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LIBYA

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ANNUAL REPORT 2020

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FOREWORD



The year 2020 was marked by two major events. Throughout the first half of the year, the fight for control over the country's considerable resources continued between the UN-recognized Government of National Accord (GNA) in the west and the Libyan National Army (LNA) in the east. In June 2020, decisive gains by the GNA led to a cessation of hostilities and the withdrawal of the LNA from the western part of the country.

The year was also indelibly marked by the COVID-19 pandemic. On 24 March 2020, Libya reported its first confirmed case of the disease. By the end of the year, almost 100 000 people had been infected with the virus. COVID-19 laid bare the country's devastated infrastructure and governance vacuum. Libya faced a pandemic on top of divided governance, widespread corruption, a collapsing economy, an armed conflict and a severely disrupted health system. Border closures and national lockdowns disrupted trade and livelihoods, and the price of basic items rose steeply. Up to 90% of PHC centres were closed in some areas, and several hospitals were forced to suspend services. Health care staff refused to report for duty because they had no personal protection equipment (PPE) and had not been paid for several months. Conflict, COVID-19 and economic collapse threatened to plunge hundreds of thousands of civilians deeper into chaos.

The extraordinarily complex political and security environment hampered efforts to contain the spread of the pandemic. The absence of national leadership led to unrealistic expectations being placed on WHO and the health sector. However, the main factors preventing an effective response are beyond WHO's control and can only be resolved through a negotiated political settlement that sets Libya on the path to stability and democracy.

As the lead agency for health in Libya, WHO was at the forefront of efforts to stem the spread of COVID-19 and support the government's

immediate and longer-term response. WHO had to reassign many of its staff and divert other resources to meet the extraordinary challenges posed by the pandemic. Working on three fronts, WHO supported the COVID-19 response, continued its humanitarian operations, and delivered medicines, equipment and supplies to keep essential health services running. The Organization worked with leaders on both sides of the political divide to help ensure that people in all parts of the country received humanitarian assistance.

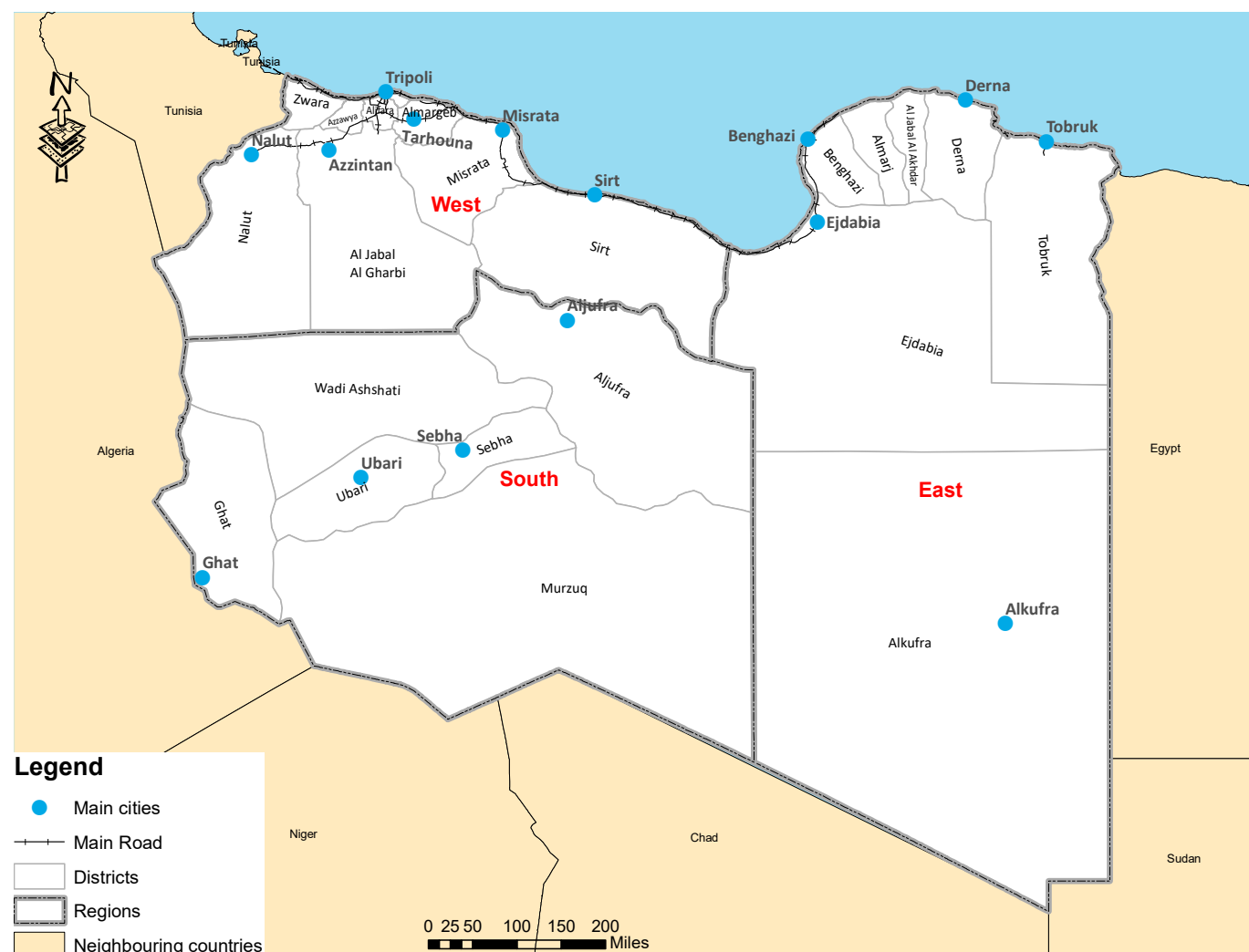
WHO continued its advocacy efforts on behalf of the health sector. WHO and UNICEF drew attention to repeated vaccine shortages that led to tens of thousands of children missing their scheduled vaccinations. Following WHO's direct intervention, the Governor of the Central Bank of Libya released immediate funds to replenish the country's vaccine supplies. WHO was also instrumental in securing the release of funds to pay Libyan health care workers who had not received their salaries for several months.

Recently, the GNA and LNA took a significant step towards negotiating a political solution to the hostilities. On 23 October 2020, military officers from both sides signed a countrywide, permanent ceasefire agreement in Geneva under the auspices of the United Nations Support Mission in Libya (UNSMIL). The agreement calls for the withdrawal of all military units and armed troops from conflict frontlines and the departure of all mercenaries and foreign fighters within 90 days. In December 2021, Libyans will hold national elections to elect a government of national unity. These developments offer the best hope in several years for a peaceful end to the conflict.

Elizabeth Holf

OVERVIEW

Political developments



Libya's three regions and 22 districts

The conflict in Libya continued in 2020, fuelled by external powers that channelled money and weapons to factions inside the country. The country's porous borders, especially in the south, allowed the smuggling of migrants, foreign fighters and weapons to continue unabated. Two competing governments – the Government of National Accord (GNA) in Tripoli and the rival government in the east backed by the Libyan National Army (LNA) continued to fight for power and resources. The situation was exacerbated by local conflicts between various factions and ethnic groups that laid bare the country's deep tribal and political divides. Although Libya has the largest oil reserves in Africa, the continuing blockade of the oil sector devastated its economy. In addition, the coronavirus disease (COVID-19) pandemic led to national lockdowns, rocketing food prices and significant loss of livelihoods, especially for the refugees and migrants who make up approximately 9% of Libya's population.

At the beginning of the year, international diplomatic initiatives seeking to end the conflict were short-lived. In January 2020, the Berlin Conference on Libya emphasized the need for a political solution to end the conflict. The following month, the United Nations Security Council [unanimously endorsed](#) the conclusions of the conference and called for a lasting ceasefire. Despite this, skirmishes between the GNA and LNA continued, with control of key locations passing back and forth between them. The LNA continued its prolonged attempt to gain control of Tripoli and

surrounding areas. In mid-April, LNA-controlled towns along the western coastal road were seized by the GNA. The town of Tarhouna, a strategic stronghold of the LNA, became a flashpoint and was attacked and besieged the same month. In June, GNA forces retook Tarhouna and other cities on the coastal road and then regained full control of Tripoli and nearby areas. The subsequent discovery of several 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.

Water and electricity cuts were used as instruments of war. In April 2020, more than two million people in Tripoli and surrounding areas were left without water for more than a week. In the spring of 2020, military activity around Tripoli disrupted hospitals' electricity supplies and damaged the only factory producing oxygen tanks, just when oxygen was critically needed for the COVID-19 response. At the height of the summer, when temperatures reached well over 40°C, continued fighting in the west cut off water and electricity supplies for prolonged periods. By July 2020, daily blackouts were averaging 12 hours per day.

In October 2020, prospects for lasting peace improved when military officers from the LNA and GNA signed a permanent ceasefire agreement in Geneva under the auspices of UNSMIL. By the end of the year, the agreement had been breached several times.

COVID-19

On 14 March 2020, in the face of the threat posed by the virus, Libya declared a state of emergency and closed all its air and sea ports. Ten days later, it reported its first confirmed case of the disease. By the end of the year, almost 100 000 people had been infected with the virus. The pandemic exposed the country's inequalities and placed a huge strain on its already severely disrupted health system. Many households were plunged into poverty. Border closures, movement restrictions and curfews imposed to reduce the spread of the virus drove up the cost of food and essential items by 20%. Many of the country's more than half million migrants and refugees no longer had access to the informal work opportunities they once had. Because of their displacement or legal status, they had limited access to health care services. Those who tried to return home found they could no longer do so because travel was extremely difficult and their sources of income had disappeared.

The extraordinarily complex political and security environment in Libya hampered efforts to contain the spread of the pandemic. Unequal access to health care put the most vulnerable, particularly refugees and migrants, at a disadvantage. There was very little coordination between the

GNA in the west and the LNA in the east. Both governments attempted to make political capital out of the COVID-19 crisis by discrediting their opponents and claiming they had the capacity to respond on their own. The lack of accountability and internal tensions within and between different government departments delayed critical decisions about releasing urgently needed funds to procure vaccines or support the COVID-19 response. In Tripoli, the position of Minister of Health remained vacant for most of the year, and the deputy Minister was wanted on corruption charges. By the end of the year, the COVID-19 national preparedness and response plan, drafted at the beginning of the pandemic, had still not been formally endorsed.

The health system, already severely damaged by years of under-investment, struggled to cope with the additional demands brought by COVID-19. At the start of the pandemic, reports indicated that in some areas, up to 90% of primary health care (PHC) centres had closed and several hospitals had been forced to suspend services because health care staff refused to report for duty without PPE. Health care workers were paid only sporadically and many were no longer reporting for duty.

People in need of humanitarian health assistance

Beset by conflict and insecurity, almost 900 000 people in the country needed humanitarian assistance, including close to 400 000 Libyans (about 6% of the population) who had been displaced. Following the LNA's failed military offensive, people slowly began returning home,

particularly in the areas around southern Tripoli. By the end of the year, the number of displaced people had fallen to around 392 000. However, the presence of landmines and unexploded ordnance posed a significant threat to returnees.

Status of health care services

More than half of Libya's health care facilities that were functioning in 2019 were forced to close in 2020. Closures were especially severe in rural areas, mainly because of security threats and lack of national and health sector funding. Those that remained open suffered frequent electricity cuts that were exacerbated by shortages of fuel to run back-up generators. Repeated stockouts of critical vaccines disrupted immunization schedules and put children at risk of life-threatening diseases such as measles and polio. WHO and UNICEF estimated that more than a quarter of a million children had missed their doses of essential vaccines. Nationwide, over two thirds of PHC centres had no antibiotics, analgesics, insulin, blood pressure medication or any of Libya's other top 20 essential medicines. Most health care staff had to wait months to receive their salaries. In

addition, many of them were reluctant to report for duty for fear of being infected with the SARS-CoV-2 virus. Between January and August 2020, only 70% of disease alerts were investigated and responded to within 72 hours.

In 2020, WHO assessed the health situation and health needs in 79 Libyan communities (comprising over 850 000 people) in 11¹ of Libya's 22 districts. Over 90% of these communities were in areas ranked as 3 or above on the severity scale². The assessment found that although hypertension and diabetes were the most commonly reported diseases, medicines to treat them were widely unavailable. The nearest health care facility for patients was on average 14 km away, and this meant that they were inaccessible for many people.

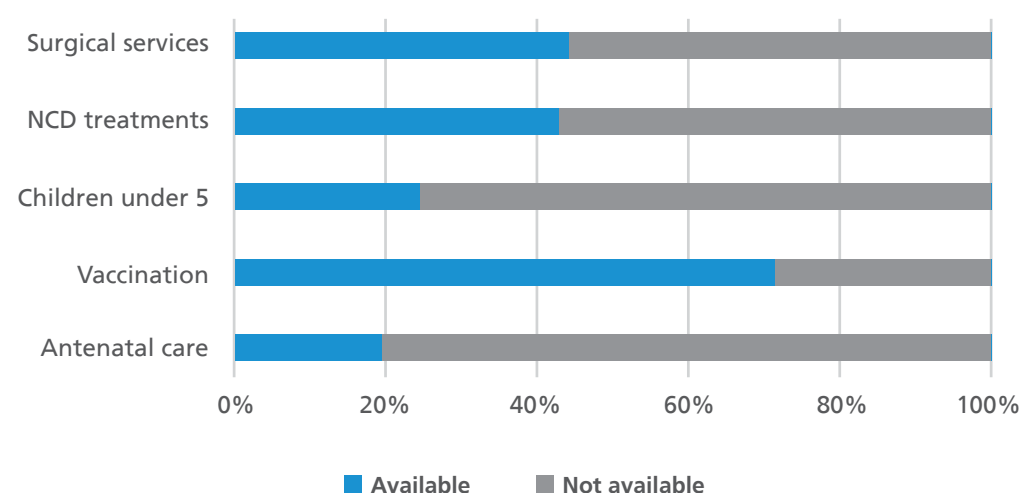
¹ East Libya: Ejdabia. West Libya: Al Jabal Al Gharbi, Al Jufra, Azzawya, Misrata, Sirt, Ubari, Zwara. South Libya: Al Kufra, Ghat, Murzuq.

² For information on the severity scale, see the section on WHO's response.



An assessment of the availability of five essential health care services in the historically underserved south revealed that only 12% of primary health care (PHC) facilities had all five services. Moreover, only 3% of facilities had stocks of all top 20 essential medicines, and almost one third had no essential medicines at all. Three quarters of communities had no antenatal care services or health care services for children under five years of age.

Availability of five essential health care services in 56 PHC facilities in south Libya



Trauma care and disability services were available only in Libya's main cities, and mental health services were almost non-existent. Immunization services experienced repeated vaccine stockouts. COVID-19 lockdowns and curfews further reduced people's access to PHC services.

Patients were increasingly referred for treatment to the main cities of Tripoli, Benghazi, Misrata

and Sebha. However, referrals were hampered by the lack of reliable ways to transfer patients for secondary or tertiary level care. Moreover, many hospitals were forced to suspend their services due to the high rates of COVID-19 infection among patients and staff, further exacerbating gaps in the health system. Many people were forced to seek private health care, diverting resources from overstretched family budgets.

Health care workforce

Libya has 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. WHO's 2020 assessment of health facilities in 11 districts showed there were six nurses for every physician. The country continues to rely heavily on foreign health care workers, even though the overseas workforce has steadily dwindled since 2011 when the conflict began.

The Ministry of Health's (MoH) plans to conduct a detailed analysis of the health workforce in 2020 had to be put on hold because of the COVID-19 pandemic. If the analysis goes ahead as planned in 2021, it will form the basis of a long-term strategy

to grow Libya's health workforce, especially in priority areas such as primary health care, nursing and mental health. Achieving this will require more training, greater recruitment, better retention and more flexibility and incentives to improve the equitable distribution of the health workforce across the country.

In 2020, WHO was actively involved in the development of a United Nations Population Fund (UNFPA) strategy to strengthen Libya's nursing and midwifery workforce. The strategy will be implemented in 2021. WHO is also in discussions with the World Bank on a three-year World Bank-funded project to strengthen Libya's health workforce.

Attacks on health care

In 2020, there were 36 confirmed attacks on health care in Libya that killed nine people and injured 23 others. In addition, military activity around Tripoli in the spring of 2020 disrupted hospitals' electricity supplies and damaged the only factory producing oxygen tanks just as shortages of oxygen to treat COVID-19 patients were beginning to be reported.

The forced closure of health facilities following attacks has an obvious immediate impact. People who need health care, including some who may have COVID-19, are no longer able to obtain it and some of them may die. In the long run, the cost of rebuilding hospitals and clinics and retraining health staff can run into hundreds of millions of dollars.

In January 2020, two health workers in Sirt were killed and another five were injured following

airstrikes. In April 2020, Al Khadra hospital in Tripoli came under sustained shelling for more than two days. The United Nations Secretary-General [issued a strongly worded statement](#) reminding all parties that medical personnel, hospitals and medical facilities were protected under international humanitarian law and that attacks on them might constitute war crimes. In early May 2020, an armed group opened fire inside the intensive care unit of Al-Jalla hospital in Benghazi. Doctors and nurses were assaulted, life-saving medical equipment was damaged, and critically ill patients had to be transferred to Benghazi Medical Centre. Later that month, the Director-General of WHO and heads of other UN agencies³ issued a [joint statement](#) expressing their alarm over the continuing attacks on health care. Despite their appeal, another 19 attacks occurred between mid-May and 31 December 2020.

³ United Nations Office for the Coordination of Humanitarian Affairs, UNICEF, International Organization for Migration, United Nations Refugee Agency, United Nations Population Fund and the World Food Programme.



A Ministry of Health warehouse lies in ruins following an attack.

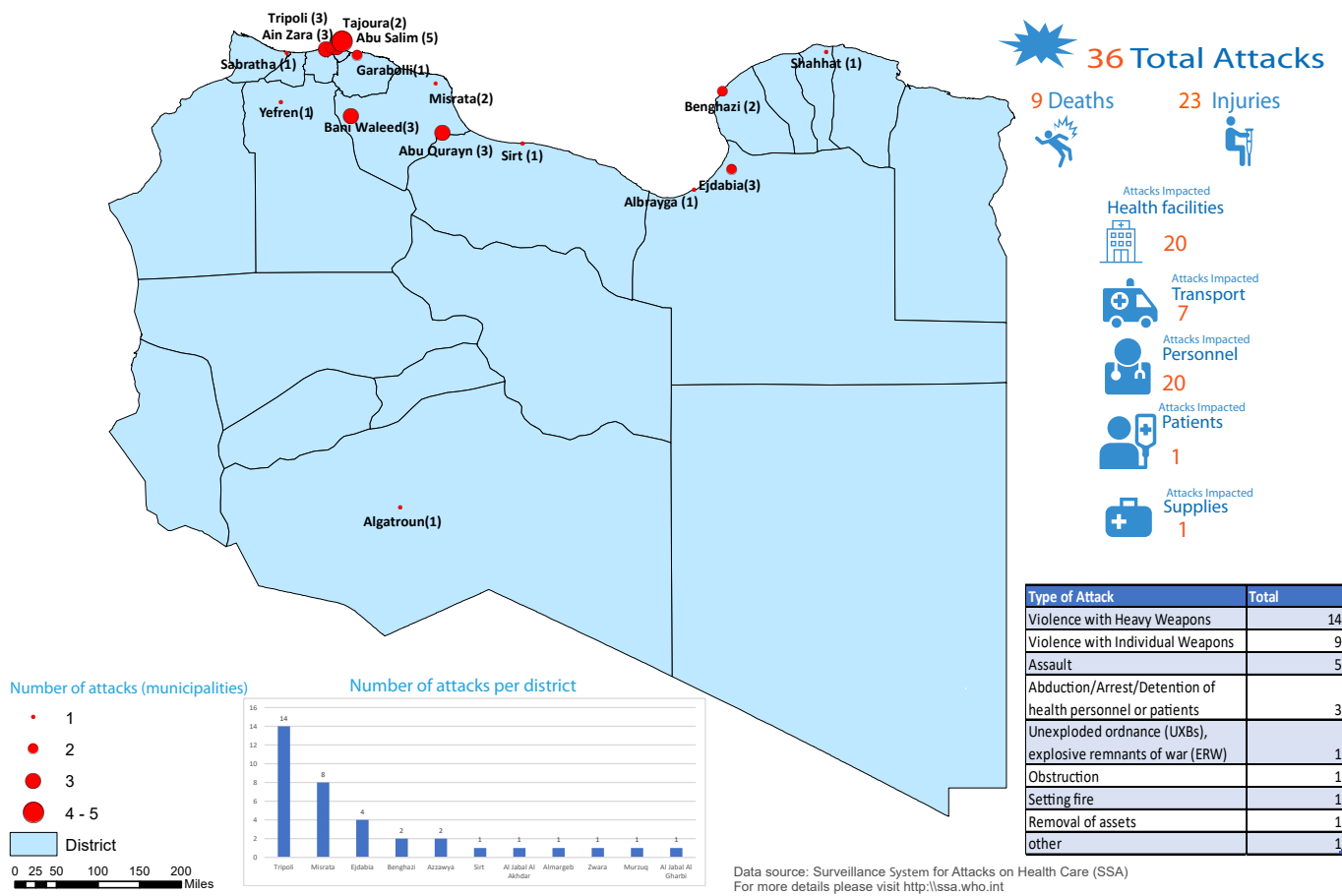
Credit: WHO

The year 2020 was also marked by the abduction of health care staff and the diversion of aid supplies. In April, two doctors, a nurse and an administrative assistant in a hospital in Sirt were kidnapped by an armed group. They were released after several weeks. In September, a professor of surgery at Al-Khadra General Hospital in Tripoli was abducted on his way to work and released a few days later. In December, a prominent orthopaedic surgeon who was also the deputy head of a major hospital in Tripoli was kidnapped by an armed group and released after four days.

In August, in a new and worrying development, militia near the town of Al Zawya (western Libya) intercepted a truck on its way to east Libya to deliver WHO humanitarian supplies. The driver was detained overnight and instructed to deliver the supplies to a nearby health care facility the following morning. WHO repeatedly asked the national authorities in Tripoli to intervene and ensure the supplies were restored to the Organization for delivery to the east. Its

requests went unanswered. In December 2020, an ambulance procured by WHO was hijacked near Misrata on its way to Benghazi for delivery to the health authorities in east Libya. Although it was released a few days later, it remains in Misrata until WHO receives assurances from the authorities in west Libya guaranteeing its safe passage to Benghazi.

WHO's mandate is to deliver aid to all who require it, regardless of their political or religious affiliations. Attacks on health care and interference by militia and other armed groups are against all humanitarian aid principles and are wholly unacceptable. Health workers throughout Libya must be allowed to do their jobs in a safe and secure environment. They are already putting their own lives at risk to care for others during the COVID-19 pandemic. Many of them lack PPE and are paid only sporadically, yet they continue to come to work every day knowing they run the risk of coming under attack, being kidnapped or contracting COVID-19.



WHO'S RESPONSE

As the lead agency for health in Libya, WHO was at the forefront of efforts to stem the spread of COVID-19 and support the government's immediate and longer-term response. WHO reassigned many of its staff and diverted other resources to meet the extraordinary challenges posed by the pandemic, while also continuing to run its life-saving humanitarian operations. WHO continuously advocated for the need to maintain other critical health care services while tackling the COVID-19 crisis. At the Organization's request, the national authorities added a ninth pillar to the COVID-19 national preparedness and response plan that addressed the need to keep essential health services running during the pandemic.

By the end of 2020, WHO's emergency operations had reached all 22 districts in the country, including areas classified as level 3 or above on the severity scale. The WHO country office (WCO) supported 196 health care facilities with equipment and supplies, and deployed 13 emergency medical teams to strengthen health care services across the country, mainly in areas where people had acute humanitarian needs. WHO'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. WHO's humanitarian assistance accounted for almost 40% of all medical procedures and consultations supported by the health sector. Over two thirds of the standard health kits distributed in 2020 were provided by WHO.

The health sector severity scale

The health sector in Libya prioritizes its response based on the humanitarian severity scale. "Severity" expresses the degree of unmet needs for people in different geographical areas. Classifying the severity of humanitarian conditions is a standard component of humanitarian needs analyses.

Humanitarian health needs in different geographic locations are classified based on a scale from 0 to 5. People in areas ranked 3, 4 and 5 are classified as being in severe, extreme and catastrophic need of humanitarian assistance, respectively.

At the end of 2020, over one million people in 72 of Libya's 100 municipalities were living in areas ranked 3 and above on the severity scale:

58 municipalities had severe needs
12 municipalities had extreme needs
2 municipalities had catastrophic needs

In May 2020, the town of Tarhouna, 65 kilometres southeast of Tripoli, was the scene of intense fighting between LNA and GNA forces. More than 3000 people fled their homes, and humanitarian agencies had very limited access to 200 000 civilians trapped inside the town and surrounding areas. The humanitarian situation was reportedly dire: electricity and water supplies had been cut, most health care facilities had been forced to suspend their services, and the town was running out of life-saving medicines. Trucks bound for Tarhouna carrying essential supplies were bombed by drones several times, leaving the town and almost 150 000 people in nearby Baniwaleed facing acute shortages of food, medicine and fuel. WHO deployed a team of six surgeons to support emergency operations, and successfully delivered life-saving supplies to both Tarhouna and Baniwaleed in three separate shipments – the only agency to do so. Other UN agencies subsequently solicited WHO's assistance in negotiating access to the area to deliver their own supplies.

Continuing insecurity forced WHO to postpone – twice – a critical humanitarian mission to the coastal town of Sirt. Sirt lies halfway between Tripoli and Benghazi and is a strategic gateway to major oil facilities. At the beginning of 2020, the LNA gained control of the town. Following the LNA's

withdrawal from Tripoli in June 2020, the focus of the conflict turned to Sirt. Military forces on both sides mobilized over the summer. There were serious concerns over the likely significant impact of an attempt by the GNA to regain control of Sirt. Humanitarian needs in the town were reported to be acute: approximately 125 000 people living in the area were at significant risk. WHO led the development of a health sector contingency plan to deliver supplies and equipment and deploy medical teams to Sirt. At the end of the year, the threat of an escalation in the hostilities remained.

Emergency Operations Centres

In February 2020, the WHO-supported emergency operations centre in Benghazi officially opened. It is the second EOC to be opened in Libya with support from WHO and donors. (The first EOC in Tripoli was inaugurated in late 2019.)

The EOCs in Benghazi and Tripoli act as central points for emergency planning and for gathering, analysing and disseminating information on the impact of the ongoing emergency on the health system and health care facilities. At the time of writing this report, the EOCs were acting as command centres for the coordination of the emergency response to COVID-19.



The first meeting of the incident management team at the Emergency Operations Centre in Benghazi.

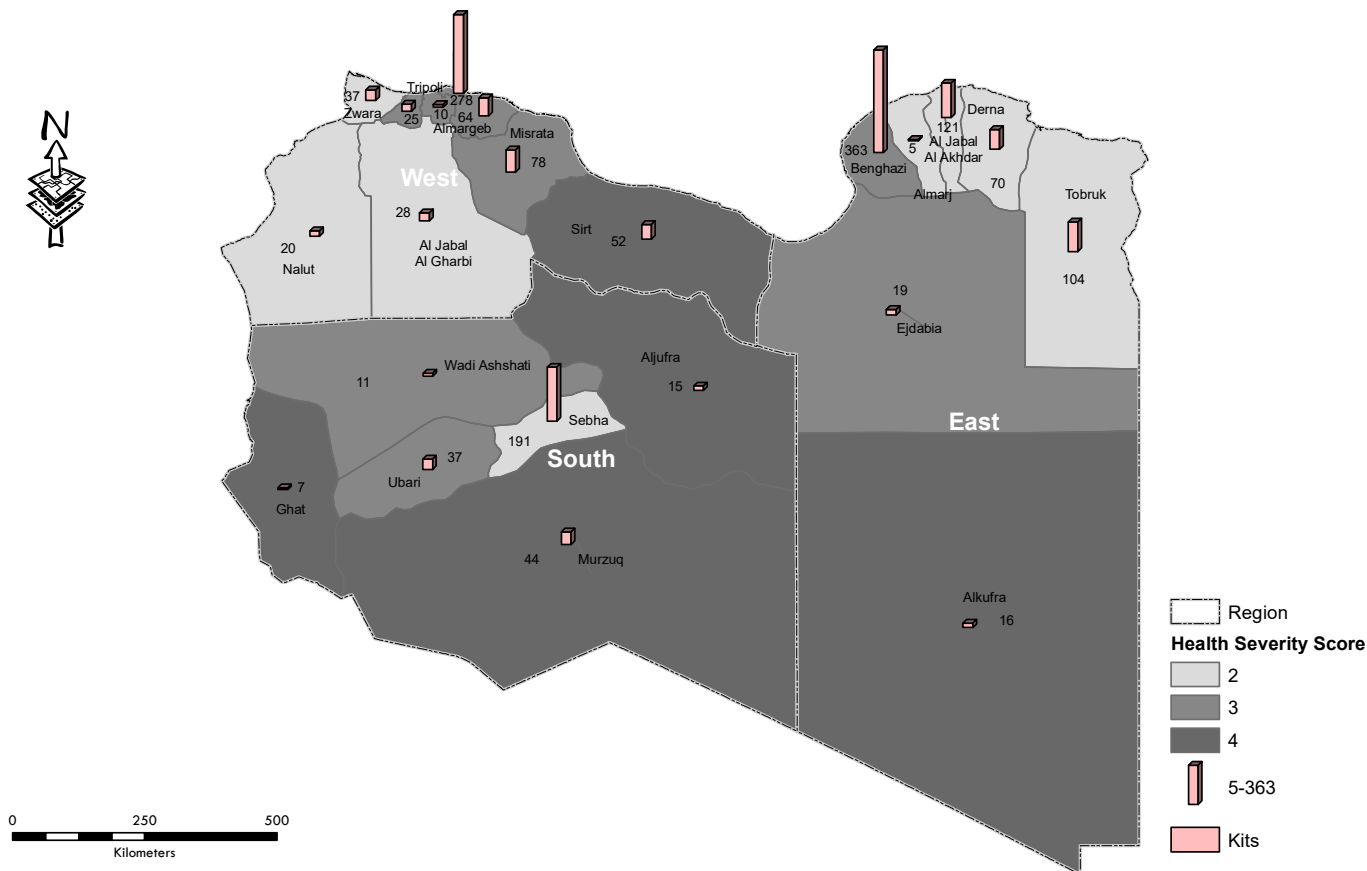
Credit: WHO

WHO's operations are governed by the humanitarian imperative of saving lives and reducing suffering regardless of political divides or where people happen to live. It is one of the few agencies that is operational and visible in eastern Libya, and the only UN agency that has actively engaged with the leadership of the LNA to secure

its backing for the immediate release of supplies and the distribution of urgently needed funds. Other UN agencies are following WHO's example and strengthening their presence in the east. WHO will continue to expand its presence in both the east and south, where needs are also severe.

Delivering emergency supplies

In 2020, WHO delivered enough kits, medicines and supplies to treat more than 1.8 million people throughout Libya.

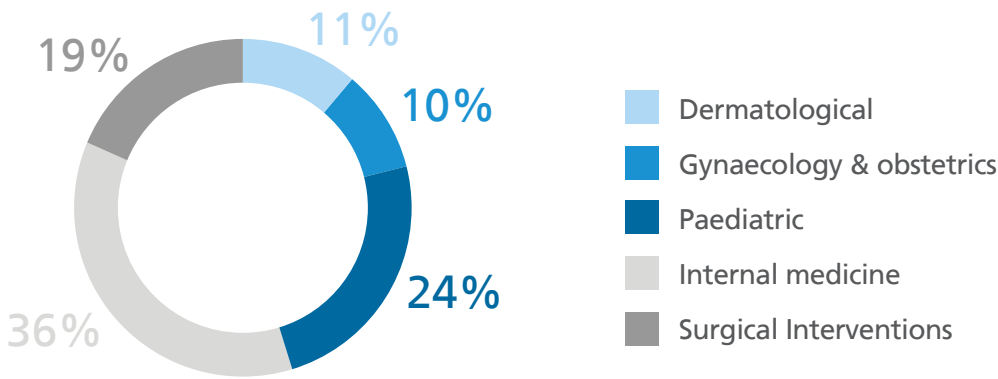


WHO supplies are delivered to a PHC centre in Tripoli.
Credit: WHO

Deploying emergency medical teams

WHO supported 13 emergency medical teams that provided services in 27 health care facilities across the country. Between 1 January and 31 December 2020, they carried out more than 133 550 medical procedures, including 24 813 trauma and surgical interventions.

Breakdown of services provided by emergency medical teams



Training health care workers

WHO trained a total of 1939 health care workers throughout the country, a 46% increase compared with 2019. This number included:

- 1470 people who were trained on topics related to COVID-19 including laboratory diagnosis, case definition and contact tracing, infection prevention and control, and risk communication.

- 469 people who were trained on topics including vaccine-preventable diseases, noncommunicable diseases, mental health and psychosocial support, the integrated management of childhood illnesses, reproductive health care and emergency and trauma care.

Because of COVID-19 travel restrictions and national lockdowns, WHO switched to virtual training for many of its planned workshops.

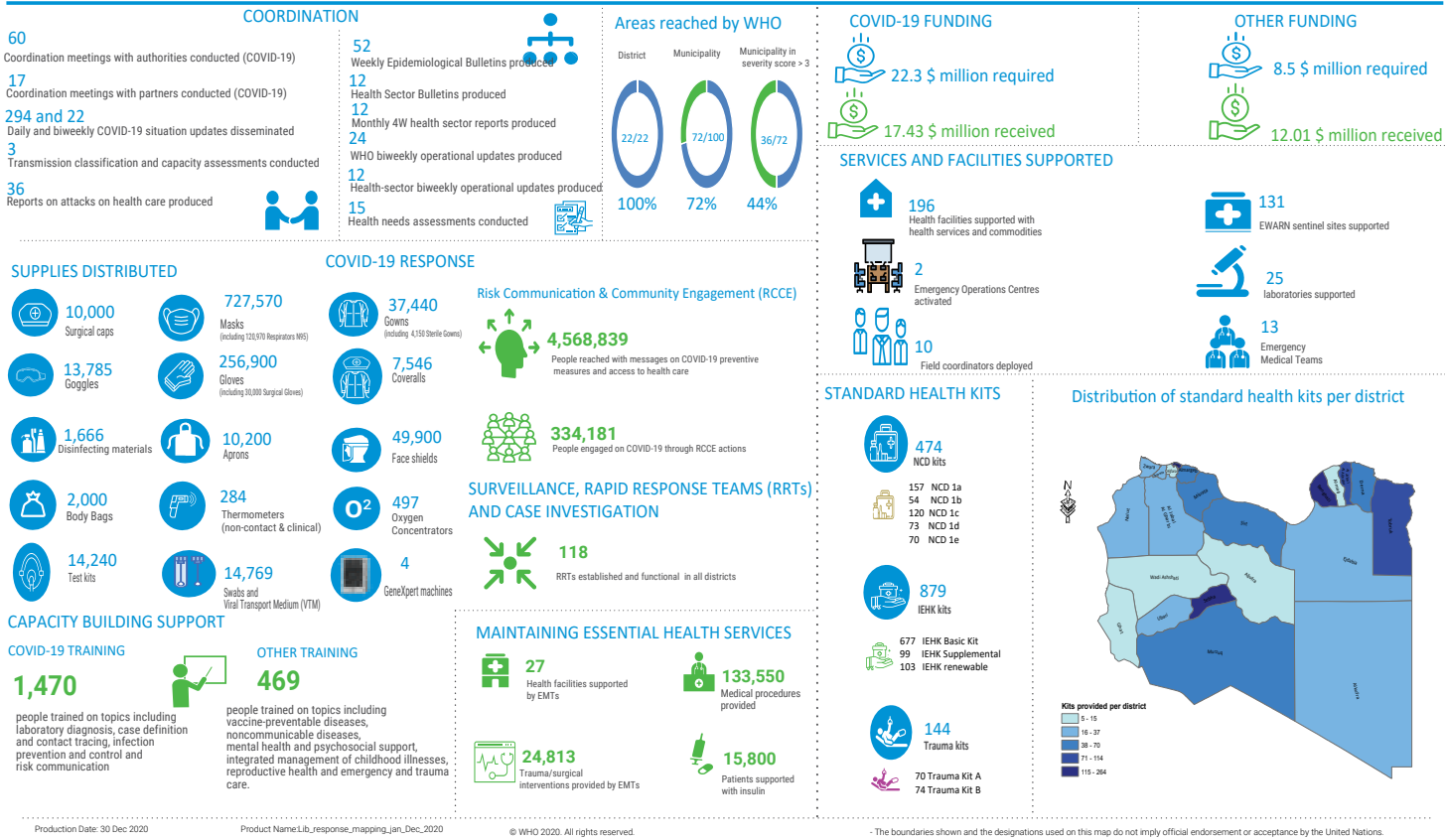


Participants at a WHO-supported workshop in Misrata.

Credit: WHO



WHO operational response, January - December 2020, Libya



PUBLIC HEALTH AREAS OF WORK

COVID-19

The first case of COVID-19 in Libya was reported on 24 March 2020. By the end of the year, official figures showed that almost 100 000 people had been reported to be infected with the virus, of whom 1440 had died (a case fatality rate of 1.5%). The number of reported deaths included only laboratory test-confirmed COVID 19 patients who were cared for in health facilities. Libya's mortality surveillance system has been badly disrupted (the last cause of death analysis dates back to 2016-2017), and the number of additional deaths from undiagnosed infections in communities remains unknown. In addition, acute shortages of tests meant that many patients did not have a confirmed diagnosis and thus were not recorded in official statistics. Therefore, the real numbers of COVID-19 cases and deaths are likely to have been much higher than indicated in official reports.

The onset of the pandemic in the midst of the conflict further disrupted Libya's health system. In March 2020, the UN and the international community [appealed](#) for a halt in the fighting to allow national health authorities and health partners to respond to the potential spread of COVID-19 in the country. The heads of WHO and other UN agencies issued a [second appeal](#) in May. Nonetheless, the fighting continued. Moreover, efforts to stem the spread of the disease were hampered by restrictions imposed by the national authorities on the free movement of medical and other humanitarian personnel. Even when exceptions were granted for humanitarian

workers, access was slowed by bureaucratic delays. Faced with the threat of the new virus, many health care staff refused to report for duty because they had no PPE or had not been paid. The traditionally neglected southern region was particularly hard hit: it had very little capacity to respond to the outbreak and received scant support from either the GNA or the LNA. At WHO's request, the acting Special Representative of the Secretary-General in Libya contacted the Prime Minister, the Minister of Finance and the Governor of the Central Bank to insist that health care workers be paid. As a result, Libyan health care workers who had not been paid for several months finally received their salaries. Nonetheless, the lack of regular salary payments for health care staff was a recurring problem throughout the year.

In the spring of 2020, Prime Minister Fayez Al-Sarraj announced a state of emergency and allocated 575 million Libyan dinars (about USD 406 million) to procure supplies and repurpose health care facilities to care for COVID-19 patients. However, there was no central system to identify needs and allocate supplies. Moreover, there was very little coordination between the central authorities and the municipalities who were at the forefront of managing the pandemic response. Municipal health initiatives were haphazard and uncoordinated either centrally or with other municipalities. The proliferation of COVID-19 committees with unclear or overlapping mandates added to the confusion. Initially, Libya did not

pursue its early attempt to join the global supply chain system set up by WHO to manage COVID-19 supplies. As a result, instead of benefiting from the highly advantageous arrangements put in place by WHO, it chose to source its own supplies bilaterally, which meant paying much higher prices than those negotiated by WHO. Faced with the lack of information from the government on the status of procurement for COVID-19 supplies, municipalities approached WHO directly for assistance. WHO attempted to streamline these requests by asking municipalities to transmit them to central levels, while at the same time supporting municipalities with its limited resources.

WHO worked daily with health authorities throughout Libya to support strategic planning,

provide technical advice, strengthen disease surveillance, issue daily epidemiological bulletins, assess health needs, and provide medicines, equipment and laboratory supplies needed to keep essential health care services running. It trained almost 1500 health care workers and community volunteers and more than one hundred rapid response teams⁴ that worked across the country to track, test and treat COVID-19 patients. The Organization worked with leaders on both sides of the political divide to secure their backing for the immediate release of supplies and the distribution of urgently needed funds. It also acted as the COVID-19 technical adviser for the UN in Libya and briefed the international diplomatic corps on the status of COVID-19 and main needs, obstacles and gaps.



WHO emergency and COVID-19 supplies and PPE are delivered to Benghazi airport.

Credit: WHO

⁴ Rapid response teams (RRTs) are responsible for collecting samples from people suspected of having COVID-19, conducting contact tracing and providing medical care. An RRT typically comprises a physician, a surveillance officer, a medical technician, a data entry officer and in some cases an epidemiologist.

WHO drew special attention to the status of the more than half a million migrants and refugees in Libya, many of whom had limited access to health care. In July 2020, faced with the rapid spread of COVID-19 across the region, WHO and the International Organization for Migration (IOM) issued a joint statement warning that countries of the region needed to create the necessary conditions for migrants and returnees to seek health care without fear of repercussions so they could protect themselves, their families and their host communities and prevent the spread of infection.

In late August 2020, WHO met with senior LNA officials in east Libya and warned them that although COVID-19 was spreading rapidly, critical supplies continued to be blocked in customs for weeks on end. Following these meetings, the LNA authorities released WHO's supplies almost immediately and promised that future COVID-19 supplies arriving in the east would be released in less than 48 hours. The authorities in Tripoli have since then followed this example.

WHO was instrumental in helping Libya prepare its nine-pillar COVID-19 preparedness and response plan (see box). The WCO successfully advocated for the inclusion of a ninth pillar that addressed the need to keep essential health services running during the pandemic. To support these services, WHO donated emergency health kits, insulin, laboratory reagents, oxygen concentrators, PPE and other supplies to health facilities throughout the country. This helped reduce the risk of the total collapse of the Libyan health care system.

To improve COVID-19 surveillance, WHO worked with the national authorities to strengthen current reporting sites and add new ones (including private facilities) through training staff and procuring IT equipment. With the National Centre for Disease Control (NCDC) and IOM, it launched a new weekly epidemiological bulletin

that consolidated COVID-19 data from health facilities and from migrant sites covered by IOM's Displacement Tracking Matrix. By the end of the year, the number of sites reporting to the disease Early Warning and Response System (EWARS) had risen from 125 (at the end of 2019) to 150. However, only 125 of these sites are actively engaged in event-based surveillance (EBS)⁵. WHO, the NCDC and the US Centers for Disease Control and Prevention are reviewing ways to expand EBS throughout the country so as to improve the detection and investigation of unexplained events at an early stage.

To strengthen laboratory capacity, the WCO deployed 12 laboratory officers to the central public health laboratory in Tripoli and regional laboratories in Benghazi and Sebha to monitor adherence with biosafety standards, provide technical guidance for the day-to-day running of laboratories and support the introduction of new diagnostics methods and techniques.

The nine pillars of Libya's COVID-19 national preparedness and response plan

1. Coordination
2. Risk communication and community engagement
3. Surveillance, rapid response teams and case investigation
4. Points of entry
5. National laboratory
6. Infection prevention and control
7. Case management and therapeutics
8. Operational support and logistics
9. Essential health services

⁵ Event-based public health surveillance 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.



Laboratory technicians attend a workshop on COVID-19 biosafety.

Credit: WHO

At the global level, the WCO worked on Libya's behalf with other international mechanisms set up by WHO and partners to tackle the pandemic. These included:

- WHO's COVID-19 Supply Chain System. The pandemic led to acute worldwide shortages of PPE, diagnostics and supplies for the clinical management of COVID-19 patients. WHO's Supply Chain System was set up in April 2020 to ensure that countries would be able to procure essential supplies at the best possible price. The system provides a single streamlined channel through which countries can order PPE, biomedical equipment and diagnostic supplies. It allows WHO to consolidate demands, purchase supplies in bulk, negotiate the lowest possible prices on behalf of participating countries, agree on allocations based on needs, and streamline the distribution and transportation of supplies. Libya enrolled in the Supply Chain System in May 2020. WHO subsequently secured supplies worth over USD 3.4 million for Libya through the Supply Chain System.
- The COVAX Facility, a global initiative that will allow countries to purchase an agreed number of COVID-19 vaccines at a guaranteed price once they become available. COVAX is co-led

by the Vaccine Alliance (GAVI), the Coalition for Epidemic Preparedness Innovations (CEPI) and WHO. On 18 September 2020, Libya signed two key documents (the Confirmation of Intent to Participate and the Commitment Agreement) to secure its participation in COVAX. Towards the end of 2020, it transferred an advance payment to COVAX to secure 2.8 million doses of vaccine initially. This will be enough to vaccinate approximately 1.25 million people (two doses per person plus 10% wastage).

- The Access to COVID-19 Tools (ACT) Accelerator. ACT was established in April 2020 by WHO, the European Commission, France and the Bill & Melinda Gates Foundation to accelerate the development and production of, and equitable access to, COVID-19 tests, treatments and vaccines. (COVAX is one of ACT's four pillars; the other three are diagnostics, treatments and health system strengthening.) Libya has expressed keen interest in procuring the new, high-quality COVID-19 antigen rapid tests that will be made available to low- and middle-income countries following agreements with manufacturers negotiated by ACT. The WCO in Libya has procured 80 000 of these new tests and is distributing them to laboratories across the country.

Despite these efforts, Libya’s capacity to test, track and treat COVID-19 patients remains weak because of low testing capacity, inadequate disease surveillance and disrupted health facilities. Health facilities in the west of the country have received the bulk of the MoH’s COVID-19 supplies, while the south continues to be seriously underserved. In 2021, WHO will focus its efforts on training and equipping additional rapid response

teams (especially in the south) and ensuring the equitable distribution of tests, medicines and supplies to underserved areas. WHO will also support the development and implementation of a comprehensive national COVID-19 vaccination plan that accommodates the need for a reliable vaccine cold chain and ensures a surveillance system to monitor adverse events following immunization.

Primary health care

The impact of the COVID-19 pandemic on essential health services is a source of great concern. Major health gains achieved over the past two decades can be wiped out in a short period of time, as has been shown in previous humanitarian emergencies caused by armed conflict or disease outbreaks such as Ebola. The collapse of essential health services – including health promotion, preventive services, diagnosis, treatment and rehabilitative and palliative services – is likely to have serious adverse health effects, especially on the most vulnerable populations (e.g., children, older persons, people

living with chronic conditions or disabilities, and minority groups). Demand and supply factors may both play a role. People may stay away from health services out of fear of catching COVID-19. Health services operations may be affected by shifting resources to fight the COVID-19 pandemic or by closures of health services or facilities. Supplies of medicines and commodities can be disrupted. In addition, societal measures such as a strict lockdown to combat the pandemic may affect people’s socioeconomic situation as well as their ability to reach the health services they need⁶.



⁶ See WHO’s [Pulse Survey](#) on the continuity of essential health services during the COVID-19 pandemic, published in August 2020.

Even before the outbreak of COVID-19 in Libya began, more than half of its PHC facilities had been forced to close due to the conflict and acute shortages of staff, medicines, supplies and equipment. Following the spread of the disease in Libya, even more centres closed, depriving thousands more people of access to essential health care.

In 2020, WHO successfully advocated for the addition of a ninth pillar to the national COVID-19

preparedness and response plan that addressed the need to keep essential health care services running during the pandemic. WHO donated medicines, health kits, supplies and equipment to the MoH for distribution to health care facilities throughout the country. The Organization trained more than 400 PHC staff on infection prevention and control measures and the case management of patients with COVID-19.



A physician examines a patient at a WHO-supported PHC centre.

Credit: WHO

WHO has recently launched a new project that aims to build the capacity of staff in 30 PHC facilities in 14 conflict-affected districts. The activities are a continuation of earlier projects supported by WHO.



Participants attend a national workshop on introducing a minimum package of health services in PHC facilities.

Credit: WHO

Communicable diseases

Childhood vaccination

Libya has been officially polio-free since 1991 and no cases of tetanus have been reported since 1993. Childhood vaccination has been mandatory since 1972. Although official data sources indicate the national vaccination coverage rate is above 95%, this figure is almost certainly inaccurate. No national household surveys to confirm vaccination figures have been conducted over the past seven years. Moreover, numerous vaccine stockouts since 2019 and the COVID-19 pandemic have severely disrupted vaccination services.

Libya's large size and the uneven distribution of its population pose logistical challenges for its vaccination programme. These challenges have been made more difficult by the presence of almost 600 000 migrants and refugees, many of whom were not vaccinated in their countries of origin and who have limited access to vaccination services in Libya. Other challenges include the lengthy process for procuring vaccines, frequent power cuts that affect vaccine cold chains, the lack of standard immunization guidelines and shortages of trained staff.

A WHO/UNICEF/NCDC assessment of the vaccine supply in Libya conducted in October 2020 found that BCG vaccines had run out in the spring of that year. Supplies of hexavalent, polio and measles vaccine were forecast to run out by the end of 2020 and no buffer stocks were available in any of the country's four main warehouses. (Hexavalent vaccine protects children against six diseases - diphtheria, tetanus, pertussis, poliomyelitis, Haemophilus influenzae type b and viral hepatitis B.)

In the spring of 2020, routine immunization services were halted for more than two months as a result of the COVID-19 lockdown. Tens of thousands of children missed their scheduled doses of vaccines. WHO and UNICEF urged health authorities to resume vaccination services immediately. Although the health authorities agreed to reactivate vaccination services, at least half the country's health care facilities and vaccination centres remained closed in the second quarter of 2020 because vaccination workers had no PPE or because they had been assigned to the COVID-19 response. By the end of the year, vaccination rates had dropped by 50% compared with 2019.



An infant is vaccinated against hepatitis B in a WHO-supported PHC centre.

Credit: WHO

WHO and UNICEF continued to draw attention to the need to maintain the immunity of Libyan children against epidemic-prone diseases. In May 2020, they issued a [joint statement](#) raising the alarm over acute vaccine shortages that were estimated to place more than a quarter of a million children at risk of illness or death. In June 2020, WHO made a direct appeal to the governor of the Central Bank of Libya to release funds to procure critical vaccines. Following WHO's intervention, the Bank released emergency funds to replenish the country's vaccine supply. In November 2020, UNICEF and WHO again drew attention to continuing vaccine shortages and urged national authorities to release additional funds for vaccines. At the end of 2020, Libya had enough supplies of all vaccines to last another two months and

was in the process of ordering enough vaccines to last until the end of 2021. However, because of bureaucratic and transportation delays caused by the COVID-19 pandemic, it takes three to five months to receive and distribute essential vaccines. Thus, it is almost certain that the country will face another vaccine stockout in the spring of 2021. Given Libya's ad hoc approach to maintaining vaccine supplies, the threat of vaccine-preventable disease outbreaks that threaten the health of hundreds of thousands of children remains very real. WHO will continue to work with the national authorities to ensure a more systematic approach to securing vaccine supplies. It will also continue its high-profile advocacy to ensure the uninterrupted flow of funds for vaccine procurement.

Tuberculosis

Tuberculosis (TB) is a serious global public health concern and one of the top 10 causes of death worldwide. Rates of TB in Libya are on the rise, and large numbers of refugees and migrants from high TB-burden countries are fuelling the epidemic. A recent IOM study showed that 39% of migrants and refugees were living in unsanitary and severely overcrowded conditions and had limited access to health care, creating conditions ripe for the spread

of the disease. Other migrants are being held in similarly overcrowded detention centres. After a decade of conflict, Libya's National Tuberculosis Programme (NTP) has acute shortages of trained staff, specialized equipment and medical supplies.

Data from WHO's most recent WHO's [Global Tuberculosis Report](#) showed that rates of TB in Libya rose sharply between 2015 and 2019.

In 2020, WHO provided first- and second-line TB drugs to the NTP, as well as six GeneXpert machines and 100 cartridges. GeneXpert 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 treatment immediately can help halt the spread of this deadly form of the disease. The machines can also be used to diagnose COVID-19.

WHO also supported training courses for 20 physicians on the case management of patients with multi-drug resistant TB. It plans to train at least 100 staff in 2021 under a joint WHO-IOM project funded by the European Union that aims to improve the detection and treatment of TB among refugees, migrants and Libyans themselves.



Migrants wait to be screened for TB at a mobile clinic.

Credit: WHO

Leishmaniasis

In the last two decades, cutaneous leishmaniasis (CL) has become a major public health problem in Libya. The increase is the direct result of population displacements, disrupted health and water and sanitation systems and poor living conditions. Visceral leishmaniasis, a much rarer and deadlier form of the disease, has become more frequent in the east and south.

In 2020, the onset of the COVID-19 pandemic severely derailed CL data collection. No data were reported from early March to late September because almost all surveillance efforts were diverted to tracking COVID-19. However, the total number of CL cases in 2020 is estimated to be less than 4000 (a significant decrease compared with the 6724 cases reported in 2019). The decline can be attributed to COVID-19 restrictions that prevented people from travelling to endemic areas, as well as the decline in the number of IDPs following the cessation of hostilities in the west. The most affected areas in 2020 were Al Jabal Al Gharbi, Al Margeb and Nalut in west Libya.

For the past three years, WHO has been the sole provider of antileishmanial treatments in Libya. In 2020, WHO procured antileishmanial medicines and delivered them to the NCDC. It also supported a three-week training course for NCDC dermatologists on managing patients with CL.



A child with leishmaniasis.

Credit: WHO

Disease surveillance and response

The COVID-19 pandemic has brought renewed urgency to efforts to improve disease surveillance in Libya. The WCO has invested heavily in the disease Early Warning and Response Network (EWARN), a simple and cost-effective way to set up disease surveillance in emergency settings. The WCO has trained surveillance officers throughout the country and has provided them with communications equipment, transportation and reporting tools. In 2020, WHO trained 118 rapid response teams on outbreak investigation and reporting. In addition, 77 surveillance officers were trained on WHO's new mobile reporting app, which includes standard reporting forms and national guidelines for case detection, outbreak investigation and contact tracing.

COVID-19 lockdowns and movement restrictions badly disrupted surveillance activities in 2020. Only 70% of reporting sites submitted regular data on the 20 notifiable diseases covered under EWARN, mainly because COVID-19 surveillance had been prioritized over all other surveillance. Between January and August, only 70-75% of EWARN alerts were investigated and responded to within 72 hours. Poor collaboration between local and national health authorities and frequent electricity and Internet cuts also hampered surveillance efforts.

Polio surveillance activities were relatively unaffected, although the national lockdown disrupted the transportation of acute flaccid paralysis (AFP) samples from Libya to the accredited polio laboratory in Tunisia. A total of 93 cases of AFP were reported (a drop of 13% compared with the 107 cases reported in 2019). Libya remains at high risk of imported cases of vaccine-derived poliovirus type 2, which is currently circulating in neighbouring Egypt and Sudan.

Surveillance for other diseases including measles, rubella, diphtheria and pertussis was disrupted. For measles, 142 suspected cases were reported, of which all but two were tested and 20 were laboratory confirmed. The last reported confirmed case of measles was in August 2020. Although there were no major measles outbreaks, over three quarters of communities assessed by WHO reported minor outbreaks of hygiene-related diseases such as diarrhoea, lice and scabies.

WHO continued to provide close technical support to the NCDC. The Organization developed handbooks for vaccination teams, updated checklists and health facility micro plans, and developed forms to monitor the vaccine cold chain. WHO continuously assessed the status of vaccination services in different health care facilities in Libya and provided laboratories with 200 AFP specimen collection kits as well as reagents, IT equipment and test kits for measles and rubella. WHO funded regular visits by the national AFP surveillance coordinator to 18 municipalities in the east and west. With WHO support, Libya published 41 weekly epidemiological bulletins in 2020.

In spite of these efforts, disease surveillance is still inadequate. There are not enough sentinel sites in the country and reporting is often sporadic. WHO plans to double the number of sites reporting to EWARN by the end of June 2021. It will continue training surveillance officers and ensuring they have the tools and equipment to support regular reporting.

Noncommunicable diseases

Although noncommunicable diseases (NCDs) account for 72% of the disease burden in Libya, essential medicines to treat them are widely unavailable. In 2020, WHO donated 66 NCD kits as well as insulin, laboratory reagents and other supplies to PHC facilities to help sustain essential health care services during the COVID-19 pandemic. The kits contained enough medicines and supplies to treat 666 000 NCD patients for three months.



Mental health

Although COVID-19 has led to increased levels of anxiety, vulnerability and psychological stress among all segments of the population, mental health services in Libya are almost non-existent. Lockdowns and curfews have reduced people's access to PHC facilities, which are the common entry point for identifying and referring patients who need mental health care. The main psychiatric hospital in Tripoli was closed for much of 2020, and outpatient services were suspended because of COVID-19 restrictions.

WHO estimates that mental health conditions (e.g., depression, anxiety and post-traumatic stress disorder) more than double when populations are affected by conflict. It is likely that one in seven Libyans – approximately one million people – needs mental health care. Improving access to mental health and psychosocial support services in Libya remains a priority for WHO. The Organization will shortly begin implementing a two-year project to strengthen mental health services throughout the country.

Reproductive, maternal, newborn, child and adolescent health

WHO's assessment of health care services showed there were acute shortages of nurses and midwives in Libya. WHO has collaborated with UNFPA on the development of a strategy to strengthen the country's nursing and midwifery workforce. This initiative, led by UNFPA, will be implemented in 2021. At the same time, WHO plans to intensify its own training activities. It will shortly introduce new reproductive, maternal, newborn, child and adolescent health (RMNCAH) guidelines, complemented by protocols for pre-conception care, family planning, antenatal and intra-partum care, in 30 PHC centres across the country. The WCO has also prepared an RMNCAH guide for master trainers.

In January 2020, the WCO signed a three-year agreement with the Bambino Gesù Children's Hospital in Rome. The agreement aims to build the capacity of medical and nursing staff in two paediatric hospitals (one in Tripoli and one in Benghazi). This follows the successful example of similar collaboration in Syria, where staff from the hospital in Rome trained their Syrian counterparts in university hospitals in Damascus and Aleppo on the latest techniques in laparoscopy, interventional radiography, paediatric catheterization and paediatric intensive care. The programme subsequently had to be put on hold because of COVID-19. It will be launched in 2021.



The WHO Representative and the head of the Bambino Gesù Hospital in Rome sign an agreement to train doctors and nurses in paediatric hospitals in Tripoli and Benghazi.

Credit: WHO

Gender-based violence

Libya is one of six⁷ countries in the Eastern Mediterranean region that have been selected to implement a project on strengthening WHO's capacity to address gender-based violence (GBV) in its emergency work. The project's main objective is to enhance the capacity of WHO, health sector partners and health care providers to deliver essential services to victims of GBV in emergency settings. In February 2020, a team from WHO's regional office in Cairo visited Libya for initial discussions with the WCO. The project was put on hold because of the COVID-19 pandemic. It will be launched in 2021.

Recognizing that no single agency can meet the multiple specialized needs of GBV survivors, WHO promotes inter-agency collaboration and works with different inter-agency working groups on sexual and reproductive health, mental health and psychosocial support, GBV and the clinical management of rape. WHO also supports MoH activities to prevent and respond to GBV, including awareness raising at community level and during health promotion events.

⁷ The other five countries are Afghanistan, Iraq, Somalia, Sudan and Syria.

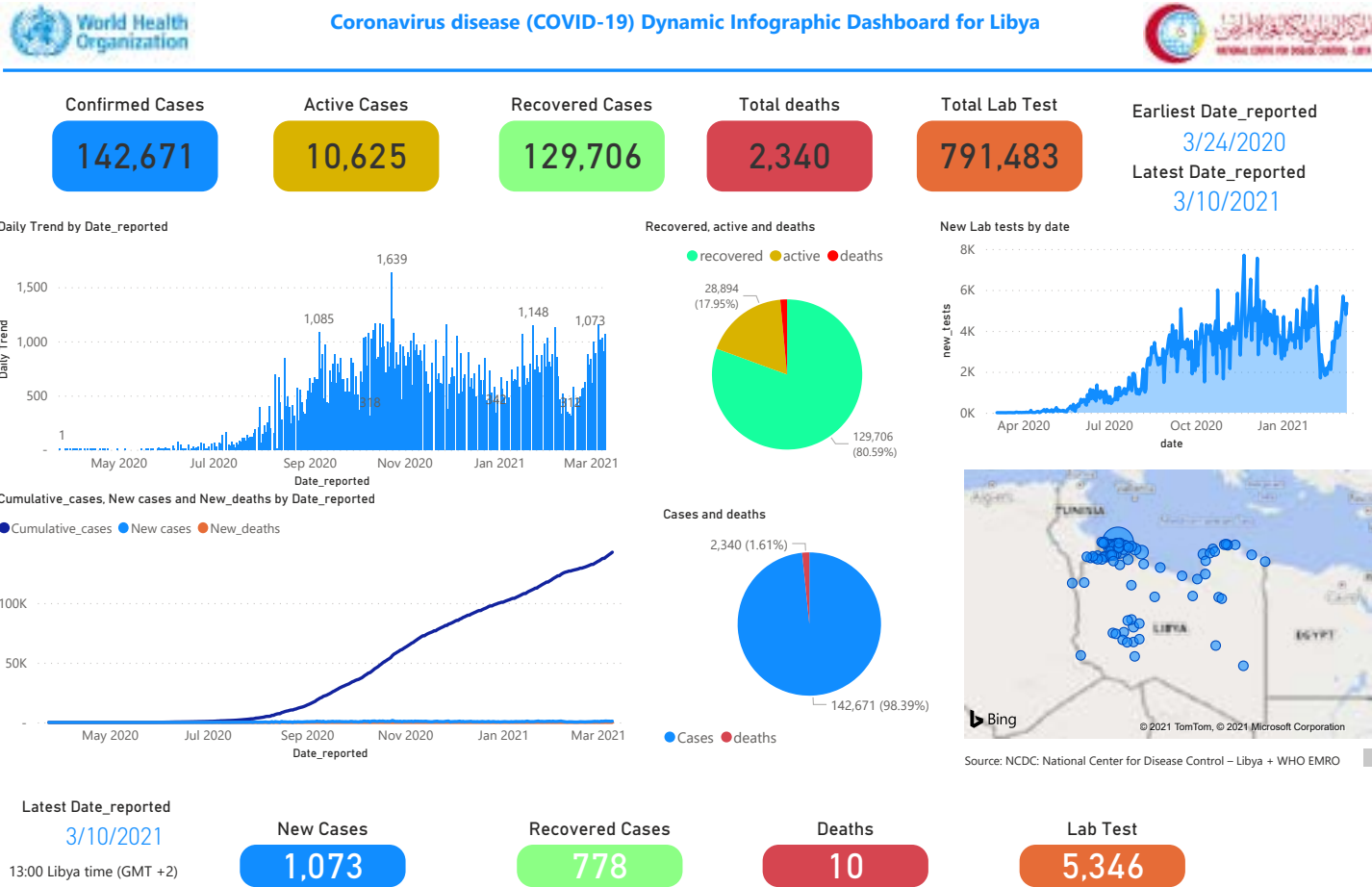
Health information system

Despite years of support and investment from WHO and other UN partners, there is still no national system to gather and analyse health information and monitor and assess health care needs. This has hampered efforts to gather information on the burden of disease, the prevalence and main causes of morbidity and mortality, and the status of health care services across the country. Among all countries in the eastern Mediterranean region, Libya has the lowest rate of reporting on the indicators in WHO's regional response monitoring framework. Although the government in Tripoli has established a health information centre, data collection and aggregation have been largely disrupted. Without either a functioning DHIS-2 or HeRAMS⁸ – the two systems that form the backbone of health information management in many countries – it is very difficult to collect, aggregate and analyse data from across the country. The political fragmentation and presence of two governments make it all but impossible to agree on priorities and support the strengthening of a countrywide system.

WHO, national authorities and health sector partners are preparing a joint health information system (HIS) workplan for 2021. The WCO is providing regular technical guidance to the HIS unit in the MoH. It is also working with the MoH to plan and conduct health facility assessments to identify main needs and gaps and prepare [maps and graphics](#) to visualize WHO and health sector activities.

The WCO has recruited international and national staff to strengthen its internal health information unit. It now produces interactive dashboards, weekly epidemiological updates, monthly infographs showing progress against key performance indicators, and custom-made maps. On behalf of its health partners, the WCO produces monthly health sector bulletins and has developed the sector's monitoring framework for the Humanitarian Response Plan for Libya for 2021. The WCO's [interactive dashboard](#), updated daily, tracks the number of COVID-19 cases and deaths across the country. The office also contributes to the monthly COVID-19 activity reports prepared by the UN Office for the Coordination of Humanitarian Affairs.

⁸ District Health Information Software 2 (DHIS2) is a free and open-source health management data platform used by many organizations including the European Union. The Health Availability Resources Mapping System (HeRAMS) was developed by WHO to monitor the status of health care facilities in emergency settings.



LEADING THE HEALTH SECTOR

WHO leads over 30 health sector partners in Libya. The health sector in Tripoli is supported by two sub-national sectors in east and south Libya. In each of these locations, WHO and its partners work closely together and meet regularly to review the emergency response, identify and fill gaps and agree on priorities. The health sector runs five thematic working groups (on gender-based violence, mental health, tuberculosis, reproductive health and migrant health). WHO coordinates the formulation and implementation of the health component of the annual Humanitarian Response Plan for Libya. WHO also coordinates the production of detailed [monthly health sector bulletins](#) that track political developments in the country, monitor the evolving health situation and the number of beneficiaries reached with health services, and identify critical gaps in the response.

On behalf of its health partners, WHO advocates for secure access to all parts of the country to deliver medicines and supplies and deploy medical teams to meet critical needs. In May 2020, WHO joined other UN agencies in issuing a joint

statement supporting the Secretary-General's call for a global ceasefire and a humanitarian pause to save lives and enable the Libyan authorities and their partners to devote their energies to stopping the spread of COVID-19.

WHO represents the health sector in meetings with the acting Special Representative of the Secretary-General for Libya and other senior UN officials. On behalf of its partners, WHO ensures that health issues are included in the agenda of UN Security Council meetings on Libya, meetings of the International Follow-Up Committee on Libya (IFCL)⁹, and other high-level fora. It regularly briefs donors and the diplomatic corps on the health situation and progress resolving difficult issues.

In late 2020, the health sector completed its annual self-assessment using the Cluster Coordination Performance Tool. The tool assesses the health sector's performance against six core functions and its accountability to affected populations. The results of the assessment will be released in early 2021.

⁹ The IFCL was launched in June 2020. Its purpose is to exert diplomatic and technical efforts to implement the agreements reached at the Berlin peace conference in January 2020.

ACCOUNTABILITY TO BENEFICIARIES

The COVID-19 response allowed WHO and the health sector to strengthen community engagement across the country. Under WHO's leadership, the health sector developed tools to analyse feedback from beneficiaries and adapt projects accordingly. Behavioural assessments were conducted to understand target audiences' perceptions, concerns, influencers and preferred communication channels. Health messages were tested on trusted community groups including

community and religious leaders, health workers, community volunteers, migrants and refugees, and youth, business and women's groups. WHO built an extensive network of media contacts to disseminate public health messages through TV, radio, the Internet, newspapers and social media. Messages and materials were adapted and communicated in local languages and those of the main migrant and refugee populations. These activities will be continued in 2021.



A WHO team visits a patient in Al-Kuwaifiya Hospital for chest diseases.

Credit: WHO

ADVOCACY

The WCO's advocacy aims to influence public policy in the country and thus help improve the overall health outcomes of Libyans, migrants and refugees. The WCO has worked to increase international awareness of Libya's acute humanitarian health needs, encourage the national authorities to act decisively to curb the COVID-19 pandemic, and promote collaboration across the political divide.

WHO's transparent and consistent advocacy is the cornerstone of its approach to delivering humanitarian health assistance. The Organization's short- and medium-term objectives are to:

- Secure safe, regular access to all parts of the country to deliver supplies and deploy medical teams;
- Establish a reliable system to refer critically ill patients to health facilities across the country;
- Negotiate an effective system to protect health facilities and health care staff;
- In collaboration with other UN partners, secure a ceasefire to allow the humanitarian community to better deliver assistance;
- Highlight the devastating impact of the conflict on health care services (e.g., the water and electricity cuts in health facilities; the risk of outbreaks of vaccine-preventable diseases; the spread of tuberculosis and other diseases; the lack of access to health care for migrants and refugees);
- Secure regular salary payments for health care workers;
- Ensure Libya's participation in the COVID-19 Supply Chain Portal and COVAX Facility;
- Work across the political divide to help overcome the current politicization of the COVID-19 response;

- Lift restrictions that prevent the rapid clearance of humanitarian and COVID-19 health supplies blocked at Libyan ports.

In the longer term, WHO aims to secure a greater portion of Libya's GDP for health care, as well as assist the UN and other international efforts to secure a permanent political solution by contributing to international health diplomacy activities.

The WCO has repeatedly highlighted several fundamental problems that must be resolved in order to strengthen Libya's health care system. They include lengthy delays in clearing humanitarian supplies blocked in customs and continued fighting that hampers efforts to contain COVID-19. WHO has consistently drawn attention to repeated vaccine stockouts that have disrupted immunization programmes and led to thousands of children missing their scheduled vaccinations. Working with UNICEF, it has issued joint press releases emphasizing the need to maintain population immunity against the epidemic-prone diseases that cause high levels of childhood morbidity and mortality. Individual Ambassadors and their colleagues have joined in these efforts and urged national authorities to resolve these longstanding issues.

The WCO has invested in building relationships with high-level representatives beyond the MoH by regularly engaging with top government officials including the Prime Minister, the ministers of finance and the interior, representatives of the COVID-19 Scientific Committee and the head of the NCDC.

Moreover, it has built constructive relationships with leaders on both sides of the political divide. Throughout the year, in her meetings with senior officials including the Prime Minister, Members of Parliament, municipal mayors and COVID-19 committees, the WHO Representative has stressed the severe threats posed by COVID-19 and the immediate steps that need to be taken to save lives and improve the response.

These efforts have met with notable success. Critical issues repeatedly highlighted by WHO are slowly being resolved. In August 2020, the WHO Representative met with Field Marshal Khalifa Belqasim Haftar (the head of the rival government in the east) and secured his commitment to authorize the immediate release of PPE blocked in customs in Benghazi. The government in Tripoli has since then followed this example. The WCO's direct appeals to the governor of the Central Bank of Libya to make funds available for critical

vaccines led to the money being released almost immediately.

The WCO also works with UNSMIL on "Health as a Bridge to Peace" (HBP), an initiative that was first adopted by the 51st World Health Assembly in May 1998. HBP provides a planning framework that helps health workers deliver health programmes in conflict settings and at the same time contributes to peacebuilding. HBP reinforces the message that without a political settlement there can be no peace, prosperity or resilient health services that are necessary to support an effective COVID-19 response.

Donors have recognized WHO's efforts. Major partners such as the European Union have made significant contributions to support WHO and health partners' work on tuberculosis and COVID-19. Funds received by WHO for its work in Libya rose more than five-fold in 2020 compared with 2019.

WHO's advocacy work in 2020

On behalf of the health sector, WHO:

- Released public statements that were published on WHO and health sector web sites.
- Held meetings with and sent formal communications to top government officials including the Prime Minister, the ministers of health, finance and the interior, representatives of the COVID-19 Scientific Committee and the head of the NCDC.
- Advocated with the governor of the Central Bank of Libya for the rapid release of funds to procure urgently needed vaccines.
- Included health advocacy issues in briefing notes and other documents prepared by the Acting Special Representative of the Secretary-General in Libya for the United Nations Security Council and other bodies including the International Follow-Up Committee on Libya.
- Worked closely with the leadership of UNSMIL and the UN Humanitarian Coordinator to integrate health messages into peace and diplomacy initiatives.
- Prepared key advocacy messages and talking points for WHO's top leadership.
- Briefed national and international media outlets on the health situation and health needs in Libya.
- Updated donors and the diplomatic corps during briefing meetings and bilateral discussions.
- Held meetings with representatives of the Interim Government in the east.
- Maintained a direct operational presence in municipalities throughout Libya and daily contacts with health authorities in these locations.

WCO STRUCTURE, INTERNAL OVERSIGHT AND MANAGEMENT

Structure

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 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 security concerns force WHO to temporarily withdraw from Libya.

Internal oversight

The WCO is implementing the recommendations of two internal assessments: an audit and a Country Functional Review.

Internal audit

In early 2020, WHO's Office of Internal Oversight Services released the findings of its audit of the WCO covering the period from January 2018 to May 2019 (before the current WHO Representative Ms Elizabeth Hoff took up her duties in July 2019). The security situation in Libya and the restrictions on the number of international staff that WHO could deploy at any one time meant that the auditor was unable to travel to Tripoli to interview staff and review office procedures. Thus, the audit was conducted from WHO's second country office for Libya in Tunis, Tunisia. (This office was established in May 2014, when fierce fighting in Libya forced

the UN to evacuate all its international staff to neighbouring Tunisia for an indefinite period.)

The auditors found that many of the WCO's administrative and financial procedures and its compliance with WHO's policies, rules and regulations were unsatisfactory. Although they recognized the challenging context in which the WCO was operating, they concluded that the lack of coordination between WHO's offices in Tripoli and Tunis, the poor supervision of administrative processes and the lack of clarity in roles and responsibilities had resulted in inadequate controls and hampered effective programme delivery.

In response to the auditors' findings that there was a lack of coordination between its offices in Tunis and Tripoli, WHO has shifted all its operations to Tripoli¹⁰. Thus far, it has been the only UN agency to do so (all other agencies retain a strong footprint in Tunis). Consolidating all operations in one office has resulted in reduced travel and per diem costs, strengthened management and coordination, and improved oversight.

The COVID-19 pandemic disrupted plans to recruit key staff to address the audit recommendations and strengthen the overall management of the office. The arrival of the new operations officer was delayed for several months, and the deployment of an experienced budget and finance officer from WHO's Regional Office in Delhi, India was postponed indefinitely. As a result, the 31 July 2020 deadline for closing the audit had to be extended. By the end of December 2020, the WCO had successfully addressed 69 of the 78 audit recommendations and was on track to implement the remaining nine by the end of March 2021.

The WCO has established rigorous new administrative and financial procedures backed up by systems to monitor and ensure compliance. Procurement and recruitment processes have been overhauled. The WCO's bank account is now fully operational and a system has been established to conduct regular bank reconciliations. The list of authorized bank signatories has been updated and includes national staff, bearing in mind the need to ensure a fail-safe system in the event that the UN decides to proceed with the emergency evacuation of all international staff. The WCO

has established a local committee to review procurement contracts and has segregated different procurement functions.

The WCO is continuing to strengthen its support systems and is seeking additional administrative and financial management expertise locally. However, experience has shown that it is difficult to hire national staff with the appropriate mix of skills and relevant experience.

Country functional review

The WCO is also implementing the recommendations of a "Country Functional Review" (CFR) conducted in late 2019 by WHO's regional office for the Eastern Mediterranean (EMRO). The CFR is primarily strategic. It aims to determine whether each WCO's Country Cooperation Strategy is aligned with the health sector needs and priorities of the host country. Based on this, it also assesses whether the WCO's workforce, strategic health direction, structure and operational functions are fit for purpose.

The CFR report was released in May 2020. It found that WHO's quota for international staff was insufficient and that the limited capacity of national staff and stringent security restrictions inside the country affected the WCO's ability to provide timely, effective support on the ground. In the areas of administration, finance, grant management and logistics, many of the CFR's findings were similar to those in the audit report. The WCO is working closely with EMRO to implement the CFR recommendations.

¹⁰ WHO has kept a small office in Tunis as a contingency measure, in the event that its international staff in Libya need to be evacuated again. The office is staffed by three professional and two support staff.

Operational constraints and mitigating measures

The suspension of fighting in June, followed by the ceasefire in October, improved humanitarian access to most parts of the country. However, COVID-19 travel restrictions and curfews were a major impediment to WHO's emergency operations. Moreover, security constraints restricted the travel of WHO international staff to many locations. The movement of WHO staff remains subject to strict UN security arrangements and out of the hands of the Organization. WHO has mitigated these difficulties by more than doubling the number of its field coordinators, from 10 to 25. They work throughout the country to assess the health situation and health needs, work closely with local health authorities to agree on health priorities, support COVID-19 and emergency operations, monitor the delivery of supplies, and

send regular reports to WHO's country office in Tripoli. In addition, 20 mobile medical teams with a combined total of 69 staff are supporting health care facilities across Libya.

In late 2020, the continuing insecurity forced WHO to postpone (twice) a critical humanitarian mission to the coastal town of Sirt. The UN follows rigorous security precautions for all missions in the country, including those that are life-saving. However, it has the capacity to support no more than two missions at any one time, which means that all UN agencies must compete for limited security resources. At WHO's insistent urging, the UN has agreed to allow the mission to take place as a priority in early 2021, with full support provided by the UN's security team.



Supplies are loaded onto a truck in Tripoli.

Credit: WHO

Delays importing WHO humanitarian supplies were significantly reduced in 2021. Thanks to WHO's sustained advocacy, the authorities in both the west and east committed to releasing humanitarian and COVID-19 supplies within 48 hours of their arrival in Libyan ports. Despite this

progress, customs procedures remain opaque and labyrinthine, and the lack of transparency means that WHO has no clear starting point from which it can negotiate standard procedures with customs officials and other authorities. Moreover, WHO and other implementing partners continue to incur

high extremely high transportation and warehouse costs. Transportation companies are forced to take lengthy routes to avoid conflict hotspots. For example, a journey from Tripoli to Benghazi (which normally takes a day and covers 1000 km) now takes up to three days and covers 1700 km. The cost of air shipments has increased due to the limited number of airlines operating cargo flights to Libya. Secure warehouse space is limited and prices are correspondingly high. WHO is working to overcome these challenges by establishing long-term agreements with warehouses, customs

authorities and suppliers. This has stabilized prices in the medium term. The WCO has reduced its distribution costs by combining deliveries to central locations for collection by end users. The establishment of bonded warehouses has allowed WHO to safely store supplies pending their release from customs, resulting in a significant decrease in demurrage charges. Lastly, the WCO has put a system in place to ensure that suppliers ship goods only after the Organization has obtained pre-approval from customs authorities.



A WHO staff member checks boxes of supplies before distribution.

Credit: WHO

Strong administrative, finance, logistics, resource mobilization, project management and procurement staff are essential to support WHO's complex humanitarian operations in Libya. (In WHO's office in Syria, these staff outnumber public health officers by four to one.) However, the travel and movement restrictions caused by the COVID-19 pandemic disrupted the WCO's plans to recruit new administrative and support staff. Leaving and entering Libya is difficult. UN flights into and out of the country are scarce

and UN staff are required to quarantine for up to two weeks before and after they arrive in the country. Moreover, working conditions inside Libya are extraordinarily difficult. Since the COVID-19 pandemic, most WHO staff have been working from home. However, frequent power cuts (sometimes for up to 20 hours per day) have meant they have had no electricity or Internet access. In the UN compound where WHO's offices are located, staff are frequently forced to go home early because of water and electricity cuts.

LOOKING AHEAD

The WCO has partly overcome these obstacles by drawing on experienced staff in other WHO offices. Staff in WHO's regional office in Cairo are providing remote daily budgetary and financial support. Experienced finance, HR, procurement, health information and communications staff from other WHO offices have been deployed on short-term missions to Tripoli. Most of these staff have been drafted in from WHO's country office in Damascus, where they have established tried-and-tested systems to support WHO's humanitarian operations. They have brought their experience to bear in helping the WCO strengthen its administrative procedures, set up procurement and tracking systems, and train local staff.

Remote support cannot fully replace staff in Libya who understand local customs and can build relationships with national counterparts. Although WHO continues to seek additional administrative and financial management expertise locally, it has been difficult to hire national staff with the appropriate mix of skills and experience. Distance working from WHO offices in other countries offers

a practical alternative to the logistical challenges of working in Tripoli itself. These arrangements also serve as a blueprint for efficient and cost-effective collaboration between WHO offices.

Because of the insecurity in Libya, the UN has imposed strict limits on the number of international staff who can be deployed in the country at any one time. In 2020, the UN recognized the extreme demands being placed on WHO and allowed it to increase its quota for international staff. The team in Tripoli has been reinforced by international staff working in operations, logistics, communications, health information and project management. The office has also hired TB, polio and PHC specialists who are working either from their home countries or in neighbouring Tunisia. 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.



Libya began the year 2020 with a full-blown regional conflict and ended with the signing of a permanent ceasefire. The year 2021 may be a turning point for the country. Oil exports have resumed, raising hopes of an economic recovery. The ceasefire is fragile but holding. The country is taking its first steps towards tackling corruption, undertaking urgent economic reforms and holding senior politicians to account. If national elections scheduled for December 2021 go ahead as planned, the country's citizens will have an opportunity to choose new leaders and elect a government of national unity. One thing is certain: after a decade of conflict, Libyans deserve peace.

The socio-economic impact of COVID-19 in Libya will be profound and long-lasting. COVID's effect on the global economy has dramatically reduced demand for oil and gas, which constitute Libya's main source of revenue. In addition to COVID-19, Libya lost billions of dollars in 2020 because of the oil blockade imposed by the LNA. At the same time, the worldwide production of goods and services has been drastically reduced. This has left Libya's health system extremely vulnerable, since it is heavily dependent on imported medicines, supplies and equipment, and services provided by international medical experts. The lack of foreign exchange is having a huge impact on all sectors of the Libyan economy and on the lives of ordinary

people. Inflation has increased and the value of the Libyan dinar has dropped. Government salaries are being cut across the board. Throughout the country, the government is increasingly unable to finance essential services (including health care). In the east, the rival government appears to be no longer able to create money from credit. The country has been facing a perfect storm of vanishing revenues, divided governance, widespread corruption and the near collapse of the health system and other basic services.

Now that oil production has resumed, Libya is again earning USD 60-70 million per day from its oil resources. It also has enormous frozen assets in banks abroad. The government must find a way to tap into these resources to cover urgent and increasing health needs and strengthen its weak and fragmented health system. Equally importantly, it must undertake profound reforms to root out the rampant corruption that permeates most of its national institutions. Without these efforts, the prospects for meaningful health reform and universal health coverage appear bleak.

WHO will continue to urge that an adequate share of Libya's GDP and its huge assets be spent on health.

Planned activities in 2021

Reliance on life-saving and life-sustaining health care services supported by the humanitarian response will continue in 2021. While IDPs, refugees and migrants have the most severe needs, returnees and non-displaced Libyans in the worst-affected areas also need humanitarian assistance. Other vulnerable groups include children and adolescents, the elderly, patients with chronic health conditions and families facing economic hardship.

Almost 1.2 million people lack regular access to primary and secondary health care services. Migrants and refugees account for almost 30% of this number. Over one million people live in areas ranked as 3 and above on the severity scale.

WHO will continue to lead the health sector and advocate for improved access to deliver supplies, assess health needs, monitor the health situation and adjust operations. While improving coordination with health authorities at all levels and acknowledging their lead role, WHO and health partners will support disease surveillance and the delivery of medicines and supplies (including those for COVID-19). Mobile teams will supplement health care services in remote, rural and hard-to-reach areas where access to such services is limited. Fixed health points and/or mobile teams will provide health care services to people in IDP camps, settlements and detention centres. Vulnerable groups including women and children, chronic disease patients and people with mental health disorders and physical disabilities will be prioritized.

WHO's activities in 2021 will aim to:

- Increase access to life-saving and life-sustaining humanitarian health assistance, with an emphasis on the most vulnerable (IDPs, migrants, refugees and returnees);
- Improve the early detection of and response to disease outbreaks;
- Enhance the response to COVID-19;
- Strengthen the PHC network and bolster the capacity of the health system to provide an essential package of health care to people throughout Libya;
- Maintain and strengthen the health information system; support the implementation of a health information strategy and mechanisms to improve data collection and management;
- Continue to engage in high-level policy dialogue to strengthen the health system. This includes efforts to strengthen leadership and governance, learn from similar contexts and support the development of health financing options;
- Support a review of the health workforce and develop a plan to review short- and long-term options;
- Support and strengthen the medical supply chain management system.

In the longer-term, WHO will continue working to support the strengthening of Libyan institutions. WHO's work is aligned with the UN's longer-term strategic framework for Libya 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 2020, the WCO, with support from WHO's regional office for the Eastern Mediterranean, initiated work on a health profile for Libya that sets out detailed recommendations for advancing the humanitarian-development peace nexus. This work will continue in 2021.

Libya is the first country that has been selected as a case study for the Sustainable Development Goals (SDG) accelerator tool developed by the United Nations Development Programme. The tool has been designed to help countries identify policies and/or programmes that can accelerate and catalyse progress towards SDG targets.

Regardless of the political circumstances in 2021, WHO will continue to work with all parties in Libya while remaining free of political interference and basing its work on the four humanitarian principles of neutrality, humanity, impartiality and independence.

ANNEX 1

VOLUNTARY CONTRIBUTIONS RECEIVED IN 2020

Funds received for COVID-19

Donor	Amount of contribution (USD)
China	3,602,133
United Kingdom Department for International Development	145,000
European Union	7,105,356
Bill & Melinda Gates Foundation	400,000
Contingency Fund for Emergencies	20,000
Central Emergency Response Fund	1,000,000
France	300,760
Canada	200,000
Germany	134,800
USAID/Bureau for Humanitarian Assistance	2,830,000
African Development Bank	480,000
Miscellaneous	1,500,000
TOTAL	17,718,049

Funds received for humanitarian projects

Donor	Amount of contribution (USD)
Italy	4,038,005
Norway	579,542
USAID	1,000,000
European Union	3,892,395
United Kingdom Department for International Development	2,702,703
TOTAL	12,212,645

ANNEX 2

FUNDS REQUIRED IN 2021

WHO projects under the Humanitarian Response Plan for 2021

	Project title	Amount (USD)
1.	Scaling up primary health care services including Expanded Programme on Immunization across Libya	2,500,000
2.	Strengthening secondary health services, including trauma, across Libya	1,500,000
3.	Strengthening noncommunicable disease and mental health services with focus on GBV across Libya	800,000
4.	Strengthening health sector coordination and information management in Libya	720,601
5.	Strengthening national disease surveillance with a focus on COVID-19, TB and HIV	550,000
6.	Libya C-19: Strengthening Libyan authorities' capacity to address Covid-19 related challenges and ensure protection of Libya's population, including vulnerable groups	3,431,017
	TOTAL	9,501,618

WHO funding requirements for COVID-19 response

Pillar N°	Pillar title	Amount (USD)
1	Leadership, coordination, planning, and monitoring	1,143,475
2.	Risk communication and community engagement	1,425,000
3.	Surveillance, case investigation and contact tracing	1,606,655
4.	Travel, trade and points of entry	577,000
5.	Diagnostics and testing	3,005,200
6.	Infection prevention and control	1,223,200
7.	Case management and therapeutics	3,808,220
8.	Operational support and logistics	3,592,654
9.	Essential health systems and services	1,941,091
10.	Vaccination	1,840,000
11.	Research, innovation and evidence	267,000
	TOTAL (excluding staff costs in Category 1)	20,429,495

ANNEX 3

MAIN ASSESSMENTS CONDUCTED AND REPORTS PUBLISHED IN 2020

Assessments conducted and reports published by WHO

- Impact of COVID-19 on the health sector
- Community health
- Bi-monthly and monthly health situation updates in selected municipalities
- Health sector assistance: migrants and refugees
- Assessment of Surveillance System for Attacks on Health Care
- Overview of WHO’s health advocacy in Libya.
- WHO Libya COVID-19 weekly and bi-weekly updates
- [WHO Libya, bi-weekly operational updates](#)
- Vaccine availability in health facilities
- Water contamination, Tobruk
- Infection prevention and control measures in isolation departments
- Public health risks in selected municipalities in the east and south

Assessments conducted by the MoH with support from WHO

- COVID-19 coordination structures at municipal level
- Treatment and isolation centres
- Primary Health Care Measurement and Improvement (PHCMI)
- Transmission classification and capacity
- Antimicrobial stewardship preparedness
- GLASS data: laboratory capacity to conduct antimicrobial testing
- Integrated disease surveillance with a focus on event-based surveillance

Reports published by the MoH with technical support from WHO

- [EWARN Libya](#) weekly update
- AFP surveillance update

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