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Research Report

Exploring Opportunities for and Barriers to Making Social Protection and Cash and Voucher Assistance more Accessible to Older Persons in Lebanon

Submitted by: **INTEGRATED International**

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CAMEALEON is an NGO-led research and learning network established in 2017 to support the effectiveness and accountability of social assistance for refugees and host communities in Lebanon. It is co-managed by the Norwegian Refugee Council (NRC), Oxfam Italy, and Solidarités International (SI).

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Acronyms

AAP	Accountability to Affected People
ATM	Automated Teller Machine
BCCT	Broad Coverage Cash Transfer program
BML	Beirut and Mount Lebanon
CAMEALEON	Cash Monitoring, Evaluation, Accountability and Learning Organizational Network
CHERISH	Community Engagement, Health, & Empowerment for Resilience & Inclusion Support for Holistic wellbeing
CVA	Cash and Voucher Assistance
ESCWA	Economic and Social Commission for Western Asia
ESSN	Emergency Social Safety Net
FGD	Focus Group Discussion
GBV	Gender-Based Violence
GSMA	Global System for Mobile Communications Association
HoH	Head of Household
ID	Identity Document
IDI	In-Depth Interview
IDP	Internally Displaced Person
IDRAAC	Institute for Development, Research, Advocacy, and Applied Care
INGO	International Non-Governmental Organization
ISF	Imam Sadr Foundation
KII	Key Informant Interview
LAU	Lebanese American University
LBP	Lebanese Pound
LRP	Lebanon Response Plan
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs
MPCA	Multi-Purpose Cash Assistance
NDA	National Disability Allowance
NGO	Non-Governmental Organization
NPTP	National Poverty Targeting Program
NRC	Norwegian Refugee Council
NSSF	National Social Security Fund
NSPS	National Social Protection Strategy

PHCC	Primary Health Care Center
PMT	Proxy Means Test
PSCS	Public Sector Cash Scheme
RQ	Research Question
SDC	Social Development Center
SDG	Sustainable Development Goals
SI	Solidarités International
SMS	Short Message Service
SP	Social Protection
UNECE	United Nations Economic Commission for Europe
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
WFP	World Food Programme

A. Executive Summary

Lebanon is facing multiple, overlapping crises, such as economic collapse, currency depreciation, and armed conflict. During this period, poverty rates have tripled to 44%, and multidimensional poverty has reached 73%[4, 5]. Older persons, who currently make up 11% of the population, are systematically affected and remain underserved by social assistance safety nets due to structural exclusions such as the digital divide, narrow eligibility criteria, and the fact that nearly 80% of the population lacks formal pension coverage[18, 24].

While national social protection programs like the National Poverty Targeting Program (NPTP) and the Emergency Social Safety Net (ESSN/AMAN) have expanded to serve approximately 225,000 households, but the scale of humanitarian cash and social protection (SP) coverage remains limited. Recent assessments indicate that only 17% of older people receive humanitarian cash assistance and just 8% benefit from state social protection[25]. The Ministry of Social Affairs (MoSA) has implemented significant policy advancements, like the 2024 Pension Law and the National Strategy for Older Persons, which aim to transition toward a rights-based, universal system. A new National Social Protection Strategy (NSPS) is in place, and operationalization is currently underway. Additionally, MoSA highlighted how it plays a major role in crisis response (e.g., leading provision of shelter and cash assistance during the 2024 aggressions by Israel) As such, many of the perceptions below pertain to past systemic gaps that the Lebanese government is working to address and must be understood in light of ongoing reforms.

This research, commissioned by the CAMEALEON consortium, addressed a critical evidence gap by documenting the lived experiences of vulnerable older persons to inform the design of more inclusive, dignified, and sustainable humanitarian and social protection programming. The study employed a **qualitative, participatory approach** across four governorates (Bekaa, Beirut and Mount Lebanon, North Lebanon, and South Lebanon) between September and October 2025. Data was collected through interviews and focus group discussions with older persons (aged 60+) and their caregivers and with key stakeholders from Lebanese government ministries, UN agencies, academia, and non-governmental organizations. Findings showcase the perspectives and lived experiences of a limited number of interviewees and focus group participants and may not be widely generalizable. Key findings are summarized below.

Accessibility

- Most older persons participating in this study who receive SP were reached through door-to-door government outreach or through information shared on social media, particularly WhatsApp.
- Outreach and communication about aid programs shared through SMS, municipalities, or local NGOs was found to be inconsistent. Many older people, especially those isolated or digitally excluded, remain unaware of available assistance.
- Older participants expressed deep skepticism toward municipalities and official actors, citing perceptions of favoritism and a lack of feedback after assessments as major causes of disengagement.
- Digitalization and reliance on social media further marginalize older adults. Platforms like Facebook and WhatsApp serve as informal information sources but are also rife with misinformation, creating confusion and eroding perceptions of the credibility of shared information about SP.
- Physical isolation and mobility constraints hinder access to information and registration processes. The absence of consistent field presence or home-based outreach often leaves home-bound or older persons with disabilities invisible to aid systems.
- Outreach efforts remain short-term, project-based, and underfunded for both SP and humanitarian cash assistance. Once donor-funded projects end, communication and follow-up mechanisms collapse, highlighting the urgent need for sustainable, community-embedded, and multisectoral outreach systems.

Barriers to access

- Older adults face compounded challenges in reaching services due to physical limitations, inaccessible infrastructure, and high transportation costs. These barriers prevent timely registration, follow-ups, or access to aid and healthcare.
- The introduction of online systems for government-led SP has helped to digitize registration, record keeping, and SP disbursement processes. However, the reliance on online systems for registration and updates marginalizes older persons lacking digital literacy, devices, or connectivity. Limited outreach and dependence on informal word-of-mouth channels contribute to misinformation and missed opportunities.
- Narrow vulnerability definitions, rigid documentation demands, and the opacity of tools like the Proxy Means Test systematically exclude older people, especially those without formal disability status or living in complex family arrangements.
- Disjointed approaches across municipalities, NGOs, and donors result in geographic and demographic inequities. Older persons newly impoverished by the crisis often fall through cracks due to outdated targeting formulas and inconsistent classification of household heads.

Societal barriers

- Deeply rooted social norms and perceptions of shame continue to prevent many older people from seeking assistance, as they view aid as charity rather than a right. This perpetuates feelings of humiliation, dependency, and invisibility.
- Ageism and the perception of older people as unproductive or less deserving of support contribute to their exclusion from political priorities, aid targeting, and community engagement.
- The erosion of intergenerational solidarity has weakened traditional family safety nets, leaving many older adults, especially those with disabilities or chronic illnesses, dependent on sporadic acts of kindness from neighbors or NGOs.
- Stigma, pride, and gendered expectations create hidden vulnerabilities among older women, persons with disabilities, and formerly middle-class older adults, who may refuse to seek aid or fail to meet eligibility criteria despite evident need.
- Psychological and emotional barriers, including loss of dignity, isolation, and a perceived loss of purpose or masculinity, compound material deprivation, underscoring the need for integrated psychosocial and community-based support.

Intersectional challenges

- Gender, disability, and age intersect to create layered exclusion, with older women facing the heaviest burdens due to combined caregiving, domestic, and financial responsibilities.
- Chronic illness and disability limit older people's mobility and access to services. Women were the most frequent to report life-long health problems, yet continue to care for others, deepening exhaustion and isolation.
- In some households, social norms and protectionist attitudes restrict women's mobility and financial autonomy. While women are often most aware of family needs, male relatives may control access to aid, phones, or cash assistance.
- Lebanese women married to non-Lebanese men are excluded from MoSA programs due to their husbands' nationality, while older women survivors of violence are excluded from shelters after age 50, revealing institutional and policy gaps.
- Limited coordination between ageing, disability, and GBV services prevents a comprehensive response to intersecting vulnerabilities. Stakeholders called for stronger integration and joint referral mechanisms to ensure inclusion of older women.

Effectiveness and sustainability

- Older persons and their caregivers who receive SP support reported that the programs helped to fulfill major needs, particularly those linked to food and shelter (rent).
- The current system is perceived as having significant gaps, characterized by "fragmented" and "donor-dependent" approaches that offer "temporary painkillers" rather than lasting solutions.
- The 2019 financial crisis and subsequent shocks systematically dismantled financial stability, eliminating income and wiping out savings (including public sector pensions and NSSF). This rendered retirement planning meaningless for both the traditionally vulnerable and formerly secure profiles (e.g., landowners, military retirees), ensuring a broad-based crisis of income.
- Poor health is the primary driver of acute vulnerability, creating a financial burden that current assistance does not always meet.
- The assistance provided is universally seen as "never enough" and "short-term, inconsistent." This is compounded by a deep-seated crisis of trust, with a universal belief that access to aid is contingent on wasta rather than legitimate need, which discourages participation and breeds cynicism.
- While survival is the priority, psychosocial, mental, and emotional needs are systematically overlooked by both older persons themselves and assistance programs. While many programs with a mental health and psychosocial support focus exist, most of the older persons participating in this study had not been involved in such programs. Loneliness, exclusion, and breakdown in traditional community relationships are severe issues. Conversely, small-scale social interventions like "organized outings" have a disproportionately positive impact, highlighting that restoring dignity and social connection is a necessary component of effective support.

Key recommendations are summarized below.

Recommendation 1: Reinforce government ownership, institutional leadership, and accountability for social protection for older persons, from system design to implementation and delivery.

- Formally designate older persons as a priority group within the National Social Protection Strategy and MoSA implementation structures.
- Establish a phased non-contributory social pension scheme.
- Affirm and operationalize government responsibility for delivering SP to older persons.
- Build public trust through transparent and accessible communication on SP strategies and implementation.
- Adequately resource and strengthen MoSA's capacity to deliver age-inclusive SP services.

Recommendation 2: A strategic transition is needed whereby donors and implementers progressively reduce direct service provision and instead focus on strengthening government-led systems, supporting community-based mutual aid, and influencing donor practices through evidence-based advocacy.

- Position the Lebanese government as the primary service provider while redefining donor program roles as supportive and complementary.
- Strengthen shock-responsive and crisis-sensitive systems anchored in public and community structures.
- Invest in disaggregated data, participatory research, and shared learning to inform public policy and donor decision-making.
- Advocate for targeting approaches that reflect household realities while supporting community-level identification mechanisms.
- Develop a coordinated advocacy strategy that promotes systems strengthening and community resilience over parallel delivery.

Recommendation 3: Medical costs and other specialized service expenses, according to needs, must be considered when calculating cash assistance values and designing complementary programs until proper subsidies are in place.

- Prioritize older persons with chronic illness within social protection follow-up and referral.
- Formalize referral pathways between social protection and public health services.
- Reduce procedural barriers to disability-related health entitlements.
- Recalibrate cash assistance values to reflect medical expenditure burdens.
- Expand access to subsidized public healthcare coverage.
- Strengthen enforcement of NDA and Law 220/2000 health entitlements.

Recommendation 4: Ensure emergency CVA delivery modalities are mobility- and age-sensitive so that older persons are not excluded from evacuation, access, or assistance continuity during shocks.

- Integrate age and mobility criteria into emergency targeting and registration systems.
- Prioritize mobility-constrained older persons in follow-up and case management.
- Adjust CVA transfer values to reflect evacuation and transport costs.

Recommendation 5: Rebuild and institutionalize community-based support and outreach structures to reduce isolation and strengthen engagement of older persons.

- Develop intergenerational and alternative community support networks.
- Institutionalize community-centered outreach models.
- Support enrolment and case mediation through community intermediaries.
- Integrate psychosocial and social connection programming.

Recommendation 6: Strengthen localized, last-mile outreach and engagement mechanisms to ensure older persons and the most isolated can access, understand, and enrol in SP programs.

- Tailor outreach channels to older persons' access barriers.
- Adapt outreach approaches to low-literacy and digitally excluded populations.
- Ensure dignity-centered and discreet outreach processes.

B. Introduction and Context

CONTEXTUAL ANALYSIS AND LITERATURE REVIEW

Lebanon's Crises Context

Lebanon hosts approximately 1.5 million Syrian refugees, including around 815,000 registered with the United Nations High Commissioner for Refugees (UNHCR)[1], alongside a large Palestinian population of about 449,957 and 100,000 Iraqis, reinforcing its status as the country with the highest per capita ratio of refugees globally[1]. Since 2019, it has faced compounded crises, including economic collapse, currency depreciation, the COVID-19 pandemic, the Beirut port explosion, and armed conflict in the south (Israel–Hezbollah escalations 2023–24)[2], leaving 60% of the Lebanese population below the poverty line[3]. The World Bank further estimates that poverty in Lebanon has tripled over the past decade, reaching 44% in 2022[4]. Multidimensional poverty, which includes access to services such as healthcare, electricity, and education, affects 73% of Lebanese people and nearly all non-Lebanese residents[4, 5].

Since 2015, over US$14 billion in aid has been mobilized,[2] but recent years have worsened conditions for millions in Lebanon[2]. According to the 2024–2025 Lebanon Response Plan (LRP)[2], Lebanon requires approximately US$2.99 billion to assist 3.6 million crisis-affected people, including 1.7 million vulnerable Lebanese, 1.4 million displaced Syrians, and about 200,000 Palestinian refugees[2].

While some programs remain in place, including the most recent UN-backed return initiative, which has facilitated the registration and return of Syrians, with a target of moving 200,000 to 400,000 refugees back to Syria under voluntary, supported conditions, overall humanitarian capacity remains under strain[6]. The humanitarian space has been experiencing funding shortfalls and setbacks, especially following the recent USAID "Stop Work" order[7, 8]. U.S. aid cuts have forced UNICEF to drastically scale back nutrition programs[9], leaving more than 50% of children under two in Lebanon facing severe food poverty, particularly in regions such as Bekaa and Baalbek [9]. Nearly 80% of families require urgent support, while 31% of households lack sufficient drinking water[9]. Beyond children, more than 30% of the population faces acute food insecurity, with vulnerable groups such as female-headed households, people with disabilities, and older people being disproportionately affected[10].

Recent aggressions from Israel, beginning in October 2023, further exacerbated the refugee and Internally Displaced Persons (IDP) situation in the country, leading to the internal displacement of 1 million people[11]. Although many IDPs returned to their villages in Southern Lebanon following the November 2024 ceasefire, they continue to face substantial unmet needs, as they returned to heavily damaged homes and communities, often without essential infrastructure or reconstruction in place[11,12].

Social Protection Landscape in Lebanon

In Lebanon, Social Protection (SP) and Cash and Voucher Assistance (CVA) represent two distinct yet parallel systems that aim to support vulnerable populations. While both rely heavily on cash transfers as a delivery instrument, they differ fundamentally in governance, intent, and sustainability.

Social Protection refers to state-led policies and programs designed to provide income security and access to essential services across the life cycle, including childhood to old age, disability, and unemployment. These programs are anchored in national institutions, laws, and strategies and are intended to be predictable and, over time, universal. Cash and Voucher Assistance, by contrast, is primarily a humanitarian mechanism. In Lebanon, CVA has been led largely by international organizations such as UNHCR and the World Food Programme (WFP), particularly in response to displacement, economic collapse, and conflict. [13, 14, 15] CVA is donor-funded, project-based, and designed to respond rapidly to shocks rather than provide long-term income security.

Understanding how these two systems have evolved over time is essential to contextualizing current gaps, overlaps, and reform efforts.

Prior to 2019 Financial Crisis

Prior to the 2019 financial crisis, Lebanon's social protection system was characterized by limited coverage and strong reliance on contributory schemes tied to formal employment. The National Social Security Fund (NSSF), established in 1963 and operational since 1965, served as the core SP institution for private-sector workers, providing health coverage, family allowances, and end-of-service indemnities. However, it did not provide a monthly pension, and large segments of the population, including informal workers, agricultural workers, and many women, were excluded. Old-age pensions were available almost exclusively to civil servants and security forces, covering only around 10% of the labor force.[25] Advocates and development professionals in Lebanon have increasingly promoted a rights-based, shock-responsive approach to reforms in the SP sphere [26, 27], with particular attention to the needs of older persons[26, 27]. This momentum stems from the fact that Lebanon's SP system has faced longstanding structural gaps, most notably lacking child benefits, comprehensive disability allowances[1], and old-age pensions[20].

Humanitarian CVA, meanwhile, was largely focused on refugee populations following the Syrian displacement crisis, with limited linkage to national SP systems.

2019–2020: Financial collapse and expansion of humanitarian cash

The 2019 financial crisis marked a critical turning point. Currency devaluation, banking restrictions, and rising unemployment eroded household incomes and savings, including NSSF end-of-service indemnities and pensions. The subsequent COVID-19 pandemic and the Beirut Port Explosion in 2020 compounded these pressures.

During this period, humanitarian CVA expanded significantly as the primary mechanism to meet basic needs. UNHCR, WFP, and NGOs scaled up multipurpose cash assistance and food or cash-based support to address acute vulnerability among refugees and increasingly among vulnerable Lebanese households[58]. At the same time, the crisis exposed longstanding structural weaknesses in Lebanon's SP system and intensified policy discussions around the need for a national social safety net.

2021–2022: Institutionalizing cash-based social assistance

In response to the protracted crisis, Lebanon began to move toward institutionalizing cash assistance within a national SP framework. The most established of these is the National Poverty Targeting Program (NPTP)[17], Lebanon's first national social safety net for people below extreme-poverty line, which provides unrestricted monthly cash transfers not tied to specific foods or services[14, 17]. This was complemented in 2022 by the Emergency Social Safety Net (ESSN) project[15], also known as AMAN program, launched by the Presidency of Council of Ministers (PCM) in partnership with the World Bank, which built on and expanded the NPTP coverage to an additional 168,000 poor and vulnerable Lebanese households streamlined through the fully digitized DAEM Social Registry[15, 37]. The Public Sector Cash Scheme (PSCS) and the Broad Coverage Cash Transfer program (BCCT) are two other schemes that have been created but lack funding[36].

2023: Policy reform momentum and lifecycle approaches

The year 2023 marked renewed momentum toward lifecycle-based and rights-based SP reform. In December 2023, the Lebanese Parliament passed Law 319, reforming the NSSF's end-of-service indemnity into a formal pension system **Non-contributory social pensions in other contexts**

[1] A National Disability Allowance was established in April 2023 to support circa 26,000 persons with disabilities and is a life-cycle rights-based SP program.

Non-contributory social pension have been successfully introduced, expanded, or assessed for feasibility across various countries, such as Bolivia, Bangladesh, Mexico, Peru, Philippines, and Uganda[52], [65]. For example:

- The role of a functioning social protection system, financed through effective taxation, in meeting these needs was highlighted in a trial of the expansion of **Bolivia's** social pension, which showed that older persons who received the pension saw significant increases in consumption, with reduced self-perceived and official poverty rates[52].
- The rapid transformation of **Mexico's** social protection landscape led to surge in pension coverage from 22 percent in 2000 to 88 percent in 2013, largely as the result of the proliferation of non-contributory schemes rather than earnings-related reforms[68].
- In **Bangladesh**, a Universal Pension Scheme was introduced in 2023 as "a pathway to self-sustained retirement for citizens." It encompasses even those with lower earnings to prepare for a self-sustained retirement within their financial capabilities[69].
- An analysis of the feasibility of a universal social pension in the **Philippine** highlighted that a universal social pension would not only eliminate targeting errors and administrative burdens linked to means testing but would also serve as a powerful tool for poverty reduction, potentially lowering the national poverty rate by up to three percentage points if a benefit of PhP 2,000 were introduced[70].

The reform aims to ensure income security, healthcare access, and protection from poverty and exclusion in old age[28], [30]. The NSSF is critical component of Lebanon's SP system particularly as pertains to end-of service indemnity, pensions, and healthcare coverage; however, even prior to the 2019 financial crisis, the NSSF faced significant gaps, and following the crisis, the NSSF now owes citizens arrears[61].

In parallel, a National Disability Allowance (NDA) was introduced in April 2023 as a life-cycle, rights-based program, its first phase has been limited to around 20,000 young persons with disabilities (ages 18–28) who hold a Personal Disability Card and receive a monthly transfer of US$40 for 12 months. More expansions have been announced since, including the 2025 expansion announcement to include eligible Lebanese persons with disabilities born on or before 1960[53]. The allowance is linked to the Personal Disability Card issued by the Ministry of Social Affairs' (MoSA) Rights and Access program that still relies on a "medical" definition of disability rather than a social one, focusing on diagnoses and impairments[54], [55]. Linking eligibility to the card significantly restricts coverage[2], as not all people with disabilities possess one, and older people in particular could remain excluded. If an older person's functional limitations don't neatly fit a listed medical category or if they view their disability as "just old age", they may not get certified.

Figure 1: Policy reforms for older persons in Lebanon

- 2024 Pension Law: Transforms the NSSF from end of service indemnity scheme into comprehensive pension system
- National Social Protection Strategy: Lebanon's first national strategy for social protection covering beyond the formally employed
- National Strategy for Older Persons: Developed to advocate for universal old age pensions not tied to employment

[2] Lebanon still defines disability based on an outdated 1980 WHO impairment classification (165 specific conditions), instead of the modern International Classification of Functioning (ICF) framework. Lebanon still defines disability based on an outdated 1980 WHO impairment classification (165 specific conditions), instead of the modern International Classification of Functioning (ICF) framework. This medical model treats disability as an individual defect to be "fixed" or cured, in contrast to a rights-based/social model that considers barriers in the environment. As a result, official statistics show an extremely low disability prevalence; only 2.6% of the population are registered PDC holders, far below the 10–15% expected by international standards. The narrow, impairment-focused criteria of Law 220/2000 thus limit who qualifies for the card.

The same period also saw the adoption of the National Social Protection Strategy (NSPS), articulating an ambitious vision to transition Lebanon's fragmented system toward a more universal, coordinated, and shock-responsive SP framework.

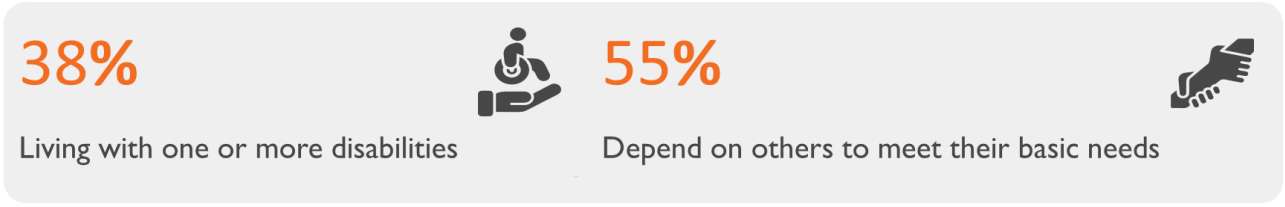
2024–2025: Consolidation and strategic direction for older persons

As of 2024–2025, reform efforts have focused on system consolidation and institutional strengthening. ESSN announced plans to further develop the DAEM Social Registry into a comprehensive SP information system, enabling households to apply to multiple programs, access financial inclusion products, and strengthen trust in government-to-person payments[38].

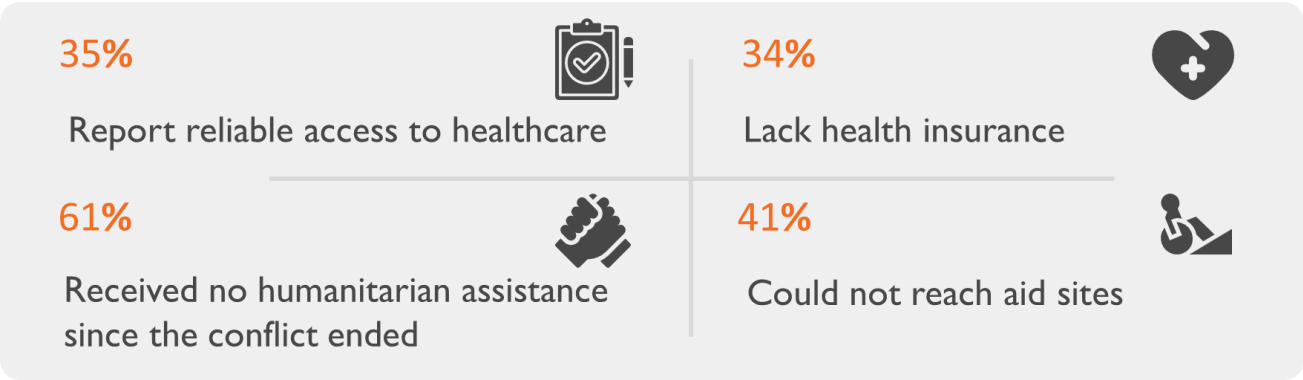
Alongside these developments, the National Strategy for Older Persons (2020–2030) takes a broader rights-based stance, calling for a universal old-age pension as an entitlement not tied to employment status[29, 31, 32]. Developed by the MoSA in partnership with UNFPA, ESCWA, and the Center for Studies on Aging in Lebanon, the strategy reflects a policy vision that extends protection to marginalized and unsecured older people[29, 31]. Its Action Plan aligns with the Madrid International Plan of Action on Ageing and the 2030 Agenda (SDGs 1, 3, 5, 8, 10, and 16), strengthens coordination among institutions, civil society, and donors, and ensures systematic follow-up on interventions to safeguard older persons' rights and wellbeing[32].

While the previous section outlined the evolution of social protection and cash assistance frameworks in Lebanon, evidence from this study and recent assessments indicates that these systems remain insufficient in addressing lifecycle vulnerabilities, particularly for older persons and persons with disabilities. The findings below examine how limitations in coverage, design, and delivery translate into exclusion and unmet needs.

While older people comprise approximately 11% of the population, expected to more than double by 2025, reaching 27.1%[57], they remain systematically underserved by social safety nets. Recent assessments confirm that only a small fraction benefits from these schemes, and even then, they face complex, fragmented processes that fail may not always to consider their specific needs[21, 22, 23]. Following the Israeli aggression on Lebanon, a needs assessment found that only 17% of older people reported receiving humanitarian cash assistance, and just 8% benefited from SP or state-provided social protection or other public benefits[25]. These gaps are particularly pronounced in rural and conflict-affected areas, such as in southern Lebanon, where the absence of structured SP leaves older people particularly exposed.



In Lebanon, nearly half of one-person households are older persons, mostly widows, with about 13% of older people living alone[34]; many continue to work informally beyond retirement with no pension coverage. Evidence also highlights malnutrition among residents of nursing homes[33], particularly those without jobs, underscoring the weakness of existing financial, social, and healthcare policies. The most acute needs identified include affordable long-term healthcare, emotional companionship, and domestic support[34], while emergency programs remain insufficient and exclude many. Consequently, around half of Lebanon's older population now relies on family remittances and external support to meet their basic needs[25].



Older women in Lebanon face greater poverty (15.4% vs. 13% for men), higher illiteracy (53% of women 85+ vs. 30% of men), and lower economic participation in old age (only 4.1% of women 65+ work compared to 25.1% of men)[39]. They are also disproportionately caregivers, with care work undervalued and burdens highest among women with fewer resources and support[41]. At the same time, women make up 67% of institutionalized older persons, reflecting their heightened vulnerability as they suffer more from isolation and neglect [25, 40]. These intersecting inequalities underscore the need for gender-responsive SP and person-centered long-term care systems.

Advocates and development professionals in Lebanon have increasingly promoted a rights-based, shock-responsive approach to reforms in the SP sphere [26, 27], with particular attention to the needs of older persons[26, 27]. This momentum stems from the fact that Lebanon's SP system has faced longstanding structural gaps, most notably lacking child benefits, comprehensive disability allowances[3], and old-age pensions[20]. While a National Disability Allowance (NDA) was introduced in April 2023 as a life-cycle, rights-based program, its first phase has been limited to around 20,000 young persons with disabilities (ages 18–28) who hold a Personal Disability Card and receive a monthly transfer of US$40 for 12 months. More expansions have been announced since, including the 2025 expansion announcement to include eligible Lebanese persons with disabilities born on or before 1960[53]. The allowance is linked to the Personal Disability Card issued by the Ministry of Social Affairs' (MoSA) Rights and Access program that still relies on a "medical" definition of disability rather than a social one, focusing on diagnoses and impairments[54, 55]. Linking eligibility to the card significantly restricts coverage[4], as not all people with disabilities possess one, and older people in particular could remain excluded. If an older person's functional limitations don't neatly fit a listed medical category or if they view their disability as "just old age", they may not get certified.

The old age pension also faces significant gaps in coverage, with the existing state pension only available for civil servants and security forces, covering just 10% of the labor force[25].In light of these shortcomings, three major initiatives have emerged: **the 2023 Pension Law (Law 219)**[28], the first **National Social Protection Strategy (NSPS),** committing to an ambitious vision to transform the existing social security system into a more universal one and the **National Strategy for Oder Persons (2020–2030)**[29]. The new Pension Law mandates the transformation of the NSSF retirement scheme from an end-of-service indemnity to a comprehensive pension system[30]. The reform aims to ensure income security, healthcare access, and

[3] A National Disability Allowance was established in April 2023 to support circa 26,000 persons with disabilities and is a life-cycle rights-based SP program.

[4] Lebanon still defines disability based on an outdated 1980 WHO impairment classification (165 specific conditions), instead of the modern International Classification of Functioning (ICF) framework. Lebanon still defines disability based on an outdated 1980 WHO impairment classification (165 specific conditions), instead of the modern International Classification of Functioning (ICF) framework. This medical model treats disability as an individual defect to be "fixed" or cured, in contrast to a rights-based/social model that considers barriers in the environment. As a result, official statistics show an extremely low disability prevalence; only 2.6% of the population are registered PDC holders, far below the 10–15% expected by international standards. The narrow, impairment-focused criteria of Law 220/2000 thus limit who qualifies for the card.

protection from poverty and exclusion in old age[28, 30]. However, despite its ambition, eligibility remains restricted, as coverage is limited to private sector workers registered with the NSSF for more than 15 years[24, 28, 30].

The National Strategy for Older Persons (2020–2030) takes a broader rights-based stance, calling for a universal old-age pension as an entitlement not tied to employment status[29, 31, 32]. Developed by the MoSA in partnership with UNFPA, ESCWA, and the Center for Studies on Aging in Lebanon, the strategy reflects a policy vision that extends protection to marginalized and unsecured older people[29, 31]. Its Action Plan aligns with the Madrid International Plan of Action on Ageing and the 2030 Agenda (SDGs 1, 3, 5, 8, 10, and 16), strengthens coordination among institutions, civil society, and donors, and ensures systematic follow-up on interventions to safeguard older persons' rights and wellbeing[32].

RATIONALE

This research seeks to fill a persistent evidence gap with nuanced, actionable data that can enable actors and stakeholders to inform the development of recommendations that would help relevant stakeholders (e.g., donors, cash and SP implementers, government stakeholders and policy makers) to redesign CVA and SP programs that are not only inclusive but dignifying, accessible, and sustainable for Lebanon's older population. It goes beyond a diagnostic of exclusion by:

- Capturing the lived experiences of Lebanon's ageing population
- Surfacing the psychosocial, emotional, and relational barriers which are often invisible in standard assessments (e.g., shame, dependency, or confusion linked to digital and bureaucratic systems).
- Generating practical recommendations for age- and gender-responsive CVA design, improved outreach mechanisms, more equitable targeting criteria, and the development of a social pension.

C. Research Purpose and Scope

The primary objective of this research is to explore the perspectives and lived experiences of the most vulnerable older Lebanese persons in relation to CVA and SP schemes, with the aim of informing the design of more effective, inclusive, and accessible programming. Specifically, the research was guided by the following secondary objectives:

- **Exploring the pillars of accessibility, inclusiveness, appropriateness, and flexibility** of CVA and SP programs towards older persons from their experience and perceptions, examining the barriers faced, including ageism, gender, chronic disease, disability, transportation, caregiver/family orientation, cultural bias, and lack of information regarding humanitarian systems and national systems in Lebanon.
- **Identifying the extent to which older people benefit from** current SP schemes and humanitarian CVA programs, including ongoing assistance, government-provided assistance, and one-time assistance in the past year.
- **Studying the effectiveness and sustainability of CVA and SP programs** based on expert opinions, existing literature, and from users' perspectives and compared to that of non-users.
- **Emphasizing use of a gendered lens** to further identify the challenges and experiences of the most vulnerable older persons.
- **Identifying the practices indicated as best practices** by older persons and stakeholders working with/on SP programs for accurately assessing their needs, addressing information gaps and enhancing targeting mechanisms to reach those most in need of cash assistance.
- **Generating insights and recommendations** originating from older persons' perspectives and validated by stakeholders working with/on SP programs that can inform the design and implementation of more inclusive and accessible CVA and SP initiatives for older persons in Lebanon.

D. Research Design and Methodology

STUDY SCOPE AND POPULATION

This study was intentionally designed to focus exclusively on individuals aged 60 and above, allowing for an in-depth examination of older persons' lived realities, needs, and perceptions in relation to CVA and SP systems. This age-specific focus ensures that the analysis generates targeted, policy-relevant insights for a population group that is often underrepresented in research and policymaking. Accordingly, the findings are grounded in older adults' experiences and are intended to inform age-responsive policy and program design, rather than to represent generational comparisons across age groups.

RESEARCH QUESTIONS AND MATRIX

We have developed a list of nine key Research Questions (RQs) (Table 1), focusing on three research domains:

1. Older persons' perceptions of CVA and SP schemes
2. Barriers to older persons' access and engagement
3. Needs, programmatic gaps, and solutions/recommendations

Ultimately, by answering these RQs, this study aims to inform policy and programming through capturing the insights generated by older persons' lived experiences, highlighting key recommendations around:

- How cash assistance programs and advocacy efforts in Lebanon can be tailored to better serve the specific needs and preferences of older persons in a more accessible, inclusive, and sustainable manner, including the assessment and understanding of their needs and preferences.
- How a gender and disability lens can be applied to the design of future CVA and SP programs to better meet the needs of older women and other marginalized groups (such as older people with disabilities, chronic diseases, and/or who either live in isolation or are internally displaced).

Table 1: Research Questions

Research Domain	Research Questions (RQ)
1: Perceptions of CVA and SP	RQ 1.1: To what extent do older persons engage with or benefit from existing CVA programs and SP schemes?
	RQ 1.2: How do perceptions and experiences of older persons regarding humanitarian systems and national SP systems influence their willingness and ability to access available assistance programs?
	RQ 1.3: How do older persons perceive the adequacy, accessibility, and effectiveness of cash assistance and SP programs in meeting their diverse needs?
2: Barriers to Access	RQ 2.1: What are the structural and social barriers that prevent older persons from participating in CVA programs and SP schemes?
	RQ 2.2: What are the gendered challenges faced by older women, particularly those in vulnerable situations (e.g., female-headed households, those with caregiving responsibilities, those who live alone with no caregivers), when accessing CVA and SP?
	RQ 2.3: What are the current gaps in outreach and targeting mechanisms, and how can they be improved to reach older persons?
3: Needs and Programmatic Gaps	RQ 3.1: What are the perceived needs of older persons (with intersecting identities) that could be supported or addressed through humanitarian cash or SP?

	RQ 3.2: To what extent do current cash assistance and SP programs meet the specific needs of older persons in terms of accessibility, inclusivity, flexibility, and sustainability? How are older persons coping without these needs fulfilled?
	RQ 3.3: What are the key challenges and gaps in the current SP landscape in Lebanon, particularly in relation to addressing the needs of older persons?

DATA COLLECTION METHODS

Methods

The research team has implemented primary data collection activities using a participatory approach that placed vulnerable older persons and, when relevant, their immediate caregivers (whether family members or hired care workers) at the center of the research. It relied on qualitative methods, including:

- **Key Informant Interviews (KII) with organizational representatives**: Remote KIIs with a range of stakeholders helped to inform the findings about the funding arrangements and options, design, delivery, and inclusivity of cash and SP programs for vulnerable older persons in Lebanon. The KIIs aimed to offer insights on the sustainability of CVA and SP programs and to provide recommendations on design and best practices to improve inclusivity, relevance, and effectiveness of these programs. The KIIs explored perceptions of accessibility, effectiveness, coordination, and systemic barriers impacting older persons' inclusion, while also identifying opportunities for improvement. Semi-structured interviews were used to facilitate open dialogue while ensuring comparability of responses (Annex II).
- **In-Depth Interviews (IDI) with older persons and their caregivers:** In-person IDIs served as a central qualitative method to capture the lived experiences of the targeted population, both recipients and non-recipients of cash and SP, as well as their caregivers. Using an inclusive, participant-centered approach, the IDIs explored how individuals navigate CVA and SP systems, including their awareness of available services, application processes, access barriers, and experiences of receiving, or exclusion from support. Interviews delved into preferences around receipt of assistance and perceptions of dignity, autonomy, and inclusion, with attention to gender, disability, and caregiving dynamics. Where required, caregivers were invited to join or support the interview process with older persons, based on participants' needs and preferences. Interviews were conducted in-person in spoken Arabic, using accessible, age-appropriate language to ensure participant comfort and comprehension.
- **Journey mapping:** INTEGRATED conducted journey mapping with four older persons who received assistance through SP (all receiving AMAN), following the IDIs. Journey mapping was used to visualize individuals' interaction with CVA and SP systems across key stages, including awareness, registration, eligibility assessment, access, use, and feedback. The outputs were used to construct detailed, anonymized journey maps of individuals' interactions with CVA and SP systems across these stages, with case-based insight to complement the broader study findings (Annex II).
- **Focus Group Discussions (FGD):** FGDs were used to gather collective insights and explore shared experiences among older persons. Discussions were facilitated in Arabic using inclusive, accessible language and culturally sensitive facilitation techniques tailored to older persons. FGDs explored community-level perspectives on the accessibility, fairness, and effectiveness of cash and SP programs, shared barriers, informal support mechanisms, and perceptions of dignity and inclusion. This method allowed the research team to surface collective narratives and group dynamics that enrich the study's understanding of systemic gaps and opportunities for more inclusive programming. Discussions were

facilitated in Arabic using inclusive, accessible language and culturally sensitive facilitation techniques tailored to older persons.

Sampling and data collection approach

Fieldwork reflected geographic, gender, and vulnerability-based diversity. The research team relied on ongoing engagement with local organizations to draw appropriate samples and to ensure cultural sensitivity and contextual relevance. The table below summarizes our sampling approach. We relied on purposive, stratified sampling, with support from CAMEALEON and pre-identified local organizations to target older persons who were recipients and non-recipients of CVA or SP. Participants were all **Lebanese men and women aged 60 or above or are direct caregivers to older persons**. Recipients were identified as people who were currently receiving cash assistance or SP or who had received it in the past year.

Based on consultations with local partners, the following priority governorates were identified to ensure that the research covers a range of areas across the country:

1. Bekaa (Mashghara and surrounding areas), facilitated by Amel Association and Sada Bekaa
2. Beirut and Mount Lebanon (BML), facilitated by Amel Association and the Order of Malta Lebanon
3. North Lebanon (Tripoli and surrounding areas), facilitated by the Institute for Development, Research, Advocacy, and Applied Care (IDRAAC)
4. South Lebanon (Tyre and surrounding areas), facilitated by Imam Sadr Foundation (ISF)

The above locations reflected community center locations where local organizations could support conducting interviews and FGDs. Participants were given the option to attend IDIs at a selected center or to have the interviews take place in their homes, if they were comfortable doing so. All participants chose to be interviewed at local organizations' centers. The research team provided them with a transportation reimbursement fee of US $10.

Across all four governorates, we conducted a total of **37[5] IDIs and 8 FGDs.** Additionally, we completed a total of **12 KIIs with 13 key experts**, including MoSA representatives, NGO representatives, and experts with thematic knowledge related to SP and/or the provision of services to older persons in Lebanon. All data collection was completed between 26 September 2025 and 31 October 2025.

Table 2: Data collection methods and target groups

Method and Target Group		Total conducted	Geographic breakdown
IDIs	Older persons who are recipients of CVA or SP	6 (2F; 4M)	Bekaa: 2 (2M) BML: 3 (1F; 2M) South Lebanon: 1 (1F)
	Older persons who are not CVA or SP recipients	21 (14F; 7M)	Bekaa: 3 (3F) BML: 12 (8F; 4M) South Lebanon: 3 (1F; 2M) North Lebanon: 3 (2F; 1M)
	Caregivers of older persons who are recipients of CVA or SP	4 (3F; 1M)	Bekaa: 1 (1F) BML: 1 (1F) South Lebanon: 2 (1F; 1M)

[5] We completed a total of 39 interviews. However, two respondents were of Syrian nationality and findings from those interviews were thus not relevant to this study.

Method and Target Group		Total conducted	Geographic breakdown
	Caregivers of older persons who are not CVA or SP recipients	6 (6F)	Bekaa: 2 (2F) BML: 1 (1F) North Lebanon: 3 (3F)
	Total	**37 (25F; 12M)**	**Bekaa: 8 (6F; 2M)** **BML: 17 (11F; 6M)** **South Lebanon: 6 (3F; 3M)** **North Lebanon: 6 (5F; 1M)**
FGDs	Older persons	8 (4F; 4M) with a total of 22 women and 22 men	Bekaa: 2 (1F; 1M) BML: 2 (1F; 1M) South Lebanon: 2 (1F; 1M) North Lebanon: 2 (1F; 1M)
KIIs	Key experts	12 with 13 key experts	N/A

The research team conducted Journey Mapping with **four IDI participants who are recipients of AMAN**, purposively selected to reflect different profiles. Journey Maps can be found in Annex III, attached as a separate file.

Rationale for sample selection

As this study aimed to gather in-depth data on the lived experiences of older persons in Lebanon, CAMEALEON and Integrated agreed to adopt a focused, qualitative approach. Given the absence of a database to facilitate sampling of CVA recipients, participants were identified in collaboration with local partners using purposive sampling.

Existing literature broadly identifies community members aged 60 and older as falling under the category of older persons. In consultations with key experts, there was also a consensus that this age category was appropriate[6]. As such, and to maximize comparability of results, our sampling is selected for individuals aged 60+. Sampling also ensured representation of older persons based on the following key criteria:

- At least 50% women
- Recipients are the ones currently receiving cash assistance or SP or received it in the past year[7]
- Representation of older persons with disabilities or chronic illnesses[8]
- Representation of older persons who are living in social isolation or are neglected (e.g., older person headed household composed of one or two older persons)
- Representation of older persons approaching retirement, as well as those engaged in the informal sector

The study prioritized older persons receiving assistance directly in the form of humanitarian cash or SP; For humanitarian assistance, this should only be cash (not in-kind). For SP, this could take the form of recognized SP schemes (e.g., AMAN, NSSF, military or public sector pension) and other social safety nets.

[6] The age of retirement in Lebanon is 64.

[7] Limited to the past year to reduce recall bias.

[8] Due to the relatively high prevalence of disability and chronic illness in the older persons population, we have identified these characteristics as part of analysis, which found that most participants suffered from some form of chronic illness or disability. We did not provide a specific target for sampling to avoid oversampling.

LIMITATIONS

As this study relied exclusively on qualitative methods with a limited sample size, we faced the following limitations.

Non-generalizable conclusions and nuanced lived experiences: The study's focus was on highlighting perceptions and lived experiences of individual respondents, with analysis of patterns and trends where appropriate. However, due to the limited sample size and the largely purposive sampling approach anticipated, findings are not broadly generalizable. Rather, the study aims to provide an in-depth analysis of these individuals' experiences and perceptions, as experts of their own realities. Additionally, the study presents nuanced lived experiences that vary widely from one individual to another, shaped by intersecting factors such as gender, disability, and socio-economic background. **Mitigation Measure:** The research identified key profile characteristics across individual experiences and constructed profile archetypes (e.g. through the Journey Mappings) to reflect commonalities, support the transferability of findings, and highlight potential for broader applicability while respecting the diversity and subjectivity of participant voices. This allowed for nuanced interpretation without overextending conclusions.

Understanding of SP: Social protection is a complex topic that may be understood differently or to a limited extent by lay people. As such, not all research participants had a thorough understanding or comfortable grasp of the topic. **Mitigation Measure:** Questions were presented in as simple a manner as possible, and field researchers attempted to define SP in an approachable manner throughout the discussion to ensure mutual understanding and to maximize the usefulness of inputs.

Sampling limitations: The sampling framework above notes that we relied on purposive sampling with the support of local partners to identify IDI and FGD participants. This included snowball sampling, to ensure that we are able to reach additional community members, particularly those living in isolation. As a result, this may introduce some bias to the results. **Mitigation Measure:** Within the objective of this study, the research team highlighted that the aim of the findings is to highlight the lived experience of individuals, and as such, this element of bias is inherent to the expected results.

Age-focused findings: The study exclusively targeted individuals aged 60 and above, which means that the findings primarily reflect the realities, needs, and perceptions of older persons. While this focus provides critical insights into a group that is often underrepresented in research and policymaking, it also limits the applicability of results to younger demographic groups who may experience social protection and CVA systems differently. Therefore, the conclusions should be interpreted within the context of older adults' lived realities and may not fully capture generational differences in access, expectations, or barriers.

ETHICAL CONSIDERATIONS

Safeguarding, protection, and Do No Harm

The study adhered to the humanitarian and research ethics principles of Do No Harm. Particular attention was given to the vulnerabilities of older persons in Lebanon, many of whom may face poverty, mobility challenges, or social isolation. All interactions with participants were conducted with respect, sensitivity, and without coercion. Interviewers were trained to recognize signs of distress and pause or stop interviews if participants showed discomfort. Field researchers were trained to provide participants with information about available support services and referral pathways where relevant. Safeguarding protocols ensured that no participant is exposed to physical, psychological, or reputational risk as a result of participation.

CAMEALEON conducted two training sessions for field moderators, ensuring a mutual understanding of Protection and Safeguarding principles.

Informed consent

All participants were fully informed about the purpose of the study, what their participation involved, and their rights, before the interview began. Information was provided in clear and accessible language (Lebanese

Arabic). Consent was voluntary, and participants were given the option to decline to answer specific questions or withdraw from the interview at any time without any consequences. Verbal consent was obtained and documented. Explicit consent was also sought for audio recording, and interviews were only recorded where that consent was received. For FGDs, audio recording only took place with the unanimous consent of participants.

Field protocols

Interviews were conducted in locations that were safe, comfortable, and convenient for participants, ensuring privacy and dignity. The timing of interviews took into account participants' schedules, mobility needs, and health conditions. Researchers adopted a respectful and empathetic approach, avoiding technical jargon or intrusive questioning. Interviewers worked in pairs where possible, to support safety and data quality, and followed a code of conduct that emphasized neutrality, non-judgement, and cultural sensitivity. No safeguarding or protection concerns were identified during data collection.

DATA SECURITY AND CONFIDENTIALITY

All data collected has been treated as strictly confidential. Personal identifiers were not included in transcripts, notes, or analytical outputs. Data has been anonymized and stored securely on password-protected devices and encrypted storage systems, accessible only to the core research team. Hard copies were stored in locked cabinets and destroyed after digitization. Audio recordings were deleted once transcriptions were complete. Data will not be shared with third parties in a form that could identify individual participants. Findings have been reported in aggregate form to protect the anonymity of respondents.

E. Findings

ACCESSIBILITY

Awareness and information sharing

Key findings:

- Most older persons participating in this study who receive SP were reached through door-to-door government outreach or through information shared on social media, particularly WhatsApp.
- Outreach and communication about aid programs shared through SMS, municipalities, or local NGOs was found to be inconsistent. Many older people, especially those isolated or digitally excluded, remain unaware of available assistance.
- Trust deficits are widespread. Older participants expressed deep skepticism toward municipalities and official actors, citing perceptions of favoritism and a lack of feedback after assessments as major causes of disengagement.
- Digitalization and reliance on social media further marginalize older adults. Platforms like Facebook and WhatsApp serve as informal information sources but are also rife with misinformation, creating confusion and eroding perceptions of the credibility of shared information about SP.
- Physical isolation and mobility constraints severely hinder access to information and registration processes. The absence of consistent field presence or home-based outreach leaves home-bound or older persons with disabilities invisible to aid systems.
- Outreach efforts remain short-term, project-based, and underfunded for both SP and humanitarian cash. Once donor-funded projects end, communication and follow-up mechanisms collapse, highlighting the urgent need for sustainable, community-embedded, and multisectoral outreach systems.

Awareness:

Awareness of National Social Protection Frameworks

At the institutional level, MoSA highlighted ongoing efforts to raise awareness and expand outreach around national social protection programs, alongside constraints that have limited their effectiveness. Representatives from MoSA emphasized that AMAN was widely promoted during periods of crisis, including COVID-19 and the economic collapse, when large numbers of households applied for assistance through nationwide registration drives while pointing out that some structural constraints have limited the effectiveness of these efforts, including incomplete and outdated data systems, funding reductions, and the deprioritization of outreach and information-sharing activities. As one MoSA representative reflected: "*We assumed that people were aware of the programs, especially AMAN, because of the scale of registration during the crisis. But deprioritizing outreach and information-sharing due to funding constraints was a mistake. Outreach is critical, particularly for vulnerable groups such as older people and persons with disabilities.*"

World Bank project documentation for the deployment of the ESSN Project indicates that communication and outreach activities, including stakeholder engagement and information disclosure, are core components of the project's design, reflecting recognition at the strategic level of the need for improved awareness and engagement mechanisms[58, 59].

While the National Strategy for Older Persons (2020–2030) establishes a rights-based policy framework at the national level, findings from this study suggest that its objectives have not translated into widespread awareness among older persons at the community level. **Across all interviewees, there is a consistent lack of awareness among older persons regarding formal, national-level SP frameworks**. This is not just a gap in knowledge about specific services, but a complete disconnection from the high-level strategic planning. Interviewees, for example, repeatedly stated they were "*not aware of the new pension law and a*

National Strategy for Older Persons (2020–2030)." Only two FGD participants, out of all older persons interviewed as part of this study, reported any knowledge at all of the new pension's law or national strategy; however, they reported that they did not trust that these would be effectively operationalized.

"The state, where is the state? I don't know anything about this aid." Female participant, Mount Lebanon.

Key experts confirm that this is a widespread issue, with one stating: "*Many older persons don't even know about these programs,*" before posing the critical questions: "*How much do they know about these programs? How much do they know about their own rights?*" This highlights a fundamental gap, suggesting that older people are not being engaged as rights-holders within a national system, but only as potential recipients of ad-hoc aid.

"*I heard that we have an ambition to be like foreign countries to take care of older persons in all aspects of their lives.*" Female participant, Bekaa

When any awareness does exist, it is not about a comprehensive system but about a few specific, tangible SP programs, most frequently AMAN. However, even their knowledge of AMAN is generally clearly fragmented and incomplete. One participant "*only knows of AMAN as an active organization*," while another, despite being aware of AMAN, was unaware of MoSA's disability card program. This pattern indicates that awareness is program-centric and likely tied to what is being visibly distributed in their immediate community, rather than a broader understanding of available entitlements. This is further complicated by a lack of clear information, with one SP expert noting that: "*Misunderstandings about program eligibility and benefits structure are common even among those who have heard of a program.*"

None of the older persons interviewed, including those residing in North Lebanon, had heard of the "Older People Friendly City" initiative, despite its public launch as a MoSA pilot in Zgharta in 2017[9]. This further illustrates the deep disconnect between national-level planning and community-level awareness. Although the Zgharta pilot predates the National Strategy for Older Persons, the Strategy later formalized similar objectives under its fifth axis on creating a safe, supportive, and age-friendly physical environment, which emphasizes promoting and developing urban and rural environments, including public buildings, outdoor spaces, transportation, and housing, that take into account the needs of older people. Reflecting on the limited follow-through of the pilot, one expert recalled, "*There was an initiative… and they were very happy about it… but nothing has been done since.*"

Awareness of Humanitarian Aid Programs

Similarly, **awareness of humanitarian aid programs among older persons is generally low, and fragmented**. Unlike national strategies, where only a very small number of participants noted knowledge of their existence, certain humanitarian programs, particularly those run by entities like Amel Association and the Red Cross, are recognized because their services are visible and localized; for instance, an interviewee in South Lebanon received Red Cross cash payments during displacement. Participants in South Lebanon and the Bekaa were relatively more aware of the different forms of emergency assistance provided both by the government and by NGOs during the 2024 Israeli aggressions on Lebanon[10]. Additionally, participants in Beirut noted awareness of emergency assistance provided to them following the 2020 Beirut port blast. Most, however, were unable to differentiate between what came from the government and what came from other actors. Interviewed experts noted that, during crises like the Beirut blast or border hostilities, organizations attempted to adapt by using mobile units and WhatsApp communication, reflecting efforts to reach isolated older persons. Yet, even when assistance reaches people, emergency programs tend to cover only fragments of needs and are often delivered as in-kind aid that does not match people's preferences or contexts. As one

[9] The "Older People Friendly City" initiative was launched in 2017 by Lebanon's Ministry of Social Affairs (MoSA) as a pilot project in Zgharta, aiming to promote inclusive urban environments for older persons. It involved developing a national guide on age-friendly cities and engaging local stakeholders in planning discussions. However, no concrete steps toward implementation were reported following the pilot phase.

[10] This was expected, as populations in South Lebanon and Bekaa were more affected during the 2024 Israeli aggressions.

participant noted: "*Some people were given hot meals and didn't want them; they told us: 'Only give us the means and we will cook ourselves."*" This issue is especially relevant for older people, who often rely on specific dietary restrictions due to chronic illnesses and deteriorating health, making unsuitable in-kind food assistance ineffective or even harmful.

A significant finding is the confusion between temporary humanitarian cash assistance and formal government entitlements or SP. Temporary NGO cash programs are sometimes mistaken for official support, or beneficiaries lack the context to distinguish them. Awareness of cash assistance is highly project-based and short-lived, with one participant noting that after the port explosion, some NGOs came and helped; but for the last two years, aid and support have halted. This fleeting nature prevents awareness from becoming entrenched knowledge. Furthermore, the reliance on word-of-mouth means that essential details about eligibility criteria are often lost or distorted, leading to the perception that organizations "*choose people based on appearance...*" or favoritism, rather than need.

Information sharing and outreach:

Older persons' access to information and inclusion in targeting mechanisms remain largely incidental rather than systematic. Most outreach strategies rely on existing program beneficiaries or pre-registered service users rather than proactive identification, meaning that the most vulnerable, particularly homebound, isolated, or digitally excluded older people, are often missed. At the same time, social and community networks are frequently cited by practitioners as an important channel for reaching people quickly in the absence of formal systems, particularly in crisis contexts. However, reliance on these networks can function as a double-edged sword, facilitating access for some while reinforcing exclusion for others.

NGO workers repeatedly told the research team that outreach through health centers captures only those already engaged in services, while others "non-clients" remain invisible due to the absence of a centralized database or standardized tools/vulnerability criteria. For example, for some NGOs, medical staff or local volunteers at the level of the Primary Health Care Centers (PHCCs) help identify the poor informally, relying on personal knowledge - "*know who is poor in their community*" - rather than systematic data collection. As one NGO worker explained: "*Access to aid often depends on informal networks, community nurses, or word of mouth, which can result in unequal access and favoritism toward those who are socially well-connected.*" Adding to that, a major accessibility issue also arises from the absence of a centralized, user-friendly information system for service mapping. As a result, many older people do not know who offers what services or how to access them. These findings were echoed during several focus groups, including a focus group discussion with older women in Tripoli, where participants expressed a shared perception of weak and informal outreach mechanisms, stating: "*We learn through people, not organizations*" and "*We call each other and inform each other*" (Female FGD participants, North Lebanon)

These gaps are further compounded by fragmentation and weak data coordination across humanitarian cash actors. A SP specialist noted that while there is extensive reporting through platforms such as ActivityInfo[11] and coordination through the Cash Working Group (CWG)[12], there is no comprehensive deduplication mechanism across programs. As she explained, *"There's a lot of reporting, but no centralized data… there's definitely a problem when it comes to deduplication."* While recent strides have been made in coordinating multi-purpose cash assistance and developing common guidelines, referral systems remain uneven, particularly within protection-focused programming. One NGO worker highlighted that "*there's a great need… but there's no*

[11] ActivityInfo is an online platform used in Lebanon's humanitarian response to support coordination and reporting by mapping activities and geographic coverage across actors. While it supports transparency and coordination at the operational level, it does not function as a beneficiary-level registry or deduplication system.

[12] The Cash Working Group (CWG) is an inter-agency coordination mechanism in Lebanon that brings together humanitarian actors implementing cash and voucher assistance to align approaches, share information, and develop common guidance, including on transfer values and program design.

consolidated platform. Each organization does something on its own, and beneficiaries must go here and there to find who is offering what."

In practice, this fragmentation results in geographical and programmatic disparities, with some areas and households overserved while others remain excluded, particularly in rural or conflict-affected regions. As one FGD participant from Bekaa noted: "*we have someone in the neighborhood who takes support and cash from a minimum of 4 organizations, while others are not getting anything.*"

At the same time, experts cautioned that the absence of deduplication does not always imply inefficiency, as different cash programs are often designed to address distinct vulnerabilities and needs. *"Just because a household is receiving multi-purpose cash assistance doesn't mean they're not facing other protection risks… different programs target different vulnerabilities."* In practice, however, the lack of integrated data systems and clear information pathways continues to limit transparency, complicate targeting, and weaken older persons' understanding of available assistance.

Vulnerability: الهشاشة

Definition: Vulnerability refers to a person's heightened exposure to social, economic, or health-related risks that limit their ability to cope with shocks or sustain well-being[67].

Contextual framing: Among older persons in Lebanon, vulnerability is shaped by multiple, overlapping factors, including age, chronic illness, disability, gender, isolation, and loss of income or savings. It reflects both individual conditions (such as health or mobility limitations) and structural barriers (such as gaps in SP systems, economic instability, and exclusionary targeting criteria). With the protracted crisis context, the vulnerability among older adults has become more widespread. Many who were once financially secure, such as pensioners or former wage earners, lost their savings and purchasing power following the 2019 financial collapse.

The gap in information flow and targeting is rooted in broader structural and resource constraints. NGOs and service providers described their outreach capacity as project-based, temporary, and highly dependent on donor funding cycles: "*Since the outreach is based on project… once the project stops, the outreach work usually stops.*" This results in discontinuity of engagement and limits the sustainability of otherwise effective approaches. For example, a small-scale initiative combining mental health support, inclusion activities and accessible information tools[13] have shown promise but could not be sustained beyond the project period due to funding limitations and the absence of state-level coordination. NGO workers indicated that effective outreach requires consistency and mobility, through home visits and mobile units, to reach homebound or chronically ill older persons, yet these measures are rarely integrated as ongoing practices: *"Many older people are not on social media, so reaching them requires traditional channels like television or billboards. But effective awareness needs to be continuous, and that is very expensive."* In the absence of sustained funding, some organizations rely on indirect "*snowball*" dissemination through partner NGOs and frontline workers, which remains uneven and insufficient for systematic outreach to older persons.

"*They were asking in the street 'who here is poor?' and people directed them to my house*" Male participant, Bekaa

Government outreach mechanisms, particularly those under MoSA, were described as extensive in terms of institutional infrastructure, including coordination with over 200 partner organizations and 160 Social Development Centers (SDCs), key informants noted that coverage remains geographically inconsistent and that many isolated communities remain unreached. Moreover, MoSA acknowledges outreach and information-

[13] The Community-Based Rehabilitation (CBR) platform is an initiative developed by the Institute for Development, Research, Advocacy and Applied Care (IDRAAC) to map and share information on services available to persons with disabilities and older people across Lebanon's governorates. The platform incorporates accessibility features adapted to different types of disabilities, including visual impairments, and aims to improve service visibility, navigation, and dignity for vulnerable populations. See: https://cbr.idraac.org/p/about-us

sharing activities were deprioritized in recent years due to funding cuts, creating gaps in awareness and communication that are now being reconsidered under the new strategy[50]. As mentioned in previous sections of this study, the ministry's reliance on online registration through SDCs[14] and digital platforms further disadvantages older persons who are digitally illiterate or lack access to the internet.

From a program design perspective, government stakeholders acknowledged that the shift toward digitalized registration and information systems involved trade-offs between efficiency, scale, and accessibility. While digitalization was expected to streamline access and reduce the need for repeated in-person visits, existing evidence indicates that older adults remain particularly exposed to the digital divide due to lower educational attainment, limited digital skills, and constrained access to technology, limiting the intended accessibility gains of such systems[45]. A MoSA representative noted that digital exclusion had been explicitly discussed during the design and rollout of programs such as AMAN, emphasizing that digitalization itself was not viewed as inherently problematic but required complementary outreach measures to avoid excluding certain groups: "*Digitalization is not bad at all, but some groups face challenges related to it. Older people and hard-to-reach communities need more outreach services and awareness.*" However, interviewees also highlighted that such mitigation measures have remained uneven in practice, with outreach and mobility constraints continuing to limit access for older persons, particularly those who are homebound or living in remote areas.

Information and outreach remain the weakest link in both humanitarian and SP systems. Many older people cannot use or access digital systems, which have become the main channels for registration or learning about available assistance. While they struggle to navigate online forms, applications, and account setups due to limited digital literacy, many also lack access to digital devices and reliable connectivity. This digitalization of information sharing creates additional exclusion, particularly among older women. As one key informant explained: "*There is a predisposition that women won't have access… men are more likely to control phones, whereas women don't have the same access. The way we've spread awareness hasn't reached older people, particularly older women, whose networks are tied to their neighborhoods.*" Data from the 2022 GSMA Consumer Survey confirms this divide[62].

Figure 2: Mobile phone ownership disparities

The GSMA report highlights how digital inclusion is stratified not only by gender and age, but also by geography and mobility status (displacement), further marginalizing older women in remote or underserved areas. This structural digital divide is compounded by usage barriers, as access does not necessarily translate into meaningful engagement with digital platforms. As one Gender Expert explained, *"a lot of these older women, even if they have access to mobile phones, they don't use social media, they don't read what's on X, online news, the ministry websites or things like that*" These gaps between access, use, and information were echoed in some participants' lived experiences:

"*I don't have a mobile phone. I only have a landline, so that's how I can be reached*" Female participant, 82 years old, Mount Lebanon

[14] While Social Development Centers are physical, community-based facilities, the registration and follow-up process has digital layers, including online databases, SMS verification, and digital record-keeping.

"*In the past, I used to hear about these things through newspapers, but now WhatsApp; if I don't have their number, how will I know?*" Female FGD participant, 64 years old, Mount Lebanon

A relevant good practice comes from **HelpAge International's Hack Your Age! initiative** in Moldova, which paired young volunteers with older people to build digital skills and reduce social isolation during the COVID-19 pandemic. In 15 communities, youth trained older adults, most of them women, on how to use smartphones, access social services online, and stay connected via apps like WhatsApp and Viber. This intergenerational approach not only increased older persons' digital inclusion but also improved wellbeing and fostered mutual respect across age groups. The UN Economic Commission for Europe (UNECE) reinforces the value of such approaches, noting that digital exclusion is particularly acute for those aged 54–74, who risk being cut off from services and social interaction. They emphasize that digital inclusion among older persons contributes to inclusive education (SDG 4), healthy ageing, and community cohesion, recommending age-friendly, human-centric digital solutions and policies that promote intergenerational solidarity and recognize older people as active contributors to society.

Inter-generational and community support therefore remains key to accessing registration platforms and online announcements, as neighbors and relatives often help spread the word. This form of community-based diffusion is viewed by state actors as a positive mechanism, reflecting the ability of programs to reach communities organically in the absence of formal outreach systems. In fact, almost all interviewed older persons reported relying on word-of-mouth to receive information about programs.

However, this informal mode of information sharing also has clear limitations, as it often leads to misinformation or delays in registration, reinforcing a sense of unequal access and fueling widespread distrust in the system, frequently attributed to *wasta* (connections) and favoritism. The public's loss of trust, combined with the absence of a transparent targeting system, hinders effective delivery of social assistance.

"*This is how some people benefit. Some people have contacts that help them access benefits, and others don't.*" Female FGD participant, South Lebanon

"*They give by favoritism (maḥsoubiyyet). If you're from the area or know someone, you get it. If not, you don't.*" Female FGD participant, Beirut

"*If you go to the municipality… it's people who are well networked who get all of the available aid, while minorities or people at home are left behind.*" NGO representative

Barriers to access

Structural and procedural barriers:

Key findings:

- Older adults face compounded challenges in reaching services due to physical limitations, inaccessible infrastructure, and high transportation costs. These barriers prevent timely registration, follow-ups, or access to aid and healthcare.
- The introduction of online systems for government-led SP has helped to digitize registration, record keeping, and SP disbursement processes. However, the reliance on online systems for registration and updates has not eliminated access barriers for all older people and, for some, has shifted them from physical to digital forms, further marginalizing older persons lacking digital literacy, devices, or connectivity.
- Limited outreach and dependence on informal word-of-mouth channels contribute to misinformation, missed opportunities and loss of trust.

- Narrow vulnerability definitions, rigid documentation demands, and the opacity of tools like the Proxy Means Test systematically exclude older people, especially those without formal disability status or living in complex family arrangements.
- Disjointed approaches across municipalities, NGOs, and donors result in geographic and demographic inequities. Older persons newly impoverished by the crisis often fall through cracks due to outdated targeting formulas and inconsistent classification of household heads.
- Limited feedback, weak grievance redress, and lack of clarity around eligibility decisions further undermine trust and access, particularly for older persons facing mobility, digital, or confidence-related barriers.

A dense set of structural obstacles was highlighted by experts, civil society actors, and older people themselves. **Physical access was the most frequently mentioned barrier**, as many implied that their villages/ neighborhoods remain poorly served, with scarce, costly, and age- or disability-unfriendly transportation options preventing older persons from reaching aid centers or healthcare services. **Beyond these mobility challenges, limited transportation also contributes to social isolation**, particularly for those living alone or in remote areas with few community interactions, as noted by an NGO worker: "*once a week, there's a taxi driver that comes on Saturday morning to take the orders of what they (older people) want… and that's the only contact they have with someone who's not an older person.*" In addition to the lack of consideration for accessibility needs in urban planning, crowded and disorganized service sites further discourage attendance, with some participants emphasizing the opportunity cost of traveling long distances to register, renew aid or produce the required papers on time.

"*Couldn't afford travel to Zahle to renew my UN food voucher… then lost it.*" Female participant married to a Syrian, Bekaa

"*I am aware that in our country there is a lot of support services, sometimes I feel that I am forgotten. People don't see us maybe because our house is far, I don't know. We don't socialize much.*" Female participant, South

"*Inability to reach primary healthcare centers can limit access to critical services. People living in social isolation are often not reached. We also need to reach those on the fringes, but there are not enough organizations to do so.*" MoSA representative

As discussed earlier, while digital systems were intended to reduce the need for physical travel, they have not fully mitigated these barriers for older persons and, in many cases, have shifted access constraints from physical to digital forms. Some participants reported being aware of assistance through social media but unable to apply due to the cost and difficulty of in-person follow-up.

"*Who wants to know should go and ask, but it's not easy for us to go; transportation is expensive*" Female FGD participant, Mount Lebanon

Social Isolation: العزلة الاجتماعية

Definition: Isolation among older persons refers to a state of social and physical disconnection that limits contact with family, friends, and community life. It is often caused by mobility challenges, poor transportation, digital exclusion, and weak outreach systems, which prevent older adults from participating in social, economic, and community activities. Isolation may also result from widowhood, geographic remoteness, or the absence of nearby family support, leading to a decline in both mental and physical health.

Contextual framing: Social isolation is a critical yet often overlooked risk among older persons in Lebanon. Limited mobility, unaffordable transport, and the lack of age-friendly infrastructure restrict access to health services, aid, and social spaces. Because outreach relies on word-of-mouth and informal networks, those living alone or without family ties often remain invisible to data collectors, NGOs, and policymakers, excluded from surveys and registries. This creates a cycle of invisibility, where isolation leads to exclusion from assistance, and exclusion deepens isolation.

Community-based initiatives, such as neighborhood older persons' groups, weekly social gatherings, and WhatsApp peer support groups, have proven effective in breaking isolation, rebuilding confidence, and restoring social roles.

Administrative and procedural complexity form one of the most consistent and pervasive barriers across all sources of data. For many older people, even when they are aware of available assistance, the process of accessing it is often notably complex (Table 3). These challenges span documentation, registration systems, eligibility verification, and feedback mechanisms. Evidence from the literature similarly highlights procedural fatigue among older people, including difficulties securing appointments and prolonged waiting times at NSSF centers, which further discourage engagement with formal systems[44]. A recent HelpAge International needs assessment further found that many older persons face barriers related to inaccessible registration and feedback mechanisms, limiting their ability to apply for, follow up on, or contest assistance decisions[25]. KII respondents from NGOs and UN agencies repeatedly noted that older people lack awareness of where or how to register and are often unable to complete multi-step online forms[15] or meet the documentation requirements of donors or government programs.

"*Older people don't know how or where to register, and many don't have valid IDs or internet.*" NGO representative

Table 3: Barriers faced by older people in accessing SP; from registration to reception

Registration	Verification	Reception
Older people often lack valid IDs, social security numbers, or bank accounts, prerequisites for many humanitarian or SP schemes, particularly cash-based assistance that require formal registration and payment through banks or money transfer agents. For the AMAN program, the digital registration process requires applicants to upload IDs, passports, bank statements, tax numbers, and vehicle registrations through an online platform, steps that assume both digital literacy and reliable internet access. **This process can be particularly challenging for older people living in vulnerable conditions, who often lack the digital skills, equipment, or connectivity**	Eligibility does not translate into access, as subsequent home verification visits further **complicate participation for those living alone or in isolated areas.** Many older people still rely on or actively request home visits to facilitate a more accurate assessment of their needs and living conditions.	Once approved, beneficiaries must collect cash payments monthly. For those enroled in the AMAN program, the aid is disbursed in U.S. dollars through money transfer operators (MTOs) after showing a valid ID, while those previously registered under the NPTP can access their aid via food e-cards, which are usable at ATMs. Despite the wide geographic coverage of MTOs and efforts to expand accepted documentation[66], mobility, health, and/or transportation constraints continue to limit effective access for many old people. Monthly cash collection often requires physical

[15] Applications are submitted online through the IMPACT/ "Daem" platform, with no paper form to submit in person.

needed to complete registration independently.		presence[16], navigation of unfamiliar financial service providers and, in practice, reliance on others to withdraw funds on their behalf.

NGO workers and SP experts confirmed that procedural requirements across both **national and donor-funded cash programs are compounded by rigid eligibility frameworks and donor protocols, which exclude older adults who fall outside narrowly defined vulnerability criteria**, for example, those who are not formally registered as "living with a disability" or who live with relatives but lack personal income. In practice, this means that an older person living with relatives may appear as "supported" in household-based assessments, even if he/she has no personal access to income or financial autonomy. Similarly, while eligibility for the MoSA disability card[17] is determined by a medical definition under Law 220/2000, many assistance programs rely on possession of the card as a proxy for disability-related vulnerability. As a result, older persons with functional limitations or mobility constraints who do not meet the strict medical criteria for the card may be deemed ineligible for certain forms of support. Such rigid categorization overlooks the nuanced realities of older persons' vulnerability and contributes to their systematic underrepresentation among beneficiaries of both humanitarian and national SP schemes.

At the local level, municipalities were often recognized by older persons as an accessible and familiar point of reference, with some continuing to view them as a reliable source of information. However, interviews with older persons and NGO workers also highlighted important limitations. Municipalities were widely described as lacking standardized and up-to-date targeting mechanisms, relying instead on fragmented records, informal knowledge and word-of-mouth to identify people in need, compounded with weak coordination, outdated civil registries, and the absence of systematic household-level assessments. These gaps were perceived to result in exclusion based on administrative rather than need-based criteria, particularly for people registered in one municipality but residing in another, as illustrated by participants' accounts. One FGD participant noted "*If someone comes from another area, even if living here for years, they don't give them*" while another participant from Tripoli explained "*I'm registered in the civil registry in Sir Dinniyeh, but I live in Tripoli. When I go to Dinniyeh they say, 'You live in Tripoli,' and when I go to Tripoli they say, 'You're not registered here.' So I don't get anything, not here, not there.*"

According to the World Bank, Lebanon's national poverty targeting program relies on Proxy Means Testing (PMT), which formulas are generally well constructed and aligned with international standards[63]. PMT offers several advantages, including reliance on objective indicators that are difficult for households to manipulate and reduced exposure to subjective bias in beneficiary selection[64]. At the same time, findings from different studies including this one suggest that challenges arise at the intersection of PMT[18] design and outreach realities, particularly for older persons. A SP Specialist noted that ESSN/AMAN coverage of older people

[16] More broadly, the Lebanese cash ecosystem remains highly physical despite digital labeling, meaning that access to so-called "digital" financial services continues to depend on in-person interactions. For older persons, this translates into persistent barriers linked to mobility, health, and reliance on intermediaries (Middle East Transparent, 2025).

[17] The Personal Disability Card (PDC) serves both as an official ID certifying disability status and as a gateway to various benefits and services established under Law 220/2000 and related decrees. However, fewer than 65% of people with severe disabilities are registered, due to restrictive definitions, limited benefits, and social stigma. Many older persons with functional limitations (disabilities acquired in later life) remain excluded in practice due to cumbersome application procedures, limited awareness, or other bureaucratic barriers (ILO, 2024).

[18] The Proxy Means Test (PMT) is a targeting mechanism used in SP programs to estimate household poverty levels when reliable income data are unavailable. It relies on statistical models that predict consumption or welfare based on observable characteristics such as housing, education, and asset ownership. While designed to improve cost-efficiency, PMTs have been shown to produce high exclusion and inclusion errors, often misclassifying households and overlooking those experiencing transient or multidimensional poverty, thereby limiting their effectiveness in accurately identifying the poorest. (Kidd, Gelders and Bailey-Athias, 2017)

remained very limited, not only because many older persons did not apply due to outreach barriers, but also because PMT variables tend to favor household profiles more common among larger or younger families. Older people living alone or in smaller households were therefore perceived as less likely to be reached or prioritized. In this context, limited transparency around PMT calculations was highlighted as an additional challenge, particularly when explaining eligibility outcomes to affected populations. Several experts pointed to the opacity of PMT implementation under AMAN, noting that "*The PMT is not shared publicly. We don't know how the formula is calculated or updated. It's treated like a black box.*"

Beyond transparency concerns, experts also pointed to definitional and categorical limitations in how PMT-based targeting is operationalized across different systems in Lebanon, including both national programs and humanitarian assistance. While PMT models typically incorporate vulnerability weightings, such as for female-headed households, households with persons with disabilities, and those with chronic illness, key informants noted that the way these categories are defined and applied is not always clear in practice. In particular, the definition of female-headed households was reported to be narrowly interpreted and could be excluding divorced or separated women or women living in non-traditional family arrangements. This narrowing of household categories was perceived to contribute to the limited visibility of older women living alone, caring for sick family member, grandchildren, or co-residing within extended family households in household-level data, potentially affecting how their needs are reflected in eligibility assessments. According to specialists, this issue is compounded by the fact that older persons are typically assessed indirectly through household vulnerability rather than as individuals with distinct needs.

This dynamic is further compounded by the use of asset-based indicators within PMT-derived models, particularly in humanitarian and national cash programs, which may disadvantage older persons who own property but lack regular income or family support. Experts noted that ownership of assets such as housing can result in exclusion even when households face significant economic hardship. This was perceived to disadvantage older homeowners and/or recently impoverished older persons, including widows or retirees whose assets reflect past stability rather than current economic vulnerability following income loss due to illness, disability, or economic shocks. Evidence from the literature further confirms that the economic crisis has severely depleted older people's savings, pushing many into poverty and preventing them from affording sufficient food or essential medicines[25]. As one key informant explained, "*There is a group of older people, including those with disabilities or from previously middle-class backgrounds, who have become impoverished but do not seek assistance. Their vulnerabilities are often hidden and not easily captured by donor categories and frequently remain unseen… the system doesn't account for people who had savings or assets before the crisis but now have nothing, they fall through the cracks.*"

This interaction was reflected in the experience of a 63-year-old woman interviewed for this study, who lives in a household that owns its home and where she serves as the primary caregiver for multiple sick family members, despite having no independent income. Her household was deemed ineligible following assessment: "*They came and did a house visit, and later they refused to support us. I called to ask why, but no one gave me an answer. I see people who are financially doing okay receiving support, and others like us not.*"

Head of Household (HoH): ربّ / ربّة الأسرة

Definition: The HoH is the person recognized as primarily responsible for the household's economic and caregiving functions, including income generation, decision-making, and management of family needs.

Contextual framing: This role is often gendered and context-dependent, men are traditionally registered as household heads even when women carry the actual financial and caregiving responsibilities, particularly in cases of widowhood, divorce, or male unemployment. In practice, many female-headed households are led by older women who combine the roles of breadwinner, caregiver, and community supporter, creating a "***triple burden***" that limits their ability to work, register for aid, or attend awareness sessions.

Despite women's de facto leadership, patriarchal norms and administrative procedures often list men as the official head of household, reducing women's visibility in targeting and aid registration. SP programs like

AMAN increasingly reach women as household heads, some not yet in older age categories, but likely to become older beneficiaries, highlighting the need for age- and gender-sensitive program design. Economic crisis and unemployment have blurred traditional gender roles, exposing hidden male vulnerability as men lose income and status, while women assume greater household responsibilities.

Several experts also highlighted limitations in the crisis-responsiveness of PMT-based targeting in Lebanon. As one specialist explained, "*Retesting and recalculating the PMT every time the economy shifts is costly and unsustainable. It's not adaptable to shock situations.*" In rapidly evolving crises, reliance on static PMT formulas was reported to limit the system's ability to capture newly vulnerable groups, including households affected by sudden unemployment, displacement, or medical emergencies.

In this context, AMAN's reliance on administratively precise but rigid targeting mechanisms was perceived to create gaps in responsiveness to the complex socio-economic realities of older people. As one INGO representative noted, "*Many (older persons) have limited awareness of the available schemes, and even when they do, complex eligibility criteria and administrative procedures discourage participation.*" These inconsistencies also point to a broader structural gap between humanitarian assistance and long-term social protection for older persons. Local organizations and aid agencies operate under non-uniform targeting criteria that vary by donor, project, and assistance modality, reflecting the fact that humanitarian cash and protection assistance are primarily designed to respond to acute risks (such as eviction, displacement, or health emergencies), rather than address age-related vulnerability as a long-term condition.

Several organizations noted that, in practice, support for older persons is often limited to sector-specific interventions, most commonly health services, medications, or protection-related assistance, rather than predictable income support. One NGO representative reflected that past experiences with CVA projects have discouraged engagement, citing "*hectic and problematic*" implementation due to inflation and restrictive eligibility criteria, leading many organizations to narrow cash support to emergency interventions or protection-related cases.

Taken together, these findings underscore the limits of relying on humanitarian programming to address the long-term, life-cycle vulnerabilities associated with ageing. They reinforce the need for a rights-based, state-led social protection system that can provide predictable and inclusive support to older persons beyond crisis-driven assistance, complementing humanitarian responses rather than substituting for them. In this context, ESSN and NPTP remain poverty-targeted programs rather than life-cycle–based social protection schemes, which limits their ability to systematically address age-related vulnerabilities.

In practice, these structural gaps translate into opaque procedures, limited feedback, and growing distrust among applicants. Both IDI and FGD participants emphasized that once applications are submitted, applicants rarely receive clear feedback or updates, constituting a procedural and accountability barrier that limits their ability to understand decisions, reapply, or seek redress. For older persons, who often face mobility constraints, limited digital access, and reliance on verbal information channels, this lack of clarity is particularly disempowering. During several FGDs, these dynamics led to heated exchanges among participants regarding the fairness and credibility of aid programs, specifically after they described multiple home assessments that never resulted in support. In many cases, interviewees were unable to clearly distinguish whether these assessments related to national social protection schemes (such as NPTP/AMAN) or humanitarian CVA programs, reflecting the blurred boundaries between systems at the community level. Some reported that rejections are seldom explained, and that there is limited recourse to appeal to decisions, while others (mostly from the North, where the NPTP was initially largely deployed[19]) mentioned never hearing back about the decision following household assessment visits leading to more distrust in the system.

[19] World Bank data indicate that approximately 41.4% of households registered under the NPTP were located in North Lebanon, reflecting the program's early geographic concentration in that region (World Bank, 2020).

Absence of feedback on rejection decisions	Absence of feedback following assessments
"*I never received feedback from AMAN about why my application was rejected, even though others better off than me received support.*" Female participant, South Lebanon "*I don't know why I was rejected. They just came once and never again.*" Male FGD participant, Mount Lebanon	Male FGD participants in Tripoli: "*We applied more than once, but we don't even know if we're still registered or not.*" "*No one told us if we have to renew or reapply from the start.*" "*They came, asked questions, and disappeared.*" "*They say there's assistance, but we see nothing. They come, take names, photos, and then leave. People wait, but no one comes back. The ones who have wasta get it, and the ones who don't wait for nothing.*"

While formal feedback mechanisms exist, including a MoSA call center[20], findings in this study suggest that these are not effectively accessed or utilized by many older persons. Several participants indicated that they only engage with services when personally contacted or invited by phone, rather than initiating follow-up themselves. As one participant explained, "*I have a phone, they can call me*" and later clarified that this preference stemmed from fear of rejection and a lack of confidence in navigating institutional processes. Others relied primarily on personal connections to access information, underscoring persistent gaps in systematic outreach and communication to older persons. These findings point to a clear gap between the formal availability of feedback mechanisms and their effective accessibility for older persons, shaped by multiple interrelated barriers (see Figure 1).

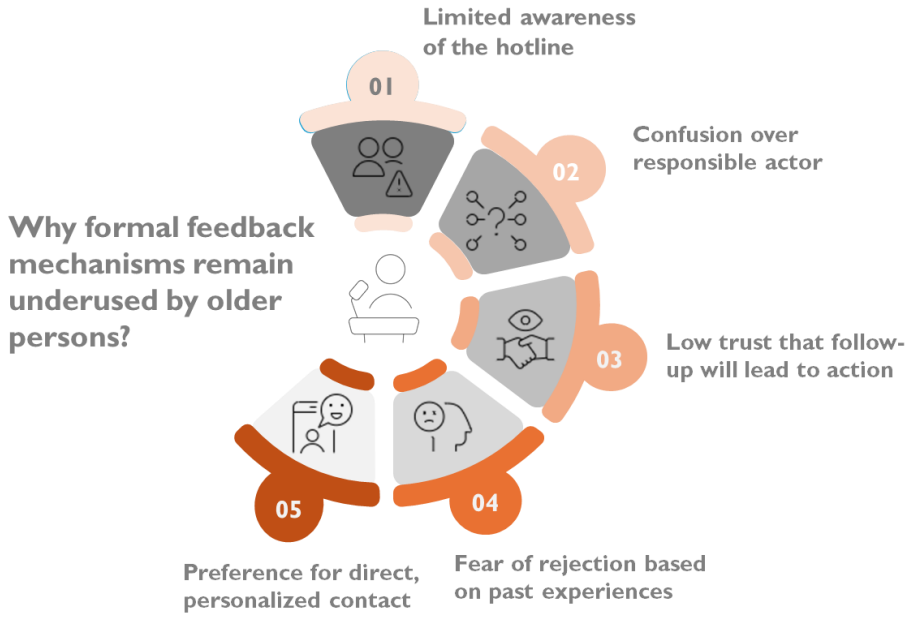


Figure 1: Combination of age-related, informational, and institutional factors limiting older persons' effective use of existing feedback and grievance mechanisms.

[20] In 2024, the Ministry of Social Affairs with support from the World Food Programme (WFP) and the World Bank, established a social assistance call center (hotline 1714) as part of broader social protection reforms in Lebanon. The hotline functions as a grievance mechanism for cash transfer and social support programs, providing information to applicants and beneficiaries and receiving complaints and feedback to support government accountability.

Societal barriers

Key findings:

- Deeply rooted social norms and perceptions of shame continue to prevent many older people from seeking assistance, as they view aid as charity rather than a right. This perpetuates feelings of humiliation, dependency, and invisibility.
- Ageism and the perception of older people as unproductive or less deserving of support contribute to their exclusion from political priorities, aid targeting, and community engagement.
- The erosion of intergenerational solidarity has weakened traditional family safety nets, leaving many older adults, especially those with disabilities or chronic illnesses, dependent on sporadic acts of kindness from neighbors or NGOs.
- Stigma, pride, and gendered expectations create hidden vulnerabilities among older women, persons with disabilities, and formerly middle-class older adults, who may refuse to seek aid or fail to meet eligibility criteria despite evident need.
- Psychological and emotional barriers, including loss of dignity, isolation, and a perceived loss of purpose or masculinity, compound material deprivation, underscoring the need for integrated psychosocial and community-based support.

Beyond administrative and structural challenges, deeply rooted social norms and perceptions help explain why many older persons do not actively seek, follow up on, or contest access to assistance. Many older men and women perceive seeking aid within some of the existing aid distribution mechanisms as shameful or undignified, viewing it as charity rather than a right. This perception was repeatedly reflected in FGDs and IDIs where participants described "humiliation" and "brokenness" when asking for help, as a 62 years-old woman explained "*Sometimes I call people if I need anything very urgent, but I feel like I am an insect.*" However, participants increasingly voiced awareness that SP should be rights-based, stressing that support for older people must be recognized as an entitlement. As a SP Specialist explained, "*A rights-based approach is critical; older people should not feel like they are pity cases but rights holders. Most programs still treat them through a care or charity lens rather than as full citizens entitled to SP, health, and pensions.*"

Ageism also remains pervasive, with older people often regarded as unproductive or undeserving of support compared to younger groups. One key informant explained that ageism exists within the humanitarian response, while another explained that it could be stemming from not being seen by political parties as a priority for electoral constituency, further elaborated, "*Politicians, NGOs, and even families do not see older people as a priority. When resources are scarce, many prioritize children over older persons.*" These perceptions reinforce social isolation and exclusion of this age group.

Ageism further manifests in the systematic exclusion of older people from participatory decision-making and policy processes. Key informants stressed that older people are rarely consulted on the design of programs or policies intended to address their needs, contributing to persistent mismatches between assistance and lived realities. This concern is echoed in the literature. A HelpAge International needs assessment conducted among older persons affected by the Israel–Lebanon escalation across multiple regions of Lebanon found that over half (51%) of respondents reported not being consulted by humanitarian actors about their needs[25]. As one expert reflected, "*Older people are not meaningfully engaged in anything. We design programs for them without asking them the questions that matter to them. How can we talk about adequacy or rights if we don't even talk to them?*" This lack of participation was described as particularly detrimental for the most marginalized groups, including older women, displaced older persons, and older people with disabilities. At the same time, some organizations are working to counteract this exclusion through community-based and localized support, in addition to providing mobility assistance, psychosocial or/and health-related services.

"*My children are paying the price of this... they are working to fulfill our basic needs with their income*" Male FGD participant, Beirut.

Prolonged economic crisis and displacement has further weakened traditional family support structures, reducing the capacity of families to consistently care for older relatives leaving many older adults increasingly dependent on limited community goodwill or sporadic neighborly assistance. One 70 years-old woman who lives alone after her husband died of illness shared that for income, her children help her. She pays for electricity and other bills from the money they give her (around 400 USD), and most of the time she tries to visit them mainly to get food. She also reported that she deprives herself from many things, because she does not want to use her children's money. "*The young people aren't working, so how can we expect to work? I don't want to be in need for my children, because my children have lots of needs*" While a male participant from Mount Lebanon, who suffers from chronic health problems linked to harsh working conditions, emphasized the role of community solidarity in meeting essential needs. As he explained: "*I am very thankful for the Lebanese community; people still support each other. Personal initiatives from the community are filling the gap left by the government. Every month I collect money so I can pay about 40 dollars to see a doctor."*

Similarly, another participant, a man with a leg amputation who uses a wheelchair described living alone with no income and full dependency on MoSA and neighbors' acts of kindness, receiving a disability allowance of 40 USD a month from MoSA and other timely cash assistance from a local organization. While he praised the Red Cross for providing wheelchairs and arranging a social outing, he underscored the lasting impact of physical and social isolation: "*I can't go without someone, I'm disabled.*"

Taken together, these accounts illustrate that while family and community solidarity remain critical coping mechanisms, they remain informal, fragile, and uneven. Reliance on personal initiatives and sporadic assistance cannot substitute for predictable, rights-based support and contributes to cycles of invisibility, dependency, and loss of dignity that limit older persons' participation in social protection and humanitarian systems. At the same time, certain older people, especially those with disabilities or from previously middle-class backgrounds who have now become impoverished, may refrain from seeking assistance due to stigma, pride, and fear of humiliation. This reluctance to seek support is well documented in literature. Community consultations conducted by Mercy Corps in Lebanon found that perceptions of shame, loss of dignity, and fear of being judged or rejected significantly deter individuals from actively pursuing cash assistance, even when needs are acute[42].

"*I don't lower myself. I have self-respect...but if there are service, we don't reject it.*" Female participant, Bekaa.

"*I don't know (about social assistance programs), and I will not run and ask people for more*" Female Caregiver, Bekaa.

"*Some people are in need but feel ashamed to ask for support. These are the people that need to be looked for*" Female FGD participant, South.

These dynamics create hidden vulnerabilities among groups who neither meet donor criteria nor have social capital needed to access informal support, including women living alone, displaced older persons, and those with disabilities. As a MoSA representative emphasized, displacement and economic collapse have fundamentally eroded older people's traditional coping mechanisms: "*Many Lebanese households and displaced people worked their whole lives and saved for emergencies, especially for health needs. When the economic collapse and dollarization happened, their savings were eroded, and displacement made the situation even harder. Cash is a solution, but it cannot be something people rely on entirely.*"

Psychological and emotional barriers:

Beyond material and structural exclusion, psychological and emotional barriers play a critical role in shaping older people's engagement or disengagement from assistance programs. Many participants associate old age with a loss of purpose, dignity, and social worth, particularly when retirement or illness leads to dependency. One woman, a former midwife at a public hospital, shared that she retired because her salary could no longer cover transportation costs, adding "*When we retire, we become worthless.*" Her words reflect not only economic hardship but also a deep internalization of ageist attitudes, where productivity is equated with value and self-worth. Similarly, among older men, the erosion of their traditional role tied to social expectations of masculinity as providers emerged as a profound emotional burden. In several focus groups, men described the shame of not being able to support their families, linking financial insecurity to a sense of failure and diminished masculinity. One participant expressed, "The hardest thing here is when a man is broken in front of his wife" another explained that he was giving the cash assistance to his adult children rather than paying for own medication. These experiences reveal how gendered social expectations magnify vulnerability in old age, as men internalize the loss of income as a loss of identity. Such psychological dimensions underscore that poverty in old age is not only material but also emotional, shaped by feelings of humiliation, helplessness, and invisibility. Without psychosocial support and opportunities for participation, older people are left isolated and disengaged, reinforcing their exclusion from both community life and SP systems.

CHERISH in Ageing

For instance, Amel Association's CHERISH in Ageing project (Community Engagement, Health, and Empowerment for Resilience and Inclusion Supporting Holistic well-being) offers a model of rights-based practice. Targeting over 750 older people in Beirut and Mount Lebanon, the project takes an integrated approach that combines psychosocial support, primary healthcare, livelihood training, and home-based assistance. Its design intentionally reduces structural and social barriers by reaching older people directly through home visits, an essential adaptation for those with disabilities, mobility restrictions, or limited transportation access. Beyond immediate care such as home cleaning services, chronic medication provision, and hot meal delivery, the project focuses on long-term empowerment through livelihood and skills training, aiming to foster independence, self-reliance, and social participation.

Importantly, the CHERISH model builds on the success of Amel's neighborhood-level Older People's Groups, including female-led volunteer groups that help reduce isolation and rebuild social ties. These community gatherings, held weekly in public spaces, encourage older people to reconnect socially, share information, and participate in recreational activities. As an NGO worker explained "*Participation in the OP groups changed them… some became more active and are now teaching recreational activities. They have been empowered to re-live their role in society.*" Such initiatives directly challenge ageist assumptions by highlighting older people as active contributors, mentors, and decision-makers within their communities.

INTERSECTIONAL CHALLENGES

Key findings:

- Gender, disability, and age intersect to create layered exclusion, with older women facing the heaviest burdens due to combined caregiving, domestic, and financial responsibilities.
- Chronic illness and disability limit older people's mobility and access to services. Older women more frequently to reported life-long health problems, yet continue to care for others, deepening exhaustion and isolation.
- In some households, social norms and protectionist attitudes restrict women's mobility and financial autonomy. Despite being primary caregivers and key knowledge holders of family needs, women may have limited control over access to aid, phones, or cash assistance.
- Lebanese women married to non-Lebanese men are excluded from MoSA programs due to their husbands' nationality.
- Limited coordination between ageing, disability, and GBV services prevents a comprehensive response to intersecting vulnerabilities. Stakeholders called for stronger integration and joint referral mechanisms to ensure inclusion of older women.
- Despite policy recognition of intersectional vulnerabilities, gaps persist between strategy and practice, with limited translation of commitments into intersectionality-responsive service delivery for older women.

Findings from KIIs, FGDs, and IDIs reveal that gender, disability, and age intersect to create layered forms of exclusion, shaping how older people experience vulnerability and access to support. For many older women, these barriers are inseparable from the triple burden of caregiving, household management, and economic survival "*We have to take care of them and work, we can't do both.*" As NGO worker described "*Older women often act as breadwinners, caregivers, and community supporters simultaneously*", roles that restrict their ability to seek income, register for aid, or attend awareness sessions. Echoing this, several women in FGDs and IDIs emphasized that they are expected to be "*strong and resilient*" yet denied rest or recognition: "*As women, we are not allowed to feel tired; we must be the sacrifice.*"

These intersecting challenges were also acknowledged at the institutional level. A MoSA representative noted that vulnerabilities are compounded when age, gender, disability, and household roles overlap, explaining that "*being elderly is one thing, but being elderly with a disability, or being a woman heading a household, creates compounded protection concerns.*" She emphasized that such profiles face heightened barriers compared to older men, particularly in contexts of limited funding and service availability. At the policy level, the National Strategy for Older Persons (2020–2030) formally recognizes older women, persons with disabilities, and other vulnerable groups, and promotes a rights-based approach to ageing. MoSA representatives highlighted ongoing coordination between elderly, women's protection, and GBV units as part of this strategic alignment. However, findings from this study suggest that these commitments have not yet been translated into intersectionality-responsive service delivery.

Disability and **chronic illness** further deepen these inequities. Many participants reported mobility constraints that prevented them from visiting aid centers or even grocery stores. Women, in particular, were more likely to report chronic illnesses such as heart disease, vision loss, or joint pain, often while continuing to care for spouses or other dependents. In general, older people interviewed with mobility limitations relied almost entirely on others for movement and information. Testimonies indicated that physical barriers, combined with the absence of home-based services, reinforce exclusion and isolation both physically and emotionally, particularly for older women whose caregiving roles, poorer health outcomes, and limited autonomy further restrict their access to assistance and social participation.

Chronic Diseases: الأمراض المزمنة

Definition: A chronic disease is a long-term health condition that persists over time and often requires continuous medical treatment, monitoring, or lifestyle management. Among older persons in Lebanon, the most common chronic diseases include hypertension, diabetes, cardiovascular disease, arthritis, and mobility-related disorders. These illnesses frequently lead to reduced independence, limited mobility, and heightened vulnerability to poverty and social exclusion.

Contextual framing: Chronic diseases represent one of the main sources of vulnerability among older persons in Lebanon, deeply affecting their ability to work, access healthcare, and maintain social participation. Older adults with chronic illnesses often face multiple layers of inaccessibility, physical, procedural, and digital. Many cannot use online registration systems or reach distant health centers due to mobility and transportation barriers. Because cash assistance programs and donor-funded aid are short-term and project-based, they rarely match the continuous, recurring costs associated with chronic diseases, such as medication, medical tests, and regular checkups. As one interviewee explained, "*Some people receive help one month and nothing the next; this doesn't match the continuous needs of older people with chronic diseases.*"

At the same time, gender norms shape access and decision-making within some households. Across interviews, several women reported being excluded from financial control: "*For food, my husband decides.*" Others mentioned feeling "*too shy*" to call for help or to approach organizations. In certain cases, women's mobility was also restricted by social expectations or protective family attitudes that discouraged them from seeking assistance outside the home. As one male participant explained, "*They're never on the ground; if my wife was alone, she wouldn't have opened the door.*" Another woman shared, "*If there's any kind of assistance, my son tells me, 'If you go and they don't give you anything, I'll be upset... Whoever wants to help should come to the house'. So, I stayed home. I'm not allowed to go.*" These testimonies illustrate how, in some families, protectionist attitudes and household hierarchies can limit women's physical access to aid registration and follow-up visits. Yet, paradoxically, many of these same women serve as primary caregivers and are often the most aware of their families' medical and nutritional needs, highlighting a gap between caregiving responsibility and decision-making power.

Structural discrimination was also reported by Lebanese women married to non-Lebanese men who are excluded from MoSA programs due to their husband's nationality: "*Because I am Lebanese and my husband is Syrian; they discriminate and won't give us services.*" Institutional stakeholders also emphasized the need to address these intersectional gaps systematically, underlining the need for stronger coordination between ageing, disability, and GBV programs to bridge service gaps, especially for older women survivors of violence, who are excluded from shelters after age 50[21]. However, some key informants noted that MoSA's engagement in these areas remains largely temporary and project-based, lacking long-term institutional commitment, while others pointed to the chronic shortage of resources and funding as a major constraint to sustaining inclusive services. Reflecting on empowerment and inclusion, as an NGO worker concluded, "*When women gain financial agency, it strengthens confidence and shared decision-making.*"

EFFECTIVENESS AND SUSTAINABILITY

Key findings:

- Older persons and their caregivers who receive SP support reported that the programs helped to fulfill major needs, particularly those linked to food and shelter (rent).
- The current system is perceived as having significant gaps, characterized by "fragmented" and "donor-dependent" approaches that offer "temporary painkillers" rather than lasting solutions.

[21] While this finding does not directly relate to CVA or SP, one key need fulfilled by both is access to shelter (e.g., rent payments).

- The 2019 financial crisis and subsequent shocks systematically dismantled financial stability, eliminating income and wiping out savings (including public sector pensions and NSSF). This rendered retirement planning meaningless for both the traditionally vulnerable and formerly secure profiles (e.g., landowners, military retirees), ensuring a broad-based crisis of income.
- Poor health is the primary driver of acute vulnerability, creating a financial burden that current assistance does not always meet.
- The assistance provided is universally seen as "never enough" and "short-term, inconsistent." This is compounded by a deep-seated crisis of trust, with a universal belief that access to aid is contingent on *wasta* rather than legitimate need, which discourages participation and breeds cynicism.
- While survival is the priority, psychosocial, mental, and emotional needs are systematically overlooked by both older persons themselves and assistance programs. Loneliness, exclusion, and breakdown in traditional community relationships are severe issues. Conversely, small-scale social interventions like "organized outings" have a disproportionately positive impact, highlighting that restoring dignity and social connection is a necessary component of effective support.

Key informants and older persons participating in interviews and FGDs highlighted perceptions that the current SP system for older persons in Lebanon is not fulfilling needs. It is characterized by a "*fragmented*" and "*donor-dependent*" approach that provides "*temporary painkillers*" rather than effective or sustainable solutions. The system is undermined by a near-total lack of trust, with access to aid perceived as being contingent on wasta rather than need.

Non-contributory social pensions in other contexts

Non-contributory social pension have been successfully introduced, expanded, or assessed for feasibility across various countries, such as Bolivia, Bangladesh, Mexico, Peru, Philippines, and Uganda[52], [65]. For example:

- The role of a functioning social protection system, financed through effective taxation, in meeting these needs was highlighted in a trial of the expansion of **Bolivia's** social pension, which showed that older persons who received the pension saw significant increases in consumption, with reduced self-perceived and official poverty rates[52].
- The rapid transformation of **Mexico's** social protection landscape led to surge in pension coverage from 22 percent in 2000 to 88 percent in 2013, largely as the result of the proliferation of non-contributory schemes rather than earnings-related reforms[68].
- In **Bangladesh**, a Universal Pension Scheme was introduced in 2023 as "a pathway to self-sustained retirement for citizens." It encompasses even those with lower earnings to prepare for a self-sustained retirement within their financial capabilities[69].
- An analysis of the feasibility of a universal social pension in the **Philippines** highlighted that a universal social pension would not only eliminate targeting errors and administrative burdens linked to means testing but would also serve as a powerful tool for poverty reduction, potentially lowering the national poverty rate by up to three percentage points if a benefit of PhP 2,000 were introduced[70].

Key trends in interviewees' vulnerability and needs

This study aimed to speak with older persons across a range of socioeconomic backgrounds and geographic locations across Lebanon, gathering evidence through a rights-based lens, rather than a vulnerability-based lens. As such, its focus was not just on speaking with the most vulnerable older persons but rather on gathering a wider range of views, perceptions, and experiences from older Lebanese persons.

However, interviewees and FGD participants reported common trends in needs, regardless of background and geography; namely, these challenges were a result of two key factors: (1) the impact of the financial crisis

against a background of ageism and labor market exclusion; and (2) health issues impacting the household's financial decision-making and expenses.

Impact of recent crises and labor market exclusion

The 2019 financial crisis, compounded by subsequent shocks like the port explosion and COVID-19, has systematically dismantled the financial stability of many older persons, eliminating their sources of income and wiping out their savings. Almost all interviewees highlighted different ways in which these crises exacerbated existing vulnerabilities or introduced new vulnerabilities. Interviewees who had already been struggling to make ends meet prior to the financial crisis have found it increasingly difficult to cope, often having to make difficult decisions to cover their most basic needs. Many are surviving from meager amounts of money (e.g., under $200 a month) pulled together from income provided by their children through remittances from abroad, income provided by their children who are in Lebanon, or through low-paid and unpredictable informal work. These findings are consistent with existing literature, which shows that while family care remains a strong cultural norm in Lebanon, it has increasingly become a fragile and uneven substitute for formal social protection. Many older adults, particularly women, depend on their children for basic expenses, medications, and support in navigating services; however, families' capacity to provide sustained care has been significantly eroded by the economic crisis, migration, and accumulated caregiving burdens[44]. This dependence can also expose older people, especially those with disabilities or over the age of 70, to risks of financial control, neglect, or abuse[25].

Several participants reported that their livelihoods were abruptly terminated as a result of the crises; participants report that a "*husband used to have a shoe factory and closed due to the situation*" or that a marketing firm "*closed down during COVID.*" Another example is a participant whose husband worked at the port: "*When the port explosion happened, they closed the company. And he got financial compensation of 200 USD at a rate of 1,500 LBP.*" This powerfully illustrates how a life-changing economic shock resulted in a final compensation payment that was both insignificant and devalued by hyperinflation.

The direct consequence of this economic collapse is a state of severe and humiliating financial precarity, forcing many interviewed older persons into a daily struggle for survival. The shift to a dollarized economy has been particularly brutal, with participants facing impossible demands; one woman said, "*I have lived in the same rented house for 26 years, but her landlord recently increased the rent from 1,500,000 LBP to $150 per month and threatened me when I couldn't pay.*" This constant financial distress leaves participants unable to cover even their most fundamental needs, which are now reduced to "*essential bills: water and electricity.*"

Many interviewees reported that they would want to work to make ends meet. They highlighted the importance of feeling self-reliant and knowing how they would be able to cover their costs independently of support. However, almost all of the interviewees we spoke with noted how challenging it was for them to secure any form of income through labor, even when they desired to do so. Many want to work to make ends meet but feel excluded from the labor market due to ageism (i.e. employers not wanting to recruit people past the age of 50) or due to their own physical inability (e.g., as a result of an injury or illness). Lebanon's ongoing unemployment rate (up to 32.6% as of 2024, according to the United Nations Development Programme), increased further by the 2024 aggressions, exacerbates this issue[46].

"*The young people aren't working, so how can we expect to work?*" Female participant, Mount Lebanon

This situation has generated a sense of frustration and loss of dignity, with one interviewee stating she feels "*humiliated without enough income to live.*" With formal work paying one interviewee as little as $5 a day before transport costs, and family-run businesses making very literal profit, many participants feel they are left with no viable path to financial stability. An expert on the rights of older persons further highlighted how "*in times of financial crisis, older persons are subjected to neglect of their needs due to financial loss for both old persons and their families.*"

Importantly, interviewees from formerly traditionally less vulnerable profiles reported now also experiencing greater need. Those who had pensions (e.g., public sector or military retirees) or those who had savings reported that they now receive only a fraction of what they believed they would receive in retirement. This has rendered life savings and retirement planning meaningless for many. For example, one couple who received 100,000,000 LL upon retirement, a sum that was once substantial but was quickly consumed just to pay for their daughter's university fees. Landowners, another typically less-vulnerable profile in Lebanon, similarly reported an increase in vulnerability as a result of a loss in liquidity.

"*What happened in the crisis has hit older people the hardest. They are relying on their savings to sustain themselves, and some of them who had come from the public sector had their pension payments and NSSF end of service indemnity.*" SP Expert

"*The whole situation is a gap; nothing is working at all in the current SP landscape in Lebanon. We used to get around 700$ a month before, and it was insufficient now; I barely get 200$ per month, how can I survive?*" Male participant, BML

Health, caregiving, and vulnerability

Poor health at the individual or household level plays a key role as a primary driver of vulnerability across the majority of interviewees. The health needs described are not minor, but rather a complex mix of severe, chronic, and costly conditions. One participant, for example, "*suffer(s) from multiple health issues heart disease, hypertension, diabetes, high cholesterol, and thyroid problems and takes 26 medications.*" This burden is frequently compounded, as many participants are not only managing their own serious illnesses but are also acting as primary caregivers. This dual role is acute for one interviewee who "*used to work as a baker but had a stroke and disc surgery and had to stop working*" and is also the "*caregiver of her daughter who has had cancer for the last 2 years.*" This creates a cycle of physical, emotional, and financial strain.

This chronic health burden translates directly into acute financial and social vulnerability. For many interviewees, a health crisis is the specific event that forced participants to stop working, leading to a total loss of income. Consequently, healthcare was cited as the most urgent need, with one participant stating, "*I need everything related to health, such as hospitalization. I might die if I can't afford hospitalization.*" This desperation forces individuals into negative coping strategies; one woman noted she "*never goes to the hospital as she cannot afford the fees*", while another interviewee explained her own health is neglected: "*I also have a hernia and need surgery, but I can't afford it because it's very expensive.*" Other interviewees reported selling off their personal belongings or household items just to cover health expenses.

The vulnerability of older persons in Lebanon is often further increased by the demanding and uncompensated role of caregiving. Many interviewees, despite managing their own severe health challenges, are the primary carers for spouses, children, or older parents suffering from debilitating conditions such as cancer, dementia, or physical disability. This role places an immense physical and financial toll on the older person. The burden is demonstrated by an interviewee who is an 82-year-old caregiver caring for her 72-year-old husband who is bedridden, while also being a cancer survivor herself and suffering from significant leg pain.

Crucially, caregiving often also means neglecting their own medical requirements. Another participant's experience illustrates this trade-off, citing that "*both my husband and I have lots of health issues. I have been neglecting a needed surgery due to a lack of money.*" Her family's limited financial resources must be prioritized elsewhere. This sacrifice of personal health for family duty accelerates their individual vulnerability and deepens overall household poverty.

"*I feel mentally exhausted when my husband gets sick and wants to go to the hospital, but I can't take him there. I'm sorry to say this, but last time he got a little sick, I told him I couldn't take him to the hospital and that if he was going to die, he would die at home. Where would I get the money? Don't blame me, my two children's salaries aren't enough to get him into the hospital.*" Female participant, BML

Prior to the 2019 financial crisis, a 2018 report by the Ministry of Public Health (MoPH) reported that "around 47 percent of the Lebanese population have health insurance coverage; and 53 percent who lack any formal coverage are covered by the MoPH.[47]" However, compounded by the multiple crises since 2019, private health insurance has become increasingly expensive[48] and coverage by the MoPH as a last resort has been severely, reduced, with a total reduction of 40% in health sector expenditure reported by the MoPH between 2018 and 2022[49]. This leaves many older persons making impossible choices between health and poverty, actively exacerbating their vulnerability, social exclusion, and needs.

"*The majority of other people in Lebanon lack access to pensions, health insurance or formal income support and this leaves them heavily reliant on family or humanitarian aid.*" NGO Representative

"*Some people used to be covered through the national program under the MoPH, but coverage is now insufficient. With the dollarization, hospitals were not accepting people. It's quite expensive. It will increase protection risks and vulnerability.*" Protection expert

Effectiveness

A MoSA representative highlighted the significant efforts that the ministry and government have undertaken to reform existing systems. As highlighted above, a new NSPS is in place, and operationalization is currently underway. As such, many of the perceptions below pertain to past systemic gaps that the Lebanese government is working to address and must be understood in light of ongoing reforms.

Additionally, MoSA highlighted how it plays a major role in crisis response. During the 2024 aggressions by Israel, MoSA played a major role in coordination of emergency response and in the provision of direct assistance (e.g., shelter and cash assistance) to affected families. One key issue that MoSA focused on was reunification of older persons with their families, as many had been left behind due to mobility issues, highlighting the importance of providing a whole-family approach to support during crisis.

Despite the critical support that SP and CVA programs provide, they may have gaps in both scale and inclusivity, often not addressing lifecycle vulnerabilities[18], particularly those of older persons and people with disabilities[18.] Nearly 80% of Lebanon's population lacks formal pension coverage[24], with many older persons dependent on family networks or informal support systems[18], [24.]

There is a significant gap between what older persons need and what programs provide. Across all participant groups, the priority needs are clear, consistent, and largely unmet. The system's ineffectiveness is not just seen as an issue of insufficient funds; many interviewees noted perceptions that the problem has been a historic and ongoing structural challenges, exacerbated by recent crises.

As noted above, **health** is the unanimous, paramount concern. The cost of medication for chronic diseases (hypertension, diabetes, etc.) and hospitalization is a "*crushing financial burden*." As one focus group participant stated, "*Covering our medical bills will reduce 40% of our financial burden.*" Another added, "*For food we can manage, but health is the issue.*" This is followed closely by **basic needs, specifically food and rent**. As a result, many interviewees reported having to choose between healthcare and basic needs like food and rent, with the majority prioritizing the former over the latter. One participant noted, "*Rent is at least $250. We need cash support for rent.*"

The assistance provided is described as "*never enough.*" Its effectiveness is crippled by a misalignment of priorities, a delivery mechanism undermined by a crisis of trust, and an operational model that creates instability and exclusion. The few instances of success are not found at the program level, but in small-scale, interpersonal actions that stand in contrast to the gaps in the wider system.

The most significant gap is seen as one of core design. Key experts view the system as ineffective because it does not address the primary, critical needs of older persons. There is a unanimous and desperate consensus that the most crushing financial burdens are healthcare and housing. Participants described the cost of medication and hospitalization as "*illogical*" and "*merciless*," with one focus group calculating that "*covering our*

medical bills will reduce 40% of our financial burden." Current programs like AMAN, however, provide relatively small cash amounts that participants say are "*never enough*", forcing them to prioritize between their immediate critical needs for survival.

In some cases, assistance is almost exclusively short-term cash or in-kind aid (like food parcels) that "*covers only fragments of needs.*" This leaves the most critical burden, health and rent, untouched. This forces older persons to resort to negative coping mechanisms, including "*skipping medication, or meals*." It leaves the two most significant drivers of poverty and vulnerability (health and rent) completely untouched, rendering the entire intervention largely ineffective at improving wellbeing.

Those who receive AMAN are generally grateful for the assistance, reporting that it does help cover some of their most critical needs; however, most reported that the value of assistance (generally reported between $65 and $140, depending on household size) was still not enough to cover all of their basic needs, with some recipients prioritizing medical care and other prioritizing food and rent. With healthcare expenses remaining unaffordable and without effective healthcare subsidies or universal healthcare in place, interviewees highlighted that the burden of healthcare expenses would continue to lower the effectiveness of programs like AMAN, unless the value of assistance is substantially increased.

"*The cash I receive from AMAN is much needed but not enough.*" Female participant, South Lebanon

There is a general sense that the government needs to be playing a greater role in ensuring their wellbeing, particularly financially and medically. This is accompanied by a wider sentiment that the government is absent and not fulfilling its duties towards older persons; at least, not at the required scale.

Against this backdrop of systemic challenges, the few examples of what is working are revealing. Effectiveness is not being achieved by a program or a policy, but by a method. Best practices identified were simple, dignified, interpersonal actions that include clear, thorough communication on assessment, selection, and provision of assistance (including assistance values, pauses, and stoppage). One focus group appreciated an organization for home visits and clear communication. The "*Red Cross [was] recognized for inclusive treatment and respect.*" The most powerful example came from a participant who said, "'*They came to my house, asked about my situation, and gave me 100 dollars twice.*'"

The effectiveness of this interaction was not just the cash, but the respect, clarity, and in-person dignity of the home visit. An approach that bypasses the digital divide, counters the narrative of corruption, and treats the person as more than a number.

NGOs have become the de facto providers of life-saving support, yet their role is recognized as temporary and limited. Older persons frequently express gratitude and trust towards specific NGOs, particularly those that offer a human touch, such as those whose teams "*came to my house, asked about my situation*" and provide tailored services like medication assistance or home visits. Views on cash and humanitarian assistance provided by NGOs contained some more nuance, though experiences with receipt of aid. Some saw them as unbiased and able to provide assistance equally; but many felt that some organizations showed political favoritism in provision of assistance, highlighting that they did not understand why households that appeared to be less in need than they were received assistance while they did not.

"*Nepotism, lack of transparency. I ask NGOs to visit people's homes to see who truly needs help — and municipalities should know that too.*" Male participant, South

However, experts understand that NGO assistance is inherently project-based and driven by "*donor criteria, not by local needs assessments.*" This means NGOs are essential for providing cash, health services, and food, but their mandate limits them to short-term emergency fixes rather than structural change. While NGOs are appreciated for stepping in, their resources are "*very limited*" and their support can be abruptly "*halted*" when funding ends, highlighting the unsustainable nature of relying on humanitarian goodwill to solve a structural national crisis.

Sustainability

Older persons and experts alike noted that programs are short-term and often stop suddenly, leaving beneficiaries in a constant state of anxiety. An NGO representative described one program as "*very amazing and nice… but it just stopped there because it was a project-based and it's not sustainable.*" This volatility is particularly damaging for older persons with chronic needs. As another NGO representative explained, "*Some people receive help one month and nothing the next; this doesn't match the continuous needs of older people with chronic diseases.*"

Interviewed experts agree that it is a clear, consensus-based path toward a sustainable and effective system. First, there is a core recommendation to move away from ad hoc projects and "charity" to rights-based, universal approaches that aspire to provide equitable access to support and services. As one NGO representative put it, "*It's the government that can do that. They need to have pension plans where every older person who is 65*." Focus groups called for a basic SP floor: *"health, food security, and cash support.*"

Additionally, without addressing older persons' crushing health expenses, no SP system will be sustainable. Health costs are seen as far too high across the board, and interviewees broadly reported that if their health costs could be better covered, then that would relieve much of the financial burden they currently experience. Without addressing these costs, the value and sustainability of any assistance provided will remain at risk.

Furthermore, sustainability was seen as being at risk as a result of a flawed delivery system resulting in a breakdown of trust and the social contract between government and citizens. To build trust, the delivery mechanism itself must be reformed. One interviewed older person highlighted that the use of "*independent distribution teams to reduce corruption*" could help in improving that sense of trust, while the majority of older persons and experts highlighted the importance of eliminating *wasta* or the sense that *wasta* was influencing decision-making around selection and provision of assistance.

While several experts highlighted that this latter point would be organically eliminated through what is currently aspirational universal coverage through SP, many interviewed older persons noted that simply providing more information and transparency around selection processes, outcomes, and reasons for outcomes would be greatly beneficial in doing so. Consolidating information through a single, trustworthy, and accessible "*consolidated platform*", campaign, and approach, ensuring that information on all available services, how to provide feedback, and closure of the feedback loop on selection criteria and decisions was seen as key towards ensuring the success and sustainability of SP schemes.

Additional unaddressed needs

The core findings of this research focus on the delivery of SP and cash assistance to older persons. However, many older persons and interviewed experts highlighted that a focus on survival and basic needs often meant that the psychosocial, mental, and emotional of older persons would be overlooked. Key experts highlighted that humanitarian assistance programs, both CVA and non-CVA, and older persons themselves often place immediate focus on tangible "*basic needs: health, food, shelter.*" This may be viewed as a rational response to the economic crisis, where resources are scarce and a medical emergency, access to shelter, or hunger can be an existential threat. However, there is a danger that psychosocial needs become ignored as a result.

Mental health and loneliness are treated as secondary concerns that cannot be addressed until financial security is achieved. In one case, a woman whose health issues compounded her financial struggles noted that she would be helped by some form of "*moral, psychological support*," indicating the awareness of the need, but its subordinate status to material aid. This oversight means that chronic stress, humiliation, and loss associated with the financial crisis and the crises that have followed since are rarely properly addressed by the assistance provided.

Isolation, loneliness, and a breakdown of traditional support networks are severe issues that compound financial and health vulnerabilities. Isolation, exclusion, loneliness, and boredom were reported as significant issues by many interviewees. This loneliness is not limited to those who are physically housebound; it is a

social isolation, reported even when not traditionally 'isolated'. For example, one interviewee stated, "*I feel like I'm an insect,*" articulating the sense of humiliation and exclusion that often accompanies the need for community or family support.

Most interviewees reported increasing household isolation and a breakdown in traditional community relationships. The severe economic pressure means families and neighbors are struggling to survive themselves, limiting the resources and time previously dedicated to mutual support. This financial strain thus translates directly into a loss of social capital, leaving older persons with less emotional and physical support precisely when they need it most. For those who are already home-bound or live alone, this breakdown of external contact leaves them entirely reliant on unpredictable formal services.

"*I am alone, I am afraid.*" Male participant, Bekaa

The limited instances where social and emotional needs have been met provide compelling evidence that targeted social engagement is a highly effective, yet neglected, component of well-being for older persons. Many interviewees highlighted that when these needs have been met, the experience has been eye-opening. These small-scale interventions, like organized outings or leisure activities, have a disproportionately positive impact on morale and mental health, demonstrating that wellbeing is not just the absence of hardship but the presence of connection.

The demand for such initiatives is clear. Recommendations from older persons frequently included a need for "*social services like outings and engagement*" and a desire for service providers to build trust through personal, human contact, such as monthly house visits. These findings suggest that future SP programming should integrate social activities as a core service, recognizing that restoring dignity and social connection is a necessary complement to financial and medical aid.

"*Each of us opened up about ourselves and our situations at home, for example, and we felt a little better, we had fun, and we felt better psychologically.*" Female participant, Beirut

F. Recommendations

Based on evidence and insights gathered through this research and as a result of discussions of preliminary recommendations with MoSA representatives and other key stakeholders, the following recommendations are presented across two key thematic areas:

1. **Policy and program design and implementation:** These recommendations aim to provide the Lebanese government, implementers (e.g., NGOs), and donors with recommendations on how to strengthen older persons' access to CVA and SP; along with recommendations on how to improve the effectiveness and sustainability of these programs.
2. **Outreach and engagement:** These are more tailored recommendations, whose aim is to provide the Lebanese government and implementers with actionable insights to support outreach towards older persons in Lebanon. These recommendations also provide evidence-based practices and insights from both key experts and older persons' themselves on how overall engagement of older persons in CVA and SP can be further strengthened. This also includes recommendations for inclusion to overcome intersectional barriers.

All recommendations include a suggested audience, disaggregated by (Lebanese) **Government, Implementers** (e.g., NGOs and other organizations that work directly with older persons to implement outreach and deliver services), and **Donors**.

POLICY, PROGRAM DESIGN AND IMPLEMENTATION

Recommendation 1: Reinforce government ownership, institutional leadership, and accountability for social protection for older persons, from system design to implementation and delivery.	
Key audience:	MoSA, Presidency of Council of Ministers, Donors

1.1 Formally designate older persons as a priority group within the National Social Protection Strategy and MoSA implementation structures:

- As MoSA and development partners finalize the next phase of the NSPS (up to 2027), older persons should be explicitly designated as a priority group within the strategy and its implementation framework to address the current lack of institutional ownership and accountability for age-related vulnerability.
- This designation should be reflected in NSPS implementation and monitoring documents and accompanied by clear internal coordination and reporting arrangements within MoSA, including the assignment of a lead unit with a mandate to coordinate across relevant units and thematic working groups, to ensure cross-sectoral alignment and address overlapping vulnerabilities.
- Donors supporting NSPS implementation should align system-strengthening investments and technical assistance with MoSA's leadership and reporting structures to reinforce coherence, government ownership, and sustainability.

1.2 Establish a phased non-contributory social pension scheme:

- Initially target the poorest and most vulnerable older persons, such as those without contributory pensions, living alone, or with disabilities, and progressively expand coverage as fiscal space allows. The scheme should be anchored within the existing SP architecture, drawing on implementation lessons from AMAN and the NDA to avoid parallel systems and ensure administrative feasibility.
- Clear eligibility criteria, benefit levels, and delivery mechanisms should be defined, with simple and accessible enrolment processes that do not rely solely on digital access and that accommodate older persons and caregivers.
- Prior to national rollout, the scheme should be piloted in selected geographic areas to test delivery modalities, grievance mechanisms, and outreach approaches.

1.3 Affirm and operationalize government responsibility for delivering SP to older persons:

- MoSA's new strategies should be translated into time-bound operational plans that clearly identify priority actions for older persons, responsible units, and coordination arrangements with municipalities and service providers.
- Accountability should be strengthened by establishing clear and accessible mechanisms through which older persons and caregivers can provide feedback, submit complaints, and receive timely responses regarding SP programs.
- In parallel, regular public reporting on the implementation of SP policies for older persons, including coverage, gaps, and operational challenges, should be institutionalized to reinforce government ownership, transparency, and visibility.

1.4 Build public trust through transparent and accessible communication on SP strategies and implementation:

- MoSA and relevant government actors to develop and implement a strategic communication plan that explains, in clear and accessible language, how existing and upcoming social protection programs, including AMAN and the expansion of the NDA operate, who is eligible, and how to apply.
- Communication efforts should rely on multiple channels tailored to older persons and their families, such as television, radio, newspapers, community announcements, and trusted social media platforms, rather than a single medium. Official information on SP should be consolidated, transparent, and regularly updated through a clear reference point, available both online and offline, to reduce confusion caused by fragmented or outdated messaging.
- Partnerships with NGOs, municipalities, and community-based organizations should be leveraged not only to amplify official messages but also to disseminate information through their networks of local organizations and social assistance providers, ensuring outreach to older persons who are socially isolated or digitally excluded. In parallel, transparent communication on implementation progress, challenges, and limitations, including delays or resource constraints, should be maintained to manage expectations and rebuild public confidence through honesty and accountability.

1.5 Adequately resource and strengthen MoSA's capacity to deliver age-inclusive SP services:

- MoSA should conduct a targeted assessment to identify gaps in staffing, skills, systems, and financing needed to deliver age-inclusive SP at scale, and increase dedicated, predictable funding for programs targeting older persons.
- Technical capacity should be strengthened through training on ageing, disability inclusion, and case management, alongside improved beneficiary management, monitoring, and grievance mechanisms to ensure timely and equitable service delivery.
- Where appropriate, decentralized implementation should be supported by equipping municipalities and local service providers with the guidance and resources needed to deliver MoSA programs consistently.

Recommendation 2: A strategic transition is needed whereby donors and implementers progressively reduce direct service provision and instead focus on strengthening government-led systems, supporting community-based mutual aid, and influencing donor practices through evidence-based advocacy.

Key audience:	Government, Implementers, Donors

2.1 Position the Lebanese government as the primary service provider while redefining donor program roles as supportive and complementary

- Donors and implementers should progressively align their programming with MoSA-led strategies and intersectoral government priorities, and transition away from parallel service delivery models.
- Donor funding modalities should prioritize government-anchored implementation, cross-ministry coordination, and absorption pathways into public systems.
- Implementers can play a complementary role by supporting policy operationalization, piloting approaches that can be institutionalized, and providing technical, logistical, and capacity-building support to MoSA, municipalities, and public service providers. This includes using tools such as joint workplans, co-branded delivery mechanisms, and transition strategies that clarify how externally supported services will be handed over to government systems over time.

2.2 Strengthen shock-responsive and crisis-sensitive systems anchored in public and community structures: As funding volatility and crisis risks persist, implementers should shift focus from standalone crisis responses toward supporting government and communities develop shock-responsive mechanisms that are durable and equitable. This includes providing technical assistance on contingency planning, improved data-sharing protocols with MoSA, and transparent targeting criteria, while supporting communities to organize local response and mutual aid mechanisms that can function during crises when formal systems are strained.

2.3 Invest in disaggregated data, participatory research, and shared learning to inform public policy and donor decision-making: MoSA, with the support of donors and implementers, should prioritize generating and using high-quality, disaggregated data on older persons in ways that are participatory, respectful, and non-extractive, and actively share findings with government counterparts. Research should support public planning, budget advocacy, and program design rather than remain confined to donor reporting. Engaging older persons from targeted vulnerable populations as knowledge-holders at multiple levels, including MoSA units and working groups, municipalities, and the programs of INGOs and other implementing agencies, can strengthen legitimacy, accuracy, and accountability across the system.

2.4 Advocate for targeting approaches that reflect household realities while supporting community-level identification mechanisms:

- Implementers should support MoSA and municipalities to contextualize and adapt targeting criteria that better reflect household realities, including recognizing older persons, particularly women, as heads of households and primary caregivers. Adjustments should include recognition of non-income vulnerabilities such as health costs, disability and social isolation.
- At the same time, implementers can help strengthen community-based identification and referral mechanisms, working with local actors, social workers and community organizations who are best placed to recognize isolation, dependency, and vulnerability beyond rigid household definitions:
    - Combining administrative targeting tools with community validation can improve inclusion while maintaining transparency and fairness.
    - Establish local outreach and identification systems through municipalities, NGOs, and community actors to identify isolated older persons excluded from registries.
    - Develop formal referral systems linking community-identified cases with MoSA databases and SP programs, combining administrative and community targeting.
    - Train social workers and outreach teams to identify hidden vulnerabilities such as neglect, mobility limitations, and psychosocial distress.

2.5 Develop a coordinated advocacy strategy that promotes systems strengthening and community resilience over parallel delivery: Implementers and partners should jointly pursue advocacy efforts that encourage donors to fund government-aligned programming, system strengthening, and community-based models rather than fragmented, projectized service delivery. This strategy should emphasize (1) evidence on older persons' needs and preferences; (2) the risks of parallel delivery for trust and sustainability; and (3) the value of investing in public systems and community mutual aid as foundations for long-term resilience and social cohesion.

Recommendation 3: Medical costs and other specialized service expenses, according to needs, must be considered when calculating cash assistance values and designing complementary programs until proper subsidies are in place.

Key audience:	Government, Implementers, Donors

3.1 Prioritize older persons with chronic illness within social protection follow-up and referral: MoSA should mandate SDCs and SP implementing partners to flag older persons with chronic illness as priority cases within existing social protection follow-up mechanisms. This prioritization would trigger:

- Referral to health and medication access pathways,
- Active follow-up and accompaniment, and
- Prevention of benefit loss due to health-related access barriers.

3.2 Formalize referral pathways between social protection and public health services: MoSA and MoPH, with implementer support, should jointly document and disseminate clear referral pathways from SDCs, these pathways should be integrated into SDC workflows rather than treated as ad hoc arrangements. Referrals would be done to PHCCs, existing public medication programs, and subsidized care.

3.3 Reduce procedural barriers to disability-related health entitlements: Relevant authorities should review how existing disability-related mechanisms (including NDA and Law 220/2000) function in practice for older persons. The focus should be on procedural adaptation and enforcement, not entitlement expansion. The focus would be on reducing documentation and mobility burdens, improving recognition of age-related functional limitations, minimizing repeated medical assessments where conditions are chronic or degenerative.

3.4 Recalibrate cash assistance to reflect medical expenditure burdens: MoSA and implementers should adjust CVA values or introduce medical top-ups for older persons with high health costs, based on expenditure analysis.

3.5 Expand access to subsidized public healthcare coverage: Implementers should advocate for MoSA and MoPH to expand the last-resort coverage and subsidies for older persons lacking insurance.

3.6 Strengthen enforcement of NDA and Law 220/2000 health entitlements: MoSA should improve enforcement, awareness, and operationalization of disability-linked healthcare entitlements for older persons.

Recommendation 4: Ensure emergency CVA delivery modalities are mobility- and age-sensitive so that older persons are not excluded from evacuation, access, or assistance continuity during shocks.

Key audience:	Government, Implementers

4.1 Integrate age and mobility criteria into emergency targeting and registration systems: MoSA and implementers should include simple indicators (such as limited mobility/homebound, disability, lack of transport, caregiver dependency) within emergency intake, verification, and outreach tools. These indicators should automatically trigger adapted delivery modalities rather than relying on ad hoc staff decisions.

4.2 Prioritize mobility-constrained older persons in follow-up and case management: MoSA and implementers should establish tracking and follow-up systems to ensure mobility-constrained older persons do not lose assistance due to displacement, inability to travel, or documentation barriers.

4.3 Adjust CVA transfer values to reflect evacuation and transport costs: MoSA and implementers should increase cash assistance values for older persons facing higher evacuation costs, including accessible transport, accompaniment, or medical transport needs.

Recommendation 5: Rebuild and institutionalize community-based support and outreach structures to reduce isolation and strengthen engagement of older persons.

Key audience:	Government, Implementers

5.1 Develop intergenerational and alternative community support networks: Implementers should design programs that create alternative care and solidarity networks linking youth and older persons. This includes intergenerational activities and training, volunteer caregiving and digital literacy initiatives, neighborhood mutual aid groups, and community-led support circles to compensate for weakened family structures.

5.2 Institutionalize community-centered outreach models: MoSA and implementers should shift outreach approaches from individual/household targeting toward collective, community-based identification and engagement models. Embed these approaches within program frameworks and strategies to strengthen early identification of isolated older persons.

5.3 Support enrolment and case mediation through community intermediaries: MoSA and implementer should establish community-level support mechanisms to help older persons navigate registration and enrolment processes. This includes outreach volunteers, social workers, NGO case managers, and community focal points who can assist with documentation, digital registration, appointment scheduling, and grievance follow-up.

5.4 Integrate psychosocial and social connection programming: MoSA and implementers should Incorporate psychosocial support, recreational activities, peer groups, and social gatherings into SP and humanitarian programming to address isolation, mental wellbeing, and social exclusion among older persons.

OUTREACH AND ENGAGEMENT

Recommendation 6: Strengthen localized, last-mile outreach and engagement mechanisms to ensure older persons and the most isolated can access, understand, and enrol in SP programs.

Key audience:	Government, Implementers

6.1 Tailor outreach channels to older persons' access barriers: MoSA and implementers should account for literacy levels, mobility limitations, digital access, and gender dynamics. Design outreach strategies using multiple complementary channels rather than a single modality. Combine SMS alerts, phone calls, in-person visits, social media, and traditional media. Messaging should be simplified and adapted to literacy.

6.2 Adapt outreach approaches to low-literacy and digitally excluded populations: MoSA and implementers should develop accessible communication and enrolment tools for older persons with literacy or digital barriers. This includes audio messaging, pictorial guides, community announcements, caregiver-mediated communication, and assisted digital registration support.

6.3 Ensure dignity-centered and discreet outreach processes: MoSA and implementers should design outreach, assessment, and verification approaches that protect privacy and minimize stigma. This includes confidential home visits, discreet enrolment procedures, gender-sensitive outreach teams, and neutral meeting spaces to maintain dignity and trust.

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Annex II: Data Collection Instruments

KII Guide

Interviewer name	
Interviewee name	
Organization	
Sex	
Role	

Consent: My name is _____. I am a researcher working with Integrated International, a learning-specialized organization working to maximize the impact of development programs throughout the Middle East and North Africa. We are conducting research on behalf of the CAMEALEON consortium, an NGO-led research and learning network established in 2017 to support the effectiveness and accountability of SP for refugees and host communities in Lebanon. This research aims to explore the perspectives and lived experiences of the most vulnerable older Lebanese persons (aged 60 and above) in relation to cash and voucher assistance and SP schemes, with the aim of informing the design of more effective, inclusive, and accessible programming.

Thank you for agreeing to speak with me today. The purpose of this interview is to understand your views and experiences. The discussion will take about 60 minutes. Your participation is completely voluntary. You can skip any question or stop the interview at any time without giving a reason.

With your permission, I'd like to audio record so I can capture your words accurately. All recordings will be deleted after completion of the transcription and analysis. If you do not wish for the audio to be recorded, then I will only take written notes. Everything you share will be kept confidential. Your name and any identifying details will not appear in reports or publications, and any information you share will be analyzed in an aggregate, anonymized format. The information will only be used for research purposes.

Do you agree to take part in this interview?

1. Tell me about yourself. What is your role in [organization]? How long have you been in this role, and what types of programs, projects, or activities do you generally oversee?
2. Tell me about your organization. How does your organization currently work with older Lebanese persons? What types of projects and activities do you currently have or have you undertaken in the past?
    a. Can you describe other programs or activities beyond the ones undertaken by your organization?
    b. Probe on cash assistance and SP programs more specifically.
3. [RQ 1.1, 3.1] Tell me about your understanding of cash assistance in Lebanon, specifically activities targeting older persons. To what extent do you believe older persons engage with or benefit from existing CVA programs and SP schemes?
    a. Who benefits from it? How?
    b. Who does not benefit from it? Why not?
4. [RQ 3.1] Tell me about your understanding of SP and SP in Lebanon, specifically for older persons.
    a. Who benefits from it? How?
    b. Who does not benefit from it? Why not?
5. [RQ 3.1] What are the top two or three needs of older persons that could be supported or addressed through humanitarian cash or SP?
    a. What would change as a result of participation in these programs? Why?
    b. What would some of the limitations be? Why?

6. [RQ 3.2] How are current cash assistance and SP programs meeting these needs?
    a. Probe on accessibility, flexibility, and sustainability
    b. What types of activities do they undertake? What is working and what is not?
    c. What are the most major gaps? Why?
    d. How do organizations currently address gaps?
7. [RQ 3.3] What are the key challenges and gaps in the current SP landscape in Lebanon? *Probe on at least three key challenges or gaps.*
    a. How does this impact older persons, in particular? Why?
    b. What strategies can be implemented to overcome the challenges you have mentioned?
    c. How are organizations currently trying to overcome these challenges? What are some example of successful approaches to doing so?
8. [RQ 2.1] In your experience, what are some of the main barriers that prevent older persons from participating in cash assistance programs and SP schemes? *Ask interviewee to share at least three barriers.*
    a. What are the structural barriers? How do they affect participation?
    b. What are the social barriers? How do they affect participation?
    c. What barriers do older persons face when utilizing complementary services and referral systems?
    d. Probe on ageism, gender, chronic illness, disability, geographic location, transportation, and lack of information.
9. [RQ 2.2] What are the gendered challenges faced by older women, particularly those in vulnerable situations (e.g., female-headed households, those with caregiving responsibilities), when accessing cash assistance and SP? *If already partially covered above, probe further using questions below.*
    a. How do these differ from the barriers faced by men?
    b. Why do women face these barriers? How do they affect their ability to access and participate in CVA and SP?
    c. How can these barriers be addressed? What are some of the current challenges in doing so? Why?
10. [RQ 2.3] What are the current gaps in outreach and targeting mechanisms for older persons?
    a. Why do these gaps exist?
    b. How can they be improved to reach the most vulnerable, particularly older persons? Who can ensure this happens and why?
11. Do you have any other thoughts or recommendations when it comes to strengthening cash assistance and SP schemes for older persons in Lebanon?

Thank you for your time.

IDI GUIDE

Interviewer name	
Interviewee name	
City/Town, Kaza, Governorate	
Age	
Sex	
If female, is she the head of household?	Yes / No
older Person or Caregiver?	older person / Caregiver
Internally displaced	Yes / No
Disability or chronic illness	Briefly describe
Living alone or isolated	Yes / No

Consent: My name is _____. I am a researcher working with Integrated International, a learning-specialized organization working to maximize the impact of development programs throughout the Middle East and North Africa. We are conducting research on behalf of the CAMEALEON consortium, an NGO-led research and learning network established in 2017 to support the effectiveness and accountability of SP for refugees and host communities in Lebanon. This research aims to explore the perspectives and lived experiences of the most vulnerable older Lebanese persons (aged 60 and above) in relation to cash and voucher assistance and SP schemes, with the aim of informing the design of more effective, inclusive, and accessible programming.

Thank you for agreeing to speak with me today. The purpose of this interview is to understand your views and experiences. The discussion will take about 60 minutes **[Note: 90 minutes if Journey Mapping interview]**. Your participation is completely voluntary. You can skip any question or stop the interview at any time without giving a reason.

With your permission, I'd like to audio record so I can capture your words accurately. All recordings will be deleted after completion of the transcription and analysis. If you do not wish for the audio to be recorded, then I will only take written notes. Everything you share will be kept confidential. Your name and any identifying details will not appear in reports or publications, and any information you share will be analyzed in an aggregate, anonymized format. The information will only be used for research purposes.

Note to interviewer: Refer to the definitions of cash assistance and SP to ensure interviewees are aware of what is meant. Remind them at least once or twice during the interview process.

Cash assistance: This is cash assistance provided by humanitarian organizations (UN & NGOs).

SP: SP is a system of support that helps people when they face difficulties like losing a job, getting sick, or growing old. It acts as a safety net through things like cash transfers, healthcare, or pensions so that everyone can meet their basic needs and live with dignity. In Lebanon, this might include AMAN (ESSN), NSSF, NPTP, and disability benefits.

Do you agree to take part in this interview?

Interview Guide (~60 minutes)

Introduction

1. Tell me about yourself, in which area do you live in? Do you live alone or with a family member?
2. ***Only ask older persons.*** Do you have a regular source income? Did you work in the past or are you currently working?
   a) If yes, where does it come from *(probe on work, remittances, and other sources of income)*? Is this or was this formal or informal work?
   b) Do you currently work and what do you do? If you're retired, what did you do previously? Probe on previous experience in government/military role (note to interviewer there is SSN law that gives pension to retired military personnel)
   c) If you have an income, to what extent does your income help you cover your main needs? Are there areas where it falls short? *Probe on if they have or if they plan to withdraw their end of service indemnity.*
   d) If you do not have an income, what are the main ways you manage your daily needs? *Probe on: support from family members/network etc.*

Understanding of cash assistance and SP programs

3. [RQ 3.1] Could you tell me about your understanding of SP and SP in Lebanon, specifically for older persons?
   a) Who benefits from it? How?
   b) Who does not benefit from it? Why not?
   c) There have been discussions about a new pension law and a national strategy for older persons (2020–2030). Have you heard about these? If yes, what do you think about them? If not, what would you hope such initiatives might address?

Responsiveness of SP to needs

4. [RQ 3.1] Could you tell me more about the extent to which you are familiar with cash assistance in Lebanon, specifically activities targeting older persons? Do you currently benefit from it?
5. [RQ 1.1] ***Only ask recipients or their caregivers.*** How do you or the person you care for engage with or benefit from existing cash assistance programs and SP schemes?
   a) Do you or are you planning on withdrawing a pension or end of indemnity payment, if available to you?
   b) How did you hear first about it? From whom?
   c) Would you feel comfortable sharing what type of support you receive, how often, and whether it is enough for your needs?
   d) How did you receive this assistance? What do you understand about the criteria, or how do you think people are selected?
6. [RQ 1.2] How do you perceive humanitarian systems and national SP systems?
   a) What do you see positively? Why?
   b) What do you see less positively? Why?
   c) How do these perceptions influence your willingness and ability to access available assistance programs?
   d) Where do you get your information from? Do you participate in any community groups or structures? What is the role of municipalities in sharing information on these issues?
7. [RQ 1.3, 3.2] ***Only ask recipients or their caregivers.*** How are current cash assistance and SP programs meeting your needs or the needs of the person you care for?
   a) Probe on accessibility, flexibility, and sustainability
   b) What needs is it fulfilling? How?
   c) What is working and what is not?

d) What are the most major gaps? Why?

8. [RQ 3.1] In your opinion, if support programs could focus on just two or three things (e.g., affordable long term healthcare, emotional companionship, domestic support) that would make the biggest difference in your life, what would they be?
   a) What would change for you as a result of participation in these programs? Why?
   b) How would or does this impact your or their living circumstances? Why?
   c) What would some of the limitations be? Why?

Experience with cash assistance programs

9. [RQ 3.3] In your opinion, what are the key challenges and gaps in the current SP landscape in Lebanon? *Probe on at least three key challenges or gaps.*
   a. How does this impact you or the person you care for? Why?
   b. When needs are not fully met, How do you manage or cope?
   c. What solutions or changes do you think can help overcome the challenges you have mentioned?
10. [RQ 2.1] What are some of the main barriers that reduce your ability or the ability of the person you care for to participate in cash assistance programs and SP schemes?
   a) What are the main difficulties that make it harder for you (or the person you care for) to take part in cash assistance or SP programs? How do you think they affect your ability to participate?
   b) How do you hear about these issues? Do you take part in any community groups, forums, or activities where such issues are discussed?
   c) Some challenges come from society, such as age, gender, health conditions, disability, distance, transportation, or lack of information. Have you faced any of these? How do they affect your ability to access support?
11. [RQ 2.3] What are the current gaps in outreach and targeting mechanisms for older persons?
   a) How do you or the person you care for learn about new policies, programs, or assistance? How are these methods working for you or the person you care for? If they're working well, what's working well? If they're not working well, why not? *Probe about community groups, meeting spaces, municipalities, and other community leaders and focal points*
   b) What would be the best way to reach you with this type of information? Why?
12. [RQ 2.1] Thinking about a time you have or the person you care for has utilized or needed to utilize complementary services (e.g., complaints or feedback mechanisms) and/or referral systems linked to cash assistance or SP:
   a. How were you able to make your concerns or needs heard? What role do organizations for older persons play in this?
   b. What was the response or outcome? How did you feel about it?
   c. What were the main barriers or challenges you faced? Why?
   d. What was the result of those barriers? How did they affect your access and engagement?
13. [RQ 2.2] ***Only ask older Women or Persons with Disabilities or Chronic Illnesses.*** As a [woman or person with disabilities or a chronic illness], what additional challenges do you believe you face when accessing cash assistance and/or SP? *If already partially covered above, probe further using questions below.*
   a. How do these differ from the barriers faced by others?
   b. Why do you think you face these barriers? How do they affect your ability or the ability of the person you care for to access and participate in cash assistance and/or SP?
   c. How can these barriers be addressed? What are some of the current challenges in doing so? Why?
14. Do you have any other thoughts or recommendations when it comes to strengthening cash assistance and SP schemes for older persons in Lebanon?

[If no Journey Mapping]

Thank you for taking the time to answer these questions. I would like to ask you a few more questions about your community.

What kinds of activities are people doing to earn money informally these days? Are these new or ongoing practices?	ما نوع الأنشطة التي يقوم بها الناس حالياً لكسب المال بطرق غير رسمية؟ هل هذه ممارسات جديدة أم. مستمرة منذ فترة؟
How do families and neighbors help each other during hard times? Can you share examples of community support you've seen or received?	كيف يساعد أفراد العائلة والجيران بعضهم البعض خلال الأوقات الصعبة؟ هل يمكنك مشاركة أمثلة عن الدعم المجتمعي الذي رأيته أو تلقيته؟
Have you or others in your community formed any groups or initiatives—like savings clubs, food-sharing groups, or co-ops—to support each other? How do these work?	هل قمت أنت أو غيرك في مجتمعك بتشكيل مجموعات أو مبادرات مثل جمعيات التوفير، أو مجموعات تقاسم الطعام، أو التعاونيات لدعم بعضكم البعض؟ كيف تعمل هذه المبادرات؟
Do you think people's access to help or resources is affected by their background—like religion, politics, or where they come from? How so?	هل تعتقد أن إمكانية حصول الناس على المساعدة أو الموارد تتأثر بخلفياتهم مثل الدين أو الانتماء السياسي أو المنطقة التي ينحدرون منها؟ كيف ذلك؟
How has the crisis affected people who have been displaced or come from other areas? Are their experiences different from longer-term residents?	كيف أثرت الأزمة على الأشخاص النازحين أو القادمين من مناطق أخرى؟ هل تختلف تجاربهم عن تجارب السكان المقيمين منذ فترة طويلة؟

Journey Mapping Guide (~30 minutes)

[If Journey Mapping] Thank you for taking the time to answer these questions. I'd now like to spend 30 minutes or so with you mapping your journey with cash assistance to better understand how you've engaged with the activity.

1. Let's start with how you learned about the assistance.
    a. How did you hear about it? Through what channels and from whom?
    b. Who did you speak with?
    c. What types of information did they share?
    d. What questions did you ask, if any?
    e. What types of referral or information systems did you access? How did you learn about them?
    f. What was your impression of the overall process? What worked well?
    g. What was missing in the process, and what more could they have done to better inform you that this program existed and about its details?
2. Now, let's think about how you were informed that you would receive the assistance.
    a. How did you learn you would receive the assistance? Who told you that you had been selected?
    b. What types of information did they communicate to you (e.g., modality, amount of assistance)? How did you receive the communication and from whom?
    c. Why do you believe you were selected to receive the assistance? What types of selection information did they share?
    d. What worked well in the process of informing you that you would receive the assistance? What would you change about this process?
3. Now, let's look at receiving the assistance itself.

   a. Approximately how long did it take for your first payment after hearing you would receive the assistance? How did you perceive the wait to find out?
   b. How much do you receive? How often? For how long?
   c. How do you access the cash? Where does it come from (e.g., from a bank, ATM, or distributed to you personally by hand)?
   d. Who withdraws it? If not you, what prevents you from withdrawing it?
   e. What's working well in this process? How does it work for you?
   f. What would you say are your main challenges in the process of accessing the cash? What would you change to improve it?
4. Now, let's talk about how you use the assistance.
   a. What are you mainly using it for?
   b. How do you prioritize? Who makes the decisions?
   c. How is this working for you? What's working well and why?
   d. What challenges have you faced, and why?
   e. How have you overcome these challenges or tried to overcome them?
   f. What further support would you need to overcome them?
5. Now, let's discuss complementary services and referral systems.
   a. Have you tried to provide feedback, complaints, or suggestions on the assistance you receive?
   b. If yes, how and to whom?
   c. What was their response and the outcome? How do you feel about the response and the outcome?
   d. If you have not tried, why not? What are the barriers or challenges?
6. Thinking about this process as a whole, let's discuss what you think works well and what you would change.
   a. In your opinion, what are some of the highlights of things that worked well for you? *Probe on at least two or three topics.*
   b. Why have these worked well specifically for you? How have they worked?
   c. What are the two or three main barriers or issues that you had to or have to overcome with the assistance? Why and how do you or have you overcome them?
   d. What would you recommend be changed to make these less of a problem for you or for others facing similar barriers or challenges in the future? How and why?
7. Do you have any other thoughts you would like to share?

Thank you for your time.

FGD GUIDE

Interviewer name	
City/Town, Kaza, Governorate	
Sex of participants	
Collect for each individual	
Age	
Internally displaced	Yes / No
Disability or chronic illness	Briefly describe
Living alone or isolated	Yes / No

Consent: My name is _____. I am a researcher working with Integrated International, a learning-specialized organization working to maximize the impact of development programs throughout the Middle East and North Africa. We are conducting research on behalf of the CAMEALEON consortium, an NGO-led research and learning network established in 2017 to support the effectiveness and accountability of SP for refugees and host communities in Lebanon. This research aims to explore the perspectives and lived experiences of the most vulnerable older Lebanese persons (aged 60 and above) in relation to cash and voucher assistance and SP schemes, with the aim of informing the design of more effective, inclusive, and accessible programming.

Thank you for agreeing to speak with me today. The purpose of this discussion is to understand your views and experiences. The discussion will take about 60-90 minutes. Your participation is completely voluntary. You can skip any question or cease participation in the discussion at any time without giving a reason.

With your permission, I'd like to audio record so I can capture your words accurately. All recordings will be deleted after completion of the transcription and analysis. If you do not wish for the audio to be recorded, then I will only take written notes. Everything you share will be kept confidential. Your name and any identifying details will not appear in reports or publications, and any information you share will be analyzed in an aggregate, anonymized format. The information will only be used for research purposes.

Note to interviewer: Refer to the definitions of cash assistance and SP to ensure interviewees are aware of what is meant. Remind them at least once or twice during the interview process.

Do you agree to take part in this discussion?

1. Tell me about yourselves. Ask each individual to take a minute to introduce themselves.
2. Do you have a regular source income? Did you work in the past or are you currently working?
    a. If yes, where does it come from (*probe on work, remittances, and other sources of income)*? Is this or was this formal or informal work?
    b. Do you currently work and what do you do? If you're retired, what did you do previously? Probe on previous experience in government/military role (note to interviewer there is SSN law that gives pension to retired military personnel)
    c. If you have an income, to what extent does your income help you cover your main needs? Are there areas where it falls short? *Probe on if they have or if they plan to withdraw their end of service indemnity.*
    d. If you do not have an income, what are the main ways you manage your daily needs? *Probe on: support from family members/network etc.*
3. [RQ 3.1] Could you tell me more about the extent to which you are familiar with cash assistance in Lebanon, specifically activities targeting older persons? Do you currently benefit from it?
4. [RQ 3.1] Could you tell me about your understanding of SP and SP in Lebanon, specifically for older persons?

   a. Who benefits from it? How?
   b. Who does not benefit from it? Why not?
   c. There have been discussions about a new pension law and a national strategy for older persons (2020–2030). Have you heard about these? If yes, what do you think about them? If not, what would you hope such initiatives might address?
5. [RQ 3.1] In your opinion, if support programs could focus on just two or three things (e.g., affordable long term healthcare, emotional companionship, domestic support) that would make the biggest difference in your life, what would they be?
   a. What would change for you as a result of participation in these programs? Why?
   b. How would or does this impact your or their living circumstances? Why?
   c. What would some of the limitations be? Why?
6. [RQ 1.2] How do you perceive humanitarian systems and national SP systems?
   a. What do you see positively? Why?
   b. What do you see less positively? Why?
   c. How do these perceptions influence your willingness and ability to access available assistance programs?
   d. Where do you get your information from? Do you participate in any community groups or structures? What is the role of municipalities in sharing information on these issues?
7. [RQ 1.1] ***Only ask recipients.*** How do you engage with or benefit from existing cash assistance programs and SP schemes?
   a. Do you or are you planning on withdrawing a pension or end of indemnity payment, if available to you?
   b. How did you hear first about it? From whom?
   c. Would you feel comfortable sharing what type of support you receive, how often, and whether it is enough for your needs?
   d. How did you receive this assistance? What do you understand about the criteria, or how do you think people are selected?
8. [RQ 1.3, 3.2] ***Only ask recipients.*** How are current cash assistance and SP programs meeting your needs?
   a. Probe on accessibility, flexibility, and sustainability
   b. What needs is it fulfilling? How?
   c. What is working and what is not?
   d. What are the most major gaps? Why?
   e. How do organizations currently address gaps?
9. [RQ 3.3] In your opinion, what are the key challenges and gaps in the current SP landscape in Lebanon? *Probe on at least three key challenges or gaps.*
   a. How does this impact you? Why?
   b. What strategies can be implemented to overcome the challenges you have mentioned?
10. [RQ 2.1] What are some of the main barriers that reduce your ability to participate in cash assistance programs and SP schemes?
   a. What are the main difficulties that make it harder for you to take part in cash assistance or SP programs? How do you think they affect your ability to participate?
   b. How do you hear about these issues? Do you take part in any community groups, forums, or activities where such issues are discussed?
   c. Some challenges come from society, such as age, gender, health conditions, disability, distance, transportation, or lack of information. Have you faced any of these? How do they affect your ability to access support?
11. [RQ 2.1] Thinking about a time you've utilized or needed to utilize complementary services (e.g., complaints or feedback mechanisms) and/or referral systems linked to cash assistance or SP:
   a. What was the response or outcome? How do you feel about it?

   b. What were the main barriers or challenges you faced? Why?
   c. What was the result of those barriers? How did they affect your access and engagement?
12. [RQ 2.2] ***Only ask older Women or Persons with Disabilities or Chronic Illnesses.*** As a [woman or person with disabilities or chronic illness], what additional challenges do you believe you face when accessing cash assistance and/or SP? *If already partially covered above, probe further using questions below.*
   a. How do these differ from the barriers faced by others?
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   c. How can these barriers be addressed? What are some of the current challenges in doing so? Why?
13. [RQ 2.3] What are the current gaps in outreach and targeting mechanisms for older persons?
   a. How do you or the person you care for learn about new policies, programs, or assistance? How are these methods working for you or the person you care for? If they're working well, what's working well? If they're not working well, why not? *Probe about community groups, meeting spaces, municipalities, and other community leaders and focal points*
   b. What would be the best way to reach you with this type of information? Why?
14. Do you have any other thoughts or recommendations when it comes to strengthening cash assistance and SP schemes for older persons in Lebanon?

Thank you for your time.

Annex III: Journey Mapping

This annex is attached as a separate document.