

Addressing violence against women in pre-service health training



Integrating content from the *Caring for women subjected to violence* curriculum



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Abbreviations

CBE	competency-based education
CRC	curriculum review committee
IPV	intimate partner violence
MCQ	multiple choice question
OSCE	objective structured clinical examination
STI	sexually transmitted infection
VAW	violence against women
WHO	World Health Organization

Glossary

Attitude	A person's feelings, values and beliefs, which influence their behaviour and the performance of tasks (1).
Behaviour	Observable conduct towards other people or tasks that expresses a competency. Behaviours are measurable in the performance of tasks (1).
Competencies	The abilities of a person to integrate knowledge, attitudes and skills into their performance of tasks in a given context. Competencies are durable, trainable and, through their expression as behaviours, measurable (1).
Competency-based curriculum	A curriculum that emphasizes the complex outcomes of learning (such as skill acquisition and behaviour change) rather than focusing on what learners are expected to learn about a subject (2).
Competent	Descriptive of a person who can perform the designated practice activities to the defined standard of their profession (1).

Curriculum	The totality of organized educational activities and environments that are designed to achieve specific learning goals. The curriculum encompasses the content of learning; the organization and sequencing of content; the learning experiences; teaching methods; the formats of assessment; and quality improvement and programmatic evaluation (3).
Education	The process of facilitating learning or the acquisition of knowledge, skills, values, beliefs and habits (4).
Health practitioner	Any person engaged in actions whose primary intent is to enhance health, for example, nurses, doctors, midwives, pharmacists, radiology technicians.
Health worker student	Any person enrolled in a pre-service training programme prior to employment in a health service setting, for example, medical, nursing or midwifery students.
In-service education or training	Any structured learning activity for persons already employed in a service setting, for example, health practitioners working in the public or private sector (5).
Intimate partner violence	Ongoing or past behaviours/acts by an intimate partner or ex-partner, such as a spouse, cohabiting partner or lover, current or past, that cause(s) physical, or psychological/emotional or sexual harm(s). This may include physical violence, emotional/psychological abuse, controlling behaviours and sexual violence or coercion.
Knowledge	Awareness or understanding of information about a subject gained through experience or study.
Pre-service education or training	Any structured learning activity that takes place prior to and as a prerequisite for employment in a service setting, for example, public health service or private practice (5).
Sexual violence	Any sexual act or attempt to obtain a sexual act using coercion or force, as well as unwanted sexual comments or advances.
Training	A form of education focused on developing skills, especially in a job setting.
Violence against women	Any act of gender-based violence that results in, or is likely to result in, the physical, sexual or mental harm or suffering of women.

Purpose and overview

1. Background

Violence against women (VAW), including intimate partner violence (IPV) and sexual violence, is common in the lives of many women (6). Violence against women is associated with many short- and long-term harmful physical and mental health problems and conditions. The health sector has an important role to play in preventing and responding to it (7). The World Health Organization (WHO) recommends training health practitioners to respond to violence against women. Box 1 summarizes WHO clinical and policy recommendations on training health care providers to respond to violence against women (15).

This document seeks to provide pre-service health training programmes, such as in medical, nursing and midwifery schools, with the knowledge and resources to better prepare their students to care for women subjected to violence.

This document is a companion to the WHO publication *Caring for women subjected to violence: a WHO curriculum for training health care providers* (subsequently referred to as the WHO curriculum) (6). It draws on WHO clinical guidelines for the health sector and is in line with the goal of a comprehensive health system response to end violence against women and girls, as outlined in the WHO Global Plan of Action (7).

This document seeks to provide pre-service health training programmes, such as in medical, nursing and midwifery schools, with the knowledge and resources to better prepare their students to care for women subjected to violence. Curriculum content on such care can ensure that future generations of the health workforce are equipped to provide empathic, high-quality care to those subjected to or affected by violence.

2. Why should health worker students learn about violence against women?

Violence against women is rooted in harmful, unequal gender norms that privilege the power and sexual entitlement of men and subordinate women. Health care practitioners, like all of us, have been socialized to assume many preconceptions and stereotypes about women subjected to violence. These attitudes can normalize violence against women in the minds of health care practitioners and lead to victim-blaming instead of helpful, supportive actions.

Intimate partner violence and sexual violence can lead to significant physical and mental health problems and conditions (8, 9). By providing safe and effective woman-centred care, appropriately trained health practitioners can help to alleviate the health consequences of violence and reduce the recurrence of violence. This care includes first-line support as well as other care, prophylaxis or treatment of sexually transmitted infections (STIs) and unwanted pregnancy, and management of common mental health consequences such as anxiety, depression and post-traumatic stress.

Yet, due to fear of stigma, discrimination and judgment, few survivors explicitly report or seek care when subjected to violence, even though they are more likely to engage with health services than those who have not experienced violence (10). Thus, it is important that health practitioners are trained to identify women being subjected to violence and to provide the medical care, support and referrals that they need.

Box 1. WHO recommendations for training health care practitioners to respond to violence against women



1. Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault should be given to health care practitioners (in particular, doctors, nurses and midwives).
2. Health care practitioners offering care to women should receive in-service training, ensuring it:
 - enables them to provide first-line support
 - teaches them appropriate skills, including:
 - when and how to inquire
 - the best way to respond to women
 - how to conduct forensic evidence collection where appropriate
 - addresses:
 - basic knowledge about violence against women, including laws that are relevant to victims of intimate partner violence and sexual violence
 - knowledge of existing services that may offer support to those who have been subjected to intimate partner violence and sexual violence
 - inappropriate attitudes among health care practitioners (for example, blaming women for the violence, expecting them to leave an abusive partner)
 - their own experiences of partner and sexual violence.
3. Training for health care practitioners on intimate partner violence and sexual assault should include different aspects of the response to intimate partner violence and sexual assault (for example, identification, safety assessment and planning, communication and clinical skills, documentation and provision of referrals).
4. Training for both intimate partner violence and sexual assault should be integrated into the same programme, given the overlap between the two issues and the limited resources available for training health care practitioners on these issues.

Source: Adapted from WHO, 2013 (15).

Comprehensive, survivor-centred training can enhance the knowledge and improve the attitudes of health practitioners and health worker students and increase their readiness to care for survivors of violence (11-14). It is important to introduce the topics of intimate partner violence and sexual violence early in pre-service health training programmes. This allows time to build sensitive, woman-centred attitudes that respect the decisions and autonomy of women subjected to violence. Education on violence against women also can increase students' comfort in talking with their future patients about partner/domestic violence, sexual violence and other "sensitive" topics. Also, development of content on violence against women helps to legitimize care for women subjected to violence as a health priority and to increase institutional support to address health issues that require particular attention to gender equality and human rights.

Education on violence against women also can increase students' comfort in talking with their future patients about partner/domestic violence, sexual violence and other "sensitive" topics

3. Who this guide is for

This guide was created for curriculum developers, policy and decision-makers, educators, programme managers, faculty, clinical instructors, and exam writers of pre-service health training programmes.

While this guide is designed primarily for pre-service medical, nursing and midwifery training programmes, several other programmes may benefit from this guide, such as those for training in social work, pharmacy, physical therapy, occupational therapy, dentistry, and for emergency medical technicians and paramedics.

4. How this guide should be used

This guide should be used in conjunction with the WHO violence against women *Caring for Survivors* curriculum (www.who.int/publications/i/item/9789240039803), which consists of 17 training sessions for health care providers and health managers on the health response to violence against women. The present document serves as a companion document to help integrate and adapt the sessions into pre-service health worker education programmes, providing guidance on planning, developing and implementing the WHO curriculum. It should be adapted to students' profession and educational level, local resources and the legal and sociocultural context of the health training programme.

This document is based on evidence concerning violence against women, but the principles could be adapted for providing care to people of any sex, gender identity, sexual orientation, level of physical and cognitive ability, race, ethnicity or age who experience violence.

Developing competencies for caring for women subjected to violence

Competency-based education (CBE) is an approach to curriculum planning, development and implementation that focuses on a student's ability to apply the desired knowledge, attitudes and skills in practice, in contrast to more conventional approaches that focus on the acquisition of knowledge, attitudes and skills (15, 16). The WHO curriculum on violence against women uses a competency-based approach to ensure that health care workers are equipped with the requisite skills to effectively care for survivors of violence. This approach is adapted here for use with students in pre-service health training programmes. Many health training programmes already use a competency-based curriculum structure.

The list on the following page, adapted from the WHO curriculum, includes suggested competencies that can be and have been incorporated into pre-service health curricula on violence against women.

The WHO curriculum on violence against women uses a competency-based approach to ensure that health care workers are equipped with the requisite skills to effectively care for survivors of violence. This approach is adapted here for use with students in pre-service health training programmes. Many health training programmes already use a competency-based curriculum structure.



Table 1. A health worker student competent to provide services for women subjected to violence:

<p>1. seeks to mitigate the health consequences of violence against women;</p>	<p>2. demonstrates self-awareness of beliefs, assumptions, potential biases and emotional responses that can affect interactions with women subjected to violence;</p>
<p>3. identifies women experiencing violence through signs and symptoms that suggest intimate partner violence and maintains a high index of suspicion;</p>	<p>4. adopts an approach to care and services that is non-blaming, non-judgemental and supportive of women subjected to violence;</p>
<p>5. communicates empathically, sensitively and effectively with patients/survivors;</p>	<p>6. demonstrates the skills to offer first-line support appropriate to their level of education for their profession and specialty.</p>
<p>7. knows how to provide appropriate treatment and care to survivors of sexual assault, including rape and abuse;</p>	<p>8. coordinates effectively with other services in caring for women subjected to violence.</p>

Overview: steps to integrate WHO training content into pre-service curricula

Whether a health care training programme wants to use the WHO curriculum to develop new content on violence against women or to enhance an existing curriculum, these three steps can guide the process:

Step 1. Plan.

The planning stage often starts with finding a faculty or staff member with an interest in addressing violence against women. This champion can help to lead the planning process, including conducting a needs assessment. A needs assessment helps to identify strengths and gaps in the existing curriculum and informs the identification of competencies that the curriculum on violence against women will address. Then, a proposal can be drafted specifying what the new curriculum content will accomplish, including competencies, and what resources will be needed. This proposal can be presented to and reviewed by the curriculum review committee (CRC) or any similar group that meets regularly to guide curricular content and structure.

The following questions can guide planning:

- “Who are potential clinical or educational champions for violence against women at this institution?”
- “How is violence against women currently covered in our curriculum, and what gaps exist?”
- “What knowledge, attitudes and skills should our students have in order to competently care for women subjected to violence?”
- “What is the timetable for implementation; who will be responsible for the updated curriculum content; and what resources will be required?”



The planning stage often starts with finding a faculty or staff member with an interest in addressing violence against women. This champion can help to lead the planning process, including conducting a needs assessment.

Step 2. Develop.



During this stage competencies are translated into a curriculum structure on caring for women subjected to violence. Decisions are made about the appropriate number and length of sessions and where the content will be covered – in dedicated sessions and/or integrated within the general curriculum or within specific topics/specialties, for example, primary care, psychiatry, obstetrics and gynaecology, paediatrics, accidents and emergencies. Educational content can be taken and adapted from the WHO curriculum. Teaching strategies can then be identified, depending on session content and local context. Once the curriculum structure is agreed, educators can be identified and trained. During this stage, it should be decided how students will be assessed, for example, written exams, direct observation, case management review or other means.

The following questions guide this step:

- “Within our existing curriculum, how will we structure and format training on care for women subjected to violence?”
- “How will facilitators be trained and mentored?”
- “What teaching strategies will be employed?”
- “How and when will student competencies be evaluated?”
- “What are the intended learning outcomes?” (for example, knowledge-based, as in understanding the relationship between violence and health, or competency-based, such as developing skills on how to ask women about intimate partner violence.)

Step 3. Implement and evaluate.



The final stage is to implement the curriculum on caring for women subjected to violence. This often starts by conducting a pilot-test, where a subgroup of students, such as third-year medical students, participates in training over a designated period. Pilot-testing is an opportunity to gather feedback and adjust the curriculum as needed. Then, the content can be scaled up to include larger groups of students over longer periods of time. Finally, evaluations from educators and students are collected and fed back to the CRC to improve future iterations of the training.

The following questions guide this step:

- “Which sessions should be pilot-tested with which students?”
- “How will students’ and facilitators’ feedback be assessed and applied?”
- “Is the curriculum content meeting its intended objectives, and how does it need to be improved?”



STEP 1.

Planning curriculum content

The planning process is perhaps the most important step in developing curriculum content on caring for women subjected to violence. The planning stage often starts with an institutional champion who has advocated development of the curriculum. Then, this individual or a subcommittee conducts a needs assessment to review current curriculum content, if any, on caring for women subjected to violence (Annex 1). Then, a proposal is drafted suggesting updates and additions to the curriculum. A CRC or similar body can review the proposal to make a final decision about the new curriculum content and its proposed competencies.

1. Identify champions to address violence against women

A champion is someone who is committed to addressing violence against women and who can advocate – with colleagues and with the administration – the inclusion of violence against women in the curriculum. It is often necessary to find such a champion, given that a curriculum on violence against women may be new to an institution and, like all new clinical and educational processes, may face challenges and obstacles to implementation. The champion's role is to develop momentum for adding the new content to the curriculum. If an influential champion is not already apparent, a senior champion may need to be recruited. During the planning stage, the champion or a group of champions may form a sub-committee to help with the planning stage tasks, and at times take on a support role to other faculty.

2. Solicit institutional support

During this stage it is important to solicit support from stakeholders from various disciplines to increase interdepartmental buy-in. It may be helpful to see if institutional or local accreditation standards exist that already include violence against women; this may increase stakeholder support. WHO, alongside several regional and national health organizations, professional associations and societies, recommends that pre-service health training include content on caring for women subjected to violence. Governments have also committed to this as one of the strategies to strengthen health service delivery and health workers' capacity to respond to violence against women (7). Advocacy from women's rights and health organizations and evidence on the health impacts of violence on women's health can help motivate more action.

3. Conduct a needs assessment

A needs assessment is a process of gathering information on how care for women subjected to violence is currently addressed in the curriculum and what will be needed to introduce new content on violence against women. The needs assessment can identify gaps between the existing curriculum and what learners should know. Annex 1 provides an example of a needs assessment, which can be adapted to local context. Review of the WHO competencies presented in Table 1 (on page 9) can help to identify gaps in the current curriculum and set goals for the new curriculum content. It can be helpful to meet with faculty, staff and students involved in the current curriculum to obtain their input and buy-in.

4. What is a curriculum review committee (CRC)?

A CRC is an advisory group that convenes regularly to review, evaluate and update curriculum at pre-service health training institutions. The CRC helps ensure that the curriculum prepares students to apply the knowledge, skills and attitudes needed for their profession. A proposal to enhance curricula by adding content on care for women subjected to violence usually would be submitted to the CRC or its equivalent for review.

Some health training programmes may not have a CRC, or they may delegate responsibility to another leadership group. In such cases changes to curricula may be made by one person or a group of people, such as heads of departments, deans of students, clinical educators or lecturers. If this is the case, a proposal can be presented to this individual or group for review.

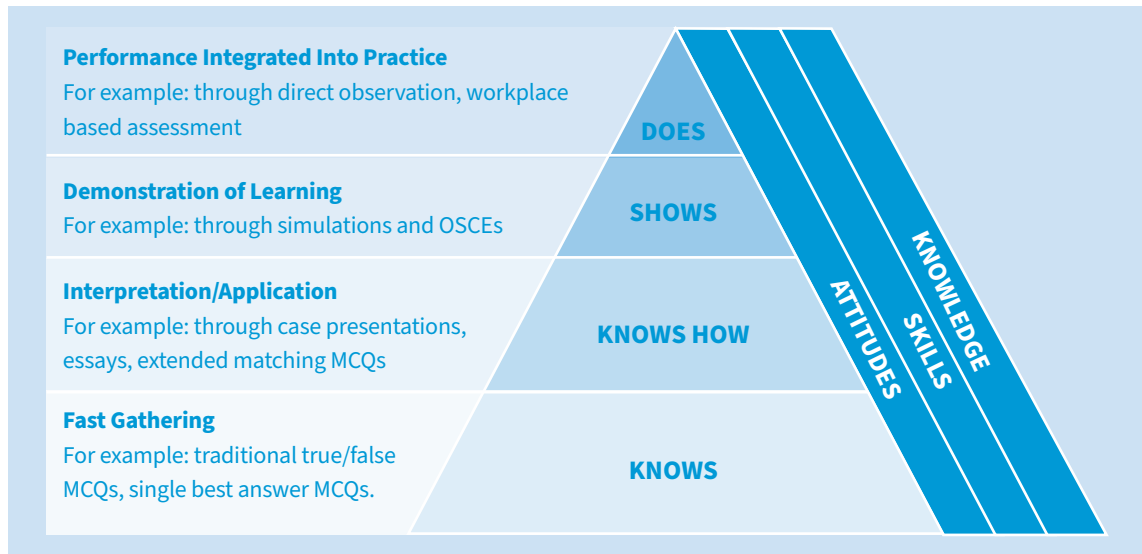
5. Establish specific, measurable competencies

Development of curriculum content should begin with the end in mind: What competencies should students develop as a result of taking the content? Review of the competencies in Table 1, adapted from the WHO curriculum, can serve as a starting point for identifying a set of competencies around which to build a curriculum.

Competencies are described in concise statements about what abilities the student should have, upon completion of the VAW curriculum content, to effectively care for survivors of violence according to their profession. Competencies should be long-lasting, trainable and measurable, such that upon completion of the module or curriculum content, the student's competence in caring for women subjected to violence can be evaluated.

Competencies should not focus on acquisition of knowledge alone, but also on the application of knowledge in practice. Measurable verbs used in competency statements reflect the “shows how” and “does” levels of performance, rather than the earlier learning stages of “knowledge” and “knows how”. Miller's pyramid of competency can help with selecting measurable verbs for the competencies (17) (Fig. 1).

Fig. 1. Miller's pyramid of competence



OSCE = objective structured clinical examination; MCQ = multiple choice question

Source: Miller, 1990 (17).

Examples of incorrect and correct ways to format competencies:



Know the five steps of first-line support (“LIVES”) to care for survivors of IPV.



Provide first-line support to survivors of IPV using the techniques of “LIVES”.

Competencies should be adapted to local health needs, as well as to local geographic, social, cultural and legal context. For example, local laws on sexual assault or domestic violence and resources available to women subjected to violence may be important factors to consider in developing locally relevant standards for competencies.

6. Develop a curriculum proposal

A curriculum proposal is a way to communicate to leadership the rationale for curricular change, explaining why it is necessary to include the subject of violence against women and how it should be incorporated into the existing curriculum. The proposal is a broad overview of what the new curriculum content or module will accomplish and what resources will be needed.

The proposal may have several components, such as:

1. brief description of proposed content for the curriculum
2. rationale/justification for changes
3. expected competencies
4. timetable for implementation
5. required resources.

The following is an overview of the contents of a typical curriculum proposal. A printable worksheet can be found as Annex 2 to this publication. Some institutions have a specific format for curriculum proposals; if so, that should be followed.

Table 2. Curriculum proposal contents

Title of new content	
Professional school	
Student year(s) of training	
Brief proposal description	
Rationale	
How does the new curriculum content fit into the profession's mission?	
Proposed competencies	
Timetable for implementation	
Course structure: Describe the proposed structure, for example, a new module, single or multiple sessions within existing curriculum. Will the sessions be mandatory or elective?	
Resources <ul style="list-style-type: none"> • When will the sessions take place? How many sessions are proposed and how long will each session be? • Who will facilitate sessions/deliver the content? • Where will sessions take place? • How will educators/trainers be supported, mentored and supervised? • What resources (for example, equipment) and support are needed for implementation? 	

7. Next steps

Once the proposal is complete, the CRC can review it, discuss questions and concerns and make recommendations. Then, the CRC can approve the final proposal and competencies of the new curriculum content. The CRC may assign specific time slots and allocate resources to the new curriculum content, which will be important to determining its structure.



STEP 2. Developing curriculum content

Once the curriculum proposal is approved, the next step is to develop the granular details of the curriculum content, including how it will be structured, delivered and assessed.

Developing curriculum content involves several stages:

- determine structure
- select session content and adapt to local context
- choose teaching strategies
- identify and prepare facilitators
- determine learner assessment methods and criteria for success.

The WHO curriculum includes 13 sessions for health care practitioners (clinical) and four for health managers; some sessions are relevant to both cadres. The training typically is delivered in two and a half to three days. However, the format of a preservice curriculum on violence against women will depend on context, resources and curricular constraints. Possible ways to structure pre-service education on caring for women subjected to violence are described below. Also, see Annex 3 for example agendas.

1. Determine structure

There are several options for structuring content on care for women subjected to violence within a broader existing health care curriculum:

1. Dedicated learning sessions

These are distinct sessions focused on intimate partner/domestic violence and sexual violence, such as those provided in the WHO curriculum. Dedicated sessions help students acquire and apply foundational knowledge, attitudes and skills to respond to violence against women in clinical settings. They can help shape attitudes, making the students more sensitive to the impact of gender and other inequalities on a woman's health and encouraging an approach to practice that respects her decisions and autonomy. Dedicated sessions (with practice) also can enhance students' interviewing skills, increasing their comfort with asking about partner violence and in caring for women subjected to violence.

a. Single learning session. Sometimes, only a single half-day of pre-service education can be allocated to care for women subjected to violence. If only a single session can be allocated, consider whether content can be spread over such annual sessions so that students learn content cumulatively over the course of earning their degrees. A single session can take multiple formats, for example:

- Lecture + patient scenario + debrief
- Lecture + small group session + role play + debrief.

b. Multiple learning sessions. Ideally, multiple sessions will be allocated to the curriculum content on caring for women subjected to violence, as the core content is too large to fit into one session, and repeat sessions consolidate learners' knowledge. This can be accomplished by adding multiple learning sessions into an existing course or by creating a new course/module on violence against women. Additionally, more sessions on VAW lead to improvements in students' survivor-centred attitudes and comfort in caring for women subjected to violence (18). The choice of which and how many sessions may depend on course structure (for example, how many hours/credits/modules can be allotted) as well as student factors, such as pre-clinical versus clinical training levels (Box 2).

Box 2: Considerations for training pre-clinical versus clinical students on caring for women subjected to violence

Pre-clinical students	Clinical students
Less familiarity with real-world clinical scenarios	More familiarity with real-world clinical scenarios
Opportunity to develop foundational knowledge, attitudes and skills prior to clinical exposure	May have already developed harmful attitudes or behaviours towards survivors in clinical settings
May have greater discomfort and require more sensitization to patient scenarios that include violence against women	Can apply lessons learned directly to clinical settings
Less developed skills in problem-solving and decision-making.	May be more open to patient scenarios that include violence.

2. Integration throughout the curriculum

Another option is to integrate topics on violence against women throughout the existing curriculum. Integration helps to demonstrate that care for women subjected to violence

is interdisciplinary and relevant to many different health topics. There are several common subjects in pre-service health training programmes that lend themselves particularly well to the discussion of violence against women. The list in box 3 includes subjects commonly covered in medical and nursing schools where content on VAW might be added; similar courses are likely to be taught in other health care professional curricula.

There are several common subjects in pre-service health training programmes that lend themselves particularly well to the discussion of violence against women.

Box 3. Common courses suitable for integration of VAW topics

Pre-clinical courses

- reproductive health
- trauma, burns, accidents and injuries
- communication, interviewing and physical examination skills
- behavioural and mental health
- medical ethics
- community/preventive medicine.

Clinical courses

- primary/ambulatory care and family medicine
- emergency medicine/accidents and emergencies
- infectious disease
- obstetrics and gynaecology
- surgery
- psychiatry
- paediatrics
- forensic medicine.

3. Multiple sessions + curriculum integration (preferred)

The preferred structure, if feasible, is to have multiple specific sessions on violence against women and topics integrated throughout the existing curriculum. This allows learners to develop foundational knowledge, attitudes and skills and to integrate those principles into the different fields of practice.

4. Electives

Another way to structure VAW education is through electives. Students who are particularly interested in caring for women subjected to violence may desire additional specialized training. Examples of electives include a course on forensic examination and evidence collection for survivors of sexual assault or on mental health care for survivors of partner violence. Community-based, participatory electives, such as sessions held at domestic violence shelters, can be particularly effective at improving comfort with caring for survivors.

2. Select content and adapt to local context

The WHO curriculum provides comprehensive resources for 13 sessions for health care providers on how to care for women subjected to violence.

Within the WHO curriculum, the

facilitator's guide provides step-by-step instructions for conducting each session.

It outlines the expected length of each session, the teaching strategies and the required facilitator's materials. The WHO curriculum also provides session slides and student handouts as well as links to online videos.

For integrating new content on care for women subjected to violence, sessions can be selected from the WHO curriculum that are most appropriate for the identified competencies, student population, resource constraints and context. If possible, it would be best to devote time to practising skills in first-line support. First-line support is covered in sessions 1 through 8; it includes the LIVES approach (Listen, Inquire, Validate, Enhance safety and Support) (Box 4). The first three steps – Listen, Inquire and Validate—are particularly important. Table 3 lists selected sessions from the WHO curriculum that may particularly benefit pre-clinical and clinical students.

The WHO curriculum provides comprehensive resources for 13 sessions for health care providers on how to care for women subjected to violence. Within the WHO curriculum, the facilitator's guide provides step-by-step instructions for conducting each session.

Box 4. First-line support: the LIVES approach

Providing first-line support is one of the most important things a health care provider can do to support a woman subjected to violence. Health care providers in any context can offer first-line support, without any special resources. The word LIVES helps students and practitioners remember the five steps of first-line support: Listen, Inquire, Validate, Enhance safety and Support.

It is essential that women subjected to violence experience support and empathy when disclosing abuse, especially if it is their first time to talk about it. Experiencing violence can be deeply traumatic, and it is unlikely that all her needs will be addressed in one visit. Women experiencing abuse may require multiple interactions with professionals from multiple sectors to receive the support and resources they need. They will be more willing to seek help in the future if they feel listened to, cared for and supported, especially during their first meeting.

Using the LIVES approach, first-line support enables health care providers to understand women's experiences and helps women recognize that they deserve to live a life free from violence. It can help identify women's readiness to take action, reassure women that they are supported, provide information on available support and help women make informed decisions about the path they wish to take to increase their safety and well-being.

Note: In classroom training the first three components of **LIVES – Listen, Inquire, Validate** – are the essential topics to cover, especially for pre-clinical students. The last two components of LIVES – **Enhance safety, Support** – may be better suited for clinical stages of training.



Table 3. Selected core sessions from the WHO curriculum for pre-clinical and clinical students

For pre-clinical students	
Session no.	Content
1	<p>Understanding violence against women as a public health problem</p> <ul style="list-style-type: none"> • Know the epidemiology of the different forms of violence against women at global and local levels. • Know the health consequences of violence against women. • Understand the role and limitations of health care practitioners in responding to violence against women. • Know about the WHO clinical and policy guidelines and clinical handbook, as well as local guidelines and laws, on responding to intimate partner violence and sexual violence against women.
2	<p>Understanding the survivor's experience and how practitioners' values and beliefs affect the care they give</p> <ul style="list-style-type: none"> • Demonstrate self-awareness of one's beliefs, assumptions, potential biases and emotional responses that can affect interactions with women subjected to violence. • Understand the circumstances and the barriers that women experiencing violence face when seeking support. • Recognize the importance of being non-judgemental and having empathy with survivors.
4	<p>Provider-survivor communication skills</p> <ul style="list-style-type: none"> • Communicate empathically and effectively with patients who have experienced violence.
6	<p>First-line support using LIV(ES), part 1: Listen, Inquire, Validate</p> <ul style="list-style-type: none"> • Know the content of first-line support (LIVES). • Demonstrate skills in offering at least the first three elements (listening, inquiring and validating) of first-line support to those who disclose abuse.

	For clinical students
5	<p>When and how to identify intimate partner violence</p> <ul style="list-style-type: none"> • Practice the minimum standards that need to be met to enquire about and respond appropriately to violence against women. • Recognize the signs and symptoms that suggest intimate partner violence. • Determine when and how to ask about intimate partner violence. • Demonstrate appropriate ways to ask about intimate partner violence.
6	<p>First-line support using LIV(ES), part 1: Listen, Inquire, Validate</p> <ul style="list-style-type: none"> • Integrate the content of first-line support (LIVES) in their practice. • Demonstrate skills in offering at least the first three elements (listening, inquiring and validating) of first-line support to those who disclose abuse.
8	<p>First-line support using (LIV)ES, part 2: Enhancing safety and providing Support</p> <ul style="list-style-type: none"> • Assess immediate risk/safety and support safety planning. • Refer to resources available in the community. • Collaborate to help survivors access other services and to provide referrals. • Provide warm referrals.
9	<p>Clinical care for those subjected to sexual assault/rape, part 1: history-taking and examination</p> <ul style="list-style-type: none"> • Take a clinical history. • Conduct an examination of a survivor of sexual assault or abuse.
10	<p>Clinical care for those subjected to sexual assault/rape, part 2: treatment and care</p> <ul style="list-style-type: none"> • Provide appropriate treatment/care to survivors of sexual assault or abuse.

Source: Adapted from WHO 2021 (6).

3. Identify teaching strategies

Several teaching strategies can be effective in adult learning environments. The techniques used may differ depending on competencies, facilitator and student factors, time constraints, and local resources and context (Table 4).

The WHO curriculum offers sessions that employ a variety of teaching strategies, such as lectures, small group sessions, role play and patient simulations, brainstorming and games, to generate critical reflections about personal beliefs and to put new knowledge into practice. Below are some of the strengths and weaknesses of different teaching strategies to consider in development of curriculum content on violence against women.

Table 4. Comparison of various teaching strategies

Teaching strategy	Strengths	Weaknesses
Lecture	<ul style="list-style-type: none"> • Distils a body of knowledge • Can quickly review key principles and concepts • More control over content and processes 	<ul style="list-style-type: none"> • Passive learning • Does not develop students' skills • Drop-off in students' attention, especially if too long • Not competency-based
Small group sessions	<ul style="list-style-type: none"> • Active learning • Builds teamwork and peer relationships • Can be a safer environment for sensitive topics • Can reveal students' personal beliefs with the opportunity to provide direct guidance 	<ul style="list-style-type: none"> • Participation can be unequal • Some students may value speed in completing task over task quality • Often more time- and labour-intensive than lectures for staff and participants
Role play and patient simulations	<ul style="list-style-type: none"> • Active learning • Skill-building • Safer environment for student skill-building • Less risk than direct work with patients • Can be engaging and motivating 	<ul style="list-style-type: none"> • Less controlable • May make some students uncomfortable • Difficult to master skills in one session, may require repetition • Not everyone can assume different roles effectively

Teaching strategy	Strengths	Weaknesses
Games	<ul style="list-style-type: none"> • Can be engaging and motivating • Mental break from engaging with intense material • Can lead to creative solutions 	<ul style="list-style-type: none"> • Require more staff guidance • Some students may not take task at hand seriously
Survivor stories	<ul style="list-style-type: none"> • Can be engaging and motivating • Can lead to sensitization/empathy better than other formats 	<ul style="list-style-type: none"> • May make some students uncomfortable or be triggering for students who have survived gender-based violence • Requires staff guidance and consent and preparation of the participating survivors
Online modules	<ul style="list-style-type: none"> • Flexible schedule • Students can work at their own pace • No commute required 	<ul style="list-style-type: none"> • Less personal interaction • Dependent on student engagement/motivation • Dependent on access to technology

Using a mix of several teaching strategies can be more engaging for students, allow them to practice skills, and improve learning for students with a variety of learning styles. Research on training on intimate partner violence has shown that more interactive and participatory approaches better improve student knowledge (18, 19).

4. Identify and prepare facilitators

The final step before implementation is to identify facilitators and how they will be trained on the new material, mentored and supported as they teach the new curriculum content. The best facilitators for the WHO curriculum have a combination of the following characteristics:

- clinical background (doctor, nurse, midwife, psychologist, counsellor, etc.)
- experience providing health care to women subjected to violence
- experience in educating adult learners, including with interactive teaching strategies
- sensitivity and personal values that support gender equality and human rights
- familiarity with local laws and policies that govern the health system response to violence against women.

In some settings some faculty and staff members may have experience educating students, even if not necessarily on violence against women. These experienced people may be asked to take on administrative, supervisory and mentoring roles. They can train other facilitators on effective teaching and class management strategies for adult learners and on ways to manage common issues that arise. An interdisciplinary team of educators can include various clinicians (physicians, nurses, midwives, social workers, psychologists) and those in non-clinical roles (for example, in social service organizations, police or legal services). Interdisciplinary teaching teams can help build teamwork and communication across professional sectors and maximize peer-to-peer learning and acceptability of the topic (see India example in Case studies, page 34).

The WHO curriculum provides detailed instructional methods and is written in an easy-to-follow format; facilitators with various background knowledge and experiences can facilitate sessions. The WHO curriculum includes a preparation checklist (adapted in Annex 4) that helps facilitators prepare for the training sessions.

5. Define how students will be assessed

It is important to decide how learners will be assessed. Ideally, this would be through evaluation of the VAW curriculum competencies. Criteria for success should be established, and whether these will be part of core or optional grading, decided. There are many established ways to measure proficiency (measure of performance) of a competency.

Oral and written assessments may be better suited to assess acquisition of knowledge and attitudes, whereas competencies of skills and behaviours are better assessed through direct observations of simulated patient interactions (such as objective structured clinical examination (OSCEs)) or reviews of activities in the work environment or case management reviews. For example, observing a structured role-play of a meeting between a student provider and a women subjected to violence is a good way to evaluate the student's ability to apply the skills of first-line support in practice.

Domains to consider in assessment include: identification of survivors experiencing violence through common signs and symptoms, ways to ask about violence using an empathic survivor-centred approach, and application of first-line support (LIVES) in caring for women subjected to violence. Evaluation forms can be designed from scratch, draw on questions from the WHO curriculum pre- and post-training questionnaires, or use other validated assessments, such as a modified version of the PREMIS tool (20) or GRIPS tool (21).

Depending on how the content is delivered, there can be separate assessments for the VAW course content, or assessments can be integrated into exams for existing subjects or specialties.



STEP 3. **Implementing curriculum content**

1. Pilot-test

A pilot-test is a “test drive” of the new curriculum content with a small group of learners over a fixed time period. It is best to test all of the curriculum content, but sometimes it is more feasible to pilot-test only selected sessions that are representative of the planned content and teaching strategies. For example, if sessions will use role play techniques, the pilot-tested sessions should include some role play techniques. If possible, pilot-tests should cover both the pre-clinical and clinical stages of learning.

During the pilot-test, facilitators’ and students’ feedback is actively and frequently sought, so that adjustments can be made immediately and potential problems are addressed early. Students’ feedback can be sought to assess whether the content was clear and useful and the methods of delivery were engaging. In debriefs after the sessions, facilitators can reflect on what went well and what could be improved. Ideally, a team leader should observe the pilot-testing sessions and provide feedback and mentoring to the facilitators. This observer also can help to identify enabling factors and barriers to implementation.

An overall evaluation of the pilot-test is very useful. Consider gathering baseline and end line data on learners’ knowledge, attitudes and confidence to addressing violence against women. The curriculum leadership should review the results and feedback from the pilot-test to highlight successes, address any concerns and make any necessary strategic adjustments. Ultimately, pilot-testing ensures that the curriculum is ready for full-scale implementation.

2. Create a safe space

During implementation it is useful to create a safe space or mechanism to support students who find that the content triggers disturbing memories of their own experience of violence. This may include warning statements before content is delivered, options to leave the room, designating a service or person where or to whom students can safely disclose their own experiences, or providing access to counselling and referral services. Facilitators, too, should have the opportunity for self-care and access to counselling in case content triggers traumatic memories of their own experiences.

3. Scale up

Lessons learned from pilot-testing can help ease the transition to full-scale implementation. During this period the final curriculum content is implemented, all facilitators are trained and mentored on the new content, and all intended student groups receive the new curriculum content on caring for women/survivors subjected to violence.

4. Evaluate and collect feedback

Collecting evaluations and responding to feedback is an integral component of curriculum success. It helps to identify what is working and what is not and to improve the violence against women content over time. The WHO curriculum provides pre-training and post-training surveys, which can be distributed to students and results regularly reviewed by facilitators and curriculum leadership.

Students who have moved from the pre-clinical stage to the clinical stages can report whether they have applied in practice anything learned in the pre-clinical stage curriculum and what areas should be emphasized in future iterations of the curriculum content. Administrative staff involved in curricular evaluation can help to obtain student feedback.

Additionally, it is important to regularly solicit feedback from session facilitators and address their concerns as they arise. This can be done through in-person interviews and written evaluations. The CRC also can review the evaluation results for discussion of further curriculum development. This process ensures that the curriculum content continues to improve with each future iteration.

Conclusion

Integrating violence against women into pre-service health worker curricula is critical to educate health worker students on survivor-centred care, begin to shape positive attitudes and behaviours, and equip them with the skills to effectively support women (and others) subjected to violence in their future practice. This manual, in conjunction with the WHO curriculum, provides the tools and guidance to help education leaders plan, implement, evaluate and scale up violence against women education in their pre-service health curricula. By working together, we can help ensure that future generations of health professionals are better prepared to care for those subjected to violence.



Case studies

Case study 1. Implementing the WHO violence against women curriculum in pre-service midwifery degrees in Timor-Leste¹

Student cadre: Pre-service midwifery students

Pre-clinical, clinical or both: Both

Planning process

- We formed a collaboration between the heads of midwifery at the National University and a private university in Timor-Leste, and researchers from an Australian University, to adapt and pilot-test the WHO curriculum.
- As the head of department and also lecturers, we had autonomy to decide course content.
- We presented the idea to the Dean of the Faculty, the Curriculum Review Committee and the Rector to gain their support. Having done research together on violence against women gave us good background knowledge and additional credibility.

Structure of curriculum content: A 16 module subject on responding to violence against women was adapted from the WHO curriculum (14 learning modules and two assessment modules) and integrated as a core subject in midwifery degrees.

Teaching strategies: Combination of lectures, small group activities including role play, guest-speakers and videos

Challenges faced and how they were addressed

- Class sizes can be very large (100 students). When individual feedback on group activities is not possible, we have a few students demonstrate best practices in front of the class. It would be good to break large classes into smaller groups.
- It was not always easy to get other midwifery colleagues on board or to get the curriculum taken up by other departments (that is, nursing and medicine). After a lot of advocacy with the Department of Higher Education accreditation body, we were successful in getting VAW designated as a core competency in the National Midwifery Curriculum. We are now supporting other universities that have midwifery degrees to take up the subject (that is, training lecturers and providing copies of curriculum resources).

¹ Prepared by Kayli Wild, LaTrobe University, Australia, with thanks to Dr Lidia Gomes, National University of Timor-Leste and Angelina Fernandes, Instituto Superior Cristal, Timor-Leste for their contribution.

Lessons learned

- The WHO curriculum material takes time and effort to adapt and refine to the national context, particularly when working across languages.
- It was important to adapt LIVES as a proper memory aid in the national language. At 6-months follow-up, 99% of students accurately recalled all the steps in giving first-line support.
- The extra time and relatively small budget spent on developing videos was worth it. Students enjoy watching them, and visual learning in their own language contributes to deeper understanding of the issues.
- Being involved in this VAW curriculum has given us greater confidence in being able to discuss and advocate addressing violence against women at national and sub-national levels and within our families. This has been the case, not only for each of us in the working group, but also for other lecturers and students involved in the curriculum.
- After four years of doing this work, we can see that other lecturers within the university are starting to take ownership of the curriculum, and we are really proud that our university is leading the way on this issue.

Impact or evaluation results

- Pre and post surveys showed significant increases across all domains of learning, with the biggest changes seen in attitudes that tolerate violence.
- Improved outcomes were sustained at six months' follow-up.

Case study 2. Introducing a single session on violence against women in a teaching hospital in Ghana²

Student cadre: Pre-service medical students

Pre-clinical, clinical or both: Pre-clinical

Structure of curriculum content: Single 2-hour session

Teaching strategies: Mix of lecture, case discussion and role play with debriefing supervised by facilitators

Challenges faced

- Finding and training local facilitators to assist in training
- Not having the curriculum delivered in clinical years to medical students.

Impact or evaluation results

Surveys adapted from PREMIS to assess student knowledge, attitudes and beliefs were collected pre- and post-training (20). The single-session training yielded statistically significant improvements in student knowledge, attitudes/beliefs and preparedness to respond to violence against women.

Lessons learned

- We learned to increase stakeholder support and buy-in for implementing the curriculum for clinical students by proposing the curriculum to the current dean of medical students and leadership in clinical departments at the teaching hospital.
- Longer term assessment to look at the sustainability of the changes found post-training needs to be incorporated in the future.

² Prepared by Dr Vijay Singh, University of Michigan Medical School and Injury Prevention Center.

Case study 3. Developing multidisciplinary violence against women curricula at the University of West Indies in Trinidad and Tobago³

Student type: Students of nursing, medicine, social work, psychology, gender studies

Pre-clinical, clinical or both: Both

Structure of curriculum content:

- Two curricula:
 - 1) Sensitization curriculum for undergraduates
 - 2) Curriculum for postgraduates including sensitization and adding greater detail on clinical skills; networking, resources and support; behaviours and values for safe, supportive care.

Development process

Preparation

- Utilized the PAHO/WHO curriculum, *Caring for women subjected to violence*, as a framework.
- Literature review included national policy frameworks, *National clinical and policy guidelines on intimate partner violence and sexual violence* (Ministry of Health and PAHO/WHO, 2022), guidelines on curriculum development and three other curricula.

Stakeholder engagement

- Consultations were held with stakeholders including academic institutions, professional organizations, clinicians and students at tertiary institutions. Gaps and needs were identified from professional, clinician, academic and beneficiary perspectives.

Curriculum development

- Developed by a multidisciplinary team from the University of the West Indies, Trinidad and Tobago.
- Pilot-tested curricula among students in medicine, nursing, midwifery, social work, psychology and gender studies (those likely to enter “helping professions”).

Teaching strategies

- Lecture, case discussion and role play with debriefing supervised by facilitators.

³ Prepared by Caroline Allen and Britta Baer, Panamerican Health Organization and WHO Regional Office of the Americas.

Challenges faced and how they were addressed

- Pilot-testing was conducted online as it was during the time of COVID-19 restrictions. Adaptations for face-to-face and blended delivery will be considered and tested.
- Development of curricula across professions required time for consensus building to agree on division of labour and prioritization of topics and to avoid overlap and duplication.
- Multidisciplinary curriculum may be difficult to implement, as teaching is generally organized by faculty and subject. Talks are underway with course organizers to resolve this.
- The course developers indicated an interest in making the undergraduate course mandatory for students in the disciplines covered. Choices between elective or prerequisite courses and infusion into other courses are under discussion at the institutional level.

Impact or evaluation results

Pre- and post-pilot training surveys were administered online to assess student knowledge, attitudes and beliefs. Improvements were seen in student knowledge, attitudes and beliefs and preparedness to respond to violence against women. Time allocated to exercises was considered too short and was extended in the final versions of the curricula.

Lessons learned

- Sensitization of students to gender equality and human rights issues and associated skills development are needed across curricula.
- The approach of interprofessional teams of trainers and students strengthens collaboration between sectors and promises to strengthen pathways of care.
- Sensitization and clinical skills building are complementary in developing professionals to respond to the needs of women subjected to violence.
- Further investment in health worker skills building would fill an important gap in responding to violence against women in the Caribbean.

Case study 4. Interdisciplinary training on violence against women: Implementing the WHO curriculum in two medical colleges in India⁴

Student occupational group: Pre-service or fifth year medical students doing resident training and in-service health practitioners – physicians, nurses and social workers from obstetrics and gynaecology, emergency medicine/casualty and general medicine

Pre-clinical, clinical or both: Both

Structure of the curriculum content

- 2 full working days with medical students, doctors, nurses and social workers trained together
- half day refresher after six months repeated with the same group
- 220 trained over a period of six months in eight groups of approximate 30 in each group
- Teams of three master trainers each, comprising senior clinical faculty, nurses and social workers with supervisory/administrative responsibility, conducted each training, with additional support from external trainers experienced in providing clinical care to women subjected to violence. A total of 26 master trainers were trained over five days.

Teaching strategies: Mix of lecture, participatory simulations and role plays, case scenario discussions and post-training monthly case reviews with senior faculty/trainers focusing on challenging cases.

Challenges faced and how they were addressed

- Finding time to train without having gaps in availability of hospital staff to provide care
 - **Solution:** Onsite training in groups of 24–30, with rotation of trainers so that not all health workers or senior faculty were pulled away from routine duties at the same time.
- Retaining learned skills over time, particularly in identifying clinical symptoms that are less obviously indicative of violence and in offering all five steps of LIVES.
 - A 6-month refresher was organized focused on role play related to LIVES and how to identify women with less obvious clinical signs and symptoms associated with violence.

⁴ Prepared by Dr Avni Amin, WHO Department of Sexual and Reproductive Health.

Evaluation results

- Pre- and post-training and, 6-month post-training surveys on knowledge, attitudes and practices of the trained medical students and health providers showed statistically significant improvements in knowledge, attitudes and practices.
- In-depth interviews with trained medical students and doctors indicated that the training was feasible, acceptable and relevant to their clinical practice.
- Over a period of nine months, 530 women disclosed or were identified by trained health workers or medical students as being subjected to partner/domestic violence.
- The Department of Medical Education and Research of the State of Maharashtra has issued a circular for the 19 medical colleges in the state to incorporate curriculum on gender into medical education. This includes teaching content on violence against women for medical students in years 4 and 5 as part of their residency training and clinical rounds.

Lessons learned

- Having senior faculty and clinicians serve as master trainers and act as champions is important in gaining credibility and acceptability and setting a norm for medical students to endeavour to care for women subjected to violence.

Sources: Arora et al., 2021 (22); Gadappa, 2022 (23); WHO Country Office for India, 2021 (24); WHO Country Office for India, 2019 (25).

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Annex 1:

Needs assessment for developing VAW curriculum content

How is VAW addressed in the current curriculum, if at all?

- ✓ Review any available information on the current curriculum's competencies/learning objectives and whether they cover violence against women (VAW) or related topics. This can be found in course syllabi or by contacting course staff and administrators.
- ✓ Consider meeting with course staff, instructors and/or students to obtain qualitative input on how VAW and related topics related to gender inequality may or may not be addressed in the current curriculum.

How do institutional and local standards include VAW in health care curricula?

- ✓ Review institutional or local accreditation standards to see if they include curricular requirements to educate students on caring for survivors of violence. This could be included within a requirement to cover “societal issues”, or the social determinants of health, or care for vulnerable groups such as those experiencing maltreatment, neglect or abuse.
- ✓ If no standards exist, consider drafting a new accreditation standard to include VAW in core health care training content; this can help foster institutional support.

What are the purpose and competencies of the new VAW curriculum content?

- ✓ Determine whether the aim of the new VAW curriculum content is sensitization, enhancing knowledge or skills-building. Some learners – for example, clinical students – may need only knowledge refreshers and skills building, while others – for example, pre-clinical students – may need sensitization, knowledge and skills building.
- ✓ Establish expected competencies of the curriculum content (for example, improving health care students' ability to respond in a sensitive way to women subjected to violence). Suggested core competencies for education are listed in each session in the WHO curriculum.

What will be covered in the VAW curriculum content?

- ✓ Review the competencies and what knowledge, attitudes, skills and behaviours students need to apply in their designated professions to effectively respond to VAW, as content often follows from the competencies of the curriculum.
- ✓ Review the suggested core sessions listed in Table 3 and brainstorm about which sessions may be most relevant and needed in your context.

Who will the VAW curriculum content address?

- ✓ Decide which professional groups and training-levels of health worker students are most likely to come into contact with women subjected to violence and prioritize their education.
- ✓ Consider whether you can incorporate and tailor curriculum content for both pre-clinical and clinical students.

Will the VAW curriculum content be mandatory or elective?

- ✓ Discuss whether the VAW curriculum content will be compulsory for all intended students or whether it will be offered as an elective course.

Who will facilitate the VAW curriculum content?

- ✓ Identify faculty, staff and facilitators to implement the VAW curriculum content. It may be helpful to partner with nongovernmental organizations or other local organizations that can provide resource persons and facilitators.
- ✓ Develop mechanisms to train facilitators on content, and processes to mentor and support them as they implement the curriculum content and its teaching strategies.

How will the VAW curriculum content be facilitated?

Format

- ✓ Sessions can be single sessions, multiple sessions (including creation of a new course) or integrated into other subjects or specialties, depending on the purpose (sensitization or skills building), available resources and time.
- ✓ Single sessions or electives may be useful when starting. Over time, VAW topics can be built into multiple sessions and integrated into the existing curriculum. For example, a module on responding to violence against women may be integrated into existing subjects such as reproductive health, accidents and emergencies, and psychiatry.

Length

- ✓ The curriculum content on VAW should be of sufficient length to be able to cover the range of topics and learning methods that build knowledge and skills and improve attitudes. Ideally, the VAW content will be delivered as an entire module or a series of sessions over time.
- ✓ Sessions can be spaced over time to suit students' availability and the course structure.

Modality

- ✓ The education methodology should allow for building skills as well as knowledge and also allow for critical self-reflection on personal attitudes towards and own experiences of violence against women.
- ✓ Use a participatory learning approach that combines lectures, case studies, group work, role plays, problem-solving and community activities.
- ✓ A woman telling (with all the necessary support) her story of violence and her experience with health services can greatly improve students' understanding. Consider guest speakers and/or available video resources to generate or stimulate understanding of women's experiences.
- ✓ Videos modelling positive interactions between patient and health practitioner can support deeper understanding and skills development.

What is needed to support and facilitate the VAW curriculum content?

- ✓ Establish the module/course structure and schedule.
- ✓ Identify the resource materials.
- ✓ Identify facilitators and provide training to ensure their readiness.
- ✓ Provide ongoing mentoring and feedback for facilitators.
- ✓ Allocate budget and resources for VAW curriculum content.
- ✓ Provide student assessments, including course credits and certification for completion of curriculum content and acknowledgement of students' expertise.

Where will the VAW sessions take place?

- ✓ Where possible, hold sessions within educational settings to promote attendance and minimize disruption of students' other obligations.

How will students be evaluated?

- ✓ Evaluate students' knowledge, attitudes and skills pre- and post-session(s), and gather students' feedback on the curriculum.
- ✓ Conduct periodic evaluations of former students to gauge the need for refresher sessions.

How will you sustain quality performance after implementation?

- ✓ Conduct regular follow-up and offer mentoring and supportive supervision to students.
- ✓ Offer refresher sessions, especially between pre-clinical and clinical stages of learning.
- ✓ Students at clinical stages of learning may be better positioned to benefit from content on how to respond to violence against women as they are more likely to be seeing patients. Skills can be evaluated through patient simulations, direct observations, reviews of documentation and case management reviews.
- ✓ Provide ongoing professional development opportunities for facilitators to build their skills in teaching VAW content and participatory education methods, and ensure that new lecturers receive training-of-trainer and mentoring support.

Source: adapted from WHO, 2017 (26).

Annex 2: Curriculum proposal contents (printable worksheet)

Title of new content	
Professional school	
Student year(s) of training	
Brief proposal description	
Rationale	

How does the new curriculum content fit into the profession's mission?

Proposed competencies

Timetable for implementation

Course structure: Describe the proposed structure, for example, a new module, single or multiple sessions within existing curriculum. Will the sessions be mandatory or elective?

Resources

- **When will the sessions take place? How many sessions are proposed and how long will each session be?**

- **Who will facilitate sessions/deliver the content?**

- **Where will sessions take place?**

- **How will educators/trainers be supported, mentored and supervised?**

- **What resources (for example, equipment) and support are needed for implementation?**

Annex 3:

Sample agendas

The full 17 sessions of the WHO curriculum are usually delivered in two and a half days. However, the existing curriculum for health care professional students often does not allow this amount of time to be dedicated to topics on intimate partner violence and sexual violence. At a minimum, sessions 1 through 6 should be taught to ensure that the first three steps of LIVES are fully covered.

The sample agendas below give examples of 1-hour, half-day, one full day and integrated trainings. Sessions are likely to take longer when facilitators are new to teaching the content, if there are group activities and if there are many students. Local context and time considerations will determine adaptations. Time should be included for energizer activities when the group needs it, such as in the afternoons, and for any pre and post assessments.

The sample agendas below give examples of 1-hour, half-day, one full day and integrated trainings. Sessions are likely to take longer when facilitators are new to teaching the content, if there are group activities and if there are many students.

1-hour session	
15 minutes	Session 1. Understanding violence against women as a public health problem <ul style="list-style-type: none"> • presentation with slides only
45 minutes	Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate

Half-day session	
10 minutes (9:00–9:10)	Introduction
15 minutes (9:10–9:25)	<p>Session 1. Understanding violence against women as a public health problem</p> <ul style="list-style-type: none"> • presentation with slides only
75 minutes (9:25–10:40)	<p>Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate</p> <ul style="list-style-type: none"> • presentation with slides (15 minutes) • Exercise 6.1: Role play to practise LIV(ES), part 1 (60 minutes)
15 minutes (10:40–10:55)	Break
45 minutes (10:55–11:40)	<p>Session 4. Practitioner–survivor communication skills</p> <ul style="list-style-type: none"> • discussion and presentation (15 minutes) • Exercise 4.1: Active listening (30 minutes)
70 minutes (11:40–12:30)	<p>Session 5. When and how to identify intimate partner violence</p> <ul style="list-style-type: none"> • presentation with slides (10 minutes) • Exercise 5.1, Option A: Role play on identification of intimate partner violence (60 minutes)
10 minutes (12:30–12:40)	Wrap-up

Full-day session	
30 minutes (9:00–9:30)	Introduction and orientation
40 minutes (9:40–10:20)	<p>Session 1. Understanding violence against women as a public health problem</p> <ul style="list-style-type: none"> • video (5 minutes) • presentation with slides and discussion (35 minutes)
15 minutes (10:20–10:35)	Break
<p>*105 minutes (10:35–12:20)</p> <p>*can be shortened by choosing only one of the two exercises)</p>	<p>Understanding the survivor’s experience and how practitioners’ values and beliefs affect the care they give</p> <p>Exercise 2.1 to explore practitioners’ values and beliefs</p> <ul style="list-style-type: none"> • Voting with your feet (30 minutes), or <p>Exercise 2.2 to understand survivors’ experience</p> <ul style="list-style-type: none"> • In her shoes (75 minutes)
40 minutes (12:20–1:00)	Lunch
45 minutes (1:00–1:45)	<p>Session 4. Practitioner–survivor communication skills</p> <ul style="list-style-type: none"> • discussion and presentation (15 minutes) • Exercise 4.1: Active listening (30 minutes)
70 minutes (1:45–2:55)	<p>Session 5. When and how to identify intimate partner violence</p> <ul style="list-style-type: none"> • presentation with slides (10 minutes) • Exercise 5.1, Option A: Role play on identification of intimate partner violence (60 minutes)
15 minute (2:55–3:10)	Break
75 minutes (3:10–4:25)	<p>Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate</p> <ul style="list-style-type: none"> • presentation with slides (15 minutes) • Exercise 6.1: Role play to practise LIV(ES), part 1 (60 minutes)
35 minutes (4:25–5:00)	Wrap-up

Integrated sessions	
Pre-clinical	
Course name	Training session(s) – number and title
Reproductive health	Session 1. Understanding violence against women as a public health problem
Trauma, burns, accidents and injuries	Session 5. When and how to identify intimate partner violence Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate Session 8. First-line support using (LIV)ES, part 2: Enhancing safety and providing Support
Patient interviewing	Session 2. Understanding the survivor’s experience and how practitioners’ values and beliefs affect the care they give Session 4. Provider–survivor communication skills Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate
Medical ethics	Session 1. Understanding violence against women as a public health problem Session 2. Understanding the survivor’s experience and how practitioners’ values and beliefs affect the care they give
Emergency medicine	Session 5. When and how to identify intimate partner violence Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate Session 8. First-line support using (LIV)ES, part 2: Enhancing safety and providing Support Session 9. Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination Session 10. Clinical care for survivors of sexual assault/rape, part 2: treatment and care

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<p>Obstetrics and gynaecology</p>	<p>Session 1. Understanding violence against women as a public health problem</p> <p>Session 5. When and how to identify intimate partner violence</p> <p>Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate</p> <p>Session 9. Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination</p> <p>Session 10. Clinical care for survivors of sexual assault/rape, part 2: treatment and care</p>
<p>Paediatrics</p>	<p>Session 5. When and how to identify intimate partner violence</p> <p>Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate</p>
<p>Outpatient/ primary care</p>	<p>Session 5. When and how to identify intimate partner violence</p> <p>Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate</p>
<p>Psychiatry</p>	<p>Session 2. Understanding the survivor’s experience and how practitioners’ values and beliefs affect the care they give</p> <p>Session 5. When and how to identify intimate partner violence</p> <p>Session 6. First-line support using LIV(ES), part 1: Listen, Inquire, Validate</p> <p>Session 12: Care for mental health and self-care for providers (if time allows)</p>

Annex 4:

Preparation checklist

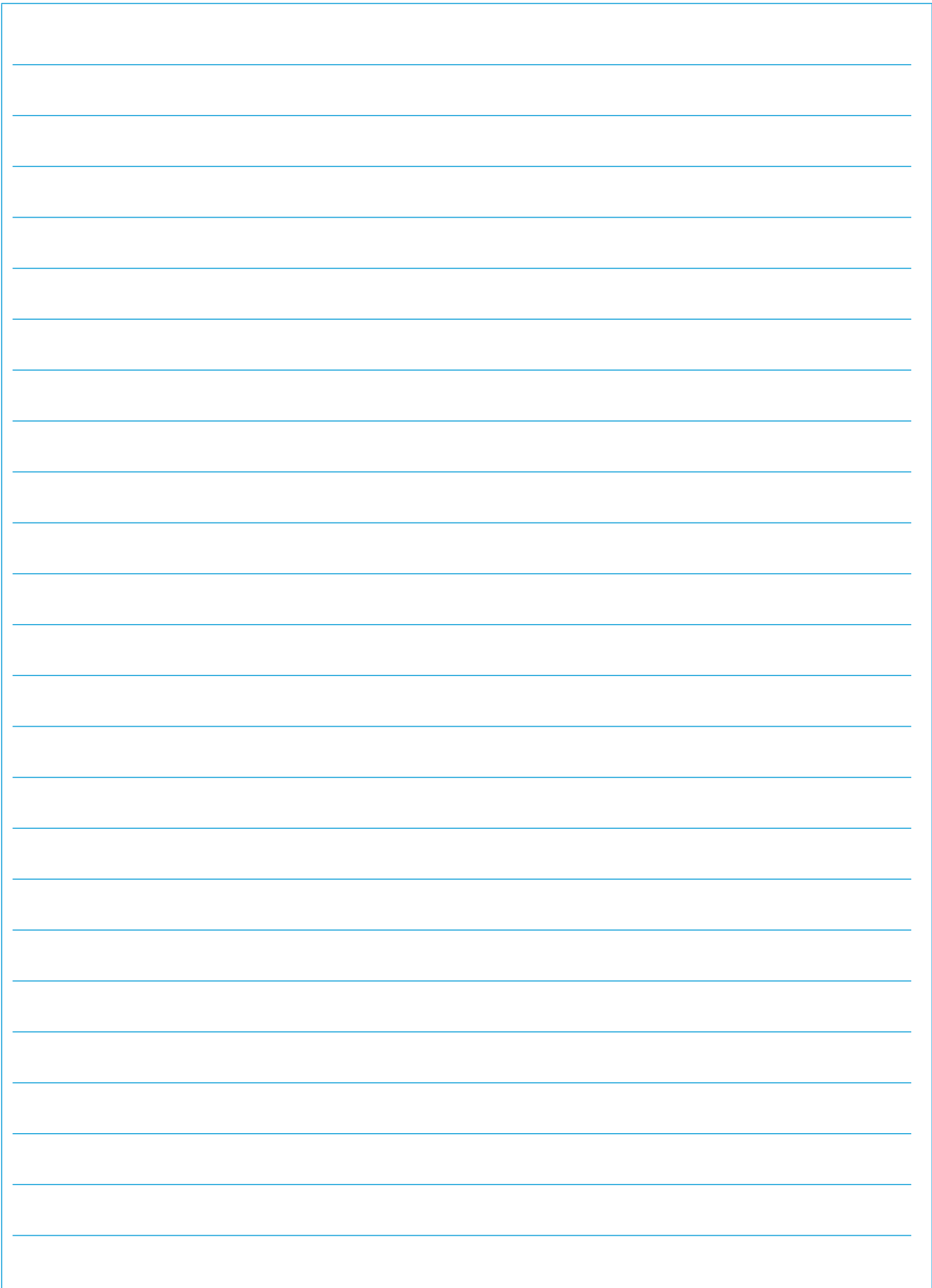
<p>Know your students</p>	<ul style="list-style-type: none"> • Know students’ backgrounds, including occupational group and whether they are in the clinical or pre-clinical stage of training. • Acknowledge that some aspects of the content may be distressing for students who have experienced violence in their own lives and ensure support is available for those who may need it (see below)..
<p>Space, supplies and equipment</p>	<ul style="list-style-type: none"> • If possible, find a space where you can use equipment such as audio-visual aids. Equipment may include: <ul style="list-style-type: none"> - computer - projector - white board - microphone with adequate speakers/sound system if the size of the room requires it. • Provide a place to go. Find an additional room or other space where students can go if they feel uncomfortable. There are likely to be survivors of violence participating, and they may need to excuse themselves from time to time. If available, you can also provide information on resources and support, such as mental health or counselling services. • Set up ahead. Arrange the room before the course begins and check equipment. • Provide tables. Set up the room with tables in small groups to allow maximum participation and discussion. Do not set up the room in lecture style with rows of chairs.
<p>Schedule, invite guests</p>	<ul style="list-style-type: none"> • Develop a schedule. Annex 2 proposes agenda options, but the schedule can be modified based on available time, type and experience of students and supplemental activities. • Allow time. If you need to change the suggested schedule, review the facilitator’s guide to ensure that sufficient time is allotted for discussions, exercises and breaks. • Invite guests. Consider if, when and how guests will be included as speakers or learners. • Award certificates? Decide whether to award completion certificates. See the WHO curriculum for a section on certificate distribution or ceremony.

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<p>Facilitator preparation</p>	<ul style="list-style-type: none"> • Materials: In advance, review all facilitator materials, including facilitator’s guide, slides, slide notes and handouts. For each session the facilitator’s guide details key points to make. Questions and probing points for semi-structured discussion are provided. Give special attention to the step-by-step instructions for each activity. • Facilitators’ roles: Review and agree on roles and responsibilities in each session. • Essential reminders and tips: Review the essential reminders.
<p>Prepare the materials and supplies</p>	<ul style="list-style-type: none"> • Prepare the students’ reading materials and handouts. • Provide the clinical handbook and other WHO resource materials ahead of time. <p>Have other materials ready to distribute at each session.</p> <ul style="list-style-type: none"> • Print the reading materials and handouts to be distributed on paper. Copy onto USB keys any files to be distributed electronically. These keys can also be used for documenting any group work assignments. • Gather supplies.

Source: adapted from WHO, 2021 (6).

Notes

A large rectangular box containing 25 horizontal blue lines for writing notes. The lines are evenly spaced and extend across the width of the box, providing a structured space for handwritten text.

For more information, please contact:
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