LIBYA

2021 Multi-Sector Needs Assessment

Libyan population

May 2022

LIBYA INTER-SECTOR COORDINATION GROUP

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About REACH

REACH facilitates the development of information tools and products that enhance the capacity of aid actors to make evidence-based decisions in emergency, recovery, and development contexts. The methodologies used by REACH include primary data collection and in-depth analysis, and all activities are conducted through inter-agency aid coordination mechanisms. REACH is a joint initiative of IMPACT Initiatives, ACTED and the United Nations Institute for Training and Research - Operational Satellite Applications Programme (UNITAR-UNOSAT). For more information, please visit our website. You can contact us directly at: geneva@reach-initiative.org and follow us on Twitter @REACH_info.

EXECUTIVE SUMMARY

For Libya, most of the year 2021 was characterised by continuous peacebuilding and unification efforts, built on the peace agreement reached in October 2020.[1] In 2021, some positive developments related to liquidity took place, such as the devaluation of the Libyan dinar.[2] This increased the availability of cash, yet liquidity issues remained, especially in the South and East.[3] Indeed, the country's protracted conflict has resulted in significant economic challenges overall. Moreover, the number of internally displaced persons (IDPs) has been steadily declining in Libya since the end of the siege on Tripoli around June 2020. Nonetheless, the return rate does appear to be plateauing to some extent.[4] Furthermore, throughout the year 2021, the COVID-19 pandemic kept on impacting the fragmented health system,[5] as well as the overall safety[6] and economic situation[7] of the country – adding an additional layer of complexity to the Libyan crisis.

As humanitarian information gaps for displaced and non-displaced populations in Libya remain, especially with the country's political, economic, and social landscapes constantly evolving, REACH, in coordination with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), on behalf of the Humanitarian Country Team (HCT), Inter-Sector Coordination Group (ISCG) and Assessment Working Group (AWG), conducted the 2021 Multi-Sector Needs Assessment (MSNA). The aim of this assessment is to inform humanitarian actors of the current needs that exist among Libyans, and to have the MSNA data feeding into the 2022 Humanitarian Needs Overview (HNO), contributing to evidence-based humanitarian response planning.

This MSNA considers the situation among Libyan non-displaced, IDP, and returnee households in baladiyas across the country, while the vulnerabilities and needs of refugees and migrants residing in Libya were assessed in a separate MSNA.[8] The MSNA uses a mixed-method approach, consisting of an initial quantitative phase involving household-level surveys and a follow-up qualitative phase that was built on key informant interviews (KIIs) and focus group discussions (FDGs). The scope of the quantitative data collection included 8,871 households across a selection of 45 baladiyas (about equally spread across Libya's three regions), conducted over the phone due to COVID-19 mitigation measures, between 14 June and 2 August 2021. Sampling was primarily purposive, with quotas for each population group per baladiya, delivering findings that are indicative, rather than representative. To address the possible over-representation of the more vulnerable households due this sampling method, 1,010 household surveys (of the total number) were carried out via random digit dialling (RDD) – randomly dialling phone numbers to reach a random sample of the population (having working cell phones). This quantitative data was supplemented and triangulated with data from 88 KIIs, for which the selection of topics and locations was informed by the household surveys' findings. This resulted in both the quantitative and qualitative part of this assessment being focused on protection, health, and food security. Additionally, the more sensitive topics of mental health and psychosocial support (MHPSS) and access to services (including GBV) were covered through KIIs, as well as through 34 FGDs.

On the whole, 51% of assessed households were found to have humanitarian needs, of which 34% had severe needs and 17% extreme needs. These humanitarian needs were primarily driven by needs in two sectors, as almost half of households with an overall need were found to have protection needs (46%), and more than one third to have health needs (38%). Furthermore, many households were having

[1] International Crisis Group, "Keeping a Libya Settlement on Track," January 29, 2021.
[2] Reuters, "Libyan liquidity crisis eases after exchange rate shift," February 3, 2021.
[3] Reuters, "Libyan central bank reunification process begins this month, says governor," December 13, 2021.
[4] IOM-DTM Libya, "IDP and Returnee Report," Round 38, July-September 2021.
[5] Amnesty International, "Libya: Historic Discrimination Threatens Right to Health of Minorities in the South amid COVID-19," April 2020.
[6] ICRC, "Libya: COVID-19 and Conflict Collide, Deepening Humanitarian Crisis," August 20, 2020.
[7] According to REACH's Libya Joint Market Monitoring Initiative (JMMI), December 2021. Access this factsheet here.
[8] Publications of REACH's 2021 Refugee and Migrant population MSNA can be accessed here.

needs in one sector only, as opposed to co-occurring sectoral needs. This was most often the case for households with protection needs, as 41% of households with this type of needs did not have any other sectoral need(s).

Overall, returnee households appeared as the population group having the highest proportion of households in need across all sectors (63%). Geographically, the Libyan region with the highest proportion of households in need was found to be the South (67%), followed by the Eastern (61%) and Western region (44%). Households' humanitarian needs were most often found to be related to protection and health, followed by food security. The main drivers causing these sectoral needs were missing documentation as well as a feeling of unsafety creating protection needs, and financial issues resulting in an unaffordability to sufficiently cover health and food needs.

Protection needs were the most often found sectoral needs among assessed households (23%) and mainly dominated in the South, where one third of the interviewed households (33%) had protection needs. These needs were found to be primarily driven by a lack of documentation, with 17% of households overall reporting that at least one of their members did not have a valid ID. This finding was highest in the South (26%), where 55% of households also reported having safety and security concerns, and 23% noted concerns that were specifically related to armed conflict. The baladiyas Wadi Etba and Ubari stood out especially, with respectively 59% and 57% of households found to have protection needs. KIs from these baladiyas, as well as from Alghrayfa (all three located in the South) reported having perceived an improvement in the security situation compared to the year prior to the assessment. Here, the main safety and security concerns reported were petty crimes (such as robberies), while risks related to travelling outside the municipality were also often mentioned. Official law enforcement agencies such as the police were reported as the main security agent overall, while tribes were pointed out as also having an important role in conflict resolution and maintaining stability within the community. Furthermore, women in southern Libya were found to be facing several, accumulating barriers to access basic services. According to KIs and FGD participants, early marriage, financial issues together with high prices, an unavailability of specialised health services, cultural barriers related to gender norms, and issues to accessing banking and legal services, created multi-layered struggles for women to access education, healthcare, and livelihoods.

Health needs were found to be mainly driven by economic barriers, together with a lack of facilities and capacity, and COVID-19 related challenges. Overall, 20% of households were found to have health needs. Of the 28% of households that reportedly needed healthcare in the three months prior to data collection, 56% reported that at least one household member had not been able to access the healthcare he/she needed, which is 14% of the total sample assessed. Among this sub-group, the overwhelming majority (70%) reported an inability to afford health services as the main barrier hindering their access to healthcare. Furthermore, among those households that had not needed healthcare in the previous months, or needed it and were able to access it, 37% reported having faced or expecting to face barriers to accessing healthcare. This was mainly due to an inability to afford services, but also because of a poor quality of services, lack of medicines, lack of trust, and overcrowding of health facilities. The highest proportion of households with health needs was found in Ghiryan, located in the Western region (50%). Here, 43% of households reported they had not been able to access the healthcare they needed in the 3 months prior to data collection. Ghiryan was one of the three baladiyas (together with Alsharguiya and Algurdha Ashshati) were KIIs about health were conducted. In these locations, the high cost of treatment, especially at private clinics, together with the liquidity crisis, were among the commonly reported main barriers to accessing healthcare. Moreover, problems related to the capacity of health centres, caused by understaffing, lack of medicines, and shortages of equipment were also frequently highlighted by KIs, especially in the South. In Alsharguiya, in particular, poor access to healthcare was often reported, as well as the non-availability of specialised services, mainly due to a lack of staff together with insufficient training of the available personnel.

The South of Libya was found to have the highest proportion of households facing food security needs (27%), compared to the country overall (13%). Moreover, findings indicate that IDP and returnee households tend to be more exposed to food insecurity than non-displaced households, as results demonstrate that 22% of the first two population groups had food security needs. The main driver of many sectoral needs appeared to be the inability to financially cover all essential expenses. Regarding essential food needs, more than a quarter of assessed households (26%) reported having experienced trouble in meeting these in the month prior to the interview because of unaffordability. This was more commonly reported by displaced households (37% of returnee and 34% of IDP households), compared to 24% of non-displaced households, and households located in the East (39%), followed by those in the South (29%) and West (19%). Furthermore, the Southern region displayed the highest proportion (6%) of households that had to reduce (totally or partially) agricultural activities in the year prior to the surveys (October 2020 to September 2021). Qualitative findings from 18 KIIs conducted in Gemienis, Suloug and Toukra (all three baladiyas located in the East) indicated that the financial situation was indeed paramount in causing food insecurity. According to the majority of KIs, food insecurity for Libyan households had increased significantly throughout the year prior to the interviews. This was allegedly explained by households' decreased income, together with the high prices of imported food products in markets. Reflecting this, households relying on daily wages were commonly perceived as the most affected group, whose livelihoods were also especially impacted by COVID-19 restrictions.

In general, the main driver of many sectoral needs in Libya appeared to be the unaffordability to cover all essential expenses. MSNA findings show that, overall, 53% of households reported they had been unable to cover all their basic needs in the month prior to data collection. This was especially true for essential health and food needs, with more than a quarter of assessed households found to be unable to meet these essential needs. More specifically, households residing in the South and displaced households (both IDPs and returnees) were most commonly found to be unable to cover at least one of their essential needs. Additionally, 61% of households explained to have experienced issues in obtaining sufficient cash. Among households with at least one member who had faced difficulties accessing markets in the month prior to the survey, mainly displaced households (58% of returnees and 57% of IDPs) reported the lack of access to cash as (one of) the reason(s) for this.

A widespread use of coping mechanisms was found across Libya, as only about one fourth of assessed households reportedly did not have to rely on (and had not yet exhausted) any type of livelihood coping strategies during the month before the survey took place, to meet their basic needs. Non-displaced households appeared to rely on emergency coping strategies to an equal degree as returnee households. Moreover, four of the five baladiyas with the highest proportions of households reportedly having employed (or exhausted) emergency coping mechanisms were located in the West. Here, a trend of diminishing purchasing power seemed to affect households, although this region was found to have lower levels of unmet essential (food) needs. These findings suggest that many of the Libyan population overall were struggling to meet their basic needs indeed, as being able to do so by employing negative coping strategies, is not a sustainable way to maintain acceptable living standards.

Overall, needs in Libya were found to be mostly driven by underlying structural factors, such as economic difficulties, as well as infrastructural deficiencies consequential to the protracted conflict. While the country is increasingly transitioning from a situation of acute humanitarian needs towards a recovery and stabilisation context,[9] protracted needs seem to remain across Libya, with about half of the interviewed households found to have unmet humanitarian needs in at least one sector.

[9] UNDP, "The Stabilization Facility for Libya: promoting sustainable and inclusive recovery," August 16, 2021.

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List of Acronyms

ACLED: Armed Conflict Location & Event Data Project
AWG: Assessment Working Group
C&M: Cash and markets
COD: Common operational dataset
CSI: Coping strategy index
CSO: Civil society organisation
DRC: Danish Refugee Council
DTM: Displacement Tracking Matrix
ECHO: European Civil Protection and Humanitarian Aid Operations
ESCWA: United Nations Economic and Social Commission for Western Asia
FAO: Food and Agriculture Organization of the United Nations
FCS: Food consumption score
FES: Food expenditure share
FGD: Focus group discussion
GBV: Gender-based violence
HCT: Humanitarian Country Team
HH: Household
HNO: Humanitarian Needs Overview
HRP: Humanitarian Response Plan
ID: Identity card
IDP: Internally displaced person
(I)NGO: (International) non-governmental organisation
IOM: International Organisation for Migration
ISCG: Inter-Sector Coordination Group
JIAF: Joint Intersectoral Analysis Framework
JMMI: Joint Market Monitoring Initiative
KI: Key informant
KII: Key informant interview
LCS: Livelihood coping strategies
LCSI: Livelihood coping strategy index
LNA: Libyan National Army
LSG: Living standard gap
LYD: Libyan dinar
MEB: Minimum expenditure basket
MHPSS: Mental health and psychosocial support
MoH: Ministry of Health
MSNA: Multi-Sector Needs Assessment
MSNI: Multi-sectoral needs index
NRC: Norwegian Refugee Council
OCHA: United Nations Office for the Coordination of Humanitarian Affairs
PSS: Psycho-Social Support Team
RDD: Random digit dialling
SNFI: Shelter and non-food items
TdH: Terre des Hommes
ToR: Terms of reference
UNDP: United Nations Development Programme
UNFPA: United Nations Fund for Population Activities
UNITAR: United Nations Institute for Training and Research
UNOSAT: United Nations Satellite Centre
USAID: United States Agency for International Development
USD: United States dollar
WASH: Water, sanitation and hygiene
WFP: World Food Programme
WHO: World Health Organisation

Geographical Classifications

Region: The highest administrative subdivision of Libya below the national level. There are three regions: the West ("Tripolitania"), the East ("Cyrenaica") and the South ("Fezzan").

Mantika: The second administrative subdivision of Libya, or the equivalent of a district. The country currently has 22 mantikas, which are regionally divided as follows, according to the UN COD[10]:

West: Al Jabal Al Gharbi, Al Jfara, Al Margeb, Azzawya, Misrata, Nalut, Sirt, Tripoli, Zwara.
East: Al Jabal Al Akhdar, Al Kufra, Almarj, Benghazi, Derna, Ejdabia, Tobruk.
South: Al Jufra, Ghat, Murzuq, Sebha, Ubari, Wadi Ashshati.

Baladiya: The third administrative subdivision of Libya, or the equivalent of a municipality. At the time of data collection for this MSNA, the country had 101 baladiyas.[11]

Muhalla: The fourth administrative subdivision of Libya, roughly equivalent to a neighborhood. Libya currently has 667 muhallas.[12]

Map 1: Libya's 22 mantikas

[10] OCHA, "Libya Common Operational Dataset," 2017.
[11] Ibid.
[12] Ibid.

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INTRODUCTION

Since 2011, Libya has experienced several waves of fighting, and the complex socio-political landscape has given way to an increasingly protracted conflict. The latter part of 2020 and most of 2021 have been characterised by continuous peacebuilding and unification efforts, built on the peace agreement reached in October 2020.[13] This initiated a peace process that was set to culminate in elections in December 2021[14], which eventually got postponed until mid-2022 or further towards the end of the year.[15]

The protracted nature of the conflict has resulted in significant economic challenges. At the macro-level, the United Nations Economic and Social Commission for Western Asia (ESCWA) estimates that the conflict has cost 783.4 billion Libyan dinars (LYD) (approx. 170 billion USD) since 2011. The losses are primarily attributed to the destruction of capital, the loss of productivity, and the decline in oil prices.[16] The 8-month long oil blockade in 2020, in particular, resulted in loss of revenue, leading to further problems related to liquidity in banks and payment of public salaries.[17] In 2021, there have been positive developments related to liquidity, such as the devaluation of the Libyan dinar.[18] This resulted in increased availability of cash, yet liquidity issues remained, especially in the Southern and Eastern regions.[19] Further economic improvements are expected as efforts to reunite the country's two competing financial institutions have been initiated by The Central Bank of Libya, despite the ongoing stalling of the political reunification in Libya in general.[20]

The conflict in Libya has additionally resulted in significant waves of displacement. As of September 2021, 38,920 families were found to be displaced, and 129,555 families were found to have returned to their area of origin.[21] The number of internally displaced persons (IDPs) has been steadily declining in Libya since the end of the siege on Tripoli around June 2020. Nonetheless, the rate of return does appear to be plateauing to some extent.[22] In the areas that have been most affected by conflict, return of displaced households is hindered by continuing security issues, lack of social cohesion, and infrastructure issues.[23] The gradual increase of returns also poses questions regarding the needs and well-being of families that have returned to certain areas, especially those areas that were heavily damaged or saw significant displacement.

Finally, these issues continue to be compounded by the ongoing spread of the COVID-19 virus. The first case in Libya was identified on 24 March 2020.[24] Different measures, including regional lockdowns and confinements, have been put in place since.[25] Up until 1 April 2022, there are more than half a million (501,705) confirmed cases in Libya and 6,415 deaths.[26] The Libyan government began its delayed rollout of vaccinations on April 10, 2021.[27] Roughly a year later, as of 23 March 2022, over 3.4 million doses of the vacccine have been administered.[28] The impacts of the COVID-19 pandemic are manifold. Firstly,

[13] International Crisis Group, "Keeping a Libya Settlement on Track," January 29, 2021.
[14] United Nations News, "Elections represent an opportunity for stability and unity in Libya," September 10, 2021.
[15] LibyaHerald, "Libya's postponed elections not expected for another 6 to 8 months," January 18, 2022.
[16] United Nations Economic and Social Commission for Western Asia (ESCWA), "The economic cost of the Libyan conflict," September 13, 2021.
[17] Al Jazeera, "Workers in Libya Struggle under Oil Blockade," April 3, 2020.
[18] Reuters, "Libyan liquidity crisis eases after exchange rate shift," February 3, 2021.
[19] Reuters, "Libyan central bank reunification process begins this month, says governor," December 13, 2021.
[20] Al Monitor, "Libyan Central Bank to begin reunification process," January 21, 2022.
[21] IOM-DTM Libya, "IDP and Returnee Report," Round 38, July-September 2021.
[22] Ibid.
[23] Ibid.
[24] Walid Abdullah, "COVID-19 infections in war-torn Libya rise to 10," Andolu Agency, April 1, 2020.
[25] IOM, "Libya — Mobility Restriction Dashboard 8 (1 - 30 September 2020)," IOM Flow Monitoring, October 6, 2020.
[26] WHO Health Emergency Dashboard, available here, [accessed 1 April 2022].
[27] Al Jazeera, "Libya kicks off delayed COVID-19 vaccination drive," April 10, 2021.
[28] WHO Health Emergency Dashboard, available here, [accessed 1 April 2022].

the fragmented health system struggles to accommodate the needs of affected people.[29] Additionally, the spread of COVID-19 in combination with continued violence pose significant threats to the safety of people in Libya.[30] Finally, the pandemic appears to have worsened the economic problems in Libya. According to REACH's Joint Market Monitoring Initiative (JMMI), the cost of the minimum expenditure basket (MEB) has increased by 28.1% compared to pre-COVID levels between March 2020 and December 2021.[31] In sum, the pandemic has added further challenges and complexity to the Libyan crisis.

Crucial humanitarian information gaps for displaced and non-displaced populations in Libya remain, as the political, economic, and social landscapes are constantly evolving in line with regional and global developments, and continue to be impacted by the COVID-19 pandemic. Building on its experience conducting Multi-Sector Needs Assessments (MSNAs) in Libya since 2016, REACH, in coordination with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), on behalf of the Humanitarian Country Team (HCT), the Inter-Sector Coordination Group (ISCG) and the Assessment Working Group (AWG), conducted the 2021 MSNA to update humanitarian actors' understanding of the needs that exist among the Libyan population. Data collected through the assessment fed into the 2022 Humanitarian Needs Overview (HNO). Additionally, findings were presented and disseminated to humanitarian actors in order to inform evidence-based humanitarian response planning. The 2021 Libyan population MSNA was funded by the Directorate General for European Civil Protection and Humanitarian Aid Operations (ECHO), the United States Agency for International Development (USAID) and OCHA.

This report presents the key findings from the 2021 MSNA. Findings from both the quantitative and qualitative data collection were analysed together to provide a comprehensive overview of needs in Libya. The report starts with a brief overview of the methodology, including an overview of the analytical framework and the limitations to keep in mind while going through the report. A summary of the top-level quantitative findings will then be presented, leading into a focus on information related to protection, health, and food security. The sections related to sectoral needs will focus especially on the findings from qualitative data collection, including those related to the topics of mental health and social networks, and gender and access to services. The findings section concludes with an overview of economic vulnerabilities and coping strategies in Libya. Finally, the conclusion to the report will summarise the key findings and highlight information gaps to be explored in further assessments.

[29] Amnesty International, "Libya: Historic Discrimination Threatens Right to Health of Minorities in the South amid COVID-19," April 2020.
[30] ICRC, "Libya: COVID-19 and Conflict Collide, Deepening Humanitarian Crisis," August 20, 2020.
[31] According to REACH's Libya Joint Market Monitoring Initiative (JMMI), December 2021. Access this factsheet here.

METHODOLOGY

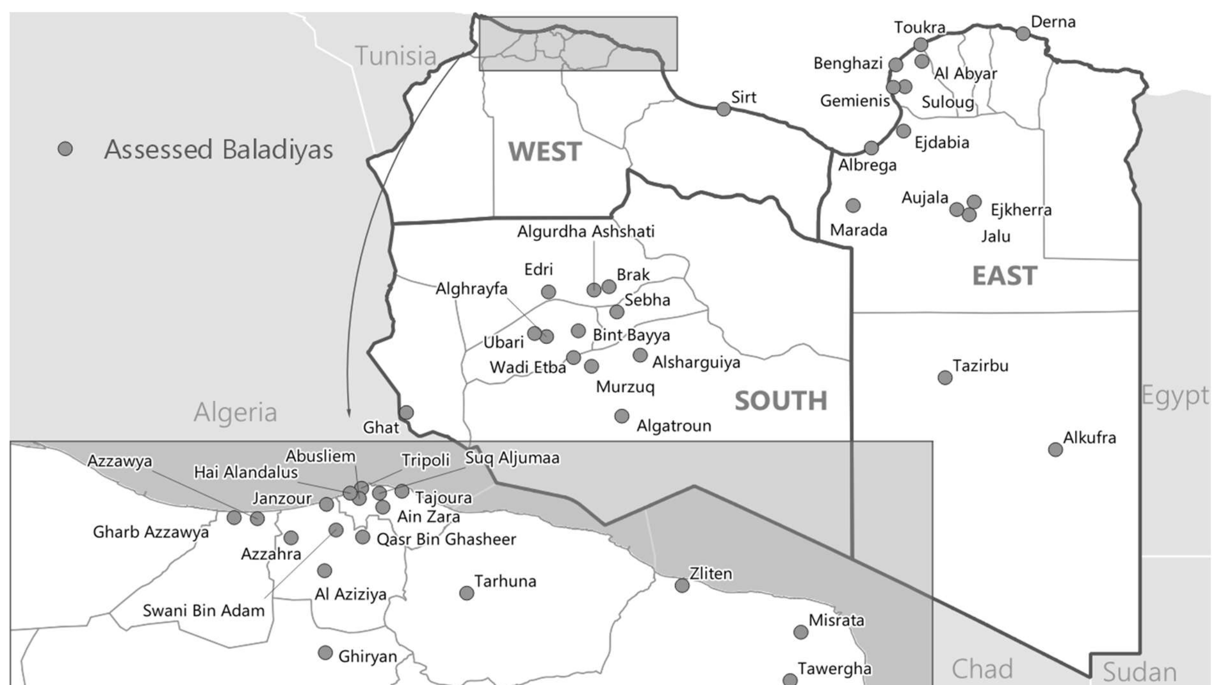
The overall aim of the 2021 Libyan population MSNA was to provide an understanding of the vulnerabilities, most pressing needs and the severity of these needs of Libyan IDP, returnee and non-displaced households, both within each sector and from a cross-sectoral perspective. The specific objective was to assess the overall severity of humanitarian needs and identify current and forecasted priority needs/concerns, by taking into account the assessed population's living standards and well-being; their pre-existing vulnerabilities; and the level of use of negative coping strategies. The analysis considers how findings differ by assessed baladiya and population group. The Methodology overview gives a detailed overview of the full methodology applied. Vulnerabilities and (severity of) needs of refugees and migrants residing in Libya were assessed in a separate 2021 MSNA.[32]

Scope

Quantitative data collection

In total, the 2021 MSNA includes data from 8,871 households that were interviewed across 45 baladiyas across the country, as presented on Map 2 below. Locations were selected taking several prioritisation criteria into account: a severity ranking of baladiyas recommended by OCHA and based on the 2021 HNO data, as well as a composite indicator developed by REACH to support prioritisation of baladiya, based on i) OCHA's severity ranking, ii) the size of IDP and returnee population, iii) the percentage of households with two or more sectoral needs according to the 2020 Libyan population MSNA,[33] iv) a severity ranking system based on the 2020 Refugee and Migrant MSNA,[34] and v) security information based on the ACLED incidents dataset[35]. The final baladiyas were selected in close collaboration with OCHA, the HCT, ISCG and AWG, while pursuing a balance between the number of baladiyas per region, a full coverage of the Tripoli and Benghazi mantikas, and the sectors' inputs.

Map 2: Assessment scope and geographic coverage



[32] Publications of REACH's 2021 Refugee and Migrant population MSNA can be accessed here.
[33] Publications of REACH's 2020 Libyan population MSNA can be accessed here.
[34] Publications of REACH's 2020 Refugee and Migrant population MSNA can be accessed here.
[35] ACLED (Armed Conflict Location & Event Data Project), "Data Export Tool," April 15, 2021.

All household-level surveys were conducted remotely over the phone between 14 June and 2 August 2021, due to COVID-19 mitigation measures. Three population sub-groups of interest were surveyed: IDPs, returnees, and non-displaced Libyans. For the purpose of this assessment, displacement was defined as displacement from the baladiya or muhalla of origin since 2011. Sampling was primarily purposive, with quotas for each population group in each baladiya, rendering findings that are indicative, rather than representative, of each population groups' experiences and situation within each baladiya. The quantitative part of the assessment consisted of a multi-sectoral questionnaire, covering the following sectors and thematic areas: food security, cash and markets (C&M), livelihoods, shelter and non-food items (NFIs), water, sanitation and hygiene (WASH), education, health, and protection (including gender-based violence (GBV), child protection, and mine action). Partners' support to quantitative data collection came from international non-governmental organisations (INGOs), Libyan civil society organisations (CSOs), and individual volunteers.

Qualitative data collection

Qualitative data collection consisted of 88 key informant interviews (KIIs) with subject-matter experts (such as social security workers, medical staff, farmers, or food vendors/importers) and individuals with relevant experiences (such as local council representatives or community leaders). These KIIs were conducted in 21 baladiyas (8 in the South, 7 in the West, 6 in the East) in October and November 2021. The topics and locations were informed by findings from the quantitative data (household surveys) of the MSNA, resulting in this part of the assessment being focused on the protection, health, and food security sectors. Additionally, the more sensitive topics of mental health and psychosocial support (MHPSS), and gender and access to services (including GBV) were investigated through KIIs. Moreover, 34 focus group discussions (FGDs) were executed, either with mixed genders or female participants only, in 12 baladiyas throughout November 2021, to collect further data about these last two topics. For this qualitative part of data collection, partners' support came from the Libyan CSOs Lifemakers, Athar, Enmaa and LIBAID, as well as the Psycho-Social Support Team (PSS) and Terre des Hommes (TdH).

Quantitative analysis

The analytical framework used for the quantitative analysis of the 2021 Libyan population MSNA household survey data is inspired by the Joint Intersectoral Analysis Framework (JIAF) – a global analytical framework to which also REACH contributed and which was lastly edited in 2021, to enhance the understanding of needs of affected populations.[36] In line with the JIAF, the MSNA measures progressive deterioration of a household's situation towards the worst possible humanitarian outcome. To achieve this, the analysis relies on two core components: the living standard gap (LSG) and the multi-sectoral needs index (MSNI). Using the scores found through these composite indicators, households are divided into different severity ratings, which classify their overall severity of humanitarian needs, from 1 ("None/Minimal") to 2 ("Stress"), 3 ("Severe") and 4 ("Extreme"). The MSNA's aim is to have this range of severities of humanitarian needs help actors understand the different objectives and priorities to be pursued by the humanitarian response.

The core elements of the MSNA's analytical framework can be defined as follows:

Living standard gap (LSG)

LSGs are composite indicators capturing households' unmet needs per sector assessed. For each sector, specific indicators were identified that measure needs ('gaps'), for which categorisations were made on a binary scale: does not ("0") or does ("1") have a gap. The threshold used to determine whether a

[36] The JIAF has been developed by the Joint Inter-Sectoral Analysis Group (JIAG). Led by OCHA and the Global Cluster Coordinators Group (GCCG), the JIAF aims to assist with identification of inter-linkages between various drivers, underlying and contributing factors, sectors, and humanitarian conditions. The JIAF seeks to enable humanitarian actors to arrive at a common understanding of who, and how many people face humanitarian needs, and which needs are most critical.

household was considered to have a sectoral gap was agreed on for each indicator together with the relevant sector partners. In addition to these 'non-critical' indicators, a set of 'critical' indicators were selected, which, on their own, indicate a gap in the sector overall. The LSG severity score was then determined for each household by taking the higher of the two scores (i.e. the aggregated non-critical indicator score or critical indicator score). A household with a severity score of 3 ("severe") or 4 ("extreme") in a given sector was considered as having an LSG in that sector, and is referred to as having a sectoral need. For example, a household was considered having a WASH need if it did not have access to a functional and improved sanitation facility (which is a critical indicator, immediately resulting in an extreme severity score of 4), or if minimum three out of the following four non-critical indicators were found to apply: a) having to rely on unimproved sources of water or on the public water network with access less than 4 days per week, b) not having access to soap, c) not having working lights and/or locks in their latrine/toilet, and d) not having access to sufficient water to meet their drinking, hygiene, and/or cooking needs (which would result in a severe severity score of 3). A complete overview of the critical and non-critical indicators that compose these sectoral composite indicators (or LSGs), is given in Annex 9 of the Methodology overview.

Multi-sectoral needs index (MSNI)

The MSNI is a composite measure of each household's overall severity of humanitarian needs across the different sectors. It is expressed on a scale from 1 ("None/Minimal") to 4 ("Extreme"), by taking the highest severity of sectoral living standard gaps (LSGs). For example, if a household has a protection and health need (so two LSGs), with a severity score of 3 and 4, respectively, its overall MSNI score will be 4. Hence, regardless of whether a household has an extreme LSG in just one sector or across multiple sectors, its MSNI score will be the same. The MSNI considers multi-sectoral needs from a big-picture perspective, by including all households with at least one sectoral need. This approach provides information on proportions of households having humanitarian needs overall, allowing for comparison across locations and population groups.

Additional analysis

Furthermore, additional analysis was conducted to identify the overall proportion of households by severity of needs, types of needs (i.e., sectoral needs), and total number of living standard gaps (LGSs), as well as the most commonly occurring needs profiles (specific combinations of LSGs). More details on the aggregation methodology can be found in the Methodology overview.

Qualitative analysis

The objectives of the qualitative phase were to triangulate findings derived from quantitative data collection and further understand the specific humanitarian needs of vulnerable population groups by providing in-depth context to specific follow-up questions. The qualitative data analysis was carried out using the software NVivo. This allowed for an iterative yet structured approach, by coding the key informant interview (KII) and focus group discussion (FGD) transcripts according to emergent themes across thematic topics of protection, health, and food security, as well as mental health and social support networks, and women's access to services for the conducted case-studies. Coding of different discussion points was done using codebooks with a coding hierarchy, which listed the key topics addressed throughout the interviews. This approach allowed for a structured and logical analysis, while still offering enough flexibility to account for unforeseen topics and insights offered by the respondents, as well as diverting discussion points across regions. Lastly, codes and summaries were exported from NVivo into a data saturation grid, which allowed to summarise the main points from across the FGDs and KIIs. The qualitative analysis followed IMPACT Initiatives' Data Saturation and Analysis Guidelines.

Limitations

As data collection was conducted remotely over the phone due to COVID-19 contingency measures, particular challenges and limitations were faced. These included a limited length of the questionnaire, impossibility to address sensitive topics, and a possible overrepresentation of the more vulnerable households due to purposive sampling (as the selection of respondents mainly relied on contact lists provided by humanitarian organisations and CSOs working in humanitarian aid and referrals by respondents). Furthermore, households without phone access and/or network connection already got excluded to this MSNA exercise by default.

Purposive convenience sampling was done to address the impossibility of complete random data collection, keeping quotas for each population group per baladiya. As the subjectivity and non-probability based nature of unit selection associated with this type of sampling leads to difficulties to defend its sample's representativeness, the sample got supplemented with random digit dialling (RDD) – a sampling method where phone numbers are randomly generated and dialled to get a random sample of the population with working cell phones. This method was employed to conduct 1,010 out of the total 8,871 household surveys; RDD could only be used to a limited extent as the MSNA did not cover all baladiyas across the entire country, which meant that a significant proportion of reached households could not be surveyed, as they would have fallen outside of the scope. More information about the sampling strategies used, can be found in Annex 3 of the Methodology overview. Additionally, another limitation of the MSNA household survey consists of the limited proportion of women interviewed (17%), as culturally, men usually answer on behalf of their household to an outside person.

Overall, in light of these limitations and challenges, it is important to note that the 2021 MSNA results are not representative per baladiya or population group and therefore not generalizable with a known level of precision. Hence, all findings presented in this report should be considered indicative only.

FINDINGS

This section highlights the key quantitative and qualitative findings from the 2021 MSNA, with the objective to provide an overview of needs in Libya. It will start with a brief introduction to the top-level quantitative findings regarding humanitarian needs, which will be presented for the whole sample first, and then by population group and geographical area. The section will then focus on the three sectors for which households' needs were most commonly found: protection, health, and food security. To better understand needs in these sectors, focus on the three sectors for which households' needs were most commonly found: protection, health, and food security. In general, the qualitative results seem to point out that needs in Libya are rather driven by underlying structural factors, such as economic difficulties and infrastructural deficiencies, as a consequence of the protracted conflict. To elaborate on this point, findings related to economic drivers of identified needs will subsequently be presented. The overall picture that emerges from the MSNA data is that Libya is increasingly transitioning from a situation of acute humanitarian needs to a recovery and stabilisation context. However, at the same time, needs seem to remain protracted across the country, as still about half of the households assessed were found to have humanitarian needs in at least one sector.

While this report does not aim to cover the entirety of quantitative data collected in 2021, more detailed information on sectoral quantitative findings can be found in the factsheets, while the bulletin provides a top-level overview of needs.

Overall humanitarian needs

To provide a general overview of humanitarian needs across the assessed population groups and baladiyas in Libya, the 2021 MSNA data is summarised using the multi-sectoral needs index (MSNI), a composite indicator designed to measure the overall magnitude of humanitarian needs of households across sectors. Its methodology is based on identifying the biggest need for each household, which is done by the calculation of living standard gaps (LSGs) or humanitarian needs per sector. Each household is assigned a severity score ranging from extreme, to severe, stress, or minimal (of 4, 3, 2 or 1, respectively)[37] for the following sectors examined within this MSNA: protection, health, food security[38], SNFI, education and WASH. The full methodology behind the calculation of composite indicators MSNI and LSGs, in accordance with the REACH MSNA Analytical Framework Guidance, and the specific indicators constructing the LSGs, can be found in the Methodology overview.

Multi-sectoral needs

Overall, 51% of assessed households were found to have humanitarian, multi-sectoral needs. More specifically, 34% had severe needs and 17% had extreme needs, with an MSNI of 3 and 4, respectively. However, these seemingly high results were primarily determined by households having needs in one sector only. Indeed, when looking at households found to be in need, the majority (55%) only had one sectoral need (i.e., LSG), as opposed to overlapping or intersecting humanitarian needs.[39] Overall humanitarian needs were found to be primarily driven by needs in two sectors, as 46% of those having an MSNI of 3 or 4 were found to have protection needs, and 38% to have health needs. Furthermore, among households with protection needs, 41% were found to only have this need, without any other co-occurring sectoral need(s). Hence, when interpreting the MSNI or multi-sectoral findings, it is important to keep this most common profile of single sectoral needs in mind. Table 1 below shows the

[37] For example, a household can simultaneously have a protection need with a severity of 4 (extreme), a health need with a severity of 3 (severe) and a food security need with a severity of 4 (extreme) and hence have three sectoral needs, or an LSG in three sectors, together with a severity of 2 (stress) for SNFI, education and WASH. Comprehensively, this household will have an MSNI of 4, as this is its highest sectoral severity score.

[38] Including aspects of the cash and markets and livelihood domains.

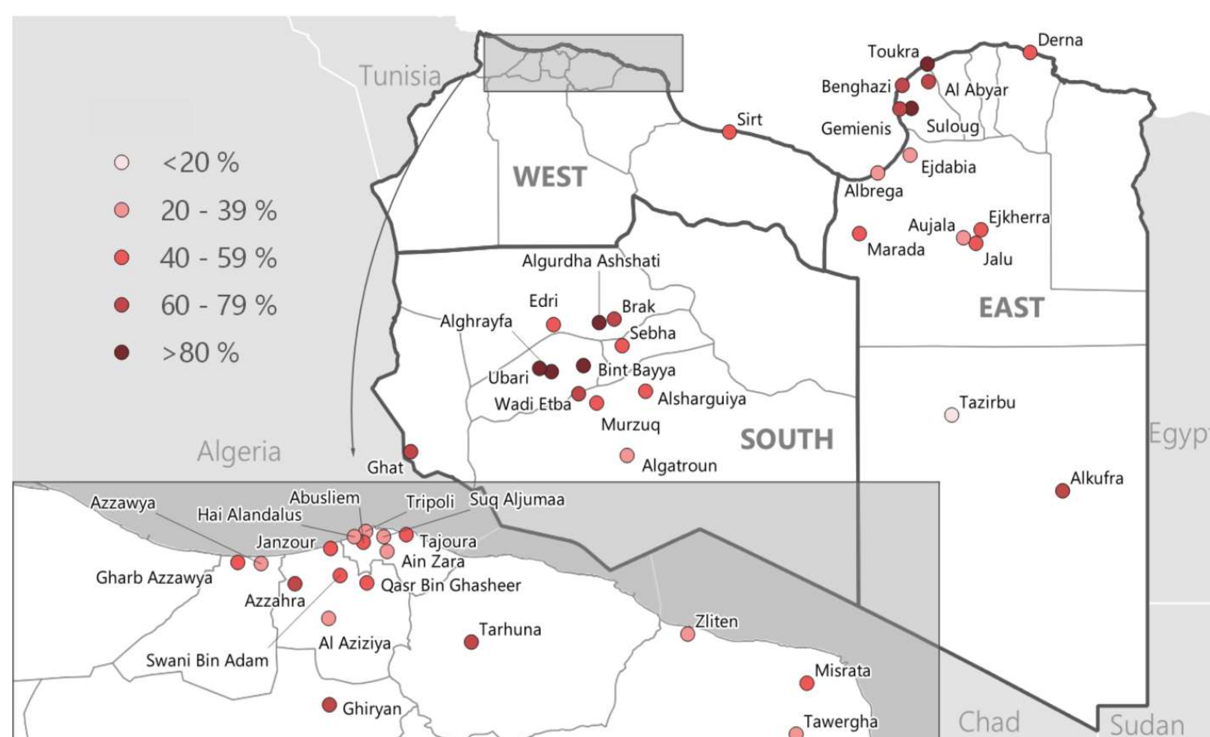
[39] As per MSNI methodology, any household with at least one sectoral need was classified as having humanitarian needs overall.

percentages of assessed households by severity of humanitarian needs overall, and disaggregated by population group and region, while Map 3 displays an overview at baladiya level. The highest proportion of households in need was found in the Southern region (67%), with especially high percentages in Ubari (93%) and Alghrayfa (91%) – both located in the mantika of Ubari, followed by Suloug (87%) in the Eastern mantika of Benghazi.

Table 1: Proportions of households per severity of humanitarian needs

	1: Minimal	2: Stress	3: Severe	4: Extreme	3 & 4: In Need
Overall	**37%**	**12%**	**34%**	**17%**	**51%**
East	28%	11%	41%	20%	61%
South	14%	20%	44%	23%	67%
West	45%	11%	30%	14%	44%
IDP	40%	9%	25%	26%	51%
Returnee	25%	12%	36%	27%	63%
Non-displaced	39%	12%	35%	15%	50%

Map 3: Proportions of households with humanitarian needs (MSNI score of 3+), per baladiya



When zooming in on households with **extreme** needs, it can be observed that, again, the South stood out as the region having the highest proportions of households in need. Indeed, 23% of Southern households were found to have extreme humanitarian needs (i.e. an MSNI score of 4), as opposed to 20% in the East and 14% in the West. The latter was also the region where the highest proportion of assessed households with no or minimal needs was recorded (45%).

When moving the analysis from the regional to the baladiya level, it can be observed that the five baladiyas having proportionally most households with extreme needs, were not located in the South: Tarhuna (58%) lies in the West, whereas Suloug (52%), Gemienis (45%), Toukra (39%) and Alkufra (37%) are situated in the East. These baladiyas appear to be outliers to the general regional pattern, primarily due to their high needs in one single sector. More specifically, for Tarhuna, 47% of households were found to have extreme WASH needs, whereas findings for the Eastern baladiyas appeared to be mainly driven by extreme food security needs. In the South, relatively high proportions of households with extreme needs were more consistently found across all its baladiyas, as opposed to being clustered in some locations only.

Key informant interviews conducted in Gemienis, Suloug and Toukra revealed that high food prices and low income were the main drivers of food insecurity within these baladiyas. Reported reasons for this were the combination of COVID-19 restrictions, political instability and security issues that increased the scarcity of imported food products on the one hand, and the lack of liquidity in banks, delayed salaries of citizens, dollar exchange rate and overall economic situation of the country on the other had. These different factors caused a deterioration in food security needs (compared to the previous year), which was mentioned by the majority of key informants. Female-headed, IDP, and poor households reportedly were the groups most likely to struggle in accessing sufficient food.

On the whole, returnee households were found to be the population group having the highest percentages of households in need across all sectors (63%). When dividing this proportion into the two severity categories humanitarian needs are composed of (i.e., severe and extreme), it can be noted that for returnee households, the proportion having severe and extreme needs is approximately equal to the share of non-displaced households and IDP households in those categories, respectively (see Table 1).

Sectoral needs

When unpacking the overall humanitarian needs of Libyan households, it is possible to examine and compare the sectoral needs or living standard gaps (LSGs) that are the drivers behind the overall needs.[40] Figure 1 gives a summary of the proportion of households per sectoral need, disaggregated by region and population group, as well as of the baladiyas with the highest percentages of households having needs in each sector.

Protection issues were found to be the main driver of humanitarian needs, followed by health and food security needs. Hence, qualitative data collection was carried out to further investigate these priority sectors, on which dedicated sections of this report will focus. These sectoral needs were found to be related to safety issues (the security situation remaining unstable, resulting in about one quarter of households reportedly having at least one safety or security concern), the deteriorated access to health facilities (due to the lingering COVID-19 pandemic, overcrowding, unaffordability of services, lack of medical staff and specialised services) and the unaffordability of food products and farmers' barriers to increase local agricultural supply – issues that appeared to be strongly intertwined.

As it was the case for the distribution of humanitarian needs in general, Alghrayfa and Ubari, both located in the Ubari mantika (South) and Suloug in the Benghazi mantika (East) consistently appeared among the top five baladiyas having the highest proportions of households in need across different sectors. However, as mentioned already, households in many baladiyas only had one sectoral need or LSG. Indeed, when zooming in on households found to have humanitarian needs, 55% only had needs in one sector, 30% had two co-occurring sectoral needs, and only 15% was found to have needs in more than two sectors.

[40] The series of sector specific indicators the LSGs are composed of are listed, together with their calculation methods, in the Methodology overview.

Figure 1: Proportions of households with sectoral needs across overall assessment sample

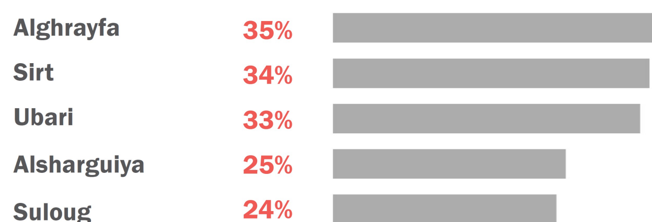
When looking at displacement status, assessed returnee households were most commonly found to have needs across all sectors, in particular for protection, health, and SNFI. Indeed, returnees are especially prone to challenges related to a lack of security or social cohesion, unavailability of basic services, and damaged infrastructure and shelter in their area of origin,[41] which might have been spurring the initial displacement.

Moreover, the non-displaced population group appeared to present more simple needs profiles in general, while returnee households tended to show a more complex picture; respectively 11% and 26% of assessed non-displaced and returnee households with multi-sectoral needs were found to have LSGs in more than two sectors (i.e., three or more sectors). When investigating households' sectoral needs geographically, needs profiles were also found to be more complex in the Southern region compared to the West, with 19% and 12% of assessed households having needs in more than two sectors, respectively.[42] Overall, it seems that the population groups and regions with the highest proportions of households in need were also those displaying the most complex needs profiles.

Figure 2 below presents the five baladiyas with the highest percentages of households having co-occurring needs in more than two sectors.[43] These baladiyas also appeared in Figure 1 as standing out for their high proportions of households with sectoral needs or LSGs, which contributes to the finding that where needs are widespread, the pattern of co-occurring needs across sectors also becomes more complex, making them a priority to point out.

[41] IOM-DTM, "Libya - IDP and Returnee Report 38 (July – September 2021)," September 30, 2021.
[42] Among households with multi-sectoral needs (i.e., having at least one sectoral need).
[43] Ibid.

Figure 2: Baladiyas with highest proportions of households having more than two co-occurring sectoral needs, among households with multi-sectoral needs



Lastly, Table 2 gives an overview of the different needs profiles that emerged from the household data. In particular, it shows that protection needs, as mentioned earlier, can be identified as the most isolated sectoral need (or living standard gap, LSG) across the MSNA, with 41% of households with a protection LSG not having any other sectoral needs. Also, more than one quarter of households with health needs or education needs, 27% and 28% respectively, only had this particular sectoral need or LSG. On the other hand, SNFI needs more often seemed to co-occur with needs in other sectors. As an example, more than one third (39%) of those households with SNFI needs were also found to have a health need.

Table 2: Single and co-occurring sectoral needs

	Protection needs (23%)	Health needs (20%)	Food Security needs (13%)	SNFI needs (12%)	Education needs (8%)	WASH needs (7%)
	Of the % of HHs with this sectoral need, the following % of HHs were found to have: [44]					
% of HHs with only this sectoral need	**41%**	**27%**	**22%**	**15%**	**28%**	**17%**
% of HHs with also a **protection needs**	100%	34%	29%	33%	23%	23%
% of HHs with also a **health needs**	30%	100%	32%	39%	24%	31%
% of HHs with also a **food security needs**	17%	21%	100%	26%	28%	27%
% of HHs with also a **SNFI needs**	18%	24%	24%	100%	17%	27%
% of HHs with also an **education needs**	9%	11%	19%	12%	100%	17%
% of HHs with also a **WASH needs**	7%	11%	15%	16%	14%	100%

[44] Explanation on how to read this table: the first row gives for each sectoral need (or LSG) the proportion of households only having that sectoral need, among the subset of households found to have this particular sectoral need (or LSG). For example: of the 23% of households found to have a protection need (or LSG), 41% only had a protection need (and no other sectoral need). The rows below look into the proportions of households also having another, co-occurring sectoral need (or LSG), per subset of households found to have a particular sectoral need (or LSG). For example: of the 23% of households found to have a protection need (or LSG), 30% also had co-occurring health needs.

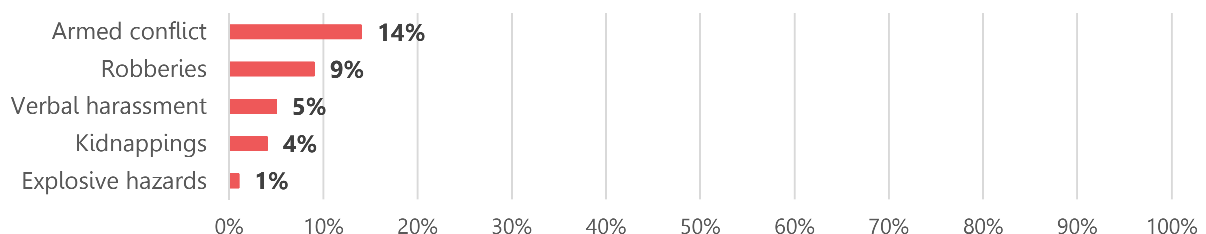
Protection

In 2021, Libya's protracted conflict continued to pose protection risks to the Libyan population.[45] The country continued to suffer from a lack of unified political leadership as the political situation remained unstable. [46]In December 2021, Libyan forces affiliated with different armed groups were deployed in Tripoli amid Libyan elections postponement decisions, creating tensions, and increasing the risk of clashes.[47] In fact, protection needs were the most found sectoral needs among assessed households (23%). Findings suggest that needs were primarily driven by a lack of documentation, as 17% of households reported that at least one household member did not have a valid ID.

Lack of documentation was most found in the South (26%). According to KIs from the South, this is mainly explained by the loss of important identification documents due to displacements caused by armed conflicts. In general, protection needs were found to be especially severe in the South, which might be partly attributed to the fragmented governance and security landscape in the region.[48] Indeed, the South particularly stands out in terms of safety and security indicators. Overall, 55% of assessed households in the South reported safety and security concerns, and 23% reported concerns specifically in relation to armed conflict, this figure tends to be quite high compared to the 14% of households who reported concerns specifically related to armed conflict overall. Additionally, 30% of households reported either feeling "unsafe" or "very unsafe" in their baladiya.

When zooming in on specific baladiyas, Wadi Etba and Ubari stood out especially, with respectively 59% and 57% of households found to have protection needs (LSG). More surprisingly, when looking at different population groups, it was found that the proportion of assessed IDP households found to have protection needs overall was relatively low compared to other population groups (among all IDP HHs, 19% have protection needs, compared to 22% non-displaced and 28% returnee households). Though the reason for this is unclear, it might be partially due to IDPs underreporting of more sensitive issues such as a lack of documentation or armed conflict due to their insecure status.

Figure 3: Top 5 most commonly reported safety concerns, by proportion of households



Error! Reference source not found. gives an overview of the top five most reported safety concerns across the assessed households. Overall, armed conflict stood out as the main protection concern, being reported by 14% of assessed households. Concerns for armed conflict and the presence of armed actors were found to be the highest and notably above the average in Tarhuna (60%), Wadi Etba (56%) and Ghiryan (37%). Again, the South was the region with the highest proportion of households reporting concerns related to armed conflict (23%), which was particularly high in the mentioned baladiyas of Wadi Etba and Algatroun. These findings can be understood in reference to the *"structural drivers of conflict*

[45] UN Security Council 8996th Meeting, "Amidst Political Crises, Libya's People Demand Elections, 'Not Endless Arguments among Elites, Well-Armed' Groups, Delegate Tells Security Council", March 16. 2022
[46] Ibid
[47] UNSMIL, "UNSMIL Statement on the Unfolding Security Situation in Tripoli," December 21, 2021.
[48] Frederic Wehrey, "Insecurity and Governance Challenges in Southern Libya," Carnegie Endowment for International Peace, March 30, 2017.

related to its weak and fractured security sector; the absence of a meaningful local economy, despite the presence of oil fields, and effective border control; and harmful meddling by northern and outside actors" as reported by one of the KIs. Moreover, the safety and security landscape in the South is characterised by a lack of central control and a complex tribal landscape that plays a significant role in community forming and establishment of political alliances[49] as the region is ethnically and tribally mixed, which continues to spread resentment over unequal access to citizenship rights caused by the systematic marginalisation of two major non-Arab communities in the south, the Tabu and the Tuareg.[50]

Findings from 18 semi-structured KIIs with local council representatives, government representatives, and CSO workers, conducted in three baladiyas in the southern region (Wadi Etba, Ubari, and Alghrayfa), indicate that the main safety and security concerns in these baladiyas were petty crimes, such as robberies. In Alghrayfa however, the KIs commonly reported petty crimes alongside more violent crimes, including armed robberies of shops and murder. Risks related to travelling outside the municipality were also reported as a cause of concern. Indeed, a government employee from Wadi Etba noted that "*the lack of security on the roads [...] reduces the movement of workers to and from the municipality. Likewise, [...] some truck drivers are afraid to move on the roads leading to the municipality, for fear of armed robbery, theft, and kidnapping"*.

Fears of communal fighting and conflict-related violence were additionally reported in Alghrayfa and Ubari, where KIs mentioned continuing social tensions and issues related to law enforcement, such as the absence of police regulations and reinforcement of safety measures within the baladiya. A KI in Alghrayfa reported that *"the abundance of robberies and theft, especially those committed by arms, has made residents feel insecure and in constant anxiety."* Moreover, communal tensions and non-conflict-related incidents were reported to cause households to feel unsafe. While official law enforcement agencies such as the police were still reported as the main security agent, the tribe was noted as having an important role in conflict resolution and maintaining stability within the community. This furthers highlights the lack of law enforcement that continues to mark the southern region, in the absence of a main regulatory body.

Overall, most KIs reported that the safety situation had improved during the year prior to the interview- only one informant in Alghrayfa reported that the situation had deteriorated, specifically referring to a lack of social cohesion in the baladiya. Although the security situation appears to have improved, according to KIs, there remained protection concerns for the population, such as inter-communal tensions and armed conflicts. Furthermore, the changing security landscape has reportedly impacted safety and security issues.

Co-occurring needs

Overall, security and safety risks or incidents were found to be closely related to other needs and, in particular, to issues related to services. Most KIs reported perceiving that COVID-19 has not had a direct impact on the security situation, though most did argue that the pandemic had affected public health as well as living standards and well-being. The KIs who reported perceiving that the security situation had been impacted by the pandemic argued this to be the case due to increased looting of shops and farms while people stayed home.

Indeed, KIs pointed out that safety concerns predominantly impact access to and functioning of markets, households' ability to secure livelihoods and food, as well as access to health services. Regarding the latter, for example, KIs in Wadi Etba reported that health workers had gone on strike in the past because of armed attacks. The biggest impact, however, appeared to be on the functioning of markets, due to

[49] Al-Hamzeh Al-Shadeedi and Nancy Ezzeddine, "Libyan Tribes in the Shadows of War and Peace," February 18, 2019.
[50] Frederic Wehrey, "Insecurity and Governance Challenges in Southern Libya," Carnegie Endowment for International Peace, March 30, 2017.

the safety concerns reported when travelling between baladiyas. Dangerous travel means that goods do not reach the markets or do it at the cost of a significant price increase. As most food is imported in Libya,[51] this situation also typically affects food security. As a government employee from Ubari pointed out, "*when the security situation is bad, it is difficult to import food items from neighbouring cities, such as Sabha or Tripoli. This will affect the prices, which will be more expensive as a result of the security situation and risks, or there will be difficulties in delivery*." Reportedly, this situation would in turn affect households' mental health and behaviours.

In fact, all KIs reported that current or past protection issues have (had) a serious impact on mental health. KIs mentioned women and children to be especially vulnerable, and some reported having witnessed behavioural changes of people in their area, including using more verbal and/or physical violence and increasing substance abuse, with a negative impact on all family members. As a KI from Alghrayfa noted *"we have now seen behaviour and habits that are alien to our society, far from our religion and values that we inherited from our parents and grandparents"*.

When looking at population groups that can be considered particularly exposed to protection concerns, IDP households were mentioned by many KIs as being especially vulnerable to safety and security risks. According to KIs in Wadi Etba, IDPs' vulnerability partly comes from the fact that they do not have access to the same social support systems and family networks that many non-displaced households have access to. An informant in Wadi Etba reported that *"there are displaced families that are considered foreign to the region, and these will not feel as safe as those who live there. The nature of Libyan society considers the family or tribe to be the primary source of protection for individuals."* Additionally, female-headed households were reported by a few KIs as being especially vulnerable, particularly when it concerns widowed mothers. This was partly explained on the grounds that women are more vulnerable to safety and security incidents because they have less access to reporting mechanisms.

Reporting to police officers or at police stations was most mentioned as the main modality to raise complaints related to safety concerns. However, this does not mean that the system is fully functional or equally accessible for all individuals – especially not for women. In fact, several KIs reported that access to reporting mechanisms for security or safety incidents is not equal for men and women. Some pointed out that women have less access to reporting mechanisms, while others stated that tribal affiliations or 'power' within the baladiya influences the ability or willingness to report incidents, as in some cases women would prefer not to report incidents at all, due to fear of social stigma and revenge. Indeed, a female informant in Ubari noted that women usually prefer that a "member of her family, brother or father, reports on her behalf, and, in many cases, not all the incidents are reported, because of the fear of spreading the news and becoming the talk of the community". Furthermore, tribal councils/groups, as well as informal mechanisms through local notables or family, were also often mentioned as potential avenues for reporting incidents. In Wadi Etba, most KIs also mentioned the possibility of reporting incidents to the local social affairs council for groups such as people with disabilities and IDPs.

Case study: Women and access to services

To understand to what extent opportunities and access to services are restricted for women in Libya, 12 KIIs were conducted with female respondents to investigate women's access to services, reporting mechanisms, and key safety and security concerns. KIIs were conducted with female representatives of local councils, civil society activists, and employees of women-led organisations. In addition to KIIs, REACH partner organisations, the Psycho-Social Support Team (PSS) and Terre des Hommes (TdH), conducted 21 FGDs in Sebha, Brak, Ubari, Alghrayfa, Tripoli and Misrata, targeting female community members.

[51] GIEWS, "Slightly below-average cereal production harvested in 2021," December 2021.

Across the assessed locations, the key basic services and opportunities that women reportedly struggle to access were education, healthcare, and livelihoods.

In the case of education, early marriage and financial issues were commonly reported barriers that may limit access to education for women. Furthermore, findings indicate that the unavailability of a university within their baladiya or the poor quality of education play a significant role in hindering women's access to higher education. A member of the Women's Union in Alghrayfa reported that *"at university level, not all the specialisations are available in the municipality, which represents an obstacle for women wishing to pursue their higher education, especially in light of the difficult security conditions in Sebha and the Northern cities, as well as the high cost of living in these baladiyas"*.

Regarding healthcare, informants mentioned high prices and financial issues as the main barriers limiting women's access to healthcare services. Additionally, the unavailability of specialised health services in many baladiyas and the consequent need to travel to far-away cities to access them also reportedly limit women's ability to access these services. In particular, access to reproductive healthcare and gender-segregated services is reportedly generally limited at public hospitals, thus forcing women to go to a private clinic, or travel to another city for treatment, which reportedly entails significant costs.

When informants were asked about women's access to livelihoods, most of them reported that the main cultural barrier faced by women is related to the gender norms classifying some types of jobs as being "unsuitable for women" (such as work taking place in remote areas, far from the home, such as oilfields). In addition, more general concerns, such as the lack of job opportunities, financial issues, including the liquidity crisis and the increase in inflation, reportedly hinder women's (as well as men's) access to livelihoods. On the other hand, women were also reported to face specific barriers to accessing banking and legal services, especially in the case of female-headed households (widowed or divorced). A female community member in Misrata reported that she is *"deprived of [her] inheritance and now is struggling with the judicial authorities"* to access her inheritance.

Overall, KIs commonly reported a perceived deterioration in access to such services in 2021, which they mostly attributed to the COVID-19 related restrictions, which often resulted in the closure of service providers, such as banks and courts, as well as to the unstable political and economic situation. For instance, widowed women reportedly struggled to access their pensions during the closure of banks and amid the liquidity crisis.

Furthermore, findings suggest that, in general, GBV services are unavailable and that, when they are available, women seeking to access such services often experience challenges to access them. Accessing GBV services[52] seems to be hard as no tangible efforts are being made to ease women's access to core GBV services, according to qualitative findings from KIIs. According to KIs, access to these services appears to be hindered by conflict-related, economic, social, and political factors, as well as COVID-19 related restrictions during last year.

> Quote from NGO worker in Alghrayfa (Ubari mantika, Southern region):
>
> ***"There is no place to resort to, whether to file a complaint or receive psychological support. However, when services are available, social stigma remains the main barrier preventing women from accessing them."***

Overall, most KIs reported that the barriers limiting women's access to GBV core services are mainly influenced by socio-cultural factors, such as stigma and lack of awareness. A KI in Alghrayfa noted that

[52] Including health, psychosocial support, security, and legal services, both in-person and remote.

"society often blames women, which makes the situation worse. The nature of society obliges women to remain silent and not to file a complaint, even to the closest people, for fear of scandal and shame". Furthermore, findings suggested that physical barriers can also play a role, as access to GBV services is hindered by long distance to facilities and transportation issues, such as high cost and lack of gender-segregated means of transportation, reportedly.

Health

In 2021, the national humanitarian health recovery plan remained to a large extent unattained, as "*the provision of an equitable, effective, and efficient health care and public health services in Libya have continued to decline*", according to the Libya Health Sector.[53] In fact, the analysis of MSNA data on health highlighted this as a key area of need, with health needs being driven by three factors: economic barriers; lack of facilities/capacity; and COVID-19. The first two factors are not new but rather have been driving factors of these needs for a long time.[54] By contrast, the COVID-19 outbreak represented a new factor – however, it seems to be mostly compounding the first two factors by further challenging the capacity of the health system and hindering livelihoods and, in turn, ability to pay for health services. Overall, 20% of assessed households were found to have health needs (i.e., having an LSG in the health sector).[55] Health needs were most commonly found among returnees (28% of assessed households), and in the South (27%). When looking at specific baladiyas, Ghiryan, a baladiya in Al Jabal Al Gharbi in the Western region, was the location where the highest percentage of households with health needs was found (50%). In particular, in Ghiryan, 43% of households reported they had not been able to access needed healthcare in the 3 months prior to data collection.

Access to healthcare

Overall, 28% of assessed households reported having needed healthcare in the three months prior to data collection. Among these households, 56% reported that at least one household member had not been able to access the healthcare they needed in this period (this amounts to 14% of the total assessed population). An additional 2% of assessed households reported that, while they had not needed healthcare during the previous three months, they thought that they would be unable to access any care in case of need.[56]

Figure 4: Among households that needed healthcare in the 3 months prior to data collection (28% of sample), proportions of households that reported not being able to access it, by region

East (n=628), South (n=160), West (n=1727)

Overall, 46% of households reported barriers to accessing healthcare. This includes both households that had not been able to access needed healthcare, and households that had been able to access healthcare or had not needed it during the previous three months. In particular, it is noteworthy that

[53] Health Cluster, WHO, "Libya Health Sector Annual Report 2021," (p.3), January 16, 2022.
[54] Ibid.
[55] The apparent discrepancy between the overall percentage of households in need (20%) and the percentages of households in severe (19%) and extreme needs (0%) is due to rounding. 19.4% of assessed households have severe needs, and 0.2% have extreme needs, which adds up to a rounded 20% of households.
[56] The discrepancy between the overall percentage of households in need according to this indicator (15%) and the percentages of households that could not access needed healthcare (14%) and the percentage of households that did not need it but have no access (2%) is due to rounding (13.5% + 1.8% = 15.3%).

among households that either had not needed healthcare in the previous months or, if needed, had been able to access it, a considerable proportion (37%) reported facing barriers to accessing healthcare, mainly due to inability to afford services, followed by poor quality of services, lack of medicines, lack of trust, and overcrowding. When zooming in on the sub-group who reported that they had needed healthcare during the previous three months but had not been able to access it (14% of the sample), it is possible to observe that, while the key barriers reported are more or less the same as for the previous group, inability to afford health services was reported by the overwhelming majority of this group (70%) as the main barrier hindering their access to healthcare, which reflects the relevance of the economic dimension when interpreting needs among the Libyan population.

These findings were echoed during KIIs conducted with local council representatives, medical staff (of public hospital, clinics, and health centres), INGO officials, and Ministry of Health (MoH) officials, in the three baladiyas Ghiryan, Alsharguiya, and Algurdha Ashshati, which were selected because health needs in these locations were found to be the highest among the surveyed baladiyas.[57] Indeed, across the three assessed locations, the high cost of treatment, especially at private clinics, together with the liquidity crisis, were among the commonly reported main barriers to accessing healthcare. Moreover, problems related to the capacity of healthcare centres, caused by understaffing, lack of medicines, and shortages of equipment were also frequently highlighted by KIs, especially in the South. In Alsharguiya, in particular, poor or no access to healthcare was often reported, alongside the unavailability of specialised services, mainly due to a lack of staff and insufficient training of the available personnel.

Finally, across the assessed locations, KIs reported that the long distance to health facilities also represents an important challenge to the population's ability to access healthcare. While distance to the closest health facility was not found to be a considerable barrier during the quantitative phase, KIs reported that distance can be a significant barrier in some cases considering the high prices and shortages of fuel, which is triangulated by Health sector's annual report of 2021, mentioning that *"regular, and prolonged fuel shortages keep disrupting critical social services and affecting people's health and livelihoods"*.[58] In addition, due to the unavailability of specialised services in all baladiyas assessed during the qualitative phase, distance can quickly become a factor in cases where specific care is needed. In Alghurdha Ashshati, for example, many KIs reported that people must travel to Sebha or even Tripoli for care, especially for specialised services. For example, almost all KIs reported that no specialised health services are available for older persons or people with disabilities within the baladiyas assessed. In the South, as mentioned above, most special cases are reportedly transferred to Sebha.

Quote from a female Ministry of Health (MoH) employee in Algurdha Ashshati (Wadi Ashshati mantika, Southern region):

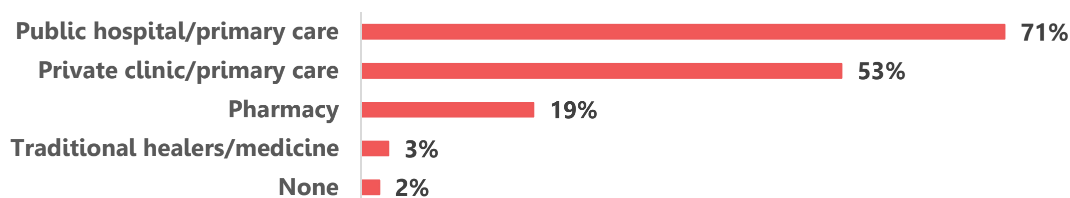
"[It would be necessary to] reduce prices at private health centres, provide medical staff and facilities to public medical centres, and provide high-quality training for medical staff."

Problems related to availability and capacity of healthcare

Overall, 29% of households reported not having access to a public hospital in their baladiya. **Error! Reference source not found.** below shows the different types of healthcare reported by respondents as being available in their baladiya.

[57] The findings draw on the knowledge of a total of 18 key informants selected based on their perceived knowledge of sectoral and cross-sectoral themes related to health in Libya.
[58] Health Cluster, WHO, "Libya Health Sector Annual Report 2021," January 16, 2022.

Figure 5: Proportions of households reported having access to types of healthcare in their baladiya, by type of healthcare



Baladiyas with the highest percentage of households reporting no access to a public hospital were found to in the West (Zliten (48%), Janzour (46%), Misrata (45%) and Hai Alandalus (40%)), as well as in the South (Algurdha Ashshati (39%)).

These findings mirror the findings from the 2021 Annual Report of the Libya Health Sector, which pointed out that *"in 2021, reports indicated that in some areas, up to 90% (out of all existing) of primary health care (PHC) centres remained closed. One third of all health facilities in the South and East of Libya are not functional, while 73% in the South and 47% in the East are partially functioning mainly due to the shortage of medical supplies and lack of human resources"*.[59] As mentioned in the previous section, shortage of medical supplies and equipment was also highlighted by KIs. Indeed, when asked about their recommendations to improve healthcare in their baladiya, most informants stressed that providing new equipment for healthcare facilities, especially technical medical machines such as X-ray or magnetic resonance imaging (MRI), was highly needed, alongside the provision of medication supplies. An increase in the number of medical staff, together with capacity building for existing personnel, was also mentioned, especially in the South.

When asked to rate the quality of healthcare in their baladiya, while some KIs reported that the general quality of care is bad in most of the healthcare facilities, most KIs reported that there is a remarkable difference in the quality of services between private and public healthcare facilities, mentioning that better quality of services can be found at private clinics. In fact, many KIs reported that trained medical staff often leave public hospitals to work in the private sector, in search of better wages and work conditions, which subsequently affects the quality of services at the public hospitals. This was echoed by interviewed doctors in Ghiryan, who reported believing that increasing the income of medical staff would improve the quality of healthcare. In addition, better quality of care at private facilities comes at a price of significantly higher costs for families: indeed, many KIs stressed that lowering the price of health services, especially regarding private clinics, is needed to improve the population's access to healthcare.

Furthermore, according to the most recent health sector annual report, only 15% of communities have services for reproductive healthcare,[60] which suggests that, even when public health facilities are available and accessible, reproductive healthcare services tend to remain inaccessible. This seems to be particularly the case in the South. A health officer at the Ministry of Health (MoH) in Al-Sharguiya noted that *"reproductive healthcare services are not available in the municipality. So, the delivery is done in Sabha hospitals or private clinics and, sometimes at home. Indeed, the municipality needs a full maternity unit."* Where such services are available in the South, the main barrier to accessing them seems to be the high cost of transportation, also related to the fuel crisis, as previously mentioned in relation to access to healthcare in general. In most cases, patients must reportedly travel to Sebha for care.

When asked about the availability of women's and girls' friendly spaces and services at healthcare facilities (including, for example, women-only spaces and the availability of female doctors), the

[59] Health Cluster, WHO, "Libya Health Sector Annual Report 2021," January 16, 2022. Strategic challenges (2021 major health system challenges of the continued largely disrupted health system) (p. 4)
[60] Ibid.

responses were somewhat mixed. While half of the KIs reported that such services were not available, others mentioned that they were either always available or available in some cases, notably when female doctors were present within the facility (reported by 5 KIs). Moreover, increasing the availability of specialised services, medication, and staff at healthcare facilities were commonly reported as recommendations for improvement, especially in the Southern region. A chief physician at a private clinic in Al-Sharguiya noted that "*the lack of doctors in the municipal or regional health centres cannot allow them to provide services on a gender basis, and women can access the facility if doctors are available at the centre and receive any type of services provided, if any*".

Finally, 40% of assessed households with children (75% of the overall sample) reported that at least one child in their family lacked an immunisation record. This percentage was found to be highest in the South, with 62% of households reporting at least one child without an immunisation record, compared to 41% in the East and 37% in the West. These findings are also supported by the health sector annual report, which expressed the concern that "*Libya continued to face repeated stockouts of critical routine immunization vaccines, compounded by difficulties securing funds from the Central Bank of Libya to place new procurement orders*".[61]

Impact of COVID-19 on health services

As pointed out in the same report, in 2021 *"health facilities across the country had to be closed due to increasing transmission of COVID-19 among health workers, lack of personal protection equipment and supplies. Of those remaining functioning, 80% of primary healthcare centres did not have any of the essential medicines"*.[62] Across all assessed locations, COVID-19 was reported by KIs to have impacted the accessibility and availability of non-COVID-19 related healthcare services. The biggest impact appears to be on the staffing and emergency services; a negative impact on surgical services and in-patient care within health facilities was also reported. Overall, most KIs reported that COVID-19 related healthcare services, such as breathing support equipment and spaces for isolation, were available. However, KIs also commonly argued that there are insufficient healthcare facilities and, within the existing ones, the stock of breathing support supplies, including oxygen bottles, seems to be severely limited due to high demand.

KIs generally reported that COVID-19 testing services were available within their baladiyas. However, findings suggest that access to these services remains hindered by many factors, including high prices, long distance to testing facilities, insufficient supply, and poor organisation within the facilities. Although COVID-19 vaccinations were commonly reported to be available for all households in the baladiyas assessed, many KIs pointed out that supplies of vaccines were mostly insufficient. In addition, the vaccination campaign seems to be additionally hindered by a generalised lack of trust and long distance to the vaccination hubs according to KIs. In general, health centres were reported to be the primary source of information regarding COVID-19 prevention and diagnosis, followed by social media, local councils, TV, and government institutions. However, some KIs reported persons with disabilities, particularly those with hearing and visual difficulties, might face barriers accessing information and diagnosis, mainly due to the unavailability of information tailored to this population group.

Finally, findings suggest that COVID-19 might have exacerbated problems in accessing a system that was already difficult to access due to existing economic barriers, lack of facilities, and limited medical capacity. In general, throughout 2021, closure of health facilities due to the COVID-19 pandemic, as well as related movement restrictions, seem to have compounded existing barriers to accessing healthcare.

[61] Health Cluster, WHO, "Libya Health Sector Annual Report 2021," January 16, 2022.
[62] Ibid.

MHPSS – Mental health and psycho-social support networks

The mental health and social support networks case study investigates the relationship between social support and mental health drawing on the knowledge of 22 mental health professionals, medical staff and social workers selected based on based on their perceived knowledge of sectoral and cross-sectoral themes related to mental health in Libya. Interviews were conducted either remotely (by phone) or in person, in 11 baladiyas (AlKufra, Azzawya, Benghazi, Ghat, Ghiryan, Misrata, Sirt, Tarhuna, Tawergha, Tripoli, Ubari). In addition to KIIs, 13 focus group discussions (FGDs) were conducted with an average of 6 local community members per FGD in 6 baladiyas (Alkufra, Ghiryan, Misrata, Sirt, Tarhuna, Tripoli). Each FGD included both men and women (FGDs were not gender-segregated).

Quote from an internally displaced female community member in the baladiya of Tripoli, Western region:

" ***The conflict has affected the mental and physical health of the majority of people inside the camp in general with different degrees."***

Some KIs, particularly from the South, reported having perceived an increased burden of psychological stress, in the form of depression (4 KIs) and anxiety (9) among Libyans during 2021. According to KIs, war and armed conflicts (15/22), and family problems such as divorce and family dispersion (13/22) were the primary factors causing distress or psychosocial issues for the community, especially among women and children. In addition, KIs reported perceiving that that sexual abuse, physical and verbal violence, and domestic violence have been on the rise, and that such violence particularly affects women. This was echoed by local community members during the FGDs, as they commonly reported perceiving psychological stress, domestic violence, and physical and verbal abuse to have escalated in recent years, increasing therefore the safety concerns among the community. Indeed, safety and security problems were commonly reported in certain areas, resulting in high proportions of people feeling unsafe; 16% of assessed households reported feeling unsafe or very unsafe in their baladiya, with high proportions found in Sebha (62% of households assessed), Tarhuna (Almargeb) (43%), Alkufra (33%), Sirt (33%), Ghiryan (Al Jabal Al Gharbi) (31%). Other factors that reportedly have an impact on mental health are poverty and financial problems, followed by displacement and unemployment. Some KIs explained that heads of household are usually under distress because they cannot provide for their family, which can result in them or other household members resorting to negative strategies to cope with insufficient financial resources.

Overall, two elements emerged from the interviews with KIs: a lack of mental health support and facilities and social stigma. KIs reported there to be a lack of mental health care services available for households; where these are available, their quality was generally described as being quite poor. Across the assessed locations, insufficiency in terms of the availability of mental health facilities and support projects was commonly reported as a main gap in the support system for the population. According to KIs, COVID-19 related measures, such as confinement and curfews, had further constrained the availability of and access to mental health support, in a country with "*non-existent mental health services*".[63] Moreover, KIs consistently reported that fear of the social stigma associated with seeking mental health support commonly prevents Libyans from accessing such services. As noted by a social psychologist in Tawergha, community members tend not to access mental health services "*because of the lack of an awareness and a positive role by media, and also because some people are afraid of the way society sees them when going to health centres to consult or treat mental disorders, as they are perceived as causing embarrassment to their community*". Furthermore, many KIs argued that there is a prominent lack of mental health expertise among the medical staff.

In general, most informants reported that the main method to deal with distress is through sports, music, and cultural activities. Several KIs also reported that community members deal with psychological issues

[63] WHO, "Health Response to COVID-19 in Libya: WHO Update #19."

by resorting to family or community support. Indeed, family and friends were reported to be the main social support system for persons experiencing distress. In addition, support by INGOs, community centres, and local female communities or religious community leaders was reported to be sought for psychological relief and well-being. Only a minority of KIs reported that people seek care by traditional healers or sheikhs. Overall, while KIs consistently reported that informal social support networks are available for persons experiencing distress, many also warned that individuals often do not receive professional treatment form mental health professionals.

When looking at population groups that can be considered particularly vulnerable to psychosocial issues, KIs commonly reported that women – particularly those subjected to domestic violence and related traumatic experiences – are among the most vulnerable groups. As (10/22) gender balanced 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 reportedly do not always report such incidents due to fear of stigma dictated by traditional gender norms. The second most reported vulnerable group was people with disabilities, mainly due to the absence of specialised centres that offer inclusion and capacity building workshops within the baladiyas. Additionally, children and IDPs were reported by some KIs as also being especially vulnerable; for IDPs this was reportedly 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 those with no or low income are especially vulnerable.

Overall, across KIIs and FGDs, a lack of mental health facilities and safe spaces emerged as a main gap in the support system for community members feeling distress. According to KIs, this gap is driven by the absence of a strong political framework and financial support, as well as a lack of social awareness about mental health and psycho-social support systems within the assessed baladiyas. Overall, these findings seem to suggest a need for the provision of specialised medical support and the establishment of awareness and inclusion programmes, especially targeting vulnerable groups. More generally, improving the quality of life, creating safe spaces, and facilitating access to services were reported by several KIs as important needed services.

Food security

Following protection and health, the third most commonly found type of humanitarian needs (LSGs) was found to be related to food insecurity, with 13% of assessed households found to have a food security need. Overall, the MSNA findings indicate that households in the South (followed by those in the East) have the highest food security needs, and that IDP and returnee households tend to be more exposed to food insecurity compared to non-displaced households. Moreover, food was among the most commonly reported priority needs, reported by 28% of households across the country.

Food insecurity: an overview

Food security needs observed in the analysis appeared to be primarily driven by an inadequate food consumption. This was measured by calculating the food consumption score (FCS) for each household – a composite score based on dietary diversity, food frequency, and relative nutritional importance of different food groups.[64] The FCS captures households' food access and adequacy,[65] and it was used as a critical indicator to measure a food security need or LSG (see paragraph 'Overall humanitarian needs'). Overall, 12% of households across Libya were found to have a borderline (7%) or poor (5%) FCS.[66]

[64] World Food Programme (WFP), "Food Consumption Analysis," 1st edition, February 2008.

[65] World Food Programme (WFP), "Consolidated Approach to Reporting Indicators of Food Security (CARI)," 2nd edition, November 2015.

[66] A 'poor' FCS has a value lower than (or equal to) 28. A 'borderline' FCS has a value above 28 and lower than (or equal to) 42. See the Methodology overview for the full calculation.

FCSs were found to vary across population groups, with 22% of IDP and returnee households having a poor or borderline FCS, compared to 11% of non-displaced households. This trend aligns with other research findings of inadequate food consumption being higher among displaced households compared to non-displaced households in Libya.[67] Geographically, 26% of the surveyed households in the South showed a poor or borderline FCS, while this was the case for 17% and 8% in the Eastern and Western region, respectively. Table 3 below gives an overview of the five baladiyas with the highest proportion of households having a borderline or poor FCS. Among these, three were found to be situated in the East (Suloug, Gemienis, Toukra), whereas the other two lie in the Southern region (Ubari and Alghrayfa). These three Eastern baladiyas, however, appear to be outliers to the general regional pattern of the East, by presenting particularly acute needs. Hence, they were selected for further research in the qualitative part of this MSNA. On the other hand, food needs in the Southern region appeared to be consistently high across all baladiyas assessed.

While food consumption remains the key indicator to measure food needs, looking at coping strategies households use to deal with a lack of food (and/or money to buy food) allows to provide additional depth to the analysis, by examining the sustainability of households' food consumption. The severity of food-related coping strategies is measured by the consumption-based coping strategies index (CSI), which was updated according to the Libyan context in early 2021 by REACH in collaboration with the Food Security Sector (FSS). This tool was then implemented during the 2021 MSNA[68] to capture the sufficiency of a household's food consumption. Furthermore, to be able to compare food insecurity across regions and contexts, the reduced CSI (rCSI) summarises five of these food-based coping strategies and associated weights. Overall, results of the rCSI highlight the same regional pattern for the South and East, as both regions had 16% of households with a medium or high rCSI score, compared to 10% in the West. This indicates that a higher proportion of households in the first mentioned regions had to rely on coping strategies – having taken into consideration the severity and frequency of the mechanisms applied.

In general, the most common coping strategy used among assessed households was having to rely on less preferred or less expensive food, reported by 48% of households. More concerning was that 30% of households reportedly had to reduce the number of meals consumed per day for all household members due to a lack of food or money to buy food in the week prior to the interview. When zooming in to baladiya level, two of those locations with the highest proportions of households having a medium or high rCSI score are located in the East (Alabyar, Suloug), whereas the other three lie in the South. As can be seen in Table 3, the baladiyas with the highest proportions of households having a medium or high rCSI score do not necessarily align with those having a borderline or poor FCS (except for Suloug), meaning that the use of coping strategies in some baladiyas might sustain food consumption. However, overall findings show that the proportion of households with an acceptable FCS is slightly lower among households having a medium or high rCSI score (76%), compared to the proportion of households with an acceptable FCS overall (88%). Additionally, exhausting food-based coping mechanisms was also incorporated in the rCSI composite indicator, which could be reinforcing this effect. Overall, the results seem to indicate that households applying consumption-based coping mechanisms might be those more likely to struggle to sustain their food consumption.[69]

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[67] World Bank Group (WBG) & World Food Programme (WFP), "Food Security and Nutrition – Libya," April 2021.

[68] The Consumption-based coping strategies index (CSI) for the Libyan context (published February 2021) gives each household a numeric score resulting from multiplying the weight per coping strategy with the frequency of engagement with that coping strategy. As a result, the higher the score, the more food insecure the household is found to be. While there is no standardised way of classifying scores, this extended CSI tool, being contextually tailored, is especially useful and reliable for comparing groups and/or regions or doing trends analysis over time. As this was the first time that the CSI was deployed, temporal comparisons are not possible at this stage.

[69] No statistical comparison of results between groups was conducted and hence findings are indicative only; no conclusive implications should be drawn from the data.

Table 3: Top five baladiyas with highest proportions of households per food security indicator

Poor or borderline FCS		Medium or high CSI score		Medium or high rCSI score		FES higher than 65%	
62%	Suloug (East)	**35%**	Edri (South)	**34%**	Edri (South)	**59%**	Gharb Azzawya (West)
59%	Gemienis (East)	**31%**	Alabyar (East)	**30%**	Alabyar (East)	**56%**	Al Aziziya (West)
56%	Toukra (East)	**28%**	Ghiryan (West)	**25%**	Suloug (East)	**54%**	Swani Bin Adam (West)
54%	Ubari (South)	**24%**	Murzuq (South)	**23%**	Alsharguiya (South)	**52%**	Azzawya (West)
46%	Alghrayfa (South)	**20%**	Sebha (South)	**23%**	Algurdha Ashshati (South)	**51%**	Azzahra (West)

Another indicator feeding into the calculation of food security needs is the food expenditure share (FES). The FES calculates the ratio of a household's expenditure on food together with its value of non-purchased (self-produced) food on the total household expenses to see how much of a household's expenses are dedicated to satisfying food needs. Together with the previously mentioned outcome indicator, the FES is a common indicator used to assess food security, as it is widely documented that the more poverty-stricken and vulnerable a household, the larger the quota of its expenses dedicated to food.[70]

In general, 23% of households were found to dedicate more than 65%[71] of their overall expenses to food across Libya. The results for this indicator show a different regional trend compared to other food security indicators, as 28% of households in the West were found to be above this threshold, compared to 13% in both the Eastern and Southern regions. Similarly, findings at baladiya level (presented in Table 3) show that all five baladiyas with the highest proportions of households having a food expenditure share of above 65% are situated in the West. When looking into the price fluctuations of the minimum expenditure basket (MEB), which mainly consists of food items required to feed a five-person household for a month, it can be noted that during MSNA data collection (June, July, August 2021) the MEB's prices in the Western region increased the most (adding up to 20% over the last year), compared to the other regions.[72] Also, according to the MSNA 2021 data, in the West, a lower proportion of households was found to rely on consumption-based coping strategies compared to the East and the South, which could indicate that households in the Western region were still able to spend money on food while households in the South and East had less to spend and therefore had to rely more on coping strategies to access food.

Moreover, this is the only food security indicator for which non-displaced households marked the highest proportion (23%), compared to 20% and 10% of returnee and IDP households, respectively, which might be related to the latter population groups potentially having to dedicate proportionally higher shares of their overall expenditure to meet their non-food related needs, such as rent for accommodation. Findings on shelter occupancy status overall indeed demonstrates that 74% of IDP households were paying rent, as opposed to 24% of returnee households and 15% of non-displaced households. Also, IDP households' rental expenses (average of 364 LYD) transcended over four times that of non-displaced households (average of 80 LYD) and about three times that of returnee households (average of 123 LYD).

[70] Tufts University, Boston, "INDDEX Project, Data4Diets: Building Blocks for Diet-related Food Security Analysis," 2018.
[71] Ibid. A threshold of 65% was used for the food expenditure share (FES), as in literature on indicators measuring food security needs, households spending over 65% of their total income on food are considered to have high food insecurity.
[72] According to fluctuations of MEB price index, monitored by REACH's Libya Joint Market Monitoring Initiative (JMMI), August 2021. Access this factsheet here.

Quote from a female CSO worker in Gemienis (Benghazi mantika, Eastern region):

"Displaced families have a major problem with not getting enough food as a result of paying for their shelter (rent). Also people without a steady income suffer from a lack of access to adequate food. [...] Families who are supported by a divorced woman or widow find it extremely difficult to obtain food, which leads to borrowing food or buying it going into debt, which also counts for those who are disabled, due their weak salary or income."

Causes and consequences of food security needs

The qualitative findings from 18 KIIs (farmers, food importers, government representatives, etc.) conducted in three baladiyas in the Eastern region of Libya (Gemienis, Suloug and Toukra), indicated that the financial situation was a main factor driving food insecurity in the region. The majority of the KIs reported that food insecurity for Libyan households had increased significantly throughout the year prior to the interviews (October 2020 to September 2021), especially among households relying on daily wages, whose livelihoods were also affected by the COVID-19 restrictions. According to most of the interviewed KIs, the deterioration in food security was mainly due to households' decreased income, together with the high prices of imported food products in the markets – thus, financial barriers to food security could be found on both the supply and the consumers' side.

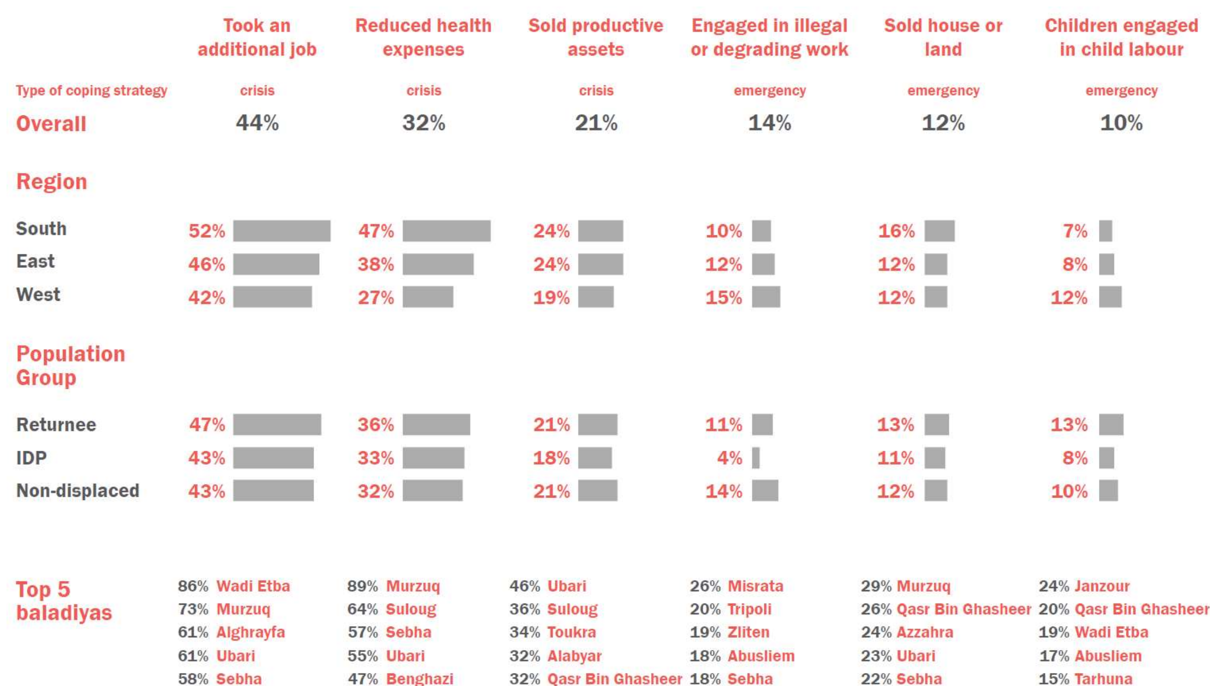
Food security needs were mentioned by the majority of KIs as being primarily interrelated with households' livelihood needs, especially among poor or displaced households. A household's income was often highlighted as the main factor affecting its ability to access sufficient food. The imposed COVID-19 restrictions were mentioned to have considerably contributed to unemployment, unpaid salaries, and lost income.[73] Indeed, findings from this MSNA's household survey showed that crisis or emergency livelihoods coping strategies (LCS, according to the LCSI)[74] were employed or had been exhausted (in the 30 days prior to data collection) by 63% of households overall. Among these strategies, taking on an additional job was reportedly the most common one (by 44% of households overall – see Figure 6), followed by reducing expenses on health and selling productive household assets. The Eastern baladiyas Suloug and Toukra – both in the top three locations with highest food security needs – particularly stood out in terms of applying crisis or emergency LCS, with respectively 85% and 86% of households relying on or already having exhausted these types of mechanisms to meet their basic needs. Only Wadi Etba and Murzuq (located in the South), were found to have a higher proportion of households that reportedly resorted to such LCS. Furthermore, more than half of the interviewed KIs mentioned that households' food security needs were strongly linked to their shelter needs, as in general displaced households often must rent their accommodation, leading to a higher cost of living and thus less money available for food. Also, during the qualitative phase, cash needs appeared to often be linked to food insecurity in the assessed baladiyas, which KIs commonly contributed to liquidity issues in banks.

That cash and food go hand in hand is further shown by the fact that about half (54%) of those households who reported food as a priority need (28%) also reported cash as a priority need. Moreover, the majority (64%) of households with a food security need reported having experienced challenges when withdrawing sufficient cash from the bank to meet their basic needs in the 30 days prior to data collection, and 29% reported having experienced delays in salary payments causing insufficient access to cash, further indicating the impact of limited finances on food security among Libyan households.

[73] Food and Agriculture Organization of the United Nations (FAO) & World Food Programme (WFP), "COVID-19 impacts on agri-food value chains: Libya," Cairo, 2021.

[74] LCSI refers to Livelihoods Coping Strategies Index: a composite indicator that is based on households reporting to have used, or exhausted, a stratified list of coping strategies in the 30 days prior to data collection. In the MSNA survey, LCSI was asked for basic needs, meaning that it was asked if households used the strategies in order to meet their basic needs. Alternatively, this tool can be used for food needs only. The methodology behind the LCSI can be found in Annex 9 of the Methodology overview.

Figure 6: Proportions of households per reported crisis and emergency coping strategy used or exhausted in the 30 days prior to data collection



Furthermore, food prices were found to be closely related to the dollar exchange rate, which worsened due to the liquidity crisis. This was mentioned by a third of the KIs and was also found in REACH's JMMI findings, which show that the official USD/LYD exchange rate has changed from 1.373 in October 2020 to 4.532 in September 2021. The JMMI also shows an increase in food prices of about 10% from October 2020 to September 2021.[75] In one third of the KIIs conducted in the three selected baladiyas, the economic instability of the Libyan state was also referred to as a lasting barrier to food security. Finally, COVID-19 restrictions were mentioned by the majority of KIs as another driver of food insecurity, as movement restrictions and border closures reportedly affected food shortages and price increases.

Hence, particularly vulnerable appear to be those having disadvantaged financial positions based on dependency. According to the majority of KIs, compared to other population groups, female-headed households are more likely to struggle accessing sufficient food. This is reportedly particularly the case for widowed or divorced women, as they often rely on government pensions, which can be hampered by delayed payments. Additionally, they reportedly often received less education and therefore might have to resort to unethical jobs to earn a living for food. Similarly, about half of the informants reported that households relying on government support are more likely to struggle in accessing food. The second and third population groups most often mentioned as being particularly vulnerable to food insecurity were displaced (IDP) and poor households, due to their higher expenses, low incomes and/or liquidity issues, which would force them to rely on negative coping strategies. Results from this MSNA's household surveys did support the finding that IDP, but also returnee households, have the highest food security needs overall.

[75] According to REACH's Libya Joint Market Monitoring Initiative (JMMI), September 2021. Access this factsheet here.

Challenges in local agriculture and food imports

To explore the topic of agriculture in the three selected baladiyas (Gemienis, Suloug and Toukra)[76] located in Benghazi mantika in East Libya, a part of data collection was dedicated to a case study on the subject, developed together with the FSS. According to the 18 KIs interviewed on food insecurity topics, the main challenges faced by farmers in this area are related to the high prices of agricultural assets, such as heavy machinery (tractors and ploughs), as well as to the unavailability of seeds and pesticides. Tractors, followed by pesticides and fertilizers, were also the main resources for agricultural activities that reportedly got lost since the beginning of the protracted crisis. Moreover, fertilizers, together with water, was mentioned as the most important resource needed to expand agriculture and increase food security in the assessed baladiyas. Water shortages, together with recurrent power outages and droughts, were indeed mentioned as another key barrier to sustain agricultural activities, especially in the mountainous areas where digging wells is both hard and expensive. In addition to fertilizers and water, the majority of KIs mentioned a need for quality seeds, followed by agricultural machinery and capital and livestock. A few KIs claimed that state regulations and support were necessary to promote agricultural activities within the country and to encourage the consumption of local products, and that expansion of agricultural supply could provide a competitive alternative for the high cost of imported food products, which they predicted would eventually result in (slightly) more food security in their area.

Most KIs reported that households in their baladiya did not rely directly on local agriculture for their food consumption. Also, more than half of the KIs mentioned that the local agricultural supply is less diverse compared to imported production, which was allegedly explained by the local agricultural production being restricted to barley and wheat, with vegetables and fruits generally being imported. Furthermore, about a third of the KIs reported local supply to be less reliable (more prone to external factors such as droughts, risks due to non-cultivation of soil, etc.). Several KIs mentioned that the local agricultural production does have a better quality but also comes with higher prices, and it was reported that local production is usually for personal use only, rather than (also) for sale.

Furthermore, Libya relies heavily on importing food products to cover its cereal consumption needs (mostly wheat and barley),[77] including from Ukraine and Russia.[78] With the Ukraine crisis that has started end of February 2022, these food import chains could be disrupted. According to the Libyan Minister of Economy, 20% of the country's wheat import comes from Ukraine, and hence Libya's wheat reserves could last for more than a year.[79] However, global concerns have arisen about a further stress on poorer North-African households' food security situation, as international food and input prices are already high and vulnerable.[80] Looking ahead, impacts of this new crisis (coming after the effects of the global COVID-19 pandemic) could escalate food insecurity across Libya, which might be found back in the food security data of the next MSNA cycle (2022).

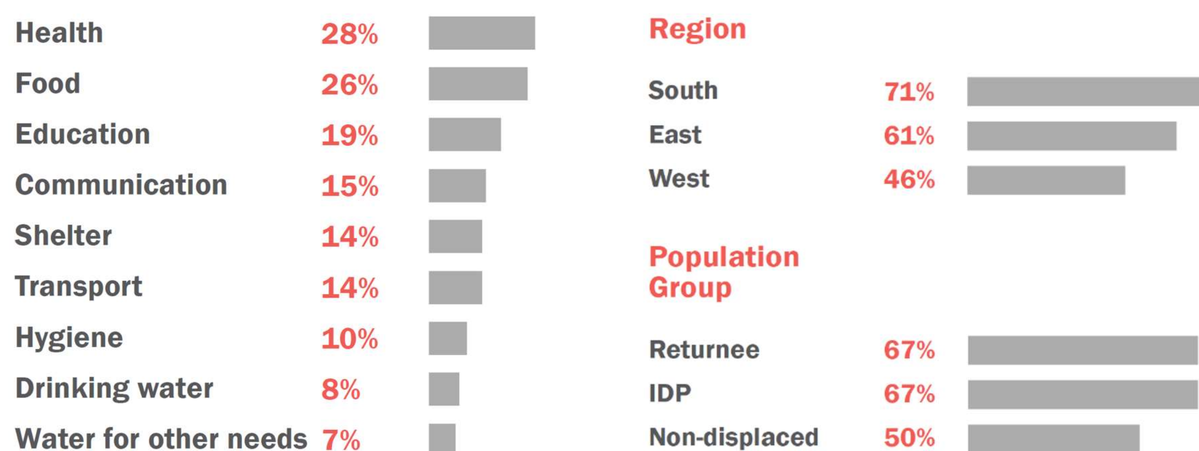
Coping strategies and economic vulnerabilities

Overall, MSNA findings suggest that many of the sectoral needs found in Libya are driven by economic factors and financial issues, causing unaffordability. Indeed, 53% of households reported that they had been unable to afford covering all their basic needs in the 30 days prior to data collection. Figure 7 gives an overview of the most commonly reported basic needs these households were unable to afford. In particular, more than a quarter of households reported having been unable to meet essential health and food needs. When further disaggregating these results, the South and East, and the displaced households (both IDP and returnee households) emerged as the regions and type of population groups

[76] These three baladiyas were selected to conduct further qualitative analysis on food insecurity, as these locations were found to have the highest proportions of households with food security needs (or a food security LSG).
[77] Food and Agriculture Organization of the United Nations (FAO), "GIEWS Country Brief Libya," December 6, 2021.
[78] France24, "Rising food prices shake North Africa as Ukraine war rages," March 13, 2022.
[79] The Libya Observer, "Wheat stock sufficient for more than a year, says minister of economy," February 26, 2022.
[80] Africanews, "War in Ukraine to hurt poor nations importing grain - UN," March 11, 2022.

with the highest proportion of households reporting having been unable to cover at least one of their essential needs. The found magnitude of these two unmet needs caused by unaffordability generally aligns with the earlier described finding of health and food security needs (after the sectoral need in protection) being most commonly occurring overall, as well as within these regions and population groups.

Figure 7: Proportion of households reporting having been unable to afford basic needs in the 30 days prior to data collection, per type of need, and disaggregated by region and population group



Furthermore, only about one fourth of assessed households reportedly did not have to rely on any type of livelihood coping strategies (LCS) to meet their basic needs. The widespread use of coping mechanisms indicates that Libyan households were indeed struggling to meet their needs. Moreover, 37% of households were found to have at least one sectoral need while allegedly having used or exhausted crisis or emergencies coping strategies, meaning that despite the use of negative coping mechanisms, their basic needs remained unmet. Additionally, 41% of households that reportedly employed (or had exhausted) crisis or emergency-level LCS in the month prior to data collection, did not appear to have any sectoral needs. However, these households could become more vulnerable to shocks and stressors in the (near) future[81], as they are (and have been) relying on unsustainable mechanisms to meet their basic needs, which might deplete their resources in the longer term. Also, as mentioned in the previous section, the highest proportions of households having food security needs were found in the Southern and Eastern regions of Libya, which were also the areas with the highest proportion of assessed households reporting the use of negative strategies to cope with insufficient economic resources. These results align, as food security needs appeared to be primarily driven by financial issues (due to low income and high prices).

When looking more closely into the different types of LCS adopted (presented in Table 4 below), no notable difference between the three regions appeared for the use of emergency LCS, while crisis LCS were found to be less applied in the West, compared to the South and East. What emergency livelihood coping strategies consist of can be found in Figure 6 in previous section; in Libya's context, these strategies are considered as being potentially conducive to harm a person's physical and psychological integrity or might lead to an immediate depletion of assets. Interestingly, four of the top five baladiyas with the highest proportions of households reported having employed (or already had exhausted) this type of LCS, were found to be located in the Western region (see Table 5).

[81] World Bank Group & World Food Programme, "Food Security and Nutrition – Libya," April 2021.

Table 4: Proportions of households per employed type of livelihood coping strategy (LCS) category

	1: None	2: Stress	3: Crisis	4: Emergency
Overall	**24%**	**13%**	**37%**	**26%**
South	12%	13%	49%	25%
East	18%	12%	45%	25%
West	28%	14%	31%	27%
Returnee	14%	19%	40%	26%
IDP	23%	17%	42%	18%
Non-displaced	25%	12%	36%	26%

Table 5: Top five baladiyas with highest proportions of households having used crisis and emergency livelihood coping strategies (LCS) in the month prior to data collection

Crisis			Emergency		
Wadi Etba	South	**71%**	**Qasr Bin Ghasheer**	West	**43%**
Toukra	East	**67%**	**Sebha**	South	**36%**
Suloug	East	**64%**	**Janzour**	West	**35%**
Murzuq	South	**64%**	**Abusliem**	West	**35%**
Ghiryan	West	**60%**	**Tarhuna**	West	**34%**

A similar pattern can be observed when disaggregating by population groups; while overall, returnee and IDP households were found to be relatively more food insecure (see previous section on food security), non-displaced households appeared to rely on emergency coping strategies to an equal degree as returnee households, and more than IDP households tended to do. The finding that households in certain baladiyas in the West, as well as non-displaced households overall, were more commonly found to use emergency LCS, while comparatively having lower levels of unmet essential (food) needs, seems to indicate that many of them were only able to meet their basic needs by employing negative coping mechanisms, which is not a sustainable way to maintain acceptable living standards. Indeed, a trend of diminishing purchasing power seemed to affect households from the Western region of Libya in particular, as mentioned earlier.

To further investigate the relation between financial issues and the presence of sectoral needs, households' economic vulnerabilities need to be taken into consideration. In terms of employment, 18% of assessed households reported that none of their household members were employed at the time of the interview. When disaggregating between the different regions, this appeared to be the case for about one fourth of households in the East (24%), compared to 17% in the West and 12% in the South. These are bigger differences than when looking into variation between population groups.

A more distinctive finding when comparing population groups against each other is that returnee and non-displaced households reportedly tended to rely more on government subsidies as their main source of income (22% and 21%, as opposed to 14% of IDP households), whereas 13% of households from the latter population group mentioned to rely on savings as a main source of income (compared to 10% and 7% of households from the first two mentioned population groups, respectively). Of the households with at least one member reportedly working (82% of the total sample), 17% mentioned that they primarily relied on temporary or daily labour as their main source of income. This is also highlighting a certain vulnerability, due to the unsustainable nature of these types of labour.

In addition, access to cash remained a key issue in the Libyan banking system and the country's economy overall, due to the protracted liquidity crisis and bifurcated payment system,[82] reflected by 28% of assessed households reporting that liquidity issues in banks prevented them from accessing sufficient cash in the 30 days prior to data collection. Overall, 61% of assessed households explained to have experienced issues in obtaining sufficient cash, and among households having at least one household member who faced difficulties to consistently accessing markets in the month prior to the survey, 44% reported a lack of access to cash (no liquidity) as (one of) the reason(s) for this. The latter barrier was found to be more commonly reported among displaced population groups (58% of returnee and 57% of IDP households), compared to the non-displaced households (41%). By contrast, no notable difference was noted from a regional point of view. Furthermore, about the same pattern became apparent when households were asked directly what their priority needs existed of, as 58%, 56% and 40% of IDP, returnee and non-displaced households, respectively, reported this to be (whether or not amid other priority needs) the access to cash.

[82] World Bank Group (WBG) - Middle East and North Africa Region, "Libya Economic Monitor," Spring 2021.

CONCLUSION

To inform humanitarian response planning for 2022 in Libya, REACH, in coordination with OCHA and the active sectors and working groups, conducted an MSNA household survey in 45 baladiyas (admin level 3) across the three regions of Libya, interviewing 8,871 households in total (over the phone). Additionally, the assessment consisted of a qualitative component, existing of KIIs and FGDs to further investigate the predominant sectoral needs found.

Overall, the MSNA results demonstrate that humanitarian needs in Libya were found to occur among about half of the assessed households (51%) and most commonly prevailed in the South, as well as among returnee households. More specifically, 34% of households overall were found to have severe needs and 17% to have extreme needs. The highest proportion of households in need appeared to be in the South (67%), with 23% of households found to have extreme humanitarian needs, and where needs appear to be deeply rooted in historical neglect and fragmented governance in the region. Returnees were found to be the population group with the highest proportion of households in need across sectors (63%). Furthermore, humanitarian needs were found to be primarily driven by economic vulnerabilities, a reliance on unstable income sources, and an inability to access essential services and cover needs due to a lack of resources. These issues are closely connected to the protracted liquidity crisis in Libya, which was exacerbated in 2021 by COVID-19 related restrictions, including the closure of essential facilities.

Protection, health, and food security needs were identified as the key sectoral needs in Libya.

Protection was the sector with the highest proportion of households falling into the severity categories classified as 'have a need' (23% overall), with the highest proportion (33%) being found in the South. Mainly standing out was that 55% of assessed households in the South reported having safety and security concerns, and 23% reported having concerns specifically in relation to armed conflict. Additionally, in this region, 30% of households reported feeling unsafe or very unsafe in their baladiya. Frequently reported incidents included petty crimes, theft, robberies and (to a lesser extent) kidnappings, according to KIs. This safety landscape indicated by the responses reflects the degree to which the protracted instability in Libya has led to localised forms of insecurity and anxiety.

Secondly, **health needs** were the next most commonly found need (for 20% of households overall). Again, health needs were mostly found among assessed returnee households (28%), and households in the South (27%). Findings suggest that the prevalence of health needs is partly rooted in the fact that the country's fragmented health system struggles to accommodate the needs of affected people.[83] In light of this, quantitative and qualitative findings highlighted key weaknesses in the Libyan health system with issues related to non-availability of health facilities, lack of medication, and limited staff being commonly reported barriers. Furthermore, among households that reported needing healthcare but having been unable to access it in the 3 months prior to data collection (28%), 70% reported that not being able to afford healthcare was a barrier impeding their accessibility.

The third most commonly found type of humanitarian needs in Libya was related to **food security**, which was found to be a severe or extreme sectoral need for 13% of assessed households. Food security needs among the assessed households were primarily driven by inadequate food consumption. Overall, the MSNA findings indicate that households in the South and East have the highest food security needs, while IDP and returnee households tend to be more exposed to food insecurity compared to the non-displaced households. Food security needs were also found to be driven by underlying contributing factors such as households' low incomes and high prices of, and reliance on, imported food products.

[83] Amnesty International, "Libya: Historic Discrimination Threatens Right to Health of Minorities in the South amid COVID-19," April 20, 2020.

In addition to the main sectoral needs found for the Libyan population, this report focused on two key sub-themes: women and access to services and mental health and psycho-social support (MHPSS). Findings from the qualitative phase indicate that mental health was a key concern for women, especially those subjected to domestic violence and related traumatic experiences, which KIs commonly perceived to have increased since the onset of the COVID-19 pandemic. KIs and FGD participants also noted the difficulties and social pressures women face when trying to access services to report instances of domestic violence or GBV, which has likely led to this issue being largely unreported and invisible, posing challenges for humanitarian responses and highlighting the need for further assessments on this topic.

The MSNA findings indicate variations in humanitarian needs across regions. The South stood out as the region most in need, scoring the highest in protection, food security and health needs (as well as, to a lesser extent, education, and WASH needs). Overall inability to financially cover all essential expenses was found to be the main driver of needs across different sectors. To better understand the complexity of needs in Libya, as well as the local dynamics by which these needs profiles are shaped, it is important that further assessments are carried out to supplement the findings from this MSNA exercise, looking specifically at the interlinkage between needs, access to essential services, sustainability of livelihoods and availability of psycho-social support networks. Understanding the specific needs and profiles of the Libyan population is imperative to build an effective and inclusive humanitarian response, especially considering the high economic vulnerabilities and the current global outlook related to the crisis in Ukraine and its impact on food security, as well as the systemic implications of a prolonged rise in oil prices on agricultural markets in Libya.