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**COMMISSION IMPLEMENTING DECISION**

**of 31.8.2020**

**on the special measure in favour of Libya for 2020**

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## on the special measure in favour of Libya for 2020

THE EUROPEAN COMMISSION,

Having regard to the Treaty on the Functioning of the European Union,

Having regard to Regulation (EU, Euratom) 2018/1046 of the European Parliament and of the Council of 18 July 2018 on the financial rules applicable to the general budget of the Union, amending Regulations (EU) No 1296/2013, (EU) No 1301/2013, (EU) No 1303/2013, (EU) No 1304/2013, (EU) No 1309/2013, (EU) No 1316/2013, (EU) No 223/2014, (EU) No 283/2014, and Decision No 541/2014/EU and repealing Regulation (EU, Euratom) No 966/2012<sup>1</sup>, and in particular Article 110 thereof,

Having regard to Regulation (EU) No 236/2014 of the European Parliament and of the Council of 11 March 2014 laying down common rules and procedures for the implementation of the Union's instruments for financing external action<sup>2</sup>, and in particular Article 2(1) thereof,

Whereas:

- (1) In order to ensure the implementation of the special measure in favour of Libya for 2020, it is necessary to adopt an annual financing Decision, which constitutes the annual work programme, for 2020. Article 110 of Regulation (EU, Euratom) 2018/1046 establishes detailed rules on financing Decisions.
- (2) The envisaged assistance is deemed to follow the conditions and procedures set out by the restrictive measures adopted pursuant to Article 215 TFEU<sup>3</sup>.
- (3) The country strategy paper and the multiannual indicative programme established for Libya for 2014-2016 has expired. As the political situation in Libya remains highly unstable, the European Commission has decided to adopt special measures since 2017.
- (4) The objective pursued by the measure to be financed under the European Neighbourhood Instrument<sup>4</sup> is to improve the health status of the population in targeted areas.
- (5) 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 2020. A high level of flexibility and responsiveness is needed to adapt EU programmes to this volatile context. Several

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<sup>1</sup> OJ L 193, 30.7.2018, p.1.

<sup>2</sup> OJ L 77, 15.3.2014, p. 95.

<sup>3</sup> [www.sanctionsmap.eu](http://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.

<sup>4</sup> Regulation (EU) No 232/2014 of the European Parliament and of the Council of 11 March 2014 establishing a European Neighbourhood Instrument (OJ L 77, 15.3.2014, p. 27).

years of instability and armed conflict have weakened the already fragile health system in the country. Libyans are currently suffering from a critical lack of access to health services. There is furthermore a lack of reliable health statistical data on which to build evidence-based decision-making. It is necessary to adopt a special measure to improve the health status of the population in targeted areas in Libya.

- (6) The action entitled ‘Strengthening the Health System in Libya’ aims at strengthen health care system at local level. It will focus on making available a minimum package of health services in targeted areas and on improving data collection for local planning and decision-making trough the expansion of the Health Management Information System.
- (7) It is appropriate to authorise the award of grants without a call for proposals, pursuant to Article 195 of Regulation (EU, Euratom) 2018/1046.
- (8) Pursuant to Article 4(7) of Regulation (EU) No 236/2014, indirect management is to be used for the implementation of the programme.
- (9) The Commission is to ensure a level of protection of the financial interests of the Union with regards to entities and persons entrusted with the implementation of Union funds by indirect management as provided for in Article 154(3) of Regulation (EU, Euratom) 2018/1046.

To this end, such entities and persons are to be subject to an assessment of their systems and procedures in accordance with Article 154(4) of Regulation (EU, Euratom) 2018/1046 [and, if necessary, to appropriate supervisory measures in accordance with Article 154(5) of Regulation (EU, Euratom) 2018/1046 before a contribution agreement can be signed.

- (10) It is necessary to allow for the payment of interest due for late payment on the basis of Article 116(5) of Regulation (EU, Euratom) 2018/1046.
- (11) In order to allow for flexibility in the implementation of the measure, it is appropriate to allow changes which should not be considered substantial for the purposes of Article 110(5) of Regulation (EU, Euratom) 2018/1046.
- (12) The measure provided for in this Decision does not fall within the categories of measures for which the prior opinion of the Committee is required. The European Parliament and the European Neighbourhood Instrument Committee established under Article 15 of the financing instrument referred to in recital 4 should be informed of this Decision within one month following its adoption.

HAS DECIDED AS FOLLOWS:

*Article 1*  
*The measure*

The special measure in favour of Libya for 2020, as set out in the Annex, is adopted.

The measure shall include the following action:

- Annex: Strengthening the Health System in Libya.

*Article 2*  
*Union contribution*

The maximum Union contribution for the implementation of the measure for 2020 is set at EUR 10 000 000, and shall be financed from the appropriations entered in the following line of the general budget of the Union:

- budget line 22.04 01 02 for an amount of EUR 10 000 000.

The appropriations provided for in the first paragraph may also cover interest due for late payment.

*Article 3*  
*Methods of implementation and entrusted entities or persons*

The implementation of the actions carried out by way of indirect management, as set out in the Annex, may be entrusted to the entities or persons referred to or selected in accordance with the criteria laid down in point 5.3.3 of the Annex.

*Article 4*  
*Flexibility clause*

Increases<sup>5</sup> or decreases not exceeding 20% of the contribution set in the first paragraph of Article 2, or cumulated changes to the allocations of specific actions not exceeding 20% of that contribution, as well as extensions of the implementation period shall not be considered substantial within the meaning of Article 110(5) of Regulation (EU, Euratom) 2018/1046, where these changes do not significantly affect the nature and objectives of the actions.

The authorising officer responsible may apply the changes referred to in the first paragraph. Those changes shall be applied in accordance with the principles of sound financial management and proportionality.

*Article 5*  
*Grants*

Grants may be awarded without a call for proposals pursuant to Article 195 of Regulation (EU, Euratom) 2018/1046 to the bodies referred to in point 5.3.1 of the Annex.

Done at Brussels, 31.8.2020

*For the Commission*  
*Olivér VÁRHELYI*  
*Member of the Commission*

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<sup>5</sup> These changes can come from external assigned revenue made available after the adoption of the financing Decision.



**ANNEX**

of the Commission Implementing Decision on the the special measure in favour of Libya for 2020

**Action Document for Strengthening the Health System in Libya**

**ANNUAL MEASURE**

This document constitutes the annual work programme in the sense of Article 110(2) of the Financial Regulation and action programme/measure in the sense of Articles 2 and 3 of Regulation N° 236/2014.

<b>1. Title/basic act/ CRIS number</b>	<b>Strengthening the Health System in Libya</b> CRIS number: ENI/2020/042-691 Financed under the European Neighbourhood Instrument	
<b>2. Zone benefiting from the action/location</b>	Libya The action shall be carried out at the following location: Libya and Tunisia.	
<b>3. Programming document</b>	N.A. – in view of the volatile security situation, the Country Strategy Paper 2014-2016 is no longer valid.	
<b>4. Sustainable Development Goals (SDGs)</b>	<i>SDG 3 Ensure healthy lives and promote well-being for all at all ages</i> limited to targets: 3.1 – 3.2 – 3.4 – 3.7 – 3.8 – 3.C and 3.D <i>SDG 2 End hunger, achieve food security and improved nutrition and promote sustainable agriculture</i> limited to target 2.2	
<b>5. Sector of intervention/ thematic area</b>	Health	DEV. Assistance: YES
<b>6. Amounts concerned</b>	Total estimated cost: EUR 10 000 000 Total amount of EU contribution: EUR 10 000 000	
<b>7. Aid modality(ies) and implementation modality(ies)</b>	Project Modality Direct management through: <ul style="list-style-type: none"> <li>– Grants</li> <li>– Procurement</li> </ul> Indirect management with the entity(ies) to be selected in accordance with the criteria set out in section 5.3.	
<b>8 a) DAC code(s)</b>	<i>121 Health, General</i> 12110 Health policy and administrative management	<i>15%</i>

	<p>122 <i>Basic Health</i> 30%</p> <p>12220 Basic health care</p> <p>12240 Basic Nutrition</p> <p>12250 Infectious disease control</p> <p>12261 Health Education</p> <p>12281 Health personnel development</p> <p>123 <i>Non-communicable diseases (NCD)</i> 25%</p> <p>12310 NCDs control, general</p> <p>12340 Promotion of mental health and well being</p> <p>12350 Other prevention and treatment of NCDs</p> <p>130 <i>Population Policies/Programmes &amp; Reproductive Health</i> 30%</p> <p>13020 Reproductive health care</p> <p>13030 Family planning</p> <p>13081 Personnel development for population and reproductive health</p>			
<b>b) Main Delivery Channel</b>	<p>Channel 1: 20000 Non-governmental organisations (NGOs) and civil society</p> <p>Channel 2: 41000 United Nations agency, fund or commission (UN)</p> <p>Channel 3: 60000 Private sector institution</p>			
<b>9. Markers (from CRIS DAC form)</b>	<b>General policy objective</b>	<b>Not targeted</b>	<b>Significant objective</b>	<b>Principal objective</b>
	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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Trade Development	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Reproductive, Maternal, New born and child health	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<b>RIO Convention markers</b>	<b>Not targeted</b>	<b>Significant objective</b>	<b>Principal objective</b>
	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"/>
<b>10. Global Public Goods and Challenges (GPGC) thematic flagships</b>	NA			

### SUMMARY

The radical change of regime in 2011 in Libya followed by civil unrest and by prolonged armed conflict since then starkly uncovered many of the chronic fragilities of the country's health system. Health crises have not been addressed because of lack of resources, low reactivity of the system itself and limited physical access to many regions.

The outbreak of the COVID-19 pandemic has weakened the already fragile health system in Libya and affected its overall socio-economic situation. Against this challenging background, the Ministry of Health is now implementing a four-year health response strategy (2018-2021). The EU action presented in this document is fully aligned with the priorities set out in this

strategy. It builds on the ongoing health projects funded by the EU and aims to strengthen health care system at local level.

It will more specifically focus on making available a minimum package of health services at local level in targeted areas and on improving data collection for local planning and decision-making through the expansion of the Health Management Information System (HMIS). It will contribute to increase Libya's readiness to deal with ongoing and future outbreaks. Indicatively, activities will include policy analysis, policy dialogue, capacity building of key stakeholders of the local health system and provision of supplies, equipment and support to infrastructure.

The action is meant to adopt a "nexus approach" in the health sector through joint analysis and strengthening coherence and complementarity between humanitarian, stabilisation and development and peace building actions in Libya.

## 1 CONTEXT ANALYSIS

### 1.1 Context Description

Libya, once a high-middle-income country with health and education indicators among the highest on the African continent, is now a lower-middle-income country<sup>1</sup> that is navigating in a challenging situation. Fully supported by the EU and the international community at large, the United Nations (UN) led political process (re-invigorated in January 2020 with the Berlin Conference), is working to find inclusive and sustainable solutions to bring back peace, stability, security and unified institutions. Nevertheless, political strife in Libya has taken a heavy toll on the well-being of the population and the economy. Libya's economy still depends heavily on oil and gas, but these productions are susceptible to disruptions due to the conflict, and, lately, to the global crisis linked to COVID-19.

With an estimated population of 6.7, million mainly concentrated in urban areas, Libya is one of the world's most volatile countries. In 2020, the United Nations have identified<sup>2</sup> 0.9 million people in need of humanitarian assistance, over 13%<sup>3</sup> of the population, with differentiated impacts by region, ethnic group, gender and age. Public service delivery remains insufficient, despite efforts to re-establish them (mainly health, education, water, sanitation and waste management) at municipal level. Libya is now ranked 110th on the 2019 Human Development Index; it is listed by the World Bank as a fragile state and above 10% of its population is considered vulnerable to multidimensional poverty<sup>4</sup>. While it is difficult to accurately assess the magnitude of the social deterioration in the absence of credible baselines and statistics, the prolonged crisis exacerbated more recently by the COVID-19 pandemic has resulted in clear trends in terms of destruction of human capital, livelihoods, basic services, and infrastructure.

Political tensions remain high and rapid stabilisation of the situation is highly unlikely in the near future. Thus, necessary measures need to be rolled out in order to mitigate the worsening social indicators and assist the resilience of the health system.

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<sup>1</sup> In 2010, before the crisis, Libya's per capita income was almost USD 12,000, the second highest in Africa. In 2016, post-crisis per capita income fell to below USD 5,000. <https://data.worldbank.org/country/libya>.

<sup>2</sup> If not otherwise indicated all figures refer to pre COVID-19 pandemic.

<sup>3</sup> UN Humanitarian Response Plan 2020 Libya [https://reliefweb.int/sites/reliefweb.int/files/resources/20200106\\_humanitarian-dashboard\\_summary\\_jan-nov.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/20200106_humanitarian-dashboard_summary_jan-nov.pdf).

<sup>4</sup> UNDP - Global Multidimensional Poverty Index 2019.

## 1.2 Policy Framework (Global, EU)

In the absence of a full-fledged national health strategy and of reliable population data that would form the basis for evidence-based decision making, the international health community, in cooperation with the Ministry of Health has agreed on a *Health Sector Response Strategy 2018-2021* intended as a guide for harmonising implementation of services in the health sector. This document draws on international best practices, elsewhere supported by the EU, in order to reach maximum coverage of the population for a minimum package of health services (the ‘Minimum Service Package’ or MSP). All components of the package are consistent with EU policies and with health-related SDGs.<sup>5</sup>

## 1.3 Public Policy Analysis of the partner country

During the Gaddafi rule, the Libyan health system, based on the right of every citizen to access all health services free of charge, was structured along the usual pyramid of primary, secondary and tertiary health care. In 2000, an initial attempt was launched to decentralise health service delivery, including resource allocation, to the district level. The country was divided into 22 Shabiat (districts) under the authority of the General People’s Committee for Health and Environment that was given the mandate to inspect and supervise both central and district level secretariats and institutions. While realisation that capacity at the local level was inadequate to sustain the system, the absence of centrally determined policies, guidelines, oversight, monitoring and organized information systems further hindered the full realisation of this decentralisation process.

More recently, renewed efforts have been launched to decentralise health service delivery with the separation of two pivotal general directorates, traditionally under the responsibility of the Minister of Health, that were elevated to the status of National Institutes with reporting duties to the Minister but working in autonomy. They are: (a) the National Centre for Disease Control (NCDC) with competencies in communicable and non-communicable diseases, laboratories, rapid response, vaccination, and resources (human, procurement) related to the diseases that are part of their mandate and (b) the newly created (February 2020) National Institute for Primary Health Care whose organisation and structuring is ongoing.

Also, at the end of 2019, the competency for management of Primary Health Care has been deconcentrated to municipalities, albeit without clear indications as to accompanying adequate financial resources and without a proper assessment of existing capacities at municipal level to take up this responsibility. As municipalities continue to be absorbed by the ongoing conflict, they are challenged to take up their announced role of health administrations.

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<sup>5</sup> 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 EUMS, 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) Communication from the commission “*On enabling the digital transformation of health and care in the digital single market; empowering citizens and building a healthier society*” COM(2018) 233 final. 25.4.2018. This communication is relevant for the building of the Health Management Information System; (8) The new European consensus on development “*Our world, our dignity, our future*”. European Union, 2018.



The action will thus be confronted with multiple actors legally entitled to stakes in the public health system but at the same time lacking adequate preparation, procedures and funding flows.

At a central level, Libya's health sector continues to struggle to agree on a health policy that addresses major transformations of its changing epidemiological profile and regulates its human and financial resources and the decentralisation process. Overall health governance in Libya remains weak, with a centralised system composed of national institutions that lacks appropriate capacity to develop and implement citizen-centred, transparent and accountable health policies and processes.

The *Health Sector Response Strategy 2018-2021*, championed by the World Health Organization (WHO), is to date the only framing document entailing a principle agreement on a list of key services, not quantified nor costed, that constitute the Minimum Service Package to be available at community, primary and secondary level of care. Libya would benefit from deepening the discussion around the MSP in order to further structure services, inputs and resources with a cost effectiveness analysis and at the same time link the offer of primary health care sector with the (overburdened) secondary hospital sector.<sup>6</sup> The response strategy lacks also a corresponding time-based implementation plan as well as an analysis of needed resources.

This being said, there are some positive elements that can be further strengthened through this action. Though piecemeal, the approach of all Development Partners has rarely followed a vertical approach, based on a single disease or condition but has always aimed at integrating services. Despite delays and shortcomings in implementation, the relevance of health programmes has always been high and the introduction of complex components such as psychosocial support since an early stage of the crisis needs to be commended. The proposed focus on primary health care in this action recognises these positive points and is anchored in the likely scalability of a primary healthcare approach based on the Minimum Service Package.

A focus on primary health care is further justified as Libya will likely not meet SDG targets on health, given the losses incurred in health and social indicators as a result of the protracted turmoil and the time required to train, deploy and retain quality human resources in sufficient numbers. Contrarily, even without formal policies or strategies, but building on massive, though unchartered, financial investments in the health sector, Libya had come a long way towards closing the gap for the Millennium Development Goals (MDGs) constantly performing amongst the top of Africa for health and most social indicators.<sup>7</sup>

#### **1.4 Stakeholder analysis**

To date, the EU's main institutional partners in the health sector has been the Ministry of Health with different departments and agencies. A partnership with municipalities limited to the rehabilitation of health infrastructures and the provision of some equipment is ongoing through the European Union Trust Fund for Africa (EUTF). While the mandate for health legally stays with multiple stakeholders, it is clear that stewardship functions should be assumed by the central Ministry of Health. Nevertheless, proactive

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<sup>6</sup> A document on Primary Health Care also exists (*Primary Healthcare Strategy 2019-2022* – Ministry of Health) however its quality and credibility are very low and the services suggested for the MSP differ from the ones of the strategy. This is a document proposed to pilot a PHC approach in 6 Municipalities (unnamed in the document itself).

<sup>7</sup> AUC, UNECA, AfDB and UNDP *Assessing Progress in Africa toward the Millennium Development Goals MDG Report 2012*. [Last checked on 20.01.2020 [https://www.uneca.org/sites/default/files/PublicationFiles/mdgreport2012\\_eng.pdf](https://www.uneca.org/sites/default/files/PublicationFiles/mdgreport2012_eng.pdf) ]

policymaking with a long-term vision for the health sector is not in place. As responsibilities on Primary Health Care (PHC) are now attributed to both the new-born institute of PHC as well as to municipalities, it is still unclear how resources and mandate will be distributed.

So far, no specific interaction for health has taken place with the Ministry of Finance, local academia, professional councils and private health sector, rapidly growing in urban areas. They are all considered powerful actors and regulators of the system and as such the action may support further coordination with them.

Target groups for the proposed action will primarily be the employees and management of public health facilities delivering the Minimum Service Package. The final beneficiaries will be the users of the public health services and communities in the geographic catchment areas who will be proactively encouraged to participate in the creation and rooting of local health networks aiming to increase community participation in the sector. The situation of marginalised and vulnerable groups, women and youth, as pivotal as any other group for the reconstruction of the country, will be taken into account in the programme.

The absorption capacities of implementing partners in general and in specific locations will need to be factored in at contracting time, as in the past most partners showed delays mostly due to the difficulty to work on site (secure access) and remotely.

### **1.5 Problem analysis/priority areas for support**

Libya's **epidemiological profile** has shown since some years a trademark transition typical of upper middle-income countries. Infant mortality has decreased. The relative prevalence of communicable diseases has also decreased, although they have been recently re-emerging. Lifestyle related noncommunicable diseases (NCD) have become more prevalent. Libya is also undergoing a demographic transition, however; while its mortality rates have declined, it still sustains fertility rates above the replacement rate. The country is equally in the midst of a nutrition transition, where we see all different forms of malnutrition coexist. The above puts the already underperforming health system under stress because a complex range of conditions should in principle be prevented and treated for the entire population.

Libyans are suffering from a **critical lack of access<sup>8</sup> to health care<sup>9</sup>**: while accuracy of data may be challenged, there is a general agreement on the worsening trend in the offer of services at alarming levels as for instance only 6% of public hospitals can offer the full array of essential service, and around 40% of PHC facilities are either closed or not offering any essential service. Most services typically found in primary health care clinics are seldom available<sup>10</sup>. Previous progress in maternal and child health is being reversed because PHC clinics lack inputs, are unable to meet the demand, or have been closed. It is worth remembering that historically the health system has been built on hospitals running on high budgets rather than on a local basic network. In an environment where the most vulnerable, less wealthy and less mobile population is increasing, it is vital to strengthen

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<sup>8</sup> Here we mean "access" in its most comprehensive meaning as the ease with which an individual can obtain needed medical services and encompasses the availability of services, their accessibility both in geographical and financial terms and their acceptability.

<sup>9</sup> 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.

<sup>10</sup> As an example, relevant to a minimum service package: only 40% of facilities offer normal delivery services. HEXA vaccine is not available in 60% of primary healthcare facilities; antenatal care visits are offered in less than 15% of primary healthcare clinics and fewer than 15% can offer adequate essential drugs.

a health system model where the most prevalent health needs of the population can be met at a local level, as proposed by this action.

**Communicable and noncommunicable diseases** are emerging, along with increasing **malnutrition** and **poor mental health**. Child stunting and overweight rates are 22% and 16.9%,<sup>11</sup> respectively, which are above the regional average<sup>12</sup>. Malaria and respiratory infections, including tuberculosis, are re-emerging due to the influx of migrants but also due to indigenous cases resulting from worsening livelihoods and a weak public health system. The limitations of the current health system in relation to dealing with communicable diseases is evident in the lack of preparedness to deal with the current COVID-19 pandemic. Mental health conditions – related to the protracted armed conflict – are increasing for the local population and are prevalent. Building on previous experience in Libya, communicable and non-communicable diseases, including mental health, will be incorporated in the service package supported by the action.

High levels of **immunisation coverage** amongst children below 2 years of age have been constantly maintained until 2014. However, coverage has started to decline since, as evidenced by multiple outbreaks erupting as of mid 2018 following a disruption in routine vaccination offered at PHC clinics and a low capacity for outreach. Libya was “polio free”; however, with inflow of migrants from polio prevalent countries, catch up campaigns have been started. It is worth pointing out that, in the unfolding COVID-19 emergency in Libya, the Ministry of Health has advised to suspend routine vaccinations in order to redeploy staff on the pandemic response. Immunisation is part of the service package that will be supported by this action.

The outbreak of the **COVID-19** in March 2020 has added to this dire situation. Although the number of cases reported in Libya is limited (as of May 2020), risks linked to this pandemic are particularly high in the country, notably due to the weak capacities of the health system, the current conflict and the situation of migrants and Internally Displaced Persons. This action will contribute to improve the resilience of the health system vis-à-vis outbreaks.

A **Human Resources for Health (HRH)** crisis is unfolding since 2014 mainly due to the departure of migrant health workers<sup>13</sup>, to the phenomenon of “ghost health personnel”<sup>14</sup> and to great disparities in the distribution of health staff across the different regions. Insufficient information is currently available on the skills mix, skills levels and training curricula for remaining health staff in Libya. No HRH strategy exists, and therefore there is no appropriate planning for health personnel to respond to changing health service conditions and epidemiological profile. It is worth underlining that for its own nature HRH planning and production will deliver results only with a mid/long term perspective, linked to the time requirements for human resources development. Building on the ongoing experience of upskilling and revision of curricula for nurses and midwives, this action proposes to continue this support and expand it.

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<sup>11</sup> Though there are no recent population based surveys (SMART), data from 1995 reanalysed already suggested a worrisome situation with 4.3% of children underweight, 3.7% wasted, 20.7% stunted, and 16.2% overweight [El Taguri Adel et al, *Nutritional Status Of Under-Five Children In Libya; A National Population-Based Survey* Libyan J Med. 2008; 3(1): 13–19]. The WB reports 22% of prevalence of stunting in U5 children in 2007 <https://data.worldbank.org/indicator/SH.STA.STNT.MA.ZS?locations=LY> [last checked on 05.02.2020]. As far as overweight most recent data set at 16.9% the prevalence of obesity for U5 children [Rafik R. Elmehdawi et al *Obesity in Libya: a review* Libyan Journal of Medicine 7(1) August 2012].

<sup>12</sup> Among the major risk factors for morbidity and mortality of Libyans are: dietary concerns, inactivity and obesity – leading to cardiovascular disease, chronic respiratory disease and diabetes. In this context it is also worth to remember that prior to 2011 crisis Libya was a net food importer by 70%.

<sup>13</sup> Migrant health workers represented a very significant share of hospital staffing with around 50% of specialized doctors and up to 90% of nurses.

<sup>14</sup> When staff is enlisted in the payroll but constantly does not show up for work.

Amongst the health determinants, Libya is among the world’s most water-scarce countries and **water services and sanitation capacities** are rapidly deteriorating. The action will ensure that water and sanitation services are available in health facilities.

While the **Health Information** Centre collects health status and system indicators, there remains an overall lack of reliable statistical population data<sup>15</sup> allowing the public health community and the Ministry of Health to build evidence-based decision-making. Service utilisation data are also not available, nor is household income-expenditure for health. The dissemination and use of the HMIS, previously supported at central level, will be further supported at local level in the targeted areas through this action.

While the action will not address directly the leadership and governance pillar, nor the healthcare financing pillar, it will engage in coordination and policy dialogue also on those two pillars. In conclusion, the action will seek to increase availability, accessibility and acceptability of health services at primary healthcare level by supporting the MSP at local level and rolling out of the HMIS at local level in order to improve evidence-based decision-making.

## 2 RISKS AND ASSUMPTIONS

Main risks for the action belong to two subsets of threats: (i) those linked to sustained insecurity warfare and further spiralling down of government and institutions and (ii) those linked to competing interests in the field, relevant for implementation. These are well-known risks in the Libya context and the design of the action pre-empts them by proposing adaptive and flexible implementation modalities.

<b>Risks</b>	<b>Risk level (L/M/H)</b>	<b>Mitigating measures</b>
Insecurity and lack of concrete progress on the peace process, which results in continued impeded access for implementing partners/donors.	H	Most programmes implemented in Libya have established modalities that allow quick adaptation to remote management modalities when needed – this will also be the case for this action. Continuous analysis of the context, with specific focus on target locations. A third party and remote monitoring system may accompany the action.
Continued absence of sector strategies and policies.	M	Continued and increased engagement of the EU in sector coordination and policy dialogue mechanisms at all levels (technical and strategic); support the evidence base for reforms through support to joint sectoral assessments. Alignment with appropriate international best practices.
Low capacities in government institutions and lack of ownership by the partner government.	M/H	Intensified coordination and policy dialogue with Libyan stakeholders and international community. Emphasis on low complexity and flexibility in implementation contracts.
Limited human resource capacities in the Libyan health sector and inadequate spread of health staff.	M	Support to design a human resource strategy in coordination with health stakeholders and international community.
Scarcity of implementing partners on the ground (also in light of COVID-19 related extra funding).	M/H	The action is designed to be implemented through a mix of actors that have established presence in country and/or experience in working in crisis situations; call for proposal modality will challenge partners to design qualitative and competitive proposals.

<sup>15</sup> The last MICS (Multiple Indicator Cluster Survey) dates back to 2003; DHS (Demography and Health survey) was never conducted in Libya and the last population-based nutrition survey (for U5 children) dates back to 1995.

Increased cost of actions resulting in impact for a small number of beneficiaries and/or for too short a time.	M/H	Adoption of and coordination in a nexus approach to strengthen joint analysis and strategies for coherence and complementarity, as well as possibly common approaches to address price hikes and maximize number of beneficiaries; leverage different EU programmes in a given targeted location for increased cost effectiveness and impact.
<b>Assumptions</b>		
<ol style="list-style-type: none"> <li>1. Libyan public health institutions remain committed to deliver citizen-centred, rights-based services in line with their primary mandate and gradually commit the requisite human and financial resources to sustain such services;</li> <li>2. Libyan public health institutions are receptive to policy recommendations made as a result of programme interventions and are able to adopt and progressively fund the relevant policies.</li> </ol>		

### 3 LESSONS LEARNT AND COMPLEMENTARITY

#### 3.1 Lessons learnt

The current action will build on the work done by the EU in Libya since 2011, specifically on previous and ongoing support to HMIS and to the advancement of nursing and midwifery education. A review process has been launched at the end of 2019 in the absence of a full impact evaluation on the ground<sup>16</sup>; this process is led by a dedicated health expert to assess relevance, efficiency, effectiveness and – to the extent possible – impact of previous health programmes in Libya. Results of this assessment (second half of 2020) will be taken into account in the implementation of the current action. Preliminary findings indicate that the EU's engagement in the health sector to date has been rather fragmented by supporting vertical approaches<sup>17</sup>; a contract in support of mutual accountability and to introduce Third-Party Monitoring (TPM) in the health sector was signed in 2018, without however bringing, so far, the desired improvement in the Ministry of Health monitoring capacities. The review further indicates that some of the previous programmes were overambitious in their design and lacked the ability or flexibility to adapt more promptly to changing conditions and realities on the ground.

Responding to these preliminary findings, the current action will seek to maintain a simple architecture built around the offer of the MSP, coupled with the strengthening of human resources in the health sector and a continued work on health information. Rather than supporting thematic areas (mental health, non-communicable diseases, blood transfusion) the action will support a concerted approach (MSP) in all targeted geographic areas thus buying into the narrative of primary health care reflected in the *Health Sector Response Strategy 2018-2021* and aligning to the actions promoted by other donors.

#### 3.2 Complementarity, synergy and donor co-ordination

Despite the absence of joint programming in the health sector, initial steps towards the activation of a nexus approach have been made; there is broad agreement within the health sector coordination group to move towards a primary healthcare approach and to

<sup>16</sup> Proper evaluation of actions in Libya – especially impact evaluations – remain challenging in the context of continued armed conflict across the larger part of the Libyan territory. Desk review and key informant interviews in the review process provide an appropriate intermediate solution to determine what worked and lessons learned.

<sup>17</sup> Contracts have been signed in support of (i) health provision for migrant populations, (ii) to build a referral system for psycho-social support and mental health care, (iii) support for the blood bank system, (iv) support of non-communicable diseases, (v) support to nursing and midwifery as part of the reinforcement to HRH and (vi) support for the national HMIS

build on early gains of health system strengthening in terms of Human Resources for Health and Health Management Information System at both national and district level. Procurement of medicines, vaccines and medical equipment is a supportive measure for health programmes but rarely a stand-alone approach championed by a single donor. Donor coordination in the health sector is so far followed up through the UN Cluster approach and, as such, still geared towards an emergency/response mechanism and annual planning cycles. The health cluster is co-chaired by the WHO and the Ministry of Health. In March 2020, the Ministry of Health has launched a high-level steering committee for health, underpinned by technical subcommittees and scientific committees with the aim to bridge the gap with development programmes and increase mutual accountability through a nexus approach.

Donor support for health in 2019 amounted to some EUR 10 million or 23% of estimated needs and targets. The UN set a target of EUR 30 million for 2020. Although severely impacted by the consequences of the conflict, health services receive relatively less ODA against a background of unknown but certainly decreasing domestic allocations. In the absence of costed strategies and of National Health Accounts (NHA) the relative weight of external donors is considerable. Requests for additional funding are being expressed by the Ministry of Health leadership and by the UN to target the COVID-19 pandemic, so far addressed by WHO pool funding and by domestic budgets.

Donors active in the health sector include German and Italian Cooperation, the Agence Française de Développement (AFD)/French Embassy, the United States Agency for International Development (USAID), the World Bank and the EU with bilateral budget, the European Civil Protection and Humanitarian Aid Operations (ECHO) and the EUTF. The EUTF has been investing in the health sector through its protection and community stabilisation pillars and is currently planning to make a substantial contribution to the COVID-19 response. EUTF interventions cover several municipalities and address gaps at various levels for vulnerable communities (health infrastructure, capacity building, service delivery, procurement of equipment and consumables). The EU will continue to maximise synergies between its different instruments, notably through its implementers' forum.

Because Libya ranks as middle-income country, it is not eligible for funding from major global health initiatives such as GAVI (the Vaccine Alliance) and the Global Fund. Non-OECD (Organisation for Economic Cooperation and Development) donors are not known to be active in the health sector. The World Bank delivered a leadership training programme to civil servants from several ministries including the Ministry of Health through an EU supported project and they will also start to work on the healthcare financing pillar.

UN agencies (WHO, United Nations Population Fund - UNFPA, United Nations Children's Fund - UNICEF and, with a focus on migrants, the United Nations High Commissioner for Refugees - UNHCR and the International Organization for Migration - IOM) are both partners and donors in the health sector along with a small presence of specialised international health NGOs.

An EU regional programme, implemented by the European Centre for Disease Prevention and Control (ECDC), was recently launched. It will cover Southern, Eastern Neighbourhood and Enlargement Countries and it will focus on the following areas: 1) Field epidemiology workforce development through the Mediterranean Programme for Intervention Epidemiology Training; 2) Stronger partner countries' capacities to assess, detect, respond and prevent threats from communicable diseases, as well as enhanced

regional cooperation in the field of preparedness and response; and 3) Integration into ECDC systems, knowledge sharing and networking.

## 4 DESCRIPTION OF THE ACTION

### 4.1 Overall objective, specific objective(s), expected outputs and indicative activities

The overall objective is to improve the health status of the population in targeted areas.

The specific objective is to strengthen health care system at local level.

The expected outputs are: (1) Minimum package of key health services available in targeted areas; (2) improved data collection for local planning and decision making.

Due to the ongoing escalation of the conflict, the geographical areas of intervention are not yet defined. They will be selected and agreed upon with the Ministry of Health on the basis of criteria that combine their strategic importance, the funding made available by the Government and by other donors, other EU programmes for which a health component would reinforce general service delivery and community resilience, specific requests from the Ministry of Health, feasibility and the “severity scale”<sup>18</sup> updated at decision time. The two expected outputs are interlinked and mutually reinforcing.

#### Main activities

The project will use capacity development tools (technical assistance, consultancies, trainings, supportive supervision, skills transfer, peer-learning and twinning mechanisms, etc.) in order to improve institutional competences at local level in the intervention areas and lay the foundations towards general strengthening of health system pillars.

#### Expected output 1: Minimum package of key health services available in targeted areas

Indicative activities:

- 1.1 Analyse the specific situation of the health sector in each targeted area. This includes local epidemiological profile, level of services, workforce, equipment and infrastructure and an assessment of the costs of the Minimum Service Package;
- 1.2 Adapt the scope of the Minimum package of key health services based on the result of 1.1. This minimum package could indicatively include reproductive, maternal and new-born health; child health and immunisation; public nutrition; communicable and non-communicable diseases; mental health/disability; a community component; the regular supply of essential drugs and vaccines and workforce training and supervision;
- 1.3 Build the capacities of key stakeholders of the local health system (doctors, nurses, clinics managers, community health workers);
- 1.4 Provide health facilities with essential medicines, medical supplies, equipment and infrastructure (based on needs, e.g. water and sanitation infrastructure);
- 1.5 Policy dialogue at central level to contribute to the ongoing process of up-skilling of the workforce, to the development of a Human Resources for health strategy, based on the results of the above activities.

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<sup>18</sup> The *Health sector severity scale* is a balanced scorecard based on the acuteness of humanitarian health response weighted by population affected (quantitative), vulnerability of the population and health service availability. It allows a rough mapping guiding mainly humanitarian response.

While upscaling of skills of the health workforce contributes to improved service delivery at the local level, capacity building efforts will need to be complemented with policy dialogue at the central level, involving not only health officials but also academia to trigger the adaptation of curricula for primary healthcare workers, as well as contribute to the much-needed HRH strategy and to the reform of curricula for recertification and continuous education of staff.

Expected output 2: improved data collection (HMIS) for local planning and decision making.

This component follows previous support to the HMIS and completes the introduction, rollout and use of new tools at local level.

Indicative activities:

- 2.1 Assess the capacities of key stakeholders involved in data collection and roll-out of the HMIS. This includes employees of the Ministry of Health and its subsidiary agencies and/or of municipalities. Support the Early Warning Alert and Response Network;
- 2.2 Develop and deliver tailor-made trainings for these stakeholders;
- 2.3 Strengthen HMIS supervisory mechanisms;
- 2.4 Ensure readiness of additional municipalities and health facilities to contribute to the HMIS. Provide equipment, including IT equipment, based on needs assessment.

## **4.2 Intervention Logic**

By focusing on the roll out of the implementation of the MSP and by improving skills of the health workforce, we assume that the most prevalent conditions responsible for excess mortality and morbidity can be attended at primary healthcare level, contributing to closing the gap towards reaching SDGs. We assume that with improved skills and better equipped facilities<sup>19</sup>, barriers to access to services will be reduced. We also assume that the basis for healthier lifestyles can start to root in the communities where the action will be rolled out through increased community engagement. In principle, the action is designed to work as closely as possible to the beneficiaries. However, the activities will feed into policy fora and policy dialogue at national level as well as into the full development of a nexus approach in the health sector that would contribute to increased sustainability of the action.

The Libyan public health context is challenged on both humanitarian and development aspects. While urgent action is needed in order to increase the offer of appropriate services for the population and curb the excess mortality for preventable conditions (expected output 1) work is needed on a series of structural pillars that, in time, will result in increased resilience of the system (expected result 2 and partially 1).

Both expected outputs contain components that will support the resilience of the health system vis-à-vis outbreaks (e.g. reinforcing capacities on Communicable Diseases, immunisation, more efficient processing of data on outbreaks...).

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<sup>19</sup> Pharmaceutical procurement modalities will be specified at contracting stage.



### **4.3 Mainstreaming**

All specific actions to be implemented under this programme will follow a rights-based approach, ensuring a gender, age and diversity-sensitive programming through participatory approaches. Reducing health inequalities was at the centre of Libyan national health policy during the seventies. However, the objective was never fully met. There are indications of increasing inequalities based on income quintile, education, residence and gender. The importance of ensuring that implementation as well as future policy making and budget allocations take inequalities into consideration cannot be understated.

Particular attention will be given to strengthening female participation in professional, social and political fora at all levels. The community component of the MSP will specifically encourage involvement of younger generations, women and disadvantaged groups (such as people living with disability). Throughout the action, equal access to health facilities for all rights-holders is a determining factor. Specific activities will be tested against their possible impact to improve access for women and girls as well as disadvantaged groups in a given community. A conflict-sensitive approach will be required in the selection of specific locations for programme interventions in line with the recent WHO severity scale.

### **4.4 Contribution to SDGs**

This intervention is relevant for the United Nations 2030 Agenda for Sustainable Development. It contributes primarily to the progressive achievement of some of the targets included under SDG 3 “Ensure healthy lives and promote well-being for all at all ages”, and specifically maternal, new-born and child health along with sexual and reproductive health (3.1, 3.2 and 3.7), non-communicable diseases including mental health (3.4), greater and more equitable access to health services (3.8), support for health workforce (3C) and support for early warning, risk reduction (3D). Specific diseases (target 3.3) may be supported as appropriate in the MSP. It also contributes to target 2.2 of SDG 2 related to ending all forms of malnutrition through the activities promoting healthier lifestyles.

## **5 IMPLEMENTATION**

### **5.1 Financing agreement**

In order to implement this action, it is not foreseen to conclude a financing agreement with the partner country.

### **5.2 Indicative implementation period**

The indicative operational implementation period of this action, during which the activities described in section 4 will be carried out and the corresponding contracts and agreements implemented, is 72 months from the date of the 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 Decision and the relevant contracts and agreements.

### 5.3 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 measures<sup>20</sup>.

#### 5.3.1 Grants: (direct management)

(a) Purpose of the grants:

Operationalisation of output 1<sup>21</sup>.

(b) Type of applicants targeted:

NGOs or consortia of NGOs.

(c) Justification of direct grants:

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

Under the responsibility of the Commission's authorising officer, the recourse to an award of grants without a call for proposals is justified because the country is in a crisis situation (Article 195 (a) of the Financial Regulation).

#### 5.3.2 Procurement (direct management)

Operationalisation of part of output 1/indicative activity 1.1 (limited to the costing of the Minimum Service Package).

Subject	Indicative type	Indicative trimester of launch of the procedure
Minimum Service Package	Services	Q1 – 2021

#### 5.3.3 Indirect management with international organisations

A part of this action may be implemented in indirect management with UN agencies with a health mandate, possibly in consortium. This implementation entails support in order to accomplish expected output 2 and partially output 1 (with a main focus on activities 1.3 and 1.5). The envisaged entities will be selected on the account of their specific technical competence and specialisation, results achieved with previous cooperation in Libya and elsewhere, capacity to deploy in the field and weight in policy fora. Efforts will also be deployed in order to sign one single contribution agreement with the UN agencies working in consortium.

<sup>20</sup> [www.sanctionsmap.eu](http://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.

<sup>21</sup> It is estimated that a maximum of 4 grants will be signed under this decision. To the extent possible, the grants will cover different geographical areas of Libya.

If negotiations with the above-mentioned entities fail, that part of this action may be implemented in direct management in accordance with the implementation modalities identified in section 5.3.1.

#### 5.4 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 provision.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realisation of this action impossible or exceedingly difficult.

#### 5.5 Indicative budget

	<b>EU contribution (amount in EUR)</b>
<b>Output 1: Minimum package of key health services available in targeted areas,</b> composed of:	<b>9 000 000</b>
– Grants (direct management) – cf section 5.3.1	7 800 000
– Procurement (direct management) – cf section 5.3.2	200 000
– Indirect management with international organisations - cf section 5.3.3	1 000 000
<b>Output 2: improved data collection (HMIS) for local planning and decision making,</b> composed of:	<b>1 000 000</b>
– Indirect management with international organisations - cf section 5.3.3	1 000 000
<b>Evaluation</b> (cf. section 5.8)	Will be covered by another decision
<b>Audit/ Expenditure verification</b> (cf. section 5.9)	Included in each contract
<b>Communication and visibility</b> (cf. section 5.10)	Included in each contract
<b>Total</b>	<b>10 000 000</b>

#### 5.6 Organisational set-up and responsibilities

Implementing partners contracted in line with the foreseen contracts in section 5.3 above are 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 (not less than semi-annually) 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 as relevant to the programme and its environment. When the "High level steering committee" recently proposed by the Ministry of Health (see paragraph 3.2 above) will be operational the steering committee of the project may be adapted.

#### 5.7 Performance and Results 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 partners' responsibilities. To this aim, each 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 results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the logframe matrix.

SDGs indicators and, if applicable, any jointly agreed indicators should be taken into account.

Reports shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. Reporting will focus on results, rather than only listing activities and inputs. Where results remain limited due to a continued volatile situation in Libya, the reporting shall focus on progress made towards achieving expected results. The final report, narrative and financial, will cover the entire period of the action implementation.

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).

## **5.8 Evaluation**

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

The mid-term, final and ex-post evaluations, if carried out, will have accountability and learning purposes, at various levels (including for policy revision), in particular with respect to the possibility to launch a further phase of the action.

The Commission shall inform the implementing partners at least 30 days in advance of the dates foreseen for the evaluation 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. 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.

## **5.9 Audit**

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 audits or expenditure verification assignments for one or several contracts or agreements.

The financing of the audit shall be covered by another measure constituting a financing decision.

## **5.10 Communication and visibility**

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU.

This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the Action, to be elaborated at the start of implementation.

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country (for instance, concerning the reforms supported through budget support), contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and contribution agreements.

The Communication and Visibility Requirements for European Union External Action (or any succeeding document) shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.

## Acronyms used in this document

ANC	Ante Natal Care visit (4 visits following Libya MSP)
DHIS	District Health Information System
EUTF	European Union Trust Fund
EWARN	Early Warning Alert and Response Network
GAVI	The Vaccine Alliance
GPC	General People's Congress
Hexa	Hexavalent vaccine is a combination of 6 vaccines
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MR	Measles and Rubella
MSP	Minimum Service Package
NCD	Non Communicable diseases
NCDC	National Centre for Disease Control
NHA	National Health Accounts
ODA	Official Development Assistance
OIC	Office for International Cooperation
PHC	Primary Health Care
PNC	Post Natal Care
SARA	Service Availability and Readiness Assessment
SDG	Sustainable Development Goals
U1/U2/U5	Children under the age of 1, 2 or 5 years
WASH	Water, Sanitation, Hygiene

## APPENDIX - INDICATIVE LOGFRAME MATRIX (FOR PROJECT MODALITY)

It is not currently possible to set a baseline for all indicators. Targets obviously depend on the baseline. However, the health indicators that are available by assessing the targeted areas at the beginning of the implementation will offer a robust basis for defining targets. Targets set will aim to close the gap of SDG as appropriate for the time span of the implementation. The Health Information System will eventually offer a standard data base against which to set benchmarks. After the first reliable data is collected, it is proposed to carry out an exercise to revise the logframe and set measurable target in cooperation with implementing partners and the Ministry of Health In this framework all efforts will be made in order to present indicators disaggregated by sex and age and whenever possible by vulnerability.

Indicators aligned with the relevant programming document are marked with '\*'; Indicators aligned to the EU Results Framework are marked with '\*\*'.

	<b>Results chain: Main expected results</b>	<b>Indicators (at least one indicator per expected result)</b>	<b>Baselines (incl. reference year)</b>	<b>Targets (incl. reference year)</b>	<b>Sources of data</b>	<b>Assumptions</b>
<b>Impact (Overall Objective)</b>	Improve the health status of the population in targeted areas.	Improvement in SDG targets [3.1 – 3.2 – 3.7 – 3.4 – 3.8 – 3C – 3D and 2.2]	TBD	TBD	<ul style="list-style-type: none"> <li>– Project data</li> <li>– HMIS data</li> <li>– Specific population and/or health facility data if surveys conducted.</li> </ul>	
<b>Outcomes (Specific Objectives)</b>	Strengthen health care system at local level.	Proportion of health facilities offering the MSP in targeted areas. Improvement of composite index derived from SARA survey	<15%  TBD	100%  TBD	<ul style="list-style-type: none"> <li>– Project data</li> <li>– HMIS data</li> <li>– SARA survey/updates</li> <li>– Specific population and/or health facility data if surveys conducted.</li> <li>– Supervision visits</li> </ul>	Security, access and mobility improve allowing offer of health services. Effective policy dialogue on PHC based on evidence, with partners and Ministry of Health.
<b>Outputs</b>	Expected output 1: Minimum package of key health services available in targeted areas	1a. Ante Natal Care #4 and Post Natal Care visits 1b. Number of women of reproductive age using modern contraception methods with EU support [**] 1c. Births attended by skilled personnel; 2. Immunisation coverage (most probably hexa vaccine for children under 1 year of age and Measles-Rubella for children under 2 years of age) in targeted locations 3. Number of women of reproductive age,	1a. TBD  1b. TBD  1c. TBD 2. TBD	1a. TBD  1b. TBD  1c. 100% 2. As per WHO standards	<ul style="list-style-type: none"> <li>– Project data</li> <li>– HMIS data</li> <li>– SARA survey</li> </ul>	Capacity to attract and retain staff. Focus maintained on the MSP. Increased domestic funding. Prompt acceptance of community participation mechanisms.

		adolescent girls and children under 5 years of age reached by nutrition related interventions supported by the EU [**] 4. Outbreaks responded within 72 hours [*] 5a. Health facilities report regularly to communities 5b. Knowledge attitude and practices in the communities for selected healthy behaviours. 6. Health facilities reporting stock outs of selected essential medicines [*] 7a. Staffing with appropriate competences/skills (% and #) 7b. Vacancy rate in health facilities	3. 0  4. 77% 5a. NO  5b. TBD  6. TBD 7a. TBD  7b. TBD	3. TBD  4. 100% 5a. YES (to be refined) 5b. TBD  6. TBD 7a. 100%  7b. TBD		
	Expected output 2: improved data collection (HMIS) for local planning and decision making.	1. Submission of timely, complete, accurate HMIS reports to national level	1. TBD	1. 100%	– Project data – HMIS data – SARA survey	