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THIS ACTION IS FUNDED BY THE EUROPEAN UNION

ANNEX 1

of the Commission Implementing Decision on the financing of the special measure in favour of Libya for 2022

Action Document for Towards a resilient health system in Libya

MEASURE

This document constitutes the annual work programme in the sense of Article 110(2) of the Financial Regulation, and action plan/measure in the sense of Article 23 (4) of NDICI-Global Europe Regulation.

1. SYNOPSIS

1.1. Action Summary Table

1. Title OPSYS Basic Act	Towards a resilient health system in Libya Special measure in favour of Libya for 2022 OPSYS business reference: ACT-61429 ABAC Commitment level 1 number: JAD.1051468 Financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)
2. Team Europe Initiative	No
3. Zone benefiting from the action	The action shall be carried out in Libya.
4. Programming document	The situation in Libya remains unpredictable and marked by political instability and armed conflict. A declaration of crisis has been issued in 2011. It was consistently renewed since then and extended again in June 2021. A high level of flexibility and responsiveness is needed to adapt EU programmes to this volatile context. The EU has planned its cooperation since 2017 through yearly ‘Special Measures’
5. Link with relevant MIP(s) objectives/expected results	NA
PRIORITY AREAS AND SECTOR INFORMATION	
6. Priority Area(s), sectors	121 Health General 122 Basic health 123 Non communicable Diseases 130 Population Policies/Programmes & Reproductive Health
7. Sustainable Development Goals (SDGs)	Main SDG (1 only): <u>SDG 3</u> - Ensure healthy lives and promote well-being for all at all ages Other significant SDGs (up to 9) and where appropriate, targets:

	<p><u>SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture</u>, specifically for: <u>Target 2.2:</u> End hunger, achieve food security and improved nutrition and promote sustainable agriculture</p> <p><u>SDG 5: Achieve gender equality and empower all women and girls</u>, specifically for: <u>Target 5.6:</u> Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.</p> <p><u>SDG 10: Reduce inequality within and among countries</u>, specifically for: <u>Target 10.2:</u> By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status.</p> <p><u>SDG 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels</u>, specifically for: <u>Target 16.6:</u> Develop effective, accountable and transparent institutions at all levels</p>			
8 a) DAC code(s)	12110	Health policy and administrative management	30%	
	12200	Basic health	50%	
	12300	Non communicable diseases	10%	
	13000	Population Policies/Programmes & Reproductive Health	10%	
8 b) Main Delivery Channel @	20000	Non Governmental Organizations (NGOs) and Civil Society		
	41000	United Nations agency, fund or commission (UN)		
	11000	Other public entities in donor country		
9. Targets	<input type="checkbox"/> Migration <input type="checkbox"/> Climate <input checked="" type="checkbox"/> Social inclusion and Human Development <input checked="" type="checkbox"/> Gender <input type="checkbox"/> Biodiversity <input type="checkbox"/> Human Rights, Democracy and Governance			
10. Markers (from DAC form)	General policy objective @	Not targeted	Significant objective	Principal objective
	Participation development/good governance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Aid to environment @	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Gender equality and women's and girl's empowerment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Reproductive, maternal, new-born and child health	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Disaster Risk Reduction @	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Inclusion of persons with Disabilities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Nutrition @	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	RIO Convention markers @	Not targeted	Significant objective	Principal objective
	Biological diversity @	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Combat desertification @	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Climate change mitigation @	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Climate change adaptation @	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Internal markers and Tags	Policy objectives	Not targeted	Significant objective	Principal objective
	Digitalisation @	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Tags			/
	digital connectivity	<input type="checkbox"/>	<input type="checkbox"/>	
	digital governance	<input type="checkbox"/>	<input type="checkbox"/>	
	digital entrepreneurship	<input type="checkbox"/>	<input type="checkbox"/>	
	digital skills/literacy	<input type="checkbox"/>	<input type="checkbox"/>	
	digital services	<input type="checkbox"/>	<input type="checkbox"/>	
Connectivity @	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tags			/	
digital connectivity	<input type="checkbox"/>	<input type="checkbox"/>		
energy	<input type="checkbox"/>	<input type="checkbox"/>		
transport	<input type="checkbox"/>	<input type="checkbox"/>		
health	<input type="checkbox"/>	<input type="checkbox"/>		
education and research	<input type="checkbox"/>	<input type="checkbox"/>		
Migration @	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reduction of Inequalities @	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
COVID-19	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

BUDGET INFORMATION

12. Amounts concerned	Budget line: 14.020110 Total estimated cost: EUR 16 000 000 Total amount of EU budget contribution: EUR 16 000 000
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MANAGEMENT AND IMPLEMENTATION

13. Implementation modalities (type of financing and management mode)	Project Modality Direct management through: - Grants Indirect management with the entities to be selected in accordance with the criteria set out in section 4.2.2
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1.2. Summary of the Action

Libya has been affected by a succession of political, economic and security crises since the initial protests in 2011, leaving behind a significantly deteriorated social fabric, reduced access to basic services, weakened national infrastructure and a struggling health system marked by on-going underinvestment. The outbreak of the COVID-19 pandemic has further exposed the many weaknesses of the Libyan health system and considerably impacted the ability of the services to meet basic health needs in the population.

With an overall objective to contribute to SDG 3 and to improve health outcomes in the Libyan population particularly among those most at risk or vulnerable, this action will invest in the preparatory steps towards building strengthened resilience in the Libyan health system while shoring up the capacity of the services to meet basic needs. Building on a recent impact evaluation and ongoing programmes, the action will promote a twin-track approach to supporting health in Libya. Firstly, investments will support local interventions to address poor access to and insufficient quality of primary healthcare services in selected municipalities in order to improve health especially for the excluded or marginalised populations. This intervention will focus on strengthening the capacity of national responsible agencies to ensure health services are delivered while also directly supporting health service delivery. At the same time, and secondly, the action will support the processes and systems needed to strengthen the technical quality and capacity of national level institutions in order to

enable better governance, policy processes, and stewardship. Cross cutting these two objectives, additional support will also be directed to the collection, management and use of essential data through the investment into health/population surveys to further strengthen evidence-based decision-making for health and lay the foundations for standardised monitoring and follow up of public health indicators.

2. RATIONALE

2.1. Context

Following over a decade of internal armed strife and conflict, Libya's health and education outcomes are far worse than they were prior to the 2011 revolution when the country was among the highest ranking nations in the African continent¹. Recent political developments increased optimism that the Government of National Unity (GNU) could take hold and begin to focus on national reconciliation and reconstruction, an essential pre-condition for lasting health systems strengthening. The swearing in of the GNU in March 2021 was a positive sign of increasing stability and reunification of the administration. Unfortunately, the GNU did not manage to organise elections by December 2021 as initially foreseen. In fact, the appointment of a new Government of National Stability (GNS) by the Libyan House of Representatives in March 2022 may lead to renewed tensions as Libya has now returned to a country ruled – de facto – by two parallel governments. The political situation thus remains volatile.

There are little reliable or recent data on the proportion of the population living below the poverty level. However, in 2016, the United Nations estimated that 9% of the population lived in multidimensional poverty and children, Internally Displaced People (IDPs) and migrants were identified as particularly vulnerable to poverty². The REACH Libyan market monitoring initiative³ shows an increase in the prices of basic goods with an increase in the Minimum Expenditure Basket (MEB)⁴ of 10% between January 2020 and August 2021 alone. Libya's economy remains fragile and anchored to oil production. For many years, the country has experienced a severe liquidity crisis and functions largely as a cash-based economy. The global COVID-19 pandemic further exacerbated the economic and social challenges of Libya since 2020 and put additional pressure on health services. Failure to approve the state budget for the 2021 and 2022 financial years has resulted in further challenges to provide adequate financing for public service delivery at all levels.

The Libyan health system, based on a mix of public and private financing and delivery, is characterised by high out-of-pocket spending especially for medicines and specialist services. Despite its commitment, public service delivery remains inadequate although efforts have been made at municipal level to re-establish health, education, water, sanitation and waste management. Although it is difficult to accurately assess the magnitude of the social deterioration in the absence of credible data and evidence, the prolonged crisis has clearly resulted in downward trends in terms of human capital, livelihoods, access to quality basic services and the condition of vital infrastructure. INFORM ranks Libya 18th of 191 countries and territories in terms of its risk of experiencing humanitarian crises or disasters in 2022⁵. Specific red flags are noted for human risks (mainly related to conflict) and the lack of institutional coping capacities⁶.

Unsurprisingly, given the lack of a political settlement, Libya lacks a national development plan. Coordination amongst government institutions remains weak and national policy processes do not support or

¹ According to the UNDP's latest Human Development Index, Libya's ranking fell from 67th in 2010 to 105th/189 in 2020.

² UN Common Country Analysis LY – Draft November 2021

³ REACH Libya Joint Market Monitoring Initiative (JMMI) - December 2021

⁴ Minimum Expenditure Basket (MEB) is the list of items that a household needs to meet daily basic needs.

⁵ INFORM is a multi-stakeholder forum for developing shared, quantitative analysis relevant to humanitarian crises and disasters. INFORM includes organisations from across the multilateral system, including the humanitarian and development sector, donors, and technical partners. The Joint Research Center of European Commission is the scientific lead for INFORM. <https://drmkc.jrc.ec.europa.eu/inform-index/>

⁶ Human risk includes: *Current conflict intensity* and *projected conflict risk*. Lack of institutional coping capacities includes: *Governance, Disarmament Demobilization and Reintegration (DDR), Communication, Physical infrastructures and Access to the health system*

incentivise sub-national/municipal decision-making in a structured way, in health as in most human development areas. The political polarisation between the west, the east and the south applies also to the health sector. Against the backdrop of generally inadequate health services, the COVID-19 pandemic has clearly revealed that the volume of preventive and curative services available in the west, though still insufficient, is far greater than the offer to the communities living in the east and the south of the country. Access to and delivery of basic services in each of the East, West and South areas of the country is variable with differences characterised by staff availability, resource flows, governance arrangements, and other factors. This variability existed prior to 2011 and, for example, inequitable access to health services was a challenge then as it is now. Although data are limited, it is likely that the inequities are more acute now than they were before the 2011 uprising.

One result of this imbalance, therefore, is that cooperation with the EU cannot be strategically guided by a national policy or plan. There is an absence of agreed governmental priorities and no formal cooperation agreement with the EU or through jointly-established partnership priorities. ***Historically the health sector has been the first area of cooperation between the EU and Libya***, even before the opening of the Delegation in Tripoli. Starting from 2005 and linked to shared political priorities to respond to the HIV-AIDS outbreak in Benghazi, health support has been offered either as a standalone sector approach or integrated into other support, for example, to the migration response. Focus has gradually shifted from supporting a targeted issue to a more comprehensive approach for Primary Health Care (PHC) and the wider institutional development of relevant health entities⁷. ***EU guidance***⁸ identifies the importance of supporting and strengthening primary health care services as a whole, increasing financial protection of households, advancing towards Universal Health Coverage (UHC), and expanding inclusivity and the quality of services. This intervention aligns to a key priority highlighted by the EU for 2019-2024, *Promoting our European way of life*. Echoing the ambition of building a *European health union*, increasing cooperation amongst Member States (MS) and with global health initiatives (GHI) like COVAX, the action should support Libya to move from a reactive mode (addressing waves of emergencies) to a more pro-active footing based on pandemic preparedness and response and the management of a range of other cross-border health threats. In this context the potential of the National Centre for Disease Control (NCDC) is vital, as well as the necessity of a solid primary healthcare network and the need for increased leadership and coordination amongst different stakeholders.

In addition, within the framework of the Joint Communication on a Renewed Partnership with the Southern Neighbourhood⁹ and the related Joint Staff Working Document¹⁰, it is reminded that Health is the first and foremost condition for decent life. The COVID-19 pandemic has raised challenges to health security and healthcare systems and impacted deeply economies and whole societies. The EU and our partners will need to draw the lessons from the COVID-19 crisis to strengthen health systems and social protection systems, preparedness and response capacities. The EU has and will continue to provide swift and substantial support to alleviate the disproportionate burden of the crisis on the most vulnerable and those at-risk, including youth and women.

⁷ ENI/2017/40359 and ENI/2020/42691. Specifically though ENI/2020/42-691 the focus on a whole primary healthcare approach in view of Universal Health Coverage has been proposed and its implementation started in late 2021/beginning of 2022. This AD will build on and expand to new municipalities.

⁸ Amongst the official EU documents for which this action is relevant we find: (1) Council conclusions on EU role in Global Health. 10.05.2010; (2) Communication from the commission “Enhancing maternal and child nutrition in external assistance: an EU policy framework” COM(2013) 141 final. 12.3.2013; (3) Communication from the commission “On effective, accessible and resilient health systems” COM(2014)215 final. 4.4.2014. While this document is primarily addressed to EU Member States, concepts and values expressed, with due adaptation, are valid for any health system. (4) On achieving universal, equitable and inclusive coverage by quality health services: Communication from the Commission “A decent life for all: from vision to collective action” COM(2014) 335 final of 2.6.2014; (5) Council conclusion on “Operationalizing the Humanitarian-Development Nexus”. 19.05.2017; (6) Joint communication to the European Parliament “A strategic approach to resilience in the EU’s external action” COM(2017)21 final. 7.6.2017 and its accompanying document: Joint staff working document “EU resilience policy framework for cooperation with partner countries and evaluation of related implementation actions” (7) The new European consensus on development “Our world, our dignity, our future”. European Union, 2018.

⁹ JOIN(2021) 2 final 9.2.2021

¹⁰ SWD(2021) 23 final 9.2.2021

In the context of the fractured governance picture in Libya, it is unsurprising that the **health donor coordination** is not actively convened and led by the Ministry of Health (MoH). Support generally follows a stop-gap and emergency management approach and only partially navigates the humanitarian-development nexus¹¹. DG ECHO has already committed EUR 1 million to tackle the Early Warning, Alert and Response Network (EWARN). Along with bilateral EU funding, the EU Trust Fund for Africa, North of Africa window (EUTF) projects have addressed gaps in the health sector at municipal level and almost a third¹² of the interventions include rehabilitation of targeted health facilities in several municipalities. As of mid-2020, EU and other donor **support targeted the COVID-19 response**. However the real size of the COVID-19 support is unknown, as the government does not report on domestic allocations nor on direct official development assistance (ODA) support or gifts received. Without clear national health priorities and leadership, it is challenging to map other donors' support and gauge possible synergies.

A recent survey¹³ on the **image and perceptions of the EU and awareness of cooperation programmes** in *Southern Neighbourhood* countries shows that, in Libya, respondents strongly associate the EU with support to refugees and displaced people, followed by human rights and health (50% of responders). While this may be linked to ongoing high-visibility funding for the pandemic, it is also relevant that 57% of responders indicated that further support is needed and they expected the EU to act.

In summary, the context for this action is weak national governance, high need amongst a diverse population, limited capacity in the health services, and poor coordination among the few donors that are present. On a more constructive note, however, the EU has gained valuable experience about how to target investments for maximum impact and will apply these lessons, crystallised in a recent comprehensive evaluation, to develop a restructured theory of change to shape this action.

2.2. Problem Analysis

Short problem analysis

Most Libyans across the country are suffering from a critical lack of access to quality health care.¹⁴ While accuracy of the data may be challenging, there is a general consensus around the acceleration of the worsening trend in health services at all levels. The Libyan health system mirrors the general fragility of the country's institutions and none of the pillars of the health system¹⁵ in Libya is functioning to its potential. For instance, while 2017 data suggested that Libya had sufficient public health facilities¹⁶ in absolute terms, data from 2020 highlight that a mere 6% of public health facilities are actually available, open, and able to offer the full package of essential health services. Furthermore, the distribution of these facilities is uneven and inequitable. In this context, poor access to health services could be understood as a proxy for dysfunctionality at various levels of the system. For instance, health workforce density, based on the government payroll, is almost double

¹¹ Active donors are few (Germany, France, Italy and most probably non traditional donors such as Turkey and Gulf countries). Germany approaches the sector with a consistent PHC perspective. The WB (World Bank) has an agreement from 2019 with the Government of Libya for USD 10 million in Reimbursable Advisory Services (RAS) for the health sector. They are de facto stopped since late 2020 and they should restart soon with an annual work plan of USD 2 million targeting health economic/financing trainings, national health accounts and Primary Health Care through Service Delivery Indicators (SDI) surveys, a capacity assessment of the Primary Health Care Institute (PHCI), capacity building in monitoring and evaluation for PHCI and other studies if requested. Libya is not part of any Global Health Initiatives such as The Global Fund and Gavi.

¹² At the level of interventions, not budget allocations.

¹³ Stantec – Gallup *Opinion poll finding and analysis for the southern Neighbourhood countries*. March 2022

¹⁴ Health data are from *Libya Service Availability and Readiness Assessment (SARA)*, WHO 2017 and updated as per Health Sector Coordination Libya – Country functional review. November 2019.

¹⁵ Health systems are traditionally described following a 6 pillar framework which includes: (1) health services, (2) health workforce, (3) health information system, (4) medical products, vaccines and technologies, (5) health financing system and (6) leadership and governance. Several countries are including also a seventh pillar (7) community participation. *Everybody business: strengthening health systems to improve health outcomes*. WHO's framework for action. 2007. This conceptual framework is by and large mirrored by other classic ways to measure the effectiveness of health systems, like for instance International Health regulations (IHR).

¹⁶ 2.8 compared to the standard 2.0 per 10,000 population.

the World Health Organization (WHO) standard for achieving Universal Health Coverage (UHC). However, inequality in distribution and skill mix (with an excess of doctors and an acute shortage of nurses and midwives) as well as widespread absenteeism and – almost certainly – thousands of ghost workers as well, explains why there is a shortage of staff to attend patients especially in primary facilities and rural areas particularly in the East and the South of the country. Procurement of medical products, vaccines and commodities has historically taken a relevant share of the Libya health budget allocations. However, availability of essential medicines was scored at 41% for hospitals and 10% for Primary Health Centres in 2017. A recent WHO survey¹⁷ on a substantial sample of Libyan municipalities shows that routine childhood vaccines are fully available in only 57% of municipalities, with the East reaching 90% of stock outs. No health information system underpins local or central decisions on staffing or procurement. The shortcomings of the information system have been evident at the onset of the COVID-19 pandemic. Services provided by public health care facilities at all levels are free of charge. The MoH, both the purchaser and the provider of all services, funds public health care facilities through a line-item budgeting process. Non-Libyans are not entitled to free health services. How the system is financed is largely unknown and out-of-pocket expenditures are believed to be high although not fully captured¹⁸. The Essential Service Package (ESP) is the basis on which the EU has been supporting healthcare delivery¹⁹. However the policy is still unfinished and has not yet been officially endorsed. Along with greater definition of services included and resources needed, the policy does not yet address issues linked to staffing, coverage and territorial distribution of services nor questions linked to equity especially vis-à-vis access to basic services by women, disabled persons and other marginalised populations.

The Libyan crisis is often referred to as **a governance crisis** and the health sector experience certainly fits this characterisation. The last attempt to support a policy process dates back to 2017 and the policies and strategies formulated at that time have never been endorsed. Despite this, Libya joined Universal Health Coverage 2030 (UHC2030) in 2018²⁰, thanks to the commitment of the Primary Health Care Institute (PHCI) and this may be the sign of a slowly emerging opportunity. UHC encompasses all the health system building blocks described above and requires a targeted approach towards more equitable delivery of a package of essential services to all people with protection from financial hardship.

Identification of main stakeholders and corresponding institutional and/or organisational issues (mandates, potential roles, and capacities) to be covered by the action.

Stakeholders. The MoH has a complex, highly articulated and ponderous governance and administrative structure that centralises many functions and decision-making processes while missing up-to-date management and stewardship. The National Centre for Disease Control (NCDC)²¹ and the Primary Health Care Institute (PHCI)²² are both semi-autonomous bodies that report directly to the Minister of Health but

¹⁷ WHO- MoH *Libya Critical Childhood Routine Vaccines Availability Assessment. Monthly Districts Health Situation Report*. February 2022

¹⁸ The out of pocket health expenditure accounted 34% of total health expenditure in 2009 either in country or abroad. Harvard University and NATO (2013), *The Libya case study: working paper of collaborative NATO-Harvard project*. 2013

¹⁹ The ESP so far addresses sexual, reproductive, maternal and new-born health; child health and immunization; public nutrition; communicable and non-communicable diseases; mental health and psychosocial support mainstreaming in all health related services as well as mental health and psychosocial services stand-alone services, disability; the regular supply of essential drugs and medical products and workforce training and supportive supervision

²⁰ UHC2030 provides a platform where the private sector, civil society, international organisations, academia and governmental organisations can collaborate together to create a movement for accelerating equitable and sustainable progress towards universal health coverage (UHC) and health systems strengthening at global and country levels. EU and Libya, along with 151 more governments, entities, UN agencies, charities and private sector entities are signatories of the [UHC2030's Global Compact for progress towards universal health coverage](#).

²¹ NCDC has a key role in public health surveillance. Formerly known as National Center for the Prevention and Control of Communicable and Endemic Diseases it was reorganised in 2010 and while it started out by focusing on communicable diseases only, with time it expanded to include non-communicable diseases, environmental health and zoonotic diseases. NCDC serves as national reference lab and central authority on Infection Prevention and Control (IPC). NCDC manages the public health surveillance systems (including EWARN), serves as focal point for International Health Regulations (IHR) and has the authority to communicate directly with WHO. Formally, all ports of entry into Libya are under the authority of NCDC for issues with a public health potential. For public health surveillance, NCDC relies on 34 branches (at various level of functionality) and on the vigilance of surveillance officers.

²² PHCI is a relatively young institutions and has so far established a central office in Tripoli. It has been mandated to oversee all Primary Health Care delivery in the country. As such it has responsibility for the development, approval and delivery of the Essential Service Package (ESP)

have developed as fairly strong technical entities despite the context they operate in. Both bodies are characterised by lighter administrative structures and a growing track record in effective action. While NCDC has greater autonomy (and, for example, can allocate and manage its own budget), the PHCI's devolution is anticipated and could be formalised shortly. The NCDC is nominally present everywhere in Libya with 34 branches. It is currently working on a plan to improve the quality of the branches nationwide. On the other hand, the role and jurisdiction of municipalities for the delivery of primary health care (PHC) is still poorly defined and open to different interpretations. The international community formally deals with the International Cooperation Office (ICO) of the MoH as well as with NCDC and PHCI individually. Most coordination happens within the UN cluster system co-chaired in Libya by WHO and the MoH.

Stakeholders for this action range from duty bearers (health institutions, municipalities, health workers) to rights holders (health workforce, communities, patients) to implementing partners and others. The choice of stakeholders for this action combines those who have the potential to influence change at the highest possible level (NCDC, PHCI and UN agencies) with those who are best placed to both deliver health services and provide evidence to feed into technical dialogue (implementing partners) and of course includes beneficiaries. Experiences from other countries point to positive benefits from increased community engagement; EU grants initiated at the beginning of 2022 will also pilot ways to involve communities in the organisation of services at primary health care level.

While *increasing the resilience of the Libyan health system* is a long term objective beyond the scope of this document, this action will *support preparatory steps towards that aim*. It will continue to support the delivery of the Essential Service Package (ESP) in a primary health care setting at municipal level, involving communities and local actors while also supporting NCDC and PHCI to strengthen and consolidate their leadership roles as started under the special measure in favour of Libya for 2020²³. These investments will help lay the ground work for the replication of the model and for further institution building in the future, once the context improves. Additionally, this action will continue to support the development of the Libyan blood bank including, in this final phase, the completion of knowledge transfer, the consolidation of the network and of the voluntary donor base. Support will also be directed to health/population surveys as a way to further strengthen evidence-based decision making for health and lay the foundations for standardised monitoring and follow up of public health indicators including for vulnerable and marginalised groups.

2.3. Lessons Learned

This action has been informed by a recent comprehensive impact evaluation of EU support to the Libyan health sector from 2017 to 2021²⁴ which has allowed to capture key strategic lessons underpinning previous assumptions and informing the development of a new theory of change. The evaluation highlighted key drivers over which donors have limited influence (government policy vacuum, exacerbated by political instability and divisions for example) but also suggests that in the past, the best results were achieved when (a) sufficient consideration was given to legal, ethical, and human rights factors to increase access to and utilisation of health services by vulnerable groups; (b) humanitarian and development strategies have been balanced with each other and worked in complement with each other; (c) a balance was preserved between the meaningful delivery of essential services to people and investments into health systems strengthening; (d) health services have been offered as an integrated package especially at primary healthcare level (rather than vertical, isolated services). In this regard, it would be important to preserve and strengthen previous investments into the Essential Service Package; (e) population data should underpin the design of projects and thus the gap in population-based data for health needs, access and coverage as well as health systems readiness needs to be addressed, and finally (f) in such a fast-changing and complex environment, it is critical to put in place a fit

²³ The decision on Municipalities to support will be the part of policy dialogue with MoH. It is foreseen to support three Municipalities, one in each region, applying for the selection most probably the same criteria based on needs and resilience that were used under Special Measure 2020.

²⁴ *Impact of the EU support to the Libyan health sector 2017-2021* - Specific Contract N° 300019986 – AESA – March 2022. This evaluation includes Special Measures 2017 along with all EUTF contracts

for purpose monitoring and evaluation approach, able to support timely course corrections, as well as tracking and measurement of impact. This will be operationalised through a separate contract under another commission decision.

The EU, the MoH, and the health authorities of the East had jointly agreed on the municipalities supported under the special measure in favour of Libya for 2020. This process contributed to building consensus on guiding criteria and facilitated the starting phase of this support.

3. DESCRIPTION OF THE ACTION

3.1. Objectives and Expected Outputs

The Overall Objective (Impact) of this action is *to improve health outcomes in the Libyan population particularly among those most at risk or vulnerable*.

The Specific Objectives (Outcomes) of this action are to:

1. Lay the foundations for enhancing and strengthening the development of health services and systems;
2. Improve access to and utilisation of essential health services ensuring equity for vulnerable populations in targeted municipalities.

The Outputs to be delivered by this action contributing to the corresponding Specific Objectives (Outcomes) are:

Contributing to Outcome 1 (or Specific Objective 1): *Lay the foundations for enhancing and strengthening the development of health services and systems.*

- 1.1 Data collection, management and utilisation capacities are strengthened;
- 1.2 Technical, delivery and stewardship capacities of the Primary Health Care Institute (PHCI) and National Center for Disease Control (NCDC) are strengthened.
- 1.3 The blood bank network and transfusion services are operational and increasingly funded from Libyan national budget resources.

Contributing to Outcome 2 (or Specific Objective 2): *Improve access to and utilisation of essential health services ensuring equity for vulnerable populations in targeted municipalities.*

- 2.1 The delivery of a quality Essential Service Package (ESP) at primary health care level is strengthened in targeted municipalities.
- 2.2 Sustainable and tailored access-to-health solutions for vulnerable and marginalised people (women, disabled, non-Libyans) are gradually incorporated into health service delivery policies and practices.
- 2.3 Meaningful community participation and engagement is increased.

3.2. Indicative Activities

Activities related to Outcome 1 are characterised by different forms of technical cooperation²⁵ (technical assistance, consultancies, trainings, supportive supervision, skills transfer, peer-learning and twinning mechanisms, etc.) aimed at supporting counterpart-led programmes (NCDC, PHCI and MoH). It focuses on the stewardship role that health entities need to surge to in order to achieve, with time, sustainable development results. Indicative activities:

Activities related to Output 1.1: technical assistance, training, knowledge transfer and studies aiming at implementing nation-wide standard surveys (i.e. SMART, MICS).

Activities related to Output 1.2: technical assistance, training, discussion fora, exchanges, operational research, local exchanges in view of a gradual uptake of health institutions' stewardship role for the system.

²⁵ *Reforming Technical Cooperation and Project Implementation Units for External Aid provided by the European Commission. A Backbone Strategy – July 2008*

Activities related to Output 1.3: technical assistance, training, networking, limited procurement of equipment/consumable or other material inputs, local exchanges, supportive supervision aimed at a final consolidation of the operations of the network of blood banks;

Activities related to Outcome 2 aim at supporting the actual health service delivery at field level. These activities focus on actions that strengthen the readiness of health facilities (health workforce, management, availability of drugs, accessibility for all, financial barriers, routine data collection and analysis) with the aim to offer quality ESP in the catchment area of the Municipalities targeted. The ESP will be further developed by PHCI.

Activities related to Output 2.1 and 2.2: technical assistance, training, supportive supervision and procurement of equipment/consumable or other material inputs aiming at the implementation at local level of all components of the Essential Service Package.

Activities related to Output 2.3: training, awareness raising, and creation of networks that will create the basis for increasing equity in service delivery.

Throughout implementation, efforts will be made to routinely link provisional results of the two outcomes to each other in order to increase the likelihood of reaching the objectives. It is clear that the two outcomes reinforce one another: The stronger the health authorities are, the more likely they will influence future public health choices of the government while at the same time, tangible results from quality ESP delivery will feed into the body of evidence for public health decisions, build health service credibility and strengthen institutional capacity. The delivery of quality health services can also contribute to reinforcing peace in a fragile post-conflict context.

3.3. Mainstreaming

Environmental Protection, Climate Change and Biodiversity

Outcomes of the Strategic Environmental Assessment (SEA) screening (relevant for budget support and strategic-level interventions)

The SEA screening concluded that no further action was required.

Outcomes of the Environmental Impact Assessment (EIA) screening (relevant for projects and/or specific interventions within a project).

The EIA screening classified the action as Category C (no need for further assessment).

Outcome of the Climate Risk Assessment (CRA) screening (relevant for projects and/or specific interventions within a project).

The CRA screening concluded that this action is no or low risk (no need for further assessment).

Data on specific resilience of health facilities to climate change²⁶ is not available. It is proposed to include a sensible choice of standard questions either in the forthcoming SARA (Service Availability and Readiness Assessment) survey or in the grants that will support specific municipalities.

Gender equality and empowerment of women and girls

As per OECD Gender DAC codes identified in section 1.1, this action is labelled as G1 (significant objective). A Gender Country Profile for the cooperation portfolio with Libya is being designed and findings will inform the contracts. The Action has a large component for gender equality and women's empowerment through the delivery of basic services to women and girls to ensure their sexual and reproductive health and rights (pillar 3 of GAP III). For example, under Outcome 1, one of the main priorities of any blood bank is to save women's

²⁶ WHO Checklists to Assess vulnerabilities in Health Care Facilities to heat waves: https://cdn.who.int/media/docs/default-source/climate-change/heatwaves-checklists.pdf?sfvrsn=a84cdc5f_5

lives at delivery either through addressing haemorrhage, one of the main causes of maternal death or through enabling caesarean sections. The essential services package (outcome 2) will be centred on the needs of women, adolescents and children. A central pillar of basic health services is sexual and reproductive health services including family planning, maternal and newborn health services, reproductive health care, post rape counselling and services to address gender based violence. Attention to adolescents and to hard-to-reach populations will be paid through integrating appropriate and feasible services in the offer of basic health services. The full range of sexual and reproductive health services, as a package, are a critical dimension of underpinning women's and girls' empowerment and the achievement of gender equality. This action will also promote structured population and health surveys which, in producing disaggregated data, will help identify the current access by and needs of women and girls to human development services and outcomes.

Human Rights

By integrating services for hard-to reach and marginalised populations into the general offer of basic health services, the Action promotes resilience, conflict prevention and peace, and non-discrimination. Ongoing healthcare delivery grants will soon start to pilot trainings on medical ethics in three municipalities in order to address the divide amongst patients and healthworkforce alike versus migrants, refugees and otherwise vulnerable populations. At the same time, these grants are piloting community participation into the management and organisation of primary health care facilities. Lessons drawn from the implementation of these ongoing contracts will be fully integrated into the implementation contracts to be signed under this action.

Disability

As per OECD Disability DAC codes identified in section 1.1, this action is labelled as D1 (significant objective). Through this action the EU will support activities that contribute to respect, protection and fulfilment of the rights and inclusion of persons with disabilities, ensuring accessibility to health services. This action will also promote structured population/health surveys where the magnitude of physical and mental disabilities in Libya will be captured, thus guiding the response of the health system.

Democracy

The empowerment of citizens and their participation in the organisation and management of the health services underlined under specific objective 2, where the action will find a viable mechanism in order to support communities to move from being passive recipients of services to engaged co-creators of adequate and equitable health services within their municipalities.

Conflict sensitivity, peace and resilience

Due concern has been given to conflict sensitivity in the design of the action. For development cooperation in health, a very recent impact evaluation has also reflected on how external aid in the health sector interacts with the results of conflict in Libya. Findings highlight important negative administrative effects (lengthened implementation time with erosion of resources for activities directly linked to results) as well as opportunities for contributing to possible greater social cohesion through addressing the rights of migrants to access health services. Positive influence has been attributed to the capacity of implementing partners to supplement commodities like medicines that are acutely and widespread missed at health facility level. A recent report²⁷ that looks at the impact of conflict economy at municipality micro level reinforces the findings in the health sector for instance recommending a twin-track approach whereby local interventions (outcome 2 of this action) are supported by the implementation of national level reforms (outcome 1).

Disaster Risk Reduction

²⁷ Peaceful Change Initiative *Unpacking the impact of conflict economy dynamics on six Libyan Municipalities*, February 2022

Libya's vulnerability to the impacts of climate change and environmental degradation necessitates proactive measures against their potential consequences., Libya has *inter alia* experienced in the past high vulnerability for heat waves that impact the health sector mainly through electricity cuts at health facility level because of general overdrawing from the grid along with major gaps in maintenance. While this action will not intervene heavily on infrastructure, implementing partners will be encouraged to promote energy self-sufficiency of health facilities should structural interventions be needed in target areas. Through previous decisions the EU (including ECHO) is supporting the establishment of a health Early Warning System to counter future COVID-19 waves as well as localised outbreaks of communicable diseases.

3.4. Risks and Assumptions

Category	Risks	Likelihood (H-M-L)	Impact (H-M-L)	Mitigating measures
Related to external environment	Insecurity and lack of concrete progress on stabilisation leading to impeded access for implementing partners.	M	M	Remote management modalities for IP; continuous analysis of the context; third party and remote monitoring system.
	External shock directly impacting the tenure of normal health services (pandemic, food/commodity shortages...).	M	H	Reorganisation of contracts in order to incorporate new priorities; work on early warning systems and generation of evidence.
Related to planning, processes and systems	Division of MoH and continued absence of sector strategies and policies.	H	M	Continued and increased engagement of the EU and Implementing Partners in technical dialogue; support generation of evidence; alignment with appropriate international best practices; emphasis on low complexity and flexibility in implementation contracts.
	Accountability for equipment purchased	M	L	Purchases will be kept to a minimum and Implementing Partners will be urged to strengthen accountable procedures
Related to people and the organisation	Human resources grievances, low motivation, unbalanced presence health workers, absenteeism.	H	M	Support to design for human resource strategy at national level (MoH) while channelling healthcare investments through independent providers, more likely to be responsive to health workers' needs.
Related to legality and regularity aspects	Shrinking operational space for IP and shrinking access for non-Libyans to health services	H	H	Dialogue with health entities (MoH, NCDC, PHCI and municipalities); medical ethics trainings; tailored solutions for hard-to-reach groups.
Related to communication and information	Visibility for the EU shadowed by implementing partners' visibility	M	L	Increased follow up on visibility plans

External Assumptions

- Political situation is sufficiently stable to allow for growing access to communities, gathering of evidence and the start of dialogue on PHC.
- No unforeseen or major external shocks force a drastic redesign of activities.
- Sufficient funds are made available for the minimal functioning of PHC services.

- There is a tacit agreement among the main stakeholders about the principal health governance strategies.
- Monitoring and supervision are possible and supported by health institutions.
- Acceptance of community participation mechanisms.

3.5. Intervention Logic

The journey to support the fragile health system in Libya towards the development of a robust, resilient system that delivers quality health services to all, effectively and efficiently, will require sustained engagement on a number of levels in order to anchor health in a solid and credible plan and strategy, while reducing the significant reliance on external donors, developing an acceptable primary health service that meets the needs of the vulnerable population and can be held fully accountable.

The underlying intervention logic for this action is that **the EU will:**

- invest in data gathering, analysis and use and strengthen technical dialogue and knowledge about clinical quality and equitable services and
- at the same time, contribute to strengthen institutions, creating professional networks and fostering a conducive environment for health professionals and managers to engage constructively, catalysing the governance processes needed to encourage health authorities to augment their role as stewards of the system both at central and at local levels, and invest in knowledge on clinical effectiveness, quality, and equity **in order to**
 - improve access to and utilisation of quality essential services by the most vulnerable populations while
 - increasing trust and meaningful engagement in health decision-making, **all of which will**
 - contribute to making the primary health service a valued, well-managed system that maximises the health of the Libyan people and contributes to good governance, peace, poverty reduction, and women’s empowerment and gender equality.

The action will increase health outcomes and avert disability and deaths through its direct support to health services to the most vulnerable populations, especially women and children. However, it will also strengthen the capacity of the Libyan health authorities to plan, design, deliver and monitor health services and engage communities around quality, appropriateness and acceptability of care, increasing accountability and strengthening health governance. As the broader political environment in Libya improves and domestic funding for health increases, the health institutions supported through this action will be in a stronger position to expand their health service delivery capacity as they will be more attuned and responsive to community needs, have more capacity to plan and budget, and a higher level of expectation about their role as duty bearers to be held accountable for services delivered.

3.6. Indicative Logical Framework Matrix

Please note: It is not currently possible to set baselines and targets for all indicators. However, the health indicators that will be available by assessing the targeted areas at the beginning of the implementation will offer a robust basis for defining targets. The health surveys and the Health Information System will eventually offer a standard data base against which to set benchmarks. It is proposed that after the first reliable data will be collected, an exercise to revise the LFA and set measurable target is conducted in cooperation with implementing partners and Libya health authorities.

Indicators marked as []** come from Commission staff working document *Launching the global Europe performance monitoring system* containing a revised Global Europe results framework 21.01.2022

Indicators marked as [§] are disaggregate by sex when referring to and counting individuals and when relevant and possible, by age, urban/rural location, disability status, or any other relevant disaggregation reflecting the mainstreaming issues.

Results	Results chain: Main expected results	Indicators	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Impact	To improve health outcomes in the Libyan population particularly among those most at risk or vulnerable	1 Universal Health Coverage (UHC) index [**]	1 60/100 (2019)	1 To Be Determined (TBD)	1 Many of the tracer indicators of health service coverage are measured by household surveys. However, administrative data, facility data, facility surveys, and sentinel surveillance systems are utilised for certain indicators.	<i>Not applicable</i>
Outcome 1	OC.1: Lay the foundations for enhancing and strengthening the development of health services and systems	1.1 # of dialogue sessions on UHC themes with involvement of national leadership and subnational delegates	1.1 0 (2022)	1.1 TBD	1.1 Projects records	<ul style="list-style-type: none"> - Political settlement grows at a sufficient level. - Effective dialogue on PHC based on evidence. - Domestic funding for health is adequate.
Outcome 2	OC.2: Improve access to and utilisation of essential health services ensuring equity for vulnerable populations in targeted municipalities.	2.1 Improvement of indexes derived from SARA survey (or alike) for targeted municipalities	2.1 TBD	2.1 Baseline + TBD%	2.1 SARA (or alike) survey records	

Results	Results chain: Main expected results	Indicators	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Output 1 Outcome 1	OP 1.1 Data collection, management and utilisation capacities strengthened.	1.1.1 # of national health surveys carried out.	1.1.1 0 (2022)	1.1.1 1	1.1.1 Availability of data	<ul style="list-style-type: none"> - Access to communities is maintained. - No unforeseen shock forces a drastic redesign of activities. - Funds invested are adequate. - Working agreement on major strategies
Output 2 Outcome 1	OP 1.2 Technical, delivery and stewardship capacities of the Primary Health Care Institute (PHCI) and National Center for Disease Control (NCDC) strengthened	1.2.1 # of policy/strategy processes initiated.	1.2.1 0 (2022)	1.2.1 TBD	1.2.1 Projects records	
Output 3 Outcome 1	OP 1.3 The blood bank network and transfusion services are operational and increasingly funded from Libyan national budget resources	1.3.1 Number of transfusion committees operational (targeted hospital). 1.3.2 Number of voluntary unpaid donors per 1,000 inhabitants (targeted areas). [§]	1.3.1 0 (2022) 1.3.2 5/1000 (2022)	1.3.1 TBD# 1.3.2 TBD/1000	1.3.1 Hospitals' records 1.3.2 Blood banks records	
Output 1 Outcome 2	OP 2.1 The delivery of a quality Essential Service Package (ESP) at primary health care level is strengthened in targeted municipalities.	2.1.1 Proportion of health facilities offering the ESP in target municipalities. 2.1.2 Number of women of reproductive age, adolescent girls and children under 5 reached by nutrition related interventions supported by the EU. [**] [§] 2.1.3 Number of women of reproductive age using modern contraception methods with EU support. [**] [§] 2.1.4 % of health service providers at primary health-care facilities who received personal supervision. [§]	2.1.1 TBD (2022) 2.1.2 TBD (2022) 2.1.3 TBD (2022) 2.1.4 TBD (2022)	2.1.1 80% 2.1.2 Baseline + TBD# 2.1.3 Baseline + TBD # 2.1.4 Baseline + TBD%	2.1.1 Project records 2.1.2 Project records National Health survey 2.1.3 Project records National Health survey 2.1.4 Project records Surveys	
Output 2 Outcome 2	OP 2.2 Sustainable and tailored access-to-health solutions for vulnerable and marginalised people (women, disabled, non-Libyans) are gradually incorporated into health service delivery policies and practices.	2.2.1 # of people directly benefiting from EU supported interventions that aim to reduce social and economic inequality [**] [§] 2.2.2 # of health workforce trained on medical ethics and rights [§]	2.2.1 TBD 2.2.2 0 (2022)	2.2.1 Baseline + TBD# 2.2.2 Baseline + TBD#	2.2.1 Project records 2.2.2 Project records	
Output 3 Outcome 2	OP 2.3 Meaningful community participation and engagement is increased.	2.3.1 Health facilities report regularly to communities 2.3.2 # of facilities with a committee with community participation	2.3.1 No (2022) 2.3.2 0 (2022)	2.3.1 YES 2.3.2 TBD#	2.3.1 Facility assessments / facility admin records 2.3.2 Facility assessments / facility admin records	

4. IMPLEMENTATION ARRANGEMENTS

4.1. Financing Agreement

In order to implement this action, it is not envisaged to conclude a financing agreement with Libya.

4.2. Indicative Implementation Period

The indicative operational implementation period of this action, during which the activities described in section 3 will be carried out and the corresponding contracts and agreements implemented, is 72 months from the date of adoption by the Commission of this financing Decision.

Extensions of the implementation period may be agreed by the Commission's responsible authorising officer by amending this financing Decision and the relevant contracts and agreements.

4.3. Implementation Modalities

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures²⁸.

4.3.1. Direct Management (Grants)

a) Purpose of the grant(s)

Grants will be awarded to implement outcome 2.

b) Type of applicants targeted

Potential applicants targeted are non-governmental organisations (NGOs) and civil society organisations (CSO). Creation of consortia and partnering of international with local organisations will be encouraged.

Under the responsibility of the Commission's authorising officer responsible, the grant may be awarded without a call for proposals to beneficiaries selected using the following criteria to be refined in cooperation with the Libyan health authorities if needed: (1) experience with implementation of health programmes; (2) experience in dealing with multi-national partnerships; (3) experience in working directly with different layers of governance structures; (4) experience in working with technical assistance set-ups, peer exchange etc. (5) proven experience in working on health service delivery in fragile, crisis or transition contexts.

c) Justification of a direct grant

Under the responsibility of the Commission's authorising officer responsible, the recourse to an award of a grant without a call for proposals is justified under crisis management aid (Article 195 (a) of the Financial Regulation) because the country is in a crisis situation, namely a situation of immediate or imminent danger threatening to escalate into armed conflict or destabilise the country.

4.3.2. Indirect Management with pillar-assessed entities

A part of this action may be implemented in indirect management with pillar-assessed entities, which will be selected by the Commission's services using the following criteria to be refined in collaboration with the Libyan health authorities if needed: (1) specific technical competence and specialisation, (2) results achieved with previous cooperation in Libya and elsewhere, (3) mandate, (4) capacity to deploy in the field and (5) weight in policy forums.

²⁸ www.sanctionsmap.eu Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails.

The implementation by the entities entails work at both national and subnational level for results detailed under the whole outcome 1.

4.3.3. Changes from indirect to direct management (and vice versa) mode due to exceptional circumstances

Taking into account the risks in terms of deterioration of the political and security context, part of the action that is foreseen to be implemented in indirect management may be reconsidered to be implemented under direct management modality (grants). Similarly, part of the action that is foreseen to be implemented in direct management (grants) may be reconsidered to be implemented under indirect management with a pillar-assessed entity.

4.4. Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply, subject to the following provisions.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (Article 28(10) NDICI-Global Europe Regulation).

4.5. Indicative Budget

Indicative Budget components	EU contribution (amount in EUR)
Implementation modalities – cf. section 4.3	
Outcome 1 <i>Lay the foundations for enhancing and strengthening the development of health services and systems</i> composed of:	7 000 000
Indirect management with international organisations – cf. section 4.3.2	7 000 000
Outcome 2 <i>Improve access to and utilisation of essential health services ensuring equity for vulnerable populations in targeted municipalities</i> composed of:	9 000 000
Grants (direct management)	N.A.
Grants – total envelope under section 4.3.1	9 000 000
Evaluation – cf. section 5.2	will be covered by
Audit – cf. section 5.3	another Decision
Communication and visibility – cf. section 6	N.A.
Contingencies	N.A.
Totals	16 000 000

4.6. Organisational Set-up and Responsibilities

Implementing partners will be fully responsible for the implementation of the action. Each partner contracted will be responsible for regular reporting to the EU Delegation, ideally through the establishment of a steering committee involving national counterparts for the specific action. Steering committees for individual actions will meet regularly and be mandated to (1) review implementation against prior established work plans and planned achievements, (2) review work plans where necessary; (3) facilitate the involvement of different stakeholders if pertinent and (4) discuss other issues relevant to the programme and its environment. If and when the "High level steering committee" pursued by MoH since some time will be operational, the steering committee of the project may be adapted.

As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission may participate in the above governance structures set up for governing the implementation of the action.

5. PERFORMANCE MEASUREMENT

5.1. Monitoring and Reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process, and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its Outputs and contribution to the achievement of its Outcomes, and if possible at the time of reporting, contribution to the achievement of its Impacts, as measured by corresponding indicators, using as reference the logframe matrix (for project modality).

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

5.2. Evaluation

Having regard to the nature of the action, a mid-term and/or a final evaluation will may be carried out for this action or its components via independent consultants contracted by the Commission.

The mid-term evaluation will be carried out for problem solving and learning purposes, in particular with respect to the progression towards health system resilience. The final evaluation will be carried out for accountability and learning purposes at various levels (including for policy revision), taking into account in particular the elements that have shown potential to contribute substantially towards system resilience and in view of greater engagement in policy dialogue.

The Commission shall form a Reference Group (RG) composed by representatives from the main stakeholders at both EU and national (representatives from the government, from civil society organisations (private sector, NGOs, etc.), etc.) levels. If deemed necessary, other donors will be invited to join.

The Commission shall inform the implementing partners at least 4 weeks in advance of the dates envisaged for the evaluation exercise and missions. The implementing partners shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports shall be shared with the partner country and other key stakeholders following the best practice of evaluation dissemination. The implementing partners and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

The financing of the evaluation shall be covered by another measure constituting a financing Decision.

5.3. Audit and Verifications

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audit or verification assignments for one or several contracts or agreements.

6. STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

All entities implementing EU-funded external actions have the contractual obligation to inform the relevant audiences of the Union's support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the actions concerned. To that end they must comply with the instructions given in the [Communication and Visibility Requirements of 2018](#) (or any successor document).

This obligation will apply equally, regardless of whether the actions concerned are implemented by the Commission, the partner country, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU Member States. In each case, a reference to the relevant contractual obligations must be included in the respective financing agreement, procurement and grant contracts, and contribution agreements.

For the purpose of enhancing the visibility of the EU and its contribution to this action, the Commission may sign or enter into joint declarations or statements, as part of its prerogative of budget implementation and to safeguard the financial interests of the Union. Visibility and communication measures should also promote transparency and accountability on the use of funds. Effectiveness of communication activities on awareness about the action and its objectives as well as on EU funding of the action should be measured.

Implementing partners shall keep the Commission and the EU Delegation/Office fully informed of the planning and implementation of specific visibility and communication activities before the implementation. Implementing partners will ensure adequate visibility of EU financing and will report on visibility and communication actions as well as the results of the overall action to the relevant monitoring committees.