



Brussels, 8.11.2017
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COMMISSION IMPLEMENTING DECISION

of 8.11.2017

**on the Special measure 2017 in favour of Libya to be financed from the general budget
of the Union**

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THE EUROPEAN COMMISSION,

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

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 action¹, and in particular Article 2(1) thereof,

Having regard to Regulation (EU, Euratom) No 966/2012 of the European Parliament and of the Council of 25 October 2012 on the financial rules applicable to the general budget of the Union and repealing Council Regulation (EC, Euratom) No 1605/2002², and in particular Article 84(2) thereof,

Whereas:

- (1) The Country Strategy Paper and the Multiannual Indicative Programme for the period 2014-2016 for Libya³ has now expired. As the political situation in Libya remains highly unstable, the European Commission has decided to move to the adoption of special measures for 2017.
- (2) The objective pursued by the special measure in favour of Libya to be financed under Regulation (EU) No 232/2014 of the European Parliament and of the Council of 11 March 2014 establishing a European Neighbourhood Instrument⁴ is to strengthen the social contract, state resilience and mutual accountability in Libya.
- (3) The action entitled "European Union Health and Accountability Programme in Libya" aims: a) to progressively strengthen the social contract and state resilience through improved access to quality health services; b) to improve accountability for results through third party verification and monitoring of development efforts.
- (4) It is necessary to adopt a financing Decision the detailed rules of which are set out in Article 94 of Commission Delegated Regulation (EU) No 1268/2012⁵.
- (5) The envisaged assistance to Libya is deemed to strictly follow the conditions and procedures set out by the restrictive measures concerning the said country.
- (6) It is necessary to adopt a work programme for grants the detailed rules on which are set out in Article 128(1) of Regulation (EU, Euratom) No 966/2012 and in Article

¹ OJ L 77, 15.3.2014, p. 95.

² OJ L 298, 26.10.2012, p. 1.

³ C(2015) 9164, 17.12.2015.

⁴ OJ L 77, 15.3.2014, p. 27.

⁵ Commission Delegated Regulation (EU) No 1268/2012 of 29 October 2012 on the rules of application of Regulation No 966/2012 of the European Parliament and of the Council on the financial rules applicable to the general budget of the Union (OJ L 362, 31.12.2012, p. 1).

188(1) of Delegated Regulation (EU) No 1268/2012. The work programme is constituted by the Annex 1, section 5.3.1.

- (7) The Commission should authorise the eligibility of costs as of a date preceding that of submission of a grant application for the reasons of extreme urgency in crisis management aid or in situations of imminent or immediate danger to the stability of a country, including by an armed conflict, where an early involvement engagement of the Union may prevent an escalation.
- (8) It is necessary to allow the payment of interest due for late payment on the basis of Article 92 of Regulation (EU, Euratom) No 966/2012 and Article 111(4) of Delegated Regulation (EU) No 1268/2012.
- (9) Pursuant to Article 94(4) of Delegated Regulation (EU) No 1268/2012, the Commission should define changes to this Decision which are not substantial in order to ensure that any such changes can be adopted by the authorising officer responsible.
- (10) The measure provided for in this Decision is in accordance with the opinion of the European Neighbourhood Instrument Committee set up by Article 15 of Regulation (EU) No 232/2014.

HAS DECIDED AS FOLLOWS:

Article 1

Adoption of the measure

The special measure 2017 in favour of Libya to be financed from the general budget of the Union, as set out in the Annex is approved.

This special measure shall include the following action:

- European Union Health and Accountability Programme in Libya

Article 2

Financial contribution

The maximum contribution of the European Union for the implementation of the special measure referred to in Article 1 is set at EUR 10,900,000 and shall be financed from budget line 22.04.01.01 of the general budget of the Union for 2017.

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

Article 3

Methods of Implementation

The elements required by Article 94(2) of Delegated Regulation (EU) No 1268/2012 are set out in the Annex to this Decision.

The eligibility of costs prior to the submission of grant applications shall be authorised as of the date set out in the Annex.

Article 4

Non-substantial changes

Increases or decreases of up to EUR 10 million not exceeding 20% of the contribution set by 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 94(4) of Delegated Regulation (EU) No 1268/2012, provided that they do not significantly affect the nature and objectives of the actions.

The authorising officer responsible may adopt such non-substantial changes in accordance with the principles of sound financial management and proportionality.

Done at Brussels, 8.11.2017

For the Commission
Johannes HAHN
Member of the Commission



This action is funded by the European Union

ANNEX

to Commission Decision on the Special Measure 2017 in favour of Libya to be financed from the general budget of the Union

Action Document for European Union Health and Accountability Programme in Libya

INFORMATION FOR POTENTIAL GRANT APPLICANTS
WORK PROGRAMME FOR GRANTS

This document constitutes the work programme for grants in the sense of Article 128(1) of the Financial Regulation (Regulation (EU, Euratom) No 966/2012) in the following sections concerning calls for proposals: section 5.3.1. A call for proposals will be launched exceptionally before the adoption of this Decision/Action Document under the so-called suspensive clause on 21 August 2017.

1. Title/basic act/ CRIS number	European Union(UE) Health and Accountability Programme in Libya — CRIS number: ENI/2017/40359 financed under the European Neighbourhood Instrument			
2. Zone benefiting from the action/location	Libya The action shall be carried out at the following location: Libya — in view of security concerns, project management functions and project activities may be relocated in Tunisia and/or neighbouring countries			
3. Programming document	N/A — in view of the protracted crisis and the volatile security situation the Country Strategy Paper 2014-2016 is no longer valid			
4. Sector of concentration/ thematic area	Sector 3: Health			
5. Amounts concerned	Total estimated cost: EUR 12,000,000 Total amount of EU budget contribution EUR 10,900,000 This action is co-financed by potential grant beneficiaries for an indicative amount of EUR 1,100,000			
6. Aid modality(ies) and implementation modality(ies)	Project Modality — Direct Management. Specific Objective 1: Grants — Call for Proposals Specific Objective 2: Procurement of Services			
7. DAC code(s)	Specific Objective 1: DAC Code 12191 (Medical Services); DAC Code 12220 (Basic Health Care) Specific Objective 2: DAC Code 16050 (Multisector aid for basic social services).			
8. Markers (from	General policy objective	Not	Significant	Main

CRIS DAC form)	targeted	objective	objective
Participation development/good governance	<input type="checkbox"/>	<input type="checkbox"/>	X
Aid to environment	X	<input type="checkbox"/>	<input type="checkbox"/>
Gender equality (including Women In Development)	<input type="checkbox"/>	X	<input type="checkbox"/>
Trade Development	X	<input type="checkbox"/>	<input type="checkbox"/>
Reproductive, Maternal, New born and child health	<input type="checkbox"/>	<input type="checkbox"/>	X
RIO Convention markers	Not targeted	Significant objective	Main objective
Biological diversity	X	<input type="checkbox"/>	<input type="checkbox"/>
Combat desertification	X	<input type="checkbox"/>	<input type="checkbox"/>
Climate change mitigation	X	<input type="checkbox"/>	<input type="checkbox"/>
Climate change adaptation	X	<input type="checkbox"/>	<input type="checkbox"/>
9. Global Public Goods and Challenges (GPGC) thematic flagships	N/A		

SUMMARY

The proposed European Union Health and Accountability Programme in Libya (EHAP) is intended to contribute to a more secure and stable Libya through a multi-sector investment in Libya's health services delivery that will include improved access to quality health services. Health service delivery is an essential public good. It is an important tool to safeguard and advance the transitional process and . After the Libyan revolution in 2011 quality and access to health services deteriorated sharply. In 2014, due to the renewed violence and the departure of foreign health workers, who used to make up a majority of health staff in the country, the demand imposed upon overstretched health services further brought to the forefront the need to re-establish a social contract that engenders trust and accountability between Libyan authorities and citizens. If responsiveness and accountability of Libyan health care institutions is not strengthened, including genuine opportunities for citizens to assert and realise their rights, peace and stability will continue to be compromised. Based on the current evidence on burden and impact on health services and the feedback from relevant implementing partners, the Ministry of Health, key health sector leaders, and opinion shapers, the following specific thematic areas have been identified as high priority: i) maternal and new-born health and blood transfusion services; ii) nurse and midwifery training and education; iii) mental health, substance abuse management and psychosocial support; and iv) non communicable diseases (NCDs) prevention and management.

In Libya, most implementing partners operate by remote management or through short in-country missions in a highly volatile context. The protracted absence of international staff and the limited monitoring and evaluation (M&E) capacities of Libyan institutions and local civil society organisations raise serious concerns on the outreach and accountability of the activities implemented through EU-funded programmes. Libyan counterparts have expressly requested that accountability for results is strengthened. The programme therefore envisages an on the ground monitoring mechanism to ensure independent verification of programme

activities and capacity building to strengthen the monitoring and evaluation capacity of Libyan Non State Actors (NSAs) and selected line ministries.

The proposed EU Programme for Health and Accountability in Libya therefore aims to contribute to:

- i) A progressively strengthened social contract and greater state resilience through improved availability, access and acceptability to quality health services with a focus on maternal and new-born health, blood transfusion services; nurse and midwifery training and education; mental health, substance abuse management and psychosocial support; and Non Communicable Diseases (NCDs) prevention and management.
- ii) Improved accountability for results through third party verification and monitoring of development efforts in line with a national framework to be defined jointly with the Government of Libya, capacity building to strengthen the monitoring and evaluation (M&E) capacity of Libyan Non State Actors (NSAs) and selected line ministries, and an enhanced EU footprint on the ground.

This comprehensive package of interventions will support the Government and the people of Libya during their transition towards peace and stability. In doing so, the programme will aim to consolidate the shift towards the delivery of an integrated, coherent, focused and ambitious package of interventions addressing health issues as a tool for social inclusion and accountability for results. The results of the two specific objectives envisaged will be mutually reinforcing.

1 CONTEXT

1.1 Sector Context

Libya is an oil-rich country with a population of 6.27 million (2015) and a Gross National Income (GNI) per capita of USD 14,330 (PPP) (2015).¹ In October 2015, the Libyan Political Agreement (LPA) was signed and subsequently endorsed by the United Nations. The agreement called for the formation of an interim Government of National Accord (GNA). In spite of broad based international support for a unity government the GNA continues to struggle to consolidate its influence over the full territory and in building the capacity of public institutions to provide basic goods and services. Due to widespread presence of militia groups, the security situation remains volatile. In 2017, oil output fell to around 0.4 million barrels per day or the fourth of potential. Gross Domestic Product (GDP) contracted by 10 per cent and per capita income fell to less than USD 4,500 compared to USD13,000 in 2012.² According to the World Bank, the liquidity crisis and 14% food inflation greatly impacted households' purchasing power.³

Libya's 2015 Human Development Index (HDI) of 0.716 is slightly below the average of 0.758 for countries in the high human development group.⁴ However, the HDI is an average measure, which masks inequality in the distribution of human

¹ World Bank Country Overview <http://www.worldbank.org/en/country/libya/overview>.

² Idem.

³ Idem.

⁴ UNDP Human Development Indicators http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/LBY.pdf.

development at the country level. Improvement over the past decades has been uneven and there are large urban-rural disparities, discrepancies between advantaged and disadvantaged regions and cities, and unacceptable differences between rich and poor. This pattern also applies to health service delivery and essential medicines. It is universally recognized that health and access to healthcare are strongly determined by socioeconomic status. In Libya, access to quality health services has progressively been reduced. Out of 98 hospitals surveyed by the World Health Organisation (WHO) in 2016, only four were found to be performing above 75 per cent functionality and 16 hospitals have been closed due to damage during the conflicts.⁵ As a result, services that have nominally been available and free of charge for most, have become unavailable or of such poor quality that they marginalise those groups that are economically and socially already disadvantaged and who are unable to purchase medical care in the private sector or travel abroad. On the other hand, preventive services, mental health and psychosocial support and primary health care are under-provided relative to need. The prevalence and incidence of NCDs in Libya have increased dramatically over the past 20 years as a result of changing lifestyles and the Libyan health system has been unable to adapt to the challenge. In situations of protracted displacement, disrupted access to treatment has further exacerbated the effects of NCDs on the population. The Libyan health system also suffers from lack of referral and access to basic and comprehensive obstetric care, prevention and management of the consequences of sexual violence and treatment of sexually transmitted infections.

Due to budgetary issues, a growing liquidity crisis, inflation, a widening black market exchange rate premium and a huge public deficit, the GNA has encountered difficulties in the management of excess demand for health services and has been criticised for being ineffective. In the meantime, needs in the sector continued to surge. No costing of health systems strengthening needs is available at present, but rehabilitation, training and capacity building needs are likely to be commensurably higher than humanitarian needs. It is therefore telling that the total funding requirement of the Humanitarian Response Plan (HRP) 2017 was USD 151 million and that 25% of it —USD 37,960,000— was allocated to priority needs in the health sector.⁶

Redressing state capacity to deliver basic services is a critical determinant of state resilience, and disequilibrium a key determinant of fragility. A focus on the gradual strengthening of the social contract and image of the state vis-à-vis its citizens is therefore an important tool for conflict resolution and stabilisation.

Libyan counterparts have raised concerns regarding due diligence practices of externally funded programmes. The protracted absence of international staff — including EU staff— and limited capacity of Libyan institutions and local civil society organisations is a cause for concern on multiple accounts. Pending the lifting of evacuation status, implementing partners —UN Agencies and most Non-Governmental Organisations (NGOs)— operate by remote management from

⁵ WHO Service Availability and Readiness Assessment (SARA) Report 2017.

⁶ The magnitude of health systems needs is self-evident particularly if one takes into consideration the fact that the humanitarian response was strictly prioritized and that it only includes life-saving interventions to address the most critical humanitarian needs of IDPs, returnees, migrants and refugees.

Tunisia where most co-ordination meetings take place, or through short in-country missions in a highly volatile context. Most UN Agencies subcontract implementation to local or international NGOs who work in co-operation with local partners. The International Desk of the Ministry of Health and the Directorate for Technical Co-operation at Ministry of Planning have also called for a results-oriented approach to enhance co-ordination and consolidation of project-based interventions.

Co-ordination frameworks have been established including mechanisms for regular dialogue with Libyan counterparts. In the health sector, the European Union Delegation to Libya (EUD) has established a high quality policy dialogue with the Libyan Ministry of Health. At the initiative of the Libyan Government, an Inter-ministerial group on EU-Libya co-operation was organised in Tunis on 8 December 2016 and priority areas—including health—were identified. Building on this success, the EU and the Government of Libya organised a second an Inter-ministerial Meeting on Health and Higher Education on 5-6 April 2017. This second meeting came at the request of the Minister of Foreign Affairs in the event of a visit by H.E. the President of the Presidential Council Fayez al-Sarraj and the Minister of Foreign Affairs to Brussels in February 2017. The meeting gathered more than 80 technical experts from the Libyan health sector allowing for content-rich discussions on ongoing and future co-operation, which are reflected in this document. These forums offer a viable platform to develop and agree on a result framework in alignment with Ministries' priorities. In turn, a third party monitoring framework would strengthen the technical credibility, quality, independence and transparency of performance information—the 'currency' of accountability—inject much needed content for discussion in these forums, and, over time, foster trust and a common understanding around shared agendas with a focus on service delivery.

1.1.1 Public Policy Assessment and EU Policy Framework

There is no agreed upon National Development Policy and no National Health Strategy or Policy. However, a number of policies and strategies in draft form including a draft strategic framework for the delivery of Primary Health Care Services have been developed by the Directorate of Primary Health Care. In addition, in April 2017, the Ministry of Health, the National Centre for Disease Control (NCDC), the United Nations Population Fund (UNFPA), The United Nations Children's Fund (UNICEF) and WHO also launched a consultative process to inform the drafting of a National Reproductive Health Strategy for the period 2017-2012. The draft should be finalised in September 2017. However, the proposed action is in line with the European Consensus on Development⁷ and with the Commission Proposal for new European Consensus on Development⁸ and the Sustainable Development Goals (SDGs), in particular SDG 3.1, 3.2, 3.4, 3.5, 3.6, 3.7, and 3.A., as well as SDG 5.4, 5.6, and 16.6⁹. The SDGs highlight the areas where continued

⁷ The European Consensus on Development, (2006/C 46/01).

⁸ Commission Communication: A Proposal for a new European Consensus on Development (COM (2016) 740 final)
⁹ SDG 3.1 — By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births; SDG — 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births; SDG 3.4 — By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being; SDG. 3.5 — Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; SDG 3.6 —

progress is required to ensure human development and dignity. In new European Consensus the EU and its Member States recognise that better health is the cornerstone of human dignity and global prosperity. They commit to pursue universal health coverage by strengthening health systems as well as partner countries' responsibilities and accountability for the sustainable provision of essential services. In line with these commitments, this action will put a strong focus on the protection of the most vulnerable. It will address the growing burden of non-communicable diseases —particularly in as far as they are poverty related; it will reduce child and maternal mortality and promote mental health.

1.1.2 Stakeholder Analysis

Main stakeholders to be involved in the proposed action include two sets of actors: duty bearers such as, frontline workers in targeted health facilities; local and central departments of the Libyan Ministries of Health, Social Affairs and Local Governance and Planning, the National Centre for Disease Control; primary health care facilities; psychiatric departments; faculties of nursing, midwifery and medicine; the Libyan Nursing and Midwifery Association; Libyan municipalities and the Libyan private sector; United Nations mandated agencies, international NGOs, local NGOs and civil society organisations (CSOs) including charities; and rights holders such as, patients and users of health services; and Libyan citizens. Non-state actors such as CSOs and Nursing and Midwifery Associations and frontline workers are duty-bearers —even though they may also be regarded as rights-holders in other respects.

The **direct beneficiaries** of this action are officials from the Ministry of Health, Social Affairs and Local Governance, NCDC, healthcare providers and managers, selected hospitals and primary health care facilities, institutions involved in the training of healthcare workers, physicians, psychologists, nurses and midwives and frontline workers. **Indirect beneficiaries** of this action are marginalised and vulnerable groups, women of reproductive age, youngsters with mental health and substance abuse disorders, People Who Inject Drugs (PWIDs), People Living with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) (PLWHAs), People Living with Disabilities (PLWDs), in particular NCD-related disabilities and visual impairments, Libyan citizens, patients and users of health care services, in particular, but not exclusively, patients suffering from chronic conditions, physicians, nurses and midwives.

Duty bearers such as the Ministry of Health, Social Affairs and Local Governance, the NCDC, primary, secondary and tertiary care facilities and Libyan municipalities are unable to meet their obligations to ensure key elements of availability, accessibility, acceptability and quality conducive to the realisation of the right to health. Nevertheless, they have shown a genuine desire to improve systemic

y 2020, halve the number of global deaths and injuries from road traffic accidents; SDG 3.7 — By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; SDG 3.A. — Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate; SDG 5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies [...]; SDG 5.6 — Ensure universal access to sexual and reproductive health and reproductive rights [...]; SDG 16.6 — Develop effective, accountable and transparent institutions.

challenges and to ensure non-discrimination in access and are acutely aware of the importance of striking a balance between services that are preventive, curative and rehabilitative and —where relevant— also encompass palliative care. The commitment of these duty bearers can be used as a point of departure for right-based programming and implementation that will correct the inherent urban-based, hospital-oriented, curative-care bias of ongoing interventions, budget allocations and individuals in decision-making positions. Rights holders (individuals and care givers) are aware of their rights, but have limited recourse to actions that can challenge the status quo. On the other hand, where services and health conditions are affected by stigma, rights holders are unable to demand that the situation is redressed. As such, particular attention will be paid towards raising the level of awareness of positive health behaviour vis-à-vis life threatening or disabling conditions that are heavily stigmatized in the community. Rights-holders will also be consulted regularly to monitor the affordability of essential health services and challenge inequality and discrimination in the Libyan health system. The action will keep a geographical balance (to the extent possible due to security and access constraint) and address beneficiaries across the country.

1.1.3 Priority Areas for Support/Problem Analysis

Strategic Objective 1: A progressively strengthened social contract and greater state resilience through improved availability, access and acceptability to quality health services with a focus on maternal and new-born health and blood transfusion services; nurse and midwifery training and education; mental health, substance abuse management and psychosocial support; and NCDs prevention and management.

Based on the current evidence on burden and impact and feedback from implementing partners, the Ministry of Health and key health sector leaders and opinion shapers from the East, South and West of Libya, the following specific thematic areas have been identified as high priority: maternal and new-born health; nurse and midwifery training and education; mental health, substance abuse management and psychosocial support; and NCDs prevention and management.

Main drivers of poor maternal health in Libya include: limited supply of nurses and midwives and inability to practice without physician supervision, increased workload, absenteeism and low motivation, disrupted access to health facilities, inadequate in-service training, low quality antenatal and post natal care, distance to health facilities (particularly in the South of Libya), cultural barriers, delayed referrals and early discharge.

Key challenges to strengthening nursing and midwifery services include: the absence of a national strategic plan for nursing and midwifery; no reliable nursing and midwifery data; weak or absent regulation, legislation, accreditation and practice standards; difficulty in retaining qualified health staff in rural areas; low salaries, lack of career incentives and poor professional image; absenteeism, low productivity and poor working conditions; limited and/or fragmented investments in continuous education; funding and training resource constraints exacerbated by the conflict.

Key challenges to efficient and effective delivery of quality mental health, substance abuse management and psychosocial support services include: substantial gaps in the

number of qualified staff; limited knowledge on mental health amongst General Practitioners; poor quality in detection at primary health care level; deficient network for treatment and follow-up; lack of evidence-based guidelines and tools; stigma of a mental disorder diagnosis; absence of HIV pre-exposure prophylaxis.

Key challenges to NCDs and their socioeconomic impact in Libya include: lack of a systematic approach and prevention strategy, operational national plans for disease management, surveillance and monitoring; limited and inconsistent data and surveillance of risk factors; deficient primary health care system; lack of access to essential medicines and technology for prevention; gaps in health financing; bureaucratic inefficiency, lack of inter-sectoral collaboration; lack of capacity, evidence-based tools and guidelines for key prevention and treatment interventions.

Strategic Objective 2: Improved accountability for results through third party verification and monitoring of development efforts in line with a national framework to be defined in close co-operation with the Government of Libya, capacity building to strengthen the M&E capacity of Libyan Non State Actors (NSAs) and selected line ministries, and enhanced EU footprint on the ground.

From 2014 onwards, humanitarian space has visibly shrunk and there are reports of patronage, fraud, mismanagement, misuse and pilferage of foreign aid, particularly in as far as black market premiums and, allegedly, donations of pharmaceuticals. At best, the impact of foreign aid is not visible. In the worst case scenario, accountability and transparency have been compromised. In the foreseeable future, all EU-funded projects and programmes will continue to require close monitoring, risk analysis and review. Limited accountability and verifiability of activities implemented remain a high risk. Difficulties have also been encountered with lack of co-ordination amongst implementing partners. Agencies see remote management as a temporary and makeshift adaptation, yet in the Libyan context it is becoming a standard operating procedure. Acknowledging the concerns mentioned above, the Government of Libya has demanded a paradigm shift to improve the current way of doing business. For this reason, the programme envisages the establishment of a third party verification and monitoring system that will prioritise service delivery and state building efforts. Its scope might be further expanded if possible and necessary. The findings will be disseminated to the co-ordination fora already in place.

Libya's endowment with ample oil resources means that, historically, there has been relatively little interaction with aid agencies. As a result, there is limited understanding of the role of Official Development Assistance (ODA) in financing development, of aid effectiveness, and of risks and vulnerabilities inherent in a post-conflict setting. Knowledge of aid effectiveness principles and how these translate into contexts of fragility and conflict can help foster constructive engagement with the EU. To this end, the development of a national result-based framework for mutual accountability would be particularly beneficial. Lastly, EU presence on the ground is extremely limited in the current situation. Increased EU presence could inform on the relevance of the programmes, the amenability of the activities/sector to weaker levels of technical oversight and (possibly) expertise, and the availability of current or potential local partners. Besides, Libyan counterparts have repeatedly underlined that direct contact is not only politically important, but that it is

indispensable towards greater oversight, understanding of context specificities and meaningful policy dialogue.

2 RISKS AND ASSUMPTIONS

Risks	Risk level (H/M/L)	Mitigating measures
Armed conflict and/or widespread insecurity threaten transition and project implementation	H	<p>Continuous political dialogue with a view to ensure negotiation of ceasefires, humanitarian corridors and/or access to critical target areas via alternative means.</p> <p>Periodic risk reassessment and contingency planning.</p> <p>Design and implementation of risk mitigation strategies.</p> <p>A flexible adaptable approach encompassing the possible reformulation of projects/programme activities.</p> <p>Redeployment of assistance to areas not affected/less affected by conflict.</p>
Due to the protracted political crisis the Libyan government is unable to act as an effective counterpart	H	<p>Flexible design of the projects envisaged under Specific Objective 1 and 2.</p> <p>Situational awareness, scenario planning, redeployment of assistance to lower levels of government or NSAs.</p>
Rapid deterioration of Libya's economy due to low global crude prices, low output, internal political fissures and disruption of oil fields and pipelines as a result of insecurity, militia rivalries, monetary crisis, and labour disputes	M	<p>Continuous political dialogue for negotiation of ceasefires.</p> <p>In depth economic and financial analysis and/or redeployment of assistance to lower levels of government or NSAs.</p>
Low absorption capacity	M	<p>Adequate programme design; close dialogue and co-ordination with Libyan counterparts and other donors; risks analysis routinely performed, mitigation strategies identified.</p>

Assumptions

The security situation does not deteriorate further allowing the implementation of the activities.

3 LESSONS LEARNED, COMPLEMENTARITY AND CROSS-CUTTING ISSUES

3.1 Lessons learned

A non-exhaustive list of lessons learned relevant in the Libyan context follows below:

- Distance from the field has reduced opportunities for dialogue with Libyan counterparts. The remote/indirect relationship with Libyan counterparts results in lack of ownership and partnership. This is all the more relevant where relations are filtered through intermediaries. A weak partnership with Libyan counterparts implies lack of coherence and synergies; lack of relevance and cost effectiveness of actions; lack of EU visibility; and disproportionate fragmentation of project portfolios. Direct EU/Libya interaction should not be delegated to third parties.
- In the Libyan context, the rate of failure of projects and programmes is relatively high. Whilst, large programmes require less administrative work and imply less transaction costs, they also bear larger risks. "Putting all eggs in one basket" (as it happens with large contracts) is not suited to the Libyan context, which instead calls for experimental approaches that can be scaled up where implementing partners can prove their capacity to implement cost effectively and timely.
- Persistent use of crisis procedures can lead to a situation of de facto monopoly, which, in turn, implies high costs and low returns on EU investments. The use of competitive procedures as the default option is critical in order to raise the quality of project design and lower costs.

3.2 Complementarity, synergy and donor co-ordination

The programme is fully complementary to other EU-funded-actions, in particular the following:

The EU-funded Libya Health Systems Strengthening (LHSS) programme —worth EUR 8.5 million and implemented by Die Deutsche *Gesellschaft für Internationale Zusammenarbeit (GIZ)* - supports comprehensive reforms for a complete overhaul of the system. Opportunities for complementarity exist in particular in as far as the use of clinical guidelines and care pathways developed by the programme for a care driven approach to diabetes management across the health community.

The EU-WHO Supply Chain Management and Health Information Systems (SHAMS) programme —a 24-month intervention worth EUR 3.8 million— aims to develop and implement supply chain standards; update drug legislation and regulation; enhance capacity to collect quality health data. Information availed through the programme will be used to set a baseline and address increasing incidence of the disease. In the coming weeks, the WHO will also assist the Libyan Government to build and strengthen capacity for NCD factor surveillance. The exercise will, in turn, inform the design of interventions under Result Area 2. In addition, critical analytical work is on-going to evaluate service availability and readiness data collected through a systematic EU-funded survey.

Specific Objective 2 of this programme is also consistent with broader state and peace building objectives. In this respect, complementary assistance is provided

through the multi-donor **Stabilisation Facility for Libya**, which provides tangible quick-wins at the local level, thus enhancing state output legitimacy and fostering a stabilising state-society contract. EU assistance in this sector is channeled through a EUR 5 million contribution to the United Nations Development Programme (UNDP)-managed Facility.

At local level, the Libya Local Governance and Stabilisation programme implemented by De Vereniging van Nederlandse Gemeenten (VNG) aims to strengthen the accountability of 22 municipal councils across Libya through targeted investments in planning and management, and through improved service delivery and participation.

This Action document reflects also the results of close dialogue with the ECHO. The interventions foreseen in this Action document are fully complementary to ECHO-funded programmes. They are based on a shared analysis of vulnerabilities and will pursue collaborative implementation, monitoring and progress tracking. The EU Delegation attaches great importance to Linking Relief, Rehabilitation and Development (LRRD) and will jointly develop with ECHO a position paper to frame operational perspectives on LRRD in health.

Investments in third party monitoring have been relatively limited. Nevertheless, in 2016, UNICEF, UNDP, World Food Programme (WFP) and the Canadian Embassy invested in capacity building of Libyan CSOs to deliver and monitor programmes. To mitigate risks associated with remote programming, UNICEF and UNDP contracted field monitoring activities to a third party monitoring partner to generate programme information to enable relevant and appropriate response to affected communities and follow up on the reach of programme supplies¹⁰. Complementarity with these initiatives will be sought through careful co-ordination at local and national level. If agreement is reached with these UN agencies, information could also be triangulated across these initiatives to progressively strengthen third party monitoring.

Donor Co-ordination

The United Nations Support Mission in Libya (UNSMIL) has the official mandate to co-ordinate international efforts to support the peace process and co-operation support to the Libyan institutions and administration. The EUD is actively participating in the co-ordination meetings in areas such as the constitutional process, stabilisation, elections, youth, local governance and health.

After a year of preparations, the co-ordination forum co-led by UNSMIL and the Ministry of Planning was launched in August 2016. The forum is led by the Ministry of Planning and foresees a Joint Technical Co-ordination Committee (JTCC) on basic services with subgroups on education, health and water and sanitation. The first meeting was held on 18 August 2016 with international desks from the three line ministries in addition to the Ministry of Social Affairs. The Head of the International

¹⁰ WFP contracted a survey firm to carry out third party monitoring of WFP food distributions. Since, 2012, the Canadian Embassy has contracted a firm with demonstrable M&E capacity to provide evaluation oversight and quality control on project deliverables with satisfactory results.

Desk of the Ministry of Health is represented in this group and is the main counterpart for the EU Delegation. In addition to this forum, since November 2016, the EU Delegation is co-chairing with the WHO Health Sector Committee (HSC) meetings that take place in Tunis on a monthly basis. These meetings gather the most important implementing partners in the health sector. The EUD also organises regular meetings with key interlocutors from the Libyan Ministry of Health including the Minister of Health and his advisers, the International Desk and the NCDC.

In November 2016, an inter-ministerial group on EU-Libya co-operation was established at the request of the Libyan authorities. Through this forum, that gathered for the first time in December 2016, the EU has aimed to foster a shared understanding of its development co-operation portfolio, promote the concept of equal partnership, improve mutual accountability and transparency, and identify common priorities. A second round of discussions took place on 5-6 April 2017 gathering more than 80 Libyan stakeholders from the health sector with a fair geographical representation. The conclusions of the meeting resulted in a matrix of agreed action points for joint follow up and reconfirmed the activities proposed in this Action Fiche as main priorities for the Libyan health sector. Since 2015, the EU Delegation has also been conducting regular co-ordination meetings with EU Member States representatives in Tunis to ensure co-operative information sharing of EU funded programmes and EU Member State activities. Last year, the Joint Co-ordination meetings focussed on ongoing programmes in the area of local governance, media and migration. This resulted in a Joint Migration Fiche that has been used as a basis for further work in this Area. For the Health sector, the EU being the only donor involved, Member States have been informed on the ongoing discussions. In the long run, and once a unified Government is in place, these co-ordination efforts could lead to an EU/Member States joint programming exercise for Libya.

3.3 Cross-cutting issues

The action will be designed and implemented following a rights-based approach that will identify and specifically target vulnerable and marginalised groups. Particular attention will be paid to women's participation and equal access to EU-supported human capital investments so as to pave the way for a democratic society where all Libyan citizens share equal rights and obligations. To help achieve this objective, gender equality will be mainstreamed in all result areas. As such, the programme will promote and support women's participation in decision-making processes within the programme (including but not uniquely through quotas). Quality maternal and perinatal health care will invariably benefit vulnerable women of reproductive age. Nevertheless, actions supported under Specific Objective 1 will also explore gender differences in substance abuse and dependence, physical and sexual abuse and as other psychiatric comorbidities and will develop specific tools to overcome barriers to treatment for women. Specific Objective 1 will also address gender-related challenges to addressing NCDs, for instance disparities between men and women in physical activity levels, gender-specific manifestations of certain NCD symptoms and risks, women unequal say in decisions pertaining to care and treatment, and women's role as caregivers. HIV and AIDS concerns will be mainstreamed in implementation strategies by identifying and addressing the underlying causes of vulnerability to HIV infection, providing awareness education particularly, but not

exclusively, to PWIDs. The action will not, per se, contribute to climate change. However, it will indirectly contribute to building a climate resilient health system in Libya by building the capacity of Libyan health services to protect population health and by preparing these services for increased needs.

4 DESCRIPTION OF THE ACTION

4.1 Objectives/results

The overall long-term objective of the programme is to strengthen the social contract, state resilience and mutual accountability in Libya through a multipronged approach whose distinctive components are mutually reinforcing.

The **specific objectives** of the programme are:

SPECIFIC OBJECTIVE 1: To progressively strengthen the social contract and state resilience through improved availability, access and acceptability to quality health services with a focus on maternal and new born health, blood transfusion services; nurse and midwifery training and education; mental health, substance abuse management and psychosocial support and NCDs prevention and management..

SPECIFIC OBJECTIVE 2: To improve accountability for results through third party verification and monitoring of development efforts in line with a national framework to be defined jointly with the Government of Libya, capacity building to strengthen the monitoring and evaluation (M&E) capacity of Libyan NSAs and selected line ministries, and to enhance EU footprint on the ground.

The **main results** will be:

Specific Objective 1:

Under Result Area One —Maternal, New-born Health and Blood Transfusion Services:

- ▶ Increased utilisation of quality antenatal and post-natal care services and early referral for a cohort of vulnerable women in particular, but not exclusively, in rural areas of the Fezzan (Murzuq, Kufra and Shati) and greater Benghazi;
- ▶ Nurses and midwives benefitting from in-service training and dissemination of best practices;
- ▶ Upgraded functions of the national blood transfusion services through standard setting, strategic and operational planning and implementation and effective co-ordination and management.

Under Result Area Two —Nurse and Midwifery Training and Education:

- ▶ National Strategic Plan for Nursing and Midwifery established;
- ▶ Pre-service training delivered to first-year students in line with a revised curriculum;
- ▶ Increased student intake in selected schools.

Under Result Area Three —Mental Health, Substance Abuse and Psychosocial Support:

- ▶ Psychosocial distress, mental health and substance abuse reduced amongst ex-combatants, marginalised youth and other at-risk groups in particular, but not exclusively, in conflict-affected areas in Eastern Libya;
- ▶ Expanded access, availability and acceptability to quality psychosocial support and mental health care including pharmaco-therapy for a cohort of mental health patients;
- ▶ Training and upskilling of mental health staff;
- ▶ Establishment of two specialised substance abuse treatment centres;
- ▶ Greater awareness about the risks and manifestations of mental illness and substance abuse amongst ex-combatants and marginalised youth.

Under Result Area Four —NCDs Prevention and Management:

- ▶ Design and roll out of a robust prevention strategy at primary health care level countrywide;
- ▶ Identification of high-risk subjects, early diagnosis and early intervention in the form of health education on lifestyle factors that increase the risk of developing chronic conditions;
- ▶ Prevention of comorbidities and complications through the use of evidence-based practice guidelines, self-management education, and regular monitoring in a cohort of patients in particular, but not exclusively, in deprived urban areas;
- ▶ NCDs management in a cohort of patients in particular, but not exclusively, in deprived urban areas in the Western, Eastern and Southern Libya —taking into account a geographical balance and needs.

Particular attention will be paid towards extending health care coverage in deprived areas of Libya and areas affected by conflict and displacement such as South of Libya and greater Benghazi.¹¹ This choice of geographical scope is to be understood not only through the lens of equity, social justice and need, but also through the lens of political relevance as this would be where the absence of the state is most acutely felt. At the same time, interventions planned under this specific objective will have to take into consideration the need for flexibility in order to accommodate changing circumstances and, if necessary, adapt to abrupt surges in needs, reduced access and/or shirking humanitarian space.

Specific Objective 2:

- ▶ Government counterparts and Libyan NSAs report a shared understanding of partnership priorities and mutual accountability principles;

¹¹ Such areas have been identified by a vulnerability assessment of Internally Displaced Persons (IDPs) across the coastal urban and rural areas of Libya. The assessment, carried out between August and November 2016, was funded by UNHCR and ECHO and conducted by Mercy Corps, in collaboration with seven Libyan CSOs. The assessment aimed to analyze the current humanitarian situation of IDPs in Libya through household surveys, key informant interviews and Focus Group Discussions. The enumerators interviewed heads of households of IDP families, local authorities, community leaders, youth, women and elderly groups' representatives.

- ▶ Policy dialogue promptly informed by third party monitoring information and feedback;
- ▶ Prompt reaction to concerns in case of limited accountability of implementing partners/projects;
- ▶ National result-based framework for mutual accountability established;
- ▶ Improved oversight and understanding of context specificities and reduced fiduciary risks.

The geographical scope of this specific objective will depend on the geographical footprint of interventions monitored.

4.2 Main activities

Activities in relation to the above result areas are envisaged as follows:

Specific Objective 1:

The main activities foreseen include, but are not limited to:

Under Result Area One —Maternal, New-born Health and Blood Transfusion Services: roll out of a comprehensive package of maternal and new-born health services targeting vulnerable, conflict-affected or displaced women. Interventions under this package shall notably include: antenatal and postnatal care strengthening; development and roll out of protocols and quality assurance tools; in-service training and dissemination of best practice; management of maternal and new born infections; establishment and roll out of a referral system in hard-to-reach rural areas; family planning; and development and roll out of a blood system strengthening strategy with a focus on self-sufficiency to be delivered, in part, through partnerships with blood services in neighbouring countries and/or in Europe.

Under Result Area Two —Nurse and Midwifery Training and Education: national strategic plan for nursing and midwifery with strong focus on estimation of staffing needs and competencies, education and training (training of trainers (ToT) combined with close monitoring and mentoring), retention, motivation and career development; establishment of a reliable nursing and midwifery database and recruitment strategy; adoption of competency-based training at pre-service and faculty levels; curriculum review; synergistic South-South and North-South partnerships to enhance faculty development.

Under Result Area Three —Mental Health, Substance Abuse and Psychosocial Support: establishment and roll out of a comprehensive package of scalable mental health, substance abuse, psychosocial prevention and treatment services including delivery of mental health services through primary health care clinics; establishment of two dedicated rehabilitation centres for substance abuse; expanded access availability and acceptability to quality psychosocial support; in-service and pre-service training plans for health personnel informed by a needs assessment and career plans and paths (delivered through ToT), close monitoring and mentoring; and awareness raising about the incidence and manifestation of mental health and substance abuse disorders and prevention of HIV transmission amongst at-risk youth and PWIDs.

Under Result Area Four —NCDs Prevention and Management: development and roll out protocols and quality assurance tools and robust in-service training of selected cadres delivered preferably through ToT close monitoring and mentoring; identification of high-risk subjects and early intervention in the form of health education on lifestyle factors that increase the risk of developing chronic conditions; early diagnosis of disease and appropriate treatment; comprehensive management of NCDs and integration into primary health care; reduction of morbidity and mortality in high-risk groups; prevention of comorbidities and complications through the use of evidence-based practice guidelines, self-management education, and monitoring; NCDs management, care and palliation; capacity building of professional networks and patients associations.

SPECIFIC OBJECTIVE 2:

The activities foreseen include, but are not limited to: i) awareness raising of government counterparts and Libyan NSAs about key concepts such as EU partnership priorities and framework for technical and financial co-operation, the Fragile State Principles and the Paris Declaration on Aid Effectiveness and their adaptation to the Libyan context; ii) the establishment of a national result-based framework for mutual accountability prioritising service delivery and state building efforts and monitoring progress to deliver better results; iii) routine reviews of the coherence of project deliverables and activities as described in progress reports and outcomes on the ground that will require, inter alia, onsite visits of project activities in accessible areas of Libya, monitoring and verification of project activities, and feedback sharing with relevant stakeholders; iv) prompt reaction to concerns raised in as far as limited accountability and verifiability of activities implemented; v) capacity building to strengthen M&E capacities of Libyan NSAs and selected line ministries; vi) support towards increasing EU on-the-ground presence for greater oversight; and vi) complementary situational monitoring and reporting.

4.3 Intervention logic

The intervention logic is guided by the critical consideration that very limited number of implementing partners are available. The absence of a "market" of implementing partners and the persistent use of crisis procedures can often lead to a situation of de facto monopoly. Such situation, in turn, implies high costs and low returns on EU investments. The use of competitive procedures as the default option is therefore critical in order to raise the quality of project design and to lower costs by encouraging innovation and maintaining competitive pressure.

EU support to third party monitoring is informed by the varied experience and rates of success of EU investments in similar contexts such as Syria, Somalia and South Sudan. A study will be launched to review remote management modalities and accountability risks in Libya. The results of this study will guide the preparation of the tender for services.

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, referred to in Article 184(2)(b) of Regulation (EU, Euratom) No 966/2012.

5.2 Indicative implementation period

The indicative operational implementation period of this action, during which the activities described in section 4.1 will be carried out and the corresponding contracts and agreements implemented, is **60 months** from the date of adoption by the Commission of this Action Document. Extensions of the implementation period may be agreed by the Commission's authorising officer responsible by amending this Decision and the relevant contracts and agreements; such amendments to this Decision constitute technical amendments in the sense of point (i) of Article 2(3)(c) of Regulation (EU) No 236/2014.

5.3 Implementation Modalities

Specific Objective 1 will be implemented through grants awarded through a Call for Proposals. Specific Objective 2 will be implemented through a service contract awarded through a Tender for Services.

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including, where appropriate, compliance of the action with EU restrictive measures¹² affecting the country of operation.

5.3.1 Grants: Call for Proposals “EU Health and Accountability Programme” (direct management)

(a) Objectives of the grants, fields of intervention, priorities of the year and expected results.

The objective of the grants shall be to progressively strengthen the social contract and state resilience through improved availability, access and acceptability to quality health services with a focus on maternal and new-born health, blood transfusion services, nurse and midwifery training and education, mental health, substance abuse management and psychosocial support, and NCDs prevention and management.

Expected results: see section 4.1.

Type of actions: The actions should address the objective as stated above.

¹² The updated list of measures in force can be found at https://eeas.europa.eu/headquarters/headquarters-homepage/8442/consolidated-list-sanctions_en

The following needs to be included in the actions:

- Joint baseline and end line surveys which will be co-ordinated by the Ministry of Health and the HSC, where relevant;
- Support to capacity building of Libyan counterparts inclusive of regular monitoring and reporting to local co-ordination mechanisms when required;
- Support to a Joint Annual Review in partnership with the Ministry of Health;
- A description of how the gender-related aspects of the proposed action will be addressed.

(b) Eligibility conditions

In order to be eligible for a grant, the applicants must:

- be a legal entity; and
- be non-profit-making; and
- be a non-governmental organisation or foundation, a public sector operator (including a development agency of a Member State of the European Union) or an international (inter-governmental) organisation as defined by Article 43 of the Rules of application of the EU Financial Regulation; and
- be directly responsible for the preparation and management of the action with the co-applicant(s) and affiliated entity(ies), not acting as an intermediary; and
- have been awarded and successfully implemented (or being successfully implementing) a grant of an amount of at least EUR 1,000,000 for a similar action in the last three years.

Subject to information to be published in the call for proposals, the indicative amount of the EU contribution per grant is EUR 1,000,000 to EUR 3,500,000 and the grants may be awarded to sole beneficiaries and to consortia of beneficiaries (co-ordinator and co-beneficiaries). The indicative duration of the grant (its implementation period) is **36 months**.

(c) Essential selection and award criteria

The essential selection criteria are financial and operational capacity of the applicant. The essential award criteria are relevance of the proposed action to the objectives of the call; design, effectiveness, feasibility, sustainability and cost-effectiveness of the action.

(d) Maximum rate of co-financing

The maximum possible rate of co-financing for grants under this call is **90%**. In accordance with Articles 192 of Regulation (EU, Euratom) No 966/2012, if full funding is essential for the action to be carried out, the maximum possible rate of co-financing may be increased up to 100%. The essentiality of full funding will be justified by the Commission's authorising officer responsible in the award Decision, in respect of the principles of equal treatment and sound financial management.

(e) Indicative timing to launch the call

This call will be launched on **21 August 2017** under a suspensive clause subject to the adoption of this Decision. The Commission shall authorise the use of the suspensive clause for the action as of a date preceding that of the adoption of the Financing Decision for the reasons of extreme urgency. The use of the suspensive clause for the launch of the call for proposals is justified on grounds of the political urgency to intervene in support to state resilience through improved health services in order to contribute to the stability in Libya.

(f) Exception to the non-retroactivity of costs

The Commission authorises the eligibility of costs prior to the submission of the grant application as of **15 October 2017**. The Commission shall authorise the eligibility of costs for the action as of a date preceding that of the adoption of the Financing Decision for the reasons of extreme urgency. The retroactivity of eligible costs is justified on grounds of the political urgency to intervene in support to state resilience through improved health services as outlined in this action document.

5.3.2 Procurement (Direct Management)

Subject	Type	Indicative number of contracts	Indicative trimester for launch of the procedure
To improve accountability for results through third party verification and monitoring of development efforts, capacity building and enhanced EU footprint on the ground	Services	1	Third Trimester 2017 (with suspensive clause)*

* The Commission shall authorise the use of the suspensive clause for the action as of a date preceding that of the adoption of the Financing Decision. The use of the suspensive clause for the launch of the call for proposals is justified on grounds of the urgency to lower the financial risk of working under remote management and to improve accountability for results, transparency and cost effectiveness of EU funded actions in Libya.

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 provisions.

The Commission's authorising officer responsible may extend the geographical eligibility in accordance with Article 9(2)(b) of Regulation (EU) No 236/2014 and 89(3) of Council Decision 2013/755/EU 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 realization of this action impossible or exceedingly difficult.

5.5 Indicative budget

Programme Specific Objective	EU contribution (EUR)	Indicative Third Party Contribution (EUR)
5.3.1 — Specific Objective 1: Grants (Call for Proposals) to progressively strengthen the social contract and state resilience through improved availability, access and acceptability to quality health services	9,900,000	1,100,000
5.3.2 — Specific Objective 2: Procurement (Service Contract) to improve accountability for results through third party verification and monitoring of development efforts and capacity building to strengthen the M&E capacity of Libyan counterparts	1,000,000	N/A
5.8 — Evaluation 5.10 — Audit	will be covered by another Decision	N/A
5.10 — Communication and visibility	N/A	N/A
Contingencies	N/A	N/A
Totals	10,900,000	1,100,000

5.6 Organisational set-up and responsibilities

Specific Objective 1: A progressively strengthened social contract and greater state resilience through improved availability, access and acceptability to quality health services.

In order to ensure transparency and accountability and provide strategic guidance on programme implementation, a Steering Committee will be established. Where suitable, a task force will be established on specific thematic priorities. Content-specific information will be shared with co-ordination fora such as the Health Sector Committee. A human rights-based approach to health aiming to develop the capacity of duty bearers and empowering rights-holders to effectively claim their health rights will be embedded in implementation. Particular attention will be paid towards patient-centred approaches and empowerment and capacity development of both duty bearers and rights holders—in particular, marginalised groups, patients and staff associations, where they exist, and civil society actors—to enable them to take part in consultative processes.

Specific Objective 2: Improved accountability for results through third party verification and monitoring of development efforts, capacity building to strengthen the Monitoring and Evaluation capacity of Libyan counterparts, and enhanced EU footprint on the ground.

Information generated through third party monitoring and verification activities will be primarily shared and discussed in the framework of bilateral meetings between the EU and Libyan counterparts. Libyan NSAs will also be invited to participate in these forums.

5.7 Performance monitoring and reporting

The day-to-day technical and financial monitoring of the implementation of this programme will be a continuous process and part of the responsibilities of the implementing partners. To this end, the implementing partners shall establish a permanent internal, technical and financial monitoring system for the programme and will elaborate six-monthly progress reports, final reports and short project updates on a quarterly basis. Every report shall provide an accurate account of the implementation of activities implemented under each specific result area, difficulties encountered, changes introduced, as well as the degree of achievement of results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the log-frame matrix. Each report will be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the project. The final reports, narrative and financial, will cover the entire period of project implementation. The European 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).

The EUD has launched several Results-Oriented-Monitoring (ROM) missions of EU funded external interventions in Libya. In view of access constraints, such missions have been conducted by teams of expatriate and Libyan consultants working in synergy. This working modality has helped avoid desk reviews with limited value added and has strengthened the veracity and independence of the findings by facilitating onsite assessments across Libya. ROMS missions will continue to be used as a support tool for project management and as a way to collect evidence about project performance. Lessons learned will be integrated in programming, design and implementation. To strengthen the rights-based approach embedded in this action information on mutual accountability will be widely disseminated via accessible formats and channels, data on access to services will be disaggregated and particular attention will be paid towards verifying that fair resource allocation and outreach to the most excluded areas and groups. Further, particular attention shall be paid towards monitoring cost effectiveness of the interventions planned under this action through Cost Effectiveness Analysis (CEA).

5.8 Evaluation

Having regard to Specific Objectives 1 and 2 of this action, a final evaluation will be carried out for this action or its components via independent consultants contracted by the Commission via an implementing partner. The Commission may, during implementation, decide to undertake such an evaluation for duly justified reasons either on its own decision or on the initiative of the partner. The Commission shall inform the implementing partner at least 30 days in advance of the dates foreseen for the evaluation mission. The implementing partner 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 partner 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 and supported with the budget indicated in section 5.5 above. In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and delegation agreements. The Communication and Visibility Manual for European Union External Action shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations. Communication and visibility activities will be supported through individual programme budgets. Investments in accountability will raise the profile of the EU vis-à-vis its Libyan interlocutors.

APPENDIX - INDICATIVE LOGFRAME MATRIX

The activities, the expected outputs and all the indicators, targets and baselines included in the logframe matrix are indicative and may be updated during the implementation of the action without an amendment to the financing Decision. The indicative logframe matrix will evolve during the lifetime of the action: new lines will be added for listing the activities as well as new columns for intermediary targets (milestones) when it is relevant and for reporting purpose on the achievement of results as measured by indicators.

	Results Chain	Indicators	Base lines (incl. reference year)	Targets (incl. reference year)	Sources and means of verification	Assumptions
Overall objective: Impact	Strengthened social contract, state resilience and mutual accountability in Libya through a multipronged approach	Maternal mortality ratio Proportion of births attended by skilled health personnel Under-five and neonatal mortality rate Mortality rate attributed to cardiovascular disease, cancer and diabetes Volume of maternal and new-born, NCDs, mental health, substance abuse and psychosocial support services delivered (disaggregated by tier) Quality of services delivered (defined as	TBD ¹³	TBD	Health strategies and plans National results-based framework Key informant interviews, surveys and opinion polls Project board meetings minutes Patients and health workers' feedback in	Stakeholders share a common understanding of priorities Political feasibility is duly taken into account Implementation is adequately sequenced Expectations are

¹³ Baseline data is not available as the Libyan context is exceptionally data-poor. Targets require adequate baseline data to be realistic. Data on service availability and readiness has been collected by the Information Centre under the Ministry of Health in partnership with the WHO, but is still being analysed. Baseline data and targets will be defined at the time of contracting and further refined during the inception phase of each project. Forthcoming Service Availability and Readiness Assessment (SARA) data will also inform a set of tracer indicators on service availability and readiness and support monitoring and evaluation of health service delivery.

		compliance with clinical guidelines and care pathways, and patient satisfaction)			pilot/non pilot areas Feedback from government officials and NSAs about accountability for results	adequately managed Momentum is sustained Local ownership principles are honoured Blueprint approaches are avoided Plans and proposals are realistic and feasible Broader public sector reforms do not hinder sector-wide processes
Specific objective(s): Outcome(s)	<p>SO1: To improve availability, access and acceptability to quality health services</p> <p>SO2: To improve accountability for results through third party verification and monitoring of development efforts in line with a national framework</p>	<p>Strategies, action plans, guidelines and tools with a focus on maternal and new-born health, blood transfusion services, nurse and midwifery training and education, mental health, substance abuse management and psychosocial support, and NCDs prevention and management, developed and partially rolled out</p> <p>Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)</p> <p>Quality of services delivered (defined as</p>	TBD	TBD	<p>Progress reports</p> <p>Project board meetings minutes</p> <p>Project documents</p>	As above

		compliance with clinical guidelines, care pathways, and patient satisfaction) Nursing and midwifery students' intake planned Accountability strengthened through TPM				
Outputs	Specific Objective 1					
	Result Area One — Maternal, New-born Health and Blood Transfusion Services					
	<ul style="list-style-type: none"> ▶ Increased utilisation of quality ANC/PNC services including family planning and early referral for vulnerable women ▶ Nurses and midwives benefitting from in-service training and dissemination of best practices ▶ Upgraded functions of the national blood transfusion services 	<p>ANC/PNC use in outpatient facilities</p> <p>Proportion of women of reproductive age (aged 15-49 years) in targeted areas who have their need for family planning satisfied with modern methods</p> <p>Evidence of use of standardised guidelines and/or care pathways in targeted facilities</p> <p>Patient satisfaction</p> <p>Perceived quality of care in outpatient facilities</p> <p>Minimum staffing levels in outpatient and inpatient facilities</p> <p>Improvements in health workers' satisfaction and productivity</p> <p>Guidelines adopted and implemented by national blood transfusion services</p>	0	10,000 women by year 3	<p>Project documents</p> <p>Progress reports</p> <p>Patient surveys</p> <p>Staff surveys</p> <p>Trainees feedback</p> <p>Monitoring visits</p>	As above
	Result Area Two — Nurse and Midwifery Training and Education					
<ul style="list-style-type: none"> ▶ National Strategic Plan for Nursing and Midwifery established ▶ Competency-based pre-service training delivered to first-year students in line with a revised curriculum ▶ Increased student intake 	<p>Health worker density and distribution</p> <p>Volume of students enrolled</p> <p>Number of nurses and midwives trained</p>	0	100 first-year students	<p>Feedback from Nursing and Midwifery Association</p> <p>Feedback from trainees</p>	As above	

in selected schools							
Result Area Three — Mental Health, Substance Abuse and Psychosocial Support							
<ul style="list-style-type: none"> ▶ Psychosocial distress, mental health and substance abuse reduced amongst marginalised youth ▶ Expanded availability, access and acceptability to quality psychosocial support and mental health care including phamaco-therapy ▶ Training and upskilling of mental health staff ▶ Establishment of specialised substance abuse treatment centres ▶ Greater awareness about risks and manifestations of mental illness and substance abuse amongst marginalised youth 	<p>Rates of harmful use of illegal substances, defined according to the national context, reduced in marginalised youth</p> <p>Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for mental health and substance abuse disorders (disaggregated by tier)</p> <p>Quality of services delivered (defined as compliance with clinical guidelines and care pathways, and patient satisfaction)</p> <p>Patient satisfaction</p> <p>Risk awareness amongst PWIDs and marginalised youth surveyed</p>	0	5,000 youth by year 3 of which 500 children affected by conflict	0	300 patients by year 3	<p>Project documents</p> <p>Progress reports</p> <p>Patient surveys</p> <p>Staff surveys</p> <p>Opinion polls</p> <p>Trainees feedback</p> <p>Monitoring visits</p>	As above
Result Area Four — NCDs Prevention and Management							
▶ Design and roll out of a robust prevention strategy at primary health care level	<p>Coverage of treatment interventions (medical, diagnostic, pharmacological and palliative care services) for priority NCDs</p> <p>Volume of early diagnosis and early</p>	TBD	TBD	0	5,000 high-risk	<p>Project documents</p> <p>Progress reports</p>	As above

<ul style="list-style-type: none"> ▶ Identification of high-risk subjects, early diagnosis and early intervention ▶ Prevention of complications ▶ Management of NCDs 	<p>intervention services delivered (disaggregated by tier) Quality of services delivered (defined as compliance with clinical guidelines and care pathways, and patient satisfaction)</p>	<p>0 0</p>	<p>subjects by year 3 500 compl. prevented by year 3 NCDs managed in a cohort of 500 by year 3</p>	<p>Patient surveys Staff surveys Trainees feedback Monitoring visits</p>	
Specific Objective 2					
<ul style="list-style-type: none"> ▶ Government counterparts and NSAs report a shared understanding of partnership priorities and principles ▶ Policy dialogue promptly informed by third party monitoring ▶ Prompt reaction to accountability concerns ▶ National result-based framework established ▶ Greater oversight and understanding of context specificities and reduced fiduciary risks 	<p>Rates of satisfaction amongst Libyan counterparts and EU representatives about partnership priorities and mutual accountability principles agreed upon Cost-effectiveness and relevance of interventions monitored (over time and as compared to a control group) Turnaround time in response to concerns about accountability Number of interventions under the umbrella of a national framework for mutual accountability</p>	<p>TBD</p>	<p>TBD</p>	<p>Project documents Progress reports Cost effectiveness analyses Monitoring reports Steering Committee meetings minutes</p>	<p style="text-align: center;">As above</p>