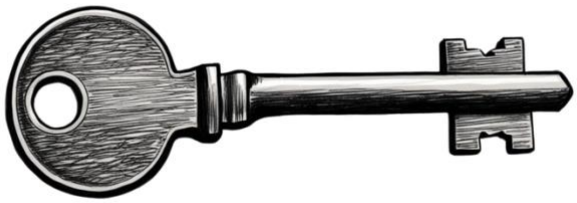
Deliverable 2.2: Case Study Report on Key Factors for Successful Organisational Change



Victim Protection in Medicine

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

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About this document

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No.	Acronym	Institution	Country
1	VICESSE	Vienna Centre for Societal Security	Austria
2	IKF	Institut für Konfliktforschung	Austria
3	GES	GESINE Intervention (Frauen helfen Frauen EN e.V.)	Germany
4	UU	Uppsala Universitet	Sweden

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Abbreviations and acronyms

ENT	Ear-Nose-Throat
DV	Domestic Violence
D	Deliverable
GÖG	Gesundheit Österreich GmbH (National Public Health Institute Austria)
IMPP	Institut für medizinische und pharmazeutische Prüfungsfragen (Institute for Medical and Pharmaceutical Examination Questions)
IP	Interview Participant
KAKuG	Bundesgesetz über Krankenanstalten und Kuranstalten ("Federal Act on Hospitals and Rehabilitation Facilities)
ER	Emergency Room
NCK	The National Centre for Knowledge on Men's Violence against Women
NKLM	Nationaler Kompetenzbasierter Lernzielkatalog Medizin (National competence-based learning objectives catalogue for medicine)
NKLZ	Nationaler Kompetenzbasierter Lernzielkatalog Zahnmedizin" (National competence-based catalogue of learning objectives in dentistry)
OSG	Opferschutzgruppe (Victim Protection Group)
PCI	Problem-Centered-Interview
UKÄ	Universitetskanslersämbetet (Swedish Higher Education Authority)
WP	Work Package

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1. Executive Summary

Hospitals and clinics are important first points of contact for victims of domestic violence, and medical staff, therefore, often engage with victims in their role as front-line responders. Although this is the case, the implementation of victim protection measures, such as staff trainings or the professional care for, and support of, victims, is often based solely on the commitment of individuals with a high degree of intrinsic motivation. In contrast, the organisational framework for domestic violence interventions is often lacking. A solid organisational framework would not only relieve some of the burden on employees involved in victim protection, but also contribute to the sustainable implementation of victim protection measures. After all, measures that are borne solely by a small circle of individuals are at risk of ending with the withdrawal of these individuals.

The *VIPROM* project addresses this issue in task 2.3 by identifying the key factors contributing to the sustainable organisational uptake of good DV training and intervention practices in the medical sector. This Deliverable (D2.2) summarises the factors and practices that contribute to the sustainable implementation of victim protection measures within medical organisations. To this end, the VIPROM project conducted 9 case studies of medical organisations (hospitals and medical training centres) across three countries (Austria, Germany and Sweden). A total of 21 interviews were conducted with employees at various levels (from management to ground-level practitioners), all of whom are involved in one way or another in victim protection within these organisations. Based on the national analyses of these case studies, a country comparison was undertaken, revealing some of the factors that reinforce the sustainable implementation of victim protection measures.

Among the less surprising findings, the results of the study reaffirm the fact that sustainable implementation requires sufficient resources, particularly in terms of personnel, time and funding. In this respect, it is important to note, however, that additional resources cannot only be provided by making new funds available. Rather, by understanding victim protection as a task of the entire organisation, the circle of committed and contributing employees can be enlarged through internal networking and cooperation. In addition to classic resources, however, it also requires sufficient recognition of work done in relation to victim protection. Ideally, this recognition should be formalised, for example, by recording victim protection work in existing time and performance tracking systems. Another important point concerning the sustainable uptake of measures, is the progression path and timing. Sustainable, realisable measures arise from practice. They can hardly be prescribed top-down, but must be taken „bottom-up" and be disseminated at the right time, for example with the framework of already planned or ongoing organisational reforms. Organisational management and policy makers are therefore required to "keep their eyes open" and to take up existing good practices and create framework conditions for their implementation, e.g. a legal basis. At the organisational level, it is also important to consider that implementation cannot be driven by every type of actor. Rather, it requires people who, due to their role in the organisation, have a sufficient degree of intra-organisational agency to anchor the topic in the organisation's consciousness.

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Yet, even those actors rely upon formal and informal practices, such as a network of allies or regular meetings between middle and senior management staff. To foster the sustainable implementation, these practices have to become part of the organisation's structure. Finally, sustainable implantation involves the strategic positioning of the topic in the formal organisational structure. Ideally, these positions are visible both externally and internally.

The findings summarised in this report are aimed at both practitioners and policy makers. Although the aim of the cross-country analytical approach was to minimise country and culture-specific aspects of the sustainable implementation, readers are to be reminded that the factors presented here are linked to specific national and cultural characteristics. Much can, therefore, be gained by also reading the findings of the national reports alongside the comparative and summarising analysis presented at the end of the deliverable.

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2. Introduction

The VIPROM project: “Victim protection in medicine: Exploiting practical knowledge of medical staff to enhance the multi-professional contact with victims of domestic violence” has set itself ambitious goals, namely the development and implementation of training modules (medical curricula) specifically tailored to the needs of medical and healthcare professionals in five countries (Greece, Austria, Germany, Sweden and Italy) to provide appropriate and responsive support to victims of domestic violence (DV) in clinical settings. Medical and healthcare professionals play a significant role in improving the health and safety of victims through early identification, adequate care and referral to specialist victim support services.

In a first step, the project consortium conducted a needs assessment (see Deliverable 2.1 “Stakeholder needs assessment”) to map the general DV-sensitivity, expertise, and related victim protection measures (such as modes of identification, interventions, documentation and referral procedures) among the medical community in the five participating partner countries (Greece, Austria, Germany, Sweden and Italy). The aim of D2.1, was to identify cross-cutting challenges and needs for the sustainable development of DV-trainings to be conducted within the medical sector relating to stakeholder-specific needs (focussing in particular on the following professional groups: physicians, nurses, medical students and midwives).

In a next step, which was carried out as part of work package 2 (WP2), the project team aimed to **identify existing good practices for successful implementation of victim protection measures in medicine**. Deliverable 2.2 “Case study report on key factors for successful organisational change” (short: D2.2), developed in Task 2.3, represents **three case studies** of such good practice examples of sustainable organisational uptake of DV training in medical education in Sweden[1] & Germany and victims protection measures in hospitals in Austria. The research identified key factors in all three case study sites: Austria (AT), Germany (GE), and Schweden (SE) that contribute to sustainable organisational adoption of good practices in DV education in the medical sector. The case studies in **Germany** and **Sweden** focused on existing **domestic violence training for medical students** (GE) and **nursing programs** (SE) to identify key factors (and challenges) required (or removed) for successful accreditation of DV education in medicine (and particularly clinical settings). The **Austrian** case study identified **factors contributing to the sustainable implementation of Victim Protection Groups** (in German: Opferschutzgruppen) as internal competence centres for DV in hospitals. A summary of the key factors identified is compiled at the end of this report (Chapter 5 & 6) and further elaborated in the VIPROM Roadmap (T6.3). The latter aims to aid in the development of strategies for a sustainable organisational embedding of the training curricula developed by VIPROM (in WP3) in all partner countries, as well as providing a blueprint for future implementations in the further European member states beyond the project runtime.

[1] Sweden was not originally planned as an individual case study, but was included at the first kick-off in Münster (February 2023), as the project partner NCK has been conducting DV training for medical professionals for quite some while and therefore can be considered as good practice example and has produced valuable insights for the project.

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The present report is organised in 6 chapters: Chapter 3 describes the social science methodology used over the course of D2.2, including the research design and questions proposed by the work package leader VICESSE, and following the agreement that led all three partners to conduct multiple case studies (three cases each) in their countries. Detailed descriptions of the case studies including the number and type of interviews, are described in the individual country reports (Chapter 4). The three individual case study reports present the research carried out in the respective country, based on three common dimensions and each concluding with key factors that were decisive for successful and sustainable implementation in these case studies. However, these can also be seen as central points of reference or guidance for other countries or medical institutions seeking to sustainably embed victim protection in medical education and clinical settings. However, despite European member states sharing some common frameworks on DV-response (such as, 'The Victims' Rights Directive; Directive on combating violence against women and domestic violence), the national and institutional specificities make the development of a uniformly applicable approach improbable and impractical. Instead, the following document aims to identify structural factors and approaches that can be adapted to specific national settings and through which different medical institutions might learn from successes or challenges experienced during the implementation processes in the cases described. The key factors identified below should, therefore, function as a strategic aid and as inspiration of adaptations to local conditions and needs. Chapter 5 and 6 cover the key findings and main conclusions for organisational measures that may enable a sustainable embedding of victim protection measures in medical institutions (hospitals, universities, clinics) to improve patient care for these special patient groups.

3. Methodology and Research Design

As leader of WP2, VICESSE employed an iterative and collective approach, leading the participating partners in the joint development of a shared research design. Initially, a basic methodology was proposed by VICESSE and discussed among all three participating partners, culminating in a common research approach on which to base a comparable data collection process and analysis method. Developing and employing a research design template intended to collect possible nationally specific approaches and constraints, a shared working document was drafted outlining a **common research design** and structuring the consensus reached between the partners on the **key issues** relating to:

i. Formulating a **common research question**.
ii. Translation of the research question into a country-specific research problem that can be addressed using **qualitative research instruments**, such as interviews.
iii. Detailed description of the methodological approach, including the criteria for participant selection and description of the recruitment method, justification of the data collection method, detailed documentation of the data collection process, documentation of the data processing and description of the analysis method.

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This collaborative approach yielded the shared decision for each partner to **conduct three separate case studies per case location**, **enabling a comparative approach both within, and between national settings** and revealing nuances and differences valuable for a more thorough understanding of the national approaches in general, and how they manifest in practice. In **Germany**, **three medical universities** that include DV training were studied, while in **Sweden** a similar study was conducted relating to **three nursing programs** that include DV training at different universities. The **Austria** case studies, in turn, compared the activities and organisation of so-called ***Victim Protection Groups*** **in three different hospitals**. The Austrian case study therefore differs from those in Germany and Sweden. Thus, it is not medical education or training programmes per se that are being investigated, but intervention measures implemented in the hospital context. However, as a key task of these Victim Protection Groups is the training and awareness-raising of colleagues in the sense of "peer-to-peer training" the Austrian case study matches with the overall concept of VIPROM. Hence, by providing insight into further and advanced training of health professionals the Austrian perspective complements the case studies from Germany and Sweden on the implementation of DV training in basic medical education.

Based on the shared **multiple case study approach** (nine case studies in total**)**, partners individually selected suitable interview partners among professionals, who ideally were responsible for conducting the training courses and/or were members of Victim Protection Groups.

3.1 Research Question

The focus of T2.3 was on revealing organisational factors that contribute to the sustainable (i.e. long-term) implementation of DV training and other victim protection measures in clinical settings. Measures were understood to be sustainable if they:

- Do not depend exclusively on the commitment and motivation of individual actors within an organisation.
- Are formally anchored either at the meso-level, i.e. the organisation itself (e.g. in the form of a compulsory course within a curriculum) or at the macro-level (e.g. in the form of legislation).
- Have a certain degree of differentiation within the organisation, e.g. they have their own (physical or digital) infrastructure, financial resources, employees, etc.

Organisational factors and conditions encompass a broad range of structural and practical elements that shape the “functioning” of an organisation and its processes. Several considerations guiding the collaborative case study approach to identify such organisational factors are listed below:

- A central factor relates to the **formal structure and legal form of the organisation** (e.g., public body/governmental authority, etc.). Studying these structural dimensions

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encompasses the investigation of: degree of autonomy of the organisation, e.g., in the use of financial resources or in setting the organisation's goals and priorities; internal decision-making hierarchies; external accountability to public stakeholders; definition and way of measuring performance indicators; self-perception of the organisation's role in society (also with regard to combating DV); importance of victim protection measures for the organisation's public and political profile and for the provision of public funds; general financial situation of the organisation.

- Another important aspect is the **historical process of the development, initiation, implementation, and long-term maintenance** of the respective measures. In addition to formal aspects such as the legal anchoring of measures, it is also important to shed light on intra-organisational factors. Who was responsible for the implementation and to whom was this responsibility assigned (top-down, bottom-up or a mixture)? Who became an intra-organisational stakeholder, why and with the approval/support of whom?
- More specific questions further focused on the **positioning and practices of the intervention,** and the people who manage it within the organisation. This factor covers questions such as: Are the people managing the program permanent employees? Do they work full time? Does their work in the program count towards their regular working hours? Are these people in management positions or not? How much decision-making power do the people in question have in designing the program? To whom are these people accountable/responsible for the "functioning" of the program? Is participation in the program in question mandatory or voluntary for other employees/people in the organisation? What are the advantages and disadvantages associated with participation?

These key dimensions further structured the individual interview guidelines and the respective country reports.

The *guiding research questions* adapted by each participating partner for the national case studies were:

1) How and what local institutional conditions are necessary for the sustainable implementation of DV training and victim protection measures in medical settings (educational institutions and hospitals)?

2) What can be learned from the experiences (constraints and enablers) of actors in the case studies for future initiatives in medical institutions despite local specificities?

3) Which key factors can be identified that can contribute to the sustainable uptake of DV-Training in European medical institutions?

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3.2 Sample, Data Collection and Interview Method[2]

3.2.1 Austria

In Austria, **three hospitals** were selected in different regions, namely western, northern, and eastern Austria. **Two of these were public and one was a private hospital**. The hospitals were selected on the basis of informal discussions with stakeholders from the field of victim protection, who referred to the long-standing existence of Victim Protection Groups in these hospitals and their good implementation. In total **8 interviews** were conducted, two at each case site and two context interviews. Within the hospitals, the aim was to interview at least one person, ideally from the **management team** of the victim protection group, as well as one person from the **hospital management**. The two context interviews were conducted to analyse the strategic "top-down" perspective on the implementation of Victim's Protection Groups in Austria. On the one hand, we interviewed two staff members of the *Gesundheit Österreich GmbH (GÖG)*. The GÖG is the Austrian National Public Health Institute and responsible for researching and planning public healthcare in Austria. Currently the GÖG is commissioned with the evaluation and support of OSG implementation in Austrian hospitals. On the other hand, we interviewed a senior staff member from the responsible ministry.

3.2.2 Germany

In Germany, partners from GESINE conducted interviews with members of **a public medical university, a private university with a medical faculty and a teaching hospital**. Cases were chosen in order to investigate different degrees of implementation and the factors that contributed to this. Thus, whereas in case DE-A a mandatory course on DV is integrated in the curriculum, in case DE-B the DV teaching module is an elective subject. Case DE-C is a medium-size, privately funded teaching hospital in a rural area of Germany. This case has the weakest implementation, as there is no dedicated class or training module, but knowledge and skill transfer on DV are loosely integrated into the training and teaching on other subjects. Three interviews were conducted in cases DE-A, two interviews in case DE-B, but only one interview in case DE-C, as the other interview partners refused to participate. In total, therefore, **6 interviews** were conducted with those responsible in the areas of university teaching, research and medical learning and training centres.

3.2.3 Sweden

In Sweden, **two universities and one college** in different regions of Sweden were selected. Each of these institutions offer a nursing programme. One of the universities is one of

[2] For better readability, the individual country reports are not included in their full length in this website version of the D2.2 report. It only includes each national context in which victim protection measures and/or teaching programmes of DV are embedded; an overview of the participant sample as well as the main conclusions of each case study analysis.

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Sweden's largest and oldest, while the second is a smaller and younger university. The college is also relatively young. The universities/colleges were chosen because they have existed for different lengths of time, and therefore have had the nursing programme for different durations. Furthermore, their organisational structures and associated organisational culture can be assumed to work in slightly different ways depending on whether they have old, i.e., centuries-old traditions or have been created in modern times. In total **7 respondents** were interviewed across these three locations, four of the respondents were chairs of the nursing programmes committee or/and as the programme director of the nursing programme (organisation management/CEO/Director). The three remaining interview partners are lecturers who have been teaching for several years, one of which is also a course coordinator.

3.3 Interview Method

All three partners employed the method of ***Problem-Centred Expert Interviews*** *(PCI)* (Witzel & Reiter, 2012) as a common approach for data collection. The concept of problem centring refers to the process of problem identification. This identification takes place during the design of a research project as well as its implementation and especially during the interviews themselves. In the present case **problem centring refers to the identification of the conditions for an organisational uptake and the sustainable implementation of victim protection measures**. A methodological characteristic of the problem-centred interview is that it encourages researchers to critically incorporate existing prior knowledge and expertise gained from literature or previous research into the interview. This methodically facilitated the integration of the results from D1.2 into the research design of D2.2. In addition to the open-ended, narrative-generating introductory questions that are also part of the PCI, such prior knowledge is used to formulate questions and then discuss them in a dialogue format between participant and researcher. The aim of the PCI is both, to generate longer narrative passages (in this case, for example, about the implementation history of the various measures) and to deepen, contrast and critically discuss specific questions that have arisen, for example, in previous interviews. **A joint methodology workshop was held on 21 December 2023 for the purpose of interviewer training**.

The interviews were conducted on the basis of a **semi-structured guideline**. Due to the different case studies, a common development of the instrument would have been counterproductive. Instead, all partners were free to develop the guidelines themselves. Nevertheless, in order to ensure a certain degree of congruence in terms of content, the research questions, which were developed jointly for the research design, served as orientation for the thematic structure of the guideline.

3.4 Analytical procedure

The shared approach for the subsequent analysis of the interview data generated, followed a common approach of reflecting initially on (i) the general background of each specific case of

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DV training, accreditation, or activity conducted by Victim Protection Groups. (ii) Partners described the selection of case locations and interview partners, and further reflected on the possible influence of the sample selection on the results generated. (iii) Each partner provided a descriptive analysis of their key insights into contributing factors for sustainable uptake in organisations. The exact form in which the descriptive results were presented (e.g., with or without the inclusion of quotes) was left to the respective partners themselves. (iv) Finally, key exploitable factors were listed, summarising key take-aways regarding the central factors relevant for other partners/countries intending to implement similar practices.

Chapters 5 and 6 of this deliverable consist of a summarising analysis of all key factors identified across the different country reports. Differences and similarities are taken into account to distil the central factors that may prove useful for the development of nationally specific implementation strategies of DV-measures. Factors identified in each national case study setting that exhibit similarities are interpreted to have potentially greater success across different institutional and national settings. These factors are assumed to be most fundamental when addressing the development in nationally specific implementation strategies. Beyond common factors, specific insights unique to different case studies may prove to be valuable for the implementation of DV-measures more similar to a specific best-practice case study. In this way, **key takeaways for the accreditation process, for example, may be found in the German or Swedish case studies**, while strategies for the **implementation of internal competence centres in hospitals may be derived from the Austrian case study**. As such, the key findings of this deliverable can be used both for an overall, or targeted strategy, to implement DV-Training in general, or implement more specific models. As we will show, central factors for sustainable implementation of DV-training in medical institutions tend to exist across all cases studied. The necessity for the provision of resources (temporal and financial) by medical institutions crop up as often as the centrality of work conducted by motivated individuals. Deeper structural and strategic insights into the specifics of accreditation in the German case studies, or the challenges of time-management in internal DV-competence centres as examined in the Austrian case studies are highly informative but may be more relevant for initiatives attempting to adopt these best-practices in new institutional or national settings.

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4. Country Reports

4.1 Austria - Sustainable Implementation of Victim Protection Groups

4.1.1 National Context

The establishment of Victim Protection Groups (*Opferschutzgruppe – OSG*) was enshrined in the "*Bundesgesetz über Krankenanstalten und Kuranstalten*" ("Federal Act on Hospitals and Rehabilitation Facilities", KAKuG, §8e) in 2011[3]. The law stipulates that via the provincial legislation the public providers of hospitals must set up Victim Protection Groups for people affected by domestic violence in the respective hospitals. The KAKuG stipulates that through provincial legislation ("*Landesgesetze*"), the regional hospital operators ("*Trägerorganisationen*") must ensure that Victim Protection Groups for victims of domestic violence are set up in hospitals. This includes all hospitals that provide acute care, which refers to all public general hospitals in Austria. In contrast, Victim Protection Groups do not have to be set up in sanatoriums or care institutions for people with chronic illnesses. The need and impetus for the legal establishment of Victim Protection Groups certainly came from practice, as medical facilities are often the first point of contact for victims of domestic violence. For this reason, many clinics were already making efforts in the area of victim protection before the law was passed. However, the lack of federal policy efforts and legal regulations led to criticism from women's organisations, women's shelters and violence protection associations, who argued a lack of commitment on the part of the government.

According to the KAKuG, the Victim Protection Groups are responsible in particular for the **early detection of domestic violence and for raising awareness among the relevant professional groups in the hospital**. The KAKuG further stipulates the minimum requirements for the composition of the OSG. Accordingly, a Victim Protection Group must include at least two representatives from the medical service, as well as a member of nursing staff and, if available, representatives from trauma surgery, gynaecology, obstetrics and the psychological/psychotherapeutic department. Hospitals in which the child protection groups, which have been required by law since 2004, take on the tasks of the OSG are exempt from this regulation. Additional requirements regarding the composition, organisation and tasks of the OSG may be contained in the various provincial laws.

Despite the long time since the law came into force, there are currently **no definitive figures on the degree of implementation**, i.e., it is unclear how many of the hospitals that are required to set up an OSG have already done so and to what extent and in what form. A research project on the degree of implementation of OSGs is currently conducted by the Health Austria GmbH (*Gesundheit Österreich GmbH* – GÖG). The GÖG is a research and

[3] BGBl. I 69/2011; latest version: BGBl. I 79/2022.

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planning institute for the healthcare system, the competence and funding centre for health promotion in Austria and is owned by the federal government. In a context interview (see Methodology subchapter) conducted with GÖG employees, the degree of the OSG implementation in hospitals was estimated at over 95%, although large differences in practical implementation can be assumed. One reason for this situation could be that the legislation does not provide financial resources for the establishment and operation of Victim Protection Groups. As far as can be seen from the relevant parliamentary materials on the legislative process at the time, OSGs were intended to operate on a cost-neutral basis, as they were not meant to be a formally organised unit in the hospital, but rather a loosely organised intervention team for "case-specific" cooperation between different professional groups.[4]

In practice, the **main task and aim of the OSGs concerns the training and awareness-raising of relevant hospital staff on the topic of domestic violence**, so that colleagues in medical, nursing, psychological and other relevant departments know how to recognise injuries related to DV; how to address the issue and discuss them with patients; how to document injuries in a way that can be used in court, as well as to inform about available organisations victims can or should contact. In addition to training colleagues, OSG members are also responsible for counselling victims and producing information material for patients, e.g., in the form of posters to be displayed in hospitals, flyers, business cards, information on the website, etc. Other activities that are of practical importance but are not required by law include networking activities with other OSGs and other front-line responder organisations, such as the police, violence protection centres, women's shelters, etc.

The Victim Protection Groups, as they exist in Austria, are a unique feature in Europe and represent an important institution for improving the protection against domestic violence in the medical field and could inspire other countries. Against the background of the objective of Task 2.3, namely the identification of sustainable implementation of DV protection measures of victim protection in the medical field, the varying degree of implementation in Austria had to be taken into account when selecting the cases. Each of the three selected cases have a different history of development based on differing implementation strategies. The descriptive comparison of these cases highlights the advantages and strengths of different forms of implementation, but also the weaknesses and risks associated with each of these forms.

4.1.2 Overview of participant sample

Across the three cases in Austria, we interviewed **six participants**. In case AT-A we interviewed one member of the hospital's medical management team and the head of the Victim Protection Group. In case study AT-B the sample included one member of the leadership team of the victim's protection group and coordinator within the regional hospital organisation ("*Trägerorganisation*") who is responsible for the strategic management of the regional implementation of victim's protections groups across all regional hospitals. For case

[4] 1200/RV 24. GP 2.

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study AT-C, where there is currently nobody leading the OSG, we interviewed the former head of the OSG at the hospital. The second interview was conducted with the head of the psychology ward who is a long-standing member of the OSG. In addition, we interviewed two staff members of the Austrian National Public Health Institute and one senior government official who is tasked with overseeing the strategic development of the OSGs across Austria. Interviews were conducted between 17th of January and 25th of March 2024 and last on average one hour.

4.1.3 Conclusions: Synthesis and Key Exploitable Factors for Sustainable Implementation

- The development of effective victim protection in hospitals (OSGs as internal competence centres for victim protection measures) needs some sort of **consistency and commitment** from the hospital management and the OSG members in order to carry out and develop their work in relation to services for DV patients, but also for their colleagues in form of offering **trainings and counselling**. Thus, effective victim protection in hospitals **requires resources** (the way in which this is ensured may vary, but in any case, it requires time and money) and should be part of a hospital's policy.

- The **location of the OSG among the highest organisational levels** and the establishment of a dedicated funded position are of central importance for the sustainable implementation**.** This generates a certain amount of organisational pressure to adequately fill the position even when people change and leave this position. This nevertheless only partial independence from specific individuals, i.e., the formal **organisational establishment of a functional role**, can be seen as an essential aspect of sustainable uptake. Because a change in leadership or committed key persons can be a decisive touchstone for the sustainable anchoring of an OSG. The **key people should ideally be "outside" the usual hospital structures** (the role of OSG leadership is linked to a leadership position, to the extent that this provides some scope for such activities).

- Also, the **question of what size an OSG** should have is relevant in this context. On the one hand, a smaller group has the advantage of quicker decision-making routes, because it is easier to coordinate. On the other hand, if the group is too small and heavily dependent on individuals – as we have seen – this could result into disintegration of the group if some (key) people leave at the same time; in this instance, bigger groups have some advantage because they can absorb – at least – the complete disappearance from laboriously built-up initiatives. However, it is also clear that it needs people who are willing to set the tone and take the initiative, but not concentrating on single persons solely.

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- As we have also seen, the advantage of bigger university hospitals is that they perform research themselves on domestic violence and its health consequences in patients, which offers them valuable **scientific resources to underpin the relevance of such victim protection centres in hospitals**. Furthermore, the practical demand of patients to be treated appropriately and of colleagues to receive appropriate support in such cases is likewise undermined by practice and research carried out in this field.

- **Good cooperation channels and communication** between the management of the OSG team, the hospital management as well as the various departments (or child protection groups) with regular exchanges is necessary. Because in this way they **can build on each other's resources and strengths to consolidate their own and combine their common efforts** leading to better treatment for patients with DV backgrounds.

- As the treatment of patients affected by domestic violence is not a topic of a specific department or profession, but a **cross-cutting issue**, this cooperation among various actors (in medicine but also beyond) is necessary. This leads to the fact that **victim protection must ideally be organised and located independently of the usual hospital structures** in order to ensure the long-term implementation of an OSG (see above point *b*).

- The connection between **professions** (professional habitus), respective **specialisations and the resulting weighting and relevance they attach to different topics and patients** must be considered. For example, the practice and profession of psychiatry tends to focus more on chronic manifestations of DV-patients than on emergency patients. However, one should not exclude the other, but rather point out that the diversity of professions can add value in the treatment of different kinds of DV patients. In any case, different specialisations also result in different focuses, which is not irrelevant to take into account when assembling an OSG, or thinking about effective victim protection in hospitals more generally.

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4.2 Germany – Sustainable Implementation of University Training Curricula

4.2.1 National Context

Despite empirical evidence showing the importance of dedicated training for medical professionals in dealing with victims of domestic violence (Walz et al. 2023), there is no **nationwide mandatory teaching on the subject of DV in medical studies in Germany.** Teaching content is defined by the Medical Faculty Association, which is also responsible for publishing the national teaching catalogues. The catalogues NKLM ("*Nationaler Kompetenzbasierter Lernzielkatalog Medizin*") and NKLZ ("*Nationaler Kompetenzbasierter Lernzielkatalog Zahnmedizin*") define competencies that should be present upon completion of the respective degree program. Relevant competencies are job-related knowledge and skills as well as overarching learning objectives such as attitudes, scientific competencies and soft skills[5]. However, teaching content on DV is not included and is therefore not part of any mandatory exams.

Independent how universities in Germany are funded (public or privately), most are largely autonomous in the design of their teaching programme and their content. This also applies to most medical universities. While certain subjects are an essential part of basic medical training, this does not include courses and content on the subject of DV as mentioned before. As a result, DV training and knowledge are neither included in examinations nor has the topic a high priority. One attempt to change this situation was made in the year 2015 by the German Medical Association on the 118th German Medical Congress[6] in Frankfurt. The Association referred to the 2013 WHO clinical and policy guidelines on the response to intimate partner violence and sexual violence against women, where the need of DV teaching in medical studies was highlighted (WHO 2013). The Congress called on the German Medical Association and the state medical associations to implement the 2013 WHO guidelines and to incorporate them into training and continuing education programs by systematically and comprehensively integrating them into the longitudinal curricula in medical studies (cf. Bundesärztekammer 2015: 279-280). While this call for action did not yield great response and although there is still no requirement in Germany to include DV-training in medical studies or other medical training, there are individual institutions or teachers who have dedicated themselves to the topic. The aim of this case study is to investigate three sites in Germany, with varying degrees of incorporating DV content into their academic training of medical students (from mandatory to mostly voluntary-based individual effort).

[5] See Medizinischer Fakultätentag (n.d.): Kompetenzbasierte Lernzielkataloge (NKLM, NKLZ) – aus den Fakultäten und für die Fakultäten. Available under: https://medizinische-fakultaeten.de/themen/studium/nklm-nklz/ (Access on 05.03.2024).
[6] See 118. Deutscher Ärztetag (2015), available under: https://www.bundesaerztekammer.de/fileadmin/user_upload/_old-files/downloads/pdf-Ordner/120.DAET/Beratungsergebnisse_118-DAET-2015_Restanten.pdf (Access on 21.02.2024).

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Three cases were analysed in Germany. Case DE-A examines a state university with the federal state of North Rhine-Westphalia as the sponsor. With around 45,000 students, this university is one of the largest in Germany. Case DE-A was selected, because DV training has been successfully mandatory implemented in the curriculum for several years. There is DV training in the form of compulsory teaching in surgery. All students of the 7th and 8th semester must complete this compulsory course. It comprises 2.5 semester hours each and is part of the block internship in surgery (7th semester), and a seminar with practice on a simulation patient (8th Semester). Case DE-B is a private university with a Faculty of Health, with the the person being interviewed is responsible for further development of teaching and research. The case was selected because, even though there is not a mandatory course for medical students, there is an elective teaching module on DV for students from the entire university ("Studium Fundamentale" The elective course takes place for 1.5 hours every week. The main difference to the courses in case DE-A is that in case study DE-B the course is only very weakly institutionally anchored (as an elective subject) and depends on the commitment and interest of a single person. Nevertheless, the continuation of the course is also successful in case study DE-B. On the basis of case DE-B, it is therefore possible to analyse in detail the (pre-)conditions that may be needed to later on establish a course permanently. The third case study DE-C case study differs significantly from the previous ones. DE-C is a medium-sized, privately funded teaching hospital in a rural area. It is possible to complete a clinical traineeship or a practical year at the hospital. While there is no dedicated course on DV, DV-related knowledge is taught on an ad hoc basis by the Chief Physician at the Clinic for Gynaecology and Obstetrics (*Ip_DeC:6*) who is also primarily responsible for supervising the trainees, and employed as a lecture at another university, where he teaches every semester. His teaching is organised in blocks and during these blocks, students come to the hospital in case of location DE-C for 3-4 weeks to attend seminars and gain practical experience. In the course of such training courses, content related to domestic violence is also presented to students. Case C was chosen, because it has the lowest degree of institutionalisation, as DV is only taught as part of other training. While this is certainly far from the ideal case of including DV training in medical education, the case does provide information about the possibility of incorporating DV-related knowledge transfer under circumstances where there is very little to no organisational support and focus on the topic.

4.2.2 Overview of participant sample

Across the three cases, in total six individuals were interviewed. **Three interviews** in case DE-A, **two interviews** in case DE-B, and one **interview** in case DE-C. The originally planned number of seven participants could not be reached as both envisaged participants in case DE-C (head of department and chairholder; vice dean for teaching) refused to participate in the study. Participants from case study DE-A have been executive staff from the areas of university teaching, research and medical learning and training centres. *Ip_DeA:1,* who is heavily involved in the coordination and organisation of teaching in surgery and gynaecology, was directly involved in the initial implementation of the DV curricula. Participant *Ip_DeA:2* is part of the management team of the medical learning centre and thus involved in the

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continuous implementation of DV training. *Ip_DeA:2* was also part of the team that drove the organisational uptake of DV training. *Ip_DeA:3* is responsible for organisational aspects like quality management. Interviews were conducted between 31.01.-26.02.2024 and lasted on average 40-60 Minutes

4.2.3 Conclusions: Synthesis and Key Exploitable Factors for Sustainable Implementation

The analysis clearly shows the need for **engaged initiators within an institution** for the topic of DV for it to be included in teaching. This involves a high degree of individual commitment, sometimes unpaid working hours and many discussions and persistence. In case DE-A, the topic could ultimately be advanced with the help of **allies within the institution**, while in case DE-B, according to the participants, there is a lack of allies and therefore it remains a case of isolated, separate commitment. This goes so far that both participants from case DE-B do not know each other due to the institutional structures, although both would like to do more for the topic of DV. Within case DE-B, there is also a different interpretation with regard to change processes: while *Ip_DeB:1* sees a fundamental problem in breaking up established structures and introducing new teaching content and just little flexibility, *Ip_DeB:2* says that there is a fundamental openness, even if it would mean effort for the people responsible. It can be assumed that *Ip_DeB:2*, in her role as Vice President for Research and Chair, has a better "standing" within the university and therefore more opportunities to exert influence.

Employees from **teaching coordination**, the **Dean of Studies Office** and other **management functions** proved to be helpful allies. In case A, it was primarily the support of the teaching coordinator and the Dean of Studies Office that ultimately ensured successful implementation. In those case studies where the implementation has not yet been successful, participants also name the Dean of Studies as the central person for change processes. This person could, for example, initiate **model study programmes** if the lecturers provide the necessary impetus.

In addition to these people, the **teaching staff** were also named, as they ultimately have to implement the teaching and, as described above, can make suggestions to the Dean of Studies. The professional group of surgeons in particular is considered to have a potentially high level of interest on the one hand and a high level of influence on the other.

While case studies DE-A and DE-B emphasise the importance of people *"within the medical system"* (medical teaching staff, clinical staff such as nursing staff) for initiating changes, as they have more acceptance within the hierarchical structures, *Ip_DeC:1* states that **external partners with expertise in the field of DV** would be more helpful. This would be due to the staff shortage in hospitals and the associated lack of willingness to take on an "*extra topic*". The staff shortage is a fundamental obstacle in teaching hospitals to recruit medical staff for the topic of DV. This shows a difference to the two universities, where staff shortage was a less emphasised issue, but rather the **lack of (mandatory) structures in the curriculum**.

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Ip_DeB:1 confirms the problem that physicians often have to offer block teaching as part of their working hours or on a voluntary basis.

In the sense of a **bottom-up approach**, another finding was that the **students** themselves can also act as advocates for a DV seminar, for example through their own interest and exerting pressure as soon as an existing, well-running DV seminar is cancelled. However, with regard to the structures described, the actual influence must be examined separately.

Due to the principle of freedom and teaching in Germany, **none of the IPs see a legal obstacle to voluntarily incorporating the topic of DV into teaching**. There is a high degree of flexibility, especially in areas such as the Studium Fundamentale or model degree programmes. However, due to the extent of teaching content, it is difficult to make room for the topic, especially in "regular" teaching since DV is not an exam-relevant topic. At this point, **the inclusion of the topic of DV in the national catalogue of learning objectives**, including IMPP questions, is considered helpful. Only then would it become mandatory in teaching. Solely *Ip_DeB:2* recommends including the topic more in the practical part in the clinic (especially in the emergency room) than into the theoretical part in the university.

The analysis **did not reveal any significant financial factors that could have a positive or negative impact** on implementation. Although the type of funding differs from case to case (private, state, third-party funding) and there is a fundamental desire for **better staffing** (e.g. for supervision or simulation patients), the positions are generally funded by the teaching load. There is merely a certain degree of planning uncertainty when using third-party funds, as there might be a competition for topics and the implementation therefore depends on the available funding. Since the implementation of DV teaching in case DE-A is mainly compensated by third-party funds and the faculty does not have to raise its own funds for this, it is interestingly, although being a state-funded university, the most insecurely financed case, while at the same time being the most "successful". This was explained by the fact that this form of funding offers the flexibility to try out innovative things.

Various factors are named for the long-term and sustainable implementation of DV teaching. On the one hand, the focus here is also on (at least) **one responsible person** who ensures that the topic remains constantly present. On the other hand, this is also **the risk factor**, because as soon as this person is no longer involved, the topic could disappear from the agenda. To prevent this, **the need to train several people on DV** and thus anchor it at a broader level was repeatedly expressed. Moreover, further training in the form of a **train-the-trainer** course was named as helpful in order to achieve a **multiplier effect**. The specialist areas of paediatrics, surgery, gynaecology, emergency services, emergency ambulance and nursing were named as relevant.

While in case DE-A, a positive **mandatory evaluation** of teaching is seen as helpful for the continuation of DV teaching and the measurement of quality, this appears not to be the case in case DE-B. The effect of a mandatory evaluation therefore seems to depend on the extent

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to which it is reflected by the teaching staff afterwards and whether change processes can be initiated as a result.

As the teaching of DV competes with other topics, there is a certain risk that it will be removed from the teaching plan after it was introduced by individual engagement. In order to counteract this and enable long-term implementation, **legal anchoring** - i.e. anchoring it in the catalogue of learning objectives - is named as a possible solution. It must be **relevant to the state exam,** so that it is taught and tested qualitatively. In addition, the recommendation was made to regularly introduce the topic into clinical practice after the state exam, for example in the form of annual training courses or short inputs, and cooperation with local victim support services. This could be done on the initiative of a **"DV commissioner"** within the hospital. For long-term acceptance of the topic in the curriculum, it would also need to remain "clinically oriented" and be **driven by people who are accepted within the medical system.**

Derived from the previous analysis the following three key take-aways for the sustainable implementation of victims protection measures in medical education can be concluded:

- Committed initiators

Committed individuals (such as, lecturers, professors, etc.) can successfully introduce the topic to large universities. Offering an elective subject, including evaluation by students, seems to be a good first step. Individual commitment can result in a good concept for DV teaching, which can serve as a basis for long-term implementation.

- Influential allies

The involvement of (influential) allies within the institution is another important component on the way to an institutional anchoring of DV teaching. People with managerial and/or coordinating responsibilities have proven to be helpful, as has the Dean of Studies' office, which has significant decision-making authority (e.g. with regard to a possible model degree program). In case DE-A, which serves as an example of good practice, regular discussions with the Office of the Dean of Studies on the subject of DV, a certain degree of "persistence" and successful public relations work, ultimately led to a mandatory implementation. Moreover, the initiation of change processes by reputable medical staff is likely to lead to success as they are able to justify the practical relevance and know the internal structures. Door openers who are accepted within the hierarchy are needed. External specialist organisations were also named as helpful.

- Strategy for sustainability

Individual commitment carries a high risk in the event that these people are no longer available, so it is not only important to have allies with decision-making power, but above all a larger number of trained employees on the subject of DV. A multidisciplinary and interprofessional train-the-trainer course (2 days, with best-practice experience from other universities) is recommended for this purpose. This could create a multiplier effect. For sustainable implementation, the topic would ideally need to be legally anchored in the curriculum and therefore relevant to exams. This would also make personnel and financial

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obstacles less of an issue. A mandatory evaluation has proven useful for ensuring quality and successful continuation. However, quality management here depends on the extent to which the evaluation is reflected upon.

Our case study has shown the chances and barriers that lie in the implementation of DV training under consideration of the different structural conditions of the case locations. When it comes to a successful implementation, it gets clear that not every good practice model can be transferred one-to-one to other locations, but that it is rather necessary to observe individually what works well and is needed to make progress in the project. The only chance in having a more or less coherent approach would be possible if the topic of DV was to be included in the national catalogue of learning objectives, however, this is currently more of a distant goal. Until then, individual leeway must be used. Nevertheless, the analysis has also shown that there are opportunities for positive developments despite the barriers listed above.

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4.3 Sweden – Sustainable Implementation of Educational Goals on Tackling Men's Violence against Women

The case studies conducted in Sweden focused on the national implementation of a new educational objective related to the knowledge area on "Men's violence against women and violence in close relationships". The particular interest of the VIPROM-project in analysing this national initiative as a best-practice case, stems from the **high degree of institutionalisation of a DV-training measure on the policy level**. No comparable policy initiative exists in any of the other partner countries participating in the VIPROM project. Though this particular policy arrangement may be unique to Sweden, the challenge of implementing a national-level policy across different regional and institutional settings is likely to provide valuable insights into key factors contributing to successful institutional uptake and sustainable implementation of DV in medical institutions and higher education. Moreover, a comparison with the case studies conducted in Germany provides interesting results regarding the differences and similarities between the Swedish implementation of national policy, and the German case studies of training programmes developed de-centrally in individual medical institutions.

4.3.1 National context

Since 2018/2019 Sweden has had a new educational objective for eight professional University programs, including education for doctors, dentists, nurses, dental hygienists, physiotherapists, and psychologists. It does not include the midwifery program though, which is one of the target groups in VIPROM.

A crucial factor in the Swedish government's decision to introduce the new knowledge goal in the Higher Education Ordinance is that the Istanbul Convention, the Council of Europe Convention on preventing and combating violence against women and domestic violence, entered into force in Sweden on 1 November 2014. The Istanbul Convention requires acceding states to ensure that professionals, who come into contact with victims or perpetrators, are trained on how to prevent and detect violence, gender equality, the needs and rights of victims, and how to prevent secondary victimisation (i.e. authorities ignorantly subjecting the victim to further abuse).

However, the process that led to the implementation of the knowledge area "Men's violence against women and violence in close relationships" in higher education has been going on for much longer. In 2004, the then National Agency for Higher Education, the predecessor to the Swedish Higher Education Authority, proposed that the government should include requirements for knowledge of men's violence against women in the degree regulations for several programmes where the profession is expected to meet victims of domestic violence. They also suggested that the National Women's Centre ("*Rikskvinnocentrum*") which was renamed the National Centre for Knowledge on Men's Violence against Women, NCK, in 2007, would be responsible for training university teachers.

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NCK has carried out two surveys, one in 2009 on the existence of stand-alone courses on men's violence against women and one in 2010 on how men's violence against women, honour-related violence and oppression, and violence in same-sex relationships were taken into account in twenty higher education programmes. The results showed that only one in three programmes taught men's violence against women at undergraduate level. Even fewer programmes taught about honour-related violence and oppression or violence in same-sex relationships.

An evaluation by NCK in 2013 of educational initiatives carried out within the framework of the Government's Action Plan to Combat Men's Violence against Women, Honour-Related Violence and Oppression and Violence in Same-Sex Relationships (skr. 2007/2008:39), and the Government's Action Plan to Prevent and Prevent Young People from Getting Married Against Their Will (skr. 2009/10:229) revealed that there were mostly short, one-off initiatives. **The evaluation concluded that there was a need for a coordinated education policy for vocational training at universities and colleges, as well as continuing education for professionals**. The National Board of Health and Welfare regulations and general advice on domestic violence from 2014 also emphasise the importance of professionals having knowledge about violence and the ability to put this knowledge into practice.

In 2015, the Swedish Higher Education Authority (UKÄ) reported a survey on how human rights, and specifically men's violence against women and violence against children, were taken into account in several programmes. **The conclusion was that teaching needed to be developed, in order for students to gain the knowledge they need to meet victims of violence** in their future professions.

Overall, these surveys and descriptions of needs in combination with the ratification of the Istanbul Convention resulted in the new educational objective entering into force by the Swedish Higher Education Authority as a result of a revision of the Higher Education Ordinance, which is a part of Swedish law. This means that every university that offers these programmes is obliged to implement this new objective. If not implemented the university loses its rights to give the programme.

Adding a new degree objective was the measure that could force the universities to implement the knowledge, as the universities in Sweden are autonomous, which means that every university has the freedom to design their programmes themselves but are bound to fulfil the degree objectives that are legally regulated. For this new objective, there is no more money or no more time in the programme given by the authorities, which means that each programme at each university must plan how to incorporate this with the rest of the obligatory objectives. The universities are predominantly state-owned, but there are also private ones in the form of non-profit foundations. Both public and private degree programmes are regulated by UKÄ and Swedish legislation. Universities and higher education institutions receive the same funds for teaching from the state, related to the number of students and performance.

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The degree objective is a knowledge goal regarding Men's violence against women and violence in close relationships and is to be examined. The degree objective is thus designed as a knowledge goal and understanding of the area, and is not about demonstrating skills and abilities, or demonstrating values and attitudes. It is not regulated how extensive the education should be in terms of credits or teaching hours. However, the knowledge goal is expected to be broken down into smaller areas and different sub-courses, tailored to the specific needs of the programmes. The government has placed funds/grants to support implementation (NCK has been a leading actor regarding the training of university teachers in this subject between 2018 -2023).

In 2020 and 2023, two different studies were conducted at the University of Gothenburg, commissioned by the Swedish Gender Equality Agency. The overall purpose of these studies was to map the implementation of the knowledge goal and identify the pedagogical support that teachers needed to implement it. The aim was also to assess how well the new knowledge goal was integrated into different programmes. In addition, the Swedish Higher Education Authority, a government agency responsible for assessing the quality of higher education, also conducted a study in 2022 to examine the treatment of the learning outcome and compared it to a previous 2015 report on teaching human rights, including freedom from violence, in higher education.

Overall, these studies (Carlsson, 2020; 2023; UKÄ, 2022) show that there are still challenges in implementing the learning outcomes. However, although the studies show that there are still challenges in implementing the degree objective, all programmes covered by the knowledge objective are currently teaching and examining the objective. Challenges include **financial constraints, limited space in the curriculum for additional relevant content, concerns about political micromanagement (concerns about political/ideological influences in relation to scientific work) and uncertainty among teachers about how to teach the subject**. One of Carlsson's conclusions is that teachers need pedagogical training at university level to develop courses and programmes related to this learning goal. In a study at Jönköping Health University, which started in 2021 and is still ongoing, but where a sub-study was published in 2023, the results show that students estimate their knowledge of the subject area as higher after training than when they started their studies, and that they gained it through teaching placements and extra jobs.

4.3.2 Overview of participant sample

Adhering to the VIPROM study design, the case studies conducted in Sweden employed the same method of problem-centred expert interviews, which means a problem-centred, process- and object-oriented interview. This means in turn, that the interview becomes a dialogue between the interviewer and the interviewee, where questions can be developed depending on what the interviewee answers to a previous question. An in-depth process takes place where there is also the freedom to ask specific limited questions at the end, which may not have been answered or raised earlier in the interview. For the analysis of the data, a simple

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thematic analysis was employed, based on the comprehensive transcription of central interview passages.

Seven interviews were conducted across three educational institutions, **two universities and one college**, all offering a nursing programme. The recruitment was conducted through emails to potential respondents. One of the universities is one of Sweden's largest and oldest and the other a smaller and younger university. The college is also relatively young. The universities/colleges were chosen because they have been in place for different lengths of time and have therefore offering the nursing programme for different lengths of time, and because their organisational structures and associated organisational culture can be assumed to work in slightly different ways depending on whether they have old, i.e. centuries-old traditions or have been created in modern times. The higher education institutions are also scattered around the country.

Four interview partners are chairs of the nursing programmes committee or/and as the programme director of the nursing programme (organisation management/CEO/Director), and have been so for 4, 5, 7, and 22 years respectively. **Three are lecturers who have been teaching for 4, 7, and 9 years**, respectively, and **one is also the course coordinator**.

These positions have different responsibilities regarding the scientific content, pedagogical responsibility (including allocation of resources, and pedagogical processes), teaching, and provision of diplomas/degrees. Being a programme coordinator means that you are responsible for ensuring that the programme meets the requirements set by the legislation, which includes that the programme has the degree objectives required for the programme and that they are met within the framework of the resources allocated.

Teachers are responsible for organising teaching so that it corresponds to the objectives and examination, assessments (constructive alignment) and directly addresses the intended learning outcomes. Jointly the programme managers and teachers constitute central functions for the implementation of, in this case, the knowledge goal of Men’s violence against and violence in close relationships, which is why we chose to interview both categories.

The interviews took place between 19 th of January and the 26 th of February 2024, via the digital communication tool Zoom, and were approximately one hour long per informant, except on one occasion when two interview partners from the same university were present at the same time. Interviews were recorded and transcribed. An interview guide with the research questions broken down into more differentiated questions was employed, but due to the interview method, the guide was not strictly followed, allowing for new questions to arise and the order of the questions to be flexible.

The interview guide centred on the two research questions derived from the general VIPROM study design and specified for the Swedish case studies:

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- How and which structural and organisational conditions are perceived as conducive (or obstructive) in the implementation of the knowledge goal by the teaching staff?

- From the perspective of the teachers/programme directors, what is required to sustainably implement DV training into medical curricula in order to achieve the knowledge goal?

The following analysis of the interviews presents interviews conducted with programme director(s) and the teaching staff separately, allowing for a clearer discussion of the results and easier description of Key exploitable factors in the next section.

4.3.3 Conclusions: Synthesis and Key Exploitable Factors for Sustainable Implementation

Our study shows that the many years of work to make it compulsory by making it a degree objective that must be fulfilled for the programmes in question, has been a successful structural model for implementing knowledge about men's violence against women and violence in close relationships. This takes into account the fact that universities in Sweden are autonomous with a great deal of decision-making power, except for the overall objectives they must fulfil. The fact that the goal must be examined, as all mandatory goals must, further strengthens the implementation.

The study shows that the universities followed their organisational structure for governance of the university when implementing this new knowledge goal. By doing so, the objective does not distinguish itself from others that are not optional for the programmes. This has benefited implementation and resulted in less resistance than previous efforts to introduce the area of knowledge.

The study clearly shows that in those **universities that had not taught the subject before, the possibility of adding the new degree objective in connection with the revision of the entire programme was an advantage that clarified the field of knowledge**. The study further shows that the objective would have been **further strengthened from a sustainability perspective if it had been both a knowledge and skills objective, as the programme leads to a professional occupation where skills are important**. The university that contributed **financial resources** for the implementation expresses greater certainty regarding the sustainability of its implementation. This is because most teachers thus had the opportunity to participate in the continuing education offered nationally in connection with the introduction of the goal, and the knowledge is covered by several teachers.

The fact that management and teachers in their own organisation have knowledge of the subject provides a greater opportunity for sustainability as they are not dependent on guest teachers/experts or so-called enthusiasts who drive the issue alone or with little support from management and colleagues.

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Some concrete points to support sustainable implementation:

- A **national obligation** of degree objectives regarding knowledge and skills, for all universities in the country, based on legislation.
- **Organisational implementation according to the hierarchical structural arrangements** that apply at each university.
- **National educational support** from an expert centre or similar body.
- **Financial and temporal possibilities** to work in terms of quality and comprehensiveness and with programmes/training and curricula.
- **Continuous training in the subject for all teachers** in the programme so that the competence is available within the university.
- Guest teachers are only invited as professionals, not to teach theory, which should be given by the university's own faculty.
- Resistance should be dealt with through knowledge and readiness to handle any emotional reactions for those exposed in their own college.

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5. Key Findings: Organisational Measures that Enable the Sustainable Uptake and Implementation of Victim Protection in Medical Institutions

5.1. Resources as a Precondition for Sustainable Implementation

One of the major issues that runs through all three case studies is the *issue of resources* (and quite often a lack thereof) and their provision for various hospital-based victim protection measures (OSGs in AT) and medical educational training (in GE & SE). Resources include various forms and means that can help such initiatives to be integrated into existing training or medical practice in a sustainable way, or prevent them if they are not sufficiently made available. However, *resources are also located at different levels*. In the Austrian case study on OSGs, for example, it was emphasised that a separate unit should be created outside the normal hospital structures to ensure and meet the requirement that victim protection is not something that is assigned to a single department or (medical) profession, but rather **a cross-professional and cross-departmental issue**. In one particular case, we have seen that this was achieved by placing the OSG at the highest level of a hospital structure (and therefore outside of usual hospital routine work), namely at directorate level. However, the Austrian law does not stipulate this in this way; on the contrary, OSGs should be cost-neutral. However, this case has shown that a funded and therefore dedicated in-house position might be meaningful in order to meet this requirement of interprofessionality in a reasonable way. At the same time, however, this is not possible everywhere due to **local institutional conditions and structure,** which must always be taken into account. However, the law (such as the knowledge goal in Sweden, or the one for OSGs in Austria) can be important as a resource and can certainly be used as a momentum for creating different forms of implementation strategies. It goes without saying that these respective policy measures must always leave enough leeway for local structures (taking into account the objective and scope of various institutions) and therefore different implementations.

Further, the provision of **necessary resources** (especially in terms of **time and funding**) would enable those responsible (i.e. for instance, the head of the OSG; or the study program manager, and even the lecturers in university education) to deal intensively with the topic and the associated tasks, such as the implementation of training, the development of training concepts (multipliers) to prepare medical professionals adequately for the treatment of patients with DV backgrounds. It is necessary to **create more sustainable structures** so that people can perform these tasks in an appropriate manner. Also, in Sweden and Germany it was emphasised that universities that have taken over the funding of training are more confident about the sustainability of the implementation. This is due to the fact that, for

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example in Sweden, most teachers have had the opportunity to participate in the nationwide training offered in connection with the introduction of the knowledge goal.

In addition to the provision of time and financial resources, **organisational recognition and appreciation** of the work invested in DV training and awareness-raising is also crucial. From *a strategic perspective*, this would also show that the work of dedicated individuals (teachers, managers, hospital staff) is part of the respective *organisational philosophy* and understanding of their jurisdictional area.

Scientific studies are also valuable resources to underpin the relevance of domestic violence in the medical field and to show that medical professionals need to be trained to treat these patients properly. This is an advantage of university/research (hospital) centres, as they very often conduct their own research on domestic violence and its health consequences in patients, which provides them with valuable insights and justification for their engagement. In addition, the practical demand of patients to be treated appropriately and of colleagues to receive adequate support in such cases is also underpinned by practice and research in this area.

Thus, **networking and exchange** between different hospitals and/or educational centres are meaningful, because in this way they can build on each other's resources and strengths leading to better treatment for DV patients. Also, in the Swedish case, the fact that management and teachers are familiar with the topic in their own organisation – **in-house expertise** – has been stressed to offer a greater chance for sustainability, as they are not dependent on guest teachers/experts or so-called enthusiasts who push the topic alone or with little support from management and colleagues. This was also stressed in the German case study in the way that the initiation of change processes by reputable medical personnel is promising, as they can justify the practical relevance and know the internal structures. **Door openers** are needed who are accepted in the medical or university hierarchy. However, **external specialists and/or organisations** (such as GESINE Intervention in Germany, NCK in Sweden, or GÖG in Austria) were also mentioned as helpful cooperation actors in this process because they can provide specialised expertise on DV and support the coordination of common efforts by bringing various people and their knowledges together.

The **relationship between healthcare professions** (professional habitus), the respective specialisations and the resulting weighting and relevance they attach to different topics and patients must be considered. For example, the practice and profession of psychiatry tends to focus more on chronic manifestations of DV patients than on emergency patients (at least in the Austrian case). However, the one is not meant to exclude the other, but rather to indicate that the **diversity of professions adds value in treating different types of DV patients**. In any case, different specialisations also lead to different focal points, which should be considered as a valuable potential when thinking about effective victim protection in hospitals or training concepts and education of medical professionals.

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5.2. Common Stages of Sustainable National Implementation of Best Practices

A central research interest in D2.2 relates to the conditions of emergence for each of the best practices analysed in the case studies. Though there are fundamental and far-reaching differences between each of national practices, a striking similarity seems to suggest itself: The **formation processes** of each of the best practice cases, its embeddedness on **policy level**, and the emergence of **coordinating/expert agencies** tasked with monitoring the national implementation, seem to follow a similar trajectory:

1. The **best practices tend to emerge decentrally**, in single medical institutions, as a result of the hard work of **motivated individuals**[7]. The struggles to establish DV-training and/or internal competence centres for DV within medical, or higher education, institutions can be very effective and result in the emergence of surprisingly sustainable practices. This can be observed particularly clearly in the formation processes of Victim Protection Groups in Austria, but is also echoed by interview partners in the Swedish case studies[8]that encountered higher education institutions whose inclusion of DV-training in the curricula pre-dates the implementation of the new knowledge goal. When analysing the Austrian cases, it is also important to note that the decentral emergence of good practices in single institutions can also inspire the adoption of similar structures in other medical institutions. Victim Protection Groups that first emerged in single hospitals in Austria, soon inspired the establishment of similar practices by motivated professionals in other medical institutions. In the early phases of the formation process of the best practices studied, we therefore not only see the relevance and potential of micro-level struggles and the agency of motivated individuals, but also the ability to inspire others and initiate a limited spread of these practices to other institutions.
2. Both the Swedish and Austrian cases suggest a common second stage of a shared trajectory: **The recognition and adoption of existing, decentral good practices on policy level**. Both national best practices have recently (within the last decade) been raised from the results of decentral struggles to national provisions on policy level. It is important to note that this is never a natural, automatic process. The step from decentral practices to enshrinement on policy level was in both cases the result of **political struggles** and lobbying. This second stage does, however, mark a shift of the sphere in which these struggles take place. While the initial emergence of best-practices on the decentral level deals centrally with the organisational constraints and interpersonal relationships between motivated individuals and other actors within medical institutions[9], the efforts to enshrine these practices on national policy level take place in the political

[7] It is relevant to note, that not all staff members in medical institutions appear to hold a similar likelihood of success in establishing new best practices. See more on the relevance of the roles and hierarchical positions of motivated individuals in key factor 5.3.
[8] See Ip_SeA1
[9] See Key Factor 5.3

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sphere, frequently beyond the influence of the motivated individuals credited with the emergence of the best practice.

Two central aspects of the second stage of sustainable implementation need to be pointed out: Firstly, the **core effect of the adoption of existing best practices on policy level resides in the rapid spread and implementation** of these practices in other medical institutions. The enshrinement on policy level and associated provisions vastly accelerated the implementation in medical institutions that had not already attempted to implement these practices on their own accord. Moreover, the national coverage, in the sense of a mandatory implementation for all medical institutions, is vastly dependent on the policy provisions. Secondly, however, the adaptation of existing practices on policy level **does not guarantee the quality of the uptake** by new medical institutions and frequently lacks measures to monitor the speed and extent of successful implementation. Again, the Austrian case can be instructive: Although the enshrinement of Victim Protection Groups in the "*Bundesgesetz über Krankenanstalten und Kuranstalten*" ("Federal Act on Hospitals and Rehabilitation Facilities", KAKuG, §8e)[10], including the legal stipulation to implement these in all Austrian Hospitals occurred in 2011, governing bodies still lack insight into the actual level of successful implementation on national level. Similarly, the case studies conducted in Sweden show vast differences in the form and sometimes quality of inclusion of DV training in nursing programmes across Swedish higher education institutions. Though covered by the same national knowledge goal, the quality and extent of implementation may vary significantly. This inability of policy level enshrinement of practices to monitor quality and scale of implementation points towards the third possible phase identified in the case studies.

3. Both the Swedish and the Austrian cases suggest a possible common development accompanying, or following, the policy level enshrinement of good national practices: **The involvement and empowerment of third-party organisations, either tasked directly with monitoring and quality assurance, or embodying centralised expertise and experience that can be requested by implementing medical institutions**. In the case of Austria, the *Health Austria GmbH* (Gesundheit Österreich GmbH – GÖG), is tasked by the Ministry of Health with developing indicators for, and conducting, a continuous monitoring of the degree of national implementation of Victim Protection Groups on national level. Moreover, they have been charged with developing minimum standards defining successful implementation in hospitals in attempt to cover not only the degree, but also the quality of uptake[11]. The Swedish Case Studies in turn, make evident the importance of centralised expertise available to all implementing higher education institutions as embodied by NCK. The possibility for all national education institutions to

[10] BGBl. I 69/2011; latest version: BGBl. I 79/2022.

[11] GÖG also closely collaborates with the association of Victim Support Groups. The latter arose as an initiative of the Support Groups themselves, independently of ministerial mandates. The association consists of members of different Victim Support Groups on national level and has the closest insight into the development on ground level. The collaboration with GÖG, in turn, provides organisational advantages (e.g. assistance in organising and hosting regular networking meetings), as well as embodying the connection between the practical and policy levels.

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request training for their teaching staff from a centralised body, or even make use of NCK teachers to provide DV training in different educational institutions, showcases the importance of third-party organisations that form the bridge between medical institutions or universities and policy level.

Though the hypothesis of three general phases of sustainable national implementation can be drawn from case studies conducted, it is important to note that they are the result of an analytical abstraction. Timing, specific interplay between the actors participating in the different stages, as well as the concrete roles each stage plays in sustainable national implementation vary between the cases and are likely to vary in other national settings. Nevertheless, a potential strategic blueprint can be derived from the observable cases: 1. The **decentral, micro-level struggles to develop DV training practices** and organisational expertise within individual medical institutions are not only **extremely important on a local level, but frequently are the initiating factor for larger policy developments**. Moreover, it appears that a certain level of sustainability and even the initial spread of good practices can be achieved within (and between) individual institutions without a corresponding national policy. 2. The **national adoption of good practices seems to depend** on (or at the very least be highly accelerated through) the **enshrinement of such practices on policy level**. However, the successful **uptake on policy level depends on the involvement of new and different actors** than those establishing the good practice in the first place. Beyond the acceleration and national coverage, however, policy level changes seem to have difficulty monitoring the actual degree of implementation as well as the quality of the same. Thus, 3. The i**nvolvement of third-party organisations, directly tasked with monitoring, quality assurance, and provision of centralised expertise appear as a central factor for sustainable implementation** on a larger scale.

5.3. Actors and Engaged Networks

The fact that the sustainable uptake and implementation of training and intervention measures cannot be achieved without the **sustained commitment** of **highly motivated individual actors** in the organisation is certainly a fundamental finding of this report, even if it is hardly surprising. Thus, without people who are motivated to work on and advocate for the topic of DV within their organisation, there is hardly a chance that DV training and interventions are organisationally anchored. However, the in-depth analysis undertaken for the present deliverable shows that organisations, due to their formal hierarchical structures, distribute the potential and the opportunity to advocate and campaign for a topic differently within the organisation. This indicates that commitment and interest are not effective drivers for the organisational uptake of measures on their own but are always shaped by and embedded in the formal-organisational context. Against this background, the following paragraph summarises **two organisational structural factors** that facilitate and drive the organisational uptake of measure and foster the sustainable implementation of them. The two factors are first, what we call "**strategic actors"**, i.e. people within the organisation who, due to their formal position have a certain degree of organisational power, second certain types of

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informal organisational structures, i.e. personal relationship networks and informal work and communication routines.

1. In terms of organisational uptake of DV training or intervention measure one of the key factors that emerged in the cases studies across all three countries is that in order to foster organisational uptake people are needed who raise awareness of the topic and keep it present within the organisational "consciousness" through constant (communication) work. A high degree of motivation, expertise and perseverance is required to implement this. However, motivation and interest are on their own not enough. Various of the conducted case studies have shown that people also need a high degree of **intra-organisational agency**. However, not all actors have this level of agency. For example, external lecturers or "grassroot" level staff may be able to address the topic but are hardly able to initiate a broader organisational discussion that also reaches the management level. Due to their formal position in the organisational hierarchy, they simply lack organisational agency. Case studies DE-B, DE-C and Se-A, among others, indicate this. In all of these cases, it can be seen that the participants, due to their position in the organisation (e.g. external lecturers or lecturers of elective instead of mandatory subjects) have less agency in placing topics high up on the organisational agenda. Rather, as the case study DE-A or case study AT-A show, people are needed who, due to their position (head of department of a hospital, head of a training centre or programme coordinator), **have the agency to communicatively perpetuate the topic within the organisation**. Hence the formal position within the organisation of these actors enables them to reach the top of the organisation (dean of studies, medical management or the hospital's sponsoring organisation) and directly and constantly "confront" the leadership level with the issue. This is necessary because in many of the cases analysed, support from the management level is required, as the planned or already implemented measures generally involve a high degree of informal agreements between various stakeholders (e.g. time off from core medical activities to carry out OSG activities or permission to offer DV courses within the university teaching framework). This applies even if, as the case studies from Austria and Sweden show, there are legal requirements for implementation. These often lack specifications or are deliberately openly formulated by the legislator and must therefore be specified by and within the organisation. At the same time, strategic actors are often still heavily involved in the "grassroots" activities of the organisations (patient care or teaching). Hence, they also reach the people at the base of the organisation (students, teachers, employees without management responsibility). In this way, **communication networks** can be created within the organisations that embed the topic in the organisational consciousness.
2. Such communication networks are necessary for the sustainable implementation because they enable, what we term, the **communicative perpetuation** of DV as an important topic within the organisation. Communicative perpetuation refers to the organisational practice of "keeping certain topics under discussion" across the various levels of an organisation, which first and foremost requires certain types of **informal organisational structures**. Two such forms stand out in the case studies, particularly

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in Germany and Austria. First, as participants in the At-A case study emphasised "**short communication channels**" between different actors. These actors include in particular the above-mentioned "strategic actors" on the one hand and members of the management level on the other. Second, as the case studies from Germany emphasise, these informal organisational structures also include good working relationships between various strategic actors, but members of the „grassroot" level can and must also be part of these relationships. Based on these, as one of the participants form case study SE-A called it low-threshold informal networks and working relationships, **networks of allies** can be formed. These networks have an extended degree of agency and outreach and thus are able to communicate the topic across multiple sectors of an organisation. As the case study AT-B shows, such informal structures can moreover include certain **organisational routines**, such as regular working meetings between management and committed stakeholders, in which the topic can be kept up to date.

5.4. Laws and Policies as Argumentative Resources and Implementation Driver

In the case studies undertaken in Austria and Germany, legal requirements are a key contextual factor that had to be taken into account in the analysis. The question in this regard was what influence the legal obligation of, on the one hand, hospitals in Austria to install Victim Protection Groups and, on the other hand, various medical training centres in Sweden to teach victim protection has on the practical implementation of DV training and intervention. The following paragraph summarises those findings that characterise legal provisions as a key factor for the implementation of victim protection measures, even if, as the various participants emphasise, the law per se is not an indispensable dimension. This is because, as for example the case studies At-A and At-B but also the analyses of the Swedish nursing programmes show, victim protection measures and training in this regard are often already in practice before the legalisation. One reason for this is that in areas such as victim protection in hospitals, support for victims does not only become necessary once a corresponding law has been passed. Rather, in such cases, policy-makers and legislators at some point (are made to) recognise that there is a need for regulatory intervention and then incorporate good practice solutions that already exist in practice into legislation. In other cases, as the Swedish study shows, other legal or strategic requirements can be understood and implemented by the actors in the field in such a way that they already cover issues that are later on addressed by a specific piece of legislation. One example of this is the case study Se-A, where the participants described that victim protection of women against male violence was already being taught as part of another degree objective before the introduction of a specific educational goal. First, it serves as an argumentative point of reference for actors in the field when discussing the implementation of measures. Second, legal requirements also drive the nationwide implementation of measures and protect against their complete dismantling. However, it should also be noted that, as the case studies from Germany show, some of the

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participants are of the opinion that sustainable implementation can only be achieved through a legal requirement.

1. The most important function of law for the sustainable implementation of victim protection measures or training is that legal requirements provide a strong justification framework for the committed actors in an organisation. If, for example, no efforts or, from the point of view of the committed actors involved, only highly inadequate efforts are made at management level to implement the legal requirements, one can always refer to these legal requirements. Thus, the law not only offers actors a simple and difficult to dispute means of justification, but also relieves them of the impression that they are pursuing certain forms of organisational changes for personal motives. The "implementation struggles", as described by the participants in the case study DE-A, also show how important this relief function can be not just for the purpose of justification, but the actual work required by committed actors. A legal requirement for the adoption of DV training in national education catalogues and examination regulations would obviate many of the struggles that need to be undertaken to instil the topic into the aforementioned organisational consciousness. Instead, these efforts could be spent on ensuring the quality and extent of implementation.
2. The second reason why the law is a central factor is that, because of legal requirements, implementation is being driven forward on a regional or even nationwide basis, i.e. also in those locations or organisations that have not yet taken any measures. Thus, the legislator adopts certain developments already occurring in practice and formalises them in the form of legal requirements, which in turn contribute to an expansion of the measure in practice.

   However, the context interviews from Austria show that this alone cannot guarantee the concrete form and quality of implementation. As both the interviewee from the ministry responsible for the OSG and the participants from the GÖG reported, little is known about the specific tasks and organisation of work, despite legal requirements. The advantage of the legislation is that at least every hospital that falls under the legal obligation has set up a specific email address and telephone number for the victim protection group. Hence, in the present cases the law, as shown in the case studies in Sweden and Austria, cannot ensure the quality and specific form of implementation, but only stipulate basic requirements. As various participants report, it is not desirable or even possible to specify more than a basic obligation and minimum standards, partly for formality but above all for practical reasons. In the case of the educational goals in Sweden, for example, the legislator cannot set such detailed requirements due to the autonomy of the universities, and such an approach would contradict the fundamental freedom of teaching. In Austria the strong federalism with a complex distribution of responsibilities between the federal legislator and provincial legislators in the healthcare system poses similar problems for the law. Moreover, the participants emphasised that overly detailed specifications would often have an inhibiting effect, as they would then be more difficult to integrate into existing arrangements and practices.

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5.5. The Strategic Use of Organisational Positioning and Timing

Operational and strategic positioning, as well as timing are always crucial when introducing new interventions. The comparative analysis of the case studies suggests that these may have been key factors in the successful implementation of good practices studied in D2.2, which can in turn be strategically employed when trying to implement such practices in new national and institutional settings. Three factors relating to strategic organisational positioning and timing in particular may prove valuable for such endeavours: 1. The strategic positioning of DV-initiatives within organisational hierarchies and networks. 2. The timing of the introduction of new DV-initiatives relative to broader organisational change. And 3. The strategic timing in the placement of the topic DV over the course of longer medical training.

1. Strategic positioning within organisational structures: In one of the Austrian cases, as mentioned above, the positioning of the OSG at the highest organisational levels (medical directorate) and the establishment of a dedicated, funded staff unit was of central importance for sustainable implementation. On the one hand, this strategic positioning increased public visibility, as the OSG is visible as a separate unit in the medical directorate in the publicly accessible hospital organisational chart. Moreover, this visible placement creates a certain organisational pressure to adequately fill the position even when personnel changes or employees leave.

   In any case, this has increased both the visibility to the public and – and this is perhaps more important – the internal relevance of the OSG. Such strategic positioning signals that protection against violence belongs to the hospital management and should therefore be understood as a firm statement about the hospital's victim protection policy. Ultimately, this increased recognition and visibility was also very useful for the further development of the OSG, as it opened many doors.
   Another important building block for the sustainable integration of DV training and interventions in the medical field was highlighted in the German case study. The German report showed very nicely that strategies based solely on individual commitment carry a high risk if these people are no longer available, so it is not only important to have allies with decision-making power, but above all, a larger number of trained staff on the subject of DV. This makes a far-reaching and different form of anchoring possible in the first place. To this end, a multidisciplinary and interprofessional train-the-trainer course, as the one developed in the VIPROM project, seems highly recommended. This could create a multiplier effect that is necessary for sustainable sensitisation of medical professionals. Furthermore, the topic should ideally be legally anchored in the curriculum and therefore relevant to examinations. This would also reduce personnel and financial hurdles.

2. The Swedish case-studies revealed the power of strategic timing in the introduction of new DV-training. Two of the three case studies stressed the value of coupling the introduction of the new knowledge goal with a larger reform of the nursing programme in their respective higher education institutions. These cases seemed to indicate that the integration of new DV-training into existing broader curricula will always pose a greater

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challenge than including DV during the drafting of an entirely new curriculum, or when reforming the composition of an existing one. This strategic approach also addresses to a certain degree the problem of crowding out other aspects of a curriculum through the inclusion of DV-training. Frequently, when speaking to medical students, professors, or administrative staff, they will stress how overladen medical studies have already become. The mandatory inclusion of the topic of DV always seems to carry the risk of crowding out some other topic or practice. Perhaps this problem can be mitigated by timing the introduction of mandatory inclusion of DV as a topic with the more general reform of a broader medical curriculum. This way, the introduction of DV-training does not appear to depend on the sacrifice of other existing elements of an established curriculum.

3. Lastly, timing of DV-training within higher education curricula could be strategically employed to effect positive change to medical practice. Specifically, DV-training early on in medical studies may increase the awareness of medical students at a stage that enables them to consider the role victimisation may play in all further aspects of medicine they will cover. Placement of such training towards the end of their studies, may in turn affect a positive influence over their behaviour as medical practitioners as the timing more closely relates to their practice of medicine, rather than their academic study of the topic.

6. Conclusion and “Take-Aways”

This report summarises the findings from a total of nine case studies in Austria, Germany and Sweden on the conditions for the sustainable implementation of victim protection measures (training and interventions). The results of the report are intended to serve as a reference for those (partner) countries wishing to introduce comparable measures. Although such measures can of course never be adopted on a one-to-one basis because they are highly “culturalised”, some factors that could help with implementation are highlighted below.
First, partner countries interested in implementing comparable measures should analyse whether victim protection measures already exist at the micro-level so to speak in their own country. “Micro-level” refers to a broad spectrum, ranging from practices on individual hospital wards or in individual teaching programmes to solutions at an organisational level (in hospitals or universities). As the various case studies show, one of the most important preconditions for sustainable implementation is the adoption of existing practices.

Second, it seems desirable to support such practices found at the micro level through policies or legislation. Such policies or laws should be developed in consultation with stakeholders from the field and offer sufficient freedom in order to be tailored in practice to the various organisational cultures. Examples of this are the laws mentioned in the Austrian and Swedish case studies, where for example, in the earlier case it is only specified which hospitals have to set up victim protection groups and, in the latter case which universities have to fulfil the educational goal, but do not specify how this is achieved in detail. Ideally, such strategies or laws should at least contain indicators on the funding or on the general resource allocation of the corresponding programmes.

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For the organisations themselves, one of the key findings is that the organisational introduction of DV measures requires the involvement of people with the corresponding “organisational agency”, i.e. employees with a certain degree of decision-making power.
Ideally, a network of allies of such actors is formed. These can mediate effectively between the organisational “grassroot” and the management level. This mediation work relies on existing or must itself establish formal and informal organisational structures e.g. working meetings with different management levels. Through the constant exchange between different “networks” in the organisations, it can ultimately be possible to raise the topic into the "organisational consciousness". The term “organisational consciousness” refers to more than just awareness of the relevance of the topic. Rather, it encompasses comprehensive intra-organisational knowledge structures as well as formal and informal arrangements. The former include, for example, knowledge about responsibilities, i.e. who the contact persons are and how the topic-related decision-making processes work. The latter, in turn, describe corresponding arrangements, such as the agreement to carry out DV-related work during regular working hours, the informal negotiation of the inclusion of DV training in a curriculum or the development of a train-the-trainer programme to ensure the dissemination of expert knowledge within the organisation.

Finally, another important finding relates to the timing of such reforms. Here various case studies showed that the implementation of DV training and intervention can be carried out more easily in the course of reforms that are already planned and taking place. In this respect, these represent "windows of opportunity".

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