Impact of COVID-19 prevention measures on humanitarian operations for Health Sector in Libya

Libya

23 April 2020
INTRODUCTION

The COVID-19 pandemic is a global health emergency that requires effective immediate action by governments and individuals. Countries throughout the world are taking unprecedented steps to respond to the threats posed by this deadly virus. Swift, radical action is essential to save lives, protect communities and stem the human-to-human transmission of the disease.

WHO has defined four transmission scenarios for COVID-19 and set out the critical preparedness, readiness and response actions for each one. Libya falls under the risk analyses of having local transmission. As of 22 April, there were 59 confirmed cases of COVID-19 in Libya. The risk of the further spread of COVID-19 is exacerbated by the growing levels of insecurity, political fragmentation, weak health and surveillance system and high numbers of migrants, refugees and IDPs. The situation is compounded by the existence of two competing governments. A Government of National Accord (GNA) in Tripoli was established in December 2015 with the support of the UN. A rival government in the east (Benghazi) is backed by the Libyan National Army (LNA) headed by Field Marshal Khalifa Belqasim Haftar. The UN-backed government in Tripoli has struggled to exert control over territory held by rival factions and intensifying geographical and political divisions between the east, west and south. Terrorist groups and armed militias have exploited the turmoil and used the country as a base for radicalization and organized crime. Libya is awash with weapons: arms from the Gaddafi era are plentiful, and materials of war continue to be shipped to the country in breach of the UN-imposed arms embargo. Despite calls for a ceasefire, the hostilities have continued, with further attacks on hospitals and health care centres.

Scale: As of 22 April 2020, the Libyan National Centre for Disease Control (NCDC) has reported 59 confirmed cases of COVID-19 in Libya, including Libya’s first COVID-19-related death. Of the confirmed cases, the majority are in Benghazi, Misrata and Tripoli. However, given the low testing capacity, with only two testing laboratories (Tripoli and Benghazi), a total of 891 tests have been performed to date, therefore, the number of people actually affected with the coronavirus is expected to be higher.

Urgency: Although strong preventive measures (border closures, restricted movement, closures of schools, cafés, restaurants, etc.) have been taken, inter-community transmission is likely and has the potential to significantly impact on Libyans, migrants and refugees, many of whom are already vulnerable due to growing levels of insecurity, political fragmentation and weak governance that have led to a deterioration of basic service delivery, particularly in the health system.

Complexity: Despite calls for a global ceasefire, fighting continues particularly in and around Tripoli. Between 1 January and 31 March 2020, United Nations Support Mission in Libya (UNSMIL) documented 126 civilian casualties (63 deaths and 63 injured) due to ongoing clashes and shelling. This constrains people’s ability to access basic supplies and services and for humanitarian organizations to reach people in need. Indiscriminate attacks (confirmed 12 attacks between January – April 2020) continue to impact civilians and civilian infrastructure, such as the attack on Al Khadra hospital in Tripoli on 7 April 2020, a 400-bed hospital that was one of the COVID-19 assigned facilities, and the attack on the Man-Made River Project that cut water to more than 2 million people, including 600,000 children. in a moment where access to water is a must to have any chance against COVID-19.
**Capacity:** Government and health system capacity to respond to the pandemic is limited. The already fragile governance systems in Libya, especially those responsible for delivering basic services, have been tested to the limits by the protracted conflict. The health information system in Libya is weak and only a limited number of health care facilities are reporting to the Early Warning and Response Network (EWARN). Contact tracing capacity is limited, and laboratory capacity is mostly confined to Tripoli, and to a lesser extent Benghazi, and needs to be expanded. In municipalities where health services were already limited but who are on the front lines of combatting the pandemic, lack funding, capacity and equipment to respond. Many points of entry, particularly land borders, are not fully secured and don’t have capacity and resources for testing and quarantining.

Identified healthcare facilities assigned for confirmed COVID-19 patients and suspected cases changes frequently due to resistance from local communities or armed groups to have these health facilities in their areas, as well as health workers’ refusals to care for COVID-19 patients without sufficient personal protective equipment (PPE). While high-level advocacy has been successful in the release of critical funds for the national COVID-19 preparedness and response plan and back pay of salaries for health workers, adequate financial resources to combat the pandemic continues to be a challenge.

Immediate needs include support to rapid response teams, procurement and distribution of personal protective equipment, procurement of laboratory diagnostic kits and supplies for COVID-19, establishment of and support to isolation sites and wards (within or outside healthcare facilities), provision of training and capacity-building, distribution of awareness materials and health education.

Health service provision was already limited in most areas and is likely to be further impacted as resources are directed to responding to the pandemic. Minority or marginalized groups, including people with disabilities, people in remote areas and older people, may face greater challenges due to pre-existing health conditions that may cause complications if they contract COVID-19 and increase their risk of mortality. Additionally, internally displaced persons (IDPs), migrants and refugees often have lost or do not have formal identification which makes it difficult to access health services.

Women and girls tend to bear caregiving responsibility for ill family members, increasing their risk of exposure to COVID-19. Essential services for women, such as sexual and reproductive health, may be deprioritized by health facilities to concentrate on COVID-19 response, thereby putting women and girls at risk of other health problems. Furthermore, women and children may be at increased risks of abuse while in home or gender-based violence (GBV) incidences due to socio-economic, psychological tensions and constraints as a result of lockdown/curfew. The reduced access to case management services and referral to specialized services, in addition to movement restrictions, will result in limiting their ability to access essential services.

Migrants and refugees in detention are at a heightened risk of being unable to access critical medical care for COVID-19 in a timely manner due to evolving access constraints partners face and a lack of established pathways for the referral of COVID-19 cases into the national healthcare system from detention. The conditions in detention centres could further exacerbate a COVID-19 outbreak given the prevalence of respiratory illness in their population.

Many IDPs, and some returnees, live in sub-standard housing, informal settlements or camp-like settings hindering their ability to adopt social distancing measures and limiting access to functional basic services and essential household necessities. With increasing prices of basic food and commodities, IDPs may
struggle to afford goods in addition to pay the rent, putting them at higher risk of eviction given that 60 per cent of IDPs who rent often have informal rental contracts.

In the absence of unification and with no political resolution in sight, the authorities look to WHO to take a decisive lead in the health response to COVID-19. As the lead agency for the Health Sector, WHO is coordinating the response and working closely with the National Centre for Disease Control (NCDC), health authorities in the West and East, and other national agencies. WHO provides necessary technical support and guidance to MoH and NCDC to develop and update national preparedness response, protocols and guidance materials aligned with eight pillars of priority response. This is supported by the Inter-Sector Coordination Group's inter-sectoral analysis of the potential impact of COVID-19 that will be used to address direct and indirect effects of COVID-19. However, the extreme insecurity and severe restrictions placed on internal travel within the country will pose huge challenges for WHO, partners and the health authorities in their attempts to respond to COVID-19 in Libya.

**Health sector structure in Libya:**

Health sector Libya is comprised of 27 actors, including 11 INGOs, 6 UN agencies, 1 national authority, 7 donors and 2 observers. There is a national health sector coordination group, led and co-lead by MoH ICO (International Cooperation Office) in Tripoli and health sector coordinator, monthly meetings.

There are 2 active sub-national health sector groups at: Sabha hub – led and co-lead by MoH/NCDC and WHO national staff, monthly meetings; organized in February 2019; Benghazi hub/Al Baida – led and co-lead by MoH Interim Government and WHO national staff, monthly meetings; organized in November 2018.

There are five thematic sub-sector working groups: Gender-Based Violence – led by UNFPA; Mental Health/Psychosocial Service Support – led by IOM and HI; Tuberculosis – led by WHO; Sexual and Reproductive Health – led by UNFPA; Migration – led by IOM.

**2020 HRP objectives:**

- **Objective 1:** Increase access to life-saving and life-sustaining humanitarian health assistance, with an emphasis on the most vulnerable and on improving the early detection of and response to disease outbreaks.
- **Objective 2:** Strengthen health system capacity to provide the minimum health service package and manage the health information system.
- **Objective 3:** Strengthen health and community (including IDP, migrants and refugees) resilience to absorb and respond to shocks with an emphasis on protection to ensure equitable access to quality health care services.

To measure the impact of above-mentioned measures, the Health sector in Libya carried out a rapid survey among its partners between 15-22 April 2020, using online survey (form available here). 19 representatives of 8 INGOs, 4 UN agencies and other structures have responded providing an overview of the impact of the COVID-19 prevention measures on their operations in Libya.
RESULTS

Many of the organizations report their activities impacted by the preventive measures related to COVID-19. 31.6% continued with only specialized services for vulnerable and high-risk cases.

### How do you continue delivery of health services and assistance now (%)?

- **No change to the operations, continue delivering health services**: 52.6%
- **Only specialized services for vulnerable/high risk cases continue**: 31.6%
- **No report**: 15.8%

10.5% of organizations report their activities impacted by the preventive measures related to COVID-19 put in hold for more than a month.

### For how long your activities put on hold?

- **ongoing**: 42.1%
- **Not Reported**: 36.8%
- **more than month**: 10.5%
- **2 weeks**: 5.3%
- **1 week**: 5.3%
**Alternative modalities of work:** To cope with the situation, most of organizations have adopted flexible work arrangements such as teleworking (75%) and staff rotation (50%).

31.3% of agencies report maintaining hotlines, while 18.8% have adopted other modalities.

<table>
<thead>
<tr>
<th>Alternative modalities of work (%)</th>
<th>(Multi choices)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teleworking</td>
<td>75.0</td>
</tr>
<tr>
<td>Staff rotation</td>
<td>50.0</td>
</tr>
<tr>
<td>Hot line</td>
<td>31.3</td>
</tr>
<tr>
<td>Other</td>
<td>18.8</td>
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</tbody>
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**Some of the additional measures that should be already adopted by the partners:**

- Ensuring that all medical staff in supported health facilities are provided with personal protective equipment (PPE)
- Posters and awareness material, with WHO and Ministry of Health guidelines on infection prevention and control are being distributed across supported health facilities
- To minimize the number of visits to the health facilities and reduce the risk of exposures. NCD patients are being provided with medicines for a 2 months’ period
- Use of hotline and WhatsApp for providing consultation and medical advice
- Rotating system among health staff present in the health facility
- Improving infection prevention and control measures in the health facilities
- Suspension of all group activities such as trainings
In addition to the major funding concerns reported, 23% of the organizations report lack of interest to work due to staff health concerns.

63% of organizations thought that movement restrictions by authorities affected the health services delivery (mainly in terms of suspension of some services).

61.5% of organizations report funding concerns related to the preventive measures.
REQUIRED SUPPORT

Most of the agencies (77.2%) report need for sharing of COVID-19 situation reports. Additionally, partners require more technical guidance (44.4%).

Libyan’s health system’s ability to maintain delivery of essential health services will depend on its baseline capacity and burden of disease, and the COVID-19 transmission context. Maintaining population trust in the capacity of the health system to safely meet essential needs and to control infection risk in health facilities is key to ensuring appropriate care-seeking behavior and adherence to public health advice.

IMPACT ON THE ACTIVITIES

Geographical analysis shows that many areas across Libya are impacted. Preventive measures are applied uniformly across the country. Specific services (such as trainings, refurbishing or rehabilitating public health facilities, referral for treatment, and mental health consultations) are more impacted by the COVID-19 preventive measures. Critical services (health services and commodities provided by public PHC facilities, delivering health services via mobile medical teams/clinics (including EMT).
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The partners continued only essential activities. Among top reported activities continued are health services and commodities provided by public PHC facilities & delivering health services via mobile medical teams/clinics (including EMT).

### Health services and assistance that continue by assessed partners (%)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public PHC facilities supported with health services and commodities</td>
<td>73.3</td>
</tr>
<tr>
<td>Delivering health services via mobile medical teams/clinics (including EMT)</td>
<td>46.7</td>
</tr>
<tr>
<td>Mental health consultations</td>
<td>46.7</td>
</tr>
<tr>
<td>Referral for treatment between different levels of care and locations</td>
<td>46.7</td>
</tr>
<tr>
<td>Outpatient consultations (excluding mental health, trauma consultations, physical rehabilitation)</td>
<td>46.7</td>
</tr>
<tr>
<td>Training /refresher training of community health workers on different health topics</td>
<td>33.3</td>
</tr>
<tr>
<td>Training /refresher training of health service providers on different health topics</td>
<td>33.3</td>
</tr>
<tr>
<td>Refurbishing or rehabilitating public health facilities</td>
<td>33.3</td>
</tr>
<tr>
<td>Public secondary health care facilities supported with health services and commodities</td>
<td>33.3</td>
</tr>
<tr>
<td>Trauma/injury related consultations</td>
<td>33.3</td>
</tr>
<tr>
<td>Providing standard health kits</td>
<td>26.7</td>
</tr>
<tr>
<td>Providing medical machines</td>
<td>26.7</td>
</tr>
<tr>
<td>Physical rehabilitation (disability) sessions/consultations</td>
<td>26.7</td>
</tr>
<tr>
<td>Providing health services to disembarkation points by fixed health points and/or mobile medical teams</td>
<td>20.0</td>
</tr>
<tr>
<td>Providing health services to official detention centers by fixed health points and/or mobile medical teams</td>
<td>20.0</td>
</tr>
<tr>
<td>Providing health services to IDP camps/settlements by fixed health points and/or mobile medical teams</td>
<td>20.0</td>
</tr>
<tr>
<td>Health facilities and community centers providing MHPSS services</td>
<td>20.0</td>
</tr>
<tr>
<td>Vaginal deliveries attended by a skilled attendant</td>
<td>20.0</td>
</tr>
<tr>
<td>Training of health workers on CMR (Clinical management of rape)</td>
<td>13.3</td>
</tr>
<tr>
<td>Caesarian sections</td>
<td>13.3</td>
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However, a few activities, mostly of group nature, were affected, such as: trainings, refurbishing or rehabilitating public health facilities, referral for treatment, and mental health consultations.
RECOMMENDATIONS

With a relatively limited COVID-19 caseload, health systems may have the capacity to maintain routine service delivery in addition to managing COVID-19 cases. When caseloads are high, and/or the health workforce is reduced due to infection of health workers, strategic shifts are required to ensure that increasingly limited resources provide maximum benefit for a population.

**Health services and assistance that are most affected (%)**

*Multi choices*

- Training /refresher training of health service providers on different health topics - 55.6%
- Training /refresher training of community health workers on different health topics - 44.4%
- Refurbishing or rehabilitating public health facilities - 44.4%
- Referral for treatment between different levels of care and locations - 44.4%
- Public PHC facilities supported with health services and commodities - 33.3%
- Health facilities and community centers providing MHPSS services - 33.3%
- Mental health consultations - 33.3%
- Outpatient consultations (excluding mental health, trauma consultations, physical rehabilitation) - 33.3%
- Training of health workers on CMR (Clinical management of rape) - 22.2%
- Providing health services to official detention centers by fixed health points and/or mobile medical teams - 22.2%
- Providing health services to IDP camps/settlements by fixed health points and/or mobile medical teams - 22.2%
- Providing medical machines - 22.2%
- Physical rehabilitation (disability) sessions/consultations - 22.2%
- Trauma/injury related consultations - 22.2%
- Providing standard health kits - 11.1%
- Public secondary health care facilities supported with health services and commodities - 11.1%
- Delivering health services via mobile medical teamsclinics (including EMT) - 11.1%
- Caesarian sections - 11.1%
- Vaginal deliveries attended by a skilled attendant - 11.1%
- Providing health services to disembarkation points by fixed health points and/or mobile medical teams - 11.1%
Maintain Continuity of Health Service Delivery

As currently the COVID-19 caseload is limited, the health sector recommends continuing and maintain delivery of health services with minor adjustments, if required. The priority categories are:

- Essential prevention for communicable diseases, particularly vaccination
- Services related to reproductive health, including care during pregnancy and childbirth
- Care of vulnerable populations such as infants and older adults
- Provision of medicines and supplies to manage chronic diseases and mental health conditions
- Continuity of critical inpatient therapies
- Management of emergency health conditions and common acute presentations that require time-sensitive interventions
- Auxiliary services such as basic diagnostic imaging, laboratory and blood bank services.

Focused Interventions in maternal health:

- Provide technical guidance for coordinated health systems assessments, with a focus on service availability and readiness assessments of Sexual, Reproductive, Maternal, Neonatal, Child and Adolescent Health services.
- Support a nationally led MISP response in humanitarian settings, from implementation to early transition towards restoration of comprehensive sexual and reproductive health services.
- Ensure continued deployment of trained health workers such as nurses and midwives.
- Support national partners in strengthening multisectoral response services through referral pathways for survivors of gender-based violence
- Support training of first-line responders on the provision of Mental Health and Psychosocial Support (MHPSS) and Psychological First Aid (PFA)

Focused Interventions in Child Health & Immunization:

- Inform via Media where to find vaccination services

Focused Interventions in Public Nutrition:

- Inpatient Nutritional Care (essential)
- Other care could be done via telephone line, consider provision of advance food voucher to beneficiaries who depend on food distribution

Focused Interventions in Communicable disease:

- Establish screening of all patients on arrival at all sites using the most up-to-date COVID-19 case definitions and adapting sites if necessary
- All OPD need to be adapted to acute and urgent presentations only, wound care and for referral to designated Emergency Rooms.
- Referrals Only for emergencies (avoid elective referrals)

Focused Interventions in NCD and Mental Health:

- Redirect chronic disease management to focus on maintaining supply chains for medications and supplies, with a reduction in provider encounters.
- Limit facility-based consultations. Ensure long term supply of chronic patients, consider phone consultations, Mental health hotline and referrals
- Mental Health and Psychosocial Support (MHPSS) Key Messages: Awareness, Positive coping for general public, vulnerable groups, and frontline responders
- Training of first-line responders on the provision of Psychological First Aid (PFA) for COVID-19
- Case identification and referral for treatment
- Follow up of patients in isolation or quarantine and their families in named facilities where they can access MHPSS consultation and support
- Integration of MH providers with Rapid Response Teams (RRT) to follow up patients, family members, healthcare workers within and after surveillance activities are done
- MHPSS providers available in established and to be established isolation sites

**Focused Interventions in Supplies and Logistics:**

- Ensure availability of drugs, equipment and other essential supplies
- Map manufacturers and suppliers
- Weekly review of critical items stocks and pipelines

**Focused Interventions in Human Resources Management and mobilization:**

- Initiate rapid training and job aids for key capacities, including diagnosis, triage, clinical management, and essential infection prevention and control
- Maximize occupational health and staff safety measures

**Continuity of critical inpatient therapies:**

- Critical inpatient therapies
- Only emergency surgery (delay elective)
- Reduce hospital stay
- Ensure separation from COVID-19 inpatient care
- Specify and map functioning facilities

**Management of emergency health conditions and common acute presentations that require time-sensitive interventions:**

- Ensure triage to avoid non urgent cases being admitted
- Set up/reinforce COVID-19 triage

**Auxiliary services such as basic diagnostic imaging, laboratory and blood bank services:**

- Reduction to support essential activities. Define list of essential lab tests
- X-ray and image services
- Maintain for support to critical activities (ER, Surgery, IPD)
- Ensure designated support to COVID19 diagnosis
For more information:

The technical guidance by topic can be accessed at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

Contact:

Mr Azret Kalmykov, Health Sector Coordinator, kalmykova@who.int