



WHO COUNTRY OFFICE, LIBYA

ANNUAL REPORT 2022



World Health
Organization

In 2022, WHO distributed across Libya educational materials on COVID-19 and vaccination, as well as masks and hygiene kits.

WHO COUNTRY OFFICE, LIBYA

ANNUAL REPORT 2022



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Organization

WHO Library Cataloguing in Publication Data

Names: World Health Organization. Regional Office for the Eastern Mediterranean

Title: WHO country office, Libya: annual report 2022 / World Health Organization. Regional Office for the Eastern Mediterranean

Description: Cairo: World Health Organization. Regional Office for the Eastern Mediterranean, [2023]

Identifier: ISBN 978-92-9274-109-9 (pbk.) | ISBN 978-92-9274-110-5 (online)

Subjects: Health Status | Health Services | COVID-19 - prevention & control | Betacoronavirus | Disease Outbreaks | Primary health care | Communicable Disease Control | Noncommunicable Diseases – prevention & control | World Health Organization | Libya | Annual Report

Classification: NLM WA 300

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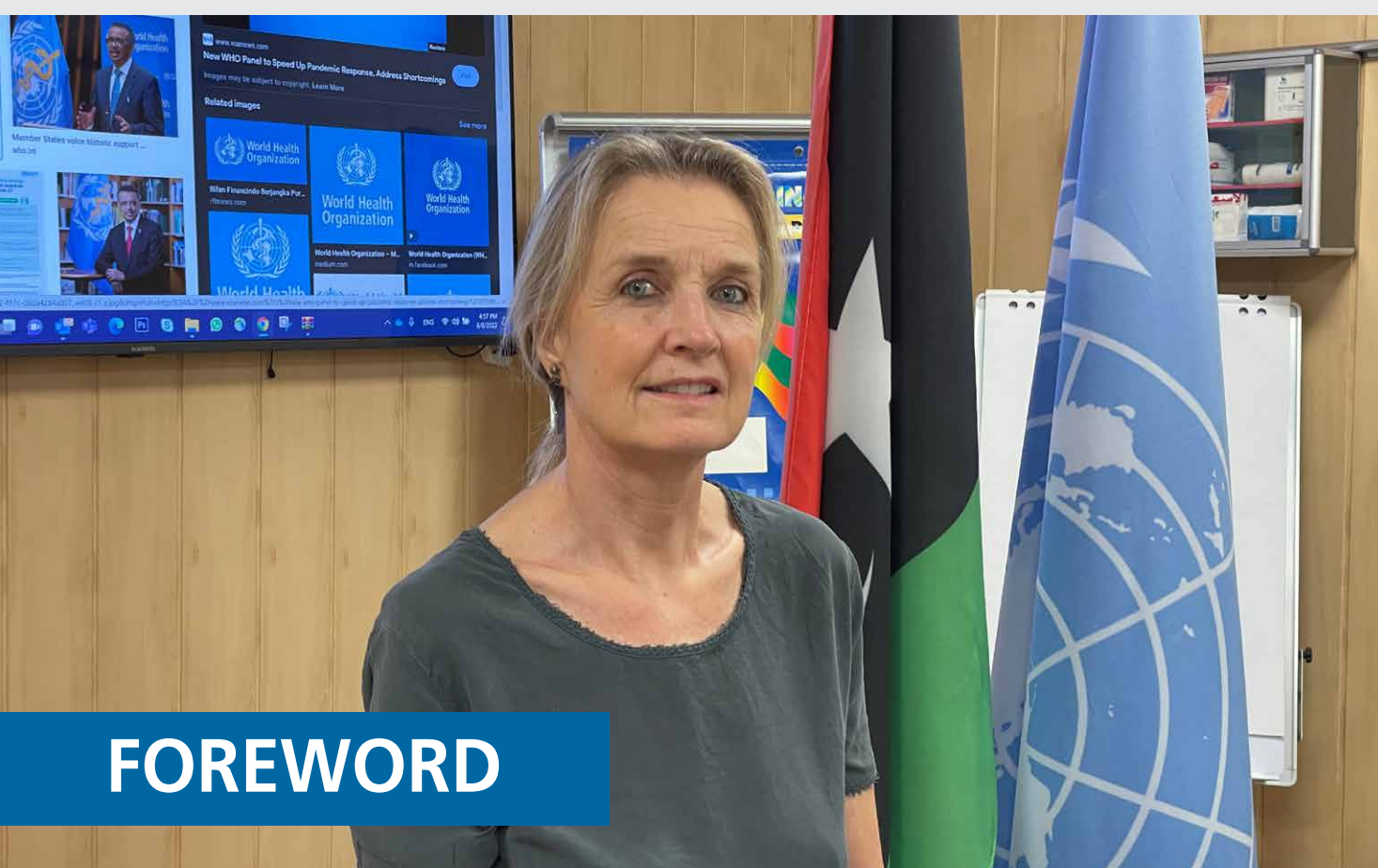
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LIST OF ABBREVIATIONS

AFP	Acute flaccid paralysis
ART	Antiretroviral therapy
CemOC	Comprehensive emergency obstetric care
CFM	Common feedback mechanism
CL	Cutaneous leishmaniasis
DHIS2	District Health Information System 2
EBS	Event-based surveillance
EMT	Emergency medical team
EPHS	Essential package of health services
EWARN	Early Warning and Response Network
GBV	Gender-based violence
GNA	Government of National Accord
GNS	Government of National Stability
GNU	Government of National Unity
GP	General practitioner
HIS	Health information system
IDP	Internally displaced person
IDSR	Integrated disease surveillance and response
IMCI	Integrated Management of Childhood Illness
IOM	International Organization for Migration
IPC	Infection prevention and control
IRC	International Rescue Committee
LPDF	Libyan Political Dialogue Forum
LNA	Libyan National Army
Mh-GAP	Mental Health Gap Action Programme
MoH	Ministry of Health
NAP	National AIDS Programme
NCD	Noncommunicable disease
NCDC	National Centre for Disease Control
NTP	National TB Programme
OPV	Oral polio vaccine
PHC	Primary health care
PHCI	Primary Health Care Institute
PLHIV	People living with HIV
RCCE	Risk communication, community engagement and infodemic management
RRT	Rapid response team
TPM	Third party monitor
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNSDCF	United Nations Sustainable Development Cooperation Framework
VDPV	Vaccine-derived poliovirus
WCO	WHO country office



FOREWORD

At the beginning of the year, there were hopes that a united Libya would continue its path towards a peaceful democracy, albeit with significant setbacks, most notably the postponing of the national elections in late December 2021. As I write this message, the country is once again divided, with sporadic outbreaks of violence among rival militias that have killed dozens of people and threatened to shatter a period of relative calm. In spite of these difficult circumstances, WHO has continued to operate across the country, working with all parties to seek the best health outcomes for Libyans. In some areas, particularly the south, this has been incredibly challenging. WHO staff have had to be strenuously neutral while advocating for health interventions based on best practice, best health outcomes and best value for money rather than narrow political interests. The Minister of Health in Tripoli changed twice in 2022, and WHO has also been dealing with another Minister of Health in the east. Navigating these changes requires great sensitivity and diplomacy; we have continued to be convincing because we have remained scrupulously impartial.

In 2022, we distributed millions of pieces of COVID-19 personal protective equipment to protect health care staff and their patients. We also continued to support the COVID-19 national vaccination campaign. However, although the Ministry of Health (MoH) committed to reaching 40% vaccination coverage by the end of the year, vaccine uptake declined as the sense of urgency around the COVID-19 response diminished. By the end of the year, only 18% of the population had been fully vaccinated.

The pandemic has highlighted the importance of strong surveillance to detect disease outbreaks before they spread, cost lives and become difficult to control. The number of sites reporting to Libya's disease early warning and response network rose from 180 at the end of 2021 to 253 at the end of 2022. Partly thanks to this strengthened surveillance, no major disease outbreaks were reported over the course of the year.

Libya still has no budget earmarked for vaccines and no systems to track vaccine supplies, monitor usage and forecast annual needs. In 2022, health facilities across the country reported regular stockouts of life-saving childhood vaccines. Acute shortages of oral polio vaccine and measles, mumps and rubella vaccine were reported 177 and 73 times, respectively. Both are critical to maintaining population immunity against the epidemic-prone diseases that cause high childhood morbidity and mortality. Through its field coordinators (who are present in all 22 districts of Libya), the WHO country office (WCO) has established a system to track vaccine availability across the country. In July 2022, based on the monthly status reports prepared by the WCO, the government released enough funds to procure sufficient vaccines until the middle of 2023. WHO will continue to advocate for regular funding to secure vaccine supplies and protect the health of children in Libya.

It is sobering to note that 80% of children in high-income countries recover from cancer, while fewer than 30% of children in low- and middle-income countries such as Libya survive this deadly disease. In January 2022, we launched our child cancer project, which aims to provide life-saving treatment for over 700 child cancer patients. It took almost a year of review and negotiations to make the project a reality, but it is now well underway. Most of the project's supplies and equipment have been delivered to participating hospitals. Our colleagues at the Bambino Gesù hospital in Rome are monitoring the project, helping us assess needs in Libya's paediatric hospitals, and sponsoring residential training for Libyan physicians. WHO is not only meeting immediate life-saving needs but supporting the training of physicians and nurses to help them save the lives of other Libyan children long after the project is over.

Recent UN assessments¹ have shown an improvement in the overall humanitarian situation in Libya following a period of relative political and economic stability. Internally displaced

Libyans have continued to return to their places of origin. At the end of 2022, a total of 134 787 people remained displaced, a reduction of almost 25% compared with the end of 2021. However, approximately 330 000 people still require some form of humanitarian assistance. Migrants and refugees account for almost two thirds of this number. The status of these groups remains a serious cause for concern. Violations of human rights and international humanitarian law continue to be reported. In January 2022, thousands of migrants were rounded up and forced into one of the country's detention centres, where many of them continue to be held indefinitely in dire conditions. WHO is continuing its work to improve their access to health care services. With UNICEF, we have successfully advocated for them to be included in the national COVID-19 vaccination campaign. Six of Libya's 24 detention centres are reporting to the disease surveillance network supported by WHO; we plan to expand this number in 2023. Our mobile medical teams are providing essential health care for migrants and refugees who are reluctant to visit health facilities for fear of being rounded up, jailed or deported. In 2022, these teams provided more than 320 000 consultations to all segments of the population.

In late 2022, the United Nations in Libya shifted from an emergency mode to a development approach – the so-called humanitarian-development-peace nexus. At around the same time, WHO reclassified Libya as a grade 2 protracted emergency, meaning that health needs in the country still require a sustained operational response. In 2023, we will work with our partners to address the structural causes of Libya's disrupted health system while at the same time responding to ongoing humanitarian needs. We know that we can count on the support of our donors as we transition to this new way of working.



¹ Humanitarian Needs Overview and Multi-Sectoral Needs Assessment

BACKGROUND

Since the overthrow of the Gaddafi regime in 2011, Libya has been locked in a political conflict characterized by a governance vacuum, disintegrating public services and violations of international humanitarian law. Terrorist groups and armed militias have exploited the turmoil and used the country as a base for radicalization and organized crime. Thus far, the conflict has defied national and international efforts to find a political solution.

For civilians, the effect of the crisis has been incalculable. At the height of the conflict, hundreds of thousands of people were displaced, and thousands more were killed or injured. The weaponization of vital services deprived millions

of people of water and electricity, including at the peak of summer when temperatures routinely exceeded 40°C. Health care facilities came under attack, forcing many centres to suspend services or close altogether. In 2019, more people were killed in Libya by attacks on health care facilities than in any other country worldwide. The conflict was also marked by egregious violations of humanitarian rights. Thousands of migrants and refugees were rounded up and held indefinitely in dire conditions in illegal detention centres. Atrocities committed included mass killings. In 2020, the discovery of at least eight mass graves, most of them in Tarhouna, prompted calls from the UN Secretary-General for a thorough investigation and for the perpetrators to be brought to justice.

Timeline of main political developments

In 2011, Libya erupted into conflict when forces loyal to Colonel Muammar Gaddafi clashed with rebel groups that were seeking to oust his government. In September of that year, following the defeat of Gaddafi, the United Nations established a special political mission (the United Nations Support Mission for Libya)² to support the country's new transitional authorities in their post-conflict efforts. Despite the UN's efforts, the crisis continued to escalate.

In 2014, Libya was divided into two separate spheres of influence in the east and west, each with its own political, government, economic and security institutions.

In late 2015, an interim Government of National Accord (GNA) was established in Tripoli with the support of the UN. Although the UN Security Council recognized the GNA as the sole legitimate executive authority in Libya, a rival government in the east (Benghazi) continued to function, backed by the Libyan National Army (LNA) headed by Field Marshal Khalifa Belqasim Haftar.

In early 2018, following intensive international efforts, Libya's rival leaders agreed to hold parliamentary and national elections. In the summer of 2019, an international initiative spearheaded by the Government of Germany and known as the Berlin Process was launched in an attempt to bring peace to the country. The results of the first phase of the process were set out at the Berlin Conference on Libya in January 2020. One of the outcomes of the conference was the establishment of a Libyan Political Dialogue Forum (LPDF) that would bring together Libyans from all segments of society to decide the future of their country.

The year 2020 saw significant progress towards peace. In October of that year, military officers

from the GNA and LNA signed a countrywide, permanent ceasefire agreement in Geneva. The following month, the LPDF held its first meeting in Tunis, Tunisia. Over 70 Libyan women and men met and agreed on a road map for holding credible, inclusive and democratic national elections.

In February 2021, the LPDF elected Prime Minister Abdul Hamid Dbeibeh to lead an interim Government of National Unity (GNU) through the process of establishing a new Constitution and holding national elections by the end of the year. However, the Libyan House of Representatives failed to approve a national budget, severely limiting the new government's ability to implement its mandate. The lack of an approved national budget also led to the near-collapse of Libya's financial sector. The country's two central banks (one in the east and one in the west) both racked up huge debts to finance their respective administrations. The UN's Special Envoy to Libya warned that managing this debt would only be possible with the unification of the banking system³.

On 21 December 2021 – three days before the date set for the national elections – the head of the High National Election Commission announced that the elections had been postponed because of growing polarization among different political groups and disputes over key aspects of the political process. In announcing the postponement, the Commission cited shortcomings in the legal framework for the elections, contradictory court rulings on candidacies, and political and security concerns. Several western countries called on the Libyan authorities to swiftly set a new election date and issue the final list of presidential candidates. The UN warned that the mobilization of forces affiliated with different political groups was augmenting tensions and increasing the risk of clashes that could spiral into major conflict.

² UN Security Council resolution 2009 (2011).

³ The banking system was unified in 2022.

2022 IN REVIEW

Political developments

Following the shock postponing of Libya's national elections on 24 December 2021, the deadlock over the leadership of the executive authority remained unresolved. On 10 February 2022, the House of Representatives unanimously appointed Mr Fathi Bashagha as Prime Minister-designate and tasked him with forming a new government within two weeks. However, the interim Prime Minister, Mr Dbeibeh, refused to acknowledge the legality of the process that had selected Mr Bashagha and did not cede power. As a result of this political stalemate, the country was once again divided between the GNU in Tripoli led by Mr Dbeibeh and a separate breakaway Government of National Stability (GNS) in Benghazi led by Mr Bashagha.

In late August 2022, Mr Bashagha stated his intention to enter the capital to take over the reins of government, and called on Mr Dbeibeh to guarantee the peaceful transfer of power. In response, the GNU declared a state of emergency in Tripoli and mobilized armed forces to defend the city. Rival armed groups engaged in clashes that led to the deaths of several dozen people and forced Mr Bashagha's supporters to withdraw.

The security situation in the west remained fluid, as armed groups forged new alliances in support of different political factions vying for control of the government in Tripoli. South Libya was beset by organized crime groups and armed clashes, and east Libya witnessed several security incidents including illegal arrests and kidnappings. Despite this, the ceasefire agreement of October 2020 largely held, although the overall situation remained tense.

Intensive efforts to resolve the impasse around the national elections continued throughout 2022. In July, the UN Security Council affirmed its commitment to a Libyan-led political process and appealed to all parties to refrain from actions that could undermine the political process or the ceasefire agreement. On 27 August, the Secretary-General urged the country's leaders to engage in genuine dialogue to address the ongoing political

deadlock and avoid any action that could escalate tensions and deepen divisions. On 2 September 2022, former Senegalese minister and UN diplomat Mr Abdoulaye Bathily was appointed as the UN Secretary-General's Special Representative for Libya. Despite his efforts to break the impasse around the country's governance, Libya failed to agree on a new constitutional framework or date for national elections.

Oil production resumed in July and was sustained at approximately 1.2 million barrels per day, which ensured a steady stream of export revenues for the newly unified Central Bank of Libya. An international working group established under the auspices of the Berlin Conference continued its consultations on supporting Libya's efforts to ensure an equitable distribution of oil revenues. It was hoped that this would build confidence, increase transparency and ensure that the country's vast wealth was used for the benefit of the Libyan people. However, the refusal of the House of Representatives to approve the GNU's national health budget for the second year running had a significant impact on the health system. Health workers were paid only sporadically and many of them resigned, exacerbating shortages in the health workforce. Widespread stockouts of critical childhood vaccines meant that tens of thousands of children missed their routine vaccine shots. Moreover, the MoH was rocked by scandal. The Minister of Health Mr Ali El Zanati was detained on 25 January 2022 following allegations of corruption. Four days later, Mr Ramadan Abu Janah was nominated as deputy Prime Minister and given responsibility for overseeing the MoH.

At the end of 2022, despite sustained support from the UN and the international community, Libya seemed no closer to resolving its intractable political differences. As the UN Secretary-General has stated, the solution to the crisis must be Libyan-led and Libyan-owned, and the Libyan people must be given the right to determine their own future through national, transparent and inclusive elections.

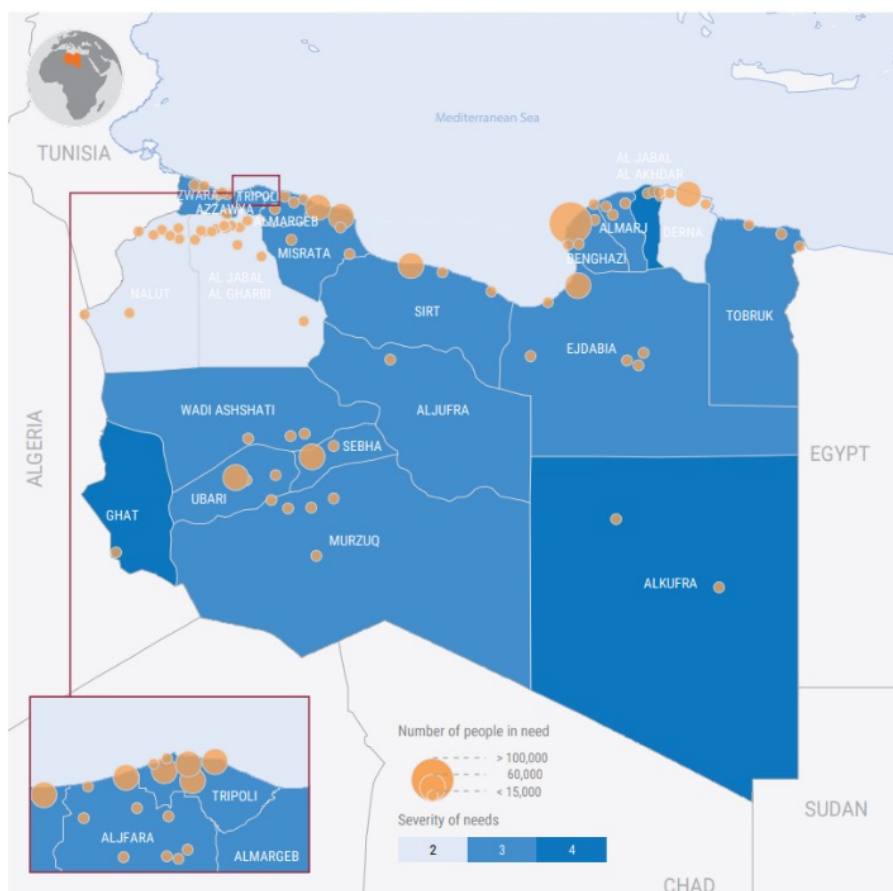
People in need of humanitarian health assistance

According to the last Humanitarian Needs Overview⁴, 803 000 people in Libya required some form of targeted humanitarian assistance in 2022. This represented an overall reduction of 36% from 2021 and highlighted the decrease in needs brought about by the end of hostilities and the general improvements in access and mobility across the country. The areas of highest need were Al Jabal Al Akhdar and Al Kufra in the east, and Ghat in the south. The latter two districts are located in remote, under-served areas close to the border with Sudan and Algeria, respectively.

While internally displaced people (IDPs), refugees and migrants had the most severe needs, returnees

and non-displaced Libyans in the worst-affected areas also required humanitarian assistance. Other vulnerable groups included children and adolescents, the elderly, patients with chronic health conditions and families facing economic hardship.

At the end of 2021, the 2021 Humanitarian Response Plan was extended until 31 May 2022 and again until the end of the year. The purpose of this extension was to monitor political developments following a period of relative stability and, based on the evolution of the crisis, determine the scope and nature of future humanitarian planning.



Map courtesy of United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA)

⁴ libya_hno_2022_english.pdf (humanitarianresponse.info)

Status of health care services

Although Libya's health care services are free at the point of delivery, the prolonged conflict has resulted in the exodus of foreign health workers and has reduced the availability of basic services. Following years of under-investment, many facilities are severely dilapidated and have acute shortages of medicines, supplies and equipment. In 2022, an assessment of 116 PHC facilities conducted by WHO and the Primary Health Care Institute (PHCI) showed that most had experienced acute shortages of antibiotics, insulin, blood pressure drugs and other essential medicines. Almost two thirds had reduced the volume of their work and/or had suspended specific treatments. A staggering 55% had directed patients to private sector or secondary care facilities.

Private health care services have continued to expand to meet needs arising from the inadequate public health care system. Data from 2019 showed that between 2007 and 2018, the number of private inpatient clinics, laboratories and pharmacies, and diagnostic centres rose by 72%, 50% and 80%, respectively. The departure of health care professionals for better-paid jobs in the private sector has exacerbated the situation for poor patients, especially those living in remote areas. For many impoverished households, health care is simply inaccessible. According to a recent multi-sector needs assessment, almost one third of households reported they had family members with unmet health care needs.

In under-served south Libya, the repercussions of disrupted health care services were starkly illustrated when a fuel tanker in Bent Bayaa burst into flames. Dozens of residents who had been waiting to buy gasoline suffered horrific injuries, and 26 of them were killed. Victims were transported to the local hospital, which did

not have the resources to treat them. They were then transferred to the medical centre in Sebha (the capital of the south), some 100 km away. As it was also not equipped to treat them, severely burned patients had to be transferred to hospitals in Tripoli and Benghazi, hundreds of kilometres away. Some patients had to be sent abroad for specialist care.

The inability of the national authorities to approve a health budget for 2021 and 2022 has affected health care at all levels and resulted in limited access to essential and specialized care for some of Libya's most vulnerable population groups. Many health staff are paid only sporadically and their morale is reportedly poor. Very few public health facilities offer a standard package of essential health care services. In 2022, COVID-19 infections among frontline health workers forced many health facilities, isolation centres and laboratories to suspend their services altogether.

Repeated stockouts of critical vaccines continued to disrupt immunization schedules and put children at risk of life-threatening diseases. Libya still has no system to track its vaccine supplies. Based on the WCO's analyses of stock levels, in July 2022, the government released enough funds to procure vaccine stocks until the middle of 2023. However, funding for vaccines remains ad hoc and unpredictable.

Lastly, despite support from WHO and other international agencies in Libya, there is still no country-wide information system to gather health data, monitor medical supplies and assess health needs or service capacity.

Health care workforce

Human resources — the health workers who actually deliver health services — are the most costly and least readily available resource in a health care system. They are also indispensable. Managers at national and local levels struggle daily with how to manage this essential resource efficiently so that they can achieve an equitable workload distribution and improve productivity.

In 2021, the MoH, with close support from WHO, published its nine-year strategy (2022-2030) for building a high-quality, skilled, motivated health workforce, distributed equitably across all levels of the health care system and all geographical areas. In 2022, WHO supported the implementation of this strategy by focusing on three main areas: 1) determining the optimum number of health workers required in Libya by health facility and by discipline; 2) developing a performance guide for health care workers; and 3) supporting the finalization of an Essential Package of Health Services (EPHS) and its associated costing methodology.

Using an assessment tool developed by WHO – the Workload Indicators of Staffing Need – the MoH and WHO analysed data from selected facilities in all regions of the country to determine the optimal number of health workers in each facility. The methodology is based on a health worker's average workload, with standard times applied to each component. A total of 17 PHC facilities in five municipalities were assessed. The results were validated through workshops that brought together participants from municipal, regional and central levels. The assessment findings will be extrapolated and applied to health facilities across the country.

Performance monitoring is key to managing and motivating the health workforce and guiding the provision of performance-based incentives. WHO supported the development of a performance management guide that included standard organigrams, key performance indicators and harmonized job descriptions. Once the guide

has been endorsed and published by the MoH, the Libyan health system will, for the first time in its history, have a comprehensive performance management system that will guide the distribution and performance evaluation of its health workforce.

Lastly, WHO supported the finalization of the EPHS and associated costing methodology. The purpose of an EPHS is to concentrate scarce resources on interventions that provide the best value for money. A well-designed EPHS can result in more effective health care by improving efficiency, equity and accountability. No single EPHS is appropriate for every country in the world. Countries vary with respect to disease burden, level of poverty and inequality, moral codes, social preferences and operational and financial constraints. (WHO 2008).

Over the past decade, Libya has made several attempts to develop an EPHS and costing methodology, none of which has been finalized. In 2022, using a tool developed by WHO⁵, the WCO worked closely with the PHCI, MoH and global experts to harmonize the different costing methodologies developed thus far. WHO will present the final methodology to the MoH in early 2023 for validation. Once approved, the tool will help the national health authorities understand:

- The annual resources that will be required to implement the MoH's health workforce strategy over the next 5-10 years
- The estimated health impact of the EPHS
- How costs compare with estimated available financing during this period.

Once the EPHS has been introduced, it will allow all segments of the population to benefit from the same high-quality health services anywhere in the country. Accurate costing will allow the MoH to allocate resources in a rational manner and thus ensure equitable staffing levels in all health facilities. Lastly, the system will allow the government to monitor expenditures in the delivery of essential health services.

⁵ The OneHealth Tool was designed by WHO to support strategic health planning in low- and middle-income countries. While many costing tools take a narrow disease-specific approach, the tool attempts to link strategic objectives and targets of disease control and prevention programmes to the required investments in health systems. The tool provides planners with a single framework for scenario analysis, costing, health impact analysis, budgeting and financing of strategies for all major diseases and health system components. It is thus primarily intended to inform sector-wide national strategic health plans and policies.

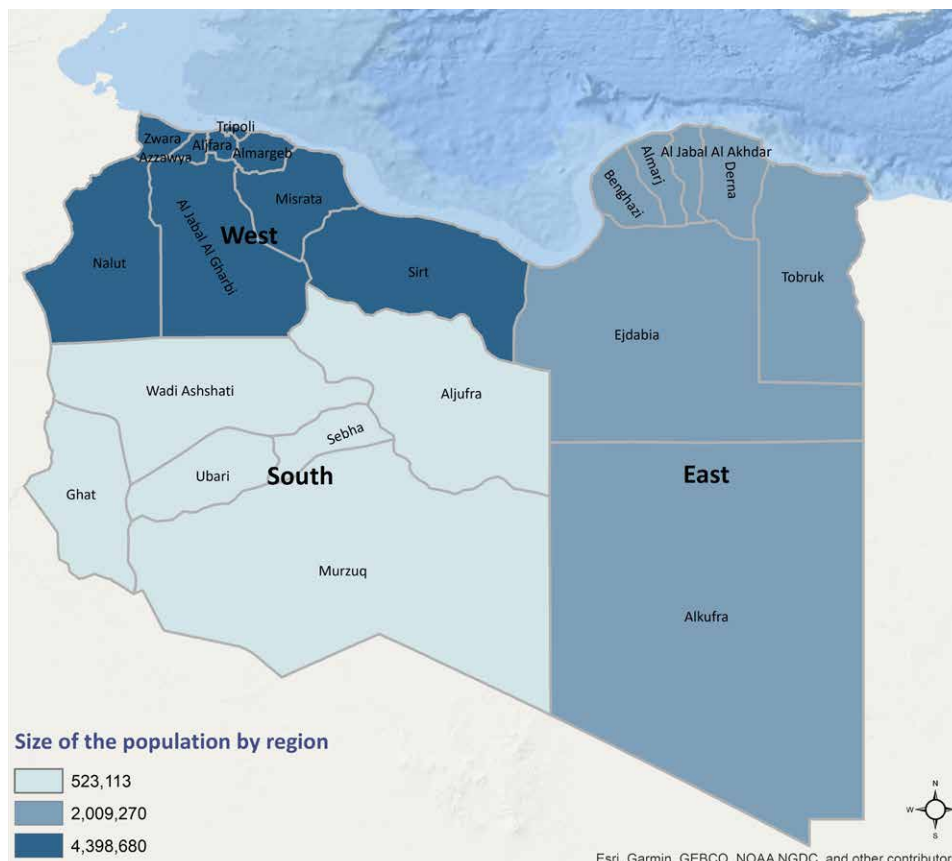
WHO'S RESPONSE IN 2022

WHO continued to support the COVID-19 response, coordinate the humanitarian health sector, and assist national efforts to rebuild Libya's health care system. WHO's emergency response operations reached all 22 districts and all 102 municipalities in the country. The WCO's humanitarian assistance accounted for almost 53% of all medical procedures and consultations supported by the health sector in 2022. (See operational snapshot on the following pages.)

The WCO's network of field coordinators worked with local health authorities and communities to assess health needs, agree on priorities, monitor the delivery of supplies and report back to WHO's office in Tripoli. Nine infection prevention and control (IPC) officers hired by WHO Libya provided technical support to 24 health facilities and COVID-19 isolation centres, and rolled out IPC guidance in hospitals.

Although south Libya continued to be largely off limits to UN agencies, WHO participated in a joint UN mission to Sebha in January 2023. This was the first time in over eight months that the UN had received security clearance to visit the area. Local health authorities asked for additional mobile medical teams to provide basic health care, as well as more medicines, supplies and equipment and better laboratory capacity.

In early 2022, widespread security operations targeting migrants, refugees and asylum seekers led to the arrest of several thousand individuals, causing many others to go into hiding. Their status remains precarious, especially as there is no legal framework that allows humanitarian agencies to assist them in a safe and predictable manner. In addition, many migrants continued to risk their lives attempting to cross the Mediterranean Sea to Europe. The WCO is implementing several



projects that focus on improving access to health services for migrants and refugees. It has also advocated strongly for them to be given the same access to health care as all other segments of the population. These efforts have met with some success: for example, in 2021, following the WCO's advocacy efforts, the MoH reversed its initial refusal to include migrants and refugees in COVID-19 vaccination efforts.

Throughout 2022, WHO worked with both governments in east and west to agree on health priorities, set work plans and implement health activities. The WCO's sub-office in Benghazi (east Libya) worked with the Minister of Health of the GNS and the head of the health committee attached to the Libyan House of Representatives (both located in the east). The main WCO worked mostly with the Ministry of Health of the GNU in Tripoli.

To emphasize its neutrality and impartiality when communicating with both governments, WHO focused above all on humanitarian needs. However, in a highly charged political context, even neutral WHO actions or statements were sometimes misperceived as being for or against one side in the conflict. Moreover, limited cooperation between the two different health authorities hampered data sharing, policy-setting and agreement on national health priorities. In the absence of this collaboration, WHO had to make its own decisions on urgent needs based on information received from its 22 field coordinators, who monitored the health situation in each district. Inevitably, however, this fragmented approach had its limitations.

In conclusion, a strong health system for Libya will depend on a unified country. The health outcomes for Libyans are unlikely to improve significantly unless and until all parts of Libya resolve their deep political differences.

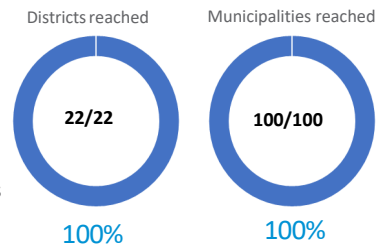


WHO operational response | 2022

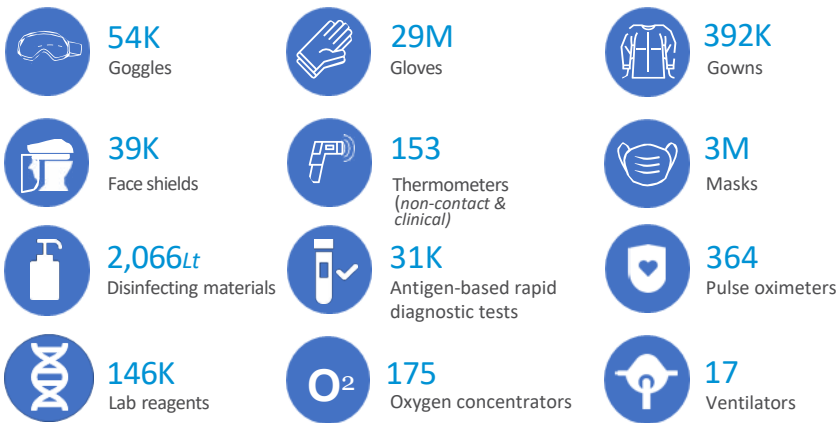
Coordination

- 36 COVID-19 coordination meetings with authorities
- 33 Coordination meetings with partners
 - 6 COVID-19 country situation updates
- 52 EWARN weekly epidemiological bulletins
- 12 Field coordination & response monthly updates
 - 9 Reports on attacks on health care
- 12 Mid-month health sector operational updates
- 12 Health sector bulletins
- 12 Monthly 4Ws health sector reports
- 24 WHO biweekly operational updates
- 27 Weekly, and 12 monthly COVID-19 epidemiological bulletins
- 4 COVID-19 laboratory assessments

Areas reached



COVID-19 response | supplies distributed



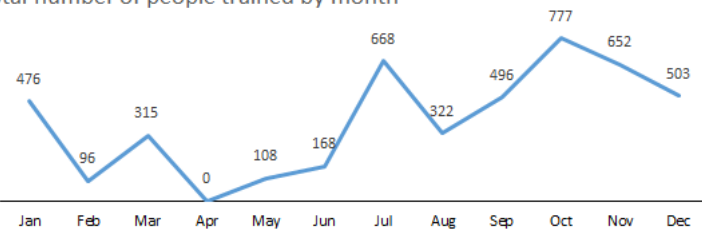
Risk Communication & Community Engagement



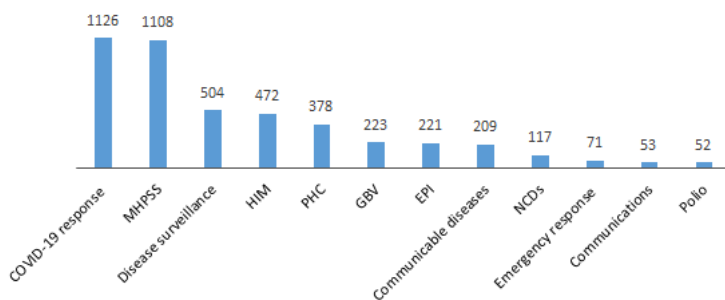
Capacity-Building Support

208 capacity-building events supported, 4,581 people trained

Total number of people trained by month



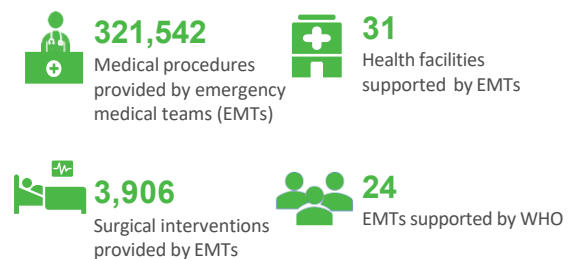
Total number of people trained by programme



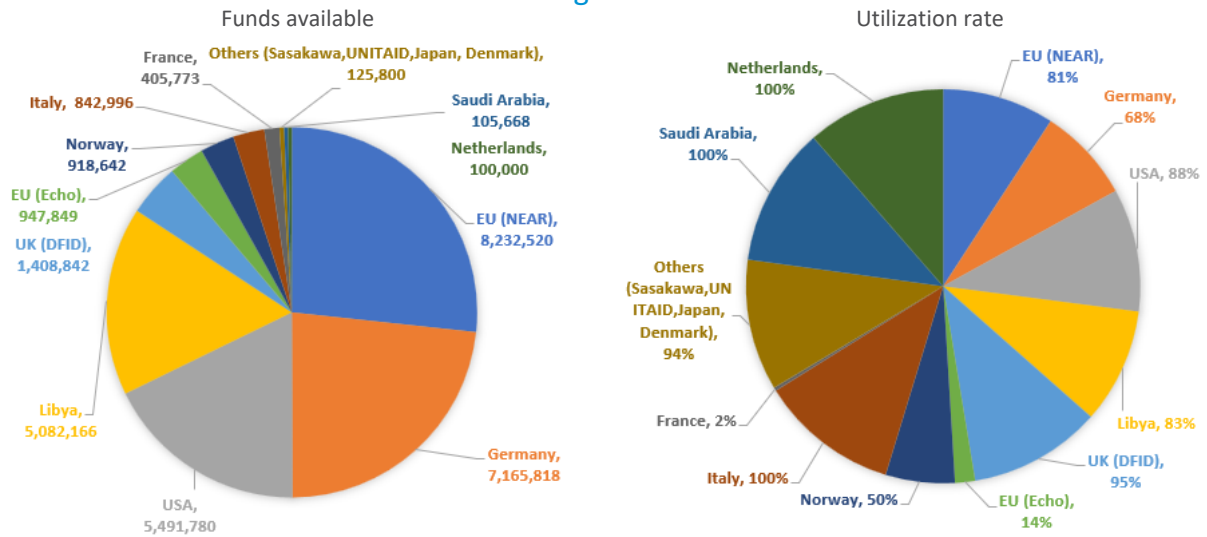
Surveillance, Rapid Response Teams (RRTs) and case investigation



Maintaining essential health services



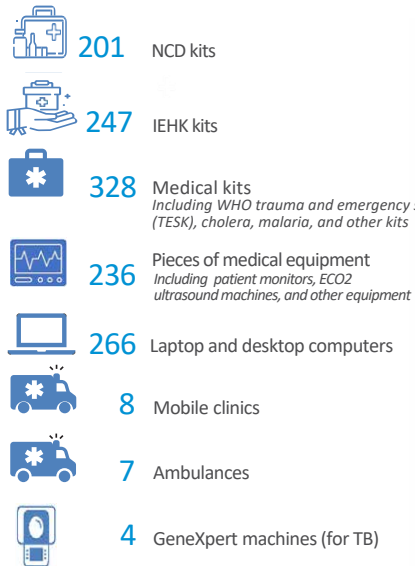
Funding received



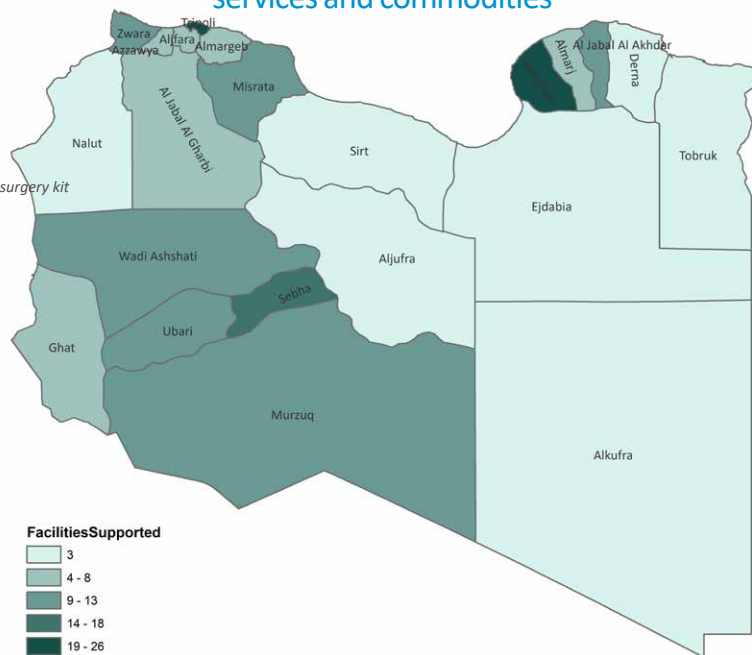
Services and Facilities Supported



Supplies Distributed



Public health facilities supported with health services and commodities



Interactive dashboards produced

[Health sector 4W 2022 HRP interactive dashboard](#) [WHO Libya operational response](#)

- The boundaries shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

PUBLIC HEALTH AREAS OF WORK

COVID-19

Although official data showed a marked decline in COVID-19 cases and deaths in Libya between April and December 2022, it has not been possible to obtain an accurate picture of the prevalence of the disease in the country. No laboratory testing data for the east (and extremely limited data from the south) have been available because the health authorities in these regions are under a separate government that does not submit information to the central authorities in Tripoli. Thus, official data on the number of COVID-19 tests carried out in 2022 cover almost exclusively those performed in the west. The mortality rate (10.5 per 100 000 population) and case fatality rate (0.6%) are almost certainly under-reported given Libya's inadequate mortality surveillance. All the above factors mask the true extent of COVID-19 in the country.

In 2022, the number of confirmed cases of COVID-19 decreased by 59% compared with 2021. Rates peaked from January to March 2022 following the emergence of the Omicron variant. There were smaller peaks in July and August (reflecting the circulation of BA.2 and BA.5.2 variants). The number of deaths decreased by 83% compared with 2021, with most deaths coinciding with the appearance of Omicron.

By the end of the year, only 18% of the population had been fully vaccinated against COVID-19. WHO recommends that countries should aim to vaccinate at least 70% of their populations, prioritizing health workers and vulnerable groups including people who are over 60 years of age and those who are immunocompromised or have underlying health conditions. Realistically, bearing in mind the vaccination rate for Libya as of the end of 2022, the country is unlikely to reach WHO's recommended target.

WHO recommends that laboratory testing capacity be maintained above 400 persons tested per 100 000 population per week. In 2022, Libya's testing rate fell to 7.5 persons per 100 000 population per week, well below WHO standards. This number represented a 67% decrease compared with 2021.

WHO also recommends that national positivity rates for COVID-19 be kept below 5%. In Libya, the positivity rate was almost 25%. This probably reflected inadequate testing (when fewer samples are tested, a higher positivity rate is likely).

COVID-19 in Libya: 24 March 2020 to 31 December 2022

507,135 confirmed cases

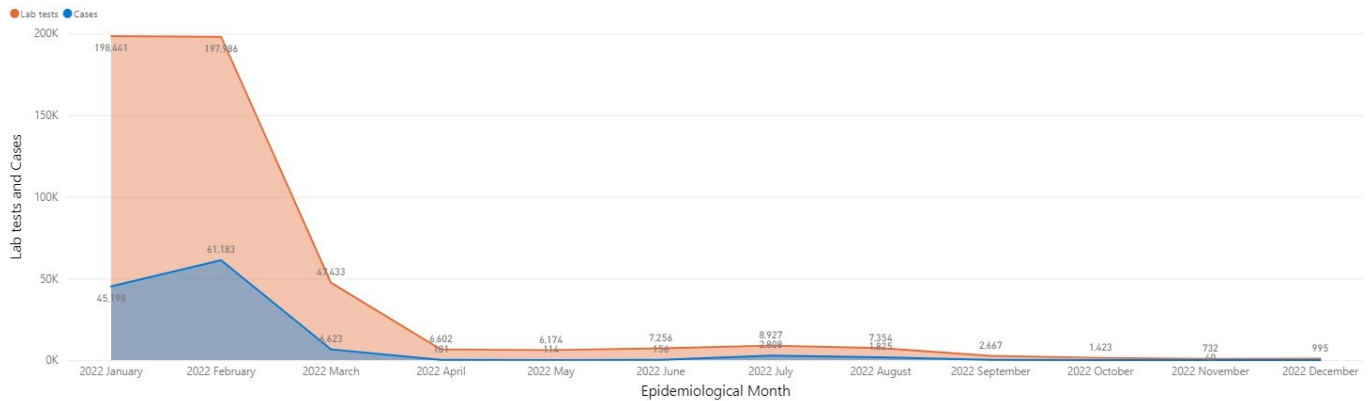
6437 deaths

2.5 million laboratory tests performed (of which 20% were confirmed positive for SARS-CoV-2)

2,316,327 people received one dose of COVID-19 vaccine

1,236,102 people received two doses of COVID-19 vaccine

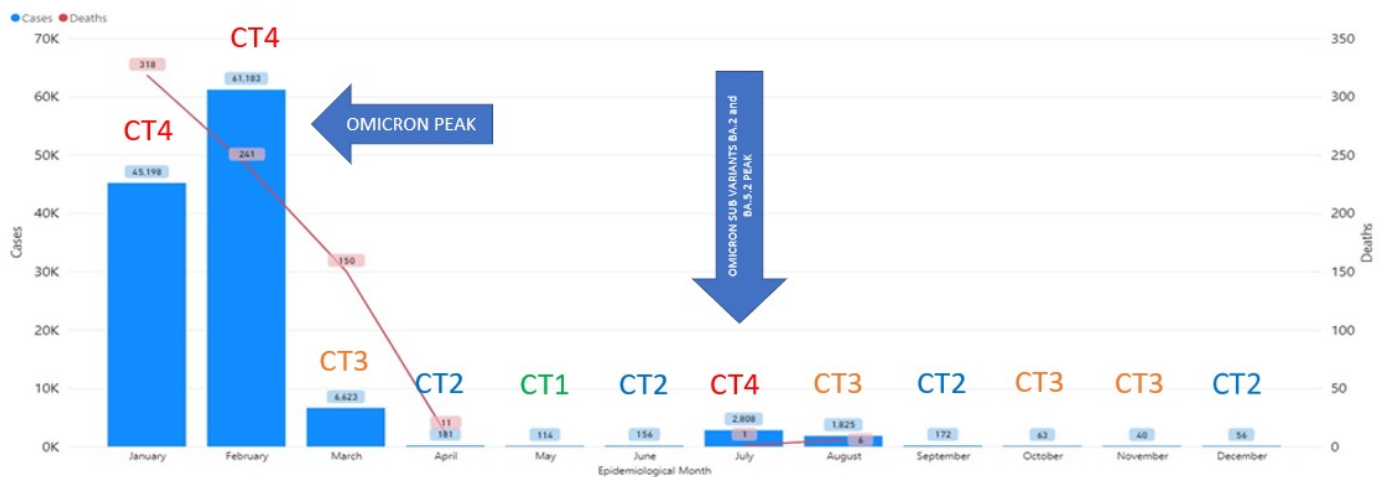
Figure 1: Number of COVID-19 laboratory tests performed vs confirmed positive cases by month in 2022 (data source: NCDC data team Libya)



The national transmission classification for Libya fluctuated throughout the year. In January, it reached CT4 (very high incidence). Between March and June, it varied between CT3, CT2 and CT1 (high,

moderate and low incidence) before reaching CT4 again in July following the circulation of BA.2 and BA.5.2 variants.

Figure 2: Change of community transmission classification by month in 2022 (data source: NCDC Libya data team)



In summary, COVID-19 remains a substantial threat given Libya's low vaccination rate, lack of data on vaccination coverage, absence of population denominators, poor testing capacity and disrupted health care system.



WHO's COVID-19 activities

WHO's COVID-19 activities in Libya were aligned with the ten pillars of Libya's national preparedness and response plan.

Pillar 1: Coordination, planning, financing, and monitoring

In 2022, WHO's coordination efforts shifted towards the vaccination campaign. WHO, UNICEF, the International Organization for Migration (IOM) and UNHCR worked with the National Centre for Disease Control (NCDC) to ensure that free access to vaccines was guaranteed for everyone, including undocumented migrants and refugees. In mid-2022, the MoH committed to reaching 40% vaccination coverage by the end of the year. However, vaccine uptake continued to decline as the sense of urgency around the COVID-19 response diminished. See pillar 10 for more information.

Throughout the year, WHO's network of field coordinators supported laboratory and COVID-19-related health needs assessments. WHO Libya received real-time information on COVID-19 from all areas of the country. WHO's offices in Tripoli, Sebha and Benghazi triangulated this information and shared it with the MoH.

Despite the political uncertainty and divided governance, WHO maintained good working relationships with national counterparts at the MoH, PHCI and other health departments and agencies. WHO worked with both the GNU in Tripoli and the GNS in the east to help ensure that people in all parts of the country had access to COVID-19 treatment and vaccination services.

Pillar 2: Risk communication, community engagement and infodemic management (RCCE)

The WCO's network of journalists and community health volunteers disseminated key messages on COVID-19 and the vaccine. The WCO trained 404 journalists and government and NGO representatives (142 men and 262 women) on RCCE. COVID-19 information materials produced by the WCO were translated into local languages and posted on social media. Radio and TV spots on COVID-19 preventive measures and vaccination were disseminated to 54 local radio stations and 17 TV channels. The WCO worked with the

NCDC on the production of similar TV and radio spots. Awareness-raising sessions in communities were conducted by trained health workers and volunteers. WHO distributed visibility materials including masks, brochures and roll-up stands to health facilities and partners. The WCO's daily COVID-19 health messages reached more than 4.8 million people via TV, radio and social media.

Pillar 3: Surveillance, epidemiological investigation, contact tracing and adjustment of public health and social measures

See the disease surveillance section of this report.

Pillar 4: Points of entry, international travel and transport, and mass gatherings

See the disease surveillance section of this report.

Pillar 5: Laboratories and diagnostics

The WCO assessed all 42 of Libya's COVID-19 laboratories throughout the year. As of the end of September 2022, only 25 (60%) laboratories were functioning at full capacity; the remainder were either closed or functioning only partially. A total of 37 laboratories (88%) were equipped with RT-PCR machines and 24 (57%) had GeneXpert machines. Laboratories in Tripoli had the highest testing capacity by far. Most laboratories reported shortages of equipment, supplies and trained staff.

In collaboration with the NCDC, WHO trained 323 laboratory technicians on COVID-19 diagnostic procedures and the management of laboratory samples. WHO donated 31 000 antigen-based rapid diagnostic tests and lab reagents, and 17 870 GeneXpert tests (one test can be used to test samples for COVID-19, influenza and respiratory syncytial virus).

Pillar 6: Infection prevention and control, and protection of health workforce

The WCO deployed nine IPC officers to provide technical support to COVID-19 isolation centres and hospitals. A total of 382 people (187 men and 195 women) were trained on IPC measures by means of formal and on-the-job training.

In 2022, the focus shifted from COVID-19-specific health facilities to health facilities in general, to help ensure that a dedicated and trained IPC focal point was available to fill critical gaps, maintain readiness for surges of COVID-19 and other emerging pathogens, and sustain the core components of IPC.

The pandemic highlighted the need for clear guidance on optimal IPC best practices. The WCO supported the NCDC's establishment of a working group to develop national IPC guidelines.

Pillar 7: Case management, clinical operations, and therapeutics

In January 2022, Libya published its COVID-19 case management guidelines, based on WHO's global guidance but adapted to the Libyan context. Also in January, following WHO's approval of the use of Tocilizumab to treat severely ill patients, the WCO helped the MoH obtain an emergency authorization to import this medicine. WHO donated 175 oxygen concentrators, 17 ventilators, 364 pulse oximeters and 153 thermometers to COVID-19 isolation centres across the country.

Pillar 8: Operational support and logistics, and supply chains

In 2022, the WCO supported 442 health facilities with medicines, supplies and equipment. It continues to monitor stock levels in health facilities and laboratories and provide supplies whenever possible.

Pillar 9: Strengthening essential health services and systems

To mitigate excess deaths due to the disruption of other health services, WHO supported the maintenance of essential health services during the pandemic. Priority services included treatments for communicable and noncommunicable diseases, maternal, newborn and child health, vaccination and emergency care. See the relevant sections of this report for more information.

Pillar 10: COVID-19 vaccination

According to the NCDC, 3 739 158 doses of vaccine had been administered as of the end of 2022. A total of 2 316 327 people had received one dose of the two-dose vaccine regimen, 1 236 102 had received two doses and 186 729 had received booster doses. Although the country had

sufficient vaccine stocks to fully immunize around 70% of its target population, only 18% had been fully vaccinated by the end of the year. The low vaccine uptake can be attributed to several factors including rumours and misinformation around the vaccine and people's reluctance to receive a second dose of a different type of vaccine. Also, the reliance on a fixed site strategy meant that vaccinators were not able to reach people in remote areas. WHO, UNICEF and IOM are working with the NCDC to improve outreach vaccination for high-priority groups, integrate COVID-19 into routine vaccination services, and strengthen communication campaigns around the vaccine. The WCO donated 100 laptops and 100 desktop computers and accessories to the NCDC for distribution to municipal vaccination data offices.

In 2021, the Sinopharm vaccine accounted for the bulk of COVID-19 vaccine stocks available in Libya. However, many people were reluctant to be vaccinated with this vaccine, either because of myths surrounding its efficacy and safety or because they had a strong preference to be vaccinated with an mRNA vaccine. The NCDC plans to procure new mRNA vaccines in 2023.

In early 2022, Libya received 252 000 doses of AstraZeneca vaccines (which do not contain mRNA). These vaccines were purchased by the Government from the COVAX Facility.

PPE provided by WHO in 2022

3 million masks

29 million gloves

392 000 gowns

54 000 goggles

39 000 face shields

2066 disinfecting materials

67 000 COVID-19 prevention kits



Community health workers attend a training workshop in Tripoli on risk communication and community engagement.

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Primary health care

Primary health care (PHC) is widely regarded as the most inclusive, equitable and cost-effective way to achieve universal health coverage. It is also key to strengthening the resilience of health systems to prepare for, respond to and recover from shocks and crises. PHC enables health systems to support a person’s health needs though the lifespan – from health promotion to disease prevention, treatment, rehabilitation and palliative care.

Currently, health spending in most countries is imbalanced towards secondary and tertiary care. However, 90% of essential health services can be delivered through PHC. In May 2022, WHO called on its Member States to reorient their health systems towards PHC⁶.

In 2022, the findings of an assessment of service readiness in 116 PHC facilities throughout Libya, conducted by the PHCI with support from WHO, showed that almost two thirds had reduced the volume of their work and/or had suspended specific treatment services. A staggering 55% had directed patients to private sector or secondary care facilities. All facilities assessed had shortages

of medicines, equipment, supplies and vaccines. These results indicate that Libya has made little progress strengthening its PHC system since the similar findings of a WHO service availability and readiness assessment were published in 2017. The timely and effective implementation of Libya’s strategy for building its health workforce, including the introduction of an EHPs, will form the basis of efforts to strengthen PHC services.

WHO is implementing a project to strengthen 17 PHC centres in six Libyan municipalities (four in the south, one in the east and one in the west). In coordination with the PHCI, WHO trained 102 district health officers on conducting rapid assessments of service availability in PHC facilities. These officers went on to assess 61 facilities in east, west and south Libya. The assessment results revealed there were severe shortage of doctors in south Libya, with nurses making up most of the health workforce in this region. These findings are consistent with those identified in Libya’s nine-year strategy (2022-2030) for building its health workforce.

⁶ Director-General’s opening remarks at Strategic Roundtable: Radical reorientation of health systems towards primary health care as the foundation of universal health coverage – 25 May 2022 (who.int).

In collaboration with national health authorities, WHO trained 64 nursing assistants on IPC and home care for COVID-19 patients with mild illness. In coordination with the Nursing College in Tripoli, 28 newly graduated nurses were trained on the basic management of COVID-19 and other emerging and re-emerging pathogens.

In early 2022, WHO and the PHCI met several times to discuss how to take forward the findings of a 2021 assessment of referral mechanisms between primary, secondary and tertiary health care levels. The assessment, conducted in Benghazi, Sebha and Tripoli, found that although the coordination of referrals from secondary to tertiary health care levels worked reasonably well, referrals from primary to secondary/tertiary health care levels were poorly organized and coordinated. WHO

and the PHCI recommended that the mechanism to refer patients from secondary to tertiary levels of care be expanded to include PHC facilities. The MoH plans to implement the recommendations over the next year. WHO and the PHCI trained a total of 62 health officers and managers from 21 districts on safe referral pathways for neonates, children, mothers and patients with life-threatening illnesses.

Between September and November 2022, in coordination with the NCDC and the National Blindness Prevention Committee, WHO supported the screening of 2457 patients in south Libya for trachoma and cataracts. A total of 227 cataract patients and five patients with trichomatous trichiasis were diagnosed and referred for surgery.



In 2022, WHO provided mobile clinics to support essential health care services in remote areas.

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Secondary health care



Oxygen is an essential medicine used to care for patients at all levels of the health care system. It is critical for treating severely ill COVID-19 patients.

The COVID-19 pandemic has highlighted the need to improve medical oxygen supplies and infrastructure globally, especially in low- and middle-income countries. In 2022, WHO hired a national biomedical engineering consultant to assess the status of Libya's oxygen supplies. Thus far, the consultant has collected data from 16 hospitals in west Libya (hospitals in the east and south will be reviewed in 2023). All assessed hospitals reported frequent shortages of oxygen, either because spare parts were lacking or because they had no capacity to create oxygen on their own using pressure swing adsorption (a technique in use since the 1970s, in which specialized equipment is used to generate oxygen by adsorbing carbon

dioxide, water vapour and other gases under high pressure). Moreover, only two hospitals had established designated oxygen stations for their intensive care units.

The data were sent to WHO's live oxygen platform repository, which aims to help countries identify their oxygen production capacities and needs, and help them make strategic decisions on how to scale up their national oxygen supplies. Once data have been collected from all parts of the country, Libya will use the information to fill gaps and determine the scope and location of medical oxygen production facilities.

In 2022, WHO procured 471 oxygen concentrators, 329 pulse oximeters and 300 000 nasal oxygen cannulas for Libyan hospitals.

Communicable diseases

Childhood vaccination

Childhood vaccination saves millions of lives every year. It is critical to the prevention and control of infectious disease outbreaks, and also one of the best health investments money can buy. It is an indisputable human right.

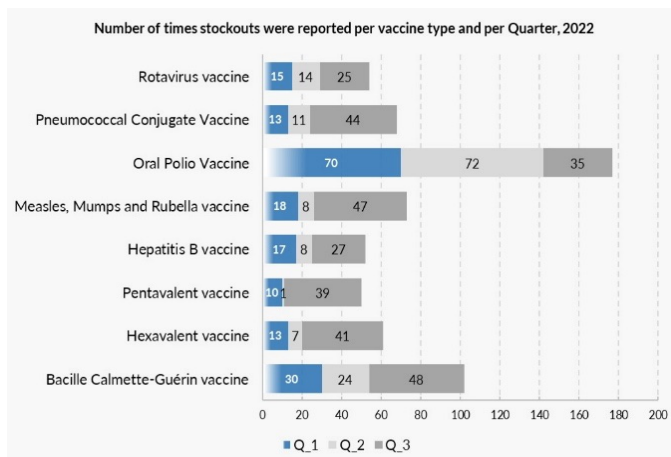
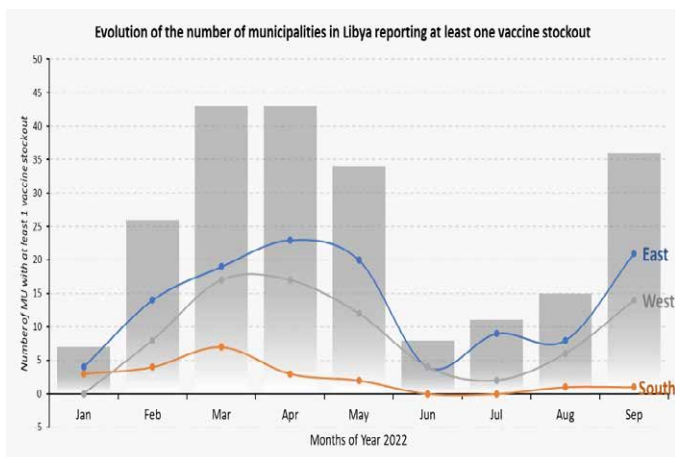
Yet, despite excellent progress, vaccination coverage has plateaued in recent years and dropped since 2020. The COVID-19 pandemic has disrupted vaccination campaigns and services and diverted health care staff and resources, resulting in the worst backslide in the past thirty years. Globally, 25 million children missed out on vaccination in 2021⁷, 6 million more than in 2019. This highlights the growing number of children at risk from devastating but preventable infectious diseases.

Libya has no earmarked budget for vaccines and no systems to track vaccine supplies, monitor usage and forecast annual needs. As a result, it continues to face regular stockouts of life-saving childhood vaccines. The graphs below illustrate the trend in the number of municipalities reporting stockouts and the frequency with which stockouts for each vaccine were reported between

January and September 2022. Stockouts of oral polio and measles, mumps and rubella vaccines were reported 177 and 73 times, respectively. Both are critical to maintaining population immunity against the epidemic-prone diseases that cause high childhood morbidity and mortality. Health facilities in east Libya suffered the most severe stockouts (the disparities between the different regions of the country may be due to poor warehouse management).



Figure1: Vaccine stockouts



⁷ COVID-19 pandemic fuels largest continued backslide in vaccinations in three decades (who.int)

In 2022, the WCO established a system to track vaccine availability across Libya. Its field coordinators regularly assessed the availability of eight essential childhood vaccines as part of their standard monitoring of the health situation in Libya's municipalities. The information was submitted via an online reporting platform to the WCO in Tripoli, which verified and analysed the data and issued monthly reports that were shared with the health authorities. Based on the WCO's analyses, in July 2022, the government released enough funds to procure vaccine stocks until the middle of 2023. WHO will continue to advocate for regular funding to secure vaccine supplies and protect the health of children in Libya.

The WCO also supported the development of vaccine monitoring and reporting tools, equipped 114 municipal vaccination supervisors with laptop

and desktop computers, and trained them in collecting, verifying and analysing vaccination data. The health authorities have adopted these tools and will use them to collect retrospective vaccine and vaccination data for 2022 and new data in 2023.



Polio immunization and surveillance activities

Libya has been polio-free since 1991. However, the presence of IDPs and refugees and the ongoing influx of migrants from polio-infected countries place it at significant risk for imported polioviruses and the circulation of vaccine-derived poliovirus type 2 (VDPV2). There has been an increase in the global prevalence of VDPV2 in children born after April 2016, when the OPV2 vaccine was removed from routine immunization in Africa. Globally, there were 495 reported cases of VDPV2 in 2022. It is increasingly prevalent in the African and Eastern Mediterranean regions.

Libya continued its acute flaccid paralysis (AFP) surveillance and polio immunization activities. A total of 101 cases of AFP were reported in 2022, a 23% increase from the 79 cases reported in 2021. This increase is likely the result of better surveillance and reporting. In addition to coordinating the collection and delivery of AFP specimens to the accredited poliovirus laboratory

in Tunisia for testing, the WCO provided stool specimen kits to the national AFP surveillance programme and trained 88 surveillance officers and hospital focal points on AFP surveillance. Throughout the year, the WCO submitted weekly AFP surveillance reports to WHO's regional and headquarters offices. A total of 112 hospital focal points and surveillance officers participated in training-of trainers courses in integrated vaccine-preventable disease surveillance, with a focus on measles and rubella.

The AFP surveillance network in Libya needs to be extremely vigilant to detect potential VDPV2 and wild poliovirus outbreaks and act quickly to contain them within 120 days⁸. The gold standard for AFP surveillance quality is determined by two indicators: at least two non-polio AFP cases per 100 000 children under the age of 15 reported annually, and at least 80% of AFP cases with two adequate stool samples. These two indicators

⁸ In accordance with WHO's Standard Operating Procedures for responding to a polio event or outbreak, a thorough outbreak response (including investigation, surveillance and vaccination) should be able to end the polio outbreak within 120 days of notification.

can be combined into a single indicator of AFP surveillance quality: a non-polio AFP rate of at least two, and specimen adequacy of at least 80%. In 2022, the non-polio AFP reporting rate for Libya was 3.95 per 100 000 children under the age of 15, and the specimen adequacy was 100%. This suggests that the surveillance system is capable of identifying cases of polio should they arise.

Algeria, which borders Libya, reported two cases of VDPV2 in July 2022. WHO trained 40 AFP surveillance officers in two districts bordering Algeria and supported the revision of Libya’s national polio outbreak preparedness and response plan and associated SOPs, which had not

been updated since 2019. The WCO is also assisting the health authorities’ efforts to prepare for the introduction of the novel OPV2 vaccine.⁹ Given the high likelihood of imported poliovirus outbreaks in Libya, the WCO will continue to support efforts to enhance the country’s ability to respond to any outbreaks.

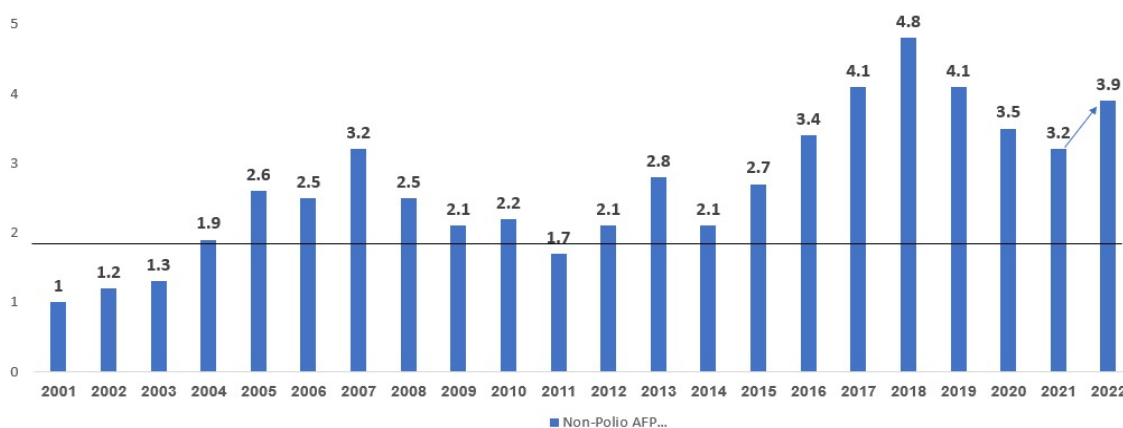
Libya plans to launch a national combined polio and measles vaccination campaign in mid-2023, with support from WHO and UNICEF. The last campaign was held in 2018 and resulted in a bivalent oral polio vaccine coverage rate of 97.7% and a measles and rubella coverage rate of 96%.

What is vaccine-derived poliovirus?

Oral polio vaccine (OPV) contains an attenuated vaccine-virus, activating an immune response in the body. When a child is immunized with OPV, the weakened vaccine-virus replicates in the intestine for a limited period, thereby developing immunity by building up antibodies. During this time, the vaccine-virus is also excreted. In areas of inadequate sanitation, this excreted vaccine-virus can spread in the immediate community (and this can offer protection to other children through ‘passive’ immunization), before eventually dying out.

On rare occasions, if a population is seriously under-immunized, an excreted vaccine-virus can continue to circulate for an extended period of time. The longer it is allowed to survive, the more genetic changes it undergoes. In very rare instances, the vaccine-virus can genetically change into a form that can paralyse – this is what is known as vaccine-derived poliovirus (VDPV).

Non-Polio AFP Rate Per 100,000 Children Under The Age of 15 | 2001 - 2022



⁹The novel oral polio2 vaccine (nOPV2) is a modified form of the monovalent oral polio vaccine type 2. Clinical trials have shown it offers comparable protection while being more genetically stable and less likely to be linked to the emergence of VDPV2 in low-immunity settings.

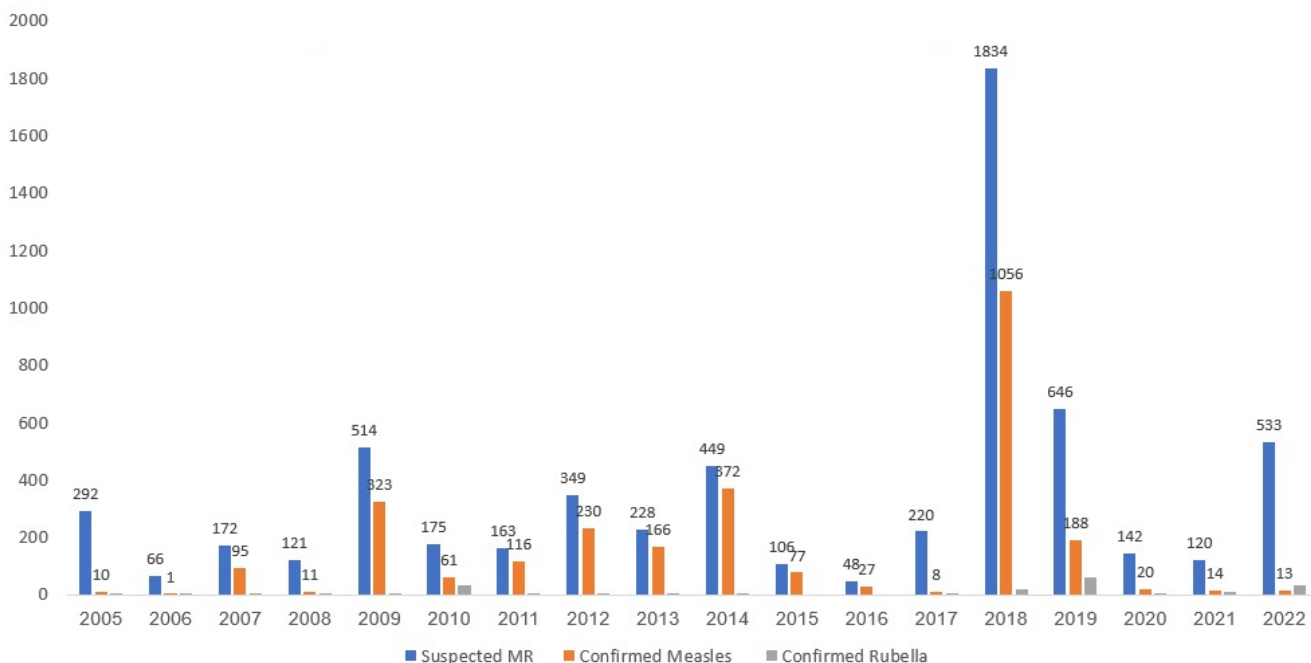
Measles

Measles is the most infectious of all the vaccine-preventable diseases. Achieving at least 95% vaccination coverage with two doses of vaccine in children across the country is needed to eliminate the threat of this highly contagious disease. Between January and September 2022, stockouts of measles, mumps and rubella vaccine were reported 73 times.

Although Libya is currently in the measles elimination phase, it continues to be at a high risk of an outbreak due to ongoing vaccine shortages, erratic surveillance, and the high turnover of surveillance staff. A total of 533 suspected measles cases were reported across Libya in 2022, a fourfold increase compared with the previous year. This rise is attributed mainly to better reporting as a result of the resumption of routine surveillance following the COVID-19 pandemic.

Vaccination coverage estimates are used to guide disease eradication and elimination efforts. They are also a good indicator of health system performance. Based on WHO-UNICEF estimates of national immunization coverage in 2021, 73% of children in Libya were estimated to have received a first dose of measles vaccine and 72% were estimated to have received a second dose. To estimate a profile for 2023, measles vaccine coverage rates in 2022 and 2023 were assumed to be the same as for 2021, the last year that vaccination coverage estimates were available. Based on these figures and the results of the combined measles and polio campaign of 2018, WHO and UNICEF estimate there will be 192 358 measles-susceptible children in 2023, nearly the same as the number of children born in 2022. Libya will remain at high risk of measles outbreaks in 2023, because the number of measles-susceptible children will outnumber the estimated birth cohort.

Suspected and confirmed Measles/Rubella Cases | 2005 - 2022

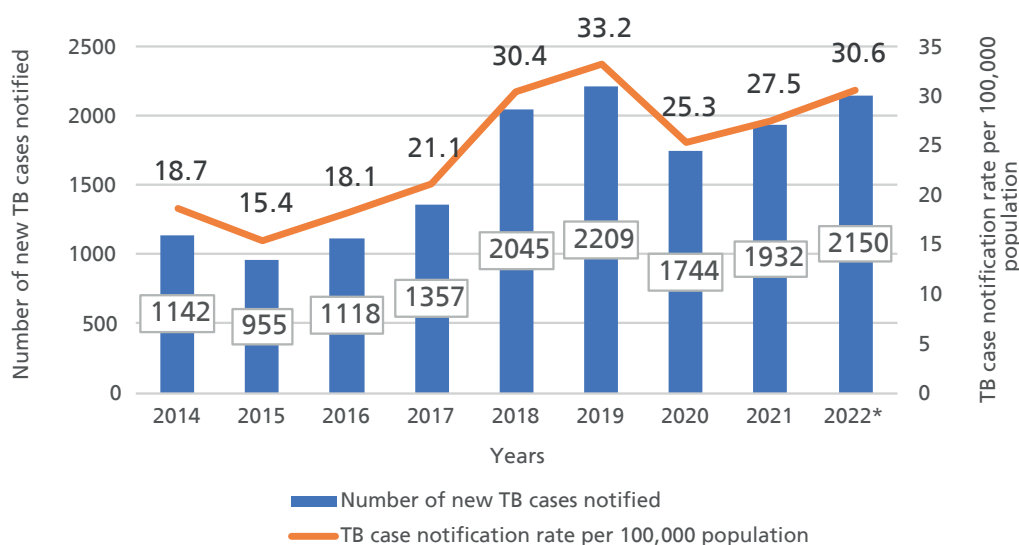


Tuberculosis

The treatment success rate is the key indicator for an effective TB programme. In 2020, the success rate for drug-susceptible TB patients in Libya initiated on treatment was 69% compared with 92% for other countries of the Eastern Mediterranean region. This shows that the country has a considerable way to go. Improvements can only be achieved through greater capacity to notify and treat TB patients, improve supervision and monitoring, and ensure an uninterrupted supply of anti-TB drugs and diagnostic products. This is especially important for children, patients with drug-resistant TB, HIV-positive individuals, migrants, refugees, prisoners and other vulnerable population groups.

According to WHO's latest Global Tuberculosis Report, 1932 new cases of TB were notified in Libya in 2021 (28 per 100 000 population). This represents an 11% increase over the 1744 new cases notified in 2020 (25 per 100 000 population). Although official TB data for 2022 have not yet been published, preliminary figures indicate that 2150 cases were notified (31 per 100 000 population). This apparent increase is likely due to the reactivation of TB diagnostic laboratories following the COVID-19 pandemic, as well as the overall strengthening of TB services in the country.

TB case notification trends for Libya 2014-2022



Although the treatment success rate for TB patients in Libya remains low, it has increased by over 10% since 2018, largely because of considerable efforts by WHO and partners to strengthen the National TB Programme (NTP) by providing equipment and supplies, training NTP staff and improving TB surveillance. An ongoing project jointly implemented by WHO and IOM focuses on improving access to TB services for vulnerable population groups, especially migrants, refugees and IDPs.

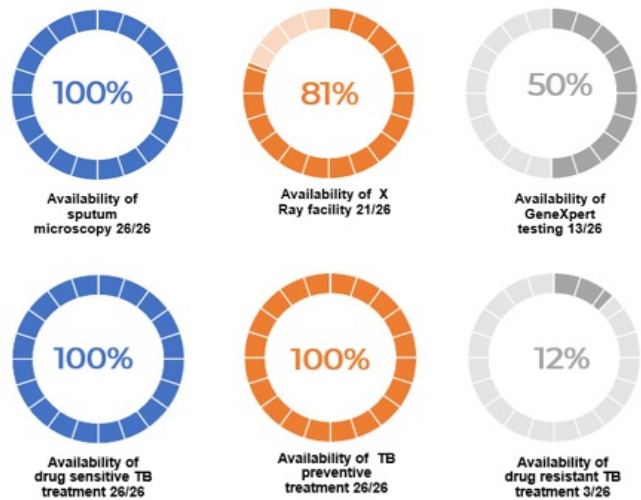
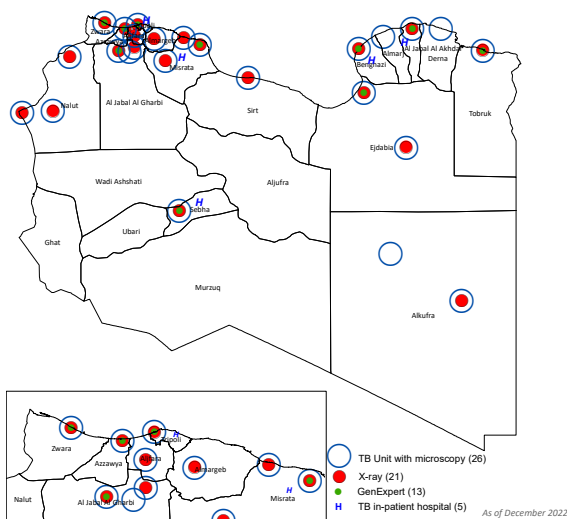
The NCDC runs 26 TB centres across the country. (Another six centres have been extensively damaged and forced to close.) In 2022, WHO procured four GeneXpert machines and 2500 GeneXpert cartridges and donated them to the NCDC. Thanks in part to this and other support from WHO, all 26 centres now offer full treatment services for patients with drug-sensitive TB. However, only three centres offer services for patients with drug-resistant TB. Although sputum microscopy is available in all centres, only 21 have

X-ray equipment and only 13 have GeneXpert machines. With support from WHO, the NTP plans to fully refurbish all centres in 2023, including by redistributing some of the equipment procured for the COVID-19 response.

In 2022, the NTP resumed supervisory visits to TB centres for the first time in several years.



Tuberculosis prevention and care services in Libya | 2022



In July 2022, WHO convened a TB awareness workshop for 54 journalists. Throughout the year, it distributed TB awareness messages for the general public in local languages via social media. A total of 267 health workers across the country were trained in TB programme management and TB preventive treatment. Another 79 staff were trained in neighbouring Tunisia.

WHO supported the finalization of an epidemiological review and the development of a national strategic plan to tackle TB over the next five years. With support from WHO, the national TB guidelines were updated and published. Despite this progress, ongoing political instability has hampered attempts to secure reliable funding for TB centres and staff.



HIV

HIV/AIDS receives little political attention or investment in many countries of the Eastern Mediterranean, including Libya. New HIV infections in the Middle East and North Africa have increased by 33% since 2010. Although AIDS-related mortality in the region declined by 22% over the same period, this is significantly less than the global decline of 52%. Data from 2021 indicated that only 67% of people living with HIV (PLHIV) in the EMR knew their HIV status¹¹. According to the Libyan National AIDS Programme (NAP), 305 new HIV infections were reported in 2021. (Data for 2022 are not yet available.) The official number of HIV cases in the country is 6983, but the real number is estimated to be at least 19% higher, mainly because of insufficient testing capacity, the paucity of HIV services and the stigma surrounding the disease.

Although antiretroviral therapy (ART) is free for all Libyan citizens, repeated stockouts have resulted in treatment interruptions and led to increasing numbers of PLHIV admitted to health facilities with advanced stages of the disease. Because physicians are not able to prescribe the optimal ART drug combinations according to Libyan guidelines, PLHIV may be switched to formulations that are not guideline-compliant, or 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 deaths among PLHIV.

Libya's pharmaceutical management and supply chain is a complex, multi-tiered system with highly compartmentalized distribution channels. As currently structured, it cannot meet the needs of either PLHIV or the healthcare providers who

serve them. Only four of Libya's eight ART centres are fully functioning (Tripoli University Hospital, Tripoli Central Hospital, Benghazi Medical Centre and the Benghazi Centre for Infectious Diseases and Immunology). There are fewer than 10 HIV testing centres in the entire country. The widespread stigma around HIV extends even to health care workers.

In 2022, the WCO met the MoH several times to advocate for regular funding for the NAP and the alignment of NAP activities with WHO's Regional Action Plan on HIV, hepatitis and STIs. As a result of these efforts, the NAP has initiated the preparation of a national plan to tackle HIV in Libya. In addition, the WCO procured enough HIV drugs to treat 2880 adults and 120 children for three months and distributed them to all regions of the country. It also supported the screening of patients for both TB and HIV in NCDC branches and TB centres.

Leprosy

The incidence of leprosy in Libya has declined steadily over the past thirty years; only one or two cases were reported in 2019 and 2020. Given concerns that these low rates could be due to the absence of active case finding (the last screening campaign was in 2008), WHO and the National Leprosy Control Programme trained more than 100 dermatologists in diagnosing and treating patients with the disease. In 2022, five new cases of leprosy were detected. WHO and the MoH plan to further improve leprosy surveillance and diagnostics capacity by training EWARD officers and laboratory technicians in eight municipalities.

¹⁰ https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update_en.pdf

Vector-borne diseases

Leishmaniasis

By 2022, the number of cases of cutaneous leishmaniasis (CL) had decreased significantly (1099 compared with 6724 cases reported in 2019). This was attributed to the decline in the number of IDPs following the cessation of hostilities in west Libya.

With support from WHO, the NCDC reactivated CL treatment services in 23 clinics located in endemic areas. WHO has been the sole provider of antileishmanial medicines in Libya for the past four years. In 2022, WHO procured rapid diagnostic kits to improve the diagnosis of CL and supported the deployment of a team of dermatologists to Tawergha city, one of the areas where CL is endemic, to treat patients with this and other skin diseases. The team recorded 17 436 consultations and follow-up visits in 2022.

Malaria

In 1973, Libya was declared malaria free. However, in 2021, there were 52 confirmed cases of the disease in central Libya (Al Jufra and Sirte) and south Libya (Al Kufra, Murzuk and Sebha). Between January and December 2022, another 92 new cases of malaria were diagnosed in the south, east and west. With the exception of a handful of patients who had no history of travel, all cases were imported, making it difficult to confirm local transmission.

With support from WHO, the NCDC is investigating the presence of the vector in the areas where the cases were recorded. In March 2022, WHO and the NCDC jointly assessed the vector control programme in south Libya. The NCDC is strengthening malaria surveillance, laboratory diagnosis and case management in the south. In July 2022, WHO supported training for 55 laboratory technicians.

Disease surveillance and response

WHO's disease Early Warning and Response Network (EWARN) is still the only functioning disease surveillance system in Libya. EWARN monitors 20 communicable diseases that comprise two categories: those (such as measles) that are highly contagious and/or life-threatening and must be reported within 24 hours, and those (such as acute jaundice syndrome) that are less contagious or life-threatening and can be reported on a weekly basis. The NCDC's surveillance team verifies all alerts within 48 hours, regardless of their category. The data submitted by EWARN reporting sites are consolidated and analysed by the NCDC and the results are published in weekly epidemiological bulletins.

EWARN performance standards stipulate that at least 80% of alerts received should be verified within 48 to 72 hours, and at least 80% of weekly reports should be completed and submitted on time. In 2022, 84% of EWARN alerts in Libya were investigated and responded to within 72 hours, exceeding the above performance standard. However, only 75% of reporting sites submitted regular data and only 55% of sites provided complete data.

There were no major disease outbreaks in Libya in 2022. Minor outbreaks of acute jaundice syndrome linked to hepatitis A infection, especially among school children, were reported in Benghazi, Igdabya and Subrata. The NCDC supported strengthened sanitation measures and hygiene awareness sessions in schools in the areas that reported cases of the disease.

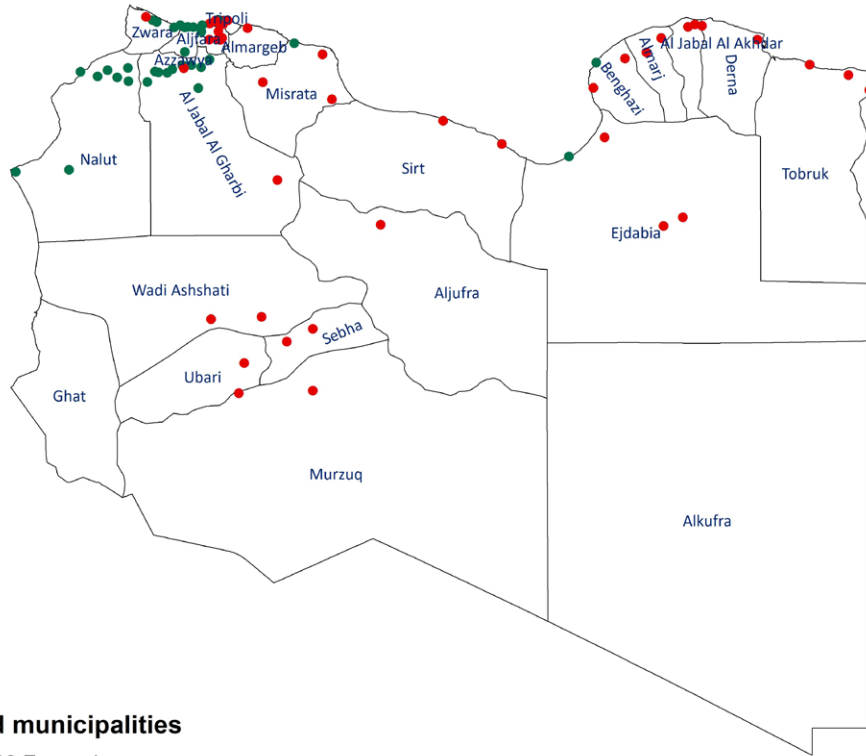
WHO continued to implement the recommendations of a comprehensive evaluation of EWARN that was conducted in 2021. In August and September 2022, in collaboration with the NCDC, it held four training workshops for surveillance officers working in 73 health facilities. In September, these facilities (including six private clinics) were added to EWARN, bringing the total number of reporting sites to 253 (an increase of 40% compared with 2022). WHO also donated 125 desktop computers to municipal surveillance officers to support timely reporting to EWARN. WHO remains on course to reach its target of 300 reporting sites by the end of 2023. Planned activities in 2023 include refresher training for surveillance officers and laboratory technicians and records management workshops for staff in reporting sites.

The WCO trained 101 health staff in Libyan airports, seaports and ground border crossing points on the International Health Regulations and WHO's COVID-19 guidelines for points of entry.

Notifiable diseases under the Libyan EWARN (those marked with an asterisk must be reported within 24 hours)

1. Acute flaccid paralysis*
2. Anthrax*
3. Acute watery diarrhoea/cholera*
4. Diphtheria*
5. Food and chemical poisoning*
6. Haemorrhagic fever*
7. COVID-19*
8. Measles*
9. Meningitis*
10. Neonatal tetanus*
11. Plague*
12. Rabies*
13. Unexpected or unusual health events*
14. Acute upper respiratory infections
15. Lower respiratory infections (suspected pneumonia)
16. Acute diarrhoea
17. Bloody diarrhoea
18. Acute jaundice syndrome
19. Pertussis
20. Typhus

EWARN 2022 | Expansion of reporting sentinel sites



Targeted municipalities

- 2022 Expansion
- 2023 Planned expansion



Influenza surveillance

In the second half of 2022, rates of influenza rose sharply worldwide, partly because of disrupted surveillance during the COVID-19 pandemic. There was also an increase in people's susceptibility to the influenza virus due to low rates of the disease in the preceding year. WHO has encouraged countries in the northern hemisphere to increase integrated surveillance for influenza and COVID-19. Libya has established three sentinel sites for influenza surveillance, which are sending weekly specimens from suspected cases to the NCDC's public health reference laboratory. WHO has trained 29 staff from the three sites on integrated sentinel surveillance for influenza and COVID-19. A separate sentinel site for severe acute respiratory illness has been established in Tripoli. Also, for the first time ever, Libya is sharing information on influenza surveillance with WHO for inclusion in the weekly and monthly epidemiological reports published by WHO's Regional Office for the Eastern Mediterranean. In 2023, WHO plans to expand influenza surveillance to four additional sites (two in Sebha and two in Benghazi).

Event-based surveillance

Event-based public health surveillance (EBS) is defined as the organized and rapid capture of reports, stories, rumours and other information about events that could pose serious risks to public health. WHO's comprehensive assessment of the Libyan EWARN was the basis for developing a plan to integrate EBS into the national system to help Libya better prepare for future pandemics. With support from WHO, the NCDC has prepared national guidelines and training materials for the EBS network and has begun piloting the system in five municipalities. A total of 10 surveillance officers and 50 volunteers were trained in EBS (including how to detect the early signs of a potential public health event).

Laboratory capacity

WHO procured 10 000 GeneXpert cartridges that can detect COVID-19, influenza and respiratory syncytial virus, as well as PCR laboratory confirmation reagents, rapid antigen tests and virus sampling kits. All supplies were given to the NCDC for distribution to laboratories throughout the country. A total of 171 health workers were trained in managing laboratory samples. Another 54 technicians from 12 public health laboratories were trained in information management and the development of standard operating procedures.

Rapid response teams

WHO trained 58 municipal rapid response teams from the west, central and Nafosa mountain regions. A total of 105 trained RRTs now cover all municipalities in Libya. Each team comprises a data manager, a surveillance manager, a physician, a surveillance officer and a laboratory technician.

Integrated disease surveillance and response

In a highly interconnected world, regional and global networks for disease surveillance are vital for controlling communicable diseases and preventing their spread across borders. In October 2021, all Member States of the Eastern Mediterranean region agreed to establish integrated national disease surveillance systems (IDSRs)¹¹, linked to global surveillance systems, by the end of 2025. WHO will assist the NCDC by providing guidelines, tools and training to support the development of an IDSR in Libya.

¹¹ EMRC68R3-eng.pdf (who.int)

Noncommunicable diseases



In June 2022, a team from the Bambino Gesù Children's Hospital in Rome visited Benghazi Children's Hospital to assess its oncology services.

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Noncommunicable diseases (NCDs) including heart disease, stroke, cancer and diabetes are responsible for 74% of all deaths worldwide. More than three-quarters of all NCD deaths occur in low- and middle-income countries. In Libya, 78% of the overall burden of disease is attributable to NCDs. The NCD epidemic has devastating health consequences for individuals, families and communities, and threatens to overwhelm health systems. The socioeconomic costs associated with NCDs make the prevention and control of these diseases a major priority for the 21st century.

At the end of 2022, the Libyan NCDC launched a survey on the prevalence of NCDs in the country. The WHO survey, known as STEPS, is a simple, standardized method for collecting, analysing and disseminating data on key NCD risk factors in countries. The survey instrument covers behavioural risk factors (tobacco use, alcohol use, physical inactivity, unhealthy diet) and biological

risk factors (obesity, raised blood pressure, raised blood glucose, and abnormal blood lipid). To date, over 120 WHO Member States have implemented the STEPS survey. By using the same standardized questions and protocols, countries can use the information yielded under STEPS not only to monitor within-country trends but to make comparisons across countries. The last national STEPS survey in Libya dates back to 2008.

To prepare for the survey, WHO trained 15 senior staff from the MoH on the STEPS methodology in October 2022. They went on to train 78 staff in 23 municipalities who will be responsible for gathering data from a core sample of 6333 families across the country chosen in coordination with Libya's National Statistics Bureau. The NCDC will use the information to monitor NCD risk factors, determine public health priorities and develop strategies to tackle NCDs.

Cancer represents 14% of the burden of NCDs in Libya, but there are critical shortages of cancer medicines in Libyan hospitals. In 2022, the WCO launched a project to improve the health outcomes of 722 child cancer patients enrolled for treatment in Libya's two main referral hospitals in Benghazi and Tripoli. It has procured enough equipment, chemotherapy medicines and supplies to treat all 722 children for a period of 18 months. In June 2022, a team from Bambino Gesù Children's Hospital in Rome visited the Children's Hospital in Benghazi to assess its paediatric cancer services. Six Libyan physicians from Benghazi subsequently completed one-month residential training at the hospital in Rome. The hospital in Tripoli will undergo the same assessment and training in 2023.

High blood pressure kills more people than any other condition. Reducing blood pressure prevents stroke, heart attack, kidney damage, and other health problems. Standardized drug- and dose-specific treatment protocols have been shown to be superior to individual treatment, and also facilitate

logistics, procurement and data collection. In collaboration with the MoH, NCDC and Libyan Cardiac Society, WHO trained 117 physicians, 28 nurses and 26 district health managers on managing patients with cardiovascular disease in PHC settings. The training was based on WHO's HEARTS package, which sets out ways to develop a standard treatment protocol for a large-scale hypertension treatment programme.

WHO supported NCD awareness-raising sessions for 107 community health workers, and trained 36 dentists and 30 nutritionists in PHC facilities on oral health and Libya's national nutrition guidelines. WHO also continued to support the national tobacco control programme. The first multi-sectoral meeting on tobacco control took place in August 2022.

Lastly, WHO distributed 201 NCD kits to health facilities across the country. The kits contained enough medicines and supplies to cover the needs of 2 million NCD patients for three months.



Specialists from Benghazi Children's Hospital arrive at the Bambino Gesù Children's Hospital in Rome for a one-month residential training.

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Mental health

One of the most striking aspects of the far-reaching effects of the COVID-19 pandemic is the huge toll it has taken on people's mental health. Rates of already common conditions such as depression and anxiety went up by more than 25% in the first year of the pandemic, adding to the nearly one billion people who were living with a mental disorder¹². In Libya, the pandemic came on top of a decade-long conflict that had already resulted in extended physical and/or mental suffering for many Libyans.

WHO continued implementing a pilot project, initiated in 2021, to introduce mental health services in 30 PHC facilities and 30 schools in 18 municipalities across Libya. In 2022, the WCO completed the distribution of psychotropic medicines to all 30 PHC facilities as well as to two psychiatric hospitals in Tripoli and Benghazi, a mental health clinic in Kufra and an addiction rehabilitation centre in Misrata. WHO trained a total of 954 people:

- 171 nurses on WHO's psychological first aid guide
- 232 general practitioners (GPs) on WHO's mental health-GAP-intervention guide (mh-GAP-IG). (This number includes 70 GPs who received refresher training.)
- 484 teachers, social workers and counsellors on the WHO school mental health package
- 22 community mental health volunteers on psychological first aid as well as awareness-raising around mental health issues
- 45 journalists on responsible reporting on suicide and other sensitive mental health topics.

A total of 134 GPs who completed phase 1 and phase 2 mh-GAP-IG training are now able to treat and prescribe psychotropic medicines for

mental health patients in all 30 PHC facilities targeted under the project. In addition, 171 nurses in the same facilities are able to provide psychosocial support. Eleven national mental health professionals are supervising these staff and providing on-the-job guidance.

In June 2022, WHO supported the participation of 12 senior MoH, NCDC and PHCI staff in a mental health training course held at the American University in Cairo. The course is designed to help mental health managers develop the skills they need to scale up mental health interventions in resource-constrained settings and promote the human rights of people with mental disorders.

Lastly and most importantly, WHO helped the national authorities develop Libya's first-ever national strategy and three-year action plan to improve mental health services and outcomes in the country. WHO organized two consultative workshops, held simultaneously in Tripoli and Benghazi, that brought together key stakeholders to prepare a first draft of the strategy, with the support of an international consultant recruited by WHO. The strategy has been finalized and is being reviewed by a national steering committee before it is submitted to the MoH for endorsement.



¹² WHO World Mental Health report, 2022

Reproductive, maternal, newborn, child and adolescent health

Globally, around a quarter of all maternal deaths occur during pregnancy. High-quality reproductive and maternal health services can prevent most of those deaths and save the lives of mothers and their babies.

WHO's assessment of antenatal care in east and south Libya, conducted in 2021, showed that comprehensive emergency obstetric care (CemOC) services were available in just over half of hospitals in the east, while less than a quarter of hospitals in the south had these services. No PHC facilities in the south and only 2% in the east had CemOC services. Alarmingly, more than half of PHC facilities in the east and over 80% of PHC facilities in the south did not offer even basic antenatal care. The vast, sparsely populated and historically neglected south suffered particularly severe shortages of staff, medicines and supplies.

In coordination with district health authorities, WHO deployed nine mobile medical teams (six in the south, two in the west and one in the east) to provide reproductive and maternal health services, including ante- and postnatal care and emergency obstetric care. More than 50 000 reproductive and maternal health care consultations were provided in 2022. WHO also trained 44 senior nurses and physicians on Libya's new package of reproductive health interventions for pregnancy, childbirth and after delivery. The package includes interim guidance on maintaining reproductive and maternal health services during the COVID-19 pandemic and treating pregnant COVID-19 patients.

Pneumonia, diarrhoea, malaria, measles and malnutrition account for more than 70% of global deaths in children under five years of age.

Although health workers often know how to treat specific diseases, they may not be trained in understanding the relationship between different childhood illnesses. (For example, diarrhoea can be both a cause and effect of malnutrition.) In 1997, WHO and UNICEF developed guidelines on the integrated management of childhood illness (IMCI). Over 100 countries have adopted the IMCI approach. However, the results of a WHO assessment in south and east Libya revealed that almost no facilities in the south and less than 40% of facilities in the east had a paediatrician or other physician who had been trained on the IMCI. In 2022, in collaboration with the PHCI, WHO trained 58 PHC physicians on the IMCI guidelines. The MoH plans to establish a roster of national trainers to disseminate the guidelines in at least 90 PHC facilities, as well as train nursing staff and community health workers through cascade workshops and supportive supervision.

In coordination with the MoH, WHO deployed 12 paediatricians to hard-to-reach areas in the south and post-conflict zones in the west and east. These paediatricians, who worked as part of mobile medical teams, provided 27 456 consultations in 2022.



A community health volunteer in Sebratha explains the importance of COVID-19 preventive measures and vaccination.

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Gender-based violence

According to the last available data (2021) on gender-based violence (GBV) in Libya, approximately 153 000 people (90 000 women and 41 000 girls) were most at risk of GBV. Migrant and refugee women, many of whom have no recognized status, accounted for more than half this number. They are not only at increased risk of sexual exploitation and abuse but also have limited access to GBV services. Migrants and refugees living in detention centres are especially vulnerable.

Health services can provide critical, timely interventions that prevent, mitigate or treat some of the health consequences of GBV and connect survivors to services that improve their health and well-being. However, such services are very limited in Libya. Moreover, GBV survivors are often reluctant to seek help due to stigma and fear of discrimination and reprisals, which can have severe consequences for their physical and mental health.

WHO is working to support the expansion of GBV services in the country. In collaboration with the MoH, in 2022 it completed the adaptation of WHO's clinical handbook on health care for women subjected to intimate partner violence

or sexual violence. Once the handbook has been endorsed by the MoH, GBV services will be recognized as an integral part of Libya's health care system. With support from WHO, the MoH plans to train national health service providers on the handbook.

Integrating GBV care into health and community services increases awareness and builds capacity at local level. The WCO trained 19 staff working in Women's Development and Training Centres¹³ on strengthening the community-based response to GBV and mental health and psychosocial support services. The training focused on understanding gender and GBV concepts and the effects of GBV on mental and physical health. The centres serve as safe spaces for women, promoting their economic, social and political empowerment.

PHC facilities are a critical entry point for helping GBV survivors. In 2022, the WCO trained 144 PHC physicians (25 male and 119 female) and 68 nurses and midwives (15 male and 53 female) on GBV services. The workshop participants were chosen from 30 PHC facilities across the country that have been selected by WHO as part of a separate project to strengthen PHC services.



¹³ The centres are managed by Gesellschaft für Internationale Zusammenarbeit.

Health information system

A well-functioning health information system (HIS) generates data that allow national authorities to identify gaps in service, identify trends and ensure that health resources are directed to where they are most needed. Libya's HIS has been badly disrupted by prolonged conflict and fragmented governance. In different parts of the country, local health authorities have established their own ad hoc information systems that are not being streamlined through a unified reporting system. Moreover, the MoH in Tripoli tends to focus on data collection rather than analysis and decision making. The result is a broken system at all levels.

Libya's five-year plan to strengthen its HIS came to an end in 2022. Its main goal was to strengthen data collection and analysis by launching the District Health Information System 2 (DHIS2)¹⁴ across the country, integrating vertical programmes with the system, and using the information yielded to develop evidence-based policies and action plans. Despite concerted efforts by WHO and other agencies including UNICEF, IOM, GIZ, International Rescue Committee (IRC), International Medical Corps (IMC) and UNFPA, this goal has been only partly achieved. Although 84% of Libya's municipalities have now been trained on using the DHIS2, reporting is inadequate and efforts to align vertical programmes with the DHIS2 have stalled. Moreover, the integration of Libya's civil registration and vital statistics system into the DHIS2 has been postponed until 2023.

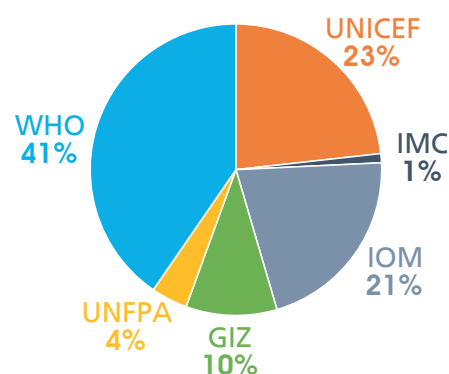
In 2022, the MoH's Health Information Centre continued to lead the roll-out of the DHIS2 across the country, with close support from WHO and partners. The WCO supported the introduction of the DHIS2 in another 24 of Libya's 102 municipalities. Almost 500 people including health staff in PHC centres and hospitals, municipal focal points and other staff were trained on the DHIS2 as well as on the analysis and management of its data. WHO distributed laptops and tablet

computers to end users to support data entry, and monitored the completeness, timeliness and accuracy of reporting. The WCO plans to launch the DHIS2 in another 16 municipalities in early 2023.

Despite good geographic coverage, DHIS2 reporting compliance was poor and the quality varied widely among municipalities. While Benghazi had the highest rates of reporting compliance and Ain Zara municipality (west Libya) met its reporting targets, Shahat municipality (east Libya) achieved only 40% of its targets. The underlying reasons for these uneven reporting rates included lack of equipment, low staff morale and high turnover, and Libya's fragmented governance. In 2023, WHO will work with the MoH to improve the quality of reporting from municipalities. This will, in turn, improve the MoH's ability to make meaningful use of the DHIS2 data collected throughout the country.

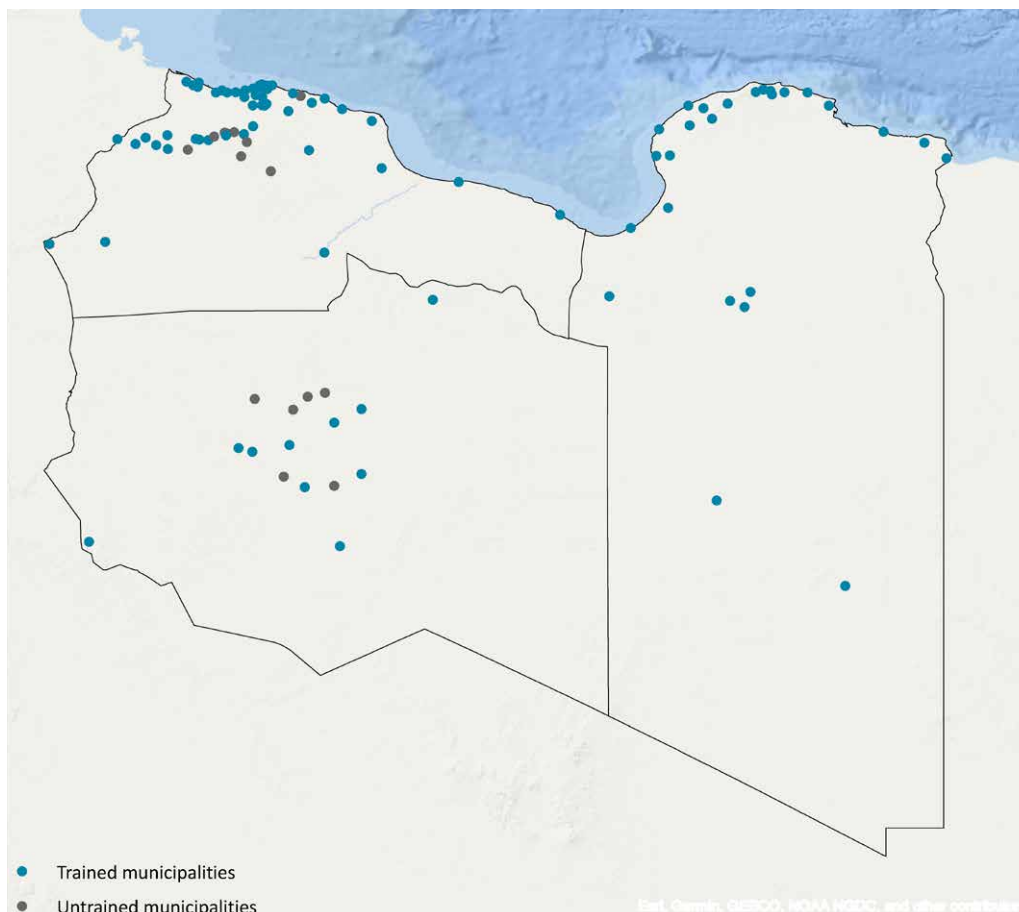
However, a harmonized HIS also depends on a unified MoH and an undivided country. Efforts to improve the Libyan HIS are unlikely to progress significantly until the MoH overcomes its current fragmentation and all parts of Libya resolve their deep political differences.

Agencies supporting the implementation of the DHIS2 in Libya



¹⁴ More than 70 countries worldwide use the DHIS2 to collect and analyse health data. 2.4 billion people (30% of the world's population) live in countries where DHIS2 is used. DHIS2 is offered free of charge as a global public good.

Coverage of DHIS2 implementation per municipality | 2022



WHO continued supporting national efforts to strengthen links between humanitarian and development information streams. In 2022, the MoH officially adopted WHO's Health Resources and Services Availability Monitoring System (HeRAMS) to assess the status of functionality and service availability of 120 public hospitals across the country.

The WCO's dedicated health information management unit provided technical support to WHO programmes, MoH counterparts and health sector partners in Libya. The data analyses, infographs and other information materials produced by the WCO supported WHO-MoH planning and coordination of health interventions. For example, the NCDC and the MoH both used WCO data to make decisions on the distribution of laboratory supplies and equipment and the establishment of oxygen facilities in public hospitals.

The WCO developed web-based data entry and reporting tools for use by its field coordinators, and linked the information generated to an interactive dashboard that produced monthly infographs on the health situation, challenges and needs. It also developed an interactive platform to visualize WHO Libya's operational response throughout the year. On behalf of its health partners, the WCO continued to manage the health sector's "Who does What, Where and When" (4Ws) tool and produced monthly health sector operational response reports.

The WCO tracked attacks on health care and reported confirmed incidents to WHO's Surveillance System for Attacks on Health Care. In 2022, there were nine attacks on healthcare in Libya that killed one person and injured eight others.

The WCO's COVID-19 infographic dashboard was updated weekly. It tracked the number of COVID-19 cases and deaths across the country. The WCO also contributed to the monthly COVID-19 activity reports prepared by the United Nations Office for the Coordination of Humanitarian Affairs.



WHO provides the MoH's Health Information Centre with IT equipment to strengthen data analysis.

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LEADING THE HEALTH SECTOR



Senior WHO representatives meet the acting Minister of Health to discuss emergency preparedness and essential health care services for people in need.

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In 2022, WHO continued to lead over 30 health cluster partners in Libya. It coordinated the production of monthly health sector bulletins and operational updates that tracked political developments in the country, monitored the evolving health situation and the number of beneficiaries reached with health services, and identified critical gaps in the response.

The WCO represented the health sector in meetings with the Special Representative of the Secretary-General for Libya and other senior UN officials. On behalf of its partners, it regularly briefed donors and the diplomatic corps on the health situation and progress resolving difficult issues.

In late 2022, the United Nations in Libya shifted from a humanitarian mode to an approach known as the humanitarian-development-peace nexus. The UN Sustainable Development Cooperation Framework for 2023-2025, prepared in partnership with the government and stakeholders across the country, will guide the UN's collective work in Libya over the next three years. The framework integrates a human rights-based approach across its interventions to help ensure that those

most vulnerable and at risk of being left behind are at the centre of Libya's peacebuilding and development agenda.

As a result of this change, the humanitarian sectors in Libya were deactivated at the end of 2022 and are being replaced by development-based coordination structures. The annual humanitarian response plans will also be discontinued. WHO and other UN agencies and partners are beginning the transition from humanitarian programming to longer-term recovery and development efforts in the context of a protracted emergency. WHO will continue to monitor health risks and needs and the performance of the health sector. It will brief health partners on the implications for the health sector of socio-political, humanitarian and security developments. It will also work with development agencies and partners to support an integrated long-term response, monitor the impacts of health interventions, promote technical standards and best practices, and provide technical expertise to health authorities at all levels.

For more information, see the "Looking Ahead" section at the end of this report.

ACCOUNTABILITY TO AFFECTED POPULATIONS

The Inter-Agency Standing Committee¹⁵ defines accountability to affected populations as an active commitment by humanitarian agencies to use power responsibly by taking account of, giving account to, and being held to account by the people they seek to assist. The WCO uses the following mechanisms to monitor accountability:

1. It participates in the common feedback mechanism (CFM) for humanitarian organizations in Libya. The CFM provides a toll-free, country-wide number that people can call to obtain information on humanitarian assistance programmes, submit feedback on services provided and obtain referrals to the humanitarian organizations best-suited to handle their requests and/or complaints. All participating organizations are required to review and resolve issues within an agreed time frame. The CFM allows the humanitarian community to collect feedback from affected people, better understand their needs and speedily resolve their problems. Of the 74 750 requests received by the CFM call centre between January and December 2022, 6617 (8.85%) were related to health. Most of these callers were refugees seeking health care. General medical consultations, gastroenterology and mental health care were the most commonly sought services (41%, 7% and 6%, respectively). None of the complaints made by callers was related to services supported or provided by WHO.
2. A third party monitor evaluates the relevance and effectiveness of the WCO's operations in all parts of the country. This includes interviewing project beneficiaries to obtain their feedback on whether the WCO's work is making a positive difference.
3. In all 22 districts of Libya, WHO's field coordinators assess evolving health needs, meet with local and municipal health officials to review WHO's projects, visit health facilities to monitor the rational use of medicines, and regularly prepare reports for the WCO in Tripoli.

The WCO's humanitarian projects use the most recent data from health and multi-sectoral needs analyses, as well as up-to-date information on the number and whereabouts of IDPs, migrants and refugees across the country. The WCO holds regular consultations with the MoH, local and regional health officials and community representatives to review planned and ongoing projects and determine whether their outcomes are achievable, realistic and will result in tangible health gains.

¹⁵ The Inter-Agency Standing Committee was created in 1991. It is the highest-level humanitarian coordination forum of the United Nations system. It brings together the executive heads of 18 organizations and consortia to formulate policy, set strategic priorities and mobilize resources in response to humanitarian crises.

COUNTRY OFFICE STRUCTURE, INTERNAL OVERSIGHT AND MANAGEMENT

Internal oversight

As part of its plan of work for 2022, WHO's Office of Internal Oversight Services conducted a second audit of the WCO to assess progress made since the first audit covering the period January 2018 to May 2019, before the current WHO Representative took over management of the office.

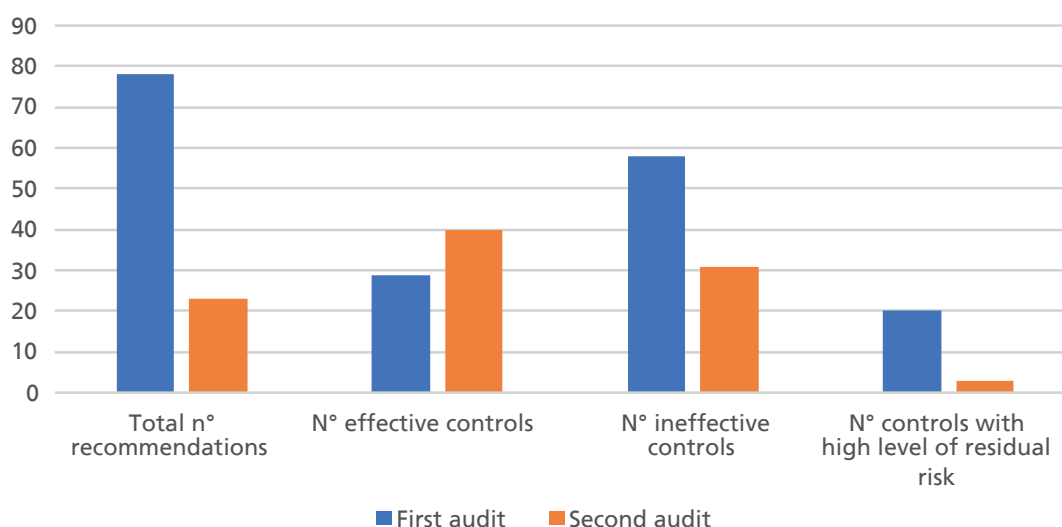
Results of first audit

The first audit report found that the WCO's financial and administrative controls were unsatisfactory¹⁶. Of the 87 controls tested, 33% were found to be effective and 67% were found to be ineffective, of which 23% had a high level of residual risk¹⁷. The auditors made 78 recommendations in 15 areas.

Results of second audit

The second audit covered the period from January 2020 to May 2022. It concluded that the WCO's financial and administrative controls were partially satisfactory, with major improvements required to address high and moderate levels of residual risk and improve operational effectiveness. Of the 71 controls tested, 56% were found to be effective, while 44% were found to be ineffective, of which 4% had a high level of residual risk. The auditors made 23 recommendations in 11 areas (a sharp decrease compared with the number of recommendations in the first audit).

WCO Libya: results of first and second audits



¹⁶ WHO has four audit ratings: 1) satisfactory; 2) partially satisfactory with some improvements required; 3) partially satisfactory with major improvements required; 4) unsatisfactory.

¹⁷ Residual risk is defined as the level of risk remaining having taken into consideration the vulnerability – the combination of likelihood to arrive at a relative assessment of risk – and the measures and controls implemented to mitigate the risk.

The recommendations in the second audit are tightly interconnected and cannot be viewed in isolation. The severe shortage of staff in the office is the underlying issue that links them all. The audit report rightly places great emphasis on the importance of segregating tasks in budget, finance and procurement, but this is virtually impossible in the WCO/Libya, given that almost half of the positions in the office organigram were vacant during the period covered by the audit. Seventeen of the 23 audit recommendations relate to budget, finance, procurement and HR. For most of 2022, the WCO had no operations officer, budget and finance officer or assistant. The focal point for procurement left in July 2021 and was replaced only in April 2022. The WCO has not been able to mitigate the situation by hiring local staff. The lack of qualified national finance/administrative staff is a challenge for all UN agencies in Libya. To compound difficulties, restrictions on the number of international staff the WCO can have at any one time has meant it has usually been unable to arrange for the short-term deployment of staff from other WHO offices.

By late 2022, the WCO had managed to fill most key positions including the budget and finance officer, procurement officer, security officer and emergency team lead. In consultation with the internal auditors and the Regional Office's regional compliance and risk manager, the WCO has set a deadline of 30 September 2023 to address all 23 audit recommendations. It is confident that, with close assistance and support from the WHO Regional Office, it will meet this deadline.

Despite severe staffing shortages, the WCO has continued to raise funds, retain the confidence of its donors and manage a complex portfolio of emergency projects¹⁸ while supporting the response to a global pandemic and working in the middle of a national conflict. The WCO staff and leadership have successfully delivered on WHO's strategic objectives in Libya. Many staff have willingly taken on two or three different roles to keep the office going.

Third party monitoring

Over the past few years, constraints on access imposed by the UN's Department of Safety and Security have limited WHO's capacity to directly monitor its operations across Libya. The WCO has hired an external agency as a third party monitor (TPM). The agency was selected based on its extensive experience evaluating humanitarian programmes in developing countries, conflict zones and fragile states.

In 2022, the TPM conducted three rounds of evaluation of WHO's operations in Libya. It assessed the WCO's training workshops and supporting documents, held key informant interviews, and visited health facilities to verify the distribution of medical supplies and equipment. Its assessment consolidated data from beneficiaries and stakeholders including the MoH.

The TPM rated the WCO's training courses as good or very good; all participants interviewed reported they had improved capacity after the training. This finding is corroborated by data collected by the WCO through pre- and post-training questionnaires. It found that some training workshops tended to be male dominated. As the WCO has explained, this is because these courses targeted health care professionals such as physicians and laboratory technicians who are overwhelmingly male in Libya. Nonetheless, the WCO is advocating with the MoH for better female participation in all training courses. The TPM found that items procured by WHO had been sent to health facilities in accordance with the distribution plans agreed by WHO and the MoH. Overall, the TPM concluded that the WCO's operations were relevant and impactful.

WHO has extended its contract with the TPM for an additional year.

¹⁸ US\$ 52 million allocated in the biennium 2020-2021; US\$ 43.6 million allocated thus far for the biennium 2022/2023.

LOOKING AHEAD

The humanitarian situation in Libya has continued to improve since the nationwide ceasefire agreement was signed in October 2020. At the beginning of 2023, the number of IDPs had fallen by almost 60% since late 2020¹⁹. Similarly, the number of people in need dropped sharply, from 803 000 at the beginning of 2022 to just under 330 000 people in January 2023. Migrants and refugees account for well over half of this number, reflecting the extreme vulnerability of these population groups. The locations where needs are greatest comprise some of the most remote, under-served areas in the country including Ghat (on the border with Algeria) and Alkufra in the east.

In late 2022, following a detailed analysis of the changing context and needs in Libya, the UN decided to shift from a humanitarian approach to the so-called humanitarian-development-peace nexus. The shift was prompted by the continuing stability in the country. Sporadic low-level armed clashes between rival militia have not escalated into full-fledged civil war as feared, and the overall humanitarian situation has remained stable.

In December 2022, the UN published its Sustainable Development Cooperation Framework (UNDESCF) for Libya. The framework will guide the UN's collective development, stabilization, resilience and peacebuilding interventions for the next three years (2023-2025). It integrates a human rights-based approach across its interventions, and sets out plans to address residual pockets of humanitarian needs. Following an in-depth analysis of the main impediments to inclusive and sustainable development in Libya, the framework is structured around four interrelated and mutually reinforcing priorities: 1) peace and governance; 2) sustainable economic development; 3) social and human capital development; and 4) climate change, environment and water.

As a result of this shift, the humanitarian sectors in Libya have been deactivated. UNOCHA is reducing its presence; a small team will be embedded in the office of the Deputy Special Representative of the Secretary-General for Libya, where it will serve in an advisory role.

WHO and other UN agencies and partners are beginning the transition from emergency programming to longer-term recovery and development efforts. However, given the continuing political uncertainty, WHO and other partners have called for a cautious approach, careful planning and continued access to flexible funding to allow them to respond in the event of a sudden-onset emergency. Humanitarian agencies have prepared a contingency plan, endorsed by the UN, that sets out how they will stay and deliver humanitarian assistance to people in need in the event of a sharp deterioration in security or a moderate, sudden-onset emergency. The plan sets out the preparations made by humanitarian partners to respond to potential crises. It foresees the rapid deployment of staff on surge missions, the undertaking of a rapid needs assessment, the issuance of an Emergency Flash Appeal and the mobilization of emergency funding mechanisms including the UN Central Emergency Response Fund. In the meantime, UNOCHA has prepared a Humanitarian Overview for 2023 that can serve as the basis for donors' humanitarian funding decisions.

During the transition period, humanitarian agencies will continue to collect and analyse data on the evolving situation and residual needs throughout Libya, to ensure that needs are captured early and that assistance reaches the people who need it most. Humanitarian response data (disaggregated by age, sex and disability status) will be collected through the Activity Info platform and shared on humanitarian web sites including Libya | ReliefWeb Response.

¹⁹ From 316 000 in October 2020 to 134 000 in August 2022.

Planned activities in 2023

WHO's main office in Tripoli and its sub-offices in Benghazi and Sebha will work with development agencies to reduce the vulnerabilities of communities most in need and strengthen the quality and availability of PHC in line with the goals of universal health coverage²⁰. WHO will advocate for migrants and refugees to be afforded the same rights as other segments of the population, including full access to health care and vaccination services.

WHO's work is aligned with the UNSDCF, which aims to ensure, inter alia, that Libyan institutions improve their capacities to design, develop and implement public and social policies that focus on the delivery of equitable, quality social services to all segments of society. In 2023, WHO will, in collaboration with the national health authorities and health partners, focus on the following priorities outlined in the UNSDCF. (Annex 1 lists the outputs and targets for which WHO is responsible.)

Improve access to equitable, high-quality health care services in Libya

The aim of an EPHS is to concentrate scarce resources on health interventions that result in more effective care, provide the best value for money and help improve efficiency and accountability. Work to develop an EPHS for Libya has been ongoing for several years. With help from an international consultant, WHO, the PHCI and IRC have harmonized the different versions of the EPHS that have been developed over the past several years, and have agreed on a costing methodology. The final EPHS was submitted to the MoH for approval in late December 2022. Once the package has been endorsed, WHO will introduce it in 17 PHC facilities in six municipalities, train health workers on its implementation, and

support its expansion to additional facilities and locations.

Increase access to basic health services for IDPs and returnees

The lack of basic services, including for health, in areas that were largely destroyed during the decade-long conflict is a major obstacle to the sustainable return of IDPs. WHO will collaborate with the MoH to facilitate the rehabilitation of and access to health facilities in these locations, and will help support the transition from humanitarian service provision to longer-term development-oriented and state-provided services.

Improve health security

WHO will support improved health security by strengthening preparedness and response mechanisms to ensure that health facilities at all levels are equipped to deal with crises including mass casualty events, sudden-onset emergencies and other situations such as disease outbreaks that are likely to severely strain health services. Health infrastructure will be rehabilitated with attention to accessibility, women's needs and climate resilience, while focusing on WHO's vision of delivering 90% of health care through properly equipped and functioning PHC facilities. WHO will contribute to efforts to increase the percentage of fully functioning health facilities from 40% (in 2017) to 60% in 2025. WHO will support work to improve the skills of the health workforce, establish effective disease surveillance and information management systems, build confidence in health care services through community initiatives, improve routine immunization and reproductive health care services, and strengthen the medical supply chain.

²⁰ Universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course. However, approximately 30% of the world's population still has no access to essential health services. The aim of Sustainable Development Goal 3.8 is to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Strengthen health information management

Timely, accurate health data are essential to support all aspects of an effective public health system, from monitoring disease trends to adopting disease prevention strategies to tracking the performance of health facilities and identifying service gaps. The COVID-19 pandemic has highlighted the crucial importance of strong health information management capacities to support effective decision-making. Thus far, 84 of Libya's 102 municipalities are using the DHIS2. WHO will work with the MoH to expand the DHIS2 to the remaining municipalities and strengthen the overall components of Libya's health information management system.

Support the strengthening of the health system

WHO will support the health system's capacity to deliver health care that responds to the needs of women, children, migrants, refugees and other vulnerable population groups. It will do this by:

- Supporting the development of all-inclusive national health policies
- Improving access to quality essential health services
- Strengthening Libya's health emergency preparedness and response, including for high-threat infectious hazards
- Enhancing multi-sectoral coordination to jointly address health priorities and the determinants of health, leaving no one behind.

WHO has recently reclassified Libya as a protracted emergency, straddling the divide between humanitarian and recovery models. Now that oil production in the country has rebounded and Libya is earning vast amounts of money, the Libyan government must tap into its own resources to strengthen its fragmented health system. WHO will advocate with the Libyan government for multi-year, predictable, flexible funding to support the Organization's work in the country. It will also solicit support from both development and humanitarian donors to address funding gaps and grey areas. Donors that support protracted emergencies normally maintain a presence in countries to allow them to assess the situation and decide on funding allocations to partners that are seen to be the most effective. Therefore, WHO will build partnerships and strengthen links with both humanitarian and development contributors at country level.

ANNEX 1

WHO outcomes & outputs under the UN Sustainable Development Cooperation Framework 2023-2025

Under the UNSDCF for 2023-2025, WHO will contribute to the following outcomes and outputs:

Output 3.1.3: Government, human rights actors, and civil society organizations have improved capacities to deliver, and create demand for quality and people-centred preventive, accessible and responsive protection services, including child protection and gender-based violence (women and men), with a particular focus on the most vulnerable

Strategic Priority 3: Social and Human Capital Development

Outcome n° and title	Outcome indicator	Baseline		Target		Other reporting agencies	
		N°/percentage	Year	N°/percentage	Year		
OUTCOME 3.1: By 2025, people in Libya, including the most vulnerable and marginalized, benefit from improved, equitable, inclusive, and sustainable social protection and basic social services	a. Coverage of essential health services	64	2017	75	2025	IOM	
	b. Prevalence of stunting among children under 5 years of age	43.5%	2020	41%	2025	UNICEF	
	c. Maternal mortality ratio*	11.6 deaths per 100,000 live births	2017	Fewer than 11.6 deaths per 100,000 live births	2025	UNICEF UNFPA	
	d. Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	54%	2016	44%	2025	N/A	
	e. Proportion of the target population covered by all vaccines included in their national programme	a. Measles for children under 2: 97%		2018	100%	2025	IOM
		b. COVID-19 for all: 15%		2021	80% of highest priority-use group** (~20% of the population)	2025	UNICEF
	f. Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	24%	2014	30%	2025	UNFPA	

Output 3.1.1: The health system has strengthened capacity to deliver and create demand for equitable, accessible, and quality health and nutrition services, particularly for the most vulnerable and marginalized groups.

Outcome indicator	Baseline		Target		Other reporting agencies
	N°/percentage	Year	N°/percentage	Year	
a. Proportion of fully functional health facilities	40%	2021	60%	2025	IOM
b. Number of functional tuberculosis clinics providing screening and treatment services	17	2021	27	2025	IOM
c. Number of primary healthcare centres providing (a) noncommunicable disease services; (b) child health services; (c) mental health and psychosocial support services; and (d) maternal health services (ANC)	(a) 100 (b) 150 (c) 30 (d) 184	2021 2021 2021 2017	200 250 100 250	2025	IOM UNICEF UNFPA
d. Number of municipalities with functional District Health Information Software 2 (DHIS2)	67	2021	100	2025	IOM UNICEF UNFPA

Output 3.1.3: Government, human rights actors, and civil society organizations have improved capacities to deliver, and create demand for quality and people-centred preventive, accessible and responsive protection services, including child protection and gender-based violence (women and men), with a particular focus on the most vulnerable

Number of service providers, government and nongovernmental institutions trained on various GBV issues in line with international standards	450 (UNFPA) 10 (WHO)	2021	1,000 (UNFPA) 50 (WHO)	2025	UNFPA
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COLLECTIVE OUTCOME 1: DURABLE SOLUTIONS FOR IDPs						
Outcome n° and title	Outcome indicator	Baseline		Target		Other reporting agencies
		N°/percentage	Year	N°/percentage	Year	
COLLECTIVE OUTCOME 1.1: By 2025, 80% of IDPs and returnees will have achieved a durable solution in harmony and with full respect of the rights of communities hosting or receiving them OME 1: By 2025, 80% of IDPs and returnees will have achieved a durable solution in harmony and with full respect of the rights of communities hosting or receiving them	Proportion of displacement affected population with improved access to basic services and adequate housing.	Health and nutrition for IDPs: 53.86%	2021	57%	2025	UNICEF
		Health and nutrition for returnees: 40.13%	2021	45%	2025	
Output CO1.1.2: Displacement-affected populations have access to adequate and decent housing as well as equal access to basic services, including health, education and WASH, protection services and social protection schemes						
Outcome indicator	Baseline		Target		Other reporting agencies	
	N°/percentage	Year	N°/percentage	Year		
Number of displacement-affected population with improved access to basic services and adequate housing.	Health and nutrition: N/A	2021	80,000	2025	UNICEF	

*In 2010, the MoH's maternal mortality ratio (MMR) baseline was 23 deaths per 100,000 live births. In 2019, based on the Libyan Cause of Death Report 2016-2017, the MoH estimated that the MMR had fallen to 11.6 deaths per 100,000 live births. However, the UN's working group on global maternal mortality rates estimated that the MMR in Libya in 2020 was 72 maternal deaths per 100,000 live births. Noting that the MoH will be the source of reporting against these indicators, a figure of 11.6 per 100,000 live births was selected as the baseline, with a target of fewer than 11.6 deaths per 100,000 live births.

** Older adults, health workers, immunocompromised persons.

ANNEX 2

Voluntary contributions received in 2022

Donor	Amount of contribution (US\$)
Germany	4,315,624
Deutsche Gesellschaft für Internationale Zusammenarbeit, Germany	373,135
United States Department of State	2,706,852
Ministry of Foreign Affairs, Norway	634,921
Ministry for Europe and Foreign Affairs, France	405,773
Directorate-General for European Civil Protection and Humanitarian Aid Operations, European Commission	1,014,199
United States Agency for International Development	900,000
National Oil Corporation, Libya	5,437,918
UNITAID	28,800
Sasawaka Health Foundation	7,000
TOTAL	15,824,222



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