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Evaluation Report



Evaluation of UNICEF Libya's COVID-19 Response

Evaluation Report

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<p>Disclaimer: Opinions and views expressed in this document are entirely those of the authors, and do not reflect opinions of the Government of Libya, UNICEF, Development Partners, or any other civil society organizations.</p>
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Abbreviations and Acronyms

AWP	Annual Work Plan
COAR	Country Office Annual Reports
CSD	Child Survival and Development
C4D	Communication for Development
EQ	Evaluation Questions
FGD	Focus Group Discussions
GDP	Gross Domestic Product
INGO	International Non-Governmental Organizations
IOM	International Organization for Migration
IPC	Infection Prevention and Control
KAP	Knowledge, Attitude and Practice
KII	Key Informant Interview
LCO	Libya Country Office
NCDC	National Center for Disease Control
NDVP	National Deployment and Vaccination Plan
NITAG	National Immunization Technical Advisory Group
PHCI	Primary Health Care Institute
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
RPBA	Recovery and Peacebuilding Assessment
SDG	Sustainable Development Goals
ToR	Terms of Reference
UASC	Unaccompanied and Separated Children
UNDP	United Nations Development Programme
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
US\$	United States' Dollar
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

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Executive Summary

This report presents findings of the Evaluation of UNICEF Libya's COVID-19 Response. Libya is considered especially vulnerable to the pandemic due to the effects from the Second Libyan Civil War, which has led to a dire humanitarian situation and the destruction of the nation's health infrastructure. As of 12 September 2023, Coronavirus cases in Libya are reported to be 507,269 with 6,437 deaths. As of 15 January 2023, a total of 3,739,158 vaccine doses have been administered with 2,316,327 people receiving at least one dose and 33.71% of Population receiving at least 1 dose.

UNICEF supported the Government of Libya in the COVID-19 response and preparedness, particularly working with the Ministry of Health. Since the onset of the COVID-19 pandemic in Libya, with the support of BMZ-KfW, the EU, USAID and the government of Japan, UNICEF has been implementing a multi-sectoral response that focuses on coordination, risk communication and community engagement, Infection Prevention and Control (IPC), and the continuity of essential services, in particular primary healthcare, education, child protection and social protection.

The purpose of the evaluation of UNICEF Libya's COVID-19 response between 2020 – 22 is twofold: *accountability and learning*. The evaluation findings, lessons learnt, and recommendations will be used to strengthen UNICEF Libya's emergency preparedness and continued efforts in supporting the Government of Libya with a focus on health. The evaluation was conducted using selected humanitarian evaluation criteria: *appropriateness, effectiveness, efficiency, connectedness, and coordination*. The methodology included desk research and collection of primary data using key informant interviews (KIIs) with stakeholders and focus group discussions (FGDs) with beneficiaries. A major limitation of the evaluation was that primary quantitative data was not collected and it relied upon the secondary literature made available by UNICEF. This may have impacted the representativeness of the findings to the general population of interest. Moreover, lack of access to government documents to make a comparison of activities and outputs with what is planned and implemented by the government is another limitation for the evaluation.

A summary of the *key findings* of the evaluation is presented below:

UNICEF has been implementing a multi-sectoral response to the COVID-19 pandemic in Libya since the onset on the virus in March 2020, with interventions focusing on Risk Communication and Community Engagement (RCCE), Infection Prevention and Control (IPC), the continuity of basic services including healthcare, education, and child protection, evidence generation, and support to COVID-19 vaccinations. The findings have been arrived at while appreciating the limitations and challenges of the context in Libya.

Appropriateness

UNICEF staff and partners as well as government officials mentioned that the response is highly appropriate as it offered timely and critical response to the vulnerable communities in Libya through strategic support at national and sub national levels with technical assistance, capacity building and at community level with raising awareness and making sure communities knew about the efficacy of vaccination and dispelling any rumours and myths associated with large scale vaccination. When despite being a rich country, the focus of Government is not on preventive and primary health care, the response supported by UNICEF was not only appropriate but lifesaving.

The implementation has been done jointly by UNICEF and partners and has strengthened capacities of Libyan health authorities. The evaluation found this to be promising. The evaluation found that the COVID-19 response is still valid and adaptive in the country and remains appropriate to the evolving development of strategic plans and community needs. The response, which initially had

outlays only for the Libyan population, went to on provide coverage to the extremely vulnerable migrant and refugee population.

The approach is found to be an appropriate one in the context (*generally and the protracted crisis*), and remains aligned with the UN strategic framework. The response remained appropriate as it considered local realities and the needs of target groups in the country. The response is coherent with the UNICEF policy of development and humanitarian nexus to support decentralised delivery of basic services at community levels.

Effectiveness

The evaluation attempted to assess the extent to which the response demonstrated expected results against the planned outputs which are outlined in annual planning documents. As this was an emergency response, planning assumptions were not included in the AWP.

The evaluation did not have any comparison group including intervention results from other programs. The operating environment in Libya is challenging, and while efforts can be measured, results are difficult to articulate and attribute to, especially in the absence of data on government programmes.

UNICEF provided support to the development of a national vaccine deployment plan; worked with partners to enable administer COVID-19 vaccines; facilitated the COVAX, provided pre-financing for COVID-19 vaccines and supplied essential lifesaving equipment and material. UNICEF supported development of an RCCE strategy in 2021, updated in 2022 on COVID-19, and collaborated with NCDC aimed at community engagement and awareness creation on the importance of vaccination and promotion of healthy practices.

Service standards: The implementing partners have developed service standards for providing services. However, while developing service standards is necessary, it may not be enough to improve service quality.

Facility survey: Implementing partners stated that they conduct activities as outlined in their respective Programme Document (PD) or Project Cooperation Agreements (PCAs) with UNICEF.

Beneficiary survey: Evidence of beneficiary feedback was seen, though limited.

Performance of service providers: There is no system to assess the performance of service providers at facilities.

Community members and even several levels of implementing partners were not directly involved in the planning of the response.

Efficiency

The evaluation found that the response is a natural fit in pandemic management.

Cost drivers: For interventions of similar nature, the most significant cost component is salaries of staff, followed by expenses on activities conducted and operational expenses.

Economy: Costs of salary and procurement of goods and services are significant cost drivers. The costs of programme implementation support, largely related to general operating costs and administrative costs in Libya are very high, generally.

Efficiency: The evaluators did not assess utilization / disbursement against budgets and hence cannot comment on the efficiency with which the inputs have been transformed into outputs so far. The evaluators note that no direct cash assistance has been provided to the government.

Delays were experienced in procurement of vaccines due to global shortages, and in warehouse management due to short staffing. At times, implementation of SBC/RCCE was affected by long lead times required for approvals.

UNICEF's Performance: UNICEF's overall performance in designing and implementation of the response has been *satisfactory*. UNICEF designed a relevant and coherent response, and with emerging needs, made mid-course corrections. It provided due consideration to the political, social,

and economic situation of the country. The planned activities in the donor proposals and the COARs for the response with the budget, timeframe, and engagement of UNICEF programmes are consistent.

The evaluation finds the response being termed as efficient in delivering critical services in wake of limited alternatives being available.

Connectedness

Coordination and Collaboration: the UNICEF response to COVID-19 was undertaken in coordination with the government, UN agencies and other development partners as well as NGOs. Stronger linkage between SBC/RCCE and the core emergency coordination mechanisms will likely strengthen the overall response.

Engagement with Local Communities: this element of the response was evaluated as weak due to security concerns and COVID 19 restrictions.

Integration with Local Systems: partially achieved, as the delivery happened at community level, however, alignment with existing local infrastructure, services, and capacities could be strengthened.

Alignment with National and International Strategies: the response has been for an emergency and does not have comparators in place to assess coherence with broader national development plans, policies, and international frameworks.

Information Sharing and Communication: data collection on RCCE ramped up significantly during COVID-19 with several quantitative KAP studies conducted, and supported by additional qualitative methods. Capacity for behavioural analysis and utilisation of data could be strengthened.

Flexibility and Adaptability: the response clearly demonstrated that it, along with all its sub components, led by the government, was able to adjust their strategies and approaches based on feedback, changing circumstances, and evolving needs.

Accountability and Transparency: UNICEF delivered the response, following internationally benchmarked operating systems including managing the procurement of human resources, supplies, technical assistance and monitoring etc.

Capacity Building: the response was bolstered by capacity strengthening efforts at all levels.

Guided by the humanitarian–development nexus, capacity building has been intrinsically embedded in the planning. Working with local partners (NGOs) and government staff and institutions is also an important factor in building potential sustainability. This is the main strength of the evaluated programme.

Coordination

UNICEF's role in initiating coordination platforms and supporting the government bodies to lead the coordination is commendable. Also, the efforts put in by UNICEF in the response were well coordinated with partners.

Gender and Human Rights

The response was designed keeping it gender-responsive. The sectoral programmes aimed at integrating their programming and carry out activities which clearly provided focus on women rights. There is limited sex and gender disaggregated data being reported, barring a few cases where trainees in capacity building interventions were segregated. The different needs, priorities and strengths of women (*and men*) were clear amongst the beneficiaries, and the same were, when asked from local authorities, included in their list of priorities. There was no evidence available to inspire confidence of the evaluators on strategies and resources available to address gender barriers and constraints. The local level stakeholders feedback concluded lack of capacity to design gender sensitive programming.

The COVID-19 crisis has had an impact on the most vulnerable residents in Libya and has exacerbated pre-existing structural gender inequalities in a predominantly patriarchal society.

Application of humanitarian principles in the approach was seen. These principles included (i) Humanity – as seen in coverage of all women and children from refugees and host communities; (ii) Impartiality – the interventions under the approach reached out to all, without discrimination between ethnic, tribal groups, nationalities, sex, etc. and; (iii) Neutrality – the approach did not take sides and refrained from engaging in controversies of a political, racial, religious or ideological nature. The approach reinforced humanitarian principles by raising awareness, building trust (*working with government, UN Agencies, INGOs, and local organisations*), and advocating for children's rights in humanitarian situations, together with state authorities and non-state entities.

CONCLUSIONS AND LESSONS LEARNT

The evaluation is of the view that there have been several successes recorded in the response in Libya to COVID-19, especially for UNICEF. During the outbreak, with an extremely small team in the Child Survival and Development (*now Health and Nutrition*) section in UNICEF, achieving what has been witnessed is remarkable. The NCDC now exudes confidence and states that it is now ready to handle similar situations in the future, *thanks to UNICEF support*. There are several key challenges in implementing an emergency response to a pandemic of COVID-19 magnitude in any country. No one was prepared to handle the pandemic and this was not unique only to Libya.

The response was appropriate in the context and circumstances as it worked directly with the key stakeholders (*Government, UN Agencies and service delivery institutions*) as well as beneficiaries. The response, has been effective and for the most part timely, given the overriding political, security, and other contextual constraints. In collaboration with government and partners, UNICEF was able to meet the needs of the vulnerable communities in an efficient manner. In view of the limited staff available within UNICEF, ongoing security concerns, the dynamic context during the period under evaluation, and the limited interventions, the response's efficiency can be considered as proficient. UNICEF formed a strong relationship with Government counterparts, and more so at the local levels (*where done*), NGOs, and the community leaders.

Outreach of the response worked well; Efforts to change behaviours faced challenges due to COVID-19 restrictions and limited implementation. Capacity building happened, but in limited dimensions; and needs to be strategized. Engagement with the government worked well, but wider engagement with NGOs is necessary to increase coverage. Human rights based approach to programming was evident. Supplies were provided but consumption has not been captured and would need emphasis. Outputs have been documented; better assessment of outcomes is needed. UNICEF decided to work with the right people (partners) and this seems to be an appropriate, effective, efficient and connected approach which has been well coordinated.

COVID-19 pandemic has made it abundantly clear that a hybrid approach toward humanitarian assistance and development cooperation is required. Thus, placing the nexus into practice is an imperative for responding effectively to this crisis, and to prepare for the next one to come.

Joint assessments, planning, programming and results framework identifying what can be adapted or scaled-up, before starting a new intervention are important. It will also be crucial that humanitarian, development and peacebuilding programmes are delivered in parallel, not sequentially.

While there was a tendency for over-reliance on messaging, UNICEF's programme responses were calibrated and adjusted over time depending on existing capacity in the country. Libya, like many other countries elsewhere, handled the unfolding COVID-19 epidemic using its existing (*yet collapsing*) health system capabilities and in the face of substantial uncertainties.

The COVID-19 epidemic has also presented several opportunities for the country to learn and utilize the lessons to strengthen the health system.

UNICEF stuck to its core principles. This has worked well in the response. Strengthening capacities of actors guaranteed an effective and efficient coverage of target groups. A comprehensive social and behaviour change (SBC) support could have catapulted results to higher numbers, as piecemeal efforts cannot change behaviours.

RECOMMENDATIONS

Global evidence indicates that COVID-19 may continue and large-scale vaccination needs to be done. Given this reality, it is imperative that the government of Libya continues its ongoing efforts to keep the epidemic under control. Presented below are some recommendations for strengthening capacities of the government system – Ministry of Health, NCDC, NITAG and PHCI in Libya. Some of these recommendations present the voices of key stakeholders which were assessed during primary data collection. These actions need to be taken up jointly by MoH with support of UNICEF and other stakeholders:

- Review and adapt public health policies and regulations to respond effectively to future pandemics. Provide exposure to national and sub national authorities on global good practices. Align structures of partners with the Government structures for a coordinated response system. Strengthen coordination between different levels of government, private sector and relevant agencies.
- Strengthen healthcare infrastructure, including hospitals, clinics, and testing facilities. Increase capacity for ICU beds, ventilators, and other critical medical equipment, expand and strengthen health workforce including surge capacity planning and experts on RCCE; assess logistics capacity in the country and address gaps - *following the International Health Regulations for Libya*.
- Strengthen coordination of demand generation activities with provision of vaccination services, including adequate infrastructure, trained staff, and robust logistics planning to ensure that the public can easily access and receive vaccinations as promised.
- *Provide technical assistance and capacity building support* to service delivery personnel at all levels especially focused on health systems strengthening and gender sensitive programming. Design and execute training programmes on RCCE and SBC for all stakeholders, as an investment in future RCCE preparedness and response. Focus on strengthening the primary health care system including allocating resources. Strengthen planning committees with participation from all key stakeholders.
- Develop and implement a robust vaccination plan, including prioritization and distribution strategies, ensuring equitable access. Strengthen the RCCE Strategy with clear and consistent communication on preventive measures; addressing misinformation and promoting reliable sources of information.
- Develop and regularly update contingency plans for future outbreaks or emergencies; ensure adequate stockpiles of medical supplies, PPE, and essential equipment and; establish mechanisms for rapid response and coordination across different sectors.
- Strengthen involvement of communities in decision-making and planning processes through on – and off-line mechanisms and technology such as social listening in partnership with local NGOs, community leaders and influencers. Institutionalise *beneficiary surveys into core data systems*: to understand social and behavioural factors, and to monitor coverage and behavioural results.

- *Knowledge management and documentation* - Strengthen documentation, data collection and reporting systems for informed decision-making. Heightened attention needed on desegregated data generation. Expand integrated digital data platform to improve data for decision-making – *Scale up Tahseen to all facilities.*
- *Establish standards / benchmarks for quality:* establish standards for implementing partners focusing on the following: *Service standards; Facility standards; Partner level performance in service delivery; Performance of service providers and Quality of Services Provided.*

1. INTRODUCTION

This chapter presents a general introduction to the assignment background and a summary of the situational analysis of Libya with a focus on the COVID-19 situation and the response underway, and provides specifically, an update on the efforts designed by UNICEF Libya Country Office (LCO) in the country.

1.1 SITUATION ANALYSIS

Libya, officially known as the State of Libya, is situated in the Maghreb region of North Africa. It shares borders with the Mediterranean Sea to the north, Egypt to the east, Sudan to the southeast, Chad to the south, Niger to the southwest, Algeria to the west, and Tunisia to the northwest. Despite being classified as an upper-middle-income country, Libya has faced a series of political and economic challenges since the 2011 revolution. This period initially held promise for a transition towards a peaceful, democratic, and inclusive Libya. However, the absence of a centralized authority and national security structure led to power struggles among factions for control over state resources from 2012 to 2013. This escalated into violent conflict in 2014, resulting in the country's division between eastern and western factions from 2016 to 2018, leading to the establishment of parallel political, governance, economic, and security institutions.¹

In October 2020, a ceasefire agreement brokered by the United Nations paved the way for the Government of National Unity to assume power in March 2021. They were tasked with preparing for elections by the end of the year. However, both presidential and parliamentary elections slated for December 24, 2021, were indefinitely postponed. In February 2022, the House of Representatives in the east designated a new Prime Minister, intensifying political deadlock and straining security, economic, and human rights conditions, exacerbating tensions among political stakeholders.² The combined impact of political instability, armed conflict, the coronavirus disease 2019 (COVID-19) pandemic and the oil blockade resulted in economic deterioration and gross domestic product (GDP) per capita declined from \$12,065 in 2010 to \$3,699 in 2020.³ Real GDP is projected to grow by 18.8 percent in 2023 after contracting by 11.4 percent in 2022.⁴

As of 2021, Libya's population was estimated at nearly 7 million, with 52 percent below 25 years of age, 31 percent under 15, and 11 percent under 5. The absence of a unified national budget since 2014 has led to limited public investment in critical services. Access to basic services has steadily declined, impacting household vulnerability and resulting in detrimental coping strategies. Multidimensional poverty among Libyans increased from 2 percent in 2014 to 9 percent in 2016. Social protection systems remain insufficient to assist those in greatest need. Food insecurity rose from 29 percent in 2015 to 37.4 percent in 2019, with more vulnerable households struggling to meet their basic dietary and nutritional requirements. This has contributed to a rise in child malnutrition, with the prevalence of stunting in children under 5 increasing from 20.5 percent in 2000 to an estimated 43.5 percent in 2020.⁵

Libya's progress towards the Sustainable Development Goals and commitments under the Convention on the Rights of the Child has been impeded by division and gaps in sectoral policies, the absence of a comprehensive national development plan, and significant data deficiencies for child-related SDG indicators.⁶

1 United Nations Sustainable Development Cooperation Framework (UNSDCF), 2023 – 25, Libya

2 ibid

3 UNICEF Country Programme Document, 2023 - 25

4 IMF Country Report No. 23/201

5 United Nations Sustainable Development Cooperation Framework (UNSDCF), 2023 – 25, Libya

6 UNICEF Country Programme Document, 2023 - 25

Libya's health and education systems have seen a marked decline in their ability to provide accessible and quality services. The maternal mortality ratio rose from an estimated 52 deaths per 100,000 live births in 2008 to 72 per 100,000 live births in 2017, with the same figure reported in 2020. Conversely, Libya continued to make steady progress in reducing child mortality rates. Although Libya offers free and compulsory education, school attendance and enrollment rates in primary and lower secondary education seem to have decreased since 2011.⁷

Prolonged conflict and severe water scarcity have led to a notable decline in water, sanitation, and hygiene services, with only 65 percent of households having access to the public water network, and 44.7 percent connected to the wastewater network. Despite its abundant hydrocarbon resources, access to electricity dropped from 100 percent in 2000 to 69 percent in 2019, impacting domestic consumption and economic growth. Renewable energy generation remains minimal, accounting for only 0.03 percent of total energy consumption in 2021, despite the country's considerable solar and wind potential.⁸

Since 2011, Libya has not had a national development plan, hindering coordinated national planning and impeding the ability of international development partners to align their support with national priorities. However, there is an expectation that a new national development plan may be formulated in 2023 based on the outcomes of the UN, World Bank, and European Union supported Recovery and Peacebuilding Assessment (RPBA) process that began in November 2021.⁹

1.1.1 Political Economy Analysis

Libya's economic situation and development have been deeply impacted by a series of political and security challenges since the 2011 revolution. Despite being classified as an upper-middle-income country, Libya has faced significant economic shocks.

The 2011 revolution initially held promise for a transition towards a peaceful, democratic, and inclusive Libya. However, the subsequent absence of a centralized authority and national security apparatus led to competition between factions for control over state resources. This created a destabilizing effect on the economy. The competition for control over state institutions and resources escalated into violent conflict in 2014. This resulted in a fragmentation of the country between eastern and western factions, leading to the establishment of parallel political, governance, economic, and security institutions. This division further hampered economic development. The political impasse has had significant impacts on security, economic, and human rights conditions.

The combined impact of political instability, armed conflict, the COVID-19 pandemic, and an oil blockade resulted in economic deterioration. Gross Domestic Product (GDP) per capita declined significantly. Real GDP is projected to rebound by 18.8 percent in 2023 after contracting by 11.4 percent in 2022. This indicates a potential turnaround in economic fortunes.

The absence of a unified national budget since 2014 has resulted in low public investment in essential services, contributing to rising poverty rates. Food insecurity increased from 29 percent in 2015 to 37.4 percent in 2019. Progress towards the Sustainable Development Goals (SDGs) and commitments under the Convention on the Rights of the Child have been hindered by fragmentation, gaps in sectoral policies, the absence of a comprehensive national development plan, and data deficiencies for child-related SDG indicators. However,

7 United Nations Sustainable Development Cooperation Framework (UNSDCF), 2023 – 25, Libya

8 *ibid*

9 *ibid*

contributing to the realization of SDG 2 and 3, UNICEF continued to focus on bridging the gaps in preventative and curative health and nutrition services in Libya. UNICEF continued to increase access and quality education through system strengthening, therefore contributing to the achievement of SDG 4. In addition to the Annual Work Plan, UNICEF and the Ministry of Education (MoE) signed a COVID-19 response plan, including support to the development of distance learning sessions on core subjects. UNICEF contributed to the achievement of SDG 6 by providing sustainable WASH services and hygiene products as soap, bleach, chlorine, and cleaning materials, together with relevant COVID-19 messaging.¹⁰

Efforts are being made, including by the UN, World Bank, and European Union supported Recovery and Peacebuilding Assessment (RPBA) process, which began in November 2021, to potentially formulate a new national development plan in 2023. This could play a pivotal role in guiding Libya's economic recovery and development in the coming years.

1.1.2 Basic Social Services

Basic social services in Libya have been significantly impacted by the prolonged period of political instability, armed conflict, and economic challenges.

Access to quality healthcare services has been compromised due to the conflict-related damage to infrastructure, shortage of medical supplies, and a decrease in qualified healthcare professionals. Although Libya provides free and compulsory education, there have been reports of declining school attendance and enrollment rates, particularly since 2011. This may be attributed to security concerns, damaged infrastructure, and the displacement of families. The quality of education has been affected by the scarcity of educational resources, as well as challenges in recruiting and retaining qualified teachers. Severe water scarcity and conflict-related damage to water infrastructure have resulted in limited access to clean and safe drinking water for a significant portion of the population. Access to proper sanitation facilities has been hindered, with a notable percentage of households lacking adequate wastewater disposal systems.

Access to electricity has decreased and has had significant impacts on domestic consumption, economic activities, and overall quality of life. Social protection systems are reported to be inadequate in supporting those most in need.

Libya serves as a migratory route towards Europe, and as a result, there are challenges in providing adequate social services for migrants and asylum-seekers. Unaccompanied and separated children face exceptional protection risks, including arbitrary detention and barriers to accessing basic services.

1.1.3 Migrants, Refugees and Unaccompanied and Separated Children

The situation of migrants and refugees in Libya is marked by a complex and challenging set of circumstances. Libya is a major transit and destination country for migrants and refugees, with a substantial number attempting to reach Europe through irregular migration routes across the Mediterranean Sea.

Libya serves as a migratory route to Europe, with an estimated 679,974 migrants in 2022, 11 percent of whom were children, and 4 percent of these were unaccompanied. Migrant and asylum-seeking children, particularly those unaccompanied and separated, face heightened protection risks, including arbitrary detention, barriers to accessing basic services, and high levels of violence, abuse, and exploitation.¹¹

¹⁰ UNICEF Country Office Annual Reports, 2020, 2021 and 2022

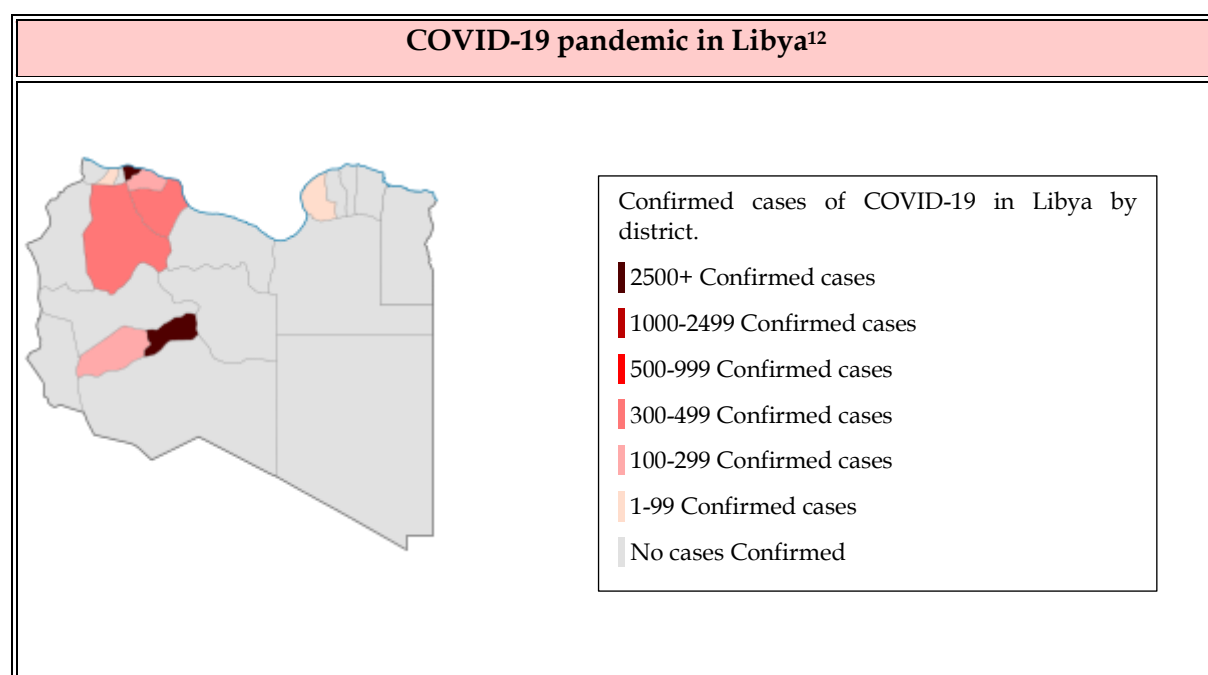
¹¹ IOM Displacement Tracking Matrix, 2023

Migrants and refugees in Libya face significant protection risks. Many migrants and refugees, including children, are arbitrarily detained in Libya, often in overcrowded and unhygienic conditions. There are high levels of violence, abuse, and exploitation faced by migrants and refugees, including cases of forced labor, sexual exploitation, and human trafficking. Access to basic services such as healthcare, education, and legal assistance is often limited for migrants and refugees.

Unaccompanied and separated children (UASC) represent a vulnerable group. They are at particular risk of exploitation, abuse, and trafficking, and often face challenges in accessing adequate protection and support. There is a lack of a comprehensive legal framework for the protection of migrants and refugees in Libya. This leaves them vulnerable to human rights abuses and exploitation. Libya is a major hub for human smuggling and trafficking networks. These networks profit from the desperation and vulnerability of migrants and refugees, exacerbating their risks. Libya has a system of detention centers where migrants and refugees are held. These facilities have faced criticism for their poor conditions, lack of adequate services, and reports of abuse. Libya does not have a functioning asylum system, which means that refugees are not able to seek formal asylum or receive official protection. As a result, they are often at the mercy of smugglers and traffickers.

Humanitarian organizations face challenges in providing assistance due to security concerns, access restrictions, and the complex political and security situation in Libya.

1.2 COVID-19 IN LIBYA



The ongoing COVID-19 pandemic was confirmed to have spread to Libya on 24 March 2020, when the first case was officially confirmed in Tripoli. Libya is considered especially vulnerable to the pandemic due to the effects from the Second Libyan Civil War, which has led to a dire humanitarian situation and the destruction of the nation's health infrastructure.

¹² https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Libya

As of 12 September 2023, Coronavirus cases in Libya are reported to be 507,269 with 6,437 deaths.¹³ As of 15 January 2023, a total of 3,739,158 vaccine doses have been administered,¹⁴ with 2,316,327 people receiving at least one dose and 33.71% of population receiving at least 1 dose.¹⁵

The prevailing situation in the country made Libya's response to COVID-19 particularly challenging. The UN urged all armed groups in Libya to allow humanitarian agencies to obtain access to health care facilities on the ground, especially in the south, to help combat the surge in cases of COVID-19.¹⁶

Most of the displaced people in the country due to fighting were living in overcrowded conditions that allow for the easy spread of the virus. In addition, the country's health system had seen a near collapse, with three quarters of Primary Health Care Clinics not functioning due to shortages in medical staff, supplies, medicine, and equipment. These shortages made it difficult to assess the true impact of COVID-19 on the population. The Development partners including the UN agencies led by WHO worked with health authorities and partners to enhance disease surveillance and monitoring and deliver critical supplies to support the response to COVID-19.¹⁷

The combination of the pandemic alongside crisis, political instability and violence in Libya further emphasized the vulnerability of the country's populace. The COVID-19 measures such as lockdown and restrictions in the movement leading to poor access to health centers and health professionals also contributed negatively to the already shattering health system of the country.

In 2020, the COVID-19 morbidity and mortality rate steadily increased. The deterioration in the healthcare system hampered efforts to control COVID-19. Existing treatment and testing facilities were predominately located in Tripoli and Benghazi and thus large areas were without access to services.¹⁸ In 2021, the third wave of COVID-19 put extraordinary pressure on the already fragile healthcare system. The Ministry of Health declared a public health emergency mid-year. Hospitals across the country struggled to respond to increased hospitalization rates, crippled with weak data systems and critical gaps in supplies and medicines, including personal protective equipment (PPE). With support from UNICEF, the COVID-19 vaccine became available in mid-2021. At the end of 2021, an estimated 27% per cent of the population had received one dose and roughly 12% had received two doses.¹⁹

In 2022, COVID-19 vaccination rates remained low, with a total of 2.3 million people receiving one dose (32%), 1.23 million people received two doses (18%) and 177,468 people received a booster dose by the end of 2022. According to UNICEF Knowledge, Attitudes, and Practices survey on COVID-19 vaccinations, 42.5 per cent of respondents indicated a lack of trust in the healthcare system as the reason for not getting vaccinated. The pandemic had negative impacts on essential service delivery. The secondary impact of COVID-19 on children included loss of education and limited access to health and nutrition services.²⁰

In 2021, the Ministry of Health launched the Libya National Deployment and Vaccination Plan (NDVP) for COVID-19 vaccine under guidance of the National Coordination Committee in

¹³ <https://www.worldometers.info/coronavirus/#!/country/libya/>

¹⁴ <https://covid19.who.int/region/emro/country/ly>

¹⁵ <https://coronavirus.jhu.edu/region/libya>

¹⁶ <https://www.who.int/news-room/feature-stories/detail/libya-fighting-covid-19-in-times-of-conflict>

¹⁷ <https://www.who.int/news-room/feature-stories/detail/libya-fighting-covid-19-in-times-of-conflict>

¹⁸ Country Office Annual Report, 2020, UNICEF Libya

¹⁹ Country Office Annual Report, 2021, UNICEF Libya

²⁰ Country Office Annual Report, 2022, UNICEF Libya

close coordination with the National Immunization Technical Advisory Group (NITAG), the National Centre for Diseases Control (NCDC) and in coordination with key partners WHO, UNICEF, IOM and UNHCR to ensure alignment of policies and plans among agencies and integration of the said plans into national governance mechanisms. This plan outlined the key actions to ensure the quality and high coverage of COVID-19 vaccines in the country under a national coordination mechanism comprising of a multi-sector steering committee and the National Coordination Committee, supported by thematic taskforces.

Several interventions were launched in Libya under the leadership of the Ministry of Health which included establishing a Risk Communication and Community Engagement (RCCE) Working Group in coordination with National Center for Disease Control (NCDC) and other national coordination structures. This working group had contributions and support from UNICEF, UN Women, GIZ, IRC, UNFPA, UNDP, and WHO. A National Vaccine Deployment Plan (NVDP) was developed. A Knowledge Attitudes and Practice (KAP) survey in 2021 revealed an urgent need to raise awareness at the community level in the areas of observing and adhering to preventative measures.²¹

The Tahseen project aims to develop an electronic platform for the National Center for Disease Control (NCDC) that serves as the national Immunization information system for Libya. The platform will register and document the vaccine status for each target person and link vaccine centers with subsidiary local offices and the vaccine main department at the NCDC along with Medical Supply Organization. The system will collect data on the number of vaccinated persons in each municipality and state and provide quick access to detailed and statistical reports.

1.3 UNICEF IN LIBYA

UNICEF is actively contributing to national initiatives aimed at enhancing access to quality services with a focus on inclusivity and risk-aware humanitarian and developmental approaches. The organization prioritizes bolstering systems for providing adaptable and robust social services of high quality, while also engaging in service provision for marginalized groups. Additionally, UNICEF employs a multifaceted approach across its programs, incorporating community involvement, behavioral change initiatives, and forming strategic partnerships with governments, institutions, civil society, the private sector, and UN agencies. Furthermore, UNICEF places emphasis on bolstering the nation's capacity for evidence generation and evidence-based decision-making.

UNICEF supported the Government of Libya in the COVID-19 response and preparedness, particularly working with the Ministry of Health. Since the onset of the COVID-19 pandemic in Libya, with the support of BMZ-KfW, the EU, USAID and the government of Japan, UNICEF has been implementing a multi-sectoral response that focuses on coordination, risk communication and community engagement, Infection Prevention and Control (IPC), and the continuity of essential services, in particular primary healthcare, education, child protection and social protection.

1.4 PARTNERSHIPS

On COVID-19, UNICEF works with the Ministry of Health, NCDC, the National Immunization Technical Advisory Group (NITAG), Primary Health Care Institute (PHCI), the Ministry of Education, Ministry of Social Affairs etc. and United Nations partners, including the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the

21 Terms of Reference, Evaluation of UNICEF Libya's COVID response, UNICEF Libya

International Organization for Migration (IOM) and the United Nations High Commissioner for Refugees (UNHCR). UNICEF also works with international and national NGOs.

1.5 THE ASSIGNMENT

In the above context, the present assignment involved an independent evaluation of the UNICEF Libya's COVID-19 Response between 2020 – 22. The terms of reference (ToR) of this evaluation is provided as Annex 1. UNICEF hired the services of ABH Partners PLC, Addis Ababa, Ethiopia, to carry out the evaluation. The evaluation was carried out between July and September 2023 with primary data being collected in Libya in August and September 2023.

1.6 THE PRESENT REPORT

This report captures the findings of the secondary and primary data and its analysis. The preliminary findings of the evaluation were presented to UNICEF on 18 September 2023. The present evaluation report further consists of the following chapters:

Chapter 2: Evaluation methodology

Chapter 3: Evaluation findings

Chapter 4: Gender and Human Rights

Chapter 5: Conclusions

Chapter 6: Lessons learned

Chapter 7: Recommendations

2. EVALUATION METHODOLOGY

This chapter outlines the approach and methodology followed in the evaluation of UNICEF Libya's COVID-19 Response. It provides an insight into the scope and objectives of the evaluation. Limitations that may have impacted the evaluation are also detailed in this chapter.

2.1 PURPOSE AND SCOPE

As per the ToR, the purpose of the evaluation is twofold: *accountability and learning*. The evaluation serves to be accountable to people and government of Libya as well as stakeholders, including donors who have supported UNICEF Libya's support to the national COVID-19 response. It also aims to provide learning opportunities for the future similar interventions in Libya and beyond. The evaluation findings, lessons learnt, and recommendations will be used to strengthen UNICEF Libya's emergency preparedness and continued efforts in supporting the Government of Libya with a focus on health.

The evaluation has covered UNICEF's nationwide support to the COVID-19 response and related interventions, including those that are implemented through UNICEF's implementing partners. While the support was multi-sectoral, a focus has been placed on health. The period subject to this evaluation was March 2020 – December 2022.

2.2 OBJECTIVES OF THE EVALUATION

The objectives of this evaluation are to examine:

- Appropriateness of UNICEF's support to the needs of the particularly vulnerable population
- Achievements/non-achievements of intended results
- Allocation and use of financial and human resources toward achievement of intended results in timely manner
- Consideration for the humanitarian-development nexus in the Libyan context.
- Effectiveness of coordination from the onset of the pandemic to rollout of response strategies and plan

Additionally, the evaluation has documented lessons learnt and recommendations actionable in short and long-term in preparedness and programming.

2.3 EVALUATION METHODOLOGY

ABH undertook the evaluation following an essentially participatory and consultative approach. The evaluation was conducted using selected humanitarian evaluation criteria to evaluate the subject: *appropriateness, effectiveness, efficiency, connectedness, and coordination*. Crosscutting themes, namely gender, human rights, and disability inclusion, has been considered throughout the evaluation. The evaluators worked according to the core principles of independence, transparency, quality, utility ethics, gender sensitivity and equity.

The evaluation collected data and information from a gender perspective by asking 'gender analysis questions' drawn from the gender analysis toolkit of UNICEF (*details provided in Section 4*). Furthermore, assessment against the criterion has been carried out using a set of evaluation questions (EQs), developed in line with the questions given in the ToR (*refer to the evaluation framework and evaluation questions at Annex 2 which also includes the methods of collecting data and the target respondents*).

The evaluation involved largely qualitative research methods including Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), and desk reviews to triangulate the information gathered (*Annex 3*).

2.3.1 Stakeholder Mapping

A stakeholder mapping was done for the evaluation and is included as Annex 4. This annex also includes the participants of the evaluation.

2.3.2 Evaluation Design

The evaluation adopted contribution analysis (*theory based approach*) to identify the contribution an intervention has made to a change or set of changes. The aim was to produce a credible, evidence-based narrative of contribution that a reasonable person would be likely to agree with, rather than to produce conclusive proof. The analysis assessed causal questions and inferred causality in the evaluation of the interventions. It should offer a step-by-step approach to help UNICEF arrive at conclusions about the contribution their interventions have made (*or is currently making*) to particular outcomes.

The evaluation is summative and used a mixed-method, participatory approach. The evaluation applied mainly qualitative methods of data collection but limited quantitative data was extracted from related documents instead of primary quantitative data collection. Qualitative data was collected using key informant interviews (KIIs), focus group discussions (FGDs), document review and a (*proposed*) validation workshop. The evaluation tools and protocols were translated into Arabic.

The ethical approval for the evaluation was obtained from UNICEF Ethical Review Board. The evaluation adhered to ethical standards within its company policies on Promoting the Protection and Safeguarding of Children and also abided by the UNEG Ethical Standards. The evaluator team complied fully with independence, impartiality, credibility, conflicts of interest and accountability standards. Respondents and participants were not identified by names and they were instead provided a Unique Identifier Code. The respondents' respect for dignity and diversity, right to self-determination, fair representation, confidentiality, and avoidance of harm was complied with. All data collection instruments were accompanied with informed consent forms in which the consent of the respondents was ensured (*please refer to the tools annexed, for details*). All data collected during the fieldwork were stored, organized, analysed, and retrieved guaranteeing confidentiality and eventually handed over to UNICEF upon closure of the assignment.

2.3.3 Literature Review

The evaluation has relied on information available through documents and reports especially the annual work plans (AWPs), Country Office Annual Reports (COARs), Donor proposals and reports, Situation Reports, Monitoring Reports etc. A large set of documents related to the project were shared by UNICEF. Though requested, there was no secondary data, financial reports, etc. available from the government. The limited information that could be generated for quantitative assessment, has been included alongside the qualitative analysis. However, the review of the entire set of documents has been helpful to understand the political, institutional, and service delivery context of the country as well as the operating environment. Bibliography (*Annex 5*) contains select readings for the evaluation.

2.3.4 Primary Data Collection

KIIs and FGDs were conducted to collect primary data. Purposive sampling methods were utilised for the evaluation targeting appropriate respondents at national, baladiya and community levels. The sampling was based on the geographical coverage of the interventions,

the responsibilities (*of respondents*) related to COVID-19 response during the period under evaluation, and the beneficiaries who got (*or were expected to receive*) different services as a result of the response.

Key Informant Interviews - Online / face-to-face individual interviews were conducted with the stakeholders who had in-depth exposure and understanding to the evaluation subject and their context. Interviewees were purposefully sampled and finalized during the inception phase. Each interview was recorded on audio recorders (when *permitted*) and notes were taken. Interviews with respondents from the national level Government Ministries, departments, other national level stakeholders like NCDC, Donor agencies and UN Agency representatives including UNICEF Sections was conducted in person by the Evaluation Team Leader in Tripoli in August 2023. KIIs at sub national levels were done by the national team members including the National Research Coordinator and trained data collectors.

Focus Group Discussions (FGDs) - The FGDs were conducted with homogenous groups. The number of participants per FGD ranged from six to twelve (*male and female*). Participants were from the amongst the community leaders and one FGD was conducted with only female community leaders. The FGD sessions took place in Tripoli, Misurata and Benghazi. The participants were selected by NCDC in consultation with the local health facilities who nominated community leaders well versed with the issues related to COVID-19 in their respective communities.

Validation workshop - A validation of preliminary findings was conducted with UNICEF team and key stakeholders including the government and donors on 18 September 2023. Feedback and comments obtained from the participants have been incorporated in this report.

With beneficiaries, three FGDs were conducted along with 54 KIIs with officials involved in the implementation of the response at various levels – National, Governorate and Municipality level including staff from Ministries, District and Primary Health Care Centres, Medical Service Directorates, Implementing Partners, UNICEF and other UN agencies, Donors and INGOs/NGOs (*please refer to Annex 4 for a list of respondents*).

2.3.5 Data Processing and Analysis

Qualitative data was processed and analyzed using Atlas.ti software. Expected responses based on the different evaluation criteria and evaluation questions were taken in to consideration when developing the code books. Transcripts of the interviews and documents were translated to English and uploaded to Atlas.ti. All interview transcripts were de-identified prior to uploading to the software. Each interview transcript and document had specific document name when uploaded to the software. All documents and interviews were coded. By grouping different codes considering their relatedness to the concept of interest, code groups were created. Similarly, document groups were created. Applying the “Report” function of Atlas.ti, reports were generated by cross-tabulating codes, code groups, documents, or document groups. Findings were then synthesized and presented by the evaluation criteria.

2.4 LIMITATIONS OF THE EVALUATION

The evaluation was conducted with a few limitations:-

As per the ToR, the evaluation did not collect primary quantitative data and it relied upon the secondary literature made available by UNICEF. The aggregated data from any and all sources are part of the qualitative assessment.

The evaluation did not undertake a community-based survey through a house to house visit which reduced the representativeness of the findings to the general population of interest (*total population of beneficiaries of the COVID19 response*).

Qualitative studies are important to have an in-depth knowledge about the process and challenges in the implementation of the response to a global pandemic, but it may be difficult to generalize to the population of interest. The evaluation did not address all possible confounding factors for the success of the nation-wide implementation of the response due to time constraints and limited coverage within the country.

Key informant interviews were not planned with community leaders due to time constraints again. Non availability of financial documents like budgets allocated from the government and other relevant government documents which may have made comparison of programme activities and outputs with what is planned and implemented easier, is another limitation.

To mitigate some of the above, a thorough review of secondary data has been conducted. Proportional number of health facilities were taken from identified municipalities to collect data on access, availability and utilization of COVID 19 vaccination and the role played by UNICEFs contribution through multi sectoral programme response including Health, WaSH, Education, SBC and Child Protection etc. to understand to what extent the response addressed issues. Health facility members who were directly involved in COVID19 response were identified to get relevant information about the programme implementation at the facility level. A validation of the preliminary findings would be conducted with a wide spectrum of stakeholders to confirm the assessment before finalization.

To date, no exercise has been undertaken to assess the fiscal sustainability of pandemic response based on influencing factors in Libya, which offered a challenge to the evaluation. The evaluators could also not access any study on cost-of-service delivery in Libya. In the absence of any available study, this evaluation could not assess whether services could be fiscally sustained in the mid-term or the longer term.

The evaluation accessed gender-disaggregated data from monitoring data made available. However, clear desegregation of status i.e. migrants and refugees offered challenges especially in the absence of government data. Participants in the evaluation had varying levels of understanding of the importance and efficacy of using desegregated data, and some were unable to use it or analyse it.

Notwithstanding the above limitations, it is expected that the findings and recommendations of the present evaluation would be useful to UNICEF, the donors, the government, development partners, and other stakeholders.

3. EVALUATION FINDINGS

This chapter opens with an introduction to the UNICEF support to COVID-19 response in Libya, which shall provide the evaluation context and scope. Thereafter, findings of the evaluation are presented using primary and secondary sources of data from Libya. The findings have been presented following the humanitarian criteria of Appropriateness, Effectiveness, Efficiency, Connectedness and Coordination. Direct quotes from primary respondents have been interspersed in the narrative, as relevant.

3.1 UNICEF SUPPORT TO COVID-19 RESPONSE IN LIBYA

National response in Libya, led by the Ministry of Health and NCDC, followed the National Response Plan against COVID- 19 with 10 pillars. Among these pillars, UNICEF co-led the working groups for Pillar 2 (RCCE), Pillar 6 (*Infection Prevent and Control / WASH*), and Pillar 9 (*Continuity of Healthcare*). In addition, UNICEF contributed to continued access to education and child protection services for vulnerable children and their families as well as the strengthened coordination.

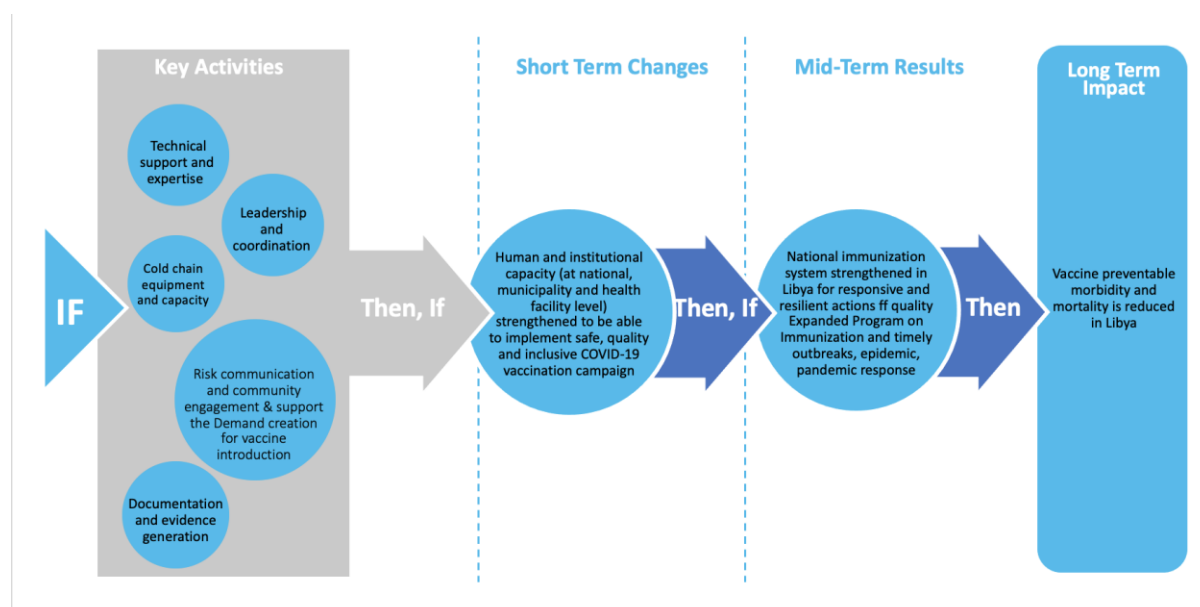


Figure 1: UNICEF's Theory of Change for COVID-19 Support in Libya

Aligned with the Libya Country Programme 2019-2021 and UNICEF Libya's Humanitarian Action for Children, UNICEF extended support to response efforts, collaborating closely with the Ministry of Health, National Center for Disease Control (NCDC), Ministry of Education, Ministry of Social Affairs, as well as other government bodies and UN agencies. UNICEF ensured continued access to education and child protection services for vulnerable children and their families.²²

During the COVID-19 pandemic, UNICEF adopted a comprehensive approach, focusing on key strategies such as enhancing coordination, strengthening institutions and capacities, utilizing communication for development, providing technical assistance, supplying essential materials and equipment, rehabilitating infrastructure, and generating evidence. The organization conducted research to monitor the socio-economic well-being of children and families during the pandemic, along with a study on the impact of COVID-19 on social service delivery in Libya.²³

²² Terms of Reference, UNICEF Libya's Response to COVID-19

²³ *ibid*

The overarching strategy of UNICEF aimed to reinforce Risk Communication and Community Engagement (RCCE), actively promoting preventative and health-seeking behaviors. It facilitated access to improved Infection and Prevention Control measures, critical medical supplies, and Water, Sanitation, and Hygiene (WASH) resources for vulnerable communities. UNICEF also supported the continuity of vital health and nutrition services, child protection, and education for children, women, and vulnerable populations, ultimately striving to limit the transmission of the virus and reduce COVID-19-related morbidity and mortality.²⁴

UNICEF collaborated with the National Center for Disease Control (NCDC) to develop and implement the National Deployment and Vaccine Plan (NDVP) for COVID-19, ensuring the safe distribution of high-quality COVID-19 vaccines through the COVAX facility. The organization conducted training for 104 vaccination supervisors and managers on cold chain and vaccine management to ensure compliance with global standards. UNICEF provided health facilities, including 700 vaccination sites, with Personal Protective Equipment (PPEs), and equipped 438 vaccination sites with cold chain infrastructure, including refrigerators, vaccine carriers, and cold boxes. Additionally, UNICEF installed 1,191 electronic monitoring devices to ensure the quality of vaccines. UNICEF also supported 106 health facilities in delivering responsive primary health services by providing oxygen therapy supplies to COVID-19 triage and treatment units. Over 500 health and non-health staff (291 female, 218 male) received training in infection prevention and control (IPC) to enhance their knowledge and skills.²⁵

UNICEF collaborated with the Ministry of Education to offer remedial classes to 20,000 children across 16 municipalities, utilizing a blended approach of face-to-face and distance education in remedial, catch-up classes, literacy and numeracy, and life skills education. Additionally, UNICEF provided training to 300 Ministry of Education staff to enhance their IT proficiency. The organization also trained school health officers and social workers on health and safety measures in schools, as well as the psychological impact of COVID-19. UNICEF distributed PPE equipment, health booklets, and posters outlining IPC measures in schools. In partnership with the Ministry of Education, UNICEF created social media content on infection prevention and control measures. The organization utilized mobile and internet technology to continue providing psychosocial support and parenting sessions.²⁶

UNICEF significantly enhanced the capacity of more than 800 personnel in delivering WASH services and in strengthening coordination at both national and sub-national levels. This effort is estimated to have benefitted approximately 245,000 individuals with sustainable WASH services and hygiene supplies across 24 targeted municipalities. UNICEF also supported access to safe water, sanitation, and hygiene to mitigate the impact of disease outbreaks.

Furthermore, UNICEF developed a research methodology to monitor the socio-economic well-being of children and families during the pandemic, conducting a comprehensive study on the impact of COVID-19 on social service delivery in Libya.²⁷

However, the reader is encouraged to assess the findings in light of the following key challenges and limitations in execution of the response by UNICEF and other partners in Libya due to operating environment prevailing in the country during the period under evaluation:-

24 Terms of Reference, UNICEF Libya's Response to COVID-19

25 *ibid*

26 *ibid*

27 *ibid*

- Ongoing security concerns, public health measures to manage the pandemic (*movement restrictions and full or partial lockdowns*), thus limiting the ability to engage with communities;
- Operational constraints, such as delays in the vaccination campaign or limited opportunities for pre and post-testing the effectiveness of RCCE initiatives impacted the timely implementation of RCCE activities and hindered evaluation of the impact;
- Lack of Human Resources: High staff turnover and a shortage of skilled/trained staff, both within UNICEF and other partners, coupled with the lack of capacity among partners and;
- Constant changes in understanding response guidelines within and outside Libya, fueled uncertainty, and mistrust: e.g. the emergence of mix-and-match vaccination policies, confusion around priority groups, lack of personal protective equipment (PPEs), and the global tidal wave of constant misinformation and rumors etc.

The following sections present the findings from primary and secondary assessment carried out in Libya during the evaluation.

3.2 RESULTS ACHIEVED

In 2020, UNICEF country office used its network with the media and on social media to support the Risk Communication and Community Engagement (RCCE) strategy, in cooperation with national authorities and addressed outbreaks with tailored messages and community engagement campaigns. UNICEF's social media platforms are considered a reliable source of information, repeatedly quoted by media. During 2020 UNICEF's account on Twitter and Facebook were verified, strengthening the credibility of its messages. UNICEF supported national counterparts to prepare for the COVID-19 vaccine, including micro-planning and support to cold chain and vaccine management, rehabilitation of PHCs, staff training, safety and quality assurance, waste management, demand creation and completion of Vaccine Introduction Readiness Assessment Tool. UNICEF continued supporting the MoE in school re-opening efforts; in June 2020, a video on the infection prevention and control measures taken by MoE for school re-opening was shared on social media, reaching more than 46,000 persons. In addition to PPE equipment distributed to different parts of the country, 10,000 health booklets and 6,000 posters on IPC measures in school were provided to the MoE to support re-opening of the schools. A total of 95 teachers (*37 men, 58 women*) were trained on education in emergencies, child-centred pedagogies and school health. Additionally, UNICEF trained school health officers and social workers on health and safety measures in school and the psychological impact of COVID-19 pandemic. UNICEF provided technical support in the development of COVID-19 response plans. UNICEF developed a research methodology for Monitoring Children and Families in COVID-19 which tracks the socioeconomic well-being of families. UNICEF played an active role in coordinating the COVID-19 response, including chairing the RCCE pillar, Infection Prevention and Control pillar and supported the provision of basic services, including health and nutrition. UNICEF was designated as the COVID-19 Supply coordinator, under the UN Resident Coordinator.

In 2021, UNICEF launched its Humanitarian Action for Children (HAC), in line with the interagency Humanitarian Response Plan, and continued to implement UNICEF's COVID-19 response plan with a focus on the rollout of CoVAX. In partnership with WHO, UNHCR, and IOM, UNICEF provided technical and operational support to the Ministry of Health and the NCDC in the development of a national vaccine deployment plan and supported coordination between government agencies. UNICEF worked with partners to enable 438 vaccination sites to administer COVID-19 vaccines, including through provision of essential cold chain

equipment and PPE. Additionally, UNICEF supported the establishment of the cold chain at the national, regional and municipal level, providing and installing 1,191 electronic monitoring devices to ascertain quality of vaccines, and distributing essential guidance and capacity building for health staff on cold chain management and vaccination supervision. Through the CoVAX facility, UNICEF provided pre-financing for the delivery of COVID-19 vaccines. National capacity development was prioritized during 2021; over 800 competent authorities were equipped with knowledge and skills to effectively implement WASH services and national and sub-national coordination between WASH authorities was strengthened. As a result of UNICEF interventions, approximately 245,000 people were provided with sustainable WASH services and hygiene supplies in 24 targeted municipalities. UNICEF used mobile and online technology to ensure that psychosocial support and parenting sessions continued when in-person service delivery was limited.

In 2022, UNICEF supported enhancing the routine immunization and response to the COVID-19 pandemic in line with the National Deployment and Vaccine Plan. UNICEF provided technical and financial support to the Government in building and expanding the cold chain capacity through the installation of solar-powered refrigerators and cold boxes/tools in 700 vaccination sites. In addition, UNICEF initiated Effective Vaccine Management (EVM) assessment in the country and three NCDC branches (*Benghazi, Sabha, Tripoli*) were equipped. Additionally, UNICEF collaborated with NCDC to scale up the community engagement and awareness creation on the importance of vaccination and promotion of healthy practices. The national RCCE strategy reached 1,110,00 people, contributing to the uptake of vaccines. The MoE remedial classes reached 20,000 children in 16 municipalities, paving the way for stronger NGO-led service delivery and crisis response coordination. Several studies were conducted in 2022 including on COVID-19 impact on Social Service Delivery in Libya.

General

UNICEF has been implementing a multi-sectoral response to the COVID-19 pandemic in Libya since the onset on the virus in March 2020, with interventions focusing on Risk Communication and Community Engagement (RCCE), Infection Prevention and Control (IPC), the continuity of basic services including healthcare, education, and child protection, evidence generation, and support to COVID-19 vaccinations.

From the early stages of discussions regarding the COVID-19 vaccine in Libya, UNICEF has provided continued, intensive technical support and assistance to the MoH and the NCDC. Most notably, UNICEF co-led and supported the development of the COVID-19 NDVP.

UNICEF also

1. Supported the establishment of the coordination framework for vaccination, including the National Coordination Committee, the Multi-Sector Coordination Committee, and other national, regional, and municipal level coordination mechanisms to ensure vaccination through the vaccination sites
2. Supported the regular update of the Country Readiness Assessment for COVID-19 vaccine introduction (Vaccine Introduction and Readiness Assessment - VIRAT).
3. Supported the establishment of taskforces to bridge capacity, planning, and implementation gaps, and ensure preparedness in key areas of vaccine introduction. The taskforces include:
 - Cold chain, vaccine and supply management
 - Training/capacity building
 - IPC and Waste management

- Adverse Events Following Immunization (AEFI) and immunization safety
 - Advocacy, Demand and Awareness creation
 - Vaccination of Migrants and Refugees
 - Monitoring, supportive supervision, and evaluation
 - IT and registration
4. Supported a national cold chain inventory covering 100 per cent of health facilities, about 700 vaccination/health sites; the first time such an exercise was conducted in Libya. Based on findings, UNICEF procured cold chain equipment including cold rooms, refrigerators, and quality assurance devices.
 5. In coordination with partners, supported the development of municipal and health facility micro-plans, incorporating refugees and migrants, covering the population of 104 municipalities, the refugee population (*provided by UNHCR*), and the migrant population (*provided by IOM*)
 6. Facilitated the establishment of a pre-registration mechanism so that priority groups are vaccinated in phase one, followed by other eligible population.
 7. Facilitated establishment of a health facility/vaccination site package to ensure services during vaccination in all targeted sites. The package includes cold chain equipment (*refrigerator, cold boxes, vaccine carriers*), PPEs (*masks and sanitizers*), posters and guidelines for the use of PPEs, awareness materials (*leaflets with Frequently Asked Questions*), roll-ups, and materials for safe disposal of vaccines and medical waste.

3.3 UNICEF ADHERENCE TO GUIDANCE NOTE ON COVID-19 PROGRAMMING

UNICEF developed a guidance note on Programming Approaches and Priorities to Prevent, Mitigate and Address Immediate Health and Socio-economic Impacts of the COVID-19 Global Pandemic on Children in April 2020 and updated it in November 2020. This guidance aimed to:-

- Provide programmatic coherence and consistency across UNICEF when addressing the immediate health and socio-economic impacts of the COVID-19 pandemic on children, families and communities;
- Support the Organization, and country offices in particular, to reprioritize and reorientate programmes for the next two to three years to address the COVID-19 crisis and its impacts.
- Inform advocacy and partner engagement;
- Contribute to organization-wide alignment across HQ divisions, regional and country offices and with National Committees; and,
- Constitute an update to the Programme Guidance dated 6 February 2020. As the COVID-19 pandemic is unprecedented and as UNICEF (*and the world*) is learning how to deal with it, adaptation and flexibility is paramount.

The guidance note was designed for UNICEF staff for developing programmatic, advocacy, fundraising and other related products, tools, programme guidance, or communications materials to support UNICEF's organization-wide response to the COVID-19 pandemic, including engaging in UN-wide planning and advocacy.²⁸

28 Guidance Note on Programming Approaches and Priorities to Prevent, Mitigate and Address Immediate Health and Socio-economic Impacts of the COVID-19 Global Pandemic on Children, UNICEF, April 2020

The guidance note clearly lays down the response mechanism, the criteria for prioritization and sequencing, programme priority areas, priority groups and programme implementation. The evaluation rereferred to the programme implementation parameters (*key implementation strategies*) in UNICEF Libya's response to COVID-19 and has come up with the following findings based on primary and secondary data:

Key Implementation Strategy	Findings
<p>Prioritization and focus</p> <p>Developing a specific focus on key programmatic areas (what) and most vulnerable groups of children and women (who and where) for scaling up programming in response to the COVID-19 pandemic.</p>	<p>The evaluation team looked for evidence of 'business as usual or otherwise' – whether UNICEF prioritized and focused resources on on-going humanitarian crises, based on capacity and emphasis on preparedness, and where the response is having the most collateral impact on children and families. The evaluation looked at whether UNICEF prioritized measures that save lives, protect health and nutrition, and alleviate suffering, based on greatest needs. Also if UNICEF considered inter-agency programme criticality assessments in the existing highly constrained environment to inform the prioritization of resources and business continuity measures.</p> <p><i>The evaluation found evidence of 'thinking out of the box' by UNICEF when it started supporting the pandemic response at the onset of the crisis. It was a unique situation, NITAG and NCDC were working in difference directions; there were no coordination meetings being conducted; vaccines were not available; health systems were stretched; schools were being closed etc.</i></p> <p><i>UNICEF supported the MoH with setting up a national response plan and advocated for coordination meetings; supported the vaccine procurement, its warehousing, carrying out the cold chain assessment and refurbishing them as well as procure new equipment etc. alongside UNICEF provided trainings to critical staff and designed the RCCE strategy; developed partnerships including with local NGOs etc. (please refer also to Section 3.1)</i></p>
<p>Utilising experience and lessons learned</p>	<p><i>The evaluation team is of the view that UNICEF Libya CO applied the experience and lessons shared through the regular guidance being provided by HQs and Regional Office. The Organization will also engage in extensive data collection and real-time analysis to ensure that programming is able to adapt as we learn more. The MENA Regional Office had created a portal for guiding the country offices within its jurisdiction - and this was put to use in Libya by the CO.</i></p>
<p>System strengthening</p>	<p><i>In line with linking humanitarian and development programmes, UNICEF focused on strengthening systems, including health supply chains and supply and distribution planning, service delivery or have been severely affected (some health services have already collapsed). UNICEF work closely with national and local governments, including through their planning, budgeting, implementation, coordination and reporting mechanisms. UNICEF invested in participatory community approaches and CSOs to build their capacity, enhance positive coping mechanisms through the RCCE strategy.</i></p>

Conflict sensitive and risk-informed programming	UNICEF identified existing conflict dynamics or strains to social cohesion to minimize the potential negative impacts for children and their communities ('do no harm'). UNICEF ensured its responses were conflict sensitive, support conflict sensitive government and partner responses, support community inclusion and participation and work with key actors, to reduce misinformation. All of UNICEF's programming was risk-informed and forward-looking to focus on 'building back better' e.g., the back to school campaigns.
Enhancing support for parenting	UNICEF's response to supporting parents during the COVID-19 pandemic was a key accelerator in achieving results for children during and after the pandemic and helped bring children back to schools.
Partnerships	<p>UNICEF LCO developed new and strengthened existing partnerships with the government, UN agencies and other international development partners during the response, which helped maintain and scale up implementation especially when the population was highly affected and prevention measures included partial or total lockdown and restriction of movements.</p> <p>However, there is no evidence of developing partnerships with local youth and women's organizations and companies who could provide the most effective means of gathering data and analysis and of reaching the vulnerable and impacted children and women during crises. These could lead to sustainability and meaningful 'building back better'.</p>
Private sector engagement	There was no evidence of efforts on partnering with the private sector, especially local private sector partners (including private providers in the health sector).
Adolescent and youth engagement and community mobilization, including women's networks	There was no evidence of efforts
Innovation, rapid learning, development of evidence and adaptive programming	UNICEF LCO had initiated an exercise of mapping all NGOs. This should include the private sector potential partners as well. The CO lacks desegregated data and evidence or access to key informants or physical databases. Adaptable programming was not seen (perhaps not contextually appropriate in Libya).
Reprioritisation and reallocation of resources	UNICEF, with support from the flexibility offered from some of the donors, reprioritised resources based on the immediate needs and reallocated resources that could not be used in the current situation. The CO reprogrammed flexible funding to respond to the crisis.
Advocacy	UNICEF undertook significant efforts on advocacy with MoH which resulted in development of the national Health Response Plans and later the NDVP. It also resulted in formation of the National Committees, and Pillar Coordination Committees.

Resource mobilization and leveraging	<i>While this aspect was not assessed, the evaluators feel that there is an opportunity for UNICEF CO along with the Regional Office to explore additional funding towards UNICEF's outbreak response as well as longer-term funding, positioning UNICEF's ongoing COVID-19 response which could highlight its role and reach in risk communication, primary health care systems strengthening, and continuity of education, protection and GBV programmes as well as to highlight the strength as the largest humanitarian warehouse with supply capacity in PPE, essential medicines, vaccine procurement and distribution etc.</i>
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3.4 APPROPRIATENESS OF THE RESPONSE

In this section, the appropriateness of the COVID-19 response in Libya has been evaluated following the relevant evaluation questions. This section is based on an extensive review of available documents, key informant interviews, and focus group discussions.

The evaluation looked at the extent to which the response's strategic design, direction, and intended results were consistent with the needs of beneficiaries, and remained suited to the conditions of the context, over time. The evaluation assessed whether the response addresses the core issues of vulnerable families, girls and boys and if it adapted itself to the changing needs and context, timely. The evaluation also looked at the alignment of the response with National and UNICEF's priorities.

UNICEF and other UN agency staff, donors, partners, government officials as well as community leaders at various levels in Libya were asked about the response and their opinion on its appropriateness. They mentioned that the response is highly appropriate as it offered timely and critical response to the vulnerable communities in Libya through strategic support at national and sub national levels with technical assistance, capacity building and at community level with raising awareness and making sure communities knew about the efficacy of vaccination and dispelling any rumors and myths associated with large scale vaccination.

Some of the interventions most cited included the coordination efforts, development of response plans, formation of coordination committees and task forces, strengthening capacities through provision of critical supplies and training, coverage of all vulnerable populations, and above all procurement and management of vaccine delivery in the country along with Risk Communication and Community Engagement (RCCE) interventions etc. When despite being a rich country, the focus is not on preventive and primary health care, the response supported by UNICEF was not only appropriate but lifesaving.

The implementation has been done jointly by UNICEF and partners. This was as per the plans developed in consultation with the Ministry of health and its bodies and also in line with the country office strategy as well as programmatic guidance on the subject developed by UNICEF. The response used capacity strengthening as one of its components and has strengthened capacities of Libyan health authorities at all levels as well as the NGOs. The evaluation found this to be promising.

UNICEF's mission is to protect the rights of women and children wherever and whenever they are not ensured. Despite a complex and fragile context, UNICEF has maintained an active presence and delivered large multi-sectoral programmes in Libya. UNICEF planned to respond to COVID-19 building on its comparative advantage, previous gains, and lessons

learned, and with emphasis on inter-sectoral approaches centered on complementary pillars of interventions in the areas of pandemic management.

The response was conceptualized to focus its interventions at the local level - to deliver and to enhance utilization at the community level - and building capacities of duty bearers in the NGO sector as well as of government functionaries. While working with NGOs, it complemented and supported the planning and implementation at various levels and thereby strengthened partners' organizational capabilities and planning skills. There was no significant recall amongst respondents on possibilities of duplication of efforts barring a few where coordination was lacking initially, but was later corrected. The evaluation found that the COVID-19 response is still valid and adaptive in the country and remains appropriate to the evolving development of strategic plans and community needs.

The response, which initially had outlays only for the Libyan population, went to on provide coverage to the extremely vulnerable migrant and refugee population.

The approach is found to be an appropriate one in the context (*generally and the protracted crisis*), and remains aligned with the UNICEF Country Programme Document, 2020 United Nations Strategic Framework Evaluation; the United Nations Sustainable Development Cooperation Framework (UNSDCF), 2023–2025; the 2020 Country Programme Evaluation; the 2022 Situation Analysis for Children, Adolescents and Women in Libya; the 2021 United Nations Common Country Analysis; the 2021 Gender Programme Review and; the 2021 report Libya Humanitarian Needs Overview.

Under the circumstances it is difficult to look at alternatives - vulnerable families and children are at stake and the socio-political situation of the country is in a dire condition. The response was the one which offered hope in mitigating the pandemic crisis.

The evaluators tried to access and assess the relevance in line with the national programme goals but policy documents could not be accessed from the government. As per the KII respondents, due to the prevailing conditions in the country, despite improvements in some levels of basic services, the Ministries have been grappling with issues such as resource constraints, staff shortage and turnover, capacity limitations, and weak transparency and accountability systems. The response has been supporting the NCDC and other institutions revisit some of their gaps and finding solutions to rectify them while addressing some of these challenges by implementing capacity building and system strengthening activities.

All the aforesaid points remained valid at evaluation of the response, reassuring the appropriateness and relevance of the objectives in the country context. However, the present evaluation finds that the response interventions are unable (*by design*) to address adequately, the issue of equitable services. The evaluation did not compare and therefore could not assess progress towards bridging regional or inter baladiya disparities and inequities in accessing basic services especially for the population with special needs, etc. in the absence of data from government-run facilities.

During FGDs, community leaders had varied opinions in their responses on appropriateness across different locations. While some complemented the government led UNICEF supported response to COVID-19 as appropriate, a few felt this was little and too late.

In Tripoli, most participants were not aware of UNICEF contribution. In Benghazi all participants knew about UNICEF support. They did not attribute any direct benefits for either themselves or their family members. Only a few pointed out the messages that were disseminated using several platforms on the web and social media. They felt that the response was delayed and the prevalent travel restrictions and crowding at market places hampered

the response uptake. Those related to the health department mentioned that they faced shortage of health workforce and medical equipment.

“The absence of some doctors from their work in health care centers, hospitals and isolation centers as well as delay in providing vaccinations to citizens compared to the rest of the world, all contributed to delayed COVID-19 response”

FGD Participant

“UNICEF contributed to the response to the Corona pandemic in Libya in the field of training and providing capabilities, but it was late.”

FGD Participant

In Benghazi, the FGD participants were fairly satisfied with the government's COVID-19 response, acknowledging the fact that it was somewhat late in dealing with the pandemic. All respondents were aware of UNICEF's assistance to the COVID-19 pandemic, and stated that there was no prejudice based on gender, disability, or refugee status. However, only half of them felt that UNICEF's support for the COVID-19 intervention met the needs of vulnerable families, girls, and boys and that further efforts are needed to address them. In terms of obtaining behavioral messages from UNICEF, all responded that messages were available through UN websites and NCDC.

“The COVID-19 response measures followed by the government were late in terms of dealing with the pandemic.”

FGD Participant, Benghazi

Due to the observations from the above, the evaluation is of the view that the response is viewed as important and appropriate to the context of Libya (*despite its limitations*). It is a human rights-based approach that encompasses indirect (*and direct*) provision of services for vulnerable population of the country and at the same time, endeavors to build the capacity of duty-bearers to fulfill their responsibilities. Additionally, UNICEF strives to strengthen and develop systems and policies for basic service delivery with sensitivity towards the specific vulnerabilities of the different groups of women and children, with consideration towards migrants and refugees, and to mainstream gender and human rights.

The response remained appropriate as it considered local realities and the needs of target groups in the country.

The response is coherent with the UNICEF policy of development and humanitarian nexus to support decentralised delivery of basic services at community levels. Coherence with the implementation of National Programmes could not be assessed in the absence of literature on the subject. Besides, as evident from the Country Office Annual Reports (COARs), the response is multi sectoral which helps in improving basic service delivery. Working with the government and NGOs and local institutions provide the scope of integrated service delivery for example at schools.

The response has enhanced coordination and synergy between UNICEF and Government as well as Development Partners and other UN agencies, it has helped build trust amongst the partners as a reliable and technically competent agency. The response was a resource intensive one, and also relied on technical assistance and supplies.

3.5 EFFECTIVENESS OF THE RESPONSE (PROGRESS IN ACHIEVING RESULTS)

The effectiveness of the response has been assessed to the extent to which it has achieved the targets in the Work Plans; whether results were realistic and if they still meet requirements. The evaluators also

looked at factors crucial for achievement or failure to achieve results. The findings of the section emanate from the secondary literature review as well as from KIIs with a cross-section of stakeholders, and FGDs.

3.5.1. Effectiveness of the Response

This section describes the extent to which the programme demonstrated expected results against the planned outputs which are outlined in annual planning documents like Annual Work Plans (AWPs) and Rolling Work Plans (RWPs). As this was an emergency response, planning assumptions were not included in the AWPs. However, an in-depth analysis of the planned outputs in donor proposals and reports against the planned interventions was carried out and is presented henceforth.

3.5.1.1 Progress towards Achieving Objectives and Targets

Progress has been assessed using available information and statistics (*wherever possible*), the figures quoted in the donor reports and UNICEF Country Office Annual Reports (COAR) for 2020, 2021 and 2022. For indicators to measure results, the evaluation made efforts to consider those included in the RWPs / AWPs of the Child Survival and Development Programme. While studying the RWP for 2019 – 22, the evaluation found that there was no planned intervention specifically for addressing COVID-19 (*which is obvious, as this was an unprecedented epidemic*) and hence an analysis was not possible. Unintended or negative results could not be ascertained from the COARs. The evaluation considered values of indicators but there was no baseline to compare with in the AWPs or donor proposals (*an analysis of donor funded interventions is presented further in the section*); hence, making it difficult to identify unintended results due to programmatic changes or modifications during the implementation period. The evaluation did not have any comparison group including intervention results from other programs. It is important to be reminded that the operating environment in Libya is challenging, and while efforts can be measured, results are difficult to articulate and attribute to, especially in the absence of data on government programmes.

For the period 2021 – 22 there were two AWPs for CSD section – one with the NCDC and another with the PHCI. The one with NCDC had an Output 2 – aiming at immunization against vaccine preventable diseases focusing on Polio and Measles. The activities listed included cold chain support; capacity building of relevant staff; C4D / awareness raising on importance of vaccination and risk communication; data management including EVM and other assessments; monitoring and supportive supervision and; documentation. With the AWP with PHCI, the following interventions were included as programme components: Training and capacity building; Supplies/Service package; Promotion of healthy Practices; Data Management; Monitoring, evaluation & documentation and; Response to emergencies (*which included a reference to pandemics in general*).

Against the above planned interventions, as per the COARs for 2021 and 2022, UNICEF provided support to the development of a national vaccine deployment plan; worked with partners to enable 438 vaccination sites to administer COVID-19 vaccines; through the CoVAX facility, provided pre-financing for the delivery of COVID-19 vaccines, co-led the RCCE working group and supported the development of the national strategy. UNICEF used mobile and online technology to ensure that psychosocial support and parenting sessions continued when in-person service delivery was limited. UNICEF collaborated with NCDC to scale up the community engagement and awareness creation on the importance of vaccination and promotion of healthy practices. UNICEF provided support to the development of a national Risk Communication and Community Engagement (RCCE) strategy, which resulted in RCCE activities, that reached 1,110,00 people, contributing to the uptake of vaccines. Additionally, the COAR states that several studies were conducted in 2022 using primary and secondary analyses, including COVID-19 impact on Social Service Delivery in Libya.

There were several other results listed in the COAR which included the MoE remedial classes reaching 20,000 children in 16 municipalities. UNICEF supported in reducing the impact of disease outbreak (*including COVID-19 infection*) by ensuring access to safe water, sanitation and hygiene, with a focus on the most vulnerable. UNICEF prioritized National capacity development and over 800 competent authorities were equipped with knowledge and skills to effectively implement WASH services and national and sub-national coordination between WASH authorities was strengthened. As a result of UNICEF interventions, approximately 245,000 people were provided with sustainable WASH services and hygiene supplies in 24 targeted municipalities.

It is difficult to compare the results against workplans in this case as this was an emergency response and many of the achievements were not initially targeted.

3.5.1.2 Progress Performance

The following analysis is done for a few of the several donor funded interventions which were requested and secured by UNICEF from donors for supporting the response to COVID-19 in Libya during the period under the purview of the evaluation.

A. Federal Ministry of Economic Cooperation and Development / Kreditanstalt für Wiederaufbau Bankengruppe (BMZ – KfW) - Support to safe, quality and inclusive introduction of COVID-19 vaccine in Libya

Output/Activity	Findings
<p>Output 1. Support the Ministry of Health in ensuring adequate cold chain system in place for roll-out of the vaccination campaign</p> <p><i>Activity 1.1. Analyze the results of the national cold chain inventory, looking at gaps and needs to improve systems for the COVID-19 vaccine and for routine immunization programmes</i></p>	<p>UNICEF supported the NCDC to hire a consultant who conducted the national cold chain inventory analysis. A gap analysis was carried out and the findings disseminated to key partners and stakeholders in July 2022. UNICEF, in coordination with the NCDC organised a dedicated dissemination workshop to discuss the findings of the analysis.</p>
<p><i>Activity 1.2 Procure cold chain equipment for the supported 426 health facilities that will be involved in the vaccination campaign</i></p>	<p>UNICEF procured and delivered cold chain equipment to 426 vaccination sites and to the medical supply stores to support the COVID-19 Vaccine transportation, handling and storage during the vaccination campaign.</p>
<p><i>Activity 1.3 Distribute, store, transport and install the cold chain equipment in the targeted health facilities</i></p>	<p>Under this activity in collaboration with the NCDC, UNICEF supported the delivery and installation of cold chain equipment in 426 vaccination sites, in addition to the installation of 26 cold rooms.</p>
<p><i>Activity 1.4 Undertake capacity-building activities for cold chain and vaccine management</i></p>	<p>In 2022, a total of 878 staff, over 852 initially targeted, saw their capacity enhanced on Cold chain and vaccine management in three regions with aim to ensure quality vaccine administration in the country.</p>
<p>Output 2. Strengthen in-country capacity for vaccination campaign</p>	<p>In 2022, UNICEF participated in all four technical coordination COVID-19 meetings organised by the</p>

<p>coordination and roll-out, including quality assurance measures</p> <p><i>Activity 2.1 Continue strengthening government-led national coordination, including NCDC, NITAG, Multi-Sectoral Steering Committee, and Task Forces</i></p>	<p>NCDC to support coordination efforts and provide technical support and guidance.</p> <p>UNICEF was an active participant in three NITAG meetings held in 2022, providing technical inputs and guidance</p> <p>UNICEF co-led the RCCE WG with NCDC. The RCCE TWG contributed to better coordination, transparency and collaboration among a myriad of partners in the country to reach communities with one voice. IEC materials were shared among partners for distribution.</p>
<p><i>Activity 2.2 Undertake refresher trainings to an estimated 6,000 vaccinators and staff critical to the roll-out of the vaccine, including vaccination monitors, with refresher trainings throughout the project and lessons learnt workshop</i></p>	<p>Vaccine supervisors and CCVM master trainers was the starting point of a cascade training for 6,000 vaccinators and health facility staff nationwide. Out of this total, 3,153 were trained by UNICEF, while the remaining staff were trained by other partners, including NCDC and WHO. Around 700 health facilities conducted vaccination activities in the country and benefited from the cascade training which was launched in the first quarter of 2022.</p>
<p><i>Activity 2.3 Implement quality assurance activities including the provision and placement of quality assurance devices, intra-campaign monitoring, post-campaign evaluations, and related documentation</i></p>	<p>In 2022, UNICEF supported the installation of cold rooms in 90 sites for the effective storage of vaccines and linkages were established with vaccination sites for timely delivery of vaccines. In addition, 426 vaccination units were equipped with cold chain equipment enabling them to effectively store vaccines.</p>
<p><i>Activity 2.4 Continue the scale-up and the roll-out of the DHIS system, incorporating data on vaccine coverage</i></p>	<p>The Libyan government initiated implementation of Tahseen, the first NCDC electronic governmental system, which was launched in November 2021. In 2022, UNICEF, in cooperation with the Health Information Center at MoH, trained 200 statistical officers and provided information technology (IT) equipment to 426 primary healthcare centers (PHCs) across the country. The training covered DHIS2 data analysis, with special focus on vaccination indicators.</p>
<p><i>Activity 2.5 Conduct a post-campaign Knowledge, Attitudes, and Practices (KAP) assessment and other evidence generation</i></p>	<p>RCCE program is based on evidence from two KAP assessments commissioned by UNICEF Libya. This Project enabled the follow-up KAP study which informed implementation of DRCCCE 2022 activities.</p>
<p>Output 3. Increase the acceptance for vaccines through demand creation, risk communication, and community engagement.</p> <p><i>Activity 3.1. Collaborate with the NCDC/MoH and other stakeholders, continue to implement</i></p>	<p>UNICEF co-led the national RCCE working group, together with NCDC. The working group played a key role in strengthening coordination between partners in the RCCE taskforce. Together with the working groups, one national DRCCCE plan was developed covering all municipalities.</p>

<p><i>the national DRCCE strategy and key messages</i></p>	
<p><i>Activity 3.2 Continue the dissemination of messages and the implementation of awareness campaigns, safety of vaccines and importance of continuation of the preventive measures and work to address rumours and manage misinformation</i></p>	<p>UNICEF, in collaboration with NCDC and the RCCE technical working group, rolled out an RCCE campaign in 25 municipalities, including the training and deployment of 149 social mobilizers for house-to-house and street-to-street community mobilization.</p>
<p><i>Activity 3.3 Plan and implement context-specific events for particular locations and groups such as migrants, refugees, minorities, and displaced populations</i></p>	<p>In collaboration with the Primary Health Care Institute of the MoH, UNICEF supported knowledge and awareness-raising sessions on the importance and benefits of COVID-19 vaccination to increase vaccine uptake of migrants in target detention centers.</p>

B. Federal Ministry of Economic Cooperation and Development / Kreditanstalt für Wiederaufbau Bankengruppe (BMZ - KfW) - Multi-sectoral Preparedness and Response to Novel Coronavirus Pandemic in Libya with the Focus on the Most Vulnerable Population

Output/Activity	Findings
<p>Output 1.1: The RCCE component of the Project will contribute to SDG 3 - Good Health and Well Being through the promotion of COVID-19 preventive measures and encouraging health-seeking behaviour.</p> <p><i>Activity 1.1.1 Coordinate and operationalize an integrated national RCCE plan and regional RCCE strategies.</i></p>	<p>Nine regular and ad hoc working group meetings were held from January to December 2022 and bulletins developed and disseminated.</p> <p>This activity was followed by the establishment of Nationwide Media Network group consisting of the trained media focal points, health promotion workers from line ministries, and partners. This network was used to disseminate messages in a timely and effective manner to counteract COVID-19 misinformation and vaccine misconceptions and to share all relevant information and exchange learning.</p>
<p><i>Activity 1.1.2 Support the development and dissemination of key prevention messages, and address rumors and misinformation</i></p>	<p>UNICEF developed and disseminated key messages on COVID-19 prevention focusing on promoting adherence to the preventive measures. Messages were broadcasted on indoor and outdoor electronic screens at the busiest malls in Tripoli and Benghazi, estimated to have reached 660,000 people.</p>

<p><i>Activity 1.1.3 Documentation and behaviour assessment</i></p>	<p>Funds from this project contributed to the follow-up COVID-19 Knowledge, Attitudes, Practices (KAP) Assessment in Libya. This KAP assessment showed that: (i) Mantikas in the East and South tend to show relatively higher resistance to vaccines; (ii) Social media is the key source of information on COVID-19 vaccines; and (iii) Protecting personal health and that of their family, and community are the main drivers of vaccination, while lack of trust in available vaccines, fear of side effects and the inconvenience of appointment times (<i>especially for females</i>) are the major deterrents.</p>
<p>Output 1.2: IPC/WASH interventions - Clean Water and Sanitation; Good Health; Quality Education and; Peace, Justice, and Strong Institutions</p> <p><i>Activity 1.2.1 Provide support to the coordination of the IPC Pillar and the WASH sector</i></p>	<p>UNICEF co-led the IPC sub-working group in collaboration with the WHO, MOH and the NCDC to ensure coordination on IPC interventions nationwide amongst local and international partners, and government counterparts.</p> <p>UNICEF also continued co-leading the WASH sector and to coordinate activities with sector partners.</p>
<p><i>Activity 1.2.2 Provide persons in collective centres, schools, and communities with access to hygiene items and information, and healthcare facility and other key staff with personal protective equipment (PPE)</i></p>	<p>UNICEF procured and distributed around 5,000 hygiene items and cleaning kits in IDP camps, schools, and the wider community to support the prevention of the spread of COVID-19. The hygiene items benefitted around 25,000 persons (12,750 females, 12,250 males). The distribution prioritised areas in the south region including Sebha, Barak, and Bint Bayah.</p>
<p><i>Activity 1.2.3 Provide capacity building and awareness-raising to national authorities, healthcare workers, and partners on IPC measures</i></p>	<p>Capacity building training reached a total of 213 staffs (140 females, 73 males)</p>
<p><i>Activity 1.2.4 Provide light rehabilitation, disinfection, cleaning and WASH services in health facilities, detention centres, IDP/collective shelters, communal spaces, and schools</i></p>	<p>The activity was completed in 2021 with the light rehabilitation works of six facilities, including three collective centres and three Primary Healthcare centres (PHCs). The scope of the rehabilitation included the repair of water and sanitation pipelines, installation of toilets seats, wash basins, water taps and heaters. The works also included tiling and ceramic work, painting, repair of windows and the doors of the latrines, and installing small water pumps and water tanks.</p>
<p>Output 2.1: Ensuring continuity of basic healthcare for women, children, and other vulnerable populations</p> <p><i>Activity 2.1.1. Equip 20 targeted health facilities and isolation sites</i></p>	<p>UNICEF delivered essential and emergency medical supplies and equipment in 20 target health facilities for provision of integrated primary health care services to affected women and children.</p>

<i>with lifesaving and essential supplies</i>	
<i>Activity 2.1.2 Strengthen evidence generation through District Health Information System (DHIS) implementation in 20 targeted health facilities</i>	Intending to strengthen primary healthcare evidence generation, UNICEF procured tablets and laptops for distribution to the 20 facilities targeted under this project.
<i>Activity 2.1.3 Build the capacity of healthcare staff on multiple disciplines (new-born, maternal and child healthcare)</i>	UNICEF and the MOH's Primary Health Care Institute (PHCI) conducted four trainings for healthcare staff to build their capacity in key areas. In total, 38 health care workers and six other staff were trained.
Output 2.2: Child Protection response of UNICEF, through MHPSS interventions <i>Activity 2.2.1 Conduct community awareness-raising sessions and campaigns to prevent child protection and violence against children</i>	UNICEF and its implementing partners conducted awareness-raising sessions on child protection for the communities in Tripoli, Misrata, Benghazi and Sabha, whilst ensuring adherence to COVID-19 preventive measures. In total, at least 4,175 community members including 2,254 parents/caregivers (2,171 women and 83 men) and 1,921 children and adolescents (1,153 boys and 768 girls) were reached.
<i>Activity 2.2.2 Build the capacity of child protection and non-child protection actors including social workers, on MHPSS, child protection approaches, and GBV prevention during COVID-19, including sessions for all partners and social workers on the prevention of sexual exploitation and abuse (PSEA)</i>	UNICEF and its partners, the IRC and DRC conducted various capacity building activities on MHPSS, child protection approaches including GBV Prevention and response and PSEA reaching 222 child protection and non-child protection actors (184 women and 28 men).
Output 2.3: Activities geared towards ensuring access to education <i>Activity 2.3.1 Conduct rehabilitation for the WASH facilities in 12 schools to Improve the situation of WASH facilities in these schools</i>	With the aim of providing school children with adequate access to water and sanitation and help prevent the spread of COVID-19, UNICEF rehabilitated the WASH facilities of four schools in the eastern region and work was underway for WASH rehabilitation of eight other schools.
<i>Activity 2.3.2 Provide quality non-formal education in community centres for vulnerable children and adolescents through remedial and catch up classes, life skills sessions, and recreational activities</i>	Intending to reach 3,000 children and adolescents with quality non-formal education services in the form of remedial classes, UNICEF initiated three small-scale funding agreements with three national organisations in the eastern municipalities of Alkufra, Tobruk and Derna.
<i>Activity 2.3.3 Provide COVID-19 related and distance/online</i>	UNICEF distributed 15 tablets to its partner Multakana in Tripoli. UNICEF and Multakana operated a community

<p><i>learning materials for children and teachers or facilitators in the targeted schools and centres (including masks, sanitizers, PPEs...)</i></p>	<p>centre (Baity centre) in the Ain Zara area of the city (funded by other donors).</p> <p>UNICEF also procured Personal Protective Equipment (PPE), including 111 5-litre hand sanitisers, 56,250 100ml hand sanitizers, and 624 thermometers, for distribution to schools in the east and the west in February 2022</p>
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C. Government of Japan for Emergency Assistance for Prevention of Further Spread of the Novel Coronavirus (COVID-19) Infection

Output/Activity	Findings
<p>Component A) Provision of supplies</p> <ul style="list-style-type: none"> <i>Improve Infection and Prevention Control (IPC) and provide critical medical and water, sanitation and hygiene (WASH) supplies</i> <p>Target</p> <ul style="list-style-type: none"> <i>At least 150,000 people, including children and women, in target countries reached with critical medical, prevention and WASH supplies/hygiene items and services.</i> 	<p>Approximately 296,463 people (151,196 females, 145,267 males) were reached with critical medical, prevention and WASH supplies/hygiene items and services</p>
<p>Component B) Soft component</p> <ul style="list-style-type: none"> <i>Strengthen risk communication and community engagement including digital engagement and rumours monitoring; develop and disseminate key messages through various channels such as social media, TV/radio programmes, community engagement, drama, community and health extension network, and through partners and other network, amplify messages to hard-to- reach population, work with celebrities/UNICEF ambassadors to reinforce core message and respond to misinformation by obtaining key messages.</i> <p>Target</p> <ul style="list-style-type: none"> <i>At least 4,800,000 million people, including children and women, reached through risk communication and community engagement activities.</i> 	<p>Approximately 4.6 million people reached through RCCE since the start of the national COVID-19 response.</p>

<ul style="list-style-type: none"> • <i>Support the provision of continued access to essential health and nutrition services for women, children and vulnerable communities, including case management</i> <p>Target</p> <ul style="list-style-type: none"> • <i>200 health care facility staff and community health workers trained in IPC</i> • <i>120,000 children and women receiving essential health care services, including immunization, prenatal and postnatal care, HIV care and GBV response care in UNICEF-supported facilities.</i> 	<p>183 staff (93 women, 90 men) were reached.</p> <p>The items provided ensured the continuation of EPI services in 702 vaccination sites for three months, reaching at least 3,500 health care workers (1,785 women, 1,715 men), and 83,000 children (42,330 girls, 40,670 boys) and their accompanying guardians.</p> <p>At least 170 health care workers (87 women, 83 men) benefitted from these items, that covered ongoing health service provision for two months. These facilities provided services for at least 5,000 COVID-19 patients (2,550 females, 2,450 males).</p>
<ul style="list-style-type: none"> • <i>Data collection social science research for public health decision making</i> <p>Target</p> <ul style="list-style-type: none"> • <i>120,000 children and women receiving essential health care services, including immunization, prenatal and postnatal care, HIV care and GBV response care in UNICEF-supported facilities.</i> 	<p>Around 1,800 patients (918 females, 882 males) and 100 emergency healthcare workers (51 women, 49 men) were reached.</p>
<ul style="list-style-type: none"> • <i>Support access to continuous education, social protection, child protection and gender-based violence (GBV) services</i> <p>Target</p> <ul style="list-style-type: none"> • <i>500,000 children supported with inclusive distance/home-based learning</i> • <i>200 personnel (staff and volunteers) across all sectors responding to COVID-19 emergency who are trained on GBV– including ‘do no harm’ and risk mitigation, protection from sexual exploitation and abuse (PSEA), safe and ethical handling, including of disclosures, and facilitating appropriate referrals for survivors</i> • <i>Number of households affected by COVID-19 receiving multisectoral cash grant for basic needs</i> 	<p>97,500 children (49,725 girls, 47,775 boys) benefitted from support to distance learning education.</p> <p>103 partners and staff (53 women, 50 men) were trained on PSEA; 6 partner staff (3 women, 3 men) were trained on child protection approaches.</p> <p>135 children (58 girls, 77 boys) provided with child protection services: MHPSS and case management.</p> <p>46 community members (16 girls, 11 boys, 16 women, 3 men) participated in community-based activities.</p>

3.5.2 Findings on Service Delivery

Key findings based on primary data collected from the implementing partners of UNICEF and the beneficiaries during the evaluation are as follows:-

Service standards: As per key informants, in most locations where the response has been assessed, the implementing partners have developed service standards for providing services. These are aligned to guidelines from MoH and other international standards and protocols. This is an encouraging trend. However, while developing service standards is necessary, it may not be enough to improve service quality.

Facility survey: Implementing partners stated that they conduct activities as outlined in their respective Programme Document (PD) or Project Cooperation Agreements (PCAs). A few mentioned having specific manuals, while others don't. It would be beneficial for UNICEF to have an assessment of activities at facilities being managed by implementing partners and at outreach sites as this is where beneficiaries are exposed to implementing partners (*also to assess safeguarding issues*).

Beneficiary survey: From the reports as well as other relevant documents reviewed, evidence of beneficiary feedback was seen, though limited, conducted by some partners. The need for use of this important tool cannot be over-emphasised and needs to be systematically carried out.

Partner level performance in service delivery: All the implementing partners stated that they have an understanding of the performance expectations. The partners have a willingness to, as well as some experience of assessing service delivery at facility levels.

Performance of service providers: As per the respondents during KIIs, there is no system to assess the performance of service providers at facilities, presently. Respective implementing partners have their systems to assess staff performance. However, this is not a standard practice across the partners.

Quality of Services Provided: The perception of improved service was underscored by several factors such as easy access to services, improved infrastructure, availability of enough numbers of qualified providers (*especially female*), use of local languages, and no discrimination in attending to beneficiaries. During the evaluation, the KII respondents were asked to respond to questions related to the factors influencing the quality of service delivery.

The challenges and constraints of service delivery cannot be expressed more than what has already been mentioned related to the operating environment. The challenges as outlined by most of the respondents during KIIs were around insecurity. Additionally, the evaluation found that high staff turnover hinders implementation. This (*maybe*) is largely due to the movement of people, inappropriate remuneration, limited growth opportunities, poor work environment, and heavy workload. Shortage of skilled/trained human resources is another constraint in effective delivery.

3.5.2.1 Engagement in Planning of Response

In most cases, non-UNICEF key informants and FGD participants indicated that they were not directly involved in the planning of the response. Only a few mentioned being aware of the planning and consultation process.

3.6 EFFICIENCY OF THE RESPONSE

This chapter deals with the evaluation of efficiency of the COVID-19 response, which includes assessment of strategic and timely allocation of resources to achieve results. It also assesses implementation and risk management. Efficiency is generally also assessed against value-for-money (VfM) and financial management and procurement; however, this was not undertaken in the

evaluation. The evaluation has mainly relied on a review of secondary literature and analysis of secondary data.

The evaluation intended to explore the extent to which the response achieved value for resources, and how results were achieved, if at all, in a timely and cost-effective manner. The evaluation could not access financial data to arrive at conclusions and relied on the COARS, Donors reports, and information shared by KII respondents.

During key informant interactions, the evaluation found that the response is a natural fit in pandemic management.

3.6.1 Assessment of Value-for-Money (VfM)

A VfM analysis collects and analyses data on the costs and results of a specific programme or service delivery arrangement. A key objective of the VFM analysis is to support service delivery and improve performance; it can give useful metrics on appropriate interventions to address service delivery challenges, including through the contracting of private or other non-public providers.

The evaluation did not require, nor the evaluators carried out a full value for money study. However, the evaluators undertook its key principles and applied it with contextual adaptation to allow an efficiency analysis, along with the use of other tools, data, and criteria.

Cost drivers: For interventions of similar nature, the most significant cost component is salaries of staff, followed by expenses on activities conducted (*in this case through procurement of supplies*) and operational expenses. Coupled with contextual and operational challenges, the response was affected by the time taken in recruitment and developing partnerships.

Economy: Given the significance of programme budgets, the *economic* aspect of VfM needs to be analyzed with reference to costs of salary and procurement of goods and services as significant cost drivers of the programme. The approach has (*though limited*) dedicated human resources within UNICEF. Additionally, procurement of supplies, services, etc. were carried out, but no documentation under the COVID-19 response could be sourced. Operational costs also contribute significantly to the budget. The evaluation found that the costs of programme implementation support, largely related to general operating costs and administrative costs in Libya are very high, generally. This is perhaps also due to the prevailing security situation in the country.

Efficiency: No allocation, expenditure or utilization data was evaluated. However, anecdotal information provided by UNICEF KII respondents mention the use of funds for intended purposes. However, the evaluators did not assess utilization / disbursement against budgets and hence cannot comment on the efficiency with which the inputs have been transformed into outputs so far. The evaluators note that no direct cash assistance has been provided to the government. This may be due to contextual reasons but would need to be understood in light of the effectiveness of using the government mechanisms as well as elements of sustainability.

3.6.2 Efficacy of the Programme Implementation

3.6.2.1 Programme Management

UNICEF programmes are managed and implemented by international and national staff and consultants. UNICEF Libya has a fully functional office in Tripoli with (*national as well as international*) staff and one field office in Benghazi. In terms of dedicated human resources for COVID-19 response, there were only four officials in the Country Office who were working under the guidance of the management. The evaluation did not conduct a staffing analysis or analysis of expenditure on PDs /PCAs between 2020 till 2022.

The presence of technically competent staff of UNICEF and its logical selection of implementing partners has resulted in efficient use of technical and fiscal resources and helped maximise the reach and coverage, to the extent possible, commensurate with funds spent. During interviews, the UNICEF officials provided the evaluators with an insight into their background, qualifications and experience, which meets standards. In the absence of assessing alternative activities (*run by the government or other partners – not required in the ToR*), the evaluation did not study the feasibility of alternatives being applied to improve the timeliness and costs.

Delays were experienced in procurement of vaccines due to global shortages, and in warehouse management due to short staffing. At times, implementation of SBC/RCCE was affected by long lead times required for approvals.

3.6.2.2 Financial Management and Procurement

No financial management analysis has been carried out by the evaluation.

Procurement was not under the purview of the evaluation, though the evaluators were made aware of several procurements during the implementation including partnerships with NGOs, hiring contractors and procuring supplies, etc. The supply team mentioned that procurement of cold chain and vaccine and PPE supplies were delayed due to the global demand at the time. To make procurement smooth, in consultation with Supply Division in Copenhagen, UNICEF Libya Country Office carried out procurement for Libya and also for Yemen Country Office. Local procurement of even available material was not allowed by Supply Division (*as they were over stocked*). Sometimes the vaccine supplies arrived in Tripoli airport, without any prior intimation. In general, procurement of supplies in the pandemic offered a huge challenge, which was overcome over time and the critical role played by the supply and procurement team at LCO, provided immense support in meeting objectives, even after some delay, but were lifesaving.

UNICEF's Performance: UNICEF's overall performance in designing and implementation of the response has been *satisfactory*. UNICEF designed a relevant and coherent response, and with emerging needs, made mid-course corrections. It provided due consideration to the political, social, and economic situation of the country.

In addition to the above, UNICEF has not taken any major initiative to develop and implement *communication* and *knowledge management* strategies. This has to be seen in the context of the political situation in the country – *what may or may not be considered as contextually insensitive*. The evaluation was not aware if UNICEF has produced any knowledge products (*e.g. documentation of best practices*). The evaluation interacted with Donors and assessed their feedback. In their opinion, the management of funds by UNICEF has been satisfactory. The evaluators ascertained the feedback from donors on UNICEF's leadership, which was positive.

Government's performance: this aspect of the programme has been presented in several sections in the preceding part of the report. Despite being a rich country, allocation of sufficient resources for primary health care has remained a constraint. However, the country willingly provided funds, in time, for securing vaccines through the COVAX facility. Another example of good governance was when the government changed the timings of vaccine administration to allow people to access vaccination at convenient timings. This change was communicated through a campaign.

3.6.2.3 Risk Management

At the appraisal stage, UNICEF was aware of the risks prevailing in the country, especially as they planned to reach out to the vulnerable populations in a crisis-affected state. The

identified risks were related to operating during the COVID, handling refugees, migrants, etc. The absence of an effective governance mechanism in many areas of the country was another risk to operate in. Cash liquidity issues and exchange rate fluctuations offered uncertainties as well. However, as informed by UNICEF officials, it had identified suitable mitigation measures while embarking on developing the response.

In summary:-

- Partnerships worked well for the response. In the absence of cash assistance to be provided to governments in Libya, this is the only mechanism available with UNICEF.
- The planned activities in the donor proposals and the COARs for the response with the budget, timeframe, and engagement of UNICEF programmes are consistent.

To conclude, the evaluation is of the view that the results achieved in the period under review (2020 – 22) cannot be termed as commensurate or otherwise in the absence of clear analysis of allocation and expenditure data (*not planned budget and/or allocation*). The resources have been utilised using all possible channels – technical assistance, supplies, capacity building, RCCE through PDs/PCAs etc., to address an emergency need, in the absence of alternative mechanisms. UNICEF continued to provide leadership through the period and coordinated with other INGOs, and local NGO partners. This contributes to the evaluation finding the programme being termed as efficient in delivering critical services in wake of limited alternatives being available.

3.7 CONNECTEDNESS OF RESPONSE

This section is devoted to assessing the connectedness of the COVID-19 response with long term development issues.

The humanitarian evaluation criterion of ‘connectedness’ refers to the degree to which humanitarian interventions and programs are effectively integrated and coordinated with other relevant initiatives, stakeholders, and existing systems. It assesses the ability of humanitarian efforts to establish and maintain meaningful connections, collaborations, and partnerships with local communities, governments, non-governmental organizations (NGOs), UN agencies, and other actors involved in the response.

The evaluation delved into evaluating connectedness. This shall assist UNICEF better understand and improve the effectiveness of its interventions, ensuring that resources are used efficiently and that the needs of affected populations are met in a coordinated and sustainable manner.

Coordination and Collaboration: the UNICEF response to COVID-19 was undertaken in coordination with the government, UN agencies and other development partners as well as NGOs. In the preceding sections, the evaluators have expressed the feedback and reflection the team collected from primary sources which have been triangulated with the secondary data available from Libya. UNICEF has been recognized for not only coordinating with others, but also initiating coordination platforms to deliver in collaboration - led by the government, supported by UNICEF and delivered by local bodies as well as NGOs. This has avoided duplication of efforts and promoted information sharing amongst the partners. Stronger linkage between SBC/RCCE and the core emergency coordination mechanisms will likely strengthen the overall response

Engagement with Local Communities: this element of the response was evaluated as weak but expected, due to security concerns and COVID 19 restrictions. However, in the context and circumstances, it may not have been possible for UNICEF to engage with the communities

in planning the response. The same applies for implementation – the evaluation recommends working with community based youth and women organizations, where present – which has not done by the partners. The feedback of RCCE initiatives, however, have been considered and the messaging has been recreated which reflects the community voice.

Integration with Local Systems: this aspect of the collective response could at best be termed as partially achieved, as the delivery happened at community level through the local systems – i.e. the PHCs, vaccination centers, schools, bayti Centers etc. However, alignment with existing local infrastructure, services, and capacities could be strengthened.. This was an emergency response and provided support to the local systems to deliver within their limitations.

Alignment with National and International Strategies: the response has been for an emergency and does not have comparators in place to assess coherence with broader national development plans, policies, and international frameworks. In any case, the pandemic response plans were developed by the Government in Libya with support from UNICEF.

Information Sharing and Communication: data collection on RCCE ramped up significantly during COVID-19 with several quantitative KAP studies conducted, and supported by additional qualitative methods. There may be a need to conduct a separate evaluation of this critical component of the response as it has potential to assist future emergency responses as well. The communication and RCCE unit of the NCDC has been fully supported by UNICEF to design and execute communication campaigns – now it needs to have the capacity and plans to evaluate the effectiveness of these interventions.

Flexibility and Adaptability: the response clearly demonstrated that it, along with all its sub components, led by the government, was able to adjust their strategies and approaches based on feedback, changing circumstances, and evolving needs.

Accountability and Transparency: this element of the response has not been fully evaluated in this evaluation and may need to rely on additional documentation to afford an opinion. However, UNICEF delivered the response, following internationally benchmarked operating systems including managing the procurement of human resources, supplies, technical assistance and monitoring etc. which, based on available documentation, were following established standards within the UN system.

Capacity Building: the response was bolstered by capacity strengthening efforts at all levels. During the evaluation, respondents from all levels have recognized the support they received from UNICEF and stated that they now have enhanced capacities to deliver their respective mandates and services, effectively and efficiently.

The evaluation is of the view that since this was a humanitarian response, it is difficult to link it with longer term programmes. However, during the primary data collection, the evaluators were informed about the plans for integrating the routine immunization programme with lessons learnt from the COVID-19 response. This, could not be evaluated though.

The evaluation delved into the assessment of whether continuation of benefits looks possible, by looking at factors that influence sustainability. It looked at risks and potentials and attempted to conclude if the gains can be sustained after the response has been concluded. It also tried to see if target groups and counterparts can adapt sufficiently to external changes and shocks.

Guided by the humanitarian–development nexus, factors influencing sustainability include capacity building, leading to enhanced skills and capacities to deliver better services efficiently and effectively (*in the current context*) and this has been intrinsically embedded in the planning. Working with local partners (NGOs) and government staff and institutions is

also an important factor in building potential sustainability. This is the main strength of the evaluated programme.

During the literature review, a lot of efforts have been seen on inclusion – be it for refugees, IDPs or returnees; children from different backgrounds; those with special needs, gender, etc. This is intrinsic to the programme execution. These efforts, either directly or indirectly make the programme and its achievements, sustainable.

Interactions with several respondents including the key informants, beneficiaries, and even UNICEF staff, revealed that the community is not yet ready (*or capacitated*) to sustain the achievements so far. Additional support would be needed by those that have been reached, while the remaining need to be covered as well. Similarly, INGOs and local NGOs would be able to generate enough expertise and resources to continue in the near future, but presently would need hand-holding from UNICEF.

In summary:-

- The response has initiated building on existing systems and stakeholder capacities.
- With constant push from UNICEF and implementing partners, strengthening capacity at local level would get institutionalized, owned, and leveraged by the government in near future. It is difficult to, at this stage, assess to what extent would the approach sustain programme delivery, due to contextual reasons.
- The response is not yet at a stage where leveraging other partners and resources to ensure sustainable programme delivery and/or sustained capacity could be assessed meaningfully.
- UNICEF is not generating evidence of the effectiveness and scalability of this response which could lead to integrating RCCE and emergency preparedness strategies with longer term programmes which may be designed in the future or to find possibilities of merging them with existing long term programmes.

3.8 COORDINATION OF RESPONSE

Coordination has been described already in the report earlier – spread across the evaluation criteria. UNICEF's role in initiating coordination platforms and supporting the government bodies to lead the coordination is commendable. Also, the efforts put in by UNICEF in the response were well coordinated with partners.

4. GENDER AND HUMAN RIGHTS

This chapter assesses the gender issues in the COVID-19 response and also how human rights have been considered in the design and implementation of the response. For the analysis, the evaluation has mainly relied on a review of secondary literature and analysis of secondary data.

The evaluation looked at gender issues as an additional criterion along with human rights. The focus on gender was to look at whether the unique needs of women and girls have been taken into consideration in the design and implementation of the approach and how the needs of women and girls were better addressed. The UNICEF Gender Policy (2021 – 30) is grounded in human right based approaches and development system reforms. It is closely aligned to the United Nations Systems-wide Action Plan of Gender Equality and the Empowerment of Women (UN-SWAP) and commitments made as part of the Inter-Agency Standing Committee Gender Accountability Framework and the Core Commitments for Children in Humanitarian Action, among others. The UNICEF Gender Action Plan (GAP), 2022–2025, operationalizes the UNICEF Gender Policy by specifying how UNICEF will promote gender equality across its programmes and workplaces. It affirms that promoting gender equality and the empowerment of women and girls is the responsibility of everyone, regardless of organizational role. The work of UNICEF on gender equality and the empowerment of girls and women is grounded in the human rights principles of non-discrimination and equality, upheld in the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of Persons with Disabilities. A human rights-based approach to programming and gender equality are complementary and mutually reinforcing approaches – UNICEF is committed to abiding by these.

4.1 GENDER

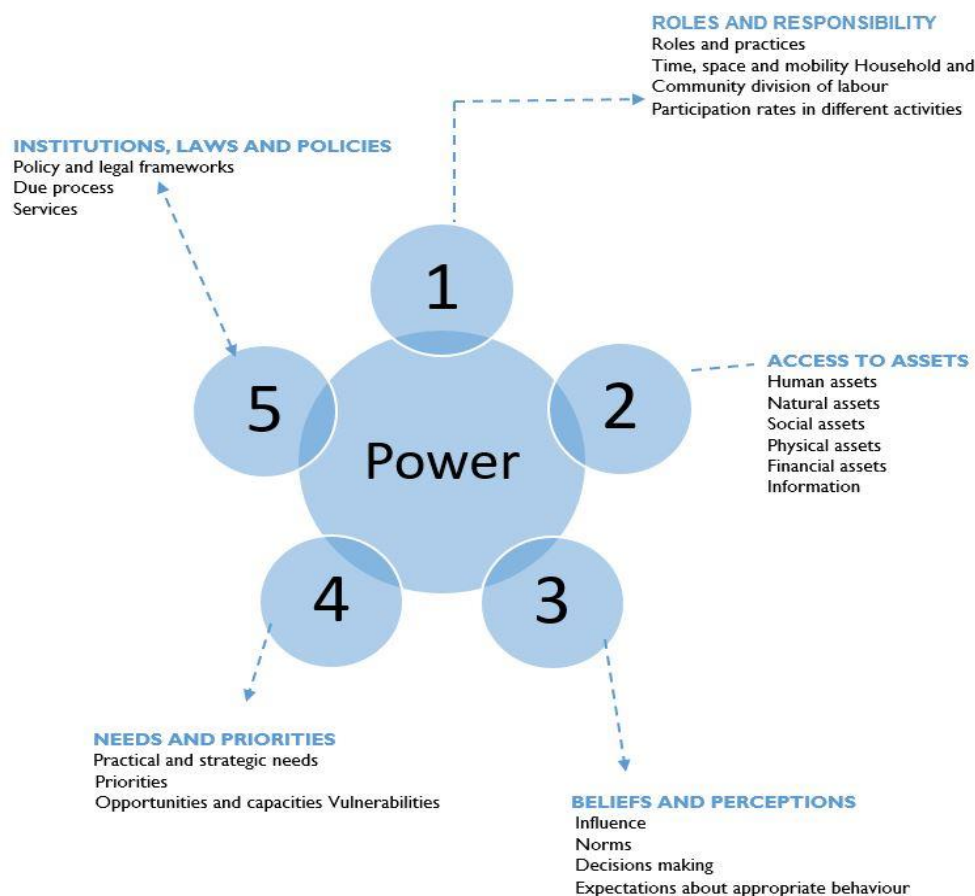
The crisis in Libya has negatively affected the lives of all Libyans, particularly women and girls who have borne the brunt of violence and instability. The ongoing conflict and gender-based discrimination has taken a toll on Libyan women and limited their economic, political and social opportunities. Women face high rates of unemployment due to the lack of recognition of their contribution to the economy. Persistent stigmas and stereotypical beliefs have increased their unpaid care work and economic vulnerability. Women are significantly underrepresented in politics, humanitarian response, conflict resolution and peacebuilding. Violence against women and girls in all its forms, including against those who publicly advocate for gender equality and women human rights defenders, which infringes on women's rights and hinders their equal participation in Libya's political, economic and social life. The lack of an adequate legal framework to effectively protect women from all forms of gender-based violence aggravates this phenomenon. The complex and protracted humanitarian and protection crisis that disproportionately impacted vulnerable groups such as migrants and refugees and people with disabilities, particularly women.

The humanitarian situation of Libyans was further aggravated by the COVID-19 pandemic whose worst impact has been felt by women and girls across the country. Engaging young women, remains difficult as they face discriminatory practices which have been worsened by the pandemic, limiting their much-needed civic and political participation.

For the current evaluation, gender analysis, was carried out from the collection and analysis of quantitative data (*numbers, percentages, proportions, ratios – though extremely limited*) and qualitative information (*preferences, beliefs, attitudes, behaviours, values, scope, etc.*) through a gender lens. The

evaluation collected data and information from a gender perspective by asking ‘gender analysis questions.’ Drawn from the gender analysis toolkit of UNICEF, the following figure mentions the five basic domains considered during the evaluation:-²⁹

1. **Roles and responsibility:** The norms that influence women's (girls') and men's (boys') behaviour structure and the type of activities they engage in and their roles and responsibility.
2. **Access to assets:** How gender relations affect access to resources necessary for a person to be a productive member of society.



3. **Beliefs and perceptions:** Drawn from cultural belief systems or norms about what it means to be a woman or man in a specific society. These beliefs affect women's (girls') and men's (boys') behavior, participation and decision-making capacity.
4. **Needs and priorities:** Differences of needs (*both practical and strategic gender needs*) between women and men, girls and boys.
5. **Institutions, laws and policies:** Focused on information about women's (girls') and men's (boys') different formal and informal rights and how they are affected by polices and rules.

29 Excerpted from Jhpiego (2016). Gender Analysis Toolkit for Health Systems

Power: Pervades all domains and informs who has, can acquire, and can expend assets and decisions over one's body.

The evaluation assessed whether needs and rights of women, men, girls and boys were respected and addressed in all aspects of the planning, execution and funding allocations for COVID-19. There were seven essentials which were assessed during the evaluation as they contribute to make programme/project more gender-responsive:-

- Whether sex - and gender - disaggregated data was being collected
- Gender divisions of labour and decision-making patterns
- Who has access to and control over resources, assets and benefits
- Different needs, priorities and strengths of women, men, girls and boys
- Complexity of gender relations in the context of social relations and gender norms
- Strategies and resources required to address the gender barriers and constraints
- Counterpart/partner capacity for gender-sensitive planning, implementation and monitoring

As per the respondents of KIIs, especially from UNICEF, and the government, the response was designed keeping it gender-responsive. From the available documentation on the response, the five sectoral programmes aimed at integrating their programming and carry out activities which clearly provided focus on women rights while supporting the government and local stakeholders in their planning, budgeting and implementation. As per the UNICEF officials, during execution as well, this sensitivity has been observed during interactions with various levels of respondents as well as from review of the relevant documents, reports, etc. However, in the absence of documentation, it is difficult to see what aspects of Gender Equality & Empowering Women (GEEW) were integrated during the planning which could have been measured during implementation.

The evaluators did not come across evidence of sex and gender disaggregated data being reported, barring a few cases where trainees in capacity building interventions were segregated. Anecdotal evidence suggests that the women were behind in numbers when it came to accessing vaccines, even though they were exposed somewhat equally to communication interventions. The evaluators did not see significant evidence of decision making patterns or access and control of resources. The different needs, priorities and strengths of women (*and men*) were clear amongst the beneficiaries, and the same were, when asked from local authorities, included in their list of priorities. Similarly, during FGDs, the beneficiaries spoke about gender norms which was endorsed also by the local authorities and other stakeholders. There was no evidence available to inspire confidence of the evaluators on strategies and resources available to address gender barriers and constraints. The local level stakeholders feedback concluded lack of capacity to design gender sensitive programming.

The evaluation also conducted additional analysis using the Inter Agency Standing Committee (IASC) checklist. IASC is committed to the principles embodied in international human rights instruments, in particular, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Declaration on the Protection of Women and Children in Emergency and Armed Conflict and the Convention on the

Rights of the Child (CRC). The provisions of these instruments are applicable equally to men and women without discrimination.

In the context of the approach under evaluation in Libya, this implies embracing principles such as: (i) gender equality and the equal protection of human rights of women and men in carrying out humanitarian and peace-building activities, as well as paying special attention to the violation of human rights of women and the provision of appropriate remedies and; (ii) integration of a gender perspective and participation of women's organizations in capacity building in humanitarian response. In the context of humanitarian – development – peace nexus, as is applicable to the response, this has been complied with alongside limitations, as observed by the evaluation team. It was not possible to assess collaboration with women's organisations.

The findings from the analysis using the checklist are presented below: -

Gender Equality Programming Checklist for the Programme

IASC Checklist Parameters	Observations / Findings from the LLSS Approach
Gender Analysis	
All needs assessments have included gender issues in the information gathering and analysis phases.	The evaluation has studied various documents where gender was included during the situation analysis when the planning was done led by the MoH supported by WHO and U NICEF as well as others. The evaluation did not assess the use of analysed needs assessment data.
Women, girls, boys, and men are consulted (together and separately) about their concerns, protection risks, opinions, and solutions to key issues.	The evaluation did not access information collected during situational analysis that may have been conducted prior to the development of the response in 2020 as no programme (approach) document was developed. However, following Human Rights-Based Approach to Programming, which is a standard for UNICEF in humanitarian situations, the evaluation asked UNICEF staff if this was done in a consultative and inclusive manner. This was confirmed, but limited to the key stakeholders in the government and development partners (only). The response was adopted following the resolution of the NDVP, which had considerations of interacting with all – women, girls, boys, and men.
Mechanisms for routine exchange of information with the population affected by the crisis are established and are functioning.	This has not been the case as observed from documents provided for the evaluation. No systematic beneficiary feedback system exists, and no evidence was provided that the affected populations are participating in a systematic information flow process.

Gender balance	
Sex breakdown of local and international staff working in the humanitarian situation by sector are routinely collected and analyzed.	The evaluation did not aim at collecting this data.
Sex breakdown of people in decision-making/senior positions are monitored.	The gender balance in UNICEF is as per its HR policy. However, at local levels in the government health care system, leadership positions for women are limited.
Needs assessment teams to have equal numbers of women and men.	Not assessed.
Disaggregated data by sex and age	
Data is being consistently collected and analysed by age and sex.	No.
Sex-disaggregated data is included routinely in reports and the implications for Programming are addressed.	No.

In conclusion, the COVID-19 crisis had an impact on the most vulnerable residents in Libya and has exacerbated pre-existing structural gender inequalities in a predominantly patriarchal society.

4.2 HUMAN RIGHTS

The evaluation looked at interventions that advance the realization of women and children's fundamental rights, including those of the most vulnerable as well as whether the interventions contribute to the realization of children's essential rights in Libya.

4.2.1 Core Commitments for Children

The Core Commitments for Children in Humanitarian Action – the CCCs – are UNICEF's central policy to uphold the rights of children affected by humanitarian crises. The CCCs promote predictable, effective, and timely collective humanitarian action, and clearly outline the areas in which UNICEF can best contribute to results. The evaluation focused on whether UNICEF met its commitments made under CCCs.

Through interactions with UNICEF and government institutions' staff, the evaluation found the application of humanitarian principles in the approach. These principles included (i) *Humanity* – as seen in coverage of all women and children including migrants and refugees (post the updated NDVP); (ii) *Impartiality* – the response interventions reached out to all, without discrimination between ethnic, tribal groups, nationalities, sex, etc. and; (iii) *Neutrality* – the response did not take sides and refrained from engaging in controversies of a political, racial, religious or ideological nature. The approach reinforced humanitarian principles by raising awareness (*social and behaviour change initiatives, etc.*) building trust (*working with government, UN Agencies, INGOs, and local organisations*), and advocating for children's rights in humanitarian situations

(particularly in advocating for school preparedness, school health initiatives, SBC campaigns, hygiene messaging etc.), together with state authorities and non-state entities.

As per the UNICEF respondents, the response adopted a human rights-based approach to programming. This approach allowed identification of rights holders (*children and their parents*) and their entitlements (*health, education, WASH, other services*), as well as corresponding duty-bearers (*NGO workers, social workers and teachers, medical and non-medical staff in health facilities, implementing partners, etc.*) and their obligations. The approach aimed at strengthening the capacities of rights holders to make their claims and of duty-bearers to honour their obligations. It focused on the realization of the rights of the vulnerable populations, and those whose rights are at risk of being violated i.e. the migrants and refugees. The approach put children (*and women*) at the center of humanitarian action, as active participants, rather than recipients of assistance.

UNICEF and the implementing partners of the response reinforced human rights-based approach to programming in humanitarian actions by (i) addressing inequalities and disparities in design, implementation, and monitoring; (ii) strengthening capacities of state authorities and non-governmental organizations as an essential strategy for joint and effective humanitarian action and; (iii) advocating for the rights and voices of children in Libya. However, one principle which could not be assessed was on promoting the participation of children, adolescents, etc. including in the design, monitoring, and analysis of the response.

The evaluation is of the view that UNICEF had initiated compliance with the provisions related to Gender Equality, Inclusion, and Human Rights in the COVID-19 response in Libya, however, a lot needs to be done further to make the response report on gender desegregated data to complete an assessment on access and coverage, especially when it comes to being gender responsive programme implementation.

5. CONCLUSIONS

The evaluation is of the view that there have been several successes recorded in the response in Libya to COVID-19, especially for UNICEF. During the outbreak, with an extremely small team in the Child Survival and Development (*now Health*) section in UNICEF, achieving what has been witnessed is remarkable. The NCDC now exudes confidence and states that it is now ready to handle similar situations in the future, *thanks to UNICEF support*.

There are several key challenges in implementing an emergency response to a pandemic of COVID-19 magnitude in any country. No one was prepared to handle the pandemic and this was not unique only to Libya. One challenge is the lack of human and fiscal resources for local service delivery bodies like the PHCs, Regional bodies of line Ministries and Schools etc. as well as municipalities to provide humanitarian response while continuing uninterrupted delivery of basic services. The local authorities in Libya faced financial constraints due to the existential crisis, and now coupled with the pandemic response, found their ability to invest in infrastructure, human resources, and service delivery, extremely limited. The security situation and restrictions related to the pandemic impacted the response. There was also pressure on global procurement of essential supplies and vaccines which further hindered the efficiency. There have also been delays in securing approvals from authorities in some cases.

Another challenge was the lack of capacity and expertise among government staff to implement and manage pandemic response. Health department lacked and needs to build their technical and administrative capacity to effectively plan, implement, and monitor humanitarian response initiatives. This requires training and support in project management, financial management, and community engagement.

The management structure to steer the response (and those in the future) needs a re-think by UNICEF. More staff or at least a surge capacity is needed so that the implementation of activities underway do not get hampered by a humanitarian response and vice versa. The fact that when needed, expert capacities were not easy to be identified for deployment is to be kept in mind. The decision of having a separate health and nutrition section aligns well with global practices and is helpful during public health emergencies.

A further challenge often is the lack of coordination and collaboration among different actors. Libya has a unique mix of its own population coupled with migrants and refugees, and has witnessed how NGOs and international development agencies often work in silos, which leads to duplication of efforts and inefficiencies. However, for the COVID 19 response, despite initial difficulties, coordination was executed smoothly. The coordination with other UN agencies at all levels has been reported to be effective and led to a coordinated response while supporting the government effectively. There was evidence of a structured mechanism with joint ownership of the respective mandates and participatory programming, which may have ensured a coherent approach and avoided duplication of efforts. Technical assistance was provided at the national and local levels.

The response was appropriate in the context and circumstances as it worked directly with the key stakeholders (*Government, UN Agencies and service delivery institutions*); with implementing partners like Amalona, DAMM and BBC Media Action as well as beneficiaries. It was adaptable and addressed needs especially on strengthening planning, resourcing and guiding key service delivery interventions. It remained appropriate through the evaluation period and is still a relevant one. The evaluation learnt that the design of specific sectoral interventions were realistically

adjusted to target all vulnerable communities through complimentary capacity building, provision of requisite equipment and vaccines and service delivery mechanisms.

The response, has been effective and for the most part timely, given the overriding political, security, and other contextual constraints. The response when designed, was a mix of both - resource intensive and technical support oriented, where technical guidance was extended to the government to design and plan interventions focused on the needs of the community. In this case, the response has been effective where implemented, and in most cases an integrated one. Effectiveness is enhanced by critical successes, in particular through mapping of the affected population, the capacity-building efforts, partnership models, reach of social media etc. Another good example is the training of vaccinators and cold chain maintenance staff as well as school readiness campaigns with support from RCCE interventions. The programme guidance developed by UNICEF on COVID 19 response has been put to optimal use - most staff within UNICEF especially in the Health and WaSH team were conversant with it. There have been no unintended results due to the interventions reported by any quarter.

In collaboration with government and partners, UNICEF was able to meet the needs of the vulnerable communities in an efficient manner, for example with the vaccination centers, schools and communication messaging. An outstanding example of on-line engagement was the BBC Media Action program, El Kul, which developed a reputation for reliable information, correcting misinformation and a platform for two-way communication which reached about 1/5 of the Libyan population.

No UNICEF staff complained about lack of resources when needed, and in fact complimented the flexibility of donors in this aspect. In view of the limited staff available within UNICEF, the dynamic context during the period under evaluation, and the limited interventions, the response's efficiency can be considered as proficient.

UNICEF formed a strong relationship with Government counterparts, and more so at the local levels (*where done*), NGOs, and the community leaders. The capacity of the main implementing agency - UNICEF, to steer the action despite various challenges should be underlined.

Sustainability (*or connectedness*) would largely be achieved through Government - *institutions like NCDC* - who have the mandate in Libya. However, NCDC along with NITAG and PHCI may need further support to develop strategic vision and plans. Otherwise, the sustainability aspect of this service-oriented approach is weak. Even though the government now has enhanced capacity and experience, it seems unlikely that the government would be able to continue to uphold the service delivery standards and would continue with quality, if support is discontinued. Additionally, the government has to allocate sufficient fiscal resources.

The evaluation is of the view that in the context of Libya, the response continues to have a gender lens attached to the implementation, albeit in limited parameters. Sex-disaggregated data is important in crisis situations. The sectoral interventions may have done this with great sensitivity and attaching importance to it, but this is not collectively visible.

Outreach of the response worked well; Efforts to change behaviours faced challenges due to COVID-19 restrictions and limited implementation. Capacity building happened, but in limited dimensions; and needs to be strategized. Engagement with the government worked well, but wider engagement with NGOs is necessary to increase coverage. Human rights based approach to programming was evident. Supplies were provided but consumption has not been captured and would need emphasis. Outputs have been documented; better assessment of outcomes is needed. UNICEF decided to work with the right people

(*partners*) and this seems to be an *appropriate, effective, efficient and connected* approach which has been well *coordinated*.

There is great value with the well-coordinated response mechanisms using the systems strengthening approach (*when possible*) for the people of Libya when implemented at scale, and in the context, critical. There are no visible alternatives or a more efficient model under the circumstances. The response has made UNICEF more relevant as it, along with partners, helped target the vulnerable population which included all residents in Libya. UNICEF decided to work with the right people (*partners*) and this seems to be an *appropriate, effective, efficient and connected* approach which has been well *coordinated*.

6. LESSONS LEARNED

This concluding chapter presents an outline on standards, expectations and several lessons learned from the COVID-19 response in Libya.

Linking humanitarian development and peace – the nexus approach

COVID-19 is a public health, humanitarian and development crisis, all at the same time. It is happening in countries with an existing humanitarian crisis, and in developing countries that never faced a humanitarian crisis but where COVID-19 has put them at the verge - or triggered - their first one. The pandemic has made it abundantly clear that a hybrid approach toward humanitarian assistance and development cooperation is required. Thus, placing the nexus into practice is an imperative for responding effectively to this crisis, and to prepare for the next one to come.

Joint assessments, planning, programming and results framework identifying what can be adapted or scaled-up, before starting a new intervention are important. It will also be crucial that humanitarian, development and peacebuilding programmes are delivered in parallel, not sequentially. UNICEF programmes and fundraising strategies showed evidence of the value of flexible funding.

In Libya, the nexus approach delivered on the basis of the right financing, inclusive partnerships, knowledge and information sharing and responses that were conflict-sensitive and drew on the full range of political, economic and social tools available.

Existing capacity in country

While there was a tendency for over-reliance on messaging, UNICEF's programme responses were calibrated and adjusted over time depending on existing capacity in the country. Libya, like many other countries elsewhere, handled the unfolding COVID-19 epidemic using its existing (*yet collapsing*) health system capabilities and in the face of substantial uncertainties.

Libya adopted top-down leadership and decentralized implementation approach to efforts against COVID-19. These efforts were centrally coordinated by a committee known as the National Coordination Committee, comprising senior stakeholders representing the Government and Development Partners reporting to the Prime Minister's office. The committee focused on planning and coordinating both the critical health emergency response as well as other functions required to mitigate effects of COVID-19 epidemic to ensure alignment of policies and plans among agencies and integration of the said plans into national governance mechanisms. This was seen as effective.

Throughout the COVID-19 epidemic, Libyan leadership put significant effort toward forging strong linkages with other sectors, including beyond health, to manage variety of response efforts. Interdepartmental coordination has been a regular and distinct feature of successful public health efforts globally and thus, Libya has relied on experience and understanding among departments to effectively respond to COVID-19. This is efficient management.

Several interventions were launched in Libya under the leadership of the Ministry of Health which included establishing several technical working and coordination groups based on the nine pillars recommended by WHO. A National Deployment and Vaccination Plan (NDVP) was developed. The Tahseen project which aims to develop an electronic platform for the NCDC and serve as the national Immunization information system for Libya are all important examples.

The COVID-19 epidemic has also presented several opportunities for the country to learn and utilize the lessons to strengthen the health system. Health system strengthening has been acknowledged as an important issue based on the recognition that a strong health system is not only the backbone of effective routine health services, but also a measure of resilience of health systems during emergencies.

Countries that largely contained COVID-19 epidemic were able to do so by rapidly expanding testing and tracing capacities. There were instances when lack of preparedness was evident with lack of planning being demonstrated by the Libyan government in ordering vaccines without adequate facilities for storing them.

The incidence and mortality rates through 2020 - 22 are comparable to several other countries with comparable populations. The lockdown measures afforded the country time to re-establish coordination mechanisms and physical infrastructure, recruit critical health workers, and conduct essential trainings. Cold chain rehabilitation which had not happened since 1950, was carried out with UNICEF support alongside carrying out the inventory of the equipment.

Communicating with migrants and refugees from 43 countries using messaging in seven languages was crucial. These are important lessons.

Experience of Libya suggests that it is critical to involve and engage with community members for awareness generation, surveillance, household preparation and improve acceptance of interventions implemented by the government.

A 'demand-driven' organizational capacity strengthening could have been better documented, if attempted by UNICEF at local levels. The involvement and collaboration with key local NGOs familiar with the geographies are a key to success. NGOs open doors for UNICEF interventions in several areas. However, the evaluation learnt that the INGOs are leaving Libya.

UNICEF stuck to its core principles. This has worked well in the response. Strengthening capacities of actors guaranteed an effective and efficient coverage of target groups. A comprehensive social and behaviour change (SBC) support could have catapulted results to higher numbers, as piecemeal efforts cannot change behaviours.

7. RECOMMENDATIONS

This section makes some recommendations for considering future action by several stakeholders, especially by the Government and UNICEF. These are based on the primary findings. The evaluators aim to address the response to COVID-19 only.

Global evidence indicates that COVID-19 may continue and large-scale vaccination needs to be done. Given this reality, it is imperative that the government of Libya continues its ongoing efforts to keep the epidemic under control. The response so far proved effective for managing the COVID-19 epidemic in Libya. Existing health emergency and response plans in the country can be strengthened based on these experiences. Improvement should be done as soon as feasibly possible to avoid loss of individual or institutional memory.

Presented below are some recommendations for strengthening capacities of the government system – Ministry of Health, NCDC, NITAG and PHCI in Libya. Some of these recommendations present the voices of key stakeholders which were assessed during primary data collection. These actions need to be taken up jointly by MoH with support of UNICEF and other stakeholders:

Policy and Governance

- Review and adapt public health policies and regulations to respond effectively to future pandemics – *conduct a review by an external independent expert. Provide exposure to national and sub national authorities on global good practices. Align structures of partners with the Government structures for a coordinated response system. Strengthen coordination between different levels of government, private sector and relevant agencies – horizontal and vertical coordination framework to be established and monitored.*

Healthcare Infrastructure and Capacity Building

- Strengthen healthcare infrastructure, including hospitals, clinics, and testing facilities. Increase capacity for ICU beds, ventilators, and other critical medical equipment, expand and strengthen health workforce including surge capacity planning; assess logistics capacity in the country and address gaps - *following the International Health Regulations for Libya.*
- Strengthen coordination of demand generation activities with provision of vaccination services, including adequate infrastructure, trained staff, and robust logistics planning to ensure that the public can easily access and receive vaccinations as promised.
- *Provide technical assistance and capacity building support to service delivery personnel at all levels especially focused on health systems strengthening and gender sensitive programming including training on gender issues to enable designing gender responsive government programmes. Design and execute training programmes on RCCE and SBC for all stakeholders. Focus on strengthening the primary health care system including allocating resources. Strengthen planning committees with participation from all key stakeholders - - Committees to have a structured agenda/calendar of events, which is monitored.*

Vaccination and Immunization

- Develop and implement a robust vaccination plan, including prioritization and distribution strategies, ensuring equitable access. *Regular updating of NDVP needed, including using it for routine immunization.*

Public Health Messaging and Communication

- Strengthen the RCCE Strategy with clear and consistent communication on preventive measures; addressing misinformation and promoting reliable sources of information. Tailor messaging for different demographic groups and communities.

Emergency Preparedness and Response

- Develop and regularly update contingency plans for future outbreaks or emergencies; ensure adequate stockpiles of medical supplies, PPE, and essential equipment and; establish mechanisms for rapid response and coordination across different sectors.

Community Engagement and Empowerment

- Strengthen involvement of communities in decision-making and planning processes through on – and off-line mechanisms and technology such as social listening in partnership with local NGOs, community leaders and influencers. Institutionalise *beneficiary surveys into core data systems*: to understand social and behavioural factors, and to monitor coverage and behavioural results.

Research and Data Collection

- *Knowledge management and documentation* - Strengthen documentation, data collection and reporting systems for informed decision-making. Heightened attention needed on desegregated data generation. Expand integrated digital data platform to improve data for decision-making – *Scale up Tahseen to all facilities*.
- *Establish standards / benchmarks for quality*: establish standards for implementing partners focusing on the following: *Service standards; Facility standards; Partner level performance in service delivery; Performance of service providers and Quality of Services Provided*.

For UNICEF, the evaluation recommends the following actions to be taken on an urgent basis to strengthen its preparedness and response capacities and of the government and partners in managing pandemic response:

- Establish a vision for the country office programme on pandemic response and link it with an accountability framework for **accountability purposes**. Develop a toolkit for pandemic response based on the global guidance (*learning*).
- Assessing gaps if any in its supply and procurement systems for emergency supplies (*learning*).
- Review the HR staffing including developing surge capacity roster and a need based comprehensive capacity strengthening strategy for all levels (*accountability*).
- Lead mapping of NGOs in Libya (*as well as private sector players*) and develop a database (*accountability*).
- Plan strategic interventions to reach children on the move (*migrant, refugee and IDP children*) and also, children living in conflict-affected and fragile settings and not to forget children with disabilities (*accountability*).

The management of such a response, in the future, would need continuous support from UNICEF unless the government can make allocations. In the current context, UNICEF needs to continue

its support as done between 2020 – 22, to sustain the gains made so far. UNICEF should now consider keeping its support less on fiscal resources, and rely mainly on technical assistance and providing guidance. It needs tenacity from UNICEF staff and partners to work in depth with the Health Systems' institutions and service delivery facilities including the PHCs, Vaccination Points, Schools, Bayti Centres etc., to be able to generate significant results which can then be demonstrated to potential donors, possibly jointly with other UN agencies.

ANNEX 1: TERMS OF REFERENCE

<https://drive.google.com/file/d/1qsmajHOjVVjC6rDnvZqsJqqXS5synUKh/view?usp=sharing>

ANNEX 2: EVALUATION MATRIX AND QUESTIONS

The Evaluation shall track:		
<ul style="list-style-type: none"> • Technical support provided to national and sub national counterparts on COVID-19 management including COVAX, micro-planning, cold chain and vaccine management, rehabilitation of PHCs, vaccination sites to administer COVID-19 vaccines, prefinancing support, staff training, safety and quality assurance, waste management, demand creation • Support provided to Ministry of Education in school re-opening efforts including remedial classes • Reach and recall of social behaviour change communication including use of social media, IEC material, use of mobile and online technology • Leadership in RCCE and development of national strategies including supporting mechanisms to capture community feedback • Distribution of PPE equipment, other supplies • Capacity building of teachers, health workers, social workers, school health officers • Support provided for NGO-led service delivery and crisis response coordination • Research studies conducted • Access to safe water, sanitation and hygiene, WASH services and hygiene supplies • Change in level of COVID-19 related coverage of health services including MNCH, Nutrition, HIV-AIDS, WASH, Education, Child Protection • Change in availability, access and/or use of services • Disruption in supplies for essential services • Changes in incidence rates • Availability of COVID-19 national plan, functional multi-sectoral, multi-partner coordination mechanism • Continuity of Essential health services during COVID-19 pandemic 		
Evaluation Questions	Data collection method	Data source / Respondents
Appropriateness		
<p>To what extent did the UNICEF-supported COVID-19 interventions meet the needs of the particularly vulnerable families, girls, and boys?</p> <p><i>Additional questions:-</i></p> <p>What was the overall strategic direction of the response and to what extent did its objectives align with and strengthen: National priorities – of the government and UN and</p>	<p>Document review</p>	<p>CPD, AWP, COARs, RAM, Sitreps, Donor proposals and reports, KAP studies, UNSDCF, Assessment reports, Programme documents, National response plans, Deployment and vaccination plans, RCCE strategy, TPM reports, Programme monitoring reports; other publications accessible online</p>

<p>Donor organisations; Local realities – implementing organisations; The needs of target groups in the country?</p> <p>How does the choice of interventions compare to other alternatives?</p> <p>How aligned is UNICEF's COVID19 response with global priorities</p> <p>How relevant is the UNICEF response to the country context?</p> <p>How relevant is the UNICEF response to government priorities?</p> <p>How relevant is UNICEF's response in addressing inherent equity gaps – taking into consideration any disparities</p> <p>How did the programme feed into, and complement, planning and implementation processes at various levels, partner organisation plans?</p> <p>How well were the response activities reflected in the monitoring and evaluation systems of the country?</p> <p>To what extent did activities complement or duplicate other existing interventions?</p>	<p>KII</p>	<p>Ministry of Health including Medical Service Directorates in Municipalities; NCDC; UNICEF; UN Agencies – UNHCR, IOM; Donors – Germany, USAID; Partners – NITAG, PHCI, AMALONA; BBC MA; Support District Health Offices and Health facilities</p>
	<p>FGD</p>	<p>Community leaders</p>
Effectiveness		
<p>Did the overall UNICEF support achieve the intended results?</p> <p>How effective was the social behavioral communication via various media and integrated into the overall response?</p> <p>To what extent did UNICEF use generated evidence into programming of the COVID-19 response?</p>	<p>Document review</p>	<p>CPD, AWP, COARs, RAM, Sitreps, Donor proposals and reports, KAP studies, UNSDCF, Assessment reports, Programme documents, National response plans, Deployment and vaccination plans, RCCE strategy, TPM reports, Programme monitoring reports; other publications accessible online</p>
<p>To what extent did the programme respond to emerging needs and changing context of the COVID-19 pandemic?</p> <p>Has there been any unintended positive/negative consequences of the UNICEF-supported interventions?</p>	<p>KII</p>	<p>Ministry of Health including Medical Service Directorates in Municipalities; NCDC; UNICEF; UN Agencies – UNHCR, IOM; Donors – Germany, USAID; Partners – NITAG, PHCI, AMALONA; BBC MA; Support</p>

<p><i>Additional questions:-</i> To what extent have the planned objectives been achieved to date? Are the programme indicators sufficiently reflecting achievements? What are the primary reasons why the objectives are or are not being achieved? To what extent have target populations been reached, particularly the most vulnerable groups, disabled etc.? Are there any factors which prevent target groups accessing the response services? What is the contribution of external environmental factors to the success or failure of the response?</p>	<p>FGD</p>	<p>District Health Offices and Health facilities Community leaders</p>
Efficiency		
<p>Have resources been allocated strategically and in a timely manner to achieve results? <i>Additional questions:-</i> To what degree were the resources invested in the response appropriately allocated and utilised compared to the outputs and results achieved? To what extent were the objectives, outputs and activities of the response coordinated with, or complementary to, those of other implementing agencies, inclusive of government and other local agencies? How far were resources being used efficiently and what alternatives were there to the modes of delivery employed; which (if any) would be more efficient? Were the outputs and results achieved at the correct time and within a reasonable period? What efforts were made to achieve cost minimisation and VfM?</p>	<p>Document review KII</p>	<p>CPD, AWP, COARs, RAM, Donor reports, UNSDCF, Assessment reports, Programme documents, National response plans, Deployment and vaccination plans, TPM reports, Programme monitoring reports; other publications accessible online Ministry of Health including Medical Service Directorates in Municipalities; NCDC; UNICEF; Donors – Germany, USAID; Partners – NITAG, PHCI, AMALONA; BBC MA; Support District Health Offices and Health facilities</p>

Connectedness		
<p>What measures have been considered for linking the key components of the programme to longer-term development issues? <i>Additional questions:-</i> If the services have to be supported institutionally, are funds likely to be made available? If so by whom? Was there a financial or economic phase-out strategy; if so how likely is it to be implemented? <i>Ownership by target groups:</i> To what extent have target groups (e.g. health workers, partner organisations) been involved in planning and implementing the process? What is the likelihood that target groups will continue to make use of relevant results (improved capacities, etc.)? <i>Policy support:</i> What support has been provided from the relevant national, sectoral and budgetary policies? Is it likely to continue after the response has finished?</p>	Document review	CPD, AWP, COARs, RAM, Sitreps, Donor proposals and reports, UNSDCF, Assessment reports, Programme documents, RCCE strategy, TPM reports, Programme monitoring reports; other publications accessible online
	KII	Ministry of Health including Medical Service Directorates in Municipalities; NCDC; UNICEF; UN Agencies – UNHCR, IOM; Donors – Germany, USAID; Partners – NITAG, PHCI, AMALONA; District Health Offices and Health facilities
Coordination		
<p>How effectively did coordination take place among different partners to leverage efforts and avoid duplication?</p>	Document review	CPD, AWP, COARs, RAM, Sitreps, Donor reports, UNSDCF, Assessment reports, Programme documents, TPM reports, Programme monitoring reports; other publications accessible online
	KII	Ministry of Health including Medical Service Directorates in Municipalities; NCDC; UNICEF; UN Agencies – UNHCR, IOM; Partners – NITAG, PHCI, AMALONA; BBC MA; Support District Health Offices and Health facilities

Gender Equality / Inclusion		
To what extent has a Gender Equality and / or Social Inclusion Strategy been implemented? What were the main gender-based barriers and challenges to response delivery and achievement of outputs and outcomes?	Document review	AWPs, COARs, Donor reports, Programme documents, TPM reports, Programme monitoring reports; other publications accessible online
Human Rights		
To what extent has a Human Rights Approach to Programming been applied in the response? What were the main human rights related barriers and challenges to service delivery and achievement of outputs and outcomes?	Document review	COARs, RAM, Sitreps, Donor reports, RCCE strategy, TPM reports, Programme monitoring reports; other publications accessible online

ANNEX 3: TOOLS FOR THE EVALUATION

I. Key Informant Interview Guide

Evaluation of UNICEF Libya's COVID-19 Response

Information and consent

My/Our name/s is/are _____ and we represent ABH Partners, Ethiopia, who has been commissioned by UNICEF to evaluate the outcomes of UNICEF Libya's COVID-19 response in Libya and particularly the appropriateness of support to the needs of the vulnerable population; achievements/non-achievements of results; allocation and use of resources; consideration for the humanitarian-development nexus and effectiveness of coordination. The evaluation is covering UNICEF's nationwide support to the national COVID-19 response and related interventions, including those implemented through UNICEF's implementing partners. While the support was multi-sectoral, a focus is on health. The period under coverage of this evaluation is March 2020 – December 2022.

You have been identified to participate in this interview as someone who is a stakeholder in and well informed about UNICEF Libya's COVID-19 response. Your participation is entirely voluntary. Your name and any Personal Identification Information (PII) shall not be recorded. Your decision on whether or not to participate will not affect your involvement in UNICEF's programmes in any way. You may choose not to answer particular questions during the discussion. You may also choose to discontinue the interview at any time for any reason. Your responses to the interview are private and confidential. This interview is not meant to evaluate you or your work/performance; rather it is meant to gain insights into UNICEF's response to COVID-19 in Libya for learning and accountability purposes.

Only the study team and UNICEF shall have access to the information you provide. To protect your privacy, we will keep the notes or recordings in private files, and only the study team and UNICEF will be allowed to use them or reuse them at the discretion of UNICEF management.

At the end of the assignment, all notes and recordings will be handed over to UNICEF and destroyed from our records.

This discussion is strictly confidential and your answers will not be associated with your name and your role/title. However, there is a small chance that you could be identified based on the description of your role and your responses to our questions. In this regard, we believe that the risk of exposure is minimal, given that the information that we are asking you about is related to the UNICEF response activities and not personal information. Your participation will not result in any risk of any kind to you as you are only expected to provide your reflection based on the knowledge you have on the subject and/or your engagement in the response. It will also not attract any direct benefits to you. However, your input may contribute to assessing accountability and learning. This discussion will take about 60 minutes.

Permission to Record Interview:

We would like to get your permission to record this interview to ensure that we accurately capture the details that you provide. We will not record the introduction section where your name may feature. However, if you do not agree to be recorded, we will not record the interview. If you agree to be recorded, only the evaluation staff will be able to access the recording. After the evaluation, all recordings will be destroyed.

Do I have your permission to record the interview? YES; NO

Our contact details and that of our Supervisor is _____
(provide phone numbers / email addresses) for you to contact us if you have any questions after the interview is over. A copy of this informed consent is being shared with you.

Do you have any questions before we start? (Answer questions).

May I start now?

Date of interview:	
Location:	
Interviewer:	
Unique Identifier Code of Interviewee/respondent (details of what they do / responsibilities)	

- Please describe to us your role with any special reference to UNICEF’s COVID-19 response.
 - What has been done by your unit / section / department / organisation for responding to COVID-19?
 - Have you been engaged in undertaking any of the response activities? How have you contributed, specifically?

Appropriateness of UNICEF’s response

- Do you think that UNICEF’s response to COVID-19 has been appropriate to the context (generally and the protracted situation) and scope of the implemented interventions?

- To what extent did the UNICEF supported COVID-19 interventions meet the needs of the particularly vulnerable families, girls, and boys?
- How has UNICEF's response informed the strategic priorities for preparations and management of similar pandemic like situations in the future?
- What was the overall strategic direction of the response and to what extent did its objectives align with and strengthen: National priorities – of the government and UN and Donor organisations; Local realities – implementing organisations?
- How does the choice of interventions compare to other alternatives?
- How aligned is UNICEF's COVID19 response with global priorities?
- How appropriate is the UNICEF response to the country context?
- How appropriate is the UNICEF response to government priorities?
- How appropriate is UNICEF's response in addressing inherent equity gaps – taking into consideration any disparities?
- How did the response feed into, and complement, planning and implementation processes at various levels, partner organisation plans?
- How well were the response activities reflected in the monitoring and evaluation systems of the country?
- To what extent did activities complement or duplicate other existing interventions?

Effectiveness of the response

- Did the overall UNICEF support achieve the intended results?
- What are the primary reasons why the objectives are or are not being achieved?
- How effective was social behavioral communication activities via various media integrated into the overall response?
- To what extent did the programme respond to emerging needs and changing context of the COVID-19 pandemic?
- Has there been any unintended positive/negative consequences of the UNICEF supported interventions?
- To what extent have target populations been reached, particularly the most vulnerable groups, disabled etc.?
- Are there any factors which prevented target groups accessing the response services?
- What is the contribution of external environmental factors to the success or failure of the response?
- To what extent did the approach focus on the core elements of the UNICEF guidelines on COVID-19?
- Have evidence-based approaches and interventions been promoted and included? Are the programme indicators sufficiently reflecting achievements?

- How do you monitor the effectiveness of the resources invested on COVID-19 response in Libya?

Specific to UNICEF sectoral interventions to support the multisectoral COVID-19 response:-

Probe: what sectoral interventions were implemented/undertaken by UNICEF's respective sections like on Health, Nutrition, Water, Education etc. List all and probe details to the extent possible.

Efficiency of the response

- Has UNICEF allocated resources strategically and in a timely manner to achieve results?
- To what extent were the objectives, outputs and activities of the response coordinated with, or complementary to, those of other implementing agencies, inclusive of government and other local agencies?
- How far were resources being used efficiently and what alternatives were there to the modes of delivery employed; which (if any) would be more efficient?
- Were the outputs and results achieved at the correct time and within a reasonable period?
- What efforts were made to achieve cost minimisation and Value for Money (VfM)?
- To what extent were partnerships created and contributed to achieving results more efficiently? *How and why?*

Connectedness of the response

- What measures have been considered for linking the key components of the response to longer-term development issues?
- Was there a financial or economic phase-out strategy; if so, how likely is it to be implemented?

Financial:

- If the services or results have to be supported institutionally, are funds likely to be made available? If so, by whom?
- Has there been a reduction in UNICEF's resource commitments which could mean that the local government took over the investments in COVID-19 response? (*evidence of financial sustainability*)

Policy support:

- What support has been provided from the relevant national, sectoral and budgetary policies?
 - *Is it likely to continue after the interventions are ceased?*

Coordination of the response

- How effectively did coordination take place among different partners to leverage efforts and avoid duplication?

Gender / Inclusion / Human Rights

- To what extent has a Gender Equality and / or Social Inclusion Strategy been implemented?
- What were the main gender-based barriers and challenges to response delivery and achievement of outputs and outcomes?

- To what extent has a Human Rights Approach to Programming been applied in the response?
- What were the main human rights related barriers and challenges to service delivery and achievement of outputs and outcomes?

In conclusion:

Anything you would like to add regarding the UNICEF response to COVID-19 in Libya? What do you want to see changed/improved in the future with regards to UNICEF's approach? What would have happened if this response was not supported by UNICEF in Libya?

II. Focus Group Discussion Guide

Evaluation of UNICEF Libya's COVID-19 Response FGD Guide for Beneficiaries

Information and consent

My/Our name/s is/are _____ and we represent ABH Partners, Ethiopia, who has been commissioned by UNICEF to evaluate the outcomes of UNICEF Libya's COVID-19 response in Libya and particularly the appropriateness of support to the needs of the vulnerable population; achievements/non-achievements of results; allocation and use of resources; consideration for the humanitarian-development nexus and effectiveness of coordination. The evaluation is covering UNICEF's nationwide support to the national COVID-19 response and related interventions, including those implemented through UNICEF's implementing partners. While the support was multi-sectoral, a focus is on health. The period under coverage of this evaluation is March 2020 – December 2022.

You have been identified to participate in this Focus Group Discussion as a beneficiary of UNICEF's contribution to the response. Your participation in the focus group is entirely voluntary. Your name/s would not be recorded. Your decision of whether or not to participate will not affect your benefits from the programme. You may choose not to answer any question. You may also choose to discontinue the focus group discussion at any time for any reason. This focus group discussion is not meant to evaluate anything concerning you as a person; rather it is meant to gain insights into UNICEF's programme in Libya. Your answers will be kept confidential and it will not be associated with your name/s. You are also requested not to share anything we discuss today with anyone not in this group, and keep this information confidential.

Only the study team and UNICEF shall have access to the information you provide. To protect your privacy, we will keep the notes or recordings in private files, and only the study team and UNICEF will be allowed to use them or reuse them at the discretion of UNICEF management. At the end of the assignment, all notes and recordings will be handed over to UNICEF and destroyed from our records.

Your participation will not result in any risk of any kind to you as you are only expected to provide your reflection on what services you received. It will also not attract any direct benefits to you. However, your input may contribute to the development of UNICEF's appropriate responses in the future. This focus group discussion will take about an hour.

Permission to Record Discussions:

We would like to get your permission to record this discussion to ensure that we accurately capture the details that you provide. We will not record the introduction section where your name/s may feature. However, if you do not agree to be recorded, we will not record the discussions. If you agree to be recorded, only the evaluation staff will be able to access the recording. After the evaluation, all recordings will be destroyed.

Do I have your permission to record the interview? YES; NO

Our contact details and that of our Supervisor is _____
(provide phone numbers / email addresses) for you to contact us if you have any questions after the discussion is over. A copy of this informed consent is being shared with you.

Do you agree to participate in this focus group discussion?

Yes, No if “Yes” start the FGD

Do you have any question before we start? (Answer questions).

May I start now?

Name location: _____ **Name community:** _____

Date: _____ **Moderator:** _____

Group Details: (*Participants list (UICs) to be attached at the end*)

- Number (of participant group) _____

NOTE: If the participants are not fully aware of the background of the response to COVID-19 in Libya, the facilitator is expected to provide a brief to the participants about the response and its activities, before commencing upon the discussions. The brief shall be designed and agreed with UNICEF to cater to the diversity and coverage of the approach.

- Please discuss the COVID-19 response led by the Government? Are you satisfied with the response interventions? *Why? Why not?*
- Did you know that UNICEF contributed to the response? If yes, what are your reflections on them?
- Would you like to discuss to what extent did the UNICEF-supported COVID-19 interventions meet the needs of the vulnerable families, girls, and boys?
- Let's discuss the services that you or family/community members accessed during 2019 – 2022 COVID-19 response. Do you feel that the services you received met your needs? *Why? Why not?*
- Did you receive the behavioural messaging supported by UNICEF? Where did you receive/access it? Did you understand the importance of those messages? Could we discuss on this issue?
- Do you all feel that if similar interventions are needed in the future, and UNICEF is not able to take them up, would the government be able to carry them forward? *Why? Why not?*
- Would the community or anyone else you know be able to take these forward? *Why? Why not?*
- In your view, did you see two or more agencies/organisations working together and reaching services for COVID-19 management to you / your community? What could be done better in the future?
- Did you see any discrimination based on gender, disability or refugee status etc. while the response was underway? What could be done to improve the situation in the future?

Would anyone like to make any final comments?

Thank you for your time.

III. Validation Workshop

Evaluation of UNICEF Libya's COVID-19 Response

Validation Workshop Informed Consent

My/Our name/s is/are _____ and we represent ABH Partners, Ethiopia, who has been commissioned by UNICEF to evaluate the outcomes of UNICEF Libya's COVID-19 response in Libya and particularly the appropriateness of support to the needs of the vulnerable population; achievements/non-achievements of results; allocation and use of resources; consideration for the humanitarian-development nexus and effectiveness of coordination. The evaluation is covering UNICEF's nationwide support to the national COVID-19 response and related interventions, including those implemented through UNICEF's implementing partners. While the support was multi-sectoral, a focus is on health. The period under coverage of this evaluation is March 2020 – December 2022.

You have been identified to participate in this validation workshop as a major stakeholder in UNICEF's contribution to the response to COVID-19. Your participation in the workshop is entirely voluntary. Your name/s would not be recorded. Your decision of whether or not to participate will not affect your role or benefits from the programme. You may choose not to validate / answer any finding / question. You may also choose to discontinue your participation in the workshop at any time for any reason. This validation is not meant to evaluate anything concerning you as a person/s; rather it is meant to gain insights into UNICEF's programme in Libya. Your answers will be kept confidential and it will not be associated with your name/s. You are also requested not to share anything we discuss today with anyone not in this group, and keep this information confidential.

Only the study team and UNICEF shall have access to the information you provide. To protect your privacy, we will keep the notes or recordings in private files, and only the study team and UNICEF will be allowed to use them or reuse them at the discretion of UNICEF management. At the end of the assignment, all notes and recordings will be handed over to UNICEF and destroyed from our records.

Your participation will not result in any risk of any kind to you as you are only expected to provide a reflection on what services you were engaged in or have knowledge about. It will also not attract any direct benefits to you. However, your input may contribute to the development of UNICEF's appropriate responses in the future. This workshop will take about two – three hours.

Permission to Record Discussions:

We would like to get your permission to record this discussion to ensure that we accurately capture the details that you provide. We will not record the introduction section where your name/s may feature. However, if you do not agree to be recorded, we will not record the discussions. If you agree to be recorded, only the evaluation staff will be able to access the recording. After the evaluation, all recordings will be destroyed.

Do I have your permission to record the interview? YES; NO

Our contact details and that of our Supervisor is _____
(provide phone numbers / email addresses) for you to contact us if you have any questions after the discussion is over. A copy of this informed consent is being shared with you.

Do you agree to participate in this workshop?

Yes, No if “Yes” start the workshop

Do you have any question before we start? (Answer questions).

May I start now?

Participant’s Details: (*Participants list (UICs) to be attached at the end*)

- Number (of participant group) _____

NOTE: If the participants are not fully aware of the background of the response to COVID-19 in Libya, the facilitator is expected to provide a brief to the participants about the response and its activities, before commencing upon the discussions related to the findings of the evaluation.

The validation workshop would commence as per the agenda developed with the Evaluation Manager.

ANNEX 4: LIST OF STAKEHOLDERS / RESPONDENTS

Stakeholders of COVID-19 Response

S.No	Organization
1	Ministry of Health
2	NITAG
3	PHCI
4	NCDC
5	Medical Service Directorates of MOH
6	Ministry of Education
7	Ministry of Water Resources
8	UNICEF
9	Embassy of Germany
10	Embassy of Japan
11	European Union (EU)
12	UNHCR
13	IOM
14	World Health Organization (WHO)
15	IRC
16	BBC Media Action
17	AMALONA organization
18	DAMM - Support

Respondents / participants in the evaluation

S.No	Name	Designation	Organization / Location
1	Michele Servadei	Representative	UNICEF
2	Marie-Consolee Mukangendo	Deputy Representative	
3	Narine Aslanyan	Ex-Deputy Representative (Programme)	UNICEF
4	Dr. Abdul Waheed	Chief of Health & Nutrition	UNICEF
5	Mohamed Mutasim	Planning Monitoring & Evaluation Manager	UNICEF
6	Dr. Mohammd Yunus	Health Specialist	UNICEF
7	Dr. Mawaheb Shelli	Health & Nutrition Officer	UNICEF
8	Dr. Mohamed Abugalia	Health Officer	UNICEF
9	Rasha Moh Elabdali	Social & Behavioral Change Officer	UNICEF
10	Cristina Brugiolo	Former Deputy Representative	UNICEF
11	Safa Belhaj	Senior Supply/procurement associate	UNICEF

12	Yuko Osawa	Chief Child Protection	UNICEF
13	Ibrahim Farah	Ex Chief of Education	UNICEF
14	Mohammad Almjadleh	WASH Officer	UNICEF
15	Amel Markos	Education Specialist	UNICEF
16	Hideyuki Tsuruoka	Evaluation Manager	UNICEF MENARO
17	Delphine Sauvageot	Health Section	UNICEF MENARO
18	Christiane Kraus	Head of Development Cooperation and Culture in Libya	Embassy of Germany
19	Amadera Masaki		Embassy of Japan
20	Sarah Bernhardt	Programme Manager – Health sector	European Union
21	Ashraf Baher	General Development Specialist USAID Libya	USAID
22	Abdulmenem Alkmashe	Director of technical cooperation office / Member of COVID 19 Steering Committee	NCDC
23	Dr. Haider Elsayeh	Director General	NCDC
24	Hazem Elogrban	Technical cooperation office	NCDC
25	Abdulrahman Saud	Immunization department	NCDC
26	Emad Enjoma	Communication department	NCDC
27	Ahmed Elarousi	Emergency Operation department	NCDC
28	Dr. Ibtisam Hadid	NITAG	NITAG
29	Dr. Ghassan Kareem	Director	PHCI
30	Dr. Meftah Lahwel	Assistant Public Health Officer	UNHCR
31	Dr. Abdul Wahid Khalaf	Field Health Coordinator	IOM
32	Naser Alkadeki	Medical Service Directorate /Vaccination	Benghazi
33	Muna Alfezani	Alhadaeq PHC	Benghazi
34	Husam Habeb	PHC Benghazi Almadina	Benghazi
35	Fakhri Suliman	Slem -Sassi PHC	East, Derna
36	Hussen Bader	Algubaa Ras Helal PHC	East, Algubaa
37	Abdmenem Eswaker	Medical Service Directorate /Vaccination	East ,Tobruk
38	Ahmed Alghrari	Municipality	Tripoli
39	Amira Hfaf	Alhani PHC	Tripoli, Suq Aljumaa
40	Hussein Hlal	Aseyahiya	Tripoli, Hay Alandalu
41	Alsead Almozoghi	Medical Service Directorate / Vaccination	West Tripoli Sabratha
42	Abdouljalel Algodrawi	Municipality	South, Sabha
43	Ayad	Althanawiya PHC	South, Sabha
44	Rajab Atloo	Algharbi PHC	West, Zwara
45	Mossa Alshtar	Alzanan Alshamali PHC	West, Zantan

46	Mohamed Shaba	Municipality	Central, Misurata
47	Khaled Abutreka	Shati alnakhil Health Unit	Central, Misurata
48	Hamdi Mohamed Omar	Jamal Abdalnaser	Central, Serte
49	Ismeal Alsweady	Municipality	Alkums
50	Mohamed Jamal	Municipality	Zantan
51	Hassan Almabrook	Municipality	Ghat
52	Khald Alwamy	Municipality	Darna
53	Yamina Touihri	Projects Officer	BBC Media Action
54	Mohammad Shukri		DAMM - Support

ANNEX 5: REFERENCES

1. United Nations Sustainable Development Cooperation Framework (UNSDCF), 2023 – 25, Libya
2. UNICEF Country Programme Document, 2023 – 25
3. IMF Country Report No. 23/201
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15. Country Office Annual Report, 2021, UNICEF Libya
16. Country Office Annual Report, 2022, UNICEF Libya
17. Terms of Reference, Evaluation of UNICEF Libya's COVID response, UNICEF Libya
18. Mid Term Review of Lebanon Country Office, Country Programme Document 2017 – 2020
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20. strengthening the role of municipalities in Lebanon, 2020 https://www.aub.edu.lb/k2p/Documents/Strengthening%20Role%20of%20Municipalities_English.pdf
21. One pager of Municipalities selection, UNICEF LCO
22. Gender Analysis Toolkit for Health Systems, Jhpiego (2016).
23. Donor Reports submitted to BMZ, USAID, Japan etc.