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Brief Report

Addressing Domestic Violence within the Greek Healthcare System: Evaluating the VIPROM Greek Exploratory Pilot Training Program and Systemic Implications

ML Psarra*, Kalemi G, Douzenis A

2nd Department of Psychiatry, Medical School, National & Kapodistrian University of Athens, Greece / Hellenic Forensic Psychiatric Association

***Corresponding author**: Psarra M.L , 2nd Department of Psychiatry, Medical School, National & Kapodistrian University of Athens

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Abstract

Background: Healthcare Professionals (HCPs) are often the first point of contact for victims of domestic violence (DV) and Gender-Based Violence (GBV). However, systemic gaps and lack of specialized training often hinder effective intervention. **Methods:** This paper reports on the Greek experience of the VIPROM project, coordinated by the Hellenic Forensic Psychiatric Association (HFPA). A 12-hour interactive training curriculum was delivered to 83 participants, including HCPs and medical students, focusing on identification, legal frameworks, and patient-centered care. **Results:** The program revealed significant legal ambiguities for non-physician staff and a critical need for standardized national protocols. Post-training feedback indicated a substantial increase in professional confidence and a call for the institutionalization of recurrent DV training. **Conclusions:** Interactive, peer-led training is a catalyst for systemic change. Addressing legal vulnerabilities and fostering inter-agency interoperability are essential steps for protecting victims within the Greek clinical setting.

Keywords: Gender-based/Domestic violence; Healthcare professionals; Medical education; VIPROM project; Clinical training; Standardized protocols

Introduction

Domestic (DV) and Intimate Partner Violence (IPV) are acknowledged worldwide as extensive public health crisis that transcend demographic boundaries like age, gender, and social status. Global data from the World Health Organization [1] highlights that a large percentage of women experience sexual or physical abuse by partners, with other demographic groups facing equally devastating impacts.

The medical field holds a vital frontline responsibility regarding early detection and the safeguarding of victims, primarily because medical staff are frequently the initial professional contact for those facing domestic abuse. Survivors often seek treatment for physical injuries or stress-induced ailments well before contacting the police or social services. Consequently, clinical environments—ranging from emergency rooms and dental offices to primary care and obstetrics—are the first places where the signs of violence are observed, placing clinicians in a prime position to document injuries and refer patients to safety.

Despite this unique "window of opportunity" for intervention, studies indicate that many medical providers feel ill-equipped to handle IPV cases effectively. Significant hurdles include insufficient training, ambiguous institutional guidelines, legal confusion, and time constraints, perceived powerlessness, alongside a fear of accidentally retraumatizing the patient. More specifically, ambiguity regarding legal duties and reporting processes often cause healthcare workers to hesitate, even when they suspect a patient is being harmed [2]. Additionally, while data often emphasizes women and children, it is vital to adopt

an intersectional lens that ensures men, seniors, the disabled, and LGBTQ+ individuals also receive equitable protection and medical support.

Overcoming these obstacles requires a dual approach: improving individual professional skills and implementing fundamental changes to the healthcare system's structure. In response to the widespread need for specialized training in the medical sector, the EU-funded project "VIPROM – Victim Protection in Medicine (Exploiting practical knowledge of medical staff to enhance the multi-professional contact with victims of domestic violence - Grant Agreement No. 101095828)" aims to harness the practical knowledge of medical staff 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 organizations, medical educators and victim support organizations in Austria, Germany, Greece, Italy and Sweden [3]. The VIPROM initiative introduces a modular European Training Platform paired with a "train-the-trainer" strategy to ensure long-term educational impact within medical institutions. By customizing materials for specific roles and integrating them directly into existing medical school curricula and professional development, VIPROM fills a historical void in standard medical education.

The educational philosophy of the VIPROM pilot in Greece was rooted in the principles of Adult Learning Theory (Andragogy), as defined by Knowles [4]. Adult learners, particularly medical professionals, are characterized by a self-directed orientation and a need for immediate relevance to their clinical practice. By utilizing the VIPROM platform's interactive modules [3], the training moved beyond passive information transfer to a problem-centered approach, addressing the intrinsic motivation of participants to solve complex patient-care challenges.

This pedagogical foundation intersects with Maslow's Hierarchy of Needs [5]. Within a professional healthcare context, "safety needs" encompass not only physical security but also legal and institutional protection. Our findings suggest that healthcare providers cannot effectively reach the level of professional mastery—or "self-actualization"—in domestic violence management if they remain preoccupied with the legal risks of reporting or the lack of institutional protocols. Therefore, the training focused on fulfilling these foundational safety needs by providing legal literacy and procedural clarity. To understand the necessity of training healthcare professionals in DV, we can look at the educational needs through the lens of Maslow's Hierarchy of Needs [5]. Furthermore, an interprofessional collaborative model is essential in DV, as no single professional can address the multifaceted needs of a survivor [6].

Needs Assessment: The Greek Context

To achieve the aims described above, the VIPROM consortium in a first step conducted an exemplary and qualitative needs assessment in all five participating partner countries, as part of Work Package 2 "Stakeholder Needs Assessment" [7].

In Greece, the Greek VIPROM partner Hellenic Forensic Psychiatric Association (HFPA) conducted eight interviews. The sample comprised of six female and two male respondents with different medical-professional background, including two orthopaedics, two nurses, one gynaecologist, one midwife and two medical students. The sample was recruited from Attikon University General Hospital, in Athens, Greece. The decisive factor for recruiting participants from Attikon University General Hospital was, on the one hand, that Attikon, as a large general hospital, has one of the highest outpatient volumes in the region and is one of the best university hospitals in Greece. On the other hand, since many of the researchers are employed there themselves, participants could be recruited more efficiently.

In general, participants had low levels of knowledge and awareness of DV related training. Interest and engagement in addressing and dealing with DV as an issue in the medical field was heterogeneous and varied between the male (physicians) and female participants (nurses, midwives and students). While the latter were comparatively enthusiastic about taking part in the study because they believe that it is their professional duty to recognize and act against DV, the male physicians seemed less concerned about the issue.

The findings from the Greek need's assessment [7] underscore critical systemic challenges and institutional gaps that currently impede effective domestic violence management. A primary concern is the presence of significant legal vulnerabilities, characterized by a disparity where physicians are legally shielded when reporting abuse, whereas essential staff—including midwives, nurses, and health visitors—lack equivalent legal coverage. This imbalance fosters a pervasive "fear of legal consequences" that effectively stifles the provision of comprehensive support to victims. Furthermore, the healthcare system struggles with profound procedural ambiguity, as professionals across various specialties report high levels of confusion regarding the specific "who, when, and what" of current reporting protocols.

These issues are exacerbated by institutional gaps, notably the failure of hospital legal departments to provide adequate support, which leaves frontline staff feeling isolated and fearful of potential litigation. Finally, the study identified significant interoperability barriers, documenting a consistent failure in inter-agency cooperation. This lack of coordination disrupts the essential victim support pathway, preventing a seamless transition from clinical identification to specialized protection services.

Methods

Training Structure

In Greece, the VIPROM project was implemented to address the urgent need for enhanced training among healthcare professionals regarding the identification and management of DV and GBV. National piloting of the curricula training courses was based on the methods taught at the VIPROM Train-the-Trainer courses and the related training handbook [8,9], to ensure that training courses are of high quality, use state-of-the-art training concepts, considering the challenges faced by stakeholders in the clinical context.

The Greek pilot training was delivered with high intensity to ensure depth of understanding and consisted of three 12-hour events conducted at Attikon University General Hospital (National and Kapodistrian University of Athens) on November 2-3 and 23-24, 2024, and at the Faculty of Medicine (Aristotle University of Thessaloniki) on November 13-14, 2024.

Analysis of Participant Demographics and Engagement

The Greek pilot training program [9] demonstrated significant reach and diversity, successfully engaging a broad spectrum of the healthcare community to foster a multi-disciplinary approach to Domestic Violence (DV) and Gender-Based Violence (GBV). It reached a total of 83 individuals, presented with a diverse composition in terms of sex/gender, professional background, and level of experience. The cohort was predominantly female, consisting of 69 women and 14 men. The participants included midwives, nurses, medical doctors (39 in total: 32 females, 7 males), and a substantial cohort of medical students (44 in total: 37 females, 7 males). The diverse professional backgrounds of the trainees contributed to a dynamic interdisciplinary engagement throughout the program.

The table below (Table 1) summarizes the quantitative distribution of the participants involved in the sessions held at Attikon University General Hospital and the Aristotle University of Thessaloniki (AUTH).

Participant Profession	Female	Male	Total
Healthcare Professionals	32	7	**39**
Medical Students	37	7	**44**
Total	**69**	**14**	**83**

Table 1: Distribution of Training Participants by Profession and Gender.

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 recognize the often subtle and complex signs of domestic violence. This was coupled with instruction on multi-professional collaboration, emphasizing 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 centered on providing patient-centered support, with specific attention given to referral pathways and strategies for empowering victims within clinical interactions.

The program's strength lay in its ability to attract staff from high-pressure and primary care environments, which enriched the training through shared clinical experiences. The professional background of participants included: Emergency Department staff, General Practitioners (GPs), psychiatrists, nurses, midwives and health visitors.

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Educational methods

The training sessions conducted in Greece [9] placed a strong emphasis on the practical implementation of the VIPROM modules [8], ensuring relevancy to the Greek healthcare context, and fostering a patient-centered approach that prioritizes trust, safety, and empathetic, non-judgmental communication. Particular attention was given to Greece's legal requirements surrounding mandatory reporting, especially within emergency medical settings.

The pedagogical approach prioritized active engagement by moving away from passive lecturing toward interactive, case-based

learning. Utilizing the VIPROM digital platform [3], the training integrated video analysis and multimedia tools to dismantle gender stereotypes and address the specific needs of vulnerable populations, including pregnant women and Roma communities. A critical element of the training involved role-playing exercises where participants practiced adopting the victim's perspective, allowing them to translate legal and ethical theory into empathetic, patient-centered communication.

Through all training sessions, trainees exhibited a profound sense of motivation and a genuine sensitivity toward the subject matter, showing a clear eagerness to master effective intervention techniques for domestic violence. The educational atmosphere was uniquely egalitarian, intentionally removing professional hierarchies to ensure that every participant, regardless of their background or years of experience, could contribute within a collaborative and respectful peer-to-peer environment.

The training sessions frequently evolved into pragmatic dialogues focused on immediate frontline procedures and the specific legal obligations of healthcare providers, driven by a desire for practical, real-world application. Notably, the medical students in attendance provided a unique spark for deeper reflection, often prompting the group to analyse the logistical and emotional pathways survivors navigate when seeking shelter and long-term support [9].

Results

To evaluate the enduring impact of the VIPROM trainings, a longitudinal study design was implemented using questionnaires administered at three distinct intervals: at the commencement of the sessions (Q1), at their conclusion (Q2), and six months post-intervention (Q3). For the final six-month follow-up (Q3), the questionnaire shifted focus toward the practical application of the training content and its influence on daily clinical practices and communication strategies. The surveys' robust methodology allowed for the empirical demonstration of the program's impact, ensuring that the findings regarding the sustainability of the VIPROM training were both accurate and measurable [10].

Findings from Q1 and Q2 revealed an overwhelming gain in professional confidence, with trainees acquiring new skills and attitudes toward victim identification [10]. Notably, medical students demonstrated higher gains in knowledge relative to their baseline, while experienced professionals confirmed a persistent need for such specialized education despite their years of practice. Data from the third survey date (Q3) proved that these gains were not transient; participants reported lasting improvements in both knowledge and clinical skills six months after the training ended. While changes in clinical skills were assessed via self-reports, knowledge gains were further validated through objective multiple-choice questions, which showed that certain aspects of domestic violence management are easier to train sustainably than others. Overall, the methodology, particularly the use of role-playing and case studies, was associated with higher training satisfaction and improved practical applicability in daily hospital work.

The longitudinal data derived from the three survey points—conducted pre-training, immediately post-training, and at a six-month follow-up—consistently demonstrate the sustained effectiveness of the VIPROM curriculum. Following the intervention, both medical students and healthcare professionals reported significant gains in their knowledge and clinical skills, which remained largely consistent and durable over the half-year evaluation period. This positive methodological impact was particularly evident among doctors and students, for whom the integration of diverse interactive strategies, such as role-playing and case studies, was directly associated with higher levels of training satisfaction and a marked improvement in the practical applicability of the content within their clinical environments. And, while the study relies on self-assessment for clinical skills, this limitation is partially offset by the inclusion of objective multiple-choice questions which provides a consistent and comparable measure of knowledge acquisition over time.

From the perspective of the instructors, post-training evaluations revealed high levels of professional and personal fulfilment. Trainers were particularly moved by the participants' open-mindedness and the quality of their engagement. They reinforced the idea that because survivors often lack access to specialized services and may only interact with the medical system during a crisis, healthcare staff carry a unique burden of responsibility. The consensus among trainers was that the initial approach of a medical professional can either serve as a vital support mechanism or a source of further trauma; therefore, education that fosters sensitivity and correct intervention is not merely a professional asset but an absolute necessity for the medical field.

In a qualitative level, to evaluate the effectiveness of the Greek pilot training, we utilized the Kirkpatrick Model of Training Evaluation [11], which provides a four-level framework: Reaction, Learning, Behaviour, and Results.

In regards with the Reaction Level, the overwhelmingly positive feedback from trainees in Greece, speaks volumes about the value of the domestic violence training programs. There was a plethora of positive remarks after the courses, in regards with their quality and comprehensiveness. Most participants commented positively on the friendly and inclusive atmosphere created by the trainers. Their remarks can be summarized to the following: "The Greek pilot training program was distinguished by its comprehensive and in-depth approach to domestic violence, focusing heavily on refined communication strategies and evidence-based guidelines for interacting with victims. A core strength of the curriculum was its reliance on thorough and complete bibliographic support, which integrated best practices from other countries to ensure high-quality standards. This theoretical foundation was brought to life through a wide range of engaging teaching methods and the utilization of a specialized educational platform that served

as a vital tool for the trainees. The learning environment was characterized by a respectful presentation style and the genuine enthusiasm, care, and friendliness of the trainers, which fostered a productive atmosphere for teamwork. This experiential nature was further enhanced by the positive impact of role-plays and the interactivity maintained between participants and trainers. Such a dynamic allowed for the exchange of real-world experiences among colleagues, leading to realistic discussions that bridged the gap between academic theory and clinical practice. Ultimately, the combination of these elements created a rich, supportive educational experience that effectively equipped professionals with the practical skills and collaborative mindset necessary for addressing domestic violence in a medical setting".

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. As described by a participant: "It was not the content that mattered the most, but the way the trainers delivered it, that made the difference" [10].

They also highlight the latent demand for this type of specialized knowledge among healthcare professionals and students. Some distinctive comments included: "It is essential to be included as a mandatory seminar course in Medical School", "I'm glad that awareness efforts are finally starting in our country!", "It should become a mandatory course for all professionals working in a hospital", "A very well-organized event, that made me realize the doctor's responsibility in domestic violence. I now consider it essential in medical training". 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 [10]."

As for Level 2 (Learning), the self-reported significant boost in confidence and the successful navigation of role-playing scenarios demonstrate that the trainees acquired new skills and attitudes toward victim identification. To that extent, the commitment of the trainees was so profound that technical discussions regarding domestic violence cases persisted informally during scheduled breaks, demonstrating interest that extended far beyond the classroom setting. Trainees willingly shared challenging workplace experiences and described common institutional obstacles, creating a peer-to-peer dialogue that allowed for a rich exchange of high-pressure clinical insights and fostered deep professional solidarity. Feedback indicated that the hands-on communication techniques were considered the most valued aspect of the training, resulting in a significant boost in professional confidence when initiating conversations with suspected victims. Beyond numerical attendance, the depth of engagement served as the primary indicator of the program's impact, as the use of interactive quizzes real-life scenarios maintained high engagement levels and fostered a strong sense of parity and mutual respect among participants.

And while long-term behavioural change requires longitudinal study, the spontaneous formation of professional networks by exchanging contact information to establish a formalized, long-term peer support system for managing complex cases in the future, suggests an immediate shift toward a collaborative and proactive professional stance (Level 3 Behaviour).

The success of the pilot led to a unanimous consensus that such training must be sustainable rather than a one-time event, with participants arguing for regular recurrence as a mandatory part of continuous professional development and an expanded scope that includes administrative and security personnel to ensure a unified institutional response. This multi-level success reinforces the necessity of institutionalizing such programs to achieve Level 4 (Results): a systemic reduction in secondary victimization and improved safety outcomes for survivors within the Greek healthcare landscape.

However, while the overwhelming feedback from participants underscores a profound desire for specialized knowledge, the program also highlights that education alone is insufficient. For long-term success, training must be accompanied by systemic changes, such as the establishment of a National Protocol and a National Register for domestic violence cases. By formalizing professional networks and addressing legal vulnerabilities, the Greek healthcare system can move toward a unified, institutionalized response that effectively prioritizes the safety and dignity of every victim.

Limitations of the Study

While the VIPROM Greek pilot provides a pioneering look into domestic violence training for healthcare professionals in Greece, several limitations must be acknowledged:

The study utilized a convenience sample recruited primarily through the trainers' personal networks. Furthermore, participants were drawn from a single university hospital (Attikon) and one medical faculty (AUTH). Consequently, the findings may not fully represent the attitudes, or systemic barriers present in regional, rural, or non-academic medical settings across Greece.

In addition, there was a significant underrepresentation of male healthcare professionals among the participants. This gender disparity limits the study's ability to draw conclusions about the training's effectiveness across the entire medical workforce and may reflect broader cultural attitudes regarding the "gendered"

nature of domestic violence work.

Finally, while the training addressed "Legal Literacy," the study was conducted within a shifting legal landscape. The "fear of legal consequences" reported by participants highlights a systemic issue that education alone cannot resolve without accompanying legislative clarity for non-physician staff.

Discussion

The Greek pilot experience of the VIPROM project [9] reflects both universal challenges in medical education and specific systemic barriers inherent to the Greek national context. When compared with results from other partner countries, such as Germany and Austria, several key themes emerge regarding the implementation of Intimate Partner Violence (IPV) and DV training.

A primary challenge shared across all partner countries was the extreme time pressure faced by practicing physicians. However, the manifestation of this barrier varied. In Germany, several clinics initially declined the training due to excessive workloads and high staff fluctuation or accepted it only under the condition of a significantly condensed format. In contrast, the Greek pilot maintained a 12-hour intensive format which suggests that while enthusiasm for IPV training is high across Europe, the traditional "intensive seminar" model conflicts with the operational realities of modern healthcare systems. Future iterations should lean toward modular and/or hybrid models to ensure even broader accessibility.

A distinctive finding of the Greek needs assessment was the profound legal vulnerability felt by non-physician staff. While partners in countries with more established protocols (such as Austria) emphasize the refinement of existing multi-agency cooperation, the Greek participants expressed a more fundamental "fear of legal consequences." This discrepancy underscores the necessity of the VIPROM curriculum's "Legal Literacy" module in countries like Greece, where legal protection for nurses and midwives in reporting cases is not yet equivalent to that of physicians. The high engagement in role-playing scenarios in the Greek pilot—specifically those involving complex populations like Roma communities—highlights a clinical workforce that is eager for intervention but feels stifled by procedural ambiguity.

As described above, when applying the Kirkpatrick Model [9], the Greek results demonstrate exceptional "Level 1 (Reaction)" and "Level 2 (Learning)" outcomes. The "peer-to-peer" and egalitarian environment observed in Greece mirrors the successful learning climates reported in other partner countries, where professional hierarchies were temporarily set aside. However, Greece showed a unique qualitative outcome in the spontaneous formation of professional support networks. This "bottom-up" institutionalization of knowledge serves as a mitigation strategy against the documented failure of inter-agency cooperation. While victims often only encounter healthcare professionals during moments of crisis, the Greek experience suggests that a well-trained, confident medical workforce can act as a bridge to specialized support, even in the absence of a robust national register or protocol.

A persistent challenge noted across the project—and acutely observed in Greece—was the underrepresentation of male healthcare professionals. The Greek pilot confirms a striking gender distribution, with significantly more women than men participating across all occupational groups. This suggests a prevailing perception of domestic violence as a "women's issue," highlighting a systemic need to clarify that protection is a universal professional responsibility and a critical area for improvement. As noted in international literature [1], an inclusive and intersectional approach is necessary to ensure equitable care for all victims, including men and LGBTQ+ individuals.

Moreover, the Greek pilot's reliance on trainers' personal networks for recruitment, while successful for this phase, reinforces the need for the institutionalization of the recruitment process, a sentiment echoed by stakeholders across the VIPROM consortium.

In regards with age, and contrary to the assumption that only new staff need training, data indicate that primarily older, experienced age groups attended, confirming a vital need for education even among seasoned professionals.

Longitudinal data from the three survey points confirm that the training achieved sustainable effectiveness, with knowledge and skill gains remaining consistent within six months of post-intervention. While the study is partially constrained by a reliance on self-reported skill assessments and a gender-imbalanced sample, the inclusion of objective multiple-choice testing and long-term follow-ups demonstrates a clear gain in clinical competency [8].

Conclusion and Policy Recommendations

To sum up the findings from the Greek VIPROM pilot training and the identified systemic gaps, a comprehensive set of recommendations for policy and practice has been proposed to ensure a more robust healthcare response. Central to these improvements is the need for customized outreach strategies that tailor recruitment to specific healthcare roles, acknowledging the unique operational challenges faced by different healthcare professionals. Simultaneously, the success of future training initiatives depends on transitioning from personal outreach to institutionalized recruitment strategies. By collaborating deeply with clinical and educational stakeholders, programs can move beyond the trainers' immediate circles to engage underrepresented groups, such as male practitioners. Implementing strategic communication campaigns across both digital and traditional platforms, while at the same time strengthening partnerships with hospitals, police departments, and women's shelters, will broaden the program's reach and solidify its credibility across multiple sectors. At the institutional level, hospitals are encouraged to enhance communication by establishing clearer internal channels

regarding GBV/DV protocols and reporting procedures, which would directly reduce professional uncertainty.

A primary objective moving forward is the continuous expansion of the participant base to ensure that capacity-building is sustained. Future sessions must prioritize an interdisciplinary pool of professionals, including those from the legal, social service, and law enforcement sectors, to reinforce a holistic response to domestic violence. To increase accessibility, especially in resource-constrained or geographically isolated areas, programs should adopt hybrid learning models that combine the flexibility of online instruction with the impact of in-person training.

The long-term efficacy of these programs relies on a commitment to quality improvement through consistent feedback loops. By treating participant input as a guide for evolving content and methodology, training remains aligned with contemporary professional standards. Furthermore, motivating professionals requires framing the training as a tangible career asset; emphasizing benefits such as enhanced clinical skills and improved patient outcomes helps shift the perception of the program from a mere obligation to a valuable professional opportunity.

To transition from a successful pilot to a resilient national safeguard, several fundamental systemic changes are recommended within the Greek healthcare landscape. The institutionalization of training is paramount, necessitating that such programs evolve from voluntary seminars into a mandatory component of both undergraduate medical curricula and continuous professional development for all hospital staff. However, education alone is insufficient without the establishment of a standardized National Protocol and a National Register for domestic violence cases, which would ensure a unified and coordinated institutional response.

Furthermore, legislative reform is essential to provide nurses, midwives, and health visitors with the same legal "shield" currently afforded to physicians when reporting suspected abuse, thereby addressing the pervasive fear of legal consequences that stifles comprehensive victim support. Strengthening inter-agency interoperability is equally critical to prevent the consistent failure in cooperation between hospitals, law enforcement, and social services that currently disrupts the vital victim support pathway [5]. Future initiatives must also move toward inclusive engagement by shifting from personal networks to institutionalized recruitment strategies, with a specific focus on engaging male healthcare professionals to ensure an equitable and intersectional approach for all survivors. Ultimately, the VIPROM project demonstrates that methodologically diverse, peer-led education serves as the vital foundation for systemic change. By addressing deep-seated legal vulnerabilities and fostering a collaborative, trauma-informed workforce, the Greek healthcare system can finally fulfil its unique responsibility as the frontline protector of victims' safety and dignity.

The future of domestic violence training lies in scaling inclusively and embedding initiatives like the VIPROM training within formal professional development and medical school frameworks. When programs are tailored to the practical logistical realities of healthcare providers and supported by strong institutional ties, they create a resilient, trauma-informed workforce. This strategic integration ensures that domestic violence awareness becomes a standardized component of professional competency, empowering providers globally to support survivors with increased confidence and cross-sector collaboration.

The implementation of the VIPROM curriculum in Greece represents a significant shift from traditional, passive medical education to a dynamic, trauma-informed framework, and a step toward a more responsive healthcare system, demonstrating that an interactive, peer-to-peer approach can significantly boost professional confidence in managing sensitive cases of domestic violence. Ultimately, the VIPROM project demonstrates that while systemic and legal barriers remain significant, interactive and collaborative education provides a necessary foundation for change, possessing the potential to transform the healthcare system's response to domestic violence.

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