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- ANNEX 1: Main assessments conducted and technical guidelines and reports published in 2019
Nine years after the fall of Muammar Gadhafi, Libya remains riven by armed conflict, economic collapse and disintegrating public services. Continued violence and insecurity coupled with political stalemate have resulted in a governance vacuum accompanied by significant insecurity and a breakdown of the rule of law. Thus far, the conflict has defied national and international efforts to find a political resolution.

Of a total population of 6.7 million, almost 4 million people, mostly women and children, require humanitarian health assistance. According to the health sector severity scale, almost 1.7 million people are in extreme need and more than 122 000 are in catastrophic need. Many people have specific vulnerabilities (gender, age, disabilities, ill health and nationality) that undermine or limit their ability to withstand the effects of the conflict. Other groups such as refugees and migrants often face abuses by state and non-state entities. Given their irregular legal status and lack of domestic support networks, they encounter racism, xenophobia and grave human rights violations. At the end of 2019, more than 3200 refugees and migrants were being arbitrarily held in appalling conditions in overcrowded detention centres, creating conditions ripe for the spread of diseases such as tuberculosis (TB). These unlawful detentions are serious human rights violations that exacerbate an already volatile situation.

Libya’s health system is close to collapse. Severe shortages of health staff, medicines, supplies and equipment have been compounded by years of under-investment in the health system and a chronic lack of transparency and accountability. Around one quarter of public health care facilities are closed, around one quarter of public health care facilities are closed, and most of those that remain open do not provide any health care services for children under five years of age. Only five of 78 hospitals assessed by WHO offer all essential services. There are acute shortages of medical specialists, midwives and nurses and huge gaps in coverage due to the uneven distribution of general physicians, most of whom work in urban areas. Although Libya has traditionally depended heavily on foreign health care workers, the overseas workforce has steadily dwindled since 2011 when the conflict began.

Some donors are understandably reluctant to fund humanitarian activities in oil-rich Libya. However, Libya’s needs will remain significant for the foreseeable future. The absence of a functioning government has made it impossible to unlock Libya’s abundant resources to support the health system and meet critical health needs. Oil production has slowed, USD 60 billion in Libyan assets have been frozen, and the country’s economic collapse has led to a major liquidity crisis. Short- and medium-term funding will be essential to stave off the further disintegration of health care and other public services and halt Libya’s spiral into further violence and decay.

While the primary responsibility for providing assistance lies with the Libyan authorities, the persistent political crisis and escalating conflict require the international humanitarian community to fill critical gaps. WHO will work to combine humanitarian and development approaches that will allow it to deliver essential health care services while laying the foundation for universal health coverage and Libyans’ right to health. Regardless of whether its operations are humanitarian or developmental, the Organization will scrupulously adhere to the four humanitarian principles of humanity, neutrality, impartiality and independence. In a country where some political factions view the UN with deep suspicion, adherence to these principles will be more important than ever.
IN 2019

Overview

In 2019, Libya remained locked in conflict, violence and political instability. The situation was compounded by the existence of two competing governments. A Government of National Accord (GNA) in Tripoli was established in December 2015 with the support of the UN. A rival government in the east (Benghazi) is backed by the Libyan National Army (LNA) headed by Field Marshal Khalifa Belqasim Haftar. The UN-backed government in Tripoli has struggled to exert control over territory held by rival factions and intensifying geographical and political divisions between the east, west and south. Terrorist groups and armed militias have exploited the turmoil and used the country as a base for radicalization and organized crime. Libya is awash with weapons: arms from the Gaddafi era are plentiful, and materials of war continue to be shipped to the country in breach of the UN-imposed arms embargo.

In April 2019, the LNA launched an offensive to capture Tripoli from the GNA. After initial advances, it has been locked in stalemate with government-backed forces for several months. The continuing fighting in Tripoli has cut off access to hospitals and left thousands of people without health care. At least 3000 people have been killed and injured and another 149 000 have been displaced. At the beginning of July, Tajoura detention centre in Tripoli holding more than 600 migrants and refugees suffered a direct airstrike that killed 50 people and injured 130 others. This prompted the international community to renew its calls for the closure of detention centres across the country. As of 31 December 2019, around 250 000 civilians in Tripoli were living in areas directly affected by the conflict, and almost half of them were living very close to battle frontlines.

While the battle for Tripoli has dominated international attention, the situation in the south has been all too often overlooked. The region is critical to the stability of Libya, but it has been historically marginalized in the country’s politics despite its ample natural resources. The United Nations Support Mission in Libya (UNSMIL) has expressed its deep concern about reports coming from the south on the mobilization of armed forces and the escalating cycle of statements and counter-statements by warring factions, signalling the growing risks of imminent conflict.

In August 2019, the dangers of working in Libya were illustrated when a bomb exploded under a UN vehicle in Benghazi, instantly killing three UN staff and severely injuring several other staff and bystanders. No one has claimed responsibility for the incident; investigations are under way by the United Nations. The same month, approximately 100 people were killed, more than 200 were injured and over 30 000 were displaced when violence flared between rival tribes in Murzuq, south Libya. By the end of the year, the number of internally displaced people (IDPs) in Libya had almost doubled to 343 000.

The number of attacks on health care rose sharply. In the summer of 2019, airstrikes on two field hospitals and two ambulances in Tripoli killed at least four doctors and one paramedic and injured several others. The Special Representative of the Secretary-General for Libya Ghassan Salamé condemned this clear pattern of ruthless attacks against health workers and facilities in the strongest terms.

Outbreaks of measles and rubella and increasing rates of cutaneous leishmaniasis, tuberculosis, pertussis and acute jaundice syndrome highlighted Libya’s vulnerability to large-scale disease outbreaks. Between 1000 and 1500 cases of acute diarrhoea have been reported each week. The clear threat of outbreaks of vaccine-preventable and other diseases is compounded by poor surveillance. Only 84% of the country’s 125 sentinel sites are sending regular surveillance data to the disease early warning and response system, which has very limited capacity to detect and respond to disease alerts.

Status of health care services

Libya’s health system suffers from severe shortages of staff, a poorly functioning medical supply chain and very weak disease surveillance and health information systems. The lack of detailed data on the main causes of mortality and morbidity has hampered efforts to analyse needs and deliver a targeted response.

Approximately one fifth of Libyan hospitals and PHC facilities are closed. There are acute shortages of medical specialists, midwives and nurses and huge gaps in coverage due to the uneven distribution of general internists, most of whom are working in urban areas. In many remote and hard-to-reach locations, poor and vulnerable communities have very limited access to health care. In areas affected by conflict, health care facilities were overwhelmed with patients.

Around 22% of Libyans and 18% of migrants and refugees faced difficulties accessing health care services. The most severe health needs were in districts affected by violence (e.g., Murzuq, Sirt and Tripoli) or that were hosting large numbers of IDPs (e.g., Benghazi, Ejdabia and Sebha).

1 Figures taken from WHO’s Service Availability and Readiness Assessment of 2017.
Planning, managing and monitoring the delivery of health care services are seriously inadequate at all levels of the health system. PHC facilities are not required to provide a standard package of services or maintain essential medicines, equipment and laboratory services to support the delivery of high-quality care. In many facilities, doctors are either not available full time or they are young and inexperienced. There are frequent stock-outs of essential medicines and there are no electronic or paper medical records that allow different physicians to monitor individual patients over time. Moreover, many PHC facilities remain open only three to four hours a day, and patients reportedly find them unsanitary. As a result, Libyans tend to bypass PHC services and go directly to the outpatient clinics or emergency services of hospitals in the belief that they are likely to be referred to these facilities anyway. This leaves hospitals even more overstretched, forcing them to direct their limited resources from seriously ill patients to others who do not require either emergency treatment or hospitalization.

Reproductive health services including ante- and postnatal care, family planning and the management of sexually transmitted infections have all but collapsed and there has been an alarming increase in rates of caesarean sections. Mental health remains chronically neglected: there are only two public mental health hospitals in the entire country, and most patients are treated in private health facilities. Childhood vaccination programmes have been interrupted and there have been widespread shortages of vaccines.

Private health care services have expanded to meet needs arising from the inadequate public health care system. In 2019, a report issued by the Libyan Ministry of Health (MoH) showed that the number of inpatient clinics, laboratories and pharmacies and diagnostic centres rose by 72%, 50% and 80% respectively between 2007 and 2018. Private health care services are poorly regulated and their burgeoning growth has occurred mainly in urban areas. Many health care professionals in the public sector have left for the private sector where they are better remunerated: this has exacerbated the situation of poor patients, especially those living in remote areas. In 2019, most injured patients have been treated in private health care facilities, with the costs of their care covered by the government.

WHO will support the government’s efforts to build effective partnerships with the private health sector and reach Libya’s goal of universal health coverage by 2030.

Attacks on health care

The number of attacks on health care rose sharply, from 36 in 2018 to 62 in 2019. A total of 76 people were killed and scores more were injured. More people were killed in Libya as a result of these attacks than in any other country worldwide. Most attacks occurred in and around Tripoli, which was the scene of intense fighting in 2019. International humanitarian law (IHL) strictly prohibits attacks against hospitals and other medical facilities, medical personnel and medical transport. WHO has repeatedly condemned these attacks as egregious violations of IHL.

“Intentionally targeting health workers and health facilities and ambulances is a war crime, and when committed as part of widespread or systematic attacks directed against any civilian population, may constitute a crime against humanity. We will not stand idly by and watch doctors and paramedics targeted daily while risking their lives to save others.”

Ghassan Salamé, the Special Representative of the Secretary-General for Libya.
1 168 407 people were reached through WHO-supported fixed health care facilities or mobile teams.

68 907 people received health care services through emergency hospital teams and mobile medical teams.

82 hospitals and health care facilities received essential medicines and medical supplies.

463 standard medical kits as well as other supplies (containing enough medicines and supplies to treat 1 099 500 people) were distributed throughout the country.

1 332 health care workers were trained on a wide range of topics including trauma care, primary health care, the management of NCDs, the health information system, disease surveillance and response, and mental health care.

5 national guidelines and policies were prepared and adopted by the MoH with close technical support from WHO.

2 new MoH emergency operations centres (one in Tripoli and one in Benghazi) were fully equipped by WHO.

Throughout 2019, WHO supported the delivery of health care services by providing medicines and supplies, deploying medical teams and training health care staff.

Delivering medicines and supplies

WHO delivered enough medicines and supplies to treat 1 099 500 patients throughout Libya.

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<th>Trauma kits</th>
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In mid-September 2019, WHO delivered medicines and supplies to serve 220 000 patients for three months to hospitals and clinics throughout Libya. The supplies will be used to treat patients with infections, injuries and chronic diseases.

Credit: WHO
In contrast to other countries (e.g., Syria) where WHO relies heavily on national NGOs to provide essential PHC services, there are no national (and few international) health NGOs in Libya. Instead, WHO has relied on emergency medical teams to strengthen health care services in areas affected by conflict.

Emergency hospital teams

WHO supported the deployment of approximately 20 emergency hospital teams (EHTs) per month to help strengthen surgical and specialized health care services in hospitals and other health care facilities. Each EHT consisted of five specialists (a general physician, a general surgeon, an obstetrician/gynaecologist, an anaesthetist and a paediatrician). Just over 38,800 people benefited from the services offered by the EHTs. Over 20% of the surgical operations carried out by the teams were on war-wounded patients – a grim reminder of the horrors of war.

WHO recruits EHT members based on standard terms of reference and trains them on triage and mass casualty management. The teams are also trained on collecting patient data using standard forms provided by WHO. The information is disaggregated by patients’ age and gender and the types of consultations provided. This allows WHO to analyse the most common causes of consultations and make sure the medicines and supplies it procures are meeting needs.

Mobile medical teams

While the primary aim of EHTs is to strengthen surgical capacity in hospitals, mobile medical teams (MMTs) aim to provide general health care services in remote, hard-to-reach and underserved areas. WHO supported the deployment of approximately four MMTs per month. Each MMT comprised a general physician, a paediatrician, a dermatologist and an obstetrician/gynaecologist. Approximately 300 people benefited from the services offered by MMTs in 2019.

Training health care workers

In 2019, WHO trained 1332 health care workers on topics including mental health in conflict settings, the case management of TB and NCDs, disease surveillance, the health information system and a family practice model for PHC facilities. Because of internal travel restrictions and security constraints, many of the courses had to be organized in neighbouring Tunisia, increasing their costs by a considerable margin.

Just under half of those trained were women. WHO encourages female staff to attend training courses by providing special incentives. For example, in societies where the free movement of women is restricted, WHO facilitates the travel of an accompanying family member so that women do not have to travel alone when they attend training workshops.
Primary health care

WHO supported a series of workshops to introduce 302 PHC nurses from south, east and west Libya to WHO’s new training package for nurses. The workshops comprised one week of theoretical sessions followed by a week of practical training. Those trained will go on to train fellow nurses inside Libya. In total, 554 managers, physicians, nurses and other clinical staff were trained on various aspects of PHC in 2019.

Secondary health care

WHO trained 30 health care staff on hospital emergency preparedness and supported the logistic arrangements for 12 surgeons from Libya’s main referral hospitals who travelled to Poitiers, France for training on damage control surgery. WHO also launched a pilot project to assess patient safety in hospitals. The results of the assessment will be published in early 2020.

Trauma care

WHO distributed or pre-positioned 113 trauma kits – enough to treat 11 300 wounded patients – to hospitals and clinics in conflict-affected areas and pre-positioned additional supplies to help respond to any escalation in violence. WHO deployed emergency teams to help hospitals cope with the influx of war-wounded, including IDPs and host communities. As the conflict continued in Tripoli, the teams performed nearly 100 operations each week. The Organization also supported training on triaging patients during mass casualty events.

AREAS OF FOCUS

Primary health care

PHC services are the backbone of health care in all countries. In late December 2017, WHO launched a two-year pilot project introducing a standard family practice model comprising 13 core elements into six PHC centres in east, west and south Libya. The project ended in late 2019; based on the lessons learned from this experience, and subject to the availability of funds, WHO plans to introduce the model in over 80% of the country’s PHC facilities, using a phased approach. WHO trained 44 community health workers on the family practice model in Libya, based on adapted regional guidelines. Another 30 health care professionals were trained on using standard indicators to monitor and assess the quality of services in PHC facilities and help improve patient safety.

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The 13 core elements of the family practice model are: 1) a clearly defined catchment population; 2) the availability of family and individual patient files; 3) a family physician roster; 4) community engagement; 5) a standard package of essential health care services; 6) a standard list of essential medicines; 7) a standard list of core staff and up-to-date job descriptions; 8) a standard set of medical equipment and furniture; 9) on-the-job training for general practitioners and support staff; 10) up-to-date treatment protocols; 11) a patient referral system; 12) a health information and reporting system; 13) services accredited by an external body.
Communicable diseases

In 2019, Libya experienced small-scale outbreaks of measles, pertussis and rubella. The number of cases of cutaneous leishmaniasis rose sharply. Over 1000 cases of acute diarrhoea were reported each week – a clear indication of poor living conditions and inadequate water and sanitation. WHO has initiated discussions with the National Centre for Disease Control and national water companies on the steps required to improve water and sanitation services.

WHO supported the MoH’s efforts to tackle antimicrobial resistance (AMR), one of the most urgent health threats the world faces today. Countries like Libya are more vulnerable to AMR because of weak regulatory systems and the over-the-counter sale of antimicrobial medicines. In 2019, the MoH, with technical support from WHO, adopted a national strategy and action plan to tackle AMR.
Caring for TB patients in south Libya

South Libya is one of the poorest, most deprived and historically neglected areas in the country. The region has been significantly affected by the conflict. Insecurity is rife and violent clashes among armed groups are common. Electricity is available only intermittently and there are widespread shortages of water, food, medicine, fuel and other basic items. Supply routes to the south have been disrupted and the journey to Tripoli is fraught with risk. Travellers are liable to be attacked and robbed or intercepted by armed groups at unauthorized checkpoints and forced to pay bribes for their safe passage.

Sebha, the regional capital of south Libya, lies deep in the Libyan desert. Large numbers of migrants pass through the town hoping to reach Europe. The National Centre for Disease Control's (NCDC) health care branch in Sebha covers a huge catchment area that extends 700 km to the border with Niger and Chad. The centre is responsible for treating all patients with communicable diseases such as TB, HIV/AIDS and viral hepatitis. Despite its huge caseload, it has few medicines and supplies and only two part-time doctors and 12 nurses. Electricity cuts are a daily occurrence but the centre has no back-up generator to maintain its power supply. Its sole X-ray machine – essential for screening patients with pulmonary TB – works only sporadically.

Most patients admitted to the centre seek treatment for TB. TB is one of the top 10 causes of death worldwide, and rates of the disease are rising in Libya. Patients with active lung TB – i.e., those who can infect others by coughing – must be quarantined until their sputum tests are negative and they can safely continue their treatment in the community. However, medicines to treat these patients are in short supply. The centre’s isolation ward is poorly equipped and there are not enough beds to accommodate patients. As a result, many of them are forced to remain in the community where they can infect other people.

Nurse Fatema Tako says that many patients travel long distances to reach the centre, paying travel costs they can ill afford. Approximately 40% of patients are refugees and migrants. “We try to support our patients but it is hard. We see so many people, but we have so little to offer them. Today, we saw a patient who had travelled hundreds of kilometres. We had to ask him to come back in three days, when a doctor would be on duty. The despair and distress of these patients are obvious. It is very difficult to have to turn them away: all my humanity and training as a nurse go against this. We need so much: more doctors, better training, more medicines and supplies and diagnostic tests. Our isolation unit is always full but it is old and dilapidated and doesn’t offer patients or us the protection they and we need.”

Forty-two-year-old Masoud Saad has tested positive for active lung TB and has been placed in isolation. He has come from Ubari, more than 150 km away, in search of treatment for his chronic cough. His local hospital prescribed medicines, but his cough worsened and so he undertook the long and difficult journey to Sebha through dusty desert roads.

Thirty days into his treatment, Masoud says he just wants to get better and return to his family. “I’m so grateful to the doctors here – I feel better already – but I miss my children. I was shocked when I found out I had TB. But I am one of the lucky ones; I am getting the treatment I need and I know that I will eventually be cured.”

In 2019, WHO supported the centre in Sebha with laboratory reagents, inter-agency emergency health kits, intravenous fluids, antibiotics and other medicines and supplies.
Childhood vaccination

According to data recently released by the National Centre for Disease Control, national vaccination coverage rates for the main childhood diseases are over 90%. Thanks to significant efforts by the national health authorities, and with support from WHO and UNICEF, the number of cases of measles has decreased substantially (from 1049 in 2018 to 188 in 2019). However, major challenges remain. Although vaccination services are offered free-of-charge to Libyans and non-Libyans, the country’s 600 vaccination centres have frequent shortages of vaccines and lack detailed vaccination plans. There are no mobile vaccination services and no strategy or programmes in place to educate communities about the importance of vaccinating children. Moreover, the presence of undocumented migrants who enter the country through informal crossing points increases the risk of disease outbreaks. As a result, there continue to be sporadic, small-scale outbreaks of vaccine-preventable diseases such as measles and rubella.

In 2019, WHO strengthened its field supervision of polio surveillance activities through rapid assessments and on-the-job training for surveillance officers in nine municipalities. The Organization also trained laboratory staff on testing samples for measles and rubella, and provided reagents and equipment to support the rapid diagnosis of these diseases. In 2020, WHO plans to strengthen national surveillance efforts, especially for polio, by improving the availability of vaccines, strengthening vaccination services (especially for IDPs and migrants) and enhancing the monitoring of and reporting on routine immunization services.

Disease surveillance and response

Disease early warning systems provide an opportunity to detect and respond to cases of epidemic-prone diseases at an early stage. In 2019, approximately 85% of Libya’s 125 sentinel sites sent regular weekly reports to the WHO-supported disease early and warning network (EWARN). WHO trained 419 health care workers on disease surveillance and reporting to EWARN. Fifteen WHO-trained rapid response teams were deployed to 15 hospitals in Libya. Each team consisted of two medical officers, a laboratory technician, a surveillance officer and a data manager. The teams were instrumental in responding to outbreaks of acute jaundice syndrome and measles and preventing their further spread. In spite of these efforts, there are notable weaknesses in the disease surveillance system. The quality of the data is often poor and doctors do not always follow the standard case definitions for notifiable diseases. Moreover, neither private health care facilities nor detention centres participate in EWARN. In July 2019, the dangers of this lack of involvement became evident when a measles outbreak in Ganfouda detention centre in Benghazi led to the infection of 10 children. The WHO-trained rapid response team in Benghazi vaccinated 95 children in the centre.

In 2020, WHO will work with the national authorities to increase the number of sentinel sites reporting to EWARN, train additional staff and review and update the case definitions for notifiable diseases.

Tuberculosis

Although Libya is a middle burden country for TB, it is hosting tens of thousands of migrants and refugees from higher TB burden countries. Many of them are picked up by the Libyan coastguard as they try to cross the Mediterranean to Europe and subsequently taken to one of the country’s 17 detention centres. As of 31 July 2019, around 5000 people were being detained in these centres, many of them in unventilated, unsanitary and overcrowded hangars with very limited access to health care. These conditions are ripe for the spread of TB. Over the course of a year, people with active TB can infect up to 10-15 other people. Without proper treatment, up to two thirds of people with active TB will die.

Data from WHO’s Global Tuberculosis Report 2019 show that the number of people with detected and notified TB in Libya increased by 33% between 2017 and 2018. However, the real number is likely to be much higher given Libya’s weak health information and disease surveillance systems. In August 2019, this was borne out by a major screening exercise in eight detention centres. Out of more than 3500 migrants who were screened for TB, seven new cases were identified and 150 existing cases were confirmed. This high burden requires immediate interventions to save lives, prevent deaths and stem the epidemic.

In 2019, WHO trained 26 health care professionals on managing TB patients (including those inside migrant detention centres), supported the preparation of updated national TB guidelines and screening protocols based on WHO’s latest guidance, and delivered medicines (including drugs to treat patients with multi-drug resistant TB) to the National Tuberculosis Programme (NTP). WHO also delivered four GeneXpert machines to the NTP for distribution to branches throughout the country. These state-of-the-art test machines dramatically shorten the time to diagnose drug-resistant strains of TB from weeks to only a few hours. Allowing health workers to quickly diagnose drug-resistant TB and enrol patients for immediate treatment can help halt the spread of this deadly form of the disease.

Leishmaniasis

In the last two decades, cutaneous leishmaniasis has become a major public health problem in Libya. Visceral leishmaniasis, a much rarer and deadlier form of the disease, has become more frequent in the east and south.

Number of cases of cutaneous leishmaniasis by month, 2019
The increase in rates of cutaneous leishmaniasis can be directly linked to the conflict, which has led to population displacements, disrupted health and water and sanitation systems and poor living conditions. A similar experience was reported from Syria, where the number of cases of cutaneous leishmaniasis rose sharply as a result of the conflict.

WHO procured antileishmanial medicines and rapid diagnostic kits, and trained dermatologists from the National Centre for Disease Control’s Zoonotic Disease Control unit on leishmaniasis case management. It also organized a Scientific Day on leishmaniasis in Tripoli in September 2019. The conference brought together approximately 100 health care professionals to share experiences and learn about the latest advances in leishmaniasis treatment and control.

Four-year-old Faris Hasan lives in Murzuq city in the south of Libya. In early 2019, he began experiencing acute abdominal pain accompanied by bouts of fever and vomiting. His condition grew worse and he rapidly lost weight. Doctors at the local clinic were unable to diagnose his illness and referred to him to the Children’s Hospital in Benghazi for further examination.

In July, Faris was admitted to the hospital with fever, jaundice and an enlarged liver and spleen. Following a bone marrow biopsy, hospital doctors diagnosed him as suffering from visceral leishmaniasis.

Visceral leishmaniasis, also known as kala-azar, is caused by a parasite transmitted through the bite of infected female sandflies. The disease is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver, and anaemia. If the disease is not treated, the case-fatality rate in developing countries can be as high as 100% within 2 years.

Outbreaks of visceral leishmaniasis are often fuelled by complex emergencies, mass population movements, famine and malnutrition. Rates of the disease have been rising in in south Libya, due to the country’s prolonged crisis.

The most effective way to treat people with visceral leishmaniasis is with injections of sodium stibogluconate. Unfortunately, this treatment was not available anywhere in the country. Faris was put on an alternative treatment but showed no improvement. His parents were in despair.

The hospital appealed to WHO for help. In September, WHO made an emergency purchase of sodium stibogluconate and rushed it to the hospital. Faris began treatment immediately and made a remarkable recovery. He has put on weight and has become a happy, mischievous little boy once again.

WHO has donated enough sodium stibogluconate to the hospital to treat 30 patients for up to one year. Professor Al Teer, Head of the hospital’s Infectious Disease Department, thanked WHO for its support. “Thanks to this donation, we will be able to treat other patients like Faris whose long-term chances of survival would otherwise be slim.”

Ms Elizabeth Hoff, the WHO Representative in Libya, said she was delighted that Faris had made such a speedy recovery. “We will continue to work with the Ministry of Health and hospitals and primary health care centres throughout Libya to fill critical gaps in medical supplies and make sure that vulnerable patients receive the care they need.”
Noncommunicable diseases

Noncommunicable diseases (NCDs) are the leading cause of death in Libya and account for 72% of the burden of disease. More than one third of adults smoke and there are high rates of obesity, cardiovascular disease and cancer.

In 2019, WHO distributed 93 standard NCD kits to PHC centres. The kits contained enough supplies to treat 930,000 chronic disease patients for three months. Given the high rates of NCDs in Libya, demand for these kits has increased since they were first introduced in June 2018. WHO briefed physicians and nurses in all three regions of Libya on the content of the kits. The Organization trained PHC doctors and nurses on managing the most common NCDs including cardiovascular disease, chronic respiratory disease and diabetes, based on recently adapted national guidelines. It also supported the MoH’s efforts to strengthen cancer surveillance and the follow up of cancer patients. It is working with the MoH to develop guidance on the main risk factors for NCDs in Libya.

Mental health

There is only one specialized mental health professional for every 300,000 people in Libya (neighbouring Tunisia has one mental health professional for every 100,000 people). Only five of Libya’s 42 cities7 are offering mental health services, and only two cities (Tripoli and Benghazi) provide in-patient services. WHO is working to fill urgent gaps in the most affected areas. In 2019, it supported the deployment of two psychiatrists (one to east and one to west Libya). Throughout 2019, they saw an average of 110 patients per week. WHO also trained 65 PHC doctors on treating patients with common mental health disorders.

In 2020, subject to the availability of funds, WHO plans to launch an ambitious project to scale up mental health services in Libya. One of the SPHERE® minimum standards for mental health is to ensure that every general health care facility has at least one trained staff member and a system in place to manage people with mental health conditions. The project aims to achieve this standard in three Libyan cities to be selected.

Reproductive, maternal, newborn, child and adolescent health

In October 2019, WHO, UNICEF and the MoH convened a workshop to adapt the WHO/UNICEF guidelines on the integrated management of neonatal and childhood illness (IMNCI) to the Libyan context. IMNCI is an integrated approach to neonatal and child health that focuses on the well-being of the whole child. It aims to reduce death, illness and disability and promote improved growth and development among children under five years of age. Over a four-day period from 22 to 25 October 2019, child health specialists from the MoH, PHC facilities, universities and hospitals across the country developed specific IMNCI guidelines for Libya. In addition, WHO completed work on a package of reproductive and maternal health interventions covering pre-conception care, family planning, antenatal and intra-partum care. In March 2019, 33 health care professionals underwent master training on this package. Subject to the availability of funds, WHO plans to launch cascade training in 2020 to allow the master trainers to pass on their knowledge to their counterparts throughout Libya.

WHO also supported the preparation of a national strategy on the prevention of mother-to-child transmission of HIV. The MoH plans to formally adopt and implement the strategy in early 2020.

Health information system

A well-functioning health information system is one of the six building blocks of a health system.8 WHO, donors and health partners are supporting the development and roll-out of the District Health Information System (DHIS-2) in Libya. The DHIS-2 is an open-source software platform to report, analyse and disseminate health information. In 2019, WHO trained statisticians and end users on the DHIS-2. Approximately 120 PHC facilities (9% of the total number in Libya) are now using the DHIS-2 to enter data on disease burden, access to health care, causes of mortality, disease surveillance, HIV surveillance, and the management of health human resources. Once the DHIS is fully up and running, it will yield evidence to help the MoH and partners plan and prioritize health programmes. Further progress in this area will be subject to the availability of funds.

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7 Libya has 14 cities with populations between 100,000 and 1 million, and 28 cities with populations between 10,000 and 100,000.
8 The Sphere movement was started in 1997 by a group of humanitarian professionals aiming to improve the quality of humanitarian work during disaster response. With this goal in mind, they developed a Humanitarian Charter and identified a set of standards to be applied in any humanitarian response.
9 The six building blocks of a health system are: 1) good health services, 2) a well-performing health workforce, 3) well-functioning health information system; 4) equitable access to essential medical products, vaccines and technologies of assured quality; 5) good health financing; and 6) leadership and governance.
Humanitarian and development agencies in conflict-affected countries have traditionally worked in silos, with neither side being familiar with or able to capitalize on the knowledge and experience of the other. Simply put, the humanitarian-development nexus (“the nexus”) seeks to coordinate their activities by removing barriers to collaboration. It calls for both humanitarian and development agencies to take the long view and work together over several years towards joint outcomes. This will facilitate meaningful progress and ease the transition from humanitarian action to health system development.

WHO participates in the nexus task force in Libya. This will allow WHO and its partners to mobilize additional resources for projects that will upgrade the capacity of the MoH and lead to more sustainable, long-term results that will restore and stabilize the health system. WHO is also working to foster closer alignment between the annual Humanitarian Response Plans and the medium-term, development-oriented United Nations Strategic Framework for Libya.

The health sector in Libya was established in 2015. It brings together over 30 health partners under WHO’s co-leadership. Since 2018, the health sector in Tripoli has been supported by two sub-national sectors in east and south Libya. In each of these locations, WHO and partners work closely together and meet regularly to review the emergency response, identify and fill gaps, agree on priorities, and adapt operations to meet evolving needs. The health sector runs five thematic working groups (on gender-based violence, mental health, tuberculosis, reproductive health and migrant health). WHO has coordinated the formulation and implementation of the health component of Humanitarian Response Plans for Libya since 2016.

The health sector collaborates closely with the WASH and protection sectors. WHO participates regularly in humanitarian country team meetings and other intersectoral coordination meetings.

To strengthen coordination between WHO and the MoH, WHO supported the establishment of two MoH emergency operations centres (EOCs), one in Tripoli and the other in Benghazi. WHO provided technical advice and installed IT equipment and furniture. It will also train EOC staff on how to manage and monitor emergency operations. The centre in Tripoli was formally inaugurated in December 2019. The inauguration of the centre in Benghazi has been delayed due to the difficulties finding local IT companies and the suspension of all flights from Tripoli to Benghazi.

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7 The United Nations Strategic Framework sets out the following goals to be reached by end 2020: 1) core government functions will be strengthened and Libyan institutions and civil society will be better able to respond to the needs of the people; 2) economic recovery will be initiated thanks to better public financial management and economic, financial and monetary policies that will stimulate investment; 3) Libyan institutions will have improved their capacity to design, develop and implement public and social policies that focus on quality social services delivery for all women and girls, men and boys (including vulnerable groups, migrants and refugees).

8 The centre opened in February 2020.
WHO’s field coordinators throughout the country regularly visited health care facilities and mobile clinics to report on health needs and current stocks of priority medicines. These reports were assembled following interviews with staff and health authorities and discussions with community leaders. Based on these reports, WHO shipped essential medicines directly to the identified hospitals and health care centres. WHO field coordinators also monitored the accuracy and timeliness of the distribution of medicines and medical equipment and the continuous availability of medicines and supplies at points of care (fixed facilities and mobile clinics).

In Libya, the weak capacity of the national health information system has hampered efforts to gather overall data on the burden of disease, the prevalence and main causes of morbidity and mortality, and the status of health care services across the country. WHO and other UN agencies (IOM and UNICEF) have invested heavily in supporting the development of the DHIS-2. When the DHIS-2 is fully up and running, it will allow both WHO and the MoH to have a better understanding of the evolving health situation in the country and plan their response accordingly.

In early 2019, WHO launched a survey to assess patients’ level of satisfaction with the health care they received from EHTs in Sabha, Ubari, Tarhouna, Benghazi and Ejdabia. Between May and October 2019, completed questionnaires were collected from 486 patients who agreed to participate. Although many survey respondents reported that the medicines they needed were not available, 85% of patients said they were satisfied with services nonetheless. This high level of satisfaction can be attributed to the fact that before the teams arrived, many patients had no access to health care of any kind.

<table>
<thead>
<tr>
<th>Month</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
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</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>15%</td>
<td>3%</td>
<td>4%</td>
<td>28%</td>
<td>17%</td>
<td>7%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Not Satisfied</td>
<td>85%</td>
<td>97%</td>
<td>96%</td>
<td>72%</td>
<td>83%</td>
<td>93%</td>
<td>95%</td>
<td>98%</td>
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</tbody>
</table>

All complaints were recorded and followed up. For example, some patients expressed dissatisfaction with the long distances they had to travel to reach the nearest health care facilities, WHO responded by deploying mobile clinics to bring services closer to beneficiaries. Also, an EHT member was removed and replaced following repeated complaints about her performance.

WHO is expanding the survey to cover additional municipalities. To avoid bias in reporting from the EHTs, WHO’s field coordinators will supervise the administration of the questionnaires and collect patients’ feedback and complaints on a weekly basis.

WHO faces many challenges implementing its humanitarian work in Libya. Divided governance structures and competing public administrations have undermined efforts to find medium- and longer-term solutions to rebuild the health system. The absence of national and international health NGOs has hampered the delivery of health care services in areas affected by conflict. Access to many parts of the country is difficult and WHO has no partners on which it can rely to monitor the health response. WHO has recruited national field coordinators who travel to hard-to-reach areas to oversee the delivery of supplies, monitor operations and report back to the WHO country office. WHO plans to expand its network of field coordinators and invest in additional training on data collection, conflict sensitivity and monitoring.

The sheer size of the country and its sparse population density, compounded by poor supply routes, especially in the south, have hampered WHO’s emergency operations and increased their costs. To help overcome this, WHO pre-positions contingency stocks in key locations whenever access permits.

All UN agencies and international NGOs are encountering significant delays clearing emergency supplies through Libyan ports. Experience has shown that the process (from the time the goods arrive till the time they clear customs) takes anywhere from two to four months. WHO incurs even longer delays because its medicines and medical supplies must undergo regulatory clearance by the country’s Food and Drug Administration. These delays greatly increase WHO’s procurement costs since goods that remain in customs incur significant demurrage and storage fees. WHO is attempting to negotiate fast-track procedures with the national authorities but has made little headway thus far. It will continue its efforts to resolve this issue.

The very limited presence of international staff inside the country has been another challenge. The UN has placed a ceiling on the number of international staff that each agency is allowed to have inside Libya at any one time. Currently, WHO is allowed only three. International staff are important because they can cast a neutral eye on planning, managing and monitoring operations. They have more international experience and exposure than national staff, who may be unused to working in emergencies. Moreover, national staff are at risk of being unfairly subjected to internal political pressures or other considerations. To help overcome this difficulty, WHO has asked for its quota to be increased to at least five. For future projects, WHO will rotate staff and consultants from Tunis to Tripoli based on whether their presence inside the country is essential and for how long. When deciding who and whether to rotate staff from Tripoli to Libya, security concerns will be the overriding consideration.

Lastly, security constraints restrict the travel of WHO staff to many locations. The movement of WHO staff is subject to strict UN security arrangements and out of the hands of the Organization. Tripoli’s only operational airport (Mitiga) is frequently closed because of skirmishes and rocket fire in the area. The situation seems unlikely to change for the immediate future. In the meantime, WHO plans to reinforce remote management through investing in tools to track goods and services delivered and recruiting third party monitors at central and sub-national levels.
WHO’S PRESENCE IN LIBYA

WHO’s main office in Tripoli is supported by sub-offices in Benghazi and Sebha and national emergency officers in the three regions. Field coordinators across all districts of the country conduct regular needs assessments, monitor the implementation of WHO’s activities and provide regular updates to the emergency coordinator in Tripoli. WHO’s office in Tunis, Tunisia serves as a backup base for additional staff and allows for the possibility of remote management from there if the security situation forces WHO to temporarily withdraw from Libya.

LOOKING AHEAD

The political stalemate, armed hostilities and liquidity crisis appear likely to continue for the foreseeable future. The arms embargo has been ineffective and the increased interference of foreign elements including armed groups from Chad, Sudan, Syria and Turkey poses a direct threat to the security and stability of Libya. The need for humanitarian health assistance will remain across the country, with further changes in political control likely to result in new population displacements and additional humanitarian needs, placing a further strain on grossly inadequate health care facilities. Attacks on health care are likely to persist, further reducing patients’ access. Discrimination against some population groups may continue, with unintended consequences. For example, the inequitable treatment of migrants may lead to increased rates of life-threatening tuberculosis if those with untreated or undetected disease are released from detention centres into society at large.

Addressing urgent needs

In 2020, WHO’s response will focus on geographical areas ranked 4 and 5 on the severity scale. On behalf of the health sector, it will work to secure faster, more flexible approvals to deliver medicines and supplies, support patient referrals and evacuations, conduct vaccination campaigns, monitor health needs and assess the health response. Unimpeded access to all parts of Libya will be essential. The Organization will continue to provide health care facilities with essential medicines, supplies and equipment to support their uninterrupted functioning. Mobile teams will supplement health care services in remote, rural and hard-to-reach areas and IDP settlements. Vulnerable groups including women and children, people with mental disorders and physical disabilities, and chronic disease patients will be prioritized.

\[9\]

The severity of needs in different geographic locations in Libya are classified based on a scale from 0 to 6. People in areas ranked 4 and 5 are classified as being in acute and immediate need of humanitarian assistance.
Training

Investing in the health workforce is an opportunity to create decent employment opportunities, in particular for women and youth. WHO will support the MoH’s review of policies for the education, employment, retention and performance of its workforce and explore ways to ensure its more equitable distribution, especially in remote, rural and under-served areas. Training activities will be decentralized to help ensure that the capacity of health workers is built throughout the country. WHO will also explore how it can work with community health structures to begin the long process of building health care capacity from the bottom up while strengthening civil society.

Nursing workforce

Nurses devote their lives to caring for mothers and children; giving life-saving immunizations and health advice; looking after older people and generally meeting everyday health needs. They and health advice; looking after older people and children; giving life-saving immunizations and under-served areas. Training activities will be decentralized to help ensure that the capacity of health workers is built throughout the country. WHO will also explore how it can work with community health structures to begin the long process of building health care capacity from the bottom up while strengthening civil society.

Primary health care

In Libya, strengthening PHC and mental health services are also priorities. WHO will support the expansion of a comprehensive family practice model, including mental health services in PHC facilities. It will also support an interim, and less comprehensive, minimum service package (MSP) designed to meet the acute needs of patients in emergency and conflict settings. The MSP will include emergency and trauma care, the management of communicable and noncommunicable diseases, maternal, neonatal and child health, mental health and psychosocial support, vaccination, disease surveillance and outbreak response.

Mental health services

Mental health services in Libya have been traditionally under-funded and neglected, and the reliance on conventional (institutionalized) models of care has resulted in limited service coverage. Given that it will require many years to establish nationwide, community-based mental health services, WHO will focus on filling urgent gaps in the most affected areas. WHO has a long history of successfully establishing mental health services during crises. For example, in Syria, now in its ninth year of conflict, mental health services are more widely available than ever before. Before the Syrian conflict began, the situation was comparable to that in Libya: mental health services were available only in two psychiatric hospitals in Aleppo and Damascus. The turning point came when WHO convened a multi-stakeholder meeting to develop a plan to scale up mental health and psychosocial support services. A key intervention was the integration of mental health services in PHC facilities. This was done by training general physicians on how to manage patients with stress, depression, psychosis, suicidal tendencies and psychosomatic conditions, using WHO’s Mental Health Gap intervention guide. Mental health care is now being offered in primary and secondary health-care facilities in more than 10 Syrian cities in some of the most affected governorates in the country. WHO aims to replicate this experience in Libya.

Disease surveillance

WHO will work with local and national authorities to strengthen disease outbreak investigation and response and increase the number of sentinel sites reporting to the disease surveillance system. It will strengthen efforts to improve screening for TB, including in detention centres, and will continue to liaise between the NTP, UN agencies and international NGOs to coordinate and streamline health care services in the centres.
Accountability to beneficiaries

WHO will also participate in the common feedback mechanism (CFM) being introduced for humanitarian organizations in Libya. The CFM will provide 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. Each request will be channelled to an organization best placed to respond. All participating organizations will be required to review and resolve all issues within an agreed time frame. The CFM will allow the humanitarian community to collect feedback from affected populations, better understand their needs and speedily resolve their problems.

Resource mobilization and advocacy

WHO will continue to appeal for short- and medium-term funding to prevent the further disintegration of health care and other public services, while at the same time advocating for the release of Libyan assets to restore the health system and fund critical health care needs.

Longer-term priorities

WHO will work with other partners to go beyond humanitarian relief and address structural issues that hinder national capacity to provide basic social services. WHO will work with development agencies through the humanitarian-development nexus to set joint outcomes - with realistic targets and deadlines - that address urgent needs while building the foundation for strong public services in support of Libya’s transition to a peaceful democracy.

DONORS IN 2019

WHO thanks the following donors for their support to its work in Libya in 2019.

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ANNEX 1
MAIN ASSESSMENTS CONDUCTED AND TECHNICAL GUIDELINES AND REPORTS PUBLISHED IN 2019

Assessments conducted by WHO

Pilot assessment of patient safety in Libyan hospitals
Assessment of Libyan Essential Medicines List 2019
Assessment of key essential indicators in public hospitals and PHC centres
Assessment of national tuberculosis guidelines
Assessment of national measles and rubella surveillance guidelines
Assessment of national acute flaccid paralysis surveillance guidelines
Assessment of Surveillance System for Attacks on Health Care
Assessment of Early Warning Alert and Response Network

Guidelines and policies prepared and adopted by the MoH with technical support from WHO

National action plan to tackle antimicrobial resistance in Libya
National measles guidelines
Updated guidelines for the surveillance of acute flaccid paralysis
National guidelines on the integrated management of neonatal and childhood illnesses
Strategic plan for reproductive, maternal, newborn, child and adolescent health in Libya, 2019-2023

Reports published by the MoH with technical support from WHO

Mapping of private health facilities of Libya, 2019
Human resources for health observatory
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