Deliverable 4.2:

Report on the Piloting of the Training Curricula

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	Universität Münster	Germany
2	VICESSE	Vienna Centre for Societal Security	Austria
3	IKF	Institut für Konfliktforschung	Austria
4	GES	GESINE Intervention (Frauen helfen Frauen EN e.V.)	Germany
5	UU	Uppsala Universitet	Sweden
6	HFPA	Elliniki Psychiatrodikastiki Etaireia	Greece
7	AOU-PR	Azienda Ospedaliero-Universitaria di Parma	Italy
8	PLUS	Paris Lodron University Salzburg	Austria

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Abbreviations and acronyms

D	Deliverable
DV	Domestic Violence
WP	Work Package
TtT	Train-the-Trainer
GBV	Gender-Based Violence

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1. Executive Summary

In response to the widespread need for specialised training in the medical sector, the EU-funded project "VIPROM – Victim Protection in Medicine" aims to harness the practical knowledge of medical staff in order to improve multi-professional support of victims of domestic violence (DV). The VIPROM project is developing European and national curricula on domestic violence for various medical stakeholders (physicians, nurses, midwives, dentists) and students (medical students and dental students) in close cooperation with medical faculties, hospitals, research organisations, medical educators and victim support organisations in Austria, Germany, Greece, Italy and Sweden.

This deliverable D4.2 *Report on Piloting of the Curricula* as part of WP4 describes the preparatory phase of trainees' recruitment strategy, the implementation of the training courses held in every partner country, the barriers and challenges faced during recruitment and implementation, as well as general recommendations on how to implement DV trainings in the medical sector successfully. Moreover, the didactic methodology used to facilitate comparable training courses in different countries as a blueprint is presented.

National piloting of the curricula training courses are based on the methods taught at the VIPROM train-the trainer courses (see D3.2) and the related training handbook to ensure that trainings are of high quality, use state-of-the-art training concepts, taking into account the challenges faced by stakeholders in the clinical context.

The national implementation of the courses in the five VIPROM countries (Austria, Greece, Germany, Italy, Sweden), was highly successful and the project was able to train the VIPROM curriculum **to 492 trainees,** using VIPROM materials and the European training platform on domestic violence. **VIPROM exceeded the number of trainees to be trained (n= 425) by 67 trainees (approx. 11.5% more).**

The present deliverable 4.2, together with deliverables D3.2 and D4.1, the training handbooks and the European training platform, serves as a didactic tool box to be used by all trainers to implement the VIPROM curricula in the most efficient way, ensuring the highest levels of competence and sustainability.

2. Introduction

2.1 Overview on WP4 and task descriptions

Work package 4 (WP4) aims to train national trainers on how to teach healthcare professionals and medical/students about domestic violence (DV) identification and how to support DV victims well, using the curricula and materials developed in VIPROM previously. Work package 4 started in June 2024 (M16) and will continue till May 2025 (M27); for an overview see Figure 1.

In short, based on the **needs assessment** (D2.1), trainings gaps and needs were identified. Consequently, **training contents and curricula** were designed (see D3.1, T3.1, T3.2) and the **training curricula for train-the-trainer** (TtT) course and accompanying TtT handbooks (T3.3, D3.2) were drafted, translated and adapted to the national context. The TtT courses have been piloted (WP4, T4.2) and the recruitment strategy was evaluated (WP5, D5.1). In this **deliverable D4.2**, the report on the *Piloting of the training curricula* is presented. This report encompasses the implementation of all training courses in 5 countries (Austria, Germany, Sweden, Italy and Greece). The evaluation of the training courses for medical stakeholders will be reported in detail in the forthcoming deliverable of WP5 (**D5.3**).

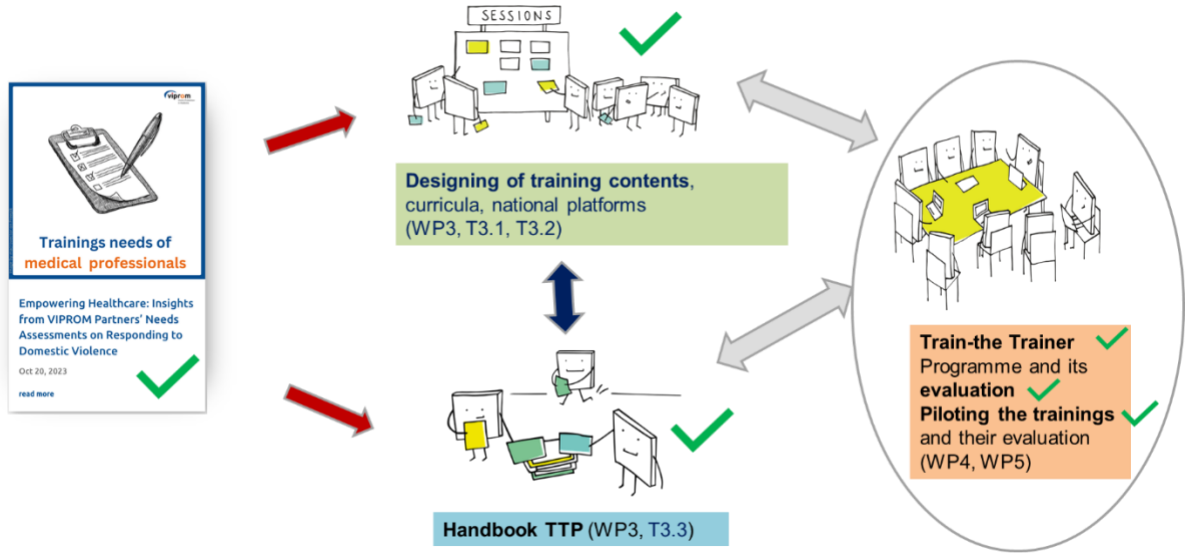

Figure 1. VIPROM in a nutshell. V = task has been completed.

WP4 includes four tasks T4.1-T4.4, this deliverable focuses on T4.3. As short recap:

- **TASK 4.1**: **Recruitment & Preparation of curricula** and **TASK 4.2 Implementing the TtT courses**

Please see **Deliverable 4.1** for further information. In short, T1 & T4.2 entailed the the preparation and implementation of the TtT trainer courses using the train-the-trainer handbook for TtT course participants, introducing the didactic concepts of the VIPROM curricula, which was previously developed with input from all partners to accompany the TtT course (see D3.2). The handbook is available in English and has been translated into German, Italian, Swedish and Greek (see also D3.2). **32 trainers across all VIPROM countries for our chosen stakeholder groups** were trained **These VIPROM trained trainers acted as competence**

centres and champions of the curricula, ensuring sustainability beyond the project duration.

- **TASK 4.3 Conduction of national stakeholder pilot trainings**.

3. Preparatory phase for the implementation of piloting the curricula training courses

3.1 Recruitment strategy

During the period April-June 24 (M14-16), two WP4 task meetings related to the organisation of WP4 TtT courses and piloting the VIPROM Curricula were held. The recruitment strategy and requirement for the national trainers are presented in detail in D4.1.

In the preparation for a successful implementation of the VIRPOM training courses for medical stakeholders, the recruitment strategy for medical professional and students was discussed. Partners concluded that appropriate channels to recruit medical trainees should include:

- Medical conferences and workshops
- Medical Journals and Publications
- Online platforms
- Hospital and Clinic Partnerships
- Professional Associations

Indicative channels to recruit medical students should comprise:

- Medical Schools and Universities
- Students' organisations
- Social media
- Online Learning Platforms
- Student Newsletters and Publications

Partners agreed that a focused approach should be tailored to each group's individual needs and interests, emphasising the importance and relevance of training programs to their professional development and that using a multi-channel approach could improve the overall success of recruiting efforts.

Following the above-mentioned indicative steps, a comprehensive recruitment plan was created to engage both medical professionals and students, ensuring a diverse and qualified participant pool for the pilot testing of the curriculum.

The recruitment strategy that was agreed upon involved the following:

- **Definition of the Target Audience:** focus on the target group you want to train and tailor your training content accordingly
- **Creation of a Compelling Value Proposition:** communicate the benefits of participating in pilot training, as well as highlight any incentives, such as increase in professional skills, issue of a certificate, or others.
- **Establishment of Intersections:** identify common platforms, conferences, and events where medical professionals and students are likely to interact, and partner with medical societies, universities, and teaching hospitals to gain access to their networks.

- **Utilisation of Online Platforms:** Create a strong online presence using social media, professional networking sites, and relevant forums, as well as compelling curriculum content that highlights its value and benefits.
- **Leverage of Academic Institutions:** collaborate with medical schools, nursing schools, and allied health programs to reach out to medical students.
- **Engagement of Professional Associations:** collaborate with medical associations in the targeted specialties, and attend conferences, workshops, and networking events to meet specialists.
- **Contact of Alumni Networks:** contact medical school and university alumni associations and use alumni networks to connect with medical professionals and students.
- **Use of Recruitment Platforms:** advertise opportunities on job boards, medical society websites, and educational platforms to conduct targeted outreach to professionals.
- **Organisation of Information Sessions/info days and Webinars:** organise workshops to explain the curriculum, its goals, and how people can contribute and highlight the collaborative aspect of pilot testing.
- **Creation of a Referral Program:** encourage partners to recommend their peers and co-workers.
- **Establishment of a Clear Application Process:** streamline the application process so that medical professionals and students can apply easily and convey timelines and expectations.
- **Maintaining of Communication:** update participants on the status of the recruitment process regularly and create a communication channel for inquiries and complaints.

In addition, partners agreed on the details of the training courses in regards with duration, group size, number of trainees per training group, time allocation as well as number of trainees per stakeholder group to be achieved by partners.

3.1.1 National recruitment

As partners faced some challenges recruiting trainees due to the tight timeframe and the high rate of seasonal sick leave (wintertime), a third T4.3 meeting was conducted to discuss mitigating measures. Prior to this third T4.3 meeting, lead partner HFPA sent a template to partners to complete to assess what could be further added or optimised in the recruitment process as well as possible barriers and ways to mitigate them.

Answers given to this template revealed that each partner country faced similar as well as different problems in the recruitment process:

- Reduced staff number due to the high rate of seasonal sick leaves
- Work overload due to the high rate of seasonal illnesses such as influenza and the related low number of staff
- Professionals ‘attitudes towards their role in identifying and combatting DV

- Existing hierarchy between medical and nursing competencies and the vulnerability of nurses to experiences of violence and the complexity of the multi-layered recruitment processes in practice.

At the T4.3 meeting several mitigation strategies were discussed such as developing recruitment guidelines to pass them on to partners and trainers, not imposing strict selection criteria, training mixed groups consisting of e.g. physicians and psychologists and offering more than one date for possible trainings. Our implemented national recruiting strategies were successful, as we were able to include more trainees as needed (see chapter 4.1). The recruitment strategy of each participating partner can be found in the following table 1.

Table 1: Trainee recruitment strategies stratified by partner countries

VIPROM country	Recruitment strategies
Austria	In Austria, trainee recruitment was conducted across two locations, Vienna and Graz, using a tailored approach for each audience. In Vienna, medical doctors were recruited primarily through personal contacts and with the support of the medical association "Ärztekammer NÖ." Emails and online announcements were key tools for outreach, resulting in the participation of 14 medical doctors specialising in areas such as general practice, gynaecology, internal medicine, and emergency medicine. Given that capacity limits were not reached, it was decided that no strict selection criteria were necessary. In Graz, the focus shifted to medical students, where the Medical University of Graz facilitated recruitment efforts.
Germany	In Germany (WWU), recruitment was carried out by the trainers using personal and professional networks. Open participation allowed any interested professional to join without restriction. In addition, the training for medical and dental students was offered by the medical faculty in the form of a mandatory elective course in the clinical part of medical school. The only limitation was the maximum number of participants that could be enrolled in one student course (n =17) to ensure a good learning environment. The GESINE network in Germany adopted a multi-channel approach to trainee recruitment, engaging local clinics, cooperation partners, and educational institutes. Recruitment efforts included face-to-face appointments, networking events, targeted emails, and personal phone calls.
Greece	In Greece, recruitment efforts for the VIPROM training sessions were led through a multifaceted strategy that combined personal contacts, academic partnerships, and digital outreach. Trainers collaborated closely with the Medical School of the National & Kapodistrian University of Athens and the Aristotle University of Thessaloniki to reach medical students, while the Greek VIPROM partner Hellenic Forensic Psychiatric Association (HFPA) promoted the sessions for medical professionals through its members, personal networks, social

	media platforms and its official website. There was no formal selection process applied, and registration was open to all interested individuals, within the predefined stakeholder groups.
Italy	In Italy, the recruitment of trainees for the VIPROM curriculum was conducted through a combination of official channels, social media outreach, and the trainers' personal and professional networks. Registration for the sessions was kept open to all stakeholders falling within the predefined groups, without implementing a formal selection process. The only limitation applied was the maximum number of participants that could be accommodated per session due to logistical constraints, ensuring a good learning environment.
Sweden	In Sweden, the recruitment process for trainees was managed directly by the trainers, who used their professional networks and workplace connections to identify potential participants. No formal selection process was established beyond a basic criterion of genuine interest in participating. This open and informal approach enabled a broad and inclusive recruitment, ensuring that those attending the sessions were intrinsically motivated.

4. Piloting of the curricula

4.1 General overview of the national implementation

Work Package 4, T4.3 focused on piloting a newly developed training curriculum addressing the needs of victims of domestic violence in medical settings. Training was carried out across partner countries with adaptations for local contexts.

The training component of the project was designed to equip healthcare professionals and students with the necessary skills and knowledge to address domestic violence effectively. **The implementation of the VIPROM curriculum was highly successful, reaching (n= 492) 11.5% more trainees than promised** (n= 425 trainees) (Table 2**).** Participants presented with a diverse composition in terms of sex/gender, professional background, and level of experience. The participants included midwives, nurses, medical doctors, psychologists, and a substantial cohort of medical/nursing students (see Table 2). The professional background of participants was largely balanced, though some differences were noted, particularly with the representation of midwives, who were slightly underrepresented in certain training locations, for example Germany and Austria. Nevertheless, the diverse professional backgrounds of the trainees contributed to a dynamic interdisciplinary engagement throughout the program.

Training programs varied slightly across locations, but consistently covered key topics such as identifying domestic violence, medical and psychological assessment, legal frameworks, and interagency collaboration. They were delivered through a blended format that combined several complementary methods, including lectures, discussions, practical exercises, and video analysis to promote active engagement and comprehension. The curriculum itself was composed of several interrelated modules, each targeting a key aspect of victim protection in medical practice. One of the primary areas of focus was training professionals to recognise

the often subtle and complex signs of domestic violence. This was coupled with instruction on multi-professional collaboration, emphasising the need for coordinated care and clear communication among different roles within the healthcare system. Legal and ethical dimensions were thoroughly explored, including confidentiality, reporting obligations, and patient rights. Another critical component centred on providing patient-centred support, with specific attention given to referral pathways and strategies for empowering victims within clinical interactions. Each training cycle concluded with feedback collection; the analysis served as the basis for adjustments of future sessions.

Overall, the training initiative succeeded in creating an engaging, reflective, and practice-oriented learning environment that addressed the nuanced needs of healthcare professionals dealing with domestic violence cases.

To summarise, as of 28 April 2025, a total of **219 medical/healthcare professionals and 273 medical students** have been trained through the VIPROM domestic violence education initiative. This achievement marks a significant milestone in building capacity within healthcare systems across participating countries. Among the trained stakeholders, the breakdown includes 22 midwives, 98 doctors, 71 nurses, and 28 other healthcare professionals, including psychologists, social nurses/health visitors, and emergency responders. The scale and diversity of participants reflect the program's strategic emphasis on interdisciplinarity and inclusivity.

Table 2: Number of trainees per country and sex/gender (m = male, f = female)

VIPROM country	Number of trained stakeholders, sex
Austria	**14** medical doctors participated, including general practitioners, gynaecologists, internists, and emergency room doctors, (11 females, 3 males) **38** medical students (27 females, 11 males)
Germany	**20** medical professionals (14 females, 6 males) **58** medical/nurse students (49 females, 9 males)
Greece	**39** healthcare professionals participated, including medical doctors, midwives and nurses (32 females, 7 males) **44** medical students (37 females, 7 males)
Italy	**102** healthcare professionals (92 females, 10 males) **133** medical students (100 females, 33 males)
Sweden	**44** healthcare professionals (41 females, 3 males)
Total number of trainees across countries	**492** (403 females**, 81.9%** / 89 males, **18.1%**)

4.2 National implementation of training courses

In the following chapter the national implementations are described in detail. On our project website also some short reports of the national stakeholder trainings can be found.

4.2.1 National trainings in Austria

In **Austria**, the training sessions were conducted in two locations: Vienna and Graz. In Vienna, a total of 14 healthcare professionals participated. In Graz, the sessions targeted a younger audience, training 38 medical students (see Table 2).

The training content in Austria was comprehensive, addressing domestic violence dynamics, the clinical assessment of victims, the legal obligations of healthcare providers, and mechanisms for interagency cooperation. These sessions aimed to build foundational knowledge and practical competencies to support victims more effectively. The Austrian training sessions primarily utilised lecture-style presentations supplemented with limited interaction and a final question and answer session. This methodological choice was partly due to time constraints and the high amount of material that needed to be covered. (A short profile of the training can be found in Annex 6.1).

One of Austria's strengths was the integration of real-life case narratives from the Austrian healthcare context, which made the sessions more relatable and emotionally impactful. Trainers noted that participants were especially responsive to modules dealing with systemic barriers that victims face, such as language, residency status, and fear of institutional reporting.

Despite the challenges in maintaining attendance, participant feedback underscored the relevance of the training content to their future or current professional practice.

4.2.2 National trainings in Germany

In Germany, **at the University of Münster (WWU),** the recruitment strategy for VIPROM training sessions was carefully structured to align with academic requirements. The training program was rolled out to two distinct target groups: medical students and practicing primary care physicians. Three training sessions were offered as compulsory elective courses for 50 medical students, fully integrated into their graduate curricula. The sessions were scheduled across three weekends - one in November and two in December 24 - providing students with flexibility while maintaining academic rigor. Enrolment was managed through the university's online portal, and participation was mandatory, with performance in the training

contributing directly to final academic evaluations. In addition, 20 general practitioners attended concise two-hour training sessions designed to fit within their demanding professional schedules.

The training sessions combined structured face-to-face lectures with self-study components, allowing flexibility and depth in learning. The content focused on the identification of domestic violence, patient-centred communication strategies, legal obligations, and interdisciplinary collaboration. The hybrid approach for students aimed to encourage active learning and reflection, while the condensed model for physicians ensured that key competencies could be acquired efficiently without overwhelming their time constraints.

The other German partner, **GESINE**, adopted a multi-channel approach to trainee recruitment, engaging local clinics, cooperation partners, and educational institutes. Collaboration with a nursing education centre enabled the scheduling of a mandatory training session on 28 April 2025 for **nursing students**. (A short profile of the German trainings can be found in Annex 6.2).

Germany's implementation of the WP4 curriculum piloting was marked by a structured, highly professionalised approach. Despite recruitment and scheduling challenges, German partners successfully trained 50 medical students and 38 medical professionals (see Table 2). The country's robust infrastructure in medical education and public health allowed for smooth deployment of the training programs, which were held primarily in university hospitals and training centres with strong participation from midwives, nurses, and clinical educators.

German sessions emphasised the intersection of domestic violence with healthcare policy and legal obligations, reflecting the strong regulatory context in the country. Particular attention was given to patient autonomy, confidentiality, and the implications of mandatory reporting laws. Trainers integrated case studies into the sessions to stimulate critical discussion and practical understanding.

4.2.3 National trainings in Greece

In **Greece**, the pilot training sessions were rolled out with considerable engagement across multiple professional and educational contexts. The local partner, HFPA, played a key coordinating role in selecting and preparing peer trainers who had both practical experience and familiarity with gender-based violence (GBV) issues in healthcare.

In total, 83 trainees successfully completed the program, including 69 women and 14 men. The participants came from a range of healthcare professions, namely emergency department staff, midwives, general practitioners, psychiatrists, nurses, and health visitors (see Table 2). The sessions followed a modular structure, mixing theoretical input with scenario-based exercises and discussions.

The training sessions conducted in Greece placed a strong emphasis on the practical implementation of the VIPROM modules. Key areas of focus included identifying subtle, non-physical signs of abuse and behavioural red flags, interpreting legal frameworks relevant to

the Greek healthcare context, and fostering a patient-centred approach that prioritises trust, safety, and empathetic, non-judgmental communication. Particular attention was given to Greece's legal requirements surrounding mandatory reporting, especially within emergency medical settings.

A wide array of instructional techniques was employed to maintain participant engagement and cater to various learning preferences. These included formal lectures, interactive role-playing, and the use of multimedia resources. Of particular importance were the role-playing sessions and case-based discussions, which served as pivotal tools for translating theory into practice. Health professionals also benefited from sharing real-world cases, highlighting the need for improved interdisciplinary collaboration. (A short profile of the Greek trainings can be found in Annex 6.3).

4.2.4 National trainings in Italy

In Italy, the piloting of the VIPROM training curriculum unfolded in both academic and clinical settings, with a focus on integrating the modules into pre-existing educational structures while also reaching practicing healthcare professionals.

Italy successfully engaged 235 trainees across multiple locations and professional backgrounds (see Table 2). Two major training courses were conducted at the Parma University Hospital, while a focused session for physicians took place in Milan. Another training was integrated into a master's program, targeting physicians and psychologists, and an additional session was organised for medical students at the University of Parma

The Italian training emphasised practical applications of the VIPROM modules. Core areas of focus included recognising non-physical and behavioural indicators of abuse, understanding legal protocols specific to the Italian medical system, and developing a patient-centred approach grounded in trust, safety, and non-judgmental communication. Trainers paid close attention to Italian legal obligations around mandatory reporting, especially in emergency care contexts, and highlighted the importance of discretion and cultural sensitivity when dealing with high-risk populations such as migrant women or minors. The trainers employed a rich variety of didactic methods, including lectures, role-playing exercises, case discussions, and multimedia presentations, ensuring high levels of engagement across diverse learning styles. Role-playing exercises and real-life case studies played a central role in the delivery of the material. Italy's multi-stakeholder approach successfully addressed different professional needs, from emergency response protocols to psychological support and legal compliance. This comprehensive coverage made the Italian sessions particularly impactful. The experiences gathered in Italy highlight the benefits of broad-based, interdisciplinary training models that prepare a wide range of healthcare providers to identify and respond effectively to domestic violence cases. A short profile of the Italian trainings can be found in Annex 6.4.

4.2.5 National trainings in Sweden

The training program reached a total of 44 participants, most of which were female (see Table 2).

This multimodal methodology was particularly well-received by participants, who appreciated the practical orientation and diversity of instructional techniques. The training emphasised the identification and management of domestic violence cases within clinical settings, interagency coordination, and legal responsibilities. Throughout the sessions, emphasis was placed on real-world application, preparing participants to respond to domestic violence disclosures effectively. A short profile of the Swedish trainings can be found in Annex 6.5.

4.3 General national training courses evaluation

Participants in all partner countries demonstrated a high level of motivation and sensitivity toward the subject matter. There was a noticeable eagerness to learn the correct methods for intervening in cases of domestic violence. The learning environment was egalitarian and free from hierarchical dynamics. Regardless of professional background or experience, each participant was treated as a peer, and this equality was reflected in the collaborative spirit of the sessions.

During group work, participants actively contributed by sharing personal experiences and perspectives. A significant focus was placed on role-playing scenarios in which individuals attempted to step into the shoes of victims, fostering a deeper understanding of the complexities and emotional dimensions involved. Discussions often turned into practical issues, especially concerning first-line procedures and legal responsibilities. The questions raised reflected both curiosity and a desire for real-world applicability.

Particularly valuable contributions came from the students, whose questions frequently sparked deeper reflection and analysis. Participants were deeply engaged and asked many insightful questions, particularly regarding the process by which women are offered shelter and support after choosing to leave violent situations.

In regards with the trainers' insights, during post-training discussions, almost all trainers expressed strong satisfaction with both the delivery and reception of the sessions. They were especially impressed by the participants' engagement and their thoughtful, open-minded approach to the topic. The trainers described the experience as personally fulfilling and professionally meaningful. They emphasised the importance of this kind of training within the medical field, particularly given that victims of domestic violence often do not have access to specialised support systems and may only encounter healthcare professionals during moments of crisis. This places a unique responsibility on medical staff to be prepared to recognise the signs of abuse and respond appropriately. Trainers stressed that the way healthcare providers approach victims can significantly influence whether those individuals feel supported or further traumatised. Consequently, training that cultivates awareness, sensitivity, and correct intervention techniques is not just helpful, it is essential.

4.3.1 Sneak preview on the feedback of the national trainings

There was a plethora of positive remarks after the trainings in all countries, in regards with quality and comprehensiveness of the training courses. Most participants commented positively on the friendly and inclusive atmosphere created by the trainers. Their remarks can be summarized to the following:

- ✓ Comprehensive and In-depth approach to the topic
- ✓ Approaches and communication with victims
- ✓ Guidelines and practices
- ✓ Exchange of experiences with colleagues and productive, realistic discussions
- ✓ Interactivity between participants and trainers
- ✓ Wide range of teaching methods that made the training engaging and rich
- ✓ Educational platform (a special and useful tool)
- ✓ Utilisation of best practices from other countries
- ✓ Respectful presentation style
- ✓ Thorough and complete bibliographic support for the content
- ✓ Teamwork and experiential nature of the training
- ✓ Positive impact of role-plays
- ✓ Care, friendliness, and enthusiasm of the trainers

The overwhelmingly positive feedback from trainees across different sessions speaks volumes about the value of the domestic violence training programs. One particularly telling piece of feedback came from a Greek participant who remarked, *"It was worth spending my weekend for this training!"* Such sentiments underscore not only the perceived importance of the topic but also the high quality of the educational experience. Furthermore, in one notable case, a medical student was so impressed by the training that she chose to attend the session a second time, despite not being counted twice in official participation figures. These cases reflect the deep resonance that the training content and delivery achieved with its audience *("It was not the content that mattered the most, but the way the trainers delivered it, that made the difference").*

They also highlight the latent demand for this type of specialised knowledge among healthcare professionals and students. Some distinctive comments included: *"It is essential to be included as a mandatory seminar course in Medical School", "It should become a mandatory course for all professionals working in a hospital."* Positive feedback like this provides a strong foundation for the continued expansion and refinement of domestic violence training initiatives, reinforcing the idea that quality education in this field can have a transformative impact on healthcare practice and patient outcomes. As participants heartfeltly stated: *"After the training, I feel more confident and safer to discuss about DV and to act, if necessary."*

Here are some more quotes related to the training courses:

"Thank you very much for the opportunity to be trained in this topic!"

"It is a very important initiative, and I hope it will be repeated in the future."

"Excellent workshop!"

"A very well-organised event, it made me realise the doctor's responsibility in domestic violence, and I now consider it essential in medical training. There should also be protocols in place in all hospitals"

"I'm glad that awareness efforts are finally starting in our country!"

"A very enjoyable educational experience!"

"A huge thank you for this unique and wonderful training!"

“The medical sector needs more trainings on DV!”

“I was really satisfied with this program!”

“Exceptional training course!”

A detailed analyses will be presented in the upcoming D5.3 on the evaluation of the Train-the trainer and stakeholder training courses by IKF in November 2025.

5. Challenges, recommendations & outlook

5.1 Challenges

Conclusions drawn from the training experience across all partner countries revealed several significant challenges that impacted on the overall implementation and effectiveness of the programme. One of the most pressing and consistently observed difficulties was related to participants’ time constraints, which were particularly pronounced among practicing physicians. These healthcare professionals often faced demanding and unpredictable work schedules, making it exceptionally difficult for them to commit to additional activities such as extended training sessions. Their limited availability due to clinical responsibilities and shift patterns emerged as a major obstacle to consistent engagement with the training content.

Recruitment of medical professionals, while initially met with enthusiasm and high levels of interest, quickly proved to be a complex and multifaceted process. Although many healthcare workers expressed willingness to participate, transforming that initial interest into confirmed and sustained involvement was challenging. The primary barriers to effective recruitment were, again, the significant time constraints experienced by potential participants, compounded by a seasonal surge in illnesses that further strained healthcare systems and reduced available capacity. For example, for the German partner GESINE, the first attempts to conduct the trainings were either declined by the clinics, due to excessive workload and fluctuation, or accepted under the specific condition of a timely training format.

These factors made it clear that the original plan to offer comprehensive 8-hour training sessions was overly ambitious and not aligned with the practical realities of healthcare professionals' workloads. As a result, training formats had to be reconsidered and adapted to better accommodate participants’ availability and needs. Minor deviations from original plans were thus recorded, mainly related to participant numbers and session durations, but these did not significantly impact the successful delivery of the program objectives. These deviations reflected the operational challenges inherent to voluntary, extra-curricular educational initiatives.

Despite the logistical and organisational challenges encountered, feedback from participants who were able to attend the sessions was overwhelmingly positive. Many reported that the training content was highly relevant to their professional practice and offered immediate practical application, particularly in recognizing subtle indicators of coercive control and forms of non-physical abuse that often go unnoticed. This positive reception underscored the value of the training and affirmed its importance within healthcare settings. It also highlighted the need to design training programs that are both flexible and responsive to the constraints faced by the target audience, allowing for greater accessibility and impact.

However, the organisational aspect of the training process presented its own set of challenges. Despite careful and detailed planning, the recruitment and event organisation

efforts placed a considerable personal burden on the trainers themselves. Much of the outreach and participant engagement relied heavily on the trainers' own professional and personal networks, which not only increased their workload but also limited the scope and reach of recruitment efforts. This reliance on personal connections revealed a structural weakness in the outreach strategy and strongly highlights the need for a more institutionalised and diversified approach to recruiting participants in future iterations of the program (see chapter 5.2).

In addition to the burden placed on trainers, the training sessions also experienced a few unexpected participant dropouts. These dropouts were primarily due to personal emergencies or last-minute scheduling conflicts, which were largely unavoidable given the nature of medical work. A particularly notable challenge arose when an overlap occurred with a major midwives' conference (as in the case of Greece), slightly affecting attendance rates despite previous attempts to avoid such scheduling conflicts. Nevertheless, even in the face of these setbacks, overall participation remained relatively robust, and dropout rates were lower than might have been expected under the circumstances.

One of the more persistent challenges encountered was maintaining consistent participation throughout the entirety of the training series. While the initial stages saw high levels of registration and interest, there was a gradual increase in attrition over time. This trend was reflected in a slight discrepancy between the number of pre-training and post-training questionnaires completed by participants, indicating that not all who began the training were able to see it through to the end.

Furthermore, the demographics of participants revealed another important area for improvement as there was a particularly low rate of participation among male healthcare professionals and younger individuals within medical stakeholder groups.

5.2 Recommendations

To enhance the accessibility, relevance, and impact of domestic violence training within healthcare systems, several strategic recommendations have emerged from practical implementation experiences. A key lesson is the importance of **adapting training formats to the realities of healthcare work environments**, which are often marked by unpredictable schedules and high workloads. Splitting training into shorter, more focused sessions - ideally two to three hours or half-day formats - has proven to be a practical solution that increases flexibility and facilitates higher participation rates among healthcare professionals. These concise modules are more manageable for busy participants and help sustain engagement throughout the training period. Specifically for students, greater institutional support and strategies to boost commitment among them e.g. such as offering academic credits or certificates may help mitigate attendance issues and enhance the impact of these educational initiatives.

Modularising and intensifying content delivery within shorter timeframes allows essential material to be conveyed effectively without overwhelming learners. Even when sessions are mandatory, such as for apprentices, the inclusion of frequent breaks is essential to manage cognitive load and ensure the absorption of complex topics. Flexibility in training formats, including **in-person, online, and hybrid options**, is also critical to accommodate varying schedules, geographical constraints, and personal preferences.

Embedding training within existing institutional structures, such as medical school curricula and hospital continuing education programs, significantly improves uptake and

sustainability. Institutional partnerships - with medical faculties, hospitals, and other healthcare providers - are essential to anchor domestic violence training as a core component of professional development. Where feasible, integrating sessions into **mandatory curricula** ensures higher attendance and positions the training as an expected professional standard rather than an optional add-on.

Incentivising participation through **certification or continuing education credits** can further encourage full engagement. Moreover, **interactive teaching methods**, such as simulations and practical exercises, are particularly effective. These not only increase engagement but also facilitate the transfer of theoretical knowledge into real-world practice. Feedback consistently shows that participants value training formats that allow for hands-on application and discussion, which helps them feel more confident and competent when dealing with sensitive domestic violence cases.

To support consistent attendance and knowledge retention, **engagement strategies should begin well before training starts**. Pre-training briefings, clear communication about training goals, and ongoing contact with participants help build commitment and clarity. Following the training, providing **continuous learning opportunities** - such as refresher modules, follow-up resources, and professional peer networks - can reinforce learning and deepen competencies over time.

It is equally important to implement **low-threshold evaluation methods** that do not deter participation or overburden attendees. Streamlined feedback forms and accessible assessment tools ensure that useful insights can be collected without creating additional barriers. In parallel, a **robust feedback mechanism** should be institutionalised to continuously refine and improve training content, delivery methods, and logistical arrangements based on participant experiences.

A critical recommendation is the **timing of training sessions**. Scheduling should deliberately avoid peak flu seasons, major holidays, or periods of high clinical demand to improve attendance. Proper calendar coordination with existing events in the healthcare sectors such as conferences or exams, is also essential to prevent conflicts that could negatively affect participation.

Effective **recruitment strategies** are central to the success of training initiatives. Outreach must extend beyond personal networks and should be institutionalised through collaboration with educational and clinical stakeholders. Customised recruitment efforts are especially needed to **engage underrepresented groups**, such as male healthcare professionals and younger practitioners, whose participation has historically been lower. Strategic communication campaigns using **diverse digital and traditional platforms** can raise awareness and drive enrolment across a broader audience. **Leveraging existing community and institutional networks and deepening institutional partnerships** including hospitals, women's shelters, and police departments can amplify recruitment efforts, build momentum around the training initiative and secure long-term program sustainability. These partnerships not only broaden reach but also strengthen the program's credibility and relevance across sectors. Collaborations with universities, hospitals, professional associations, and other key stakeholders are essential to embedding training into formal education and professional development frameworks. Such integration not only strengthens the legitimacy and visibility of the training but also ensures that domestic violence awareness becomes a standard component of professional competency across sectors.

A key priority is the **ongoing expansion of the participant base**, with additional professionals to be scheduled for future training courses. This continued rollout is critical to ensure that

capacity-building efforts are sustained over time and that a broader spectrum of professionals across disciplines is engaged. Future training sessions should place particular emphasis on **diversifying the participant pool** including professionals from healthcare, social services, the legal sector, and law enforcement to reinforce a truly interdisciplinary approach to domestic violence prevention and response.

Training programs are increasingly encouraged to **integrate best practices** into their design and delivery. Building on proven models, expanding the availability of **hybrid learning environments** combining online and in-person instruction can further increase accessibility, especially for participants in geographically dispersed or resource-constrained settings.

Future trainings should be combined with a continued emphasis on **quality improvement through feedback loops**. Ongoing assessment and incorporation of participant input will allow training content, methodologies, and logistics to evolve in line with professional standards and emerging challenges. This commitment to continuous learning and adaptive program design reinforces the broader goal of long-term, system-wide change.

Finally, emphasising the **concrete professional benefits** of the training such as improved clinical skills, enhanced patient care, and career development opportunities can significantly boost motivation to attend. Framing the training as not only a duty but also an asset to professional practice ensures it is perceived as relevant and valuable.

In summary, the future direction of domestic violence training initiatives should emphasize **scaling inclusively, enhancing educational design, forging strong institutional ties, reaching underserved areas, and continuously improving based on real-world feedback**. Effective domestic violence training in healthcare settings depends on a combination of **adaptability, strategic planning, interactive content, and inclusive outreach**. Programs that are tailored to the logistical and cognitive capacities of healthcare professionals, embedded within institutional structures (see D2.2), and supported by continuous engagement and feedback mechanisms are more likely to achieve sustained impact. Such thoughtfully designed and implemented training initiatives play a critical role in equipping healthcare providers with the skills and confidence needed to identify and respond to domestic violence with sensitivity and competence. Moving forward, continuous investment in training, strategic dissemination of materials, and enhanced integration into professional education pathways will be essential to sustain momentum and build a resilient, trauma-informed healthcare workforce capable of effectively supporting survivors of violence.

By following these general recommendations, training programs can further elevate their impact and empower a wide range of professionals – also in other countries beyond the VIPROM partner countries to respond to domestic violence with greater competence, confidence, and good collaboration.

5.3 Outlook

After the completion of the training courses, the next steps will be **task 4.4**: European Webinar Series completion (M25-35). Currently, in **task 4.4** (European Webinar Series)**,** 5 webinars have already been held and are continuing within the time frame.

Looking ahead, the continued growth and refinement of domestic violence training initiatives require a clear strategic vision centred on inclusivity, sustainability, and responsiveness to evolving professional needs. Building upon established foundations, upcoming training

sessions should aim not only to replicate past successes but to expand the program's reach and deepen its overall impact through targeted improvements and innovation.

Partners have already planned or scheduled new trainings in 2025 and 2025 beyond this task. Further plans involve **expanding outreach to rural and underserved communities**, where access to training has historically been limited and where awareness gaps remain significant.

6. Annexes

Annex 6.1: Brief report on the Austrian training

Recruitment:

Medical Students

- Recruitment was conducted through personal contacts and the medical association “Ärztekammer NÖ”, via emails and website announcements.
- No strict selection criteria were applied, as space limitations were not reached.

Other Medical Stakeholders

- Recruitment was conducted via the Medical University of Graz for medical students.

Completed trainings:

Medical Students

- **Number of trainees:** 38 fourth- and fifth-year medical students.
- **Demographics:** 27 women, 11 men, aged 22-30, with an average age of 24.5 years.
- **Training locations**: Medical University of Graz & Frauengesundheitszentrum Graz.
- **Training focus:** Use of interactive methods (videos, roleplay, group exercises). **Challenges**: Notably, there was a significant dropout rate for the second session among the students. Several challenges were identified, including competing academic commitments and the voluntary status of the training, which reduced participants' perceived obligation to attend.

Medical Doctors (Primary Care Physicians)

- **Number of trainees:** 14 medical doctors participated, including general practitioners, gynaecologists, internists, and emergency room doctors.
- **Demographics:** 11 women, 3 men, aged 30-76, with varying experience in domestic violence (DV) issues.
- **Training location:** Ärztekammer NÖ, Vienna.
- **Training focus:** Lecture-style presentation, minimal interaction, Q&A session
- **Challenges**: Time constraints for participants, especially doctors with demanding workload

Annex 6.2: Brief report on the German trainings

Recruitment:

Medical Students

- Three VIPROM training sessions were offered as compulsory elective graduate courses for medical students.
- Enrolment was managed online through the medical faculty, and attendance was mandatory for students as part of their academic requirements.

Other Medical Stakeholders

- Despite initial interest, securing participation for concrete training sessions proved difficult. A high rate of illness among stakeholders, including key trainers, posed significant challenges.

Completed trainings:

Medical Students

- **Number of trainees:** 50
- Training locations: University of Münster and Witten/Herdecke Medical University
- **Demographics:** 42 females, 8 males, aged 22–34 years
- **Training focus:** Face-to-face learning**:** 13 study weeks (1 SW = 45 minutes), Self-study assignments: 15 hours, total duration: 28 study weeks (SW). Methods used: role-plays, group discussions, online surveys, video analysis, and case studies
- **Challenges:** none

Medical Doctors (Primary Care Physicians)

- **Number of trainees:** 20 (trained in two 2-hour sessions)
- **Demographics:** 16 females, 4 males, aged 28–42 years
- **Training location:** Rostock, Germany
- **Training focus:** Communication strategies, documentation, and legal aspects related to domestic violence cases
- **Challenges:** Seasonal illnesses (e.g., influenza, pneumonia) prevented planned trainings in early 2025 - Busy schedules of stakeholders limited their ability to commit to lengthy training sessions - despite the original interest and efforts of the responsible director to implement the training for her nurses' team, which highlights the necessity of DV training for this specific stakeholder group, a scheduled training had to be cancelled due to low registration

Nursing students (GESINE training):

Recruitment:

- Recruitment efforts included face-to-face appointments, networking events, targeted emails, and personal phone calls.
- Despite the proactive recruitment strategy, significant barriers emerged.
- To overcome these challenges, the team strategically shifted their approach by engaging a long-standing and trusted partner, the Dörte-Krause-Institute—a nursing education centre affiliated with the hospital.

Completed trainings:

- **Number of trainees:** 8
- **Demographics:** 7 female, 1 male – age range: 20-27 years
- **Training location:** Nursery School (Dörte-Krause-Institut)
- **Training focus:** Use of the structure provided in the Train-the-Trainer course in Münster regarding the basic, advanced and optional content. Power Point as base plus a more interactive approach: activating the knowledge of the students, opening dialogues, individual or group works and role-plays, using case studies provided by the nurses from their daily practice.
- **Challenges:** High workload and fluctuation -The evaluation process posed an additional burden on already overstretched clinics, leading some institutions to decline participation altogether.

Annex 6.3: Brief report on the Greek trainings

Recruitment:

- In Greece, recruitment efforts for the VIPROM training sessions were led through a multifaceted strategy that combined personal contacts, academic partnerships, and digital outreach.
- There was no formal selection process applied, and registration was open to all interested individuals, within the predefined stakeholder groups.

Completed trainings:

Medical Students

- **Number of trainees:** 44 medical students, primarily 4th & 5th year
- **Demographics:** 37 female, 7 males
- **Training locations:** AKISA Building, Medical School, National & Kapodistrian University of Athens (NKUA) – Medical School, Aristotle University of Thessaloniki (AUTH)
- **Training focus:** Role-plays, group discussions, online surveys, video analysis, and case studies
- **Challenges:** None

Healthcare Professionals

- **Number of trainees:** 39
- **Demographics:** 32 female, 7 males
- **Breakdown of participants**: 9 midwives, 14 nurses, 14 medical doctors, 2 other healthcare professionals (social nurses)
- **Training location:** AKISA Building, Medical School, National & Kapodistrian University of Athens (NKUA)
- **Training focus:** Role-plays, group discussions, online surveys, video analysis, and case studies
- **Challenges:** An overlap with a midwives' congress that resulted in a few dropouts

Annex 6.4: Brief report on the Italian trainings

Recruitment:

- In Italy, the recruitment of trainees for the VIPROM curriculum was conducted through a combination of official channels, social media outreach, and the trainers' personal and professional networks.
- Registration for the sessions was kept open to all stakeholders falling within the predefined groups, without implementing a formal selection process.
- The only limitation applied was the maximum number of participants that could be accommodated per session due to logistical constraints, ensuring a good learning environment.

Completed trainings:

Medical Students

- **Number of trainees:** 133
- **Demographics:** 100 females, 33 males
- **Training locations:** Parma University Hospital, University of Parma, Milan
- **Training focus:** Lectures, group work, videos, case studies, simulations

Healthcare Professionals

- **Number of trainees:** 102
- **Demographics:** 92 female, 10 males
- **Breakdown of participants**: 9 midwives, 40 nurses, 36 medical doctors, 17 other healthcare professionals (psychologists, coordinators)
- **Training location:** Parma University Hospital, University of Parma, Milan
- **Training focus:** Lectures, group work, videos, case studies, simulations
- **Challenges:** Difficulty ensuring constant participation throughout the training series - The number of completed post-training questionnaires was significantly lower than the number of pre-training questionnaires due to participant dropout - Low participation of males and young healthcare professionals, with the highest participation among females aged 50–59.

Annex 6.5: Brief report on the Swedish trainings

Recruitment:

- In Sweden, the recruitment process for trainees was managed directly by the trainers, who used their professional networks and workplace connections to identify potential participants.
- No formal selection process was established beyond a basic criterion of genuine interest in participating.
- This open and informal approach enabled a broad and inclusive recruitment, ensuring that those attending the sessions were intrinsically motivated.

Completed trainings:

Healthcare Professionals

- **Number of trainees:** 44
- **Demographics:** 41 females, 3 males
- **Breakdown of participants**: 4 midwives, 17 nurses, 14 medical doctors, 9 other healthcare professionals (psychologists)
- **Training location:** Västerås, Uppsala
- **Training focus:** 8-hour training session + 4 hours of preparation with presentations, discussions, practical exercises (role-play), video watching

Challenges: A few dropouts due to heavy workload – 1 course didn't start due to low registration level – not able to train medical students -trained less psychologists than expected