

An Exploration of Health and Peace Programming in Libya



The Roman city of Leptis Magna in Khoms, Libya. Source: Shutterstock.

Interpeace

SREO Consulting, Ltd.

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ABOUT SREO

SREO Consulting is an independent, non-partisan research and monitoring and evaluation consultancy based in Istanbul, Turkey. SREO Consulting is committed to serving humanitarian and development actors operating in the most challenging environments around the world by providing unbiased and actionable data, analysis, and research.

The SREO team has experience working in Syria, Turkey, Iraq, Lebanon, Jordan, Tunisia, Libya, Yemen, Mali, Afghanistan, and Pakistan.

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ABOUT Interpeace

Interpeace is an international organization that prevents violence and builds peace in Africa, the Middle East, Asia, Europe, and Latin America. Over the last 27 years, Interpeace has worked to promote trust in order to bring societies together. Interpeace supports communities in locally designing and leading programs that span from grassroots communities to senior-level decision-makers. Interpeace's approach is to help different parts of society identify and harness their common strengths for long-lasting peace. Interpeace also supports fresh thinking and expert advice related to peacebuilding and violence reduction.

List of abbreviations

DDR	Disarmament, Demobilization and Reintegration
EU	European Union
FGD	Focus Group Discussion
FR	Field Researcher
GBV	Gender Based Violence
GNA	Government of National Accord
GNC	General National Congress
GNU	Government of National Unit
HDP Nexus	Humanitarian-Development-Peace Nexus
HoR	House of Representatives
IP	Implementing partner
KII	Key Informant Interview
LNA	Libyan National Army
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
MoU	Memorandums of understanding
NATO	North Atlantic Treaty Organization
NFZ	No fly zone
NGO	Non-governmental Organization
NTC	National Transitional Council
ODK	Open Data Kit
PHC	Primary healthcare
PPE	Personal Protective Equipment
R2P	Responsibility to protect
SEA	Sexual Exploitation and Abuse
SREO	SREO Consulting Ltd.
SSR	Security Sector Reform
ToR	Terms of Reference
UNFPA	United Nations Population Fund
WHO	World Health Organization
WHS	World Humanitarian Summit

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Executive Summary

The ramifications of armed conflict and political unrest on health systems and human health are wide ranging. While this is not a new concept, the COVID-19 pandemic has brought renewed awareness to the potential for health emergencies to amplify pre-existing political tensions and create new grievances. The Humanitarian-Development-Peace (HDP) Nexus has called for additional focus on the interdependent nature of public health and peacebuilding. These two sectors traditionally operate in silos, but have intrinsic overlap. The HDP Nexus seeks to frame these areas of overlap as opportunities for new programming in places affected by conflict and political grievances.

SREO was contracted by Interpeace to assess the current status of health and peace programming in Libya by both national and international actors. SREO conducted 25 focus group discussions (FGDs) and 50 key informant interviews (KIIs) across Libya during March of 2022 with community members, healthcare workers, government officials, religious leaders, international organizations and non-governmental organizations (NGOs), and national NGOs. These interviews assessed understandings of the joint health and peace programming concept, awareness of health and peace programming currently underway in Libya, and opportunities for future health and peace programming in the Libyan context.

Key findings include:

- Both domestic and international actors provided **emphatic examples about the important overlap between health and peace programming**, and the unavoidable reality of their interaction in conflict-affected settings.
- Despite this, many of these same actors **struggled to articulate what health and peace programming is** and often took time throughout their interviews to settle on their own definition of the concept. This prevented many from identifying pre-existing health and peace programming currently underway in Libya.
- **Health and peace programming is operating in silos** in Libya, while a recognition for the need for cross-sectoral collaboration was expressed by international organizations, NGO staff, and community members interviewed.
- When examples of health and peace programming in other countries were provided, **three different types of health and peace programming emerged** from these interviews: hybrid programming, health-supported peace programming and peace-supported health programming.
- **Libya's healthcare system has many weaknesses** which have worsened over the course of the armed conflict. These span from poor quality public hospital services, unaffordable private hospital services, and poor medical infrastructure including medication shortages, medical equipment shortages and poorly maintained buildings.
- **Libyans and healthcare workers do not feel safe traveling to healthcare facilities** and healthcare services are sometimes provided in very close proximity to ongoing conflict. For those who are unable to access care at home, traveling to receive care in another city is challenging due to both costs and security concerns.

- **Health facilities are sometimes targeted by armed groups.** Healthcare workers also described an inability to respond to conflict related injuries and mass casualty events due to insufficient training and resource availability. Concurrently, increased conflict related violence due to extensive arms proliferation and injuries caused by mines has increased the need for these kinds of emergency services.
- The lack of trust in healthcare workers and government officials, including government support for health facilities, has weakened the ability for the healthcare systems to adequately provide medical care. Patients do not always believe that healthcare workers are accurately diagnosing problems and, those that can afford it, prefer to travel to Egypt or Tunisia for care. Government corruption and misuse of funds for the medical system has exacerbated and validated this lack of trust in the healthcare system. Only those with connections to influential people and the wealthy feel confident that they can access medical care.
- **Access to mental health services are poor** due to the low number of training psychiatrists and psychotropic medications are insufficiently supplied. Despite the enormous need for mental health care amplified by the armed conflict, the social stigma and the lack of a cultural framework for seeking mental health also bars those from seeking the mental healthcare that they need. Non-medical professionals such as religious figures are preferred by many Libyans who are in need of mental healthcare services, but are dissuaded from seeking them due to their unavailability and the fear of their community finding out.
- Interviews with community members and healthcare workers posited **key areas for starting points for health and peace programming in Libya.** These examples include programming aiming to reduce attacks on health facilities, establishing humanitarian corridors for patients seeking care, increasing institutional trust through strengthening access to medication/medical equipment or refurbishing hospitals, and partnering with trusted community members such as imams to increase awareness and access to MHPSS services.
- **Social cohesion is weak, with low levels of trust among citizens, and also between citizens and state institutions.** Moreover, according to some participants, there are grievances and presence of intragroup tensions, including related to migrants, serving as a barrier for marginalized groups to access healthcare services.

Recommendations:

- **Develop a needs-assessment guide for health and peacebuilding actors in Libya to identify opportunities for cross-sectoral programming** where technical expertise in both fields can support programmatic barriers and dire needs. One version of the guide can be produced for health actors while another can be produced for peacebuilding actors.
- **Advocacy and education is needed** within the public health and peacebuilding sectors in order to empower both health and peace actors to:
 - 1) **Understand the three different types of health and peace programming:** hybrid programming, health-supported peace programming and peace-supported health programming;
 - 2) **Promote the use of an internal needs-assessment guide** with both health and peace programming actors to identify key areas where specific health and peace programming

activities can be empowered by cross-collaboration with health or peacebuilding technical experts.

- 3) **Seek support from funding agencies** to provide financial backing and support the development and implementation of new programming.
- Consider **hosting a countrywide workshop with all health and peacebuilding stakeholders operational in Libya** to unveil the needs assessment guide, demonstrate how it can be used, and advocate for programmatic development with cross-sectoral partnerships.
- **Consider using the examples provided in this report for possible health and peace programming opportunities** for future programming as examples to sensitize possible actors through these broader advocacy initiatives.

Background

The multifaceted relationship between health and peace has received increased attention since the start of the COVID-19 pandemic. Armed conflict disrupts health systems, leads to casualties, produces mental and physical disabilities, and has increasingly featured targeted attacks on health facilities. Rates of sexual violence, infant mortality, food insecurity, and infectious disease typically occur in times of war. Health emergencies and infectious disease outbreaks, such as the Ebola outbreaks in West Africa and the Democratic Republic of the Congo, can act as additional stressors on public systems, inflame previous tensions, and can lead to new grievances. The COVID-19 pandemic has been a uniquely protracted, international health emergency. According to the Interpeace 2020 annual report, 46 states experienced deteriorating security, violence increased by 10%, and over 5,000 COVID-related security incidents were recorded during the first year of the pandemic¹. Violent protests and intensified political grievances occurred in both peaceful settings as well as settings affected by armed conflict. While the COVID-19 crisis is an ongoing stressor, the linkages between health and peace are central to other key areas such as disarmament, social cohesion, and psychosocial support activities in post-conflict settings.

The World Health Organization (WHO) produced a thematic paper on health and peace to outline the linkages, call for greater global accountability, and encourage targeted programming and policies². Estimates indicate that currently, 1.8 billion people live in fragile, conflicted-affected, and vulnerable settings while this is expected to affect half of the world's poor by 2030³. Interpeace is partnering with WHO and the United Nations Population Fund (UNFPA) in order to develop an increased focus on health and peace programming at policy and programmatic levels. Libya was identified as an opportune setting for this work. SREO Consulting Ltd. was contracted by Interpeace to develop an assessment of current actors, needs and programming for health and peace with an emphasis on mental health and psychosocial support (MHPSS) programming. This is meant to inform the development of future programming tailored to the needs identified by both experts and community members in Libya.

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Libya's Conflict

The first civil war

¹ Interpeace (2020) Shaping Future Peacebuilding: Annual Report 2020. Available here: https://www.interpeace.org/wp-content/uploads/2021/08/AR_2020_Web.pdf [Accessed 31 March 2022].

² World Health Organization (2020) WHO Thematic White Paper on Health and Peace. Available here: https://www.un.org/peacebuilding/sites/www.un.org.peacebuilding/files/un_pb_review-who_health_peace_thematic_paper_final_0.pdf [Accessed 31 March 2022].

³ World Health Organization (2020) Health & Peace Initiative. Available here: https://apps.who.int/gb/ebwha/pdf_files/EB150/B150_20-en.pdf [Accessed 31 March 2022].

On 15th February 2011, Fathi Terbil, a lawyer who represented the families of the infamous Abu Salim prison massacre in 1996⁴, was arrested following public attempts to have the massacre's perpetrators tried in open court⁵. The families represented by Terbil took to the streets in Benghazi to demonstrate against his detention, igniting a wave of protests that quickly escalated into a popular uprising and later into a civil war. At the time, Libya was one of the most stable countries in the region⁶. The "Arab Spring" in neighboring Tunisia and Egypt, and later across many Middle Eastern countries, and the exceptionally high levels of media attention might have signaled to the local and international opposition a unique opportunity to topple Ghaddafi's long-standing authoritarian regime.

In Benghazi, matters went from bad to worse when protesters attempted to attack an army barracks, prompting a reportedly "shoot to kill" government response that quickly escalated. Many of Ghaddafi's loyalists fled to Tripoli, further complicating existing divisions between Tripolitania and Cyrenaica. The rebel army promptly moved to Tripoli. The call to arms was unprecedented in Libya's modern history: Ghaddafi kept one of the largest arsenals in the world⁷, and its armories were left unsecured as the regime fell. Ghaddafi's depots were looted by different organizations, militias, and criminal organizations. These weapons were used for self-defense and attacking enemy forces while some were sold on black markets. Although the exact numbers are unknown, this event made Libya the world's largest uncontrolled ammunition stockpile, estimated to be between 150,000 to 200,000 tons.⁸

In March 2011, the National Transitional Council (NTC) was already formalized in Benghazi to lay the foundations for a new government once Ghaddafi, as it was confidently assumed, was removed from power. Western powers welcomed the NTC, and quickly the North Atlantic Treaty Organization (NATO) started an intervention under the UN Security Council Resolution 1973, based on the auspicious concept of Responsibility to Protect (R2P). NATO allies enforced a no-fly zone (NFZ) and a naval blockade, supporting the multiple groups of local fighters that had mobilized to fight the regime, resulting eventually in its demise in August 2011 and the subsequent death of Ghaddafi in his hometown of Sirt in October 2011.

The General National Congress (GNC) was elected by popular vote in 2012 with the challenge of transitioning Libya onto a democratic path. This new government inherited a country that lacked a formal constitution and kept institutions deliberately weak. Ghaddafi relied on informal units mostly composed

⁴ Abu Salim is a maximum security prison in Tripoli where 1.270 prisoners were shot and killed in 1996, according to Human Rights Watch.

⁵ Foreign Policy (2011). What if Libya staged a revolution and nobody came? Available here: <https://foreignpolicy.com/2011/02/18/what-if-libya-staged-a-revolution-and-nobody-came/> [Accessed 31 March 2022].

⁶ Oakes, J., (2021). *War Lord: Khalifa Haftar and the Future of Libya*. Print.

⁷ *The Guardian* (2011) *Where is Gaddafi's vast arms stockpile?*. Available here: <https://www.theguardian.com/world/2011/oct/26/gadaffis-arms-stockpile> [Accessed 31 March 2022].

⁸ AP NEWS (2011) *UN: Impact of long Libya war on civilians is 'incalculable'*. Available here: <https://apnews.com/article/africa-united-nations-us-news-tripoli-north-africa-333fe41a6bab5d9223aa563507733a03> [Accessed 31 March 2022].

of his tribesmen and those close to him. Without a Ministry of Defense and neglected formal defense forces, it was difficult for the NTC to establish an effective army command, relying on militias and armed groups known in Libya as the *thuwwar*. While the GNC promised to dissolve the *thuwwar* and strengthen the formal security sector, these initiatives were not successful. As the ones who fought the regime, *thuwwar* wanted legitimacy. Consequently, Libya formalized a hybrid institution that allowed these armed groups to operate on behalf of the government, putting a number of armed groups on the new government's payroll. Moreover, the GNC failed to form political unity: it was not unusual for the GNC to have its base stormed by powerful militias to demand political concessions. In addition, Islamists who used to be imprisoned or were obliged to flee into exile during Ghaddafi's era had re-emerged, winning several seats in parliament (mainly with the Muslim Brotherhood and Salafists)⁹, clashing with the more secular views of the winning coalition.

The second civil war

Growing rivalries undermined political development. In 2014, when the GNC refused to stand down at the end of its term, General Khalifa Haftar launched a campaign (Operation Dignity) against Islamist forces within the GNC, calling for elections. When the polls took place, some defeated Islamist parties rejected the results. They did not recognize the newly elected House of Representatives (HoR), which had appointed Khalifa Haftar the head of the Libyan National Army (LNA). The security situation continued to deteriorate, especially when Islamist militias seized Tripoli's airport (Operation Libya Dawn), making the HoR move to Tobruk and join the LNA forces, sparking a second civil war. In January 2015, a ceasefire was negotiated, leading to the country's division into two overall administrative centers, one in Tripoli/Misrata and the other in Tobruk. A peace agreement was signed at the end of 2015, backed by the United Nations and recognized by the international community, forming the Government of National Accord (GNA). However, despite the initial agreement between all parties, the HoR later withdrew their support, becoming the GNA's main rival in the country. Libya remains divided between the GNA forces controlling the west (Tripoli, Misrata) and LNA forces controlling the east (Benghazi).

The fight for control of Libya's resources and institutions in April 2019 escalated with the launch of the Western Libya Campaign by the LNA to capture Tripoli. The forces allied to the GNA eventually repelled the LNA in June 2020. Still, protests against constant power cuts¹⁰, insecurity and poor management of the COVID-19 outbreak sparked in the areas controlled by the GNA and the LNA. In October 2020, a peace agreement was signed involving trust-building measures aiming to create opportunities for a future unification of military institutions. In 2021, the Government of National Unit (GNU) was formed as part of the peace agreement, giving Libya its first unified government since 2014, even though in practice the country is still very much divided between the 3 regions (Tripolitania in the northwest, Cyrenaica in the east and Fezzan in the south).

⁹ In 2012, the National Forces Alliance, a coalition of secular and independent groups won 64 seats, while the Muslim Brotherhood's Justice and Construction Party took 34 seats, while Salafi parties picked up another 27 seats—a total of 61 seats for Islamists.

¹⁰ Aljazeera (2020). *Anger in Libya's Benghazi over power cuts, living conditions*. Available here: <https://www.aljazeera.com/news/2020/9/11/anger-in-libyas-benghazi-over-power-cuts-living-conditions> [Accessed 31 March 2022].



Figure 1: Map of the 3 regions in Libya Source: Wikipedia

The GNU term was supposed to end with new elections in December 2021. However, the polls have been postponed by the Prime Minister, who is yet to set a new date.

Currently, Libya is enjoying a moment of relative stability following the reported compliance with the peace agreement. The lifting of the oil blockade¹¹ and the resumption of oil exports have increased oil production, which has improved the prospects for economic gains in 2022.¹² Peacebuilding actors are considering this time as a momentum for furthering Security Sector Reform (SSR) and Disarmament, Demobilization and Reintegration (DDR) programming. It is unlikely that Libya will be able to move ahead without addressing the proliferation of armed groups, the small arms that flooded the country since the uprising, and addressing the local grievances. The ceasefire has allowed for investigations of human rights and international law violations that have been reported by all parties to the conflict, including mass killings, arbitrary detention, torture, and the recruitment of child soldiers.¹³

Inter-communal conflict and national reconciliation

Other factors influence the Libyan conflict on a more local level, such as ethnic, tribal, and regional tensions, as well as clashes between so-called revolutionary and counterrevolutionary forces.¹⁴ Libya's social fabric is based on traditional identities such as families, tribes and clans, where each individual member is accountable for the collective reputation of their community. Libya is composed mostly of Arabs, Amazighs, Touaregs and Tebus, with more than 90% of the population descending from Arabs,

¹¹ Reuters (2020). Libya's Haftar says he will lift oil blockade, with conditions. Available here: <https://www.reuters.com/article/libya-oil-idUSKBN2692QK> [Accessed 31 March 2022].

¹² world Bank (2021). Global Prospects Report. Available here: <https://www.worldbank.org/en/publication/global-economic-prospects> [Accessed 31 March 2022].

¹³ UN News (2021) Libya: War crimes likely committed since 2016, UN probe finds. Available here: <https://news.un.org/en/story/2021/10/1102052> [Accessed 31 March 2022].

¹⁴ Ibid, 2021

ethnic Arabs and Berbers claiming affiliation to one of the more than 140 different tribes and clans.¹⁵ A tribe is a powerful source of protection, sense of belonging and social cohesion, especially in times of conflict and uncertainty. It can also be a means of obtaining privileges, patronage, accelerating bureaucracy and gaining influence. Tribal leaders - *sheikhs* - have an important role as mediators: tribal justice coexists with the formal justice system, sometimes being considered as more transparent, faster and more effective than the latter, as such decisions are based on traditional, conservative concepts that are familiar to the community and widely accepted. Tribal affiliation has intensified since the 2011 uprising.¹⁶ Moreover, old tribal alliances - particularly those loyal to the regime - have shifted, and the strong militarization of the tribes made less prominent tribes more evident and influential, while other traditional tribes had their reputations and influence damaged during the conflict. The contextualization of Libyan tribes' is integral to understanding the past, current and future events within the conflict.

Libya is traditionally segregated into three regions: **Tripolitania** is more connected to the Maghreb and is where the academic, administrative and economic elites are based. During the Ghaddafi regime, Tripolitania had developed faster than the other regions, with its Arab tribes having more access to the government while other regions' tribes were marginalized. **Cyrenaica** is traditionally connected to Egypt and Middle Eastern tribes while **Fezzan**, the third region, has closer ties with sub-Saharan Africa, such as Chad and Niger. Ghaddafi promoted an Arab nationalist ideology, often marginalizing non-Arabic ethnicities and tribes such as the Amazigh, Touaregs and Tebus of Fezzan, while favoring the Arab tribes of Tripolitania and Cyrenaica to a lesser extent.

In Tripolitania, the *Warfallah* makes the most prominent tribe, with up to 1 million members, with a strong base in Bani Walid. Other influential tribes are the *Qadhadfa*, Muammar Ghaddafi's tribe based in Sirte¹⁷ and the regime's last stronghold, and the *Zintani*: mostly located in the western town of Zintan, they became more influential following the uprising while joining Haftar's forces, accessing heavy weaponry and controlling oil fields. The Amazighs are a minority in Tripolitania and have fought since 2011 for the right to speak their language and use their symbols, which were prohibited by Ghaddafi. Traditional tribes reportedly find them to be a threat to Libya's identity and political influence.¹⁸

In Cyrenaica, the nine Sa'adi tribes and the 24 Marabtin tribes¹⁹ are the most powerful. There are endemic hostilities that escalated to intertribal warfare between the Zuwayas, a Marabtin tribe, and the Tebus due to the NTC choice of assigning the Tebus, and not the Zuwayas, to enforce border control and checkpoints. The interim government was not capable of addressing the country's traditional tribal cleavages. In the meantime, in Fezzan, the Tuaregs and Tebus struggle to achieve political representation and access to

¹⁵ Lamma, M. (2017). The Tribal Structure in Libya: Factor for fragmentation or cohesion? Available here: <https://www.frstrategie.org/web/documents/programmes/observatoire-du-monde-arabo-musulman-et-du-sahel/publications/en/14.pdf> [Accessed 31 March 2022].

¹⁶ Ibid, 2017

¹⁷ Hatitah, Al-Awsar (2019). Libyan Tribal Map: Network of Loyalties that will determine Ghaddafi's fate. Available here: <https://www.cetri.be/Libyan-Tribal-Map-Network-of?lang=fr> [Accessed 31 March 2022].

¹⁸ Ibid, 2019

¹⁹ Ibid, 2019

resources. Fezzan, the region where most non-Arab tribes are located, is the poorer region that receives less attention from Libyan authorities and suffers from lack of investments and public services. According to Amnesty International²⁰, Tebus and Tuaregs face discrimination in southern Libya in accessing essential services, including healthcare, education and getting legal documents such as a national ID. *"In al-Kufra, Tebus were unable to access the south-eastern city's only university as it is located in an area controlled by rival armed groups."*^{20"}

Refugees and migrants

Despite the conflicts, Libya has been not only a transit but also a final destination for migrants. From January to September of 2021, more than 1,300 migrants have died or disappeared while trying to cross the Mediterranean Sea. Meanwhile, Libya's strict legislation has sent more than 10,000 migrants and refugees to overcrowded detention centers, reportedly without due process and involving several human rights violations. Many refugees and migrants suffer from lack of legal status and access to basic services due to nepotism and discrimination.²¹

Libya's Health System

Overview

Prior to the war, Libya's health system showed key areas of promise in achieving important public health objectives.²² However, due to ongoing conflict, the quality of Libya's healthcare system severely declined: a high number of healthcare facilities - especially at primary health care (PHC) level - are closed and in need of repair. According to the 2021 Humanitarian Needs Overview, more than 803,000 people lack consistent access to primary and secondary health care services (roughly 11% of Libya's population of 6.8 million)²³. This includes 132,000 displaced people, 115,000 returnees, 281,000 non-displaced Libyans, 232,000 migrants and 43,000 refugees. Reports indicated that a third of all health facilities in the south and east of Libya are closed, while 73% in the south and 47% in the east are partially functioning.²⁴ Moreover, regular power and water cuts, and fuel shortages, are disrupting critical services: only six out of 227 health facilities assessed in the south reported sufficient levels of electricity to function.²⁵ The lack of security across the country has decreased access to healthcare facilities, damaged their infrastructure and led to shortages of equipment, medicines and staff. In addition, Libya's health system has struggled to respond to the COVID-19 pandemic. The outbreak has led to the closure of several health facilities due

²⁰ Amnesty International (2021) Libya 2021. Available here: <https://www.amnesty.org/en/location/middle-east-and-north-africa/libya/report-libya/> [Accessed 31 March 2022].

²¹ Ibid, 2021

²² OCHA (2021) Humanitarian Needs Overview, 2022 (December 2021). Available here: <https://reliefweb.int/report/libya/libya-humanitarian-needs-overview-2022-december-2021-enar> [Accessed 31 March 2022].

²³ World Bank (2022) Population Tool- Libya. Available here: <https://data.worldbank.org/indicator/SP.POP.TOTL?locations=LY> [Accessed 25 April 2022].

²⁴ Ibid, 2021

²⁵ OCHA (2021) Health (Libya). Available here: <https://www.humanitarianresponse.info/en/operations/libya/health> [Accessed 31 March 2022].

to lack of personal protective equipment (PPE) and high levels of transmission among the staff. The outbreak has exacerbated the challenges faced by the health sector by increasing the demand for services, supplies and human resources.

Governance

The Ministry of Health (MoH) has recently been unified under the GNU, but establishing the local health authorities and offices in different municipalities is yet to be finished. Catchment areas and populations are also not established, nor a comprehensive plan to rehabilitate the health sector in the country so meaningful reforms can be implemented. During 2022, the MoH has signed a few memorandums of understanding (MoU) with France, Turkey and Egypt for international cooperation in the health sector. According to the health cluster, the revision, harmonization and costing of the Libyan Essential Package of Health Services is necessary to inform decision-making.

Even though Libyan law guarantees free and public healthcare for all, in practice, the private sector is growing fast with minimal regulation or oversight over the private health facilities. This movement has alarmed the Libya Health Cluster²⁶. Moreover, wealthy Libyans reportedly travel abroad to seek healthcare in neighboring countries. These dynamics have resulted in huge gaps in service availability. As of 2021, only 20% of communities have child health and emergency services, 25% have general clinical services, 15% have services for reproductive health care, and 15% have services for noncommunicable and communicable diseases.

Key challenges and priorities

According to an internal analysis, the MoH identified the following key challenges in the Libyan healthcare system: fragmentation of health sector institutions, weak governance, lack of accountability, extreme shortages of medical supplies and health staff, a badly disrupted PHC network and severe funding shortages. During a health cluster assessment in 2019, it was highlighted that 33% of PHCs had zero essential medicines available. According to assessments conducted by the International Medical Corps (IMC) in 2019,²⁷ the key challenges of the health sector include:

- Lack of training for healthcare professionals.
- Lack of specialized response in terms of the reproductive and mental health capacity.
- Shortage of staff with no general or specialist doctors, such as psychologists, midwives and psychiatrists.
- Lack of capacity for ante-natal care.
- Lack of efficient referral system and ambulance services.
- Lack of data for evidence-based nutrition programming.

Routine health services, such as child health, non-communicable diseases and mental health are likely to continue to be deprioritized and concentrated to largely urban locations as the limited capacity is focusing

²⁶ Libya Health Cluster (2021) Annual Report. Available here: <https://reliefweb.int/report/libya/health-sector-libya-annual-report-2021>

²⁷ Ibid, 2021

on the COVID-19 response, while aiming to strengthen essential health services.²⁸ Due to the severe deterioration of conditions in Libya, quantifying the disease burden via incidence and prevalence of specific medical conditions including mental health care conditions has been hindered by a poor disease surveillance system²⁹. Libya does not currently have a data dictionary, standardized data management protocols, data quality control measures, and does not currently have a web-based surveillance system in place to collect epidemiological data³⁰. Consequently, the true disease burden is not possible to accurately quantify and to support the development of evidence-based public health programming.

The Humanitarian, Development and Peace Nexus

Recurrent violent conflicts have become more protracted and complex in nature, involving more non-state groups, regional and international actors. This trend reinforces the importance of developing longer-term interventions that address humanitarian needs, while considering development and peacebuilding challenges. The landmark resolutions on “sustaining peace” adopted in April 2016 by the UN General Assembly and Security Council have emphasized UN efforts to prioritize the importance of violent conflict prevention as well as the need to address their drivers and root causes.³¹ Strengthening the Humanitarian-Development nexus was identified by the majority of stakeholders as a top priority at the World Humanitarian Summit (WHS) in 2016. The Humanitarian- Development-Peace (HDP) nexus aims to bring three sectors into closer alignment to effectively address both the immediate needs of people affected by conflict as well as the underlying causes of protracted crises. This approach ensures that humanitarian operations can focus on acute needs and those in the development sector in order to plan for long term resilience for vulnerable people, and promoting peaceful and robust communities.

Global health and peace

WHO’s Constitution recognizes the connection between health and peace, stating that “*the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States*”.³² For WHO, the nexus means expanding universal health coverage in fragile and conflict-affected settings in a way that promotes more inclusive societies, advocates for

²⁸ Ibid, 2021

²⁹ Abdulshafea (2021) The epidemiology of common mental disorders in Libya: Available here: <https://ejnpn.springeropen.com/articles/10.1186/s41983-021-00408-y> [Accessed 31 March 2022].

³⁰ WHO (2020) HDPNx for health profile: Libya. Available here: https://applications.emro.who.int/docs/9789290227182-eng.pdf?TSPD_101_R0=0847ec2a77ab2000c4fe139b9b73cff43e746ad766efb567744d254f89ae4dfbb602e962b4272d8d08727d94aa143000b744f78b47fd53941f195f8d8cc6afddddd8d03ddc33f2188d56ce5b45ffcce1453f42b518fc799d7a5e036cc24ddc5d8 [Accessed 31 March 2022].

³¹ United Nations (2020) Peacebuilding and sustaining peace Report of the Secretary-General. Available here: https://www.un.org/peacebuilding/sites/www.un.org.peacebuilding/files/documents/sq_report_on_peacebuilding_and_sustaining_peace.a.74.976-s.2020.773.200904.e_4.pdf [Accessed 31 March 2022].

³² WHO (2021) WHO Constitution: <https://www.who.int/about/governance/constitution#:~:text=The%20health%20of%20all%20peoples,is%20of%20value%20to%20all> [Accessed 31 March 2022].

equitable access to essential health services (such as social cohesion, resilient and robust response to recurrent crises), and contributes to addressing the root causes of tension and marginalization.³³ The promotion of health interventions is now seen as a contributing factor in achieving positive effects on world peace. The interconnectedness of health and peace supports the fact that even health initiatives and healthcare providers can play a significant role in contributing to peace in various forms.³⁴

The COVID-19 pandemic has further exacerbated fragilities and grievances, eroded social cohesion within and among communities, and significantly exacerbated gender inequalities and violence against women and girls. COVID-19 has underscored the importance of switching from crisis response to prevention and the need to better anticipate, prevent and prepare for major risks by having stronger legal frameworks and better tools for managing risks.³⁵

Methodology and Data Collection

In March of 2022, SREO conducted 25 focus group discussions (FGDs) and 50 key informant interviews (KIIs) with key stakeholders, experts, community members, and healthcare workers across Libya from March 15th, 2022 until March 29th, 2022. Data collection occurred in two stages inside of Libya. Interviews were conducted in Arabic, recorded and transcribed before being translated in English. Analysis was conducted in MAXQDA after the development of a codebook through an iterative process based on the first several interviews. After the first stage of interviews were conducted and analyzed, key characteristics were identified to guide the planning for the second stage of data collection.

The first stage included 17 FGDs with a combination of healthcare workers and community members in 11 Libyan cities (please see Annex 1 for the locations of all FGDs). KIIs were also conducted during stage 1 including 16 KIIs with healthcare workers based in urban hospitals (please see Annex 2 for the locations of all KIIs). During the second stage of data collection, SREO conducted 5 FGDs with religious leaders including imams, muktars and sheikhs. An additional 23 KIIs were conducted including 7 KIIs with change agents³⁶, 7 KIIs with government and public service officials including Ministry of Health and Ministry of Interior officials, 4 KIIs with Libyan NGOs, and 5 KIIs with psychiatrists and mental health professionals.

Throughout both stages of data collection in Libya, 5 KIIs were conducted remotely in English via Skype with experts based abroad and in international organizations including the World Health Organization (WHO), Expertise France, the International Committee of the Red Cross (ICRC), and the Peaceful Change

³³ Ibid, 2021

³⁴ Chattu, Vijay Kumar & Knight, W.. (2019). Global Health Diplomacy as a Tool of Peace. *Peace Review*. 31. 148-157. 10.1080/10402659.2019.1667563.

³⁵ UN (2022) Peacebuilding and sustaining peace, Report of the Secretary-General. Available here: <https://reliefweb.int/report/world/peacebuilding-and-sustaining-peace-report-secretary-general-a73668-s202266-enarruzh> [Accessed 31 March 2022].

³⁶ Change agents have previous experience with peacebuilding forums and have partnered with Interpeace in the past during peacebuilding workshops in Libya.

Initiative (PCI). These interviews were recorded and transcribed through the same coding process used for the interviews conducted in Arabic.

Themes Explored in the Data Collection Tools

During the first round of data collection, SREO tools approached several relevant themes related to health and peace based on the initial desk review, such as:

- The Libyan healthcare system, its structural barriers, current needs, and how the system has changed since the beginning of the uprising in 2011. SREO also explored the mental health and psychosocial (MHPSS) sector's main challenges and needs, and how its activities can impact peacebuilding programming, which was further explored in the second round of data collection.
- Participants' understanding of the health and peace concept, capturing their insights and perspectives on the theme, and assessing the extent of which health-related programs in Libya are currently informed by peacebuilding and vice-versa.
- Social cohesion questions were included to understand the quality of the relationships and interactions between different groups (mainly different tribes and at a lower level between host and refugee communities), as well as the levels of trust between the local community and the most relevant governmental and non-governmental actors.
- SREO has also inquired participants about their perceptions on security, conflict and peace.

In the second round of data collection, SREO added additional questions to the tools related to:

- Alternative avenues for MHPSS services based on the stigma and access barriers revealed in the first round of data collection including non-medical alternatives for psychosocial support.
- Additional questions about conflict-related injuries including arms proliferations and mines.
- Additional questions about social cohesion to further explore insights about local grievances.

Limitations

Scope of barriers to the healthcare system: This exclusively qualitative study is not an exhaustive, technical review of the barriers and health system challenges experienced across Libya. Extensive research has been produced by both academics and international organizations about key challenges facing Libya's healthcare system since 2011. The problems described in the findings section are meant to contextualize the lived experiences of the participants in this study. This is meant to provide background for the programmatic opportunities based on the needs of those living within these restrictions. Themes observed are representative of the study participants' opinions alone and are not generalizable.

Identified needs are possible starting points for programming and are not meant to be exhaustive: The needs and examples provided for possible health and peace programming are suggested as possible starting points based on needs described in interviews. They are not meant to represent all opportunities for programming and were not intended to represent a full systematic review.

Report focuses on nationals as opposed to migrants: While migration into and through Libya is a key component of the context, the scope of this report focused on the experiences of Libyan nationals who are able to both reflect on the deterioration of their health system since the conflict began and to also describe their experiences with the broader national framework for accessing medical care via the health scheme and service availability as predominantly designed for Libyan nationals.

COVID-19 not explored as a primary theme: Interpeace produced a report on health and peace in the context of the COVID-19 pandemic in 2021. Because this theme has already been explored by Interpeace in previous research, this report aimed to take a longer-term perspective on the changes that have occurred in the health system since 2011 and to not only focus on the last few years. Consequently, data collection tools and analysis strategically focused on the broader trajectory of the health system and public health needs of the population without an emphasis on COVID-19 as a more recent stressor.

Findings

Interpretations of the health and peace programming concept

Interpretations of what health and peace programming meant to different actors were diverse. Despite the longstanding awareness that these key areas overlap in many ways, interview participants indicated that the majority of the dialogue concerning health and peace programming still operates in silos in Libya with no formalized process for integrating programming. Data collection tools were designed to allow for a flexible, subjective representation of the parameters for health and peace programming based on how the interview participant could apply these concepts to specific professional experiences. Many participants were not aware of the health and peace concept. A Libyan NGO staff member described this by saying *“The concept of “health and peace” is not known and I have never heard of it being used in this way.”* This lack of familiarity was the norm among interview participants.

Despite this lack of familiarity among both public health actors and peacebuilding actors, there was a palpable enthusiasm for the importance of addressing the overlap of both sectors. Many actors struggled to initially apply the health and peace framework due to its broad nature or to define it in their own terms. An official at a peacebuilding NGO struggled to describe or define health and peace programming, but went on to say that *“Health programming can enhance a clear guiding principle based on equity and respect. Even if health programming is not built for peace programming purposes, we are achieving and planning for well-being and laying the foundation for social cohesion with this work. Through this we achieve some peacebuilding outcomes.”* These sentiments concerning the inextricable linkages between health and peace were unilaterally expressed in interviews.

Over the course of interviews, participants would become more established in their working definition of the concept and make connections with more specific prescriptions. One participant’s attempt to describe the potential impact for health programming as an entry point for peace expressed this by saying *“It needs to be based on an understanding of health dynamics and conflict dynamics in that particular context. And then designing your programme explicitly to address that, depending on what your ambition is. So I think, yeah, it depends, I guess the short answer, yes, but it depends.”* This participant's generalized and iterative approach was reflected in other interviews. Participants consistently moved between confidence that these approaches are essential and confusion over how to articulate them. Without the support of a broader framework to consider the health and peace concept within, interview participants struggled to provide clear concrete responses. This suggested a need to better establish an operating definition of health and peace programming to empower actors to use technical expertise in both fields when complementary approaches are needed.

When asked for concrete examples of health and peace programming, three general categories of health and peace programming emerged:

Health and Peace Collaboration Type	Definition ³⁷	Example
Hybrid Programming	Programming where technical expertise was equality informed by peacebuilding actors and public health actors.	MHPSS programming to address post-conflict trauma, feelings of resentment and revenge which are led by public health professionals and peacebuilding actors focused on social cohesion.
<u>Peace-supported health programming:</u> Health Programming supported by Peace Programming	Programming where health programming needs peacebuilding technical support to remove obstacles, prevent problems, and facilitate access.	A vaccination program is unable to vaccinate children in an area controlled by an armed group. Peacebuilding experts facilitate dialogue to grant access to the vaccinators.
<u>Health-Supported Peace Programming:</u> Peacebuilding supported by Health Programming	Programming where peacebuilding programming needs health sector technical support to facilitate reconstruction, violence prevention, civilian and military peacekeeping, humanitarian assistance, etc.	A Humanitarian Mine Action (HMA) program needs the health sector technical support to provide medical and psychological long-term assistance to the victims and survivors of explosive remnants of war, which is a pillar of HMA programming.

This framework is not only meant to provide structure and categorization to a multidisciplinary concept, but is meant to lay the groundwork for which actors are meant to take the dominant technical lead.

Most interview participants talked about the need for or having had experience directly with peace-supported health programming or health-supported peace programming. A peacebuilding actor in Libya described past programming which supported health as a social service provision in other conflict settings with an emphasis on vulnerable groups. Health actors described initiatives conducted in other settings such as in Gaza to reduce feelings of resentment and treat the harmful impacts of living in a conflict zone. Stabilization programming in conflict-affected areas included examples of refurbishing health facilities and filling gaps in medical equipment in under-resourced health facilities.

Awareness of Current Health and Peace Programming in Libya

Due to the uncertainty expressed by respondents concerning the parameters of the health and peace concept, concrete examples of existing health and peace programming were difficult for respondents to provide. When asked about current health and peace programming, most KII participants indicated that they were not aware of current programming in Libya, often after a pause to further consider their

³⁷ This definition was formulated by SREO for the purposes of interpreting the findings of this study within the Libyan context only.

response. Community members and physicians were also not aware of programming which covered topics related to both health and peace. A physician in Sirt described some MHPSS awareness raising sessions conducted by WHO to help sensitize the community to the idea of using mental health services. This programming covered war-related trauma and the importance of getting mental health services in areas affected by conflict. Despite this, this respondent did not initially identify this as health and peace programming. A Red Crescent staff member described ongoing initiatives to provide psychosocial support to conflict-affected communities including awareness sessions, direct PSS services, and confidentiality protections to put beneficiaries at ease. The International Rescue Committee (IRC) described collaboration with the Red Crescent in addition to their own PSS programming. A staff member at a local NGO also described past initiatives from UNICEF to provide PSS to internally displaced children in Ghat. This individual indicated that they hoped that these initiatives would expand to adults as well since trauma due to the armed conflict is so widespread. Likewise, a local NGO staff member working as an implementing partner (IP) with UNFPA indicated that they have provided PSS as part of their reproductive health programming in Libya with the Italian organization GVC in Sebha, Wadi Shati, and Dhari. An additional NGO staff member that worked in an IP organization with a UNDP stabilization project indicated that there was a small health component to their work in the past.

WHO officials described an ongoing project to provide mental health services at the primary healthcare level. This programming is training general practitioners and family practitioners to be able to diagnose, treat and follow-up with ten priority mental health conditions. Many of these conditions have additional risk factors related to armed conflict including depression, stress-related conditions, and psychosis. WHO is also supporting the supply chain for psychotropic drugs because medications are not available at the primary healthcare level. While it's generally not permissible for non-psychiatrists to prescribe psychotropic medicines, this program provides training specifically to general practitioners to be able to do so.

Despite describing this health and peace related programming with mental health, when asked about whether this individual knew about health and peace programming in Libya they said, *"No. Just recently I actually had 2 meetings with the Interpeace organization so we had a discussion and we are planning to have a short activity together related to mental health."* Consequently, even among those already implementing health and peace related programming, the lack of a frame of reference made them unable to identify this type of programming within the health and peace concept.

Some health actors including some local NGOs that are working as implementing partners (IPs) with UNFPA in conducting reproductive health programming emphasized the additional urgency of providing these services due to the armed conflict. This reaffirms many of the convictions expressed by health actors that armed conflict deepens the health needs of affected communities. Despite this emphasis on the overlap, interviews conducted with local implementing partners revealed that they were not aware of any health and peace programming currently being conducted in the country.

Opportune Areas for Health and Peace Programming

Supply and infrastructure deficits within health facilities

Interviewed across the country corroborated the findings from the literature review conducted on health system barriers in Libya. Health facilities experience key deficits in essential resources such as medical equipment, medications, funding, and reliable electricity due to poor access to generators and fuel. These deficits were additionally apparent during the COVID-19 pandemic, during which PPE was in short supply. Ministry of Interior and Ministry of Health officials described an additional deterioration of an already fragile health system as a result of the COVID-19 pandemic. Physicians also described the absence of a fully functional disease surveillance system and insufficient public health research to truly be able to address the burden of disease in their communities. Many health facilities, especially in more remote parts of the country such as Sebha in the south, described patient catchment areas which far exceeded their hospital's service capacity.

Health facilities suffer from large operational gaps such as missing important departments or services such as ICUs and operating rooms. Public hospitals are often in old buildings which are in serious need of maintenance. For example, Brak General Hospital was opened in the 1990's and has enormous unmet rehabilitation needs, which has left the building unfit as a health facility. A key informant in Jumail indicated that hospital rehabilitations that started before the conflict remain ongoing and were never completed, which has resulted in the use of inadequate buildings for health facilities. A physician in Sirt described this by saying *"Most of the public buildings are old and dilapidated, and even if maintenance was conducted, it is usually only in some sections, offices, and clinics. All of the public entities are suffering when it comes to infrastructure."* Laboratory services in Bani Walid, Benghazi and Ghat were limited in the hospitals due to insufficient supplies. Despite health services being provided for free, patients have no choice but to receive laboratory services elsewhere and to incur the costs themselves.

Key medical equipment such as X-ray machines and computed tomography (CT) scans were unreliably operational in hospitals surveyed across the country including in Benghazi and Ghat. Large discrepancies in access were noted between what is available in large urban areas and smaller cities or rural areas. A respondent in Kufra described his mother needing to go to Benghazi for a surgery because the health facilities in Kufra didn't have the necessary supplies and there was only one surgeon available. The family had to go into debt in order to finance both the procedure and the costs of travel. These deficiencies were punctuated by feelings of despair among hospital staff. A physician in Kufra expressed this by saying *"There is no infrastructure, the situation in this regard is very bad. The health centers don't meet minimum standards. We have been suffering for 10 years. Sometimes we receive 10 doses of medicine in a service area of ten thousand people. It is not enough."* Ministry of Interior officials also reflected that this sense of despair extends beyond the health sector by saying *"Some people have hope that things will change for the better, but the majority of people don't have this hope."*

Medication supply availability was poor in most hospitals including in Benghazi, Brak, Ghat, Misrata, Nalut, and Kufra. One hospital in Benghazi described a dire situation in which the monthly supplies provided to the facility always run out at the end of the month before the next shipment arrives. These shortages in

Misrata resulted in patients sourcing medications from elsewhere and needing to cover the costs out-of-pocket. A physician in Tobruk described this nationwide issue by saying *“All health centers in Libya have the same problem, there is a shortage in terms of the general medicines and the specialized medicines with minimal supply or support provided by other organizations such as WHO. The needs of the health center are greater than the provided support.”* A different physician in Tobruk indicated that the quality of the pharmaceuticals supplies has declined as well since facilities are often depending on expired medicines or cold chain items which were not refrigerated. Physicians across the country talked about an expanding black market for smuggled medications whose origins and quality cannot be ascertained.

Many physicians described the decline in hospital capacity since 2011. A physician in Benghazi illustrated this point by saying *“In Benghazi, we have lost about 1,100 hospital beds. There are 400 which were broken in Al Hawari, 300 broken beds in the 7th October hospital, and about 400-500 beds in Al Jamhuri hospital. Other equipment and medications were also lost. We have lost all of these things. Most of our staff has left the country or stopped working in the health sector, and caused overcrowding in some hospitals, where there are good doctors.”* This diminished health facility capacity with a loss of qualified physicians who left the country over the course of the last 10 years has made it harder for physicians to meet the demand for medical services in the country.

Some remote parts of the country do not have enough health facilities which means that local residents have to travel long distances to get medical care such as in Brak, Ghat or Kufra. One resident described this by saying *“Here, in Kufra, especially regarding heart diseases and strokes, people can’t access treatment because there isn’t a center that treats heart diseases, which forces people to travel 1,000km to seek treatment, and this causes people to incur a lot of expenses and make a lot of effort. Some of those patients even die on the road before reaching Benghazi or Tripoli to receive treatment.”* Stories like this were shared by other participants that lived in southern Libya. Others expressed that healthcare workers and facilities are much more concentrated in the cities which has produced huge geographical gaps in access to healthcare.

The divide between public and private medical care

Despite these common themes observed across most health facilities, interview participants indicated that there were large differences in the quality of care provided at public and private health facilities. Key informants in Jumail and Sirt described the improved quality of services in private facilities, but that the services were prohibitively expensive for most Libyans. Ministry of Health officials and physicians described the lack of oversight over the establishment of these private facilities and an inability to regulate affordability problems.

One FGD participant in Sirt indicated that only a minority had access to private care and indicated *“For example, there are some companies in Sirt that provide medical insurance for their employees, so these employees are able to seek services in the private sector, but 90% of the citizens don’t have access to these services because the public sector, such as Ibn Sina hospital, the polyclinic, and health facilities suffers a lot from the lack of supply, delays in payroll management and financial problems, and the delays of the*

Ministry of health and the affiliated authorities.” Participants frequently described superior care available at private facilities, but that the high costs meant that most individuals still sought care at strained public facilities. As one FGD participant described *“It is easily available in the private sector, but it’s not affordable. For example, if you are used to buying medicines for blood pressure or diabetes for 30 Dinars, it’s so common that one day that the price has changed to 40 or 50 Dinars, and they will tell you that it’s because of the road closure and expenses.”*

In Ghat, participants described this by saying *“The private sector is the main health sector where it has all the needed equipment while the public sector lacks the needed equipment and your turn might take a whole month.”* Physicians also voiced concerns that health staff were more easily retained at private facilities because they were able to provide better salaries and contracts than public hospitals can provide. This also contributed to a feeling among patients that this draw to the private sector has made them view the medical field as more profit driven than humanitarian. A physician in Tripoli described an environment in which price gouging and profit are prioritized by physicians by saying *“The medical community (healthcare workers and the hospital system) is very exploitative, when there is a new medical solution available, the treatment will be very expensive. For chronic disease care, I only have 60% trust in the medical community.”* These discrepancies between public and private care have exacerbated health equity challenges for Libya’s most vulnerable.

Human Resource and Capacity Obstacles

While most facilities indicated that there was a sufficient number of staff available, they described an unequal distribution of staff, insufficient specialty staff, and staff unreliably reporting to work due to unreliable salary payments, low salaries, or unsupportive contracts. Some hospitals indicated that they had a sufficient number of staff, but that healthcare workers were not always reliably conducting their responsibilities and did not always come to work. Despite the sufficient number of nurses in Misrata for example, the quality and reliability of the nursing workforce still was not sufficient to meet the needs of the patient population. Insufficient and unreliable funding has also affected the healthcare workforce which has limited reliable salary payments. A physician in Sirt expressed this by saying *“There is always a deficiency regarding nursing and assistance staff, and the main reason is that they work without receiving any salary. Some of them have been working for one or two years without getting paid.”* Health staff frequently describing the demotivating effect of not receiving salaries for months on end which eventually leads them to seek employment in the private sector or to leave the medical field all together.

Hospitals in Bani Walid, Benghazi, Brak, Kufra, and Tripoli described the need for additional training for healthcare workers, but not having access to them. The only hospitals that indicated that they had sufficient training conducted within their facilities were hospitals that had medical residency programs where trainings were embedded into the facility. The one healthcare worker in Benghazi that indicated that they received additional training related to COVID-19 stated *“We received those trainings from international organizations on responding to COVID-19 cases as well as other but I didn’t attend them so I have no idea about them.”* The WHO and the ICRC have been able to provide supplementary trainings to

healthcare workers across Misrata, but that this only partially meets the demand described by health staff.

A physician in Misrata described insufficient capacity to deal with conflict related injuries that can occur in large waves during war. They said *“The conflict causes crises and this affects all of our services. After the conflict started in Libya, there was a proliferation of weapons and this increased the conflict. Sometimes many injured persons come to this hospital and this hospital is not equipped for such cases, the hospital can cover individual cases, but not many casualties at the same time.”* This lack of training for mass casualty incidents limits the ability for the health facilities to function in conflict settings and also puts additional pressure on the staffing shortages that many hospitals face. The proliferation of weapons and landmines has also led to many accidental deaths and dismemberments. An NGO staff member described the problem of children accidentally finding guns leading to firearm accidents among children. Likewise, targeted programming is being conducted to serve people who have lost limbs due to landmines through providing them with prosthetics and PSS, but that the health facilities themselves are unable to meet the demand for these services due to insufficient training and supplies. These challenges in treating conflict-related trauma were more broadly associated with limited emergency capacity to treat trauma related to other causes including automobile accidents.

An FGD participant in Misrata also highlighted issues of tribal authority influencing health facility hiring practices. This participant explained that *“There are conflicts between the tribes and the health facility, where the idea of the Libyan community looks at positions as part of the tribe’s power over the area (e.g. a tribe should take over its facilities such as ports, oil production facilities, and even small primary healthcare centers where they prefer to hire inexperienced people from the tribe instead of experienced people from outside of the tribe). Because of this, medical graduates are not able to be hired in these positions.”* Consequently, health facility staffing can be largely influenced by local politics instead of qualifications based on medical training. These relationship-based hiring practices, whether tribal or otherwise, led many physicians to describe healthcare workers who are unable to perform basic tasks and have the same level of medical knowledge as ordinary citizens.

Tribal issues also affect capacities and access to healthcare. A physician in Tobruk also described access challenges determined by the tribes who feel authority over who obtains care by saying *“This is a tribal community and major hospitals are affiliated with the people with most power during the conflicts.”* NGO staff in Sebha also described similar challenges with tribal authorities brokering medical access. Consequently, tribal authorities can play a deleterious role in both the staffing of health facilities, but also the distribution of services in areas where they hold influence.

Availability and awareness of mental health resources

While there was unilateral consensus across interviews that the armed conflict has been traumatic for Libyans, several factors contribute to mental health needs remaining untreated. Security challenges as a result of the armed conflict, examined in the context of the health sector, have deeper implications across the rest of the country. An FGD participant in Tobruk described this by saying *“The number of psychological*

cases significantly increased since 2011 as a result of the war and the trauma. The main issue is the lack of awareness from the families of the patients about the care they need. There are many people who were injured in the armed conflicts...especially those whose limbs were amputated or the ones who suffer from psychological trauma." A physician in Nalut also described the protracted nature of this trauma by indicating that many community members live in constant fear of an escalation of the crisis and a return to very serious conflict. FGD participants in Tobruk described an increase in extreme overreactions or violent outbursts as being common in their communities when ordinary problems arise as a result of widespread trauma. Ministry of Interior officials interviewed in Tobruk and municipality officials in Ghat and Sirt described a rise in crime extraneous to the armed conflict including kidnapping, robberies, banditry, human trafficking, and random acts of violence. Smuggling is widespread near border areas such as Nalut where smuggling basic supplies such as gasoline from Tunisia became an important avenue for some Libyans in order to financially survive. This mental health burden on a societal level has changed public life for all Libyans and profoundly affected perceptions of social interactions.

The effects of long-term exposure to conflict

Witnessing and being the victims of these crimes have exacerbated mental health problems and contributed to a tense environment where many Libyans live in fear. Many Libyans have participated in the conflict, witnessed deaths, experienced physical injuries or disability, or lost loved ones. A respondent in Tobruk described this by saying *"People are living with the daily news of someone murdered, another kidnapped, another is gone, and didn't return, etc. We all fear to even walk small distances or to have the simplest political or even sports debate since we fear that such disputes might get us killed. A great percentage of the youth feel increasing anxiety since arms are everywhere in Libya. Excessive thinking about their future and the future of their children, and of how to live in a country whose conditions are unfortunately becoming worse by the day affects us all."* A Ministry of Interior official expressed that the negative mental health impacts cannot improve until the conflict ends *"The security situation is the most important factor for the community and for individuals and it has a great impact on the mental health of individuals who can't operate without security, and the current security situation has a negative impact on the community and individuals."*

A physician in Benghazi described the lack of service availability by saying *"We need mental healthcare especially for the elderly. We don't have mental healthcare at the hospital even for those who have been traumatized."* Since 2011, community members described negative coping strategies such as increased substance abuse and domestic conflict in their communities in response to living with a prolonged conflict and an inability to maintain resilience amid worsening conditions. Respondents in Tripoli also indicated that some people joined armed groups in order to cope with the chaos and to feel like they were fighting for their communities. In the outskirts of Benghazi and within Benghazi, community members indicated that the substance abuse issues seen among youth were exacerbated by a lack of mental health services. In Rajma, a public hospital official indicated that youth in their area suffered from post-traumatic stress after being recruited into armed groups. These respondents said that youth were especially vulnerable, but had no targeted PSS services available to them.

Access to mental health services and stigma

A technical expert at an international organization indicated that some urban areas, predominantly in Tripoli and Benghazi, are well equipped with mental health staff while rural areas in particular experience serious shortages. This is partially exacerbated by the Board of Psychiatry's services being suspended for a period which resulted in few psychiatrists receiving certification after residency across the country. This obstacle is expected to improve since their services have now been resumed and additional psychiatrists have begun to receive certification again. Despite this touch of optimism, both WHO representatives and local NGO staff indicated that there are only about 25 certified psychiatrists in the entire country. Consequently, many mental health care workers are operating with insufficient training.

Stigma against mental illness and a lack of a cultural framework for receiving mental health services were largely influential. Some respondents even indicated that loved ones who are suffering worry that even inquiring about where to get mental health services may affect their social standings in their communities if the information were to spread. A physician in Sirt expressed this by saying *"The problem is that society here doesn't approve of the idea of mental health support or psychiatrists, so the people who come for that kind of care are only the ones who suffer serious mental illnesses, and not those who are seeking general support."* A physician in Misrata described the stigma against mental illness to be so strong that some community members with a mentally ill children do not let them leave the house for fear of being judged by their neighbors. A physician in Tobruk expressed that psychological distress is normal in these communities due to the challenges since 2011, but still did not view these challenges as falling into the purview of mental health related problems. His response suggested a perception that mental health services are only for those with serious mental illness by saying *"The hardships of life have affected people significantly, which put pressure on them and stressed them to the point that they feel like they have mental issues, but they don't."* This suggests a need even among healthcare workers to increase awareness about the role of psychosocial support services and that they are not only designed for those with severe mental illness.

A few hospitals described the effectiveness of awareness raising sessions which have increased mental health referrals and recognition of common symptoms of depression for instance. Despite this, many facilities indicated a sharp decline in these sessions since the conflict began, and recent examples of successful awareness raising sessions remained rare. Physicians indicated that these awareness raising sessions were often hampered by the deep cultural stigma. When asked about whether patients seek mental health services, a physician in Bani Walid said *"These services are not available at all. There's no such thing as mental healthcare in the city and no one is asking for it."* KIs conducted in hospitals indicated that psychiatrists are not available in many facilities. Many respondents described having acquaintances or loved ones that resorted to suicide in the absence of adequate mental healthcare to help them cope with the trauma experienced during Libya's conflict.

In rural areas, patients must travel long distances to obtain mental health services. Additionally, the need for anonymity when seeking mental health services is so strong that some people will travel to other cities to avoid being recognized. A physician in Al Marj described this by saying *"However, most people from Al*

Marj seek services in Benghazi and other areas in order to avoid being recognized and this is the same for people in other cities as they are afraid of being bullied for seeking such services." These experiences were shared by individuals interviewed in Nalut and Sebha as well. Due to the armed conflict and concerns about safety in transit and the costs of travel, many participants indicated that this option is not realistic for all individuals suffering from mental health issues.

The executive director of a local NGO indicated that there are only two specialized mental health centers in the entire country which are located in Benghazi and Mistrata. A health facility in Misrata described the need for more specialized mental health services as well by saying *"There is a department for mental health in Misrata, but it is not fully operational. This department receives external cases, but those who suffer from chronic cases within the hospital don't receive full services. I don't know if this is because of mismanagement or because of service limitations. This department should have specialized mental health services to be able to provide good psychological support for these patients. Based on this, the mental health field is neglected."* This suggested that, even in settings where mental health services are available, that more advanced, specialized or long-term treatment is not available.

Alternatives to mental healthcare

Despite the barriers in seeking mental health care from a trained mental health professional, physicians described patients seeking mental healthcare services from non-medical sources such as religious leaders or traditional healers who indicate that their services can exorcize spiritual problems which they claim are the root cause of their mental health issues. Some of the physicians viewed some of the traditional healers as scam artists while others genuinely believe in the service that they are providing. Religious leaders such as imams are also trusted within their communities for individuals who are seeking solace from challenges that they are experiencing. As described by a physician in Tripoli, Libyans are *"conservative people who are committed to religion. We resort to religion regarding our psychological illnesses and issues."* Respondents from all over the country described their belief in God as one of the few things that helps them cope with their circumstances and that it is their primary support for remaining hopeful for the future.

Religious leaders described providing emotional support through supporting the religious beliefs of community members. Many religious leaders even tried to alleviate the barriers to traditional mental health services, but experienced varying levels of success in doing so. A religious leader in Tobruk described fundraising campaigns where he helped community members gather the funding to receive mental healthcare services. This individual visits the homes of the patients in order to assess the extent of the financial need and to also respect requests for confidentiality. This allowed for the patients to gather the necessary funds for medical care from their community without being identifiable and to benefit from the religious values in their community which support charitable giving.

In addition to encouraging community members to seek mental health care through gathering funds, a Mukhtar in Sirt described this by saying *"As a Mukhtar, we conducted meetings and we were able to get medications through the municipality. However, the provision of medication needs to also come with*

sufficient medical staff and health infrastructure in order to provide sufficient care. People are currently seeking the support of Imams due to the poor economic situations.” Other religious leaders indicated that seeking out religious sources of emotional support were preferred since it was free and their desperate economic circumstances barred them from considering traditional medical care. The need to avoid social stigma was also a reason that individuals sought out psychosocial support from religious leaders instead of medical professionals. This is because it is not socially stigmatized to talk to religious leaders about emotional challenges, but that fears about confidentiality make the idea of seeking traditional medical support additionally unobtainable. A psychiatrist interviewed in Tobruk described a mental health awareness initiative partnering with imams in order to more easily reach community members based on this pre-existing level of trust.

Another religious leader in Tobruk described these factors as further hindering the ability to prevent additional mental health issues and trauma. These issues act in a vicious cycle where perpetrators of crime often have trauma themselves, which when treated, may prevent additional harm and violence being inflicted by them on the community. This religious leader indicated that when people seek mental health support from religious leaders for problems such as addiction or post-traumatic issues in place of psychological treatment from medical professionals, it can make it harder to break this cyclical relationship.

Mistrust of government officials

Community members and healthcare workers expressed distrust in government officials and allegations of corruption. A physician in Kufra described uncertainty about where money in the health sector truly goes by saying *“even though a lot of money and billions of assets are spent on the health sector, there is managerial corruption and poor implementation.”* An NGO official in Ghat indicated that *“The government spends a lot, but the warehouses are empty and only simple medications are available.”* A healthcare worker in Brak described this insufficient government funding and lack of leadership from government officials to be the result of *“confusion within the government”* which reflected broader negligence. FGD participants in Sirt indicated that *“inequality, marginalization, and insufficient attention from the national authorities in Sirt, in addition to favoritism and nepotism”* all contribute to a lack of equal access to healthcare.

Healthcare workers in Sirt expressed that corruption within the Ministry of Health perpetuates the equipment and medication shortages experienced in facilities. They described this by saying *“The Ministry of Health has so much debt to hospitals and health facilities, such as for payroll. The main problem is the corruption of the Ministry of Health which is affecting all the supplies. For example, if Ibn Sina hospital in Sirt is supposed to be expecting a medical shipment, the Ministry neglects this, while the WHO donates for us to keep the hospital operating.”* A physician in Sirt also partially blamed the lack of trust in the government for physicians choosing to leave the health sector by saying *“Some doctors even decided to leave the medical sector and have another type of business. This is also because we worked for a period of time without receiving salaries. We worked for a year without getting paid.”* Physicians in Benghazi, Misrata and Bani Walid expressed similar frustrations with and lack of trust in government.

This mistrust in government included a lack of confidence in public health services as well. Participants across the country expressed a lack of trust in the public hospital system and were not confident that they could reliably receive medical care from these entities. A participant in Sirt directly stated *“I never trust the public hospitals.”* While another stated that without personal connections getting adequate medical care is not a reasonable expectation. They described this by saying *“As a citizen, I don’t feel confident getting medical care if I don’t have acquaintances or relatives with connections. Otherwise, it’s impossible to get the service.”* These issues of favoritism were echoed by FGD participants in Tobruk who indicated that family and friends of physicians are not always asked to pay for services. Another participant went on to say *“People who have government positions have good access to public health services, and rich people have access to private health services, while average people have the worst access to health services as they lack the money and the connections, and due to the lack of medical services.”* Ministry of Interior and Ministry of Health officials corroborated that minimal trust in government actors interferes with their ability to effectively improve the security situation across the country.

A healthcare worker in Brak indicated that these trends are only worsening by saying *“There is a loss of trust in public institutions and hospitals that is driving people to seek private hospitals instead. This loss of trust has been increasing, not decreasing.”*

One resident of Rajma outside of Benghazi viewed the decline of the health system to be inextricably linked to the decline of the country over the course of the conflict. He stated that *“The health system problems will be solved when all the country’s political problems are solved, because it is impossible for a small community to solve these nationwide problems.”* These feelings of helplessness and a lack of agency to improve conditions within and external to the health sector were salient after 10 years of conflict. A healthcare worker in Brak emphasized that they hoped the government would pay more attention to the challenges facing health facilities in the south due to poor administrative management, insufficient staffing, and supply shortages.

Low levels of trust in the ability to obtain high quality healthcare has fueled medical tourism outside of Libya among Libyans. Healthcare workers in Tobruk described patients traveling to Egypt or Tunisia to receive medical care since there was more trust in both the quality of medical care received there as well as the quality of the medications. Consumers of medical care across the country described stories of extreme medical errors such as a cast being put on the left arm instead of the right arm by a physician due to an error made by a radiology technician. These egregious medical errors made some Libyans fear seeking medical services at all.

This environment has also contributed to a tense environment between patients and healthcare workers. An FGD participant described an attack in their hospital in Tobruk by saying *“One of our female doctors was attacked by the companions of a patient and they strangled her. She survived the attack, but she wouldn’t come back to the hospital without security.”* A lack of trust in the expertise and abilities of healthcare workers has also fueled violence against healthcare workers by patients or loved ones of patients when a healthcare worker is unable to achieve a specific outcome or save a patient’s life. In turn,

many participants indicated that morale among healthcare workers is low and contributes to disrespectful behaviors towards patients.

Attacks on health facilities and fighting near health facilities

As was reflected in the background literature, many health facilities themselves have described being targeted by armed conflict or having struggled to remain operational in close proximity to armed conflict in several cities including Bani Walid, Benghazi, Brak, Sirt and Tripoli. Diverse challenges such as reduced capacity for care, damaged facilities, direct attacks from armed groups, and fears of being attacked in-transit to the facility for both healthcare workers and patients. Ministry of Interior officials, Ministry of Health and municipality members echoed the destabilizing nature of the armed conflict on the provision of health services and expressed an inability to shield the health sector from these negative effects of the war.

Healthcare workers described fighters coming to the hospital to have their injuries treated and then being targeted inside of the health facilities. Some facilities described enormous interruptions after being directly targeted in attacks where their health facility was destroyed. Repairing these facilities took time and operations were suspended. One hospital in Tripoli described this experience by saying *“In 2019, we were forced to abandon an entire section because it was in front of where the conflict was occurring, and from time to time, a bullet or a shell would hit the façade of the hospital, so we had to evacuate it, and this reduced our admission capacity significantly.”* Likewise a hospital in Benghazi described the challenges of having an increased demand for services due to reduced capacity as a result of the armed conflict. They also described the concurrent decline in quality of care by saying *“the gynecology and delivery hospital was damaged as a result of war, which affected the quality of the services we provide. We aren’t able to provide the internal medicine services, gynecology, deliveries, and surgeries with the same quality as before. This increased the burden on the hospital.”*

A hospital in Beni Walid described revenge related attacks from armed groups due to supply shortages by saying *“When an armed person comes and doesn’t receive the medical service, not because of the medical staff and their assistants, but because of the lack of certain medicines; hence, the health facility gets destroyed and sabotaged.”* This was described in Benghazi as well where a member of a rebel group died and the rebel group came and destroyed the dialysis clinic at the hospital in retaliation.

Another facility in Tripoli indicated that patients feel less safe at the health facility due to its close proximity to fighting *“Patients won’t accept being admitted in a section where there are sounds of gunshots all the time, sounds of explosions, random bullets hitting the building, and there was this one time that a rocket hit the hospital and damaged the power generator (this specific incident caused a lot of doctors and hospital staff to refrain from coming to the hospital in fear for their lives).”* This reduced feelings of security for both patients and physicians.

Health facilities in several locations described that both patients and healthcare workers fear for their physical safety in transit to the hospital. A hospital in Tripoli described this by saying *“The recent war also*

resulted in reducing the number of personnel working at the hospital because they couldn't reach the hospital in fear that they might get injured. There were times when only 4 doctors were available at the hospitals, in addition to some nurses and managerial staff members." This was also expressed by a physician in Sirt who stated *"My area is currently considered a conflict zone, and at any point, all roads leading to this area might be blocked. Because of that, some people are forced to travel for 800 km instead of 200 km. Also, some members of the medical staff became unable to come to Sirt because of that."* A hospital in Benghazi indicated that, even when patients tried to seek care, security-related road closures physically barred them from doing so. Ambulance staff in Jumail described these road closures as serious barriers to both emergency medical needs and access to care for noncommunicable diseases such as cancer and diabetes. In Tobruk, this has contributed to individuals delaying medical care for treatable illnesses until they are much more serious or life threatening.

While these experiences were common, experiences of attacks on or in facilities were not universal and did not always accompany precautions or operational changes in an attempt to reduce the likelihood of attacks. A hospital in Tripoli adapted to this by telling patients that had to travel further to reach the facility to not take the risk and to not seek healthcare. This corroborated experiences of several patients across the country that indicated that they felt less secure in-transit which resulted in them being reluctant to seek medical care for long standing health issues.

Social Cohesion

The concept of social cohesion³⁸ suggests individuals can develop strong ties to each other so as to think and act as a group, even when they are not kin. These ties promote willingness to cooperate, reinforcing channels for socialization, enabling a sense of belonging, shared values, social compliance, trust among its members and communities of interpretation. Weak social cohesion increases the risk of fragmentation, marginalization, inequality, violent conflict, and poses a barrier for reconstruction. Moreover, previous research on the subject has shown a significant correlation between social cohesion and higher levels of subjective well-being.³⁹ Complex approaches to social cohesion often involve multiple dimensions: political, economic, and social. Researchers interested in social cohesion in the Arab region distinguish the concept along two dimensions: horizontal (citizen-citizen) and vertical (citizen-state). SREO inquired FGDs and KIs participants about their opinions on both dimensions. Nonetheless, it is vital to highlight that this study was not intended to measure the levels of social cohesion in Libyan society and to only feature experiences of interview participants.

³⁸ For the purpose of this study, SREO considered social cohesion as defined by the UNDP: "a state of affairs concerning both the vertical and the horizontal interactions among members of a society characterized by a set of attitudes and norms that include trust, a sense of belonging, and the willingness to participate and help, as well as their behavioral manifestations."

³⁹ Klein, Carlo(2011). Social Capital or Social Cohesion: What Matters For Subjective Well-Being? Social Indicators Research, 110(3), 891–911. doi:10.1007/s11205-011-9963-x

Horizontal Social Cohesion (citizen-citizen)

Trust and security

Perception of trust has been a core measure of social cohesion across the relevant literature. When asked if they trusted the people from their community, the majority of participants disagreed: *“I trust my niche, but I don’t know the whole community, and after the revolution the situation became more dangerous.”* Lack of trust among citizens is a common civil war legacy, and as a result, individuals become more suspicious of outgroups and often perceive the world as an unfriendly, dangerous place. Interviewees talked about their sense of security in their communities, and most highlighted that the lack of security is an obstacle to accessing healthcare in Libya as well as to the population's general wellbeing. Urban crime, such as theft and kidnappings were the most mentioned security threats; although explosive remnants of war have also been mentioned as a threat, mainly in the rural areas. Nonetheless, many recognized that the country is safer than it used to be following the uprising. This sense that the security situation is improving is very positive, as human insecurity - realistic or symbolic - has been associated with group anxiety and discrimination, and with lower levels of social cohesion.

As shown in the example above, most participants reiterated trusting their ingroups (mainly family and/or tribes), which supports the idea that bonding (ingroup relations) is stronger than bridging (outgroup/intra-group relations) in most locations. In sociological literature, both concepts are relevant for positive social cohesion, however, bridging is more commonly associated with inclusive and heterogeneous societies. In contrast, bonding reinforces social cohesion of more homogeneous groups, often promoting the marginalization of different outgroups.⁴⁰ The weakness of Libya’s bridging capacity has also been suggested by the participants' views on security, identity and their perceptions of migrants, which will be discussed below.

Identity / Sense of belonging

Tribal affiliation has been widely acknowledged by participants, with many stating that tribal leaders – the *Sheikhs* – are the most trusted authority in their communities. These answers must be considered carefully due to the power dynamics in the area: following the uprising, the social and security fragmentation was intense, with local actors - sometimes of tribal character - providing local governance, filling the political vacuum and exacerbating the influence of tribal leaders. However, this is not the case in every location, such as Tripoli and Tobruk, for example. Moreover, apart from tribes, some participants have also identified themselves as Arabs or Muslims, showing pan-national identities and frequently taking pride in describing themselves as traditional and conservative. As one participant in Brak stated: *“Our community is a religious, loving, giving, and cohesive community with Islamic principles.”*

Tobruk, for example, is a district where tribal structures are stable and well integrated into the security apparatus, with prominent local tribes occupying positions of influence. Still, an FGD conducted with local community leaders revealed that even though they consider Libya’s society cohesive and inclusive, they did not consider certain outgroups as members of their community: *“In the beginning of the 70s, Qadhafi*

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tried to make a demographic change and brought Africans to the southern areas of Libya (...) For example, Murzuq witnessed conflict, but the people of Murzuq are not Libyans, they are from another country. The same with the Awbari, some were accused of joining ISIS. But they are not originally from Libya so they are an outsider society."

When participants were asked how people from different tribes/ethnicities interact with each other, many recognized the existence of intergroup tensions, with some suggesting that access to healthcare services may vary according to one's tribal affiliation. As raised by a change agent in Kufra: *"We are Arabs and proud of this, and they are from Tabbo and proud of this, we have conflict (...) They can come and receive treatment here, knowing that they have their own hospitals and clinics, and they have their own budget. While we can't go to their areas and receive treatment."* Nonetheless, most participants said that even though healthcare services are limited, all Libyans can equally access it. A KII with an NGO staff member clarified that even though access to healthcare services is theoretically available to all Libyans, the situation in some locations is different in practice, implying that the power dynamic may differ from one place to another. This tribalization of service delivery in certain locations negatively impacts social cohesion, promoting non-inclusive attitudes towards certain groups and marginalization. Most importantly, it underscores the need for contextualized data.

Social cohesion and migrants

Participants have also acknowledged that many migrants in Libya suffer from marginalization, especially black migrants from African countries. One KI mentioned that *"black Africans are treated differently and perceived as inferior"*, while another one said that migrants have more difficulty accessing services than their Libyan counterparts. As a destination and transit country, Libya has received more than 600,000 migrants from different countries. In addition, a KI mentioned that he would not like to have illegal migrants as neighbors and that migrants disrupted the social cohesion, linking them to the proliferation of small arms, street crime, mental illnesses and spread of diseases. These statements suggest negative feelings, such as anger or fear, against illegal migrants from part of the population, as well as potential ostracism and marginalization. Still, some KIIs showed positive feelings of compassion and empathy. Interestingly, some did not feel comfortable talking about it. According to a Change Agent from Tobruk, *the majority now is cautious not to speak about this subject, and avoid speaking about such sensitive topics.*

Vertical Social Cohesion (citizen-state)

Trust in state institutions and political participation

According to KIIs, Libyans do not trust local governance, with many believing that local authorities are not acting in the communities' best interests, suggesting a lack of representation in decision-making. As mentioned, Sheikhs and other tribal leadership were considered by some participants as more effective than formal institutions. Currently, Libya lacks a widely accepted central government, with a plethora of local actors acting as governance providers. The lack of trust in the state's capacity to provide security to

its citizens has been observed by several participants, who pointed out that the local population resorted to obtaining guns for self-protection: *"There is lack of trust because people see that institutions cannot solve any problem, there is no security institution that people can rely on, the municipality currently is divided into two parts, the community council became almost unavailable, so you can only trust family (...)* On the other hand, there are people who carry firearms, are affiliated with persons who carry firearms or have other means of protecting themselves; however, as long as there is no Libyan law or institutions that can enforce this law, both the people with power and the people with no power will always feel afraid." Participants also highlighted that the decision-making process is limited to certain people in leadership positions, and is not accessible to those without connections and influence. Moreover, a KI mentioned that the youth has little participation in the decision-making process.

Trust and security

Even though most participants pointed out the proliferation of small arms as a driver of human insecurity, the volatility and fear of victimization experienced in Libyan public life makes even those who recognize gun availability to be a security threat unwilling to consider giving up their guns. Stories of communities being vulnerable to armed groups, urban crime, carjacking and kidnappings fueled this determination to retain gun ownership. A participant in Sirte described this by saying that *"what made the militias and gangs take over Sebha is the fact that the people of Sebha didn't carry guns. There is a lack of government intervention, and armed people will control the area if the people of the area don't carry weapons, therefore, carrying a weapon is necessary for people as a deterrent."* Nonetheless, disarmament is often considered a necessary condition to sustainable peace in the aftermath of conflict. In the eyes of several national and international stakeholders, a new momentum for Security Sector Reform (SSR) and Disarmament, Demobilization and Reintegration (DDR) was brought about following the ceasefire agreement signed in October 2020 and the prospect of the 2022 elections. As such initiatives seem more possible, the formal security sector's ability to address insecurity and monopolize the use of force is essential for the country's state-building process.

Moreover, ERW contamination has also been identified as a driver of insecurity, especially in Sirte. Numerous conflicts have exacerbated the level of ERW contamination, threatening lives, causing injuries and disabilities, as well as presenting a mental burden for the victims, their families and those who live under its constant threat. It also impedes the safe access of basic services, such as health and education; impedes the safe return of IDPs, and access for humanitarian actors to provide or restore basic services to marginalized populations. A community leader mentioned that *"in Sirte, neighborhoods still have IED and landmines contamination and it is catastrophic. There is a lack of awareness among people and we hope that there will be international support to dismantle them."* Another participant added that *"there are camps and compounds from where, recently, dead bodies were extracted, adding to the psychological burden. As for injuries, their impact is not limited to the injured person, but his family and relatives. And the view of the destruction of your house causes a mental scar in the long run, especially when you have to see it every day."* When asked about the government's initiatives to solve the issue, a participant from Sirte mentioned that he is not aware of any intention from the government to rebuild the damaged structure and clear the contaminated land.

Vertical trust and access to healthcare

Physicians and religious leaders indicated that this lack of trust in the government poses a distinct barrier to deeply needed interventions which could improve the health of Libyan communities, including disarmament, mine action, expansion of mental health service availability, and the roll out of the COVID-19 national vaccination program. A religious leader in Brak described this by saying *“The lack of trust in the government and the conflict parties is preventing people from seeking such services and we saw that during the COVID-19 vaccinations where people don't trust the government.”* Likewise, trust in government officials is so low that attempts to pay citizens for their weapons in exchange for money and promises of increased security in their cities failed. This highlights the limitations at the government level to address many of the barriers to improved healthcare access and health outcomes in the community after over a decade of conflict. Participants also highlighted that the decision-making process is limited to certain people in leadership positions, and is not accessible to those without connections and influence. Key informants also highlighted that there were few avenues for youth to participate in decision making or share their preferences for how they imagine the future of Libya. The limitations to these relationships pose distinct barriers to improving the health sector and creating pathways to peace.

Prospective Programming at the Intersection of Health and Peace

This study was meant to serve as an initial assessment of the extent to which health and peace programming is currently being implemented in Libya and was not meant to be an exhaustive list of all opportunities for programming. Despite this, many areas were highlighted in interviews where programmatic collaborations can begin related to health and peace programming:

Health serving as appropriate entry point for peacebuilding

- Public health programming in partnership with religious leaders to raise awareness and increase access to mental health services.
- Public health programming to increase hospital capacity to respond to conflict related physical injuries and to train physicians for mass casualty events.
- Training first responders and public/private health staff on data collection on gun violence related incidents through a peacebuilding approach.

Peacebuilding creating the space for better health and prevention of health-related challenges

- Peacebuilding programming to prevent attacks on health facilities.
- Peacebuilding programming to establish humanitarian corridors to health facilities for patients seeking medical care.
- Hybrid programming to increase the availability of medical equipment and medications to health facilities.
- Peacebuilding programming to support disarmament and a reduction in gun-related injuries.
- Peacebuilding programming to clear ERW contaminated land and support survivors and victims' families.
- Peacebuilding programming to reduce gun violence by offering small arms risk education within public health messaging. In affected areas, also include ERW risk education.
- Peacebuilding programming to create community-based collaborative problem-solving models to address gun violence and promote social cohesion by engaging men and boys in discussing the root causes and consequences of conflict (including physical injuries) to individuals and society.

Health as a pillar of the social contract (and peace)

- Peacebuilding programming to increase participation and representation by integrating young women and men into decision-making processes at the local level, including by establishing youth councils and similar mechanisms which give young women and men a platform for participating in mainstream political and social discourse.
- Hybrid programming to provide training to health staff on the local security/social context to minimize exclusion of marginalized groups from healthcare.
- Hybrid programming to provide accessible, continuous and robust data on social cohesion and conflict assessments at the areas where health programs are being implemented.

- Hybrid programming, using an MHPSS approach, to apply primary prevention approach to enhance the social environment for youth and children⁴¹ by focusing on reducing the risk factors that may increase the chances of the youth to engage in armed conflict and marginalization of minorities in the future. The program should promote inclusion, mental healthcare and tolerance, mixing children from different communities and social backgrounds in social activities.

Conclusion and Recommendations

Libya's health system has been profoundly affected by armed conflict since 2011. Health facilities operate in buildings that are in desperate need of repair without a sufficient supply of essential medicines or medical equipment. Staff are inconsistently paid at public facilities and often do not receive adequate training. Public confidence in the ability to receive medical care when it is needed is very low and reflects deeper mistrust in public systems due to government corruption. While the general public has been profoundly traumatized by the conflict since 2011, the public health workforce is unable to meet the physical or mental health needs of the population as a result of the conflict in the form of trauma care and PSS services. The pre-existing social stigma and fear of community members branding them as "crazy" forces many to not seek care or to travel long distances for mental health services. Likewise, many lack a framework for even considering seeking PSS support for post-traumatic symptoms because of the pervasive idea that mental healthcare is only for those with severe mental illness. This has resulted in many seeking support from non-medical actors such as religious figures. The degradation of Libya's health system and wide ranging problems present many opportunities for health and peace programming to target areas of need.

Because the impact of armed conflict has deep ramifications on the functioning of health systems, Libya could benefit from programming that addresses the overlap in public health and peacebuilding spheres. The HDP Nexus is making an effort to frame that these two sectors are intrinsically linked and can no longer operate in silos. The health and peace programming space in Libya needs to be bolstered by a more concrete establishment of a framework within which actors can assess the opportunities and need for health and peace programming. This can be done through establishing a guided process through which health actors can conduct a summary of activities which are most impeded by social dynamic problems in order to identify spaces for peace programming expertise to support them. Despite strong consensus that these linkages are unavoidable, there is limited awareness of the health and peace programming concept among both public health and peacebuilding actors currently operating in Libya. When asked about the programming that these actors are currently involved in within the country, many actors who stated that they did not know about any health and peace programming in Libya then do go on to describe programming that involved both components. Within examples given, three primary categories of health and peace programming emerged: hybrid programming, peace-supporting health programming, and health-supported peace programming.

⁴¹ Halsall, T., Lachance, L. & Kristjansson, A.L. (2020) Examining the implementation of the Icelandic model for primary prevention of substance use in a rural Canadian community: a study protocol. Access here: <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-020-09288-y> [Accessed 21 April 2022]

Advocacy could be done through development of an internal needs assessment guide for both health actors and peace building actors. After introducing the concept, individuals could be guided through the process of assessing areas of their work that are hindered by the lack of public health expertise or a lack of peacebuilding expertise. Once a health program identifies a peace related issue, this can trigger a scoping process for which kinds of peacebuilding actors can participate in their work and in what capacity. After identifying areas that could be strengthened through intersectional health and peace programming, a registry of all of the health and peacebuilding actors active in Libya can be provided to supplement and encourage awareness of possible partnerships. Moreover, the current stage of state fragmentation shows a need for contextualized data to understand the local power dynamics.

In order to strengthen these advocacy initiatives, a workshop could be held to introduce these public health and peacebuilding actors to each other. The concept of cross-sectoral programming between these groups could be explored with an emphasis on highest priority needs. This could create an opportunity to provide more concrete avenues for implementing these concepts which can empower actors to conduct health and peace programming within Libya.

Annex 1: FGD Locations by Cities

During stage 1, FGDs were conducted in the below 11 cities. Urban and rural KIIs were conducted in cities with more than 100,000 people while only 1 KII was conducted in the center of a city whose population was under 100,000 people.

Stage 1 FGD locations:

City	Number of Urban FGDs	Number of Rural FGDs
Tripoli	2	1
Benghazi	1	1
Misrata	1	1
Tobruk	1	1
Sirt	1	1
Birak	1	0
Al Marj	1	0
Al Kufrah	1	0
Ghat	1	0
Nalut	1	0
Bani Walid	1	0

Stage 2

During stage 2, FGDs were conducted in the below 5 cities with a combination of religious leaders including imams, mukhtars, and sheikhs:

City	Number of FGDs
Misrata	1
Tobruk	1
Sirt	1
Birak	1
Al Marj	1

Annex 2: KII Locations by Cities

Stage 1

During Stage 1 of data collection, healthcare workers in hospitals were interviewed in the following 9 cities.

Stage 1 hospital KII locations:

Cities	Total number of KIIs with HCWs
Tripoli	4
Benghazi	2
Misrata	2
Tobruk	2
Sirt	2
Birak	1
Al Marj	1
Al Kufrah	1
Bani Walid	1

Additionally, KIIs were conducted with stakeholders over the phone including government officials and NGOs.

Stage 2

During stage 2, SREO conducted 23 KIIs, including 7 KIIs with change agents, 7 KIIs with government/public service officials, 4 KIIs with Libyan NGOs and 5 KIIs with psychiatrists and mental health professionals. Please note that the KIIs with psychiatrists and local NGO officials were conducted over the phone and not in specific locations across the country.

Stage 2 change agents KII locations:

Cities	Total number of KIIs with HCWs
Ghat	1
Nalut	1
Tobruk	1
Birak	1
Al Marj	1
Al Kufrah	1
Bani Walid	1

Stage 2 Government / public service KII locations:

Cities	Total number of Klls with HCWs
Misrata	2
Sirt	1
Tripoli	2
Birak	2

Annex 3: Health Actors Operational Libya

According to the 2021 Health Cluster report⁴², the following 33 public health actors are working within Libya. This includes 1 national authority, 13 INGOs, 6 UN agencies, 2 observers, 4 national NGOs, 1 national society and 6 other types of entities:

- Ministry of Health
- ACF (Action Against Hunger)
- CEFA (The European committee for training and agriculture)
- Emergenza Sorrisi
- Expertise France
- Handicap International – Humanity & Inclusion
- Helpcode
- IMC (International Medical Corps)
- IRC (International Rescue Committee)
- MSF France
- MSF Holland
- PUI (Premiere Urgence Internationale)
- TdH (Terre des Hommes – Italy)
- WeWorld-GVC
- AICS (Italian Agency for Development Cooperation)
- Chemonics International Inc.
- GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit)
- LPFM (Libya Public Financial Management Program)
- Voluntas Policy Advisory (Voluntas)
- The World Bank (WB)
- ICRC (International Committee of Red Cross)
- IFRC (International Federation of Red Cross and Red Crescent Societies)
- LRC (The Libyan Red Crescent Society)
- Psychosocial Support team (local NGO)
- Organization of Development Pioneers
- Alsafwa
- Migrace
- IOM (International Organization for Migration)
- UNDP (United Nations Development Programme)
- UNFPA (United Nations Population Fund)
- UNHCR (United Nations High Commissioner for Refugees)
- UNICEF (United Nations Children’s Fund)

⁴² Health Cluster Libya (2021) Annual Report. Available here: https://reliefweb.int/sites/reliefweb.int/files/resources/health_sector_libya_annual_report_2021.pdf [Accessed 31 March 2022].

- WHO (World Health Organization)

Humanitarian Response⁴³ also provided a list of programming up to June of 2021 that is being conducted in Libya which can be viewed below⁴⁴:

Organization	Project Name (as of June 2021)
WHO	Public health support to Libya
WHO	Institutionalizing and Strengthening the Capacity to Address Gender-Based Violence in the Health Cluster and in WHO's Emergency Work
WHO	Support to WHO COVID-19 strategic preparedness and response plan
WHO	Support to WHO COVID-19 strategic preparedness and response plan
WHO	Seroepidemiology Unity and Solidarity studies-CR Solidarity fund
WHO	Improving access of vulnerable population to quality primary health care services in conflict affected districts in Libya
WHO	Responding to life-saving health needs for Libyan IDPs, returnees, and host communities
WHO	Saving lives in Libya by support the direct response to COVID-19 and strengthening overall health system
WHO	Strengthening Libyan authorities capacity to address COVID-19 related challenges and ensure protection of Libya' population, including vulnerable groups
WHO	Strengthening national TB response across Libya with a focus on most vulnerable population (in consortium with IOM)
WHO	Strengthening the coordination and availability of Libyan effective (SCALE) mental health care in primary health care services
WHO	Implementation of leprosy control activities in 2021
WHO	Support to WHO COVID-19 strategic preparedness and response plan

⁴³ Humanitarian Response (2021) Inventory of Health Sector Projects Libya June 2021. Available here: <https://www.humanitarianresponse.info/en/operations/libya/document/inventory-health-sector-projects-libya-june-2021> [Accessed 31 March 2022].

⁴⁴ Please note that there were some blank rows in the inventory of health sector projects which have been removed because they are not complete. This included rows for programming with ACF, AICS, DRC, Emergenza Sorrisi, Expertise France, IFRC, and LRC.

WHO	Support to WHO emergency program
WHO	Support to WHO COVID-19 strategic preparedness and response plan
CEFA	Hand in Hand for a better health care in the South West (13 Health Facilities targeted in the Municipalities of Sebha, Brak Al Shati, Murzuq, Qatroun, Shwerif)
CEFA	MORE RAM - More Opportunity Resilience and Health for Refugees, Asylum-Seekers and Migrants in Libya
Chemonics	Providing technical support to NCDC
Chemonics	Solar Power for Ubari Medical Centers and Ubari Airport
GIZ	Improving Primary Health Care Provision in Libya
GIZ	Procurement, technical support and training for hospitals and laboratories to support the fight against COVID-19 in Libya (SFF)
HI	Improving access to essential services for vulnerable people excluded from humanitarian assistance in Libya
HI	Inclusive Humanitarian Assistance, Health and Protection Response for the Most Vulnerable, Crisis Affected Persons in Libya
HI	Promoting inclusive access to quality health services in Misrata (In consortium with IRC)
HI	AMAL: action for mental health assistance in Libya
HI	SALAM MHPSS response in Libya
Helpcode	“Restoring quality health care services in Zawya and Ghat District in Libya”
ICRC	Primary Health Care Project: 21 PHCC regularly supported with infrastructure rehabilitation, drugs and consumables. Also PPE in 2021
ICRC	Diabetic Centers regular Support (Misurata, Ajdabia and Sabha) with Insuline, essential drugs, and consumables
ICRC	Pre-Hospital Emergency Care and Trauma First Aid: national assessment/ development of EMT/ Contingency plan for Mass casualty incident
ICRC	Hospital Project: before 2021 hospital support. Starting from 2021 Emergency Department Support. Material donation, capacity building, functioning improvement)

ICRC	Physical Rehabilitation Program supporting 3 centers in Janzour, Misurata, and Benghazi with capacity building (inside and outside Libya) material and one one one coaching.
ICRC	Health Care in Detention: working with Health department at MoJ to improve access and availability of health services in prisons
ICRC	4 Mobile Health Clinics of 12 months each, 3 medical Convoys and First Aid trainings (150 persons) through the LRCS
IMC	Expanding Access to Essential Primary Healthcare, Respiratory Care for Severe COVID-19 Patients, and Comprehensive and Lifesaving GBV Services for Internally Displaced Persons (IDPs) and Conflict-Affected People in Libya
IMC	Strengthening protection and resilience of vulnerable groups in COVID-19 emergency
IMC	PEERS: Protection Enabling Environment and Resilience Services
IMC	Capacity Building in COVID-Testing and Treatment in Libya
IMC	Improving primary health care in deprived and post-conflict areas in Libya
IOM	Protecting vulnerable migrants and stabilizing communities in Libya - Health and protection assistance to crisis affected populations, with a special focus on migrants inside detention centres and in urban settings
IOM	EU-IOM Joint Initiative for Migrant Protection and Reintegration in North Africa - Support pre-departure health assistance for the Voluntary Humanitarian Return programme (the health component is screening of migrants returning to countries for fitness to travel)
IOM	Enhancing Disease Prevention and Response to COVID-19 in Ubari, South of Libya
IOM	Fostering health and protection to vulnerable migrants transiting through Morocco, Tunisia, Egypt, Libya, Yemen and Sudan (Phase III)
IOM	Libya COVID-19: Supporting Libyan authorities to address COVID-19 related challenges and assisting vulnerable groups
IOM	Managing mixed migration flows: Protection, health assistance and community engagement - Strengthening national TB response across Libya
IOM	Response Program to the needs of most vulnerable population in Libya through prevention and sensitization activities
IOM	Emergency Response and assistance to displaced population/s
IOM	Promoting rights-based solutions for vulnerable migrants through a Migrant Resource and Response Mechanism (MRRM) in Tripoli, Libya

IOM	Support to Integrated Border and Migration Management in Libya - (health component)
IOM	Pre-departure medical screening for resettlement of refugees to Norway
IOM	Pre-departure medical screening for resettlement of refugees to Canada
IOM	Cooperation on Migration and Partnerships to Achieve Sustainable Solutions (reaching to migrants with integrated services in communities including health - MRRM), Tripoli
IOM	Promoting rights-based solutions for vulnerable migrants through a Migrant Resource and Response Mechanism (MRRM) in Tripoli, Libya (reaching to migrants with integrated services in communities including health - MRRM)
IOM	Migrant Resource and Response Mechanism (MRRM) in Libya (reaching to migrants with integrated services in communities including health - MRRM (extension of previous phase) - Zwara, Baniwaleed
IOM	Access to international protection for persons in third countries in RDPP framework in North Africa (MRRM mechanism in Libya including the health component), Ghat
IRC	Promoting Social Cohesion*Consortium project led by DRC
IRC	Promoting inclusive access to quality health services in Misrata
IRC	Libya Equal Access and Development for Recovery (LEAD for Recovery)* **A consortium project led by IRC with 4 separate contracts/awards.
IRC	Integrated health and protection response to migrant communities in Tripoli
IRC	Integrated health and protection assistance to PoCs in Tripoli and Misrata
LPFM	Libya Public Financial Management Program
MSF-F	Zuwara PHC:PHC/MH mobile clinics in migrant communities; Support to Al Baraka PHC with Gernal OPD & MH
MSF-F	BaniWalid PHC - Primary Health Care: Mobile Clinicv for IDP & Migrants, Health care & support in safe house of Al Bayt, Al- Aamn local NGO
MSF-F	Bani Walid WH: - Women Health (ANC/PNC & gygne concultations)-support to PHCof Al Madani
MSF-F	Misrata TB: TB out patient consiltation in support to NCDC, TB Unit for IPD cases in MMC
MSF-F	Misrata PRISONS (Tammima, Alssekit, Alhuda)

MSF-H	Tripoli Health project (Primary health care and referral services in Detention centers), Mobile clinic in Migrants Community & TB services support to Specialized health centers
PUI	Enhance protection environment and access to essential services for conflict-affected communities in southeast of Libya
PUI	Libya Equal Access and Development for Recovery (consortium)
PUI	Supporting quality and dignified health care for vulnerable Libyan and non-Libyan populations in Cyrenaica region, Libya.
TdH	ROLL THE SLEEVE UP! Support the vaccination roll-out in Libya* *Consortium project led by TDH
WB	Not specified.
UNFPA	Advancing Midwifery, Nursing and Specialized Nursing in Libya
UNFPA	Expanding Protection Environment and Services for Mixed Migration Flows and Vulnerable Libyans along Migration Routes in Libya and Supporting Local Socio-Economic Stabilization
UNFPA	Provision of integrated essential gender-based violence prevention/mitigation/ response and sexual and reproductive health services to vulnerable women and girls in Libya
UNHCR	Integrated health and protection assistance to refugees and asylum seekers in urban Tripoli and Misrata, detention centers and disembarkation points
UNICEF	Libya COVID-19: Protecting and responding to the needs of the most vulnerable populations from the Coronavirus Disease 2019 (COVID-19) pandemic in Libya
WeWorld-GVC	Libya Equal Access and Development for Recovery (LEAD for Recovery)* *A consortium project led by IRC with ACTED, PUI
WeWorld-GVC	Emergency programme in Libya to improve basic health and protection services for the most vulnerable population in South of Libya
UNDP	LVG for producing PPE under the Stabilization to Recovery Transition (START) in Libya Project
UNDP	Support PPE production under START project
UNDP	Provision of Medical Oxygen (bengazhi + Tripoli) under SFL
UNDP	Medical equipment (Sabha + Ghat) under SFL
UNDP	Telemedicine Initiative for Libya

UNDP	Medical Waste Incinerators (Gharyan Hospital)
UNDP	Solar Power Isolation Centre and Medical Lab (Bent Bia)
UNDP	Pesticide Sprayer Truck (Tobruk Municipality)
UNDP	COVID-19 Isolation Rooms for PwDs
UNDP	Rehabilitation of Bani Walid General Hospital (Support the rehabilitation of diabetes healthcare facility and convert it to fully equipped isolation facility)
UNDP	Rehabilitation + Supply and installation of (1) Portable Sewage Treatment Plant at Tajoura Cardiology Hospital, Tripoli
UNDP	Supply, installation and commissioning of vertical multi-stage centrifugal pump and Air Conditioner (HVAC) in Abo Salim Hospital-Accident Department
UNDP	Rehabilitation of Abdelkafy Physical Therapy Center
UNDP	Rehabilitation of Mental Health & Psychosocial Support Center
UNDP	Support for local PPE production through provision of raw materials and machinery for a local small manufacturing enterprise
UNDP	Rehabilitation of the immigration Covid-19 isolation center in Alkufra (20 bed capacity)
UNDP	Provide Medical equipment to Ghat
UNDP	Construct and equip an isolation unit with a capacity of 20 beds as a preventive and precautionary measure in Derna
UNDP	Provide Medical equipment Sebha
UNDP	Rehabilitation of Jerdina Rural Hospital COVID-19 Isolation Center
UNDP	Supply and Installation of 30 KW Hybrid Solar Power System for Libyan Korean Centre
UNDP	Supply and Installation of Medical Oxygen Generator Facility Benghazi, Libya
UNDP	Supply and installation of Medical Oxygen Generator Facility for Tajoura Cardiology Hospital, Tripoli
UNDP	Supply of Medical equipment for Sabratha Health Center
UNDP	Supply of (6) ICU ambulances

Annex 4: Number of Participants per FGD

The first stage included 17 FGDs with a combination of healthcare workers and community members in 11 Libyan cities. During the second stage of data collection, SREO conducted 5 FGDs with religious leaders including imams, muktars and sheikhs in 5 cities.

Seventeen FGDs with healthcare workers and community members in the order that they were conducted:

FGD number	City	Total participants
1	Bani Walid	6
2	Benghazi	6
3	Sirt	6
4	Benghazi	7
5	Ghat	5
6	Kufra	5
7	Misrata	6
8	Nalut	5
9	Misrata	4
10	Sirt	6
11	Tobruk	6
12	Al Marj	5
13	Brak	6
14	Tobruk	5
15	Tripoli	5
16	Tripoli	6
17	Tripoli	5

Five FGDs with religious leaders including imams, muktars and sheikhs in the order that they were conducted:

FGD number	City	Total participants
1	Bark	4

2	Al Marj	3
3	Misrata	5
4	Sirt	5
5	Tobruk	5