



Technical Report

Evaluation of Wraparound Services for Women from Immigrant, Refugee, Ethnocultural and Racialized Communities Facing Gender-Based Violence

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- COSTI Domestic Violence Services, Toronto
- La Maison Toronto, Scarborough
- Safe Centre of Peel (SCOP), Brampton
- Settlement Assistance and Family Support Services (SAFSS), Scarborough
- York Region Centre for Community Safety (YRCCS), Newmarket

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Purpose of this document

This paper is a technical report accompanying the Summary Report (Kerr et al., 2023) and Program Blueprint (Dinshaw, In preparation) for a project titled, “Evaluation of Wraparound Services for Immigrant, Refugee, Non-Status and Ethnocultural Women Facing Gender-Based Violence”. It provides details and supplementary materials to the summary report for purposes of readers who want more technical information than could be included in the main report. It also includes most of the content of the Summary Report.

Project overview

Background

The GBV Community Research Project was a four-year research and evaluation initiative, managed by COSTI and funded by Women and Gender Equality Canada (WAGE). The project aimed to develop a set of program blueprints for culturally appropriate, coordinated, evidence-based promising practices to support GBV survivors from racialized and newcomer communities. These program blueprints, which comprise detailed descriptions and resources that enable organizations to implement the program model, will be submitted to WAGE for dissemination across Canada.

The project involved five community-based agencies in the Greater Toronto area, all of which provide multiple services to women affected by violence from family members or intimate partners. The period of the project was from mid-2019 to September 2023.

The original intent of the project was to compare the effectiveness of two models of service delivery. One model, represented by COSTI, offers integrated services within a single organization. The second model, represented by four other agencies, links several different organizations together via formal co-location and referral partnerships. Both models addressed the initial stages of service delivery, from initial screening and intake to assessment, safety planning, referral and system navigation.

During the past two years, it became evident that the project was dealing with only one program model, not two. The differences between the two original program models were found to be minor. They were combined into one overall program model that will be described in one program blueprint.

Project objectives

The project had three sets of outcomes:

- **Service outcomes:** High quality, evidence-based and accessible services that are culturally appropriate and result in client satisfaction.
- **GBV survivor outcomes:** Increased safety-related empowerment and a reduction in risk through knowledge, skills and a greater understanding of GBV issues among survivors, their families and networks.
- **System outcomes:** Adoption of the project’s evidence-based program model by organizations across Canada, resulting in improved services and outcomes for GBV survivors.

A key component of the project was a community-based research design that engaged service-providing agencies and GBV survivors (in a participatory researcher role) in designing the data collection instruments, defining the program model and leading the research project. Both

service providers and participatory researchers were paid for their involvement, to reduce barriers and recognize their vital contributions.

The project addressed existing inequities in the service system by:

- Engaging GBV service providers and GBV survivors in designing the program model, refining data collection tools and providing governance to the overall project;
- Designing the program model based on principles of equity and empowerment, focusing on barriers faced by racialized and newcomer women in Canada, while incorporating other social determinants of health such as lack of transportation, low income, disabilities and preferred language;
- Incorporating a community consultation process to assess emerging findings and make changes to the analytic framework based on feedback;
- Enabling continuous improvement based on feedback from GBV survivors, collected via several channels to ensure accessibility.

Participating partners

Five organizations (also called ‘hubs’) were engaged in co-designing and implementing the project. All hubs provide direct services to GBV survivors within the Greater Toronto Area. Three hubs (COSTI, La Maison and SAFSS) are single organizations that provide multiple services. Three hubs are formal networks of partnering organizations that provide coordinated services in a single location. All of them provide intake, information, safety, short term counselling and referral services to women affected by violence, as well as other services (housing, shelter, legal counsel), depending on their resources.

COSTI, as well as being one of the hubs, acted as overall project administrator and disbursed funds to the hubs for project implementation. Each hub provided in-kind support from senior management involved in the governance of the project, along with paid support from ‘hub champions’ funded by the project. The hubs are:

- COSTI (administrative lead), Toronto
- Settlement Assistance and Family Support Services (SAFSS), Scarborough
- Safe Centre of Peel (SCOP), Brampton
- York Region Centre for Community Safety (YRCCS), Newmarket.
- La Maison Toronto, Scarborough

See the Supplementary materials section for demographic information about the population served at each hub.

Program model

This project studied promising practices that are based on Coordinated Community Response (CCR) models, in which a bundle of services for GBV survivors and their families is provided in one location. Coordinated Community Response models have been demonstrated to be effective in responding to GBV (Klevens, Baker, Shelley, & Ingram, 2008; Robinson, 2006), and could be described as a promising practice. See *Supplementary materials: Relevant program models* for more details.

The CCR variants investigated in this project were the Family Justice Center (FJC) model, COSTI’s single agency model, and La Maison’s support services related to a 20-bed domestic violence shelter.

The Family Justice Center (FJC) model was first developed in the early 2000s, designed as a refinement of CCRs, and has been adopted worldwide – more than 100 now in operation,

depending on the definition of the model (Abt Associates, 2018; Simmons, Howell, Duke, & Beck, 2016). According to a recent environmental scan of FJC's in the U.S., four elements define the model: co-location, multi-agency; multi-disciplinary, and targeting provision of services to adult survivors of family violence and their families (Abt Associates, 2018).

COSTI's Violence Against Women services emerged out of COSTI's role as a multi-service agency for immigrants and refugees throughout the Toronto area. Leveraging COSTI's comprehensive array of services, including job search assistance, housing support, settlement assistance and more, the Family and Mental Health Services Centre under COSTI's umbrella adopted a mandate to assist women impacted by domestic violence.

La Maison Toronto, as a shelter for francophone women located in Scarborough since its inception, was obliged to provide a range of services to women affected by violence because of the lack of francophone services in the area.

All five hubs are funded by the Ontario Ministry of Children, Community and Social Services Violence Against Women (VAW) program that supports agencies to help women and their children live free of domestic violence. All of the hubs were therefore required to administer a client satisfaction survey, which included questions related to age group, region, satisfaction with services received and satisfaction with wait times¹.

Evaluation Approach

This evaluation project was designed as a systems-change intervention. Data was reported to stakeholders throughout all the phases of the project to inform and change practice, and to provide accountability to GBV survivors and partners.

The project design was based on implementation science, which concerns the translation of evidence-based practices to real-life implementation in different community contexts. This translation process is well-defined and occurs in discernable stages which often take two to four years before the evidence-based practice is fully implemented (Fixsen et al., 2005). It explicitly addresses sustainability from the first stage, in that implementation drivers like funding, policies, feasibility, training etc. are assessed and developed throughout the process.

The evaluation took a realist approach, drawing on realist tenets about the nature of reality and how causation works². A realist evaluation starts by articulating a program's theory of change – the underlying causal mechanisms by which a program creates change – then explores how those mechanisms work under specific conditions. What distinguishes realist evaluation from other theory-based evaluation approaches is its emphasis on context. It frames social service programs as sets of mechanisms interacting with contextual factors to make change: mechanism + context = outcomes. In order to fully understand a program and assess its outcomes, the evaluator must identify the program's theory, explore the environment within which the program is implemented, and ask not just whether the program works, but how and why it works, for whom, to what extent, under what circumstances, and for what duration³.

This focus on understanding how, under what conditions and for whom programs work, makes for a good fit with the research design selected for this project, which used an implementation science approach to define, implement, improve and document evidence-based practices across five locations. By directing attention to the environmental factors that inform program outcomes, a realist evaluation can identify the conditions under which the program blueprints may plausibly

¹ From [Violence Against Women \(VAW\) client satisfaction survey data - Datasets - Ontario Data Catalogue](#)

² (Pawson & Tilley, 1997)

³ (Westthorp, 2014)

be adopted and stipulate the environmental factors required for success. Finally, its emphasis on inter-group comparisons aligns realist evaluation with gender-based analysis+ (GBA+)⁴.

For example, this project was designed as a community research project from its inception. The governance and feedback processes were designed to engage service providers, service recipients and members of the racialized and newcomer communities served by the hub organizations.

Each hub developed its own strategy for engaging GBV survivors as paid participatory researchers, who provided input into data collection tool design, recommendations for program model development and feedback on draft reports. Participatory researchers engaged directly in research by conducting structured interpersonal interviews with survivors who are receiving services at the hubs.

The feedback and engagement mechanisms, including frequent contact between the COSTI project manager and hubs and client suggestion polls, were designed to lead to service improvements at the hub organizations, as well as improvements in the management of the project.

Evaluation Methodology

Data collection techniques included literature review, qualitative interviews, surveys, process analysis, focus group sessions, and the development of a program quality checklist.

Population and sample

The target population comprised racialized and newcomer women (immigrant, refugee and non-status) who were receiving GBV support services from the five hub partners. Most of these women encounter various challenges including low income, insecure housing (if they are attempting to leave their current living situation), legal issues and/or childcare.

The sampling methodology varied between hub organizations and data collection tools. Some hub organizations attempted to collect data from every client during the study period, while others planned to use a convenience sample. By 2022 it became evident that none of the hubs were able to collect data from every client for various reasons, so the methodology was a convenience sample based on the feasibility of asking clients to spend time responding to data collection in the context of the available time and whether they were in crisis.

The study collected data directly from service recipients via telephone and face-to-face interviews and self-administered online and paper surveys. Additional data regarding the type and quality of services delivered to recipients was gathered via process analysis and regular interviews with hub staff.

Demographic questions on the main data collection instrument included immigrant status, race, age and gender identity, and the analysis included those variables. The study did not specify sample sizes from demographic segments.

Service recipients in crisis were not asked to participate in the study because they were not able to give informed consent. This decision had implications for the study's inclusivity, as it could have resulted in the exclusion of a particularly vulnerable segment of the research population.

⁴ GBA+ is an analytical process for assessing how diverse groups of people may experience policies, programs and initiatives. The GBV Community Research Project incorporates GBA+ in each of its stages, in keeping with WAGE requirements.

Many service recipients who initially presented as in-crisis were asked to participate in the research during a repeat visit, when the crisis had passed.

Data collection tools

The project used several tested data collection instruments approved by hub partners. Data collection activities were managed by project staff and mostly conducted by service providers in each of the project partner agencies.

All data collection tools were provided in both French and English, including staff interview protocols. Data collection instruments filled out by clients were available in twelve languages: French, English, Arabic, Bengali, Gujarati, Hindi, Italian, Persian, Punjabi, Spanish, Tamil and Urdu, except for the Suggestion Poll, which did not include Italian. They were designed to be mobile responsive (readable on small phone screens) but could also be distributed in paper format.

The instruments are described in Supplementary Materials below. In summary, they were:

1. **Program Quality Checklist:** The checklist, developed and revised over the first year of the project with the contribution of the evaluation team, hub champions, management advisory members and the COSTI project manager, captured program fidelity for the program model. It was used to clarify and define the important elements of practice, and then to allow each partner organization to rate themselves on those elements. The checklist was based on a literature review of effective and responsive services in domestic and intimate partner violence, interviews with partner organizations, and a detailed process analysis of each organization to assess how their services are carried out. The checklist was administered to each hub partner in summer of 2021 to establish a baseline and was re-administered near the end of the project, in summer of 2023.
2. **Measure of Victim Empowerment Related to Safety (MOVERS):** This was the main outcome measure for the project. 'MOVERS' assesses change in individual survivors over time and is designed as a clinical tool to build safety empowerment in survivors during sessions, as well as act as an evaluation metric (Goodman et al., 2015). The project selected MOVERS because of its potential as an organizational intervention, to build partners' capacity to deliver services correctly and to respond to client feedback.

There are two versions of the MOVERS scale. One is a paper or online version to show to clients during administration by staff and was available in 12 languages. The other is a spreadsheet version filled out by the service provider in the context of services. In both cases, demographic information was linked to the participant only if the participant signed an informed consent form. Pre-post administrations were connected by a non-semantic client code generated by the data collection tool. No names or personal identification were linked to the data.

3. **Client Feedback Survey:** Early in the project we planned to distribute a client survey incorporating the Inclusivity scale of the Trauma informed Practice Scale (TIPS) (Sullivan & Goodman, n.d.) plus the Survivor Defined Practice Scale (Goodman et al., 2016) plus an overall satisfaction question. This instrument, initially approved by the advisory group, was found to be a confusing duplication of the existing Client Satisfaction Survey mandated by the Ontario Violence Against Women program. Both staff and clients raised concerns about the overlap, prompting the project advisory committee to opt for the removal of this tool.
4. **Suggestion Poll:** A three-question poll developed by LogicalOutcomes using a sense-making approach. Respondents were invited to make one suggestion, then asked to categorize it and rate its importance. The poll could be administered via an online survey, or in a quick interview.

5. **Impact Interview:** An interview protocol developed by LogicalOutcomes incorporating the ‘Most Significant Change’ technique and a suggestion poll. This qualitative interview aimed at identifying the active components of the services from the perspective of clients. Interviews were done by hub staff or students.
6. **Staff interviews and process analysis:** Throughout the project the evaluation team carried out many interviews with each hub, separately. Initially the interviews focused on defining the program model and process (see Supplementary materials: Process flow diagrams). Once data collection began, monthly interviews were conducted to assess the progress of data collection and to troubleshoot issues (see Supplementary materials: Data collection tools). In the later stages of the project, the interviews shifted focused on exploring the impact of the data on service delivery and on identifying lessons from the project.

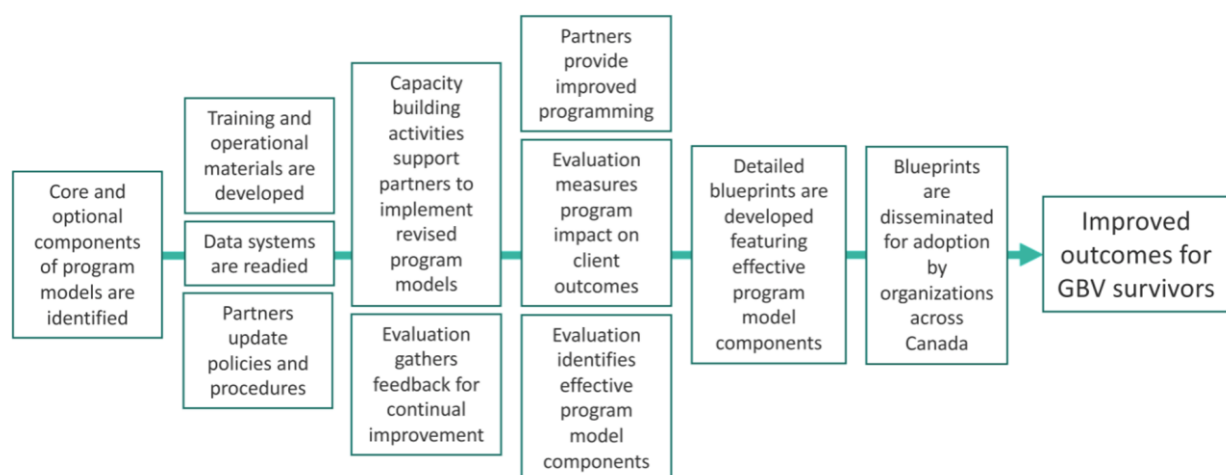
Key activities

Over the course of the project, COSTI’s project management team worked with the LogicalOutcomes evaluators and project partners to:

1. Define the core components of each partner’s program model
2. Review, refine, and revise (where necessary) each component
3. Develop training materials and a coaching strategy to support the implementation of revised program model components
4. Implement the revised components, aiming for harmonization of program components across partner agencies
5. Obtain an ethical review from the Community Research Ethics Office (CREO)
6. Conduct a two-year evaluation of the revised program models, in which data-based feedback is used for continual program improvement
7. Produce a final evaluation report, with recommendations derived from analysis of process and outcomes data
8. Develop, review and finalize program model blueprints, to be shared with WAGE for dissemination across Canada.

There was a significant overlap between project management activities and evaluation activities. The evaluation expended its scope in defining program components while reducing some of the data collection activities.

The integrated workplan, incorporating project management and evaluation planning, is summarized below:



Evaluation Questions

The project used multiple lines of investigation to pursue the following evaluation questions:

1. To what extent have GBV survivors been involved in the design and implementation of the program model(s)? How many survivors from each key population group participated in planning, implementation and evaluation activities? In what ways did they influence the project?
2. To what extent has the overall project achieved its planned results?
3. What are the core components of the program model(s), and to what extent are each of them supported by theory and evidence?
4. To what extent were the program models implemented correctly (based on program fidelity measures)?
5. To what extent did the programs meet the needs of GBV survivors and their communities? How did outcomes differ between hubs and among key population groups, and why?
6. What lessons were learned from project implementation?
7. What is the potential of the program models to be replicated elsewhere in Canada?
8. How are the program models and their effects sustainable?
9. Do either of the program models have the potential to become a best practice (based on criteria endorsed by WAGE) and if so, what would be the next step?

Results

Program model definition

We carried out a scan of the literature regarding support services for GBV survivors from racialized and newcomer communities. We then narrowed down the scope of the program model in a series of discussions with hub partners, using an online ‘post-it’ notebord on LucidChart.

We started by identifying the values frameworks underlying GBV services provided by the hubs, including anti-oppressive and anti-racist, feminism, harm reduction, healthy families and more (see Figure 1 below). Given the complexity and intersectionality of the women served by these agencies, we used this approach to ensure that potentially conflicting values were being acknowledged and incorporated into the project.

We then identified the main program models that emerged from the literature review and from discussions with the hub partners, including information and referral, counselling, settlement services and so on (Figure 1).

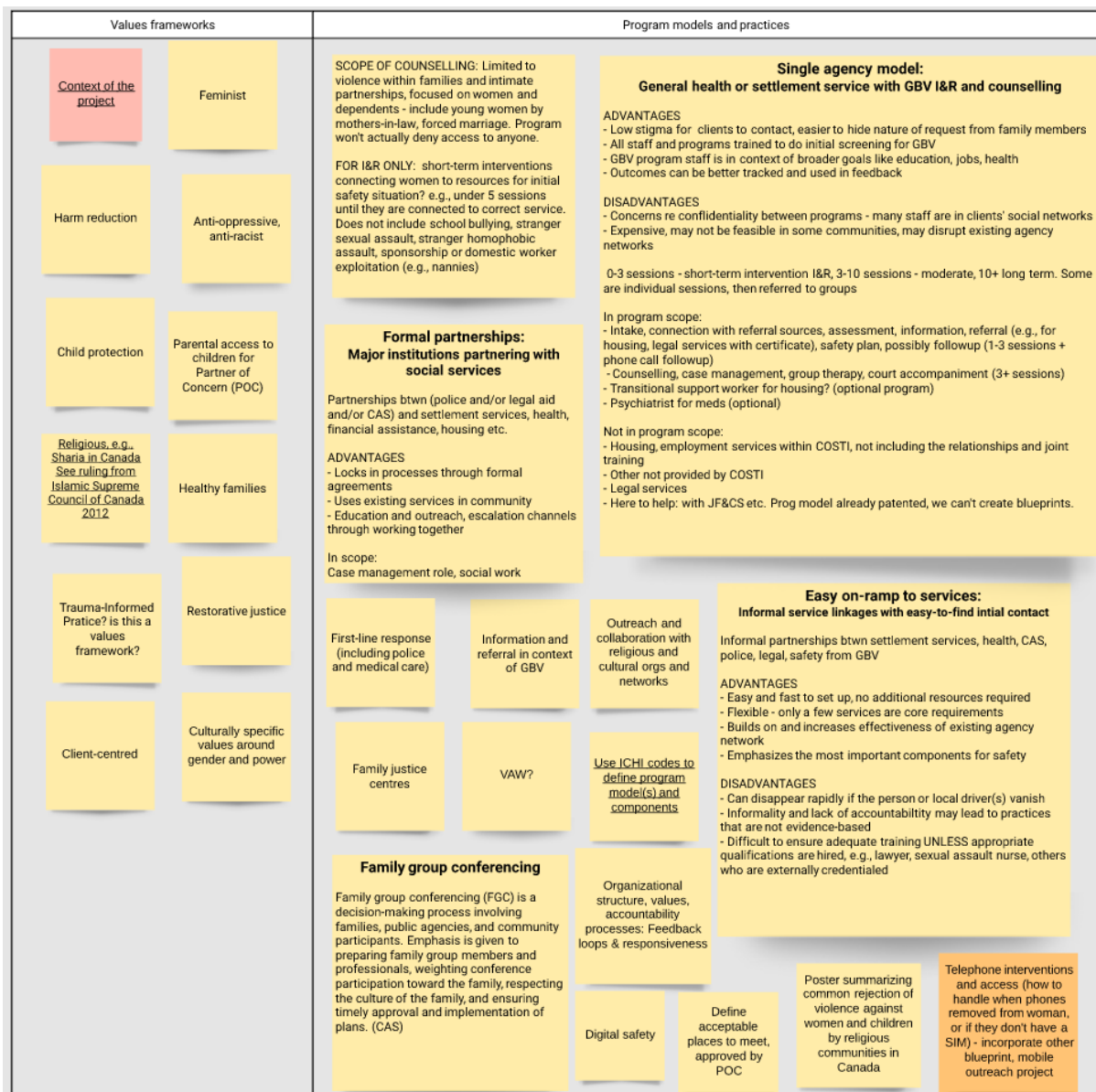


Figure 1: Values frameworks and program models for GBV project

The project partners are strongly influenced by the Ontario Collaborative Response to Family Violence (OCRF) which was formed as a variant of the Family Justice Center model. The OCRF comprises six hubs that bring together a total of 106 coordinated agencies. An environmental scan in 2016 (Bergen & Singh, 2016) itemized the services sought and received at each of the OCRFV hubs as follows:

1. Crisis intervention
 - Early police services
 - Early victim services
 - Domestic violence early services
2. Intervention and supports
 - Assessment
 - Child protective services

- Child welfare
 - Employment services
 - Financial assistance
 - Housing
 - Legal Aid and Services
 - Mental health/Addictions
 - Settlement and immigration services
 - Sexual Assault and Rape Services
 - Youth Services
 - Additional services
3. Prevention
- Community education
 - Violence
4. Universal supports
- Food and clothing
 - Parent education
 - Support groups
 - Additional services

The participating hubs in this project provide some but not necessarily all these services and not all of these services are co-located in one place. All hubs coordinate some services through formal referral relationships characterized by active referrals (often called ‘warm transfers’).

We then collectively narrowed the scope of the program model for this project as follows:

Outcomes – Safety, health and well-being for survivors of domestic or intimate partner violence and their children. The emphasis of the program model is on addressing immediate safety risks including violence, legal and financial jeopardy, homelessness and mental health crises.

Community served – Women affected by or at risk for violence in their homes or from members of their family or intimate partners, AND who are racialized or are newcomers to Canada. Other groups are served by the partner organizations and will benefit from the model, but this program model focuses on the needs of the defined target group. Notably, the model does not explicitly address people identifying as transgender or non-binary, nor does it cover violence occurring in educational or occupational settings.

Program activities – A Coordinated Community Response model comprising:

- Screening for domestic violence among all women requesting services from the sponsoring organizations
- Assessment of the woman’s risk and resources
- Safety planning
- Education regarding relevant resources and options in dealing with violence

- Referral to appropriate services including police, legal, settlement, Children’s Aid and the other services identified in the OCRF intervention and supports list above, including related case coordination and follow-up
- Provision of counselling or mental health services

The program model as defined in this project does not include the provision of services related to housing, finance, legal and so on, though individual hub partners may offer those services.

The core processes and sub-processes that comprise the program model are described in the Supplementary Materials section below (see Figure 2 for the overview of the process flow).

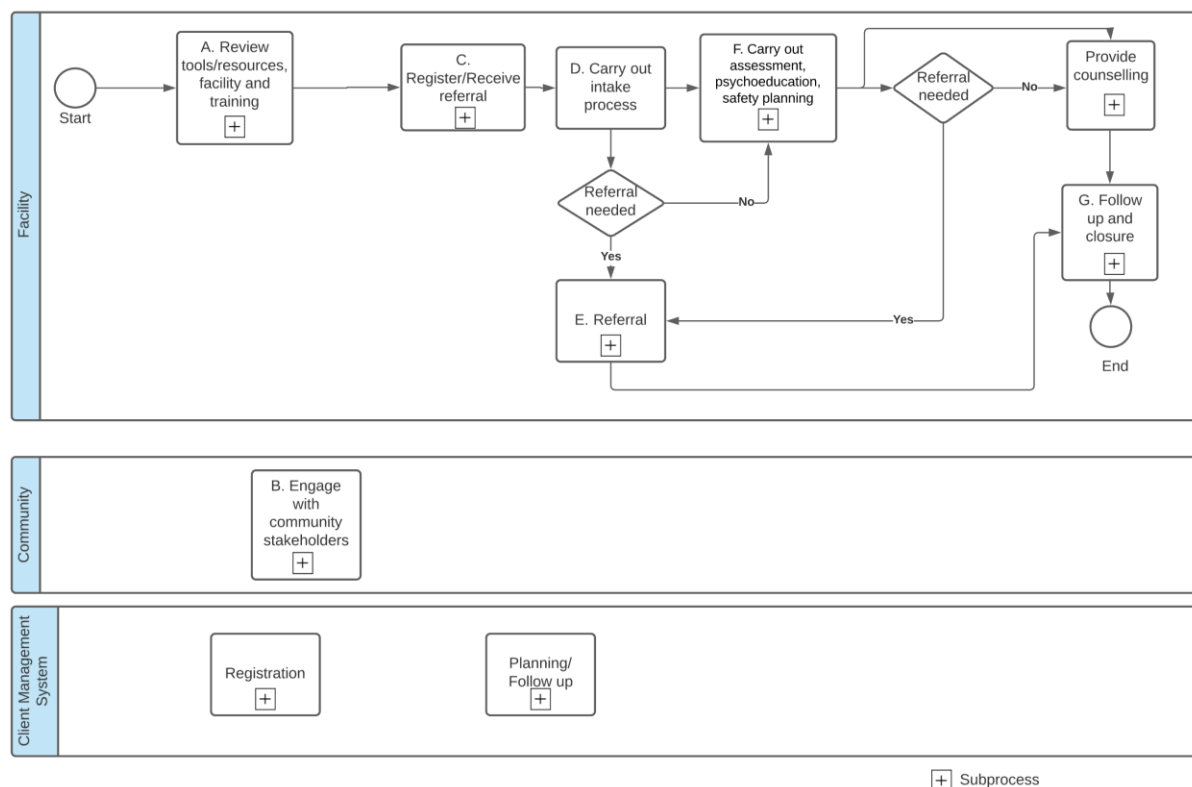


Figure 2: Process overview

The literature review was updated based on the results of the Program Quality Checklist and will be summarized in the final report, linked to the components that have been found to be effective, including:

- Outreach and community education
- Accessible and culturally appropriate settings and resources
- Staff training and protocols regarding screening, assessment and safety planning
- Trauma-informed and survivor-defined practice
- Collaborations and referral relationships with a defined set of services and agencies
- Active referral processes (‘warm transfers’) that ensure clients are accepted by the receiving services

For details on these practices, see the Program Quality Checklist in the Supplementary Materials section.

Engagement with survivors

One of the evaluation questions was, “To what extent have GBV survivors been involved in the design and implementation of the program model?” The original project plan included many channels of input from survivors throughout the project:

- **Participatory researchers:** One or more participatory researchers was recruited by each hub, aiming for women from racialized and/or newcomer communities who had experienced violence, to provide guidance on program design and implementation. Participatory researcher guidelines were developed (including eligibility criteria), incorporating feedback from the ethical review provided by the Community Research Ethics Office and shared with all hubs in 2020 and 2021. Hubs recruited a total of six participatory researchers (two from COSTI and one each from the others) all of whom were former clients of participating hubs who were newcomers and/or racialized. Hubs engaged them to provide feedback on program quality checklist and draft data collection tools in 2020-2021, paying them \$30/hour for their participation. Their feedback was then incorporated into the program design and data collection tools.

None of the hubs was able to maintain participatory researcher involvement beyond the initial phase of the project. Either the researcher did not respond to requests for input, or they dropped out early in the project. The challenges of recruiting and engaging with researchers from communities of interest, even when paying for their participation, in the context of the pandemic, proved unfeasible. As a replacement, the project team conducted a series of focus groups sessions as a substitute.

- **Focus group sessions:** In mid-2022, the COSTI project team, in collaboration with WomanACT, carried out six focus group sessions with a total of 27 women experiencing domestic and intimate partner violence to engage survivors in program model design (Ahmed & Dinshaw, 2023). Participants were recruited to ensure representation from women with disabilities (n=8), women identifying as LGBTQ+ (n=3), senior women (n=2) and francophone women (n=7). The focus groups also included six refugees, 11 women with children and seven women who immigrated to Canada under spousal sponsorship. The results were incorporated into the development of the program blueprint.
- **Mid-term interviews:** Three participatory researchers were interviewed by Dorothy Nyambi of LogicalOutcomes in May/June 2021 to gather feedback on their experience with the project. The results were incorporated into recommendations for improved project communications between the hubs.
- **Project updates:** The COSTI project manager collected bi-monthly project updates from hub champions, including engagement with participatory researchers.

Program fidelity

The Program Quality Checklist (see Supplementary materials for full checklist) was completed by all hub partners in a series of interviews between July 26 and September 9, 2021. The hub champion and sometimes another staff from each partner-hub, met with a senior evaluator (Gillian Kerr or Dorothy Nyambi), taking one or two sessions to fill the checklist. Each hub champion had seen (and generally contributed to) multiple versions of the checklist over the previous months during its development and the most recent version was shared with them before the interview.

In the 2021 interviews, we found areas of broad consensus and other areas requiring further clarification but overall, hubs reported close alignment with the program model design as defined by hub partners. The total number of responses for each broad category is shown below (total respondents were five hubs). There are a few instances where a respondent selected two options and they have been counted.

The program quality checklist was reviewed at the end of the project in collaboration with each hub. Farishta Dinshaw, the resource developer from COSTI, attended the interviews. Items lacking ample support from agencies were excluded from the program blueprint. For example, screening and referrals pertaining to traumatic brain injury are currently not part of the program model during the implementation phase. Notably, the concept of 'Case Closure' was not explicitly outlined within the program model. Agencies implemented case closures in accordance with their respective funders' requirements or organizational procedures. From the perspective of the GBV program model, it was important that clients to have the flexibility to return as needed, accommodating changes in their circumstances, without their cases being prematurely closed.

Capacity					
	<i>Yes and it is mandatory if using this program model</i>	<i>Yes and it is strongly recommended if at all possible</i>	<i>No, but we plan to implement it in next year because it is mandatory</i>	<i>No, it is either nonapplicable or unfeasible for us</i>	<i>Don't know</i>
Where & how services delivered (accessibility) (22 items)	81	19	9	10	2
Trained & qualified staff (8 items, will be expanded) ⁵	28	1	8	3	0
Protocols & procedures (25 items)	115	2	16	4	1
Compliance with Provincial/Territorial regulations (3 items)	15	0	1	0	0
	<i>None: Your organization does not have any relationship or contact with them</i>	<i>Awareness: You have knowledge of them but no effort is taken to organize activities beyond individual client referrals</i>	<i>Communication: You and they have an active program of communication and information sharing</i>	<i>Cooperation: You and they use knowledge of the other's work to guide and modify service planning</i>	<i>Collaboration: You and they jointly plan the offering of service and modify services based on advice and input from mutual discussions</i>
Partnerships with other groups & service providers (11 items)	0	2	12	13	18
	<i>No relationship or no local availability or characterized mainly by conflict, broken communication and/or dropped referrals.</i>	<i>Limited relationship: Awareness of one another & occasional referrals but organizations do not actively work together to resolve barriers.</i>	<i>Basic working relationship: Referrals are sent or received, process may be delayed or have problems, problems not regularly raised and resolved.</i>	<i>Strong informal referral relationship: Active referrals are sent and received smoothly, problems raised and resolved. Possibly</i>	<i>Strong formal referral relationship with written agreement, regular contact, not dependent on one person. Referrals sent and received</i>

⁵ The list of training and qualifications will be expanded based on a review of job descriptions and training materials. In many cases, a professional's scope of practice will include competencies that mean further training is not required (e.g., a vocational rehabilitation counsellor can provide employment supports).

		<i>Mainly neutral or positive contacts.</i>		<i>dependent on a small number of people and their social networks.</i>	<i>smoothly, problems are raised and resolved.</i>
Referral relationships (18 items)	0	4	11	10	38
Processes					
	<i>True almost all of the time</i>	<i>True most of the time</i>	<i>Sometimes true if feasible</i>	<i>Sometimes/ mostly true, we want to improve</i>	<i>Non-applicable</i>
Intake (12 items)	54	7	0	0	1
Safety planning and assessment (21 items)	88	1	10	0	6 ⁶
Service provision (10 items)	40	5	2	3	2
Referrals process (8 items)	21	1	2	0	6 ⁷
Closure (5 items)	17	0	2	4	2

An important caveat is that the results of this first administration of the checklist, based as they were on interview responses, were not audited objectively. Like all such checklists, objective data collection will almost certainly reveal inconsistencies. To validate the interview responses, we have reviewed objectively verifiable items from the checklist (e.g., listings of languages on 211/FindHelp profiles, whether web sites are up-to-date, accurate and include 24-hour hotline numbers, and the content of written protocols and procedures).

Project management progress

The COSTI project team tracked project activities, including training sessions, management reference group meetings, monthly check-in meetings to troubleshoot and monitor data collection progress, advisory meetings and the development of protocols and procedures that were associated with designing and implementing the program design. For example, training was provided in Gender-Based Violence (April 2021, directed at participatory researchers), trauma-informed practice (June 2021 with 25 participants), and traumatic brain injury (September 2021 with 21 participants). The Resource Developer and COSTI project manager developed resources and provided training sessions throughout the project in response to client feedback and the refinement of the quality checklist. Each deliverable, activity and data collection tool was reviewed according to a GBA+ lens to ensure that barriers to participation and negative impacts were minimized for the women receiving services, based on the Gender Based Analysis + Checklist toolkit developed by Women’s Centre Calgary (Azuelos, 2019).

An interim review was carried out by Dorothy Nyambi in May and June 2021 regarding overall relevance of the project and communication between the hubs and the COSTI project management office. The evaluation questions were:

1. Do stakeholders have a shared understanding of the project and its anticipated outcome?

⁶ 5 out of the 6 ‘non-applicable’ scores related to carrying out a traumatic brain injury screening

⁷ 5 out of the 6 ‘non-applicable’ scores were for medical referrals based on traumatic brain injury screening

2. Is the partnership and project progressing towards expected results i.e. to inform the blueprint?
3. What value-add do stakeholders see / gain in participating?
4. What key adjustment need to be made to ensure anticipated results are achieved on time?

Dr Nyambi reviewed key documents including the evaluation plan, MOVERS tool and partnership agreements and held structured interviews with staff, hub champions and participatory researchers from four organizations: COSTI, YRCCS, Peel Catholic Family Services (SCOP's sponsor) and SAAFS. La Maison had not yet joined the project and were not interviewed.

In summary:

- 80% of respondents reported satisfaction with the project set-up and design and 100% reported appreciation and approval of the MOVERS outcome instrument.
- There is a lack of hub staff capacity to carry out the requirements of the project, partly due to the double burden of dealing with COVID and its implications for increased violence against women in the home.
- There is a need to enhance communication between the COSTI project management office, potentially through a revitalized approach, to re-energize the partnership following this challenging period within the sector. For instance, COSTI should reaffirm the purpose and objectives of the research project, ensuring that all participants have a clear understanding of the project's purpose, methodology, the benefits they receive, and the value they contribute.
- Meetings should be more frequent and use current project governance structures e.g. monthly project advisory groups. The Management Reference group should meet at least twice a year.
- Training and guidance should be provided on how MOVERS can add value in all phases of the client's journey, as well as guidance on when it should not be administered (e.g., not in an emergency phase)

The results were reported to the project advisory committee and several improvements were made in communication processes, including additional advisory group meetings, bi-annual management reference group meetings and a frequent project update newsletter (total of 13) to increase engagement across the hubs.

MOVERS Results

The MOVERS (Measure of Victim Empowerment Related to Safety) tool was the main outcome measure used in the project. Rather than measuring safety directly, MOVERS measures level of safety-related empowerment as perceived by the woman who is at risk. The tool is designed to track survivor success over time and to glean insights about the effectiveness of program supports. The tool identifies three key components of safety-related empowerment and introduces measures to evaluate outcomes for each. The three MOVERS subscales are "Keeping Safe," "Getting Support," and "Making Compromises" (called 'Trade-offs' in the MOVERS user guide (Goodman, L.A. et al., 2015)

MOVERS data was collected between November 2020 and July 2023. There were 381 MOVERS administered in total, which included 34 follow-ups. The analysis of MOVERS data focuses on findings with a minimum of ten participants.

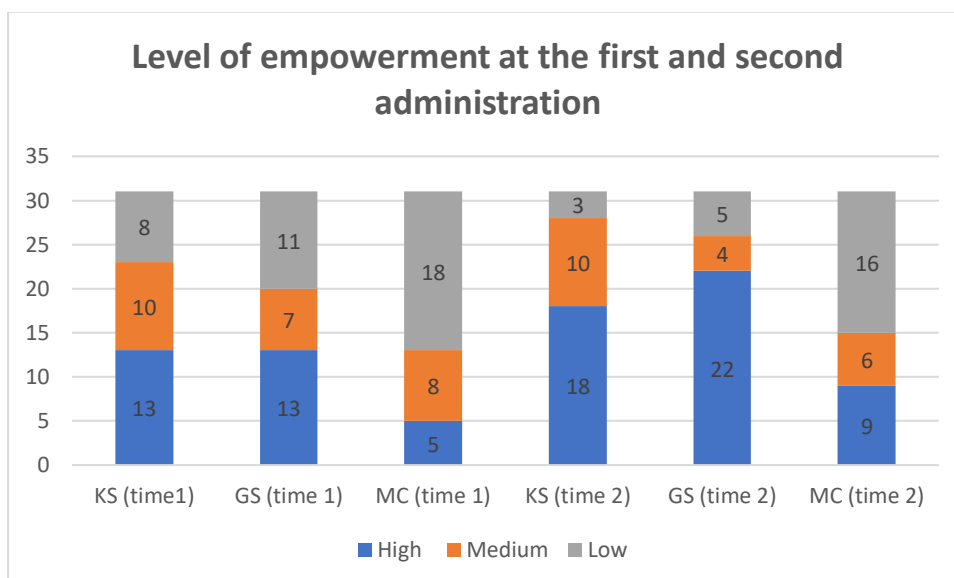
The follow-ups included a second administration of the MOVERS survey for 31 clients and a third administration for three clients. Of the 31 clients who completed MOVERS twice, 19 had improved scores from time one to time two. 11 participants moved to a higher empowerment category from time one to time two administration. Four clients scored lower on their second

MOVERS survey, while the remaining five follow-up scores remained unchanged at the second administration. All three clients who completed a third MOVERS survey had increased their scores from the first to third administration and moved to a higher empowerment category. Two had improved scores from the second to third administration and one participant’s score remained unchanged from time two to time three. Fifty percent (n=17) of time two follow-up responses had scores in the high empowerment category, compared to 38 percent (n=144) for all MOVERS participants. In short, the follow-up scores reveal improvements in levels of safety-related empowerment among most participants who completed the MOVERS tool a second and third time.

Analysis of sub scores revealed improvements from the first to second administration in average scores for all subscales. The largest improvement occurred with the subscale “Getting Support,” with an improvement in average score of 11.5 percent at the second administration. The second largest improvement in sub scores occurred with “Keeping Safe,” with an improvement in average score of 9.7 percent. This was followed by “Making Compromises,” which had the smallest improvement at 5.6 percent. The table below illustrates the average subscale scores at time one and time two.

	Keeping Safe	Getting Support	Making Compromises
Time one	73	73	56
Time two	80	84	62

Changes in sub scores can also be observed by the number of participants who moved to a higher empowerment category for individual subscales at the second administration. The following tables illustrate the empowerment scores for each subscale at time one and time two.



Level of empowerment at time one	Keeping safe	Getting support	Making Compromises
High	n=13	n=13	n=5

Medium	n=10	n=7	n=8
Low	n=8	n=11	n=18

Level of empowerment at time two	Keeping safe	Getting support	Making Compromises
High	n=18	n=22	n=9
Medium	n=10	n=4	n=6
Low	n=3	n=5	n=16

Follow-up sub scores for time two revealed improvements for each subscale, as indicated by the number of participants who moved to a higher empowerment category. By this measure, “Keeping Safe” yielded the largest improvement, with 12 participants who moved to a higher empowerment category. Two participants moved from the low to high empowerment category, four moved from the medium to high empowerment category and six moved from the low to medium empowerment category. For “Getting Support,” 11 participants moved to a higher empowerment category at the second administration. Three participants moved from the low to high empowerment category, three moved from the medium to high empowerment category, and one moved from the low to medium empowerment category. For “Making Compromises,” 10 participants moved to a higher empowerment category at the second administration. Four of these participants moved from the low to high empowerment category, four moved from the low to medium empowerment category, and two moved from the medium to high empowerment category. The following table illustrates these increases in empowerment category for each subscale at the second administration.

Increases in empowerment category at the second administration			
Subscale	Low to medium	Low to high	Medium to high
Keeping safe (n=12)	n=6	n=2	n=4
Getting support (n=11)	n=1	n=7	n=3
Making Compromises (n=10)	n=4	n=4	n=2

Please note that it was extremely challenging to collect MOVERS data throughout the project, impacting the comparability of the results. In the final phase of data collection from March to August 2023, the project focused on collecting follow-up MOVERS results and demographic information from clients to the extent of increasing funding to each hub, enabling them to offer each participant up to \$50 for answering MOVERS and demographics questions.

We were concerned that the women filling out MOVERS were self-selected and therefore may have had different demographic characteristics from the total population of clients. The evaluators tested this by comparing demographics of clients served with clients filling out

MOVERS in COSTI’s Domestic Violence (DV) program. COSTI collects detailed demographic data on all their clients and provided the summaries to us. A comparative table can be found below.

We conclude that MOVERS respondents mirrored the broader client demographic, particularly for COSTI, with one notable discrepancy. The MOVERS sample included a much greater percentage of Canadian citizens than the DV clients as a whole (34% vs 22%). COSTI staff reported that newcomers often felt uncomfortable being questioned about their immigration status, which may have resulted in lower response rates among non-Canadian citizens.

	COSTI DV clients (%)	COSTI MOVERS sample
Clients served	N=281	N=64
Clients between the ages of 25 and 65	84%	92%
Canadian citizens	22%	34%
Convention refugee/refugee claimants	3%	6%
English-speaking	50%	47%
Spanish-speaking	15%	14%

Analysis of MOVERS scores reveal some notable differences in the safety related empowerment of racialized and newcomer participants compared to Canadian citizens and non-racialized participants. Specifically:

- Canadian citizens exhibited the highest MOVERS scores with 48 percent of respondents scoring in the high empowerment category and only 14 percent in the low empowerment category.
- Permanent residents and convention refugees exhibited the lowest MOVERS scores with only 30 percent of permanent residents and 21 percent of convention refugees scoring in the high empowerment category. Thirty-two percent of permanent residents and 36 percent of Convention refugees/refugee claimants scored in the low empowerment category.

Immigration status	# of Surveys	% of Surveys	Level of Empowerment	
			High	Low
Canadian citizen	108	28%	48%	14%
Convention refugee or refugee claimant	14	4%	21%	36%
Non-status	2	1%	50%	50%
Permanent resident	63	17%	30%	32%
Student or visitor	3	1%	33%	33%
Prefer not to answer	3	1%	67%	0%
No demographic data	188	49%	35%	22%
	381	100%		

Figure 3: Level of empowerment by immigration status

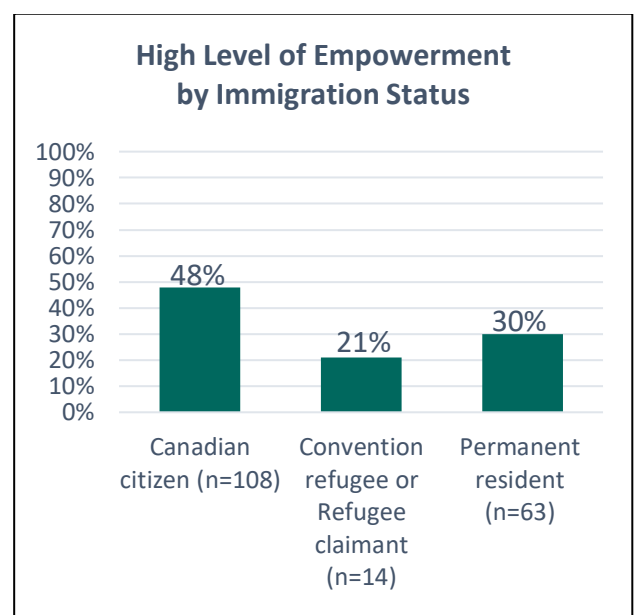


Figure 4: High level of empowerment by immigration status

Large differences in MOVERS scores were also observed across racial identities.

- Participants of European descent had the highest empowerment scores, with 58 percent of participants scoring in the high empowerment category. None of these participants scored in the low empowerment category.
- Latino participants had the second highest MOVERS scores with 44 percent of participants scoring in the high empowerment category and 25 percent in the low empowerment category.
- High empowerment scores were similarly distributed across the other racial categories with high empowerment scores ranging between 31-37 percent and low empowerment ranging from 25 to 29 percent for Black, Middle Eastern, and South Asian participants.

Racial Category	# of Surveys	% of Surveys	Level of Empowerment	
			High	Low
Black	59	15%	37%	25%
Middle Eastern	35	9%	31%	29%
South Asian	49	13%	37%	27%
East/Southeast Asian	6	2%	67%	0%
Latino	16	4%	44%	25%
Indigenous	2	1%	100%	0%
White European descent	12	3%	58%	0%
Another category	3	1%	100%	0%
Prefer not to answer	1	0%	100%	0%
Do not know	10	3%	30%	0%
No demographic data	188	49%	35%	22%
	381	100%		

Figure 5: Level of empowerment by racial category

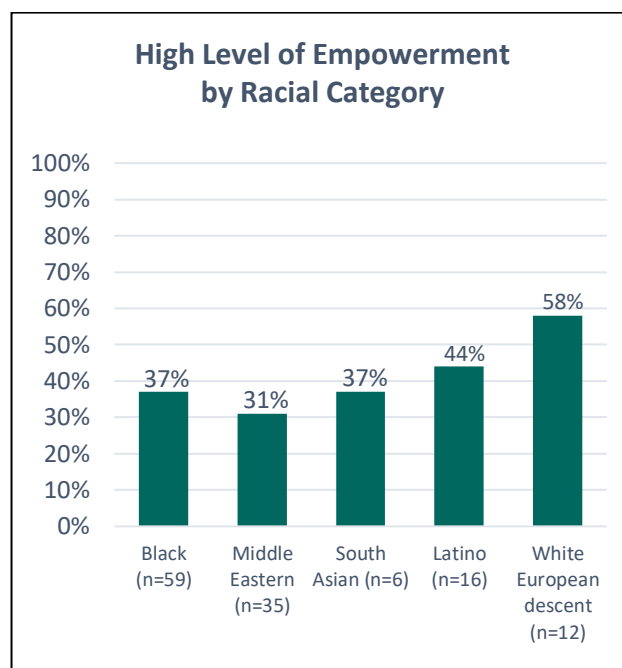


Figure 6: High level of empowerment by racial category

The lowest empowerment scores were concentrated among racialized newcomer women. Black and Middle Eastern newcomer participants had the lowest empowerment scores. There were 33

Black newcomer participants. Six of these participants scored in the high empowerment category (9%), while 12 scored in the low empowerment category (36%). There were eighteen MOVERS responses from Middle Eastern newcomer women (all permanent residents). Five of these participants (18%) scored in the high empowerment category, while 10 scored in the low empowerment category (56%). These scores contrast sharply with the scores of Canadian citizens of European descent, who all scored in the high empowerment category.

Participant sub scores also reflect differences in scores between racialized newcomer women and Canadian citizens of European descent, with racialized newcomer participants scoring lower on each sub scale. The following table compares average sub scores for Canadian citizens of European descent, Black newcomer participants and Middle Eastern permanent residents.

	Canadian citizens of European descent	Black newcomer participants	Middle Eastern permanent residents
Keeping Safe	91.4	67.6	63.9
Getting Support	92.1	67.4	74.4
Making Compromises	71.4	64.7	64.5

Average subs scores for Black and Middle Eastern newcomer women were similar, although Black newcomer participants scored slightly lower than Middle Eastern permanent residents on “getting support” and slightly higher on “keeping safe.” Both Black and Middle Eastern newcomer participants had lower average scores for all subscales compared to Canadian citizens of European descent. The largest difference between average subscale scores for racialized newcomer participants and Canadian citizens of European descent can be observed for “keeping safe” and “getting support.”

The difference in subscale scores for these groups is also illustrated by a comparison of scores by empowerment category. The tables below highlight the participant scores by empowerment category for each subscale for Black, newcomer participants, Middle Eastern permanent residents, and Canadian citizens of European descent.

Black newcomer participants (n=33)			
Empowerment category	Keeping Safe	Getting Support	Making Compromises
Low	n=10 (30.3%)	n=12 (36.4%)	n=15 (45.5%)
Medium	n=13 (39.4%)	n=11 (33.3%)	n=6 (18.2%)
High	n=10 (30.3%)	n=10 (30.3%)	n=13 (39.4%)

Middle Eastern permanent residents (n=18)			
Empowerment category	Keeping Safe	Getting Support	Making Compromises

Low	n=7 (38.9%)	n=5 (27.8%)	n=14 (77.8%)
Medium	n=5 (27.8%)	n=3 (16.7%)	n=3 (16.7%)
High	n=6 (55.6%)	n=10 (55.6%)	n=1 (5.6%)

Canadian participants of European descent (n=12)			
Empowerment category	Keeping Safe	Getting Support	Making Compromises
Low	n=0 (0%)	n=2 (16.7%)	n=4 (33.3%)
Medium	n=4 (33.3%)	n=0 (0%)	n=3 (25%)
High	n=8 (66.7%)	n=10 (83.3%)	n=5 (41.7%)

As illustrated by the tables above, Black and Middle Eastern participants scored substantially lower than Canadian citizens of European descent for subscales “Keeping Safe” and “Getting Support.” Black newcomer participants had the lowest percentage of participants in the high empowerment category for “Keeping Safe,” at 30 percent. Black permanent residents (n=18) and refugees/convention refugees (n=12) both had 33 percent of scores in the high empowerment category for this subscale, while the sole non-status Black participant scored in the low empowerment category. Middle Eastern permanent residents had 56 percent of participants in the high empowerment category for “Keeping Safe.” Comparatively, 67 percent of Canadian citizens of European descent scored in the high empowerment category for “Keeping Safe.”

For “Getting Support,” 30 percent of Black newcomer participants scored in the high empowerment category. Black permanent residents had the lowest scores for this subscale, with only 22 percent scoring in the high empowerment category. Scores for Middle Eastern permanent residents were considerably higher, with 56 percent of Middle Eastern permanent residents scoring in the high empowerment category. Canadian citizens of European descent scored the highest for this subscale with 83.3 percent scoring in the high empowerment category.

The differences in scores were less pronounced between Black newcomer participants and Canadian citizens of European descent for “Making Compromises,” with 39.4 percent of Black newcomer participants scoring in the high empowerment category and 41.7% of Canadian Citizens of European descent scoring in the high empowerment category for this subscale. Notably, Middle Eastern newcomer participants had the lowest scores for “Making Compromises,” with only 5.6 percent scoring in the high empowerment category.

Overall, subscores indicate that newcomer racialized participants experience more challenges with keeping safe and getting support than Canadian citizens of European descent. Black newcomer women experience the greatest challenges to maintaining safety, according to subscores. Subscores also identify Black permanent residents as the group that experiences the greatest challenges to getting support. Subscores also indicate that Middle Eastern permanent residents are much more likely to make compromises for their safety than any other group.

Smaller differences in safety-related empowerment can also be observed across age groups. The 18-29 year old category had the highest empowerment scores, with 48 percent of respondents in the high empowerment category and 15 percent in the low empowerment category. This was followed by the 40-49 year old category, with 41 percent of respondents in the high empowerment category and 22 percent in the low empowerment category. High scores were evenly distributed among the 30-39, 50-59, and 60-69 age groups.

Age Range	# of Surveys	% of Surveys	Level of Empowerment	
			High	Low
Under 18 years	2	1%	0%	0%
18 to 29 years	52	14%	48%	15%
30 to 39 years	143	38%	34%	21%
40 to 49 years	110	29%	41%	22%
50 to 59 years	44	11%	35%	35%
60 to 69 years	22	6%	32%	27%
70 years or over	6	2%	33%	17%
Prefer not to say	3	1%	33%	0%
	381	100%		

Figure 7: Level of empowerment by age

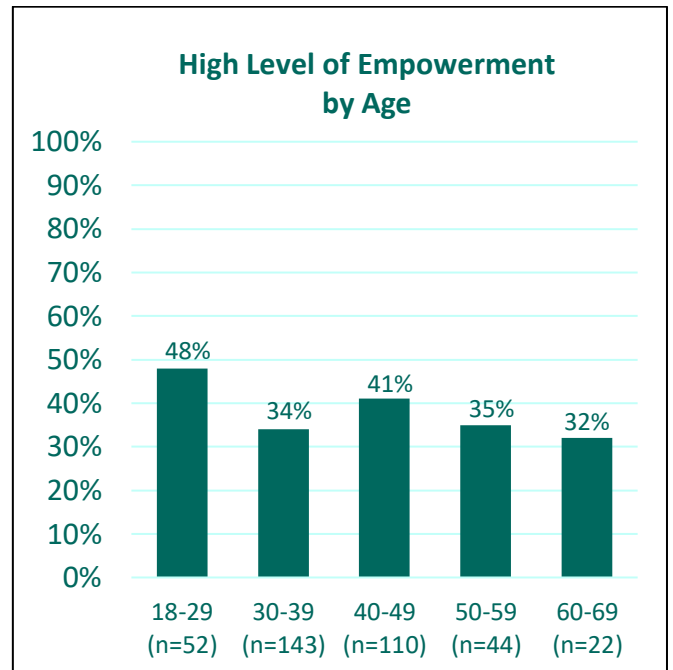


Figure 8: High level of empowerment by age

Participants with children under the age of twelve had higher empowerment scores than those without children. Forty-three percent of participants with children under the age of twelve scored in the high empowerment category, compared to 36 percent of respondents without children under the age of twelve. Conversely, 18 percent of participants with children under the age of 12 scored in the low empowerment category, compared to 27 percent of participants without children under the age of 12.

Parent of a child aged 12 or under	# of Surveys	% of Surveys	Level of Empowerment	
			High	Low
Yes	115	30%	43%	18%
No	78	20%	36%	27%
No demographic data	188	49%	35%	22%
	381	100%		

Figure 9: Level of empowerment by parental status

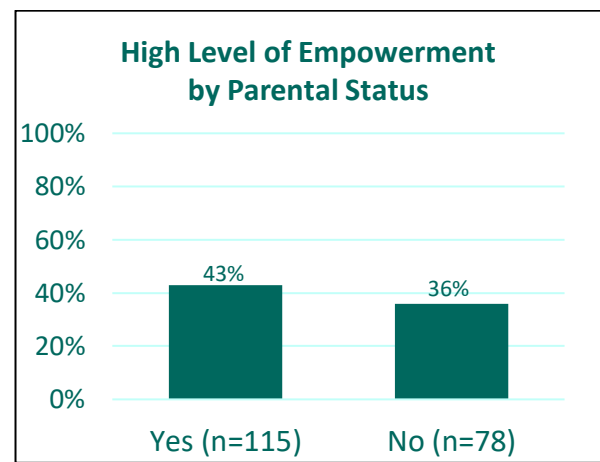


Figure 10: High level of empowerment by parental status

Demographic information is not available for participants who did not sign informed consent. Results were similar for the two groups, suggesting that the detailed demographic results are representative of the total group of respondents.

Empo			
Presence of demographic data	# of Surveys	% of Surveys	Hi
Yes	193	51%	40
No	188	49%	35
	381	100%	

Figure 11: Level of empowerment by the presence of demographic information

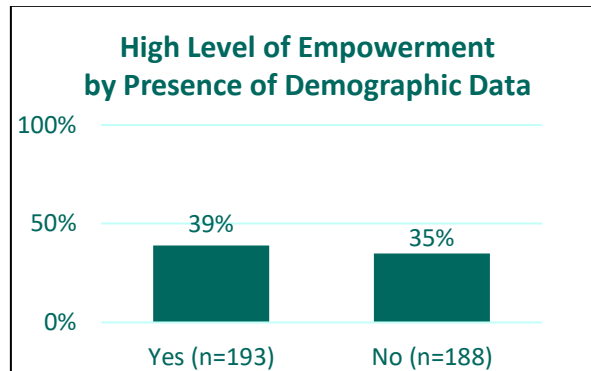


Figure 12: High level of empowerment by the presence of demographic information

Impact Interviews and Suggestion Poll Results

There was a total of 130 responses for the Impact Interviews and 133 responses for the Suggestion Poll over the period of January 2022 to March 2023, out of a total potential population of about 1300 clients. The Suggestion Polls were anonymous and there may have been repeated responses from an individual respondent. The respondents for Impact Interviews were selected in two ways: (a) Hub staff could invite a client for an interview using any criterion they wished (130 responses), or (b) Hub staff requested an interview along with all follow-up MOVERS administrations (a total of three responses).

Impact Interviews included a suggestion question, resulting in a total of 247 suggestions drawn from the Interviews and the stand-alone Suggestion Polls.

Hub staff reported several challenges to data collection. These challenges pertained to client comfort and interests, time constraints, resource limitations and challenges with technology. Some clients were uncomfortable with the technology used for online surveys or reluctant to spend time answering questions that were not related to their needs. Hub staff also reported that routine emergencies and crises in their facilities impeded data collection efforts, as these situations took precedence over other matters. Staff shortages and related time constraints were also cited as key challenges.

The qualitative analysis was conducted through a process of carefully reading participant responses, identifying relevant themes, developing codes for each theme and revising and refining the codes. The first step was to read through each response to identify the broad themes conveyed by the participants. Once the themes were identified, codes were developed for each theme. Excel was used to create a spreadsheet containing the participants' responses and the corresponding codes. The initial columns of the spreadsheet comprised the participant responses, survey ID, question ID, and agency, while subsequent columns contained the corresponding codes. Each response was evaluated to determine whether a code applied, denoted by a "1" or "0" in the corresponding cell. A "1" indicated the code's applicability to the response, whereas a "0" signified its non-applicability. This table facilitated the organization of responses and enabled the identification of data patterns. Following the initial coding and analysis, responses were re-examined to extract more detailed customer feedback pertinent to each code.

The most common suggestions offered by participants were related to wait times, communication and resources. Specifically, participants requested shorter wait times for services (n=35), improved communication from program staff (n=24), and access to more specialized

resources (n=21). For example, participants indicated that more updates from staff would be helpful, along with faster response times to inquiries. In terms of resources, participants listed items such as lawyers who specialize in domestic violence, more programs for children and more financial resources. In addition to suggestions, participants also provided positive feedback about the program. Notably, 116 participants commented on the high quality of the program and/or provided thank you statements for services received. Eighty-eight participants felt supported by the program. These responses included statements such as feeling empowered, not alone, supported by program staff, and feeling like they can ask for help when needed. Sixty-two participants commented on the high quality of program staff. These responses included statements about staff being caring, supportive, compassionate, professional, respectful, trustworthy and good listeners. Some responses included strong words such as “excellent” and “lifesaving” to emphasize their high regard for staff.

The results are summarized in the following tables:

Suggestions	
Shorter wait times	35
Improve communication	24
More specialized resources	21
More respect/kindness	12
Provide more in-person services	11
Housing needs unmet	10
More programs and recreation	10
Extend hours	9
Amenities/maintenance concerns	8
Unmet needs (undefined)	7
Improve food	7
Disorganized services	6
Hire more workers	6
Problems with agency partners	6
Misplaced help	4
Safety (more safety protocol)	3
Equitable distribution of chores	2
Fix telephone line (options are confusing)	2
Freedom to spend nights elsewhere	1
Improve accessibility	1

Figure 13: Suggestion table

Positive Feedback	
Good program	116
Feel supported	88
Good staff	62
Good resources	61
Gained knowledge/skills/information	57
Psychological benefits	41
Increased confidence	33
Big impact	27
Received housing help	15
Good environment	11
Good follow-up	11
Increased safety	10
Children benefited	9
Improved motivation	6
Improved decision-making	4
Organized services	4
Left relationship	3
Improved health	2
Improved finances	2

Figure 14: Positive feedback table

Staff interviews

Staff of participating hubs were interviewed frequently throughout the project via videoconferences (mainly Microsoft Teams if hosted by LogicalOutcomes or COSTI; otherwise using whatever platform preferred by the hub). In most cases, hubs were interviewed separately to encourage frank discussions. All participants gave permission to share individual hub discussions with the COSTI project manager except for a few private interviews carried out by

Dorothy Nyambi of LogicalOutcomes in mid-project to explore any potentially sensitive communication issues within the project. In addition, the evaluators attended advisory group meetings at major milestones. One of the main findings of the project is that adequate engagement with staff required frequent meetings with individual agencies to dig into problems and discuss sensitive issues.

Interview topics varied by the project phase. The first two years focused on the elements of effective program design; the selection and implementation of data collection tools; and a refined evaluation plan that incorporated GBA+ analysis and feedback from an ethics review board. The results of this phase were captured in the Program Quality Checklist (see Program fidelity section above) and the final data collection tools themselves (see supplementary materials).

In the second and third years (with several months overlapping between phases), the emphasis shifted towards addressing the challenges associated with implementing program enhancements and gathering data. During meetings, participants had access to meeting notes displayed onscreen, allowing for collective viewing and corrections.

The final two years were dedicated to refining insights and implementing ongoing improvements informed by data collection and training sessions conducted by the project team. Once more, meeting notes were displayed onscreen to facilitate consensus among participants regarding the meeting's key points.

The project went through many changes over the course of four years. Not only did the COVID pandemic restrict in-person services through much of 2020 and 2021, but it also increased the risk (and incidence) of violence against women in their homes and reduced the availability of staff at each of the five participating agencies.

In addition, the process of defining and refining the program service model and working with agencies to collect feedback from their clients resulted in changes to the research design and the program model itself.

The main topics emerging from the meetings and interviews were:

- Defining core elements of program design for newcomer and racialized women, including ways to provide remote service delivery during COVID.
- The challenges of collecting and engaging with data from clients.

Defining elements of program design during a pandemic

The hubs selected for this project had extensive experience in offering support to women facing the threat of violence from family members or intimate partners. Initially chosen for their proficiency in assisting newcomer and racialized women, they excelled in providing comprehensive assessments and referrals to various services within a shared physical space. However, the onset of the pandemic early in the project disrupted service delivery, compelling agencies to redesign their approaches to client interactions and collaboration with referral partners.

Elements that were incorporated into the program model included:

1. Adoption of distance service provision using phone and videoconferencing, with associated changes in processes and procedures.

Remote service provision presented both advantages and challenges. While it offered convenience, it posed challenges to clients, staff and agencies. Many clients had difficulty in reaching out for help and engaging with services, particularly those unable to leave their houses and/or needing to use phones discreetly to avoid other members of the household over hearing

them. Staff had to deal with diminished boundaries between home life and exposure to intensely stressful work, including the problem of finding private spaces to have confidential conversations with clients. Agencies had to change their information systems to permit work from home including Voice Over IP phone lines and new security procedures. Almost everyone had to deal with all the challenges of online communication, from internet bandwidth to privacy controls to accessibility for women without computers or smartphones.

On the other hand, there were some significant improvements to accessibility as hub partners realized they could provide remote services via phone and online conferencing. This was especially important for women who had difficulty in travelling long distances to geographically located services.

2. Focus on processes for coordinated services rather than administrative structures.

Originally, the project planned to investigate and compare two program models for delivering Gender-Based Violence services to newcomer and racialized women:

- A single-agency model, defined as one organization delivering multiple services via internal referrals and coordination with other departments in the same organization
- A multiple-agency model, defined as a coordinated service staffed by several organizations and co-located in one accessible place.

On investigation, the distinction between the two was found to be administrative, not programmatic. In other words, all the hub partners provide a mix of intake, assessment, safety planning, support and referrals using processes that were very similar. The fact that some of these multiple services were managed within one formal organization while others were managed across several organizations with formal partnerships did not result in fundamentally different models. The focus of the project turned to defining that one program model, investigating its effectiveness, and developing program blueprints for it.

Over months of developing and refining the program model based on extensive consensus-building and refinement among project partners and supported by a literature review of effective components, and changed with input from staff and clients, the project defined the following established and promising practices:

- Outreach and community education
- Accessible and culturally appropriate settings and resources
- Staff training and protocols regarding screening, assessment and safety planning
- Trauma-informed and survivor-informed practice
- Collaborations and referral relationships with a defined set of services and agencies
- Active referral processes that ensure clients are accepted by the receiving services
- Processes that can be carried out remotely (via phone and online meetings)

Most of these processes are included in the program quality checklist (see supplementary materials) and the program blueprint (in preparation by COSTI). Issues that arose in staff interviews included:

- Some important elements in the program model were not actually feasible to provide. For example, it is essential that women who are at high risk of serious injury get immediate help in developing a safety plan and/or obtaining medical help. Funding constraints and high need often prevented timely services. Is this a fault of the program model, in that it did not define processes that are feasible given the Canadian context? Is it the fault of the agencies in that they should be somehow more efficient? Is it responsible to define a model that can't be achieved in practice? This painful question was not resolved, but the

hubs did attempt to differentiate essential from recommended practices to help service providers prioritize. Collaboration is expensive and must be incorporated into the funding model, not only the program model.

- Given the diversity of newcomer and racialized women at risk of violence, it is essential that services be informed and guided by the women themselves. Factors that affect the experience of domestic violence include household structure, religious and cultural beliefs, linguistic barriers and the risk of racial discrimination by the criminal justice system and social services. Survivor-informed practice is vital to responsive services.
- In principle, it is important to post available languages in the online 211 database ([211 Ontario](#)) and agency web sites so that women can be referred to services that can communicate with them. Staff turnover means that languages on agency web sites are often out of date. Furthermore, the staff who update web sites and databases may not be in communication with the staff of domestic violence services in the same agency. This is a systems navigation problem in the information and referral sector and should be addressed by system-wide services like 211.on.ca and over-the-phone interpretation.
- Staff turnover was an ongoing challenge throughout the project, and new staff were often untrained in some of the skills required in this complex program model. The project team at COSTI provided many workshops on topics requested by hubs, including Trauma Informed Practice, in addition to the regular training provided by each hub. Training is both expensive and vital. It should be provided for all new staff immediately after they begin working with clients, which is difficult to coordinate due to frequent staff turnover.

Structured progress notes were taken for 34 monthly meetings between March 2022 and April 2023. The major themes were raised repeatedly for each hub and are summarized below.

Problems with data collection

The evaluators and the COSTI project manager made great efforts to make data collection accessible, secure, confidential, easy to use by staff and multilingual. Each question, measure and instrument were reviewed repeatedly by hub partners to gain consensus. Each participating hub was paid for staff time to participate in project activities, including data collection, as well as earmarked funding to pay clients for their participation in the project. Clients were given gift cards of between \$20 and \$50 for responding to surveys, with the amount and type of gift card chosen by each agency based on their knowledge of their clients.

Despite these efforts, numerous challenges arose during the data collection process. The COVID-19 pandemic was a major distraction to the process of selecting and testing measures. Unexpected limitations in the originally selected software resulted in a different platform configuration from the original design. An elaborate Excel-based data collection tool, created with the intention of avoiding online collection of sensitive client data, encountered frequent technical issues. Some staff members repeatedly used incorrect survey links or misplaced them, while others struggled with comprehension of the instructions. Moreover, the turnover of staff necessitated repeated explanations and support for the data collection procedures. The evaluator's technical support budget was exhausted and addressing and rectifying various data and reporting issues across multiple agencies with diverse technical systems incurred considerable expenses. In fact, the costs associated with testing, troubleshooting and training in the context of numerous agencies rendered the project financially unfeasible for most evaluations or short-term projects.

The burden of collecting feedback from clients was higher than anticipated. Our focus changed to simplifying instruments and collection processes, and emphasizing how agencies can see anonymized feedback often enough to make improvements to services.

Partly because of the pandemic and its impact on services and partly responding to the concerns of hub partners regarding the burden of data collection, the evaluation design was changed to emphasize processes for collecting, analyzing and using client feedback in a context of remote service delivery.

Challenges included:

- Clients were often in crisis when first contacting service providers. Service priorities were to assess risk level and situation, define a safety plan and respond to urgent needs. Sessions might be limited or cut off unexpectedly because of interruptions from household members during phone calls or because clients were secretly attending the agency and were expected to be at home. There were constant compromises on service availability. Collecting data for evaluation was a low priority in comparison.
- Staff members were overwhelmed by the demands of client care, frequently extending their work hours without compensation. Many were reluctant to dedicate their personal volunteer time to completing forms, even when the agency was financially compensated for such tasks. While senior management within agencies may have been incentivized to prioritize data collection, frontline staff typically did not share the same level of motivation.
- Both staff and clients were unconvinced that data would result in service improvements for themselves or others. Staff understandably didn't see data collection as an intrinsic part of their work, nor did they see how it would benefit the women they were serving.
- Several staff reported that asking clients for demographic information including race and immigration status created additional anxiety and interfered with the rapport between staff counsellor and client.
- Clients who are at risk of household violence tend to be unavailable for follow-up interviews. They often stop attending appointments, change phone numbers or refuse to answer mysterious phone calls from 'unknown' numbers. (Domestic violence services use 'unknown' numbers for calls to clients for confidentiality reasons.)
- Originally, the project intended to incorporate a client satisfaction survey into its evaluation plan. However, agencies expressed concerns about potential confusion due to duplication of efforts. The Ontario government's Violence Against Women (VAW) program already requires the use of an extensive and intricate client satisfaction survey as a condition of funding. This survey collects anonymous feedback directly submitted to the Ontario government, with a summary of aggregated data shared with agencies in PDF format approximately a year later. Regrettably, this survey isn't tailored to provide actionable insights for service improvements. Clients may be asked to complete multiple VAW surveys for a single episode of care, as each agency is obligated to collect data, potentially resulting in redundancy. Although the evaluators sought permission from the Ontario Ministry of Children, Community and Social Services to analyze the VAW satisfaction survey data, logistical constraints rendered this unfeasible. Moreover, the response rate for the survey was extremely low; statewide, the average annual response rate per funded agency falls below ten (Ministry of Children, Community and Social Services, 2021), a trend consistent with the findings from the participating hubs in this project. Agencies have expressed in interviews, "*it's really hard to get the women to respond*".
- Translation of the data collection tools from English into 11 other languages was a long, drawn-out process resulting in many errors and revisions, including copy-and-pasting errors that were not caught before launch. At each stage and revision, each instrument in every language had to be reviewed by a speaker of that language and checked to ensure that the review actually did happen. The project used high quality professional translators with built-in accuracy checks, but errors were introduced after the original translations. A published translation of one of the instruments had actually reversed the meaning of one

of the questions. These problems are not unusual in any multilingual evaluation, but the costs should be planned for.

- Keeping client information private was a fundamental design principle for the project. This presented many technical challenges because the project included multiple agencies, each with its own IT systems and security policies. Technical solutions had to be reviewed by each agency. IT staff for agencies were not funded to support external projects and were justifiably concerned about the flow of data. Raw MOVERS data collected by agencies included client names since results were used for service delivery, and it took months to design an Excel-based data collection tool that would protect client confidentiality by keeping raw data within each agency. Excel is not a stable platform for data collection, and constantly broke, requiring ongoing technical support and troubleshooting from the evaluators. By the end of the project several agency management staff had forgotten that the informed consent provisions approved by respondents forbade copying anonymous quotes to use in reports.
- Agencies did not collect detailed service delivery data that could be used in evaluation. Process metrics, such as number of days between first contact and the completion of an assessment, completion of safety plan and successful referrals to essential services, are critical to assessment and improvement of complex program delivery. Without process metrics, agencies must rely on informal feedback from staff and clients, which became more difficult with remote management.
- The main outcome measure for the project was intended to be MOVERS, a measure of safety-related empowerment for women seeking services. As an outcome measure it was not useful because of the barriers to scheduling pre- and post- administrations. It was rarely administered to women in crisis or with limited time availability for their initial sessions, meaning that by the time the 'pre-survey' was done the woman had already received several program interventions. 'Post-surveys' were challenging because typically women dropped out of services rather than going through a formal case closure process. As the GBV project progressed the evaluators asked for any follow-ups at any time just to explore the patterns of responses. Despite agencies offering up to \$50 in gift cards, follow-ups were rare. As a service delivery tool and guide to discussion, several agencies found it useful. One agency has formally committed to keep using MOVERS in service delivery, two plan to use it sometimes but not universally and two will stop using it at the end of the project.
- In most cases, agencies expressed that the results of the various data collection tools were not helpful. When pressed, agencies admitted that they were already aware of the information. They all collect feedback informally while some use formal satisfaction surveys. Agencies that did find client data helpful wanted to include quotes from the responses in reports to their Board and other stakeholders. They were disappointed that the wording of the informed consent prevented them from using direct quotes and felt the restriction diminished the value of the information.

What worked

- **Monthly meetings with each hub** to resolve data collection problems and discuss results. This was the biggest single success in the entire evaluation. Once data was being collected and reported regularly (and accurately) the meetings reduced to every two months. Before implementing regular meetings, it would often take weeks to identify issues within agencies, followed by additional weeks to address them due to challenges in gathering everyone for troubleshooting sessions. Following an initial phase of confusion and dissatisfaction, agencies expressed contentment with the project's communication approach once regular individual agency interviews were established.

- **High quality translations** of data collection instruments. From one agency: *“Languages are really helpful for MOVERS. We don’t have one in Mandarin, and it took 45 minutes to do MOVERS because the interpreter had difficulty. Sending clients a copy of MOVERS in their own language, they really like seeing it, it helps them respond.”*
- **Gift cards to encourage client responses (to some extent).** Gift cards were helpful but not sufficient to elicit high response rates. Agencies experimented with gift cards throughout the project. The most effective approach used digital gift cards, buying 30 at a time, giving 10 to each staff person, ordering more once depleted and tracking them with a SharePoint list with client initials, emails, date and the person who assigned them. That agency reported that *“It’s very effective and easy to use and clients love it.”* Two agencies found that online gift cards were unfeasible and handed out physical cards instead. Towards the end of the project, agencies were offering up to \$50 in gift cards for each survey response, which required a time commitment of under 30 minutes. Despite the incentives, agencies encountered difficulty securing responses. Each agency had different experiences with the type and format of successful gift cards.
- **Impact interviews with appreciative comments.** Open-ended interview responses were shared in monthly staff meetings using interactive Power BI reports. Agencies reported, *“We get great insights and feedback from clients. The clients want their voices heard, they are enthusiastic about giving feedback.”* *“Staff administering data collection tools feel a sense of accomplishment by completing these tools with clients. Clients feel empowered and these tools provide an opportunity to give feedback.”* The impact interview protocol explicitly sought appreciative responses along with suggestions, which turned out to be a major benefit. Appreciative responses increased the chance that all client responses would be read and valued by staff. It’s hard to listen to complaints and criticism in an already emotionally draining job. *“It’s been really rewarding for us... we do monthly operational meetings and staff read the responses.”* *“To hear positives is really powerful and rewarding.”*
- **Consolidated interactive reports.** Several hubs said that the Power BI reports of suggestions and comments provided a convenient way to summarize issues for senior management, funders, their boards of directors and for proposal-writing.
- **MOVERS (for some agencies).** Two agencies found MOVERS useful to engage clients in discussions about their priorities and needs and plan to continue it in service delivery after the end of this project. Conversely, the other agencies found it mildly interesting and/or useful but did not see sufficient value in continuing its use.

Conclusions

Background

The main goal of the project was to develop, refine and test an effective program model and then create a program blueprint for replication.

The program design was informed by consultation, literature search and many iterations based on discussion with participating agencies. The program model generally fits within an ‘advocacy’ model “guided by person-centred, strength-based perspectives and grounded in empowerment theory” as defined by (Trabold et al., 2020), supplemented in one agency by a women’s shelter (La Maison) and in another agency by mental health counselling (COSTI).

Training and capacity development was provided to participating agencies to improve practice and to further develop the blueprint.

Implementation of the project was heavily affected by the COVID-19 pandemic. Staff were often unavailable due to illness, high staff turnover and an upheaval of agency processes. The

demands of remote service delivery resulted in some benefits for clients who were able to receive services online or over the phone. For many other clients, according to agency reports, the pandemic led to an increase in isolation and violence.

As the project progressed, we realized that a major evaluation question centred on how to collect and engage with survivor feedback. Rather than being just one of the many activities it turned out to be a central problem.

Program blueprint

The program model as it was designed and refined over the period of the project is described in a separate document, available from COSTI (Dinshaw, In preparation) . See the 'Program Quality Checklist' section below for an early version of the model in the format of a program fidelity instrument.

Safety-related empowerment

Analysis of MOVERS scores reveal significant differences in the safety-related empowerment levels among racialized and newcomer participants, compared to participants of European descent and Canadian citizens. As such, the highest levels of empowerment were observed among Canadian citizens of European descent, while the lowest scores were concentrated among Black and Middle Eastern newcomer participants. The largest differences in sub scores between racialized newcomer participants and Canadian citizens of European descent occurred with the subscales "Keeping Safe" and "Getting Support." This finding is consistent with information gathered through the staff interviews and client feedback surveys. For example, staff interviews highlighted challenges with translation services that can make services less accessible to newcomer women. Responses from the impact interviews and focus group discussions both include suggestions for improving service accessibility by providing better translation services. The focus group results emphasize this point, highlighting the need for information dissemination, translation services and services that are culturally sensitive. Lower sub scores for "Getting Support" among racialized newcomer women indicates a need to improve the accessibility and inclusiveness of resources for this group.

In this regard, the MOVERS findings are also consistent with the broader literature identifying barriers to accessing supports among racialized newcomer women experiencing domestic violence. A substantial body of literature suggests that immigrant and racialized women are a particularly vulnerable segment of the GBV survivor population and face unique barriers to accessing supports. For example, unfamiliarity with services, social and geographic isolation, and a lack of culturally and linguistically appropriate services can prevent immigrant women from accessing services (Guruge & Humphrey, 2009). These barriers can be exacerbated by the financial challenges often associated with immigration (Piquot & Lu, 2017), experiences of racism, and a general mistrust of service providers (Guruge et al. 2010). These findings provide some context for understanding the lower MOVERS scores observed among the racialized and newcomer participants in this study and highlight the need for a program model that is culturally safe, intersectional, and survivor informed.

Client feedback

Client feedback included responses to the impact interviews (n=119) and the suggestion poll (n=133), as well as six focus group discussions with 27 program participants. The client feedback surveys contained many positive comments about the program, including 116 statements about the high quality of the program and expressions of gratitude. The most common suggestions from participants centred on wait times and communication. Participants specifically requesting shorter wait times for services (n=35) and improved communication, such as more follow-up from program staff (n=24). These suggestions are consistent with information gathered from staff interviews and hub meetings, which indicated that high staff turnover,

general staffing shortages, and funding constraints created service delays. These challenges were exacerbated throughout the pandemic. Although agencies were unable to identify a concrete solution to these challenges given the funding constraints, they did distinguish between recommended and essential practices to identify key processes that must be prioritized during service delivery. In doing so, agencies can ensure that the most essential service components are prioritized and delivered in a timely manner. For example, many participants cited long wait times for assessment and referrals, and better access to housing as important areas for improvement.

Focus group discussions yielded several recommendations pertaining to domestic violence prevention and service delivery. Participants suggested a one-stop solution, stating that services should be available in one place. Key recommendations centred on early prevention through education, financial independence for survivors and ethno-cultural diversity in service delivery. For example, some participants (employed Canadian citizens with proficient English language skills) suggested education, beginning at the elementary school level, and strict punishment for perpetrators of abuse. Participants also suggested better legal protections for victims of abuse. Participants also suggested that newcomer women should be provided with resources and information packages in various languages upon arrival in Canada. All participants emphasized the need to empower women through financial independence. Participants noted that financial independence can help women make critical decisions about their safety and the safety of their children. Access to safe, secure and affordable housing was identified as essential to women's safety, as homelessness is traumatizing and puts women at risk of returning to an abuser. Participants also identified access to employment resources as a key factor in promoting financial independence. Finally, participants suggested that services should be developed through an ethno-cultural diversity lens, accounting for the specific traditional and cultural experiences of GBV survivors. Participants noted that newcomers are particularly vulnerable due to language barriers and cultural experiences that make it difficult to disclose abuse. Service providers must be trained in cultural diversity and translation services should be readily available.

The client feedback echoes themes that have been identified in the broader literature on GBV survivors and is consistent with some findings from the MOVERS survey that indicate lower levels of safety-related empowerment among racialized and newcomer participants. Client feedback is consistent with the literature highlighting the unique challenges experienced by racialized and newcomer women in terms of accessing services that are linguistically and culturally appropriate (e.g. Guruge & Humphrey, 2009). Client feedback is essential for ensuring that services are responsive to needs of clients with diverse experiences. As such, it is imperative that services are culturally sensitive and informed by survivors' experiences.

Challenges of collecting and engaging with data

There were many obstacles at every step of working with client data. In fact, data collection presented many overlapping barriers, consuming a significant portion of the project's resources in devising solutions. Project participants eventually realized that the processes related to collecting and engaging with information from survivors and clients could. Eventually, project participants recognized that the procedures related to collecting and engaging with information from survivors and clients could serve as a valuable contribution to the sector.

The main challenges and their respective solutions were:

- Agency staff were reluctant to ask women in crisis to be involved in a research study. The consent process was time-consuming and involved asking sensitive questions about immigration status and race. Often there was time pressure to assess risk of violence or meet urgent needs. **Solution:** For ethical reasons, the client's needs took priority. The research design abandoned the idea of a random or complete sample, and responses were analyzed to generate hypotheses rather than conclusions about the services.

- Agencies struggled with staff turnover and disruption related to the pandemic, and it was necessary to keep re-training and reminding staff to go through the data collection process in addition to their other responsibilities. **Solution:** The COSTI project manager and evaluators instituted monthly update meetings with each hub until data collection problems were solved and provided training to new staff as they joined the project.
- The data collection tools were not integrated into client management processes and were stand-alone add-ins that had to be managed separately in addition to regular client note-taking. Information technology staff for each agency were not resourced to provide support for these tools. The necessity for collecting sensitive client data across several agencies with different IT platforms led to the development of a complex Excel-based tool that was easily broken with continual problems with data errors and staff confusion. **Solution:** The evaluators made several revisions to simplify the Excel tool for users. However, this was only a partial solution. The primary solution would involve transitioning away from using Excel for data collection and integrating data tools into the regular client management system.
- Both staff and clients perceived the added responsibility of data collection for the project as having little value, resulting in a very low response rate. This was despite a generous budget allocated for staff time and respondent gift cards (\$20 to \$30 per interview). To address this issue, the project implemented two solutions: First, to boost the response rate, the value of gift cards for a single interview was increased to \$50. Second, to enhance the perceived value for staff, the project introduced regular meetings with each agency to present and discuss client feedback. Additionally, agencies were reminded that specific funding was designated for data collection purposes.

Recommendations

Most of the recommendations arising from this project are embedded in the program blueprint developed by COSTI (Dinshaw, In preparation). The following recommendations concern evaluation and program improvement and are relevant to other gender-based services beyond the program model used in this project.

1. Use client data only to improve services

This point is fundamental to evaluation and monitoring in general and underlies the rest of the recommendations. **Client data presents many technical and ethical problems** that it should be clearly useful, either to individual clients or to the program as a whole.

- There are huge costs and barriers to data collection and reporting in domestic violence services. Data collection in particular presents a burden to both staff and clients, and unnecessary documentation has been shown to decrease staff morale and have other negative effects (Ommaya et al., 2018; Zegers et al., 2020).
- The benefits of data should be larger than the costs. If data is not being used to improve services, it should not be collected. This may require negotiations regarding funder-mandated surveys to improve their timeliness and usefulness.
- The costs of data collection, analysis and security should be adequately funded, including ongoing technical support and staff training.
- The results of data analysis must engage front-line staff as well as agency decision-makers. That means that reports should be relevant, frequent (e.g., monthly) and probably interactive so that staff can explore results, test hypotheses and see the impact of service changes. If front-line staff do not value the results of data collection, the data is unlikely to be accurate.

2. Use survivor-informed practice

Survivor-informed practice (Goodman et al., 2016; Kulkarni, 2018) is one of the main elements underlying the program model. Survivor-informed practice prioritizes the empowerment and engagement of survivors in the services they receive. This approach overlaps with client-informed and deliberate practice in that feedback from clients is continuously collected and used in service delivery. Client-informed and deliberate practice are related to lower drop-outs, higher client satisfaction, decreased negative impacts, greater counsellor effectiveness and higher impact in social services (Gondek et al., 2016; Graßmann et al., 2020; Miller et al., 2020; Swift & Greenberg, 2012), while survivor-informed practice emphasizes in particular the intersectional nature of gender-based violence. For managers, client feedback gives them a view into service delivery and allows them to spot problems that should be addressed. Client feedback can also provide proxies for outcomes, accountability, empowerment (Benitez et al., 2022) and thus can reduce the need for other types of measurement.

Survivor-informed practice requires engaging with ongoing feedback from survivors to improve services. The steps include collecting feedback, reviewing it, discussing it with agency decision-makers, changing services in response to the feedback and repeating the cycle (Brattland et al., 2018).

Specific suggestions for using client feedback include:

- Client feedback can be collected in many ways, including during sessions or informal conversations, not necessarily via structured surveys and focus groups.
- Client feedback, regardless of how it is collected, should be reviewed regularly with staff (e.g., in monthly staff meetings), using a standard agenda that includes follow-up actions. Actions might include assessing the importance of issues by interviewing more clients or discussing service improvements with managers. The evaluation measure would be a summary of the actions deriving from the client feedback and could be collected from staff meeting notes (for example) or task lists.
- Open-ended qualitative responses seem to have the most impact on staff, especially when the responses include appreciation for good work. When staff could see words of praise and recognition, they have found it very rewarding and were more able to pay attention to suggestions and criticisms. Working in the field of domestic violence is emotionally draining, and evaluation should minimize negative effects on staff while maximizing benefits to clients. In comparison to open-ended responses, aggregated scores and numbers from client surveys are difficult to interpret and may not be compelling to staff.
- When utilizing qualitative responses, agencies need to ensure the confidentiality of comments. Even without names, it's sometimes possible to deduce the identity of a respondent. Despite the clear statement in the informed consent section of Suggestion Polls that anonymous excerpts would not be quoted, several agencies had overlooked this constraint by the project's conclusion and had intended to include quotes in reports to their Board or funders. We suggest that informed consent on client feedback tools incorporate permission to quote excerpts anonymously, as it's likely to occur regardless.
- Where process or outcome metrics are not feasible (see next sections), agencies may interview a small sample of clients to assess service process and impact.

3. Use process metrics to improve program quality

We know from implementation research that program models are not useful in isolation (Fixsen et al., 2005). Without continual tracking and improvement to maintain program fidelity, programs tend to stray from their official models.

There are many ways to assess program fidelity (Carroll et al., 2007) but not all are useful in practice, especially for complex interventions involving people with multiple vulnerabilities (Hasson et al., 2012). In fact staff training, which is a type of fidelity measure, sometimes results in poorer actual fidelity! (Muhammad et al., 2021). For the most effective approach to measurement, agencies should track a small number of key metrics that show whether the most important elements of service delivery are on track. This information should be embedded into the client management system as a regular part of service delivery. In cases where this data is not collected in their management systems, agencies may select a random or strategic sample of clients for process tracking.

It is important to define the key elements, sometimes called the ‘active ingredients’, of the program model. The basic GBV program model involves several steps: Initial intake, assessment, safety planning, referral and follow-up. Some agencies provide additional services such as counselling or shelter. The core elements of the model are survivor-informed practice, rapid intakes and assessments, appropriate safety planning and appropriate referrals that meet client goals. Further, referrals are supported by close relationships with children’s protective services, police, housing and emergency response at minimum. Essential metrics are:

1. The consistent use of up-to-date protocols for intake, assessment, safety planning, referrals and collaborations consistent with the program model. This includes staff training and supervision to ensure that new staff are familiar with and use the processes defined by the agency.
2. Within 48 hours of first contact, the majority of referrals (e.g., 80%) including self-referrals will have completed initial intake, which includes a brief risk assessment, initial safety tips, and advice on appropriate resources. [as minimum necessities: food, clothing, shelter, emergency response]
3. Within two-weeks of first contact, most eligible intakes (e.g., 70%) will have a full assessment and safety plan, rising to almost all (e.g., 95%) within four weeks.
4. Demonstrated use of client feedback in service delivery over the period of a year (e.g., as evidenced in notes of program changes). Collecting client feedback is just one part of the process; agencies must also demonstrate that this feedback has been utilized to enhance their services.
5. Demonstrated problem-solving and collaboration with core referral partners over the period of a year (e.g., as evidenced in notes of case conferences). Core partners include at minimum children’s protective services, police, housing and emergency responses. It’s not enough to show that meetings are occurring; the agency should show evidence of trouble-shooting and frequent communication around issues or specific clients.

If agencies or funders define clear service standards (e.g., 80% of initial referrals to be contacted within 48 hours) they can trouble-shoot if metrics fall below the service standard. For example, agencies might call clients back in the evenings, change the way they do follow-ups, work with referral partners to improve processes, make a case for additional funding, advocate publicly for better services, and more.

Implementing detailed process metrics requires a large investment in time and money and does not necessarily result in improved services unless they are incorporated into regular management processes (De Vos et al., 2009; Institute for Healthcare Improvement, 2021; Sampath et al., 2021).

4. Delay outcome measurement until client feedback and process metrics are implemented

Before agencies implement outcome measurement, they should first prioritize the implementation of client feedback and process metrics, unless outcome measurement directly

benefits service delivery. Rather than focusing on outcome measures, agencies should initially utilize process metrics and client feedback as outlined above.

There are two main reasons for this recommendation.

First, outcomes for gender-based violence are difficult to measure and even more difficult to validate against objective risk and health outcomes (Goodman et al., 2015; Hackett et al., 2015; Put et al., 2019). It is especially difficult to get statistically valid data in domestic violence services given the barriers to data collection described above (Sullivan, 2011). That means that outcome measures should not be aggregated and compared between agencies because the results will be misleading at best.

Second, outcomes are not as useful as client feedback and process metrics in managing service delivery. If a program is based on evidence and has been shown to work with a given population, the most appropriate use of measurement is to ensure that the services are being delivered correctly according to the program model and that clients are able to influence the services they receive. Outcome measures are generally not relevant since they are measured too late to impact a client's services, are considered by staff, and are unlikely to be reliable.

Specific suggestions related to the use of outcome measures include:

- Agencies should select outcome measures that are feasible to collect and that provide useful information for their own service provision. These will be different depending on an agency's objectives. Examples include MOVERS, safety assessments, clients' satisfaction with services, clients' progress toward meeting their goals, changes in the extent of violence and/or trauma that clients experience, and changes in clients' knowledge (Macy et al., 2015).
- If funders wish to collect outcome measurements related to domestic violence services, they should allocate funds for specific validation research using objective measures and external researchers. For example, one potential approach could involve assessing the health and safety outcomes of women at risk of violence by leveraging the Ontario ICES database (Schull et al., 2020) to link their health records with the provision of domestic violence services. However, it's important to acknowledge that this approach may pose significant ethical and logistical challenges and may be unfeasible in practice.

Outcome measures, when they are used, should be integrated into a client management system so that they are incorporated into service delivery, do not require staff to switch IT platforms, and include demographic data for use in planning and service equity.

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Supplementary Materials

Also see the following separate files relating to the project, available from COSTI:

- Program blueprint (Dinshaw, In preparation)
- Report on focus group sessions (Ahmed & Dinshaw, 2023)
- Zip file containing MOVERS spreadsheet tool, the PDF multilingual versions of MOVERS and brief technical documentation

Demographic characteristics of clients served by hubs

At the beginning of the project each hub provided descriptions of the number and demographic characteristics of their clients over a recent 12-month period, summarized below in alphabetical order. Some hubs have detailed and accurate data derived from client management systems while others relied on their staff’s knowledge of the people they served. The information was gathered for the most current year available; generally 2020, and should be treated as rough estimates.

COSTI Toronto

Female clients served	784
DV female clients served	226
Syrian refugee support program	129
Psychiatric services provided to clients	236
Women’s group	26
Clients from GTA	99.9%
Phone in-take	90%
Walk-in clients	10%
Nationality or background	Majority of clients are of European descent. Others are African, Caribbean, and Middle (Syrian refugee population).
Languages	English, Italian, Arabic, Spanish, Farsi/Persian/Dari, Somali, Tagalog including Filipino, French. Few Hindi/ Urdu, Turkish
Age	15 to 65+ years
Educational background	Majority has Secondary school diploma, Primary school (8 years or less), College diploma, university degree (bachelors)

La Maison

Clients served	49
Children served (childminding)	26
Nationality or background	Majority of clients are of Sub-Saharan African descent (73.9%). Others are from North Africa, Caribbean (Haiti), Canada, and Pakistan.
Languages	French, Lingala, Arab, Urdu, Akan, Swahili, Kirundi, Mina, Portuguese, Umbundu, and French Créole
Age	16 to 56+ years
Educational background	Majority has at least a secondary school diploma (78%) with 30.4% of the women having a college diploma or university degree (bachelors) and only 21% with a primary school education level

Safe Centre of Peel (SCoP) Brampton

Clients served	423
Children served (childminding)	179
Number of phone assessments	350
Number of onsite assessments	174
Nationality or background	Largest population: South Asian. Other populations served: African, Caribbean, Middle Eastern, Latino, Caucasian. Many clients do not disclose ethnicity
Languages	Hindi, Urdu, Punjabi, Arabic, English, French
Age	Highest age groups are: 20-49

Settlement Assistance and Family Support Services (SAFSS) Scarborough

Clients served - women	165
Clients served - children	8-10
Nationality or background	South Asia (India, Pakistan, Srilanka and Bangladesh), Middle East, Afghan, Iran and Iraq.
Languages	Pashto/Farsi/Dari, Tamil, Hindi, Urdu, Bengali

Educational background	Varied – some have post secondary; majority have secondary education. (Iran, Bangladesh and India have postgraduation, highly qualified)
Age	20-55 years and some are older

York Region Centre for Community Safety (YRCCS) Newmarket

Clients served	430
Average number of services accessed onsite	2
Nationality or background	Iranian, South Asian and Asian
Languages	Farsi, Urdu and Cantonese

Data collection tools

The instruments in this section were for clients of GBV services. The Program Quality Checklist, which was answered by staff of the hub partners, is in the subsequent section.

There were minor variations in wording of the instruments based on whether the data collection tool was presented online, in interviews or in paper form. For example, an online survey had buttons at the bottom of each page stating [PREVIOUS] and [NEXT] or [SUBMIT].

The data collection tools were:

- Measure of Victim Empowerment Related to Safety (MOVERS): A 13-point scale administered by service providers. This tool provided clinical insight into GBV survivor progress and generated anonymized outcomes data for aggregate analysis.
- Client Feedback Survey: An anonymous, self-administered online or paper survey, which collected service recipient ratings of service quality and inclusion.
- Suggestion Poll: An anonymous, self-administered online or paper survey, which collected service recipient suggestions for service improvement.
- Impact Interview: A brief structured interview, administered by participatory researchers or hub staff to collect service recipient-reported outcomes and suggestions for service improvement.
- Hub interviews: Open-ended interview protocols for staff of participating hubs to collect information about program delivery and the progress of the project.

Measure of Victim Empowerment Related to Safety (MOVERS)

Overview

The Measure of Victim Empowerment Related to Safety (MOVERS) was the main outcome measure used in the project. To protect client confidentiality, the evaluators created a complex Excel workbook to collect and report on longitudinal MOVERS data.

The MOVERS spreadsheet tool exported data into a secure encrypted SharePoint document library (on a second anonymized data management workbook), once per month. The data collection sheet included macros that enabled a hub to administer MOVERS including instructions, scripts and dropdown/plugin answers. For security, the second workbook included a column with a client code that was automatically generated to hide personal data. Each month the data was imported to a second Excel sheet for analysis.

The tool was created in both English and French, including all instructions. Screenshots are below.

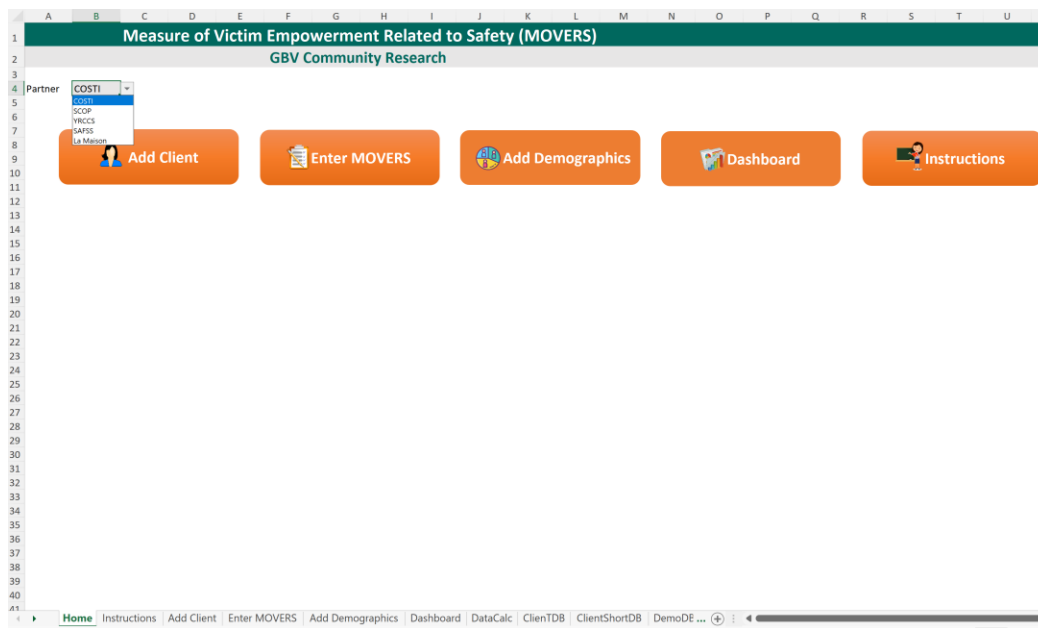


Figure 1: MOVERS tool - Home page


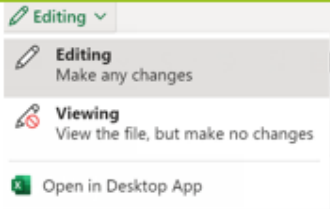
B	C	D	E	F
 Measure of Victim Empowerment Related to Safety (MOVERS) Instructions - GBV Community Research				
Introduction				
The purpose of this tool is to enable staff to collect and report on MOVERS scores when they administer MOVERS to clients.				
Steps				
<ol style="list-style-type: none"> 1 Open this spreadsheet as a Desktop App (see the image on the right). 2 Save the file in a shared folder on your network where you can find it later. Allow editing and accept the security warning. 3 Add new clients in the 'Add Client' tab. 4 Every time you administer MOVERS, enter the score in the 'Enter MOVERS' tab. 5 See your results in the 'Dashboard' tab. 6 When you get the client's consent, complete the client's demographic information in the 'Add Demographics' tab. 7 Once a month, to submit the data to the GBV project: Create a new spreadsheet in your GBV shared folder at https://sisngo.sharepoint.com/sites/GBV called AGENCY_MONTH_YYYY_MOVERS. 8 Go to the 'DataCalc' tab in this tool. Select all by clicking the upper-left corner of the table and then pressing CTRL+A. 9 Copy and paste as Value into your new file. There should be no names or year of birth. 10 Save the file. 				
Important notes				
<ul style="list-style-type: none"> * Always save the file after entering a new record (Client, Demographics or MOVERS) so you don't lose the new information. * For existing Clients, go to the 'Enter MOVERS' or 'Add Demographics' tab and select the client's name and year of birth from the dropdown picklists. * Do not save this file in your local computer. Always use this tool using your partner shared folder. If this is not possible, you will not be able to use this tool. * Always open the tool as an desktop App to make sure the tool works properly. * This workbook was built to be used by one person at a time. Do not try to save two versions at the same time or you may lose data. 				
References				
Measure of Victim Empowerment Related to Safety (MOVERS) at https://sites.google.com/bc.edu/goodman-research-team/measures/measurement-of-victim-empowerment-related-to-safety This Excel tool was developed by LogicalOutcomes www.logicaloutcomes.net .				

Figure 2: MOVERS tool - Instructions

Home
Measure of Victim Empowerment Related to Safety (MOVERS)

Home
Add Client
Enter MOVERS
Add Demographics
Dashboard

Client Name*

Year of Birth YYYY (e.g. 1979)

*mandatory field
If you have the client consent in the first MOVERS administration, please go to 'Add Demographics'.

Clear Screen
Home
Save

Figure 3: MOVERS tool - Add client

Home
COSTI

Home
Add Client
Enter MOVERS
Add Demographics
Dashboard

1 Find the client

If client name is not in this list, create a new client.

Client*

Client
Maria Care-1995

2 Enter MOVERS for this period

Stage*

Administration Date* YYYY-MM-DD

Enter an answer to each individual question or the Total Score by MOVERS subscale (Keeping Safe, Getting Support, Making Compromises). Please do not fill both

Keeping Safe

1. I can cope with whatever challenges come at me as I work to keep safe.

2. I know what to do in response to threats to my safety.

3. I know what my next steps are on the path to keeping safe.

4. When something doesn't work to keep safe, I can try something else.

5. When I think about keeping safe, I have a clear sense of my goals for the next few years.

6. I feel confident in the decisions I make to keep safe.

Keeping Safe*

Getting Support

7. I have a good idea about what kinds of support for safety that I can get from people in my community

8. I feel comfortable asking for help to keep safe.

9. I have a good idea about what kinds of support for safety I can get from community program and services.

10. Community programs and services provide the support I need to keep safe

Getting Support*

Making Compromises

11. I have to give up too much to keep safe.

12. Working to keep safe creates (or will create) new problems for me.

13. Working to keep safe creates (or will create) new problems for people I care about.

Making Compromises*

Total MOVERS*

Please review MOVERS

*mandatory field

Clear Screen
Home
Save

Figure 4: MOVERS tool - Enter MOVERS data

Measure of Victim Empowerment Related to Safety (MOVERS)

Home Add Client Enter MOVERS **Add Demographics** Dashboard

- Find the client *If client name is not in this list, create a new client.*
 Client*
 Client
 Maria Cara-1995
- Enter Demographic data for this client
 - Gender*
 - Referral Type*
 - Parent child(ren) of 12 or under*
 - Immigration Status*
 - Racial Category*
 - Language
 - English*
 - French*
 - Other Language
 - Program provides services in at least one of languages of client*
- Click on Save

*mandatory field

Clear Screen Home Save

Figure 5: MOVERS tool - Enter demographic data

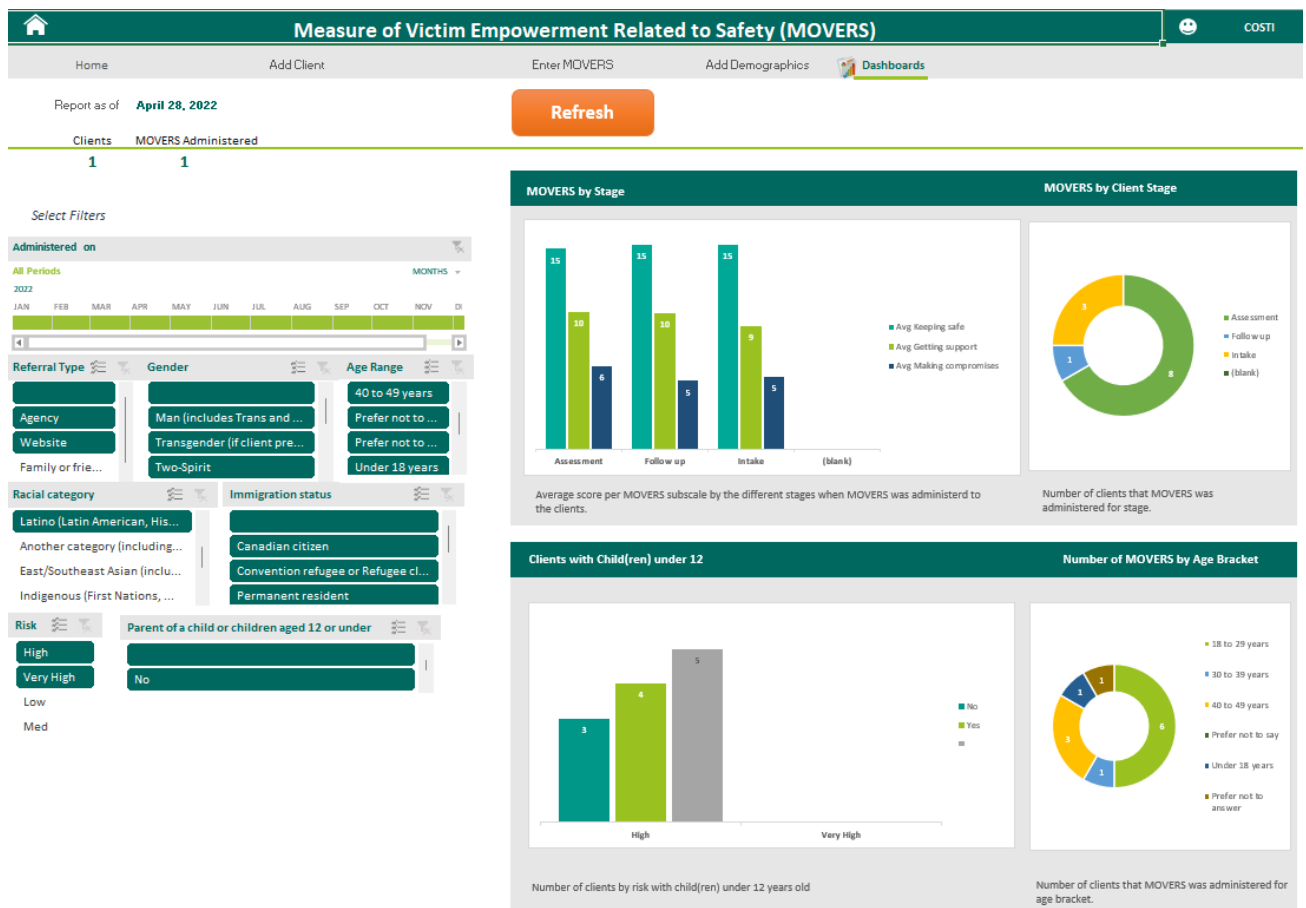


Figure 6: MOVERS tool – Dashboard seen only by hub staff, not evaluators

Client Code	Client Name	Year of Birth	Assessed on	Stage	Keeping safe	Getting support	Making compromises	Total score	Client Age	Referral Type	Intake Date	Year of Birth	Gender	Immigration status	Racial category	English	French	Other	Agency referral	Parent of a child or	Partner	Month	Year	Age	K5 %	G5 %	M5 %	Score %	Risk	Age Range
A02144676-11	Marie-Claire	1995	2022-05-01	Intake	12	8	5	25	35	Family or friends	2022-05-01	1995	Female	Permanent resident	Latin American, Hispanic, descendent	Yes	Yes	Quebec	Yes and from staff who speak this language	Yes	COST1	5	2022	27	100	100	100	100	Low	18-24

Figure 7: MOVERS tool - Client summary data with names, seen only by hub staff, not evaluators

A	B	C	D	E	F	G	H
Client Code	Administered on	Stage	Keeping safe	Getting support	Making compromises	Total score	Referral Type
A02144676-11	2022-05-15	Intake	15	8	5	28	Family or friends

Figure 8: MOVERS tool - Client summary data with client ID. This is the only page uploaded to evaluation portal

Wording

YOUR SAFETY

You may be facing a variety of different challenges to safety. When we use the word safety in the next set of questions, we mean safety from physical or emotional abuse by another person.

I'm going to read you some statements that describe how you may be thinking about your safety right now. For each statement, I'll ask you to tell me how true it is on a scale of 1 to 5, where 1 is "never true" and 5 is "always true".

When you are responding to these questions, it is fine to think about your family's safety along with your own if that is what you usually do.

[Never true, Sometimes true, True half the time, Somewhat true, Always true]

Keeping safe

1. I can cope with whatever challenges come at me as I work to keep safe.
2. I know what to do in response to threats to my safety.
3. I know what my next steps are on the path to keeping safe.
4. When something doesn't work to keep safe, I can try something else.
5. When I think about keeping safe, I have a clear sense of my goals for the next few years.
6. I feel confident in the decisions I make to keep safe.

Getting support

7. I have a good idea about what kinds of support for safety that I can get from people in my community (friends, family, neighbours, people in my faith community, etc.).
8. I feel comfortable asking for help to keep safe.
9. I have a good idea about what kinds of support for safety I can get from community program and services.
10. Community programs and services provide the support I need to keep safe

Making compromises

11. I have to give up too much to keep safe.
12. Working to keep safe creates (or will create) new problems for me.
13. Working to keep safe creates (or will create) new problems for people I care about.

DEMOGRAPHIC DATA IS COLLECTED DURING THE INTAKE PROCESS AND ENTERED INTO THE MOVERS DATA COLLECTION TOOL BY THE STAFF PERSON.

Age

- Under 18 years

- 18 to 29 years
- 30 to 39 years
- 40 to 49 years
- 50 to 59 years
- 60 to 69 years
- 70 years or over
- Prefer not to answer

Gender identity (to be filled out by staff, with questions of clarification if appropriate)

- Woman (includes Trans and Cis)
- Man (includes Trans and Cis)
- Non-binary
- Transgender (if client prefers this to 'Woman' or 'Man')
- Two-Spirit
- Not listed above

Immigration status

- Permanent resident
- Convention refugee or refugee claimant
- Student or visitor
- Canadian citizen
- Non-status
- Prefer not to answer

Languages spoken well enough to have a conversation (choose all that apply)

- English
- French
- Other

Program provides services in at least one of languages of client (choose one)

- Yes we have staff who speak this language
- Yes through interpreters
- No

Racial category (Instructions if appropriate: "Which of the following categories best describes you? If you belong to more than one category, choose the one that is most relevant for the services you are receiving. We ask this question because many people face discrimination because of their race.")

- Black (including African, Afro-Caribbean, African Canadian descent)
- East/Southeast Asian (including Chinese, Korean, Japanese, Taiwanese descent or Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent)
- Indigenous (First Nations, Métis, Inuk/Inuit descent)
- Latino (Latin American, Hispanic descent)
- Middle Eastern (Arab, Persian, West Asian descent including Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish)
- South Asian (including East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean)
- White European descent (including White North American)
- Another category (including any not described above)
- Do not know
- Prefer not to answer

Suggestion Poll

Overview

See a demo at [Suggestion Poll \(sis.ngo\)](https://www.sis.ngo)

The suggestion poll was very brief, and could be posted on the hub's web site, included in email signatures, or sent out occasionally to stakeholders to ask for input. It could be used with clients, participants, volunteers, staff or community members.

Description

This suggestion poll uses sense-making techniques to engage participants in making thoughtful suggestions and to reduce the costs of qualitative analysis. Respondents are asked to narrow down their feedback to one suggestion, rated by priority and categorized by common elements of service quality. If the survey includes demographic measures and program information (e.g., branch, type of program), the reports can quickly drill down to actionable information quickly and inexpensively.

The instrument is intended to engage respondents as participants in service improvement. It is not designed for open qualitative research, and expects respondents to provide thoughtful succinct feedback that can be easily understood and aggregated. The categories and priority ranking are explicitly designed to probe for recommendations around a wide range of management topics, including accessibility.

Because of the cognitive demands of the 3-stage measure (selecting the most important suggestion, prioritizing it and categorizing it), this instrument can be used as an interview protocol. Questions can be translated and explained by the interviewer. Alternatively, suggestions can be collected by hub champions in staff meetings or other sources and entered into the suggestion poll one by one. In those cases, the category can be filled out by the staff based on the content of the suggestion but the 'priority' rating can be ignored.

Wording

Your suggestion

How can we serve you better? This short survey asks for a suggestion to help us improve our programs.

Before you take this survey you should know:

- The survey should take just a few minutes to complete.
- The survey will not ask for your name.
- You can quit the survey at any time.
- Your relationship with our agency will not change if you do not take or finish this survey.
- Your answers will be shared with LogicalOutcomes, an organization that collects data for our agency.
- Your suggestions will be shared with agency staff, combined in a list with suggestions from other participants. Staff will be able to read all of the suggestions but will not know your name or anything else about you.

If you have any questions about this survey, please see the SIS privacy policy or contact us at [email] or [phone]

Take a minute to think about your suggestion. What is it about? Choose the closest match.

- Being treated with respect
- Location, hours or languages
- Waiting to get services

- Website and communications
- Other
- No answer

Write your suggestion here. Do not include any information that could identify you.

How important is this suggestion? (Choose one of the following answers)

- Very important
- Important
- Not very important
- No answer

Impact Interview

Overview

See a demo at [Impact Interview \(sis.ngo\)](#)

Description

This interview protocol was designed to be used by staff or volunteers with clients and program participants. It could be done individually or in a group, on the phone or face-to-face. It could be translated into any language on the fly by the interviewer, so it did not require respondents to use English or French, or to read and write. Questions could be simplified and explained during the interview.

The instrument invited clients and participants to recommend changes to the program based on their perspective as experts in their own experiences. It was an invitation to contribute as a partner, not a way to collect unstructured ideas and reactions. The interviewer was instructed to capture suggestions using wording that could be reported to staff without revealing identity, and clearly enough that action could be taken. In other words, interviewers were asked to strip responses of identifiable information and summarize suggestions in clear actionable statements.

We suggested that each staff person carry out one interview per month or every two months, with results discussed at monthly staff meetings. Alternatively hubs could ask volunteers to interview a small sample every couple of months. Interviewers could talk to their own clients or intentionally talk only to clients who they did not work with.

The instrument assumes that it is not using a random sample. Instead, interviewers were asked to think of it as extending an invitation to act as an advisor to the program, and select people who represent key groups and also are willing to reveal their opinions. Methodologically it draws from usability engineering methods in which a sample size of one to three can be meaningful. One of the main benefits is that staff gain insight into their own programs. In that way it is an organizational change intervention in itself.

In the GBV project, the Impact Interview had two types of administrations. One is tied to MOVERS data via an anonymous client ID after the client has provided informed consent. (They were offered a gift card for their participation.) The other administration was completely anonymous, with no demographic data or link to client identification.

Wording

To be carried out by a staff or volunteer at a hub organization, with a service recipient.

ABOUT: This interview protocol gives clients a chance to share:

- Their experience with your program
- The impact your program has had on their lives
- A suggestion for program improvement

BEFORE YOU START:

- Please read through the protocol before your interview, so that you're familiar with all the questions.
- The protocol is a script, but there's no need to stick to it word-for-word. Feel free to rephrase questions, using words that your respondent can understand.
- Enter details directly into the online form OR print the interview, complete the paper version by hand, then enter your results here.
- Do not write any details that would allow staff to recognize this participant.

DEALING WITH COMPLAINTS:

This interview invites clients to make suggestions for improvement, but you may also hear complaints. Please follow your organization's complaints protocol in responding to any complaints.

TIPS FOR CONDUCTING INTERVIEWS:

Good interviewers work with their respondent to understand, respond to, and capture what is said. Here are some effective techniques:

1. Pay attention: Your respondents are experts on their experience. Treat them as an expert who has agreed to give you advice. Create a comfortable atmosphere. Clear away distractions (phone, laptop), and focus your attention on your respondent. Give your respondent time to think and speak.
2. Reflect: Try to capture and re-phrase key ideas, to confirm that your understanding is correct.
3. Observe: Pay attention to nonverbal cues, like facial expressions, gesture and posture. Listen with your eyes as well as your ears.
4. Empathize: Try to understand the respondent's emotions and feelings, and identify and acknowledge them. Listen in a supportive, nonjudgmental way.
5. Clarify: Use clarifying and probing questions to show your respondent that you're engaged. Encourage them to reframe or expand on important ideas.
6. Summarize: Towards the end of the interview, briefly summarize what you have heard. Work with your respondent to refine their suggestion and determine its importance.

Introduction and impact

Our agency is working to improve the programs we offer. One way we do this is by asking people who participate in our programs how we can make our programs better.

Today we're going to talk about [Program]. I'll start by asking what you like about the program, and how it may have changed things for you. I'll finish by asking you for a suggestion to help us improve.

Before we begin you should know the following:

- This interview is completely voluntary.
- I'm hoping for 15 min of your time today, but we can take longer if you want.

- I will not record your name.
- You can tell me at any time not to write something down.
- You can skip any questions that you don't want to answer. You can ask me to stop the interview at any time.

Let me know if you want to learn more about this evaluation or about how the information you share with me will be used - I will share contact info for the evaluation team.

I'll ask again, to make sure that you're comfortable doing this interview: Is this okay?

1. Let's start with something positive: What do you like about our program?

2. How have the services or support you've received through our agency changed things for you?

3. This is a question about program impact. Impact is usually positive but could be negative. Prompt: Has this program brought about any changes in your life? What is the most important change?

Suggestion

Let's talk about how we could make our program better. Do you have a suggestion for improvement?

TIPS FOR INTERVIEWERS:

- Encourage your respondent to come up with one suggestion that you can bring back to your team. Do not include any identifying information or direct quotes that could identify the person.
- Capture their response, then ask how important the suggestion is. This will help your team to prioritize suggestions later on.
- The question "What is this suggestion about?" is for you to fill in. By coding the suggestion now, you will make it easier to analyze the data you collect.

4. What is your suggestion?

5. How important is this suggestion? (Choose one of the following answers)

- Very important
- Important
- Not very important
- No answer

6. What is this suggestion about? Choose the closest match.

- Being treated with respect
- Location, hours or languages
- Waiting to get services
- Website and communications
- Other
- No answer

7. Is there anything else that you'd like to talk about today? Anything else we should know about your experience with our program?

These questions help us learn about the people we serve.

How old are you?

- Under 18 years
- 18 to 29 years
- 30 to 39 years
- 40 to 49 years
- 50 to 59 years
- 60 to 69 years
- 70 years or over

How would you describe your gender? (Choose one of the following answers)

- Woman
- Man
- Non-binary
- Not listed above
- Prefer not to answer

What is your immigration status?

- Permanent resident
- Convention refugee or refugee claimant
- Student or visitor
- Canadian citizen
- Non-status
- Prefer not to answer

What languages do you speak well enough to have a conversation? (choose all that apply)

- English
- French
- Other

Does this program serve you in a language that you can speak fluently?

- Yes the staff speak my language
- Yes through interpreter
- No

Which of the following categories best describes you? If you belong to more than one category, choose the one that is most relevant for the services you are receiving. We ask this question because many people face discrimination because of their race.

- Black (including African, Afro-Caribbean, African Canadian descent)
- East/Southeast Asian (including Chinese, Korean, Japanese, Taiwanese descent or Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent)
- Indigenous (First Nations, Métis, Inuk/Inuit descent)
- Latino (Latin American, Hispanic descent)

- Middle Eastern (Arab, Persian, West Asian descent including Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish)
- South Asian (including East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean)
- White European descent (including White North American)
- Another category (including any not described above)
- Do not know
- Prefer not to answer

Thank you for your time. Do you have any questions about this interview?

Hub interview protocol

Overview

Wording

Progress notes for Hub monthly meetings

This structured interview captures the progress of evaluation activities for participating hubs of the GBV project (Evaluation of Wraparound Services for Immigrant, Refugee, Non-Status and Ethnocultural Women Facing Gender-Based Violence). It is designed for note-taking in monthly meetings starting May 2022.

1. Hub. If this meeting is for more than one hub, choose 'Other' and list the participating organizations.
2. Date of meeting
3. Meeting attendees
4. Number of suggestions, impact interviews and MOVERS responses so far Use the current numbers on the Power BI report and MOVERS dashboard that are shared in the meeting. They do not have to be completely up to date.
5. Issues and problems re data collection or GBV project management
6. Insights about data collection to share with others
7. Improvements to services as a result of data collection
8. Rating of GBV project in the past month

	Needs improvement	Okay	Good
Data collection tools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communication with GBV project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Usefulness of collected data to our services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. Next steps and tasks for followup

Data collection and management system

The evaluation project used a custom configuration of the Service Information System (SIS), an evaluation platform developed by LogicalOutcomes, that combines several applications from Microsoft Office linked to an open source survey platform.

SharePoint was the evaluation portal ‘home’ for the evaluation and project management team. It included project management documents, meeting notes and presentations, survey links, the MOVERS tool, and other materials for managing the project. Each hub had access to folders for their custom data collection tools using role-based permissions.

Power BI was used to show results from the Suggestion Poll and Impact Interview. Reports were bilingual, in English and French. Power BI reports pulled each text element from a metadata library in SharePoint, which supports multilingual captions and enables rapid edits to multiple reports with shared text elements.

For the final evaluation, data was downloaded into Excel for analysis.

Document quality rubric

For use in assessing quality of written deliverables

	Meets expectations	Requires revision
Content	Document shares high-quality information, analysis, recommendations and/or instructions.	Content is poorly researched or thought out. Document is insubstantial and/or contains superfluous information.
Organization	Document is clearly organized; sections proceed logically and are easy for readers to navigate. Longer documents include a table of contents.	Document is poorly organized and challenging to navigate.
Language	Language is clear, precise, and appropriate to the communications objectives and audience.	Language is ambiguous, difficult to understand, or inappropriate.
Formatting	Document uses built-in headings and styles. Fonts are easy to read and consistent throughout. Headings are correctly ordered and sized (H1, H2, H3 etc.). Spacing is appropriate and consistent. Footer identifies author, title and date. Page numbers are correctly formatted. Document passes accessibility check.	Document does not use built-in headings and styles. Fonts are poorly chosen and/or inconsistent. Headings are inconsistent in their sizing, style or use. Spacing is inconsistent. Footer and page numbers are absent or inconsistent. Accessibility check reveals unresolved issues.
Tables, charts and figures	Tables, charts and figures are clearly labelled and easy to understand. Multiple-page tables feature heading rows that repeat at the top of the table.	Tables, charts and figures are not appropriately labelled and are difficult to follow/understand.
Documentation and references	Any sources used are correctly documented, using appropriate citation.	Sources are not acknowledged or inconsistently cited.
GBA+	Document demonstrates sensitivity to the diverse vulnerabilities, needs and capacities of GBV survivors.	Document demonstrates inadequate attention to the diverse vulnerabilities, needs and capacities of GBV survivors.

Stakeholder input (for major deliverables)	Stakeholders are invited to review the document and request revisions. Revised document includes (reasonable) revisions.	Final draft is presented without adequate stakeholder input.
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Data collection and storage

- The Suggestion Poll and Impact Interview surveys were created in LimeSurvey, an open source web application that provides mobile-responsive multilingual surveys, hosted on Canadian servers. A gateway plugin enabled Power BI to securely retrieve data from LimeSurvey’s MySQL database.
- The Program Quality Checklist was a Microsoft Word document designed for administration in an online interview with hub staff in 2021 and then 2023. It collected no confidential information.
- The MOVERS tool was a Microsoft Excel workbook with complex flows described below. The use of a spreadsheet for data collection presented many technical problems and required months of troubleshooting because each staff person had a different computer system (and most were working from their homes). However, it was the only way we could ensure that confidential personal client information was kept within the agency systems.
- Microsoft Forms was used to capture structured interviews with hub staff in monthly meetings with the senior evaluator, starting May 2022. We used Forms because of the ease of developing and analyzing the data, and because there was no confidential information in these interviews. Forms data is stored in U.S. servers unlike the rest of the data in this project.

Program Quality Checklist

NOTE: This Checklist is in the form of a data collection tool, using small font to be used during screen-sharing sessions with hub staff. It was used to inform program blueprint design and training materials developed by the COSTI team.

Version: October 31 2021

Introduction

This program quality checklist captures the elements of effective and culturally appropriate practice as defined by the Gender-Based Violence Community Research Project.

The development of the checklist was used to clarify and define the important elements of practice, and then to allow each partner organization to rate themselves on those elements. It is based on literature reviews of effective and responsive services in the area of domestic and intimate partner violence, interviews with partner organizations, and a detailed process analysis of each organization to assess how in fact their services are carried out. It has been developed and revised over the timespan of the project (2020-2023). More information about the research project and the research underlying this model can be found at the GBV Community Research Project SharePoint site at <https://sisngo.sharepoint.com/:w:/r/sites/GBV/> [link is for hub partners only].

The checklist is a summary of a particular program model. We are not suggesting that this program model is the only, or best model for service delivery. Other organizations wishing to set up Gender-Based Violence (GBV) services can review alternate Program Blueprints that are being developed across Canada with funding from WAGE. There are many program models addressing people who are affected by or at risk for gender-based violence. If an organization does not score highly on this particular checklist, it may mean they are following another model.

The GBV Community Research program model can be summarized by defining what the program is trying to achieve, who it serves, and how program quality is measured.

What the program is trying to achieve and who it serves:

1. **Outcomes** – Safety, health and well-being for survivors of domestic or intimate partner violence and their children. The emphasis of the program model is on addressing immediate safety risks including violence, legal and financial jeopardy, homelessness and mental health crises.
2. **Community served** – Women affected by or at risk for violence in their homes or from members of their family or intimate partners, **AND** who are racialized or are newcomers to Canada. Other groups are served by the partner organizations and will benefit from the model, but this program model focuses on the needs of the defined target group. For example, the model does not explicitly address people who identify as trans or non-binary, nor violence in the school or workplace.

Program quality:

3. **Capacity** – The resources that the program can draw upon to deliver effective and culturally competent DV services, including physical facilities, staff, training, procedures, protocols and information systems.
4. **Processes** – The activities and processes that are actually applied in practice with clients. For example, the organization may have an excellent safety plan protocol (Capacity) but rarely implement it according to the protocol (Process). This program model focuses on the processes of initial intake, safety planning, needs assessment, active referral and initial case coordination until immediate safety needs are met (often called 'Information and Referral Services'). It does not include the provision of other services like housing, legal advice etc.
5. **Participant experience** – Participants' perception of the services they receive, including overall satisfaction and the extent to which they perceive staff as being sensitive to their individual needs and styles and responsive to various aspects of their identity and culture.

The Program Quality Checklist addresses Capacity and Processes. The other elements – Outcomes, Community served and Participant experience – are measured by other data collection tools. See the GBV Community Research Project SharePoint site for details.

Instructions

This is a long and complex checklist that is designed to be filled out in an interview with an evaluator. You and the evaluator may require more than one session to complete it. We suggest that you make notes on your copy before the interview, but it's up to you.

Definitions:

'Our organization' means the parent organization or sponsoring organization of the hub. It includes all services, not only DV services.

'Our DV services' or **'Our program'** refers to the department or program that provides direct services for women affected by domestic and intimate partner violence.

'Clients' are survivors of domestic and intimate partner violence who request or receive services from your organization or DV program.

'Staff' are workers or counsellors who interact directly with Clients. They may be hourly contractors or even trained volunteers who are supervised by paid staff.

NOTE: Questions and areas that require clarification are shown in red throughout this document. These issues will be clarified in the program blueprint.

When filling out the checklist, think about other organizations that may use this program model

to provide DV services in the future, and try not to set impossible standards for them. No program is perfect, but we can define the essential elements of practice that are required for the model. If you score an element as ‘Mandatory’ but your own program does not meet that criterion, do you mean that it is not really mandatory, or does it mean that your program should address the element in the next year? **Only select ‘Mandatory’ if you believe that a program should not be delivering services at all, or should select another program model, rather than compromise on it.**

Remember that problems in capacity and processes are generally caused by a lack of resources like funding, physical assets and high quality training. Low scores do not mean that your organization is not adequately committed or hard working. We are all constrained by funding. No program will get a perfect score, but our results will help us to understand our situation and where we can most improve.

Finally, based on the results of this checklist we may be able to create protocols, procedures and training materials that can be distributed to other organizations as part of the Program Model. At the end of the survey we ask if you would be willing to share your materials. By the end of this project, we hope to contribute to the national GBV sector by defining the core, minimum elements that must be in place for adequate service to racialized and newcomer women.

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PROGRAM QUALITY CHECKLIST

Name of Organization:	
Date:	
People who answered this checklist:	

Please feel free to send comments on this checklist to the evaluators. Highlight your notes to ensure that we see them.

Capacity

These questions combine your opinion about whether each item is necessary for this program model and also whether your organization actually provides it.

1, Where and how services are provided

This section is about where and how your clients receive services from your program. It is about accessibility, safety and being a welcoming place to come with children if necessary.

Where and how services are provided	Yes and it is mandatory if using this program model	Yes and it is strongly recommended if at all possible	No, but we plan to implement it in next year because it is mandatory	No, it is either nonapplicable or unfeasible for us	Don't know
The physical facilities of DV services:					
Location can be reached via public transit					
Entrances and washrooms are secured against unwanted entry					
Staff are able to close doors, have white noise machines or use other strategies to maintain client privacy while in session					
Space is warm and comfortable					
Space features culturally inclusive, affirming artwork/ posters					
Snacks, tea or coffee are available to clients					
Culturally-appropriate non-perishable items are available (food, clothing, toiletries, diapers, etc.) for clients to take with them					
Children's toys and equipment are available on site, age-appropriate and well-maintained					
Childminding is available onsite while adult client is in session					
Our organization ensures that DV services are accessible to women in crisis by:					
Providing emergency transportation from clients' homes to the location or health services (includes bus tickets, taxi chits)					
Providing services via phone					
Providing services via online communication					
Providing phone intake after business hours					
Posting a local or provincial 24 hour crisis phone line on organization website, voice mail and outreach materials					
Providing services in languages requested by clients either via interpreters or multilingual staff					
Our organization provides outreach by:					
Placing outreach materials locally (at libraries, settlement service organizations, community centres, places of worship, laundromats)					
Distributing culturally appropriate information material in various locations (court settings, health centres, college and university campuses, places of worship, etc.)					
Including GBV content (e.g., how violence affects children, safe and healthy relationships) in other activities carried out by organization (Language Instruction for Newcomers to Canada classes, newcomer orientations, citizenship training classes etc.)					
Conducting outreach over social media					
Listing DV services on 211.ca including languages available					
Providing accurate and up-to-date information about DV services on organization's website (requires an assigned staff person who posts updates quickly)					
Attending community events to distribute outreach materials to other service providers and community members					
Reviewing all outreach events and materials across entire organization for consistency with anti-oppressive practice					

1. Partnerships with other groups and service providers

Effective DV services must have formal and informal partnerships with other organizations and services. The following services may be internal (e.g, another department of the same organization) or external.

Collaborations and Partnerships	None: Your organization does not have any relationship or contact with them	Awareness: You have knowledge of them but no effort is taken to organize activities beyond individual client referrals	Communication: You and they have an active program of communication and information sharing	Cooperation: You and they use knowledge of the other's work to guide and modify service planning	Collaboration: You and they jointly plan the offering of service and modify services based on advice and input from mutual discussions
<i>Our organization has collaborative relationships with:</i>					
Children's Aid Society					
Police					
Organizations and groups serving racialized, ethnocultural and newcomer groups in your catchment area					
Organizations providing DV services					
Settlement service organizations					
Criminal justice sector organizations					
Colleges and universities					
School boards					
Faith-based institutions					
Representatives from funders or government					
Municipal, provincial and federal networks and forums on GBV (for example, forums on femicide)					

Referral Relationships	No relationship or no local availability or characterized mainly by conflict, broken communication and/or dropped referrals.	Limited relationship: Awareness of one another and occasional referrals but organizations do not actively work together to resolve barriers. Mainly neutral or positive contacts.	Basic working relationship: Referrals are sent or received, process may be delayed or have problems, problems not regularly raised and resolved.	Strong informal referral relationship: Active referrals are sent and received smoothly, problems raised and resolved. Possibly dependent on a small number of people and their social networks.	Strong formal referral relationship with written agreement, regular contact, not dependent on one person. Referrals sent and received smoothly, problems are raised and resolved.
<i>Our program sends and receives referrals with:</i>					
Emergency housing					
Housing services					
Food banks					
Medical care					
Family counselling and mediation					
Police services					
Legal counsel					
Court support (Victim Witness, Family court, Legal Aid Ontario, court support workers at shelters)					
Parenting support					
Short-term individual counselling					
Long-term (over 10 sessions) individual counselling and emotional support/ advocacy					
Mental health services, individual and/or group					
Support for children and youth					
Financial literacy services					
Financial assistance					
Employment services					
Settlement services					
Addiction treatment					

2. Qualified and trained staff

Qualified and trained staff are the most important part of any service. All front-line staff including reception and non-DV program personnel should know basic screening questions and be trained how to recognize DV. All staff of DV programs should receive specific training. Note that both training and also protocols and guides (next section) are important in handling DV situations.

Qualified and trained staff	Yes and it is mandatory if using this program model	Yes and it is strongly recommended if at all possible	No, but we plan to implement it in next year because it is mandatory	No, it is either nonapplicable or unfeasible for us	Don't know
All front-line staff of our organization receive regular training (at hiring and at least every 2 years) in:					
Signs of risk for DV and how to refer client to DV services for assessment or information					
Staff providing direct services to DV survivors receive regular training (at hiring and at least every 2 years) in:					
Assessing case urgency					
Identifying need to refer client for medical assessment and traumatic brain injury					
Culturally appropriate services to racialized and newcomer women					
Sponsorship and sponsorship debt in relation to immigration					
Femicide					
Trauma-informed care					
Supporting colleagues in handling concerns and discomfort relating to DV or difficult cases					
FOR RESOURCE DEVELOPER: This whole section needs implementable definitions, example job descriptions and preferably links to training materials. Some professional qualifications come with defined competencies, and do not have to be defined separately (e.g., clinical interviewing for clinical social workers). Qualifications may include: Client-empowering practice Cultural safety in service provision How to make effective referrals Clinical interviewing and redirecting Safety planning Requirements in job description: Vulnerable Sector Check, First aid and CPR, suicide prevention training, drivers license and vehicle.					

3. Protocols and procedures

See protocols and procedures in the Family Friends program and/or those submitted by partners.

Protocols and procedures	Yes and it is mandatory if using this program model	Yes and it is strongly recommended if at all possible	No, but we plan to implement it in next year because it is mandatory	No, it is either nonapplicable or unfeasible for us	Don't know
Screening – Our organization has sample scripts or protocols that help staff for all programs:					
How to ask a client about DV					
What to say and do if a client discloses DV					
Explain to clients why staff is discussing DV with them					
Inform clients about confidentiality and any mandated reporting requirements					
Educate clients about impact of violence on self and children					
Describe safe and healthy relationships, ones that aren't and how it affects health					
Have tested procedures for what to do if a perpetrator is on-site and displaying threatening behaviors or trying to get information					
Risk assessment – Our DV program has:					
A validated tool or instrument for risk assessment (Add detail here with examples, e.g., ODARA)					

Protocols and procedures	<i>Yes and it is mandatory if using this program model</i>	<i>Yes and it is strongly recommended if at all possible</i>	<i>No, but we plan to implement it in next year because it is mandatory</i>	<i>No, it is either nonapplicable or unfeasible for us</i>	<i>Don't know</i>
How to do safety planning with clients who disclose current DV					
Our Safety Plan protocol includes:					
Safety during a violent incident					
Safety if client is living with the abuser or preparing to leave					
Safety in residence					
Safety with a protection or restraining order					
Safety on the job and in public					
Safety planning with children					
Safety and technology					
Safety and emotional wellbeing					
Our organization collects and responds to feedback:					
Our program or organization does yearly evaluations and the results influence program planning (may be informal)					
Our organization provides clear instructions and tools for making complaints and suggestions using many channels and locations, and they are explained to every client					
A client feedback survey is regularly administered					
Client complaints/suggestions/feedback are reviewed at least twice a year					
Changes are made in response to client feedback					
A community needs assessment is done at least every five years to learn about local survivor needs and priorities (may be done by other organizations in the community)					
Our organization protects privacy and manages client information appropriately:					
Our organization has policies and protocols on data protection including policies related to file storage and confidentiality, and include remote service delivery					
Staff receive training on data privacy and protection (including staff from all partner organizations for multi-organization hubs)					
Client information system supports coordinated services and case management among different departments or organizations (e.g., client does not have to go through multiple intakes)					

4. Compliance with Provincial/Territorial regulations

All programs should meet local regulations, but the following ones are particularly important in providing DV services.

Compliance with Provincial/Territorial regulations	<i>Yes and it is mandatory if using this program model</i>	<i>Yes and it is strongly recommended if at all possible</i>	<i>No, but we plan to implement it in next year because it is mandatory</i>	<i>No, it is either nonapplicable or unfeasible for us</i>	<i>Don't know</i>
Our organization meets relevant provincial or territorial regulations regarding:					
The safety and well-being of staff and volunteers consistent with the Occupational Health and Safety Act and other relevant provincial standards.					
Accessibility to persons with disabilities consistent with AODA					
Privacy and protection of personal information					

Processes

Processes are only about what happens with clients within the DV services. It does not include screening done elsewhere in organization or other management processes such as staff training.

Any processes that do not directly involve the client are covered under the Capacity section above.

Answer each item based on the experience of the clients of your program.

5. Intake

	<i>True almost all the time</i>	<i>True most of the time</i>	<i>Sometimes true if applicable and feasible</i>	<i>Sometimes/mostly untrue and we want to improve</i>	<i>Not applicable</i>	<i>Don't know</i>
When clients are referred or contact your organization with DV risks:						
High-risk clients receive immediate service						
Referrals receive follow-up within 48 hours						
Minimum 3 attempts are made to follow-up with phone calls after referrals from external organizations						
Initial appointment is scheduled within 48 hours of initial contact (assuming client has availability)						
Initial intake and appointment occur within 1 week of initial contact (assuming client has availability)						
The intake process captures safety status and risk level						
The intake process captures source of referral						
The intake process captures contact information for safe communication						
The intake process captures need for an interpreter						
The intake process captures children's exposure to violence (including questions about CAS involvement)						
The intake process captures priorities for support						
The intake process captures demographic data						

6. Safety planning and assessment

	<i>True almost all the time</i>	<i>True most of the time</i>	<i>Sometimes true if applicable and feasible</i>	<i>Sometimes/mostly untrue and we want to improve</i>	<i>Not applicable</i>	<i>Don't know</i>
Meeting immediate safety needs:						
High-risk, high-urgency, complex cases receive priority response						
Preliminary safety planning is provided over the phone						
A safety plan is sent to client via email or other channel if it is safe to do so						
CAS is notified where children under 12 years old have been exposed to abuse.						
The client is informed of CAS role and the CAS process if children are exposed to abuse						
The police are contacted if there is an immediate risk of homicide						
Doing a full assessment:						
Staff works with client to develop safety plan and prioritize next steps						
Client is provided with written form of full safety plan that meets organization's protocol assuming this is safe						
Staff discusses results of assessment and screening (for example, MOVERS) with client						
Staff captures informed consent						
Staff take child(ren) to childminding or minds child(ren)						
Staff reviews intake information with client for accuracy						
The client is informed about DV, including concepts using culturally-relevant psychoeducation tools (for example, Power and Control Wheel, etc.)						
Client has opportunities to tell their story in full over the entire course of interaction with the staff [not clear what this means; sometimes it is more helpful to redirect and de-escalate]						

	<i>True almost all the time</i>	<i>True most of the time</i>	<i>Sometimes true if applicable and feasible</i>	<i>Sometimes/mostly untrue and we want to improve</i>	<i>Not applicable</i>	<i>Don't know</i>
Staff documents key details for analysis						
Staff uses active listening skills, validates and re-states information for accuracy [this requires training and protocols in capacity section]						
Staff supports client to de-escalate their emotional state						
Staff works to build trust and rapport						
A risk assessment is conducted using a validated instrument (eg ODARA) [provide examples]						
A traumatic brain injury assessment is conducted using a validated instrument [provide examples]						
Staff ask about financial needs, including sponsorship and sponsorship debt where applicable (for example, financial assistance, housing, income support, etc.)						

7. Service provision

	<i>True almost all the time</i>	<i>True most of the time</i>	<i>Sometimes true if applicable and feasible</i>	<i>Sometimes/mostly untrue and we want to improve</i>	<i>Not applicable</i>	<i>Don't know</i>
During every contact clients receive empowering and respectful services:						
The wait time for scheduled appointments is no longer than 10 minutes in the waiting room						
Staff supports client to list and prioritize needs						
Staff guides client toward sources of support						
Staff provides client with resources for self-care						
Staff ensures that client has a clear sense of next steps						
Staff ensures that client has safety-related empowerment, e.g., knows how to protect themselves and where to get help, after leaving each session						
Staff ensures that client is receiving timely access to coordinated services [e.g., follows up on active referrals]						
Clients provide feedback on how staff approach their case and the feedback is used to identify staff training or support needs						
Case conferences are carried out for complex/high-risk cases						
Management and allied professionals are involved in case planning to coordinate support in urgent/complex/high-risk cases						

8. Referrals

This section is about meeting clients' diverse needs in a coordinated and efficient way. Evidence on active referrals, especially for vulnerable people with problems in communicating privately and safely from homes with return phone calls.

	<i>True almost all the time</i>	<i>True most of the time</i>	<i>Sometimes true if applicable and feasible</i>	<i>Sometimes/mostly untrue and we want to improve</i>	<i>Not applicable</i>	<i>Don't know</i>
Our organization provides active and timely referrals:						
An immediate referral to medical care is made if traumatic brain injury screen result is positive [some programs do not do TBI screens but do make referrals to medical services if client is injured. Clarify this by reviewing actual program procedures]						
Client is connected to appropriate onsite and off-site services through an active referral (see referral relationships in 'capacity' section)						
Staff facilitates connection with CAS and police						
Staff explains duty to report to CAS if children involved						
Staff provides insight into role of CAS if children involved and facilitates connection including on-site meetings if it is feasible or appropriate						

	<i>True almost all the time</i>	<i>True most of the time</i>	<i>Sometimes true if applicable and feasible</i>	<i>Sometimes/mostly untrue and we want to improve</i>	<i>Not applicable</i>	<i>Don't know</i>
Client is asked if child(ren) witness or has been exposed to abuse						
Staff provides insight into role of police and provides support						
Staff advocates for client as needed with CAS and police						
Staff schedules appointments with service providers						
Staff coordinates appointments and follows up with providers to ensure the referral is successful						
Staff arranges interpretation for client where needed						
Staff shares information (with client consent) with service providers to support targeted and coordinated services						
Clients are not obligated to re-tell their story unless it is important for privacy protection (prevents re-traumatization)						

9. Closure

There is inconsistency re case closure procedures. If there is no formal case closure, how are these steps carried out?

	<i>True almost all the time</i>	<i>True most of the time</i>	<i>Sometimes true if applicable and feasible</i>	<i>Sometimes/mostly untrue and we want to improve</i>	<i>Not applicable</i>	<i>Don't know</i>
When a client completes a course of DV services:						
Staff revisits client file and questions client whether their goals were met						
Client invited to complete satisfaction survey						
Case closure form captures relevant details and case files are kept for 7 years from date of last in-person appointment						
Staff follows up with client before closing case to ensure services are accessed and needs are met						
3-6-month follow-up call gauges safety-related empowerment and presents opportunity to return						

Final Questions

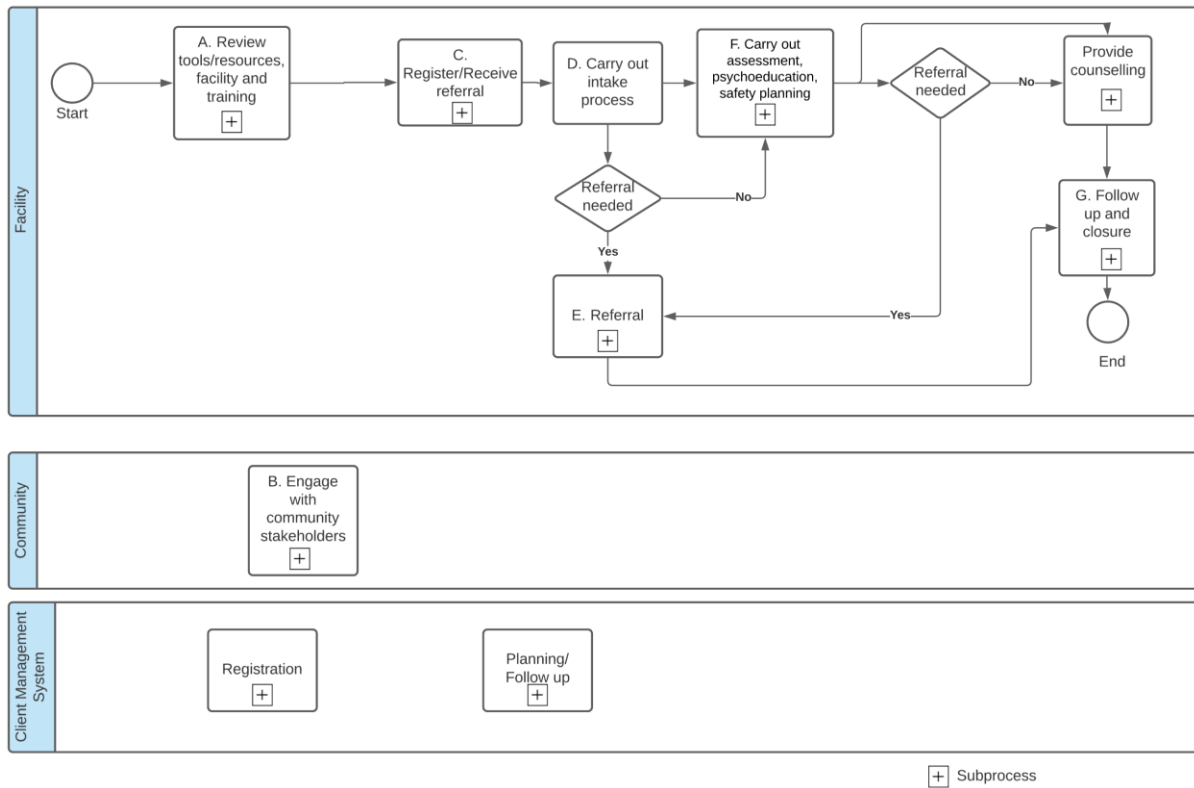
Do you have comments or suggestions about this survey or the items? Are we missing something important or including something we shouldn't?

Are you willing to share your organization's protocols, scripts or procedures with other organizations?

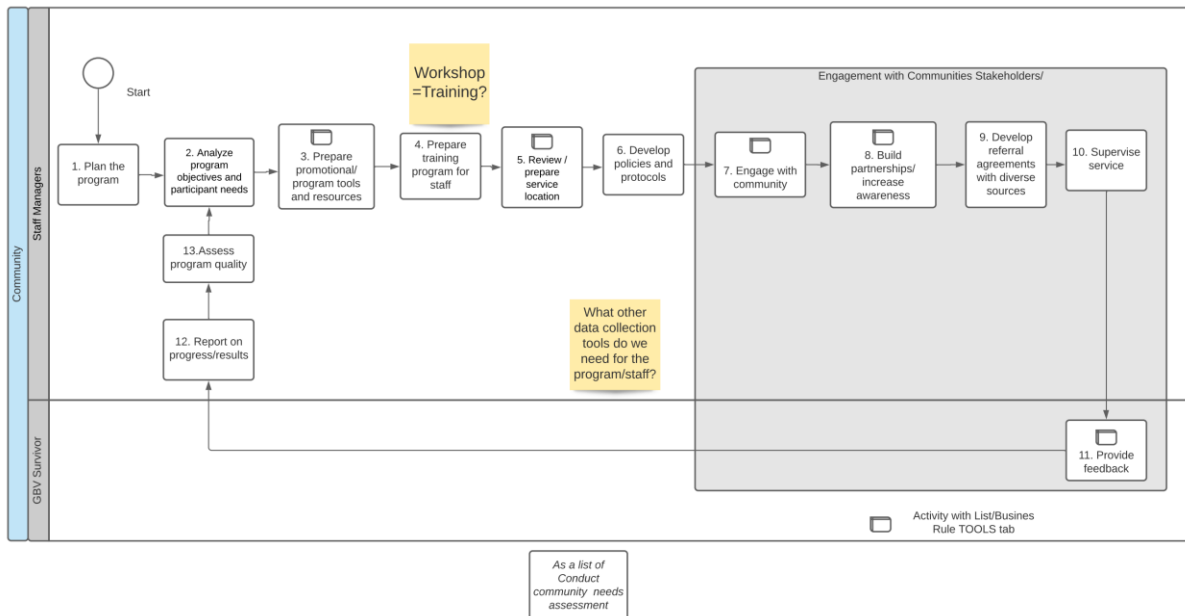
Do you want to see protocols, scripts or procedures from other organizations that you might incorporate into your programs?

Process flow diagrams

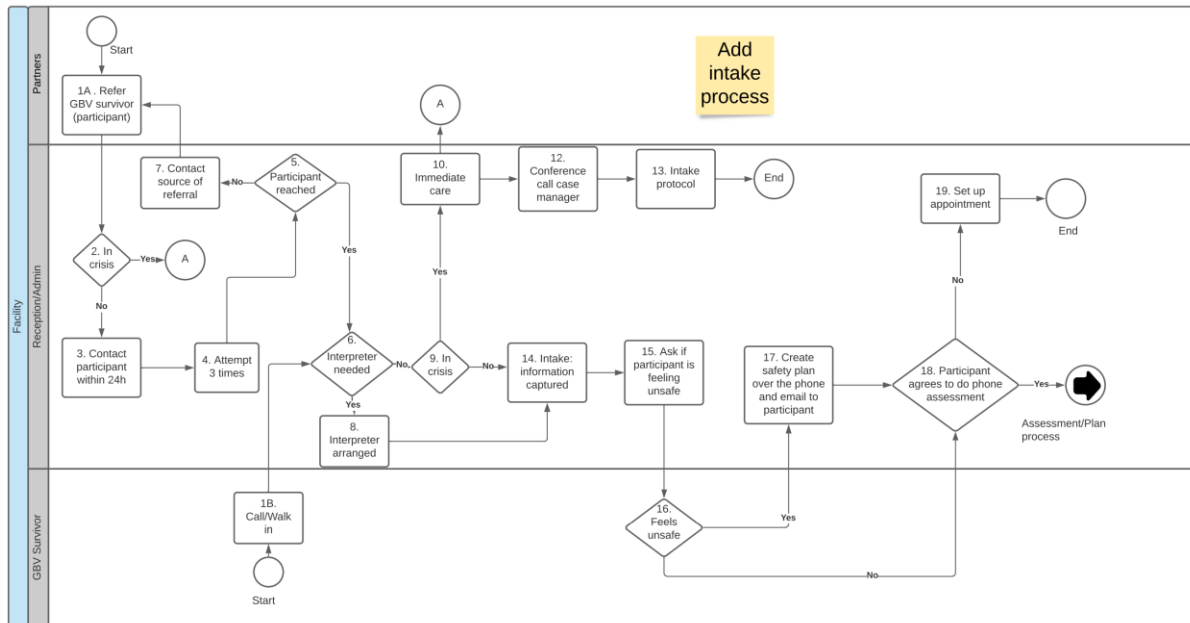
Process Overview



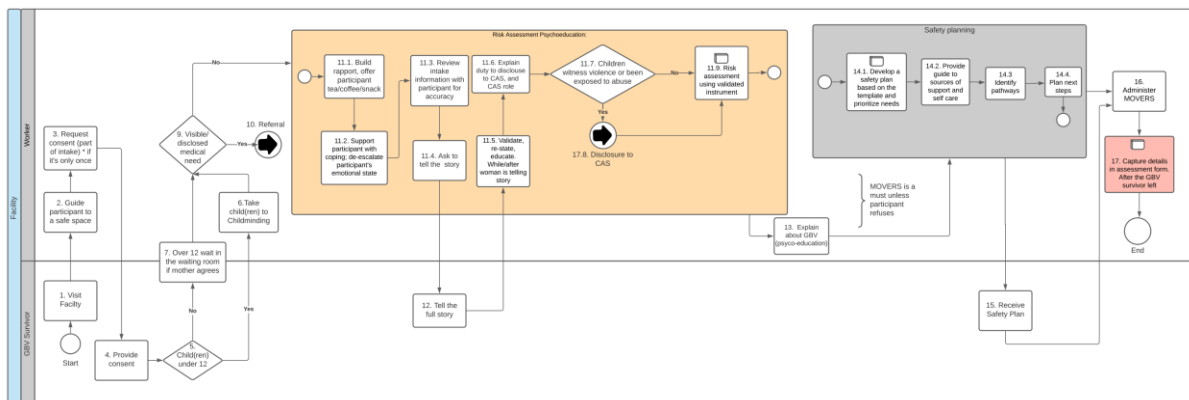
Program Design and Setup



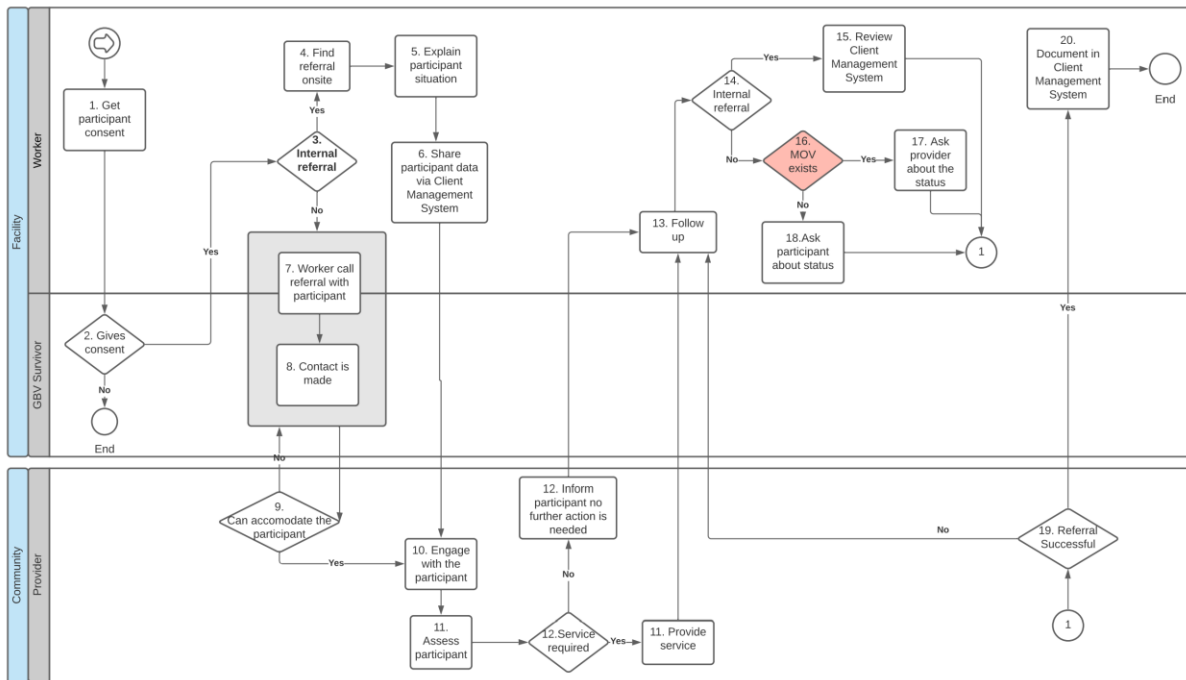
Registration and Intake



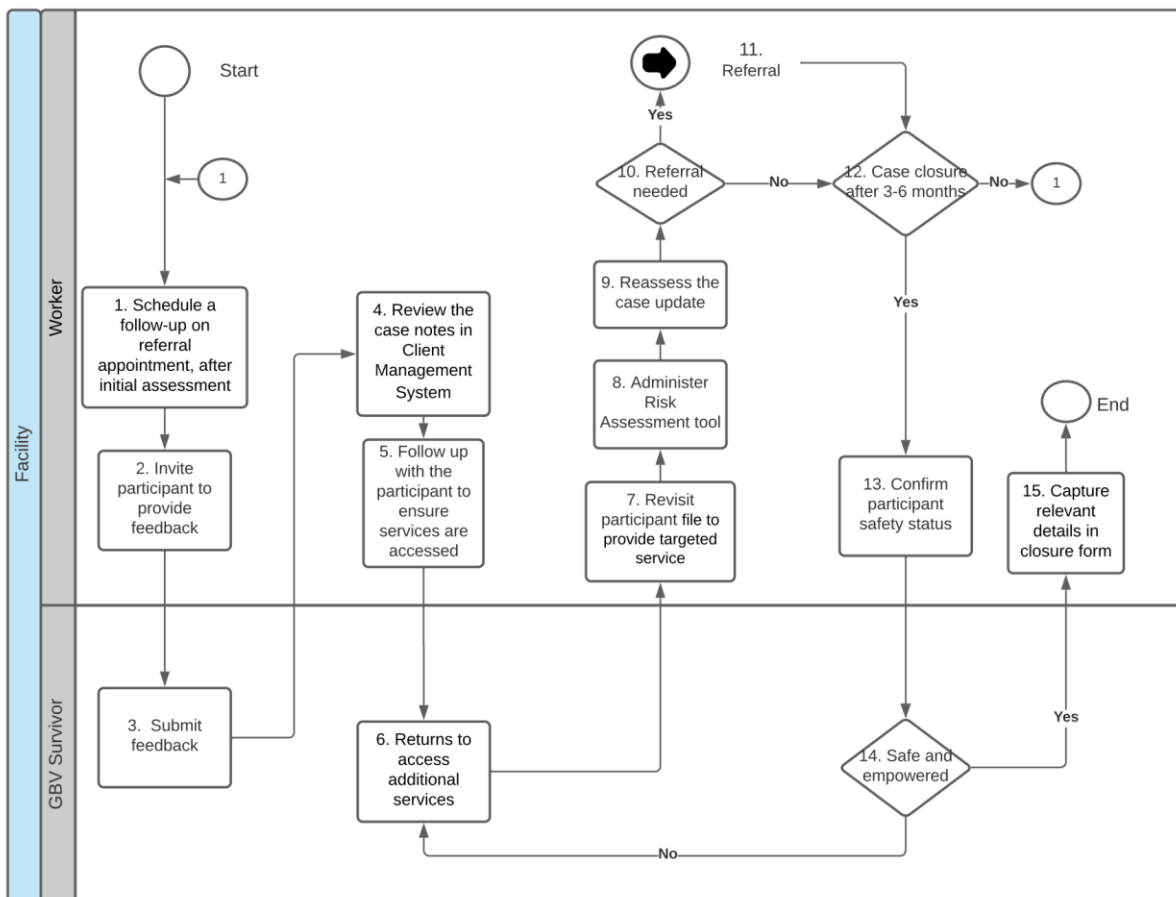
Assessment and Planning



Referrals



Closure and Followup



Program digitization elements

This section describes the program model using the World Health Organization’s ‘SMART Guidelines’ (Mehl et al., 2021): “Standards-based, Machine-readable, Adaptive, Requirements-based, and Testable ... a comprehensive set of reusable digital health components (e.g., interoperability standards, code libraries, algorithms, technical and operational specifications) that transform the guideline adaptation and implementation process to preserve fidelity and accelerate uptake” (World Health Organization, 2021)

The content below is excerpted from a supplementary Excel workbook, available on request, which includes the information required to convert the program model into a client management system and associated processes.

This material will be the responsibility of the Program Resource Developer to further refine if users find it helpful in creating the program blueprint.

Personas and user scenarios

List of personas

Occupational title	Subtype	Description	Different Names	ISCO Code
Participants	GBV Survivor* Children Person of concern Other family and friends	Person subject to risk violence is the primary client receiving Gender Based Violence services from the staff, specially the workers. Persons subject to risk of violence includes women who have been subjected to Gender-Based Violence, including the needs of their children. Also marginalized populations such as IRMS survivors, older adults, racialized survivors, and LGBTQ+ survivors. The program is specialized on GBV survivors from immigrant and refugee communities, and particularly for racialized women and women with precarious immigration status, fragmentation of services can constitute an insurmountable barrier to accessing support. Characteristics: -Low income -Immigrants from Northwestern Europe, the Philippines, Australia, New Zealand and the United States had rates of chronic low-income comparable to that of the Canadian-born population, at 4-5% -Don't speak English or French -Difficulties to get a job Perpetrator or Person of concern. Men, Family members. Reasons behind the violence are: -Poverty -Immigration stress and isolation	Client Victim Participant GBV Person subject to risk violence	N/A
Staff	Reception/admin Worker (provide assessment/safety planning and referral)* Counselor (mental health services) Referral partner (the one that refer to housing, resource or destination, psychiatrist) Managers	Staff is any COSTI person involve in the service provided to the GBV participant. The main Persona is the worker, who provide assessment and psychoeducation once the participant reach out the program. Make sure that the safety planning is done and refer the participant to other members of the internal staff or other services providers like: -Police to create a report -Medical care -Social Worker -Financial assistance -Legal counselling -Housing -Therapy -Addiction treatment -Court Support The Staff work is to make sure the GBV Person subject to risk of violence had the proper service, giving also a follow up plan for the case until the closure. Staff (other members) also make sure the tools, resources and settings are according to the standards in order to make the participant safe.		
Stakeholders	Community members Service providers	Stakeholders are external personas that interact with the program. Service providers are Legal counselors. Community members are any person that belongs to a community. People from school boards, colleges and universities, cultural organization, among others.	* Services providers in the ecosystem * Community members	

Participant persona

Name	Title	Age	Status	Languages	Nationality	City	Type	Children	Occupation	Religion	Related Personas	Income level
Samirah	GBV Survivor	27	Married	Arabic	Algerian	Toronto	Person subject to risk violence	2 kids	Restaurant server	Islam	• Children • Person of concern • Other family and	Low income



"I feel there is no hope. No one can understand my situation. I am worried for my children and I have nowhere to go, but it's always be that way"

Access	Internet (mobile)
Challenges	Physically abused by her husband Worried by the safety of her children No family and friends in this country
Motivations	I need to provide stability to my children I want to live better Private and security
Character	Isolated Shy
Technology use	

Worker persona

Name	Title	Age	Status	Languages	Nationality	City	Type	Children	Occupation	Religion	Related Personas
Amy	Worker	42	Separated	English French	Canadian	Toronto	Worker	1	Domestic Violence Advocate	Catholic	



"I know what it feels like to be submitted to violence on a daily basis. No woman or any other person should be suffering what I suffered"

Bio	Amy is a domestic violence survivor. The fact that she could overcome this, made her work to change the life of others that subject to abusive and toxic relationships of any kind.
Access	
Challenges	Wants to have clear guidelines to provide the service to the victims Need training to reach out all type of cases. Need the proper tools and resource to provide a better service Needs to do many paperwork and input contact interaction in the system.
Motivations	Share her experience with others and broke the cycle Reach others in abusive relationships
Character	The survivor advocate

Other personas

Persona	Name	Title	Age	Status	Languages	Nationality	City	Type	Quote	Children	Occupation	Religion	Related Personas	Income level	Access	Sex	Challenges	Motivations	Character	Technology use	Notes	Key Points		
GBV Survivor	Sahrah	Person subject of violence	27	Married	Arabic	Algerian	Toronto	Participant	"I feel alone in Canada. No one can understand my situation. I was married for 10 years and I have 2 children, but I'm still in a dangerous situation."	2 kids	Restaurant server	Islam	• Canadian • Person of colour • Other family and friends	Low income	Internet (mobile)	Female	Physical assault by her husband. Married by the utility of her children. No family and friends in this country.	Need to provide stability for my children. I need to feel better. Peace and security.	Controlled by her husband.	Controlled by her husband.	Controlled by her husband.	Controlled by her husband.	Controlled by her husband.	Controlled by her husband.
Children	Amir	Perpetrator	30	Married	Arabic	Algerian	Toronto	Participant		2 kids	Islam			Low income						Controlled by his family (Facebook, WhatsApp, etc.)				
Other family and friends	Maria	Spouse	35	Single			Toronto	Participant	"I am happy to be in Toronto and have the opportunity to meet new people"		Restaurant server			Low income	Internet (Community activities)	Female	New center that wishes to spend more time with friends.	Wants to get experience to get new opportunities. Likes to go forward to get a better place. Likes to be involved in the community to know more people.	Controlled by her husband (Facebook, WhatsApp, etc.)	Controlled by her husband (Facebook, WhatsApp, etc.)	Controlled by her husband (Facebook, WhatsApp, etc.)	Controlled by her husband (Facebook, WhatsApp, etc.)	Controlled by her husband (Facebook, WhatsApp, etc.)	
Neurodiversity	Jay	Worker	20	Single	English/French	Canadian	Toronto	Staff	"I need to be organized and motivated. I don't like to be interrupted or affected by the noise when I'm working. I'm not used to silence on a daily basis. No woman or any other person should be suffering what I suffered"		Bank	Catholic		Medium income						Controlled by his family (Facebook, WhatsApp, etc.)				
Witness	Alex	Worker	40	Separated	English/French	Canadian	Toronto	Staff			Worker	Catholic			Medium income					Controlled by his family (Facebook, WhatsApp, etc.)				
Client Management	Amy	Worker	42	Separated	English/French	Canadian	Toronto	Staff			Worker	Catholic			Medium income					Controlled by his family (Facebook, WhatsApp, etc.)				
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Client Management	Amy	Worker	4																					

User scenarios

User scenario	Key Personas	User Scenario Description	Corresponding Business processes	Data elements to be collected	Decision-support logic to be embedded	Functional and non-functional requirements	Notes
GBV referred by person	Participant: Person subject to risk violence: Samirah Other Family and Friends: Maria Registration: Reception/admin: Lily	Maria notices that Samirah came to work with bruises last week. After talking to her, she understands that those were made by Samirah's husband. As Maria knows to the library workshop, there is an agency in Toronto that provides services for domestic violence, she contacts the agency to refer Samirah giving the receptionist, Lily, Samirah's contact information. Lily asks Maria about Samirah assess the high priority of the cases asking Maria about if she understands Samirah is at risk of homicide. As the answer is no, Lily asks Maria if Samirah requires interpreter and gives Maria information about the safety of the program. Lily verifies that they have no record of Samirah and calls her, introducing her and the role of CSST and the explaining the reason of the call. Then Lily asks Samirah if she is in a safe place to talk. Samirah is not in a good position to talk freely, Lily tells her to call back to the agency. Samirah calls back and Lily explains why was she calling and asks her if she is in crisis or high risk. Samirah says no. Lily offers to make an appointment asking the demographic information. Lily asks if Samirah feels unsafe. Lily creates a safety plan with Samirah over the phone and asks if it's safe to send it over the email. As the answer is "no", both set up an appointment. Lily also tells Samirah that she can go with the children to the appointment. Lily records the intake in the Client Management System.	C. Appointment E. Referral D. Intake	Name of Participant (GBV Survivor/Referral) Phone (GBV Survivor/ Referral) Email (GBV Survivor/ Referral) Type (GBV Survivor/ Referral) GBV offender Relationship (GBV Survivor) Religion (GBV Survivor) Gender Ethnicity Address (GBV Survivor) Children (GBV Survivor) Nationality (GBV Survivor) Requires Interpreter (GBV Survivor) Risk Priority (GBV Survivor) Note Date of Birth (GBV Survivor) Violence Situation Safety status/risk level (for Femicide etc.) Priorities for support Status (Referred, Contacted, Active, Inactive)* for follow up Business Rule	Calculation of age based on data of birth Decision support based on if the GBV has been contacted for an appointment after the referral (3 attempts)	Recording data for later use Reminder pro-up Password protection User management based on roles Personal data restriction Detailed information forms	
			C. Appointment	Appointment Date/Time Appointment Address Subject/Service Name (GBV Survivor, Worker) Email			
Intake in crisis	Participant: Person subject to risk violence: Samirah Other Family and Friends: Maria Registration: Reception/admin: Lily Case Management: Angela	Samirah is referred or expressed that is at risk of homicide. Lily assesses Samirah risk with having the conversation with her. Lily called Amy, Worker, and the Case Management, Angela, and other allied professionals to coordinate the support to Samirah. During and after the call, Amy and Angela explain Samirah the duty to report to CAS and provides insight into role of CAS. Then Amy and Angela coordinate that is located on site. Amy also insight into the police and medical services. Amy connects/calls the police to help Samirah with the submitting the report. Amy also asks Lily to contact transportation for Samirah in case a referral is necessary	C. Appointment E. Referral D. Intake F. Assessment/Safety Plan Referral	Name (GBV Survivor) Case management Worker assigned Sexual orientation Religion Date of birth Language Children Perpetrator Referral Type Referral information Risk Priority Violence Type (Physical Assault, Sexual Assault, Stalking, etc.) Services Service Provider (internal or external) Treatment provided Consent Sexual Assault Visible medical injuries Child abuse Weapons GBV Story Safety plan	Consent validation Priority Risk trigger immediate case management (crisis process)	Consent management validation	
GBV first visit	Participant: Person subject to risk violence: Samirah Staff: Reception/admin: Lily Worker: Amy Staff: Counsellor	Samirah visits the facility with her two kids. She meets Lily who greets, welcomes her. As the children are both under 12 years old (3 and 8 years old) Lily talks to them and take them to the Childminding. Lily locates Samirah a safety place and offers her some refreshments while waiting for the worker. Lily calls the worker that will help Samirah. Amy introduces her self, explains the service briefly, and asks Samirah to sign a consent. Samirah agrees. Amy access to the system and make sure that the information of Samirah is accurate and also asks her for other demographic details that are missing from the initial intake. Samirah tells the full story, explaining that the last time her husband almost killed her, by choking her and hitting her. Amy active listens, provides supports to de-escalate Samirah emotional state and documents the key details for analysis. Amy starts evaluating Samirah risks and safety status, using the MOVERS, Traumatic Brain Injury screening tool to determine the priority of the case. Amy also asks questions to determine if Samirah's children are at risk. Amy determines that Samirah does not need immediate medical care, nor the kids are subject to violence. Amy informs Samirah about GBV using the Power and control wheel briefly. Samirah is hesitant to proceed with the report since she is alone in the country, her family is Islam and she does not feel she has any option to escape of her current situation. Amy explains the options and starts talking about the plan, which Samirah agrees to listen and participates as much as she can. Amy starts with Samirah the safety plan which includes safety during a violent incident, at home, on the job or public places, etc. They work to list Samirah priorities and needs. Since Samirah wants to leave the house immediately, Amy gives her resources for housing, self care and source of support. Amy keeps capturing the list into the Client management system. Amy starts coordinating the immediate services, calling the police so Samirah can do the report, emergency housing, medical care, legal counsel, along other services like financial, psychiatry. Samirah goes to the police to fill out the report. Amy makes sure that before Samirah leaves the facility she has all that she needs to be safe, making sure that she has all the services and referral appointments set up and also recording all of this into the client management system. Internal counselling for mental health are managed on the Client Management System as well. Amy also set up an appointment to follow up with the case for her and Samirah.	D. Intake F. Assessment/Safety Plan E. Referral	Risk level MOVERS TBI Service Type Referral Provider Appointments Plan with information	Decision-support logic to trigger based on if the participant has children, ask for CAS		
GBV visits	Participant: Person subject to risk violence: Samirah Staff: Reception/admin: Lily Stakeholder: Service Provider	Samirah visits the facility for the follow up appointment with Amy. Amy review the Client Management System to review the case and the pending actions and referrals. Amy asks Samirah if she has visited/contacted the referrals and if the services have been successful. Amy administers MOVERS instrument to reassess Samirah's current situation on the case. Samirah needs more services and it's referred to a service provider, in this case a Food Bank and Parenting support. Amy calls them to set up the appointment in the presence of Samirah. Amy also validates the safety plan with Samirah and set up the next appointment to follow up the case with Samirah. After Samirah leaves the facility, Amy record the interaction into the Client Management System.	C. Registration F. Assessment/Safety Plan E. Referral	Referral Name Referral Address Referral Phone Referral email Appointment Referral: Date Appointment Facility: Date Location Participants Note MOVERS Referral status (Pending, Scheduled, Successful, Unsuccessful)			
GBV last visit	Participant: Person subject to risk violence: Samirah Staff: Reception/admin: Lily Stakeholder: Service Provider	Amy reviews her cases and finds Samirah has 6 months in the program and has an appointment coming up. Samirah visits the facility for the follow up appointment with Amy. Amy review the Client Management System to review the case and the pending actions and referrals. Amy asks Samirah if she has visited/contacted the referrals and if the services have been successful. Amy administers MOVERS instrument to reassess Samirah's current situation on the case. Samirah does not need anymore services/referral. Amy confirms with Samirah if she feels safe and empowered. Amy document the relevant information into the (closure form Client Management System).	C. Registration F. Assessment/Safety Plan E. Referral G. Follow up / Closure	Closure form?			

Data elements and indicators

The core data processes are listed below:

Process Name	Process ID
	ID used to reference this process through Digital Adaptation Kit DAK or WHO
Title	
A.	Program setup
B	Community engagement
C	Registration
D	Intake
E	Referral
F	Assessment & safety planning
G	Follow up & Closure

Core data elements

Excerpt:

Activity ID	Activity Name	Data Element ID (Table.dataelement)	Data Element Name	Description and Definition
GBV.CIA	GBV survivor is referred by a third party survivor	Contact.contactid	Unique Identification	Unique identifier generated for new clients or a universal ID, if used in the country
		Contact.firstname	First Name	Contact Name according to the type of contact
		Contact.lastname	Last Name	Contact Name according to the type of contact
		Contact.createdon	Contact Creation Date	Date of the contact creation
		Contact.type.name	Contact Type	GBV Referral, GBV Survivor, Child
		Contact.address1_line1 Contact.address1_line2 Contact.address1_city Contact.address1_country	Address	Client's home address or address that the client is consenting to disclose

Full table:



Indicators

Excerpt:

Indicator code	Indicator name	Numerator Definition	Numerator Computation	Denominator Definition	Denominator Computation	Disaggregation
GBV.IND.2	Organizational partnerships	SCORE ON CHECKLIST - PARTNERSHIP DOMAIN		N/A		Type of organization
GBV.IND.3	Percentage of staff trained in specific topic(s)	Number of staff workers that received training in specific topic(s)	COUNT of all staff workers that received training for specific topic(s) during a reporting period	Total of staff workers of the agency	COUNT of all staff workers working in the agency within the last reporting period	Training topic (Psychological support, Trauma informed practice, Femicide, etc.)
GBV.IND.4	Existence of protocols and procedures on specific topic(s)	SCORE ON CHECKLIST - PROTOCOL DOMAIN		N/A		Protocol/Procedure topic
GBV.IND.5	Percentage of GBV survivors served from specified group	Number of GBV survivors from specified group who received service	COUNT of GBV survivors who received service in reporting period from specified group	Total of GBV survivors who received service	Count of all participants who had the first contact within the last reporting period	Age Gender Ethnicity Marital Status Type of Violence (physical, psychological, etc.) Perpetrator (Intimate Partner, Family member or other)

Full table:

Indicator code	Indicator name	Numerator Definition	Numerator Computation	Denominator Definition	Denominator Computation	Disaggregation	Reference	Notes and questions
GBV.IND.1	Community outreach and engagement	SCORE ON CHECKLIST - COMMUNITY OUTREACH DOMAIN		N/A		Type of organization		What kind of engagement?
GBV.IND.2	Organizational partnerships	SCORE ON CHECKLIST - PARTNERSHIP DOMAIN		N/A		Type of organization		add percentage of agencies with partnerships with specified type of service providers, eg police, CAS
GBV.IND.3	Percentage of staff trained in specific topic(s)	Number of staff workers that received training in specific topic(s)	COUNT of all staff workers that received training for specific topic(s) during a reporting period	Total of staff workers of the agency	COUNT of all staff workers working in the agency within the last reporting period	Training topic (Psychological support, Trauma informed practice, Femicide, etc.)		
GBV.IND.4	Existence of protocols and procedures on specific topic(s)	SCORE ON CHECKLIST - PROTOCOL DOMAIN		N/A		Protocol/Procedure topic		
GBV.IND.5	Percentage of GBV survivors served from specified group	Number of GBV survivors from specified group who received service	COUNT of GBV survivors who received service in reporting period from specified group	Total of GBV survivors who received service	Count of all participants who had the first contact within the last reporting period	Age Gender Ethnicity Marital Status Type of Violence (physical, psychological, etc.) Perpetrator (Intimate Partner, Family member or other)		Should it be compared to community composition? Or focused on percentage who get action plan/safety plan/first contact?
GBV.IND.6	Number of GBV survivors referred to external services	Number of GBV survivors who had been referred to external services	COUNT of GBV survivors who have a referral			Referral Type (Internal, External, Police, Active)		
Change	Percentage of participants that created full Safety Plan	Number of participants that created full Safety Plan	COUNT of GBV survivor who had been assessed	N/A		Age Gender Language spoken?		
GBV.IND.7	Number of participants that received risk assessment	Number of GBV survivor who had been assessed	COUNT of GBV survivor who had been assessed	N/A		Assessment type (Risk Assessment Tool, Medical Assessment Tool, Traumatic Brain Injury, etc.)		
GBV.IND.8	Number of GBV survivor cases closed	Number of case management closed within reporting period	COUNT of all GBV survivor cases with status Closed	N/A		Reason Gender		
GBV.IND.9	Number of surveys/ feedback that are by participants	Number of surveys filled out by GBV survivor within a reporting period		N/A		By quarter, year		
GBV.IND.10	Percentage of cases of emergency visits	Number of GBV survivor with high priority/critical (Police, Case management conference, medical)	COUNT of all GBV survivor with high priority/critical	Total of GBV survivor registered or with a first contact	Count of all participants who had the first contact within the last reporting period	Type (medical, police, housing, CAS, transport, financial, etc)		
GBV.IND.11	Number of appointments set up for a participant within a reporting period	Number of appointments set up for a participant within a reporting period	COUNT of all appointments created for GBV survivor	N/A		First Appointment Within 24 Hours First Appointment After 24 Hours Follow up		
GBV.IND.12	Safety planning provided	Number of Safety planning provided to a participant	COUNT of all Safety planning submitted to the GBV survivor	N/A		Over the phone, Emergency sent to the participant By Interaction (Registration/Intake, Assessment meeting)		
GBV.IND.13	Consent received	Total of cases that provide consent	COUNT of all consent received by the GBV survivor	N/A		Type (service, referral and information (chart))		
GBV.IND.14	Assessment tools applied	Number of assessment applied within a reporting period	COUNT of all assessment tool	N/A		Type (Risk, medical, traumatic brain injury)		
GBV.IND.15	Percentage of GBV survivor feeling safe	Total of GBV survivor feeling safe after a service is rendered	COUNT of all feeling safe participants with a case open record within a reporting period	Total of participants with a case open within a reporting period	COUNT of participants with open case	By type		From score of client feedback survey
GBV.IND.16	Percentage of successful referral	Total of referral that has been successful	COUNT of all referral	Total of all referral within a reporting period	COUNT of all referral created within a reporting period	Type (Internal, External) Service Provider (CAS, Police, Hospital, Housing, Legal Service, Financial Service, Transport, etc.)		Distinguishing outgoing referrals vs incoming referrals
GBV.IND.17	Average days from referral to first session	Average number days from participant referral to the program (registration) to first session (Intake/assessment)	COUNT of all days from the participant referral to the program (registration) to a third party to the first session multiply by the total of sessions	N/A		Age Gender Ethnicity Marital Status Type of Violence (physical, psychological, etc.) Perpetrator (Intimate Partner, Family member or other)		Should this be hours, not days? 48 hours? Percentage of clients?
GBV.IND.18	Number of referrals made	Total of all referral within a reporting period	COUNT of all referral created within a reporting period	N/A		Type (Internal, External) Service Provider (CAS, Police, Hospital, Housing, Legal Service, Financial Service, Transport, etc.)		
GBV.IND.19	Number sessions total in current episode/journey	Total of session/interactions per case per participant	COUNT of all sessions (meetings/phone) for a case for a participant	N/A				
GBV.IND.20	Number weeks from first to final contact	Number of weeks from the first to final contact	COUNT of weeks from the first appointment to the closure	N/A				
GBV.IND.21	Number of children under 17 years	Total of children under 17 years of women treated		N/A		Age Ethnicity Violence type		

Context of GBV services for newcomer and racialized women in Ontario

The published and grey literature was scanned for insights on the barriers faced by women experiencing domestic and intimate partner violence, as well as promising program models. The results were used as inputs into the program model, and are summarized below.

Needs and barriers

The geographic and administrative fragmentation of support services in Ontario presents barriers to access that affect all GBV survivors. Studies show that for immigrant, refugee, and non-status (from now on referred to as newcomer) and racialized women, barriers to accessing services are heightened in a number of ways. These barriers can result in GBV survivors dropping out of the systems that are meant to provide them support, and returning to unsafe situations. The program blueprint addresses the following barriers:

Knowledge of services:

Newcomer women often lack knowledge of the services available to them. Their assumptions about the availability or efficacy of services, and the risks entailed in accessing services, may be very different from those of most Canadian-born survivors. They may have trouble accessing information resources in their own language. And they may feel overwhelmed by the information they do receive, which directs them to a complex and unfamiliar service landscape.

Scheduling multiple appointments:

The task of making appointments with multiple service providers is complicated by barriers around finance and language. Not all women have easy access to a phone: mobile phones and phone plans are expensive, and phones are easily broken or taken away. Indeed, abusive partners may restrict access to a phone in an effort to systematically isolate survivors (Guruge & Humphreys, 2009). Where women do have access to a phone, language barriers can make calls to new agencies intimidating and confusing.

Attending multiple appointments:

The prospect of traveling to multiple, unfamiliar destinations to attend appointments is often intimidating for newcomer women. Where public transit is available, fares and travel times represent real barriers to many survivors, who may feel pressure to return home from appointments before an abusive partner returns or calls (Guruge & Humphreys, 2009). Travel to attend just one or two appointments or submit paperwork might require a full day off work. For women with young children, long travel times are more stressful.

Transportation barriers are further heightened for women living in rural areas, where public transit options may not exist. GBV survivors from rural areas may not have access to a vehicle for many reasons; it is not uncommon for abusers to restrict survivors' mobility, in part by keeping them financially dependent (Guruge & Humphreys, 2009; Wisniewski, Paquet, & Arseneault, 2016). Survivors with disabilities face further challenges around transportation and physical access; attending multiple appointments is particularly difficult for this group (Chang et al., 2003).

Childcare:

Women from immigrant and refugee communities often experience social isolation, and are less likely than Canadian-born women to have access to free informal care for their children. Financial barriers restrict their access to paid childcare. In the absence of childcare options, GBV survivors have to bring their children with them to appointments. They may feel constrained in what they can say in the presence of their children (Jeshani, 2010). This decreases the efficacy of services.

Language barriers:

Language barriers can contribute to difficulties at every stage of newcomer women's journeys to health, from learning about available supports to receiving effective services. Few agencies have access to professional translators with training in the area of GBV survivor support. As a result, time-sensitive services may be delayed due to the lack of an interpreter (Jeshani, 2010). In some cases, volunteer or untrained interpreters may not interpret accurately, which can compromise service efficacy and lead to inappropriate decisions by authorities (D. Abraham & Rahman, 2008). Non-professional interpreters may lack training in client confidentiality, which can increase the risk to GBV survivors, particularly if the interpreter comes from the same community as the survivor (personal communication with V. Tyyska, Jan 7, 2019). Finally, the stress of dealing with language barriers can further negatively affect GBV survivors' psychological and emotional wellbeing (Guruge, Collins, & Bender, 2010).

Uncoordinated service response:

The experience of navigating different organizational cultures, terminologies, protocols and messaging around GBV can be disorienting, stressful, and re-traumatizing for GBV survivors. With every new intake process, survivors are forced to re-tell their story and thus relive their experience of violence. The stress of having to repeat their stories to new service providers is a recurring theme in interviews conducted with GBV survivors as part of the needs assessment conducted by Catholic Family Services of Peel-Dufferin (Jeshani, 2010). Studies show that having to respond to repetitive questions regarding experiences of violence and abuse can contribute to depression, anxiety disorders, and post-traumatic stress disorder among GBV survivors (Guruge, Collins and Bender, 2010).

Fear of police involvement, CAS, and immigration authorities:

GBV survivors from immigrant and refugee communities and racialized Canadian-born women may fear the prospect of police involvement, which many women perceive as both potentially dangerous to themselves and their families, and further stigmatizing for their ethnocultural community (personal communication with V. Tyyska, Jan 7, 2019).

Survivors consulted for the needs assessment study conducted by Catholic Family Services of Peel-Dufferin reported fear of Children's Aid Society involvement as a significant barrier to accessing services, and expressed a preference for accompaniment by their counsellor while meeting with CAS staff (Jeshani, 2010).

Survivors who are dependent on an abusive spouse for sponsorship, or whose refugee claims are attached to an abusive partner's, are less likely to seek help in response to GBV, for fear of jeopardizing their immigration status (Mattoo, 2017). Women who have achieved permanent residence or citizenship may share this hesitance, as fear of immigration authorities is sometimes stoked by abusive partners as a means of exerting control (Merali, 2008; Thurston et al., 2013). Fear of immigration authorities may be further heightened for women who have experienced a breakdown in their spousal sponsorship or whose immigration status has otherwise been rendered precarious, leading them to avoid any interaction with healthcare providers or police (Mattoo, 2017).

Culturally insensitive service provision:

Newcomer and racialized GBV survivors face legally, emotionally, and financially complex and challenging situations. Their perceptions of their circumstances and the options available to them will be informed both by culturally-inflected values and assumptions and by their personal character, immigration status, and larger biography (Okeke-Ihejirika et al., 2018). Service providers who lack insight into these contextual factors are unlikely to provide effective support. In their study of domestic violence and housing insecurity among immigrant women in three Canadian cities, Thurston et al. (2013) found that survivors tended to avoid mainstream GBV programming, and sought help through immigrant-serving agencies first. The authors note that "cultural competence... in agencies appeared to greatly facilitate their ability to support the

women" (Thurston et al., 2013, p.294). They recommend a “coordinated, multipronged, and multisectoral approach” to supporting newcomer GBV survivors, including settlement service agencies, health services, and the criminal justice system.

Obstacles to addressing barriers

The support services that GBV survivors require cut across multiple sectors, so that a fully-coordinated response must involve a range of actors from the criminal justice, family law, social service, and health and mental health sectors. Cross-sector collaboration of this sort is one of the recommendations made by a Justice Canada report on interactions among the family, child protection, and criminal sectors of the justice system in relation to family violence (Government of Canada, 2014). As noted in the report, however, coordination across sectors is difficult to achieve.

Developing and maintaining close working partnerships among diverse agencies is challenging work, and requires considerable investment of resources. Leadership is needed to bring together diverse agencies, build trust across sectors, and align mandates, philosophies, and approaches among partners. Management staff are kept busy with their immediate responsibilities; few have the capacity to reach out to prospective partners, work through communication bottlenecks, generate goodwill through meetings and site visits, and establish mutually-agreeable procedures and protocols for working together. Managers also need to cultivate buy-in from program staff, who may not support the changes that multi-agency/multi-sectoral coordination in service provision requires.

For agencies seeking to co-locate, the challenges are further heightened. These groups must find a physical space to house several agencies, hire a hub coordinator, devise a decision-making structure and approach to cost-sharing, adopt a shared system for tracking clients, develop information materials, agree to shared objectives and build shared protocols. While the Family Justice Centre provides a promising approach to co-located, multi-sectoral service delivery, the question remains as to how to adapt a model of this type to meet the complex requirements of a given community, with the unique mix of resources available.

Relevant program models

The programs studied in this project are all based on Coordinated Community Response (CCR) models, in which a bundle of services for GBV survivors and their families is provided in one location. Coordinated Community Response models have been demonstrated to be effective in responding to GBV (Klevens et al., 2008; Robinson, 2006), and could be described as a promising practice. However, the definition of CCRs is not detailed enough to support the development of in-depth program blueprints.

Family Justice Centers

The Family Justice Center (FJC) model was first developed in the early 2000s, with the opening of the San Diego FJC in 2002. FJCs were designed as a refinement of CCRs, and have been adopted worldwide – over 100 are now in operation, depending on the definition of the model (Abt Associates, 2018; Simmons et al., 2016). According to a recent environmental scan of FJC's in the U.S., four elements define the model: co-location, multi-agency; multi-disciplinary, and targeting provision of services to adult survivors of family violence and their families (Abt Associates, 2018).

Early evidence suggests that “communities that adopt the FJC approach to service delivery see significantly improved outcomes including (but not limited to) reduced homicides, increased victim safety, increased autonomy and empowerment for victims, reduced fear and anxiety for victims and their children, reduced recantation and minimization by victims when wrapped in services and support, increased efficiency in collaborative services to victims among service providers, increased prosecution of offenders, and dramatically increased community support

services to victims and their children (e.g., Gwinn & Strack, 2010; Hoyle & Palmer, 2014; Kennedy, 2013)" (Simmons et al., 2016).

Services provided by each FJC vary, and despite the massive investments made in the model in many countries, the core components have not been formalized. Researchers have pointed out that while studies of FJCs reveal overall positive outcomes, the components of the model have not been defined clearly enough to define the model and guide replication of the most effective elements (Simmons et al., 2016). Definition is challenging because one of the attributes of the model is a responsiveness to local situations and an ability to work with a variety of partners. Total standardization is not possible.

This project aims to address this gap through use of a theoretically robust intervention science approach. Following a process of clarification and quality testing, we will develop blueprints describing the 'operating system' of the FJC program model in sufficient detail to support replication of the program's key components anywhere in Canada. The model that we arrive at will be evidence-based, culturally safe, based on Trauma and Violence-informed practices, and effective with immigrant and refugee GBV survivors, their families, and their social networks.

FJCs in Ontario: The OCRFV

The FJC model was first introduced to Ontario in 2006, when the Family Violence Project of Waterloo Region was established. Centres in Brampton, Oshawa, Newmarket, Peterborough and Scarborough followed, with the Ontario Collaborative Response to Family Violence forming as a means of sharing best practices among the different centres. The OCRFV now comprises six hubs, which bring together a total of 106 coordinated agencies.

While the hubs are diverse in terms of their size, the demographic composition of the population they serve, and the particular combination of services they offer, each uses a co-located, multi-agency, multi-disciplinary model to provide support to adult GBV survivors and their families.

An environmental scan in 2016 (Bergen & Singh, 2016) itemized the services sought and received at each of the OCRFV hubs as follows:

Crisis intervention

- Early police services
- Early victim services
 - Domestic violence early services

Intervention and supports

- Assessment
- Child protective services
- Child welfare
- Employment services
- Financial assistance
- Housing
- Legal Aid and Services
- Mental health/Addictions
- Settlement and immigration services
- Sexual Assault and Rape Services
- Youth Services
- Additional services

Prevention

- Community education
- Violence

Universal supports

- Food and clothing
- Parent education
- Support groups
- Additional services

Populations

This project's catchment area includes much of southwestern Ontario and the GTA, a region that is notable for the density of its immigrant and refugee population. In 2016, the population of immigrants and non-permanent residents living in the cities, towns, and rural areas that comprise the project's catchment stood at 2.9 million, or 50% of the overall population (Statistics Canada, 2017). The visible minority population was larger, at 3.2 million (Statistics Canada, 2017). While we know that most recent immigrants to Ontario come from Asia, the Middle East, and Africa, southwestern Ontario and the GTA attract people from all over the world. The GBV survivors whom our partners serve are therefore highly diverse: COSTI alone provided support to GBV survivors from 70 different countries last year.

Economic conditions

Immigrants to Canada are more likely to live in poverty than their Canadian-born counterparts. Liu and Piquot's study of chronic low income – defined as having a family income under a low-income cut-off for five consecutive years or more – shows that in 2012, the rate of chronic low income among immigrants was 3.3 times higher than the Canadian-born population (Piquot & Lu, 2017). There are large differences by place of birth: immigrants from Northwestern Europe, the Philippines, Australia, New Zealand and the United States had rates of chronic low-income comparable to that of the Canadian-born population, at 4-5% (vs. 3.6% for the latter group). Those from East and South Asia had rates of 17% to 19%. The chronic low income rate was lower for economic class immigrants than for family class immigrants and refugees, but fairly even across different levels of educational attainment. Finally, in 2012, chronic low income was almost as prevalent among immigrants in Canada for 16-20 years as among recent immigrants.

Explanation for these statistics lies in part in the significant barriers to employment that newcomers to Canada face. In addition to barriers related to race and language is the lack of recognition accorded foreign credentials and experience. Professional regulatory bodies do not recognize immigrants' qualifications, and employers prefer applicants with Canadian work experience. Among racialized women immigrants, obstacles related to gender and race further heighten barriers to employment (Dlamini et al., 2012).

As the studies reviewed in the following section show, unemployment and poverty influence both the prevalence of gender-based violence among immigrant and refugee communities in Canada, and women's vulnerability to that violence.

Incidence of GBV

Very little large-scale research exists on gender-based violence against IRNS and racialized Canadian-born women, with the majority of studies using qualitative methods to understand the experiences and needs of GBV survivors from specific communities (see Okeke-Ihejirika et al., 2018, for a recent review). While the Canadian Centre for Justice Statistics releases an annual report on Family Violence in Canada, the data contained in its most recent report is disaggregated by gender, age, and geographic region alone: its utility from a GBA+ perspective is therefore limited. In 2017, intimate partner violence (IPV) represented nearly one-third (30%) of all police-reported violent crime in Canada, affecting almost 96,000 victims, close to 80% of whom were women (Statistics Canada, 2018). IPV was the kind of violence most commonly experienced by women, accounting for 45% of police-reported violence committed against female victims aged 15 to 89; violence perpetrated by non-spousal family members represented

a further 11%. Women living in rural areas were subject to the highest overall rates of IPV (743 victims per 100,000 population), with rates of victimization that were three and a half times higher than those for men in rural areas.

Of the 665 spousal homicides committed between 2007 and 2017, over 80% involved female victims. Two-thirds (62%) of spousal homicides were preceded by a history of family violence, with police-reported motives for these homicides including an argument or quarrel (50%), frustration, anger or despair (24%) and jealousy (17%), a set of emotions that are common among partners exerting control over victims (Statistics Canada, 2018).

It should be noted that the prevalence rates released by Statistics Canada are dependent on victim reporting. Many factors influence women's decisions to report their abuse, including severity and frequency of abuse, fear of reprisal, shame, economic circumstances, anticipated impact on children, and previous negative encounters with the police (Felson et al., 2002; Hyman et al., 2006). The decision to report abuse will look different for marginalized populations such as IRNS survivors, racialized survivors, and LGBTQ+ survivors. These groups face additional barriers, including language barriers, lack of familiarity with the Canadian legal system, distrust of medical professionals and law enforcement, and lack of appropriate/culturally competent services (Ard & Makadon, 2011; Guruge & Humphreys, 2009; Raj & Silverman, 2002).

With that proviso, Brownridge and Halli's secondary analysis of Statistics Canada's 1999 survey on criminal victimization (Felson, Messner, Hoskin, & Deane, 2002; Hyman, Forte, Du Mont, Romans, & Cohen, 2006), finds that intimate partner violence in 1999 was more prevalent among immigrant women from developing countries than it was among Canadian-born women. The authors locate the cause of violence in the sexually proprietary behaviour of male partners from developing countries, and note that the risk of violence increases where immigrant women are more highly educated than their partners. Their recommendations include "educating these men about the rights and roles of women in Canadian society and violence prevention" (2002, p. 469). This study tells us something useful about the incidence of violence among newcomer communities. However, analyses that point to non-Western forms of patriarchy as the cause of gender-based violence in immigrant and racialized communities risk further pathologizing an already stigmatized population. They also miss a much larger set of situational/structural risk factors: the social isolation, cultural dislocation, unemployment, poverty and racism that characterize many immigrants' and refugees' experience of immigration and settlement.

Causes of GBV

Stress brought about by migration

Tysska's qualitative research into family violence in Punjabi and Tamil communities in Toronto suggests that while patriarchal norms and practices inform intimate partner abuse, the risk of violence is heightened by stresses associated with the immigration process itself (2009). Many of the GBV survivors who participated in the study reported that the violence had either begun or escalated after immigration. Their testimonies locate the causes of abuse in poor housing and working conditions, intense financial pressure, cultural dislocation and attendant issues of substance abuse and mental illness.

Although not a prominent theme in Tysska's interviews, shifts in gendered roles and familial dynamics commonly follow from migration, and can result in conflict and violence. Guruge et al.'s study of intimate male partner violence in Toronto's Tamil community (2010) reveals that when male partners experience downward career mobility following immigration, some use violence to reassert their authority over their more employable wives. Language barriers, the loss of informal social networks and supports, the lack of recognition accorded to newcomers' professional training and experience, and racism in society at large all contribute to immigrant men's inability to fulfill gendered expectations around employment and income generation. Those expectations are rooted in culturally-informed ideas about men and masculinity, which accord men a breadwinner role, from which certain rights and responsibilities follow. The inability to fulfill that breadwinner role, its disorienting and demoralizing effects, and the violence that can follow are

well documented in the literature on GBV in immigrant communities (see Guruge, Shirpak, et al., 2010, for a review).

Premigration trauma

Guruge et al's research with Tamil newcomers in Toronto raises the issue of exposure to war violence, its impact on both men and women's mental health, and its contribution to gender-based violence following migration. Participants in Guruge et al's study associated exposure to or participation in war violence with intolerance, anger, suspicion and aggression at home – emotional states that can lead to family violence (2010). These findings are confirmed by other studies, with Gupta et al. asserting a statistically significant association between premigration exposure to political violence and recent perpetration of intimate partner violence among immigrant men in Boston (2009). An understanding of trauma and its effects is essential for agencies working with refugees, who are likely to have experienced traumatic events prior to migration. This understanding should inform the knowledge and skills of service providers, as well as the organization's policies and procedures (see Mattoo, 2017).

If the many shifts and challenges associated with the settlement experience increase the likelihood of violence occurring in the home, so too do they heighten IRNS women's vulnerability to that violence, by limiting their sources of support, and reducing their tendency to seek help.

Social isolation as a source of vulnerability

Immigration to a new country erodes the informal social networks that might otherwise offer protection or support to women experiencing gender-based violence. Indeed, not only does immigration reduce women's informal networks in size, it also results in changes to their structure and composition, with implications for women's safety. Gendered patterns of immigrant selection in Canada mean that women are more likely than men to enter the country as the spouse of a primary applicant, or arrive as a sponsored family member (Hudon, 2018).

Guruge and Humphreys (2009) explore the consequences of this pattern in their article on access to support among IPV survivors in Toronto's Sri Lankan Tamil community. Among Sri Lankan Tamils, men are usually the first family members to immigrate. Once settled, a man typically sponsors his natal family, along with his wife and children. This results in a situation in which the couple live with or near the husband's family, while the wife's family remains in Sri Lanka. Back home, a woman's family and friends would offer support, advice, and resources to help her deal with IPV. They might provide sanctuary to a survivor or share financial resources. Indeed, the very need to answer to a woman's network – her uncles, brothers, cousins – places limits on a husband's power and autonomy. But post-migration, women's networks are significantly reduced, with the consequence of reduced support for women who are victims of IPV. This pattern is confirmed by numerous studies, involving research participants from a diverse range of immigrant communities (Abraham & Tastsoglou, 2016; Ahmad et al., 2009; Raj & Silverman, 2002; Tyyskä, 2009; Yoshioka et al., 2003).

Reluctance to seek help

The decision to seek help in dealing with abuse is complicated by women's commitment to defined gender roles, fear of social stigma, fear of economic consequences, worry over the impact on children, and fear of deportation, among other factors (Ahmad et al., 2009; Guruge & Humphreys, 2009; Hyman et al., 2006).

Coping

In their scoping review on IPV in Canadian immigrant communities, Okeke-Ihejirika et al. (2018) note that while immigrant women are a diverse group whose responses to abuse will vary, many IRNS survivors turn to emotion-focused coping methods – behaviours that help to mitigate psychological distress and reduce negative outcomes – rather than employing problem-focused coping strategies, such as actively seeking help.

The South Asian immigrant survivors who took part in Ahmed *et al.*'s research in Toronto (2009) pointed to prescribed gender roles within the family and community as inhibiting help-seeking behaviour. Participants suffered multiple mental, physical, and social consequences before seeking help from a professional, or even sharing the abuse with someone close to them:

Many participants discussed the meaning of their silence. On one side, they used silence as a strategy to divert attention away from themselves, and viewed this practice as an indicator of their own strength, as opposed to their weakness. On the other hand, women felt that the social prescription of 'silence' enhanced their vulnerability to abuse because their husbands took advantage and the situation worsened (617).

A reliance on silence, self-sacrifice, and more internally-focused coping strategies is by no means limited to Ahmed *et al.*'s research participants; research with Japanese-Canadian survivors (Takano, 2006), Tamil-Canadian survivors (Kanagaratnam *et al.*, 2012), and first-generation Portuguese-Canadian women surfaces similar themes (Barata *et al.*, 2005; Souto *et al.*, 2019)

Social pressure to stay

Where IRNS survivors do reveal their experience to family members, the counsel they receive might further delay their decision to pursue formal sources of help. Sri Lankan Tamil participants in Guruge and Humphrey's research (2009) reported pressure from family to remain married, even when abuse was known, in order to preserve the family's status in the community. The authors note that given the subtle and overt racism that Tamil women experience in Canadian society, maintaining standing in their own ethnocultural community is an important consideration. Nonetheless, negative responses to a disclosure of abuse can be damaging to survivors' mental health. In their research with low-income African American survivors, Kocot and Goodman (2003) found that women's coping mechanisms deteriorated, and their likelihood of developing PTSD and depression increased when they received avoidant responses, ambiguous advice or advice to stay with their partners from their closest friends and relatives.

Given the reticence of many IRNS and ethnocultural women to seek help, Okeke-Iherjirika *et al.*'s recommendations around culturally-sensitive approaches to service provision include working to help women build safety nets for themselves and their children, and pursuing advocacy work in immigrant communities so that survivors and their neighbours, friends and family are better informed about GBV and the services available.

GBV in the LGBTQ+ Community

LGBTQ+ newcomers experience discrimination based on their race, gender identity and expression, sexual orientation and socioeconomic status. As a result may feel excluded from mainstream society, from queer communities and from ethno-specific communities (Doctor & Bazet, 2008). Although little research into the prevalence of GBV among this specific group exists, Statistics Canada data for 2014 shows that members of the LGBTQ+ community were twice as likely as heterosexuals to report having been the victim of spousal violence during the previous 5 years (8% versus 4%, respectively). This difference was greater for lesbian or bisexual women compared to heterosexual women, at 11% versus 3% (Statistics Canada, 2016). Statistics Canada does not collect data on trans people, but the Trans PULSE project – a study of the social determinants of health among trans people in Ontario – found that 20% of its 433 survey respondents had been physically or sexually assaulted (Bauer & Scheim, 2015). The Trans PULSE report notes that violence against trans people is heavily underreported.

Gender-based violence against LGBTQ+ newcomers is likely underreported. They face many of the same barriers to reporting and accessing assistance as heterosexual survivors in IRNS survivors do, including language barriers, social isolation, limited knowledge about available services, fear of deportation, and fragmented, culturally insensitive service responses. However, LGBTQ+ survivors also experience discrimination and exclusion from social networks due to their sexual orientation. Those who have not disclosed their sexual orientation to their social circles

may hesitate to confide in friends or family (Ard & Makadon, 2011). Additionally, they may be apprehensive about seeking help from settlement service agencies or law enforcement due to concerns about facing discrimination (OCASI, n.d.).

GBV and abuse of older adults

Gender-based violence against older IRNS and ethnocultural women in Canada has received relatively little scholarly attention. This, despite the fact that immigrants constitute a fairly large portion of older adults in Canada, particularly in urban areas. In Toronto, 63% of all seniors are immigrants (Turquotte & Schellenberg, 2007).

No prevalence rates exist for older IRNS women. However, older immigrant women experience a range of different forms of abuse by their husbands, children, and/or children-in-law, including emotional, physical, sexual, and financial abuse (Guruge, Kanthasamy, et al., 2010). Tyyska *et al.*'s research with older adults in Toronto's Punjabi and Tamil communities identifies shifts and stresses associated with the immigration and settlement experience – unemployment, economic constraints, role reversals and a deterioration in social status, particularly of older adults – as a cause of abuse (2012). Social isolation, linguistic barriers, and a deep distrust of service providers and police surface as a barrier to accessing help. Guruge *et al.*'s research with older women in Toronto Sri Lankan Tamil community (2010) emphasizes the overlapping forms of prejudice that these women face in Canadian society. Racism, sexism, class prejudice and ageism combine to render racialized older IRNS women highly dependent on their children, vulnerable to abuse, and likely to experience discrimination by service providers.

Evaluation framework

This evaluation framework was developed as input to the evaluation plan and was used to ensure that evaluation activities remained consistent with the project's long term outcomes. Many changes to the actual data collection tools were made throughout the four years of the project as described in the technical report.

The ultimate outcome is that GBV survivors are better supported across sectors.

There are three groups of **medium and long-term** outcomes. In order of their expected achievement, they are:

- Service outcomes – high quality, evidence-based and accessible services that are culturally safe according to GBA+, and that result in client satisfaction.
- Client outcomes of GBV survivors – Increased safety, adequate housing, financial security, health, well-being, and a reduction in risk through knowledge, skills and a greater understanding of GBV issues among their families and networks.
- System outcomes – Adoption of promising practices and subsequent impacts on GBV services and survivors across Canada, based on blueprints created by this project.

Short term outcomes

The immediate results of project activities will be:

- Gaps in support to survivors and their families are identified.
- Core components of each of the two program models are defined clearly enough to implement them correctly across sites and organizations.
- Revisions in practice that emerge from the clarification of core components are adopted by hub management, including approvals for staff training.
- GBV survivors from diverse groups of immigrants and refugee communities (selected based on GBA+ segmentation), as well as partners and networks working with the hubs, are engaged and benefit from their involvement in co-design.

Outputs

The major deliverables of this project are:

- Replicable blueprints for promising practices that are evidence-based, culturally safe, are based on Trauma and Violence-informed practices, and that are shown to be effective with immigrant and refugee GBV survivors, their families, and their social networks.
- Training sessions, training and coaching materials, policies and procedures and other materials that will enable hubs to adopt evidence-based modifications in the two program models.
- High quality services provided to GBV survivors and their families and social networks, based on refined and improved practices.
- High quality stakeholder engagement processes involving GBV survivors and community networks at every stage of the project.

Each deliverable will be rated according to quality metrics and rubrics throughout the project, to give immediate and useful feedback to the hubs.

Medium-term outcomes (expected to occur once one or more short-term outcomes have been achieved, 3-5 years following start of project)

Expected results	Indicators	Baseline data	Targets	Data sources	Data collection methods	Frequency	Responsibility
System outcomes (beyond project partners) 1. Stakeholders from organizations across Ontario incorporate core components in their work with GBV. 2. Organizations and service providers decide to adopt effective program models based on blueprints. 3. Service providers, survivors and those at risk of GBV have better access to GBV-related information, training and support. 4. Practitioners and policy-influencers have better access to GBV-related evidence. 5. Funders promote effective and culturally appropriate GBV services based on blueprints.	# of 211 Findhelp Ontario entries showing settlement services addressing GBV, OR GBV services serving newcomer women	Current number in 2019	Increase of 10 listed services in Ontario by 2024	Findhelp database at 211Ontario.ca	Findhelp database download and comparison based on structured searches using the 211taxonomy	To be determined by WAGE	T.B.D., in partnership with WAGE and Findhelp
	# of downloads for blueprints and materials relating to core components, e.g. job descriptions, service quality audits, procedures # of organizations who report applying promising practices in their work, including specific core components like safety plans	N/A	15 programs and 200 individual practitioners across Canada by 2025	Website with blueprint tools and discussion group Technical assistance forum supported by COSTI	Analysis of user access and participation (sign-up may be required for access to detailed guidance and tools on web site to track usage) Technical assistance tracking	To be determined by WAGE	WAGE will provide web tracking and download data
	# of seminars, conferences and events referring to program models or core components # of funding guidelines, clinical guidelines and RFPs referring to program models or core components	Results during Exploration stage (first six months of project)	High placement in Google searches for identified search terms by 2024	Google and Google Scholar	Structured web search looking for program model information, blueprints, conferences, RFPs and granting opportunities, using a defined vocabulary. (This indicator will also provide insight on how to optimize searchability of project information through Search Engine Optimization)	Annual (the first 2 administrations will test the sensitivity of the search strings)	Evaluators will create and test web search strings, and collect search results annually WAGE could adopt this to measure uptake at a national level
GBV survivor outcomes (at participating hubs) 6. GBV survivors and their children have increased safety, financial security, adequate housing, social inclusion, mental and physical health, and reduced risk factors for GBV and its associated impacts. 7. Broader families and social networks of GBV survivors, including culturally diverse	Measure of Victim Empowerment Related to Safety (MOVERS) Humiliation, Afraid, Rape, and Kick questionnaire [HARK] Arizona Self-Sufficiency Matrix or Sustainable Livelihoods Assets (for safety, housing, financial security, childcare, employment, education, life skills, family/social relations, mental health etc.) Well-being – WHO-Five Well-Being Index (available in over 30 languages)	During intake process for each GBV survivor	Significant improvement over intervention period for each person over entire period of project (2024)	Client progress notes	KoNote or aggregated data from client management system, assuming consent from hub and each client	At beginning of client involvement, then every 1 to 6 months, depending on indicator	Evaluators refine indicators, create data collection tools Hub champion and IT lead in each hub implement data collection processes Service providers collect data with client in each session

<p>communities, initiate engagement with services on behalf of persons at risk of GBV.</p>	<p>Reduction in health costs and morbidities derived from Ontario health insurance records (optional, to be considered)</p>	<p>During intake process or at any time during interventions</p>	<p>Significant reduction in injuries, illnesses, health care costs over period of project (2024)</p>	<p>ICES (Ontario Health Insurance Plan database)</p>	<p>OHIP number sent to ICES along with name of hub (no service records). This requires informed consent at hub and client levels. Unlikely for this project but may be possible for future research. Costs to be investigated with ICES.</p>	<p>Ongoing. ICES can assess medium- and long-term health impacts based on level of program fidelity at the respective hubs.</p>	<p>Each hub to decide whether to collect OHIP number; each client to decide whether to provide OHIP number ICES to do analysis with security-screened researchers.</p>
	<p># of referrals or inquiries from families and social networks of GBV survivors</p>	<p>During Installation phase (2020)</p>	<p>Significant increases annually</p>	<p>Phone and contact records of each hub</p>	<p>Annual comparisons of phone/email inquiries. May require setting this up at each hub.</p>	<p>Annual</p>	<p>Hub champions, assisted by project manager</p>
<p>Service outcomes (at participating hubs)</p> <p>8. Those impacted by or at risk of GBV, including survivors, are better supported by accessible, culturally appropriate, evidence-based and high-quality services.</p> <p>9. Service providers are trained and confident in effective practices.</p> <p>10. Communities, including immigrant and refugee groups and culturally diverse communities, are more supportive of GBV services.</p> <p>11. Services have GBV survivors engaged in ongoing feedback on program design and implementation</p>	<p>Proportion of GBV survivors who received high quality, culturally safe and appropriate care (as defined by program models)</p> <p>Proportion of GBV survivors referred who completed referral</p> <p># on waiting list or rejections for service for each component of service, e.g., intake, crisis management, safety planning, childcare, housing.</p> <p>Proportion of GBV survivor clients and community members reporting satisfaction with cultural safety</p>	<p>At beginning of Initial Implementation phase (Oct 2020)</p>	<p>Significant improvement from 2020 to 2024</p>	<p>Service quality assessment tools (to be developed)</p> <p>Waiting lists, referral tracking</p> <p>Consumer satisfaction surveys</p> <p>Qualitative interviews</p>	<p>Self-assessment (during Initial Implementation phase) and onsite peer review assessment.</p> <p>Annual comparisons of waiting list and service refusals</p> <p>Ongoing analysis of consumer satisfaction surveys</p> <p>Content analysis of interviews</p>	<p>Twice for service quality</p> <p>Annual for waiting list, service refusal statistics</p> <p>Quarterly analysis of customer satisfaction surveys and interviews</p>	<p>Evaluators develop quality rubrics and report results of customer satisfaction surveys</p> <p>Project manager arranges logistics</p> <p>Hub champions carry out peer reviews and consumer / community interviews.</p>
	<p>Availability of social services to GBV survivors within an accessible distance</p> <p>Availability of GBV hotlines to non-official language speakers in Ontario</p> <p># of hubs providing multilingual services</p>	<p>At beginning of Initial Implementation phase</p>	<p>Significant improvement from 2020 to 2024</p>	<p>Findhelp database</p>	<p>Analysis of Findhelp database using structured search on 211taxonomy</p>	<p>Twice – at beginning of Initial Implementation, and at end of project</p>	<p>Project manager, with help from Findhelp</p>
	<p>Quality of GBV survivor participation in Project Advisory Group</p>	<p>Beginning of project</p>	<p>High ratings throughout project</p>	<p>Complaints and suggestion thematic analysis</p> <p>Brief satisfaction polls</p>	<p>Qualitative analysis and ratings on satisfaction polls</p>	<p>Continuous, using rotating samples. Annual report</p>	<p>Evaluators will develop data collection tool</p> <p>Project manager will collect and report</p>
<p>Short-term outcomes (Outcomes directly attributable to project outputs, expected to occur 1-3 years into the project)</p>							

Expected results	Indicators	Baseline data	Targets	Data sources	Data collection methods	Frequency	Responsibility
GBV survivor outcomes GBV survivors receiving services from hubs: 1. Are satisfied with services they receive; 2. Have responsive, timely and appropriate services to meet their needs; 3. Have knowledge and skills to reduce risks and obtain resources; 4. Have increased safety, financial security, adequate housing, social inclusion and mental and physical health. 5. Communities and families of those impacted by or at risk of GBV are supportive of GBV services provided by hubs, particularly among immigrant- and refugee groups.	Content analysis of client complaints and suggestions	During Installation phase		Complaint systems and client suggestion polls	Complaint system data is aggregated and exported for analysis. Content analysis of client suggestion polls.	Ongoing	Evaluators set up data collection tools
	Measure of Victim Empowerment Related to Safety (MOVERS) Arizona Self-Sufficiency Matrix or Sustainable Livelihoods Assets (for housing, financial security, childcare, etc.), with client goals identified. Well-being – WHO-Five Well-Being Index (available in over 30 languages)	During intake process for each GBV survivor, as soon as data systems are set up	Significant improvement for each person	Client progress notes	KoNote or aggregated data from client management system, assuming consent from hub and each client. These instruments should be used as case management tools, and to track client-defined goals, not just for evaluation.	Ongoing	Evaluators set up data collection tools Each service provider collects ratings as part of service delivery
	# of referrals or inquiries from families and social networks of GBV survivors	During Installation phase	Significant increases annually	Phone and contact records of each hub	Annual comparisons of phone/email inquiries. May require setting this up at each hub.	Annual	Hub champions, assisted by project manager
	Confidence and rated knowledge of service providers regarding evidence-based core components	During Installation phase	High ratings by end of Initial implementation stage	Quizzes and self-assessment by service providers	Assessments carried out before and after training sessions	Ongoing – before and after training sessions	Hub champions, with logistics provided by project manager
Service outcomes 6. Hubs and their service providers have the capacity, confidence, knowledge and skills to deliver program models correctly. 7. Each hub provides services that are consistent with its program design, core components and service quality guidelines. 8. Participating hubs deliver evidence-based, accessible, culturally appropriate and high-quality services. 9. Hubs have close partnerships and service provision/ referral relationships with other organizations.	Program fidelity and quality ratings for hub services, including partnerships and referrals	At beginning of Initial Implementation phase	High ratings by end of Full Implementation phase (2024)	Self-assessment ratings of quality carried out at each hub	Self-assessment (during Initial Implementation phase) Process analysis, i.e., tracking small groups through an intake and referral process	Three times – at Installation, Initial Implementation and Full Implementation	Evaluators develop quality rubrics Hub champions carry out self-assessment ratings and process analysis
	Proportion of positive responses to the SDPS+TIPS scale	At beginning of Installation phase	Significant improvement 2020 to 2024	SDPS+ client survey	Ongoing analysis of SDPS+ client survey	Quarterly analysis	Evaluators report results of SDPS+ surveys
	Proportion of GBV survivor clients and community members reporting satisfaction with cultural safety	At beginning of Installation phase	Significant improvement from 2020 to 2024	Service quality assessment tools (to be developed) Consumer satisfaction surveys	Ongoing analysis of consumer satisfaction surveys Content analysis of interviews	Twice for service quality Quarterly analysis of customer satisfaction	Evaluators report results of customer satisfaction surveys.

				Qualitative interviews		surveys and interviews	Project manager arranges logistics. Hub champions carry out consumer / community interviews.
Engagement outcomes 10. Community members, front-line workers and GBV survivors are engaged in development and implementation of program models. 11. GBV survivors are satisfied with their engagement in program materials. 12. Hub service providers, practitioners and other stakeholders are satisfied with their engagement in program materials.	Level of satisfaction and engagement of GBV survivors, front-line workers and community members in project activities	At end of Exploration phase	High ratings throughout project	Suggestions, complaints and satisfaction polls	Content analysis of qualitative data, and ratings of satisfaction polls	Ongoing data collection and analysis; quarterly reporting to team	Joint responsibility – hubs carry out ongoing analysis of complaints, evaluators report quarterly [GK: use results from Dorothy Nyambi's interviews]
	# GBV survivors recommending changes to program models # organizations recommending changes to program models	At end of Exploration phase	High ratings throughout project	Tracked contributions to reports and consultation materials in meetings, phone calls, emails	Content analysis of meeting and content notes	Ongoing data collection and analysis; annual reports	Project manager GK: org's all participated, lots of recommendations. Missing: community input and GBV survivor
	# contacts with GBV survivors in engagement processes # contributors from GBV survivor groups and communities	At end of Exploration phase	High ratings throughout project	Meeting and event tracking	Meetings and contacts with GBV survivors and communities will be tracked using KoNote or Contact Management System	Ongoing data collection and analysis; annual reports	Project manager and hub champions
Project outcomes 13. Gaps in support to survivors and their families are identified. 14. An increased understanding of the lived experience of underserved populations is acquired. 15. Core components of program models are identified.	# project milestones achieved	Beginning of Exploration stage	Adherence to milestones throughout project	Project management system	Reports from project management system	Ongoing. Annual reports.	Project manager
	Proportion of major recommendations accepted and implemented by hub decision-makers # of networks and partnerships developed Satisfaction of engagement with networks and partners	End of Exploration stage	High ratings throughout project Increases of networks by 2024	Meeting and consultation notes Interviews with hub decision-makers and networks/ partners	Content analysis of meeting and consultation notes throughout project (through Contact Management System or KoNote) Content analysis of interviews	Annual	Project manager Hub champions to provide data

<p>16. Networks and partnerships of service providers are created or strengthened.</p> <p>17. Evaluation of project is completed successfully and on time.</p> <p>18. Blueprints of the promising practices meet quality criteria.</p> <p>19. Hub decision-makers and managers adopt improvements in program models based on evidence and stakeholder input.</p> <p>20. Evaluation and information systems for data collection, analysis and reporting are functional, usable and secure.</p>	<p>Quality ratings of each deliverable. Each report will be scored based on compliance with GBA+ analysis and a comparison of the expected functionality or content with the deliverable. For example:</p> <ul style="list-style-type: none"> • Usability of data collection and information system • Quality of demographic analysis of hub catchment areas, requests for service, intake data <p>Each major deliverable, including communication plan, final report and data systems, will be described in a format that can be rated with a quality review checklist.</p>	At first deliverable	High ratings throughout project	Reports generated by the project	Review of each deliverable with a scoring checklist based on defined objectives	At submission of each deliverable	<p>Project manager and reviewers. Reviewers will be drawn from the Project Advisory Group.</p> <p>GK: rate data collection tools</p>
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Outputs (Direct products or services stemming from project activities)

Expected results	Indicators	Baseline data	Targets	Data sources	Data collection methods	Frequency	Responsibility
<p>Service delivery</p> <ul style="list-style-type: none"> • Numbers and demographic breakdowns of persons served, including GBV survivors and their children. • Provision of high-quality services in each core program component 	<p># GBV survivors and family members served</p> <p>Quality ratings of core component services on defined criteria based on GBA+, cultural safety, stakeholder engagement, trauma and violence-informed practice and evidence base.</p>	At first deliverable	High ratings throughout project	<p>Aggregate data exported from project partner client tracking systems</p> <p>Reports submitted by implementation team</p>	Review of each deliverable with a scoring checklist based on defined objectives	<p>Ongoing. Annual reports</p> <p>At submission of each deliverable</p>	<p>Project manager and hub champions</p> <p>Project manager and reviewers</p>
<p>Stakeholder engagement</p> <ul style="list-style-type: none"> • Brief reports of community demographics, needs and gaps related to GBV, to be used in local service design for each hub. • Annually updated communication and stakeholder engagement plans. • Meetings and feedback processes compliant with 	<p>Quality of reports as described in short-term outcomes above, including ratings of stakeholder engagement plan and milestones. For example, the stakeholder engagement plan will have measurable objectives re. GBV survivor involvement – levels of participation and diversity by gender, age, social condition, immigrant/refugee status, family composition, sexual orientation,</p>	At first deliverable	High ratings throughout project	Reports submitted by implementation team	Review of each deliverable with a scoring checklist based on defined objectives	At submission of each deliverable	Project manager and reviewers

<p>defined communication protocols.</p> <ul style="list-style-type: none"> Report on number, intensity of involvement and demographic composition of GBV survivors providing feedback on service delivery, and extent to which their input was incorporated. 	<p>ethnicity, culture, religion and health status.</p> <p># contacts with GBV survivors in engagement processes # contributors from GBV survivor groups and communities # of meetings and contacts with GBV survivors that meet defined communication protocols and processes</p>	<p>At end of Exploration phase</p>	<p>High ratings throughout project</p>	<p>Meeting and event tracking</p>	<p>Meetings and contacts with GBV survivors and communities will be tracked using KoNote or Contact Management System</p>	<p>Ongoing. Annual reports</p>	<p>Project manager and hub champions</p>
<p>Project management</p> <ul style="list-style-type: none"> Detailed workplan containing activities, timeline and responsibilities for the project. Implementation plan for each hub. Project management reports tracking progress against activities and deliverables. Training and coaching sessions and updated written materials. Reports described in Activities above. Data collection, secure data management and reporting tools for client outcomes, service outputs and program fidelity 	<p>Quality of plans against criteria of feasibility, fit with project objectives, GBA+ analysis.</p>	<p>At first deliverable (workplan)</p>	<p>High ratings throughout project</p>	<p>Reports submitted by implementation team</p>	<p>Review of each deliverable with a scoring checklist based on defined objectives</p>	<p>At submission of each deliverable</p>	<p>Project manager</p>
<ul style="list-style-type: none"> Project management reports tracking progress against activities and deliverables. Training and coaching sessions and updated written materials. Reports described in Activities above. Data collection, secure data management and reporting tools for client outcomes, service outputs and program fidelity 	<p># of project milestones completed on time</p> <p>Quality of deliverables (training, coaching sessions, written materials etc.) rated against expected criteria. For example, data collection tools and management system will be assessed against usability, feasibility, cost, acceptance by hub partners, and cultural safety.</p>	<p>Beginning of Exploration stage</p>	<p>Adherence to milestones throughout project</p>	<p>Project management system</p>	<p>Reports from project management system</p>	<p>Ongoing. Annual reports</p>	<p>Project manager</p>
<p>Evaluation</p> <ul style="list-style-type: none"> Reports summarizing service outputs, program fidelity and client outcomes. Statistical analyses of program results, comparing costs and outcomes between program models, pre- and post-intervention, pre- and post-fidelity implementation, and contribution analysis of core program components, disaggregated using GBA+ analysis. 	<p># project milestones achieved on time</p> <p>Quality ratings of each deliverable. Each report will be scored based on compliance with GBA+ analysis and a comparison of the expected functionality or content with the deliverable. Each major deliverable, including evaluation plan, final report and data systems, will be described in the initial workplan in a format that can be converted to a quality review checklist.</p>	<p>Beginning of Exploration stage</p>	<p>Adherence to milestones throughout project</p>	<p>Project management system</p>	<p>Reports from project management system</p>	<p>See workplan for reporting dates</p>	<p>Project manager</p> <p>Evaluators will recommend quality checklists for each deliverable – including blueprints – to be approved by advisory group.</p> <p>Project manager will rate</p>
<ul style="list-style-type: none"> Statistical analyses of program results, comparing costs and outcomes between program models, pre- and post-intervention, pre- and post-fidelity implementation, and contribution analysis of core program components, disaggregated using GBA+ analysis. 	<p>Quality ratings of each deliverable. Each report will be scored based on compliance with GBA+ analysis and a comparison of the expected functionality or content with the deliverable. Each major deliverable, including evaluation plan, final report and data systems, will be described in the initial workplan in a format that can be converted to a quality review checklist.</p>	<p>At first deliverable (workplan)</p>	<p>High ratings throughout project</p>	<p>Reports submitted by implementation team</p>	<p>Review of each deliverable with a scoring checklist based on defined objectives</p>	<p>At submission of each deliverable</p>	<p>Evaluators will recommend quality checklists for each deliverable – including blueprints – to be approved by advisory group.</p> <p>Project manager will rate</p>

<ul style="list-style-type: none"> Final report summarizing level of evidence for the efficacy of program models and recommendations for adoption and adaptation. 							<p>deliverables with a review team to ensure oversight (e.g., reports delivered by the PM will be rated by someone else)</p>
<p>Blueprints</p> <ul style="list-style-type: none"> One or more program blueprints Submission of blueprint(s) to WAGE for translation to French and dissemination 	<p>Rating of Blueprints will be done using criteria provided by WAGE</p>				<p>Review with a scoring checklist based on WAGE criteria</p>	<p>On development of draft and final blueprints</p>	