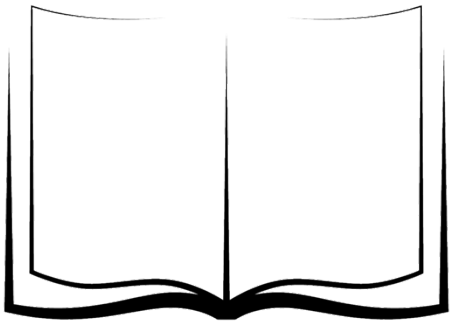
WP3: T 3.3
Train-the-Trainer Handbook



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Victim Protection
in Medicine

Exploiting practical knowledge of medical staff to enhance
the multi-professional contact with victims of domestic violence

Co-funded by
the European Union

Grant Agreement No. 101095828.

Contents

List of Abbreviations

DV	Domestic Violence
VIPROM	Victim Protection in Medicine
SPP	Simulated Patient Program
CIT	Critical Incident Technique

Preface

There is a pressing need to improve medical support for victims of domestic violence (DV). This can be accomplished, for instance, through tailored advocacy measures combined with **ongoing training for medical professionals**. Enhanced support within the healthcare system is of particular importance, as a significant number of victims of violence initially seek help from health services. Consequently, it is essential for medical professionals, as frontline responders, to possess adequate knowledge and feel empowered to assist victims beyond their medical obligations.

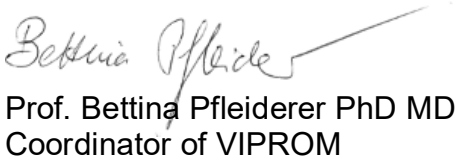
To accomplish this goal, VIPROM has developed a training curriculum tailored for various stakeholder groups within the medical sector and an accompanying Train-the-Trainer program to ensure high quality and sustainability.

The curricula are based on the training materials, training tools and the information being available on the European training platform on domestic violence. This platform is modular and **tailored to the needs of trainers who will teach DV**. The platform serves **not as a standalone self-study tool for learners**, but rather as a resource to complement their training or evaluate their knowledge following training sessions. Trainers have the flexibility to select from a **diverse range of materials** within each Module, with certain content being mandatory. This handbook explains in 8 chapters the tools being used in our curricula.

The handbook will **serve as a guidebook for our VIPROM training courses**. While it does not replace attendance at any Train-the-Trainer course, it will establish the necessary framework for effectively utilising our VIPROM training materials as trainers.

It is my pleasure as coordinator of the Training handbook for the EU Project **VIPROM: *"Victim Protection in Medicine - Exploiting practical knowledge of medical staff to enhance the professional contact with victims of domestic violence"*** to share this training handbook with you now.

Sincerely yours,



Prof. Bettina Pfleiderer PhD MD
Coordinator of VIPROM

1. Introduction

1.1 Train the trainers in a comparable way

Domestic violence (DV) remains a major problem in the European region[1] and is one of the greatest health risks for women as well as other victim groups such as children, men and non-binary people face in their lifetime[2]. Even though many international policies have addressed DV as a serious (public) health problem[3] and the need for better support for victims in the medical sector, frontline health professionals still do not have sufficient knowledge about DV and lack sufficient skills on how to identify, communicate with and better support victims within or even beyond their medical duty[4]. In addition, the sustainable implementation and organisational anchoring of specialised training or standardised screenings in the health sector remains a problem.[5] This points to the need for continuous training as frequently requested by medical staff. Thus, advocacy measures tailored to the medical sector combined with ongoing training for medical professionals are needed[6].

The aim of the VIPROM project is to develop and implement training programs specifically tailored to the needs of the medical sector to improve support for victims of DV in an appropriate and responsive manner. Also, the project developed a Train-the-Trainer program to ensure an organisationally embedded knowledge transfer taking into account the special needs of the different medical stakeholders (physicians, nurses, midwives, medical students, dentists and dental students in some countries).

In the first year of the VIPROM project, the consortium conducted a needs assessment in all five participating partner countries (Austria, Germany, Greece, Italy, and Sweden). The main aim has been to understand the structural barriers and enablers for further implementation of DV training, as well as the needs of specific medical stakeholder groups. The analyses of the data have shown that improving the knowledge and awareness of healthcare professionals in dealing with DV victims is crucial to identify and provide adequate care to victims. The interviews also shared that the trainings should be interactive and multidisciplinary, focusing on practical skills and should be stakeholder-specific. Based on the needs analyses the VIPROM curriculum was designed.

The primary focus of this short VIPROM training handbook is to provide trainers with all the information they need to make the best possible use of the VIPROM teaching tools and to become familiar with the used methods in order to set up training courses tailored to medical sector and meeting the common goals developed as part of the

[1] World Health Organization. 2019. 'The Health System Response to Violence against Women in the WHO European Region: A Baseline Assessment'. Geneva. https://www.who.int/europe/publications/i/item/WHO-EURO-2019-3780-43539-61155

[2] Miller, Elizabeth, and Brigid McCaw. 2019. 'Intimate Partner Violence'. The New England Journal of Medicine (380): 850-857. DOI: 10.1056/NEJMra1807166

[3] Council of Europe. 2018.' Gender Equality Strategy 2018-2023'. Strasbourg;

[4] World Health Organization. 2013. 'Addressing Violence against Women in Health and Multisectoral Policies: A Global Status Report'. Web Annexes. Geneva.

[5] Hooker, Leesa, Rhonda Small, and Angela Taft. 2016. 'Understanding Sustained Domestic Violence Identification in Maternal and Child Health Nurse Care: Process Evaluation from a 2-Year Follow-up of the MOVE Trial'. Journal of Advanced Nursing 72(3):533–44. doi: 10.1111/jan.12851.

[6] European Union Agency for Fundamental Rights. 2015. 'Violence against Women: An EU Wide Survey: Main Results'. Luxembourg.

VIPROM project. Stakeholders should be trained in all participating partner countries in high quality in a comparable manner to facilitate comparable evaluation of training. Trainers at national level will be familiarised with the didactic concepts of our curricula as well as with the relevant materials for each stakeholder group.

The trainers trained under the VIPROM project will pilot our curricula in each of the partner countries and act as centres of competence and curricula champions to ensure sustainability beyond the project duration. This will enable each partner country to benefit from the same coherent and effective training on the subject of domestic violence and to develop equivalent skills and know-how.

1.2 What can you find in the handbook?

In this handbook, trainers can find a summary of available training contents on the European training platform on domestic violence (www.training.improdova.eu). This is supplemented by didactic information on how to use the VIPROM training materials. All materials have undergone evaluation by national expert focus groups in each participating country. This will ensure further optimisation and tailor the content even better to the practical needs in the medical sector. All content has been adapted to national context and translated into 5 national languages (German, Swedish, Greek, Italian and adopted to Austrian context) and was included in the training platform to facilitate the national adoption of the curricula and wide dissemination. The handbook presents in a nutshell, an introduction of the European Training Platform on Domestic Violence[7] in the health sector and its content (Chapter 2), followed by an introduction of the VIPROM training curriculum, why it is important to consider stereotypes and biases in training, as well as acquiring basic intercultural competence (Chapter 3). Then it continues with introducing a framework which will enable trainers to install a secure training environment for learners, encourage trainers to develop essential soft skills and introduce interactive training tools (Chapter 4). In Chapter 5, trainers will be made familiar with some important teaching techniques being used in VIPROM and their importance. Chapter 6 highlights why it is of essence to use national adaptations of our materials and get a better understanding of the methods used to evaluate the success of training courses at the end of the handbook (Chapter 7).

In addition to the knowledge required to set up VIPROM training courses, this handbook also highlights the important soft skills that are essential to consider when training various stakeholder groups on domestic violence. These skills include the ability to listen, to provide constructive feedback, to take into account the potential biases and traumas of the participants in the training course, intercultural communicative competence, knowledge of and sensitivity to existing stereotypes, and the ability to self-analyse; to be aware of one's own biases and traumas, in order to prepare for the training course in the best possible way, taking care of both the participants and oneself.

[7] European Training Platform on Domestic Violence, https://training.improdova.eu/en/, accessed 09.04.2024

1.3 Key takeaways

- Sustainable implementation and organisational anchoring of specialised training or standardised screenings remains challenging in the medical sector.
- The VIPROM project is developing and implementing tailored training programs for the medical sector to improve support for domestic violence victims.
- A Train-the-Trainer program is crucial for ensuring embedded knowledge transfer, considering local needs of medical actors and institutions.
- Understanding local healthcare professionals' needs and structural barriers/enablers is essential for further implementation of domestic violence training.
- The handbook introduces the European Training Platform on Domestic Violence https://training.improdova.eu/en in healthcare and its content, serving as a guidebook for VIPROM training courses.

2. Introducing the VIPROM Training Platform

2.1 Overview of the Modules

The training platform provides trainers with training materials and content related to domestic violence, equipping users with the knowledge and skills necessary to teach the various stakeholder groups to be taught (nurses, midwives, medical doctors, and dentists and medical and dental students). **It consists of a modular structure with 9 Modules and a separate section for trainers stratified by teaching tools** (e.g., case studies, videos). All Modules are interlinked. The platform is a living document and is to be actualised on a regular basis. **All materials are evidence-based and supported by references.** The content has been reviewed by domestic violence experts from the VIPROM partners. We put a strong focus on stakeholder specificity: Gynaecology / Obstetrics, Surgery: Emergency Room, Paediatrics and Dentistry. A special focus has been to include the dental sector in our training, as this stakeholder group is usually overlooked in all previous trainings. A lot of new materials were designed in particular for this stakeholder group.

Here are the Modules available on the VIPROM training platform:

- Module 1: Forms and dynamics of domestic violence
- Module 2: Indicators of domestic violence
- Module 3: Communication in cases of domestic violence
- Module 4: Medical assessment and securing of evidence
- Module 5: Risk assessment and safety planning
- Module 6: International standards and legal frameworks in Europe
- Module 7: Interorganisational cooperation and risk assessment in multi-professional team
- Module 8: Stereotypes and unconscious bias
- Module: Data and statistics

2.1.1. Available materials for learners and trainers

Modules 1-8 allow access to downloadable tailored content factsheets which summarise the main content of each Module, knowledge assessment which assess the user's understanding, many tasks for reflection either used in class or given as home assignments or group work. Interactive elements such as case scenarios and practical exercises provide users with hands-on learning opportunities, allowing learners to apply their knowledge in real-world situations. Comprehensive training materials are also provided, including training videos, supplementary reading materials, and other resources for trainers. This ensures that trainers have access to all the tools they need to facilitate engaging and informative training sessions. The content sources for each Module are available on the training platform.

Image by Gerd Altmann on Pixabay

2.2 Module 1: Forms and dynamics of domestic violence

50 women in Europe die from male domestic violence every week![8]

2.2.1 Short description

Module 1 gives information on definitions and forms of domestic violence (DV) with a special focus on vulnerable victim groups such as people with disability, elderly or LGBTIQ+ individuals. To recognise and address the experiences of individuals from multiple marginalised groups, the sex and gender aspects of domestic violence and the relevance of intersectionality will be also explained. In addition, information on victims and perpetrators of DV will be shared as well.

Module 1 focuses on the following topics:

- Significant definitions when talking about domestic violence.
- Sex and gender aspects in domestic violence
- Forms and types of domestic violence
- Special types of domestic violence
- Victims and perpetrators of domestic violence

Trainers have a range of training materials at their disposal, including videos, case studies and factsheets. Those can be found here.

2.2.2 Key takeaways

Learners will

- **be familiar** with the definitions of domestic violence, intimate partner violence, and gender-based violence.
- **understand** the relevance of sex / gender and intersectionality aspects to differentiate between various types of domestic violence and to identify marginalised individuals.
- **recognise** the multifaceted nature of domestic violence, its most common forms and its special types.
- **understand** the behaviour of victims and the relational dynamics in the cycle of violence.
- **understand** who the victims of DV are, who are the perpetrators and what leads them to DV.

[8] Data vary depending on the sources

Image by macrovector on Freepik

2.3 Module 2: Indicators of domestic violence

As a health professional, you will be the first and only contact for many victims.

2.3.1 Short description

Module 2 gives information on **how to identify victims of DV in the healthcare system and related challenges and the impact of DV on victims**. Physical and psychological impact of DV is described, including the impact on children. Marginalised victim groups are presented including violence e.g., against men and the elderly. Moreover, the role of and impact on those witnessing domestic violence will be presented in an excursus.

Medical professionals will find specialised indicators for recognising and supporting victims with a focus on gynaecology/obstetrics, in the emergency room (surgery), paediatrics and dentistry.

Module 2 focuses on the following topics:

- Signs of unhealthy relationships
- The role medical professionals play in identifying domestic violence
- Impact of domestic violence
- Indicators of domestic violence

Trainers will find a range of training materials including videos, case studies and factsheets here.

2.3.2 Key takeaways

Learners will

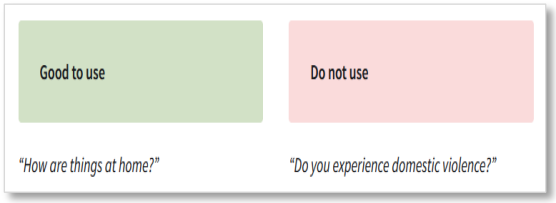
- **understand** the multifaceted consequences of domestic violence on victims, families, and communities, including physical, psychological, and social impacts.
- **acquire the skills** to identify potential indicators and “red flags” - using behavioural, physical, and emotional cues.
- **recognise the emotional and psychological** effects of witnessing domestic violence, particularly on children, and understand the importance of creating safe environments for all family members.
- **recognise the domestic violence indicators in general and being specific** for gynaecology/obstetrics, the emergency-room (surgery), paediatrics and dentistry.

2.4 Module 3: Communication in cases of domestic violence

"Never assume and always ask!"[9]

2.4.1 Short description

Module 3 delves into the various aspects of communication when addressing domestic violence. Medical professionals will find in this Module specialised information on how to communicate with victims with a focus on gynaecology/ obstetrics, emergency room (surgery), paediatrics and dentistry.



By starting with potential barriers to disclosure, medical professionals can be sensitised to the various challenges that make it difficult for DV victims to openly discuss their situation. Medical professionals can learn more about the principles of communication strategies (e.g., open-end questions, normalising the situation, asking direct questions), including trauma-informed care, patient-centred care, and gender sensitive language. The main part of the Module consists of practical examples of screening questions (good to use – do not use), responding to a disclosure (phrases to use – not to use) and further communication aspects. Here, the Module offers a wide range of phrase examples they can include in their practice. Additionally, to this, the Irish College of General Practitioners[10] offers helpful guidelines that can be included. The warm referral to specialised services should be trained including referral opportunities even if the patient doesn´t "need" further support.

Module 3 focuses on the following topics:

- Understanding the complexities related to the disclosure of domestic violence.
- Employing effective communication strategies.
- Crafting appropriate responses to patients experiencing domestic violence.

Trainers have a range of training materials at their disposal, including videos, case studies and factsheets. Those can be found here.

2.4.2 Key takeaways

Learners will

- **recognise** the barriers to disclosure.
- **acquire knowledge** about patient-centred conversation techniques which can help to disclose domestic violence.
- **learn** about trauma-informed communication with DV victims after disclosure.
- **learn** about specific information on gynaecology/obstetrics, emergency room (surgery), paediatrics and dentistry.

[9] The Royal Australian College of General Practitioners (RACGP) https://www.racgp.org.au/

[10] Kenny, N., ní Riain, A. et. al. (2022). Domestic Violence and Abuse – a Guide for General Practitioners. The Irish College of General Practitioners (ICGP) https://www.drugsandalcohol.ie/36284/1/ICGP-Domestic-Violence-QRG-Summary.pdf

2.5 Module 4: Medical assessment and securing of evidence

The solicitors said there just wasn't enough evidence on my health records. Nothing to suggest my ex was to blame for my injuries. I thought my doctor had written down everything I said.

2.5.1 Short description

Module 4 provides an overview of how cases or suspected cases of domestic violence need to be documented, how medical exams will be carried out respectfully and related legal and ethical aspects. It covers general legal procedures and respectful evidence collection, principles of clear documentation, injury description guidelines, proper photography techniques, observation of patient behaviour, and follow-up protocols. It emphasises patient comfort and confidentiality while ensuring accurate and legally admissible documentation. Including tailored information for gynaecology/obstetrics, surgery/emergency room, paediatrics and dentistry.

Module 4 focuses on the following topics:

- Medical assessment and documentation.
- Consent and confidentiality.
- Ways to document and secure evidence: photography, sample, writing.
- Discharge and follow-up.

Trainers have a range of training materials at their disposal, including videos, case studies and factsheets on medical assessment and securing evidence. Those can be found here.

2.5.2 Key takeaways

Learners will

- **know** the legal aspects of documentation and securing evidence.
- **understand** the important aspects to be considered after the disclosure of domestic violence.
- **conduct** thorough physical assessments of victims.
- **employ** appropriate techniques for injury photography.
- **collect** and preserve samples/evidence.
- **implement** discharge and follow-up procedures for victims.

2.6 Module 5: Risk assessment and safety planning

> "Women's perceptions of safety and the likelihood of reassault [emerged as the] most consistent and strongest risk marker."[11]

2.6.1 Short description

Module 5 gives information on general and high-risk factors for domestic violence (DV) which is vital to recognise and prevent DV among patients in the health sector. This Module also contains sex and gender aspects important to consider when conducting risk assessment and safety planning. Including communicating safety measures and risk assessment in addition to spotlights on staff working in gynaecology/obstetrics, surgery/emergency room, paediatrics and dentistry. Healthcare professionals are not necessarily required to carry out a risk assessment or safety planning themselves but should have knowledge of the overall process to provide the patient with adequate information and support.

Module 5 focuses on the following topics:

- Risk assessment
- Safety planning
- Risk factors for DV
- Sex and gender aspects in risk assessment
- Communicating Safety Measures and Risk Assessment

Trainers have a range of training materials at their disposal, including videos, case studies and factsheets. Those can be found here.

2.6.2 Key takeaways

Learners will

- **understand** how to conduct comprehensive risk assessments.
- **recognise** sex and gender dynamics in risk assessment.
- **understand and develop** safety-planning strategies to support victims.
- **develop** awareness of different types and levels of risks when dealing with patients exposed to violence.

[11] Maram Practice Guides Foundation Knowledge Guide, State of Victoria, Australia, Family Safety Victoria, February 2021, p. 36, available at https://www.vic.gov.au/maram-practice-guides-and-resources

2.7. Module 6: International standards and legal frameworks in Europe

"Universal Declaration of Human Rights (UDHR): the most translated document in the world".[12]

2.7.1 Short description

Module 6 will give you an overview of international frameworks with spotlights on the Istanbul Convention and the National frameworks.

Module 6 focuses on the international frameworks such as:

- Universal Declaration of Human Rights (UDHR)
- Beijing Declaration and Platform for Action
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Declaration on the Elimination of Violence Against Women (DEVAW)
- UN Convention on the Rights of the Child (CRC)
- Convention on the Rights of Persons with Disabilities (CRPD)
- 1951 Refugee Convention
- UN-Resolutions
- UN Sustainable Development Goals (SDGs)
- European Convention on Human Rights (ECHR)
- Convention on Cybercrime (Budapest Convention)
- Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention)
- Victims' Rights Directive
- European Parliament Resolution (16/09/2021)

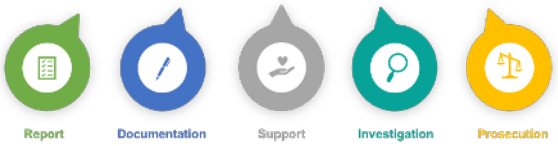
Trainers can find a range of training materials here.

2.7.2 Key takeaways

Learners will

- **understand** what kind of international standards and legal frameworks exist in Europe.
- **be familiar** with the international organisations that actively monitor and report on the implementation of human rights.
- **understand** the legal framework of the European Union regarding human rights, domestic violence, rights of children, rights of persons with disabilities, cybercrime.
- **understand** the purpose of the Istanbul Convention.
- **be aware of** legal frameworks in other countries.

[12] United Nations https://www.un.org/en/about-us/universal-declaration-of-human-rights



2.8 Module 7: Interorganisational cooperation and risk assessment in multi-professional teams

"Risk assessment is a cornerstone in domestic violence prevention".[13]

2.8.1 Short description

Module 7 describes how the various stakeholders – police, legal sector, social sector and medical sector – work together in cases of domestic violence, related challenges and chances when working together well. Best practice examples are presented to demonstrate that risk assessment works best in inter- and multi-professional teams. Finally, the criminal procedures in DV cases and the several essential steps to be followed to ensure a thorough and just response, are shown. As criminal procedures do vary nationally, exemplarily criminal procedures in cases of domestic violence as applied in Austria, Germany, Greece, Hungary, Italy, Finland, France, Portugal, Spain, and Sweden are shared.

Module 7 focuses on the following topics:

- Inter-Agency Cooperation
- Risk Assessment, also in times of disasters
- Cooperation between Agencies with Focus on the Health Sector
- Criminal Procedure in Cases of Domestic Violence and National Criminal Procedures

Trainers can find training materials related to Module 7 here.

2.8.2 Key takeaways

Learners will

- **understand** how frontline responders work with a special focus on the medical sector and multi-faceted challenges in times of a pandemic such as COVID-19 disasters.
- **understand** the role of interagency cooperation in the health sector and why cooperation in multi-professional teams is most successful in tackling domestic violence.
- **acquire** knowledge about criminal procedures in general and that they vary between counties.

[13] Kropp, P. R. (2004). Some Questions Regarding Spousal Assault Risk Assessment. Violence Against Women, 10(6), 676–697. https://doi.org/10.1177/1077801204265019

Sources: https://end-gender-stereotypes.campaign.europa.eu/index_en

2.9 Module 8: Stereotypes and unconscious bias

It is important to foster self-awareness, recognise harmful attitudes and behaviours, and highlight the broader societal implications of these phenomena.

2.9.1 Short description

Module 8 shows the impact of stereotypes and unconscious bias on our perceptions and behaviours in the context of domestic violence. This Module aims to provide the knowledge and tools needed to challenge stereotypes and confront unconscious biases. Assessing and addressing these biases is crucial, as biases can influence how we perceive and interpret situations and thus lead to unfair judgments and misconceptions about victims and perpetrators of domestic violence, and inadvertently perpetuating victim-blaming or minimising the severity of abuse. Additionally, Module 8 presents important topics such as gender norms and societal expectations and the portrayal of women in the media and its impact. This Module is designed as a self-study part, however related content will be presented in selected cases in other Modules.

Module 8 focuses on the following elements:

- Significant definitions
- Origin and manifestation of biases in the context of DV
- Anti-biases strategies and how to counter personal biases

2.9.2 Key takeaways

Learners will

- **understand** the origin and factors that contribute to the development of unconscious biases and stereotypes and their impact on decision making and behaviour.
- **define** key terms related to unconscious bias, stereotypes, and prejudices.
- **recognise** and analyse instances of unconscious bias in everyday situations, and, particularly in the context of domestic violence.
- **engage** in self-reflection to identify personal unconscious behaviours and develop strategies for addressing delicate situations in the context of domestic violence.
- **develop the ability** to establish the connection between unconscious thinking patterns and the concepts of diversity and inclusion.

2.10 Module on data & statistics

Identifying the economic costs of gender-based violence contributes to better informed decision-making and supports policy development.

2.10.1 Overview of the content

The Module on data and statistics provides background information for trainers to make learners understand the impact of domestic violence on society and on the individual level, and related costs. It includes international data on domestic violence as well as national data and statistics from 12 European countries (Austria, Finland, France, Germany, Greece, Hungary, Italy, Portugal, Scotland, Slovenia, Spain, and Sweden).

The national part presents information on statistical data such as, e.g., prevalence, age distribution of domestic violence, and number of deaths, victim surveys and costs of domestic violence. The final section presents recommendations for improving future data collection for policymakers and other stakeholders on the management level.

This Module focuses on the following elements:

- International and national data on domestic violence
- Costs of domestic violence
- Recommendations for improving data practices

2.10.2 Key takeaways

Learners will

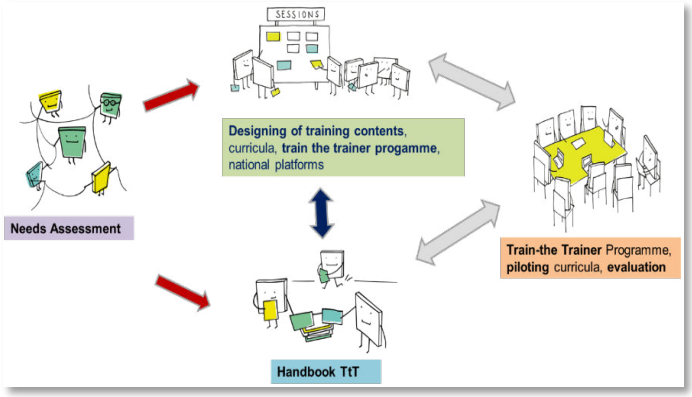
- **acquire** knowledge on statistical data regarding domestic violence to better understand their societal and individual impact.
- **recognise** that domestic violence can kill the victim.
- **understand** that many data about domestic violence are flawed and how data collection and analysis must be improved to get better data.

3. Stakeholder-Specific VIPROM Curricula on Domestic Violence

3.1 Training of stakeholder-specific VIPROM DV curricula

3.1.1 Design of DV training tools and materials

One of the goals of the EU project VIPROM is to **develop training curricula on domestic violence (DV)** tailored to various medical sector stakeholder groups (students, nurses, midwives, medical doctors, dentists). Input from WP2 (repository of existing training on domestic violence and needs assessment) was used to design state-of-the art training tools and materials, which can be found on our VIPROM training platform. Module content underwent expert evaluation and subsequent refinement.



This training content was subsequently structured into **a curriculum tailored for frontline responders in the medical sector**, initially at the European level, and later adapted to national contexts, translated into 4 languages (German, Italian, Greek, Swedish) and tailored to the Austrian context. To ensure consistency across curricula taught in our partner countries and enhance the sustainable implementation of national curricula, **a train-to-trainer course** was developed.

3.1.2 Train-the-Trainer courses

At the **VIPROM European Train-the-Trainer course**, experienced trainers from our partner countries are introduced to the **concepts and methods to be used**. These trainers will **train national trainers in their respective countries** on **how to** teach the VIPROM curricula to stakeholders from the medical sector. A focus will be put on interactive training tools such as the use of simulation patients in training and the creation of a safe training environment, rather than on specific training content.

Objectives of the Train-the-Trainer course:

To implement didactic concepts for teaching domestic violence (DV), including its identification, documentation, and communication within the healthcare sector, for trainers.

Learning goals: At the end of the trainer course, participants will have the skills to…

- **reflect** the relevance of the implementation of DV.
- **develop** an attitude and an emotional commitment towards DV implementation.
- **receive** didactic tools to create their own curriculum: e.g., SMART criteria, constructive alignment.
- **express or formulate** adequate learning goals for their countries.
- **be able** to use the critical incident technique (CIT).

- **give** constructive feedback or elaborate how to use constructive feedback to learners**.**
- **experience** a simulation scene and reflect them.
- **reflect** the relevance of emotional competence and self-care.

All training formats which are suitable to use in DV training can be found in Appendix I, the agenda of the European Train-the-Trainer course can be found in Appendix II.

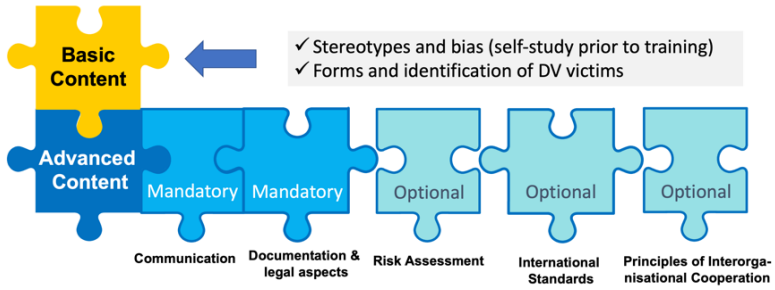
3.1.3 Requirements for accreditation

In order for the DV curriculum to be accredited[14] for teaching medical students, it needs to fulfil the following criteria: a) documentation of all learning materials and modularisation of content (VIPROM training platform), b) basic idea of university didactics (Train-the-Trainer course), c) tailored to the target group (tailoring the training materials to: gynaecology/obstetrics, emergency room, paediatrics, dentists), d) learning objectives of the course(s) (VIPROM training platform) and state of the art training methodology (Train-the-Trainer methods). Group size needs to be tailored to content and form of teaching (8-10 participants/trainer). Course duration should be a minimum of 12 hours including self-study units. At the end of the course an evaluation is required.

3.1.4 Short description of the VIPROM DV curriculum

The VIPROM curriculum to train stakeholders in the medical sector involves a minimum of 8 h face-to-face training combined with self-study of Module 8 (Stereotypes and biases). **It will consist of 3h teaching** of **basic content** (Stereotypes, forms of DV and identification of DV victims), **4h of teaching of advanced content** (Communication, documentation and legal aspects) and **1h of optional content** for every trainer to be chosen (risk assessment, international standards/national standards, inter-organisational cooperation).

Trainings should be done as follows:



- In several units or on a full day.
- In mixed or homogenous groups.
- Mandatory basic and advanced content.
- Optional content.

To ensure consistency in evaluations across partner countries, each training session must cover similar content and utilise comparable training tools and methods in both the basic and advanced segments. This alignment will be introduced and discussed with trainers before and during the European training course.

[14] Accreditation of study programmes is recommended to ensure the quality of individual study programmes, the criteria is a summary of accreditation of the various partner countries; they will be part of a deliverable next year.

3.2 Stereotypes and prejudices in the context of domestic violence

3.2.1 Why is awareness about stereotypes so important?

Stereotypes and unconscious biases play a significant role within the context of domestic violence. Research has shown that certain roles and stereotypes multiply undesirable and harmful behaviours (CETS No. 210, Preamble, 43). They can influence how we perceive and interpret situations and thus lead to unfair judgments and misconceptions about victims and perpetrators (see: Module 8 of the training platform).

> **Article 14 – Education**
> "1) Parties shall take, where appropriate, the necessary steps to include teaching material on issues such as equality between women and men, non-stereotyped gender roles, mutual respect, non-violent conflict resolution in interpersonal relationships, gender-based violence against women and the right to personal integrity, adapted to the evolving capacity of learners, in formal curricula and at all levels of education." (CETS No. 210)"

Therefore, taking measures to overcome gender stereotypes by including the topic into teaching material is also anchored in the Istanbul Convention[15] on a legally binding level:

Unreflected stereotypes can lead to victims either not being recognised or not receiving adequate support. This, for example, can be seen in the case of marginalised victim groups e.g., individuals with a migration background or people with disabilities: A lack of intercultural competence and language barriers can lead to communication difficulties. Those affected might feel misunderstood and prospectively may avoid services due to fear of discrimination or inconvenient situations.

Especially when it comes to refugees, there are many biases about gender roles and a lack of knowledge for their life situation, for example about the limited access to services during the asylum procedure. Insufficient training for professionals and service providers on addressing the specific needs of disabled victims can lead to inadequate treatment. Moreover, disabled victims face a problem of a lack of accessible support services and accommodations for disabled victims, lack of good accessibility for physically disabled, communication aids, or assistance animals (read more about this in Module 8, "Biases in the context of domestic violence and their consequences").

3.2.2 Why is self-reflection so important?

In addition to the examples above, reflection about stereotypes and biases should already start by questioning the perception and assumptions about one´s own and the other sex and gender. To make an example, the perception of a female health care professional can be influenced by her sex (being female), her gender (e.g., how she sees her own role as a woman) and her own mind-set and expectations (e.g., woman can be very aggressive, too). Gendered perception runs the risk of re-victimising the

[15] Council of Europe Convention on preventing and combating violence against women and domestic violence (CETS No. 210): https://rm.coe.int/168008482e

victim by not considering the victim as an autonomous individual. This might lead to victims not sharing all information that is relevant for the risk assessment because they do not feel as being taken seriously. Moreover, a health care professional may not take male victims' complaints seriously and may downplay the incident, because in this frontline responder's worldview, it is almost impossible to conceive that men can also become victims of domestic violence. In conclusion to this, integrating sex and gender aspects into risk assessment instruments is crucial for health care professionals. More on the topic, "Sex and Gender Aspect in Risk Assessment" can be found on the training platform Module 5.

In the worst case, biases can lead to a reversal of guilt and victim blaming. This is particularly common in the case of sexual offences. Victims of rape often have to deal with inappropriate questions through medical professionals, police or judges. Moreover, societal stigmatisation has a huge impact on the healing process of the victims. This can lead to those affected blaming themselves and thus negatively impacting the criminal proceedings against the perpetrators. Module 8, for example, offers a good exercise to reflect potential victim blaming. These types of self-reflections can be unpleasant as they confront us with our own biases. In order to become aware of one's own stereotypes, it is important to do them on a regular basis.

3.2.3 Tasks for reflection

To practise self-reflection, Module 8 offers several tasks for self-reflections by providing videos, song lyrics and celebrity case studies. One example – taken from Module 8 – can be seen here:

Task for reflection

1. What is the main message of the video?
2. How and on the basis of which characteristics do you divide people into groups? What characteristics do you ascribe to them? Which discourses determine these "classifications", where do your prejudices come from (circle of friends, media, politics)?
3. What do these considerations mean for diversity and inclusion in our society?

Moreover, the training requires participants to complete a home assignment on stereotypes and biases before the start of the course and to be sensitised to the topic in advance by using case studies (see Chapter 4.4).

3.2.4 Case studies

The content of Module 8 is not taught as a stand-alone Module but is integrated into the other Modules. To get more sensitisation about the life situation of victims, six case studies are to be incorporated into the training in the context of the content of the corresponding Modules (Table 3.1)

Case studies taken from Module 8	Discussed in the context of…
Examples/List of unconscious bias	Module 1
Case study: Drug addiction and/or perpetrator-victim-reversal	Module 2
Case studies: DV against men and/or migrant women	Module 3
Case studies: LGBTIQ+ and/or high social status	Module 4
Case studies: Older male victim	Module 5
Case study: Disability	Module 7

Table 3.1: Case studies taken from Module 8 to be discussed in the context of the content of the corresponding Modules.

The inclusion of case studies in each Module is intended to help us question our own stereotypes and to take people's individual life situations into account. Because we remember: there is no such thing as "the typical victim"!

3.2.5 Key takeaways

By the end of the training course, the participants should be able to

- **identify** and categorise different types of biases and their impact on decision-making and behaviour.
- **recognise and analyse** instances of unconscious bias in everyday situations, and, particularly in the context of domestic violence, the influence of unconscious non-verbal behaviour patterns on communication.
- **engage** in self-reflection to identify personal unconscious behaviours and develop strategies for addressing delicate situations in the context of domestic violence.
- **apply** knowledge to real-life scenarios through case studies to develop concrete alternatives for action.

3.3. Intercultural Competence & Culturally Responsive Trainings

3.3.1. Intercultural learning aspects in VIPROM trainings

The VIPROM Train-the-Trainer course and related curriculum promotes intercultural learning, which involves the acquisition of transferable intercultural competence and takes a multi-level approach to the integration of intercultural competence. This means developing not only skills, but also mindsets and flexible behavioural repertoires that can be applied to intercultural interactions in general, rather than skills specific to one culture. Furthermore, there is a positive and significant relationship between individual

cultural competence and systems cultural competence.[16] Therefore, our approach to intercultural competence is not limited to individual skills, but is social change-oriented, aiming at long-term changes in curricula, leadership and health systems.

When introducing the idea of "cultural responsivity" in domestic violence training, it is important to **first make "culture' relevant to the context"**. Culture mediates both, care-giving and care-receiving. It acts as an invisible gatekeeper when it comes to decision-making, value orientations and agency specifically in the context of domestic violence, for example: an individual's culture influences help-seeking behaviour[17], the different ways in which domestic violence is experienced, the culture-specific risk factors encountered,[18;19] as well as the cultural values endorsed by individuals.[20;21] You can ask how culturalized gender roles (in concepts of the patriarchal family, of familismo and machismo, etc.) change approaches to seek help when experiencing domestic violence. Stories of male victims of domestic violence can be shared to initiate empathy by showing how men can be victims (countering dominant gender bias) and exploring how concepts of masculinity are culturalized (see all chapters in Module 8).

Trainers need to **explore relevant definitions of culture** with the trainees, treating "culture" not as a static entity (a 'thing', e.g., glasses that can be put on and taken off), but as a dynamic concept that emerges from different experiences and interactions. It is important to **integrate a cultural self-reflection** exercise since self-awareness is closely linked to cultural responsiveness. Reflecting on experiences from childhood to adulthood can help to reflect on personal struggles and privileges throughout life. The respective Intercultural Competence framework (see Fig.3.3 below) outlines 3 major phases and transitions (T1 & T2) that people need to resolve with the help of diverse experiential input:

1. **Ethnocentric (EC)** - perceiving one's own cultural view as the only viable and 'normal' one.
2. **Ethnorelative (ER)** - accepting the existence of other viable perspectives, yet lacking genuine appreciation for them.
3. **Intercultural (IC)** - genuinely valuing difference by 'hardwiring' culture, i.e. integrating cultural otherness into one's neurological wiring. This allows for the authentic use of new ways of seeing and making sense.

[16] Pyles, L., & Kim, K. M. (2006). A multilevel approach to cultural competence: A study of the community response to underserved domestic violence victims. *Families in Society*, *87*(2), 221-229 DOI:10.1606/1044-3894.3515

[17] Kim, J. E., & Zane, N. (2016). Help-seeking intentions among Asian American and White American students in psychological distress: Application of the health belief model. *Cultural Diversity and Ethnic Minority Psychology*, *22*(3), 311. DOI: 10.1037/cdp0000056

[18] Rai, A. (2021). Indirect experiences with domestic violence and help-seeking preferences among south asian immigrants in the United States. Journal of Community Psychology, 49(6), 1983-2002. DOI: 10.1002/jcop.22492

[19] Parra-Cardona, J. R., Escobar-Chew, A. R., Holtrop, K., Carpenter, G., Guzmán, R., Hernández, D., & González Ramírez, D. (2013). "En el grupo tomas conciencia (In group you become aware)" Latino immigrants' satisfaction with a culturally informed intervention for men who batter. Violence against women, 19(1), 107-132.

[20] Choi, Y. J., Orpinas, P., Kim, I., & Ko, K. S. (2019). Korean clergy for healthy families: Online intervention for preventing intimate partner violence. *Global health promotion*, *26*(4), 25-32. DOI: 10.1177/1757975917747878

[21] Marrs Fuchsel, C. L., & Brummett, A. (2021). Intimate partner violence prevention and intervention group-format programs for immigrant Latinas: A systematic review. Journal of family violence, 36(2), 209-221. doi: 10.1007/s10896-020-00160-6

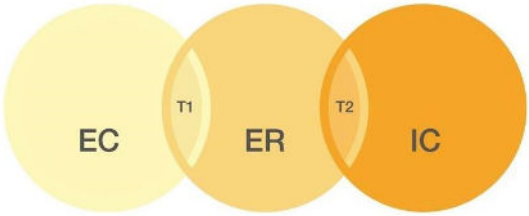


Fig.3.3: The Intercultural Competence® Framework[22]

A brief presentation of the complex ICC framework should introduce **basic terminology and the concept of cultural responsiveness**, i.e., the extent to which people can understand, embody and feel "culture" and communicate effectively (i.e., make sense of other people's realities) in multicultural environments. In order to design culturally responsive domestic violence training, it is necessary to **address deeper cultural issues** such as empathy (e.g., see various forms of care), cultural humility, trust & respectful communication with victims.

It is important to focus on the cultural aspects of these concepts in training, such as establishing respect in your interactions to build trust, safety and well-being by treating people not as you would like to be treated, but as they would like to be treated by you.

For this purpose, it is important to **include 'affective items' in the training**, i.e. items that have acquired their affective meaning through their association with a degree of pleasantness or unpleasantness and a degree of arousal in the experience of a culturalized individual's experience. Such training items provide the learner with the opportunity to explore strategies for coping with challenging complex socio-emotional situations by experiencing the emotional dynamics involved. One can include authentic **stories (videos, ted talks, podcasts**, etc.) from e.g. victims with various intersecting identities in terms of cultural & racial background, social class & status, gender & sexuality, etc. See the VIPROM training platform for case studies, podcasts and ted talks (e.g. Module 8).

More examples can be found in:

- Module 2: Excursus: Outsiders as witnesses of domestic violence
- Module 3: Various case studies
- Module 5: Sex and gender aspects in risk assessment & Spotlight on Gynaecology/Obstetrics

3.3.2 Key takeaways

By the end of the training course, the participants should be able to

[22] Breninger, B. (2021). A Perceptual Architecture of Intercultural Competence: Avenues for Tracking Cultural Expertise. Newcastle upon Tyne: Cambridge Scholars Publishing.

- Acquire transferable intercultural competence and become culturally responsive
- Define Intercultural Competence and be able to make culture relevant in domestic violence
- Address deeper cultural issues from intersectional perspectives with confidence

4. Training Environment, Selection of Trainers and Training Tools

4.1 How to create a safe space for training?

In adult education, trainers need to use teaching techniques that consider the characteristics of adults, as well as the ways they learn. Adult learners need primarily to believe that they are in an educational environment where there is mutual respect, both between the trainer and the trainees, as well as the trainees among themselves. In addition, they need to feel like active members of the team, whose success depends on everyone's contribution. Finally, everyone needs to be committed to a training "contract", which will be co-decided among the members of the group.

The environment should be **non-judgmental**, **respectful**, and **inclusive**. Open communication and active listening should be encouraged, while ground rules need to be established, to ensure respect and confidentiality. The trainers should use a strengths-based and people-driven approach to uncover the assets their trainees have to offer.

4.1.1 Reinforcement

Reinforcement is a very necessary part of the teaching/learning process; through it, trainers encourage correct modes of behaviour and performance. One needs to use it on a frequent and regular basis early in the process to help the students retain what they have learned, and to encourage them to participate in the learning. Reinforcement includes both verbal and non-verbal behaviour. For example, each time someone participates, regardless of whether the answer is correct or wrong, trainers should thank them for their contribution. This is a powerful form of reinforcement and increases participation quite quickly.

Learners who use inappropriate humour, or display hostility towards discussing the topic of domestic violence need to be heard and encouraged to consider alternate points of view without shutting them out of the conversation. Reinforce their participation, not the negative comments.

The following are suggestions for reinforcement at the beginning of a training session:

- Each time a participant contributes a voluntary answer, give him/her a playing card. As you give out cards, other people will want to receive one, and so will begin to contribute. Continue until each person has at least one playing card. At the end of the session, you can give out small tokens to each person as a reward for their participation, and the playing cards build anticipation as people wonder what their purpose is.
- Reinforcement is also non-verbal. Use open, welcoming gestures to encourage participation. Get excited about contributions to encourage more people to speak. Ask participants to build on each other's contributions.

Trainers who have experienced domestic violence might find it challenging to conduct a workshop on domestic violence. Talking to someone they trust about their feelings beforehand can be helpful. As trainers, it's their responsibility to foster a supportive learning environment where everyone feels encouraged to participate.

4.1.2 How can you prepare as a trainer to talk about domestic violence?

- Be aware of your feelings about violent relationships. Journaling, talking to a trusted friend, or drawing pictures about your feelings will help to release any emotions that otherwise may appear in a workshop and catch you off guard.
- If you choose to share your experiences and opinions, make sure you tell the group that these are your personal ideas. Other people may not share them, and you need to accept this.
- Think about how you may feel and what you might do if someone in the group shares a personal story that reminds you of your own life. Be aware that talking about violence can bring up strong and uncomfortable feelings for you as well as for participants in the training session.
- "Debrief" with someone you trust after the session to talk about your feelings. This could be a friend or family member. Alternatively, give yourself time to go for a walk or write your feelings down on paper.

To deal with resistance and hostility, trainers will need to be open about their expectations for the course. It is critical to explain to participants how the trainer wants them to help create a safe environment for sharing and reinforce that there will be no judging of opinions or points of view. There will be an acceptance that everyone in the group is in a different relationship with this topic and must approach the topic from where they are. Not everyone will change his or her mind within one Module or one week. Instead, the trainer should encourage participants to respectfully debate the issues with each other, using the principles of human rights and the rule of law as guidelines. Violence against partners/family is an intensely personal and emotional subject. If someone becomes angry, withdrawn, sad, or tearful, the trainer needs to have a plan on how to deal with this. For example, you might stop the workshop and talk privately with the person or refer the person to appropriate resources. You will need to be very flexible with the timing of exercises and breaks, being sensitive to the emotional load in the group, but recognise the need to cover a lot of content.

To make the training safe and rewarding, there are some aspects one should consider:

- ➢ **Training shall be voluntary.** There should not be any pressure to participate, for whatever reason, in an educational process as it usually has a negative effect.
- ➢ **The educational objectives must be clear.** The trainer ensures that participants' goals in a training program are clear, realistic, and aligned with their subjective and objective needs. Therefore, it is crucial to assess educational needs before starting a project and discuss educational objectives during the kick-off meeting.
- ➢ **The training program is well organised at all levels**: Often, there is a negative behaviour of the trainees when, despite all the efforts and the quality of the trainers, the program has weaknesses in terms of infrastructure, educational material, secretarial support, fulfilment of financial and/or other obligations to the participants.
- ➢ **The content is directly related to the needs and experiences of the trainees**: The examples and reflection tasks should be closely linked to situations that learners are facing or will face. It is also advisable to give them many opportunities to reflect so that they can use their experiences, processes and learn from them.

- **Active participation in the educational process is gradually encouraged**: Depending on the atmosphere formed, the trainer should gradually leave the ground for initiative and motivate the trainees to actively participate in the learning process.
- **The learning barriers are explored and addressed**: The trainer should assess, with great respect for each individual trainee, the factors that may hamper learning and are inherent in the group for which she/he is responsible.
- **A learning climate** characterised by meaningful communication, collaborative spirit and mutual respect should be attained and serve as the basis for the above-mentioned conditions to work effectively.

Finally, several other elements besides the training environment should be considered as part of the trainer's preparation: the trainer's emotional setup, materials, and learners. Important items to consider can be found in Appendix III.

4.1.3 How to address traumatisation of trainers and attendants of training?

It can be emotional and difficult for people to discuss topics that touch them personally, such as domestic violence. One way of dealing with this is to agree on group norms at the beginning of the course to help shape the discussion. As part of the opening of the workshop, the trainer may want to engage the group in making a list of basic rules to be respected in the workshop. Sample basic rules for discussion:

- Confidentiality of participants will be respected.
- One person at a time may speak. Request permission to speak by raising your hand.
- Everyone is allowed his or her opinion, and everyone is allowed to respectfully disagree.
- There is no obligation to share personal experiences or history with the group. Participants should only do this if they feel comfortable.
- Remind the group that violence can bring up strong feelings of hurt, anger, and despair. These are normal feelings.
- Decide how the group can show support. Have counselling referrals on hand if anyone feels the need to talk to somebody after the course.

It is important to understand that domestic violence can have a great impact on people's lives and can induce secondary trauma. Therefore, it is crucial to develop strategies to manage it and assume techniques on how to avoid re-traumatisation.

4.1.4 How to provide constructive feedback to trainees?

- Be clear and specific with your feedback.
- Use a supportive and positive tone.
- Provide feedback on time.
- Encourage two-way communication and ask for the trainee's perspective.
- Set realistic and achievable goals for improvement.

4.1.5 Self-care of trainers

As a trainer of DV, remember to:

Regularly take time for relaxation and activities you enjoy.

- Maintain a healthy lifestyle, including regular exercise, a balanced diet, and adequate sleep.
- Seek support from colleagues, friends, and family.
- Practice mindfulness and stress management techniques.
- Practice self-awareness to know how you feel.

4.2 How to select trainers for national training?

The major focus in a training program for health professionals for recognition of domestic violence lies in creating a safe place for the completion and sustainability of the training, rather than on its content. Still, the following steps must be taken into consideration beforehand[23]:

1. **Educational Needs Analysis**
   - ➢ Assessment of the training needs of each stakeholder group
   - ➢ Identification of specific skills and knowledge required in each area.
   - ➢ Provision of personalised training and development for trainers, according to needs.
2. **Definition of Trainer Profiles.** Create detailed profiles for trainers, including educational qualifications, experience, and specialisations.

Selecting trainers for national training involves careful consideration of various factors. Trainers need to have the following characteristics:

- **Subject Matter Expertise**: Trainers should have a deep understanding of the topic they will be teaching. It is very important for those delivering the training to be experienced trainers on domestic violence, because of the information provided in the manual which assumes previous knowledge of the subject and presents targeted material specific to the subject.
- **Training Experience**: Trainers should have experience in delivering training and facilitating professional development. They must have at least 1-year experience in delivering training to adult learners.
- **Communication Skills**: Effective communication skills are crucial for trainers. They should be able to explain complex concepts in a way that is easy to understand.

[23] TRAIN-THE-TRAINER MANUAL Checklists, Guidelines and Templates for Active-Learning Workshops, United Nations https://www.unsiap.or.jp/sites/default/files/pdf/tnetwork_1703_tottotmanual.pdf

- **Teaching Methods**: Trainers should be familiar with a variety of teaching methods, be able to adapt their approach to suit different learning styles and be capable of teaching in an inclusive manner of human rights, gender, culture, ethnicity, and diversity.
- **Ability to Engage Participants**: Trainers should be able to create an engaging and interactive learning environment.
- **Understanding of the Training Needs**: Trainers should be able to develop and deliver the training content according to the needs of the learners. They need to familiarise themselves well with the contents of the manual, feel comfortable delivering the content, initiate and manage group exercises and activities as well as be prepared about how to deal with sensitive issues and emotions that may emerge during the training. In some cases, trainees may express traumatising experiences. The trainer should be able to deal with such cases and provide initial support but also be prepared to direct the trainee to more appropriate professional sources of support. Principles of confidentiality should also be applied.

4.3 How to address biases?

Being a trainer in domestic violence requires self-reflection. Before taking on training one must understand, reflect and analyse one's own biases. Not only must this be taught but the trainer must reflect: everyone has biases, regardless of gender, education, or social status. Understanding the origin of biases allows us to explore the root causes and underlying mechanisms that contribute to the formation and perpetuation of biases. Our individual biases are influenced by our systems of thinking and our experiences.

4.3.1 Biases in the context of DV and their consequences

Teaching violence must include gender norms and expectations as they dictate our beliefs. Harmful gender norms have a negative impact on patients who are subjected to violence and may lead to victim blaming and invalidation of the experiences the victim has undergone. These are factors to be considered when training DV:

- The lack of positive (non-violent) masculine ideals in the society
- The lack of marginalised groups in the media
- The objectification of women in general

These are jointly contributing to negative gender norms and biases. Note that harmful gender norms are only some societal norms important to consider in training as there are other norms connected to e.g. sexuality, ability and age. For more insights have a look at Module 1.

Image by Gerd Altmann on Pixabay

4.3.2 Anti-biases strategies

Teaching about domestic violence must also include anti-biases strategies. There are strategies professionals can use in order to care better for the patients or victims of domestic violence. These are e.g.:

- Counter stereotype imaging = work against stereotypes
- Individuation = focusing on the uniqueness of each person
- Contact theory = positive contact helps reduce stereotypes
- Perspective taking = putting yourself in the other person's shoes

Make use of interactive teaching activities to address and allow the learners to understand the strategies. Highlight that by realising one's own biases one can work on changing them.

Remind the learners to counter their own biases:

- One has to accept that everyone has biases
- Understand where they come from
- When proven wrong identify where the mistakes are
- Analyse and reflect on the identified biases and mistakes further.

4.4 Using innovative and interactive training tools in DV training

Innovative and interactive training elements are tools for trainers to help participants access the content, explore the topic, understand key points, and develop their own responses. The chosen training methods should be consistent with the objectives of the training. Thus, trainers need to first define their training objectives and then to be able to choose the best elements to reach those goals.

Important questions to address are for example: the topics you want to cover and time available for doing so, what stakeholder group you are teaching and what training format to use?

Interactive learning elements are well suited for learners to reflect their own attitudes, to get a better understanding of situational context and to improve their communication skills.

4.4.1 Case studies

Case studies are available for all Modules of the training platform including questions to discuss with learners. Case studies can be found on the training platform under training material for the health sector under a given Module. For example see Module 2.

One could also use cases of celebrities **("VIP cases")** to engage learners more emotionally, examples can be found in Module 8, Chapter 4. Celebrity cases presented here are Harvey Weinstein, Donald Trump and Chris Brown.

4.4.2 Quizzes

Quizzes can be used as a self-study tool for your students to test knowledge and understanding of the training. Knowledge assessments can be found on the training platform under training material for the health sector under a given Module.

4.4.3 Role plays

In role play, each participant should identify with their assigned role e.g., Julia (child as victim), David and Lea (parents), and Dr. Anderson (paediatrician). Participants should remain in character and **respond based on their assigned role's perspective.** The role play should progress organically, with participants engaging in conversation and interactions based on the setting and scene provided.

Depending on the size and composition of the group, you have the flexibility to vary the role play scenarios: repeat the role play again using different settings of victims and/or perpetrators. This time, e.g., the victim is David and Lea witnessing the violence, David's physically impaired wife Elisabeth, or David's old father Arthur who lives with him.

What students should learn in this role play?

- They should **understand the dynamics of domestic violence depending on the role and group they belong to**.
- **They should practise empathy and perspective taking** according to their stakeholder role.

First, a setting is introduced, followed by a scene and some initial dialogue to be continued by the learners "**How could the conversation continue at this point?"**. Role plays will end by a reflection session guided by questions e.g. "As Lea, the child, how did it feel to take on the perspective of the witness observing the yelling and shouting?"

4.4.4 Using simulation patients

> "…I wondered if it was a simulated injury or the actress´s reality…"
> (Medical student after the parcourse assessment in surgery)

Using simulated patients (SP) is an innovative educational approach in medical training. Actors who are trained to portray specific medical scenarios and patient profiles realistically are being used. These actors simulate a wide range of medical conditions, symptoms, and behaviours, offering medical students an opportunity to enhance their clinical skills, communication, and empathy.

Why can it be beneficial to incorporate SPs into a curriculum for medical students or other stakeholders from the medical sector when teaching domestic violence (DV)?

- **Realistic Scenarios**: SP can accurately portray victims of DV, presenting various emotional and physical signs. This enables them to learn how to identify and handle potential cases of DV in a safe and controlled environment.
- **Develop trauma-sensitive communication** skills
- **Non-Judgmental Environment**: the setting can provide a non-judgmental space to practise their skills without fear of making mistakes or causing harm. This fosters an atmosphere of learning, ensuring that learners feel more confident when dealing with sensitive issues such as DV.

Information on how to prepare and train SPs for their roles can be found in our VIPROM blog Introducing the Münster simulated patient program (SPP) to teach domestic violence to medical students and professionals.

4.4.5 Blended-learning scenarios

The term blended learning describes a variety of teaching scenarios that all have in common that they consist of a combination of virtual and non-virtual components and is usually a self-directed learning activity. VIPROM also uses this type of tool, where learners can choose from various answers and are presented with a different scenario depending on the answer. Students appreciate this kind of puzzle character.

An example can be found in Module 2: Violence during pregnancy in the spotlight gynaecology/obstetrics.

4.4.6 Key takeaways

- Use teaching techniques that consider the characteristics of adults, as well as the ways they learn
- Create safe spaces for learning; the teaching environment should be non-judgmental, respectful, and inclusive.
- Selecting trainers for national training involves careful consideration of various factors. Preparing for training is crucial, and ought to include the training environment, the trainer itself, materials, and learners.
- Trainers need expertise in the subject and diverse teaching methods for an engaging learning atmosphere.
- As a trainer, one should also practise self-care; seek support from colleagues, friends, and family.

- Develop strategies to manage possible traumatisation of trainers and assume techniques on how to avoid re-traumatization.
- Teaching how to address biases is essential while teaching about DV. It requires knowledge on cognitive biases as well as space and time for self-reflection.
- Interactive learning elements are well suited for learners to reflect their attitudes, to get a better understanding of situational context and to improve their communication skills. The VIPROM curriculum uses simulation patients, role plays, quizzes and case studies combined with guiding questions for reflection as interactive tools. They can be found under training material for the health sector under a given Module.

5. Didactic Tools and Methods in Curriculum Development and Teaching

"Teachers play a crucial role in curriculum development.
Critical steps in the process include needs assessment, goal setting,
content selection, instructional methods, and assessments."[24]

5.1 Essential steps in curriculum development

In order to develop a well-founded curriculum, one needs to start with a needs assessment and define goals (Chapter 1, VIPROM deliverable D2.1), to create and select content (Chapter 2 and Chapter 3), select suitable instructional methods (Chapter 4, and this Chapter 5) and assess the learning outcomes (Chapter 7) to further optimise the curriculum. Most of the steps listed have been presented in the previous chapters.

This chapter introduces **some didactic tools and methods which trainers** can use to reach their goals of teaching domestic violence to learners in an engaging and sustainable manner[25].

5.2 Didactic tools and methods for curriculum development

5.2.1 SMART criteria - defining teaching objectives

The SMART criteria are a powerful tool for trainers to define their learning goals, taking those points into consideration:

- What can the learners already do?
- What should the students be able to do?
- What training formats are needed so that students can do what they are supposed to be able to do?

The SMART criteria serve as a simple framework for the definition of teaching goals, ensuring that they are clear, focused, and practical. Trainers can successfully reach only those teaching goals that meet all 5 criteria.

[24] https://elearningindustry.com/alternative-perspective-on-the-teachers-role-in-curriculum-development

[25] Milan Klement, MODERN DIDACTIC TOOLS AND THE POSSIBILITIES OF THEIR IMPLEMENTATION INTO THE EDUCATIONAL PROCESS, March 2012 Problems of Education in the 21st Century 38(1), DOI: 10.33225/pec/12.39.83; https://www.scientiasocialis.lt/pec/node/files/pdf/vol39/82-92.Klement_Vol.39.pdf (accessed 14 March 2024)

SMART = **S**pecific/ **M**easurable/**A**chievable/Attractive/**R**elevant /**T**ime-bound:

Goals have to be	
Specific:	Goal is clearly defined, is not vague, but very concrete. The W-questions are useful here to ask: "What, Why, Who, Where, and Which?" "What do I want to reach?"
Measurable:	Success of a goal can be measured qualitatively and/or quantitatively "How do I know that I have established my goal?"
Achievable/attractive	Goals may have challenges, but they can be achieved with the materials available- e.g., "How can I reach my goal?" "How can I stay motivated to reach this goal?"
Relevant	The goal is relevant for the learning objectives e.g., "Is this important for the learners to know?"
Time-bound	Goals need a deadline when they can be reached. "Can I reach this goal with the given resources and time-frame available?"

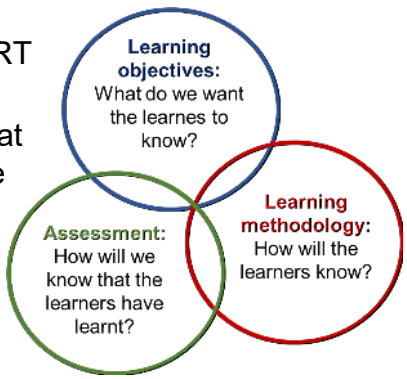
5.2.2 Constructive alignment - higher education for students

"Constructive alignment (CA) is an outcomes-based approach to teaching in which the learning outcomes that students are intended to achieve are defined before teaching takes place." [26]

In short, constructive alignment (CA) is a didactic concept in higher education learning that aims to **align** curriculum planning and teaching methods with learning objectives and forms of assessment. It was developed by Biggs & Tang.[27] The aim is to make the course relevant to the students and be considered as being fair.

If you apply CA as didactic method you need to

- **define** the learning objectives by using e.g., SMART criteria.
- **select teaching/learning activities** (methods) that train knowledge and competences expected in the examinations.
- **select examination tasks and forms** that allow these learning objectives to be meaningfully tested and assessed.



[26] https://www.tru.ca/__shared/assets/Constructive_Alignment36087.pdf
[27] https://web.archive.org/web/20170918084111id_/http://drjj.uitm.edu.my:80/DRJJ/MQAGGPAS-Apr2011/What-is-CA-biggs-tang.pdf

- **inform** learners **prior to the course about teaching objectives.**

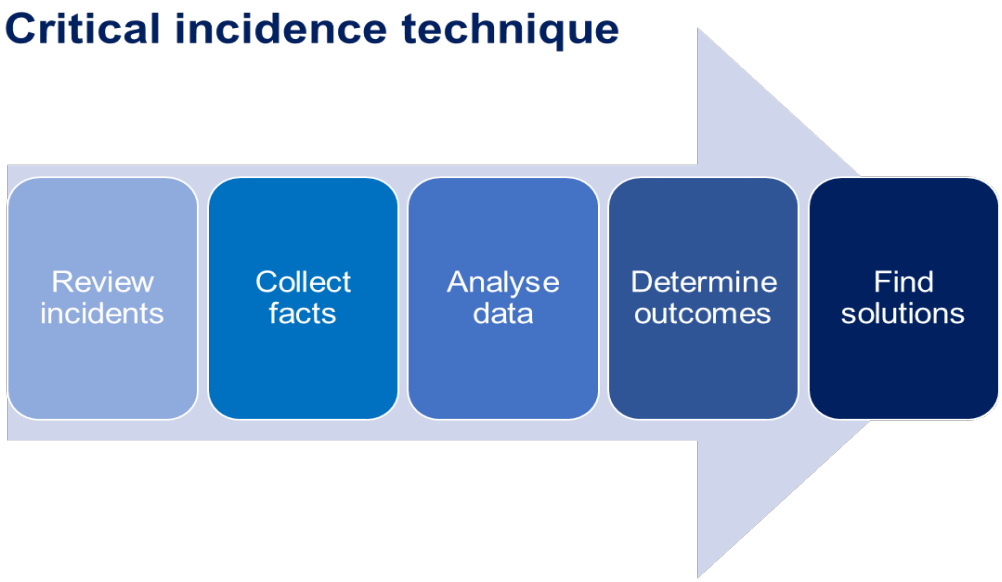
Please take a moment to watch this informative video on CA, which provides a thorough explanation of the concept: https://www.youtube.com/watch?v=OIiDjwLWs4I

5.2.3 Critical incidence technique (CIT) to develop simulation scenes

> "The CIT focuses on human behaviours in natural settings rather than on the opinions of participants about what is critical in human behaviour in specific situations."[28]

CIT is a **psychological interviewing method**[29] that can be used to filter out events that are critical to success, which can then be used to develop simulation scenes e.g., in simulation hospitals or for concrete points of reference for training. CIT was developed in 1954 by John C. Flanagan[30]. **It is useful for direct observations of human behaviour in a structured and comparable manner**.

For example: **where, when and why no further questions were asked by whom in the outpatient clinic** whether domestic violence may have been present/or not accurately documented, etc.



[28] Peltola, M., Isotalus, P., & Åstedt-Kurki, P. (2022). The Critical Incident Technique (CIT) in Studying Health Care Professional–Patient Communication. The Qualitative Report, 27(9), 1868-1889. https://doi.org/10.46743/2160-3715/2022.5580.
downloaded from: https://nsuworks.nova.edu/cgi/viewcontent.cgi?article=5580&context=tqr

[29] Hughes, Hilary, (2008). Critical incident technique. In Lipu, S, Lloyd, A, & Williamson, K (Eds.) Exploring Methods in Information Literacy Research. Centre for Information Studies, Charles Sturt University, Australia, pp. 49-66. downloaded from: https://eprints.qut.edu.au/17545/

[30] Flanagan, J. C. (1954). The critical incident technique. Psychological Bulletin, 51(4), 327–358. https://doi.org/10.1037/h0061470

5.2.4 Overview on the CIT process:

- Expert interviews to **identify requirements for a task or competence**: e.g., documentation of injury of a DV victim in the emergency room
- **Define the critical event**: e.g., Injuries of a DV victim were not documented accurately
- **Listing** of particularly effective or ineffective behaviours:

    - Describe particularly effective or ineffective behaviours.
    - Describe the situation and behaviour as specifically as possible: e.g., "Dr XY demonstrated behaviour B in situation A and solved problem D with the support of person C".
    - What circumstances/framework conditions led to the situation and the behaviour?
    - What exactly was effective/ineffective about the behaviour?
    - What were the consequences of the behaviour?

- **Discussion and categorisation** by an expert group
- **Creation** of the **requirements profile**
- **Implementation in procedures**
- **Development** of a simulation scenario

An example how it could be used in the medical sector can be found in the paper from Peltola et al. who used the CIT to study health care professional-patient communication[31].

5.3 Didactic tools during and after teaching

Several good methods to secure a safe learning environment, how to deal with traumatisation of learners and trainers and how to ensure your well-being as trainers can be found in Chapter 4.1 of this handbook.

5.4 Key takeaways

- **SMART criteria** = Specific + Measurable + Achievable + Attractive + Relevant + Time-bound; only those teaching goals which meet all 5 criteria can be successfully reached by trainers.
- **Constructive alignment** is a didactic concept in higher education learning that aims to align curriculum planning and teaching methods with learning objectives and forms of assessment to make the course relevant to the students and be considered as being fair.
- **Critical incidence technique** is a psychological interviewing method that can be used to filter out events that are critical for a positive outcome e.g., identification of DV victims in the emergency room.
- What makes a great teacher? Please watch this 6 min video: https://www.youtube.com/watch?v=KVLTxKyxioA

[31] Peltola, M., Isotalus, P., & Åstedt-Kurki, P. (2022). The Critical Incident Technique (CIT) in Studying Health Care Professional–Patient Communication. The Qualitative Report, 27(9), 1868-1889. pp. https://doi.org/10.46743/2160-3715/2022.5580.
downloaded from: https://nsuworks.nova.edu/cgi/viewcontent.cgi?article=5580&context=tqr

6. National TTT-Programme

6.1 Why national adaptation and translation of material is needed?

6.1.1 National adaptation

Adapting material developed in VIPROM to national context is crucial for several reasons:

- **Cultural Relevance:** Every nation has its unique cultural context, societal norms, and legal frameworks. Training materials need to be adapted to these contexts to ensure they are relevant and effective.
- **Language Proficiency:** Not everyone is proficient in English, the language in which the original training materials in VIPROM were developed. Translating materials into the local language ensures that the content is accessible for and understandable to trainers and learners.
- **Local Challenges and Solutions:** Different regions face different challenges regarding domestic violence. National adaptation allows for the incorporation of local national challenges and solutions into the training materials.
- **Policy and law alignment:** Training programs need to align with national policies and regulations. This alignment can only be achieved through national adaptation.

6.1.2 Translation of materials

Translating developed materials to the national languages offers several benefits:

- **Improved Comprehension:** Learners can better understand and engage with the material when it is in their native language.
- **Increased Productivity:** When learners do not have to struggle with language barriers, they can focus more on the actual subject matter, leading to a better uptake.

6.2 Key takeaways:

- **Adapting** training material to the national specific contexts makes them:
  - **Culturally** relevant and responsive
  - **Aligned** with national challenges and policies
  - **Accessible and understandable**
- **Translating** materials into the national languages ensures that the content can be used and understood in the respective countries well and is culturally responsive.

7. Evaluations of Trainings

7.1 Training as an evolving practice

As any trainer knows, training is never "done". As contexts – and with them participants' prior knowledge and needs – change, training has to be adapted in order to ensure high quality outcomes. While some of these permanent adaptations are necessarily done on the fly, i.e. as spontaneous reactions to the situation at hand, participants' reactions and group dynamics, some tools can be helpful to assess learning outcomes, to collect participants' feedback in a systematic fashion and to use this data for further improvement. The following section offers some suggestions on how to incorporate assessments and feedback in training of professionals.

7.1.1 The role of assessments and feedback

Chapter 5 of this handbook explained the role of "constructive alignment", i.e. the coordination of learning outcomes, teaching activities as well as assessment and feedback formats, which frame training contents.

Assessments are used to evaluate whether participants reached defined learning outcomes and are therefore an indirect measure of training quality. They are of high importance as they can provide the best approximation for training effectiveness. Yet, especially in the context of voluntary training for professionals, assessments have to be planned carefully and used sparingly, in order not to dampen participants' motivation. Both, assessment exercises that are too difficult and leave participants with the impression that they failed in some way *and* exercises that are too easy and make participants feel that they didn't learn much and are wasting valuable time, can prove devastating for motivation.

On a very general level, a distinction can be drawn between **summative assessments** – i.e. some kind of exercise (e.g. a quiz) at the end of the training – and **formative assessments** – i.e. small(ish) tasks accompanying the training, which are designed to offer insights into the learning process. In adult education the latter is generally preferred as it fits the goal of an "**assessment for learning**" rather than an "assessment of learning."[32]

In contrast to assessments that measure participants' performance vis-à-vis defined learning outcomes, **feedback** methods focus on participants' subjective impression of the training, with their prior expectations providing the implicit standard. There is a wealth of different – more or less standardised – methods to choose from, depending e.g., on group size, degree of formality of the setting, relations between participants as well as between participants and trainers etc. As with assessments feedback can (and even should) be collected at the end of a training, but can also be implemented during the process in order to allow for continuous adaptations.

The distinction between the two approaches notwithstanding **methods for assessment and feedback can often be combined** in order to save valuable training

[32] Bin Mubayrik, H. F. (2020). New Trends in Formative-Summative Evaluations for Adult Education. SAGE Open, 10(3). https://doi.org/10.1177/2158244020941006

time. This also holds true for most of the following suggestions, which were selected based on ease of use and time-efficiency.

7.1.2 What (and how) to ask participants

One key component of getting valuable feedback is to manage **participants' expectations**. Spare a few minutes at the beginning of the training to explain the planned learning outcomes and to gather information about what participants' themselves expect to learn. This includes being honest about unrealistic or inflated expectations – if there are topics that the training cannot cover, one should provide suggestions for further reading or learning materials for self-study (and follow-up on these promises). These first few minutes can also be used to activate participants' **prior knowledge** on training contents, e.g. by asking them how confident they are on a scale of 1-5 that they could spot indicators for DV when dealing with a patient or how often they have already acted on suspicions of DV. If prior knowledge is relatively equal among participants this might help you to tweak your training according to needs, if the group is heterogeneous, you might identify the most knowledgeable participants, who could take the role of co-trainers. Already at this point one general recommendation may be helpful: by always taking notes, trainers can arrive at a more comprehensive picture of participants' needs, preferences, strengths and potential.

In terms of possibilities for collecting expectations as well as prior knowledge the available **tools** have been broadened considerably in recent years. In a face-to-face-setting with a smaller group a simple chart paper and/or sticky notes are often completely sufficient. In bigger groups and online settings, a multitude of digital tools can be used (among many others: Slido, Mentimeter, Kahoot and similar polling tools offer the necessary functions; tools for mind-mapping like e.g. Miro or Mindmeister, as well as Whiteboards, Padlets or just any online pad or text-tool can be used by trainers). Important is hereby only that the outcome can be saved in some way for future reference. One possible advantage of polling tools is that they allow for identification of participants by name so entries can be linked to individuals - this can be used for knowledge assessment at later stages (using full names), but also for fun exercises, e.g. to have quizzes with a winner (using nicknames). But of course in many cases anonymity also has its merits, so the decision whether to have an anonymous poll or a personalised one has to be taken on a case-by-case basis.

While many **methods** of formative assessment are designed for longer courses, there are some simple approaches that can be implemented without using up more than a few minutes of training-time. One method, which has the added benefit of getting participants to reflect upon contents, thereby fostering conversion to long-term memory, is the use of "1-minute-papers". Usually just before a break, learners are given a prompt or question and one (possibly up to three) minute(s) to write about it. Which prompts to use depends on the aim: You can trigger reflection on the contents and assess whether learners got the most important points (e.g. "*What was the most important insight you gained during the last input/exercise/lecture?" "Which questions remain*?"). You can ask participants to draw connections to their everyday work-practices (e.g. *"How will the contents be useful in your daily practices?"*) or stress the feedback-aspect e.g. by asking: *"What aspects of the input/exercise/lecture felt most challenging?" "What parts do you feel unsure about?"* Especially with the last line of questioning, anonymity can be helpful.

The form these "papers" take can vary broadly: If you have a bit more time to spare you can e.g. ask for mind-maps instead of texts and/or let learners work in groups, thereby benefiting from peer-instruction.[33] Especially if your group is big, the latter might be the best choice. And of course, any number of online-tools for mind-mapping and/or (collaborative or individual) text creation might be used, although it is sometimes argued that writing by hand is most helpful for reflection. When picking your tool, make sure that the resulting "products" are immediately available for a very quick review so you can spot possible gaps or misconceptions right away and address them accordingly.

Depending on training methods, it can be useful to implement **peer-feedback** in order to guarantee that all learners stay actively involved (e.g. while some of them perform a role play or simulation). Peer-feedback has to be announced in advance, rules of peer-feedback have to be introduced (Table 7.1) and it is most helpful when peers get a short list of content-specific criteria detailing what to look for in their peers' performance (e.g.: focus on communication including body language; focus on use of language in explanations for patients etc.). Peers might also be tasked with concentrating on different issues, if they are confronted with a complex situation. Of course, general rules for feedback apply:

Table 7.1: Rules for peer-feedback[34]

Giving Feedback	Receiving Feedback
Descriptive (not judgemental)	Attentive
Specific and precise	Take notes
Constructive (future-oriented)	Do not interrupt
Respectful	Don't offer explanations or justifications
Timely	Be mindful of emotional reactions (take time if necessary)
Positive (offer ideas for development)	If necessary, ask clarifying questions at the end

Peer-feedback should ideally benefit both, the person who gives feedback and in their role as an attentive observer often notices hitherto unknown details as well as the person who receives it. The task of the trainer is mainly to safeguard adherence to feedback-rules.

In much the same way as content-specific criteria for peer-feedback are provided, trainers can also develop criteria for **participants' self-assessment**, e.g. fostering reflection after an exercise. Questions might be as simple as *"What felt easy?", "What*

[33] Serious Science. (2014). Peer Instruction for Active Learning. (Video with Eric Mazur). Retrieved 5 March 2024, from https://serious-science.org/peer-instruction-for-active-learning-1136

[34] Table 1: Rules for peer-feedback. Adapted from https://infopool.univie.ac.at/startseite/lehren-betreuen/feedback/peer-feedback/ [accessed 5 March 2024; translation by the authors]

was difficult?", "At which point did I feel I lacked knowledge or preparation?" However, as some participants might be overly self-critical and feel even more insecure after this reflection, it is recommended to use this technique as a preparation for discussion rather than a stand-alone tool.

Last but not least, **quizzes** can be used in a variety of ways – most of which have little resemblance to the multiple-choice exams everyone dreads. The online-tools mentioned above offer possibilities for different kinds of questions (single or multiple choice, open questions, sorting exercises etc.) and include options for anonymous knowledge assessment. While quizzes can of course be used in a fruitful way to assess participants' knowledge by means of factual questions (possibly using gamification elements like crowning a 'winner' for the highest number of correct answers), they can also be used to collect feedback by posing questions about the training itself, e.g. asking about participants' satisfaction or the applicability of contents using a mix of closed and open questions.

Of course – especially in small groups – **feedback** might also be collected in person, in which case it might be worth thinking about providing an alternative anonymous way for participants, who don't feel comfortable speaking up. One way of collecting minimal feedback, which can be implemented at multiple times during a training (e.g. before each break) consist of a simple line of emojis, ranging from exhilarated to deeply sad, where participants put a pin or post-it to the respective emoji when they are leaving the room; see image below. This simple method gives both trainers and participants an impression of the general mood without taking up time or breaking the rhythm of the training. As different participants will have different preferences, it is always good practice to mix and match different methods.

Image by Subham by Pixabay

7.1.3 Knowledge assessment for students

Knowledge assessment in institutions of higher education is a specific setting as the assessment includes a decision on students' further progress in their studies. Depending on curricula, participation in a training/course might be mandatory for students, which can lead to extrinsic motivation - i.e. good grades - playing a bigger role than for adult participants taking part in a training voluntarily. Teachers/trainers might be bound by organisational rules, e.g. mandating a final exam (i.e. a summative assessment) rather than allowing for a formative assessment to determine grading. Still, many of the principles outlined above can apply.

Most importantly, even if grades depend on a final exam, **aspects of formative assessment** (e.g. 1-Minute-Papers, quizzes, peer-feedback and self-assessment…) can still be included in the course as they help teachers / trainers as well as students to develop a good sense of where they are on their learning journey. In case your course allows for formative assessment for grading the whole toolbox is at your disposal, including i.a. the possibility to include multiple quizzes in your lectures, to ask students to write essays or reflection papers, have them prepare presentations etc. Many of these tasks can be done alone, in pairs or as a team and it is of course good practice to have a great variation in forms.

In case you're bound to hold a **final exam**, constructive alignment will offer the guidelines to help with that. Just as you asked yourself which learning / teaching methods to use in order for students to reach the desired learning outcomes when designing your course, you can now ask yourself how to assess these learning outcomes in a meaningful way. While it is viable to ask students to simply repeat some of the most important contents they have learned about in the course (e.g. to explain the "cycle of violence" that is often seen in cases of DV), the main focus should be on applying knowledge to problems, e.g. by working through a case study. This approach gives students a chance to show that they understood rather than just memorised the contents and that they can work with what they learned (it also has the added benefit of making most forms of cheating unfeasible). Depending on the setting (on-campus, online, group size etc.) cases or other inputs which students need to work with can be presented in different forms (e.g. as text or video).

No matter which type of exercise(s) students have to complete it is of utmost importance that the description of tasks and questions are absolutely clear and on-point. Especially final exams, which only provide a one-time picture of students' knowledge and are necessarily limited in the diversity of methods by time and organisational constraints, need to be designed carefully in order to mitigate adversarial effects on students, who face language-barriers, disabilities or other issues. In some cases, providing an alternative form (e.g. offering an oral exam instead of a written one) might be necessary.

7.2 Key takeaways

- Assessment and Feedback are an integral part of training design and should be planned as carefully as learning outcomes and training methods
- Especially with adult learners and professionals' formative assessment and feedback methods should be used to evaluate and evolve trainings ("assessment for learning", rather than "of learning")
- Take notes
- Methods for assessment and feedback are plentiful and don't need to be complicated or time-consuming to be effective
- Online-tools can be fun to use, but they are not a prerequisite for good practice
- Trust learners and include them in assessment-methods – e.g. via peer-feedback, peer-learning or self-assessment
- Use mixed methods

8. Appendices

Appendix I: Possible training formats

Training format	Target group	Pros	Cons
Workshop/Seminar on specific topics	• Medical professionals (e.g., physicians, nurses) • Students	• Interactive learning • Fostering empathy	• Requires structuring and qualified trainers
Lectures	• Medical professionals (e.g., clinic staff, hospital) • Students	• Easy to organise • Reach large groups • Time-efficient	• Low interaction • Limited motivation
Role plays/ Simulations	• Medical professionals (e.g., emergency room staff, physicians, nurses) • Students	• Develop practical skills (e.g., communication with victims)	• Some may feel uncomfortable; resilience of participants needed • Quality dependent (e.g., can foster biases)
Online Webinars/E-Learning	• Medical professionals • Students	• Flexibility • Learn at own pace • Easily updated	• Limited interaction • Challenges to assess understanding • E-learning: additional webinar in larger groups necessary afterwards
Group discussions/Case studies	• Medical professionals • Students	• Knowledge exchange • Critical thinking • Analyse realistic scenarios	• Requires moderation • Some may hesitate to share personal experience

Self-reflection/Journaling	• Medical professionals • Students	• Encourages long-term changes	• Time consuming • Self-motivation required
Multi-professional workshops/seminars (e.g., mix them at a second level)	• Medical professionals • Law enforcement personnel/Legal professionals • Students	• Enhances collaboration • Practical experience	• Requires coordination with multiple professions
Specialised training formats (e.g., trauma informed care, paediatric, forensic evidence collection, cultural competence	• Medical professionals (e.g., paediatricians, paediatric nurses, forensic nurses) • Students	• Focuses on specialised content • Enhances sensitivity	• May require (significant) training • (Highly) specialised training • Group dynamic knowledge of the trainers necessary

Appendix II: VIPROM Train-the-Trainer program on DV-Trainings

Proposed duration: 1,5 days

Overarching goal:

- Implementation of didactic concepts on teaching domestic violence (DV), its identification, documentation and communication within the health sector for trainers.

Preparatory work prior to course:

- Please explore the VIPROM homepage and test the training Modules.
- Please explore in advance Module 8 on stereotypes and bias.

Timeline	Contents	Methods used
Day 1		
1h	Introduction and creation of a safe space for participants of the TtT-course	Group discussion, setting the framework
30 min	Reflection on how to create a safe setting for participants of trainings	Maslow, Chatham House rules, Framework
15 min	Short coffee break	
1,15 h	Introduction of training platform	Interactive input
1h	Lunch break	
1h	Simulation setting	Experiencing
1,5h	Feedback simulation	
1h	Self-care and self- support	Input and exercises
30 min	Reflection and wrap-up day 1	
Day 2	**Contents**	**Methods used**
45 min	SMART criteria and constructive alignment	Input
45 min	Critical incidence technique (CIT)	Group discussion
15 min	Short coffee break	
1h	Feedback rules to students and structure	Input and tridem exercise
45 min	Planning my own curriculum	
15 min	Wrap-up, farewell	

Appendix III: Preparing for a training

Several different elements should be considered as part of the trainer's preparation, including the training environment, the trainer itself, materials, and learners. When we train, we need to prepare:

- **Us**: Are we familiar with the teaching material? Do we need notes? Do we have enough time?
- **Our Equipment and Materials**: Trainers are invited to utilise the educational material by applying active educational techniques of experiential character that activate the self-directed learning of learners, leading them to enhance the climate of self-evaluation / self-reflection of their own behaviour and attitude. There is provision of the special educational manual for trainees to be distributed to all participants. It would be appropriate to distribute the manual at the beginning of the training process for the trainees to have the opportunity to study it and express possible questions or disagreements. It is also important for trainers to have the opportunity throughout the training to use various sources (e.g., images or videos) using printed or digital audio-visual material in the present time (e.g., online). Therefore, in a well-equipped room there must be a computer with a projector and internet connection, a whiteboard and a paper board with markers, stationery (reference adhesives, pens, coloured cardboard, fasteners or pasting material, etc.). Is everything available as promised and in good working order?
- **Our Training Area**: The available space, its layout, and the equipment available must be specifically provided. Specifically, a room of 35 m^2 is enough to meet the needs of 12 trainees and one trainer (including the auxiliary space and the area where the trainer will move). We must consider that in several phases of the training, trainees will be asked to work in groups or to implement a role-play exercise. In addition, trainees are suggested to sit close to each other, as comfortably as they can, utilising collaborative shapes (e.g., semicircle or Π arrangement), so that direct visual contact and communication-cooperation between them are possible.
- **Our Trainees**: Have arrangements been made to have their work duties fulfilled in their absence? Is this the right time for them? (e.g., not during their lunch break)

Delivery steps checklist:

- List all set-up requirements beforehand and make sure someone oversees the provisions. These include a laptop, projector & remote control, easel and flip chart, copies of training materials, tent cards for learners' names, enough tables, and chairs, etc.
- Get to the training room an hour early to set up the room, test the equipment, and make sure all materials are organised and ready to use.
- Obtain the phone number of the venue's technical support team in case a problem arises during the day.
- Find out how to operate the room lighting and adjust the room temperature.
- Confirm arrangements regarding break times and lunch with the provider, if appropriate. Locate and check the restroom facilities.
- Greet participants and welcome them as they arrive.