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Public Health Situation Analysis- Short Form
Libya

Initiated by: Country Office ☒ Regional Office ☒ HQ ☐

Type of emergency	Main health threats	UN Level: N/A **WHO-ERF** G2	Security level(s)- General Source: United Nations Department of Safety and Security	INFORM risk October 2021
• Displacement • Conflict • Epidemics	• Largely disrupted public health system • COVID-19 • Communicable diseases: childhood vaccination; disease surveillance and response, TB; leishmaniasis • Non-communicable diseases (including mental health) • Reproductive, maternal, newborn, child and adolescent health		Countrywide: High	**6.2** (Rank: #18)

1. Summary of Crisis

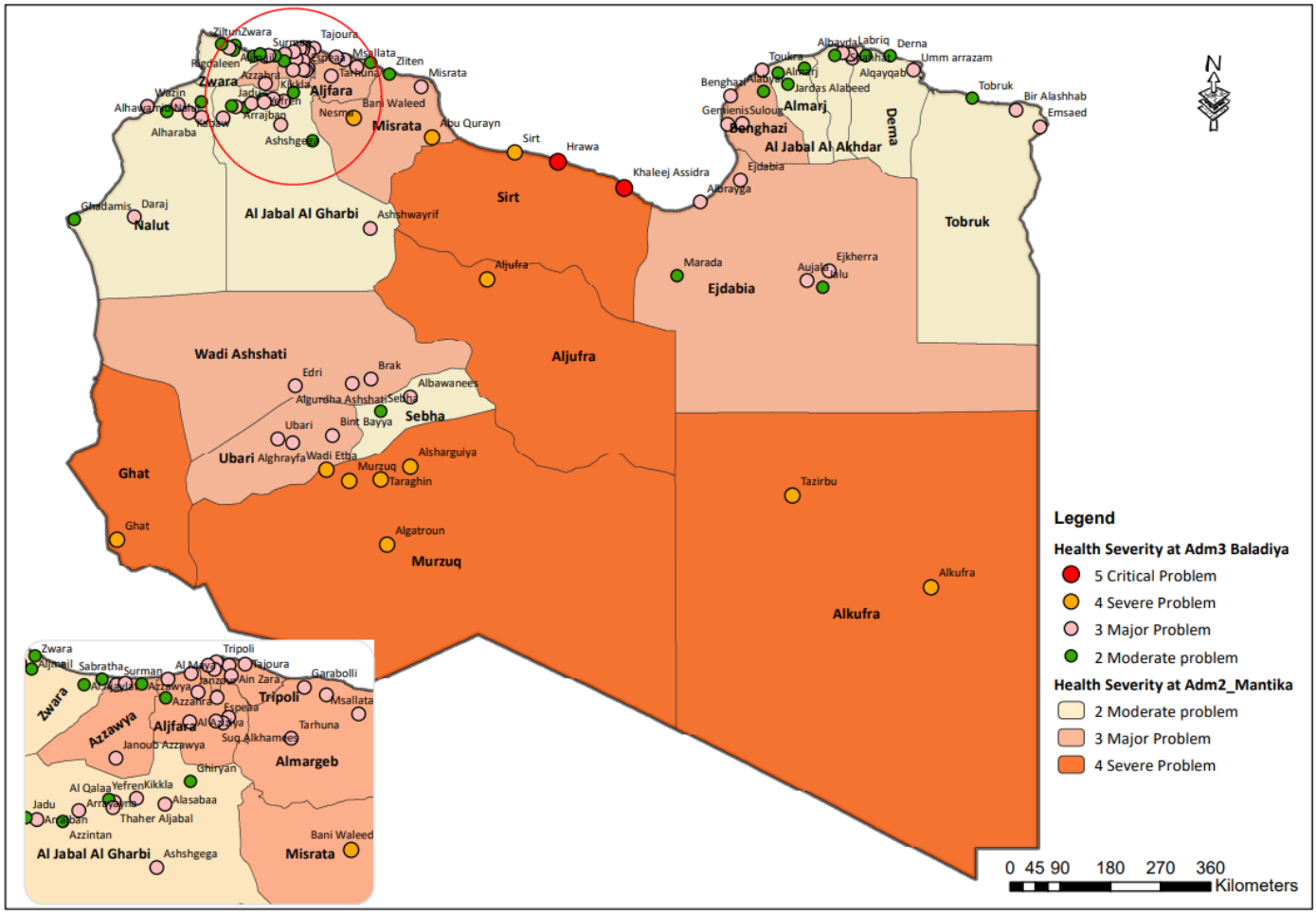
Libya is at a critical juncture. Since the de facto truce was established in June 2020, the UNSMIL-facilitated peace process has achieved several key milestones (ceasefire agreement signed in October 2020; an interim Government of National Unity (GNU) selected by the Libyan Political Dialogue Forum (LPDF) in February 2021; national presidential and parliamentary elections scheduled for 24 December 2021).

The unification of the Ministry of Health (MoH) has gone smoothly: The Minister of Health of the interim government in the east has handed over responsibilities to the Minister of Health of the GNU. However, the political and peace-building landscape remains fragile. The marked divide between the east and west will take time to resolve. The Libyan authorities define the top challenges as follows: fragmentation of health sector institutions, weak governance, lack of accountability, extreme shortages of medical supplies and health staff; a badly disrupted PHC network, and severe funding shortages.

Libya remains classified as an L2 emergency country. Approximately 1.3 people were in need in 2021 (a 40% increase compared with 2020). Regular, prolonged power and water cuts and fuel shortages kept disrupting critical social services and affecting people's health and livelihoods. The uncertainty of national as well as international investment for humanitarian and developmental health care programs hinders short- and longer-term reforms.

Libya remains one of the most vulnerable countries in the region due to the presence of foreign armed groups, trafficking of drugs and migrants, uncontrolled borders, organized crime and corruption. The crisis has a strong protection dimension, with violations of international human rights and humanitarian law against civilians, including conflict-related sexual violence and grave violations against children and attacks on civilian infrastructure. Moreover, hundreds of thousands of migrants and refugees in Libya have limited access to health care services.

Libya Health Sector: Health Severity Score 2021



Key Health Risks over coming month

Public health risk	Level of risk***	Rationale
COVID-19	High	Although, after a decreasing trend since mid-August 2021, case and death incidence rates in the country have begun to plateau. Still, Libya remains classified under the high incidence of community transmission (CT3) with Alpha, Beta and Delta Variants of Concern (VOC) circulation and an adequate level of lab testing capacity at national level. At the brink of the 'fourth wave' from Europe, with 8% fully vaccinated population and despite efforts by donors and health sector the inequities become grave at sub national level. Testing capacities remained limited in East (90/100000 pop) and in the South (47/100000 pop) and positivity rates high in East (24%) and South (41%). Risk remains high in West while extremely high in East and South regions.
Violent Trauma and mass casualty	Moderate	Libya continues to be one of the most vulnerable countries in the region due to the present threat of large-scale hostilities, the presence of foreign armed groups, the trafficking of drugs and migrants, uncontrolled borders, organized crime and corruption. The situation will be exacerbated by the continuing spread of COVID-19 in Libya. Violent injury contributed a substantial disease burden in the country. Only 40% of communities have emergency services. The signed ceasefire at the end of 2021 decreased the number of

		earlier reported clashes of 2020 which led to increased needs for trauma and post-trauma disability care. Reliance on life-saving and life-sustaining health care services is increasing across the country in 2021 as the availability of essential medicines is a major challenge (70% of functioning PHC facilities do not have any of the top 20 essential medicines).
Malaria	Low	Libya is malaria free country. Most detected malaria cases were imported cases mainly between migrants coming from epidemic area, also some Libyan nationality cases who visited epidemic countries were detected. Few Libyan cases infected without travel history but no confirmation on local transmission or about presence of Anopheles mosquitoes specially in southern area. NCDC' experts sent to area where cases detected without travel history or other transmission methods as blood transfusion or surgical operation to study presence of malaria vectors. There are few indicators of vector presence in south which consider as concerns of roll back of malaria local transmission after 50 years absence. At the same time there is no malaria guidelines or suitable surveillance program specially in last ten years. There is no national lab protocol for malaria. Country faced interruption in malaria drugs and prophylaxis supplies.
Attacks on healthcare	Moderate	In 2019 – 62 reported attacks, 76 deaths and 52 injuries. In 2020 – 36 reported attacks, 9 deaths and 23 injuries. In 2021 – 2 reported attacks, 0 deaths and 0 injuries. Since signing the ceasefire, the frequency of attacks on health has largely reduced while the risk remains high in post-election period of early 2022.
Measles	High	Libya is in the measles elimination phase. Last big measles outbreak reported in Libya on 2017-2018 with more 1,000 cases reported. National vaccination campaign was conducted in 2018. Measles virus still circulated in Libya. Measles surveillance system is affected by COVID-19 pandemic. Measles program suffers from HR turnover and no action plan developed for last 2 years. No specimen transportation mechanism in place. Routine vaccination coverage for measles in last two years didn't clear specially with COVID-19 situation. Measles surveillance network need urgently support with refresher training and motivation. Train vaccine supervisor on coverage rate calculation is urgently needed. Country didn't have plan for supplementary immunization activities or national immunization days regarding measles. Also, there is no program for rubella congenital syndrome surveillance and no awareness campaigns conducted after 2018, measles ep situation picture not clear in last two years, program faced a lot of challenges specially without allocated fund for activities and for program operation cost.
Influenza	High	No stand influenza surveillance program in place, national influenza center in Libya does not function. 2 sentinel sites selected for ILI and SARI. Influenza Lab has full capacity for detection and confirmation with shortage of trained human resources. Regular influenza vaccination campaigns conducted every year with moderate acceptance between target groups due to lack of awareness campaigns on important of vaccine to protect risk groups from influenza complications.
Leishmaniasis	High	In the last two decades, CL has become a major public health problem in the country. The COVID-19 pandemic compounded by the political conflict interrupted EWARN and fragmented data about CL cannot reflect the real situation during 2020 and 2021.

Water-borne diseases	High	Water-borne diseases in Libya are one of the main causes of morbidity in Libya. Most cases are acute diarrehea, bloody diarehea and acute jaundice syndrome specially among children. There are hot areas for mentioned diseases with poor sanitation and pure water supply infrastructure. No cases of cholera reported in Libya but cholera outbreaks reported in neighboring countries, treat of cholera still serious problem specially with weak border health management and high migrant flow. In last October there are 2724 acute and bloody diarrehea reported cases from EWARN sentinel sites.
Tuberculosis	High	The National Tuberculosis Control Program notified 1744 TB cases out of 4000 estimated cases is 2020 which is less than 45% (Global average - 59%). The treatment success rate for the TB patients registered in 2019 is only 70% which is also less than global average of 86%. MDR TB treatment services are not fully operational in all the regions of the country and TB HIV coordination is yet to be operationalized. There is no National Strategic Plan to prioritize the high impact interventions to achieve TB elimination in the country. Infection and prevention activities are yet to be prioritized in the country.
HIV	High	Although ART is free for all Libyan citizens, shortages have recently led to treatment interruptions and increasing numbers of PLHIV admitted in very advanced stages of the disease with high mortality. Among those who are not able to buy drugs from neighboring countries, sharing of ARVs and relying on partial treatment with one- or two-drug regimens are reportedly common. In this scenario, the development of resistance to first-line ARV drugs is a serious concern, which is further complicated by the lack of capability for resistance monitoring in Libya. Instability within the MoH causes problems with procurement, contracts and financial matters. Libya's pharmaceutical management and supply chain is a complex, multi-tiered, bureaucratic system with multiple and highly compartmentalized distribution channels. As currently structured, the system cannot meet the needs of two important stakeholders: PLHIV and the ART center healthcare providers who serve them. Prolonged, recurrent stock-outs for critical ART medications [particularly pediatric formulations, lopinavir/ritonavir, (LPV/r), Raltegravir (RAL)], for testing reagents and supplies, and for medications used to treat common opportunistic infections, have become more acute in the last year at virtually all ART centers. This situation is problematic as physicians are not able to prescribe the optimal ART drug combination according to Libyan guidelines. PLHIV may be switched to formulations that are not guideline complaints, or worse, they may skip their medications entirely because they are not available. The net result is likely to be greater drug resistance, increased morbidity, and earlier death among PLHIV.
Plague	High	Last outbreak of plaque was in June 2009 in Tobruk. 6 cases reported with one death, the possibility of reoccurrence of plague in the same area still high specially with presence of reservoirs and agent cause. Lack of detection capacity in lab and delay of diagnosis may cause a big disaster particularly with absence of treatment protocol and trained HR.
Brucelosis	High	Libya considered as endemic country for brucellosis. No accurate date on human cases in last ten years but outbreaks in animal side reported by Animal Health Control Centre.

IDPs, migrants and refugees	High	199,949 are IDPs, 648,317 are returnees, 610,128 are migrants, 41,404 are registered refugees and asylum- seekers. Despite that the fact of the present cessation of hostilities and improvements in the general security situation with possible references that "Libya remains in the post-crisis stage of transition and recovery", the living conditions of migrants have further deteriorated in the already overpopulated detention centres and heightened the risk of possible outbreak of communicable diseases including COVID-19. Health sector coverage of detention centers remained non-comprehensive. Of concern was a rapid security deterioration across the detention centers and temporary suspension of work by humanitarian health partners (e.g., negative ramifications of law enforcement structures in detaining almost 5,000 migrants over the period of two days in Tripoli in October 2021).
Hepatitis C	Low	Hepatitis C cases reported with low incidence rate. There are good procedures in blood banks to test all blood bags by viral screening, the same procedures with all patients admitted to hospitals for surgery operations or delivery. Prevalence rate as general low compared with neighboring countries.
Rift Valley fever	Moderate	There are no human cases reported in Libya but some research studies results confirm exposure to RVFV in life period (presence IgG antibodies). There are cases among animals reported in last years detected in animal survey conducted by Animal health control center in Alkofra, Alshati, Ubari and also in south area.
Flood and heat wave	Moderate	As a result of flash floods, certain parts of the country get negatively impacted with a moderate-severe disruption of social services, including health. In addition, Libya is characterized by rising temperatures and extreme heat in Libya when it becomes essential to protect health service providers and patients. During summer 2021 and the latest heat wave a large number of functioning health facilities remained closed; shortages of electricity were of common nature; in those facilities where generators were available, fuel supplies were not sufficient; key medical staff could not report to work.

3. Health Status and Threats

Population mortality:

There is no updated information available for the last years (see reasons below). Earlier, the draft of the Libya national health policy set up four goals:

Indicator	Baseline	Year and source	Target value (2030)
Life expectancy at birth	71.9 years (both sexes)	2016	74.9 years (both sexes)
Maternal mortality ratio	9 per 100,000 live births$	2015	6 per 100,000 live births
Neonatal mortality ratio	7.1 per 1,000 live births	2016	7.1 per 1,000 live births
Under 5 mortality rate	12.9 per 1,000 live births#	2016	12.9 per 1,000 live births

Table 6. Trends in key indicators, 1990-2007

Indicator	1990	1995	2000	2007
Infant mortality rate (per 1000 live births)	27.0	24.4	21.0	16.7
Under-5 mortality rate (per 1000 live births)	43.0	30.1	27.0	20.1
Maternal mortality ratio (per 100 000 live births)	77	77	40	27

Vaccination coverage:

National Immunization Program (NIP)

The NIP is led by the NCDC through the National Immunization Administration (NIA) with support from a national immunization technical advisory group (NITAG) and partners including the pharmaceutical sector, medical suppliers, UNICEF and WHO. Vaccination in Libya has been mandatory since 1972. The national immunization schedule includes more than 10 vaccines to vaccinate the targeted children annually. Immunization activities are implemented in cities, towns, and villages under the supervision of local National Immunization Program (NIP) supervisors. The NIA relies mainly on 649 fixed immunization sites to deliver routine immunization services, complemented by outreach/mobile teams that support vaccination activities in schools. Vaccines are supplied by the national cold store and distributed to four regional cold stores in Fazzan, Misrata, Benghazi and Tripoli. The NIP's key challenges include 1) the late procurement of vaccines due to lengthy administrative processes, 2) lack of monitoring and supervision, 3) poor vaccine stocks management to facilitate the timely and efficient implementation of the programme and track vaccines, and 4) high numbers of migrants and internally displaced people (IDPs) who are not covered by outreach programmes and who require special focus and support.

Despite these challenges, Immunization coverage rates remained high during the last decade until 2018, ranging between 95-97%.

Since 2019, routine immunization coverage began to decrease to 75% at national level due to continued conflict, prevailing insecurity, COVID -19 pandemic, and frequent nationwide stockouts of some vaccines which will greatly increase the risk of the resurgence of vaccine-preventable diseases such as measles and polio.
In 2021, the situation worsened as a result of the delay in the arrival of the required amount vaccines to vaccinate the annual target for reasons related to pre-purchase procedures, as all used vaccines were fully provided as of September 2021, which contributed significantly to the decrease in the immunization coverage and the accumulation of large numbers of Children eligible for vaccination since the beginning of this year.

COVID-19 vaccination coverage

COVID-19 vaccines are being delivered by National Immunization Program since the begging of the vaccination campaign in April 2021, NIP providers who working at Fixed immunization posts are carrying out the vaccination process including effective vaccine management. NIP supervisors at all level are supervising vaccination campaign activities.

As of 25th November 2021, 1612033 (22%) of the target population received the 1st dose (partially vaccinated), while 552117 (7%) received the 2nd dose (fully vaccinated).
According to IOM Libya weekly Migrant COVID-19 vaccination update ended 13th November 2021, a total of 4,918 migrants (496 females and 4,422 males) have received the 1st dose (partially vaccinated), out of which, 612 migrants (12%) have received the 2nd doses (fully vaccinated).

The average monthly coverage since the beginning of campaign ranged between 20 thousand (lowest coverage) in May to 50 thousand (highest coverage) in August, then it began to gradually decrease in September and October 2021. The required vaccination coverage to interrupt virus transmition cannot be reached if the monthly coverage continues at this low rate. Reasons behind accessibility and utilization must be addressed and the corrective actions should be undertaken to increase vaccination coverage.

Internally displaced people, Refugees and Migrants:

July -September 2021 IDP and returnee data of IOM Displacement Tracking Matrix's (DTM) Mobility Tracking in Libya illustrates that a year since the ceasefire agreement signed on 23 October 2021, the general security situation in Libya has remained stable, with no new mass displacements reported during 2021 while the trend of previously displaced families returning to their places of origin continued. However, by the end of September 2021, 199,949 individuals were still displaced in Libya despite the cessation of hostilities and improvements in the general security

situation. This indicates that while the overall humanitarian situation has improved, Libya remains in the post-crisis stage of transition and recovery.

The number of returnees identified increased to 648,317 individuals. Return of displaced families to their places of origin has continued, albeit at a slower rate, indicating that the most vulnerable families affected by the armed conflict, and those who cannot recover the pre-crises levels of household wellbeing and socio-economic capacities remain displaced.

DTM Libya identified a total of 610,128 migrants from over 44 nationalities in the 100 Libyan municipalities during data collection (July – September 2021). The number of migrants has continued to increase during the reporting period, continuing a trend which started in January 2021. However, the number of migrants in Libya continues to remain slightly lower than pre-pandemic levels and significantly below that of 2019 for the corresponding period of time (655,144 migrants present during June - July 2019; Round 26). Before the beginning of 2021, the migrant population in Libya had decreased consistently following the onset of the COVID-19 pandemic and the subsequent economic downturn which resulted in increased unemployment, a reduction in available labour opportunities, tightened security controls and mobility restrictions.

UNHCR reports 212,593 Libyans as currently internally displaced (IDPs), 643,123 as IDP returnees, 41,404 registered refugees and asylum- seekers. 362 refugees and asylum-seekers released from detention in 2021. 6,738 vulnerable refugees and asylum- seekers departed since 2017 (539 so far in 2021). So far in 2021, a total of 27,551 asylum-seekers, refugees and migrants have been reported as rescued/intercepted by the Libyan Coast Guard (LCG).

Population group	PiN 2020	PiN 2021	% of Reduction
IDPs	172,871	131,832	24%
Migrants	303,740	232,000	24%
Non-displaced	501,939	281,303	44%
Refugees	46,245	43,000	7%
Returnees	228,084	115,439	49%
Total	1,252,879	803,574	36%

Violent trauma and Mass casualty:

Libya continues to be one of the most vulnerable countries in the region due to the ever-present threat of large-scale hostilities, the presence of foreign armed groups, the trafficking of drugs and migrants, uncontrolled borders, organized crime and corruption. The situation will be exacerbated by the continuing spread of COVID-19 in Libya. Violent injury contributed a substantial disease burden in the country. Only 40% of communities have emergency services. The signed ceasefire at the end of 2021 decreased the number of earlier reported clashes of 2020 which led to increased needs for trauma and post-trauma disability care. Reliance on life-saving and life-sustaining health care services is increasing across the country in 2021 as the availability of essential medicines is a major challenge (70% of functioning PHC facilities do not have any of the top 20 essential medicines). Emergency health care, as well as treatment services for patients requiring specialized care, must be continued to be maintained. As per practice, 80% of the humanitarian need (present and potential) is driven by violent conflict. Migrant and refugee populations further increase the demands on emergency and trauma systems, while the political context and bureaucratic constraints applied by local authorities constrain the current strategic and system planning. Sophisticated and well-resourced response mechanisms are not in place to tackle high incidence of violent injury. Only a very small number of international organizations have developed capacities for providing trauma care in Libya. Most humanitarian health agencies have not prioritized injury care because of mandate issues, security concerns and capacity and resource gaps.

Attacks on health care:

2019 – 62 reported attacks, 76 deaths and 52 injuries. 2020 – 36 reported attacks, 9 deaths and 23 injuries. 2021 – 2 reported attacks, 0 deaths and 0 injuries.

Since signing the ceasefire, the frequency of attacks on health has largely reduced while the risk remains the same. Health sector is not active in reporting. Mainly WHO updates and reports based on social media or its network of 25 field coordinators, sub-offices. Protocols of information sharing was not done for Libya as not operationally

necessary. Basically, there is no framework due to complexity and sensitivity of the issue and stakeholders involved. Verification process (minimum two sources) is not in place with the required triangulation of data. Not capturing all the incidents – only media picked up. Politically driven conflict – a biased reporting and a one-side approach. Protection of medical facilities and notification mechanism is highly sensitive and disputable. De-confliction, sharing of coordinates is a challenge. There was a need to separate WHO roles and responsibilities to report on "wounded/casualties" during the conflict as directly politized issue and enormous pressure. Another point addressed was expectation from WHO to name the perpetrators while focus should be on impact. Another aspect – increased incidents in 2019/2020 with medical personnel associated with the Ministry of Defense and reporting issues.

Gender-based violence (GBV):

In 2021 an estimated 153,000 people are most at risk of GBV, requiring sustained prevention and response services including 30,000 displaced, 16,000 returnees, 26,000 non-displaced Libyans, 63,000 migrants and 16,000 refugees. Of the total, 90,000 are women (59%) and 41,000 are girls (26%). Movement restrictions, curfews, closures of services and limitation in social contacts has led to stark increases in GBV risks, which has been compounded by acute shortages of GBV services reducing entry points for survivors to receive timely and quality care. Migrant and refugee women, many of whom have no recognized status have an increased risk of sexual exploitation and abuse. Migrants and refugees in detention centres are most at risk given reporting of widespread abuses that are documented. Along with the discrimination in accessing to specialized services experienced by migrants and refugees further limits their access to support.

The significant gaps in GBV services across Libya means that health consequences, including serious mental health consequences, sexually transmitted infections, unplanned pregnancies, and other possibly life-threatening health complications remain unaddressed. Scaling up and establishing comprehensive GBV prevention and response services are urgently required, especially in geographic locations that lack any specialized GBV services and are affected by increased conflict and displacement. Advocacy on establishing protective legal mechanisms for women and girls, to end impunity for perpetrators due to the legal loopholes and unlimited humanitarian access to detention facilities needs to be strengthened.

Communicable diseases:

COVID-19

After a decreasing trend since mid-August 2021, case and death incidence rates in the country have begun to plateau. At the national level, Libya reported a minimal change but a declining trend in cases, deaths and COVID-19, with a high incidence of community transmission and adequate lab testing capacity Libya remains classified under the high incidence of community transmission (CT3) with Alpha, Beta and Delta Variants of Concern (VOC) circulation and an adequate level of lab testing capacity as national level. Libya has been presented with a hiatus to prepare and respond to the next coming 'fourth wave' of Europe. With COVID vaccination rates for fully vaccinated still remain 8% for the Libyan population, the previous peak of cases and death is likely to repeat itself. As we drill down from national to subnational levels, the inequities become glaring in terms of preparedness and response. Positivity rates remain very high in the East (23.8%) and South (41%), CFR remained high in the East (11) and South (4.8) and in the South, testing is only being done in only two districts out of six namely Sabha and Aljufra which is attributable to low reporting of cases by RRTs and constraints in lab supplies in all districts in the South and the pattern is repeated is repeated in Eastern districts too. Eleven districts across the country have no to limited testing capacity and remains limited in East and South as a whole. Vaccine administration in Libya is not keeping up with supplies. Doses administered are much less than doses received with only 46% vaccine utilization and attributed to vaccination hesitancy and low uptake factors although the vaccine supply remains adequate. Within migrants , only 4918 migrants have been vaccinated with only 12% of these numbers fully vaccinated. There are security-related (fear of persecution/arrest) issues by the non-Libyan population to come out for vaccination due to recent crackdowns. Oxygen stock outs are frequent at major isolation centers in East there is no official government-based data available on oxygen needs and consumption. Similarly, official MOH data on case management capacities is not available and life saving medicines for COVID like low molecular weight heparin and tocilizumab not available. PPE stocks are also frequent.

Influenza

Influenza surveillance program in establishment phase, national influenza center not function yet, only one lab has the capacity of influenza lab detection, most of clinicians don't use influenza case definition for diagnosis. There are frequently delay on vaccine supply due to administration arrangements. No data available on genotypes circulated in Libya but there are no human avian influenza cases reported, only between birds reported on 2013.

Leishmaniasis

In the last two decades, CL has become a major public health problem in the country. Almost all cases have occurred in the northwest (e.g., Tripoli, Al Jabal Al Gharbi) and the south (mainly Wadi Al Hayaa) as shown in the map. In Libya, the sandfly season lasts from May to October. Most cases (60%) are recorded between November and February each year, peaking in January. Since 2017, surveillance of cutaneous lieshmaniasis (CL) has been integrated into the disease Early Warning Alert and Response Network (EWARN). Between epidemiological week 2 in 2018 and epidemiological week 2 in 2019, a total of 2977 patients with CL were reported through EWARN. As of epidemiological week 44, in 2019, before the COVID-19 pandemic, a total of 4185 cases had been reported. This number represents a significant increase compared with the same period in 2018, indicating an outbreak as defined by the EWARN standard operating procedures which might be explained by improving surveillance and people displacement. The COVID-19 pandemic compounded by the political conflict interrupted EWARN and fragmented data about CL cannot reflect the real situation during 2020 and 2021.

Measles

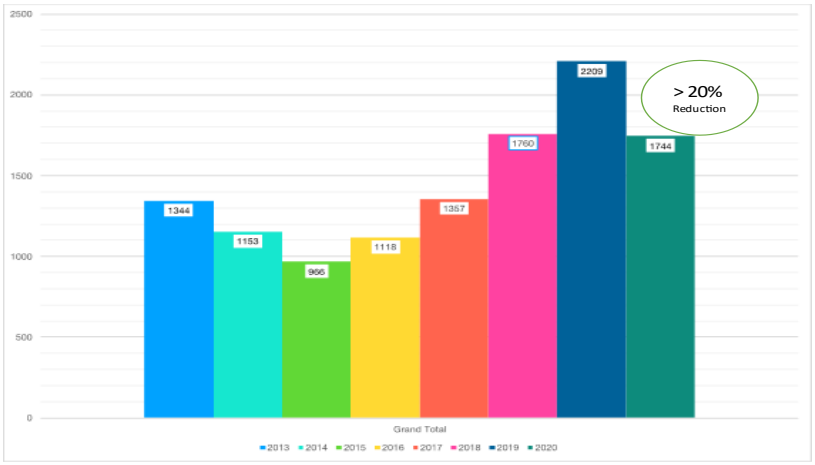
Libya after 2018 measles outbreak and vaccination campain which conducted on Dec 2018 as respond to this outbreak must have good surveillance program to monitor disease progress and suplementry vaccination activities to prevent outbreaks, routine vaccination coverage rate affected by COVID-19 and no accurate data on it.

Malaria:

Libya free country of malaria but there are high risk of roll back after 50 years absence, if NCDC reports confirm presence of vector in Libya the infection cycle will be completed and local transmission will start. Shortage of chemoprophylasis in public sector and travel medicine not introduced in the contry make travel to epidemic countries high risk. Recently, the surveillance and Rapid response team administration at NCDC announced the record of 19 cases of Malaria in Libya since January 2021, with some cases with unclear history of travel which increase the possibility of local transmission and mandate to intensify the investigation to detect the vector in the area where the cases recorded, to strengthen the surveillance network and to build up the capacity of the medical doctors on the management of Malaria cases.

TB:

Libya adopted WHO endorsed directly observed treatment -short course (DOTS) TB treatment from over last 2 decades. The National TB Program under the aegis of National Center for Disease Control (NCDC) in Ministry of Health (MOH) is responsible for implementation of TB control activities across Libya. The NTP is delivering the TB services through 27 designated TB units (11 in Western Region, 4 in Central Region, 1 in Southern Region, and 11 in Eastern Region) and 5 TB & chest hospitals (Abusitta-Tripoli, Zraiq-Misrata, Shahat, Sabha and Kuwaifiya-Benghazi hospitals). The TB diagnostic and treatment services are available in all these centers free of cost. Most of TB resources are repurposed for COVID 19 Management led to disruption of TB services (over 20% reduction of TB cases) in 2020 (see Figure). The country recorded less than 70% treatment success rate for the patients registered for treatment in 2019. The inpatient services are available only in 2 hospitals in the country and 15 MDR TB patients are registered for treatment in 2020. The domestic funding is covering only human resource component of NTP and all the other activities including drug procurement are from donor driven projects. Figure: Trend in TB Notification: 2013-2020 (Source – WHO Global TB Report 2021)



The high priority issues in TB control program include development of National Strategic Plan, Advocacy for sustained domestic investment to implement all the components of TB control, expansion of TB diagnostic services in difficult to reach areas, systematic screening of migrants, refugees and other vulnerable population, decentralized MDR TB treatment services, bi-directional screening of TB HIV patients, robust recording & reporting, supervision, monitoring & evaluation, drug logistics management, building partnerships and TB preventive treatment to high risk individuals.

HIIV:

The estimated HIV prevalence in the MENA region where Libya is located is quite low, amounting to less than 0.1 percent. In the year 2018, the number of PLHIV in MENA was estimated to be around 240 000 [160 000 – 390 000] (UNAIDS/WHO 2018).

2004-2005: Seroprevalence Studies, Libya	Number	Prevalence		
		HBV	HCV	HIV
(2004-5) Libyan Nat'l Sero-prevalence Study (NCIDPC)	65,711	2.2	1.2	0.13
(2008) Health Certificate Applicants, Medical Reference Lab-TMC (Gammo et al.)	3,314	2.1	2.5	1.1

Libya HIV data 2019 - 2020		
HIV/AIDS	2019	2020
PLHIV (all registered) 66%	6419	6789
PLHIV on regular follow up	3388	3279
PLHIV receiving treatment	3292	3186
% of PLHIV receiving treatment (Estimated by spectrum)	%54	%49
HIV deaths	332	378
HIV incidence		0.05 [0.04 - 0.07]
HIV prevalence		0.1

Current challenges:

- Lack of a pre-defined budget for the purchase of pharmaceuticals and other medical commodities.
- Disconnections between various levels in the system, namely hospitals, NCDC, and MOH.
- Absence of Health Information Systems to HIV facilities and no data record.
- Absence of national unified procurement procedures resultant in acquiring expensive pharmaceutical brand names over genetics.

- There is almost no civil society engagement in the areas of HIV prevention, treatment, and support. Libya's most vulnerable groups and those with the highest HIV prevalence rates namely, migrants, and prisoners, sex workers, and drug users - are not a key focus for any civil society group's efforts.
- Prevention of mother-to-child transmission (PMTCT) services is not optimal although the country has taken steps in recent years to improve them and National guidelines for PMTCT need to be updated.
- National guidelines for the treatment of HIV were created in 2010 and developed in November 2016, but it needs to be updated.
- Libya has three Anti-Retroviral Treatment (ART) centers: Tripoli Central Hospital ID-TCH, Tripoli University Hospital ID-TUH, and the Jomhuriya Hospital (Benghazi), and the most comprehensive and advanced ART site is the Benghazi Centre For Infectious Diseases and Immunology (BCIDI); but generally, there are no medications among all the above-mentioned HIV centers. The lack of diagnostic tools and medications is negatively impacting the PMTCT program.

Malnutrition and child health:

The current under 5 year mortality rate in Libya is estimated to be 13 deaths per 1000 live births, with over half of these deaths occurring during the neonatal period (the first 28 days of life). Malnutrition, diarrhea, and pneumonia generally contribute to a major proportion of deaths in children under 5. The most recent formally accepted figures on the prevalence of these health conditions dates from 2007. A more recent report on a household survey done in 2014 has not received universal endorsement given that the summary of results is at times inconsistent with the results presented. Survey results indicate that levels of malnutrition measured were a 30% prevalence for stunting, 9% wasting, and approximately 25% of children under 5 were reportedly overweight. These figures are not dramatically different from UN estimates made for 2013, where prevalence of various forms of malnutrition in children under 5 years were reported as 21% stunting, 6.5% wasting, 3% severe wasting, and 22.4% overweight. The MoH reported a prevalence for low birth weight of 4% for 2013. Prevalence of diarrhea in children under 5 during the preceding 2 weeks was 14%, with similarly reported prevalence of 28% for cough, and 25% for fever. Of the 8% of children with suspected pneumonia (based on analysis of observed symptoms), 83% saw a doctor either in a public or a private health facility.

Noncommunicable diseases and injuries:

In Libya, 78% of the overall burden of disease is attributable to non-communicable diseases. Cardiovascular diseases account for 43%, cancers 14%, respiratory diseases 4% and diabetes mellitus 5% of all deaths, and 18% of adults between the ages of 30 and 70 years are expected to die from one of the four main non-communicable diseases. Risk behaviour is common in Libya. A 2010 survey amongst youth (13–15 years of age) found that more than 13% have ever smoked cigarettes (20% boys, 7% girls), while 36% of youth have been affected by passive smoking. A survey in 2014 found that 13% of those aged over 15 regularly smoked cigarettes (24% male, 2% female). Per capita consumption of alcohol is 0.1 liters of pure alcohol per capita per year, which is amongst the lowest national rates recorded worldwide. The prevalence of other risk behaviours is high, however, with the rate of insufficient physical activity among adolescents at 77% (11–17 years of age, 78% boys, 88% girls). The overall age-standardized rate for insufficient physical activity is 38% (33% males and 43% females). Raised blood pressure affects 36% of adults over 18 years, (40% males and 31% females), while obesity affects 28% of the population (20% males and 36% females).

The incidence and prevalence of NCDs in Libya continues to increase as a consequence of changing lifestyles and the increasing prevalence of risk factors, particularly obesity. Steps are being taken to tackle the burden of non-communicable diseases (NCDs). The WHO Framework Convention on Tobacco Control was signed by the Libyan government in 2004, and the protocol on illicit tobacco trade was signed in 2012. The non-communicable disease program was established at the end of 2010, with components for surveillance, nutrition, violence and injury, disabilities and rehabilitation, and mental health and substance abuse. Although availability rates for NCD services are high, overall readiness scores - which reflect the actual ability to deliver services - are low for both hospital and PHC level services.

The Ministry of Health and the health sector partners in Libya prioritized four important areas for improving the access and quality of health care services, one of which is NCD prevention and management. This is timely since a 2017 Service Availability and Readiness Assessment (SARA) indicated a low level of preparedness for NCDs, despite the fact that 78% of all of the total burden of disease in Libya is due to chronic diseases (SARA, 2017).

Mental Health:

There are no published data on the prevalence of mental health disorders in Libya before 2011, when the conflict began. WHO estimates that mental health conditions more than double when populations are affected by conflict. It is likely that one in seven Libyans - over one million[1] people - need mental health care for conditions such as depression, bipolar disorder, post-traumatic stress disorder, anxiety and schizophrenia.
In 2017, a service availability and readiness assessment (SARA) conducted by WHO showed that mental health care was grossly inadequate: only six hospitals, one clinic and four primary health care (PHC) facilities were providing mental health services. A complementary mapping of private health care facilities conducted by WHO in 2019 showed that mental health services, especially for patients with severe conditions, were very limited.
An assessment of mental health and psychosocial support (MHPSS) conducted in Libya in 2017 states that "m*ental health is a chronically neglected field in the country with many longstanding problems that predate the conflict that started in 2011, including underdeveloped community and specialized services, shortage of qualified workforce, lack of facilities, social stigma towards people with mental illness and funding marginalization".* Around three decades ago, psychiatric hospitals in Benghazi and Tripoli, each with approximately 200 beds, were established to treat people with mental health conditions across the country. However, shortages of mental health professionals and psychotropic medications have drastically affected the accessibility and functionality of both hospitals. The situation is compounded by the rampant stigma of mental health illness and the overall shortages of psychiatrists, psychologists and nurses.

Data on drug use in Libya are limited. However, anecdotal data indicate the problem has been growing since 2011. Although Libya has never been a hub for the cultivation and production of drugs, instabilities in the region and changes in drug trafficking routes (with some now transiting through the country) have led to the greater availability of illicit drugs. The real number of drug users in unknown because many users do not come to the attention of the authorities due to stigma and fear of legal consequences. Heroin users, most of whom are injecting drug users, account for 97% of treatment-seeking patients. Most drug users live in urban areas and begin using drugs around the age of 14.

A mental health situation analysis conducted in the first half of 2021 in 16 municipalities from all regions including 165 primary health care centers using mhGAP situation analysis tool. It was found that there is no system in place to gather information, to monitor and to assess the needs related to mental health of public health facilities. Additionally, the results showed that mental health and psychosocial support services are not available at PHC level. Only few centers in three municipalities provide basic psychosocial support services and only one municipality (Sebha) provides psychotropic medicines for patients without continuity.

Currently with the support of WHO, 30 PHC health centers in 18 municipalities across the country (Hai Al Andalus, Ain Zarah, Al Sawani, Sidi Saeh, Tarhonah, Zwara, Azzawia , Zletin , Ghiryan, Nalut, Misrata, Sirt , Benghazi, Al Bayda, Ejdabia, Al Kufra, Sebha and Murzuk) provide integrated mental health services through more than 100 trained health professionals. The doctors received training on mhGAP-Intervention Guide version 2.0 which has been endorsed by MOH as reference/protocol to manage mental health conditions at PHC centers. Specialized trained mental health professionals provide clinical supervision for PHC trained doctors while they provide mental health services, and the essential psychotropic medicines will be available in these canters before the end of 2021. In addition, 30 schools were selected in the above-mentioned municipalities to provide mental health services based on WHO School Mental Health Package. Moreover, the process of developing the National Mental Health Strategy has been initiated.

The long-lasting violence in the country is believed to further increase the proportion of the population in need of mental health and psychosocial support, requiring a combination of immediate and longer-term interventions. Following decades of neglect, it will take years to build services that can cope with the emerging needs.

[1] Numerator of population affected by conflict is 22% of PIN based on WHO projected estimates published 2019/ denominator PIN added to numerator 14 % of total population in Libya minus PIN/denominator total population minus PIN. Percentages are calculated from WHO's new estimates for mental health needs in conflict settings published here https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30934-1/fulltext. By adding the total number of Libyans with mental health conditions in areas without PIN, based on global burden of disease, at least 1 003 840 Libyans (1 in 7) would need mental health support.

Determinants of Health:

Water and Sanitation Hygiene

A lack of repair and maintenance, as well as attacks and force shutdowns, on water infrastructure has put extra strain on the already aged water networks. This has led to a further deterioration of water infrastructure and availability of services. In 2021, this has been compounded by frequent electricity cuts, causing further disruptions to water supplies in some of the most highly populated areas. Equally, sanitation and wastewater management systems do not function adequately and only 10 of 24 wastewater treatment plants are functioning. Garbage and solid waste are mostly left on the street or buried, increasing the risk of disease. The deteriorating economic situation in the country, and the increase in the prices of essential hygiene items, compounded by COVID-19, means many people cannot afford to follow hygiene practices in order to safeguard their wellbeing.

While all segments of the population have been affected, displaced people, refugees and migrants, particularly those in detention centres, have some of the most severe needs considering the often-overcrowded living conditions and a lack of access to water and sanitation services. About 39 per cent of all displaced people and 12 per cent of affected returnees are in need of WASH assistance. Displaced people are more likely to be living in sub-standard accommodation where access to WASH services is less readily available. Ten per cent of affected non-displaced Libyans are estimated to be in need of WASH assistance. Urban areas have been particularly affected by disruptions to water supplies and sanitation services and have higher percentages of people that rely on bottled water as their primary means of accessing safe water.

Twenty-one per cent of all migrants and 30 per cent of all refugees are in need of WASH assistance, with the highest number of those in need in Tripoli. Migrants and refugees are particularly in need due to their normally poorer living conditions, compared to Libyans. Migrants and refugees that are in detention centres or living in sub-standard accommodation have the most acute needs given the crowded conditions and inadequate access to WASH services.

Access to water, hygiene and sanitation services, particularly in detention centres, collective shelters, schools and health facilities, as well as disinfection and cleaning are urgently needed to both reduce the risk of spreading COVID-19 and the risk of other diseases and illnesses. This should go hand-in-hand with increased awareness raising and communication of key hygiene messages to ensure safe hygiene behaviours. For refugee and migrant communities these messages need to be linguistically and culturally appropriate.

Support to WASH facilities to ensure basic functionality, particularly in those areas where water infrastructure has been particularly damaged, such as urban centres that have experienced conflict, is needed to ensure accessibility of safe water. COVID-19 response and polices also need to explicitly integrate WASH policies and principles.

Operational constraints and some key systematic obstacles in health service delivery

Devaluation of the Libyan currency in the beginning of 2021 and situation with public health funding deteriorated due to outstanding debts of hundreds of millions LYD for previously procured medicines, supplies, equipment and construction works and delays to approve the 2021 national budget by the end of 2021.

Field missions across the country detected remaining structural systematic challenges in overall health governance with recognized humanitarian needs linked to the disrupted network of public health facilities, lack of supplies (medicines, consumables and equipment), lack of specialists.

Roll out of COVID-19 vaccination was significantly delayed in the country with the first COVD-19 vaccine reaching the country on 8 April 2021 with nationwide vaccination campaign started on 10 April. The national COVID-19 preparedness and response plan has not been developed for 2021 while the plan comprised of UN and INGOs inputs was updated and disseminated (an estimated of 52 million USD).

2021 illustrated remaining needs across the country, including support to rapid response teams, procurement and distribution of PPE, procurement of lab diagnostic kits and supplies, equipment, establishment and support to the isolation sites/wards, provision of continuous capacity building support, risk communication and community engagement. Situation with funding and support to the isolation centers remained critical. The number of earlier

planned isolation centers was significantly reduced while a main number of facilities could not activate the work due to the absence of government's support, including HR support.

Health situation deteriorated largely in some parts of the country. In the south closure of health facilities, absence and decreased testing capacities, absence of a comprehensive surveillance system, social stigma, spreading COVID-19 infection among health workers.

Proliferation of various emergency committees to respond to COVID-19 response across the country required the necessity for more centralized coordination and management with significant revision of the overall process.

In this situation health sector continued its pandemic response while supporting the health authorities' efforts to respond to COVID-19 in Libya through key response pillars defined in a comprehensive UN/INGO COVID-19 preparedness and response plan, including normative technical guidance to help Libya rebuild its health system (working across the humanitarian/development divide).

Health sector continued to receive continuous requests for assistance from different health facilities and municipalities.

A remaining challenge is to activate the health information system maintaining its data collection and analysis across the country. Libya remains one of few countries not reporting on key health performance indicators despite all earlier launched initiatives

A WHO led evaluation conducted in April 2021, identified the main challenges: insufficient human and financial resources; poor supervisory, monitoring and evaluation capacity; and weak linkages to laboratory diagnostic services. The lack of regular, accurate and timely EWARN data meant that national authorities were not able to make informed decisions about the extent of outbreaks and the response required.

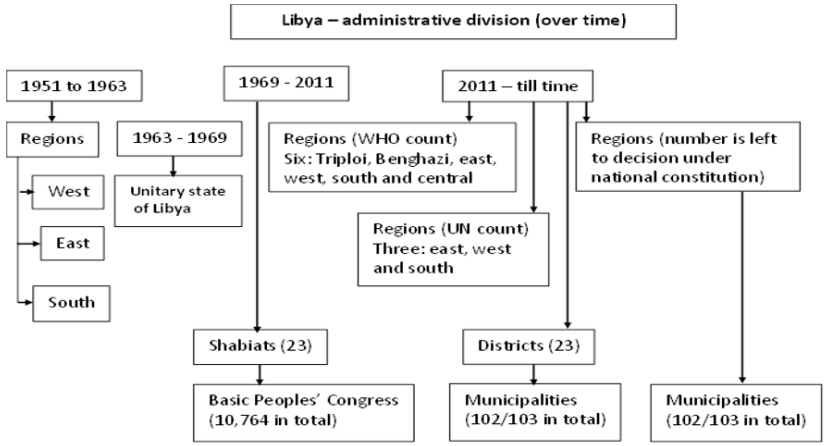
Despite sufficient financial resources and the government's frequent declarations of increased spending on health, there are acute shortages of health care facilities, staff, medicines and supplies across the country. Hence the need for external actors to continue to support the public health system in place. Systemic health sector failures and gaps should be addressed collectively and urgently, using national and international funding and drawing on the best available technical expertise.

The living conditions of migrants have further deteriorated in the already overpopulated detention centres and heightened the risk of possible outbreak of communicable diseases including COVID-19. Health sector coverage of detention centers remained non-comprehensive. Of concern was a rapid security deterioration across the detention centers and temporary suspension of work by humanitarian health partners (e.g., negative ramifications of law enforcement structures in detaining almost 5,000 migrants over the period of two days in Tripoli).

Natural hazards

The Libyan Arab Jamahiriya is one of the driest countries in the world, with only 7% of its land receiving annual rainfall of over 100 mm. About 95% of the country is desert. Nonetheless, as a result of flash floods, certain parts of the country get negatively impacted with a moderate-severe disruption of social services, including health. In addition, Libya is characterized by rising temperatures and extreme heat in Libya when it becomes essential to protect health service providers and patients. During summer 2021 and the latest heat wave a large number of functioning health facilities remained closed; shortages of electricity were of common nature; in those facilities where generators were available, fuel supplies were not sufficient; key medical staff could not report to work.

Pre-crisis health system status



Prior to 2011, Libya's health system and outcomes were improving, with notable progress being made across various health related indicators. The 2009 Millennium Development Goals Report for Libya stated that the country was on track to meet its targets by 2015. Libya was characterized as: Polio free country since 1991; Measles: Elimination Phase; Malaria Free; Limited TB MDR Cases; Best Immunization Program.

Table 2. Health status indicators, 2007–2008

Health indicator	Value	Year
Neonatal mortality rate (per 1000 live births)	10.8	2007
Infant mortality rate (per 1000 live births)	17.6	2007
Maternal mortality ratio (per 100 000 live births)	27	2007
Under five-mortality rate (per 1000 live births)	20.1	2007
Newborns with birth weight at least 2.5 kg (%)	95	2007
Children with acceptable weight for age (%)	95	2007
Number of reported new cases of:		
Malaria	7	2008
Cholera	0	2008
Poliomyelitis	0	2008
Pulmonary tuberculosis	772	2008
Measles	8	2008
Diphtheria	0	2008
Tetanus	2	2008
Neonatal tetanus	0	2008
AIDS	303	2008
Hepatitis B	2451	2008
Hepatitis C	1264	2008
Meningococcal meningitis	22	2008

Table 4. Indicators of primary health care coverage, 2008

Health indicator	Value
Population with access to local services (urban and rural) (%)	100
Infants immunized against tuberculosis (%)	100
Infants immunized with DPT (%)	98
Infants immunized against poliomyelitis (%)	98
Infants immunized against hepatitis B (%)	95
Infants immunized against measles (%)	95
Pregnant women immunized against tetanus toxoid (%)	45
Deliveries attended by trained personnel (%)	99.9
Infants attended by trained personnel (%)	100
Population with access to safe drinking water (%)	97.6
Population with adequate excreta disposal facilities (%)	99

Strategic priorities 2010-2015 included:

- Developing a long-term national vision for health development and reforming and upgrading the health system;
- Strengthening the national system for human resources development through evidence-based policy formation, better coordination and strategic partnerships;
- Upgrading the national health promotion, education, healthy lifestyle, road safety and injury prevention programmes;
- Upgrading the national programmes for mental health and prevention and control of noncommunicable diseases;
- Developing national policies, strategies and mechanisms with the aim of maximizing the contribution of programmes/ sectors that deal with environmental and social determinants of health;
- Developing policies and mechanisms to strengthen partnership and improve coordination of technical and material support by partners;
- Maintaining the good progress achieved in control of communicable disease and strengthening the surveillance system and capacity to deal with epidemic and pandemics;
- Strengthening preparedness and capacity for health provision during emergencies.

In-crisis health system status

As of today, there is no health policy in Libya. The 2009 Millennium Development Goals (MDG) Report for Libya stated that the country was on track to attain the MDGs by 2015. Reliance on lifesaving and life-sustaining health care

services supported by the humanitarian response will continue across the country amidst chronic insecurity and COVID-19 pandemic.

Recently unified the Ministry of Health (MoH) is committed to lead the process of developing a national health sector recovery strategy with support from health sector organizations while facing challenges when the provision of equitable, effective and efficient health care and public health services in Libya have continued to decline.

Governance in health system required introduction of structural reforms (decentralization), empowering the lower levels in the health system hierarchy. Earlier designed comprehensive organizational structure of the Ministry of Health at national, regional and municipal level has not yielded positive results. The current protracted crisis in Libya prevents a proper recovery of the health system and the implementation of meaningful reforms.

Health service delivery envisaged universal health access by all to the quality and safe health services without facing financial risk. It also required safe, effective, quality and affordable essential medicines and vaccines were available to all. Revision, harmonization and costing of the Libyan Essential Package of Health Services (sexual, reproductive, maternal and new-born health; child health and immunization; public nutrition; communicable and non-communicable diseases; mental health and psychosocial support mainstreaming in all health related services as well as MHPSS stand-alone services/disability; a community component; the regular supply of essential drugs and medical products and workforce training and supportive supervision) is a must, based on a data-driven approach in its governance and decision-making processes.

Reorganization of health services, establishment of regional/district health authorities and the municipal health offices is yet to be completed. The health facilities are not mapped within their geographical boundaries. Catchment area are not identified and registered. There is a need for the comprehensive plan for revamping (infrastructure and basic amenities, equipment and supplies) and revising the current number of facilities in the health care delivery network.

The situation has been exacerbated by the mismanagement of many health facilities. In 2021, reports indicated that in some areas, up to 90% (out of all existing) of primary health care (PHC) centres remained closed. One third of all health facilities in the south and east of Libya are not functional while 73% in the south and 47% in the east are partially functioning mainly due to the shortage of medical supplies and lack of human resources. Out of the total facilities assessed in 2021, 37% (80) health facilities were reported damaged (fully and partially damaged). Outsourcing services of public health facilities to private companies is of alarming concern. Only 20% of communities have child health and emergency services, 25% - general clinical services, and 15% - services for reproductive health care and noncommunicable and communicable diseases.

Health facilities across the country had to be closed due to increasing transmission of COVID-19 among health workers, lack of PPE and supplies. Of those remaining functioning, 80% of PHC centers did not have any of the essential medicines.

Treatment of non-communicable diseases become largely unavailable, including medicines for diabetes (e.g., insulin). Support for disability services for more than 100,000 people is one of the most common requests. No disability-specific surveys took place from the national level.

Libya continued to face repeated stockouts of critical routine immunization vaccines, compounded by difficulties securing funds from the Central Bank of Libya to place new procurement orders. There are acute shortages of medicines for child cancer patients and patients with life-threatening diseases such as TB and HIV/AIDS. The banking system remains dysfunctional and international organizations have only limited ability to withdraw cash in Libyan dinars to fund its humanitarian operations and COVID-19 response.

A majority of regularly assessed communities report high rate of incidence of diarrhoea, lice and scabies and influenza-like illnesses. Absence of data highlights the seriousness of the actual situation on the ground.

Levels of support for rehabilitation of health facilities in remote rural areas were not sufficient, including roll of mobile medical teams in those locations.

While *the health workforce* the overall number exceeds the WHO/SDG standards. However, inadequate skills mix, maldistribution between geographic areas and the different levels of health care, the traditional fact of over excessive HR registered for Libya are of highest concerns. Proliferation or over excessive traditional present health infrastructure should be reviewed: Tertiary Care Medical Centers (5); Secondary Care (97) (Rural Hospitals (32), General Hospitals (23), Teaching Hospitals (31), Specialized Hospitals (11); Primary Health Care (1355) (PHC Units (728), PHC Centers (571), Polyclinics (56).

The efficiency of the workforce is also impacted by irregular payment, internal displacement. Establishment of the staffing norms is necessary for different levels of care as a tool for deploying adequate numbers of health workers in health service delivery network equitably across regions. In 2021 the first steps were initiated to support enhancement of health human workforce.

Pharmaceuticals and other health technologies - There are chronic shortages of medicines, equipment and supplies, and very few public health facilities are offering a standard package of essential health care services. Medicines that are supplied through specialized centers, such as tuberculosis and HIV medicines, as well as mental illness and family planning medicines, are limited or not available in health facilities.

Health information system - Despite years of support and investment from international community, there is still no national system to gather and analyze health information and monitor and assess needs, absolute lack of population/health data and the lack of data culture. There is no data available with the health authorities on a number of functioning and non-functioning public health facilities.

Health system financing commits the government defining a formula for the equitable distribution and allocation of financial and human resources, health care network, training institutions and such entities between regions, municipalities and between facilities, including hospitals at different levels of care. Authorities have not been approving the health budget for 2021 for months.

Although health care at public sector facilities is free for all citizen, distrust and disruption of services have led to a growing private sector. It is also a challenge to distinguish between the public and private sectors because dual practice is prevalent in Libya. In the private sector, payments are out of pocket, making fee-for-service the dominant method of payment with very limited regulation. Out of pocket expenditure as a percentage of total health expenditure keep increasing. There is minimal oversight and regulation of pharmacies.

At present, the Government's financial inputs are mainly limited to the disbursement of salaries with no or very little allocation for drugs, diagnostics tests and equipment. Health sector continues to advocate for an adequate amount of Libya's GDP and part of its huge assets to be spent on health. The government must find a way to tap into these resources to cover urgent and increasing health needs and strengthen the weak health system to achieve Universal Health Coverage.

4. Humanitarian Health Response (3/4Ws)

Health sector Libya is comprised of 33 actors, including 1 national authority, 13 INGOs, 6 UN agencies, 2 observers, 6 others. 4 national NGOs and 1 national society.

1	Ministry of Health	National authority
2	ACF (Action Against Hunger)	International NGO
3	CEFA (The European committee for training and agriculture)	International NGO
4	Emergenza Sorrisi	International NGO
5	Expertise France	International NGO
6	Handicap International – Humanity & Inclusion	International NGO
7	Helpcode	International NGO
8	IMC (International Medical Corps)	International NGO
9	IRC (International Rescue Committee)	International NGO
10	MSF France	International NGO
11	MSF Holland	International NGO
12	PUI (Premiere Urgence Internationale)	International NGO
13	TdH (Terre des Hommes – Italy)	International NGO
14	WeWorld-GVC	International NGO

15	AICS (Italian Agency for Development Cooperation)	Other
16	Chemonics International Inc.	Other
17	GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit)	Other
18	LPFM (Libya Public Financial Management Program)	Other
19	Voluntas Policy Advisory (Voluntas)	Other
20	The World Bank (WB)	Other
21	ICRC (International Committee of Red Cross)	Observer
22	IFRC (International Federation of Red Cross and Red Crescent Societies)	Observer
23	LRC (The Libyan Red Crescent Society)	National society
24	Psychosocial Support team	National NGO
25	Organization of Development Pioneers	National NGO
26	Alsafwa	National NGO
27	Migrace	National NGO
28	IOM (International Organization for Migration)	UN Agency
29	UNDP (United Nations Development Programme)	UN Agency
30	UNFPA (United Nations Population Fund)	UN Agency
31	UNHCR (United Nations High Commissioner for Refugees)	UN Agency
32	UNICEF (United Nations Children's Fund)	UN Agency
33	WHO (World Health Organization)	UN Agency

There is a national health sector coordination group, led by the MoH ICO (International Cooperation Office) in Tripoli and co-lead by 100% dedicated health sector coordinator.

There are 2 active sub-national health sector groups: Sabha hub – led by south MoH and co-lead by "double-hatted" WHO national staff (it is organized in February 2019); Benghazi hub/Al Baida – led by east MoH and co-lead by "double-hatted" WHO national staff (it is organized in November 2018).

There are 7 established thematic sub-sector working groups:

Name of the group	Location	Lead	Co-lead
Migration health sub-sector working group	Tripoli	MoH	IOM
Reproductive health sub-sector working group	Tripoli	MoH	UNFPA
Tuberculosis sub-sector working group	Tripoli	MoH	WHO
MHPSS (Mental Health Psychosocial Support) sub-sector working group	Tripoli	MoH	IMC / IOM
COVID-19 IPC (Infection Prevention Control) sub-sector working group	Tripoli	MoH	WHO / UNICEF
PHC sub-sector working group	Tripoli	MoH	TBC
COVID-19 RCCE sub-sector working group	Tripoli	MoH	UNICEF

Earlier organized coordination groups were discontinued: "Medical supplies working group": The work of the group was led and coordinated by WHO; Joint Technical Coordination Committee (JTCC); National Economic and Social Developmental Board (NESDB); Basic Services WG; Health sub-sector WG: The work of the group was lead and coordinated by the Ministry of Planning.

In 2020, more than 3,970,842 people were defined in need of health assistance, lacking consistent access to primary and secondary health care services. This number included nearly 1,663,000 people in extreme need and more than 122,000 people in catastrophic need, according to the health sector severity scale. The health sector wide approach planned to target 1,785,072 people in 58 municipalities, identified as having the most severe needs.

In 2021, a total 1,195,389 people needed health compared to 3,970,842 in 2020. Of this number, 1,016,839 (15%) people have acute health needs for 2021, compared to 3,628,213 (53%) in 2020. The decrease in numbers was explained by the temporary ceasefire negotiated in 2020, which allowed better access to different areas of the country. For 2021, 72% of municipalities were in areas ranked 3 and above on the severity scale (compared with 85% in 2020). This included 58 municipalities ranked as 3, 12 municipalities ranked as 4 and two municipalities ranked as 5 on the severity scale.

Population group	**Affected**	**Inter-sector**	**Health**	**Health %**	**Health Target**

	population	PIN	PIN		
Migrants	538,264	303,740	301,026	25%	104,664
Returnees	273,756	228,084	180,482	15%	61,196
IDPs	392,241	172,871	168,728	14%	97,847
Refugees	46,245	46,245	46,245	4%	44,003
Nondisplaced	1,224,935	501,939	498,908	42%	143,085
Total	**2,475,441**	**1,252,879**	**1,195,389**	**100%**	**450,795**

In 2022, health sector will follow the inter-sector PIN and target.

Population Group	PIN 2021	PIN 2022
IDPs	197,351	131,832
Migrants	320,417	232,000
Non-Displaced	432,900	281,303
Refugees	74,293	43,000
Returnees	170,429	115,439
Total	**1,195,389**	**803,574**

Health became and remained a central point of one of inter-sector overall objectives for 2021 planning.

2021 HRP Strategic Objectives:

Strategic Objective #1- Physical and Mental Wellbeing: *Prevent disease, reduce risks to physical and mental well-being, and strengthen the protection of civilians in accordance with international humanitarian law, human rights laws and other international legal frameworks.*

Strategic Objective #2- Living Standards: *Facilitate safe, equitable and dignified access to critical services and livelihoods to enhance people's resilience and ensure they meet their basic needs.*

Objective 1: Increase access to lifesaving and life-sustaining humanitarian health assistance, with an emphasis on the most vulnerable (including IDPs, migrants, refugees and returnees) and on improving the early detection of and response to disease outbreaks.

Under the first objective, the health sector provide an essential package of integrated health care services at primary and secondary health care levels. The package will include emergency and trauma care, the management of communicable and noncommunicable diseases, maternal, neonatal and child health, mental health and psychosocial support, vaccination, disease surveillance and outbreak response. Outpatient consultations will be supported. Patients will be referred for treatment between different levels of care. The number of skilled birth attendants at deliveries will be increased. Mental health and psychosocial support services will be integrated into primary and secondary health care facilities and community centres. Mobile medical teams will be deployed to support health facilities, and emergency vaccination activities will be streamlined through provision of cold-chain equipment and required training. The number of sentinel sites reporting to the disease surveillance system will be increased and disease alerts and outbreaks will be investigated, verified within 72 hours and responded.

Objective 2: Strengthen health system capacity to provide the essential package of health services and manage the health information system.

Under the second objective, health care facilities are provided with essential medicines, supplies and equipment to support their continuous functioning. This will include COVID-19 related supplies. Where necessary, the health sector will support the refurbishment or rehabilitation of health facilities. Mobile teams will supplement health care services in remote, rural and hard-to-reach areas where access to such services are limited. Fixed health points and/or mobile teams will provide health care services to people in IDP camps, settlements and detention centres. The health sector will also continue to report attacks on health care personnel and facilities through WHO's Surveillance System of Attacks on Healthcare (SSA).

Objective 3: Strengthen health and community (including IDP, migrants and refugees) resilience to absorb and respond to shocks with an emphasis on protection to ensure equitable access to quality health care services.

To support the strengthening of health and community resilience, health care providers and community health workers are trained on the provision of essential care services including the clinical management of rape. A ToT approach (via central level) will be prioritized to enable reaching out municipalities (local level).

5. Information gaps & recommended information source

In Libya, the Ministry of Health (MOH) Health Information Centre (HIC) was established in 2006 under Law No. 4 of 1990. Its mandate is to collect routine data from health facilities, conduct health surveys, train staff for the statistical units and issue statistical reports. Currently the HIC is headed by a director-general who oversees 26 staff including statisticians, information technologists, data entry and documentation clerks and a health information consultant. The HIC is organized into five offices: statistics and research, data analysis, information technology, documentation, and administration and finance. The HIC is located in Tripoli and theoretically oversees the East and South, though its capacity to effectively supervise and mobilize resources for local branches is extremely limited.

In pre-conflict Libya, the HIC received health information from the statistical offices of all hospitals and district-level directorates of health. It consolidated the information and produced annual reports. Thus, service usage data and outcome data were available to some extent, albeit with gaps in information collection and reporting and incomplete information on the burden of disease. Some of the HIC's annual reports from 2010 to 2015 are available on the HIC website http://seha.ly/.

Since the armed conflict began in 2011, the flow of information to the HIC has decreased substantially and shows obvious gaps. For example, the HIC has information on vital statistics such as birth registrations, but information from death certificates is estimated to be only around 60%.

The weak capacity of the HIS has hampered efforts to gather overall data on the burden of disease, the prevalence and main causes of morbidity and mortality, and the status (accessibility, availability) of health care services across the country. Currently, the most effective reporting system relies on performance indicators that are reported through standard "Who does What, Where and When" (4Ws) completed by UN agencies and mainly international nongovernmental organizations. Libya is one of the very few countries in the Eastern Mediterranean region (EMR) that do not have the capacity to report against the indicators in WHO's response monitoring framework (see table below).

Core Indicator	Availability
Requested fund by health sector	Available
Funds received	Available
# Total Population	Available
# People in need of humanitarian health assistance	Available
# People targeted for humanitarian health assistance	Available
# Targeted people reached	Available through 4W
# Sentinel surveillance sites	Available through 4W
# Sites reporting timely	Available through 4W
# Attacks on health facilities and personnel	Available through 4W
# Health workers trained/ retrained	Available through 4W
# Active health cluster/sector partners	Available through 4W
# Beneficiaries from the medical kits and treatment course provided	Available through 4W
# Mobile clinics supported	Available through 4W
# outbreaks detected and investigated with 72 hours	Available through 4W
Total number of outbreaks	Available through 4W
# Consultations	Country level data is not available through HIS
# Deliveries	Country level data is not available through HIS
# Normal Deliveries assisted by skilled attendants	Country level data is not available through HIS
# Trauma cases supported	Country level data is not available through HIS
# Mental health and psychosocial support interventions provided	Country level data is not available through HIS
# of physical rehabilitation sessions.	Country level data is not available through HIS
# Health facilities	Country level data is not available through HIS
# Under 1 targeted for measles vaccine	Country level data is not available through HIS
Crude mortality rate	Country level data is not available through HIS
Under five children mortality ratio	Country level data is not available through HIS

# Functioning health facilities	Country level data is not available through HIS
# Accessible facilities	Country level data is not available through HIS
# Doctors per 10000 population	Country level data is not available through HIS
# Nurses per 10000 population	Country level data is not available through HIS
# Under 1 vaccinated against measles	Country level data is not available through HIS
# CEMoNC units	Country level data is not available through HIS
# BEmONC units	Country level data is not available through HIS
# of health facilities with IPC program	Country level data is not available through HIS
# of health facilities with full minimum health service packages	Country level data is not available through HIS
# primary health care units	Country level data is not available through HIS
# primary health care units fully functional	Country level data is not available through HIS
# primary health care units partly functional	Country level data is not available through HIS
# primary health care units nonfunctional	Country level data is not available through HIS
# of hospitals	Country level data is not available through HIS
# of hospitals fully functional	Country level data is not available through HIS
# hospitals partly functional	Country level data is not available through HIS
# hospitals nonfunctional	Country level data is not available through HIS
Estimated number of pregnancies per year	Country level data is not available through HIS
# ANC visits a pregnant woman has received during pregnancy	Country level data is not available through HIS
# midwives per 10000 population	Country level data is not available through HIS
# children (6 months - 15 years) who had measles vaccine	Country level data is not available through HIS
# 3rd dose of DPT/PENTA (0-12 months)	Country level data is not available through HIS
# children (0-12 months)	Country level data is not available through HIS

In addition to the above, chronic gaps promote a culture that mutually reinforces lack of data and lack of accountability for the MOH decision-making process. For example:

- There is no system in place to track the performance (at central or regional levels) of public health facilities.
- Despite technical support provided thus far, there is no country-wide system to gather information to monitor and assess needs, response capacities and funding requirements.
- Health facilities' catchment areas and administrative boundaries are not defined.
- The HIS does not use information from the Bureau of Statistics and Census and other partners.
- Libya lacks a comprehensive costed M&E plan, standardized guidelines for data management, institutionalized data quality assessments and a functioning integrated web-based HIS.
- Despite significant investments, the DHIS2 has not yet yielded the expected results. Implementation has been continuously delayed and the system has been introduced in only 60 of the country's 100 municipalities. No funds are available to implement DHIS2 vertical programme reporting.
- WHO's Health Resources Availability Monitoring System (HeRAMS) has not been launched in Libya.
- The lack of a reliable HIS increases the risks of communicable disease outbreaks with the potential to spread across Libya given its porous borders and the numbers of migrants and nomadic communities transiting the country.
- Libya lags behind in producing several products that are part of the Global Health Cluster's Public Health Information Service toolkit. The country has no tools to measure the health status and health threats of affected populations, measure the availability of health resources and services, or assess the performance of the health system.

As of today:

- National level plans were not formulated in 2021 due to systematic health systems challenges (listed above).
- All hazard national preparedness plan is not available.
- Health sector provided all required technical support and guidance to the national health authorities, but no progress had been reached.
- Health sector supported the technical mission to Libya focused on disease surveillance and health information management from WHO Regional Office. Follow up action is in place in line with its key recommendations.

The best way to illustrate the situation with contingency planning, or its absence, is in the findings of the EWARN evaluation mission. The objectives of the mission were:

- Describe the EWARN system and how it operates
- Assess the effectiveness and usefulness of EWARN to meet system objectives
- Measure EWARN attributes
- Evaluate rapid response team capacity and operation

- Provide recommendations and practical measures for improvement.

Key findings included:

- Administrative structure needs to be revisited
- Hospital administration is not aware of EWARN (lack of acceptance)
- Inadequate understanding of EWARN operationality among all levels
- Lack of coordination between CPHL and EWARN
- Not a single sample was sent to CPHL for verification through EWARN system (except for measles and AFP)
- Immediate reporting and alert verification components of EWARN are under functioning
- Alerts are not verified
- Majority of the standard EWARN reporting tools are not available/ used
- Outbreak investigation reports are not unified/structured properly
- No budget allocations, training, supervisory plan available
- Lack of need forecasting and planning/stockpiling for the medical, laboratory and other required supplies

International Information Management consultant was recruited during the last quarter of 2021 to:

- Carry out a scoping analysis for the existing HISs (e.g., DHIS2, EWARN, HeRAMS), tools (e.g., 4Ws), and data management processes.
- Review the existing functions, structure of information management and capacity in WHO Libya, opportunities, and gaps.
- Support health sector partners in terms of consolidating, analyzing and disseminating data on the ongoing response, as needed.
- Review the core list of indicators that partners should report against, their feasibility, availability and reliability of data sources, timeliness and completeness of data, and gaps in reporting.
- Preparing an action plan, in coordination with HIC/MoH, for rolling-out the DHIS2 in the remaining 40 municipalities in 13 districts.
- Support the health sector in launching Health Resources and Services Availability Monitoring System (HeRAMS) in Libya, using systematic and innovative data management approaches. HeRAMS is an essential component of emergency management, the humanitarian-development nexus, health systems strengthening and universal health coverage.
- Align the HeRAMS existing format and master list of health facilities to the global HeRAMS standard data model, considering the local requirements of MoH and national guidelines.
- Provide training to the national MoH/HIC FP on the online HeRAMS global platform. Note: based on the MoH and health sector priorities, other areas could be addressed such as: M&E Framework, national capacity building, developing HISs normative documents and SOPs at national level.

6. Key References on health sector response deliverables

Links to interactive dashboards and updates:

- Health sector 4W 2021 HRP interactive dashboard
- COVID-19 Libya interactive dashboard

Products	If online - Link
HRP	https://www.humanitarianresponse.info/en/operations/libya/health
HNO	https://www.humanitarianresponse.info/en/operations/libya/health
M&E framework for HRP	https://www.humanitarianresponse.info/en/operations/libya/health
4Ws	https://www.humanitarianresponse.info/en/operations/libya/health
Severity matrix	https://www.humanitarianresponse.info/en/operations/libya/health
EOC dashboard or any dashboards published	Under development
Report hub report to OCHA	OCHA uses regular health sector IM documents for own inputs.
Monthly siterps	Mid-month sector operational updates; https://www.humanitarianresponse.info/en/operations/libya/health
Donor reports	Up to separate organizations
Activity info report to EMR	https://www.activityinfo.org/app#form/cjvoxh7fa1/table/s1819182515
Rapid assessments or any other assessments reports	https://www.humanitarianresponse.info/en/operations/libya/health

Assessment Registry	https://www.humanitarianresponse.info/en/operations/libya/health
HeRAMS dashboard or SARA report	HeRAMS not rolled out in Libya; SARA report in 2017 (see below)
HMIS reports	Under development
Health facilities report forms	Developed under DHIS2 tool, available with the MoH
EWAR reports	https://www.humanitarianresponse.info/en/operations/libya/health
Attack on health care	https://www.humanitarianresponse.info/en/operations/libya/health
Health cluster bulletins.	https://www.humanitarianresponse.info/en/operations/libya/health
Health sector COVID-19 response monitoring framework	https://www.activityinfo.org/app#form/cg3qm1lkkjm7k4p8/table
Health sector working group minutes	https://www.humanitarianresponse.info/en/operations/libya/health
Morbidity and mortality assessment reports.	Mortality report was produced by MoH in 2019 (internal, a copy is available).
Interactive dashboard for products: COVID-19, KPI, 4Ws etc.	https://www.humanitarianresponse.info/en/operations/libya/health
Health sector annual report	https://www.humanitarianresponse.info/en/operations/libya/health
Any other IM product.	https://www.humanitarianresponse.info/en/operations/libya/health

Other key IM related deliverables include:

- Bi-annual inventory of health sector projects in Libya
- Quarterly overview of capacity building events supported by sector in Libya
- Quarterly overview of rehabilitation activities supported by sector in Libya
- Quarterly updated health sector contact list
- Annual CCPM
- Inventory of health sector projects
- Regularly updated health sector email list

Key web sites:

https://www.who.int/health-cluster/countries/libya/en/
https://www.humanitarianresponse.info/en/operations/libya/health
https://www.facebook.com/Ministry.of.Health.Ly/
https://www.facebook.com/NCDC.LY/
https://ncdc.org.ly/Ar/

7. Contacts

- WHO Country Director in Libya - Ms Elizabeth Hoff, hoffe@who.int
- WHE Team Lead – TBC
- Health sector coordinator – Mr Azret Kalmykov, kalmykova@who.int
- IM focal point – Mr Diya Natuh, natuhd@who.int
- COVID-19 Technical Team Lead – Dr Salah-ud-din Sadi, sadis@who.int

Contact information of health sector related coordination groups, Libya, November 2021

Name of the group	MoH lead name	MoH lead email	Co-lead name	Co-lead email
National health sector coordination group	Asaddiq El Saeh	ico@health.gov.ly	Azret Kalmykov	kalmykova@who.int
Sub-national health sector coordination group	TBC	TBC	Abdelaziz Alahlafi	alahlafia@who.int
Sub-national health sector coordination group	Khalid Al Shareef	khalid1979alshrif12@gmail.com	Radhia Shaban	shabanr@who.int
Migration health sub-sector working group	Husamadin Asaibi	h.m.asaibi@gmail.com	Arif Hussain	ahsyed@iom.int
Reproductive health sub-sector working group	Alia Shiboub	ashiboub@phci.gov.ly	Mohammad Ghaznavi	ghaznavi@unfpa.org
Tuberculosus sub-sector working group	Mohammed Furjani	furjanim@yahoo.co.uk	Santosha Kelamane	kelamanes@who.int
MHPSS (Mental Health Psycosocial Support) sub-sector working group	Husamadin Asaibi Duaa Mermosh Nadia ben Younis	h.m.asaibi@gmail.com d.mormesh@phci.gov.ly benyounis.nadia@gmail.com	Sarah Rizk	sarizk@iom.int
			Thomas Eliyahu Zanghellini	tzanghellini@InternationalMedicalCorps.org
COVID-19 IPC (Infection Prevention Control) sub-sector working group	Latifa Bettamer	Latbett@hotmail.com	Ahmed Salem	salema@who.int
			Mohammad Almjadleh	malmjadleh@unicef.org

PHC sub-sector working group	Hisham Gdara	hishamgdara@phci.gov.ly	Mohamed Hashem	hashemm@who.int
COVID-19 RCCE sub-sector working group	Abdulmenem Alkmashe	a.alkmashe@ncdc.gov.ly	Mohammad Younus	myounus@unicef.org

Recommended Actions:

CO:

1. Requires immediate support with assignment of the following critical functions: WHE Team Lead, Operations Officer, Health Sector Coordinator, Operations and Logistic Officer, Health Information Management Officer.
2. Support to Procurement both virtually and a possible surge mission on international procurement to Libya.
3. Deployment of EMRO staff to help Libyan MoH and WHO Immunization Officer to better plan and coordinate scale up of COVID-19 vaccination in Libya.
4. Requires immediate support with technical level support from RO and HQ following the findings of 2 EMRO evaluation missions in 2021 to Libya: disease surveillance, information management.
5. In the coming 3 months, there might be an exacerbation of emergency on health side, with warehouses running dry at end of year, low funds at the end of biennium and financial complexities and long/constrained supply chains, it might become very difficult to support Libyan authorities within health sector to provide immediate back up and relief. There should be a discussion of contingency funds and supplies that may be made available if such a situation arises in next 3-4 months.
6. Support to procure medicines like LMWH, tocilizumab, malaria, leishmania, HIV, TB, Hepatitis B and C.
7. Support for activation of National Influenza Center in Libya.
8. Requires immediate support by EMRO with technical follow up and operationalization of 7 EOCs funded by WHO in 2019, 2020, 2021.
9. Requires a more thorough and concrete technical follow up between the CO response (as per the lines of regular biweekly operational update) and responsible EMRO departments. This is to be extended to the implementation of developed workplan for 2022-2023.

RO EMRO:

HQ:

8. PHSA Contributors

WCO:

- A team of technical officers

Regional office:

HQ