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Country Cooperation Strategy for WHO and the Libyan Arab Jamahiriya 2010–2015

Libyan Arab Jamahiriya

World Health Organization
Regional Office for the Eastern Mediterranean

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Abbreviations

AIDS	Acquired immunodeficiency syndrome
CCA	Common country assessment
CCS	Country cooperation strategy
DOTS	Directly observed treatment, short-course
DPT3	Diphtheria, pertussis, tetanus vaccine (3 doses)
EC	European Commission
EPI	Expanded Programme on Immunization
EU	European Union
FCTC	Framework Convention on Tobacco Control
FDA	Food and Drug Authority
GDP	Gross domestic product
GPC	General People's Congress
GPCHE	General People's Committee for Health and Environment
HBV3	Hepatitis B vaccine (3 doses)
HIV	Human immunodeficiency virus
ICD	International classification of diseases
ICT	Information and communications technology
IOM	International Organization for Migration
MDGs	Millennium Development Goals
OPV3	Oral poliovaccine (3 doses)
PHC	Primary health care
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Section 1

Introduction

Section 1. Introduction

The Country Cooperation Strategy (CCS) reflects the medium-term vision for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS process reflects global and regional health priorities with the aim of bringing together the strength of WHO support at country, Regional Office and headquarters levels in a coherent manner to address the country's health priorities and challenges.

The CCS, in the spirit of Health for All and primary health care (PHC), examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, the determinants of health and upstream national policies and strategies that have a major bearing on health. The exercise aims to identify the health priorities in the country and place WHO support within a framework of 4–6 years in order to have a stronger impact on health policy and health system development, strengthening the linkages between health and cross-cutting issues at the country level. This medium-term strategy does not, however, preclude a response on other specific technical and managerial areas in which the country may require WHO assistance.

The CCS takes into consideration the work of all other partners and stakeholders in health and health-related areas. The process is sensitive to evolutions in policy or strategic exercises that have been undertaken by the national health sector and other related partners. The overall purpose is to provide a foundation and strategic basis for planning as well as to improve WHO's contribution to Member States towards achieving the Millennium Development Goals (MDGs).

The CCS mission was composed of the senior health managers from Ministry of Health, the WHO Representative in the Libyan Arab Jamahiriya and staff from the WHO Regional Office for the Eastern Mediterranean in Cairo. A national WHO consultant prepared a preliminary review of the health situation and challenges in the country. In the process of development of the strategy, a series of meetings and reviews were conducted with a many officials from concerned ministries and institutions and representatives of UN agencies, key potential internal and external partners.

The CCS (2010–2014) was developed in a context of overall transition and persisting challenges. Institutional development and capacity building, formulation of national health policy and strategy, noncommunicable disease as well as health system reform have been priorities for the country for a number of biennia and remain so. In addition to these priorities, the proposed national health reform also aims at encouraging participation of the private sector in the delivery of health services through the introduction of health insurance.

Section 2

Country Health and Development Challenges

2.1 Geographic and administrative profile

The Libyan Arab Jamahiriya is located in North Africa, with total land area of 1 665 000 km^2. The country borders Algeria, Chad, Egypt, Niger, Sudan and Tunisia and has 1900 km of coastline along the Mediterranean Sea.

The climate is Mediterranean along the coast, which basically consists of four seasons. It is dry and hot in the extreme desert interior with the exception of Sabha in the south. The main cities are concentrated in the northern part of the country along the coastal area. The seven largest cities are Tripoli, Benghazi, Alzawia, Musrata, Derna, Sirte and Sabha.

The administrative system of the country is relatively decentralized. The country is divided into 23 *shabiat* (districts), each of which consists of a number of people's congresses. The total number of people's congresses is 468. Each *shabia* has a functional secretariat of health, which is responsible for health services within that *shabia* and is under the supervision of the General People's Committee for Health and Environment (GPCHE).

2.2 Demographic profile

The total estimated population at mid year 2008 was 5 527 000 people, with a population density of 3.3 persons per km^2. The northern part of the country is the most populous, with 85% of the population on 10% of the land area.

According to the general census in 2006, the population growth rate fell from 2.9% to 1.8% during the period 1984–1995. Similarly, the percentage of population under 15 years of age declined from 39% in 1995 to 32% in 2006. The proportion of population over 60 years is 6%. As part of the vital registration system, every family has a "family book", in which all family members are registered and vital events such as births, deaths and marriages are recorded. 86% of the population lives in urban areas, and the annual growth rate in urban areas is much higher than in rural areas.

The scattered population, vast geographical area and the influx of a substantial number of immigrants strain existing health and social services and are potential risks for the spread of communicable diseases. National demographic indicators for 2008 are given in Table 1.

2.3 Economic and social profile

The Libyan economy depends primarily upon revenues from the oil sector, which contributes 95% of export earnings, about one-quarter of GDP, and 60% of public sector wages. The removal of international economic sanctions is helping the country attract greater foreign direct investment, especially in the energy sector. Libyan oil and gas licensing rounds continue to draw high international interest; the National Oil Company has set a goal of nearly doubling oil production, to 3 million bbl/day, by 2012. The country is laying the groundwork for transition to a more market-based economy.

Table 1. Demographic indicators, 2008

Indicator	Value
Male population	2 802 189
Female population	2 724 811
Crude birth rate (per 1000 inhabitants)	24.9
Crude death rate (per 1000 inhabitants)	4.0
Population growth rate (%)	2.8
Crude fertility rate (per woman)	2.7
Life expectancy at birth (years)	
Male	70.2
Female	74.9
Total	72.3
Population aged 15 years and above (%)	68.9
Average family size (persons)	6.0
Population density (persons per km2)	3.3
Population doubling time (years)	30
Average marriage age for males (years)	34
Average marriage age for females (years)	31
Urban population (%)	86
Rural population (%)	15

Source: [1,2]

The non-oil manufacturing and construction sectors, which account for more than 20% of GDP, have expanded from processing mostly agricultural products to include the production of petrochemicals, iron, steel and aluminum. The Libyan Arab Jamahiriya imports about 75% of its food.

- 26.4% of females participate in economic activities, however, the overwhelming majority are in the agricultural sector. The unemployment rate in 2006 was at 20.7% (21.6% male and, 18.7% female). The country has an estimated per capita GDP of over US$ 15 200 per annum.[3] The share of public health expenditure is 3.3% of the total GDP expenditure, which is relatively low.
- The country boasts the highest literacy and educational enrolment rates in North Africa. Literacy among the population over 15 years

1 General Information Authority report, 2007

2 *Demographic, social and health indicators for countries of the Eastern Mediterranean 2009.* Cairo, WHO Regional Office for the Eastern Mediterranean, 2009

3 General Information Authority report, 2008

is 88.5% (males 93.7%, females 83.2%), which is well above that in neighbouring countries. The substantial improvements in education in the past two decades have reduced illiteracy among females from 39% in 1980 to less than 16 % in 2006. Meanwhile, the overall combined primary, secondary and tertiary enrolment rate in 2006 was 88%, higher than in any of the neighbouring countries. Education is compulsory between the ages of 6 and 15 years. Secondary education starts at age 15 and lasts for three years. Unusually for the Region, female students tend to have more schooling than their male peers.

2.4 Health profile

2.4.1 Overview

The government provides free health care to all citizens, with GPCHE responsible for health services delivery. Through a chain of public health facilities, the GPCHE provides health care services and regulates the growing private health sector. The Libyan Arab Jamahiriya spent 3.3% of its GDP and 7.5% of general government expenditure on health services in 2007. The per capita government health expenditure is US$ 363.[4]

Although the health service is free of charge for all citizens, it is estimated that 20% of expenditure on health is out-of-pocket expenditure paid for private care either in country or abroad.

2.4.2 Health status indicators

Health status indicators are shown in Table 2.

2.4.3 Communicable diseases

Overview

The Centre for Infectious Diseases Control is responsible for the prevention and control of communicable diseases. The Centre has a number of scientific committees which guide different preventive and control programmes and plans in their respective areas of specialty (e.g. tuberculosis, HIV/AIDS, malaria). The Centre has 24 branches in every *shabia*.

Expanded Programme on Immunization

The Centre is responsible for immunization: the national programme has been successful in achieving a high rate of routine immunization coverage. There is good awareness of the need for vaccination among the population at large. In 2008, immunization coverage of 95% was reported for DPT3, OPV3, measles vaccine and HBV3.

A network of 36 programme managers is implementing the immunization programme at district level. These managers are in technical contact with the Centre. A hepatitis B and C sero-prevalence survey completed in 2004 showed prevalence rates for hepatitis B of 2.18%, and hepatitis C of 1.19%. A vaccination programme for *Haemophilus influenzae* type b has been initiated and during 2006, 2007 and 2008, extra vaccination campaigns were conducted to raise immunity among specific age groups (cohort of 1988). Poliomyelitis has been eradicated, and a surveillance programme for polio as well other communicable diseases is in place.

[4] General People's Committee for Health and Environment statistical report, 2009

Table 2. Health status indicators, 2007–2008

Health indicator	Value	Year
Neonatal mortality rate (per 1000 live births)	10.8	2007
Infant mortality rate (per 1000 live births)	17.6	2007
Maternal mortality ratio (per 100 000 live births)	27	2007
Under five-mortality rate (per 1000 live births)	20.1	2007
Newborns with birth weight at least 2.5 kg (%)	95	2007
Children with acceptable weight for age (%)	95	2007
Number of reported new cases of:		
Malaria	7	2008
Cholera	0	2008
Poliomyelitis	0	2008
Pulmonary tuberculosis	772	2008
Measles	8	2008
Diphtheria	0	2008
Tetanus	2	2008
Neonatal tetanus	0	2008
AIDS	303	2008
Hepatitis B	2451	2008
Hepatitis C	1264	2008
Meningococcal meningitis	22	2008

Source: [5,6]

The Centre has 51 adult vaccination centres. The Centre also conducts large-scale vaccination in schools during school immunization days to boost immunity. The success and achievements of EPI in the Libyan Arab Jamahiriya has been recognized by the Arab League and in WHO regional meetings.

The country has identified four priority areas for period 2008–2012: prevention and control of HIV/AIDS, vaccine-preventable diseases and tuberculosis, and surveillance of communicable diseases.

HIV/AIDS prevention and control

Based on the national sero-prevalence surveys in 2004, the prevalence rate of AIDS is at 0.13% of the general population. There were 9378 registered cases of AIDS at the end of 2008 (both nationals and foreigners).[4] A situation analysis in 2004 showed that 87% of AIDS cases were among injecting drugs users. Knowledge, attitudes and practices studies are needed; in this regard a series of studies is planned to be undertaken as part of the forthcoming strategic planning exercise. National guidelines have been

5 Pan Arab Project for Family Health survey, 2007

6 National Centre for Infectious Diseases Control report, 2008

formulated for management of people living with HIV/AIDS. A special centre is providing treatment to AIDS patients.

The strategic plan for 2008–2012 for HIV/AIDS prevention and control has been developed. The strategy includes the introduction of a harm reduction programme and establishment of voluntary testing and counselling in major cities. To mobilize local leaders and resources, AIDS prevention committees have been established in each *shabia*. A revised school curriculum has also been developed to fight HIV/AIDS. Recently a memorandum of understanding was signed for technical and financial support from the European Union for building national capacity on HIV/AIDS and other infectious diseases.

Tuberculosis

Although the Libyan Arab Jamahiriya has a low incidence of tuberculosis, 60% of cases occur in the productive age group of 15–56 years. The national tuberculosis programme started implementing the WHO-recommended DOTS treatment strategy in 1998, and achieved the regional targets of nationwide coverage of the strategy in 2000. In 2008, 871 cases (621 nationals, 250 foreigners) of tuberculosis were notified in public facilities working under the DOTS strategy. The DOTS treatment success rate was 63.5% in 2007.[7]

The national strategy to fight tuberculosis has three main goals: implementation of the DOTS strategy according to WHO guidelines; revision and updating of the medical faculties' curricula; and improvement of tuberculosis laboratories by establishment of a multiple drug resistance laboratory and use of advanced techniques in diagnosis.

Surveillance and forecasting

A division of the Centre responsible for disease surveillance is located in Zleiten. It has established a surveillance network and performs several training activities on data collection and handling guidelines. In addition, national guidelines for disease surveillance have been adapted and the reporting system is operational in all districts. Three types of surveillance are conducted: sentinel, case-based and general.

The Centre has an efficient early warning and detection system and the occurrence of any outbreaks in the country is detected quickly. The Centre is conducting a diploma course in surveillance. The backbone of Centre's surveillance and early detection programme is the existence of strong laboratory with highly qualified staff supported by a scientific committee. An electronic surveillance system is expected to be implemented soon.

The Centre has been at the forefront of events regarding pandemics such as influenza H1N1 and currently registers all passengers from abroad and conducts public information campaigns to combat the spread of disease in the country. The centre could be a potential candidate for WHO collaborating centre.

An outbreak of leishmaniasis was detected in the past several years. Strong control measures have been taken, resulting in drop of incidence in 2010. Efforts are

[7] National Centre for Infectious Diseases Control report, 2007

continuing to reduce incidence to the lowest possible level. The Regional Office and other international institutions have collaborated in these efforts. Neglected tropical diseases and zoonotic and diarrhoeal diseases (except Rotavirus) are reported regularly as part of community-based surveillance.

The priority needs for the Centre are technical assistance for further strengthening of surveillance, and an in-depth evaluation and appraisal of strengths and weaknesses with special emphasis on communication and documentation.

2.4.4 Noncommunicable diseases

The prevalence and incidence of noncommunicable diseases have increased dramatically over the past 20 years. Cardiovascular diseases, hypertension, diabetes and cancer contribute significantly to mortality and morbidity and have put a considerable strain on health expenditure. The main causes of death (reported by national authorities) are cardiovascular diseases (37%), cancer (13%), road traffic injuries (11%) and diabetes (5%). The prevalence of risk factors for noncommunicable diseases has risen as a result of changing lifestyles. More than 30% of the adult male population smokes regularly. Results of the Global School Health Survey in 2007 show that 15% of schoolchildren aged 13–15 years currently use some form of tobacco products, and 6% of students currently smoke cigarettes. Obesity is also emerging as a major health problem. The survey reports almost 42% of students have been in a physical fight in a 12-month span and almost 60% of schoolchildren do not have easy access to safe water in school. Furthermore, the survey showed an inadequate programme of health awareness in schools.

A stepwise survey conducted by the GPCHE in collaboration with WHO in 2009 showed a high prevalence of noncommunicable disease risk factors among the population (Table 3).

Currently the PHC network is supposed to address noncommunicable diseases. However, the programme needs major development and strengthening. Special programmes and approaches are needed to change health behaviour. As well the criteria, procedures and protocol to deal with noncommunicable diseases at PHC level and referral care also need special focus. The association of cardiologists has initiated a number of programmes for promotion, care and monitoring of noncommunicable diseases, and these efforts are a good platform on which to build. Given the successful experience with establishment of a communicable diseases centre, creating a special centre to tackle noncommunicable diseases and lifestyle-related issues may produce similar good results. GPCHE recently decided that the National Centre for Infectious Diseases Control will also tackle noncommunicable diseases. This may provide an innovative approach to consolidate promotion, prevention, education, monitoring and treatment in order to to deal with the issue.

Approximately 1.2% of the population is blind, mainly due to cataract. Trachoma remains endemic in some pockets in the country. The Libyan Arab Jamahiriya signed the Vision 2020 declaration of support, but a national plan has not yet been developed. Disease control strategies, human resources for eye care and strengthening of infrastructure are needed, along with extra funds.

Table 3. Results of the Stepwise survey on noncommunicable disease risk factors among adults aged 25–64 years (2009)

Risk factor	Total	Male	Female
Daily smokers (%)	23.8	47.6	0.1
Daily smokers smoking manufactured cigarettes (%)	88.8	88.8	—
Consumption of less than 5 servings of fruit and/or vegetables on average per day (%)	97.4	97.0	97.9
Low levels of activity (< 600 metabolic equivalent minutes per week) (%)	43.9	36.0	51.7
Not engaging in vigorous activity (%)	78.4	69.3	87.4
Overweight (body mass index ≥ 25 kg/m2) (%)	63.5	57.5	69.8
Obesity (body mass index ≥ 30 kg/m2) (%)	30.5	21.4	40.1
Raised blood pressure (systolic blood pressure ≥ 140 and/or diastolic blood pressure ≥ 90 mmHg or currently on medication for raised blood pressure) (%)	40.6	45.8	35.6
Raised blood pressure (systolic blood pressure ≥ 140 and/or diastolic blood pressure ≥ 90 mmHg) who are not currently on medication for raised blood pressure (%)	59.7	68.4	48.5
Raised fasting blood glucose or currently on medication for raised blood glucose (%)	16.4	17.6	15.1
Raised total cholesterol (≥ 5.0 mmol/L or ≥ 190 mg/dl or currently on medication for raised cholesterol) (%)	20.9	19.0	22.7
None of the above risk factors (%)	0.2	0.4	0.1
Three or more of the above risk factors, aged 25 to 44 years (%)	51.2	57.4	44.5
Three or more of the above risk factors, aged 25 to 54 years (%)	78.0	80.2	67.0
Three or more of the above risk factors, aged 25 to 64 years (%)	57.4	68.3	52.2

Road traffic crashes, which result in 6 deaths per day and even higher figures for disability, account for a significant burden of disease. The National Committee for Road Traffic Injuries has developed a national strategy for road safety that includes better emergency services for the injured.

The safety of food supplies is the responsibility of the National Food and Drug Control Centre, which analyses over 12 000 samples annually. The database on nutritional values of the typical Libyan diet is inadequate. There is a need to further discuss the food safety programme, elaborate on ongoing activities in a systematic fashion

and identify requirements to strengthen the programme. The programme is supported by very good laboratory facilities; however, inspection, monitoring processes and enforcement of regulations are areas that need strengthening.

On 18 June 2004, the Libyan Arab Jamahiriya signed the Framework Convention on Tobacco Control (FCTC) which was officially ratified on 7 June 2005. In May 2009, the GPC issued a decree banning smoking in public places and prohibiting advertising of all tobacco products in the media. The decree also prohibits selling cigarettes to any person less than 18 years old and obliges tobacco producing and importing companies to label all cigarette packs with warnings on the front side. This decree has been implemented and enforced. Several surveys have been conducted for situation analysis, such as the Global Youth Tobacco Survey, Global School-based Student Health Survey and STEPwise survey. The key stakeholders are the GPCHE, Ministry of Education, health committees at shabia level, youth associations and nongovernmental organizations. Tobacco control approaches include health-promoting schools, health education and tobacco control legislation. However, there are still many areas in the national tobacco-free programme that need strengthening and development.

2.4.5 Women, children, adolescent and elderly health

Women and child health

While health indicators and level of literacy among women are very good, still health of women and children will be advanced by strengthening the maternal and child health programme as an integrated part of primary health care. Development of sex-disaggregated health data is needed, particularly on noncommunicable disease and lifestyle-related diseases. Reproductive health in its totality has not been evaluated. WHO support would be beneficial to assess and provide recommendations for improvement and further refinement on maternal health and child health, in consideration of country's epidemiological profile. As in many other countries of the Region, consanguineous marriage is common. In this respect screening is needed for hereditary and genetic factors that affect health, and premarital counselling and testing should be strengthened. Special programmes are also needed to address the health effects of genetic disorders.

Adolescent health

Libyan Arab Jamahiriya is a dynamic society and hence children are exposed to variety of factors that both positively and negatively impact their health. While the health services provide good coverage and children and youth enjoy a good level of nutrition and access to relatively good schools, there are a number of concerns such as the use of tobacco among schoolchildren. The potential risks of HIV/AIDS and use of illicit drugs are other concerns that require vigilance by health and other authorities. A well developed and intersectoral adolescent health programme is required that is coordinated with school health, healthy cities, health-promoting schools, environmental health, lifestyles etc and integrated into the PHC system.

Elderly health

With provision of good health coverage and overall economic development resulting in increased life expectancy and modern lifestyles, elderly health is assuming greater importance. A strategic elderly health programme is needed within the PHC system, including referral care as well as family and community care.

2.4.6 Occupational health

Although occupational health has been identified as a key priority area in the national health plan, there is no focal point in the GPCHE. However, the Ministry of Labour has an occupational safety programme. There are academic courses in medical schools on industrial hygiene and occupational health. There is need to establish a programme of occupational health in GPCHE. The proposed programme requires a focal point and staff and resources for planning, programme development and training. The training and development of occupational health inspectors are vital. The proposed programme should be integrated into the PHC system. There should be close collaboration between the Ministry of Labour and GPCHE.

2.4.7 Health system development

Organization of the health system

In accordance with public health law no 106 of 1973, the People's Congress and its People's Committees guarantee the right of citizens to health care. Since March 2006, there has been a move towards centralization and synchronization at various levels. The country has been divided into 23 *shabiat* and General People's Congress decided to re-establish the secretariat of health under the name of General Peoples Committee for Health and Environment and give it the authority to inspect and supervise the central institutions and the secretariats of health at the *shabia* level.

The GPCHE is currently responsible for:

- Proposing national health policies and plans
- Supervision and inspection of *shabia* health committees
- Establishing standards and regulations for both public and private health service providers
- Supervision of central health bodies including tertiary hospitals and research and training institutions
- Coordination with various sectors.

The secretariats of health in all *shabiat* provide comprehensive health care including promotive, preventive, curative and rehabilitative services to all citizens free of charge through primary health care units, health centres and district hospitals. In addition to *shabiat* secretariats of health, the army and the National Oil Company provide health services to members of the armed forces and company employees. A growing private health sector is also emerging, although currently it has a limited role.

The capacity of GPCHE for exercising the health stewardship function at the central level needs to be developed. At the same time, capacity at local level also needs upgrading.

Health services

Primary health care structure

The organization of primary health care services starts at the periphery. Basic health care is offered at this first level through PHC units and centres. There is an intermediary level between the first and second PHC level, where more elaborate services are rendered through polyclinics and clinics at workplaces. At the second level the district and general hospitals provide care to those referred from the first level. At the third level, in specialized and teaching hospitals, advanced care is provided to those referred from the second level. The referral system needs improvement, as many centres operate on an open access basis. Indicators of PHC coverage are shown in Table 4.

- Almost all levels of health services are decentralized and all hospitals are managed by secretariats of health at *shabia* level except Tripoli Medical Centre and Tajoura Cardiac Hospital, which are centrally run.
- First level (unit/centre) usually serves a population of 5000–10 000. The primary health care centres are staffed by: a physician, a nurse, a dentist, a laboratory technician, an X-ray assistant, a pharmacist and a medical records clerk. In some large centres maternal child health, paediatrics and outpatient surgical services are provided.
- In a few urban areas, 3–4 PHC centres are supported by polyclinics, where the specialists from the catchment areas hospital provide services to patients. There are a total of 45 polyclinics in the country.

The priority needs in PHC centres are:

- Strengthening of staff capacity for quality of care and patient safety
- Scaling up hygiene standards, health care waste collection and disposal
- Continuous monitoring of behaviour and correctness of health centre staff and patient satisfaction
- Electronic recordkeeping
- Electronic connectivity for distance consultation and advice on diagnoses and treatment.

Hospital autonomy

All hospitals in Libyan Arab Jamahiriya are considered as independent institutions based on decree no. 9 (2004) of the General People's Committee. The law gives hospitals the authority to have their own budgets and to have special bank accounts for income. The hospital director also has the authority to recruit all cadres of health staff according to regulations.

Each hospital has a scientific committee that decides on technical issues. There is also a board of directors that consists of heads of all the different departments in each hospital. The decree clearly states the roles and responsibilities of the board of directors.

The hospitals have the authority to contract some housekeeping services (building works, cleaning, catering and maintenance work) as well as medical imaging and laboratory services to private contractors.

Many hospitals operate at very low occupancy rate, employ excess staff and use resources inefficiently. The ratio of hospital beds to population is the highest (37 per 10 000) among the countries of the Region (Table 5).

Table 4. Indicators of primary health care coverage, 2008

Health indicator	Value
Population with access to local services (urban and rural) (%)	100
Infants immunized against tuberculosis (%)	100
Infants immunized with DPT (%)	98
Infants immunized against poliomyelitis (%)	98
Infants immunized against hepatitis B (%)	95
Infants immunized against measles (%)	95
Pregnant women immunized against tetanus toxoid (%)	45
Deliveries attended by trained personnel (%)	99.9
Infants attended by trained personnel (%)	100
Population with access to safe drinking water (%)	97.6
Population with adequate excreta disposal facilities (%)	99

Source: [8]

Table 5. Public health facilities, 2008

Health facilities/services	Value
Specialized hospitals	25
Central hospitals	18
General hospitals	21
Rural hospitals	32
Total no. of public hospitals	96
Total beds in public hospitals	20 289
Total beds in welfare clinics	1 060
Total beds in private clinics	1 433
Total beds all hospitals	22 782
Beds per 10 000 population	37
Primary health care facilities	1 424

Source: [9]

[8] National Centre for Infectious Diseases Control annual report, 2008

[9] Health Information Centre health statistical report, 2009

The priority needs in hospitals are as follows:

- Training of selected staff on hospital administration and management
- Technical support for disposal of large amounts of expired medicines
- Strengthening/developing of medical waste management including waste segregation, collection, treatment and disposal
- Strengthening of staff skills and updating/developing procedures and protocols for patient safety
- Strengthening of staff skills and updating/developing procedures and protocols for monitoring and control of nosocomial infections
- Development of operational research and studies on quality of care, behaviour of hospital staff and patient satisfaction
- Electronic recordkeeping
- Electronic connectivity for distance consultation and advice on diagnostic, treatment and surgical procedures support.

Private sector

The government has decided to encourage the expansion of private clinics and hospitals. As well, serious attempts are being made to introduce the family physician practice along with the necessary rules. The total number of private hospitals and clinics is 103, with a total of 2088 beds. Most of these facilities are located in Tripoli, Benghazi, Musrata and Alzawea. There are 415 outpatient clinics, 297 dental clinics, 1934 pharmacies and 311 laboratories in the private sector.[9]

Human resources

Human resources assessment, production and management is a high priority for the health sector. There are no clear plans to match needs with number and categories of health personnel. The lack of accreditation system, weak intersectoral collaboration, lack of link between continuous medical education programmes and career development and inadequate training in management are other factors that hinder health care delivery.

In the public sector there are 9 medical schools, 7 dental schools and 6 pharmacy schools producing human resources for health. In addition, 14 nursing schools and 9 allied health sciences and technical institutions produce allied health personnel. However, production is not planned or organized based on need. There are also frequent changes in curriculum.

In 2008 there were 18 physicians, 3.3 dentists, 3.6 pharmacists and 54 nurses and midwives per 10 000 population.[9] There is an imbalance in the distribution of health personnel, as many favour urban areas and hospital practice. Systematic performance appraisal and periodic recertification testing are not in place.

Nursing is dependent on expatriate staffing. Most qualified nursing staff are not Libyan. In the past few years, nursing education has been established for nationals to meet the increasing demand. A 3-year diploma course after secondary school has been established, but many difficulties remain. Teaching staff are not well qualified, curricula are not up-to-date and attraction to the profession remains low. Management

is also weak. However, attempts are being made to tackle most of these areas. WHO is assisting in revision of curricula, establishing a bachelor's degree in nursing and improving management.

There is a Human Resources Development Office in the GPCHE and at *shabiat* levels with a national policy, strategies and plans for human resources and annual training programmes.

Health information system

Establishment of the Health Information and Documentation Centre to coordinate collect and report on national health data has been a positive step towards the development of national health information system. Health information is part of GPCHE; activities include collecting data from all health facilities, issuing national health statistical reports, conducting health surveys, regularly updating and disseminating essential health indicators and training health personnel on the use of international classifications of disease and statistical packages.

The General Authority for Information and Documentation, which is under the cabinet of ministers, collects, processes and disseminates information on the most important socioeconomic demographic indicators, and vital statistics. The General Authority acts as a central data bank for all development sectors. The Health Information and Documentation Centre publishes an annual report containing updated health indicators and trends in collaboration with General Authority.

Through an ongoing vital registration system, every family in the country has a "family book" in which all the family members are registered, and vital events such as birth/marriage/death are recorded. There are also regional vital registration offices all across the country.

The National Centre for Infectious Diseases Control, through its surveillance and monitoring systems, provides excellent and up-to-date data on communicable diseases in the country.

The library of the Libyan Board of Medical Specializations and libraries of medical colleges also furnish health information and medical library services. These libraries are supported through funds-in-trust from national institutions. In addition, the Regional Office supports these libraries as part of the collaborative programme. Most of the medical libraries have access to Medline on CD-ROM. Training courses were provided through the Regional Office to medical librarians. The libraries receive WHO publications on a regular basis.

Information and communication technology (ICT) is increasingly recognized as an essential element to support health care services. Currently, ICT activities are isolated and uncoordinated, without adequate communication and consultation between the different ongoing programmes. Awareness on ICT issues among staff is not optimal. This is largely the result of inadequate computer literacy among health professionals, many of whom have not had training or orientation in this field.

In summary, health care informatics expertise is inadequate. The information and telecommunication infrastructure in health care institutions is weak. Most hospitals,

primary health care centres, medical colleges and other health facilities do not have the necessary infrastructure to benefit from e-health solutions. For example, hospital and health facility records and information are not computerized.

There are other challenges in health information system. Vital statistics data need improvement. The cause of death is not clearly reported. This is the result of insufficient training and relevant skills by the physicians that certify e-deaths. Another important challenge is use of information in planning and policy development.

The main priorities for information systems are as follows.

- Strengthening shabiat information systems.
- Training of physicians to identify the cause of death accurately.
- Strengthening utilization of data that the health information centre collects for planning and policy development.
- Preparation and implementation of consolidated national strategy and plan for development of ICT in the health sector, including training of staff and utilization of e-health.
- Developing and implementing a process and programme for continuous accreditation and qualitative analysis of information collected and fed to the health information centre.
- Promoting the collection of qualitative information such as patient satisfaction, patient safety, health care personnel behaviour by the PHC system and strengthening the health information system to collect and consolidate such data and report them in annual reports or as needed.

Medicines and health technology

The Libyan pharmaceutical sector is predominantly public, with the government aiming to provide medicines to all citizens. This vision is embedded in the orientation of the health care system in the country. Until recently the institutional responsibilities of partners involved in medicine and medical supply management have not been clear.

The rational use of medicines, registration and classification is now the responsibility of the Directorate of Pharmaceuticals Control and Medical Supply at the GPCHE. A Food and Drug Administration (FDA) has been established and is responsible for medicine quality control. The FDA, using laboratory facilities available in the Faculty of Pharmacy, is controlling the quality of medicines for human use, biological and blood products as well as vaccines. Medicines and medical equipment are supplied solely by the Pharmaceutical Control and Medical Supply Directorate.

Until recently a budget was allocated for purchasing medicines, mainly through imports. The selection, supply, quality control, regulation and use of medicines were serious challenges. Because of the problems in supply management and regulation of medical products, there were situations when ample medicines were available in the central stores and hospitals and expired there before being supplied to peripheral health facilities. Indeed, disposing of expired medicines has become a major problem. However with recent actions the management of medicines and medical equipment is moving in the right direction.

In relation to medicines and supplies, collaboration with WHO is sought in the following areas.

- Review of the national medicines policy and building capacity in good manufacturing practices
- Assessing the registration system, including classification, with the aim of upgrading the system
- Securing ISO accreditation for the FDA medicine quality laboratory
- Monitoring drug resistance
- Clarifying the role of the pharmacists association in national medicines management

Universal health coverage

The General People's Congress issued a decree in March 2009 on developing a health system based on solidarity, and universal coverage through social health insurance schemes and welfare funds and private insurance. The basic aims of the decree are to provide equitable, quality and responsive health care in an efficient and cost effective manner. This is a challenge that will require a corresponding legislative framework and institutional development and leadership. As a first step the public health laws should be reviewed and updated.

Currently, health services are provided to every citizen free of charge, but a debate is ongoing on universal coverage including different health care financing options and delivery approaches. To support this debate, information on health care financing needs to be developed through the national health accounts exercise. WHO input will be needed to support assessment of various approaches and the necessary policy dialogue. This process is crucially important and consequently should be designed and conducted with due care. This is a high priority of the government and it should be one of the main strategic objectives of the CCS.

Health system research

Currently many ad hoc studies and surveys are undertaken by different health programmes. However, there is no national health system priority research agenda or strategy. There is an urgent need for operational research on aspects of the health care delivery system. Qualitative data and findings on patient safety, patient satisfaction, management and effectiveness of services are some examples of needs. WHO collaboration should assist the government in identifying a national health system research strategy and developing the necessary framework for its implementation.

2.4.8 Emergencies

An emergency preparedness plan was recently developed and will be reviewed by the GPCHE's high committee; however, it still lacks detailed and thorough analysis. Core situation analyses such as hazard analysis, risk assessment and vulnerability analysis should be undertaken to support the health sector preparedness plan for emergencies.

Other assessments are also needed to serve as a basis of the emergency and response plan, including desktop health risk assessment, analysis of the existing health system, stakeholders' analysis and capacity assessment.

The preparedness plan should provide a comprehensive coordination framework within the health sector and with other sectors. The plan should also include capacity for proper monitoring and evaluation of preparedness and response activities by health and other related sectors. In the light of the impact of pandemic (H1N1) 2009, the country started to develop a multisectoral emergency and preparedness plan in cooperation with WHO and other UN agencies with the aim of rendering sustainable services during emergencies.

2.5 Environmental and other social determinants of health and partnership

2.5.1 Environmental health

Water resources management

The Libyan Arab Jamahiriya is one of the driest countries in the world, with only 7% of its land receiving annual rainfall of over 100 mm. About 95% of the country is desert. Total mean annual runoff calculated or measured at the entrance of the wadis in the plains (or spreading zones) is roughly estimated at 200 million m^3/year, but a large part of it evaporates. Therefore, the regular renewable surface water resources are estimated at 100 million m^3/year. This amount shows the available renewable water in the country is 10 times below the poverty ceiling of per capita 2000 m^3/year.

In 1984, the Great Man-made River Project was initiated to transport fresh water from underground aquifers in the south-east to major urban areas in the north, and also to provide water to irrigate up to 500 000 hectares of arid desert. The World Bank has estimated that annual water usage is equivalent to over 7.5 times the annual renewable freshwater resources. The coastal aquifers are recharged by rainfall but over-abstraction of groundwater has caused a severe water level decline and seawater encroachment.

To augment water supply, a number of desalination plants of different sizes have been built near large municipal centres and industrial complexes. The existing operating capacity of installed plants is about 65 million m^3/year, but the total water produced is only between 20 million and 30 million m^3/year since most of the desalinization plants are not in good operating condition. However, the government now has developed plans to build 11 new desalination plants and upgrade and optimize the existing ones.

The General Water Authority (GWA) is the sole agency responsible for the investigation, development and management of water resources in the country. UNDP has been supporting the GWA since 1997, and a new UNDP–GWA project was agreed in January 2009.

Water supply and sanitation

The reported water supply and sanitation coverage is 97.6% and 99%, respectively. The high coverage rates may not show the total picture, however. Data on the status of water supplies in terms of quality, access, water rates, etc. are not easily available. Most cities have piped water supplies, and rural areas are well covered. The government has prepared a national plan for improvement of water supply and sanitation systems in main cities and currently international engineering firms are contracted for the design

and implementation of these schemes. According to data from the General Sewage and Water Authority, at least 25 sewage treatment plants exist in the country and most have primary and secondary treatment. The present level of wastewater treatment is estimated at about 40 million m^3/year. All treated wastewater is used for agricultural purposes. The provision of water supply and sanitation is the responsibility of General Sewage and Water Authority in the Ministry of Utilities.

Urbanization

National decentralization policy is aimed at stabilizing population growth patterns so that people do not rush to large cities. Despite its success in slowing rural to urban migration, there are clear signs of rapid urban growth, at least in Tripoli. As the country heads towards a market economy, the situation will be exacerbated. Increased and congested traffic and some level of air pollution are in evidence. UNDP is helping with solid waste management, however there is an urgent need for establishment of urban development plan, where provision of environmental health services and safeguards are ensured. As part of the proposed healthy city project, other environmental health issues such as green areas, chemical safety and housing and health could be addressed.

Special attention should be given to slum areas and the poor sections in urban areas for improvement of environmental health and overall conditions.

Environment

The Environmental Authority in GPCHE is responsible for monitoring of environmental healthy quality; this includes drinking-water quality surveillance and monitoring, monitoring and health impact of air pollution and solid waste management (domestic and medical waste). The authority requires institutional strengthening, capacity-building and training of staff. There is a need for in-depth review of environmental health priorities and the capacity of GPCHE to cope with them. Emphasis should be placed on establishment of national norms, criteria and standards and essential services needed to implement and enforce environmental health standards. Since many agencies and authorities are involved, it will be critical to create consultative mechanisms and forums, for example with WHO support GPCHE may host a joint environment forum every three months and invite all institutions, agencies, associations and interested groups and individuals.

2.5.2 Partnership

Since similar to GPCHE, other sectors have created a central authority, there is a critical need for the health and related sectors to have formal and informal consultative, collaborative and coordinating mechanisms. Currently, the actual collaboration takes place at *shabia* level. However, it is not clear whether the collaboration at *shabia* level is systematic and sustained or activity- or project-based. There is need for conducting an in-depth assessment of modes of collaboration and cooperation between GPCHE and other committees and authorities and members of civil society dealing with social determinants of health, at both central and *shabia* level. Health-related projects and collaboration by UN agencies could be included in this assessment. Based

on such an assessment, forums and venues will be established for collaboration and partnership.

2.5.3 Millennium Development Goals

The Libyan Arab Jamahiriya has made significant progress towards achieving the targets of the Millennium Development Goals, as shown in Table 6.

2.6 Main challenges

2.6.1 Health system

- Lack of technical health policy and planning function inside the planning department.
- Need for strengthening capacity of national institutions and personnel to implement health programmes.
- Further development of national health information system in areas of data for decision-making, ICT and development of e-records for the health sector.
- Health care financing policy and universal coverage schemes options.
- The need for national human resources development plan, policy and strategy and a comprehensive system for continuous professional development.
- Inadequate health systems research as an integral part of national health development.
- Inappropriate management of medicine supply and distribution.
- Need for revitalization of PHC regarding the quality of care, skill mix and competencies and referral pathways.
- Health management and leadership development.
- Health facilities accreditation and quality improvement.
- Review and upgrading of public health law.
- Lack of framework to facilitate joint action by health related sectors and institutions.

2.6.2 Communicable diseases

- Potential public health risks posed by AIDS.
- Need for further strengthening of the disease surveillance system.

2.6.3 Noncommunicable diseases and lifestyle-related health conditions

- High incidence of cardiovascular diseases, diabetes and hypertension and cancer.
- High mortality and disability due to road traffic crashes.

Table 6. Trends in key indicators, 1990-2007

Indicator	1990	1995	2000	2007
Infant mortality rate (per 1000 live births)	27.0	24.4	21.0	16.7
Under-5 mortality rate (per 1000 live births)	43.0	30.1	27.0	20.1
Maternal mortality ratio (per 100 000 live births)	77	77	40	27

Source: [5,10]

[10] Pan Arab Project for Child Health survey, 1995

- High prevalence of physical inactivity and unhealthy diet.
- The use of tobacco and illicit substances, especially among youth.
- The need for developing an adolescent health programme.

2.6.4 Emergency

- Lack of adequate assessment and vulnerability studies.
- Absence of sustained intersectoral efforts for preparedness.

Section 3

Development Cooperation and Partnerships

Section 3. Development Cooperation and Partnerships

3.1 External assistance

Currently, the Libyan Arab Jamahiriya receives no external funds as development aid from any source of any kind. However, the lifting of the embargo and the re-activation of relationships with the United States and Europe have brought expectations that technical assistance will be offered in health sector development and especially health system reform.

3.2 UN system

The contribution of UN agencies other than WHO to health development has been relatively scarce, but it is expected to be strengthened in the near future. UNDP is actively working in the health sector through two UN thematic groups. The HIV/AIDS group has been functional since 2003. The country contracted UNDP to conduct rapid assessment of drug abuse and a drug abuse thematic group has just been formed. UNDP also helps the General Authority for Water in water resources management. Furthermore, UNDP provides assistance in solid waste management and supports for the joint EU, Government, WHO and UNDP project on healthy cities.

UNDP confirmed that the preparation of the Common Country Assessment (CCA) process will start soon, and will be followed by the United Nations Development Assistance Framework (UNDAF) exercise for the first time in this country. The results are expected to be finalized some time in 2015.

In terms of technical assistance, UNDP has organized a seminar on privatization demonstrating the experience of others. It is also planning to organize seminars on project management for capacity-building of government officials.

3.3 Way forward

Technical cooperation exists with Italy, and there are efforts to try to involve other countries as well. It expected that the continued cooperation with UNICEF will strengthen the UN team in the country.

Now that the country has normalized relationships with western countries, there are potentials for collaboration with bilateral donors on health and related sectors. As far as health is concerned, WHO has a comparative advantage in assisting governments in development and strengthening of proposals for external assistance. The UN system as whole has an opportunity to facilitate the flow of external technical assistance. The preparation of the CCA has therefore become a priority. The CCA and UNDAF will help in better coordination and harmonization of external technical assistance.

3.4 Challenges

- Preparation of carefully considered health project proposals to be assisted by external partners.
- Ensuring that external assistance is focused on capacity-building and strategic issues.

- Ensuring health projects, in addition to curative services, will also address, prevention, social determinants of health, and lifestyle and health literacy.

Section 4

Current WHO Cooperation

4.1 WHO Representative's Office

The CCS comes at an opportune moment for the national authorities and the WHO country office. The changes being introduced in the country, including decentralization, privatization and the relaxation of restrictions on importation of medicines and medical equipment, and the re-establishment of the GPCHE will have a positive impact on the health services. The new environment will demand WHO to be proactive and provide effective, responsive and timely technical support for various aspects of health development, especially health system, human resources development, prevention and control of noncommunicable diseases and lifestyle-related conditions.

The country office was established in 1963, and was managed by an international WHO Representative until 1980, after which the office was managed by a national WHO Representative. Since January 2010, a new international WHO Representative heads the office.

4.2 Facilities

The country office is housed in the Secretariat of Health Services and Environment and has very limited office space. Internet connectivity exists but needs improvement. The office is connected to GPN and videoconference facilities exist.

4.3 Main areas of WHO support

In the past 2–3 biennia, WHO collaboration on communicable diseases has been substantial. The existence of the Centre for Infectious Diseases Control has been an important factor. Collaboration has been particularly active in the areas of routine immunization, HIV/AIDS, tuberculosis and surveillance.

Despite noncommunicable disease being a major burden in the country, collaborative efforts in this area have been not adequate. Efforts have been ad hoc and patchy, and a dedicated centre or central body is needed, similar to the one for communicable diseases. WHO collaboration has addressed tobacco control and health-promoting schools. There has been a communication gap between the national programmes and WHO which stems from lack of a central unit. Stronger collaboration is needed in the areas of health promotion, healthy lifestyles, noncommunicable diseases, road safety and mental health.

In terms of health system development, WHO collaboration on nursing education has been active. A national strategy on nursing education and career development has been developed and is now the basis for production and management of the nursing profession. With the exception of nursing, in other areas of health system development, environmental health and emergency efforts have been ad hoc and irregular.

4.4 Collaboration with the UN system

WHO collaborates with UNDP and UNAIDS as a member of UN thematic groups on HIV/AIDS and substance use. There is an initiative on healthy cities that will be funded by the EU through UNDP in which WHO has an important role in technical implementation. WHO also works with UNHCR, IOM, UNFPA and the United Nations Information Centre.

4.5 Challenges for the WHO programme

- Responding to changes in the country and providing technical support for setting policies, strategies, norms and protocols for different health programmes.
- Developing procedures and plans for utilization of external and internal expertise to help the national programmes.
- Providing expanded help in the areas of noncommunicable diseases, healthy lifestyles and environmental health.
- Strengthening communication with various government institutions and arranging for smooth implementation and information exchange on collaborative programmes.
- Securing extrabudgetary resources necessary to support planned activities.

Section 5

Strategic Agenda for WHO Cooperation

5.1 Guiding principles and strategic objectives

5.1.1 Overview

The timing of this CCS coincides with an important transitional era in the Libyan Arab Jamahiriya. The country has opened up its economy and is now encouraging trade, commerce and economic collaboration with other countries. The new accelerated economic activities will have major positive direct and indirect impacts on health. The time is opportune to incorporate health safeguards into all economic, industrial, infrastructural and social development to protect and maximize the health of people and future generations.

The General Peoples' Congress has re-established the GPCHE to lead the national health development and strengthen the planning and operation at the *shabia* level. The organization of the GPCHE and its ability to set the directives, policies and strategies will have the most significant impact on future health development in the Libyan Arab Jamahiriya in the near and distant future. At the same time, the GPCHE has initiated a health system reform which is based on primary health care revitalization that responds to current health demand and requirements.

5.1.2 Guiding principles

In view of the above WHO collaboration with the Libyan Arab Jamahiriya will be implemented in line with the following guiding principles:

- Strategic and catalytic health concerns that have wide-scale impact
- Health system strengthening and capacity-building, especially in policy-setting and normative and regulatory functions
- Human resources education and development
- Partnership
- Quality and utilization of existing resources
- Equity and social justice in health access and quality.

The government has adopted a 5-year development plan 2009–2013 that focuses on optimal utilization of existing infrastructure, assessing and managing the priority health and health-related challenges, promoting public–private partnership and working towards universal coverage through effective financing options and integration of services. Due importance should be given to safeguarding health in development and the environment.

During the CCS mission, extensive consultations were held with national decision-makers, national health programme managers from health-related sectors, civil society and other key stakeholders. After careful consideration of prevailing and projected priority health challenges a consensus was reached that WHO collaboration with the Libyan Arab Jamahiriya during 2010–2015 will focus on eight strategic priorities. Detailed plans of action should be developed for each strategic priority that include allocation of resources, implementation time-frame and an integrated vision of health care.

5.2 Strategic priorities

5.2.1 Developing a long-term national vision for health development and reforming and upgrading the health system

Strategic approaches

- Develop a wide-scale consultation system with all key stakeholders, including the establishment of a national health forum.
- Assist in defining the essential roles of the GPCHE in setting policy, national strategies, needed reforms, standards and norms and in regulation of the private sector.
- 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.
- Assist in accreditation of health facilities.
- Support development of a responsive health care financing option.
- Strengthen the management and updating of regulation of medicines, vaccines and health technologies, including quality assurance of imported medicines.
- Promote the use of standards, norms and criteria for use of health technologies and equipment in the public and private sectors.
- Strengthen the capacity for analysis and use of health information in policy, planning and management.
- Strengthen the utilization and expansion of e-health in recording, education and services.

5.2.2 Strengthening the national system for human resources development through evidence-based policy formation, better coordination and strategic partnerships

Strategic approaches

- 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.
- Assist in developing an integrated and reliable human resources information system and coordination mechanisms with all key sectors.
- Establishing a system for continuous professional development for all health personnel.
- Strengthen the accreditation system for institutions that are educating human resources for health.
- Strengthen the national regulatory systems, supported by appropriate legislation, to certify, register and license health personnel.
- Support periodical review and updating of medical, nursing and allied health curricula to meet regional and international standards.
- 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.

5.2.3 Upgrading the national health promotion, education, healthy lifestyle, road safety and injury prevention programmes

Strategic approaches

- 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.

5.2.4 Upgrading the national programmes for mental health and prevention and control of noncommunicable diseases

Strategic approaches

- Monitor and evaluate noncommunicable 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 cross-sectoral approach and collaboration with concerned professional associations.
- Upgrade health care delivery and incorporate the control and management of noncommunicable diseases into the primary health care system.
- Assist in the establishment of disease-specific registry, and strengthen cancer registry.
- Upgrade mental health care through primary health care and prevention of substance abuse.

5.2.5 Developing national policies, strategies and mechanisms with the aim of maximizing the contribution of programmes/ sectors that deal with environmental and social determinants of health

Strategic approaches

- 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.
- Initiate healthy cities, healthy *shabiat*, healthy schools, etc. projects and programmes.

5.2.6 Developing policies and mechanisms to strengthen partnership and improve coordination of technical and material support by partners

Strategic approaches

- Develop a health sector partnership profile, including key ministries (besides GPCHE), international, bilateral and multilateral agencies, development banks, civil societies and other national and *shabiat* level associations.
- Strengthen the technical capacity of the international department of GPCHE for better partnership in external collaboration and participation in UN and regional governing bodies meetings and assemblies.
- Develop a WHO/GPCHE technical support and advisory arrangement for coordinating and optimizing the effectiveness of technical support from bilateral and international agencies and development banks.

5.2.7 Maintaining the good progress achieved in control of communicable disease and strengthening the surveillance system and capacity to deal with epidemic and pandemics

Strategic approaches

- Conduct in-depth assessment and strengthening of electronic disease surveillance.
- Further develop preparedness and response for control and management of potential pandemics in line with the International Health Regulations.
- Strengthen capacity in the GPCHE and *shabiat* to implement the strategic plan for prevention and control of HIV/AIDS, 2008–2012, in close collaboration with all partners.
- Support the implementation of harm reduction and voluntary counselling on substance use and focus on injecting drug users.
- Implement the relevant guidelines and further strengthen the centres that provide health care to people living with AIDS.
- Support awareness-raising and help with implementation of the adapted school curriculum to fight HIV/AIDS.
- Support the existing tuberculosis prevention, treatment and control programme, including improving the recording and reporting system.
- Strengthen drug resistance testing laboratories and usage of advanced techniques.
- Provide technical support for periodical in-depth evaluation of EPI, and introduction of new vaccines.
- Strengthen the communication and documentation activities of the Centre for Infectious Diseases Control, especially with the international health community.
- Strengthen tropical disease control, including training of a core group of staff in tropical diseases especially zoonotic diseases.

5.2.8 Strengthening preparedness and capacity for health provision during emergencies

Strategic approaches

- Assess the current systems and capacity at all levels and prepare a national emergency vulnerability profile identifying major potential risks and gaps in the health system for preparedness and response.
- Assist in development of a national and a prototype *shabia* preparedness plan for the health sector.
- Support the finalization of a coordinated UN joint strategy for emergencies.
- Identify potential toxic chemical plants and industrial complexes and prepare a plan for dealing with chemical emergencies including the required medical and health care services.

Section 6

Implementing the Strategic Agenda: Implications for WHO

Section 6. Implementing the Strategic Agenda: Implications for WHO

6.1 Country level

Availability of core technical capacity in the WHO country office in Tripoli is a prerequisite for efficient and timely implementation of the CCS. In consideration of the strategic directions formulated, the WHO country office should be technically and administratively reinforced.

Agreed upon procedures should be established with the national authorities, as well as liaison and coordination of the office with the different districts. Periodic backstopping for the country office by external or local technical expertise, whether on a part-time or full-time basis, should be provided to ensure timely and effective implementation of the CCS. The administrative capacity of the office must be strengthened with in-house and external training in management, public relations and communications skills. More technical capacity is also needed in areas of health system development, noncommunicable diseases and environmental health.

In view of the size of the country and decentralized health system, the establishment of two WHO sub-offices with required running cost and communication support could be considered.

Recognizing the fact that regular budget allocations based on operational planning can provide only limited financial input to collaborative activities, the allocation of necessary funds from national resources, in the form of funds-in-trust, is a prerequisite for successful implementation of the strategy.

6.2 Regional level

Taking into account the critical changes that have taken place in the country, WHO support for implementation of the CCS should be elevated at all levels, especially at regional level. There is a major need for backstopping on health system development, noncommunicable diseases and particularly environmental health. In these areas, in different missions should visit the country to develop detail plans of action. Support will also be needed from the Regional Office for development of an emergency preparedness and response plan.

6.3 Global level

Support and an increased level of contact will be needed from headquarters in collaboration with the Regional Office, particularly in the areas of noncommunicable diseases, health technology, emergency preparedness and health legislation.

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