Community Health

Policy and Implementation Landscape Mapping in the Middle East and North Africa Region 2024

Libya Country Brief

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1. Community health in Libya

Community health policy in place	Community health workers recognized as part of the national health workforce	Total number of community health workers currently deployed	Inclusion of community health workers in emergency preparedness plans	Domestic funding available	Community engagement mechanisms in place	Formal linkages between community health and other sectors available
No	No	985	No	No	No	Yes

1.1 Country context

Libya, also known as the State of Libya, is a country in North Africa with a total population of 6.47 million. Current per capita expenditure on health is US$171.[1] Libya's government is in transition. A provisional government, the Government of Libyan National Unity, was established in 2021 following the peace process in 2020.[2] Formal elections have been delayed due to ongoing political differences and insecurity.

The administrative system in the country is centralized, although efforts are being made to decentralize services. In terms of local government, the country is divided into 101 municipalities.[3] Each municipality has a functional council with directorates responsible for implementation and monitoring of health, education, economy and other sectors.[4]

1.2 Overview of community health

Following the conflicts in 2011 and 2014, the health care system in the country became fragmented and there was a deterioration in service delivery due to constraints in technical capacity and limited funding. Despite the peace process in 2020, Libya continues to face an unstable security situation and political landscape, which negatively impacts health service provision, including for community health.[5]

While the government recognizes the importance of community health, there is no current framework for community health at the national level or integration of services. Community health service delivery models are largely based on non-governmental organization (NGO) interventions and priorities, and are characterized by vertical programmes with limited sustainability.

1 Health Information Center, Annual Statistical Report for the Health Sector, HIC, 2022.
2 Health Cluster Libya (2021). Health Sector Libya Annual Report 2021-2022, WHO.
3 United Nations (2019). Strategic Framework for Libya 2019-2022, United Nations. https://www.undp.org/sites/g/files/zskgke326/files/2022-06/UN-Startegic-Framework-for-Libya-2019-2022.pdf
4 Celik, Y., & El Taguri, A. (2021). Reforming Health System in Libya. Statistical, Economic and Social Research and Training Centre for Islamic Countries (SESRIC). https://sesricdiag.blob.core.windows.net/sesric-site-blob/files/article/774.pdf
5 UNICEF (2022) Libya: Consolidated Emergency Report. UNICEF. https://open.unicef.org/sites/transparency/files/2023-05/Libya%20CER%202022.pdf

2. Health systems pillars

2.1 Governance and accountability

- There is currently no formal framework for community health services in Libya.
- The Primary Health Care Institute (PHCI) Strategy for 2023 emphasizes the importance of community health and integration of services. Specifically, community orientation and community engagement are highlighted as core elements of family practice. This commitment to integration has yet to be operationalized.[6]
- Some integration with primary health care (PHC) exists through short-term projects funded by NGOs. These services do not continue past the duration of the project, leading to poor sustainability.
- District health offices provide minor support for health services at the community level. This is often provided in the context of emergencies and is also dependent on the availability of resources. There is no ongoing or stable support available from the government.
- Current efforts at the community level are guided by a document created in 2018 entitled *Strategic Directions for Establishing Community Health Workers (CHWs) Programme*. This document has not been endorsed but rather is used as a framework to guide CHW programming.
- The private sector is not routinely engaged in community health in Libya. There are no mechanisms to encourage and organize their participation. Some engagement was observed during the COVID-19 response mainly with vaccinations.

2.1.1 Community engagement and accountability

- There is limited experience and knowledge on meaningful community engagement in the country. Activities that do occur tend to be limited to the duration of the associated intervention and are not sustainable.
- The document, *Strategic Directions for Establishing CHWs* (2018), foresees participation of CHWs in decision-making processes as well as linkages with the food and nutrition and water and sanitation sectors. That stated, there are currently no mechanisms in place to allow for this participation and it is unclear the extent to which intersectoral linkages are operational.[7]

Insight: Community health committees during COVID-19

- Although community health is not formally integrated into health service delivery systems in Libya, some engagement during emergencies does occur. During the COVID-19 pandemic, for example, the local government in Libya mobilized health committees at the municipal level. These municipal health committees coordinated with one another and worked together to engage directly with communities to provide services, such as facilitating access to the COVID-19 vaccine and conducting education and health promotion activities. The health committees were made up of relevant stakeholders, including district health managers. Regular meetings were held for coordination purposes.
- After the COVID-19 pandemic ended, these committees were dissolved, and no similar mechanisms were reestablished. Currently, GIZ is aiming to reinstate and revitalize these health committees, further integrating them into existing mechanisms to ensure sustainability.

6 The Primary Healthcare Institute (2023). Primary Health Care Strategy 2023, PHCI.
7 WHO and UNICEF (2018). Strategic Directions for Introducing CHWs to Libya, WHO.

2.2 Health management information systems

- Since 2018, DHIS2 is the health management information system (HMIS) used in Libya under the support and control of Health Information Centre (HIC) in the Ministry of Health (MoH). Data on community health services, however, are not included.
- There is limited data on community health services collected at the community level using a paper-based system. The data are collected by CHW supervisors and then sent to the data management office at the District Health Office, before being shared with PHCI and HIC. It is not fully clear how data on community health services are managed, analysed and reported into the national system, and to what extent they are available and accessible at the central level.

2.3 Medicines and health commodities

- Overall, there is limited information available on supply systems for medicines and health commodities for community health programmes in Libya.
- The document, *Strategic Directions for Establishing CHWs* (2018), recommends that community health programmes should use existing systems for logistics support for medicines and supplies to the facilities, and that a monthly report should be recorded, outlining the stock position of medicines and supplies. That stated, there is no evidence of any integration with the national supply system, including Logistics Management Information System (LMIS).
- Support for medicines and health commodities is primarily provided by NGOs with minor support provided by district health offices and PHCs according to availability of resources.
- Under current laws, CHWs are not able to provide curative services or prescribe any medications.

2.4 Health workforce

- CHWs are not recognized as part of the national health workforce in Libya, and do not receive salaries from the government. They are deployed by NGOs, who provide financial support for the duration of their projects.
- Different types of CHW cadres are defined and deployed by NGOs according to the aims of their project. The only commonly accepted cadre that operates without restriction is health promotion/education.
- There is currently no CHW master list with a record of all those actively serving communities. Recently, the Africa Centre for Disease Control (CDC) estimated that there are approximately 1,000 CHWs in the country, covering 10 per cent of the country's population.[8]
- The high number of health workers from other PHC cadres create obstacles in advocating for official recognition and establishment of CHWs in an already flooded health workforce environment.
- In practice, there are no regularly utilized criteria for selection of CHWs, but there is a preference for choosing from other health workers. CHW supervisors are chosen among an existing CHW pool.
- A training module for CHWs was endorsed by PHCI (2019). NGOs use this module for their trainings.[9]

8 Africa Centres for Disease Control. (2024). Country Consultation Workshop for Stronger, More Equitable PHC and Emergency Preparedness and Response [PPT], Africa CDC.
9 The Primary Healthcare Institute, CHW Basic Training Module, PHCI, 2019.

2.5 Service delivery

- There is no formal model for service provision at the community level in Libya. Currently, models are based on NGO interventions and priorities and vary accordingly. Most services provided relate to vertical programmes.
- The Africa CDC and UNICEF are currently supporting a scale up plan with the MoH for community health. These plans specifically focus on emergency preparedness and response (ERP), immunization and PHC interventions, including nutrition, communicable and non-communicable diseases, environmental health, and reproductive, maternal, newborn and child health.[10]
- CHWs are not able to provide direct service delivery in the country due to a lack of formal recognition. This lack of integration into the formal health workforce means that they do not benefit from protections or legal provisions for service delivery. Most programming is therefore focused on health promotion and education.

2.6 Partnerships and financing

- Partners and financing are strongly linked as the country relies largely on external funding from partners for community health.
- Expenditure on health as a percentage of GDP is 4 per cent, while the proportion of government budget allocated to health is 6 per cent as of 2022.[11]
- There is no specific budget for community health services; it is deducted from the general health expenditure with PHCI and NCDC providing some support from their own budgets.
- The lack of formal recognition of CHWs creates obstacles in making a case for budget allocation at both central and local levels.
- External partners play an important role in supporting community health, including through providing funding for training and supplies. The main external partners supporting community health efforts include UNICEF, WHO, IMC, IOM, GIZ, UNHCR, and IRC, and more recently, Africa CDC.

2.7 Cross-cutting issues

2.7.1 Gender

- There are no gender sensitive recruitment or training policies in Libya. There is also no module on gender sensitivity included in the PHCI endorsed training curriculum.

2.7.2 Emergency Preparedness

- CHWs and their supervisors are not currently integrated into emergency preparedness plans in Libya.

2.7.3 Refugees and IDPs

- There is minor involvement of IDPs and refugees as part of CHW workforce within their respective communities. Community leaders of refugee groups are recruited to facilitate access to these communities to facilitate service provision.

10 Africa Centres for Disease Control (2024). Country Consultation Workshop for Stronger, More Equitable PHC and Emergency Preparedness and Response [PPT], Africa CDC.
11 World Bank Group (2024). Data: Libya. World Bank. https://data.worldbank.org/country/libya

3. Conclusions

3.1 Challenges

- The lack of formal community health framework makes it difficult to justify any national or district-level budget allocations.
- Current community health programming is dependent on NGO funding, which leads to poor sustainability.
- Community health workers are limited in services that they can provide due to a lack of formal status in the country.
- An overflooded primary health care health workforce (e.g., nurses, dentists) operating at the level of primary health facilities makes it difficult to justify a new cadre of health workers for community health.

3.2 Enablers

- Strong experiences in emergencies and during the COVID-19 pandemic, including good collaboration among stakeholders and community engagement, that can be learned from and/or scaled up.
- Existence of a guidance document that could inform future community health strategies and CHW programming and that can be adapted for endorsement.
- Many PHC health workers are available, who could potentially be reoriented or included in community health endeavours.

3.3 Future policy directions

- **Establish policies and strategies to organize and institutionalize the work around community health:**
  - Establish a multi-sectoral committee for strategy development with a clear terms of reference. The committee should include representation from PHCI, NCDC, MoH HR directorate, Ministry of Local Governance, Ministry of Education, the National Economic and Social Council, and other stakeholders.
  - Review, update and endorse key documentation, including the Strategic Directions for Establishing CHW Programme for Libya (2018) and the training modules developed by WHO, UNICEF and IRC, ensuring gender sensitivity is included in training as well as regular capacity building.
  - Review existing health cadres (e.g., health inspector) and look at where it might be possible to reorient, transform or incorporate community health responsibilities.
  - Ensure dedicated budget line for community health initiatives as linked to the revitalized CHW cadre.
- **Establish strong monitoring mechanisms, including:**
  - A reporting mechanism and pathways to allow for sending and receiving regular report updates; and
  - Creation of a community-based information system, in collaboration with HIC, and to include incorporation into DHIS2.

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United Nations Children's Fund (UNICEF)

Regional Office for the Middle East and North Africa

15 Abdel Qader Al-Abed Street
P. O. Box 1551
Amman 11821 Jordan
Tel: +962-550-2400
menaro_Info@unicef.org
www.unicef.org/mena

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