Libyan Population Multi-sectoral Needs Assessment (MSNA) 2021: Health & MHPSS Findings

March, 1st 2022


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Agenda

1. Introduction
2. Health
- Methodology overview
- Summary of key findings
- Indicators' discussion
3. MHPSS
- Methodology overview
- Summary of key Findings

Introduction

Libyan population MSNA

MSNA Overall objectives

- Update humanitarian actors' understanding of the current **needs that exist** in the country.
- Inform the **2022 Humanitarian Needs Overview** (HNO) and the **Humanitarian Response Plan** (HRP).
- Contribute to a more **targeted and evidence-based** humanitarian response.

Presentation objectives

- Present the 2021 MSNA **qualitative findings** for health and MHPSS .
- Identify **key messages** from these qualitative findings.
- Have a first **discussion about the health indicators** for the 2022 Libyan population MSNA.

Timeline for data collection

Quantitative phase

14 June – 2 August

Telephone interviews

Establishing what the humanitarian needs are, where they are, and who is most affected

Qualitative phase training

September

Qualitative phase

October - November

Key informant interviews & focus groups discussions

With community representatives, sector experts, INGO workers, activists, people from the affected community, etc.

Main objectives, to:

- Triangulate findings derived from quantitative data collection
- Understand the specific humanitarian needs of vulnerable population groups
- Provide in-depth context to specific follow-up questions

December – February 2022

Analysis

Produce data saturation grids illustrating the findings per topic and summarise these by coding transcripts into subthemes.

Methodology overview

Quantitative phase

June, July & August 2021

8.871 household interviews

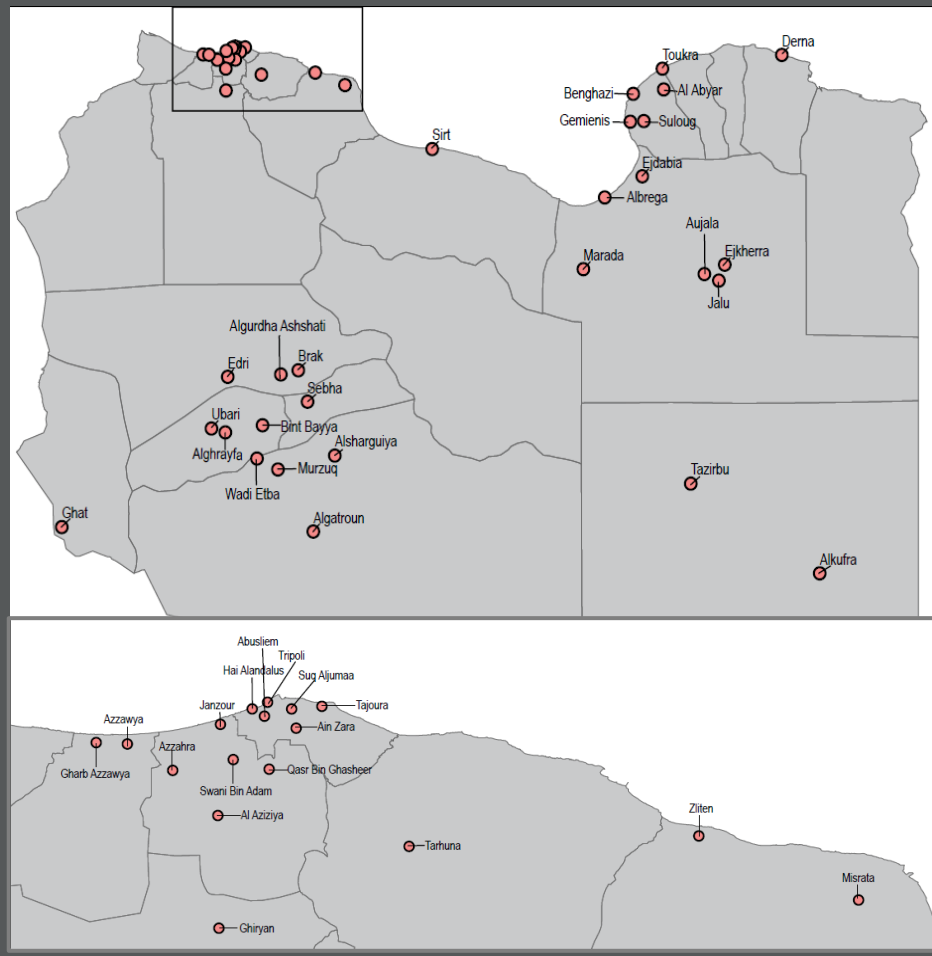
45 baladiyas covered

Non-representative sampling, all surveys conducted over phone (1010 using Random Digit Dialing)
> findings not generalisable with a known level of precision, but indicative

3 population groups

- Non-displaced: **3.967 – 45%**
- IDP: **2.731 – 31%**
- Returnee: **2.173 – 24%**

8 sectors/thematic areas covered: Food Security, Cash & Markets and Livelihoods, Health, SNFI, WASH, Education, Protection, AAP



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Methodology overview

Qualitative phase

October & November 2021

88 Key Informant Interviews (KIIs)
34 Focus Group Discussions (FGDs)

- Conducted by REACH and its partner CSOs
- In-person or over the phone (remotely)

Topics covered

Protection

- **18 KIIs in 3 baladiyas** > Alghrayfa, Ubari, Wadi Etba

Health

- **18 KIIs in 3 baladiyas** > Al-Sharguiya, Ghiryan, Algurdha Ashshati

Food Security

- **18 KIIs in 3 baladiyas** > Gemienis, Suloug, Toukra

Gender and access to services & GBV

- **12 KIIs in 5 baladiyas** > Alghrayfa, Brak, Ejdabia, Sebha, Ubari
- **21 FGDs** > Alghrayfa, Brak, Ejdebia, Misrata, Sebha, Tripoli, Ubari

Mental health and social support networks (MHPSS)

- **22 KIIs in 11 baladiyas** > AlKufra, Azzawya, Benghazi, Ghat, Ghiryan, Misrata, Sirt, Tarhuna, Tawergha, Tripoli, Ubari
- **13 FGDs** > Alkufra, Azzawya, Ghiryan, Misrata, Sirt, Tarhuna, Tripoli


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Health Qualitative Tool

Overarching research question:

What are the causes and consequences of needs related to health?

Research questions:

1. What are the main barriers to accessing health care in the baladiya?
2. To what extent are specialised health services available and accessible?
3. Are COVID-19 related information and health services readily available and accessible?
4. How has COVID-19 impacted the accessibility and availability of non-COVID-19 related health services?

Key informants & Baladiyas covered

Total number of KI interviews		18
KIs' gender	Female KIs	8
	Male KIs	10
Baladiyas covered	Al-Sharguiya	6
	Ghiryan	6
	Algurdha Ashshati	6

Profiles of KIs	
• Medical Staff (doctor, nurse)	9
• Employee Ministry of Health	6
• Member of the COVID crisis committee of Ghiryan	1
• Member of municipal council	1
• Civil and human rights activist	1

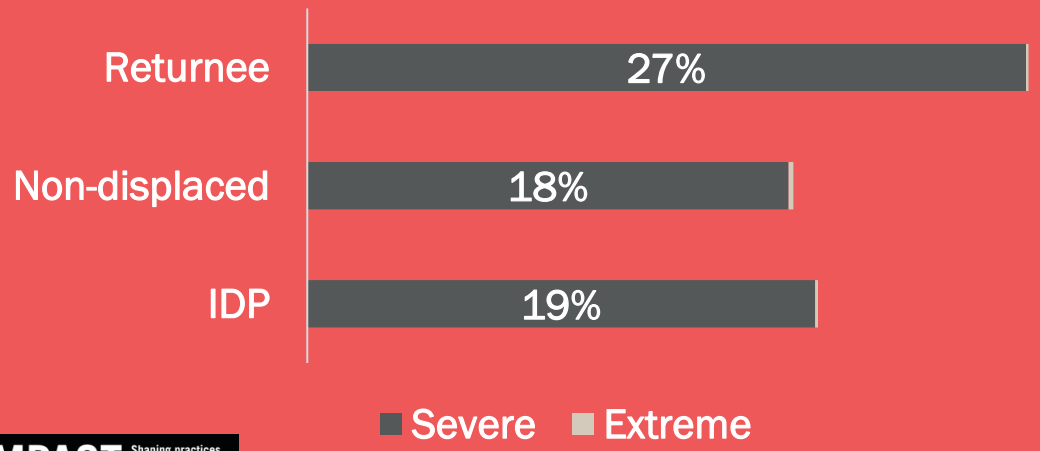
Profiles of baladiyas covered

- Top 3 baladiyas with a Health LSG (triggered by quantitative data)
- Discussions with sectors, partners & field staff

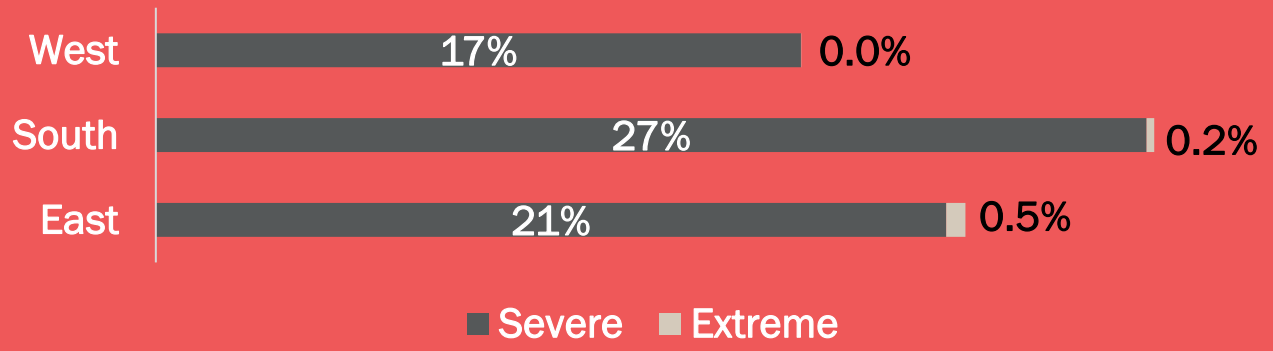
Health Living Standard Gaps (LSG)

20% of households have a health LSG: 19% were found to have severe health needs,while 1% had extreme health needs

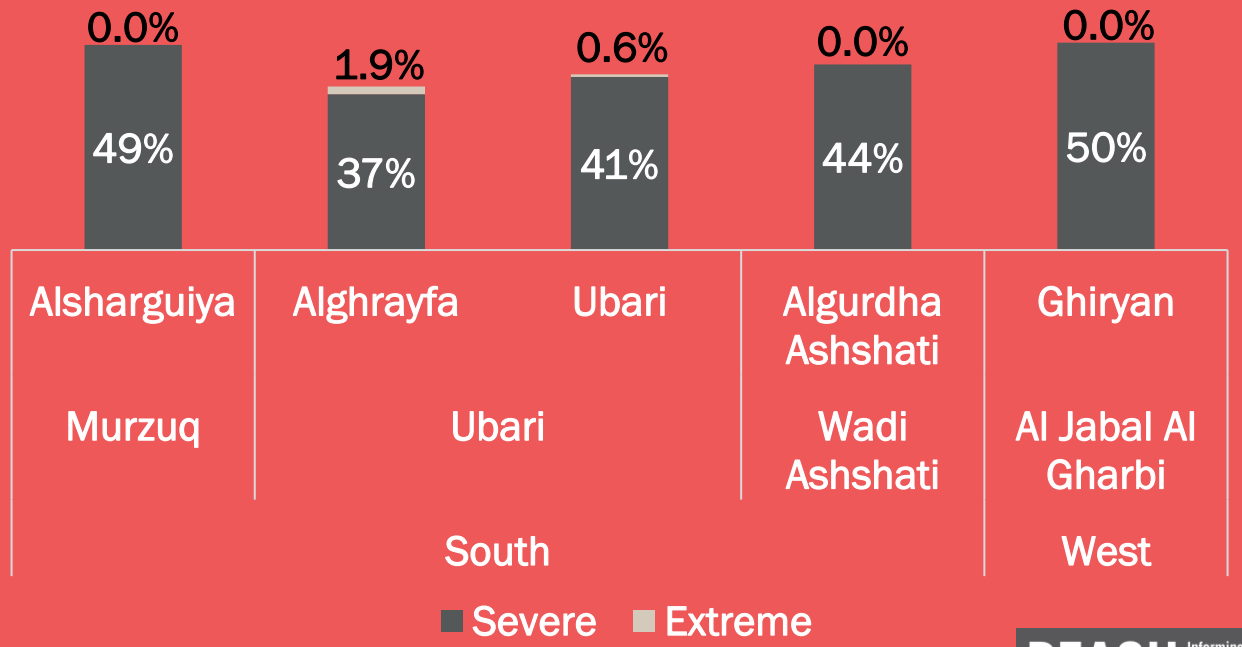
% of households with a health LSG, by displacement status



% of households with a health LSG, by region



Top 5 baladiyas by % of households with a health LSG



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Analysis process of KI interview transcripts

An iterative and data based process to monitor data saturation from the KI interviews was applied.

Qualitative analysis was conducted through the qualitative analysis programme Nvivo, allowing for an iterative and cooperative approach to coding different emergent themes across thematic topics.

- From the translated transcripts, a preliminary codebook with node hierarchy (consisting of themes & subthemes) was created.
- On all transcripts, binary coding (0-1) was carried out, to determine if any part of a KI's transcript was related to a certain subtheme (regardless of being an answer to a specific questionnaire question).
- Throughout the analysis, node structure was constantly revised to remain flexible so that new insights and ideas diverting between regions could be captured.
- Among KIs, emergent topics were identified (such as references to the high cost of treatment, especially at private clinics, and the liquidity crisis) which is a considerable barrier to accessing health care.

Strengths and Limitations of the Qualitative Analysis

Geographical coverage

Data collection focused on 3 baladiyas located in the Western and Southern regions. Therefore, no comparison can be done countrywide.

Inclusive Sample

Gender balance fairly met (8 women and 10 men)

Interviews conducted in Arabic

Subtle and specific details may have gotten lost during the translation process.

Access to healthcare

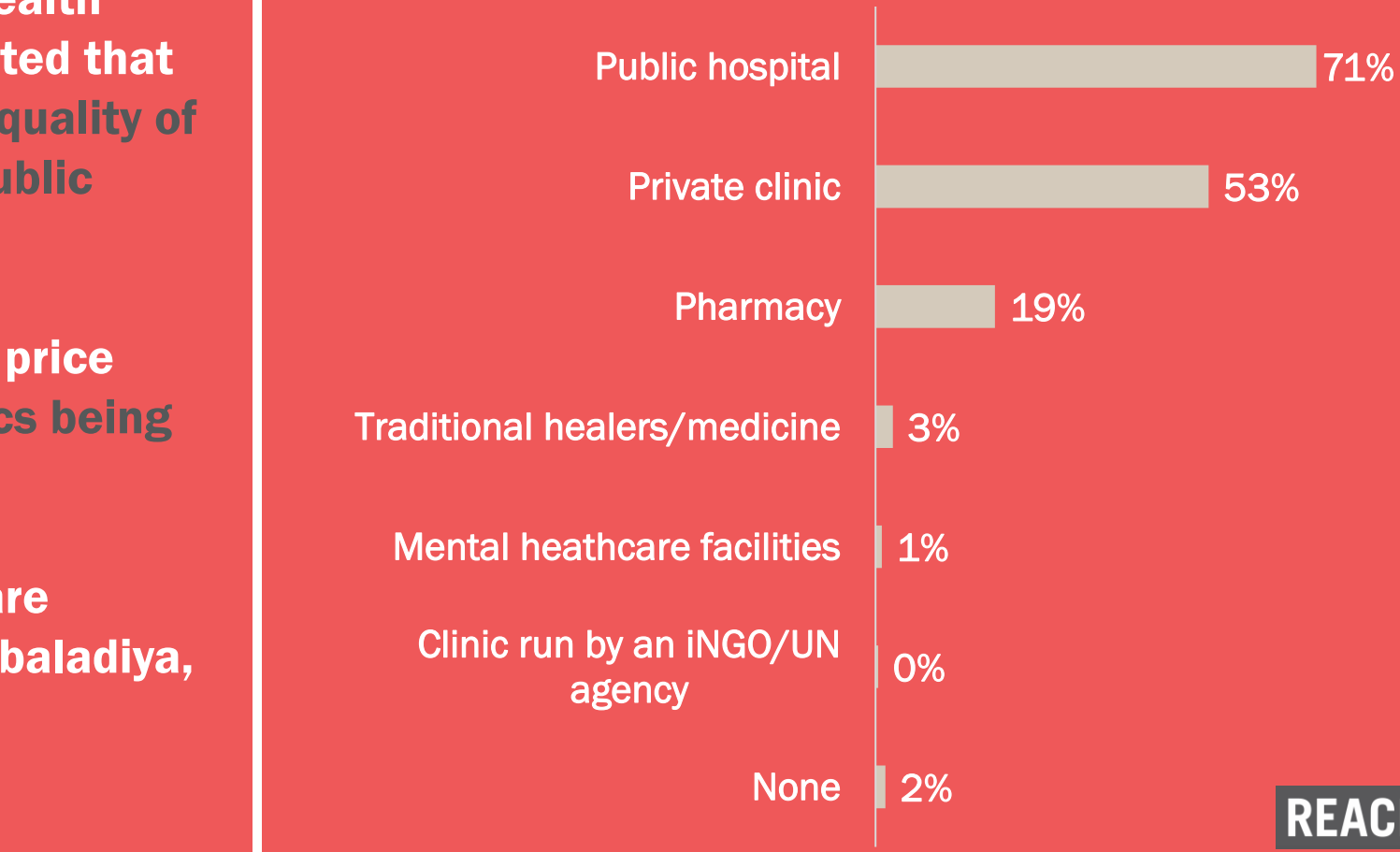
When asked to rate the quality of health care in the baladiya, most KIs reported that there is a remarkable difference in quality of services between the private and public healthcare facilities.

A third of KIs argued that there is a price difference, referring to private clinics being more expensive.

6 KIs reported that private healthcare services were not available in their baladiya, especially in Al-Sharguiya.

29% of households reported not having access to a public hospital.

% of households reporting having access to different types of healthcare, by type of healthcare facility

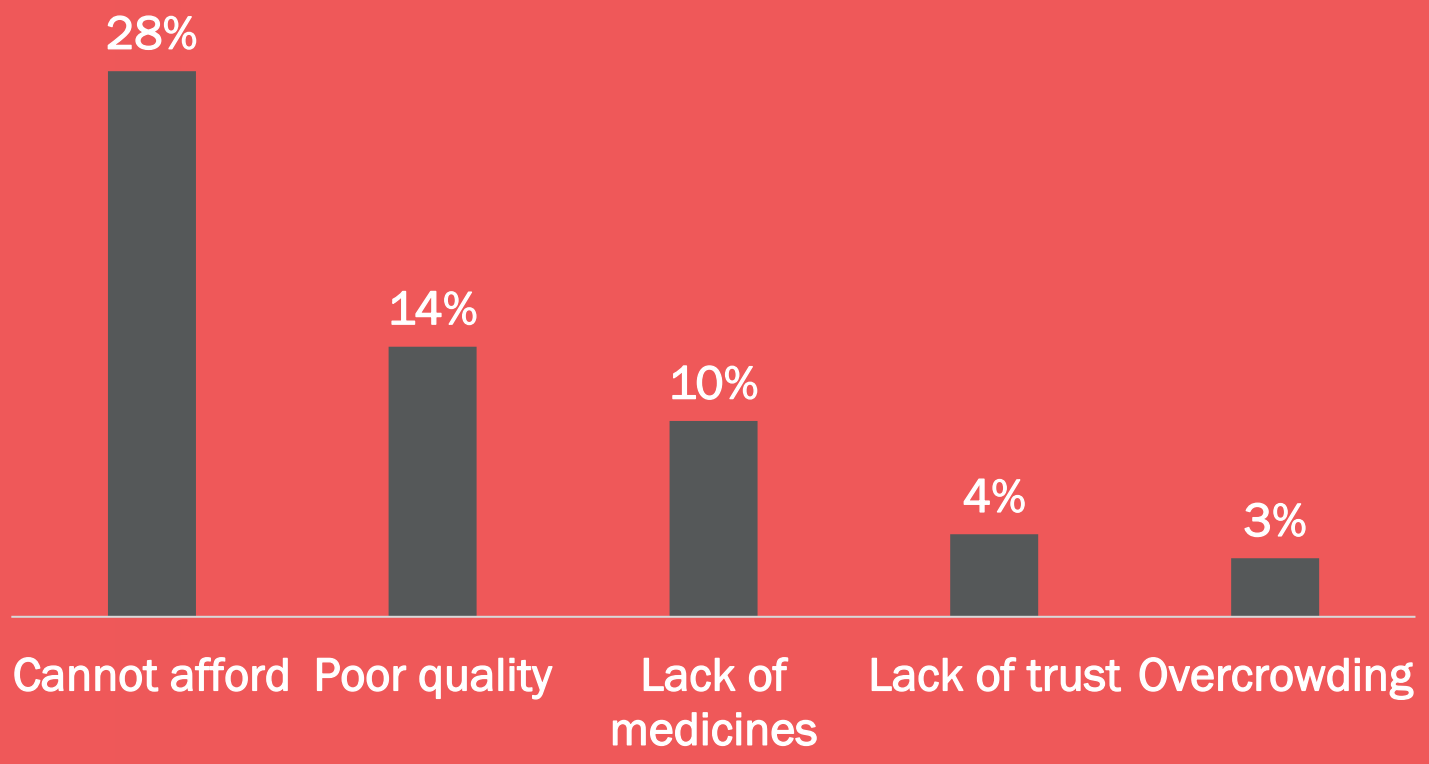


Barriers to healthcare

46% of households reported having experienced barriers or issues accessing healthcare

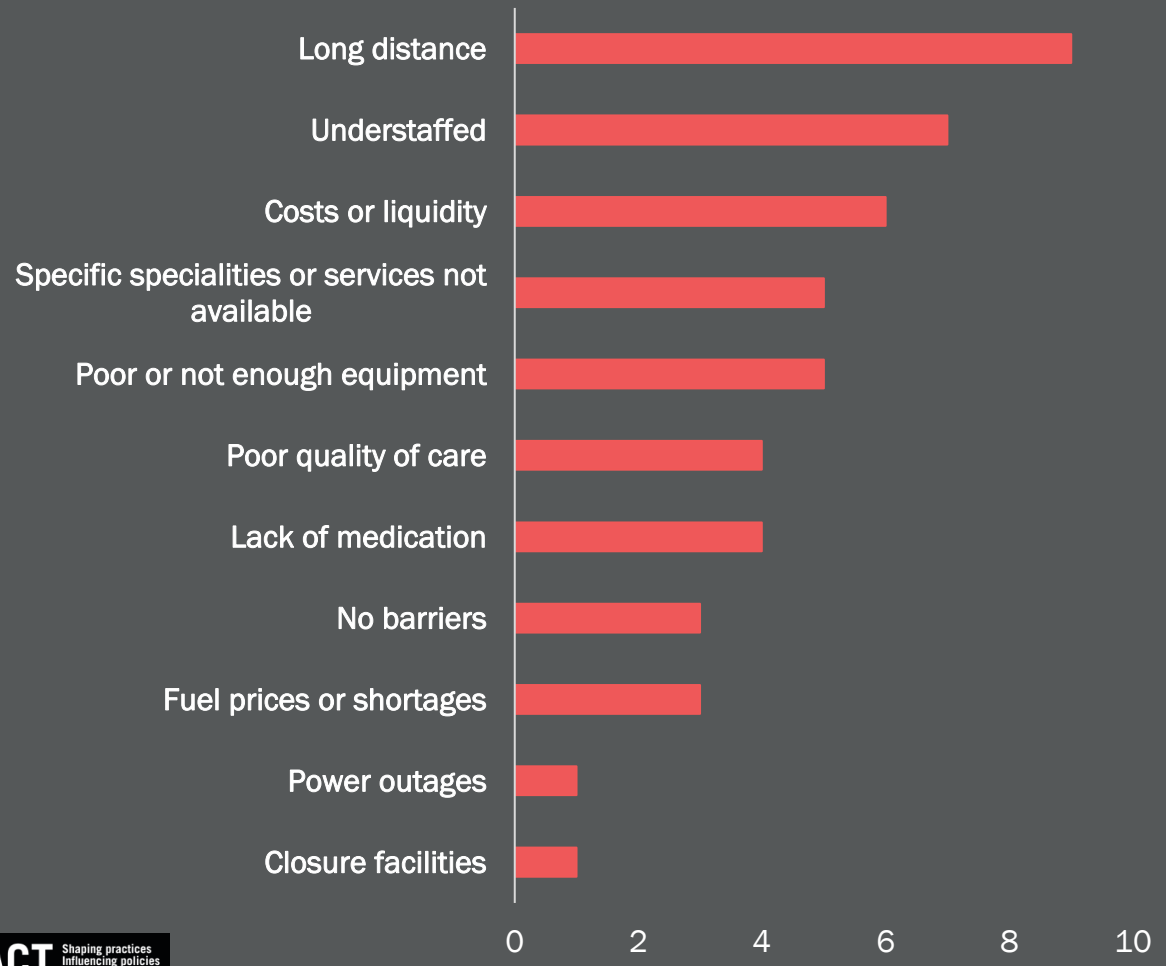
Among those households who could not access healthcare when needed (14%), 70% reported that not being able to afford healthcare was a reason

5 most commonly reported barriers to accessing healthcare, by % of households



Barriers to accessing health care

Most commonly reported barriers to accessing health care, per number of KIs:

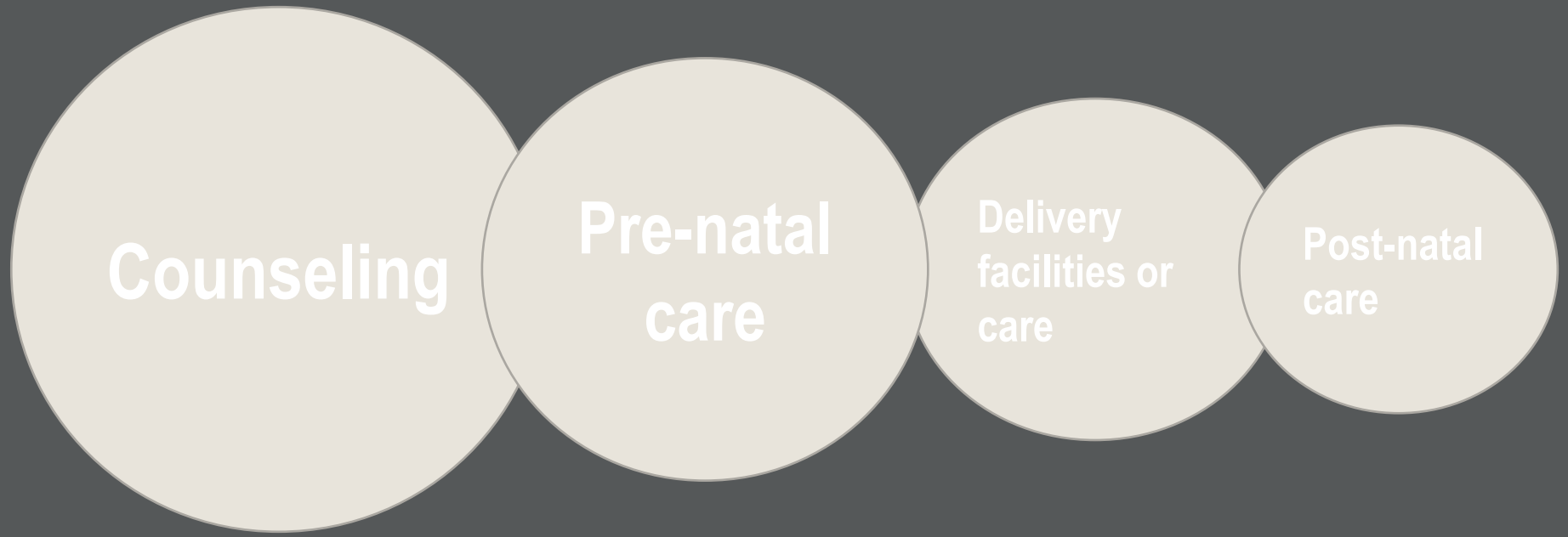


What are the main documentation barriers to accessing health care?

12 KIs reported not perceiving any documentation-related barriers to accessing healthcare, while 5 KIs perceived that the requirement to have birth certificates could pose a barrier to access, and 5 reported other forms of documentation.

"Services are not provided at the Newborn Health Care Center without documents or a vaccination card, and the health card is not provided to citizens without any identification documents."
Health Officer at MoH, Female KI in Al-Sharguiya

Access to reproductive health care



Types of reproductive healthcare accessible to households in their baladiya, according to KIs.

Barriers to accessing reproductive healthcare

11/18 KIs reported that households do not have access to reproductive healthcare, these KIs were located in Algurdha Ashshati and Al-Sharguiya.

In the South, the main barrier to accessing reproductive heathcare services while available seems to be the high cost of transportation, also with regard to the fuel crisis. In most cases, patients have to travel to Sebha for care.

Gender-segregated health services

9/18 of the KIs reported that segregated services are not available, others argued that segregated services were always available or are available in some cases, when there are female doctors within the facility (5 KIs).

Isolated spaces for women were less commonly reported to be available by KIs from the south compared to KIs in Ghiryan.

Female doctors were only reported to be available by 3 KIs.

"The lack of doctors in the municipal or regional health centers cannot allow them to provide services on a gender basis, and women can access the facility if doctors are available at the center and receive any type of services provided, if any".

Chief physician at a private clinic, Female KI, Al-Sharguiya

"Reproductive healthcare services are not available, as they are not available in the municipality where the delivery is done in Sabha hospitals or private clinics and also, sometimes in homes and the municipality needs a full maternity unit."
Health Officer at MoH, Female KI in Al-Sharguiya

Specialised health services

Almost all KIs (16/18) reported that there were no specialised health services for older persons or people with disabilities in their baladiyas.

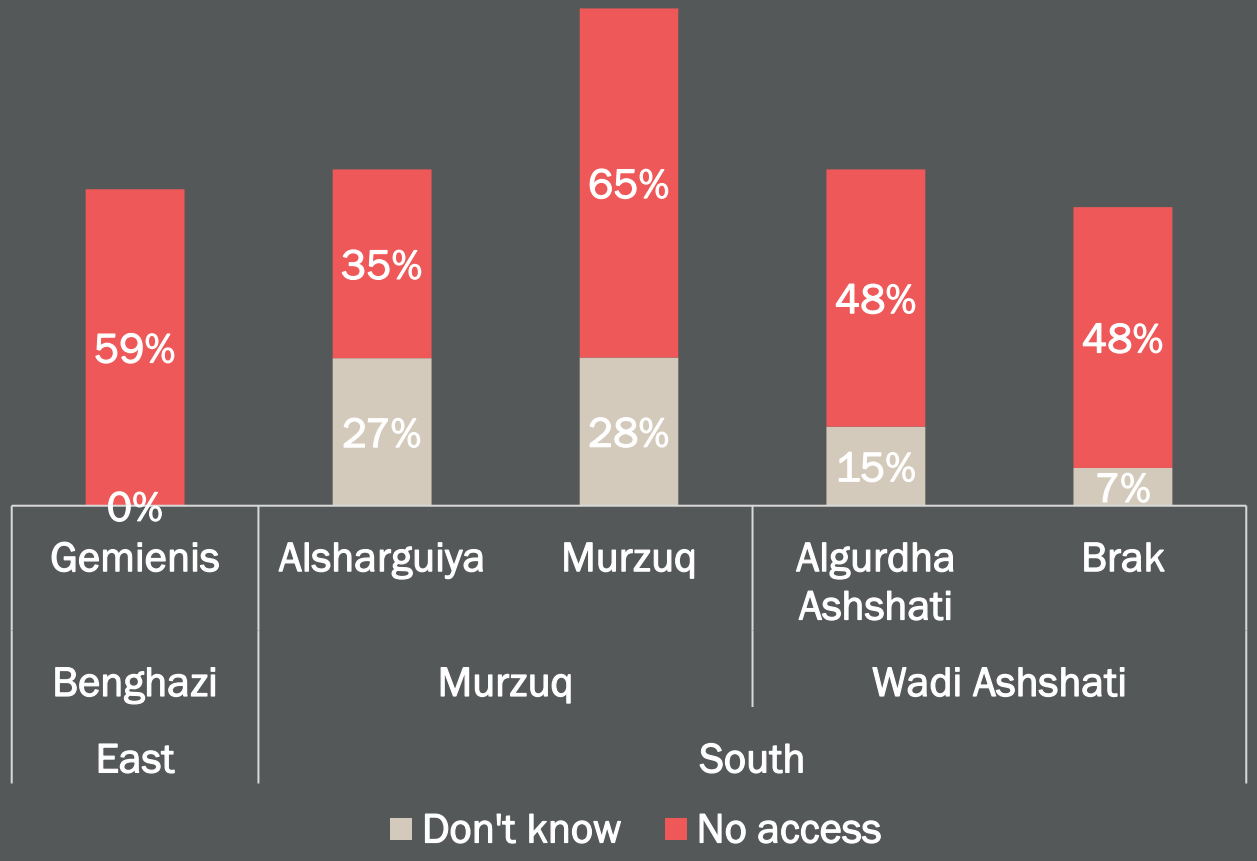
KIs in the South reported that cases requiring specialised care are transferred to Sebha.

"Neither the municipality nor the area have specialised services in the care of the disabled, home care or hospital care, whether public or private. As directors of municipal health centers, my colleagues and I hope this service will be available soon."
Employee at Ministry of Health, Male KI in Al-Sharguiya

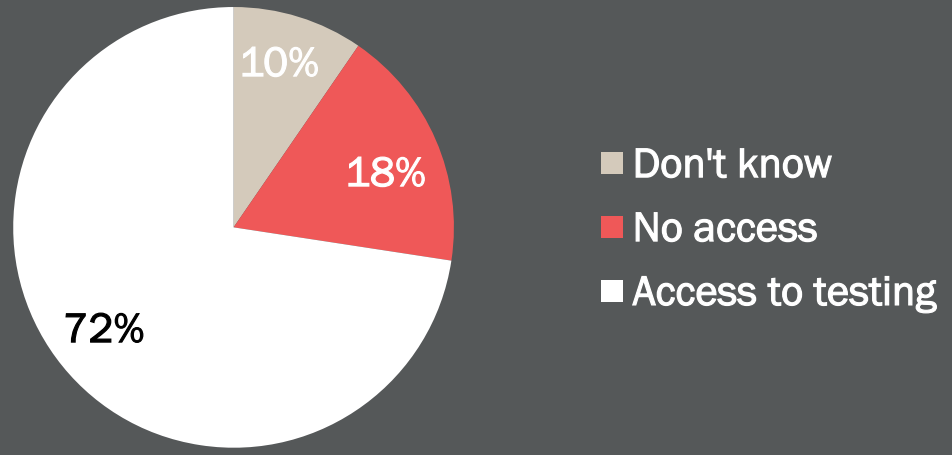
"There's no interest in conditions that need physical therapy within public health centers, especially for the elderly. There is also no pediatric health care with autism syndrome, epilepsy and people with disabilities."
Member of municipal council, Female KI in Algurdha Ashshati

COVID-19 testing

Top 5 baladiyas with the highest proportion of households reporting either not having access to COVID-19 testing facilities in their baladiya, or not knowing whether they have access



% of households per response to the question if they have access to COVID-19 testing in their baladiya



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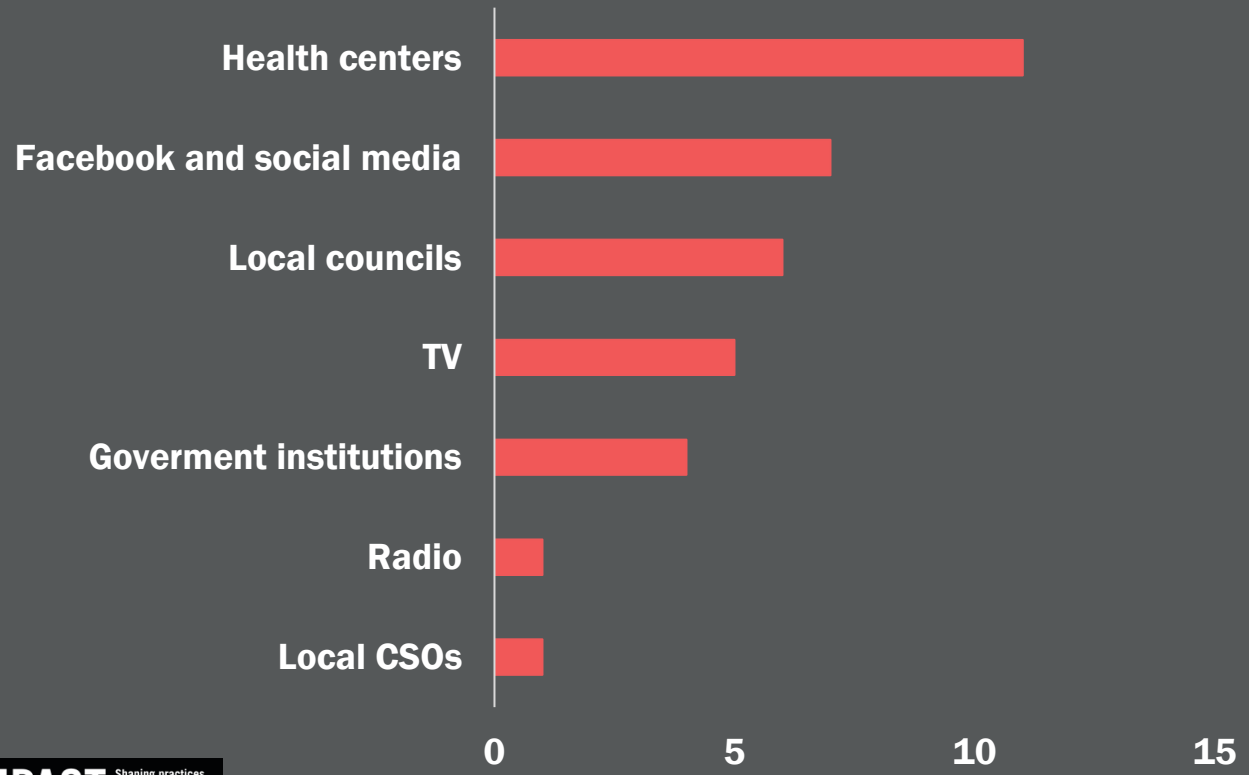
COVID-19 Information

Information channels used to access information about COVID-19 prevention, symptoms, and testing, per number of KIs



People with disabilities and older persons were commonly reported as being especially vulnerable to COVID-19 health risks.

Some KIs (5/18) argued that their vulnerability partly comes from the fact that they do not have access to the same prevention and diagnosis that many groups have access to, and to their generally weaker immune system, especially among older persons.

COVID-19 services

COVID-19 related healthcare services, such as breathing support and isolation, were commonly reported to be available in facilities.

However, most KIs argued that there are insufficient healthcare facilities and breathing support supplies and devices such as oxygen bottles, mostly due to overcrowding or lack of space and medical staff.

COVID-19 testing

Some KIs reported barriers to COVID-19 testing, with the most commonly reported barrier being the fact that tests were too expensive, reported by 8 KIs. Other barriers were long distance, insufficient supply, poor organisation, and uneven access to tests.

Two KIs reported that testing was well-organised.

COVID-19 vaccinations

7/18 KIs reported that supplies of vaccines were mostly insufficient, this was particularly reported by KIs in Ghiryan.

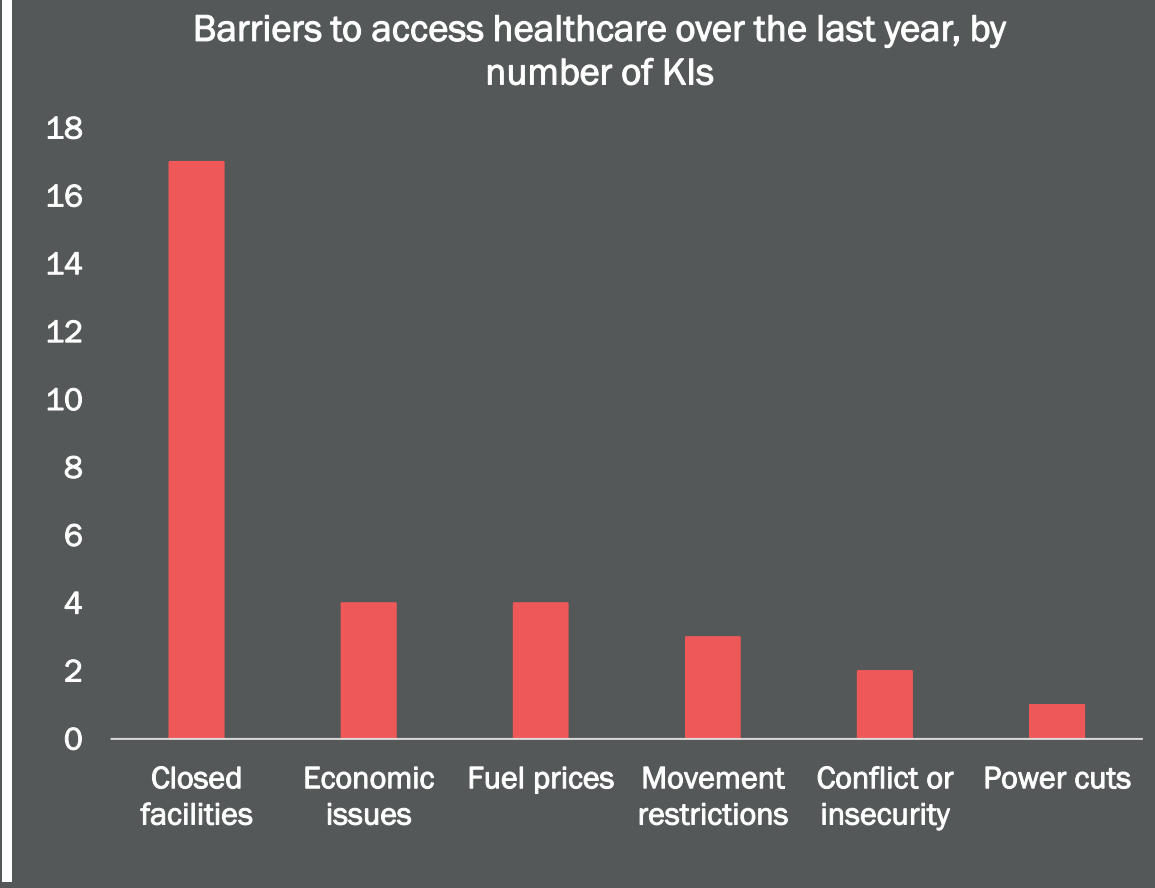
Lack of trust and long travel have been reported as the main barriers to accessing vaccination services by 2 KIs.

COVID-19 Impact on health services

17/18 KIs acknowledged that COVID-19 has impacted the accessibility and availability of non-COVID-19 related healthcare services.

17/18 KIs argued that the closure of health facilities has impeded healthcare access more than normal over the last year.

KIs commonly reported that COVID-19 impacted the availability of the medical staff, and some reported perceiving that emergency services, surgical services, and/or in-patient care were affected.



How to improve health care access in the baladiya?

- Awareness raising of public
- Build new facilities
- Hire more staff
- Improve income of medical staff
- Lower prices
- More medication available
- New equipment
- Specialised services available
- Training of staff

A majority of KIs reported a need for **providing new equipment for healthcare facilities**, especially technical medical machines such as Xray or MRI , alongside **conducting capacity building trainings for medical staff**.

The availability of specialised services, more medication and more staff at the healthcare facilities were commonly reported as well, especially in the South.

Key qualitative takeaways on health

- According to KIs, economic barriers, lack of facilities and medical capacity; and COVID-19 were the main drivers of health needs across the assessed locations
- Findings suggest that the COVID-19 security measures, high prices and lack of specialised services all had an impact on access to healthcare services within the baladiya.
- According to KIs, COVID-19 has impacted households' access to healthcare services in the last year, especially due to the closure of facilities
- According to KIs, persons with disabilities and older persons were particularly vulnerable to COVID-19 health risks.
- It was reported that training of medical staff, provision of specialised services and new equipment could improve the health situation in Libya.

Health LSG framework

Critical indicator

Critical indicator	Severity rating			
	None/Minimal	Stress	Severe	Extreme
	1	2	3	4
% of households with access to public and private health care	Access to healthcare AND no members were not able to access it when needed		No access to healthcare reported, but no members were not able to access healthcare when they needed it OR no access to healthcare but members were able to access it when they needed it	No access to healthcare or access to traditional healers only AND members needed healthcare in the 3 months prior to healthcare but could not access it
	85%		15%	0.16%

Non-critical indicators (3 out of 4 indicators required for a severity of 3)

Non-critical indicators	Classification	
	No need	Need
	0	1
% of households that reported facing challenges accessing health care	No problems	At least one problem
	63%	37%
% of households that can access primary health care within one hour using their normal mode of transportation.	Less than 1h	More than 1h
	99%	1%
% of households with at least one child without an immunization record	All children have a record	At least one child does not have a record
	70%	30%
% of households with access to COVID-19 testing facilities	Yes	No or 'don't know'
	27%	73%

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Discussion: Indicators for MSNA 2022

- What are the key changes to make to the health critical and non-critical indicators for the 2022 MSNA?
- What indicators to keep, what to change? Suggestions?


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Mental Health and social support networks

Main/overarching research question:

To what extent are communities under distress, and what kind of services or support (formal and informal) are available to community members?

Research questions

1. Is the community under distress? To what extent is stress an issue in the community?
2. What kind of services and support systems are in place for people that are struggling?
3. Are there any barriers to accessing services and support systems?
4. Are any groups especially affected by stress or barriers to accessing support?
5. What behaviour changes are caused by mental stress?

Methodology

KIIs (phone-based or F2F) with (mental) health professionals
In-person FGDs (facilitated by partners) with community members with similar lived experiences

Scope

Prioritise locations with most recent conflict incidences, such as Tripoli/Sirt and locations in the South

Mental Health and social support networks (MHPSS)

- **22 Key Informant Interviews** (KIIs) with equal gender based KI profiles in 11 baladiyas: AlKufra, Azzawya, Benghazi, Ghat, Ghiryan, Misrata, Sirt, Tarhuna, Tawergha, Tripoli, Ubari

- **13 Focus Group Discussions** (FGDs) with an average of 6 local community members per FGD in 7 baladiyas: Sirt ,Tarhuna, Ghiryan, Azzawya, AlKufra, Misrata and Tripoli

Each FGD included both men and women (FGDs were not gender-segregated).

PSS team member at women and children NGO	1
Specialist at Ministry of Social Affairs (MoSA)	1
Head of Awareness and Guidance Team at INGO	1
Psychiatrist	6
PSS team manager	1
Doctor	6
Social worker	3
Social worker at Ministry of Education (MoE)	3

Analysis process of qualitative interview transcripts

An iterative and data based process to monitor data saturation from the KI and FGD interviews was applied.

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- From the translated transcripts, a preliminary codebook with node hierarchy (consisting of themes & subthemes) was created.
- On all transcripts, binary coding (0-1) was carried out, to determine if any part of a KI's transcript was related to a certain subtheme (regardless of being an answer to a specific questionnaire question).
- Throughout the analysis, node structure was constantly revised to remain flexible so that new insights and ideas diverting between regions could be captured.
- Among KIs, emergent topics were identified (such as references to the lack of facilities and mental health centers and the lack of expertise within the field which is a huge barrier to Mental Health and social networks).

Strengths and Limitations of the Qualitative Analysis

Geographical coverage

Data collection focused on the top baladiyas triggered by quantitative data and recommendations from partners. Therefore, no comparison can be done countrywide.

Inclusive Sample

Gender balance fairly met however a potential limitation can be that FGDs were not gender-segregated.

Also, sensitive issues may have been under-reported

Interviews conducted in Arabic

Subtle and specific details may have gotten lost during the translation process.

Psychological issues

Anxiety and depression were commonly reported as urgent psychological issues within the community, this is reported particularly in the south.

KIs commonly reported types of violence that have psychological implications within the social context that have increased in recent years are sexual abuse, physical and verbal violence and domestic violence.

The majority of KIs reported that war and armed conflicts, addiction and family problems, such as divorce and family dispersion, were the primary causes of psychosocial issues within the community living in the assessed baladiyas, especially among women and children.

In all FGDs, participants reported urgent psychological issues within the social context that had increased in recent years.

Participants commonly reported perceiving that physical and verbal violence and sexual abuse were among such urgent issues that had increased, and some reported domestic violence.

These are reported to be especially among women.

Services

❖ Formal services available within the baladiya:

5/22 KIs reported that community members under distress can access formal services offered by mental health professionals in public health facilities.

6/22 KIs reported having no formal services available at all within their baladiyas

"Despite the efforts of the Kufra Center for Mental Health to provide quality psychological services to citizens, these efforts are unable to keep pace with the psychological needs of the area due to the severe shortage of medicines, the lack of proper rehabilitation for the team inside the center, and the inadequate place to provide psychological services." Female KI in Al Kufra

❖ Informal services available within the baladiya:

Most KIs argued that the main informal services provided within the baladiya for community members under distress are led by INGOs and community centers mainly through organising awareness-raising workshops and recreational activities.

Only 2 KIs reported that informal services can be available at schools within their baladiyas.

On the other hand, seven KIs reported that no informal services were available in their baladiya.

Informal support systems

Several KIs reported that community members deal with psychological issues through family support, community support, or seeking treatment at a hospital or clinic (when available), while a minority was reported to seek traditional healers or sheikhs instead of professional treatment.

In addition, local female communities (5) or religious community leaders (4) were reported to be sought for psychological relief and well-being.

However, 9 KIs reported that most of these social support systems were mostly ineffective, as the community members experiencing psychological issues do not receive professional treatment from mental health professionals.

Main gaps in the support systems

A majority of KIs aknowledged that the main gap in the support systems for community members feeling distress was the lack of mental health facilities and safe spaces in most of the assessed locations.

Barriers to accessing services

Findings from the qualitative phase suggest that the lack of facilities and mental health centers and fear of social stigma are common barriers to accessing MPHSS services.

Some KIs argued that the barriers to accessing the services were mainly:

- The bad economic situation, such as the liquidity crisis and low incomes
- The lack of transportation and fuel issues
- The lack of expertise within the field, both in terms of the medical staff and also the government officials repsonsible for the health development projects within the baladiyas.

The feeling of insecurity, and lack of documentation were also reported as barriers to accessing services, especially among women and IDPs.

Vulnerable Groups

The group that was most commonly reported to be vulnerable to psychosocial issues are women, especially those subjected to domestic violence and related traumatic experiences. As many KIs argued, their vulnerability partly comes from the fact that they do not have access to the same social support systems that men have access to, as women do not report such incidents due to fear of social traditions and stigma.

The second most commonly reported vulnerable group was people with disabilties, mainly due to the absence of specialised centers that offer inclusion and capacity building workshops within the baladiyas.

Additionally, children and IDPs were reported by 6 KIs as being especially vulnerable, mainly due to the traumatic experiences they went through during the armed conflicts and displacement process. Also, a few KIs explained that people with mental disorders and no or low income are vulnerable.

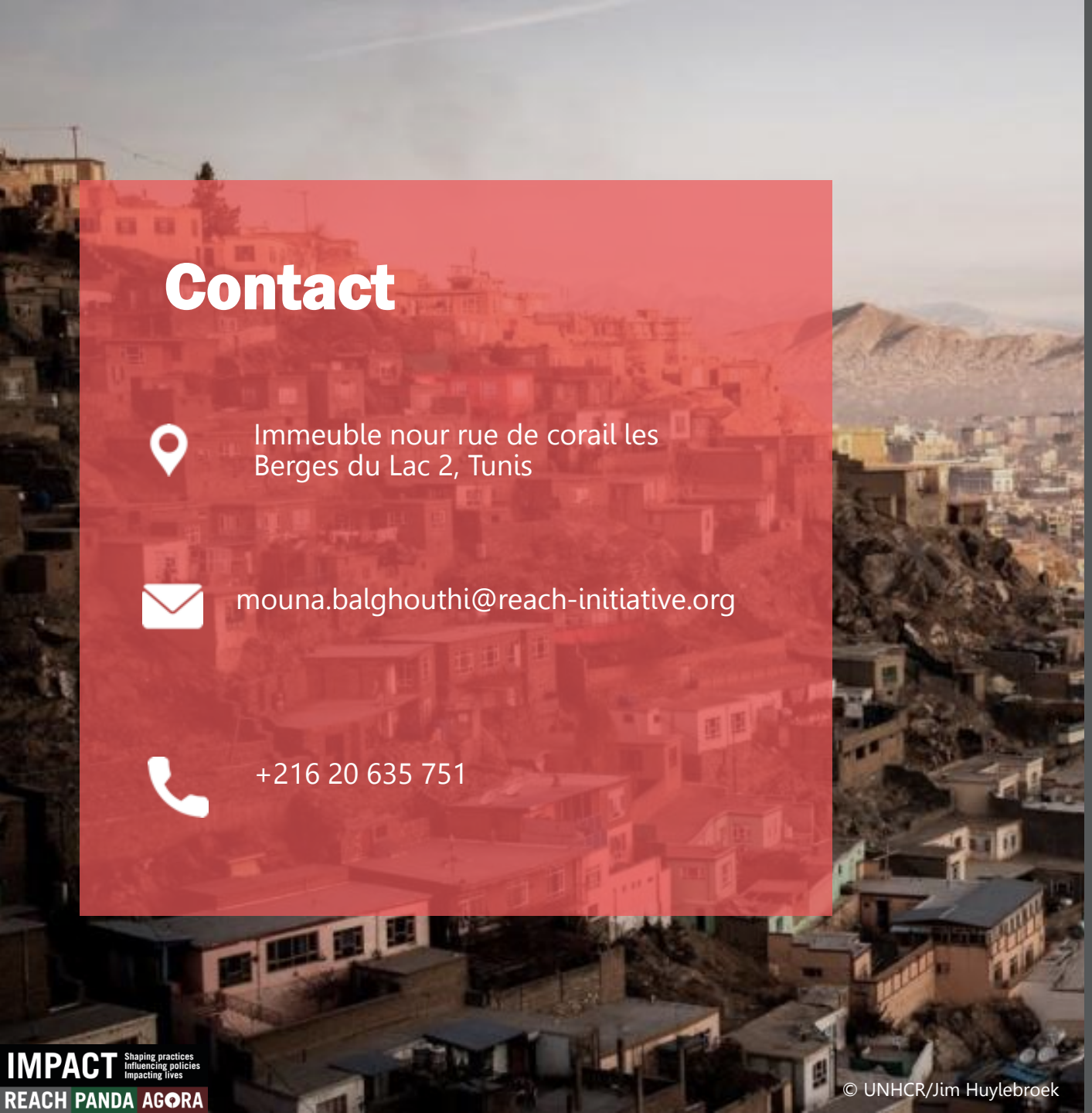
Needed Support

A majority of KIs reported that the most needed services are the provision of medical support and establishment of awareness and inclusion programmes, especially for the vulnerable groups.

More generally, improving the quality of life, creating safe spaces, and facilitating access to services were mentioned as important services that were needed.

Key qualitative takeaways on MHPSS

- According to KIs, lack of facilities and safe spaces were the main drivers of MHPSS needs across the assessed locations
- Findings suggest that informal support systems are generally available, but some doubt their effectiveness to treat community members under distress.
- According to KIs, the most most needed services are the provision of medical support and establishment of awareness and inclusion programmes, especially for the vulnerable groups.
- Findings suggest that women and people with disabilities were particularly vulnerable to distress and psychological issues.
- It was reported that the lack of mental health facilities and safe spaces and fear of social stigma are common barriers to accessing MPHSS services.



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