Modified Action Fiche for Libya

1. IDENTIFICATION

Title/Number	Programme of support to the strengthening of rehabilitation services for people with disabilities in Libya (ENPI/2010/22782)		
Total cost	EU contribution: EUR 2 million		
Aid method / Method of implementation	Project approach – direct centralised management		
DAC-code	12191	Sector	Medical Services

2. RATIONALE

2.1. Sector context

On 3 December 2010 a Financing Decision of EUR 2 million for a Programme of support to the EU Action Plan for Benghazi – Phase 6 and last phase was adopted. The Benghazi Action Plan in Libya started in November 2004 and since then the EU has provided expertise to the Benghazi Centre for Infectious Diseases and Immunology (BCIDI), and contributed to the treatment of the cohort of 400 children infected after the HIV outbreak at the Benghazi Children Hospital in the late 1990s. Under the Instrument for Stability, an additional EUR 1 million was committed in 2008 for a complementary programme to "Develop and Implement a National HIV / AIDS Strategy in Libya (DINHAS)." Thus, the EU's commitment in the field of HIV / AIDS amounts to EUR 7 million for the period 2007-2010.

But since the adoption of the final phase of the Benghazi Action Plan, the situation in Libya has considerably changed. On 17th February 2011 the revolution started in Libya and on 22nd February 2011 all EU development co-operation with the Libyan Government was suspended. Meanwhile, the opposition forces based in Benghazi in Eastern Libya, established the National Transitional Council (NTC). The parties of the "International Contact Group"[1] recognised during its recent fourth meeting in Turkey (15 July 2011) the NTC as a legitimate governing authority. NTC has proclaimed the liberation of Libya on 23 October and is about to form an interim government whose seat will be in Tripoli. Before the outbreak of the civil war in Libya it is estimated that about 7,000 doctors were accredited in Libya that means 1.3 per 1,000 inhabitants. Three referral centres for adults with physical disabilities based in Tripoli, Misrata and Benghazi[2], five referral centres for physically disabled children and 21 "day-time" units existed throughout Libya. An estimated number of 160,000 to 200,000 disabled persons were living in Libya before the war, including

[1] Beside Western countries representatives the following participants took part of the decision: Arab League (AL), Gulf Cooperation Council (GCC) and the Organisation of Islamic Cooperation (OIC).

[2] Until December 2008, the Benghazi Rehabilitation Centre received support provided by the Italian Development Cooperation.

those injured by road traffic accidents[3] and previous land mine injuries. With the outbreak of the civil war in Libya the number of newly injured persons requiring treatment has rapidly increased with a roughly estimated number of 15,000 during the first three and a half months of the conflict. As many as 10% of the newly wounded may have had amputations. This includes combatants and civilians, especially those affected by landmines and unexploded ordnances.[4]

It is anticipated that the numbers of persons requiring rehabilitation (both physical and psychosocial) will rise even more after the conflict has ended as experience in other countries has shown. Unexploded ordinance and land mines continue to be a threat long after conflict has finished. Land mines have been used during this conflict5 and it is reported that both Gaddafi supporters and rebels planted landmines6, many of these will be in unmarked areas.

In consequence to the heavy and violent fighting in Libya, the already weak health system is overburden and health care and assistance is supported by international organisations. The immediate and long-term needs are overwhelming. In July 2011 it was reported that the drugs supply chain in Libya was interrupted. According to UN and other international organisations[7] in July 2011 severe additional needs were reported, such as:

- Emergency assistance to war related injured and casualties;
- Qualified personnel such as nurses, midwives and other specialised medical staff like surgeons and orthopaedists;
- Surgical and other medical equipment (radiotherapy, etc.);
- Flexible primary health care to the increasing number of internally displaced persons (IDP) which mounted up to a total of 243,000 IDPs in mid June 2011, mainly in the eastern part of Libya, but also in the Nafusa mountain region;
- Safe blood transfusion service;
- Power supply for field and mayor hospitals;
- Water supply[8].

3 The incidence of road traffic accidents in Libya is one the highest in the region.

4 According to the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA) the explosive remnants of war (ERW) which are scattered over wide areas are posing serious risks to civilian populations, particularly children. In addition to risks posed by the destruction of ammunition storage areas, there are reports that parties to the conflict are laying landmines. In June, minefields were discovered near Zlitan (60 km west of Misrata) and near Zintan (Nafusa Mountains).

5 http://www.hrw.org/news/2011/07/19/landmines-libya-technical-briefing-note

6 http://www.globalpost.com/dispatch/news/regions/middle-east/110827/libya-gaddafis-land-mines-still-threat

7 These are: International Committee of the Red Cross (ICRC), International Medical Corps, Médecins sans Frontières, Handikap International, World Health Organization (WHO), Agency for Technical Cooperation and Development (ACTED), the European Commission, international press, etc.

8 Water is provided through the Great Man Made River. The necessary pumping depends of the availability of electricity generated through fuel which is running short and further on spare parts and monitoring systems are required to guarantee continuous supply.

UN OCHA stated that the Libyan health system is hampered by a lack of capacity in most of the areas of care. This refers to the overall managerial capacities but also to the absence of migrant workers who have now left the country and on which the health system relied on.

According to the World Health Organization (WHO) and under a middle- and long-term perspective it is of utmost necessity to support the rehabilitation of war wounded combatants and civilian casualties as a result of fighting and of landmines and unexploded ordnances. Mainly the internally displaced persons (IDP) are exposed to major landmine risks when they are returning to their homes. Under all thinkable scenarios of the current war in Libya, this problem will remain the case for some time to come. The effective management, the appropriate treating and long-term rehabilitation by building up a comprehensive rehabilitation service responding to those both with conflict related injuries and other physical disabilities will remain a priority and will have a long-term impact on the transition towards a functioning, prosperous and democratic State and civil society.

The European Commission is considering supporting the emergency rehabilitation services for the war injured persons, as well as humanitarian demining actions and first aid and referral assistance. The EU humanitarian response is focusing on the immediate needs due to the current conflict but not on the long term needs or not including those with pre-existing conditions.

Under the approach of linking relief to rehabilitation and development (LRRD), the future needs of the war injured and other disabled people imply specialised orthopaedic treatment, appropriate prostheses, physiotherapy treatment, psychosocial support activities, but also capacity building of the national rehabilitation service centres.

In view to assess the needs and design a path for future co-operation, from 5th to 8th April 2011, a joint EU mission to Benghazi, led by the European External Action Service (EEAS) took place. Among several other recommendations, the mission proposed to make use of the Benghazi Action Plan (BAP) Phase VI financing decision. On the basis of a common agreement between involved stakeholders and EU decision-taking levels the following approach should apply for development co-operation with Libya: immediate, straight-forward, flexible and donor co-ordinated.

2.2. Lessons learnt

Experience shows that building trust over the long term is crucial for the success of any programme in Libya. It is also particularly important under the current circumstances of transition towards democratisation and peaceful re-foundation of the Libyan state. Nevertheless, the envisaged health programme has to consider that the Libyan society and local / regional and future national entities have very limited practical experience of international and multilateral co-operation and the efficiency of public administration capacities is so far very low.

Thus the following shall be kept in mind:

(1) A linking relief to rehabilitation and development approach towards the long-term support of rehabilitation services shall build on the experiences and best practices gained during the initial emergency rehabilitation phase.

(2) Since huge efforts are required in the future to restructure and convert the Libyan health system in an effective service provider, the envisaged medical rehabilitation programme should be implemented in close co-ordination with the new Libyan Health Authority and building upon the existing although weak institutions for rehabilitation services.

(3) The new Libyan Health Authority under the National Transitional Council is committed to develop a proper donor co-ordination scheme which requires at this stage further strengthening.

(4) Monitoring as implemented in previous programmes in Libya is a key tool to follow up, control and improve programme implementation. A proper monitoring scheme should be put in place and systematically involve all stakeholders.

2.3. Complementary actions

EU co-operation activities with Libya began in 2005 with the gradual normalisation of Libya's foreign relations. The European Union's co-operation focused on health and HIV / AIDS, through the Benghazi Action Plan and Instrument for Stability (IfS) action, and on migration via the thematic programme for co-operation with Third countries in the areas of migration and asylum and its predecessor AENEAS. In the health sector, the EU was the most important donor.

Since the 22nd February 2011 all aid co-operation with Libya was temporarily suspended, but the EU provided immediately humanitarian assistance. Since June 2011 activities to support the up coming civil society under the IfS scheme started and others are under way of contracting to be financed by the European Instrument for Democracy and Human Rights (EIDHR) and the European Neighbourhood and Partnership Instrument (ENPI) funds.

In parallel to the present action fiche for the health sector, a second modified action fiche for the migration sector in Libya is presented (reference PE/2011/7513). Between both sectors complementary actions are proposed. In the field of migration one important component refers to the disarmament, demobilisation and reintegration of former combatants[9] meanwhile the here proposed rehabilitation measures provide an additional medical assistance scheme very much needed for effective reintegration of disabled former combatants.

The modification of the Financing Decision follows a medium- and long-term perspective under the umbrella of a "linking relief to rehabilitation and development" approach.

2.4. Donor co-ordination

Donor co-ordination of interventions and exchange of information has always been a key element of the European Commission and implementing partners in Libya. This approach will be maintained through close co-ordination with the new Libyan Health

9 The 17 February Revolution in Libya is primarily based on the involvement of young men who are serving as combatants or self-styled security forces on the opposition side. Their disarmament, demobilisation and reintegration into the Libyan society are much needed as a crucial part to the local and national reconciliation efforts, to the establishment of rule of law and internal security as well as to the peaceful transition process towards democratisation.

Authority of the National Transitional Council. The NTC Health Minister is actually convoking all accessible external actors in the health sector to regular donor co-ordination meetings which are actively backed up by the World Health Organisation (WHO). This incipient donor co-ordination scheme needs to be further strengthened. The EU office in Libya and the implementing partner will support it and co-ordinate closely the foreseen actions with the involved international and national stakeholders.

Under the current crisis in Libya a wide range of international organisations and non-governmental organisations (NGO) are actively providing humanitarian assistance in different parts of the country and in different fields of the health sector. First of all it is the WHO with so far a total funding of USD 7.69 million providing emergency health response under the UN OCHA operations. WHO is managing the provision for the East and West Libya of medicines and medical supplies purchased through the partially liberated frozen assets.

Other active entities are the International Committee of Red Cross (ICRC) who is working closely with the Libyan Red Crescent providing humanitarian assistance including surgical and medical supplies and first aid medical assistance. Local volunteers are trained to clear unexploded munitions and explosive ordnance disposal teams are working mainly in those areas into which the internally displaced civilians are returning. The EU is so far funding the ICRC, but also the UK International NGO called Merlin, the latter for emergency support in the western Nafusa mountain region.

In addition, there are other International NGOs such as Handicap International, Save the Children, Johanniter Orden and the Czech "People in Need". For the time being, they are mainly based and working in the Eastern part of Libya. Handicap International is providing unexploded ordnance risk-education actions in Benghazi, Ajdabiya and Misrata, meanwhile e.g. People in Need is equipping a field hospital in Daphnia (western Misrata region). In addition, a vast number of unknown solidarity groups and individuals financed by the Libyan diaspora are helping in the health sector.

The most important International NGOs actually working in most parts of Libya and providing immediate first medical aid and surgical interventions are Médecins sans Frontières (MsF) and International Medical Corps UK (IMC). MsF assists the war wounded combatants close to the frontlines through the establishment of advanced medical posts and surgical field hospitals. And IMC is providing assistance through its international volunteers (actually around 60 nurses and specialised medical staff) in the accessible parts of Libya. It provides surgical equipment, supplies and surgical teams for three health facilities in the western mountains and in Misrata, but includes in Eastern Libya also primary health in Ajdabiya and surrounding areas with regular visits of mobile health teams, emergency medic training, psychosocial first aid training for frontline health workers, etc. In other words, MsF follows exclusively a humanitarian assistance approach meanwhile IMC covers both, emergency and development aid.[10]

[10] IMC received funds from Department for International Development (DFID) (EUR 0.5 million) and US Office for Foreign Disaster Assistance (USD 1.75 million). From MsF no information was provided.

Given this important number of health related international actors in Libya, it is thus of utmost importance to co-ordinate closely through the Health Ministry convoked sector donor co-ordination round-table.

3. DESCRIPTION

3.1. Objectives

The main objective of this action is to strengthen the physical rehabilitation services in Libya, initially to be provided in Benghazi and Misrata. The programme will be implemented in close collaboration with the Ministry of Health and will expand to the West and Tripoli once the situation is stabilised.

This includes the strengthening of appropriate medical assistance and specialised surgery services, psycho-social support and counselling, capacity building and outreach patient assistance schemes, all these elements playing a pivotal role in providing an efficient and quality treatment.

3.2. Expected results and main activities

This programme will provide direct rehabilitation services, technical assistance, mobility and assistive devices, training, support through the establishment of mobile units, information and awareness raising activities. It will focus in a first stage to the Eastern part of Libya and will the eventually expand to other parts of Libya. Indicatively the following components are envisaged:

- Expand the capacity for rehabilitation at the Benghazi Medical Rehabilitation Centre

Expansion of the in-patient facility, upgrade of training for physiotherapists, occupational therapists, on the job training for technicians and physiotherapy aides, consultations and assessments of clients in the Benghazi Rehabilitation Centre, production and delivery of prosthetics and orthotics devices, delivery of assistive devices such as crutches and walkers, training in usage and maintenance of devices, follow up of clients, setting up of a client / user group, psychosocial support activities, information campaign on general and specific disability issues.

- Training of related Libyan health staff

Analysis of training needs of current staff including: physiotherapists, prosthetics' technicians, occupational therapists, design and implementation of upgrading training programmes, identification of other staff such as nurses in the centre's who need specialist training and implement basic training programmes on disability, developing training programmes on disability for general nurses with a view to disability being mainstreamed into the healthcare system.

- Provision of physical rehabilitation services in rural areas through the Prosthetics and Orthotics Mobile Units

Two mobile units for provision of orthotics and prosthetics deployed, assessment of clients, casting for prostheses and orthoses, trial fitting and delivery of devices produced in the rehabilitation centers and mobility devices including training,

physiotherapy treatment of clients, awareness training on disability for clients and family members and follow up in the field.

- Development of a comprehensive outreach service

Identification of suitable locations for "satellite" centers (to be placed in rural areas / hospitals, clinics), identification of suitable community workers (health volunteers, nurses, disabled people), training on identification, referral and simple rehabilitation, home visits for basic physical rehabilitation, mobility devices assessment / delivery.

The supervision and monitoring of the programme activities will be undertaken by a Committee under the chair of the new Ministry of Health. Actions and service implemented will be in line with the UN Convention of Rights for Persons with Disabilities and UN Standard Rules and WHO guidelines.

3.3. Risks and assumptions

Shortages in the provision of basic and specialised health services are of growing concern at this stage of the civil war and revolutionary transition in Libya. Therefore, the so far uncertain political future of Libya is an important risk. This requires that the programme implementation shall follow a flexible, but also an immediate impact oriented approach.

A second risk relates to the political priorities and administrative capacities of the future new legitimate Libyan Government as well as of the regional and local institutions in facilitating the implementation of this programme, and to ensure co-ordination between the different stakeholders.

Another risk concerns the lack of experience of the new Libyan authorities in the implementation of co-operation programmes with the EU.

In order to mitigate these risks the EU is committed to continue developing its co-operation with Libya, under the umbrella of the National Indicative Programme for 2011-2013, and strengthen its presence on the field according to the developing of the overall conditions in Eastern and other parts of Libya. Effective co-ordination with all the involved stakeholders will be a key factor of success. The European Commission will foment partnerships and co-ordination with and between EU Agencies, EU Member States, International organisations and NGOs involved in the field of health which could have an added value and impact on the results of the programme.

Finally, it is essential that the new Libyan Government facilitates the issuance of recognised entry permissions for the international experts in order to carry out the programme.

3.4. Crosscutting Issues

The programme addresses good governance and human rights issues. Good governance will be addressed through capacity building measures for the concerned health staff i.a. regarding the use of protocols and best practices for the different stages and areas of medical rehabilitation. Human rights will be a central issue in all

the activities undertaken by this action with a special focus on vulnerable groups (minors, women, severely disabled, child soldiers, long-term work incapacity, etc.).

3.5. Stakeholders

The final beneficiaries of this programme are the Libyan population and the affected war injured combatants and disabled civilians. The main stakeholders are the national, regional and local health authorities and medical staff in the affected areas.

4. IMPLEMENTATION ISSUES

4.1. Method of implementation

The method of implementation is direct centralised management through the signature of a grant contract with International Medical Corps UK (IMC). This organisation has been chosen because of its two-folded institutional capacity in the field of medical emergency aid and development co-operation in the health sector.

In addition, IMC is the most important International NGO active in Libya during the war and will play certainly a key role in the post-war reconstruction process. IMC has a proven record of institutional expertise in the field of medical rehabilitation programmes. The European Commission contracted already more than EUR 14 million with IMC, mainly for health programmes in crisis situation such as Afghanistan, Gaza and Pakistan. These programmes include i.a. assistance to mental illness, integrated health care and health services for internally displaced persons. Thus it is the sole capable and most efficient implementing partner in the current situation in Libya. Due to the nature of the actions to be implemented, the reigning crisis situation in Libya and the recognised and proven institutional experience and present major involvement in the emergency health aid in war stricken Libya of International Medical Corps UK make them the most suitable contractors to carry out this action. As in the socio-cultural context of Libya trust building relationships are of utmost importance for the success of any intervention, it is indeed important to work with an implementing partner knowledgeable of the Libyan context as this will support the sustainability of results and allow reaching a higher impact through this programme.

Therefore, this programme will be implemented through a grant contract directly awarded to International Medical Corps UK on the basis of the Articles 168 (1)(a), 168(1)(f) and 168(2) of the Implementing rules of the Financial Regulation.

IMC will be the signing contractor and may eventually include as partners other specialised International NGOs such as Handicap International and ICRC.

4.2. Procurement and grant award procedures

The centrally managed contract will follow EU procedures and be awarded and implemented in accordance with the procedures and standard documents laid down and published by the European 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 Regulation (EC) No 1638/2006 - European Neighbourhood and Partnership Instrument.

2) Specific rules for grants

The essential selection and award criteria for the award of grants are laid down in the Practical Guide to contract procedures for EU external actions. They are established in accordance with the principles set out in Title VI 'Grants' of the Financial Regulation applicable to the General Budget. When derogations to these principles are applied, they shall be justified, in particular in the following cases:

– Financing in full (derogation to the principle of co-financing): the maximum possible rate of co-financing for grants is 80% of total eligible costs for Actions financed by ENPI Regulation. Full financing may only be applied in the cases provided for in Article 253 of the Commission Regulation (EC, Euratom) No 2342/2002 of 23 December 2002 laying down detailed rules for the implementation of the Financial Regulation applicable to the General Budget.

– Derogation to the principle of non-retroactivity: a grant may be awarded for an action which has already begun only if the applicant can demonstrate the need to start the action before the grant is awarded, in accordance with Article 112 of the Financial Regulation applicable to the General Budget.

The grant contract will allow for subcontracting with other entities to implement specific programme components within the given limits for grant contracts. (General Conditions Article 1.3)

4.3. Indicative budget and calendar

The programme will be financed by the European Union with a contribution of EUR 2 million covering up to 100% of the programme budget. The operational duration of the programme is indicatively up to a maximum of 36 months. It is foreseen that the programme will build on the results of other short-term emergency rehabilitation aid programmes.

The indicative breakdown of the budget is as follows:

Budget lines	**Amount (in EUR)**
Grant Contract with IMC (UK) – medical rehabilitation programme	2,000,000
Total Costs	**2,000,000**

4.4. Performance monitoring

The programme will be regularly monitored by the Delegation of the European Union to Libya. Result Oriented Monitoring (ROM) could be carried out by the European Commission. Monitoring indicators and sources of verification will be defined and applied throughout the implementation of the programme. Monitoring reports will provide the base for corrective measures and will be followed upon by the team.

4.5. Evaluation and audit

The Commission reserves the right to carry out verification missions, in agreement with the grant contract it will sign with International Medical Corps UK.

4.6. Communication and visibility

All visibility activities will be implemented in accordance with the "EU visibility Guidelines for External Actions".