INTERAGENCY GENDER BASED VIOLENCE CASE MANAGEMENT TRAINING REPORT

5-9 November 2018 - Tunis, Tunisia

I. Introduction

The Interagency Gender Based Violence Case Management Training was held in Tunis from the 5th to the 9th of November 2018 within the framework of the UNFPA's global mandate to coordinate Gender-based violence (GBV) prevention and response in humanitarian settings. The primary objective of this training is to build understanding of, and capacity in, case management for GBV survivors. In support of this, the training also aimed to improve understanding of GBV, its causes and consequences, the underpinning theoretical frameworks and survivor-centered approaches.

The training brought together front line workers including social workers, caseworkers, and case managers directly dealing with GBV survivors. A total of 31 (29 female, 3 male) participants from the UN, INGOs and NGOs participated in the workshop, which was faciliated by GBV specialists from UNFPA and International Rescue Committee, namely Ken Otieno, GBV sub-sector coordinator, Lara Chlela, GBV specialist and Domenica Costantini, GBV specialist.

The following is a list of agencies that attended the training:

- *UNFPA implementing partners: Al Bayan, Elssafa, Women Union and Amazounet*
- *UNICEF implementing partners: Elssafa*
- *The International Organization for Migration (IOM)*
- *The International Medical Corps (IMC)*
- *The International Rescue Committee (IRC)*
- *Cooperazione e Sviluppo (CESVI)*
- *The United Nations High Commissioner for Refugees (UNHCR)*
- *INTERSOS*

This five-day participatory workshop combined training, information sharing, and planning. It was of a largely interactive nature as the facilitators focused on soliciting feedback, questions, and comments from the participants. PowerPoint presentations were also coupled with group

activities to enhance collaboration and coordination between the different agencies represented in the workshop.

II. Opening Session

This inaugural session included the official opening of the workshop. Its objectives were to contextualize the training, introduce the participants and facilitators, and review the training agenda, structure and process.

The opening speech delivered by Ms. Berangere Boell-Yousfi, UNFPA Representative in Libya, contextualized the issue of GBV within the larger frame of humanitarian crises. This context, she maintained, discourages reporting since women do not speak up for fear of social stigma. Moreover, in times of crises, not only women are victims of GBV. Men and boys can be victims too. She also thanked the individuals doing field work in Libya to ensure proper GBV prevention and response for their dedication and hard work and expressed her aspiration that this training will be the beginning of many other trainings of this sort.

The speech also highlighted the importance of working jointly to improve the services provided by the GBV sub-sector. Its key achievements so far include: completion of GBV service mapping and gap analysis, finalization of the GBV referral pathway for Tripoli, and completion of the Interagency GBV action plan. UNFPA envisages that, in 2019, at least 4 GBV working groups will be functional inside Libya. For the achievement of this goal, Ms. Berangere urged the participants to stay at the forefront of GBV prevention and response, as well work collectively and in a more coordinated manner.

The second part of this inaugural session covered the main objective of the training, which was introduced as such: To build understanding of, and capacity in, case management for survivors of Gender-based violence. It also explained the key components of the agenda and established group agreements for the workshop which mainly revolved around openness to sharing ideas and opinions, active listening, mutual respect, creating a non-judgmental environment, and group safety.

The participants were then asked to note down their expectations regarding the training. The following is a summary of the participant’s expectations.

Establishing a communication network + an internal local network
Exchange of expertise
Clinical case management capacity building
Building understanding of case management
Developing a well-defined strategy to approach GBV survivors
Improving GBV case management skills to provide better services
Learning how to convince GBV victims of speaking up
Dealing with children GBV survivors
More material support
Gaining more knowledge

The participants were then asked to fill out a pre-test using code names, to respect their confidentiality.

III. Training sessions

Session 1: GBV Basics Review

The objectives of this session were to refresh the participants' understanding of key terminology and to review the types, causes and consequences of Gender-Based Violence.

The participants were divided into four groups. Each group was assigned one of the four terms: gender, power, Gender-Based Violence, and Informed Consent, and asked to come up with a general definition of the term. The difference between the participants' initial answers and the technical definitions are summarized in the following table:

Term	*Initial group definition*	*Technical definition*
Gender	Social adjectives and traits, changeable, determined by society and the environment, learned through education and communication,	• The difference between sex and gender. Sex refers to the biological and physical characteristics that define men and women. Whereas gender refers to the social differences between males and females that are learned. Though deeply rooted in every culture, social differences are

	acquired not innate.	changeable over time, and have wide variations both within and between cultures. "Gender" determines the roles, responsibilities, opportunities, privileges, expectations, and limitations for males and for females in any culture. ➢ Gender as socially-created, learned, changeable and always changing.
Power	Influencing individuals and groups using authority and/or force (violence.) / could be linked to gender.	• Different kinds of power (power over, power with, power to, power within) – women and girls having less power than men and boys. Use of power over involving force, control, coercion.
Gender-Based Violence	A negative use of power against an individual based on their gender. A harmful act committed against a person based on their gender. Emotional and/or physical harm or abuse.	• Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is **based on socially ascribed (gender) differences** between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. Perpetrators are most often male, survivors are most often female – based on power differences. • The difference between gender-based violence and other types of violence illustrated through examples.
Informed Consent	Ensuring that the survivor is fully aware of his/her rights and the services available, then giving us the permission to share their stories with other service providers.	• Agreement to an action based on complete information, sufficient capacity (including age and mental well-being), and freedom of choice. When there is no viable alternative, or those alternatives are constrained through force, threat, manipulation or coercion, it is not consent. • 3 pillars: maturity, having access to information, not being under pressure.

The next part of the session was centered on types and examples of GBV. The participants were asked to brainstorm examples of physical, sexual, emotional/psychological & socio-economic violence forms of GBV. It was explained that many types of violence overlap into two or more categories (for example, rape may have a sexual, physical and psychological element to it) and

that for this exercise it is not important to decide one category for each example of violence, but rather to brainstorm all the kinds that may exist in each category.

Examples of participants' answers include:

Physical: Beating and disfiguring

Sexual: Rape and genital mutilation

Emotional/ Psychological: Neglect and threats

Socio-economic: material exploitation of girls and depriving girls of education

In discussing the causes and consequences of GBV, the facilitator used the metaphor of a tree. This exercise, called the GBV tree, helps to understand and visualize GBV (represented by the trunk of the tree), its causes (the roots), contributing factors, and consequences (the leaves).

The following ideas, brainstormed by the participants, were placed on the tree:

Consequences	*Causes*	
	Root Causes	*Contributing Factors*
Psychological harm Feeling of rejection Economic results / dependence Health problems Lack of educational knowledge and awareness Social stigma Depression/Trauma/ PTSD/Suicide Unwanted pregnancy/ neglect	Inequality between men and women The culture of that society/ customs Patriarchal society Abuse of power	Lack of awareness of human rights Psychological problems Poverty Absences of protective laws Wars and crises

The key messages of this session were:

- Power inequality is the deepest root cause of violence. This is communicated, reinforced and perpetuated by culture, religion and social norms.
- GBV has severe consequences for survivors, as well as for their families and communities.
- Although GBV is affected by context – e.g. exacerbated in emergencies – it exists everywhere around the world, including western countries.

Session 2: GBV Attitudes and Perceptions

The learning objectives of this session were to: 1) Identify and begin to assess one's own attitudes and perceptions relating to GBV; 2) Utilize survivor-centered attitudes in daily practice with survivors of GBV; and, 3) Recognize that working with survivors of GBV requires support from colleagues, supervisors, and oneself.

The session started with a collective exercise in which the participants were asked to stand in the center of the room, listen to the statements read by the facilitator, think about whether the community in which they live/work would consider each statement true or false, and move accordingly to the True or False label in the room. The following statements were read out by the facilitator:

- It is okay for a husband to beat his wife if she disobeys him. → The majority of the participants said their communities consider this statement false. Two said the opposite.
- Raped women are responsible for the incident if they were not dressed properly. → The participants were divided.
- Husbands can have sex with their wives any time they want to. → The participants were divided. Some of them said they were not sure because it's a taboo topic.
- Women should stay home at night if they do not want to be assaulted. → The majority said their communities consider this statement true. 6 participants said the opposite.

For the second activity in this part of the workshop, the facilitator drew an image of a GBV survivor and asked the participants to give him/ her a name. They opted for "Jack". Participants were then asked to put themselves in the place of the survivor and think about the things that s/he might hear from those around him/her. They were divided into four groups, assigned one of the following roles - family, friends, community leaders, religious leaders - and then asked to write down the things each group might say to a survivor in their community. The participants wrote down statements on post-it notes and stuck them on the picture of the survivor. The facilitator then used the expressions of blame and support to highlight the role of the case-worker as someone who does not blame but rather helps and supports the victim.

Within the same line of thought, volunteer participants were asked to act out an extract entitled "are you asking for it?" from the "Crisis Line Trainer's Manual". The story shows a robbery victim being interviewed in an accusatory manner. The story was used to demonstrate how rape and sexual assault victims, especially women, are often considered at-fault for the violence inflicted upon them. A discussion ensued about victim-blaming and there was a general agreement between the participants that the victim should not be blamed for the incident.

The facilitator then engaged the group in a discussion about their own attitudes. The following statements were read out to solicit feedback from the participants:

- ❑ Statement: "In order to protect a survivor a service provider should always report a case of intimate partner violence or sexual violence to the police."
- ➢ Participants: Reporting to the police should be done with the informed consent of the victim.
- ❑ The best solution for a woman who is in an abusive relationship is to leave the abuser.
- ➢ Women do not always want to leave their abusive partners. The safe home should be the last resort. The service provider should give her all of the available options and alternatives.
- ❑ Women who stay in abusive relationships are consenting to the violence from their abuser.
- ➢ Not necessarily. There are several other factors to consider: psychological factors and social pressure, children, etc.
- ❑ Survivors who have been raped should not tell anyone in the community so as not to be stigmatized
- ➢ This is very questionable.

The facilitator then put emphasis on the following key messages:

- ✓ We all bring our own attitudes and beliefs to this work, and some of these attitudes may be harmful to survivors without our knowing it. It is important to recognize and begin to challenge our own attitudes.
- ✓ Survivor-blaming is common in many communities, and is something that we must actively strive to avoid and counter in our work with survivors.
- ✓ There are power relationships inherent in our work with survivors, and we must strive to develop relationships of power *with* rather than power *over.*
- ✓ Survivor-centered attitudes involve putting the best interests of the survivor first, ensuring that all work is based on what the survivors wants and needs rather than our own opinion of what s/he wants and needs.

The participants were then given a handout entitled "The Crocodile River Story" and asked to rank each character in order, from the most offensive character to the least offensive character. There was a general agreement that Moses is the number 1 perpetrator for raping Sarah. Then comes Abdul. There were different opinions about where to put Amal, Waffa and Sarah for various reasons. The facilitator explained that there are no right or wrong answers in the Crocodile River story, only judgments, and it is important to recognize what these judgments are, to be able to set them aside and not to impose them on the people seeking help. It was also noted that survivors have different reaction to trauma that might range from violence to laughter and it is important to be aware of this and not jump to conclusions.

The facilitator closed this part with a reminder that in case a service provider is facing difficulties reconciling their own attitudes with what they need to do at work, it is crucial to seek guidance and advice from a supervisor.

Session 3: GBV Guiding Principles and Survivor-Centered Approach

The objectives of this session were presented as such: 1) To identify the guiding principles for GBV case management, 2) To understand the role of a caseworker, and, 3) To be aware of the responsibilities of a caseworker.

The facilitator started by explaining that the guiding principles provide ethical and practical guidelines for the provision of services to the survivors. The CM guiding principles include: right to safety, right to confidentiality, right to dignity and self-determination, and non-discrimination.

The participants were divided into 4 groups and asked to discuss how each guiding principle can be demonstrated through actions. The outcome of the group activity can be summarized as follows:

Non-Discrimination	Respect	Security and Safety	Confidentiality
*Accepting survivors regardless of: Nationality, religion, race, age, sexual orientation,	*Active listening and giving the survivor attention. *Respecting their wishes. *Making them feel like	*Make sure you maintain confidentiality so that the perpetrator does not know/ harm the survivor. *Provide her with	*Providing a safe place which ensures the respect of the confidentiality principle and makes the survivor feel safe. *Reassuring the survivor about the confidentiality of the information provided by

gender and social status. *Equal treatment. *Respecting cultural sensitivity.	an active agent so they can overcome their problem. *Not forcing the survivor to speak up. *Accepting and respecting their humanity. *Giving him all the necessary information. *Building trust with the survivor. *Giving them the right to decide on their own destiny.	information about the services available, for example, shelter (if she wants) and (pip kit) *Empower the survivor by giving her the choice to make her own decision.	him/her. *Providing physical and psychological support and reinforcing the role of relatives (to make the person feel important) *Overcoming difficulties to help the victim get the assistance and support he/she needs (such as informing her of her civil rights.) *Facilitating the communication process and opening channels to communicate with the victim.

The participants were then given examples of different situations and asked to determine which principles were being violated. This exercise was used to highlight the importance of adopting a survivor-centered approach which aims to create a supportive environment in which each survivor's rights are respected and in which the person is treated with dignity and respect.

A survivor-centered approach recognizes that every survivor:

- ➢ Has equal rights to care and support
- ➢ Is different and unique
- ➢ Will react differently to their experience of GBV
- ➢ Has different strengths, capacities, resources and needs
- ➢ Has the right, appropriate to her/his age and circumstances, to decide who should know about what has happened to her/him and what should happen next
- ➢ Should be believed and be treated with respect, kindness and empathy.

The facilitator closed this session by emphasizing the following attitudes and recommendations which are crucial to any GBV service provider:

- ✓ People have the right to live a life free from violence.
- ✓ Survivors are not at fault or to blame for the violence they experience.

✓ Survivors should not be stigmatized, shamed, or ridiculed for the violence they have experienced.

✓ Survivors speak the truth about the violence they have experienced.

✓ Survivors should not be forced to disclose or report their experience to anyone.

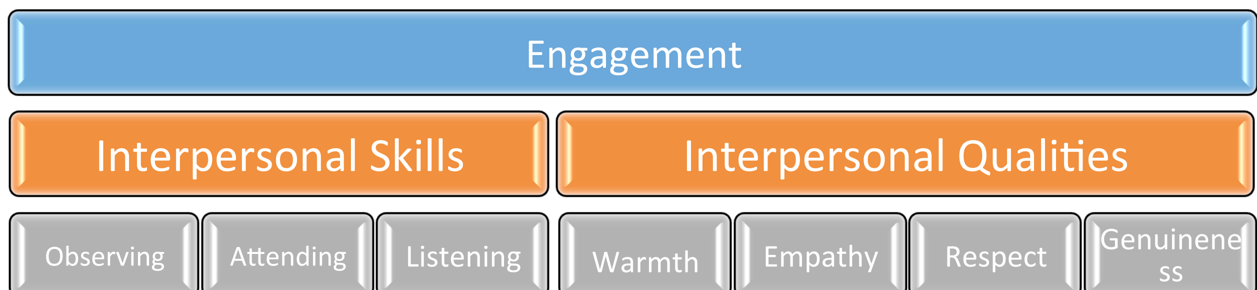
✓ Survivors have the right to make their own decisions about their care and about their lives.

✓ Survivors can recover and heal from their history and experiences of violence.

Session 4: Communication Skills

The objectives of this session were to: 1) Understand the importance of strong communication skills, 2) Define engagement and its components, and, 3) learn and practice various communication skills.

The facilitator highlighted the importance of good communication skills in strengthening the helping relationship with the survivor, empowering survivor to feel cared for and respected by the helper/service provider, and truly engaging with them. Engagement is achieved through the use of both interpersonal skills and interpersonal qualities. The following illustration details what these skills and qualities are:



The facilitator elaborated on these skills and qualities based on the feedback of the participants. The following ideas were emphasized:

<u>Observing:</u> the importance body language. The observation should not make the survivor feel uncomfortable.

<u>Attending:</u> attending to their needs/ offering them a seat/ glass of water, etc.

<u>Listening:</u> active listening/ Appropriate listening skills/ Verbal and nonverbal aspects/ Eye contact which varies across cultures/ Space (choosing the best setting to engage the speaker.)/ Cultural differences in ways of attending and listening.

Warmth: The environment needs to reflect warmth. A smile is global. Facial expressions are important. Warmth encourages disclosure.

Empathy: The cross-cultural aspect of empathy/ Understanding the feelings and emotions of the survivor from her own point of view/ The importance of balance/ Professionalism.

Respect: Not judging the survivors. Making them feel validated.

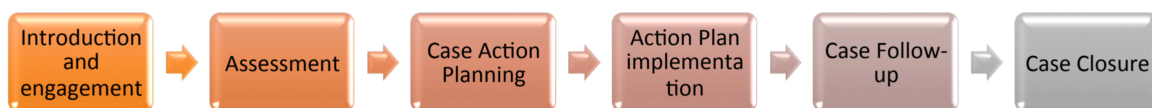
Genuineness: Being true and honest. We should not fake a smile, or make them promises that we cannot keep. We should not raise their expectations to unrealistic levels.

The presentation also covered 3 crucial elements in face-to-face communication which are words, tone of voice and nonverbal behavior (body language). Indeed, body language consists of postures, gestures, facial expressions, and eye movements. The cross-cultural differences in nonverbal communication were discussed in order to raise the participants' awareness and improve their communication skills across cultures. To practice what they learned, the participants were asked to have a conversation in pairs about their feelings that week using only nonverbal communication. After a few minutes of nonlinguistic communication, they could speak with each other verbally to see how close they were to understanding their partner's message. The participants had mixed reactions to the exercise. Some found it easy while others found it quite difficult.

The next part of the presentation dealt with communication strategies, which were listed as: active listening, effective questioning, validating feelings, using healing statements, following the survivor's pace, using simple and same language, and using silence when appropriate. The facilitator, together with the participants, conducted a more detailed analysis of these strategies. It was explained, for instance, that active listening can be achieved through paraphrasing and summarizing what the survivor says, clarifying when necessary, reflecting content and/or feelings and helping the survivor focus if they drift into other topics. The participants added to this list the need to reduce sources of distraction or interruption, respecting the survivor's wish not to be recorded, and avoiding suspicious behavior such as writing too much or whispering to a colleague which could trigger the survivor's anxiety. The same method of discussion and analysis was applied to effective questioning, validating feelings, and healing statements. Group and pair activities allowed the participants to practice applying these communication strategies through role-plays and handouts showing examples of healing statements and other useful tips for effective communication.

Session 5: Overview of GBV Case Management

The objectives of this session were to: 1) Learn the definition of case management, and, 2) Learn the steps of case management. The PowerPoint presentation delivered for this purpose defined case management as *"a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process."* Volunteer participants were then given large pieces of paper which include the different steps of case management and asked to put them in the correct order. The facilitator then went through each step in accurate order and worked together with the participants to summarize the key tasks for each step.



Session 6: GBV Case Management Step 1 – Introduction and Engagement –

The objectives of this part of the training workshop were presented as such:

- To learn to greet and comfort a survivor to effectively build rapport.
- To explain confidentiality and the exceptions to confidentiality.
- To guide survivors through the process of informed consent in a safe and empowering manner.

As an opening activity, participants were asked to observe two role-plays (found in handout 6.1 entitled "Greet and Comfort") and then discuss the positive and negative aspects of the caseworker's approach in each role-play. They made the following observations about each scenario:

Scenario 1	*Scenario 2*
-No introduction -Did not explain her work, what and why -Left the door open → Didn't respect confidentiality -Promising sentence -Didn't let the survivor talk -It sounded more like an interrogation than an interview (Unnecessary questions) -Told the survivor she knew her from the village → Made her uncomfortable	-Engaged/ active listening -Respecting the guiding principles -Good tone of voice -Empowering the survivor: let her decide if she wants the door open or close. -Empathy -Reassuring the survivor/ less pressure -Offering the possibility of taking a break: Following the pace of the survivor.

The participants were then asked to work together to write a definition of informed consent and discuss why informed consent is important. It was then defined as *"the voluntary agreement of an individual who has the legal capacity to give consent. The survivor must have the capacity and maturity to know about and understand the services being offered and must be legally able to give her consent."* It is important because it demonstrates respect, shows the survivor we intend to be collaborative and empowering, and shows that we understand the need to be accountable to the survivor. Informed consent is needed for all the stages of the process.

There are 5 steps of obtaining informed consent:

1. Explain the case management process
2. Explain confidentiality
3. Explain client information
4. Explain the survivor's rights
5. Ask the survivor if they have any questions and if they would like to continue.

The facilitator, together with the participants, looked into the details of each step. They addressed the issue of confidentiality and the exceptions to confidentiality. Exceptions may exist in cases where survivors threaten to harm themselves or others, in cases involving minors or survivors with disabilities (where their caregivers must be involved) or where mandatory reporting policies exist.

Session 7: GBV Case Management Step 2 – Assessment –

The objectives of this part of the training workshop were to:

- Use supportive communication to facilitate disclosure
- Develop an understanding of the survivor's situation and what happened
- Conduct a thorough assessment of a survivor's needs

The participants were asked to offer an initial definition of assessment and its components. The facilitator then offered a more technical definition which states that assessment is *"the act of gathering information or data from a person and evaluating it for the purpose of making a decision about the person's care. Good assessment safely and slowly assesses the survivor's situation and experience of violence with a focus on listening, not asking."*

After distributing copies of handout 7.1 which includes a scenario between a caseworker and a survivor who is having an emergency, the facilitator divided the participants into groups and asked them to discuss what the caseworker did well and what could be improved. Their comments are summarized in the following table:

Good points	***Negative points***
-Reassuring the survivor about respecting her confidentiality. -Emphasizing security. -Asking about her health. -Explaining the importance of getting medical assistance. -Suggesting solutions to reassure her (suggesting to go with her to the hospital) -Good body language.	-Allowing the neighbor to be there to hear the details of the case. -Closed questions -Not enough empathy -Not asking if she went to any other organization for help. Why? to avoid wasting time or making her relive the negative experience.

The pre-assessment activities were then explained at length. These activities include: Asking the survivor about their immediate safety, addressing any urgent medical needs, and determining if other service providers have already been involved. In the initial assessment, caseworkers should focus on two key assessment points: 1. Facilitating a disclosure from the survivor and 2. assessing the survivor's potential needs. Each of these assessment points were developed in further detail. Participants were introduced to strategies that can help facilitate a supportive conversation and make the survivor feel more at ease during assessment. These strategies include, among others, beginning the conversation with basic questions, listening carefully to the story as the survivor tells it, watching the survivor's body language closely for any signs of discomfort, encouraging and emphasizing through non-verbal and verbal communication, among others.

Participants were also introduced to the proper way of gathering basic information about the survivor's background, the nature of the violence/abuse, who the perpetrator is and their access to the survivor, when the last incident took place, and the frequency of violence. The facilitator recommended opting for a conversation instead of a list of questions, following the survivor's pace and taking cues from them as to what they want to talk about.

The issues related to having a translator or interpreter present during the interview with the survivor were addressed in a presentation by Mr. George Theodory, protection programme coordinator at INTERSOS. He addressed the key challenges or operational barriers that the survivor and caseworker can face, and the possible solutions which include: training the interpreters, having different genders, conducting regular follow-ups, signing a code of conduct, opting for Skype or phone if it makes the survivor more comfortable, etc.

The participants were then asked to observe a role-play between a caseworker and a survivor, enacted by two volunteers who have scripted roles for a "bad interviewing" scenario, and point out what the caseworker could have done differently. The participants pointed out the following errors: no greeting, no introduction, using the phone, investigation-like, too many questions, judgements, no empathy, and lack of interest. The facilitator then reminded the participants of the components of building a relationship with the survivor which are validating and empowering, fostering trust, reassuring and non-blaming and expressing empathy.

The PowerPoint presentation also provided an overview of the assessment of needs and how the survivors' needs usually fall into one of four categories: safety, medical, psychosocial, and legal. Each of these categories was explained at length and corroborated with examples. Participants were also asked to enact role plays and conduct the different types of assessment using their newly-acquired knowledge.

Session 8: GBV Case Management Step 3 – Case Action Planning –

The objectives of this part of the training workshop were to:

- Be able to work with a survivor to map their needs
- Create a thorough plan with a survivor to connect them with services
- Understand how to document the case action plan with and for a survivor

After a brainstorming activity about the different needs survivors might have and the interventions they might need, case planning was defined as *"a collaborative effort between the caseworker and the survivor in which they identify interventions that can address the survivor's needs and then discuss the positive and negative aspects of each referral. In order to complete*

this step thoroughly, the caseworker must be familiar with typical interventions and services available in the community." Participants were asked to read and organize the steps which are the following:

1. **Summarize the assessment** (safety, psychosocial and legal needs)
2. **Check in with the survivor**
3. **Discuss each need with the survivor**: Participants practiced this step by working in small groups to map out the survivor's needs. Each group was given a case study that includes information from an assessment and a "needs map". For each of the needs the group identified from the case study, they determined where to place it on the needs map, then they discussed their answers as a large group.
4. **Carry out safety planning**
5. **Get informed consent to provide referrals**: Participants practiced this step using the case study from handout 9.1 and completed the Case Action Planning chart below using the resources available in their own work. Their answers were as follows:

ACTION POINTS/ GOALS	WHO	BY WHEN
Providing the survivor with professional training.	IMC	After a month
Referring the survivor to a health facility	Medical facility	As soon as possible
Providing available treatment for her physical pain.	The case worker	As soon as possible
Keeping her safe.	IOM	As soon as possible
Providing psychosocial support: Introducing her to other women.	The case worker	As soon as the opportunity allows it.
Providing the survivor with cash assistance.	Cesvi	3 days to a week

6. **Identify who will be responsible for facilitating services**
7. **Make accompaniment plans**
8. **Document these agreements on a case action plan form**
9. **Identify a time and place for a follow-up meeting**
10. **Discuss any issues or concerns with your supervisor**

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Session 9: GBV Case Management Steps 4, 5 & 6 – Implementation, Follow-up and Case Closure –

This part of the training workshop sought to elaborate on the three remaining case management steps. Its objectives were to:

- Effectively implement the case action plan with the survivor
- Understand how to use case conferencing to support the survivor
- Conduct appropriate case follow-up

Step 4: Implementation

The purpose of implementation is to connect the survivor to relevant service providers through referrals, support them in accessing those services safely and ensure that the services are well coordinated. It has 4 steps which are to make referrals, advocate for and support survivors in accessing services, lead case coordination and provide direct services if relevant. The proper way to advocate for the survivor was explained through the example of one to one advocacy. It was also noted that meeting with service providers to provide information about the abuse could be helpful to the survivor by saving him or her the pain associated with repeating their story. An illustration of this was the enactment of a role-play entitled "the referral web story" which demonstrates how tiresome and gruesome it is for a survivor to have to repeat their story to different people who might or might not be empathetic and helpful. The role-play prompted a discussion about the situation of referrals in Libya. In some areas, such as Tripoli, the procedure is clear and is implemented by the relevant parties. But in other areas, such as Sabha, the process still needs improvement. The facilitator explained that this training could be an opportunity for the participants to go back and train others in order to improve the overall functioning and success of referral pathways. This was met with approval and enthusiasm on the part of the participants.

The question of referral pathways was also addressed at length. Referral pathways are established systems of coordination between service providers in a given setting. Referral pathways help to coordinate services, should have multiple entry points, ensure service providers know other services that are available and how to access them, and should be clear and documented.

Step 5: Follow-up

The purpose of follow-up is to assess the status of the survivor's situation and case action plan. It is carried out through meeting with or contacting the survivor as agreed, reassessing safety, reviewing and revising the case action plan and implementing the revised case action plan.

Step 6: Case closure

The purpose of case closure is to recognize when the work is finished with a survivor and terminate with the survivor in a safe and supportive way. It is carried out through determining if/when the case should be closed, documenting the case closure, if possible, administering client feedback survey and safely storing the closed case file (moving the closed file to a new cabinet).

A case can be closed in the following cases:

- ✓ When the client's needs are met and/or her support systems are functioning
- ✓ When the survivor wants to close the case
- ✓ When the survivor leaves the area, or is relocated to another place
- ✓ When you have not been able to reach the survivor for a minimum of 30 days

The facilitator noted that it is important to be clear about when the case should be closed to avoid piling up pending cases and hindering productivity and efficiency.

Session 10: GBV Case Management Responses to Intimate Partner Violence (IPV)

The objectives of this session were to: 1) Understand the dynamics, causes and consequences of intimate partner violence (IPV), 2) Accurately and thoroughly assess safety with a survivor of IPV, and, 3) Create comprehensive, easy to follow safety plans with survivors of IPV.

The participants worked in small groups to come up with a definition of intimate partner violence and explain the difference between IPV and marital conflict. They agreed that IPV refers to domestic violence by a husband, fiancée, current or former, which leads to physical, psychological or moral harm. It is different from marital disputes in that disputes can take place without violence. IPV, also called domestic violence (DV), was subsequently defined in a more technical manner as "*a pattern of abusive behavior in an intimate relationship that is used by one person (who is usually a man) to gain or maintain power and control over the other person (who is usually a woman).*" It can have physical, sexual, emotional, economic, psychological and spiritual forms and includes behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound the victim.

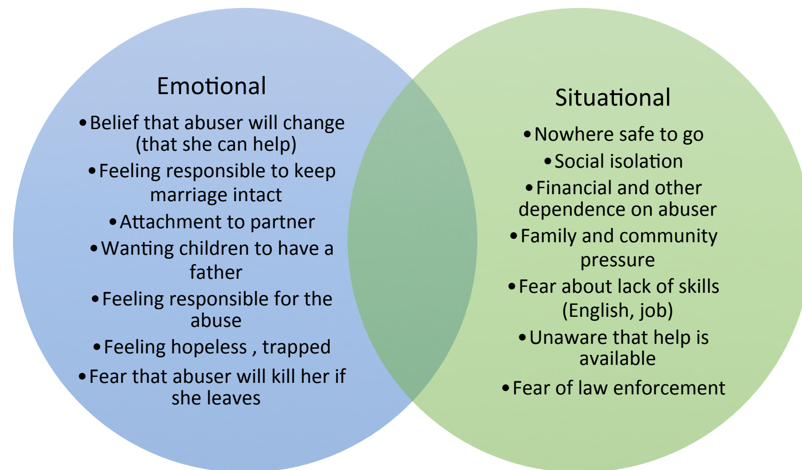
The presentation then addressed the question of "why do abusers abuse?" Excuses include "She knows better than to talk to me like that." "If only she hadn't done that." "Women have gained too much power." "I was under a lot of stress at work." "That's what husbands do." "I was drunk. I wasn't thinking clearly." "Women need to learn how to act.", etc. The idea that factors are both internal and external, while the violence is only internal, shows that the real purpose is to control the other person and make them submit to the authority of the abuser.

The facilitator and the participants then delved into the dynamics of IPV. It was explained that violence is mostly about power and control, that it is a vicious cycle, that abusers make calculated choices and that they emphasize and exploit women's tendency to blame themselves. The power and control wheel was used to break down and introduce many of the common patterns of IPV situations. Participants were then asked to work in small groups and discuss how to explain the dynamics of IPV to survivors using the information they have just learned. Such techniques as using questions to make her realize her own situation, explaining her rights and the need to avoid obvious or uncomfortable questions such as "don't you know it's wrong?" were reiterated by the participants.

The next part of the presentation dealt with the physical and psychological consequences of IPV such as constant fear and stress, sadness and isolation, self-blame, guilt and stigma. The participants then brainstormed on the question of why women stay. They provided the following explanations:

Doesn't know it's violence.	Doesn't have another choice/ Worse choice	Fear of stigma.	Fear for her children.	Lack of financial resources.	Love of the partner
Lack of protection	A state of surrender/ psychological state	No support system	Low self-esteem	Does not feel protected by the law	Fear of the unknown/ another form of violence

These reasons, as explained, all come down to fear. The PowerPoint presentation went into more details by listing the emotional and situational factors that could make a woman decide to stay.



Reasons to leave, on the other hand, include: deterioration of health, feeling of humiliation, protection of the children, desire to get a better life, constant oppression, inability to bear anymore abuse, fear for her life, and gaining knowledge of her rights. These reasons to leave might seem less impactful to the victim than the reasons to stay, which is why caseworkers should not be quick to judge women in this situation.

Supporting IPV victims can be achieved through:

- ✓ Referral to essential services (as for all cases)
- ✓ IPV-specific services
- ✓ Focus on safety
- ✓ Psychosocial support: Providing information

Participants were then asked to discuss the safety planning they are currently doing with IPV survivors and to point out what the good practices are and what can be improved. It was then explained that the goal is not to be idealistic or to aspire to stop the violence altogether, but to minimize or reduce damage. Participants were provided with a scale that can help them evaluate the survivor's feeling of safety. It was also noted that part of the safety assessment should be to help the survivor identify and understand patterns of abuse. Doing so can help the survivor better plan, avoid or respond to them. The risk assessment tool as also introduced as a way to assess present danger. The facilitator walked the participants through a list of questions about the survivor's exposure to physical harm and risks of violence, and explained how caseworkers can use this tool efficiently.

A group activity followed this explanation. Participants were divided into small groups, provided with handout 10.1 and asked to assess the survivor's safety using the skills and tools they just learned.

The next part of this presentation covered the question of how to include the survivor in the safety planning process, which would allow her to proceed with a pre-determined course of action. The caseworker's role is to help her plan for exactly what she would do in life threatening situations, and this would minimize the harm done by the perpetrator by identifying resources, ways to escape, means to avoid harm and places she can temporarily go to for safety.

In a role-play, participants were asked to work in pairs, as a survivor and a caseworker, to draft a safety plan, and halfway through the play, switch roles. At the end of the activity, they were asked to discuss their experiences as survivor and social worker.

Questions from the participants at this point revolved around the lack of services available to IPDs in some areas, which the facilitator answered by stressing the need to find alternative solutions when possible. Otherwise, the participants and other caseworkers need to work together to share resources or receive more trainings to be able to offer psychosocial support, for instance. In all cases put forth by the participants, it was emphasized that the caseworker should not try to influence or direct the survivor's choices.

The final part of the presentation covered the provision of accurate information to the survivor about the causes and dynamics of IPV and the normal responses and feelings that a woman in an abusive relationship may have. This is a part of providing psychosocial support for the victim because it may reduce self-blame and shame about the violence she has been or is experiencing as well as validate and normalize her reactions to it.

Handout 10.3 was distributed to review key messages with the participants before closing the session. These key messages provide a survivor with information about IPV, how it influences a person and what are natural reactions to it.

Session 11: GBV Case Management Response to Adolescent Girls

To open this session, the facilitator presented global statistics about the situation of women and adolescent girls and the violence they are subjected to. It was explained, for instance, that nearly half of all sexual assaults worldwide are against girls aged 15 and younger. The objectives of this session were then listed as follows:

- To define early marriage and the consequences for girls and communities
- To describe the various case management responses to early marriage

The PowerPoint presentation focused on the specificities of working with adolescent girls. It defined early/ forced marriage as *"as a formal marriage or an informal union that happens*

before the age of 18 years." Early marriage is embedded in many cultural and social practices. It is for this reason that working with the topic of early marriage requires a sensitive and careful approach and being sure that any interventions supports the girl and does not put her at risk for any harm.

The participants were divided into groups to discuss early marriage in their communities, including the risk factors, protective factors, and what they see the role of the caseworker to be. The frequency of early marriages in Libya was a subject of debate due to the lack of studies showing the prevalence of early marriage or GBV. The risk factors mentioned by the participants include poverty, lack of education, the culture, wars and crises, family crises, economic and social factors, lack of freedom, drug abuse, internal displacements, etc. As far as solutions are concerned, they suggested raising awareness, providing more jobs, promoting education, advocacy, legislations, and women empowerment.

The facilitator then elaborated on case management responses and the essential steps that need to be followed in order to provide good quality services. The assessment and actions required differ slightly depending on the girl's situation: whether she is at risk for an early marriage or she is already married. The role of the caseworker in each situation was explained at length in order to ensure the safety of the girl and service providers. The presenter also explained the proper process to obtain informed consent depending on the girl's age and her situation. The participants were then given the chance to practice applying this information by discussing different case studies and the procedures that need to be followed to obtain consent in each case.

In the second part of this session, emphasis was placed on imminent risk cases, and the detailed case management steps related to it. The overview of case management responses in this situation includes understanding how the girl feels about the marriage, providing information to the girl, potentially engaging a supportive adult (after assessing the risks involved) and moving to risk reduction it the decision to marry the girl still moves forward. The participants were divided into small groups and asked to discuss providing information about early marriage to both girls and parents or family members: How to do that? What topics might be difficult? And how to properly address them? The questions of sexual life and reproductive health were brought to the fore as sensitive topics and there was a general agreement between the participants that messages need to be adapted to the girls' ages and the local context.

The next part dealt with risk reduction in case the decision to marry the girl still moves forward. The role of the caseworker was explained as *"preparing the girl to navigate her new relationship and environment in a way that minimizes her risk of violence and health*

complications." Participants were taught how to achieve this in the most empathetic and efficient manner with the potential help of a supportive caregiver. The focus was placed on safety planning, advocating for the girl and providing her with information and services.

The role of the caseworker when dealing with girls who are already married, on the other hand, focuses on assessing the girl's situation, whether she is subjected to physical and/or sexual violence, her financial situation, whether or not she is attending school, her social support system, and her overall feelings about the marriage. Based on this assessment, the caseworker can move to action planning. An action plan should include providing information and services to the girl, safety planning, identifying a supportive adult, identifying positive coping strategies and making referrals as necessary.

Session 12: Supervision

The objectives of this session were to:

- Gain a foundational knowledge of the purpose and function of supervision.
- Understand how to utilize various supervisory tools to evaluate performance.
- Describe the different ways in which supervision can be conducted

Supervision was defined as "*the ongoing, regular meeting of a supervisor and a supervisee to assess and monitor skills and practice in a supportive manner*." The supervisor's role is to provide support, advice, direction and quality oversight to case management services, ensure staff are trained and prepared for their caseworker role and be on-hand for consultation in emergency situations. Supervision has three functions which are: supportive, educational and administrative. To make sure these functions are accurately understood, participants were asked to classify the foci of supervision into one or more functions.

The purpose of supervision can be summarized in ensuring that helpers and service providers are able to put knowledge and skills from training into practice, providing staff with the opportunity to discuss their work and receive constructive feedback, monitoring and managing staff stress, among others. A supervisor's role is to focus more on strengths rather than weaknesses.

Participants were asked to come up with three guiding principles that are necessary for positive supervision experiences. Their feedback includes ideas such as being cooperative, solution-based, educational, interactive, neutral, non-biased, non-discriminatory, and continuous. The PowerPoint presentation then showed that supervision needs to be regular and consistent, collaborative, an opportunity for learning and professional growth, safe and an opportunity to 'model' good practice.

The presentation also elaborated on supervision tools which are necessary to ensure consistency and oversight, protocols and policies, and methods. It focused on individual supervision in relation to both new cases and ongoing cases. The participants were given the time to practice through an activity that allowed them to comment on the performance of a fictional supervisor and point out the areas that need improvement based on the information they had just learned. Participants were also briefly introduced to the case management quality checklist and case file review.

Session 13: Staff Care

This session of the workshop was designed to help the participants:

- Understand the types of traumatic stress and their impact
- Gain awareness of the signs of burnout and vicarious trauma
- Understand how to utilize tools and methods for self-care and stress management

The first part of the presentation focused on the definition of stress and its different types: cumulative stress, critical incident stress and vicarious trauma, as well as its cognitive, physical, emotional, spiritual, philosophical and behavioral signs. The facilitator solicited feedback from the participants about the type of stress they face at work, and then asked them to work in groups to discuss what the individual case worker can do to take care of him/herself, what the team can do together for mutual care and support, and what the organization/supervisor can do to support employee well-being. Their answers are summarized in the following table:

As an individual	As a group	As an organization/supervisor
Time management Taking breaks Practicing hobbies or sports Self-assessment and awareness (of stress levels, emotional state, etc.)	Relaxation sessions for the team Team-building/ bonding activities Spending time together (having lunch for instance) without talking about work Taking care of each other: Choosing a person to share problems with. Outdoor activities	Distributing cases equally between the workers. Providing a break room / massage room/ Retreats/ Prayer place Open-door approach Activities away from work Changing rhythm or work dynamics Varied tasks Trips for employees Offering yoga classes or relaxation exercises Trainings Offering psychological counselling (confidential/ free) Classical music in the workplace

		Monitoring stress levels/ Providing a positive work environment Flexible schedules

The PowerPoint presentation also covered the ABCs of self-care and self-care techniques, which can be physical, emotional/relational and spiritual.

IV. Training Action Planning

In order to reach concrete action points, the participants were grouped together based on the agency or organization they represent and asked to provide collective answers to the following points:

- Assess the **areas where you need support** in order to initiate or strengthen the provision of case management services in your agency.
- Provide **immediate steps** at your organization level to initiate or strengthen case management in your organization **within the next one month** for follow-up.
- Provide **suggestions or recommendations** on how we can collectively ensure **continuous learning and experience sharing**.

INTERSOS	**Question 1:** -Secure fund -Center establishment **Question 2:** -Center establishment -Staff recruitment and training -Case management implementation -Donors mobilization **Question 3:** -Create google group where experiences, discussions and materials can be shared.
IRC	1. Action planning, safety plan, more in-depth session on adolescent girls. 2. Steps: Case management forms (to familiarize) how to fill out the forms Follow-up service mapping, be familiar with referral pathways Skype call session (Misrata/ Tripoli) to discuss challenges. 3. More trainings with case studies. Conference meetings, regular area-based

	Lessons learn/ challenges Meetings for advocacy / for services to survivors.
CESVI	1) Improve referral system (other NGOs) -create a friendly space for survivors instead of office space. -create a private space so that it is not publicly known survivors are coming for GBV. 2) Provide immediate assistance (refreshments and cash) (not all projects have the same issue) -Activating durable solutions. 3) Specialized GBV case management training. -Monthly follow-up with team and communicating well with each other.
IOM	1) -Private space to conduct interviews. -More staff to delegate case management -More accurate work plan -Inclusiveness and project updates -Time management -Clear structure, proper implementation 2) - Initiating GBV CM forms - Mapping local GBV providers for referral - More local NGOs - Create a platform between authorities and NGOs - Self-care process for staff 3) - Follow up on field challenges - Strengthen internal and external advocacy - A group to share experiences.
IMC	1/2) -Hire capable staff -Ensure safety of the staff -Clear line of case management work plan -Provide a secure place to keep the files -Trainings for any GBV related forms → services provided by other NGOs. -Balance work load for the staff -Make your staff take leave 3)-Regular meetings with the affected staff. -Monitoring the work
Amazounet Libya	1) Hiring new members such as a second psychologist, a legal specialist, an administrative employee, and a lawyer, as well as intensifying GBV case management trainings. 2) Providing services such as transportation and accommodation for the working team since we are the only center covering the needs of the entire Eastern region. We aspire to expand our scope of work because some survivors find it difficult to reach us. 3) Providing equipment and tools for services such as drawing and knitting tools to draw the survivors to the center. -Working during the next month on a campaign against GBV by raising awareness through media outlets, lectures, dialogues, drawings and

	psychodrama. -Continuing to manage the cases that keep coming to the center. -It is preferable to intensify trainings for the same team who is carrying out the work and raise its efficiency periodically. -Linking or twinning between centers and organizations specialized in providing these services at the Libyan level to exchange expertise and collectively advocate for GBV issues.
Noor Al Hayat	1) -Trainings – hiring a larger number of employees – financial support – professional and technical support – excellent medical counselling and services. Using media outlets and social media platforms to raise awareness and improve the work. 2) Team trainings – continuing to study and go more in-depth in this field – starting the work. 3) Books and scientific research – benefiting from previous expertise – the internet – communicating with the other groups to exchange expertise and achieve mutual benefit.
Women Union – Sabha	- Awareness-raising lectures. - Identifying some GBV case and managing them. - Establishing an awareness and entertainment program for battered women. **Steps:** -Conducting awareness-raising sessions for battered women. (knowing the type of cases) -To guide teenagers through Scouting, the Red Crescent and educational institutions. -Holding regular meetings with other similar organizations to increase and exchange expertise. **Recommendations:** -Providing a well-equipped office for GBV case management; a social worker, psychologist, legal specialist, health specialist. -Providing a delivery room for the women held in detention centers. -Providing forms, samples and checklists necessary for doing the work. -Ensuring and developing expertise through workshops. -Providing means of transportation.
Al Bayan	1) – A larger place with a garden and a private room for the children of battered women. - Recruiting GBV specialists. - Some equipment. -Training and raising the efficiency of caseworkers, supervisors and specialists. - Implementing the 16-day campaign plan. 2) -Updating case management investments to meet international standards. 3) -Networking between the organizations that attended the training under the supervision of the Fund to exchange information and stay up-to-date.
Elssafa –	1) -Training and raising the efficiency of caseworkers and supervisors. -Implementing the 16-day plan in Tripoli, Sabha, and Benghazi.

Tripoli, Sabha, Benghazi	2) -Updating case management investments to meet international standards. 3) -Networking between the organizations that attended the training under the supervision of the Fund to exchange information and stay up-to-date.

Before moving to the closing remarks, participants were asked to fill out the post-test using the same code names they used for the pre-test in order to demonstrate the new knowledge they acquired throughout the five-day training.

V. Closing Remarks.

The closing section included comments from the participants who expressed their enthusiasm, commitment and engagement to providing comprehensive care and support to GBV survivors, and their willingness to cooperate in order to improve the situation in Libya. There were several expressions of gratitude on the part of the participants who said they look forward to meeting regularly and working together, with the help of UNFPA.

The closing speech by Ms. Maanasa Reddy, Protection Sector Coordinator, thanked the trainers and the participants for their efforts throughout the training, urged them to continue working together, emphasized the importance of localization and bringing about positive changes from inside the local communities, and asked the participants to join the Libyan protection cluster e-mail list in order to stay in touch and be part of the international community. She also encouraged them to find ways to integrate their programs and services within their local communities and remain engaged on an individual and bilateral level.

Annex A: Agenda –

TRAINING DAY 1 – Monday 5 November 2018

8.30 – 10.30	Welcome, Introduction, Expectations and Pre-test
10.30 – 11.45	Coffee break
10.45-12.30	Session 1: GBV Basics Review
12.30-13.30	Lunch
13.30-15.00	Session 2: GBV Attitudes and Perceptions
15.00 -15.15	Coffee break
15.15-16:45	Session 3: GBV Guiding Principles and survivor-centered approach
16.45 – 17:00	Daily Evaluation Wrap-up

TRAINING DAY 2 – Tuesday 6 November 2018

9.00 – 9.30	Welcome and Review of Day 1
9.30 – 10.30	Session 4: Communication Skills
10.30-10.45	Coffee break
10.45-11.45	Session 4: Communication Skills (cont'd)
11.45-12.30	Session 5: Overview of GBV Case Management
12.30-13.30	Lunch
13.30 -15.00	Session 6: GBV Case Management Step 1 – Introduction and Engagement
15.00 – 15.15	Coffee break
15.15-15.45	Session 6: GBV Case Management Step 1 – Introduction and Engagement (cont'd)
15.45-16.45	Session 7: GBV Case Management Step 2 – Assessment
16:45-17.00	Daily Evaluation Wrap-up

TRAINING DAY 3 – Wednesday 7 November 2018

9.00 – 9.30	Welcome and Review of Day 2
9.30-10.30	Session 7: GBV Case Management Step 2 – Assessment (cont'd)
10.30-10.45	Coffee break
10.45-11.45	Session 7: GBV Case Management Step 2 – Assessment (cont'd)
11.45 – 12.30	Session 8: GBV Case Management Step 3 – Case Action Planning
12.30-13.30	Lunch
13.30-14.30	Session 8: GBV Case Management Step 3 – Case Action Planning (cont'd)
14.30-15.00	Session 9: GBV Case Management Steps 4, 5 & 6 – Implementation, Follow-up and Case Closure
15.00-15.15	Coffee break
15.00-16.45	Session 9: GBV Case Management Steps 4, 5 & 6 – Implementation, Follow-up and Case Closure (cont'd)
16.45 – 17.00	Daily Evaluation Wrap-up

TRAINING DAY 4 – Thursday 8 November 2018

9.00 – 9.30	Welcome and Review of Day 3
9.30-10.30	Session 10: GBV Case Management Responses to Intimate Partner Violence
10.30-10.45	Coffee break
10.45-12.30	Session 10: GBV Case Management Responses to Intimate Partner Violence (cont'd)
12.30-13.30	Lunch
13.30-15.00	Session 11: GBV Case Management response to Adolescent girls
15.00-15.15	Coffee break
15.15-16.45	Session 11: GBV Case management response to Adolescent girls (Cont'd)
16.45-17.00	Daily Evaluation Wrap-up

TRAINING DAY 5 – Friday 9 November 2018

9.00 – 9.30	Welcome and Review of Day 4
9.30 – 10.30	Session 12: Supervision
10.30 – 10.45	Coffee break
10.45-12.30	Session 12: Supervision (Cont'd)
12.30-13.30	Lunch
13.30-15.00	Session 13: Staff Care
15.00-15.15	Coffee Break
15.15-16.30	Session 13: Staff Care (Cont'd)
16.30-17.00	Post-test, feedback form and closing remarks

Annex B: Daily Evaluations –

The participants made the following comments/requests in their **evaluation of Day 1:**

- The facilitators need to pay more attention to time management.
- They requested time for prayers after the lunch break.
- The interpreters speak too quickly sometimes.
- The training and PowerPoint presentations should include more Arabic content.
- There should be similar trainings in Libya.
- The facilitators need to focus on everyone in the room, not just some groups.

The participants made the following comments/requests in their **evaluation of Day 2:**

- Uncomfortable chairs, but it's good that there is a chance to move around during the activities.
- No time for response after translation.
- The facilitators need to pay more attention to time management.
- The discussion should remain on topic. No side talks.
- Longer breaks for lunch and prayer
- Some people talk for too long → The comments should be more focused.
- Other participants should be careful about their body language (less arrogance)

The participants made the following comments/requests in their **evaluation of Day 3:**

- More activities to avoid boredom.
- The facilitators need to pay more attention to time management.
- The voice of the translator is sometimes a little low
- Discussion consistency: not going off topic
- We need to practice all the points to make sure they are fully understood
- More exchange of ideas and expertise would be helpful.

The participants made the following comments/requests in their **evaluation of Day 4:**

- Longer breaks
- More opportunities for networking
- Asking to receive the educational material on a USB drive
- More focus on the Libyan context. Some topics such as sex education are sensitive in Libya and this material needs to be adapted to the Libyan context.
- Overall general satisfaction with the training.

Annex C Final Evaluation

1. **I found the duration of the workshop to be:**
- Too long (0)
- Too short (3)
- Appropriate (23)

2. **I found the time given to session and discussion appropriate.**
- I agree (20)
- I partially agree (6)
- I disagree

3. **Did the course fulfill your expectations?**
- Yes, beyond my expectations (9)
- Yes, according to my expectations (16)
- Partially, please explain: (1)
- Not at all, please explain:____

4. **I found the teaching methodologies used (Presentations, group work, interactive teaching, etc.) during the workshop to be:**
- Very good (24)
- Good (2)
- Not so good, any suggestions:______________________________________
- Not good at all, any suggestions:_____________________________________

5. **What is your opinion of the facilitators? (1 = Not good at all, 4 = very good)**
- 1
- 2
- 3 (2)
- 4 (24)
-

6. **Will you have the occasion to apply the knowledge acquired during the workshop to your work?**
- Yes (22)
- To a certain extent (4)
- Not at all

7. **Did the workshop strike the right balance between theory and practice?**
- Yes (19)
- Partially (7)
- Not at all

8. **Do you have any suggestions to improve the workshop? Please explain what should be improved and how it should be improved.**

- More time for more activities.
- Better organize the participants' interventions and comments.
- To have more training days and less daily training time.
- Avoid mixing languages.
- More training and capacity building for supervisors.
- Work on the participants' values using role play.
- Ensure that participants have the same level of understanding of GBV concepts to avoid time wasting.
- To study in more depth some topics such as work plan and safety.
- Dedicate one day to lessons learnt from different areas of Libya
- More case study and focus on case management steps.

9. **What did you like in the workshop? What were the strong points of the workshop?**

- New information especially self-care.
- Very good learning materials and great variety of activities, which reinforce team work.
- The training interactive way and the information transfer methods.
- The high care and respect to the participants.
- The diversity of profiles attending the training.
- The use of practical examples and presentations

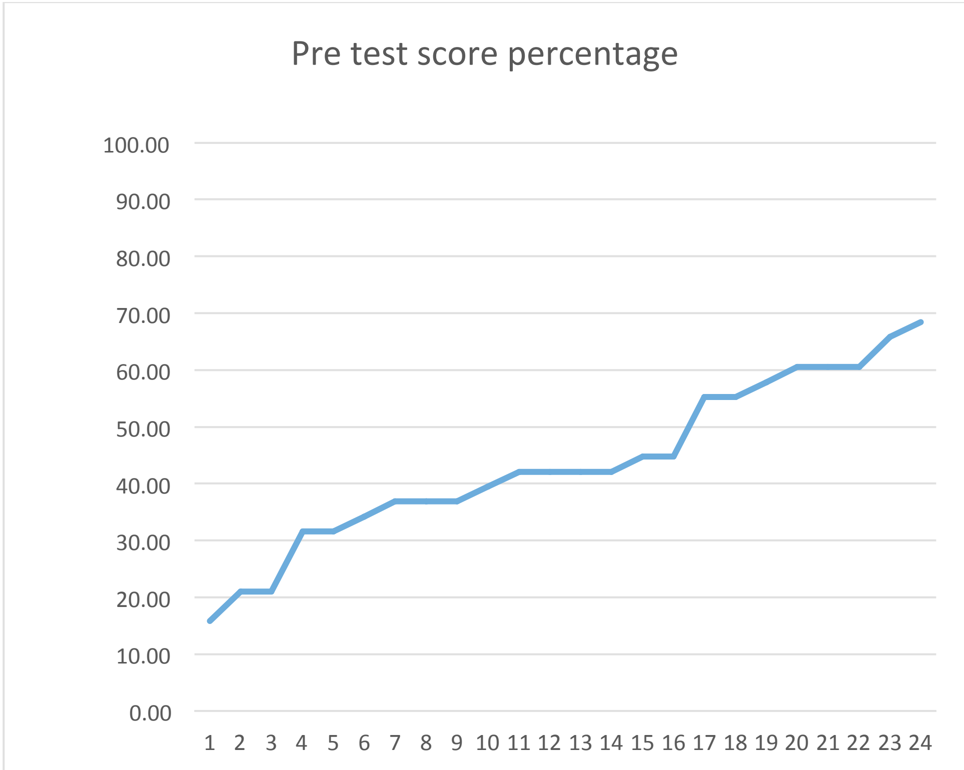
Annex D: Training evaluation (Pre-post test)

On the first and last day of the training, an identical pre and post-tests were taken by participants which included different questions covering several topics discussed throughout the training days, the aim of the test is to assess participants' knowledge and examine the level of improvement in their understanding and experience of some globally used terms and GBV case management principles.

The lowest score percentage in the pre-test was 15.79% while it was 47.37% in the post test. Similarly, the highest score percentage was 68.42% in the pre-test and 94.74% in the post one.

As a result of the training, all 25 participants have shown a high level of improvement with 7.89% being the least improvement percentage achieved and 63.16% being the most.

Participant	Pre-test score	Percentage	Post test score	Percentage	Improvement percentage
P1	6	15.79	19	50.00	34.21
P2	8	21.05	18	47.37	26.32
P3	8	21.05	32	84.21	63.16
P4	12	31.58	20	52.63	21.05
P5	12	31.58	30	78.95	47.37
P6	13	34.21	35	92.11	57.89
P7	14	36.84	20	52.63	15.79
P8	14	36.84	22	57.89	21.05
P9	14	36.84	31	81.58	44.74
P10	15	39.47	24	63.16	23.68
P11	16	42.11	33	86.84	44.74
P12	16	42.11	29	76.32	34.21
P13	16	42.11	25	65.79	23.68
P14	16	42.11	29	76.32	34.21
P15	17	44.74	20	52.63	7.89
P16	17	44.74	28	73.68	28.95
P17	21	55.26	32	84.21	28.95
P18	21	55.26	33	86.84	31.58
P19	22	57.89	33	86.84	28.95
P20	23	60.53	30	78.95	18.42
P21	23	60.53	36	94.74	34.21
P22	23	60.53	35	92.11	31.58
P23	25	65.79	34	89.47	23.68
P24	26	68.42	32	84.21	15.79
P25	29	76.32	35	92.11	15.79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70.00
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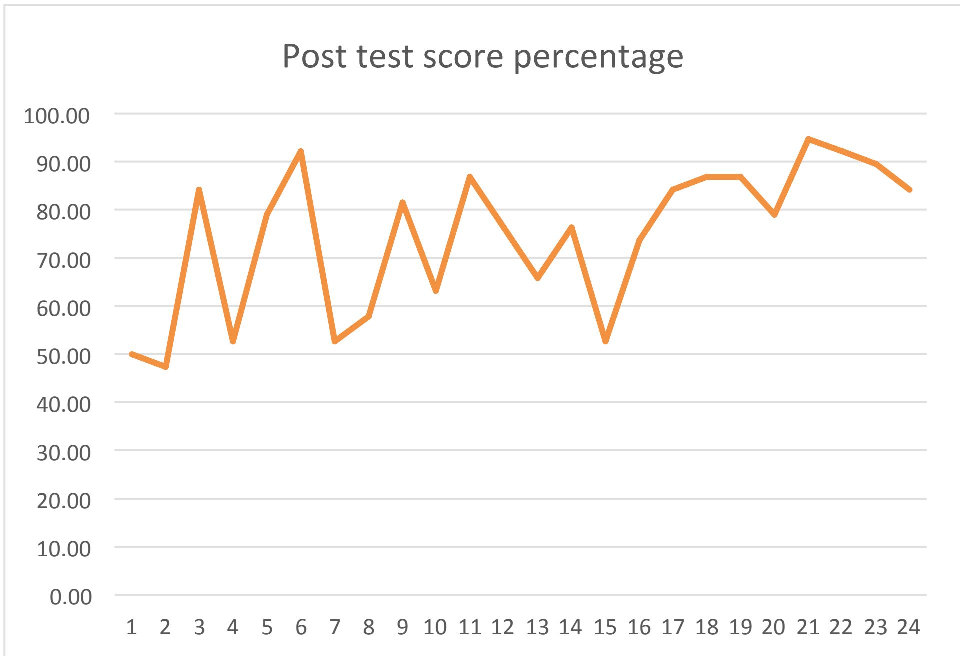
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