ACTION DOCUMENT

THE EUROPEAN UNION EMERGENCY TRUST FUND FOR STABILITY AND ADDRESSING THE ROOT CAUSES OF IRREGULAR MIGRATION AND DISPLACED PERSONS IN AFRICA

1. IDENTIFICATION

Title	**Reference: T05-EUTF-REG-16** Fast track emergency response to COVID-19 in NoA countries for the most vulnerable populations
Zone benefitting from the action / Localisation	Potentially all countries within EUTF NoA depending on needs and potential funding increase: Algeria, Egypt, Libya, Morocco and Tunisia. This AD will give priority to emergency needs in Egypt and Algeria while also considering those in Tunisia and Morocco to a lesser extent, while waiting for potential increased contributions to broaden its scope[1].
Total cost	Total estimated cost[2]: EUR 10 000 000 Total amount drawn from the Trust Fund: EUR 10 000 000
Aid modality(ies) and implementation modality(ies)	**Indirect management** through Contribution Agreements with UN agencies (primarily IOM and possibly UNHCR and/or WHO[3]). Other UN agencies could receive funds depending on needs and gaps. This will be the privileged modality. Depending on the availability budget **direct management** through **grants** could be applied too.
DAC – codes	72011 – Basic health care services in emergencies 12250 – Fight against infectious diseases 72010 – Material relief assistance and services
Main delivery channels	41000 - United Nations agency, fund or commission (UN) 47066 – International Organization for Migration (IOM) and other UN Agencies 22000 - Donor country-based NGO
Markers	

Policy objectives	Not targeted	Significant objective	Principal objective
Participatory development / good	☐	X	☐

[1] There is an ongoing reformulation of non-spent funds to respond to COVID-19 in Libya

[2] The total needs being much higher, this AD has an emergency first response vocation and the intention to attract funding coming from MS. For the time being (launching) it just considers the funding coming through EUTF aiming at becoming a basket fund depending on the evolution of the needs and the capacities of the potential contributors.

[3] WHO is already heavily supported by DEVCO and ECHO.

	governance			
	Aid to environment	X	☐	☐
	Gender equality and empowerment of women and girls	☐	X	☐
	Trade development	X	☐	☐
	Reproductive, maternal, newborn and child health	☐	X	☐
	Disaster Risk Reduction	☐	☐	X
	Nutrition	X	☐	☐
	Disability	X	☐	☐
	Rio Markers	**Not targeted**	**Significant objective**	**Principal objective**
	Biological diversity	X	☐	☐
	Combat desertification	X	☐	☐
	Climate change mitigation	X	☐	☐
	Climate change adaptation	X	☐	☐
	Migration marker	☐	☐	X
	Digitalisation	X	☐	☐
	COVID-19	☐	☐	X
SDG	SDG 3 Good Health And Well-being SDG 10 Reduced inequalities SDG 17 Partnerships			
Valetta Action Plan Domains	3. Protection and asylum			
Strategic objectives of the Trust Fund	**EUTF Objective 3**: Improved migration management in countries of origin, transit and destination, in particular the priority action n. 3. Strengthening protection and resilience of migrants and forcibly displaced and their host communities.			
Beneficiaries of the action	*These first estimates of number of beneficiaries by country are indicative figures only. The total number of potentially eligible persons is (much) higher in the respective countries. Figures are still under discussion, including with national authorities, and may require further refinement according to needs and gaps and the evolution of the COVID-19 situation. They will also depend on availability of additional funding:* 200,000 vulnerable migrants and forcibly displaced people in Egypt 50,000 vulnerable migrants and forcibly displaced people in Algeria 2,000 vulnerable migrants and forcibly displaced people in Tunisia 20,000 vulnerable migrants and forcibly displaced people in Morocco Libya: to be determined (there is an on-going reformulation of non-spent funds to respond to COVID 19 in Libya)			
Derogations, authorised exceptions, prior approvals	The Commission authorises the costs incurred as soon as the action document is approved, deeming them eligible because of the crisis situation in the context of the COVID-19 pandemic (ARES (2020)1792308 - 27/03/2020). Retroactivity of the actions			

	financed by this AD is due to the nature of the activities to support. 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 responsible authorising officer 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. See Article 9(2)(b) of Regulation (EU) No 236/2014) and the crisis declaration (Ares(2020)1792308 - 27/03/2020) including a derogation to the rule of origin and the rule of nationality.

2. RATIONALE AND CONTEXT

2.1. Summary of the action and objectives

The **overall objective** of the action is to contribute to reducing acute vulnerabilities and improve resilience in light of the COVID-19 pandemic in NoA countries.

The **specific objective** is to respond to emergency needs related to the effects of the COVID-19 crisis on NoA countries, focusing on migrants and forcibly displaced persons (including returnees, stateless people, asylum seekers, refugees and internally displaced persons), hereafter "migrants and forcibly displaced persons", especially the most vulnerable and at risk among them, as well as their host communities.

Among NoA countries, and considering the limited amount of funds of this AD, the actions will be primarily focused on Algeria and Egypt. Tunisia will be considered too as well as Morocco, depending on needs, gaps and funds available. Libya is of equal concern, but at the moment of writing this AD a solution for a specific COVID-19 response Action in Libya is sought.

The Action contributes to **Objective (3) "Improved migration management in countries of origin, transit and destination"** of the EU Trust Fund for Africa and in particular to the **Priority Action III - Strengthening protection and resilience of migrants and forcibly displaced and their host communities.** The action is also aligned with the Valletta Action Plan Priority Domain 3 "Protection and asylum" and with the Joint Communication to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, Brussels 8 April 2020 and the Team Europe approach, mainly with its first component: urgent, short-term emergency response to the health crisis and the resulting humanitarian need. The other two components could be addressed (health systems strengthening and socio economic impact) if additional funds are available and according to needs in the target countries.

The Action is also aligned with international appeals, namely the WHO Strategic Preparedness and Response Plan (including its Strategic Update April 2020), the Global Humanitarian Response Plan, including appeals from IOM and other UN agencies.

The Action takes into account EU commitments to engage in nexus programming in crisis contexts.

2.2. Context

2.2.1. *International and national context*

On 31 December 2019 a cluster of pneumonia infections of unknown origin was reported in Wuhan City, People's Republic of China. The virus behind this pneumonia spread fast, affecting all continents, which led to WHO announcing a pandemic on 13 March 2020. As of 17 April 2020, according to WHO, there are over 2.1 million confirmed cases reported globally and more than 144,000 deaths. While the COVID-19 can affect people of all ages, the severe form of the illness is more common among the elderly and people with chronic underlying conditions.[4]

The pandemic is also straining communities, increasing calls for social protection, shrinking business activity and disrupting supply chains with an impact on social stability and security as a consequence of NPI (Non Pharmaceutical Interventions) measures that have been enforced in most countries. In different ways, almost all countries in the world are declaring states of emergency, closing borders, implementing containment measures up to full lock downs and curfews and closure of services and businesses. In addition to the health impact of COVID-19 and of the public health measures, which is the first priority, a broad range of socio-economic and psycho-social impacts are already visible in the world. Inequalities will be further accentuated by the crisis and the most vulnerable will bear the brunt of the recession.

Due to unprecedented worldwide demand for personal protective equipment (PPE) and for specific medical equipment for intensive care, the world is competing for scarce resources and experiencing shortages of a large array of essential equipment needed by both the health workforce and the general public in order to limit the spread of the virus. This places healthcare professionals at high risk, limits the capacity to avoid transmission and prevents treating complicated COVID-19 cases, which require full functional Intensive Care Units (ICU).

Socio-economic shocks are negatively affecting people's incomes and their capacity to work. This is particularly catastrophic for migrants and forcibly displaced persons, who, often due to their legal status, are more likely to rely on jobs in the informal economy and on daily wages. They will see their capacity to work suddenly reduced without having access to social compensatory measures leading them to resort to negative coping strategies. Their access to health systems, usually already insufficient for their needs, will be further reduced because of a limited capacity of the system to maintain "normal operations" while being confronted with

[4] European Centre for Disease Prevention and Control https://www.ecdc.europa.eu/en/news-events/information-covid-19-specific-groups-elderly-patients-chronic-diseases-people

this major crisis. The limited knowledge of the local culture of these groups, including the language of the reception country, will further bar them from seeking appropriate help if and when needed. These communities may also suffer from stigma and blame for the disease.

North of Africa (NoA) countries

As of 15 April 2020, 19 countries in the Middle East and North Africa region have registered 105,419 confirmed cases of COVID-19 (and 5,699 associated deaths)[5] (72% in Iran).

The pandemic has mobilised the capacities of governments, the private sector and civil society across the region to prevent and mitigate the spread of COVID-19. All countries in the MENA region have implemented containment measures, enforced curfews and closure of borders, services and businesses. Developing countries are mirroring the responses of developed ones. They are preparing their health systems, trying to get protective equipment in a progressively more expensive market, communicating with their populations, closing education institutions, markets and most of business. Cuts or suspension of salaries are measures to be expected.

All NoA countries are registering cases despite reduced country testing capacities in most of them, which could suggest higher numbers[6]. Despite the different levels of preparedness and response capacities of NoA countries' health systems, it is safe to assume that all of them would be unprepared to bear the brunt of a massive demand for ICU beds and specialised care. In countries like Libya for instance, the health system has seen a continuous deterioration linked to the conflict, closure of health facilities, lack of human resources and medical supplies. On the opposite end of the spectrum, the relatively better prepared Tunisian health sector nevertheless shows important pockets with low levels of service and important inequalities (e.g. urban/rural divide). While the Tunisian health care system is mainly managed by the Ministry of Health and its 24 regional directorates in each of the country's governorates, the state's role in funding health care is gradually shrinking, not least because of serious economic challenges and the expansion of private health entities. According to the World Bank, Egypt's healthcare system is relatively underfunded[7], with a limited number of physicians (0.8 physicians per 1,000 persons) and hospital beds per person (1.6 beds per 1,000 persons), which could restrict its ability to handle a possible large influx of COVID patients. Migrants and forcibly displaced persons may also experience practical difficulties in accessing public hospitals or could fear contracting the virus or being detained.

In addition to this, the population structure of the NoA region, with the exception of Egypt that has a young population, is quite similar to that of the EU. Older people represent a growing share of their populations, as most of them are in epidemiological and demographic transition (due to decrease of infant mortality and increase of life expectancy). An increase in the prevalence of non-communicable diseases (cardiovascular, hypertension and diabetes) is

[5] UNICEF MENA COVID-19 Novel Coronavirus (COVID-19): UNICEF support to the Middle East and North Africa.

[6] 14 April 2020 (cases, deaths): Egypt (2,190, 164); Algeria (2,070, 326); Morocco (1,838, 126); Tunisia (726, 34); Libya (26, 1). Coronavirus map: Tracking the Global Outbreak, NY Times.

[7] Egypt spends less than five percent of its GDP on health, and its system could quickly be overstretched, given the population of roughly 100 million. It also has an extremely high population density in the urban areas.

well documented, prompting the need for health systems to scale up their response capacities in terms of ICU for acute forms of COVID-19.

The International Health Regulations (IHR, 2005) represent an agreement between 196 countries including all WHO Member States, to work together for global health security. Through IHR, countries have agreed to build their capacities to detect, assess and report public health events. WHO plays a coordination and advisory role in IHR and, together with its partners, helps countries to build capacities. IHR also include specific measures at ports, airports and land crossings to limit the spread of health risks to neighbouring countries and to prevent unwanted travel and trade restrictions so that traffic and trade disruption is kept to a minimum. Countries periodically self-assess their capacities to enforce these regulations while fulfilling their obligation to inform to the World Health Assembly (WHA) on the implementation of these regulations, main gaps and achievements. These self-assessments are afterwards crosschecked by WHO experts and corrected if needed. If the compliance with IHR was on average 73% in the EURO (European) WHO region, in the EMRO WHO region (Eastern Mediterranean region comprising all NoA countries but Algeria – which belongs to AFRO WHO region) was of 65% with relevant differences between Libya 41%, Tunisia 66%, Egypt 82% and Morocco 75% - Algeria is at 80%)[8].

Often government mitigation measures in response to COVID-19 are implemented amid a dramatically worsening financial and economic crisis that has already crippled a number of countries in the region, leading to a loss of livelihoods, high levels of inflation, and increasing strain on weak public systems[9]. In the region, migrants and forcibly displaced persons are at high risk. Many reside in settlements, where an outbreak could exacerbate social tensions with host communities, possibly leading to stigmatization, exploitation, violence or deportation. Migrants and forcibly displaced people are also less likely to find comfort through community and family networks.

Joint European Response

As stated in the Joint Communication to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, Brussels 8 April 2020, "*As the virus does not discriminate between people and knows no borders, this historic crisis* ***requires a fast, massive and coordinated global response*** *to protect all people, save lives and tackle the economic fallout. Now is the time for international* ***solidarity and leadership****, not isolation; to reach out more internationally, not less; to provide transparency and facts, and counter disinformation. The European Union (EU), as the world's largest donor and a leading economic power, is already at the forefront of this effort. The Union has already taken a series of concrete and quick actions to support our partners*".

[8] All of these are self-assessments. Source: https://extranet.who.int/e-spar#capacity-score

[9] Even if some countries within NoA are launching strong and early constructed public answers to limit the spread of the pandemic and to attenuate its socio-economic impact on the different vulnerable groups, it is safe to assume that migrants and forcible displaced will be in a difficult position to benefit from these measure and the containment measures will hamper the capacities of the vulnerable migrants to get access to informal resources they are usually making. It is important to collaborate with national governments to help them to reach these populations.

"*The EU's response follows a Team Europe approach. It draws contributions from all EU institutions and combines the resources mobilised by EU Member States and financial institutions, in particular the European Investment Bank (EIB) and the European Bank for Reconstruction and Development (EBRD).(…) In line with the approach agreed at the G20 and promoted by the UN, the EU's response addresses the humanitarian, health, social and economic consequences of the crisis*" acknowleding that the pandemic effects will be most acutely felt by populations already affected by humanitarian crises and conflict, such as migrants, refugees, internally displaced persons, as well as women, children, elderly and disabled people and other minorities. "*EU's response addresses short-term emergency needs as well as the longer-term structural impacts on societies and economies, thus reducing the risk of destabilisation. It reinforces both governmental and non-governmental actions.*"

This AD will focus on the first priority, contributing to address short-term emergency needs with a special focus on migrants and forcibly displaced persons. Should additional funds be available, the scope of this AD would allow for expanding interventions under the other two priorities outlined in the EU Joint Communication and in line with national priorities and existing gaps.

Vulnerable populations

Migrants and forcibly displaced persons are particularly vulnerable[10] to the impact of the COVID-19 pandemic due to restricted access to health services, restricted legal recognition and access to national social protection mechanisms, language and cultural barriers, potentially suffering from stigma along with living on a very limited social/family network.

The degree of vulnerability of migrants and displaced populations in the target countries varies depending on the host country, and the measures taken by their Governments to address their immediate needs.

Some migrants live in densely populated areas, out of reach locations or in overcrowded facilities, often experiencing limited or lack of adequate water and sanitation infrastructures. Many of them are not just living but also working in fragile and at-risk conditions as well. The impact of the COVID-19 situation seen so far on migrants and forcibly displaced persons in third countries is likely to entail an increased risk for these populations to contract the virus due to a certain lack of awareness of prevention measures and the extreme difficulties to practically implement them even if they are aware. Physical/social distancing, isolation, language barriers, conflict/humanitarian situations are harmful for migrants and forcibly displaced persons in the light of the pandemic. In addition to this, COVID-19 measures are also affecting implementing partners' possibilities for movement, hampering access of humanitarian workers and aid delivery.

The EU response will thus strive to protect, assist and advocate for these groups in line with EU's values and commitments. Other vulnerable populations to COVID-19 are likely to be people with disabilities, women and men belonging to minority communities, victims of

[10] These is based on common reflections and guidance shared by IASC, UN, EU and main stakeholders, together with lessons learnt of previous epidemics and risk situations, although there is not enough specific data/studies on COVID-19 to establish causality yet.

increased domestic violence, prisoners, HIV-positive people, drug addicts, sex workers and of course, the elderly.

Some concrete examples of difficulties for migrants can be exemplified with the situation of Detention Centres (DC) in Libya, where it is particularly difficult to implement distancing or isolation measures given the overcrowded settings, with no or restricted access to water, and poor hygienic conditions.

In countries like Egypt, vulnerable populations struggle to observe preventative measures such as social distancing and frequent hand-washing because they mainly depend on informal day labour and live in crowded conditions sometimes with up to thirty individuals sharing accommodation. They cannot afford to purchase adequate hygiene materials. Measures introduced by the government to reduce the spread of COVID-19 include limiting working hours and restricting movements within certain hours of the day. These measures have resulted in a loss of income and livelihoods for a cross-section of the population particularly those who are already vulnerable among the mixed group of potentially up to six million refugees, migrants, persons who are in a refugee-like situation and persons in a mixed-migration movement.

In Algeria, the ongoing difficulties in accessing basic services as food, housing and health care is imposing an extra burden on vulnerable populations' status, increasing their risk to become victims of abuse, violence and exploitation. Working conditions are also severely affected all over the country. The lack of mobility and the consequent isolation of migrants is raising concerns over a possible increase in cases of sexual-gender based violence and of mental disorders. Travel and mobility restrictions are particularly affecting transit centres in Algeria, where the number of migrants has increased and assistance is needed. Restrictions are affecting also asylum seekers after UNHCR was obliged to suspend the interview for "refugee status determination", and also given the fact that not all who need, have access to the interview currently conducted by telephone.

In Tunisia, COVID-19 is also having a significant impact on vulnerable populations. Country-wide containment measures have resulted in loss of income, especially for daily workers and those working in the informal sector, and are limiting market access, while a spike in prices of basic goods has been observed. Migrants and forcibly displaced populations are exhausting their savings and are unable to cover rent, food, medicine and other essential needs, resorting to negative coping mechanisms, such as lower food consumption and selling off assets. In the event of an outbreak of the virus among these groups, the social cohesion between them and local communities could be at stake. Protection consequences are starting to emerge as well. Many migrants fear being stigmatised if they are infected, and that intercommunal tensions may rise further. Reported cases of sexual and gender-based violence are surfacing through UNHCR helplines. In addition, the closure of all private and public schools has affected attendance of refugee and asylum-seeking children who are already enrolled. Without school, and the much needed school canteens, children may be at increased risk of negative coping mechanisms such as hazardous child labour or begging, and their families could need more support to stay safe.

Concerning treatment, in some countries there could be an increased difficulty to treat some potentially infected migrants and forcibly displaced persons due to their often more limited

access to health care systems, or to the lack of capacity to treat them. For example, in Egypt, migrants and refugees often face difficulties accessing medical treatment although they have the same right to primary public healthcare as Egyptian nationals. Indeed, the Egyptian government grants refugees and asylum-seekers of all nationalities access to primary health care at a par with Egyptian nationals. However, there exists a lack of awareness about refugee rights at different levels. Also, cases of discrimination combined with the delays in issuance of official UN documentation and residence permits could have consequences for access to essential health care services and even increase the risk of arrest and detention. The WHO has recommended that CSOs/NGOs monitor possible spread within migrant communities and accompany refugees and migrants to hospitals, for translation and other support. There are already reported cases of refugees in labour being denied the possibility of giving birth in hospitals, due to stigma and the fear of the virus. On the other hand, there is also some fear of the virus and suspicion of the public health system among migrants and forcibly displaced persons. In Egypt, migrants' access to health care services prior to COVID-19 was in general already limited, and with the impact of the current outbreak, the continuation of basic health services for migrants will become a substantial challenge for the country.

Further cases of stigmatisation of migrants and forcibly displaced persons might be possible too, mainly linked to exclusion from existing COVID-19 mitigating measures as well as misinformation and rumours, common in epidemics, which could fuel a perception of migrants and forcibly displaced persons as virus carriers or spreaders. In these cases, these vulnerable populations might be hiding their symptoms and failing to present for treatment.

Finally it has to be acknowledged that the longer-term impact of COVID-19 on migrants and forcibly displaced persons is difficult to predict, but it is possible that the COVID-19 becomes a test for multilateral action to protect the most vulnerable, migrants and forcibly displaced persons among them. It has to be also noted that the impact may also be felt in Sub Saharan countries and countries of origin to which they send remittances. In most NoA countries, migrants' remittances to countries of origin such as Mali (5,5% of GDP), Senegal (10% of GDP), Cote d'Ivoire, Somalia and Eritrea are an essential source of resilience and a considerable amount of money flowing into these countries, creating economic safety nets for their societies. These remittances are likely to drastically decrease and have a negative impact on the livelihoods and economies of these countries. Worldwide, the impact of COVID-19 is already estimated to cause a drop of a more than USD 100 billion in global remittances to developing countries[11], including North African countries (with Egypt being largely dependent on remittances from its migrants in the Gulf region). In Libya, for example, there is currently an estimated figure of 650,000 migrants, many of them long-time residents, out of whom 79%[12] are working and sending remittances to their countries of origin.

[11] https://www.knomad.org/sites/default/files/2020-4/Migration%20and%20Development%20Brief%2032_0.pdf
[12] IOM (January, 2020). DTM Libya Round 28 Migrant Report.

2.2.2. *Sector context: policies and challenges (per country)*

Egypt

According to IOM Egypt, Egypt could be hosting more than six million migrants[13], of which an estimated 900,000 are estimated to be vulnerable. It is common that they have underlying medical conditions. The same goes for the approximately 250,000 registered refugees and asylum-seekers that Egypt hosts. More than 84% of them were already classified as "severely" or "highly" vulnerable to COVID-19. Nevertheless, only 12% of the most vulnerable refugees and asylum seekers among these, about 30,000 individuals, were within the remit of UNHCR's multi-purpose cash assistance for a monthly amount that only covered roughly 50% of their basic needs.

As already mentioned, in Egypt protection risks of migrants and forcibly displaced persons are likely to increase as a result of COVID-19, causing revenue losses and negative societal impact and stigma. Moreover, their protection may administratively be compromised by the COVID-19 induced limbo, as identity and residency documents currently cannot be obtained or renewed. This could entail increased risks of losing access to services and access to protection. Since they often have no savings or other governmental or family safety nets, the economic shock from COVID-19 will likely leave these groups in extreme vulnerability unless interventions are deployed immediately.

The Government of Egypt's (GoE) ability to provide support to migrants and forcibly displaced people may also be hampered by the decline of the global economy. The International Monetary Fund (IMF) currently projects the Egyptian economy to grow at 2.8% the coming fiscal year, compared to the previously predicted 5.6% GDP growth. Expected losses in the tourism sector will also impact the GoE's fiscal position and room for manoeuvre. This will reduce economic opportunity for most vulnerable populations in Egypt, making it plausible that they instead seek opportunities for livelihoods elsewhere. Since the outbreak, many refugees and migrants have suddenly lost their income. Since there are no camps in Egypt, migrants and forcibly displaced persons live and make their living among their host communities. However, the loss of income generated by the measures in place has already led to hundreds of families being evicted as they were unable to pay their rent. They often cannot afford essentials like food and hygiene items. Among them there are also people with underlying medical conditions such as hypertension, diabetes, etc., which make them at higher risk also for infection with COVID-19. Frontline community-based organisations are receiving daily phone calls from these vulnerable populations asking for assistance, food, and money for rent.

Egyptian authorities are currently working on their national strategic response, to be coordinated by the Prime Minister's office. The Ministry of Health and Population (MoHP) and the Ministry of Social Solidarity (MoSS) are in charge of the medical-sanitary and socio-economic aspects respectively. Both have foreseen the inclusion of migrants and forcibly

[13] IOM estimation was presented in a roundtable meeting organized by the Egyptian Ministry of Foreign Affairs and the International Organization for Migration on 8 July 2019.

displaced persons within their responses[14]. Poor villages and urban slum areas are prioritised for intervention. Despite migrants' and forcibly displaced persons' inclusion within the national plans, the mechanisms to do so are not clearly defined yet, which could hinder their already reduced access to public health services as well the delivery of socio-economic basic needs assistance.

The international organization(s) selected as implementing partners of this Action in Egypt will present the action in Egypt to MoFA (Ministry of Foreign Affairs) for their coordination with line Ministries.

Algeria

Since 25 February, date in which the first COVID-19 case was detected in Algeria, the Algerian Government has progressively been adopting preventive and containment measures to avoid the spread of the virus. This includes closure of aerial and terrestrial borders (17 March), restrictions on international and in-country movements, closure of restaurants and public spaces, including the airport (19 March), suspension of public transportation (21 March) and partial or total quarantine (23 March).

On 17 March, the President of the Republic established a national scientific Commission for monitoring and evaluating the pandemic COVID-19 while a multisector crisis unit was put in place under the coordination of the Prime Minister. An alert and response unit was also created within the cabinet of the Ministry of Health and the following three units were established to oversee the coordination and response to the spread of the virus: unit for epidemiological surveillance; unit for follow up of patients and management of beds and unit for tools of diagnosis, protection and treatment. According to the Ministry of Health such system will be replicated within the wilayas. Case management is done by the hospital facilities identified by the Ministry of Health. Currently there are 315 such facilities and each one is equipped with between two and ten beds reserved for patients of COVID-19. As of 5 April 2020, all wilayas are under partial quarantine and one wilaya, Blida, is under total quarantine[15]. Most of the cases are reported to be located in the wilayas of Blida, Alger, Oran and Setif although 47 wilayas out of the existing 48 have been already touched by the virus.

In Algeria there are currently around 50.000 vulnerable migrants from sub-Saharan Africa reported to be in need of urgent assistance (IOM estimates). As a result of the pandemic and of the restrictive measures taken to contain the spread of the virus, migrants across the country are reportedly in distress and in need of help. The restriction of international and in-country movements resulted in greater number of migrants being stranded in Algeria. In addition, due to the pandemic and related restrictive measures many migrants lose their jobs (often in the informal economy) and struggle to access food, essential non-food items, housing solutions and basic services.[16].

[14] The MoHP is leading the health response to the virus, while MoSS is focusing efforts on socio-economic protection of vulnerable groups across Egypt. The MoSS will intervene in cooperation with the United Nations agencies and NGOs like Red Crescent supporting vulnerable groups with cash, food, hygiene kits and medication.
[15] Rapid Protection Assessment, IOM, 4 April 2020.
[16] Rapid Protection Assessment, IOM 6 April 2020

Libya

The COVID-19 pandemic came at a moment of extreme fragility for Libya as the Libyan health system is severely under-equipped to face the challenge that COVID-19 presents. Nine years of instability and insecurity have undermined the wellbeing of the Libyan population. The Libyan health system, enjoying seemingly endless flows of funds under Qaddafi's leadership, allowing for mass staffing with foreign medical personnel, developing excellence in many clinical branches, failed to remain structured and resilient in the face of diminishing financial allocations and increasing warfare.

With the conflict and years of instability, and with a lack of qualified medical professionals, the health system has nearly collapsed. Many public healthcare facilities are closed and those that are open lack staff, medicines, supplies and equipment. Many facilities have been directly attacked or damaged during the fighting, and those that remain functional are overburdened or cannot be maintained. Health challenges in Libya concern the main health pillars of any health system (financing, governance, human resources, drugs and equipment, services). The government's financial inputs are mainly limited to disbursement of salaries (sometimes with delays, for instance salaries of January and February 2020 have just been paid while the whole month of March is still pending), with no or very little allocation for drugs, diagnostic tests, or equipment. This is affecting the health of the whole population, but above all that of the most vulnerable. The Libyan public health system is also challenged by divided governance structures, competing public health administrations and the lack of a real mid- to long-term strategy to rebuild the public health system.

Migrants and forcibly displaced persons are disproportionally affected due to their legal situation described above and mainly by the fact of not having full access to the public health system. According to IOM Libya's Displacement Tracking Matrix[17], 74% of migrants and forcibly displaced persons have limited or no access to health services. While the Libyan health system in principle does not discriminate, in practice, migrants and forcibly displaced persons are underserved due to lack of resources and their legal status. Their access to the health system is often limited to private hospitals, greatly adding to treatment costs and highlighting the need for enhanced public sector capacity, and/or to finding opportunities with INGOs, heavily relying on humanitarian community health partners for service delivery and supported referral to these private health facilities.

In addition to this, migrants and forcibly displaced persons in DCs (and some of those outside DCs as well) live in overcrowded and unsanitary conditions, creating conditions conducive for the spread of COVID-19. As has already been said, discrimination is widespread and misperceptions that migrants and forcibly displaced persons are vectors of communicable diseases are common. There are already reports on migrants and forcibly displaced persons being blamed for COVID-19. Current restrictions prevent them from being able to work, while they have no access to any national social or economic safety net.

On 16 April 2020, 49 cases of the virus had been confirmed in Libya. However, the shortage of test kits and weak surveillance systems means that the real spread of the infection is not

[17] IOM Libya, DTM Round 29 April 2020

really known and cannot yet be predicted. Community transmission has started and it is predicted to spread in the coming weeks despite the planned NPI measures.

While both the Government of National Accord (GNA) and the Libyan National Army (LNA) have welcomed the UN's call for a humanitarian truce to enable authorities to respond immediately to the threat posed by the virus and both of them have adopted firm measures to respond to COVID-19, including financial engagements, fighting in and around Tripoli has increased since the beginning of the pandemic, including attacks on health facilities. It should be noted that each entity has its own COVID-19 committee and cooperation and exchanges are rare. Different NPI measures are being enforced on each side and communication is highly politicized. As of 17 April, the national response plan to COVID-19 has not yet been released.

Morocco

The coronavirus pandemic was confirmed in Morocco at the beginning of March, when the first case was recorded. On 23 April, Morocco reported 3,568 confirmed COVID-19 cases and 155 deaths.

To cope with this crisis the government declared the state of health emergency on 20 March, and adopted containment measures including quarantine, the need for signed authorizations for movement, the obligation to wear masks, and prohibition of all forms of public gatherings. Migrants and forcibly displaced persons, whose administrative status is often non-regularised, find themselves with very little freedom to circulate and to reach associations delivering aid, or to seek healthcare assistance. This is in addition to seeing their informal income generating activities prohibited. Outreach to migrants and forcibly displaced persons is becoming difficult, especially in the forests in the North/East of the country, and in the informal settlements. Psychological assistance to victims of trauma, including for women victims of violence, which was already limited before the crisis, is either suspended or provided by telephone when possible.

Non-governmental organisations struggle to undertake the needed outreach activities unless a specific authorisation is granted from the local authorities. The response by the Government (emergency fund) does not always meet the needs of migrants. With the extension of the confinement, private donations made available by various international actors may soon come to an end. While UNHCR has managed to ensure exceptional cash transfers to 7,000 refugees (April), the extension of the confinement has given rise to renewed needs and demands for help from asylum seekers, which are received by the local office on a daily basis. Thousands of migrants registered for food aid at the Rabat Cathedral are facing a three-week waiting period due to the restrictive distribution measures and the limited human resources that can be made available in the current situation. With uncertainty as to the end of confinement and an economic downturn looming, vulnerabilities may rapidly increase, risking of potentially endangering social cohesion in a sensitive socio-economic context.

Tunisia

In order to contribute to reducing the impact of the pandemic of COVID-19, Tunisian authorities have introduced measures to limit the spread of the virus including a general country-wide curfew from 6am until 6pm, except for essential businesses (grocery shopping,

medical care) in the vicinity. Air, sea and land journeys are suspended, border restrictions are in place, travel is banned between cities and regions, non-essential businesses are closed and screening and quarantine measures stepped up. Although it is too early to determine the long-run impact of COVID-19 on the Tunisian economy, at the time of writing the country-wide lockdown has hit services very hard, including the tourism, trade and transportation sectors that account for more than a quarter of all jobs in the economy. This will directly affect the most vulnerable groups.

Albeit constrained by limited mobility, migrants and other forcibly displaced persons are currently able to access national health care facilities. UNHCR provides support to pay for health-related expenses as UNHCR's Persons of Concern (PoC) lack sufficient economic resources. However, a recent health assessment conducted by WHO with UNHCR in May 2019 in areas with a high concentration of PoCs, revealed the existence of major gaps in the health system, namely the lack capacity to cope with a significant increase in the number of patients, lack of access to specialized medical equipment and transport, limited training of medical personnel, and a lack of medical specialists.

Key challenges at country level include: i) border closures, import/export and port restrictions, fuel/commodity price fluctuations affecting UNHCR and partners' ability to contract commercial service providers; ii) travel restrictions, lack of transport options and access impediments limiting the scope of response by UNHCR and partners; iii) lack of comprehensive data and analysis to better monitor the potential implications of COVID-19; iv) delivery of COVID-19 essential medical supplies delayed and not meeting expected requirements due to shortages.

Africa CDC

It is worth mentioning the challenge ahead for Africa CDC (Centre for Disease Control). Africa CDC is a specialised technical institution of the African Union established to support public health initiatives of its Member States and strengthen the capacity of their public health institutions to detect, prevent, control and respond quickly and effectively to disease threats. Africa CDC is a relatively young structure now confronted with demands that most likely exceed the capacities to assist their Member States. DEVCO foresees funding for Africa CDC, WHO and ECDC (European Centre for Disease Control) within its health /COVID-19 programming.

2.2.3. *Justification for use of EUTF funds for this action*

EUTF is a key instrument to fund actions supporting vulnerable migrants and forcibly displaced persons in the NoA countries.

Protection and the resilience of migrants and forcibly displaced persons and their host communities is one of the priorities of EUTF in the region, and this action is designed to contribute to the response to some of the most pressing needs resulting from the pandemic. As far as possible, and depending on Implementing Partners' capacities, through different funding instruments (e.g. EUTF, ENI, funds from DG ECHO or others), the EU is already refocusing some components of its current interventions, in response to more pressing needs linked to the COVID-19 outbreak. In Libya this is the case of partners such as IRC, IMC, IOM, UNFPA, UNHCR and CESVI, among others, who are increasing their activities in the

field of awareness-raising, risk communication and community engagement, distribution of hygiene kits supplies, specialised training for health workers, socio economic measures for most vulnerable, medical equipment procurement, drugs supplies and disinfection and fumigation at DCs and DPs[18]. In Morocco and Egypt, existing projects are expanding some activities – where applicable – to support the country to better inform vulnerable and marginalized groups about the risks related to COVID-19 exposure. In Morocco, under the Regional Development and Protection Programme, humanitarian assistance has been extended by two months in Casablanca for 100 beneficiaries through the partnership between IOM and Humanity and Inclusion, and budget allocations for up-coming contracts are being revisited to address needs in Oujda and Nador. In Tunisia, the component of the EUTF-funded PROGRES, set up jointly with Tunisian authorities, which entails service provision for the sustainable reintegration of returnees, is also looking at its activities to ensure support for health services to the most vulnerable and their families.

However, due to restrictive measures and the lack of PPE, implementing partners are struggling to maintain access while complying with curfews and restriction of movement and to maintain the safety of their staff.

Like other countries around the world, NoA countries have largely suspended flights, including humanitarian flights in some cases (Libya), and closed borders, except for repatriation of nationals and transportation of goods. As a consequence, returns and evacuations have been stopped, which has a direct impact on return and readmission. This is directly affecting T05-EUTF-NOA-REG-04 *Facility for Migrant Protection and Reintegration in North of Africa*- IOM, which has seen its operations halted, as well as T05-EUTF-NOA-REG-REG-04 *Enhancing protection, live saving assistance and solutions, including resettlement for PoC with international protection needs in Libya, West Africa (Niger, Rwanda and other suitable locations*)-UNHCR, which covers Emergency Transit Mechanisms for refugees and asylum seekers. Both programs have achieved considerable results since 2017 supporting the evacuation of 5,000 PoC by UNHCR as well as 50,000 stranded migrants and forcibly displaced persons supported by IOM to voluntarily return to their countries of origin[19].

Overall it is too early to assess the impact on migratory movements. Temporary restrictions of access to territories have contributed to curbing irregular migration for the time being, but increased internal displacements or new flows may emerge. The COVID-19 measures seem to have made smuggling operations more difficult, which may result in smugglers shifting to other contraband or looking for other clandestine routes/options.

A move to implementation of further restrictive measures cannot be excluded. In Libya there have been pressures from humanitarian partners and stakeholders to release migrants and forcibly displaced persons in DCs but although there have been some releases, there is no general release yet.

[18] Other possibilities of funding reorientation in Libya are being analysed at the present moment.
[19] EUTF data.

2.3. Lessons learnt

There are no real comparable experiences to this pandemic that can allow a consideration of lessons learnt. Nevertheless, there are experiences from past outbreaks, ongoing situations and assessments of health challenges at country level (IHR) that allow us to draw likely applicable lessons.

- Do not leave anyone behind: Strive to find the most vulnerable populations affected: focus on the most vulnerable;
- Health systems are essential for the response to COVID-19 but health depends on many more factors than solely the health system: social determinants of health (information; education; water and sanitation; nutrition; income; etc.) are crucial in the health status of the population and have to be tackled;
- It is important to respond to the most pressing needs while as much as possible reinforcing health systems comprehensively, covering all the key health pillars (governance, financing, human resources, service delivery, drugs and equipment and health information systems) to enable them to respond to the current pandemic and the ones that may come afterwards, while strengthening their capacity to cope with current pathologies, health promotion and prevention;
- COVID-19 has quickly shown that there is an urgent need to deploy new methods and channels to safely deliver assistance while protecting the beneficiaries, project staff and volunteers from getting infected. This might imply a wider need for new ways of working (e.g. remote, telephone, online), new infrastructures, medical supplies, medical insurance and PPE so that the implementing partners can continue to contribute to protecting the most vulnerable people on the ground;
- While advocacy for the mainstreaming of migrants and forcibly displaced persons into public health and social protection systems as well as into social safety nets to increase the resilience of the communities must be maintained, it is challenging in emergency conditions.

2.4. Complementary actions and synergies

The magnitude of the pandemic requires coordinated actions to face the challenges ahead.

On 25 March UNOCHA launched a major humanitarian appeal to face COVID 19 and mitigate its impact particularly on fragile countries with weak health systems and Humanitarian Response Plans ongoing (HRP) (Libya and Egypt included). Total needs amount to USD 2.1 billion (EUR 1.86 billion). This figure represents the additional humanitarian needs arising from COVID-19 in countries with already humanitarian need plans on-going (there are no disaggregated needs per country at the moment of writing this AD as countries are working on their preparedness and response plans and updating their HRPs).

In February 2020, WHO had already released the Strategic Preparedness and Response Plan to 2019 Novel Coronavirus, amounting USD 675,680,427 (out of which USD 640 million are for scaling up country preparedness and response). WHO field offices are currently updating

their needs, preparedness and response plans. It is worth noting here that the decision to freeze the US contribution to WHO will have an impact also on country operations and on the very precious coordination role WHO is playing.

IOM launched an appeal in March reviewed in April for an amount of USD 499 million for activities to be implemented until December 2020 and tackling four key strategic priorities at the community, national and regional levels: (1) effective coordination and partnerships as well as mobility tracking; (2) preparedness and response measures for reduced morbidity and mortality; (3) efforts to ensure that affected people have access to basic services, commodities and protection; and (4) to mitigate the socio-economic impacts of COVID-19.

UNHCR and UNICEF also launched global and regional appeals.

At country level the appeals/plans are being launched/updated as exemplify below.

In Algeria, the UN response plan against the pandemic has been accepted and endorsed by the Algerian Government. WHO already supported the country with provision of PPE and, along with UNICEF, is currently finalising a common plan to strengthen the community awareness and engagement against the spread of the virus. With the technical assistance of WHO, the National Institute of Public Health continues to work on the strengthening of the coordination and the response capacity of the following wilayas: Bouera, Boumerdes, Tizi Ouzou, Blida, Annaba et Constantine and it is also planning to target the wilayas of Biskrah, El Quad and Bejayah.

In Egypt, the UN Resident Coordinator has shared the Country COVID-19 Preparedness and Response Plan (CPRP) covering health related aspects for an initial 3-months period from April to June 2020. The UN Resident Coordinator has also developed the UN Egypt Socio-Economic Response Plan (SERP) to focus on addressing acute social and economic impacts of the COVID-19 outbreak, outlining immediate actions that the UN will be undertaking to support the most vulnerable[20]. This plan was designed in line with the 2018-2022 UN Partnership Framework (UNPDF) for Egypt. Its four pillars are: 1) inclusive economic development (prosperity), 2) social justice (people), 3) environmental sustainability and natural resource management (planet) and 4) women's empowerment (women). A fifth pillar on mixed migration was also added given the specific increased vulnerabilities that this group faces because of the outbreak. It is set with an initial timeframe of six months, starting from 1 April to 30 September 2020. In this context, IOM has developed the Global Strategic Preparedness and Response Plan (SRP) Coronavirus Disease 2019. It focuses on addressing both the public health and the humanitarian and development concerns presented by the ongoing global pandemic. IOM's plan is aligned with the WHO's plan launched on 3 February 2020. IOM concentrates on the following areas of intervention, namely: Health, Camp Coordination and Camp Management, Displacement Tracking and Protection.

[20] Actions being funded from this AD will build on both of these response frameworks and will particularly aim to tackle the SERP to focus on addressing acute social and economic impacts of the COVID-19 outbreak, outlining immediate actions that the UN will be undertaking to support the most vulnerable. The SERP is in line with the 2018-2022 UN Partnership Framework (UNPDF) for Egypt and includes a pillar on mixed migration given the specific increased vulnerabilities that this group faces because of the outbreak. The focus of this plan is to address the immediate impacts, by building on existing projects, programmes and delivery mechanisms.

UNHCR is a key partner of the Government of Egypt for refugees' registration and support. In order to address increasing needs and lack of resources exacerbated by the COVID crisis, UNHCR –Egypt has prepared in April 2020 a Concept Note "Addressing urgent protection and assistance needs of refugees and asylum-seekers in Egypt during COVID-19 pandemic" which provides a solid basis for a support along 4 priority items (Protection, Cash transfer, Public Health and Education).

In Libya, the requirement for the COVID-19 Health Sector Plan stands at USD 14.3 million, with around USD 4.2 million received as of 26 April 2020 (30% of the funding requirement). While funding to the 2020 HRP has increased, it remains significantly underfunded overall. As of 26 April 2020, USD 11.3 million has been received, 10% of the requested USD 115 million. The Inter-Sector Coordination Group conducted an exercise that identifies USD 30.8 million (additional to the USD 14.3m for COVID-19 Health Sector Plan) to be required for critical HRP activities addressing the direct and indirect impacts of COVID-19 on the most vulnerable people in need over the next three months. There is ongoing advocacy to clarify how the LYD 500 million (USD 351 million) earmarked for the COVID-19 response by the GNA will be allocated.

In Morocco, UNHCR recently launched an appeal for additional funds to enable additional cash transfers to refugees in view of the extension of the confinement period. The support modalities could be extended to asylum seekers reaching an additional figure of 10,000 people.

Under ENI, an EU regional programme on Health Security was recently launched. It will be implemented by the European Centre for Disease Prevention and control. It will cover Southern, Eastern Neighbourhood and Enlargement Countries and it will focus on the following areas: i) field epidemiology workforce development through Mediterranean Programme for Intervention Epidemiology Training; ii) 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, response and 3) integration into ECDC systems, knowledge sharing and networking

2.5. Donor coordination

In light of the magnitude of the challenges ahead, a proper donor coordination is essential. The European Commission is coordinating a common response to the outbreak of COVID-19 within the EU. This includes action to reinforce the Member States' public health sectors and mitigate the socio-economic impact in the European Union (see section 2.2.1 Joint European Response). The European Commission has been mobilising all the means at its disposal to help the EU Member States coordinate their national responses. Providing objective information about the spread of the virus and efforts to contain it is part of the response.

As for the response dedicated to the NoA, a dedicated Task Force has been established within DG NEAR to actively monitor the situation in the region and oversee the funding and assistance requests, closely liaising with EEAS, DG ECHO, DG HOME, EU Delegations, donors and IFIs. To ensure that this action is fully aligned with the national response to the outbreak and is well coordinated with national and international partners, this implementation

will be done in close coordination with the national authorities, EU Delegations, UN organisations under the Resident Coordinator system and other stakeholders through:

- The dedicated COVID-19 national coordination structures set up by national authorities to coordinate the response to the outbreak with relevant partners.
- Development Partner Groups and when relevant Humanitarian Coordination Teams
- Regular interactions with the EU Delegations

The EU Delegations in NoA countries will ensure coordination and alignment with national priorities and avoid overlaps with other funding including from the EC within the framework of international and national plans and appeals as described in the previous section. Efforts will have to be made locally to ensure the establishment of a comprehensive coordination mechanism that allows securing equitable coverage of needs at national level.

It will be of outmost importance to complement the national efforts in alignment and harmonisation with national authorities, while contributing to reinforce national capacities through the implementing methods agreed and the interventions proposed.

3. DETAILED DESCRIPTION

3.1. Objectives and expected outputs

The **overall objective** of the action is to contribute to reduce acute vulnerabilities and improve resilience in light of the COVID-19 pandemic in NoA countries.

This aligns with EUTF NOA Strategic Objective 3. To strengthen protection and resilience of those in need.

The **specific objective** is to respond to emergency needs related to the effects of the COVID-19 crisis on NoA countries, focusing on migrants and forcibly displaced persons, especially the most vulnerable and at risk among them, as well as their host communities.

This aligns with EUTF NOA Specific Objective 3.V. Access to and quality of services for target groups and host communities is improved.

The **expected immediate outcomes/results**, deliverables or benefits of activities to be delivered by this Action are aligned with EU Joint communication and are the following:

(i) Urgent, short-term emergency response to the health crisis and the resulting humanitarian needs.

If further funds become available, this AD could tackle the two other outcomes foreseen in the Joint Communication namely: ii) Support to health systems strengthening, including water and sanitation and iii) Addressing the economic and social consequences of COVID-19 in the most vulnerable populations.

3.2. Main activities

3.2.1. *Activities associated with each output*

An indicative list of possible activities and outputs associated with outcome 1 follow below. At this stage the activities are *indicative* and will be refined in the contracts according to needs, implementing partner capacities and gaps.

Not all of the activities will necessarily be implemented and additional ones in relation with the objective and outcomes may be added if needed

Immediate outcome 1: Provide urgent, short-term emergency response to the COVID-19 health crisis and the resulting humanitarian needs.

Output 1.1: Safe spaces[21] and protection for the most vulnerable populations provided

Indicative Activities:

- Provide triage and quarantine location for the most vulnerable populations to mitigate risks of COVID-19 as well as quarantine spaces of suspected/confirmed cases;
- Identify safe spaces for unaccompanied children, women, people with physical or mental disabilities, elderly and any other person having a specific needs;
- Improve hygiene conditions in safe spaces, through the scale up of WASH services and other Infection and Prevention Control (IPC) measures;
- Clear referral mechanisms to refer the most vulnerable populations without access or with restricted access to health services who develop COVID-19 to needed services;
- Dialogue/advocacy with authorities to address in legislation the inclusion of migrant workers and their access to social and health services, capacity strengthening, training.

Output 1.2: Immediate services are provided: health, housing, food, NFI, cash-support, psychological and psychosocial support

Indicative Activities:

- Food supply (incl. vouchers) and NFI (including PPEs, hygiene and dignity kits);
- Support for housing;
- Emergency unconditional multi-purpose cash transfers for individuals/ households needing assistance;
- Health care support (referrals, consultations and drugs);
- Psychological and psychosocial support;
- Support to/creation of "hot lines";

[21] Morocco is not concerned by the reference to the establishment of safe spaces.

- Cash for work to support income generation for migrants and forcibly displaced persons, social cohesion with host communities and slow adaptation to socialization after a long period of isolation.

Output 1.3: Health facilities and health staff are supported (including protective equipment and IPC measures)

Indicative Activities:

- Support to Primary Health Care Clinics (PHC), social care institutions and staff including provision of medical supplies and PPE;
- Services to ensure acceptable level of hygiene and health standards in the premises where social care beneficiaries are hosted ;
- Support laboratory capacities and procurement;
- Support local HMIS (Health Management Information Systems);
- Capacity strengthening of relevant national authorities, and their health systems, including training of staff.

Output 1.4: Risk communication and community engagement initiatives implemented

Indicative Activities:

- Creation of effective mechanisms for 'remote' awareness-raising and psychological support for the migrant communities regarding hygiene measures, social distancing, measures against Gender Based Violence and stigmatisation;
- Awareness raising among migrant and host communities (to be specified at project level);
- Capacity strengthening of relevant national authorities, and training of staff;
- Social cohesion interventions among migrant and host communities (to be specified at project level).

Output 1.5: Services to vulnerable groups at Ports of Entry (PoE) provided

Indicative Activities:

- Health needs assessment at the PoE to identify health needs;
- Development and dissemination of SOP (Standard Operating Procedures) at PoE level;
- Procurement of PPE, equipment and needed medication;
- Establishment of temporary isolation spaces at PoE;
- Strengthened referral systems;
- Capacity strengthening of relevant national authorities, and training of staff;
- Support for properly equipped ambulances.

Output 1.6: Supports for medium term needs are provided

Indicative Activities:

- Cash for work to support income generation for migrants and forcibly displaced persons, social cohesion with host communities and slow adaptation to socialization after a long period of isolation;
- Support to micro-businesses that include migrants and forcibly displaced persons.

3.2.2. *Target groups and final beneficiaries*

The action should primarily target migrants and forcibly displaced people together with their host communities. Priority will be given to the most vulnerable.

Particular attention should be given to unaccompanied minor children, women, people with physical or mental disabilities, elderly and any other person having a specific need. Host communities, local communities and civil society organisations will also be targeted by the present action with particular attention to activities of social cohesion.

3.3. Risks and assumptions

Risk	Level of risk (High/ Medium/ Low)	Mitigating measures
Lack of collaboration from the authorities, encumbering civil society participation to address COVID threat	L	Early engagement with relevant authorities at highest level, shared programming, joined labelling for visibility
Constraints/impossibility to reach vulnerable populations	H	Foresee alternative measures, local- remote representatives, reinforce communication by phone and internet if possible, promote outreach through local leaders and community engagement[22]
Logistical constraints (transportation, delivery, blockage, delays, barriers to export/import), lack of products and equipment	H	Early engagement with national authorities and relevant clusters, policy dialogue and advocacy, negotiating exemptions to travel restrictions linked to life saving interventions.
Supply chain problems, lack of providers and/or inflation	H	Alternative options of procuring at both sub-national and national levels. Close coordination with other implementing partners for joint purchasing
Absorption capacity of implementing partners	H/M	Strong planning to ensure smooth and timely implementation, reinforcement of country office staffing, recruitment of consultants if needed, subcontract through NGOs (national and international).
Poor quality of the materials delivered	M	Strong quality control, collaboration with WHO and follow accreditation systems in place
Cash liquidity and cash fluctuations	H	Foresee cash disbursements and follow market prices in advance

The assumptions for the success of the Action and its implementation include:

- Local authorities/ governments maintain authority, and environments are safe enough to implement planned activities;
- Relevant authorities grant permissions to carry out interventions, visits and provision of services in all premises. Authorities and other stakeholders remain cooperative and facilitate support to implementing partners' staff;
- The security, public health situation and political environment allow for access and response to the needs of targeted population and will not further deteriorate to a level preventing project implementation. Access to locations is not hindered by lack of security, conflict, local authorities and leaders, government restrictions and military interventions;
- Local communities and beneficiaries understand the aim of and support the project activities;
- Target population continue to be able and willing to participate in project activities;

[22] Some guidance by UN agencies' practices has been issued. See for instance UNHCR's Operationalizing Protection during COVID-19 Case Studies and Practices from the Field, 27 March 2020.

- Safety of civilians is adequately ensured.

3.4. Mainstreaming

Human rights: Ensuring the protection of human rights is at the heart of the EU policy. Human rights, including conditions of migrants and forcibly displaced persons, is regularly addressed in the constant EU dialogue with authorities. Rights-based approach (RBA)[23] is a central part of the strategy of intervention designed under this Action and frames activities to be implemented therein. As a consequence, the Action will be implemented through a constant monitoring of RBA during all phases of the projects supported within the Action (including the principles of do-no-harm), based on the toolbox prepared by the European Commission[24].

The Action will strongly focus on the well-being and personal development of migrants and forcibly displaced populations, in full respect of their human rights. It will be based on non-discrimination principles and participation of beneficiaries as well as confidentiality and right to privacy. Protection mechanisms taking into account the vulnerability of the migrants and forcibly displaced persons will always be ensured and be at the forefront of all considerations.

Gender: This Action will be in line with EU Gender Action Plan (GAP II) which provides the framework for the EU's promotion of gender equality through external action for the period 2016-2020.

The profound conservative nature of some of the NoA countries, as well as the challenges in ensuring social protection, along with sometimes a fragmentation of the health systems, make challenging to address needs, especially for vulnerable groups, in a timely and adequate manner.

Migrant women, girls and female unaccompanied minors usually have greater needs. Gender considerations will be also integrated in recruitment procedures to ensure gender-specific assistance, planning, implementation and monitoring and evaluation of all activities.

Data will have to be collected and disaggregated by gender and age, giving particular concern to confidentiality and informed consent.

Specific activities funded by the Action will have to ensure participation of both men and women including steering committees and decision-making committees. To achieve this, right communication with target population, appropriate times and locations for activities will be designed based on their convenience to both women and men.

The Action will also ensure that attitudes and practices that contribute to discrimination against, marginalization of, or violence against women, girls, men or boys, are challenged.

[23] The implementation of an RBA is founded on the universality and indivisibility of human rights and the principles of inclusion and participation in the decision-making process, non-discrimination, equality and equity, transparency and accountability. These principles are central to the EU development cooperation, ensuring the empowerment of the poorest and most vulnerable, in particular of women and minors.

[24] 4 A Rights-Based Approach, encompassing all human rights for EU development cooperation - Tool-Box, Commission Staff Working Document, 29 April 2014 version): https://ec.europa.eu/europeaid/rights-basedapproach-encompassing-all-human-rights-eu-development-cooperation-tool-box-commission_en

Populations with **specific vulnerabilities** (women and adolescents head of households, victims of trafficking, people with physical, mental and intellectual disabilities or pregnant and lactating women) are always at the heart of EU focus and will be served using methodologies that ensure access and prevent harassment. Sensitivity to vulnerability and confidentiality is important in order to promote the wellbeing of beneficiaries. Relevant data will be sex-disaggregated to ensure aims and objectives are appropriately reaching populations.

This action seeks to increase the **resilience of migrants and forcibly displaced persons,** civil society organizations and NoA bodies in the targeted areas. This will be done through direct capacity building trainings, coordination and guidance to implementing partners. Diversification of initiatives and local partners in response to community identified priority needs will broaden the positive impact of implementation through their access to different geographic and social areas. Engagement of community members across tribal, ethnic, and national divides through inclusive activities will contribute to improved social engagement, in turn contributing to social cohesion and thus benefiting migrant members of each community.

This Action supports the design and mainstreaming of a conflict-sensitive approach, including **Do No Harm** principles according to RBA. Activities will encourage positive inter- and intra-communal interactions to promote concepts of team spirit, respect, non-violence, neutrality as well as messages of solidarity and peace. These aspects will be monitored through EUTF Third Party Monitoring exercises.

The Steering Committee will have the responsibility to adjust implementation so as to better mainstream cross-cutting issues.

3.5. Stakeholder analysis

UN agencies implementing the interventions will support and contribute to the efforts of national authorities at central and local levels, strongly coordinating with Inter-ministerial task forces and committees created to fight COVID-19, Ministries of Health and Social Affairs and other relevant bodies and institutions according to the interventions carried out both at central and at local/municipal level.

UN agencies will also work closely with the United Nations Country Teams, the Intersectoral Committees, UNOCHA and the World Health Organisation (WHO) as lead of the overall response. They will rely on existing partnerships with NGOs and CSO to boost implementation.

WHO has the global mandated action for the coordination of all outbreaks such as COVID-19 pandemic as well as a health advisory and technical support role. WHO has the operational expertise and institutional memory to implement projects in close coordination with national health authorities across the countries. It also has the operational infrastructure on the ground, warehouse and transportation capabilities, network of focal points, M&E capabilities, etc. It has a proven capacity to reach out and deliver any type and quantity of health supplies to the end users in different parts of the countries.

IOM is the leading international organisation for migration and acts with its partners in meeting the growing operational challenges of migration management, uphold the human

dignity and well-being of migrants, advance the understanding of migration issues and encourage social and economic development through migration. IOM is quite active on health too. Since January IOM is mobilised across the world to combat COVID-19 pandemic in line with WHO recommendations mainly in the pillars of risk communication and community engagement, cross border coordination, trainings, surveillance, enhance surveillance and wash services among others.

UNHCR is also a key partner with the exclusive global mandate to ensure international protection of those entitled, provide multi-sectoral assistance to refugees and asylum-seekers and seek durable solutions for PoCs. It is also responding to COVID-19 within the frame of their actions and in line with WHO priorities.

Other UN agencies such as UNICEF and WFP, as well as non-governmental organisations, are also responding to the pandemic and could be explored according to needs and gaps.

4. IMPLEMENTATION ISSUES

4.1. Financing agreement, if relevant

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

The envisaged assistance is deemed to follow the conditions and procedures set out by the restrictive measures pursuant to Article 215 TFEU.

4.2. Indicative operational implementation period

The indicative operational implementation period of this action, during which the activities described in section 3.2 will be carried out is from the adoption of this Action Document by the Operational Committee until 31 December 2024, i.e. the end of the implementation period of the EUTF for Africa. Any postponement of the expiry date of the Trust Fund, currently set at 31 December 2020, shall automatically postpone the indicative implementation end date of this action by an equivalent additional period.

4.3. Implementation modalities

The Action will be mainly implemented through indirect management (Contribution Agreement/s) with UN agencies, depending on needs assessment and gaps following art. 62(1) of FR 2018/1046. Foreseen implementing partners are the UN agencies considering their respective mandates, expertise, the local needs and existing funds.

The criteria to choose the partners will be therefore their mandate and role in the local contexts; their expertise in dealing with outbreaks and their added value; focus on health and/or resilience/basic needs and/or livelihoods preservation; focus on the most vulnerable populations targeted by EUTF; operational presence and capacity within NoA countries through national staff on the ground; presence of sub offices; network of implementing partners; remote monitoring systems in place.

In view of the required emergency response, top-ups to existing contracts entailing activities of similar nature could be considered.

Under the responsibility of the Commission's authorising officer responsible, the recourse to award of grant(s) without a call for proposals is justified because of the crisis situation in the context of the COVID-19 pandemic (ARES (2020)1792308 - 27/03/2020).

The Commission authorises that the costs incurred as soon as the action document is approved as eligible because of the crisis situation in the context of the COVID-19 pandemic (ARES (2020)1792308 - 27/03/2020).

4.4. Indicative budget

Component	Amount EUR
UN agencies and potentially grants	**10 000 000**
Total	**10 000 000**

4.5. Monitoring and reporting

The implementing partners must establish a permanent internal, technical and financial monitoring system for the action in compliance with the Monitoring and Learning System of the EUTF- North of Africa to generate data on progress of the Action on a regular basis and prepare regular progress reports and final reports. In addition to these, implementing partners will issue quarterly flash reports consisting of a two-pager following a simple template providing a description indicating milestones attained and progress achieved toward indicator targets for each output.

In the initial phase, the indicative logical framework agreed in contract and/or the agreement signed with the implementing partners must be complemented as much as possible and taking into account the character of the action with baselines, milestones and targets for each indicator[25].

In line with chapter 2.5 above, the EU Delegations will have a strong role in monitoring and coordination of the actions at national level.

Progress reports provided by the implementing partners should contain the most recent version of the logical framework agreed by the parties and showing the current values for each indicator. The final report should complete the logical framework with initial and final values for each indicator. The final report, financial and descriptive, will cover the entire period of the implementation of the action.

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).

[25] Partners will have to align and harmonise their interventions with NoA M&E framework.

The implementing partners will report on a number of relevant common EUTF indicators of the selected results for this Action[26] (see list in English/French published on the EUTF website). As relevant, other indicators can be selected and reported on from the lists of sector indicators defined with thematic units.[27]

Project Implementing Partners will be required to provide regular data, including the evolution of the actual values of the indicators (at least every three months) to the contracting authority, in a format which is to be indicated during the contract negotiation phase. The evolution of the indicators will be accessible to the public through the EUTF website (https://ec.europa.eu/trustfundforafrica/) and the Akvo RSR platform (https://eutf.akvoapp.org/en/projects/).

4.6. Evaluation and audit

If necessary, evaluation, ad hoc audits or expenditure verification assignments could be contracted by the European Commission for one or several contracts or agreements.

Audits and expenditure verification assignments will be carried out in conformity with the risk analysis in the frame of the yearly Audit Plan exercise conducted by the European Commission.

Evaluation and audit assignments can be implemented through service contracts, making use of one of the Commission's dedicated framework contracts or alternatively through the competitive negotiated procedure or the single tender procedure.

4.7. 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, which will be developed early in the implementation. The measures are implemented by the Commission, the partner country, the contractors, the beneficiaries and/or the entities responsible in terms of legal obligations regarding communication and visibility. Appropriate contractual obligations will be included in the grant agreements as well as contribution agreements etc.

Communication and visibility requirements for the European Union are used to establish the communication and visibility plan for the action and the relevant contractual obligations.

[26] EN: https://ec.europa.eu/trustfundforafrica/sites/euetfa/files/eutf_results_indicators_41.pdf
FR: https://ec.europa.eu/trustfundforafrica/sites/euetfa/files/eutf_results_indicators_41_fr.pdf
[27] http://indicators.developmentresults.eu User name/password: results.

List of acronyms

AD	Action Document
Africa CDC	Africa Centres for Disease Control
CSO	Civil Society Organisations
DC	Detention Centre
DTM	Displacement Tracking Matrix
ENI	European Neighbourhood Instrument
EU	European Union
EUDEL	European Union Delegation
EUTF	European Union Emergency Trust Fund
GAP	Gender Action Plan
GBV	Gender Based Violence
GDP	Gross Domestic Product
GNA	Government of National Accord
GoE	Government of Egypt
HMIS	Health Management Information Systems
HRP	Humanitarian Response Plan
ICU	Intensive Care Unit
IDP	Internal Displaced Person
IHR	International Health Regulations
IMF	International Monetary Fund
IOM	International Organisation for Migration
IPC	Infection Prevention and Control
LCG	Libyan Coast Guard
LNA	Libyan National Army
MENA	Middle East and North Africa
MHPSS	Mental Health and Psychosocial Support
MoHP	Ministry of Health and Population
MoSS	Ministry of Social Solidarity
MS	Member States
NCDC	National Centre for Disease Control
NFI	Non-Food Items
NGO	Non-Governmental Organisation

NoA	North of Africa
NPI	Non Pharmaceutical Interventions
OAU	Organisation of African Unity
OCHA	Office for the Coordination of Humanitarian Affairs
OPD	Out Patient Department
PHC	Primary Health Care
PoC	Person of Concern
PoE	Port of Entry
PPE	Personal Protective Equipment
RBA	Rights Based Approach
RRM	Rapid Response Mechanism
SAR	Search and Rescue
SDGs	Sustainable Development Goals
SOPs	Standard Operating Procedures
UN	United Nations
UNCT	UN Country Team
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund.
WHA	World Health Assembly
WHO	World Health Organisation

Annex: Indicative Logical Framework Matrix

Additional note: The term "results" refers to the outputs, outcome(s) and impact of the Action (OECD DAC definition).

	Results chain: **Main expected results (maximum 10)**	**Indicative Indicators** **(at least one indicator per expected result)**	**Sources and means of verification**	**Assumptions**
Impact (Overall objective)	To contribute to reduce acute vulnerabilities and improve resilience in light of the COVID-19 pandemic in NoA countries. (EUTF NOA Strategic Objective 3. To strengthen protection and resilience of those in need)	Average degree of resilience of individuals. Average scores on the "Connor-Davidson Resilience Scale (CD-RISC)"	To be collected by EU via external assistance	*Not applicable*
Outcome(s) (Specific Objective(s)	To respond to emergency needs related to the effects of the COVID-19 crisis on NoA countries, focusing on migrants and forcibly displaced persons, especially the most vulnerable and at risk among them, as well as their host communities. (EUTF NOA Specific Objective 3.V. Access to and quality of services for target groups and host communities is improved)	% of migrants and forcibly displaced people supported by the Action disaggregated by gender and age (all types of assistance)	To be collected by EU via external assistance	Local authorities/ governments maintain authority, and environments are safe enough to implement planned activities; Relevant authorities grant permissions to carry out interventions, visits and provision of services in all premises. Authorities and other stakeholders remain cooperative and facilitate support to implementing partners'
Immediate outcome 1	Provide urgent, short-term emergency response to the COVID-19 health crisis and the resulting humanitarian needs	1.1.% of migrants and forcibly displaced people accessing health care when needed disaggregated by gender and age 1.2. % of migrants and forcibly displaced people receiving health support 1.3. % of migrants and forcibly displaced people receiving socio-economic assistance (cash and other assistance)	1.1. 1.2. Partner reports, medical reports	

Output 1.1.	Safe spaces for the most vulnerable populations provided	1.1.1. # of migrants and forcibly displaced people supported with safe spaces disaggregated by gender and age and other vulnerabilities (UASC) 1.1.2. # of migrants and forcibly displaced people quarantined in quality spaces disaggregated by gender and age and other vulnerabilities (according to needs) 1.1.3. # of safe spaces for migrants and forcibly displaced populations improved through infrastructure rehabilitation	1.1.1; 1.1.2; 1.1.3: Engineering works, plans, progress reports, photos	staff; The public health situation and political environment allow for access and response to the needs of targeted population and will not further deteriorate to a level preventing project implementation; Access to locations is not hindered by security, public health concerns, conflict, local authorities and leaders, government restrictions and military interventions; Local communities and beneficiaries understand the aim of and support the project activities; Target population continue to be able and willing to participate in project activities; Safety of civilians is adequately ensured.
Output 1.2	Immediate services are provided: health, housing, food, NFI, cash-support, psychological and psychosocial support	1.2.1. # of migrants and forcibly displaced persons provided medical consultations in PHC disaggregated by gender and age 1.2.2. # of migrants and forcibly displaced persons referred to hospitals disaggregated by gender and age 1.2.3. # of migrants and forcibly displaced persons hospitalized disaggregated by gender and age 1.2.4. # of migrants and forcibly displaced persons supported with food/cash	1.2.1; 1.2.2; 1.2.3. 1.2.4 : Partner reports, Medical reports, Distribution lists	
Output 1.3	Health facilities and health staff supported (including protective equipment and IPC measures)	1.3.1. # of PPE delivered 1.3.2. # of relevant health personnel trained 1.3.3. # of test kits/reagents supplied for laboratory and effectively used 1.3.4. # of health facilities supported with drugs, lab equipment, infrastructure, HMIS and/or training	1.3.1; 1.3.2; 1.3.3. 1.3.4 : Health facilities reports, lists material distributed, equipment lists, hand over forms, attendance lists	
Output 1.4	Risk communication and community engagement initiatives implemented	1.4.1. # of communities/municipalities with community engagement plans developed 1.4.2. # of risks communication plans supported with specific measures (drafting, disseminating, publishing, etc) 1.4.3. # of people reached for awareness raising and distribution of PPE materials disaggregated by gender and age	1.4.1; 1.4.2; 1.4.3. 1.4.4 : photos, partners' reports, report from field staff, municipalities reports	
Output 1.5	Services to vulnerable groups at Ports of entry (PoE) are provided	1.5.1. # of PoE effectively working 1.5.2. # of people provided services at PoE 1.5.2. # of health-related SOPs developed at PoE	1.5.1; 1.5.2: engineering work, photos, partners' report	
Output 1.6	Supports for medium term needs are provided	1.6.1. # of cash for work services provided 1.6.2. # of microbusinesses supported	1.6.1; 1.6.2: Beneficiaries' lists, partners'reports	