DIGNITY Publication Series
SURVEY
#8

CONSEQUENCES OF TORTURE AND ORGANIZED VIOLENCE

Libya Needs Assessment Survey

Fathi Ali
Ahlam Chemlali
Morten Koch Andersen
Mette Skar
Henrik Ronsbo
Jens Modvig

جامعة بنغازي
مركز البحوث والاستشارات
University of Benghazi
Research and Consulting Centre

DIGNITY
DANISH
INSTITUTE
AGAINST TORTURE

CONSEQUENCES OF TORTURE AND ORGANIZED VIOLENCE

Libya Needs Assessment Survey

Fathi Ali

Research & Consulting Center, University of Benghazi

Ahlam Chemlali

Morten Koch Andersen

Mette Skar

Henrik Ronsbo

Jens Modvig

DIGNITY - Danish Institute Against Torture

United Nations Map of Libya with cities, roads, and the current twenty-two Districts or Shabiyah of Libya. United Nations Cartographic Section Department of Peace-Keeping Operation.

Source: *http://www.un.org/Depts/Cartographic/map/profile/libya.pdf*

Executive Summary

The data collection was completed in October 2013. 2,692 household interviews were included in the national survey.

Every fifth household responded to having a family member disappeared, 11% reported having a household member arrested and 5% reported one killed. Of those arrested, 46% reported beatings, 20% positional torture or suspensions, 16% suffocation and from 3 to 5% reported having suffered sexual, thermal or electrical torture. In short our data support the allegations that widespread human rights violations and gross human rights violations have taken place in Libya.

The consequences at the level of the population are massive: 29% of individuals report anxiety and 30% report depression, while PTSD symptoms were reported by 6%. These results indicate that the respondents at the time of interview could still be in an acute or post-acute stage and have yet to reach the post-trauma stage, hence we predict that the prevalence of post-traumatic stress reactions will increase over time, if or when the internal conflict subsides.

Furthermore, our data show that internal displacement is major concern in Libya. A total of 18% of the respondents reported being internally displaced during the internal conflict, and 16% remains so at the time of the interview, indicating a major source of long-term human suffering and political instability.

In these times of distress and crisis respondents have had almost no access to international humanitarian assistance. Only 2% report having been helped by NGOs. Libyans overwhelmingly have resorted to local resources for social support: 72% indicate they used family networks and 48% friends, 43% Libyan medical doctors, 24% used religious leaders and 18% used traditional healers.

Overall, we conclude that both the short-term consequences of the internal conflict as well as the long-term consequences of the Gaddafi regime are in large measures still unaddressed. In order to deal with life stress, 59% indicated they needed assistance in terms of justice, legal remedy and compensation, while 44% indicated they needed health and medical assistance. Thus, the report concludes that any future government of Libya faces massive challenges in alleviating human suffering and improving mental health. However, as the internal conflict continues more and more people are affected by human rights violations aggravating mental health afflictions, straining the social fabric and the capacity of the Libyan state.

Contents

List of Figures

List of Tables

Foreword

Since September 2011, DIGNITY has been working in Libya in an attempt to assess the state of human rights and mental health so as to identify areas of possible collaboration and find potential partners, for the benefit of the Libyan people. The focus has been on the needs of the people and their families detained and tortured during the 40 year of Moammar Gaddafi's regime and those traumatized during the revolution, mainly the young men fighting the war. Likewise most other international organizations at the time, DIGNITY went to Benghazi which was the center of the revolution, home of the interim government and safe area for internationals. Though the war was raging in the west of the country the city was a joyous place and foreigners were welcomed with great enthusiasm. Everyone was in celebratory mood as the revolutionary forces, pushed back and eventually defeated the regime with the assistance of NATO. A state based on democratic ideals, human rights and rule of law principles became a possible reality, unimaginable for more than 40 years. Many challenges were still ahead but people, at that time, went to their work places, volunteered for humanitarian support of those unfortunate to be hurt by the war and participated in numerous committees under the interim government to build an institutional foundation and social fabric of the new Libya.

It was a time of action, initiative and achievement but also a time of reflection, concern and eagerness to access new information and knowledge on issues which had been ignored and repressed by the regime. Torture, traumatization and mental health entered the public vocabulary which it had not been part of before. The interim governments and health professionals recognized the need for knowledge based assistance and capacity building of Libyan professionals to deal with the effects of the war; social, somatic and mental. However, information regarding health and social conditions within the population was not available, in the aftermath of the violent conflict. The idea for this research and the collaboration between DIGNITY, Birzeit University and Benghazi University, Research and Consulting Centre, was formed by the recognition that information was lacking. It was made possible by the eagerness of the Libyan researchers, under the leadership of Dr. Fathi Ali, to produce relevant and needed information about social conditions in Libya, to plan for adequate and relevant assistance for those in need. The research aims

to contribute to a better understanding of the Libyan society today and concludes with the publication of this report.

A line of people have been involved in the conceptual development of the study and the finalization of the report. Dr. Yoke van der Meulen and Dr. Rita Giacaman, Institute of Community and Public Health, Birzeit University, were instrumental in development of study methodology and questionnaire and responsible for the initial qualitative research stage in collaboration with Lotte Buch Segal, Institute of Anthropology, University of Copenhagen. Shr-Jie S. Wang, DIGNITY, undertook proof reading of data tables identifying areas for improvement and further analysis. The study was jointly funded by the Danish Foreign Ministry as part of The Arab Initiative, the Benghazi University and the Libyan Ministry of Health.

The authors, October 2014

Introduction

Since the beginning of the Libyan revolution that began in Benghazi in the days of 15-17 February 2011, the country has gradually collapsed into a state of regionalism, tribalism and factionalism that have resulted in territorial, political and religious conflicts. The revolt against 42 years of Moammar Gaddafi's dictatorship spurred the formation of numerous armed groups and militias across the country, mainly based in regional and tribal affiliations, to fight and eventually defeat the regime with the assistance of NATO. In the aftermath of the armed revolt, demobilization and assistance to revolutionaries and torture victims was high on the political agenda. However, elected parliamentarians and several governments were not able to make them surrender their arms and provide adequate assistance to reintegrate revolutionaries – *thuwwar* – and fighters into society.

The lack of trust in the state as an institution of authority and unwillingness to give up recently gained power and territorial control combined with mistrust amongst the armed groups along tribal and regional lines, prevented the demilitarization of the country. The government's authorization of the largest armed groups to act as security providers in the country and to safeguard vital infrastructure including prisons, as an attempt to ensure peace and bring the armed groups under the umbrella of the state, proved futile. Torture and human rights abuses widespread during the Gaddafi regime, persecution of political opponents and oppression of the general population through fear, continued to be utilized by the militias towards alleged regime loyalist and political opponents, primarily in military camps and detention centers with the acceptance or ignorance of the government and parliament.

With the loss of the initial revolutionary momentum when political solutions and ideas waned off – epitomized by the inability to agree on a constitutional legal framework – different armed groups continued to mobilize young men and strengthen their military capability. New armed groups have mushroomed and some have grown into political extreme ideologies.

Intensified competition over access and control of resources; oil fields, shipping lines, airports and harbors, and antagonisms between the groups over the role of religion within

the structures of the state or as the state by divisive interpretations of sharia, have spurred localized violent conflicts and warfare across the country. This was not just the result of political inexperience and inability with parliamentarian and democratic rule but also the consequence of a lacking state apparatus where oil revenues and state funds disappeared and never reached the society at large.

Consecutive governments (interim and elected) have tried to take control of the state and state institutions, the territory and its natural resources but have failed time and again, often by the direct challenge by one or the other of the armed groups. Without the armed groups' acknowledgement of authority, government and parliament decision making become void, implementation fails and the expected effects do not materialize e.g. adequate demobilization programmes and assistance to victims. Disagreements between elected governments and armed groups have resulted in violent seizure of the parliament, threats to politicians and even kidnapping of the president and members of parliament to achieve specific demands or decisions.

This lack of trust in the parliamentary system, the democratic process and governmental authority has left society fragmented and in conflict on the question of how to align state formation and governance with national identity, tribal affiliations and regional allegiances. The political fragmentation and violence have created a prolonged volatile situation of uncertainty and insecurity in society. Violence and fighting have resumed or maybe never really stopped but this time not against a common adversary but as fragmented across the country, South, East and West, over access to resources, infrastructure, territory and political identity. Increasing numbers of people are affected by the fighting and escape to neighboring countries. Exact figures are unknown but it was estimated that during the intense fighting in Tripoli in August 2014, up to 6000 migrated to Tunisia each day, to escape the violence.

The fighting appears to be difficult to contain due to the numerous actors involved and the fragmentation of conflicts, notwithstanding foreign interference, the depth of the societal division and the complexity of the different localized conflicts across the country and their interrelations.

Nonetheless, to provide adequate and relevant assistance it is crucial to know how people are affected, how they manage the situation and what needs they might have for support. This study was designed to assess the situation within the general population to bring forth their needs, in the face of war and torture, and address coping and assistance seeking practices and bring out perceptions of the respondents immediate and prospective futures.

The ambition is that DIGNITY and other international actors and national institutions e.g. the Ministry of Health, will utilize the results for improved, adequate and relevant assistance programs for the benefit of the victims of war and torture and their families in Libya.

2.1 Aim of study and survey objectives

The aim of the study is to provide data, which can guide DIGNITY's and other actors supportive interventions for tortured and otherwise traumatized people (political prisoners, combatants of the recent events, and families, especially wives and children, and others who have been exposed to political violence), including

A. Information about the occurrence/prevalence of different traumatic experiences and exposure to torture in the target population during the previous regime and during the uprising,

B. Information about previous help-seeking behavior and coping mechanisms as well as current needs for assistance, support, and treatment in the population according to traumatic experiences of different population groups, in line with culturally understandable and acceptable methods,

C. Information about selected health, well-being and functioning variables in relation to exposure to organized violence.

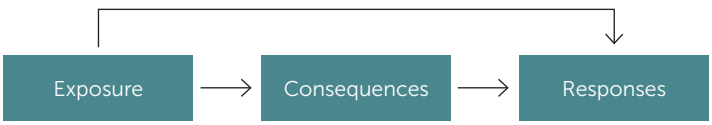
Each of these questions were addressed in different sections of the questionnaire relating to different types of health-related tools and approaches. Each section was deliberately chosen to yield information on population experiences and needs and addressed in the study.

Theory

3.1 Conceptual module of the questionnaire

The survey questionnaire was structured according to the conceptual model of the study in order to investigate the experienced violent exposure within the population; the health-related problems, and population responses to the identified health concerns. The model is shown in figure 1 below depicting the relation between the concepts. The figure shows that exposure to torture and organised violence leads to health-related consequences, which affect help-seeking behavior and coping mechanisms. The exposure can also directly affect the responses.

Figure 1: Relation between concepts.



3.2 Composition of the questionnaire

Exposures

The survey assessed different traumatic experiences in four selected settings where torture and organised violence were likely to occur, namely during arrests/pre-trial detention, public demonstrations, the front lines, and during displacement as a consequence of the armed conflict. The exposure was assessed employing a context specific and modified version of the Harvard Trauma Questionnaire (HTQ). The selection of relevant traumatic events in the arrest/pre-trial detention setting was informed by the experiences of ex-prisoners and

revolutionaries, which were detected in the qualitative pre-study (1). Torture was a major consistent and recurrent theme in the interviews (1). Hence, the modified list of traumatic events comprised of torture methods experienced, witnessed, heard of, or committed by the informants (1). A total of seven torture methods were included for the assessment in the questionnaire. The majority of the methods concerned physical pain and was related to bodily injury or head injury (2), such as beatings, positional torture and suffocation. Through the qualitative pre-study it became apparent that also psychological torture was widespread and prevalent (1). Hence, the questionnaire included threats and humiliations as torture methods. Furthermore, methods inflicting both physical and psychological pain, such as sexual torture and suffocation were also included as separate methods. To ensure that the respondents of the questionnaire had a common reference frame and to increase their understanding of the methods in question, local idioms were used to explain and elaborate on the different torture methods (1,3). For example, the concept of positional torture was explained by the word 'Honda'. Honda was a torture chamber in the main prisons in Libya, where the prisoner was tied up to two metal bars, positioned as the Honda car symbol (1).

To select traumatic events for the three open settings, namely demonstrations, front lines and displacement, our study aligned with methods included in the Libyan Health and Humanitarian Needs Assessment (March 2012) conducted by UNFPA and partners. By drawing on the same traumatic events, which previously had been assessed, it could be inferred that these events were prevalent in the period following the uprising in 2011 in Libya (4,5). The included methods were predominantly war-like conditions (2), such as shootings and shelling. However, excessive use of force, such as beatings was also reported (4), and therefore included in the list of traumatic events in open settings. Furthermore, rape and other forms of sexual abuse have been documented in many conflicts (6) and also reported in Libya (7,8), which also emerged in the qualitative pre-study (1).

Consequences

The assessment of health-related consequences included both physical and mental health as well as pain, function and well-being to make a comprehensive assessment of the health status of the Libyan population. Self-reported health was used as an overall measure of the health status (Short Form Health Survey (SF-36)). Mental health consequences were assessed using two standardised instruments (HTQ and Hopkins Symptom Checklist (HSCL-25)), which allowed to explore the level of PTSD, depression and anxiety related symptoms in the population. The function level and disability was measured by EuroQuality of Life scale (EQ-5D), a scale previously used in Libya (9) indicating self-perception of mobility, self-care, usual activities, pain and anxiety/depression.

Responses

This part of the questionnaire investigated how the population responded and acted to the traumatic experiences and the health-related consequences. This made it possible for the respondents to indicate what kind of effective support and assistance they had received to

cope with life stress and from whom. The questionnaire included locally relevant actors such as medical doctors, traditional healers, religious leaders and family and friends. To identify needs for rehabilitation and support the questionnaire included questions on what kind of help and assistance the Libyan population would like receive and from whom. The respondents could indicate needs of practical assistance, legal assistance, medical assistance, and livelihood assistance. Lastly, the questionnaire asked about the populations' prospects of the future.

Mixed methods

Recognizing the fact that the Libyan population just came out of 42 years of dictatorship and that torture, war trauma and mental health not had been part of the vocabulary and practice in Libya, questions regarding these issues could be socially and politically stigmatizing. Hence, the design and methodology of the survey had to be grounded in the local context and culture. The method was chosen to flesh out local idioms, vocabularies and worldviews, to provide quality information and ensure a proper reflection of the Libyan society at this particular moment in its history and be able to produce contextual consistent recommendations for action and intervention on a national scale.

To ensure sufficient depth and breadth the combination of qualitative and quantitative methods in a mixed methods approach were chosen by the researchers from DIGNITY and ICPH-BU Institute of Community and Public Health – Birzeit University (ICPH-BU), to capitalize on the strengths of both approaches and to gain greater confidence in the conclusions generated. The idea is that using a mixed methods approach increases the likelihood that the sum of the data collected will be richer, more meaningful and ultimately more useful (3).

Mixed method is defined as a research procedure involving the collection, analysis and integration or combination of both quantitative and qualitative data to answer research questions (3). Epistemologically, it is the "third methodological movement" that involves the pragmatic method and system of philosophy (10). Additionally the qualitative studies can help form which questions to ask in the quantitative questionnaire i.e. how the questions are written, wordings, phrasings etc. Pragmatism has emerged as a common alternative to the either/or choice of positivism and constructivism of the quantitative and qualitative approach, respectively offering an epistemological approach that justifies the integration of methods in order for researchers to best frame, address and provide logical and practical answers to their research questions (10).

From a method perspective, mixed methods research has several essential characteristics. *First,* it involves the collection and analysis of both quantitative and qualitative data. Although many discussions exist in the literature about what constitutes these types of data, a useful distinction exists in whether the investigator collects open or closed-ended data (3,10). Instrument data with closed-ended response categories would clearly be quantitative data,

whereas interview-focus group data with open-ended responses to interviewer questions would be qualitative data.

Second, the quantitative and qualitative data collection must be rigorous and follow procedures for good research designs, such as selection criteria, sampling, sample size, multiple sources of data, and other concerns such as fidelity of procedures, and access and permissions (3). Data analysis as well should be conducted using rigorous procedures in recording data, inspecting it, analyzing it, representing it in tables and figures, and drawing interpretations from it.

Third, a central component of mixed methods research is the integration or combination of quantitative and qualitative data. In mixed methods terms, this procedure is called mixing, and it can occur in three ways: merging, connecting, or embedding (3).

The mixed method design chosen for the needs assessment survey was Exploratory Sequential Design (ESD) by using qualitative interviews to build on and strengthen the quantitative questionnaire (1). Exploratory sequential mixed methods data collection strategies involve collecting data in an iterative process whereby the data collected in one phase contribute to the data collected in the next.

The purpose of the *three-phase*, exploratory mixed methods study will be to explore participant views with the intent of using this information to strengthen and feed into a quantitative need assessment questionnaire. *The first phase* is a qualitative exploration of the exposure, response and consequences of torture and violence via individual in-depth interviews to facilitate the report of sensitive violations e.g. rape, sexual torture, humiliations, from survivors of torture from the Gaddafi era, ex-prisoners as well as combatants involved in fighting and their relatives in Benghazi, Libya. Thus, the qualitative themes and codes of *phase 1* become a starting point for adapting in a questionnaire in *phase 2*. *In phase three*, the questionnaire will be tested with a larger population sample in a quantitative phase of the study.

Needs assessment survey

The needs assessment survey can highlight areas of unmet needs and provide objectives to work towards to meet these needs and deciding rationally the most efficient and effective way to improve the population's health (11). An overview of the actual need of the torture victims targeted will therefore not only seek to prevent a possible waste of resources but also give guidelines as to how and to whom the care should be focused. Additionally, drawing on data from other post-conflicts settings, can suggest which forms of care that may be appropriate.

When trying to appropriately identify a need, the discrepancy between a current condition and a wanted condition must be measured. A needs assessment is a way of systematically determining and addressing such discrepancies or needs. Thus the aim of a needs assess-

ment survey is to gather information to plan, negotiate and change services for the better. In this process a picture of current service provision is developed (12).

Furthermore, a needs assessment survey should not only be a method of measuring ill health in a population. It should also account for ethical, clinical, economic and political considerations i.e. by identifying inequalities in health and in access to services and by including recommendations as to how resources should be most effectively used in addressing the found needs (11).

In order to carry out a needs assessment survey, self-report questionnaires are useful as these are applicable in larger samples (13). The questionnaires and associated scales used in current studies often are a modification of previously developed and validated instruments. The instrument is adjusted, so that it fits the aims and study population of the current study. When making these adjustments an issue to consider would be the cultural preconceptions of the study population. I.e. one must consider if the rating scale of the instrument is appropriate to use in non-western cultures in which perceptions of pain and suffering can be different and more complex than the western rating scales are able to account for (13). There is a growing recognition of the value of incorporating culturally specific idioms of distress into assessments of mental health when working in non-Western conflict and post-conflict situations (14). Since cultural differences are tied to variations in the social construction of reality - which is in turn influenced by cultural differences in cognition and the experience and expression of emotion - the perception of what a traumatic experience is, as well as individual and social responses, can conceivably vary greatly (15). Hence, local idioms and cultural themes were incorporated in the needs assessment survey.

3.3 Description of sampling strategy and sampling method

This part elaborates in issues related to the population of the survey, sample size, sampling frame, and sampling method.

The population of the survey

The population of the survey (2,692 household) are the residents of Libya (Libyan and non-Libyan 18 years old and above).

Sampling frame and sampling method

The most recent population census of 2006 was used as a sample frame. In this census Libya is divided into 22 Shabiyahs (province) and these Shabiyahs are further divided into 667 Mahallahs (Locality). The survey covered all the 22 Shabiyahs with no area excluded.

A stratified multi-stage random sampling technique was used. This method ensures a complete demographical and geographical representation of the Libyan population.

In the first stage, the number of the interviews was allocated in proportion to population size of each of the 22 Shabiyahs.

In the second stage, a number of Mahallahs was randomly selected in each Shabiyah, using Probability Proportional to Size (PPS) sampling technique. In this technique, the probability of selecting a sampling unit (e.g., Mahallah) is proportional to the size of its population. It gives a probability (i.e., random, representative) sample and assures that individuals in larger Mahallahs have the same probability of getting into the sample as those in smaller Mahallahs, and vice versa. In total 101 Mahallahs were selected across Libya.

In the third stage, a number of households were selected in each Mahallah. A Sketch map for each Mahallah was drawn and each Mahallah was divided into approximately equal-sized segments. Depending on the number of interviews allocated, one or more segments were randomly selected and the number of households in each segment was estimated. A skip figure was calculated by dividing the estimated number of households in each segment by the number of the interviews. This skip figure was used to select households by Systematic Sampling Method.

In each household, an individual was randomly selected by using Kish grid Method (27)). The survey operated a call-back system which revisited temporarily unavailable targets for up to three times. If the targeted individual was not available after three time call-back, there was no replacement from the same household, but a new household was selected instead.

A face-to-face personal interviewing technique, in respondents' homes, was used to collect data.

Field Work administration

This part elaborates in issues related to the organization of the fieldwork, data gathering, and quality control.

The Research and Consulting Centre (RCC) has an established face to face field interviewing team of around 100 interviewers. Most interviewers have been with the centre for quite a long time and draw on extensive experience of conducting surveys all over the country, including the most challenging locations and amongst the most difficult people to reach.

Fieldwork organization and quality control procedures

The field work took place in October 2013 and lasted a month, where interviewers were organized in 7 teams. Each team had a team leader and two supervisors and each supervisor had five or six interviewers working under his/her supervision. In the

field, teams worked as groups where each team used two vehicles to reach targeted Mahallahs. In this way a rigorous quality control routine could be implemented as shown below.

The quality control procedure of RCC starts from the careful selection of the interviewers. All the interviewers have university education and have been trained in the latest survey and interviewing techniques. In particular, the training course covers areas like: theoretical perspectives of social research, practical aspects of the research, especially those related to the Libyan context, and ways to insure high response and low refusal rates.

The candidates of the training course get evaluated and take exam and only those with very good evaluation get selected to participate in the fieldwork. Moreover, interviewers were requested to spend a great deal of time familiarizing themselves with the survey questionnaire, its logic and consistency and the support materials, including documents for the implementation of quality control. In mock sessions, researchers practiced the survey questionnaire and were monitored by their supervisors and team leaders 4. Some of the interviewers have already participated in several surveys with the centre.

During the fieldwork, interviewers had to apply RCC quality control procedure which required the supervisors to attend part of at least 10% of the interviews to make sure that they were done correctly and to do a call back for at least 10% of the interviews to check and ask interviewees a limited number of questions from the survey to see if there was any kind inconsistency between the completed survey questionnaire and the back-check answers. If there were any inconsistencies, interviewers would be instructed to resolve them.

On average 13% of the interviews were partly attended and monitored by the supervisors and nearly 16% of the interviews were back-checked by supervisors or team leaders. The procedure required also interviewers to check their work at the end of the day, resolving inconsistencies and calling back interviewees where errors were detected. At the end of this process they signed the completed questionnaires and passed them to their supervisor.

Supervisor then checked the completed questionnaires of each of their interviewers, resolving any inconsistencies and passed them on to their team leaders. After receiving the completed questionnaires, team leaders checked them again and reported the progress to project manager.

The data entry was through scanners using Remark Office Software which minimized human errors and helped detecting any inconsistencies. After the data entry, statisticians checked the data files for any kind of inconsistencies, out of range values, or potential fakes.

Refusals and non-availability

The survey team took several steps to ensure that no group is marginalized from participation by the way in which the survey was delivered and to keep the refusal rate minimum. First, interviewers were trained in methods for convincing potential respondents to participate.

Table 1: Refusal rates

A -	Total issued	2,847
B -	Addresses established as empty, demolished or containing no private dwellings	13
C -	Selected respondent too sick/incapacitated to participate	14
D -	Selected respondent away during survey period	15
E -	Refusal at selected address	65
F -	Personal refusal by selected respondent	12
G -	Unproductive interview (interviews with more than 25% of the questions not answered)	36
H -	productive interview (full and partial)	2,692

In general, the table shows that the refusal rate is around 5.4% which can be considered within the acceptable and expected range in such surveys. Second, interviewers were provided with documentation to ensure that the introduction to the survey would be compelling, giving the respondents good reasons for wanting to take part, and ensuring that they see it to their benefit to do so. Third, the survey operated a call-back system which re-visited temporarily unavailable targets for up to three times and there was no replacement of unavailable respondents within the same household. Instead a new household was selected.

Results

A total of 2,847 households were visited of which 2,692 respondents successfully completed the interview corresponding to a response rate of 94.6%. This section is divided into three. First section is about the socio-demographic background of the household respondents; sex, origin, ethnicity, age, education and employment. Second section shows the violence exposure at arrest, detention, demonstrations, frontline and displacement. Third section, describe the consequences of violence exposure self-reported health and mental health, coping and perceptions about futures, in a war-torn country.

4.1 Background characteristics of study population

The following section describes the socio-demographic background characteristics of the study population. The gender balance of the household survey was secured with 50.1 % male and 49.9 % female respondents.

The geographic and ethnic characteristics of the study population are shown in Table 2. The majority of the respondents identified themselves as Arab (95.1%) and from Libya (97.0%). A total of 80% identified their household as a member of a tribe.

Table 2: Geographic and ethnic characteristic of study population

Country of origin in the household	Frequency	Percent
Libya	2,612	97.0
Egypt	21	0.8
Palestine	18	0.7
Syria	10	0.4
Morocco	7	0.3
Other	14	0.4
Refused	10	0.4
Total	2,692	100.0
Ethnic group		
Arab	2,558	95.1
Amazigh	111	4.1
Tuareg	13	0.5
Taboo	9	0.3
Total	2,692	100.0
Household member of tribe		
Yes	2,153	80.0
No	539	20.0

The respondents' predominant self-identification as Arab Libyans combined with the high number of tribal affiliation emphasize tribalism and associated territorialized regional ties as important determinants in society, national identities and political configurations. It reflects the early creation of the major armed groups in the country based in Benghazi, Misrata and Zintan. It explains the challenges of state formation, problems of creating a unified security structure and lack of agreement on a democratic discourse and system e.g. constitution and legal system, when allegiances and legitimacy of authority rests in territorialized tribal hierarchies and historical power structures.

Figure 2: Age distribution of respondents

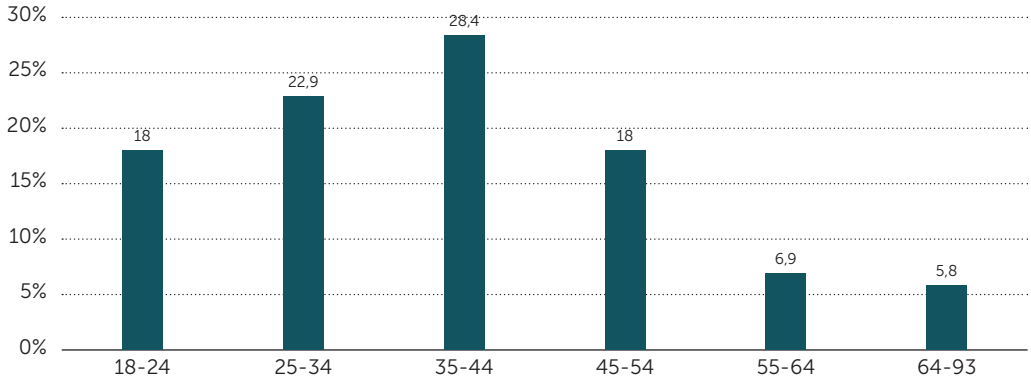


Figure 2 shows the age distribution of respondents. The largest part of the respondents was aged 35-44 years (28.4%). The oldest age groups were the least represented with only 6.9% in the age group from 55-64 and 5.8% in the age group from 65-94 years.

Figure 3: Distribution of education level of respondents

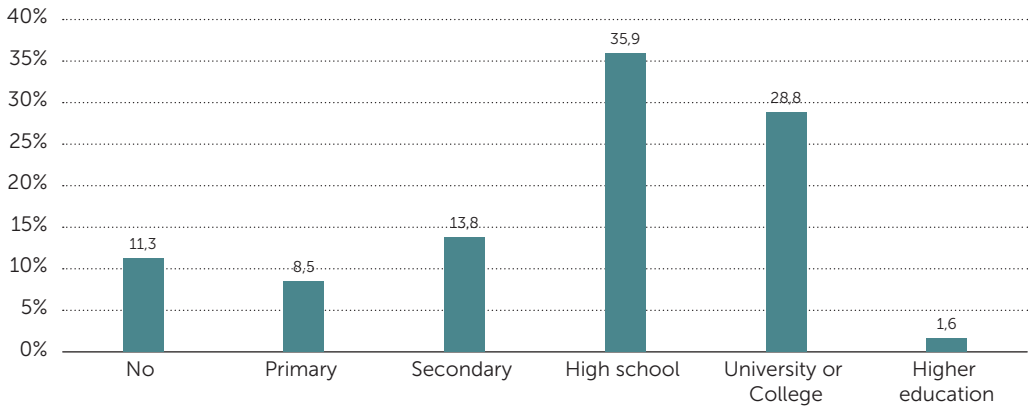


Figure 3 shows the distribution of education level of respondents. In general the education level was high, with only 11.3% reporting "no education". A total of 35.9% reported "high school" as the highest obtained educational level and a total of 28.8% had a university or college degree. The table shows the relatively high educational level in the country underlining the hope and prospect of the development of democratic institutions and rule of law that dominated national and international discourse, just after the fall of Gaddafi.

Table 3: Employment status of household head

Employment	Frequency	Percent
Retired	449	16.8
Unemployed (unable to work)	60	2.3
Unemployed (able to work)	108	4.1
Student	41	1.5
Homemaker	136	5.1
Employed, manual work	47	1.8
Employed, government	1,356	50.9
Employed, private	110	4.1
Private business	293	11.0
Employer	65	2.4

Eleven respondents refused to answer (0.4%) and 16 (0.6%) answered "don't know".

Table 3 shows distribution of employment status of household head. Most household heads reported to be employed by government (50.9%), followed by retired (16.8%) and having their own business (11.0%). The table illustrates that a possible break down of state and state structures will instantly and directly affect the income and livelihood of the majority of the population. The Libyan state economy is heavily dependent on oil revenues. The many attempts of armed groups to disrupt or control oil facilities and ports for shipment consequently undermine the capacity of the state to function as a state. Until the arrival of armed groups and *Shura*, with a jihadist Salafist ideology, the conflict between the armed groups along tribal lines and political configurations was mainly about the organization and distribution of state resources i.e. oil revenues. In this regard it is noticeable that the government throughout the conflict and fighting has been able to produce and export oil and that it via the revenues compensates the registered thuwwars' on a monthly basis.

4.2 Exposure

The study assessed different occurrences of violence exposure in three different settings. First, torture in arrest and detention is assessed. Secondly, exposure in relation to the revolution of 17th February 2011, at demonstrations and at the frontlines is assessed. Thirdly, exposure in connection with displacement is assed. Lastly, exposure to violence is assed at household level.

Arrest and detention

154 (5.7%) of respondents reported to have been arrested, detained or imprisoned, and 82 of them (53.2%) were exposed to torture or violence during their arrest. Of the arrested 149 (96.8%) were men and 5 (3.2%) women. Table 4 shows the distribution of torture exposure during arrest and detention according to age groups. The table shows that the oldest age group reported the highest proportion of torture exposure; however there were only 3 persons in this age group. A high proportion in all age groups reported torture exposure.

Table 4: Torture exposure during arrest according to age groups

Age group	Torture exposure during arrest (n (%))	No torture exposure during arrest (n (%))	Total
18-24	10 (40%)	15 (60.0%)	25
25-34	30 (62.5%)	18 (37.5%)	48
35-44	19 (48.7%)	20 (51.3%)	39
45-54	12 (50%)	12 (50.0%)	24
55-64	8 (57.1%)	6 (42.9%)	14
65-93	3 (75.0)	1 (25.0%)	4
Total	**82 (53.2)**	**72 (46.8%)**	**154**

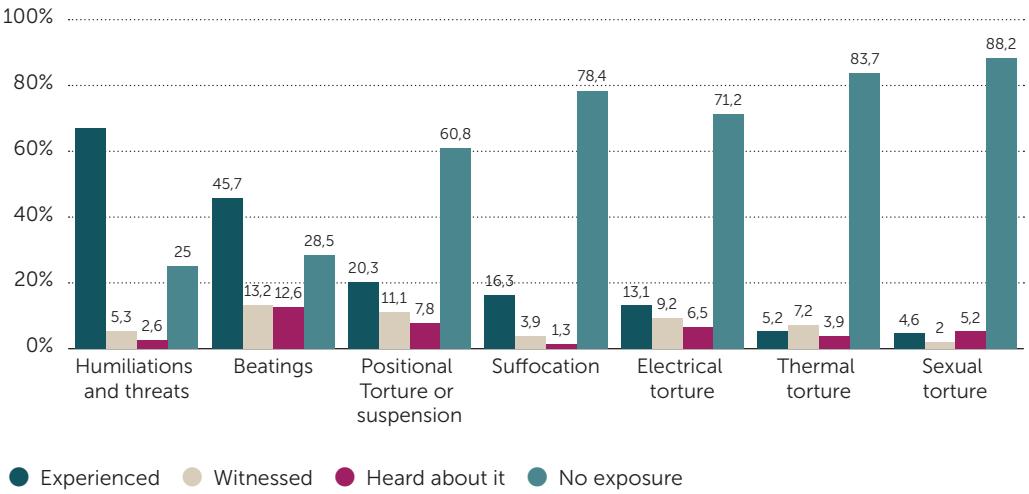
Figure 4 shows the distribution of exposure to different torture methods according to the modality of the exposure. The most common torture method was humiliations and threats (67.1%), followed by beatings (45.7%) and positional torture (20.3%). This is also in line with the qualitative findings. Interestingly 102 persons responded they had experienced humiliations and threats, although only 82 answered yes to being exposed to torture. This could indicate that the perception of torture of most Libyans do not include psychological torture like humiliations and threats.

The most commonly witnessed method was electrical torture (19.2%), followed by beatings (12.6%) and positional torture (11.1%). Least witnessed is sexual torture (2%). A very low response rate for the last item is nonetheless expected. Sexual torture is usually denied by the perpetrator and his victim. This is no different in Libya. Several reports have indicated that rape and sexual torture was used as a systematic weapon of warfare and widespread during the revolution, by all sides of the conflict (16).

In the qualitative study several thuwwar described witnessing rape, and expressed a sense of powerlessness or helplessness at the frontlines, because it was witnessed from a distance or shown as videos on mobile (1). Male on male rape has historically been shrouded in secrecy due to the stigma men associate with being raped by other men. The rape of men by men has been documented as a weapon of terror in warfare (17,18). Sexual assault and

especially male on male rape is extremely taboo and saturated in stigma; it is hidden by the victims who are afraid and too ashamed to speak out and because of a society that is not prepared to listen and risk ostracism and exclusion. These mechanisms are emphasized and reinforced in a patriarchal and conservative society as the Libyan. However, it is well noticing that in all the cases of rape or sexual violence mentioned, it is more 'heard about', than experienced and witnessed.

Figure 4: Prevalence rates of exposure to torture methods during arrest and detention, distributed by modality of exposure



Demonstrations and public gatherings

The Libyan uprising began in Benghazi with a series of popular demonstrations against the Gaddafi regime which quickly developed into armed confrontation. During and after the armed revolt, demonstrations and mass gatherings were used by different groups to promote a variety of political agendas, mainly in the bigger cities. In the beginning, the demonstrations and public gatherings were aimed at influencing government (interim and elected) to initiate and change policies or actions. When the armed groups changed from security providers and enforcer of order, to destabilizing forces competing for power and territory and consequently undermining the authority of elected governments and city councils, people used demonstrations to protest the presence, influence and activities of the armed groups in their locality. At times these demonstrations and popular protests succeeded in pushing the armed groups out of certain areas or sites e.g. hospitals, check points, bases etc. and at other times the protests ended up in violence with injured and deaths.

15 November 2013, 50 people were killed and more than 500 injured in Tripoli when a Misrata based armed group, opened fire on a large demonstration against the presence of outside militias in the city. Though, this was the largest casualty at a single demonstration, people have hereafter not refrained from participating in public gatherings across the country. It has been the main way for ordinary people and populaces to voice concerns and promote or amend policies and agenda's. Demonstrations and public gatherings continue to be widespread. A total of 781 (29.3%) respondents reported being exposed to violence during demonstrations. The distribution of exposure according to age groups is shown in Table 5. The exposure to violence was evenly distributed according to age groups, with approximately one third of the respondents in each age group reporting violence exposure.

Table 5: Violence exposure during demonstration distributed by age groups

Age group	Exposed to violence during demonstrations (n (%))	Not exposed to violence during demonstrations (n(%))	Total
18-24	140 (29.2%)	340 (70.8%)	480
25-34	178 (29.0%)	435 (71.0%)	613
35-44	250 (33.1%)	506 (66.9%)	756
45-54	131 (27.4%)	347 (72.6%)	478
55-64	48 (26.5%)	133 (73.5%)	181
65-94	34 (21.8%)	122 (78.2%)	156
Total	**781 (29.3%)**	**1,883 (70.7%)**	**2,664**

Figure 5: Prevalence rates of violence exposures during demonstration distributed by modality of exposure

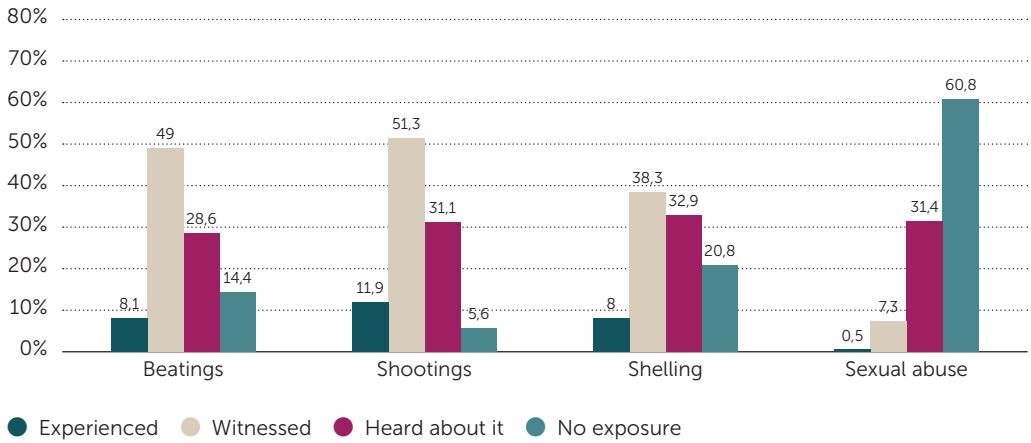


Figure 5 shows the distribution of exposure to violence during demonstrations, according to modality of exposure. The most commonly exposure experienced was shootings (11.9%) followed by beatings (8.1%) and shelling (8%). The figure shows that among half of respondents reported witnessing beatings (49%) and shootings (51.3%), followed by shelling (38.3%). Around on third of respondents reported hearing about the four different violence exposures. It is noticeable that sexual abuse is almost as high as the four more common violent exposures, even though very few respondents report to have experienced or witnessed the act first-hand. This attests to the substantial difficulties in assessing and investigating sexual violence.

Armed conflict

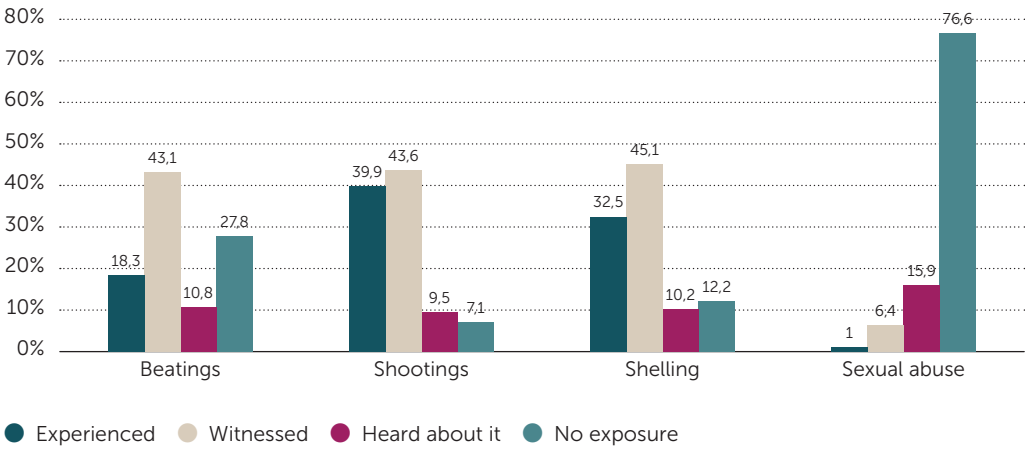
When the armed conflict against the Gaddafi regime began and took momentum, mobilization into the armed groups rapidly rose and the numbers of fighters and other forms of frontline assistance rapidly increased. A total of 296 individuals (11%) went to the frontlines, and as Table 6 illustrates the presence at the frontlines was spread over all age-groups, with the younger age groups reporting higher participation rates than the older ones. Of the 296 respondents reporting going to the front lines, 27 (9.1%) were women and 269 (90.9%) were men.

Table 6: Participation at the front lines distributed by age groups

Age group	Went to front lines (n (%))	Did not go to front lines (%))	Total
18-24	67 (13.8%)	417 (86.2%)	484
25-34	78 (12.6%)	539 (87.4%)	617
35-44	80 (10.5%)	684 (89.5%)	764
45-54	51 (10.5%)	434 (89.5%)	485
55-64	14 (7.6%)	171 (92.4%)	185
65-94	6 (3.8%)	151 (96.2%)	151
Total	**296 (11.0%)**	**2,396 (89.0%)**	**2,692**

There is almost equal distribution amongst the initial four age groups, though with a slight overrepresentation amongst the age group of 18-24. However, the mobilization of people did not end with the down fall of Gaddafi regime. On the contrary, the proliferation of regional and tribal affiliations and strife over power and territory has promulgated continued mobilization, primarily of younger men. The Warriors Affairs Commission registered 120.000 people as revolutionary fighters, eligible for state support. However, today the commission estimates there are 250.000 people mobilized into the armed groups, compared to the 50.000 people that are believed to actually have fought the war against the regime.

Figure 6: Prevalence rates of violence exposure at the front lines, distributed by modality of exposure



The insecure and unstable political situation in Libya does not give any indications of when and how, if any, demobilization is possible in the near future. The influence and position of the armed groups in society as well as their internal strife and divisive political agendas, determine the possibility of peace and stability in the country. With continued fighting and mobilization, more people are expected to be involved in armed combat and experienced violence exposure at the numerous frontlines, across the country. The most common exposure experienced was shootings (39.9%), followed by shelling (32.5%) and beatings (18.3%).The most commonly exposure witnessed was shelling (45.1%), closely followed by shootings (43.6%) and beating (43.1%). Very few (6.4%) witnessed sexual abuse and even fewer (1%) reported to have experienced it. As for hearing about it, it is noticeable that the most common exposure was reported hearing about sexual abuse (15.9%) at the front lines. More than beatings (10.8%), shelling (10.2%) and shootings (9.5%).

Again, sexual exposure appears to be a special form of violent exposure with few reported 'experienced' and 'witnessed' but proportionally very high numbers of 'heard about it'. Sexual abuse has been on the political agenda in Libya since the early days of the revolt. Claims of mass rape by the Gaddafi forces, especially in and around Misrata and Tawergha, and sexual torture in the detention centers have been reported, though not documented due to the sensitivity of the issue and social stigma of being victimized. Nonetheless, it appears to be a non-addressed and to a certain extent silenced problem in Libya today.

Displacement

A total of 17.7% of respondents reported displacement during and after the conflict of 17th of February 2011. Of those displaced a total of 89.9% reported still being displaced 3 years

after the conflict. It should be noted that the reason for displacement is not known. The proportion of displacement according to age groups was similar across all age groups (results not shown).

Table 7: Proportion of respondents experiencing displacement

Experienced displacement	Frequency	Percent	Percent of displaced (n=475)
Yes, and I still am	427	15.9	89.9
Yes, but not anymore	48	1.8	10.1
No	2,217	82.4	-

One of the most displaced communities in Libya are the Tawerghans. Tawerghans fled their hometown in August 2011 as armed fighters from the nearby city of Misrata approached. About 35,000 Tawerghans are displaced across the country and have been prevented from returning by armed groups from Misrata. The Misrata groups accuse Tawerghans of fighting with pro-Gaddafi forces during the 2011 conflict and committing war crimes in Misrata.

The late President Muammar Gaddafi's use of African mercenaries to quell the uprising against his autocratic regime revived a deep-rooted racism between Arabs and black Africans. Many Arabs felt Gaddafi abandoned them for black Africans ever since he became a "pan-Africanist" and sponsored development outside the borders instead of Libya. Gaddafi and his inner circle preferred black Africans and Libyans from the south over Libyans from the east (19, 20, 21). Discrimination is common not only against migrant Black Africans, but also against darker-skinned Libyans, especially from the south of the country (19). While the airing of Gaddafi's so called "black mercenaries" by Western media ignited the issue, a xenophobic attitude towards these refugees and labourers appears to have existed for years. The recurrent attacks could be racially motivated because some actual Libyan mercenaries and soldiers were freed under a tribal agreement. Many immigrants and refugees seeking the shores of Europe regularly fall victims of racism and violence. Furthermore, the uprising of armed groups with Salafist ideology has been long reported to harbor extremist ideologies and an intense ethnic racial hatred. With the increase of their numbers in the east of the country, the violence against minorities ethnic and religious could be expected to rise.

Figure 7: Prevalence rates of violence exposure during displacement, distributed by exposure modality

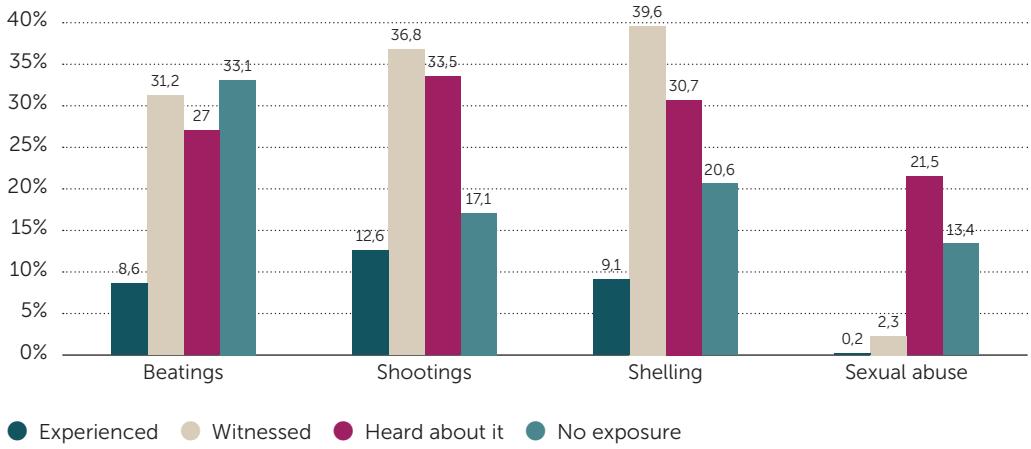


Figure 7 shows the prevalence rates of different violence exposures during displacement according to modality of exposure. The figure shows that most respondents were indirectly exposed through witnessing or hearing about violent acts when displaced. The most commonly exposure experienced was shootings (12%), shelling (9.1%) and beating (8.6%). Almost a fourth of displaced persons reported having heard about (21.5%) or witnessing sexual abuse (2.3%).

Household exposure

Table 8 shows the proportion of households reporting household members arrested (11.0%), disappeared (19.4%) and killed (5.1%). A total of 44 respondents reported all three events at the household level. It is noticeable that every 20 household reports to have a family member killed and that every 5 household have a family member disappeared. With 11% household reported arrests and 5.1% killed, it gives an indication of the oppressive methods utilized by the Gaddafi regime and how these methods of oppression embraced society to the household level. However, how the large numbers of disappearances and the consequences of the deaths affect the social at an individual, family and societal level are not known and would require more in-depth research, but have created a deep felt distrust within the Libyan society and disbelief in government institutions and authorities.

Table 8: Household members arrested, disappeared and killed

Arrested, disappeared and killed	Frequency	Percent
Households with members arrested		
Yes	296	11.0
No	2,396	89.0
Households with members disappeared		
Yes and still is	505	18.8
Yes, but home now	17	0.6
No	2,170	80.6
Households with member(s) from household killed		
Yes	138	5.1
No	2,554	94.9

42 years of sustained and brutal dictatorship have instituted hesitations of trust within the population, as a protective measure against regime agents and informers. The revolt and toppling of the regime did not eradicate the institutionalized distrust in society and give way to new forms of sociality and social interaction. The prolonged war and the political crisis can be seen as an outcome of the mistrust, across regional and tribal lines, which limit the options and possibilities to form a shared political vocabulary and build a functional state, based on democratic institutions and rule of law.

4.3 Consequences

Despite the high level of exposure most Libyans report that their health is good, while only 16.1 % of the respondents report to be in fair or poor health conditions.

Table 9: Prevalence of self-reported health

Health	Frequency	Percent
Excellent	822	30.5
Very good	699	26.0
Good	739	27.5
Fair	239	8.9
Poor	193	7.2
Total	**2,692**	**100.0**

The respondents' health status was furthermore assessed by employing the EuroQOL five dimensions questionnaire, a health related quality of life questionnaire (EQ-5D). The results are shown in Table 10, comparing the responses of males and females using chi^2-test. The table shows significant difference between males and females for all domains of the self-perceived health status scale. Significantly more females reported some problems with mobility, self-care, usual activities, pain or discomfort and depression or anxiety.

Table 10: Comparison of self-perceived health status between males and females

Self-perceived health status today

Characteristics	Males		Females		Total		X^2-value	P-value
	No.	%	No.	%	No.	%		
Mobility								
No problems	1,146	85.0	992	73.9	2,138	79.4		
Some problems	199	14.8	342	25.5	541	20.1	50.80	<0.001
Confined to bed	4	0.3	9	0.7	13	0.5		
Self-care								
No problems	1,268	94.0	1,216	90.5	2,484	92.3		
Some problems	72	5.3	112	8.3	184	6.8	11.27	<0.01
Incapable	9	0.7	15	1.1	24	0.9		
Usual activities								
No problems	1,223	90.7	1,083	80.6	2,306	85.7		
Some problems	100	7.4	222	16.5	322	12.0	56.96	<0.001
Unable	26	1.9	38	2.8	64	2.4		
Pain or discomfort								
None	903	66.9	675	50.3	1,578	58.6		
Some	354	26.2	567	42.2	921	34.2	82.61	<0.001
Extreme	92	6.8	101	7.5	193	7.2		
Anxiety or depression								
None	806	59.7	665	49.5	1,471	54.6		
Moderate	422	31.3	557	41.5	979	36.4	32.12	<0.001
Extreme	121	9.0	121	9.0	242	9.0		

Table 11 shows how much pain interfered with normal work during the last 4 weeks. The table shows that approximately 40% of respondents experienced pain interfering with work at some level

Table 11: Prevalence of pain during past 4 weeks

Pain interfering with normal work	Frequency	Percent
Not at all	1,588	59.0
A little bit	533	19.8
Moderately	267	9.9
Quite a bit	115	4.3
Extremely	189	7.0
Total	**2,692**	**100.0**

Table 12 shows the prevalence of different chronic diseases.

Table 12: Proportion of chronic disease

	Frequency	Percent	Total	Missing
Mental disease	16	0.7	2,690	2
Cancer	17	0.7	2,688	4
Heart disease	98	3.7	2,687	5
Asthma and bronchitis	248	9.3	2,690	2
Diabetes	304	11.3	2,689	3
Ulcer or disease in stomach	332	12.4	2,687	5
High blood pressure	347	12.9	2,687	5
Allergy	405	15.1	2,688	4
Arthritis	474	17.7	2,688	4

The prevalence is based on respondents reporting being told by their doctor that they suffer from the disease.

Table 13 shows self-reported causes of stress. The most commonly reported cause of stress was political instability (63.6%) followed by the collapse of the country (61.2%), insecurity about life right now (56.6%) and insecurity about the future (46.4%).

Table 13: Self-reported causes of life stress

Causes of stress	Yes	No	Refused
The destruction of my home	321 (11.9)	2,349 (87.3)	22 (0.8)
The collapse of the country	1,647 (61.2)	1,016 (37.7)	29 (1.1)
Displacement from my home	468 (17.4)	2,202 (81.8)	22 (0.8)
Inability to find work	529 (19.7)	2,140 (79.5)	23 (0.9)
Lack of financial means of survival	868 (32.2)	1,790 (66.5)	34 (1.3)
Insecurity about life right now	1,525 (56.6)	1,135 (42.2)	32 (1.2)
Insecurity about the future	1,248 (46.4)	1,383 (51.4)	61 (2.3)
Political instability	1,711 (63.6)	927 (34.4)	54 (2.0)
My health condition	784 (29.1)	1,879 (69.8)	29 (1.1)
The safety of my family	1,111 (41.3)	1,556 (57.8)	25 (0.9)
The violence I experienced	701 (26,0)	1,967 (73.1)	24 (0.9)

Table 14 shows the prevalence of different symptoms representing post-trauma stress disorder (PTSD), depression and anxiety respectively. The symptoms of PTSD comes from the Harvard Trauma Questionnaire, for which a cut-off of >=2.5 has been shown to indicate a symptom load corresponding with a diagnosis of PTSD. In this study the prevalence of PTSD, thus was 6.1%.

The symptoms of depression and anxiety are based on the Hopkins Symptom Checklist-25 and a cut-off of >1.75 has been shown to indicate depression and anxiety respectively. The study showed that 28.9% had a symptom load corresponding to anxiety and 30.3% had a symptom load corresponding to depression.

Table 14: Prevalence of psychological symptoms according to severity

PTSD symptoms	Extremely N (%)	Quite a bit N (%)	A little N (%)	Not at all N (%)	Mean score	% with high symptom load
Recurrent nightmares	73 (2.7)	139 (5.2)	438 (16.3)	2017 (74.9)	1.4	6.1
Feeling jumpy. easily startled	102 (3.8)	177 (6.6)	546 (20.3)	1837 (68.2)		
Feeling as if you don't have a future	132 (4.9)	193 (7.2)	476 (17.7)	1851 (68.8)		
Anxiety symptoms	**Extremely N (%)**	**Quite a bit N (%)**	**A little N (%)**	**Not at all N (%)**	**Mean score**	**% with high symptom load**
Suddenly scared for no reason	63 (2.3)	128 (4.8)	440 (16.3)	2,030 (75.4)	1.5	28.9
Feeling fearful	131 (4.9)	227 (8.4)	728 (27.0)	1,584 (58.8)		
Faintness. dizziness or weakness	41 (1.5)	104 (3.9)	390 (14.5)	2,133 (79.2)		
Feeling tense or keyed up	110 (4.1)	273 (10.1)	992 (36.8)	1,293 (48)		
Depression symptoms	**Extremely N (%)**	**Quite a bit N (%)**	**A little N (%)**	**Not at all N (%)**	**Mean score**	**% with high symptom load**
Blaming yourself for things	124 (4.6)	243 (9.0)	684 (25.4)	1,610 (59.8)	1.6	30.3
Difficulty in falling asleep or staying asleep	152 (5.6)	223 (8.3)	579 (21.5)	1,716 (63.7)		
Feeling sad	198 (7.4)	254 (9.4)	729 (27.1)	1,490 (55.3)		
Feeling of worthlessness	154 (5.7)	199 (7.4)	408 (15.2)	1,981 (70.2)		
Feeling everything is an effort	188 (7.0)	297 (11.0)	576 (21.4)	1,603 (59.5)		
Feeling hopeless about the future	151 (5.6)	186 (6.9)	482 (17.9)	1,839 (68.3)		

4.5 Coping

The study assessed coping and indicated need for assistance. Approximately 40% of respondent indicated that they saw themselves becoming free of life stress with some help.

Table 15 shows from which sources the respondents indicated to have received effective help to deal with life stress. The most commonly reported source of support was family (68.1%), followed by friends and neighbors (44.2%). Only 2.2% indicated receiving effective help from NGO.

Table 15: Distribution of respondents receiving effective help to deal with life stress

Have you received effective help or support to deal with life stress from any of the following?	Yes	No	Refused
Family	1,833 (68.1)	831 (30.9)	28 (1.0)
Friends and neighbors	1,190 (44.2)	1,470 (54.6)	32 (1.2)
Religious leader e.g. Sheik	449 (16.7)	2,202 (81.8)	41 (1.5)
Traditional healer e.g. Al-Hijama	349 (13.0)	2,309 (85.8)	34 (1.3)
Medical doctor in community	170 (6.3)	2,494 (92.6)	28 (1.0)
Medical doctor in hospital	539 (20.0)	2,123 (78.9)	30 (1.1)
NGO	60 (2.2)	2,600 (2692)	32 (1.2)

Respondents were also asked to indicate from which sources they needed support. The predominant sources indicated were family (72.1%), followed by friends and neighbors (48.0%) and medical doctors in hospital (28.5%).

Table 16: Indicated needs of support for dealing with life stress

Do you need support for dealing with life stress from any of the following?	Yes	No	Refused
Family	1,940 (72.1)	723 (26.9)	29 (1.1)
Friends and neighbors	1,292 (48.0)	1,369 (50.9)	31 (1.2)
Religious leader e.g. Sheik	647 (24.0)	2,010 (74.7)	35 (1.3)
Traditional healer e.g. Al-Hijama	488 (18.1)	2,169 (80.6)	35 (1.3)
Medical doctor in community	422 (15.7)	2,240 (83.2)	30 (1.1)
Medical doctor in hospital	767 (28.5)	1,891 (70.2)	34 (1.3)
NGO	299 (11.1)	2,352 (87.4)	41 (1.5)

Libya has a practice of not seeking support for psychological problems, and the few trained psychologists and psychiatrists have very limited experience of treating trauma and consequences of torture and war (22). In addition and as a consequence of the lack of priority from the state, severe social stigma exists regarding those affected by mental illness (23). Mental illness is by many considered a demonic possession and psychiatric symptoms are attributed to the act of pagan symbols like the evil eye, magic or sorcery (24). A common form of help seeking behaviour is traditional healers or 'Sheikhs' who communicate with evil spirits 'Jinns'. Going to 'Al-Hijama' is also preferred by many Libyans. Hijama in Arabic is derived from 'hajm' which means 'sucking'. Blood Cupping (hijama) is the process of applying cups to various points on the body by removing the air inside the cups to form a vacuum, in order to suck 'bad' blood out. It is viewed by some practitioners as a cure that can cure all diseases and alleviate black magic and possession (25). Almost a fourth of the respondents (24%) indicate they need support from religious leaders to cope with life stress and 18.1% indicate traditional healers for support. This finding was also consistent with the qualitative pre-study (1).

Nonetheless, the importance of religious leaders and traditional healers in society, medical doctors also play a vital role in health seeking behavior. Looking at medical doctors in general and the official health institutions, both at hospital and in community, 44.2% of the respondents seek their assistance for life stress.

Table 17 shows which kind of help respondents would like. The most commonly indicated help wanted was justice, legal remedy and compensation (59.3%), followed by financial and livelihood assistance (52.2%) and some to talk with and get advice from (52%). It is interesting to note that even 40% of the respondents have some form of pain in their daily work, more than 60% feel stress because of the political situation, 6% with PTSD symptoms, and approximately 30% for anxiety and depression, respectively, the respondents mainly wants legal remedy and compensation for their injuries, before practical or medical assistance.

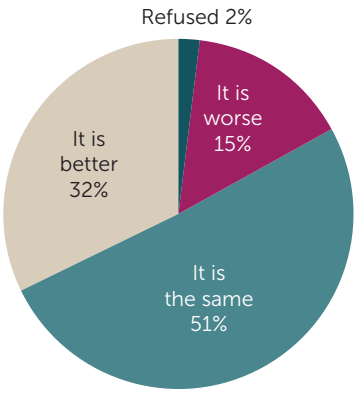
Table 17: Prevalence of wanted help

What kind of help would you like to receive?	Yes	No	Refused
Family	1,010 (37.5)	1,645 (61.1)	37 (1.4)
Friends and neighbors	1,405 (52.2)	1,262 (46.9)	25 (0.9)
Religious leader e.g. Sheik	749 (27.8)	1,921 (71.4)	22 (0.8)
Traditional healer e.g. Al-Hijama	1,129 (41.6)	1,550 (57.6)	22 (0.8)
Medical doctor in community	1,596 (59.3)	1,057 (39.3)	39 (1.4)
Medical doctor in hospital	1,399 (52.0)	1,271 (47.2)	22 (0.8)
NGO	1,178 (43.8)	1,494 (55.5)	20 (0.7)

4.6 Perceptions of the future

Respondents were asked to indicate how their life situation had evolved since the armed revolt against the Gaddafi regime. Figure 8 show that approximately half of respondents felt their situation was the same. 32.0% indicated that their situation was better; however for 15.4% their situation was worse.

Figure 8: Evolvement of life situation from conflict until today



Remembering the survey was conducted in a period of relatively peace, the situation for the population where the recent fighting and violence takes place can be expected to be worsened and the outlook less optimistic. Disregarding later conflict developments in the country, it is noticeable that almost one third of the respondents experienced an improvement in their life situation after the fall of Gaddafi. This despite the political situation was unstable and the parliament was struggling to agree on leadership and legal foundations for the nation including the constitution.

Figure 9 shows the distribution of perceptions of the future. Approximately half of respondents perceived that the situation would be the same; approximately 1/3 thought it will be better and 15% thought their situation would evolve to be worse.

Figure 9: Perceptions of the future

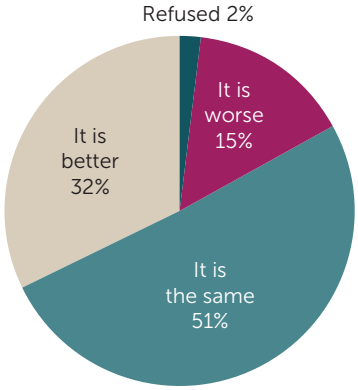


Figure 9, draws a positive and optimistic outlook of the respondents, again despite the lack of political developments and growing instability. At the time, it showed a belief in the future and a conviction that the situation will improve or at least not degrade further over time. The growing instability and spread of violent conflict across the nation and within the major cities, challenges the results but they nonetheless show that a large proportion of the population, at the time, had a hope of betterment and improvement of their lives. In the wake of the recent political configurations and conflict along both religious; jihadist salafist/non-jihadist salafist, regional and tribal divisions, the outlook could have changed to the worse. The extensive migration out of the country, testifies to a radically changed outlook and perception of the immediate future.

Conclusion

This study was completed in late 2013. Since then, the country has experienced increasing violent conflict in the east, west and south. Armed groups have gained ground and claimed superiority of the parliamentarian political system. Fighting and violence dominates society continuously fortifying political positions and antagonisms along tribal lines and regional divisions. Peace, state formation and rule of law appears to be a distant image which fades everyday as fighting intensifies and escalates, and divisions grow deeper, undermining political solutions. The dream of a united peaceful and democratic Libya, which dominated peoples hopes and political discourses in the wake of the downfall of Gaddafi's regime have given way to a vocabulary and practice of violence, fragmentation, fear and hostility. The future of Libya is uncertain but as the results of the study show the effects and consequences of violent conflict is deep and will influence Libyan society in the years to come, regardless of political system and rule.

It is noticeable that every fifth household in the survey responds to have a family member disappeared, 11% arrested and 5.1% killed. Regardless, if the three categories are about same or different events, the loss of family members and especially the disappearance of family members and the insecurity concerning the whereabouts of their bodies, create prolonged sufferings within the families of the deceased. The sheer numbers of the disappearances will greatly affect the entire society for years to come, individually, family wise and societal.

Some issues are even clouded by a powerful social stigma and secreted by perpetrators and victims, to an extent that it is almost impossible to investigate and therefore to assess. Sexual violence and abuse based on 'the heard of' responses appears to be widespread and a regular feature at all sites of conflict. 21.5% have heard about it when displaced, 15.9% at the frontlines, 31.4% at demonstrations and 5.2% at arrests and detention. This despite the highest response of sexual abuse exposure was 4.6% during arrest and detention and 7.3% witnessed at demonstrations. This can be a combination of two things which regardless of its composition and relation requires further research. The discrepancy between heard about, and experienced and witnessed, can be caused by the fact that

very few cases actually exist or have occurred and that it is based on rumors and fearful imaginations of the dangerous other and the unknown. The discrepancy can also be caused by the fact that people do not dare or want to come forward due to presence of powerful social stigma and taboo, surrounding both male and female sexual abuse and violence.

The survey was conducted in a period of relatively peace in the country and some of the results might not reflect the situation today. With the increase and spread of violent conflict to the major cities, the experience and effect of violence can be foreseen to be much higher and deeper. This does not just call for more assistance to handle the socio-economic, health and mental health affects but also calls for more targeted research to be able to deliver adequate and relevant assistance, when this is possible. For instance the study shows that the majority of respondents use family networks (72.1%) and friends (48%) in time of distress and crisis, and that religious leaders (24%) and traditional healers (18.1%) play an important role after the medical doctor (43.2%). Furthermore, when asked about assistance needed, the majority of the respondents emphasize justice, legal remedy and compensation (59.3%) before health and medical assistance (43.8%). This indicates that the oppression of the Gaddafi regime and the consequences for the population is still unaddressed and lie in wait for political solutions and national resolution. The current violent conflict and political struggles do not obliterate 42 years of dictatorship and annihilate social suffering and the victims' demands for recognition and reparation. It adds layers of insecurities'; anxiety and depression, as well as somatic pain for the physically wounded and tortured, to an already injured population.

The mental health results indicate that prevalence of anxiety and depression is much higher than PTSD, respectively 29% anxiety, 30% depression versus 6% PTSD. This could point toward that the respondents at the time of interview may still have been in the acute or post-acute stage and have yet reach the post-trauma stage. Consequently, the numbers could potentially increase over time, if/when the conflict subsides, and people move out of the conflict mode into the post traumatic stage of suffering.

With the upheaval of violence and disorder mainly in the cities, growing numbers of people can be expected to be subjected to distressing experiences and events that can cause an increase in the prevalence of anxiety, depression and PTSD in the population, alongside physical injuries and somatic pain. With the spread of the conflict, increasing numbers of people can be expected to develop health and mental health problems and in need of some form of assistance, from counselling, traditional and religious healing to psychiatric treatment, to alleviate their problems and pains.

This report illustrates the consequences of armed conflict in Libya and points to the massive challenge of alleviating suffering, any future government or rule will have to address. The need for assistance increases as the conflict affects more and more people

and the health system is increasingly strained, overwhelmed with patients and overworked staffs, deficient of the expertise to diagnose and treat mental health problems. The identified problems and needs within the population will not disappear, whether ignored or because of ignorance. It will affect the future of Libya and the attempts to build lasting peace, stability and rule of law, regardless of the shape and form it might take.

References

1. Chemlali, A. (2013). Victims of torture and related violence in Libya : a qualitative assessment with a view to enhance a quantitative needs assessment in a post-conflict context. University of Copenhagen, Copenhagen. Retrieved from http://doc.rct.dk/doc/mon2013.046.pdf

2. Amnesty International. (2014). *Torture in 2014: 30 years of broken promises*. Amnesty International. Retrieved from http://www.amnestyusa.org/sites/default/files/act400042014en.pdf

3. Jong, J. T. V. M. de, & Ommeren, M. van. (2002). Toward a Culture-Informed Epidemiology: Combining Qualitative and Quantitative Research in Transcultural Contexts. *Transcultural Psychiatry*, *39*(4), 422–433. doi:10.1177/136346150203900402

4. UNFPA, Benghazi Medical Center, & League of Arab States. (2012). *Libyan Health and Humanitarian Needs assessment Survey*. Benghazi. Retrieved from http://www.libyanhealthservices.com/uploads/1/0/3/7/10376524/libyan_health_and_humanitarian_needs_assessment_survey_-_final_report_march_2012.pdf

5. Mollica, R., McDonald, L., Massagli, M., & Siolove, D. (2004). Measuring Trauma, Measuring Torture: Instructions and Guidance on the Utilization of the Harvard Program in Refugee Trauma's Versions of The Hopkins Symptom Checklist-25 (HSCL-25) & the Harvard Trauma Questionnaire (HTQ). Cambridge: Harvard Program in Refugee Trauma.

6. Zwi, A., Garfield, R., & Loretti, A. (2002). Collective Violence. In E. G. Krug, L. Dahlberg, J. Mercey, A. Zwi, & R. Lozano (Eds.), *World report on violence and health*. Geneva: World Health Organisation.

7. BBC. (2014). Libya rape victims to be compensated. Retrieved April 14, 2014, from http://www.bbc.com/news/world-africa-26270890

8. UN News. (2011, June 8). Evidence emerging of use of rape as tool of war in Libya – ICC prosecutor. Retrieved April 14, 2014, from http://www.un.org/apps/news/story.asp/story.asp?NewsID=38664&Cr=libya&Cr1=#.U0uw7leLWjY

9. Salam, A. ., Alshekteria, A. ., Mohammed, H. A. ., Al Abar, N. ., Al Jhany, M. ., & Al Flah, M. . (2012). Physical, mental, emotional and social health status of adolescents and youths in Benghazi, Libya. *Eastern Mediterranean Health Journal*, *18*(6), 586–597.

10. Creswell and Zhang (2009). *The Application of Mixed Methods Designs to Trauma Research.* Journal of Traumatic Stress, Vol. 22, No. 6, December 2009, pp. 612–621.

11. Wright J, Williams R, Wilkinson J R (1998). Development and importance of health needs assessment BMJ 316.

12. Marshall T, Simpson S, Stevens A, (2001). *Health care needs assessment in prisons: a toolkit* Journal of Public Health Medicine vol. 23 no. 3: 198-204

13. Elsass P, Carlsson J, Jespersen K, Phuntsok K, (2009). *Questioning western assessment of trauma among Tibetan torture survivors* Torture vol. 19 no. 3: 194-202

14. Shoeb et al. (2007). The Harvard Trauma Questionnaire: Adapting a Cross-Cultural Instrument for Measuring Torture, Trauma and Posttraumatic Stress Disorder in Iraqi Refugees. Int J Soc Psychiatry 2007 53: 447.

15. Jayawickreme N, Jayawickreme E, Goonasekera MA & Foa EB. (2009). *Distress, wellbeing and war: qualitative analyses of civilian interviews from north eastern Sri Lanka.* Intervention 2009, Volume 7, Number 3, Page 204 – 222.

16. UK Reuters, (2011). *Rape used as weapon of war in Libya and elsewhere - U.N.* June 10, 2011. Available: http://uk.reuters.com/article/2011/06/10/uk-un-rape-idUKTRE75947120110610

17. The Guardian, The Observer (2011). *The Rape of Men.* 17 July 2011. Available: http://www.guardian.co.uk/society/2011/jul/17/the-rape-of-men

18. Groth, A. Nicholas, and Ann W. Burgess. (1980). *Male Rape: Offenders and Victims.* American Journal of Psychiatry 137.7 (1980): 806-810.

19. All Africa (2011). *Libya: Uprising Revives Entrenched Racism Towards Black Africans.* 21 March, 2011. Available: http://allafrica.com/stories/201103211518.html

20. Somalilandpress (2011) *Libya: Rebels execute black immigrants while forces kidnap others*. 4 March, 2011. Available: http://somalilandpress.com/libya-rebels-execute-black-immigrants-while-forces-kidnap-others-20586

21. Glen Ford, (2011). Race and Arab Nationalism in Libya. 09 March 2011

22. Sophie Arie (2011). Agencies prepare to deal with mental health problems in Libya after 42 years of repression. BMJ 2011;343:d5653 doi: 10.1136/bmj.d5653.

23. IMC (2011). Libya Mental Health and Psychosocial Support Assessment Report. November 2011

24. Omar Reda (2012). *A Letter from Libya: An Urgent Need for Trauma-informed System of Care.* Department of Psychiatry, OHSU, Portland, Oregon, USA. Ibnosina Journal of Medicine and Biomedical Sciences (2012).

25. Ahmed El-Wakil (2011). Observations of the popularity and religious significance of blood-cupping (al-hijama) as an Islamic medicine. Contemporary Islamic Studies, Vol. 2011, 2.

26. Kish, Leslie. (1949). *A Procedure for Objective Respondent Selection within the Household*. Journal of the American Statistical Association 44 (247): 380–87.

Consequences of Torture and Organized Violence: Libya Needs Assessment Survey

DIGNITY International Publication Series no. 8

www.dignityinstitute.org

Layout: Eckardt ApS
Printed in Denmark 2015 by Lasertryk

ISBN 978-87-9087-870-2 (print)
ISBN 978-87-9087-869-6 (online)