

Multi-Sector Needs Assessment

Libya

November-December 2020



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LIST OF ACRONYMS AND ABBREVIATIONS

AAH Action Against Hunger
DTM Displacement Tracking Matrix
FCS Food Consumption Score
FGD Focus group discussion
FSL Food Security & Livelihoods
HH Household
HNO Humanitarian Needs Overview
HRP Humanitarian Response Plan
IDP Internally displaced person
(I)NGO (International) non-governmental organization
KI Key informant
KII Key informant interview
LYD Libyan dinar
MHCPGP Mental Health, Care Practices, Gender and Protection
MHPSS Mental Health and Psychosocial Support
MSNA Multi-Sector needs assessment
NFI Non-food item
NDP Non-displaced people
OCHA United Nations Office for the Coordination of Humanitarian Affairs
rCSI reduced Coping Strategy Index
NFI Non-Food Items
PHC Primary Healthcare Centers
ToT Training of trainers
UN United Nations
WASH Water, sanitation, and hygiene
WFP World Food Programme

EXECUTIVE SUMMARY

RESPONDENT PROFILE AND PRIORITIES

Of the households surveyed, 62% were IDPs, 27% returnees and the remaining 11% were non-displaced persons. Half of the IDPs assessed were living in camp or camp-like settings. Of the total number of households, 63% were not living in the current *baladiyah* before 2011. On average, there were 5.4 individuals per household and 6% of households were hosting individuals from another *baladiyah*.

KEY FINDINGS

The top priority needs identified by households were access to cash (28%), food (17%), medical care (16%), shelter support (11%) and employment (6%).

COVID-19

- Generally high awareness of key preventative measures such as handwashing
- High prices of soap and hand sanitizer prior to the conflict
- Healthcare workers are not sufficiently aware of international or national guidelines
- Primary health care facilities have insufficient access to medicine and equipment

FOOD SECURITY AND LIVELIHOODS

- There is more profound food insecurity in the East, with 51% to 68% (in Benghazi and Ajdabiya) of families in food insecurity versus 27% in the West (Tripoli).
- 69% of households reported not having enough money to meet basic needs. The main reason is the liquidity crisis.
- 11% and 21% of households had respectively a poor or borderline Food Consumption Score based on the adjusted thresholds.
- 16% of assessed households had a r-CSI score greater than 19, indicating that they are resorting to severe coping strategies. A quarter of respondents reported having debt
- Unemployment reaches 69% within working-age household members, of which 78% are women

WASH

- access to drinking water from the public network in the Tripoli and Zintan is lower compared to Benghazi and Ajdabiya, water quality does not match national and international standard in particular in Benghazi
- 62% of households reported being unable to meet total water needs within the last month
- Across all respondents, 44% reported that bottled water was the main source of drinking water.
- FGDs reported that 70% of the wells were polluted by sewage water and are currently unsuitable for use.
- IDP households in camps and other vulnerable communities living outside city limits in particular do not have access to network water and rely on water trucking
- Poor solid waste management in some locations particularly in IDP camps
- High level of knowledge regarding handwashing and hygiene practices in general but limited access to hygiene related items including soap due to elevated cost
- High level of access to improved sanitation facilities
- 39% of IDPs responding and 12% of affected returnees need WASH assistance

HEALTH

- Almost three quarters of all respondents reported facing challenges to access health care
- Limited household financial capacity to access medical care and medication
- Assessed PHCs face challenges with water and electricity supply, with half suffering from daily power cuts and two-thirds lacking a functioning water source within the facility
- Assessed PHCs face issues with supply of medicine and medical equipment
- Healthcare staff have low technical capacities, with limited access to trainings and knowledge of relevant guidelines. Half of all interviewed healthcare staff reported never receiving any further training or capacity building since graduating from their formal education.
- Public healthcare facilities are perceived to be of inadequate quality

MENTAL HEALTH, CARE PRACTICES, GENDER AND PROTECTION

- Limited access to adequate mental health services
- Healthcare workers not sufficiently trained or aware of mental health issues
- The majority of the household reports observing behavioral issues in children within the household
- 12% of households reported that there was someone within their household with a physical or cognitive impairment
- Majority of assessed adults show signs of poor well-being and signs of psychological distress
- Important community barriers related to mental health issues (stigmatization, taboos)

ASSESSMENT

BACKGROUND AND OBJECTIVE

Libya is in its ninth year of instability and conflict following the fall of the Gaddafi regime in 2011. During 2020, the country saw the continuation of armed clashes between the Government of National Accord (GNA) and the Libyan National Army (LNA) and although a cease-fire was signed on 23 October 2020, the prospects for a long-term peace agreement are still highly uncertain.

Insecurity, with its negative impact on the economic situation and availability of basic services, has remained the main driver of displacement in Libya. There has not been a re-escalation of fighting since the cease-fire agreement of October 2020, and there have been returns among IDPs. Nonetheless, the total number of people displaced across the country is around 390,000; 30% higher today compared to the same time in 2019. In 2020, the Libyan humanitarian situation has been further compounded by the continuing spread of COVID-19, which has undermined the economy and stressed the health system.

From a population of 6.7 million, 1.8 million people are affected by the ongoing crisis and 900,000 people are in need of humanitarian assistance. Given the continued insecurity and displacement in 2020, as well as the community transmission of COVID-19, in 2021 the humanitarian needs are anticipated to be significantly higher.

Action Against Hunger (AAH) conducted the Multi-Sector Needs Assessment (MSNA) in four *mantikas* of Libya in November/December 2020 in order to (a) provide relevant and timely information about the current humanitarian context in Libya; (b) contribute to a more targeted and evidence-based humanitarian response; and (c) inform the 2021 Humanitarian Needs Overview (HNO) and the Humanitarian Response Plan (HRP). This assessment seeks to provide a more detailed understanding of the needs in the sectors of health, mental health, WASH, and food security and livelihoods sectors, in areas with a high concentration of populations of concern such as IDPs and returnees.

METHODOLOGY

This MSNA followed a mixed-methods approach, with both quantitative and qualitative components. The quantitative component included a total of 697 Household interviews. The qualitative component included interviews with 42 Health Care Workers interviewed from the 17 Primary healthcare centers; 14 Focus Group Discussions and finally 15 Key informants' interviews. Population clusters were selected according to the expected level of vulnerability, based on the proportion of internally displaced persons (IDPs), returnees and other non-displaced people. In both Tripoli and Benghazi, the assessment targeted specifically semi-urban areas where needs were expected to be higher. Ajdabiya was added following a request by the authorities to assess needs in that area and Zintan because being an area with returnees. The sectors covered in this MSNA are Food Security and Livelihoods, Water Sanitation & Hygiene (WASH), Health and Nutrition, and Mental Health Care Practices Gender and Protection.



Figure 1: Map of assessed areas

1. Household surveys

697 household surveys were conducted in Tripoli, Benghazi, Zintan and Ajdabiya.

A cluster sampling methodology was employed for the selection of the households to avoid sampling bias and ensure that the households were as representative as possible of the areas sampled. The population of IDPs was divided into smaller clusters. HHs were randomly selected within each cluster. Communities were selected based on a purposive sampling strategy based on the population data from the IOM DTM (Round 32, August 2020) in order to identify the communities

Location	Mantika	Estimated IDP Returnees	Clusters	Interviews Completed
Ain Zara	Tripoli	25,000	10	13
Wadi Al Rabea	Tripoli	15,000	9	32
Tajoura	Tripoli	8,000	5	26
Tawergha Camp 1 & 2 (Al-Fellah)	Tripoli	2,295	6	48
Phone calls	Tripoli	N/A	0	29
Zintan Center	Zintan	1,000	30	213
Down Town	Benghazi	1,600	12	85
Al-Sabri	Benghazi	1,200	9	65
IDPs Camp (Al-Hallis)	Benghazi	1,200	9	65
Algloz	Ajdabiya	450	8	39
Bosnian company (IDP camp)	Ajdabiya	1,350	22	82
	Total	57,095	120	697

with IDP camps as well as greater numbers of IDPs and returnees.

Within each cluster, AAH conducted a random selection of houses at the site in coordination with relevant authorities (municipal authorities, local councils or camp management).

The *mantikas* of Zintan and Ajdabiya were selected in order to have a better understanding of semi-urban contexts, as they are 180km and 160km respectively from Tripoli and Benghazi. Due to the nature of the purposive sampling strategy employed, the findings presented in the report are indicative only and may not reflect the needs of the overall population of Libya.

The table above shows the number of interviews done in each location based on the cluster sampling strategy. 29 households were reached through phone calls after learning that they had left their previous area of residence in Tajoura and Ain Zara

2. Assessment of 17 Primary Health Care facilities

AAH assessed primary health care facilities providing services to the population clusters targeted as part of the household interviews in

order to provide an understanding of the conditions of healthcare provision for population groups determined to be most vulnerable at the onset of the assessment. AAH assessed 17 healthcare facilities using its Observatory Health Facility Audit Questionnaire, an assessment tool designed to present an audit of various dimensions of the health facilities operations. This includes human resources, services provided, logistics, health information system, finance, leadership, and governance. The tool asks respondents to report on the status of the health facility on the day of the survey. This assessment was only conducted on public Primary Health Care Centers (PHCs) that were delivering health services to the 11 communities targeted through the household interviews at the time of the assessment, and they were identified following the household interviews and through coordination with the Ministry of Health. The total estimated coverage of the 17 facilities was 52,148 people in areas a range of rural, semi-urban and urban areas. The following healthcare facilities were assessed:

Mantika	Name of the Health Facility
Ajdabiya	Dora clinic
Ajdabiya	7 October Clinic
Benghazi	Al-Sabri Al-Sharqi Health Center, Al-Zaryaiah
Benghazi	Al Hallis Camp clinic
Benghazi	Benghazi City Clinic
Tripoli	Primary health care clinic alfalah 1 (B)
Tripoli	Al-Fellah 1 PHC
Tripoli	Alnashie PHC / Tajoura
Tripoli	Primary health care in Al Fallah 2)
Tripoli	Ztarna PHC / Wadi Alrabeia -Tajoura
Tripoli	Wadi Al-Rabie PHC
Tripoli	Al-Naeem PHC
Tripoli	Alnaser Salah Aldeen PHC / Ain zara
Tripoli	Alnasib Altethkari / Ain Zara
Zintan	Algharbie PHC / Alqwasim -Zintan
Zintan	Alshamali Health Center
Zintan	Alsharqi Health Center (Awlad khalifa)

Table 2: Assessed PHCs in each *mantika*

Please refer to Annex 2 (Map of Assessed PHCs) for further details on the location of each PHC.

3. Interviews healthcare workers

AAH interviewed 42 healthcare workers working at the PHCs assessed. Respondents included medical

staff (doctors, nurses, and dentists) as well as support staff such as pharmacists, administrators and laboratory technicians.

4. Focus Group Discussions

AAH conducted 14 FGDs in the following 7 areas. The discussions were segregated by gender and sought to include people of various ages, marital status and employment status as well as women who were pregnant or lactating.

Mantika	Location
Ajdabiya	Algloz
Ajdabiya	Bosnian Company (IDP camp)
Benghazi	Down Town
Benghazi	Al-Sabri
Benghazi	Al-Hallis (IDP camp)
Tripoli	Tawergha Camp (Fellah Area)
Zintan	Zintan Center

Table 3: FGDs conducted in each *mantika*

The purpose of the FGDs was to complement the information collected in the household interviews and PHC assessments in order to have a better understanding of the community perception of needs and access to services. Each FGD covered all the main sectors addressed in the household interview and FGDs were not separated by sector.

5. Key Informant Interviews (KIIs)

The Key Informant Interviews targeted people who were well informed about the humanitarian situation in their communities. These qualitative in-depth interviews targeted 15 people across the 4 *mantikas*.

As with the FGDs, the KIIs were conducted in order to complement the information collected through other tools. All sectors addressed in the household interview were also referenced in the KIIs.

- The methodological choice to define population vulnerable places based on the DTM and local data may have omitted small, vulnerable pockets in each city that will not be represented in our assessment.
- The report is intended to provide a picture of vulnerability as a whole and cannot provide representative data for specific population categories such as ethnic groups or the reasons, the date of their displacement, and their place of origin.

COVID-19 MITIGATION MEASURES

During the data collection AAH has implemented protective procedures to protect teams and respondents from COVID 19, based on the recommended protocol from GNC, and shared with Libyan Health authorities.

CHALLENGES AND LIMITATIONS

FINDINGS

FOOD SECURITY AND LIVELIHOODS

The level of food security was assessed through the Food Consumption Score (FCS), the Household Dietary Diversity Score (HDDS) and the reduced Coping Strategy Index (r-CSI)¹.

The overall food security context in the targeted communities appears concerning, particularly in the Eastern areas. Though the majority of households assessed were found to have an acceptable FCS based on the adjusted thresholds, 11% and 21% of households had respectively a poor or borderline score.

Comparatively, REACH 2020 MSNA reported that 11% of HHs can be classified as having a 'poor' or 'borderline' FCS.

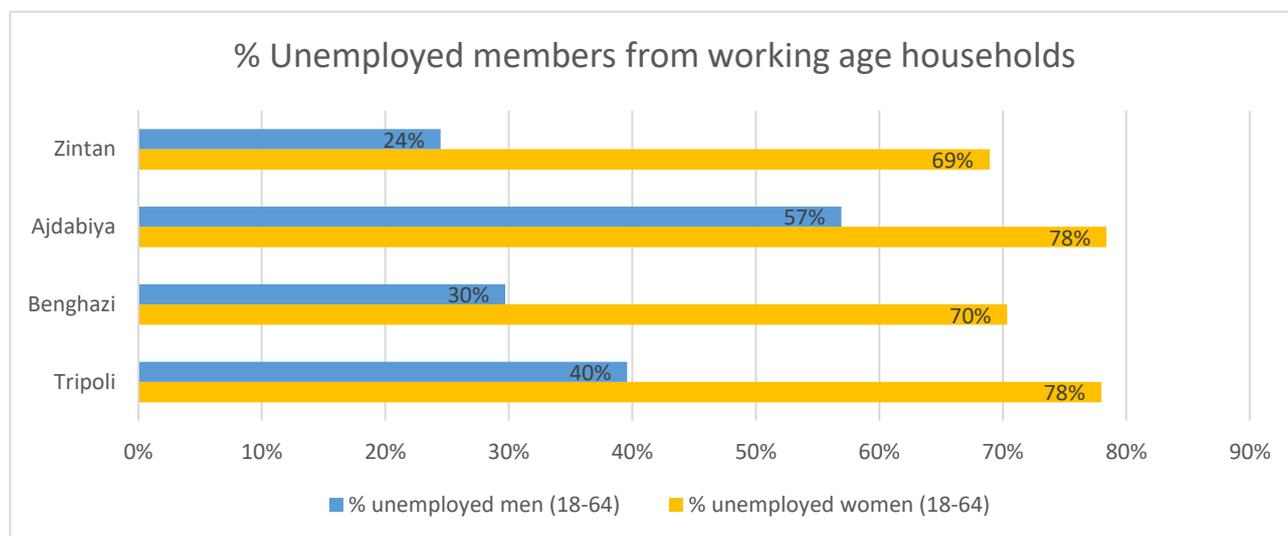
The combined proportion of poor or borderline scores was highest in Ajdabiya (68%) and Benghazi (51%) and lower in Zintan (29%) and Tripoli (27%). The overall proportion of households with a poor or borderline HDDS was 14%, with again the highest proportions in Ajdabiya (30%). The higher HDDS scores compared to the lower FCS scores indicate that while households may be experiencing some level of food insecurity, there remains regular access to a wide variety of food items.

16% of assessed households had a r-CSI score greater than 19, indicating that they are resorting to severe coping strategies. 69% of households across all four *mantikas* reported not having enough money to meet basic needs, with the proportion highest in Benghazi (88%), Tripoli (80%)

and Ajdabiya (80%). In comparison, this figure was much lower in Zintan (35%). The main reasons for reported for not having enough money to obtain food were reported to be unable to withdraw money (30%), salary too low (29%), lack of work opportunities (19%) and salaries not regularly paid (19%).

A quarter of respondents reported having debt of some amount, with the highest percentage in Ajdabiya (40%). From households having debt, the main purposes for borrowing money were reported to have been food (39%), other basic needs (20%), healthcare (15%) and rent (12%). This is in line with the top priority needs identified by all households, suggesting that households must engage in cycles of borrowing in order to meet basic household needs. Accessing salaries remains a significant problem in Libya due widespread liquidity issues. Respondents from FGDs reported that they were regularly unable to make sufficiently large withdrawals from banks (with most withdrawals limited to 400 LYD) and that they faced long queues.

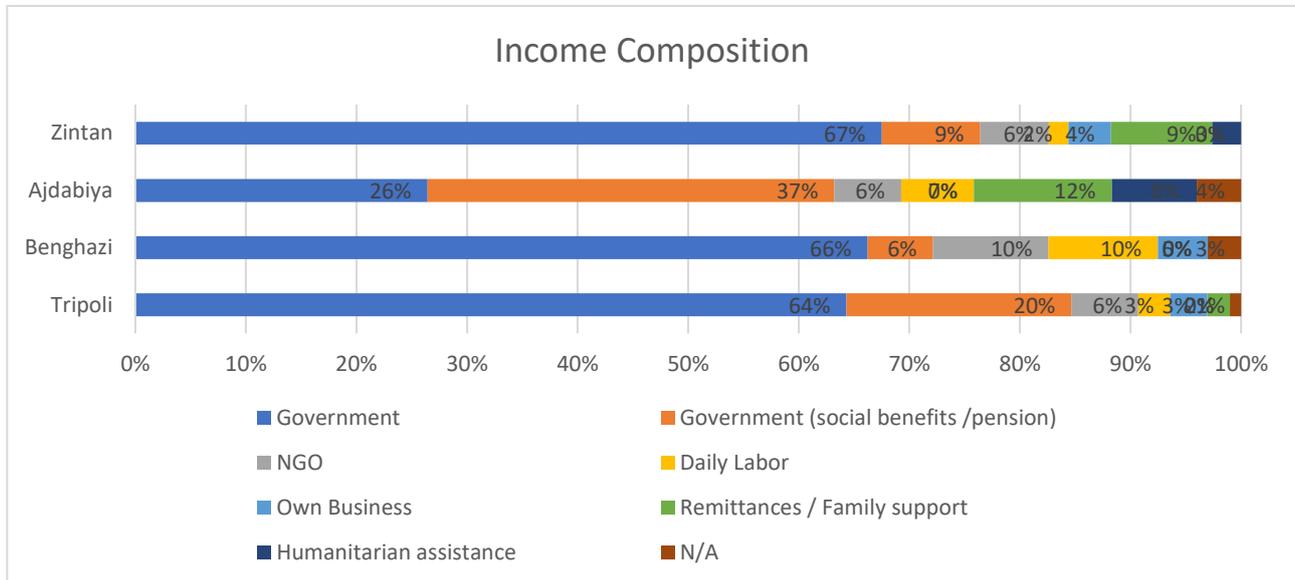
On average, unemployment within the working-age HH members is very high, with 69% of the HH members in working-age unemployed in Benghazi, of which 78% are women.



¹ Please see the annex for further details on these indices

57% of the households interviewed are receiving some income from the government, 27% social benefits. In Tripoli, 84% of the income received by all the households, 6% of the incomes are attributed to NGOs, 3% from daily labor, 3% owning their businesses, and 2% from remittances or family

support. Although humanitarian assistance is more present in Tripoli and Benghazi, it appeared as an income for families only in Zintan and Ajdabiya, which can be explained by the fact that in Tripoli and Benghazi, humanitarian aid is not considered as an income anymore.



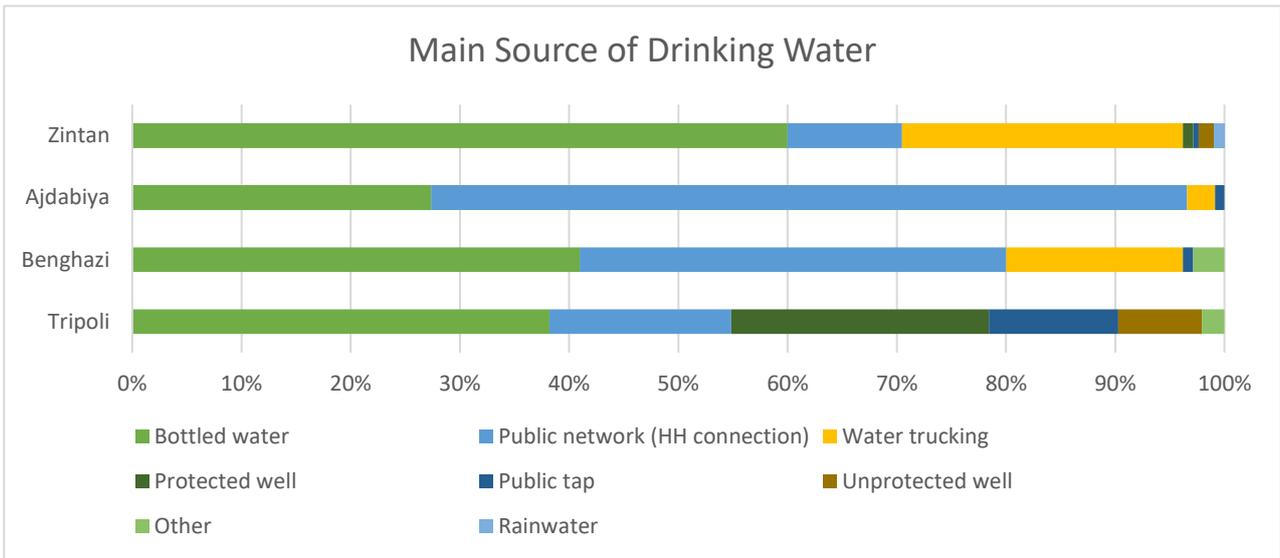
WATER, SANITATION AND HYGIENE

Water Access

Water access remains an issue of major concern across the assessed *mantikas*. Overall, 62% of households reported being unable to meet total water needs within the last month, and this proportion was highest in Zintan (68%) and Tripoli (65%). Across all respondents, 44% reported that bottled water was the main source of drinking water. The Western *mantikas* of Tripoli and Zintan had low levels of access to the public network (<20%), with most households relying on bottled water, private wells, and publicly accessible taps in addition to the public network. Access to the network was highest in Ajdabiya, where 69% of respondents reported it as the main source of water. Figure 2 below provides further information on the main source of drinking water for the households addressed in each *mantika*.

Overall, 28% of the respondents perceived water quality as being poor. Benghazi had the lowest proportion of respondents reporting that the water was fine to drink, with the most common complaints being that the water did not taste good and that it caused health issues like diarrhea. The majority of respondents in all *mantikas* other than Tripoli reported using some form of treatment method for drinking water, mainly boiling, filters, disinfection tablets. In line with the above findings on a high level of concern about the drinking water quality in Benghazi, respondents from this *mantika* reported the lowest proportion of households not using any treatment method.

Some IDP camps were found to not be covered by the public water network. FGDs and KIIs reported that Fellah IDP camp in Tripoli has been disconnected from the water network since August 2020 and inhabitants are mainly relying on unprotected wells. Throughout the country, electricity cuts contribute to limited water access. Many IDPs were reported to have left the Ain Zara



and Tajoura neighborhoods due to frequent electrical cuts, water shortages and poor environmental hygiene.

FGDs and KIIs reported that communities in Zintan collect water from tankers at wells at the bottom of the mountains. The public network is reportedly only functioning once a month and residents rely on water trucking when this is not available. In Ajglöz, FGDs reported that 70% of the wells were polluted by sewage water and are currently unsuitable for use.

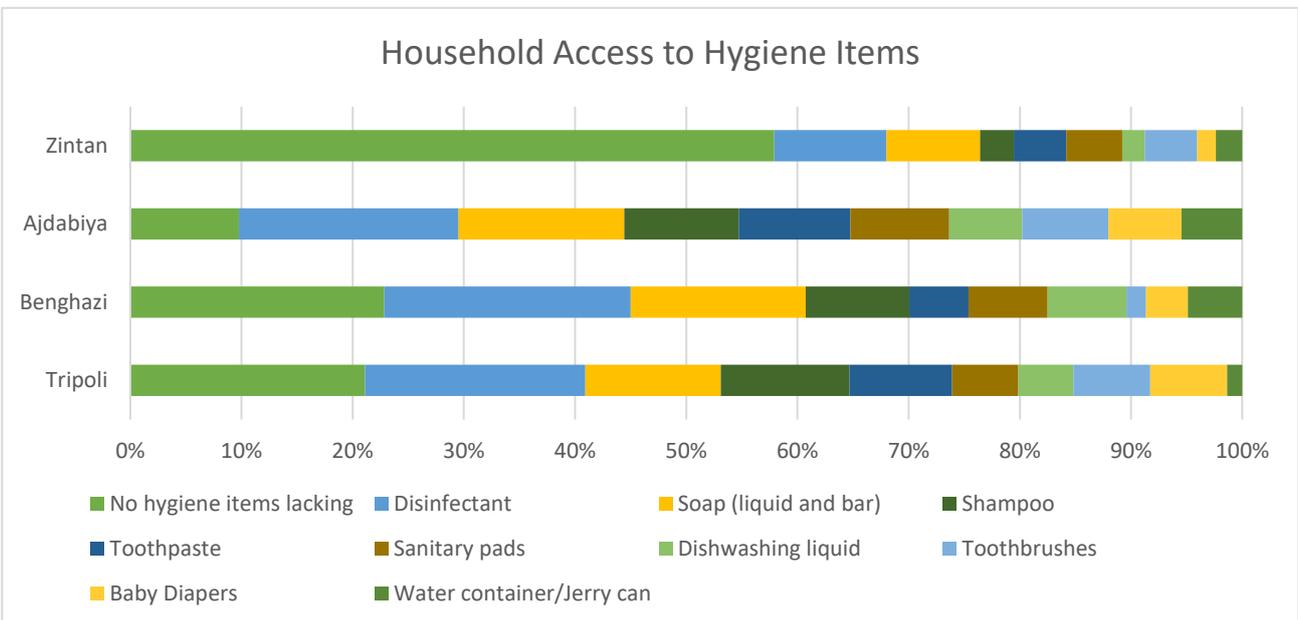
In general, the assessment found a lack of trust in the public water network and its suitability for drinking. Communities appear to rely significantly on bottled water for drinking water, which can

contribute to household expenses and contributes to waste creation.

Sanitation

There were no major issues with sanitation identified in this assessment. Almost all respondents reported having access to an improved flush or pour latrine. All households also reported that their latrine was connected to either a sewer network, septic tank or cesspit. While there may be additional issues related to wastewater treatment, this issue was not covered by this assessment.

While overall solid waste management was reported to be sufficient, there were gaps identified in specific areas such as Fellah camp and Bosnian camp, where household interviews and FGDs reported that solid waste was collected irregularly



or burned, leading to stagnant water, pest issues, rodents and unhygienic conditions.

Hygiene Practices and Access to Hygiene Items
Respondents generally reported regularly handwashing and a strong understanding of critical moments of handwashing. Similarly, most respondents reported washing hands with both water and soap. Rates were consistent between geographic areas.

Approximately half of respondents reported being able to purchase all required hygiene products. Soap, surface disinfectant, shampoo and toothpaste were the main items unable to be purchased which were reported by the other half. The main reasons reported for this were that the items were too expensive; availability in the market was not identified as an issue.

HEALTH

According to health assessments conducted in 2020 and shared by the Libyan Health Working Group, the main health sector challenges were poor governance, lack of accountability and transparency regarding the use of funds, and distribution of equipment from national to municipal levels. The fragmentation of service delivery within the health sector has led to more than half of facilities functional in 2019 reportedly no longer functioning in 2020. Reasons for this development are believed to be insecurity, lack of funding, electricity cuts, shortage of fuel and the general presence of non-state actors such as foreign armed groups and organized crime groups.

Almost three quarters of all respondents reported facing challenges to access health care when needed, with the main limitations being lack of money to pay for healthcare, lack of medical staff, health facilities have been damaged and distance to healthcare facility is too high.

20% of households reported that someone in the household had been ill in the last 30 days. Of these households, 57% reported going to a health facility to access health care. Ajdabiya, Benghazi and Zintan had the highest rates of households who reported not going to a health facility when someone was sick. The main alternatives reported when households could not access formal health facilities were traditional medicine and home remedies.

69% of households reported that they were able to travel by car to a health facility within 30 minutes. The highest rates of respondents who reported being unable to do so were in Benghazi (39%) and Tripoli (30%).

Two thirds had at least one woman have a live birth within their household within the last 2 years, with 92% reporting that an obstetrician had been present at the birth. This figure was lowest in Zintan (77%) where some respondents reported that a nurse, certified midwife or a general practitioner had been present. There were no notable cases of births being assisted by uncertified midwives, or friends and relatives.

IYCF practices appear sub-optimal. 83% of all households who reported a live birth within the last 2 years reported feeding the child with bottled milk or baby formula before 6 months of age. This rate was around 55% in 2003 in the MICS, In the last 2 years, 93% used Breast Milk Substitute before 6 months of age according to WHO 2019 Health system assessment. While the assessment did not assess detailed IYCF practices, this is potentially an area of concern that should be further researched in the future.

KIIs and HH survey participants reported a general lack of trust in the overall healthcare system by the public. There was a belief that public health facilities do not have the tools and equipment required for the correct diagnosis and that healthcare staff are not qualified for their positions. In Zintan, respondents reported that they referred to use alternative (“traditional”) treatments or adapt to a particular condition rather than seeking treatment at public facilities. There was also belief that public facilities were insufficient, but respondents lacked the funds to pay for treatment at private health facilities, where they believed there was a higher quality of care. There was a general preference to travel to Tripoli or Tunisia for major treatment not only due to the perceived higher quality of care but also the wider availability of care related to mental health, physiotherapy and oncology.

Primary Healthcare Centre Assessment

The 17 PHC assessment revealed an alarming picture of the healthcare facilities operating in areas with a high proportion of vulnerable communities. The assessed facilities were

predominantly small facilities providing outpatient treatments with less than 5 available beds on site. Half do not receive any financial funding from within Libya's healthcare system beyond payment of the payroll of staff. While they are supposed to receive medicine and medical equipment from the Medical Services (an administrative entity within the Ministry of Health), there were frequent shortages reported due to delayed, insufficient non-existent deliveries from the MoH. Other forms of support were reported to come from national (3 PHCs) and international partners (5 PHCs) and the municipality (2 PHCs).

Staff and doctors reported donating their own funds for critical equipment in some cases. 11 PHCs report being unable to meet their operational objectives with the funds collected. 16 out of 17 PHCs do not have a financial process aimed to prepare and respond to a direct impact on the health system's intrinsic structure (e.g., preventing access to the facility or the delivery of drugs and materials).

The available treatment within the facilities was very limited. 16 on the PHC assessed didn't propose adequate basic maternal services and 9 of them don't offer any nutrition care or growth monitoring for children less than 5 years. Participants of the FGDs in Zintan reported that women in the communities were concerned about the quality of delivery services in the area, and oftentimes resorted to private health facilities in case there were complications.

Water and energy management issues appeared to affect almost all assessed PHCs. 2 PHCs reported having almost no access to electricity. While the remaining 15 PHCs accessed electricity through the public network, all reported either daily or weekly power cuts. Only 5 of the PHCs reported that they had access to a generator as an alternative source of electricity. The situation is similar for water access. 4 PHCs reported that there was no functional hand-washing point within the facility and 12 PHCs reported that they did not have a functional source of drinking water within the facility.

For general water use, the facilities appeared to fall into two categories. The PHCs within city limits were connected to the public water network but due to poor quality, only used this water for cleaning purposes. The second category is PHCs

outside city limits (such as within IDP camps) or operating out of war-damaged buildings. These facilities were not connected to the public water network and so were required to purchase water (either daily or weekly) through water trucks, as well as purchase drinking water separately. The medical waste management system is functional in 5 facilities under 17.

PHCs reported very minimal capacity and operational structure for the management of medicine and medical supplies. 5 PHCs reported not having any mechanism for processing orders and deliveries of supplies and a further 3 facilities reported only having paper-based mechanisms. Almost all PHCs (14) reported that the available supplies were insufficient for neither normal nor peak situations and a similar number also reported that they had no way of obtaining additional medicine or equipment in the case of a shock or sudden increase in needs. Most of the healthcare workers interviewed in the PHCs reported having experienced stock-outs of nutritional inputs within the last three months and they identified that the lack of supplies, equipment and medicine was the main problem that they faced while working.

Community engagement, communication and referral capacities also appeared highly lacking in the assessed PHCs. 8 PHCs did not have a mechanism established for communication between the facility and the communities they serve, while 7 used social media channels for this purpose. Similarly, 16 PHCs did not have any mechanism in place for following up with patients referred to other facilities or otherwise ensuring that additional services were accessed. 16 PHCs did not have strategies designed to access patients in remote areas, did not offer home visits for those unable to reach the facility and did not have an established means of transportation for transporting patients. Data from FGDs and KIIs confirm the communities faced significant problems with transportation and reaching health facilities, particularly for vulnerable groups.

Half of all interviewed healthcare staff reported never receiving any further training or capacity building since graduating from their formal education. One pharmacist reported working for 26 years in the health sector without ever receiving a professional skills training. Out of the remaining staff who reported attending a training, only 6 were

within the last three years and half were related to COVID-19.

MENTAL HEALTH, CARE PRACTICES, GENDER AND PROTECTION

The percentage of household members medically diagnosed with mental disorders is high, with 11% and 4% of our respondents, respectively, in Tripoli and Benghazi.

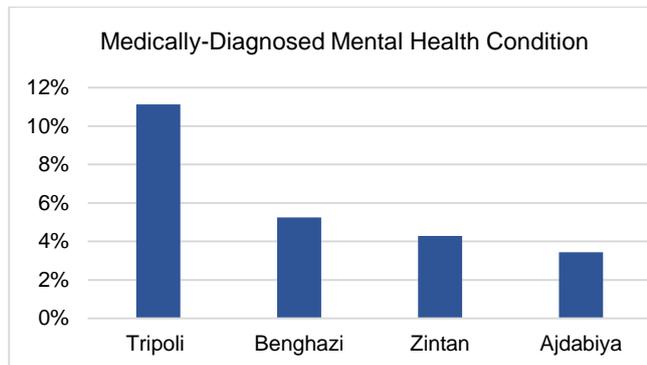


Figure 4: Households reporting individuals with medically diagnosed mental health conditions within the household. Note: Other responses included “don’t know”, “prefer not to answer” and “no medically diagnosed conditions within the household”.

Only 7 out of the 40 reported that they had sufficient access to treatment, with the remaining reporting that they had limited or no access, or that they do not access services due to stigmatization issues. Lack of trained staff, lack of medicine, and lack of community-based services were reported to be some of the main reasons for not having sufficient access to treatment.

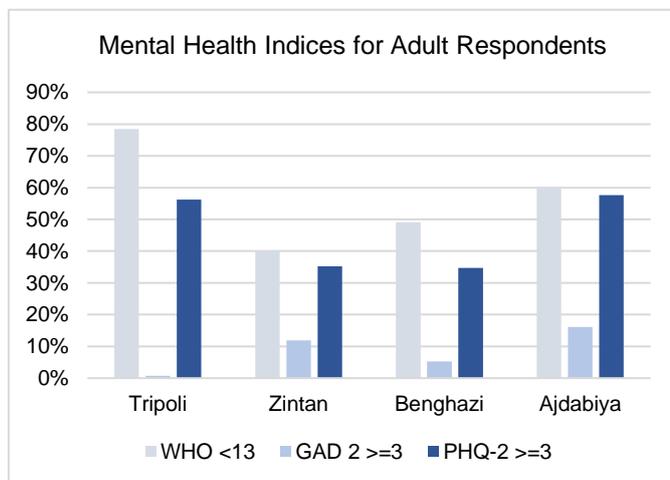


Figure 5: Mental health indices for adult respondents

12% of households reported that there was someone within their household with a physical or cognitive impairment, with most of these being reported among adults for both men and women. While there was a large variety in the types or causes of impairment, more than two thirds reported that they did not have or limited access to adequate care to treat and manage their conditions.

Behavioral issues are observed in children under 18 within the household were reported by 24% of respondents. This figure was highest in Benghazi (34%) and particularly in the Al-Sabri area where an alarming 78% of households reported negative changes in behavior. The most commonly reported behaviors were angry or aggressive outbursts, new or recurrent bedwetting, new or recurring fears, changes in appetite or eating habits, and excessive crying. For adolescent children (aged 13-17), the main negative behaviors were reported to be angry or aggressive outbursts, changes in appetite or eating habits and becoming withdrawn from family and friends. These behavioral issues among children and adolescents seems to be related to traumatic stress, situational and parental stress, domestic violence, neglect and absence of available services for supporting children, adolescents and families.

FGDs described the significant impact of the conflict context on children’s wellbeing, as respondents identified children’s most severe concerns as being those related to weapons, conflict, displacement, and armed violence. They also noted that children lacked opportunities for entertainment and education as further compounding these issues.

The household interviews included questions for the WHO Well-Being Index, the Patient Health Questionnaire (PHQ2) and the Generalized Anxiety Disorder 2 screening tool (GAD2). These screening tools are designed to provide an initial understanding of respondents overall mental well-being and are not diagnostic tools. A score of less than 13 on the WHO Index indicates overall poor mental wellbeing. Across all respondents, 54% scored less than 13 with the percentage being highest in Tripoli (78%) and Ajdabiya (60%).

The PHQ2 is scored from 0-6 and a score of 3 or greater suggests that the individual is likely to have a depressive disorder and further follow-up is needed. 43% of all respondents scored 3 or higher,

with the highest proportion in Tripoli (81%). The GAD2 is also another brief initial screening tool designed to determine the likelihood of a generalized anxiety disorder and for identifying cases where further diagnostic evaluation is necessary. Though the overall number of respondents who scored above the threshold limit of 3 was low (8%), there was large variation between the *mantikas*, ranging from 16% in Ajdabiya to 1% in Tripoli.

The lack of mental health or psychosocial support services at PHCs in the assessed areas and the high rates of psychosocial issues reported amongst the household respondents demonstrate the necessity of expanding access to critical services at the primary healthcare level. The Fella camp in Tripoli, Ajdabiya and Zintan were areas where mental health care services were identified to be particularly lacking and where FGD respondents were unable to identify available services. In Ajdabiya, there were reportedly no health facilities or hospitals accepting patients with mental health conditions in the entire *mantikas*, necessitating referral to Benghazi, which is 160 km. Even within Benghazi, there was only one facility identified which presently accepts patients for mental health and psychological services.

FGDs and KIIs also provided further context to the difficulty of accessing critical mental health services in the assessed areas. Respondents identified the stigma around mental health problems, the psychological impact of difficult living conditions and the limited availability of essential mental health services as the main barriers to accessing mental health and psychosocial support services. They further noted the limited training of healthcare workers in this domain.

RECOMMENDATIONS

FOOD SECURITY AND LIVELIHOODS

- Improve access to food and other basic need through cash and voucher assistance for the most vulnerable
- Livelihood intervention to improve access to income and support employment

WASH

- Targeted WASH support to vulnerable households and water authority to improve access to clean drinking water
- WASH infrastructure rehabilitation and improvement in IDP camps and semi-urban areas including solar power systems to keep infrastructure working during frequent electric outage
- Ensure adherence to safe behaviors in the face of COVID-19 pandemics

HEALTH

- strengthening the system in order to improve accessibility and quality of Health services by
- Supporting dissemination and operationalization of PHC guideline and protocols, and especially COVID protective measures
- Propose capacity building of healthcare workers and Health management at local level
- Support rehabilitation of primary health care structures
- Furthermore, develop an understanding of the nutritional situation at local level (SMART survey could be an option) in order to adapt future support to nutrition specific or sensitive interventions
- Strengthening IYCF practices where relevant
- WASH rehabilitation of targeted healthcare facilities serving vulnerable populations

MENTAL HEALTH, CARE PRACTICES, GENDER AND PROTECTION

- Training healthcare workers on providing mental health services
- Initiate MHPSS and care practices services for vulnerable groups at primary public health and community levels
- Understand better barriers and perceptions, for an appropriate promotion of mental health and protection

Annex

Annex 1: Food Security Indexes

The Food Consumption Score (FCS) is a continuous variable (minimum of 0 and a maximum of 112) measuring dietary diversity, food frequency, and the relative nutritional importance of food groups based on a seven-day recall of food consumed at the household level and we can divide it into the three following categories and, for our purposes, using the adjusted thresholds:

Food consumption group	Standard threshold	Adjusted thresholds (oil and sugar are eaten daily)
Poor	0 – 21	0 – 28
Borderline	21 – 35	28 – 42
Acceptable	> 35	> 42

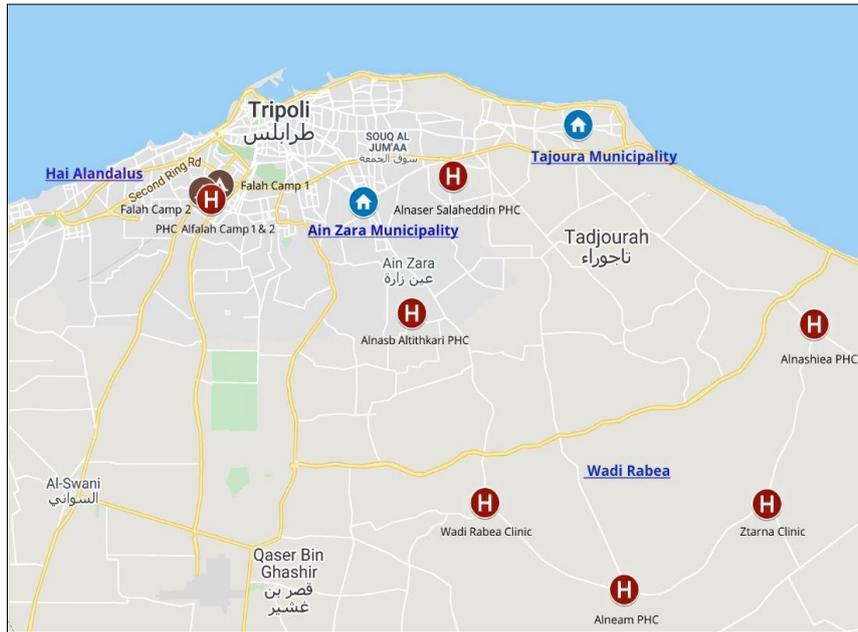
Regarding the Household Dietary Diversity Score (HDDS), we can divide it into the three following categories with IPC as the integrated food security phase classification. It is a proxy measure of household food access and is calculated based on questions on household consumption of food items from 12 different food groups in the previous 24 hours:

HDDS	Standard threshold
IPC Phase 4-5	0 – 2
IPC Phase 3	3– 4
IPC Phase 1-2	> 5

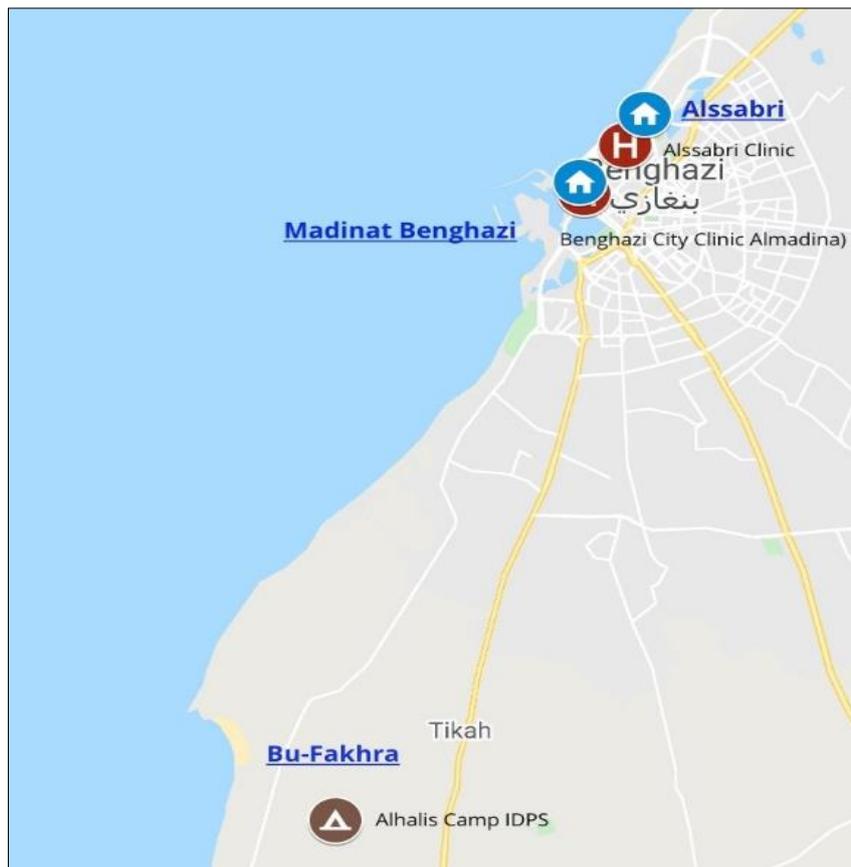
Regarding the reduced-Coping Strategy Index (r-CSI), we can divide it into the three following categories with IPC as the integrated food security phase classification. r-CSI measures the behavior of households over the past seven days when they did not have enough food or money to purchase food:

r-CSI	Standard threshold
IPC Phase 1	0 – 3
IPC Phase 2	4 – 18
IPC Phase 3	> 19

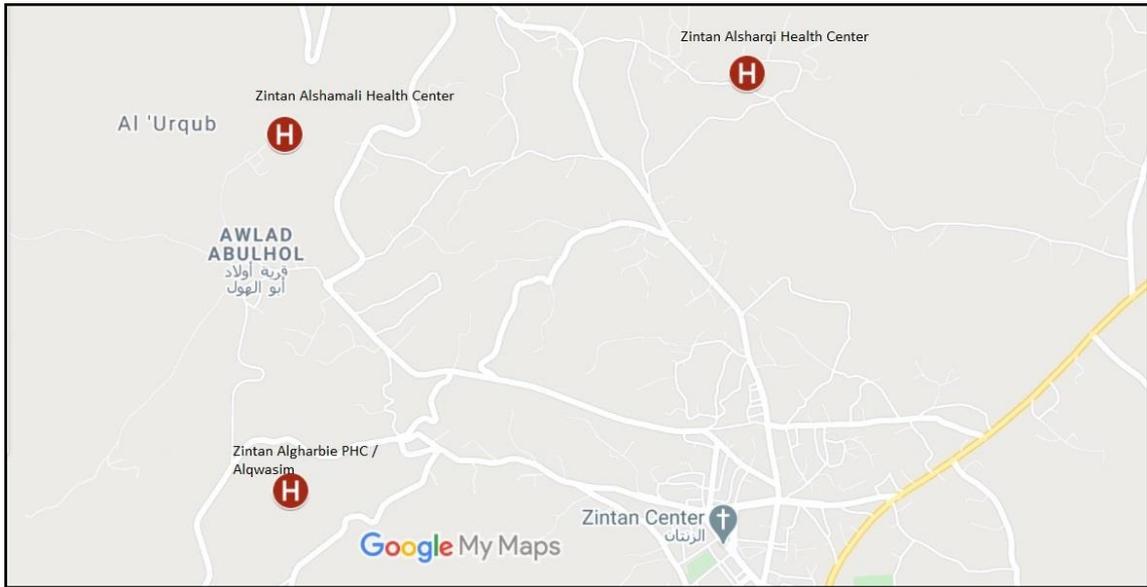
Annex 2: Maps of the Targeted Primary Health Centers



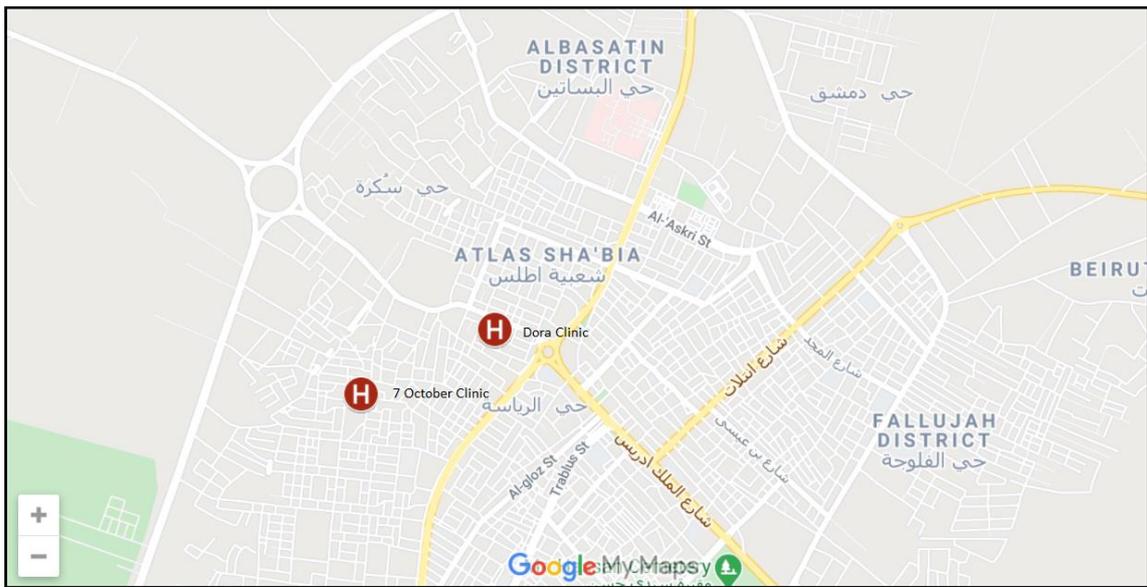
Primary Health Centers in Tripoli



Primary Health Centers in Benghazi



Primary Health Centers in Zintan



Primary Health Centers in Ajdabiya