

Mapping of mental health and psychosocial support in post conflict Libya

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The violent conflict that erupted in Libya and toppled the Gaddafi regime in 2011 has significantly impacted social services and the health infrastructure in the country. The influx of international humanitarian organisations has led to many initiatives to strengthen mental health care and psychosocial support services for the Libyan population. However, with a new and fragile government and many different international actors, in addition to emerging national initiatives, it was difficult to determine who was doing what. As a result, the situation was somewhat unclear. On the request of the new Libyan health authorities, the international NGO International Medical Corps conducted a 4Ws mapping (Who is Where, When, doing What) of the current mental health and psychosocial support activities in Libya that focused on vulnerable areas impacted most by the conflict. The authors, who were involved in the 4Ws mapping, describe the main results and discuss the challenges they faced. They conclude that this was a useful exercise for organising and sharing information that was previously unavailable. The tool helped link different organisations, that previously did not know which services were being offered elsewhere, and thereby contributed to a better understanding and cooperation among actors.

Keywords: 4Ws mapping, coordination, Libya

Introduction

Libyan context

Major unrest against Muammar Gaddafi's regime erupted in Benghazi, eastern Libya, on 17 February 2011, days after the

resignation of Hosni Mubarak, the former president of Egypt. Gaddafi, and his supporters, retaliated violently as the uprisings gained popularity throughout the country. Soon after, the situation descended into intense armed conflict between the regime and protesters. NATO coalition forces became involved when air-borne bombardments of civilians continued, despite the 17 March adoption of UN Security Council Resolution 1973, which imposed a no-fly zone over Libya (BBC News, 2012). The conflict was characterised by a series of offensives and counter-offensives between opposition and rebel-led forces. Rebels eventually gained control of all remaining Gaddafi loyalist pockets in the country. On 20 October 2011, Gaddafi was captured and killed by rebel forces, and on 23 October, Libya was declared 'liberated' from Gaddafi's rule. The National Transitional Council (NTC) has been in place since 27 February 2011, and general elections are scheduled for 2012. It is estimated that some 30,000 Libyans died in the war (Laub, 2011) and that there have been thousands injured, some of whom have required amputations.

As in all conflict affected population centres, the violence severely impacted social services, the health infrastructure, and the daily lives of civilians. Normal supply chains have been disrupted, resulting in shortages of food, critical medical supplies and equipment. Key medical staff fled at the same time health facilities were attempting to treat

and manage increased caseloads. In addition, electricity and water cuts, as well as destruction of the physical infrastructure, have all added to civilian hardships. As of April 2012, the situation in many conflict affected parts of Libya that had experienced fighting, is continuing to stabilise. In these areas, humanitarian organisations are phasing out their emergency response, and switching to longer term planning and recovery activities. It was, therefore, essential to map initiatives and support services in order to optimise activities.

Project context

The International Medical Corps (IMC) is an international nongovernmental organisation (INGO), and has been on the ground responding to the crisis in Libya since February 2011. IMC has been supporting health services in eastern Libya, Misrata and Zliten, the Western Mountains, and Tripoli, as well as the Egyptian and Tunisian border regions. They have supported services by means of mental health and psychosocial support (MHPSS) activities, such as training in psychological first aid (PFA) for staff working in health care and community organisations. IMC also worked with Libyans, in leadership roles, to set up a coordination group consisting of national and international organisations that were engaged in mental health or psychosocial activities. This group met weekly in Tripoli to share information and discuss needs. With the support of the World Health Organization (WHO) in Libya, similar coordination groups have also been set up in Benghazi and Misrata.

Although coordination efforts existed, it remained difficult for the mental health leadership to keep track of which agencies were where doing what. This was particularly difficult, as prior to the conflict, INGOs

had a limited presence in Libya and it was challenging to understand the work of each agency. Furthermore, the coordination group and the leadership were relatively isolated in Tripoli, with little knowledge and communication with actors outside of the city. In October 2011, IMC accepted the request of the Libyan Ministry of Health, and other governmental officials involved in mental health, to conduct a 4Ws (Who is Where, When, doing What) mapping of current mental health and psychosocial support activities in Libya, which focused on vulnerable areas impacted heaviest by the conflict (Benghazi, Misrata, Tripoli and the Nafusa Mountains). The organisation was well positioned for this task, due to its having a presence in the four main affected regions in the country. In addition, there was good communication between sites, as well as the ability to dedicate resources quickly for the mapping, including staff and operational support such as drivers. Furthermore, as a co-leader of the coordination group, and having been engaged in mental health activities and needs assessments, relationships had already been established with both several international organisations and local actors involved in mental health and psychosocial activities.

The following goals were agreed upon:

- 1) Identify gaps in current MHPSS activities and services
- 2) Avoid duplication of activities
- 3) Improve coordination between different organisations and agencies
- 4) Provide information to better plan for future activities and services

Methods and procedures

The 4Ws mapping tool and adaptation to the Libyan context

The 4Ws mapping tool used in Libya, was developed by WHO and the IASC Reference

Group to provide detailed information about which organisations or agencies were implementing what kinds of activities, in which regions, and within which specific time frames (O'Connell et al., 2012). The different types of activities were organised in a way that fits within the IASC (2007) pyramid, showing the range of different mental health and psychosocial responses in emergencies, from the very specialised to the more basic types of support (Inter-Agency Standing Committee, 2007).

The mapping was conducted from November–December 2011. As a first step, the team drafted a 4Ws mapping tool for Libya, based on discussions with regional and global experts from WHO and IMC, and on experiences from previous mapping in Jordan (Baca et al., 2012).

After the draft was created, the 4Ws team sought out NGOs, agencies and individuals for feedback. All NGOs participating in the coordination group were requested to nominate other organisations that were implementing relevant activities. This 'snowball effect' had been successful within other contexts, but proved to be difficult in Libya as a result of the fluid context with newly forming civil society organisations.

All known organisations, involved in implementation or planning of relevant activities, received the 4Ws draft and were asked to provide suggestions for improving the tool in order to be of the most use within the Libyan context. Based on those suggestions, the following changes were made to the tool:

- 1) *Inclusion of national actors, such as government and nongovernmental agencies, including pre-emergency services and supports*

The original 4Ws mapping tool had been designed for humanitarian emergencies where international organisations implemented various MHPSS

programmes. The Libyan authorities and leadership specifically requested inclusion of national organisations and agencies, including those that existed before the conflict, especially as this information had not been systematically collected previously. Taking such an inclusive approach was better suited to the Libyan context where various new local civil society organisations were rapidly forming. Some individuals were also taking up mental health initiatives and were providing new services to meet the significant needs of isolated communities, such as those in the Nafusa Mountains, Zawarah, and Zawiah. There were also significant gaps in coordination between actors in different parts of the country. The inclusive approach was therefore taken to assist both national and global organisations in planning and coordination.

- 2) *Capturing training details*

At the time of the mapping, several national and international organisations were training specialised staff (psychologists, social workers, general health workers and paraprofessionals) in various topics to improve mental health and psychosocial support services. However, these various trainings were not always carefully planned nor coordinated. In order to capture the training activities, and plan for more coordinated and longer term capacity building of key staff, additional details of training activities (e.g. groups trained and hours of training) were added to the mapping.

- 3) *Implementing activities of specific types of MHPSS professionals*

In Libya, many different types of professionals have been engaged in training others in mental health, including

general staff (e.g. nurses and medical students) and non-specialised volunteers. One reason for this was that a limited number of mental health professionals existed in Libya, while the need for relevant activities and services was high. Therefore, an additional category was added to the mapping, indicating which types of professionals implemented activities.

4Ws mapping implementation

The 4Ws team was co-led by an expatriate MHPSS programme manager (C.F.), and one national staff (A.K.), it also included two Libyan programme staff that provided support for follow-up data collection. The finalised 4Ws data spreadsheet file package was emailed to 45 actors in November 2011 and contained three active sheets:

- 1) Sheet 1 for filling out information about the organisation
- 2) Sheet 2 for filling out details of activities
- 3) Sheet 3 with a list of the 11 MHPSS activities and their corresponding sub-activities

The 4Ws team actively approached participants for outstanding submissions and clarifications, as well as made site visits to all four regions, for three to 10 days each. Preliminary findings were presented to the MHPSS working group in Tripoli. The report was also emailed to all participants and shared with the IASC MHPSS Reference Group and the WHO.

Results of Libyan 4Ws mapping

Who: participating actors (Table 1).

Where: geographic locations (Fig. 1).

Before the conflict, health services, including mental health, had been centralised within the main geographical locations such as

Tripoli and Benghazi, which is reflected in the mapping. Another reason for the higher level of activities in Benghazi is that it has been under control of the transitional government since February 2011, while Misrata and Tripoli have only been under transitional government control since late August/early September 2011 (Figures 2 and 3).

Figure 3 displays where INGOs are located. It is important to note that some organisations had planned programmes, but had not yet started. Similarly, several agencies' activities were scheduled to end in the beginning of 2012.

When: initiation and duration of activities

Before 2011, MHPSS activities and services had been mainly confined to the psychiatric hospitals in Benghazi and Tripoli, which opened in the 1960s. A considerable increase in services started to occur in 2011, with the beginning of the Libyan conflict. Out of 117 activities, 36 had confirmed end dates, most in early 2012, but 27 of them were planned to continue if funding could be found. Many INGO respondents cited the uncertainty of future funding as a barrier in identifying a specific end date.

Another observation was that most international organisations had short term projects, and as a result were uncertain about future programming; this in turn created challenges for planning and longer term sustainability (Figure 4).

What: types of MHPSS activities

Table 2 lists MHPSS activities from the 4Ws data collection spreadsheet that were most frequently provided in emergencies. This list of activity codes and sub-codes is not intended to be exhaustive. Code 11 for 'General activities' broadly includes assessment, training, orientation, supervision and research (Table 2 and Figures 5 and 6).

Table 1. Participating actors

National NGOs	International NGOs	Government bodies	Independent/private actors
Libyan Association of Psychological Health	Danish Church Aid	Tripoli Psychiatric Hospital	Dr Assim AlHabani and Dr Wejda AlMash Hadani (Misrata)
Libyan Association of Psychosocial Support	International Medical Corps (IMC)	Benghazi Psychiatric Hospital	Dr Akram Idrisi (Zwarah)
Libyan Red Crescent	Hilfswerk Austria International	Tripoli Central Hospital	Amal Alghad Private Clinic (Misrata)
Office for Martyrs and Missing Statistics	International Organisation for Migration	Benghazi Medical Centre Psychology Department	Dr AbuSalam (Nafusa Mountains)
Office of Medical and Psychosocial Support for 17 February Injured	Mercy Corps	Benghazi University Psychology Department	Dr Anwar (Alzawyah)
Tawassel Organisation	Médecins Sans Frontières – Belgium	National Centre of Disease Control	
	Acts of Mercy	Misrata Mental Health Center	
	Save The Children		
	WHO		

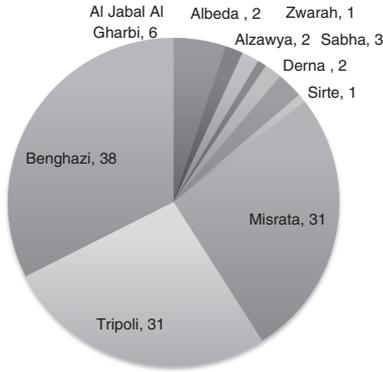


Figure 1: Geographical distribution of activities (per district/shaibya in Libya).

A significant percentage of actors conducted trainings (39%, 46 out of 117). The types of targeted trainees included social workers (15), psychologists (9), volunteers (9), teachers (7), medical staff (4), and psychiatrists (2). One primary observation was that while many of the activities focused on children and adolescents, not one single activity was focused on parents, nor strengthening the parent–child relationship.

Intervention concentration according to level base on the IASC Guidelines pyramid

The IASC (2007) pyramid shows a layered system of different mental health and psychosocial activities and considerations, ranging from basic support needed by most of an affected population, to very specialised mental health services that are needed only by a small proportion. The different types of activities are complementary, and illustrate that people are affected in different ways, and require different kinds of support, following an emergency (Figure 7).

The activities mapped in Libya according to levels on the pyramid show that most (45, 63%) interventions fall under level 1, ‘Specialised services’. This is followed by non-specialised services (14, 19%), ‘Community/family support’ (8, 11%), and ‘Basic services’ (5, 7%). This may indicate that many psychosocial actions at level 1 are often not conceptualised as such, and may be missed in mapping. It is important to note that direct interventions were accounted for, but not training activities.

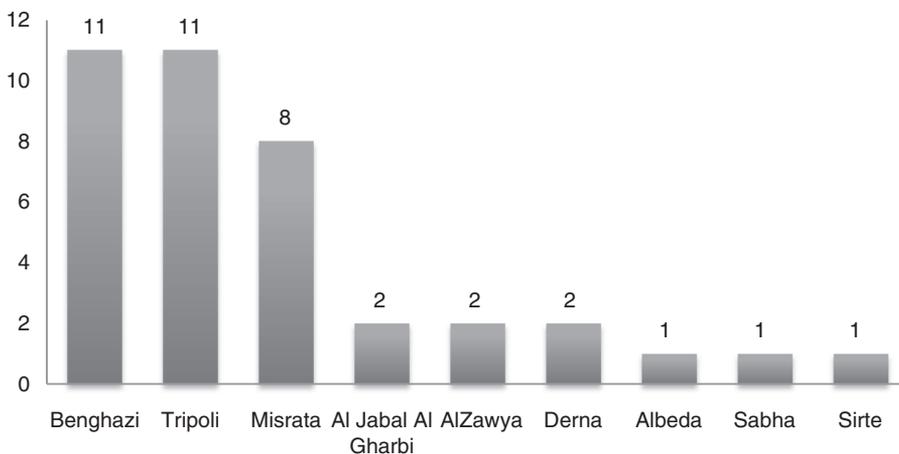


Figure 2: Geographical distribution of actors (per district/shaibya in Libya).

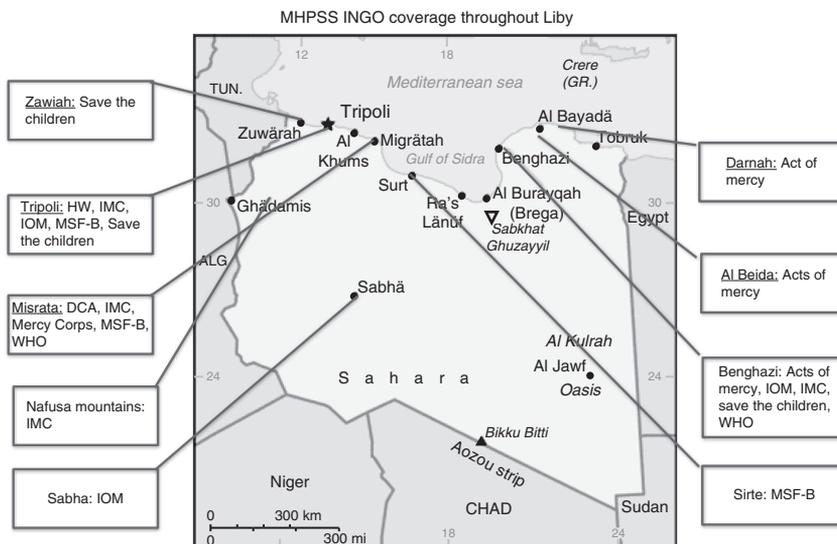


Figure 3: Geographical distribution of international actors (per district/shaibya in Libya).

Discussion

Limitations

The 4Ws mapping exercise in Libya had several limitations. It should be noted that the 4Ws tool is designed to provide information only, and not to assess whether activities follow guidelines, or are of good

quality. In addition, all of the data collected are based on self reporting from the organisations that were interested in participating and who may have presented themselves in a favourable way. The mapping is also based only on those organisations that were identified by the mapping team, while other

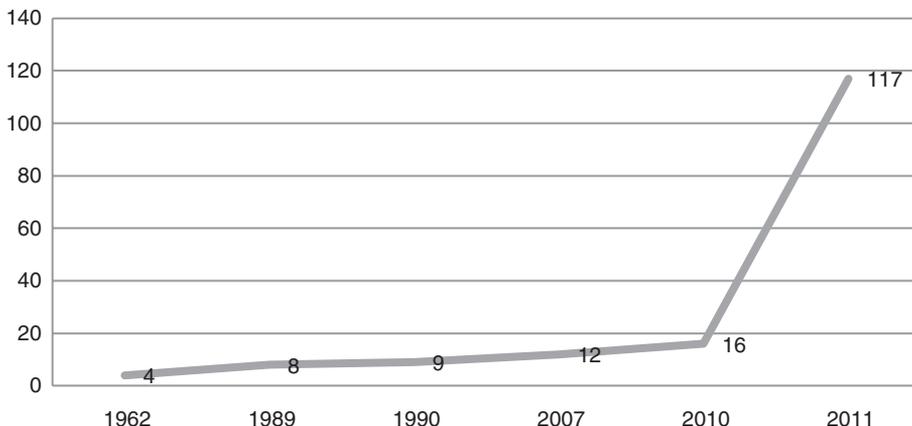


Figure 4: Initiation of activities.

Table 2 4W Activity codes and descriptions^a

Activity code	Description of 4Ws Activity codes
Activity 1	Information dissemination to the community at large
Activity 2	Facilitation of conditions for community mobilisation, community organisation, community ownership or community control over emergency relief in general
Activity 3	Strengthening of community and family support
Activity 4	Safe spaces
Activity 5	Psychological support in education
Activity 6	Supporting the inclusion of social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation
Activity 7*	(Case focused) psychosocial work
Activity 8*	Psychological intervention (e.g., counselling, psychotherapy)
Activity 9*	Clinical management of mental disorders by non-specialised health care providers (e.g. PHC, postsurgery wards)
Activity 10*	Clinical management of mental disorders by specialised mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/general health facilities/mental health facilities)
Activity 11	General activities to support MHPSS

^a See O'Connell et al., 2012.

organisations that were not linked with the coordination group in some way, could not be captured.

Challenges and lessons learned

Response time Participating organisations were given two weeks to respond but some of them took up to six weeks. This slow response time could be attributed to a number of factors. Many of the organisations may have not seen the benefit of contributing to the mapping, and may have been reluctant to dedicate the necessary time and effort to fill in the tool.

Difficulties with the data spreadsheet mapping tool

For the most part, gathering information from organisations was time consuming, and required significant follow up, including phone calls, emails and site visits. Several

actors had difficulty with the tool, and sections were filled out incorrectly or were left incomplete (e.g. dates, human resources, etc.). One of the difficulties identified with using the tool correctly was that staff from participating organisations were not always familiar with software programme. Future mapping should provide the option of filling out a paper version of the tool, or the possibility to gather the data via interview.

Translation and national staff Due to limits of time and resources, it was not possible to create an Arabic translation of the Libyan 4Ws mapping tool. A translation would be useful for further mapping activities. It should also be noted that it was essential to have national staff co-lead the mapping, in order to effectively connect with national

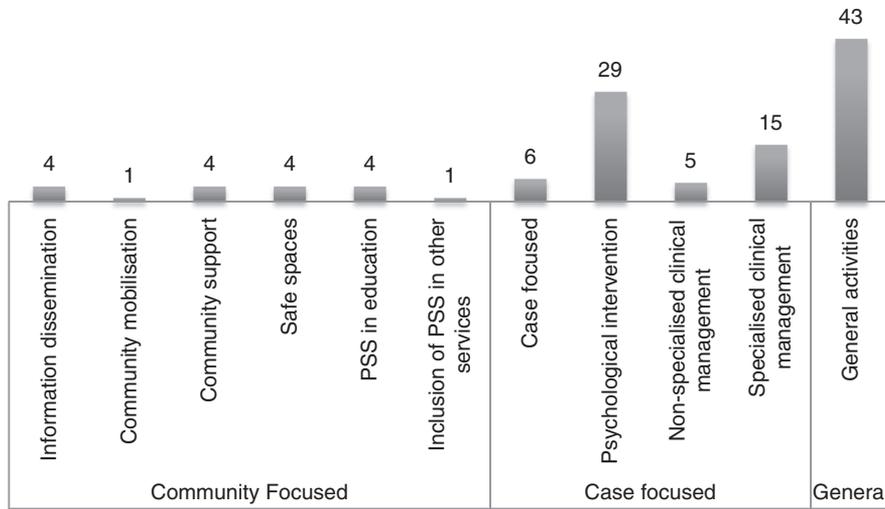


Figure 5: Number of activities per category.

partners and discuss the importance and use of the mapping.

Common understanding of terminology and relevant activities The meaning of ‘mental health and psychosocial support’, was not always clear to national actors who tended to think that this category only referred to specialised mental

health services provided by psychiatrists or psychologists. There was also a common presumption, among many national actors and some international actors, that the best way to promote mental health was to provide psychotherapy or psychiatric services. Therefore, many organisations may

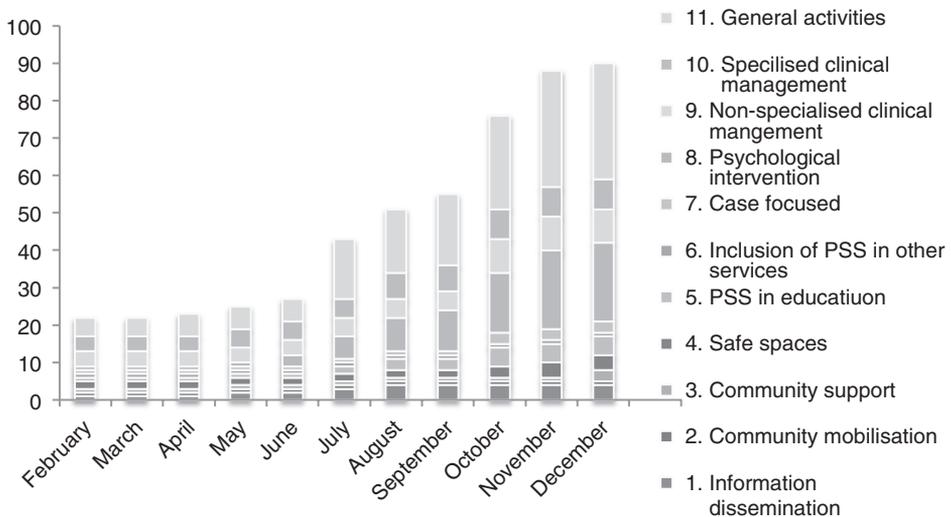


Figure 6: Emergency response activities over time in Libya in 2011.

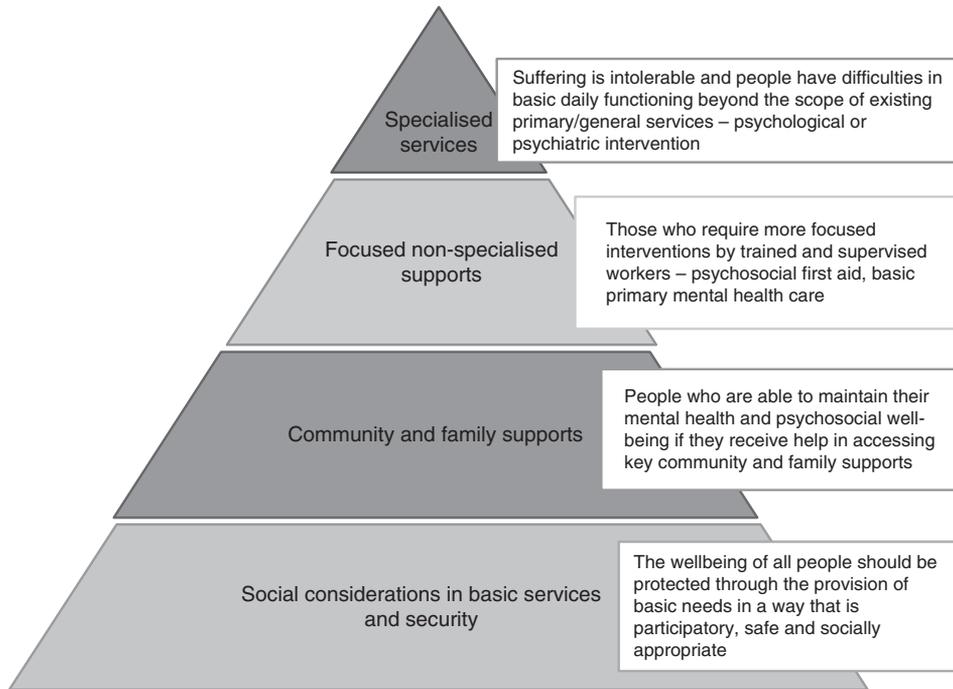


Figure 7: IASC Guidelines pyramid.

have perceived that the mapping did not apply to their work. This is probably another reason why many activities in the bottom half of the pyramid (e.g. mental health considerations in meeting basic needs, such as health and shelter, or connecting families and communities) were not captured. Furthermore, some activity codes were also perceived to be too vague, which left interpretation up to the participant. Future mapping efforts may benefit from additional workshops to explore a wider public health approach, which could also provide information on a full range of relevant activities, such as community support and the role of non-specialised staff, including general health care providers or volunteers. Each category of the mapping tool should also be discussed within a workshop or working group to generate a common understanding, and definitions for each category that are

locally understood. The mapping team should also receive additional training in category definitions, before conducting interviews.

Rapidly changing and increasing number of local organisations It was difficult to identify all potential, national actors as new civil society organisations have been emerging since the conflict. Prior to the conflict, the few local NGOs offering social welfare services were closely monitored and controlled by the government. There have been over 250 new NGOs registered by the TNC's Ministry of Social Affairs in Benghazi. In an 8 month period since 17 February 2011, over 10,000 local NGOs were formed under and registered with the Ministry of Society and Culture according to their figures. There has also been an increased number of organisations starting in Tripoli. In May 2011, the TNC Public Engagement Unit conducted a

one day workshop for 27 Benghazi based NGOs to assess their needs. Findings revealed that the lack of financial resources and facilities, the difficult security situation, and insufficient supplies were major limitations. The NGOs expressed the need for stronger communication and relations with the public authorities, international NGOs and other relevant stakeholders. Furthermore, many of these developing NGOs still did not have defined missions or activities, so they could not clearly identify themselves as potential candidates for mapping. This made it difficult to capture all local organisations. It is very likely that more activities, falling within different layers of the pyramid (including basic services) could have been identified if data from all national actors could have been included.

Limited pre-existing information about mental health services and activities Before the mapping, there were no official records nor data on mental health professionals under the Ministry of Health in Libya, such as the number of psychiatrists, psychologists, social workers, and psychiatric nurses, and where they were working in the country. In addition, prior to the conflict, civil society in Libya was essentially non-existent, and information about rapidly emerging civil society organisations was not systematically reported nor organised. This made it difficult to identify relevant actors to approach.

Lack of pre-existing coordination and new leadership Another challenge in identifying appropriate actors was that very little coordination and referral mechanisms existed prior to the conflict. Additionally, since the conflict, most leaders of institutions, such as health facilities, have been replaced. Even during the mapping exercise, a new cabinet and group of Ministers were selected. This made gathering informed knowledge of activities difficult.

Geographic limitations The four selected geographic areas were chosen because they were impacted by the conflict, had high population concentrations, and most INGOs were active in those areas. However, other smaller cities had also experienced severe fighting and destruction, but were not included (e.g. Zawiyah). Therefore, it is likely that the mapping did not capture service gaps in other vulnerable areas (e.g. it was reported that Zawiyah had few mental health services and activities), therefore national actors operating in these areas were not included in the mapping.

Mapping categories Based on experiences with the mapping, some of the categories should be further modified. For example, having an activities category on the 'assessment' was confusing to those filling out the tool, as many had conducted initial needs assessment before starting activities. The question 'do people receive incentives for participation in activities provided?' had been added, based on experiences in Jordan (Baca et al., 2012), but it was found that it was not applicable to the Libyan context and therefore should be omitted from future mapping in Libya.

More information on training The details collected on training (which was a sub-category, despite being a frequent activity) were inadequate and could have been more comprehensive. The specifics of the training (length of training, professions of the training participants, and numbers of people trained) were absent in several of the responses. Given that many organisations were involved in training activities, it would have also been useful to obtain more detailed information, such as how trainees were chosen, time frame, and whether or not there was any follow up. In this mapping, the authors found that training was often very short or not followed-up by supervision. Therefore, future mapping would benefit

from an additional category focused on training in order to obtain more accurate and comprehensive information, as identified above.

Capturing activities of national organisations It is likely that many local actors involved in relevant programming have been missed due to: rapidly emerging new civil society organisations, limited pre-existing information, lack of understanding of mental health definitions, focus on a limited range of geographic locations, and difficulty communicating and coordinating across a vast region. By addressing some of these factors, future mapping should comprehensively capture more activities of national organisations.

Costs and benefits of the mapping

Costs The mapping was costly. In order to carry out the process, committed human resources were required, including one programme manager and three national programme officers, one of whom was committed full time to gathering data, follow-up and clarifying inputs from partners, interviewing actors, data cleaning and analysing the data. One of the motivations of the mental health leadership in Libya was to avoid duplication, and to determine which actors' proposals would be approved for new projects proposed to the MoH. This was problematic, however, because as described above, mapping does not measure the quality of services being delivered. Following the mapping exercise, the findings were presented to the coordination group and recommendations were discussed, but this could have been more beneficial if more of the mapping participants from different regions could have been included.

Benefits There were several benefits of the mapping, consistent with initial goals. The tool helped link different organisations,

which previously did not know what services were being offered elsewhere. The mapping also helped inform national and international actors about best practices in the global mental health field, particularly around coordination. Overall, this was a useful exercise for organising and sharing information that was previously unavailable, and as a systematic process involving various actors in mapping, as well as in discussions on how to develop and improve the tool.

Future plans and recommendations

Future recommendations for the Libyan context include repeating the 4Ws mapping exercise to reflect MHPSS services over a longer period of time, as the context in Libya continues to change rapidly. Future mapping should also aim to be more inclusive and participatory, capturing more of the national emerging civil society actors and governmental efforts. In addition, the mapping could be used to better link actors providing different levels of care. This would include inviting organisation to coordination meetings, with the aim of ultimately creating referral pathways. Advocacy and additional efforts are also needed to further integrate mental health and psychosocial support into other sectors including health, education, and protection, as well as into the existing programmes of national agencies.

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