Libya
Emergency type: complex emergency
Reporting period: 01.08.2019 to 31.08.2019

| 6.6 million total population | 554,000 people in need of health | 388,000 people are targeted by health sector | 269,000 IDPs (120,000 since April 2019) | 445,000 returnees | 641,000 migrants and 55,586 refugees* (50,882 refugees in August 2019) |

**HIGHLIGHTS**

<table>
<thead>
<tr>
<th>Target</th>
<th>Total reached (July)</th>
<th>2019 HRP Indicator</th>
</tr>
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<td>388,000</td>
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<td>70,000</td>
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<td>Number of beneficiaries reached with specialized healthcare services through emergency medical teams</td>
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Three UN workers killed following Benghazi car bomb attack.

Health sector is to become more proactive in prioritizing collection of information on health needs and gaps, especially among public health facilities.

A number of present health sector organizations have not demonstrated the expected flexibility to shift operational response to the south from elsewhere.

There is an underlying point that even if the de-confliction has not been reached, it is the responsibility of parties of the conflict under the IHL to ensure that health facilities remain non-targeted in the fighting zones.

Key health asks should be in place in the Principled Framework for intervention in Detention Centers.

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<th>Required (US$ m)</th>
<th>Funded (US$ m)</th>
<th>Coverage (%)</th>
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<tr>
<td>43.5</td>
<td>9.8</td>
<td>22.6</td>
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SITUATION OVERVIEW

The general security situation in Libya was characterized with continued armed conflict, in particular, in areas south of Tripoli. Though, no major progress has been made by either side in conflict in terms of territorial gain, both parties continued with offensive actions indicating intention to gain tactical control in the battle fronts. Shelling/airstrikes against Mitiga airport did not directly impact UN personnel, assets and operations. It hinders UN air operations and threatens to affect the UN as a collateral damage. The pattern of rockets/artillery being launched towards Mitiga airport during evening, night and early morning hours, heightened risks of aviation incident such as collateral damage. There are an increasing number of incidents reported in the southern region, compounded by the security vacuum with continuous movement of armed groups from different directions. Southern region, for weeks, has been subject of violence between local Arab LNA-affiliated forces and ethnic Tebu backed by their tribesmen from Chad as well as the GNA’s Southern Protection Force. Western region has experienced fierce clashes in Gharyan area.

10 August, reportedly a female patient died inside of the ambulance while waiting for more than 4 hours not being able to pass through Rad-Jdir gate (Libya/Tunis border). It was shared that this area has been largely overcrowded at that moment. Obstruction of access for ambulance carrying patients constitutes a type of the attack on health care.

17 August 2019, Bendelwah PHC and the area around were continuously shelled (at least 3 shells hit the PHC) which led to the evacuation of the staff and patients. All patients were relocated to Tasawah rural hospital. A flash update was produced.

21 August, in Benghazi, a brawl followed by gunfire was reported in al-Jalla hospital, involving local military personnel.


Special Representative of the Secretary-General for Libya Ghassan Salame statement on the explosion in Benghazi https://unsmil.unmissions.org/special-representative-secretary-general-libya-ghassan-salame-statement-explosion-benghazi

Three UN workers killed following Benghazi car bomb attack, as Security Council meets in emergency session, honours their ‘ultimate sacrifice’ https://news.un.org/en/story/2019/08/1044111
PUBLIC HEALTH RISKS, PRIORITIES, NEEDS AND GAPS:

Principled Framework for intervention in Detention Centers

The Migrants and Refugees Platform group has been working on the draft of the framework for intervention in detention centers. Inputs were provided, including the points that health sector interventions and position for the response can be different from any existing standards for interventions by other sectors as in many instances health service providers act as “providers of last resort”. There are no sector specific standards for detention centers besides the known Sphere, Health Cluster Guide, WHO guidelines on health in prisons. To ensure access to health care it is essential that:

- Parties to grant approvals and/or find alternative security arrangements that would allow for permanent medical teams’ presence, to enable life-saving treatment and/or referral to public and/or private hospitals.
- Parties to facilitate internal referrals of cases between different health service providers, including after 5pm. Where referrals outside of the DC are required, parties are obliged to facilitate their transportation in a timely and safe manner with special attention to the pregnant women/ girls in need of immediate referral due to any Emergency obstetric care. Children referred to nearby hospitals should not be transferred by themselves and/or separated from their mothers.
- Authorities to grant approvals for transportation of medical supplies to improve the provision of health services inside detention centers and referral hospitals in surrounding areas.
- All relevant parties should facilitate the transportation of all supplies needed to provide life-saving and life-sustaining assistance, particularly medical supplies.
- Humanitarian actors should be allowed to establish permanent presence in the DC, deploy mobile teams and refer detainees to services located outside the DC, in particularly medical services, as needed.

Regardless of any other factors, health authorities, together with health sector organizations, aim to place the availability of the following services not only inside the detention centers but outside, in the communities hosting different categories of vulnerable population:

- Provide outreach (life-saving and life-sustaining) services (including RH) through temporary deployment of medical mobile teams and clinics
- Increase immunization coverage through fixed and outreach teams
- Supporting the diagnostic and treatment services by provision of medical equipment and supplies needed for PHC and RH services at health facility or mobile team/clinic
- Detect, identify and respond to communicable disease outbreaks (including TB)
- Increase NCD/PHC primary healthcare coverage and quality
- Increase Mental Health and Psychosocial Support Services
- Provide integrated reproductive health (RH) and gender-based violence (GBV) services
- Strengthen and improve the emergency referral system to access secondary and tertiary health care services in public and private health facilities as well as to strengthen the level of preparedness and response for and management of trauma and other types of patients
Inter-agency contingency plan – closure of detention centers

While there is a work in place to finalize the current inter-sector draft, health sector highlights the essential nature of ensuring access of any person from a detention to the range of essential public health services. Among risks and mitigation measures, strong planning is necessary to prevent, detect and respond to any potential outbreak of communicable diseases linked with a regular screening and follow up of a health status of DC’ population.

Public health facilities

The needs of 7-9 public hospitals in the south (Ash Shati, Ghat, Murzug, Sabha and Wadi AlHaya districts) region must be continuously assessed and addressed. Similarly 158 PHC centers in the south have to be visited for needs identification and follow up plans for possible assistance. 12-14 public hospitals in the east (Al Jabal Al Akhdar, Al Marj, Darnah, Tubrag districts) region and 154 PHC centers must be properly assessed. More information is necessary on quantity and quality of health services of 19 hospitals and 93 PHC centers in Benghazi region. Equally the needs of 23 hospitals and 286 PHC centers in Tripoli are to be identified. Availability of services through 31 dialysis centers should be checked as well as coverage and sufficient stocks with 6 blood centers across the country. This has to be carried in coordination with authorities on the ground.

Reported shortages of HIV medicines: Operational options are looked at to fill in the gap with provision of necessary HIV medicines as reported from different parts of the country.

Annual 2019 EPI/Polio work plan for Libya

There is an existing 2019 plan clearly stipulating the roles and responsibilities of all engaged stakeholders, including NCDC, WHO and UNICEF. The work plan regulates that:

- NCDC to timely and regularly allocate operational cost for Measles/Rubella, AFP and EWARN surveillance activities (transportation for sample, communication, lab maintenance, investigation, and supportive supervision and monitoring).
- NCDC to issue a decree indicating that municipality surveillance officers to be guided, supervised, technically supported, and monitored by central surveillance administration unit at NCDC.
- WHO to take the lead in capacity building of surveillance officers by means of funding and conducting trainings in areas of AFP, Measles and EWARN, also develop and print surveillance guidelines.
- NCDC, WHO and UNICEF to have in place SOPs and allocate budget to be used for immediate outbreak investigation and response.
- NCDC and WHO to work closely in AFP, Measles and EWARN data collection, analysis, interpretation and dissemination of reports.

Tuberculosis situation

According to NTP, 1,815 TB cases were registered in 2018 including 10 MDR/RR TB cases. Of these, 250 cases including 3 MDR/RR cases were detected in detention centers. Of the MDR/RR cases in detention centers, 2 died. In 2019, 985 new TB cases were registered (1 January to 30 June), including 21 MDR/RR – 10 Libyan and 11 non-Libyan people. In 2019, 21 MDR-TB/RR cases detected. 6 died. Only 3 patients started their second-line treatment. 700 cases of migrants are currently on treatment. Of these, 352 cases are in detention centers while 348 are in community settings.
Challenges:

- Existing lab confirmation (unavailability of LPA, shortages of culture, etc.). The NTP could confirm lab results only for 10 out of 21 patients.
- Continuation of treatment by second-line TB drugs (3 MDR patients started the treatment).
- Situation with availability of TB drugs: There are reported gaps in availability of TB drugs in Benghazi. There are estimated 6 MDR patients in the east of the country while the current stock covers the needs of 2 patients for 2 months. Operational solutions are being sought.
- The issue of isolation of TB suspected and confirmed patients require a follow up. The MoH and MSF reached decision to activate Misurata “chest” hospital for this purpose for migrants’ treatment. Further clarity is required on Abusita hospital as previously agreed upon to serve as the inpatient facility for TB patients. Ultimately there was a rejection from the hospital’ administration not to accommodate the TB services on the premises of this hospital. The MoH proposed an alternative location – the infectious department of Tripoli central hospital. The discussion revealed the need for further dialogue between the NTP and the MoH administrations.
- The NTP is concerned seriously about all fatality cases and aims to put in place the system of mortality prevention. The screening across the country indicates that the TB cases are being now detected in those settings/areas which were never reported before the conflict. There is a need for more support. There are multiple challenges.

A way forward:

A need to have very quick actions to further progress on earlier made commitments and agreements. All international actors (WHO, IOM, IRC, MSF, IMC, UNHCR and others) have a continuous interest to support the NTP. There are pending issues which require immediate decisions such as:

- Understanding of solutions for inpatient health care for TB patients: there is a need to agree on facility identification.
- A common strategy should be elaborated, identifying the approach for all.
- An update is required on the progress of the development of the TB guidelines. The deadline for NCDC comments is 28 August.
- A solution is necessary to meet the needs for TB drugs in the east of the country.
- Mapping of roles of different partners in all detention centers is completed but a further dialogue is necessary on line lists, provided treatments/protocols, referrals, etc.
- Accurate figures are required on TB case fatalities.
- Besides WHO plans to provide support with first and second line TB drugs, there is a necessity to understand other partners’ plans and capabilities for the same.
- WHO is to update on the details of the delivery of four Xpert machines and assigned role for receiving the samples from specific detention centers for testing.

During the last TB sub-sector meeting on 1 August it was agreed that “the meeting will be on monthly basis (first day of the month). Additional meetings will be conducted once a week with each INGO and NGO by NCDC as per the following schedule: MSF – Thursday; IOM – Monday; IMC – Tuesday; Libaid – Wednesday; JMC – Tuesday.”

Needs assessments, monitoring and evaluation

Health sector is to become more proactive in prioritizing collection of information on health needs and gaps. There are various focal points and representatives on the ground working closely with municipalities, health authorities, and health facilities. Health sector assessment registry has been developed exactly to serve this purpose. There is an operational understanding of key types of health assistance which may be required in different types of emergency situations: trauma,
referrals, disease surveillance, vaccination, mental health, MCH/RH, NCDs, deployment of medical teams (for PHCs or hospitals), reactivation of dozens of available PHC centers via fixed health points, etc.

There is a remaining gap to link the needs on the ground with response capabilities by health sector. This needs to be addressed either through re-prioritization or additional resource mobilization. Health sector is to focus on post-distribution mechanisms (whether related to supplies or services). All inquiries/requests/complaints about health services/supplies should be closely monitored especially in those areas receiving humanitarian assistance.

Cluster Coordination Performance Monitoring (CCPM)

Health sector Libya will launch a regular annual exercise related to the Cluster Coordination Performance Monitoring (CCPM) in September.

“The Cluster Coordination Performance Monitoring (CCPM) is designed to enable the systematic and transparent assessment and monitoring of health cluster/sector performance against its six core functions (as determined by the IASC) and its’ accountability to affected populations. The CCPM - combined to the Cluster Description (CD) - aims at ensuring efficient and effective coordination, taking stock of what functions work well what functions need improvement. It raises awareness of support needed from HC/HCT, WHO or the Global Health Cluster through self-reflection and increased transparency and partnership.” More information is available here: https://www.humanitarianresponse.info/en/how-to/improve-cluster-performance.

Attacks on health care, de-confliction, key advocacy asks

Anticipating further security deterioration across the country, presence (accessibility, functionality, levels of damage) of an estimated 100 public hospitals, 1400 public PHC centers, 537 private outpatient clinics, 235 inpatient clinics (hospitals), 19 diagnostic imaging centers, dozens of field mobile medical teams on the ground can be directly and indirectly impacted by the violence. The de-confliction mechanism and procedures are in place but do not have the necessary “buy in”, “trust” by a variety of health service providers for many reasons. The issue of “accountability”, if and when an attack on health care takes place and holding a specific party to the conflict responsible, is not the prioritized one. A range of health service providers assume that a de-confliction may automatically guarantee and/or prevent a potential attack, which is not the case. Many of service providers are of the opinion that sharing GPS coordinates serve the exact purpose of intentional target of a health care provider. Sharing GPS coordinates remain a challenge for obvious reasons by humanitarian actors. There are serious reservations expressed. GPS coordinates of all public health facilities are available with the relevant technical department of the Ministry of Health. At this stage sharing GPS coordinates of public health facilities with the UN system is not plausible. Health sector is to continue its dialogue with the national authorities to seek opportunities for sharing formally the GPS coordinates of all public health facilities. Similarly, further advocacy will be continued with the humanitarian organizations.

At the same time, there is an underlying point that even if the de-confliction has not been reached, it is the responsibility of parties of the conflict under the IHL to ensure that health facilities remain non-targeted in the fighting zones.

Rapid response mechanisms in health sector

Health sector earlier developed and agreed upon on a number of preparedness and response documents, where roles and responsibilities were assigned and all related points covered, including: Scenario-based Contingency Plan, Annual Emergency Preparedness and Response Plan, Health Sector Response Strategy, Minimum Health Service Package.

Different elements elaborated under these plans should have been operationalized during the latest events in the south of the country. The criticality of the situation in the south was clearly demonstrated and justified. At the same time the health response has been limited until now to the national, local health authorities and a few humanitarian agencies and organizations. A number of present health sector organizations have not demonstrated the expected
flexibility to shift operational response to the south from elsewhere. This becomes very important and linked to the “access” advocacy point – if provided in broader terms, it will have to transliterate into a larger comprehensive package of health response by different organizations (from life-saving to life-sustaining operations).

A better dialogue is necessary with the national authorities on exchanging information on levels of provided assistance while fully recognizing the leading role of the authorities in support of referrals/evacuation, delivery of health supplies, enabling vaccination response, continuation of care for patients with chronic needs, provision of approvals for humanitarian organizations, etc. Rapid response mechanism should be more effectively continued via different modalities, including replenishment of health supplies, support to the referral hospitals, and deployment of specialized health teams, especially for post-surgery care as a high number of wounded people would continue to require specialized health care.

Disease surveillance (measles)

On the earlier reported increase of measles cases, the necessary follow up technical consultations were carried out, concluding that there were not yet nationally endorsed Measles Surveillance Guidelines, where clear definitions of outbreaks (suspected or confirmed) could be referred to. This has been prioritized in the 2019 workplan. The first consultative workshop is planned to take place on 3-5 September 2019. At present, EWARN operational guidelines is used to define measles outbreaks and based on these definitions none of 96 measles lab confirmed cases (aggregated data from January to July 2019) has met the above criteria. Increase in the number of detected cases (suspected) might be attributed to the improvement of surveillance activities and increase in number of reporting sites. The number of suspected and confirmed measles cases has dropped dramatically after December 2018 campaign. According to the July report (aggregated data of January – July 2019), almost 50% (45 out of 96) of the confirmed measles cases occurred in children below one year of age. This age group was not covered by the aforementioned campaign and properly not covered by the routine as well due to the fact the 1st MMR dose administered by age of 12 months.

- The independent monitoring result was less than 95%. That indicates there were pockets of unvaccinated children due to many reasons.
- The effectiveness of the vaccine depends on the age of the child at a time he has been vaccinated (the younger the age vaccinated the less seroconversion-susceptible for measles infection).
- The measles vaccine is highly light sensitive. Staying for one hour in temperature of 20-250c after reconstitution can loses its potency by 50%.
- To get protected from measles infection 99%, the child has to be vaccinated 2 doses of measles vaccine.
- More over the continuous influx migrants (probably unvaccinated) could also be added factor.

The recommendations are as follows:

- Laboratory confirmation of the reported suspected cases
- Ensure adequate clinical management of cases
- Intensify surveillance and notification of suspected cases
- Strengthen routine immunization
- Increase community awareness on measles infection

In addition, there is need to address the issue of reported “missed opportunities for vaccination” as there is a continuous displacement across the country and vaccines’ stock out issues. UNICEF plans to carry out a consultancy to supervise the Effective Vaccine Management (EVM) assessment, which will be followed by an EVM improvement plan.
EWARN and epidemiological situation updates

Average completeness of reporting is 81%. Total number of consultations is 145,919, out of which 20,304 EWARN notifiable cases were reported.

- Respiratory illness - AURI: 12,227 (60%). Most cases are reported from Baniwaleed municipality. ALRI: 2919 (14%). Most cases are reported from Subrata municipality.
- Water borne disease - Acute Diarrhea (AD): 4413 (22%). Most are reported from Baniwaleed municipality. Bloody Diarrhea (BD): 204. Most are reported from Ghanian municipality. Acute Jaundice Syndrome (AJS): 135. Most are reported from Baniwaleed municipality.
- Vaccine preventable disease - Suspected Measles (SM): 31. Most are reported from Benghazi (7), Ubari (6) and Zliten (5). Acute Flaccid paralysis (AFP): 4 from Benghazi (2), Zawia (1) and Misurata (1). Pertussis: 20. Most are reported from Subrata municipality. Meningitis (suspected): 34. Most are reported from Benghazi municipality.
- Other diseases - 278 cases were reported, including leishmaniasis (173). Most are from Baniwaleed municipality and food poisoning (105). Most are from Al-Abyar municipality.

Public health response - Besides separately reported response in Murzug area, on 19 August Al-Abyar hospital reported to NCDC about more than 90 cases of food poisoning. All cases were exposed to a contaminated food from the same restaurant. Some children were referred to Benghazi children hospital. Surveillance administration followed the event.

Southern Libya: violence around Murzugh

The situation remained critical. 104 public health facilities are located in the areas of conflict. Almost 20 public health facilities are in Murzugh municipality. All of these health facilities are and in potential danger of direct and indirect impact of ongoing conflict and its escalation. It was estimated that 95-105 people have been killed and 220-270 injured during the clashes in and around Murzugh. The displacements movement increased toward Sabha, Tragen, Wadi Ettebah, Ubari and Al Gatroun. An estimated of 10,000-14,000 people are displaced.

There is a need for more health sector organizations to scale up life-saving and life-sustaining health response. Strengthening cold chain system across the south remains one of the key priorities. Advocacy should be continued to call for an impartial access to the functioning health facilities by all patients regardless of their background.

Health sector priorities are:

- Strengthen outreach services: to provide static and mobile essential health services at the IDP sites, accessible areas, and health facilities.
- MHPSS outreach: To cover IDP sites and expand further through additional teams and setting up private spaces for counseling sessions if possible.
- Coordination of health response at a local level to be strengthened (especially in terms of referral of cases to reduce duplication of efforts).
- Referral of cases with regards to timeliness and acceptability of cases in receiving hospitals. Follow up on cases during admission and post discharge.
- Provision of life-saving and essential medicines, supplies and equipment as facilities continue to bear the burden.
- Support outreach immunization services in IDP sites and accessible areas to cover all children into the routine immunization program.
- Expand EWARN coverage to all IDP sites/locations through assigned EWARN focal points to provide systematic weekly reporting as well as assigned central rapid response teams to conduct daily visits for investigation of any emerging outbreaks or diseases.
• Assess physical disability caseload and planning for required interventions.
• Conduct Raise Awareness sessions on health prevention and promotion (including MHPSS/GBV, First Aid, IYCF, hygiene practices, etc.).

HEALTH SECTOR ACTION/RESPONSE

• 12 organizations provided inputs to 4W for July (GIZ, TdH, IMC, IOM, IRC, MSF-OCA, HI, UNFPA, UNICEF, WHO, UNHCR, PUI).
• Top 5 covered detention centers by number beneficiaries are Triq al Sika in Tripoli followed by Zintan in north-west, Al Sabaa in Tripoli, Az zawyal Al Nasr in north-west and Janzour in Tripoli.
• Most of health supplies distributed in July went to Tripoli, Ejdabia, Murzugh, Ubari and Al Margeb mantikas.
• 95% of support provided by health sector organizations is at the PHC level.
• The majority of health sector organizations provide support in Tripoli (8), followed by Al Jabal Al Charbi (5), Benghazi (5), Sebha (4) and Misrata (4).
• The highest number of beneficiaries reached services and supplies in July were in Ejdabia, Ubari, Derna, Wadi Ashshati and Tripoli.

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Health sector coordination (national and sub-national)

Leading:
• National health sector coordination group
• Sub-national health sector coordination group in Benghazi
• Sub-national health sector coordination group in Sabha

Participating:
• Area coordination group (ACG) West – Tripoli
• Area coordination group (ACG) East – Benghazi
• Area coordination group (ACG) South – Sabha

National health sector coordination meeting was carried out on 21 August in Tripoli. Participants included: IRC, AICS/Italian Cooperation, WHO, IOM, IMC, FADV, UNICEF, Emergency Sorrisi, UNHCR, UNFPA, GIZ, MoH (ICO, HR, PHC, HIS, Emergency Management), NCDC (TB), ICRC (observer). The following issues were discussed: overview of health sector response (health sector composition, attacks on health care, reporting on “casualties”, health sector assessment registry, bi-weekly operational update, health coverage by different modalities, 4W July 2019 HRP, response to Murzugh conflict), TB situation in the detention centers, coordination of health sector activities in the detention centers, capacity building events: consolidated approach.

Sub-national health sector meeting in Benghazi: The 4th sub-national health sector working group coordination meeting is being scheduled for 2 September in Benghazi. More details will be made available separately.
Health sector annual workplan for Libya 2019

Supporting Service Delivery

1.1 Provide a platform to ensure that service delivery is driven by the agreed strategic priorities

1.1.1 List of national and sub-national health partners, observers, etc. is developed and updated

1.1.2 Conduct monthly (and ad hoc, when necessary) national and sub-national health sector meetings (Tripoli, Benghazi)

1.1.3 Share the minutes and agenda before each meeting

1.1.4 Prepare a quarterly updated snapshot on attendance of national and sub-national health sector meetings

1.1.5 Elect co-coordinator from international and national NGOs (if necessary)

1.1.6 Participation in HCT (Humanitarian Country Team) or AHCT as an observer and ISC (Inter-Sector Coordination) meetings

1.1.7 Updating the health sector on their roles and responsibilities following the IASC Cluster functions

1.1.8 Update earlier developed ToR of Health Working Group, Libya

1.2 Develop mechanisms to eliminate duplication of service delivery/activities

1.2.1 Introduction of reporting tools (4Ws) to the IMOs of the health partners (via workshop)

1.2.2 Collection of monthly updates on 4Ws (2019 HRP), production and dissemination of monthly snapshots

1.2.3 Monthly and quarterly analysis and review of 4Ws health sector indicators

1.2.4 Provision and consolidation of bi-weekly inputs (operational updates)

Informing Strategic Decision Making for the Humanitarian Response

2.1 Needs assessment and gap analysis

2.1.1 Harmonization and standardization of health needs assessment tools (via workshop)

2.1.2 Review and update the health component (MSNA) of Humanitarian Needs Overview and other coordinated needs assessments and surveys

2.1.3 Preparation and consolidation of health sector assessment registry (quarterly updates)

2.1.4 Update of Public Health Situation Analysis

2.2 Analysis to identify and address (emerging) gaps, obstacles, duplication, and cross-cutting issues.

2.2.1 Prepare and disseminate weekly EWARN bulletins.

2.2.2 Sensitization workshop, DHIS2 tool for health sector.

2.2.3 Prepare and disseminate 4Ws indicators' reports for rapidly evolving conflicts (if and when appear) across the country

2.2.4 Analyze, prepare and disseminate monthly MVH reports (Attacks on Health care), SSA

2.2.5 Cross-cutting: Strengthen coordination with WASH, Protection and other sectors

2.2.6 Cross-cutting: Strengthen coordination with all technical sub-sector working groups (MHPSS, Migration, TB, and SRH)

2.2.7 Cross-cutting: Enhance and expand the issues of Reproductive Health as a standing agenda at both, national and sub-national levels (upon consultations with UNFPA)

2.3 Joint analyses supporting response planning

2.3.1 Operational response plans (national and sub-national levels) are developed based on consolidated inputs

Planning and Strategy Development

3.1 Develop sectoral plans, objectives and indicators directly support realization of the HC/HCT strategic priorities

3.1.1 Bi-annual update of earlier developed "Health Sector Response Strategy 2018-2021" (via workshop)

3.1.2 Develop health sector response plan (HRP), objectives, activities, indicators, targets

3.1.3 Enhance participation and contribution of health sector partners (100%) with projects for HRP

3.1.4 Strategic and technical "defence" of health sector strategy with the authorities

3.2 Adherence to and application of standards and guidelines

3.2.1 Identifying and sharing national and international standards and guidance

3.2.2 Key identified standards and guidance are adapted in consultation with the authorities

3.3 Clarifying funding needs, prioritization, and sector contributions to sector funding needs

3.3.1 Strategic and technical review of health sector projects submitted to HRP

3.3.2 Monthly and quarterly update (FTS) of health sector funding situation

3.3.3 Advocate for availability, preparation, submission, regular updates of health sector projects for Humanitarian Pool Funds (HPF), if and when available

3.3.4 Strategic and technical review of health sector projects submitted for HPF, if and when available

3.3.5 Quarterly update of HPF funded projects

Advocacy

4.1 Develop the list of advocacy issues for Libya (updated on a monthly basis) - access to the conflict and non-conflict zones, medical evacuation, violence against health, different governance structures, etc.

4.2 Regular updates of health advocacy points with the engaged stakeholders (HCT, UNSMIL, UN Security Council, etc.)

Monitoring and Reporting on implementation of sector strategy and results

5.1 Monitoring and reporting on implementation of cluster strategy and results

5.1.1 Training on 4W monitoring and reporting for health partners

5.1.2 Production and dissemination of 4W key performance indicators' monthly snapshots

5.1.3 Preparation and dissemination of monthly health sector bulletin, Libya

5.1.4 Preparation and disseminating of situation updates based on the evolving situation across the country (West, South, East, Central, Tripoli, and Benghazi)
Situation in and around Gharyan - Health sector follows up with its focal points in Gharyan areas where armed clashes have been reported. Health sector is concerned about the impact of reported violence on functionality of 53 primary health care centers in the municipality. Gharyan hospital has a solid absorptive capacity.

Request for assistance from Derna - WHO provided the requested support with health supplies (10 basic IEHK kits) to Derna hospital.

Southern Libya: violence around Murzugh

A close coordination is in place with the engaged local authorities in health response, including the Murzugh crisis committee, Sabha Municipality Council and Sabha Medical Center and others. Rapid response teams and surveillance officers are deployed to visit IDP locations across the south. Active and passive surveillance measures have been put in place. UNICEF facilitated the delivery of necessary vaccines to the targeted health facilities in Wadi Etba, Tragen and Um AlAraneb. The response with health supplies and support has been provided by WHO (Taraghin, Murzugh general hospitals and Tasawah rural hospitals have been reached with health supplies). The hospitals (Sabha Medical Centre, Taraghin and Ubari hospitals and Tasawah rural hospitals) continue referral services for wounded and patients with chronic conditions. To address the needs of families displaced from Murzugh to Benghazi area, WHO deploys an Emergency Medical team with an equipped mobile clinic. In addition, WHO EMT has been deployed from Ubari hospital to cover 2 locations (Al Greefah and Bent Baya rural hospitals) hosting Murzugh IDPs. One EMT provided surgeries and consultations on the premises of Sabha medical center and 1 WHO supported psychiatrist conducted sessions in Ubari general hospital, Sabha psychiatric clinic and Alshatti general hospital.

Coverage of DCIM Detention Centers (as per 23 August) by health sector partners: There are a total of 4,809 people in detention centers, including 88% males and 12 females. 27% are minors – under 17 years old.
Azzawya Al Nasr | 1120 | 761 | IOM (through IP-STACO), IMC, UNICEF (nutrition)
Gharyan al Hamra | 0 | 0 | 
Zintan (Thaher Al Jabal) | 583 | 574 | IOM, IMC, UNICEF WASH, MSF-OCP, UNICEF (nutrition)

**TOTAL:** 2111 1485

**WEST**
Zliten | 71 | 46 | IMC, MSF - OCP
Suq al Khamis (Khumus) | 198 | 194 | IMC, MSF – OCP, UNICEF (nutrition)
Karanim (Misrata) | 227 | 144 | IOM (through IP-STACO), IMC, MSF - OCP
Sirt | 106 | 60 | 

**TOTAL:** 602 444

**SOUTH**
Sebha | 0 | 0 | 
Brak | 0 | 0 | 

**TOTAL:** 0 0

**EAST**
Albayda | 20 | 12 | PUI (through UNHCR)
Shahhat | 28 | 15 | PUI (through UNHCR), IOM (through IP-STACO)
Tobruk | 26 | 6 | IOM (through IP-LRC)
Alkufra | NA | NA | IOM (through IP-LRC)
Ejdabia | 62 | 35 | PUI (through UNHCR)
Ganfouda | 308 | 151 | PUI (through UNHCR), IOM (through IP-LRC), UNICEF (nutrition)
Tolmaitha | 9 | 9 | Reported by: PUI (through UNHCR)

**TOTAL:** 444 219

Response on visceral leishmaniosis – WHO and NCD follow up on treatment of 6 diagnosed children, including 2 reported this week in Bengazi children hospital. In 2019 – there were 27 children admissions (all from the southern part of Libya), including 3 mortality cases.

EPI/Polio Eradication program

- Purchase and delivery of electronic equipment for NCDC.
- Administration, agenda, presentations, and planning for the upcoming trainings completed.
- Training of 52 focal points (pediatricians and clinicians) from clinics and referral hospitals working on AFP, Measles and EWARN surveillance) from 30th August 2019 -1st September 2019.
- Development of EPI/Polio program operational plan as a part of Libya operation plan 2020 – 2021. The plan included more than 38 activities under 6 main areas (routine immunization, AFP, Measles, VPDs, EPI/Polio activities among high risk groups, and M&E).
- Consolidation and dissemination of last two AFP/Measles bi weekly epidemiological update report (Epi week 31, 32, 33 and 34). 4 AFP cases reported during the period from Al Jabal Al Akhdar, Alkoms and Al Zawiyah districts. Specimens from suspected cases delivered to Pasteur Polio lab in Tunis.
- Consolidation and dissemination of weekly epidemiological update reports (Epi week 30-33) for AFP/Measles.

Reported outbreak of “yellow fever” in Derna

NCDC and WHO visited Derna hospital from where 17 suspected acute jaundice syndrome (AJS) cases were reported from Al Gabal Al Akhdar area. All patients were discharged after the treatment. The NCDC will support the hospital with lab reagents to confirm the diagnosis (most likely food borne Hepatitis A disease). Tobruk and Benghazi rapid response teams were put on a stand by. The necessary notifications were sent to the health and environmental administrations to follow up on the issues of water quality, water supply, and hand hygiene.

Coordination of capacity building events: Health sector organizations are requested to share proactively information on any planned activities to support different capacity building events inside and outside of the country. A common position, standardized approach, is necessary on the amounts paid for accommodation, DSA, transport costs, incentives, etc. There is a dedicated HR department in the MoH responsible for HR support and learning plans.
There is a need to keep this HR department fully informed about capacity building events supported by the international community. Additional technical discussions should be carried out on the way forward to consolidate the process of capacity building events across the country. If necessary, a separate technical working group may be proposed while focusing on humanitarian and development aspects of capacity building events.

- WHO and NCDC, 30 August- 1 September, Tunis, “AFP, Measles Surveillance Hospital Focal Points (Pediatricians and Clinicians)” Training Workshop. This training is aiming towards inculcating and refresh the baseline knowledge of Measles/AFP Surveillance Hospital Focal Points, and to enhance and strengthen surveillance system through integration of both AFP and Measles surveillance, with main focus on the following objectives: 1. Strengthening measles elimination programme through its integration with Acute Flaccid Paralysis (AFP) Surveillance; 2) Promote early active detection and reporting of Measles and AFP cases. Participants: 39 hospital focal points (pediatricians and GPs) representing 35 municipalities nationwide.

- WHO and NCDC, 3 – 5 September, Tunis, “Developing National Measles Surveillance Guidelines and updating AFP Surveillance Guideline. The objectives are: to develop Measles and AFP surveillance guidelines, case definitions and posters; to provide key reference materials for health service providers; to strengthen understanding and uniform application of measles and polio knowledge among health service providers. Participants: 8 national public health professionals.

- IOM, in coordination with the Health Information Center of MOH, organized two training events on the use of District Health Information System tools and provided with Tablets in Al Marj and Al Baydha for a total of 37 MoH staff from different parts of the Eastern Region.

- 2-6 September, Tunis, UN Women-OCHA Training of Trainers on Gender in Humanitarian Action (GiHA). 3 slots are reserved for the health sector. IRC, IMC, UNHCR nominations are received.

- WHO, 19-23 August, Tunis, one week ToT workshop for master trainers on the adapted training manuals for CHWs in Libya. Participants: 25.

- GIZ, Preparation for Family Practice orientation trainings for District Health Managers and Health Representatives from 16 municipalities (northwest and south Libya) in cooperation with MoH an MoLG.

- UNICEF, cold chain and vaccine management ToT training for 90 district vaccine supervisors as part of a cascade training for around 2,000 vaccinators nationwide. Another middle-level managers training for 24 EPI managers. Health facility routine immunization microplanning ToT training for 90 district vaccine supervisors. Health facility routine immunization microplanning cascade training for 670 vaccination center supervisors nationwide.

Joint Operational Framework between the Global Health and Protection Clusters

The Global Health Cluster and Global Protection Cluster are undertaking over the next six months with collaboration from the Child Protection, GBV, Mine Action Areas of Responsibility (AoR) and IASC Mental Health and Psycho-Social Support (MHPSS) Reference Group looking at strategies to integrate and coordinate health and protection response in humanitarian crises. After consultation members of Steering Group have identified Libya as a country context they would like to examine further as there are strong health and protection needs, where all the sub-clusters are activated. The aim would be to talk to sub/cluster/working group coordinators and key stakeholders about this issue in Tunis as well as talk to those based in Tripoli and sub-nationally remotely (e.g. VSAT/calls, etc.). The consultant’ visit has been scheduled from 29th August to 7th September. The work will be closely co-coordinated by health and protection sector coordinators (Mr Azret Kalmykov and Mr Yasin Abbas) for Libya.

Health sector partners’ updates:

Emergenza Sorrisi supports a mobile clinic in Al Nasser DC in Zawiya 6 days a week providing PHC services to 188 patients (44 females,144 males), including medicines. Another team works 3 days a week in Daher Al Jabel Zintan DC
providing PHC services to 220 patients, including medicines. Earlier the organization set up 3 prebab clinics in Ain Zara, Tajoura and Tarek Al Sika.

**IMC:** Mobile Medical Units (MMUs) provide primary health care inside 8 Detention Centers and 20 polyclinics on semi-weekly schedule. There is one IMC’s clinic inside the Community Development Center (CDC) in Gorgi. IMC responded to at least 4 Rescue at See (RAS) operations. In addition to general PHC consultations, mental health services are being made available as well as referrals to public and private sector. IMC follows up closely with NCDC on the line list of treated TB patients to avoid duplication of services. The organization also completes its assessment phase for support of pre-selected PHC centers. Three PHC centres were requested by the MoH (Tamanhant PHC/Albawani, Sidi Khalifa PHCC/Nalut, Alkwassim western PHC/Azzintan). There are 2 other PHCs included in the project: the polyclinic/Algarabolli and Martyrs PHC/Janzour.

**IOM:** IOM medical team and implementing partners reached 2,078 migrants and IDPs in 14 locations including detention centers, IDP camps, PHC center and communities. Additionally, 50 cases were referred to hospitals and clinics for diagnostic and inpatient care. 1,225 migrants who expressed their interest in Voluntary Humanitarian Return to their country of origin or qualified to Resettlement programs received medical screening/check-up by IOM medical teams. In Addition, 480 migrants in Dhahr Aljabal DC benefitted from an anti-scabies campaign in the DC. IOM medical team and IPs also attended to the health needs of migrants recued in 9 Rescue at Sea operations in Alkhums and Abusitta DPs.

**GIZ:** Preparation of implementation plans to improve quality of services at 5 PHCCs (Implementing partner - IMC).

**UNHCR** through its implementing partners provide 18,599 medical consultations (Disembarkation: 680 - Detention: 11,509 -Urban: 6,410). Health IPs (IMC and PUI) continue to provide health services in several detention centers across Libya. During the first 2 weeks of August 645 primary health care consultations and 2 referrals, 5 psychiatric consultations were at detention centers. 289 new medical consultations, 170 follow up medical consultations, 14 psychiatric consultations, 30 out-patient referrals were at the CDC clinic. 52 medical consultations were provided in response to interceptions by Libyan coast guards in Tripoli. GDF medical team provided follow up for 22 cases of pregnancy and 21 tuberculosis cases (through NCDC).

**UNFPA** supports Werimma PHC center in Tajura district in Tripoli, providing BEmONC by 3 mobile medical teams (OBGYN, Pediatrics, General medicine), 24/7 maternal and newborn health services. An estimated of 150 women, 120 children are covered and 100 general consultations provided on a biweekly basis.

**UNICEF** closely monitors the situation in Tripoli and the vicinity. Maintains close contacts with Murzuq health staff and ready to transport IEHK kits to Murzuzg hospital; Alahali PHC (Field hospital); Tragen hospital; Tasawah hospital. In coordination with the MoH, UNICEF will send one 50 KVA generator to Tasawah hospital. If necessary, UNICEF is ready to replenish the stocks of cholera kits and ORS that was prepositioned earlier with NCDC. Under PHC services support: UNICEF prepares an integrated Maternal and Child Health, immunization and nutrition package targeting 24 health facilities in 24 migration affected municipalities, 3 other health facilities in the eastern migration route and 3 extra health facilities in Sebha. The package will include capacity building of the staff in the targeted health facilities on Integrated Management of Childhood and Newborn Illness (IMNIC), Essential Newborn Care (ENC), Emergency Obstetric and Newborn Care (EmONC), Infant and Young Child Feeding (IYCF). Supplies and equipment: UNICEF will provide the targeted health facilities with supplies, equipment and lifesaving medications to ensure the availability of health services for a year at least. This includes rehabilitation of WASH facilities, C4D advocacy promotion of healthy practices, supportive supervision. UNICEF decided to provide 670 PHC centers within the 24 targeted municipalities with first aid equipment. For EPI program UNICEF sends 2 solar and 1 regular refrigerators to Ghat and procured Fridge Tag 2 (FT2). Arabic translation and instruction have been completed to train staff to operate. UNICEF provided Gherian, Sert (Ibn Siena) and Abuhadi hospitals with 3 IEHK kits, for 30,000 population for 3 months. 2 IEHK
kits have been assigned to Abumeliana PHC center in Tripoli. Under nutrition program UNICEF distributed emergency food rations to 350 detainees in Ghanfouda DC in Benghazi, 600 detainees in Dhaher Aljabal (Zentan) DC in Zintan. UNICEF is planning to procure more nutritional supplements: High Energy Biscuit (HEB); Emergency Food Rations (BP-S); Micronutrient powder; Micronutrient tablets. SMART survey is being under the preparation with MoH/PHC and Bureau of Statistics and Census (BSC), ACF and WFP. Under HIS program, as part of the 24 municipalities’ support, UNICEF in partnership with Health Information Center and in coordination with WHO has committed to support the implementation of District Health Information System 2 (DHIS2) in all the health facilities in those municipalities, an average of 670 health facilities, which represent around 40% of all the health facilities in Libya. The support will include capacity building of the staff on the DHIS software and sponsoring the technical support for 2 years by HISP India (on going). Providing the HIS focal points with tablets (in the bidding process); providing the district health officer (DHO) and 2 more staff with laptops for their clearance of the data (in the bidding process).

SUCCESS STORY:

Emergenza Sorrisi - Two diabetic patients among the migrants complained about lack of necessary medicines. The organization was able to provide sufficient number of insulin pens for at least 4 months for both of them

INFORMATION SOURCES:

https://www.who.int/health-cluster/countries/libya/en/
https://reliefweb.int/country/lyb
https://www.humanitarianresponse.info/ru/operations/libya
EWARN: https://ncdc.org.ly/Ar/

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