

We All Can Help: Evaluation of an Online Gender-Based Violence Learning Series

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Abstract

Gender-based violence (GBV) is a persistent and pervasive public health problem and requires a collaborative response, especially from the health system. Health-care professionals (HCPs) are uniquely positioned to address GBV because they are often the first trusted professional that survivors interact with. Therefore, it is critical that HCPs are trained and equipped to provide an effective response. This capstone evaluates the uptake of *Gender-Based Violence: We All Can Help*, an online GBV Learning Series for HCPs in British Columbia. Evaluation findings revealed a low uptake to the learning series and identified logistical and internal barriers that HCPs face. This capstone uses the Theory of Planned Behavior to structure and understand these barriers to series' uptake. Finally, recommendations, informed by literature and evaluation data, are offered to improve uptake of the series to ultimately strengthen the health sector's response to GBV.

Keywords: Gender-based violence; evaluation; online learning; health-care professionals; barriers; uptake

This capstone is dedicated to the survivors of gender-based violence. Your experiences have shaped the tension of this work. Thank you for your bravery, fortitude, and resilience; your stories matter. I will continue to be an ally and speak out with you.

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List of Acronyms

BCWH	BC Women's Hospital + Health Centre
GBV	Gender-based violence
HCPs	Health-care professionals
TVIP	Trauma and violence informed practice

Chapter 1. Introduction

Gender-Based Violence

Gender-based violence (GBV) is violence and abuse against someone based on their gender, gender identity, or gender expression and is intended to control and harm the individual (Status of Women Canada, 2018a). Violence refers to a physical act that is harmful whereas abuse refers to a pattern of harmful events or behaviors; both of which are rooted in power and control exerted over another individual (Status of Women Canada, 2018a). Earlier definitions of GBV referred to sexual violence against women and girls. However, in the 2000's, it was recognized that violence is a gendered issue, involves many forms, and affects various populations differently (UN Women, 2013). Anyone can be a victim of GBV but it most commonly affects women and girls. Other populations that are also disproportionately affected by GBV include Indigenous peoples, LGBTQ2S+, people living in rural and remote areas, immigrants, and people with disabilities.

Currently, GBV is an overarching term encompassing many forms of violence and abuse with two most pervasive forms of GBV being intimate partner violence and sexual assault at the global level (WHO, 2013a). Other forms of GBV include sexual harassment such as stalking, cyber bullying, threats and verbal abuse, financial control, forced early marriage, trafficking, and female genital mutilation. Violence is not always interpersonal but can also be perpetrated by laws, institutions, and other social-structural factors; in turn, this goes back to reinforce gender inequities (Brucket & Law, 2018).

Within Canada, 47% of sexual assault cases were against women between the ages of 15 to 24. Over 67% of Canadians report knowing a woman who has experienced sexual assault or intimate partner violence (Status of Women Canada, 2018a; BC Women's Hospital + Health Centre, 2019). With regard to intimate partner violence, Indigenous women in Canada are three times as likely than non-Indigenous women to be victims and lesbian and bisexual women have three and a half times the chances of being victims than heterosexual women (Status of Women Canada, 2018a). These statistics are disheartening and emphasize the need for a collective response, especially from the health sector, to better engage with and support survivors in BC.

Situating this capstone report

In January 2019, BC Women's Hospital + Health Centre, Perinatal Services of BC, and the Ministry of Health started an evaluation of the *Gender-Based Violence: We All Can Help* learning series. This is a provincial online learning series aiming to educate HCP on how to identify, address, and respond to GBV to improve the health sector's response in BC. This capstone report is nested within the larger evaluation and presents select findings. Specifically, this capstone a) presents the promotional activities of the GBV learning series b) presents the evaluation process and findings c) uses the Theory of Planned Behavior to understand the findings and d) makes recommendations to improve uptake of the series.

This report extends upon work I completed in my 11-week summer practicum. During that time, I helped with promotion and evaluation activities of the GBV learning series. The timeline of my practicum was to create an evaluation Advisory Committee in May and to help conduct interviews and focus groups in June and July. After my practicum ended, from August to December 2019, I continued to collect data, started analyzing data, made presentations to the Ministry of Health and the Advisory Committee, and started report writing with my team.

Before my practicum, I had never worked in the field of GBV. This was not an area I wanted to engage in because I, along with many friends around me, have personal experiences with GBV and struggle to understand it. Nevertheless, my practicum led to emotional, mental, and academic growth and brought light to a harrowing issue. It not only helped me own my voice but became the catalyst in jumpstarting my desire for working and advocating for women's health and rights.

Chapter 2. Background

2.1. Review of relevant literature

The purpose of this literature review is to understand the need for a health sector's response to GBV. This review describes the vast health effects of GBV, the critical role that health-care professionals (HCPs) play in addressing GBV, and the recommended HCP response as suggested by the World Health Organization. HCPs refer to physicians, nurses, midwives, doulas, and allied health professionals. Next, the review discusses Canada's and specifically British Columbia's response to GBV. HCPs have voiced feelings of ill-preparedness when responding to survivors of GBV that stems from a lack of training (Leppakoski, Flink & Paavilainen, 2014), demonstrating the need for the creation of effective training programs. The *Gender-Based Violence: We All Can Help* learning series addresses this gap in training and teaches HCPs how to address and respond to GBV in BC.

Health effects of GBV

GBV threatens the health of individuals in a myriad of ways across the life-course and significantly contributes to the burden of ill health. Women who experience physical violence often suffer injuries, especially to the head, neck, and face which can lead to disabilities (WHO 2013a). In extreme cases, GBV can result in homicide or death by suicide (Heise, Ellsberg & Gottmoeller, 2002). Additionally, chronic conditions such as gastrointestinal disorders or chronic pain are common among survivors of GBV (Heise et al., 2002). GBV also gives rise to behavioural and mental health conditions, particularly substance use and depression (McCloskey, 2016; WHO, 2013b). The sexual and reproductive health of women is also impacted by violence; for example, female survivors have an increased chance of experiencing sexually transmitted diseases and unwanted pregnancies (Nankinga, Misindie & Kwagala, 2016; WHO, 2013b). These mothers are at a higher risk of unsafe abortions, pregnancy complications, and delivering preterm or low birthweight babies. Many of the effects of GBV are immediately apparent, however, other effects may only surface with time. These statistics should be taken with the understanding that GBV is vastly underreported and the true burden of adverse health effects is likely to be far greater.

Role of health-care professionals in responding to GBV

GBV is a global public health concern and requires urgent and collaborative action. The adverse effects experienced by survivors requires them to extensively use health-care resources (Garcia-Moreno et al., 2015). Women who experience violence, regardless of disclosure, use health-care services more often than women who do not (Garcia-Moreno et al., 2015; WHO, 2013a). HCPs are usually the first trusted professional contact by survivors and they are the first access point to the health-care system that can presumably provide support and safety (Husso et al., 2012; Garcia-Moreno et al., 2015). This puts HCPs in a unique position to identify and respond to GBV and their engagement is critical to the care that survivors will receive.

A health-care professional's response to GBV should be informed by trauma and violence informed practice (TVIP). An approach informed by TVIP is built on understanding how the effects of trauma and violence contribute to the current state of a survivor (Wilson, Fauci & Goodman, 2015). Disclosure of violence and trauma is not necessary to TVIP. Rather, HCPs should pay particular attention to the emotional, physical, and cultural safety of the survivor and ensure that their interaction does not contribute to retraumatization. An effective response should prioritize the needs of a survivor and involve the survivor in the response efforts (Butler, Critelli & Rinfrette, 2011).

Recommendations from the WHO

In 2013, the World Health Organization released new clinical and policy guidelines which gave six recommendations on how the health sector can respond to intimate partner and sexual violence against women (WHO, 2013a). The WHO does not advocate for universal screening for intimate partner violence and sexual violence against women; rather, they identified the need to train HCPs on violence and the associated health indicators and how to ask about violence when it arises.

Most recently in December 2019, the WHO released a new training curriculum for HCPs on how to properly care for women affected by violence (WHO, 2019). The curriculum is targeted for use in low and middle-income countries and implements the recommendations from the clinical and policy guidelines. It teaches HCPs how to offer front-line support by using a trauma-informed and culturally safe LIVES approach

(Listen, Inquire, Validate, Enhance Safety and Support) when responding to intimate partner violence and sexual violence against women.

2.2. Canada and British Columbia's response to GBV

In June 2017, the Government of Canada released a strategy called 'It's Time: Canada's Strategy to Prevent and Address Gender-Based Violence' (Status of Women Canada, 2018b). It focuses on 3 areas: prevention, support for survivors and their families and promotion of responsive legal and justice systems. Within BC, the provincial government is providing \$18 million dollars over three years to improve counselling, outreach and crisis support for victims of sexual assault, domestic violence and other crimes (Government of BC, 2019). There is no provincially coordinated action plan to address GBV, rather efforts stem from a variety of different sectors. Examples of the work BC has invested in include the creation of the Provincial Domestic Violence Plan, responding to sexual violence and misconduct at post-secondary institutions, creating the Advisory Council on Indigenous Women and educating the public. Currently, there are 70 community-based victim service programs and over 240 violence against women programs in BC.

GBV places a substantial economic burden on the Canadian health-care system; intimate partner violence alone costs Canada \$4.8 billion annually (Status of Women Canada, 2018a). Research by Devine, Spencer, Eldridge, Norman & Feder (2012) suggest that training programs for HCPs to address violence can be cost effective on a societal perspective and therefore, it is important that education and training programs are assessed. There are various programs available in BC addressing different forms of GBV but there is limited research on their effectiveness.

2.3. The need for a GBV learning series

There is a clear need for educational programs to train HCPs in properly addressing GBV. In literature, the most commonly identified barrier to addressing the topic of GBV is feeling ill-prepared from lack of training (Leppakoski, Flink & Paavilainen, 2014, Sundborg, Saleh-Stattin, Wandell & Tornkvist, 2012; Husso et al., 2012). Many HCPs feel ill-equipped and desire additional education to become more knowledgeable and better prepared to respond (Sundborg et al., 2012). Training HCPs has shown to

improve their knowledge and attitudes towards addressing violence in Canada and abroad (Kaplan & Komurcu, 2016; Gutmanis, Beynon, Tutty, Wathen & MacMillan, 2007). Although training for violence may increase knowledge and awareness, it does not necessarily change behavior or intervention (Zaher, Keogh & Ratnapalan, 2014). Nevertheless, it is still important to increase knowledge and awareness of this topic. Hamberger et al. (2004) suggested that not everyone in the health system requires the same level of training to address violence, rather, they recommended implementation of different training models according to the professional.

Appendix A shows the educational training opportunities available to different professionals to address different forms of violence in BC. The other courses available are targeted toward professionals dealing with a specific form of GBV and typically requires a cost. *Gender-Based Violence: We All Can Help* is the first learning series addressing the health-care professional's response to GBV in BC. The GBV series is unique because it addresses the broader category of GBV for a variety of different health-sector professionals instead of focusing on one form of GBV or one type of professional.

2.4. Gender-Based Violence: We All Can Help online learning series

BC Women's Hospital + Health Centre, in partnership with Ending Violence Association of BC and the Ministry of Health created a four-part learning series on Learning Hub (an online provincial learning platform) to educate HCPs on how to identify, address and respond to GBV. The series advocates for HCPs to use the trauma-informed and culturally safe LIVES approach to address GBV as suggested by the World Health Organization (WHO, 2014). The acronym LIVES stands for listen, inquire, validate, enhance safety and support access to services.

- 1. Listen:** listening closely, with empathy and approaching clients without judgment.
- 2. Inquire:** inquiring about the survivor's needs and concerns, including physical and emotional health concerns.
- 3. Validate:** validating a survivor's experience, believing them, and demonstrating understanding about what they have been through.

4. **Enhance Safety:** showing concern for and discussing their safety, including helping the survivor recognize potential risks to their safety.
5. **Support Access to Services:** supporting the survivor to identify their options and facilitating connection to appropriate referrals that the survivor chooses to access.

The series was launched in March 2018 and over 1071 learners have completed one or more courses. This series teaches HCPs to employ a trauma-informed practice technique when supporting patients. The first course is on understanding GBV and the different forms in which it can present. The second course is focused on identifying GBV. The third course teaches HCPs how to respond to GBV and how to use trauma informed language. The fourth and final course is about vicarious trauma and how to address the impacts of GBV on HCPs. The goal of the series is to increase awareness and knowledge to improve the health-sector's response to GBV.

The first and the fourth courses are intended for a broad audience (i.e., anyone working in the health sector, from administrative staff to front-line workers). The second and third courses focused on identifying and responding to GBV are designed predominantly for front-line workers who are most likely to interact with people experiencing GBV. However, the entire series is open access and free for anyone to complete.

Potential barriers to series' uptake

Before the series was made, there was acknowledgement of potential barriers to uptake of the series. There is no specific literature on barriers to uptake of an online learning series about GBV for HCPs. There are anticipated barriers in three topics: a) gender-based violence b) online learning and c) continuing education for HCPs, which can be extrapolated to apply to this GBV learning series.

GBV is a heavy, sensitive, and potentially triggering topic which can inhibit uptake of the learning series. HCPs are often unclear with their role in addressing GBV (Garcia-Moreno et al., 2015b). Addressing GBV may feel like 'opening Pandora's box' for HCPs (Boyle, Robinson & Atkinson, 2004) and time constraints can further restrict them from engaging in this topic (Leppakoski et al., 2014). HCPs are also hesitant to engage in GBV because of unclear referral pathways and the belief that the health system is inadequate to support survivors (Roelens, Verstraelen, Egmond & Temmerman, 2006).

Barriers to continuing education for HCPs have been identified in physicians (Ikenwilo & Skatun, 2014), nurses (Lalonde et al., 2013), and midwives (Teekens, Wiechula & Cusack, 2018). These barriers include time constraints due to an employer, workload, or from personal lives, lack of compensation, and lack of accreditation. Traveling for continuing education was a barrier especially for HCPs in rural areas (Lalonde et al., 2013). Furthermore, internal barriers such as insufficient motivation and energy discouraged participation in continuing education (Ikenwilo & Skatun, 2014; Teekens, Wiechula & Cusack, 2018). Organizational barriers such as the lack of policy to promote education were also noted (Savodelli, Naik, Hamstra & Morgan, 2005). Moreover, a hurried and stressful work environment, such as the ones in nursing practices, may prevent additional learning in the workplace (Atack & Rankin, 2002).

Online learning also presents a set of challenges. Logistical barriers include the need for computers, wifi (O'Doherty et al., 2018) and technological skills (Childs, Blenkinsopp, Hall & Walton, 2005). Online learning can also be an isolating experience and cause anxiety (Gillett-Swan, 2017). Furthermore, the nature of sensitive topics such as sexual abuse lends in-person learning to be favored over online learning (Rheingold, Zajac & Patton, 2012).

This learning series did not try to address all the potential barriers to uptake, however, some were inherently minimized by the design and applicability of the series. This learning series is composed of short online modules that cover GBV broadly. It aims to address the knowledge gap that HCPs identified and train them in how to understand and respond to GBV. This series is considered generalist training and is meant to equip HCPs with tools to support survivors encountering any form of GBV. The online platform aims to cater to the busy workload of HCPs and maximize flexibility while minimizing the barriers of geography, privacy, time, and money. The series is compatible on any mobile device and laptop, not just on a specific health authority authorized computer.

2.5. Purpose of this capstone report

This capstone report is part of a larger evaluation done by BC Women's Hospital + Health Centre, Perinatal Services BC, and the BC Ministry of Health. This capstone presents select process and findings and aims to:

1. Describe promotional activities for the *Gender-Based Violence: We All Can Help* learning series
2. Describe and report the findings of an evaluation of the *Gender-Based Violence: We All Can Help* learning series to identify barriers to uptake
3. Use the Theory of Planned Behavior to understand the barriers identified in the evaluation
4. Identify recommendations to improve series' uptake

Chapter 3. Promotion of the GBV Learning Series

This learning series was promoted across the province using print, digital, and in-person presentations. Promotion started months before its launch in March 2018 until the end of the evaluation period, Dec 6, 2019. Print materials consisted of posters, postcards, and buttons while digital promotion included newsletter articles and advertisements, email and social media campaigns, and video testimonials from maternity care providers. The evaluation Advisory Committee strengthened promotional efforts by acting as series champions and advocating for the series through word-of-mouth promotion. They also connected us to partners which allowed us to deliver in-person presentations of the first course. Traveling to different cities in BC for the evaluation enabled the opportunity to also promote the series.

3.1. Measuring impact of promotion and engagement

As of December 6, 2019, over 1000 learners have completed one or more courses, with 436 people completing the full GBV series. Completion numbers for individual courses are much higher because learners are able to take courses at their own pace and in any order. Over a thousand people have completed course #1, Understanding GBV, as it is the shortest and easiest to complete. This number also includes the participants who received Learning Hub credit from the in-person presentations we delivered during the evaluation period.

Figure 1. GBV series and individual course completions up to Dec. 6, 2019

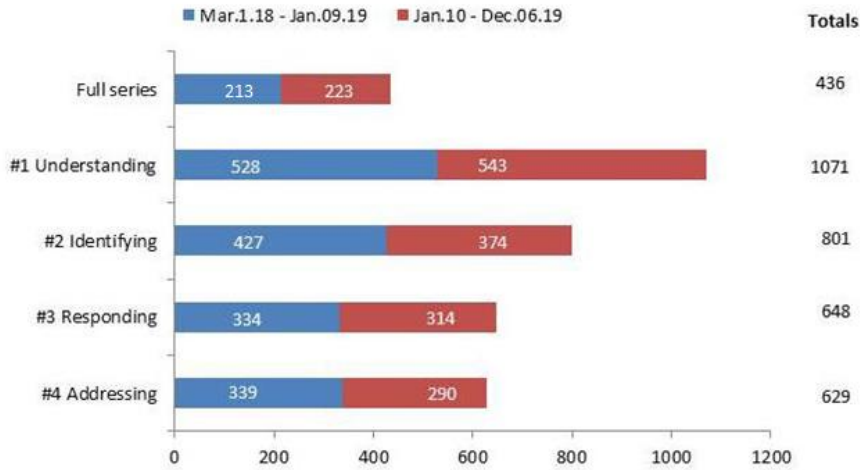
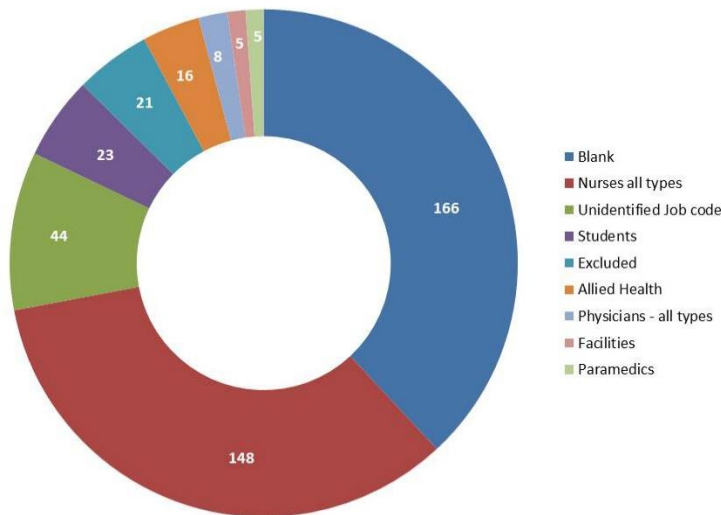


Figure 1 shows an average 48% increase in completions since January 2019, with a 67% increase in completions since July alone, suggesting that promotional activities during the evaluation process may have had a positive effect on course completion.

Figure 2. Number of people who completed the series by job code (n=436)



Nurses and nurse practitioners made up the largest number of people who completed the series by job code (n=166) after “blank”. The blank job code captures the fact that users of the Learning Hub platform are not required to fill out the job code field, and hence, some of the blanks may actually be clinicians and other health-care professionals.

Chapter 4. Evaluation of the GBV Learning Series

4.1. About this evaluation

In January 2019, a year-long evaluation was started to assess the effectiveness of the *Gender-Based Violence: We All Can Help* online learning series. This evaluation was led by BC Women's Hospital + Health Centre and Perinatal Services BC and collaborated with stakeholders across British Columbia. Evaluation data came from 26 key informant interviews, 4 focus groups, and 2 online surveys and provided insight into the learning series' reach, uptake, and effectiveness for health-care professionals. The full evaluation was conducted by a project team consisting of Ann Pederson, Tatiana Popovitskaia, AJ Murray, Alix Woldring, and myself. While the evaluation focused on three areas (reach, uptake, and effectiveness), this capstone report will focus on the uptake of the series. This report presents the relevant evaluation process and findings, uses the Theory of Planned Behavior to understand barriers to uptake, and offers recommendations for improving series' uptake.

Ethics was not required for this evaluation because it was a quality improvement project aiming to improve the learning series. Similarly, this capstone falls under TCPS 2, Article 2.5 as a quality improvement study and I obtained clearance from ethics from SFU's Research Ethics Board. Although ethics approval was not required, this evaluation was still conducted in an ethical manner. This evaluation obtained verbal consent from participants before collecting data, anonymized data, used a professional transcription agency, and upheld confidentiality in the interviews, focus groups, and surveys.

4.2. Evaluation purpose and approach

The purpose of this evaluation was to provide information to collaboratively develop recommendations for improving the reach, uptake, and effectiveness of the GBV learning series. An external evaluation specialist guided this evaluation by providing insight on the approach and methods. This evaluation used a utilization-focused approach in order to provide information to support decision making and program improvement. The creation of an Advisory Committee strengthened this evaluation by

providing provincial expertise to help us better understand GBV in different contexts in BC and by advancing series promotion.

The full evaluation answers 9 evaluation questions. This report answers the first two questions:

1. What is needed to increase the uptake of the series?
2. What prevents people from taking or completing the series?
3. How has the series been promoted?
4. What promotion strategies are most successful for which audiences?
5. Which organizations can further support uptake?
6. To what extent does the series increase awareness, knowledge, and confidence?
7. To what extent have learners been able to recognize and respond to GBV and create safe service environments?
8. What are the series strengths (quality and relevance)?
9. How can the series be improved?

4.3. Advisory Committee

In May 2019, we established an Advisory Committee to support this evaluation. Members were invited to join the committee in 2 ways: we invited members from our previous GBV Advisory Committee (for series creation) as well as colleagues in our existing networks, and we did a search for health-care leaders with expertise in GBV. The committee consisted of representatives from the Provincial Health Services Authority, First Nations Health Authority, Vancouver Coastal Health, Interior Health, Providence Health Care, Vancouver Island Health, Fraser Health, and Northern Health as well as Ending Violence Association of BC and Midwives Association of British Columbia. Advisory Committee members provided expertise in a variety of health-sector areas including nursing, Indigenous cultural safety, anti-violence services, women's health and safety in Vancouver's Downtown Eastside, and patient experience.

Advisory Committee members acted as champions to help with promotion and dissemination of the series and provided feedback during the evaluation on the

effectiveness of the series, on the initial findings, and on strategies to improve reach and uptake.

Table 1. Timeline of evaluation activities

The evaluation started in January 2019 and ended on Dec 6, 2019.

Time period	Evaluation activities
January	<ul style="list-style-type: none"> ● Evaluation plan development ● Initial project meeting
February to March	<ul style="list-style-type: none"> ● Evaluation tools development ● Data collection
March to August	<ul style="list-style-type: none"> ● Interim summary report development ● Data collection
September to October	<ul style="list-style-type: none"> ● Data collection and analysis ● Work planning session with the Ministry of Health
November to December	<ul style="list-style-type: none"> ● Sharing of findings with the Advisory Committee ● Final evaluation report development

Chapter 5. Evaluation Methods

5.1. Data sources

This evaluation collected data from health-care organizations and individuals around the province. Participants came from academic institutions, non-profits, professional associations, and health-care organizations. Individuals held positions such as clinical educator, researcher, GBV knowledge expert, curriculum development expert, health-care professionals and health-care administrator. The HCPs interviewed included physicians, nurses, midwives, occupational therapists, and first responders. Interview subjects had varying degrees of familiarity with the series, or with other similar online violence prevention courses.

5.2. Data collection methods

This was a mixed methods evaluation and the project team collected both quantitative and qualitative data through key informant interviews, focus group discussions, and surveys. The mixed methods nature of this work enriched the data by providing a deeper understanding of GBV in the health system. These three methods produce different data which adds breath to the findings. Using three methods is also a way to validate the findings and increase credibility (Green & Thorogood, 2014, p281).

Before the data collection period, the project team developed evaluation tools that included survey, interview, and focus group guides, which were used to steer the conversations (Appendix B). Key informant interviews allowed for substantive, in-depth responses while focus groups facilitated interaction between different health-care professionals which enriched and increased diversity of the responses. Interaction between participants also allowed for consensus and differences to be deepened or resolved. The survey responses provided demographic data and feedback on the series that individuals might have offered in person.

The data collection period began with key informant interviews. This was followed by focus group discussions and then the surveys were administered in the last two months of the data collection period. There was overlap of all three data collection methods in July, August, and September. There were no overlapping participants between key

informant interviews and focus group discussions. Separating participants was not a deliberate choice but it allowed for new voices and opinions to be heard.

Data collection was an iterative process where lessons from key informant interviews were taken to improve future interviews and focus groups. Insights from interviews changed the selection of future key informants. These insights also allowed for continuous modifications to the interview and focus group guides and facilitation techniques. General ideas provided in interviews were also carried into the focus group discussions, allowing the participants to build upon or assess previous remarks.

Key informant interviews

Key informants were purposefully selected to represent each health authority and to maximize heterogeneity of type of health-care professionals in BC. Their selection was also dependent on the relevance of their work to GBV. A few key informants were also selected through snow-ball sampling where they were recruited through personal recommendations. Saturation was reached when key informants discussed the same topics and no new information was generated. Towards later interviews, we sought to interview people who would provide more relevant data on the important concepts that were emerging.

We conducted 26 key informant interviews with existing and potential course delivery partners. Existing delivery partners were people who had been actively engaged in the development of the series and its promotion such as the regional health authorities and the Provincial Health Services Authority. During these interviews we asked participants about their existing approach to promoting the series, what they saw as the barriers to uptake of the series, and strategies for improving the series' reach and uptake. Potential delivery partners were organizations that had successfully advanced similar educational initiatives, such as UBC Continuing Professional Development and the San'yas Indigenous Cultural Safety Training. The interviews focused on learning about their organizations and identifying opportunities for partnership.

Each interview lasted between 45-60 minutes and was conducted either in person or by phone. Two people from the evaluation team attended each interview; one person led the interview while the other took written notes. The interview guide was adapted

accordingly for existing or potential delivery partners and the questions were not circulated beforehand. Each interview was audio recorded with permission.

Focus group discussions

Focus group participants were selected by criterion purposeful and snow-ball sampling. Each focus group served a different purpose and participants were asked to join the focus group based on whether or not they were front-line HCP and whether they had taken the series. Emails to recruit focus group participants were sent out and all participants who expressed interest were included. Snow-ball sampling was used when managers and leaders helped to recruit people who fit the criteria of the focus groups.

We conducted 4 focus group discussions with 26 health-care professionals in Victoria, Kelowna, Vancouver, and Prince George. The focus groups in Victoria and Kelowna were for front-line health-care professionals who had taken one or more courses in the series. The focus group in Vancouver was for program and research staff who had taken one or more courses in the series. During the focus groups in Vancouver, Victoria, and Kelowna, the discussion focused on what they thought were the key strengths of the series, areas for improvement, and the relevance of the series to their role. In Prince George, the focus group was conducted with HCPs who were not enrolled in the series. Participants were asked for their insights on the barriers to accessing the series, strategies for promoting the series to their colleagues, and the applicability of the series to their work.

Each focus group was 60 minutes long and participants attended in person or by teleconference. Two to four people from the evaluation team attended each focus group. One team member led the focus group while the others took notes. A focus group guide was adapted for each type of audience and the questions were not given to the participants beforehand. Each focus group was audio recorded with permission from participants. All focus group participants were given an honorarium for their time.

Online surveys

Two online surveys were created, both of which could be completed in under 15 minutes. There was a need for two surveys because these two populations had distinct characteristics and different experiences of the learning series. Survey #1 was designed

for health-sector professionals who had taken one or more courses in the series. This survey asked questions about the motivation behind taking the series and how the series contributed to HCP's understanding of GBV. Seventy-three people completed this survey. Survey #2 was designed for health-sector professionals who had not taken any courses in the series. Survey #2 asked questions about barriers to completing the series and what kind of supports was needed to facilitate uptake. One hundred and four respondents completed this survey. The surveys were open from June until the beginning of September.

Both surveys used convenience and criterion purposeful sampling; the surveys were promoted to those who fit the criteria and those that were easily accessible. Survey #1 was distributed via email to all those who were registered on Learning Hub and had taken 1 or more courses in the series. Survey #2 was distributed via email to those who were registered on the Learning Hub but had not taken any courses. Both surveys were promoted by the project team at BC Women's Open Forum, during key informant interviews and focus groups, and during in-person promotional presentations of the series. Both surveys were advertised in BC Women's and PHSA staff newsletters, on the PHSA POD (staff intranet) and via posters displayed in public areas at BCWH and PSBC. Additionally, we provided the Advisory Committee with posters, text, and links and encouraged them to spread the word through their networks.

Upon completing either of the two surveys, participants were given the option to click on a separate link and consent to a 15 minute phone interview to discuss the value of the series. At the end of both surveys participants were invited to enter their names into a draw for a \$50 gift card.

5.3. Data analysis

Key informant interviews and focus group recordings were professionally transcribed by an independent transcription agency and participant identities were anonymized. The project team developed an inductive coding scheme (Appendix C) to systematically categorize the data and ensure consistency between coders. First, the team read line by line through two transcribed interviews, discussed emerging codes from the raw data and came to agreement on the codes. I coded the qualitative data using NVivo coding software and another member of the project team reviewed my coding. This was an

iterative process; as I coded more interviews, I continually clarified and improved the coding scheme. After coding, the team sat together to combine codes and group them into categories that aligned with the 9 evaluation questions. From these categories, central themes within each question emerged. An evaluation specialist from BC Women's Hospital + Health Centre analyzed the survey data to produce descriptive statistics using SPSS.

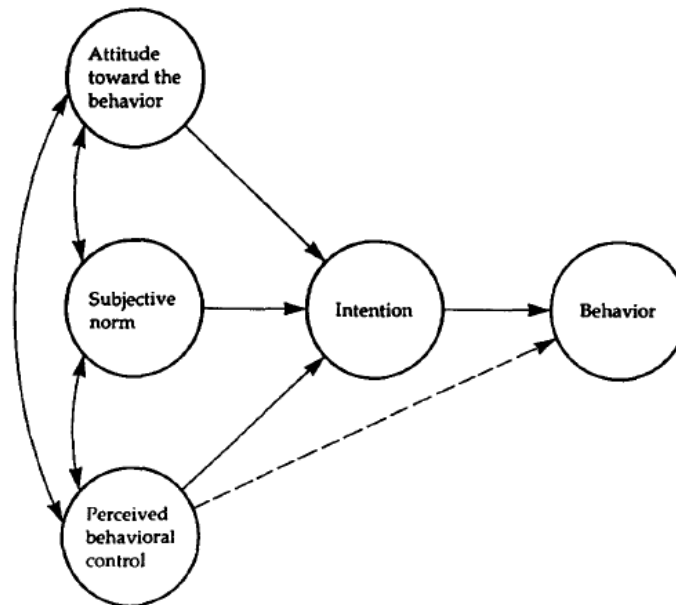
This evaluation ensured internal validity in multiple ways. Before collecting and analyzing data, the project team was aware of their own personal bias, attitudes, and perceptions. Using interviews, focus groups, and surveys allowed for triangulation of the data. The data was coded and reviewed by two people to ensure consistency and reliability. Themes from the analysis and opinions about its meaning were discussed within the project team, this enriched the understanding of the data because team members were already familiar with the context.

5.4. The Theory of Planned Behavior

Before presenting the evaluation findings, this capstone will outline the Theory of Planned Behavior (TPB). TPB is a helpful tool to understand and structure the barriers to uptake of the learning series. The findings are first presented thematically, then the TPB is used to further categorize and enrich its understanding.

The Theory of Planned Behavior (TPB) is a commonly used model to predict intentions and behavior and the most appropriate model to predict behavior of health professionals (Godin, Belanger-Gravel, Eccles & Grimshaw, 2008). TPB has been used to study a variety of practices among HCP such as sexual health interventions (Miller et al., 2015), domestic violence screening (Natan, Khater, Ighbariyea & Herbert, 2016), and hand hygiene practices (White et al., 2015). Regarding intimate partner violence, TPB has been used to understand survivors and their intentions to leave (Edwards, Gidycz & Murphy, 2014; Byrne & Arias, 2004). There is a paucity in understanding GBV using a systematic frame for analysis; applying the TPB in this work seeks to contribute to this gap.

Figure 3. The Theory of Planned Behaviour



Note: Reprinted from “The Theory of Planned Behavior”, by Ajzen, I., 1991, *Organizational Behavior and Human Decision Processes*, 50 (2), p.179.

The Theory of Planned Behavior (TPB) was first coined by Icek Ajzen to explain human behavior (Ajzen, 1991). In this framework, behavior is influenced by three variables: attitude towards the behavior, subjective norms, and perceived behavioral control. These variables influence the intention for the behavior which lead to actual behavior implementation; usually, a stronger intention increases the likelihood that the behavior will be executed. Attitude towards the behavior means the degree to which the person has a positive or negative appraisal of the behavior. Subjective norms refer to mainstream society’s views and pressures about the behavior that other people hold which can affect the individual’s perception of the behavior. Perceived behavioural control refers to the ease or difficulty in performing this behavior and includes assessing the available resources and opportunities to facilitate this behavior. If the perceived behavior control reflects actual control over a behavior, there can be a direct link affecting behavior. The diagram shows possible feedback effects between variables.

Chapter 6. Evaluation Findings: Series' uptake

6.1. Identified barriers to uptake of the learning series

These findings are from all the data and its source will be highlighted when appropriate. Triangulation of the data from key informant interviews, focus groups, and surveys increased depth and validity to these findings. In this evaluation, participants said while they were personally able to complete the series, they acknowledged that barriers to taking the series did exist within the health system. The identified barriers are presented in two groups: logistical factors and internal factors.

Logistical barriers affecting series' uptake

Lack of time

The most frequently mentioned barrier to series' uptake was a lack of time. According to key informants, knowing that completing the learning series would take 4 hours discouraged some potential learners from registering for the series. Key informant interviews and focus group discussions revealed that learners felt it was difficult to find a 4-hour block of time to complete the series and also reported that 4 hours was a challenging length of time to sustain focus for such a heavy topic. Participants reported a heavy workload which decreased their willingness to devote time to engage in the series.

Lack of paid and protected time for series completion

Lack of guaranteed paid and protected time to complete the series was an identified barrier to completion by both key informants and focus group participants. Interviewees reported that the busy schedules of HCPs made it unrealistic for them to complete the series on their own time without pay. Interviewees noted that it was particularly difficult for managers of clinical shift workers to find coverage to enable employees to complete the series during work hours.

Lack of private space to complete the series

Interviewees and focus group participants were aware that the content of the learning series might be triggering. The content was described as "heavy" and participants

therefore felt it was necessary to spend time and focus on the material rather than stopping and starting or superficially engaging with the material. For some learners, the series prompted reflection on their past experiences encountering survivors of GBV and brought up feelings of guilt at their failure to intervene. Interviewees highlighted the need for private space to properly engage with the material. In many offices and clinical settings, computers are in high-traffic areas with little to no privacy, failing to provide a safe space for employees to complete the series. In order to watch the videos without disturbing others, employees also require headphones which may not be readily available or appropriate, particularly in clinical settings.

Difficulties with the delivery platform and curriculum format

Interviewees and focus group participants identified several issues with the Learning Hub platform through which the series is delivered. The estimated time to complete the courses was not accurate, making it confusing and frustrating for learners who had reserved a block of time to complete the course. In particular, the first course had a one-hour estimated completion time, when in reality only took seven minutes to complete.

Key informants, focus group participants, and survey respondents all noted a general lack of awareness of the series among HCPs. One such barrier noted by key informants was the invisibility of the series on the Learning Hub platform. In order to find the GBV series on the Learning Hub, learners had to remember and type in the exact title of the series. Key word searches using common terms such as “violence” or “domestic abuse” were not successful in finding the series.

Apart from the issues with the Learning Hub, interviewees also commented that online learning was not suitable for different learning styles. Several key informants reported feeling isolated from working through the courses individually. They suggested that having a discussion forum to discuss the emotions that surfaced during the training with other learners would be helpful. Some interviewees inquired about the possibility of adapting the series to a blended learning model with both online and in-person components and an interactive forum which could improve series’ uptake.

Internal barriers affecting series' uptake

Lack of perceived relevance of gender-based violence to health-care professionals

Evaluation participants reported that not all HCPs believe addressing GBV is part of their role, which may further decrease the likelihood that they would complete the GBV series. One key informant noted that there is an assumption that GBV is an issue that is “*up to the police or it's up to the individual person who is being harmed or is harming*”. This suggests that some HCPs may see GBV as the responsibility of other public services. We observed a general impression that GBV is not a priority in health care, and hence, HCPs may not see it as a high priority in their work.

Fear of addressing the topic of GBV

An interviewee stated, “*you feel like you are opening a box of uncertainty*”.

Several interviewees stated that HCPs were often afraid of or lacked the confidence to respond to GBV. HCPs feared re-traumatizing patients by inquiring about GBV, repeatedly referring to it as ‘opening Pandora’s box’. This fear may be compounded by the perceived constraints of short appointments, minimal opportunity to adequately and sensitively respond to and address the patient’s needs and develop a plan for their safety, and a lack of resources to offer patients.

One interviewee voiced, “*So I am just this emotionless robot delivering care to you. And that's a barrier to empathy... and a barrier to creating rapport with someone*”.

An interviewee stated that it was difficult being composed when delivering care to a survivor and was uncertain as to what emotion to display. HCP’s fears of re-traumatizing patients may prevent them from thinking there is anything they can do about GBV, and hence, they may be less motivated to take a course on GBV than someone who believes they can help their patients who have experienced GBV. Key informants also reported that HCPs feared damaging their relationships with patients by inquiring about GBV. One concern was the danger of putting the mother’s children at risk of apprehension,

and the other was that patients would blame the HCPs for any action on the part of the legal system or the Ministry of Child and Family Development.

Inadequate referral mechanisms to address GBV

Several participants stated that they believed the referral mechanisms for HCPs were not adequate and that the BC health system is ill-equipped to respond to GBV. Key informants and focus group participants both suggested that if they ‘open Pandora’s box’, there needs to be appropriate referral mechanisms and resources to support victims of GBV. HCPs expressed frustration at not being able to “close the loop” and noted that the current health-care system does not address continuity of care. Key informants and focus group participants seldom mentioned VictimLink BC, suggesting that knowledge of this resource is very limited.

One focus group participant exclaimed, “*So to feel confident as a provider that I've got your back and I'll be able to protect [you], I can't actually say that. And that's [not being able to protect a survivor] a powerless feeling*”.

“We can’t solve the issue” – misunderstanding the role of health-care professionals

Some key informants reported that many HCPs did not adequately understand their role in responding to GBV. HCPs may feel that they do not have the power to “fix”, stop ongoing violence, or remove victims from vulnerable situations. This misunderstanding points to the need to educate HCPs to ensure they understand that it is not their role to solve GBV but to follow the LIVES approach (listen, inquire, validate, ensure safety, support services).

6.2. Critical analysis of barriers using the Theory of Planned Behaviour

The following analysis will use the TPB to provide structure to further understand the barriers to uptake of the GBV online learning series as identified in the evaluation. Barriers will be split under three variables: attitudes, subjective norm, and perceived behavioural control.

Variable 1: Attitudes toward taking the GBV learning series

A positive or negative appraisal to taking the GBV learning series is dependent on a HCP's attitude towards GBV. This can be split into two themes: opening Pandora's box and inadequate referral mechanisms.

Opening Pandora's box

GBV is a heavy topic that elicits mixed emotions. One major theme that came from the evaluation data, which is supported by existing literature, is that addressing GBV is like 'opening Pandora's box'. This metaphor was used by HCPs to describe the uncertainty of what will happen if they ask about GBV and insinuates that more harm is created when GBV is unpacked and discussed. Williston and Lafreniere (2013) used a similar metaphor, 'opening a can of worms', to describe this phenomenon, demonstrating the belief that bringing up GBV is intimidating and cannot be undone. There is reluctance and fear to open this box of sorrow, pain, and misfortunes because it requires emotional involvement and can lead to negative repercussions (Lavis, Horrocks, Kelly & Barker, 2005; Boyle, Robinson & Atkinson, 2004).

In addition, data from this evaluation showed that HCPs fear giving the wrong response, taking the wrong course of action, and contributing to further trauma. Effective communication requires careful treading and the lack of this practiced skill can be a source of anxiety. Williston and Lafrenier (2013) compare this communication to "a delicate dance" wherein one misstep can impact the whole performance. The possibility of damaging relationships with patients and being blamed for negative outcomes was also voiced by key informants in this evaluation. Once a patient acknowledges GBV with a HCP, it can lead to legal or police action which can result in resentment and bitterness towards the HCP especially in cases where children are involved. HCPs lack the confidence and knowledge in how to navigate these situations which can be barriers to their engagement in the topic.

Another factor identified by participants impacting their fear of opening Pandora's box is the scarce time and short duration of health-care appointments which do not allow for the opportunity to meaningfully unpack GBV. Some HCPs feel pressure to address issues of greater prevalence (Leppakoski et al., 2014; Sugg & Inui, 1992). Given the multitude of other questions and health issues HCPs need to address, GBV may not be

prioritized. Considering these limitations, HCPs are wary of the appropriate response to patient disclosures of GBV. Therefore, it is typically easier for HCPs to turn a blind eye, distance themselves, and wait for other individuals working in other sectors to open Pandora's box.

Inadequate referral mechanisms to address GBV

Once Pandora's box is open, HCPs are unsure of the next step. Best practices for GBV screening and effective interventions are unclear, messy, and hold uncertain outcomes (Lavis et al., 2005; Husso et al., 2012; Gerbert et al., 2002). The evaluation participants and data from existing literature highlighted that HCPs have uncertainty with respect to navigating the referral systems for GBV. HCPs in BC are at a loss at what the referral system is, how it works, and how to access it. Moreover, HCPs do not believe that once referrals are made, the health system is set up to support survivors (Roelens, Verstraelen, Egmond & Temmerman, 2006). A review by Macy, Ferron, and Crosby (2009) found that even if survivors seek and receive health services, their specialized health needs are not adequately addressed. Thus, HCPs may be reluctant to refer a patient even if they are aware of the referral system. Beyond the health system, HCPs also noted a lack of trust in community-based agencies that serve survivors (Taft, Broom, & Legge, 2004). A lack of referral mechanisms negatively affects HCP's attitude toward addressing GBV.

Evaluation data and existing literature show that there is fear about the contents of 'Pandora's Box' and uncertainty regarding referral mechanisms. These can contribute to the negative attitudes HCPs hold and act as barriers to uptake of the GBV learning series. Addressing these internal barriers is crucial to increase motivation for HCPs to take the series.

Variable 2: Subjective norm of addressing GBV

Another way to understand some of the internal barriers to series' uptake is to unpack the social pressures and views experienced by HCPs. Societal norms upheld by the surrounding community inevitably influence HCP's perceptions in addressing GBV.

Unclear role for addressing GBV

HCPs can be influenced by sociocultural norms which perpetuate a dialogue that normalizes and accepts GBV instead of working to change it (Garcia-Moreno et al., 2015). GBV is a hushed topic and the social norm is to remain silent and avoid taking responsibility to address it; a way HCPs perpetuate these societal norms is by believing that GBV is irrelevant to their work. The evaluation data showed that some HCPs believed addressing GBV is outside their role and that the responsibility lies within other sectors. Some HCPs view violence not as a health issue but as a social problem rooted in society's expectations and norms that perpetuate violence (Robinson, 2010; Lavis et al., 2005). Similarly, there is a belief that the responsibility for GBV lies in housing and social services because they can provide the immediate services survivors need. HCPs also believe that GBV should be dealt with by the police or criminal justice system given their power in society (Baraldi, de Almeida, Perdoná, Vieira & dos Santos, 2013; Lavis, 2005). Even when GBV is recognized as a health issue, literature shows that many HCPs are unclear as to which specialist health-care department it pertains (Husso et al., 2012). It is evident that there are differing cross-sectoral and departmental roles and responsibilities to address the vast effects of GBV. The overlapping and ambiguous boundaries for the roles of each sector make it easy to defer work to other groups. In this way, remaining silent and inaction are maintained by the normative belief that addressing GBV is outside the scope of work for HCPs. There is no social pressure from the surrounding community to address GBV which can influence an individual's intention to take a learning series to appropriately respond to this problem.

Physicians as problem solvers

Another societal norm influencing HCPs relationship with GBV is the common idea of physicians as problem solvers. The biomedical model of health reduces the scope of health and encourages the belief that a physician's only role is to treat diseases (Garcia-Moreno et al., 2015b). However, this belief should not be applied to GBV because the nature of violence is slow and complex. The inability to immediately and directly deal with GBV may surface feelings of inadequacy and frustration in HCPs (Robinson, 2010). This sentiment is shown in the evaluation data when HCPs voiced that part of their fear and despair stems from not being able to "fix" GBV. Evaluation participants revealed their misunderstanding of the LIVES approach. It should not be used as a tool to solve

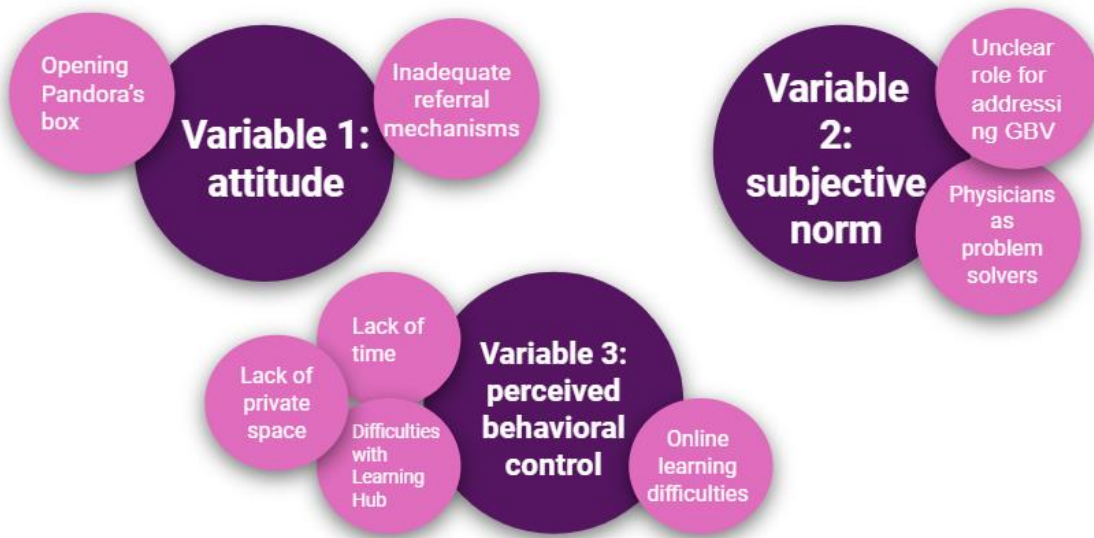
GBV but as a guidance framework to confidently and sensitively enter into discussion surrounding GBV.

Uptake of the learning series is difficult with the prevailing socio-cultural norms and narratives that isolate GBV as a problem to be solved by specific sectors. These harmful beliefs contribute to the ambivalence toward GBV as a relevant problem among HCPs. If the surrounding community carries these beliefs, then HCPs will be less likely to take the series. In order to increase motivation to participate in training, HCPs and those around them need to first see their role as relevant to an effective response.

Variable 3: Perceived behavioral control about GBV learning series

The third variable acting as a barrier to uptake of this learning series is perceived behavioral control. The evaluation highlighted four main logistical issues relating to available resources and opportunities for the series' uptake. Evaluation participants acknowledged that lack of time from work and personal life was the biggest barrier to their learning, which was previously identified by Ikenwilo and Skatun (2014), Lalonde et al. (2013) and Teekens et al. (2018). Next, HCPs were hesitant to take the series due to lack of compensation from their employers; it cannot be assumed that HCPs have the financial freedom or willingness to do free work. Evaluation participants also stated the need for private space to complete the series which was often limited in occupational settings. This evaluation supported the work of Rheingold et al. (2012) by showing that online learning may not be the best option for teaching HCPs about GBV. Evaluation participants felt lonely from online learning and wanted a more supportive interactive learning environment. Regarding the Learning Hub, learners stated that they encountered logistical problems and were commonly unaware of courses offered on the platform. These four logistical barriers experienced by HCPs contribute to low perceived behavioral control which can negatively impact both the intention to take the series and the actual uptake of the series.

Figure 4. Using TPB to structure barriers



Chapter 7. Discussion

There are over 138,000 public health-sector workers in BC (Health Employers Association of BC, 2020). The evaluation data shows that less than 1% of BC health-sector workers have completed the first GBV course. First, there is upfront acknowledgement that this learning series was not constructed in ideal terms because it lacked participant involvement. It evolved from a policy directive and BC Women's Hospital + Healthcare was contracted to execute the work. The development, form, and core content were stipulated by a pre-determined contract. Because this learning series had to have a provincial reach, making the series online was the most cost-effective method. Learning Hub was used as the platform because it was an existing resource that most health authorities utilized which simplified the design process.

Additionally, creation of this series was constrained by a short timeline and limited resources. One reason the series had low uptake was because there was no structure for ongoing promotion and implementation. There was no provincial press release about the series, and much of the promotion happened at the same time as the evaluation activities later in the timeline. Uptake of the series would be higher if there was somebody on their project team dedicated to series promotion. Other online provincial courses such as San'yas Indigenous Cultural Safety have a wider reach and uptake because they have accompanying time, money, and institutionalization by making it mandatory. Although the barriers identified in the evaluation data are not necessarily new, decisions about the series were made because it was the best and most cost-effective choice within the available options.

The low uptake of the series in BC illustrates the many barriers that HCPs face. The evaluation confirmed many of the barriers outlined in literature and offers more insight into the specific context in BC. The findings between each data collection method were consistent and triangulation of the data increased its validity. Barriers were first analyzed thematically and split between logistic and internal barriers. After, they were further categorized under three variables using the TPB.

Various barriers affect HCPs' attitudes (variable 1) in addressing GBV. In accordance with existing literature, this evaluation found that a significant barrier for HCPs is fear of addressing GBV. HCPs fear opening Pandora's box (Lavis et al., 2005; Williston &

Lafreniere, 2013) and feel ill equipped to engage with GBV (Gutsmanis et al. 2007; Husso et al., 2012; Leppakoski, Flink & Paavilainen, 2014; Sundborg, Saleh-Stattin, Wandell & Tornkvist, 2012). In a foundational study, Sugg and Inui (1992) interviewed 38 physicians and identified sources of fear in opening Pandora's box: losing control of the situation, powerlessness to change the situation, loss of relationships built with patients, and fear of offending the survivor by asking questions. Participants in this evaluation directly expressed these same reasons except for losing control of the situation. This fear of addressing GBV underscores the need for training to build confidence and knowledge. Taking this learning series provides an opportunity for HCPs to learn how to appropriately engage and support survivors while maintaining healthy boundaries. There is a responsibility for HCPs to move beyond their fear, knowing that opening these discussions are possible and may better serve the survivor.

Additionally, evaluation participants voiced that the lack of referral mechanisms limit how they respond to survivors, a barrier supported by existing literature (Roelens et al., 2006; Gerbert et al, 2002). In BC, options for referral include helplines, community-based and police-based programs, counselling programs, outreach services, and transition houses. Making a referral entails knowing the available resources, offering to contact the service, offering to go with the survivor to the service, and following up (Victim Services and Crime Prevention Division, 2007). The BC government advocates for the use of VictimLink BC, a 24/7 confidential helpline for all victims of crime. However, evaluation participants demonstrated low awareness of this resource. The challenge for HCPs is knowing what updated resources are available and how to access them. There is no clear direction or strategy for referrals in each scenario nor is there collaboration between sectors. The disjointed and unclear nature of the referral system makes it difficult for HCPs to provide an effective response.

A significant barrier under the category of subjective norm (variable 2) is the uncertainty around the role HCPs play in addressing GBV. Similar to sentiments expressed by Baraldi et al. (2013), evaluation participants believe GBV was a problem but felt the responsibility to address it lies within another sector such as the criminal justice system. GBV spans across sectors and there is a need for everyone to be actively involved in the response to support survivors. Furthermore, some evaluation participants viewed GBV from a treatment perspective and were disheartened at their inability to "fix" GBV. This view is supported by Robinson (2010) where HCPs believe that opening GBV in a

discussion warrants a solution. However, the LIVES approach is not intended to solve this complex problem, rather, it is meant to increase awareness and knowledge and build confidence in HCPs to enter into conversations about GBV. This can be unsettling for HCPs who are trained to see health issues as problems to solve.

Finally, the logistical barriers, categorized under perceived behavioural control (variable 3), identified in this evaluation supported the work of Ikenwilo and Skatun (2014), Lalonde et al. (2013) and Teekens et al. (2018). In addition to the limitations of a stressful work environment as outlined by Attack and Rankin (2002), evaluation participants emphasized that the heavy nature of GBV increased the need for a private space to focus on the material. This evaluation contributed further to the literature by outlining barriers specific to Learning Hub and suggested that a higher engagement in the learning series is dependent on improving difficulties in formatting and the learning platform.

There were two barriers found in literature that this evaluation did not identify. First, HCPs as survivors of GBV was not mentioned by evaluation participants. Lavis et al. (2005) illustrate that HCP's personal experience of violence may prevent them from addressing GBV in patients. There were no self-identified survivors among the evaluation participants, however, it is acknowledged that HCPs are not immune to GBV and can themselves be survivors of violence. Research shows that up to 48% of Canadian nurses experience domestic violence in their lifetime (Calgary Domestic Violence Collective, 2013). Second, this evaluation did not touch on gender of the HCP. A study by Taft, Broom & Legge (2004) identified gender to be influential in addressing GBV because it can be considered a woman's task. Although it was not identified as a barrier in these evaluation findings, it can still affect who addresses GBV. Further research is needed to understand how personal experiences of violence and gender affect HCPs' provision of care to survivors.

7.1. Limits to the evaluation

Several limitations to the evaluation should be considered. The convenience purposeful sampling used in the key informant interviews, focus groups, and surveys limits transferability to other settings because it is non-random and may be biased.

Participants involved in the evaluation may be people who have strong opinions and are

willingly active in addressing GBV, thereby creating participation bias. Another limitation is the difficulty in receiving feedback from the Advisory Committee. We aimed to strengthen internal validity through a peer review process however, only one Advisory Committee member offered feedback on the evaluation findings which limits the validity of the data. Furthermore, the evaluation data may be biased because the project team was involved in both promotion and evaluation. Because the team is invested in promoting the series, they might be more prone to gather positive feedback while neglecting the negative when collecting data. Participants might also be hesitant to raise negative feedback knowing the project team was involved in creating the series. However, we tried to mitigate this by ensuring that the people on the team involved in series creation were not involved in data collection.

Limitations also exist when applying this theory to the evaluation data. HCPs are not a homogenous group, and there will be individual factors for the three variables (attitude, subjective norm, and behavioural control) that affect intention and behavior. Furthermore, even when all three variables are favorable and cultivate high intention, there may be unforeseen obstacles and barriers. The TPB is not a completely linear relationship and people's intentions may not always lead to behavior change (Perkins et al., 2007). A factor that was not identified in this evaluation but was raised by Godin et al. (2005) as a contributor to the TPB is moral norm. This refers to the feeling of moral obligation toward a behavior. Given that the role of HCPs is to care for the wellbeing of others, HCPs who feel a moral obligation to address GBV may have increased intention to take this learning series.

Ultimately, the TPB is not a comprehensive framework but offers a useful theoretical tool to understand the many barriers HCPs face to uptake of the GBV learning series. Moving forward, any efforts to further improve this series should account for HCPs' attitudes, subjective norms, and perceived behavioral control regarding GBV. Addressing these variables will increase motivation for HCPs to engage in this GBV learning series and improve the health system's response.

Chapter 8. Recommendations to improve series' uptake

1) Recommendations for addressing attitude and subjective norm of GBV to increase series' uptake

1.1 Using series champions as mentors and role models for addressing GBV

Series champions, people who advocate for the series and provide feedback, should act as mentors and role models to bring attention and prioritize responding to GBV.

Leppakoski et al. (2014) suggested that a mentoring action plan can help staff with addressing violence. Series champions are usually leaders in their workplaces and have established trust and credibility with their staff. By advocating for the series, they help to normalize and decrease any stigma associated with addressing GBV. When champions hold personal responsibility to address GBV in their work, that can encourage similar sentiments in their staff. Furthermore, champions can create spaces to debrief and provide emotional and mental support to their staff while they are taking the series.

Fears around opening Pandora's box, responding inadequately, re-traumatizing patients, and vicarious trauma can be raised and addressed by mentors. Having mentors not only challenges the social norms and relevance of GBV as a topic, but also provides personal motivation and emotional support for staff to take the learning series.

1.2 Work through series in teams

Another method to address negative attitudes that HCPs have about GBV is to work through the learning series in teams within a workplace. Coles et al. (2013) found that working in teams prevents secondary traumatic stress, or vicarious trauma, in primary care professionals. Working in teams is a form of accountability and facilitates increased dialogue and vulnerability between peers which can be an empowering experience. This is an opportunity for HCPs to discuss their fears around addressing GBV including methods of establishing healthy boundaries with their patients. Working alongside peers also normalizes taking the series and can be a way to address social norms and perceived relevance of GBV. Managers should consider incorporating this learning series as a part of their educational training that can take place at team meetings.

1.3 Adapt the series to incorporate a blended learning component with in-person modules, an online discussion board, or an online course moderator

Online learning is an effective and efficient method to reach many learners, however, it comes at the cost of learning in isolation. Evaluation data showed that learners wanted discussions and interactions with each other. Rheingold et al. (2012) found that both online and in-person training on sexual abuse were acceptable, but learners who had in-person training felt more emotionally supported. In-person learning provides an opportunity to discuss training alongside peers which can be emotionally and educationally helpful; this is especially important given the sensitivity of GBV as a topic. Providing human interaction during the series can reduce the fear working through difficult material and shift the attitudes regarding GBV to facilitate uptake to the series.

1.4 Establish appropriate referral mechanisms to support survivors

Establishing appropriate referral mechanisms and resources to external support services is critical in caring for survivors. Colombini et al. (2012) advocate that a health system response is only effective if there are linkages between health policy, HCPs, external agencies, and health-care delivery. Evaluation participants highlighted inadequate and fragmented referral mechanisms underlying their fear which restricted engagement with GBV. Development of clear and centralized networks of support allows HCPs to feel more at ease to refer survivors because their patients will no longer be lost or abandoned in the system. For referral services that already exist in BC such as VictimLink BC, increased promotion will help inform HCPs of its existence.

1.5 Institutionalize series at all levels of the health system

There are various ways to increase series' uptake within the health system. Within health authorities, the series could be incorporated into the orientation packages for new hires. Additionally, the series can be included in the list of mandatory professional education required for HCPs before they begin working. The Ministry of Health can create a policy that institutionalizes the series and provides funds for its implementation. Institutionalizing the series shows everyone that GBV is a priority in the health system, emphasizes the role that each worker plays, and normalizes the training.

1.6 Seek accreditation and endorsement of the series

Accrediting the series such as giving Continuing Medical Education credits for physicians will increase series' uptake. Accrediting this series also shows the public that

GBV is recognized as an important issue and institutions are making it a priority by educating their HCPs. Endorsement from professional organizations and associations will strengthen the series' credibility and visibility. For example, having Doctors of BC or the College of Physicians and Surgeons of BC advocate for the series will facilitate series' uptake. Both accreditation and endorsement will increase relevance of GBV as an issue for HCPs.

2) Recommendations for improving perceived behavioural control to increase series' uptake

2.1 Dedicated time and compensation to series completion

Providing learners with dedicated time to complete the series during work hours was the strategy most frequently endorsed by evaluation participants. However, it was noted that creating time during work hours would require coverage for shift workers in clinical settings. Compensating employees for course completion was raised as another method to facilitate uptake. Both time and compensation would increase perceived behavioural control and facilitate easier access to taking the series.

2.2 Improve Learning Hub

According to respondents, greater awareness of the series could be cultivated if the series was placed in a more prominent location on both the Learning Hub and on health authority websites. This would keep HCPs up to date on free courses that are available and ease the course search process. Removing the logistical Learning Hub problems will increase uptake to the learning series.

Chapter 9. Conclusion

GBV continues to be a hidden and relentless public health problem which emphasizes the importance of a response from the health sector. It is necessary that HCPs are trained to identify, address, and respond to survivors of GBV. This evaluation identified logistical and internal barriers to uptake for HCPs for the *Gender-Based Violence: We All Can Help* learning series. Critical findings show that more time and private space to engage in training is needed. Internal barriers such as fear and relevance of GBV and uncertainty about a HCP's role also need to be addressed. Key recommendations include institutionalizing the series, developing a better referral system, and working through the series in teams or under the guidance of mentors. These recommendations seek to establish GBV as a priority at both the organizational and individual level. Future research should evaluate the barriers specific to each type of HCP to understand their needs and how personal experiences of GBV can affect a HCP's response. Ultimately, a health sector's response is just one part of a larger endeavour to provide better care for survivors of GBV and a holistic response requires effective partnership and communication between multiple sectors. GBV demands everybody's care, concern, and action; we all can help.

Chapter 10. Critical Reflection

I am endlessly thankful for my practicum opportunity, the people on my GBV team, and for the ability to stay on the project to finish the evaluation until the very end. This allowed me to write my capstone on something I was deeply invested in. During my practicum, I learned the reality of working in a government health authority. Witnessing and experiencing difficulties in a highly complex system encouraged me to work harder and taught me the importance of holding to my principles, speaking up, and standing alongside others. I also learned that participatory approaches, while important and meaningful, are harder to implement in reality and may not be a high priority to other stakeholders. I am determined to learn how to improve upon participatory approaches and make more meaningful connections.

Writing this capstone was a challenging but rewarding experience. It pushed me to put on my public health hat and use a theory to structure the evaluation data. The two public health core competencies I developed in the practicum and capstone were: CC3. Methods of Population and Public Health Assessment, Diagnosis, and Analysis and CC8. Policy and Program Planning, Implementation and Evaluation. My practicum and capstone significantly deepened the skills I learned in HSCI803: Qualitative Research Methods, especially conducting interviews, focus groups, and coding on NVivo. In particular, I was very aware of 'myself as an instrument' in qualitative research (Rew, 1993) and the values, ideas, and biases I carried into this work. SFU courses provided a strong foundation to build on and I am grateful to be able to apply these hard skills into the real world.

Working with GBV was heavy and difficult at times. I was growing increasingly aware of the magnitude of damage that can form in relationships and how pervasive violence is in our society. The rising momentum to unveil GBV continually reminded me of how much more work there needs to be done. What provided me with encouragement was resting on the power of healing and the knowledge that experiences of violence are not the end of a survivor's story. Being in this project encouraged me to own up to my own experiences and find my voice. In the era of the #MeToo movement, I am here to stand in solidarity with survivors.

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Appendix A. Educational opportunities related to gender-based violence in BC

Organization/Association	Training to address GBV	Hours	Costs
BC Women's Hospital, Ending Violence Association of BC, Ministry of Health	Gender-Based Violence: We All Can Help: online 4 module learning series to educate HCP on how to understand, identify and address GBV	4	Free
Ending Violence Association of BC	-EVA BC's Annual Training Forum for anti-violence workers in BC -Be More Than a Bystander (BMTB) offers an in-person program for Indigenous community presentations, Train-the-Trainer, Resource industry workplaces	Training forum is 2 days. BMTB programs vary in length.	Costs are variable.
BC Society of Transition Houses	<u>Online courses</u> -Foundations in Violence Against Women -Increasing Access for Indigenous Women -Legal Issues Supporting Women and Children Experiencing Violence Training & Webinar Series -Building Supports: Promising Practices <u>In-person courses</u> -Reducing Barriers	Online courses take 4-6 hours. In person courses are variable.	Online courses range from \$60 for full members to \$125 for associate and non-members. In person courses are variable.
Health Employers Association of BC	The Provincial Violence Prevention Curriculum consists of 8 online modules, one classroom module, and an advanced team response module for all health-care workers in BC.	Unknown	Free
Learning Hub	-Urban Health Program: safeCARE is a blended learning course which teaches nurses how to provide trauma-informed and culturally safe care when working with people who use substances.	Variable	Free

Organization/Association	Training to address GBV	Hours	Costs
	<ul style="list-style-type: none"> -BC Emergency Health Service - Violence Prevention for Paramedics Students -BCEHS – Domestic Violence -Sexual Assault Care e-learning -Sexual Health in Healthcare: Tips for Breaking the Ice -Sexual Health and Intimacy: Residential Care – Clinical Protocol (PAQ) -Prism Education Series: Transgender Inclusion 101 -Violence Prevention (Island Health, Providence, Fraser) -Violence Prevention -PVPC for Physicians -Violence Prevention Alerts Documentation (Island Health) -IHealth: Violence Prevention Alerts Documentation – Dufferin -CST Skill Sharpener Video: Violence Risk Screening -Highlights of Island Health’s Violence Prevention Policies -Violence Risk Assessment – Introduction to the Provincial Violence Risk Assessment Standard -Violence and Aggression Alert – Fast Facts Online -Violence and Aggression Alert – Acute Care -Violence Prevention – Advanced Team Response (Fraser Health) -Provincial Violence Prevention for Low Risk Departments – 7 Modules -Violence Prevention for Correctional Health Care Employees -Violence Prevention – PVPC – Advanced Team Response -VCH Workplace Health – Violence Prevention Advanced Team Response ATR 		

Organization/Association	Training to address GBV	Hours	Costs
	<ul style="list-style-type: none"> -Provincial Violence Prevention for Medium and High-Risk Departments – 8 Modules -Restraints & Policy Session – RJH -Sexual and Physical Abuse: Pediatric- Emergency Forensic Nurse Examination - Clinical Protocol (PAQ) -Adult Abuse and Neglect – ReAct (online) -Recognizing and responding to adult abuse -Resident Abuse and Neglect: Residential Care – Clinical Policy (PAQ) -ReAct: Act on Adult Abuse and Neglect – It’s Your Duty (online) -Abuse, Neglect or Self-Neglect of Vulnerable or Incapable Adults – Part 1 -Duty to Report (VCH – Online) 		
Open School BC	Domestic Violence Safety Planning is an online course (7 modules) for social workers to assist victims of domestic violence.	8-10 hours	\$45
UBC continuing professional development	‘Improving Risk Assessment and Management of Violence’ is an online module for family physicians, specialists, and other health-care professionals.	4-5 hours	Free
Justice Institute of BC	‘Family Violence: Impact on Separation and Divorce’ is an online course for counsellors on relationship violence.	21	\$612.11
BC Municipal Safety Association	‘Prevention of workplace violence’ is a workshop for employees to promote safety from violence.	4 hours	\$75 per person
BC Teacher’s Federation	‘Promoting Healthy Youth Relationships: Educating Against Gender-Based Violence’ is a workshop for teachers on GBV.	Workshop	NA

Organization/Association	Training to address GBV	Hours	Costs
Public Service Alliance of Canada	Domestic Violence at Work: PSAC Training for Representatives is a course for PSAC union representations.	2 days	NA
MOSAIC	Training and education for front-line service providers responding to violence against immigrant women in Northwest BC	Previously delivered 3 full-day training sessions to front-line workers in Kitimat, Prince Rupert and Terrace. Training guide is now available.	Training guide is free
University of the Fraser Valley	'Sexualized violence prevention' provides training for institutions to make a sexualized violence prevention course.	3 days	NA

Appendix B. Interview and focus group guides

Key Informant Interview Guide - Existing Delivery Partners

Purpose

15 key informant interviews will be conducted with representatives from the regional health authorities, First Nations Health Authority, Provincial Health Services Authority (including Perinatal Services BC, BC Reproductive Mental Health Program) or other existing partners who have been actively engaged in promoting the course (e.g., Ending Violence Association, General Practice Services Committee (GPSC)) to document existing approaches to promoting the course, barriers to uptake of the course, and strategies to improve uptake.

Logistics

- Duration between 45 – 60 min
- 1 main interviewer, 1 note taker
- Interview will be audio recorded

Introduction

Thank you for agreeing to speak with me today. I would like to talk to you about the Gender-Based Violence: We All Can Help Improving the Health Sectors' Response online training series that your organization has promoted. As you know, this course was a collaboration between the BC Ministry of Health, the Ending Violence Association of BC and the BC Women's Hospital + Health Centre with support from its Foundation. Its purpose is to increase the awareness of and response to gender-based violence (GBV) across the BC health system workforce. This year, the BC Ministry of Health has contracted BC Women's Hospital + Health Centre and Perinatal Services BC to conduct an evaluation of the effectiveness of the online Gender-Based Violence training series. The goal of our evaluation is to assess the quality and effectiveness of the Gender-Based Violence: We All Can Help online training series and identify opportunities to expand the reach and uptake of the course. Your input will assist us with ongoing quality improvement.

With your permission, I would like to record our conversation which should last about 45 minutes. Only the transcriptionist and I will listen to the recording and then it will be erased. We will produce a written transcript or notes of our conversation. The information you provide will be collated with the responses from others and included in one or more evaluation reports. In reporting the results of the survey we will not include any individually identifiable responses.

I want to remind you that you may choose not to answer specific questions and you can end the interview at any point. Would you still like to proceed?

Main interview questions

1. How many employees are there at your organization?
2. How does the GBV series align with your organization's mission, services, or priorities?
3. Who or which group in your organization is/are responsible for staff education or professional development?
4. How does this series fit into other PD offerings that you provide?
5. Is there someone in your organization who became a champion for the series? How did this person champion the series?
6. Who else in your organization could be a champion for the series? What supports would a champion need?
7. How did your organization promote the GBV series?
8. Were there costs incurred (or other resources used) in the promotion work? Please explain.
9. How did your organization support staff to take the course? (probes if not mentioned: policies, time off, compensation, group session, CME credits, included in orientation package, mandatory for PD plans)
10. What sort of feedback or comments have you heard from staff about the series?
11. What would further support dissemination in your organization?
12. What would further support your staff in taking the series?
13. What are barriers for people in your organization to take the series?
14. What would support your staff in addressing GBV in their work?
15. How couldn't this course be sustainably embedded into the health care system in BC?
16. Do you have further ideas about how to promote the series/ GBV course?
17. Is there any other feedback you would like to share about the GBV course?

Other information to collect

18. Priority area:

- Maternity care
- Mental health/ substance use
- Emergency care and first responders
- General practice
- Other, please explain_____

19. Type or organization:

- Provincial government
- Health authority
- Education institution
- Regulatory body or college (e.g. college of physicians)
- Professional association
- Union
- Community-based organization
- Funding body or foundation
- Other, please explain_____

20. Jurisdiction (geographic reach):

- Provincial
- Regional
- Other, please explain_____

21. List of personnel in the health delivery organization

- Designated health profession
 - Dental hygiene
 - Dental technology
 - Denturism
 - Dietetics
 - Massage therapy
 - Midwifery
 - Naturopathic medicine
 - Nursing
 - Occupational therapy
 - Opticianry
 - Physical therapy
 - Psychology
 - Psychiatric nursing
 - Traditional Chinese medicine and acupuncture
 - Practical nursing
 - Audiology, hearing instrument dispensing and speech-language pathology
 - Chiropractic

- Optometry
- The practice of pharmacy
- Dentistry
- Medicine
- Podiatric medicine
- Clinical perfusion, respiratory therapy, radiation therapy and medical laboratory technology

- Other personnel
 - Policy makers
 - Researchers
 - Managers/leaders
 - Clerical staff
 - Administration (program/project coordinators)
 - Non-medical support staff (e.g., Quality, IT support, Accounting, Communications, etc.)
 - Maintenance support staff (e.g., Housekeeping, Security, facilities, etc.)

Key Informant Interview Guide - Potential Delivery Partners

Purpose

3 key informant interviews - Potential partner organizations and groups that have successfully advanced similar educational initiatives for a health care audience to identify and document opportunities for partnership.

Logistics

- Duration between 45 – 60 min
- 1 main interviewer, 1 note taker
- Interview will be audio recorded
- If contacting person by e-mail, send link to series and provide description of course (include one pager or link to website)

Introduction

Thank you for agreeing to speak with me today. I would like to talk to you about the Gender-Based Violence: We All Can Help online learning series. A collaboration between the BC Ministry of Health, BC Women's Hospital + Health Centre, and the Ending Violence Association of BC, this online series have been designed to increase awareness of gender-based violence (GBV) and to improve the health system response in British Columbia. This online series is designed for anyone who works in the health sector. It teaches skills and techniques for responding to disclosures of gender-based violence, and addressing the impacts of vicarious trauma, which may arise for some health workers.

This year BC Women's Hospital + Health Centre, in partnership with Perinatal Services BC, is conducting an evaluation of the effectiveness of the online Gender-Based Violence courses within the learning series. The goal of our evaluation is to assess the quality and effectiveness of the course. Your input will assist us with ongoing quality improvement.

With your permission, I would like to record our conversation which should last about 45 minutes. Only the transcriptionist and I will listen to the recording and then it will be erased. We will produce a written transcript or notes of our conversation. The information you provide will be collated with the responses from others and included in one or more evaluation reports. Any excerpts from our conversation that are included in the reports will be presented in such way that they cannot be traced back to you.

I want to remind you that you may choose not to answer specific questions and you can end the interview at any point. Would you still like to proceed?

Main Interview Questions:

1. About how many employees do you have?
2. How does the GBV series align with your organization's mission, services, or priorities? Do you think this topic is of value to your staff? Are you interested in working with us to offer this series to your staff?
3. How would this series fit into existing professional development offerings?
4. How do you support these types of PD offerings? (probes if not mentioned: policies, time off, compensation, group session, CME credits, included in orientation package, mandatory for PD plans)
5. Is there someone in your organization who is responsible for staff education or professional development? How could we work with them to promote this series?
6. How do you think the series can be promoted to your staff? (probe: ask about different strategies for different groups)
7. Is there someone in your organization who can be a champion for the series? What type of things would the champion do? What support would they need?
8. Do you anticipate any costs or other resource needs for promotion work? Please explain
9. What would support dissemination in your organization?
10. What would support your staff in taking the series?
11. What would support your staff in addressing GBV in their work?
12. How can this course be sustainability embedded into the health care system?
13. Is there anything else you would like to share about the GBV series or how to promote it?

Other information to collect

22. Priority area:

- Maternity care
- Mental health/ substance use
- Emergency care and first responders
- General practice
- Other, please explain _____

23. Type or organization:

- Provincial government
- Health authority
- Education institution
- Regulatory body or college (e.g. college of physicians)
- Professional association
- Union
- Community-based organization
- Funding body or foundation
- Other, please explain _____

24. Jurisdiction (geographic reach):

- Provincial
- Regional
- Other, please explain _____

25. List of personnel in the health delivery organization

- Designated health profession
 - Dental hygiene
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 - Midwifery
 - Naturopathic medicine
 - Nursing
 - Occupational therapy
 - Opticianry
 - Physical therapy
 - Psychology
 - Psychiatric nursing
 - Traditional Chinese medicine and acupuncture
 - Practical nursing
 - Audiology, hearing instrument dispensing and speech-language pathology
 - Chiropractic
 - Optometry
 - The practice of pharmacy
 - Dentistry
 - Medicine
 - Podiatric medicine
 - Clinical perfusion, respiratory therapy, radiation therapy and medical laboratory technology

- Other personnel
 - Policy makers
 - Researchers
 - Managers/leaders
 - Clerical staff
 - Administration (program/project coordinators)
 - Non-medical support staff (e.g., Quality, IT support, Accounting, Communications, etc.)
 - Maintenance support staff (e.g., Housekeeping, Security, facilities, etc.)

Key Informant Interview Guide - Potential partner organizations and groups who delivered similar courses online courses

Purpose

2 - 3 potential partner organizations and groups that have successfully advanced similar educational initiatives for a health care audience to identify and document opportunities for partnership

Logistics

- Duration between 45 – 60 min
- 1 main interviewer, 1 note taker
- Interview will be audio recovered
- If contacting person by e-mail, send link to series and provide description of course (include one pager or link to website)

Introduction

Thank you for agreeing to speak with me today. I would like to talk with you to learn about your organization's experience with online training for the health sector workers. We are hoping to learn from your experience with developing and delivering online courses to a large target audience from the BC health sector work force.

We are evaluating the Gender-Based Violence: We All Can Help Improving the Health Sector's Response online training series course and are looking for ways to better promote the course in the future. This course was collaboration between the BC Ministry of Health, BC Women's Hospital + Health Centre, and the Ending Violence Association of BC. Its purpose is to increase the awareness of and response to gender-based violence (GBV) across the BC health system workforce. This online series is designed for anyone who works in the health sector. It teaches skills and techniques for responding to disclosures of gender-based violence, and addressing the impacts of vicarious trauma, which may arise for some health workers.

With your permission, I would like to record our conversation which should last about 45 minutes. Only the transcriptionist and I will listen to the recording and then it will be erased. We will produce a written transcript or notes of our conversation. The information you provide will be collated with the responses from others and included in one or more evaluation reports. In reporting the results of the survey we will not include any individually identifiable responses.

I want to remind you that you may choose not to answer specific questions and you can end the interview at any point. Would you still like to proceed?

Main interview questions

1. Please tell me about your experience developing and promoting online training.
2. Who have been the target audience? How have you reached them?
3. How long has the course been offered?
4. Is the course fully online or does it have in-person or blended elements?
5. What strategies have you used in reaching your target audience? What have been the most successful strategies?
6. What has not worked?
7. How do you promote your course? Which strategies do you find are most effective for reaching many people with few resources?
8. How many learners have taken your course?
9. What supports do you provide for encouraging people to take the course? (Probes if not mentioned: CME credits, time off, compensation, group sessions, etc.)
10. What kinds of costs are associated with successful strategies? What resources are assigned to implementing the course (e.g., maintenance, updating, promotion, evaluation, etc.)? (Probe: ask about FTEs and other costs)
11. What barriers exist for attracting learners or learners completing the course?
 - a. If yes, how did you address this?
 - b. If no, why do you think your courses are popular?

Preamble: summary of outreach strategies that have been employed and impact. (Example: we have distributed postcards in conference swag bags and see an increase in people taking the course immediately after a conference. Currently we have 500 people who have completed the course and our target is 30,000). What advice would you have from your experience to increase the uptake of the GBV series?

12. What opportunities for partnerships or champions do you see to increase uptake of the GBV course?
13. Is there any other feedback you would like to share about the GBV course?
14. Do you have further ideas about how to promote the series?

Other information to collect

26. Priority area:
 - Maternity care
 - Mental health/ substance use
 - Emergency care and first responders
 - General practice
 - Other, please explain _____
27. Type or organization:
 - Provincial government
 - Health authority
 - Education institution
 - Regulatory body or college (e.g. college of physicians)

- Professional association
- Union
- Community-based organization
- Funding body or foundation
- Other, please explain_____

28. Jurisdiction (geographic reach):

- Provincial
- Regional
- Other, please explain_____

29. List of personnel in the health delivery organization

- Designated health profession
 - Dental hygiene
 - Dental technology
 - Denturism
 - Dietetics
 - Massage therapy
 - Midwifery
 - Naturopathic medicine
 - Nursing
 - Occupational therapy
 - Opticianry
 - Physical therapy
 - Psychology
 - Psychiatric nursing
 - Traditional Chinese medicine and acupuncture
 - Practical nursing
 - Audiology, hearing instrument dispensing and speech-language pathology
 - Chiropractic
 - Optometry
 - The practice of pharmacy
 - Dentistry
 - Medicine
 - Podiatric medicine
 - Clinical perfusion, respiratory therapy, radiation therapy and medical laboratory technology
- Other personnel
 - Policy makers
 - Researchers
 - Managers/leaders
 - Clerical staff
 - Administration (program/project coordinators)

- Non-medical support staff (e.g., Quality, IT support, Accounting, Communications, etc.)
- Maintenance support staff (e.g., Housekeeping, Security, facilities, etc.)

Online Survey of Learners Who Have Completed Series or Some Courses

Purpose

To assess how the course has changed course registrants' level of awareness and knowledge of gender-based violence among registrants who have completed the whole series or some courses of the Learning Series.

Logistics

- Checkbox (online survey platform, Checkbox.com) will be used to construct the survey and collect data
- Introduction will explain informed consent and privacy issues
- Invitations to be sent by email

Introduction (1st page of the online survey)

Thank you for taking 15 minutes to complete this survey. You are helping the BC Ministry of Health, BC Women's Hospital and Health Centre and the Perinatal Services BC to evaluate the effectiveness of the Gender-Based Violence: We All Can Help Improving the Health Sector's Response online training series.

<https://learninghub.phsa.ca/Courses/17362/gender-based-violence-we-all-can-help-improving-the-health-sectors-response>

This training series consist of four courses. You may have completed individual course or the whole curriculum of 4 courses.

Your participation in this survey is voluntary and anonymous. You can end the survey at any time or choose to skip questions. Your responses will be grouped with the responses from others and excerpts from your survey responses may be used in evaluation reports.

At the end of the survey you can click on a link to enter your name into a draw for a \$50 gift card. Please note that even if you do enter your name for the draw, your name will not be linked to your survey answers.

For more information about the survey or if you have any concerns, please contact Tatiana Popovitskaia – Project Manager at Perinatal Services BC.

Thank you for your participation!

Survey questions

1. How did you hear about the gender-based violence series/course? Choose all that apply:
 - E-mail
 - Website
 - Promotional material (e.g., post card, flyer, etc.)

- Conference or presentation
 - Webinar
 - Staff meeting
 - Newsletter
 - Manager or supervisor
 - Colleague
 - Social media
 - Other, please explain _____
2. Why did you decide to take the GBV series or course(s)?
- Interested in learning about GBV
 - Required for work
 - Recommended by friend or colleague
3. Which of the following courses have you completed (choose all that apply):
- Course 1 - Understanding GBV
 - Course 2 - Identifying GBV
 - Course 3 - Responding to GBV
 - Course 4 - Addressing the Impact of GBV
 - Don't recall
4. When did you complete your last course:
- Within the last month
 - About 3 months ago
 - About 6 months ago
 - About a year ago
 - Don't recall
5. What barriers or challenges did you encounter to complete the series or sections of the courses?
- Yes, please indicate which of the following barriers you experienced. Choose all that apply:
 - Lack of time
 - Technical issues with the Learning Hub
 - Problems in remembering my password
 - Problems accessing a computer
 - Lack of private space to go through the course
 - Language or content was hard to understand
 - Content was upsetting
 - The course did not provide enough information to support me in addressing GBV
 - My manager was not supportive of me taking the course
 - I did not find the content relevant to my job
 - I found the content too basic
 - Other, please explain:
 - No
6. What would make it easier for others in your workplace to take the course(s) or full series?

- Dedicated time during work hours
- A group session
- In-person workshop
- CME or professional development credits
- Compensation for time spent
- If the series was part of my personal learning plan
- Access to computer during work hours
- Private space during work time to complete the series
- Other, please explain:

- 7.** To what extent was the series our course relevant to your work?
- A great deal
 - Somewhat
 - Not very much
 - Not at all
 - Not sure
- 8.** To what extent did the series or course(s) increase your awareness of GBV?
- A great deal
 - Somewhat
 - Not very much
 - Not at all
 - Not sure
- 9.** To what extent did the series or course(s) increase your understanding and knowledge of GBV?
- A great deal
 - Somewhat
 - Not very much (what would further increase your knowledge and understanding?)
 - Not at all (what would further increase your knowledge and understanding?)
 - Not sure
- 10.** If you answered “not very much” or “not at all”, what would have increased your knowledge and understanding?
- 11.** After taking the series or course(s), how prepared do you feel to be able to identify GBV?
- Very prepared
 - Somewhat prepared (what would further prepare you? – fillable box)
 - Not at all prepared (what would further prepare you?)
 - Not sure
- 12.** If you answered “somewhat prepared” or “not at all prepared”, what would help you to feel more prepared?
- 13.** After taking the series or course(s), how confident do you feel in being able to respond to GBV?
- Very confident
 - Somewhat confident (what would further support you?)

- Not at all confident (what would further support you?)
 - Not able to assess
14. If you answered “not very confident” or “not at all confident”, what would help you to feel more prepared?
15. Since taking the series or course(s), have you been in a situation where you identified someone experiencing violence?
- Yes
 - To what extent did the information from the course help you?
 - A great deal (please describe how the course was helpful)
 - Somewhat (please describe how the course was helpful)
 - Not really (what would have supported you to identify or respond to the experience of violence?)
 - Not at all (what would have supported you to identify or respond to the experience of violence?)
 - Don't remember
 - How did you support the person?
 - No
16. Did you refer the person to VictimLinkBC/other support services?
- Yes
 - No
 - Don't recall
17. To what extent did the GBV course(s) help you in this instance?
18. If you answered “a great deal” or “somewhat” to Q15, please describe how the course was helpful
19. If you answered “not really” or “not at all to Q15, what would have helped you identify or respond to this experience of violence”?
20. Thinking about the series overall, is there any content missing you feel should have been included?
21. What else should have been included in the course?
22. Is there any other feedback you would like to share about the series/course(s)? Or GBV in the health system?

Demographic questions:

23. How old are you?
- 20 and under
 - 21 - 30
 - 31- 40
 - 41 - 50
 - 51 - 65
 - 66 and older
24. Do you identify as:
- Woman
 - Man
 - Transgender

- Gender Variant/non-conforming
 - Other_____
 - Prefer not to answer
- 25.** What is the highest level of education you have completed?
- Some high school
 - High school
 - College, university or technical school
 - Post graduate
- 26.** Which of the following best describes your employment field?
- Healthcare professional
 - Other employment
- 27.** If you answered “health professional”, do you work in any of the following areas?
- Maternity care
 - Mental health/ substance use
 - Emergency care and first responders
 - General practice
 - Other, please explain_____
- 28.** Which of the following best describes your job?
- Health professional
 - Dental hygiene
 - Dental technology
 - Denturism
 - Dietetics
 - Massage therapy
 - Midwifery
 - Naturopathic medicine
 - Nursing
 - Occupational therapy
 - Opticianry
 - Physical therapy
 - Psychology
 - Psychiatric nursing
 - Traditional Chinese medicine and acupuncture
 - Practical nursing
 - Audiology, hearing instrument dispensing and speech-language pathology
 - Chiropractic
 - Optometry
 - The practice of pharmacy
 - Dentistry
 - Medicine
 - Podiatric medicine
 - Clinical perfusion, respiratory therapy, radiation therapy and medical laboratory technology

- Other personnel
 - Policy makers
 - Researchers
 - Managers/leaders
 - Clerical staff
 - Administration (program/project coordinators)
 - Non-medical support staff (e.g., Quality, IT support, Accounting, Communications, etc.)
 - Maintenance support staff (e.g., Housekeeping, Security, facilities, etc.)

29. If you answered “other employment”, which of the following best describes your job?

- Administrative
- Clerical staff
- Maintenance and support staff
- Managers/leaders
- Non-medical support staff
- Policy maker
- Researcher
- Other, please explain_____

30. Which type of organization do you work for?

- Provincial government
- Health authority
- Education institution
- Regulatory body or college (e.g. college of physicians)
- Professional association
- Union
- Community-based organization
- Funding body or foundation
- Other, please explain_____

Are you willing to be interviewed further by phone?

If you would be willing to participate in a 15 minute phone interview to help us more fully understand the value of the course to you, please click here (*launch into a new survey to collect contact info, and let person know their survey response will not be linked to their contact info*).

Online Survey of People Who Haven't Registered for the Training Series or Have Registered but Have Not Completed Any Courses

Purpose

To identify barriers to their enrollment and strategies to improve reach among this group.

Logistics

- Checkbox will be used to construct the survey and collect data
- Introduction will include informed consent
- Invitations to be sent by email

Introduction (1st page of the online survey)

Thank you for taking 15 minutes to complete the survey. You are helping the BC Ministry of Health, BC Women's Hospital and Health Centre and the Perinatal Services BC to evaluate the effectiveness of the online "Gender Based Violence: We All Can Help – Improving the Health Sector Response" training series. This training series consist of four courses. We would like to hear from you whether or not you have taken any of the courses this curriculum.

The survey will take about 15 minutes to complete.

Your participation in this survey is voluntary and anonymous. You can end the survey at any time or choose to skip some questions. Your responses will be grouped with the responses from others and excerpts from your survey responses may be used in evaluation reports.

At the end of the survey you can click on a link to enter your name into a draw for \$50 gift card. Please note that even if you do enter your name for the draw, your name will not be linked to your survey answers.

For more information about the survey or if you have any concerns, please contact Tatiana Popovitskaia – Project Manager at Perinatal Services BC.

Thank you for your participation!

Survey questions

1. Did you know that there is an online series of four courses to help you understand and respond to gender-based violence?
 - Yes, I have registered for the series but have not yet been able to complete any courses (add in "how did you hear about it?" question)
 - Yes I am aware of the series but have not yet registered (add in "how did you hear about the series?" question)
 - No I was not aware of it, skip to question 3

2. What are (some of) the reason(s) that you have not registered or did not complete any of the courses? [Select all that apply?]
- Lack of interest
 - The series did not seem relevant to me or my work
 - I prefer in-person training
 - Lack of time
 - Technical issues with the Learning Hub
 - Could not remember my Learning Hub password
 - My manager was not supportive of me taking the series
 - I have problems accessing a computer
 - I lacked private space to take the course
 - The content would have been upsetting to me
 - Other, please explain:
3. What would support you to take the series?
- Dedicated time during work hours to complete the series
 - A group session where we had the opportunity to talk about the course
 - An in-person workshop
 - CME or professional development course credit
 - If the course was put into my personal learning plan
 - Compensation for time spent taking the course
 - Access to a computer during work time
 - Private space during work time
 - Other
4. Is there anything else you would like to share about the GBV series?

Demographic questions:

5. How old are you?
- 20 and under
 - 21 - 30
 - 31- 40
 - 41 - 50
 - 51 - 65
 - 66 and older
6. Do you identify as:
- Woman
 - Man
 - Transgender
 - Gender Variant/non-conforming
 - Other_____
 - Prefer not to answer
7. What is the highest level of education you have completed?
- Some high school
 - High school

- College, university or technical school
- Post graduate
- 8. Which of the following best describes your employment field?
 - Healthcare professional
 - Other employment
- 9. Which of the following best describes your job?
 - Health professional
 - Dental hygiene
 - Dental technology
 - Denturism
 - Dietetics
 - Massage therapy
 - Midwifery
 - Naturopathic medicine
 - Nursing
 - Occupational therapy
 - Opticianry
 - Physical therapy
 - Psychology
 - Psychiatric nursing
 - Traditional Chinese medicine and acupuncture
 - Practical nursing
 - Audiology, hearing instrument dispensing and speech-language pathology
 - Chiropractic
 - Optometry
 - The practice of pharmacy
 - Dentistry
 - Medicine
 - Podiatric medicine
 - Clinical perfusion, respiratory therapy, radiation therapy and medical laboratory technology
 - Other personnel
 - Policy makers
 - Researchers
 - Managers/leaders
 - Clerical staff
 - Administration (program/project coordinators)
 - Non-medical support staff (e.g., Quality, IT support, Accounting, Communications, etc.)
 - Maintenance support staff (e.g., Housekeeping, Security, facilities, etc.)

10. If you answered “health professional”, do you work in any of the following areas?

- Maternity care
- Mental health/ substance use
- Emergency care and first responders
- General practice
- Other, please explain _____

11. If you answered “other employment”, which of the following best describes your job?

- Administrative
- Clerical staff
- Maintenance and support staff
- Managers/leaders
- Non-medical support staff
- Policy maker
- Researcher
- Other, please explain _____

12. Which type of organization do you work for?

- Provincial government
- Health authority
- Education institution
- Regulatory body or college (e.g. college of physicians)
- Professional association
- Union
- Community-based organization
- Funding body or foundation
- Other, please explain _____

Are you willing to be interviewed further by phone?

If you would be willing to participate in a 15 minute phone interview to help us more fully understand the value of the course to you, please click here (*launch into a new survey to collect contact info, and let person know their survey response will not be linked to their contact info*).

Interview and Focus Group Questions with Learners Who Have Completed the Series or One or More Courses

Purpose

To understand the impact of the series on registrants who have completed series or some courses of the Training Series

Logistics

- Small group between 6-10 participants
- Duration about 45 min
- 1 main interviewer, 1 note taker, 1 observer

Introduction

Thank you for agreeing to speak with me today. We are evaluating the Gender-Based Violence: We All Can Help Improving the Health Sector's Response online training series course and are looking for ways to better promote the course in the future. We are hoping to learn from your experience with this course.

This course was collaboration between the BC Ministry of Health, BC Women's Hospital + Health Centre, and the Ending Violence Association of BC. Its purpose is to increase the awareness of and response to gender-based violence (GBV) across the BC health system workforce. This online series is designed for anyone who works in the health sector. It teaches skills and techniques for responding to disclosures of gender-based violence, and addressing the impacts of vicarious trauma, which may arise for some health workers.

This year, the BC Ministry of Health has contracted BC Women's Hospital + Health Centre and Perinatal Services BC to conduct an evaluation of the effectiveness of the online Gender-Based Violence training series courses. The goal of our evaluation is to assess the quality and effectiveness of the course and identify opportunities to expand the reach and uptake of the course. Your input will assist us with ongoing quality improvement. Your input will assist us with ongoing quality improvement.

I am going to ask you a series of questions so I can understand how you view this series and what might further support employees like yourself in taking the series.

With your permission, I would like to record our conversation which should last about 45 minutes. Only the transcriptionist and I will listen to the recording and then it will be erased. We will produce a written transcript or notes of our conversation. The information you provide will be collated with the responses from others and included in one or more evaluation reports. In reporting the results of the survey we will not include any individually identifiable responses.

I want to remind you that you may choose not to answer specific questions and you can end the interview at any point. Would you still like to proceed?

Mention:

- Keeping what is said confidential and not disclosing what was said (for focus group)
- Compensation
- What to do if the conversation brings up uncomfortable feelings.

Main questions

1. What motivated you to take the course(s) or series?
2. Which of the courses have you completed? (list courses for person)
3. How helpful was the course or series in helping you understand gender-based violence (GBV)?
4. How helpful was the course or series in helping you know how to respond to GBV?
5. What impact did the course(s) have on you?
6. Since taking the series or course(s), have you been in a situation where the experience of gender-based violence was identified?
 - a. To what extent did the course help you in this situation?
 - b. How did you support the person?
 - c. If you had not taken the courses, how do you think you would have responded?
7. How can the series or courses be improved?
8. What is missing from the series?
9. What would support others in taking the course(s)?
10. What prevents others from taking the course?
11. What would further support you in responding to GBV?
12. Is there anything else you would like to share about the series/courses or its impact on you?

Interview and Focus Group Questions of People who have not registered for series or courses or were not able to complete courses

Purpose

To assess how the course has changed course registrants' who have completed series or some courses of the Training Series level of awareness and knowledge of gender-based violence.

Logistics

- Small group of between 6-10 participants
- Duration about 30 min
- 1 main interviewer, 1 note taker, 1 observer

Introduction

Thank you for agreeing to speak with me today. We are evaluating the Gender-Based Violence: We All Can Help Improving the Health Sector's Response online training series course and are looking for ways to better promote the course in the future.

This course was collaboration between the BC Ministry of Health, BC Women's Hospital + Health Centre, and the Ending Violence Association of BC. Its purpose is to increase the awareness of and response to gender-based violence (GBV) across the BC health system workforce. This online series is designed for anyone who works in the health sector. It teaches skills and techniques for responding to disclosures of gender-based violence, and addressing the impacts of vicarious trauma, which may arise for some health workers.

This year, the BC Ministry of Health has contracted BC Women's Hospital + Health Centre and Perinatal Services BC to conduct an evaluation of the effectiveness of the online Gender-Based Violence courses. The goal of our evaluation is to assess the quality and effectiveness of the course and identify opportunities to expand the reach and uptake of the course. Your input will assist us with ongoing quality improvement. Your input will assist us with ongoing quality improvement.

I am going to ask you a series of questions so I can understand how you view this series and what might further support employees like yourself in taking the series.

With your permission, I would like to record our conversation, which should last about 20 minutes. Only the transcriptionist and I will listen to the recording and then it will be erased. We will produce a written transcript of our conversation. The information you provide will be added to the responses of others. Anything from our conversation that is included in evaluation reports will be presented so that it cannot be traced back to you. As we go through the interview, please let me know if there are any questions you would

prefer not to answer. You are also free to end this interview at any time, for any reason. Would you still like to proceed?

Mention:

- Keeping what is said confidential and not disclosing what was said in this focus group.
- Compensation
- What to do if the conversation brings up any uncomfortable feelings.

Main questions

1. Do you think people working in the health care system should be aware of gender-based violence (GBV) and know how to respond?
2. Did you know that there is a series of 4 one hour online courses on GBV?
 - a. If knew about course: What has stopped you from taking the GBV series or completing the courses?
 - b. If did not know, would you be interested in taking the series?
3. What would support you in taking the series?
4. What would make it easier for others in your workplace to take the series?
5. Have you ever been in a situation where the experience of violence was identified?

If yes,

- a. How did you deal with this?
 - b. What would have supported you?
6. Is there anything else you would like to share about responding to GBV?

Appendix C. Inductive coding scheme

Code – overarching category	Sub-code		Code definition
1	1.1	Promotion – organizations reached	Real organizations like PHSA, Island Health
	1.2	Promotion – costs	Human and financial costs associated with course promotion
	1.3	Promotion – audience targeted	Public health nurses, nurse educators etc.
	1.4	Promotion – effectiveness of promotional strategies for our GBV course	Result of promotional strategies (i.e. low effectiveness because they did not click the link) – both positive and negative
	1.5	Promotion – strategies/activities that they have done to promote our GBV course	- events used by BC Women’s Hospital, partners -# of course champions in executive level -ie: verbally, including in orientation package -motivation, reminders
2		Course champions	Existence, effectiveness, numbers, champion positions, who they are, looking at each organization by sector and time, future champions and suggested within their organization
3		Course sustainability	What is needed to be done to sustainably embed this course into health system?
4		Barriers to taking the course for learners	Apathy, do not think its relevant, re-traumatized, time, unsure of what GBV is, not for my population, workers only do what is mandatory
5		External enablers + supports for taking the course for learners	time, physical space, financial reimbursement, CMA credits, professional development, reminders from supervisor, ease of login
6		Potential promotional partners	Any time they mention someone we should contact

7		Resources needed to support uptake	health system/institutional level. If looking at course barriers: lack paid time, ministry hasn't made this a priority so we can't make it a priority, policy directive, priority setting, CMA credits, cost to print poster What is needed from the system – getting schools involved, requirement of each employee to work, high level policy support,
8	8.1	Content -awareness	Awareness of GBV
	8.2	Content - knowledge	Knowledge of tools (LIVES, Victimlink BC) Knowledge of how to identify GBV
	8.3	Content - confidence	Confidence responding to GBV
	8.4	Content - practicality/application of course	How to respond to GBV
	8.5	Content -development	Anything with content development
9	9.1	Practice change -recognizing signs of GBV	Being able to recognize signs of GBV
	9.2	Practice change-responding to signs of GBV	Being able to respond to signs of GBV
	9.3	Practice change – barriers specifically to practice change	Barriers from changing their practice
10		VictimLink BC	Any talk of Victimlink BC
11	11.1	Positive aspect of course – high quality	
	11.2	Positive aspect of course – good design	
	11.3	Positive aspect – high relevance	
12	12.1	Problems and suggested improvements on online delivery mechanism of course	Improvements on learning hub, technical issues, accessibility issues, troubles logging in
	12.2	Problems and suggested improvements on course content	Content improvements ie. lack of Indigenous and LGBTQ2S representation
13		Discussion on learners feelings on course	

14		Internal self-motivation to take the course (self-identified)	Internal drive, seeing as relevant to their own practice.
15	15.1	Promotion of similar online course– organizations reached	
	15.2	Promotion of similar online course –costs	
	15.3	Promotion of similar online course – audience targeted	
	15.4	Promotion of similar online course – effectiveness of their promotional strategies	
	15.5	Promotion of similar online course – strategies/activities	