Republic of Lebanon

Social Action Plan

Toward Strengthening Social Safety Nets

and Access To Basic Social Services

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I. INTRODUCTION

1. **In its efforts to reduce poverty, improve social indicators, and achieve the Millennium Development Goals (MDGs), the government of Lebanon (GOL) has developed a social action plan**. This plan is an integral part of GOL's economic and social reform program, not only because it aims to improve the living conditions of the most vulnerable and poor groups but also because it is a critical element for a sustainable long-term economic growth.

2. **The Social Action Plan aims to form a social alleviation strategy for medium and long term actions to be executed in collaboration with relevant stakeholders. This paper contains some basic starting points for the strategy while prioritizing immediate measures, particularly specific interventions needed in Education, Health, Social and Local Development areas, where these interventions are to be integrated – at a later stage – within the framework of the comprehensive social strategy.** This paper, attempts, through available data, to emphasize the shortcomings of the social sectors, in an effort to design the appropriate interventions. Based on careful review of the social files, the objectives of this plan 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.

3. **An annual package of more than $75 million is designed to improve some social indicators through specific interventions designed to target the most needy population of the society.** These interventions will be based on a scientific identification criteria system in-order to allocate the resources to the neediest in terms of regions and groups. The government will provide, based on these criteria: (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. These interventions will be monitored and evaluated regularly. Pilot projects will be launched and beneficiaries will have to re-apply on a yearly basis.

4. This paper starts by briefly reviewing the major problems and challenges in the social sectors in section II. It then discusses in Section III some institutional measures to address these problems, proposes a set of measures to strengthen social safety nets (Section IV), and concludes with a road map for social sectors policy reform.

II. BACKGROUND

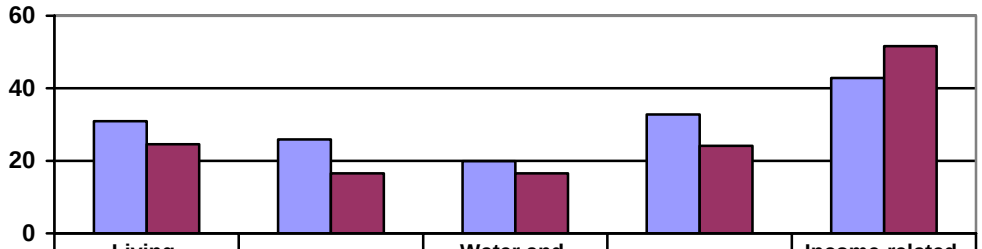
5. **Poverty is a serious problem in Lebanon despite some apparent improvement in the last decade.** While poverty data in Lebanon are not very accurate, various estimates put the extreme poverty rate at about 5 percent of the population, while estimates for relative poverty are around 25 percent of the total population.

6. **There is a huge disparity in the distribution of poverty with a heavy concentration in certain regions.** Hermel, Baalbeck and Akkar witness the highest poverty rates whereas it goes down to 0.7 percent in Beirut. Data also point to an increase in urban poverty especially in Lebanon's largest cities suburbs such as Beirut, Tripoli and Saida, as illustrated by poverty-driven symptoms (child labour, over-crowdedness and deteriorated environment conditions (Box # 1)).

Box 1: Poverty Profile

In 1998, The Mapping of Living Conditions (UNDP – MoSA), that measured poverty using the Unsatisfied Basic Needs approach (UBN), estimated that one third of the Lebanese households lived in poverty. These households are unevenly distributed among the different governorates, districts and cities. More recent money-metric studies also estimate that 7% of the population lives below the lower poverty line. On the other hand, the Multi-Purpose Survey (2004) will permit the calculation of poverty based on internationally adopted monetary indicators as well as based on the Living Conditions Index. However, preliminary poverty calculations on the basis of the Living Conditions Index have revealed that 5% of the households live in extreme poverty (as compared to 7% in 1995) and 19 percent of households live in relative poverty (28% in 1995). This shows a 6% of improvement during the last decade in the fields of education, housing and access to water and sanitation. However, income related indicators mainly in employment and economic dependency have worsened considerably, while the geographic and social distribution of poverty did not change. Poverty continues to be spread unevenly and is more prevalent among agriculture workers and unskilled workers in services, construction, and industries (the majority are illiterate or semi-illiterate). Rural areas still witness higher incidence of extreme poverty, while cities and urban areas host the highest number of poor.

Living Conditions of households (1995 and 2004) - Percentage of poor households



	Living Conditions Index	Housing	Water and Sewage	Education	Income-related indicators
1995	30.9	25.9	19.9	32.8	42.8
2004	24.6	16.6	16.6	24.1	51.6

Box 1 - Continued

Persistent regional disparities and the Geography of Poverty
In 1998, the Mapping of Living Conditions showed that regional disparity was a major characteristic of poverty in Lebanon. The four peripheral districts (Qadas) of Bent Jbail, Hermel, Akkar, and Marjayoun had a deprivation incidence of more than 60% of their resident population as compared to less then 20% for the central districts (Qadas) of Keserwan, Metn and Beirut. Recent studies show no change in these patterns of disparity.

For example, in 1996, Akkar accounted for 12% of the total number of the poor in Lebanon, and 23% of the extremely poor. It was characterized with poor socio-economic indicators that revealed very poor conditions in comparison with other regions. The preliminary results of the 2004 MPS, using the same living conditions index of 1998, shows that Akkar continues to have the highest share of deprived households in Lebanon

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7. **Available data on poverty in Lebanon reveal that poverty is most acute among the following groups:**

- **Big households characterized by high dropout rates and child labor**. The estimated number of deprived households with more than 7 members (national household average is 4.3 members) is 26,000, out of which 6,500 live in very low living conditions (2004 figures).

- **Female headed households**. The majority of the female headed households are old women. These households are widowed women living alone or with one family member. They are above the working age (65 years) and lack sustainable livelihoods. The estimated number of very poor female headed households is 3,500 (2004 figures).

- **Disabled (and their households)**. Studies have revealed that poverty rate among the disabled is 3 times the rate at the national level. Priority in this respect should be given to the enforcement of the law 220 in providing free health care to the holders of disability card, increasing job opportunities and elaborating additional programs benefiting the poor disabled. The total number of disabled holding the disability card of MoSA is 55,000 in 2005.

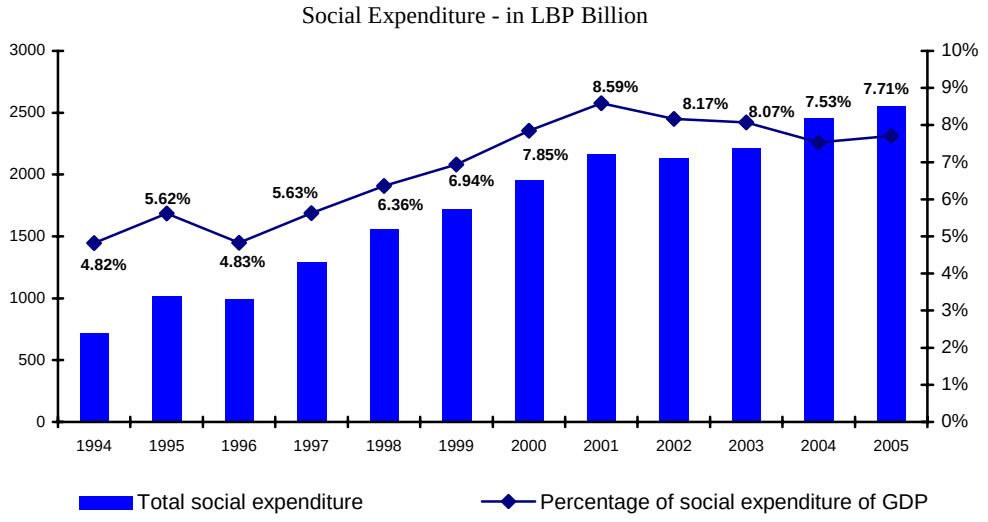
- **Elderly living alone, working children (and their households), households of prisoners**.

- **Illiterate or poorly educated individuals who are not covered by any health or social scheme including pregnant women, children, and elderly.**

8. **In recent years, a large part of statistical database in Lebanon has been updated. Further quantitative and qualitative data on the poverty profile in Lebanon were made available through the results of the multi-purpose household survey** in the second half of 2006, providing a tool for more effective policies and targeting mechanisms and helping in the formulation of a comprehensive social development strategy. The Social Action Plan has also been elaborated based on available data including the findings of the Multi-Purpose Survey.

9. **Social outcomes in Lebanon are weak and are not commensurate with the level of spending, which is comparable to spending in developed countries.** Even though the national mean averages might look good in many occasions, yet there is a big discrepancy in the social indicators between the regions and the social groups. During 2001-2004, social spending (public and private) represented 21 percent of GDP (excluding pension and end of service indemnity). In 2005, public spending on social sectors represented more than 42 percent of primary expenditures, 27 percent of total expenditure and 8 percent of GDP. Spending on social safety nets is estimated at about 2 percent of GDP but with a limited coverage. Informal safety nets (e.g., NGOs, worker remittances) are larger and more extensive but remain susceptible to shocks.

10. **Since the early nineties, the Government of Lebanon is exerting continuous efforts to improve the social indicators by promoting social development**. This effort was reflected in the evolution of social spending since 1994 whereby increased social spending (including pension and end of service indemnity) in the consecutive budgetary laws of the past ten years cumulated to more than LBP 19,000 billion (equivalent to USD 13 billion). The increase in social spending achieved a substantial growth reaching to 260% between 1996 and 2005. On the other hand, the share of social spending in total expenditures (excluding debt service) has been on constant rise. In addition, percentage of total social spending from GDP has exceeded 8% in the last years going up from 4.8% in 1994. The chart and table below reveal the evolution of social spending between 1994 and 2005.



Budget Law	Education and Culture Ministries	Ministry of Public Health	Ministry of Social Affairs	Pension and End of Service Indemnity	Total social expenditure (including pension)	Percentage of social expenditure from budget expenditure (excluding debt	Percentage of social spending of GDP

						service)	
1994	338	124	52	200	714	25.98%	4.82%
1995	467	159	68	320	1014	30.25%	5.62%
1996	408	150	88	340	986	25.56%	4.83%
1997	582	160	95	452	1,289	34.53%	5.63%
1998	684	261	94	520	1,559	37.84%	6.36%
1999	660	251	68	744	1,723	38.33%	6.94%
2000	707	274	93	875	1,949	41.56%	7.85%
2001	863	315	107	878	2,163	38.62%	8.59%
2002	833	290	106	900	2,129	43.68%	8.17%
2003	826	285	100	1,000	2,211	48.07%	8.07%
2004	904	345	109	1,100	2,457	48.37%	7.53%
2005	905	360	87	1,200	2,552	41.84%	7.71%

11. **Although the government spends close to 4 percent of GDP on education, education indicators remain unsatisfactory, knowing that total spending on education by both the private and public sectors reached 11% of the GDP**. Lebanon has one of the lowest ratios of pupils to teachers (9 students to 1 teacher in public schools – a very low ratio in comparison with the International standards especially that the teachers' distribution varies among the schools. Drop out and repetition rates in public schools are high, hovering around 22% and 48% respectively whereas the total cost per student is almost the same between public and private schools at the basic education level (in the elementary and intermediate level – grades 1 to 9). Spending on human resources per student is 35 percent higher in public schools than in private schools, while spending on educational materials and equipment in public schools is lower than spending in private schools.

12. **Health indicators are also weak and do not match high spending (public and private) incurred on health (12% of GDP – government spending amount to one third) and per capita health spending in Lebanon is $697 per year.** It is worth noting that 53% of the Lebanese population is not included in the NSSF. The reason for high health care costs in Lebanon is related to the nature of the health system that relies on hospitalization instead of relying on primary and preventive care. In addition, to the high cost of the health bill in Lebanon, the uneven distribution of resources and health services per regions is another challenge in the health system. These weaknesses are translated into a huge disparity in the health indicators among the regions. The Ministry of Public Health (MOPH) spends more than 70 percent of its budget to cover the hospitalization care of patients mainly in private hospitals while public hospitals have a low occupancy rate of 56 percent. Primary health care

and public health expenditure appear to account for no more than 10 percent of the ministry's budget. These indicators require effective measures to deal with the current situation.

III. IMPROVING SOCIAL INDICATORS

a. Social Strategy

13. **A basic step in improving social indicators is for the government to formulate a comprehensive social strategy.** The inefficiency of social spending is caused by the absence of a comprehensive framework for social policy, as a result of a weak coordination amongst concerned ministries and stakeholders leading to duplication of efforts and waste of resources. In addition, there is little systematic targeting in existing programs compounded by a deficiency in standard data on poverty and social indicators. For example, the distribution of public schools is not based on cost effectiveness analysis or on demographic needs, leading to a waste of resources that could have been used more efficiently to enhance the quality of education especially in non-performing schools. In general, the distribution of social spending allocated at relevant ministries is not consistent with the size of the social problems and the priorities to be covered in-order to address the problems of deprived regions and vulnerable social groups.

14. **The government will form an inter-ministerial committee with the main tasks of coordinating government efforts and elaborating an overall social strategy.** The committee will be composed mainly of concerned ministries, the Ministry of Social Affairs (MOSA), the Ministry of Education (MEHE), the Ministry of Public Health (MOPH), the Ministry of Finance, the Ministry of Labour (MOL), and the Ministry of Economy. The inter-ministerial committee will coordinate among its members to produce in the coming few months, in collaboration with relevant non governmental organizations and representatives of the civil society, a social strategy, that will constitute the framework for concerned ministries to develop their own sectoral strategies. This committee will base its work on previous efforts of primary parties in the social sectors, especially those who have worked on sectoral strategies or prepared overall social strategies, and will initiate the clarification of tasks between concerned ministries to avoid duplication in services offered by the Ministry of Public Health, the Ministry of Education and the Ministry of Social Affairs.

15. **The inter-ministerial committee will be concerned with the monitoring and evaluation of social safety nets programs, the overlapping among ministries, and the establishment of a social database**. Substantial savings are expected to be incurred due to the elimination of duplication and overlapping. The committee members will coordinate to establish and use the social database to improve targeting and reduce waste. An assessment of the existing social safety nets should be regularly conducted to identify areas for improvement and potential savings.

b. Improving Efficiency of Social Programs

16. **A number of conditions are necessary to set up an efficient social safety nets system.** These include a) setting clear mandates for various actors and coordination mechanisms; (b) The "Multi Purpose Household Survey" was completed in the fourth quarter of 2006, and the Proxy Means test to help identify poor households is to be completed by end of 2007; (c) deciding on a clear strategy for identifying priority beneficiary groups; (d) enhancing human capital resources for a better implementation (October 2007); and (e) developing adequate targeting and delivery mechanisms. All the social safety net measures are expected to be in place by end 2007 (in parallel, the elaboration of a national social strategy should be moving forward).

17. **Targeting and delivery mechanisms are keys for the development of an efficient social safety nets system**. Since income is not a sufficient social indicator in Lebanon, proxy-means testing need to be developed in-order to target needy people. The targeting mechanism is to be conducted with accuracy and flexibility at the same time, while attempting to have a transparent and computerized system. The Social Development Centers of MOSA, along with the Local development projects, and municipalities could provide the mechanism to identify household eligibility and monitor their compliance to the set of conditions. Beneficiaries will have to re-apply for eligibility every year. An immediate assessment should be conducted to evaluate the targeting and efficacy of any existing program especially when it is scaled up.

18. **In order to resolve data problems, a strategic Statistical Master Plan (SMP) will be adopted nationally**. The SMP would be the first step towards improving the statistical database in general and the social database in particular to avoid double dipping. The SMP would set out a medium-term action plan covering all aspects of producing, disseminating, and related to production and publication of statistical data.

IV. SOCIAL SAFETY NETS

19. **While some problems require medium-and long-term actions, the government will take actions that would have an immediate impact on the most vulnerable groups. (Matrix I)**. To this end, there is a need to (i) strengthen existing social safety nets; (ii) put in place new safety net schemes, and (ii) revisit the current allocations in order to improve assistance and social services. Within this framework, the government will provide cash transfers to poor senior citizens, female-headed household and the disabled and improve education indicators; increase access to education particularly for poor households, provide free access to primary health care to the poor, and promote local development initiatives to reduce regional disparities. Each of these pillars is discussed briefly below:

a. Reducing Poverty

20. **Under the government's social action plan, MOSA will scale up existing cash transfers to poor senior citizens**. The number of poor senior citizens benefiting from this program will increase from 1000 to 8,500, and the amount of assistance will triple, from $200 to $600 per year per person. Total cost to be covered by the government would reach $5 million per year.

21. **The government will also introduce new cash transfers to female-headed poor households** to be accompanied by an economic empowerment program for women. The program is expected to support about 6000 female headed households living in very poor conditions at the rate of $800 a year and a total cost of about $5 million a year.

22. **The social plan also aims to target poor households and large families with children either not enrolled in school or under the legal age to work.** These households usually suffer from financial strains at the beginning of the school year and their children are most at risk of dropping out from school and start working at an early age. The program targets very poor households (6,500 households) that meet a number of conditions (children not enrolled or working). The Ministry of Social Affairs would provide support and follow up on condition that households would comply with a number of conditions (keeping children at school till end of compulsory education, participating in illiteracy classes, etc.). The support could take the form of conditional cash assistance or another form depending on the situation of households. Annual cost is estimated at $4 million with an average of $600 per household.

23. **The aim of the Action Plan is also to increase resources and expand the programs targeting disabled poor, through**:

- **The support of poor households with a disabled member.** The support includes choosing from a selection of list of services and exemptions such as health care, training, and cash transfers. This program should target around 3,000 very poor households with an estimate of $2 million a year.

- **The increase allocations of for "The Right & Access Project", an operating modern and automated system,** that provide 15 types of proximity services (chairs, beds, health services) to about 55,000 holders of disability IDs. Due to insufficient resources the program works for only 7-10 days a month. Allocations for this program should be tripled, to provide uninterrupted services all month long. The cost of this support is estimated at $3 million a year.

24. **Improving the already existing "full in-house service"** benefiting 6,700 special cases (mentally challenged) to serve 7,500 cases with a total estimate of $1 million.

25. **The Government intends to establish a program to address the problem of working children and children at risk of delinquency.** Figures of 2004 have revealed that around 1300 children between 5-10 years old and 8,000 children between 10-15 years old are working (in addition to 2,600 and 7,000 children respectively who are involved in unpaid

domestic work). The issue of child labor is a very prominent aspect of poverty in urban regions. Households that have working children are targeted by the other programs intended for very poor households. However, this program would intervene through vocational training, life skills, support to bring children back to school, improve health and legal conditions, etc. The details of the program need further elaboration and accordingly cost estimation is not accurate, however, a preliminary estimate of cost is about $6 million.

26. **The Government will adopt a unified system for poor households to be exempted either partially or fully from paying certain social services fees** (Public school fees, health care and hospitalization cost). An automated registration system of beneficiary households would be established to identify beneficiaries and to issue unified electronic cards at a later stage. Identifying the beneficiaries and establishing the database will be under the responsibility of the Inter-ministerial committee for social issues. Exemptions and services would be decided upon collectively by concerned parties including governmental and non-governmental organizations. The total cost for establishing the system and provision of services is $1 million.

b. Improving Access to Primary Education

27. **To deal with the problem of high dropout rates in public schools, the government will launch a special program for poor students and their households to reduce cost of education on these households** through the provision of in-kind donations or exemptions. The program should target schools and regions that are very carefully selected based on performance indicators of public schools and based on school reports of specific social cases that need direct support. The total cost of this project is $7 million a year.

28. **The government will improve the ongoing school food program**. Currently the MEHE has partnered with international NGOs and Balamand University to provide daily meals for 34,000 children in 176 schools. At the same time, MOSA is currently implementing school food programs in 7 schools (mostly private) with a total number of 3,300 beneficiaries, however, the selection of schools is not based on clear poverty criteria. An immediate assessment should be conducted to evaluate the targeting and effectiveness of these programs, set relevant criteria for school selection, and identify schools in poor areas with high prevalence of malnutrition in cooperation with concerned ministries and stakeholders. The report of the school health program on the nutrition conditions of children will form a solid base for selection of schools. The cost of this project is estimated at $2 million.

29. **The MEHE will prepare a program to ensure basic education for all through supporting students at risk of repetition and dropout and students with special needs, by providing school books and stationery and cancel registration fees in public schools.** The MEHE will also launch support measures for vocational and technical training in different fields. This project will target the students in basic education with a total cost estimate of $9 million.

c. Improving Access to Basic Health Care

30. **The government is also committed to improving basic health care and reducing infant and maternal mortality rates with special attention to social-regional disparities related to this indicator**. The government will scale up its already existing health program within the framework of the MOPH by conducting health campaigns (screening and medical tests) and increasing awareness for promoting health well being of children and pre and post natal health of poor women. A social and regional map will be prepared to implement interventions in the regions where these rates drop below the national averages. The total cost of this assistance is estimated at about $6 million.

31. **The government will also enhance the existing school health program**. This is an efficient and ongoing program that brings together line ministries (MEHE, MOPH and MOSA), international organizations (UNICEF and WHO), and specific NGOs, that covers all primary schools in Lebanon. However there is scope to further improve this program, by raising the number of MD visits to schools, expanding the program to basic education, providing schools with first aid kits, establishing a relevant database, enhancing reporting capacity, and using these reports to monitor MDG achievements related to children malnutrition and mortality, and using the output of this program to identify schools eligible for food program. The total cost promoting the school health program is estimated at about $3 million.

32. **The MOPH will implement and improve the free health care system for the holders of the Disability Card (Law # 220).** In this respect, a mechanism with a work plan will be put in place to provide health care and free hospitalization (in both public and private hospitals) to the disability card holders. Execution of the program will be monitored on regular basis. This program will also be tested for duplication with other programs addressing to other social groups (elderly, pregnant women, children) in the framework of the social development strategy. The program will be elaborated in collaboration between MOPH, MOSA and the National Committee for the Disabled. Cost is estimated at $4 million a year.

33. **The social action plan aims at expanding health coverage for elderly suffering from chronic diseases through improving and developing the current chronic disease program**. Estimated cost is $5 million a year.

d. Local development

34. **Local development programs constitute another safety net for the poor and very poor population.** The primary aim of most of these programs is to reduce regional disparities in accessibility to basic infrastructure, create jobs, reduce unemployment and reduce internal migration of rural population to urban regions. Poor regions will be identified based on the findings of different social development programs such as CDP and ESFD. MOSA, along with other concerned ministries and municipalities will launch small Scheme Local Development Projects *(*e.g. improve access to safe drinking water, promote establishment of small scale enterprises, and use of alternative solar energy, etc.) to be

implemented in collaboration with municipalities and NGOs. (Priority will be given to the problem of polluted drinking water in 10 regions where diseases are high due to the regular contamination of water). Cost of implementing the suggested local development projects is $12 million.

35. **The social action plan aims also at establishing a mapping system of local development projects.** The goal of this mapping is to ensure coordination and complementarities among current actors in local development to optimize the use of resources, avoid duplication, and strengthen development initiatives and safety nets in local communities. The mapping would include the geographic location and the development projects for the 80 neighborhoods and villages identified by ESFD, the 68 villages identified by CDP within the 10 poverty clusters in addition to MOSA rural development initiatives.

VI. ROADMAP FOR SOCIAL SECTORS POLICY REFORMS

36. While the inter-ministerial committee will formulate the overall social strategy, the concerned social ministries will be working on developing their own sectoral strategies (Matrix II).

37. **The Ministry of Social Affairs plans to restructure its relationship with NGO's to improve the quality and efficiency of its services and interventions**. In addition to improving targeting and monitoring and realizing some savings, the ministry will (i) promote rural development projects according to the new standards (OMSAR); (ii) develop programs that will expand the role of MoSA to other vulnerable social groups or individuals and households; (iii) complete the automation of the ministry with e-links to the social development centers; (iv) enhance the efficiency of the social development centers as an instrument for integrated local development; and (v) complete the set up of a comprehensive social database.

38. **The Ministry of Education developed an education strategy to improve efficiency, reduce waste, and promote and expand access to good quality basic education**. The ministry will undertake several procedural measures, including: implementing the school mapping system (adopting the Geographic Information System) that will help in re-distributing resources and merge incompetent schools. Once the training centers in the regions are completed, ensure the ministry will also improve its training centers, conduct regular training for teachers, and introduce accountability by putting in place objectives and standards to be followed.

39. **The main objective of the ministry of public health is to improve accessibility to and affordability of primary health services to the population.** The ministry will (i) strengthen its capacity to provide universal access for basic health needs, (ii) evaluate the work of public hospitals and set up a minimum acceptable size for these hospitals to improve

efficiency and quality of services, (iii) set up clear standards and norms for the provision of health services and for accreditation of public and private hospitals, (iv) expand and better implement the Preventive Health Care Network, (v) reconsider the appropriate number, type, and geographic distribution of human and physical resources, and (vi) improve the "carte sanitaire" legislation and ensure its adequate implementation.

40. **Finally the Government is willing to develop a communication strategy** that goes in parallel with the institutional dialogue between the parties concerned with the implementation of a social action plan and the elaboration of a social development strategy. The communication strategy will set the ground to ensure transparency and to provide the space for all concerned and interested parties to discuss any development related subject and to ensure commitment of all stakeholders to the plan (national and local, governmental and non-governmental).

Matrix I – Proposed Social Safety Nets Action Plan (Timeframe: 2006-2007)

Time Frame for introducing targeting system to identify poor for Social Safety Net programs:

Begining 2007: Completion of the **Multi Purpose Household Survey**: helps in identifying regions with highest poverty rates.

End 2007: Completion of the **Proxy Means Targeting Formula** for effective targeting & identification of low income households.

End 2007: Preparation for implementation of new targeting system & training of concerned staff.

End 2007: A pro-poor social assistance program launched.

Target Group		Short-Term Measures	Responsible Party	Additional Estimated Cost/Year	Indicators	Impact & Justification
Poverty Reduction	**Poor Senior Citizens**	Expand support to poor elderly (nutrition, cash assistance, etc.) 8,500 poor elderly with a $600/annum.	MOSA	**$ 5 M**	> 65 years 14% of the very poor are elderly	Poverty alleviation. Improving basic living conditions.
	Poor Female headed-households	Cash transfers to benefit the **poorest** single female headed households in identified regions. (could target 6000 households* $800/annum)	MOSA	**$ 5 M**	poverty incidence higher among female headed households	Poverty alleviation. Improving basic living conditions. Could include empowerment component.
	Poor households with at least one member affected by disability	Cash transfers provided to the **poorest** households in coordination with other types of services offered to the disabled (3000 households * $600)	MOSA	**$ 2 M**	15,000 households (20% of the disabled are very poor).	Poverty alleviation, and integration of disabled within family.
	Poor Disabled	Scale up & improve the already existing "full in-house service" from 6,700 special cases (mentally challenged) to target 7,500 cases.	MOSA	**$1 M**		Improve services & integration of disabled persons. Already $ 10 M are being spent on poor disabled
		Increase budget of "The Right & Access Project" by 3 times. The project provide 15 types of proximity services to about 55,000 holders of disability IDs.	MOSA	**$ 3 M**	The project works with one third of its capacity	Improve services & integration of disabled persons. Increase capacity of project.
	Poor Families (>7) with at least 1 drop out child working underage.	Conditional Cash Transfers. The project will target 6500 families with an estimate of $600/ family.	MOSA	**$ 4 M**	High Drop Out Rates	Alleviate Poverty and Improve Drop Out Rate.
	Partial or full exemption of social services fees for poor families.	Gradually, establish database of poor households eligible for social assistance. Introduce electronic identification cards to receive a number of services and exemptions (depending on conditions of households).	Inter-Ministerial Committee	**$1M**	Currently, the total estimate of poor families with similar living conditions is 50,000 Household.	Improve quality of Social Services provided for the poor.
	Working Children	A program to eradicate worse forms of child labor and combat child labor under the legal age as well as protect children at risk of delinquency. The project will target around 10,000children working under the legal age with an estimate of $600/ child.	MOSA MOL ILO NGO's	**$6 M**	Large numbers of working children underage.	Lessen the number of underage working children and improve the drop out rates.
	School food program	Improve the on-going School food program in public schools. Current program benefit 40,000 children	MEHE MoSA NGO's Municipalities	**$2 M**		Improve health conditions of poor students.
Education	**Children at risk of dropping out of basic education.**	A program to reduce drop out rates of poor children before completion of compulsory education. Elementary and Intermediate education cost is between $200-300 per year in public schools. Total number of students in basic education in public schools I 250,000 student. 25,000 students should be targeted with an average of $300 per student.	NGO's under the supervision of: MOSA and MEHE	**$7 M**)	Drop-out rate: 22% Enrollment rate: 71% in 2005	- Increase access to education through alleviating the income obstacle. - Reduce drop-outs rates & Promote children's human capital development. - Improve basic living conditions. - Upgrade and enhance current school health program and monitoring.

	Ensuring basic education for all	Reduce drop out and retardation rates in basic education in public schools. Addressing educational and psychological causes leading to drop out and repetation ▪ Identify needs ▪ School support program ▪ Improve educational material and resources ▪ Improve psycho-social programs ▪ Provide free school books to students in public schools (revolving book program) ▪ Cancel registration fees (grades 7-9) ▪ Improve programs for special needs students ▪ Gradual establishment of pre-schools in poor regions.	MEHE	**$ 10 M**	-Drop-out rates 21%. (grades 1-6) -23% (grades 7-9) in 2006	- Ensure that all poor children will be able to complete primary schooling. - Drop out rates are reduced.
Health	**Improve existing school health program**	Medical visits, health care services in schools, The project will target 1,150 school, 250,000 students - $10 per student.	MEHE MOPH NGO'S International Organizations	**$ 3 M**		
	Low Income households, vulnerable groups: Poor Infants & Poor Pregnant Women	Scale up the already existing health program (clinic health visits and screening) aiming at promoting health well being of children (under five) and women (pregnant mothers-Pre and Post natal).	MoPH in coordination with MoSA	**$ 6 M**	-Maternal Mortality: 88/100,000 [MoPH] -Infant Mortality 18.6/1,000 – The rate is tripled in poor regions.	- Improve basic living conditions - Improve preventive health care awareness; increase access to health services vaccines & medicines through alleviating the income obstacle. - Decrease infant & maternal mortality rates.
	Poor patients suffering from key chronic conditions (e.g. diabetes, HIV-AIDs and mental illness)	Establish voucher distribution system for poor patients suffering from key chronic conditions (e.g. diabetes, HIV-AIDs, mental illness)	MoPH	**$ 5 M**		- Ensuring wider financial protection for poor individuals, particularly the elderly, from the costs of chronic illness
	Poor & Vulnerable groups (elderly and under five children)	Free hospitalization for the poor	MoPH MoSA	**$ 4 M**	14% of the very poor are elderly	Provision of greater financial protection for elderly & children
Local Development	**Poor Communities**	Small scheme local development projects working with municipalities, NGOs, and other partners *(o/w access to safe drinking water* in priority areas)*	MOSA * MOSA/MOPH/ CDR/ Municipalities	**$ 12 M**	5% of households are very poor	Improve basic living conditions. Addressing regional disparities. Coordinate local development interventions. CDP and ESFD are spending around $ 23 M on local development projects
			TOTAL	**$ 76 M**		

Source of Social Indicators: - MDG Goals- MDG Costing Lebanon 2005; Social & Municipal Development – Poverty Targeting System, CRI, 2002; MOSA, UNDP, CAS National Household survey, preliminary results 2004 Social Outlook; *.PAPFAM(Pan Arab Project for Family Health) 2005;*

Matrix II – Proposed Social Sectors Policy Reforms

Issue	Objective	Measures & Reforms	Time Frame
Coordination and Governance of Social Issues	Create the Inter-ministerial committee that will play a central role in formulating guidelines to prevent duplication, coordinate & integrate the work among all stakeholders in terms of policy planning and decision-making process	- Council of Ministers decision to establish the Committee, to be supported by technical unit. - Formulate a social development strategy - Eliminate duplication and overlapping in social interventions	Beginning 2007 End-2007 End 2007
Statistical issues	Have a comprehensive centralized social database to be able to efficiently target poor household and avoid double-dipping from individuals benefiting from different safety net schemes provided by different ministries.	- Finalize analysis of the multi-purpose household survey data - Complete tools and mechanisms for the proxy means testing - Formulate the statistical master plan and start its implementation process	Mid 2007 End 2007 End 2007
Ministry of Social Affairs services	Reform MOSA's safety net programs and other social programs (Social Development Centers, projects with NGOs, Social Welfare programs, etc.)	- Organize the contractual relationship between MoSA and social welfare institutions (Eligibility criteria, automation, etc.) - Adopt new criteria for the execution of local development projects - Reform handicraft department and the "Maison de L'Artisanat" - Restructure the social development centers both in terms of locations and roles to increase efficiency of MoSA's intervention at the local level - Reform the social training center - Complete the modernization and computerization of MOSA with links to the social development centers	Mid 2007 Mid 2007 Beginning 2007 2007 – 2008 Mid 2007 Mid 2008
Health services	Improve accessibility, affordability and quality primary health services Improve efficiency of health insurance sector and coverage levels for poor	- Incorporate primary health care benefit into public sector health coverage plans - Implement the carte Sanitaire plan - Require referrals from primary practitioners for subsidized MOH hospital coverage - Develop contracting methods for selected primary health care services - Introduce transparency and accountability processes in public sector primary health care facilities - Establish continuous professional development plans for MOH primary healthcare practitioners - Expand national accreditation program to primary healthcare facilities - Strengthen the financial management and ICT infrastructure of the public health insurance funds - Harmonize and possibly integrate administrative functions of public health insurance funds	2007 mid 2007 Currently in Parliament 2008 2007 mid 2007 2008 2008 Mid-2007
Educational services	Development of an integrated reform program built on outputs from the strategic planning process that is currently in hand	- Completion of the National Education Sector Strategy - Adoption of the strategy by Council of Ministers - Finalize the of "Private Higher Education Organization" Draft law - Restructure the MEHE - Identify tasks and training for employees - Establishment of an information management unit - Implement the school information system in all public schools - Finalize the Law of the Lebanese University - Establish the Action Plan for implementing the Strategic Goals - Education for All Plan - Implement the school optimization according to the school map - Computerizing MEHE Departements (EMIS System) - Computerizing the Official Exam Department - Data- Bank for Official Exams Questions - Training Principles of Official Schools on Modern Management Systems - Continuing Training System for Teachers	January 2007 Feb 2007 End 2006 End 2006 October 2008 2006 March 2007 End 2006 February 2007 End 2006 September 2007 October 2007 October 2007 October 2007 January 2008