

VOICES UNHEARD

LIVED EXPERIENCES AND SYSTEMIC BARRIERS

TO SRH AND GBV SERVICES IN LIBYA

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PREFACE

This report was prepared with the aim of providing evidence that reflects the lived realities of women in Libya and the perspectives of service providers and policymakers who work daily in challenging circumstances. It is not intended as a critique of individual efforts or institutions, but rather as a resource to highlight barriers that women face and to identify opportunities for improvement.

The report uses terms such as SRH and GBV as defined by internationally recognized frameworks. We recognize that some of this terminology may not fully reflect local expressions or may feel restrictive. However, using these definitions allows the report to align with global policy and research standards while ensuring that Libyan women's experiences are connected to broader international discussions. Throughout the report, women's own words and perspectives are centered to ensure that their realities remain the foundation of the analysis.

The findings highlight both significant challenges in accessing SRH and GBV services and the resilience and resourcefulness women demonstrate in navigating them. Many healthcare providers and community actors continue to work with dedication despite limited resources, and their efforts represent important foundations for future progress.

The recommendations presented here begin with smaller, incremental steps that reflect women's own priorities and can serve as entry points for longer-term reforms. Our hope is that this report will act as a constructive tool for dialogue and collaboration, supporting efforts to build a stronger, more inclusive system of care and protection for women, families, and communities across Libya.

LIST OF ABBREVIATIONS AND ACRONYMS

CEDAW – Convention on the Elimination of All Forms of Discrimination Against Women

FGD – Focus Group Discussion

GBV – Gender-Based Violence

IASC – Inter-Agency Standing Committee

KI – Key Informant

MISP – Minimum Initial Service Package

NGO – Non-Governmental Organization

RMNCAH – Reproductive, Maternal, Newborn, Child, and Adolescent Health

SRH – Sexual and Reproductive Health

UN – United Nations

WHO – World Health Organization

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EXECUTIVE SUMMARY

This report presents findings from a multi-method qualitative study on sexual and reproductive health (SRH) and gender-based violence (GBV) services in Libya. Conducted between 2023 and 2025 in Tripoli, Benghazi, and Sabha, the research combined a desk review, in-depth interviews with women, focus group discussions, key informant interviews with providers and policymakers, and service mapping. It provides the first comprehensive qualitative assessments of women's health and protection in Libya to date.

The study shows that women's access to SRH services is shaped by both systemic challenges and social expectations. Care is concentrated in a small number of overstretched hospitals, requiring women to travel long distances under difficult conditions. Public facilities are often perceived as poor in quality, which leads many women to turn to private clinics despite high costs. Family planning services were described as limited or inconsistently available, and sometimes treated with suspicion. At the same time, women emphasized that access to contraception and counseling is essential for health, wellbeing, and family survival. Strong social expectations for repeated pregnancies, particularly the preference for sons, further influenced women's reproductive choices and carried significant health and social consequences.

Challenges are even greater in relation to GBV. Comprehensive services, shelters, and survivor-centered care were described as largely absent. Women explained that disclosing violence is dangerous and shameful, and that existing legal procedures often expose them to retaliation or police involvement rather than protection. For many, remaining quiet was seen as the safest way to cope.

Guardianship structures were often described as both protective and restrictive. While many families saw them as a way to safeguard women, in practice they sometimes limited women's ability to access healthcare and protection independently. This was particularly challenging for widows and divorced women, who faced heightened risks and stigma.

Despite these constraints, women demonstrated resilience and voiced clear demands for change. They resisted harassment, limited pregnancies, pursued education and work, and used digital platforms to share awareness. At the same time, they called for stronger laws, more confidential and accessible services, safe spaces, and opportunities for economic independence.

Grounded in these lived experiences, the study identifies five priority areas for reform: breaking the silence and reducing stigma, supporting women's access to health and protection, addressing the health consequences of strong expectations around childbearing, strengthening access to essential SRH and GBV services, and investing in resilience and pathways to reform. Together, these recommendations provide a roadmap for building more accessible, responsive, and survivor-centered systems in Libya.

BACKGROUND AND CONTEXT

Libya exemplifies a context where sexual and reproductive health (SRH) and gender-based violence (GBV) remain both underprioritized and undertheorized within global policy and scholarly discourse(1,2). Where Libya does appear, analyses often default to culturalist framings that reduce violence and restricted access to questions of “tradition” or “patriarchy.” Such accounts obscure the structural and institutional forces that shape service delivery, while also erasing the diversity of women’s lived realities and everyday forms of resistance(3).

For clarity, this report draws on internationally recognized definitions. According to the World Health Organization, sexual and reproductive health means “a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease or infirmity” (4,5). It implies that people are able to have safe, satisfying sexual lives and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Similarly, the Inter-Agency Standing Committee defines gender-based violence as “an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed differences between females and males” (6). GBV includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty.

Since the fall of Muammar Gaddafi in 2011, Libya has experienced a prolonged period of political instability, armed conflict, and fragmented governance(1,7). The erosion of the rule of law, proliferation of armed groups, and weakening of state institutions have contributed to a worsening humanitarian situation(8,9). These con-

ditions have had a disproportionate impact on women and girls, limiting their access to safety, health services, and justice(10). Despite repeated calls by international agencies to strengthen SRH and GBV systems, investment has been limited and national strategies have not been fully implemented(9,11).

Sexual and Reproductive Health in Libya

SRH provision in Libya has been shaped by decades of political instability, underinvestment, and policy fragmentation(7,12). Like many conflict-affected settings, Libya has experienced severe disruptions in service delivery, and access to essential care remains uneven. International frameworks such as the Minimum Initial Service Package (MISP) emphasize the prioritization of SRH in emergencies(13), yet its implementation in Libya has been weak and inconsistent.

Historically, Libya’s health indicators compared favorably with regional peers, with near-universal antenatal coverage and high rates of skilled birth attendance(12,14). However, the collapse of governance structures and deterioration of health institutions have led to fragmented service provision and widening inequities in access to care(9). The Ministry of Health regulates a mix of public facilities and a growing but still limited private sector, while municipal health offices are responsible for service delivery across more than 100 municipalities. Despite a relatively high number of healthcare workers nationally, human resources are poorly distributed, with acute shortages of specialists in rural and southern regions(7,15). Facilities are often under-equipped, and staff lack updated training in counseling, adolescent health, and rights-based approaches(9,11,16).

BACKGROUND AND CONTEXT

Maternal health outcomes have worsened over the past decade. The maternal mortality ratio rose from 52 per 100,000 live births in 2015 to 72 in 2017, with evidence suggesting continued increases linked to declining emergency obstetric care and reduced availability of skilled birth attendants in conflict-affected areas(16). Contraceptive access and family planning services remain underdeveloped. Libya has one of the lowest contraceptive prevalence rates in North Africa, with high unmet need for family planning (17,18). Services are concentrated in a small number of facilities, often plagued by stockouts, limited method choice, and lack of trained staff(11,16). Most provision occurs through pharmacies rather than integrated health facilities, underscoring systemic neglect of family planning in public policy(15).

While the Libyan government has made commitments to strengthen reproductive, maternal, newborn, child, and adolescent health through strategies such as the 2019 five-year RMNCAH plan, implementation has been limited and has not translated into improved coverage or quality of care(11,19).

Gender-Based Violence in Libya

GBV in Libya is widespread, exacerbated by conflict, institutional collapse, and persistent gender inequality(1,2). Although Libya is party to key international human rights treaties, including CEDAW and the UN Declaration on the Elimination of Violence Against Women, compliance has been largely symbolic(20). The state has not enacted comprehensive domestic legislation on GBV(21).

The existing legal and policy environment offers minimal protection. There are no standalone laws criminalizing domestic violence, sexual harassment, or marital rape(21). Some Penal Code provisions could theoretic-

-ally apply to sexual violence, but they are rarely enforced, and other provisions actively disadvantage women, such as clauses that allow perpetrators of rape to avoid punishment by marrying their victims(22,23). A Draft Law on Protecting Women from Violence, finalized in 2023, would criminalize a range of abuses including domestic violence and marital rape. However, its adoption and implementation remain uncertain(24,25), reflecting the broader challenges of advancing women's rights protections in Libya.

Humanitarian assessments indicate that many women in Libya are at heightened risk of GBV, yet most cases remain unreported due to stigma, fear of prosecution, and the lack of institutional support(10,26). The criminalization of extramarital sex further deters survivors from seeking help, as women may face prosecution themselves if pregnancy results from assault(26,27). Service delivery is fragmented and under-resourced: Libya lacks a coordinated national policy framework on GBV, and while the Inter-Agency Minimum Standards for GBV in Emergencies recommend a multi-sectoral approach, implementation has been limited(11,28).

The broader sociopolitical environment continues to constrain women's safety. Formal courts, tribal justice mechanisms, and customary law often exclude women's rights considerations and prioritize reconciliation over justice(29). Women who engage in public life or activism frequently face harassment, intimidation, and violence, with reports of threats against women's rights activists and systematic suppression of women's public expression(10,30). NGOs and international agencies have attempted to fill service gaps, but their efforts are restricted by insecurity, resource shortages, and the absence of reliable data(29).

THE NEED FOR CONTEXTUALLY

GROUNDING EVIDENCE

Despite multiple assessments by humanitarian actors, Libya lacks systematic data on SRH and GBV service provision(11,16). National monitoring frameworks are underdeveloped, and less than one-fifth of indicators needed to track gender-related Sustainable Development Goals are available(31). The absence of reliable data does not indicate a lack of need, but rather reflects a context shaped by political silencing, social stigma, and institutional collapse(1,32).

This report responds to these gaps. Drawing on a desk review, interviews, focus group discussions, key informant consultations, and service mapping across three cities, it documents women's lived experiences and provider and policymaker perspectives. The findings identify systemic barriers that undermine access to care and highlight women's own strategies of navigation and calls for reform. By centering women's voices while situating them within Libya's legal, institutional, and political context, the report contributes evidence that can inform more effective, inclusive, and rights-based responses to SRH and GBV in fragile settings.

STUDY AIMS AND METHODS

The aim of this study was to assess the accessibility, availability, and quality of SRH and GBV services in Libya, and to explore how women experience these services within broader legal, institutional, and social systems. The research also sought to identify gaps in service provision and to propose actionable recommendations for policy and programmatic reform.

A multi-method qualitative design was adopted. The study began with a desk review of available documents related to SRH and GBV in Libya, including published literature, institutional and humanitarian reports, available unpublished documents, and relevant laws, policies, and national strategies issued or available since 2011. This review helped situate the study within Libya’s legal, institutional, and service context and informed the development of the data collection tools. As summarized in Table 1 and shown in Figure 1, primary data collection included in-depth interviews with women, focus group discussions, and key informant interviews with service providers, policymakers, and civil society representatives. These were complemented by service mapping in Tripoli, Benghazi, and Sabha, which provided information on the availability of SRH and GBV services, referral systems, and facility-level capacity. The desk review and service mapping are integrated into the analysis of health system gaps, legal and policy context, and regional inequities rather than presented as stand-alone chapters.



FIGURE 1: STUDY SITES MAP: TRIPOLI, BENGHAZI, AND SABHA

Ethical approval for the study was obtained from relevant institutional review boards, and participants were recruited with careful attention to confidentiality and informed consent. Illustrative verbatim extracts from interviews and FGDs are included with anonymization to reflect participant voice while maintaining confidentiality. The study prioritized women’s lived experiences while also incorporating provider and policy perspectives to capture a comprehensive view of the SRH and GBV landscape.

STUDY DESIGN AND DATA COLLECTION SUMMARY

Data Collection Method	Number	Details
Desk review	2011 to 2026	Contextual documents on SRH and GBV
In-depth Interviews with Women	17	lasted 60-70 Minutes
Focus Group Discussions	9 groups (60 women)	Groups stratified by marital status
Key Informant Interviews (KIs)	11	Service providers, policymakers, and civil society representatives
Service mapping	3 cities	SRH and GBV services, referral systems, and facility capacity

MAIN FINDINGS

Conditional and Unequal Access to SRH Services

Our research revealed that across Libya, access to SRH and GBV services is highly fragmented, conditional, and deeply unequal. Women and key informants repeatedly emphasized that while some care exists, it is unreliable, selective, and shaped by systemic weaknesses and social expectations.

Overcrowded Hospitals and an Expensive Alternative

Some SRH services are provided free of charge in the public sector, particularly antenatal and postnatal care. However, the quality of care varied significantly, leaving women vulnerable at critical moments in their reproductive lives. Delivery care was heavily concentrated in a few major hospitals, often forcing women to travel long distances under precarious conditions. One key informant explained:

“We consider our hospital—Benghazi Medical Center—the only center that provides specialist services for reproductive health in this region. We also receive patients from the entire eastern region. Kl. Benghazi

This concentration placed immense strain on resources and staff. As another provider described,

“They have to admit them, which causes a backlog at the hospital. Sometimes a woman might be in a critical situation, needing surgery right away, but the hospital is at capacity and cannot accommodate more. Kl. Sabha

Women bore the consequences of these systemic constraints. Fatma from Benghazi shared the story of her neighbor

“She lives very far she went into labor at night, and after several checkpoints she gave birth in the car.

Even when services were accessible, women frequently reported poor treatment in public hospitals. Sahar, from Sabha, reflected:

“The services are weak, low quality, even though some doctors are good, but those are usually busy and hard to get an appointment with. In the public hospital, you suffer. There are not even chairs to sit on, no beds, and you would be treated badly.

As a result, many women turned to private clinics for delivery and reproductive care. Fatma from Benghazi explained:

“Because of the issues within the public hospital, I have my child births in private clinics... The hospital is seriously overwhelmed, they don't provide good care, this forces you to go to the private hospitals. I would never give birth in a public hospital after what I have seen.

While private care was often seen as safer and more respectful, it was also prohibitively expensive. As one key informant in Tripoli emphasized,

“You have to be very specific on the place you go for delivery. It's very expensive in the private sector.

Family Planning as a Matter of Health and Survival

Family planning services were described as largely absent from Libya's health system. Zomorod, from Sabha, stated simply:

“I haven't heard of any [family planning] services.

Salha, from Benghazi, echoed this, saying:

“We don't have the concept of family planning.

In some settings, family planning was not only absent but also treated with suspicion. Within this context, contraception was socially discouraged, politicized, and morally scrutinized. One FGD participant captured this stigma :

“Contraceptives are like committing a crime.

1

MAIN FINDINGS

Conditional and Unequal Access to SRH Services

A key informant from Tripoli noted that discussions of contraception were often misinterpreted:

“Family planning might get misunderstood that we want people to stop having children. Because we want to reduce the population

Some participants and key informants noted that contraceptive services were sometimes perceived as linked to foreign agendas or as a threat to national identity. These perceptions filtered into everyday care, shaping how providers responded to women's requests. Salma, 20, from Benghazi, recounted how her relative was denied contraceptives outright:

“My relative was denied contraceptives by a doctor who doesn't support family planning.

Yet women themselves consistently framed family planning in very different terms, describing it as a matter of health, survival, and economic necessity. A provider shared the case of a woman who confided:

“I live with a man who drinks and beats me and the kids. I don't want to get pregnant from him, but I have no support. Where would I go? My brothers treat their wives the same. At least here, I'm surviving. Divorce to go where?

Cost for some was another decisive barrier. A Sabha participant explained that intra-uterine devices were

“often only inserted in private clinics, and cost ... too expensive for many families.

A few noted that pharmacies sometimes filled this gap by offering oral contraceptives, although access was uneven. Nesma, 43, from Tripoli, described her own adjustment to rising costs:

“I used to get the good ones [pills]... but the price went up, and I couldn't afford them. So I started using the regular pills.

These constraints are compounded by broader cultural understandings of sexual and reproductive health, which remain closely tied to fertility and childbearing. Fatma, from Benghazi, explained,

“SRH means delivering children, childbirth and deliveries, cesarians. It also includes unintended pregnancy but does not mean contraception

Aisha, from Sabha, added,

“To me [SRH] means infertility, not being able to get pregnant [and] pre-pregnancy care in preparation for getting pregnant.

Together, these accounts illustrate how family planning in Libya sits at the intersection of political suspicion and women's urgent health and economic needs. While some perceive family planning as a foreign concept, women themselves described it as essential to safer motherhood, family wellbeing, and basic survival in fragile conditions.

These gaps matter because family planning is central to preventing unsafe pregnancies and ensuring adequate spacing between births, which is critical for protecting maternal and child health.

1

MAIN FINDINGS

Conditional and Unequal Access to SRH Services

Childbearing Pressure

Women's reproductive lives in Libya appeared to be shaped less by individual choice and more by powerful pronatalist norms. Across sites, motherhood was described as the primary marker of womanhood, with strong expectations that women would have children early, repeatedly, and preferably sons.

Participants emphasized that pressure to reproduce began immediately after marriage. Fatma, 27, from Benghazi, described,

“The society, they ask you, did you get pregnant? When will you have a child? A boy? A girl? The social pressure is hard on the women...I was forced to have the second child so I can belong and continue.

These expectations extended well beyond one or two children. Rania, 45, from Sabha, explained,

“A woman must have at least three kids. This is what society tells her.” Abeer, 29, from Sabha, added, “Even four children are not enough.

The pressure was often enforced within families, especially by mothers-in-law. Fathia, 40, from Benghazi, recalled,

“If you are pregnant with a girl, pack your bag.

Majdoleen, 26, also from Benghazi, remembered her mother-in-law placing children in her lap and saying,

“Maybe this will get you pregnant.

Men were also subject to these expectations, with fatherhood framed as a measure of masculinity. Fatma, 27, from Benghazi, explained,

“Even if her husband is convinced and doesn't want children, they will fear society. What will the community say about us?... They will say I am not man enough to have children, or that he is staying with his wife despite her not being able to have children. She is faulty. So they have to prove otherwise and have children.

The impact of these pressures on women's health and wellbeing was significant. Many described exhaustion, depression, and physical strain from repeated pregnancies. Aya, 27, from Tripoli, shared,

“My husband keeps asking me to have another child... I'm so tired physically and mentally... I'm taking antidepressants... I can't get pregnant, but he is not understanding this.

Fatma, 27, from Benghazi, reflected,

“It delayed my educational progress and my career and my health. I am 27 and my health is not the health of a 27-year-old girl. I feel I am battling life like I'm in my forties.

Coping ranged from reluctant compliance to quiet resistance; economic realities sometimes pushed families to reconsider.

2 MAIN FINDINGS

No Safe Door to Knock On: Gaps in GBV Care

The gaps were even more severe for GBV survivors. Participants described a complete absence of comprehensive GBV case management and support services. Across all research sites, women described a complete lack of institutions able to provide safe, confidential, and survivor-centered care.

Fatma, a 27-year-old from Benghazi, explained,

“There is no specialized unit or institution, or even a specialist. I haven’t seen or heard of any. It’s hard to answer this because I don’t see anything that supports women. I suffer from that too

Abeer, 29, from Sabha, echoed this sentiment:

“Nothing, nothing is available.

Key informants confirmed these accounts. One explained,

“There are no government-affiliated places that offer these services, and no medical or health centers provide comprehensive GBV case management. Some health centers may have departments for psychological support, but these are not tailored specifically for GBV survivors (KI, Tripoli).

The lack of shelters compounded women’s vulnerability. Shelters were described as non-existent. As one informant in Benghazi described,

“Shelters are not available, and society doesn’t accept the concept of women shelters at all. So, there’s no way to provide her with a place to go. You can try to help her manage the violence she’s experiencing, but there’s no shelter or protection center.

Even in the few places where “dar riasa” care homes existed, they were not protective spaces but rather perceived as punitive

institutions. A key informant in Sabha explained,

“Unfortunately, even in areas where care homes exist, they don’t admit GBV survivors unless there’s a decision from the prosecution.

The absence of safe alternatives forced women back into abusive households. Rola, 47, from Tripoli, emphasized,

“The concept of women living alone does not exist.

Hana, an FGD participant from Benghazi, described her own experience: after reporting abuse and separating from her husband, she had no option but to return to her family home, where she remained under pressure and lost custody of her children.

Although some international and local organizations have established safe spaces for women and girls, these were described as scattered, limited, and often invisible to those most in need. Many women reported not knowing that such spaces existed, while others cited transportation or social restrictions as barriers to reaching them.

Silence as Survival

Women across interviews and FGDs consistently described how silence was both expected and enforced in cases of GBV. Speaking out was framed as shameful and dangerous, with survivors often left with no safe avenues to report or seek support. Hana, 40, from Benghazi, explained,

“The concept of women going to the police doesn’t exist. Abeer, 29, from Sabha, echoed:

“I have never heard of anyone who was subjected to violence and went to the police.

This silence was reinforced by social expectations that framed

2 MAIN FINDINGS

No Safe Door to Knock On: Gaps in GBV Care

disclosure as dishonorable. Rania, 49, from Sabha, explained,

“If a woman was beaten and had to go to the hospital, she would say she had fallen. She will be protecting the perpetrator because it’s usually a family member.

Mona, 42, from Tripoli, added,

“This is how they taught us, that it’s shameful to say, shameful to reveal the secrets of your home.

Women feared not only stigma but also retaliation. Maram, 39, from Benghazi, reflected,

“Going to the police will make things worse. A woman going to the police is very looked down upon; she will be considered a morally bad woman

Malak, Tripoli, described the risks:

“If you go to complain or speak up you might be subjected to more violence...you will find yourself caught in another mess...sometimes, you might even get a bullet.

Even where services existed, survivors described the lack of confidentiality and trust as a deterrent. One key informant explained:

“It’s very difficult. Even when you provide a service for a woman, she doesn’t want to report it...we receive cases where they appear in distress and with physical trauma indicative of attack or beating, but she would say something like I fell on my side, while her hand would show marks of being hit. She would say no, no one hit her.

Legal requirements further complicated care. Healthcare professionals are obligated to report physical or sexual assault, which meant police involvement was unavoidable. As a key informant in Benghazi explained,

“We face problems with referral to health services; mainly, cases refuse to go because of mandatory reporting.

Even when services existed, legal and institutional barriers reinforced the silence, leaving women dependent on systems that often perpetuated the very violence they faced

The absence of survivor-centered GBV services leaves women without safe options, perpetuating cycles of violence and undermining trust in institutions meant to provide protection.

3 MAIN FINDINGS

3 **Compounded Vulnerability: Protection, Control, and Access**

Participants described guardianship as an established part of the social structure in Libya, one that assigns fathers, brothers, or husbands a primary role in women's lives. This system was often spoken of as a form of protection and family responsibility. At the same time, women explained that protection and discipline were closely intertwined, with guardians expected not only to support but also to correct and control female relatives.

It was within this blurred line between care and control that violence frequently emerged and often justified. Nadia, 23, from Benghazi, recalled,

“Every time there's a problem between [siblings], he sits her down and hits her, saying, 'I'm your brother, and I'm hitting you.'”

Amal, 37, from Sabha, described how this logic of care justified violence:

“It is violent, but we justify it for them...I feel their violence is for my benefit, out of fear for me”

Social beliefs about women's roles further reinforced male control. As Roqaya, 19, from Tripoli explained,

“They can be strict and believe women belong to kitchens, shouldn't drive, a woman has less brain.”

Attempts to resist these norms often resulted in punishment. Asala, 49, from Benghazi explains:

“If you have a differing opinion, you're subjected to violence...from husband and family.”

For women without male support, this system created an even sharper vulnerability. The absence of a guardian left them with

what participants repeatedly described as “no alternatives.” Nahla, 43, from Tripoli, reflected,

“Those [referring to women who are more vulnerable to GBV] who don't have a backbone or support, of course, support is God, but more often it's the man who becomes the support she needs.”

In practice, this left many women forced to remain in abusive marriages or return to violent family homes.

Unmarried, widowed, or divorced women were described as especially vulnerable. Majdoleen, 26, from Benghazi, explained,

“Divorced women and widows, because of the way society looks at them, are abused, physically and mentally, mainly by their family. She is regarded as bringing shame.”

The impact of guardianship extended beyond the household and into health services. Participants explained that decision-making about women's health was often mediated through husbands or male relatives, even when care was urgent. Women providers described cases where doctors would not proceed without male consent, effectively placing critical health interventions under the authority of family members rather than the woman herself. This practice reinforced women's dependency and sometimes delayed or blocked care.

Coping with Violence and Limited Options

Faced with few formal protections, women developed coping strategies to endure violence and minimize harm. The most common was el mosaiera (playing along), where women stayed quiet to avoid escalating abuse. Rania, from Tripoli, explained,

“I just go along with things, so he doesn't punish me, hit me, or argue with me. I just keep quiet.”

3 MAIN FINDINGS

3 **Compounded Vulnerability: Protection, Control, and Access**

Women described silence as both a survival tactic and a way to protect their families. Samia, 21, from Tripoli, explained,

“It’s better to stay quiet than to cause a problem for my father and my brothers

Malath, 21, from Tripoli, described how speaking out could escalate harm:

“They were harassing me and followed me home...When I got inside, my father saw I was scared and asked me about it...I told him...He confronted them, and it turned into a situation.

Others sought help within family or tribal systems, though these mechanisms rarely provided lasting safety. Sana, 42, from Tripoli, explained,

“Women subjected to violence seek support from their families... We don’t have protection institutions If the family can’t support her, she has no choice but to endure the violence.

Mareea, 36, from Sabha, added,

“Because we are a tribal community, they talk to him, socially, to get an oral promise that he won’t hit her again

though women emphasized that such promises often failed, with violence recurring.

With few alternatives, many felt trapped. Sally, 19, from Benghazi, explained,

“Even if the woman wants to leave, sometimes she doesn’t have the option. Would I leave and go back to my abusive brothers and abusive father?

Zaina, 47, from Tripoli, summarized the impossible choices she faced:

“It’s either the hell (naar) from my husband or the hell from my brothers

For some, marriage itself was seen as a temporary escape from family abuse. Waad, 42, from Tripoli, explained,

“A lot of women would get married just to escape their house and the abuse and all the chores.

Majdoleen, 26, from Benghazi, echoed:

“[Women] would try to get married to escape violence at home.

Those without supportive male relatives or strong networks face heightened risks. Leveraging social networks and supportive community ties may help some women navigate these constraints, but without systemic change, these remain fragile and insufficient substitutes for protection and rights.

Women Demand Change

Amid widespread barriers, women demonstrated resilience and voiced clear demands for reform, using strategies that ranged from quiet coping to active resistance and calls for systemic change.

Despite constraints, women described acts of quiet and overt resistance. Some sought to limit pregnancies, others resisted harassment, and many turned to work or education as pathways to greater autonomy. One participant from Benghazi said,

“ I decided early, right after the four kids, to not have more children.

Economic participation was consistently linked to resilience. Hania, 44, from Benghazi, explained,

“ I work with my car, as a driver, whether he is there or not, I have expenses, so I relied on myself.

Rania, 45, from Sabha, connected these changes to broader social shifts

“ The economic crisis pushes women to the work market, either public or private... they became more independent and less accepting of violence.

Awareness and information also shaped women’s sense of agency. Ameera, 19, from Benghazi, explained,

“ Women are more aware nowadays; it was worse before the internet and when women relied only on what their families taught them

Yet women active in awareness initiatives faced backlash. Moneera, 30, from Sabha, described,

“ In my area, I am the only one that is active and goes to awareness sessions... sometimes I hear them talk bad about me. They accuse me of ‘ruining’ other women.

Amid stories of coping and resistance, participants consistently called for systemic change. Maram, 39, from Benghazi, stressed the need for stronger protections:

“ It is necessary for decision-making bodies to enact laws to prevent violence. Libyan laws are not strict and are not being applied. They need to be amended and enforced.

Women emphasized economic independence, with Fatma, 27, from Benghazi, saying,

“ A woman should have a separate stipend at age 18 and have independence.

Others demanded equal access to services. Aya, 27, from Benghazi, explained,

“ A woman, whether married, single, or widow, they are all women, and we need to give them more support, especially those in need.

Calls for shelters and protection institutions were strong. Roa, 19, from Tripoli, stated,

“ A protection agency or institution, a place where she can live in and ensures her rights.

Participants also emphasized the importance of mental health services and awareness campaigns. Abeer, 29, from Sabha, explained,

“ First thing, psychological support, awareness campaigns, mental health, policewomen, protection of women and girls

Women linked reform to changing entrenched norms. Ayat, 27, from Tripoli, reflected,

“ We need to raise awareness; they [society] were raised that this is normal... The girl saw her mom and dad in violence, so that’s what she expects.

MAIN

FINDINGS

4

Women Demand Change

Others highlighted the role of digital platforms in reaching women and girls. Laila, 40, from Tripoli, explained,

“ I think the most effective thing is through the internet and media. I mean, nowadays, this has the most impact, and even in schools.

These testimonies reveal that while coping strategies and resistance remain central to women’s survival, they are not enough. Women articulated a clear demand for systemic reforms, including stronger laws, confidential services, shelters, and awareness programs. Without these, coping will remain a matter of survival rather than meaningful choice.

Women’s coping mechanisms, while vital for survival, cannot replace systemic protections. Leveraging these strategies alongside women’s calls for stronger laws, safe shelters, economic independence, and awareness campaigns that engage both women and men is critical to ensure resilience translates into dignity, safety, and real choice.

THE BIGGER PICTURE

INTERSECTING BARRIERS TO GBV AND SRH SERVICES IN LIBYA

The evidence from women across Libya paints a consistent picture. Access to SRH and GBV services in Libya is not determined by availability alone but by the intersection of weak systems, restrictive norms, and institutional silence. While maternity care exists, it is concentrated in overstretched hospitals, leaving many women to face dangerous journeys, overcrowding, and inadequate treatment. Family planning services are largely absent, and when contraceptives are available, they are often unaffordable, denied by providers, or scrutinized through moral and political lenses.

For women facing violence, the picture is even bleaker. Comprehensive GBV services and shelters are missing, forcing survivors back into abusive households or unsafe marriages. Independence is socially unacceptable, leaving women with “no alternatives.” Guardianship structures and pronatalist expectations reinforce these constraints, tying women’s access to care and safety to the approval of male relatives and to cultural pressures to marry early, reproduce repeatedly, and bear sons.

Within these constraints, women cope through silence, accommodation, and secrecy. Some use contraception without their husband’s knowledge, others seek refuge in work or education, and many rely on social media to expand awareness. Yet women also voiced a clear vision for change: stronger laws, confidential services, safe shelters, economic independence, and awareness campaigns that challenge entrenched norms.

The findings make clear that women’s survival strategies are not enough. Women across Libya are demanding systemic reforms that shift their lives from coping and secrecy toward dignity, safety, and meaningful choice.

Without systemic change, women will remain trapped between unsafe services and social constraints. Decision makers must prioritize concrete reforms, accessible health care, confidential GBV services, and economic supports, that turn survival into security.

RECOMMENDATIONS FOR ACTION

Grounded in the lived experiences of Libyan women

Break the Silence and Reduce Stigma

- Incorporate values-clarification into training as part of quality of care.
- Support discreet community engagement on GBV as a wellbeing issue.
- Pilot confidentiality protocols at the facility level.

Promote Women's Independent Access

- Issue facility-level guidance affirming women's right to care.
- Expand financial, legal, and psychosocial support programs.
- Prioritize immediate steps while recognizing longer-term legal reform.

Address the Health Consequences of Pronatalist Pressures

- Integrate counseling on safe birth spacing into maternal care.
- Train providers to address risks of closely spaced pregnancies.
- Embed messages on women's wellbeing into outreach programs.

Strengthen Access to Essential SRH and GBV Services

- Develop interim standards for maternity, obstetric, and reproductive health.
- Strengthen referral systems for obstetric emergencies and GBV cases.
- Integrate survivor-centered GBV case management into facilities.

Invest in Women's Resilience and Pathways to Reform

- Expand safe spaces integrated into existing facilities.
- Invest in mental health and psychosocial services.
- Support sustainable livelihood and vocational programs.
- Engage donors for sustained SRH and GBV investment.

CONCLUSION

The evidence in this report demonstrates that women's access to SRH and GBV services in Libya is shaped less by the existence of services than by systemic silence, restrictive norms, and institutional neglect. Maternity care remains concentrated in a handful of hospitals, family planning is politicized and unaffordable, and GBV services are absent. Guardianship and pronatalist pressures reinforce these barriers, leaving women dependent on male approval and vulnerable to cycles of abuse.

These dynamics undermine health outcomes, erode trust in institutions, and expose women to serious risks. Coping strategies such as secrecy, silence, and endurance may allow survival but cannot substitute for systemic protections. Women's testimonies across Libya reflect both their resilience and their insistence on reform.

The implications extend beyond individual health. Without systemic change, women will remain trapped between unsafe services and social constraints, with consequences for public health, social cohesion, and Libya's broader development trajectory.

Urgent action is required. Decision makers, civil society organizations, and international partners must act decisively to expand access to care, protect survivors, reduce stigma, and dismantle structural barriers. Transforming survival into dignity, safety, and meaningful choice is both a public health necessity and a fundamental matter of rights.

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About Cambridge Reproductive Health Consultants

Cambridge Reproductive Health Consultants (CRHC) is a non-profit dedicated to improving reproductive health and advancing reproductive justice globally. Drawing on expertise across multiple disciplines, the organization works to expand access to safe, legal, high-quality, and affordable reproductive health care, with particular attention to low-resource, refugee, and conflict settings. CRHC pursues this mission through action-oriented research, program development, and the production and delivery of evidence-based reproductive health resources and training.



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