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-NOA-LY-12** **Protecting most vulnerable populations from the COVID 19 pandemic in Libya**
Zone benefitting from the action / Localisation	Libya
Total cost	Total estimated cost: 21 682 863EUR Total amount drawn from the Trust Fund: 21 000 000 EUR Co-financing UNICEF: USD 585 199 (pledged amounts from other donors) (estimated value in EUR: 500 000) Co-financing WHO: 144 661 EUR Co-financing IMC: 38 202 EUR
Aid modality(ies) and implementation modality(ies)	**Indirect management** through Contribution Agreements with UN agencies Activation of the fall-back option (direct management - grants) as foreseen in section 4.3
DAC – codes	72011 - Basic health care services in emergencies 12250 - Fight against infectious diseases 15190 - Facilitation of orderly, safe, regular and responsible migration and mobility 16050 - Multisector aid for basic social services
Main delivery channels	41037 – World Health Organization (WHO) 47066 – International Organization for Migration (IOM) 41122 – United Nations Children's Fund (UNICEF) 21000 – International Medical Corps (IMC)
Markers	

Policy objectives	**Not targeted**	**Significant objective**	**Principal objective**
Participatory development / good governance	☐	X	☐
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
	COVID marker	☐	☐	X
	Digitalisation marker	X	☐	☐
SDG	SDG 3 Good Health And Well-being SDG 6 Clean Water and Sanitation SDG 10 Reduced inequalities SDG 16 Peace, Justice, and Strong Institutions SDG 17 Partnerships			
Valetta Action Plan Domains	3. Protection and asylum			
Strategic objectives of the Trust Fund	EUTF Objective 3. Better migration management; EUTF NOA Strategic Objective 3. To strengthen protection and resilience of those in need			
Beneficiaries of the action	At least 963,332 beneficiaries will benefit from this action[1].			
Derogations, authorised exceptions, prior approvals	The European Commission authorises 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). Retroactivity to the actions financed by this AD 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 European Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realisation of this action impossible or exceedingly difficult. 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.			

[1] IOM: 120,000 members of vulnerable groups, such as migrants and forcibly displaced people benefiting from health assistance and multi-sectoral services; WHO: Total direct beneficiaries around 643,332, distributed across the main pillars of the response: Case Management - 14,143; National Coordination - 162; RRT - 50,946; National Laboratory - 67,186; RCCE - 1,270; IPC - 1,600; and Maintaining Essential Health Services - 508,015; UNICEF: An estimated 200,000 persons benefitting from IPC/WASH, protection, and/or essential and lifesaving health supplies. The IMC intervention will additionally benefit around 30.000 people (to be specified at the moment of the contract signature).

2. RATIONALE AND CONTEXT

2.1. Summary of the action and objectives

The **overall objective** of the action is to prevent the spread of COVID-19 and to reduce avoidable morbidity and mortality in Libya. This corresponds to EUTF North of Africa Window (EUTF-NOA) Strategic Objective 3: to strengthen protection and resilience of those in need.

The **specific objective** is to provide specialised support to the Libyan authorities to address COVID-19 related challenges as well as assist the most vulnerable population in Libya, in particular (but not exclusively), migrants and forcibly displaced persons[2]. This aligns with Specific Objective 3.V: Access to and quality of services for target groups and host communities is improved.

This Action is aligned 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 two first components being the first one "Urgent, short-term emergency response to the health crisis and the resulting humanitarian needs" and the second "Support to strengthen research, health and water systems". The third objective, tackling the economic and social consequences, will be partially addressed.

In the absence of a Libya comprehensive preparedness and response plan, the Action is 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, UNICEF and other UN agencies. In addition to this, it is aligned to the preparedness and response plan to address the threat of corona virus launched in the country by the National Centre Diseases Control (NCDC).

The health cluster within the country has developed a COVID-19 plan consolidating activities of 14 UN Agencies and INGOs, amounting to USD 15 million for immediate health response and structured through nine basic pillars: 1: Coordination; 2: Risk communication and community engagement; 3: Surveillance, rapid response teams and case investigation; 4: Points of entry; 5: National laboratory; 6: Infection prevention and control; 7: Case management; 8: Operational support and logistics; 9: Maintenance of essential services. The Libya Humanitarian Response Plan (HRP) has also been reviewed (end April 2020) to contemplate COVID-19 direct and indirect needs[3].

This Action will be structured through three main outcomes, namely: i) Support to **coordination mechanisms**, detection and surveillance; ii) **Preventive measures** to decrease risks and support most vulnerable groups and iii) **Public health response** to the health crisis

[2] Including returnees, stateless people, asylum seekers, refugees, internally displaced persons as well as their host communities, conflict-affected population, especially children, women, and groups with specific needs, hereinafter "migrants and forcibly displaced persons".

[3] Overall total HRP requirements linked to COVID-19 response are of USD 102,104,149 (USD 23,913,499: direct contribution to COVID-19 response and USD 78,190,651: indirect contribution to COVID-19 response). Out of the USD 102 million, USD 30.8 million are just for the period from April to June 2020.

and humanitarian needs. Within the framework of these three outcomes, the nine pillars (named outputs in the log-frame of this Action) will be tackled to the extent possible.

2.2. Context

2.2.1. *International and regional context*

International context

On 31 December 2019 a cluster of pneumonia of unknown origin was reported in Wuhan City, People's Republic of China. The virus spread fast, affecting all continents which led to WHO announcing a pandemic on 13 March 2020. As of 23 May 2020, according to WHO, there are over 5.1 million cases reported globally and more than 337,000 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 straining communities, increasing calls for social protection, shrinking business activity and disrupting supply chains, with repercussions for social stability and security as a consequence of NPI (Non Pharmaceutical Interventions) and containment measures that have been enforced in most countries. In addition to the health impact of COVID-19, a broad range of socio-economic and psycho-social impacts are already visible. Inequalities are being 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 specific medical equipment for intensive care, there have been shortages of essential equipment needed by both the health workforce and the general public to limit the spread of the virus. Socio-economic shocks are 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 are seeing the availability of work suddenly reduced without having access to social support measures, and may resort to negative coping strategies. Their access to health systems, usually insufficient for their needs, is likely to be further reduced as health systems struggle to maintain "normal operations" while tackling a major crisis.

Overall impact at region level and in Libya

All countries in the MENA region have implemented containment measures, enforced curfew 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 businesses. Cuts or suspension of salaries are to be expected.

[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.

In Libya the health system has already seen a continuous deterioration linked to the conflict, with closure of health facilities, lack of human resources and drugs. Measured against the International Health Regulations (IHR) average of readiness in the EURO WHO region is at 73%, while in Libya is at 41%.

Although the last census in Libya took place in 2006, the demographic structure of the North Africa region is similar to that the of the EU with the elderly representing a growing share of the population and a prevalence of the underlying conditions recognised as risk factors for COVID-19.

Vulnerable groups

The longer-term impact of COVID-19 on migrants and forcibly displaced persons is difficult to predict. However, migrants and forcibly displaced persons are particularly vulnerable[5] to the impact of the COVID-19 pandemic due to restricted access to health services, restricted legal recognition, and restricted access to national social protection mechanisms, as well as limited social networks to draw on. They may further encounter language and cultural barriers and suffer from stigma, or even alleged blame for the disease. In Libya, they often live in densely populated areas, or in overcrowded facilities, often experiencing limited or lack of adequate water and sanitation infrastructure. Many of them are not only living but working in high risk conditions for contagion.

The risks for these groups are increased by a both a lack of awareness of the necessary prevention measures and the difficulties to implement, for example, physical distancing. Social isolation, language barriers, and the conflict increase the vulnerability of migrants and forcibly displaced persons during the pandemic. In particular in Detention Centres (DCs) in Libya, isolation measures are difficult to implement, given the overcrowding, and risks are increased by restricted access to water and poor hygienic conditions.

The EU response aims at protecting, assisting and advocating for these groups in line with EU's values and commitments.

Health impact

71% of the migrants interviewed in DTM Round 29 (January – February 2020) faced constraints in accessing health care before the COVID-19 outbreak[6]. In addition, the measures taken to contain the virus have led to a sharp rise in food prices across Libya, with an apparent increase of 50% or more being reported in most cities and occasional spikes of up to 900%. As a consequence, migrants have reported having limited access to adequate food and other essential goods. Preliminary findings of IOM DTM's Emergency Food Security Assessment[7] conducted in April 2020 confirmed rising migrant food insecurity driven by increasing unemployment rates, with one third of migrants reporting insufficient food consumption.

[5] 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

[6] International Organization for Migration (IOM), 2020. DTM Migrant Report R29. http://dtm.iom.int/libya

[7] International Organization for Migration (IOM), 2020. *Migrant Emergency Food Security Assessment – Preliminary Findings.* https://dtm.iom.int/reports/libya-%E2%80%94-migrant-emergency-food-security-assessment-preliminary-findings-may-2020

In Libya, treatment of infected migrants and forcibly displaced persons will face not only the difficulties of their restricted access to health care systems, but also suffer from the way COVID-19 measures are affecting humanitarian partners' work. Restrictions on movement, constrain their ability to deliver aid to migrants who depend on it. Nevertheless, implementing partners are negotiating exemptions with Libyan authorities in order to be able to continue their interventions.

COVID-19 measures have also disrupted the delivery of critical essential healthcare services. For instance, routine vaccinations have stopped on most sites since 18th March 2020 due to the lack of preparedness measures and availability of PPEs for the staff working at health facilities. The overall vaccine stock has declined and no new purchasing orders have been approved by the Central Bank. Immediate measures are therefore required to ensure uninterrupted availability of vaccines against childhood diseases and adequate protective measures. Any delays could put children, and the whole country, at risk of additional outbreaks of disease.

Economic impact, vulnerable groups

Libya's mitigation measures in response to COVID-19 have to be seen against a context of 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. The necessary measures taken by Libya to stop the spread of COVID-19, have increased economic hardship, in a country already strained by war and the fuel blockade. At the same time as incomes are reduced, the prices of food, other commodities and the general cost of living have gone up. Libya Joint Market Monitoring Initiative observed increases in cost of living by as much as 50.4% in certain cities.[8].

Although the vast majority of migrants interviewed in Libya through DTM in January and February 2020 reported being employed (83%), the restrictions placed on freedom of movement in Libya as a public health measure to counter the spread of COVID-19 are expected to increase migrant workers' unemployment and may lead to negative coping mechanisms[9]. Much of the work available to migrant labourers is temporary and insecure and has dried up as a result of the curfews. There is also a prejudice against hiring migrants because of fears that the overcrowded housing that many live in places them at a higher risk of infection.

Unemployment is listed as one of three key factors for migrants' vulnerability in Libya in successive DTM reports.

Other Impacts

[8]Libya Joint Market Monitoring Initiative (JMMI) April 02, 10, 2020. https://www.impact-repository.org/document/reach/a67a3694/REACH_LBY_Situation-overview_JMMI_April-2020-Week-1.pdf

[9] The coping capacity of migrants has been assessed using the Livelihood Coping Strategies, which measures the extent to which individuals engage in longer-term alteration of income earning or food production patterns and one off responses such as asset sales to meet their immediate food security needs in times of crisis or shock. One of the most frequently adopted strategy is reported to be "consuming less preferred or less expensive food", together with "limiting portion sizes", "reducing the number of meals" and "increasing short food supplies through borrowing food or relying on help from family or relatives".

One of the most concerning risks from the pandemic is that further stigmatisation of migrants and forcibly displaced persons could increase fuelling perception of migrants and forcibly displaced persons as virus bearers or spreaders. Stigmatisation increases risks that these populations hide symptoms or fail to present for treatment.

While conditions in Libya worsen both the evacuation programme of the UN High Commissioner for Refugees (UNHCR) and the IOM's voluntary return scheme have been temporarily put on hold as a consequence of the closing of air space and borders. The deteriorating conditions, coupled with the lack of alternative routes out of the country, might further drive migrants to risk dangerous attempts to cross sea or land borders. With the help of information campaigns, the amount of these dangerous attempts can be reduced. Another concern are the forced deportations of migrants, mainly in the east, that have been reported[10]. On the other hand, it has been reported that migrants in some DCs may be now unwilling to leave due to fears of the virus. Another outcome to monitor is the potential for economic hardship outside of Libya. If incomes collapse and living standards drop further, migratory pressures from sub-Saharan Africa will increase. At the same time, even if the situation remains fluid, communities in southern Libya might be confronted with a potential increase or adaptation of smuggling dynamics[11].

The pandemic is also having a significant impact on children, particularly those from vulnerable groups. The closure of schools will affect the learning growth of children. Loss of household income following enforced measures to control the pandemic will have adverse effects on the financial capacity of parents and caregivers to access the basic goods and services essential to meeting children's needs. Control measures that do not account for the gender-specific needs of girls, as well as women, may furthermore increase their exposure to protection risks and negative coping mechanisms such as early marriage or child labour.

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*".

"*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*

[10] https://www.iom.int/sites/default/files/situation_reports/file/april_2020_iom_libya_monthly_update.pdf

[11] Smugglers are resilient and adaptable. Since the significant public clampdown on people smuggling in March, in response to the COVID-19 threat, there have been no equally prominent anti-people-smuggling operations. Smugglers seem to have adapted to the stricter policies in Libya by taking alternative routes, and migrants continue to travel, although at lower rates than before the crisis. Low-level and clandestine smuggling seems to have continued along alternative routes. Smugglers will likely continue to show resilience and versatility.

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 contribute to addressing short-term emergency needs arising from the virus with a special focus on migrants and forcibly displaced persons, as well as strengthening health support including through nutrition, water and sanitation, to respond to the impact of the current pandemic but also to strengthen resilience against future outbreaks and boost the capacities of the health system to provide essential services, in line with national priorities. The socio economic impact on the most vulnerable populations will be taken into account in the choice of actions.

2.2.2. *Sector context: Libya health system and COVID-19 response*

Libyan health system and most vulnerable populations

The COVID-19 pandemic came at a moment of extreme fragility as the Libyan health system is severely under-equipped to face the challenge that COVID-19 presents. Nine years of instability and insecurity have affected the wellbeing of the Libyan population. With the beginning of the conflict and the following years of instability and with the reduced number of qualified medical professionals, the health system has heavily suffered. Many public health care facilities have been directly attacked or damaged due to fighting and as a consequence they are closed. Some of those that are open are often overburdened or lack staff, medicines, supplies and/or equipment. Health challenges in Libya tackle all main health pillars (financing, governance, human resources, drugs and equipment, service delivery and health information system). The government's financial inputs are mainly limited to disbursing salaries, with no or very little allocation for equipment and medical consumables. The Libyan public health system is also challenged by divided governance structures, unclear decentralization and with no real mid-long-term strategy to rebuild the public health system.

While the Libyan health system in principle does not discriminate, in practice, very often migrants and forcibly displaced persons are underserved due to lack of resources and due to their legal status[12]. Their access to the health system is often limited to private hospitals, greatly adding to treatment costs, and/or to finding opportunities with INGOs, thus heavily relying on humanitarian community health partners for service delivery and supported referral to these private health facilities.

COVID-19 response in Libya: overview

[12] Migrants and forcibly displaced persons are disproportionally affected due to their legal situation and by the fact of not having full access to the public health system. According to IOM Libya's Displacement Tracking Matrix, 71% of migrants have limited or no access to health services.

While as of 22 May 2020, 72 cases and 3 deaths[13] have been confirmed in Libya showing that for the time being the country is containing the spread, the shortage of test kits and deficiencies in the surveillance systems suggest that the real spread of the infection cannot be predicted. Points of entry (PoEs) to screen travellers arriving from affected areas have been established at three airports (Mitiga, Misrata and Benina), four seaports and border entry points at Ras Jdder, Wazen and Msaed.

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, fighting in and around Tripoli has increased since the beginning of the pandemic, including several attacks on health facilities[14]. MoH has released case management guidelines, but it seems unlikely that the comprehensive preparedness and response plan for Libya will be released soon.

The national preparedness and response plan concerning COVID-19 launched by NCDC has been reviewed by WHO and the MoH has already circulated comprehensive COVID-19 case management guidelines. Both GNA and LNA have taken measures to fight the pandemic and they have created their own scientific COVID-19 committees with functions mainly linked to the local follow-up of the pandemic and recommendation to the political level on appropriate measures to take. Measures taken differ so that in the west a 24/7 curfew was imposed (just for 10 days and a reduced curfew from1800 to 0600 applies since 28 April), while the east applies a 12 hours/day curfew. With the exception of grocery stores and pharmacies, all shops have been closed and circulation by car has been banned. Schools and banks have been closed and 90% of public sector employees requested to work from home.

At the beginning of the spread of COVID-19 in Libya, the Prime Minister announced that LYD 500 million (approximately USD 351 million) would be released for the COVID-19 response. While the MoH is using LYD 100 million for procurement of equipment and medical consumables and the NCDC is using some LYD 6 million for coordination, the big effort of the authorities is to be highlighted, but there is no full transparency on the money flow yet, making need assessment and harmonization of the response difficult.

In addition, the MoH issued a decree transferring the management and financing of primary health services to municipalities. On 30 March 2020, the authorities announced that LYD 75 million (approximately USD 52.6 million) had been allocated for municipalities across the country for procurement of essential equipment and consumables. Some municipalities refused to accept the money preferring that procurement is handled at central level. While preparedness measures are being undertaken both in east and west, the south is more remote and needs special attention, especially in view of recent increase of cases and weakness of the health system in this region.

WHO is working on the basis of a nine pillar plan already mentioned (Pillar 1: Country Level Coordination, Planning and Monitoring; Pillar 2: Surveillance, Rapid Response Team and Case Investigation; 3: National Laboratories; 4: Case Management; 5: Infection Prevention

[13] Cases rapidly increasing in the south

[14] Based on data from January-May 2020, Libya is the country with the highest number of attacks on health care in the world followed by Afghanistan and Syria.

Control/WASH; 6: Risk Communication and Community Engagement; 7: Operational Support and Logistics; 8: Points of Entry; 9: Maintaining Essential Health Services), under which the international community has aligned its support. To date, every single pillar has important shortcomings due to difficulties in coordination and leadership.

The Libyan health system has difficulties to rapidly scale up the testing capacities: while test kits and machines are finally arriving, there are several complications to move the equipment out of Tripoli, ultimately affecting the much-needed testing surge country-wide. The identification of health structures is still lagging behind, with obstacles to fulfil COVID-19 safety requirements in an escalating military offensive. The ongoing specific training for health responders is hampered by protests brought about by delays in paying health staff salaries while routine medical services have been interrupted (i.e. vaccination). The lack of a solid network of community health workers along with difficulties to access health facilities, also favours the spread of fake news and information.

Other sectors are also facing the secondary impacts of the outbreak and have mobilized responses. In mid-March, the Ministry of Education (MoE) announced the closure of schools for two weeks, since then extended indefinitely as it is happening in several countries. To reduce the impact on children, the MoE, with the support of UNICEF has put in place education classes through TV channels and is exploring opportunities to conduct interactive sessions through the internet. UNICEF is also supporting the MoE both on the short term by developing instruments to measure the TV education programme outreach, conducting an awareness campaign to inform parents of the availability and importance of distance learning, but also on the long term by supporting plans to ensure a safe return to school.

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

EUTF is the most important financial instrument for migrants and forcibly displaced persons in Libya. With an important component on protection and on health, EUTF has the capacity to react and partially contribute to the response to some of the most pressing needs originated by the pandemic as well as promote the inclusion of migrants/refugees into COVID response actions, including their access to health and other essential services. As much as possible and depending on Implementing Partners' capacities, through different funding instrument (e.g. EUTF, ENI, ECHO), the EU is already refocusing some components of its current interventions, mainly those addressing health, in response to more pressing needs linked to the COVID-19 outbreak. EUTF's current partners such as IOM, UNHCR, UNICEF, IRC, IMC, GIZ, AICS, UNDP, UNFPA and CESVI, among others, are increasing their activities in relation to COVID-19 in different domains, such as awareness raising, risk communication and community engagement, distribution of hygiene kits supplies, socio economic measures for most vulnerable, medical equipment procurement, drugs supplies and disinfection and fumigation in DCs. By 20 May 2020 at least €1,3m have been reoriented to respond to COVID-19 pandemic.

At the same time, implementing partners are struggling to maintain access and be compliant to curfews and restriction of movements while maintaining the safety of their staff. To respond to beneficiaries in urgent need of assistance, especially upon disembarking in Libya, IOM has been granted authorization to provide such assistance beyond curfew. WHO has successfully managed to reach agreements with the authorities across the country to provide

exemptions for staff and non-staff movement and cargo transportation[15]. UNICEF, has been able to continue operations through obtaining the necessary permissions from the local authorities to deliver assistance during curfew hours and through working with national partners[16]. Where possible, implementation modalities have also been adjusted and taken on-line to ensure critical assistance continues to be delivered while observing the current restrictions.

The impact on migratory movements is difficult to assess as the situation remains fluid. Restrictions of access to territories imposed by various entities may have contributed to temporary blockages of both regular movements and irregular migration. However, this has the potential to turn into increased internal displacements or accumulations of irregular migrants who might be in need of assistance. In Libya, unpredictable SAR capacity to intervene of the Libyan coast guard together with increasingly difficult situation for migrants and forcibly displaced persons, along with the economic shock and decrease in employment and living standards, may add to the wish to leave the country. At the same time, these circumstances and the imposed mobility restrictions, confinement and border closures with neighboring countries, could also make irregular crossings departing from Libya riskier.

2.3. Lessons learnt

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

- Do not leave anyone behind: Strive for finding the most vulnerable populations affected;
- Health systems are essential for the response to COVID-19 but health depends on much more factors than solely the health system: social determinants of health (information; education; water and sanitation; nutrition; income…) are crucial in the health status of the population and have to be tackled;
- Importance to respond to more pressing needs while as much as possible reinforcing health systems comprehensively involving all its pillars to be able to respond to the current pandemic and the ones that may come afterwards while keeping or scaling up capacity for resolution of current pathologies, health promotion and prevention;
- Confinement measures have increased protection risks for women, girls and boys, including exposure to violence, and have impacts on their overall well-being. A care crisis is also unfolding, with heightened risks related to family separation, the lack of parental or family care and the lack of alternative care options.

[15] WHO offices in Tripoli, Benghazi and Sabha continued to be operational. 10 field coordinators were actively deployed in the field. During March-April 2020 WHO de livered 170 tons of essential health supplies across the country to 100 health facilities. The biggest constraint was the transportation aspect.
[16] Such as the Libyan Red Crescent, who is largely exempt from the COVID-19 restrictions.

- Discrimination against refugees and migrants from sub-Saharan Africa is a barrier to accessing healthcare and protection services, especially for women. A recent survey showed that more female refugees and migrants perceived discrimination as a barrier to healthcare and other services in comparison to their male peers.
- It is important that health interventions include an extensive awareness and community engagement strategy. Evidence-based strategies informed by the identification of major gaps and bottlenecks, as well as effective coordination between UN agencies, are also important success factors.

2.4. Complementary actions and synergies

The magnitude of the pandemic obliges to promote complementary actions to face the challenges ahead. At global level on 25 March UNOCHA launched a major humanitarian appeal to face COVID- 19, mitigate its impact particularly on fragile countries with weak health systems, and strengthen ongoing Humanitarian Response Plans (HRP). Total needs amount to USD 2.1 billion (EUR 1.86 billion). This amount represents the additional humanitarian needs originated by COVID-19 in all countries with already ongoing humanitarian need plans.

In February 2020, WHO had released the Strategic Preparedness and Response Plan to 2019 Novel Coronavirus amounting USD 675,680,427. WHO field offices were at the same time updating their needs and preparedness and response plans. It is worth to note here that the decision to freeze American contribution to WHO will have an impact also on country operations and on the much precious coordination role WHO is playing in the pandemic.

IOM launched an appeal in March (reviewed in April), outlining funding requirements of USD 499 million across 140 countries to tackle four key strategic priorities at the community, national and regional levels: i) effective coordination and partnerships as well as mobility tracking; ii) preparedness and response measures for reduced morbidity and mortality; iii) efforts to ensure that affected people have access to basic services, commodities and protection and iv) to mitigate the socio-economic impacts of COVID-19.

UNICEF MENA is appealing for USD 287 million including USD 16.1 million for Libya, in the key areas of risk communication and community engagement, WASH/IPC, child protection, and education in emergencies.

The Libya HRP, coming from pre-pandemic assessments, sought a total of USD 115 million in order to support 345,000 among the most vulnerable. This plan, so far backed to 5%, foresaw about US$ 30 million specifically for health (with confirmed pledges for about 7.5%). In light of COVID-19[17] a further USD 38.8 million have been pledged. It is worth to mention here that while needs are evolving and will most probably increase as the socio-economic implications unfold, it is extremely difficult to have a clear overview of contributions made in the specific polarized context of Libya. The Inter-Sector Coordination Group (UNOCHA Libya) has been working with sectors to identify activities, either within

[17] Data are evolving and can be checked at https://fts.unocha.org/appeals/931/summary [last checked on 15.05.2020]

the 2020 HRP or new interventions, which will complement a multi-sector COVID-19 response within the HRP[18].

The absence of a comprehensive national preparedness and response plan to COVID-19 also makes it difficult to pinpoint and estimate needs in terms of hospital preparedness and needs to support human resources, equipment and commodities[19]. The uncertainty on the use of domestic budget as well as external donations, mainly from non-OECD countries, greatly limits the coordination of the distribution of aid.

This Action will strongly coordinate with new AD T05-EUTF-NOA-LY-11, focusing on protection, and new AD T05-EUTF-NOA-LY-13, focusing on community stabilisation. The latter focus more on the third component of the Joint Communication while this one is mainly focused on the second component and also on the first one.

2.5. Donor coordination

In light of the magnitude of the challenges ahead, an effective donor coordination is vital. The European Commission has been mobilising all financial instruments at its disposal to help the EU Member States coordinate their national responses.

Visegrad 4 donors took a particular interest in supporting the reallocation of funds from programme: Support to integrated border and management – Phase II in Libya, in order to finance the present Action Document.

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

- The dedicated COVID-19 national coordination structures set up by Libyan authorities to coordinate the response to the outbreak with relevant partners, including NCDC;

[18] End April 2020, the released revision of the HRP to contemplate COVID-19 direct and indirect needs amounts to USD 102,104,149 (USD 23,913,499: direct contribution to COVID-19 response and USD 78,190,651: indirect contribution to COVID-19 response). Out of the USD 102 million, USD 30.8 million are just for the period from April to June 2020.

[19] COVID-19 Health Sector Plan coordinated by WHO stands at USD 15 million, with around USD 4.5 million received as of 11 May (30% of the funding requirement), mostly due to internal reprogramming. The 10 April IOM Libya launched an appeal of USD 7.5 million (from April to December) with interventions tackling coordination and partnerships; risk communication and community engagement; disease surveillance; PoE; national lab system; IPC wash; case management and continuity essential services; protection; displacement matrix; socioeconomic impact. As of the 12 May 2020, UNICEF Libya's COVID-19 preparedness and response plan was estimated at USD 16.1 million. UNICEF's response addresses needs in risk communication and community engagement, IPC and critical medical and WASH supplies, direct and secondary impacts on protection and education, and data collection and analysis of secondary and socio-economic impacts. UNICEF's response plan also contributes towards the UNICEF Country Programme and the HRP.

- Central, regional and local authorities;
- Development Partner Groups, Humanitarian Coordination Teams, Health Cluster and WHO;
- Regular interactions with CSO, INGOs, NGOs, beneficiaries.

A regional programme on Health Security was recently launched under ENI. It will be implemented by the European Centre for Disease Prevention and Control (ECDC). It will cover Southern, Eastern Neighbourhood and Enlargement Countries and it will focus on strengthening of epidemiological capacities in third countries and a more effective interfacing with ECDC lead network.

The EU Delegation in Libya will ensure coordination and alignment with national priorities and avoid overlaps with other funding within the framework of international and national plans and appeals as described in the previous section. A parallel financing decision under ENI on strengthening the Libyan health system has been developed in cooperation with the EUTF and seeks to improve long-term health system support beyond the COVID-19 crisis. 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.

With regards to COVID-19 coordination in particular, the UN community in Libya has acted early by establishing a COVID-19 dedicated operational group under OCHA leadership. While overall coordination of COVID-19 response across the country is facilitated by WHO, each agency is actively participating as per their mandate and comparative advantages. In Libya, EUDEL has been so far backing the coordination role of WHO and UNSMIL for the COVID-19 crisis.

3. DETAILED DESCRIPTION

3.1. Objectives and expected outputs

The **overall objective** of the action is to prevent the spread of COVID-19 and to reduce avoidable morbidity and mortality in Libya. This corresponds to EUTF NOA Strategic Objective 3: to strengthen protection and resilience of those in need.

The **specific objective** is to provide specialised support to the Libyan authorities to address COVID-19 related challenges as well as assist the most vulnerable populations in Libya, in particular (but not exclusively) migrants and forcibly displaced persons. This aligns with Specific Objective 3.V: Access to and quality of services for target groups and host communities is improved.

The indicative logical framework below follow the 9 pillars approach so far implemented by the international community in Libya. Each pillar encompasses an early phase entailing life-saving and rapid response activities as well as activities that aim to preserve and increase the capacity of the health system. It is important to note also the time-dimension of each activity: with the aim of covering the entire country by the end of implementation, most of the activities will necessarily start where conditions permit an immediate roll out and further expand to new areas when needed and permitted by field conditions.

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:

Outcome 1: **Coordination mechanisms and improved detection through surveillance**

Coordination mechanisms are essential to strengthening relevant capacities and responses in a strategic way. In addition, capacity for good health surveillance is essential to contain the spread of the virus and strengthen the health system. Outputs will include:

Output 1.1. Coordination to deliver strategic, technical, and operational support through existing mechanisms and partnerships increased (*Pillar 1*).

Output 1.2. Epidemic intelligence through real-time surveillance systems for rapid detection of suspected cases and verification of COVID-19 and comprehensive and rapid contact tracing enhanced (*Pillar 3*).

Output 1.3. Mobility and displacement tracking and analysis of internal mobility trends that may impact disease spread enhanced (*Pillar 3*).

Outcome 2. Preventive measures to decrease risks and protect vulnerable groups

Establishing preventive measures is an urgent need to reduce chances of the disease spread. This is of particular importance among vulnerable populations, such as populations on the move with low ability to practice social distancing and living in poor sanitary conditions. Outputs will include:

Output 2.1. Awareness of how to prevent spread of COVID-19 in the population, including migrants and host commmunities. though risk communication and community engagement strategy raised (*Pillar 2*).

Output 2.2. Health measures at point of entries (POE) for travelers to detect imported cases implemented (*Pillar 4).*

Output 2.3. Infection prevention and control procedures in healthcare facilities, DCs and shelters hosting migrants, schools and local communities to protect health care workers and beneficiaries from infection by COVID-19 implemented (*Pillar 6*).

Output 2.4. Access to WASH services and a clean environment through fumigation and disinfection increased (*Pillar 6*).

Outcome 3. Response to the public health crisis and humanitarian needs

The outbreak of COVID-19 has taken its toll on the most vulnerable populations already facing protection risks, thus calling for immediate action. Depending on future developments, the pace of recovery and geographic differences, actions will be modulated as appropriate. Outputs with include:

Output 3.1. National capacity of laboratory diagnosis of COVID-19 for timely confirmation and management of large-scale testing in the country strengthened (*Pillar 5*).

Output 3.2. National capacity of case management for COVID-19 to mitigate the impact and prevent the spread of any outbreak across the country increased (*Pillar 7*).

Output 3.3. Supply systems in health and other relevant sectors through operational and logistical support improved (*Pillar 8*).

Output 3.4. Essential health services provided in public health care facilities and through direct implementation, protection monitoring and multi-sectoral assistance enhanced (*Pillar 9*).

3.2. Main activities

3.2.1. *Activities associated with each output*

An indicative list of possible activities associated with outcome/output follow below. At this stage the activities are just indicative and will be refined in the contracts according to national authorities' priorities, needs, implementing partner capacities and gaps. Not all of them will necessarily be implemented.

Output 1.1: Coordination to deliver strategic, technical, and operational support through existing mechanisms and partnerships increased (*Pillar 1*).

Indicative activities:

- Provide technical support to the national technical/steering committee both in Tripoli and Benghazi. Assisting the authorities in developing, revising, monitoring, evaluating and strengthening sectoral national action plans and national contingency plans which, where pertinent, provide legal and operational resources in responding to the cross-border COVID-19 crisis[20];
- Advocate for all migrants and forcibly displaced populations to be included in the national COVID-19 response, ensuring they can access to necessary services, without fear of stigma[21];
- Conduct risk assessment of vulnerable populations and implementing bodies including forecasting of expected COVID cases, diagnostics and management requirements or response measures;
- Activate additional national emergency operations centres;
- Equip COVID-19 national public health facilities with IT tools to enhance health information management;
- Foster mutual accountability activity on the domestic budget made available for COVID and the external pledges;
- Facilitate national and regional inter-sectoral coordination through support to the Ministry of Health, other government ministries and national actors[22];

[20] Contingency plans can be developed at the local/district level, as well as at national level but also between Libya's neighbouring countries given the cross-border nature of the crisis

[21] This could consist in undertaking media campaigns and publishing research underlining how protecting migrants means protecting the broader Libyan population among others

- Assist relevant national agencies active in border management in enhancing inter-agency coordination on COVID-19 preparedness and response in the cross border coordination mechanism[23];
- Raise awareness regarding migration data collection and privacy considerations in public health emergency settings, balancing the need for increased information sharing with continuing privacy considerations[24].

Output 1.2: Epidemic intelligence through real-time surveillance systems for rapid detection of suspected cases and verification of COVID-19 and comprehensive and rapid contact tracing enhanced (*Pillar 3*).

Indicative activities:

- Expand existing national EWARN sentinel reporting sites[25] to conduct COVID 19 surveillance (equipment, support rapid response teams, transportation, communication tools, etc);
- Train surveillance officers on case detection, data collection, notification, contact tracing and data analysis related to COVID-19; training technical officers from NCDC surveillance department on data cleaning and data analysis;
- Support national authorities in the establishment of ILI (Influenza Like Illness) and SARI (Severe Acute Respiratory Infection) surveillance sites to be included in COVID-19 surveillance;
- Develop, review, print and disseminate national guidelines for case detection, outbreak investigation, reporting forms and contact tracing;
- Support national authorities in implementing country specific model for data collection, data cleaning, data analysis and report dissemination;
- Establish and train community-based surveillance network to detect COVID-19 suspected cases in community[26]: train government counterparts and key partners on community evidence based surveillance, participatory mapping exercises;
- Conduct random screening for COVID-19 in high risk groups, including those with ILI and SARI according to national protocols and guidance;
- According to national priorities, expand RRTs by geographical and population distribution to cover all municipalities and districts, Train RRTs on case detection, specimen collection, contact tracing, outbreak investigation on COVID-19;

[22] Including those involved in border management, municipalities and other local authorities, consular staff and organization of a coordination platform involving all stakeholders which will hold regular meetings.
[23] Including referrals and support to voluntary returns/repatriation, and emergency consular assistance – in the spirit of integrated/coordinated border management.
[24] Particularly through developing initial SOPs for reporting and disseminating information on health and mobility, under the condition that this does not violate individuals' privacy.
[25] Include detention centers in reporting sites using EWARN by trained officers and equipped by electronic devices in 125 existing sites and possible extending to additional 125.
[26] Particularly among border communities, Points of Entry (PoE), and migrant dense areas;

- Procure PPEs for rapid response teams to conduct contact tracing, outbreak investigation and sampling;
- Support the DHIS2 establishment and roll out.

Output 1.3. Mobility and displacement tracking and analysis of internal mobility trends that may impact disease spread enhanced (*Pillar 3*).

- Mobility mapping to support contact tracing based on travel history;
- Conduct rapid health surveillance amongst mobile vulnerable populations such as IDPs, Returnees, and Migrants to facilitate safe provision of ongoing humanitarian response activities;
- Support national agencies in inter-agency coordination on reporting and data dissemination for purpose of public health interventions and advocacy.

Output 2.1. Awareness of how to prevent spread of COVID-19 in the population, including migrants and host commmunities. though risk communication and community engagement strategy raised (*Pillar 2*).

Indicative activities:

- Support national authorities in the development of key messages on the prevention of COVID-19[27] based on rapid behaviour assessments to understand key target audiences, perceptions, concerns, and preferred communication channels;
- Actively promote the inclusion of migrants/refugees into COVID response actions
- Support the dissemination of these key messages through mass media (TV and radio spots), social media, other media channels, mosque speakers, strengthening radio health channel of NCDC, campaigns, support for air time, TV time, SMS/whatsapp messaging, hotlines-helplines (to be staffed and equipped) etc.; support MoH spokeperson and communication department;
- Support the detection of rumors or misinformation[28] and a process to develop and issue rapidly evidence-based clarifications;
- Conduct training on effective dealing with media and spokesperson and risk communication trainings[29];
- Organize risk communication activities and awareness raising sessions through municipal authorities, civil society organizations (CSOs), consular representatives,

[27] Leaflets, posters, billboards, audiovisuals, guidelines, graphic motion videos on the importance of keeping physical distance and staying at home. Materials will be produced in multiple languages and media to communicate effectively with various populations sub-groups, including migrants, persons with special needs, persons with limited access to technology, etc.

[28] Dispel rumors and misinformation and media monitoring (strengthening the use of the helpline and NCDC official Facebook page, live radio and TV channel interaction, Q&A through social media)

[29] Addressed to: main and back up spokesperson, community leaders/celebrities, senior governmental staff at the national and district levels of the ministry of health, front line health professionals, active communication professionals, etc

migrant community leaders or other networks, to improve awareness of COVID-19, and community engagement activities[30] to promote communities' active participation in prevention, preparedness and outbreak response[31];

- Support the establishment of community feedback mechanisms to systematically collect information on community perceptions, concerns, and questions, and utilize community feedback findings to refine community engagement and other response activities;
- Mainstream RCCE across all pillars and sectors (for example, ensuring risk communication reaches POEs, schools, etc).

Output 2.2. Health measures at point of entries (POE) for travelers to detect imported cases implemented (*Pillar 4).*

Indicative Activities:

- Ensure coordination and support to the POE Technical Committee, including through meetings to ensure effective planning and response across priority border crossing and capacity building;
- Assist the authorities in developing preparedness and health response plan and emergency contingency plan at PoE and update and disseminate SOPs for the detection in coordination with partners, investigation and management of passengers/travellers;
- Conduct technical and infrastructural needs assessments in priority POEs: Provision of support to the Libyan authorities to increase their capacity to implement COVID 19 response measures, including through infrastructure restoration and provision of equipment;
- Strengthen existing referral systems, with special consideration to the individuals and groups in situations of vulnerability and ensure effective mechanism to transport patients from PoE to referral hospitals.

Output 2.3. Infection prevention and control procedures in healthcare facilities, DCs and shelters hosting migrants, schools and local communities to protect health care workers and beneficiaries from infection by COVID-19 implemented (*Pillar 6*).

Indicative Activities:

- Provide necessary equipment and supplies to hospitals and other health facilities, RRT members, laboratory personnel, staff and migrants in DCs, collective centres and communities;

[30] Foster community-led actions through collaborating with religious and tribal elders and influencers, women's and mother's groups, youth groups, the Scouts, etc. and the establishment of community health management groups, with the participation of local level authorities and health facility management

[31] Community gatherings will be in small groups in well-ventilated spaces. These interventions will be accompanied by distribution of hygiene kits, for men, women and children. Comprehensive briefings will be organized for all staff prior to the start of the campaign. Protective measures and use of protective equipment (masks, sanitizers) will be in place throughout the activities.

- Provide capacity building and awareness-raising to national authorities, healthcare workers, staff intervening in DCs, and partners on infection prevention and control measures;
- Technically support developing national IPC guidelines and protocols;
- Support the implementation of triage, early detection, and infectious-source controls, including information on respiratory symptoms and to practice respiratory etiquette;
- Support the establishment and equipment of prefabricated isolation spaces for migrants in case of outbreak of COVID-19 within the space of DC compounds.

Output 2.4. Access to WASH services and a clean environment through fumigation and disinfection increased (*Pillar 6*).

Indicative Activities:

- Provide fumigation, disinfection, cleaning and WASH services in DPs, DCs, shelters and open centres, schools as well as in relevant national facilities;
- IPC interventions to improve water and sanitation.

Output 3.1. National capacity of laboratory diagnosis of COVID-19 for timely confirmation and management of large-scale testing in the country strengthened (*Pillar 5*).

Indicative Activities:

- Conduct mapping and assessment of country public health laboratories, capacities, levels and role in national lab system, including regarding the availability, usage and detection equipment, and preparedness to respond to COVID-19 outbreak;
- Procure necessary stock of supplies – laboratory equipment[32];
- Support the development of national Public Health laboratory policy and standards, Public Health Laboratory Quality Management Systems QMS and SOPs on infection control to respond to COVID-19;
- Capacity building;
- Build Public Health Lab. quality control country task force;
- Support and reinforce the Rapid Response Teams for surveillance and case finding, tracing contacts and sample collection.

Output 3.2. National capacity of case management for COVID-19 to mitigate the impact and prevent the spread of any outbreak across the country increased (*Pillar 7*).

Activities:

- Technically support develop case management protocols, standard operating procedures and guidelines adapted to the context in Libya;

[32] Such as PCR machines, GeneXpert machines), reagents, kits/cartridges, shredder for lab medical waste, testing kits, medical consumables and necessary personal protection equipment to control spread of infection

- Support health facilities identified for COVID-19 response according to needs, assess capacity of the intensive care unit in designated treatment hospitals and support if needed;
- Train physicians and auxiliary staff on the management of COVID-19 inpatient services;
- Support the recruitment and deployment of COVID-19 medical mobile team (MMT) according to national priorities;
- Provision of life-saving medications and supplies for the COVID-19 critical case management conditions;
- Support the monitoring of the geographical distribution of the teams and strengthen their presence in the south and communities with vulnerable groups;
- Train and support community health workers on home care for patients with suspected COVID-19, IPC and case management;
- Assist in developing of referral services through equipped teams and ambulances building on early experiences.

Output 3.3. Supply systems in health and other relevant sectors through operational and logistical support improved (*Pillar 8*).

Activities:

- Support the mapping of resources and supply systems/stocks of reserves;
- Support the review procurement process for medical and other including import and customs procedures and promote local outsourcing to promote local industry and sustainability;
- Review the existing supply chain and management system and local capacity for medical and supplies including disease control commodity package;
- Coordinate and provide the MoH and implementing partners of the items, specifications and quantities of medical, diagnostics and PPEs supplies required;
- Coordinate with other implementing agency (UNDP) in developing capacity of the national laboratory on equipment and supplies.

Output 3.4. Essential health services provided in public health care facilities and through direct implementation, protection monitoring and multi-sectoral assistance enhanced (*Pillar 9*).

Activities:

- Provide necessary services to migrants in DCs and at DPs, including screening for COVID-19 symptoms and sensitize migrants through interpersonal interactions;

- Support the provision of health care services in PHC centers and through mobile teams according to national case management guidelines and strategies for the most vulnerable populations according to gaps and potential needs[33];
- Support the referral of migrants and forcibly displaced populations for secondary and tertiary care services for life saving interventions to prevent morbidities and long-term disabilities;
- Assist the health facilities under the MOH by helping to fill gap in human resource, equipment, medicines and supplies and to implement DHIS;
- Community hosting program, emergency direct and transparent assistance for stranded migrants, displaced population and persons in need of specific care and protection;
- Distribute Non-Food Items (NFIs), family hygiene and sanitation kits including soaps, liquid soaps and water collection kits to protracted IDPs who have limited access to income and employment opportunity;
- Provide food packages to extremely vulnerable migrants and forcibly displaced populations;
- Monitor the situation of migrant communities and other vulnerable communities in regard to safe and meaningful access to services and information, as well as an updated analysis on the impact of the COVID-19 pandemic and response on the protection situation within the communities;
- Conduct community awareness raising sessions and campaigns to prevent child protection risks;
- Build the capacity of child protection and non-child protection actors including social workers, teachers, national partners on MHPSS, CP approaches, and GBV prevention approaches during COVID-19, provide sessions to all partners and social workers on prevention of sexual exploitation and abuse (PSEA);
- Capacity building of health staff and national authorities.

3.2.2. *Target groups and final beneficiaries*

This Action will support as beneficiaries:

Relevant Libyan authorities from the Ministry of Health (MoH), Ministry of Interior, Ministry of Local Government, Ministry of Social Affairs (MoSA), Ministry of Education (MoE), National Centre for Disease Control (NCDC), General Company for Water and Wastewater (GCWW), General Authority for Water Resources (GAWR).

[33] Essential prevention for communicable diseases, vaccination for children; reproductive health, provision of medicines and supplies to manage chronic diseases and mental health conditions; management of emergency health conditions and common acute presentations that require time-sensitive interventions, MHPSS services to vulnerable groups, mental health conditions including psychiatric services and hospitalized care

Vulnerable population of Libya, including persons affected by COVID-19, IDPs, returnees, migrants, refugees, asylum seekers, host communities and conflict-affected population, especially children, women, and groups with specific needs.

Direct beneficiaries: At least 963,332 beneficiaries will benefit from this action[34].

Indirect beneficiaries: An estimated 4.8 million people reached through RCCE and 1.7million people living in severity scale 4 and 5 would benefit too.

3.3. Risks and assumptions

Risk	Level of risk (High/ Medium/ Low)	Mitigating measures
Lack of collaboration/support from the authorities due to conflict, political instability, political distance and high turnover of management (for instance at DCIM or others)	M	Early engagement with relevant authorities at highest level, shared programming, joined labelling for visibility; close monitoring of the political and security situation; lose engagement and technical collaboration with authorities, technical mid-level management and municipalities; foster active and efficient coordination mechanisms; invest in analysis to guide conflict sensitive design and implementation.
Constraints/impossibility to reach vulnerable populations due to movement restrictions hindering response and preparedness	H	Follow up the current evolution and adapt accordingly; foster new methods according to access measures/foresee alternative measures such as local- remote representatives, reinforce communication by phone and internet if possible, promote outreach through local leaders and community engagement; negotiate humanitarian access taking into account safety of the staff an national regulations; extend efforts to work with national partners with a large local network (for example, LRC, Scouts, and others).
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

[34] IOM: 120,000 members of vulnerable groups, such as migrants and forcibly displaced people benefiting from health assistance and multi-sectoral services; WHO: Total direct beneficiaries around 643,332, distributed across the main pillars of the response: Case Management - 14,143; National Coordination - 162; RRT - 50,946; National Laboratory - 67,186; RCCE - 1,270; IPC - 1,600; and Maintaining Essential Health Services - 508,015; UNICEF: An estimated 200,000 persons benefitting from IPC/WASH, protection, and/or essential and lifesaving health supplies. Please see note in page 2 about beneficiaries.

		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; collapse of bank system/lack of available cash	H	Foresee cash disbursements and follow market prices in advance; explore alternatives to establish a system to ensure cash available for implementation in Libya; careful planning of bank transfers to ensure sufficient liquidity; direct provision of supplies and transfers to service providers; using bank accounts in Tunis in line with HACT policies and procedures
Threats against employees of international organisations in Libya.	M	Close coordination with local authorities and communities for safe access; regular communication with local staff, modifying work locations and times.
Work permits and visas for international staff withheld.	H	Maintain constant relation with relevant Libyan authorities and engage in joint advocacy for better access and facilitation of international presence in Libya; when security situation does not allow international staff to travel to Libya, national staff in place to guarantee the continuity of the intervention.
Gender inequality - as women are often expected to contribute disproportionately towards coping strategies and recovery.	M	GBV response is adopted as a mainstreamed gender approach during the inception and implementation of the action.
Exposure to COVID-19 health risks for staff, partners, and beneficiaries	M	SOPs for activities to be implemented in the context of COVID-19 have been or are being developed. All distributions and activities will be implemented under these SOPs; PPE will be provided to frontline workers who will be involved in distributions, follow-up and monitoring; Partners will be trained on COVID-19 SOPs, the use of PPE, and other safety measures
Fragile health and water systems can have implications on response and preparedness activities; for example, shutdown of water supply, electric outages, etc.	H	Bridge critical and relevant capacity gaps, where possible; continuous high-level advocacy will be done to ensure the minimum investments are done in these essential systems
Lack of access to DCIM managed detention and collective centres	M	To facilitate access, coordination through UN partners and work through national partners will be done closely; continuous advocacy for the release of all people from detention centres
Lack of qualified workforce or workforce willing to take the risk of exposure to COVID-19	M	Continued competency specific training of relevant staff; Protective measures and SOPs will be place (see above); Utilize staff working in other programmatic units to fill the gap.
A shortage of supplies required (PPEs, disinfecting supplies, hygiene supplies) and an increase in prices	H	Joint coordinated procurement, both at Both at international and local levels, procurement will be done to address possible supply issues to ensure implementation and continuity of activities.

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

- Local authorities/ government 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 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;
- 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 EU dialogue with Libyan authorities. Rights-based approach (RBA)[35] is a central part of the strategy of intervention designed under this Action and frames activities to be implemented therein. Therefore, 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[36].

Protection mainstreaming is also at the heart of IOM's humanitarian response in Libya. When implementing its activities, IOM respects the need to protect the rights of migrants irrespective of their nationality or migration status, promote that these rights are respected, protected and fulfilled by the State and that migrants are aware of their rights. This includes placing the best interest of migrants at the centre of all activities and referrals to appropriate specialized services for those in need of specific protection assistance[37].

[35] 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.

[36] 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

[37] Recognizing that the most vulnerable migrants often have the least access to services in Libya, often due to security concerns, risks of detention, discrimination and stigmatization, IOM strives for outreach to these groups, and also arrange activities in appropriate locations, with safeguards in place, and at times convenient to the affected population. Special attention will be paid to reduce barriers to access to the most vulnerable groups, such as to persons with disabilities and children.

WHO will continue focusing on the following core components: availability, accessibility, acceptability and quality of provided and targeted health services. For each of these components there are mechanisms in place to assess, report, monitor and evaluate in coordination with national authorities, health and inter-sector partners. WHO has made a commitment to mainstream human rights into healthcare programs and policies on national and regional levels by looking at underlying determinants of health as part of a comprehensive approach to health and human rights.

UNICEF's work in Libya and globally, across all sectors and programme stages, is guided by human rights and child rights principles, including universality, non-discrimination, the best interests of the child, the right to survival and development, the indivisibility and interdependence of human rights, accountability and respect for the voice of the child[38]. With the increased protection risks brought about by the crisis for women and children, especially those from particularly vulnerable groups, UNICEF's interventions contribute to ensuring a protective environment for women and children where their rights are upheld and where violence against women, boys, and girls, regardless of their background, is prevented. UNICEF supports those who have obligations to respect, protect and fulfil rights, by helping them develop their capacities to do so, including government counterparts, implementing partners, and parents and caregivers; and also supports those with rights to develop their capacity to claim their rights[39].

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. Migrant women, girls and female unaccompanied minors usually have greater needs.

All specific actions to be implemented under this programme will have to be designed following a rights-based approach, ensuring a gender, age and diversity-sensitive programming through participatory approaches, as well as the challenges in ensuring social protection, along with fragmentation of the health system, make challenging to address needs, especially for vulnerable groups, in a timely and adequate manner.

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

[38] For UNICEF, a human rights-based approach to programming means that the ultimate aim of all UNICEF-supported activities is the realization of the rights of children and women, as laid down in the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

[39] This is done through the provision of technical support and capacity development, direct assistance, awareness-raising and communication, as well as ensuring that reporting and monitoring mechanisms are in place

designed based on their convenience to both women and men. All training sessions will engage female health and social workers, especially for MHPSS and GBV activities, to enable access to girls and women. UNICEF also ensures that partnerships are gender-sensitive and have equal proportions of male and female. Interventions, especially RCCE and other awareness-raising activities, will be informed by assessments on barriers to accessing information such as language, literacy, access to technology, etc., to ensure women, children, and other vulnerable groups are reached.

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

Populations with **specific vulnerabilities** (women and adolescents head of households, victims of trafficking, people with physical disabilities or pregnant and lactating women) 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 Libyan authorities. 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.

3.5. Stakeholder analysis

The choice of involving UN partners is well justified for the specific profile that the action proposes: to address a crisis of this magnitude, political leverage is essential in order to ease administrative bottlenecks and speed the response. In terms of international procurement of specific equipment and consumables, UN agencies are uniquely placed thanks to a well maintained network which, specifically for medical equipment, already proved in the past to be of high standards, assuring quality control of desired quality and being relatively faster than other routes.

UN agencies implementing the interventions will support and contribute to the efforts of national authorities in a conflict sensitive manner at central and local levels, strongly coordinating with the national authorities in Tripoli, Benghazi and sub-national at a municipality level, 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, NCDC Technical Scientific Committee, UNOCHA and WHO as lead of the overall response. They will rely on existing partnerships with NGOs and CSO to boost implementation.

UN agencies, namely IOM, WHO and UNICEF, have been operational from the beginning of preparedness and response efforts, and stand ready to assist Libyan authorities to respond to the COVID-19 outbreak, with operational and technical support, as structured within the already developed nine pillars, while at the same time providing assistance to Libya's population, specially to vulnerable groups, such as IDPs, migrants, women and children. All three agencies are key members of health sector working group and operationally present across the country. Full level coordination is in place.

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 will ensure close coordination with relevant government entities in Libya, in particular the DCIM, Ministry of Health, National Centre for Disease Control (NCDC), Ministry of Interior, Ministry of Defence and Ministry of Foreign Affairs, WHO and the Health Sector, also with local community leaders, and IOM regional offices. The prevention and surveillance activities for COVID 19 would be coordinated closely with NCDC and WHO. Coordination will be further enhanced through the Technical Working Group and Contact Group that will convene monthly. This mechanism will ensure government buy-in and in addition will serve as a platform to discuss bottlenecks, constraints, and the progress of the project.

UNICEF has existing Memorandums of Understanding and joint work plans with other UN agencies, including with IOM. Drawing on its global expertise and mandate, UNICEF is co-leading the RCCE sub-group of the response, and is leading sectoral response coordination for the WASH, Education, and Child Protection sectors. UNICEF is also coordinating with WHO and IOM on the response pillar on maintaining essential and lifesaving health services to mitigate the negative impact of COVID-19 on services.

IMC (International Medical Corps) has different branches operating in Libya, among them IMC UK and IMC Croatia. The latter is already implementing the contract T05-EUTF-NoA-LY-01 T05.1357 - *Strengthening protection and resilience of vulnerable groups in COVID-19 emergency* in affiliation with IMC US. The intervention is reaching its end at the end of March 2021. IMC is also a co-partner in the EUTF-NOA-LY-08 T05.121 contract with CESVI.

IMC has a solid foothold in Libya, developed over the past years. It has a large operational presence and capacity through national and international staff on the ground, sub offices, network of implementing partners and remote monitoring systems which are key factors allowing an effective impact on the ground.

IMC was the first international non-governmental organisation (INGO) to enter Libya following the outbreak of conflict in February 2011 launching an emergency response to provide lifesaving interventions for the local populations. IMC has continued focusing on medical relief programming and gained significant in-country expertise and widespread programmatic reach through supporting conflict affected populations, targeting Libyans, migrants, refugees and asylum seekers, both in detention centres and urban areas. IMC has provided basic health care in Benghazi, Khoms, Kufrah, Misrata, Sabha, Al-Shati, Tripoli, Zliten, Zawya, Zwara, Gharyan and Zintan. IMC remains committed to operate in the dynamic and security-sensitive environment to the fullest extent possible.

IMC has the capacities to rapidly scale up their health actions already including COVID-19 response activities.

4. IMPLEMENTATION ISSUES

4.1. Financing agreement, if relevant

Not applicable.

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.

Extensions of the implementation period may be agreed by the Commission’s responsible authorising officer by amending this Decision.

4.3. Implementation modalities

The Action will be mainly implemented through indirect management (Contribution Agreements) with UN agencies depending on needs assessment and gaps.

Partners have been pre-identified based on effective operational presence in Libya at countrywide level (national offices and sub offices, mixture of national and international teams), specific mandate, specific technical competence and leverage, maintenance of a trusted network of implementing partners (to whom subcontract specific actions), capacity to direct and remote monitor and follow up. The potential pre identified partners are WHO, IOM and UNICEF.

WHO will follow established "due dilligence" policies and procedures while identifying an contracting potential implementing partners. WHO will aim to identify existing scientific/health/medical societies and associations and any other registered legal entities that have the relevant expertise. WHO will partner with "Libyan Red Crescent Society" on five key areas of activities: conduct supervisory home visits for COVID-19 home care; disseminate information and guide on safe care seeking behavior, conduct risk community

trainings in conjunction with leaders and influencers in the community, community based surveillance and monitor essential health care services.

IOM stresses its extensive experience in empowering governments and communities to prevent, detect and respond to health threats along the mobility continuum, whilst advocating for migrant-inclusive approaches that minimize stigma and discrimination. While migration and mobility are increasingly recognized as determinants of health and risk exposure, the volume, rapidity, and ease of today's travel pose new challenges to cross-border disease control and suggest the need to adopt innovative, systemic and multi-sectoral responses. IOM has a strong presence throughout the country, with more than 350 staff including third-party field staff and 60 medical staff. IOM will further subcontract its trusted partner agency WFP who will play an important role in the area of food provision to vulnerable migrants.

UNICEF will leverage existing partnerships and working relationships with civil society organizations and government partners. UNICEF currently works with 19 national and international organizations with a solid presence in different parts of the country. These partners will play an important role in awareness-raising, risk communication, and community engagement interventions. Current NGO and CSO partners include but are not limited to, International Rescue Committee (IRC), CESVI, INTERSOS, ACTED, Elsafa, Multaqana, Scouts, Noor El Hayat, and Libyan Society. UNICEF also has ten existing annual work plans with government counterparts, with one currently under development. These partners include the Ministries of Social Affairs, Health, Education, Interior, and the Department to Combat Illegal Migrants. UNICEF also has working relations with a number of municipalities which will greatly facilitate program implementation.

The Commission authorizes 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)7334142).

Even if grants are not the modality privileged in this Action Document, if it is finally needed to use grants, under the responsibility of the Commission's authorising officer responsible, the grants may be awarded without a call for proposals to NGOs to be selected using the following criteria: (i) operational presence in Libya at countrywide level (if possible national and subnational presence and mixture of national and international teams); (ii) specific mandate in implementing health or health related interventions; (iii) specific technical competence and leverage; (iv) capacity to direct and remote monitor and follow up; (v) experience in working directly with national/sub-national governments or governance structures in Libya; (vi) proven experience in working on health service delivery in fragile, crisis or transition contexts.

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)7334142).

This option will be activated through the first amendment of this Action Document with a grant to IMC. This beneficiary complies with the selection criteria for a direct award established above.

4.4. Indicative budget

Component	Amount EUR	Co-financing EUR
IOM	**8 000 000**	
WHO	**6 000 000**	**144 661**
UNICEF	**6 000 000**	**500 000**
IMC	**1 000 000**	**38 202**
Total	**21 000 000**	**21 682 863**

4.5. Monitoring and reporting

The implementing partners must establish a permanent internal, technical and financial monitoring system for the action and prepare regular progress reports and final reports.

In the initial phase, the indicative logical framework agreed in contract and/or the agreement signed with the implementing partners must be complemented with baselines, milestones and targets for each indicator[40]. 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 narrative, 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).

In this respect it should be noted that the EUTF has launched two Third-Party Monitoring exercises in Libya, with which implementing partners of this Action should fully cooperate.

The implementing partners will report on a number of relevant common EUTF indicators of the selected results for this Action[41] (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.[42]

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/).

[40] Partners will have to align and harmonise their interventions with NoA M&E framework
[41] 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
[42] http://indicators.developmentresults.eu User name/password: results

WHO and other agencies will track the progress of the project through the existing health sector 4W reporting tool and OCHA developed COVID-19 response tool. WHO will work closely with Health Information Center of the MoH to enhance reporting and monitoring capabilities over municipalities and health facilities targeted by the project. Third-party evaluation will be envisaged.

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 financing agreement, purchase and grant agreements and delegation as well as contribution agreements.

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.

List of acronyms

AD	Action Document
Africa CDC	Africa Center for Disease Control
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisations
DC	Detention Centre
DTM	Displacement Tracking Matrix
DP	Disembarkation Point
ENI	European Neighbourhood Instrument
ETM	Emergency Transit Mechanism
EU	European Union
EUDEL	European Union Delegation
EUTF	European Union Emergency Trust Fund
EWARN	Early Warning, Alert and Response Network
GACS	General Administration for Coastal Security
GAP	Gender Action Plan
GBV	Gender Based Violence
GDP	Gross Domestic Product
GNA	Government of National Accord
HMIS	Health Management Information Systems
HRP	Humanitarian Response Plan
ICU	Intensive Care Unit
IDP	Internal Displaced Person
ILI	Influenza Like Illness
IMC	International Medical Corps
INGO	International Non-Governmental Organisation
IOM	International Organisation for Migration
IPC	Infection Prevention and Control
IRC	International Rescue Committee
JTCC	Joint Technical Coordination Committee
LCG	Libyan Coast Guard
LNA	Libyan National Army
MENA	Middle East and North Africa
MHPSS	Mental Health and Psychosocial Support
MMT	Medical Mobile Team
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
PWD	Persons with Disabilities
RBA	Rights Based Approach
RCCE	Risk Communication and Community Engagement
RRM	Rapid Response Mechanism
RRT	Rapid Response Team
SAR	Search and Rescue
SARI	Severe Acute Respiratory Infection
SC	Steering Committee
SDGs	Sustainable Development Goals
SOPs	Standard Operating Procedures
TB	Tuberculosis
UN	United Nations
UNCT	UN Country Team
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund.
UNSMIL	United Nations Support Mission in Libya
VHR	Voluntary Humanitarian Returns
WFP	World Food Program
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)**	**Indicators**[43] **(at least one indicator per expected result)**	**Sources and means of verification**	**Assumptions**
Impact (Overall objective)	To prevent the spread of COVID-19 and to reduce avoidable morbidity and mortality in Libya. 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)" Morbidity and mortality rate	To be collected by EU via external assistance	*Not applicable*
Outcome(s) (Specific Objective(s)	To provide specialised support to the Libyan authorities to address COVID-19 related challenges as well as assist the most vulnerable population in Libya, particularly (but not exclusively) migrants and forcibly displaced persons EUTF NOA Specific Objective 3.V. Access to and quality of services for target groups and host communities is improved	Access to health services aimed at addressing COVID-19: % increase to COVID-19 related health services	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' staff;
Immediate outcome 1	Coordination mechanisms and improved detection through surveillance	An integrated Multi-sectoral Response Plan is established with the linkages to the other coordination forums such as Education, Child Protection, WASH, MRE and others # of coordination mechanisms established and supported # of functional surveillance mechanisms # % of municipalities reporting Covid-19 cases	Online publication	

[43] Health data, if not otherwise specified, will always be disaggregated by gender and age

Output 1.1	Coordination to deliver strategic, technical, and operational support through existing mechanisms and partnerships increased (Pillar 1).	# of coordination meetings with MOH # of coordination meetings with partners	Signed attendance sheets; meeting minutes	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 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.	Epidemic intelligence through real-time surveillance systems for rapid detection of suspected cases and verification of COVID-19 and comprehensive and rapid contact tracing enhanced (Pillar 3).	# of established RRT # of PPE distributed to RRT and surveillance officers # of NCDC's and other surveillance officers trained from MOH and partners (per type of training)	Equipment lists; Receipts; Hand-over forms; Signed attendance sheets; IOM DTM website	
Output 1.3.	Mobility and displacement tracking and analysis of internal mobility trends that may impact disease spread enhanced (Pillar 3).	# of COVID-19 mobility tracking reports #of contract tracers trained # of reports on mobility trends produced		
Immediate outcome 2	Preventive measures to decrease risks and protect vulnerable groups	A national risk communication & community engagement plan is shared through the existing coordination mechanisms # of people reached with key messages (vulnerable groups and general population) # of people screened/detected/referred at PoE # of people provided with hygiene items, disinfectants, PPE and relevant prevention information # of people with increased access to prevention facilities # % of healthcare facilities, DCs and shelters hosting migrants, schools supported with fumigation, disinfection, cleaning and WASH interventions	Meeting minutes	
Output 2.1.	Awareness of how to prevent spread of COVID-19 in the population, including migrants and host commmunities. though risk communication and community engagement strategy raised (Pillar 2).	# of coordination meetings with the authorities on risk communication strategy and activities # of awareness campaigns conducted for targeted groups on COVID-19	Signed attendance sheets; meeting minutes; photos; field reports	

Output 2.2.	Health measures at point of entries (POE) for travelers to detect imported cases implemented (Pillar 4).	# % of PoE with established and equipped health control offices and isolation spaces	Equipment lists; Receipts; handover forms; photos	
Output 2.3.	Infection prevention and control procedures in healthcare facilities, DCs and shelters hosting migrants, schools and local communities to protect health care workers and beneficiaries from infection by COVID-19 implemented (Pillar 6).	# of municipalities received IPC protocols # of municipalities improving triage systems # of healthcare facilities, DCs and shelters hosting migrants, schools receiving IPC protocol and triage	Weekly progress reports; contracts; handover forms; payment forms	
Output 2.4.	Access to WASH services and a clean environment through fumigation and disinfection increased (Pillar 6).	# people provided with improved WASH and disinfection services		
Immediate outcome 3	Response to the public health crisis and humanitarian needs	Stakeholders report to have an improved capacity to respond to public health needs # % increase in people tested # % of ICU equipped hospitals # % of public health care facilities equipped with essential services resources # of migrants and IDPs with access to health assistance # of vulnerable migrants and IDPs receiving food assistance # children and women receiving essential healthcare services, (immunization, prenatal and postnatal care, HIV care and GBV response care) # children, parents and primary caregivers provided with community based mental health and psychosocial support and GBV services	Surveys, meeting minutes, correspondence	
Output 3.1.	National capacity of laboratory diagnosis of COVID-19 for timely confirmation and management of large-scale testing in the country strengthened (Pillar 5).	# of laboratory equipment provided # of provided test kits # of trainings conducted	Equipment lists; receipts; handover forms; photos; Signed attendance sheets;	

Output 3.2.	National capacity of case management for COVID-19 to mitigate the impact and prevent the spread of any outbreak across the country increased (Pillar 7).	# of mapping exercise conducted on availability of ICU and isolation rooms # of hospitals with ICU equipped with necessary supplies and equipment	Field reports; equipment lists; receipts; handover forms;	
Output 3.3.	Supply systems in health and other relevant sectors through operational and logistical support improved (Pillar 8).	# of mapping exercise conducted on resources and supply systems	Activity logs and reports	
Output 3.4.	Essential health services provided in public health care facilities and through direct implementation, protection monitoring and multi-sectoral assistance enhanced (Pillar 9).	# of public health care facilities further equipped with essential services resources # of protection monitoring and multi-sectoral assistance resources provided	Activity logs and reports; health facility logs and records; partner and programme monitoring reports	