Action Fiche for Libya

1. IDENTIFICATION

Title/Number	Libya health systems strengthening (LHSS) programme (EU-LHSS)		
Total cost	EU contribution: EUR 8.5 million		
Aid method / Method of implementation	Project approach – Direct centralised management		
DAC-code	12220	Sector	Health

2. RATIONALE

Libya is an oil-rich country with a population of 6,422,772 and a Gross National Income (GNI) per capita of USD 16,270 (PPP). In February 2011, Libya was plunged into an all-out civil conflict. As a result, the 42-year rule of Colonel Muammar Gaddafi was brought to an end on 23 October 2011. Following a period of interim rule by the National Transitional Council (NTC), on 7 July 2012, the country held its first national elections in more than 50 years. The newly elected 200-member National General Congress replaced the NTC and will appoint a ruling cabinet.

The conflict had an unprecedented impact on the country. Several thousand lives were lost and thousands were displaced as a result of the conflict. GDP growth declined by 60 percent as oil production fell to as low as 22 thousand barrels per day in July 2011[1]. Further, the onset of the civil war forced approximately 600,000 migrant workers to flee Libya, making it the largest migration crisis since the first Gulf War in 1991.

European Union (EU) support to health systems strengthening in Libya responds to needs articulated by the Libyan government in the course of 2011, during an international conference held in January 2012, during a formulation mission, which took place in July/August 2012, and in the framework of a National Health System Conference held in Tripoli on 26-30 August 2012.

EU support to health sector reform in Libya is in line with the *European Neighbourhood Policy* (ENP)[2], which aims to promote good governance and social development in Europe's neighbours, and with the *European Neighbourhood and Partnership Instrument* (ENPI),[3] which is structured around strengthened dialogue on priority multi-sector reforms, institutional support and the objectives of the UN's Millennium Development Goals.[4] EU involvement in this sector also directly translates the tenets of the renewed European Neighbourhood Policy (ENP) adopted

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1 World Bank Country Data 2012 available at http://www.worldbank.org/en/country/libya.

2 EC Communication to the Council, the European Parliament, *European Neighbourhood Policy Strategy Paper*, (COM(2004)373 final).

3 EC Regulation No 1638/2006 of the European Parliament and of the Council of 24 October 2006 laying down general provisions establishing a European Neighbourhood and Partnership Instrument (ENPI). The European Neighbourhood Instrument (ENI) will further strengthen the link between policy and assistance.

4 In 2006, the European Commission Communication on Strengthening the European Neighbourhood Policy further recognised public health as an area that could benefit from co-operation between the EU and ENP partners. European Commission Communication to the Council and the European Parliament, *Strengthening The European Neighbourhood Policy* (COM (2006)726 final) 4 December 2006.

on 24 May 2011, which offers new types of support for more sections of society, and introduces more incentives to pursue reform.[5]

Beyond the needs expressed by the government of Libya and underlying policy frameworks for EU action in support to health systems strengthening, the rationale for investing in health sector reform in Libya is two-pronged:

In a post-conflict environment, **health systems strengthening can play a major contribution to** both **social stability** and, more widely, to the **state and peace building agenda**. It has long been recognised that public service provision enhances government performance, legitimacy and perceptions of responsiveness thereby reducing societal propensity towards conflict. Governance reforms have wider consequences for the consolidation of the state that extend beyond the institutions necessary for the direct delivery of health services. They spill over from the health sector into civil society; they impact upon perceptions of the legitimacy of the state; they encourage governments into greater levels of responsiveness and contribute to enhanced legitimacy; they bridge the divide between belligerent communities; and, most crucially, they contribute to the protection of core institutions and people, thus consolidating stability. Besides, health issues can be a vanguard of reintegration and demobilisation processes, a major priority in the Libyan context.

Health systems strengthening is also a **driver of economic growth**, which is at the forefront of the agenda of Libya's newly elected government. In fact, improved population health and job creation are mutually-supportive objectives. Good health has a positive, sizable and statistically significant effect on aggregate output. Conversely, poor health generates an economic burden to individuals, companies and countries. In particular, an unhealthy population generates higher healthcare costs, which hinder economic growth, and greater public expenditures.

The proposed intervention focusing on democratic transition and institution-building and stronger partnership with the population as well as sustainable and inclusive growth and economic development is in line with the two Joint Communications of the European Commission and of the High Representative of the EU for Foreign Affairs and Security Policy "A partnership for democracy and shared prosperity with the Southern Mediterranean"[6] and "A new response to a changing Neighbourhood"[7].

2.1. Sector context

The Libyan health care delivery system reflects past systemic imbalances and the impact of the civil war. Weakened health services are largely deficient in their capacity to attend to the needs of the population. The increased prevalence of mental disorders and physical disabilities –a consequence of the conflict– further exacerbate the situation.

Basic health status indicators for Libya (reported in table 1 below) are mixed[8]. Life expectancy and health-adjusted life expectancy (HALE) are among the best among the Middle East and North Africa (MENA) region at 73 and 64 years respectively. On the other hand, maternal and infant mortality rates –51 per 100,000 live births and 24 per 1000 live births respectively– are on par with MENA, but behind the

5 Joint Communication of the European Commission and of the High Representative of the EU for Foreign Affairs and Security Policy "*A new response to a changing Neighbourhood*", COM (2011)303 of 25 May 2011.

6 COM(2011)200 of 8 March 2011.

7 COM(2011)303 of 25 May 2011.

8 Data has been compiled from WHO World Health Statics 2012 and Eurostat 2008.

averages of EU Member States and other upper Middle Income Countries. Libya has achieved high coverage in most basic health areas. Births universally take place in health facilities and are attended by skilled health personnel. In 2011, Libya reported high routine immunisation coverage rates (99% for BCG and 98% for DPT1, DPT3, measles and polio).[9] However, concern has been raised that estimates are based on data that are of varying, and, in some instances, unknown quality, and in recent years the rate of coverage has reportedly slowed down.

Table 1 Basic Health Status Indicators

	Libya	MENA (Mean)	EU 27 (Mean)	Upper Middle Income (Mean)
Life expectancy at birth (yrs)	73.0	71.0	79.4	71.0
Maternal mortality (per 100,000)	51.0	--	7.0	
Infant mortality (per 1,000)	24.0	31.0	7.5	10.0
Total fertility rates	3.4	3.0	1.55	
Contraceptive use (any method)	49.0	58.0	--	
Adult literacy rate (%)	89.0	67.0		93.0
Urban population (%)	78.0	50.0		59.0
Improved water (%)	97.0	85.0		93.0

The burden of disease is rapidly shifting from communicable to non-communicable diseases, largely due to demographic and lifestyle changes. In 2012, WHO reported that the years of life lost from non-communicable diseases in Libya are three times higher than from communicable diseases.[10] The main causes of death (reported by national authorities) are cardiovascular diseases (37%), cancer (13%), road traffic injuries (11%) and diabetes (5%). The prevalence of risk factors for non-communicable diseases has risen as a result of changing lifestyles. More than 30% of the adult male population smokes regularly. Obesity is also emerging as a major health problem. At the same time, infectious diseases such as tuberculosis, hepatitis and HIV/AIDS remain problems of concern.

The **demographic pattern** reflects a young population in an epidemiologic transition of decreasing mortality and fertility and rising longevity and life expectancy. The implications of these demographic and epidemiological transitions are far reaching and **the socio-economic impact, in particular, will be enormous**. Libya is expected to face a rapid increase in health spending in the medium-term. This will in turn further increase public pressure on the government to expand health coverage. Additional fiscal space would need to be generated through internal structural reforms, including productivity gains and better social targeting of health subsidies.

9 BCG, or bacille Calmette-Guerin, is a vaccine for tuberculosis (TB). DPT1 and DPT3 are short for the first and third Dose of Diphtheria Toxoid, Tetanus Toxoid and Pertussis vaccine. WHO *Vaccine-Preventable Diseases: Monitoring System Global Summary* 2012

10 Bayard Roberts, Preeti Patel, Martin McKee, 'Non-Communicable Diseases and Post-Conflict Countries', *Bulletin of the World Health Organisation* 2012 (Vol. 90, pp. 2-2A) available at http://www.who.int/bulletin/volumes/90/1/11-098863/en/

Besides, the health delivery system must be completely reorganised since non-communicable diseases require clinical management in a primary care setting and population-based interventions on health promotion.

Health service delivery is financed, owned and directly managed by the government of Libya through the Ministry of Health. However, dual practice and absenteeism are widespread and these two factors considerably reduce the footprint of the public sector in health care delivery. The size of the private sector is unknown, but estimated to be growing rapidly and in an unregulated fashion. There is currently no strategic framework to guide decision-making on resource allocation and no health service package to identify core services to be delivered across the three tiers (namely, primary health care units, general hospitals and tertiary care specialised hospitals). Decision-making is highly centralised. Resources (both financial and human) are concentrated at secondary and tertiary care levels, whilst primary health services are severely under-utilised.[11] There are also considerable gaps in data collection and analysis, including disease surveillance, and in as far as drug procurement and supply chain management. Quality of health service delivery is variable and there is no systematic quality monitoring in place. There are no accreditation standards for hospitals and no re-licensing requirements. **Levels of trust in public service delivery** are notoriously low. As a result, those who are financially able seek health care in the private sector or abroad, mainly in Tunisia, Egypt, Jordan and Europe.

The potential of Libya's **health workers** to produce health is shortened by severe attrition, overproduction, misapplied skills, absenteeism, poor support and lack of supervision, which collectively result in losses in output and productivity. Currently, there is no workforce analysis and no policy for the annual intake of students in the faculties of Medicine, Nursing and Dentistry. As a result, the supply of health workers does not match required skills and scopes of practice. In particular, Libya is faced with excess production of some types of health workers (without adequate use) and underproduction of other cadres. Poor human resources management has also resulted in suboptimal deployment and use of health professionals. The quality of medical and nursing education is variable and there is no standardised curriculum.[12] There are also limited tools available for human resource management and performance monitoring and patchy investments in continuous professional development and skills upgrading.

Table 2 Health Service Delivery Indicators

	Libya	MENA (Mean)	EU 27 (Mean)	Upper Middle Income (Mean)
Physicians (per 10,000)	19.0	18.3	33.2	17.0
Nurses and midwives (per 10,000)	68.0	15.6	65.0	26.1
Hospital beds (per 10,000)	37.0	21.6	61.0	39.0

[11] In 2010, visits to primary care totalled 8,860,684 against 8,732,038 visits to hospital outpatient departments. This typifies a poor referral system and contrasts with systems where primary care services at least 70-80% of ambulatory care needs.

[12] Active-learning techniques such as Problem-Based Learning (PBL) are not uniformly applied.

As a percentage of GDP, Total Expenditure on Health (THE)[13] is certainly low (3.9%) but in absolute terms the amount is similar to what is spent in other MENA countries. Public expenditure predominates, but private spending –which is largely out-of-pocket– has been growing rapidly and reached 34% in 2009, according to WHO estimates. **Public health spending constitutes only 5.5% of government budget**, which is low both in absolute terms and as compared to both EU Member States and other Upper Middle-Income countries. Currently, health services are provided free of charge, but it is the poor quality of service delivery and low trust that deter utilisation. Rigorous examination of health financing options is urgently needed, together with a sound financial management system to optimise the use of resources. In as far as **provider payment mechanisms**, all publicly provided health care services are paid using only incremental salaries and line item budgets. This contributes to low productivity, technical inefficiencies and low returns on investment. A long-term plan is needed to align payment policies with quality improvements.

Table 3 Health Financing in Libya

	Libya	MENA (Mean)	EU 27 (Mean)	Upper Middle Income (Mean)
Total health expenditure as % of GDP	3.9	4.3	75.0	71.0
General government expenditure on health as % of total expenditure	66.00	74.90	74.90	54.80
General government expenditure on health as % of total government expenditure	5.50	7.10	14.60	10.50
Per capita total expenditure on health (PPP int. $)	722	324	2,218	565

In sum, the **challenges to the newly formed Libyan government are manifold** and complex. There are urgent needs to reform and strengthen capacity for effective and efficient health service delivery; to ensure effective planning, financing and management of health services; to correct glaring inefficiencies in workforce production, development and management; and not least, to **address** the burden of disease arising from the conflict. The Libyan government is also faced with rising expectations from both the public and health workforce who are demanding rapid improvements of the deteriorated public services.

Despite these challenges **there are also considerable opportunities for reform at present**. Significant pressure exists for the newly elected government to improve service delivery outcomes for its citizens. In turn, political leadership is committed to 'higher level' goals. *There is a relatively brief window of opportunity* during which the government and the international community –effectively, the EU, WHO and possibly the UK Government– can have a significant impact on restructuring systems and reformulating policy before these systems and institutions become entrenched and resistant to change. Needs have been clearly articulated by health sector stakeholders in the National Health System Conference held in August 2012. Donor engagement in this sector is limited and the EU has a de facto leadership. This may reduce the risk of fragmentation and facilitate co-ordination. Finally, and most

[13] THE are funds mobilised by the system, i.e. the sum of General Government Expenditure on Health and Private Expenditure on Health.

importantly, there are competent cadres within the Ministry of Health and articulate interlocutors within the Libyan health workforce. Libyan healthcare leaders have shown great potential to provide transformative leadership. They also have considerable exposure to diverse models of health care delivery. Their greatest challenge will be to sustain the momentum of health care reform, encourage the definition of national health objectives, and renounce the temptation to import 'ever-ready' blueprint models for health care delivery.

2.2. Lessons learned

Evidence from **previous** conflict and post-conflict experiences suggests the following:[14]

1. **Best practice is unlikely to be found embodied in a specific "best policy" or model.** Rather, it emerges from a judicious balance of context-sensitive exploration, rational appraisal of alternatives, and restrained generalisation of specific experiences.
2. **Sensible estimates of the likely effects of different approaches** may help managers to make informed **decisions**, **to narrow the spectrum of options and to choose *realistic* strategies**.
3. **Alternative costed scenarios showing the merits and costs of each approach** in maximising the **dimensions** mentioned above, as well as the disadvantages, may encourage a productive debate among stakeholders.
4. **Local participation should be pursued to the largest possible extent**. A thoroughly crafted strategy needs to be disseminated, understood and incorporated into the plans of the most important stakeholders, to stand a true chance of being followed.
5. **Policy reform is a profoundly political process**. Interest groups inside the health sector may feel threatened by a chosen strategy and react, sometimes openly, but often covertly. Their grievances should be **anticipated**.[15]
6. **Adopting an alternative service delivery model usually implies the introduction of new management systems**, or substantive changes to existing ones. These implications, often overlooked by decision-makers, must be made explicit as soon as possible, *before the choice is made*.
7. **Implementation needs to be split into discrete components and adequately sequenced**. Without translating a chosen strategy into operational goals and plans, the discipline embedded in the overall strategy is likely to be bypassed even by implementers with a genuine commitment to it.

Evidence from the EU-funded Libyan-European Partnership on Infectious Diseases Control (LEPIDC) programme suggests the following:[16]

1. Political frames are carriers of institutional inertia and path dependence. Success hinges on sustained and relentless pursuit of specific obstacles disabling change, an insider's perspective, managing by facts and evidence, building trust and mutually satisfying relationships.
2. Achieving long-term transformational results requires political backing, strategic coherence and shared ownership, together with the adoption of institutional processes and control measures appropriate to the context.

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14 WHO (2009) Analysing Disrupted Health Sectors - A Modular Manual.

15 Michael R. Reich, "The Politics of Health Sector Reform in Developing Countries: Three Cases of Pharmaceutical Policy", Health Policy 32 (1995) pp. 47-77.

16 WHO (2009) Analysing Disrupted Health Sectors - A Modular Manual

3. Engagement in the Libyan context (generally under a stabilisation rubric) requires quick decision-making and devolution of control, underpinned by predictable and flexible funding.

2.3. Complementary actions

EU support to health systems strengthening is fully complementary to broad civil service and public expenditure management reforms, which are being pursued with EU assistance. The EU-funded facility for public administration and capacity building –worth €4.5 million– was launched in 2012 and aims to contribute to the modernisation, stabilisation and functioning of public administration in Libya. In particular, the facility aims to support the stabilisation of key functions of the state, and credible public financial management. **The convergence and simultaneity of core governance reforms and health sector reforms will multiply the value added of EU assistance.** This programme will collaborate closely with the facility in the context of macroeconomic planning, by ensuring that health is well reflected in medium-term expenditure frameworks; on issues of pay, conditions and health workers' retention; and, with increasing decentralisation, by working with local government.

Other EU-funded actions in support to HIV/AIDS and health are also complementary and will be closely co-ordinated with the outputs of this programme, in particular LEPIDC, which aims to strengthen the capacity of the Libyan Government to develop appropriate responses in the management of HIV/AIDS and other infectious diseases. The programme resumed in January 2012 and operates in five regional hospitals across Libya. This phase of implementation reflects a fundamental shift of focus from knowledge transfer to quality of learning outcomes based on pedagogic and curriculum development.

There is **limited donor involvement** in the health sector. Donor support was mobilised during the crisis in the form of in kind contributions and humanitarian aid, but has since been phased out.

In January 2012, delegations from the Ministry of Health of Libya and Ministry of Social Affairs and Health of Finland held initial discussions on support to the development of plans and strategies in the prioritised areas of primary health care and mental health. The Government of Finland provided expertise through the National Institute for Health Welfare (THL), in close co-operation with WHO. A concept paper was prepared on the core definition and ingredients of primary health care, drawing upon international principles adapted to the Libyan context. The experts also prepared a Draft Master Plan for Mental Health. No follow up is foreseen by the Government of Finland to technical assistance provided in these areas. Nevertheless, the EU has established close contacts with THL in Finland.

The UK Department of Health has carried out several missions to Libya that led to a Memorandum of Understanding (MoU) signed the Libyan Minister of Health during the World Health Assembly meeting in Geneva in May 2012. The MoU includes comprehensive technical assistance to be made available to support reforms in the health sector. The MoU is to be financed by the Government of Libya in its entirety. There is no clear indication at present that the Government of Libya will mobilise funding towards the MoU. However, the EU is engaged with all parties in order to ensure full complementarity and close co-ordination between the result areas of this programme and the activities covered under the MoU, if they are indeed financed by the Government of Libya.

2.4. Donor co-ordination

In September 2012, the Ministry of Planning set up thematic Working Groups (WGs) and nominated focal persons within each Ministry to further policy dialogue and development co-operation. Meetings are to take place on a monthly basis. The EU will use the WG on health as a forum for dialogue and co-ordination. The World Health Organisation (WHO) is actively engaged in policy dialogue with the Government of Libya and will support co-ordination.

In the meantime, the EU has engaged the Ministry of Health and Libyan healthcare leaders in dialogue concerning the objectives of the programme through regular meetings.

3. DESCRIPTION

3.1. Objectives

Overall objective

To improve efficiency, effectiveness and quality of health service delivery in Libya.

Specific objective

To strengthen strategic planning, financing as well as management and quality of health service delivery through targeted reforms and pilot interventions.

3.2. Expected results and main activities

Results will be delivered through the mobilisation of long-term and short-term technical assistance, through targeted trainings, through the organisation of forums for multi-stakeholder dialogue, and through pilot interventions, which will test innovative approaches and inform the reform process whilst delivering quick-impact results.

Result 1: Strategic Planning, Health Financing and Capacity Strengthened

National health strategy, related policies and action plans developed; health financing options identified; provider payment mechanisms reviewed; and capacity of the Ministry of Health and Health Professionals Associations strengthened at all levels

EU support in this result area will address needs related to strategic planning, health financing, capacity development, dialogue and governance. Such needs have been identified as major priorities to reform health care delivery and are complementary to the other two result areas described below.

Main activities:

Under '*strategic planning*', activities may include but are not limited to: support to the development of a health strategy and action plan; the design and costing of a Health Service Package defining services, levels and tiers of service delivery and referral mechanisms in line with the health strategy; support to specific sub-sector policies and strategies; and the identification of options for multi-sectoral collaboration.[17]

Under '*health financing*', activities may include but are not limited to: the projection of short-term and long-term health care costs; a health expenditure survey and the

[17] This may include a health promotion policy and strategy and specific policies reflecting multi-sector collaboration with other ministries.

identification of options for efficiency gains; the development of a strategy and sequenced action plan to operationalise efficiency gains; a review of provider payment mechanisms for each tier of health service delivery and the identification of options and entry points for provider payment reforms; the design, accelerated roll out and assessment of payment reform pilots; and the development of a strategy and sequenced action plan to phase in payment reforms.

Under '*capacity development, dialogue and governance*', activities may include but are not limited to: a review of the Ministry of Health assets and needs, functions and structure at central and regional level; support towards the establishment or strengthening of forums for dialogue with frontline workers, health professionals associations, health consumers' organisations and the public; targeted interventions to build the capacity of health professionals' associations; and the design and roll out of a comprehensive Communication Strategy to creatively raise awareness and foster dialogue about health sector reforms.

Result 2: Service Delivery and Quality of Health Care

Health Service Package successfully rolled out in pilot areas; options for public private partnerships identified; quality of outcomes framework and accreditation standards developed and selected quality improvements reported

EU support in this result area will improve health service delivery and quality of health care with a mix of short term/quick impact programme deliverables and long term interventions.

Under the rubric '*Health Service Delivery*', activities may include but are not limited to: the completion of health facility mapping and gap analysis for both public and private health facilities[18]; an accelerated action plan and management framework for the roll out of a Health Service Package including the identification of roll out phases and pilot areas for fast track implementation with due attention paid to primary health care;[19] a mapping of private service delivery and the identification of entry points for public private partnerships; the establishment and strengthening of a forum for dialogue with the private sector; and the roll out of pilot public private partnerships.

Under *'Quality of Health Care'* activities may include but are not limited to: the definition of key quality indicators for quality improvement; support towards the establishment of a platform on clinical governance to develop and roll out protocols and quality assurance tools; support to quality assurance functions within the Ministry of Health, in particular supportive supervision; the design and implementation of pilot programmes on quality improvement, focusing largely on bottom up initiatives for quick impact and/or other evidence-based quality improvements by frontline workers and health care managers; integration of bottom up approaches into the reform cycle; the design of an accreditation policy, act and phased implementation plan; client surveys in pilot areas; and the organisation of mediatised forums for dialogue with the public regarding the quality of health service delivery and expectations.

Result 3: Workforce Planning, Development and Management

[18] This particular deliverable will include the identification of needs with regards to human resources, the functionality of health information systems, the availability of drugs and supply logistics and practical steps required to bridge the gaps.

[19] This activity will include the redefinition of services to be delivered by each tier.

Recruitment and retention targets in place; pre-service and in-service training needs assessed and partially addressed through targeted training and partnerships with training institutions; curricula ***upgraded and standardised; licensing standards and management tools developed and rolled out in pilot areas***

EU support in this result area will address critical deficiencies encountered in human resource planning, development and management.

Under '*Workforce Planning*', activities may include but are not limited to: a workforce analysis and projection of human resource needs (including needs for specific selected categories); a short- and a long-term workforce plan; the identification of targets for students intake for medical/paramedical/nursing students; recruitment and retention plans for nurses and doctors; options for re-tasking and retraining to strengthen primary health care delivery; and regular dialogue with the Libyan health care workforce on proposed reforms.

Under '*Workforce Development*', activities may include but are not limited to: a sequenced action plan for phased upgrading and standardisation of curricula in accordance with international standards; the redesign of selected curricula; the identification of in-service training needs and the development of a menu of options for re-tasking, in-service training and continuous professional development for selected cadres; costing and accelerated roll out plans for the most urgent needs; and regular dialogue with the Libyan health care workforce on proposed reforms.

Under '*Workforce Management*', activities may include but are not limited to: the development, accelerated roll out and/or testing of selected human resources management and performance tools in pilot areas;[20] a review of dual practice arrangements and proposals for reform; the design and roll out of financial and other incentives (i.e. public awards, trainings, etc.) to enhance productivity and service quality; and the identification of options for phased re-licensing of health cadres, including a projection of their training needs.

3.3. Risks and assumptions

Several risks can be identified:

The slow pace of implementation of reforms coupled with high expectations creates frustrations among stakeholders who see little evidence of a governance dividend being delivered. To address this important risk a common understanding of reform priorities and political feasibility is needed. Besides, careful analysis of the policy context, including stakeholders, is an important prerequisite for successful health care reform. This analysis will further clarify expectations and resource support needs. This, in turn, needs to be translated into action plans, costed, financed and adequately sequenced.

Analytical and policy work does not translate into changes in everyday practice at the point of delivery. All policy-related/analytical inputs will be sequenced and complemented by time-based and costed frameworks for phased implementation. In addition, policy development will be concurrent with bottom-up approaches focusing on the 'politics of implementation'. Bottom up change initiated at the point of

[20] Tools could include a code of conduct and ethical standards; minimum working hours; reporting lines; job descriptions and skill requirements to be developed progressively for all cadres (with a phased approach starting at primary health care level and in line with the Health Service Package); career paths for all cadres; guidelines for the development and review personal and team objectives and targets; performance assessment and management tools; and disciplinary measures.

delivery by frontline health workers will be supported throughout the programme. A critical element will be the creation of interfaces to share ideas, provide mutual support and give voice to health care providers. The creation of a point of contact with citizens/users will further add meaning to the concept of social contract. Prominence will be given to piecing together the different levels of reform. Success stories and bottom up approaches will also be used to manage expectations, retain political credit, manage interest group pressure and celebrate improvements in service outcomes thus sustaining reform momentum.

Quality and high turnover of technical assistance mobilised may adversely impact on programme deliverables. Technical assistance will be selected through a rigours process facilitated by an independent committee made of key project stakeholders. The committee will regularly review the performance of Long Term Assistants (LTA) against set benchmarks. To the extent possible, short-term technical assistance will be planned well in advance so that adequate expertise can be sourced. In addition, the programme will endeavour to provide an adequate mix of technical and managerial skills.

Reforms are 'top down' or donor-driven with low ownership across the administration, health managers and staff. This risk will be mitigated through consensus-building and participatory approaches, and pilot programmes operationalising local ownership principles. Blueprint approaches inhibiting flexibility and openness to local input will be avoided at all costs[21].

Dependency on external factors such as broader government public sector reforms reduces the locus of control for sector-wide ***reforms***. Due attention will be paid to the public reform agenda and its role in determining the success of sector-wide reform processes. The programme will be closely co-ordinated with the EU-funded facility for public administration and capacity building.

Partial and piecemeal reforms are introduced to signal change without proper sequencing of sector-wide development milestones. The programme will endeavour to facilitate the development of a coherent national strategy to frame policy priorities with respect to addressing coverage, quality, access, and efficiency. In addition, external inputs will be mapped, building towards a division of labour amongst partners.

It is noted that risk analysis and risk management will be mainstreamed throughout project implementation.

3.4. Cross-cutting issues

The design of public services is a far more political matter than is often recognised. Rather than being a neutral process, a historical review of service provision shows that it has been used as a political tool for building state legitimacy and strengthen the social contract. By reforming service delivery accountability mechanisms, **the action will directly support** state responsiveness, state legitimacy and social cohesion, which are **core elements of the state building agenda**. Service delivery can also address **underlying causes of conflict**, i.e. social exclusion, and services

[21] The pursuit and co-ordination of a range of comprehensive reform plans will be led by the Ministry of Health, with structures and processes designed to support country ownership and leadership. Proposals for reform will be validated by a wide cross-section of national stakeholders. The programme will also strive to develop co-ordination structures that allow health professionals associations, civil society and front line health workers across Libya to participate to the extent that is both appropriate and feasible. Their capacity and leadership will also be strengthened over time through targeted actions.

such as health can be used as entry points for wider peace-building processes. With regards to non-state provision of health care services, developing a strategic framework for state intervention through regulation, contracting and mutual agreements will also contribute to state legitimacy. Given the particular political juncture in Libya, which combines an oppositional political climate with rising expectations, ensuring that the state's role in service delivery is clearly communicated is key.

Regarding gender, the action endeavours to support women's participation in health sector reform by ensuring their access to the programme's capacity-building measures and by **mainstreaming gender in health sector strategies, policies and plans**.

3.5. Stakeholders

The **direct beneficiaries** of this action are the Ministry of Health, health professionals associations, healthcare leaders, health care providers and managers, selected hospitals and primary health care facilities, frontline workers and health care consumers. Other key stakeholders include the Ministry of Finance, the Ministry of Planning, the Ministry of Roads and Transport, the Ministry of Higher Education, medical schools, schools of nursing and institutes of higher education involved in the training of healthcare workers. **Indirect beneficiaries** include the General National Congress (GNC), the media and the citizens of Libya.

4. IMPLEMENTATION ISSUES

4.1. Method of implementation

The programme will be implemented under direct centralised management through a service contract with Belgian technical Cooperation (BTC) , acting as lead agency within the European Network of Implementing Development Agencies (EUNIDA). The service contract will be awarded by direct agreement, in line with EU crisis procedures.

EUNIDA was established in 2000 as a grouping of EU Member States implementing agencies with a public mandate to develop, manage and implement sustainable development programmes.[22]

A steering committee comprising the EU Delegation and health sector stakeholders, including the Ministry of Health and health professionals' associations, will be established to define governance and management arrangements.

4.2. Procurement Procedures

Contracts

All contracts implementing the action must be awarded and implemented in accordance with the procedures and standard documents laid down and published by the Commission for the implementation of external operations, in force at the time of the launch of the procedure in question.

Participation in the award of contracts for the present action shall be open to all natural and legal persons covered by the ENPI Regulation.

[22] The purpose of the network is: i) promoting the exchange of information between EU implementing agencies; ii) devising common strategies in the field of international development activities, especially on behalf of the European Union; and iii) implementing programmes and projects of the highest quality.

Considering the nature of the actions to be implemented, the reigning crisis situation in Libya and the recognised expertise and experience of the member agencies of EUNIDA in the health sector and in the region make them the most suitable contractor to carry out the action.

Therefore, the programme will be implemented through a service contract directly awarded to BTC acting as lead agency within EUNIDA on the basis of Art 242(1) of the implementing rules of the Financial Regulation.

4.3. Indicative budget and calendar

The programme will be financed by the European Union with a contribution of **EUR 8.5 million** covering 100% of the programme budget.

Indicative Budget	EU contribution (in EUR)
Service contract	8,500,000

The foreseen operational duration of the action is 48 months from signature of the contract.

4.4. Performance monitoring

The programme will be subject to both internal and external result oriented monitoring using the log-frame as a tool to review progress and take corrective action. Progress towards stated objectives will be regularly monitored using a variety of methodologies, including desk reviews of narrative reports and other project outputs (i.e. analyses, draft policies and plans and draft documents), semi-structured interviews with key stakeholders, and on-site assessments of pilot projects and programmes. In addition, the programme may be subject to Results Oriented Monitoring (ROM) reviews against set criteria (relevance, efficiency, effectiveness, impact, and sustainability).

4.5. Evaluation and audit

One mid-term review and a final evaluation will be carried out respectively 18 months after the programme inception phase and at the end of the programme. External audits will also be carried out as required by European Commission procedures. The programme may also feature action research to empower practitioners to act as catalysts for each other's learning and professional growth, to document changes and to build an evidence-base.

These evaluations and audits will be funded from other sources than the project budget.

4.6. Communication and visibility

The action will include information and communication activities as per the Communication and Visibility Manual for EU External Actions[23]. All communication and visibility activities will be carried out in close co-operation with relevant services of the European Commission and the Delegation of the European Union to Libya.

[23] The Communication and Visibility Manual for EU External Actions replaces the EU Visibility Guidelines for External Actions (September 2005) and is available at: http://ec.europa.eu/europeaid/work/visibility/index_en.htm.