Multi-Sector Needs Assessment (MSNA)

Health
November 2018

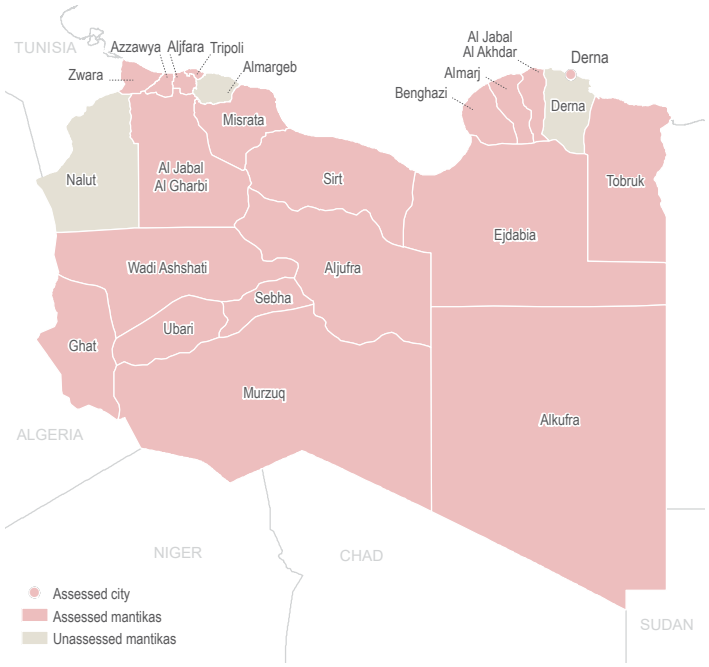
LIBYA

CONTEXT AND METHODOLOGY

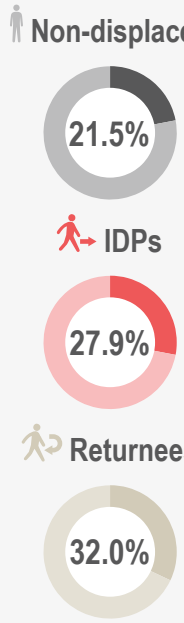
As the Libyan crisis enters its eighth year, episodic clashes between a multiplicity of armed actors continue to affect several regions, with an estimated 1.62 million displaced and non-displaced people affected in 2017[1]. From 1 January - 31 October 2018, UNSMIL documented at least 175 civilian deaths and 335 injuries[2]. The crisis in Libya is the result of conflict, political instability and a vacuum of effective governance, resulting in a further breakdown of functioning systems with considerable security, rule of law, social and economic consequences[3]. The most pressing humanitarian needs identified are protection, health and cash & livelihoods[4], though as the humanitarian situation evolves, the strategies adopted by households to meet their needs remain underexplored.

In light of these continued knowledge gaps, with facilitation from REACH, the Inter-Sector Coordination Group (ISCG) conducted a multi-sector data collection exercise between 23 July and 6 September 2018 to provide updated information on the needs and vulnerabilities of affected populations in Libya. 5,352 households (HH) were interviewed, including non-displaced (2,449), IDP (1,691) and returnee (1,212) HHs, across 20 Libyan mantikas[5]. Findings are generalisable at mantika level for each assessed population group with a **confidence level of 95% and a margin of error of 10%** (unless stated otherwise).

ASSESSMENT COVERAGE



Households with an unmet need in the health sector: 22.8%



SECTORAL AND MULTISECTORAL NEEDS

To understand sectoral needs, multiple indicators were assessed to gauge whether a household (HH) had an unmet need, as further explained in the annex. Overall, the greatest reported unmet needs were in the health sector with just under **one-quarter of all households in Libya with an unmet need in health**. A higher proportion of returnee households had unmet needs with one-third in need. **Health issues were overwhelmingly concentrated in southern Libya**, where nearly one half of all HHs required health assistance in Wadi Ashshati, Murzuq, Sebha, and Alkufra.

To strengthen coordination of humanitarian planning and to aid integrated responses, it is important to understand the overlapping needs households face across multiple sectors. Across Libya, t**he most commonly reported intersection of unmet needs was between the health and WASH sectors**, affecting at least one-fifth of HHs in Alkufra, Derna, Murzuq and Sirt. Issues with shelter and WASH most commonly compounded health problems for returnees, while issues with shelter and protection most commonly compounded health problems for IDPs. Of particular concern were returnees in Azzawya; 47% of HHs had simultaneous unmet needs in health and protection.

	HHs with an unmet need in the health and protection sectors	HHs with an unmet need in the health and shelter sectors	HHs with an unmet need in the health and WASH sectors
Non-displaced	2.3%	2.5%	7.1%
IDPs	10.9%	10.0%	7.6%
Returnees	8.7%	17.2%	14.1%

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ACCESS TO HEALTHCARE

10.4% of HHs having a member ill in the 15 days prior to data collection reported not having been to a health facility[6].

Top 3 health facilities visited by HHs with an ill member, per population group[6 7]:

Non-displaced		IDPs		Returnees	
51.1%	Private clinic	30.7%	Public hospital	33.1%	Public hospital
26.5%	Public hospital	26.2%	Private clinic	23.0%	Private clinic
13.3%	Public polyclinic	20.1%	Public primary health care facility	13.5%	Public polyclinic

19.5% of HHs reported facing challenges in accessing health facilities when needed.

Top 3 barriers reported by HHs facing challenges in accessing health facilities, per population group[6 7]:

Non-displaced		IDPs		Returnees	
44.5%	Lack of medical staff	46.0%	No or lack of money to pay for care	41.5%	Health facilities damaged or destroyed
36.3%	No or lack of money to pay for care	43.9%	Lack of medical staff	39.1%	No or lack of money to pay for care
31.2%	Lack of medical supplies	35.6%	Lack of medical supplies	37.6%	Lack of medical staff

Of HHs visiting a health facility in the 15 days prior to data collection, top 3 criteria for choosing a facility[6 7]:

1. Proximity of the facility
2. Availability of skilled health staff in the facility
3. Availability of medical equipment in the facility

Reported time needed to access the nearest facility (% of HHs), per mantika:

	< 15 min	15 - 29 min	30 - 59 min	1 - 2 hours	< 2 hours
Al Jabal Al Akhdar	83.9%	13.8%	2.3%	0.0%	0.0%
Al Jabal Al Gharbi	49.3%	32.7%	14.4%	2.4%	1.2%
Aljfara	74.5%	21.9%	1.9%	1.8%	0.0%
Aljufra	49.2%	46.1%	4.7%	0.0%	0.0%
Alkufra	40.5%	44.4%	9.6%	4.2%	0.4%
Almarj	83.6%	15.9%	0.5%	0.0%	0.0%
Azzawya	9.3%	55.0%	27.6%	5.7%	0.4%
Benghazi	30.8%	45.8%	19.5%	3.7%	0.3%
Derna	10.5%	75.8%	10.0%	3.1%	0.0%
Ejdabia	28.2%	50.9%	15.7%	4.8%	0.4%
Ghat	71.7%	20.4%	5.4%	0.8%	0.6%
Misrata	84.8%	14.4%	0.7%	0.2%	0.0%
Murzuq	41.7%	44.9%	6.4%	0.0%	5.1%
Sebha	49.4%	44.9%	5.4%	0.0%	0.0%
Sirt	39.2%	39.5%	20.9%	0.4%	0.0%
Tobruk	32.3%	60.6%	7.1%	0.0%	0.0%
Tripoli	45.7%	41.7%	11.6%	1.0%	0.0%
Ubari	57.6%	20.6%	8.6%	13.1%	0.0%
Wadi Ashshati	30.4%	41.3%	28.3%	0.1%	0.0%
Zwara	93.3%	6.4%	0.2%	0.0%	0.0%

PREGNANCY AND BIRTH

Top 3 types of delivery assistance reported by HHs having at least one woman giving live birth in the 2 years prior to data collection[6 7]:

79.4% of HHs with at least one child under 2 years old reported that women fed their children using bottled milk or baby formula until 6 months of age[6].

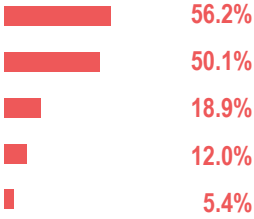
VACCINATION

34.2% of children were reported to have a vaccination card.

CHRONIC DISEASES

27.1% of HHs reported one or more member(s) suffering from chronic diseases[8].

Main reported chronic diseases[7]:



70.1% of HHs in which one or more member(s) are suffering from chronic diseases reported having limited or no access to medicine[6].

Of HHs reporting at least one member suffering from chronic diseases, % of HHs reporting limited or no access to medicines, per mantika[6]:

	Limited access	No access
Al Jabal Al Akhdar	40.7%	0.0%
Al Jabal Al Gharbi	74.9%	9.3%
Aljfara	96.6%	0.0%
Aljufra	82.2%	11.5%
Alkufra	82.1%	5.8%
Almarj	25.7%	18.8%
Azzawya	79.1%	0.1%
Benghazi	66.7%	0.7%
Derna	89.4%	0.9%
Ejdabia	70.1%	0.0%
Ghat	94.3%	0.0%
Misrata	30.8%	0.1%
Murzuq	38.9%	24.9%
Sebha	23.3%	12.8%
Sirt	82.1%	3.4%
Tobruk	46.6%	6.8%
Tripoli	56.3%	25.5%
Ubari	88.4%	7.8%
Wadi Ashshati	90.0%	3.4%
Zwara	100.0%	0.0%

MENTAL ILLNESS

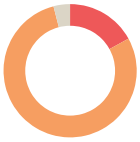
4.3% of HHs reported one or more member(s) having been diagnosed with a mental disorder.

66.2% of HHs in which one or member(s) have been diagnosed with a mental disorder reported having limited access to the needed healthcare. **47.4%** reported no access at all[6].

Of IDP HHs having at least one member diagnosed with a mental disorder, % of HHs with access to mental health care services:

27.1% No access
37.2% Limited access
33.7% Adequate access
2.1% Preferred not to answer

Of returnee HHs having at least one member diagnosed with a clinical mental disorder, % of HHs with access to mental health care services:



17.1% No access
79.4% Limited access
0.0% Adequate access
3.6% Preferred not to answer

1 Libya Humanitarian Needs Overview, OCHA, 2018
2 UNSMIL, Human Rights Report on Civilian Casualties, 2018
3 https://www.unocha.org/middle-east-and-north-africa-romena/libya
4 Libya Humanitarian Needs Overview, OCHA, 2018
5 Libya is divided into four types of administrative areas: 3 regions (admin level 1), 22 mantikas or districts (admin level 2), 100 baladiyas or municipalities (admin level 3), and muhallas, which are similar to neighbourhoods or villages (admin level 4).
6 Due to limited sample size for this indicator, results are indicative and not representative
7 Multiple response options could be selected.
8 Classify as chronic disease: blood pressure, heart disease, diabetes, asthma, joint pain (arthritis), chronic back pain (spinal cord), cataract, stomach ulcers, epilepsy.

CALCULATING UNMET NEEDS AND MULTISECTORAL NEEDS

For each sector, an index of unmet needs was calculated using one or multiple individual needs indicators* selected by each active sector in Libya. If a household reported having an unmet need for one of the sectoral indicators, then they were considered to have unmet needs in that sector. The percentage of households with unmet needs per mantika and population group was then calculated.

The only exception is the Protection sector where, due to the large number of individual sectoral indicators, a threshold weighting was applied to displaced households (IDPs and returnees). In this instance, households were required to report having an unmet need for two or more indicators in order to be considered as having unmet needs in the sector.

* Each of these indicators was also used by OCHA to calculate the People In Need (PIN) figure for the Humanitarian Needs Overview.

Multisectoral needs:

The multidimensional index of needs for each household was subsequently calculated as a total of the number of sectoral needs that the household faced (maximum of 6). This aggregated number can then be extrapolated to the mantika and national levels for each population group. Analysing the % of households by the number of sectors they have unmet needs in provides an understanding of the geographic variation in which humanitarian needs converge. Population groups and areas with a higher proportion of households with unmet needs in multiple sectors, such as in three or more at the same time, are likely to face acute problems in meeting their basic needs.

Multisectoral analysis presents an opportunity to identify and understand the interrelationships between sector-specific indicators that contribute to overall household needs. Adopting an integrated sector approach can help assess the impact of current and future interventions aimed at mitigating humanitarian needs. The multisectoral analysis presented above investigates the % of households that have needs in two sectors, for example in Protection & Health, presenting findings by each sector.

SECTORAL INDICATORS

Protection:
% HHs losing civil documentation because of conflict and not reapplying
% HHs facing protection-related barriers to receiving humanitarian assistance
% HHs reporting presence of explosive hazards
% HHs with with members injured or killed by an explosive hazard
% of returnee HHs facing protection-related problems upon return
% IDP HHs hosting displaced family members or other displaced persons
% IDP HHs hosting displaced under 18 or unaccompanied children
% IDP HHs evicted or threatened with eviction in the past 6 months
% IDP HHs with members diagnosed with a clinical mental disorder or physical disability
% IDP HHs with children under 18 who have worked in the past month
% IDP HHs displaced more than once since 2011

WASH:
% HHs reporting insufficient quantity of drinking water in the past month

Shelter & NFI:
% IDP and returnee HHs living in unfinished buildings, collective centres, informal settlements or open areas
% HHs living in heavily damaged or destroyed shelters
% HHs needing assistance to cover energy needs
% HHs recently evicted or threatened with eviction
% HHs reporting squatting as occupancy type

Education:
% HHs with at least one school-aged child not enrolled in school
% HHs with at least one school-aged child not regularly attending school

Health:
% HHs with an ill family member who did not go to a health facility
% HHs facing challenges accessing health facilities due to damaged/ destroyed health facilities; no available health facilities that can accept new patients; lack of money to pay for care; lack of medical staff in general; lack of medical supplies
% HHs reporting more than 1 hour by car to nearest health service provider
% HHs with a women who gave birth in last 2 years, consulted by an uncertified midwife; nurse; relatives/friends; or no one
% HHs with a family member diagnosed with a chronic disease, clinical mental disorder or physical disability with no access to medicines/ healthcare

Food security:
CARI Analysis; Food Consumption Score, food expenditure share, coping strategies

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