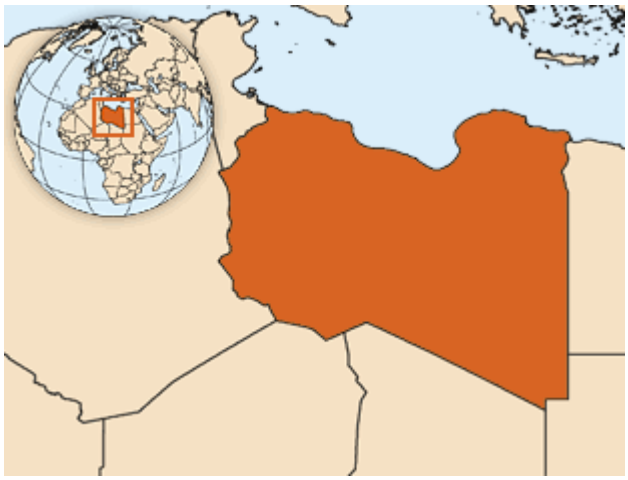
World Health Organization

Country Cooperation Strategy at a glance

Libya



http:// www.who.int/countries/en/

WHO region	Eastern Mediterranean
World Bank income group	Upper-middle-income
Child health	
Infants exclusively breastfed for the first six months of life (%) ()	
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2016)	97
Demographic and socioeconomic statistics	
Life expectancy at birth (years) (2015)	70.1 (Male) 72.7 (Both sexes) 75.6 (Female)
Population (in thousands) total (2015)	6278.4
% Population under 15 (2015)	29.8
% Population over 60 (2015)	7
Poverty headcount ratio at $1.25 a day (PPP) (% of population) ()	
Literacy rate among adults aged >= 15 years (%) (2007-2012)	90
Gender Inequality Index rank (2014)	27
Human Development Index rank (2014)	94
Health systems	
Total expenditure on health as a percentage of gross domestic product (2014)	4.97
Private expenditure on health as a percentage of total expenditure on health (2014)	26.46
General government expenditure on health as a percentage of total government expenditure (2014)	4.93
Physicians density (per 1000 population) (2014)	2.092
Nursing and midwifery personnel density (per 1000 population) (2014)	6.905
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2016)	7.1 [4.7-10.5]
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2016)	12.9 [9.0-18.5]
Maternal mortality ratio (per 100 000 live births) (2015)	9 [6 - 15]
Births attended by skilled health personnel (%) (2010)	99.9
Public health and environment	
Population using safely managed sanitation services (%) (2015)	26 (Total)
Population using safely managed drinking water services (%) ()	

Sources of data:
Global Health Observatory May 2017
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

The ongoing civil conflict and armed fighting have interrupted many of the health programs and are impacting negatively on all aspects of health and on the health sector with large-scale displacements, damage to vital infrastructure including health facilities and thousands of dead and injured. Security constraints, damage or closure of health facilities and some main warehouses, departure of foreign health professionals and reduced budgetary provision for medicines and supplies are among main reasons for health services provision. An estimated 1.056 million people are in need of humanitarian assistance in health sector (0.76 million are targeted in 2018 by health partners). The Service Availability and Readiness Assessment (SARA) survey carried out by WHO in 2016-2017 covered all 1,656 public health facilities in Libya and determined that 17.5% of hospitals were closed, and 20% PHC facilities were non-functional. While the general readiness score for the provision of basic services by functioning hospitals was 69%, general readiness score for primary health care facilities was only 45%, indicating that the capacity to provide basic health services in these facilities is severely constrained. The greatest limitation was found in the availability of basic medicines across the country, with a score of only 16%. The health profile in Libya had changed in the last decade with an increasing burden of non-communicable diseases due to demographic and life style changes. In 2012 cardiovascular diseases accounted for 37% of causes of death followed by cancer 13% and road traffic Injuries accident. Similarly, obesity rates have been increasing in the last decade. HIV infection rates are rising especially among intravenous drug users but only eight facilities in Libya offer counselling and testing for HIV. The availability of preventive and curative services for children <5 in Libya is limited. Over one-third of municipalities cannot provide child health care to their constituents. Where PHC facilities do offer them, the service package is generally limited, focusing primarily on diagnosis and treatment of malnutrition, and treatment of pneumonia. Trauma and obstetric care are difficult to access in security compromised areas and current provision of mental health care services, psychosocial counseling and care for dis abilities is inadequate to meet the needs of the conflict-affected population. Libya's immunization coverage rates have been consistently high, with coverage for all antigens estimated and measured to be 97% or higher. The country has maintained its polio-free status since 1991, and no cases of tetanus have been recorded since 1993. Libya is currently in the early stage of measles eradication, although some transmission still occurs, with 8 confirmed cases of measles reported by NCDC in 2017, and 7 cases of rubella.

HEALTH POLICIES AND SYSTEMS

The public health sector is the main health services provider. Health care services are delivered through a network of primary health care units, centers, polyclinics, and rehabilitation centers, general hospitals in urban and rural areas and tertiary care specialized hospitals. Since 2012, the health strategic plan of the Government of Libya aimed to improve equitable access and the quality of health services as well as access to psychosocial support and protection of vulnerable groups, such as children and IDPs. Different health policies were reviewed/developed in view of these plan and some of them were approved, while others are pending for approval. The increased armed clashes, defragmentation of governance and administrative disputes since mid-2014 have led to the freezing of the implementation and approval of the new health policies till date.

With the aim of improving preventive health care and detection and response to communicable diseases, National Center for Disease Control (NCDC) was established in 2002 in Libya to guide different programs on communicable diseases. In 2010 the same center was designated to guide the non-communicable diseases preventive and control programs. The NCDC has 51 adult vaccination Centers and a network of 36 program managers implementing the immunization program at district level. The Early Warning Alert and Response Network has been strengthened and expanded: 125 sentinel sites weekly report on 19 priority communicable diseases; 52 weekly bulletins were issued and 35 Rapid Response Teams trained in 2017.

While there is a shortage of specialist medical doctors across the country, the number of general health workforce in Libya meets the targets both for minimum availability of health workers set by WHO, as well as the minimum numbers estimated to be needed for the achievement of the SDGs. It is notable, however, that 302 PHC facilities that reported through SARA survey as not providing any services employed 14,598 staff, while the 175 facilities that report providing only a single service, such as immunization, employ an average of 61 staff per facility. This suggests a need to review human resources requirements and deployment across the PHC facilities.

COOPERATION FOR HEALTH

Currently, the United Nations (UN) system is currently represented in Libya by 20 UN agencies, funds and programmes. These UN functions and the international financial institutions (World Bank and IMF) are brought together under the umbrella of the United Nations Country Team (UNCT). All international UN staff has been evacuated from Libya in November 2014, which has minimized the operational and implementation capacity of the UN agencies in Libya. The evacuation has been lifted in February 2018 and UN is implementing gradual return to Tripoli in 2018. A framework between the Government of Libya and the UNCT was designed as derived from the interim Government's National Strategy and Vision and aims to support the areas of security, democratic governance, transitional justice, social reconciliation, economic recovery and basic service delivery.

Health sector, co-chaired by the Ministry of Health and WHO, is bringing together 12 international partners working in the field of health in Libya. Health partners have closely coordinated their strategies for 2018 through the development of the Humanitarian Response Plan, and will continue close cooperation during the implementation phase. At the same time, the process of formulating UN Strategic Framework for 2019-2020 has started with a view to complement current humanitarian efforts and support stabilization efforts and post-conflict recovery in Libya.

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Country Cooperation Strategy *at a glance*

WHO COUNTRY COOPERATION STRATEGIC AGENDA (continuing in 2018)

Strategic Priorities	Main Focus Areas for WHO Cooperation
STRATEGIC PRIORITY 1: Developing long term national vision for health development and reforming and upgrading the health system	• Develop wide scale consultation system with all key stakeholders including the establishment of a national health forum and supporting setting policies , national strategies and reforms • Assist in development and implementation of updated primary health care and family practice projects and in defining the exact roles, responsibilities and functions of various levels in PHC referral system. • Strengthen the supply chain management and update regulation of medicines, vaccines and health technologies, including quality assurance of imported medicines. • Promote the use of standards, norms and criteria for rational use of health technologies and equipment in the public and private sectors. • Strengthen the capacity for analysis and use of health information (HIS) in policy, planning and management. • Strengthen the utilization and expansion of e-health in recording, education and services.
STRATEGIC PRIORITY 2: Strengthening the national system for human resources development through evidence based policy formulation better coordination and strategic partnerships	• Assist in developing a national plan for human resources in consideration of the national health profile and in consultation with key authorities and concerned stakeholders, an HRH information system, and a system for continuous professional development for all health personnel. • Strengthen the accreditation system for institutions that are educating human resources for health And Review curricula. • Strengthen the national regulatory systems, supported by appropriate legislation, to certify, register and license health personnel. • Formulate required plans of action and implement nursing education reforms outlined in the national nursing education strategy developed with support from WHO in 2005, with special focus on entry into professional practice (pre-registration) education.
STRATEGIC PRIORITY 3: Upgrading the national health promotion, education, healthy lifestyle, road safety and injury prevention programmes	• Develop or strengthen evidenced based health education/communication strategies and programmes with special focus on mothers, schoolchildren and youth. • Strengthen road safety and injury prevention through a multisectoral collaborative programme with partners, with special focus on youth and involvement of parents. • Support the establishment of a national elderly health care programme.
STRATEGIC PRIORITY 4: Upgrading the national programmes for mental health and prevention and control of noncommunicable diseases	• Monitor and evaluate non-communicable diseases prevention and control efforts including strengthening of surveillance systems. • Promote research for the prevention and control of noncommunicable diseases through the establishment of national reference centres and networks. • Promote partnerships for the prevention and control of noncommunicable diseases through the appropriate crosssectoral approach and collaboration with concerned professional associations. • Upgrade health care delivery and incorporate the control and management of non-communicable diseases into the primary health care system, with establishment of disease specific registry
STRATEGIC PRIORITY 5: Developing national policies strategies and mechanisms with the aim of maximizing the contribution of programmes and sectors that deal with environmental and social determinants of health	• Develop an evidence-based strategy and methodologies to promote and document the contribution of health related sectors to health development. • Develop evidenced-based strategies and approaches to enhance collaboration between health and • related sectors and civil society organizations. • Scale up the environmental health authority in the GPCHE to fulfil its regulatory and surveillance role.

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