Adapting and evaluating WHO's curriculum for health providers responding to violence against women: Final report on pre-service training pilots in Timor-Leste

Kayli Wild and Angela Taft
Judith Lumley Centre, La Trobe University

July 2019

Working group:
Kayli Wild, La Trobe University
Lidia Gomes, Universidade Nacional Timor Lorosa'e
Angelina Fernandes, Instituto Superior Cristal
Luisa Marcal, Psychosocial Recovery & Development in East Timor (PRADET)
Guilhermina de Araujo, La Trobe University
Angela Taft, La Trobe University

Contents

1. Introduction

We undertook the following objectives for the WHO Sexual and Reproductive Health program:

1. The adaptation and development of a local Timorese version of the draft 2018 WHO Pre-service curriculum on Violence Against Women (VAW)
2. Preparation of lecturers for teaching this curriculum
3. Piloting and evaluation of adapted curriculum

This report represents the final feedback from the full evaluation of our pilot program of the VAW curriculum for pre-service health care providers. We report briefly on the adaptation process and material preparation, but specifically on developments from the previous report in 2018 that outlined the curriculum adaptation. We report fully below on the piloting and evaluation.

2. Background

In 2016 we began a formal collaboration between the Judith Lumley Centre (JLC), La Trobe University and the Department of Midwifery, Universidade Nacional Timor Lorosa'e (UNTL) to examine the existing knowledge and practices of midwives responding to violence against women, and what support they require in this challenging work (Wild et al. 2016; Wild et al. 2018). This collaboration and the inclusion of staff from an additional University in Timor-Leste, Instituto Superior Cristal, a trauma response NGO, PRADET and support from Rotary Foundation has resulted in the development of additional teaching and learning materials including four training videos, printed facilitator and student guides with readings, handouts and posters, and all materials on USB sticks for students and lecturers, that support this curriculum implementation and evaluation.

This now completed work is contributing to Timor-Leste's National Action Plan on Gender-based Violence (SEM 2017), which outlines the importance of pre-service training, as well as in-service training implemented within a supportive health system. It also fulfils the strategic priorities of Timorese Universities to support teaching and learning that is innovate, addresses gender equality, builds community resilience and increases research capacity. The aim of this report is to outline findings from the pilot studies, and to share important insights with others who may be adapting the curriculum in other countries.

3. Preparation and adaptation

3.1 Partnership development

At the end of 2016 we formed a working group with UNTL faculty leaders (the Dean of Medicine and Health Sciences, Head of Department of Midwifery and a Curriculum specialist) and presented the findings from the study with midwives to UNTL's academic board to highlight the need for pre-service training for health providers to respond to domestic and sexual violence. There was support from the academic board to further this work.

We invited Instituto Superior Cristal and PRADET to be part of the working group. It was important to have representation from an advocacy service, who brought on-the-ground experience and in-depth knowledge of the legal context and referral pathways in Timor-Leste. It was useful to have two Universities to conduct the pilots with, to understand factors affecting implementation across different contexts and to discuss issues of intellectual property up front.

The partnership with WHO as a funder and basing the training content on WHO's draft curriculum was important for increasing the legitimacy and cross-sector applicability of the work. This meant that even with multiple agencies working on different aspects of the health system response (National Guidelines, in-service training, our pre-service training), they were all stemming from the same fundamental concepts and global leadership provided by WHO.

3.2 Curriculum adaptation process

The pre-service training was adapted primarily from the WHO in-service training package (draft January 2018). The process involved the working group, plus a Tetum language specialist, coming together for 3 weeks in Melbourne to develop the course structure and learning objectives. An iterative process then followed where Kayli Wild drafted the content, based on the WHO curriculum as well as other sources from Timor-Leste and internationally[1] and the working group met several more times in Dili over the next 6 months as the content was refined. The adaptation process benefitted from our formative research with women survivors and midwives, which we had conducted previously as a group, as it provided intimate knowledge of the actual health system context and needs of providers working in the field.

When the first English draft was complete, it was translated through a collaborative process by the Timorese members of the working group, led by our local researcher Guilhermina de Araujo. What

[1] These sources included PRADET's Medical Forensic Examiner Training and 4R Training (Recognise, Respect, Respond, Refer), Ministry of Health's (2017) Draft Guidelines on Health Sector Response to Gender-based Violence, UNFPA's (2015) Solomon Islands Facilitator's Manual on Strengthening the Health Response to Violence Against Women and Children (particularly their group activities), the SASA! Activits Kit (Michau 2008), the PACTS Study Guide (Bruton et al. 2016), data from the 2010 and 2016 Demographic Health Surveys (NSD 2010, Taft & Watson 2013, GSD 2018), the Nabilan survey (TAF 2016) the experiences and quotes from Timorese midwives from the Pateira Kontra Violensia study (Wild et al. 2016), and interviews we conducted with 28 survivors of violence (preliminary findings).

worked well was 'translation by consensus' and using both academic and lay meanings when translating difficult words and concepts. The first complete draft in Tetum was then peer reviewed by English/Tetum speakers from The Asia Foundation's ending violence against women program (*Nabilan*) and further improvements were made. After each pilot the working group came together again to discuss what worked well, analysed the evaluation results and adjusted the content accordingly.

Being adaptable and flexible with our budget and timeline was also important because the context in Timor-Leste is unpredictable (for example Government re-elections, delays in Government funding for Universities to function). If we put too many tight conditions on how the project was implemented the process would have failed.

3.3 Content adaptation

We based the Timor-Leste pre-service course on the WHO pre- and in-service modules because the WHO pre-service content was very short. Students may start with a lower knowledge base than in-service providers and therefore benefit from longer and more intensive time to cover training content and exercises. Consensus amongst our working group, and in consultation with other Timorese Universities, is that the pre-service course should either be a whole subject (14 x 2hr modules plus 2 modules for assessment) or part of an existing subject (8 or 9 x 2hr modules). We have therefore created two versions which Universities can utilize depending on their course structure.

Violence against children is a pressing issue in Timor-Leste, with 70% of men and women reporting physical and/or sexual abuse as a child (including high rates of sexual abuse against boy children) (TAF 2016). In recognition of this, an important addition to the WHO training course was including the issue of child abuse and how to respond to children, and also to people with disabilities. This was seen as fundamental by many stakeholders in Timor-Leste and is consistent with other NGOs working on addressing domestic violence. *We believe it is imperative that the WHO global curriculum includes children.*

Translating LIVES into a mnemonic that makes sense in the local language was very important for students to remember the steps in a good response. In addition, our initial discussions with Tetun speakers revealed the potential misinterpretation of the word Validate (Valida, Validar, Validasaun) which could be misunderstood as meaning health providers should check the accuracy of the woman's story with the perpetrator or the woman's family.

Some guidance from WHO headquarters on why adapting LIVES is important and how it can be successfully achieved would be helpful, for example, why the mnemonic was developed, metaphors to think about when developing a new mnemonic in a different language, key principles to incorporate, problems to avoid (i.e. how validate translates).

English LIVES		Tetum direct translation of LIVES		Adapted version of LIVES - Hahu Relasaun		Translation of Hahu Relasaun – Begin a good relationship
L	Listen	**R**	Rona	**Ha**	Hatene sinál ba violesia	Know the signs of violence
I	Inquire	**H**	Husu	**Hu**	Husu kona-ba problema	Ask about problems
V	Validate	**V**	Valida	**Re** **La** **S**	Reasaun empátiku Labele fó sala vitima Segredu	Respond with empathy Don't blame the victim Confidentiality
E	Enhance safety	**A**	Aumenta Seguru	**Au**	Aumenta Seguru	Enhance safety
S	Support	**S**	Supporta	**N**	Nafatin tau matan	Continue support

A strength of the WHO curriculum was the focus on practical skills (role plays, case studies, discussion and guest speakers). These were retained and expanded on. For example, we added additional activities and a visit to referral services. Based on the feedback from students, the guest speakers were given 45 minutes including the lively questions that inevitably follow. The guest speakers were built into the modules, not an optional extra, because we found if the activities were optional they were generally not done by the lecturers. *Optional extras should be avoided, if they are important they should be included.*

Initially the students were required to do some of the group activities in their own time (visit a referral service, prepare a presentation) but due to the limited resources and heavy workload of students (including domestic work at home) we built those exercises into the contact hours. The site visits to referral services were popular and valued by students. While there are readings included in the training course and students are directed to do these readings at home, not many of the pilot participants actually did them. Therefore *it is not realistic to expect that students or training participants will complete tasks outside of the actual contact time.*

Many of the role plays were simplified because reading and comprehension takes a lot longer in Tetun than it does in English. Because of this, more time needed to be allocated for the group activities. The role plays that were most complicated for students were the ones that instructed them to read point 1 and 2 to the provider and reveal the rest of their history based on what the provider asks. We changed these to first person stories (you are a 25 year old woman…) with headings of 'history' and 'symptoms' and asked them to describe their symptoms to the health provider. We also added answers to the case study questions and other interactive exercises so facilitators have correct discussion points to work with (minimises risk of misinformation).

The first pilot results showed that beliefs and attitudes, specifically attitudes that tolerate violence, started low were the most resistant to change. We revised this module extensively, taking some extra exercises from the Solomon Islands curriculum and additional ideas from SASA's approach to exploring gender and power. After further piloting we refined the group activity which challenges

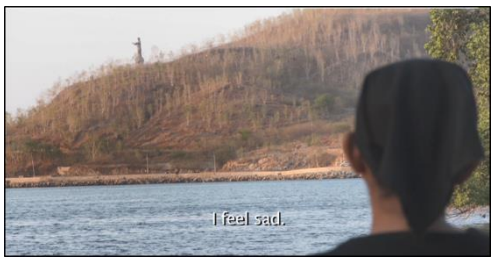
when violence is acceptable, and we went through all the activities carefully with the trainers. *The final pilot showed a much better result in shifting attitudes and we believe this is a module that should not be skimmed.*

3.4 Learning materials

We knew from the research with midwives that video-based teaching material was very important

for their learning so the production of a **video role play** was built into the budget with some funds from Rotary Foundation. Through our research with women survivors, we made **three video narratives** that shared their real stories and highlighted the ongoing effects of trauma, barriers to getting help and what care they want from health providers. These stories from women were very powerful and the feedback from both lecturers and students was that they were very useful for creating a deeper understanding and promoting empathy. *Two additional videos were included, the WHO animation on health system strengthening (dubbed in Tetum) and a video from the midwives' study on the Law Against Domestic Violence and the role of midwives in responding well*.

The qualitative evaluation revealed that students really liked ALL the videos, however, given the high cost of producing them it would be helpful to formally evaluate the effect of different types of visual material (i.e. role play vs. women's stories vs. interviews with midwives) and the impact on students' understanding and empathy. This would provide useful information about where to allocate resources for production of visual learning materials that are most likely to be effective.



We made the facilitator's guide easier to follow by including a snapshot of the PowerPoint slide and more detailed notes beside it. The facilitator's guide includes all the role play scenarios and handouts with answers and discussion points. The lecturers work in extremely resource poor settings and it is difficult for them to photocopy role plays and provide basic supplies such as butcher's paper and markers. This is in addition to more systemic problems such as lack of projector, laptop, speakers and lack of electricity during certain times of the day. *To address these constraints the need for additional material was minimised and the student's guide includes a larger snapshot of the PowerPoint slides as well as the handouts and role play scenarios for each module*.

The final pre-service training package includes a facilitator's manual, PowerPoint teaching slides, student guide, 4 videos and a set of readings (with plans for a textbook/handbook in 2020). Upon handover of the course to Universities to proceed into the future (sustainability), the materials will need to be easily accessible. We had USBs with the Hahu Relasaun steps printed very economically, which contain all the learning material. These can be given to facilitators and new students and they can print their own hard copy of the student guide, watch the videos at home and keep as a

reference in their future work. *The USBs and hard copies of the facilitator and student guides will be put in the University libraries in both English and Tetun. To facilitate ongoing access to the course material in Timor and more widely we are constructing a webpage to host it. All the outputs can be accessed at this link* www.latrobe.edu.au/reducing-violence.

4. Piloting

4.1 Capacity building with trainers

Capacity building with our own team and with other lecturers took place through a condensed version of the curriculum with the same content, but conducted over 4 days. We found it was necessary to test the draft on ourselves, where Angela Taft was the trainer and the rest of the working group were the students. This provided us with good insight into what the students were expected to do and how, how the translations were coming across, and for trainers to get a better understanding of how the content and exercises worked. This was decided after the first pilot, and in hindsight this would be important to do earlier.

We also conducted the lecturer training with 15 lecturers and clinical instructors, the pre-post training results are presented below. *We are now working on developing a sustainable system of support for training new lecturers who will be teaching the subject, ongoing refresher training, and peer support throughout their teaching.*

4.2 Training course delivery

Between September 2018 and May 2019, three pilot studies were conducted with a total of 69 (commencing and 61 completing) nursing and midwifery students at the two Universities (UNTL and Cristal).

1. The first pilot was with 14 commencing, and 11 completing, second year midwifery students
2. The second pilot was with 30 commencing, and 26 completing, currently practising midwives who were upgrading from a Diploma 1 to Diploma 3
3. The third pilot was with 25 commencing, and 24 completing, nursing and midwifery students who were nearing the completion of their degree
4. Lecturer training was with 16 commencing, and 15 completing, lecturers who taught nursing and/or midwifery at the two Universities, as well as clinical instructors who supervised students during their placements within hospitals and health centres.

The feedback from lecturers is that *it is better to place the course toward the end of their three year degree*, when they already have a strong foundation in the subjects covered in the course such as HIV, STIs, patient communication, ethics, confidentiality, record keeping etc.

After each pilot was complete we analysed the evaluation results as a team and revised the course content so that it filled gaps in knowledge and better met students' learning needs.

4.3 Evaluation methods

The evaluation was adapted from the tools provided in the WHO training package (draft January 2018), the final version of which are included in the facilitators' manual. The evaluation consisted of:

1. Pre-post training survey assessing knowledge, attitudes and self-efficacy before, after and 6 months following training
2. Observation of classes by a research assistant, using a structured observation tool
3. Qualitative interviews and group discussions with students and lecturers after the training
4. Student feedback form administered after each module *(Note: this method was abandoned after the first pilot as the forms were time consuming to administer, resulted in a lot of data to sort through, but the information was not useful as the students tended to restate the topics they learned rather than reflect on their relative value. In addition, the tick box section on what they liked/disliked provided no contextual information or meaning).*

By far the most useful evaluation method was the pre-post training questionnaire. It yielded good insight into very specific areas where the curriculum was meeting students' learning needs and where it needed to be improved and was an excellent tool for improving the content over successive pilots. *However, after we translated and pilot tested the initial WHO tool we found it needed to be substantially simplified for Timorese students.*

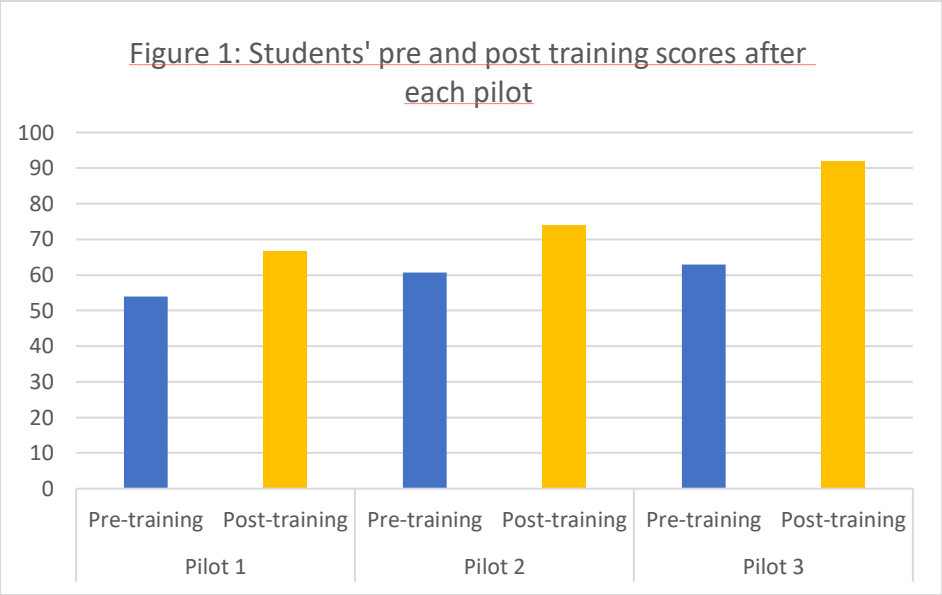
We changed the Likert scale to just two or three options (true/false/I don't know). We changed the wording of section questions that were not clear and were confusing when translated, for example asking 'indicate which one…' led some students to only choose one option out of all the below (rather than 'choose true/false for each option'). We also added questions that assessed additions to the curriculum such as the impact on children and the vulnerability of women with a disability.

To analyse the pre-post-test scores, a score of 0,1,2 was allocated to each response, so that higher scores indicated correct responses. The questions were grouped and scored in category ranges including Knowledge (0-36), Warning signs (0-7), Ways of asking (0-5), Helpful responses (0-10), Attitudes (0-22), Acceptability for a man to hit his wife (0-14), Professional role (0-10) and Self-efficacy (0-20). Proportional scores were calculated for each category pre- and post-training and are presented as a proportion of total possible score in the graphs. We used a Mann-Whitney U statistical test to assess pre-post proportional differences and significance at $p \leq 0.05$.

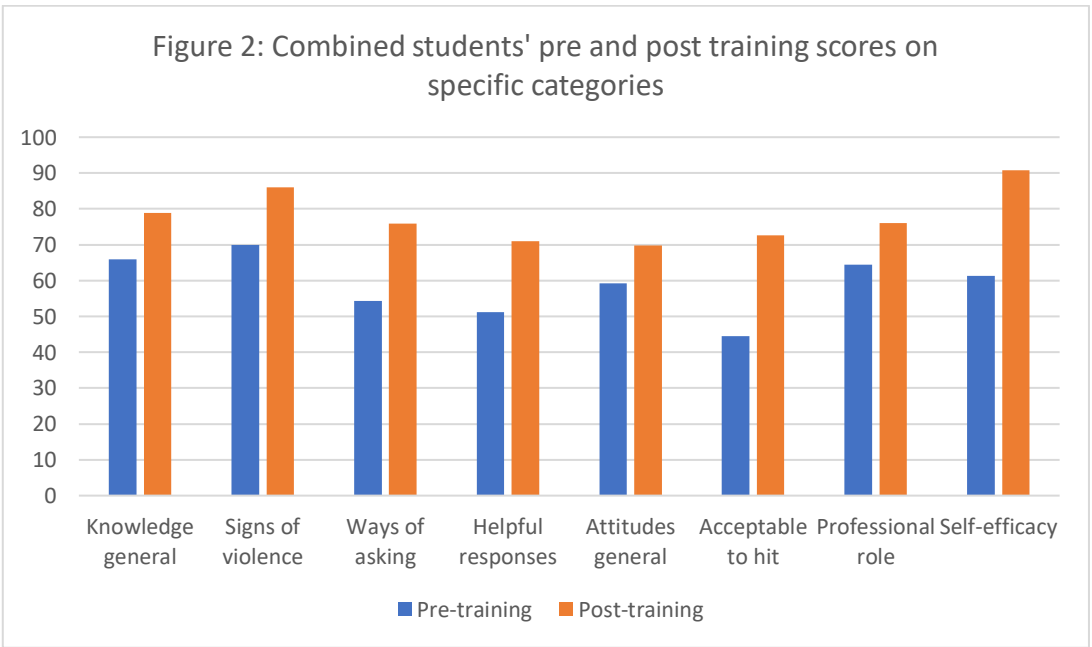
5. Results

5.1 Learning outcomes

The pre-post training survey showed an increase in students' total knowledge score after the training, and this score increased progressively with each of the three pilots (Figure 1). The progressive increase in total knowledge score after each pilot was likely a result of improvements we made to the course content after each pilot, as well as the continued focus on building the capacity of our own team of lecturers to teach the content and facilitate skills-based exercises.



We also did an analysis across the different knowledge areas, which showed that combined across the three pilots, the students demonstrated statistically significant increases in knowledge, signs of violence, ways of asking, helpful responses, self-efficacy and less acceptance of violence (Figure 2). After revising the module on beliefs and attitudes, students' attitudes tolerating violence was one of the areas of most significant change as a result of the training (Figure 2: Acceptable to hit).

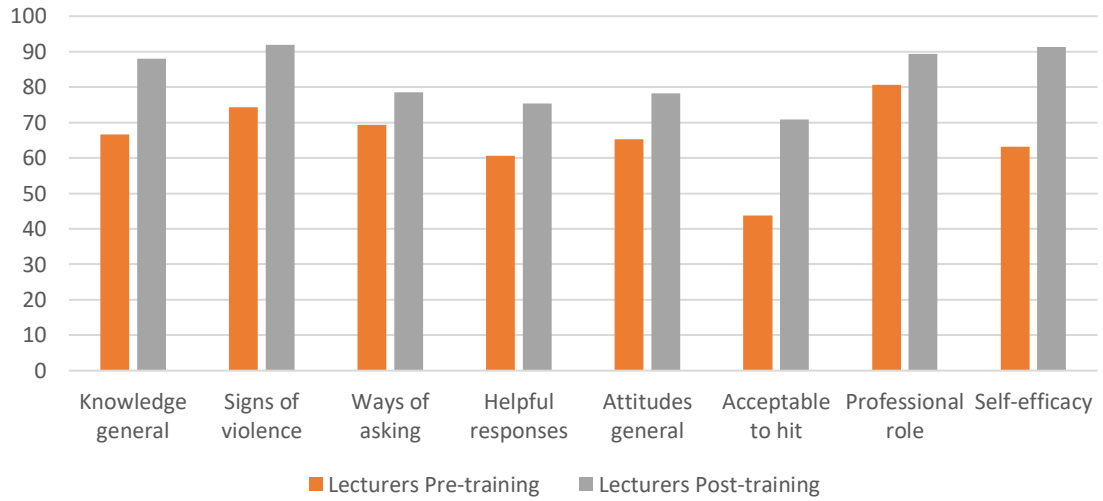


We added a question to the post-test questionnaire to assess whether the students remembered all the steps in Hahu Relasaun (this was added for the final pilot). The final group of 24 students obtained a near perfect score of 99.7% recalling all the steps, with the only mistake being one student who put Respond Well instead of Respond with Empathy.

These findings from the student evaluations are very encouraging and demonstrate the substantial impact of the training, which lays a strong foundation for future health providers to respond to violence against women in children in Timor-Leste.

The results from the training with 15 lecturers and clinical instructors showed they started with higher knowledge scores than students and achieve very good outcomes, with significant increases in knowledge, signs of violence, helpful responses, self-efficacy and less acceptance of violence (Figure 3). It should be noted that this pilot was conducted using the first draft curriculum and before additional training for our core group of trainers. We expect better outcomes from subsequent cohorts on ways of asking and helpful responses.

Figure 3: Lecturers' pre and post training scores on specific categories



5.2 Qualitative finding

Interviews were conducted with students individually for the first pilot (n=11). No interviews were conducted for the second pilot. In the third pilot the class was divided into two groups and two group discussions were held (n=24). After the lecturer training, group discussions were held with lecturers and clinical instructors as two separate groups (n=12). All the discussions were audio recorded with verbal consent, and transcribed into English. A group discussion was also held with all members of the working group (n=6) to get their perspectives and feedback for this report. Thematic analysis of the data was conducted to examine students' and lecturers' perspectives on the valuable things they learned, what content and resources were useful or not, challenges in their teaching/learning, and suggestions for improvement.

The feedback from students during the post-training interviews was that they thought the course was important because it addresses the reality of violence against women and children, which they said happens a lot in Timor, including some students who disclosed their own experiences. While many students had already heard about domestic violence, for others it was their first time learning about the issues.

> *"This course is important because it teaches us about types of violence. Sometimes at home I hit my little sisters and brother, I didn't realise that hitting someone is a crime. From now on I will not hit my little sisters and brother, I will talk to them." – Student 16, Pilot 3*

> *"As a future midwife this subject is important. Before I didn't know the meaning of domestic violence. The video role play was a good example for me, through the video I learned how to help women or my patients" – Student 4, Pilot 1*

Students found the course interesting, with a lot of valuable information. They were particularly interested to learn about the different types of violence and that hitting a spouse and beating children is a crime under Timorese law. Students commented that they now knew how to build a good relationship with their clients, understood the importance of body language, could avoid blaming the victim, could respond to a woman's psychological and emotional needs and knew how to do a referral.

> *"Usually when my friend shares her problems with me I blame her and give her bad advice, but through this course I understand not to blame the victim." – Student 13, Pilot 3*

The students enjoyed gaining knowledge as well as experience during the role plays and group exercises. The videos were particularly well received, including the discussion questions that followed. They also liked the PowerPoint slides, student guide and USB, which they said they could look at at home and use as a reference when they begin working. Other important aspects of the

course for student learning were the guest speakers, and physically visiting the advocacy services. They felt domestic violence was an important part of a midwife's job and felt ready to implement their skills to help reduce violence in the future.

> *"I like the steps of Hahu Relasaun, they are simple words but they have huge meaning for me." – Student 17, Pilot 3*

> *"This training is helpful because it opened my mind. I am ready to use these skills. Even in the next five years I think I will still remember about this subject" – Student 2, Pilot 1*

It was interesting that several students pointed out that they now knew what to do if violence happens in their family or with their neighbours and will share information they learned more widely. This indicates the broader application and potential impact of the training beyond the clinical setting and in their own lives. It highlights the important additional role these future health providers have as advocates at the community and family level.

> *"I feel happy because I learned about domestic violence. If it happens in my family or with my neighbour I can help them. If you repeat this course I would like to attend again" – Student 1, Pilot 1*

Suggested areas for improving the course (based on the first 8 and 9 module structures), were more activities and more time for the activities, organise the groups to present in front of the class instead of with each other, avoid delivering all the modules over a few days, allow time for a 10 minute break within each 2 hour module, and make sure the room is big enough for the group work. Some students pointed out the need to teach the course to all health providers and several said that if the course was run again they would like to attend.

The lecturers and clinical instructors who participated in the training said this course was extremely important, particularly health providers knowing their role in responding to domestic violence and being able to address women's psychological needs not just their physical pregnancy. After the training, they said they now knew about the importance of their client's safety, the organisations they could refer women to and the need for follow up. Several participants pointed out that knowing the 7 steps of *Hahu Relasaun* meant they could provide a good response to survivors. One lecturer said that now she has the skills to help her students when they are upset on campus.

> *"I feel happy to have the opportunity to attend this training. Before we just focussed on our patients' pregnancy but we didn't see their psychology or we weren't interested in their*

problems. Through this training we know more and in the future we can implement in our workplace." – Lecturer 4

The lecturers who participated in the training, as well as the core group who conducted the training with students, liked the videos because they were so much easier for the students to understand compared with reading. They also liked the group activities and PowerPoint slides (although one mentioned there should be no more than 20 slides for each module). The role plays were particularly important learning tools and they suggested the role plays should be done in front of the class and that the training should be longer in order to learn the content more deeply (1 to 2 weeks was suggested for the lecturer training). The lecturers discussed how they would include material from the training course in the other subjects they teach.

"I think the video role play is important because when I see the video I can quickly understand the better way to respond, and learn about the good words to say to women." – Lecturer 9

The clinical instructors felt very strongly they needed national guidelines on domestic violence from the Ministry of Health (which are in development) and that it would be good if the Ministry of Health could prioritise violence as a health issue. Several expressed the need for all health providers to attend this training course, especially those working within hospitals, maternity wards and emergency departments. They also talked about the need to socialise in communities about the nature of domestic violence and that it is a crime. The clinical instructors said they are ready to implement their new skills in their workplace, but they would like to attend refresher training.

"I think attending this 3 day training has had a huge benefit to us as health providers, because this subject is new. My suggestion is in the future we should continue this training for our colleagues who are midwives, nurses and doctors so we can reduce domestic violence which is high in our country." – Clinical instructor 1

6. Knowledge translation and dissemination

From our meetings with the University Deans, Rectors and Heads of Department, there is a strong commitment to incorporate this pre-service training course into the nursing and midwifery curricula at the pilot Universities, and there has been interest from other health-related Universities in Timor-Leste. The course has already been incorporated as a core subject in the midwifery program at Cristal and will be incorporated into nursing next year. At UNTL the course was initially planned as half a subject taught as part of Reproductive Health, but there are plans to incorporate it as an entire core subject in both nursing and midwifery after accreditation in September 2019.

There is strong support for this training course to be included in the medical curriculum at UNTL, but there are several challenges to overcome because they are still using the Cuban curriculum which they are not able to change. UNTL University leadership will advocate for its inclusion when the medical curriculum review and handover to Timor happens in September 2020. In the meantime it could be run as an additional elective for Medical students.

We have met with the other Timorese Universities that have health degrees and they are very interested in including the training course in their nursing and midwifery curricula, as well as working with us to adapt it for their public health degree. Feedback from Universities is that it is important to have it as whole subject and a core unit (compulsory) with 14 modules (plus 2 modules for assessment). We will have both 9 and 14 module versions available on our LTU website in Tetum and English. The new Universities requested practical support in preparing to teach the subject, such as lecturer training and putting the learning materials for students and lecturers into their library. Ideally they would like to access this training and support this year with a view to start teaching the subject in their Universities next year.

> *"This curriculum is important because women are getting violence and midwives and nurses don't know how to care for them. In our culture women are supposed to follow the men but this is not right. It's good to have the curriculum to change this." – Male Head of Department, Dili University*

We plan to continue to support our lecturers and to conduct additional training for other Universities in the short term. We are planning strategies for ongoing support for lecturer trainers, including further development of a national cohort of expert trainers on VAWC (from Universities, INS, PRADET) who can do ongoing refresher training for lecturers, this may include upgrading teaching qualifications and content expertise of the national trainers, and a Facebook page to facilitate peer support.

Our working group as well as other lecturers are keen to see more support for in-service training and creating an enabling environment for students to do this work when they graduate and enter the workforce. They expressed the need for further evaluation of in-service training and the impact on practice.

In addition to the University sector, there has been extensive engagement with and presentations

to related Timorese organisations throughout the project, such as Ministry of Health, National Institute for Health (INS), WHO, UNFPA, UNICEF, Marie Stopes, Health Alliance, The Asia Foundation, John Snow, and Ministry of Social Solidarity and Inclusion. There is now significant interest by INS, Marie Stopes and Health Alliance to adapt the curriculum for in-service training. We plan to explore opportunities to evaluate further work in this area, on models of training as well as support for implementation at the district and facility level.

This project has been presented at several international conferences, including the *12th Biennial Conference of the Global Network of WHO Collaborating Centres for Nursing and Midwifery*, 17-20 July 2018, Cairns; the *International Domestic Violence and Health Conference*, 20-21 November 2018, Melbourne; *the Research for Development Impact Conference*, 12-13 June 2019, Melbourne; and the *Timor-Leste Studies Association Conference*, 27-28 June 2019, which gained positive feedback and further contact with NGO and government staff.

7. Discussion

This project has been a very rewarding experience for our team and has strengthened the collaboration between the Universities in Timor and Australia. We hope we have passed on the valuable lessons we have learnt so that others who develop their curricula can benefit from these. One lesson was that the partnership with WHO as a funder and basing the training content on WHO's draft curriculum was important for increasing the collaborative potential and cross-sector relevance of the training because, regardless of whether the focus is on pre- or in-service training or national guidelines, the same essential messages are being communicated. The WHO country representative has been supportive of this work and we have tried to keep the local WHO and UNFPA staff informed about progress, so that they are abreast of what we are currently doing.

Below we have tried to list our learnings in the form of recommendations that the WHO office may like to pass on to others. Our belief is that it is imperative that the WHO global curriculum includes children and some guidance from WHO headquarters on why adapting LIVES is important, and how it can be successfully achieved, would be helpful. For example, why the mnemonic was developed, metaphors to think about when developing a new mnemonic in a different language, key principles to incorporate, problems to avoid (i.e. how validate translates).

We believe the pilot is a really critical phase for all countries, as our first pilot results showed that beliefs and attitudes, specifically violence-tolerant attitudes were the most resistant to change. However, the final modified pilot showed a much better result in shifting attitudes and we believe this careful process of refining content with lecturers while also building the expertise of a national cohort of trainers was integral to the successful learning outcomes.

We are now working on developing a sustainable system of support for training new lecturers who will be teaching the subject, ongoing refresher training, and peer support throughout their teaching. This should be a conscious consideration for all countries as they develop pilots with the ultimate aim of sustainability of all aspects of the course following the pilot phase.

8. Conclusion and recommendations from our learning

1. The curriculum should include children. If the focus is only on women/IPV it is a missed opportunity to address the very real issue of child physical and sexual abuse. In addition, midwives and women survivors in our previous research were very concerned about the needs of the children and the impact of violence directly or indirectly on children. It is useful to apply the universal principles of a good health system response to other vulnerable groups to avoid confining students' thinking on the issue.
2. Include in the introduction of the curriculum the need to think about the translation of LIVES and the possible misinterpretation of 'Validate' across languages.
3. The WHO training package required careful and collective adaptation to the local context and language, with particular attention paid to processes of 'collaborative translation', peer review, evaluation, refinement and capacity building of trainers.

4. The interactive and skills-based content was an important strength of the WHO curriculum, but role plays and case studies should be simplified. The need for any resources (photocopying, equipment, supplies) should be minimal.
5. Given the importance of visual learning methods for students' understanding, a budget specifically for local, video-based resources (such as a role play demonstrating good practice and stories from survivors) should be included in the adaptation plan.
6. More research should be done to understand what forms of learning materials produce the best knowledge and empathy outcomes in differing resource and literacy environments, in order to know where to prioritise resource development.
7. The curriculum materials should be easily accessible in multiple ways. We found it was necessary to have them printed, put in the libraries, on USBs, and on a website to make access easier for students and lecturers who faced significant resource constraints.
8. All the additional items should be budgeted for (printing facilitator and student guides for pilots as well as for use in libraries; USB sticks; travel allowance, venue hire, catering and facilitator fee for training outside of normal university teaching; projector, laptop and speakers; and wider dissemination such as additional lecturer training, learning materials for other universities and ongoing support).

9. The pre-service curriculum needs to be long enough to cover all the essential competencies. A full subject in the final year is ideal and a half subject is sufficient, but there is likely to be little benefit if only a few contact hours are allocated to the topic.
10. When developing pre-service training it is useful to also have a plan for a systems approach within health services, so that students can be supported when they enter the workforce (i.e. in-service training and an enabling environment such as consultations conducted in private, enough time to talk with clients, support from senior staff and managers, guidelines, systems for documenting and reporting, etc.)
11. A lot of political work needed to be done in the background (leadership from within Universities, standing by our University partners and advocating for the curriculum with them). This needed to be done in person through a wide range of meetings in order to promote legitimacy and ensure sustainability of the curriculum. Enough time and resources should be allocated for these processes.
12. It would be useful to plan for sustainability after curriculum development, through formal and ongoing partnerships between Universities in high-, middle- and low-income countries. This could include providing hard copies of student and facilitator manuals in University libraries, online resources or USBs and computers so that students without a computer or internet access at home can still access the material and study, and periodic updating of material. This is in addition to ongoing refresher training, and mentoring and support for lecturers once the curriculum is integrated.

9. References

Bruton C, Coles J, Western D, McKay H (2016). *An innovative Primary care program Advancing Competency To Support family violence survivors (PACTS): Study Guide.* Melbourne: Monash University.

GDS, MoH, ICF (2018). *Timor-Leste Demographic and Health Survey 2016.* Dili: General Directorate of Statistics (GDS) and Maryland: ICF.

Gibbons M (2012). *Handbook for Medical Forensic Examination for domestic violence, sexual assault and child abuse Timor-Leste.* Dili: PRADET.

Michau L (2008). *SASA! Activists Kit for Preventing Violence against Women and HIV.* Raising Voices. Kampala: Uganda.

MoH (draft 2017). *Health Sector Response to GBV/IPV: National Guideline for Health Care Providers to address Gender-based Violence including Intimate Partner Violence*. Dili: Ministry of Health.

NSD, Ministry of Finance & ICF Macro. (2010). *Timor-Leste Demographic and Health Survey (DHS) 2009-10.* Dili: National Statistics Directorate & ICF Macro.

SEM (2017). *National Action Plan on Gender-based Violence 2017-2021.* Dili: Secretary of State for the Socio-economic Promotion of Women (SEM).

PRADET (2014). *Recognising & Responding to Domestic Violence, Sexual Assault and Child Abuse: A Guide for Health Workers (4R Training Manual)*. Dili: PRADET.

The Asia Foundation (TAF). (2016). *Understanding Violence Against Women and Children in Timor-Leste: Findings from the Nabilan Baseline Study.* Dili: The Asia Foundation.

Taft A, Watson L. (2013). Violence Against Women in Timor-Leste: Secondary Analysis of the 2009-10 Demographic and Health Survey. Melbourne: La Trobe University.

UNFPA (2015). *Strengthening the Health Response to Violence Against Women and Children Solomon Islands: A Practice Training Manual for Health Care Professionals & Training Facilitator Handbook*. Suva: UNFPA Pacific Sub-Regional Office.

WHO (draft January 2018). *VAW Training Curricula* (in-service and pre-service facilitator's guide, in-service and pre-service learner's guide, in-service and pre-service PowerPoint slides). Geneva: World Health Organisation.

Wild K, Taft A, Gomes L, Madeira I, Matos LC, de Araujo G, Fernandes A, McDonald S. (2016). *Building a primary health care response to violence against women: The knowledge and needs of midwives in three districts of Timor-Leste*. UNTL, Dili and La Trobe University, Melbourne.

Wild K, Gomes L, Fernandes A, de Araujo G, Madeira I, Matos LC, McDonald S, Taft A (2019). Responding to violence against women: A qualitative study with midwives in Timor-Leste. *Women and Birth*, 32(4):e459-e466.