B. Social Safety Nets

The purport and functions of what has come to be referred to as social safety nets and social funds fall within the general policy framework for combating poverty. The latter varies between poverty alleviation or reduction and eradication or elimination of poverty. Each of these terms denotes a different approach for addressing the problem of poverty and the type of policies to fight it - whether by dealing with its direct and immediate consequences, and/or confronting its causes and mechanisms, or by focusing on one level and not the other (e.g. local or sectoral).

Safety nets have been described as being compensatory measures for offsetting the social costs associated with structural adjustment programmes. They aim to accomplish the following objectives:

- To reduce poverty and unemployment.
- To improve the chances of success of structural adjustment programmes.
- To establish the infrastructure and new social institutions to improve the effectiveness of the services provided and their impact on beneficiaries.

Social safety nets and social funds may cover a set of programmes for those population groups that benefit the least from economic growth, including job creation, income support, provision of services in the social, health and education domains, etc.

1. Basic social needs

The war obliged the state and society to adjust to the needs and demands of that phase. Whereas the role of the state and central authority declined, especially at the level of providing basic services to citizens, that of the non-governmental sector expanded, particularly relief and emergency work and provision of health services and direct assistance (monetary and in kind). Family and religious institutions and structures played a complementary role in maintaining social solidarity and resolving emergency problems, especially those related to education, health and the accommodation of displaced persons. In addition, various political forces and militias established organizations and channels to provide a variety of assistance (cash transfers, assistance to families of "martyrs", education grants, and assistance to compensate for damage caused by bombardment and military operations, etc.).

Although the war period produced its own mechanisms of adjustment to the new and growing needs of that period, the state was not totally absent. Despite the sharp weakening of the public administration, the state continued to finance the livelihood of the families of tens of thousands of employees (salaries and pensions). The greatly diminished role of the state was particularly felt in reduced outlays as a result of the inability of the government to collect taxes and other fees and revenues, and the interruption by citizens of payments for electricity, water and telephone services.

The role played by NGOs in meeting the urgent needs of the population, especially during the war period, is emphasized. Their services covered various types of relief work, as well as health, education and recreational services. These organizations could, therefore, be regarded as social safety nets spread among different regions and social groups. However, no attempt is made here to study and evaluate the services provided by these organizations due to the lack of information. Hence, the

rest of this section will concentrate on examining the role of public sector institutions and entities in this domain.

Available information indicates a growing need for social policies in the following domains:

- Formulation of a comprehensive policy for health care accessible to all,
- Finding solutions to the housing problem,
- Dealing with the cost and quality of education,
- Formulation of a public transport policy that meets the needs of the country,
- Improving wages and expanding employment opportunities.

Meeting the basic needs of the population requires, in the first place, providing productive employment opportunities to generate the necessary incomes to respond to these needs. It also means providing through public social institutions at least part of public services, as well as meeting emerging needs of specific groups, to be supplemented by social safety nets and or specialized funds.

2. The social security system and its institutional structure

Two types of social security systems may be distinguished. The first has a permanent institutional set-up, while the second is akin to the notion of safety nets, and is generally of a temporary or emergency nature whether institutionalized or not.

The national social security system is characterized by the following basic features:

- Multiplicity of institutions that include mainly the National Social Security Fund (NSSF), the Cooperative of Public Sector Employees, insurance schemes for the security sectors (the army and internal security forces mainly), private insurance companies and schemes covering specific professional sectors.
- Variations in membership requirements and dues, and in extent of coverage.
- Overlap in coverage; a family being covered by more than one scheme.
- Differences among institutions in the type of benefits offered, and the inadequacy of some (pension systems) and the absence of others (unemployment benefits).

However, the most important feature of the existing system is its failure to cover all Lebanese citizens. Thus, the percentage of those covered by health insurance - which has the most extensive coverage - does not exceed 56 percent of the population according to sources of the Ministry of Finance (also, see below).

Before proceeding to examine the activities of the various institutions, the following table outlines the type of services offered and the population categories covered by the main public institutions.

Table III-2: Social insurance: categories covered and types of services offered by public institutions, 1996

Institution/Beneficiaries	Benefits
National Social Security Fund Workers and employees of	Family allowances (20% of

the private sector. Employees and workers (including contractual workers) of public institutions and independent offices not governed by the law of employees. Teachers of public schools. Taxi owners and drivers. Journalists. University students (Fishermen, tobacco farmers and seasonal workers to be included in the future).	the minimum wage for the spouse and 11% for each child; the total, however, not to exceed 75% of the minimum wage). Sickness and maternity allowances (90% of hospitalization costs, 80% of consultations and medications). End-of-service indemnity. (Work-related accidents and sickness branch have not been put into effect despite having been provided for).
Cooperative of Public Sector Employees Employees of the public sector governed by the law of employees.	Hospitalization and medical expenses (90% of hospitalization costs and 75% of consultations and medicaments and dental treatment, for the employee; and 75% and 50%, respectively, for family members. Education grants (75% of tuition fees for pre-university level, up to 5 children). Social allowances (marriage, death, and child delivery). Employees benefit from end-of-service indemnity or a pension system (not included under the Cooperative; but through Ministry of Finance).
Security sectors insurance	Hospitalization and medical expenses (100% for the military, 75% for spouse

Army Medical Brigade Cooperative of Internal Security Forces	and children, 50% for other members of the family). Educational grants (75% of pre-university tuition fees, and 50% of university fees).
All military sectors The army Internal Security Forces State Security Public Security Customs Officers	Social allowances (marriage, death and child delivery). The military benefit from end-of-service indemnity and a pension system (not included under the provisions of the Medical Brigade or the Cooperative; but through Ministry of Finance).

a. National Social Security Fund. The NSSF is the principal social security institution in the country; in principle, it covers all employees and workers (including some independent categories) in the private sector. In practice, however, coverage is incomplete, as some employers fail to declare all those who are employed by them and to register them with the Fund.

The NSSF was established in 1963. It is financed by contributions from each of the government, employers and registered employees as follows:

- Sickness and maternity insurance branch: subscription equivalent to 15 percent of salary, of which employers contribute 12 percent and employees 3 percent; applicable up to a maximum limit equivalent to three times the minimum wage.
- Family allowance system: subscription equivalent to 15 percent of salary, divided between employers (75 percent) and employees (25 percent).
- End-of-service indemnity: subscription equivalent to 8.5 percent of salary, paid entirely by the employer. Discussions have been going on to shift from the end-of-service indemnity system to old-age-insurance.

The NSSF suffers from two major imbalances with respect to coverage. The first is the decline in the extent of coverage relative to the size of the labor force. Whereas the number of registered establishments reached 34,451 end of 1996, compared with 32,485 establishments in 1974, the percentage of those registered dropped from 38 percent (231,500) of the labor force in 1974, to 28.1 percent (308,591) in 1996.

The second imbalance is the geographical variation in coverage. This is explained by the concentration of economic activity and, hence, establishments affiliated to the NSSF in Beirut and Mount Lebanon area. Table III-3 below shows that the degree of concentration of registered employees is higher than it is in the labor force; which indicates that a large number of employees in the regions are not declared (it is noted, though, that agricultural workers are not covered by the NSSF). The table

shows that concentration in economic activity is reflected in the social security system; hence, its weak coverage of peripheral and rural areas, which also means that economic and social marginalization go together.

Table III-3: Geographic distribution of employees registered with the NSSF, 1996 and Cooperative of Public Sector Employees, 1995

Region	NSSF		Labor force	Cooperative of Employees
	(Number)	(Percent)	(Percent)	(Percent)
Beirut and Mount Lebanon	255,891	82.9	59	58
North Lebanon	21,721	7.0	16	19
South Lebanon	17,040	5.5	13.7	15
Bekaa	13,939	4.6	11.3	10
Total	308,591	100.0	100.0	100

Source: The National Social Security Fund, 1996; Issa, Najib, The Labor Force Situation, paper presented to the United Nations Development Programme, Beirut, 1996; and, Cooperative of Public Sector Employees, Annual Report 1995.

As for the relative weight of various types of benefits and allowances, Table III-4 shows that in 1994 the highest share went to health (41.3 percent), compared to 29 percent for each of family allowances and end-of-service indemnities. It should be noted, however, that the real value of the benefits has declined dramatically. According to one estimate, the decline amounted to 40 percent between 1974 and 1991. As for the end-of-service indemnity, its average value fell from US$16,600 in 1982 to US$ 5,000 in 1992, or by two-thirds.

Table III-4: Relative weight of various types of benefits offered by the NSSF, 1994 (Percent)

Type of benefit	1994
Health	41.3
- Hospitalization	20.4
- Consultation and medicaments	20.9
Family allowances	29.3
End-of-service indemnities	29.4
Total: - Percent	100.0
- LL Million	205,836

Source: Director - General of the National Social Security Fund.

b. Cooperative of Public Sector Employees. The Cooperative of Public Sector

Employees has a membership of about 55,000 at the end of 1995. The geographical spread of its benefits is less concentrated compared to the NSSF, a reflection of the fact that the distributive role of the public sector is greater than what it is in the private sector (see Table III-3 above).

The benefits handed out by the Cooperative of Public Sector Employees were roughly equally divided between education grants (51 percent), on the one hand, and health (46 percent), and birth, marriage, and funeral expenses (3 percent), on the other.

c. Security sectors. Detailed and complete information on the geographic-regional affiliations of members of the security forces is lacking. However, direct observation and field surveys carried out in certain rural areas, indicate that the majority of the military, and of security forces in general, come from the remote rural areas of Akkar, Baalbeck, Hermel and the South.

Three field studies carried out in 1995-1996 in the cadas (districts) of Bcharre, Hermel and Western Beka'a, showed that 18.4 percent of men of working age in Hermel, Qa'a and Ras Baalbeck were enrolled in the army and security forces; 11.2 percent in Western Beka'a; and 9.4 percent of those in Bcharre. For Akkar the ratio could well be equal to that for Hermel if not higher. This finding highlights the direct and important role which the military establishment plays, through the benefits it provides to its members and their families in covering rural areas, where it assumes, in part, functions of a safety net. However, these percentages do not give a clear picture of the share of the different regions in total outlays, nor with respect to the types of benefits extended, which cannot be deduced due to lack of information.

Table III-5 below shows beneficiaries from services extended by social insurance in the military sector.

Table III-5: Beneficiaries from the social insurance services provided by the military sectors, 1994
(Number)

Institution	Members	Beneficiaries
Lebanese army	45,000	252,000
Internal Security Forces	15,000	84,000
Other security forces	5,500	30,800
Total	65,500	366,800

Source: Dr. Dominique M. De Biollet, and Dr. Rafic Baddoura, Le financement des soins de santé au Liban, WHO, March 1995.

d. Private insurance companies. The Association of Insurance Companies puts the number of insurance companies operating in the different insurance fields at 81 companies. Membership can be on an individual or a group basis, as many professional associations and institutions enter into group insurance contracts covering their active members. It is estimated that private insurance companies covered between 7 and 8 percent of the population in 1994/95. However, the activities of these companies are concentrated mainly in urban areas, especially in Beirut and Mount Lebanon.

The share of health insurance, specifically hospitalization, has grown very rapidly in the past few years, relative to other types of coverage. The share of hospitalization in total private insurance coverage rose from 7 percent in 1987 to 21 percent in 1989, and to 43 percent in 1991 and 51 percent in 1994.

It is important to note that the terms of insurance become more difficult, and premiums higher, the greater the need of applicants for health insurance. High age groups, and people with chronic health conditions or in need of continuing treatment, find great difficulty in contracting with insurance companies, or their contracts will not be renewed if they fall sick or require increasing medical treatment during the period of the basic insurance contract (in 1992, the percentage of non-renewed contracts reached 25 percent). This means that old and retired persons, the handicapped, and people suffering from chronic illness, are virtually excluded from the services provided by the private sector.

e. Overall coverage rate. Notwithstanding the discrepancies in estimates relating to the number of subscribers and beneficiaries covered by the different social security institutions, an attempt has been made to compare official estimates with estimates obtained from other sources, based on two hypotheses: a minimum of 2.8 beneficiaries and a maximum of 3.3 beneficiaries, for each insured person; except in the security sector where a single ratio of 5 to 1 was used. Table III-6 below summarizes the results of this exercise.

Table III-6: Social insurance: distribution of beneficiaries by institution
(Percent of total population)

Institution	First hypothesis	Second hypothesis	Posarac (World Bank)	WHO
National Social Security Fund	27.3	32.2	28.0	38.5
Cooperative of Public Sector Employees	5.0	5.3	9.0	12.2
Security Sector	9.7	11.3	11.0	
Insurance Companies	7.0	7.0	8.0	17.1
Total	49.0	55.8	56.0	67.9

Source: Posarac and WHO: adapted from WHO mission report on financing health services, June 1996.

The above table provides estimates of the distribution of health coverage by the main insurers and shows that between 7 and 17 percent of the population have procured private insurance, representing generally the well-to-do segment of the population. Coverage provided by the NSSF is estimated to range between 27.3 and 38.5 percent. Coverage provided by the public sector ranges between 12.2 and 20 percent. This means that social insurance covers 49 to 67.9 percent of the population., which means that the balance of 32 to 51 percent could be liable for coverage by the Ministry of Health. It is emphasized that due care ought to be taken in interpreting the above figures in view of the wide disparity in estimates of coverage by the different schemes.

3. Temporary and emergency assistance

A distinction was made at the beginning of this section between two categories in the social security system: the permanent institutions and benefits structures, and

the temporary and relief programmes and institutions. The main programmes and institutions of the second type, which functions could be considered to fall within the framework of social safety nets, are reviewed below.

*a. Ministry of Public Health.*The population covered by social insurance is estimated to represent *grosso modo* just over half of the Lebanese population. Moreover, all public insurance schemes are employment-based and, particularly the NSSF, cover only a portion of the medical bill. Actually, the Ministry of Public Health is the insurer of last resort. The Ministry is expected to provide a safety net, in the sense that all uninsured persons are entitled to coverage by the Ministry of hospital services and other prescribed therapies. The Ministry has adopted a system of direct funding for the treatment in private hospitals of patients who are not covered by any insurance system. This covers hospitalization care for normal treatment, and as well for costly treatment especially heart surgery, and kidney and cancer cases. The Ministry provides also medicines to chronically ill patients who are in financial need. In this sense, the Ministry of Public Health assumes the role of a safety valve for the health sector at the curative-hospitalization level. This activity finances about 20 percent of beds in private hospitals through direct contracting and absorbs more than 80 percent of the Ministrys budget.

However, there are reasons to believe that there are overlaps and abuses which impede the delivery of services to deserving people. More than half of the beneficiaries from the coverage extended by the Ministry are dependent persons such as spouses and children, elderly people; and, even professionals who supposedly benefit from private insurance or social insurance schemes. The system transfers the cost of expensive therapies to the Ministry. The current management system does not allow the detection of abuses and the targeting of the needy population. With respect to the latter, it appears that the vulnerable and poorer segments of the population have difficulties accessing health care services even with the Ministry of Public Health paying for the uninsured. Even though there is excess bed capacity in the private sector, hospitals appear to be often reluctant to provide services to people with low income because of delays in reimbursement by the Ministry to hospitals, or fear that the patient will not be able to pay the fifteen percent share of the bill.

Table III-7: Medical insurance: coverage by institution and type of health service, 1995
(Percent)

Service	Private insurance	Public insurance	Ministry of Health	Out-of-pocket	Aid	Mixed	No response	Total
Hospitalization	20.3	24.5	11.8	34.1	2.8	5.7	0.8	100
Prosthesis	-	4.5	-	91.8	0.7	0.8	2.2	100
Ambulatory care	4.1	16.1	0.3	76.5	1.4	0.9	-	100
Laboratory services	5.4	16.8	0.5	74.7	1.2	0.3	1.7	100
Radiology	8.3	19.2	1.7	65.5	0.7	2.0	-	100
Physiotherapy and nursing	3.6	12.5	-	71.4	7.1	-	5.4	100
Dental treatment	0.4	4.3	0.1	92.3	0.9	0.1	1.9	100
Medicines	2.3	13.9	1.1	79.3	2.5	0.3	-	100

Source: Dr. Dominique M. De Biollet, and Dr. Rafic Baddoura, Le financement des soins de santé au Liban, WHO, March, 1995.
Ministry of Health/WHO, National Household Survey of Health Expenditures, Beirut, 1995.

In spite of the multiplicity of public and private health financing institutions and the presence of social insurance schemes, the largest share of national health expenditures is borne directly by citizens, as shown in the Table above. Health expenditures weigh heavily on the household budget. Even for hospitalization expenditures, out-of-pocket outlays represent one-third of the total; the contribution of the Ministry of Health being only 12 percent, and 45 percent contributed by public and private insurance. For all other categories, out-of-pocket expenses represent between 65 percent and 92 percent of the total. Ambulatory care is essentially covered by out-of-pocket outlays. Public and private insurance covers barely 20 percent as under the different systems coverage is often partial and seldom extends to all needed services, whereas the uninsured are not covered by any arrangement for ambulatory services. Laboratory services, drugs and dental treatment, which represent a major part of the medical health bill, are also mainly paid out-of-pocket. It is reasonable to assume that the lower income households spend a larger proportion of their income on health care than higher income households.

b. Ministry of Social Affairs The Ministry of Social Affairs is the successor to the Social Development Office - the oldest institution for social development and care in Lebanon. The Office was established in the early sixties when modern notions of development were introduced, and a serious attempt was made to establish a network of service and development institutions in all regions, especially rural ones, relying on cooperation with local organizations and communities through participation agreements for executing and administering projects.

The role of the Social Development Office, and its affiliated services centers, declined during the war. At present it is functioning within the Ministry of Social Affairs, having been previously attached to the Ministry of Labor and then the Ministry of Health. Currently, the Ministry of Social Affairs is the most important structure for social safety nets in the direct sense.

The responsibilities of the Ministry range from caring for the less privileged groups such as the handicapped and widows, etc., to taking care of urgent needs in rural areas, health and social care networks, centers of comprehensive services, etc.. In addition, important contributions are made by the Ministry to relief operations during emergencies.

Table III-8: Distribution of social centers by Mohafazat, 1995

Mohafazat	Comprehensive services centers	Social - health centers	Total
Beirut	1	1	2
Mount Lebanon	10	9	19
North Lebanon	5	16	21
Bekaa	8	2	10
South Lebanon	9	26	35
Total	33	54	87

Source: The Ministry of Social Affairs, Annual Report 1995 (in Arabic).

The basic support infrastructure for the activities of the Ministry consists of health centers and comprehensive services centers attached to it. These centers, which are the most important legacy of the Social Development Office, number in total 87 centers, of which 33 are of the comprehensive type and 54 are social and health centers, distributed as shown in Table III-8 above.

The largest number of centers is found in the South, with only two centers in Beirut; which is a reflection of the rural orientation of these centers. Health services dominate the activities of these centers and benefited 77 percent or 153,261 beneficiaries in 1995. The Ministry has prepared a study on the requirements for reactivating the comprehensive services centers, with a view to rehabilitating the manpower resources and raising the level of empowerment activities.

In 1994, the Ministry entered into contract with 146 social welfare institutions. These contracts benefited 35,169 persons (see Table III-9) and covered such activities as caring for orphans and their education; caring for some acute social cases (extreme poverty, divorce or separation, chronically-ill persons, etc.); caring for old people; and special programmes for delinquent females. The benefits were spread among all the Lebanese regions, but predominantly in Beirut and Mount Lebanon. Caring and educational services (for orphans and social cases) were the main services provided.

Table III-9: Social welfare contracts by type and Mohafazat, end of 1995

Mohafazat	Number of institutions	Orphans	Social cases	Sucklings	Old people	Delinquent females
Beirut	16	2,075	5,444	454	40	-
Mount Lebanon	66	2,387	10,365	265	185	100
North Lebanon	22	857	2,501	80	157	-
Bekaa	17	589	1,890	75	85	-
South Lebanon	25	966	3,579	205	10	-
Total	146	6,875	23,779	1,079	477	100

Source: The Ministry of Social Affairs, Annual Report 1995 (in Arabic).

The contracts with civil organizations in 1993 covered more than 230 thousand beneficiaries. However, the distribution of beneficiaries and the types of projects carried out reveal the same structural flaw: a dominance of health services (about 80 percent of the total). The same pattern continued in 1994, with 131 contracts entered into by the Ministry with civil organizations and associations, covering 169 projects, of which 105 projects where health and social centers.

The services of the Ministry cover 3,551 handicapped persons, or 3 percent of the handicapped population, by means of contracts signed with 36 establishments that care for the handicapped; 16 of these establishments are located in Mount Lebanon and another 8 in Beirut.

The projects of the Ministry of Social Affairs include development projects in the regions, which were covered by 322 contracts in 1995. In addition, the Ministry organizes volunteer work camps (ten each year) to help in executing these projects.

The scope of the project covers repair works in villages, irrigation canals, agricultural roads, apiculture, and social activities.

The Ministry aims to strengthen the development component of its activities and the role and potential of the comprehensive services centers to establish effective cooperation with the civil sector and to coordinate social work at the local level.

c. Ministry for the Displaced and Fund for the Displaced The Ministry for the Displaced through the Fund for the Displaced makes direct cash payments to compensate evacuation of displaced (and those occupying houses) and for repair and reconstruction of houses by returnees (see section K below).

The approach followed by the Ministry and Fund for the Displaced combines social and political-security considerations; hence, the flexibility observed in the definition of the beneficiaries from its operations and in the amounts paid as compensation.

There is a large discrepancy between the process of evacuation and that of return; or rather, that the two operations have not always been related as they should be. In part, this could be explained by the fact that cash payments have often served to support the income of families receiving compensation, thus diverting these resources from the intended purpose.

d. Council for the South The Council for the South was established in the 1970s to compensate Lebanese citizens for damages caused by Israeli attacks in the South. The role of the Council, however, expanded considerably during the war years, and especially after the conclusion of the Taef Accord in 1989.

Table III-10: Council for the South: compensation paid to individuals, 1994-1995

	1994		Up to September 1995	
	Number	Percent of expenditures	Number	Percent of expenditures
Martyrs' families	180	8.2	78	4.3
Wounded	393	5	358	3.6
Treatment aid	1,245	1	319	0.3
Released persons	63	0.3	97	0.8
Imprisoned persons	352	3	348	5.7
Persons sustaining damage	11,165	82.5	9,140	85.3
Total	13,398	100.0	10,340	100.0
		(LL 41.6 billion)		(LL 39 billion)

Source: Council for the South, Report on Activities for 1994 and up to September 1995 (in Arabic).

The assistance provided by the Council is at two levels: to individuals and to community projects at the village or town level. The bulk of payments made to individuals (over 80 percent) has gone to compensate for material damage (Table III-10); the balance going to the families of victims of Israeli attacks, and to assisting imprisoned and/or released persons. As for project assistance, it appears that most of the disbursements were for electricity projects, repair and rehabilitation of public buildings and water projects (see Table III-11).

Table III-11: Council for the South: assisted projects, 1994-1995

	1994	Up to September 1995
	Percent of expenditures	Percent of expenditures
Sewers	1.5	1.9
Roads	3.2	3.5
Buildings	28.4	31.0
Hospitals and health centers	0.7	1.1
Water	19.9	23.3
Electricity	45.3	38.9
Removal of rubble	1.0	-
Miscellaneous projects	0.0	0.3
Total	100.0	100.0
	(LL 88.6 billion)	(LL 85 billion)

Source: Council for the South, Report on Activities for 1994 and up to September 1995 (in Arabic).

It is clear that there is an overlap between the activities carried out by the Council and those of other ministries and institutions, such as the Ministries of Public Works, Electricity and Water Resources, Public Health, Social Affairs; and the High Relief Committee. In other words, the Council assumes functions that also fall within the competence of several ministries, in addition to functions that are normally carried out by municipalities and local councils. In this sense, and given the wide scope of activities entrusted to it, the Council does not fit the description ascribed to safety nets, i.e. well-defined functions that do not overlap with those of other institutions.

e. High Relief Committee. The High Relief Committee was established in the 1970s to meet the emergency and relief needs resulting from the war; subsequently, it was also entrusted with responsibility to deal with the effects of natural and other disasters. It is responsible for receiving and distributing external emergency aid. The Committee is headed by the Prime Minister and established at ministerial level since 1993; representatives from line ministries, government agencies and civil and social organizations are called upon as required.

During the 1993-1996 period, the Committee provided a wide range of assistance, including cash payments to victims of Israeli attacks and to those affected by natural disasters; assistance in kind and equipment to health centers; and, some local infrastructure works. The activities of the Committee have consistently been directed to where relief was needed without discrimination between regions or social groups.

It is not possible to assess the real importance of each of these interventions due to the lack of information on the volume and distribution of outlays; however, the overall characteristics of the Committee's interventions indicate that: these interventions have been very diversified to the extent of appearing virtually uncoordinated, reflecting perhaps the nature and variety of needs to which the Committee caters; the Committee acts on occasions as a source of funding for projects, referring their implementation to concerned ministries and other entities, and on other occasions it assumes direct responsibility for providing assistance and project execution; and, lack of clarity in the intervention criteria.

The High Relief Committee took the initiative in 1996 to prepare, with support of

the United Nations Development Programme, a national disaster preparedness and management plan. The Committee invited cooperation of concerned public institutions and non-governmental organizations towards this end.

In 1993, the High Relief Committee considered a proposal to establish a community development fund aimed at achieving a number of objectives, including widening the geographic and beneficiaries base of the reconstruction process; assisting in the development of rural areas through support of local institutions; providing assistance to areas and groups in need to enable them to catch up with growth at the center, and reducing its possible negative impact on job opportunities and incomes.

The proposal was based on the following assumptions: that the process of reconstruction and rehabilitation of the infrastructure did not adequately cover around 30 percent of the rural population who live in villages and towns of less that 10,000 inhabitants; and that the institutional and administrative capabilities of the ministries concerned with social issues could not cater to the needs of these regions; in addition to the absence of local government structures.

The scope of activities involved rehabilitation and maintenance of water and sewers networks; building local roads and streets; development and expansion of local institutions of health and education; and in addition, the organization of vocational training and rehabilitation sessions to improve employment opportunities.

The project proposal for a community development fund was fully studied, but a decision has not yet been taken to establish it. This project is considered to be a rational attempt to establish a social safety net since the end of the war

4. Conclusion

In the specific situation of Lebanon, transiting from a long period of violence through economic recovery and reconstruction towards self-sustaining development, there is an evident need for broad support measures including the provision of welfare assistance to marginalized and deprived groups, compensation and incentive measures to victims of war and displaced, and to those left behind in the ongoing process of reconstruction and development. It is in this broad sense that the concept of social safety net must be understood in the context of Lebanon.

In the past few years, there have been significant gains, although not evenly spread, but there have also been considerable economic pressures as government resumed collection of taxes and other revenues, and adjusted upward fees and charges for public services. Incentive measures and supporting action are increasingly claimed from the authorities to enable citizens to meet their obligations without unduly affecting their living standards. Available data lead to conclude that *grosso modo* half the population is not covered by social insurance; in addition, important groups continue to suffer the consequences and effects of war, thereby severely reducing their capacity to contribute to the recovery and to fully exploit their potentials towards improving their personal and family lives.

This means that the population to be targeted by social safety nets and emergency and temporary assistance arrangements is large. It may be envisaged to include:

- Low and limited-income employees and wage earners.
- Inhabitants of rural areas.
- Retired and elderly people.

- Unemployed and marginalized persons.
- Orphans, handicapped and the chronically ill.
- Displaced families.

The requirements for assistance, not in order of priority, which emerged from the above discussion are as follows:

- Various types and levels of health care.
- Efficient retirement schemes.
- Educational assistance.
- Programmes to assist the unemployed.
- Empowerment activities and programmes to support the weak and vulnerable groups.

DON'T STOP HERE .. THERE IS MORE TO READ IN CHAPTER THREE GO TO SECTION C:
LABOR SITUATION