access Programme and Model Center for Persons with Disability include: access to care through specialised institutions providing a package of care, education, therapy and other services, including residential care (provided through contracted institutions by the MoSA Division of Disabled Affairs); receipt of specialised equipment (through the Rights and Access Programme). Law 220 also includes the right for people with disability to: health, rehabilitation and support services; accessible built environment; quotas of accessible vehicles and houses; to education; quotas in public and private employment; to limited social security; and to certain fiscal exemptions and tax benefits (ESCWA and League of Arab States, 2014; UNICEF, 2016).

More specifically, the services to PDC holders through MoSA's Division of Disabled Affairs, and the Rights and Access Programme are the following:

The Rights and Access Centres: There are 8 Rights and Access Centers across the country. These Centers can issue the Personal Disability Card which is valid for a specified duration (maximum 5 years), and they ensure rehabilitation aids and access to specialized services. The Programme has developed an automated, decentralized administrative system (UNICEF, 2016).

Fiscal exemptions through the Rights and Access Programme: Pursuant to the provisions of Law 220/2000, and as per Ministerial Decision No. 257/1 (30 November 2000), the MoSA issues "disability certificates" to PDC holders (and organizations of or for persons with disabilities), to facilitate exemption from municipality taxes, built property taxes, customs tax on cars and car registration fees" (ILO, 2013).

Provision of rehabilitation aids through the Rights and Access Programme: MoSA provides rehabilitation aids and special care supplies to PDC holders. These aids and supplies include: mobility aids (wheelchairs, canes, walkers, crutches, etc.); beds and pressure-relief mattresses to prevent bedsores and complications; essential medical care/healthcare/hygiene supplies; physical/occupational therapy; speech therapy; hearing aids depending on funding (used to be provided but currently pending) (UNICEF, 2016)

Care services implemented by specialised institutions contracted through MoSA Division of Disabled Affairs: MoSA contracts approximately 103 institutions across Lebanon to provide comprehensive care packages for PDC holders and people with learning difficulties (Report from UNICEF, 2018). These services include physiotherapy and other treatments, and the provision of care, training, rehabilitation and education. In addition, persons with disability are able to access the following services through MoSA:

Social Development Centers provide free consultation and some medication for persons with disabilities (UNICEF, 2016).

Model Center for Persons with Disability: MoSA keeps special files for children with a learning disability who are not eligible for registration with MoSA, after conducting IQ tests at MoSA's Model Center for Persons with Disabilities. Based on the results of the tests, children are referred to specialized institutions contracted by MoSA, and can benefit from the "learning disabilities" adaptive education program covered by MoSA. As of December 31, 2015, there 2,970 cases. Important to note that negotiations are underway to transfer the Learning Disabilities file from MoSA to the Ministry of Education & Higher Education (MEHE) (UNICEF, 2016: 6). The Center also provides some free linguistic treatment to children who suffer from language difficulties (delayed growth and stuttering, delayed language pronunciation, dyslexia, and other types of learning difficulties) (UNICEF, 2016).

Social care for children

Traditionally accounting for two-thirds of MoSA's budget, institutional care constitutes a fundamental pillar of the formal infrastructure of services for children in Lebanon (MoSA 2011; UNICEF, 2012). The country has a long history of enrolling children from poor and deprived families into residential institutions for the purpose of caring for their basic needs. The practice dates back to the mid-nineteenth century and the arrival of foreign missionaries. During the first world war, these efforts were expanded through the provision of support to widows and orphans by philanthropic organisations. Residential institutions continued to grow during and in the aftermath of more recent conflicts, under the patronage of prominent Lebanese families and different religious groups. The institutional care system, and the modus operandi of contracts between MoSA and the institutions providing care for children that has arisen over time, is deeply connected to the powers of Lebanon's confessional system (Jawad, 2009).

Today, the majority of children in institutional care provided via MoSA are not orphans or abandoned, nor are they children in need of special temporary protection; they are mostly children from low-income households who receive a combination of services including accommodation/shelter, feeding and education through the MoSA-supported private and charity, mostly faith-based, institutions. In this report, the focus is on the MoSA programme of "social care for children in institutions contracted by MoSA", which specifically provides support, including social assistance-type services in the form of accommodation, feeding, education and more, to poor children via MoSA-contracted institutions. This programme needs to be differentiated from wider institutional care services for children in conflict with the law and at risk of violence and abuse. In practice, the MoSA programme labelled as "social care for children in institutions" serves as the country's primary provider

of social assistance to poor Lebanese households with children. For such children, MoSA-contracted institutions de facto acts as a boarding school, with the majority of children attending school and residing in the institution for the duration of the school week and returning to their families during the weekends and school closures (UNICEF, 2012).

According to recent MoSA data, around 23,000 children are in residential care institutions contracted by MoSA (2% of all Lebanese children). In total, around 35,000 children are in residential care across the country, accounting for 3-4% of the total of Lebanon's children (Child Frontiers, 2017). MoSA specifically finances the placement in MoSA-contracted institutions of children from poor families. This is reflected in one of the reasons commonly cited for the increase in number of care institutions contracted by MoSA between 2011 and 2014: the deteriorating social and economic conditions of families and increasing demand from institutions to enter into contracts with MoSA, partly as a result of the Syrian crisis (Child Frontiers, 2017).

National Poverty Targeting Programme (NPTP)

The National Poverty Targeting Programme (NPTP) is an initiative aimed at addressing one of the historic gaps in Lebanon's social assistance schemes: the absence of a mechanism to identify and direct resources to Lebanon's poorest. At its core, the NPTP is a database of information on Lebanon's extreme poor. Information on applicant Lebanese households is collected via social workers at the SDCs and used to compute a score (centrally, at the NPTP central management unit), on the basis of a proxy-means test, which is in turn used to rank households to identify the poorest. This information, in turn, is used to determine whether a household is eligible for social assistance programmes which rely on the NPTP database (more on these below).

Following a pilot phase (2008-2009), the NPTP was launched in November 2011. The NPTP programme was officially established by a Cabinet Decree in June 2009.

The Decree specified the mandate of the two main units responsible for the implementation of the core functions of the NPTP, namely the Central Management Unit (CMU) hosted in the presidency of Council of Ministers, and the NPTP unit hosted in the Ministry of Social affairs. The NPTP is a programme within the government budget but is not established by law. Since 2014, a law proposal has been in negotiation within parliament aiming to institutionalize the NPTP project and make it an integrated programme within MoSA (it is currently listed as a MoSA 'emanating project') (Ibrahim, 2016; IPC-IG, 2017).

The main objective of the NPTP, according to the initial project document, is to “*establish a national targeting system to be used by the Government in the delivery of social transfers and services that improve living standards of the population - in particular the poorest and most vulnerable*”. The NPTP's objectives were to improve the efficiency, effectiveness and poverty impact of Lebanon's social safety net programmes and ensure that government assistance reaches the poorest and most vulnerable (Ibrahim, 2016).

According to 2018 MoSA-provided data, NPTP registry holds information for 150,000 households. Among these, in 2017, 105,849 households were *Halla* card holders, recently renamed *Hayat* card (460,281 individuals according to World Bank, 2017), meaning they were eligible for NPTP-related programmes, specifically, education and health subsidies (see Table 1). These figures compare with an estimate of 147,600 individuals living below the *extreme* poverty line of US\$3.6/per capita/day and 1,176,700 individuals living under the poverty line of US\$8.6/per capita/day according to the RPA 2016 (UNDP, 2016).

Following the recertification process of 2017-18, whereby the information on households in the database was verified and a new proxy means test formula applied, the number of households eligible card holders decreased to 43,000.

Currently, the NPTP database is used to deliver three main programmes, all of which are managed and delivered via NPTP MoSA (Ibrahim, 2016; IPC-IG, 2017; World Bank, 2017):

(a) Education subsidies

All children in NPTP beneficiary households of school age are eligible for the education subsidy. Initially, the subsidies covered children in basic education in public schools, secondary education and vocational training. Starting in school year 2014/15, the Ministry of Education and Higher Education (MEHE) announced that education for all Lebanese and non-Lebanese children would be provided free of charge in the public system until grade 9, which is the final compulsory grade students should attend. This is expected to continue in the near future as part of the international community to the RACE (Reaching All Children with Education) programme. Since then, the NPTP focus has been on children in secondary school and vocational training. For secondary education, the fee waiver exempts students from contributing the 30% of costs not covered by the universal secondary education subsidy: secondary education is 70% subsidized, students contribute 30% of the costs.

(b) Health subsidies

Promote health care and access to public hospitals through a waiver of 10-15% for hospital co-payments; also waives fees of Public Health Centres (PHCs) and SDCs regarding some medications, especially for chronic diseases, and outpatient consultations and treatments. Eligible households are also entitled to benefit from the chronic diseases medication program run by the Ministry of Health.

(c) E-vouchers

Introduced in 2014, food assistance via an electronic card food voucher programme; the electronic card is loaded with a monthly allowance of US\$ 27 per person capped at 5 persons per household to buy foodstuffs at around 500 registered shops scattered all over the country. This e-card is different from the *Halla/Hayat* card because its technology loads vouchers, cash, registers and validates holder information (IPC-IG, 2017). The e-card targets the poorest 10,008 households in the NPTP registry, up from 5,076 in previous years (key informant interviews, Beirut November 2017).

In addition to the three schemes outlined above, the NPTP is being utilised for the *NPTP pilot Graduation programme*, seeking to “promote sustainable levels of income among the poorest NPTP households” (World Bank, 2017). The NPTP-G will target 600 households from among the 10,000 recertified NPTP beneficiary households (World Bank, 2017).

The NPTP has also been used to deliver the following initiative by the ministry of Public Health (MoPH) and small scale and one-off initiatives promoted by UNICEF and World Vision (World Bank, 2015):

Primary Healthcare Restoration Project: aims to restore access to essential healthcare services for poor Lebanese affected by the influx of displaced Syrians (funded via World Bank 15 million USD from the Lebanon Syria Trust Fund). Specifically, the project aims to provide 150,000 NPTP beneficiaries with a package of basic

health services through the MoPH Network of Primary Health Care Clinics. The CMU has provided a list of the poorest 150,000 NPTP beneficiaries to the Primary Healthcare Project that is expected to be launched later this year. Priority in the selection of beneficiaries is given to those living in areas most affected by the Syrian crisis. The packages include screening, preventive, and health promotion visits, essential clinical and diagnostic tests, prenatal and post care visits, consultation visits for the treatment of diabetes and hypertension and prescription medications (World Bank, 2015b).

UNICEF Winterization Programme: targets 80,000 vulnerable Lebanese children (a total of 32,000 households) with a one-time 40\$/child ATM card with technical assistance provided by WFP. The CMU has provided the list of eligible beneficiaries to UNICEF. The NPTP team is also involved in the implementation of this program. As a first step, the NPTP team, through its network of 700 social workers undertook a rapid assessment and verification of eligible households' location and information.

World Vision Programme: World Vision targeted a total of 170 NPTP households in Central Bekaa for a period of five months with a benefit of 175\$ per household per month beginning in August 2015. The NPTP CMU provided World Vision with a list of the poorest 170 NPTP households in Central Bekaa in July 2015.

4.2 Disability

How effective are MoSA's programmes and services for people with disabilities? How are risks of exclusion mitigated?

In Lebanon, the *official* statistics on disability are reported through the number of officially recognised Personal Disability Card (PDC) holders. In terms of coverage, as of December 2017, 103,262 persons with disability had registered and received the PDC which accounts for 2.6% of the population¹² (MoSA, 2018). However, whilst this is similar to other estimates of disability in the region¹³, this figure is much lower than international estimates which suggest that persons with disability represent 10-15% of the population (e.g. World Health Organization (WHO) and Disabled World). There are number of reasons for the low rates of reported disability which are discussed further below, and they include the definition and classification of disabilities used¹⁴, stigma associated with reporting disability, and low take-up of the PDC.

The tables below show the distribution of registered persons with disability (PDC holders) by age, gender, place of residence (by governorate), and type of disability.

¹² Based on the assumption that the population of Lebanon is 4.0 million (Ibid.).

¹³ Disability prevalence rates in the Arab states range from 0.5 percent to 4.9 percent of the total population (ESCWA/League of Arab States (2014) Disability in the Arab Region: an overview, Beirut, page 10 cited in Lakkis et al., 2015)

¹⁴ For example, a 59-country study conducted by the World Health Organisation between 2002 and 2004 found disability prevalence rates of 15.6 percent for adults 18 and over (Lakkis et al., 2015).

Table 6: Number of PDC holders - by age

Age	Number	Percentage
0 to 5	2,276	2.21%
6 to 13	7,004	6.79%
14 to 17	3,932	3.81%
18 to 26	10,015	9.72%
27 to 64	46,006	44.63%
65 and above	33,852	32.84%
Total	103,085	100%

Source: MoSA Disability Rights Programme, 2018

Table 7: Number of PDC holders - by gender

Gender	Number	Percentage
Male	63,219	61.33%
Female	39,866	38.67%
Total	103,085	100%

Source: MoSA Disability Rights Programme, 2018

Table 8: Number of PDC holders - by governorate

Governorate	Number	Percentage
Beirut	7,348	7.13%
Mount Lebanon	38,226	37.08%
North	18,741	18.18%
South	13,080	12.69%
Bekaa	17,337	16.82%
Nabatieh	8,353	8.10%
Total	103,085	100%

Source: MoSA Disability Rights Programme, 2018

Table 9: Number of PDC holders - by type of disability

Type of Disability	Number	Percentage
Motor	62,084	54.21%
Mental	32,152	28.08%
Hearing	9,360	8.17%
Visual	8,297	7.25%
Educational Difficulties*	2,623	2.29%
Autism	1,031	1%
Total	114,516	100%

* A diagnosis has been made by a psychologist that the individual holding the disability ID card has learning difficulties which might be caused directly by his disability or due to health-social issues or another situation. The diagnosis is issued through the Model Center for the disabled.

Note: Definitions as per Ministry of Social Affairs

Source: MoSA Disability Rights Programm and MoSA pers comms. November 2018.

As the tables above indicate, there are disparities in the number of PDC holders across gender, age, and location across the country, suggesting that some populations are not accessing the PDC and its associated services. Disaggregating the figures on prevalence of persons with disability by age and sex, shows that the *official figures* report more men/boys than women/girls with disability. As of December 2017, more men than women are registered and receive the PDC: 61% men compared to 39% women (MoSA Disability Rights Programme, 2018). A similar imbalance was reported in 2004 CAS statistics which found 64% of men with a disability compared to 35% of women (ESCWA and League of Arab States 2014). The UNDP RPA (2016) also finds that 58.2% males and 41.8% females report disability. The reasons for this gender imbalance are unclear, although suggestions that cultural issues and taboos are one explanation as to why women / girls may not report disability (KII with MoSA; Social Impact Inc. 2012).

In terms of age, the UNDP RPA (2016) found that disability is most prevalent in the 65+ age groups where 10 per cent of the population suffers from at least one kind of disability. However, the highest number of PDC holders falls in the 27-64 age bracket. Data reported in CEDAW (2014) of PDC holders also notes that the highest number of PDC holders are recorded among both men and women in the 34-65 age group, followed by the over-65s, noting that the proportion of PDC holders is higher amongst women than men in the over 65 group, and less in the 34-65 group (CEDAW, 2014).

Official statistics for children find that children registered with a PDC (aged 0-17) account for 12.8% of all the registered persons with disabilities in Lebanon (MoSA Disability Rights Programme, 2018). Data from 2016 suggests that, assuming children form 31% of the total 4 million Lebanese population (based on CAS data in Tutelian, 2013 cited in UNICEF, 2016), registered children with disabilities account for 1.06% of children in Lebanon. This is a relatively low rate of registered children and youth with disabilities (UNICEF, 2016). In contrast, the 2009 MICS found that 8% of children aged 2-9 have at least one form of disability (cited in Maestral International and CRI, 2017a, unpublished).

Also of note is the geographic distribution of PDC holders. As Table 8 above shows, a high proportion of PDC holders are in Mount Lebanon (almost double that of other areas). One reason cited for this is because of the existence of institutions in that area to provide services for persons with disability and people may move from other areas to Mount Lebanon – e.g. people coming in from rural areas where there are limited or no services for the disabled (KII with MoSA, March 2018). Another consideration is the higher density of the population in that area, and high numbers of the poor residing in Mount Lebanon. A number of studies suggest a strong link between poverty and disability in Lebanon (Chaaban and el Khoury, 2015; Lakkis et al., 2015; Rebuild Lebanon, 2007; UNDP RPA, 2016).

In the context of the Syrian crisis and the potential for the PDC to respond to increased numbers of people with disability, the non-Lebanese population are not entitled to hold a PDC, and therefore non-citizens are not granted access to specialized services for disability in the same way Lebanese nationals are (UNHCR, 2016). However, recent studies suggest that there is a significant need for services to support the non-Lebanese population with disability which is not currently being met (see Box 9).

Box 9: Disability amongst non-Lebanese population

Although accurate data reflecting numbers, types of disabilities, geographical distribution, conditions and needs among the displaced *Syrian population* is still unavailable, based on the findings of the 2017 Vulnerability Assessment of Syrian Refugees in Lebanon, 14% of Syrian households reported a member with a disability, a slight increase from 12% of households in 2016. Children with disabilities comprised 2.3% of the displaced population, and they are among the most marginalized groups in Lebanon.

The prevalence of disability among both *Palestine Refugees in Lebanon (PRL) and Palestine Refugees from Syria (PRS)* is reported around 10% (approximately 32,000 people) (AUB-UNRWA 2016). Social marginalization is reportedly further exacerbated by the limited access to and limited availability of specialized rehabilitation services, as well as the general lack of awareness in relation to the needs and rights of persons with disabilities (UNHCR, 2016). Again, women, children and elderly persons with disabilities are reported to be particularly vulnerable to discrimination, exploitation and violence. In particular, reports suggest that “suffering is greatest amongst women and girls with disabilities who rarely leave their homes; a combination of overprotection by families, social discrimination, and limited accessibility to services lead to more exclusion and isolation” (Mousawat, 2016 cited in UNICEF, 2016: 45).

A major need, and assistance gap, reported in the literature relates to displaced Syrian children with intellectual disabilities. Children with disabilities are often overlooked in humanitarian action and become even more marginalized as fewer resources are available during emergencies (Save the Children, 2016 cited in UNICEF, 2016: 38). These children are reported to be among the most neglected, exploited and abused. Although some mental health and psychosocial support services are being provided, specialized services for those with intellectual disabilities are still lacking (UNICEF, 2016).

There are also challenges beyond low levels of coverage of the PDC which relate to the adequacy and appropriateness of services provided for people with disability.

For instance, despite adding new provisions concerning children with disabilities (autism and learning difficulties) (UNCRC, 2016), specific gaps for persons with disability have been identified across the lifecycle, with early years services for children under 4 years identified as a key gap. UNICEF (2016) reports that early prevention programs or initiatives provided by *ministries of public bodies* do not currently exist. MoSA’s social care services start at the age of 3, and there is limited work and awareness raising done with the parents before this age (UNICEF, 2016: 31; KII with MoSA, March 2018; pers comms MoSA November 2018).

There are also other unmet needs for children with disabilities. Maestral International and CRI (2017) report that these gaps include day care programmes for children with disabilities, psychosocial support to children or families/parents going through difficult periods in their lives, or living with a disability or a mental health difficulties that leads to destructive behaviour, and rehabilitation services for children with disabilities.

Other key gaps identified include inadequate services for youth education. According to the youth policy document, the main challenges facing youth in Lebanon are problems related to education and in particular the issue of school dropouts, low level of participation in public and political life, unemployment and migration (UNICEF, 2016: 32). Most youth with disabilities have limited or no access to education or employment. The high cost of education is a key barrier, but so are the physical inaccessibility of schools and institutes, and the absence of adapted educational facilities and curricula that address the needs of students with disabilities (UNESCO, 2013 cited in UNICEF, 2016: 32).

Indeed, a study by the Center for Educational Research and Development (CERD) (2014) finds that very few children with disabilities attending integrated public schools hold a disability card, raising questions about whether they are at other specialized schools, on the street, working, or at home (cited in UNICEF, 2016). Moreover, this study also suggests that school infrastructure, systems and curricula is not adapted to their needs. Prevailing social attitudes also show a bias towards integrating children with intellectual disability into

mainstream schools. A recent study conducted with Lebanese, Syrian and Palestine refugees showed that only 18% of those surveyed believed children with intellectual disabilities should go to regular pre-schools and schools (UNICEF, 2017b).

Interviews with MoSA (March 2018) also suggest that the lack of care services delivered to persons with disability at home is also a key gap.

Finally, another gap is around Gender-Based Violence (GBV) and child Protection (CP). It is difficult to find safe spaces to receive children with disabilities who are in need of protection (MoSA pers comms. November 2018). There are also very limited number of NGOs in Lebanon that receive children with disabilities subject to GBV, and almost none of the concerned NGOs receive Syrian children with disabilities subject to GBV and needing protection. As part of the LCRP programming, there is a focus on addressing the needs of children with disabilities under GBV and CP including the provision of psycho-social support (PSS) and case management services (UNICEF, 2016).

An analysis of constraints and enablers

Legislation, regulation, policy framework

Law 220 on the Rights of Disabled Persons (Law 220/2000) (ESCWA, 2014), is built around a set of rights which integrates citizens with disabilities into social and economic life, “through employment, transport and housing quotas, and guarantees of health and educational services” (Lakkis et al., 2015: 4). Whilst it is recognised that significant legislative and social progress has been made towards the rights and dignity of people with disability, there remains criticism of the interpretation of disability in Lebanon as mainly “medical” rather than also social (e.g. as seen in the adoption of the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2006¹⁵). This definition includes only four of the seven types of disability identified by the WHO (MoSA, 2011), and excludes certain disabilities (e.g. mild hearing impairments, those with chronic diseases, those with non-curable psychological problems, etc.) (UNICEF, 2016, Authors’ interviews, November 2017; ILO, 2013). This has a number of implications, one important one which is the classification of those eligible to receive the PDC, and therefore the services which they are eligible to receive. Another key challenge is the implementation of the law, which is discussed more below, as well as the gap in eligibility for the non-national population.

Lebanon’s National Commission for Persons with Disabilities develops policy and proposes plans and projects (UNCRC, 2016). However, there is no disability policy or national strategy (KII with MoSA, March 2018) although relevant approaches to support those with disability are referred to in the National Development Strategy (2011). The National Plan and Lebanese Crisis Response Plan are currently under review, with a new four-year plan being developed (2017 – 2020). Mainstreaming Disability under the National Plan and LCRP is still in its planning phase (UNICEF, 2016).

Policy design

The Rights and Access Programme (R&A programme) is the overarching programme which identifies people with disability and delivers the PDC, as well as delivering some services to PDCs through the Rights and Access centres. MoSA started issuing the PDC in July 1995 (UNICEF, 2016), and the MoSA Division of Disabled Affairs contracts institutions to deliver services to PDC holders. People who have been classified as disabled

¹⁵ The CRPD was signed but has not been ratified by Lebanon. There is a current ongoing effort led by Fe-Male for the ratification of the CRPD (Pers Comms. UNICEF Lebanon, November 2018).

and therefore hold the Personal Disability Card are able to access a variety of services provided by a range of ministries (MEHE, MoPH, MoSA). The programmes and services operating through the R&A programme and the Division of Disabled Affairs include access to specialized institutions providing a package of care, education, health, therapy and other services, including residential care (provided through contracted institutions by the MoSA Division of Disabled Affairs); receipt of specialised equipment (through the Rights and Access Programme) and fiscal exemptions and tax benefits (through the Rights and Access Programme). In addition, there is a Learning Difficulties programme for children with disabilities (but not necessarily PDC holders).

There is an active civil society body advocating and lobbying for appropriate policy and services for persons with disability, and Lebanon's Law 220/2000 is considered to be one of the more progressive laws on disability in the region (ESCWA, 2014).

However, interviews with key informants in Lebanon in November (2017) and March (2018) and a review of recent literature, indicate that there are a number of challenges related to policy design and meeting the needs of people with disability in Lebanon. For example, KIIs report that the services provided by contracted institutions are based on existing services which are not often updated according to changes in disability categories, or monitored to respond to current needs, and are based on available funding, rather than on needs assessment of the current (and new and increasing) population in need (KII with MoSA, November 2017 and March 2018). There is no annual review, for example, on the types of services delivered (KII with MoSA March 2018). Whilst key informant interviews also note that non-state actors provide services for people with disability according to local need, overall there are major gaps identified in terms of the provision of services to people with disability, especially to children with disability (under 3 years), youth, and the elderly.

Indeed, despite recent updates concerning children with disabilities (such as autism) (UNCRC, 2016), specific gaps have been identified across the lifecycle, with early years services for children under 3 or 4 years identified as a key gap. Indeed, UNICEF (2016) reports that early prevention programs provided by public bodies do not currently exist. A child with disability cannot be admitted to an NGO contracted with MoSA before the age of 4 years, and there is limited work and awareness raising done with the parents before this age either (UNICEF, 2016: 31; KII with MoSA, March 2018).

There are also other unmet needs for children with disabilities, as discussed above. These include a lack of day care programmes and rehabilitation services for children with disabilities through SDCs, (Maestral International and CRI, 2017), inadequate services for youth education and lack of home care services (KIIs with MoSA, March 2018), and services for gender-based violence (GBV) and child protection (CP) (UNICEF, 2016).

These gaps also reflect broader MoSA priorities, in that most services are offered to adults, with gaps in terms of services for the elderly (KII with MoSA in November 2017 and March 2018).

Policy implementation in practice

Applying for the PDC

The PDC is demand based and reaches a significant number of people. However, there are also concerns of exclusion from the scheme, thought to be a result of various reasons. These include lack of information about the PDC, concerns that stigma associated with disability may prevent people (especially women and girls) from applying for a PDC, as well as the limitations in the medical model restricting types of disability entitling people to apply for the card.

There are also other challenges limiting the take-up of the PDC which are related to the implementation of the scheme in practice. Key informant interviews with MOSA staff reported that there are no ongoing awareness campaigns to raise the profile of the PDC services (Authors' Interviews, November 2017 and March 2018). At present, awareness is generated at particular times of the year, notably the world disability day. However, this is insufficient, and many people are unaware of the services that exist. There is also limited awareness and knowledge about the registration process among persons with disabilities and their families or caregivers (UNICEF, 2016; Authors' interviews, November 2017). Even where information is available, the process is often tied up with informal social and political networks, meaning that those with less power and connections do not have easy access to this information (Lakkis et al., 2015).

Moreover, challenges are also identified in terms of accessing the assessment centres because of geographic location of the 8 centres (Authors' interviews, 2017).

Delivery of services

A significant number of services have been provided by MoSA and contracted institutions to people with disability. Between 2000 and 2017, 188,951 fiscal exemptions certificates had been issued to persons with disability (MoSA, 2018); from 1997 to 2017, MoSA has delivered adjacent services to 37,491 people, including the provision of wheelchairs, crutches, sticks, walkers, medical shoes, beds, mattresses, anti-bedsore air mattresses, as well as aids for handling incontinence: urine catheter, diapers, urine bags, and colostomy (MoSA, 2018). In total, MoSA contracts approximately 103 institutions across Lebanon to provide residential and external comprehensive care packages for people with disability, which include education, health, nutrition, physiotherapy etc. for PDCs. In 2017 there were 19,307 people with disability who benefited from care services (MoSA, 2018).

Despite the provision of these services, the literature and KIIs with MoSA (November 2017 and March 2018) highlights key capacity, resource and financial sustainability constraints when it comes to implementing the Law 220/2000 (and also the Rights and Access Programme) across all the relevant ministries, and other relevant services for persons with disability in Lebanon. These are related to lack of material and financial resources, lack of staff training and specialised staff with appropriate skills, and lack of a short-medium action plan (UNCRC, 2017; MoSA pers comms. November 2018).

For example, Rebuild Lebanon (2007) reports that limited financial resources means that the Rights and Access programme works only with one-third of its capacity ([staff work] between one week and ten days a month). Other reports also show that there are not enough spaces for children with disabilities to meet demand and certain disabilities are not accommodated in the services provided, including autism (Child Frontiers, 2017).

Related to this, MEHE established a Special Needs Department (SND) in 2012 which staffed one coordinator to collaborate with the Department of School Counseling and Guidance (Direction d'Orientation Pédagogique et Scolaire (DOPS) in referring children with learning difficulties to other specialized programs at specialized NGOs contracted by MoSA. However, a lack of funding has constrained the SND to develop and implement plans, and it only relies on grant project funding (UNICEF, 2016).

Service provision gaps through SDCs are also apparent. Part IV of Law 220/2000 stipulates that each person with disability has the right to an accessible environment, including public buildings and facilities as well as private facilities used by the public¹⁶ (Article 33) (UNICEF, 2016). UNICEF (2016) report, however, that most

¹⁶ Within this context, a Decree No. 7194 was issued in December 2011 that enforces the implementation of Article 34 of Law 220/2000 that requires all newly constructed buildings, including public buildings and facilities as well as private facilities used by the public, to abide to the stipulated standards. The decree also requests from concerned urban planning bodies that provide construction permits to ensure that the required standards are met and to monitor implementation (UNICEF, 2016)

of MoSA's Social Development Centers (SDCs) are inaccessible to persons with disabilities (although there are plans to rectify this). In an assessment asking various stakeholders about the barriers to accessing SDCs¹⁷, people with disabilities is the group that was most often mentioned as unable to access the SDC (Maestral International and CRI, 2017a).

Moreover, there are limited specialized staff and specialized institutions to respond to the needs of people with disability (UNCRC, 2017). Reports note that there is a lack of specialized facilities available for people with disabilities, children with certain disabilities, such as autism and children with mental health problems (as well as refugees or the displaced populations, who have often suffered extreme trauma and children who have multiple or complex needs) (Child Frontiers, 2017; Maestral International and CRI, 2017a; UNICEF, 2016). Indeed, social workers repeatedly report that a key challenge is finding places for children in need of protection, and that where children are placed actually most often dictated by vacancies rather than need (Child Frontiers, 2017).

Other challenges include weak information programmes and education campaigns aimed at social and educational integration, the lack of an empowering environment for people with disability, and the lack of early detection and interventions centres (UNCRC, 2017).

Interviews with MoSA staff also suggest the variation in service provision geographically is also a key challenge. Just over half of the 103 contracted institutions delivering services for people with disability operate in Beirut and Mount Lebanon (KII with MoSA March 2018), with over half of the care budget going to Mount Lebanon alone (MoSA Disability Rights Programme, 2018). Other studies also report that the concentration of residential care in certain parts of the country means that some children are required to travel far from home to access services, and that the special needs of some groups are not met because of services provide general care rather than specialist care (Child Frontiers, 2017).

Complaints and appeals mechanisms

In terms of appeals mechanisms, if professional assessment has not deemed that there is any disability according to the official classification of disability (and therefore that the person is not eligible for the PDC), the applicant may submit an objection to MoSA – Department of Persons with Disability Affairs. The department is required to respond within a month from the date of submission of the objection. If there is no response within this timeframe, then the applicant has the right to revert to the National Council for Disability Affairs (NCDA). The decision of the NCDA to reject the application is irrevocable (UNICEF, 2016: 9).

In 2013, MoSA launched a mechanism aimed at seeking information and receiving and following up on complaints through number “1714”. The hotline is a joint venture between the Ministry of Social Affairs and the Ministry of Health to receive and handle all types of comments and complaints, including by persons with disabilities or their families about medical problems or hospitalization issues with public or private hospitals in Lebanon (ILO, 2013). MoSA Division for Disability Affairs also operates an open-door policy where people can discuss in person any questions or complaints that they have (KII with MoSA, March 2018).

In addition, the observatory on the Rights of Persons with Disabilities was also established, which includes a network of civil society associations and NGOs to provide an interactive complaints system (UNCRC, 2016). And under an initiative of the Lebanese Physical Handicapped Union, the integration network, associations of

¹⁷ The assessment asked many different people—SDC and IP directors, social workers in SDCs and IPs, health personnel in SDCs, school principals, beneficiaries (adults and youth) and non-beneficiaries—if they believe there are barriers to people using the SDC and or the safe space in the SDC (Maestral International and CRI, 2017a).

people with disability, Ministry of Social Affairs and other concerned bodies, “Disability Monitor” was launched in August 2013 to monitor violations of Law no. 220/2000. Between March and September 2012, documented 39 complaints (34% from males and 66% from females) (CEDAW, 2014: 129).

Administration and coordination

Providing services to people with disability requires a coordinated and coherent approach and involves a number of ministries and non-state actors. Mechanisms in place to promote partnership and coordination with various stakeholders on the issue of disability include:

Institutional coordination:

- The **National Commission (NC) for PWD Affairs** led by MoSA - a permanent decision-making body whose decisions are implemented by the departments of the Ministry of Social Affairs¹⁸. The NC is responsible for elaborating public policies and strategies on PWD affairs in coordination with the concerned public bodies and civil society organizations.
- the **Higher Council for Childhood**¹⁹ which established **13 coordination committees** covering all areas of the rights of the child²⁰ (including children with disabilities) with representatives from all ministries, NGOs, trade unions and a number of universities and experts in the field of childhood. They play a coordinating and networking framework role to gain support for the direction and objectives of the Higher Council for Childhood, as well as participation in, and provision of substantive support for the preparation of the National Plan for Childhood (UNCRC, 2016).
- A joint committee was formed in 2002 between the **Ministry of Public Health (MoPH) and the National Council for Disability Affairs (NCDA)** (to implement the free health service provision for PDC holders).

Key programme linkages and coordination:

- **Social Development Centres:** Children and youth with disabilities can benefit from the general social services of the SDCs as any other eligible Lebanese citizen; SDCs provide free consultation and medication for persons with disabilities (UNICEF, 2016).
- **Access to free services from the MoPH:** Persons with a PDC can receive hospital care in governmental hospitals as well as in contracted private hospitals, and benefit from medications for acute diseases provided by MoPH. In addition, MoPH covers a number of specialized rehabilitation services for persons with disabilities (such as physical and occupational therapy, prosthetic and orthotic devices (UNICEF, 2016).
- **National Poverty Targeting Program:** Personal Disability Cards (PDCs) are required to be submitted with the application whenever a household has members with disabilities (MoSA website). This factor

¹⁸ The NC is headed by the Minister of Social Affairs and it consists of 4 representatives of each of the following groups: Persons with Disability, Disabled Persons Organizations, NGOs giving specialized services for PWD, and MoSA. The members of the NC are elected for a three-year mandate (Maestral Interantional and CRI, 2017b).

¹⁹ Higher Council for Childhood: Currently, MoSA has one coordination mechanism in place that is supposed to coordinate child rights at a policy level. This is the Higher Council for Childhood (HCC) that is led by the Minister of Social Affairs, and has a secretariat function established under the auspices of MoSA. Facilitated by its secretariat, the HCC has the tasks of recommending public policy, coordinating planning and programming of projects for improving the situation of children in all rights areas, including in the area of protection (Maestral Interantional and CRI, 2017b: 109)

²⁰ legislation, children with disabilities, health, culture and information, child participation, prevention, protection from violence and abuse, children in conflict with the law or at risk of delinquency, early childhood education, family environment and alternative care, street children, refugee children, protection from abuse through the Internet

is taken into consideration in the assessment and scoring process for the selection of beneficiary households (UNICEF, 2016).

- **Children with disability in residential institutions:** Approximately 1,411 children with disabilities received residential care in 2018 (MoSA pers. Comms. November 2018).

However, there are a number of challenges underlying institutional coordination arrangements. For instance, a report by Maestral International and CRI (2017b) finds that the National Commission for PWD Affairs has limited capacity for coordination by MoSA, largely explained by lack of clarity over roles and responsibilities in delivering their mandate (Maestral International and CRI, 2017b: 109). Similarly, the same study reports that in practice the HCC is also a weak coordinating mechanism because of limited authority and capacity (Maestral International and CRI, 2017b).

Moreover, coordination and coherence are hindered by weak communication and follow up for disability in line ministries or other governmental institutions, no articles on disability are included in the constitution and there is no national disability strategy or plan (ESCWA and League of Arab States, 2014; KII with MoSA March 2018; MoSA pers comms. November 2018). This makes enforcing the implementation of Law 220/2000 across the various different line ministries challenging. For instance, few parts of the law are currently respected and many institutions do not recognize the PWD card, requiring prior approval for every service (MoSA, 2011).

The proliferation of non-state actors also poses a challenge for coherence and integration. ESCWA (2014: 73) describes that “organizations providing services for persons with disabilities are often fragmented. Many civil society organizations target their services towards specific types of disability and the medical needs related to it. However, this fragmentation renders the actions of every organization small in scale without being able to make significant changes and can make it difficult for persons with disabilities and their families to find the organization that provides services for their needs” (ESCWA 2014: 73).

Participation and process

Civil society – notably young active persons with disabilities and active DPOs – have historically played a major role in lobbying and advocating for the rights of people with disability and shifting policy and attitudes from a charitable to a rights-based approach. Their actions were critical in the formation of the ‘National Committee for the Disabled’ in 1993, and to the passing of Law 220/2000 by the Parliament (UNICEF, 2016).

DPOs continue to play a major role in advocacy, policy making, and service provision – particularly pressuring key actors to establish executive decrees and to enforce implementation of Law 220/2000 (UNICEF, 2016: 36). Moreover, in the absence of an official coordination body among concerned stakeholders on disability, in 2013 the “Disability & Older Age Working Group” (DOAWG) was formed by international and national organizations. This groups aim to advocate for persons with disabilities and older persons among refugees and in host communities, to coordinate stakeholders to make disability and old age issues more visible among relevant policies and plans. Group meetings have been attended by UN agencies and other international agencies which further supports the visibility of the rights of these groups (UNICEF, 2016).

Financing and fiscal capacity

The 2017 budget for the Rights of the Disabled Persons Programme was LBP 12.837 billion, of which LBP 7 billion were allocated for the year 2017 from the 2017 budget, with the difference (around LBP 5 billion) taken from the reserve, and credits allocated for projects and other centers belonging to the 2012-2017 budgets (MoSA pers comms. November 2018). In terms of the MoSA allocation, LBP 6,558,967,206 was spent in 2016 (out of

the LBP 7,000 million). The MoSA budget remains the same for 2018 (MoSA Disability Rights Programme, 2018). Within the care budget, over half goes towards services in Mount Lebanon (reflecting the higher number of PDC holders there). KIIs from MoSA officials report that there are financing constraints to the delivery of the Rights and Access Programme, which also have implications for the adequacy and appropriateness of services available to persons with disability.

Measurement, monitoring and evaluation

Measuring the prevalence of disability

MoSA collects data on PDC holders disaggregated by sex and age: 0-5 (pre-mandatory school); 6-13 (mandatory schooling); 14-17; adult. However, reliable data on the prevalence of disability beyond those who hold a PDC is difficult to obtain for many reasons, including issues around self-reporting disability and the classifications of disability used by surveys, as well as the official classification used to determine eligibility for the PDC. Measurements which look beyond the medical model to include social function are more likely to result in recording higher prevalence rates (ESCWA and League of Arab States, 2014).

As mentioned above, the prevalence of disability in Lebanon appears to be low by international standards, and there are also different rates of disability which vary according the source (see Box 10). This variation in reporting makes it challenging to inform appropriate policy and design.

Box 10: Reporting the prevalence of disability in Lebanon

The following surveys use different methods and definitions to assess the prevalence of disability, thereby reporting variations in disability in Lebanon.

The recent UNDP RPA (2016) reported 2.8% of the population with disability (UNDP 2016)].

Other sources report higher estimates of disability. MoSA, for example, estimates the prevalence of PWD to be around 4% of the population (cited in UNICEF, 2016).

Earlier data from 2004 also show variations in figures – data from a World Bank report (2005), based on country-level data available at the United Nations Statistics Office reported high prevalence rates between 3.5% to 9.5% of the population (133,200 and 356,400 persons with disability respectively) (ILO, 2013).

Data from the Pan Arab Survey for Family Health in 2004 estimated approximately 4.3% of the population with disability, with 1.8% severe disability (cited in Chaaban and el Khoury, 2015).

Data from Ministry of Social Affairs, National Survey of Family Health, 2004 cited disability prevalence at 4% (150,364 persons) (ILO, 2013).

Data from Central Administration of Statistics et al. in 2004 reports disability at 2% of the population.

In 2004, a survey of household living conditions conducted by the Central Administration of Statistics (the Household Living Conditions Survey) found there were 73,896 persons with disabilities in Lebanon, of whom 36 percent were female.

Monitoring and evaluation

MoSA monitors the work of NGOs contracted to provide better services to persons with disabilities. Monitoring is carried out by a team of professional and trained social workers from MoSA who visit every contracted NGO at least once per month to monitor and control service provision to persons with disabilities, particularly children, who are covered by MoSA (UNICEF, 2016: 18). The monitoring team assess the conditions of children and the services they receive from the NGO at different levels: Safe environment, programs, services, and existing specialized team (Ibid.). Quarterly and annual reports are written, and the annual report determines whether the NGO contract is reviewed and extended or terminated. In 2012, an article was added to the contractual agreement between MoSA and the contracted NGOs, requiring them to comply with, and apply the ‘Convention on the Rights of the Child’ (UNICEF, 2016: 18).

The role of civil society also plays a large role in monitoring persons with disability experiences of service delivery, as described above (Disability Monitor, 2013).

However, general limitations with monitoring and evaluation have been identified. The CRC (2017) reports that concerns have been raised about the capacity of MOSA staff to properly assess the quality of care for children with disabilities, noting that children with disabilities are especially vulnerable to abuse and exploitation. Whilst individual staff may intervene and take action when needed, there does not appear to be any official institutional processes, system or mechanisms at the Ministry level in place to feed this back into improved policy / implementation in practice.

KIIs with MoSA does suggest that this depends on the nature of the complaint, and that if any concerns are raised about an institution, then MoSA will discuss this with the institution (KII, March 2018). UNICEF (2016) also notes a gap in monitoring as MoSA social workers do not evaluate NGO programs associated with

education since it is considered to be the responsibility of the Ministry of Education & Higher Education (MEHE); however, MEHE also does not visit these specialized institutions since they consider them to be under the responsibility of MoSA (UNICEF, 2016). In addition, no data are gathered on the impact of response services [through SDCs] for particular groups of vulnerable individuals such as children with disabilities (Maestral International and CRI, 2017a).

Moreover, there remain large gaps in knowledge on the impact of programming. As far as we are aware there have been no impact evaluations of the services available for PDCs.

4.3 Social care for children

How effective is MoSA's institutional care for children?

It is estimated that children in institutional care form around 3-4% of the total child population in Lebanon. Of the total 35,000 children in institutional care, 23,000 are in residential care institutions contracted by MoSA (around 2% of Lebanese children) (Child Frontiers, 2017; UNICEF, 2012).

For most children, institutional care acts as a boarding school first and foremost whereby a safe living environment, feeding and education are the primary elements of social care provision. A fundamental question concerns the effectiveness of this arrangement in terms of providing social assistance support to children. This question, and related debate, are not new to Lebanon. Policy planning documents and the literature highlight the imperative of promoting family-based support in the first instance and to recur to institutional care only as a measure of last resort. Examples include MoSA's 2011 National Social Development Strategy and MoSA's National Plan to Safeguard Children and Women 2014-2016. Both refer to the importance of family strengthening and the priority for policy to "provide assistance to support children within their homes... leave institutionalisation as last resort".

In practice, however, this does not appear to be happening as the number of children in care remains high and the number of institutions contracted by MoSA to provide such services is increasing. In both cases, fundamental reasons are linked to poverty and worsening living conditions in the context of the Syria crisis (KIIs; Child Frontiers, 2017). Key informants explained that previous efforts to reform the system (for example in 2006-7) fell flat as a result of strong opposition by the provider institutions. At the time, MoSA reform priorities shifted focus to the establishment of the NPTP.

Support for the institutional care approach is in part accompanied by a pejorative view of the ability of low-income or poor families to manage their affairs and look after their children properly. Institutions commonly explain that children can be better safe-guarded in the institutional care system (KIIs). NGOs that support the institutional care framework of provision, including parents among them, point out that children live better in social care institutions than they do at home (KIIs).

Financial considerations were also raised by key informant interviews and are mentioned in documents as a rationale for this arrangement. MoSA key informants explained that the reliance on social/institutional care to provide basic services to children is financially more viable than providing social assistance directly to families (see more on finances below). At the same time, MoSA's Family Affairs Division has sought to strengthen support to family-based care, but its budget remains limited, as the institutional care approach continues to prevail.

A review of the literature and information drawn from key informant interviews points to concerns about this arrangement for the provision of children's services and that the needs of children are not adequately assessed as part of the institutional care programme, leading to institutional care for children being a one-size fits all solution for all vulnerable children, whether they suffer from income-poverty or are at risk in their home environment. This means that the institutional care programme is in fact potentially harming a category of children who are vulnerable to income poverty, rather than lacking a caring home environment.

A Child Frontiers (2017) report listed the main factors influencing the effectiveness of services for children in institutional care and at times acting as barriers to institutional care reform are as:

- Addressing the root causes of placement into care, such as poverty, lack of access to quality education, and child abuse or neglect
- Improving decision making about entry into care so that children are only placed when necessary, and ensuring case management and reintegration support once in care
- Supporting or creating other forms of care
- Ensuring that the broader child protection system is supportive of reform.

An analysis of constraints and enablers

Legislation, regulation, policy framework

The current arrangement is at least partly the result of a conceptual lumping together of child protection and social protection for children, reflected in some of existing legislation and policy documents. The lack of clarity and separation between the two at the conceptual level is a key issue in Lebanon and has compounded the current configuration of institutions and service provision for children.

The literature points to important gaps in the law regulating child protection and de facto also elements of social service provision for children. It calls for improvements starting with an adequate and comprehensive definition of child rights and a related systematic regulatory framework for dealing with families in crisis and child poverty. In particular, Law 422/2002 on “protection of minors in conflict with the law or at risk” contains gaps leading institutional care is not as coherent or well-integrated as it needs to be to provide adequate support for the child.

In terms of operations, legislation and official documentation adopted over the years have sought to address some of the conceptual and operational gaps outlined above. Examples include the 2004 Decision 121 on “social care for children in institutions contracted by MoSA”, providing the programme's main regulatory framework and, with regards to the implementation of Law 422/2002, the adoption in 2017 of Standard Operating Procedures (SOP).

Decision 121/2004 was released by MoSA to clarify what groups of children can benefit from the services of social care in institutions contracted by the MoSA. It stipulates that the following groups are eligible for placement in MoSA-contracted institutions: Infants (under 4 years old); Orphans (4-18 years old); Children designated as a “difficult social case” (quotation marks in original Arabic) (4-18 years); Children “at risk” (4-18 years). A high degree of poverty (fakr shadeed) is considered in Decision 121 as one of the criteria for accepting a child in the “difficult social case category”. The ‘degree of poverty’ is assessed by SDC social workers on the basis of a questionnaire and a comprehensive study of family circumstances. An indicator taken into account is housing quality. In all placement-related decisions, parental consent is essential. Decision 121 does not provide guidance on minimum standards of care.

The 2015 SOPs establish the criteria of eligibility and processes of entry to institutional care for children at risk or in conflict with the law. Annex 9 of the SOP (2017) lists the criteria for placement. It emphasises the importance of children remaining with their families where possible.

Policy design

Inclusion in social care for MoSA-supported placements is based on children's and families' circumstances with an emphasis on those in need and poverty as outlined by Decision 121 (see previous section). Some commentators observe that this overlooks the presence of parents who might be able to look after their children within the family environment had they had better access adequate direct support and other opportunities to tackle adverse circumstances (e.g. Jawad, 2009).

The focus on residential care and the current arrangement, have meant a lack of resources destined to providing support directly to the family and assistance to address the root causes of children's and families' problems, enabling children to remain in the home. This stands in the way of coherence and integration of institutional care services. The high reliance on institutional care means that the service provided to children is not always appropriate.

A key issue remains in terms of the standard of care provided to children. The quality of food, shelter and basic educational and physical needs varies across care homes and is dependent on the resources and ethos of that organisation. The reliance on state education systems or religious schools owned by the care institutions means that children are being integrated into Lebanese society through the care home that has taken charge of them. KIIs confirmed that a workshop will take place in the summer of 2018 to review the provision of care standards in social care institutions.

Policy implementation in practice

A child's selection for entry into institutional care is officially initiated by social workers via the SDC. By design, it is they who identify a child for placement in care and facilitate their placement with the institutions directly. Poverty and vulnerability are criteria for placement in MoSA-supported placements and these are established and assessed by the social workers. In practice, key informants, including social workers interviewed, explained that the institutional care homes themselves play an active role in the identification and selection of children and their placement within their facilities.

By law, social workers are required to regularly monitor MoSA-contracted care homes. KIIs mentioned the low ratio of social workers to institutions as a challenge to the effective monitoring of institutional care. Moreover, the monitoring of institutions that operate outside of MoSA contracts is not undertaken by the Ministry (KIIs).

There are no formal grievance mechanisms in place.

The SOPs adopted in 2015 providing a guide on criteria and procedures for placement in institutional care for at risk children are now being extensively used by social workers and seen to offer a more systematised, consistent decision making and case management process. They are also considered as improving collaboration between agencies and encouraging work with families before court proceedings and placement into care (Child Frontiers, 2017). This may offer a good practice model that can also be adopted by the MoSA programme for social care in institutions.

Administration and coordination

MoSA-contracted institutions are regularly monitored. Yet to a large extent they operate in an independent manner, partly because they are financially independent and primarily operate to serve their own communities based on their own criteria of operation. The wider system, comprising also non-MoSA contracted institutions, is overseen by leading political factions of each community and is supported by prominent families and religious groups. This leads to variations in practice in type and quality of services provided and raises concerns about inclusion and fairness. With the view of promoting improved integration of services, greater accountability and transparent monitoring, an important step, as discussed with KIIs, would be the establishment of a comprehensive central registry of all approved child welfare and protection providers, covering their mandates and services and the elaboration of rigorous standards for all residential care institutions and their regular monitoring.

Financing and fiscal capacity

Although the Lebanese Government has long acknowledged the need to promote family-based care, it continues to invest considerable resources in the maintenance of care institutions for children (UNICEF, 2012). MoSA's Social Welfare Department spends an estimated 60-70 per cent of its annual budget on the provision of care to children in welfare institutions, with an average annual cost of LBP1.5 million per child (MoSA, 2011; UNICEF, 2012).

An argument in support of the current set up for the provision of essential services to children via MoSA-supported institutional care is that it is financially advantageous compared with the alternative of directly supporting families. MoSA spends 4US\$/day (spent in residential care) to support a child in social care, for a total of US\$1,000/year (KIIs). MoSA aims to cover 66% of the cost per child, covering accommodation, food and education among other services that are provided, and co-financed, directly by the contracted institution (MoSA KIIs and documentation shared, 2018).

MoSA officials explained that from a financial standpoint, given available resources, this is an economical and more feasible arrangement for the government compared with providing direct support to families (KII). On the other hand, critics of the current set up, the channelling of public resources to private/charity institutions, argue that it detracts financing for other essential services, for instance, leaving little opportunity to fund essential services directly to families (KIIs).

4.4 National Poverty Targeting Programme

How effective is the NPTP? How are exclusion risks mitigated?

The NPTP database is a historic initiative to identify and help direct public services and support to the poorest Lebanese. Its effectiveness hinges on the processes of household NPTP registration, beneficiary identification (identification of households eligible for *Halla*, renamed *Hayat*, and/or e-voucher cards) and information management over time, as well as the type and scale of services and transfers administered.

The process of household information registration and entry into the NPTP database critically matters to the NPTP's effectiveness and has important implications for people's inclusion in social assistance programmes. The registration process is mostly on-demand, with people approaching the SDCs and an initial application form submitted to social workers at the SDC. A communications campaign at the launch of the NPTP in 2011

aimed to inform the public of the initiative. No additional outreach activity has been carried out since then or is planned. KIIs and Ibrahim (2016) highlight concerns that limited awareness of the NPTP among the public, including the target population of extreme poor, may lead to exclusion errors. Registration at the SDC is open on a rolling basis, allowing people in principle to apply for registration at any time at the SDCs.

In terms of coverage, the number of households for whom the NPTP database contains information initially grew steadily to reach 150,000 in 2017. The number of household *Halla*, now *Hayat*, card holders initially increased to 105,849 and has since decreased to 43,000 following the 2017-18 recertification process – see Table 9. These figures compare with an estimate of 118,662 households living below the extreme poverty line of US\$5.7/per capita/day and 335,085 households living under the poverty line of US\$8.6/per capita/day according to the UNDP RPA 2016 (UNDP, 2016).

In the targeting mechanism employed to identify programme beneficiaries through the NPTP, up until its review in 2017/18, exclusion concerns were voiced in relation to two groups:

- **Women:** The *Halla/Hayat* cards are issued under the name of the head of the household. In at least 88% of cases, the household head is male (Ibrahim, 2016). If using a card issued to the man head of household, women must prove they are members of the household, generating an additional burden and potential barrier to women using the card and related services (NB together with the cards, a registration certificate is delivered to the families with the names and dates of birth of every household member that can benefit from the subsidies and e-voucher; to access these benefits, a person must carry the card, certificate and ID, IPC-IG, 2017).
- **Older persons:** available evidence suggests that the original PMT approach tended to exclude older persons/HHs headed by older persons. It indicates that health indicators of the applicants not enrolled in the NPTP because they did not have a low enough PMT score are worse than the ones of beneficiaries as a result of the PMT indicators/methodology and associated exclusion of households with older persons. One of the reasons for the recent revision of the PMT variables and formula seems to be in response to this concern. The revised methodology should secure improved coverage of the elderly. According to most recent MOSA data, the percentage of elderly enrolled in the NPTP programme has decreased from 7.15% in the old database to 6.1% in the new database (MOSA personal communication November 2018).

The effectiveness of the NPTP should also be discussed in relation to its potential responsiveness to shocks and ability to be used as a tool to scale up support to a higher number of people. In this respect, the number of households for which information is available in the database and its regular updating are critical. The wider the net is cast, in terms of number of households for which accurate information is available in the database, the greater the potential for this tool to be used effectively in response to growing need for support. The steady growth in the number of households for which information is available in the database is a positive indicator, pointing to the tool's potential use to scale up provision, for instance in the context of a shock.

Beyond the NPTP database details (registration process, targeting rules, population coverage), the effectiveness of the NPTP critically depends on the take-up and adequacy of the services it is used for.

The NPTP education, health and e-card food voucher programmes

NPTP coverage and take-up rates of the three programmes administered via the NPTP are reported in Table 10.

Table 10: NPTP coverage and programme take-up by year

Year	N of HHs in registry	N of HHs <i>Halla/Hayat</i> card holders	N of NPTP hospitalisation subsidy take-up	N of NPTP education subsidy take-up	N of NPTP food voucher beneficiary households
2012		25,000			
2013		34,000	5,910	9,920	
2014		72,000	17,395	26,484	5,076
2015		105,849	30,950	35,521	5,076
2016		105,849	32,066	19,457	10,008
2017	150,000	105,849	16,736	13,813	10,008
2018		41,372	3,396 (not full year)	8,948 (not full year)	

Source: MoSA (2018); *n of student beneficiaries* World Bank (2017)

MoSA officials remarked that the education and health subsidy take-up numbers indicated adequate take-up. However, according to some studies and to KIIs, the subsidy take-up figures are low (e.g. Ibrahim, 2016; World Bank, 2017).

With regards to the hospitalisation subsidies, challenges to its effective take-up in practice include:

- the low number of NPTP-contracted hospitals, resulting in limited options for hospitalisation for NPTP beneficiaries;
- significant delays in hospitals and health facilities being reimbursed for their services by the NPTP, resulting in hospitals/facilities becoming hesitant to admit NPTP beneficiaries;
- beneficiaries having to pay a share of their treatment in hospitals, even when part of the cost is subsidised;
- the mismatch between beneficiaries' healthcare needs and the services offered under the NPTP; a significant number of beneficiaries requiring primary healthcare services or a specialist consultation rather than hospitalisation which is covered by the NPTP (KIIs and Ibrahim, 2016).

Reasons for low take-up in practice of the education subsidy include:

- the opportunity cost of registering students in school is high and the related high number of NPTP households relying on their out-of-school children's income to survive;
- the low regard for public schools, considered to provide low-quality education; beneficiary households preferring their children to remain out of school unless/until they are able to afford private quality education (KIIs and Ibrahim, 2016).

With regards to the e-voucher, the MoSA-NPTP (and WFP) figures report complete take-up, at the cap of 10,008 households. The WFP surveys indicate a significant impact of the e-vouchers on food consumption, dietary diversity and coping strategies. Available documentation, including World Bank NPTP project documents, are in general agreement that the e-voucher has been effective, should be continued and possibly expanded to include additional beneficiaries.

An analysis of constraints and enablers

Legislation, regulation, policy framework

Although the NPTP is listed in the government budget, and was introduced and originally regulated by Cabinet Decree, it is not established by law. This has implications for its continuation and sustainability over time. Its financing – see section below – also matters with this respect. Since 2014, a law proposal has been discussed by Parliament. The proposal aims to institutionalize the NPTP project and make it an integrated programme within MoSA.

NPTP implementation is outlined in an Operations Manual covering the main stages and processes of application, registration, information management. However, consultations with MoSA NPTP staff indicated limited/no awareness of its existence, possibly reflecting weak government ownership of NPTP documentation. Beyond this document, according to the interviews conducted with key informants, there are no additional documents regulating and standardising the NPTP, its components and the roles and responsibilities of key actors including social workers, heads of SDCs and field officers.

Policy design

Targeting and the PMT: The targeting of heads of households with the *Halla* and e-cards defined in terms of male bread-winners risks generating barriers for women's access to NPTP programmes. By design, the original PMT awarded higher scores to households with older persons, leading to a higher rate of exclusion from NPTP programmes of older persons. This has been corrected in the revised PMT methodology.

Recertification/information update: the recertification or updating of NPTP information is carried out in an ad hoc fashion, meaning that it is unclear and uncertain when changes in NPTP household circumstances (including births, deaths, changes in health and economic circumstances) will be picked up by the system. The absence of the clear regulation of recertification processes and timeline could lead to lengthy time gaps between updates and irregular practices; these in turn will affect NPTP effectiveness and impact.

Levels/types of subsidies and costs of services: available evidence suggests that the design of the education and health subsidies, the types of costs they cover and how their levels compare with the full cost of required services

and the opportunity costs of attending school limit NPTP hospitalisation and education service take-up, in turn affecting NPTP impact.

Policy implementation in practice

Household registration: the initiative of applying for NPTP registration rests with the individual or the household. In the first instance, they are required to approach the SDCs and submit the initial application form. The communications campaign which accompanied the launch of the NPTP in 2011 had limited impact in terms of information dissemination to the target population of the most vulnerable Lebanese according to one study (Ibrahim, 2016). This raises concerns about the potential for some of the most vulnerable to be excluded from the outset. The open, rolling nature of the registration process means households can apply at any point in time.

Information dissemination and raising awareness: The launch of the NPTP was accompanied by a public communication and media campaign. According to Ibrahim (2016)'s survey, only a small percentage of beneficiaries interviewed had learned about the NPTP through the media campaign. A large majority had heard about the NPTP from neighbours and friends. According to the same study, key informants and beneficiaries criticised the communication campaign for creating the impression that the NPTP only targeted the most marginalised groups in terms of delinquent and homeless people, leading some to prefer not to be associated with the programme. In addition to creating stigma, the campaign was also perceived as inadequate to reaching the poorest and in accurately depicting the circumstances of the Lebanese population (Ibrahim, 2016).

NPTP information requirements and management: the informational requirements for the NPTP database and computation of the PMT score imply considerable data collection and management costs. The streamlining of these efforts via an electronic MIS system could help facilitate the complex management process, including the information transfer between SDCs, NPTP MoSA and CMU NPTP. It could also facilitate enhanced information exchange with line ministries that are critical to the effective functioning of the services provided via the NPTP (especially Ministries of Health and Education) and promote the greater reliance on the NPTP as a tool to direct resources to poor and marginalised areas and/or individuals.

SDC capacity: the launch of the NPTP was accompanied by investments in the infrastructure and staffing of SDCs. Household visits by social workers to fill out the NPTP questionnaire following a household's application may have high displacement times and related transportation costs and also pose security concerns. As a result, there is some evidence of questionnaires being completed at SDCs or elsewhere rather than at the household premises. At the same time, the growth in the number of social workers since the introduction of the NPTP is reported by some key informants interviewed as unjustified and as posing a human resources/management problem (especially as more recent recruits have undergone less/no training and skills capacity has been awarded less attention in the push to recruit).

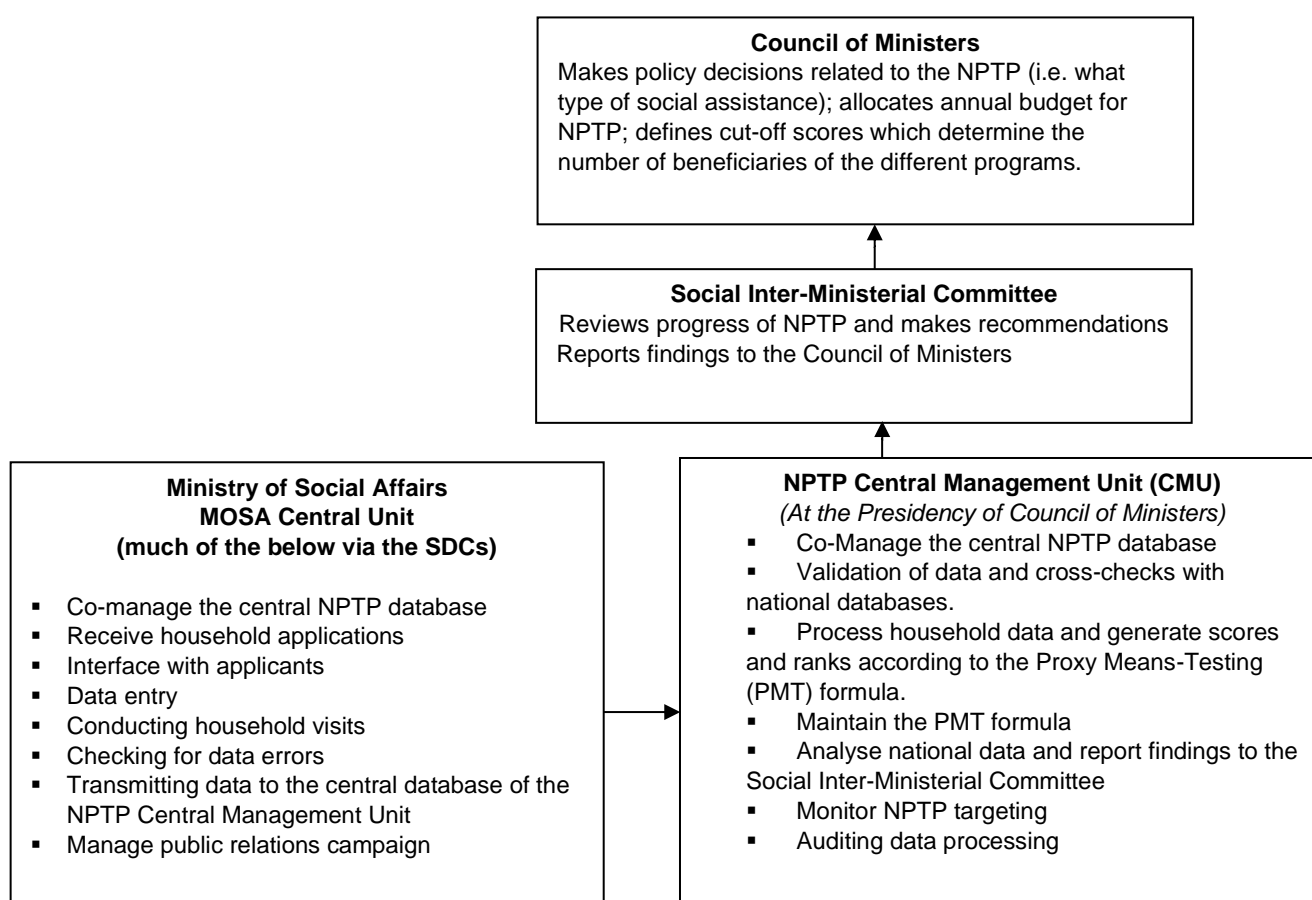
Complaint and appeals mechanism: An NPTP complaints and appeals mechanism is in place through which NPTP applicants and/or Halla card holders can submit claims to the SDCs and MoSA. Ibrahim (2016) describes that households who feel they are excluded while they should be included present a complaint to the SDC, mostly through the social worker.

The complaining household is asked to deliver proof and justification. Once these are presented through supporting documents, claims are sent to MoSA NPTP who in turn passes them on to CMU once they have been assessed and validated. The CMU then makes a decision about whether to include/exclude a household (Ibrahim, 2016).

NPTP coordination

The allocation of coordination responsibilities between the CMU and the MoSA-NPTP unit reflects the intention of separating strategic policy choices and decision-making (CMU) from NPTP implementation and fieldwork coordination and management (MoSA NPTP).

Figure 1: NPTP coordination and management allocation of responsibilities



Source: Ibrahim (2016)

Key informants and document review indicate that the institutional arrangement and allocation of NPTP responsibilities are generally clear. The management of the NPTP database, and its use to identify poor Lebanese and deliver social assistance in particular, requires close collaboration and ongoing information exchange across units, specifically the MoSA central Unit and the Central Management Unit at the Presidency of the Council of Ministers. While overall this arrangement appears to be working, key informants and available documents report some challenges to the regular communication and coordination between the two units as regards information management and sharing practices across the two bodies. In particular, MoSA NPTP receives data on a rolling, continuous basis from the SDCs and is responsible for incorporating information in the database. It is unclear however with what frequency the updated/expanded database is shared with the CMU.

Financing and fiscal capacity

Social assistance to extreme poor Lebanese delivered via the NPTP is primarily financed by the Government of Lebanon, who fully finances the hospitalisation and education subsidies (Ibrahim, 2016; World Bank, 2017). In 2012, the Council of Ministers allocated US\$28 million for the financing of the basket of benefits consisting of health and education subsidies (World Bank, 2017). The NPTP has also attracted donor funding, including US\$10 million from the Lebanon Syria Crisis Trust Fund and contributions received from the United Nations High Commissioner for Refugees (approximately US\$6.1 million), the German Cooperation (approximately US\$1.8 million), and the United Nations Central Emergency Response Fund (US\$0.9 million) (World Bank, 2017). The e-Card voucher scheme is financed by donors. Donors also contribute to the operational costs of the NPTP database.

International donor financing has supported the establishment of the NPTP and its maintenance over time. At the same time, reliance on external donor support has had implications for government ownership, tool and programme institutionalisation and continuity. With regards to the programmes delivered using the NPTP, an example is provided by the interruption experienced in the e-card food voucher scheme, funded by the joint effort of the World Bank, UNHCR, German Government and WFP, reflecting donor funding availability and interest²¹ (Ibrahim, 2016; World Bank, 2017).

Measurement, monitoring and evaluation

The CMU team are responsible for basic NPTP monitoring. According to World Bank (2017), the existing monitoring system is ‘producing sufficient indicators for basic monitoring’.

Although basic aggregate information on number of households in the NPTP, number of Halla card holders and take up of services/benefits were made available for the purpose of this study by the MoSA NPTP unit, these were not readily available. Information on the NPTP database recertification process, beyond basic aggregate numbers (e.g. the number of recertified families with records showing they are eligible for the NPTP card are around 41,000), were not made available. Both the MoSA unit and the CMU explained that they had not carried out any basic analysis of reasons for households no longer qualifying for the card. More detailed information is mostly available via the World Bank.

A report outlining and assessing progress on NPTP implementation was completed by Yasmine Ibrahim at the Consultation and Research Institute (CRI) in 2016. It covers four sets of questions regarding NPTP relevance, effectiveness, efficiency and sustainability and relies on key informant interviews as well as on a survey of NPTP programme beneficiaries. With regards to the programmes delivered via the NPTP, in the case of the food voucher, two surveys, a post-distribution monitoring tool and baseline survey, were carried out. Furthermore, licensed shops are regularly followed up by around 20 WFP personnel.²²

²¹ The e-card food voucher scheme for extreme poor Lebanese benefits from the WFP’s operating e-card food voucher for Syrian displaced. The first four months of the NPTP e-voucher (November 2014-February 2015) were fully funded through a 3.4 million USD grant from UNHCR. The programme was discontinued for the months of March-April 2015 due to lack of funding. The WFP was able to secure funding for the month of May; World Bank funding of 3.9 million USD for the ecard food voucher were transferred to the WFP account for June-Sept 2015; following the full disbursement of the WB funds, the Embassy of Germany in Beirut financed the month of Oct-Nov; the UNHCR committed to financing Dec 2015-February 2016; MoSA then requested additional financing from the Lebanon Syria Crisis Trust Fund for the ecard food voucher and additional 10 million USD were approved, permitting the programme to expand to 10,000 households (World Bank, 2015a).

²² On average 70 shops are visited monthly and post distribution monitoring reports are produced (key informant interviews, Beirut November 2017; IPC-IG, 2017). According to the World Bank (2015a), the two surveys were completed during November 2014

5 Emerging issues and ways forward

5.1 Social protection in Lebanon

To strengthen social protection in Lebanon, the following recommendations emerge from this study:

i) Conceptualizing and defining social protection

Traditionally, social protection in Lebanon has been characterised by social insurance for formal sector workers and comparatively low spending on social assistance for vulnerable Lebanese, mostly in the form of education and health fee waivers. The high reliance on non-governmental private and civil society, mostly faith-based, organisations to deliver social assistance also characterises the Lebanese experience. The bulk of MoSA's budget is destined to such organisations for the provision of services to children in institutional care. Spending on services for people living with disabilities and older persons is also mostly channelled through private institutions. This arrangement reflects the historically weak State-led provision of public services and the prevailing 'laissez-faire' approach which has distinguished economic and social policy in Lebanon.

This configuration is accompanied by a range of definitions of social protection, its objectives and tools, including, in some contexts, blurred lines between protection – such as, importantly, child protection – and *social* protection. At the same time, public perception surveys (e.g. Silva et al., 2013) indicate strong public support for government's responsibility in providing assistance to vulnerable Lebanese and the widespread perception that government does not do enough against this objective.

Efforts such as the 2007 National Action Plan, and more recent social protection policy developments documented in this report, including the establishment of the NPTP, provide important building blocks to continue to promote informed, nationally-owned policy debate aimed at clarifying definitions, objectives and tools. The growing presence of the humanitarian sector in Lebanon and efforts to strengthen the humanitarian-development nexus via social protection also present an opportunity, and urgent necessity, to foster informed discussion with the view of clarifying where objectives overlap/are distinct, appropriate tools and financing mechanisms.

ii) Institutional mandates and coordination between MoSA, Ministry of Education and Higher Education, Ministry of Public Health and Ministry of Labour

One of the primary objectives of social protection is to help ensure people access basic services, for instance in education and health, with a focus on those that are at risk of being excluded as a result of poverty and

(baseline), and in three cycles thus far as follows: January/February 2015, May/June 2015, and July/August 2015, to monitor and study the distribution and the effect of the e-card food voucher programme. In addition, three food security indicators were calculated, Food Consumption Score, Dietary Diversity Score and Coping Strategy Index, to study the health effect of the e-card on beneficiary households (World Bank, 2015a).²²

disadvantage over the course of the life cycle. The majority of MoSA social assistance in fact takes the form of education and health fee waivers, supports the provision of services via institutional care organisations, and facilitates access to such services or the direct provision of services via SDCs. The use of the NPTP to implement education and health fee waivers for Lebanon's 'extreme poor' and the *Primary Healthcare Restoration Project* aiming to step up healthcare provision to NPTP families via Primary Health Care Clinics are examples of such efforts.

One of the points of discussion with regards to this set up is whether it would be more effective and equitable to invest public resources in the provision of good quality public education and health services. In the case of MoSA's high reliance on private/civil society institutions providing education to poor children in MoSA-sponsored institutional care, analysts and practitioners alike have pointed out that such arrangements mean MoSA is in effect subsidising MoEHE-funded services, leading to overlaps and duplications in costs.

While there are good reasons why social assistance should be used to identify individuals not accessing basic services and to tackle barriers to accessing services, the design and coordination of such efforts could more closely involve sectoral ministries to minimise risks of duplication and overlap. There is a need for clear discussion on mandates and allocation of responsibilities across different ministries to avoid duplication of efforts and inefficiencies.

iii) Social protection financing

Fiscal constraints and fiscal capacity are commonly cited as challenges to the establishment of adequate social assistance. Low levels of financial resources are one of the reasons cited for low levels of social spending and redistribution. Three options moving forward include raising additional revenue, the reallocation of resources and enhanced spending efficiency.

Lebanon's tax revenue composition and tax structure are characterised by comparatively limited revenue from personal income and corporation tax, high reliance on indirect taxation and high tax exemptions and tax evasion among the wealthy. Fiscal reform could raise revenue by tapping into resources that are undertaxed, for instance through reforms to address high tax exemptions and the absence of inheritance tax (e.g. Assouad, 2017). In addition to holding potential for raising additional revenue for social spending, such efforts would strengthen fiscal equity and directly address Lebanon's high levels of income and wealth inequality.

Another source of social protection financing are employer and employee contributions. Comparatively low social insurance coverage and persistent high informality point to the potential to increase contributions-financed social protection through a combination of efforts to formalise employment and to improve systems to collect contributions.

Another option for increasing fiscal space for social protection involves the reallocation of spending. An option supported by the IMF and World Bank involves raising savings through the reform of electricity subsidies. Accounting for 3% of GDP, such expenditures mostly subsidise the electricity company's deficit and disproportionately benefit wealthier income groups. Calls to reform this subsidy are not new. The IMF has repeatedly called for the reform of the electricity subsidy, accompanied by a strengthening and expansion of Lebanon's social safety net through the related savings (e.g. IMF, 2018a; Ray and Schmitz, 2016).

Finally, the rationalisation of spending through greater efficiency of current social policies and programmes, is an additional way forward. For example, efforts to reduce and avoid duplications in expenditures on education

and health services, and improved coordination across these sectors and social assistance could help free up resources for social protection financing.

iv) Social assistance and social insurance – striking the right balance

The development of the NPTP provides an opportunity to strengthen the targeting of resources to poor Lebanese. Discussions on how to further develop the NPTP and its use are among the most lively in this sector, including among the donor community (in both the humanitarian and social policy-social protection sectors). This raises questions about the balance between: a) categorical and asset- or means-tested social assistance policies and b) assistance and social insurance in Lebanon.

As this report has shown, Lebanon's categorical social assistance programmes play an important role and their effectiveness critically hinges on investments in their improvement. As efforts to strengthen and improve the NPTP and associated targeted interventions are stepped up, as reflected in recent plans, initiatives to improve alternative categorical social assistance schemes for particular vulnerable groups, such as people with disability, should also move forward (for examples of specific priority actions see more in the next section). A careful discussion and planning around the use of the NPTP and the balancing of the objectives of targeting resources to the extreme poor and of improving the reach and effectiveness of public services more widely should be welcomed. With regards to social insurance, efforts to extend SI to informal workers and to improve the sustainability and levels of support of SI schemes should not be allowed to weaken since SI needs to operate alongside SA for the realisation of a sustainable SP system.

v) The role of the private sector and non-governmental organizations

Moving forward, given the current configuration, one option is to continue to rely on the private sector and non-governmental organisations while stepping up investments in publicly financed and provided services. This two-pronged approach would enable the strengthening of publicly provided services, with important implications for equity and the social contract.

vi) The humanitarian – development nexus

The Syrian crisis has exacerbated existing weaknesses in the Lebanese social policy system. However, there are also important examples of how the Government of Lebanon and international partners have responded to the crisis with increased financial and technical support for national institutions, and the poor Lebanese population. This presents an opportunity for much-needed investment in State capacity to finance and deliver good quality social services, including social protection. The NPTP provides a good example of programming in this regard, and investment in administrative tools and platforms which can be shared across humanitarian and poverty reduction activities are further opportunities for strengthening response in this protracted crisis, and enabling cross-learning of best practices to inform and strengthen the national social protection system in Lebanon.

5.2 Strengthening social assistance

The report identifies the following policy issues and recommendations to strengthen the three MoSA programmes related to disability, children in institutional care and the NPTP:

Disability

Legislation, regulation, policy framework

- The model used to classify the prevalence of disability interprets disability as mainly medical, thereby restricting the number of people with disabilities eligible for the PDC and their access to specific services. There is scope to adjust the official definition of disability by ratifying the Convention on the Rights of Persons with Disabilities (CRPD) by the Lebanese government, which takes a much broader categorisation of persons with disability.
- In addition, there should be a review of the existing criteria for the classification of disabilities based on scientific studies and specialists related to all types of disabilities, and a review of the classification of types of disabilities that are currently not included.
- Moreover, there is also a need to promote the integration, inclusiveness and participation of people with disabilities within a national system of protection, not only related to targeting people with disability, but also responding to the specific needs and vulnerabilities they face. Attention to disability should be strengthened in the new National Strategic Plan of MoSA, the LCRP, and future national social protection system approaches.

Policy design

- Currently, policy design for people with disability has not kept pace with the needs of the population. It is necessary to develop accurate information systems which feed into policy – both in terms of updated and regular assessments of the needs of those with disabilities, including disaggregated by age and sex, are required, as well as information on the type and quality of services provided by contracted organisations. Indeed, critical service gaps have been identified, which include early intervention programmes for children under 4, day programmes for children with disability, identifying the needs of adolescents with disability and supporting their transition into society after leaving social care institutions, providing more services for GBV survivors with special needs; services for people with a wide range of physical and intellectual disabilities, and rehabilitation services.
- These services all need to be spread geographically for improved accessibility, and not concentrated in just a few areas. A re-examination of the distribution of specialized services by region and type is needed.
- There is also a need to continue to decrease the number of residential care beneficiaries, and increase the quality and quantity of other external care services across Lebanon. These include the protection of children with disabilities including improved identification, referral, and financing mechanisms.

Policy implementation

- Improving implementation capacity and coordination mechanisms are essential for ensuring that service delivery meets the needs of people with disability. Promoting awareness about the PDC and services is a vital first step to increasing coverage of the scheme.
- There is also an urgent need to focus on equipping the SDCs to receive persons with disability to obtain health services, and to refer people to specialized services in coordination with the Rights of the Disabled Programme. In addition, establishing specialized model centers that can provide a package of specialized services for people with special needs within the limits determined by the MoSA is needed. In addition,

improvements are required in the infrastructure of SDCs to be accessible to people with disability; and an increase the number of qualified social workers in SDCs who are able to assess the appropriate services needed for children with disabilities. This would include providing adequate rights-based training and capacity building of all personnel in contact with children with disabilities at all levels.

- Additional diagnostics need to be developed to classify and identify capacity, and increased capacity and funding is also needed for existing agencies to provide care for people with disability.
- Additional training and awareness raising is also needed, for example, relating to the particular needs of Lebanese children with disability and refugee children with disability.
- Standards need to be set to ensure the quality of specialized services provided through institutions and associations contracted with the MoSA and which adopt the accreditation system to ensure compliance.

Policy coordination

- Whilst there are coordination mechanisms in place between agencies delivering services to people with disability, they require strengthening. Contracts with specialized institutions include academic education services for people with disability. However, there is also a need for increased coordination between the Division for Disability Affairs and the Rights and Access Programme, to promote coordinated policy across health and education – especially around inclusive and accessible health and education - in coordination with MOPH and MEHE. This also includes defining the roles and responsibilities of MoSA and MEHE for children with learning difficulties.

Financing, fiscal capacity and sustainability

- Moving forward, a more detailed analysis of MoSA spending on disability services, and options for further addressing the financial constraints to delivering appropriate services for people with disabilities is needed. This should also include a discussion with other relevant services (e.g. health, education, protection) on how to promote financial efficiency across sectors.

Measurements, M&E (data)

- There are significant gaps in data on people with disability in Lebanon. Whilst there are basic statistics collected on the number of cards, by age, gender, geography and type of disability etc., data gaps remain related to the situation of people with disability (both card holders and non-card holders), the services delivered by contracted institutions, and the impacts of current programming. As such, there is a need to improve data collection around regular monitoring of the PDC services, on those with disabilities who do not have a PDC, and evaluations on the impacts of services, in order to inform and refine future design of appropriate programmes and services for people with disability.

Children in institutional care

Legislation, regulation, policy framework

- This report highlights the need for clearer legislation and regulation to clarify the goals of MoSA's social and institutional care programmes and the categories of vulnerable children it is equipped to assist.
- More specifically, there is a need for conceptual clarification of the distinction (and overlaps) between child protection and social protection for children. How are the objectives of the two distinct? What are the policy tool and resources available to pursue the two? Moving forward, how should these evolve?
- Policy documents (such as Decision 121) clarifying the scope and criteria to be used in the identification of children for placement in social care by MoSA are helpful. The SOP elaborated to help standardise procedures and practice as concerns the implementation of Law 422 are also to be welcomed. Similar or

equivalent documents regulating social care and the type and quality of services provided would help further clarify mandates and standardise practices.

Policy design

- The high reliance on private and/or civil society, typically faith-based, institutional care organisations for the delivery of MoSA-financed services (such as education) to children from poor backgrounds has important implications for the types of services provided and the needs addressed by MoSA. Moving forward, the ongoing debate on the role these institutions play and MoSA's degree of reliance on them – how this matters to the services provided and the children covered but also to policy financing, wider policy provision and people's perceptions of MoSA's role – will need to be stepped up and encouraged/facilitated.

Policy implementation

- On the regulation of social care via MoSA-contracted services institutional care processes, Decision 121 provides guidance on the identification criteria. Still, there is limited information on and regulation of the types and quality of services provided. The SOPs adopted in relation to child protection services represent an important step forward in guiding and standardising procedures and outcomes for children in conflict with the law and at risk.
- Adequate training for social workers and their preparation with respect to formal MoSA regulation and standardisation efforts is vital.

Policy coordination

- A key question here concerns issues of overlap and coordination with services provided by other ministries, typically the Ministry of Education. For example, there are concerns of duplications of government expenditures and efforts in the provision of education services, with private and civil society institutional care providers potentially benefiting from subsidisation from both MoSA and the Ministry of Education in the provision of education to children in their care. Moving forward, a clear mapping of such financing and service provision streams and discussion on potential rationalisation of expenditures is warranted.

Financing, fiscal capacity and sustainability

- The financial implications of the current arrangements remain a point on which there needs to be more careful inquiry. The financing of institutional care absorbs the bulk of MoSA's budget. According to official regulation, MoSA aims to cover 66% of the cost of a child from a low-income background in social care, while the institution (private/faith-based) covers the remaining cost. Based on some KIIs, this is a financially smart and viable arrangement compared to what is perceived to be the more costly alternative (for government) of financing services directly provided to families. Yet questions remain about a) the allocation of MoSA funds and their prioritisation of institutional care and b) whether the current arrangements are indeed cost-effective from GoL's perspective.

Measurement, M&E and data

- SDCs collect information on children that enter institutional care (MoSA-sponsored). This remains mostly in paper form. An electronic registry of such information could be valuable. Ideally, it would include information on all children in the care system, including those not MoSA-sponsored.
- Similarly, while information on MoSA-contracted institutions is regularly collected and stored, efforts to systematise such information electronically and to include institutions that do not have contracts with MoSA would be helpful.

National Poverty Targeting Programme

Legislation, regulation, policy framework

- The NPTP remains a MoSA emanating project, not established by law, though regulated by national decree. Its reliance on donor support in its operation and implementation, while providing critical support to the NPTP, also has implications for government ownership and continuity. Efforts to strengthen the GoL's regulation of this tool – including via the law proposal under discussion – could strengthen government ownership and secure continuity.
- A clear discussion of the NPTP's purpose and scope should be promoted moving forward. The tool was established to identify Lebanon's 'extreme poor' and direct resources to them. The recently completed NPTP database recertification process has led to a reduction in the number of households with 'eligible' Halla/Hayat holder profiles to 41,400 (from 105,000). Plans for a new round of outreach and registration weren't underway at the time of the most recent KIIs, including with CMU staff (May 2018).
- In terms of the use of the NPTP and type of programme/service delivered through it, efforts to ensure that the database (as a whole, not just with respect to card holders) is used to guide policy and promote enhanced coordination across ministries (including social assistance, health, education etc.) should be a priority in new policy regulation. The Primary Healthcare Restoration Project provides an important example. Within MoSA, the implications and potential use of this registry - both its information and infrastructure – for wider policy, including for people with disabilities and children in social care services could be carefully considered.

Policy design

- Programmes delivered via the NPTP in practice so far involve health and education subsidies (with some take-up concerns) and food e-vouchers (to 10,000 households). The NPTP has also been used for other programmes (e.g. the PHC restoration project) and the new 'graduation' pilot targeting 600 households. Original discussions of the NPTP envisaged it would be used to deliver transfers in cash. These have not been implemented in practice. The future use of the NPTP to deliver different types of transfers is under discussion nationally and by international donors, including those primarily active in the humanitarian sector. Moving forward, promoting such discussion among Lebanese counterparts will be critical to ensuring national ownership and continuity.
- The NPTP population coverage matters to the potential use of the tool, including, critically, to scale-up and adjust social protection in a timely and efficient manner in response to changing circumstances. With respect to both inclusiveness and responsiveness criteria, the tool should expand its outreach, gather, consolidate and maintain information for a high number of households, that exceeds the number of extreme poor.
- Based on KIIs, including with social workers, awareness of the NPTP among the public, including the target population of poor/vulnerable Lebanese, is limited. Those that are aware of its existence are unclear about what the NPTP delivers in practice. Studies of the e-voucher point to its beneficial impact for beneficiaries. Moving forward, a careful analysis and discussion of what policies to provide via the NPTP and how to strengthen its role in delivering services and transfers to poor Lebanese should be a priority.

Policy implementation

- The effective implementation of the NPTP relies critically on: a) adequate communication and outreach, informing the public of the scheme's objectives, application process and policies delivered, b) social workers and the SDCs, c) information management, flow and use. Moving forward, a new outreach campaign would help to ensure that potentially eligible families submit their application. As the number of social workers has grown with the launch and implementation of the NPTP, issues concerning their training

and preparation remain. The updating or recertification of information in the NPTP could be more clearly regulated, to ensure maximum time limit and regular update of information in the registry. This should be accompanied by regular basic monitoring of trends and profiles of households for whom information is available.

Policy coordination

- The rationale for the CMU-MoSA unit set up is clear. KIIs revealed that there is scope to improve the regularity and frequency of communication between the two.
- As mentioned above, the NPTP database and related services could be better linked with other MOSA and wider social policy services. For example, there is scope to coordinate and strengthen links across initiatives for children in institutional care and NPTP beneficiary households or households in the NPTP database.

Financing, fiscal capacity and sustainability

- MOSA has over the years requested additional financing from the GoL's budget to support the NPTP. Efforts to minimise overlaps and duplication across ministries, as outlined above, along with efforts to raise additional domestic revenue (as per above) are critical in this respect and could free up/raise resources for the sustainable financing of this important tool.
- The reliance on donor funding for NPTP implementation has successfully supported NPTP implementation. However, it is also associated with issues of programme continuity for instance with respect to high staff turnover at the MoSA unit, and, to some extent, government ownership. Moving forward, continued efforts to strengthen a) technical capacity (e.g. on database management and data analysis, policy coordination) at MOSA and, b) relatedly, available financial resources for the NPTP from both domestic and international sources is advisable. See more on wider government fiscal capacity above.

Measurement, M&E (data)

- Efforts should be stepped up in the production and dissemination of basic NPTP monitoring information. Beyond basic numbers on total number of households in the registry and number of Halla/Hayat card holders, these would include information on the types of transfers/services managed via the NPTP and their take-up. Such information should also capture the dynamics of NPTP registry implementation and management, including number of applicants, excluded applicants (from the registry), card holders and beneficiaries, recertification and diagnostics of the updating/recertification process.
- Such information should be documented and reviewed on a regular basis to inform policy making and promote processes of transparency, accountability and programme legitimacy. The CMU and MoSA Unit produce such information upon specific requests, for instance from the World Bank. Institutionalising the regular production and dissemination of such descriptive statistics is advisable.
- The commissioning of additional monitoring, process analysis and evaluation studies to external experts is also desirable, with the objective of informing policy reform, promoting accountability and policy legitimacy. To date, there is only one published study of this kind we are aware of (Ibrahim/CRI, 2016).

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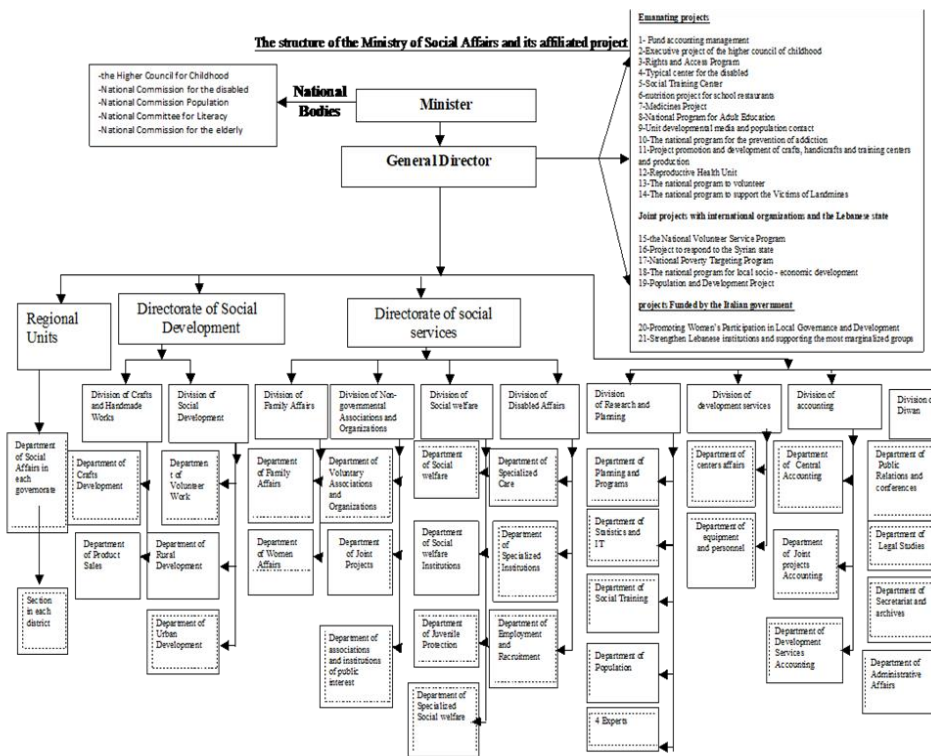
Annexes

Annex 1 Interviews in Beirut - November 2017 and April-May 2018

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	Mrs. Mireille Al Alam	Head of Women's Affairs Department:	mireillealam@hotmail.com
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	Mrs. Marie Al Hajj	Head of Disabled Department:	mhajjsaliba@hotmail.com
	Mrs. Nada Fawaz	Head of Social Welfare Department:	nf14270@gmail.com
	Mr. Adnan Nasreddine	Head of Social Development Centers Division	adonsd@hotmail.com
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UN Women	Ms. Faten Tibi	Program Manager	faten.tibi@unwomen.org
ESCWA	Ms. Gisela Nauk	Chief, Social Policy Section	nauk@un.org
Mutual Fund for Judges	Mr. Ali Ibrahim	Head of Mutual Fund for Judges	
Ministry of Labor	Mr. Georges Ayda	Director General	
Government Employees' Cooperative	Yehya Khamis	Director General	
Health Mutual Funds in Lebanon	Mr Ghassan Daou	Head of the Health Mutual Funds in Lebanon	
EU Madad	Ryan Knox		

Annex 2 MoSA organigram (November 2017)



Annex 3 Poverty and inequality measurement in Lebanon 1961-2018

Author	Survey year	Poverty indicators used	Main findings
Mission IFRED (1961)	1960	Income-based indicators	50 percent of population below poverty line
Schemeil (1976)	1973-75	Income-based indicators	22 percent of population below poverty line
UN-ESCWA (1995)	1993	Income-based criteria used for defining poverty	28 percent of poverty and 7.5 percent of extreme poverty. Poverty was concentrated in Beka'a and North Lebanon regions. Higher poverty rates among agricultural workers.
MoSA and UNDO (1998)	1996	Living Conditions Index based on Unsatisfied Basic Needs	214,000 households, or 32.1 percent of households live below the satisfaction threshold
UNDP (2004)	Summary		Share of low income population declined from 50 percent in 1959-1960 to 22 percent in 1973-1974 and increased again to 52 percent in 1994-1995.
Gaspard (2004)	Summary	Income-based indicators and the use of Gini for inequality	Income-based Gini declined from 0.5 in 1960 to 0.44 in 1997. Gini based on expenditure declined from 0.51 in 1951 to 0.47 in 1997.
UNDP (2008)	2004-05	Income-based indicators of poverty	28.5 percent of poverty and 8 percent of extreme poverty in 2004/2005. The Gini coefficient was about 0.361. Large regional disparities in headcount poverty rates with the North, South and Beka'a being the poorest. Poverty was highest, deepest and most severe for illiterate and unemployed individuals. Agricultural, self-employed and non-salaried workers were more likely to be poor. Using backward and forward simulations, extreme poverty was shown to decline from 10 percent in 1997 to eight percent in 2004/2005, but increasing afterwards to 8.4 percent in 2007.
CAS	2011-12	Household consumption-based indicators	Data to be analyzed once the large non-response bias has been addressed.
World Values Survey, the Arab Barometer and the Survey on Financial Capability	2010-13	Well-being indicators and income-based	About 30-32 percent of population estimated to be poor using subjective well-being questions and income information (measured in different ways in different surveys).
World Bank (2013e)	2012-2014	Consumption-based indicators	Syrian crisis is estimated to increase poverty among the Lebanese population by 170,000 people by 2014 with existing poor being pushed deeper into poverty.
Labour Force and Household's Living Conditions Survey (LFS)	2018		
Multiple Indicators Cluster Survey (MICS)	2019		
Household Budget Survey (HBS)	2019		

Source: World Bank (2015); RPA (2016); authors.

Annex 4 CODI social protection programme performance criteria

Criteria	Description
1. Inclusiveness	The social protection programme offers adequate coverage along the life cycle ensuring there are no significant coverage gaps and full inclusion of the poorest and most vulnerable. This entails ensuring non-discrimination, gender equality, availability of and accessibility (addressing distance, information awareness, and transaction costs).
2. Adequacy	The social protection programme provides regular, predictable and sufficient benefits, and services are adequate and meet the social protection needs of the population.
3. Appropriateness	The programme is aligned with national priorities. The social protection programmes and services that are part of the system complement each other.
4. Respect for Rights and Dignity	Programmes and services that are part of the social protection system are embedded in national law and regulations. In addition, the provision of programmes and services are in line with human rights standards and principles to avoid humiliation of the persons covered. Efficient and accessible complaint and appeal procedures are available.
5. Governance and Institutional Capacity	The social protection programmes and services have clear operating procedures with roles and responsibilities of all stakeholders involved in social protection. There is sufficient institutional capacity (adequate number of staff and set of skills).
6. Financial and Fiscal Sustainability	The financial resources allocated to social protection are aligned with national priorities. Legal and institutional frameworks articulate the long term financial requirements to ensure long term sustainability.
7. Coherence and Integration	Institutional arrangements are in place to enhance coordination across institutions responsible for the design, management and delivery of social protection actions. Concrete efforts to reduce fragmentation, overlaps, and duplication.
8. Responsiveness	The social protection programme is flexible to adapt in light of changing social protection needs. Changes may arise from socioeconomic, natural or political developments. These may require short term rapid responses and/or longer-term adjustments.
9. Incentive compatibility	The social protection programmes are designed in a way that they complement each other and don't create negative incentives among them nor offset disincentives to work, save and contribute.

Source: Elaboration from CODI What Matters Guidance Note



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