UNFPA LIBYA COUNTRY PROGRAMME EVALUATION

1ST COUNTRY PROGRAMME 2019 – 2022

FINAL EVALUATION REPORT

JANUARY 2022

MAP OF LIBYA[1]

Source: Maps of the World (https://www.mapsofworld.com/lat_long/libya-lat-long.html)

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[1] The boundaries and names shown and the designations used on the maps on this site do not imply official endorsement or acceptance by the United Nations Population Fund

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The Evaluation Team hope that the findings and recommendations presented in this report will positively contribute to building a sound foundation for the development of 2ndUNFPA Libya country programme, national development plans and UNSF in Libya.

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ABBREVIATION AND ACRONYMS

A&Y	Adolescents and Youth
ARV	Antiretroviral
AWPs	Annual Work Plans
CBOs	Community Based Organizations
CEDAW	Committee on the Elimination of all Discrimination Against Women
CHW	Community Health Worker
CMR	Case Management of Rape
CO	Country Office
COVID-19	Corona Virus Disease – 2019
CPD	Country Programme Document
CPE	Country Programme Evaluation
CRC	Convention on the Rights of the Child
CSO	Central Statistical Office
EUTF	European Union's Africa Trust Fund
CSOs	Civil Society Organizations
DHIS2	District Health Information System 2
EmONC	Emergency Obstetric and Newborn Care
EQ	Evaluation Questions
ERG	Evaluation Reference Group
ERH	Sexual Reproductive Health
EU	European Union
EUTF	European Union Trust Fund
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GE	Gender Equality
GEWE	Gender Equality and Women's Empowerment
GPS	Global Program System
HCT	Humanitarian Coordination Team
HIV	Human Immunodeficiency Virus
HRP	Humanitarian Response Plan
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Convention on Economic Social and Cultural Rights
ICPD	International Conference on Population and Development
IDPs	Internal Displaced Persons
IEC	Information Education and Communication
IMC	International Medical Corps
IMS	Information Management System
IOM	International Organization for Migration
IPs	Implementing Partners
IRC	International Rescue Committee
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interviews
LibAid	Libyan Humanitarian Relief Aid
LRC	Libya Red Crescent
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MoE	Ministry of Education
MoH	Ministry of Heath

MoI	Ministry of Interior
MoJ	Ministry of Justice
MoSA	Ministry of Social Affairs
NCDC	National Centre for Disease Control
NGO	Non-governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs.
ODA	Oversees Development Assistance
OECD/DAC	Organization for Economic Cooperation and Development
PAPFAM	Pan Arab Project for Family Health
PD	Population Dynamics
PHC	Primary Health Care
PPE	Protective Personal Equipment
PSEA	The Prevention of Sexual Exploitation and Abuse
RH	Reproductive Health
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health
SARA	Service Availability and Readiness Assessment
SIS	Strategic Information System
SGGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
ToC	Theory of Change
ToR	Terms of Reference
UN	United Nations
UN WOMEN	The United Nations Entity for Gender Equality and the Empowerment of Women
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Emergency Children Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNSMIL	The United Nations Support Mission in Libya
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organization
WGSS	Women and Girls Safe Space

Table 1: Key Facts Table

Indicators	Facts (Data Value)	Source/ Year
Land		
Geographical location	Middle East North Africa	World Bank (2020)
Surface area	1,759,500 sq.km	World Bank (2020)
People		
Population (2020)	6,930,271million	Libyan National Bureau of Statistics and Census (NBSC)/Projections (2021)
Population aged below 15 years	31.1	NBSC/Projection (202
Population aged 15 – 24 years	16.1%	NBSC/Projections (2021)
Population aged below 30 years	63.4%	NBSC/Projections (2021)
Population aged 65 years and above	4.3%	NBSC/Projections (2021)
Women of reproductive age (15 – 49)	56.1%	NBSC/Projections (2021)
Urban population	88%	NBSC
Rural population	12%	NBSC
IDPs	278,000	World Bank (2020)
Population growth Rate	1.8%	NBSC/Projections (2021)
Health		
Infant mortality rate (deaths per 1'000 live births)	9.9	World Bank (2019)
Neonatal mortality rate (deaths per 1'000 live births)	6.5	World Bank (2019)
Under-5 mortality (deaths by 1'000 live births)	11.5	World Bank (2019)
Adolescent fertility rate (per 1'000 women	6	World Bank (2019)
Contraceptive prevalence rate (% of women aged 15-49)	27.7%	PAPFAM (2014)
Unmet need for contraceptive use	40%	PAPFAM (2014)
Maternal Mortality ratio (per 100'000 live births)	72 (modelled)	World Bank (2017)
Life expectancy at birth	73	World Bank (2019)
Total fertility rate (average number of children per woman)	3.4%%	PAPFAM (2014)
Adults aged 15-49 HIV prevalence rate	0.1%	World Bank (2020)
Proportion of births attended by skilled health personnel	100%	World Bank (2013)
Total of Health Expenditure (% of GDP)	6.05%	World Bank (2011)
Government		
Type of government	Transitional Government	Election guide (2020)
Head of government	Prime Minister	Election guide (2020)
Economy		
GDP (US$)	25,418,461,530	World Bank (2020)
GDP annual growth rate	-31.3%	World Bank (2020)
Per capita income	15,816	World Bank (2020)
Unemployment rate	19.0% (national estimate)	World Bank (2020)
Consumer Price Index (2008=100%)	268.2	NBSC / 2020
Youth unemployment rate	48.7%	World Bank (2012)
Multidimensional Poverty Index	2.0%	UNDP HDR (2020)
Social and Development Indicators		
Human Development Index rank	105	UNDP HDR (2020)
Literacy rate	86.1% (15 years and older)	UNESCO (2004)
Net enrolment in Primary school	98%	World Bank (1983)
Net enrolment in secondary school	58%	World Bank (1983)
Gender Inequality Index	0.252%	UNDP HDR (2019)
Seats held by women in national parliament	16.0%	UNDP HDR (2019)

STRUCTURE OF THE COUNTRY PROGRAMME EVALUATION REPORT

This Country Programme Evaluation Report is structured according to the UNFPA Evaluation Handbook. The preliminary pages prior to the main chapters of the report includes acknowledgements, acronyms and abbreviations, the list of tables and figures, a key facts table and an Executive Summary. Chapter One introduces the purpose and objectives of the Country Programme Evaluation, outlines its scope as well as the methodology and processes. Chapter Two, describes the programme implementation context, highlighting the development challenges, in addition to the national strategies, and the role of external assistance. Chapter Three describes the UN and UNFPA strategic response as well as the UNFPA response through the 1st CP and its interventions.

Chapter Four presents the findings of the CPE guided by the evaluation questions under each evaluation criteria of relevance, effectiveness, sustainability, efficiency, coordination, Coverage and Connectedness. Chapter Five covers the conclusions to the report presented at both strategic and programmatic levels; and the Lessons learnt. Chapter Six provides the CPE recommendations and are also presented at strategic and programmatic levels. Finally, the report provides the following annexes: Terms of reference, list of persons/ institutions visited and interviewed, documents reviewed, evaluation matrix, the CPE agenda

EXECUTIVE SUMMARY

Purpose, Scope and intended audience: This report presents the process, findings, conclusions and recommendations of the UNFPA 1st programme cycle (2019– 2022) Country Programme Evaluation (CPE). The evaluation serves three primary purposes: (a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, (b) support evidence-based decision-making, and (c) contribute key lessons learned to the existing knowledge base on how to accelerate the implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD)[2]. Further, the CPE is aimed at providing the UNFPA CO in Libya, national stakeholders, the UNFPA ASRO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Libya 1st CP (2019-2022) and to broaden the evidence base for the design of the next programme cycle. The specific objectives of the CPE were; to provide an independent assessment of the relevance, effectiveness (in terms of progress towards the expected outputs and outcomes set forth in the results framework of the CP), efficiency and sustainability of UNFPA support; provide an assessment of the geographic and demographic coverage of UNFPA humanitarian action and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives; provide an assessment of the role played by the UNFPA CO in the United Nations system-wide coordination mechanisms for development assistance and humanitarian action with a view to enhancing the United Nations collective contribution to national development and humanitarian results; and draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme cycle. The geographical scope of the evaluation included all the regions covered by the CP, with all the four thematic CP areas covered and for the period 2019 – 2021. The main intended audience for the CPE report will be UNFPA Libya CO; the GNU; the UNCT and the Humanitarian Country Team (HCT) in Libya; the UNFPA Arab States Regional Office, (ASRO); UNFPA HQ; and donors operating in in Libya; among other wider groups of UNFPA stakeholders.

The 1st UNFPA Libya Country Programme: The 1st Country Programme was designed to contribute to national needs and priorities. The programme articulates UNFPA's strategic priorities and programmatic interventions in Libya in four outcome areas, namely; i) sexual and reproductive health and reproductive rights (SRHR); ii) youth development and participation (hereinafter referred to as "adolescents and youth," A&Y); iii) gender equality and women's empowerment (GEWE); and iv) population dynamics (PD). The UNFPA support was targeted to cover 2019-2020, but was extended twice up to 2022 to allow for the finalization of the new Strategic Framework and alignment with the new CP. The programme was designed to contribute to strengthening access to SRH and GBV services especially among the marginalized and vulnerable population, including migrants and asylum seekers. The design and implementation of the CP emphasised strengthening the capacities of the stakeholders to improve SRHR, A&Y, GEWE and PD indicators in the country, utilizing all the five modes of engagement: advocacy and policy dialogue; capacity development; knowledge management; partnership and coordination, and service delivery.

CPE Methodology: The design of the CPE was guided by the UNFPA Evaluation Handbook on how to conduct a country programme evaluation[3], in addition to the formats of the design and evaluation reports. The CPE was a theory-based non-experimental design using a participatory approach, and guided by a set of 10 questions that address the evaluation criteria mentioned earlier. The consultants determined the sample frame from the list of stakeholders, from a stakeholders' mapping by the CO and used a purposive sampling method to select participants for the CPE. The stakeholders' selection process was guided by the thematic areas of engagement with UNFPA. The sampling frame included IPs, partners from government and civil society organisations (CSOs), donors, strategic partners and, direct and indirect beneficiaries.

The CPE adopted mixed methods in data collection, namely; i) document review; ii) remote-based key informant interviews (KIIs) at group and individual levels with the selected stakeholders and CO staff (a total of 58 sessions); and iii) Focus group discussions with stakeholders and beneficiaries (three sessions). In addition, triangulating the sources and methods of data collection, the evaluation used both qualitative and quantitative data in the analysis and generation of the evaluation report. The data were collected virtually due to COVID-19 restrictions through Zoom, Google Meet and WhatsApp platforms with direct and indirect beneficiaries. Ethics and quality control requirements

[2] https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2019
[3] Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA, 2019

were adhered to by the consultants and assured by the Evaluation Manager. There were no major challenges encountered during the field phase, and the purpose and objectives of the CPE were fully met with invaluable support from the CO team.

Main Results and Conclusions: Relevance: The UNFPA Libya 1st CP was strategically adapted to address national priorities and population needs, implemented in collaboration and consultation with the various line ministries, including Ministry of Health, Ministry of Youth, Ministry of Social Affairs, Ministry of Planning, the Bureau of Statistics and Census, Ministry of Education, Ministry of Higher Education, and other line ministries, directly contributing to their respective objectives, and making it relevant to the national needs. In addition, the CP was in alignment with the UNSF 2019-2022, International Conference on Population and Development, and the UNFPA Strategic Plan 2018-2021 and is contributing to the Sustainable Development Goals (SDGs), the New Way of Working and the Grand Bargain. There was responsiveness in the CP implementation towards humanitarian and emerging needs, occasioned by changes in the implementation context, especially conflicts leading to displacement, floods, migrants, and asylum seekers during the 1st CP implementation period. There was evidence of high level consultations during design and implementation with the government and various stakeholders, advancing national ownership and capacity building. Instability in the government however limited commitment and capacity of the government to monitor implementation. Absence of national development strategy also limited the determination of national needs and the extent of the response. UNFPA Libya immensely contributed to addressing national development needs in reproductive health, for adolescents and youth, GBV prevention and response, population data, and to respond effectively to humanitarian situations in the country. At the national level engagement, UNFPA prioritized areas of need, especially with the development of the RMNCAH strategy and areas of RH gaps, and mainstreamed gender and a human rights focus, addressing gender-based violence (GBV), and tailoring response also to the migrant population. UNFPA Libya also strengthened GBV prevention and response and, to some extent, advocacy towards elimination of harmful practices in the country. In addition, the UNFPA's strength is recognized in and depended upon its areas of programme responsibility within the UN Country Team (UNCT) and Humanitarian Country Team (HCT), and contributed to its functioning through leading technical working groups, participating in the various joint programmes and collaborations enhancing coordination. There is however an opportunity to strengthen strategic partnership for ownership of the CP results, in addition to integration of the programme components to improve efficiency, effectiveness and sustainability.

Effectiveness: The CP achieved most of the output targets across the components, ensuring that the programme addressed the felt development and humanitarian needs in the areas of UNFPA's mandate in the county. Under the **Sexual and Reproductive Health and Rights (SRHR**) component, UNFPA contributed to ensuring increased access for women and girls to high quality sexual and reproductive health services, with a focus on humanitarian settings; and improved capacity and resilience of health systems for the provision of integrated sexual and reproductive health (SRH) services, including for the most vulnerable. UNFPA contributed to enhanced access to SRH service delivery in Libya through supporting the government in the development of the RMNCAH (2018 – 2023) strategy and its costed action plan, which contributed to guiding the services and targets for the country. UNFPA also supported the delivery of BEmONC and CEmONC services to the targeted vulnerable and marginalized populations through rehabilitation and equipment of primary health facilities, and deployment of mobile health teams. The CO strengthened quality health service delivery through training of healthcare workers. Furthermore, the CO strengthened nursing and midwifery association and curriculum development aimed at increased skilled birth attendance and leadership in service provision. UNFPA also stimulated demand for SRH services by deploying community health workers (CHW) in the target communities to create awareness and provide information on services available. UNFPA financially and technically supported strengthening of capacity of the country, in collaboration with the MoH, on the minimum initial service package (MISP) for SRH in crisis situations, thereby facilitating provision of lifesaving services and capacities to respond to the SRH needs of the crisis-affected populations in Libya's humanitarian context, in addition to supporting integration of SRHR delivery in the HRP. The 1st CP contributed to strengthening resilience of the health system through capacity building of the country's healthcare providers, development of Nursing and Midwifery Policy; RMNCAH Policy; and HIV&AIDS Policy, enhanced surveillance through supporting the roll-out and functioning of the DHIS and provision of infrastructure to implement it, enhanced integration of RH into national health systems, and improving RH commodity management system. UNFPA also

supported advocacy for regulation and standardization of nursing and midwifery profession and recognition of the role of midwives, in addition to supporting association. During COVID-19, the CP supported improved resilience of the health system through training packages to health workers on COVID-19 in relation to SRH, MISP, HIV VCT, breast cancer awareness and prevention, EmONC and leadership training for Midwifery. There were however gaps in the strategy and guidelines implementation, due to limited capacity and high turnover of the government authorities and among the healthcare workers. Non-prioritization of birth spacing in Libya also hampers the achievement of the unmet family planning needs. There is room for institutionalization, especially strengthening government engagement and ownership in service provision, in addition to enhancing family planning service access.

Under the **Adolescents and Youth** component, UNFPA technically and financially enhanced participation of adolescents and youth in peacebuilding and in strengthening social cohesion, enhanced their empowerment and their involvement in decision-making. The 1st CP contributed to amplifying the relevance and importance of the youth participation in governance and state building through advocacy activities further development of youth life skills and citizenry. Further, the programme enhanced access to adolescent and youth reproductive and rights (ASRHR) information and participation in advocacy mechanisms on ASRH and GBV, increasing their involvement in addressing GBV issues and contribution to the empowerment of women and girls in the country. UNFPA enhanced engagement of the youth and improved their technical skills and employability through training and capacity strengthening. The youth also increased their access to MHPSS and PSS services through participation in social media platforms facilitating their empowerment with information given the context. UNFPA, further, contributed to strengthening youth access to income through training and supporting them on vocational skills, in addition to granting the seed capital for business opportunities, enhancing their meaningful economic engagement. However, inadequate A&Y integration in the CP, absence of youth-friendly services, absence of national strategy and limited resource allocation to the A&Y component in the CP limited the scope in targeting.

The **Gender Equality and Women's Empowerment (GEWE)** component contributed to strengthening of the country's capacity in GBV prevention and response mechanisms through enhanced multisectoral coordination and leadership in GBV SS, enhanced advocacy on GBV, strengthened EVAW law development (awaiting endorsement), enhanced accountability mechanisms, and enhanced provision of comprehensive GBV response services for survivors. The establishment of the Women and Girls' Safe Spaces (WGSS) facilitated access to PSS, life skills, livelihood opportunities, and referral services for legal support and treatment by the GBV survivors. The integration of GBV prevention and response into health service delivery through establishment of GBV Unit in the MoH will enhance clinical management of rape. UNFPA enhanced elimination of overlaps and leveraged resources, and enhanced partnerships for prevention and response to GBV in the country through technically and financially supporting and leading the GBV SS coordination. UNFPA, together with UN Women, enhanced gender mainstreaming across the UNCT; in addition to supporting establishment and operation of GBV Information Management System (GBV IMS) for evidence-based programme and streamlining response. Further, UNFPA enhanced access to discrete access to PSS, legal counselling and referral to immediate health services for the people in need through the rollout of free-toll hotline service available to the general population. However, there remains challenges and gaps that inhibit prevention and response system to address gender-based violence; including; unfavourable legal and justice systems, harmful practices, weak referral pathways, fragmented response, and deep-rooted social and cultural beliefs that still allow discrimination and violence against women

There were mixed results under the **Population Dynamics** component of focus. UNFPA contributed to strengthening generation of data in the country through capacity building of the National Bureau of Statistics and Census (NBSC) in developing georeferenced boundaries facilitation accuracy in sampling and estimation of population, and strengthening capacities in in the use of GIS in data generation. UNFPA also supported in-depth analysis of past population data up to the lowest level of governance, increasing availability of data for decision-making. UNFPA also contributed to the humanitarian response, especially in targeting key populations through generation and development of COD-PS for use in the determination of people in need (PIN). The delay in conducting of population and housing census hampers evidence-based policy formulation and programming. Instability and delays in allocation of the resources by the government for periodic survey delays access to data for decision-making. Inadequate allocation of the resources to the PD component of the CP was notable. There was also inadequate reporting on targeting of people with

disabilities or aging population. UNFPA was identified not to be active in its data area of responsibility both in the UNCT and HCT, with little contribution current data for decision-making, in addition to limiting monitoring of SDGs.

There was evidence of enhanced **efficiency** in delivery of the CP and achievement of the results through strategic programme approaches and management of operations. UNFPA utilized strategic partnerships with the government, the UN agencies and donors ensuring favourable implementation framework, leveraged resource, synergies and funding opportunities for the CO. Partnerships with the implementing partners (IPs), most of which were local NGOs facilitated wider geographical coverage, enhancing access to hard-to-reach areas and marginalized populations, enhancing efficiency. The CO's staff had the right skill-sets in all the programme and administrative areas, however to a little extent adequate for the delivery of the CP. Further, UNFPA bridged this gap of staff by contracting a third party contractor which made it easier and faster to hire, unlike the long processes taken through the UN recruitment system. The CO staff largely complied with the operation systems facilitating efficiency in delivery of the CP. The office typology and context in Libya had pros and cons, with the existence of the Tunis office where most coordination support was provided, had challenges in the long bureaucracies in approvals and visa for staff to move freely to Libya. This however affected all the UN agencies in Libya and all non-Libya staff regardless of whether they were part of the Tunis or Tripoli office. It was however a challenge to establish the extent to which this was an issue since the staff confirmed that coordination was effective, in addition to the limitation of accommodation facilities in Tripoli for international staff. The M&E system was fairly robust and facilitated measurement of performance and feedback on programme deliverables, but mostly donor-driven, with clear processes and activities embedded in the CP management and delivery. The CO facilitated programme coordination and review mechanisms for the CP and with the IPs and other stakeholders, ensuring effective support supervision and capacity enhancement in programme quality. Inadequate movement options for technical staff limited support supervision, especially for the IPs, limited capacity and commitment of the government in monitoring and unstable context affected the efficiency in CP delivery. There is also room for improvement especially in terms of enhanced focus on results by the CO and IPs.

UNFPA incorporated **sustainability** in the design and delivery of the 1st CP through promoting national ownership and institutionalization of service delivery and support. UNFPA facilitated a consultative process during design of the CP, in addition to collaborating and supporting line ministries'' felt needs, contributing to the sectoral goals. UNFPA strengthened capacity of the government and IPs, in addition to investing resources on strengthening the capacities of the service providers to transfer skills. Absence of strategies and instability in the government limited likelihood of continuity and commitment of the government on the CP results. The partnership with the local NGOs building trust into the community, ensured support of the programme interventions and ownership of the CP results. UNFPA also invested heavily in capacity building in the various components, including development of policy, strategy, guidelines, SOPs and tools; enhancing skills transfer and institutional strengthening to enhance delivery of services. Inadequate engagement of the government, high staff turnover and inadequate funds threaten the possibility of sustainability.

UNFPA utilized its comparative advantage with the UNCT and HCT to enhance functioning **coordination** mechanisms among the UN agencies. UNFPA visibly participated and significantly contributed in the functioning of the coordination mechanisms through building on the triple mandate of leading coordination, accountability and capacity building, and its contribution to the achievement of the UN Strategic Framework (UNSF). UNFPA was an active participant and used areas of strength to effectively and efficiently contribute to running the UN coordination mechanisms. UNFPA participated in enhancing UNCT coordination through joint programmes and collaborating with other UN agencies, especially in the humanitarian response, gender, adolescent and youth, and RH. Absence of government strategy or development plan limited opportunities for collaboration and contributory support among UN agencies. The context also limited room for collaboration, with cases of overlaps reported during the period.

UNFPA's contribution to the humanitarian response enhanced targeting and reach to the vulnerable and marginalized populations through partnerships, capacity building, integration, standardization of response, coordination and leveraging resources, and service mapping across the country. Through partnership with IPs and government, the 1st CP reached and responded to most humanitarian cases arising during the period, enhancing **coverage**. UNFPA ensured **connectedness** through

strengthening capacities of the actors, development of strategies, guidelines and policies to guide implementation, coordination and promoting integration of programmes and national ownership in the humanitarian response mechanisms, in addition to supporting development of preparedness plans. However, the instability in government and protracted humanitarian situation in Libya, coupled with weak institutions and governance systems, inadequate capacities and response systems, limit connectedness of the CP results.

Main Recommendations

1. The 2nd CP should incorporate strengthening of advocacy, strategic partnerships and innovative resource mobilization to maximize its potential to contribute to strategic results within the country, while at the same time providing additional service support and capacity development to the most vulnerable and marginalized populations and targeting underserved and needy areas, while focusing on durable solutions to the existing humanitarian crisis.
2. Enhance development and strengthening of the level and intensity of policy dialogue in the CP's component areas to enhance structured engagement with the national authorities for desired support and realization of desired changes in policy
3. Prioritize increased partnership and strengthen integration within the CP in the implementation of the CP components to increase efficiency and continue optimizing on the operations management strategies, including enhanced internal controls, finance and logistics management, human resources, among others, in addition to diversifying resource mobilization and strengthening staff capacity building in their respective areas weakness.
4. UNFPA should continue capacity building and systems strengthening, in collaboration with the government line ministries, in addition to increased engagement of the municipalities, IPs and strengthening of affected communities' structures to enhance oversight in the COVID-19 constraints.
5. There is a need for the UNFPA CO to continue building and strengthening partnerships with other UN agencies, in addition to sourcing and pooling resources to support joint activities of the UNCT thereby enhancing the comparative advantage of UNFPA, in addition to eliminating overlaps and duplication of efforts and coverage.
6. There is need to strengthen the intervention logic of the CP results and resources framework to ensure measurable outcome and output indicators as well as stronger alignment of interventions to the outcomes and outputs. Invest in operations research to inform the CO on the changes arising from the knowledge-based and advocacy interventions.
7. UNFPA should continue to strengthen technical and financial support for integrated services in the areas of its mandate in SRHR, emphasize advocacy and partnership to ensure government commitment and ownership in the implementation of the RMNCAH strategy and SOPs for quality service delivery and institutionalization of the programme strategies in the country.
8. Enhance demand creation for increased uptake of services especially by the most vulnerable and those left furthest behind, in addition to supporting scale-up of interventions to address FP.
9. UNFPA should enhance staff capacities to increase integration of youth- and adolescent friendly RH information, services and reproduction rights into SRHR and GEWE components, in addition to strengthening partnerships and coordination with government and non-state actors to increase access to SRH services by the youth and adolescents.
10. Strengthen consolidation of youth programming and coordination in the country through the development of a national youth policy and strategy, including implementation action plan, while at the same time continue to build the capacity of the youth on leadership skills and ability to influence policy and strategy.
11. UNFPA, through its leadership in GBV SS coordination should continue to rally counterparts to advocate for development and strengthening of legal and institutional framework for GBV response to ensure accountability to the affected populations.
12. UNFPA Libya should work with national counterparts for the mainstreaming and operationalization of gender issues in relevant national strategies and policies.
13. UNFPA should ensure strengthening national capacities on data generation, and policy formulation and programming, in addition to strengthening institutionalization and utilization of data.
14. Increase emphasis, resources and leverage on the unique mandate and competencies of the CO in PD to support advocacy and results in all focal areas for enhanced evidence-based programming.

CHAPTER 1: INTRODUCTION

The United Nations Population Fund (UNFPA), Libya Country Office (CO) is currently implementing the 1st cycle of the UNFPA Programme supports to the internationally-recognized Government of National Unity in Libya. The initial country programme (CP), 2019 to 2020 was first extended up to 2021 to align with the extended United Nations Strategic Framework (UNSF)[4] and further extended to 2022 to allow for the finalization of the new Strategic Framework and alignment with the new country programme[5]. The CP is implemented covering four thematic areas, namely i) sexual and reproductive health and reproductive rights (SRHR); ii) adolescents and youth (A&Y); iii) gender equality and women's empowerment (GEWE); iv) population dynamics (PD).

The UNFPA Libya CO has commissioned the Country Programmes Evaluation (CPE) in compliance with the 2019 UNFPA Evaluation Policy[6]. The policy guided the design, management and governance of the CPE process, in addition to the Norms and Standards, and Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, established by the United Nations Evaluation Group (UNEG).[7]

1.1 Purpose and Objectives of the CPE

As guided by the CPE terms of reference (ToR), and in line with the 2019 UNFPA Evaluation Policy[8], the purpose of the evaluation served three primary purposes: (a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, (b) support evidence-based decision-making, and (c) contribute key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD). Further, the CPE aimed at providing the UNFPA CO in Libya, national stakeholders, the UNFPA ASRO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Libya 1st CP (2019-2022) and to broaden the evidence base for the design of the next programme cycle.

Specifically, the objectives of the CPE were, to:

1. Provide an independent assessment of the relevance, effectiveness (in terms of progress towards the expected outputs and outcomes set forth in the results framework of the CP), efficiency and sustainability of UNFPA support.
2. Provide an assessment of the geographic and demographic coverage of UNFPA humanitarian action and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives.
3. Provide an assessment of the role played by the UNFPA CO in the United Nations system-wide coordination mechanisms for development assistance and humanitarian action with a view to enhancing the United Nations collective contribution to national development and humanitarian results.
4. Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme cycle.

The main audience and primary intended users of the CPE are: (i) The UNFPA Libya CO; (ii) the GNU; (iii) the UNCT and the Humanitarian Country Team (HCT) in Libya; (iv) the UNFPA Arab States Regional Office, (ASRO); (v) and donors operating in in Libya. The evaluation results are also of interest to a wider group of stakeholders, including: (i) Implementing partners of the UNFPA Libya CO; (ii) UNFPA headquarters divisions, branches and offices; (iii) the UNFPA Executive Board; (iv) academia; (v) local civil society organizations and international NGOs; and (vi) beneficiaries of UNFPA support (in particular women and adolescents and youth).

1.2 Scope of the Evaluation

The scope of the CPE have been defined by;

- **Geography:** The evaluation covered all the key regions (Tripoli, Benghazi, Sebha, Sirte, Ghat and Um Alaraneb) where UNFPA implemented interventions in Libya.
- **Thematic CP Focus:** The evaluation covered the four thematic areas of the 1st CP, including SRHR, A&Y, GEWE and PD. In addition, the evaluation will cover cross-cutting issues such as human rights and gender equality, disability, displacement and migration status, and transversal aspects of coordination; monitoring

[4] DP/FPA/2021/11 – Extensions of the Country Programmes
[5] Ibid
[6] See Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA (2019)
[7] See The UNFPA Libya 1st Country Programme Evaluation Terms of Reference
[8] https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2019

and evaluation (M&E); accountability to affected populations (AAP); innovation; and strategic partnerships.

- **Temporal:** The evaluation covered interventions planned and/or implemented within the period of the current CP: 2019 - 2022.

1.3 Methodology and Process

1.3.1 Methodology

1.3.1.1 Evaluation Criteria and Evaluation Questions

The evaluation was conducted through assessment of four Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD/DAC) evaluation criteria of relevance, effectiveness, efficiency and sustainability[9], in addition to the strategic positioning of UNFPA within the UNCT and the role it has played in United Nations system-wide coordination mechanisms. Given the humanitarian context in Libya, the evaluation also examined the extent to which UNFPA provided life-saving services to the affected population groups and how well the support gave consideration to longer-term solutions during implementation of emergency intervention by examining the criteria of coverage and connectedness[10] respectively. The assessment of the CP performance along the evaluation criteria entailed utilizing evaluation questions (EQs) as stated in Table 2. The assessment and analysis of the EQs informed the development of the CPE Matrix (Annex 2), which guided the assumptions and indicators for ascertainment during the evaluation, defining sources of data collection methods, tools and data collection and analysis.

1.3.1.2 Evaluation Approaches

The evaluation design, methodology and process were consistent with the UNFPA Evaluation Handbook "*How to design and conduct a CPE at UNFPA*" and its implementation was in accordance to the Norms and Standards, and Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, established by the United Nations Evaluation Group (UNEG). The evaluation team used mixed methodologies in the design of the CPE for comprehensive data generation and triangulation to effectively meet the objectives of the assignment. The design of the CPE was non-experimental given the expected descriptive and non-normative nature of the objectives and the related EQs. This design was relevant due to the time and resource constraints and allowed the evaluation team to analyse the contributory relationship between the programme interventions and their effects on the UNFPA CP strategy.

The CPE design was based on analysis of the theory of change of the programme which informed the design of the data collection tools, analysis and conclusions on the performance of the programme. This entailed analysis of how the CP outputs contributed to the overall achievement of the results of the CP, as well as those in higher level plans such as the UNFPA Strategic Plan and national plans. To illustrate the links from inputs, outputs and to the outcomes of the 1st CP, and since the CP did not have a Theory of Change (ToC), the evaluation team constructed one, as illustrated in Figure 1. The analysis of the ToC shows that the logical design of the CPE was fairly clear and the modes of engagement and interventions were delivered within the context of the identified strategies and assumptions, the CP would logically achieve its outputs and contribute to the outcomes. This is the logic assessed during the CPE.

Table 2: Evaluation Questions by Criteria

Relevance
EQ 1: To what extent is the country programme adapted to: i) the needs of diverse populations, including the needs of marginalized and vulnerable groups; ii) national development strategies and policies; iii) the strategic direction and objectives of UNFPA; iv) priorities articulated in international frameworks and agreements, in particular the ICPD and SDGs; and v) the New Way of Working[11] and the Grand Bargain[12].
EQ2: To what extent has the Country Office been able to respond to changes in national needs and priorities, including those of vulnerable or marginalized communities, or to shifts caused by crisis or major political changes including the ongoing COVID-19 pandemic?

[9] The OECD/DAC Criteria for International Development Evaluations https://www.oecd.org/dac/evaluation/49756382.pdf

[10] See The UNFPA Libya 1st Country Programme Evaluation Terms of Reference.

[11] See: https://www.agendaforhumanity.org/sites/default/files/20170228%20NWoW%2013%20high%20res.pdf.

[12] See: https://interagencystandingcommittee.org/grand-bargain.

Effectiveness
EQ3: To what extent have the interventions supported by UNFPA contributed to the achievement of the expected results (outputs and outcomes) of the country programme and any other revisions that may have been done in view of the COVID-19 pandemic? In particular: i) increased access and use of quality sexual and reproductive health services, in particular by populations affected by humanitarian crisis; ii) increased participation of adolescents and youth, including the most vulnerable, in decision-making and enhanced youth leadership to promote sustainable development, peace and security; iii) advancement of gender equality and the empowerment of all women and girls, with a particular focus on prevention and response to GBV; and iv) increased use of demographic intelligence in the development of evidence-based humanitarian and development plans, policies and programmes at national and local levels?
EQ4: To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?
Efficiency
EQ5: To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme?
Sustainability
EQ6: To what extent has UNFPA been able to support implementing partners and beneficiaries (women and adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?
Coordination
EQ7: To what extent has the Country Office contributed to the functioning and consolidation of United Nations system-wide development and humanitarian coordination mechanisms?
Coverage
EQ8: To what extent have UNFPA humanitarian interventions systematically reached all geographic areas in which affected populations (women and adolescents and youth) reside?
EQ9: To what extent have UNFPA humanitarian interventions systematically reached the most vulnerable and marginalized groups (women and adolescents and youth with disabilities; migrants and refugees, those of racial, ethnic, religious and national minorities; etc.)
Connectedness
EQ10: To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women's organizations, health facilities, communities etc.) to better prepare for, respond to and recover from humanitarian crisis?

In the analysis of the ToC, the process established the mechanisms of change, considering the risks, critical assumptions and the implementation context underlying the programme logic. The evaluation team reviewed the ToC, depicting the sequence of expected changes across the intervention logic of the country programme. The ToC further illustrates how the planned interventions under the CP are expected to contribute to a sequence of results (outputs and outcomes) that contribute to the strategic goal of UNFPA, as defined in the UNFPA Strategic Plan 2018 – 2021. The interpretation of the causation process guided the evaluators in understanding the CP's contribution to the observed results and in gathering evidence to validate the conclusions on the performance of the programme in the period of implementation. The analysis showed that the outputs were adequate and were likely to contribute to the achievement of the results, amid the constraints of volatile and unstable context of implementation. Adjustments were made to refocus the causal links (arrows ⇧) across the results chain. The interlinking arrows (⇔) entailed linking the result areas to reflect integration within the programme and the contribution that implementation of the interventions and achievement of the results at both output and outcome levels results into the strategic goal. In addition, the evaluators added the modes of engagement and strategies for each thematic area. The assumptions and risks in the ToC fit well with the assumptions in the evaluation matrix, in addition to reflecting the consideration in the analysis of the contextual implementation framework.

The evaluators ensured that the CPE was implemented in an inclusive and participatory manner, involving key stakeholders across the country, in order to leverage on a wide range of views on the performance of the CP, and to take into consideration the local context and cultural sensitivities. Particular attention was paid to ensure that the end results provided analytical framework for reporting on different socio-demographic groups.

1.3.1.3 Methods for Data Collection and Analysis

The Evaluation Matrix (**Annex 5**) adapted to the country programme implementation context provided the framework of the evaluation and was key for the data collection and analysis. The Evaluation Matrix details what was evaluated, taking into consideration the evaluation criteria, evaluation questions and related assumptions assessed, defining the indicators. It also shows how the evaluation was done, eliciting the sources of information and data collection methods required to answer the evaluation questions. After data

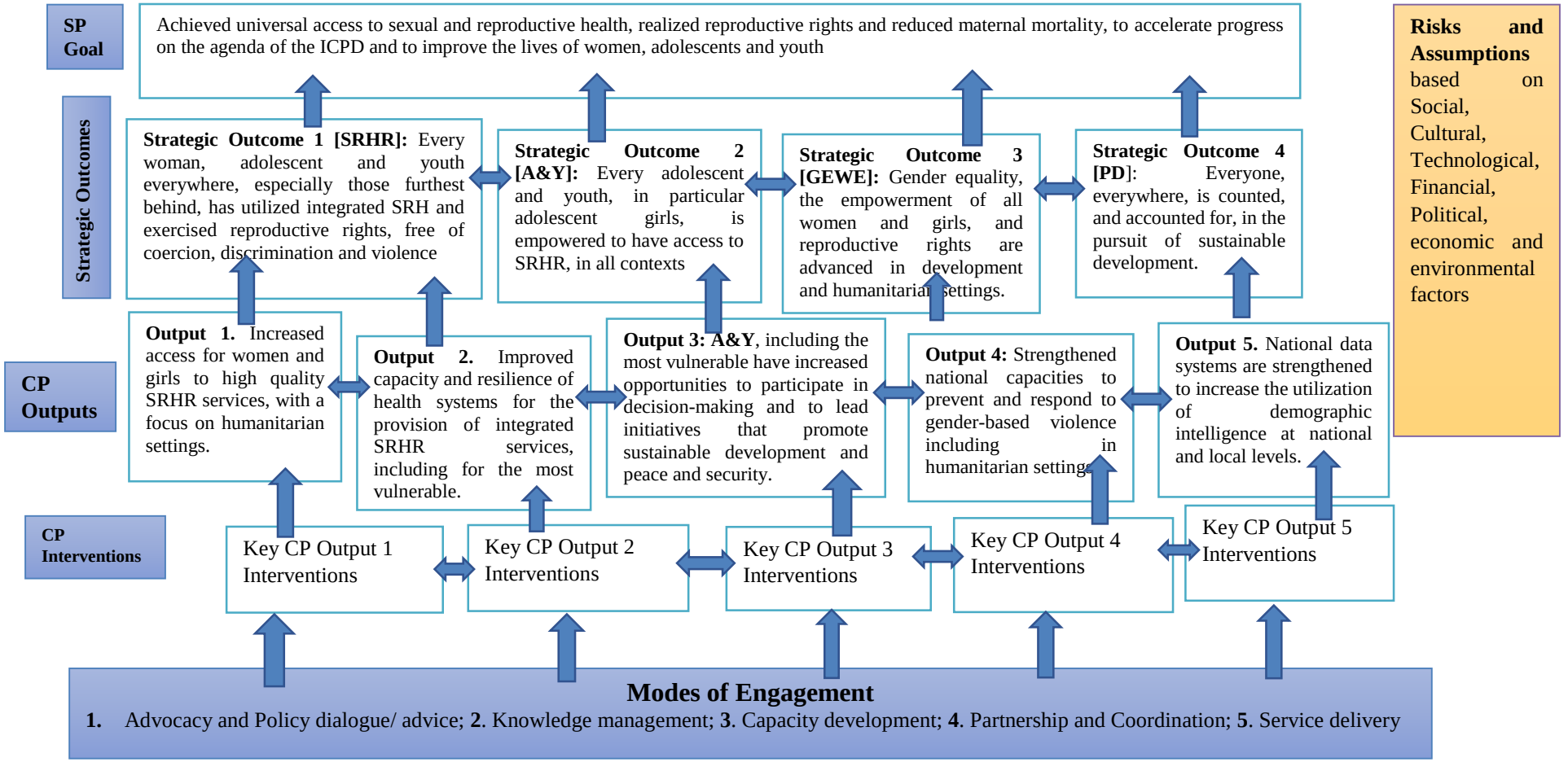
collection, the Evaluation Matrix provided the foundation for drafting the findings for each evaluation question and for drawing conclusions and formulating recommendations that cut across different EQs.

As mentioned earlier, the evaluation methods used both quantitative and qualitative methods for data collection. The **data collection methods** were designed around the evaluation questions, related assumptions and indicators proposed in the Evaluation Matrix and taking into account the limitations that may arise during data collection. To ensure an effective and feasible way to collect the data and information required to fully answer the evaluation questions presented in this report, the evaluation team used data collection techniques as described in the section that follows. Key to note is that in compliance with the UNEG Ethical Guidelines for Evaluation, the evaluation team clarified the purpose of the CPE to the respondents and verbally sought their consent before beginning any interview sessions, especially during interviews and FGDs.

Document Review: This entailed, but was not limited to, review of programme-related documents and analysis of their content to elicit the CP design, implementation and management, and monitoring and evaluation. The consultants conducted the initial review of programme documents to inform the design report of the CPE. This was a continuous process during the evaluation, to enrich the quality and content of the report. Over the course of the evaluation, the evaluation team identified and obtained other key documents with the support of the UNFPA Libya CO, in addition to other related secondary sources to inform the evaluation process. Documentary evidence was a major part of this evaluation given the constraints that arose in accessing primary data, especially in the context of COVID-19, security and travel restrictions, where some information was not accessed from the primary sources. Further, the quantitative performance of the programme as defined by the CPD Results Framework informed by documentary evidence in the various reports provided by the UNFPA Libya CO [List of documents reviewed are in Annex 3]. These have been referenced as appropriate in the report, to provide evidence-based feedback on the programme performance.

Focus group discussion (FGD) – The FGDs have been designed to gather information among primary programme beneficiaries, including those benefiting from UNFPA capacity building interventions in the period of coverage. These were targeted to include those who directly benefited from the UNFPA CP support during the period of implementation, including adolescent and youth, and community level beneficiaries like women and girls supported by UNFPA CP. There were FGD sessions conducted with groups of female, and others mixed male and female beneficiaries, especially for the youth, looking at the benefits of the programme to the female and male population members, respectively. The discussion guides were designed thematically to gather information regarding the extent to which the programme achieved its intended results, in addition to establishing some of the arising needs and/or unintended results. This technique was used based on its advantage of collecting data quickly and effectively from a large number of programme beneficiaries. Its preference was also on ability to provide further insights into data obtained from other categories of respondents. In order to enrich the data on the performance of the programme, the evaluators used purposive sampling selecting participants in the FGDs, especially beneficiaries, guided by their interaction with the programme, in addition to ensuring that specific performance issues are captured as guided by the evaluation questions. This was to ensure balanced representation of respondents from all the different socio-economic backgrounds. While each FGD aimed to compose of at least 8-10 participants ensuring balance in terms of sex and programmatic focus area, the evaluation team was cognizant of the limitations posed by COVID-19 control-restrictions on gathering and the possible remote nature of data collection to reduce the number of participants. Further, the evaluation team was composed of a local consultant who was able to access the beneficiaries in their areas of residence, especially for sessions with beneficiaries, all of whom were able to better express themselves in the local language, movement allowing, to conduct the discussions. Among the consultants was also a lady who facilitated sessions with women and girls on sensitive topics, especially on sexuality and GBV, considering the conservative nature of the context on discussions on sexuality. The FGD guides were also engendered to capture gender related details to inform the programme's performance along gender lines, in addition to collecting other disaggregated details of beneficiaries; for example, the CPE team sought to know the male involvement in FP services and how they were influencing the uptake of the services.

Figure 1: The Constructed CP Theory of Change.



Key Informant Interviews (KII): This entailed conducting interviews, remotely, with individuals or groups as key informants from a range of stakeholders identified in the stakeholders' map (Annex 7). This technique was useful in getting feedback and inputs from the processes and results of the Country Programme for those who interacted with the programme both at field and policy levels based on the objectives of the CPE. The respondents included key stakeholders of the Country programme, including donors and strategic partners[13]. Those targeted included UNFPA Libya CO staff, officials from the government line ministries, representatives of UN agencies, UNFPA donors, strategic partners, and national and international NGOs as implementing partners, among others. Group interviews[14] were also conducted with key informants to collect key information on progress towards the intended outputs and outcomes of the Country Programme. The evaluation team used interview guides for KIIs with stakeholders in the various thematic areas of programming. The interview guides were designed and captured gender and other disaggregated information and providing insights into the various needs across the gender and sex divide, and others marginalized groups like IDP, PWDs, among others. The respondents were also a mix of male and female.

Field organization

Organization of field data collection was dependent on planning between UNFPA and the evaluation team. The Evaluation team worked with the Monitoring and Evaluation Analyst based in Tripoli who mobilized and secured appointments with the list of respondents as selected and shared by the evaluation team. To ensure independence of the interview process, the evaluation team generated and shared meeting links with all the target respondents.

1.3.1.4 Data Validation, Analysis and Reporting

The evaluation team validated collected data on a routine basis through debriefing sessions, building themes along the CPE objectives. The data analysis methods employed depended on the type of data gathered to contribute to the findings of the report. The quantitative and qualitative data from primary and secondary sources were assessed and referenced, with findings and systematically triangulated to ensure that they were robust. The process involved contribution analysis, content analysis and trend analysis. Beneficiary focus group and key informant interviews were assessed through thematic content analysis, and data were quantified, where appropriate, from different primary sources. Contribution analysis identified how far documented inputs and activities were sufficient and relevant to the outputs and outcomes and likely to have contributed meaningfully to them. This involved exploring the theory of change in the results chain logic for each component area of the country programme. In addition, descriptive statistics have been used to describe or summarize key characteristics of quantitative data obtained from secondary sources, especially, the programme Annual SIS and financial reports. The descriptive statistics have been presented in the form of charts and graphs for financial reports. The evaluation matrix has informed the analysis and report writing.

1.3.2 Selection of the Sample of Stakeholders

The evaluators adopted a participatory approach in selecting the stakeholders to participate in the evaluation as respondents. Based on the initial stakeholders' map provided by the UNFPA Libya CO and a review of Atlas project and relevant programme documents provided by the CO in preparation for this design report, and the initial discussion with the UNFPA thematic component teams, the evaluators selected stakeholders to participate in the CPE. The stakeholders map identified the stakeholders involved in the design, implementation and monitoring of the 1st Country Programme (2019-2022), and those partners who did not work directly with UNFPA, yet played a key role in a relevant thematic area of programming or specific outcome area of the Country Programme. The stakeholders' map constituted the sampling frame for KIIs, group discussions and FGDs. Further, in consultation with the UNFPA CO staff, as well as complementary document reviews, the final list of stakeholders to participate in the KIIs, FGDs and group interviews were identified.

The evaluation focused on major categories of stakeholders across the thematic areas of programming or outcomes areas of the 1st CP. As per the scope of the CPE, the consultants identified respondents from all the geographical areas (provinces and districts) the programme covered. This also determined the selection of the respondents, especially based on geographical coverage in the country. While the programme was implemented in nearly all the provinces, the IPs selected were representative of the programme areas covered and due to their length of engagement by UNFPA, where the evaluators selected those with longer stint with UNFPA to be able to talk

[13]The Strategic partners are those implementing similar programmes as UNFPA and were contacted for their relevance in the framework of implementation

[14] Groups interviews were conducted in situations where various contributions from members of an office or entity were collected during an interview session, for example sessions with the CO thematic members can include more than one person during the interviews.

about the achievements of the CPs, and have been selected to participate in the CPE activity. Specific interventions in various locations, like youth activities or safe GBV houses were selected in consultation with the team on the ground. Further, the consultants also ensured as much as possible inclusion of various beneficiary groups e.g. those from marginalized groups, including people living with disability (PWD), women, girls and boys. The following were the respondents selected and participated in the CPE:

- **UNFPA Libya CO staff:** Senior management of the UNFPA Libya CO; technical specialists and associates in the thematic areas of programming of the CP; and staff of operations and cross-cutting units. They were selected based on their hands-on experience on the performance of the CP.
- **Government counterparts:** Officials of relevant line ministries and institutions (Health, Planning, Youth, Women Affairs, and National Bureau of Statistic and Census (NBSC), Departments, among others) and other government institutions in the supported areas.
- **Implementing partners:** Staff of non-governmental organizations in their respective areas of coverage (Ref. Annex 7).
- **Direct beneficiaries:** These included the direct beneficiaries, be it through capacity building and development or service delivery support, including health workers, adolescents and youth, health facility staff, economics and statistics department trainees, education staff, midwives and trainees, among others.
- **Indirect beneficiaries**: Women of reproductive age, adolescents and youth in communities at programme implementation sites of UNFPA and its implementing partners, including clients of reproductive and maternal health, as well as family planning services; adolescents and youth participating in youth-led programmes and various activities and capacity building workshops at youth centres; religious leaders, among other indirect beneficiaries.
- **Donors:** Representatives of bilateral donor agencies funding interventions implemented by UNFPA and/or implementing projects in thematic areas of programming of UNFPA and geographic areas where UNFPA and its IPs operate.
- **United Nations agencies**: The United Nations Resident Coordinator and the United Nations Emergency Relief Coordinator, and representatives of relevant United Nations agencies (UNDP, UNICEF, WHO, UN Women were identified with the UNFPA team; including members of system-wide development and humanitarian coordination mechanisms (GBV sub-cluster and RH working group), where possible.
- **Special group** (Sub-cluster leads) – These were selected to gather information on the coordination mechanisms within the SC under UNFPA's leadership.

Table 3: Summary of the Sample

Type of Respondent	Type of Data Method	No. conducted
IPs	Group/Individual Interviews	23
Government	Group/Individual Interviews	10
UN Agencies	Group/Individual Interviews	10
UNFPA	Group/Individual Interviews	9
Beneficiaries	FGDs	3
Donors	Group / Individual Interviews	3

Limitations, Risk and Biases

1. **Remote data collection mechanisms** due to the constraints emanating from the COVID-19 response and insecurity restrictions the consultants conducted the interviews remotely, in addition to verifying some of the support provided by the CP. The evaluation team maximized liaison with the national consultant on the ground to visit some of the CP locations and was able to share with the team what they verified. The evaluation team utilized a lot of information from various reliable sources for triangulation of information shared by the respondents, and confident that the information shared in this report is reliable and can be verified.
2. Limited information and quality of relevant documents and reports given to the evaluation team. The evaluation team used cross validation from stakeholders, staff, secondary documents, in addition to using expert opinions for objective evidence, to mitigate the potential bias. On the other hand, none of the limitations was sufficient

to invalidate the evaluation, and the team is confident that a wide, sufficiently representative range of stakeholders was reached at national and community levels.

3. This CPE was based primarily on qualitative information collected from government counterparts and implementing partners (direct beneficiaries) rather than from programme indirect beneficiaries for evaluation of outcome level results, due to the nature of the design of the CP interventions, which were aimed at strengthening the capacity of the government and its stakeholders to deliver in key areas and providing direct GBV and SRH services. The evaluation assessed achievement of the CP outputs and the likelihood of results at the outcome level. The scope of this exercise did not allow the team to collect quantitative data from the field, thus the analysis and conclusions are based on quantitative data collected from the Country Office through secondary sources. This is already a source of bias. However, the evaluation team triangulated the data sources to make conclusions on the arising phenomenon, mitigating any bias that would have arisen based on data sources.
4. Inadequate details on disaggregated programme data and the extent to which the programme impacted the various targeted groups, limiting the consultants' level of analysis of the data. The consultants however designed CPE questions to capture information on various beneficiaries and how the programme impacted them, in addition to depending on related secondary data to conclude on the findings.

1.3.3 Evaluation Process

In line with the standard evaluation process outlined in the UNFPA Evaluation Handbook "How to design and conduct a CPE at UNFPA", the evaluation process entailed the following phases and key activities.

Table 4: Phases and Key Activities of Evaluation

Phase	Main Activity
Preparatory (done by the CO)	● Drafting and approval of the ToR; Hiring of Consultants ● Establishment and orientation of the Evaluation Reference Group (ERG) ● Inform key stakeholders about the evaluation ● Compile Initial list of documentation\Stakeholder mapping and list of Atlas Projects.
Design (**Done majorly by the Evaluation Team**)	● Evaluation kick-off meeting between the Evaluation Manager and the evaluation team. ● Documentary review; Stakeholder mapping ● Analysis and constructing the intervention logic (theory of change) of the programme ● Finalization of the list of evaluation questions; and preparation of Evaluation Matrix. ● Developing data collection, sampling, and analysis strategy ● Development of the CPE work plan for the field phase; Drafting of the Design Report ● Presentation of the draft Design Report to the ERG and inclusion of its feedback ● Submission and approval of the Design Report
Field (**Evaluation Team, with support from the CO**)	● Meeting with the UNFPA Libya CO staff to launch the data collection. ● Meeting of evaluation team members with relevant programme officers at the UNFPA CO. ● Data collection at national and sub-national levels. ● Debriefing meeting on preliminary findings, conclusions and recommendations to UNFPA CO, IPs and ERG
Reporting (**Evaluation Team, with support from the CO**)	• Comprehensive data analysis, integrating comments provided during the debriefing with UNFPA CO and ERG • Development and submission of first draft of the CPE Report for review by the CO and ERG • Preparation of Second Draft CPE Report based on review comments of CO and the ERG • Submission of the Second Draft CPE Report for review • Evaluation Quality Assurance; Validation Workshop; Production of Final CPE Report • Approval of the CPE Report • Development of an Evaluation Brief
Dissemination and Use (**UNFPA**)	Management response to the CPE recommendations Development of the dissemination strategy Dissemination of the CPE findings and lessons learnt

CHAPTER 2: COUNTRY CONTEXT

2.1 Development Challenges and National Strategies

Libya is a country in the Northern part of Africa bordered by the Mediterranean Sea on the north, Egypt on the east, Sudan on the southeast, Niger and Chad on the south, and Tunisia and Algeria on the west as shown in Figure 1. The country has a landmass of 1,759,500 square kilometres.[15] In 2020, the country was estimated to have a population of 6.93 million people, of which about 49.5% were women.[16] The country has an annual growth rate of 1.8% and a Total Fertility Rate of 3.4 children per woman in 2019. Life expectancy at birth in 2020 was 73 years, which was 70 years for men and 76 years for women. Under-5 mortality rate is 11.5 deaths per 1,000 livebirths.[17] Infant mortality rate has been on a steady decline in the country since 1990 and currently about 10 per 1,000 livebirths.[18] It is projected that the population of Libya would hit about 9.8 million people by 2050. 31.1% of the Libyan population are 14 years old and younger while the population above 64 years is 4.5%.[19] The age dependency ratio (working population i.e. those 15-64 years/ (those younger than 15 years + those older than 64 years)) is 54.6[20] Majority (>85%) of the Libyan population live in urban areas.[21]

Libya is classified as an upper middle-income country by the World Bank. However, since the conflict began in 2011, the income of the country has taken a nosedive with GNI per capita income dropping from US$12,830 to US$4,850 over a 10 year period (2010-2020).[22] Current GDP growth rate is at -31.3%. Human development index (HDI) in Libya for 2019 is 0.724 (0.798 in 2010 and 0.789 in 2012).[23] This HDI is higher than the average value (0.705) for Arab states but lower than GCC countries (varying between 0.78 to 0.87). Libya has been affected by instability and conflict since 2011, with growing levels of insecurity, political fragmentation, and a significant deterioration of public services, exacerbating existing vulnerabilities of Libyans, migrants and refugees. Years of war and instability have sent the economy into a downward spiral which is visible in the decline in the GDP and GNI income per capita outlined above. The war around Tripoli that erupted in April 2019 reversed the momentum of the relative economic recovery over 2017-18. Indeed, Libya managed to more than double its oil production over the two-year recovery period, to reach 1.17 million barrels per day (bpd) in April 2019, however, oil production declined to 0.1 million bpd in 2020.

Generally, due to the current governance and security dynamics, there is no overarching national strategic development plan upon which the country development strategies are aligned to. These include the different sectoral areas contained in the UNFPA-targeted thematic outcomes. However, the development and humanitarian partners, including the United Nations continue to provide support to the authorities to develop plans to which development, stabilization and humanitarian plans are aligned[24].

2.1.1 Sexual and reproductive health

The health system suffers from severe shortages of health staff, supplies and equipment, compounded by years of under-investment and lack of maintenance. According to WHO's recent assessments[25], only 40 per cent of communities have access to child health and emergency services, only 35 per cent to general clinical services, and only 15-20 per cent to reproductive health care and non-/and communicable disease services.

The provision of sexual and reproductive health services in Libya, including ante-and postnatal care, family planning and the management of sexually transmitted infections have all collapsed due to the ongoing conflict. There has been an alarming increase in rates of caesarean sections throughout the country. Among the population in need of almost 1 million, there would be an average of 140 births per day, of which 15% would need Emergency Obstetric and Newborn Care (EmONC) to ensure the safety of the mother and the baby. Family planning is not available in public health facilities and limitations to quality sexual reproductive health services risk leading to higher mortality rates among women and children. Contraceptive prevalence, measured by the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception in Libya today is 28%[26], attributed to inadequate access to services, poor knowledge of the different types of contraceptive methods available and

[15] World Bank, "Country Profile."
[16] Ibid
[17] UNICEF, "Libya (LBY) - Demographics, Health & Infant Mortality."
[18] World Bank, "Country Profile."
[19] United States Census Bureau, "International Data Base."
[20] World Bank, "Country Profile."
[21] Ibid.
[22] World Bank, "Country Profile."
[23] United Nations Development Program, *Human Development Report 2020*.
[24] HRP 2021
[25] WHO, Community Health Assessment in Libya, May 2020
[26] World Bank, "Country Profile."

social norms associated with the use of contraceptive methods. The knowledge of family planning services by women in humanitarian settings is comparatively lower than those in more stable set-ups,[27] as two out of every five married women 15-49 years have an unmet need for contraceptive services. [28] In Libya, only a form of counselling is provided, without provision of contraception[29]. The destruction of health facilities is likely to continue to limit access to these services unless specific interventions are made to address the shortfall. Despite dedicated efforts to integrate reproductive health services in humanitarian response, long-term and permanent family planning methods are rarely offered, methods that might be the most suitable for some classes of clients.[30] Due to lack of appropriate access to family planning services, there is likely going to be an increase in unintended pregnancies, engagement in unsafe abortion and its devastating consequences.

Total Fertility Rate in Libya has been on the decline from 3.4 in 2014, it is currently estimated at 2.2 children per woman.[31] On the contrary, Maternal mortality ratio (MMR) has reversed from gains made between 1990 and 2015, and has been on the rise from about 9 maternal deaths per 100,000 livebirths to 72 maternal deaths per 100,000 livebirths in 2021.[32] This rise is despite skilled birth attendance maintained at about 100%. As such, the increase in number of maternal deaths observed might not be unconnected with the decline in the quality and breadth of services provided by health facilities across the country due to the ongoing conflict. There is an acute shortage of obstetricians/ gynaecologists and midwives in the country with only 467 midwives available in all hospitals in Libya where they are allowed to provide basic emergency obstetric and neonatal care.[33]

Before the conflict, the Libyan health system, with its advanced hospital services and large network of primary health care facilities oversaw declining maternal mortality and the achievement of the Millennium Development Goal 5. Unfortunately, the years of crisis have negatively impacted the system of financing of services, health information flows, management of referrals, availability of medicines, supply-chain management, human resources, and the overall quality of service delivery. Maternal death surveillance and response programming has suffered, particularly in the south of Libya where only 12.1 per cent of the health facilities provide antenatal care and only 8.5 per cent of the health facilities provide delivery services. There is only one voluntary counselling and testing centre in Tripoli and seven others that provide only testing for HIV without counselling. The total number of people living with HIV registered at hospitals in Libya as of December 2017 is 3,848. More than 90% of pregnant women living with HIV are receiving effective antiretroviral (ARV) for the prevention of mother to child transmission of HIV.[34]

The Service Availability and Readiness Assessment carried out by the Ministry of Health and WHO in 2017 highlighted that most facilities lack a supply of post-rape care kits and emergency contraception, while health staff have not received any training on the clinical management of rape.[35] The lack of specialized services, including for gender-based violence (GBV) survivors, and the lack of trust in existing health services is chronic in Libya. According to the Health Sector 2019 findings in Libya, 23-25% of assessed 1,145 public primary health care (PHC) facilities are closed. Also, 0% of essential services are available in 230 (26%) of open PHC facilities.

2.1.2 Adolescent and Youth

The proportion of the young people, aged 14 years and younger, make up a little above a quarter (27.4%) of the population in Libya.[36] In a youth survey of 2016, young Libyans described safety and security as the main challenges they face, followed by lack of employment opportunities, life skills and education. Despite the proliferation of armed groups and youth enrolment in them, the majority of Libyan youth are ready and willing to participate in social development, economic productivity and peacebuilding initiatives. HIV prevalence in the youth (15-24 years) is relatively low at 0.1% and available evidence points to high knowledge of the causes of HIV, which is likely to

[27] McGinn et al., "Family Planning in Conflict."
[28] World Bank, "Country Profile."
[29] https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1773693
[30] McGinn et al., "Family Planning in Conflict."
[31] National Center for Disease Control and Pan Arab Project for Family Health, "Libya Family Health Survey"; UNFPA Libya, *Libya Situation Analysis: Women and Youth Building Sustainable Peace and Development in Libya*.
[32] UNICEF, "Libya (LBY) - Demographics, Health & Infant Mortality"; World Health Organization. Regional Office for the Eastern Mediterranean, *Libya Health Profile 2015*.
[33] World Health Organization. Regional Office for the Eastern Mediterranean, *Libya Health Profile 2015*.
[34] UNICEF, "Libya (LBY) - Demographics, Health & Infant Mortality."
[35] Ministry of Health, Libya and World Health Organization, *Libya 2017 Service Availability and Readiness Assessment - Full Report*.
[36] UNFPA Libya, "| United Nations Population Fund."

influence their risk-taking behaviours.[37] Adolescent birth rate in Libya is relatively low at 5.8 births per 1,000 girls when compared with Tunisia (7.8 births per 1,000 adolescents) and Jordan (25.9 births per 1,000 adolescents) or the average for Arab States (46.8 births per 1,000 adolescents).[38]

Adolescent girls in humanitarian settings experience an increased risk of forced and early marriage as well as early childbearing and its attendant negative consequences for their health.[39] Such early childbearing could increase their risk of obstructed labour at delivery due to their underdeveloped pelvis. Prolonged labour can result in poor outcomes for the child or the mother increasing neonatal and maternal mortality outcomes. While the young mother might survive early childbearing, she might have to live with the consequences of such early birth such as obstetric fistula. Many with such conditions are stigmatized and suffer as outcasts from their communities. Damage to the reproductive tract at childbirth could also result in *gynatresia* and loss of interest in sexual life. Young women forcefully displaced might also be vulnerable to sexual exploitation and trafficking.[40]

Due to their mobility, young people may lose the opportunity for education and literacy and lag behind their peers. While Libya currently has high secondary school completion rates, the persistence of violence in some parts of the country may limit children and young people in this conflict zone from achieving their potential. Lack of education comes with its reduced opportunities for employment, especially in the female population that already face some bias in employment in Libya as most of them work in public education sector, which will require formal academic qualifications. Since the breakdown of law and order, many young Libyans now engage in substance abuse. A qualitative study conducted in Tripoli described drugs as being cheaper than food.[41] Although HIV rates are currently low, the risk of its rapid propagation is high in the population using injectable drugs and has the potential to become a generalized epidemic as has been seen in other countries that have had localized epidemics propagated in this way. Children of parents who witnessed violence are more likely to face harshness and hostility at home which can be a consequence of post-trauma stress, depression, anxiety, social problems and externalization of frustration.[42] This can result in mal-adjusted children and a new generation of dissociated adults.

2.1.3 Gender Equality and Women's Empowerment

Libya was ranked a high 40th out of 152 countries on the human development index in 2014.[43] More than 4 out of every 5 women above 14 years in the country in 2012 were literate and this high literacy level has been maintained. Female participation in the labour force in 2019 was 34%.[44] The gender inequality index (GII) for Libya in 2019 was 0.252, placing the country 52nd out of 162 countries ranked.[45] This ranking bettered neighbouring Arab nations such as Tunisia (65th) and Jordan (109th). A higher proportion of women complete secondary school education when compared to men (70.5% vs 45.1%).[46] However, despite as many women as men with university degrees, women still find it difficult taking leadership positions in the workplace due to workplace bias and violence.

In the current climate, there are notable threats to safety and security throughout the country, in particular for women and girls. Libya has not enacted any legislation for the prevention of, punishment for and protection from domestic and GBV. According to the protection sector response plan for 2018, 307,000 women of reproductive age are in need of protection, including internally displaced persons, returnees and women in host communities. The Libyan Family Health Survey conducted in 2014 found that 8.2 per cent of women and girls aged between 15-49 years were subjected to abuse in the year before the survey. 79.1 per cent of women experienced verbal abuse and this percentage was even higher among divorced women and in poorer families. Physical assault represented 11 percent of the registered cases of violence, while 2.6 per cent of those surveyed stated they had been subjected to sexual assault.

Only 16% of parliamentary seats are held by women.[47] A survey of women in 2013 found that the majority of them (71%) said they were somewhat interested in matters of politics and the government.[48] Despite this high interest, their participation in the election at 66%

[37] The World Bank, "Labor Force, Female (% of Total Labor Force) - Libya | Data."
[38] United Nations Development Program, *Human Development Report 2020*.
[39] UNFPA, "Adolescent Girls in Disaster & Conflict."
[40] Iyakaremye and Mukagatare, "Forced Migration and Sexual Abuse."
[41] Elamouri et al., "'Now Drugs in Libya Are Much Cheaper than Food.'"
[42] Eltanamly et al., "Parenting in Times of War."
[43] United Nations Development Program, *Human Development Report 2014 | United Nations Development Programme*.
[44] The World Bank, "Labor Force, Female (% of Total Labor Force) - Libya | Data."
[45] United Nations Development Program, *Human Development Report 2020*.
[46] Ibid
[47] Ibid
[48] Abdul-Latif, "Libya Status of Women Survey 2013."

was 22 percentage points lower than for the men. In addition, women were more likely to vote in line with their spouses or family's choices whereas the men were more likely to have independent opinions.[49] This suggests their decision-making process might still be controlled. While about two-thirds of men either strongly or somewhat supported women's participation as candidates in the elections, this was still less than what the women wanted for themselves (69% vs 81%).[50] Such observation might lead to the opposition of women from taking leadership positions.

The impact of conflict on women and girls in Libya has been particularly severe. Women and girls are extremely vulnerable in such context and face increased levels of sexual violence. Female refugees, IDPs and asylum seekers often lack access to sexual and reproductive health services, GBV prevention and response services as well as access to the justice system. For both displaced persons and communities trapped in conflict, worsening security concerns from the state and the community often result in limiting the freedom of movement for women and girls, with the assumption that this would be best for their protection. The status of women and girls continues to be impacted by discriminatory traditional practices and social norms. Child/early and forced marriage remains widespread despite having a law in Libya setting the age of marriage by 18 years, but the implementation of the law is still not in place in some locations. According to the PAPFAM 2014 report, child marriage was 3.9% for under 18 and 0.7% for under 15 ever-married women aged 15-49, meaning that the percentage of women exposed to marriage before 18 years was below 1.9% of the total population of women in Libya in 2014.

Women and children have been known to bear the brunt of the violence associated with conflicts. Although boys and men equally suffer GBV in conflict such as selective genocide and sexual abuse, they are majorly the perpetrators.[51] Women are at increased risk of violence due to their vulnerability.[52] They suffer immediate and long-term consequences of the violence. They may engage in sex for survival when in Internally Displace Person (IDP) or refugee camps. On the long term, women who suffer GBV have a 16% increased risk of having low birth weight babies, twice as likely to have an abortion and are at increased risk of contracting HIV/AIDS.[53] Girls are also forced into marriages or held as sex slaves. Asides, these direct effects of violence, response systems for addressing the health and social consequences of the GBV are lacking. This is because of the closure of facilities and also due to less prioritization of reproductive health and GBV response in such situations. Survivors of violence may also have to live in the same community with the perpetrators without obtaining justice due to the collapse of the system.

2.1.4 Population Dynamics

The conflict that arose following the deposition of the long-serving leadership of Colonel Muammar Qaddafi and the subsequent civil war has led to untold hardship. Between February 2011 and February 2012, a systematic cross-sectional survey across sixteen provinces in the country found that more than 21,000 people were killed and another 19,700 injured.[54] More than 270,000 people (about 4%) have been internally displaced in Libya due to the ongoing civil war. The dire security situation has brought about a crisis situation that has turned Libya into a hub for trafficking of humans, organs and arms.[55] The breakdown of law and order caused an increase in trafficking and a fear of invasion in the European Union. As a result, member states supported efforts to prevent trafficking before reaching their shores by outsourcing border security thereby empowering militias and warlords in Libya.[56] Government operated detention centres have been identified to be in use by militia men where abuse of refugees and migrants take place. Migrants and refugees have been held in slavery-like conditions including records of the sale of migrants for labour.[57]

An assessment of the National Statistical System, led by the NBSC and supported by the Organization for Economic Co-operation and Development and UNFPA in 2017, showed that Libya has limited strategic, technical and human capacities to produce demographic data for decision-making for public and private users. There are also gaps in the integration of socio-demographic intelligence in national and sub-national plans and programmes. The Bureau of Statistics and Census was established by law in 1953 which was revised in 1963 with the mandate to collect

[49] Ibid

[50] Ibid

[51] Al-Tuwaijri and Saadat, "Gender Based Violence in Fragile, Conflict, and Violence Situations."

[52] Ibid

[53] World Health Organization, *Global and Regional Estimates of Violence against Women.*

[54] Daw, El-Bouzedi, and Dau, "Libyan Armed Conflict 2011."

[55] Al-Dayel, Anfinson, and Anfinson, "Captivity, Migration, and Power in Libya."

[56] Nakache and Losier, "The European Union Immigration Agreement with Libya."

[57] Al-Dayel, Anfinson, and Anfinson, "Captivity, Migration, and Power in Libya."

population and social statistics. Unfortunately, their ability to deliver has been challenged and the last census conducted in Libya was in 2006.[58] An assessment of the Civil Registration and Vital Statistics (CRVS) system in 2016 found several issues with the system. Prior to the conflict, Libya was a major destination of jobs for economic migrants from neighbouring countries, sub-Saharan Africa and the middle east. However, its administrative systems for the documentation of records of migrants has been suboptimal.[59]

2.1.5 COVID-19 in Libya

The first case of COVID-19 in Libya was recorded on the 21st March, 2020 in a 73-year-old returnee from Saudi Arabia.[60] The client was nursed at a health facility in Tripoli until he successfully tested negative after care and returned home. However, not long thereafter, the first death due to the outbreak was recorded in an 85-year-old woman on 2nd April 2020.[61] The number of cases rose quickly to 3,695 by July 31 2020 of which 74 mortalities were recorded, a case fatality rate of 2%.[62] However, the pandemic coexisting with a civil war that has forced a significant population to abandon their homes in search of better opportunities creates a recipe for an explosive outbreak.[63] By the 31st December 2021, the number of confirmed cases had reached 388,734 and 5,710 deaths.[64] Furthermore, food production has been crippled and the majority of the food consumed in the country now is imported.[65] Thus, border closures, used as a control measure in several countries can have disastrous effects on the Libyan population, including significant nutritional impact. Furthermore, the country gets almost all its revenue from export of crude oil and its products for which the closure of the border limits the ability to continue to export products and raise the much-needed resources to keep the country afloat.

COVID-19 also affected people's access to different health services and support. Many already overburdened health facilities concentrated their efforts to fight the pandemic and were not able to provide primary health service support, which particularly affected access for women to reproductive health services. Migrants, refugees and other people without formal identification documents faced additional barriers in accessing health, education and other services, due to a lack of required legal documentation[66]. The dire shortage of health workers and the closure of several health facilities as a result of the conflict limits the access of the Libyan people to adequate health services, especially intensive care services in the outbreak.[67] In addition, citizens are poorly informed about the disease. Cultural and social norms that favour people gathering in places is a major risk for the explosion of cases in Libya which requires urgent attention. Globally, it is estimated that the outbreak will result in 10% decline in the use of sexual and reproductive health services which will result in more than 48 million women with an unmet need for sexual and reproductive health services resulting in more than 15 million unintended pregnancies, almost 2 million women experiencing major obstetric complications with an additional 28,000 maternal deaths and more than 2.5 million newborns experiencing major complications without care resulting in additional 168,000 newborn deaths.[68] It is likely that the share in Libya will be high due to the double catastrophe. There are advocacies on the need to leverage telemedicine as an important strategy for improving access to sexual and reproductive health services during the pandemic.[69] However, internet access in Libya is significantly limited and thus, telemedicine is unlikely to be able to reach those that need the SRH services.

2.2 The Role of External Assistance

External assistance has contributed to restoring the normalcy in Libya. The support that has been received by the country traverses various sectors including the humanitarian, social and infrastructure services, education, health and population, economic infrastructure and services, and other unspecified sectors.[70] Table 1 presents the trend of official development assistance (ODA) provided to the country since 2011. The largest contribution in a year

[58] Bureau of Statistics and Census, Libya and UNFPA Libya, *National Statistical System Assessment of Libya*.
[59] International Organization for Migration, *Assessment of Data Collection and Statistics on International Migration in Libya*.
[60] Elhadi, Momen, and Ali Senussi Abdulhadi, "A COVID-19 Case in Libya Acquired in Saudi Arabia."
[61] National Centre for disease control, Libya, "COVID-19 Report."
[62] Daw, El-Bouzedi, and Ahmed, "The Epidemiological and Spatiotemporal Characteristics of 2019 Novel Coronavirus Diseases (COVID-19) in Libya."
[63] Elhadi and Msherghi, "COVID-19 and Civil War in Libya."
[64] National Centre for disease control, Libya, "COVID-19 Report."
[65] Swesi, El-Anis, and Islam, "Food Insecurity Coping Strategies in Conflict-Affected Libya."
[66] 2021 Humanitarian Needs Overview, Libya
[67] Ministry of Health, Libya and World Health Organization, *Libya 2017 Service Availability and Readiness Assessment - Full Report*.
[68] Riley et al., "Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health In Low-and Middle-Income Countries."
[69] Oyediran, Makinde, and Adelakin, "The Role of Telemedicine in Addressing Access to Sexual and Reproductive Health Services in Sub-Saharan Africa during the COVID-19 Pandemic"; Galle et al., "A Double-Edged Sword—Telemedicine for Maternal Care during COVID-19."
[70] OECD, "Creditor Reporting System (CRS)."

was in 2011 when the uprising began. Development assistance subsequently declined but started rising again in 2016. The ODA contribution in 2019 was US$185.730 million.

Table 5: Official Development Assistance between 2011 and 2019

Year	Aid received (US Dollar, Millions)	Year	Aid received (US Dollar, Millions)
2011	475.287	**2016**	107.089
2012	101.835	**2017**	347.265
2013	68.788	**2018**	202.509
2014	93.656	**2019**	185.730
2015	64.857		

Source: OECD database (https://stats.oecd.org/Index.aspx?DataSetCode=crs1#)

Between 2018-2019, the largest ODA contribution was to the social and infrastructure services which received 52% of the assistance. Next was the humanitarian aid which received 34%. Other sectors received the remaining 16% for the period. The distribution is presented in Figure 2. The top donors in the period are EU institutions (US$71.87 million), the United States (US$65.03 million) and Germany (US$43.55 million). See Figure 3 for distribution. The United States Agency for International Development (USAID) in 2021 fiscal year committed more than $27 million in financing to the country.[71] The European Union has been battling illegal immigration and over an 18 month period (from January 1 2019 to June 30 2020), committed 61.6 million Euros as part of the European Union Integrated Border Management Assistance Mission mandate.[72]

Figure 2: Bilateral ODA by Sector for Libya, 2018-19 average[73]

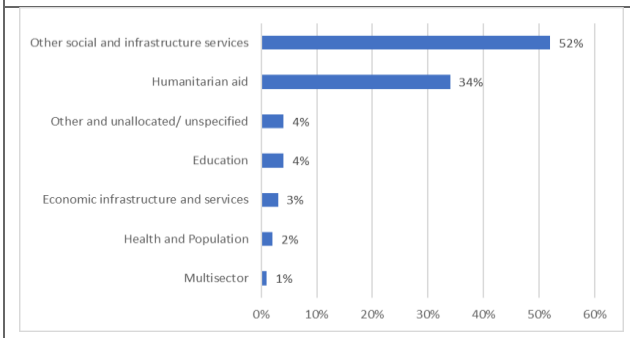
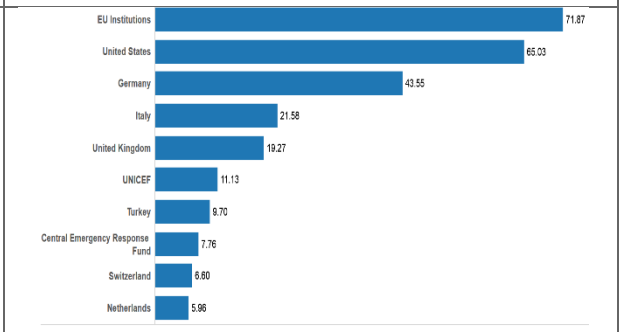


Figure 3: Top Ten Donors of Gross ODA for Libya, 2018-2019 average, USD million[74]



[71] USAID, "Libya | Humanitarian Assistance | U.S. Agency for International Development."
[72] Al-Dayel, Anfinson, and Anfinson, "Captivity, Migration, and Power in Libya."
[73] Source: OECD database (link)
[74] Source: OECD database (link)

CHAPTER 3: UNITED NATIONS/UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1 UNFPA Strategic Response

Globally, UNFPA is seeking to "achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development (ICPD), to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality". In pursuit of this goal, UNFPA works towards three transformative and people-centred results, namely; (i) end preventable maternal deaths; and (ii) end the unmet need for family planning; (iii) end GBV and all harmful practices, including female genital mutilation and child, early and forced marriage. [75]

The Strategic Plan transformative results will contribute to the achievement of the Sustainable Development Goals (SDGs), in particular good health and well-being (Goal 3), the achievement of gender equality and the empowerment of women and girls (Goal 5), the reduction of inequality within and among countries (Goal 10), and peace, justice and strong institutions (Goal 16). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure that no one will be left behind and that the furthest behind will be reached first.

UNFPA is mandated by the International Conference on Population and Development (ICPD) – held in Cairo in 1994 – to reduce infant and child mortality, reduce neonatal and maternal mortality and increase access to reproductive health services including family planning. The Cairo consensus placed population and development issues within a human rights-based framework, and UNFPA is committed to integrating human rights into its work globally. The Strategic Plan also responds to other global frameworks underpinning the 2030 Agenda, including the Sendai Framework for Disaster Risk Reduction 2015 – 2030 of the Third United Nations World Conference on Disaster Risk Reduction, the 2015 Paris Agreement on climate change, and the 2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development.

Building on ongoing collaboration among United Nations organizations, UNFPA contributes to strengthening inter-agency policy and programming approaches that are truly cross-cutting and able to address complex, multidimensional issues. As a member of the UNCT, UNFPA works with the other United Nations agencies and country programme partners to monitor and assess the progress achieved against the UNDAF outcomes. In humanitarian contexts, inter-agency accountabilities will be detailed through mechanisms such as the common humanitarian action plan, the consolidated appeal process, the inter-agency flash appeal and the transitional or early recovery appeal process.

Regional Strategy-Arab States

The current context in the Arab States, including Libya, is complex and spans a range of humanitarian and development realities in the region. There are acute humanitarian challenges, including a large refugee crisis, internal displacement, and GBV exacerbated by conflict. At the same time, ongoing development needs require attention, such as the need for an improved policy and legislative environment, enhanced institutional capacities, strengthened health systems, and improved availability of reliable and relevant data. Involvement in and proximity to acute and protracted crises have put additional strains on the capacities and resources across the region, and due to the fluid situation on the ground, changed priorities of governments and partners.[76]

The Arab States regional office aims to increase the contribution of UNFPA to United Nations system-wide results, coordination and coherence in the Arab States by: (a) increasing UNFPA leadership in United Nations Development Group sub-groups and sectors , including through co-chairing the Gender Thematic Group, the Sustainable Development Goals Country Support Group, and the Sustainable Development Goals Data Group; (b) pursuing joint programmes at the regional level with United Nations partner organizations; (c) providing specific support to country offices on implementation of standard operating procedures for "Delivering as one"; and (d) following-up on implementation of relevant 2016 quadrennial comprehensive policy review of operational activities for development of the United Nations system action points.

The regional interventions action plan is aligned with

[75] UNFPA strategy 2018-2021
[76] Annex 6. Global and Regional Interventions.pdf

the UNFPA strategic plan, 2018 – 2021 and complements country programmes in Arab States. The Arab States regional office identified priority areas within each outcome area of the strategic plan that respond to the specific needs and gaps in the region. Sexual and reproductive health interventions focus on the improvement of quality of care and human resource capacity by strengthening midwifery, the integration of sexual and reproductive health services including family planning, and addressing inequities in access to services and achieving reproductive rights. The two priority areas for empowering and engaging youth are to provide the knowledge, capacity, and tools to make informed decisions regarding their sexual and reproductive health, and to provide opportunities for increased youth leadership, particularly in the context of youth, peace and security and sustainable development. To promote the advancement and fulfilment of women's and girls' sexual and reproductive health and reproductive rights, the action plan will focus on promoting human rights activism and bolstering advocacy for a coordinated set of essential and quality multi-sectoral services available to survivors of GBV.

It will also work to enhance multi-sectoral coordination on elimination of harmful traditional practices, particularly female genital mutilation and child, early and forced marriage. Lastly, changing population structures, migration and other determinants require that national policies address these factors and be responsive to the changing dynamics of the region. The regional interventions therefore focus on advancing regional and country initiatives related to the demographic dividend, supporting the generation of demographic intelligence, and strengthening population related data systems to enable quality data collection and analysis.

3.2 UNFPA Response through the Country Programme

3.2.1 Description of UNFPA first Country Programme

UNFPA has been working with the Government of National Accord in Libya since 2017 towards enhancing sexual and reproductive health and rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. The UNFPA support was provided to Libyan authorities under the framework of the 1st Country Programme (CP) 2019-2020. The CP got approval twice for extension of its implementation period. The first extension was done due to an agreement between the Government of Libya and the UNCT agreed to extend the Strategic Framework for Cooperation between the Government and the United Nations to extend up to the end of 2021. The second extension was done up to 2022 to allow for the finalization of the new Strategic Framework and alignment with the new CP.

The programme is implemented with the goal of improving the health and well-being of women and youth, particularly focusing on the most vulnerable and those left furthest behind. It also contributes to the transformative results of ending preventable maternal deaths, ending unmet need for family planning, and ending GBV and harmful practices.[77] The country programme is also closely linked to the United Nations Strategic Framework, contributing to two out of the three outcomes of this framework, namely strengthening Libyan institutions and civil society and improving Libyan institutional capacity to design and implement social policies that focus on quality service delivery.

Classified as a 'pink' country[78], with a focus on policy and advocacy work, the CP also focuses on capacity-building, knowledge management and service delivery as modes of engagement for implementing the programme, due to the humanitarian situation. Particularly, service delivery is provided in conflict-affected hard-to-reach areas, and is defined by the absence of national capacity to provide sexual and reproductive health and GBV prevention and response services, throughout Libya.

Designed to contribute to national needs and priorities, the programme articulates UNFPA's strategic priorities and programmatic interventions in Libya in four outcome areas, namely; i) sexual and reproductive health and reproductive rights; ii) adolescents and youth; iii) gender equality and women's empowerment; and iv) population dynamics. These are further described in the section that follows.

[77] https://www.unfpa.org/sites/default/files/portal-document/DPFPACPDLBY1_EN.pdf

[78] See UNFPA Strategic Plan 2018 - 2021

Table 6: Country Program Result Areas

Result Area	Planned Interventions
Strategic Outcome 1: Sexual and reproductive health and rights: Every woman, adolescent and youth everywhere, especially those furthest behind, have fully exercised their reproductive rights and have access to sexual and reproductive health services free of coercion, discrimination and violence.	
CP Output 1: Increased access for women and girls to high quality sexual and reproductive health services, with a focus on humanitarian settings	▪ Supporting health facilities and mobile teams to expand coverage to the areas affected by humanitarian situations; ▪ Building the capacity of the health care providers on the minimum initial service package; ▪ Providing outreach by to communities to enhance demand; and ▪ Advocating for policies to increase access of migrants and refugees to SRHR information and services.
CP Output 2: Improved capacity and resilience of health systems for the provision of integrated sexual and reproductive health services, including for the most vulnerable	▪ Assessing human resource needs and building the capacity of the health care providers on reproductive health and midwifery guidelines, protocols and referral pathways; ▪ Enhancing surveillance systems, including in the area Maternal Death Surveillance and Response; ▪ Advocating for the expansion of HIV voluntary counselling and testing centres; ▪ Integrating reproductive health in the budgeted national health emergency preparedness plan; ▪ Supporting the development of the Logistics Management and Information System
Strategic Outcome 2: Youth development and participation: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and rights, in all contexts	
CP Output 3: Adolescents and youth, including the most vulnerable, have increased opportunities to participate in decision-making and to lead initiatives that promote sustainable development and peace and security.	▪ Supporting the development of a national youth strategy and an action plan, with youth participation. ▪ Building capacities of youth on life skills and citizenship education; ▪ Supporting youth networks to contribute to achieving sustainable development, peace, and security in their communities and country; and ▪ Operationalizing UNSCR 2250 and convening a national coalition and programme on youth, peace and security.
Strategic Outcome 3: Gender equality and women's empowerment: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings	
CP Output 4: Strengthened national capacities to prevent and respond to gender-based violence including in humanitarian settings.	▪ Leading and supporting a functional interagency gender-based violence coordination system; ▪ Enhancing capacities of national partners to address gender-based violence through a multi-sectoral, survivor-centric approach with specialized case management and psychosocial support; ▪ Supporting the development of sexual reproductive health/gender-based violence referral pathways and management information systems; and ▪ Policy engagement and advocacy for national ownership of the gender-based violence essential services package.
Strategic Outcome 4: Population dynamics - Everyone, everywhere is counted, and accounted for, in the pursuit of sustainable development	
CP Output 5: National data systems are strengthened to increase the utilization of demographic intelligence at national and local levels	▪ Providing technical support and capacity building to plan for a national census by 2021; ▪ Providing support to conduct regular municipal level household surveys to inform humanitarian and development planning; and ▪ Providing technical support to increase the use of data at national and subnational levels for informing policy.

3.2.2 The Financial Structure of the Country Programme

At the time of programme design, UNFPA proposed $9.2. million (Regular Resource US$ 1.5 million and Other Resources US$ 7.7 million) for the execution of the 1st Libyan Country Programme over the first two-year period 2019 to 2020[79]. However, the CO successfully requested for an extension of the CP life by two years with an indicative total budget of USD 4, 2005,130. There were however no details of budget variation upon extensions. Based on the data accessed from the financial resources, the CO managed to mobilize 14,065,661.47 as at the end of 2021. (Regular Resource USD 3.4 million and Other Resource USD 10.7 million)[80]. This is shown in Table 7 below stating yearly budget and CP component, also represented in Figure 3.1.

[79] UNFPA 1st CPD 2019 - 2022

[80] CP Financial report

Table 7: CP Budget amount for 2019 - 2021

	2019	2020	2021	Total
SRHR	1,256,689.14	2,342,360.51	2,271,630.79	5,870,680.44
A&Y	131,148.51	443,227.34	598,536.23	1,172,912.08
GEWE	1,866,663.09	2,022,100.47	2,399,950.03	6,288,713.59
PD	55,117.51	83,151.72	55,753.96	194,023.19
PCA	342,223.17	177,764.40	19,344.60	539,332.17
Total				**14,065,661.47**

Source of CP funds

UNFPA CO mobilized a total of US$ 3,386811 from regular sources, while other sources had US$ 10, 678,849.66. These are as shown below in Figure 5

Figure 4: Libya 1st CP Budget amounts by Component and Year (000)

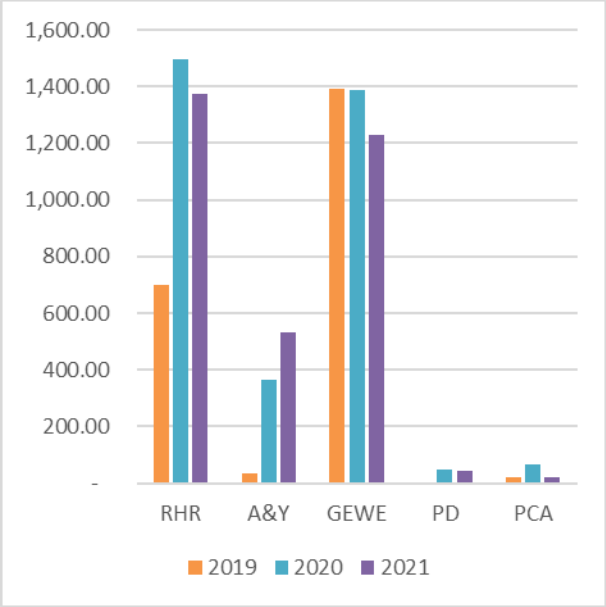
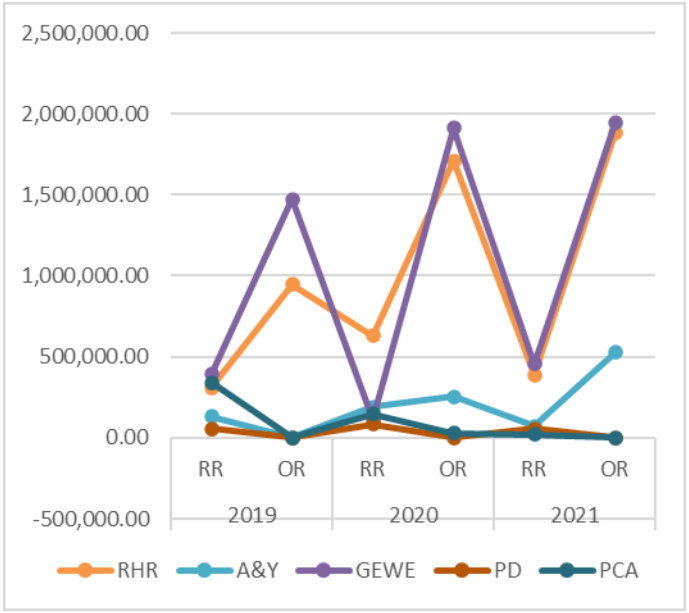


Figure 5: CP Budget Utilization by Funding Source



CHAPTER 4: FINDINGS: ANSWERS TO THE EVALUATION QUESTIONS

4.1 Introduction to the Chapter

This chapter presents the findings of the 1st Country Programme Evaluation, in compliance with the UNFPA Evaluation Handbook on how to conduct Evaluation. It involves addressing the evaluation questions in relation to the evaluation criteria. The findings have been guided by the evaluation matrix in Annex 4 of the report, triangulating multiple data sources as elaborated in the methodology design. The extent to which the results have been realised is described in the text, with some of the findings generalized for the interventions of the 1st CP as the feedback is based on opinions expressed on the performance of the programme, especially on the result areas and respective interventions implemented. The results are presented in response to the OECD-DAC evaluation criteria of relevance, effectiveness, efficiency and sustainability; and UNFPA's strategic criteria of coordination within the UNCT, and the humanitarian context related criteria of coverage and connectedness.

4.2 Relevance

Summary of Findings: The UNFPA Libya 1st CP was strategically relevant and aligned to the national and international development needs. The design was well adapted to the needs of the populations, particularly, the needs of the most vulnerable and marginalized. UNFPA CP also contributed to the government priorities in SRHR, A&Y, GEWE and PD through supporting the line ministries agenda. The CP was fully aligned to the UNFPA global Strategic Plan 2018 – 2021, and UNSF (including extension of the CP to align). The CP also contributed to the achievement of the ICPD Programme of Action and the SDGs, especially goals 3, 5, 10 and 17, The evaluation also revealed that there were consultations during the design and implementation of the CP, involving the government entities, IPs and beneficiaries. There was evidence of the CP being responsive to the changing needs and environment especially during the conflict and during periods of high level of displacement and adapting programme implementation ot COVID-19. UNFPA Libya is considered a valued partner both for the government and IPs and other stakeholders due to the contributions it is making in the development and humanitarian framework within Libya. However, absence of government strategies limited the levels of achievement, in addition to affecting effective support of the government towards achieving the targets.

EQ1: To what extent is the country programme adapted to: i) the needs of diverse populations, including the needs of marginalized and vulnerable groups; ii) national development strategies and policies; iii) the strategic direction and objectives of UNFPA; iv) priorities articulated in international frameworks and agreements, in particular the ICPD and SDGs; and v) the New Way of Working and the Grand Bargain

4.2.1 Alignment of the CP to the National Strategies and Policies

Analysis of the CP document and interviews with the various CPE respondent participants reveal that there is evidence of the CP being adapted to address national priorities and population needs. The sources further revealed that UNFPA 1st CP was implemented in collaboration and consultation with the various line ministries, including Ministry of Health, Ministry of Youth, Ministry of Social Affairs, Ministry of Education, Ministry of Higher Education, Bureau of Statistics and Census and other line ministries, directly contributing to their respective objectives, and making it relevant to the national needs. It is also evident that the CP implementation required approvals from the governments, both in the East and West, to allow, particularly the IPs, to implement the respective UNFPA-supported activities in the respective targeted locations, manifesting their support to the CP.

There is evidence that the Libyan authorities were consulted during the development of the CPD, capturing the priorities of the government. Interviews with the CO and IP staff also stated that the CP was highly informed through consultations of the vulnerable populations, identifying the needs which informed the kind of interventions and areas to be targeted. For example, the IPs and CO staff confirmed conducting surveys to identify gaps, especially with the youth and migrants, informing the kind of interventions to be implemented with them. The development of the CP was also contributed to the UNSF whose development was as a result of consultative efforts with the targeted authorities and populations. It is also evident from the CP results and resource framework (RRF) that the programme directly contributes to four national priority areas through implementation of its components in RH, A&Y, GEWE and PD (CPD).

Further, there is evidence through document review and interviews that the line ministries participated in the implementation of the CP interventions. For example, Ministry of Youth is the Co-Chair of the Youth Working Group together with UNFPA; establishment of the GBV Unit within the MoH, in consultation with UNFPA shows direct contribution to the national priorities; and MoH participation in the Health Sector coordination mechanisms supported by UNFPA together with other UN agencies. UNFPA also grounded the CP approach to addressing GBV and RH based on human rights and gender equality principles, incorporating contextual sensitivity in addressing the needs, including considering Islamic values.

4.2.1.1 Sexual and Reproductive Health and Rights

A situation analysis report of 2018 synthesized evidence on the sexual and reproductive health and rights (SRHR) need of the Libyan people with the greatest priority identified as the need for access to healthcare services. The Humanitarian Response Plan (HRP) of 2019 identified more than 500,000 people in need of healthcare services, including reproductive health services. The situation analysis also showed gross inadequacies in human resources especially in nursing and midwifery where there were only 467 midwifes (5.4% of the medical doctors) and 10 663 (1.2 nurses per 1 physician) professional nurses in the country's public health system. The breadth of SRHR services provided by UNFPA included the provision of healthcare services at primary health facilities through mobile clinics, support to the improvement of midwifery training in the country through the development of a curriculum in collaboration with the Ministry of Health and the Nursing and Midwifery Association and improvement of surveillance through capacity building on the district health information system (DHIS2) (document review and interviews), were effective in addressing the identified needs of the vulnerable populations. UNFPA embedded capacity building in the activities provided to the health workers on various aspects of SRHR through the minimum initial service package (MISP) components, leadership training, maternal, Newborn and child healthcare, among others, to address the capacity gaps in the country.

In response to the inadequacy of resources to support delivery of the SRH services in the country, UNFPA supported procurement of SRH kits and commodities and facilitated their distribution to the health facilities supported through the MoH. Non-discriminatory services to migrant and host communities helped in alleviating the suffering of many vulnerable migrants who were casted out of the public service system in Libya, according to policy and because of the dire needs of the Libyan citizens which have not been met (interviews and document review). All the activities implemented by UNFPA through 1st CP in the period of review were in response and contributed to addressing the felt needs of the vulnerable populations and the locations in need (interviews and document reviews).

Review of documents and interviews revealed that all the primary health facilities ceased working after the collapse of the Col. Muammar Gaddafi's government. In addition, there was registered decline in the availability of the healthcare workers to provide quality and professional services to the vulnerable populations, especially in remote and resource-constrained locations and to the asylum seekers and migrant populations. The 1st UNFPA CP supported the delivery of the health services to the migrant populations, asylum seekers, host communities and other remote locations through the mobile health clinics. Each mobile health team comprised of a gynaecologist, a paediatrician, an anaesthetist, a nurse/midwife and a community health worker, enabling access to quality health services, including SRH commodities. While the Libyan health system had many primary health facilities, they were not expected to provide comprehensive healthcare services including SRH services. Rather, deliveries were undertaken at the district hospitals. Sometimes, women have had to travel more than 1200Km to Tripoli just to give birth. With the UNFPA's contribution to the rehabilitation and equipment of the primary health facilities, the Libyan doctors at these hospitals have started transferring their service to the facilities, hence reducing the burden or facility pressure (interviews). UNFPA further invested in training of nurses and midwives, in addition to the strengthening of the community health workers to enable surveillance and share information on available services in the targeted locations. Recognizing the dilapidated health infrastructure, UNFPA supported the rehabilitation and equipment of health facilities to enable them resume operation, enabling access to health service delivery (Document review and interviews).

The SRH services provided through the UNFPA support were in alignment with the national needs, aimed at improving provision of maternal and neonatal health. UNFPA facilitated provision of these services in collaboration with the MoH, and utilized the services of the Libyan government health workers, in addition to being provided in government health facilities. Interviews revealed that the services were provided in facilities that had been abandoned due to

shortage of health workers or destroyed during the conflict, with UNFPA making them work through financial and technical support. The UNFPA's IPs who facilitated provision of the services filled the critical gaps left by the instability which led to poor government functions and resulted in many health workers going months without pay and thus, poorly motivated to provide care at the government health facilities (Document reviews and Interviews).

One important pillar of the six pillars of health systems strengthening framework is the health information system (HIS). The situation analysis report of 2018 identified the HIS as an important pillar that must be embedded in the strengthening of the health system, especially in the south of Libya. The routine health information system (RHIS) is important for collecting data from health facilities and service delivery points and contributes to monitoring the health system performance. The country lacked a surveillance or RHIS in place to serve as an early warning system. UNFPA, as a member of the health sector coordination mechanism supported the deployment and institutionalization of the District Health Information System 2 (DHIS2) in Libya through training of 20 municipalities, provision of infrastructure for its operation in the health facilities. UNFPA also supported training of several health workers on the use of the DHIS2 system during this period. In addition, UNFPA supported, for the first time, the inclusion of the RH indicators on maternal health which enabled surveillance through data collection from the facilities. Surveillance of COVID-19 morbidity was also monitored through the DHIS2 (Interviews and document reviews). It was however reported by the respondents during the CPE that the DHIS2 has not been effectively operationalized to provide its functions.

Recognizing the gaps in strategies and policies to guide service delivery or strategic response, during the 1st CP, UNFPA supported the development of various health-related policies and strategies. These included Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), HIV and AIDS and midwifery training curriculum; including supporting training on clinical management of rape (CMR). The RMNCAH strategy enabled focusing and guiding of the RH service delivery, including providing direction on the procedures of delivery and identification of gaps. The strategy for midwifery was to support the training of Libyan nationals as nurses and midwives to address the human resources for health shortage, and this was marshalled into a curriculum development activity. UNFPA also supported the MoH in producing and translating a costed plan of its activities into both Arabic and English so that more people could have access to and understand the document. While these policies were important toward the health service delivery in the country, including informing the future of the health landscape, there were concerns on the level of their implementation of various laws. The government's capacity and commitment to implement the same was cited as a gap. Implementation of some guidelines like the CMR was also challenged given the mandatory requirement for the survivors of sexual assault to report to the security, in addition to being perceived as a taboo limiting reporting (Interviews).

The activities implemented by UNFPA during this first CP were implemented as described in the annual work plan (AWP) and targeted the vulnerable, disadvantaged, marginalized and excluded population groups in a prioritized manner. These interventions as described above, met the need of many vulnerable people, especially by increasing access to SRHR services and provision of reproductive health commodities. The targeted population were consulted directly and indirectly as evidenced in the review of national assessments, including HNO and HRP data and consultations held with government officers including the Minister of Health and approval of strategic plans before activities were rolled out. The expected results, targets and implementation strategies outlined in the CPD and the AWPs are in line with the priorities, results and targets of the United Nations Strategic Framework (UNSF) for Libya as presented above.

4.2.1.2 Adolescent and Youth

During the UNFPA 1st CP, the CO technically and financially supported the youth interventions aimed at increasing their participation in the local governance, decision-making and their involvement in peacebuilding and security. In addition, UNFPA supported the youth populations on developing their technical and soft skills, including life skills on varied technical skills.

UNFPA recognized the fact that the Libyan youth did not have access to online resources on GBV and SRHR to learn from and enabled a digital engagement through establishing the online platform (Interviews). Given that the GBV and SRH are treated as taboo topics and they did not have the space to discuss the same, UNFPA, using a rights perspective enabled the youth to access the information. This was also premised on the fact that Libyan youth aged between 18 and 24 years were digitally literate and could access the internet. Interviews with IPs confirmed that the topics became acceptable and the youth participated actively in the sessions with confirmation of learning about the topics.

Recognizing the gaps that exist in the country where young people are not involved in state building, governance, peacebuilding and without empowerment, UNFPA, in the 1st CP, supported and advocated for the inclusion of youth in decision-making through engagement of various stakeholders to give voice to the needs of the youth and provide linkages that seek to recognize the young people as key contributors of country's development and in the humanitarian process. UNFPA worked with the newly-established MoY and other stakeholders to effectively advocate at national level on behalf of youths on their needs such as employment opportunities, capacity building and youth participation in decision-making, peace building processes and community –based peaceful cohesion.. These confirm its relevance in contributing to the needs of the youth (Interviews and document reviews). The youth in various ways, led by the UNFPA, in support of the national stakeholders, including local CSOs, contributed to implementation of the youth-targeted programmes in the country, addressing evidenced needs as identified through assessments, consultations and gaps identified during implementation (Interviews and Document reviews).

Libya has more than 63.4% of the population being under 30 years old, with employment rate at more than 19%[81]. UNFPA, through the 1st CP, supported initiatives to increase the youth employability and income generating activities through engaging them in Technical and vocational skills training (TVET) and provision of small grants respectively (Interviews and document reviews). Document reviews and interviews also indicate that the youth were involved in the war and conflict, and this support contributed to giving them opportunities dissuading them from recruitment to join the war and conflict, in addition to reducing their vulnerability.

Libya has experienced more than a decade of conflict with the governance systems and infrastructure crumbling, amid conflict. The youth, despite being populous, lack a forum that coordinate their issues in the country, with inadequacy of resources to target them. UNFPA, through the UNCT supported the establishment of Youth Working Group (YWG) which enabled coordination of stakeholders engaged in youth activities in the country, providing an opportunity for the youth to be targeted with various interventions (Document review and Interviews). With the establishment of MoY, under the GNU, youth activities have been coordinated under the YWG, with the ministry co-chairing, ensuring that the activities contribute directly to the ministry's strategic goals.

During the 1st CP, UNFPA technically and financially supported the development of the RMNCAH strategy which includes the adolescent Reproductive health (ARH), addressing the gaps in targeting the young people with services. This also provided an opportunity to capacity building of the healthcare workers to provide ARH services and advocate for the rights of the young people's rights to information on the same (Interviews with MoH, IPs and UNFPA CO staff). There was however limited documentation on youth ARH services provided to the youth during the period of assessment. Interviews however revealed that the CP focused more on information of the youth on the RH and GBV themes, but less was captured on the services.

Even though the UNFPA's A&Y component contributed to addressing the felt needs of the adolescent and youth in the country, it had resource constraints, limiting the extent to which the interventions could yield more results compared to the needs, which were reported to be enormous. The unavailability of the youth strategy, in addition to absence of specific ministry dedicated to respond to youth matters also limited the extent to which the focus on the youth needs. The inadequate government commitment to the development of A&Y-related programmes, thereby limiting their prioritization. There is however an opportunity with the establishment of a MoY, which enables refocusing the youth activities to address their needs (Document review and interviews).

4.2.1.3 Gender Equality and Women Empowerment

Throughout the last ten years of conflict in Libya, the impact on women and girls has been particularly severe. Women and girls are highly vulnerable in such a context and face increased levels of sexual violence. Female refugees, IDPs and asylum seekers often lack access to sexual and reproductive health services, GBV prevention and response services as well as access to the justice system. For both displaced persons and communities trapped in conflict, worsening security concerns from the state and the community often limit the freedom of movement for women and girls, with the assumption that this would be best for their protection. The status of women and girls continues to be impacted by traditional discriminatory practices and social norms. In response to the impact of conflict and the needs of the emergency humanitarian situation in Libya, UNFPA's GEWE programme provided funding opportunities to design and implement GBV-related activities at the

[81] NBSC (2021 estimates); and World Bank (2020)

community level implemented by Libyan civil society organisations (document reviews and Interviews).

The UNFPA responds to the humanitarian needs of the beneficiaries by aligning their interventions to the Humanitarian Response Plan (HRP), which is based on the Humanitarian Needs Overview (HNO). The HNO identified the needs of local communities through the coordination mechanisms of different subsector clusters and working groups. It also identified the significant needs on protection of the refugees and migrants since they suffered the highest risks, compared to other groups of concern[82].

The Libyan government ratified various international obligations such as those stated in the Committee on the Elimination of all Discrimination Against Women (CEDAW) and treaties like the International Convention on Civil and Political Rights (ICCPR), International Convention on Economic Social and Cultural Rights (ICESCR) and Convention on the Rights of the Child (CRC)21 .[83] However, there is little or no commitment by the government in the implementation of the ratified treaties and obligations with reservation put on their implementation.

UNFPA's GEWE component is based on the understanding that the latest Libyan draft constitution guarantees gender equality. However, the current situation on the ground reflects inequality between women and men. For example, the 2013 Libyan Women's Status Survey concluded that young Libyan women are subjected to harassment and abuse in public places. Yet, the government has not taken any measures to stop these incidents. Moreover, domestic violence incidents are considered a private matter. Currently, protection services for women and girls are very limited in Libya, with no multi-sectoral referral system and functional coordination mechanism for survivors of violence.[84] UNFPA's support to the GBV sub-sector coordination mechanism provides a platform, bringing together GBV-responding stakeholders to facilitate service delivery and operation standards[85] and supporting laws.

At the policy level, it was challenging for UNFPA to work on GBV as the government did not acknowledge violence against women as wrong or a priority. However, UNFPA engaged the Ministry of Social Affairs (Ministry of Social Affairs (MoSA), Ministry of Health (MoH), Ministry of Justice (MoJ), Ministry of Education(MoE), Ministry of Interior (MoI) , to supervise the hotline operation services that a local Libyan civil society organisation (CSO) implements. This enabled collection of information on violations and facilitated referrals and case management for the GBV survivors in compliance with the existing pathways internal and external.

UNFPA-supported GEWE interventions were relevant to bridge the gaps and respond to the needs of girls and women at risk. UNFPA and implementing partners held consultative meetings and needs assessment studies to design interventions relevant to the needs of girls and women. These facilitated identification of relevant interventions, addressing felt needs for the survivors. These were also found to be context-specific. These included; conducting awareness and legal support services to those in need, livelihood support to vulnerable women and girls; psychosocial support (first aid psychosocial) and specialised services to those with mental health issues; supporting case management and referral approach (Interviews and Document review). Furthermore, interviews with UNFPA IPs confirmed that GBV interventions respond to the actual needs of vulnerable Libyan and non-Libyan girls and women. However, more focus should be given to strengthen the women in economies and livelihood, as reported by beneficiaries and women CSOs.

UNFPA confirmed conducting need assessments overview with their network of local CSOs to address the community needs. Additionally, UNFPA partner CSOs reported conducting a needs assessment with beneficiaries before submitting their annual work plan to UNFPA. For example, Women Union and Amazonat conducted a need assessment and took beneficiaries' feedback and inputs before submitting their AWPs to UNFPA for funding. GBV remains a sensitive and taboo issue in Libyan society. However, UNFPA has made significant achievements in putting GBV at the centre of the public attention, involving government, private sector and civil society actors.[86]

4.2.1.4 Population Dynamics

Document review and interviews with the CO and Government staff confirmed that Libya's national statistical systems faces several challenges in almost all areas of statistical capacity leading to negative impact on the statistical production which include political unrest and statistical uncertainty resulting from it. Other challenges include insufficient

[82] Humanitarian Needs Overview page 6

[83] https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Countries.aspx?CountryCode=LBY&Lang=AR

[84] UN Strategic framework page 20

[85] Interviews

[86] UNFPA Annual Report 2019

resources and infrastructure; lack of statistical coordination between sectors; weak compilation of routine data between ministries, administrations and agencies, and statistical advocacy in promoting the use of statistical data; among others, including weak legal framework not keeping pace with the recent developments, and the lack of sufficient physical infrastructure and information and communication technology (ICT) infrastructure which impedes generating qualitative data. In addition, the last national population and household census was conducted in 2006, and in addition to the movement of populations due to the conflict manifesting the inadequacy of data to inform decision-making (Interviews and document reviews).

Analysis of documents and interviews with the government and CO staff indicate the UNFPA contributed to strengthening of the national data system and also contributed to utilization of data to inform decision-making both at the national and local levels during the period of review. UNFPA supported the National Bureau of Statistics and Census (NBSC) of the Ministry of Planning to plan for a national census, conduct household surveys and capacity build them in their areas of need. The CP also contributed to the humanitarian programming with the Common Operational Dataset for Population Statistics (COD-PS), contributing to the production of Humanitarian Need Overview (HNO) and the Humanitarian Response Plan (HRP), informing the decision in targeting of the most vulnerable populations (SIS (2019 – 2021) reviews and Interviews with CO and UNOCHA staff).

Recognizing the need to develop the capacity of the country on increasing the demographic intelligence for humanitarian and development to through providing technical assistance to the NBSC on the National Statistics Development Strategy (NSDS) through focusing on generation of sex and age disaggregated data, supporting the initiation of the geo-referencing and tracing of geo-boundaries to prepare for demographic survey, in addition to updating sample frame to get the national level indicators, especially on social development areas like family planning, GBV, and the other outcome level indicators. Further, UNFPA started working with the African Union to update the national statistics given the obsolete data available (Interview with CO, UNOCHA and NBSC staff). The CP also supported the NBSC and the MoH's Health Information Centre to conduct an assessment to map the issues with civil registration aimed at strengthening civil registration and vital statistics (CRVS) system (Interviews with MoH and CO staff).

Even though UNFPA, contributed to the strengthening of the national statistics systems during the 1st CP, there were limitations that affected implementation of the various planned activities. These include delays in allocation of resources for the population census and CRVS; having two separate governments in the west and east inhibit decision-making; conflicts; challenges of delayed approval by the government, inadequate capacity by the NBSC and other sectoral statistical offices[87].

4.2.2 Alignment of the CP to UNFPA Strategy 2018 – 2021

The UNFPA Libya 1st CP is to a greater extent aligned with the UNFPA strategic plan 2018 – 2021 (SP), in both design and delivery. Document review and interviews with CO, IP and Government staff revealed high alignment of the CP components with those of the SP, directly contributing to the achievement of the SP overall goal aimed at achieving universal access to reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the (ICPD) agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality. Further, with women, adolescents and youth the key beneficiaries of the work of UNFPA, achievement of the goal is enabled by addressing human rights, gender equality and population dynamics. Interviews also established that the CP has specific interventions targeting migrants, IDPs and refugees, which are in line with the SP. While the CP is also aligned to the SP, especially using the SIS reporting template, and capturing its performance across the four component areas, the A&Y component is more skewed towards youth participation, peace and security, instead of increasing their access to ASRH and GBV (Document review and Interviews).

While the CP was designed along the SP's business model classifying Libya as Pink Country[88], the massive humanitarian and human rights crisis from early 2019 and prolonged till 2020 affected its operationalization of the CP, and UNFPA strengthened alignment with the SP, in addition to

[87] Interviews with MoP, CBS and CO staff

[88] UNFPA approach of classifying countries of operation based on their development realities and conditions, defining the need and ability to finance criteria. Libya was classified as an upper middle-income country with the support emphasising advocacy and policy dialogue, knowledge management and capacity development as modes of engagement, excluding service delivery. This however changed in 2019 due to the eruption of conflict in the country.

enhancing focus on addressing the needs of the populations affected by the humanitarian crisis in the country, by mobilizing resources outside the core resources to finance the interventions, incorporating all SP modes of engagement, including service delivery, especially under RH and GBV due to the changes in the implementation context[89]. The 1st CP is also aligned to the SP is confirmed by the reporting based on the Strategic Information Systems (SIS), where the outputs are covered according to the SP. Even though the CP endeavoured to strengthen national policies and the international development agenda, there was little evidence knowledge management and integration of population dynamics in sustainable development, SRHR, adolescent and youth, and gender equality[90]. Further, the period of implementation has seen the Youth and PD components being mainstreamed due to lack of resources and inadequate prioritization due to COVID-19 (Interviews with CO).

4.2.3 Alignment of the CP to Priorities in the International Frameworks

- ***ICPD*:** The 1st CP interventions directly contributed to the ICPD Programme of Action (ICPD – POA) with its programmatic focus of improving the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality, through enhancing access to comprehensive reproductive healthcare, women and girls' empowerment and capacity in production of demographic data to inform decision-making in Libya[91]. The CPE further reveals that UNFPA programme prioritizes marginalized and vulnerable populations with services and also contributes to eradication of forms of discrimination along sex, age, disability and social backgrounds.

- ***Sustainable Development Goals:*** The development of the CP was in alignment with the Sustainable Development Goals (SDG), in particular Goal 3 (Good health and wellbeing), Goal 5 (Gender equality) and Goal 10 (Reduced inequalities)[92]. Interviews with staff, partners and beneficiaries indicated that UNFPA Programme in Libya facilitated access to health services by the vulnerable and needy populations through the support of mobile health clinics, development of policies increasing quality access to skilled birth attendance, capacity building and provision of health services in areas of need. This contributes to the achievement of Goal 3. Analysis of programme reports and interviews with CO, IPs, Government respondents and beneficiaries also indicated that UNFPA Libya contributed in enhancing gender equality through supporting women's empowerment and social development interventions for women and girls. These included skills development, providing psychosocial support and advocating for women and girls' rights. The CP design and implementation also aligned itself in the supporting the enactment of the elimination of violence against women (EVAW) law and targeting of vulnerable populations affected. Interviews and document review also revealed that the CP contributed to the achievement of Goal 17 (Partnership building) through promoting partnership strategy in the implementation of the CP. Further, there was contribution of the CP on Goal 16 (Peace, Justice and Strong institutions) through the support of youth programmes aimed at building cohesive and peaceful coexistence among the conflicting communities. The reporting on the Goals was however hampered by a number of challenges including not accurate evidence as it is difficult to collect the data due to the instability[93].

- ***New Way of Working and the Grand Bargain***: Interviews with IPs, Government and CO staff confirmed UNFPA's contribution to the New Way of Working (NWoW), where it supported efforts to reduce need, risk and vulnerability in Libya. UNFPA supported the identification of needs, especially in the gender area of responsibility (AoR), through compilation of data on the humanitarian set-up. In addition, UNFPA was part of both UNCT and HCT, involved in planning for the development and humanitarian response endeavours in the country. The GBV sub-sector coordination, led by UNFPA, fronted a collective responsibility from stakeholders toward elimination and response to GBV in the country. the participation of UNFPA in the humanitarian data generation contributed to the targeting of vulnerable populations through the HRP. In addition, UNFPA promoted partnerships with the local civil society organizations (CSOs) as implementing partners where their capacities

[89] DP/FPA/CPD/LBY/1: UNFPA Country Programme Document 2019 – 2020, and interviews with CO staff
[90] Interviews with CO, UN Agencies, IPs and document review
[91] Interviews with IPs, Government and CO Staff and document review
[92] DP/FPA/CPD/LBY/1: UNFPA Country Programme Document 2019 - 2020
[93] Interviews with Ministry of Planning and CO staff

were strengthened to deliver services in areas of need and support in various locations in the country. In addition to the CSOs being financed to deliver their interventions, building their capacities assures their capability to implement similar activities without external support (Interviews with IPs and CO staff, and document reviews[94]). Further, UNFPA contributed to peace building mechanisms in the country the support to activities in building cohesion in their localities[95]. It was however clear during the interviews that most of the local NGOs had limited capacity and mainly depended on UNFPA for their funding, something that can have far-reaching effects on their continuity.

- ***CP alignment with the United Nations Strategic Framework:*** The CP is well aligned to the United Nations Strategic Framework (UNSF) in Libya by contributing to two out of the three outcomes areas of the framework. The CP's SRHR and GEWE components are aligned to the UNSF's 1st results area which focuses on delivery of quality social services for all (including vulnerable groups and migrants) in Libya towards enhancing human security and reducing inequalities; while CP's Adolescent and Youth, and Population Dynamics components are aligned to the 3rd result area of the UNSF which aims at strengthening core government functions and Libyan institutions and civil society to respond to the needs of people (Interviews with CO and UNRCO staff and CPD).

EQ2: To what extent has the Country Office been able to respond to changes in national needs and priorities, including those of vulnerable or marginalized communities, or to shifts caused by crisis or major political changes including the ongoing COVID-19 Pandemic?

In the period of review, Libya experienced a series of emerging issues leading to new needs that necessitated response from the development and humanitarian actors in the country in order to reduce the effects to the targeted populations. Review of documents and interviews with various stakeholders and staff indicated that UNFPA was very responsive and immensely contributed to the emerging needs in the areas of mandate during the 1st CP implementation period, confirming its capacity to adapt and respond to priorities.

UNFPA's responsiveness to emerging national priorities and needs was evidenced almost throughout the CPs implementation. To begin with review of the CPD and interviews indicated that the 1st CP was to focus mainly on development with few components of humanitarian response. With the outbreak of conflict in 2019, the national priorities changed and the CP had to be readapted to provide lifesaving services and peacebuilding interventions. For example, the implementation of the Midwifery project had to be suspended in 2019 due to the armed conflict in Tripoli that started in April 2019, shifting the Libyan authorities' priorities as agreed upon in 2018 (SIS 2019). In addition, the CP's RRF, especially the indicators were also reviewed and addressed based on the changing context. For example, the RH indicator on training the of the healthcare providers was reviewed to include PPEs and COVID-19 related information. Further, the CP activities have been guided by the annual humanitarian response plans (HRPs), and these guided the fundraising mechanisms for UNFPA, in alignment with targeting the people in need (PIN).

In the advent of the COVID-19, in addition to the conflict, UNFPA's responsiveness and capability to respond to emerging needs manifested itself, with interviews indicating that the CO reprogrammed, including reallocating funds to respond to the effects that this came with. To start with, UNFPA incorporated integration of COVID-19 infection, prevention and control (IPC) into its programming, including being a member of COVID-19 Working group. Further, UNFPA engaged in resource mobilization endeavours to fill the funding gaps that existed. For example, European Union approved changes in the programme align with the arising needs, including holding online training sessions and meetings to enable continuity of activities. Towards ensuring continuity of life saving services, UNFPA supported maternity health facilities with personal protective equipment (PPE). The need to address the conflict issue amidst COVID-19 pandemic, UNFPA mainstreamed COVID-19 in Adolescent and Youth interventions to target the youth with funds to advocate against COVID-19, in addition to training and providing them with start-up kits to recover from the economic effects of COVID-19. UNFPA also reviewed the way interventions were conducted including holding virtual training meetings for stakeholders and this training focused on infection, prevention, and control (IPC) as needed. (Interviews

[94] Annual Work Plans; SIS and Budget Analysis
[95] Interviews with CO, IP, Government and UN staff, and document reviews.

and document reviews). As a result of the COVID-19 outbreak, UNFPA supported COVID-19 preparedness training, mainstreaming it into the main trainings.

Under the European Union's Africa Trust Fund (EUTF) project, UNFPA has scaled up its interventions to protect migrants and refugees in detention centers (DCs) and urban areas, with a focus on women and girls at high risk of GBV. In 2021, by virtue of the project, over 4,587 migrants benefited from SRH and GBV services and over 3,387 received awareness on SRH and GBV issues. Regular monitoring visits were conducted to assess the situation of the detainees especially focusing on women and children. These visits also monitored services including psychosocial support and dignity kits distribution to detainees.[96] During the pandemic's first year, as a commitment to continue supporting the people of Libya in a humanitarian context marred by a decade-long instability further exacerbated by the COVID-19 pandemic, UNFPA managed to mobilize EUR 285.000 support from the France Government to maintain and expand the Psychosocial Helpline and legal consultations on emotional, domestic and physical abuses to vulnerable communities, especially survivors of Gender-Based Violence (GBV)[97]

4.3 Effectiveness

EQ3: To what extent have the interventions supported by UNFPA contributed to the achievement of the expected results (outputs and outcomes) of the country programme and any other revisions that may have been done in view of the COVID-19 pandemic? In particular: i) increased access and use of quality sexual and reproductive health services, in particular by populations affected by humanitarian crisis; ii) increased participation of adolescents and youth, including the most vulnerable, in decision-making and enhanced youth leadership to promote sustainable development, peace and security ; iii) advancement of gender equality and the empowerment of all women and girls, with a particular focus on prevention and response to GBV; and iv) increased use of demographic intelligence in the development of evidence-based humanitarian and development plans, policies and programmes at national and local levels?

4.3.1 Sexual and Reproductive Health and Rights

Summary of Findings: The 1st CP contributed to increased access for women and girls to high quality SRH services both in development and humanitarian set ups, through provision of integrated health services by supporting static and mobile health facilities, building capacities of the healthcare providers in collaboration with MoH on MISP, and development of strategy and policy engagement. In addition, UNFPA supported advocacy mechanisms for migrants and refugees to access health care and SRH services, thereby facilitating provision of lifesaving services and capacities to respond to the RH needs of the crisis-affected populations in Libya's humanitarian context. Little could however be achieved on birth spacing as this was considered a taboo topic in the country, in addition to its non-prioritization by the government.

UNFPA also contributed to strengthening resilience of the health system through capacity building of the country's healthcare providers, development of guidelines and protocols [Nursing and Midwifery Policy and Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Policy and HIV&AIDS Policy], enhanced surveillance through supporting the functioning of the DHIS, enhanced integration of RH into national health systems, and improving RH commodity management system. Further, UNFPA supported advocacy for the regulation and standardization of nursing and midwifery profession and recognition of the role of midwives, in addition to supporting association. During COVID-19, the CP supported improved resilience of the health system through training packages to health workers on COVID-19 in relation to SRH, MISP, HIV VCT, breast cancer awareness and prevention, EmONC and leadership training for Midwifery

The Sexual and Reproductive Health and Rights (SRHR) component of the UNFPA Libya 1st CP was designed to ensure increased access for women and girls to high quality SRH services, with a focus on humanitarian settings; and improved capacity and resilience of health systems for the provision of integrated SRH services, including for the most vulnerable[9899]. The component had two outcome indicators and seven output level indicators, and the respective achievement in each of the output level indicators are as illustrated in Table 4.2 below[100]. Further, the component was implemented both directly by UNFPA through direct implementation and IPs respectively. During this first CP, All the SRH

[96] UNFPA News Letter 2021
[97] UNFPA News Letter 2021, page 7
[98] DP/FPA/CPD/LBY/1
[99] DP/FPA/2021/11
[100] SIS 2019, 2020 and 2021

component targets were achieved except for one indicator on accreditation of public midwifery schools and ensure that they follow national preservice curriculum based on International Confederation of Midwives/WHO standards.

Table 8: M&E Framework for the Reproductive Health and Rights Component of the 1st Libya CP [101]

UNFPA Strategic Plan outcome: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated Reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence						
Indicators	**Baseline**	**Targets**	**Achievements**			**Comments**
			2019	**2020**	**2021**	
CP Output 1: Increased access for women and girls to high quality sexual and reproductive health services, with a focus on humanitarian settings						
Number of health personnel that have the capacity to implement MISP at the onset of a crisis (cumulative)	60 (2017)	237	88	132	271	Target achieved and surpassed
Number of primary health care service providers and managers with skills and knowledge on the utilization of current SRHR guidelines and protocols	108 (2018)	250	9	937	1353	Target achieved and surpassed
Number of women reached with information on integrated sexual and reproductive health services (cumulative)	20,000 (2018)	100,000	81,758	124,908	172,865	Target achieved and surpassed
CP Output 2: Improved capacity and resilience of health systems for the provision of integrated sexual and reproductive health services, including for the most vulnerable						
Accreditation policies are created and endorsed by MoH for nursing and midwifery education	No	Yes	N/A	N/A	N/A	This is a new indicator introduced with the 2022 CPD extension. The CP however supported the MoH on development of nursing and midwifery policy. The accreditation was not prioritized in 2021 and postponed to 2022, as the focus changed when the new government came into being and prioritized elections, and therefore approvals for policies were not given much consideration.
Number of health facilities supported for functional Voluntary Counselling and Testing centres for HIV/ AIDS	1	3	1	Not reported on	5	Target achieved
Number of secondary and tertiary public health facilities that provide essential health services package for survivors of GBV (cumulative), including (CMR)	6	12	5	15	17	Target achieved and surpassed

Increased access for women and girls to high quality sexual and reproductive health services, with a focus on humanitarian settings

UNFPA contributed to increased access for women and girls to high quality SRH services both in development and humanitarian set ups, through provision of integrated health services by supporting health facilities and mobile teams, building capacities of the healthcare providers on MISP, and development of strategy and policy engagement, including advocacy for migrants and refugees to access health

[101] Green implies that the target has been achieved; Yellow means the achievement is significant; Red means far from being achieved

care and SRH services. UNFPA facilitated effective access to services by the conflict affected populations through partnerships and collaborations with different stakeholders (Interviews and Document review).

UNFPA enhanced access to RH service delivery in Libya through supporting development of the RMNCAH policy (2018 – 2023) and its costed action plan for implementation, which contributed to guiding the services and targets for the country, given that there was no strategy for the same. UNFPA also supported provision of BEmONC services to the targeted vulnerable and marginalized populations through rehabilitation and equipment of primary health facilities, and supporting mobile health team (documents reviews and interviews). Interviews and document reviews also revealed that the rehabilitation of the health facilities, in addition to supporting them with equipment and essential commodities, including drugs enhanced access to the services, reducing time spent visiting health facilities.

Through partnerships with local and international NGOs, UNFPA technically and financially supported mobile health teams, each of which comprised of obstetrics and gynaecologist, mental health and psychosocial support (MHPSS) counsellor, paediatrician, anaesthetist, nurses and midwives, as well as community health workers. UNFPA also contributed to providing kits and equipment to ensure functioning of the facilities. Selection criteria is used in collaboration with the MoH teams to select the facilities for support. These contributed to providing reliable and quality health services in the target locations, particularly the hard-to-reach locations and those occupied by the crisis-affected populations and migrants. UNFPA prioritized migrants and areas of conflicts, ensuring vulnerable populations access integrated GBV and RH services (Interviews with CO and IP staff). With the Libyan set-up not prioritizing service delivery to migrants, this support came in handy to the migrant populations both in detention camps and hosted by the communities. The teams facilitated provision of antenatal, postnatal and neonatal care, birth spacing information and methods, treatment and care for STIs, cervical and breast cancer screening services, referral to advanced (CeMONC) and emergency obstetric health services at the district health facilities. With the closure of more than 90% of the primary healthcare facilities in Libya due to conflict and not-prioritization, the mobile health teams bridged service gaps increasing access to skilled health care by the reproductive women and girls (Interviews and document reviews). UNFPA also supported laboratory services to screen infections, ensuring quality treatment and expert service. The CO also supported drug and commodity supplies to the facilities serviced by the mobile and static health teams. Further, UNFPA targeted support to remote communities along migrant routes by providing medical teams that delivered comprehensive services in these locations. It is hoped that by demonstrating that these PHCs could provide some level of comprehensive care, this can be adopted by the Ministry of Health and the model scaled across the country. This will further help in improving access to RH services for the majority of the Libyan people.

UNFPA contributed to the provision of improved access to skilled birth attendance in Libya by strengthening of midwifery and nursing capacities through education, supporting midwifery association, and development of training curriculum for the midwives. The midwifery curriculum was developed in collaboration with Tripoli University and Ministry of Higher Education. While the development of curriculum was completed, it needed to be accredited by the line ministry for it to be operationalized, and this had not happened at the time of the evaluation. It is however hoped that this will contribute to institutional strengthening for the training of midwives, bridging the existing human resources in the Libyan healthcare provision. UNFPA supported the midwifery and nursing association, especially on leadership and management targeting experienced nurses and midwives. It was however noted that the midwifery association is an amorphous[102] outfit, limiting level of engagement to support professionalization the association by UNFPA. These contributed immensely to ensuring quality midwifery services and enhancing access to skilled birth attendance, especially in the hard-to-reach areas, including marginalized populations, thereby contributing to reduced maternal mortality rate in the country (Interviews with IPs and CO staff).

UNFPA also supported the training of the NGOs and other health workers across the country on RH services. This contributed to improving the quality of RH services delivered. More than 1300 primary health care service providers and managers were empowered with skills and knowledge on the utilization of current SRHR guidelines and protocols. An additional 275 health workers were trained on the MISP. Furthermore, 27 health workers were trained as master trainers for MISP. Libya is now regarded as self-sufficient as these highly skilled health workers can subsequently pass this knowledge on to other

[102] The purported midwifery and nursing association is run by an individual who interviews indicated personalizes the running of its affairs, including family members' involvement.

professionals (Document reviews and interview with CO and IPs staff). These health workers provided RH services to more than 21,000 women and girls in 2021 alone.

UNFPA stimulated demand for RH services by deploying community health workers (CHW) in the target communities. CHW were a new introduction to the health workforce in Libya and UNFPA was instrumental in the creation of this cadre of health professionals (Document reviews and Interviews). UNFPA through its IPs supported development of the curriculum and terms of reference for this group of health workforce. CHWs supported health promotion and education activities in the communities where UNFPA worked. They were valuable to gaining the confidence of the communities since they were usually members of the communities they oversaw and could speak foreign languages (including English and French) spoken by many migrants and refugees that were predominantly targeted by UNFPA (Document reviews and interviews). CHWs facilitated reaching more than 172,000 women with integrated messages on sexual and reproductive health services through the 1st CP. They also provided information to the indigent people on the type of services available at the health facilities. They informed them that there was no cost attached to receiving care at the UNFPA managed health facilities. UNFPA utilized new media to reach more Libyans and migrants beyond the five cities where its partners were predominantly located. Advocacy sessions on social and mainstream media across the country was noted to have reached over 100,000 people in 2021 alone.

UNFPA contributed to strengthening capacity of the country, in collaboration with the MoH, on the minimum initial service package (MISP) for RH in crisis situations, thereby facilitating provision of lifesaving services and capacities to respond to the RH needs of the crisis-affected populations in Libya's humanitarian context. UNFPA took the lead and ensured that stakeholders were trained and had the capacity to respond, ensuring comprehensive RH service delivery. In addition to the healthcare providers and other stakeholders, including UN agencies, UNFPA also facilitated training of the mobile teams on MISP, covering HIV testing and counselling, COVID-19 preparedness, clinical management of rape (CMR) which was done in collaboration with WHO, ToT of MISP, training of Midwives and nurses on Cervical and breast cancer awareness and screening. These contributed to enhancing access to comprehensive RH service delivery (Interviews and document reviews). A total of 275 health workers were trained on MISP during the 1st CP. The training on MISP has been impactful as one of the health facilities that received the training in Tripoli within a short time was able to put their learnings to use. Earlier visit to the facility's warehouse had revealed a dysfunctional warehousing process where items were piled without appropriate inventory, but due to the training, the warehouse manager was able to put the knowledge gained on warehouse management and supply chain system into use and was able to arrange the warehouse properly and with appropriate labelling of items making it easier to access and follow items (interviews). However, following training, such proper practices contribute to improvement in management of requisitions as well as reduction in wastages through First-in-First-out principle.

UNFPA also supported the commemoration of various international days with various activities, which formed platforms for advocacy mechanism on different RH issues. In collaboration with the MoH's National Centre for Disease Control, UNFPA supported commemoration of World AIDS Days, where stakeholders distributed information, education and commination (IEC) materials targeting the high-risk migrant populations and asylum seekers (Interviews and document reviews). UNFPA also supported commemoration of international midwifery days where it worked with the Libyan Women against Cancer, in addition to using the platforms to elevate the role of midwives in ensuring safe delivery. In addition, UNFPA supported 25 prominent journalists and sensitized media on the role of midwives in provision of RH services during crises (document review, interviews). UNFPA also increased awareness on breast cancer by training media journalists from 7 TV/ radio channels on the importance of screening, early detection and treatment for breast cancer survival (document reviews, interviews). These journalists have since gone ahead to use their various platforms to sensitize members of the host community on radio and newspapers on various health related issues (interviews).

In the humanitarian set-up, UNFPA supported the humanitarian response planning (HRP) through ensuring that women and girls' issues were included in the RH strategic documents in the HRP targeting the migrant to access services. UNFPA ensured this through reviews and monitoring of the HRP information, ensuring inclusion of RH indicators, in addition to ensuring that the service package was also defined in the plan, deployment of doctors, including female midwives, and collaboration with other stakeholders to deliver this. UNFPA also enhanced referral mechanisms and ensured implementation

through follow-ups. In addition, UNFPA enhance advocacy and awareness raising targeting communities for service access (Interviews and document reviews). Through advocacy, UNFPA ensured government adopted services and policies to provide humanitarian services from national resources. It was however a gap, especially in getting commitment of the government to adopt policies for use, due to instability (Interviews).

While UNFPA supported delivery of birth spacing, in addition to heightened advocacy and awareness creation, little could be achieved as this was considered a taboo topic in the country. On the other hand, there is a belief that Libya is a rich country, with high GDP and therefore birth spacing is not a priority. UNFPA however trained the CHWs to create awareness and create demand for the services to promote birth spacing a right and choice. UNFPA also strengthened access to RH commodities for health facilities. This is however challenged in some areas. For example, in Benghazi, UNFPA trained healthcare workers and provided them with rape treatment kit. This data can be used to accuse one another or used against the person (Interviews).

Improved capacity and resilience of health systems for the provision of integrated sexual and reproductive health services, including for the most vulnerable

UNFPA targeted improvement of resilience of the health system through capacity building of various cadres of healthcare professionals, development of guidelines and protocols, enhancing surveillance, advocacy for expansion of HIV Voluntary counselling and testing (VCT) in the country, enhanced integrated RH into national health systems, and improving RH commodity management system[103].

UNFPA enhanced the resilience of the health system by supporting the development of three policies through the period of the 1st CP. These are the Nursing and Midwifery Policy, Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Policy and HIV/AIDS Policy (which was led by WHO). Of the two policies championed by UNFPA, the RMNCAH policy has been concluded and is already being implemented, although respondents were of the opinion that it needed a strong will and leadership from the MoH to see important components of the policy implemented across all departments in the Ministry (Interviews and SIS reviews). On the other hand, the Nursing and Midwifery policy while developed, is yet to be finalized due to the need for a validation meeting to be organized by the government of Libya. The rapid turnover of senior officers in the Ministry of Health has not helped as new officers need to first understand the workings of the Ministry before performing (interviews). The last 2 years has seen rapid turnovers sometimes in just 3 months in leadership of the Ministry thereby challenging the deliverables hinged on the government to be achieved (Interview and document reviews).

UNFPA supported the strengthening and visibility of the Nursing and Midwifery Association in the country. The association was described as 'dysfunctional' by a respondent without byelaws or a national office. The association also did not conduct regular elections into offices, although there is a national champion who is leading the association. UNFPA enhanced the functionality of the association by providing grants to the association through its partners. The lack of a structure and an association bank account did not enable UNFPA to engage this association directly. UNFPA supported the association in printing various IEC materials in which the logo of the association was placed on these documents (interviews). Furthermore, UNFPA gave visibility to this association by inviting the association to the delegation table and making this organization a strong voice for nurses and midwives in Libya during the development of the curriculum and the policy on nurses and midwives. UNFPA also exposed members of the association to leadership training so that they can be better organized and by so doing, be a strong voice for the nursing and midwifery profession in the country.

UNFPA further advocated for the regulation and standardization of nursing and midwifery profession and the uplifting of the role of midwives in Libya through orientation of 40 participants from different stakeholders and departments from Ministry of Health, Ministry of Education and National Centre for Disease Control (document review). Nursing and midwifery profession is not looked upon in Libya and there are only about 1,000 midwives in the entire country with a uneven distribution, with many concentrated in the urban areas (document review and interviews). Midwives are known to be instrumental to the delivery of maternal and newborn care in different low and middle income countries across the globe. However, their role in Libya has been relegated because they are not even permitted to take on roles that they have been trained for because of lack of recognition. Their numbers are also inadequate to advocate

[103] UNFPA Libya CPD (2019 -2022)

meaningfully. To plug the gap created in human resources for health, UNFPA supported the Ministry of Health, Nursing and Midwifery Council, Ministry of Higher Education and their partners in the development of a curriculum for the training of nurses and midwifes. UNFPA engaged two international experts to work with local experts to get this assignment completed. The collaboration between the international and local experts also facilitated knowledge transfer and capacity building of in-country experts. It is hoped that upon completion, Universities in Tripoli and Benghazi will begin training midwives who can subsequently take up assignments across the country, especially in the south where there is an acute shortage of health professionals.

UNFPA improved access to HIV voluntary counselling and testing services in the country through the establishment of 5 voluntary counselling and testing centres. These centres established have served as training points for new centres and some of those trained have gone ahead to establishing their own testing centres thereby having a multiplier effect on the healthcare system. By establishing HIV testing centres, UNFPA has contributed to increasing the number of people who know their HIV status and adopt positive behaviours that reduce the transmission of the virus to previously uninfected people.

UNFPA enhanced RH surveillance in the country through supporting the roll-out of the district health information system version 2 (DHIS2) in 20 municipalities. In the development of this, UNFPA ensured inclusion of RH indicators which facilitated maternal and neonatal surveillance in the targeted municipalities. Initially these indicators were never included, neither were they captured as they were not prioritized by the government. With their inclusion and training in the DHIS2, the surveillance and monitoring of RH systems has been enhanced in the targeted 25 facilities in the municipalities. In the roll-out, UNFPA facilitated training of healthcare workers to capture the indicators in addition to providing them with the right infrastructure to facilitate capture, analysis and reporting on the respective health indicators. It was however reported that the roll-out of DHIS2 was not effective and needed to be facilitated to work (Interviews). It was however observed that while DHIS2 works well for isolation centres for COVID-19 tracking, respondents noted that it is yet to achieve its potential to be the backbone of the routine health information system in the country. The role of the government in facilitating use of the surveillance data was also stated during the interviews as non-existent.

During the period, UNFPA contributed to health sector coordination mechanism, as an active member and a lead of the RMNCAH subsector technical working group. Interviews indicated that this participation ensured reach to needy people in a systematic manner and leveraging of resources and met frequently to share and strategize on how to share activities, in addition to eliminating overlap (Interviews). This also enhanced advocacy on RMNCAH strategy for government involvement, in addition to M&E.

COVID-19

In 2020, due to the emergency needs to respond to the COVID-19 pandemic, UNFPA improved the resilience of the health system by providing training packages to 809 health workers on COVID-19 in relation to Sexual and Reproductive Health (SRH), the Minimum Initial Service Package (MISP), Comprehensive SRH trainings, HIV VCT, breast cancer awareness and prevention, Emergency Obstetric and Newborn Care (EmONC) and leadership training for Midwifery. UNFPA also supplied 50,418 Personal Protective Equipment (PPE) as part of rapid scale up of services due to the pandemic (SIS 2020 and interviews). The PPEs were new interventions that was initiated as an important need following the outbreak of the COVID-19 virus and the declaration of a pandemic early in 2020. These PPEs were instrumental in the continued provision of services to the population early in the pandemic. It also helped with the protection of the health workers who were providing these services to the population (Interviews).

4.3.2 Adolescent and Youth

Summary of Findings: The 1st CP technically and financially supported the development of youth life skills and citizenry. UNFPA also supported increased participation of the youth in governance and peace building, in addition to increasing their involvement in addressing GBV issues and contribution to the empowerment of women and girls in the country. Further, UNFPA enhanced engagement of the youth and improved their technical skills and employability through training and capacity strengthening. The youth involvement in advocacy mechanisms on GBV and SRH were also meaningful. Inadequate allocation of resources, and absence of a national youth policy and strategy limited reach and focus.

The Adolescent and Youth component of the UNFPA Libya 1st CP was designed to increase opportunities for

the adolescents and youth to participate in decision-making and lead initiatives that promote sustainable development, peace, and security. This was to be achieved through development of the national youth strategy, build the capacities of the youth on life skills and citizenship education, supporting youth networks to contribute to sustainable development, peace, and security in their communities and country and operationalizing UNSCR 2250 and convening a national coalition and programme on youth, peace and security[104][105]. The component had one outcome indicator and three indicators at the output level as illustrated in Table 4.2 below[106]. Further, the component was implemented through three local IPs [Tracks for Peace and Development, Libyan Red Crescent, Ilistishari Initiative and Life Makers Association] with UNFPA mainstreaming the interventions into the other CP components.

Table 9: M&E Framework for the Adolescent and Youth Component of the 1st Libya CP[107]

Strategic Outcome 2: Youth development and participation: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and rights, in all contexts						
Indicators	**Baseline**	**Targets**	**Achievements**			**Comments**
			2019	**2020**	**2021**	
CP Output 3**: Adolescents and youth, including the most vulnerable, have increased opportunities to participate in decision-making and to lead initiatives that promote sustainable development and peace and security.**						
Number of youth-led initiatives on UNSCR 2250 developing peace and security implemented at community level	10 (2017)	28	3	29	56	Target achieved. However the component experienced budget cuts during the period of implementation
Availability of a functional Inter-ministerial committee for the Libyan National Youth Strategy	No	Yes			No	This activity was challenged by the contextual factors which did not facilitate its implementation, until a GNU was constituted, with a MoY being put in place for the first time. While UNFPA made efforts to discuss the concept of forming an inter-ministerial committee with the Ministry of Youth and with the National Board for Economic and Social Development, the temporary nature of the government made it difficult to proceed and had to be put on hold.
Number of young people who benefited from life skills training and citizenship education	1,500	4,000	1,296	3,138	4,649	The target is achieved and surpassed

Increased opportunities for the adolescents and youth to participate in decision-making and lead initiatives that promote sustainable development, peace, and security

UNFPA contributed to the achievement of this result area through supporting the youth participate in dialogue sessions with the aim of championing their issues, increasing their participation in championing their interests, in addition to providing them with basic services to realize quality of life.

During implementation of the UNFPA 1st CP, the CO contributed to increasing the involvement of the youth in the peacebuilding activities through providing them with opportunities to engage with the decision-makers and stakeholders (Interviews and document reviews). It is imperative to note that during the war and conflict in Libya, the youth never participated in the decision-making, but were part of the conflict through influence of the respective leaders. UNFPA therefore supported them, targeting their empowerment to be able to contribute to the governance processes in the country. for example, in 2019, UNFPA supported the 'Fasting for Peace' Initiative by young men and women to promote youth participation on peacebuilding issues, in addition to promoting their participation in the

[104] DP/FPA/CPD/LBY/1
[105] DP/FPA/2021/11
[106] SIS 2019, 2021 and 2021

[107] Green implies that the target has been achieved; Yellow means the achievement in significant; Red means far from being achieved

design of the Peacebuilding Fund project in Sirte and in the design of messages for the 16 days' campaign of activism through social media. This was premised on the fact that the youth population is huge and could be the key for stabilization or more conflicts (Interviews). UNFPA supported the youth initiatives enhancing cooperation and engagement of relevant authorities on youth programming in Libya. In targeting Sirte, UNFPA supported the youth (male and female) to overcome the effects of conflict in the region, having been at the heart of conflict for more than a decade (Interviews and document reviews). This was done through provision of Peacebuilding Fund (PBF) to the tune of US$650,000. While the fund was not adequate for the youth activities, it was limited to peacebuilding activities. Sirte was also a target since ISIL was active in the area targeting the youth who were easy recruits into the conflict. Through this support, more than 1000 young women and men were supported through funding 49 youth-led initiative, enhancing their income access having lost a lot including relatives in the conflict, including joining terrorist groups for solace or revenge. These were averted as the youth got engaged in meaningful activities. UNFPA also gave priority to young women and girls and youth who had lost relatives for the support (Interviews).

UNFPA also supported the Libyan youth on the Youth, Peace and Security (UN Resolution 2250) through the Y-PEER programme. This activity enhanced the participation of the youth in political, economic and peace issues in the country through forums and public sessions. The youth also targeted topics like prevention, protection, disarmament engagement, and reintegration from the armed groups, with interviews confirming that the programme targeted converts from armed groups. UNFPA also ensured conflict-sensitive approach ensuring no harm was made to any of the participating youth through working with the community structures (Interviews).

Towards increasing the involvement of the youth on addressing GBV issues and contribution to the empowerment of women and girls in the country, UNFPA, through the IPs supported the youth through a number of mechanisms to increase their knowledge on GBV. Taking cognisance of the sensitivity of the topic, UNFPA supported utilization of social media to engage them. This facilitated provision of accurate information on the sensitive gender issues, in addition to helping them open up to wider views on the same, addressing the harmful social norms (Interviews and document reviews). To facilitate access to information, UNFPA promoted use of platforms that were familiar to the youth, namely; writing, singing, social media, dancing. While UNFPA worked with Huna RW Media to follow up on the efficacy of the messages shared on social media, the effectiveness of this feedback could not be established (interviews).

UNFPA also contributed to strengthening the capacities of the youth through training them on life skills and citizenship education in various Libyan cities, including reaching the IDPs and migrants. This enabled the youth to learn and be able to live cohesively among the host communities and the migrants, as confirmed during interviews with the IPs. Interviews and reports confirmed that young people from different parts of the municipalities attending trainings together and conducting activities together, including debates and discussion on topical issues, including in the neighbourhood, something that could not happen, leave alone talking to each other, before the CP interventions. UNFPA also conducted some events in Tripoli, dedicated to Sirte targeting the youth highlighted the importance of the city on peace issues in the country, in addition to never being accepted in other regions of the country (Interviews), a confirmation that social cohesion was enhanced through the CP. It is also worth noting that these activities were conducted together with migrants, who initially were treated with contempt mostly associated with negative perceptions, including crime and disease, including HIV morbidity. UNFPA also supported the youth through conducting training on PSS for young women and men, in addition to enhancing information access on integrated messages on RH and GBV rights.

During the period of review, UNFPA utilized various mechanisms to target the youth and engage them on awareness raising on a number of topics including peacebuilding, GBV and youth empowerment. UNFPA utilized sports to provide a platform for the targeted youth in Libya. During these sessions, UNFPA and/or IPs utilize it to share information on topical issues. Interviews with IPs and CO staff revealed that the sessions were instrumental as the youth were able to freely interact with the facilitators on the topics of interest. UNFPA also trained journalists to produce short video with key messages targeting the youth and promoting behaviour change among them (Interviews). Reports also show that the UNFPA Libya CO supported sponsored two youth civil society activists to the Nairobi Summit on ICPD25 to advocate for youth issues in Libya. It is however not clear how this has been of benefit to the youth, in addition to if there were any commitments be the government in Libya.

Towards advocacy mechanisms on youth access to

GBV and SRH information, UNFPA supported use of sports engagement, debates and theatre for the youth and the general populace. These platforms were also used by the youth to advocate on topical issues affecting them, including peacebuilding and responsible youth engagement in development issues like addressing issues of drug abuse (Interviews). The youth also used the platforms to ensure increased awareness on harmful cultural practices such as human trafficking, early marriages and GBV. Enhanced debates among adolescent girls and boys facilitated improvement in knowledge on health rights. Despite UNFAP enhancing access to RH information by the adolescent and youth, access to adolescent reproductive health (ARH) was not pronounced in the CP. Given the special needs and sensitivity of RH in the context, the programme may need to concretize this to increase their targeting. Interventions like establishing and integration of adolescent and youth-friendly services and training health staff on the same will be important to facilitate access (review of documents).

> When the youth started talking about their issues, especially GBV and RH rights, they received resistance, but with support and frequent engagement, they have embraced what they share, participate actively and they confirmed that they needed it and felt in control of their lives and reproductive health **– IP respondent during the CPE**

According to the programme staff, the youth increased their self-awareness on impending retrogressive cultural issues such as forced marriages and rape in the society that downplays their efforts to pursue their careers and aspirations. Awareness messages on HIV&AIDS were continuously provided to the youth in public awareness session through class facilitations. Theatre performances were effective in disseminating information on the significance of ARH among the youth. Such performance also targeted elimination of child marriages and promoting girl child education by advocating against the practices, with changes reported during community sessions (Document reviews and Interviews).

UNFPA also utilized capacity building as a means to engage the youth and improve their technical skills and employability. The targeted youth in Sabha were trained on how to identify their needs and youth community-based organizations (CBOs) trained on grants application, reporting in preparation for grants application. UNFPA trained 100 male and female youth, clustered into four groups in order to register what type of training they needed. Reports and interviews show that the youth were trained on time management, project writing and grants writing, conducted through workshops. It is worth noting that targeting youth in Sabha had challenges of the municipalities threatening that the support and advocacy to the youth, especially the awareness creation and on rights-based issues was against culture. UNFPA, through the IPs, however utilized the trust they had with the community to deliver the activities. UNFPA also supported training of over 600 youth on various topics, including, CV writing, cover letters or scholarship so as to go forward and away from the conflict, public speaking Business plans and management and support using available resources (Interviews and document review). It was not however clear on how the youth utilized these skills training to empower themselves. UNFPA however supported11 youth groups on entrepreneurship and supported the 11 groups with grants to launch cleaning campaigns and awareness raising on COVID-19 IPC, creating employment (Interviews). It is though not clear how this endeavour is sustainable, but feedback confirms appreciation of the UNFPA-supported activities through their participation and support (Interviews and document review).

UNFPA also utilized social media platforms to engage the youth on issues of interest. The IPs ensured that the sessions were moderated, with the youth given an opportunity to ask questions and supportive responses provided, with the youth appreciating the support. The youth were also referred for those who needed help, especially PSS, and the IPs followed up to ensure that they received the support. Data analysed to assess the users revealed that mostly the users were youth. These enabled the youth to open up on issues affecting them and those that were considered a taboo to talk about (Interviews).

It is imperative that non-existence of a youth policy and strategy, and target ministry limited targeting of youth and effective delivery of the youth agenda. Currently, the targeting is not structured, neither is it programmed to contribute to the bigger national picture of indicator. There is also inadequate information on youth programme and extent of targeting. The creation of the Ministry of Youth, under the GNU, presents an opportunity (Interviews and document reviews). UNFPA was however flexible in targeting of the youth. For example, since in 2021, the topical issues were on the elections, an area that is not a focus for UNFPA, but it had to change to talk about election, ensuring that the youth were aware of their rights to participate in the governance systems in the country (Interviews).

UNFPA supported coordination of the youth activities in the country through supporting the Youth Technical Working Group (YWG) within the UNCT, in addition to co-chairing it with the MoY, which enhanced coordination and targeting of the youth issues in the country, in the absence of a strategy and policy. This brought together the UN agencies intervening on youth issues in Libya, enhancing leveraging of resources, in addition to addressing issues of duplication, geographical coverage, and enhanced communication on activities each of the members were implementing (Interviews and document review). It is through this coordination that the PBF project in Sirte was conceived with UNDP leading while WFP provided food assistance and interventions, UNICEF responsible for rehabilitation of schools and UNFPA responsible for CSO training and support, with enhanced coordination (Interviews). This has also enabled the engagement of the National Council for Social and Economic Forum to enhance discussion and advocacy for youth issues in the country in the absence of a strategy.

While the youth population in the country is high, the component received less funding allocation, and most of the programme funds were dedicated to GBV and SRHR components. In addition, A&Y aspects were to be integrated into the other components, but this was not much evidenced in the document reviewed and confirmed by the interviews conducted with the CO staff. The component also receives contextual challenges, for example perception that discussing sex information is treated as a taboo issue. Strong cultural challenges limited information access (Interviews). However, there is little to show the changes as the CP did not invest in operations research to monitoring the changes in knowledge among the youth targeted. It is however imperative to note that changes in behaviour take time to manifest. The absence of a strategy also led to some donors preferring (perceived as imposition) particular geographical locations with youth interventions while that would not be the case if needs were considered.

4.3.3 Gender Equality and Women's Empowerment

Summary of Findings: The 1st CP contributed to strengthening of policy, legal and accountability mechanisms and access to GBV services through strengthening multisectoral and survivor-centred approach to GBV preventions and response through supporting a comprehensive one-stop service women and girls' safe spaces (WGSS). UNFPA also enhanced synergies and leveraging of resources, partnerships for prevention and response to GBV in the country through technically and financially supporting the GBV sub-sector coordination, in addition to collaborating with IOM, WFP and UNICEF in the RRM for humanitarian response. Unstable context, non-prioritization of GBV programming by the government, absence of legislation, deeply-rooted social and cultural beliefs and inadequate capacity in the country hinder GEWE in the country.

The Gender Equality and Women's Empowerment (GEWE) component of the UNFPA Libya 1st CP was designed to contribute to strengthening of the national capacities to prevent and respond to gender-based violence (GBV) including in humanitarian settings[108][109]. The component had one outcome indicator and five output level indicators. The respective achievement in each of the output level indicators are as illustrated in Table 4.3 below[110]. Further, the component was implemented both directly by UNFPA through direct implementation and IPs respectively. During this first CP, all the component targets were achieved except for some details that need to be clarified in the SIS on the achievement of the targets.

[108] DP/FPA/CPD/LBY/1
[109] DP/FPA/2021/11
[110] SIS 2019, 2021 and 2021

Table 10: M&E Framework for the GEWE Component of the 1st Libya CP[111]

Strategic Outcome 3: Gender equality and women's empowerment: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings						
Indicators	**Baseline**	**Targets**	**Achievements**			**Comments**
			2019	**2020**	**2021**	
CP Output 4: Strengthened national capacities to prevent and respond to gender-based violence including in humanitarian settings.						
Existence of an inter-agency functional GBV coordination mechanism	No (2017)	Yes	Yes	Yes	Yes	Target achieved. The GBV SS existed and facilitated coordination of GBV response among the stakeholders.
Existence of national mechanism to engage multiple stakeholders, including civil society, faith-based organizations, and men and boys, to prevent and address gender-based violence	No	Yes	Yes	Yes	Yes	Target achieved
Number of GBV information management system and products developed (SOPs, Strategy, Assessment, tools)	0	4	Not reported	4	4	UNFPA facilitated development of GBV SS Strategy, GBV SOPs, GBV SS Service updated service mapping tool and initiated the rollout of the GBV Information Management System (GBVIMS+/ PRIMERO).
Number of women and girls subjected to violence who have accessed the essential services package	N/A	3000	2,076	20,455	1,369	The number reported for the Milestones in the quarters are more than those reported under the indicator for both girls and women supported.
Number of the minimum standards applied for the prevention of and response to gender-based violence in emergencies	N/A	15	15	15	15	This was reported as happening, with a 'Yes', but the number of the minimum standards applied was not captured, but stated as *15 or more minimum standards applied.*

Strengthened national capacities to prevent and respond to gender-based violence including in humanitarian settings.

UNFPA aimed to strengthen the national capacities to prevent and respond to GBV in the country, including in humanitarian settings through leading and supporting a functional inter-agency GBV coordination system; enhancing capacities of national partners to address GBV through a multi-sectoral, survivor-centric approach with specialized case management and psychosocial support; supporting the development of sexual reproductive health/gender-based violence referral pathways and management information systems; and policy engagement and advocacy for national ownership of the gender-based violence essential services package (Libya CPD 2019 – 2022). Feedback from reviews and interviews with various stakeholders, including CO staff indicated that UNFPA was able to achieve a lot under this component, enhancing prevention and response to GBV in Libya.

Strengthened multisectoral and survivor-centred approach to GBV

[111] Green implies that the target has been achieved; Yellow means the achievement in significant; Red means far from being achieved

UNFPA contributed to strengthening multisectoral and survivor-centred approach to GBV preventions and response through supporting a comprehensive one-stop service women and girls' safe spaces (WGSS), enabling access to various services by the survivors. During the period of evaluation, UNFPA facilitated access to PSS, including MHPSS; dignity kits; livelihoods training; case management and referrals by the vulnerable women and girls in the target locations affected by conflict (Interviews and Document reviews). These were implemented through IPs in Tripoli, Misrata, Benghazi and Sabha cities. These enabled GBV survivors to access multi-sectoral lifesaving services, including psychosocial support services, life skills, protection and able to express themselves without any social stigma or harm, in addition receiving information on issues relating to women's rights, health, and services; further contributing to the empowerment and protection of vulnerable women in crisis-affected areas and enabled detection of GBV cases (SIS review and interviews). These spaces provided an entry point for comprehensive and integrated RH and GBV services including ensuring close follow-up by the service providers across the target locations in the country (Interviews).

Case Management: UNFPA financially and technically contributed to strengthening the GBV case management processes in the country. UNFPA supported training on GBV case management and enhanced referrals of GBV cases from the WGSS to specialised service providers through the established pathways. 245 persons trained on various aspects of GBV.[112] Together with members of the GBV sub-sector members, UNFPA supported the mapping of services across the country to enhance service access by the survivors (Interviews with CO staff, IPs and SIS reports). Serious cases of GBV refuse to be referred to government institutions, especially to hospitals, police and public prosecutors, out of fear for their lives from being killed by their families, and for fear of stigmatizing their families.

At the WGSS, UNFPA as reported by IPS provides socio-economic empowerment to affected women and girls by supporting them to access technical and vocational skills in hairdressing, catering, tailoring, and dressmaking, and others based on their needs and demands. After training, the beneficiaries are supported with start-up kits to enable them to initiate their businesses from the skills gained, which are strengthening and improving the social status of women and girls in their respective communities. However, start-up groups have enabled very limited number of women to run small businesses after livelihood training due to challenges in lack of financial resources to purchase raw materials and key equipment for their projects such as: sewing machine, and electric mixer.

As a successful model, one of the organizations (the Women's Union) opened a small workshop for the production of children's clothing and bedding, which opened the way to provide an opportunity for ten women to work in this project. The WGSS also provided safe spaces for girls to meet and express themselves, take part in reading and learning English language and computer literacy courses (Interviews and Document reviews). Besides, the WGSS participated in social media campaigns and distributed dignity/hygiene kits. These interventions have contributed to empowering and protecting vulnerable women in crisis-affected areas and detecting GBV cases. They also enhanced women's life skills and self-confidence to face the troubles of daily life and sometimes protected women victims of rape and sexual harassment from being killed by their families.

UNFPA also supported legal awareness sessions held at the WGSS to strengthen women and girls' awareness towards ending early marriage, inheritance of women from their families and migrants' rights. But the legal intervention is still limited only in the context of awareness and does not include providing legal services related to dealing with the case when it reaches the police, the prosecution and the courts (Interviews and SIS reports).

Strengthening GBV Policy guidelines, strategies and evidence based response

During the period of evaluation, UNFPA, in collaboration with other stakeholders, contributed to the strengthening of GBV policy guidelines and strategies through coordination leading the development of the GBV sector strategy, standard operating procedures (SOPs), updated service mapping tool and initiated the rollout of the GBV-Information Management System, (GBV-IMS), called PRIMERO.

GBV-IMS became effective and was introduced to service providers and partners in Libya to increase safety and equality in GBV case management service provision and documentation. The system allowed service providers to gather and analyse data on GBV incidents and systematically prepare response

[112] UNFPA Newsletter, 2021

strategies. Additionally, under this pillar, UNFPA developed the procedural manual for GBV and for case management to enhance the quality of services provided by the national partners. This intervention also corresponds with developing the GBV strategy in 2020. Interviews with CO staff indicated that only two IPs within the gender sub-sector have access to the GBV-IMS. The reason is the sensitivity of documenting information related to victims of violence, especially rape and the lack of sharing information protocol. If a victim's family finds such information, they may kill her. Also, if this information falls into the hands of armed militias, they will exploit these women to engage in prostitution.

The Rapid Response Mechanism (RRM)

Document reviews and interviews with IPs indicate that UNFPA, in collaboration with IOM, WFP and UNICEF, responded effectively to the Covid-19 within the humanitarian context and the IDPs using the rapid response mechanism (RRM), targeting Tripoli, Murzuq, Sabha, Benghazi and Ghat. Accordingly, UNFPA distributed dignity kits; 7,878 in 2019, 14,000 in 2020 and 2,126 in kits in 2021. in addition, 4000 male kits were distributed to the male IDPS in the displaced settlements The dignity kits were sensitive to women's needs, contained items for female hygiene, health, protection and well-being, and were distributed in the WGSS and IDP camps. These contributed to protection and enhancement of dignities for the vulnerable population, at risk of COVID-19 infection.

Through procurement and distribution of dignity kits, UNFPA enabled increased access to integrated SRH and GBV services to the affected populations, especially GBV survivors and IDPs. The dignity kits were distributed through the IPs and mobile teams.[113] Interview with IPs confirmed that UNFPA, in partnership with the Libyan MoSA, INGO, IMC and local women-led organisations, initiated and expanded various projects in 2020. These projects aimed to prevent and respond to all forms of GBV, particularly violence against women, especially migrants, refugees, and host communities.

UNFPA supported structuring on a solid basis the interventions involving relevant governmental institutions and actors, including MOSA and MOH, to combat GBV. In 2020, in partnership with LibAid and with the support of the European Union Trust Fund (UETF) for Migration, UNFPA had, for the first time, scaled up its interventions to protect migrants and refugees in detention centres, especially women and girls who are at high risk of GBV. UNFPA conducted several monitoring visits and provided psychosocial support services inside the detention centres. Despite the limited services offered to women in detention centres, they are still essential services that provide medical and personal needs, in addition to legal assistance.

Commemoration of International Days for Advocacy

UNFPA, in collaboration with GBV stakeholders, supported awareness-raising campaigns to eliminate harmful practices, like GBV among girls and women at a national and sub national level. Interviews and reviews of SIS reports indicated that the 16 Days of Activism against GBV aimed to attract members of the Libya community to be active participants and eliminate violence against women and girls. The themes for the days were determined through survey conducted by UNFPA to determine community priorities, in addition to existing gaps in practices, enhancing evidence-based advocacy. Additionally, the campaign aimed to expand accountability to address GBV in Libya by all. It pushed for a mass mobilisation of all communities to promote collective responsibility in the fight to eliminate violence against women and girls and encourage society to acknowledge that GBV is an issue of criminal and social justice and social norms issue. The campaign emphasised that solutions to GBV include changing society's attitudes towards women and holding the government responsible for implementing a national law to protect girls and women's rights. Interviews with IPs confirmed that the advocacy and awareness efforts on empowerment of women and girls are slowly yielding results, with parents allowing their girls to go to school in addition to allowing them to acquire technical skills (language and computer skills), a situation that could never be witnessed before the awareness raising campaigns.

UNFPA employed different ways to address girls' early marriage and GBV in the community. In collaboration with CBOs, UNFPA supported funded community activities through capacity building, in addition to targeting youth and adolescents for awareness sessions, particularly addressing the issue of child, early and forced marriage.[114] UNFPA 2019 annual report confirmed that the campaign used technology[115], social media, arts, journalism, religion, culture and customs to promote its key messages. The campaign reached 7,327 people through awareness sessions and over 1.5 million people through social media. Interviews with IPs also confirmed that the campaign included developing social media materials

[113] Interviews with UNFPA gender team, IPs and Beneficiaries
[114] Interviews with youth organizations
[115] UNFPA Annual report 2019

to engage youths in fighting GBV, and this was observed to reducing use of aggressive language towards women and girls.

Toll- free hotline GBV

In 2019, UNFPA Libya launched the first hotline with the free number 1417[116], in partnership with the local NGO PSS Team and under the supervision of the Libyan MOSA. This activity is part of the UNFPA GBV component. The hotline proved instrumental in providing psychosocial support, legal counselling and referral to immediate health services for the people in need. In 202, the hotline provided support to 14,382 individuals, 10,315 of which were women and girls.[117] Moreover, interviews with UNFPA partner CSOs confirmed that the hotline was an critical tool to support vulnerable women and girls. Also, the UNFPA team confirmed that the hotline currently operates for 12 hours a day, and they plan to operate it for 24 hours. The hotline is also available in three languages Arabic, English and French.

Strengthened capacity and Partnerships in GBV response

UNFPA promoted institutionalization of GBV response by establishing the GBV Unit within the MoH. It also strengthened the capacities of national partners and women organisations through the Training of Trainers on case management and CMR. It provided technical support and organised training on case management with the global team. This training was certified to enable participants to share this knowledge by training their colleagues. The trainings were conducted despite the challenges of securing the funding and the COVID-19 restriction. Moreover, UNFPA has a task force that collaborates with the global team to monitor each implementation plan of trainees and their knowledge sharing experience. Collaborating with UNFPA global team ensured providing high-quality training. UNFPA Libya staff also monitored the training to ensure that trainees could transfer this knowledge to others through peer-to-peer learning on case management.

Additionally, UNFPA with the support of the Regional office and WHO regional office conducted ToT CMR training adopting the new manuel in partnership with MoH. 24 Health providers from different health facilities targeted and several sub trainings conducted in different locations (Tripoli, Sabha and Benghazi).

Moreover, UNFPA supported municipality personnel by developing guidelines in the referral pathway in Tripoli. It trained 298 municipalities staff on GBV issues and assessments to enhance municipalities staff capacities to collect data systematically. To strengthen the capacity of the local governance structures in addressing gender-based violence (GBV) issues in Libya, UNFPA and UN Women, along with local partners, have scaled up activities to build the capacity of municipalities and enhance the resilience of local communities by providing services to GBV survivors and those at risk. This project is generously funded by the Government of Catalonia and the Municipality of Barcelona.[118] Also, 34 CSOs became aware of the importance of the government role in fighting GBV through legislation and documentation. 68 employees from different governmental sectors also received training on reporting, structured planning and implementing conferences. As a result, these employees have become capable of providing high-quality service to Libyan communities.

Multisectoral Coordination of GBV Response in Libya

Interviews and document reviews indicated that UNFPA contributed to strengthening GBV response coordination through its support and leadership of the GBV sub-sector (GBV SS) under the Libya Protection Sector. With technical and financial support, UNFPA, as a co-chair, facilitated conduct of monthly meeting of stakeholders, including Ministry of Social Affairs with key issues discussed, informing programme in the various areas of responsibility. Interviews confirmed that the coordination mechanisms also enabled leveraging resources and partnerships to ensure that areas of gaps were prioritized for response by the partners. Resource allocation was also ensured, maximizing achievement with the available resources and eliminating duplication of effort among the actors addressing GBV. Interviews with partners and CO staff further confirmed the coordination mechanism has enhanced advocacy mechanisms aimed at responding to GBV in the country, particularly in the humanitarian set up. In addition, the respondents stated that the GBV SS was a useful forum for enhancing implementation and monitoring of GBV response and prevention. Interviews also revealed that UNFPA support through GBV SS facilitated access to GBV services in the target locations through mapping of partners with respective services and coordinating training of humanitarian actors, ensuring vulnerable

[116] UNFPA Annual report+ interview with GBV team
[117] UNFPA Annual Report 2019
[118] UNFPA Newsletter 2021

women, girls, boys and men benefited from GBV prevention and response activities. This also enhanced referral mechanisms for the targeted populations.

Participation and with UNFPA's leadership of the GBV SS enabled harmonization of key messages, especially for advocacy on GBV response and prevention. The GBV SS coordination was also used by the country coordination mechanisms to strengthen capacities of the members on various aspects on GBV response and prevention (Interviews and document reviews). Interviews and document reviews established that the GBV SS facilitated monitoring of GBV activities in the humanitarian set-up through contribution of information in the HNO, further enabling mainstreaming of GBV in the HRP, with gender marker included in the plans and mechanisms for implementation included in the bids, in addition to facilitating allocation of more resources at the national level for prevention and response (Interviews and document reviews). The GBV SS also supported the members to report through the 4Ws and compile the reports in order to fill the GBV gaps and assess the needs, further enabling assessing extent of response (Interviews). Interviews and document reviews further indicate that UNFPA collaborated with various partners to develop SOPs, response strategies and technical guidelines for GBV service response. For example, UNFPA collaborated with UNCEF to develop the GBV Case management SOP and training of members on the same to strengthen capacities on case management in the country.

While UNFPA and partners strived to improve GBV [prevention and response, there were still gaps in response mechanism, particularly the male involvement was not so pronounced in the mechanisms, perceived sensitivity of the topics of discussion like child marriage and GBV may also affect the results. The instability of the governance structures is also limiting especially in implementation of strategies.

At the UN level, UNFPA also collaborated with UNICEF to develop ToR of Prevention of Sexual Exploitation and Abuse (PSEA), including steps to ensure protection while clashes are ongoing.[119] This facilitated establishment of a committee and development of tools for reporting on the same by the partners as described under the section on coordination (Interviews). Interviews also indicated that UNFPA collaborated with UN Women and UNSMIL to contribute to development of the EVAW law. These are also described in the coordination section.

Other Challenges affecting the achieved results[120]

1. The Libyan government and leadership does not prioritize GBV and consider it to be highly sensitive and should not be talked about in public, in addition, the high turnover.
2. The ongoing armed conflict in certain areas in Libya affects the implementation and limits staff availability in the field. It also affects the mobile team and restricts their movement in certain areas.
3. Implementing partners' data collection is insufficient. To mitigate this challenge, the M&E team has conducted an M&E capacity assessment targeting implementing partners and identified key action points to build up their capacity in data collection, recording and reporting.
4. Financial banking restrictions and inflation are high risks hindering local partners receipt of payments from UNFPA and other donors. also, the availability of liquidity of money is another issue.
5. Power cuts, electricity issues and internet coverages remain one of the challenges.
6. Roads between governorates are highly dangerous, and the movement restrictions cause high transportation costs.

4.3.4 Population Dynamics

UNFPA contributed to the strengthening of information generation to inform evidence-based programming, both technically and financially through partnerships and capacity building. UNFPA was the main and official source of population data for the humanitarian operation during the 1st CP. Further, UNFPA facilitated provision of projections using statistical model with high level of precision thereby providing accurate data for decision-making. Inadequate financial allocation, government restrictions on data collection limited effectiveness.

The PD component of the CP was directly implemented by UNFPA, in collaboration with the NBSC and other government institutions, aimed at strengthening information generation to inform evidence-based programming, both technically and financially through partnerships. UNFPA ensured this through supporting training and providing technical assistance (document reviews and Interviews). Due to the inadequacy of resources and contextual demands in the humanitarian response, the component was

[119] UNFPA Annual report 2019

[120] Annual Reports 2019, 2020 and 2021

integrated across the other programme components (Interviews).

Table 11: M&E Framework for the Population Dynamics component of the 1st Libya CP[121]

Strategic Outcome 4: Population dynamics - **Everyone, everywhere is counted, and accounted for, in the pursuit of sustainable development**						
Indicators	**Baseline**	**Targets**	**Achievements**			**Comments**
			2019	**2020**	**2021**	
CP Output 5: **National data systems are strengthened to increase the utilization of demographic intelligence at national and local levels**						
Number of household rapid assessments of the populations affected by a humanitarian crisis conducted	1 (2018)	3	1	1	1	The target is achieved, but includes the baseline conducted in 2018.
Percentage of municipalities able to generate and use mapping to illustrate the vulnerability of the population to disasters and humanitarian crises (%)	10 (2018)	20	6	29	20	Target achieved
National Census Action Plan developed and endorsed	No	Yes	No	No	Yes	Instead of a census action plan, the Libyan authorities agreed to have a demographic survey, with an action plan that includes population estimation, and UNFPA supported in its design from concept note until its approval.

Strengthened national data systems for increased utilization of demographic intelligence at national and local levels

During the period of evaluation, UNFPA supported strengthened data generation to enhance understanding and utilization through the production of the Common Operational Dataset for Population Statistics (COD-PS) with age, sex and geographic disaggregation up to administration level 3, facilitating demographic projection for the non-displaced Libyans. UNFPA also supported NBSC in digitizing enumeration areas (EA) in six municipalities, enabling production of maps and geo-reference population data at EA level, with the ArcSoft GIS, and the NBSC supported on generating of data used in the Pan-Arab Project for Family Health (PAPFAM) 2014 and the household Multi-Sector Needs Assessment (MSNA) RH indicators. In addition, the CP also supported the NBSC's capacity in producing geo-referenced data (document review and interviews). In collaboration with NBSC and National Centre for Disease Control (NCDC), UNFPA conducted a trend analysis of previous household surveys conducted in Libya between 2014 and 2018. These will contribute data supporting determination of key social, health and demographic changes that affected the Libyan population during the years of conflicts and political instability (interviews and document reviews). In addition, the data will also be used for production of prioritized SDG indicators, including determining proxy indicators, where they are absent.

Towards producing data to inform decision-making, UNFPA supported production of multidimensional poverty index (MPI) in collaboration with the Oxford Poverty and Human Development Initiative (OPHI) of University of Oxford. It is though not clear how this was used to inform decisions in the development of the country. While at the design stage the CP was to support the conduct of population and housing census since the last census was conducted in 2006 and needed to be updated, it was not possible due to financial and technical limitations. In order to remedy this, UNFPA supported the NBSC to develop a concept note to conduct demographic survey, which is a hybrid census, incorporating population estimation, with the support of the UNFPA headquarters (HQ) on the usage of the delimitation of the enumeration units. A meeting supported by UNFPA already held in Senegal with UNFPA experts meeting with the government authorities and consensus built on the methodology (Document review and interviews). The concept note was approved by the government, but faced challenges with financial allocation as it was to be done in 2020 and now allocated and slated to take

[121] Green implies that the target has been achieved; Yellow means the achievement in significant; Red means far from being achieved

place in 2022 (document review and interviews). It is hoped that the conduct of the demographic survey will include population estimation and should allow for updating the 2006 Census demographic data at municipality and national levels, in addition to enabling estimation of the various social indicators, including those of RH, Gender and GBV, and youth. With the planned demographic survey, nationwide enumeration will facilitate determination of the sampling frame, in addition to using GIS technology for geo-referencing using satellite imagery for areas with large population displacement. This will also contribute to the conduct of the full census as the frame shall have been determined and the boundaries for the municipalities clearly defined with the current support of the NBSC by UNFPA (interviews and document reviews). At the time of the CPE, however, the Minister for Finance faced a legal case and had fled the country, posing another challenge to the activity especially on allocation of budget.

Under the humanitarian response, UNFPA contributed differently in informing the performance towards provision of services to the affected populations. Towards executing the UN global mandate, UNFPA was the main and official source of population data for the humanitarian operation. With over 15 years without updated census data, UNFPA enhanced evidence-based programming through providing projections using statistical model with high level of precision thereby providing accurate data for decision-making in the HRP across the three years (interviews). UNFPA is a member of the humanitarian intersectoral working groups including assessment and Information Management Working Groups since it co-leads and a member on the GBV SS and health sectors respectively, and by extension, part of the protection sector (document review and interviews). As part of the different sector or areas of responsibility (AoR), UNFPA contributed to the analysis of humanitarian needs overview (HNO) for the sector and humanitarian monitoring and quality of programming through ensuring coordination of partners' reporting on the RMNCAH and GBV, and interviews revealed that UNFPA sectors were effective in complying with the reporting mechanisms.

The country's humanitarian response also benefited from UNFPA's relationship with the NBSC, supporting the humanitarian operation through providing the COD dataset enhancement defining the administrative boundaries and the related population targeted, disaggregated by age, sex and administrative boundary. This informed the country's humanitarian response cycles (interviews). While this is a key aspect of informing humanitarian response, there were challenges in accessing the information from the NBSC, with their capacity also being cited as a limitation on accessing various data details from the government, especially on the administrative boundaries as the current ones do not provide the real picture (interviews). UNFPA was however reliable in getting this data from the government (NBSC) which facilitated decision-making.

With the inadequacy of updated data, and given that UNFPA is an authority in data generation, the stakeholders interviewed expressed inadequacy in the area as they expected UNFPA to conduct a country-level assessment to provide country level details for status on population. UNFPA however cited challenges within the context, including non-allocation of resources and difference in priorities and focus by the government to conduct the assessment. Inadequate investment on data collection by the humanitarian partners and prioritization of service delivery, was also cited as a contributing factor to data generation across the targeted population (interviews). Division of the authorities and inadequate capacities also limited data generation, with the current main sources of data being survey conducted by REACH Initiative and IOM DTM for regular migrants and IDPs and returnees (interviews and document reviews). UNFPA is also part of the Rapid Response Mechanisms – UNFPA, IOM, WFP and UNICEF which facilitated rapid response to people in need (PIN) and the data provided contributed to timely information of the response through conducting a rapid assessment (Interviews and document review).

Towards enhancing health information systems, UNFPA supported the roll-out of the District Health Information System (DHIS2) in collaboration with health stakeholders, including the Ministry of Health. UNFPA supported in training of health staff in 14 municipalities, in addition to providing them with electronic machines to the municipalities to be used by the trainees to transmit the data to the provincial levels for statistical analysis. It is imperative to note that during the development and operationalization of the DHIS2, UNFPA influenced the inclusion of maternal and child health indicators, enabling capturing from the health facilities (interviews with MoH, UN agencies and CO staff). The CPE established that the

> It is the first time data on maternal mortality rate is being collected in the country. We initially thought that the cases were not there or too few to be collected, and never saw the need to capture it. With its inclusion in the DHIS2, through the support of UNFPA, it has enhanced surveillance within the target health facilities, in addition to supporting decision-making – **KII Respondent from MoH, Libya.**

data generated from the health facilities through the DHIS2 had begun to show a difference, enhancing surveillance on maternal and neonatal surveillance, and the dashboard showing the summary (interviews). It was though reported during the interviews that the coverage for the DHIS2 was still limited and needed to be expanded.

UNFPA contributed to strengthening capacities of various stakeholders in the country and supporting on data generation. During the period under review, the regional office facilitated a training for the NBSC on geo-referencing. UNFPA also hired consultants to train the NBSC on GIS and use of data collection softwares, skills that were confirmed to have been very useful in strengthening data generation and analysis, informing policy and programming, including resource allocation. UNFPA also agreed with the NBSC to complement their database on SDG monitoring, with a new unit created in the Ministry of Planning to work on this. In addition, UNFPA utilized South-South cooperation with Paris21 to support the NBSC on the development of the National Strategy for the Development of Statistics (NSDS) and according to the African Union set of guidelines for statistical system[122] to improve the quality of data and production of statistics. The implementation and roll-out of the NSDS has been slowed down and halted respectively due to political division in the country (Document review and Interviews).

At the local level, the geographical boundaries of 200 *muhallas* digitalized, covering about 20% of the municipalities, by the NBSC, with the capacities of the municipalities strengthened to produce maps illustrating population vulnerabilities. However, it was reported that only six of the municipalities had the technical capacities to use these maps for the purpose of decision-making. While UNFPA played a critical role in strengthen the statistical systems in the country, including informing the humanitarian programming cycle, some stakeholders felt that UNFPA has deteriorated in provision of this support to the stakeholders, with a feeling that the agency can do more, given its statistical expertise, and the existing gaps in information. There were also reported delays and inactivity in provision of population data to the humanitarian coordination team for response planning.

4.3.5 Integration of Gender and Human Rights

EQ4: To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?

The 1st CP was anchored on a rights-based approach through targeting and supporting marginalized and vulnerable populations with services and advocacy mechanisms to engage duty bearers and rights holders to increase the voices of the marginalized and at-risk groups, including the migrants, and people with disabilities, while at the same time aiming to eliminate harmful practices. Gender is mainstreamed across the thematic areas. However, capturing of sex disaggregated data was limited, in addition to inadequate focus on disability.

Generally speaking, the UNFPA Libya CP delivery was anchored on a rights-based approach, while at the same time mainstreaming gender into the four components of focus. From document analysis and interviews, the programme design and implementation incorporated human rights approaches and gender mainstreaming in its strategies of targeting marginalized and vulnerable populations with services and advocacy mechanisms to engage duty bearers and rights holders to increase the voices of the marginalized and at-risk groups while at the same time aiming to eliminate harmful practices. UNFPA further ensured that there was inclusion in the services delivery, with interviews revealing that UNFPA supported assessments, advocacy training and supporting development of SOPs, strategies and policies to increase targeting and reduce effects of marginalization.

UNFPA embedded human rights perspectives in the delivery of its services on SRHR. UNFPA ensured access to SRHR services at the facilities it oversaw did not require being a citizen or a legal resident of Libya, thereby ensuring a human rights perspectives to the delivery of the services. It was also not specific to any gender, age group or race. The services supported by UNFPA were noted to be particularly targeted at vulnerable populations in the community and also those held in detention camps.

[122] The African Union, through the Strategy for the Harmonization of Statistics in Africa (SHaSA) supports production of statistics using methodologies that reflect realities in the member countries and enabling comparison across the counties.

UNFPA's focus on integrated RH needs and rights of the most vulnerable, including people with disabilities, marginalized women and girls, among others is also evidence of a human rights perspective. In addition, UNFPA supported the selection of locations with needs through the availability of data contributing to the HNO, with locations lacking service delivery being targeted through the mobile health teams indicating the intention to reach those most in need. Nonetheless, the entire orientation of the UNFPA CP supports the realisation of rights to RH including for safe motherhood, cancer care, family planning, HIV prevention, for adolescents, around GBV and for the empowerment of women (document review and interviews).

The CP enhanced youth targeting through conducting assessments and ensuring that there were no discriminations against those marginalized, including ensuring that there were no negative attributes on the migrants (interviews). The action of supporting host families with migrants, including youth, with cash and making efforts, through CESVI, to link the migrants with their families is also based on enhancing their rights and dignities (document reviews and interviews).

The GEWE component of the CP is gender focused and, interviews confirmed UNFPA's commitment to ending gender inequality and human rights violations, which are key barriers that must be addressed to end GBV and harmful practices, including child marriage, sexual violence and other types of discrimination and vulnerability; embracing a rights based approach to support the affected populations. Interviews conducted with IPs confirmed that they upheld inclusion and empowerment in their quest to provide services to the affected populations. For example, the component supported different advocacy and policy mechanisms that aim to ensure accountability on human rights of marginalized groups, gender equality, women's reproductive rights issues and GBV preventions and response in the country (Interviews and document review). In addition, there were also support for training of IPs on gender issues, establishment of women and girls'-friendly safe spaces (WGSS), and including the support to vulnerable women and girls in the humanitarian settings and GBV survivors with dignity kits (Interviews with IPs and CO staff). These principles were found to be consistently applied in programme planning and implementation processes. Further, interviews with IPs revealed that the WGSS gave equal opportunities to women with disabilities, who did not have a chance to go school, on TVET. This exhibited the rights-based approach.

UNFPA in the PD support to the NBSC supported the production of gender, age and sex disaggregated data from the in-depth analysis of previous reports to inform programming decisions. This provided the opportunity to draw on the age, gender and diversity dynamics. It is not however clear how the data was used to target age or gender-related focus in the programmes supported by UNFPA during the period of review. While the interviews indicated programme focus on gender mainstreaming, review of programme reports did not however provide sex and age disaggregated data among the beneficiaries of the programme (document review and interviews). The support to NBSC also enabled capturing data on the elderlies, in addition to people with disabilities. There CP's focus on inclusion and targeting without discrimination is evidenced in the programme deliverables, especially in the humanitarian response. There is however no evidence of a specific programme targeting the PLWDs or the elderlies, based on assessments or analysis conducted through the CP.

With rights-based approaches and mainstreaming of gender inherent in the design and implementation of the CP, UNFPA ensured that monitoring processes also captured the same, including reporting from the field. Inherent. UNFPA developed gender-relevant indicators at the outcome and outputs levels and guided the CP reports from the IPs through development of templates guiding collection of gender-disaggregated data from IPs. For example, UNFPA reported on the '*Number of disabled women and girls subjected to violence that have accessed the essential services package'*, and highlights the commitment to inclusion (SIS reviews). UNFPA programming, among other stakeholders, faces challenges, especially contextual given that there are existing patches of conflict, which is prone to abuse of human rights, and may not be reported due to fear of reprimand or incarceration. Further, the interventions, especially in GEWE are affected by inadequacy of policies, in addition to the Libyan government and society remaining very conservative and with GBV considered a taboo. The youth programming was also limited in funding, and therefore not much could be captured (document reviews and interviews).

4.4 Efficiency

EQ5: To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme?

Summary of Findings: Overall, the CO made good use of its human, financial, technical and administrative resources to deliver the programme activities, in addition to strengthening internal controls, ensuring compliance and accountability. There is however room for improvement especially in terms of enhanced programme integration, increased focus on results, and enhancing adaptation of programming within COVID-19 context.

4.4.1 Programme strategic management

UNFPA put in place strategic mechanisms to facilitate the programme delivery in an efficient manner. Firstly, the CO employed partnership as a mechanism to facilitate the 1st CP delivery. UNFPA partnered with various stakeholders emanating from donors, government, IPs, UN agencies, among others to ensure the programme was implemented in an efficient manner. To begin with, UNFPA strategically partnered with both international and local NGOs as IPs to ensure implementation of the CP. Partnership with international NGOs enabled capacity development and compliance of the locals facilitating efficient CP delivery (Interviews and document reviews). Partnership with local NGOs enabled access to hard-to-reach and areas, targeting the vulnerable populations with much-needed services on SRHR, A&Y, and GEWE. In addition, the local NGOs facilitated understanding of the local context, which enabled faster decision-making, including effectiveness in negotiation with the authorities for access to the target locations of service's needs. Partnership with the local organizations also ensured acceptance from the communities targeted. This ensured efficiency in delivery of the CP services. For example, UNFPA international and national staff, being UN staff, needed to undergo a lot of approvals to move to the field, and therefore partnering with local IPs made it easier for them to move freely, without much restrictions (Interviews and SIS).

UNFPA was applauded by the respondents during the CPE as being very strategic and was depended on by the peers to facilitate participation of the government in the activities of the UN or other endeavours. This was due to the relationship that was fostered by the CO, through the leadership, in addition to the recognition of the role played by the government in policy and strategic support. UNFPA worked closely with various government line ministries to deliver the components[123]. This enabled participation of various government entities in the activities of the agencies. Partnerships with the government also contributed to advancing advocacy mechanisms especially on development, ratification and implementation of various policy documents and guidelines (interviews and document review). For example, UNFPA was depended on to bring on board the various government agencies including women Members of Parliament to the EVAW-led committee, which facilitated support to the endeavour (Interviews). UNFPA partnership relationship with the government also enabled resource mobilization. For example, UNFPA's partnership with NBSC enabled allocation of funds to finance the implementation on the demographic surveys. In addition, partnership with the government facilitates support with facilities, like the health facilities being used through UNFPA support to provide services, instead of leasing or constructing which would lead to a lot of capital venture (interviews and document reviews).

Through partnership with international NGOs, there was evidence of contribution into the delivery of the CP services, through leveraging of resources from other sources (Interviews). The NGOs reported co-sharing, ensuring that UNFPA did not incur all the costs involved in delivering the CP services. The arrangement also came with capacity to deliver programmes, with technical knowhow as the NGOs were selected based on their global technical expertise in particular thematic areas. This also reduced costs on staff and operation. For example, it would have been expensive engaging staff to implement the CP interventions (Interviews with IPs and CO staff).

UNFPA also contributed to strengthening coordination with various entities within the various CP components. This was through participating as a member of sector, co-chair, joint programmes or facilitating coordination mechanisms within the UNCT or HCT. Participation in the technical working groups enabled standardization of delivery of services through development of technical guidelines and standard operation procedures, enhancing quality of service. Participation in a technical multi-stakeholder

[123] Document reviews and Interviews

group ensured leveraging or resources, reducing overlaps and also ensuring wider reach with services (Interviews and document reviews). There was also evidence of training activities with experience sharing which enabled capacity strengthening, including synergies among stakeholders. For example, during the 16 days of activism, UNFPA ensured development and dissemination of harmonized advocacy messages (Interviews).

UNFPA's partnership with donors also contributed to the CP's interventions being financed to support the existing needs in the country along the components. Interviews with donors indicated that UNFPA Libya CP focus was relevant to their strategic objectives in the region. For example, the European Union Trust Fund (EUTF) focus is to ensure mainstreaming of gender in line with its Gender Action Plan, in addition to ensuring increased access to primary healthcare, including RHR in Libya, areas which UNFPA also focuses on and these enabled access to resources to facilitate delivery of the CP components (Interviews and document reviews). Further, EUTF's gender strategy with a specific component on GBV is in line with UNFPA's focus on GBV in the country through supporting local CSOs. In the period of coverage by the CPE, UNFPA managed to mobilise USD 14,065,661.5, which was made possible through an effective and aligned CP components (Interviews and document reviews). There were though concerns on UNFPA's responsiveness and pro-action in decision-making, especially on provision of information or taking action as required by the donors (Interviews).

UNFPA also utilized technical assistance through provision of expert advice and support to the government and stakeholders in the CP components of RH, A&Y, GEWE and PD, which facilitated effective transfer of skills and knowledge on the subject matters, further strengthening capacities. In addition to the technical staff that the CO had to support programme implementation, UNFPA also utilized the services of consultants, both international and national, facilitating expertise transfer of knowledge and skills. The act of utilizing local consultants also provided an opportunity to sustain skills transfer (Document reviews and Interviews). UNFPA also utilized the South to South Cooperation to facilitate expert transfer of skills and delivery of the programme. For example, UNFPA received support from Nairobi and Turkey on implementation of the Training of Trainers (ToT) on Leadership, Management and Governance (LMG), through recruitment of a technical specialist with the help of ICM and Nairobi Midwifery Association to train Nursing and Midwifery Leaders of Libya, with the logistics, visa and venue arrangement being facilitated by UNFPA Turkey (Document review and Interviews).

UNFPA leadership was also hailed as contributed to a lot for facilitating delivery of the CP. UNFPA first Country Representative under the CP was credited for her advocacy prowess and made a lot of efforts in raising the profile of UNFPA in all the areas of responsibility and this worked effectively, in addition to raising more resource the CP intervention (Interviews with Donors and UN agencies). Her early departure and delay in filling the vacuum left by her departure caused some leadership and programmatic setbacks, especially in decision-making and advocacy mechanisms, and wavered the confidence of partners in UNFPA's ability to deliver in their commitment without her, as noted by some of the stakeholders interviewed. The deployment of a new representative, despite having been done has not gone without the challenge of a new leader having to understudy the country and activities before being able to effectively pilot the organization's activities. However, it is noted that the organization was able to recover from its leadership challenges and achieve almost all its targets.

Despite dedicated effort for effective coordination of activities, there was one instance where coordination was suboptimal or could have been improved. For instance, IMC implemented activities across SRHR and GBV for UNFPA. However, because the management of these thematic areas were by different officers within UNFPA, the organization requested for separate reports for the two themes from the same partner. This placed undue pressure on the partner and made reporting cumbersome and sometimes repetitive. There was a delay in granting partners approval to work in Tripoli which led to a setback by about six months by the partner contracted to work in that city. While this setback delayed implementation of activities, it did not impact on achieving the targets that were meant to be achieved at the end of the period. The government had also committed to providing mannequins for demonstration sessions. However, these were not delivered when needed. The non-availability of these mannequins influenced the quality of trainings delivered to participants on RHR practices.

UNFPA utilized communication as a strategy to raise its profile among stakeholders in and out of the country. With the existence of the UNFPA's communication unit, and introduction of an Annual Newsletter, *Voices from Libya*, its visibility and profiling has improved among the stakeholders (Interviews with CO and UN agencies' staff). The

Communications Specialist also has been representing UNFPA in the Inter-Agency Communication Group in the UN as Chair of the Communications Group since September 2021, and this has enabled positioning of UNFPA to profile its CP activities in the country. For example, initially, UNFPA was not so much pronounced in its work on SRHR, GEWE, Youth and PD, but because of it's the representation in within the UNCT, this improved, and came out as an agency contributing to the effective identification and support of the migrants and vulnerable populations. This has also facilitated delivery of common coordination mechanisms ensuring leveraging of resources including conducting messaging activities together and in a coordinated manner, including communications on elections, advocacy issues, Social media groups, promotion of vaccination, Newsletter for the UN in Libya, among others (Interviews).

4.4.2 Organizational and Resource Management

Interviews and document reviews indicated that UNFPA's organizational and operational management mechanisms were fairly efficient and effective in delivering the CP processes. Skilled human resources were in place, financial systems and management across the CP working well, with financial resources being effectively distributed and accounted for. There was also significant resource mobilization during the period of review as stated in Chapter 3. UNFPA put in place mechanisms to ensure organizational and resources were management in an efficient manner, ensuring achievement of CP results.

On ensuring organizational effectiveness, UNFPA CO put in place mechanisms to ensure monitoring and quality assurance. These were evident in the execution approaches which were both through national and direct execution (NEX and DEX). UNFPA had a clear and robust system for ensuring checks and balances, and to ensure that IPs were accountable for deliverables in a timely manner. The evaluation established that there was a strong and consistent system at UNFPA CO to review quarterly work plans, partner financial and programme reports and provide required feedback mainly on completeness, quality of reporting and absorption/utilisation rates of the funds. UNFPA CO ensured that regular audits were carried out with the IPs and results shared with them, and action taken on weak areas. Leadership of UNFPA also took bold actions to reduce operational and transactional costs to improve efficiency by reducing the international NGOs as IPs (Interviews and Document reviews).

UNFPA, to a little extent, spearheaded integration approach in the delivery of the CP. While interviews and document stated that there was integration of the CP delivery, there were evident coordination gaps across the four CP components. The evaluation gathered during the interviews the fragmentation in the delivery of the programme. There were however aspects of mainstreaming of GBV and RHR in the A&Y, but they were mainly at informational level. There was also no evidence of coordination of the activities among the respective component teams, towards reducing operational costs or increasing programmatic efficiency by reducing duplication and operational costs as well as increasing interactions among staff and IPs. Given the context of implementation, UNFPA recruited staff through the third-party contractor (CTG) to cover project areas not accessible by staff due to United Nations Department for Safety and Security (UNDSS) requirements that do not apply third-party recruited staff. The CTG-recruited staff were able to access hard-to-reach areas and impact, value and visibility in the humanitarian context of implementation. Recruitment through CTG ensured efficiency as it was responsible for the operations of the staff, including security which is a huge impediment for the UN staff in Libya (Interviews).

There is evidence that UNFPA Libya increasingly endeavoured to improve its operational efficiency over the years of implementation to ensure efficiency in the delivery of the CP. During the period of evaluation, UNFPA had two main offices in Tripoli and Tunis, in addition to two satellite offices in Benghazi and Sabha. The presence of UNFPA in Tunis facilitated CO support during crisis and emergencies. Interviews though indicated that the distance in Tunis and the red tape involved in approvals and length of time for visa processing for the staff wanting to travel to Libya inhibited efficiency since most international staff were based there. This however affected all the UN agencies in Libya and all non-Libya staff regardless of whether they were part of the Tunis or Tripoli office. On the other hand, the office in Tripoli ensured overall coordination of the CO operations, including finance, procurement and logistics, and programme staff. The field offices in Benghazi and Sabha enabled effective follow-up in the field activities for UNFPA, however they had staffing challenges. This also enabled UNFPA Libya to conduct its operations effectively, saving time and enhancing quality of supervision. UNFPA's presence in the field was highly valued by the IPs interviewed as it contributed to coordination and oversight for efficient delivery (Interviews with IPs and CO staff and document reviews). UNFPA also used third party recruitment to fill vacant positions in the field (Sabha and Benghazi, and some in Tripoli) to

ensure ease of access to programme locations and capacity building. For example, the WGSS staff employed by the third-party contractor, CTG, capacity built the IPs and staff in the set-ups and also facilitated reporting mechanisms for the IPs. There were also concerns of positions remaining vacant due to shortage of funds. Security also affected recruitment of staff by UNFPA (Interviews). There were still concerns where UNFPA had sufficient staff in Sabha and Benghazi, while in Tripoli, there were shortages of operation staff. In addition, UNFPA RHR team were predominantly based in Tunis, because there was limited space for UNFPA in the UN compound in Tripoli and travel to Libya from Tunis requires multiple levels of approval. This limited UNFPA's presence on the ground, especially on advocacy issues.

Interviews established that UNFPA Libya had the right staff skill sets and were reported to be generally effective and appropriate for their roles, especially in the implementation context, facilitating delivery of programme and operational functions. Interviews with IPs and other stakeholders also revealed that UNFPA had a supportive CO leadership which was identified as a contributing factor in ensuring that the implementation of the CP was effective. The IPs and government staff reported that the CO staff exhibited high level of passion in the delivery of their responsibilities. Coordination among the CO staff however inadequate as depicted in the nature of working relationships where IPs supported to deliver RH and GEWE component would share individual reports to the component heads, something that the leadership may need to work on to reduce inefficiency and harness the benefits that this comes with (interviews with CO and IP staff).

UNFPA contributed to improving office efficiency, especially on procurement and shipment of items into the country. Interviews indicated that the CO used to face challenges of delays in clearing shipments of commodities and items into the country, contributed by the office typology of the CO, where shipment documents would be sent to Tunis, where communication with Tripoli was an issue with staff in Tunis having little understanding of the context in Libya. UNFPA contracted a company on a needs basis to handle the clearance which in 2021 was reported to have resulted in positive outcomes, with no delays reported (Interviews). In addition, UNFPA also hired a local staff based in Tripoli to handle the same, instead of documentation being sent to Tunis, and this led to improvement in the processes. Despite the UNFPA team's efficient procurement, they faced challenges with the host government's purchasing policies which were long and depended more on personal connections than paperwork procedures (Interviews).

Interviews also revealed that the CO reduced delays emanating from procurement, especially those done by the headquarters (HQ) by preparing the Procurement plans for the following year by November preceding the year of implementation in January. Respondents also ensured that there were efficiencies in the procurement mechanisms with what is in the plan being implemented through constant monitoring and follow-ups. This was also the case with local procurements where follow up were done with the programme staff to submit their plans in time, which was realized. The team also expressed challenges where the procurement planning was done based on the available funds, while during the year would get emergency funds, requiring procurement of items for use in the year but they were not planned for.

Financial management within the organization was reported to be effective given existing internal controls facilitating the operational decisions. Interviews with the IPs indicated that the disbursement processes were effective, save for the IPs that did not have accounts outside of Libya who had challenges accessing their cash (IP and CO interviews)[124]. UNFPA Libya surpassed the indicative 1st CP budget by nearly five million USD in the three years of assessment, though the initial CP was to take place for 2 years, and the extension did not indicate how much was allocated for the subsequent years[125] of the extension. The process of budgeting and disbursement of the funds to IPs were confirmed to be clear and started with a budgeting process once the IP drafted their AWPs, with the budget guiding the planning. The financial team monitored the budget through financial reports via Atlas (Interviews).

UNFPA conducted annual audits using an external audit firm, with the IPs, mostly for those funded to the tune of USD 150,000 or more, or depending on the risk level involved, which is conducted on an annual basis if high risk. For low or moderate or low risks involved, the audit decision will follow the threshold (Interviews). UNFPA also conducted spot checks at least once per year depending on the expenditure level. UNFPA is part of the HACT and utilize the same audit firm to conduct the audit, reducing costs. UNFPA also conducted micro-assessments of IPs before they

[124] UNFPA disbursed funds in Tunisia and IPs without back accounts in Tunis found it challenging to access their funds. Issues were raised on excessive bureaucracy with lengthy systems of compliance to open an account

[125] The CPD was supposed to end in 2020, but was extended twice to align itself to the extended UNSF.

started working, and this ascertained the level of risk in an IP. Micro-assessments were conducted for the IPs in 2019 and 2020. IPs confirmed that the results of the audits were shared with them and recommendations addressed. Interviews with CO and IPs staff also revealed that UNFPA utilized the results of both the Micro-assessment and audit to plan capacity building for the IPs, which was effectively delivered.

4.4.3 CP Monitoring and Evaluation

The 1st CP's monitoring and evaluation (M&E) in place is fairly robust, facilitating planning and monitoring processes, as well as reporting. The CPE established through interviews with CO staff and SIS reviews that UNFPA used different mechanisms to capture performance and monitor progress of the CP, and ensure accountability to the various stakeholders involved in the country. The UNFPA M&E system is hinged on the CP's results and resources framework (RRF), the UNSF and the donors (Interviews with CO staff).

UNFPA used a global web-based SIS for annual reporting and compliance monitoring system, enabling the CO to plan, monitor and report; and is integrated with the regional, and headquarter offices for real-time status of the CP by outcome area. This was reported through interviews with the CO to be highly efficient as it enabled them to easily track progress, in addition to aligning with the UNFPA SP. The CO employed different mechanisms to assess the CP's performance and capture feedback, in addition to ensuring compliance to the accountability mechanisms in place.

The 1st CP utilized the planning mechanisms to develop the results and resources framework, which effectively facilitated alignment of the CP with the national priorities, the UNSF and UNFPA SP, with resources and targeted stakeholders clearly allocated and identified as confirmed by the document review and interviews with CO staff. There was also a confirmation of annual planning mechanisms, including setting targets based on the RRF for the CP, facilitating follow-up on progress and performance on the indicators [126]. UNFPA also held annual review sessions for the IPs, with the participation of all the relevant CO staff, facilitating experience sharing and enabling the teams to address arising challenges, in addition to planning for the following annual programme cycle[127].

UNFPA Libya put in place monitoring mechanisms, including reporting on a periodic basis to allow for assessing progress based on the planned activities. Interviews and reviews confirmed that UNFPA effectively utilized Global Programming System (GPS), AWPs and SIS to assess the effectiveness of the implementation of the CP intervention. Further, it was confirmed that UNFPA depended on an electronic system based on KoBo Toolbox for data collection and reporting by the IPs and the RH and GBV teams, enabling daily data sharing on the performance of the CP, and with consolidation directly contributing to the SIS. The M&E team confirmed training the IPs and programme staff on the system making it easy for them to utilize it for reporting. There was also confirmation of a clear formulae in place to verify the data and in case of any discrepancy, there is follow up made with the respective IPs or staff, making it an effective tool for assessing the CP performance. Interviews with donors and CO staff also confirmed that the UNFPA reporting processes were effectively done through the support of the KoBo platform for reporting, especially given the context where some donors, particularly EUTF, expected narrative reports[128] to be delivered on a weekly basis.

On financial monitoring, UNFPA used FACE forms that the partners used to report on a monthly basis, and this was effective for monitoring the budget utilization by the IPs, and in case of deviations, corrective actions were taken. Interviews also revealed that Spot checks were also conducted at least once per year per IP depending on expenditure level and the risk involved, by UNFPA to assess their compliance and quality assurance. In addition to ensuring compliance, this also contributes to minimizing the inherent risks about delivery of the CP. In the period of evaluation, UNFPA conducted audits based on the cycles of the IPs, conducted by external auditors commissioned by the headquarters, in addition to be a members of the Harmonized Approach to Cash Transfer (HACT) where UNICEF and UNDP are members and complemented each other in the audits, which also contributed to efficiency in the delivery of the CP as the IPs already audited by any of the agencies are not audited (Interviews and document review).

In addition to the field monitoring visits by the M&E staff from Tripoli, the programme component staff also had an active role in monitoring of CP component activities. UNFPA also had monitoring focal points in Sabha and Benghazi cities to cover West and East respectively. The field monitoring activities enabled feedback provision to the IPs, support supervision to the IPs, including capacity building them in areas of

[126] Interviews with CO and IP staff and Annual Planning 2019 - 2021

[127] Interviews with IPs and CO staff

[128] The KoBo platform only captured the data on programme achievement, and not financial details which were captured by the Finance team.

weakness. Interviews with the CO staff also revealed that UNFPA incorporated accountability to affected populations (AAP) through conducting surveys to measure the satisfaction of the beneficiaries, in addition to utilizing complaint boxes where beneficiaries could provide their feedback on the delivery of the CP. On the other hand, UNFPA also collaborated with third party monitors, Altai Consulting and Global Initiative, engaged by the EU Trust Fund, where UNFPA prepared a monthly plan and shared with them for verification on the implementation status. This was also confirmed to have contributed to UNFPA monitoring and learning from their implemented interventions since the results were shared with them by the donor.

The IP reporting was confirmed to be compliant with UNFPA requirements, with regular daily, weekly, quarterly and annual reports based on the timelines and reporting templates provided by UNFPA. The IPs across the programme areas confirmed being clear on the reporting system and that it also served their interest in improving their understanding of their performance (Interviews with CO and IPs, and document review). UNFPA also confirmed report through the SIS on an annual basis, providing the CO with the opportunity to consolidate the performance. Analysis and review of the annual reports reveals that the quality of the narrative report tended to focus on activity achievements over outputs and measured contribution to outcomes. This is a limitation requiring strengthening, especially on capacity development on results-based management. There was however registered improvement, especially on results capturing in the 2021 SIS which indicated an improvement in quality (report reviews). While in the design of the CP there was a costed evaluation plan in the annex for the GBV and SRH, the CO decided to conduct a CPE to enhance accountability and to support evidence-based programming, especially for the next programme cycle (Interviews with CO staff). Interviews also revealed that the oversight role of the government was limited, or not there, despite approvals for operations of field missions, due to the limited human resources, technical and financial capacities to undertake the same, and difference in political affiliations – conflict.

The M&E unit for the CO is led by an expatriate M&E/ Reporting Analyst, based in Tunis, and assisted by a national M&E Analyst based in Tripoli. While the expatriate staff is based in Tunis, with security and travel clearance required for her travel to Tripoli, and at times limited, the national analyst is able to access programme sites, security allowing, to support the IPs in their areas of weakness, which was reported by the IPs as quite useful for their learning. In order to remedy the contextual challenges, especially access, the M&E teams have devised mechanisms of frequent communications, especially with the daily data submission through the KoBo platform has facilitated effectiveness and assurance in the deliveries by the IPs and other programme activities[129]. There was also confirmed support from the ASRO M&E Advisor who facilitated a training workshop on RBM, and workshop on experience-sharing from the region with similar contextual set-up, in addition to conducting missions to Libya to support[130].

There was evidence on utilization of M&E information for reporting to the donors, UNSMIL, and assessing IP performance; keeping track on performance based on the CP targets; and assessing partner capacities for effectiveness. For example, from analysis of deliverables by the IPs, which had technical quality issues and challenges, the CO hired two staff with technical skills and communication and assigned them to the WGSS. Interview feedback confirmed that the hired staff were able to capacity build the staff at the WGSS improving the quality of their deliverables. While interviews revealed that there is little capturing of learning points in the reports, there were reviews done by the programme teams with the IPs and targets set based on experiences, and payments to IPs being based on performance.

[129] Interviews and review of documents

[130] Ibid

4.5 Sustainability

EQ6: To what extent has UNFPA been able to support implementing partners and beneficiaries (women and adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?

Summary of Findings: The Libya 1st UNFPA CP was implemented in collaboration and partnership with both local and national partners. The CO facilitated national ownership through consultation and development strategies directly contributing to the objectives of the line ministries. Further, the line ministries contributed to the CP deliverable through management and monitoring of the some of the facilities e.g. the WGSS by the MoSA. The CP implementation modality of working with national IPs also enhanced trust within the community, thereby enhancing ownership. The CO also strategically strengthened the capacity of the national stakeholders and institutions, spanning the technical areas and needs across the components, including policy and strategy development, guidelines SOPs and tools development. This also facilitated skills transfer, thereby enhancing technical capacity to deliver quality services. Limited government capacity both financially and technically, to monitor and retain the trained skilled personnel, in addition to weak governance exacerbated by political instability, will hinder continuity of the gained results by the CP in the context.

4.5.1 National Ownership

Despite the volatility in the context of the CP implementation, UNFPA put in place mechanisms to ensure long term effects on the results for the partners and beneficiaries supported to the extent possible. During the period of review, UNFPA utilized partnerships with local implementing partners, constructed facilities, capacity built the government and stakeholders on various aspects of the CP components, supported development of strategies and standard operating procedures, and strategically collaborated with the government departments ensuring long term results[131].

Towards implementation of the CP, interviews with key informants indicated that UNFPA collaborated with the government agencies during implementation, promoting consultation and ensuring that the interventions contributed to addressing government strategies. This promoted national ownership of the results of the interventions support and therefore the possibility of sustainability. UNFPA worked closely with the Ministries of Health, Youth, Social Affairs, Education, Higher Education; Planning and higher learning institutions; among others, including NBSC, where the ministries directly contributed their staff and paid their salaries, providing facilities for interventions and participating in development of strategic documents for use by the ministries[132]. Interviews with the UN agencies revealed UNFPA's comparative advantage in bringing on board the government ministries to participate in various programme activities. For example, the Youth Working Group is co-chaired by the Ministry of Youth, and the ministry has in the past hosted the monthly meetings, including inviting people for the same. Interviews and document reviews also revealed the leadership taken by the Ministry of Social Affairs, especially in the case management and the management of the WGSS. Further, there were contributions made by the government department in supporting the work of UNFPA. For example, in the municipalities where UNFPA delivered the health services there were contributions, with drivers being allocated to be the mobile health teams to be on stand-by for referral purposes. In addition, they coordinated meetings with health facilities. During the programme implementation, there were committees established by the municipalities to follow up. The municipalities also addressed any security issues affecting the UNFPA teams[133]. There is also evidence of the government taking a driving seat on the UNFPA support during the assessment and identification of the youth to be supported through the provision of the Youth against COVID-19 grant in 14 different service areas[134]. UNFPA also utilized government facilities to deliver the CP interventions. For example, the health services under the RH components were implemented in the government hospitals, including primary health facilities, confirming support and ownership (Interviews with government, IPs and CO staff and document review). During the period of review, there is evidence of the government continuing to support the work of UNFPA. For example, the government allocated finance to conduct demographic survey, though this was not released during the period of assessment, but earmarked to be used in 2022. In addition, there was evidence of the government establishing police stations with Women's departments, a manifestation of institutionalization of results (Interviews with IPs).

[131] Document reviews and Interviews with CO Staff, IPs, UN Agencies and Government representatives.
[132] Ibid
[133] Interviews with staff from CO, IPs and UN agencies
[134] Interviews CO and IPs staff

The UNFPA's partnership approaches, utilizing the support of local IPs to implement the CP interventions also creates a sense of ownership, especially building on local knowledge and understanding of the local context and needs. The IPs also confirmed that they were, in most times, consulted in the design and this facilitated their ownership of the programme interventions. For example, the Gender IPs exhibited ownership of the WGSS interventions as its scope resonated with mandate and would continue to look for funding opportunities to continue delivering GBV, life skills and livelihood services to the local community, if UNFPA funding ended. This also enabled the IPs to design the activities supported by UNFPA, in line with their organizations strategic focus; further embedding ownership and assuring continued appeal to the stakeholders even after the conclusion of the contract with UNFPA (Interviews and document reviews). Further, UNFPA also worked with the community members especially, the youth on addressing issues on peace and will be able to continue with the activities. The interviews also revealed that the communities supported the UNFPA activities through donation of consumables in the health facilities. They also had charity and donations to the health facilities, in addition to providing protection of the facilities, ensuring no one is harassed[135].

> Libya is characterised by many policies and strategies produced by consultants hired by various agencies in the country as once developed, they simply stay on the shelves. There is disorganized and fragmented implementation, with no oversight role by the government and does not step out to deliver the continuity of the deliverables that they ask the agencies to be done for them – **KII with a UNFPA Stakeholder**

UNFPA contributed to the development of various policies and strategies, at the request of the various ministries, which shows ownership of the programme interventions[136]. Under RH component, UNFPA supported the MoH to develop the RMNCAH strategy and respective costed action plan, which guided the RH activities supported by the MoH in the country. Towards strengthening nursing and midwifery service delivery, UNFPA also supported the MoH, in collaboration with Tripoli University to develop review of the Midwifery Curriculum and development of the regulatory framework for the midwifery and nursing, which have been completed and yet to be approved by the government. It is believed that their approval and utilization with enhance quality services and compliance by the midwives and nurses[137]. Under GEWE, UNFPA contributed to development of various SOPs, strategies and provided a foundation for strengthening the legal and legislative framework on gender in the country through collaboratively advocating and supporting the development of EVAW law.

Even though there were indicative factors for sustainability, interviews with various stakeholders[138] revealed a lot of gaps limiting national ownership , especially within the government structures. ownership is quite limited, especially with the fragmentation of the government. Further, interviews revealed that there were high and frequent staff turnovers, especially the leaderships at ministries while also derailed continuity of the support provided by UNFPA. While several respondents assured of the huge resources available at the disposal of the government of Libya, they were quick to point out the poor coordination of activities and inefficient allocation of resources which threatens the sustainability of the programs that have been rolled out and the gains that have been recorded. Additionally, the respondents reported that there was inadequate commitment of the government to continue implementation of the interventions supported by the CP. On the other hand, while there were involvement or consultations on the policies and strategies of support, most of them were developed by consultants, limiting the government's level of engagement. There were also reported structural challenges, especially from the government regulations. For example, while UNFPA supported on the training on the CMR, it has not been implemented due to the requirement of mandatory reporting of cases to the police before being referred to the health facilities to be limiting reporting of cases of rape (interviews and document reviews). Additionally, other services such as the hotline will not continue if UNFPA reduces funding, especially that UNFPA and not MOSA covers the hotline financial cost. Also affecting the sustainability of services is the security situation in Libya, which keeps fluctuating and affects donor's willingness to support some areas (interviews).

4.5.2 Capacity Building

UNFPA's contribution in developing the partners' capacities in various aspects of the CP's components strategically ensures sustainability of the programme results. The assumption is that capacity building improves the ability of the people to be able to deliver in their respective areas of expertise and to continue implementing the results, including scaling up the interventions. UNFPA focused on strengthening both personal and institutional capacity development across

[135] Ibid
[136] Interviews with Government and CO staff
[137] Ibid
[138] UN agencies, IPs and COs

the CP themes.

Under the RH component, UNFPA enhanced the capacities of the country on various aspects of the CP. UNFPA contributed to the development of the capacity of the healthcare workers on Voluntary HIV Counselling and Testing (VCT), and those trained provided the services to various populations and enabled reach of the Libyan population with the services, as reported by the IPs and CO staff interviewed. UNFPA's support to the development of the Midwifery curriculum and strategy is instrumental to institutionalizing nursing and midwifery service provision across the country[139], in addition to working with the University of Tripoli for implementation and working in collaboration with the MoHE for accreditation purposes. Should the curriculum be approved, and the University of Tripoli and other institutions of higher learning begin training in nursing and midwifery, this will provide seasoned professionals for the industry that and will contribute to filling the human resource gaps in the health service delivery[140]. This improvement in skills enhances quality skilled birth attendance and services. UNFPA further supported the delivery of leadership training for members of the midwifery and nursing association, which also enhances strategic thinking and resource management, in addition to standardization of services delivered by the members[141]. These assure sustainability.

UNFPA facilitated transfer of skills through engagement of international experts who worked closely with national experts to deliver in their technical areas of focus. For example, during the development of the Midwifery and Nursing curriculum, UNFPA engaged two international experts who also worked with local experts to deliver the curriculum. This facilitated skill transfers from the international experts to the national experts who will remain in the country to provide the support to deliver in similar skills area. development, in midwifery and nursing programs. These international experts worked with local experts to deliver the curriculum. Through this process, the international experts were able to transfer knowledge and skills to the local experts. Thus, should the curriculum require a review in the future, these local experts who have been exposed to the curriculum development process can take up this assignment for the government of Libya (interviews with MoH and CO).

UNFPA also supported the development of various policies and strategies like the RMNCAH strategy and costed work plan, for the first time, and will provide guidance on the issues of focus in the areas on RH. Others include SOPs and EVAW law, and other institutional support strategies like IEC/BCC materials developed to guide advocacy mechanisms. UNFPA also supported capacity building of country institutions and over time, these organizations have grown based on the capacity building efforts and mentoring provided by UNFPA and are better positioned to be able to seek funding from other sources and expand the delivery of services to the Libyan people[142]. UNFPA's strategic support to the MoH and MoSA staff to provide primary healthcare services and GBV case management and support, respectively enhanced their capacity to deliver on the services[143].

UNFPA invested in the capacity building of frontline workers at the national levels and municipalities through conducting various trainings. Some of the examples of training conducted under the 1st CP included training members of the municipalities on GBV; MISP and CMR, women CSOs on gender and advocacy; training of the NBSC on GIS and data generation and analysis; DHIS2 training and support; training of the youth on cohesion and peace; and health workers on delivery of RH services. The training mostly targeted the personnel who were already in public service and assured continuity and utilization of the skills gained in the short and medium term, even with the end of UNFPA support. There were also aspects of integration of the results of UNFPA support into government plans. For example, GBV was mainstreamed into and prioritised in government plans where the government's capacities were developed and gradually mentored to ensure continuity (Interviews with CO and IP).

UNFPA supported the health facilities with gynaecologists and trained the midwifes and there were plans to hire midwives to stay in their facility so as to continue with the service provision[144]. Through advocacy with the Libyan authorities, UNFPA ensured establishment and strengthening the capacity of the Gender unit under the MoH to ensure that GBV is prioritized in the health service delivery, targeting CMR. Further, UNFPA ensured institutionalization of skills through promoting master trainers who cascaded the trainings to the municipalities and lower level governance structures[145]. UNFPA also supported the

[139] Interviews and document reviews
[140] Ibid
[141] Ibid
[142] Interviews with IPs and COs
[143] Interviews with CO and Government staff
[144] Ibid
[145] Interviews with CO, IPs and Government staff

NBSC on geo-referencing of boundaries, which will be used to determine with precision sampling frames[146]. There were however concerns on the utilization of the skills gained to provide services. For example, the DHIS2 was reported to be ineffective by some respondents and that its operationalization never took off.

UNFPA also supported vulnerable women and girls, and youth to receive livelihood skills through access to TVET, with some supported with grants to establish business. While there was no evidence capturing the difference that the support contributed in the livelihoods of those supported, the technical skills will remain with them and would be in a position to apply them (Document reviews and interviews with IP and FGDs). In a focus group discussion, Libyan women confirmed that the knowledge gained through the WGSS in psychosocial support would sustain as they applied it in their daily lives. This knowledge helped women recover from the psychological stress brought on by war. While the small business livelihood initiatives are not fully developed yet to sustain themselves, the beneficiaries reported suffering from the high prices of raw materials and the lack of sufficient capital for their business initiatives to stand alone and generate profit. The female youth interviewed confirmed that the language and information and communication technology courses improved their college performance.

Despite the capacity of various stakeholders being strengthened in different areas, there were concerns on the ability to continue to provide, especially specialized services such as those provided by the obstetrician and gynaecologist, the paediatrician and anaesthetist after funding ceases. IPs interviewed pointed out that the provision of these services requires skilled human resources that are not readily available, or when available, are highly sourced and need to be paid for their services, which the government is not structured to provide. Thus, challenges with the government capacity and commitment to take up the role in making resources available and retaining expert care at the health facilities can unwind the gains that have been made in this 1st CP on access to healthcare services by the Libyan and vulnerable populations. Further, there were also gaps in the plans by the government to follow-up on the capacity building accomplishments by UNFPA and other agencies during the CP[147].

4.6 Coordination

EQ7: To what extent has the Country Office contributed to the functioning and consolidation of United Nations system-wide development and humanitarian coordination mechanisms?

UNFPA Libya is a highly valued member of the both the UNCT and the HCT, and actively contributed to the functioning of the UN coordination mechanisms within the country, enhancing services delivery and capacity building of the country. UNFPA effectively utilized its comparative advantage within the UNCT and HCT, leading both TWGs and Sub-sectors, to advance accountability and results. UNFPA also collaborated and implemented joint programmes with related-UN agencies and this facilitated further coordination, ensuring enhanced use of comparative strength among the agencies. The complexity with the Libyan context, absence and/or unclear government strategies, however, limited the level of coordination mechanisms within the UNCT and HCT.

Libya UNCT is coordinated independently from the Resident Coordination Office to ensure UN support in the country is delivered and the functioning of the coordination mechanisms. Interviews with UN agencies revealed that UNFPA is an active member of the UNCT and participates in the inter-agency Programme Management Team, Operations Management Team, Security Management Team in addition to chairing the UN Communications, Youth Working, M&E Groups and co-chairing the PSEA group with UNICEF, in addition to leading thematic areas of the UN framework, based on its comparative advantage. Interviews confirmed strong linkages and synergies the UNCT members describing UNFPA as highly pro-active and reliable in the areas of its mandate. In addition, UNFPA was recognized for the large coordination role it is taking within the UNCT and UN HCT, leading key functions, given its size, in addition to being a great advocate for the people affected by the conflict (Interviews). In Benghazi, UNFPA volunteered one of its female staff to be the focal point on security issues concerning female UN staff (Annual report review and interview with CO staff).

As the Chair of the M&E Group, UNFPA's

[146] Interviews with NBSC and CO staff

[147] Interviews and document reviews

contribution to the UNCT coordination mechanisms was recognized in leading the revision of the UNSF before extension to 2022, and led the review of RRF, including the indicators and the goals for the UNCT, making them relevant for the period of extension. Interviews revealed that UNFPA steered this process proactively worked with the other UN agencies in the UNCT and effectively delivering the expected results with the new UNSF being approached for use. Further, UNFPA also initially co-chaired M&E Working Group, jointly with WFP, after which UNFPA led the group autonomously from the second half of 2021, and actively contributed to the first joint inter-agency reporting exercise on the UNSF) 2019-2020 for Libya (SIS review and Interviews with RCO, CO and WFP staff). Most recently, in the Common Country Analysis, UNFPA and WFP worked on the 1st Pillar, gathering and informing the UNSF. UNFPA also took lead in the 1st Pillar in the UN COVID-19 response (Interviews).

In the period of review, UNFPA participated in joint programmes or collaborated with various UN agencies to deliver in various areas of responsibilities. UNFPA actively participated in the successful creation and rollout of the Rapid Response Mechanism (RRM) for Libya, in partnership with UNICEF, IOM and WFP, ensuring completion of all the 13 Minimum Preparedness Actions jointly addressing the needs of the displaced families and those affected by floods in targeted locations in Libya, with UNFPA supporting them with dignity kits, while UNICEF, IOM and WFP provided WASH services, Health interventions and food assistance respectively (Document reviews and interviews). UNFPA CO managed to mobilize EUR 5 million from the EUTF Migration and EUR 500,000 from Italy to respond to the IDP needs during the 2019 conflict in Tripoli Document review). UNFPA also collaborated with WFP and UNDP in the implementation of the human security project on advocacy targeting peace and security. In this programme, each member had a clear role and location to target, with UNFPA in Sirte training line ministries on local governance targeting peace and development as it was already in the same location supporting youth. UNDP on the other hand implemented the programme in Sabha, since it was already implementing stability fund in the same location, providing soft skills development, with WFP being the administrative and coordination focal point, while at the same time was already supporting agriculture farmers (Interviews and document review). Interviews revealed that the partnership effectively delivered on its mandate enhancing the nexus linkage between peace and development through strengthening local governance through line ministries. UNFPA also implemented the Sabha Nexus pilot project, jointly with UN Women and WFP (Interviews and Document review).

In collaboration to support lifesaving activities implemented together with WFP, UNFPA and UN Habitat facilitated in access to city profile data to support evidence-based programme through identification of the vulnerable populations, informing targets (Interviews with WFP and CO staff, and document review). With UNFPA's comparative advantage in working with the youth and women the youth and women centres, and WFP targeted the youth for vocational skills training, it was easy to engage with UNFPA on the Livelihoods and resilience project targeting youth exposed to military and war economy (Interviews with WFP and CO staff, and document review). In this engagement, UNFPA and WFP also collaborated in verification of the beneficiaries, depending on the UNFPA's network of youth and women for assistance, in addition to conducting labour market assessment, with WFP gaining from the good statistics on GBV (Interviews). UNFPA also worked collaboratively with UN Women on a number of programmes, including gender and humanitarian action (GEHA) capacity building municipal and women CSOs on gender issues in humanitarian set-up; Communication and Gender where UNFPA took lead in the development of communication materials on political violence against women and reporting; and drafting of the elimination of violence against women (EVAW) law, in collaboration with UN Women and UNSMIL. UNFPA's contribution, especially on conducting advocacy with the authorities, was lauded by the respondents as very important in the delivery of the results. The respective agencies are also working on increasing advocacy efforts for establishing protective legal mechanisms for women and girls and to end impunity for perpetrators.[148]

During the period of review, UNFPA, in a joint collaboration with UNICEF and IOM in the municipalities projects, ensured a comprehensive package to people affected by conflicts. In this engagement, UNFPA focused on WGSS and providing dignity kit and helping them to access lifesaving services. UNICEF focused on child protection in, consultation with MoH and MoSA, and how they could access services; while IOM focused on shelter for the affected populations (Interviews). UNFPA also coordinated with UNHCR to deliver the WGSS support to enable building the capacities

[148] Document review

providing emergency services, and joint FGDs during registration of migrants and refugees (Interviews).

Towards alignment of the UNFPA programme with the UNSF, interviews with UN agencies and CO staff and document reviews revealed that UNFPA priorities and mandate were well reflected in the UNSF with UNFPA contributing to two out of three thematic pillars both programmatically and financially in the implementation of the framework. The framework includes the UNFPA-related results areas of RHR, adolescent and youth, gender equality and women's empowerment, and populations dynamics. While the framework is expected to provide synergies among the UN agencies in the country to ensure delivery as one unit during implementation, interviews with various UN agencies indicated that there was room for improvement to ensure effectiveness in delivery. There was however feedback on the strengthened coordination among the agencies, especially in planning, sharing information, and working together on joint or complementary programmes with contributions of each agency (Interviews with UNICEF, WFP, UN Women, UNDP and CO staff).

UNFPA also contributed to the joint advocacy with UNICEF and UN Women on COVID-19 pandemic, developing various advocacy briefs for the need to support GBV response in the country amid the pandemic. UN Women also contributed in developing of the guiding notes gender issues so as not to lose sight in the times of COVID-19. UNFPA and other UN agencies also contributed to joint functions like the 16 Days of Activism, International Women's Days, International Youth Days, among others ensuring that the themes and messages developed and communicated were in shared manner among the UN agencies. As the lead of the co-chair of the Communications group, UNFPA ensured frequent convention of meetings among the UN agencies (Interviews).

UNFPA co-chaired the PSEA sub-group with UNICEF, working closely with the RCO. In this collaboration, they were able to develop SOP on how to file complaints on PSEA, supported the preparation of the PSEA Action Plan endorsed by members, developed ToR for the PSEA steering committee (SC) composed by the heads of agencies and UNCT, based on the IASC and relevant UN resolutions. In the established SC structure, there is also the GBV WG, Protection WG and the advisory to the structure facilitating leveraging resources and information gathering, harmonization of tools and finalization and approval of the Action Plan by the SC and HCT. It is imperative to note that an inter-agency network for agencies had been established in 2019, but was not successful up to 2020 because UNFPA did not have the resources, but with the collaboration between UNFPA and UNICEF, this has yielded so many results, enhancing implementation, with UNFPA coordinating the efforts within the UNCT[149]. Further, UNFPA and UNICEF collaborated in the development of the Case Management SOPs, with the inclusion of the Child Protection (CP) task force, with reviews of CP SOP getting reviews from the GBV subsector in response to GBV, led by UNFPA. UNFPA global team also provided 10 days of training on GBV case management to UN agencies, international NGOs and representatives of government and IPs, enhancing coordination in GBV response (interviews).

During the period of review, UNFPA collaborated with various UN agencies towards the development of policies, strategies and guidelines in the various thematic areas of CP focus. During COVID-19, UNFPA led in the development of guidelines on essential health services during COVID-19, with partners, including related UN agencies, guided on what to focus on with regards to IEC/BCC materials, PPE and distribution of dignity kits (Interviews). This eliminated duplication, leveraged resources and also ensured quality adherence to procedures. UNFPA also led the development of GBV SOP in collaboration with WHO and UNICEF. This also enhanced collaboration ensuring standardization of services and procedures.

Under the PD, UNFPA contributed to strengthening evidence-based programming among the UN Agencies in the humanitarian sector coordinated by the UNOCHA by sharing data from the GBV Sub-Cluster, sex and age-disaggregated analysed data for use in decision-making (Annul Reports and Interviews). In addition, UNFPA contributed to the data used for the humanitarian response planning (HRP) and establishing the needs overview (HNO) by the UN agencies. Further, UNFPA was part of the joint rapid needs assessment by the UN agencies whenever there was humanitarian crisis in the country, in addition to collaboration with OCHA under PD (COD-PS), besides overall humanitarian coordination. UNFPA was also reported to be taking a lead and active HCT, especially with the leadership in GBV focus within the UNCT, in addition to reporting to the UNCT (Interviews with CO, RCO, WFP, UNICEF, and reports). During the development and operationalization of the DHIS2, across the targeted

[149] Interviews and document reviews

locations in the country, UNFPA participated alongside GIZ, UNICEF, IOM, and WHO, where training of municipalities was shared among the agencies[150]. This enhanced coordination in the delivery of the DHIS2.

UNFPA also participated and co-chaired technical working groups within the UNCT and UN HCT. Interviews revealed that UNFPA effectively represented its mandate in the GBV AoR in UNCT and the Libyan people, and was depended on to provide guidance on GBV by the UN and other stakeholders. For example, the UN agencies agreed to the recommendations provided by UNFPA on how to deal with cases of GBV survivors through the referral mechanisms. UNFPA is also one of the seven members of the Inter-agency common feedback mechanism administered by WFP. Particularly, UNFPA operates a specific hotline for the for those affected in the humanitarian context due to sensitivity, confidentiality and specialized support on GBV (Interviews and reports). UNFPA also led the GBV Working Group under the protection sector. As the co-lead of the RMNCAH working group with MoH, UNFPA contributes to the achievements of the Health Sector led by WHO. In this arrangement, UNFPA supported the development of the RMNCAH strategy 2018 – 2023, in addition to supporting the MoH to come up with a costed work plan. This enabled understanding of common issues (Interviews and Document review).

Towards provision of health services to the underserved communities, UNFPA collaborated with UNICEF and WHO to ensure coverage of various target groups affected. In this arrangement, UNICEF was reaching more health facilities and in coordination in identification of gaps, UNFPA supported those populations not covered by UNICEF with the mobile health clinics. On the other hand, WHO and UNICEF trained health facility staff on child health and so UNFPA also complemented them in areas not covered by the two agencies, manifesting coordination and ensuring leveraging of resources and ensuring no overlap (Interviews with UNICEF and CO staff). UNFPA also collaborated with IOM to extend health services to the detention centres through conducting training on MISP and equipment support (Interviews).

To ensure effective and relevant response to the humanitarian crisis, under the Fast Track Procedures (FTP), UNFPA together with UNDP and UNICEF applied the Harmonized Approach to Cash Transfer (HACT) framework. In this arrangement, the agencies depended on one another to conduct micro-assessment of the IPs. This led to reducing time spent on conducting individual agency and leveraging of resources on micro-assessment, in addition to ensuring effective finance and administration management in emergency and feedback provision (Interviews and SIS reports).

While there were coordination mechanisms that worked well, with UNFPA contributing or facilitating the harmonious implementation of interventions among the UN agencies in Libya, interviews indicated that there were complexities within the Libya UNCT operation is complicated, even for the agencies themselves. For example, since the agencies are supposed to contribute to the government strategies, there were no clear government strategies to guide and facilitate operational focus (Interviews). In other quarters, donors also have different interests and this fragments response and support to the country. For example, some donors believe that stopping terrorism is the priority, while the others believe otherwise, thereby fragmenting the focus of various agencies supported by the donors with different focus in the country (Interviews). Cases of duplications and overlaps were reported. An example is where it was found out that a school received support from two UN agencies, but they did not know as they never spoke to each other. In addition, in the new UNSF, there were clashes reported among the UN agencies engaged in Peacebuilding as it was broad and was not clear on the extent of delimitation for the agencies under the peace area of responsibility. However, feedback was that the RCO continues to ensure the operations of the agencies are guided by the guidelines (Interviews). It was also reported that the different coordination mechanisms within the UNCT and HCT never spoke to each other (Interviews). The RCO's office however confirmed that efforts are being put in place to engage the group leaders and strengthen communication, in addition to emphasizing the use of UNSF with pillars clearly defined for the agencies, with the agencies willing to do more to ensure coordination.

[150] Interviews and document reviews

4.7 Coverage

EQ8: To what extent have UNFPA humanitarian interventions systematically reached all geographic areas in which affected populations (women and adolescents and youth) reside?

EQ9: To what extent have UNFPA humanitarian interventions systematically reached the most vulnerable and marginalized groups (women and adolescents and youth with disabilities; migrants and refugees, those of racial, ethnic, religious and national minorities; etc.)

Through the 1st CP, UNFPA contributed to ensuring reach of the affected geographical areas where the affected populations through partnership with the local and international NGOs. The CP mainly focused and concentrated activities in areas identified to be in most need, especially along migrant routes and remote areas without functional healthcare services, in addition to supporting identification of the needy areas through data capture. Further, the CP supported the HNO and HRP, in addition to reporting mechanisms enhancing coverage of the vulnerable and marginalized groups.

UNFPA endeavoured to ensure that the affected populations in the country were reached with the CP interventions. Through partnerships with both international and national organizations, UNFPA ensured coverage of the areas with need[151]. Further, through the mobile teams, UNFPA ensured that the places that needed. UNFPA put in place mechanisms to ensure that geographical areas in which affected populations resided.

During the 1st CP, UNFPA contributed to the national response on humanitarian crisis, in close coordination with other actors in the field, led by UNOCHA. As a member of the RRM, in partnership with UNICEF, IOM and WFP, ensured targeting of people affected by the crisis and reaching them with targeted services relieving their sufferings (Document reviews and interviews). In partnership with the LRC, and building on their national coverage of networks ensured that the affected populations were reached with RH services and information on the other CP thematic areas. Further, UNFPA enhanced training on MISP, facilitating capacities and competencies to deliver in the thematic areas of responsibility. In other aspects, UNFPA utilized assessments to identify areas of need to be targeted with services. For example, UNFPA contributed to the HNO which informed the HRP, ensuring that all the geographical locations with humanitarian needs were targeted. The extent of the CP coverage with the service is a challenge ascertaining as data and the extent of need was not clear and not harmonised among the stakeholders (interviews with IPs and CO staff, and document reviews).

During the period of review UNFPA employed partnership mechanisms with local and international NGOs to access locations where the needs were, ensuring reach of people affected by disaster to be reached with services. In addition, the NGOs also had stronger logistics management, distribution and storage capacity in remote areas of Libya to preposition required kits, and ensured effective response whenever needed (Document review and interviews).

In the period of coverage, UNFPA contributed to strengthening the capacities of the humanitarian actors in the country, with interviews indicating improvement in the quality of response and coverage of services provided to the people affected by crisis. UNFPA took lead in enhancing the capacities of various stakeholders in facilitating training on MISP, giving the programme a wider coverage and reach with services and response. While the training covered all the MISP components, it was however not easy to establish the extent to which the gained skills on MISP was utilized by the IPs and other stakeholders in ensuring coverage of the geographical locations affected. The CP's support to various entities enabled distribution of RH and dignity kits supplies and availability of service points through mobile health clinics provided wider coverage of the programme in the affected areas (Interviews with IPs and CO staff). During crisis, UNFPA responded through supporting mobile health clinics and provided services in the affected areas.

UNFPA's activities were mainly concentrated in areas identified to be in most need, usually along migrant routes and remote areas without functional healthcare services (interviews and document reviews). RHR activities have been focused in the south of Libya, Tripoli and Benghazi and in detention camps where illegal migrants are temporarily held. Activities generally targeted vulnerable populations including migrants, IDPs, and women and girls in need across the country. UNFPA improved access to RHR services through its IPs. Al-Safwa operated two mobile clinics

[151] Interviews with IPs, CO staff and Document reviews.

in Sabha and Tripoli. Other IPs (LRC and Migrace) also provided services in different parts of the country including Benghazi, Sebha, Ghat and Um Alaraneb.

During international AIDS day, UNFPA collaborated with the National Centre for Disease Control to raise awareness and distribute IEC materials widely with the purpose of increasing the knowledge and awareness of the Libyan population on HIV and AIDS, its means of transmission, lifestyle modification to mitigate its risks as well as treatment services available. The organization also utilized the social media to disseminate this health and GBV information with the aim of reaching more people across the country.

UNFPA services were strategically targeted at reaching the vulnerable and marginalized groups in the society including women and children, migrants, asylum seekers and those in detention camps (document review, interviews). The health facilities supported by UNFPA were strategically identified to be along migrant routes and in remote communities without ready access to healthcare services (interviews). The activities were also designed to cover people without presenting identification items to show whether they were Libyan citizens or not unlike in government health facilities where presentation of such identification is a prerequisite to receiving healthcare services (interviews and document reviews).

Prior to community entry, UNFPA, together with the IPs conducted a situation analysis / assessments of the country and consulted with various stakeholders including women, children, IDPs and those in detention to establish the marginalized and most vulnerable populations deserving services (Interviews and document reviews). The organization also utilized legacy assessments conducted by the government and the World Health Organization including the Service Availability and Readiness Assessment (SARA) and the Pan Arab Project for Family Health (PAPFAM) to inform targeting of the populations with services. For instance, findings from SARA were instrumental in identifying parts of the country that had challenges in RHR services. It also revealed areas in the country which were underserved by health workers and this information informed the design of UNFPAs programming.

Including migrants in the same activities with the host community was a challenge, where social cohesion remained fragile among migrants, refugees and Libyans. UNFPA, through its partners, was able to conduct joint activities to overcome the restrictions of social cohesion in the targeted areas. However, Libyan society still considers migrants as a source of violence and extremism. Analysis of data from different respondents and reports reviewed was suggestive that country stakeholders were quite satisfied with the coverage of services provided by UNFPA. However, there were equally some stakeholders that believed that UNFPA could deliver more interventions across a wider geographic area with the resources at its disposal.

Most of the period of review was plagued by the COVID-19 pandemic which affected access and delivery of services within the country, including limiting movement of populations. Document review and interviews revealed that the UNFPA country office acted fast in light of the COVID-19 outbreak, also thanks to UNFPA's responsiveness and capacity in the mobilization of resources from the various donors and flexibility to repurpose RR. UNFPA CO procured and distributed PPE for essential workers from MoH, and mobile medical teams to ensure continuity of their services as well as promote hygiene and dignity items for particularly vulnerable women and girls, such as women migrants in detention centres.

4.8 Connectedness

EQ10: To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women's organizations, health facilities, communities etc.) to better prepare for, respond to and recover from humanitarian crisis?

Summary of Findings: The 1st UNFPA CP contributed to strengthening capacities of the national stakeholders, development of strategies, guidelines and policies to guide implementation, coordination and promoting mechanisms to enhance youth participation in peace building with the aim of providing long-term solutions to the conflict situation in the country.

While the context in Libya is not conducive enough to facilitate development-humanitarian-peace nexus, UNFPA endeavoured, through the CP, to contribute to building mechanisms to facilitate longer term results in the programme implementation. UNFPA

contributed to this through strengthening capacities of the actors, developing strategies, guidelines and policies to guide implementation, supporting the youth participate on peace activities, coordination and promoting integration of programmes and national ownership of interventions and results[152].

> If the youth engage cohesively, there will be no war in this country…. and without peace, there won't be development **– KI from Government department**

Towards contributing to addressing the issues of conflict in the country, UNFPA immensely supported a number of initiatives aimed at promoting peace among the various target groups. The youth component was majorly anchored on building and strengthening mechanisms for peaceful co-existence among the youth, in addition to promoting this among the other community members using interactive theatre, participating in training to influence others, using social media to engage on peace among the youth and the country at large[153]. For example, UNFPA supported the youth to promote peaceful coexistence between the host community, and refugees and IDPs through football, establishing youth clubs, debating, participatory educative theatre and promoting acceptance of the refugees and migrants by the host communities[154]. As the co-chair of the YWG, UNFPA facilitated promotion of the youth participation in addition to capacity building them on peacebuilding which facilitated their involvement in negotiation and peace building in the country (Interviews). There was however no report of youth participating in the negotiation. UNFPA also strengthened women participation in peace and security, in line with the UN security council resolution (UNSCR) 1325[155]. Under the Joint programme with WFP and UNDP, UNFPA conducted training to the line ministries on human security addressing the root causes of conflict targeting soft skills and promoting local governance which is also designed to contribute to development (Interviews). In recognition of the increased focus on stability and shifting humanitarian needs, UNFPA is a member of the Peace and Development nexus (Nexus WG), and contributes to the strategic direction on the same (Interviews).

UNFPA also supported the felt needs, especially among the youth and affected women, with regards to enhancing employment opportunities for the same. With the establishment of the WGSS, the CP supported the vulnerable women and girls on training on TVET and other soft skills including language and other skills development, with the aim of increasing their employability hence addressing their need for increased livelihood access[156]. On the other hand, during COVID-19, UNFPA supported the youth to address their economic needs through the Youth and COVID-19 grants, which in addition to combating the effects of COVID-19 to the youth, enhanced livelihood opportunities to the youth The CO also introduced face masks as livelihood source for vulnerable women who produced the same and sold them to the community members (Interviews).

During the 1st CP, UNFPA facilitated rehabilitation activities for the various structures within the country. UNFPA implemented these in the primary health facilities, including equipping them with the necessary equipment, enabling them to provide the needed health services (Interviews). UNFPA also utilized government facilities and supporting them to deliver services using the same, enhancing their capabilities to deliver. Working the government in many aspects including being in coordination mechanisms, like working with the line ministries as co-chairs of the various technical working groups enhances the government participation and support in decision-making on the interventions (Document reviews and interviews).

The period of review saw UNFPA support a lot of capacity building endeavours to enable transfer of skills on various themes. UNFPA has been instrumental in building capacity across different themes of services in Libya. UNFPA trained master trainers on MISP who subsequently cascaded the knowledge to other staff, enhancing capacity of the country on MISP. This strategy fosters capacity for the continued propagation of appropriate knowledge on MISP in the country. UNFPA further supported the institutionalization of Midwifery and nursing studies through development of curriculum and working with institutions of learning to facilitate this. Establishment of the gender unit within the MoH in addition to training of the health staff on CMR was an aspect of institutionalization and will continue to be there even after UNFPA's support stops. Implementation of CMR was however challenged due to contextual issues, especially with the need for compulsory requirement of reporting to the police limits confidentiality (Document reviews and interviews). Additionally, the Gender Unit has minimal access to accurate data of females suffering from rape or

[152] Document review and Interviews
[153] ibid
[154] Document review and interviews
[155] Ibid
[156] Ibid

pregnancy resulting from rape (Interviews). UNFPA's support to coordination mechanisms facilitated effective response within the humanitarian context and thereby enhancing leveraging of resources to reduce the effects of humanitarian crisis. Through the support to the Midwifery and Nursing association on leadership training, the CPs facilitated transfer of skills and enabled increased levels of decision-making among the midwives and nurses. In addition, the organization through its partners supported the establishment of VCT centres and training and deployment of counsellors into the centres, and will be able to continue even when the UNFPA programme ceases.

UNFPA supported development of various strategies, SOPs and a centralised management information system to collect data on GBV cases; and to guide the implementation process for various aspects of the CP thematic areas. UNFPA supported development of RMNCAH which will continue to guide the delivery of the RH services to the populations. The development of SOPs in various thematic areas, including CMR, Case management, GBV, PSEA, among others will continue to guide the quality standards for the delivery of services. It is however worth noting that there is low commitment of the government on the utilization of the developed strategies (Interviews). In addition, UNFPA supported the development of the EVAW law to address the gender inequality and discrimination of women in politics and contributing to their empowerment (Interviews).

UNFPA's support to the generation of data for decision-making facilitated response to the various humanitarian response and development within the country. Interviews with various stakeholders revealed that UNFPA through leading the GBV AoR capacity built stakeholders on GBV and facilitated mainstreaming of Gender in the HRP, enhancing the consciousness of the stakeholders on the importance of the same. Further, UNFPA supported the NBSC to establish geo-referenced boundaries which will be used in sampling across the country, further facilitating identification of development needs for prioritization (Interviews and document reviews).

Interviews and document reviews revealed that UNFPA supported development of knowledge materials, especially targeting behaviour change themes on peace, GBV, family planning, women's empowerment, COVID-19, among others. These will contribute to enhancing knowledge transfer. However, behaviour change takes time and the extent to which this changed during the period of review could not be established.

CHAPTER 5: CONCLUSIONS

5.1 Introduction

This section presents the conclusions drawn directly from the findings presented in Chapter four, presented with both strategic and programmatic focus, especially based on the evaluation criteria. The strategic level (covering relevance, efficiency, sustainability, coverage, connectedness and coordination), and programmatic level covering the CP component areas.

5.1 Strategic

Conclusion 1: Consistent with the UNFPA Strategic Plan and priorities in the international frameworks, the 1st UNFPA CP is well aligned with the national priorities and population needs both in design and implementation. The CP effectively responded to the changing environment and needs including humanitarian settings. However, the delivery of the programme was limited on the adolescent and youth RH (ARH) and PD. Inadequate funds allocation to PD and AY components; contextual challenges of instability due to conflict and COVID-19 hampered the extent of relevance, effectiveness and sustainability of UNFPA results and benefits in the country.

Associated Recommendation: 1

Origin: EQ 1, EQ 3, EQ 6, EQ 10 **Priority**: High

The 1st CP has been relevant and effectively aligned to both the international and the national agenda for both the RHR and GEWE, including attempting to ensure compliance and conformity to the international frameworks. UNFPA contributed to addressing the felt needs, particularly focusing on the humanitarian response given the contextual demands in GBV and RH services, and youth support, working with the line ministries. UNFPA remained particularly catalytic in supporting institutionalisation of integrated RHR, HIV&AIDS and GBV through training and strengthening capacities of various government entities, and demonstrated gender responsiveness, and attention to human rights in the delivery of the CP. The CP was reviewed, with the onset of conflict in 2019 and COVID-19 in 2020 to reflect the reality, including refocusing the resources on supporting humanitarian response, employing all modes of engagement to deliver the CP interventions. The limitations noted included inadequate focus of the ARH, with limited funds allocated to the PD and A&Y components. The country continues to have high population growth with a youthful population structure and severe inequalities, in addition to uncertainty in stabilization given that the governance structures are still fragile.

Conclusion 2: The implementation of the UNFPA 1st Country programme for Libya has been hindered by absence of national strategy and policy frameworks.
Origin: EQ 1, EQ 3, EQ 6 **Priority**: High

Associated Recommendation: 2

The absence of national strategies and policies mainly due to instability in the government with feuding factions, leading to lack of consensus among stakeholders and inadequate commitment of the government line ministries on policy directions led to a gap in directing programme focus with clear goals and targets to be achieved as a country. The absence of a national youth strategy and policy made it impossible to lay foundation for the targeting of the youth, in addition to providing guidance of the response and coordination mechanisms among stakeholders. Further, the inadequacy in population dynamics policy limits targeting of key populations including the ageing and people living with disability, including monitoring of SDGs. UNFPA successfully supported the MoH and other partners in the development of RMNCAH and GBV-related SOPs and guidelines. However, the inadequate commitment of the government and constant changes in ministries' leadership and contextual challenges affected consistency in the implementation of the strategies and policies, making it is difficult for UNFPA to respond fully to the needs of the affected Libyan populations.

Conclusion 3: The CO supported delivery of multiple initiatives across the CP with a number of IPs, employing multiple programmatic and operation management strategies facilitating efficiency in the delivery of the CP. However, limitation in CP integration, IP staff capacity and contextual challenges, will continue to affect the efficiency in the delivery of the CO support to the country.

Origin: EQ 3, EQ 5, EQ 7, EQ 8, EQ9

Associated Recommendation: 3

Priority: Medium

UNFPA utilized strategic and operational partnerships to ensure the programme was efficiently delivered. The choice of IPs, both international and local

facilitated capacity building, reach and reduced operation costs. The technical assistance provided through the CO support enabled transfer of skills and enhanced standardization of quality of service delivery in the areas of focus. Coordination and collaborative approach to implementation of activities was cost-effective in delivery of the CP. UNFPA programme had qualified technical staff who managed and coordinated the activities with the stakeholders, further providing effective guidance for quality service delivery. Inadequate CP integration, to a little extent, however, hampered efficiency in delivery of the CP, as there were opportunities, for example, to integrate RH and A&Y components to cover budget gaps in A&Y. On the other hand, the inadequate capacity of the IP staff and CO staffing gaps derailed support supervision, especially in the field with IPs. CP operational support was reported to be moderately effective, but with incidences of delays caused by shipment, planning, bureaucracy by the government in purchases of drugs and commodities, and rigidity in the UN system, especially on movement of staff

Conclusion 4: UNFPA strived to strengthen sustainability through different mechanisms, including development of strategies, policies and guidelines; upholding of consultations with government line ministries and institutions; capacity building and institutionalization of response, among others. However, this was highly limited by the limited capacity and high turnover of the government entities and the unpredictability of the governance systems.

Origin: EQ 1, EQ 3, EQ 6, EQ 10 **Priority**: High

Associated Recommendation: 4

UNFPA promoted capacity building and promotion of national ownership among the national stakeholders through leveraged resources, development of guidelines, training curricula and strategy development, advocacy and coordination. The strategic selection of partners, especially the local organizations enhanced targeting of the marginalized populations, particularly women, girls and youth, and community level of engagement on programme themes. Development of guidelines and SOPs to guide service provision was a great achievement, however implementation, oversight and support supervision by the government to ensure compliance and delivery is lacking.

Conclusion 5: Strategically, UNFPA utilized its comparative advantage in its AoR, and was an active member of the UNCT and HCT, and valued partner of key stakeholders. The CO chaired working groups and participated as an active member of the various coordination mechanisms, including participating in joint programmes with selected UN agencies. However, the context of operation limited the coordination framework within the UNCT, with cases of overlaps reported, providing room for strengthening coordination among the UN agencies.

Origin: EQ1, EQ2, EQ3, EQ7 **Priority:** High

Associated Recommendation: 5

UNFPA immensely contributed to the UN coordination mechanisms in the country, in addition to the CP priority areas fitting well into the UNSF result areas. The CO actively engaged in the various working groups of the UNCT and HCT, in addition to leading and co-chairing some of them, including GBV SS, M&E WG, Communications, and PSEA. UNFPA had joint programmes with UNDP, UNICEF, WFP, IOM, in addition to collaborating with UN Women, UNHCR, OCHA, WHO and UNSMIL along its areas of comparative advantage, particularly A&Y, GBV, Gender and SRH. UNFPA also contributed to sharing of information through monitoring delivery, participated in and led UNCT campaigns, in addition to working alongside others, for instance in data and evidence (DHIS2) and humanitarian assistance (COVID-19 response). The next UNSF provides an opportunity for UNCT and HCT stakeholders to strengthen coordination mechanisms. Particularly, UNFPA needs to enhance its advocacy strength and footprint in its AoR and to gather sister UN agencies around its priorities.

Conclusion 6: The CP M&E systems in place was fairly robust and facilitated capturing of feedback on its performance. There was also remarkable improvement in the capturing of results level performance of the CO on the CP during reporting over the years of coverage, manifesting improved capacity and focus of the CO on results. However, there is need for strengthening of the results focus at sector levels, and IPs partners, in addition to mechanisms to monitoring changes in the advocacy interventions like the A&Y activities, for example assessing knowledge and behaviour changes among the targeted populations.

Origin: EQ3 and EQ5 **Priority:** High

Associated recommendation: 6

UNFPA put in place a robust M&E system, especially on capturing of performance by the IPs and the sector staff based on the donor requirements. It was also evidence of efficiency promoted by the M&E system in place ensuring timely deliverables on the implementation progress. The 2021 SIS report had evidence of improved reporting on results, unlike in the previous years emanating from the trainings conducted by the M&E and ASRO teams on RBM. The intervention logic could however be improved to capture the extent to which results were being realized. In addition, there is room for enhanced capacity of the CP sectors and IPs to enhance capturing of results, especially on utilization of the support provided by the CP. The CP also supported advocacy interventions, especially under the A&Y component and GEWE, and there was little captured during reporting on the changes emanating from the interventions.

5.2 Programmatic

5.2.1 Sexual and Reproductive Health and Rights

Conclusion 7: The CP made huge contribution in strengthening access to SRHR services through integrated mobile health clinics, development of RMNCAH Strategy and providing guidelines in the implementation framework, the development of which guided the provision of quality services to the targeted populations. UNFPA also strengthened the capacity of healthcare providers to provide quality maternal and child health and integrated SRH and GBV, access to HIV and cervical cancer treatment services, including integration of COVID-19 IPC. There is however room for institutionalization, especially strengthening government engagement and ownership in service provision, in addition to enhancing family planning service access.

Origin: EQ1, EQ3 **Priority:** High
Associated recommendation: 7

UNFPA contributed to increasing access to SRH services to the Libyan people and the marginalized and vulnerable populations through provision of integrated mobile SRHR service, strengthening capacities of service providers and development of strategy, guidelines and SOPs for standardized quality of services in the country during the 1st CP. The development of the RMNCAH strategy and the action plan allowed for the guidance and effective targeting of implementation and delivery of SRH services to the affected population, including capacity building of the healthcare system, including infrastructure. UNFPA is a valued humanitarian partner, having advocated for and provided quality technical support to integration of SRH and GBV support in emergency and humanitarian responses, including through training on MISP and provision of guidelines for quality service delivery. Inadequate institutionalization and volatile government support limits the extent that could be achieved or sustained from the UNFPA CP results. UNFPA also ensured integration of COVID-19 into RH and GBV programming, ensuring protection and safety of the providers with PPEs, while at the same time facilitating unlimited services access. Family planning service access was however limited by contextual challenges which UNFPA contributed to addressing, but there is still more to be done to eliminate misconceptions.

Conclusion 8: UNFPA contributed to strengthening the resilience of the health system through enhanced capacity in nursing and midwifery; rehabilitation and equipment of health facilities, enhanced RH surveillance; increased strengthening of advocacy and enhanced delivery of HIV VCT and Cancer service provision; and strengthened RH commodity and logistics management. There were however concerns of inadequate demand creation and institutionalization of RH services.

Origin: EQ1, EQ3, E6 **Priority**: High

Associated Recommendation: 8

UNFPA strengthened the resilience of the health system in the country through supporting delivery of nursing and midwifery service by training, association support and development of midwifery training curriculum in coordination with higher institutions of learning aimed at increasing access to and institutionalization of skilled birth attendance. The curriculum is however yet to be endorsed by the government due to competing priorities, while it needs to be validated by the government. UNFPA also supported the rollout of DHIS2 through training of targeted municipalities, including training of staff on the use thereby enhancing SRH surveillance. UNFPA also supported leadership training for the nurses and midwives to help in providing strategic delivery of the related services. UNFPA supported the purchase of various medical equipment and reproductive health commodities, in addition to rehabilitation of primary health facilities contributing significantly to the access

and delivery of UNFPA's support to the Libyan people. Demand creation and institutionalization of SRH service delivery was identified as a gap, leading to limited awareness and access to SRH services, especially non-prioritization.

5.2.2 Adolescent and Youth

Conclusion 9: ASRH was an underdeveloped area, limited to information without targeted services to the youth and adolescents.

Origin: EQ1 and EQ3 **Priority:** High

Associated Recommendation: 9

UNFPA Libya CP utilized various mechanisms to strengthen access to information on SRH and GEWE by the youth in the country. The use of social media played a bigger role in informing the youth on various aspects of SRH and GEWE, particularly GBV, addressing myths and misconceptions, and ensuring the rights of everyone is upheld. UNFPA was able to engage young people through technology and online platforms to increase their access to SRH information and services. While UNFPA supported the development of the RMNCAH, the implementation of the ARH part was not put in place or pronounced in the programme. The youth were sensitized in ARH area, but there was no targeted service access by the targeted category given their need for specialized attention and the sensitivity in the context. Allocation of resources was also limited in the CP delivery.

Conclusion 10: Participation and contribution of the youth in peacebuilding and local governance, as well as youth employability, were enhanced in the country. The scope of engagement was however limited by the contextual challenges, including absence of a dedicated Ministry of Youth to drive and coordinate the youth agenda in the country.

Origin: EQ 1, EQ 3, EQ6 **Priority**: High
Associated recommendation: 10

During the implementation of the CP, UNFPA contributed to enhancing the youth participation in peacebuilding and local governance. The programme emphasized advocacy, life skills training and citizenship education for the targeted youth, enhancing cohesion among the youth in the country. Further, UNFPA also strengthened the youth employability and access to income through TVET and grants support. UNFPA also coordinated the Youth Working Group, bringing together stakeholders responding on youth issues and ensuring expanded targeting. The absence of youth strategy and policy also limited the extent of targeting of the youth and addressing their felt needs. The establishment of the MoY, for the first time in Libya provides an opportunity to enhance strategic and policy development and structured engagement of the youth in addressing issues of national importance.

5.2.3: GEWE

Conclusion 11: UNFPA greatly contributed to strengthening GBV prevention and response in Libya through strengthening coordination, collaboration and response mechanisms through development of GBV-related SOPs, supporting review of the EVAW law and through supporting advocacy and service provision. There is however disjointed response among stakeholders, particularly to weak and inadequate legal frameworks for enhanced access to GBV response services by the survivors.

Origin: EQ 1, EQ 3, EQ7 **Priority**: High
Associated recommendation: 11

UNFPA had considerable achievements in the GEWE component, particularly in strengthening the capacity and increased engagement of the key stakeholders on GBV case management and coordination mechanism, in addition to development of guidelines and SOPs, ensuring leveraged resources to ensure response and support to the GBV survivors. UNFPA also demonstrated a comparative advantage in the coordination of the GBV SS, enhancing access to GBV services, including inadequate justice system. While UNFPA strengthened GBV referral mechanisms within the target locations, there is weak coordination among the stakeholders and the legal systems, hindering response. Currently, there is a requirement by the government to ensure mandatory reporting of a rape case to the police before any medical assessment can take place. With rape associated with shame, this mandatory reporting requirement hinders reporting and thereby cases go unresolved and the survivors continue to suffer in silence. UNFPA also strengthened evidence-based GBV response through the establishment and supporting of GBV IMS to capture data and also facilitate the response. This was however plagued by the inadequate number of stakeholders registered, capacity and guidelines for operationalization. UNFPA has also supported the efforts to revise the law in collaboration with UNSMIL/HR and UN Women since 2020, including recruiting an international consultant to support the review of the existing law to

ensure alignment with the international standards and best practices in different countries in the region., facilitating review meetings with the committee of experts in the country, and conducting workshops. Despite the efforts made by UNFPA, the process is taking time and careful steps to ensure full support from different concerned counterparts. It is hoped that this will yield results.

Conclusion 12: UNFPA strengthened gender mainstreaming and rights-based approach to programming, ensuring compliance with international development frameworks. The government is, however, not fully committed and equipped to integrate gender into their policies and action plans, including inadequate community level response. There is a need for continued engagement with the related government bodies and community structures to do so.

Origin: EQ 1, EQ 3, EQ7 **Priority**: Medium
Associated recommendation: 12

The 1st UNFPA CP in Libya was successful in supporting the legal framework, EVAW and strengthening capacities of stakeholders and advancing advocacy mechanisms to eliminate harmful practices against women and girls. UNFPA also ensured inclusion and implementation, including monitoring of the Gender Marker in the HRP during the period of review, enhancing mainstreaming of gender into the country programming. UNFPA continued its efforts to reflect gender in a clear actionable plan with concrete interventions aimed at supporting women empowerment through the WGSS, supporting MHPSS, advocacy, and livelihood and provision of protection services to vulnerable women and girls also were commendable efforts. However, it is to be noted that the government structures are weak and not fully committed to ensure gender empowerment. In addition, socio-cultural practices and beliefs also affected the CP achievements.

5.2.4 Population Dynamics

Conclusion 13: UNFPA contributed to strengthening design and generation of data as a foundation for evidence-based programming. However, the extent to which this was articulated in the CPD versus implementation was limited by the CP focus that was sub-optimal, in addition to being limited by contextual factors including government instability.

Origin: EQ 1, EQ 3, EQ6 **Priority**: High
Associated recommendation: 13

UNFPA's planned activities under the PD component were affected by conflict, inadequate financial allocation and change in government priorities. The government priority to conduct Population Census was derailed by conflict thereby changing the focus to have a demographic survey, with an action plan that includes population estimation with UNFPA supporting the development and approval of the concept note for this. Feedback from stakeholders indicated that UNFPA had potential not utilized in strengthening generation of data and integration of population dynamics into planning and monitoring in the country.

Conclusion 14: There is less emphasis and resources focused on Population Dynamics, despite this being a unique mandate of UNFPA within the UN. There was also inadequate integration of population dynamics into the planning of sectoral strategies.

Origin: EQ1, EQ 3, EQ7 **Priority**: Medium
Associated recommendation: 14

The programme has focused less emphasis and investment on PD in terms of human and financial resources despite being the only UN agency with the mandate and competence on data and the data needs in the country. There is a need for greater emphasis, increased resources and leverage on PD for enhanced evidence-informed advocacy and improved results in all development areas, in line with the UNFPA Strategic Plan.

5.3 Lesson Learnt and Unintended Consequences

Lessons Learnt

1. It is necessary to plan for project activities realistically, estimating time and resources needed efficiently. Long delays in the completion of project activities thereby requiring extension of grants repeatedly can strain donor confidence and relations.
2. Involvement of young people in programming, particularly peacebuilding project, and other decision-making processes is key in ensuring 1st CP-supported interventions are responsive to the needs of and utilise approaches appropriate for young people.
3. Mainstreaming of gender and human rights are inherent in the 1st CP and could benefit from utilising a clear rights-based framework to enhance the focus, with stronger attention to the rights of particularly vulnerable populations.
4. Given that no other agency focuses on population

dynamics, the dependence on UNFPA to strengthen capacity for generation, dissemination and utilisation of population data at all levels and to provide high level technical and financial (where necessary) support remains a high priority.

5. The design of the project whereby capacity can be transitioned to national institutions over time should be advocated everywhere as this approach is less expensive and can translate into self-sustainability
6. Capacity building of the local IPs provide a foundation for sustainability, in addition to enhancing efficiency in the delivery og the programme.

Unintended Consequences

The evaluation team did not observe or establish any unintended results as a result of the implementation of this CP.

CHAPTER 6: RECOMMENDATIONS

6.1 Strategic

Recommendation 1: UNFPA needs to continue aligning the CP to Libya's felt development and humanitarian needs. The 2nd CP should incorporate advocacy, strategic partnerships and innovative resource mobilization to maximize its potential to contribute to strategic results within the country, while at the same time providing additional service support and capacity development to the most vulnerable and marginalized populations in underserved and needy areas while focusing on durable solutions for the existing humanitarian crisis.

Origin: EQ 1, EQ 3, EQ 6, EQ 10

Target: Country Office **Priority**: High

Associated Conclusion: 1

Implications: The 2nd CP focus should be aligned to the changing international and national priorities, building on its comparative advantage. The CP should strengthen advocacy and strategic development, and capacity to mobilize resources from existing and new sources. Additionally, service support and capacity development should continue where most required, especially in the humanitarian context, while at the same time building resilience to facilitate humanitarian-development-peace nexus.

Recommendation 2: Enhance development and strengthening of the level and intensity of policy dialogue in the CP's component areas to enhance structured engagement with the national authorities for desired support and realization of desired changes in policy

Origin: EQ 1, EQ 3, EQ 6

Target: Country Office **Priority**: High

Associated Conclusion: 2

Implications: Intensify advocacy efforts in order to maintain a high profile for the CP's programme focus on the national agenda through highlighting the needs of marginalized and vulnerable groups. Build partnerships to influence the government decisions on policies and strategies.

Recommendation 3: Prioritize increased partnership and strengthen integration within the CP in the implementation of the CP components to increase efficiency and continue optimizing on the operations management strategies, including enhanced internal controls, finance and logistics management, human resources, among others, in addition to diversifying resource mobilization and strengthening staff capacity building in their respective areas weakness.

Origin: EQ 3, EQ 5, EQ 7, EQ 8, EQ9
Target: Country Office **Priority**: Medium
Associated Conclusion: 3

Implications: The CO, in consultation with the HQ could explore non-traditional source of funds. UNFPA should also enhance integration of the CP components and partnerships with local IPs for efficiency and leveraging of resources and wider coverage. Optimization of operations will also enhance compliance and efficiency in delivery of the CP.

Recommendation 4: UNFPA should continue capacity building and systems strengthening, in collaboration with the government line ministries, in addition to increased engagement of the municipalities, IPs and strengthening of affected communities' structures to enhance oversight within the COVID-19 and migration constraints.

Origin: EQ 1, EQ 3, EQ 6, EQ 10

Target: Country Office **Priority**: High

Associated Conclusion: 4

Implications: More resources allocated for institutional capacity development of the various partners, continue strengthening the capacities in systems implementation and strengthening collaborations on strategies to realize lasting solutions to the IDPs and integration of the refugees and migrants. In addition, strengthen capacities of humanitarian-affected population to enhance their resilience. To address COVID-19-related challenges, strengthen capacities of the community level stakeholders to take responsibilities for ensuring effective delivery of services; strengthen community structures.

Recommendation 5: There is need for the UNFPA CO to continue building and strengthening partnerships with other UN Agencies, in addition to sourcing and pooling resources to support joint activities of the UNCT thereby enhancing the comparative advantage of UNFPA, in addition to eliminating overlaps and duplication of efforts coverage.

Origin: EQ1, EQ2, EQ3, EQ7
Target: Headquarters and CO **Priority:** High
Associated Conclusion: 5

Implications: UNFPA should continue to optimally make use of its comparative advantage in its AoR, especially as a UN data agency and the leader in integrated programming anchored on SRH, gender and human rights. UNFPA should also continue to work jointly within UN agencies responding on similar areas to increase efficiency and effectiveness of the interventions e.g. GBV, SRH and A&Y could benefit from enhanced UNCT coordination mechanisms.

Recommendation 6: There is need to strengthen the intervention logic of the CP results and resources framework to ensure that it has relevant outcome and output indicators as well as stronger alignment of interventions to the outcomes and outputs. Invest in operations research to inform the CO on the changes arising from the knowledge-based and advocacy interventions.
Origin: EQ3 and EQ5 **Target**: Country Office

Associated Conclusion: 6 **Priority:** High

Implications: Review the intervention logic to ensure a clearer strategic linkage between outcomes, outputs and planned interventions for each of the components. Enhance operations research to assess changes occurring, especially on interventions with the A&Y and GBV which are information-based and may not be able to assess changes immediately. For example, conducting, on a periodic basis, knowledge, attitude and practices (KAP) among the target groups to establish the progress made. There is also need to strengthen results-focus by the programme and IP staff.

6.2 Programmatic

6.2.1 Reproductive Health and Rights

Recommendation 7: UNFPA should continue to strengthen technical and financial support for integrated services in the areas of its mandate in SRHR, emphasize advocacy and partnership to ensure government commitment and ownership in the implementation of the RMNCAH strategy and SOPs for quality service delivery and institutionalization of the programme strategies in the country.
Origin: EQ1, EQ3
Target: Headquarters and CO
Associated Conclusion: 7 **Priority:** High

Implications: Strengthening technical and financial support for integrated SRHR services will enhance both technical and operational capacities to ensure continued access to the services. Advocacy and partnership with the government agencies will promote national ownership and support for implementation of the programmatic approaches and strategies, thereby enhancing sustainability

Recommendation 8: UNFPA should enhance demand creation for increased uptake of services especially by the most vulnerable and those left furthest behind, in addition to supporting scale-up of interventions to address family planning.

Origin: EQ1, EQ3, EQ 6 **Target**: Country Office

Associated Conclusion: 8 **Priority:** High

Implications: UNFPA and partners should institute a strategy to generate demand for SRH services that outlines interventions aimed at increasing access to and utilisation of SRH services and addresses barriers. Community mobilization and engagement of structures should be developed and supported. The needs of particularly vulnerable women and adolescent girls, and those in humanitarian settings should take priority. Increased advocacy should be enhanced among partners and engagement of stakeholders.

6.2.2 Adolescent and Youth

Recommendation 9: UNFPA should enhance capacities to increase integration of youth- and adolescent friendly RH information and services and reproduction rights. Strengthen partnerships and coordination to increase access to RH services by the youth and adolescents.

Origin: EQ1, EQ3 **Target**: Country Office
Associated Conclusion: 9 **Priority:** High

Implications: The CO should build capacities for integration of youth and adolescent friendly services within the health facilities, in addition to leveraging resources for greater access to ASRH services by the youth in the country. Demand creation will also be needed through enhanced advocacy for service delivery and access.

Recommendation 10: Strengthen consolidation of youth programming and coordination in the country through the development of a national youth policy

and strategy, including implementation action plan, while at the same time continue to build the capacity of the youth on leadership skills and ability to influence policy and strategy.
Origin: EQ1, EQ3, EQ7

Target: Country Office **Priority**: Medium

Associated Conclusion: 10

Implications: The CO should advocate and use its comparative advantage for meaningful engagement and targeting of the youth through financing and technically supporting the development of National Youth Policy and Strategy. In addition, the policy action plan should also be in place to guide implementation. More resources will be required to engage stakeholders and resource persons in the development of the strategy. Enhanced coordination for harmonized targeting and response to youth issues will be ensured.

6.2.3 GEWE

Recommendation 11: UNFPA, through its leadership in GBV SS coordination should continue to rally counterparts to advocate for development and strengthening of legal and institutional frameworks for GBV response to ensure accountability to the affected populations.

Origin: EQ 1, EQ 3, EQ7 **Priority**: High
Target: ASRO and CO
Associated Conclusion: **11**

Implications: There is a need to develop and institutionalize access to GBV services by the survivors. UNFPA should scale up its technical capacity and systems strengthening of GBV prevention and response; support expansion of the establishment of the comprehensive GBV centres (WGSS) in the hard-to-reach areas and for marginalized populations. Further, UNFPA should support strengthening of the referral systems, especially access to the justice system by the GBV survivors through enhanced capacity strengthening and coordination among the police, prosecutors and lawyers.

Recommendation 12: UNFPA Libya should continue to work with national counterparts for the mainstreaming and operationalization of gender issues in relevant national strategies and policies.
Origin: EQ 1, EQ 3, EQ 7
Target: Country Office **Priority:** Medium

Associated Conclusion: 12

Implications: UNFPA, together with the national counterparts, should increase the provision of expertise and technical assistance to the government in order to mainstream gender into national policies and development frameworks. UNFPA should also continue to target adolescents and youth as agents for change.

6.2.4 Population Dynamics

Recommendation 13: UNFPA should ensure strengthening national capacities on data generation and policy formulation and programming, in addition to strengthening institutionalization of the utilization of data.

Origin: EQ 1, EQ 3, EQ 6
Target: ASRO and CO **Priority**: High
Associated Conclusion: 13

Implications: There is a need for increased capacity of the country on data generation. Increased advocacy to the government to allocate increased resources for implementation of surveys. Advocacy for reduced bureaucracy in government when it comes to access to data will also be needed to foster effective dissemination of data informing programming. Targeted institutionalization of data generation through capacity strengthening and establishment of structures will be important.

Recommendation 14: Increase emphasis, resources and leverage on the unique mandate and competencies of the CO in PD to support advocacy and results in all focal areas for enhanced evidence-based programming.

Origin: EQ 1, EQ3 and EQ 7
Target: ASRO and CO
Associated Conclusion: 14
Priority: Medium

Implications: Increased emphasis and focus on PD will call for enhanced resource mobilization, including increased human resources. UNFPA's advocacy role on evidence-based programming is likely to enhance achievement of results, especially in RH, A&Y, GEWE and targeting of key populations with services.

ANNEX
Annex 1: Terms of Reference

Terms of Reference

United Nations Population Fund (UNFPA) Libya 1st Country Programme 2019-2022

Country Programme Evaluation

September 2020

Contents

Acronyms

ASRO	Arab States Regional Office
BSC	Bureau of Statistics and Census
CO	Country Office
CP	Country Programme
CCA	Common Country Analysis/Assessment
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
DSA	Daily subsistence allowance
ERG	Evaluation Reference Group
EQA	Evaluation Quality Assessment
EQAA	Evaluation Quality Assurance and Assessment
GBV	Gender-based Violence
GNA	Government of National Accord
LNA	Libyan National Army
HCT	Humanitarian Country Team
HNO	Humanitarian Needs Overview
HRP	Humanitarian Response Plan
ICPD	International Conference on Population and Development
M&E	Monitoring and Evaluation
NESDB	National Economic Social Development Board
PAPFAM	Pan-Arab Project for Family Health
RO	Regional Office
SDGs	Sustainable Development Goals
SRHR	Sexual and reproductive health and rights
ToR	Terms of Reference
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNPDF	United Nations Partnership for Development Framework
UNSDCF	United Nations Sustainable Development Cooperation Framework
WHO	World Health Organization

1. INTRODUCTION

The United Nations Population Fund (UNFPA) is the lead United Nations agency for delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. UNFPA expands the possibilities of women and young people to lead healthy and productive lives. The strategic goal of UNFPA is to "achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development (ICPD), to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality".[157] In pursuit of this goal, UNFPA works towards three transformative and people-centred results: (i) end preventable maternal deaths; (ii) end the unmet need for family planning; and (iii) end gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage. These transformative results will contribute to the achievement of the Sustainable Development Goals (SDGs), in particular good health and well-being (Goal 3), the achievement of gender equality and the empowerment of women and girls (Goal 5), the reduction of inequality within and among countries (Goal 10), and peace, justice and strong institutions (Goal 16). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure that no one will be left behind and that the furthest behind will be reached first.

UNFPA has been operating in Libya since 2012. The support that the UNFPA Libya Country Office (CO) provides to the internationally-recognized Government of National Accord in Libya under the framework of the 1st Country Programme (CP) 2019-2021, builds on national development needs and priorities articulated in: (i) the Joint Country Assessment: Pathways towards a Stable and Resilient Libya (2018) developed by the United Nations Country Team (UNCT); (ii) the United Nations Strategic Framework (UNSF) 2019-2020 (extended until 31 December 2021); (iii) the Libya Humanitarian Needs Overview (HNO) 2018 and Humanitarian Response Plan (HRP) 2018; (iv) the national Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategy (RMNCAH) 2019-2023; (v) the National Statistics Development Strategy (NCDC) 2018-2023; (vi) the Libyan Household Multi-sectoral Needs Assessment (2016) conducted by the national Bureau of Statistics and Census (BSC) and UNFPA; (vii) the Service Availability and Readiness Assessment (SARA) (2017) prepared by the World Health Organization (WHO); (viii) the Gender Based Violence Situational Analysis in Libya (2017) conducted by UNFPA; (ix) the Libyan National Family Health Survey, Pan-Arab Project for Family Health (PAPFAM) reports 2007 and 2014 prepared by the BSC; and (x) the study on The Libyan Youth Today: Opportunities and Challenges (2016) jointly undertaken by UNFPA, the Ministry of Planning and the National Economic Social Development Board (NESDB).

The 2019 UNFPA Evaluation Policy requires CPs to be evaluated at least once every two programme cycles. The country programme evaluation (CPE) will provide an independent assessment of the relevance and performance of the UNFPA 1st CP 2019-2021 in Libya, and offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results. The CPE will also draw key lessons and provide a set of actionable recommendations for the next programme cycle.

The evaluation will be implemented in line with the *Handbook on How to Design and Conduct Country Programme Evaluations at UNFPA* (UNFPA Evaluation Handbook), which is available at: https://www.unfpa.org/EvaluationHandbook. The handbook provides practical guidance for managing and conducting CPEs to ensure the production of quality evaluations in line with the United Nations Evaluation Group (UNEG) norms and standards and international good practice for evaluation. It offers step-by-step guidance to prepare methodologically robust evaluations and sets out the roles and responsibilities of key evaluation stakeholders at all stages in the evaluation process. The handbook includes a number of tools, resources and templates that provide practical guidance on specific activities and tasks that the evaluators and the Evaluation Manager perform in the different evaluation phases.

The main audience and primary intended users of the evaluation are: (i) The UNFPA Libya CO; (ii) the GNA; (iii)

[157] UNFPA Strategic Plan 2018-2021, p. 3. The document is available at: https://www.unfpa.org/sites/default/files/resource-pdf/DP.FPA_.2017.9_-_UNFPA_strategic_plan_2018-2021_-_FINAL_-_25July2017_-_corrected_24Aug17.pdf.

the UNCT and the Humanitarian Country Team (HCT) in Libya; (iv) the UNFPA Arab States Regional Office, (ASRO); (v) and donors operating in in Libya. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) Implementing partners of the UNFPA Libya CO; (ii) UNFPA headquarters divisions, branches and offices; (iii) the UNFPA Executive Board; (iv) academia; (v) local civil society organizations and international NGOs; and (vi) beneficiaries of UNFPA support (in particular women and adolescents and youth). The evaluation results will be disseminated to these audiences as appropriate, using traditional and new channels of communication and technology.

The evaluation will be managed by the Evaluation Manager within the UNFPA Libya CO, with guidance and support from the Regional Monitoring and Evaluation (M&E) Adviser at ASRO, and in consultation with the Evaluation Reference Group (ERG) throughout the evaluation process. A team of independent external evaluators will conduct the evaluation and prepare an evaluation report in conformity with these terms of terms of reference.

2. COUNTRY CONTEXT

In December 2015 the Libyan Political Agreement was signed which led to the establishment of a Presidency Council and a Government of National Accord in Tripoli, the internationally recognized Libyan Government. Despite this agreement and the launching of the Libya Action Plan in 2017, violence and turmoil continue to adversely affect the population and hinder social, economic and political development. Prior to the current conflict, Libya was ranked 55 out of 187 countries on the Human Development Index, yet in 2016 the ranking dropped to 102 out of 189 countries. The ongoing crisis has affected all aspects of life for the population of Libya.

An upper-middle income country, Libya has been affected by instability and conflict since 2011, with growing levels of insecurity, political fragmentation, and a significant deterioration of public services, exacerbating existing vulnerabilities of Libyans, migrants and refugees. Years of war and instability have sent the economy into a downward spiral. The war around Tripoli that erupted in April 2019 reversed the momentum of the relative economic recovery over 2017-18. Indeed, Libya managed to more than double its oil production over the two-year recovery period, to reach 1.17 million barrel per day (bpd) in April 2019, however, oil production declined by 0.1 million bpd at end July 2019.[158]

The last census was conducted in 2006, and projections by the BSC for 2018, estimate that the population of Libya will reach approximately 6.5 million with 24 per cent between the ages of 10-24 years.

The protracted conflict and the deteriorating security situation in Libya have led to multiple displacements, loss of livelihood opportunities, and destruction of formal and informal social protection and supportive services. Out of the 1.8 million people affected by the crisis, more than 893,000 people are in need of some form of humanitarian assistance, including more than 212,000 women. Conflict has caused the displacement of more than 430,000 IDPs and 626,000 migrants and refugees are present in the country. They lost community and family protection and are facing significant risks to their lives and well-being.[159] Migrant women and girls are reported as being the most exposed to sexual and physical abuse, with limited access to sexual and reproductive health services. There is also under-reporting of gender-based violence in host communities.

The situation is further compounded by the COVID-19 pandemic, with over 11,000 cases reported as of 24 August 2020, and has severely disrupted access to life-saving sexual and reproductive health services. Reports indicate that in some areas, 90% of functioning Primary Health Care (PHC) centers have closed due to COVID-19, because healthcare staff refused to work in the absence of Personal Protective Equipment (PPE) (Health Sector monthly updates 2020). In addition, communities are losing trust in the capacity of the health system to safely meet essential needs and to control infection risks in health facilities. This in turn has negatively affected the appropriate care-seeking behavior and adherence to public health advice.

[158] Source: World Bank.
[159] Libya HNO 2020.

COVID-19 is also compounding existing inequalities for women and girls, and deepening discrimination against other marginalized groups, especially for migrants and refugees. Both, increase in the direct mortality from the outbreak and indirect mortality from vaccine-preventable and treatable conditions are reported by UNFPA's IPs. Reproductive health services including ante- and postnatal care, family planning and the management of sexually transmitted infections (STIs) have almost collapsed and there has been an alarming increase in rates of caesarean sections. Similarly, family planning and mental health issues, especially among women and girls, remain chronically a neglected area in the health care institutions. There are only three public mental health hospitals in the entire country, and most patients are treated in private health facilities and none of the public health institutions provide any kind of family planning counseling or health services in Libya.

Sexual and Reproductive Health

In 2014, the total fertility rate was 3.4, compared to 2.7 in 2007 and the unmet need for family planning was 43 per cent, according to the Libya Family Health Survey. In 2015, the maternal mortality ratio was 9 per 100,000 live births, however these figures do not take into account stark regional disparities and the deterioration of health services since 2014. Before the conflict, the Libyan health system, with its advanced hospital services and large network of primary health care facilities oversaw declining maternal mortality and the achievement of the Millenium Development Goal 5. Unfortunately, the years of crisis have negatively impacted the system of financing of services, health information flows, management of referrals, availability of medicines, supply-chain management, human resources, and the overall quality of service delivery. Maternal death surveillance and response programming has suffered, particularly in the south of Libya where only 12.1 per cent of the health facilities provide antenatal care and only 8.5 per cent of the health facilities provide delivery services. There is only one voluntary counselling and testing centre in Tripoli and seven others that provide only testing for HIV without counselling. The total number of people living with HIV registered at hospitals in Libya as of December 2017 is 3,848. The Service Availability and Readiness Assessment carried out by the Ministry of Health and WHO in 2017 highlighted that most facilities lack a supply of post-rape care kits and emergency contraception, while health staff have not received any training on the clinical management of rape. The lack of specialized services, including for GBV survivors, and the lack of trust in existing health services is chronic in Libya. According to the Health Sector 2019 findings in Libya, 23-25% of assessed 1,145 public primary health care (PHC) facilities are closed. Also, 0% of essential services are available in 230 (26%) of open PHC facilities.

The provision of sexual and reproductive health services, including ante- and postnatal care, family planning and the management of sexually transmitted infections have all collapsed due to the ongoing conflict. There has been an alarming increase in rates of cesarean sections throughout the country. Among the population in need of almost 1 million, there would be an average of 140 births per day, of which 15% would need Emergency Obstetric and Newborn Care (EmONC) to ensure the safety of the mother and the baby. Family planning is not available in public health facilities and limitations to quality sexual reproductive health services risk leading to higher mortality rates among women and children.

Youth and adolescents

Young people in Libya make up a quarter of the population. In a youth survey of 2016, young Libyans described safety and security as the main challenges they face, followed by lack of employment opportunities, life skills and education. Despite the proliferation of armed groups and youth enrolment in them, the majority of Libyan youth are ready and willing to participate in social development, economic productivity and peacebuilding initiatives.

The PAPFAM 2014 report highlighted that adolescent birth rate in Libya was at 6.5% for ever-married women aged 15-49, while highlighted that the value for "HIV knowledge for adolescents and youth" was at 81.4% for married women aged 15-19 and 82.6% for married women aged 20- 24. No SRH-related data is available for unmarried adolescents and youth.

Gender-Based Violence

In the current climate, there are notable threats to safety and security throughout the country, in particular for women

and girls. Libya has not enacted any legislation for the prevention of, punishment for and protection from domestic and gender-based violence. According to the protection cluster response plan for 2018, 307,000 women of reproductive age are in need of protection, including internally displaced persons, returnees and women in host communities. The Libyan Family Health Survey conducted in 2014 found that 8.2 per cent of women and girls aged between 15-49 years were subjected to abuse in the year before the survey. 79.1 per cent of women experienced verbal abuse and this percentage was even higher among divorced women and in poorer families. Physical assault represented 11 per cent of the registered cases of violence, while 2.6 per cent of those surveyed stated they had been subjected to sexual assault. More recent studies have indicated that the 2014 survey suffered from significant under-reporting, likely due to cultural and social sensitivities.

The impact of conflict on women and girls in Libya has been particularly severe. Women and girls are extremely vulnerable in such context and face increased levels of sexual violence. Female refugees, IDPs and asylum seekers often lack access to sexual and reproductive health services, GBV prevention and response services as well as access to the justice system. For both displaced persons and communities trapped in conflict, worsening security concerns from the state and the community often result in limiting the freedom of movement for women and girls, with the assumption that this would be best for their protection. The status of women and girls continues to be impacted by discriminatory traditional practices and social norms. Child/early and forced marriage remains widespread despite having a law in Libya setting the age of marriage by 18 years, but the implementation of the law is still not in place in some locations.

UNFPA's implementing partners' reports indicate that incidents of GBV have increased as a result of the ongoing conflict in Tripoli and other cities; incidents ranging from sexual violence, including rape, physical violence, denial of resources, opportunities and services, intimate partner's violence/domestic violence and child marriage. However, the numbers don't reflect the actual prevalence rates, due to fear of retaliation and social stigma, lack of specialized services including lack of trust in existing health services and providers as a barrier for seeking help; survivors fear that they will not receive the care they need due to the attitude, lack of supplies and capacity of service providers. Displaced women and girls, women heads of households, separated and unaccompanied girls and boys, women and girls living with disabilities and from marginalized groups are at greater risk.

According to the PAPFAM 2014 report, child marriage was 3.9% for under 18 and 0.7% for under 15 ever-married women aged 15-49, meaning that the percentage of women exposed to marriage before 18 years was below 1.9% of the total population of women in Libya in 2014.

Population Data

An assessment of the National Statistical System, led by the BSC and supported by the Organization for Economic Co-operation and Development and UNFPA in 2017, showed that Libya has limited strategic, technical and human capacities to produce demographic data for decision-making for public and private users. There are also gaps in the integration of socio-demographic intelligence in national and sub-national plans and programmes.

3 UNFPA Country Programme

UNFPA has been working with the Government of National Accord in Libya since 2017[160] towards enhancing sexual and reproductive health and rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. UNFPA is currently implementing the 1st CP in Libya.

The 1st CP (2019-202 1) is aligned with national development priorities, the United Nations Strategic Framework (UNSF) 2019-2021, UNFPA Strategic Plan 2018-2021 and the Sustainable Development Goals, in particular Goal 3, Goal 5 and Goal 10, as well as the Libya HNO and HRP. It was developed in consultation with Government, civil

[160] To be noted that it is only in August 2018 that Libya CO received the official accreditation with the agreement signature with the Libyan Government. This is why no CPD could be formalized for the years 2017-2018.

society, bilateral and multilateral development partners, including United Nations organizations, the private sector and academia .

Through its CP 2019-2021, UNFPA adopted a community-based approach with adolescents and youth and women engagement through emergency risk management programmes and institutional capacity-building, with the goal to improve the health and well-being of women and adolescents youth, particularly focusing on the most vulnerable and those left furthest behind, namely displaced women and girls, women heads of households, separated and unaccompanied girls and boys, women and girls living with disabilities and from marginalized groups, including migrant and refugee groups. UNFPA's strategic priorities and programmatic interventions in Libya are articulated in four areas: a) sexual and reproductive health and reproductive rights; b) adolescents and youth; c) gender equality and women's empowerment; d) population dynamics.

The UNFPA Libya CO delivers its country programme through the following modes of engagement: : (i) advocacy and policy dialogue, (ii) capacity development, (iii) knowledge management, (iv) partnerships and coordination, and (v) service delivery]. The **overall goal** of the UNFPA Libya 1st CP (2019-2021) is **universal access to sexual and reproductive health and reproductive rights and reduced maternal mortality**, as articulated in the UNFPA Strategic Plan 2018-2021. The CP contributes to the following **outcomes** of the UNFPA Strategic Plan 2018-2021:

- **Outcome 1.** *Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence*.
- **Outcome 2.** *Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts.*
- **Outcome 3.** *Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings.*
- **Outcome 4.** *Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development*.

The UNFPA Libya 1st CP (2019-2021) has four thematic areas of programming with distinct **outputs** that are structured according to the four outcomes in the Strategic Plan 2018-2021 to which they contribute.

Outcome 1: Sexual and reproductive health and reproductive rights

Output 1.1 Increased access for women and girls to high quality sexual and reproductive health services, with a focus on humanitarian settings. This is to be achieved by:
(a) supporting health facilities and mobile teams to expand coverage to the areas affected by humanitarian situations; (b) building the capacity of the health care providers on the minimum initial service package; (c) providing outreach to communities to enhance demand; and d) advocating for policies to increase access of migrants and refugees to SRHR information and services.

Output 1.2. Improved capacity and resilience of health systems for the provision of integrated sexual and reproductive health services, including for the most vulnerable. This includes: (a) assessing human resource needs and building the capacity of the health care providers on reproductive health and midwifery guidelines, protocols and referral pathways; (b) enhancing surveillance systems, including in the area Maternal Death Surveillance and Response; (c) advocating for the expansion of HIV voluntary counselling and testing centres; (d) integrating reproductive health in the budgeted national health emergency preparedness plan; (e) supporting the development of the Logistics Management and Information System.

Outcome 2: **Youth development and participation**

Output 2.1. Adolescents and youth, including the most vulnerable have increased opportunities to participate in decision-making and to lead initiatives that promote sustainable development and peace and security. This includes: (a) supporting the development of a national youth strategy and an action plan, with youth participation; (b) building capacities of youth on life skills and citizenship education; (c) supporting youth networks to contribute to achieving sustainable development, peace, and security in their communities and country; and (d) operationalizing UNSCR 2250 and convening a national coalition and programme on youth, peace and

security.

Outcome 3: Gender equality and women's empowerment

Output 3.1. Strengthened national capacities to prevent and respond to gender-based violence including in humanitarian settings. This includes: (a) leading and supporting a functional inter-agency gender-based violence coordination system; (b) enhancing capacities of national partners to address gender-based violence through a multi-sectoral, survivor-centric approach with specialized case management and psychosocial support; (c) supporting the development of sexual reproductive health/gender-based violence referral pathways and management information systems and (d) policy engagement and advocacy for national ownership of the gender-based violence essential services package .

Outcome 4: Population dynamics

Output 4.1. National data systems are strengthened to increase the utilization of demographic intelligence at national and local levels. This includes: (a) providing technical support and capacity-building to plan for a national census by 2021; (b) providing support to conduct regular municipal level household surveys to inform humanitarian and development planning; and (c) providing technical support to increase the use of data at national and subnational levels for informing policy.

In addition, the UNFPA Libya CO takes part in activities of the UNCT under the leadership of the United Nations Resident Coordinator, with the objective to ensure inter-agency coordination and efficient delivery of tangible results in support of the national development agenda and the SDGs.

The **theory of change** that describes how and why the set of activities planned under the CP are expected to contribute to a sequence of results that culminates in the strategic goal of UNFPA is presented in Annex A. The theory of change will be an essential building block of the evaluation methodology.

The UNFPA Libya 1st CP (2019-2021) is based on the following results framework presented below:

Libya /UNFPA 1st Country Programme (2019-2021) alignment to the SP (2018-2021)

Goal: Achieved universal access to sexual and reproductive health, realized reproductive rights, and reduced maternal mortality to accelerate progress on t ICPD agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality			
UNFPA Thematic Areas of Programming			
I. Sexual and reproductive health and reproductive rights	**II. Adolescents and youth**	**III. Gender equality and women's empowerment**	**IV. Population dynamics**
UNFPA Strategic Plan Outcomes			
Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.	**Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts .**	**Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings.**	**Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development.**
UNFPA Libya 1st CP Outputs			
Output 1. Increased access for women and girls to high quality sexual and reproductive health services, with a focus on humanitarian settings. **Output 2.** Improved capacity and resilience of health systems for the provision of integrated sexual and reproductive health services, including for the most vulnerable.	**Output 3.** Adolescents and youth, including the most vulnerable have increased opportunities to participate in decision-making and to lead initiatives that promote sustainable development and peace and security.	**Output 4.** Strengthened national capacities to prevent and respond to gender-based violence including in humanitarian settings.	**Output 5.** National data systems are strengthened to increase the utilization of demographic intelligence at national and local levels.
UNFPA Libya 1st CP Intervention Areas			
(a) supporting health facilities and mobile teams to expand coverage to the areas affected by humanitarian situations; (b) building the capacity of the health care providers on the minimum initial service package; (a) assessing human resource needs and building the capacity of the health care providers on reproductive health and midwifery guidelines, protocols and referral pathways; (b)	(a) supporting the development of a national youth strategy and an action plan, with youth participation; (b) building capacities of youth on life skills and citizenship education; (c) supporting youth networks to contribute to achieving sustainable development, peace, and security in their communities and country; and (d) operationalizing UNSCR	(a) leading and supporting a functional inter-agency gender-based violence coordination system; (b) enhancing capacities of national partners to address gender-based violence through a multi-sectoral, survivor-centric approach with specialized case management and psychosocial support; (c) supporting the development of sexual reproductive health/gender-based violence referral pathways and management information systems	(a) providing technical support and capacity-building to plan for a national census by 2020; (b) providing support to conduct regular municipal level household surveys to inform humanitarian and development planning; and (c) providing technical support to increase the use of data at national and subnational levels for informing policy.

(c) providing outreach to communities to enhance demand; and d) advocating for policies to increase access of migrants and refugees to SRHR information and services.	enhancing surveillance systems, including in the area Maternal Death Surveillance and Response; (c) advocating for the expansion of HIV voluntary counselling and testing centres; (d) integrating reproductive health in the budgeted national health emergency preparedness plan; (e) supporting the development of the Logistics Management and Information System.	2250 and convening a national coalition and programme on youth, peace and security.	and (d) policy engagement and advocacy for national ownership of the gender-based violence essential services package.	

5. EVALUATION PURPOSE, OBJECTIVES AND SCOPE

4.1. Purpose

The CPE will serve the following three main purposes outlined in the 2019 UNFPA Evaluation Policy: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; and (iii) contribute key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action of the 1994 ICPD.

4.2. **Objectives**

The **purpose** of this CPE is:

i. to provide the UNFPA CO in Libya, national stakeholders, the UNFPA ASRO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Libya 1st CP (2019-2021) .
ii. to broaden the evidence base for the design of the next programme cycle.

The **objectives** of this CPE are:

i. Provide an independent assessment of the relevance, effectiveness (in terms of progress towards the expected outputs and outcomes set forth in the results framework of the CP), efficiency and sustainability of UNFPA support.
ii. Provide an assessment of the geographic and demographic coverage of UNFPA humanitarian action and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives.
iii. Provide an assessment of the role played by the UNFPA CO in the United Nations system-wide coordination mechanisms for development assistance and humanitarian action with a view to enhancing the United Nations collective contribution to national development and humanitarian results.
iv. Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme cycle.

4.3. **Scope**

Geographical Scope
The evaluation will cover the following key regions where UNFPA implemented interventions Tripoli, in the West, Benghazi, in the East; and Sabha, in the South of Libya .

Thematic Scope
The evaluation will cover the following thematic areas of the 1st CP: sexual and reproductive health and reproductive rights; adolescents and youth; gender equality and women's empowerment; and population dynamics. In addition, the evaluation will cover cross-cutting issues such as human rights and gender equality, disability, displacement and migration status, and transversal aspects of coordination; monitoring and evaluation (M&E); innovation; and strategic partnerships.

Temporal Scope
The evaluation will cover interventions planned and/or implemented within the period of the current CP: 2019-2020. (CP cycle is 2019-2021)

5. EVALUATION CRITERIA AND PRELIMINARY EVALUATION QUESTIONS

5.1. **Evaluation Criteria**
In accordance with the methodology for CPEs outlined in the UNFPA Evaluation Handbook (see section 3.2, pp. 51-61), the evaluation will examine the following four OECD/DAC evaluation criteria: relevance, effectiveness, efficiency and sustainability. It will also use the evaluation criterion of coordination to assess cooperation and partnerships of UNFPA within the UNCT and HCT and whether UNFPA interventions promote synergy and avoid

gaps and duplication. As the UNFPA CO has been operating in humanitarian settings, the evaluation will also use the humanitarian-specific evaluation criteria of coverage and connectedness to assess to what extent UNFPA has been able to reach affected populations with life-saving services and work across the humanitarian-peace-development nexus and contribute to building resilience.

Relevance	The extent to which the objectives of the UNFPA country programme correspond to population needs at country level (in particular, those of vulnerable groups), and were aligned throughout the programme period with government priorities and with strategies of UNFPA.
Effectiveness	The extent to which country programme outputs have been achieved and the extent to which these outputs have contributed to the achievement of the country programme outcomes.
Efficiency	The extent to which country programme outputs and outcomes have been achieved with the appropriate amount of resources (funds, expertise, time, administrative costs, etc.).
Sustainability	The continuation of benefits from a UNFPA-financed intervention after its termination, linked, in particular, to their continued resilience to risks.
Coordination	The extent to which UNFPA has been an active member of, and contributor to existing United Nations system-wide coordination mechanisms for development assistance and humanitarian action
Coverage	The extent to which major population groups facing life-threatening suffering were reached by humanitarian action.
Connectedness	The extent to which activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account.

5.2. Preliminary Evaluation Questions

The CPE is expected to provide answers to a number of evaluation questions which are derived from the above criteria. The evaluation questions will delineate the thematic scope of the CPE and are meant to formulate key areas of inquiry that are of interest to various stakeholders, thereby optimizing the focus and utility of the CPE.

The evaluation questions presented below are indicative and preliminary. Based on these questions, the evaluators are expected to develop a final set of evaluation questions based on these preliminary questions, in consultation with the Evaluation Manager at the UNFPA Libya CO and the Evaluation Reference Group (ERG).

Relevance

1. To what extent is the country programme adapted to: i) the needs of diverse populations, including the needs of marginalized and vulnerable groups; ii) national development strategies and policies; iii) the strategic direction and objectives of UNFPA; iv) priorities articulated in international frameworks and agreements, in particular the ICPD and SDGs ; and v) the New Way of Working[161] and the Grand Bargain[162]
2. To what extent has the Country Office been able to respond to changes in national needs and priorities, including those of vulnerable or marginalized communities, or to shifts caused by crisis or major political changes including the ongoing Covid-19 Pandemic?

Effectiveness

3. To what extent have the interventions supported by UNFPA contributed to the achievement of the expected results (outputs and outcomes) of the country programme and any other revisions that may have been done

[161] For more information, please see: https://www.agendaforhumanity.org/sites/default/files/20170228%20NWoW%2013%20high%20res.pdf.
[162] For more information, please see: https://interagencystandingcommittee.org/grand-bargain.

in view of the Covid-19 pandemic? In particular: i) increased access and use of quality sexual and reproductive health services, in particular by populations affected by humanitarian crisis; ii) increased participation of adolescents and youth, including the most vulnerable, in decision-making and enhanced youth leadership to promote sustainable development, peace and security ; iii) advancement of gender equality and the empowerment of all women and girls, with a particular focus on prevention and response to GBV; and iv) increased use of demographic intelligence in the development of evidence-based humanitarian and development plans, policies and programmes at national and local levels?

4. To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?

Efficiency

5. To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme?

Sustainability

6. To what extent has UNFPA been able to support implementing partners and beneficiaries (women and adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?

Coordination

7. To what extent has the Country Office contributed to the functioning and consolidation of United Nations system-wide development and humanitarian coordination mechanisms?

Coverage

8. To what extent have UNFPA humanitarian interventions systematically reached all geographic areas in which affected populations (women and adolescents and youth) reside?
9. To what extent have UNFPA humanitarian interventions systematically reached the most vulnerable and marginalized groups (women and adolescents and youth with disabilities; migrants and refugees, those of racial, ethnic, religious and national minorities; etc.)

Connectedness

10. To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women's organizations, health facilities, communities etc.) to better prepare for, respond to and recover from humanitarian crisis?

The final evaluation questions and the evaluation matrix will be presented in the design report.

6. APPROACH AND METHODOLOGY

6.1. Evaluation Approach

Theory-based approach

The CPE will adopt a theory-based approach that relies on an explicit theory of change, which depicts how the interventions supported by the UNFPA CO in Libya are expected to contribute to a series of results (outputs and outcomes) that lead to the overall goal of UNFPA. The theory of change also identifies the causal links between the results, as well as critical assumptions and contextual factors that support or hinder the achievement of desired changes. A theory-based approach is fundamental for generating insights about what works, what does not and why. It focuses on the analysis of causal links between changes at different levels of the results chain that the theory of change describes, by exploring how the assumptions behind these causal links and contextual factors affected the

achievement of intended results.

The theory of change will play a central role throughout the evaluation process, from the design and data collection to the analysis and identification of findings, as well as the articulation of conclusions and recommendations. The evaluation team will be required to verify the theory of change underpinning the UNFPA-Libya 1st CP (2019 - 2021) (see Annex A) and use this theory of change to determine whether changes at output and outcome levels occurred (or not) and whether assumptions about change hold true. The analysis of the theory of change will serve as the basis for the evaluators to assess how relevant, effective, efficient and sustainable the support provided by the UNFPA Libya was during the period of the 1st CP.

As part of the theory-based approach, the evaluators shall use a contribution analysis to explore whether evidence to support key assumptions exists, examine if evidence on observed results confirms the chain of expected results in the theory of change, and seek out evidence on the influence that other factors may have had in achieving desired results. This will enable the evaluation team to make a reasonable case about the difference that the UNFPA- Libya 1st CP (2019-2021) made.

Participatory approach

The CPE will be based on an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at national and sub-national levels. The UNFPA Libya CO has developed a stakeholders map (Annex B) to identify stakeholders who have been involved in the preparation and implementation of the CP, and those partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context. These stakeholders include representatives from government, civil society organizations, implementing partners, the private sector, academia, other United Nations organizations and international non-governmental organizations, donors and, most importantly, beneficiaries (women and adolescents and youth). They can provide insights and information, as well as referrals to data sources that the evaluators should use to assess the contribution of UNFPA support to changes in each thematic area of programming of the CP. Particular attention will be paid to ensuring participation of women, adolescent girls and young people, especially those from vulnerable and marginalized communities.

The Evaluation Manager in the UNFPA-Libya CO has established an ERG comprised of key stakeholders of the CP including: governmental and non-governmental counterparts at national level, the UNFPA ASRO M&E Adviser, UNFPA Libya CO staff members from the different thematic areas of programming, as well as other relevant stakeholders. The ERG will provide inputs at different stages in the evaluation process.

Mixed-method approach

The evaluation will primarily use qualitative methods for data collection, including document review, interviews, group discussions and observations through field visits, as appropriate. The qualitative data will be complemented with quantitative data to minimize bias. Quantitative data will be compiled through desk review of documents, websites and online databases to obtain relevant financial data and data on key indicators that measure change at output and outcome levels.

These complementary approaches described above will be used to ensure that the evaluation: (i) responds to the information needs of users and the intended use of the evaluation results; (ii) upholds gender and human rights principles throughout the evaluation process, including, to the extent possible, participation and consultation of key stakeholders (rights holders and duty-bearers); and (iii) provides credible information about the benefits for recipients and beneficiaries (women and adolescents and youth) of UNFPA support through triangulation of collected data.

6.2. **Methodology**

The evaluation team shall develop the evaluation methodology in line with the evaluation approach and guidance provided in the UNFPA Evaluation Handbook. The handbook will help the evaluators develop a methodology that meets good quality standards for evaluation at UNFPA and the professional evaluation standards of UNEG. It is expected that, once contracted by the UNFPA Libya CO, the evaluators acquire a solid knowledge of the handbook.

The CPE will be conducted in accordance with the UNEG *Norms and Standards for Evaluation*[163], *Ethical Guidelines for Evaluation*[164], *Code of Conduct for Evaluation in the UN System*[165], *and Guidance on Integrating Human Rights and Gender Equality in Evaluations*[166]. When contracted by the UNFPA CO Libya, the evaluators will be requested to sign the UNEG *Code of Conduct* prior to starting their work.

The methodology that the evaluation team will develop builds the foundation for providing valid and evidence-based answers to the evaluation questions and for offering a robust and credible assessment of UNFPA support in Libya. The methodological design of the evaluation shall include in particular: (i) a theory of change; (ii) a strategy for collecting and analyzing data; (iii) specifically designed tools for data collection and analysis; (iv) an evaluation matrix; and (v) a detailed work plan.

The evaluation team is strongly encouraged to refer to the Handbook at all times and use the provided tools and templates at all stages of the evaluation process.

The evaluation matrix

The evaluation matrix is centerpiece to the methodological design of the evaluation (see Handbook, section 1.3.1, pp. 30-31 and Tool 1: The Evaluation Matrix, pp. 138-160 and the evaluation matrix template in Annex C). The matrix contains the core elements of the evaluation. It outlines (i) *what will be evaluated:* evaluation questions for all evaluation criteria and key assumptions to be examined; and (ii) *how it will be evaluated*: data collection methods and tools and sources of information for each evaluation question and associated key assumptions. By linking each evaluation question (and associated assumptions) with the specific data sources and data collection methods required to answer the question, the evaluation matrix plays a crucial role before, during and after data collection.

In the design phase, the matrix helps evaluators to develop a detailed agenda for data collection and analysis and to prepare the structure of interviews, group discussions and direct observation at sites visited. During the field phase, the evaluation matrix serves as a reference document to ensure that data is systematically collected for all evaluation questions and that data is documented in a structured and organized way. At the end of the field phase, the matrix is useful to ensure that verified and sufficient evidence has been collected to answer all evaluation questions or, on the contrary, to identify data gaps that require data collection to be extended. In the reporting phase, the evaluation matrix serves as a reference for drafting the findings for each evaluation question and for drawing conclusions and formulating recommendations that cut across different evaluation questions.

As the evaluation matrix plays a crucial role at all stages of the evaluation process, it will require particular attention from both the evaluation team and the Evaluation Manager. The evaluation matrix will be drafted in the design phase and must be included in the design report. The evaluation matrix will also be included in the annexes to the final evaluation report, to enable users to access the supporting evidence for the answers to the evaluation questions.

Finalization of the evaluation questions and assumptions

Based on the preliminary evaluation questions presented in the present terms of reference (see section 5.2) and the theory of change underlying the CP (see Annex A), the evaluators are required to finalize the set of questions. In their final form, the questions should reflect the evaluation criteria (see section 5.1) and clearly define the key areas of inquiry of the CPE. The final evaluation questions will structure the evaluation matrix (see Annex C) and shall be presented in the design report.

The evaluation questions must be complemented by a set of critical assumptions that capture key aspects of how and why change is expected to occur based on the theory of change of the CP. This will allow evaluators to assess whether

[163] http://www.unevaluation.org/document/detail/1914
[164] http://www.unevaluation.org/document/detail/102
[165] http://www.unevaluation.org/document/detail/100
[166] http://www.unevaluation.org/document/detail/980

the preconditions for contribution to results at output and, in particular, outcome levels are met. The data collection for each of the evaluation questions and assumptions will be guided by clearly formulated quantitative and qualitative indicators, which need to be specified in the evaluation matrix.

Consideration for Covid-19 restrictions

Due to the ongoing Covid-19 pandemic that has necessitated travel and entry restrictions in many countries across the region and the world at large, a substantial part of this evaluation may be conducted remotely. It is also noted that even in situation when travel is permitted, local laws, and/or requirement for social distancing may limit the kind of person-to-person interactions that may be required for the purpose of interviews and data collection. While the prevailing local conditions and social distancing restrictions may limit person-to-person direct contact, it is expected that specific approaches would be adopted by the evaluation team to ensure that key stakeholders and beneficiaries are reached through innovative means including but not limited to remote data collection, document reviews, online interviews, zoom sessions for FGDs, among others.

Sampling strategy

The UNFPA- Libya CO will provide an initial overview of the interventions supported by UNFPA, the locations where these interventions have taken place, and the stakeholders involved in these interventions. As part of this process, the UNFPA-Libya CO has produced a stakeholder mapping to identify the whole range of stakeholders that are directly or indirectly involved in the implementation, or affected by the implementation of the CP (see Annex B)

Based on information gathered through desk review and discussions with the CO staff, the evaluators will refine the initial stakeholders map and develop a comprehensive stakeholders map. From this stakeholders map, the evaluation team will select a sample of stakeholders at national and sub-national levels who will be consulted through interviews and/or group discussions during the data collection phase. These stakeholders must be selected through clearly defined criteria and the sampling approach outlined in the design report (for guidance on how to select a sample of stakeholders see Handbook, pp. 62-63). In the design report, the evaluators should also make explicit what groups of stakeholders were not included and why. The evaluators should aim to select a sample of stakeholders that is as representative as possible, recognizing that it will not be possible to obtain a statistically representative sample.

The evaluation team shall also select a sample of sites that will be visited for data collection, and provide the rationale for the selection of the sites in the design report. The UNFPA-Libya CO will provide the evaluators with information on the accessibility of different locations, including logistical requirements and security risks and concerns. The sample of sites selected for visits should reflect the variety of interventions supported by UNFPA in terms of thematic focus of programming and context.

The final sample of stakeholders to be consulted and sites to be visited will be determined in consultation with the Evaluation Manager based on the review of the design report.

Data collection

The evaluation will consider primary and secondary sources of information. For detailed guidance on the different data collection methods typically employed in CPEs, see Handbook, section 3.4.2, pp. 65-73.

Primary data will be collected through semi-structured interviews with key informants at national and sub-national levels (government officials, representatives of implementing partners, civil society organizations, other United Nations organizations, donors, and other stakeholders), as well as group discussions with service providers and beneficiaries (women and adolescents and youth) and direct observation during visits to programme sites.

Secondary data will be collected through desk review**,** primarily focusing on annual and mid-year reviews of the CP, progress reports and monitoring data, evaluations and research studies (incl. previous CPEs, assessments of the CP, evaluations by the UNFPA Evaluation Office, research by international NGOs and other United Nations organizations

etc.), housing census and population data, and records and data repositories of the UNFPA-Libya CO and its implementing partners, such as health clinics/centres. Particular attention will be paid to compiling data on key performance indicators of the UNFPA-Libya CO during the period of the 1st CP (2019-2021-year). The evaluation team will ensure that data collected is disaggregated by sex, age, location and other relevant dimensions (e.g., disability status) to the extent possible.

The evaluation team is expected to dedicate a total of [3] weeks for data collection in the field. The data collection tools that the evaluation team will develop, which may include protocols for semi-structured interviews and group discussions, a checklist for direct observation at sites visited or a protocol for document review, shall be presented in the design report.

Data analysis

The evaluation matrix will be the major framework for analyzing data. Once all data will have been entered into the evaluation matrix for each evaluation question, the evaluators should identify common themes, patterns and relationships in the data. The evaluators shall also identify areas that should be further explored to fully answer the evaluation questions and thus cover the whole scope of the evaluation (see Handbook, sections 5.1 and 5.2, pp. 115-117).

Validation mechanisms

All findings of the evaluation need to be firmly grounded in evidence. The evaluation team will use a variety of mechanisms to ensure the validity of collected data, including (for more detailed guidance see Handbook, section 3.4.3, pp. 74-77):

- Systematic triangulation of data sources and data collection methods (see Handbook, section 4.2., pp. 94-95);
- Regular exchange with the Evaluation Manager at the CO;
- Internal evaluation team meetings to corroborate data and information for the analysis of assumptions, the formulation of emerging findings and the definition of preliminary conclusions ; and
- The debriefing meeting with the CO and the ERG at the end of the field phase where the evaluation team present the preliminary findings and emerging conclusions.

Data validation is a continuous process throughout the different evaluation phases. The evaluators should check the validity of data and verify the robustness of findings at each stage in the evaluation, so they can determine whether they should further pursue specific hypotheses (related to the evaluation questions) or disregard them when there are indications that these are weak (contradictory findings or lack of evidence). The validation mechanisms will be presented in the design report.

7. EVALUATION PROCESS

The CPE process can be broken down into five different phases that include different stages and lead to different deliverables: preparatory phase; design phase; field phase; reporting phase; and facilitation of use and dissemination phase. Quality assurance must be performed by the Evaluation Manager and the evaluation team leader throughout all phases to ensure the production of a credible, useful and timely evaluation.

7.1. Preparatory Phase *(Handbook, pp.35-40)*

The Evaluation Manager at the UNFPA Libya CO will lead the preparatory phase of the CPE, which includes:

- Establishment of the ERG.
- Drafting the terms of reference (ToR) for the CPE with support from the ASRO M&E Adviser and in consultation with the ERG, and approval of the draft ToR by the Evaluation Office.
- Selection of consultants by the CO, pre-qualification of the consultants selected by the Evaluation Office, and recruitment of the consultants by the CO to constitute the evaluation team.

- Compilation of background information and documents on the country context and CP for desk review by the evaluation team.
- Preparation of a first stakeholders map (Annex B) and list of Atlas projects (Annex D).
- Development of a communication plan by the Evaluation Manager in consultation with the communications officer at the UNFPA Libya CO to support dissemination and facilitate the use of evaluation results. This plan should be updated as the evaluation process evolves, so it is ready for immediate implementation when the final evaluation report is issued.

7.2. Design Phase *(Handbook, pp.43-83)*

The evaluation team will conduct the design phase in consultation with the Evaluation Manager and the ERG. This phase includes:

- Evaluation kick-off meeting between the Evaluation Manager and the evaluation team.
- Desk review of initial background information and documents on the country context and CP, as well as other relevant documentation.
- Review and refinement of the theory of change underlying the CP (see Annex A).
- Formulation of a final set of evaluation questions based on the preliminary evaluation questions provided in the ToR.
- Development of a comprehensive stakeholders map and sampling strategy to select sites to be visited and stakeholders to be consulted in Libya through interviews and group discussions.
- Development of a data collection and analysis strategy, as well as a concrete work plan for the field and reporting phases (see Handbook, section 3.5.3, p. 80).
- Development of data collection methods and tools, assessment of limitations to data collection and development of mitigation measures.
- Development of the evaluation matrix (evaluation criteria, evaluation questions, assumptions, indicators, data collection methods and sources of information).

At the end of the design phase, the evaluation team will develop a **design report** that includes the results of the above-listed steps and tasks. The design report will be developed in consultation with the Evaluation Manager, the ERG and the ASRO M&E Adviser. The template for the design report is provided in Annex E. The ASRO M&E Adviser will approve the design report.

7.3. Field Phase *(Handbook, pp. 87 -111)*

The evaluation team will undertake a field mission to Libya to collect the data required to answer the evaluation questions. Towards the end of the field phase, the evaluation team will also conduct a preliminary analysis of the data to identify emerging findings and conclusions to be validated with the CO and the ERG. The field phase should allow the evaluators sufficient time to collect valid and reliable data to cover the thematic scope of the CPE. A period of 3 weeks is planned for this evaluation. However, the Evaluation Manager will determine the optimal duration of the field mission in consultation with the evaluation team during the design phase.

The field phase includes:

- Meeting with the UNFPA Libya CO staff to launch the data collection.
- Meeting of evaluation team members with relevant programme officers at the UNFPA Libya CO.
- Data collection at national and sub-national levels.

At the end of the field phase, the evaluation team will hold a **debriefing meeting with the CO and the ERG** to present the emerging findings and preliminary conclusions from the data collection. The meeting will serve as a mechanism for the validation of collected data and information and the exchange of views between the evaluators and important stakeholders, and will enable the evaluation team to refine the findings, finalize the conclusions and develop credible and relevant recommendations.

7.4. Reporting Phase *(Handbook, pp.115 -121)*

In the reporting phase, the evaluation team will continue the analytical work (initiated during the field phase) and prepare a **draft evaluation report**, taking into account the comments and feedback provided by the CO and the ERG at the debriefing meeting at the end of the field phase.

This draft evaluation report will be submitted to the Evaluation Manager for quality assurance purposes. Prior to the submission of the draft report, the evaluation team must ensure that it underwent an internal quality control against the criteria outlined in the Evaluation Quality Assessment (EQA) grid (Annex F). The Evaluation Manager and the ASRO M&E Adviser will subsequently prepare an EQA of the draft evaluation report, using the EQA grid. If the quality of the report is satisfactory (form and substance), the draft report will be circulated to the ERG for comments and feedback. In the event that the quality of the draft report is unsatisfactory, the evaluation team will be required to revise the report and produce a second draft version.

The Evaluation Manager will collect and consolidate the written comments and feedback provided by the members of the ERG. On the basis of the comments, the evaluation team should make appropriate amendments, prepare the **final evaluation report** and submit it to the Evaluation Manager. The final report should clearly account for the strength of evidence on which findings rest to support the reliability and validity of the evaluation. Conclusions and recommendations need to clearly build on the findings of the evaluation. Conclusions need to clearly reference the specific evaluation question(s) upon which the answer(s) build, while recommendations need to reference the conclusion(s) from which it has (they have) been logically derived.

The evaluation report is considered final once it is formally approved by the Evaluation Manager at the UNFPA Libya CO.

7.5. Facilitation of Use and Dissemination Phase *(Handbook, pp.131 -133)*

In the facilitation of use and dissemination phase, the evaluation team will develop a **PowerPoint presentation for the presentation of the evaluation results** that summarizes the key findings, conclusions and recommendations of the evaluation in an easily understandable and user-friendly way.

The Evaluation Manager, together with the CO communications officer, will implement the communication plan to share the evaluation results with the CO, ASRO, ERG, implementing partners and other stakeholders. The Evaluation Manager will also ensure that the final evaluation report is circulated to relevant business units in the CO, invite them to submit a management response, and consolidate all responses in a final management response document (see Annex G). The UNFPA Libya CO will subsequently submit the management response to the UNFPA Policy and Strategy Division in HQ. The Evaluation Manager, in collaboration with the communications officer at the UNFPA Libya CO, will also develop an evaluation brief that makes the results of the CPE more accessible to a larger audience (see sections 8 and 10 below).

The final evaluation report, along with the management response and the independent EQA of the final report will be included in the UNFPA evaluation database, available at the web page of the Evaluation Office. The final evaluation report will also be circulated to the UNFPA Executive Board and will be published, along with the management response and the evaluation brief, on the UNFPA Libya CO website.

EXPECTED DELIVERABLES

The evaluation team is expected to produce the following deliverables:

- **Design report.** The design report should translate the requirements of the ToR into a practical and feasible evaluation approach, methodology and work plan. It should include (at a minimum): (i) a stakeholders map; (ii) an evaluation matrix (incl. the final set of evaluation questions, indicators, data sources and data collection methods); (iii) the evaluation approach and methodology, with a detailed description of the agenda for the

field phase; (iv) and data collection tools and techniques (incl. interview and group discussion protocols). For guidance on the outline of the design report, see Annex E.

- **PowerPoint presentation of the design report.** The presentation will be delivered at an ERG meeting to present the contents of the design report and the agenda for the field phase. Based on the comments and feedback of the ERG, the Evaluation Manager and the Regional M&E Adviser, the evaluation team will develop the final version of the design report.
- **PowerPoint presentation for debriefing meeting with the CO and ERG.** The presentation provides an overview of key emerging findings and preliminary conclusions of the evaluation .It will serve as the basis for the exchange of views between the evaluation team, UNFPA Libya CO staff (incl. senior management) and the members of the ERG who will thus have the opportunity to provide complementary information and/or rectify the inaccurate interpretation of data and information collected. .
- **Draft and final evaluation reports.** The final evaluation report *(maximum 70 pages plus annexes)* will include evidence-based findings and conclusions, as well as a full set of practical and actionable recommendations to inform the next programme cycle. A draft report precedes the final evaluation report and provides the basis for the review of the CO, ERG members, the Evaluation Manager and the Regional M&E Adviser. The final evaluation report will address the comments and feedback provided by the UNFPA Libya CO, the ERG, the Evaluation Manager and the ASRO M&E Adviser. For guidance on the outline of the final evaluation report (see Annex H).
- **PowerPoint presentation of the evaluation results.** The presentation will provide an overview of the findings, conclusions and recommendations to be used for dissemination purposes.

Based on these deliverables, the Evaluation Manager, in collaboration with the communications officer at the UNFPA CO in Libya will develop an:

- **Evaluation brief.** The evaluation brief will be a short and concise document that provides an overview of the key evaluation results in an easily understandable manner, to promote use among decision-makers and other audiences. The structure, content and layout of the evaluation brief should be similar to the briefs that the UNFPA Evaluation Office produces for centralized evaluations.

All the deliverables will be developed in English language.

QUALITY ASSURANCE AND ASSESSMENT

The UNFPA Evaluation Quality Assurance and Assessment (EQAA) system aims to monitor the quality of centralized and decentralized evaluations at UNFPA through two processes: quality assurance and quality assessment. While quality assurance occurs throughout the evaluation process, starting with the ToR of the evaluation and ending with the final evaluation report, as well as the preparation of management responses and follow-up/verification of their implementation, quality assessment takes place following the completion of the evaluation process and is limited to the final evaluation report only.

The EQAA of this CPE will be undertaken in accordance with the guidance and tools that the UNFPA Evaluation Office developed as part of the EQAA system of the evaluation function at UNFPA (see https://www.unfpa.org/admin-resource/evaluation-quality-assurance-and-assessment-tools-and-guidance). An essential component of the EQAA system is the EQA grid (see Handbook, pp. 268-276 and Annex F) which defines a set of criteria against which draft and final evaluation reports are assessed to ensure the independence, impartiality, credibility and utility of evaluations.

The Evaluation Manager is primarily responsible for quality assurance of the key deliverables of the evaluation. However, the evaluation team leader also plays an important role in undertaking quality assurance. The evaluation team leader must ensure that all members of the evaluation team provide high-quality contributions (form and substance) and, in particular, that the draft and final evaluation reports comply with the quality assessment criteria

outlined in the EQA grid.[167] The evaluation quality assessment checklist below , which is based on the EQA grid (see Annex F), outlines the quality criteria that the draft and final versions of the evaluation report are expected to meet.

1. Structure and Clarity of the Report To ensure the report is clear, user-friendly, comprehensive, logically structured and drafted in accordance with standards and practices of international organizations, including the editorial guidelines of the UNFPA Evaluation Office
2. Executive Summary **To provide an overview of the evaluation, written as a stand-alone section, including key elements of the evaluation, such as objectives, methodology and key findings, conclusions and recommendations.**
3. Design and Methodology To provide a clear explanation of the methods and tools used, including the rationale for the methodological approach. To ensure constraints and limitations are made explicit (including limitations applying to interpretations and extrapolations in the analysis; robustness of data sources, etc.)
4. Reliability of Data To ensure sources of data are clearly stated for both primary and secondary data. To provide explanation on the credibility of primary (e.g. interviews and group discussions) and secondary (e.g. documents) data established and limitations made explicit.
5. Analysis and Findings To ensure sound analysis and credible evidence-based findings. To ensure interpretations are based on carefully described assumptions; contextual factors are identified; cause and effect links between an intervention and its end results (including unintended results) are explained.
6. Validity of Conclusions To ensure conclusions are based on credible findings and convey evaluators' unbiased judgment of the intervention. Ensure conclusions are presented in order of priority; divided into strategic and programmatic conclusions; briefly summarized in a box that precedes a more detailed explanation; and for each conclusion its origin (which evaluation question(s) the conclusion is based on) is indicated.
7. Usefulness and Clarity of Recommendations To ensure recommendations flow logically from conclusions, are realistic and operationally feasible. Ensure recommendations are presented in order of priority; divided into strategic and programmatic recommendations (as done for conclusions); briefly summarized in a box that precedes a more detailed explanation of the main elements of the recommendation and how it could be implemented effectively; and include a priority level (high/medium/low), target (administrative unit(s) to which the recommendation is addressed), and origin (which conclusion(s) the recommendation is based on).
8. United Nations System-wide Action Plan (SWAP) Evaluation Performance Indicator – Gender Equality To ensure the evaluation approach is aligned with the SWAP of the United Nations (guidance on the SWAP Evaluation Performance Indicator and its application to evaluation can be found at http://www.unevaluation.org/document/detail/1452) and UNEG guidance on integrating human rights and gender equality in evaluations that can be found at: http://www.uneval.org/document/detail/980.

The EQAA process for this CPE will be multi-layered and will involve: (i) the Evaluation Manager at the UNFPA Libya CO, (ii) the ASRO M&E Adviser, and (iii) the UNFPA Evaluation Office; whose roles and responsibilities with regard to EQAA are described in section 11. Management of the Evaluation in this ToR.

[167] The evaluators are invited to look at good quality CPE reports that can be found in the UNFPA evaluation database, which is available at: https://web2.unfpa.org/public/about/oversight/evaluations/. These reports must be read in conjunction with their EQAs (also available in the database) in order to gain a clear idea of the quality standards that UNFPA expects the evaluation team to meet.

Annex 2: List of Interviewed Stakeholders

	Name of interviewee	Name of the organization	Title
	Government Ministries and Institutions		
1.	Dr. Fouzia benghashir	Ministry of Education	MOE Focal Point
2.	Dr. Mostafa Alshibani	Ministry of Foreign Affairs	
3.	Dr. Kamel Azabi	Ministry of Health	MOE Focal Point
4.	Um Al Khair	Ministry of Health	Director of Planning Dep
5.	Ammar Zokra	Ministry of Planning	
6.	Malek Hanesh	National Centre for Disease Control	SRH Project Manager
7.	Ali Shiboub	National Centre of Disease Control	
8.	Mr. Hashem Shadi	Ministry of Youth	Communication Officer
9.	Mohamed Zrebiga	Ministry of Youth	International Corporation Officer
10.	Ms Saida Berwin	Ministry of Youth	Technical Advisor
11.	Dr. Alia M. Shiboub	Ministry of Health	Primary Health Focal Point and Head of HIV and AIDS Department
12.	Mr. Ezeddin Daafous	NBSC	Director of Human Resources
13.	**IPs and Beneficiaries**		
14.	Afaf Alwelwal	Albayan NGO	Director
15.	Haithem Mousa	Alistishari Initiative	Manager
16.	Haitham Mousa	Al-Safwa NGO	
17.	Ahmed Zbeda	Alsafwa NGO	Project Manger
18.	Mohamed Shawqi	Al-Zawiya city	Youth Beneficiary
19.	Mahasen Ibrahim	Amazonat	WGSS Beneficiary
20.	Sukayna Fathalla	Amazonat	WGSS Beneficiary
21.	Aamal Mohammad Hashim	Amazonat	WGSS Beneficiary
22.	Isra Hatem Alarabi	Amazonat	WGSS Beneficiary
23.	Khadija Omar	Amazonat	WGSS Beneficiary
24.	Basma Hasan	Amazonat	WGSS Beneficiary
25.	Khadija Albsikri	Amazont	Director
26.	Dr. Mohamed Ibrahim	Health Information Centre	Director
27.	Reema Hamidan	Huna Libya	Project Manager
28.	Jack Hukill	IMC	Country Director
29.	Hend El Miladi	IMC	President
30.	Jed Jeddy	Istishari	CSO, Gender, Youth, RH Coordinator
31.	Kahlid Elmarghni	LibAid	Deputy Board of Director
32.	Ali Elsherif	Life makers Association	Project manager
33.	Dr Osama Sultan	LRC NGO	Head, International Relations
34.	Ahmed Zbedah	LRC NGO	Programme Coordinator
35.	Dr. Nasser Eldersy	LRC NGO	Head of Heath department and UNFPA Programmes Coordinator
36.	Hend El Miladi	Midwifery Association	Project coordinator
37.	Nour Dhawi	Migrace NGO	M&E Focal Point
38.	Dr Nasser Eldersy	Migrace NGO	Head of Department and UNFPA Programme Coordinator
39.	Malek hnesh	Migrace NGO	SRH Project Manager

40.	Khaled Alyaqubi	Psychosocial Support Team	Project Manager
41.	Mohamed Shaaban	Radio of Sirte University	Youth Beneficiary
42.	Abdulhaq Faiz	Rugby 2018	Co-founder
43.	Amna Saad	Sirte City Pioneers Initiative	Youth beneficiary
44.	Suzan Abdallah	Sirte City Pioneers Initiative	Youth beneficiary
45.	Said Ramadan	Sirte City Pioneers Initiative	Youth beneficiary
46.	Mohamed Yaseen	Sirte University (Director of Innovation & Entrepreneurship Centre)	Youth Component Beneficiary facilitator
47.	Ebtesam Elgusbi	Tracks for Peace and Development	Director
48.	Yunes Abdussalam	Trainee	Youth beneficiary Journalist ()
49.	Hanan Moftah Saadi	Trainee, Strategic Planning and financial management for NGOs	Youth Beneficiary
50.	Hafsaa	Women Union NGO	Director
51.	M. Shaban	Y-PEER Network	
52.	Moaied Eltajouri	Y-PEER Network	Focal Point
	UN Agencies		
53.	Zahra Zlitni	IOM	GBV Focal Point
54.	Gemma Sanmartin	OCHA	Deputy head of Office
55.	Omar Al Daher	OCHA	Information Management Officer (IMO)
56.	Naeun Choi	Resident Coordinator's Office	Development Coordination Officer
57.	Zainab Basiuni	Resident Coordinator's Office	M&E Officer
58.	Maram Akrout	UN Women	Project coordinator
59.	Byashim Byashimov	UNDP	Programme Specialist – Youth
60.	Khadija Elboaish	UNDP	Gender Specialist
61.	Winnie Chiku Banda	UNHCR	Associate Protection Officer
62.	Sofia Tekidou	UNHCR	Protection Specialist
63.	Joshua Orawo	UNICEF	CP Subsector Coordinator
64.	Yukinori HIBI	WFP	Head of Programme
65.	Azret Kalmykov	WHO	Former Health Sector Coordinator
66.			
	Donors		
67.	Monica Tineo	Catalonia Development Agency	Technical Officer – Mediterranean Region [Humanitarian Coordinating the Area]
68.	Jordi Cortes Roldan	Barcelona Municipality	–International Corporation
69.	Sarah Bernhardt	European Union	Nursing and Midwifery Coordinator
70.	Giuseppe Vasquez	European Union	EUTF project focal person
71.	Amane Kobayashi	Japan Embassy	Deputy Head of Mission to Libya - Political, Economic and International Cooperation with UN agencies
	UNFPA CO Staff		
72.	Omer El faroug	UNFPA	GBV Sub-Sector Coordinator
73.	Mohamed Tahir	UNFPA	Programme Specialist, SRH
74.	Hakeem EL Khemri	UNFPA	Programme Analyst – SRH
75.	Abdulraheem Abood	UNFPA	Programme Assistant
76.	Slaman Khalid	UNFPA	Communication Manager
77.	Marta Dafano	UNFPA	Monitoring and Evaluation (M&E) / Reporting Analyst
78.	Mohamed El Omari	UNFPA	M&E Analyst
79.	Hafedh Ben Milad	UNFPA	Head of Programmes
80.	Zineb Khadhraoui	UNFPA	A&Y
81.	Mohamed Elmagbri	UNFPA	A&Y Coordinator

82.	Silvia Sanchez	UNFPA	EUTF Programme Manager
83.	Tahir Ghaznavi	UNFPA	Programme Specialist, SRH
84.	Abdulhakem Elkhamri	UNFPA	Programme Analyst – SRH
85.	Nao Tojo	UNFPA	Programme Analyst
86.	Ahlam Sofan	UNFPA	GEWE Team Leader

Annex 3: List of reviewed Documents

1. IPs Annual Work Plans 2019
2. IPs Annual Work Plans 2020
3. IPs Annual Work Plans 2021
4. Country Programme Document
5. CPD Extensions 2021 and 2022
6. UNFPA Annual Work Plans 2019
7. UNFPA Annual Work Plans 2020
8. UNFPA Annual Work Plans 2021
9. UNFPA annual report 2021
10. UNFPA annual report 2019
11. UNFPA annual report 2020
12. 2019 Annual Planning Report
13. 2020 Annual Planning Report
14. 2021 Annual Planning Report
15. 2020 Annual Newsletter
16. 2021 Annual Newsletter
17. Humanitarian Needs Overview 2019
18. Humanitarian Needs Overview 2020
19. Humanitarian Needs Overview 2021
20. Humanitarian Response Plan 2019
21. Humanitarian Response Plan 2020
22. Humanitarian Response Plan 2021
23. National Statistics Development Strategy (NCDC) 2018-2023
24. Libyan Household Multi sectoral Needs Assessment, 2016, Bureau of Statistics and Census (BSC) and UNFPA
25. UNFPA Evaluation Policy, 2019
26. UNFPA strategic plan, 2018-2021
27. UNFPA strategic plan, 2018-2021- Annexes
28. List of Atlas projects
29. Stakeholders mapping
30. CPE Terms of Reference
31. UNFPA Evaluation Handbook on how to conduct CPE
32. UNFPA Financial data
33. 2021 Q1 Monitoring Report
34. 2021 Q2 Monitoring Report
35. United Nations Strategic Framework (UNSF) 2019-2020 (extended until 31 December 2021)
36. UNSF 2019 – 2022 Final Evaluation Report, 2021
37. UNCT, Libya, Joint Country Assessment, Pathways towards a Stable and Resilient Libya, 2018
38. Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategy (RMNCAH) 2019-2023
39. Service Availability and Readiness Assessment (SARA), WHO, 2017
40. Gender Based Violence Situational Analysis in Libya, UNFPA, 2017
41. Libyan National Family Health Survey, PAPFAM report 2007 and 2014, BSC
42. The Libyan Youth Today: Opportunities and Challenges, UNFPA, MOP and NESDB, 2016
43. Libyan Household Multi sectoral Needs Assessment, 2016, Bureau of Statistics and Census (BSC) and UNFPA
44. UNFPA Libya Situation Analysis 2018

Annex 4: List of Atlas Projects by Country Programme Output and Strategic Plan Outcome

Year 2019

GENDER EQUALITY								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1	3006E	PN6688	Tracks For Peace and Developmt	Provide GBV services	Libya (Sabha)	16,820.00	16,807.00	99.92%
Activity 2	3006E	PN6688	Tracks For Peace and Developmt	Support cost	Libya (Sabha)	1,180.00	1,180.00	100.00%
Activity 3	FPA90	PN6688	Tracks For Peace and Developmt	Provide GBV services	Libya (Sabha)	24,760.00	24,760.00	100.00%
Activity 4	FPA90	PN6688	Tracks For Peace and Developmt	IP Support cost	Libya (Sabha)	1,733.00	1,733.00	100.00%
Activity 5	FPA90	PN6977	Cooperazione e Sviluppo Libya	Project support	Libya (Misratah)	668.00	668.00	100.00%
Activity 6	FPA90	PN6977	Cooperazione e Sviluppo Libya	Provision of PSS and CM	Libya (Misratah)	3,403.00	3,403.00	100.00%
Activity 7	FPA90	PN6977	Cooperazione e Sviluppo Libya	Support cost	Libya (Misratah)	284.00	284.00	100.00%
Activity 8	JPA73	PN6977	Cooperazione e Sviluppo Libya	Project support	Libya (Misratah)	4,583.00	4,583.00	100.00%
Activity 9	JPA73	PN6977	Cooperazione e Sviluppo Libya	Provision of PSS and CM	Libya (Misratah)	10,828.00	10,828.00	100.00%
Activity 10	JPA73	PN6977	Cooperazione e Sviluppo Libya	Support cost	Libya (Misratah)	1,078.00	1,078.00	100.00%
Activity 11	3006E	PN6978	Elssafa Center	Support AlBayan center-Tripoli	Libya (Tripoli)	22,430.00	22,430.00	100.00%
Activity 12	3006E	PN6978	Elssafa Center	Support Elssafa center-Tripoli	Libya (Tripoli)	39,252.00	39,252.00	100.00%

Activity 13	3006E	PN6978	Elssafa Center	Support cost	Libya (Tripoli)	4,318.00	4,318.00	100.00%
Activity 14	3006E	PN6986	Psychosocial Support Team	Deployment of mobile team	Libya (Tripoli)	25,000.00	25,000.00	100.00%
Activity 15	3006E	PN6986	Psychosocial Support Team	Support cost	Libya (Tripoli)	1,751.00	1,750.09	99.95%
Activity 16	FPA90	PN6986	Psychosocial Support Team	Provide GBV services	Libya (Benghazi)	35,090.79	35,090.79	100.00%
Activity 17	FRA11	PN6986	Psychosocial Support Team	Establish hotline services	Libya (Tripoli)	86,585.94	48,631.75	56.17%
Activity 18	FRA11	PN6986	Psychosocial Support Team	Support cost	Libya (Tripoli)	6,112.00	3,404.20	55.70%
Activity 19	UOG69	PN6986	Psychosocial Support Team	Awareness raising activities	Libya (Benghazi)	18,945.00	18,945.00	100.00%
Activity 20	UOG69	PN6986	Psychosocial Support Team	Provide dignity kits	Libya (Tripoli)	90,000.00	90,343.00	100.38%
Activity 21	UOG69	PN6986	Psychosocial Support Team	Provide GBV services	Libya (Benghazi)	99,678.00	99,678.00	100.00%
Activity 22	UOG69	PN6986	Psychosocial Support Team	Support cost	Libya (Tripoli)	10,592.39	10,249.39	96.76%
Activity 23	UOH03	PN6986	Psychosocial Support Team	Provide dignity kits	Libya (Tripoli)	123,836.00	123,836.00	100.00%
Activity 24	UOH03	PN6986	Psychosocial Support Team	Deploy mobile team	Libya (Tripoli)	63,947.37	62,350.00	97.50%
Activity 25	UOH03	PN6986	Psychosocial Support Team	Support cost	Libya (Tripoli)	11,200.00	11,200.00	100.00%
Activity 26	UOG69	PN7004	International Rescue Committee	Provision of PSS and CM	Libya (Misratah)	16,951.00	16,950.37	100.00%
Activity 27	UOG69	PN7004	International Rescue Committee	Project support	Libya (Misratah)	16,977.80	16,977.80	100.00%
Activity 28	UOG69	PN7004	International Rescue Committee	Provision of PSS and CM	Libya (Misratah)	49,055.77	49,055.77	100.00%
Activity 29	UOG69	PN7004	International Rescue Committee	Referral services	Libya (Misratah)	11,487.56	11,487.56	100.00%

Activity 30	UOG69	PN7004	International Rescue Committee	Risk mitigation and reduction	Libya (Misratah)	20,248.27	20,248.27	100.00%
Activity 31	UOG69	PN7004	International Rescue Committee	Conduct safety audits	Libya (Misratah)	18,363.85	18,363.85	100.00%
Activity 32	UOG69	PN7004	International Rescue Committee	Support cost	Libya (Misratah)	9,315.00	9,315.00	100.00%
Activity 33	3006E	PN7090	The Scouts -Libya	Awareness raising activities	Libya (Tripoli)	12,384.00	12,384.00	100.00%
Activity 34	3006E	PN7090	The Scouts -Libya	Support cost	Libya (Tripoli)	866.00	866.00	100.00%
Activity 35	CAA90	PN7090	The Scouts -Libya	GBV Campaign	Libya (Tripoli)	23,638.00	23,638.00	100.00%
Activity 36	CAA90	PN7090	The Scouts -Libya	Support cost	Libya (Tripoli)	1,654.00	1,654.00	100.00%
Activity 37	UOG69	PN7090	The Scouts -Libya	Provide dignity kits	Libya (Tripoli)	10,250.00	10,250.00	100.00%
Activity 38	UOG69	PN7090	The Scouts -Libya	Support cost	Libya (Tripoli)	718.00	718.00	100.00%
Activity 39	UOH03	PN7090	The Scouts -Libya	Provide dignity kits	Libya (Tripoli)	4,950.00	4,950.00	100.00%
Activity 40	UOH03	PN7090	The Scouts -Libya	Support cost	Libya (Tripoli)	347.00	347.00	100.00%
Activity 41	3006E	PU0074	UNFPA	Operational support cost	Libya	78,304.89	69,308.25	88.51%
Activity 42	3006E	PU0074	UNFPA	Operational support cost	Libya	34,029.45	34,301.63	100.80%
Activity 43	3006E	PU0074	UNFPA	Cover GBV Officer salary	Libya	5,100.00	3,400.00	66.67%
Activity 44	3006E	PU0074	UNFPA	Operational support cost	Libya	138,449.75	138,784.90	100.24%
Activity 45	3006E	PU0074	UNFPA	Operational support cost	Libya	21,034.73	20,871.83	99.23%
Activity 46	3FPBF	PU0074	UNFPA	Organize CM training	Libya	58,400.00	54,821.22	93.87%
Activity 47	CAA79	PU0074	UNFPA	Salaries/benefits (IP, LPOST)	Libya	2,500.00	518.07	20.72%
Activity 48	CAA79	PU0074	UNFPA	Visibility	Libya	2,458.00	2,500.28	101.72%
Activity 49	CAA90	PU0074	UNFPA	Procure RH/Dignit kits	Libya	170,730.00	173,103.14	101.39%

Activity 50	CAA90	PU0074	UNFPA	GBV Campaign	Libya	36,100.22	36,357.00	100.71%
Activity 51	CAA90	PU0074	UNFPA	Salaries/benefits (IP, LPOST)	Libya	16,553.00	19,069.88	115.20%
Activity 52	FPA90	PU0074	UNFPA	Operational support cost	Libya	119,136.11	119,180.87	100.04%
Activity 53	FPA90	PU0074	UNFPA	Salaries/Benefits (IP, LPOST):	Libya	2,957.41	2,957.41	100.00%
Activity 54	FPA90	PU0074	UNFPA	Salaries/benefits (IP, LPOST)	Libya	203,602.09	203,602.09	100.00%
Activity 55	FPA90	PU0074	UNFPA	Training and workshops	Libya	1,301.48	1,301.48	100.00%
Activity 56	UOG69	PU0074	UNFPA	Procure RH/Dignit kits	Libya	59,793.00	60,055.32	100.44%
Activity 57	UOG69	PU0074	UNFPA	Operational support cost	Libya	28,642.00	28,642.06	100.00%
Activity 58	UOG69	PU0074	UNFPA	Salaries/benefits (IP, LPOST)	Libya	30,602.58	30,602.12	100.00%
Activity 59	UOG69	PU0074	UNFPA	CERF third party monitoring	Libya	4,000.00	4,000.53	100.01%
Activity 60	UOG69	PU0074	UNFPA	CERF third party monitoring	Libya	6,000.00	5,999.99	100.00%
POPULATION DYNAMICS								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1	FPA90	PU0074	UNFPA	Operational support cost	Libya	18,095.72	18,109.02	100.07%
Activity 2	FPA90	PU0074	UNFPA	Salaries/Benefits (IP, LPOST)	Libya	34,561.39	34,561.39	100.00%
Activity 3	FPA90	PU0074	UNFPA	Technical assistance	Libya	450.43	450.43	100.00%
Activity 4	FPA90	PU0074	UNFPA	Training and	Libya	458.70	458.70	100.00%

				workshops				
Activity 5	FPA90	PU0074	UNFPA	Operational support cost	Libya (Misrata)	18,096	18,109	100.1%
Activity 6	FPA90	PU0074	UNFPA	Salaries/Benefits (IP, LPOST)	Libya (Misrata)	34,561	34,561	100.0%
Activity 7	FPA90	PU0074	UNFPA	Technical assistance	Libya (Misrata)	450	450	100.0%
Activity 8	FPA90	PU0074	UNFPA	Training and workshops	Libya (Misrata)	459	459	100.0%
REPRODUCTIVE HEALTH								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1	CAA90	PN6816	Tripoli Crisis Managemet Group	Securing_RH Equipment	Libya (Tripoli)	29,500.00	29,233.00	99.09%
Activity 2	CAA90	PN6816	Tripoli Crisis Managemet Group	Provision of SRH&GBV services	Libya (Tripoli)	52,831.00	51,660.00	97.78%
Activity 3	CAA90	PN6816	Tripoli Crisis Managemet Group	Support cost	Libya (Tripoli)	7,632.70	5,662.86	74.19%
Activity 4	FPA90	PN6816	Tripoli Crisis Managemet Group	Provision of SRH&GBV services	Libya (Tripoli)	16,675.00	16,675.00	100.00%
Activity 5	FPA90	PN6816	Tripoli Crisis Managemet Group	Support cost	Libya (Tripoli)	1,167.25	1,167.25	100.00%
Activity 6	UOG69	PN6816	Tripoli Crisis Managemet Group	Securing_RH Equipment	Libya (Tripoli)	62,222.00	62,222.00	100.00%
Activity 7	UOG69	PN6816	Tripoli Crisis Managemet Group	Provision of SRH&GBV services	Libya (Tripoli)	34,856.00	34,856.00	100.00%
Activity 8	UOG69	PN6816	Tripoli Crisis Managemet Group	Support cost	Libya (Tripoli)	6,795.46	6,795.46	100.00%
Activity 9	3FPBF	PU0074	UNFPA	RH Institutional Development	Libya	15,000.00		0.00%

Activity 10	CAA79	PU0074	UNFPA	Salaries/Benefits (IP, LPOST):	Libya	12,453.00	12,452.60	100.00%
Activity 11	CAA79	PU0074	UNFPA	Procurement for SRH Component	Libya	600.00	600.00	100.00%
Activity 12	CAA79	PU0074	UNFPA	Salaries/Benefits (IP, LPOST)	Libya	15,311.71	11,355.13	74.16%
Activity 13	EUB15	PU0074	UNFPA	Advocacy campaigns	Libya	18,000.00	2,468.85	13.72%
Activity 14	EUB15	PU0074	UNFPA	BO Finance Specialist	Libya	7,217.00	6,952.69	96.34%
Activity 15	EUB15	PU0074	UNFPA	Operational support cost	Libya	66,447.00	70,723.22	106.44%
Activity 16	EUB15	PU0074	UNFPA	Salaries/Benefits (IP, LPOST)	Libya	196,683.00	193,294.47	98.28%
Activity 17	EUB15	PU0074	UNFPA	Planning nurses and midwives	Libya	20,000.00		0.00%
Activity 18	FPA90	PU0074	UNFPA	UNFPA contribution to ENI fund	Libya	1,049.52	1,049.52	100.00%
Activity 19	FPA90	PU0074	UNFPA	Kits procurement and logistics	Libya	954.50	1,009.95	105.81%
Activity 20	FPA90	PU0074	UNFPA	Operational support cost	Libya	139,366.18	137,841.45	98.91%
Activity 21	FPA90	PU0074	UNFPA	Salaries/Benefits (IP, LPOST)	Libya	92,283.33	92,283.33	100.00%
Activity 22	FPA90	PU0074	UNFPA	Technical assistance	Libya	9,971.49	9,971.49	100.00%
Activity 23	FPA90	PU0074	UNFPA	Training and workshops	Libya	48,393.37	49,702.86	102.71%
Activity 24	UOG69	PU0074	UNFPA	Kits procurement and logistics	Libya	396,978.32	392,596.61	98.90%
Activity 25	UOG69	PU0074	UNFPA	Operational support cost	Libya	802.00	802.00	100.00%
Activity 26	UOG69	PU0074	UNFPA	Salaries/Benefits (IP, LPOST)	Libya	53,145.42	53,145.42	100.00%
Activity 27	UOG69	PU0074	UNFPA	Third party monitoring	Libya	16,000.00	15,920.62	99.50%

Youth								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1	FPA90	PU0074	UNFPA	Office rent, office supplies, fuel, vehicle maintenance, other equipment maintenance, common premises, common security related cost, Int. and local consultants etc.	Libya	53,398.58	53,428.60	100.06%
Activity 2	FPA90	PU0074	UNFPA	COORDINATING AND MONITORING THE IMPLEMENTATION THE PBF PROJECT IN SIRTE- LIBYA	Libya	8,815.55	8,815.55	100.00%
Activity 3	FPA90	PU0074	UNFPA	Salaries and benefits of international and local staff	Libya	43,858.29	43,858.29	100.00%
Activity 4	FPA90	PU0074	UNFPA	Provide technical assistance (including CTG staff and consultant for youth)	Libya	3,136.36	3,136.36	100.00%
Activity 5	FPA90	PU0074	UNFPA	Conduct training and workshops	Libya	851.88	851.88	100.00%
Activity 6	FPA90	PU0074	UNFPA	Celebrations of international youth day	Libya	4,254.55	4,254.55	100.00%
Programe Coordination and Assistance								
Activity 1	FPA90	PU0074	UNFPA	Salaries/Benefits (IP, LPOST):	Libya	1,589.79	1,589.79	100.00%

Activity 2	FPA90	PU0074	UNFPA	Operational support cost:	Libya	16,808.28	16,808.28	100.00%
Activity 3	FPA90	PU0074	UNFPA	Communication	Libya	6,803.08	6,803.08	100.00%
Activity 4	FPA90	PU0074	UNFPA	Operational support cost	Libya	189,020.04	189,070.61	100.03%
Activity 5	FPA90	PU0074	UNFPA	Salaries/Benefits (IP, LPOST)	Libya	132,856.03	132,856.03	100.00%
Activity 6	FPA90	PU0074	UNFPA	Technical assistance	Libya	11,043.27	11,043.27	100.00%
Activity 7	FPA90	PU0074	UNFPA	Training and workshops	Libya	2,554.54	2,554.54	100.00%

Year 2020								
GENDER EQUALITY								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1	EUB23	PN7257	International Medical Corps UK (Libya)	Awareness raising activities	Libya (Tripoli, Sabha)	230,647	198,451	86.0%

Activity 2	EUB23	PN7257	International Medical Corps UK (Libya)	Procure & distribute DKits	Libya (Tripoli, Sabha)	120,000	0	0.0%
Activity 3	ITA46	PN7257	International Medical Corps UK (Libya)	Procure & distribute DKits	Libya (Tripoli, Sabha)	94,000	60,483	64.3%
Activity 4	EUB23	PN7257	International Medical Corps UK (Libya)	IP M&E activities	Libya (Tripoli, Sabha)	681	0	0.0%
Activity 5	EUB23	PN7257	International Medical Corps UK (Libya)	GBV essential package training	Libya (Tripoli, Sabha)	17,410	2,126	12.2%
Activity 6	EUB23	PN7257	International Medical Corps UK (Libya)	Provide GBV services	Libya (Tripoli, Sabha)	112,150	49,133	43.8%
Activity 7	EUB23	PN7257	International Medical Corps UK (Libya)	GBV technical training to IPs	Libya (Tripoli, Sabha)	34,883	8,229	23.6%
Activity 8	EUB23	PN7257	International Medical Corps UK (Libya)	Program management implm	Libya (Tripoli, Sabha)	25,789	12,897	50.0%
Activity 9	EUB23	PN7257	International Medical Corps UK (Libya)	IP support cost	Libya (Tripoli, Sabha)	37,909	18,959	50.0%
Activity 10	ITA46	PN7257	International Medical Corps UK (Libya)	IP support cost	Libya (Tripoli, Sabha)	13,012	9,485	72.9%
Activity 11	3FPBF	PU0074	UN POPULATION FUND	Organize CM training	Libya		32	
Activity 12	FPA90	PU0074	UN POPULATION FUND	Operational support cost	Libya	26,299	13,617	51.8%

Activity 13	EUB23	PU0074	UN POPULATION FUND	Salaries/benefits (IP, LPOST)	Libya	229,374	229,375	100.0%
Activity 14	FPA90	PU0074	UN POPULATION FUND	Salaries/benefits (IP, LPOST)	Libya	25,598	42,953	167.8%
Activity 15	FRA11	PN6986	Psychosocial Support Team	Establish hotline services	Libya (Tripoli)	111,633	96,092	86.1%
Activity 16	FRA11	PN6986	Psychosocial Support Team	Support cost	Libya (Tripoli)	7,814	6,332	81.0%
Activity 17	FRA11	PN6986	Psychosocial Support Team	Training and workshops	Libya (Tripoli)			
POPULATION DYNAMICS								
Activity 1	FPA90	PU0074	UN POPULATION FUND	Operational support cost	Libya	26,299	13,617	51.8%
Activity 2	FPA90	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	Libya	19,951	19,951	100.0%
Activity 3	FPA90	PU0074	UN POPULATION FUND	Training and workshops	Libya	845	846	100.0%
REPRODUCTIVE HEALTH								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1	EUB15	PU0074	UN POPULATION FUND	Advocacy campaigns	Libya	7,000	4,247	60.7%

Activity 2	FPA90	PU0074	UN POPULATION FUND	Kits procurement and logistics	Libya			
Activity 3	EUB15	PU0074	UN POPULATION FUND	Curricula, strategy translation	Libya	6,337		
Activity 4	EUB15	PU0074	UN POPULATION FUND	Meetings for sylabus	Libya	5,000		
Activity 5	EUB15	PU0074	UN POPULATION FUND	Securing_RH Equipment	Libya	69,603	4,054	5.8%
Activity 6	EUB15	PU0074	UN POPULATION FUND	leadership training program	Libya	37,677	25,155	66.8%
Activity 7	FPA90	PU0074	UN POPULATION FUND	leadership training program	Libya	30,000	61,277	204.3%
Activity 8	EUB15	PU0074	UN POPULATION FUND	Birth Simulators and manikins	Libya	113,301	3,587	3.2%
Activity 9	EUB15	PU0074	UN POPULATION FUND	Develop Nat'l N&M Strategy	Libya	35,000		
Activity 10	FPA90	PU0074	UN POPULATION FUND	Operational support cost	Libya	147,303	162,997	110.7%
Activity 11	EUB15	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	Libya	245,214	233,407	95.2%

Activity 12	EUB23	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	Libya	253,213	251,947	99.5%
Activity 13	FPA90	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	Libya	69,925	71,904	102.8%
Activity 14	3FPBF	PU0074	UN POPULATION FUND	RH Institutional Development	Libya	14,930	11,204	75.0%
Activity 15	FPA90	PU0074	UN POPULATION FUND	RH Institutional Development	Libya	7,401	5,315	71.8%
Activity 16	EUB15	PU0074	UN POPULATION FUND	S2S M_Health for Nurse & Midwi	Libya			
Activity 17	EUB15	PU0074	UN POPULATION FUND	Situation analysis midwifes	Libya	4,500		
Activity 18	EUB15	PU0074	UN POPULATION FUND	Package midwives and nurses	Libya	65,498	14,138	21.6%
Activity 19	EUB15	PU0074	UN POPULATION FUND	Training of nurses mentors	Libya			
Activity 20	FPA90	PU0074	UN POPULATION FUND	Training and workshops	Libya	2,020	2,015	99.7%
Activity 21	EUB15	PU0074	UN POPULATION FUND	Planning nurses and midwives	Libya	42,340		

Activity 22	EUB15	PU0074	UN POPULATION FUND	Midwifery and nursing guide	Libya	15,900		
Activity 23	ITA46	PN6816		Securing_RH Equipment	Libya (Tripoli)	1,000	800	80.0%
Activity 24	ITA46	PN6816		Provision of SRH&GBV services	Libya (Tripoli)			
Activity 25	ITA46	PN6816		Support cost	Libya (Tripoli)	3,577	3,563	99.6%
Activity 26	EUB23	PN7257	International Medical Corps UK (Libya)	Securing_RH Equipment	Libya (Tripoli, Sabha)	132,594	116,740	88.0%
Activity 27	EUB23	PN7257	International Medical Corps UK (Libya)	Generating Evidence for HIV	Libya (Tripoli, Sabha)	20,000		
Activity 28	EUB23	PN7257	International Medical Corps UK (Libya)	HIV Testing & PSS counseling	Libya (Tripoli, Sabha)	20,600	18,018	87.5%
Activity 29	EUB23	PN7257	International Medical Corps UK (Libya)	MISP & CMR Trainings	Libya (Tripoli, Sabha)	10,681	3,468	32.5%
Activity 30	ITA46	PN7257	International Medical Corps UK (Libya)	MISP & CMR Trainings	Libya (Tripoli, Sabha)	35,000	15,321	43.8%
Activity 31	EUB23	PN7257	International Medical Corps UK (Libya)	Provision of SRH&GBV services	Libya (Tripoli, Sabha)	134,600		

Activity 32	ITA46	PN7257	International Medical Corps UK (Libya)	Provision of SRH&GBV services	Libya (Tripoli, Sabha)	72,362		
Activity 33	EUB23	PN7257	International Medical Corps UK (Libya)	Program management implem	Libya (Tripoli, Sabha)	20,678	14,919	72.2%
Activity 34	EUB23	PN7257	International Medical Corps UK (Libya)	IP support cost	Libya (Tripoli, Sabha)	30,395	21,931	72.2%
Activity 35	ITA46	PN7257	International Medical Corps UK (Libya)	IP support cost	Libya (Tripoli, Sabha)	7,891	5,850	74.1%
Activity 36	EUB23	PN7257	International Medical Corps UK (Libya)	SRH Awareness Raising Activity	Libya (Tripoli, Sabha)	25,900	10,950	42.3%
Activity 37	EUB23	PN7257	International Medical Corps UK (Libya)	IP M&E related technical costs	Libya (Tripoli, Sabha)	681	35	5.2%
Activity 38	EUB23	PN7257	International Medical Corps UK (Libya)	Improve SRH health info system	Libya (Tripoli, Sabha)	20,890	14,107	67.5%
Activity 39	EUB23	PN7257	International Medical Corps UK (Libya)	Training and workshops	Libya (Tripoli, Sabha)	47,590	36,425	76.5%
Youth								
Strategic plan Outcome:								

Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1	UJA88	PN6688	Tracks for Peace and Development	Youth&policy maker engagement	Libya (Sirte)	20,515	20,514	100.0%
Activity 2	FPA90	PN6688	Tracks for Peace and Development	Quick impact grants	Libya (Sirte)	16,441	16,441	100.0%
Activity 3	UJA88	PN6688	Tracks for Peace and Development	Y&A gain capacity in Sirte	Libya (Sirte)	25,225	25,225	100.0%
Activity 4	FPA90	PU0074	UN POPULATION FUND	Operational support cost	Libya (Sirte)	30,692	23,358	76.1%
Activity 5	UJA88	PN6688	Tracks for Peace and Development	Operational cost	Libya (Sirte)	33,500	4,450	0.0%
Activity 6	FPA90	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	Libya (Sirte)	6,499	4,901	
Activity 7	FPA90	PN6688	Tracks for Peace and Development	IP support cost	Libya (Sirte)	1,291	1,286	99.6%
Activity 8	UJA88	PN6688	Tracks for Peace and Development	IP support cost	Libya (Sirte)	10,121	10,121	100.0%
Activity 9	UJA88	PN6688	Tracks for Peace and Development	Y participate political process	Libya (Sirte)	32,813		

Activity 10	UJA88	PN6688	Tracks for Peace and Development	conflict resolution training	Libya (Sirte)	69,317	23,105	0.0%
Activity 11	FPA90	PU0074	UN POPULATION FUND	conflict resolution training	Libya	3,999	1,341	33.5%
Activity 12	FPA90	PN6688	Tracks for Peace and Development	Capacity building to y-peer ne	Libya (Sirte)	2,000	1,937	96.8%
OTHER PROGRAMMATIC AREA:								
Activity 1	FPA90	PU0074	UN POPULATION FUND	Operational support cost	Libya	187,770	50,578	18.6%
Activity 2	EUB23	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	Libya	29,000	29,000	100.0%
Activity 3	FPA90	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	Libya	481,618	51,460	10.7%
Activity 4	FPA90	PU0074	UN POPULATION FUND	Technical assistance	Libya	28,610	28,591	99.9%
Activity 5	FPA90	PU0074	UN POPULATION FUND	Training and workshops	Libya	9,999	10,895	100.8%

Year 2021					
GENDER EQUALITY					
Strategic plan Outcome:					
Country Programme Output:					
Annual work plan *(code and name):*					
Activity 1	DKA49	PN6986	Psychosocial Support	Provision of awareness on GBV	9,990

			Team			
Activity 2	ESB11	PN6986	Psychosocial Support Team	BGV MUNICIPALITY - PROVISION	114,844	
Activity 3	ESD01	PN6986	Psychosocial Support Team	BGV MUNICIPALITY - PROVISION	79,897	
Activity 4	FRA11	PN6986	Psychosocial Support Team	Establish hotline services	136,893	
Activity 5	DKA49	PN6986	Psychosocial Support Team	Support cost	3,835	
Activity 6	ESB11	PN6986	Psychosocial Support Team	Support cost	8,039	
Activity 7	ESD01	PN6986	Psychosocial Support Team	Support cost	5,593	
Activity 8	EUB23	PN6986	Psychosocial Support Team	Support cost	3,136	
Activity 9	FRA11	PN6986	Psychosocial Support Team	Support cost	9,583	
Activity 10	EUB23	PN6986	Psychosocial Support Team	WGSS set up, services and acti	89,600	
Activity 11	DKA49	PN7050	Libyan Women Union in the Sout	IP Support cost	4,819.5	2,816.68
Activity 12	DKA49	PN7050	Libyan Women Union in the Sout	WGSS set up, services and acti	68,850	40,238.55
Activity 13	CAB09	PN7149	Libyan Humanitarian Relief	PSS Mobile teams	34,725	34,725
Activity 14	EUB23	PN7149	Libyan Humanitarian Relief	PSS Mobile teams	51,875	36,775
Activity 15	CAB09	PN7149	Libyan Humanitarian Relief	RRM Distribution activities	27,060	27,060
Activity 16	EUB23	PN7149	Libyan Humanitarian Relief	RRM Distribution activities	14,336	14,335
Activity 17	CAB09	PN7149	Libyan Humanitarian Relief	IP Support Cost	4,324.95	4,324.95

Activity 18	EUB23	PN7149	Libyan Humanitarian Relief	IP Support Cost	3,967.25	3,577.7
Activity 19	EUB23	PN7257	International Medical Corps UK	Awareness raising activities	68,468.6	60,715.99
Activity 20	CAB09	PN7257	International Medical Corps UK	Procure & distribute DKs	16,500.64	5,634.73
Activity 21	EUB23	PN7257	International Medical Corps UK	Procure & distribute DKs	120,000	120,000
Activity 22	ITA46	PN7257	International Medical Corps UK	Procure & distribute DKs	33,516.87	33,516.87
Activity 23	ZZT07	PN7257	International Medical Corps UK	Procure & distribute DKs		0
Activity 24	EUB23	PN7257	International Medical Corps UK	IP M&E activities	341	0
Activity 25	DKA49	PN7257	International Medical Corps UK	GBV essential package training	3,587.82	-207.07
Activity 26	EUB23	PN7257	International Medical Corps UK	GBV essential package training	11,949.95	112
Activity 27	EUB23	PN7257	International Medical Corps UK	Provide GBV services	63,017.42	25,645.52
Activity 28	ITA46	PN7257	International Medical Corps UK	Provide GBV services	14,466.05	657.69
Activity 29	DKA49	PN7257	International Medical Corps UK	GBV technical training to IPs	3,044.97	2.74
Activity 30	EUB23	PN7257	International Medical Corps UK	GBV technical training to IPs	26,654.02	8,904.68
Activity 31	CAB09	PN7257	International Medical Corps UK	Program management implm	825.53	281.74
Activity 32	DKA49	PN7257	International Medical Corps UK	Program management implm	700.97	6.73
Activity 33	EUB23	PN7257	International Medical Corps UK	Program management implm	14,521.55	10,768.91
Activity 34	ITA46	PN7257	International Medical	Program management implm	2,399.65	1,708.73

			Corps UK			
Activity 35	ZZT07	PN7257	International Medical Corps UK	Program management implm		0
Activity 36	CAB09	PN7257	International Medical Corps UK	IP support cost	1,212.83	414.15
Activity 37	DKA49	PN7257	International Medical Corps UK	IP support cost	513.36	-14.1
Activity 38	EUB23	PN7257	International Medical Corps UK	IP support cost	21,346.68	15,830.3
Activity 39	ITA46	PN7257	International Medical Corps UK	IP support cost	3,526.78	2,511.83
Activity 40	ZZT07	PN7257	International Medical Corps UK	IP support cost		0
Activity 41	DKA49	PN7341	Stichting RNW Media	GBV Prevention Awareness	37,384	15,145
Activity 42	EUB23	PN7341	Stichting RNW Media	GBV Prevention Awareness	53,458	48,451.52
Activity 43	JPD23	PN7341	Stichting RNW Media	GBV Prevention Awareness	19,617	
Activity 44	DKA49	PN7341	Stichting RNW Media	Support cost	2,617	1,059.88
Activity 45	EUB23	PN7341	Stichting RNW Media	Support cost	3,742	3,150.32
Activity 46	JPD23	PN7341	Stichting RNW Media	Support cost	1,373	
Activity 47	DKA49	PN7594	Albayan for women and children	IP Support cost	2,401	2,387
Activity 48	EUB23	PN7594	Albayan for women and children	IP Support cost	5,673	2,794.19
Activity 49	JPD23	PN7594	Albayan for women and children	IP Support cost	2,558	1,781.99
Activity 50	DKA49	PN7594	Albayan for women and children	WGSS set up, services and acti	34,300	34,100

Activity 51	EUB23	PN7594	Albayan for women and children	WGSS set up, services and acti	81,027	40,725.15
Activity 52	JPD23	PN7594	Albayan for women and children	WGSS set up, services and acti	36,558	30,381.09
Activity 53		PN7698	National Organization of Amazo	Support Cost		
Activity 54		PN7698	National Organization of Amazo	WGSS set up, services and acti		
Activity 55	ESB11	PU0077	UN DEVELOPMENT FUND FOR WOMEN	Support Cost	3,400.64	
Activity 56	ESB11	PU0077	UN DEVELOPMENT FUND FOR WOMEN	Provision of Trainings	42,508	42,508.92
Activity 57	EUB23	PU0074	UN POPULATION FUND	Warehouse rent in Tripoli	26,851	7,913.19
Activity 58	FPA90	PU0074	UN POPULATION FUND	Warehouse rent in Tripoli	7,952	
Activity 59	EUB23	PU0074	UN POPULATION FUND	Communication activities	25,000	5,022.87
Activity 60	FPA90	PU0074	UN POPULATION FUND	Communication activities	7	23.22
Activity 61	FPA90	PU0074	UN POPULATION FUND	Personnel Protection Equipment	874	470.66
Activity 62	FPA90	PU0074	UN POPULATION FUND	CPD evaluation	25,334	25,230
Activity 63	FPA90	PU0074	UN POPULATION FUND	GBV International Consultant	70,000	45,160.44
Activity 64	EUB23	PU0074	UN POPULATION FUND	GBV coordination interventions	29,768	4,770.41
Activity 65	FPA90	PU0074	UN POPULATION FUND	HACT assurance activities	10,484	10,439.08

Activity 66	ESB11	PU0074	UN POPULATION FUND	Operational support cost	5,495	5,494.86
Activity 67	EUB23	PU0074	UN POPULATION FUND	Operational support cost	214,185.01	170,121.04
Activity 68	FPA90	PU0074	UN POPULATION FUND	Operational support cost	215,524.51	189,410.91
Activity 69	FPA90	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST):		26.13
Activity 70	DKA49	PU0074	UN POPULATION FUND	Salaries/benefits (IP, LPOST)	215,000	214,032.63
Activity 71	ESB11	PU0074	UN POPULATION FUND	Salaries/benefits (IP, LPOST)	34,000	36,203.6
Activity 72	ESD01	PU0074	UN POPULATION FUND	Salaries/benefits (IP, LPOST)	15,000	11,924.19
Activity 73	EUB23	PU0074	UN POPULATION FUND	Salaries/benefits (IP, LPOST)	319,300	250,151.95
Activity 74	FRA12	PU0074	UN POPULATION FUND	Salaries/benefits (IP, LPOST)	32,536	61,899.15
Activity 75	JPD23	PU0074	UN POPULATION FUND	Salaries/benefits (IP, LPOST)	111,000	17,960.64
Activity 76	FPA90	PU0074	UN POPULATION FUND	Salaries/benefits (IP, LPOST)	58,787	54,585.23
Activity 77	EUB23	PU0074	UN POPULATION FUND	Technical assistance	35,169.31	38,005.89
Activity 78	JPD23	PU0074	UN POPULATION FUND	Technical assistance	26,000	2,567.41
Activity 79	FPA90	PU0074	UN POPULATION FUND	Technical assistance	20,633.32	17,524.7
Activity 80	DKA49	PU0074	UN POPULATION FUND	Training and workshops	20,000	20,567.91
Activity 81	EUB23	PU0074	UN POPULATION FUND	Training and workshops	49,959	
Activity 82	JPD23	PU0074	UN POPULATION	Training and workshops	92,000	58,786

			FUND			
Activity 83	3006E	PU0074	UN POPULATION FUND	Training and workshops	30,000	29,998.8
Activity 84	FPA90	PU0074	UN POPULATION FUND	Training and workshops	25,000	77,031.66
POPULATION DYNAMICS						
Activity 1	FPA90	PGLY02	Bureau of Statistics and Censu	Survey - assessment	27,781	22,225
Activity 2	FPA90	PU0074	UN POPULATION FUND	COVID19 equipment	379	370.55
Activity 3	FPA90	PU0074	UN POPULATION FUND	Evaluation	10,988	11,310
Activity 4	FPA90	PU0074	UN POPULATION FUND	Evaluation	10,988	11,310
Activity 5	FPA90	PU0074	UN POPULATION FUND	Survey - assessment	9,823	1,718.49
Activity 6	FPA90	PU0074	UN POPULATION FUND	Technical assistance	27,478.56	25,277.92
Activity 7	FPA90	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)		166.45
REPRODUCTIVE HEALTH						
Strategic plan Outcome:						
Country Programme Output:						
Annual work plan *(code and name):*						
Activity 1	FRA12	PN6805	Libyan Red Crescent	SRH awareness & promotion		0
Activity 2	EUB23	PN6805	Libyan Red Crescent	Supplies procurement&logistics	1,000	1,000
Activity 3	FRA12	PN6805	Libyan Red Crescent	Supplies procurement&logistics		-2,740
Activity 4	FRA12	PN6805	Libyan Red Crescent	RH Commodities & Supplies		2,740
Activity 5	EUB23	PN6805	Libyan Red Crescent	Deployment of medical teams	30,500	30,500

Activity 6	FRA12	PN6805	Libyan Red Crescent	Deployment of medical teams	5,302	5,302
Activity 7	FPA90	PN6805	Libyan Red Crescent	Deployment of medical teams	1,768	1,768
Activity 8	FRA12	PN6805	Libyan Red Crescent	Programme post		0
Activity 9	EUB23	PN6805	Libyan Red Crescent	Support cost for LRC	2,205	
Activity 10	FRA12	PN6805	Libyan Red Crescent	Support cost for LRC	371.18	371.18
Activity 11	FPA90	PN6805	Libyan Red Crescent	Support cost for LRC	123.82	123.82
Activity 12	3FPBF	PN7257	International Medical Corps UK	Securing_RH Equipment	14,070.48	14,070.48
Activity 13	EUB23	PN7257	International Medical Corps UK	Securing_RH Equipment	18,584.07	5,153.79
Activity 14	ITA46	PN7257	International Medical Corps UK	Securing_RH Equipment	15,645.45	15,645.45
Activity 15	EUB23	PN7257	International Medical Corps UK	HIV Testing & PSS counseling	135	191
Activity 16	DKA49	PN7257	International Medical Corps UK	MISP & CMR Trainings		0
Activity 17	EUB23	PN7257	International Medical Corps UK	MISP & CMR Trainings		21,223.12
Activity 18	ITA46	PN7257	International Medical Corps UK	MISP & CMR Trainings	13,329.54	13,329.54
Activity 19	CAB09	PN7257	International Medical Corps UK	Deployment of medical teams	4,386.19	4,386.19
Activity 20	EUB23	PN7257	International Medical Corps UK	Deployment of medical teams	50,856.6	73,001.27
Activity 21	FRA12	PN7257	International Medical Corps UK	Deployment of medical teams	47,350	47,350
Activity 22	ITA46	PN7257	International Medical Corps UK	Deployment of medical teams	43,828.97	43,828.97
Activity 23	3FPBF	PN7257	International Medical Corps UK	Program management implem	703.52	703.52
Activity 24	CAB09	PN7257	International Medical	Program management implem	219.31	219.31

			Corps UK			
Activity 25	DKA49	PN7257	International Medical Corps UK	Program management implem		0
Activity 26	EUB23	PN7257	International Medical Corps UK	Program management implem	5,116.28	5,002.96
Activity 27	FRA12	PN7257	International Medical Corps UK	Program management implem	2,367.5	2,367.5
Activity 28	ITA46	PN7257	International Medical Corps UK	Program management implem	3,640.2	3,640.2
Activity 29	3FPBF	PN7257	International Medical Corps UK	IP support cost	1,034.18	1,034.18
Activity 30	CAB09	PN7257	International Medical Corps UK	IP support cost	322.38	322.38
Activity 31	DKA49	PN7257	International Medical Corps UK	IP support cost		0
Activity 32	EUB23	PN7257	International Medical Corps UK	IP support cost	7,520.92	7,354.35
Activity 33	FRA12	PN7257	International Medical Corps UK	IP support cost	3,480.23	3,480.23
Activity 34	ITA46	PN7257	International Medical Corps UK	IP support cost	5,351.09	5,351.09
Activity 35	EUB23	PN7257	International Medical Corps UK	SRH Awareness Raising Activity	14,950.26	0
Activity 36	EUB23	PN7257	International Medical Corps UK	IP M&E related technical costs	305.89	0
Activity 37	EUB23	PN7257	International Medical Corps UK	Improve SRH health info system	6,782.71	0
Activity 38	EUB23	PN7257	International Medical Corps UK	Training and workshops	10,710.98	490
Activity 39	UJA88	PN7491	Alistishari org	Nation wide awareness campaign	50,000	47,269.32
Activity 40		PN7491	Alistishari org	Survey		
Activity 41	3FPBF	PN7537	ALSafwa National	SRH awareness & promotion	2,500	2,500

			Organization			
Activity 42	EUB23	PN7537	ALSafwa National Organization	SRH awareness & promotion	18,500	8,488
Activity 43	JPD23	PN7537	ALSafwa National Organization	SRH awareness & promotion	15,800	9,906
Activity 44	EUB23	PN7537	ALSafwa National Organization	Supplies procurement&logistics	7,500	1,750.7
Activity 45		PN7537	ALSafwa National Organization	EmONC training		
Activity 46		PN7537	ALSafwa National Organization	Procurement medical equipment		
Activity 47	EUB23	PN7537	ALSafwa National Organization	HIV Testing & PSS counseling	72,000	19,720
Activity 48	EUB23	PN7537	ALSafwa National Organization	Deployment of medical teams	191,960	62,302.26
Activity 49	3FPBF	PN7537	ALSafwa National Organization	Programme post	3,882	3,882
Activity 50	DKA49	PN7537	ALSafwa National Organization	Programme post	2,118	2,118
Activity 51	EUB23	PN7537	ALSafwa National Organization	Programme post	27,000	18,000
Activity 52	3FPBF	PN7537	ALSafwa National Organization	IP support cost	1,247.88	1,247.4
Activity 53	DKA49	PN7537	ALSafwa National Organization	IP support cost	652	651.39
Activity 54	EUB23	PN7537	ALSafwa National Organization	IP support cost	25,822.5	10,422.68
Activity 55	JPD23	PN7537	ALSafwa National Organization	IP support cost	4,982.74	3,907.82
Activity 56	EUB23	PN7537	ALSafwa National Organization	Improve SRH health info system	10,000	
Activity 57	3FPBF	PN7537	ALSafwa National Organization	Trainings and workshops	11,450	11,438.5

Activity 58	DKA49	PN7537	ALSafwa National Organization	Trainings and workshops	7,195	7,187.5
Activity 59	EUB23	PN7537	ALSafwa National Organization	Trainings and workshops	44,929	40,207.6
Activity 60	JPD23	PN7537	ALSafwa National Organization	Trainings and workshops	55,382	50,021.5
Activity 61	EUB23	PN7593	Abiro Almotawasit / Migrace	SRH awareness & promotion	5,000	5,000
Activity 62	JPD23	PN7593	Abiro Almotawasit / Migrace	SRH awareness & promotion	5,500	5,500
Activity 63	JPD23	PN7593	Abiro Almotawasit / Migrace	Supplies procurement&logistics	2,200	2,200
Activity 64	JPD23	PN7593	Abiro Almotawasit / Migrace	Deployment of medical teams	139,900	138,779
Activity 65	EUB23	PN7593	Abiro Almotawasit / Migrace	IP Support cost	1,162.7	
Activity 66	JPD23	PN7593	Abiro Almotawasit / Migrace	IP Support cost	11,625.6	4,605.72
Activity 67	EUB23	PN7593	Abiro Almotawasit / Migrace	Capacity building activities	11,110	11,110
Activity 68	JPD23	PN7593	Abiro Almotawasit / Migrace	Capacity building activities	18,980	18,980
Activity 69		PN7642	YPEER Libya	International HIV Day campaign		
Activity 70	FPA90	PU0074	UN POPULATION FUND	Communication		4.95
Activity 71	FPA90	PU0074	UN POPULATION FUND	HACT activities for IPs	4,547	6,544
Activity 72	FPA90	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	14,195	14,194.92
Activity 73	ESB11	PU0074	UN POPULATION FUND	Techn Assist & Staff travels	7,033	1,498
Activity 74	ESD01	PU0074	UN POPULATION FUND	Techn Assist & Staff travels	1,099	

Activity 75	EUB23	PU0074	UN POPULATION FUND	Techn Assist & Staff travels	27,000	16,307.8
Activity 76	FPA90	PU0074	UN POPULATION FUND	COVID19 Emergency provisions	1,157	1,156.95
Activity 77	FPA90	PU0074	UN POPULATION FUND	Communication		3.05
Activity 78	FPA90	PU0074	UN POPULATION FUND	COVID19 equipment	49	46.22
Activity 79	FPA90	PU0074	UN POPULATION FUND	Audit for IPs		3,107.04
Activity 80	FPA90	PU0074	UN POPULATION FUND	Operational support cost		-93.42
Activity 81	CAB19	PU0074	UN POPULATION FUND	Technical assistance - IC cont	3,658.54	
Activity 82	FPA90	PU0074	UN POPULATION FUND	Technical assistance - IC cont	19,881.04	15,406.7
Activity 83	EUB15	PU0074	UN POPULATION FUND	Adviocacy campaignes	7,000	
Activity 84	FPA90	PU0074	UN POPULATION FUND	Adviocacy campaignes	6,484	6,483.89
Activity 85	EUB23	PU0074	UN POPULATION FUND	Supplies procurement&logistics	40,000	8,487.12
Activity 86	JPD23	PU0074	UN POPULATION FUND	Supplies procurement&logistics	10,000	7,907
Activity 87	FPA90	PU0074	UN POPULATION FUND	Supplies procurement&logistics	81,534	84,470.68
Activity 88	FPA90	PU0074	UN POPULATION FUND	RH Commodities & Supplies	1,730	0
Activity 89	FPA90	PU0074	UN POPULATION FUND	Communication and visibility		0
Activity 90	EUB23	PU0074	UN POPULATION FUND	Communication activities	15,015	812.45
Activity 91	FPA90	PU0074	UN POPULATION	Communication activities		103.54

			FUND			
Activity 92	FPA90	PU0074	UN POPULATION FUND	Personnel Protection Equipment	1,140	1,549.17
Activity 93	EUB15	PU0074	UN POPULATION FUND	Curricula, strategy translati	21,150	0
Activity 94	EUB15	PU0074	UN POPULATION FUND	sylabus	5,000	
Activity 95	CAB09	PU0074	UN POPULATION FUND	Securing_RH Equipment	24,833.13	11,141.2
Activity 96	EUB15	PU0074	UN POPULATION FUND	Securing_RH Equipment	111,235	157,677.49
Activity 97	EUB23	PU0074	UN POPULATION FUND	Securing_RH Equipment		30,089.45
Activity 98	FRA12	PU0074	UN POPULATION FUND	Securing_RH Equipment	24,430.35	24,194.76
Activity 99	ITA46	PU0074	UN POPULATION FUND	Securing_RH Equipment	343.81	
Activity 100	JPD23	PU0074	UN POPULATION FUND	Securing_RH Equipment	59,000	
Activity 101	FPA90	PU0074	UN POPULATION FUND	CPD evaluation	33,060	33,060
Activity 102	FPA90	PU0074	UN POPULATION FUND	HACT assurance activities	13,681	10,058.21
Activity 103	EUB15	PU0074	UN POPULATION FUND	leadership training program	46,594	67,166.45
Activity 104	FPA90	PU0074	UN POPULATION FUND	leadership training program		95.73
Activity 105	EUB15	PU0074	UN POPULATION FUND	Birth Simulators and manikins	115,990	-0.66
Activity 106	EUB15	PU0074	UN POPULATION FUND	N&M Cons workshops & meetings	13,616	0
Activity 107	FRA12	PU0074	UN POPULATION FUND	Deployment of medical teams	37,448	16,581.14

Activity 108	FPA90	PU0074	UN POPULATION FUND	Deployment of medical teams	6,722.08	13,058.44
Activity 109	EUB15	PU0074	UN POPULATION FUND	Develop Nat'l N&M Strategy	76,660.5	43,050.51
Activity 110	EUB23	PU0074	UN POPULATION FUND	Operational support cost	119,138.08	106,983.06
Activity 111	FRA12	PU0074	UN POPULATION FUND	Operational support cost	23,914	146.26
Activity 112	FPA90	PU0074	UN POPULATION FUND	Operational support cost	107,315.49	64,645.02
Activity 113	EUB23	PU0074	UN POPULATION FUND	Technical assist &staff travel	27,000	20,722.34
Activity 114	UJA88	PU0074	UN POPULATION FUND	Technical assist &staff travel	24,500	8,402.94
Activity 115	FPA90	PU0074	UN POPULATION FUND	Technical assist &staff travel	15,800	10,738.43
Activity 116	EUB15	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	181,000	149,391.44
Activity 117	EUB23	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	236,300	199,325.67
Activity 118	FRA12	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	12,334	10,439.45
Activity 119	JPD23	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	40,000	40,647.22
Activity 120	FPA90	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	146,922	132,573.71
Activity 121	EUB23	PU0074	UN POPULATION FUND	Programme post		78,844
Activity 122	3FPBF	PU0074	UN POPULATION FUND	RH Institutional Development	4,340	4,340
Activity 123	EUB15	PU0074	UN POPULATION FUND	Situation analysis midwifes	4,500	
Activity 124	EUB15	PU0074	UN POPULATION	Technical assistance	7,500	9,465

			FUND			
Activity 125	EUB23	PU0074	UN POPULATION FUND	Technical assistance	32,886.33	24,627.59
Activity 126	JPD23	PU0074	UN POPULATION FUND	Technical assistance		14,171
Activity 127	FPA90	PU0074	UN POPULATION FUND	Technical assistance	20,643.47	22,551.81
Activity 128		PU0074	UN POPULATION FUND	Specialized tools for nurses		
Activity 129	EUB15	PU0074	UN POPULATION FUND	Package midwives and nurses	50,700	0
Activity 130	JPD23	PU0074	UN POPULATION FUND	Package midwives and nurses	5,000	4,146
Activity 131	EUB15	PU0074	UN POPULATION FUND	N&M education policy&strategy	58,800.5	34,337.94
Youth						
Strategic plan Outcome:						
Country Programme Output:						
Annual work plan *(code and name):*						
Activity 1	UJA88	PN6688	Tracks For Peace and Developmt	Grants Awarding Scheme	40,001	40,000
Activity 2	UJA88	PN6688	Tracks For Peace and Developmt	Grants awarding scheme youth	159,570	71,297.02
Activity 3	UJA88	PN6688	Tracks For Peace and Developmt	media and awareness campaining	40,000	19,142.65
Activity 4		PN6688	Tracks For Peace and	PROJECT SUPPORT		

			Developmt			
Activity 5	UJA88	PN6688	Tracks For Peace and Developmt	IP support cost	20,279	4,905.36
Activity 6	UJA88	PN6688	Tracks For Peace and Developmt	trainings & capacity building	50,130	19,636.86
Activity 7	EUB23	PN7057	Life Makers Association	Grants Awarding Scheme	46,100	37,620.92
Activity 8	EUB23	PN7057	Life Makers Association	Support Costs	3,227	2,283.46
Activity 9	UJA88	PN7057	Life Makers Association	Support Costs	9,240	5,276.36
Activity 10	FPA90	PN7057	Life Makers Association	Support Costs	785.05	784.44
Activity 11	UJA88	PN7057	Life Makers Association	Youth Capacity Building scheme	132,000	131,970.56
Activity 12	FPA90	PN7057	Life Makers Association	Youth Capacity Building scheme	11,214.95	11,206.34
Activity 13		PN7491	Alistishari org	PROJECT SUPPORT		
Activity 14	UJA88	PN7491	Alistishari org	IP SUPPORT COST	3,500	2,538.87
Activity 15		PN7642	YPEER Libya	IP support cost		
Activity 16	FPA90	PU0074	UN POPULATION FUND	Communication		8.01
Activity 17	UJA88	PU0074	UN POPULATION FUND	Conflict Sensitivity Assesment	35,000	19,450
Activity 18	FPA90	PU0074	UN POPULATION FUND	Personnel Protection Equipment	607	621.82
Activity 19	UJA88	PU0074	UN POPULATION FUND	Enterpreneurship assessment	12,000	11,051.13
Activity 20	FPA90	PU0074	UN POPULATION FUND	CPD Evaluation	17,785	17,400
Activity 21	FPA90	PU0074	UN POPULATION FUND	CPD Evaluation	17,785	17,400

Activity 22		PU0074	UN POPULATION FUND	IP Assurance activities HACT		
Activity 23	FPA90	PU0074	UN POPULATION FUND	Audit for IPs	7,287	10,551.87
Activity 24	FPA90	PU0074	UN POPULATION FUND	Operational support cost	167.81	167.81
Activity 25	EUB23	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	9,000	5,304.96
Activity 26	FRA12	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	10,000	6,787.63
Activity 27	UJA88	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	9,000	7,589.92
Activity 28	FPA90	PU0074	UN POPULATION FUND	Salaries/Benefits (IP, LPOST)	40,355	30,721.53
Activity 29	UJA88	PU0074	UN POPULATION FUND	Technical assistance IC Con	41,815.21	30,991

Annex 5: Evaluation Matrix

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Relevance **EQ1:** To what extent is the country programme adapted to: i) the needs of diverse populations, including the needs of marginalized and vulnerable groups; ii) national development strategies and policies; iii) the strategic direction and objectives of UNFPA; iv) priorities articulated in international frameworks and agreements, in particular the ICPD and SDGs; and v) the New Way of Working and the Grand Bargain			
Assumption 1.1: The UNFPA funded interventions under review are adapted to the needs of the population and addressed national priorities and international framework agreements	● Evidence of accurate needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of diverse stakeholder groups prior to the programming of the SRHR, PD and GEWE components of the CPD ● Evidence of systematic use of findings from needs assessments in programme planning, design and selection of target groups and prioritization in CPD and AWPs. ● Extent to which the interventions as described in the AWPs, were targeted at the most vulnerable, disadvantaged, marginalized and excluded population groups in a prioritized manner. ● Extent to which the interventions implemented met the needs of the most vulnerable, disadvantaged, marginalized and excluded groups. ● Extent to which targeted populations were consulted in relation to programme design and activities throughout the programme.	● UNFPA CO M&E Framework ● Strategic Information System (SIS) annual reports. ● National policy/strategy documents. ● Needs assessment studies (incl. Humanitarian Needs Overviews) ● Evaluations – Global Progress report SDGs, ICPD POA. ● Key Informants from Government, IPs, CSOs and UNFPA CO ● Direct and indirect beneficiaries. ● Libya CPD 2019 – 2022	● Document review ● KI interviews ● Focus groups with beneficiaries and communities in targeted sites ● Focus groups with direct and indirect beneficiaries and communities in targeted sites, where possible

Findings: 1.1

Alignment of the CP to the National Strategies and Policies

There is evidence of the CP being adapted to address national priorities and population needs, in addition to implementation of the CP in collaboration and consultation with the various line ministries, including Ministry of Health, Ministry of Youth, Ministry of Social Affairs, Ministry of Education, Ministry of Higher Education, Bureau of Statistics and Census and other line ministries, directly contributing to their respective objectives, and making it relevant to the national needs. It is also evident that the CP implementation required approvals from the governments, both in the East and West, to allow, particularly the IPs, to implement the respective UNFPA-supported activities in the respective targeted locations, manifesting their support to the CP.

There is evidence that the Libyan authorities were consulted during the development of the CPD, capturing the priorities of the government. Interviews with the CO and IP staff also stated that the CP was highly informed through consultations of the vulnerable populations, identifying the needs which informed the kind of interventions and areas to be targeted. For example, the IPs and CO staff confirmed conducting surveys to identify gaps, especially with the youth and migrants, informing the kind of interventions to be implemented with them. The development of the CP was also contributed to the UNSF whose development was as a result of consultative efforts with the targeted authorities and populations. It is also evident from the CP results and resource framework (RRF) that the programme directly contributes to four national priority areas through implementation of its components in RH, A&Y, GEWE and PD.

SRHR:

- The CP supported the delivery of the health services to the migrant populations, asylum seekers, host communities and other remote locations through the mobile health clinics. UNFPA further invested in training of nurses and midwives, in addition to the strengthening of the community health workers to enable surveillance and share information on available services in the targeted locations. Recognizing the dilapidated health infrastructure, UNFPA supported the rehabilitation and equipment of health facilities to enable them resume operation, enabling access to health service delivery.
- The SRH services provided through the UNFPA support were in alignment with the national needs, aimed at improving provision of maternal and neonatal health. UNFPA facilitated provision of these services in collaboration with the MoH, and utilized the services of the Libyan government health workers. Interviews revealed that the services were provided in facilities that had been abandoned due to shortage of health workers or destroyed during the conflict, with UNFPA making them work through financial and technical support. The UNFPA's IPs who facilitated provision of the services filled the critical gaps left by the instability which led to poor government functions and resulted in many health workers going months without pay and thus, poorly motivated to provide care at the government health facilities.
- UNFPA, as a member of the health sector coordination mechanism supported the deployment and institutionalization of the District Health Information System 2 (DHIS2) in Libya through training of 20 municipalities, provision of infrastructure for its operation in the health facilities. UNFPA also supported, for the first time, the inclusion of the RH indicators on maternal health which enabled surveillance through data collection from the facilities. Surveillance of COVID-19 morbidity was also monitored through the DHIS2.
- UNFPA supported the development of various health-related policies and strategies, including RMNCAH, HIV and AIDS and midwifery training curriculum; including supporting training on CMR. The RMNCAH strategy enabled focusing and guiding of the RH service delivery, including providing direction on the procedures of delivery and identification of gaps. The strategy for midwifery was to support the training of Libyan nationals as nurses and midwives to address the human resources for health shortage, and this was marshalled into a curriculum development activity. UNFPA also supported the MoH in producing and translating a costed plan of its activities into both Arabic and English so that more people could have access to and understand the document.
- ***Challenge***: There were concerns on the level of their implementation of various policies and strategies. The government's capacity and commitment to implement the same was cited as a gap. Implementation of some guidelines like the CMR was also challenged given the mandatory requirement for the survivors of sexual assault to report to the security, in addition to being perceived as a taboo limiting reporting.

Adolescent and Youth:

- UNFPA, in the 1st CP, supported and advocated for the inclusion of youth in decision-making through engagement of various stakeholders to give voice to the needs of the youth and provide linkages that seek to recognize the young people as key contributors of country's development and in the humanitarian process. UNFPA worked with the newly-established MoY and other stakeholders to effectively advocate at national level on behalf of youths on their needs such as employment opportunities, capacity building and youth participation in decision-making, peace building processes and community –based peaceful cohesion. The youth in various ways, led by the UNFPA, in support of the national stakeholders, including local CSOs, contributed to implementation of the youth-targeted programmes in the country, addressing evidenced needs as identified through assessments, consultations

and gaps identified during implementation.

- UNFPA, through the UNCT supported the establishment of Youth Working Group (YWG) which enabled coordination of stakeholders engaged in youth activities in the country, providing an opportunity for the youth to be targeted with various interventions. With the establishment of MoY, under the GNU, youth activities have been coordinated under the YWG, with the ministry co-chairing, ensuring that the activities contribute directly to the ministry's strategic goals.
- UNFPA technically and financially supported the development of the RMNCAH strategy which includes the adolescent Reproductive health (ASRH), addressing the gaps in targeting the young people with services. This also provided an opportunity to capacity building of the healthcare workers to provide ASRH services and advocate for the rights of the young people's rights to information on the same. There was however limited documentation on youth ASRH services provided to the youth during the period of assessment. Interviews however revealed that the CP focused more on information of the youth on the RH and GBV themes, but less was captured on the services.
- *Challenge*: The A&Y component had resource constraints, limiting the extent to which the interventions could yield more results compared to the needs, which were reported to be enormous. The unavailability of the youth strategy, in addition to absence of specific ministry dedicated to respond to youth matters also limited the extent to which the focus on the youth needs. The inadequate government commitment to the development of A&Y-related programmes, thereby limiting their prioritization. There is however an opportunity with the establishment of a MoY, which enables refocusing the youth activities to address their needs.

GEWE:

- UNFPA engaged the Ministry of Social Affairs (Ministry of Social Affairs (MoSA), Ministry of Health (MoH), Ministry of Justice (MoJ), Ministry of Education(MoE), Ministry of Interior (MoI), to supervise the hotline operation services that a local Libyan civil society organisation (CSO) implements. This enabled collection of information on violations and facilitated referrals and case management for the GBV survivors in compliance with the existing pathways internal and external.
- UNFPA-supported GEWE interventions were relevant to bridge the gaps and respond to the needs of girls and women at risk. UNFPA and implementing partners held consultative meetings and needs assessment studies to design interventions relevant to the needs of girls and women. These facilitated identification of relevant interventions, addressing felt needs for the survivors. These were also found to be context-specific. These included; conducting awareness and legal support services to those in need, livelihood support to vulnerable women and girls; psychosocial support (first aid psychosocial) and specialised services to those with mental health issues; supporting case management and referral approach (Interviews and Document review).
- UNFPA confirmed conducting need assessments overview with their network of local CSOs to address the community needs. Additionally, UNFPA partner CSOs reported conducting a needs assessment with beneficiaries before submitting their annual work plan to UNFPA. For example, Women Union and Amazonat conducted a need assessment and took beneficiaries' feedback and inputs before submitting their AWPs to UNFPA for funding. GBV remains a sensitive and taboo issue in Libyan society. However, UNFPA has made significant achievements in putting GBV at the centre of the public attention, involving government, private sector and civil society actors.

PD:

- UNFPA contributed to strengthening of the national data system and also contributed to utilization of data to inform decision-making both at the national and local levels during the period of review. UNFPA supported the NBSC of the Ministry of Planning to plan for a national census, conduct household surveys and capacity build them in their areas of need. The CP also contributed to the humanitarian programming with the COD-PS, contributing to the production of HNO and the HRP, informing the decision in targeting of the most vulnerable populations.
- UNFPA developed the capacity of the country on increasing the demographic intelligence for humanitarian and development to through providing technical assistance to the NBSC on the NSDS through focusing on generation of sex and age disaggregated data, supporting the initiation of the geo-referencing and tracing of geo-boundaries to prepare for demographic survey, in addition to updating sample frame to get the national level indicators, especially on social development areas like family planning, GBV, and the other outcome level indicators. Further, UNFPA started working with the African Union to update the national statistics given the obsolete data available (Interview with CO, UNOCHA and NBSC staff). The CP also supported the NBSC and the MoH's Health Information Centre to conduct an assessment to map the issues with civil registration aimed at strengthening CRVS system.
- *Challenge*: There were limitations that affected implementation of the various planned activities. These included delays in allocation of resources for the population census and CRVS; having two separate governments in the west and east inhibit decision-making; conflicts; challenges of delayed approval by the government, inadequate capacity by the NBSC and other sectoral statistical offices.

Assumption 1.2: The UNFPA-supported interventions are aligned with the UNFPA Strategic Plan 2018-2021 and international normative frameworks, policies and standards and the New Way of Working and the Grand Bargain	● Extent to which the interventions implemented are in line with the SDGs and the UNFPA Strategic Plan 2018-2021. ● The expected results, targets and implementation strategies outlined in the CPD and the AWPs are in line with the priorities, results and targets of the United Nations Strategic Framework (UNSF) for Libya. ● Programme implementation Framework aligned to the New Way of Working and the Grand Bargain and international frameworks	● UNFPA SP 2018-2021 ● SDGs ● Government officials at national and state levels ● Needs assessments ● Proposals ● CPAP ● AWPs	● Document review ● Interviews with UNFPA Country Office staff ● Interviews with other United Nations agencies ● Interview with government officials ● Interviews with IPs ● Interviews with actors (i.e., NGOs working in the areas in which UNFPA works, but that do not partner with UNFPA)

Findings: 1.2

UNFPA Strategy 2018 – 2021

- The UNFPA Libya 1st CP components are highly aligned to the SP components, directly contributing to the achievement of the SP overall goal aimed at achieving universal access to reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality. Further, with women, adolescents and youth the key beneficiaries of the work of UNFPA, achievement of the goal is enabled by addressing human rights, gender equality and population dynamics. Interviews also established that the CP has specific interventions targeting migrants, IDPs and refugees, which are in line with the SP. The 1st CP is also aligned to the SP is confirmed by the reporting based on the Strategic Information Systems (SIS), where the outputs are covered according to the SP
- *Gap*: The A&Y component is more skewed towards youth participation, peace and security, instead of increasing their access to ASRH and GBV. While the CP was designed along the SP's business model classifying Libya as Pink Country, the massive humanitarian and human rights crisis from early 2019 and prolonged till 2020 affected its operationalization of the CP, and UNFPA strengthened alignment with the SP, in addition to enhancing focus on addressing the needs of the populations affected by the humanitarian crisis in the country, by mobilizing resources outside the core resources to finance the interventions, incorporating all SP modes of engagement, including service delivery, especially under RH and GBV due to the changes in the implementation context. Even though the CP endeavoured to strengthen national policies and the international development agenda, there was little evidence knowledge management and integration of population dynamics in sustainable development, RHR, adolescent and youth, and gender equality[168]. Further, the period of implementation has seen the Youth and PD components being mainstreamed due to lack of resources and inadequate prioritization due to COVID-19.

Alignment to Priorities in the International Frameworks

- ***ICPD*:** The 1st CP interventions directly contributed to ICPD – POA with its programmatic focus of improving the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality, through enhancing access to comprehensive reproductive healthcare, women and girls' empowerment and capacity in production of demographic data to inform decision-making in Libya. The CPE further reveals that UNFPA programme prioritizes marginalized and vulnerable populations with services and also contributes to eradication of forms of discrimination along sex, age, disability and social backgrounds.

- ***SDGs:*** The CP was in alignment with the SDGs, particularly Goal 3 (Good health and wellbeing), Goal 5 (Gender equality), Goal 10 (Reduced inequalities) and Goal 17 (Partnership building). To a little extent, the CP contributed to Goal 16 (Peace, Justice and Strong institutions) through the support of youth programmes aimed at building cohesive and peaceful coexistence among the conflicting communities. The reporting on the Goals was however hampered by a number of challenges including not accurate evidence as it is difficult to collect the data due to the instability[169].

- ***New Way of Working and the Grand Bargain***: UNFPA contributed to the NWoW, where it supported efforts to reduce need, risk and vulnerability in Libya. UNFPA supported the identification of needs, especially in the gender area of responsibility (AoR), through compilation of data on the humanitarian set-up, in addition to planning for the development and humanitarian response endeavours in the country.
- ***CP alignment with the United Nations Strategic Framework:*** The CP is well aligned to the United Nations Strategic Framework (UNSF) in Libya by contributing to two out of the three outcomes areas of the framework. The CP's SRHR and GEWE components are aligned to the UNSF's 1st results area which focuses on delivery of quality social services for all (including vulnerable groups and migrants) in Libya towards enhancing human security and reducing inequalities; while CP's Adolescent and Youth, and Population Dynamics components are aligned to the 3rd result area of the UNSF which aims at strengthening core government functions and Libyan institutions and civil society to respond to the needs of people

Relevance

EQ2: To what extent has the Country Office been able to respond to changes in national needs and priorities, including those of vulnerable or marginalized communities, or to shifts caused by crisis or major political changes including the ongoing COVID-19 Pandemic?

[168] Interviews with CO, UN Agencies, IPs and document review
[169] Interviews with Ministry of Planning and CO staff

Assumption 2.1: The CP is adapted to the national priorities and effectively responded to the changes caused by external factors in an evolving country context, including in the context of COVID-19	• Evidence of capacity and flexibility in programming approaches to respond to emerging needs including for COVID-19 response • Evidence of financial capacity to respond to arising needs • Evidence of repeated needs assessments conducted by UNFPA and/or implementing partners, identifying the varied needs of diverse groups and lessons learned during programming period • Extent of CP interventions in the four thematic areas of programming were adapted to emerging needs, demands and priorities of the population, in particular the most vulnerable, disadvantaged, marginalized and excluded population groups	• UNFPA CO M&E Framework • Strategic Information System (SIS) annual reports. • Emergency Preparedness and Response Plans (EPRPs). • National policy/strategy docs. • Needs assessment studies (including HNOs). • KI from Government, CSOs and UNFPA CO • Humanitarian Response Plans • Humanitarian programming documents • HCT members • Implementing partners	• Document review • KI interviews • Focus groups with beneficiaries and communities in targeted sites
Findings: 2.1 • UNFPA CO. was responsive to emerging national priorities and needs was almost throughout the CPs implementation through review of the CPD during the outbreak of conflict in 2019, to align to the national priorities adapting it to provide lifesaving services and peacebuilding interventions. • The CP's RRF, especially the indicators were also reviewed and addressed based on the changing context. For example, the RH indicator on training the of the healthcare providers was reviewed to include PPEs and COVID-19 related information. Further, the CP activities have been guided by the annual HRPs, and these guided the fundraising mechanisms for UNFPA, in alignment with targeting the people in need (PIN). • The CO also reprogrammed during COVID-19, including reallocating funds to respond to the effects that this came with, including incorporating integration of COVID-19 infection, prevention and control (IPC) into its programming, including being a member of COVID-19 Working group; engagement in resource mobilization endeavours to fill the funding gaps that existed. • UNFPA mainstreamed COVID-19 in Adolescent and Youth interventions to target the youth with funds to advocate against COVID-19, in addition to training and providing them with start-up kits to recover from the economic effects of COVID-19. UNFPA also reviewed the way interventions were conducted including holding virtual training meetings for stakeholders and this training focused on infection, prevention, and control (IPC) as needed. As a result of the COVID-19 outbreak, UNFPA supported COVID-19 preparedness training, mainstreaming it into the main trainings.			
Effectiveness **EQ3:** To what extent have the interventions supported by UNFPA contributed to the achievement of the expected results (outputs and outcomes) of the country programme and any other revisions that may have been done in view of the COVID-19 pandemic? In particular: i) increased access and use of quality sexual and reproductive health services, in particular by populations affected by humanitarian crisis; ii) increased participation of adolescents and youth, including the most vulnerable, in decision-making and enhanced youth leadership to promote sustainable development, peace and security ; iii) advancement of gender equality and the empowerment of all women and girls, with a particular focus on prevention and response to GBV; and iv) increased use of demographic intelligence in the development of evidence-based humanitarian and development plans, policies and programmes at national and local levels?			
Assumption 3.1: The planned UNFPA-supported intervention outputs and outcomes under SRHR, A&Y,	• Degree of completion of outputs planned in the M&E Framework against indicators and targets • Extent to which M&E of programme achievements indicate timely meeting of outputs.	• The Global Programming System (GPS), AWP and annual reports (SIS) • Annual Review and Planning	• Documentary review • Interviews with Line Ministry project coordinators and other IP and non-IP staff

GEWE and PD are being or are likely to be achieved	● Extent to which the response was adapted to emerging needs, demands and national priorities during the period of implementation	reports and related documents ● IPs (government, NGOs) ● UNFPA/ CO staff ● CP Results Framework ● IP Progress reports ● Beneficiary groups ● Relevant MTR reports ● UNCT reports	● Group meeting with UNFPA staff ● Focus Group Discussion with beneficiaries
Assumption 3.2: The UNFPA-supported intervention results effectively responded to achieve targeted results within the constraints of the context, including COVID-19	● The speed and timeliness of response (response capacity) ● Adequacy and quality of the response ● Evidence of changes in programme design or interventions reflecting context and influencing factors i.e. change in population needs and government priorities, COVID-19 response etc. ● Evidence of facilitating factors ● Evidence of mitigate measures on the challenges during implementation of the UNFPA-supported interventions	● GPS AWPs ● APRs/SIS ● CO staff ● Government partners ● Implementing partners	● Document review ● KI interviews

Finding 3.1 and 3.2

- **SRHR**

Achievements under Output 1:

- UNFPA technically and financially, and in collaboration with the MoH, supported mobile health teams, each of which comprised of obstetrics and gynaecologist, MHPSS counsellor, paediatrician, anaesthetist, nurses and midwives, as well as community health workers, in addition to supporting provision of kits and equipment to ensure functioning of the facilities. These contributed to providing reliable and quality health services in the target locations, particularly the hard-to-reach locations and those occupied by the crisis-affected populations and migrants, ensuring vulnerable populations access integrated GBV and RH services The teams facilitated provision of antenatal, postnatal and neonatal care, birth spacing information and methods, treatment and care for STIs, cervical and breast cancer screening services, referral to advanced (CeMONC) and emergency obstetric health services at the district health facilities. The mobile health teams bridged service gaps increasing access to skilled health care by the reproductive women and girls
- UNFPA contributed to the provision of improved access to skilled birth attendance in Libya by strengthening of midwifery and nursing capacities through education, supporting midwifery association, and development of training curriculum for the midwives, in collaboration with Tripoli University and Ministry of Higher Education.
- UNFPA also supported the training of the NGOs and other health workers across the country on RH services. This contributed to improving the quality of RH services delivered. Libya is now regarded as self-sufficient as these highly skilled health workers can subsequently pass this knowledge on to other professionals
- UNFPA stimulated demand for RH services by deploying community health workers (CHW) in the target communities. CHW were a new introduction to the health workforce in Libya and UNFPA was instrumental in the creation of this cadre of health professionals.

Achievements under Output 2:

- UNFPA enhanced the resilience of the health system by supporting the development of three policies through the period of the 1st CP, namely, Nursing and Midwifery Policy, RMNCAH Policy and HIV&AIDS Policy. The implementation of the RMNCAH however need a strong will and leadership from the MoH to see important components of the policy implemented across all departments in the Ministry. The Nursing and Midwifery policy while developed, is yet to be finalized due to the need for a validation meeting to be organized by the government of Libya. The rapid turnover of senior officers in the MoH has not helped as new officers need to first understand the workings of the Ministry before performing.
- UNFPA supported the strengthening and visibility of the Nursing and Midwifery Association in the country. The association was however 'dysfunctional'as it operated without byelaws or a national office. It also did not conduct regular elections into offices, although there is a national champion who is leading the association.
- UNFPA enhanced RH surveillance in the country through supporting the roll-out of the district health information system version 2 (DHIS2) in 20 municipalities. In the development of this, UNFPA ensured inclusion of RH indicators which facilitated maternal and neonatal surveillance in the targeted municipalities. Initially these indicators were never included, neither were they captured as they were not prioritized by the government. With their inclusion and training in the DHIS2, the surveillance and monitoring of RH systems has been enhanced in the targeted 25 facilities in the municipalities. It was however reported that the roll-out of DHIS2 was not effective and needed to be facilitated to work, however it worked well for the isolation centres for COVID-19 tracking.
- During the period, UNFPA contributed to health sector coordination mechanism, as an active member and a lead of the RMNCAH subsector technical working group, ensuring reach to needy people in a systematic manner and leveraging of resources and met frequently to share and strategize on how to share activities, in addition to eliminating overlap. This also enhanced advocacy on RMNCAH strategy for government involvement, in addition to M&E.
- Due to the emergency needs to respond to the COVID-19 pandemic, UNFPA improved the resilience of the health system by providing training packages to health workers on COVID-19 in relation to SRH, the MISP, Comprehensive SRH trainings, HIV VCT, breast cancer awareness and prevention, EmONC and leadership training for Midwifery. UNFPA also supplied PPE as part of rapid scale up of services due to the pandemic.

Adolescent and Youth

- UNFPA contributed to increasing the involvement of the youth in the peacebuilding activities through providing them with opportunities to engage with the decision-makers and stakeholders. UNFPA supported them, targeting their empowerment to be able to contribute to the governance processes in the country. for example, in 2019, UNFPA supported the 'Fasting for Peace' Initiative by young men and women to promote youth participation on peacebuilding issues, in addition to promoting their participation in the design of the Peacebuilding Fund project in Sirte and in the design of messages for the 16 days' campaign of activism through social media. This was premised on the fact that the youth population is huge and could be the key for stabilization or more conflicts. This was done through provision of PBF to the tune of US$650,000. While the fund was not adequate for the youth activities, it was limited to peacebuilding activities. Sirte was also a target since ISIL was active in the area targeting the youth who were easy recruits into the conflict. Through this

support, more than 1000 young women and men were supported through funding 49 youth-led initiative, enhancing their income access having lost a lot including relatives in the conflict, including joining terrorist groups for solace or revenge. These were averted as the youth got engaged in meaningful activities. UNFPA also gave priority to young women and girls and youth who had lost relatives for the support.

- UNFPA also supported the Libyan youth on the Youth, Peace and Security (UNSC Resolution2250) through the Y-PEER programme. This activity enhanced the participation of the youth in political, economic and peace issues in the country through forums and public sessions. The youth also targeted topics like prevention, protection, disarmament engagement, and reintegration from the armed groups, with interviews confirming that the programme targeted converts from armed groups. UNFPA also ensured conflict-sensitive approach ensuring no harm was made to any of the participating youth through working with the community structures
- UNFPA supported use of sports engagement, debates and theatre for the youth and the general populace to enhance advocacy mechanisms on youth access to GBV and SRH information. These platforms were also used by the youth to advocate on topical issues affecting them, including peacebuilding and responsible youth engagement in development issues like addressing issues of drug abuse, in addition to ensuring increased awareness on harmful cultural practices such as human trafficking, early marriages and GBV.
- The youth also increased their self-awareness on impending retrogressive cultural issues such as forced marriages and rape in the society that downplays their efforts to pursue their careers and aspirations. Awareness messages on HIV&AIDS were continuously provided to the youth in public awareness session through class facilitations. Theatre performances were effective in disseminating information on the significance of ASRH among the youth. Such performance also targeted elimination of child marriages and promoting girl child education by advocating against the practices, with changes reported during community sessions. The youth were also referred for those who needed help, especially PSS, and the IPs followed up to ensure that they received the support.
- UNFPA supported coordination of the youth activities in the country through supporting the Youth Technical Working Group (YWG) within the UNCT, in addition to co-chairing it with the MoY, which enhanced coordination and targeting of the youth issues in the country, in the absence of a strategy and policy. This brought together the UN agencies intervening on youth issues in Libya, enhancing leveraging of resources, in addition to addressing issues of duplication, geographical coverage, and enhanced communication on activities each of the members were implementing
- *Challenge*: The component received less funding allocation, and most of the programme funds were dedicated to GBV and SRHR components, in addition to contextual challenges. The absence of a strategy also led to some donors preferring (perceived as imposition) particular geographical locations with youth interventions while that would not be the case if needs were considered.

Gender Equality and Women's Empowerment (GEWE)

- UNFPA strengthened the national capacities to prevent and respond to GBV in the country, including in humanitarian settings through leading and supporting a functional inter-agency GBV coordination system; enhancing capacities of national partners to address GBV through a multi-sectoral, survivor-centric approach with specialized case management and psychosocial support; supporting the development of sexual reproductive health/gender-based violence referral pathways and management information systems; and policy engagement and advocacy for national ownership of the gender-based violence essential services package
- UNFPA contributed to strengthening multisectoral and survivor-centred approach to GBV preventions and response through supporting a comprehensive one-stop service women and girls' safe spaces (WGSS), enabling access to various services by the survivors. During the period of evaluation, UNFPA facilitated access to PSS, including MHPSS; dignity kits; livelihoods training; case management and referrals by the vulnerable women and girls in the target locations affected by conflict. These enabled GBV survivors to access multi-sectoral lifesaving services, including psychosocial support services, life skills, protection and able to express themselves without any social stigma or harm, in addition receiving information on issues relating to women's rights, health, and services; further contributing to the empowerment and protection of vulnerable women in crisis-affected areas and enabled detection of GBV
- UNFPA financially and technically contributed to strengthening the GBV case management processes in the country. UNFPA supported training on GBV case management and enhanced referrals of GBV cases from the WGSS to specialised service providers through the established pathways. Together with members of the GBV sub-sector members, UNFPA supported the mapping of services across the country to enhance service access by the survivors. However, serious cases of GBV refuse to be referred to government institutions, especially to hospitals, police and public prosecutors, out of fear for their lives from being killed by their families, and for fear of stigmatizing their families
- UNFPA, in collaboration with other stakeholders, contributed to the strengthening of GBV policy guidelines and strategies through coordination leading the development of the GBV sector strategy, standard operating procedures (SOPs), updated service mapping tool and initiated the rollout of the GBV-IMS, called PRIMERO. The GBV-IMS became effective and was introduced to service providers and partners in Libya to increase safety and equality in GBV case management service provision and documentation. The system allowed service providers to gather and analyse data on GBV incidents and systematically prepare response strategies.
- Through procurement and distribution of dignity kits, UNFPA enabled increased access to integrated SRH and GBV services to the affected populations, especially GBV survivors and IDPs. The dignity kits were distributed through the IPs and mobile teams.

- UNFPA, in collaboration with GBV stakeholders, supported awareness-raising campaigns to eliminate harmful practices, like GBV among girls and women at a national and sub national level.
- UNFPA Libya launched the first hotline with the free number 1417, in partnership with the local NGO PSS Team and under the supervision of the Libyan MOSA. This activity is part of the UNFPA GBV component. The hotline proved instrumental in providing psychosocial support, legal counselling and referral to immediate health services for the people in need. In 202, the hotline provided support to 14,382 individuals, 10,315 of which were women and girls.
- UNFPA promoted institutionalization of GBV response by establishing the GBV Unit within the MoH. It also strengthened the capacities of national partners and women organisations through the Training of Trainers on case management and CMR. It provided technical support and organised training on case management with the global team.
- UNFPA contributed to strengthening GBV response coordination through its support and leadership of the GBV SS under the Libya Protection Sector. With technical and financial support, UNFPA, as a co-chair, facilitated conduct of monthly meeting of stakeholders, including Ministry of Social Affairs with key issues discussed, informing programme in the various areas of responsibility, enhancing the coordination mechanisms which also enabled leveraging resources and partnerships to ensure that areas of gaps were prioritized for response by the partners. Resource allocation was also ensured, maximizing achievement with the available resources and eliminating duplication of effort among the actors addressing GBV. Participation and with UNFPA's leadership of the GBV SS enabled harmonization of key messages, especially for advocacy on GBV response and prevention. The GBV SS coordination was also used by the country coordination mechanisms to strengthen capacities of the members on various aspects on GBV response and prevention
- At the UN level, UNFPA also collaborated with UNICEF to develop ToR of Prevention of Sexual Exploitation and Abuse (PSEA), including steps to ensure protection while clashes are ongoing. This facilitated establishment of a committee and development of tools for reporting on the same by the partners as described under the section on coordination. Interviews also indicated that UNFPA collaborated with UN Women and UNSMIL to contribute to development of the EVAW law. These are also described in the coordination section.

Population Dynamics

- UNFPA supported strengthened data generation to enhance understanding and utilization through the production of the COD-PS with age, sex and geographic disaggregation up to administration level 3, facilitating demographic projection for the non-displaced Libyans. UNFPA also supported NBSC in digitizing enumeration areas (EA) in six municipalities, enabling production of maps and geo-reference population data at EA level, with the ArcSoft GIS, and the NBSC supported on generating of data used in the PAPFAM 2014 and the household MSNA RH indicators.
- The CP also supported the NBSC's capacity in producing geo-referenced data, in collaboration with NCDC and conducted a trend analysis of previous household surveys conducted in Libya between 2014 and 2018.
- Under the humanitarian response, UNFPA contributed differently in informing the performance towards provision of services to the affected populations through being the main and official source of population data for the humanitarian operation (HRP and HNO) and humanitarian monitoring and quality of programming through ensuring coordination of partners' reporting on the RMNCAH and GBV, and interviews revealed that UNFPA sectors were effective in complying with the reporting mechanisms.
- UNFPA contributed to strengthening capacities of various stakeholders in the country and supporting on data generation through facilitating a training for the NBSC on geo-referencing, GIS and use of data collection softwares, skills that were confirmed to have been very useful in strengthening data generation and analysis, informing policy and programming, including resource allocation. UNFPA also agreed with the NBSC to complement their database on SDG monitoring, with a new unit created in the Ministry of Planning to work on this. In addition, UNFPA utilized South-South cooperation with Paris21 to support the NBSC on the development of the National Strategy for the Development of Statistics (NSDS) and according to the African Union set of guidelines for statistical system to improve the quality of data and production of statistics.

Effectiveness

EQ4: To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?

Assumption 4.1: UNFPA Libya CP integrated a gender-responsive and human rights-based approach to program planning, implementation, and monitoring	● Number of cases responded through health sector response to GBV project ● Number of GBV case reported and handled through health sector	● Health sector response to GBV project documents ● Health sector response to GBV project implementing partners	● Document review and analysis ● Secondary data analysis from projects and implementing partners regarding GBV.

Findings: 4.1

- The CP design and implementation incorporated human rights approaches and gender mainstreaming in its strategies of targeting marginalized and vulnerable populations with services and advocacy mechanisms to engage duty bearers and rights holders to increase the voices of the marginalized and at-risk groups while at the same time aiming to eliminate harmful practices. UNFPA further ensured that there was inclusion in the services delivery through supporting assessments, advocacy training and supporting development of SOPs, strategies and policies to increase targeting and reduce effects of marginalization.
- UNFPA embedded human rights perspectives in the delivery of its services on RHR through ensuring access to RHR services at the facilities it oversaw did not require being a citizen or a legal resident of Libya, thereby ensuring a human rights perspectives to the delivery of the services. It was also not specific to any gender, age group or race. The services supported by UNFPA were noted to be particularly targeted at vulnerable populations in the community and also those held in detention camps.
- UNFPA's focus on integrated RH needs and rights of the most vulnerable, including people with disabilities, marginalized women and girls, among others is also evidence of a human rights perspective. In addition, UNFPA supported the selection of locations with needs through the availability of data contributing to the HNO, with locations lacking service delivery being targeted through the mobile health teams indicating the intention to reach those most in need.
- The CP enhanced youth targeting through conducting assessments and ensuring that there were no discriminations against those marginalized, including ensuring that there were no negative attributes on the migrants
- The action of supporting host families with migrants, including youth, with cash and making efforts, through CESVI, to link the migrants with their families is also based on enhancing their rights and dignities
- The GEWE component of the CP is gender focused and, interviews confirmed UNFPA's commitment to ending gender inequality and human rights violations, which are key barriers that must be addressed to end GBV and harmful practices, including child marriage, sexual violence and other types of discrimination and vulnerability; embracing a rights based approach to support the affected populations.
- UNFPA in the PD support to the NBSC supported the production of gender, age and sex disaggregated data from the in-depth analysis of previous reports to inform programming decisions. This provided the opportunity to draw on the age, gender and diversity dynamics. It is not however clear how the data was used to target age or gender-related focus in the programmes supported by UNFPA during the period of review.
- ***Gap***: Review of programme reports did not however provide sex and age disaggregated data among the beneficiaries of the programme

Efficiency

EQ5: To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme?

Assumption 5.1: Implementing partners received UNFPA financial and technical support as planned and in a timely manner, and UNFPA was able to mobilize appropriate resources in a timely manner to support the implementation of the Country Programme.	● Percentage of planned vs. actual resources ● Evidence that implementing partners received the planned resources to the foreseen level in AWPs ● Evidence that implementing partners received resources in a timely manner ● Evidence of coordination and complementarity among the programme components of UNFPA ● Evidence of progress towards the delivery of multi-year, predictable, core funding to implementing partners ●	● AWPs and APRs/SIS and IP, government reports ● UNFPA CO financial reports ● UNFPA CO staff ● Government officials ● Implementing partners ● Resource mobilization strategy	● Document review ● KI interviews ● Group interviews
Assumption 5.2: The UNFPA main and sub-offices were appropriately staffed (the right number of people with the right competencies and skills	● Evidence that UNFPA personnel (all types of contracts) have adequate expertise and experience to deliver development and humanitarian assistance ● Evidence that UNFPA CO staffing structure is appropriate for	● UNFPA CO Staff interviews ● HR structure	● Documentary review ● Key Informant and group interviews

in the right positions)	timely and effective implementation, including in humanitarian settings ● Extent to which existing human resource management policies, rules and procedures enable the timely and effective implementation, including in humanitarian settings		
Assumption 5.3: Programme strategic approaches, administrative, procurement and financial procedures as well as the mix of implementation modalities led to efficient achievement of programme outputs	● The planned inputs and resources were received as set out in the AWPs and agreements with partners. ● The resources were received in a timely manner according to project timelines and plans ● Budgeted funds were disbursed in a timely manner ● Quality technical assistance to build capacity was available to the level planned ● Evidence that technical assistance increased capacity among recipient stakeholders ● Inefficiencies were corrected as soon as possible	● AWPs and SIS and IP, government ● UNFPA CO financial reports ● UNFPA CO, government and IP staff	● Document review ● Interviews with CO, Government and IPs staff
Assumption 5.4: CO has robust M&E systems in place and efficiently utilised	● Evidence of M&E system and documentation ● Evidence of utilization of M&E information in informing the programme strategies	● CP Resource and Results Framework ● Programme Reports (SIS and Annual Planning reports) ● UNFPA CO Staff	● Document review ● Interviews with CO, Government and IPs staff

Finding 5.3

- UNFPA employed partnership as a mechanism to facilitate the 1st CP delivery. UNFPA strategically partnered with both international and local NGOs as IPs to ensure implementation of the CP. Partnership with international NGOs enabled capacity development and compliance of the locals facilitating efficient CP delivery. Partnership with local NGOs enabled access to hard-to-reach and areas, targeting the vulnerable populations with much-needed services on RHR, A&Y, and GEWE. In addition, the local NGOs facilitated understanding of the local context, which enabled faster decision-making, including effectiveness in negotiation with the authorities for access to the target locations of service's needs. Partnership with the local organizations also ensured acceptance from the communities targeted. This ensured efficiency in delivery of the CP services. For example, UNFPA international and national staff, being UN staff, needed to undergo a lot of approvals to move to the field, and therefore partnering with local IPs made it easier for them to move freely, without much restrictions
- UNFPA contributed to strengthening coordination with various entities within the various CP components through participating as a member of sector, co-chair, joint programmes or facilitating coordination mechanisms within the UNCT or HCT. In addition, participation in the TWG enabled standardization of delivery of services through development of technical guidelines and standard operation procedures, enhancing quality of service.
- UNFPA also utilized technical assistance through provision of expert advice and support to the government and stakeholders in the CP components of RH, A&Y, GEWE and PD, which facilitated effective transfer of skills and knowledge on the subject matters, further strengthening capacities. In addition to the technical staff that the CO had to support programme implementation, UNFPA also utilized the services of consultants, both international and national, facilitating expertise transfer of knowledge and skills. The act of utilizing local consultants also provided an opportunity to sustain skills transfer.
- UNFPA leadership was also hailed as contributed to a lot for facilitating delivery of the CP, with UNFPA being credited for advocacy prowess and made a lot of efforts in raising the profile of UNFPA in all the areas of responsibility and this worked effectively, in addition to raising more resource the CP intervention.

Findings 5.1 and 5.2

- UNFPA's organizational and operational management mechanisms were fairly efficient and effective in delivering the CP processes. Skilled human resources were in place, financial systems and management across the CP working well, with financial resources being effectively distributed and accounted for. There was also significant resource mobilization during the period of review as stated in Chapter 3. UNFPA put in place mechanisms to ensure organizational and resources were management in an efficient manner, ensuring achievement of CP results.
- UNFPA CO put in place mechanisms to ensure monitoring and quality assurance, as evidenced in the execution approaches which were both through national and direct execution (NEX and DEX). UNFPA had a clear and robust system for ensuring checks and balances, and to ensure that IPs were accountable for deliverables in a timely manner. The evaluation established that there was a strong and consistent system at UNFPA CO to review quarterly work plans, partner financial and programme reports and provide required feedback mainly on completeness, quality of reporting and absorption/utilisation rates of the funds. UNFPA CO ensured that regular audits were carried out with the IPs and results shared with them, and action taken on weak areas.
- UNFPA, to a little extent, spearheaded integration approach in the delivery of the CP, in addition to coordination gaps across the four CP components. The evaluation gathered during the interviews the fragmentation in the delivery of the programme. There were however aspects of mainstreaming of GBV and RHR in the A&Y, but they were mainly at informational level. There was also no evidence of coordination of the activities among the respective component teams, towards reducing operational costs or increasing programmatic efficiency by reducing duplication and operational costs as well as increasing interactions among staff and IPs.
- UNFPA had two main offices in Tripoli and Tunis, in addition to two satellite offices in Benghazi and Sabha, with the presence of UNFPA in Tunis facilitating CO support during crisis and emergencies. The distance in Tunis and the red tape involved in approvals and length of time for visa processing for the staff wanting to travel to Libya inhibited efficiency since most international staff were based there. On the other hand, the office in Tripoli ensured overall coordination of the CO operations, including finance, procurement and logistics, and programme staff. The field offices in Benghazi and Sabha enabled effective follow-up in the field activities for UNFPA, however they had staffing challenges.
- Financial management within the organization was reported to be effective given existing internal controls facilitating the operational decisions. IPs indicated that the disbursement processes were effective, save for the IPs that did not have accounts outside of Libya who had challenges accessing their cash
- *Challenge*: There were still concerns where UNFPA had sufficient staff in Sabha and Benghazi, while in Tripoli, there were shortages of operation staff. In addition, UNFPA RHR team were predominantly based in Tunis, because there was limited space for UNFPA in the UN compound in Tripoli and travel to Libya from Tunis requires multiple levels of approval. This limited UNFPA's presence on the ground, especially on advocacy issues.

Finding 5.4

• The 1st CP utilized the planning mechanisms to develop the results and resources framework, which effectively facilitated alignment of the CP with the national priorities, the UNSF and UNFPA SP, with resources and targeted stakeholders clearly allocated and identified as confirmed by the document review and interviews with CO staff. There was also a confirmation of annual planning mechanisms, including setting targets based on the RRF for the CP, facilitating follow-up on progress and performance on the indicators. UNFPA also held annual review sessions for the IPs, with the participation of all the relevant CO staff, facilitating experience sharing and enabling the teams to address arising challenges, in addition to planning for the following annual programme cycle. • UNFPA used FACE forms that the partners used to report on a monthly basis, and this was effective for monitoring the budget utilization by the IPs, and in case of deviations, corrective actions were taken. In addition, Spot checks were also conducted at least once per year per IP depending on expenditure level and the risk involved, by UNFPA to assess their compliance and quality assurance. UNFPA also conducted audits based on the cycles of the IPs, conducted by external auditors commissioned by the headquarters, in addition to be a members of the Harmonized Approach to Cash Transfer (HACT) where UNICEF and UNDP are members and complemented each other in the audits, which also contributed to efficiency in the delivery of the CP as the IPs already audited by any of the agencies are not audited. • The IP reporting was confirmed to be compliant with UNFPA requirements, with regular daily, weekly, quarterly and annual reports based on the timelines and reporting templates provided by UNFPA. The IPs across the programme areas confirmed being clear on the reporting system and that it also served their interest in improving their understanding of their performance. • In order to remedy the contextual challenges, especially access, the M&E teams have devised mechanisms of frequent communications, especially with the daily data submission through the KoBo platform has facilitated effectiveness and assurance in the deliveries by the IPs and other programme activities. There was also confirmed support from the ASRO M&E Advisor who facilitated a training workshop on RBM, and workshop on experience-sharing from the region with similar contextual set-up, in addition to conducting missions to Libya to support. • There was evidence on utilization of M&E information for reporting to the donors, UNSMIL, and assessing IP performance; keeping track on performance based on the CP targets; and assessing partner capacities for effectiveness. For example, from analysis of deliverables by the IPs, which had technical quality issues and challenges, the CO hired two staff with technical skills and communication and assigned them to the WGSS.		
Sustainability **EQ6:** To what extent has UNFPA been able to support implementing partners and beneficiaries (women and adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?			
Assumption 6.1: The benefits of the CP are likely to continue beyond the life of the programme and UNFPA has been able to support its partners and the beneficiaries in developing systems, mechanisms and capacities that ensure the durability of outputs, and eventually outcomes	• Extent of ownership of each project by implementing partners • Partnerships formed and enhanced and the accomplished results • Resources mobilized • Extent to which Government and implementing partners at national and sub-national levels have allocated adequate budget for continued implementation of interventions and safeguarding the gains that have been made in the thematic areas of programming. • Extent to which UNFPA has taken any mitigating steps to strengthen areas with gaps hindering sustainability • Evidence of the development of exit strategies in the thematic areas of programming to hand over UNFPA-supported interventions to Government and/or implementing partners at national and sub-national levels • Evidence of Libya Government contribution to the UNFPA-supported programme areas • Evidence for enhanced capacity of the Government and IPs at national and state levels to implement interventions in the	• Beneficiary groups • Government Ministries/Departments • Implementing partners • UNFPA Country Office staff • AWPs • Previous evaluations • Projects and Interventions exit strategies • Government Ministries Policies and budget documents • Training reports • NGOs and Academia • CP sites • Country Office staff (Relevant Program Officers)	• Document review • KI and Group Interviews • Focus groups with beneficiaries • Interviews with POs • Interviews with implementing partners • Interviews with beneficiaries

	thematic areas of programming without the technical support of UNFPA • Extent to which programmes in the three thematic areas of programming were developed and implemented in a participatory multi-stakeholder process to promote ownership • Evidence of increased programme integration in Libya Government sector policy frameworks in the programme country and national development plans		

Finding 6.1

- UNFPA utilized partnerships with local implementing partners, constructed facilities, capacity built the government and stakeholders on various aspects of the CP components, supported development of strategies and standard operating procedures, and strategically collaborated with the government departments ensuring long term results. UNFPA promoted national ownership of the results of the interventions support and therefore the possibility of sustainability through working with, the Ministries of Health, Youth, Social Affairs, Education, Higher Education; Planning and higher learning institutions; among others, including NBSC, where the ministries directly contributed their staff and paid their salaries, providing facilities for interventions and participating in development of strategic documents for use by the ministries.
- The UNFPA's partnership approaches, utilizing the support of local IPs to implement the CP interventions also creates a sense of ownership, especially building on local knowledge and understanding of the local context and needs. UNFPA, in most times, consulted the IPs in the design and this facilitated their ownership of the programme interventions. For example, the Gender IPs exhibited ownership of the WGSS interventions as its scope resonated with mandate and would continue to look for funding opportunities to continue delivering GBV, life skills and livelihood services to the local community, if UNFPA funding ended. The communities also supported the UNFPA activities through donation of consumables in the health facilities.
- *Challenges*: There were a lot of gaps limiting national ownership, especially within the government structures. ownership is quite limited, especially with the fragmentation of the government. High and frequent staff turnovers, especially the leaderships at ministries while also derailed continuity of the support provided by UNFPA. There was also poor coordination of activities and inefficient allocation of resources which threatens the sustainability of the programs that have been rolled out and the gains that have been recorded. Inadequate commitment of the government to continue implementation of the interventions supported by the CP. Development of the policies and strategies of support by the consultants limiting the government's level of engagement, in addition to structural challenges, especially from the government regulations.
- UNFPA contributed to the development of the capacity of the healthcare workers on Voluntary HIV Counselling and Testing (VCT), and those trained provided the services to various populations and enabled reach of the Libyan population with the services. UNFPA's support to the development of the Midwifery curriculum and strategy is instrumental to institutionalizing nursing and midwifery service provision across the country, in addition to working with the University of Tripoli for implementation and working in collaboration with the MoHE for accreditation purposes.
- UNFPA facilitated transfer of skills through engagement of international experts who worked closely with national experts to deliver in their technical areas of focus. For example, during the development of the Midwifery and Nursing curriculum, UNFPA engaged two international experts who also worked with local experts to deliver the curriculum.
- UNFPA invested in the capacity building of frontline workers at the national levels and municipalities through conducting various trainings including, training members of the municipalities on GBV; MISP and CMR, women CSOs on gender and advocacy; training of the NBSC on GIS and data generation and analysis; DHIS2 training and support; training of the youth on cohesion and peace; and health workers on delivery of RH services.
- Through advocacy with the Libyan authorities, UNFPA ensured establishment and strengthening the capacity of the Gender unit under the MoH to ensure that GBV is prioritized in the health service delivery, targeting CMR, in addition to ensuring institutionalization of skills through promoting master trainers who cascaded the trainings to the municipalities and lower level governance structures. UNFPA also supported the NBSC on geo-referencing of boundaries, which will be used to determine with precision sampling frames. There were however concerns on the utilization of the skills gained to provide services. For example, the DHIS2 was reported to be ineffective by some respondents and that its operationalization never took off.
- UNFPA also supported vulnerable women and girls, and youth to receive livelihood skills through access to TVET, with some supported with grants to establish business. There was no evidence capturing the difference that the support contributed in the livelihoods of those supported, however, the technical skills will remain with them and would be in a position to apply them.
- *Challenge*: There were concerns on the ability to continue to provide, especially specialized services such as those provided by the obstetrician and gynaecologist, the paediatrician and anaesthetist after funding ceases. Thus, challenges with the government capacity and commitment to take up the role in making resources available and retaining expert care at the health facilities can unwind the gains that have been made in this 1st CP on access to healthcare services by the Libyan and vulnerable populations. There were also gaps in the plans by the government to follow-up on the capacity building accomplishments by UNFPA and other agencies during the CP.

Coordination

EQ7: To what extent has the Country Office contributed to the functioning and consolidation of United Nations system-wide development and humanitarian coordination mechanisms?

Assumption 7.1: The UNFPA CP has actively contributed to the UNCT working groups and	● Evidence of active participation in UN inter-agency working groups ● Evidence of the leading role played by UNFPA in UN inter	● Programming documents regarding UNCT joint initiatives ● Monitoring/evaluation reports of	● Documentary analysis ● Interviews with UNFPA CO staff ● Interview with the UNRC

joint initiatives	agency working groups or joint initiatives ● Evidence of exchanges of information between UN agencies ● Evidence of joint programming initiatives; plans for joint programming. ● Evidence of UNFPA participating in the coordination mechanisms within the UNCT and HCT	joint program and projects ● UNCT and HCT members ● CO staff ● Resident Coordinator	Interviews with UNCT other UN agency members

Findings: 7.1

- UNFPA Libya is an active member of the UNCT and participates in the inter-agency Programme Management Team, Operations Management Team, Security Management Team in addition to chairing the UN Communications, Youth Working, M&E Groups and co-chairing the PSEA group with UNICEF, in addition to leading thematic areas of the UN framework, based on its comparative advantage. There were strong linkages and synergies the UNCT members describing UNFPA as highly pro-active and reliable in the areas of its mandate
- As the Chair of the M&E Group, UNFPA's contribution to the UNCT coordination mechanisms was recognized in leading the revision of the UNSF before extension to 2022, and led the review of RRF, including the indicators and the goals for the UNCT, making them relevant for the period of extension.
- UNFPA participated in joint programmes, in addition to collaborating with various UN agencies to deliver in various areas of responsibilities. For example; UNFPA actively participated in the successful creation and rollout of the RRM for Libya, in partnership with UNICEF, IOM and WFP, ensuring completion of all the 13 Minimum Preparedness Actions jointly addressing the needs of the displaced families and those affected by floods in targeted locations in Libya, with UNFPA supporting them with dignity kits, while UNICEF, IOM and WFP provided WASH services, Health interventions and food assistance respectively UNFPA also collaborated with WFP and UNDP in the implementation of the human security project on advocacy targeting peace and security. In this programme, each member had a clear role and location to target, with UNFPA in Sirte training line ministries on local governance targeting peace and development as it was already in the same location supporting youth.
- UNFPA's contribution, especially on conducting advocacy with the authorities, was lauded by the respondents as very important in the delivery of the results. The respective agencies are also working on increasing advocacy efforts for establishing protective legal mechanisms for women and girls and to end impunity for perpetrators.
- UNFPA priorities and mandate were well reflected in the UNSF with UNFPA contributing to two out of three thematic pillars both programmatically and financially in the implementation of the framework. The framework includes the UNFPA-related results areas of RHR, adolescent and youth, gender equality and women's empowerment, and populations dynamics. There was also feedback on the strengthened coordination among the agencies, especially in planning, sharing information, and working together on joint or complementary programmes with contributions of each agency.
- UNFPA also contributed to the joint advocacy with UNICEF and UN Women on COVID-19 pandemic, developing various advocacy briefs for the need to support GBV response in the country amid the pandemic. UN Women also contributed in developing of the guiding notes gender issues so as not to lose sight in the times of COVID-19. UNFPA and other UN agencies also contributed to joint functions like the 16 Days of Activism, International Women's Days, International Youth Days, among others ensuring that the themes and messages developed and communicated were in shared manner among the UN agencies. As the lead of the co-chair of the Communications group, UNFPA ensured frequent convention of meetings among the UN agencies.
- UNFPA co-chaired technical working groups within the UNCT and UN HCT, especially in its mandate in the GBV AoR in UNCT and the Libyan people, and was depended on to provide guidance on GBV by the UN and other stakeholders. For example, the UN agencies agreed to the recommendations provided by UNFPA on how to deal with cases of GBV survivors through the referral mechanisms. UNFPA is also one of the seven members of the Inter-agency common feedback mechanism administered by WFP.
- *Challenges*: There were complexities within the Libya UNCT operation is complicated, even for the agencies themselves. For example, since the agencies are supposed to contribute to the government strategies, there were no clear government strategies to guide and facilitate operational focus. In other quarters, donors also have different interests and this fragments response and support to the country. Cases of duplications and overlaps were reported. In addition, in the new UNSF, there were clashes reported among the UN agencies engaged in Peacebuilding as it was broad and was not clear on the extent of delimitation for the agencies under the peace area of responsibility.

Coverage

EQ8: To what extent have UNFPA humanitarian interventions systematically reached all geographic areas in which affected populations (women and adolescents and youth) reside?

EQ9: To what extent have UNFPA humanitarian interventions systematically reached the most vulnerable and marginalized groups (women and adolescents and youth with disabilities;

migrants and refugees, those of racial, ethnic, religious and national minorities; etc.)			
Assumption 8.1: The UNFPA Development and Humanitarian action reaches and addressed the identified needs of all the population groups facing life-threatening suffering, such as IDPs, Refugees, migrants, PWDs COVID-19, etc.	• Evidence of needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of vulnerable populations in various vulnerable and marginalised groups in the country prior to the programming of the SRHR, PD and GEWE components of the CPD • Evidence of systematic use of findings from needs assessments in programme planning and design and the selection of target groups for UNFPA-supported interventions • Extent to which the planned interventions in the CP thematic areas of programming, as described in the AWPs, were targeted at the most at risk groups in a prioritized manner. • Extent to which the actual interventions implemented on the ground address the needs of the most at risk groups. • Extent to which the most at risk groups were consulted in relation to programme design and activities throughout the programme	• UNFPA CO M&E Framework • Strategic Information System (SIS) annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Key Informants from Government, CSOs and UNFPA CO • Direct and indirect beneficiaries.	• Document review • KI interviews • Focus groups with beneficiaries and communities in targeted sites • Focus groups with direct and indirect beneficiaries and communities in targeted sites
Assumption 9.1: The UNFPA Humanitarian action reached and addressed the identified needs of all the population groups facing life-threatening suffering, such as arm conflicts, displacements, COVID-19, etc.	• Evidence of needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of vulnerable populations in various geographical areas in the country prior to the programming of the SRHR, PD and GEWE components of the CPD • Evidence of systematic use of findings from needs assessments in programme planning and design and the selection of target groups for UNFPA-supported interventions • Extent to which the planned interventions in the CP thematic areas of programming, as described in the AWPs, were targeted at the most at risk groups in a prioritized manner. • Extent to which the actual interventions implemented on the ground addressed the needs of the most at risk groups. • Extent to which the most at risk groups were consulted in relation to programme design and activities throughout the programme	• UNFPA CO M&E Framework • Strategic Information System (SIS) annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Key Informants from Government, CSOs and UNFPA CO • Direct and indirect beneficiaries • HRPs for the period	• Document review • KI interviews • Focus groups with beneficiaries and communities in targeted sites • Focus groups with direct and indirect beneficiaries and communities in targeted sites

Findings: 8.1 and 8.2

- UNFPA contributed to the national response on humanitarian crisis, in close coordination with other actors in the field, led by UNOCHA through membership of RRM, in partnership with UNICEF, IOM and WFP, ensured targeting of people affected by the crisis and reaching them with targeted services relieving their sufferings (Document reviews and interviews). In partnership with the LRC, and building on their national coverage of networks ensured that the affected populations were reached with RH services and information on the other CP thematic areas.
- UNFPA enhanced training on MISP, facilitating capacities and competencies to deliver in the thematic areas of responsibility. In other aspects, UNFPA utilized assessments to identify areas of need to be targeted with services. For example, UNFPA contributed to the HNO which informed the HRP, ensuring that all the geographical locations with humanitarian needs were targeted. The extent of the CP coverage with the service is a challenge ascertaining as data and the extent of need was not clear and not harmonised among the stakeholders.
- UNFPA employed partnership mechanisms with local and international NGOs to access locations where the needs were, ensuring reach of people affected by disaster to be reached with services, in to having stronger logistics management, distribution and storage capacity in remote areas of Libya to preposition required kits, and ensured effective response whenever needed
- UNFPA's activities were mainly concentrated in areas identified to be in most need, usually along migrant routes and remote areas without functional healthcare services, with SRHR activities being focused in the south of Libya, Tripoli and Benghazi and in detention camps where illegal migrants are temporarily held, and activities generally targeted vulnerable populations including migrants, IDPs, and women and girls in need across the country.
- UNFPA services were strategically targeted at reaching the vulnerable and marginalized groups in the society including women and children, migrants, asylum seekers and those in detention camps. For example, the health facilities supported by UNFPA were strategically identified to be along migrant routes and in remote communities without ready access to healthcare services and were also designed to cover people without presenting identification items to show whether they were Libyan citizens or not unlike in government health facilities where presentation of such identification is a prerequisite to receiving healthcare services
- UNFPA, together with the IPs conducted a situation analysis / assessments of the country and consulted with various stakeholders including women, children, IDPs and those in detention to establish the marginalized and most vulnerable populations deserving services. The organization also utilized legacy assessments conducted by the government and the World Health Organization including the SARA and the PAPFAM to inform targeting of the populations with services.
- *Challenge*: Including migrants in the same activities with the host community was a challenge, where social cohesion remained fragile among migrants, refugees and Libyans. Libyan society still considers migrants as a source of violence and extremism. There were stakeholders that believed that UNFPA could deliver more interventions across a wider geographic area with the resources at its disposal. The COVID-19 pandemic affected access and delivery of services within the country, including limiting movement of populations.

Connectedness

EQ10: To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women's organizations, health facilities, communities etc.) to better prepare for, respond to and recover from humanitarian crisis?

Assumption 10.1: UNFPA Libya strategic leadership on youth and women contributed to stronger capacities in the results and resources framework of the 2019-2022 Country Programme and contributes to bridging the development-humanitarian nexus by enhancing capacities at individual, community and systems level	• Evidence of the existence of an exit strategy with timelines, allocation of responsibility • Evidence of details of a handover process from UNFPA to the government departments and/or development agencies • Evidence of allocation or plan for resource allocation post-response • Evidence that affected communities are mapped and targeted with interventions • Evidence of the existence of a transition strategy from humanitarian action to development, which specifies timelines, allocation of budget and roles and responsibilities • Extent to which the capacity of individuals, in particular women, adolescents and youth, has been increased to reduce vulnerability	• UNFPA CO • UNCT sites • Key Implementing Partners • Donors • Results and resources Framework • UNFPA Staff • Government staff • NGO/IP Staff • Programme reports	• Key Informant Interviews Documentary analysis • Document review • Interviews with staff • Group Interviews

	to and adapt to humanitarian crises, as well as transform livelihoods to successfully cope with humanitarian crisis • Extent to which the capacity of communities to prepare for, mitigate the impact of, and recover from humanitarian crisis has been enhanced • Extent to which the preparedness of the health and social protection systems at national and state levels and the capacity to deliver services in the mandate areas of UNFPA has been increased • Extent to which UNFPA humanitarian assistance was linked specifically to peacebuilding initiatives		

Findings: 10.1

- UNFPA immensely supported a number of initiatives aimed at promoting peace among the various target groups, including majorly anchoring the A&Y component on building and strengthening mechanisms for peaceful co-existence among the youth, in addition to promoting this among the other community members using interactive theatre, participating in training to influence others, using social media to engage on peace among the youth and the country at large. As the co-chair of the YWG, UNFPA facilitated promotion of the youth participation in addition to capacity building them on peacebuilding which facilitated their involvement in negotiation and peace building in the country.
- UNFPA also strengthened women participation in peace and security, in line with the UN security council resolution (UNSCR) 1325. Under the Joint programme with WFP and UNDP, UNFPA conducted training to the line ministries on human security addressing the root causes of conflict targeting soft skills and promoting local governance which is also designed to contribute to development. In recognition of the increased focus on stability and shifting humanitarian needs, UNFPA is a member of the Peace and Development nexus (Nexus WG), and contributes to the strategic direction on the same.
- With the establishment of the WGSS, the CP supported the vulnerable women and girls on training on TVET and other soft skills including language and other skills development, with the aim of increasing their employability hence addressing their need for increased livelihood access. On the other hand, during COVID-19, UNFPA supported the youth to address their economic needs through the Youth and COVID-19 grants, which in addition to combating the effects of COVID-19 to the youth, enhanced livelihood opportunities to the youth The CO also introduced face masks as livelihood source for vulnerable women who produced the same and sold them to the community members
- UNFPA facilitated rehabilitation activities for the various structures within the country through implementation of the health services in the primary health facilities, including equipping them with the necessary equipment, enabling them to provide the needed health services. UNFPA also utilized government facilities and supporting them to deliver services using the same, enhancing their capabilities to deliver. Working with the government in many aspects including being in coordination mechanisms, like working with the line ministries as co-chairs of the various technical working groups enhances the government participation and support in decision-making on the interventions.
- UNFPA supported development of various strategies, SOPs and a centralised management information system to collect data on GBV cases; and to guide the implementation process for various aspects of the CP thematic areas. UNFPA supported development of RMNCAH which will continue to guide the delivery of the RH services to the populations. The development of SOPs in various thematic areas, including CMR, Case management, GBV, PSEA, among others will continue to guide the quality standards for the delivery of services.
- UNFPA supported development of knowledge materials, especially targeting behaviour change themes on peace, GBV, family planning, women's empowerment, COVID-19, among others. These will contribute to enhancing knowledge transfer.
- *Challenges*: There is low commitment of the government on the utilization of the developed strategies. Behaviour change takes time and the extent to which this changed during the period of review could not be established.

Annex 6: Interview Guides

Key Informant Interview Guide for UNFPA Staff and UN Agencies

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Write names of all participants and their roles in the organization
d. **Probe: Focus on vulnerability, gender, disability and human rights as appropriate**

1. Rationale for the 1st CP and Interventions undertaken

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
- Who was consulted regarding the design? To what extent were they consulted?
- What other actors have been involved, how does this activity contribute to that of others?

2. Relevance

- How is the [SRHR, A&Y, GEWE or PD] component of the 1st Country Programme (CP) aligned to the a) national needs and priorities in Libya such as articulated in the national and sectoral policies b) Partners and beneficiaries needs? c) UNFPA Strategic Priorities and strategic plan? d) International frameworks, policies and strategies on [SRHR, A&Y, GEWE or PD] and human rights? **(probe for the needs first)**
- What aspects of the national and sectoral policies do you consider are covered in the 1st CP?
- Were the objectives and strategies of the Country Programme M&E Framework discussed and agreed with national partners? [Probe]
- How did you identify the needs prior to the programming of the [SRHR, A&Y, GEWE or PD] components?
- Who was consulted regarding the design? What other actors have been involved, how does this activity contribute to that of others?
- In your view, does UNFPA have the right strategic partnerships? Mutual benefit, critical to achieving shared vision
- Were there any [SRHR, A&Y, GEWE or PD] needs or priorities of the implementing partners that the country program did not address adequately or at all? If Yes, what were these needs and priorities

3. Effectiveness

- What are the indications that the approach is working or making progress toward goals established for the CP (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence)?
- Overall, what are the achievements of the 1st CP in respect of the [SRHR, A&Y, GEWE or PD] component area**?** **Probe** for evidence
- How have the outputs been utilized?
- What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?
- What factors have facilitated effective implementation of the 1st CP? Which ones hindered?
- What do you consider to be the best practices from the 1st CP?
- To what extent did internal communication strategies on various CP components facilitate improved outcomes of the other components in terms of funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered achievement of results.
- Were there any changes in national needs and global priorities during the implementation period? How did UNFPA CO respond to these changes?
- To what extent has UNFPA responded to [SRHR, A&Y, GEWE or PD] emerging issues in the IDP Settlements or calamities? What were the factors that facilitated UNFPA response to such emerging issues? What were the factors that hindered the UNFPA response to such SRHR emerging issues?

Note: Remember to ask for documents if not already shared

4. Efficiency

- How many staff are in your unit? Qualified with appropriate skills?

- Do you think your staff strength and capacity are enough for the 1st CP implementation and achievement of results?
- How timely did you receive resources for implementing this programme?
- How timely were resources for interventions disbursed to implementing partners? Were the resources sufficient for implementing partners to complete activities?
- Describe UNFPA CO administrative and financial procedures in the 1st CP?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 1st CP implementation? [**Probe]**
- Were there any delays? If yes, why? And how did you solve the problem?
- Are there occasions when the budget was not enough or you overspent?
- How appropriate was the programme approach, partner and stakeholder engagement for CP implementation and achievement of results?
- Have the programme finances been audited?
- To what extent were the activities managed in a manner to ensure delivery of high quality outputs and best value for money?
- Any additional funding from the Government and other partners?
- How robust and adequate is the M&E System in place to enable measurement of the CP performance during implementation? How are M&E results used to support the CP management?

5. Sustainability

- What mechanisms is UNFPA putting in place to ensure that the results of the CP are sustained beyond the programme cycle?
- How is partner capacity building integrated into UNFPA mode of engagement with partners?
- How have national partners utilized capacity developed through UNFPA support?
- How are national partners involved in UNFPA programming?
- To what extent are the benefits likely to go beyond the programme completion?
- Are the strategies, plans, protocols and practices developed within the programme anchored on IPs institutional arrangements
- Do you believe that there is political will and national ownership behind the CP interventions, and is this changing? Have programmes been integrated in institutional government plans?
- How has UNFPA addressed changes in knowledge and perceptions of the target beneficiaries based on various aspects of the programme?

6. UNCT Coordination

- Is there any Inter-Agency Technical Working Group on this 1st CP, involving other UN Country Team?
- What role has UNFPA played in the UNCT joint programs? Any specific contributions? Any lessons learned?
- What are the UNCT coordination structures and mechanisms in place?
- How active, relevant and effective is UNFPA in the UNCT?
- What is the role of UNFPA CO in the United Nations Country Team coordination structures and mechanisms in Libya? What partnerships exist? Any specific contributions to the achievement of results?
- What are the special strengths of UNFPA when compared to other UN agencies and development partners?
- How do implementing and national partners perceive UNFPA?
- Is UNFPA collaborating with other UN Agencies in implementation of interventions? Which UN Agencies and in which interventions? What are the roles of UNFPA and other UN Agencies? How has this contributed to the achievement of UNFPA results?
- How and to what extent are UNFPA priorities and mandate reflected in the UNDAF

7. Coverage

- How does UNFPA CP respond to humanitarian needs in Libya? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable?
- To what extent does UNFPA programme target the vulnerable and those in displacement in Libya?
- To what extent has UNFPA responded to SRH on the humanitarian and emerging needs in the IDP Settlements or calamities?
- What were the factors that facilitated UNFPA response to such adolescent and youth humanitarian and

emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- Budget allocation for humanitarian programme interventions

8. Connectedness
- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of SRHR in Libya?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing SRHR
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

Key Informant / Group Interviews: Government / IPs (adapted for **SRHR, A&Y, GEWE and PD)**

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current programme cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Write the names of all the Participants and their roles in the organization
d. **Probe: Focus on vulnerability, gender, disability and human rights as appropriate**

1. Rationale of the Partnership and activities engaged in
- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target populations (SRHR, A&Y, GEWE and PD needs)?
- Have you conducted a problem analysis, needs assessment? Who was consulted regarding the design?
- What other actors have been involved, how does this activity contribute to that of others?

2. Relevance

- To what extent is the [SRHR, A&Y, GEWE or PD] component of the 1st Country Programme (CP) aligned to the a) national needs and priorities in Libya such as those articulated in the national and sectoral policies; b) International frameworks, policies and strategies on gender equality and human rights
- What aspects of the national and sectoral policies do you consider are covered in the 1st CP?
- How were needs of vulnerable groups (i.e. youth, girls, women, young mothers, marginalized) addressed during the programming or planning process for your UNFPA project activities?
- What criteria did you use in the selection of target groups in the field of [SRHR, A&Y, GEWE or PD]? [**Probe** if the identified needs of these target groups included in the criteria]?
- Were there any [SRHR, A&Y, GEWE or PD] needs or priorities of the implementing partners that the CP did not address adequately or at all? If Yes, what were these needs and Priorities
- How does the CP intervention interface/merge with your institutional programmatic objectives and strategies?
- How were needs of your institution identified prior to the programming of the [SRHR, A&Y, GEWE or PD]?
- Do you see the work of UNFPA and its implementing partners as supporting the right interventions to address SRH/GEWE/GBV/PD needs, harmful practices and discrimination against women and girls?

3. Effectiveness
- Looking at the implementation so far, to what extent have the planned 1st CP outputs/targets been achieved? Were the intended beneficiaries reached? **Probe**
- What are the indications that the approach is working or making progress toward goals established to be achieved in 2021?

- How did UNFPA provide support for challenges in the implementation of interventions to address outputs and outcomes.
- To what extent did the support address the needs of the target groups i.e. women of reproductive age, survivors of GBV, adolescents and youth, boys and men?
- What factors have facilitated effective implementation of the 1st CP? What factors hindered/affected successful implementation of the programme?
- What else should be done to make the programmes more effective?
- Has there been evidence of expected or unexpected results from work on SRHR/GEWE/GBV/A&Y/PD that has been supported by UNFPA?
- How timely was the disbursement of UNFPA funds to the IPs? Probe for any challenges
- How many times did you experience a humanitarian crisis or a political change during the 1st CP? How did UNFPA support in each of the instances? Probe for the services or support provided
- To what extent has UNFPA responded to SRHR emerging issues in the IDP settlements or calamities? What were the factors that facilitated UNFPA response to such SRHR emerging issues? What were the factors that hindered the UNFPA response to such SRHR emerging issues?
- How did UNFPA ensure programme integration of gender and a human-rights approach, including people with disabilities
- To what extent did UNFPA support use of disaggregated demographic and socio-economic data for evidence-based planning and development.

4. Sustainability

- What measures are in place for programme continuity in the absence of continued UNFPA support? [**Probe** e.g. re output/outcome areas integrated in institutional/government policies and plans/budget allocations]. In which areas do you need support to continue on your own?
- To what extent have your capacities been strengthened in the areas of support by UNFPA?
- How have you utilized capacity developed through UNFPA support?
- How is capacity building integrated into UNFPA mode of engagement with its partners?
- Do you have other sources of technical and financial support? **[Probe]**
- What is the likelihood of sustained benefits (e.g. through capacity building, improved M&E and other systems, population data availability, etc. with or without continued UNFPA support)? **[Probe]**
- How has UNFPA ensured effective partnership in the country to facilitate strong sectoral networks in the country? **Probe** how they have participated
- Is your organization/agency a member of any national or local coordination mechanism (including bilateral dialogues) where UNFPA shares technical expertise either as a member or as a leader? [**Probe**: What are these coordination mechanisms?

5. Efficiency

- How appropriately and adequately are the available resources (funding and resources) used to carry out activities for the achievement of the outputs?
- How timely did you receive resources for implementing this programme? Were there delays? If yes, why and how did you solve the problem?
- To what extent were the activities managed in a manner to ensure delivery of high quality outputs and best value for money?
- Any additional funding from the Government or other partners for the programmes funded by UNFPA?
- Do you think UNFPA CO administration and financial procedures are appropriate for 1st CP implementation?
- How about the programme approach, partner and stakeholder engagement, was it appropriate for implementation and achievement of results?
- How did UNFPA support capacity development for implementers of interventions?
- What implementation challenges were encountered?
- Were agreed outputs delivered?
- Was the programme approach, partner and stakeholder engagement appropriate for results delivery?
- Which partnerships were more strategic in bringing about results and value-for money?
- Were institutions adequately equipped to deliver on results-based management/ M& E for the CP?

6. Coordination

- How is the UNFPA programme coordinated? What role does UNFPA play and what role do you play in

coordination?
- Is there any Inter-Agency Technical Working Group on this 1st CP, involving other UN Country Team?
- Can you say how well the activities are coordinated, overlapping and how is this handled?
- Is UNFPA playing an active coordination or leadership role around SRH, A&Y, GEWE and PD in the country?
- What are the special strengths of UNFPA when compared to other UN agencies and development partners?
- How do implementing and national partners perceive UNFPA?
- What partnerships exist? Any specific contributions to the achievement of results? Any challenges?

7. Added Value
- What unique strategies/interventions in SRH, A&Y, P&D or Gender of UNFPA add value to the work of other development partners, especially the UN system? Please give examples
- What strategic partnerships at the National level and /or local level has UNFPA supported that produced results and are worth replicating and institutionalizing?
- What specific technical contribution has UNFPA made to the country's development agenda

Key Informant Interview/ Focus group discussion Guide for CP Beneficiaries

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Capture every participant's name
d. **Probe: Focus on vulnerability, gender, disability and human rights as appropriate**

I would like to know the type of support you received from (**UNFPA implementing partner**)

1. Relevance
- What are the national needs and priorities in Libya/in your community in terms of the development agenda with regards to CP component (SRH, A&Y, GEWE and PD)?
- How important is the work supported by (UNFPA implementing partner) to these needs and priorities at the local, provincial and national levels?
- Does the (UNFPA implementing partner)'s work address the needs in (SRH, A&Y, GEWE and PD)?
- How has (UNFPA implementing partner) consulted you in the identification of your local needs in (SRH, A&Y, GEWE and PD)?
- How has (UNFPA implementing partner) integrated support for the marginalized, gender and other human rights?

2. Effectiveness
- To what extent has (UNFPA Implementing Partner) support reached the intended beneficiaries? **Probe** for vulnerable groups in the locality
- Are different beneficiaries appreciating the benefits of the UNFPA interventions? For example,
- What are the specific indicators of success in your programme?
- How are gender relations and human rights being influenced by the activities undertaken by the programme? Are there ways to sustain the positive changes?
- What do you think has worked best? What has not worked well
- What factors contributed to the effectiveness or otherwise?
- What else should be done to make the programmes more effective?

3. Sustainability
- What are the benefits of the programme interventions to you?
- To what extent are the benefits likely to go beyond the programme completion?
- What measures are in place at the end of the programme cycle for the various programmes to continue?

- Have programmes been integrated in institutional/government plans?
- How does the UNFPA CO/ (Implementing partner) ensure ownership and durability of its programmes?

Interview Guide for UNFPA Donors and Strategic Partners

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Capture every participant's name

Probe: Focus on vulnerability, gender, disability and human rights as appropriate

1. Rationale for the Strategic Relationship

- What is the strategic involvement of [Donor/ partner] in Libya?
- What specific needs is your institution addressing in the country?
- Which specific areas did your institution support the Libya 1st CP (**Donor**)?

2. Relevance

- How is UNFPA CP contributing to addressing the same strategy that your institution is involved in the country
- How relevant is UNFPA programming in addressing the country needs in the areas of (SRH, A&Y, GEWE and PD)? [**Probe** for specific approaches]
- What is UNFPA's comparative advantage in the country?

3. Effectiveness

- To what extent would you say UNFPA is addressing the national needs and priorities in Libya?
- What has been realized in the country because of UNFPA's CP since 2019 to present? [Results achieved compared to plans – **Probe** for capacities developed]
- What has worked well and what has not worked well?
- Are there gaps in UNFPA's approaches? How would they be improved?

4. Efficiency and Sustainability

- M&E systems in place, ensuring
    - Timely reporting
    - Use of data to inform decision-making
- Capacities in place
- Effectiveness of partnership approaches

5. Coordination

- How active, relevant and effective is UNFPA in the coordination mechanisms in the country?
- How does UNFPA contribute to the coordination within the country? Probe for specific responsibilities
- Where there are areas of potential overlap with other UN mandates, how is this resolved? e.g. re gender, disability, human-rights based programming, response in humanitarian situations as well as main focal areas of SRH, A&Y, PD
- What are UNFPA CO strengths, weaknesses/ limitations, and opportunities to improve in its programming in the country?

Annex 7: Stakeholders Map

Donor	Implementing agency							Other partners							Rights holders	Other
	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	Other	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	Other		
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS																
Strategic Plan (2018-2021) Outcome 1: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.																
CP Output 1: Increased access for women and girls to high quality sexual and reproductive health services, with a focus on humanitarian settings and CP Output 2: Improved capacity and resilience of health systems for the provision of integrated sexual and reproductive health services, including for the most vulnerable																
If relevant, Atlas/GPS Project (code and name)																

Canada; European Union (Neighborhood Instrument; EUTF); France; Italy; Japan; UNICEF, UNOCHA/CERF;	Ministry of Health; National Centre for Disease Control; Control; Primary H	Libyan Business Women Association; Libyan Midwifery Association; Tripoli Crisis Management Group; Libyan Red Crescent (LRC)	International Medical Corps (IMC); AlSafwa National Organization; Migrace			University of Tripoli - Faculty of Midwifery and Nursing; University of Casablanca	Y-PEER Network	Ministry of Health; National Center for Disease Control; MoH; Human Resources Directorate – MoH; Ministry of Education;				UNICEF; WHO; Resident Coordinator			Conflict-affected populations, particularly women at reproductive age and their newborns; IDPs, migrants, refugees, returnees and asylum seekers in Libya; people with disabilities; health workers of UNFPA supported health facilities and benefitting from UNFPA	

	ealthcare Institute (PHCI)														training s, midwives and nurses	
YOUTH DEVELOPMENT AND PARTICIPATION																
Strategic Plan (2018-2021) Outcome 2: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts																
CP Output 3: Adolescents and youth, including the most vulnerable have increased opportunities to participate in decision-making and to lead initiatives that promote sustainable development and peace and security																
If relevant, Atlas/GPS Project (code and name)																

UN Peacebuilding Fund, European Union (EUTF); UN Women; UNESCO		Tracks for Peace and Development; Y-PEER Network; Life Makers Association (LMA); Alistishari; Rugby 2018 (under LMA)						Ministry of Youth Ministry of Local Governance; Health Office in Sirte		Youth Working Group (YWG) members		UNDP; UNICEF; UNWOMEN; WFP; UNESCO; Youth Working Group (YWG) members; Resident Coordinator	University of Sirte		Young people in Libya, Youth-led Civil Society Organizations; IDPs, migrants, refugees, returnees and asylum seekers in Libya; people with disabilities.	
GENDER EQUALITY AND WOMEN'S EMPOWERMENT																
UNFPA Strategic Plan (2018-2021) Outcome 3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings																
CP Output 4: Strengthened national capacities to prevent and respond to gender-based violence including in humanitarian settings																
If relevant, Atlas/GPS Project (code and name)																

Canada; Denmark; UNFPA Emergency Fund; European Union (EUTF); France; Italy; Japan; Catalonia – Barcelona; UNOCHA/CERF		Albayan NGO; Amazonat; Elssafa Center; Huna Libya; LibAid (Libyan Humanitarian Relief Agency); Libyan Scouts;; Tracks for Peace and Development; Women Union; Psychosocial Support Team	CESVI; International Medical Corps (IMC); International Rescue Committee (IRC)	Albayan NGO; Amazonaet; Elssafa Center; For You Libya; Huna Libya	UN WOMEN			Ministry of Social Affairs; Women Empowerment Unit (Prime Minister's Office); Ministry of Women Affairs; Ministry of Justice; Ministry of Local Governance; Ministry of Migration Affairs Ministry of	For You Libya;	GBV Sub-Sector Working Group (GBV SSWG) members		IOM, UNHCR, UNICEF, UN WOMEN; WFP; Resident Coordinator; GBV SSWG members			Conflict-affected populations, particularly vulnerable women and girls in Libya; IDPs, migrants, refugees, returnees and asylum seekers in Libya; people with disabilities; social workers and government officials benefitting from UNFPA trainings	

								Health (GBV Unit); Ministry of Interior (Family and Childrden Unit);								
POPULATION DYNAMICS																
UNFPA Strategic Plan (2018-2021) Outcome 4: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development																
CP Output 5: National data systems are strengthened to increase the utilization of demographic intelligence at national and local levels																
If relevant, Atlas/GPS Project (code and name)																

UN Trust Fund for Human Security	Bureau of Statistics and Census (BSC)				UN-HABITAT	University of Oxford		Ministry of Planning – Bureau of Statistics and Census (BSC); Health Information Centre		REACH		UNOCHA; UN-HABITAT; Resident Coordinator			All people in Libya, including IDPs, migrants, refugees, returnees and asylum seekers in Libya; people with disabilities	

*WRO= Women's Rights Organization