Abbreviated version of Deliverable 5.1: Evaluation Strategy

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	WWU	Westfälische Wilhelms-Universität Münster	Germany
2	VICESSE	Vienna Centre for Societal Security	Austria
3	IKF	Institut für Konfliktforschung	Austria

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Abbreviations and acronyms

DV	Domestic Violence
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer

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1. Evaluation Strategy – Executive Summary

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 ambitious goals of developing and implementing training modules (medical curricula) specifically tailored to the needs of medical and healthcare professionals in five countries to provide appropriate and responsive support to victims of domestic violence (DV). Medical and healthcare professionals play an important role in improving the health and safety of victims through early detection, adequate care and referral to specialised victim protection services. Thus, the main aims of the VIPROM project consist of developing curricula tailored to the specific needs of the medical sector, implementing these curricula, and developing train-the-trainer programmes to teach these curricula.

To safeguard adherence to the highest standards in fulfilling these goals **a mixed-method evaluation strategy** including the perspective of trainers, participants and experts was developed by project partner IKF. An overview of this strategy is presented in this document, i.e. an abbreviated version of Deliverable D5.1 Evaluation Strategy Report. This evaluation strategy aims to assess the quality and scope of the contents of the various curricula developed in WP3 as well as the quality and impact of the implementation of the various curricula for all stakeholder groups across all six training sites. The first section will elaborate on the evaluation of the contents of the curricula (T5.2). The second section introduces the evaluation of the curricula piloting, i.e. the trainings themselves. The annexes contain guidelines and templates created by IKF, which are needed for the conduction of T5.2 by the involved partners (IKF, VICESSE, WWU, GES, HFA, AOU-PR, UU). As far as the evaluation of the curricula piloting, i.e. trainings (T5.3) is concerned, this deliverable sets out the overall strategy, rationale and methodology, but refrains from providing detailed guidelines for practical implementation as these can be only targeted more efficiently once details of the trainings are developed in all partner countries.

2. T5.2 Content Evaluation of the modules of the training platform

In T5.2 the contents of the curricula are evaluated. The design of Task 5.2 has slightly changed from the project application: Whereas originally focus groups with stakeholder groups were planned for this evaluation part, **focus groups** will instead be conducted with **domestic violence experts** with in-depth knowledge of the medical sector. Evaluation of the content of the module of the training platform will be shared between the partner countries. There are several reasons for this decision: First, the contents of the modules have been already based on well-established research results and reflect the state of the art in the field of domestic violence. Additionally, in the context of WP3, the project partners internally checked, processed and commented all modules. Therefore, they do not need an evaluation in terms of factual correctness, but rather in terms of selection, presentation, and practical relevance for professionals in the medical sector.

While the methodical choice to hold group discussions on these issues is sound – the expert conversation and the possibility to account for multiple perspectives are vital in this respect – content needs to be reduced as it is simply not possible to work through eight modules in a group session. Therefore, the decision was taken that each country should focus on one of the modules – with the exception of Germany, where the two partners will each evaluate one module, respectively. This resulted in a second necessary change in the content evaluation strategy, moving from stakeholder-groups to expert groups as stakeholders (medical professionals), who are not (yet) experts in the field of DV, would de facto need to finish the training before being able to give a well-reasoned opinion on our questions. Through the

needs assessment (D2.1) regarding knowledge and skills of the various stakeholder groups (doctors, nurses, midwives, dentists) it became clear that most stakeholders in the medical sector do not have sufficient knowledge about the topic of domestic violence and are unable to provide meaningful feedback. DV experts on the other hand, have the opportunity to focus on presentation, relevance and applicability rather than the contents themselves. As national adaptation is one key feature in the evaluation, each country is responsible for selecting the experts for their group discussion, with a focus on the inclusion of experts from the medical sector. In order to lower the organisational burden, expert group discussions can be held online or offline, according to preference and resources.

As a result of these changes Modules 1-5 & 7 are divided among partners, with each partner responsible for discussing and assessing one of these modules. Module 8, which deals with the cross-cutting issue of stereotypes and unconscious biases in the context of DV, will be divided and evaluated in an integrated fashion, i.e. fitting content will be discussed in relation to Modules 1 to 5 and 7 by the respective partners.

The evaluation of Module 6 'International standards and legal frameworks in Europe', which focusses on legal issues and is partly country-specific, will be evaluated separately by each partner. Thus each partner country will have one to two DV experts checking module 6 for accuracy.

The modules to be evaluated are allocated to the respective partners/countries as follows. The division of work between partners within Austria will be organised according to needs and resources.

Modules 1-5 & 7	Country / Partners
Module 1: Forms and dynamics of domestic violence	Greece (HFA)
Module 2: Indicators of domestic violence	Germany (WWU)
Module 3: Communication in cases of domestic violence	Sweden (UU)
Module 4: Medical assessment and securing of evidence	Italy (AOU-PR)
Module 5: Risk assessment and safety planning	Austria (IKF, VICESSE)
Module 7: Interorganisational cooperation and risk assessment in multi-professional teams	Germany (GESINE)

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

Module 1: **Forms and dynamics of domestic violence:** This module provides an overview on the various forms of DV as well as theoretical background. From module 8 the topic of unconscious biases is integrated, with the central question of whether all stereotypes and unconscious biases relevant to the medical sector are covered. Since module 1 mostly focuses on basic theoretical knowledge on DV, this section of **module 8** can be productively integrated in the focus group.

Module 2: **Indicators of domestic violence:** This module covers health consequences for DV victims and contains knowledge on how to recognize DV cases in the medical sector. Those parts of module 8 that concern the topic of language should be integrated here, with a particular focus on perpetrator-victim-reversal as well as a case study on a female DV victim, who is addicted to drugs. These parts of **module 8** align very well with the purpose of module 2, since they allow for an in-depth discussion of their implications in regard to indicators of DV.

Module 3: **Communication in cases of domestic violence**: This module centres on the professional and trauma-sensitive communication when addressing domestic violence with the patients and provides knowledge on underlying complexities, different communication strategies and appropriate responses. From **module 8** two case studies were selected: The case study of a man being a DV victim and the case study of a migrant woman being a DV victim. These case studies embody the complexities of addressing DV with patients and of communicating with them on this issue, which are covered in module 3, as well as the highly relevant issue of language barriers.

Module 4: **Medical assessment and securing of evidence**: This module offers information on how to document (suspected) DV cases, how medical exams should be conducted and also covers legal and ethical aspects related to cases of DV. From **module 8** again two case studies were selected to integrate into module 4 in the context of the focus group to be conducted: The case of a bisexual woman being a DV victim in her lesbian relationship and a woman with a high social status being a DV victim. These cases were chosen, because of their complex implications for a sensitive documentation (e.g. problem of outing the bisexual woman) and issues connected to psychological violence.

Module 5: **Risk assessment and safety planning**: This module covers the topic of assessing the risk of victims of DV and necessary measures to improve their safety. From **module 8** the case study of an old man being victim of DV was selected to integrate in module 5, since this is a particularly vulnerable case.

Module 7: **Interorganisational cooperation and risk assessment in multi-professional teams**: This module covers the topic of inter-agency cooperation, underlying challenges and components of a successful multi-agency partnership. From **module 8** the case study of a disabled woman being a victim of DV was selected to integrate in module 7, since this is case poses complex challenges for multi-professional teams and interorganisational cooperation.

Using the **guidelines** for the group discussion, the **consent form** and the **reporting templates**, which are provided as **annexes** to this evaluation strategy, all partner countries send their national results to IKF (internal deadline: 6 May). IKF will integrate the information from all countries into deliverable D5.2, which will focus on recommendations for the revision of the curricula (due date: 15 June 2024).

3. T5.3 Evaluation of the Curricula piloting

In order to allow for a comprehensive evaluation, it is necessary to not only evaluate the curricula, but also the trainings themselves that use these materials. This has to be done at the pilot stage as a prerequisite for any necessary changes to the training courses themselves, including aspects of didactics, methodological approaches and practical applicability in order to ensure the sustainable achievement of learning outcomes.

The evaluation of the curricula piloting consists of several parts: (1) feedback of trainers on the train-the-trainer course, (2) observations of trainings in all partner countries, (3) analysis of three waves of online-questionnaires filled in by participants of the pilot-trainings in all partner countries, and (4) two focus groups with trainers concerning national specificity and cultural sensitivity. Results from these different forms of data guarantee a comprehensive evaluation of the whole process of curricula piloting.

The **combination of qualitative and quantitative approaches** was chosen for several reasons. It combines the strengths of both methodological approaches and through triangulation it works against weaknesses of any one specific methodology. Surveys allow us to gain quantitative knowledge on items of interest, like participants prior knowledge of DV, their attitudes on the issues covered, participant's impressions of the trainings and the applicability of the contents in their everyday professional practices. By surveying the population at three different points in time, potential changes in knowledge and attitudes that are related to the training can be assessed. However, survey-data is based on self-reporting, which can impact the accuracy of results, especially in a cross-country analysis, where answers need to be interpreted in the light of different cultural standards (e.g. of assertiveness). This is why it is important to enrich our results through qualitative methods, including feedback forms, group discussions and (participatory) observations. While the two former allow for contextualisation of quantitative findings through interpretation of the curricula and the training by experts (i.e. trainers), the latter allows for more immersive insights into the training setting and the collection of data from an 'observer's' position, who is not directly involved in the trainings. Here the focus can be on group dynamics, didactic and methodical approaches of the trainings, and the interaction among participants as well as between participants and trainers. At the same time training observation on its own is prone to limitations and biases (e.g. selection of what is *relevant* information cannot be fully objectified,

or in other words: it is bound to the 'observer's' indirect involvement in the situation). Therefore, reflective reasoning and the standardised survey provides an important corrective. The combination of qualitative and quantitative approaches allows for a balanced and nuanced data collection, which is necessary for a comprehensive evaluation.

The evaluation of the curricula piloting takes place between October 2024 and October 2025 (M20-M32). As tools for data collections and templates for reporting need to be based on a more detailed knowledge of the trainings in all partner countries, an English-language draft version will be provided by IKF to all partners in September 2024 in order to allow for translation and implementation of the survey-questionnaires by October 2024 (start of the trainings). The feedback from trainers on the train-the-trainer-courses (1) will be collected earlier (see below). After data collection is finished, IKF will formulate a comprehensive report (**D5.3, due date: October 2025**)