



Fair Care

Peer-trainer course - People in need of care

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Final Version: 09.04.2026

Peer-trainer course - People in need of care

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Introduction

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The FairCare peer training course for people with disabilities and older people with care needs not only aims to strengthen their empowerment but also to qualify them as trainers who can contribute to adult education within the FairCare framework. Peer counselling and peer support are well-established methods based on the principles of the Independent Living movement of people with disabilities and aim to promote empowerment and self-determination.

The training course is a central element of the FairCare project, as it provides the foundation for a high-quality, practice-oriented and inclusive learning programme in long-term care. Through close cooperation between the partner organisations and the involvement of the project advisory groups, a professionally grounded curriculum was developed that takes into account the perspectives and needs of all target groups and presents the content in a clear and practice-relevant way.

The training course is particularly relevant because it follows a user-oriented development process. The involvement of people with lived experience in care contexts ensures that the learning content reflects the actual needs of older people, people with disabilities, informal carers and professional care workers. The train-the-trainer approach also enables the sustainable transfer of knowledge and competences and contributes to the development of a first generation of FairCare trainers.

The training course therefore contributes to fostering inclusive learning processes, strengthening digital competences and supporting equal cooperation among all stakeholders involved in long-term care.

1.1 Self-Assessment

What is the module about?

This module supports participants to reflect on their personal strengths, needs, preferences, and boundaries in everyday care situations. It creates a safe and accessible space where participants can recognise what helps them feel respected and involved. Participants develop a short personal “My Profile” to guide their participation in FairCare and strengthen collaboration with carers and peers.

What should participants know at the end of the module?

Participants will:

- Recognise their personal strengths and support needs.
- Identify what helps them participate actively and feel respected.
- Understand the importance of expressing preferences in care relationships.
- Produce a short personal “My Profile” to guide future collaboration.

Overview over subtopics

- Self-awareness and strengths
- Personal needs and boundaries
- Participation and communication preferences
- Psychological safety and respectful feedback

For online sessions:

Tools you need open before the online session starts: Video call (Zoom / Teams / Meet) | Google Form link | Shared Board PPTX | Easy-to-Read Slides | Feelings Cards (PDF)

Before-session checklist

- ☐ Google Form is live and link is copied.
- ☐ Shared Board PPTX is open and ready to share.
- ☐ Easy-to-Read Slides PPTX is open.
- ☐ Feelings Cards PDF is open in a separate window.
- ☐ Captions are enabled in your video call.
- ☐ All chat messages are saved in a text file ready to paste.
- ☐ Breakout rooms are configured (pairs, random assignment).
- ☐ You have a quiet, well-lit space for the session.

1.1.1 Welcome, Safe Space & Gentle Warm-up

Duration

15–20 minutes

Materials required

Ground rules poster, Easy-to-Read slides, flipchart/whiteboard, captions (online), quiet corner (face-to-face)

Theoretical Background

Based on principles of Care Ethics and adult learning theory, psychological safety is essential for reflection and empowerment. Participants engage more meaningfully when autonomy and the right to pass are clearly established.

Instructions for implementation



Face-to-Face

- Arrange seating in a circle or café style.
- Explain confidentiality and right to pass (“You choose what to share.”).
- Conduct accessibility checks (light, seating, sound).
- Agree on 4–5 simple ground rules (plain language, one voice, respect time).
- Warm-up prompt (choose one):
 - “One thing I am good at in daily life.”
 - “One thing that helps me on a difficult day.”

Online

- Activate captions and chat.
- Present one slide with a warm-up prompt.
- Invite sharing via voice or chat.
- Remind participants of the right to pass.

Instructions:

Share screen: Open your Easy-to-Read Slides (Slide 1 — Cover). Start the video call.

Enable captions: Turn on live captions in your video call settings before participants join.

Paste in chat:

Welcome to the FairCare session! This is a safe space. You only share what you want to share. You can always pass. Please turn on captions if you need them (look for CC in your call settings).

Share screen: Switch to Slide 2 — Ground Rules. Read them aloud slowly.

Paste in chat:

Our ground rules for today: Speak in plain language. One voice at a time. Respect each other's time. You can always pass. What is shared here stays here

Share screen: Switch to Slide 3 — Warm-up Question. Read it aloud.



Invite responses: Give 2 minutes. Invite participants to respond via voice OR chat.
Acknowledge each response warmly. Remind the right to pass.

Timing: Allow 15–20 minutes total for this activity.

1.1.2 Guided Self-Reflection & “My Profile” Completion

Duration

40–45 minutes

Materials required

- “My Profile” card (Easy-to-Read), Strengths–Needs–Helps chart, Feelings cards, markers;
- Online: e-form (Google Forms), shared board (Slides/Miro), optional voice-note option.

Theoretical Background

Grounded in self-determination theory and empowerment approaches, structured self-reflection increases autonomy, confidence, and participation in care processes. Visual and Easy-to-Read tools enhance accessibility and inclusion.

Instructions for implementation

Face-to-Face

- Introduce 3-column chart:
 - Strengths
 - Needs
 - What helps
- Prompt participants:
 - “What I’m good at.”
 - “What I need support with.”

- “What helps me feel respected.”
- Use Feelings cards to support naming emotions and boundaries.
- Participants complete the “My Profile” card individually (10–12 min).
- Trainer provides quiet roaming support; quiet corner available.
- Participants transfer 3–5 key points onto the final profile card.

Online

- Share digital “My Profile” form.
- Provide structured prompts on slides.
- Offer voice-note submission option.
- Optional breakout rooms for discussion before completing form.
- Encourage voluntary posting of 1 key strength on a shared board.

Instructions:

Share screen: Switch to Slide 4 — Reflection Questions. Keep this visible.

Paste in chat — Google Form link:

Here is the link to your My Profile form:[PASTE YOUR GOOGLE FORM LINK HERE]Take your time. There are no right or wrong answers. You have about 10–12 minutes.

Paste in chat — feelings cards:

If it helps you, you can look at the Feelings Cards PDF while you fill in the form. Your trainer sent it to you before the session. Which feeling is closest to how you feel right now?

Individual reflection: Give participants 10–12 minutes to complete the form individually. Stay on the reflection slide. Keep your microphone muted. Type encouragement in chat if needed.

Optional: Breakout rooms: Open breakout rooms of 2–3 people for 5 minutes of discussion before completing the form. Bring everyone back before moving on.

Shared Board — Activity 1: Open the Shared Board PPTX. Switch to Slide 1 — Strengths Wall. Share your screen.

Paste in chat — strengths wall:

Optional: Share one word or short phrase about a strength you have in daily life. Type it in the chat and your trainer will add it to our shared screen.

Collect strengths: As participants share, type their strength (one word or short phrase) into the text boxes on the Shared Board slide. You don't need to collect everyone — 5–8 contributions is enough.

Timing: Allow 40–45 minutes total for this activity.

1.1.3 Pair-Share & Gentle Peer Feedback

Duration

20–25 minutes

Materials required

- Pair feedback mini-card; flipchart;
- Online: breakout rooms, shared slide.

Theoretical Background

Peer affirmation strengthens self-esteem and builds mutual recognition. Structured feedback reduces anxiety and promotes respectful communication.

Instructions for implementation

Face-to-Face

- Form pairs.
- Provide mini-card script:
 - “Two things I value in you are...”
 - “One thing that could help you participate is...”
- Swap roles.
- Group harvest: invite volunteers to share one helpful support.
- Trainer lists common supports (e.g., visual agenda, extra time, written summaries).

Online

- Breakout pairs.
- Paste feedback script in chat.
- Harvest key supports on shared slide.
- Save slide for documentation.

Instructions:

Open breakout rooms: Assign participants to pairs randomly. Set a timer for 10 minutes.

Paste in chat before opening rooms:

You are about to go into a pair conversation. When you are with your partner, take turns saying: "Two things I value in you are..." "One thing that could help you participate is..." Swap roles. You have 10 minutes.

While rooms are open: Monitor. You can pop into rooms briefly. Leave 30 seconds warning before closing.

Shared Board — Activity 2: Close breakout rooms. Open the Shared Board PPTX. Switch to Slide 2 — Harvest.

Paste in chat — harvest:

Welcome back! Who would like to share one helpful support you heard in your conversation? Something that could help you or others participate more easily? Type it in the chat or unmute to speak.

Collect supports: Ask volunteers to share one helpful support they heard. Type responses into the Harvest slide as participants speak. Aim for 3–5 themes.

Summarise: Read back the top themes from the harvest. Thank participants for sharing.

Timing: Allow 20–25 minutes total for this activity.

1.1.4 Evaluation of the lesson

- Attendance record.
- % of participants who completed “My Profile.”
- Quick comfort check (thumbs up / sideways / down).
- One-question exit reflection:
- “What helps you most to feel involved in FairCare?”
- Trainer reflection: note 2 strengths and 1 improvement for next session.

For online sessions:

Share screen: Switch to Slide 5 — What you will take away. Read the outcomes aloud.

Paste in chat — exit question:

Last question before we close: What helps you most to feel involved in FairCare? Type your answer in the chat or just react: I feel good about today. It was okay. I need more support

Comfort check: Ask participants to react with (comfortable), (somewhere in between), or (not comfortable). Thank everyone.

After session: Download Google Form responses (Responses tab > download icon > CSV). Save the Shared Board PPTX with participant contributions for documentation.

Self-care reminder: Note 2 things that went well and 1 thing to adjust for next time. This is built into the evaluation criteria.

References

The module is grounded in Self-Determination Theory (Deci & Ryan, 2000; Ryan & Deci, 2017), Care Ethics (Tronto, 1993, 2013), and participatory learning approaches (Freire, 1970), recognising participants as active co-creators of their care relationships. In line with the UNCRPD (2006), the structured “My Profile” tool operationalises autonomy and

participation through accessible co-creation methods (Pulford et al., 2011; Sanders & Simons, 2009).

Self-Determination Theory

Deci, E. L., & Ryan, R. M. (2000). The “what” and “why” of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, 11(4), 227–268.

https://doi.org/10.1207/S15327965PLI1104_01

Ryan, R. M., & Deci, E. L. (2017). *Self-determination theory: Basic psychological needs in motivation, development, and wellness*. Guilford Press.

Care Ethics

Tronto, J. C. (1993). *Moral boundaries: A political argument for an ethic of care*. Routledge.

Tronto, J. C. (2013). *Caring democracy: Markets, equality, and justice*. New York University Press.

Participatory Learning & Empowerment

Freire, P. (1970). *Pedagogy of the oppressed*. Continuum.

Freire, P. (1998). *Pedagogy of freedom: Ethics, democracy, and civic courage*. Rowman & Littlefield.

Co-Creation and Participatory Design Approaches

Pulford, L., Nordstokka, K., Friesen, C., Sigaloff, C., Moerbeek, K., & Loon, L. (2011). *Co-creation Guide. Realising Social Innovation together*.

Sanders, L., & Simons, G. (2009). *A social vision for value co-creation in design*. Open Source Business Resource, (December 2009).

UN Convention on the Rights of Persons with Disabilities

United Nations. (2006). *Convention on the Rights of Persons with Disabilities*.

Relevant articles:



Article 3 – General principles (respect for inherent dignity, individual autonomy, full participation).

Article 19 – Living independently and being included in the community.

Official text available at:

United Nations. (2006). Convention on the Rights of Persons with Disabilities.

<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

Learning material

My Profile card (Easy-to-Read, large print)

Strengths–Needs–Helps chart (A4, icon-based)

Feelings cards (pictograms, large print)

Pair feedback mini-card

Easy-to-Read slides (high contrast)

Digital equivalents (Google Form, Slides/Miro board)

1.2 Identification with one's role

What is the module about?

This module supports people in need in exploring how they identify with their role within the care and support system. Through peer counselling activities, participants reflect on how their identity has been shaped by experiences of vulnerability and how it can evolve. The module uses narrative tools to foster awareness, empowerment, and systemic understanding.

What should participants know at the end of the module?

By the end of the module, participants should:

- Recognize how they currently identify with their role within the support system.
- Understand that identity is dynamic and can change over time.
- Become aware of the interconnected roles within the care ecosystem.
- Identify personal and relational resources that support positive change.

Overview over subtopics

- Different roles in the care system
- Expectations and relational dynamics
- Emotions in receiving care
- Personal responsibility and action

1.2.1 Identity Awareness and Video Reflection

Duration

40 minutes

Materials required

- Projector and speakers
- Selected videos (These are videos without sound. If you know of any thought-provoking videos in your native language that are suitable for this activity, they might help stimulate reflection. Feel free to use them)
 - <https://www.youtube.com/watch?v=CCQ9v6XMC6c&t=6s>
 - https://www.youtube.com/watch?v=96xGUa1a_zs
- Post-it notes
- Markers
- Flipchart

Theoretical Background

Within a **Theory of Change** perspective, the first step toward transformation is awareness: if participants recognize how they see themselves, change becomes possible. The cineforum-like video reflection acts as a projective and metacognitive tool, activating autobiographical memory and emotional recognition. Audiovisual narratives support identity exploration through meaning-making processes (Bruner, 1991). Guided discussion promotes metareflection, helping participants distinguish between internalized labels and personal identity.

Instructions for implementation

- Introduce the theme: “Who am I beyond the label of ‘person in need’?”
- Show the selected video (5–10 minutes).
- Participants individually write on post-its:
 - How does it mirror my story?
 - What does this say about how I see myself today?

- Post the notes on a shared board.
- Peer sharing in a circle (voluntary).
- The facilitator highlights emerging identity themes (strength, resilience, fear, change).

1.2.2 Telling My Story, Reclaiming My Voice

Duration

75 minutes

Materials required

- Smartphone/audio recorder
- Quiet space
- Optional microphone

Theoretical Background

In the Theory of Change pathway, awareness evolves into action: if individuals narrate their story, they reposition themselves as authors rather than passive recipients. Narrative Identity Theory (McAdams, 2001) highlights storytelling as central to identity construction. Recording and re-listening (radio/podcast format) enhances reflexivity, coherence, and self-recognition. Community radio research shows audio narration can foster empowerment and dialogical learning in educational contexts.

Instructions for implementation

- Introduce storytelling as a way to reconnect with one's life story beyond the "care receiver" role.
- Prompt: "Tell a story about a moment in your life when you felt strong or meaningful."/ "How has your role changed over time?"

- Participants share orally in pairs or small groups.
- Volunteers may record their story (podcast style).
- Invite participants to listen to their recording (individually or in group if they agree).

1.2.3 Understanding Roles in the Care System

Duration

60 minutes

Materials required

- Three large human silhouettes (paper sheets)
- Markers (different colors)
- Sticky notes

Silhouettes labelled:

- Person in Need
- Formal Caregiver
- Informal Caregiver

Theoretical Background

According to **Bronfenbrenner's Ecological Systems Theory**, identity is shaped within interconnected relational systems. Mapping roles (person in need, formal and informal caregivers) increases systemic awareness and reduces internalized blame. The visual method used is commonly known as **Body Mapping**, a participatory visual approach that externalizes experiences and expectations. Visual participatory methods facilitate collective meaning-making and empowerment.

Instructions for implementation

Divide participants into small groups.

Assign or rotate the three silhouettes.

For each silhouette, participants write:

- What should this person have? (skills, attitudes, resources)
- What do we expect from them?
- What difficulties might they face?

Use different colors for expectations vs. difficulties.

Groups present their reflections.

Facilitator leads discussion focusing on:

- Overlapping expectations
- Unrealistic demands
- Hidden burdens in the system

1.2.4 Evaluation of the lesson

Evaluation can be conducted through:

- Final reflection circle (one word describing how participants feel now and "Has your perception of your role changed?"
- Written anonymous feedback.
- Facilitator observation (engagement, emotional shifts).

References

Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry*, 18(1), 1–21.

<https://doi.org/10.1086/448619>

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.



de Jager, A., Tewson, A., Ludlow, B., & Boydell, K. M. (2016). Embodied ways of storytelling: A systematic review of body-mapping. *Global Public Health*, 11(5–6), 672–693.

<https://doi.org/10.1080/17441692.2015.1060902>

Gordon, J. (2011). Community radio in the twenty-first century. *Journal of Radio & Audio Media*, 18(2), 166–179. <https://doi.org/10.1080/19376529.2011.562478>

McAdams, D. P. (2001). The psychology of life stories. *Review of General Psychology*, 5(2), 100–122. <https://doi.org/10.1037/1089-2680.5.2.100>

Learning material

- Silhouette templates

2.1 Peer-approach and counselling

What is the module about?



The module introduces the concept of the peer approach and explains the meaning of the term “peer,” its historical background, and its core principles and attitudes. It provides an overview of the guiding principles and methodological foundations of peer counselling and peer support. In addition, the module examines how the peer approach can contribute to democratic participation and collaborative learning. Participants are introduced to the relevance and potential of peer-based methods in different social and support contexts.

What should participants know at the end of the module?

- Understand the concept of the peer approach, including the definition of “peer,” its historical background, and its core principles and attitudes.
- Become familiar with the guiding principles and methodological foundations of peer counselling and peer support.
- Recognize the role of the peer approach within a democratic and participatory context.
- Reflect on the opportunities, limitations and challenges of applying the peer approach in practice.

Overview over subtopics

1. Basics of the Peer Approach
 - a. Definition of “Peer”
 - b. Core Principle
 - c. Historical Background
 - d. Peer Attitude
 - e. Peer Counselling
 - f. The Peer Approach in a Democratic Context
2. Opportunities, limitations and challenges of the peer-approach

2.1.1 Basics of the peer approach

Duration: 35 Minutes

Materials required:

Face-to-face setting

- Prepared presentation
- Laptop or computer to display the presentation
- Projector or screen so all participants can see the slides
- Speakers if the presentation includes audio or video
- Flipchart or whiteboard to note additional ideas or questions from participants
- Markers
- Remote clicker or presenter tool (optional) to move through the slides

Online setting

- Prepared presentation
- Digital whiteboard or shared document (optional) to collect questions or key points

Theoretical Background

Peer counseling is a form of support in which people with similar life experiences counsel each other. The approach is based on the idea that shared experiences create a special level of understanding and empathy, which can complement or sometimes even enhance professional counseling (Rappaport, 1993). The concept was developed in the 1990s in the United States by students with disabilities together with university professors.

The theoretical foundation of peer counseling is strongly influenced by Carl R. Rogers' client-centered approach from humanistic psychology. Rogers emphasized empathy, acceptance, and authenticity as key conditions for effective counseling. These principles are reflected in peer counseling, where counselors use their own experiences to build an authentic and trusting relationship with the person seeking advice. Empowerment is another central element, aiming to strengthen individuals' autonomy and self-efficacy by supporting them in activating their own resources and developing their own solutions (Zimmermann, 2000).



Social constructivist perspectives also play a role, emphasizing that meaning and knowledge are developed through shared reflection and dialogue (Gergen, 1985).

Peer counseling should be distinguished from peer support. While peer counseling is usually structured and often requires training, peer support is a broader and often informal concept that includes any type of mutual support between people with shared experiences. Peer support focuses mainly on emotional encouragement, whereas peer counseling aims to work more systematically on challenges and solutions.

The key principles of peer counseling include equality between counselor and client, empowerment, self-disclosure, and a non-directive approach that encourages people to develop their own solutions (Jordan, 2022). Peer counseling is used in many areas, such as psychosocial support, inclusion work with people with disabilities, and addiction recovery programs.

Instructions for implementation

In this session, moderators introduce the peer approach and peer counselling using a prepared presentation. The focus should be on explaining the basic principles and key ideas of the peer approach, providing participants with a clear understanding of the concept and its background.

The presentation is already prepared and should be used to guide the session. The input should last approximately 25 minutes and should cover the main foundations of the peer approach.

After the presentation, allow about 10 minutes for questions and discussion. During this time, participants can ask clarifying questions and, if relevant, briefly share their own experiences with peer support or working as peers.

Ensure that there is enough time for interaction at the end so participants can reflect on the content and connect it with their own perspectives or practice.

2.1.2 Opportunities, limitations, challenges

Duration: 65 Minutes

Materials required:

Face-to-face setting

- Flipchart sheets (at least three per group) or worksheets titled:
 - Opportunities
 - Limitations
 - Challenges
- Markers for writing on the flipcharts
- Tape or flipchart stand to display the sheets
- Timer

Online setting

- Digital whiteboard or collaboration tool (e.g., Miro, Mural, Padlet, Jamboard)
- Three sections or boards labeled or worksheets:
 - Opportunities
 - Limitations
 - Challenges
- Timer

Theoretical Background

Peer counselling offers many benefits but also involves several challenges. One difficulty is maintaining professional distance. Because peer counselors draw on their own experiences, they may become emotionally too involved or unintentionally project their own feelings onto



the counselling process. This can lead to taking on the emotional burden of the person seeking support and may affect the counsellor's own well-being (Repper & Carter, 2011).

Another challenge is that many peer counsellors lack formal training in counselling or psychological methods. Although they bring valuable experiential knowledge, they may feel uncertain or reach their limits when dealing with complex or traumatic situations. Role conflicts can also arise because peer counsellors are both supporters and individuals with similar lived experiences, which may create uncertainty if their role is not clearly defined. In addition, peer counselling has limits: serious crises or severe mental health issues should be addressed by professionally trained specialists.

To address these challenges, several measures are important. Regular supervision and self-reflection can help peer counselors maintain professional distance and manage emotional stress. Training and continuing education can strengthen counselling skills and provide guidance on ethical and crisis-related issues. Clear role definitions can reduce uncertainty and role conflicts. Furthermore, strong cooperation with professional counselling services ensures that people seeking support can be referred to specialized help when necessary. Finally, peer counselors themselves should have access to psychosocial support to prevent overload and maintain their well-being.

Instructions for implementation

Divide the participants into small groups of 2–4 people. Briefly explain that the goal of the activity is to reflect on the peer approach by identifying its opportunities, limitations, and potential challenges.

Ask the groups to discuss the following three guiding questions:

- **Opportunities:** What positive impacts and strengths do you see in the peer approach?
- **Limitations:** In which situations might the peer approach reach its boundaries?

- **Challenges:** What obstacles might arise when applying the peer approach in practice?

Each group should collect their ideas on three separate flipchart sheets or digital boards. The sheets should be titled Opportunities, Limitations, and Challenges (40 Minutes).

At the end of the discussion, each group prepares a short presentation summarizing their key ideas and sharing the most important points with the whole group (20 Minutes).

2.1.3 Evaluation of the lesson - Reflection and wrap-up

Duration: 15 Minutes

A short reflection helps participants consolidate the key ideas of the session and connect them to their own experiences and perspectives.

1. Individual reflection (about 2–3 minutes)

Ask participants to briefly reflect on the following questions:

- What was the most important idea or insight for me today?
- What will I take with me for my practice or my role as a peer?
- Is there an open question or a point I would like to explore further?

Participants may write down a few key thoughts.

2. Short group exchange (about 5–7 minutes)

Invite participants to share some of their reflections with the group. Possible guiding questions include:

- What was particularly helpful or interesting for you today?
- Has your perspective on peer counseling or the peer approach changed?
- Which opportunities or challenges stood out to you?



Key points can be briefly collected on a flipchart, whiteboard, or digital board to make the main insights visible to the group.

References

Gergen, Kenneth J. (1985): The social constructionist movement in modern psychology. In: American Psychologist, 1985, 40 (3), S. 266–275.

Jordan, Leonora Micah (2022): Peer Counseling: Method, Metaphor, or Mindset?, 2022.

Rappaport, Julian (1993): Narrative Studies, Personal Stories, and Identity Transformation in the Mutual Help Context. In: The Journal of Applied Behavioral Science, 1993, 29 (2), S. 239–256.

Repper, Julie/Carter, Tim (2011): A review of the literature on peer support in mental health services. In: Journal of Mental Health, 2011, 20 (4), S. 392–411.

Zimmerman, Marc A. (2000): Empowerment Theory. In: Rappaport, Julian/Seidman, Edward (Hrsg.), Handbook of Community Psychology, Boston, MA, S. 43–63.

Learning material

- Presentation on the peer approach

2.2 Self-Advocacy

What is the module about?

This module focuses on strengthening self-advocacy skills among care recipients, enabling them to actively participate in decisions about their care and daily life. It supports



participants in understanding their role as experts of their own needs and experiences. The module also develops proactivity and the ability to request changes or support in a constructive and respectful way. Through practical examples, participants learn how to express their interests effectively while maintaining positive relationships with caregivers and services.

What should participants know at the end of the module?

By the end of the module, participants will understand the importance of self-advocacy and their role in making informed decisions about their care and daily life. They will be able to actively participate in care-related decision-making and express their needs in a clear and constructive way. Participants will develop basic skills in proactivity, including how to request changes or support appropriately. They will also learn how to give feedback and represent their interests while maintaining positive relationships with caregivers and services.

Overview over subtopics

- Self-advocacy, key concepts
- Decision-making participation
- Proactivity, initiative taking
- Constructive self-representation

2.2.1 Understanding self-advocacy and participation in care decisions

Duration: 20 Minutes

Materials required

Face-to-face setting

- Prepared presentation

- Laptop to display the presentation
- Projector
- Flipchart or whiteboard
- Markers

Online setting

- Prior registration with an email address
- Digital collaborative and interactive training tools (e.g. Mentimeter, Miro, Slido)

Theoretical Background

Self-advocacy refers to the ability of individuals to understand and express their own needs, preferences, and rights within care settings. It is based on the principle that care recipients are active participants in their own care and the primary experts of their lived experience. Participation in decision-making is a key element of person-centred care, ensuring that individuals are involved in choices about daily activities, treatments, and support services that affect their lives. Constructive self-advocacy combines assertiveness with respect, meaning that individuals can express their needs clearly without creating conflict or damaging relationships with caregivers or services.

Instructions for implementation

Start with a **short**, simple **explanation of self-advocacy** and emphasize the key message:

"You are the main expert on your own life and needs."

Use a short storytelling video or real-life example showing a care recipient involved in a decision (e.g. daily routine, treatment, or support options).

Follow with a guided **group discussion** using simple questions:

- What decisions can I be part of?
- How do I usually express my needs?

- What stops me from speaking up?

Include a **mini quiz** (interactive, informal) with 3–5 simple statements (true/false or multiple choice), e.g. “I can ask questions about my care plan.” Or use a simple case scenario activity where participants decide how they would respond in a situation (e.g. disagreeing with a care decision).

Close with a short **reflection round**: each participant shares one sentence about what they would like to try in their own care decisions.

2.2.2 Proactivity and requesting support or change

Duration: 20 Minutes

Materials required

Face-to-face setting

- Prepared presentation
- Laptop to display the presentation
- Projector
- Flipchart or whiteboard
- Markers

Online setting

- Prior registration with an email address
- Digital collaborative and interactive training tools (e.g. Mentimeter, Miro, Slido)

Theoretical Background

Proactivity in care means that individuals do not only react to situations, but also actively take initiative to influence their daily life and care conditions. It includes recognising needs



early and asking for appropriate changes or support. Taking initiative is closely linked to empowerment, which strengthens the individual's sense of control and autonomy in care situations. Constructive communication is essential when requesting support or change, meaning that needs should be expressed clearly, respectfully, and in a solution-oriented way.

Instructions for implementation

- Short **warm-up** scenario where participants imagine a daily care situation that is not working well (e.g. timing of help, food, medication routine). Introduce the idea of proactivity: taking initiative instead of waiting for others to solve the problem.
- Run a **role-play activity** where participants practice how to ask for a change or support (e.g. "I need help earlier in the morning" or "I would like a different option"). Include a simple action planning exercise: participants complete one sentence – "Next time I need something, I will..."
Add peer feedback in pairs or small groups, focusing on clarity and respect in communication ("Was it understandable? Was it polite and clear?").
- Close with a short sharing round where participants say one situation they would like to change in their daily care.

Learning activity 3 - Constructive self-advocacy in real-life situations

Duration: 20 Minutes

Materials required

Face-to-face setting

- Prepared presentation
- Laptop to display the presentation
- Projector

- 
- Flipchart or whiteboard
 - Markers

Online setting

- Prior registration with an email address
- Digital collaborative and interactive training tools (e.g. Mentimeter, Miro, Slido)

Theoretical Background

Constructive self-advocacy refers to the ability to express one's needs, preferences, and concerns in a clear, respectful, and non-confrontational way while maintaining positive relationships with caregivers and services. It is based on communication skills such as assertiveness, active listening, and the ability to give and receive feedback. Learning from both positive and negative examples helps individuals understand how communication style can influence care relationships and outcomes.

Instructions for implementation

- Use **storytelling examples or short video clips** showing both positive and negative communication situations in care settings (e.g. respectful request vs. aggressive or unclear communication). Follow with a guided group reflection focusing on differences in communication style and outcomes.
- Pair activity where participants rewrite negative statements into constructive self-advocacy phrases (e.g. "Nobody listens to me" → "I would like to be heard in my care decisions").
- Close with a sharing round where participants give one example of how they will try to communicate more constructively in the future.

2.2.3 Evaluation of the lesson

- Start with a “thumbs up / thumbs sideways / thumbs down” evaluation, allowing participants to quickly indicate how confident they currently feel about self-advocacy in their present life situation.
- Run a mini quiz game (oral or cards) with simple statements, e.g.:
 - “I can ask for changes in my care.”
 - “It is okay to express my needs respectfully.”
 True/false or yes/no format.
- Close with a short group reflection on what they will try in real life situations.

References

Freire, P. (1970). *Pedagogy of the Oppressed*.

Zimmerman, M. A. (2000). “Empowerment Theory.” In J. Rappaport & E. Seidman (Eds.), *Handbook of Community Psychology*.

Rogers, C. R. (1951). *Client-Centered Therapy*. Houghton Mifflin.

Learning material

- PPT presentation – key concepts of self-advocacy, participation, and communication
- Storytelling videos / real-life examples – positive and negative care situations
- Case studies & scenario cards – decision-making and communication practice
- Role-play activities – practicing proactivity and self-advocacy skills
- Mini quiz & games – simple true/false or interactive reflection tasks
- Group reflection & peer sharing – discussing experiences and learning from each other

3.1 Communication

What is the module about?

The module introduces the basic principles of effective communication and explores common barriers that can hinder mutual understanding. It focuses on how to clearly express needs, possibilities and personal boundaries in different care situations. In addition, the



module presents alternative forms of communication that can support inclusive and accessible interaction.

What should participants know at the end of the module?

Participants will understand the basic principles of effective communication and recognize common barriers that may hinder understanding. They will learn how to express their needs, possibilities and personal boundaries clearly in care-related situations. In addition, participants will become familiar with alternative forms of communication that support inclusive and accessible interaction.

Overview over subtopics

- Basics of Communication
- Barriers in Communication
- Communicating needs, possibilities and boundaries
- Alternatives of communication

3.1.1 Basics of Communication

Duration: 35 minutes

Materials required

Face-to-face setting

- Prepared presentation
- Laptop or computer to display the presentation
- Projector or screen so all participants can see the slides
- Speakers if the presentation includes audio or video
- Flipchart or whiteboard to note additional ideas or questions from participants
- Markers
- Remote clicker or presenter tool (optional) to move through the slides



Online setting

- Prepared presentation
- Digital whiteboard or shared document (optional) to collect questions or key points

Theoretical Background

Basics of Communication

Communication is a process of interpersonal interaction that enables the exchange of information, ideas, and emotions. It takes place between two or more people and is a fundamental basis for social interaction. Communication is a skill that can be learned and improved through practice and conscious reflection.

The effectiveness of communication depends on how well a message is received and understood by another person. The quality of communication has a decisive influence on building supportive and harmonious relationships. When communication is successful, challenges and conflicts can be addressed constructively and may even contribute to strengthening the relationship.

Sender-Receiver Model

The sender-receiver model is a basic model of communication. The sender intends to convey a message and encodes their idea into recognizable signs, which are transmitted as a message. The receiver perceives this message and must decode it in order to understand its meaning.

In most cases, the sent and received messages match, meaning that understanding has occurred. To verify this, the receiver can provide feedback by explaining how they understood the message. This allows the sender to check whether their intended message was correctly received. This process is called feedback.

The Four Sides of a Message

According to Schulz von Thun, every message contains four layers. The factual content includes the objective information. Self-disclosure reveals what a person communicates about themselves, such as feelings, attitudes, or role perception. The relationship aspect indicates how the sender views the receiver and their relationship. The appeal expresses what the sender wants the receiver to do or how they want them to respond.

Active Listening

Active listening was developed by Carl Rogers as a method of psychotherapeutic communication, but it is also useful in many other areas of life as it promotes mutual understanding. The listener tries to empathize with the thoughts and feelings of the speaker in order to better understand their behavior, even if it initially seems inappropriate or unclear. The goal is not to adopt the other person's perspective, but to temporarily take it in order to understand it. Active listening is especially important in discussions, but also challenging, as people often focus on formulating counterarguments instead of truly listening.

The basic principles of active listening include empathy, congruence, and unconditional acceptance. Empathy refers to the ability to understand another person's thoughts and feelings. Congruence means that verbal and nonverbal signals are consistent, for example when facial expressions match what is being said. Unconditional acceptance means respecting and valuing the other person regardless of their behavior or opinions.

Active listening can be divided into three levels. The first level focuses on the relationship and involves showing attention through eye contact, an open posture, and short verbal signals such as "hm" or "yes." These signals should appear authentic rather than mechanical.

The second level concerns content understanding. Key statements are paraphrased in one's own words to check understanding. This is not mere repetition, but a reformulation of



essential content. In some situations, it may be appropriate to briefly interrupt in order to avoid misunderstandings.

The third level focuses on reflecting emotions. The listener verbalizes the emotional content of what has been said, phrased as tentative assumptions. This allows the speaker to confirm or correct them and often leads to greater clarity about their own feelings. It is important to respect the speaker's response and not insist on one's own interpretation.

Nonviolent Communication (Rosenberg)

Nonviolent communication is a method for respectful interaction. It focuses on one's own emotions and needs rather than on making accusations. The goal is to avoid causing harm in communication. A clear distinction is made between observation and interpretation: observations are described as objectively as possible, while evaluations and conclusions are explicitly identified as such. This creates transparency and reduces misunderstandings.

According to this method, concerns are expressed in four steps:

1. Observation: describing the situation objectively
2. Feeling: expressing one's emotional response
3. Need: identifying underlying needs
4. Request: making a clear and respectful request aimed at finding a shared solution

Nonverbal Communication

Nonverbal communication includes all forms of communication that do not involve spoken language. Since verbal statements are often imprecise and open to interpretation, nonverbal signals help clarify meaning. Communication psychology distinguishes seven types of nonverbal communication:

1. Eye contact: signals attention and politeness; lack of it may be perceived as disinterest

- 
2. Facial expressions: support and complement verbal messages by expressing emotions
 3. Gestures: body movements that emphasize or reinforce statements; culturally influenced
 4. Body language (posture and movement): conveys openness or rejection
 5. Appearance: clothing and outward presentation used to create impressions
 6. Tactile communication: communication through touch, interpreted depending on context and relationship
 7. Proxemics: physical distance between individuals, influenced by social norms and relationships

Alternative Forms of Communication

Augmentative and alternative communication (AAC) includes methods that support people with limited or no spoken language. The goal is to enable and improve communication. A distinction is made between alternative communication, which replaces spoken language, and augmentative communication, which supports existing speech.

Body-based communication includes facial expressions, gestures, gaze, body movement, and sounds. These forms are widely accepted and particularly important for individuals with limited speech. Sign languages are also important visual communication systems and are recognized as full languages with their own grammar, such as German Sign Language.

Non-electronic communication aids use objects, photos, drawings, symbols, or written language to support communication. In addition, electronic aids such as speech-generating devices are used. These may use digitized speech (e.g. recorded buttons) or synthesized speech (e.g. tablets or computers).

Plain and Easy Language

Easy Language is a specially developed form of language for people with disabilities and learning difficulties. It is a simplified version of standard language and part of accessible



communication. It uses simple words, short sentences, and a clear structure, typically corresponding to language levels A1–A2.

Plain Language is a simplified form of everyday language, often described as citizen-friendly language. It corresponds to level B1 and uses shorter sentences and simpler structures. Technical terms, foreign words, and metaphors are avoided to ensure clarity. Its goal is to reach as many people as possible, including those with limited reading skills.

Instructions for implementation

In this activity, moderators give a presentation introducing the basic principles of communication. A prepared presentation is available and should be used to guide the session. Moderators should briefly explain the main concepts and examples presented in the slides and connect them to practical situations where possible.

Participants should be encouraged to ask questions at any time during the presentation if something is unclear. Moderators should also invite them to share their own experiences or observations related to communication, as these contributions can enrich the discussion and help link the theoretical content to real-life situations.

3.1.2 Barriers in Communication

Duration: 35 Minutes

Materials required

Face-to-face setting

- Flipchart or whiteboard
- Markers, paper and pens
- Timer



Online setting

- Presentation slide or shared screen with the guiding question
- Digital whiteboard or collaboration tool (e.g., Miro, Mural, Jamboard, Padlet) to collect key points in the plenary
- Timer

Theoretical Background

Various barriers can arise in communication that make understanding information more difficult or even impossible. A sensory barrier occurs when a sensory channel, such as vision or hearing, is impaired, meaning that information cannot be received in the intended way. In such cases, content needs to be adapted, for example through audio description or by reading written information aloud.

A knowledge barrier arises when content comes from a specialized field and is difficult to understand due to its complexity. Closely related to this is the technical language barrier, where complex terminology, long sentences, and specialized expressions further hinder comprehension, as is often the case in official letters or contracts.

Cultural barriers result from differences in norms and communication styles between cultures. What is considered polite in one culture may be perceived as inappropriate in another, which can lead to misunderstandings.

A cognitive barrier exists when information is too complex in terms of language or content and therefore cannot be processed. In such cases, people may not understand what is expected of them.

Language barriers occur when people speak different languages and are unable to understand each other.



Media barriers can take different forms: information may be presented in an unfamiliar symbol system, transmitted through an inaccessible sensory channel, or remain inaccessible due to a lack of technical resources or media literacy.

These barriers can occur individually or in combination and can significantly impair communication (Rink, 2020) .

Instructions for implementation

This activity uses the Think–Pair–Share method to explore communication barriers in the context of long-term care and to identify strategies for addressing them.

Begin with an individual reflection phase. Ask participants to think about the following question: *What communication barriers can occur in long-term care settings?* Encourage them to reflect on situations involving residents, family members, and care professionals. Participants should take a few minutes to write down examples based on their own experiences or observations (5 Minutes).

Next, ask participants to form pairs. In the pair discussion, they exchange their ideas and discuss the question: *What strategies could help avoid or overcome these communication barriers in long-term care?* Encourage participants to consider practical approaches, such as respectful communication, active listening, adapting communication to individual needs, or dealing with emotional or stressful situations (15 Minutes).

Finally, bring everyone back together for a short plenary sharing. Invite several pairs to briefly present the most important insights from their discussion. The moderator can collect key points on a flipchart, whiteboard, or digital board. The aim is to identify common communication challenges in long-term care and to share practical strategies for addressing them (10 Minutes).

3.1.3 Communicating Needs, Possibilities and Boundaries

Duration: 35 Minutes

Materials required

Face-to-face setting

- Printed case studies describing typical communication situations
- Handout explaining I-messages and You-messages
- Paper or moderation cards for participants to write down their responses
- Pens for participants
- Flipchart or whiteboard to collect examples of I-messages from the groups
- Markers

Online setting

- Digital case studies (e.g., shared as slides, PDF, or in the chat)
- Digital handout explaining I-messages and You-messages
- Shared document or digital whiteboard (e.g., Miro, Mural, Padlet, Google Docs) for groups to write their examples

Theoretical Background

In conflict situations, people often lose objectivity and begin to make accusations or assign blame to the other person. This type of communication is known as “**you-messages**.” Such messages are frequently perceived as hurtful and tend to escalate conflicts rather than resolve them.

When confronted with you-messages, individuals often react defensively. They may withdraw from the situation or respond with counterattacks, as they feel patronized,



criticized, or ignored. This dynamic makes constructive dialogue more difficult and can further intensify the conflict.

Moreover, you-messages shift the focus away from one's own emotions and needs. Instead of expressing personal feelings or concerns, they place responsibility on the other person, which limits the possibility of mutual understanding.

An example: "You never listen to me."

In communication, **I-messages** are a way of expressing one's own internal processes and emotions, giving them a clear self-expressive character. Rather than blaming or criticizing the other person, they focus on sharing personal feelings and perspectives. For this reason, I-messages are less likely to be perceived as hurtful and instead support constructive and respectful communication.

I-messages play an important role in effective conflict management. By focusing on one's own experiences and emotions, they help create an atmosphere of mutual respect and understanding. This approach reduces defensiveness and opens space for dialogue, making it easier to address disagreements in a productive way.

A typical I-message follows three steps. First, the speaker describes their own feelings in response to a situation or the behavior of the other person. Second, they explain the reason for these feelings in a clear and factual manner. Finally, they outline the impact or consequences of the situation.

An example: "I feel unheard when I'm interrupted."

Instructions for implementation

This activity focuses on practicing communication skills in the context of **long-term care**, with particular attention to expressing **needs, possibilities, and personal boundaries**.



Begin with a **short introduction to the concepts of I-messages and You-messages**. Explain the difference between the two communication styles and highlight how I-messages can help express feelings, needs, and limits without blaming or accusing the other person. Brief examples can help illustrate the difference.

After the introduction, divide participants into **small groups** and provide them with **short case studies related to situations in long-term care**. These scenarios may involve communication between care recipients, family members, or care professionals.

In the group work phase, participants analyze the case studies and discuss how communication in the situation could be improved. As part of the exercise, they practice **formulating I-messages** that clearly express needs or boundaries in a respectful and constructive way.

Encourage participants to draw on their own experiences and to discuss how these communication strategies could be applied in real-life situations within long-term care. At the end of the activity, a few groups may briefly share their examples with the larger group.

3.1.4 Evaluation of the lesson

Duration: 15 Minutes

Use the final part of the session for a **short reflection and wrap-up**. The aim is to help participants review the key ideas of the session and connect them to their own experiences or practice.

Begin with a **brief group discussion**. Invite participants to share their main takeaways from the session. Possible guiding questions include: *What was the most important insight for you today?* or *What will you take with you for your practice in long-term care?*

Encourage a few participants to contribute their thoughts so that different perspectives become visible.



Finally, briefly **summarize the key learning points** that emerged during the session. This may include central concepts, practical communication strategies, or important reflections from the group discussion. The goal is to close the session with a clear overview of the most important insights.

References

Rink, I. (2020). Kommunikationsbarrieren. In: Maß, C.; Rink, I. (Hrsg.). Handbuch Barrierefreie Kommunikation. S. 29 - 66. DOI: 10.26530/20.500.12657/43216

Schmitz, B (o.J.): Handout Grundlagen Konfliktbearbeitung/Konfliktmanagement. Für: Evangelischer Fachverband für Arbeit und Soziale Integration (Hrsg.) https://www.efas-web.de/files/teges/Teges_Handout_Konflikt_FINAL_SCREEN.pdf

Hellrung, U.; Giel, B. (2023). Unterstützte Kommunikation. URL: <https://www.socialnet.de/lexikon/Unterstuetzte-Kommunikation>

Von Thun, F. (1981). Miteinander reden 1. Störungen und Klärungen: Allgemeine Psychologie der Kommunikation. ISBN: 978-3-499-17489-6

Züricher Hochschule für Angewandte Wissenschaft (o.J.): Nonverbale Mittel der Kommunikation. https://moodle2.zhaw.ch/pluginfile.php/170521/mod_resource/content/0/Nonverbale_Kommunikationsmittel.pdf

Learning material

- Presentation on communication
- Handouts "I-messages and You-messages"
- Case Studies



3.2 Relationship networks

What is the module about?

This module explores the concept of peer relationships and peer counselling, focusing on how people in similar life situations can support each other through shared experiences. It highlights the importance of mutual support, personal development, and learning from both positive and negative examples. Participants will reflect on how peer connections can strengthen coping skills and emotional wellbeing. The module also introduces practical ways



of communicating, motivating, and supporting each other in caregiving and care-receiving contexts.

What should participants know at the end of the module?

By the end of the module, participants will understand the concept and importance of peer relationships and peer counselling. They will be able to identify how peer support can contribute to emotional wellbeing and personal development. Participants will recognize positive and negative examples of peer interaction and caregiving communication. They will also gain basic ideas on how to communicate and support each other constructively in peer settings.

Overview over subtopics

- Peer relationships and peer counselling
- Building peer support connections
- Communication with peers and caregivers
- Positive and negative examples in peer support
- Motivation and mutual support strategies

3.2.1 Understanding peer relationships and peer support

Duration: 25 Minutes

Materials required

Face-to-face setting

- Prepared presentation
- Laptop to display the presentation

- 
- Projector
 - Flipchart or whiteboard
 - Markers

Online setting

- Prior registration with an email address
- Digital collaborative and interactive training tools (e.g. Mentimeter, Miro, Slido)

Theoretical Background

Peer relationships are supportive connections between people who share similar life experiences and can provide emotional and practical support to each other. These relationships are based on equality, shared understanding, and mutual learning rather than professional hierarchy. Peer counselling refers to informal support where individuals help each other by sharing experiences, listening, and offering perspective based on lived experience. Such relationships can reduce isolation, increase confidence, and strengthen coping skills in everyday life situations.

Instructions for implementation

- Start with a short introduction and **concept clarification** using simple language and examples (e.g. “someone in a similar situation helping another person”).
- PPT presentation with **key definitions** and visual examples **of peer support situations** in everyday care contexts. The PPT presentation also helps participants understand that peer support is based on shared lived experience rather than professional expertise.
- Facilitate a guided **comparison exercise: peer support vs. professional support**, strongly structuring participant reflection. Key points to highlight and discuss:
Peer support: shared experience, emotional understanding, equality, informal advice

Professional support: expert knowledge, formal responsibility, structured interventions, ethical/legal framework

Guide participants to reflect on questions such as:

- When do I prefer peer support, and why?
- When is professional help necessary and why?
- Can these two types of support complement each other?
- Close with a **one-word round** where participants describe peer support (e.g. “helpful”, “safe”, “understanding”).

Include an activity where participants sort real-life examples into “peer support” or “professional support”.

3.2.2 Communication and expressing difficult topics in peer relationships

Duration: 20 Minutes

Materials required

Face-to-face setting

- Prepared presentation
- Laptop to display the presentation
- Projector
- Flipchart or whiteboard
- Markers

Online setting

- Prior registration with an email address
- Digital collaborative and interactive training tools (e.g. Mentimeter, Miro, Slido)

Theoretical Background



Peer relationships are built through open communication, where participants share experiences not only about themselves but also about their caregiving situations and their caregivers. This exchange helps build trust, understanding, and a sense of belonging within the group. A key focus is how to safely and constructively talk about difficult topics, such as conflicts, unmet needs, or negative experiences with caregivers, while still maintaining respect and openness. Participants learn from both positive and negative examples of peer interaction, including how relationships can either strengthen or weaken depending on communication style and attitude.

Motivation within peer groups is also important: participants can encourage each other through role modelling, shared activities (e.g. sport, work routines), and storytelling of personal experiences or guest speakers' stories.

Instructions for implementation

- Start with a short **storytelling warm-up**, where participants share a brief experience about either peer support or communication with caregivers (positive or negative).
- Use a guided **group discussion** focusing on how peer relationships are formed and maintained through sharing experiences, including sensitive topics such as conflicts or unmet needs. Introduce a comparison activity with examples, where participants identify positive and negative ways of connecting with peers (e.g. supportive listening vs. judgemental responses).
- Optionally invite a **guest speaker or video storytelling**, showing real-life peer support experiences to deepen reflection.
- Close with a group **reflection round**, where participants share one way they can improve how they connect with peers in the future.

3.3.3 Peer motivation, storytelling and building supportive networks

Duration: 20 Minutes

Materials required

Face-to-face setting

- Prepared presentation
- Laptop to display the presentation
- Projector
- Flipchart or whiteboard
- Markers

Online setting

- Prior registration with an email address
- Digital collaborative and interactive training tools (e.g. Mentimeter, Miro, Slido)

Theoretical Background

Peer support networks are strengthened when individuals actively motivate each other and share lived experiences in a safe and respectful environment. Storytelling helps participants make sense of their own situations while also learning from others. Positive examples of peer interaction can inspire confidence and resilience, while negative examples help identify behaviours or communication styles to avoid. Motivation within peer groups can be enhanced through role modelling, shared goals, and everyday encouragement.

Instructions for implementation

Start with a **short storytelling circle**, where participants share one positive experience of peer support, motivation, or inspiration from others in similar life situations.



Then move into a focused input and discussion on **concrete peer motivation strategies**, highlighting practical, real-life ways participants can actively support and motivate each other:

- Creating peer groups, clubs, or communities (online or in-person) for regular meetings, sharing experiences, and mutual encouragement
- Connecting with NGOs and community organisations:
 - that support disability and care-related empowerment work
 - participating in NGO-led workshops with role models, such as people active in sport, employment, travel, or independent living
 - getting involved in advocacy and community projects, such as local accessibility improvements, inclusive city development, or accessible tourism initiatives
- Emphasising the importance of work as a strong motivational factor, including understanding different forms of employment. Exploring alternative forms of work, such as project-based work, remote work, volunteering, or flexible employment opportunities
- Encouraging participants to become active communicators and “peer influencers”, sharing experiences through blogs, Instagram, social media posts, or online diaries

Include a **group reflection** on which of these motivational pathways are realistic and accessible for participants and what support they would need to start.

Close with “**Motivation chain**” activity: participants sit in a circle and each person gives a short positive or encouraging message to the next participant (e.g. “You are strong because...”, “What I appreciate in you is...”).

3.3.4 Evaluation of the lesson

- Start with a “traffic light” evaluation, where participants indicate on a colour scale how well they understood the material and how confident they feel: green = clear, yellow = partly clear, red = needs more support.
- Use a group reflection circle focusing on one key question: “What was the most useful idea or example for me today?” Include a peer feedback round, where participants share one positive thing they learned from another participant during the session.

References

Mead, S., Hilton, D., & Curtis, L. (2001). *Peer Support: A Theoretical Perspective*. Psychiatric Rehabilitation Journal.

Solomon, P. (2004). *Peer support/peer provided services: Underlying processes, benefits, and critical ingredients*. Psychiatric Rehabilitation Journal.

Learning material

- PPT presentation – key concepts of peer relationships, peer counselling, and communication tools
- Storytelling (participants + guest speaker) – real-life experiences of peer support and caregiving situations
- Video materials – positive and negative examples of peer interaction and communication
- Interactive activities (peer feedback, motivation chain, sorting tasks) – active participation and learning from each other
- Optional digital tools (social media examples, blogs, online peer groups) – exploring real-world peer networks



4.1 Conflict management

What is the module about?

This module focuses on understanding and managing conflicts between care recipients and both formal and informal caregivers within the framework of fair, inclusive, and person-



centered care promoted by the FairCare project. It addresses key issues identified in the FairCare application and survey results, such as communication barriers, emotional stress, and unclear expectations in care relationships. Through participatory and reflective learning, the module helps participants develop practical strategies to prevent conflicts, handle disagreements effectively, and foster respectful and cooperative care environments across Cyprus and other European regions.

What should participants know at the end of the module?

By the end of the module, participants will be able to explain the main causes and dynamics of conflicts in care settings, including the roles of communication, emotions, and dependency. They will be able to identify different types of conflicts and implement basic strategies to prevent and de-escalate challenging situations. Participants will also develop awareness of FairCare principles, such as respect, inclusion, and self-determination, and will be able to recognize situations involving risk, neglect, or violence and respond appropriately in accordance with European care standards.

Overview over subtopics

The module begins with “Without Conflicts,” emphasizing prevention through empathy, trust, and effective communication. It then proceeds to “Types of Conflicts,” where participants explore interpersonal, emotional, and role-related conflicts in care settings. The section “Conflict in General” introduces key concepts, causes, and escalation processes, as well as basic resolution techniques.

4.1.1 Collaborative Analysis of Real-Life Scenarios

Duration

Approximately **40 minutes**

- Introduction: 10 minutes

- Group work (analysis): 20minutes
- Feedback and discussion: 10 minutes

Materials Needed

Face-to-Face

Workshop

Printed case studies featuring real-life caregiving scenarios, along with flipcharts or whiteboards, markers, and sticky notes.

Online

Workshop

Digital case studies (PDFs or slides), video conferencing platforms (e.g., Zoom or Microsoft Teams), breakout rooms, and shared digital tools (e.g., Google Docs or virtual whiteboards like Miro).

Theoretical Background

This activity uses the FairCare participatory learning approach, which emphasizes experiential learning, reflection, and collaboration. It incorporates key concepts from conflict theory, such as identifying different conflict types (interpersonal, emotional, role-related, and cultural conflicts) and understanding their underlying causes.

The activity reflects FairCare survey results, showing that miscommunication, stress, and unclear expectations often lead to conflict in care settings. By analyzing real-life scenarios, participants connect theory with practice and gain a clearer understanding of conflict dynamics in person-centered care environments.

Instructions for Implementation

Face-to-Face Workshop

The trainer briefly explains the different types of conflict and divides participants into small groups. Each group receives a different real-life scenario from a caregiving setting. Participants read the scenario, identify the type(s) of conflict involved, and discuss possible causes.



Groups jot down their main points on flipcharts or sticky notes. Then, each group shares their findings with everyone, followed by a brief guided discussion where the trainer explains concepts and connects responses to FairCare principles like respect, inclusion, and cooperation.

Online Workshop

The trainer introduces the activity and shares the scenarios digitally. Participants are divided into breakout rooms and assigned one scenario each. In their groups, participants discuss and identify the type(s) of conflict and contributing factors, recording their answers on a shared document or virtual platform whiteboard.

After finishing the group work, participants return to the main session where each group briefly shares its analysis. The trainer guides discussion, offers feedback, and connects the results to FairCare methodology and real-world care practices, promoting active engagement and reflection.

4.1.2 What Contributes to Successful Cooperation in Care?

Duration

Approximately **40 minutes**

- Introduction: 10 minutes
- Group discussion: 20 minutes
- Feedback and summary: 10 minutes

Materials Needed

Face-to-Face Workshop

Flipcharts or whiteboard, markers, sticky notes.

Online

Workshop

Video conferencing platform (e.g., Zoom or Microsoft Teams), breakout rooms, shared digital whiteboard (e.g., Miro or Google Docs).



Theoretical Background

This activity is based on the FairCare methodology, which promotes collaboration, mutual respect, and inclusive participation in care relationships. It emphasizes principles of person-centered care, focusing on trust, communication, and shared decision-making. FairCare survey results indicate that positive cooperation reduces conflicts, improves care quality, and strengthens relationships between caregivers and those receiving care. This activity encourages participants to reflect on factors such as empathy, role clarity, and effective communication.

Instructions for Implementation

Face-to-Face Workshop

The trainer introduces the topic and asks participants to consider situations where cooperation in care was successful. Participants are divided into small groups and asked to identify key factors that contributed to effective collaboration (e.g., communication, trust, respect).

Groups jot down their ideas on flipcharts or sticky notes. Each team quickly shares their insights, followed by a facilitator-led discussion where common themes are identified and connected to FairCare principles.

Online Workshop

The trainer introduces the activity and assigns participants to breakout rooms. Each group discusses examples of effective cooperation, without conflicts in care and identifies key success factors. Participants record their ideas in a shared digital space.

Groups then return to the main session to share their results. The trainer highlights key points and connects them to FairCare values like inclusion, participation, and fairness.

4.1.3 Understanding Ways to Escalate and Resolve Conflict

Duration

Approximately **40 minutes**

- Introduction: 10 minutes
- Demonstration and discussion: 20 minutes
- Reflection and feedback: 10 minutes

Materials Needed

Face-to-Face Workshop

presentation slides, printed diagrams of conflict escalation stages, whiteboard or flipchart, markers.

Online Workshop

presentation slides, video conferencing platform (e.g., Zoom or Microsoft Teams), screen sharing, and optional short video examples.

Theoretical Background

This activity is grounded in conflict-escalation theory and fundamental conflict-resolution models, and is customized for caregiving settings. It encourages the FairCare approach by emphasizing early detection of conflict signals and positive intervention strategies.

According to FairCare research, conflicts in care settings often escalate due to miscommunication, emotional stress, and unmet needs. Recognizing the stages of escalation helps participants intervene early and apply techniques such as active listening, de-escalation, and collaborative problem-solving.

Instructions for Implementation

Face-to-Face Workshop

The trainer explains the stages of conflict escalation using simple examples from care settings. A brief demonstration, such as role-play or a scenario, shows how a conflict develops and how it can be de-escalated.



Participants then discuss in small groups how they would respond at different stages of the conflict. The session ends with a whole-group discussion in which key resolution techniques are summarized and linked to the FairCare principles of respect and safety.

Online Workshop

The trainer uses slides or a short video to introduce the escalation model. Participants are then encouraged to discuss in breakout rooms how conflicts can be handled at different stages.

Each group shares their ideas during the main session. The trainer provides feedback, highlights effective strategies, and reinforces practical conflict-management techniques for real care situations.

4.1.4 Evaluation of the Lesson

The evaluation adopts the FairCare participatory approach, emphasizing active engagement and reflection instead of formal testing. Participants' learning is evaluated through involvement in group discussions, role-playing, and scenario-based activities, showcasing their ability to apply conflict management strategies in real-world situations. Additional evaluation tools include brief reflection exercises, self-assessment, and peer feedback, which promote ongoing learning and the practical transfer of skills to actual care settings.

References

FairCare Project Application and Methodology (Erasmus+ KA220)

FairCare Survey Findings on Communication, Cooperation, and Conflict in Care Settings

European Commission – Policies on Inclusive, Person-Centered Care and Social Inclusion

World Health Organization – Framework on Integrated, People-Centered Health Services

European and National Safeguarding Frameworks, Including Those Applied in the Cypriot Healthcare and Social Care System



Learning material

Printed case studies featuring real-life caregiving scenarios, along with flipcharts or whiteboards, markers, and sticky notes.

Digital case studies (PDFs or slides), video conferencing platforms (e.g., Zoom or Microsoft Teams), breakout rooms, and shared digital tools (e.g., Google Docs or virtual whiteboards like Miro).

Presentation slides, printed diagrams of conflict escalation stages, whiteboard or flipchart, markers.

4.2 Solution and Reflection

What is the module about?

This module supports participants in reflecting on experiences related to care situations and identifying possible ways to deal with challenging situations. Through peer exchange and discussion, participants explore different perspectives and develop practical solutions. The module encourages active participation and strengthens the ability of people in need of care to contribute as peer-trainers in learning and support processes.

What should participants know at the end of the module?



Participants will:

- Reflect on personal experiences related to care situations.
- Recognize different perspectives in challenging situations.
- Explore possible solutions through peer discussion.
- Strengthen their participation and voice in care relationships.

4.2.1 Sharing Experiences

Duration

40 minutes

Materials required

Flipchart

Markers

Note cards

Theoretical Background

Sharing experiences is a key element of adult learning and peer learning. According to experiential learning theory (Kolb, 1984), experiences become a source of knowledge when combined with reflection and discussion.

Instructions for implementation

Participants think about a challenging care experience and write:

- what happened
- how they felt

They then share their experiences in small groups and identify common themes.

4.2.2 Finding Solutions Together

Duration

45 minutes

Materials required

Case study cards

Flipchart

Markers

Theoretical Background

Collaborative problem-solving supports collective learning and enables participants to explore different perspectives and develop practical solutions.

Instructions for implementation

Participants work in small groups and discuss:

- What is the problem?
- What might be the reasons?
- What solutions could help?

Each group briefly presents their ideas.

4.2.3 Reflection Circle

Duration

30 minutes

Materials required



Reflection cards

Flipchart

Theoretical Background

Reflection is an important part of participatory adult education (Freire, 1970). Through dialogue participants connect learning with their personal experiences.

Instructions for implementation

Participants sit in a circle and discuss:

- What did we learn today?
- Which idea was most useful?
- How can this help in real care situations?

Evaluation of the lesson

- Short feedback round
- Anonymous comments
- Observation of participation

Exit question:

“What idea or solution will you remember from today’s activity?”

4.2.4 References

Freire, P. (1970). Pedagogy of the Oppressed.

Kolb, D. (1984). Experiential Learning.

Schön, D. (1983). The Reflective Practitioner.

United Nations. (2006). Convention on the Rights of Persons with Disabilities.



Learning material

Reflection cards

Case study cards

Flipchart

Worksheets

Easy-to-Read slides

5.1 Evaluation

What is the module about?

This module introduces participants to fair, inclusive, and participatory evaluation in care settings, where those needing care are actively involved in assessing their own experiences. It shifts evaluation from a top-down process to a shared, collaborative practice, with all stakeholders: people in need of care, informal caregivers, and formal caregivers, contributing equally.

Through interactive activities like peer feedback, reflective dialogue, and collaborative tool design, participants learn how evaluation can improve communication, build trust, and enhance the quality of care. The module emphasizes that evaluation isn't just about measuring outcomes but also about understanding experiences, expressing needs, and strengthening relationships. Aligned with the FairCare methodology, the module promotes self-determination, empowerment, and democratic participation, ensuring that people in



need of care are recognized as active contributors and co-creators of knowledge within care systems.

What should participants know at the end of the module?

By the end of this module, participants will be able to:

- Understand the concept of fair and participatory evaluation in care settings
- Recognize the importance of including the voices of people in need of care in evaluation processes
- Apply basic peer feedback techniques in a respectful and constructive manner
- Reflect on their own experiences and identify strengths and challenges in care relationships
- Design simple, accessible evaluation tools tailored to different care environments

Overview over subtopics

The module is structured around six interconnected subtopics that progressively improve participants' understanding and skills.

What Is a Fair Evaluation? An introduction to participatory evaluation and its role in enhancing care quality and promoting inclusion.

Peer Feedback in Practice: Applying respectful and supportive methods to give and receive feedback.

Reflective Dialogue: What Have We Learned? Facilitated reflection on personal experiences and collective learning within the group.

Designing evaluation tools: Developing simple tools (e.g., feedback forms, checklists, visual scales) tailored to participants' needs and abilities.

5.1.1 What is a Fair Evaluation?

Duration

30 minutes

Materials Needed

Short written or visual scenarios illustrating fair and unfair evaluation practices, flipchart or presentation slides, markers.

Theoretical Background

This activity is grounded in constructivist and dialogue-based learning, where participants build understanding through reflection on real-life experiences. In the FairCare methodology, evaluation is understood as a participatory and inclusive process, ensuring that people in need of care have an equal voice in decisions affecting their lives.

Face-to-Face Implementation

The trainer introduces two contrasting scenarios of care evaluation (one inclusive, one excluding the person in need of care). Participants discuss in pairs or small mixed groups which scenario is fair and why. The trainer then facilitates a short plenary discussion, guiding participants to identify key principles such as respect, inclusion, transparency, and shared decision-making.

Online Implementation

The trainer presents the scenarios through slides. Participants respond using chat or a live poll, followed by a short discussion. If possible, breakout rooms are used for small group reflection. The trainer summarizes key points, ensuring that all perspectives are acknowledged.

5.1.2 Peer Feedback in Action

Duration

45 minutes

Materials Needed

Care-related scenario cards, simple feedback guidelines, worksheets or shared digital documents.

Theoretical Background

This activity is rooted in peer learning and social learning theory, where participants gain knowledge through interaction and sharing experiences. It embodies the FairCare principle that knowledge is co-created among people in need of care, informal caregivers, and professionals, fostering cooperation and mutual understanding.

Face-to-Face Implementation

Participants are divided into small mixed groups. Each group receives a scenario and practices giving feedback from diverse perspectives. The trainer observes and supports the process, promoting respectful communication and equal participation. A brief plenary discussion emphasizes good practices and challenges.

Online Implementation

Participants are assigned to breakout rooms. Each group receives a scenario and works together in a shared document. They discuss and create feedback, which is then briefly presented in the main session. The trainer highlights respectful communication and inclusive participation.

5.1.3 Reflective Dialogue – What Have We Learned?

Duration

45 minutes

Materials Needed

Reflection questions, flipchart or digital board (e.g., Padlet, Miro).

Theoretical Background

This activity leverages experiential and reflective learning to foster self-awareness and empathy. Reflection is a central part of the FairCare methodology, helping participants connect their learning with personal experiences and enhance care relationships.

Face-to-Face Implementation

Participants form a circle. The trainer asks guiding questions such as “What did you learn?” and “What was challenging?” Participants share their thoughts, and the trainer records key ideas on a flipchart, emphasizing common themes. Participants share key insights and recommend improvements.

Online Implementation

Participants share reflections through chat or a digital board. The trainer organizes responses into themes and invites a few participants to elaborate. The session ends with a brief summary connecting reflections to FairCare principles. Participants share key insights and recommend improvements through chat or a digital board.

5.1.4 Evaluation of the Lesson



This module's evaluation uses a participatory and reflective approach, consistent with FairCare principles. This evaluation approach guarantees that all participants can express their perspectives in accessible ways, promoting a more inclusive and meaningful assessment of learning outcomes.

Evaluation methods include:

- Ongoing observation of participation and engagement during activities
- Peer feedback during group exercises and discussions
- Reflection activities (oral or written) where participants share what they learned and how they felt.
- Final feedback session where participants share key insights and recommend improvements.

References

FairCare Project Application (KA220-ADU – Cooperation Partnerships in Adult Education)

FairCare Methodology: Definition, Objectives, and Methods

FairCare Survey Results and Recommendations Summary

Learning material

Short written or visual scenarios illustrating fair and unfair evaluation practices, flipchart or presentation slides, and markers.

Care-related scenario cards, simple feedback guidelines, worksheets or shared digital documents.

Reflection questions, flipchart or digital board (e.g., Padlet, Miro).

5.2 Next Steps

What is the module about?

This module supports participants in reflecting on how the learning experiences of the FairCare training can be transferred into action. Building on the knowledge and skills developed throughout the course, participants explore what makes a learning centre inclusive, effective and empowering in care contexts. The module introduces the relevance of intersectionality when designing learning spaces and supports participants in imaginatively designing and simulating a FairCare Training Centre. Through collaborative design, role-play and feedback, participants consolidate their role as active contributors and potential peer trainers within FairCare.

What should participants know at the end of the module?

By the end of the module, participants will:

- Be familiar with the concept of intersectionality and its relevance for care, learning and inclusion

- Reflect on how different life situations and identities influence participation in learning and care
- Gain confidence in imagining, designing and contributing to FairCare Training Centres as peer actors

Overview over subtopics

- Inclusive and effective learning environments
- Accessibility and participation in learning spaces
- Intersectionality in care and education
- Designing a FairCare Training Centre
- Reflection, feedback and peer perspectives

5.2.1 Designing a FairCare Centre with an Intersectional Lens

Duration

40 minutes

Materials required

Flipchart or whiteboard

Intersectionality axes (age, disability, gender, income, migration, digital access)

Online: shared digital board or slides

Theoretical Background

This learning activity is grounded in intersectionality theory, which explains how different social positions—such as **Race and Ethnicity; Gender and Sex; Social Class and Socioeconomic Status; Sexual Orientation; Functional Diversity/Ability Status; Age and Ageing; Religion and Culture; Geographic Location**—interact and shape people's



experiences of participation, exclusion and power. Rather than viewing these factors separately, an intersectional approach recognises their combined effects within specific social and institutional contexts.

In adult education and care-related training, intersectionality has been shown to be a key analytical and practical tool for designing inclusive learning environments. Research and practice demonstrate that learning spaces which fail to consider intersecting barriers tend to reproduce exclusion, while intersectional approaches contribute to fairness, accessibility and meaningful participation. International frameworks such as the UN Convention on the Rights of Persons with Disabilities and UN Women's intersectionality guidance emphasise the need to embed intersectionality into programme design, not as an abstract concept but as a practical design principle for services, education and community initiatives.

Instructions for implementation

Face-to-Face

Introduction

The facilitator briefly introduces intersectionality in accessible language, emphasising that people experience care and learning through multiple, interconnected factors rather than through a single identity. The focus is placed on how these intersections affect access, voice and participation in care-related learning spaces.

Collective Mapping with the Power Flower

Participants group in small groups and draw a flower and its petals. The petals are labelled with different intersectionality axes, such as:

- Age
- Disability / health condition
- Care role

- Income or employment situation
- Gender
- Migration or language background
- Digital access

Participants are encouraged to add other petals.

Each group will collectively fill in the petals focusing on how different parts of people's lives affect their access to care and learning spaces. Each **petal** represents an important life factor that affects participation.

- Emphasise that no one needs to explain their own identity
- Keep the conversation focused on **learning centre design**
- Redirect personal stories gently to **structural patterns**

Potential guiding questions to fill in each petal:

Petal	Guiding Question
Age	How does age affect access to care?
Disability / Health	What kind of access or support is needed?
Care Role	How does the person relate to care?
Income / Employment	How does money or work time affect access?
Gender	Are there caregiving or participation expectations?



Migration / Language Are language or legal barriers present?

Digital Access Can people use online tools easily?

Plenary Reflection

Each group shares their key insight. The facilitator guides reflection with questions such as:

- Which combinations of these factors (petals) tend to be well supported in care and learning settings?
- Which combinations are more likely to face barriers to participation?
- Which intersections are often overlooked when designing learning centres?
- How could these insights influence the design of a FairCare Training Centre?

The discussion concludes by linking intersectionality to accessibility, fairness and participation as core FairCare principles.

Online

The facilitator prepares:

- A **shared digital Power Flower template** (e.g. in Miro, Mural, Padlet or Google Slides), with:
 - A central circle labelled *"FairCare Training Centre"*
 - Pre-labelled petals:
 - Age
 - Disability / Health condition
 - Care role

- Income / Employment situation
- Gender
- Migration / Language background
- Digital access
- Optional empty petals that groups may label themselves
- Breakout rooms for small-group work (3–6 participants per group): Each group will collectively fill in the petals focusing on how different parts of people's lives affect their access to care and learning spaces. Each **petal** represents an important life factor that affects participation.
- Emphasise that no one needs to explain their own identity
- Keep the conversation focused on **learning centre design**
- Redirect personal stories gently to **structural patterns**

Potential guiding questions to fill in each petal:

Petal	Guiding Question
Age	How does age affect access to care?
Disability / Health	What kind of access or support is needed?
Care Role	How does the person relate to care?
Income / Employment	How does money or work time affect access?
Gender	Are there caregiving or participation expectations?

Migration / Language Are language or legal barriers present?

Digital Access Can people use online tools easily?

- Clear written instructions visible on the shared board or in the chat

All participants return to the main room.

Each group shares **key insights**, not their entire map.

The facilitator guides reflection with questions such as:

- Which combinations of factors tend to be **well supported** in care and learning settings?
- Which combinations are more likely to face **barriers to participation**?
- Which intersections are often **overlooked** when designing learning centres?
- How could these insights influence the **design, organisation or facilitation** of a FairCare Training Centre?

5.2.2 What Makes a Learning Centre Effective? Learning center simulation

Duration

90 minutes

Materials required

Flipchart or board

Markers



Large sheets of paper for each participant

Short visual examples of different learning spaces

Online: Shared digital collaboration tool (e.g. Miro, Padlet, Google Slides)

Prepared digital boards with:

- Cluster areas labelled *Space, Materials, Facilitation, Atmosphere*
- Blank canvases for group design

Visual examples (photos, short videos or testimonials of informal learning spaces)

Digital icons or emojis (💖 and ?) for feedback

Theoretical Background

This activity is based on principles of participatory adult education and inclusive learning environments. According to Social Innovation Education, learning spaces should support dialogue, accessibility, shared ownership and mutual respect. Research on adult learning highlights that physical and social environments influence participation, confidence and learning outcomes, particularly for people with care and support needs.

Instructions for implementation

Face-to-Face

- The facilitator introduces the guiding question: *“What makes a learning centre effective and welcoming?”*
- Show 2–3 simple examples (videos, testimonials, photos) of different informal learning spaces (e.g. community centre, peer group, participatory and co-creative spaces).
- Participants reflect and write down in small groups on how the spatial layout, accessibility, materials, and facilitation are in these examples and if they’ve got ideas



from their own experiences these should be added. The focus is on accessibility, atmosphere, communication and participation.

- Groups share key points in plenary; the facilitator clusters answers under headings such as *space, materials, facilitation, atmosphere*.

Part 2:

After a break and following the clusters created before each group is invited to *imagine and design* a FairCare Training Centre, with the following guiding question:

- If we could build a FairCare Learning Center together:
 - What would it look like?
 - What happens there?
 - Who comes?
 - What makes it special?

The groups answer through drawing, doodling, symbols — not just words. Each group will create in large pieces of paper their own piece that will represent the answer to these questions. It has to be as clear as possible for the others to understand it.

The pieces of paper will be hung around the room.

Everyone walks around, looks at others' visions, and places sticky notes with ♥ for what they like and ? for what they wonder about.

Then all the group is back together and can synthesize Core Elements:

- What ideas appear again and again in the different pieces of paper from the different groups?
- What must this learning center have to make people feel safe, respected, and curious?

Each group creates a mini-model (physically using cards, markers, or digitally on Miro/Padlet) of their ideal learning space for the training.



Ideally include: seating arrangement, visual aids, accessibility features, and spaces for reflection or role-play.

Online

The facilitator introduces the guiding question clearly: *“What makes a learning centre effective and welcoming?”* Participants are reminded that the focus is on accessibility, atmosphere, communication and participation.

The facilitator shares 2–3 simple examples via screen-sharing (e.g. short videos, testimonials or photos of community learning spaces, peer groups or co-creative environments).

Participants are invited to observe how space, facilitation and interaction are organised.

Then, participants are divided into small breakout groups. Each group works on a shared digital board and reflects on the examples and their own experiences. They add notes under the headings:

- Space / Layout
- Materials & Tools
- Facilitation & Interaction
- Atmosphere & Relationships

The focus remains on identifying elements that support or hinder participation.

All participants return to the main room.

Each group shares key impressions.

The facilitator clusters responses live under the four headings, creating a shared overview of essential features of welcoming learning spaces.

Part 2

After a short break, the facilitator introduces the design challenge:

“If we could build a FairCare Learning Centre together:

What would it look like?

What happens there?

Who comes?

What makes it special?”

Participants return to their breakout groups. Each group creates a visual representation of their FairCare Training Centre using their digital canvas. Groups are encouraged to use drawings, symbols, icons and minimal text to clearly communicate their ideas.

The design should ideally include:

- Seating or spatial arrangements
- Accessibility features
- Visual aids and learning materials
- Spaces for reflection, dialogue or role-play

All group designs are displayed in plenary.

Participants explore the different designs and add feedback directly on the boards:

- ♥ for elements they appreciate or find inspiring
- ? for aspects they are curious about or would like to understand better

The facilitator leads a reflection with guiding questions:

- What ideas appear repeatedly across the designs?
- What does the learning centre need to make people feel safe, respected and curious?



Together, the group identifies key elements that should characterise FairCare Training Centres.

Evaluation of the lesson

Evaluation follows the FairCare participatory approach and focuses on reflection rather than performance.

Methods include:

- Short reflection round: *"One idea I take with me"*
- Visual feedback (traffic light or scale) on confidence about future involvement
- Trainer observation of participation and engagement
- Optional short written or digital feedback

References

FairCare Project Application (KA220 – Adult Education)

FairCare Methodology and Social Innovation Education Framework

Freire, P. (1970). *Pedagogy of the Oppressed*.

Crenshaw, K. (1989). *Demarginalizing the Intersection of Race and Sex*.

United Nations (2006). *Convention on the Rights of Persons with Disabilities*.

Learning material

Visual examples of learning spaces

Intersectionality axes showed in a visual and easy way

Role-play cards

Flipchart templates or digital boards



Reflection prompts and feedback forms